2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

**Public Comments Submitted Regarding OHCA Proposed Spending Target**

**Part 1**

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**From:** on behalf of Aaron Stroh
**To:** HCAI OHCA
**Subject:** Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
**Date:** Monday, February 12, 2024 1:32:43 PM

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Dear Office of Health Care Affordability Board,

Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Type text here

Sincerely,
Mr. Aaron Stroh
6137 Wasson Ln  Sacramento, CA 95841-2059

# American College of Obstetricians and Gynecologists

## District IX

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409 12th St SW
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DIRECT: (202) 863-2564
MAIN: (800) 673-8444
EMAIL: cmccormick@acog.org

March 11, 2024

Secretary Mark Ghaly, M.D.
Chair, Health Care Affordability Board
Department of Health Care Access and Information
202 West El Camino, Suite 800
Sacramento, CA 95833

**Re: Proposed Statewide Health Care Spending Target - Opposition to Current Recommendation**

Dear Secretary Ghaly and Members of the Health Care Affordability Board:

On behalf of the American College of OB/GYN's District IX (ACOG), I am providing comments regarding the Office of Health Care Affordability (OHCA) staff recommendation of an annual 3% statewide health care spending growth target for 2025-2029.

This staff recommendation is based on the single economic indicator of the median household income growth from 2002 – 2022, which is unrelated to the increasing cost of practicing medicine. Adopting a 3% health care spending growth target, which most physician practices and health care entities will be unable to meet, will negatively impact access to health care for Californians, particularly for communities that have historically lacked equitable access to quality health care. <u>ACOG joins its physician colleagues to urge the Health Care Affordability Board (Board) to take the time to explore alternatives to the unrealistic staff proposal before casting the most important vote you are charged with making.</u>

***The Cost of Providing Health Care and Historical Health Care Spending Growth Should Be Factored into the Target***

In December 2023, the Centers for Medicare and Medicaid (CMS) projected that the increase in the Medicare Economic Index (MEI) – the cost to practice medicine - will be 4.6% in 2024. It is critical to consider, rather than ignore, the <u>cost</u> of providing health care when setting California's spending growth target. In the last ACOG survey of members, the majority of physician practices in this state were still worried about their financial health after the height of the pandemic was behind us. Setting a spending growth target that disregards the rate of inflation, increasing labor costs and those for necessities such as medical supplies and utilities is more likely to drive smaller practices to be acquired by larger, more costly health care systems than it is to save consumers money.

If the Board sets a target lower than the actual cost of providing health care, providers will be pressured to deliver less medically necessary health care. If

Californians cannot access care, patients, their employers and taxpayers will be paying for insurance coverage they cannot use. Affordability is only meaningful if there is access to care.

Moreover, if the state's spending growth target is unrelated to the cost of providing health care, it will be difficult to get buy-in from the health care entities subject to the cost targets to make changes that are within their power without coming at the expense of quality patient care.

Further, the average annual growth in per capita health care spending should be considered when setting a spending growth target. According to CMS for California, the 10-year average annual change in per capita health care spending from 2010-2020 was 4.7%, and the 20-year average annual change in per capita heath care spending from 2000-2020 was 5.4%. It is unfeasible to meet a 3% health care spending growth target considering that CMS estimates the cost to practice medicine in 2024 will grow by 4.6% and the average annual change in per capita health care spending was no less than 4.7% in the 20 years from 2000 – 2020.[1]

As has been mentioned by many witnesses testifying before you and by members of the OHCA Advisory Committee, the rate of household income growth is unrelated to the factors driving cost increases in health care. Additionally, the choice by OHCA staff to use the median household income over 20 years (with years that include the greatest recession since the 1920s) would result in a 3% target that is artificially low. If the Board continues down the questionable path of using median household income as the sole factor in determining the spending growth target, it would be more appropriate to look at the median income over the last ten years, which is 4.1%, and the current projection for median household income growth for 2026, which is 3.6%.

***Access to Care Needs to Be Considered Along with Affordability***

Health care affordability is a concept that does not and should not exist in a vacuum. SB 184, Chapter 47, Statutes of 2022 that created the Office of Health Care Affordability specifically names "Access, Quality and Equity of Care" among its goals. These three priorities coupled with affordability are the quadruple aim of the Office of Health Care Affordability. Currently, many Californians already have difficulty getting timely access to health care. Covered California's narrow provider networks were recently raised as a concern by an OHCA board member, followed by the statement from another Board member that those with large employer coverage are also having trouble getting timely appointments with specialists. A 3% target put in place for 5 years will undoubtedly result in longer wait times for most California patients.

***Health Care Growth Spending Targets in Other States***

The statements that have been made at your Board meetings that could lead one to believe that California is simply replicating what has worked in other states omit most of the relevant facts. We encourage you to look at the health care spending growth targets that were initially adopted in other states, what factors informed their decisions, and how those targets have been modified since initial adoption. <u>No other state has set its initial spending growth target as low as 3%</u>. For example, in 2013 in Massachusetts, the health care spending growth target was set at 3.6%, based on the state's estimated potential growth state product (PGSP). Then it was lowered to 3.1% in

[1] State Health Expenditure Accounts by State of Residence, 1991-2020, Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trendsand-reports/national-health-expenditure-data/state-residence.

2018 (PSPG -.5%), and then the target was increased to 3.6% in 2023.[2] PGSP is comprised of several economic factors, including the expected growth in national labor force productivity, state labor force, national inflation and state population growth. Delaware set its benchmark for 2019 to 3.8% via Executive Order. Oregon's benchmark was determined by the state's Sustainable Health Care Cost Growth Target Implementation Committee. It considered PSPG, wage and personal income growth and set its cost growth target at 3.4% for 2021–2025 with a planned reduction to 3.0% for 2026–2030. Connecticut set a 3.4% cost growth benchmark that is a blend of the growth in per capita PGSP and the forecasted growth in median income of state residents, with a recommended reduction to 3.2% for 2022 and 2.9% for 2023–2025. And as mentioned by OHCA's consultant at the February 2024 Board meeting, these other states set their targets before the current inflationary situation and there is little optimism about states meeting the targets set for 2023 and 2024.

Based on a review of five other state spending targets, it appears that California is contemplating setting an overly ambitious and unobtainable target at the outset, rather than where other states set their initial targets. As you begin your work with health care entities to attempt to meet spending growth targets, we urge you to consider the increasing cost of providing care. Your initial spending growth target should be one that health care entities can achieve without reducing access to quality care. Instead of starting at an unrealistic place, we suggest that the Board set the spending growth target for 2025 at a level that considers the increased costs of providing care and then you can lower the percentage over time. Additionally, given that the Board has currently only considered one option and California has no experience with this yet, we think that setting spending targets for five years is ill-advised.

***Consolidation Implications***

According to a 2019 California Health Care Foundation Report, prices for both inpatient and outpatient services increase when there is more market concentration or consolidation[3]. If the Board sets the health care growth spending target too low, high-cost outliers will continue to be just that – high-cost outliers, and smaller entities will give up and be swallowed up by larger, often more expensive systems. Setting the targets too low will drive the very consolidation that leads to increased health care costs that you hope to prevent.

***MCO Tax Should Be Considered***

A new Managed Care Organization (MCO) Tax was enacted in 2023 and will provide much needed rate increases for Medi-Cal providers for the first time in thirty years to increase access to care for the one in three Californians who are enrolled in Medi-Cal. The Coalition to Protect Access to Care worked with the Administration and the legislature to make this historic investment in the Medi-Cal system a reality. Over $1 billion annually of this spending will be new investment in primary care, aligned with the call in OHCA statute for increased investment in primary care. All of the new revenue from the MCO tax that will be invested in Medi-Cal and workforce expansion will help to increase access to care, particularly for low-income

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[2] Joel Ario, Kevin McAvey, and Amy Zhan, State Benchmarking Models: Promising Practices to Understand and Address Health Care Cost Growth, Manatt Health, June 2021.

[3] Richard Sheffler, Daniel Arnold, Brent Fulton, Health Care Prices and Market Consolidation in California, California Healthcare Foundation, October 2019. https://www.chcf.org/publication/the-skys-the-limit/#market-concentration

Californians. Failing to account for this critical new spending that will improve access to care for Californians when setting the spending growth target undermines all of the work we are collectively doing to improve patient care in the Medi-Cal system.

***Putting Cost Targets in Place for Five Years Before Any Data Available***

The proposal to keep a 3% target in place for five years is too long a timeframe for an initial spending target. California's lack of experience with collecting the data and calculating Total Health Care Expenditures for the state, let alone setting and maintaining a spending growth target, is among the arguments for setting targets that last for no more than two or three years. While predictability is important, it is critical that the Board gain information and employ some of the flexibility that was discussed during the Senate Rules Confirmation hearings and in your February Board meeting to adjust targets when appropriate. Sector-specific targets may be warranted, and if so, the Board should begin work on those for as early as 2026.

***Revise Proposal: Consider Economic Factors That Impact the Cost of Health Care Delivery***

ACOG respectfully asks the Board to reject the staff's recommendation of a 3% annual statewide health care spending growth target because it is both unrealistic and does not take into consideration critical factors such as the actual cost of providing health care such as labor costs, supply costs, medical equipment costs and inflation.

We urge the Board to set a cost target for 2025 that considers the economic realities of today, and the next 18 months, rather than reaching back to the Great Recession that lasted from 2007-2009 and including household income growth during that period to arrive at an artificially low spending growth target unrelated to costs today.

The Board's cost target should be set at a level that is attainable for most health care entities without patient care suffering as a result, rather than creating a situation where health care providers universally fail to meet the cost target and the state moves no closer toward achieving the goals that led to the creation of OHCA.

ACOG urges the Board to consider the spending target's impact on more than just the hope of affordability. This spending target will have real-life impacts on patient access and quality of care. It would be counterproductive to sacrifice quality and access to care.

We look forward to working with you on this and other critical issues before the Office of Health Care Affordability Board this year and beyond. For more information or questions, please contact Ryan spencer at (916) 396-9875 or rspencer@rgsca.com.

Sincerely,

Ryan Spencer
Legislative Advocate

cc: Elizabeth Landsberg, Director of the Department of Health Access and Information

| | |
|---|---|
| **From:** | [redacted] on behalf of AJ Cho |
| **To:** | HCAI OHCA |
| **Subject:** | Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations |
| **Date:** | Saturday, February 24, 2024 12:02:01 AM |

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Dear Office of Health Care Affordability Board,

Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Sincerely,
Mx AJ Cho

**From:** "A.L. Steiner"
**To:** HCAI OHCA
**Subject:** Health care costs too much, Trust me I know
**Date:** Friday, February 16, 2024 10:38:17 AM

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board Members,

My name is A.L. Steiner and I am writing to you today to share my health care story.

My health care costs me more than $500 per month.

Health care costs are too expensive and clearly unsustainable. While these costs continue to increase, everyday folks like me are forced to compromise our health, choosing between delaying care, skipping tests, or failing to fill prescriptions to save money. Slowing the growth of health care costs leaves more money for me, helping me to pay for other basic needs like food, rent, utilities, and additional living expenses.

I am respectfully urging you not to make any adjustments that would adversely affect or delay the implementation of health care affordability protections. Specifically, maintaining a 3 percent annual spending growth target for 2025 - 2029 that is based on the median income between 2002- 2022, rather than on the growth of the economy. All too often, consumers have been burdened by a health care system that does not prioritize the health and well-being of the patient. I am counting on the Office of Health Care Affordability to hold industry accountable and not put profits over the people who rely on the health care system to survive.

Thank you for your consideration.

Sincerely,
A.L. Steiner

United States

**From:** Alicia Freeman
**To:** HCAI OHCA
**Subject:** Health care costs too much, Trust me I know
**Date:** Wednesday, March 6, 2024 7:44:22 AM

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Dear Office of Health Care Affordability Board Members,

I am writing to you today to share my health care story.

My health care costs me more than 500.00 per month.

Health care costs are too expensive and clearly unsustainable. While these costs continue to increase, everyday folks like me are forced to compromise our health, choosing between delaying care, skipping tests, or failing to fill prescriptions to save money. Slowing the growth of health care costs leaves more money for me, helping me to pay for other basic needs like food, rent, utilities, and additional living expenses.

I am respectfully urging you not to make any adjustments that would adversely affect or delay the implementation of health care affordability protections. Specifically, maintaining a 3 percent annual spending growth target for 2025 - 2029 that is based on the median income between 2002- 2022, rather than on the growth of the economy. All too often, consumers have been burdened by a health care system that does not prioritize the health and well-being of the patient. I am counting on the Office of Health Care Affordability to hold industry accountable and not put profits over the people who rely on the health care system to survive.

Thank you for your consideration.

Sincerely,
Alicia Freeman

United States

**From:** Allan Rosson
**To:** HCAI OHCA
**Subject:** Health care costs too much, Trust me I know
**Date:** Friday, February 16, 2024 10:38:11 AM

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board Members,

My name is [Allan Rosson] and I am writing to you today to share my health care story.

My health care costs me more than $ ____700.00__ per month just for a simple Kaiser bronze plan.

In Dec 2023 I had to change my Kaiser Silver Plan to a Bronze plan because the cost increase of the silver plan was going to be over 800.00 per month for me alone! Since making that change, Kaiser has sent me premiums with an incorrect billing amount way in excess of the bronze plan price they quoted me and after numerous phone calls and a filed grievance, I have been unsuccessful in getting them to fix the problem. I have paid all my premiums on time but they recently sent a grace period notice threatening canceling my insurance.
I am self employed and make just enough that I don't qualify for the affordable care act. So I have fallen through the cracks. These costs are outrageous! Health Insurance is a racket!

Thank you for your consideration.

Sincerely,
Allan Rosson

United States

**From:** on behalf of Allison Rensch
**To:** HCAI OHCA
**Subject:** Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
**Date:** Monday, February 12, 2024 3:54:12 PM

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Dear Office of Health Care Affordability Board,

Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Sincerely,
Ms. Allison Rensch

**From:** on behalf of Almetrez Thomas
**To:** HCAI OHCA
**Subject:** Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
**Date:** Sunday, February 25, 2024 10:48:35 AM

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Dear Office of Health Care Affordability Board,

Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Sincerely,
Captain Almetrez Thomas

**From:** Ana Ramos
**To:** HCAI OHCA
**Subject:** Health care costs too much, Trust me I know
**Date:** Wednesday, February 21, 2024 12:04:16 PM

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Dear Office of Health Care Affordability Board Members,

My name is Ana Ramos and I am writing to you today to share my health care story.

My health care costs me more than $ _____1400_ per month.

Health care costs are too expensive and clearly unsustainable. While these costs continue to increase, everyday folks like me are forced to compromise our health, choosing between delaying care, skipping tests, or failing to fill prescriptions to save money. Slowing the growth of health care costs leaves more money for me, helping me to pay for other basic needs like food, rent, utilities, and additional living expenses.

I am respectfully urging you not to make any adjustments that would adversely affect or delay the implementation of health care affordability protections. Specifically, maintaining a 3 percent annual spending growth target for 2025 - 2029 that is based on the median income between 2002- 2022, rather than on the growth of the economy. All too often, consumers have been burdened by a health care system that does not prioritize the health and well-being of the patient. I am counting on the Office of Health Care Affordability to hold industry accountable and not put profits over the people who rely on the health care system to survive.

Thank you for your consideration.

Sincerely,
Ana Ramos
[redacted]

United States

**From:** Andrea Freeland
**To:** HCAI OHCA
**Subject:** Health care costs too much, Trust me I know
**Date:** Wednesday, February 28, 2024 3:31:02 AM

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Dear Office of Health Care Affordability Board Members,

I am writing to you today to share my health care story.

My health care costs me more than $800 per month.

Health care costs are too expensive and clearly unsustainable. While these costs continue to increase, everyday folks like me are forced to compromise our health, choosing between delaying care, skipping tests, or failing to fill prescriptions to save money. Slowing the growth of health care costs leaves more money for me, helping me to pay for other basic needs like food, rent, utilities, and additional living expenses.

I am respectfully urging you not to make any adjustments that would adversely affect or delay the implementation of health care affordability protections. Specifically, maintaining a 3 percent annual spending growth target for 2025 - 2029 that is based on the median income between 2002- 2022, rather than on the growth of the economy. All too often, consumers have been burdened by a health care system that does not prioritize the health and well-being of the patient. I am counting on the Office of Health Care Affordability to hold industry accountable and not put profits over the people who rely on the health care system to survive.

Thank you for your consideration.

Sincerely,
Andrea Freeland
[redacted]

United States

**From:** Andrea Kinloch
**To:** HCAI OHCA
**Subject:** Health care costs too much, Trust me I know
**Date:** Thursday, February 15, 2024 10:30:17 AM

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board Members,

My name is Andrea Kinloch and I am writing to you today to share my health care story.

My health care costs me more than $ _1,475_____ per month.

Health care costs are too expensive and clearly unsustainable. While these costs continue to increase, everyday folks like me are forced to compromise our health, choosing between delaying care, skipping tests, or failing to fill prescriptions to save money. Slowing the growth of health care costs leaves more money for me, helping me to pay for other basic needs like food, rent, utilities, and additional living expenses.

I am respectfully urging you not to make any adjustments that would adversely affect or delay the implementation of health care affordability protections. Specifically, maintaining a 3 percent annual spending growth target for 2025 - 2029 that is based on the median income between 2002- 2022, rather than on the growth of the economy. All too often, consumers have been burdened by a health care system that does not prioritize the health and well-being of the patient. I am counting on the Office of Health Care Affordability to hold industry accountable and not put profits over the people who rely on the health care system to survive.

Thank you for your consideration.

Sincerely,
Andrea Kinloch

United States

**From:** Andrew C. Lee
**To:** HCAI OHCA
**Cc:** sdiaz@cpehn.org
**Subject:** Support 3% spending target
**Date:** Tuesday, March 5, 2024 5:49:57 PM

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Dear OHCA Boardmembers,

I strongly support the recommendation by OHCA staff for a 3% cost growth spending target over five years. Three percent is the least we can do – it won't make healthcare more affordable but may keep it from becoming more unaffordable. It will reduce disparities in health outcomes.

SEARAC (Southeast Asia Resource Action Center) is a national civil rights group that convenes 15 Southeast Asian direct service organizations across CA on health equity issues. Our communities are less likely to be insured than the average Californian and face unique, often costly, health care needs due to our refugee backgrounds.

That is why we urge you to support the recommendation by OHCA staff for a 3% cost growth spending target TODAY!

Sincerely,

**Andrew C. Lee**
(*pronouns: he/they*)
Senior California Policy Manager
Southeast Asia Resource Action Center (SEARAC)

**From:** a[redacted] on behalf of Anita Youabian
**To:** HCAI OHCA
**Subject:** Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
**Date:** Monday, February 12, 2024 2:54:03 PM

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Dear Office of Health Care Affordability Board,

Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Sincerely,
ms Anita Youabian
[redacted]

**From:** Ann Anterasian
**To:** HCAI OHCA
**Subject:** Health care costs too much, Trust me I know
**Date:** Thursday, February 15, 2024 10:32:15 AM

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board Members,

My name is Ann and I am writing to you today to share my health care story.

My health care costs me more than $ 1800__ per month.

Health care costs are too expensive and clearly unsustainable. While these costs continue to increase, everyday folks like me are forced to compromise our health, choosing between delaying care, skipping tests, or failing to fill prescriptions to save money. Slowing the growth of health care costs leaves more money for me, helping me to pay for other basic needs like food, rent, utilities, and additional living expenses.

I am respectfully urging you not to make any adjustments that would adversely affect or delay the implementation of health care affordability protections. Specifically, maintaining a 3 percent annual spending growth target for 2025 - 2029 that is based on the median income between 2002- 2022, rather than on the growth of the economy. All too often, consumers have been burdened by a health care system that does not prioritize the health and well-being of the patient. I am counting on the Office of Health Care Affordability to hold industry accountable and not put profits over the people who rely on the health care system to survive.

Thank you for your consideration.

Sincerely,
Ann Anterasian

United States

**From:** Anna Heller
**To:** HCAI OHCA
**Subject:** Health care costs too much, Trust me I know
**Date:** Wednesday, February 28, 2024 3:32:37 AM

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Dear Office of Health Care Affordability Board Members,

I am writing to you today to share my health care story.

I currently pay $1900 a month to insured myself along with my husband and two children. We pay another $600 a month on average on top of our health insurance premiums in out of pocket medical bills and perscription costs. WHY? This is outrageous, when I already pay for supposedly good health insurance. I can barely afford the insurance let alone the extra costs.

Health care costs are too expensive and clearly unsustainable. While these costs continue to increase, everyday folks like me are forced to compromise our health, choosing between delaying care, skipping tests, or failing to fill prescriptions to save money. Slowing the growth of health care costs leaves more money for me, helping me to pay for other basic needs like food, rent, utilities, and additional living expenses.

I am counting on the Office of Health Care Affordability to hold industry accountable and not put profits over the people who rely on the health care system to survive.

Thank you for your consideration.

Sincerely,
Anna Heller
[redacted]

United States

Megan Brubaker
Engagement and Governance Manager
Office of Health Care Affordability
2020 West El Camino Ave. Suite 1200
Submitted via: OHCA@HCAI.CA.GOV.

March 11, 2024

Re: Adoption of Statewide Cost Target

America's Physician Groups is a national association representing more than 350 physician groups with approximately 170,000 physicians providing care to ninety million patients. APG's motto, 'Taking Responsibility for America's Health,' represents our members' commitment to clinically integrated, coordinated, value-based healthcare in which physician groups are accountable for the costs and quality of patient care.

We open this letter with a reminder that APG was one of the supporters of SB 184, and that its members have a 30-year history of taking responsibility for the cost of health care through their willing assumption of financial and utilization risk in partnership with fully insured and regulated payers.

**Using a Cost Target for a "Chilling Effect" on Provider Behavior:** APG strongly urges OHCA's Affordability Board members to consider the unintended consequence of adopting a 3% statewide cost target without sufficient advance research and solely for its impact on provider behavior as a tool for optics. Other stakeholders have raised the inherent problems with the rationale cited for the adoption of the 3% cost target, including the failure to address current cost drivers, future infrastructure financing needs and workforce aging. APG agrees with those arguments cited in the CHA and Kaiser Permanente submittals. Additionally, we have asked repeatedly in the OHCA public meetings how a 3% target will impact current capitated contract renewal rates, which are in the 4.8 – 5% range, according to DMHC data on health plan premium rate filings. To our knowledge, the OHCA staff have not undertaken an analysis to determine whether the adoption of a 3% statewide target will have a detrimental impact on sustainable capitation revenue for our risk bearing organization ("RBO") members. And yet, at the same time, OHCA has advanced a draft Alternative Payment Model Standards and Adoption Goal Recommendation, which calls for greater adoption of risk bearing payment models by payers. It seems counter-productive to pursue the later strategy if the adopted cost growth target would not support a sustainable basis for greater adoption of risk by providers. This is why APG recently joined with the California Association of Health Plans and the Association of California Life and Health Insurance Companies in a letter to Secretary Mark Ghaly to take the time necessary to fully evaluate the implications of cost target adoption.[i]

**Conflict with Knox Keene Sustainable Provider Payment Requirements:** The Knox Keene Act provisions for sustainable provider payment to risk bearing organizations (Health & Safety Code Sections 1375.4, 1375.5, 1375.6, 1375.7, and California Code of Regulations, Sections 1300.75.4.1, 1300.75.4.2, 1300.75.4.3) would conflict with the adoption of a cost target that imposes a requirement on payers to offer a capitated rate that is lower than financially feasible for a risk bearing organization to accept and remain financially solvent.

**Recognizing Unsustainable Coverage Models**: The imposition of growth caps is a rough approach to achieving the goals of affordability and quality. Changing the inputs to our health care system – by moving away from fragmented care delivery in disaggregated coverage plans will produce faster and more sustainable results. In a recent report submitted by the Integrated Healthcare Association the comparative performance of the two main systems for commercial coverage was highlighted, revealing that HMO plans with integrated delivery models generated a 3.12% cost increase over 5 years, while competing PPO plans with fragmented, fee-for-service based networks suffered cost increases of 9.93% during the same period.[ii] Isn't this sufficient data upon which to base an immediate and concerted effort to shift the majority of coverage in the California employer-sponsored market toward the model that generates the best results for total cost of care, lowest out of pocket consumer costs, and higher measure quality performance?

To put it another way, APG once asked the actuarial consulting firm Milliman to opine on the impact to the California commercial coverage market if there were no capitated-delegated provider model. Milliman's Chris Girod penned a blog that concluded:

> *Using the 2015 IHA data, if managed care plans (as represented by HMOs) had not existed, the per capita healthcare expenditures among commercial health plan enrollees would have been approximately 5% higher in 2015, totaling approximately $3 billion more in statewide healthcare expenditures. And that is just for commercial plan members, whose costs comprise approximately one-half of the statewide total healthcare expenditures. The IHA data for the Medicare population suggests that their costs would also be higher without managed care plans.*[iii]

The Milliman blog cites to the 2013 Berkeley Forum Report, A New Vision for California's Healthcare System: Integrated Care with Aligned Financial Incentives.[iv] Over ten years ago, the Report envisioned a progressive shift toward integrated delivery system models based on global budgets that would generate savings to the California health care system of approximately $110 billion over a decade. California missed the opportunity to adopt this model formally and largely ignored the supportive data contained therein until the passage of SB 184, which contained the provisions for adoption of alternative payment models. The provision now expressed in the Alternative Payment Model Standards and Adoption Goal Recommendation is a modest step forward toward the transformative goals expressed in the Report.

It appears from this information that a tenable solution to achieve affordability without sacrificing quality has already been identified by reputable sources in California.

**Take Action to Incent Adoption of Better Coverage Models for Consumers:** Our preference would be to urge the immediate adoption of requirements upon employers to offer more coverage models that meet the model cited in the Berkeley Forum Report. However, such mandates may not be obtainable under current law. APG therefore urges the Legislature, Administration and the OHCA Affordability Board to adopt additional goals that would support proven cost savings and quality of care improvement strategies – including the following:

- Comparative public transparency of the overall total cost of care for various coverage models within the traditional Medicare, Medicare Advantage, Self-funded employer market, Fully Insured PPO and HMO markets, and Medi-Cal managed care.
- Comparative, uniform quality measurement of outcomes in the foregoing market segments that is publicly transparent for consumers.
- Statutory requirements for the offering of coverage models that provide lower total cost of care and higher quality outcomes.

These additional actions will raise awareness among California consumers to seek out health coverage models that deliver lower total cost of care and higher quality outcomes, or to demand their offering. Public transparency of total cost of care is a powerful tool to educate consumers on the value of their health care dollar spend. Following up greater transparency with requirements to adopt coverage plans that provide lower total cost of care helps consumers even more. We believe that these actions will increase the rate of transformation of the California health care system toward a more affordable, accessible, and equitable system, which is the underlying goal of the SB 184 legislation.

Thank you for the opportunity to participate in this effort and to provide comments on this important recommendation.

Sincerely,

William Barcellona, Esq, MHA
Executive Vice President for Government Affairs

Attachments: Joint letter, IHA Report, Milliman Blog, Berkeley Forum Executive Summary.

[i] Joint letter to Mark Ghaly of March 5, 2024
[ii] Jeff Rideout, IHA. Did You Know? Highlights from IHA's Atlas and Align.Measure.Perform (AMP) data. DMHC FSSB Presentation 02282024. (February 28, 2024). Accessed on March 11, 2024 at: https://dmhc.ca.gov/Portals/0/Docs/DO/FSSBFeb2024/AgendaItem5_HealthCareandQualityAtlas.pdf.

[iii] Christopher Girod, Milliman. Healthcare under the Delegated Risk Model in California: Lower cost, high quality, (July 16, 2018). Accessed on March 11, 2024 at: https://www.milliman.com/en/insight/healthcare-under-the-delegated-risk-model-in-california-lower-cost-high-quality.

[iv] Berkeley Forum, School of Public Health, University of California, Berkeley. A New Vision for California's Healthcare System: Integrated Care with Aligned Financial Incentives. (2013), accessed on March 11, 2024 at: https://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/A-New-Vision-for-California%E2%80%99s-Healthcare-System.pdf.

# Attachments to APG Comment Letter

Please note: The first attachment includes a joint comment letter submitted by CAPH, ACLHIC, and APG. This letter can be found on page 123 of this document.

# "DID YOU KNOW?"

*Highlights from IHA's*
*Atlas and Align.Measure.Perform. (AMP) data*

**Jeff Rideout, MD, MA**

**CEO, Integrated Healthcare Association**

**DMHC FSSB presentation 02282024**

# About the Integrated Healthcare Association and our work

We're a non-profit IRS business league organized to provider trusted and unbiased health information.
Our board of directors includes leaders from across the healthcare industry

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# Performance Measurement at IHA

Since 2003, our measure set has tracked **provider level data for quality, resource use, and cost measures** that have the biggest impact on care outcomes. **AMP**

In 2015, we added broader measurement of healthcare performance including plans, non-integrated provider networks and geographies to provide a statewide view of where healthcare is working well and where it's not. **Atlas**

Since 2017, we've consistently measured **cost of care, quality, and utilization** allowing us to provides insights and trends. **Atlas and AMP**

Align. Measure. Perform. | Atlas | EDGE

- 20M member claims under management
- 15 health plans submitting data regularly
- 200 physician organizations participating
- Pioneered the use of Onpoint in California
- Providing analytics for Covered CA and CalPERS

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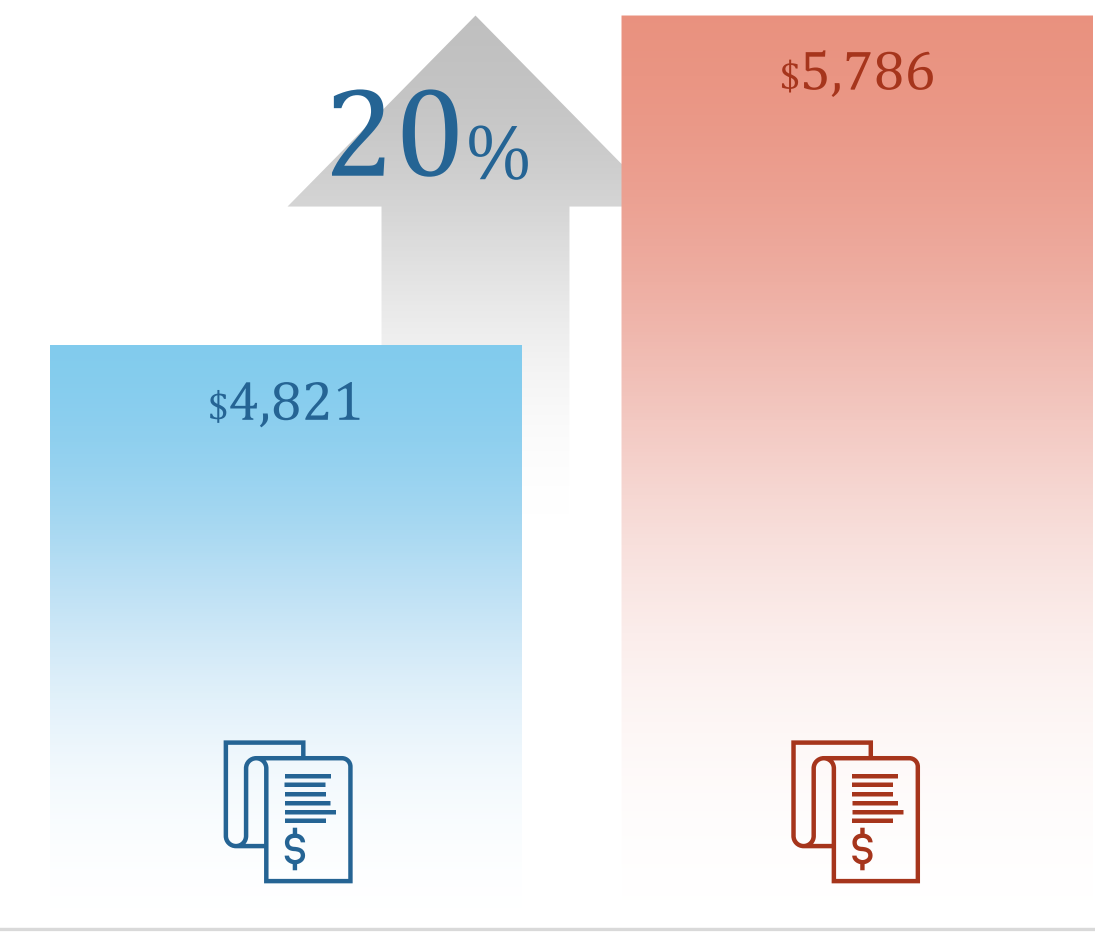
# What does the Atlas data tell us about cost of care?

# The Total Cost of Care has risen 20% over the last 5 years in California.

Commercial data only




Based on geographical and clinically risk adjusted TCOC

Risk adjusted and normalized to a Commercial California statewide population using Johns Hopkins ACG System

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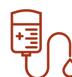
# Specialty pharmacy has been a big contributor with a 266% increase.

| | MY 2017 | MY 2021 | Change |
|---|---|---|---|
| Total Pharmacy | $776 | $895 | 15% |
| Specialty Pharmacy | $88 | $322 | 266% |

TOTAL PHARMACY


SPECIALTY PHARMACY

Costs shown are per member per year

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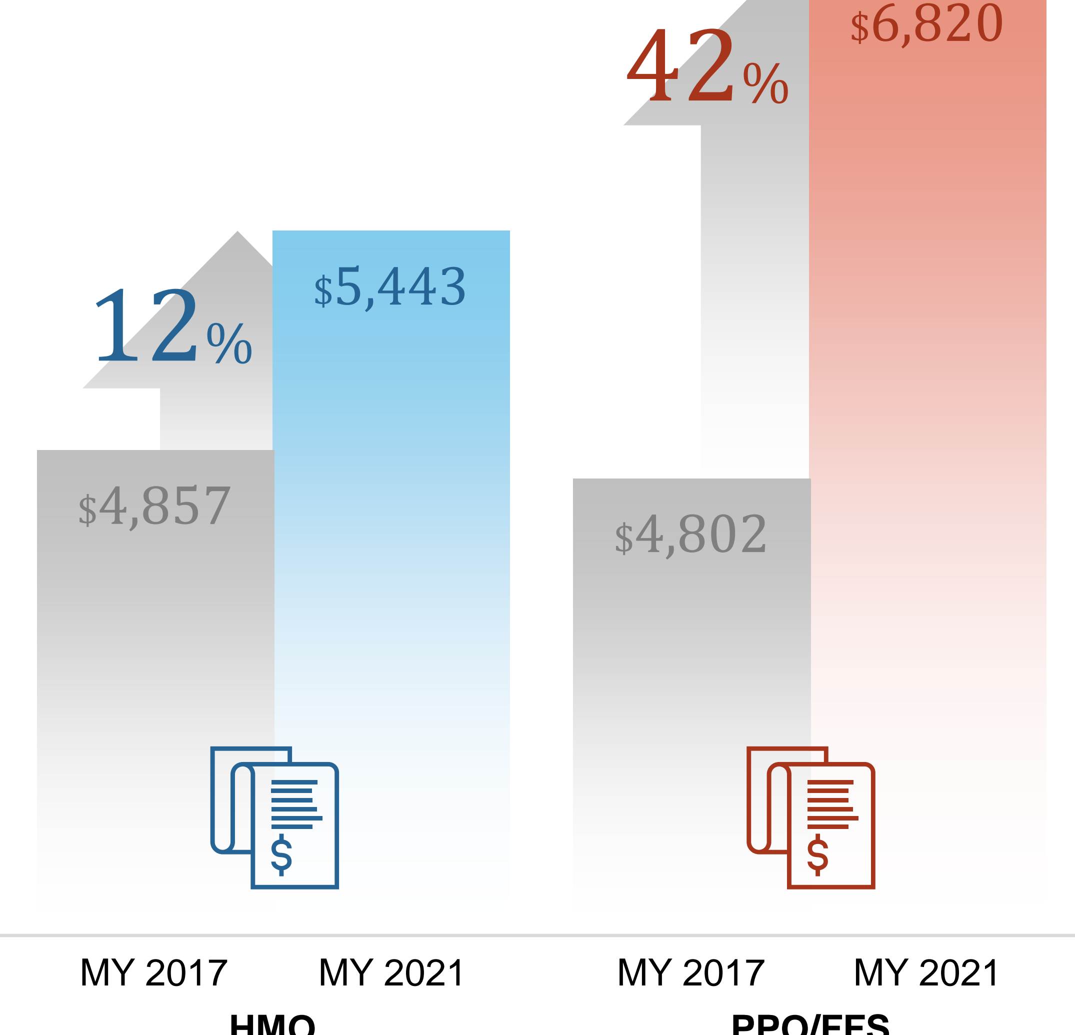
# There are significant differences depending on the degree of integration at the provider level.

The majority of HMO product providers accept some level of risk




Based on geographical and clinically risk adjusted TCOC

Risk adjusted and normalized to a Commercial California statewide population using Johns Hopkins ACG System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# OHCA proposes a five-year, single fixed value statewide spending target of 3.0% for 2025-2029.

