Department of Health Care Access and Information
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Health Care Affordability Board
October 24, 2023
Public Comment

The following table reflects written public comments that were sent to the Office of Health Care Affordability email inbox.

Date	Name	Written Comment
November 20, 2023	Jennifer Robles on behalf of Health Access California	See Attachment #1.
December 13, 2023	Ben Johnson on behalf of California Hospital Association	See Attachment #2.

Attachment #1

HEALTH ACCESS CALIFORNIA

November 20, 2023,

Mark Ghaly, M.D., Chair
Health Care Affordability Board
Secretary, California Health and Human Services Agency

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

2020 W. El Camino
Sacramento, CA

Re: October 24, 2023, Board Meeting

Dear Chair Ghaly, Director Landsberg and Deputy Director Pegany:

Health Access California, the statewide health care consumer advocacy coalition committed to quality, affordable health care, offers comments on the October 24, 2023, Health Care Affordability Board meeting presentation and related work.

Consumer Affordability: The Mission of The Health Care Affordability Board and the Office of Health Care Affordability

Health Access supports the staff recommendation on keeping health care cost growth to less than 5% a year as well as basing the statewide cost growth target on growth in median income. This approach places consumer affordability at the center of this work. Additionally, as a core basis of its mission, we urge that the Office tracks consumer affordability, including premiums as a share of income, cost sharing, medical debt and other financial consequences of lack of affordability.

The mission of the Office of Health Care Affordability, and the Health Care Affordability Board, is to lower cost growth and improve the affordability of care and coverage for consumers, working families, and purchasers while improving quality, access, outcomes and equity. The eight articles of the enabling statute are designed to work together to accomplish the triple aim of lower cost growth, improved quality and greater equity. The lack of affordability of both care and coverage for California consumers is the reason the Office exists.

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Lack of Consumer Affordability of Care and Coverage

The worst consequences of the lack of consumer affordability fall on those who can afford it the least and those who need care the most, either because of illness or the social determinants of health. The lack of affordability for consumers and working families hinders access to care, increases the likelihood of being uninsured, and exposes low- and middle-income consumers to delayed or skipped care, medical debt and other negative financial consequences.

At the October 2023 meeting, the Board heard from Californians living with multiple sclerosis, needing drugs that cost $90,000-$100,000 a year along with lab tests and doctor visits as well as medically necessary durable medical equipment not covered by commercial coverage. Any consumer who knows the amount of their annual out of pocket maximum is a consumer with very serious health care needs. Even a middle-income family living on $100,000 or $150,000 a year is likely to face serious financial strain when faced with medical costs of $5,000 or $10,000 a year, on top of all the other costs California families face to pay for basic needs from housing to food to utilities and needs like retirement and the kids' education. If an adult cannot work due to disability, that further impoverishes the family.

Any discussion of consumer affordability must be grounded in the reality that 60% of Californians make less than $83,200 per year and 80% make less than $151,100 per year. Those fortunate few who live on family incomes higher than $150,000 a year are less than 20% of California's population[1].

No Other Wealthy County Has a Dominant Form of Coverage that Inflicts the Most Costs on Those who Can Afford Costs the Least and Those who Need Care the Most

The reality is that no other wealthy country has a universal coverage system where the dominant form of coverage inflicts the most costs on those who can afford it the least and those who need care the most. As a recent study is aptly titled: "Paying for It: Costs and Debt Making Americans Sicker and Poorer[2]." Any analysis that points to the experience of other countries must be prepared to address what every other wealthy nation has already addressed: the regressivity of employer-sponsored insurance and the utter lack of affordability for those in the bottom three quarters of the income distribution.

Costs in US and California Three or Four Times as High as Other Wealthy Nations

Any discussion of health care costs across wealthy nations should be taken in the context of the high base of costs in this country and this state as well as the worse results in terms of health outcomes and lack of consumer affordability. At the March 2023 initial meeting of the Board, the staff presentation, citing a recent Commonwealth Fund study, pointed out that the United States spends three to four times more on health care than other wealthy nations with the U.S. spending over $12,000 per capita while other wealthy nations spend $4,000-$5,000[3]. High health care costs in the U.S. do not result in better care, better outcomes or greater equity. The

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opposite is true: this country has worse health outcomes, lack of affordability of care and coverage, medical debt and all of it worse for communities of color.

Mission of the Office of Health Care *Affordability*

The point of an office of health care *affordability* is to begin to address the negative impacts of high health care costs by slowing the rate of growth in those costs while improving care, outcomes and equity. In the October 2023 Board presentation, staff recommended that health care cost growth in California be constrained to less than 5% annually and the cost growth target should be based on median income, relying on historical data smoothed over a number of years to address volatility. In light of the mission of OHCA and the lack of affordability for consumers and other purchasers, Health Access supports both these recommendations. Excusing a rate of growth based on comparisons to other countries that protect affordability for consumers with a far lower base of costs fails to take account of the reality of US and California as high-cost outliers.