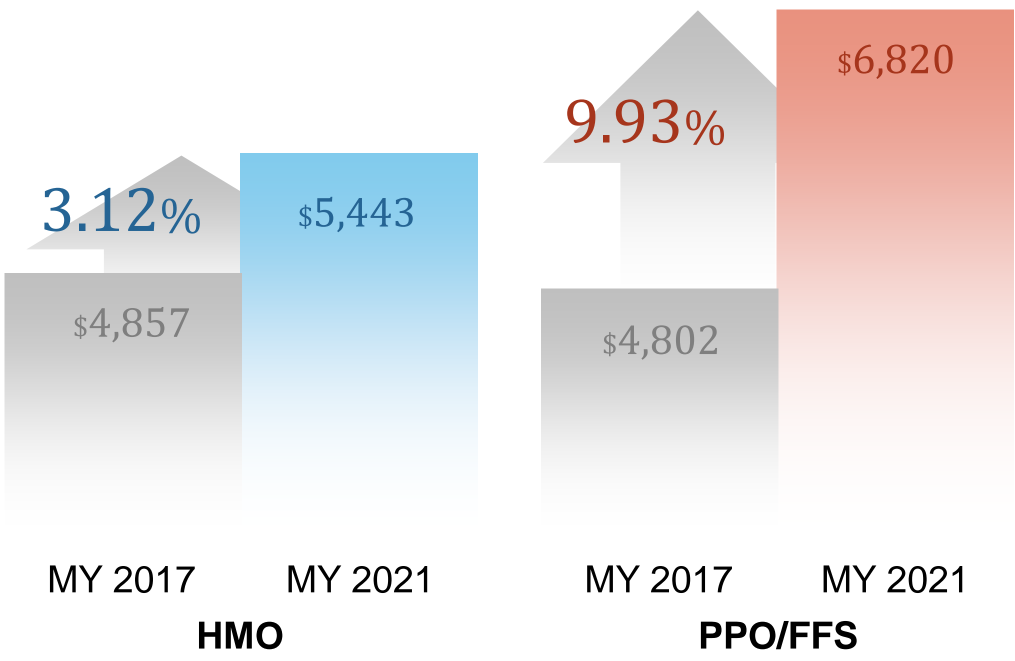
What does IHA Atlas information tell us regarding historical spending?

## Atlas vs. OHCA historical cost information

**4.98%**
**Atlas TCOC average annual increase**
across all commercial plans in a five year "look back"

**5.2%**
**OHCA average annual per capita healthcare spending**
increase from 2015-2020

## Atlas integrated vs. non-integrated average annual increase

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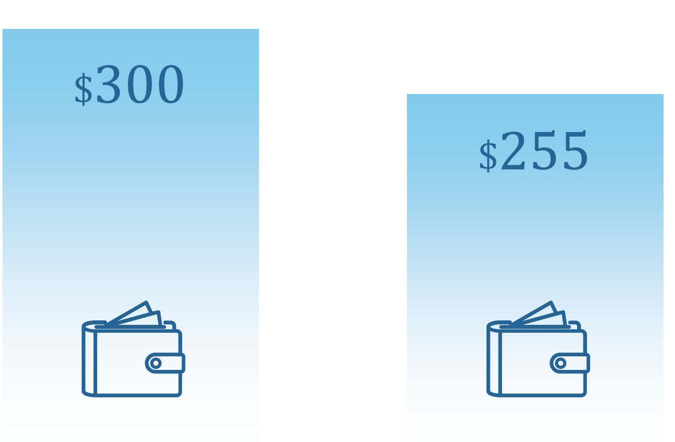
# For patients, integrated care means lower out-of-pocket costs

Financial risk sharing associated with lower member out-of-pocket costs




$724

MY 2021 data

**FULL RISK**
*Professional and Facility Capitation*

**PROFESSIONAL RISK ONLY**

**NO RISK**
*Fee for Service*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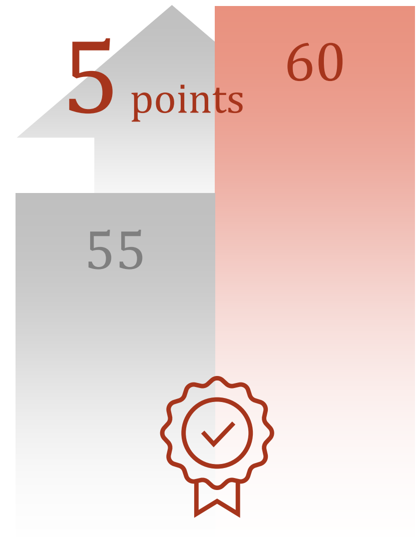
# What do Atlas and AMP data tell us about quality of care- Focusing on the "Core 4"?

# All risk types showed increases in Clinical Quality, but "No Risk" is still below the 2017 rate for integrated care.

NOTE of caution: claims only information which is incomplete

4 points
69
65

3 points
66
63




MY 2017 MY 2021
**FULL RISK**
*Professional and Facility Capitation*

MY 2017 MY 2021
**PROFESSIONAL RISK ONLY**

MY 2017 MY 2021
**NO RISK**
*Fee for Service*

Commercial data only; composite consists of 8 quality measures: 2 of 4 are Core 4

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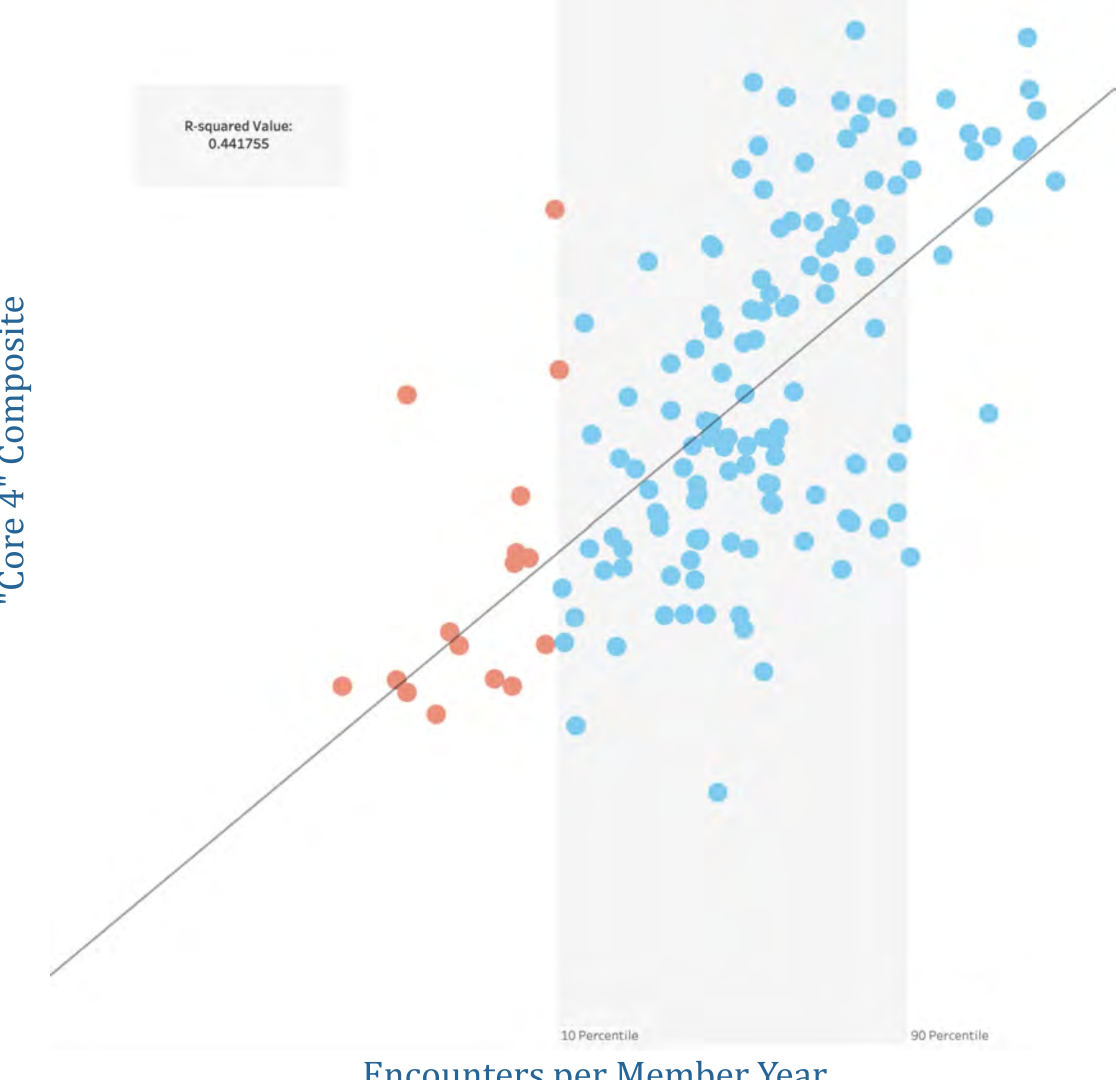
# Data challenges: encounter performance highly correlated to quality scores

IHA has already identified those PO/IPAs that are most challenged



# Data challenges: the critical contribution of clinical data to performance

Performance boost seen for "Core 4" measures

| Measure | CLAIMS ONLY | CLAIMS + CLINICAL | Boost |
| --- | --- | --- | --- |
| Controlling High Blood Pressure | 15% | 47% | 32% |
| Hemoglobin A1c (HbA1c) Control | 51%* | 57% | 6% |
| Colorectal Cancer Screening | 46% | 61% | 15% |
| Childhood Immunization Status | 18% | 46% | 28% |

*HbA1c Control (<8%) performance can be supplemented with lab data in the claims only rates

Rates averaged across health plan reported rates in MY 2021 for Commercial HMO

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# The “boost” range also confirms the variability across plans

| “Core 4” Measures | Range of difference across health plan reported rates (0%–100%) |
|---|---|
| Controlling High Blood Pressure (NQF #0018) | 2% – 73% |
| Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8%), (NQF #0575) | 0% – 27% |
| Colorectal Cancer Screening (NQF #0034) | 7% – 21% |
| Childhood Immunization Status (Combo 10) (NQF #0038) | 12% – 55% |

*HbA1c Control (<8%) performance can be supplemented with lab data in the claims only rates

Rates averaged across health plan reported rates in MY 2021 for Commercial HMO

Claims only rates provided by Onpoint and claims + clinical data rates provided by FinThrive

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# Health plans have high rates of “known” race and ethnicity data, but a lot of variability re: information collected directly from members

**81%** of AMP health plan members have complete race and ethnicity data

Commercial, Medi-Cal, and Medicare data are included for each health plan.

13 million members are reflected in the data

Proportion of overall health plan race and ethnicity data by data source

| | HP 1 | HP 2 | HP 3 | HP 4 | HP 5 | HP 6 | HP 7 | HP 8 | HP 9 | HP 10 | HP 11 | HP 12 | HP 13 | HP 14 | HP 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Direct | 89 | 37 | 93 | 7 | 64 | 35 | 99 | 26 | 97 | 11 | 14 | 96 | 21 | 50 | 100 |

Direct Indirect


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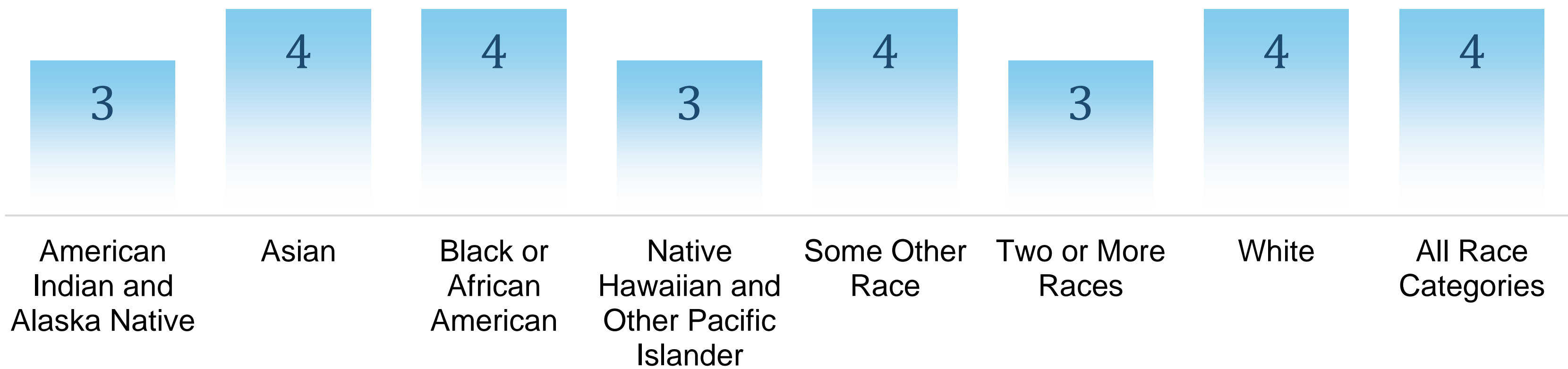
# Using race and ethnicity data is critical in identifying low performance in care and health outcomes for all of California enrollees

Number of IHA affiliated commercial plans (out of 15) that meet Medicaid 50th percentile, by race, for controlling blood pressure

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# This variability extends to critical spending categories like primary care

## Results from IHA/CQC CAPCI program

2021 Primary Care spending percentage by commercial health plan product

EPO PPO HMO

Commercial Population Average, 8.7%

3.8% 4.4% 5.8% 6.4% 6.5% 6.6% 6.6% 7.2% 7.4% 7.5% 7.7% 8.1% 9.2% 9.6% 10.1% 11.1% 11.3% 13.7%

# Why it matters: A need for alignment

# Purchaser and regulator programs – alignment and impact

DMHC Quality and Health Equity Program is just part of what is emerging statewide

| | DMHC Quality and Health Equity Program | Covered CA Quality Transformation Initiative-2025 | CalPERS Clinical Performance (QAMS)-2026 | DHCS Managed Care Accountability Program-active | VOLUNTARY CA Advanced Primary Care Initiative |
|---|---|---|---|---|---|
| Measures | 13 measures<br>96 plans affected | 6 measures<br>13 QHPs affected | 8 measures<br>12-13 plans affected | 18 measures<br>25 MCOs affected | 12 measures<br>4 plans to date |
| FINANCIAL PENALTIES | $TBD | $49.4M | $TBD | $3.4M (2023, pre-appeal) | NONE-upside incentive only |

- Require clinical data for accuracy (all programs)
- Includes the "Core 4" (all programs)
- Includes race & ethnicity stratification *(method may vary)* (all except CA Advanced Primary Care Initiative)

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# How does IHA's historic approach fit with OHCA activities?

- Total Healthcare Expenditure (THE) vs. Total Cost of Care (TCOC)
- Risk adjustment- age/sex only or also adjusted for clinical condition
- Sector specific analysis with capitated medical groups/IPAs as a sector ("RBO")-accelerated by OHCA in regulations and DSG
- Capitation data inclusion/exclusion-accelerated by OHCA in regulations and DSG
- Defining APMs consistently
- Primary care definitions re: spending, performance and practice level analysis
- Quality's role in the "affordability" discussion
- Health equity's role in the "affordability" discussion
- Sourcing information- central vs. organization specific

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16 July 2018

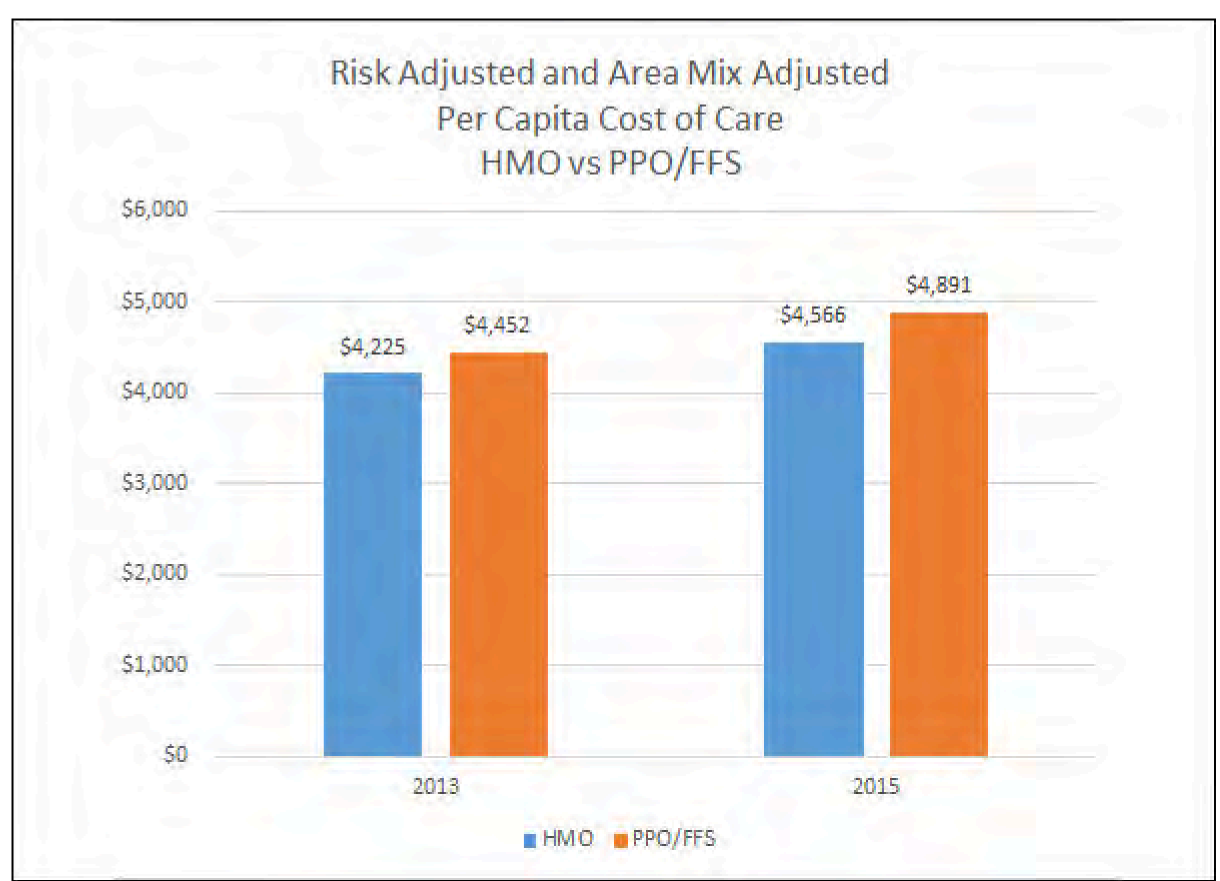
Health insurance is increasingly difficult to afford. As reported in the 2018 Milliman Medical Index (MMI), the typical American family of four covered by an average employer-sponsored preferred provider organization (PPO) plan will have annual healthcare expenditures totaling approximately $28,166. Californians are not exempt from this trend, also paying increasingly high costs for their healthcare. According to the 2013 Berkeley Forum report, employer-sponsored health insurance premium rates were projected to nearly double from 2011 to 2022, ultimately reaching $31,728 for family coverage in 2022. Those premium increases will be borne by both employers and employees. According to the MMI, on average premiums are funded approximately two-thirds by employers and one-third by employees through payroll deduction.

Some good news for Californians is that they would likely be paying a lot more without managed care plans that use the delegated model. In brief, the term "delegated model" describes a health insurance plan where financial risk for healthcare services is transferred from an insurance company to healthcare providers (e.g., physicians or hospitals). Most commonly this involves the insurance company paying a fixed, per capita dollar amount (a capitation rate) to a group of physicians, and the physicians assume financial responsibility to provide all professional services for each health plan member. They may also have full or partial risk for hospital services provided to those same members. In California, capitation can only be used in health maintenance organization (HMO) plans. Other common types of plans, PPO-style plans and other fee-for-service (FFS) plans, cannot use capitation.

Measuring the impact of the delegated model on healthcare expenditures is tricky for at least two reasons. First, the average person who enrolls in an HMO plan might have a different health status from the average PPO/FFS plan enrollee. For example, they might be younger, or just healthier than average. Second, per capita healthcare costs vary by geographic area, for a variety of reasons. HMOs tend to be concentrated in urban areas, while PPO/FFS plans are prevalent in all areas of the state.

**IHA Atlas data quantifies savings**

Fortunately, data published by the Integrated Healthcare Association (IHA) allows us to compare per capita healthcare expenditures for HMO versus PPO/FFS plans, adjusted for differences in the mix of members by health status and by geographic area. Results indicate that for commercial health insurance plans (i.e., non-Medicare, non-Medicaid), total healthcare expenditures per capita are lower under HMO plans than under PPO/FFS plans, as shown in the graph below. They were 5% lower in 2013 and 7% lower in 2015.*




As previously mentioned, providers can also take on varying degrees of financial risk. For example, they might assume risk for just professional services, which is the most common type of capitation arrangement. They might also have a shared risk arrangement for

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capitation, adjusted for differences in average member risk scores. In aggregate, without geographic area mix adjustment, the data indicates that total healthcare expenditures per capita were 6% lower under HMO plans using global capitation than under HMO plans only using professional services capitation. However, the data volume is relatively low for global capitation members, and heavily skewed toward Southern California. The data did not seem robust enough to provide a reliable comparison of costs under the two plan types after adjusting for differences in the geographic mix of members.

Moving along the spectrum of managed care with global capitation at one end, we find more loosely managed plans at the other end. Such plans do not use capitation, although they often incorporate certain managed care activities, such as large case management and disease management programs. Accountable care organization (ACO) plans tend to fall at this end of the spectrum. On a risk-adjusted basis, the IHA data indicates that total healthcare expenditures per capita were lower for members in ACOs than for members not in ACOs. They were 6% lower in 2015, the only year for which IHA has published this data, on risk-adjusted and area-mix-adjusted bases, suggesting that even less aggressive forms of managed care can yield savings. However, the IHA data did not allow for a direct comparison of per capita costs between ACO and HMO plans, on risk-adjusted and area-mix-adjusted bases.

**Patient out-of-pocket expenses and quality**

Lower costs are nice, of course, but only if costs are not simply shifted to patients, and only if the quality of care remains high. The IHA data suggests that managed care plans may be achieving all of these outcomes.

The IHA data measures how much of healthcare expenditures are paid by health plans versus patients. The plan-paid percentage of expenditures is higher under HMO plans than under PPO/FFS plans. In 2015, the only year for which this data is available, HMO plans paid 92% of healthcare expenses and members paid 8%. In contrast, PPO/FFS plans paid only 82% and members paid 18%.

To help measure quality, the IHA researchers collected 10 Healthcare Effectiveness Data and Information Set (HEDIS) clinical quality measures for specific health conditions, and created an aggregate measure, called the Clinical Quality Composite. The Composite measure suggests that the quality of care in HMO plans is higher than the quality of care in PPO/FFS plans. That conclusion is also supported by differences in the risk-adjusted readmission rates, which are slightly lower for HMOs in 2015, the first year that IHA published this statistic.

**Conclusions**

While managed care plans might not be the perfect solution for every person and in every area of the state, they are a valuable part of California's long-term solution to providing high-quality care at affordable prices. Using the 2015 IHA data, if managed care plans (as represented by HMOs) had not existed, the per capita healthcare expenditures among commercial health plan enrollees would have been approximately 5% higher in 2015, totaling approximately $3 billion more in statewide healthcare expenditures. And that is just for commercial plan members, whose costs comprise approximately one-half of the statewide total healthcare expenditures. The IHA data for the Medicare population suggests that their costs would also be higher without managed care plans. Comparable data is not available yet from IHA on the Medicaid population, but it would likely tell a similar story.

---

*[*] The IHA's March 1, 2018, press release posted on their website cited a 9% difference, which may have not been adjusted for the differences in the mix of members by geographic area. After making that mix adjustment, we calculated a slightly lower difference, at 7%.*

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# A NEW VISION
## FOR CALIFORNIA'S HEALTHCARE SYSTEM:
### Integrated Care with Aligned Financial Incentives

Diabetes group visit
Nutrition counseling
Palliative care
Medication management
Daily exercise
Home health aide visit
GLOBAL BUDGETS

## PARTICIPANT LIST

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**U.S. Department of Health and Human Services****
Herb K. Schultz, Regional Director (Region IX)

* During 2012, Bruce Bodaken retired as President and CEO of Blue Shield of California, and Paul Markovich replaced him.

** These individuals' participation in the Forum meetings/discussions does not represent any formal endorsement of the Report by their state or federal Department/Agency nor in their official individual capacities as elected or appointed public officials at the aforementioned Departments/Agencies.

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**Clare Connors, MPH, Research Associate

**Pictured on next page:**

**Standing (left to right): Clare Connors, Evan Gallagher, Tien Pham, Michael Kass, Anthony Barrueta, Sue Kim, Robert Reed, Pam Kehaly, Paul Markovich, Diana Dooley, Bart Asner, George Halvorson, Barry Arbuckle, Wade Rose, Mike Murphy, Patricia Clarey, Bonnie Preston, Thomas Priselac, Yumna Bahgat, Ian Morrison, Brent Fulton**

**Sitting (left to right): Stephen Shortell, Liora Bowers, Richard Scheffler**

**Inset at top (left to right): Bruce Bodaken, Dave Jones, Lloyd Dean, Herb Shultz, Jay Gellert, Robert Margolis, Patrick Fry**

# Berkeley Forum

*for Improving California's Healthcare Delivery System*

PHOTO BY PEG SKORPINSKI

The Berkeley Forum, established in January 2012, includes select CEOs of California's health systems, health insurers and physician organizations, along with state regulators and policymakers, that are collaborating to improve the affordability and quality of healthcare for all Californians. The University of California, Berkeley's School of Public Health serves as a neutral facilitator for discussions and the analytic staff for this effort.

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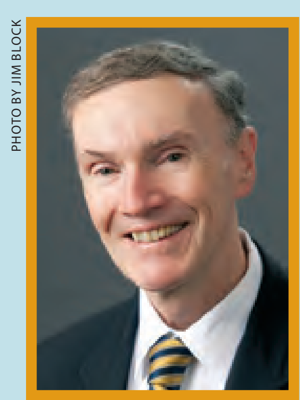


PHOTO BY JIM BLOCK

Stephen M. Shortell, PhD, MPH, MBA

# PREFACE

**Our nation has embarked on one of the boldest social initiatives in its history: To expand health insurance coverage to nearly all Americans while simultaneously trying to reduce the rate of increase in healthcare spending. The challenge is great everywhere in the country, but especially here in California, due to our state's large and diverse population and its sizeable number of uninsured residents.**

Some social problems are so complex that they cannot be solved by any single firm, industry, sector or government agency acting alone. Instead, they require a partnership and leadership across organizations. Recognizing this, private and public sector leaders in California came together to address the challenge of developing a more affordable and cost-effective healthcare system that would contribute to improved population health for all Californians.

This was the motivation behind the Berkeley Forum for Improving California's Healthcare Delivery System. The Forum includes the CEOs of six of California's leading health systems, three health insurers and two large physician organizations, along with the California Secretary of Health and Human Services, the U.S. Department of Health and Human Services Region IX Director and California insurance regulators (see "Participant List" on the inside front cover of the report).[1] The University of California, Berkeley School of Public Health was pleased to serve as a neutral facilitator for discussions and as the analytic staff for this effort. "A New Vision for California's Healthcare System: Integrated Care with Aligned Financial Incentives" is the result of the collective work of all involved.

This report is based on extensive analysis and careful investigation using multiple data sources (see appendices), in consultation with healthcare experts at both the state and national level. In the pages that follow, we provide a brief history and background of the state's delivery and payment systems, along with a discussion of the healthcare affordability crisis. We then analyze how seven specific initiatives might reduce healthcare spending relative to the state's gross domestic product, or bend the "Cost Curve," defined in this report as the share of Gross State Product (GSP) spent on healthcare. Particular emphasis is paid to the 5% of Californians who routinely account for more than half of the state's healthcare expenditures in a given year. We also assess two specific initiatives aimed at improving the health and healthcare of Californians, one involving increasing physical activity, the other expanding palliative care. And we lay out a vision for California's future healthcare system that is intended to better align financial incentives and increase care integration.

This document complements Governor Brown's "Let's Get Healthy California" report of December, 2012. The Governor's report established baseline indicators and target goals for assessing the health of Californians in priority areas, along with examples of initiatives. This report provides estimates of the expenditure reductions that can be achieved by pursuing some of those initiatives. To have their maximum impact,

[1] The participation by the California Secretary of Health and Human Services, the U.S. Department of Health and Human Services Region IX Director and California insurance regulators in the Forum meetings does not represent any formal endorsement of the Report by their state or federal Department/Agency nor in their official individual capacities as elected or appointed public officials at the aforementioned Departments/Agencies.

the initiatives will require sustained leadership from the healthcare delivery, public health, education, housing, labor, transportation, social services and related sectors, all working together.

The ultimate result of these efforts will be measured by improved affordability and a healthier California. While much is already happening, this report urges accelerated action. We need to reach farther and dig deeper. We all need to put our oars in the water and start rowing in the same direction to make California the healthiest state in the nation at a cost that we can afford. I hope you will engage with the ideas and analyses in this report and think hard about what you will do to move us forward.

Best wishes,

**Stephen M. Shortell, PhD, MPH, MBA**
*Chair of the Berkeley Forum for Improving California's Healthcare Delivery System*
*Blue Cross of California Distinguished Professor*
*Dean, School of Public Health*
*University of California, Berkeley*
*February, 2013*

**If you want to go fast, go alone. If you want to go far, go together.**

*Old African proverb*

# EXECUTIVE SUMMARY

In a typical day, Californians spend over $850 million on healthcare. In a typical year, 53% of the state's healthcare expenditures are spent by just 5% of the population. More alarming is the fact that by 2022, total employer-based insurance premiums for a family are projected to consume almost a third of median household income. Similarly, the share of the Gross State Product consumed by healthcare continues to grow; it is projected to rise from 15.4% in 2012 to nearly 17.1% in 2022, reducing our ability to invest in other crucial areas. We also face a continuing obesity epidemic that results in growing rates of chronic diseases skewed to the lower end of the socioeconomic ladder. Additionally, the state's healthcare system will be stressed even further due to several million additional Californians gaining insurance coverage via the Affordable Care Act. These are just some of the reasons it is critical that we address the financial sustainability of the state's healthcare system without delay. It is time for fundamental change. It is time for action.

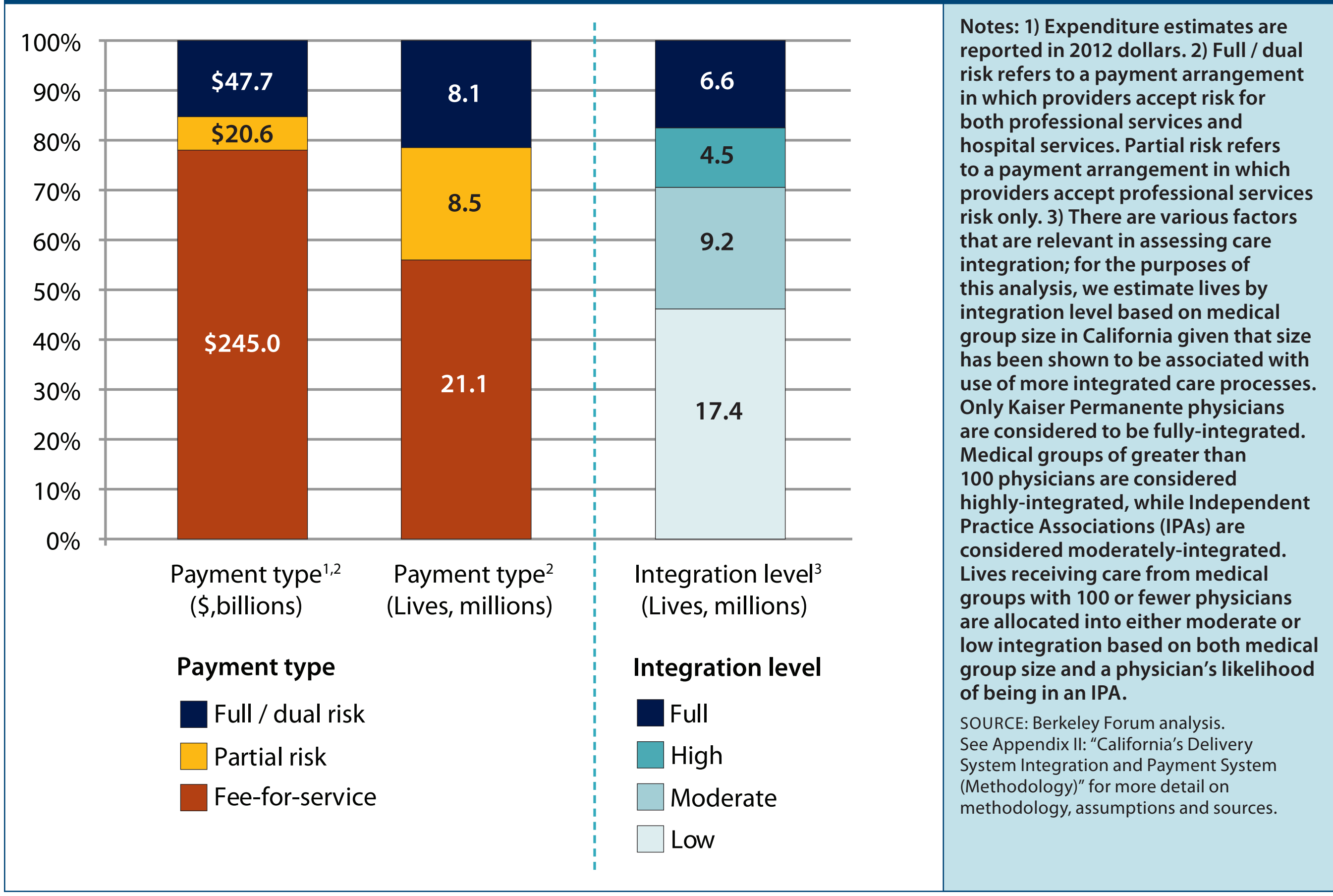
Recognizing this, California private and public sector leaders came together in an unprecedented collaborative effort, with academic expertise and analytic support provided by the University of California, Berkeley's School of Public Health, to address these challenges. Determined to avoid solutions divorced from societal, regulatory and political realities, the Forum has devised a transformational, bottoms-up approach to creating a more affordable, cost-effective healthcare system that would, at the same time, improve Californians' health and well-being.

These are ambitious goals. To attain them, the Forum supports a flexible approach to payment reform, including shared-savings as well as bundled and episode-based payments that can facilitate the transition towards broader implementation of risk-adjusted global budgets.

## BERKELEY FORUM VISION

**In response to our healthcare challenges, the Forum Vision calls for a rapid shift towards integrated systems that coordinate care for patients across conditions, providers, settings and time, along with risk-adjusted global budgets that encompass the vast majority of an individual's healthcare expenditures. Specifically, the Forum endorses two major goals for California to achieve by 2022: 1) Reducing the share of healthcare expenditures paid for via fee-for-service from the current 78% to 50%; and 2) Doubling, from 29% to 60%, the share of the state's population receiving care via fully- or highly-integrated care systems. The Berkeley Forum also calls for greater emphasis on population health, including lifestyle and environmental factors that promote good health.**

## FIGURE 1E: BREAKDOWN OF PAYMENT MECHANISMS AND DELIVERY SYSTEM INTEGRATION IN CALIFORNIA, BY LIVES AND DOLLARS, 2012




Notes: 1) Expenditure estimates are reported in 2012 dollars. 2) Full / dual risk refers to a payment arrangement in which providers accept risk for both professional services and hospital services. Partial risk refers to a payment arrangement in which providers accept professional services risk only. 3) There are various factors that are relevant in assessing care integration; for the purposes of this analysis, we estimate lives by integration level based on medical group size in California given that size has been shown to be associated with use of more integrated care processes. Only Kaiser Permanente physicians are considered to be fully-integrated. Medical groups of greater than 100 physicians are considered highly-integrated, while Independent Practice Associations (IPAs) are considered moderately-integrated. Lives receiving care from medical groups with 100 or fewer physicians are allocated into either moderate or low integration based on both medical group size and a physician's likelihood of being in an IPA.

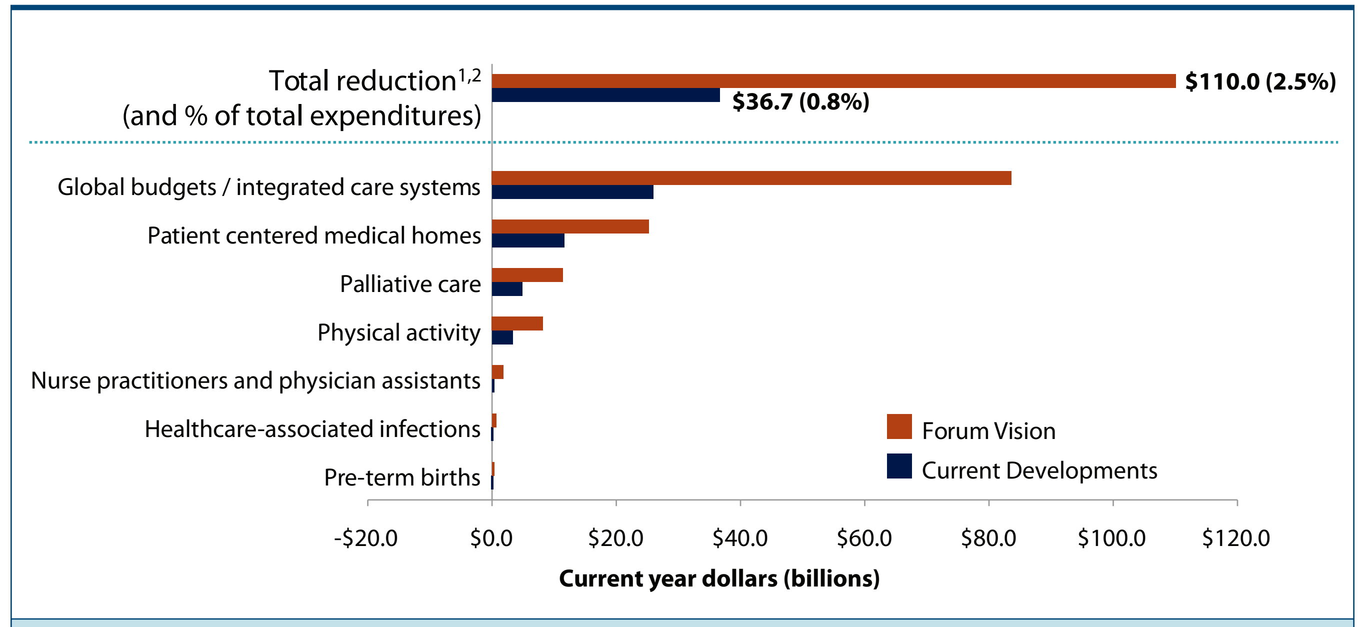
SOURCE: Berkeley Forum analysis. See Appendix II: "California's Delivery System Integration and Payment System (Methodology)" for more detail on methodology, assumptions and sources.