Health Access strongly recommends: Tracking consumer affordability, or lack of it, in terms of:

- Premium or share of premium as a percent of income by quintile or decile.
- Cost sharing, including copays, deductibles, cost sharing and other measures such as actuarial value, again as a percentage of income by quintile or decile.
- Financial and health impacts of lack of affordability, including medical debt, care delayed or skipped, and other measures of collateral damage.

Health Access also supports the staff recommendation:

- Supporting the staff recommendation that health care cost growth slow to less than 5% per year
- Basing cost growth on median wages or median income

Multi-Year Targets, No Further Phase in of Targets

Multi-year targets provide predictability, mitigating lag times in data reporting and allowing time for system change. Health Access recommends that the initial target be set with a five-year time horizon with annual "check-ups" to assess changes in the health care market as well as to allow for extraordinary circumstances such as a global pandemic or the introduction of a high-cost drug such as Sovaldi.

In the future, three-year targets should be the goal to assure progress and allow for assessment of the impact of targets by entity and region.

Conversely, Health Access sees no need for a phase-in of targets beyond that which is already built into the law. OHCA was created in 2022 after almost five years of negotiation, legislative action, and Governor's budget proposals. The first target year is 2025 and the first enforcement year is not until 2026 with action not until 2027. Enforcement occurs in "progressive" stages,

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each of which will take months or even years, allowing health care entities considerable time to come into compliance.

Adding another five years to the statutory phase in would mean a full decade of inaction before consumers and purchasers benefit from slower cost growth. Should costs double again before OHCA acts? A further delay would send the wrong signal to consumers, purchasers and the health care industry itself. As enacted, the statute does not permit a reduction in health care costs: the law defines the cost target as a "cost *growth* target," eliminating the possibility of actual cost savings. To our profound regret, this injury to consumers is built into the law, leaving us with only the hope that the lack of affordability will not get worse. Adding a five-year delay would add injury to injury.

Health Access recommends:

- An initial five-year target with annual check-ups
- Moving to three-year targets as the Office moves to multiple targets
- No additional phase-in of targets beyond the years-long delay already built into the statute

Population Indicators: Is the Risk Worth the Effort?

In reviewing the staff presentation as well as some of the underlying studies and related work, it is our considered view that there may be less to the impact of population indicators than meets the eye. At the macro level of a statewide target, many of the adjustments contemplated would create opportunities for upcoding and abuse as well as requiring considerable further analytic effort to refine. We ask whether the risk is worth the effort. In this section, we elucidate further and offer recommendations.

Aging

The presentation uses data from the California Department of Finance which reflects the reality that the very large baby boom cohort, born 1946 to 1964 is now largely over age 65. What the slide omits is that almost everyone over age 65 is on Medicare, a program that is largely beyond the reach of OHCA[4]. As detailed by CBO, most of the costs associated with aging are borne by Medicare and Medicaid: long term care is primarily a Medicaid cost. Long term care spending in commercial coverage is vanishingly small. Because the models are based on data that does not appear to take market segment into account[5], we are skeptical about the estimates. The impact of aging on a target adjustment is very small, except with respect to Medicare, a program that California does not operate or control, as well as Medi-Cal, a joint state-federal responsibility.

Disability

What is true of the estimated adjustments for aging is even more true for the estimated adjustments for disability. Disability status along with disability related health expenditures vary

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sharply by market segment: persons who are sufficiently disabled to be unable to work are disproportionately likely to be covered by Medi-Cal, Medicare, or both, and disproportionately less likely to be covered by employer coverage or individual market coverage. Even those with commercial coverage often have secondary coverage through Medi-Cal, Medi-Cal or both to cover benefits and services not covered by commercial coverage such as durable medical equipment or serious mental disorders.

The studies on which this analysis relies are national studies that rely on self-reported disability status and largely predate the ACA expansions. In reviewing them, we unearthed a state-specific study that found that 70% of disability-related health expenditures in California are paid by Medicare, Medicaid or both.[6] The adjustments should be corrected to reflect the reality of the impact of disability on market segments. This will significantly reduce the likelihood and magnitude of any target adjustment for the commercial market and somewhat increase it for Medicare and Medi-Cal.

Chronic Illness

Staff notes that chronic illness is correlated with aging and disability status, creating substantial multi-collinearity that would complicate any analysis. Staff also notes that the analyses they have found to date are not disaggregated by market.

Upcoding is a particular peril with respect to chronic illness. While some chronic conditions have objective measures, even preventive cancer screenings have been the subject of debate for decades because of the risk of unnecessary care and false positives with all the attendant worry for real consumers. Other conditions such as arthritis, asthma, and depression may be even more subject to upcoding: is someone asthmatic because they had pediatric asthma that has not recurred? From the perspective of underwriters pre-ACA, the answer was yes but is that the clinical reality is less clear. What about arthritis? Pain is notoriously subjective, however crippling the reality may be. Federal investigations into Medicare Advantage fraud confirm that diagnosis upcoding occurs. Again, the perverse financial incentives that lead to upcoding are a considerable concern in basing adjustment on chronic illness diagnosis.