The Forum Vision was developed considering the characteristics of California's unique healthcare system, namely:

- Californians already have relatively low utilization of healthcare services—including rates of **hospital admissions and inpatient days at 79% and 74%, respectively,** of the rest of the U.S.
- California has the **9th lowest per capita personal healthcare spending** among states in the country.
- Health maintenance organizations (HMOs) with providers under full or partial risk insure 44% of California's population, about double the U.S. share. However, fee-for-service reimbursement still accounts for about $245 billion (or 78%) of healthcare expenditures, and only about 11 million Californians (or 29%) receive care in fully- or highly-integrated systems (see Figure 1E).

To assess the potential of the Forum Vision to create a more affordable healthcare system, we estimated the potential expenditure reductions associated with seven different initiatives, most of which target populations with the highest healthcare expenditures. We did so under two scenarios: 1) "Current Developments," which considers unfolding market forces, policies and regulations and is distinct from the status quo, which is based on historical trends; and 2) the "Forum Vision," which calls for aggressive changes, such as increased reliance on integrated care systems, risk-adjusted global budgeting, and population health practices (see Figure 2E).

## FIGURE 2E: HEALTHCARE EXPENDITURE REDUCTIONS IN CALIFORNIA FROM INITIATIVES UNDER THE CURRENT DEVELOPMENTS AND FORUM VISION SCENARIOS, 2013 – 2022 TOTAL




**Notes: 1) Total projected healthcare expenditures in California from 2013 – 2022 are $4,387 billion (in current-year dollars). 2) The "total reduction" is adjusted for savings overlap among the individual initiatives.**

SOURCE: Berkeley Forum analysis. Refer to Appendices IV-XI for expenditure reduction estimates for each initiative as well as to Appendix III: "California Cost Curve, Healthcare Expenditures, and Premium Projections (Methodology)" for projections of California's healthcare expenditures under the status quo from 2013 – 2022.

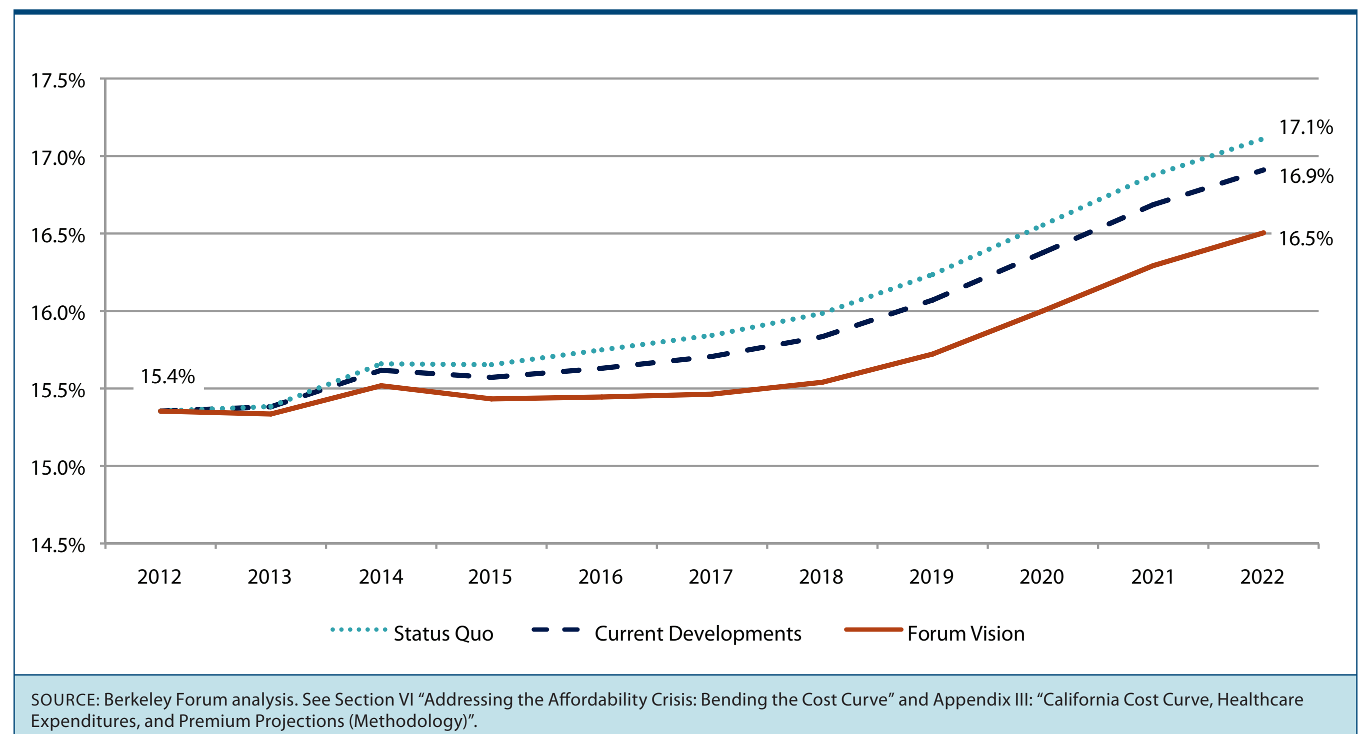
Under the Current Developments scenario, these initiatives are expected to reduce healthcare expenditures by $37 billion between 2013 and 2022. This reduction represents 0.8% of the $4.4 trillion in total healthcare expenditures projected under the status quo (see Figure 2E).

Under the Forum Vision, we estimate:

- **A $110 billion** reduction in healthcare expenditures from 2013 to 2022, representing **2.5% of the total $4.4 trillion in projected healthcare expenditures** under the status quo during these 10 years (see Figure 2E).
- An average reduction of **$802 per California household per year** over this period, and **$1,422 per household in 2022.**
- A reduction of the projected 2022 "Cost Curve," or healthcare expenditures as a share of GSP, from **17.1% to 16.5%** (see Figure 3E).

The above initiatives represent great opportunities for improving the health and healthcare of Californians. Additional initiatives not explored here would also complement the Forum Vision, and could lower expenditures beyond the 2.5% projected under the Forum Vision. The Berkeley Forum participants endorse the above seven initiatives and support their implementation to help achieve the Forum Vision. Furthermore, Forum participants believe that two of these initiatives warrant additional attention and have a significant potential for reducing expenditures while improving health and healthcare quality. First, the Forum calls for a statewide effort to increase the rates of physical activity among all Californians. Secondly, the Forum supports increased palliative care access for seriously ill patients, as a means of providing fully-informed, person- and family-centered care, and an enhanced quality of life for this population.

## FIGURE 3E: CALIFORNIA COST CURVE: PROJECTED HEALTHCARE EXPENDITURES AS A SHARE OF GROSS STATE PRODUCT UNDER DIFFERENT SCENARIOS, 2012 – 2022




SOURCE: Berkeley Forum analysis. See Section VI "Addressing the Affordability Crisis: Bending the Cost Curve" and Appendix III: "California Cost Curve, Healthcare Expenditures, and Premium Projections (Methodology)".

The Forum recognizes several significant challenges to implementing the Forum Vision. One is the need for a new regulatory framework that allows for the development of more integrated care systems, both incentivizes and promotes efficiency and quality, and ensures market-based competition. Other challenges to the Forum Vision include growing rates of employer self-insurance and government policies and market forces that are contributing to a decline in HMO enrollment among those with employer-sponsored insurance.

Forum participants remain committed to working together and with others in establishing new policies, regulations, approaches and shared practices that would help facilitate implementation of competing integrated care systems and adoption of risk-adjusted global budgets. Forum members additionally support Medicare and Medicaid patients receiving care from coordinated settings, and their providers engaging in deeper and broader risk-based contracting. Forum members also recognize that for their Vision to be achieved, various policy and regulatory changes will be necessary at the state and federal level, including changes to Medicare's reimbursement and benefit structure and to the existing state-federal Medicaid financing approach. Finally, the Forum reinforces the need for continued efforts by stakeholders in the healthcare delivery, public health, education, housing, labor, transportation, and social services sectors, along with the employer community, and supports the goal of Governor Brown's "Let's Get Healthy California" report to make California the healthiest state in the nation by 2022.

SECTION I

# Introduction

**It's Tuesday, and 38 million Californians are starting their daily routines—driving children to school, heading to the office, running errands or enjoying retirement. Over one million of those Californians will earn their living as part of the state's healthcare workforce.[2] Many of their friends and neighbors will interact with the healthcare system in other ways. Nearly 300,000 will visit their doctor. More than 750,000 prescriptions will be filled. And more than 10,000 people will be admitted to the most intensive of all healthcare settings—the hospital.[3]**

One of these people, 62-year old Mr. Jones, is an obese man who has suffered from hypertension for years.[4] Diagnosed with congestive heart failure (CHF) three years ago, he was rushed to a San Diego hospital last week due to fever, chills and shortness of breath. Mr. Jones was treated for pneumonia with complications, and after four days, was released from the hospital with four new prescriptions. Unfortunately, these medications were added to a medicine cabinet containing ten other prescription drugs—drugs that Mr. Jones wasn't taking as directed. The doctors treating him in the hospital were unaware of these other medications, and the difficulty Mr. Jones had with complying with his prescription regimen. When Mr. Jones returned home from the hospital, he was confused and unsure of whom to ask about his pills. But his first appointment with his family doctor was not scheduled until several days later. As a result, Mr. Jones was rushed back to the hospital in serious condition, due to a combination of drug interactions and failure to adhere to his recommended treatment.

On the same day that Mr. Jones is fighting for his life, 1,375 new Californians are being born.[5] Over a third of them are delivered via C-section,[6] including baby boy Wong. The infant's arrival in Fresno results in a price tag of slightly under $8,400.[7] By contrast, had he come into the world in Sacramento, the price would have been around $13,700. Had baby boy Wong been born vaginally, not only might there have been health benefits to him and his mother, but the delivery price would likely have been only about two-thirds as much. Fortunately, baby boy Wong arrived full term, increasing his chances of being healthy. But there were some scares along the way.

**These three stories are a small sample of the events taking place in California's healthcare system daily. On a typical day, Californian's spend about $265 million on hospitals, $235 million on physicians and $100 million on pharmaceuticals— almost $800 million on healthcare, every single day.**

[2] Bates, et al. (2011).

[3] The reported statistics are rough estimates for illustrative purposes only. Hospital statistics are based on data from the California Office of Statewide Health Planning and Development (2010). Physician visits and prescription drug statistics are based on data from the Medical Expenditure Panel Survey.

[4] The individuals referenced in this section are not real people (nor do their names represent specific persons) but are only illustrative sketches.

[5] California births in 2011 from California Department of Public Health (2011).

[6] Centers for Disease Control and Prevention (2011).

[7] Based on Milliman's analysis of Thomson Reuters MarketScan Commercial Claims and Encounters Database 2008-2010. Not adjusted for relative cost of living within California.

During a visit to her community health clinic in her sixth month of pregnancy, Mrs. Wong exhibited troubling signs that she may be at risk for preterm delivery. Via in-home assistance and a nurse coordinator, Mrs. Wong enjoyed active monitoring throughout the remainder of her term. The happy result was that baby boy Wong avoided all of the grave health risks associated with premature birth. In addition, tens of thousands of dollars in medical expenses were saved.

On this Tuesday a year ago, 48-year-old Mrs. Hernandez was one of the nearly 200,000 Californians annually diagnosed with diabetes.[8] Because of her health plan and medical group, she was quickly able to enroll in a comprehensive diabetes management program. As a result, Mrs. Hernandez was able to get her blood sugar under control. She was also encouraged to make some lifestyle changes designed to slow the progression of the disease. She and her 19-year-old daughter now take half-hour fitness walks every morning. They also enjoy their regular Saturday morning trip to the farmer's market to buy fresh produce. Mrs. Hernandez hopes that her efforts may help her daughter prevent the onset not only of diabetes, but also of other health problems that run in the family. For Mrs. Hernandez, the results are already apparent, both in her improved health and in the greatly reduced cost of her treatment. The annual expense for her maintenance medications along with the cost of all her appointments with her health care providers is about $1,000[9]—far below the $11,000 annual average to treat diabetes.[10]

These three stories are a small sample of the events taking place in California's healthcare system every day. On a typical day, Californian's spend about $285 million each on hospital and physician services and $110 million on pharmaceuticals—a little over $850 million on healthcare in all.[11]

Hundreds of thousands of Californians, each of them presenting with any of countless conditions, will arrive at a healthcare facility on a given day. The resulting costs are borne by all Californians, whether or not they are actively taking part in the healthcare system; it comes through higher insurance premiums and higher taxes. Californians spend an average of $23 a day, every single day, on healthcare, representing about 23% of the median wage in the state.[12]

This affordability crisis prompted private and public-sector leaders of California to come together via the Berkeley Forum. During a series of meetings over the past year, and using research provided by the Forum staff, the Berkeley Forum discussed the factors that affect California's healthcare utilization, costs and prices. The group benchmarked the state's performance in health status, care quality and affordability in the context of the state's considerable geographic and socioeconomic variations. Throughout the process, Forum participants were mindful of the basic characteristics of California's unique system: higher physician integration, provider accountability and the delegated model, and better financial alignment through full and partial risk-based payments. The Forum's discussions centered on expanding these approaches to even more segments of the state's healthcare system, including additional physicians, facilities and patients. As the discussions progressed, a profound concern emerged about the growing burden of poor health not only on individuals, but also on at-risk populations and on the system as a whole. Forum participants developed and endorsed a broad Vision calling for a rapid shift towards fully- or highly-integrated care systems, along with risk-based payment mechanisms that prioritize population health. Adopting this Vision would result in fundamental changes to how we conceive of, deliver, and pay for healthcare in California.

These fundamental changes are the heart of this report. Section II expands on the Forum Vision summarized above. Section III includes a history of California's healthcare system, and analyzes current performance in areas such as care integration and risk-based payment mechanisms. Section IV discusses health status and healthcare quality in the state, while Section V assesses the growth rates and increasing concentration of California healthcare expenditures. It also provides projections for those expenditures and for employer-sponsored health insurance premiums. To help address the growing affordability challenge, Section VI assesses the impact of the Forum's seven initiatives on bending the "Cost Curve" over the coming ten years. Section VII offers additional context and recommendations involving two Forum priority areas—physical activity and palliative care. Section VIII discusses several challenges to implementing the Forum Vision. The report concludes in Section IX with a discussion of the key strategies and initiatives involved in implementing the Forum Vision. We finish the report by returning to the vignettes of the three Californians described in the Introduction, providing a perspective on how the Forum Vision would positively shape health and healthcare experiences in the state.

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[8] Behavioral Risk Factor Surveillance System (2010).

[9] The $1,000 estimate is an approximation, and is based on four physician visits ($100 each), four educator/nutritionist visits ($80 each), lab work ($200), and metformin ($100), all representing typical costs for a controlled diabetic without complications.

[10] Dall, et al. (2010). To arrive at this estimate, we took the cited figure from the study of $9,677 in 2007 and increased it at the rate of California's per capita healthcare expenditures through 2012 (See Appendix III: "California Cost Curve, Healthcare Expenditures and Premium Projections (Methodology)").

[11] Breakdown for services based on Kaiser Family Foundation (2009a) estimates, using total 2012 California healthcare expenditures (See "Appendix III: "California Cost Curve, Healthcare Expenditures and Premium Projections(Methodology)").

[12] Median wage data from U.S. Bureau of Labor Statistics (2011); Based on total 2012 healthcare expenditures, regardless of payer source. (See "Appendix III: "California Cost Curve, Healthcare Expenditures and Premium Projections (Methodology)"). Note that we assume 240 working days a year to calculate total wages; however healthcare expenditures are based on 365 days in a year.

## SECTION II

# The Forum Vision

**In response to our healthcare challenges, the Forum Vision calls for a rapid shift towards integrated systems that coordinate care for patients across conditions, providers, settings and time, along with risk-adjusted global budgets that encompass the vast majority of an individual's healthcare expenditures. Specifically, the Forum endorses two major goals for California to achieve by 2022: 1) Reducing the share of healthcare expenditures paid for via fee for service from the current 78% to 50%; and 2) Doubling, from 29% to 60%, the share of the state's population receiving care via fully- or highly- integrated care systems. The Berkeley Forum also calls for greater emphasis on population health, including lifestyle and environmental factors that promote good health.**

Over the last three decades, healthcare providers, insurers and purchasers have attempted numerous initiatives to reduce healthcare expenditures while improving health outcomes. These included provider-centered methods such as disease management and hospital discharge programs, as well as consumer-oriented efforts such as wellness incentives to maintain healthy lifestyles and greater cost-sharing to reduce unnecessary care. Many of these initiatives lead to quality improvements and expenditure reductions. But Californians have nonetheless continued to face a combination of rising expenditures and sub-optimal health outcomes. As a result, our healthcare system is experiencing ever-greater financial challenges, including higher premiums and cost-sharing, lower levels of employer-sponsored coverage and major pressure on state and federal budgets. Simultaneously, Californians are experiencing an epidemic of poorly managed chronic diseases, caused in large part by growing rates of obesity and inactivity, along with increasing health disparities among socio-economic groups. There are many individual initiatives underway to address these challenges. But the Forum believes that for all their benefits, they do not go far enough. Much more needs to be done, and done soon.

To seriously address the state's healthcare challenges, the Forum believes that the fundamental structure of healthcare delivery and financing must change. The Forum believes that healthcare must be delivered via systems that coordinate care for patients across conditions, providers, settings and time, and are paid to deliver good outcomes, quality and patient satisfaction at an affordable cost. Specifically, the Forum recommends significant payment reform that aligns financial and clinical incentives. The act of tying providers to a risk-adjusted global budget that encompasses the full spectrum of a population's healthcare needs is the single most important step that can be taken to achieve the twin goals of better health and better healthcare.[13]

Within or alongside risk-adjusted global budgets, various payment mechanisms for providers or facilities may be warranted. In addition, patients may opt to pay extra on their own for additional benefits or services. The Forum supports a pluralistic approach that encompasses many different reform initiatives, such as shared-savings, bundled and episode-based payments. These efforts can help address care fragmentation and misaligned incentives, as well as facilitate the transition towards deeper and broader implementation of risk-adjusted global budgets. The Forum Vision is not tied to any particular product type, such as HMOs or PPOs, and recognizes that market forces may require that products evolve to allow innovative payment models to emerge, such as risk-based payments in PPOs or increased cost-sharing in HMOs. Regardless of the extent of risk assumed, having consistent payment methodologies across different payers and providers would mitigate the extraordinarily high and growing burden of administrative inefficiencies in our current system. For example, consistent payment systems could greatly streamline billing, claims processing, prior authorizations and eligibility verification. Payment mechanisms should be risk-adjusted for the underlying health status of the patient population, and also adjusted for factors that promote the public good, such as medical education, community benefits and care provision in underserved areas.

The Forum believes that integrated care systems composed of sufficiently scaled medical groups and hospital and health systems can provide the platform for effective stewardship of both the health and financial risk of a population. As part of this Vision, individual or small physician practices, free-standing hospitals, nursing homes, rehabilitation centers and other components of the care continuum would be brought together in new organizations that could be held accountable for the overall health and care of patients. It is crucial that these new organizations have patient populations large enough to properly support investments in areas such as

[13] In California's dual regulatory structure, capitation arrangements are restricted to Department of Managed Health Care regulated Health Maintenance Organization (HMO) products, and are not allowed in Department of Insurance regulated Preferred Provider Organizations (PPOs). Therefore, this report primarily uses the broader terminology of global budgets rather than global payments. Global budgeting refers to a pre-determined expenditure target for a defined population, and providers take upside (and potentially downside) risk on whether the budget is met, but not necessarily 100% of the risk. Reimbursement for services may still be on a fee-for-service basis. In contrast, a global payment is akin to a pre-determined per-member per-month capitated payment, wherein providers take both upside and downside risk at 100%, which can be mitigated through reinsurance.

information technology, new care practices, outcomes data collection and evidence-based initiatives. The Forum expects that fundamental payment reforms would unleash the power of innovation and care redesign on the scale necessary to achieve better health at a more affordable cost. Indeed, the few examples of fully-integrated delivery systems that exist today demonstrate that financial accountability for a population's health is a very effective motivator of innovative practices in prevention, chronic disease management and care for seriously ill patients. These organizations are the country's pioneers in effective use of the physician and non-physician workforce, alternative care sites, health information technology, patient engagement and care management tools.

As we implement this Vision, it is important to remember that a highly competitive market among integrated healthcare systems is crucial to preventing organizational complacency or undue market leverage, which could result in insufficient choices and higher prices for patients and purchasers. Payers and consumers should always be able to choose among viable competing options of integrated systems; these systems might span geographies by combining traditional practice sites and virtual networks. Innovations such as telemedicine, remote monitoring and connections between central expertise "hubs" and small practice "spokes" can help support competition, particularly in more rural settings. The Forum also supports transparency in the reporting of standardized measures of quality and outcomes, since complete and free access to information will promote competition, empower patients and fuel additional improvement within the healthcare system. Implementing mechanisms to capture claims details within capitation arrangements, which is not standard practice today, is also necessary to support robust measurement, internal quality improvement and overall system transparency.

The Forum supports engaging Californians directly in taking active responsibility for healthier lifestyles and value-driven healthcare decisions. However, the Forum also believes that providers and payers have a responsibility to help patients make optimal clinical and financial decisions involving the care they receive. As such, the Forum is concerned about current trends that distance providers and payers from value-driven accountability for healthcare, such as the movement away from HMO principles or the adoption of blanket cost-sharing approaches without regard to value. While such approaches are perhaps attractive to purchasers because they reduce patient demand in the short-term, the Forum believes they ultimately make less attainable the long-term goal of better health at a more affordable cost. The Forum strongly supports benefit designs that promote healthier lifestyles, patient engagement and shared decision-making as important steps towards cost-effective, high-value care.

The Forum expects that the accountability resulting from risk-based payments would support greater investment in the long-term health of patients. Transparency in risk-adjusted outcomes, moreover, could facilitate the purchasing of healthcare services in support of good health. The Forum recognizes that environmental and behavioral factors are paramount in influencing health outcomes. The choices individuals make in areas such as nutrition or medication adherence are usually affected by factors outside of the healthcare system, but nonetheless can be contributors to poor health status and outcomes. California should collectively create a culture of health that crosses socioeconomic and demographic lines and touches all Californians every day, in all aspects of their lives and work. A critical part of this effort will involve creating environments where the default option is healthier food and smaller portions, as well as increased physical activity, especially walking. This sort of transformation will require dedication and collaboration across the employer, healthcare, education, transportation and housing sectors.

There are numerous other important issues affecting the healthcare system that we do not address here, including the technology "arms race," the incompatibility of electronic health record systems, the cost-shifting from public to private payers and the healthcare system's growing regulatory burdens. Nonetheless, we believe successful implementation of the Forum Vision will result in a healthier population and a more efficient healthcare delivery system. Of course, this Vision will require work on the part of all stakeholders; business models and processes will have to change, and the public will have to be educated and engaged. Fortunately, California is particularly well-positioned to lead the nation in fundamentally restructuring its payment system to facilitate the greater integrated care and prioritization of prevention envisioned in this report. A distinguishing characteristic of our system is high HMO[14] enrollment and the presence of large medical groups, both of which have helped create well-established processes to address population health needs. At the same time, because our hospitals are both larger and more likely to be part of a multi-hospital system, they are capable of undertaking the sorts of financial risks and investments that would be challenging for smaller hospitals. As California is home to some of the nation's leading integrated delivery systems, as well as a growing number of ACOs[15] and other risk-based health delivery models, we are confident that our state has the foundation to make this major leap forward.

[14] For the purposes of the report, we define HMOs to include Knox-Keene licensed HMOs, as well as HMO "look-alike" plans offered by Medicare Advantage and Medi-Cal, such as Medi-Cal County Organized Health System Plans. These plans share characteristics such as mandatory selection of a primary care physician, utilization review, lower patient cost-sharing and capitated payments for some or all of the care provided.

[15] Unless stated otherwise, this report does not use the term Accountable Care Organization (ACO) to refer to a specific model or insurance product, but rather to all entities that 1) provide care for a specified group of patients, 2) operate under a global budget or spending target that encompasses most or all of an individual's healthcare services, 3) report on and receive incentives related to quality of care, and 4) share financial risk.

SECTION III

# The California Healthcare System: Past and Present

**The Forum Vision sets out a path for California's healthcare system that emphasizes a rapid shift towards fully- or highly-integrated care systems and risk-based payment mechanisms that emphasize population health. But achieving that future for California requires an understanding of the state's past. Therefore, we begin with a short history of California's healthcare delivery and payment system. We then discuss characteristics of the current system and then assess the system's performance with respect to the goals of the Forum Vision.**

## A. A brief history

California is unique not only in its high level of HMO enrollment, but also in its use of risk-based payments and the delegated model, both of which transfer risk and a range of care management functions from health plans to provider organizations. Under the delegated model, health plans contract with physician groups, providing a capitated payment per enrollee in exchange for the group's assuming responsibility for downstream costs, utilization management and chronic disease care management for their assigned enrollees. The presence of large physician organizations—many with strong hospital affiliations—along with the significant presence of Kaiser Permanente (Kaiser), made acceptance of this model more attractive in California.[16]

Kaiser began offering health plans to the community in 1945, and by 1976, membership had grown to about three million.[17] The Kaiser model includes a partnership involving the health plan, hospitals and large multi-specialty medical groups. Faced with Kaiser's success—the organization enjoyed a 15%-20% price advantage in the insurance market until the 1990s—other California health plans and providers began seeking a competitive response.[18] Demand for Health Maintenance Organization (HMO) plans increased after passage of the federal Health Maintenance Organization Act of 1973, which required employers to offer at least one HMO product in markets where they were available.[19] Physicians started forming medical groups and Independent Practice Associations (IPAs), composed of private-practice physicians who jointly negotiated with insurers, mainly on a capitated basis. These physician groups began developing methods for managing the health of their patient populations, specifically for reducing hospitalizations. The result was that health plans transferred risk and care management responsibilities to these physician groups. As interest grew in risk-based payments as a means to reduce unnecessary utilization, health plans began transferring some of the institutional (hospital) risk to providers. Many hospitals were involved in forming affiliated IPAs, often encouraged by health plans to create joint arrangements to manage this risk. Capitation[20] was used extensively to deal with both institutional and professional services risk.

However, this broad physician-hospital capitation model was not without its problems. Many risk-bearing organizations went bankrupt, which led to stricter regulations on the type and amount of risk that could be assumed. Many HMO patients experienced hurdles in accessing care and in complying with complex administrative requirements,[21] resulting in a backlash against the concept by both consumers and employers. Most significantly, perhaps, hospitals lost substantial revenue due to the processes established by HMOs to help reduce hospitalizations. Hospitals determined that they were not recouping enough revenue from the joint risk agreements to compensate for their growing overcapacity. As smaller hospitals consolidated and larger systems emerged, hospitals saw opportunities for more attractive reimbursement via a traditional model based on admissions. Commercial inpatient rates increased quickly, further attracting hospitals to move towards separate service-based reimbursement in which they had greater negotiating leverage.[22] Physician groups also began reducing the level and inclusion of capitation, carving out areas such as prescription drugs and mental health. By the early 2000s, commercial HMO coverage rates and the use of broad physician-hospital capitation had declined from their mid-1990s peak.[23]

## B. The current delivery and payment system

Despite these developments, the delegated model HMO is still more important in California than in other states, because of its long history and the more recent movement of patients into Medi-Cal and Medicare

[16] California HealthCare Foundation (2009b).

[17] Group Health Association of America (1977).

[18] McCarthy, et al. (2009).

[19] Gruber, et al. (1988).

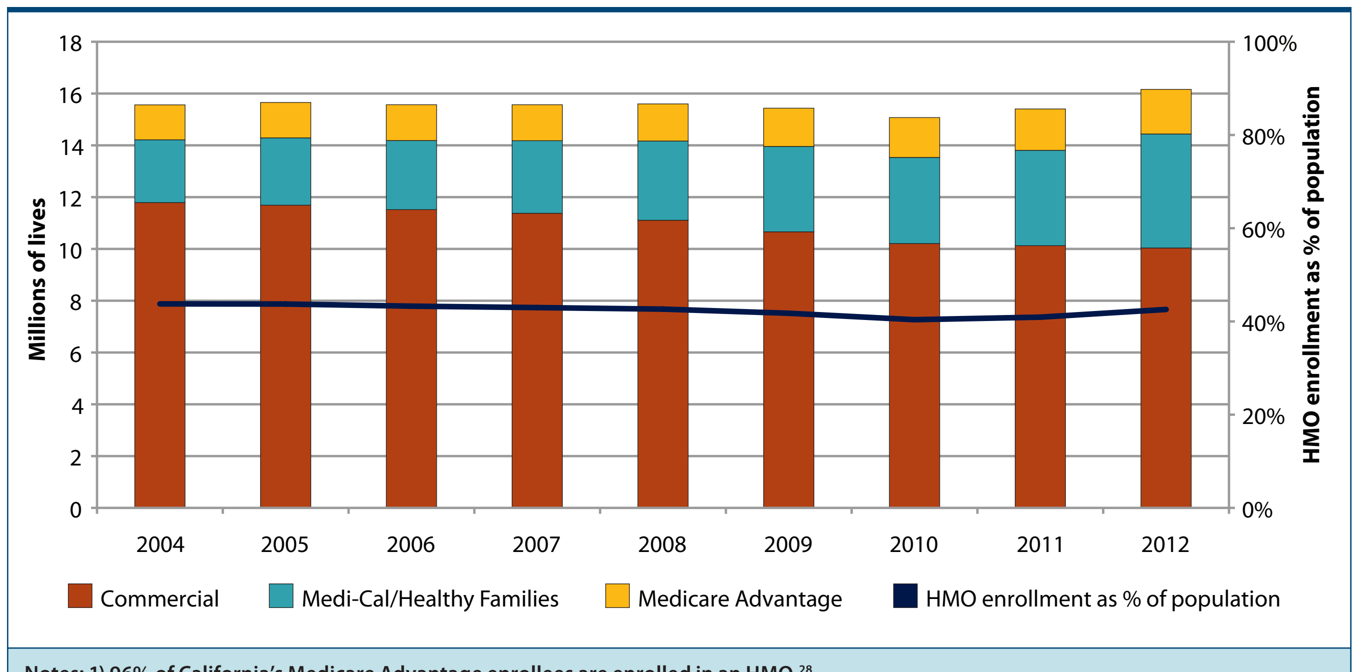
[20] Capitation is a payment arrangement in which a provider receives a set payment per patient to provide health services during a defined time period.

[21] For an illuminating case study on the state of HMOs in the late 1980 and early 1990s, see Kane, et al. (1996).

[22] Based on an interview with Tom Williams, President and CEO of Integrated Healthcare Association on July 20, 2012.

[23] Robinson (2001).

## FIGURE 1: HMO ENROLLMENT IN CALIFORNIA, 2004 – 2012




**Notes: 1) 96% of California's Medicare Advantage enrollees are enrolled in an HMO.[28]**

SOURCE: Berkeley Forum analysis using Cattaneo & Stroud Inc. (2012a).[29]

managed care. In California, 44% of the population is covered by an HMO, and this share has remained relatively consistent over the last eight years.[24] This share is about twice the U.S. HMO rate,[25] which has been declining over the past ten years in favor of Preferred Provider Organization (PPO) / Point of Service (POS)-type plans. The composition of the California HMO population has shifted dramatically; commercial HMO enrollment has declined by nearly 15% since 2004 while enrollment in public programs has increased (Figure 1). California's Medicare Advantage enrollment grew 37% between 2004 and 2012,[26] and Medi-Cal managed care enrollment grew 82% during the same period.[27] Large medical groups that were instrumental in developing the delegated model in California have been challenged by this demographic change in the HMO population, as Medi-Cal payments do not make up for the lost revenue from commercial patients. With the change in the HMO payer mix, there has also been a shift in the physician groups caring for HMO patients, as there is often little overlap between the medical groups who treat the commercial and Medi-Cal populations. The movement of additional populations into Medi-Cal managed care, such as the recent mandated enrollment of dual-eligible Medi-Cal/Medicare members, is also requiring HMOs to develop new capacities for effectively managing the care of some of the sickest populations with the most complex healthcare needs.

Due to its long history with HMO contracts and the delegated model, California has led the nation in clinical and financial integration among physicians. Physician organizational structure varies greatly within the state depending on such factors as urbanization, local preferences and hospital and insurer markets. Many physicians have joined medical groups, which are defined as an organization with common ownership that can span various practice sites and counties. In California, 41% of physicians practice in medical groups of more than 25 physicians, and 80% of these physicians are in groups of more than 100 (see Figure A1 in Appendix I).[30] On the other hand, 35% of the state's physicians are either solo practitioners or are in a group of between two and four physicians. Figure 2 shows that 15 counties in California have at least 40% of their physicians practicing in groups of 25 or more. While the Bay Area and surrounding counties, along with several counties in Southern California, have higher penetration of medical groups with more than 25 physicians, many counties are still served by physicians in smaller medical groups.

[24] Cattaneo & Stroud Inc. (2012a).

[25] Kaiser Family Foundation (2012).

[26] Kaiser Family Foundation (2004); Kaiser Family Foundation (2012d).

[27] Cattaneo & Stroud Inc. (2012a).

[28] Mathematica Policy Research/Kaiser Family Foundation Analysis of CMS Medicare Advantage enrollment and landscape files 2011-2012 (2012).

[29] Cattaneo & Stroud's HMO Medical Group Enrollment Report is based on a survey of medical groups with six or more primary care physicians and at least one direct HMO contract.

[30] IMS Health Incorporated (2010).

Many of California's smaller group physician practices are often part of a "virtually integrated" IPA, which jointly negotiates with insurers and cares for HMO patients. Between 2004 and 2012, the enrollee population shifted towards larger risk-bearing organizations, many of them IPAs.[31] For example, in 2004, there were 13 HMO-accepting physician organizations with over 1,000 physicians, caring for slightly under 8 million Californians. By 2012, there were more than twice as many, and they cared for more than 10 million Californians (see Figures A2 and A3 in Appendix I).

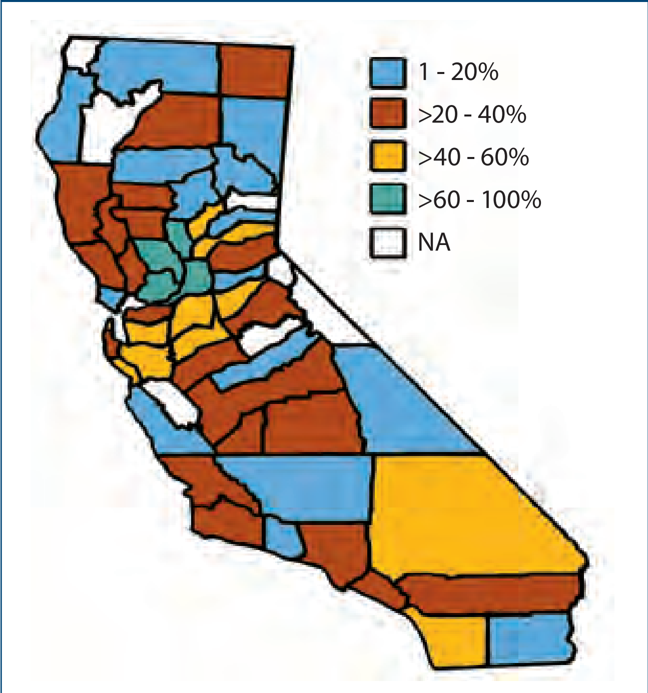
The prevalence of HMOs and large physician organizations has put California at the forefront of initiatives to encourage higher-quality healthcare. For example, the California Pay for Performance (P4P) Program is the largest non-governmental physician incentive program in the United States. It measures dozens of indicators involving approximately 35,000 physicians in over 200 groups on behalf of eight health plans representing 10 million people. This year, the program is making a significant shift towards a shared savings model, in which payments will be based on a combination of quality and efficiency.[32]

The California delivery system is also characterized by large hospitals and health systems that provide a network of integrated care. Relative to the rest of the United States, California hospitals are more likely to be part of a larger health system and have a greater number of hospital beds, ICU beds and admissions per bed (see Table A1 in Appendix I).[33] ACOs are more likely to be successful in a delivery system such as California's, which is characterized by large, multispecialty medical groups, formal or informal partnerships with hospitals, established physician leadership and experience with payment methods other than the traditional fee-for-service approach.[34]

It is estimated that 623,700 Californians are currently served by one of 41 operational ACOs, as tracked by Cattaneo & Stroud Inc. As of January, 2013, Los Angeles County's 16 ACOs covered approximately 213,000 patients, followed by Orange County's 11 ACOs covering 94,600. Enrollment in California ACOs varies from as few as 500 patients to as many as 68,000 (the Heritage Provider Network's Pioneer ACO) with an average of 15,200 (see Table A2 and Figure A4 in Appendix I, for more information on California ACOs).[35]

Many see ACOs as a way to extend HMO principles to the state's non-HMO population, which represents slightly more than half of all Californians. If complementary accountable care models proliferate in the state, millions of other Californians served by physicians and health systems affiliated with an ACO may benefit from the "spillover" of new care practices developed for the ACO population. Some question whether ACOs are a step backwards for those covered under HMO plans, as the reimbursement landscape in California has for decades included capitation, shared risk pools and pay for performance quality incentive programs.[36] However, even within the delegated model, many risk agreements with providers do not include all healthcare services. As a result, some recent commercial ACOs are combining traditional HMO payment models like capitation with both quality measures and shared risk pools based on total expenditures for an individual.