Health Access recommends:

- If the use of population indicators is contemplated, far more detailed analysis that reflects market segments as well as perverse incentives for upcoding be analyzed and considered prior to implementation.
- Until such analysis is available, do not adjust targets based on population indicators. This follows the lead of other states, none of which use population indicators and most of which have moved away from clinical risk adjustment.

Adjustments to the Spending Target?

A series of policy decisions are embedded in the question about whether to adjust the spending target:

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- Is an adjustment industry-wide or entity-specific? Both? Neither?
- Does it occur annually or on an ad hoc basis?
- Is it prospective or post-hoc?
- Do the Board and staff adopt standards for adjustments, exemptions or exceptions?

The slide discussing the experience of other states can be summed up as an approach of "we'll know it when we see it" rather than relying on rigid, prospective criteria. Health Access recommends that the Board and the Office establish a clear, transparent, and standardized process by which target adjustments may be raised and considered to avoid abuse of this new system of accountability. Just as with clinical risk adjustment and the impact of aging or disability, further examination may illuminate the frailty of the policy case for a suggested adjustment. In our view, adjustments be generally governed by standards or guidelines as well as the flexibility to respond whether it is a once-in-a-century pandemic or a very particular health institution such as Rancho Los Amigos Rehabilitation Hospital in Downey that unquestionably serves those most in need[7].

The Law

The enabling statute requires consideration of possible adjustments and provides an "including but not limited to" list of potential adjustments such as emerging diseases and technology without requiring adjustment for any of them[8]. The obligation to consider possible adjustments to the methodology is an obligation on the Office, not the Board.

The law also allows for adjustments necessary to maximize federal financial participation in the Medi-Cal program. The law further requires adjustments for collective bargaining agreements, which are legally binding agreements governing wages and benefits of health care workers. For entities without such legally binding agreements, adjustments for labor costs should be based on documented labor costs rather than prospective labor costs.

Proposed Guidelines or Standards

Some of these will emerge as OHCA, both the Board and the staff, does the work of implementation. A few principles seem in order:

- Exceptions should be rare, and an exception should not swallow the rule. Exceptions should not make the spending target meaningless.
- Adjustments and exceptions, and the grounds for either, should be public and subject to discussion and subsequent review.
    - The frequency of review should depend on the nature of the adjustment:
        - In some cases, an adjustment should be in place for a year or two until circumstances change (competitors to Sovaldi emerged, the pandemic abated with vaccines changing the impact).
        - In other cases, such as the Rancho Los Amigos example, review would be triggered if the role of the facility changed.

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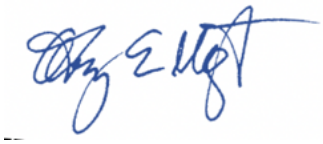
- The grounds for the adjustment or exception should be publicly known and discussed in a public forum so that those seeking the dispensation must publicly justify the request to those who pay the bills, that is, consumers and other purchasers. The basis for the justification must be subject to public scrutiny, not private manipulation.

- Regional-level adjustments should be considered to force slower rates of growth in regions that are above state-average costs, especially without higher health care worker wages or better outcomes. If consumers and other purchasers are forced to pay more to get care, they should get more.
- Entity-specific adjustments should be regarded with particular skepticism and subject to independent analysis of any assertions made by the particular entity.

We look forward to further discussion of adjustments. We will evaluate proposed adjustments against the evidence presented of the need for them and the degree to which such evidence is publicly available and can be independently validated. Also, as the discussion of aging, disability and chronic illness indicates, the possibility of upcoding and the differential impacts by market segment as well as the sheer scale of the adjustment are important considerations as well.

We appreciate your consideration of these comments. Please contact us with any questions.

Sincerely,



Beth Capell, Ph.D.
Policy Consultant

Anthony Wright
Executive Director

cc: Members of Health Care Affordability Board
Assemblymember Wood, DDS, Chair, Assembly Health Committee
Senator Eggman, LCSW, Chair, Senate Health Committee
Assemblymember Weber, M.D., Chair, Assembly Budget Subcommittee #1
Senator Menjivar, Chair, Senate Budget Subcommittee #3
Mary Watanabe, Director, Department of Managed Health Care

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Attachment #2

California Hospital Association

December 13, 2023

Mark Ghaly, MD
Chair, Health Care Affordability Board
1215 O St.
Sacramento, CA 95814

Subject: **CHA Comments on the October 24, 2023 Health Care Affordability Board Meeting and November 30, 2023 Health Care Advisory Committee Meeting**
(Submitted via Email to Megan Brubaker)

Dear Dr. Ghaly:

On behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) thanks the Office of Health Care Affordability (OHCA) for the opportunity to comment on the October Health Care Affordability Board and the November Health Care Advisory Committee meetings. In this letter, we reiterate our comments on OHCA's proposed data collection regulations and provide a number of critical considerations as OHCA progresses toward setting California's first spending targets.

CHA Supports Collecting Data from Payers, With Some Major Concerns

In our December 1 comment letter on the draft regulations, we expressed support for the proposed approach of collecting Total Health Care Expenditure (THCE) data from health plans and insurers for enrolled and insured state residents. Health plans and insurers are better positioned than providers to comprehensively identify and report THCE, reducing the complexity of the data collection process and avoiding serious data commensurability and quality issues.

While we support OHCA's overall approach to data collection, we have a number of concerns with the proposed regulations and supplementary guidance. Our most fundamental concerns relate to the absence of a process for validating the expenditures attributed to providers and rules for how health plans and insurers must perform this attribution. Without such a process, we fear reported THCE data will lack the transparency, validity, and standardization necessary to support OHCA's mission.

Additionally, we remain concerned with the decision against using clinical risk adjustment, as reflected in there being no mechanism for gathering clinical risk information in the proposed

regulations. Failing to include clinical risk adjustment could unduly punish providers who serve particularly vulnerable populations, producing a dangerous financial incentive. Moreover, without proper clinical data to accompany THCE reports, policymakers and stakeholders will find it difficult to evaluate the extent of such effects and the impacts of changes in patient acuity on entities' spending growth.

Finally, we have questions and concerns with the lack of specificity around how stakeholders will be consulted when changes to the data collection regulations and guidance are being made, how these data will be supplemented and merged with statutorily required data from other sources, and several other technical issues. We look forward to working with OHCA, the board, and advisory committee to improve these critical issues before the draft regulations are finalized.

Understanding of Cost Drivers Is a Prerequisite for Setting an Appropriate Spending Target

Despite its significant progress toward the setting of spending targets — and the tight calendar for making related decisions – OHCA has only conducted cursory public discussions of the underlying drivers of health care costs and their growth. This is concerning given that setting an appropriate spending target that avoids serious negative consequences depends on a clear understanding of these drivers. Below are some of the drivers that OHCA must recognize and incorporate into its thinking in setting an attainable spending target.

Why Does the U.S. Look Worse in Cost Efficiency Compared to Peer Countries? The U.S. as a whole, and California specifically, performs worse than other countries on raw measures of how much we spend on health care and the outcomes achieved with that spending. However, a deeper analysis of the reasons for the U.S.'s comparatively bad performance reveal how poorly calibrated spending targets could, despite achieving lower spending, ultimately harm patient care.

- **Poor Outcomes.** High-level indicators such as mortality, morbidity, and even avoidable deaths would seem to indicate that the U.S. health care system performs poorly compared to peer countries in treating patients. However, differences in underlying risk factors and the social determinants of health explain a significant portion of this discrepancy. For example, American obesity rates are 37% versus an average of 25% in 11 peer countries.[1] Similarly, the U.S. has a diabetes prevalence rate of nearly 11%, whereas its peer countries have an average rate of less than 6%.[2] The same is true for serious mental illness – for example, the prevalence of schizophrenia is over 40% higher in the U.S. than the other 11 peer countries.[3] Add in the effects of higher rates of death in the U.S. due to car accidents, shootings (including suicides), and drug overdoses, which

[1] CHA calculations based on 2016 data from the World Health Organization, obtained from https://ourworldindata.org/obesity.
[2] CHA calculations based on 2021 data from the International Diabetes Federation, obtained from https://diabetesatlas.org/data/en/indicators/2/
[3] CHA calculations based on 2019 data from IHME, Global Burden of Disease (2020), obtained from https://ourworldindata.org/grapher/schizophrenia-prevalence

collectively explain between 30% and 50% of the difference in life expectancy between the U.S. and certain peer countries,[4] and the picture of a grossly ineffective health care system is muddied.