## FIGURE 2: PERCENT OF PHYSICIANS PRACTICING IN MEDICAL GROUPS OF MORE THAN 25 PHYSICIANS IN CALIFORNIA, BY COUNTY, 2011




**Notes: Medical groups can span multiple counties and size is defined by number of physicians under a common ownership structure, rather than number of physicians in a particular office location. NA: not available.**

SOURCE: Berkeley Forum analysis using IMS Health Incorporated (2010).

[31] Cattaneo & Stroud Inc. (2012a). This data source only includes organizations that have six or more primary care physicians and at least one HMO contract.

[32] Yanagihara (2012).

[33] Health systems are defined by the American Hospital Assoication (2011) as either "a multi-hospital or a diversified single hospital system. A multi-hospital system is two or more hospitals owned, leased, sponsored, or contract managed by a central organization. Single, freestanding hospitals may be categorized as a system by combining three or more, and at least 25%, of their owned or leased non-hospital pre-acute or post-acute health care organizations."

[34] Crosson (2011).

[35] Cattaneo & Stroud Inc. (2013).

[36] Frohlich, et al. (2011).

## TABLE 1: HEALTHCARE UTILIZATION IN CALIFORNIA VS. REST OF THE U.S., 2005 – 2009

| Healthcare Service | Incidence Rate Ratio: California vs. Rest of the U.S. | Standard Error |
|---|---|---|
| Number of inpatient discharges | 0.76*** | 0.04 |
| Number of inpatient days | 0.83* | 0.07 |
| Number of emergency room visits | 0.78*** | 0.03 |
| Number office-based physician visits | 0.91*** | 0.02 |

**Notes: Results are based on negative-binomial regression models, which control for gender, age, race/ethnicity, income, insurance status, number of key medical conditions and body mass index. The sample size for each model was 155,776. Asterisks indicate the significance level of the incidence rate ratio as compared to one: *p<0.05 and ***p<0.001.**

SOURCE: Berkeley Forum analysis using MEPS-Household Component, 2005-2009.

## C. California's current performance compared to the Forum Vision

California has a long history of HMOs with risk-based payments and integrated care, facts often cited as major reasons for the state's lower-than-average healthcare utilization. For example, in 2010, California's rates of hospital admissions and inpatient days were 79% and 74%, respectively, those of the rest of the U.S.[37]

We explored whether some of the lower hospital utilization may be explained by California having relatively higher rates of uninsured[38,39] and a younger population,[40] as well as larger Asian and Latino populations, all groups that tend to have lower healthcare utilization.[41] To account for demographic and health differences between California and the rest of the United States, we used the 2005-2009 Medical Expenditure Panel Survey—Household Component (MEPS-HC) to compare utilization between California and the rest of the United States, controlling for gender, age, race/ethnicity, income, insurance status, number of key medical conditions and body mass index.[42] Table 1 shows that California's adjusted utilization is still significantly lower than the rest of the country. Specifically, Californians' rate of inpatient discharges and inpatient days were only 76% and 83%, respectively, of the rest of the country. This provides evidence that California healthcare system characteristics, including greater use of risk-based payments and integrated care than other parts of the country, may contribute to lower utilization in the state. Our findings are consistent with those of earlier research, such as a 1996 study showing that areas of California with the highest HMO penetration were able to reduce hospital utilization over a 10-year period by 44%, compared to just 29% for the areas with the lowest HMO penetration.[43] Similarly, a 1995 study showed that capitated California medical groups demonstrated lower hospital admissions and lengths of stay for non-Medicare patients, with such groups reporting average annual hospital days of 134 per thousand HMO enrollees, compared to an average U.S. rate of 297 per thousand HMO enrollees.[44]

Further evidence for the ability of risk-based payments and integrated care to reduce utilization comes from Medicare beneficiaries. A California study found risk-adjusted rates of inpatient days were 30% lower for Medicare Advantage patients than for fee-for-service Medicare patients.[45] More broadly in the United States, a nationwide comparison of Medicare Advantage and fee-for-service Medicare patients from 2003-2009, which used a study design that matched patients based on factors including age, sex, race and health status, still found 20-30% lower utilization of services such as the emergency department and ambulatory surgery for Medicare Advantage patients.[46]

These results are consistent with a California Association of Physician Groups' (CAPG) report that shows Medicare Advantage patients in California averaged 69% of the number of hospital days of Medicare fee-for-service patients (1,174 vs. 1,706 hospital days per thousand

[37] Berkeley Forum analysis using Kaiser Family Foundation (2010).

[38] California Healthline (2012).

[39] Hadley, et al. (2008).

[40] U.S. Census Bureau (2009).

[41] Agency for Healthcare Research and Quality (2011).

[42] All analyses involving the Medical Expenditure Panel Survey in this report were conducted while Christopher Whaley and Brent Fulton were Special Sworn Status researchers of the U.S. Census Bureau at the Center for Economic Studies. Research results and conclusions expressed are those of the co-authors and do not necessarily reflect the views of the Census Bureau. These results have been screened to insure that no confidential data are revealed.

[43] Robinson (1996).

[44] Robinson (1996).

[45] America's Health Insurance Plans, Center for Policy & Research (2009).

[46] Landon, et al. (2012).

enrollees, respectively).[47] Furthermore, CAPG "elite group" Medicare patients in California averaged fewer than 800 days per thousand enrollees in 2009.[48] The CAPG "elite groups" are large multi-specialty medical groups that score highest in four quality domains measured by CAPG: care management processes, health information technology, transparency and patient-centered care. Many "elite groups" have assumed institutional risk in addition to professional services risk. The CAPG report did not control for demographic and health status differences between Medicare Advantage and fee-for-service Medicare beneficiaries; however, its results are consistent with the California and nationwide Medicare Advantage studies discussed above, which did control for such factors.

Evidence of the ability of integrated systems to reduce costs is rapidly emerging. Although there are various systems across the United States that have attained high levels of integration (e.g. Geisinger Health System, Kaiser Permanente and Intermountain Healthcare) data about these organizations' costs are mostly proprietary, and comparisons are difficult because of selection bias and varying risk profiles.[49] Similarly, ACOs are in a relatively early stage of adoption across the United States, and thus broad evidence is not yet available. Nonetheless, support for the Forum Vision can be found in various studies of care systems that share characteristics of early ACO adopters. For example, one recent study found that Medicare beneficiaries treated by physicians in large multi-specialty practices (many of which were integrated with hospitals or health plans) received between 5% and 15% better quality of care, and had healthcare expenditures that were $272 (3.6%) per year lower, than a comparison group treated under fee-for-service Medicare.[50] Similar efficiencies have been found in studies of provider groups that handle most aspects of patient care and that take on financial risk for improving care and lowering expenditures. An evaluation of the Medicare Physician Group Practice Demonstration, the predecessor to the current Medicare Shared Savings program, showed a cost savings of $114 per beneficiary, or 1.4%, for those receiving care from physicians participating in the demonstration project.[51] Even greater savings of $500 per-member per-year were achieved for the dual-eligible population. In California, a Milliman evaluation of the CalPERS Accountable Care Organization offered by Blue Shield of California with its partners Dignity Health and Hill Physicians showed an average annual reduction in expenditures of 7.3% for the two-year study period.[52] As the results from similar projects continue to be evaluated, we expect additional evidence to emerge.

Several studies[53] have pointed to the ability of integrated delivery systems to meet the main criteria identified in the groundbreaking Institute of Medicine report *Crossing the Quality Chasm,*[54] including evidence-based care processes; effective use of information technology; coordination of care across patient conditions, services and settings; and use of performance measurement for accountability.

Figure 3 (on the following page) shows a Forum analysis of the current state of payment methods and integration in California's healthcare system, based on estimates and assumptions regarding HMO penetration, capitation arrangements, medical group size and "virtually integrated" IPA physician participation rates.

As shown in Figure 3, despite a high HMO penetration in California and the prevalence of risk-based payments, the vast majority of medical services in the state are still paid for on a fee-for-service basis. Overall, we estimate that approximately $245 billion, or 78% of California's estimated $313 billion healthcare expenditures in 2012, came through fee-for-service arrangements. Approximately 16.6 million of 38 million Californians (44%) are covered under a contract that includes at least partial risk-based payment, including 8.1 million (21%) under full or dual risk (which includes physician and hospital services). Partial risk payments through non-Kaiser Health Maintenance Organizations (HMOs), however, generally only capitate physician services. Therefore, the vast majority of healthcare services, such as hospitalizations, mental health care and prescription medications, are paid via fee-for-service reimbursement, even for HMO patients. It is important to note, however, that physicians with partial-risk contracts have some incentive to manage hospitalizations for their HMO populations, even though the hospital payment is considered fee-for-service. These incentives stem from health plans and physician organizations layering on top of capitation certain performance measures that financially reward providers based on the hospital utilization patterns of their patients.[55]

Figure 3 also shows that California has a significant portion of its population receiving care through either fully-integrated delivery systems or highly-integrated systems (defined as a medical group with more than 100 physicians). About 11.1 million Californians (29%), virtually all of whom are publicly or privately insured, receive care from such systems. However, an estimated 17.4 million Californians (46%) still receive their care from low-integration systems, which tend to include small practices mostly unaffiliated with IPAs. Approximately

[47] Sanofi Managed Care Digest (2012).

[48] California Association of Physician Groups (2012).

[49] One study that was able to overcome some of these limitations was the RAND Health Insurance Experiment, which showed that individuals randomly assigned to an HMO plan had 28% lower expenditures than those assigned to a fee-for-service plan. For a discussion of these results see Newhouse (1993).

[50] Weeks, et al. (2010).

[51] Colla, et al. (2012).

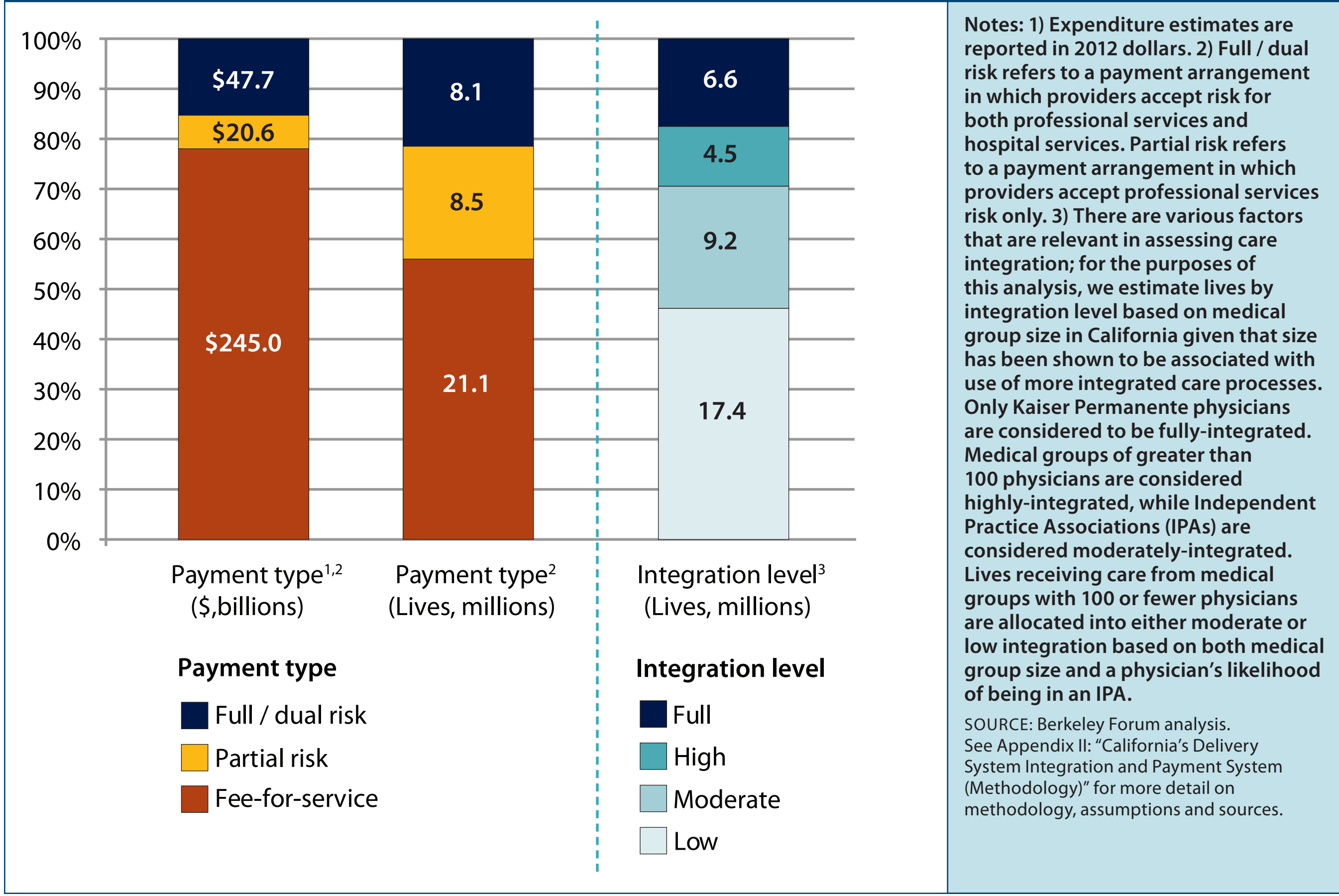
[52] Markovich (2012).

[53] Casalino, et al. (2003); Shortell, et al. (2004); and Crosson (2005).

[54] Institute of Medicine (March 2001).

[55] Rosenthal, et al. (2001).

## FIGURE 3: BREAKDOWN OF PAYMENT MECHANISMS AND DELIVERY SYSTEM INTEGRATION IN CALIFORNIA, BY LIVES AND DOLLARS, 2012




**Notes: 1) Expenditure estimates are reported in 2012 dollars. 2) Full / dual risk refers to a payment arrangement in which providers accept risk for both professional services and hospital services. Partial risk refers to a payment arrangement in which providers accept professional services risk only. 3) There are various factors that are relevant in assessing care integration; for the purposes of this analysis, we estimate lives by integration level based on medical group size in California given that size has been shown to be associated with use of more integrated care processes. Only Kaiser Permanente physicians are considered to be fully-integrated. Medical groups of greater than 100 physicians are considered highly-integrated, while Independent Practice Associations (IPAs) are considered moderately-integrated. Lives receiving care from medical groups with 100 or fewer physicians are allocated into either moderate or low integration based on both medical group size and a physician's likelihood of being in an IPA.**

SOURCE: Berkeley Forum analysis. See Appendix II: "California's Delivery System Integration and Payment System (Methodology)" for more detail on methodology, assumptions and sources.

7.3 million of these 17.4 million are uninsured, whose care in safety-net settings is often haphazard and uncoordinated. An additional 9.2 million Californians (24%) generally receive care from moderately-integrated care systems, which represent mostly mid-sized medical groups or practices affiliated with IPAs. Although IPAs often exhibit a level of clinical and financial alignment comparable to large medical groups, in this analysis, we consider them to be moderately-integrated. This is because it is common for physicians to belong to multiple IPAs. Thus, the scope and impact of an IPA's care management practices and financial incentives may be weakened relative to those of large medical groups.

California is well-positioned to shift towards a more coordinated, cost-effective healthcare system given its high rate of HMO enrollment and its highly organized medical groups and health systems. Nonetheless, we have a long way to go before the Forum Vision is fully realized, particularly in transitioning Californians out of low-integration settings and shifting healthcare expenditures away from the fee-for-service model.

The Forum Vision was informed by the unique history of HMOs and the delegated model in California, including the tumultuous 1990s, a period of provider bankruptcies and anti-HMO consumer backlash. But the Forum does not fear a repeat of those events, for several reasons. First, the regulatory structure has since evolved to better ensure that consumers are protected and medical groups and health plans are monitored for solvency. Second, new models of integrated care and risk-based payment, such as ACOs, evaluate using criteria that reward quality as well as cost control.[56] For example, the Medicare Shared Savings Program has 33 quality measures that determine payments to providers.[57] An increasing culture of transparency, in which consumers have access to information on care quality, is also a key component of many integrated care models. Our final reason for optimism about the successful implementation of the Forum Vision is the 20-plus years of experience that California's providers and health plans have had in managing population health and risk-based payments.

[56] For more background on ACOs, see Singer, et al. (2011) and Bowers, et al. (2011).

[57] Centers for Medicare & Medicaid Services (2012).

## SECTION IV

# California's Healthcare System Performance with Regards to Health Status, Health Disparities and Care Quality

**The preceding section provided evidence that relative to other states, California's healthcare system encourages more integration and accountability. We now examine how the California system performs with regards to health status, health disparities and care quality. The good news is that Californians on average tend to be healthier than other Americans, with higher life expectancy,[58] lower rates of smoking and lower rates of colorectal and breast cancer deaths.[59]**

Nonetheless, California has significant room for improvement in both health and healthcare, whether by its own historical standards or in comparison to top-performing states or health plans. One indication that progress still needs to be made comes from the fact that significantly greater numbers of Californians currently consider themselves to be in poor or fair health: 18.1% in 2010 compared to 15.5% in 1996.[60] Among the health-related statistics that clearly need improvement are high uninsured rates, growing rates of chronic disease and obesity and persistent health disparities. A recent review of quality of care metrics paints a mixed picture, with some areas improving but others worsening. Last December's "Let's Get Healthy California"[61] report provides a more thorough analysis of these issues.

According to the U.S. Census Bureau, California had the ninth-highest uninsured rate in the country in 2010.[62] A 2009 study showed that one in five non-elderly Californians was uninsured, greatly reducing their ability to access care.[63] Approximately two in five uninsured California children, and half of uninsured adults, reported not seeing a healthcare provider in the past year, about four times the rates of their counterparts with employer-based insurance. Approximately half of uninsured California adults report having no usual source of care, more than five times the rate for adults with employer-based insurance.[64]

A paramount cause for concern, in both California and the entire United States, is the growing obesity epidemic. Between 1995 and 2010, obesity rates in California rose nearly 70%, from 14.6% to 24.7%, according to the Behavioral Risk Factor Surveillance System (see Table 2 on the following page).[65] Without significant changes, 46.6% of Californians are expected to be obese by 2030, according to a recent study by Trust for America's Health.[66,67] Obese children and adolescents face double the risk for mortality before the age of 55 when compared to their non-obese counterparts.[68] There is a high correlation between obesity and low physical activity rates and a host of diseases, including type 2 diabetes, coronary heart disease and stroke, hypertension, arthritis, and cancers of the breast, kidney and colon. The picture is not entirely bleak; California experienced a slight increase in physical activity rates between 2001 and 2009. Still, almost half of Californians do not attain the minimum physical activity levels recommended for good health.[69]

Table 2 shows growing rates of other chronic conditions that parallel the rise in obesity among Californians. Diabetes, hypertension and high cholesterol among adults increased 69%, 16% and 30%, respectively, between the mid-1990s and 2009-2010.

Another challenge for the California healthcare system involves health disparities among different socioeconomic and geographic populations. There are a number of factors associated with poor health, including lower income levels, lack of health insurance and membership in a minority group.

Almost nine million Californians, or 23.5% of the state's population, live in poverty as assessed by the Census Bureau's newly developed Supplemental Poverty Measure (SPM), which includes factors such as government benefits and cost of living. This is the highest in the country, and much higher than the average U.S. rate of 15.8%.[70,71] Fully 35% of low-income California adults report being in poor or fair health, compared to just 14% of the more affluent.[72]

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58 Kaiser Family Foundation (2012).

59 Commonwealth Fund (2009).

60 Behavioral Risk Factor Surveillance System (2012).

61 California Health and Human Services Agency (2012).

62 California Healthline (2012).

63 Lavarreda, et al. (2012).

64 California Health Interview Survey (2009).

65 Behavioral Risk Factor Surveillance System (2012).

66 Levi, et al. (2012).

67 Though not directly comparable to this California estimate, a recent study looks at evidence that prevalence of obesity in the United States has leveled off. In contrast to linear time trend forecasts that indicate 51% of the U.S. population will be overweight in 2030, Finkelstein, et al. (2012) estimates that about 42% of the U.S. population will be obese in 2030.

68 Franks, et al. (2010).

69 Behavioral Risk Factor Surveillance System (2011).

70 Short (2012).

71 Using the Census Bureau's traditional poverty measure, California's rate is 16.3% vs. the U.S.'s rate of 15.0%.

72 California Health Interview Survey (2009).

## TABLE 2: HEALTH STATUS, CHRONIC CONDITIONS AND LIFESTYLE FACTORS OVER TIME FOR CALIFORNIA ADULTS, 1995 – 2010

| Measure | Year[1] | | | | % change over timeframe |
|---|---|---|---|---|---|
| | 1995 / 1996 | 2000 / 2001 | 2004 / 2005 | 2009 / 2010 | |
| Fair or poor health | 15.5% | 16.0% | 17.6% | 18.1%* | 16.8% |
| Obese | 14.6% | 21.9%* | 22.7%* | 24.7%* | 69.2% |
| Overweight or obese | 50.9% | 59.4%* | 60.6%* | 61.6%* | 21.0% |
| Diabetes[2] | 5.1% | 6.5% | 7.1% | 8.6%* | 68.6% |
| Hypertension | 22.1% | 23.3% | 25.7%* | 25.7%* | 16.3% |
| High cholesterol | 28.0% | 31.7% | 35.2%* | 36.5%* | 30.4% |
| Current asthma | NA | 7.2% | 7.2% | 7.7% | 6.9% |

**Notes: Asterisks indicate no overlap in the 95% confidence intervals between the year shown and the benchmark year. The Behavioral Risk Factor Surveillance System (BRFSS) adjusts data for population characteristics such as gender and ethnicity, but does not control for confounding factors or conditions. 1) Most BRFSS data is collected once every two years, in either even or odd years. Where data are available for both years (e.g. both 1995 and 1996), the latter year data is used. Intervals between comparison years vary, as they were selected to provide the longest time range to observe trends. 2) The diabetes category does not include pregnancy-related or pre-diabetes cases.**

SOURCE: Berkeley Forum analysis using Centers for Disease Control and Prevention (1995 – 2010).

Health disparities among California's racial and ethnic groups are well-documented.[73] At 21.1%, African-Americans are more likely to report poor or fair health status, compared to 11.7% of Caucasians.[74] African-Americans have almost twice the rates of mortality amenable to healthcare as non-African-American Californians, at 175 vs. 96 deaths, respectively, per 100,000 people.[75] In 2009, 10.6% and 12.9% of California's Latino and African-American population, respectively, reported having been diagnosed with diabetes, compared to the 6.3% rate among non-Latino whites.[76] Between 1999 and 2007, California's Office of Statewide Health Planning and Development (OSPHD) evaluated 16 indicators among ambulatory-sensitive care conditions, such as bacterial pneumonia, diabetes-related amputations and adult asthma.[77] The analysis showed lower age- and gender-adjusted performance for African-American patients in 14 out of 16 indicators—often two or three times worse than for Caucasians. There appears to be some improvement in this area, however, as OSPHD data revealed a decrease in disparities for 10 indicators for African-Americans, and for thirteen indicators for Latinos, during the study period. According to the Agency for Healthcare Research and Quality, some factors that contribute to these persistent disparities include environment or lifestyle issues, poor access to or a low quality of outpatient care and higher predisposition for diseases.[78]

Finally, California has room for improvement in terms of care quality. California ranks 29th among the 50 states in overall healthcare quality, according to the 2011 AHRQ National Healthcare Quality Report, which measured performance in such areas as preventive care, acute and chronic care quality, and patient experience (see Table A3 in Appendix I).[79] Much of California's population with chronic conditions could benefit from better care management. The Right Care Initiative's analysis of select Healthcare Effectiveness Data and Information Set (HEDIS) measures, a tool used widely by health plans, found that Kaiser and Sharp health plans were the only California insurers to regularly reach the national 90th percentile mark in such indicators as adequate screening and management of hypertension, diabetes and cholesterol.[80] An OSHPD analysis of ambulatory-care sensitive conditions between 2005 and 2009 showed mixed results.[81] There was an improvement in six conditions, including dehydration, but declines in four others, including hypertension. But there was sobering news from a study that extrapolated from U.S.

[73] Agency for Healthcare Research and Quality (2011).
[74] Lavarreda, et al. (2012).
[75] Commonwealth Fund (2009).
[76] California Health Interview Survey (2009).
[77] Tran, et al. (2010).
[78] Agency for Healthcare Research and Quality (2011).
[79] Ibid.
[80] California Department of Managed Health Care (2012).
[81] California Office of Statewide Health Planning and Development (2012).

data to estimate healthcare-associated infections: Each year, about one in 20 hospitalized Californians develops a healthcare-associated infection, resulting in 12,000 deaths.[82]

The Berkeley Forum analyzed the implementation of six evidence-based Care Management Practices (CMP), such as use of patient disease registries and point of care reminders, for four chronic diseases in large medical groups in California compared with the rest of the United States (see Table A4 in Appendix I).[83] Patient-centered medical homes, which have generally been shown to reduce admissions and emergency department visits, often use a combination of CMPs. In four[84] of the six CMPs compared, medical groups in California and those in the rest of the United States generally demonstrated similar frequency of CMP availability. California performs significantly better, however, with regards to employing patient registries and nurse care managers for diabetes, asthma and congestive heart failure. Overall, large California medical groups employ more CMPs than similarly sized groups in the rest of the United States with regards to these three conditions. Depression was the only condition in which California performed similarly to the rest of the U.S. average for all six CMPs. Overall, however, there is still room for significant improvement, as a mere 4.1% of large medical groups in California, and 3.4% of those in the rest of the country, use all six evidence-based Care Management Practices in all four key chronic diseases.

In summary, it is these challenges—a large population of uninsured residents; the growing burden from obesity and other chronic diseases; the continuing disparities among socio-economic groups; and the persistent problems with care quality—that prompted the Berkeley Forum to recommend the fundamental changes to California's healthcare system outlined in the Forum Vision.

[82] California Department of Public Health (2009-2010).

[83] Rittenhouse, et al. (2010); Shortell (2011).

[84] These four CMPs are: 1) provide patient educators, 2) physician feedback on quality, 3) patient reminders and 4) point-of-care reminders.

**SECTION V**

# The Affordability Crisis: An Examination of California's Healthcare Expenditures and Insurance Premiums

**In the previous section, we examined the performance of the California healthcare system with regards to coverage, health status, disparities and quality. We now move on to discussing its financial sustainability. We first assess how healthcare expenditures in California compare to those in the United States as a whole. We then analyze the high concentration of healthcare expenditures in the state. We estimate the growing share of California's Gross State Product that is being devoted to healthcare, and the alarming growth projected for employer-sponsored health insurance premiums over the coming ten years. We conclude by discussing how healthcare spending will become increasingly unaffordable for families, employers and the government.**

## A. Assessing California's healthcare expenditures

In 2009, California ranked ninth lowest among U.S. states in personal healthcare expenditures per capita, at $6,238 versus the U.S. average of $6,891.[85] Moreover, California has a lower healthcare utilization rate than the U.S. average, for some of the reasons discussed in Section IIIC above, "California's current performance compared to the Forum Vision."[86]

In contrast to its lower relative utilization, California has high unit costs compared to the rest of the country. For example, an adjusted inpatient overnight stay cost 30% more in California in 2010 than the U.S. average, $2,566 vs. $1,910.[87] There are several reasons for this. First,

[85] Centers for Medicare & Medicaid Services (2009) and Cuckler, et al. (2011); CMS releases state-level data on personal healthcare expenditures, rather than total healthcare expenditures (which also include the net cost of private health insurance, government healthcare administration costs, government public health activities and healthcare investments). As a point of comparison, at the national level in 2009, personal healthcare expenditures per capita were $6,891, or 84% of the $8,163 in total healthcare expenditures per capita.

[86] Also see Appendix XII: "Assessing California's Healthcare Spending (Brief)" for more background on healthcare utilization and unit costs in California.

[87] Kaiser Family Foundation (2012). The adjustment is described by KFF as: "Adjusted expenses per inpatient day include expenses incurred for both inpatient and outpatient care; inpatient days are adjusted higher to reflect an estimate of the volume of outpatient services."

because the California system emphasizes the use of lower-cost settings whenever possible, those patients actually admitted to full-service hospitals are likely to have more acute conditions that are more expensive to treat. Second, California is expensive overall; the Berkeley Forum estimates the state's cost of living may be about 20% to 30% higher than the national average.[88] An important element of this high unit cost is the relatively low supply and high wages associated with the non-physician workforce.[89] For example, registered nurses on average earn more in California than they do in any other state, with wages about 36% higher than in the rest of the country.[90] Finally, California hospital costs may also be higher because of regulations unique to the state, such as robust seismic building codes and the mandatory minimum nurse-to-patient staffing ratio.

Healthcare costs are the major determinant of California's employer-sponsored health insurance premiums. But other factors drive premiums as well, such as the cost-shifting that results from uninsured patients and low Medi-Cal reimbursement, as well as the presence of large provider groups with strong negotiating leverage. California's higher HMO penetration, along with some of the most generous insurance mandates in the country, may result in richer benefit packages but subsequently higher premiums (for more information on the factors affecting healthcare spending in California, see Appendix XII: "Assessing California's Healthcare Spending (Brief)").

While these factors help explain the current level of healthcare spending in California, it is medical technology, or new or broader applications of treatments, that is principally responsible for the continuous growth in expenditures. Several studies have concluded that around half of all such growth can be tied to medical technology.[91] Recently, one study estimated that medical technology accounted for 27-48% of the growth in healthcare spending per capita from 1960-2007.[92] Other key factors included income growth (29-43%) and higher medical prices (5-19%). Changes in coverage expansion and benefit design, administrative costs and population aging also affected growth, albeit less so than the other factors. Some of these elements are inter-related; for example, higher incomes coupled with more expansive insurance coverage helps to fuel medical technology growth.

## B. California's 5/50 population

A major opportunity for reducing overall healthcare expenditures lies in lowering the spending attributable to the most expensive individuals. A Berkeley Forum analysis of the concentration of healthcare expenditures using the 2009 Medical Expenditure Panel Survey—Household Component (MEPS-HC) revealed that 5% of Californians accounted for 53% of the state's healthcare expenditures, with expenditures 10.7 times those of the average Californian. This concentration of healthcare expenditures is similar to that of the country as a whole.[93] The top 25% spent 3.6 times the average, and accounted for 89% of California's healthcare expenditures (see Figure A5 in Appendix I).

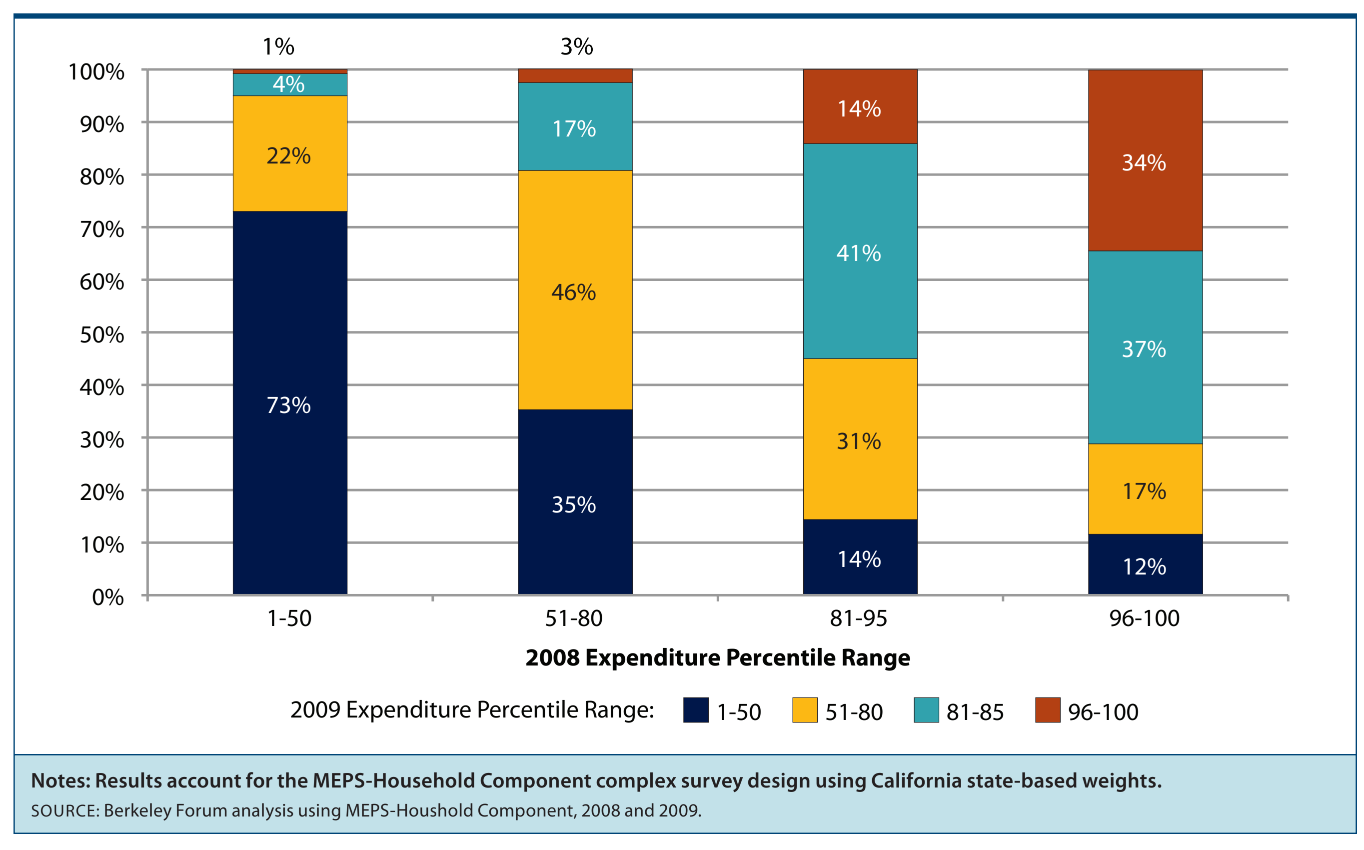
There are certain characteristics among this top 5% cohort (see Table A5 in Appendix I). Women and individuals older than 50 represent about three-fifths of the group. About half is privately insured, one-quarter is in Medicare and one-tenth are Medicare and Medicaid dual-eligibles. About one-third of the top spenders are obese, and many have chronic conditions, including high blood pressure (56%), heart disease (28%), high cholesterol (46%), diabetes (21%), joint pain (41%) and arthritis (48%). All of the above characteristics (except for being privately insured) are significantly more common among those in the top 5% than those in the bottom 95% of spenders. For example, there is a statistically significant prevalence ratio (2.0) of obese people in the top 5% vs. in the bottom 95%.

Another striking characteristic of top healthcare spenders is the likelihood of their remaining high spenders year after year, as shown in Figure 4. Of the top 5% of spenders in 2008, 34% remained in the top 5% the following year, and 71% were in the top 20%. In contrast, among the bottom 50% of spenders in 2008, only 1% transitioned to the top 5% in 2009, while three-quarters remained below the median. A similar analysis of the top 20% of spenders in 2008 revealed that 59% remained in the top 20% in the following year. This tendency of high spenders to persist as such across multiple years is much the same in the rest of the United States.

The California Department of Health Care Services recently analyzed the spending of 3.1 million fee-for-service Medi-Cal beneficiaries between 2005 and 2010, and found that the top 5% accounted for 66% of total Medi-Cal fee-for-service expenditures.[94] Part of that high concentration is due to the complex challenges faced by this population. For example, blind and disabled beneficiaries account for 15% of the total studied population, but 63% of the top 5% cohort.[95] Of note, long-term care beneficiaries only accounted for 3% of the top 5% cohort.[96] Of the top spenders in 2005 who were still enrolled in Medi-Cal fee-for-service the following year, 56% remained in the top 5%. Five years later in 2010, 45% of the enrolled top-spending beneficiaries from 2005 still remained in the top 5% (see Figure A6 in Appendix I). This high persistence is likely partly the result of the blind and disabled, with their increased healthcare needs, accounting for a large share of the top 5% cohort.