- **High Costs.** In addition to explaining the U.S.'s poor performance on health outcome measures, the higher risk factors present in the U.S. population help to explain its higher costs. Per the Centers for Disease Control and Prevention (CDC), 90% of U.S. health care expenditures are for individuals with chronic disease (roughly 50% of the U.S. population), implying that individuals with chronic diseases have costs as high as 9 times of those of other individuals. With such an enormous discrepancy in per capita costs, a 1 percentage point increase in the share of the population with chronic diseases leads to 1.6% higher per capita costs overall. This shows that even small differences in risk factors between countries leads to large differences in health care spending. In addition to different levels of need for health care, the U.S. has higher costs due to a number of structural factors, including:
    - **High Health Care Labor Costs.** Health care labor costs are significantly influenced by physician and nursing salaries. U.S. physicians earn 70% more than those in a subset of peer countries for which data is available (Canada, France, Germany, Japan, Switzerland, and the United Kingdom). Similarly, hospital nurses' salaries are around 50% higher in the U.S. than peer countries, with California's nurses' salaries (for the profession as a whole) being nearly 40% higher than the national average *after accounting for differences in cost of living*. [5]
    - **High Pharmaceutical Prices.** The U.S. is an outlier in the prices its residents pay for pharmaceuticals, paying roughly 150% more for drugs than peer countries. Research from the Journal of the American Medical Association reveals that pricing failures in this area produce $170 billion in waste in health care expenditures in the U.S., reflecting over 4% of total U.S. spending on health care.[6]
    - **Care Coordination Failures and Failures to Provide Preventive Care.** California's health care system regularly fails to provide adequate access to preventive care and coordinate care more generally — causing more care than is necessary in acute care settings. Here, hospitals are bearing the consequences of these upstream failures. At the front end, hospitals treat thousands of patients per year in emergency departments whose visits could have been avoided through timely primary and behavioral health care, such as is available in peer countries. At the back end, hospitals are forced to delay the discharge of hundreds of thousands of

[4] Fenelon A, Chen L, Baker SP. Major Causes of Injury Death and the Life Expectancy Gap Between the United States and Other High-Income Countries. *JAMA.* 2016;315(6):609–611. doi:10.1001/jama.2015.15564
[5] International data is from the OECD on the remuneration of health professions. California versus national comparison is from the Bureau of Labor Statistics Occupational and Employment and Wage Statistics, adjusted for cost of living using the Bureau of Economic Analysis's regional price parity estimates.
[6] Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. *JAMA.* 2019;322(15):1501–1509. doi:10.1001/jama.2019.13978

patients per year due to failures among health plans and insurers to effectively coordinate transitions to lower levels of care. Using member survey data, we recently estimated that discharge delays result in 1 million medically unnecessary hospital inpatient days (and 7.5 million unnecessary emergency department boarding hours) annually, at an estimated cost of $3.25 billion. (Average length of hospital stay is one measure where the U.S.'s performance is in line with peer countries.)

- **Administrative Inefficiencies.** The existing patchwork of payer policies related to utilization management, payment, and reporting rules introduces enormous inefficiencies into the U.S. health care system. More troublingly, it takes time away from providing patient care. The CBO recently estimated the provider administrative savings that could be realized from a harmonization of payer administrative policies (in this case through the adoption of a single-payer program, present in certain of our peer countries). In effect, the cost of the administrative inefficiencies that they identify would translate into $10 billion to $20 billion in annual savings in California alone and reflects another factor behind the U.S.'s flagging performance in terms of cost effectiveness.

The above findings clearly show that OHCA's task of reducing health care spending growth without negatively impacting access to quality health care will be challenging and must proceed with appropriate caution. OHCA does not have an obvious ability to reduce labor costs given existing workforce challenges and state policies like nurse staffing ratios and a new health care worker minimum wage law. OHCA lacks authority to regulate spending on pharmaceuticals. While OHCA may encourage greater investment and performance in the areas of preventive care and care coordination, whether and how long it will take to realize these improvements is highly uncertain. Finally, OHCA does not have authority to require payers to standardize and streamline their utilization management and payment rules. Without improvements in these areas, health care entities would have to look elsewhere for savings, including areas with potential negative implications for quality, access, and equity.

Critical That OHCA Set an Attainable Spending Target

Spending Targets Must Strike a Balance Between Promoting Affordability and Access to a High-Quality, Equitable Health Care System. While promoting affordability is undoubtedly a principal objective of the spending target, it is not the only goal. Rather, state law clearly prescribes the consideration of other objectives in the setting of spending targets. Specifically, statute requires that the spending targets:

> "Promote the goal of improved affordability for consumers and purchasers of health care, *while maintaining quality and equitable care*, including consideration of the impact on persons with disabilities and chronic illness." *(emphasis added)*

To date, the issues presented to the board have narrowly focused on one of these multiple objectives, neglecting to consider whether spending targets at the levels being contemplated

would properly promote quality and equity, including for vulnerable populations. Below, we demonstrate why spending targets set at low levels would be incompatible with the letter and intent of state law, as well as why other aspects of the methodologies being considered lack justification.

A Target Exclusively Based on Median Family Income Would Be Unsustainably Low. A spending target based on measures of average or median income or wage growth is intended to limit health care spending growth to what individual families can afford. We understand the intuitive appeal of this approach, as shared by some members of the board and advisory committee. However, a deeper look at these measures reveals that they are inconsistent with the underlying realities of supporting even a highly cost-effective health care system.

Household Consumption Patterns Do Not Remain Fixed Over Time. Labor market, technological, and demographic trends cause different sectors of the economy to grow at different rates. Neglecting to recognize this by tying health care expenditure growth to economic indicators unrelated to the underlying drivers of health care cost growth could lead to harmful underinvestment in the sector. It is critical to understand that households' and society's consumption patterns change over time as incomes grow, technologies evolve, and labor market dynamics shift. Today, households may spend significantly less of their income on goods subject to significant cost-saving innovation (e.g., televisions). Alternatively, they may shift expenditures toward certain goods and services as their incomes increase. For example, while Americans' incomes have grown in the aggregate by 175% since 2000, their spending on restaurant meals has increased by over 300%, spending on hotels and other accommodations increased by nearly 225%, and spending on internet access increased by over 700%.

Two major patterns help explain which types of expenditures are likely to grow faster than income. First, industries that are labor intensive tend to grow relatively more expensive over time, as they do not benefit as much from cost-saving automation as do more capital-intensive industries. Labor is a major input in the health care sector (as it is for restaurants and hotels), partially explaining the relatively higher cost growth in the sector. Second, industries that introduce major new products through technological innovation also tend to grow more rapidly than industries focused on refining and improving existing products. Health care is a dynamic sector that regularly introduces revolutionary new and often expensive treatments that are then quickly adopted, a dynamic similar to the widespread adoption of internet access since 2000. Neither of these underlying forces can – or in the case of life-saving and -improving technologies, should – be overcome by OHCA regulations.

No Peer Countries Achieve Health Care Spending Growth at the Levels Being Considered for a Target. State statute and basic policy prerogatives require OHCA and the board to consider the sustainability of the spending targets. In this light, we ask OHCA to consider whether peer countries, including several that are often used as models for what the U.S. health care system should look like, achieve spending growth levels comparable to what OHCA is considering. *The answer to this question is a clear no.* Between 2000 and 2019, 11 peer countries including Australia, Canada, Sweden, and the United Kingdom averaged 6.3% in annual per capita health

care expenditure growth, as compared to 3.1% average annual wage growth (similar to that in California, as well as to the state's median income growth).[7] These consistent trends among peer countries with diverse health care systems demonstrate that drivers other than health care policy – like labor market dynamics, technological evolution, population aging, and chronic disease prevalence – are behind the relatively high growth in health expenditures. Ultimately, this suggests that a target that is not reflective of the underlying drivers of health care cost growth, such as one solely based on average wages or income, would result in severe underinvestment in California's health care system and seriously undermine access to quality care.

Other States Have Set Spending Targets in Excess of GDP Growth. Spending target programs have been implemented in 8 other states. As a recent report from the California Health Care Foundation shows, 7 out of 8 of these states set spending targets in excess of prior years' GDP growth. Average GDP growth in the 8 states was 2.2% from 2016 to 2019, whereas their spending targets for 2021 through 2023 averaged 3.3%. Accordingly, California would be a major outlier if it set a target lower than recent years' GDP growth, which would be the case if it adopted an unadjusted target based on median family income growth.

Massachusetts' Experience Shows It Has an Unattainable Target. Massachusetts has 9 years of experience assessing statewide health care expenditure growth against its spending target, which is either 3.6% or 3.1% depending on the year. The result: missing the target 5 times out of 9, or 4 times out of 7 if you exclude the COVID-19 years. In the final two years before COVID-19, statewide spending exceeded the target by 16% (half a percentage point) and 32% (a full percentage point). This raises questions about whether Massachusetts has set a realistic spending target given the true divers of health care spending growth.

While Massachusetts does not release the names of health care entities that missed the target, assuming little to no skew in the distribution of individual entities' spending growth, the data imply that well over half of health care entities can be expected to have missed the target in any given year. As such, the spending target in Massachusetts fails to distinguish and identify outliers with unjustifiably high spending growth, instead casting uncertainty over the bulk of the health care industry around whether they will be a target of potentially arbitrary enforcement action unlike the bulk of their peers who similarly missed the target. With greater enforcement tools at its disposal, OHCA must, at the outset, establish an attainable target that will actually distinguish between spending-growth outliers and those that are in line with what broader economic, health, and demographic trends dictate.

Recent Elevated Inflation Levels Must Be Accounted for in Spending Targets. The last time inflation was as high as today was around 1990, over 30 years ago. According to state budget analysts, inflation levels are likely to persist over the next several years. Neglecting to

[7] Data obtained from the OECD.

incorporate these inflation expectations into California's target would leave the state's health care system unable to afford medical supplies, upgrades to its physical and technological infrastructure, and compete with other states and sectors for workers. Nearly all of the other 8 states with spending target programs set their targets before the rampant inflation that took off in 2021 following the onset of the COVID-19 pandemic. This makes other states' targets, if unadjusted for inflation, poor benchmarks for California's target. As described further below, this also creates problems for using older historical data as the basis of a California target based on an economic indicator, since this data similarly does not account for expected inflation over the next several years.

Furthermore, as was shared by Mr. Bailit, consultant to OHCA, medical inflation tends to lag inflation in the general economy by one-to-two years. This means that the inflation we currently are experiencing is likely to ripple through the health care sector in the first and second years of the spending target (2025 and 2026). This translates into a 1 percentage point to 2 percentage point increase in what an appropriate spending target would be, at least for the early years but also in the later years if current inflation levels persist.