[88] Berkeley Forum analysis using U.S. Census Bureau (2011) and U.S. Census Bureau (2012).
[89] See Appendix XII: "Assessing California's Healthcare Spending (Brief)" for sources and additional data on nurse practitioner and physician assistant wages and supply.
[90] U.S. Bureau of Labor Statistics (2011).
[91] Newhouse (1992); Cutler (1995); Smith, et al. (2000).
[92] Smith, et al. (2009).
[93] Zuvekas, et al. (2007).
[94] California Department of Healthcare Services (2012).
[95] Ibid.
[96] Ibid.

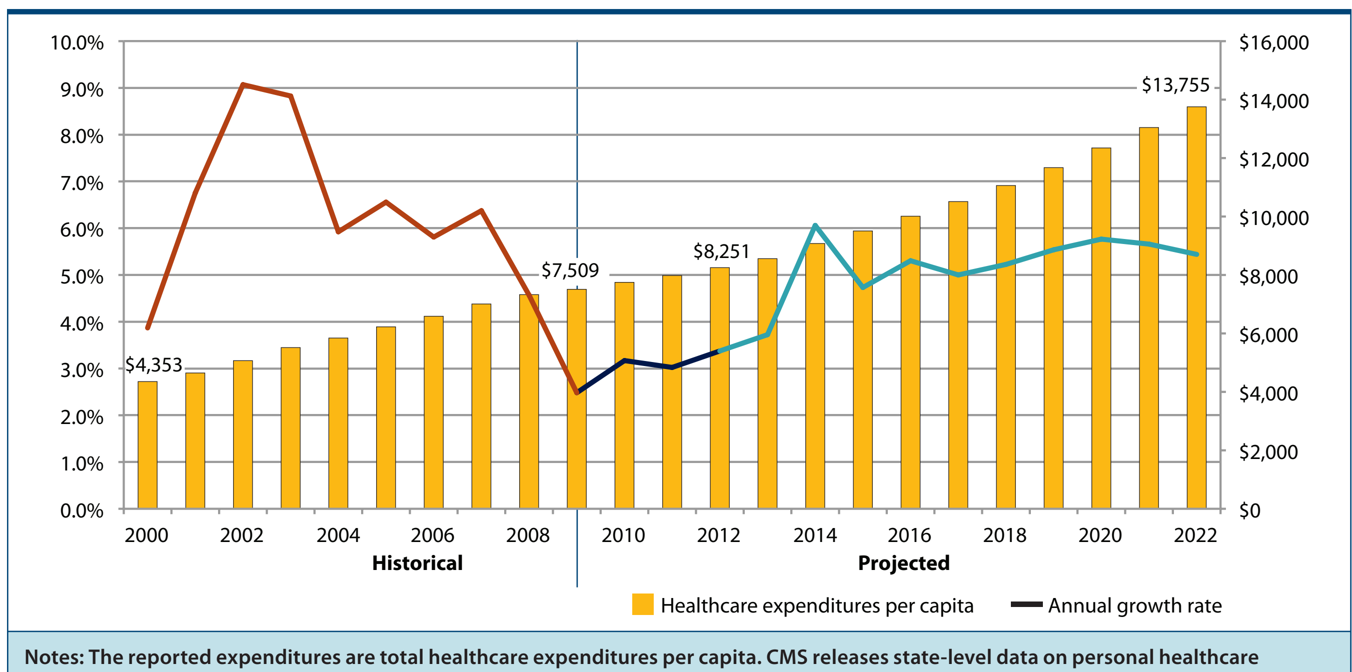
## FIGURE 4: HEALTHCARE EXPENDITURE PERCENTILE COHORT TRANSITIONS BETWEEN 2008 AND 2009 IN CALIFORNIA




**Notes: Results account for the MEPS-Household Component complex survey design using California state-based weights.**

SOURCE: Berkeley Forum analysis using MEPS-Houshold Component, 2008 and 2009.

## FIGURE 5: HISTORICAL (2000 – 2009) AND PROJECTED (2010 – 2022) HEALTHCARE EXPENDITURES PER CAPITA AND ANNUAL GROWTH RATE IN CALIFORNIA

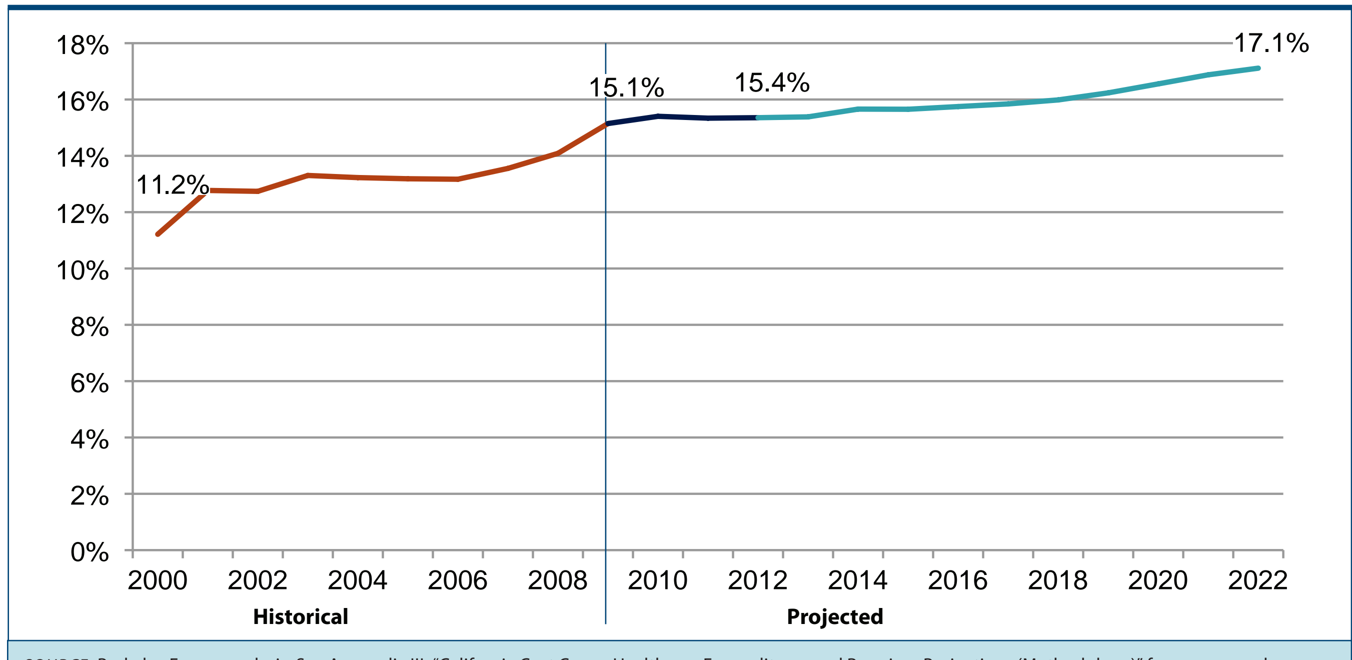



**Notes: The reported expenditures are total healthcare expenditures per capita. CMS releases state-level data on personal healthcare expenditures, which we adjusted upward to reflect total healthcare expenditures per capita. Healthcare expenditures per capita are reported in current-year dollars.[97]**

SOURCE: Berkeley Forum analysis. See Appendix III: "California Cost Curve, Healthcare Expenditures and Premium Projections (Methodology)" for sources and additional detail.

[97] Note that the term "current-year dollars" throughout the report is equivalent to current or nominal dollars.

## FIGURE 6: CALIFORNIA'S COST CURVE: HISTORICAL (2000 – 2009) AND PROJECTED (2010 – 2022) HEALTHCARE EXPENDITURES AS A PERCENT OF GROSS STATE PRODUCT




SOURCE: Berkeley Forum analysis. See Appendix III: "California Cost Curve, Healthcare Expenditures and Premium Projections (Methodology)" for sources and additional detail.

## C. The growing healthcare Cost Curve

The overwhelmingly high concentration of healthcare expenditures is a cause of concern. However, it's the high growth in average per capita healthcare expenditure that provides the greatest impetus for the fundamental changes called for by the Forum Vision. After growing at the relatively low average annual rate of 3.7% in nominal terms between 1991 and 2000, the average annual growth rate between 2000 and 2003 spiked to 8.2% (see Figure 5). Between 2000 and 2009, per capita healthcare expenditures in the state grew at an average annual rate of 6.3%, from $4,353 to $7,509. The annual per capita growth rate began decreasing near the end of the decade, falling to 2.5% in 2009, largely due to the 2008-2009 recession.[98]

Figure 5 also shows projected per capita healthcare expenditures in current-year dollars and growth rates through 2022. Based on historical tracking between the United States and California, we applied the Centers for Medicare & Medicaid Services (CMS) national projected per capita healthcare expenditures growth rates to the state, with certain modifications. For example, we independently estimated the impact of the Affordable Care Act (ACA) coverage expansion on California to arrive at projections for 2014 (see Appendix III "California Cost Curve, Healthcare Expenditures and Premium Projections (Methodology)"). The figure shows that per capita healthcare expenditures in California are expected to grow to $13,755 in 2022, representing an average annual growth rate of 5.2% between 2012 and 2022.[99] Due to the ACA coverage expansion in 2014, we project a 6.1%[100] increase in per capita healthcare expenditures that year, followed by annual growth rates between 4.7% and 5.8% through 2022.[101] Aggregate healthcare expenditures in the state are expected to reach $572 billion in 2022, and total $4.4 trillion between 2013 and 2022.[102]

To benchmark healthcare expenditures, we examined the Cost Curve, which shows California's healthcare expenditures as a percent of Gross State Product (GSP). Figure 6 shows that the Cost Curve grew from 11.2% to 15.1% between 2000 and 2009.[103] In the early and late

[98] Martin, et al. (2012).

[99] For reference, in 2022, healthcare expenditures per capita are projected to be $10,856 in 2012 dollars, representing a real average annual growth rate of 2.8% between 2012 and 2022.

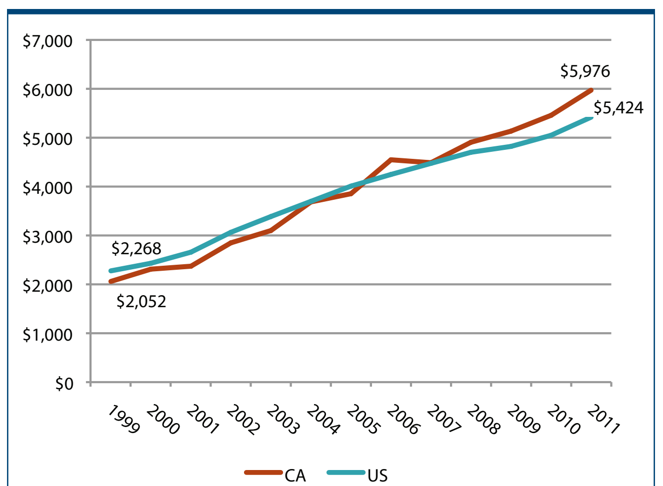
[100] For reference, the 2014 growth rate in per capita healthcare expenditures is 3.6% in constant 2012 dollars.

[101] There are several reasons why per capita healthcare expenditures do not grow as much as may be anticipated in connection with ACA coverage expansion. Some of these include: 1) the uninsured already have some existing healthcare expenditures prior to coverage expansion, 2) A Berkeley Forum analysis using Cal-Sim (2012) projections indicates that the newly insured are expected to represent only about 5.5% of the state's under-65 population in 2014, and 3) Medi-Cal, which has below-average per capita healthcare expenditures, partly due to relatively lower reimbursement rates, will cover many of the state's newly insured.

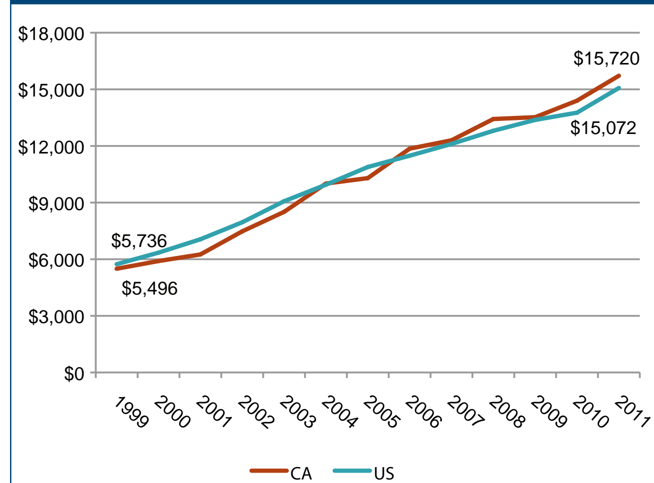
[102] For reference, aggregate healthcare expenditures are estimated to total $452 billion in 2022 and $3.8 trillion for the period between 2013 and 2022, in constant 2012 dollars.

[103] The share of California's GSP represented by healthcare expenditures is less than the share of the United States' gross domestic product (GDP) represented by healthcare expenditures, which was 17.9% in 2009.

## FIGURE 7: TOTAL EMPLOYER-SPONSORED HEALTH INSURANCE PREMIUMS FOR SINGLE COVERAGE IN CALIFORNIA AND THE UNITED STATES, 1999 – 2011



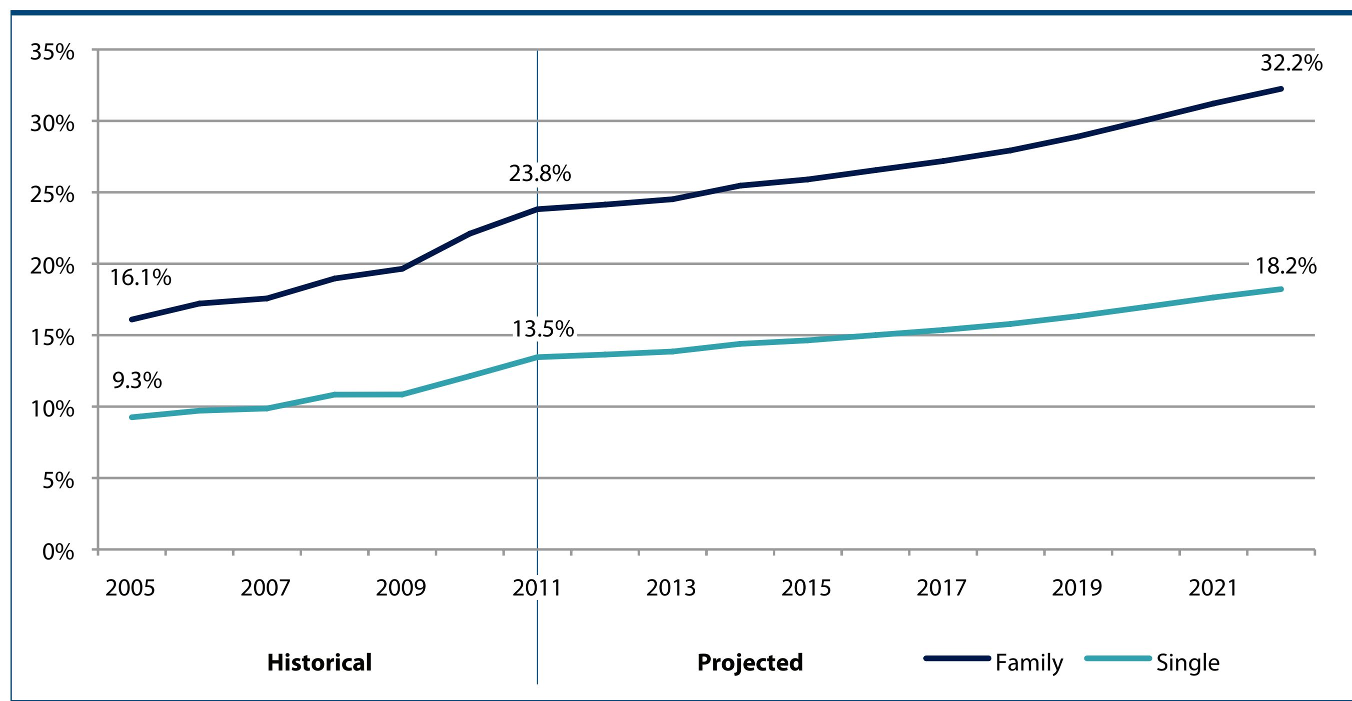

## FIGURE 8: TOTAL EMPLOYER-SPONSORED HEALTH INSURANCE PREMIUMS FOR FAMILY COVERAGE IN CALIFORNIA AND THE UNITED STATES, 1999 – 2011




**Notes: Premiums include both employer and employee contributions. Premiums are reported in current-year dollars.**

SOURCE: Kaiser Family Foundation Employer Survey 1999-2003 and California HealthCare Foundation Employer Benefits Survey 2004-2011.

## FIGURE 9: HISTORICAL (2005 – 2011) AND PROJECTED (2012 – 2022) EMPLOYER-SPONSORED HEALTH INSURANCE PREMIUMS FOR SINGLE AND FAMILY COVERAGE AS A PERCENT OF MEDIAN HOUSEHOLD INCOME IN CALIFORNIA




**Notes: Premiums include both employer and employee contributions.**

SOURCE: Berkeley Forum analysis. See Appendix III "Methodology: California Cost Curve, Healthcare Expenditures, and Premium Projections" for sources and more detail.

part of the decade, the Cost Curve grew rapidly, with healthcare expenditure growth outpacing GSP growth by an annual average rate of almost 6 percentage points. In contrast, the Cost Curve was relatively flat in the middle of the decade, a brief period during which economic growth stayed on pace with the rise in healthcare expenditures.

Figure 6 also shows the projected change in the Cost Curve over the coming ten years.[104] Based on these estimates, healthcare expenditures are projected to increase from 15.4% to 17.1% of GSP between 2012 and 2022. During this period, aggregate healthcare expenditures are forecast to grow 6.2%[105] annually, or about 1.1 percentage points more than the 5.1% annual aggregate GSP growth rate.[106]

## D. The growing burden of health insurance premiums

The impact of growing healthcare expenditures is directly felt by employees and employers in the employer-sponsored insurance (ESI) market through higher premiums. In the 2010 – 2011 period, approximately 45% of Californians received healthcare coverage via employer-sponsored insurance.[107] Californians have historically enjoyed slightly lower premiums in the ESI market as compared to the United States, even though California has a higher cost of living.[108] In recent years, however, California premiums began to increase faster than those in the United States overall (see Figures 7 and 8). Total premiums (meaning both employer and employee contributions) for both single and family coverage via ESI in California have increased just over 9% on average annually in nominal terms since 1999, and, unadjusted for cost of living, surpassed the U.S. level in 2006.

Although not paid for directly by individuals, the employer contribution to premiums is important in assessing overall affordability, because an increase in employer contributions to premiums invariably often comes in lieu of increased wages. Thus, rising premiums affect not only healthcare affordability but also a family's standard of living.

To assess health insurance affordability for California families, we considered total ESI premiums as a percent of median household incomes, both for single and family households under 65. Figure 9 shows that the relative cost of single coverage via ESI in California increased by almost 50% between 2005 and 2011, growing from 9.3% to 13.5% of median single-person household income. Similarly, premiums for family coverage under ESI increased from 16.1% of median family household income in 2005 to 23.8% in 2011. These large increases are the result of premiums growing at an average annual rate of about 7.5%, while during the same period median household incomes grew at an average annual rate of just 1.1% for single-person households and 0.5% for family households.

We project that total ESI premiums will grow at an average annual rate of 6.6% between 2011 and 2022.[109,110] Total premiums for single coverage via ESI are projected to rise from $5,976 in 2011 to $12,062 in 2022 (see Figure A7 in Appendix I). For family coverage via employer-sponsored insurance, premiums are projected to grow from $15,720 in 2011 to $31,728 in 2022.[111] As in previous years, premiums are projected to grow significantly faster than household income.[112] As a result, the percent of median household income devoted to total premiums for ESI between 2011 and 2022 is projected to increase from 13.5% to 18.2% for single coverage and from 23.8% to 32.2% for family coverage, as shown in Figure 9. This anticipated decline in health insurance affordability over the next decade will have a significant negative impact on the standard of living for California families by substantially reducing the amount they have to spend on items other than healthcare.

## E. Fiscal challenges

The growth in healthcare expenditures is also a pressing concern for federal and state budgets. The ACA includes $716 billion in cuts to Medicare over ten years, mostly through reductions in reimbursements to providers and Medicare Advantage plans.[113] Medicare benefits, however, were enhanced by the ACA, particularly for preventive care and by the elimination of the "donut hole"

[104] We forecast California GSP through 2022 by applying the national economic forecasts utilized in CMS projections. See Appendix III: "California Cost Curve, Healthcare Expenditures, and Premium Projections (Methodology)" for more detail.

[105] For reference, the aggregate healthcare expenditures and aggregate GSP average annual growth rates in constant 2012 dollars are estimated to be 3.7% and 2.6%, respectively, between 2012 and 2022.

[106] The approximate 1 percentage point difference between aggregate and per capita healthcare expenditures growth during this period (6.2% aggregate vs. 5.2% per capita) is due to the expanding California population.

[107] Kaiser Family Foundation State Health Facts (2011).

[108] See Appendix XII: "Assessing California's Healthcare Spending (Brief)" for more information on cost of living in California.

[109] To forecast ESI premiums in California, we adjusted our annual 2012-2022 projections of healthcare expenditure per capita growth rates upward, to account for ESI premiums having grown at 1.6 times the rate of healthcare expenditures per capita over the past decade. However, our baseline projections assume that ESI premiums will only grow at 1.3 times the rate of per capita healthcare expenditures in California. (See Appendix III "California Cost Curve, Healthcare Expenditures and Premium Projections (Methodology)" for sources and more detail.)

[110] For reference, the average annual growth rate projections for both single- and family-coverage ESI between 2011 and 2022 is 4.1%, in constant 2012 dollars.

[111] For reference, single-coverage ESI premiums are projected to grow from $6,106 to $9,519 and family-coverage ESI premiums are projected to grow from $16,061 to $25,041 between 2011 and 2022 in constant 2012 dollars.

[112] We estimated median household income by adjusting our projections of annual average per capita income growth downwards slightly between 2012 and 2022, as median household income grew more slowly than average household income over the past decade. (See Appendix III: "California Cost Curve, Healthcare Expenditures and Premium Projections (Methodology)" for more detail).

[113] Harvey, et al. (2012).

in prescription drug coverage. Nonetheless, Medicare spending is projected to nearly double in the next ten years, from $550 billion in 2012 to $1.1 trillion in 2022, and projected to increase from 3.7% of U.S. Gross Domestic Product (GDP) in 2012 to 4.3% in 2022.[114] The projected growth in Medicare spending is principally caused by anticipated new healthcare technologies.[115] But it is also affected, albeit to a lesser extent, by the many new beneficiaries entering the program as the baby boom generation reaches eligibility age. Even more significant growth is expected for Medicaid. The federal outlay for the program was $253 billion in 2012, but is projected to increase to $592 billion in 2022, primarily because most of the ACA's Medicaid coverage expansion is being funded by the federal government.[116] Overall, the increased spending projections for the two programs severely strain the U.S. budget.

Much the same is happening at the state level. Medi-Cal is the second-largest expenditure in California's general fund, behind only K-12 education.[117] The state's dire fiscal situation in recent years has put pressure on Medi-Cal's budget, resulting in decreased provider reimbursement and an attempted 10% across-the-board reduction in provider payments that has been the subject of several court challenges. Low provider reimbursements, combined with benefit reductions and movement of Medi-Cal beneficiaries into managed care, have tempered the rate of increase in Medi-Cal expenditures. At 56% in 2008, California currently has the fourth-lowest Medicaid to Medicare reimbursement ratio in the country for physician services.[118] Consequently, only 57% of the state's physicians were accepting new Medi-Cal patients in 2008, and these physicians are often concentrated in an even smaller share of practices.[119] With the large expansion of Medi-Cal under the ACA, there is a concern about the long-term growth in the state's overall Medi-Cal spending despite the fact the expansion is mostly funded by the federal government. Furthermore, the increased demand for services that will result from the ACA expansion leads to concerns about provider access, which is already limited.

In summary, healthcare in coming years is expected to become increasingly unaffordable for families, for employers, and especially for the federal and state governments.

[114] Blom, et al. (2012).

[115] Smith, et al. (2009).

[116] Ibid.

[117] California HealthCare Foundation (2009a).

[118] Kaiser Family Foundation (2012).

[119] Bindman, et al. (2010).

SECTION VI

# Addressing the Affordability Crisis: Bending the Cost Curve

**Aware of the significant problems with affordability in our healthcare system, the Berkeley Forum examined several initiatives for reducing the growth of healthcare expenditures.**

## A. Examined initiatives

The Forum participants endorse seven initiatives for implementation in California, listed in Table 3. These initiatives were selected for several reasons, the main one being the interest expressed by Forum participants. Other factors included California's unique delivery system and demographics, the magnitude of the initiative's potential reduction in healthcare expenditures, the evidence supporting quantification of the initiative's impact and the feasibility of actually implementing it. As much as possible, the analyses take into account California's unique socioeconomic, demographic, geographic, health and healthcare system characteristics.

Table 3 provides a brief description of each initiative and describes its adoption under two different scenarios: the Current Developments and the Forum Vision scenarios. Appendices IV-XI contain a comprehensive description of each initiative. Each appendix describes the underlying problem, discusses the proposed initiative, and reports the estimated healthcare expenditure reductions under both scenarios. They also explain the methods and assumptions used to generate the estimates, and discuss evidence of the initiative's possible health outcomes and care quality benefits. Depending on the initiative, these benefits might include a reduction in chronic disease burden, improved mental and emotional health, increased longevity and better patient and caregiver experience—among others.

The Current Developments scenario is based on an assessment of unfolding market forces, policies and events. Chief among these is the ACA, with its subsidiary provisions such as the Medicare Shared Savings Program and the penalties being imposed by CMS for hospital-acquired infections and re-admissions. The scenario also takes into account growing Medicaid primary care access challenges, private payers' experimentation with new delivery and payment methods, and the growing awareness of the benefits of palliative care and physical activity. The Current Developments scenario is distinct from the status quo, which is based on historical trends.

## TABLE 3: INITIATIVES EXAMINED BY THE BERKELEY FORUM

| Initiative | Description | Key Indicator | Current Rate | Current Developments Rate (2022) | Forum Vision Rate (2022) |
|---|---|---|---|---|---|
| Global Budgets / Integrated Care Systems | Increase the number of people who receive care from integrated care systems that operate under risk-adjusted global budgets, which encompass primary care, specialty care, facilities and pharmaceuticals. | Percent of insured Californians served by integrated care systems using risk-adjusted global budgets. | 23%[120] | 45% | 70% |
| Patient-Centered Medical Home | Increase use of patient-centered medical homes to more effectively manage care for patients with chronic diseases and to reduce their avoidable / non-urgent emergency department and inpatient visits. | Percent of patients with at least one chronic condition enrolled in a PCMH. | 25%[121] | 50% | 80% |
| Palliative Care | Increase use of concurrent curative and community-based palliative care for seriously ill patients, including advanced care planning and physical, emotional and social support. | Percent of seriously ill patients receiving community-based palliative care.[122] | 10%[123] | 30% | 50% |
| Physical Activity | Increase rates of physical activity to improve the health of currently inactive Californians. | Percent of Californians considered inactive. | 48.7%[124] | 46.3% | 43.8% |
| Nurse Practitioners and Physician Assistants | Increase use of nurse practitioners (NP) and physician assistants (PA) for primary care services, at a lower cost structure than for physicians. | Percent of office-based visits to primary care clinicians provided by NPs and PAs. | 9.8% (NP)<br>2.2% (PA)[125] | 11.8% (NP)<br>3.2% (PA) | 24.5% (NP)<br>5.5% (PA) |
| Healthcare Associated Infections | Reduce five common healthcare-associated infections (HAI).[126] | Number of five common HAI cases per facility | Varies by HAI[127] | Reduce by 22% | Reduce by 40% |
| Preterm Births | Improve prenatal health and birth outcomes by expanding prenatal care and education efforts targeting high-risk pregnancies. | Percent of births that are preterm (24-37 weeks)[128] | 9.7%[129] | 9.5% | 9.4% |

[120] This estimate includes Kaiser Permanente members as well as those in other global budget/integrated care system arrangements in California, based on ACO data from Cattaneo & Stroud Inc. (2012a&2013).

[121] Rittenhouse, et al. (2008).

[122] For the purpose of this analysis, seriously ill patients are those in the last year of life with any of the following conditions: cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, amyotrophic lateral sclerosis (ALS), cirrhosis and HIV. The number of seriously ill patients is adjusted upward by 25% to account for those with less common conditions or who are in an earlier stage of a disease.

[123] We estimate that about 20% of California patients who need community-based palliative care have access to it, and about half of those currently receive that care, thus arriving at a 10% current rate. See assumptions in Appendix VII: "Palliative Care (Initiative Memorandum)."

[124] Behavioral Risk Factor Surveillance System (2011).

[125] Berkeley Forum analysis of 2007-2009 Medical Expenditure Panel Survey Office-Based Medical Provider Visits files.

[126] The five healthcare-associated infections include central line-associated blood stream infections, methicillin-resistant Staphylococcus aureus, Clostridium difficile infections, vancomycin-resistant enterococci and surgical site infections.

[127] California Department of Public Health (2010); See Appendix X: "Healthcare-Associated Infections (Initiative Memorandum)."

[128] A second indicator for this initiative is the number of preterm births that benefit from an additional one-week gestation period. Under the Current Developments and Forum Vision scenarios, we assume 2.1% and 3.1%, respectively, of preterm births will be delayed by one week.

[129] We assume that the rate will be 9.7% by 2013, based on last available data of 9.8% in 2011. Centers for Disease Control and Prevention (2011); see Appendix XI: "Preterm Births (Initiative Memorandum)."

## TABLE 4: HEALTHCARE EXPENDITURE REDUCTIONS IN CALIFORNIA FROM INITIATIVES UNDER DIFFERENT SCENARIOS, 2013 – 2022

| ($ billions) | 2022 Only | | Total: 2013 – 2022 | |
|---|---|---|---|---|
| | Current Developments | Forum Vision | Current Developments | Forum Vision |
| Projected status quo healthcare expenditures | $572.2 | | $4,387.1 | |
| Expenditure reduction by initiative[1] | | | | |
| 1. Global budgets/integrated care systems | $4.8 | $14.8 | $25.9 | $83.6 |
| 2. Patient-centered medical home | $1.9 | $5.2 | $11.6 | $25.2 |
| 3. Palliative care | $0.9 | $2.3 | $4.9 | $11.4 |
| 4. Physical activity | $0.7 | $1.7 | $3.4 | $8.2 |
| 5. Nurse practitioners and physician assistants | $0.1 | $0.4 | $0.3 | $1.8 |
| 6. Healthcare-associated infections | $0.0 | $0.2 | -$0.2 | $0.7 |
| 7. Pre-term births | $0.0 | $0.1 | -$0.2 | $0.1 |
| Total reduction[2] | $6.8 | $20.3 | $36.7 | $110.0 |
| Total reduction as a percent of projected expenditures[2] | 1.2% | 3.6% | 0.8% | 2.5% |
| Healthcare spending under new scenarios | $565.4 | $551.9 | $4,350.4 | $4,277.0 |

**Notes: All estimates are in current-year dollars. (1) The table includes a point estimate of the expenditure reduction for each initiative, and estimate ranges are included in Appendices IV-XI. For the Current Developments scenario, the expenditure reduction point estimate for each initiative is based on the midpoint of the low and high estimate range. For the Forum Vision scenario, the point estimate is the high estimate in the range, because we assume this scenario includes initiatives that are more in-depth and effective than may be possible under the Current Developments scenario. (2) To avoid double-counting expenditure reductions that may occur in two or more initiatives (primarily between global budgets/integrated care systems and the other six initiatives), the total is based on 100% of the reduction from global budgets/integrated care systems (Initiative 1), 75% of the reductions from Initiatives 4, 5, 6 and 7, and 50% of the reductions from Initiatives 2 and 3.**

SOURCE: Berkeley Forum analysis (see Appendices IV-XI).

In contrast, the Forum Vision is based on a scenario in which there is a much more pronounced shift towards risk-based payments and integrated care systems that better align clinical and financial incentives and that also prioritize population health. Thus, under the Forum Vision, adoption rates as well as the effectiveness of the various initiatives are assumed to be significantly higher than under the Current Developments scenario. For example, approximately 23% of insured Californians currently receive care under global budget or ACO arrangements.[130] We assume this percentage will increase to 45% under the Current Developments scenario, but to 70% under the Forum Vision scenario.[131]

For each initiative, we estimated potential healthcare expenditure reductions relative to the status quo projections presented in Section V of the report. Our methods were informed by a number of relevant studies, such as RAND's study on Massachusetts and the Lewin Group's study on New York.[132] In modeling potential expenditure reductions, we generally chose methodologies and assumptions that were more conservative. Although the Forum's initiatives are expected to potentially have a significant positive effect on morbidity, mortality rates and healthcare quality, this analysis primarily focuses on estimating their impact on healthcare expenditures. Appendices IV-XI provide additional context on the non-monetary benefits of the initiatives, such as quality of care, health outcomes and patient satisfaction.

For the Current Developments and Forum Vision scenarios, Table 4 shows the estimated reduction in California healthcare expenditures from each initiative, as compared to projected status quo healthcare expenditures, for the period 2013-2022. We report the midpoint of the expenditure reduction range provided in the Initiative Memorandums in Appendices IV-XI for the Current Developments scenario, but we report the high estimate of the expenditure reduction range for the Forum Vision scenario. This is because under the Forum Vision, adoption rates as well as the effectiveness of the

[130] This estimate includes Kaiser Permanente members as well as those in other global budget/integrated care system arrangements in California, based on ACO data from Cattaneo & Stroud Inc. (2012a&2013).

[131] If California were to attain the Forum Vision goal of 50% of expenditures being paid for outside of fee-for-service, it would most likely mean an even higher percent of Californians (e.g. 70% as modeled) receiving care in systems utilizing risk-adjusted global budgets. This is because global budgets may still entail some use of fee-for-service payments.

[132] Eibner, et al. (2009); Lewin Group (2010).

## TABLE 5: IMPACT OF INITIATIVES ON REDUCING THE PROJECTED GROWTH RATE OF HEALTHCARE EXPENDITURES IN CALIFORNIA

| | Status Quo | Current Developments | Forum Vision |
|---|---|---|---|
| Healthcare Expenditures ($ billion) | | | |
| 2012 | $313.2 | $313.2 | $313.2 |
| 2022 | $572.2 | $565.4 | $551.9 |
| 2012 – 2022 average annual growth rate | 6.2% | 6.1% | 5.8% |
| Gross State Product | | | |
| 2012 – 2022 average annual growth rate | 5.1% | 5.1% | 5.1% |
| Difference between healthcare expenditure and GSP average annual growth rates (percentage points) | 1.1 | 1.0 | 0.8[1] |

**Notes: (1) The "Difference" is based on non-rounded average annual growth rates. All estimates are in current-year dollars.**

SOURCE: Berkeley Forum analysis.

various initiatives are assumed to be significantly higher than in the Current Developments scenario. To estimate the cumulative impact of these efforts, we adjusted for the potential overlap of two or more initiatives. The risk-adjusted global budgets/integrated care systems initiative itself comprises numerous components. For the other six initiatives, we included only 50-75% of their estimated reductions, because we assumed the remainder were already accounted for in the estimate for the risk-adjusted global budgets/integrated care systems initiative.[133]

Table 4 shows that under the Current Developments scenario, these initiatives are expected to reduce healthcare expenditures by approximately $37 billion,[134] or 0.8% of projected total spending, between 2013 and 2022.[135] Under the Forum Vision scenario, the savings in healthcare expenditures are estimated to triple, to $110 billion.[136] That $110 billion represents 2.5% of projected $4.4 trillion in total status quo healthcare expenditures during the same period. In 2022, the share of projected status quo healthcare expenditures represented by expenditure reductions reaches 3.6%, because of the higher adoption of the initiatives that will have occurred by then. The majority of spending reductions in both scenarios is attained by increasing the share of the population receiving healthcare from global budget/integrated care system arrangements, since the aligned financial incentives associated with globally budgeted arrangements can trigger a virtuous cycle of synergistic improvements to the system. For example, the Sacramento ACO formed by Blue Shield of California, Hill Physicians and Dignity Health to care for 41,000 commercial HMO beneficiaries in CalPERS focused on lowering expenditures through initiatives in five key areas: improving information and data exchange; coordinating processes (e.g. discharge planning); eliminating unnecessary care; reducing variation in practices across physicians and care settings; and reducing pharmacy expenditures. Following the global budgets/integrated care systems initiative, the next major sources of expenditure reductions under the Forum Vision include increased use of patient-centered medical homes and palliative care, and increased physical activity. While some initiatives, such as reducing the rate of preterm births or healthcare-associated infections, show low relative savings, they were included because of evidence of their expected overall positive impact on care quality, healthcare outcomes and patient experience.

Table 5 shows the annual healthcare expenditure growth rate from 2012 to 2022 under the status quo projections as well as the Current Developments and Forum Vision scenarios. Aggregate healthcare expenditures under the status quo are projected to increase by a 6.2% annual rate between 2012 and 2022. The Current Developments scenario is predicted to slightly lower that growth rate,

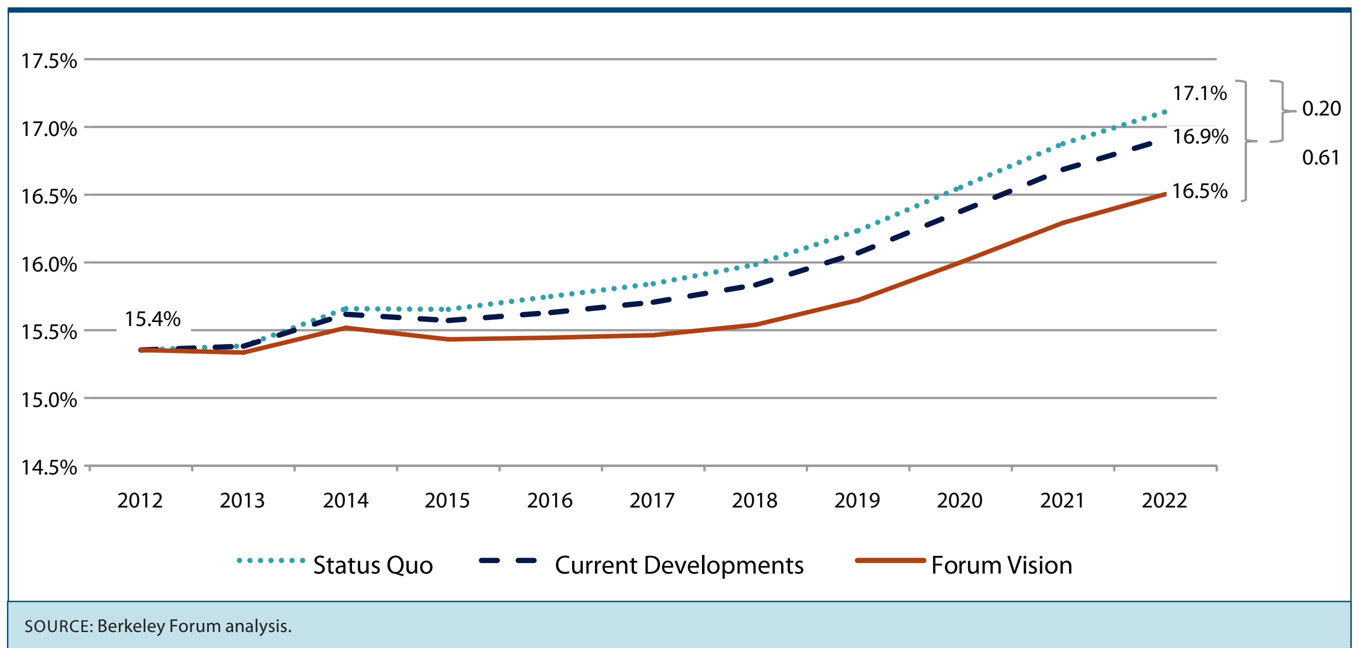
[133] When totaling expenditure reductions across the initiatives, we used 50% of the expenditure reduction for palliative care and patient-centered medical homes, since chronic disease management and palliative care are often high priority areas for organizations operating under global budgets/integrated care systems. We used 75% of the expenditure reduction for physical activity, nurse practitioners and physician assistants, preterm births and healthcare-associated infections, because these initiatives may not be specific priority areas for organizations operating under global budgets/integrated care systems. Increasing physical activity will likely involve a broader coalition of stakeholders than what global budgets/integrated care system arrangements can accomplish singlehandedly. Increasing use of NPs and PAs may require addressing scope of practice regulations. Reducing rates of preterm births requires lifestyle, education and other social-service initiatives that may be further outside the scope of a global budget/integrated care system arrangement. Finally, many hospitals already have programs in place to reduce healthcare-associated infections and will be further motivated to do so by upcoming CMS financial incentives to reduce HAIs (California Healthline (2011)). Further investigation is needed to better understand the expenditure reduction overlaps across initiatives.

[134] For reference, this amount is equivalent to $31 billion in constant 2012 dollars.

[135] Healthcare-associated infections and preterm births did not result in expenditure decreases under the Current Development scenario because of the cost to implement the initiatives. However, these initiatives may still be worthwhile to implement due to their expected improvements to health outcomes and care quality.

[136] This amount is equivalent to $93 billion in constant 2012 dollars.

## FIGURE 10: CALIFORNIA COST CURVE: PROJECTED HEALTHCARE EXPENDITURES AS A SHARE OF GROSS STATE PRODUCT UNDER DIFFERENT SCENARIOS, 2012 – 2022




SOURCE: Berkeley Forum analysis.

to 6.1%, only minimally reducing California's healthcare expenditure burden.

The continued lack of affordability under the Current Developments scenario highlights the need to fundamentally transform healthcare financing and delivery along the lines suggested by the Forum Vision. We conservatively estimate that between 2012 and 2022, the growth rate in annual healthcare expenditures will decrease from 6.2% under the status quo to 5.8% under the Forum Vision. This translates to an average annual reduction in healthcare expenditures of $802 per California household during this period, or $1,422 per household in 2022.[137]

Under the Forum Vision, California is closer to meeting one of the cost indicators in Governor Brown's December, 2012 "Let's Get Healthy California" report, which aims for healthcare expenditures to grow at the same rate as Gross State Product by 2022. Under the status quo, healthcare expenditures grow at an average annual rate of 1.1 percentage points faster than GSP between 2012 and 2022. The Current Developments scenario reduces this differential to an average of 1.0 percentage point annually during this period. Under the Forum Vision, healthcare expenditures grow only an average of 0.8 percentage points faster than GSP annually through 2022.

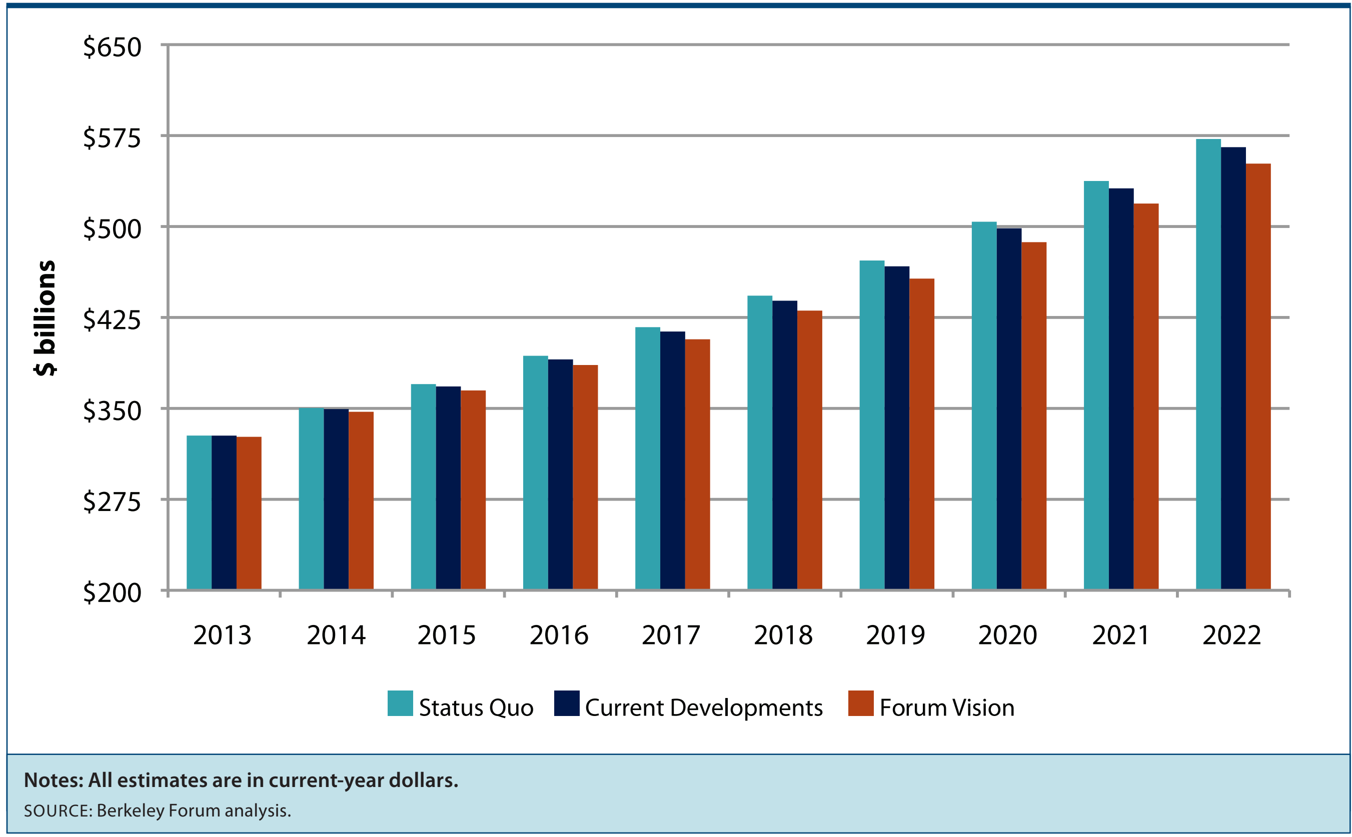
Figure 10 shows the impact of both scenarios in bending the Cost Curve relative to the status quo during the coming 10 years. For the status quo and each scenario, healthcare expenditures represent a greater share of GSP over time, particularly in the last several years of the period. Under the status quo, the Cost Curve increases from 15.4% in 2012 to 17.1% in 2022. Under the Current Developments scenario, the Cost Curve reaches 16.9% by 2022. Under conservative estimates for the Forum Vision, California is able to bend the Cost Curve much further by 2022, decreasing it to 16.5%. The difference deserves emphasis: Under the Forum Vision, California is able to bend the Cost Curve in 2022 by three times as much as in the Current Developments scenario: 0.61 percentage points vs. 0.20 percentage points.

Figure 11 (on the following page) shows healthcare expenditures for the status quo, Current Developments scenario and Forum Vision scenario during 2013-2022. During the initial years, the difference in spending between the status quo and the scenarios is small, as most of the initiatives are in the early stages of adoption. Much of the spending reductions occur in the years closer to 2022, as significantly greater uptake rates of each initiative begin to pay off through reduced healthcare expenditures. To illustrate the contrast, the expenditure reduction under the Forum Vision represents just 0.3% of the status quo's projected expenditures in 2013, but 3.6% by 2022. One implication of this expenditure reduction trend is that we would expect these initiatives to generate even greater expenditure reductions and a further bending of the healthcare Cost Curve beyond 2022.

There are several limitations in the above analysis. Although the latest studies and the best available data were used to estimate expenditure reductions, the results should be viewed only as approximations, because in many cases, the evidence is still emerging (see

[137] These amounts are equivalent to $680 and $1,122, respectively, in constant 2012 dollars.

## FIGURE 11: PROJECTED CALIFORNIA HEALTHCARE EXPENDITURES UNDER DIFFERENT SCENARIOS, 2013 – 2022




**Notes: All estimates are in current-year dollars.**

SOURCE: Berkeley Forum analysis.

limitations in Appendices IV-XI: Initiative Memorandums). Furthermore, to estimate the cumulative expenditure reduction across the initiatives, we adjusted for the potential overlap of two or more initiatives (primarily between global budgets/integrated care systems and the other six). However, the magnitudes of the adjustments could be refined through further study. Furthermore, certain initiatives may have synergies that lead to expenditure reductions that are greater than the sum of the individual initiatives.

There are many other initiatives that we did not study that could significantly contribute to bending the Cost Curve. Among these are further payment reforms (e.g. value-based insurance design, reference pricing and global payments), delivery reforms (e.g. telemedicine and centers of excellence), unit-cost reducers (e.g. hospital construction regulatory approval process reforms, health information technology and administrative simplification), and population health (e.g. sugar-sweetened beverage tax and tobacco use).

These initiatives do not account for the potential of additional healthcare expenditures due to three areas. First, the Forum Vision will likely result in a more consolidated healthcare delivery system, creating the potential for reduced market competition. This issue is discussed in Section VIII "Challenges to Achieving the Forum Vision." Second, if these initiatives lead to increased longevity, this may itself increase healthcare expenditures at the population level. This issue is discussed in Appendix VIII: "Physical Activity (Initiative Memorandum)," in which we examine the latest research on the effect of increased longevity on healthcare expenditures. Third, there is the potential that supplier-induced demand could partially or fully eliminate the estimated reductions.

We do not attempt to determine which stakeholders (e.g. consumers, employers, insurers, providers or the government) would benefit from any healthcare expenditure reductions. In a competitive provider and insurance market, those reductions would flow to all purchasers of health insurance and healthcare services. However, in cases where the market is not competitive, the savings from the initiatives could be captured as profits or surpluses by healthcare providers or insurers, rather than be passed along as savings to consumers.

It is important to put these results in the context of other studies that estimated expenditure reductions from various initiatives, including RAND's study on Massachusetts, the Lewin Group's study on New York and the Commonwealth Fund's study on the United States.[138]

[138] Eibner, et al. (2009); Lewin Group (2010); The Commonwealth Fund (2013).

All three estimate the impact of a series of initiatives on reducing healthcare expenditures, but only the Commonwealth Fund aggregates the reductions across its initiatives, estimating a 4.8% reduction in national healthcare expenditures over 10 years. Nonetheless, these three studies generally show higher potential expenditure reductions than those projected in this report. There are several reasons for this. First, we have generally been more conservative in our modeling methodology and assumptions than other studies, including the assumptions we made about potential savings, penetration rates and adoption speed. The expenditure reductions we estimate under the Forum Vision scenario may be particularly conservative given the great change to the healthcare system articulated by the Forum Vision, with its potential for additional resulting synergies. For example, the rate of expenditure reductions may accelerate as the initiatives are implemented more comprehensively and become self-reinforcing. Second, we model fewer and different types of initiatives than those modeled by the other studies. Third, several initiatives on our list are more targeted (e.g. preterm births or healthcare-associated infections) than those in other studies, and thus may be expected to have a lower impact on overall expenditures. Last, California has less room for improvement, as our state already enjoys significantly lower per capita healthcare expenditures than either New York or Massachusetts.[139] Many of the modeled initiatives target utilization, and for some of the reasons cited in Sections III and IV of this report, California already performs relatively well in this regard.

In summary, under the Forum Vision scenario, the initiatives are projected to reduce healthcare expenditures by $110 billion (or $93 billion in constant 2012 dollars), representing 2.5% of the total $4.4 trillion in projected status quo expenditures during 2013-2022. Although this reduction only modestly lowers healthcare expenditures' share of GSP as compared to status quo projections, in absolute terms the amounts involved are significant. The $93 billion is equivalent to more than two-thirds of California's state budget, approximately $142 billion for 2012-2013.[140] On a per-household basis, the reduction is equivalent to $802 annually between 2013 and 2022, or $1,422 per household in 2022. Furthermore, we expect that Californians would potentially enjoy significant improvement in their healthcare experiences, outcomes and quality of care under the Forum Vision scenario (see the Initiative Memorandums in Appendices IV-XI for additional information). Looking beyond 2022, we expect the Forum Vision scenario to show even greater impact on healthcare expenditures and the Cost Curve relative to status quo projections, as the changes become more entrenched and their benefits more pronounced.

[139] Kaiser Family Foundation (2009b).

[140] California Department of Finance (2012). The $142 billion total budget includes the budgets from the General Fund, special funds, and selected bond funds, as reported by the California Department of Finance.

SECTION VII

# Two Areas of Focus

**The initiatives described above were examined to estimate their impact on reducing healthcare expenditures in California over the next 10 years. From the above initiatives, Forum participants have selected two that demonstrate especially significant potential savings, and which could therefore play an outsized role in improving health status and healthcare quality for Californians. These two areas are first, physical activity promotion, and second, palliative care.**

The rationale for selecting those two is as follows. As healthcare providers and payers, Forum participants are well aware of the increasing prevalence and earlier onset of chronic disease, which takes a major toll on Californian's well-being, productivity, longevity and fiscal resources. As was described earlier in the 5/50 analysis, chronic diseases and obesity are found commonly in the top 5% of healthcare spenders in the state. Emerging research on the critical importance of physical activity led Forum participants to concentrate on this particular issue. The Forum has also chosen to highlight palliative care because of studies that show a vast discrepancy between the care patients say they would like to receive in the last few months of life and the care they actually get. Another reason for this focus is the high concentration of spending on seriously ill patients. Forum participants believe that palliative care principles promote shared-decision making and person-centric care that can help counteract the tendency towards providing clearly futile end-of-life treatments that bring enormous discomfort to patients and their families. Attention to palliative care is also important because the single biggest contributor to increased healthcare costs is the introduction of new technologies and treatments.[141] This section provides background and recommendations in these two areas.

## A. Physical activity promotion

Overweight and obesity, along with sedentary lifestyles, are major challenges to the health status of Californians and the effectiveness of our healthcare system. More than 60% of adults[142] and over 30% of children 10-17 in California are overweight or obese.[143] In 2007, 48.7% of Californians were physically inactive.[144]

[141] Smith, et al. (2000).

[142] Behavioral Risk Factor Surveillance System (2011).

[143] Kaiser Family Foundation (2012f).

[144] Behavioral Risk Factor Surveillance System (2011).

The costs associated with these conditions were estimated to be $41.2 billion in 2006, divided roughly equally between direct healthcare expenditures and indirect costs such as lost productivity.[145] Obesity is deeply intertwined with physical activity status, with confounding effects on health.

Making California the healthiest state in the nation by 2022, the goal laid out by Governor Brown's December 2012 "Let's Get Healthy California" report and supported by the Berkeley Forum, will require improvement in some of these indicators. The Berkeley Forum sees a particular opportunity to encourage increased levels of physical activity among Californians. While physical activity rates are directly affected by behavior and health status, obesity and overweight present complex physiological processes that can be especially challenging. The recent evidence suggesting the relative importance of even moderate physical activity levels in countering chronic disease and cancers is yet another reason for the Forum to highlight this issue. A *Lancet* study from last year estimated that 5.3 million of 57 million premature deaths around the world in 2008 could be attributed to physical inactivity.[146] Another study of 116,564 women showed that physically inactive middle-aged women had a 52% higher risk of early death, a doubling of cardiovascular-related mortality and a 29% higher cancer-related mortality when compared to women who were physically active.[147] The World Health Organization estimates that physical inactivity is the primary cause of approximately 21-25% of breast and colon cancers, 27% of diabetes and 30% of coronary heart disease cases.[148] On the other hand, increased physical activity is associated with numerous positive health outcomes, many of which accrue early on, including decreases in depression, improvements in mood and energy levels, better arthritis management and greater longevity.

A 2002 analysis in the *American Journal of Preventative Medicine* provides one of the most comprehensive comparisons of various initiatives to increase physical activity levels, especially walking.[149] It found that informational campaigns, such as "point-of-decision prompts" in schools or the workplace, can encourage such physical activities as using the stairs instead of the elevator or walking in lieu of driving. Social support initiatives are even more effective, particularly ones that focus on changing physical activity behavior through social networks. Policies providing enhanced access to physical activity combined with informational outreach efforts, such as constructing walking trails and then distributing maps of them, have also consistently been proven to be effective. While California law requires a minimum of 200 minutes of physical education every 10 days for public elementary schools, and 400 minutes for middle and high schools, schools often lack the funding to comply with these mandates.[150] Forum participants encourage the development of California's schools as environments that support physical activity and healthy eating.

Comprehensive employer-based initiatives that include many or all of the above components are also expected to result in increased activity levels. Workplace-based programs often include frequent presentations about physical activity, the distribution of pedometers to encourage walking, and lectures and instructions on stretching and walking. Also important in the workplace are point-of-decision prompts, sporting events and other employer-sanctioned exercise times, the construction of walking paths and the distribution of walking maps.[151] Other initiatives that have been implemented successfully by employers include access to gyms and fitness centers, subsidies for nutritious foods in cafeterias, specialized care programs for chronic conditions such as diabetes and COPD and the free availability of health education materials.[152] Such efforts become even more effective when they are designed to complement each other, are cross-promoted, and are supported by the workplace environment and culture. Also useful are employee "challenges" that incorporate team support and encourage friendly competition.

The Berkeley Forum agrees with the Institute of Medicine that tackling the obesity and inactivity epidemic will require extensive collective efforts from policymakers, public institutions and food manufacturers, among others. In "Accelerating Progress in Obesity Prevention," the Institute of Medicine recommended a range of efforts that could be undertaken by healthcare stakeholders.[153] These included providers serving as models for incorporating healthy eating and active living into worksite practices and programs; routine screening for excessive consumption of sugar-sweetened beverages and providing counseling on their associated health risks; routine body mass index screening; insurance premium discounts for healthy behaviors; and employer-sponsored health and wellness promotion activities.

The Forum supports an active role for California healthcare organizations in promoting wellness and healthy lifestyles. Given the geographic and socioeconomic diversity of the state's healthcare system employees, a focus on improving physical activity and general wellness in this population could potentially help address overall health disparities in the state. A strategic commitment to employee health and support

[145] California Center for Public Health Advocacy (2009).
[146] Lee, et al. (2012).
[147] Hu, et al. (2004).
[148] World Health Organization (2012).
[149] Kahn, et al. (2002).
[150] California Center for Public Health Advocacy (2006).
[151] Naito, et al. (2008).
[152] Interviews with Forum participants' employee wellness leaders.
[153] Glickman, et al. (2012).

from an organization's leadership, along with activity "champions" at all ranks, are key to this process. Forum organizations currently use incentives ranging from small tokens to financially significant premium discounts as a way of rewarding increased health awareness by their employees, including participation in health assessments and the attainment of goals for improved health outcomes. Organizations are still developing better methods to measure their return on investment for these programs. They are also attempting to better understand which programs are most effective and how employees can be best motivated to stay involved in them. Other challenges include effectively tracking employee improvement over time and finding an appropriate balance between rewarding both effort and outcomes. The Forum sees significant room for collective dedication, a shared effort and continuous improvement in the area of employee wellness.

Forum participants are considering opportunities to initiate a joint physical activity challenge among healthcare employees—perhaps incorporating friendly competition among organizations, complementing existing employee initiatives such as Blue Cross' Fitness Challenge and KP (Kaiser Permanente) Walk. Forum leaders would like to explore forming a learning collaborative among California organizations' employee health leaders. The goal would be to provide a venue to share best practices and experiences involving effective employee wellness programs, as well as addressing challenges to engagement and measuring return on investment. While the National Business Group on Health has a collaboration along these lines, a local effort focused specifically on California might have a greater impact. The Forum also supports the launching of a multi-sector state-wide walking campaign in California, potentially building upon Kaiser's existing EveryBody Walk efforts.

An emphasis on the healthcare workforce is expected to have spillover effects into the general population. For example, Kaiser-sponsored farmers' markets serve not only employees and patients, but also local communities. Similarly, investments in walking, among other activity-related improvements, can be expected to increase physical activity for employees of healthcare organizations. These programs could be expanded over time and extended into the surrounding communities. By cultivating a culture of health not only for their own employees but also at healthcare settings in general, California healthcare organizations can set an example for the rest of the state.

## B. Palliative care

The most important test of a healthcare delivery system may well be its ability to provide high-quality, patient-centric, cost-effective care for seriously ill patients. While many patients usually have unrestricted access to complex tertiary care for advanced illnesses, the Berkeley Forum nonetheless believes there is significant room for improving the care provided for California's seriously ill patients. Specifically, the Forum supports widespread use of palliative care, which is "patient and family centered care that optimizes quality of life…[and] involves addressing physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information, and choice,"[154] alongside curative treatments. In comparison, current medical practices often overwhelmingly emphasize technical interventions (such as chemotherapy, invasive procedures, hospitalization and intensive care) regardless of likely benefit to either quality or length of life. In the process, the wishes of the patients and caregivers are often sidelined.

A recent study by the California HealthCare Foundation found that Californians prefer dying a natural death at home, in a process that stresses pain relief, symptom amelioration and spiritual support, along with shared decision-making. However, 42% of California deaths still occur in hospitals (2009) and 61% of Medicare deaths are not served by hospice (2010).[155] Given that the federal Medicare hospice benefit requires a six-month prognosis and that patients forgo curative care, the median hospice enrollment length is only 18 days, since both patients and providers select hospice care only very near the point of death.[156] California is in the bottom 10% of states based on a hospital intensity index in the last two years of life—with a higher than U.S. average number of hospital days (11.7 days vs. 10.9) and with more patients with seven or more ICU days in the last six months of life (20.3% vs. 15.2%).[157]

Nevertheless, the Forum is encouraged by the progress that has been made in the care of seriously ill patients in California over the past decade. There has been a significant increase in inpatient palliative care services, with 53% of all hospitals, and 82% of hospitals with more than 250 beds, offering such care in 2011.[158] Legislative policy[159] and implementation support by the California Coalition for Compassionate Care has led to high levels of awareness of POLST (Physician Orders for Life Sustaining Treatment) advanced care planning forms within nursing homes and among emergency medical service and emergency room physicians. There has also been increased attention paid to reducing acute care transfers from nursing homes to hospitals, via efforts such as the 2007 PREPARED pilot program in Sacramento and the national INTERACT project. These initiatives are further

[154] Center to Advance Palliative Care.
[155] O'Malley, et al. (2012).
[156] Hospice Association of America (2012).
[157] The Dartmouth Atlas of Healthcare (2012).
[158] California HealthCare Foundation (2012).
[159] California Coalition for Compassionate Care (2009).

encouraged by CMS' new penalties on select readmission rates.[160] Medi-Cal has undertaken a leading pediatric palliative care pilot program led by the Children's Hospice and Palliative Care Coalition. Preliminary results show a notable increase in patient and family well-being as well as cost-savings.[161]

Other state governments and local organizations have taken their own steps to promote palliative care. The Joint Commission's Advanced Certification Program for Palliative Care, launched in 2011, is a major effort to ensure high-quality standards for inpatient palliative care programs.[162] Various national insurers are reimbursing for some concurrent curative and palliative care services, where the latter are often provided by hospice and home health agencies.[163] New York in 2008 passed landmark legislation that requires health care providers (nursing homes, hospitals, assisted living facilities and others) to facilitate access to palliative care counseling and information for all patients with advanced life-limiting conditions.[164] Finally, Oregon's centralized state registry of POLST forms allows providers across the state to have 24-hour access to patients' advanced planning directives.[165]

However, various challenges still greatly limit broad accessibility to palliative care services in California, including fee-for-service reimbursement, fragmented care systems, an insufficiently trained workforce and lack of mandatory accreditation quality standards. Even with these constraints, California organizations such as Sutter (Advanced Illness Management), Sharp (Transitions) and Kaiser have led the way in providing comprehensive home and community-based palliative care services for seriously ill patients. The Forum supports the person-centric approaches undertaken by these organizations, which have generally shown improved patient satisfaction and quality of life while significantly reducing healthcare expenditures. Their programs serve as examples for the community-based palliative care initiative examined in Section VI above, "Addressing the Affordability Crisis: Bending the Cost Curve". The Forum expects the rise of ACOs and the movement of Medi-Cal and Medicare patients into managed care to further promote the development of community-based palliative care programs in California.

Based on the vast evidence in favor of palliative care, the Berkeley Forum strongly favors widespread access to quality palliative care for patients with serious illness, appropriate to their individual circumstances. Given the realities of limited resources, it may be desirable to initially prioritize palliative care services for conditions such as oncology, advanced chronic obstructive pulmonary disease and congestive heart failure. These diseases are among those most commonly targeted by palliative care providers, and evidence for their efficacy is more abundant.[166] Building upon the milestone American Society of Clinical Oncologists provisional recommendation that palliative care alongside standard care "should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden,"[167] Forum participants would like to consider opportunities to provide greater access to palliative care to patients with metastatic cancer.

To support the expected increased need for palliative care capabilities among current and future providers, the Forum also encourages greater investment in workforce development. California State University's newly established Palliative Care Institute, which aims to train every nursing and social work student —as well as the current members of those professions—in basic palliative care principles, can assist with this effort. Health systems may want to consider facilitating palliative care training opportunities for their staff and providing exposure to palliative care during residency programs. The Palliative Care Institute aims to assist with another key endeavor that the Forum supports—educating the general public about the importance of advanced planning in matters involving serious illness. Forum participants further encourage the development and uptake of quality provider standards relating to palliative care, such as the Joint Commission certification in inpatient palliative care. Finally, Forum participants strongly believe that progress towards the Forum Vision, which articulates a rapid move towards risk-based payments and integrated care systems, is critical to increasing the adoption of palliative care.

[160] Glasmire (2011).
[161] Gans, et al. (2012).
[162] Sacco, et al. (2011).
[163] Meier (2012).
[164] Cook (2011).
[165] Oregon Health & Science University (2011).
[166] See Appendix VII: "Palliative Care (Initiative Memorandum)".
[167] Smith, et al. (2012).

## SECTION VIII

# Challenges to Achieving the Forum Vision

**While Forum members fully support the Vision, initiatives and endorsements in this report, they also recognize that achieving them will require industry and policy leaders to overcome significant challenges. Here, we discuss several of these challenges, including the potential of provider consolidation to inhibit market competition and the growing schism between HMO and PPO plans.**

## A. Provider consolidation and healthcare market restructuring

The Forum Vision calls for moving toward integrated healthcare systems with risk-based reimbursements that align clinical and financial incentives to promote better health outcomes, increase care quality and patient satisfaction, and reduce the growth in healthcare expenditures. This process will undoubtedly result in mergers, joint ventures, partnerships and new contractual relationships among providers and health plans, as these organizations seek organizational structures that will allow them to share risks and resources in order to better address the full care continuum.[168] However, there is a concern that provider consolidation and integration may threaten the competitive market. Particularly in geographic regions with few hospitals or independent medical groups, it may not be possible to have multiple integrated care systems. In some cases, non-competitive markets may result. Even in a market with many providers, some providers may be able to set higher prices depending on their reputation for quality and their position within insurers' contractual networks. Insurers are often compelled to include "must-have" providers in their network to make their plan attractive to consumers. Such providers may recognize their preferential status, and use this to negotiate favorable contracts.[169]

Some research indicates that although payment reforms and integrated systems can produce higher quality care at lower cost, they also run the risk of creating provider market power that, if exercised, could offset some or all of those gains in efficiency.[170] One study of U.S. hospital mergers and acquisitions in the past two decades suggests that the consolidation of hospital markets drives up prices.[171] Diminished competition may allow hospitals to charge higher prices, since they face a lower risk of being excluded from the insurers' contractual networks. A recent study showed that facilities in non-competitive local markets charged higher prices and were more profitable than similar hospitals in competitive local markets.[172]

Recent research has also examined the role of physician employment by hospitals as well as physician practice consolidation. One study examining the recent trend towards more physician employment by hospitals showed that although there may be improvement in clinical integration and care coordination, the cost of that care may increase.[173] Among the possible reasons for this finding are that physician reimbursement may be higher for services rendered at hospitals than in physicians' offices, and that at times, physicians may be influenced by hospitals to order more expensive care or increase referrals and admissions.[174] Consolidation of individual physician practices can also potentially lead to higher prices, as larger physician groups with added bargaining power can negotiate for higher capitation rates. Increasing capitation rates, leading to higher HMO premiums, may be one of the reasons commercial HMO enrollment has declined in recent years. Although the above studies are not definitive, they raise issues that compel policymakers to better understand the changing nature of the healthcare market.

Reaping the full benefits of the financial and clinical integration discussed in the Forum Vision will likely require addressing a new set of regulatory issues, so that these larger systems can be monitored to assure that costs are reasonable and outcomes meet expectations. These new monitoring systems will likely need to be different from the traditional antitrust approaches used by the Federal Trade Commission and the Department

[168] For a discussion of organizational structures and regulatory mechanisms that support integrated care and market competition, see Enthoven (1993).
[169] Bowers, et al. (2011).
[170] Berenson, et al. (2010).
[171] Ibid.
[172] Robinson (June 2011).
[173] O'Malley, et al. (2011).
[174] Robinson (2011).

of Justice. For example, it may be useful in evaluating healthcare organizations to include consideration of whether there is evidence of competition-reducing physician or hospital exclusivity, gaming of risk-adjustment methodologies to select the healthiest patients, or cost-shifting from public to private payers.[175] Failure to respond to the regulatory challenges posed by changing healthcare markets will likely inhibit the implementation of the Forum Vision.

## B. Declining enrollment in HMOs

Along with the problems associated with reduced market competition, there are several other challenges to implementation of the Forum Vision. First, there are indications that market forces and the regulatory environment have caused Californians, particularly in the employer-sponsored insurance market, to turn away from HMOs—the product that has been most associated with integrated care systems and risk-based payment. For example, commercial enrollment in non-Kaiser HMOs dropped by 20% between 2004 and 2009.[176] Some employers have grown skeptical about the ability of HMOs to contain costs more effectively than other insurance products. Surveys of California employers indicate that HMO premiums increased at an average annual rate of 9.7% between 2001 and 2011, while PPO premiums increased at a slightly lower rate of 9.0%.[177] It is important to note, however, that because HMOs tend to have more generous benefit designs than PPOs, it is difficult to compare total cost growth between the two product types. Nonetheless, some employers who had expected HMOs to deliver lower annual premium increases are now turning to high-deductible PPOs. Many believe that this trend will continue, especially since the new fees on health plans included in the ACA are estimated to result in a 3-4% premium differential between insured and self-funded plans. That fact is likely to encourage employers to self-fund PPO plans rather than purchase fully insured HMO plans.[178,179]

HMO plans also tend to have rich benefit packages with minimal cost sharing, partly due to tradition and partly due to regulations.[180] As employers seek to control their employees' healthcare expenditures, HMOs have found it difficult to compete against new high-deductible PPO plans. Developing HMO plans with higher deductibles and other cost-sharing mechanisms has been administratively challenging, as the traditional delegated model HMO does not have the infrastructure in place to adjudicate claims involving deductibles and coinsurance. These plans have not been widely adopted by consumers, who may view rich HMO plan benefits as the tradeoff for the closed networks and prior authorization requirements of HMOs.

There are also concerns that traditional HMOs will not be price-competitive in the new California Health Benefit Exchange. Subsidies in the Exchange are based on the second lowest cost "Silver" plan, defined as one that pays an average 70% of the expenditures, with the participant paying an average of 30%. It is anticipated that a Silver plan will have much higher deductibles, copayments or coinsurance than have been traditional for California HMOs. Some people believe that California's dual regulatory system has contributed to the current situation, since rich HMO plans offered under the Department of Managed Health Care (DMHC) compete with plans with much higher levels of cost-sharing that are regulated by the Department of Insurance.

Even if the delegated model HMO remains robust in California, there are administrative obstacles that will need to be addressed to fully attain the Forum Vision. For example, to encourage the transparency and care integration described in the Forum Vision, health plans will need to receive claims-level data for members treated by delegated medical groups in lieu of encounter data, which has proven to be a poor substitute. Furthermore, to move towards global payments rather than global budgets, California would have to revise current regulations limiting capitation to DMHC products.

Since the Forum Vision is not tied to a particular product type, such as HMOs or PPOs, the challenge is to ensure that if HMO enrollment declines, the plans that replace them align with the Forum Vision of risk-adjusted global budgets and integrated care systems. Attaining this will require efforts from employers, providers and health plans alike.

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[175] Scheffler, et al. (2012).

[176] Cattaneo & Stroud Inc. (2004-2010). Kaiser HMO enrollment has not experienced the same trend, as total Kaiser enrollment increased 3% between 2004 and 2009.

[177] California HealthCare Foundation (2011a).

[178] A November 2012 Oliver Wyman study "Annual Cost to Insurers Allocated by State" estimates that insurance premiums in California will rise between 2.9% and 3.7% when the ACA fees are fully implemented in 2017. A premium differential of 1-2% already exists between insured and self-funded plans, as insured plans are subject to premium or franchise taxes, while self-funded plans are not. (Wyman (2011)).

[179] The Knox-Keene Act does not permit capitation within the PPO product structure. HMOs cannot be self-funded by employers because any capitation agreement would be considered a form of insurance.

[180] California HealthCare Foundation (2009a).

SECTION IX

# Conclusion

**Healthcare in California is becoming less affordable to families, employers and governments. Our predominantly fee-for-service payment system often results in incentives that lead to uncoordinated care, fragmented care delivery, low-value services and sub-optimal population health. Although a national leader in HMOs and delegated care, California still has only 29% of its population receiving care through fully- or highly-integrated care systems. In California today, 78% of healthcare is still paid on a fee-for-service basis. When compounded with behavioral and environmental factors, these structural issues result in less-than-optimal health status and rapidly growing healthcare expenditures. We project that healthcare expenditures will increase to 17.1% of our Gross State Product by 2022, diverting resources from investments in areas such as education, housing and infrastructure. Typical California individuals and families with employer-sponsored insurance are expected to see total health insurance premiums representing about 18.2% and 32.2% of their household incomes by 2022, respectively.**

There is evidence that as a result of the ACA, California's healthcare delivery system is already evolving to foster more integrated care delivery and risk-based payments and to bring innovation and competition to the commercial, Medicare and Medi-Cal markets. Successfully tackling these challenges, however, requires a fundamental change in the financial and clinical incentives underlying healthcare. In the long term, the Forum believes that widespread adoption of risk-adjusted global budgets, or provider financial risk for the full spectrum of its patients' healthcare needs, would most comprehensively align incentives and thus provide better healthcare at a more affordable cost. Risk-adjusted global budgets should encompass services ranging from prevention to curative to palliative care, among others.

As an intermediate step, the Forum supports various risk-based payment methods tied to accountability and improved outcomes, such as shared-savings, bundled or episode-based payments. The Forum believes that competing, integrated systems have the best chance of supporting the investments and risk management necessary for adoption of the Forum Vision. Realizing this Vision would free organizations from fragmented care and other constraints of fee-for-service medicine. It would also encourage prioritization of population health, adoption of proven chronic care management practices and implementation of palliative care principles. Innovative process changes would include shifts towards lower-cost sites of care, more effective use of the physician and non-physician workforce, and more rapid adoption of proven health information technologies and patient engagement tools.