A Spending Target Solely Based on Median Family Income Growth Would Not Accommodate Policy Changes Already in Effect. Policy changes at the federal, state, and local levels are among the largest drivers of changes in health care spending over time. For example, expenditures in the Medi-Cal program have more than doubled since the Patient Protection and Affordable Care Act implemented in 2024, kickstarting a swell of subsequent policy activity. This reflects an 8% annual rate of growth, in contrast to 3% annual growth in inflation over this period. Policymakers continue to approve financing and delivery system reforms that will significantly increase health care expenditures going forward.

Mandates affect health care entities' costs, while changes to state programs often affect entities' revenues. For example, we estimate that the new health care worker minimum wage law will raise health care industry-wide costs by more than $7 billion after several years at close to full implementation. While entities may receive some minimal funding from Medi-Cal and Medicare to cover these costs, to a significant degree they will have to look to commercial payers to recognize the higher cost of doing business. On the revenue side, for example, state policymakers are finally recognizing the longstanding shortfalls in Medi-Cal provider reimbursement and the resulting access challenges for low-income residents. Over the next few years, Medi-Cal provider payments are expected to increase by billions of dollars.

In the aggregate, the impact of these and other major changes in policy are anything but negligible. Looking at only the 10 top policy changes set for implementation over the next several years, we estimate that cost increases from mandates will average 1% ($5 billion) per year. The impact of changes in public programs on health care entities' revenues similarly will be around 1% per year. Failing to account for these and other impacts of federal, state, and local policy changes would punish health care entities for decisions outside of their control and impede their ability to sustain ongoing services.

Developing a Spending Target Based on Historical Data Raises Questions and Concerns. OHCA staff have stated a preference for using historical data rather than projections for setting a spending target based on economic indicators. The stated reason for this preference appears to be wariness of the influence of subjective judgments about what the future will hold when making projections. However, this perspective fails to account for the subjective judgments inherent in selecting an appropriate historical period to apply for a future-looking target. First, the length of the period utilized to set a target is hugely impactful, resulting in a 1.5 percentage point swing based on, for example, whether a 20- or a 10-year period were chosen. OHCA staff's potential preference for a 20-year historical average for setting the target happens to include the largest recession in a century. Why is a 20-year window appropriate? Does the 2002-to-2004 period – let alone the Great Recession period – reflect an appropriate forecast of what median income growth will look like in the future if the goal of adopting a target on this basis is to hold health care spending growth to the growth in families' incomes? Ultimately, using a historical average packages highly impactful subjective judgments into a simple but impossible to scrutinize decision on what period to use. By contrast, using projected data involves serious and transparent grappling with what the future will look like in light of underlying factors and trends. For this reason, we request that the board question OHCA staff's stated preference and continue to consider adopting a projection-based target.

Historical Period Selected by OHCA Ignores Most Recent Data. Perhaps more concerning than OHCA staff's preference for using historical as opposed to projected data for setting the spending target, OHCA is ignoring more recent data on median income growth that should inform the spending target. Specifically, the data OHCA has been using cuts off the 20-year average growth rate for median household income in 2021, despite 2022 data being available. This results in a 2 decimal point reduction in the average growth rate of this economic indicator. Why OHCA would ignore the most recent data is entirely unclear, particularly since the principles of forecasting generally recommend placing greater weight on the most recent trends. If OHCA does elect to use historical data, we recommend it use the most recently available data.

Adjustments to Account for Drivers of Health Care Spending Are Necessary. Adjustments to a target based on a single economic indicator are essential to ensure sustainability under the spending target and prevent harm to vulnerable populations that are protected under statute. Below are adjustments that OHCA should include in its spending target methodology.

- **Aging.** Older individuals have per capita health care expenditures that are 5-to-9 times those for younger people. California's population is projected to age significantly over the next decades. In the European Union, for example, aging alone is expected to increase the share of GDP spent on health care by 1.3 percentage points over the next 40 years.[8] If the health care system is going to accommodate their higher health care needs, an adjustment to the spending target to account for the aging of California's population is essential.

[8] Williams, Gemma A., et al. How Will Population Ageing Affect Health Expenditure Growth?, European Observatory on Health Systems and Policies, 2019, www.ncbi.nlm.nih.gov/books/NBK550603/