The Forum endorses a two-part, 10-year goal. The first is a rapid shift towards risk-adjusted global budgets that will reduce the share of healthcare expenditures being paid via fee-for-service from the current 78% to 50% in 2022. The second is a doubling of the share of the state's population receiving care via fully or highly integrated care systems from 29% to 60% by 2022. Attaining these targets will require a significant shift from the current payment and delivery paradigms. Today, there are almost 11 million Californians in Medicare fee-for-service and commercial PPO plans. In 2014, the estimated 700,000[181] newly insured Californians entering the California Health Benefit Exchange through the ACA are more likely to be covered under a PPO plan rather than an HMO plan. Three million Medi-Cal members, including nearly 900,000 dual-eligibles, are currently in fee-for-service, although the state plans to transition much of this population to managed care over the coming years. For the approximately 8.5 million Californians served by partial risk arrangements, there remains a great opportunity for a transition into broader and deeper risk-based payment systems. Further, there is currently minimal alignment of incentives in caring for uninsured Californians, who today often receive care only in acute or emergency settings.

In order to help attain the 10-year goals mentioned above, Forum participants commit to work on policies, regulations and shared practices that would help facilitate implementation of risk-based payments and competing integrated care systems. Forum participants anticipate developing more expansive coordinated care systems that encompass a greater number of providers across the care continuum. Additionally, Forum leaders

[181] Cal-Sim (2012) Enhanced Scenario estimates on net newly insured via commercial insurance in 2014. See Appendix III: "California Cost Curve, Healthcare Expenditures, and Premium Projections (Methodology)".

hope to increase Medicare Advantage enrollment in the state. For Medicare and the commercial populations, they hope to expand both the population covered by risk-based contracts as well as the contracts' scope and depth. The Forum favors new partnerships established with and among small provider organizations, including those in more rural parts of the state. Public and private sector Forum leaders hope to partner with each other to rapidly and effectively transition the dual-eligible, special needs and Medicaid populations to coordinated care settings.

To achieve these goals will require sustained collaboration by stakeholders in the healthcare, education, infrastructure and social services sectors, particularly to promote healthier environments and improved population health. Employers must be involved in implementing healthier worksites and offering higher-value health insurance choices. Forum leaders hope to develop and market affordable, integrated care offerings to self-insured employers. Implementation of the Forum Vision will also require working with federal policymakers on issues involving federal-state cooperation. These issues include better alignment of incentives across Medi-Cal and Medicare, along with improvements in traditional Medicare, Medicare ACO and Medicare Advantage programs. Additional areas that the Forum hopes to influence include rapid transformation of the safety net to include more coordinated care systems, as well as the development of provider risk-sharing arrangements in Medicaid.

As part of its Vision, the Forum also supports a transformational shift towards the purchasing of healthcare services that proactively support good health. The Forum would like to explore innovative government, market-driven or private-public financing and investment opportunities to promote healthy behaviors and environments. A prime example would be the implementation of state-wide walking campaigns. Also crucial is an increased reliance on palliative care in supporting the physical, emotional and spiritual needs of the seriously ill. Finally, the Forum endorses the seven initiatives analyzed in Section VI: "Addressing the Affordability Crisis: Bending the Cost Curve." In addition to risk-adjusted global budgets/integrated care systems, increasing physical activity rates and increasing palliative care access, all of which the report has highlighted, the four other initiatives include increased use of patient-centered medical homes, increased use of nurse practitioners and physician assistants, reduced rates of healthcare-associated infections and reduced rates of preterm births.

Of course, there are challenges involved in achieving such a Vision. A major one involves developing new regulatory mechanisms to promote effective competition among large integrated care systems, in order to balance the efficiencies brought by integration with the potential for that integration to reduce market competition. Alternative integrated care structures to serve rural areas will need to be considered, such as referral hub and spoke models and increased use of telemedicine. Centers of excellence should also be considered. Healthcare stakeholders, along with employer organizations, will need to ensure that neither California's dual insurance regulatory structure nor the shift towards self-funded insurance and consumer-directed healthcare detract from the Forum Vision. Finally, insurers and providers must work together with Medi-Cal and the Exchange Board to see that California implements the Affordable Care Act as effectively as possible, increasing coverage in a way that supports the goals of integrated care, aligned incentives and improved population health.

The challenges to attaining the Forum Vision are clearly worth facing. All Californians would benefit from a healthcare system that delivers value to patients and purchasers, is focused on improving outcomes and promotes prevention and population health. We conservatively estimate that healthcare expenditures as a share of our Gross State Product can be reduced by 2022 to 16.5% under the Forum Vision, as compared to status quo projections of 17.1%. Such a reduction in healthcare expenditures would free $110 billion, or 2.5% of total healthcare expenditures over the coming ten years. At the full adoption rates projected in 2022, these initiatives would reduce healthcare expenditures by 3.6% in the final year. The overall impact of these initiatives translates to $802 per California household annually over the coming ten years, and $1,422 in 2022.

How might the delivery system envisioned by the Forum look for the three Californians we met at the start of this report?[182] On that Tuesday, Mr. Jones was facing a hospitalization for congestive heart failure. But perhaps that hospitalization and its resulting expenses could have been avoided if Mr. Jones had received coordinated team-based care, supported by a real-time monitoring device tracking his health. Once his illness advanced, Mr. Jones and his family would receive specialized physical, psychological and emotional assistance, as well as symptom and pain relief through a care process that prioritizes informed, shared-decision making. If before his disease had progressed, Mr. Jones had received the comprehensive health coaching common in chronic condition management programs, he might have been

[182] The individuals referenced in this section are not real people (nor do their names represent specific persons). The people are illustrative sketches that represent a large group of individuals.

able to make the changes to his diet and physical activity levels that have been demonstrated to slow the progress of CHF and other chronic conditions.

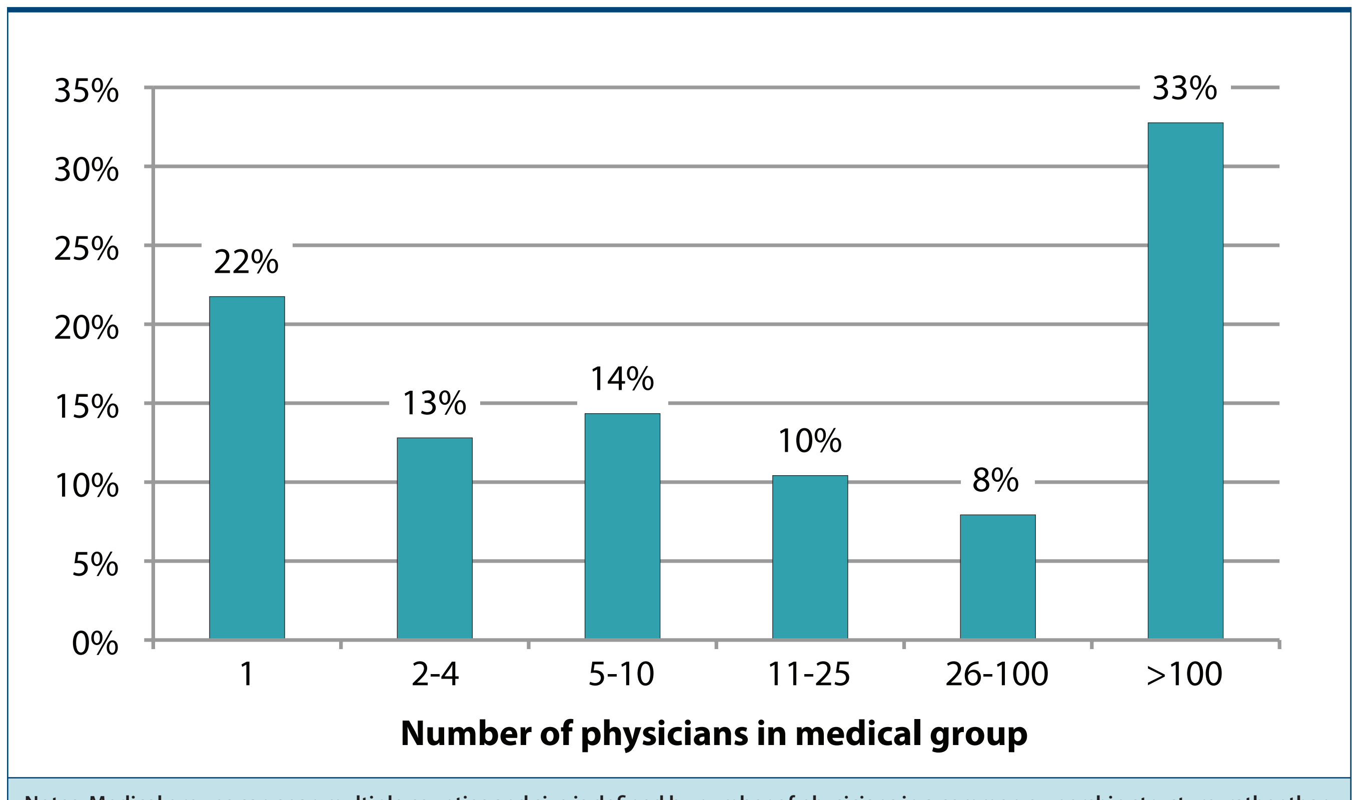
Mrs. Wong, who endured a complicated pregnancy ending in a C-section, may benefit from the Forum Vision's emphasis on providing greater value to both patients and purchasers. The Forum envisions Mrs. Wong being able to have high-quality data on outcomes and treatment options well before she needed care. When selecting among the health plans offered by her employer, she would be able to make an informed choice about the plan and provider right for her. Furthermore, under a care system that promotes long-term health outcomes and value, C-sections would be limited to situations of medical need, rather than personal preferences or unjustified practice variations among physicians.

For Mrs. Hernandez, who has kept her diabetes under control by receiving proactive management from her healthcare providers and by making changes in her lifestyle, implementing the Forum Vision might include a value-based insurance design that waives co-pays for maintenance medications or offers other incentives to keep her and her daughter healthy. Mrs. Hernandez would have access to a support and educational network that includes other diabetic patients, and she would regularly communicate with her care team by phone or e-mail. Default options in Mrs. Hernandez' workplace and community would promote walking, and her daughter's after-school schedule would include numerous outdoor activities.

**The above scenarios portray an achievable goal for how California's healthcare system should function. While some Californians experience such care today, too many others are excluded from its benefits. California is uniquely positioned to demonstrate to the nation that the healthcare delivery system can be transformed to serve all residents in an affordable and effective way. The Forum strongly believes that efforts to make its Vision a reality must begin today.**

# Appendix I: Additional Tables and Figures

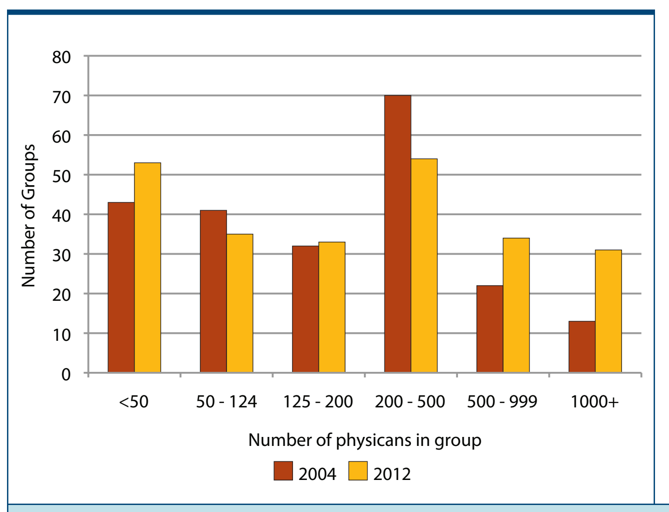
## FIGURE A1: PERCENT OF CALIFORNIA PHYSICIANS PRACTICING BY MEDICAL GROUP SIZE, 2011



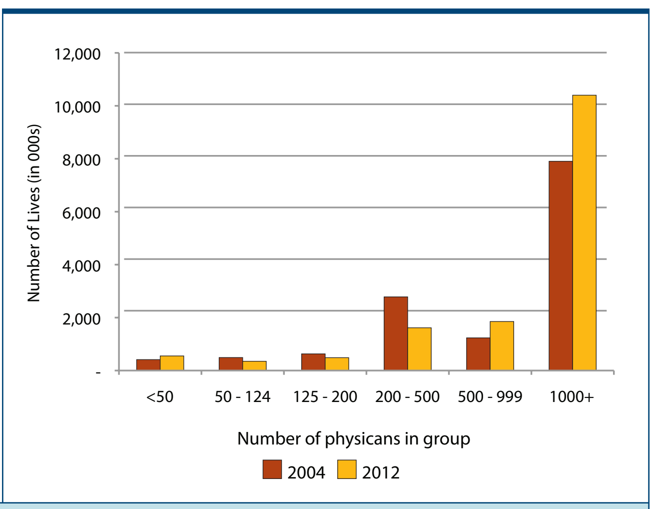

**Notes: Medical groups can span multiple counties and size is defined by number of physicians in a common ownership structure, rather than number of physicians in a particular office location.**

SOURCE: IMS Health Incorporated (2010).

## FIGURE A2: DISTRIBUTION BY PRACTICE SIZE OF HMO-ACCEPTING PHYSICIAN PRACTICES IN CALIFORNIA (2004, 2012)




## FIGURE A3: LIVES COVERED BY HMO-ACCEPTING PHYSICIAN PRACTICES IN CALIFORNIA (2004, 2012)




**Notes: Only includes groups with six or more PCPs and at least one HMO contract, including Medi-Cal, Medicare and commercial.**

SOURCE: Berkeley Forum analysis using Cattaneo & Stroud Inc. (2012a).

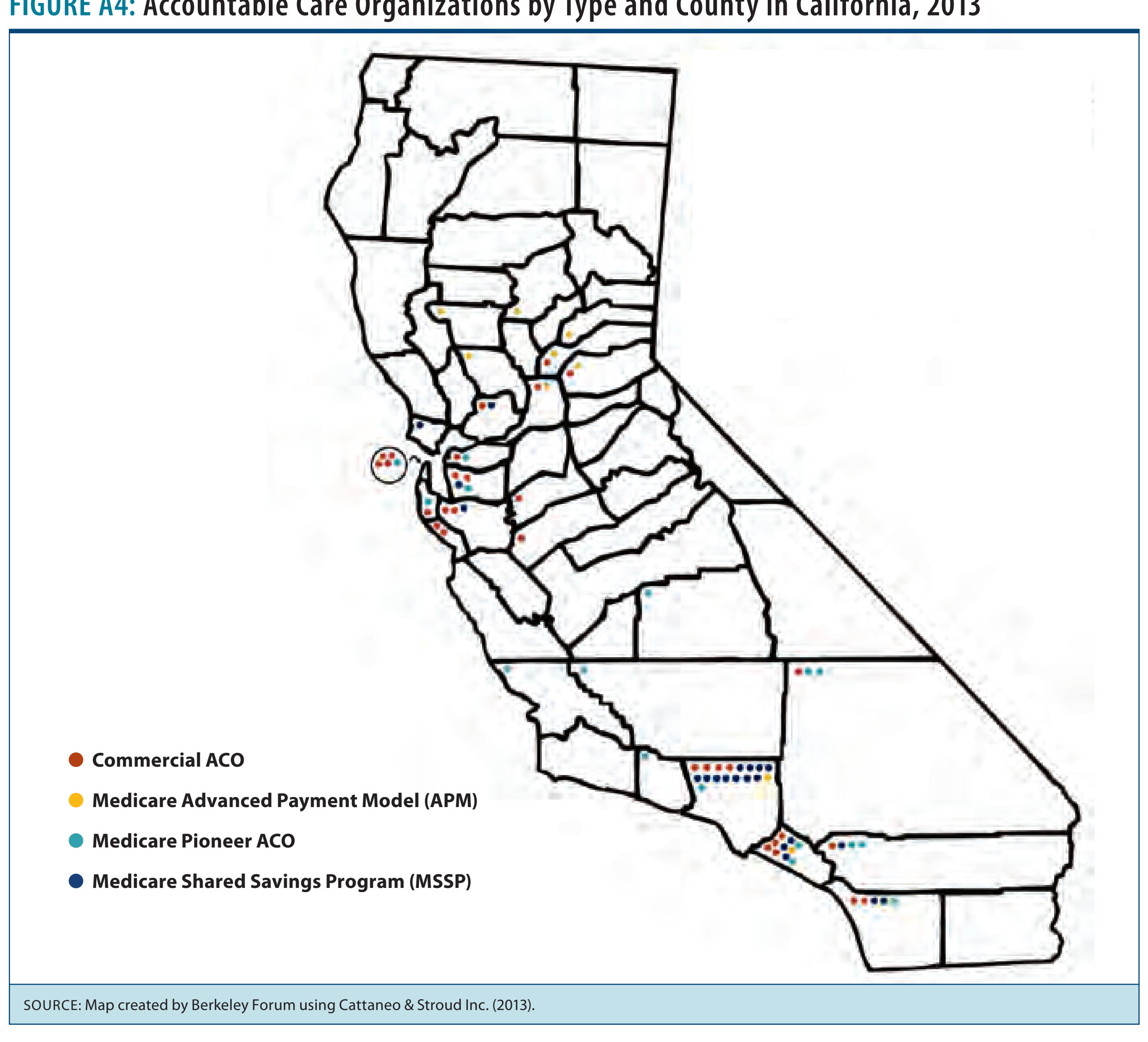
## TABLE A1: ORGANIZATIONAL AND PAYMENT CHARACTERISTICS OF CALIFORNIA VS. REST OF THE U.S. HOSPITALS, 2011

| | California | Rest of the U.S. |
|---|---|---|
| Hospital is a member of health system | 65% | 57% |
| Average number of hospital beds / hospital | 205 | 150 |
| Average number of ICU beds / hospital | 22.7 | 17.8 |
| Total admissions / bed per year | 43 | 34 |
| Contracts directly w/employers on a shared-risk / capitated basis | 7.3% | 2.7% |
| Percent of hospital net patient revenue paid on a capitated basis | 2.9% | 0.6% |
| Percent of hospital net patient revenue paid on a shared risk basis | 4.8% | 0.6% |

**Notes: Analysis was conducted at the individual hospital level with the following sample sizes: California (422) and Rest of the U.S. (5,912). All reported statistics are unadjusted means or proportions. The California results are statistically different than the Rest of the U.S. results at the 0.05 significance level.**

SOURCE: Berkeley Forum analysis using American Hospital Association (2011) database.

## FIGURE A4: Accountable Care Organizations by Type and County in California, 2013




SOURCE: Map created by Berkeley Forum using Cattaneo & Stroud Inc. (2013).

## TABLE A2: List of Accountable Care Organizations Operating in California, 2013

| ACO Name | Sponsor | County | ACO Type | Lives Served | Total Physicians |
|---|---|---|---|---|---|
| AllCare IPA/Doctors Medical Center | Blue Shield | Merced, Stanislaus | Commercial ACO | 8,000 | 519 |
| Access Medical Group/St. Johns Health Center/NantWorks | Blue Shield | Los Angeles | Commercial ACO | 7,000 | 305 |
| Accountable Care Clinical Services/ Preferred ACO | Medicare | Los Angeles | MSSP | 2,500 | 25 |
| Accountable Care Clinical Services-Orange | Medicare | Orange | MSSP | 500 | 8 |
| Affilitated Physicians Medical Group ACO | Medicare | Los Angeles, Orange | MSSP | 10,000 | 75 |
| Akira Health | Medicare | Santa Clara | MSSP | 5,000 | 36 |
| APCN-ACO | Medicare | Los Angeles | MSSP | 9,800 | 125 |
| ApolloMed Accountable Care Organization | Medicare | Los Angeles | MSSP | 10,000 | 175 |
| AppleCare Medical Group | Medicare | Los Angeles, Orange | MSSP | 8,000 | 250 |
| Brown & Toland Physicians | Medicare | Alameda, Contra Costa, San Francisco, San Mateo | Pioneer ACO | 17,000 | 190 |
| Brown & Toland Physicians | CIGNA | San Francisco | Commercial ACO | 6,000 | 650 |
| Brown & Toland/CPMC | Blue Shield | San Francisco | Commercial ACO | 23,000 | 1373 |
| Cedars-Sinai Medical Center | Medicare | Los Angeles | MSSP | 8,000 | 215 |
| Golden Life Healthcare | APM | Butte, Colusa, El Dorado, Nevada, Placer, Sacramento, Yolo, Sutter, Yuba | Advanced Payment Model | 6,000 | 504 |
| Greater Newport Physicians/Hoag Hospital | Blue Shield | Orange | Commercial ACO | 11,000 | 643 |
| HealthCare Partners Medical Group | Blue Flex | Los Angeles, Orange | Commercial ACO | 44,000 | 3615 |
| HealthCare Partners Medical Group | Medicare | Los Angeles, Orange | Commercial ACO | 45,000 | 418 |
| Heritage Provider Network | Medicare | Kern, Los Angeles, Orange, Riverside, San Bernadino, San Luis Obispo, Tulare, Ventura | Pioneer ACO | 68,000 | 1981 |
| Hill Phsicians/Dignity Health/UCSF | Health Net | San Francisco | Commercial ACO | 10,500 | 907 |
| Hill Physicians/Dignity Health – Sacramento Area | Blue Shield | El Dorado, Placer, Sacramento | Commercial ACO | 41,000 | 607 |
| Hill Physicians/Dignity Health/UCSF – San Francisco | Blue Shield | San Francisco | Commercial ACO | 5,000 | 907 |
| John Muir Health | Blue Shield | Alameda, Contra Costa, Solano | Commercial ACO | 17,500 | 823 |
| John Muir Physician Network | Medicare | Alameda, Solano, Contra Costa | MSSP | 7,000 | 112 |
| Meridian Holdings | Medicare | Los Angeles, Riverside | MSSP | 5,000 | 13 |
| Meritage ACO | Medicare | Marin, Sonoma | MSSP | 8,000 | 581 |
| Monarch HealthCare | Medicare | Orange | Pioneer ACO | 17,300 | 350 |
| National ACO | APM | Los Angeles, O range | Advanced Payment Model | 5,600 | 24 |
| North Coast Medical ACO | Medicare | San Diego | MSSP | 6,800 | 281 |
| Palo Alto Medical Foundation | CIGNA | Alameda, San Mateo, Santa Clara, Santa Cruz | Commercial ACO | 21,000 | 1163 |
| Physicians Medical Group of Santa Cruz/ Dominican Hospital | Blue Shield | Santa Cruz | Commercial ACO | 8,000 | 257 |
| Premier ACO Physicians Network | Medicare | Los Angeles, Orange | MSSP | 8,500 | 175 |
| PrimeCare Medical Network | Atena | Riverside, San Bernadino | Commercial ACO | 2,000 | 3725 |
| Primier Choice ACO | Medicare | Riverside, San Bernadino | Pioneer ACO | 13,500 | 800 |
| San Diego Independent ACO | Medicare | San Diego | MSSP | 5,000 | 96 |
| Santa Clara County IPA | Blue Flex | Santa Clara | Commercial ACO | 26,000 | 814 |
| Sharp HealthCare | Aetna | San Diego | Commercial ACO | 2,200 | 656 |
| Sharp HealthCare | Blue Flex | San Diego | Commercial ACO | 22,000 | 1114 |
| Sharp HealthCare | Medicare | San Diego | Pioneer ACO | 32,000 | 800 |
| St. Joseph Health | Blue Shield | Los Angeles, Orange | Commercial ACO | 37,000 | 1318 |
| UCLA ACO | Medicare | Los Angeles | MSSP | 19,000 | 1450 |
| Torrance Memorial Integrated Physicians | Medicare | Los Angeles | MSSP | 15,000 | 355 |
| | | | **Total** | **623,700** | |

**Notes: The number of physicians is not totaled, because many physicians are part of multiple ACOs.**

SOURCE: Cattaneo & Stroud Inc. (2013).

## TABLE A3: SELECTED HEALTHCARE QUALITY MEASURES IN CALIFORNIA AND THE UNITED STATES

| | California | U.S. |
|---|---|---|
| **Preventive Care Quality Measures** | | |
| Adults 18+ who have not had their blood cholesterol checked within the last 5 years | 25% | 26% |
| Adults 50-75 years who have never received a colorectal cancer screening | 42% | 36% |
| **Acute Care Quality Measures** | | |
| Hospital patients with pneumonia who did not receive recommended care practices | 8% | 7% |
| Heart attack patients not receiving percutaneous coronary intervention (PCI) within 90 minutes of hospital arrival | 12% | 12% |
| **Chronic Care Quality Measures** | | |
| Diagnosed diabetics over 40 years old who have not received flu vaccine in the last 12 months | 46% | 29% |
| **Patient Experience/Satisfaction** | | |
| Patients reporting that staff sometimes or never explained medicines prior to giving them | 25% | 24% |
| Patients reporting that they were not given information about what to do during recovery | 20% | 18% |

SOURCE: AHRQ National Healthcare Quality Report 2011.

## TABLE A4: CARE MANAGEMENT PRACTICES (CMPS) AMONG PHYSICIAN ORGANIZATIONS WITH TWENTY OR MORE PHYSICIANS IN CALIFORNIA AND THE REST OF THE U.S., 2006 – 2007

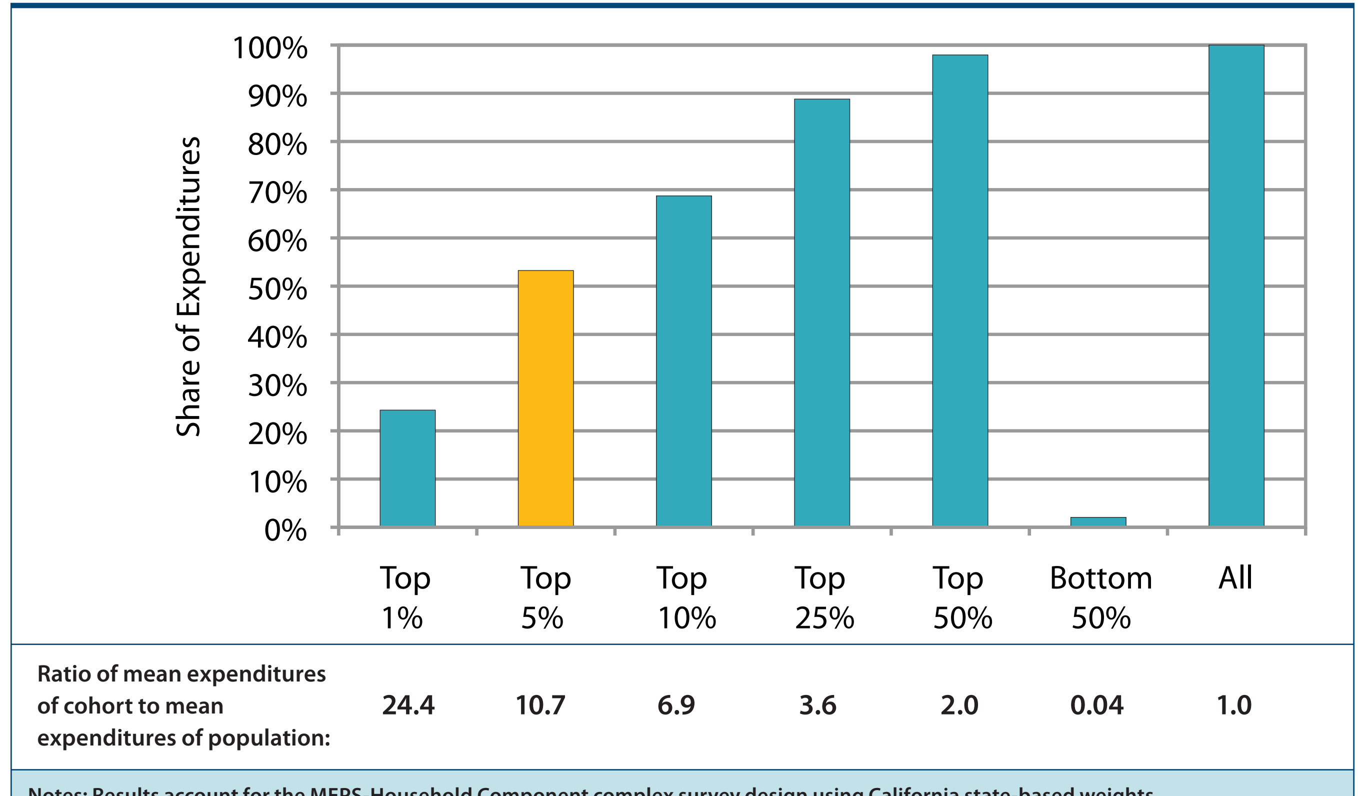
| Type of CMP | Diabetes | | Asthma | | CHF | | Depression | | All Four Conditions | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Rest of the U.S. | CA | Rest of the U.S. | CA | Rest of the U.S. | CA | Rest of the U.S. | CA | Rest of the U.S. | CA |
| Patient list or registry | 64.7% | 80.3%* | 54.7% | 76.6%* | 52.3% | 70.6%* | 38.7% | 44.8% | 36.7% | 43.6% |
| Provide patient educators | 74.7% | 72.7% | 52.7% | 56.0% | 53.8% | 53.3% | 37.2% | 32.2% | 32.3% | 27.3% |
| Physician feed-back on quality | 63.8% | 70.5% | 50.0% | 67.4%* | 50.0% | 52.2% | 35.0% | 28.7% | 32.9% | 27.3% |
| Nurse care managers | 46.8% | 69.4%* | 33.7% | 59.2%* | 39.0% | 63.9%* | 23.2% | 28.7% | 21.3% | 28.5% |
| Patient reminders | 49.4% | 55.2% | 33.7% | 38.0% | 35.5% | 33.9% | 21.4% | 16.7% | 20.7% | 16.3% |
| Point-of-care reminders | 53.2% | 47.5% | 36.4% | 36.4% | 35.5% | 28.3% | 24.8% | 19.5% | 21.0% | 16.9% |
| Percent using all 6 CMPs[1] | 19.7% | 25.1% | 8.3% | 14.7%* | 9.2% | 11.7% | 4.0% | 5.2% | 3.4% | 4.1% |
| Mean # of CMPs used (out of 6)[1] | 3.5 | 4* | 2.6 | 3.3* | 2.7 | 3* | 1.8 | 1.7 | 10.6 | 12.1* |

**Notes: An asterisk indicates a statistically significant difference (p<0.05) between California and the rest of the United States.**
**(1) The last two rows of the "All Four Conditions" column refer to the percent of physician organizations using all six Care Management Practices (CMPs) for all four conditions, and the mean number of CMPs used across all four conditions, respectively.**

SOURCE: Berkeley Forum analysis of National Study of Physicians Organizations 2 (NSPO2).[183]

[183] Shortell (2011) and Rittenhouse, et al. (2010). For the last decade, the National Survey of Physician Organizations has collected extensive data from physician organizations of all sizes. The survey has collected information on practice size, ownership, type, and volume of patients seen; management and governance of the organization; compensation models; relationships with health plans; and implementation of care management processes (CMPs) and quality improvement approaches — with a specific focus on four key chronic illnesses (asthma, congestive heart failure, depression, and diabetes).

## FIGURE A5: SHARE OF HEALTHCARE EXPENDITURES ACCOUNTED FOR BY CALIFORNIA POPULATION COHORTS RANKED BY EXPENDITURES, 2009




| Ratio of mean expenditures of cohort to mean expenditures of population: | 24.4 | 10.7 | 6.9 | 3.6 | 2.0 | 0.04 | 1.0 |
|---|---|---|---|---|---|---|---|

**Notes: Results account for the MEPS-Household Component complex survey design using California state-based weights.**

SOURCE: Berkeley Forum analysis using MEPS-Household Component, 2009.

## TABLE A5: DEMOGRAPHIC CHARACTERISTICS AND MEDICAL CONDITIONS OF TOP 5% VS. BOTTOM 95% HEALTHCARE EXPENDITURE COHORTS IN CALIFORNIA, 2009

| Variables | Full Sample (N=5,803) | Top 5% of Spenders (N=236) | Bottom 95% of Spenders (N=5,567) | Ratio of Top 5% to Bottom 95% (1) | |
|---|---|---|---|---|---|
| **DEMOGRAPHIC CHARACTERISTICS** | | | | | |
| Female | 50% | 64% | 50% | 1.3 | *** |
| **Age (years):** | | | | | |
| 0 to 2 | 5% | 2% | 5% | 0.4 | *** |
| 3 to 19 | 28% | 8% | 29% | 0.3 | *** |
| 20 to 29 | 13% | 9% | 13% | 0.7 | |
| 30 to 39 | 13% | 8% | 14% | 0.6 | *** |
| 40 to 49 | 13% | 13% | 13% | 1.0 | |
| 50 to 59 | 13% | 25% | 12% | 2.1 | ** |
| 60 to 69 | 8% | 14% | 7% | 1.9 | *** |
| 70 to 79 | 4% | 9% | 4% | 2.5 | *** |
| 80+ | 3% | 13% | 2% | 6.0 | *** |
| | 100% | 100% | 100% | | |
| Died | 1% | 5% | 1% | 10.7 | ** |
| **Race:** | | | | | |
| White | 40% | 57% | 39% | 1.4 | *** |
| Black | 6% | 8% | 5% | 1.5 | * |
| Hispanic | 41% | 23% | 42% | 0.5 | *** |
| Asian | 10% | 9% | 10% | 0.9 | |
| Other | 3% | 4% | 3% | 1.2 | |
| | 100% | 100% | 100% | | |
| **Insurance Status:** | | | | | |
| Private | 52% | 51% | 52% | 1.0 | |
| Medicaid only | 14% | 7% | 14% | 0.5 | *** |
| Medicare only | 8% | 23% | 7% | 3.1 | *** |
| Medicare-Medicaid Dual Eligibles | 2% | 9% | 1% | 7.3 | *** |
| TRICARE | 1% | 1% | 1% | 0.8 | |
| Other public (2) | 6% | 4% | 6% | 0.6 | * |
| Uninsured | 17% | 5% | 18% | 0.3 | *** |
| | 100% | 100% | 100% | | |
| **Household income:** | | | | | |
| <$20,000 | 19% | 29% | 18% | 1.6 | ** |
| $20,000-$40,000 | 20% | 22% | 20% | 1.1 | |
| $40,000-$60,000 | 15% | 9% | 15% | 0.6 | *** |
| $60,000-$100,000 | 23% | 20% | 23% | 0.9 | |
| >$100,000 | 24% | 21% | 24% | 0.9 | |
| | 100% | 100% | 100% | | |
| **Education:** | | | | | |
| Less than high school | 25% | 17% | 26% | 0.7 | *** |
| High school or equivalent degree | 42% | 47% | 42% | 1.1 | |
| Some college | 6% | 5% | 6% | 0.8 | |
| College degree | 17% | 18% | 17% | 1.0 | |
| Some graduate school | 9% | 13% | 9% | 1.5 | |
| | 100% | 100% | 100% | | |

SEE NOTES ON FOLLOWING PAGE

## TABLE A5 (CONTINUED): DEMOGRAPHIC CHARACTERISTICS AND MEDICAL CONDITIONS OF TOP 5% VS. BOTTOM 95% HEALTHCARE EXPENDITURE COHORTS IN CALIFORNIA, 2009

| Variables | Full Sample (N=5,803) | Top 5% of Spenders (N=236) | Bottom 95% of Spenders (N=5,567) | Ratio of Top 5% to Bottom 95% (1) | |
|---|---|---|---|---|---|
| **PRIORITY CONDITIONS (ever had, ages 18+ [except when noted])** | | | | | |
| High blood pressure | 28% | 56% | 26% | 2.1 | *** |
| Heart disease (any type) | 10% | 28% | 9% | 3.1 | *** |
| Heart disease (coronary) | 4% | 15% | 3% | 4.3 | *** |
| Heart disease (angina or angina pectoris) | 3% | 9% | 2% | 4.2 | ** |
| Heart disease (heart attack or myocardial infarction) | 3% | 11% | 2% | 4.9 | *** |
| Heart disease (other) | 8% | 18% | 7% | 2.6 | *** |
| Stroke or transient ischemic attack | 3% | 11% | 2% | 5.4 | *** |
| Emphysema | 1% | 7% | 1% | 6.2 | ** |
| Chronic bronchitis | 1% | 2% | 1% | 3.2 | |
| High cholesterol | 29% | 46% | 28% | 1.6 | *** |
| Cancer | 9% | 24% | 8% | 3.0 | *** |
| Diabetes | 8% | 21% | 7% | 2.9 | *** |
| Joint pain | 17% | 41% | 16% | 2.6 | *** |
| Arthritis | 18% | 48% | 16% | 2.9 | *** |
| Asthma (all ages) | 9% | 20% | 8% | 2.5 | *** |
| ADHD/ADD (ages 5 to 17) | 6% | 13% | 5% | 2.4 | |
| **Number of priority conditions:** | | | | | |
| Mean | 1.0 | 2.8 | 0.9 | 3.2 | *** |
| 0 | 57% | 22% | 58% | 0.4 | *** |
| 1 | 18% | 12% | 19% | 0.6 | *** |
| 2 | 10% | 15% | 10% | 1.4 | * |
| 3 | 7% | 19% | 6% | 3.1 | *** |
| 4+ | 8% | 32% | 7% | 5.0 | *** |
| | 100% | 100% | 100% | | |
| **BODY MASS INDEX (BMI)** | | | | | |
| Underweight | 1% | 3% | 1% | 3.4 | |
| Normal weight | 25% | 27% | 25% | 1.1 | |
| Overweight | 26% | 28% | 26% | 1.1 | |
| Obese | 17% | 33% | 17% | 2.0 | *** |
| No response (includes all children) | 31% | 9% | 32% | 0.3 | *** |
| | 100% | 100% | 100% | | |