- **Health and Disability Characteristics.** Unfortunately, California's population is trending toward higher rates of chronic disease and disability. CDC data shows that individuals with chronic diseases have 5-to-9 times higher average health care expenditures than other people. Similarly large gaps hold for individuals with disabilities as well. To ensure the spending target does not harm these groups, as is required by statute, adjustments are necessary to support these vulnerable populations that rely on the health care system to survive and thrive. Such adjustments are all the more necessary given OHCA's reluctance to employ clinical risk adjustment.
- **Ramp-Down Period.** For the spending targets to be effective in promoting affordability without harming access, quality, and equity, health care entities will need to make new investments and make changes to their care processes to shift toward value-based care. Such changes will not bear fruit immediately. In fact, better management of chronic conditions often will require higher upfront expenditures, with savings only to be realized over the years or decades that follow. In recognition of the time it takes to improve care and outcomes, OHCA should aim for a reasonable transition period to lower spending growth by scheduling a gradual ramp-down to an appropriate long-term target. Failing to do so would result in health care entities scrambling to cut their spending growth in faster and easier ways, such as by reducing service lines, not providing high-cost yet high-value services, and taking steps to protect themselves against sharp shifts in the risk profiles of their members.
- **Policy Changes.** Federal, state, and local policy changes already adopted will add billions of dollars in new spending in health care. Such changes include, but are not limited to, the new health care minimum wage, Medi-Cal reimbursement increases from the managed care organization tax and the hospital quality assurance fee, and ongoing adjustments to Medi-Cal and Medicare payment rates to ensure reasonable access to health care for program beneficiaries. To avoid punishing health care entities for policy decisions made by government officials, the spending targets must be adjusted to account for the policies' financial impacts.
- **Inflation.** As described earlier, if OHCA fails to appropriately factor inflation into an economic indicator-based spending target, such as by using a historical period when inflation was largely at historic lows, the spending target methodology should incorporate an adjustment to account for elevated inflation levels persisting into the next several years. Failing to do so would result in an unattainable spending target, preventing health care entities making a good-faith effort to comply from being able to afford the workers and supplies needed to care for their patients. California Department of Finance forecasts general inflation in the state to be roughly 3% over the next several years, roughly a half percentage point higher than historical inflation over the past 20 years. Given that medical inflation lags general inflation, it will be critical to recognize the higher expected levels of medical inflation throughout the first several years of the spending targets.

Hospital Capacity and Its Workforce Would Have Been Severely Constricted If a Low Target Had Been in Place in the Last 10 Years

The 20-year average annual growth of median family income is roughly 3%. By contrast, health care expenditures in California and the U.S. as a whole have grown at around 5% per year. Accordingly, a target set at the median family income growth rate would reflect a 40% reduction in the health care expenditure growth. How such a drastic reduction in spending growth could be achieved without serious losses in access and quality is unclear and unfathomable. And yet, to date, the OHCA has not seriously grappled with this question.

Had hospitals been subject to such a target for the last 10 years, $32 billion would have been diverted away from patient care in the last year alone. With nearly 50% of hospital expenses going to labor (which equated to over $60 billion in 2022), hospitals would have had no choice but to freeze the growth in their workforces or wages and benefits. If pursued through hiring freezes, 89,000 high-paying, secure jobs never would have been created over the last decade. If done through lower wage and benefit growth, hospital workers' compensation could have only grown at about half the actual rate, creating challenges around recruitment and retention of an already scarce workforce.

Contrary to what may be believed, obtaining these savings in other areas of hospitals' balance sheets simply would not have been possible. Expenditures on the wages and benefits of hospital management represent a mere 10% of total labor expenses, meaning you could eliminate all hospital leadership, all nursing supervisors, and other management and barely scratch the service in obtaining the necessary savings to meet the spending targets.

Zooming in further reveals that the losses described above could not be covered by reducing hospital margins and executive pay, unlike some allege. Operating margins for hospitals average between 3% and 4%. As of 2022, the hospital field as a whole had net income of just $1.4 billion despite total operating revenue of $135 billion. Executive pay similarly is not a meaningful driver of hospital expenses, typically representing a negligible proportion of total hospital expenditures and lower than other industries.

Hospitals' major other expenses are supplies and drugs, purchased services like food services, payments covering physicians' professional fees, and facility maintenance and improvements (including to comply with the state's seismic safety laws). It is unclear how hospitals could have cut these expenses without directly reducing their overall service levels, including through service-line closures, reducing capacity in their already overwhelmed emergency departments, and eliminating hospital beds. Patients would have suffered, waiting longer and traveling farther for life-saving emergency care and labor and delivery services, and hospitals' capacity to meet the intense needs brought about by the COVID-19 pandemic would have been in serious jeopardy.

Incorporate Measurement of Health Care System Performance Now

State law requires the state's spending targets to be established in a manner that maintains quality and equity. While OHCA has a plan for establishing the spending targets before the

summer 2025, it has yet to incorporate considerations of quality and equity into the target setting process. This is problematic insofar as OHCA is determining how much the state and its residents should spend on health care before deliberating over what we want our health care system to achieve. We therefore ask the office to accelerate its consideration of how quality, equity, and value more broadly are to be maintained and improved in conjunction with the imposition of spending targets.

Conclusion

Thank you for the opportunity to comment on the October Health Care Affordability Board and November Health Care Affordability Advisory Committee meetings.

Sincerely,

Ben Johnson
Vice President, Policy

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