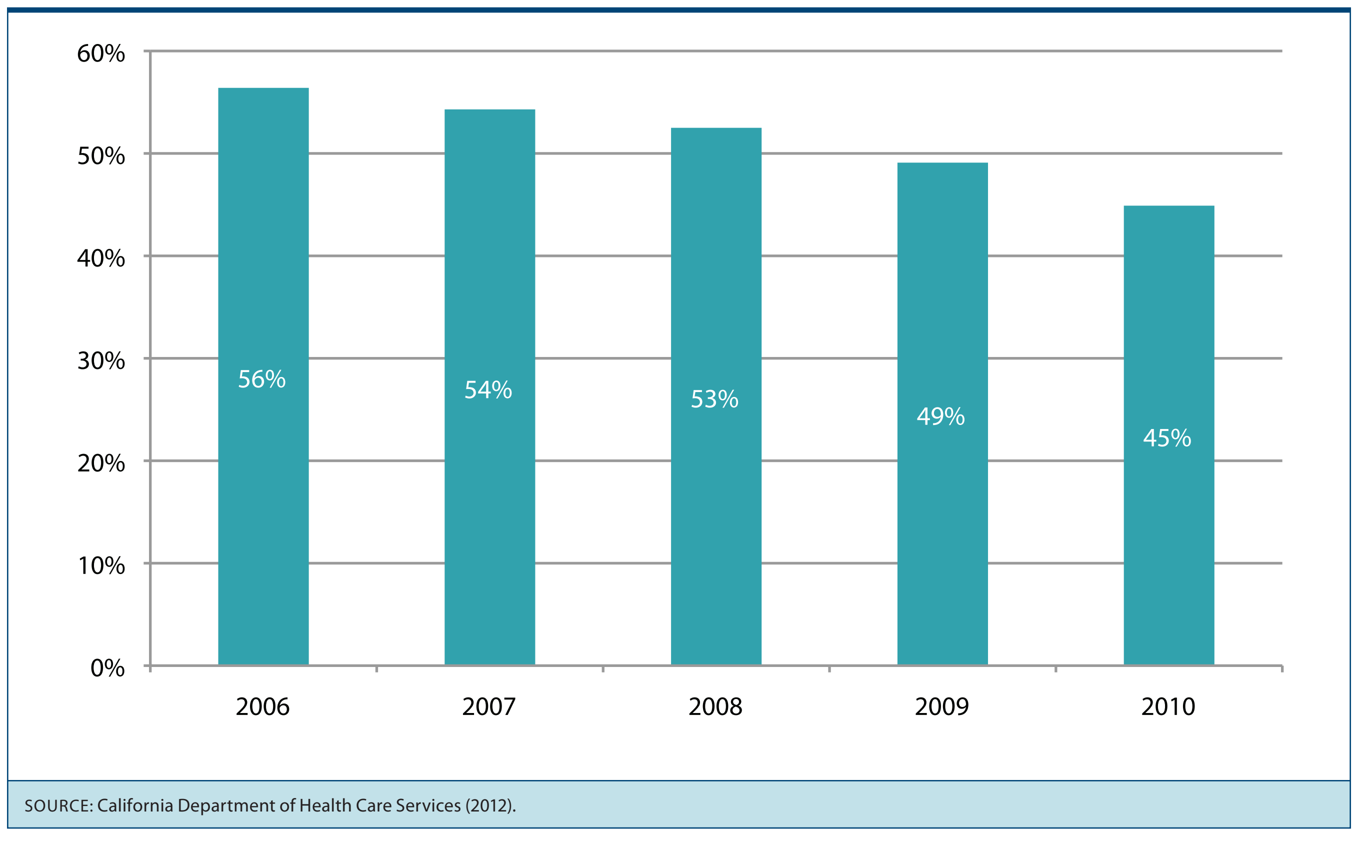
**(1) Ratio is statistically different than 1 at the following significance levels: *p<0.1, **p<0.05, ***p<0.01**

**(2) Other public insurance includes individuals with, for example, county-based plans and individuals who had a mix of different types of public plans during the year.**

**Note: All results account for MEPS complex survey design using California state-based weights. The reported sample sizes (N) are for the full sample; however, some variables had missing values. The sample of the 236 top 5% spenders represents 5% of the weighted sample.**

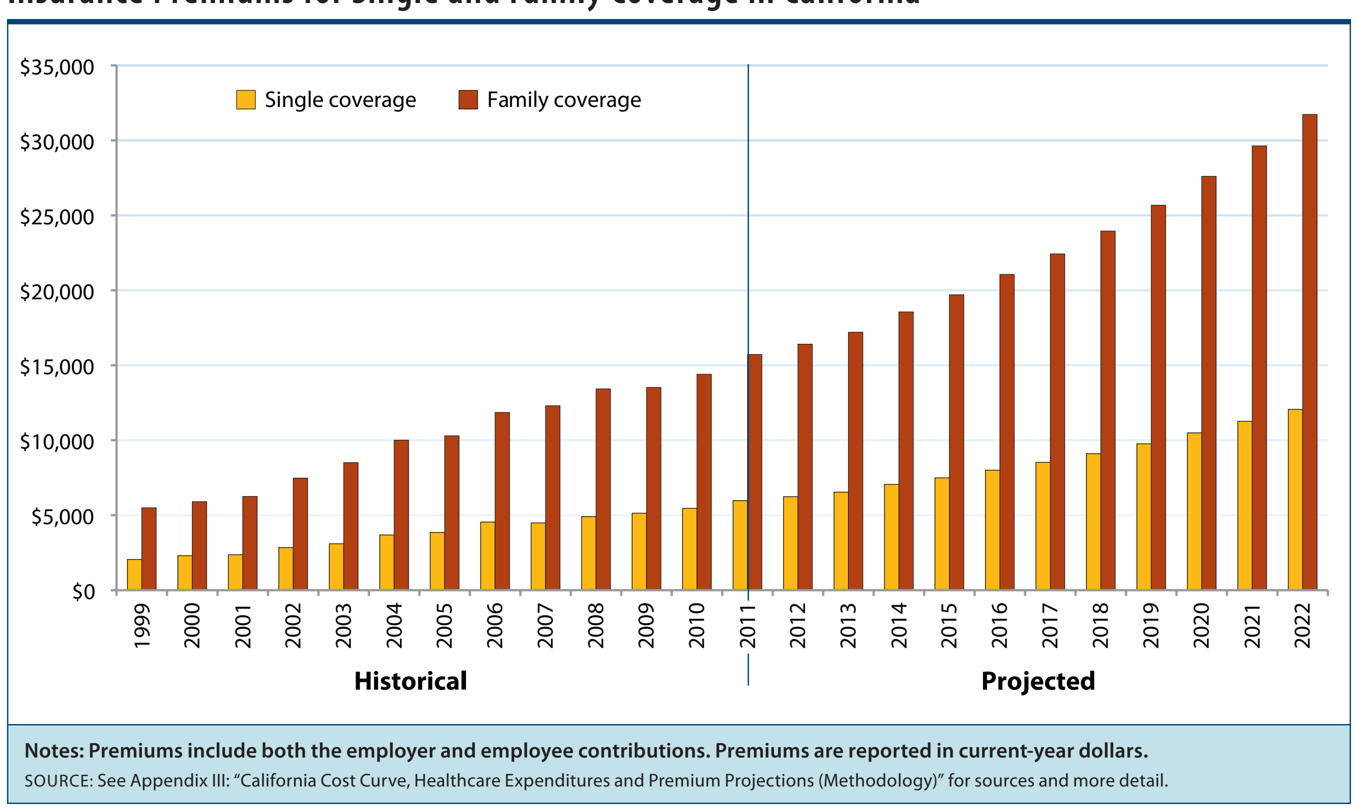
SOURCE: Berkeley Forum analysis using Medical Expenditure Panel Survey—Household Component, 2009.

## FIGURE A6: SHARE OF MEDI-CAL'S TOP 5% HEALTHCARE SPENDING COHORT IN 2005 THAT REMAINED IN THE TOP 5% FROM 2006 – 2010




SOURCE: California Department of Health Care Services (2012).

## FIGURE A7: Historical (1999 – 2011) and Projected (2012 – 2022) Employer-Sponsored Health Insurance Premiums for Single and Family Coverage in California




**Notes: Premiums include both the employer and employee contributions. Premiums are reported in current-year dollars.**

SOURCE: See Appendix III: "California Cost Curve, Healthcare Expenditures and Premium Projections (Methodology)" for sources and more detail.

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- Blue Shield of California, Kathy Swenson, Senior Vice President
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- California Health and Human Services Agency, Jim Suennen, Associate Secretary, Office of External Affairs
- Cedars-Sinai Medical Center, Richard Jacobs, Senior Vice President for System Development and Chief Strategy Officer
- U.S. Department of Health and Human Services Regional Office, Bonnie Preston, Outreach and Policy Specialist
- Dignity Health, Wade Rose, Vice President of External and Government Relations
- HealthCare Partners, Barton Wald, Regional Medical Director
- Health Net, Patricia Clarey, Senior Vice President, Chief Regulatory and External Relations Officer, Chief Compliance Officer
- Kaiser Permanente, Anthony Barrueta, Vice President of Government Relations
- MemorialCare Health System, Scott Joslyn, Senior Vice President and Chief Information Officer
- Monarch HealthCare, Jay Cohen, President and Chairman of the Board
- Sutter Health, Robert Reed, Chief Financial Officer

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- Deborah A. Freund, PhD, President of Claremont Graduate University
- Elizabeth McGlynn, PhD, Director of Kaiser Permanente Center for Effectiveness and Safety Research
- Cathy Schoen, MS, Senior Vice President for Policy, Research and Evaluation of The Commonwealth Fund
- Tom Williams, DrPH, President and CEO of Integrated Healthcare Association (IHA)

**We are grateful for the contributions of time, data and/or input from the following organizations. Their contribution does not indicate endorsement of the findings in the report:**

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- California Department of Managed Health Care
- California HealthCare Foundation
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- Center for the Health Professions at the University of California, San Francisco
- Center to Advance Palliative Care
- Health Research and Educational Trust, American Hospital Association
- IMS Health Incorporated
- Integrated Healthcare Association
- Milliman, Inc.
- Office of Statewide Health Planning and Development
- Pacific Business Group on Health
- U.S. Department of Health and Human Services

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- Staff at the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare (http://petris.org/), University of California, Berkeley School of Public Health produced the report and conducted most of the research and analyses for this report.
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Berkeley Forum
for Improving California's Healthcare Delivery System

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# A NEW VISION FOR CALIFORNIA'S HEALTHCARE SYSTEM

| | |
|---|---|
| **From:** | Barbara Salvini |
| **To:** | HCAI OHCA |
| **Subject:** | Health care costs too much, Trust me I know |
| **Date:** | Friday, February 16, 2024 10:32:15 AM |

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board Members,

My name is Barbara Salvini and I am writing to you today to share my health care story.

I am very concerned that the FDA had many drugs pulled off the market because they were so old they grandfathered into the system pre formation of the FDA. I ran into this with my bovine thyroid medication and without this drug I get terrible leg and chest cramps. I had to buy it illegally from Canada. I have friends that go to Mexico to get their prescriptions filled. Other drugs for rare conditions were taken off the market here but are available in other countries.

Why do other countries allow medication to be shipped in by individuals from reputable companies but we don't? This would go a long way in lowering costs.

A pharmacist in my town told me that there were drugs for mental health that reset patient brains and then could be tapered off. He said these old drugs were cheap and had low suicide rates but he could no longer get them. He said some customers that were moved to the new drugs were stuck on them for life and they were so expensive they could take a half dose or skip meals because they couldn't afford them.

The federal government needs a branch that is not controlled by the industry that will look into these old drugs and determine if they are safe. It is apparent that the drug industry is manipulating the drugs available and the type researched and brought to market to make people dependant. I would also like to see government sponsored research and evaluation of private and university research on ancient herbs and remedies so doctors can refer patents without worry of litigation and can do so with scientific data.

Pharmaceutical companies say they need the high costs so they can pay for new research. I would prefer our government to sponsor more research and testing on promising drugs. So we can find cures instead of long term drug programs. We can then put production of the drugs manufacturing out to the lowest bidder.

I am respectfully urging you not to make any adjustments that would adversely affect or delay the implementation of health care affordability protections. Specifically, maintaining a 3 percent annual spending growth target for 2025 - 2029 that is based on the median income between 2002- 2022, rather than on the growth of the economy. All too often, consumers have been burdened by a health care system that does not prioritize the health and well-being of the patient. I am counting on the Office of Health Care Affordability to hold industry accountable and not put profits over the people who rely on the health care system to survive.

Thank you for your consideration.

Sincerely,
Barbara Salvini

United States

**From:** Benjamin Etgen
**To:** HCAI OHCA
**Subject:** Health care costs too much, Trust me I know
**Date:** Wednesday, February 28, 2024 3:36:25 AM

You don't often get email from [redacted]. Learn why this is important

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board Members,

I am writing to you today to share my health care story.

My health care costs me more than 800 per month.

Health care costs are too expensive and clearly unsustainable. While these costs continue to increase, everyday folks like me are forced to compromise our health, choosing between delaying care, skipping tests, or failing to fill prescriptions to save money. Slowing the growth of health care costs leaves more money for me, helping me to pay for other basic needs like food, rent, utilities, and additional living expenses.

I am respectfully urging you not to make any adjustments that would adversely affect or delay the implementation of health care affordability protections. Specifically, maintaining a 3 percent annual spending growth target for 2025 - 2029 that is based on the median income between 2002- 2022, rather than on the growth of the economy. All too often, consumers have been burdened by a health care system that does not prioritize the health and well-being of the patient. I am counting on the Office of Health Care Affordability to hold industry accountable and not put profits over the people who rely on the health care system to survive.

Thank you for your consideration.

Sincerely,
Benjamin Etgen

United States

| | |
|---|---|
| **From:** | [redacted] on behalf of Benjamin Wynne |
| **To:** | HCAI OHCA |
| **Subject:** | Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations |
| **Date:** | Friday, February 23, 2024 3:12:20 PM |

[You don't often get email from [redacted].com. Learn why this is important at https://aka.ms/LearnAboutSenderIdentification ]

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board,

Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Sincerely,
Mr. Benjamin Wynne

**From:** [redacted] on behalf of Bo Fahey
**To:** HCAI OHCA
**Subject:** Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
**Date:** Wednesday, February 14, 2024 10:50:18 AM

---

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Dear Office of Health Care Affordability Board,

Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Sincerely,
Mrs. Bo Fahey
[redacted]

| | |
|---|---|
| **From:** | on behalf of Bob Leppo |
| **To:** | HCAI OHCA |
| **Subject:** | Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations |
| **Date:** | Monday, February 12, 2024 1:39:32 PM |

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CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board,

Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Sincerely,
Mr. Bob Leppo

**From:** [redacted] behalf of Bruce Coston
**To:** HCAI OHCA
**Subject:** Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
**Date:** Thursday, February 15, 2024 3:38:34 AM

---

[You don't often get email from [redacted] Learn why this is important at https://aka.ms/LearnAboutSenderIdentification ]

CAUTION: This email originated from outside of the organization.

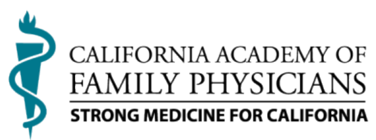
Dear Office of Health Care Affordability Board,

Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

Stop the insanity , and use Marcus Schulze CSSD. 2x Condorcet Voting to comply with the Universal Declaration of Human Rights part 21.3 . Increase the social safety net with minimum income .

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Sincerely,
Mr. Bruce Coston



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March 11, 2024

Mark Ghaly, M.D.
Chair, Health Care Affordability Board
2020 West El Camino Ave Conference Room 900
Sacramento, CA 9583

*Sent via email to OHCA@hcai.ca.gov*

RE: Office of Health Care Affordability (OHCA) Recommendations to the California Health Care Affordability Board: Proposed Statewide Spending Target

Dear Dr. Ghaly,

The California Academy of Family Physicians (CAFP) and our more than 10,000 family physicians, residents, and medical students thank you for considering our comments regarding the Office of Health Care Affordability's (OHCA) proposed spending targets. CAFP commends OHCA for its invaluable work on reform efforts to make California's health care system more equitable, high-quality, and cost-efficient.

**Affordability is a Barrier to Health Care Access**

In 2023, more than half of all Californians (53 percent) reported postponing care because of the cost, many of which also reported that delayed care led to worsening health outcomes. Such high costs of care disproportionately affect Black (36 percent) and Latinx (40 percent) Californians who are twice as likely to have difficulty paying for medical bills compared to White (20 percent) Californians.[i] When patients forgo care, especially primary care, because of a fear of what care will costs them, it makes them sicker and increases the cost of care. Prioritizing primary care is essential for advancing equitable healthcare and for shifting the paradigm of reactive care that is perpetuated when patients cannot afford to get the care they need, when they need it, and from providers they trust and want to receive their care from.

**Investing in Primary Care Drives Lower Costs and Improves Health Outcomes**

CAFP recommends that the OHCA Board reconsiders the proposed approach to setting a statewide healthcare spending target without necessary systems changes that promote primary and preventive care. A reduction in spending

without changes to how care is provided could have unintended consequences. A spending target that simply reduces spending on the same set of services may not be effective and without appropriate risk-adjustment, may create incentives to avoid the hardest to treat patients.

Primary care is the backbone to a person-centered, prevention-oriented healthcare delivery system and has been shown to advance health equity, positive health outcomes, better quality of care, and lower overall healthcare costs per person.[ii] Currently, primary care is grossly underfunded- where national data shows that primary care accounts for about 5 percent of total health care dollars—with investments declining across all payers since 2019.[iii] In California, 6.3 percent of total healthcare dollars are spent on primary care. Prioritizing primary care spending is crucial for offsetting more expensive costs of care.

CAFP is supportive of advancing ways to address the dire healthcare affordability challenges that burden Californians across the state. OHCA's proposed three percent growth proposal is below current health care inflation. However, current health care inflation assumes that we will continue to provide care inefficiently. Pouring more money into a system that includes incentives for expensive specialty care in everything from physician training to payment, is not sustainable. CAFP is hopeful that a spending growth cap accompanied by significant system transformation and risk adjustment would result in system incentives to provide more primary and preventive care.

Thank you for the opportunity to provide input on addressing healthcare spending and prioritizing equitable and accessible healthcare in California. Should you have any questions, please contact Marissa Montano at mmontano@familydocs.org.

Sincerely,

Raul Ayala, MD, MHCM
President, California Academy of Family Physicians

Cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information

Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Members of the Health Care Affordability Board:

David M. Carlisle, MD, PhD
Secretary Dr. Mark Ghaly
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Dr. Richard Pan

---

[i] California Health Care Foundation, The CHCF 2024 Health Policy Survey, January 2024.
[ii] Phillips KE, Haft, H, and Rauner, B. The Key to Improving Population Health and Reducing Health Disparities: Primary Care Investment, *Health Affairs*, July 27, 2022.
[iii] Jabbarpour Y, Jetty A, Byun H, Siddiqi A, Petterson S, Park J. The Health of US Primary Care: 2024 Scorecard Report — No One Can See You Now. The Milbank Memorial Fund and The Physicians Foundation. February 28, 2024.

1415 L Street, Suite 850
Sacramento, CA 95814

916.552.2910

www.calhealthplans.org

March 11, 2024

Sent via email:
ohca@hcai.ca.gov

Mark Ghaly, M.D.
Chair, Office of Health Care Affordability
1215 O Street
Sacramento, CA 95814

**Re: Statewide Spending Target**

Dear Secretary Ghaly and OHCA Board Members:

The California Association of Health Plans (CAHP) represents 43 public and private health care service plans (plans) that collectively provide coverage to over 28 million Californians.

We share the Office of Health Care Affordability's (OHCA) long-term vision of creating a workable system that will manage health care cost growth and improve affordability, but that calls for thoughtful, in-depth analysis and discussion of underlying methodologies so we can get things right the first time. Numerous health care entities, including payers, will be subject to OHCA's statewide spending target, and this letter conveys our recommendations OHCA should consider in adopting and implementing a realistic, achievable target.

## We Support the Overarching Tenets of OHCA's Spending Target Program

First, we applaud OHCA for going where no California agency has gone before when it comes to slowing health care spending growth. Californians deserve health care that is accessible, affordable, and high-quality, and we want to be part of the solution.

Our members support a multi-year spending target that is subject to annual review and adjustment by the OHCA board to take into consideration technology and other market conditions. OHCA's spending target program holds incredible potential to be successful as long as the underlying rationale is thoughtfully developed. The blueprint is nearly complete, but we identified some elements that must be fully examined and understood before OHCA approves it.

## OHCA Should Explore Reasonable Alternatives in Collaboration with Industry Partners

OHCA's process of setting such a critical, industry-wide benchmark should be driven by thoughtful discourse, comprehensive analyses, and careful consideration for all underlying factors that may impact implementation. We appreciate OHCA's prior discussion around adjustments for new technologies or population-based measures, but this discussion is incomplete. Even if OHCA recommends against making adjustments to the target based on both of those factors, reasonable alternatives exist that should be taken into consideration before anything is finalized.

## I. Revisit the Discussion About Historical Average Median Household Income

We understand why OHCA chose to use median household income as the indicator for setting the spending target, but several stakeholders and board members have commented on OHCA's proposal to use an arbitrary 20-year average growth rate of historical median household income data. OHCA's rationale is that this approach "better reflects long-term patterns rather than relying on uncertain forecasting methods." We disagree. California's spending target program must have a meaningful, realistic baseline, and using a 10-year historical average is more appropriate. The last 10 years of spending are more reflective of the next 10 years of spending, and relying on the most recent decade provides a more realistic trend line for factors such as inflation and the impact of the COVID-19 Public Health Emergency on household income.

## II. Consider a Progressive Target Approach and the Value of Incremental Improvement

In addition, while we support a multi-year target, we recommend using an approach that sets a more realistic target for years one and two with more aspirational targets near the end of the cycle. This approach would give entities a runway or ramp-up period to reach the desired end goal, as well as credit for incremental improvement. We all want this spending target program to be successful, and there is a major window of opportunity here for OHCA to discuss reasonable alternatives with stakeholders, refine the methodology, and make it achievable for the industry.

## III. Specifically Acknowledge and Account for California's Work on Equity, Quality, and Access

OHCA should also take into account any impacts that its requirements could have on quality of care and health equity in the state's healthcare system, especially considering California's geographic variances. Efforts must be made to ensure that the target and its methodology would not negatively impact current advancements or ongoing efforts to improve quality and equity of care for Californians that are collectively being advanced by the Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS), Department of Managed Health Care (DMHC), and Covered California. Furthermore, actuarial analysis should be performed on the spending target to determine any impact that it may have on existing state and federal payment initiatives, such as the Medi-Cal Targeted Rate Increases that are already being developed by DHCS. Coordination with other state agencies and existing payment initiatives is critical to avoid confusion and unintended consequences. The board should include language in the spending target regulation that acknowledges, protects, and ensures that California's groundbreaking health care reform efforts are accounted for in the annual adoption of spending targets and/or in the retrospective review of performance.

## OHCA Should Apply Lessons Learned from Other States Before Finalizing the Current Proposal

When presenting statistics and research, OHCA and its consultants have frequently referenced other states that have implemented cost growth programs. Before adopting a spending target for a state as large and complex as California, we urge OHCA to take a sincere look at the implementation experiences, both positive and negative, of those other states to help inform California's methodology.

Some states, like Massachusetts, are still grappling with issues around attribution several years after their cost growth benchmarks went into effect. Similarly, Oregon is revisiting the enforcement piece of its cost growth program since many health care entities were unable to meet the target. The Oregon Health Authority is contemplating revisions to its regulations that will allow the enforcement process to consider several reasonable causes for exceeding the target, some of which California has discussed but elected not to consider. For example, Oregon's reasonableness determination proposes to apply unforeseen market conditions or other equitable factors, including, but not limited to: changes in mandated benefits codified in state or federal law, pandemics or natural disasters, new pharmaceuticals or medical treatments entering the market, population health or health equity investments, and inflation.[1]

Even if OHCA does not adjust for certain cost drivers and market conditions prospectively, when it's time for the board's annual review of spending target performance, we strongly urge OHCA to take a page from Oregon's playbook and review the impact of factors such as technology, inflation, the price of high-cost drugs, labor costs inclusive of mandatory state wage increases, utilization, and unit-cost trends of medical services.

In addition, the Connecticut Office of Health Strategy recently recommended that the state's 2024 cost growth benchmark be increased from 2.9% to 4.0% due to the impact of inflation. When OHCA is looking at setting a target for a five-year block of time, it needs to account for the realities of what's happening in the marketplace.

We ask that OHCA share any benchmark analysis that was considered and/or performed to compare the proposed spending target against those set by other states for the purposes of identifying similarities and/or differences with the supporting rationale of those targets with is being proposed by OHCA for California. OHCA should invite industry experts from other states to the table so California can glean insight from their experiences and lessons learned—even better, California can apply that insight to the methodology now so the industry can avoid missteps later.

## A Transparent Goal Calls for a Transparent Process—There are Many Questions Left to Answer

OHCA's enacting statute emphasizes the importance of transparency, and we are concerned about the lack of visibility and proper discourse leading to the formation of the spending target.

### I. The Industry is Still Missing the Full Picture of TME Data Capture, Reporting, and OHCA's Process Leading to Enforcement

Stakeholders still need a more detailed understanding of how Total Medical Expenses (TME) are going to be analyzed and displayed for providers so they can generate actionable information. Before OHCA adopts the spending target, we need clarity on how OHCA will present and characterize the information, because it will ultimately affect entities' performance against the benchmark. If health care entities are going to be held accountable to a common goal, when they are modeled so differently from one another, they need to know what that goal looks like and how OHCA will parse out the TME formula.

[1] Oregon Administrative Rules, Chapter 409, Division 65, Rule 0035 (OAR 409-065-0035), Reasonable Causes of Cost Growth (proposed February 14, 2024)

As OHCA begins receiving THCE data and building its baseline report, engaging industry stakeholders early and often will ensure that the information collected is actionable and helpful. This format of data collection and attribution is novel and untested in California, and we want to be proactive partners to OHCA in shaping its first public report. It would be beneficial to give stakeholders a preview of what data is going to be included and discuss how it will be presented before the report is issued.

In addition, more discussion is needed surrounding the enforcement process, specifically what OHCA's assessment will entail if an entity exceeds the spending target, and how other sectors will be held accountable to the target. We understand the multi-step enforcement framework outlined in statute, but it is still unclear how OHCA will analyze spending data and how the agency will investigate an organization prior to initiating enforcement.

Successful implementation of any initiative requires involved parties to start with the right tools. Addressing the above knowledge gaps would supply California's health care entities with the right tools to help OHCA reach its long-term affordability goals.

**A May Vote Would Better Ensure Fair Consideration of All Stakeholder Feedback**

Considering all of the above, it would be a mistake for OHCA to rush the adoption of such an important measure when public comments are due on March 11, the OHCA Advisory Committee meets on March 19, and the OHCA board meets less than a week later on March 25. With barely a week in between each step, public comments will not be granted proper review and there will not be enough time for thoughtful discussion and consideration by the Advisory Committee and Board. To ensure the adoption of a fully informed, achievable spending target, OHCA should utilize all available time under the statute and reserve its formal vote for the May 22nd board meeting.

CAHP appreciates OHCA's consideration of our members' comments and concerns.

Sincerely,

Charles Bacchi
President and CEO

Cc: Members of the Health Care Affordability Board

March 5, 2024

Sent via email:
ohca@hcai.ca.gov

Mark Ghaly, M.D.
Chair, Office of Health Care Affordability
1215 O Street
Sacramento, CA 95814

**Re: Statewide Spending Target Adoption Timeline**

Dear Secretary Ghaly and OHCA Board Members:

The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America's Physician Groups (APG) represent California's physician organizations, health insurance brokers, and health plans. Collectively, our members are the backbone of California's health care system and its economy. We all serve a common purpose: ensuring that Californians have access to quality, affordable health care. We also represent the health care entities that will be subject to the first-ever statewide spending target proposed by the Office of Health Care Affordability (OHCA).

As our organizations review and analyze the spending target proposal, we strongly urge OHCA to avoid taking quick action to adopt a 3.0% spending target. Instead, OHCA should take this action, as allowed under statute, at the May 2024 board meeting for the following reasons:

With the creation of OHCA, we are confident that California will continue to make incredible strides in addressing health care affordability. However, as stakeholders and partners, we also believe OHCA's mission must be driven by thoughtful discourse, comprehensive analyses, and careful consideration for all underlying factors that may impact implementation. No matter what value is assigned to the spending target, this will be one of the most significant decisions OHCA will ever make, and OHCA should take all available steps to ensure the target's underlying methodology is realistic and informed. We represent a major portion of the health care entities subject to this target, and if future enforcement is on the table, starting with a foundation that allows for little to no consideration of our industry's public comments is insufficient and fails to account for the realities of California's health care landscape.

Furthermore, from a process perspective, it would be inappropriate to rush the adoption of such an important measure when public comments are due on March 11, the OHCA Advisory Committee meets on March 19, and the OHCA Board meets less than a week later on March 25. With barely a week in between each step, public comments will get lost in the shuffle and there will not be enough time for thoughtful discussion and consideration by the Advisory Committee and Board.

While our associations have unique perspectives on the specific underpinnings of the spending target, we all agree that the OHCA Board would make a significant mistake if it votes to adopt the proposed spending target in March. Stakeholders deserve more meaningful engagement with OHCA before anything is finalized. OHCA's enacting statute emphasizes the importance of transparency, and we are concerned about

the lack of visibility and proper discourse leading to the formation of the spending target. California's health care industry needs more time to analyze the underlying methodology and address outstanding issues prior to adopting such a critical benchmark.

As an industry, we strongly urge the OHCA Board to delay the spending target vote until May—this way, OHCA would still meet its June 1st statutory deadline while giving all stakeholders ample opportunity to provide feedback. Rushing such an important decision would be a grave disservice to California's health care partners and to the public. We all want the spending target to be achievable and effective, so let's take the time to get it right.

Cc: Members of the Health Care Affordability Board

**From:** Candace Polzin
**To:** HCAI OHCA
**Subject:** Health care costs too much, Trust me I know
**Date:** Wednesday, March 6, 2024 7:44:20 AM

You don't often get email from c[redacted]. Learn why this is important

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board Members,

I am writing to you today to share my health care story.

My health care costs me more than [$427 per month. This is just for Covered CA, not including my prescriptions or visits. I am a single person making 50K in Los Angeles County, I have nobody to split rent with and am responsible for everything yet the subsidies do not keep the cost of living and circumstances in mind. It is cheaper to go without, but I can't afford a catastrophe to bankrupt me.

Health care costs are too expensive and clearly unsustainable. While these costs continue to increase, everyday folks like me are forced to compromise our health, choosing between delaying care, skipping tests, or failing to fill prescriptions to save money. Slowing the growth of health care costs leaves more money for me, helping me to pay for other basic needs like food, rent, utilities, and additional living expenses.

I am respectfully urging you not to make any adjustments that would adversely affect or delay the implementation of health care affordability protections. Specifically, maintaining a 3 percent annual spending growth target for 2025 - 2029 that is based on the median income between 2002- 2022, rather than on the growth of the economy. All too often, consumers have been burdened by a health care system that does not prioritize the health and well-being of the patient. I am counting on the Office of Health Care Affordability to hold industry accountable and not put profits over the people who rely on the health care system to survive.

Thank you for your consideration.

Sincerely,
Candace Polzin
[redacted]

United States

March 11, 2024

Megan Brubaker
Engagement and Governance Manager
Office of Health Care Affordability
Department of Health Care Access and Information
2020 West El Camino Avenue
Suite 1200
Sacramento CA 95833

*Submitted electronically via ohca@hcai.ca.gov*

**RE: Proposed Statewide Health Care Spending Target Concerns**

Dear Ms. Brubaker,

On behalf of the members of the California Association of Public Hospitals and Health Systems and the millions of patients they serve, I am writing to voice our concerns on the Office of Health Care Affordability's (OHCA's) proposed statewide health care spending target of 3.0% for 2025-2029. While we support OHCA's goals to improve health care affordability for patients and consumers, we are deeply troubled by the potentially detrimental impacts this could have on health care access in California and the financial stability of our state's health care safety net.

California's 21 public health care systems, which include county-operated and -affiliated facilities and the five University of California medical centers, are the core of the state's health care safety net, delivering high quality care to more than 3.7 million patients annually, regardless of ability to pay or insurance status. Public health care systems play an outsized role in caring for at-risk communities. Although they represent just six percent of all California hospitals, public health care systems provide 35% of all Medi-Cal and uninsured hospital care statewide. Public health care systems also provide a range of comprehensive services and train nearly half of all new doctors in hospitals across the state.

As safety net providers, public health care systems understand firsthand how health care costs can be a major barrier for patients in accessing needed services and what the burden of medical financial hardship can mean for individuals and their families. These systems have played a longstanding role in serving our state's low-income and uninsured populations and have supported and helped to implement numerous statewide efforts to expand and strengthen coverage, especially in Medi-Cal. For patients that face affordability challenges, public health care systems and their counties have also implemented a number of financial support programs to offer services for free or at a reduced cost.

While we strongly support efforts to make health care more affordable for patients and we recognize that more must be done to achieve affordability across the state, we have significant concerns with the current spending target proposal of 3.0% for 2025-2029. We respectfully offer the following comments in response to this proposal and urge consideration by the Health Care Affordability Board (board) and OHCA:

**Median Household Income Should Not Be the Sole Indicator to Determine the Target**
We empathize with OHCA's intentions to tie the health care spending target to a proxy for consumer affordability, i.e., the historical growth rate of median household income. While we believe this is aspirational, the historical growth of median household income should not be the sole indicator to base the target. Median household income growth is largely arbitrary to health care cost pressures and spending growth drivers, and consequently, is not a realistic target health care entities can work towards meeting.

OHCA's enabling statute provides direction that the target must be set in a way that maintains access to high quality and equitable care, while promoting affordability.[1] The statute also outlines certain factors that must be considered in developing the target, including the historical trends and projections of economic indicators and population-based measures, among others. Certain economic indicators, like Gross State Product (GSP), are aligned more closely with the historical rate of health care spending growth and may be a more appropriate measure to base the target from. Several other states with similar affordability programs have even set their targets above their state's average GSP growth.[2] Additionally, the aging of California's population will undoubtedly impact the level of services that are needed, and consequently spending that is beyond the control of providers. For the spending target to be attainable and realistic, population-based measures like aging should also be factored into its development.

While some discussion has been had by OHCA and the board on these areas, OHCA has set them aside in the proposed spending target methodology. We would urge the board to reconsider incorporating these factors into the methodology so that an attainable target can be set. We would also encourage OHCA and the board to consider the spending target framework being proposed by the California Hospital Association (CHA) to ground its thinking around the target development and additional adjustments that should be looked at.

**Health Care Cost Drivers Must Be Considered**
In addition to the factors described above, to have credibility, the spending target methodology should also be connected to what providers are experiencing at the ground level and account for significant health care cost and spending drivers, especially those that are beyond the control of providers. These external pressures will exist regardless of what the target is set at and if they are not acknowledged, there will likely be blunt and harmful impacts to health care access. Among others, these include:

Labor – Typically, labor costs represent more than 50% of a hospital's expenses.[3] At public health care systems, this may be even higher. Some systems have reported that labor represents 65-75% of their total expenses. Since the pandemic, public health care systems and other providers have also been dealing with extreme workforce shortages, which has only put pressure on systems to significantly increase wages and other benefits year after year to recruit and retain workers. At the national level, clinical labor costs rose by almost

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[1] Health and Safety Code, sections 127501 - 127501.12. Retrieved from: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=107.&title=&part=2.&chapter=2.6.&article=2.
[2] Melnick, G. (2022). Health care cost commissions: How eight states address cost growth. *California Health Care Foundation.* Retrieved from: https://www.chcf.org/wp-content/uploads/2022/04/HealthCareCostCommissionstatesAddressCostGrowth.pdf
[3] American Hospital Association. (2022). 2022 Costs of Caring. *American Hospital Association.* Retrieved from: https://www.aha.org/guidesreports/2023-04-20-2022-costs-caring

40% between 2019 to 2022 alone.[4] During the same time, contract labor expenses for hospitals increased over 250%[5] – a resource public health care systems have had to increasingly rely on to help fill staffing needs. Further, pension costs continue to be a specific challenge that our members face.

Pharmacy and technology – Pharmaceuticals and new technologies also represent a significant portion of public health care systems' costs and there is little ability to control these. Pharmacy and technology advances offer new opportunities for patients to treat conditions that were once regarded as untreatable and can expand the scope of medicine, but this also comes at a cost. Some experts believe new medical technology is estimated to account for one-half to two thirds of annual health care spending increases.[6] For example, when Sovaldi launched, it was a transformative and life-changing drug for patients with hepatitis c. It also came with a significant price tag, with its list price at $84,000 per course of therapy.[7] During its first year on the market, it drove $8 billion in list price expenditures and between 2014 to 2017, 5% of total spending for all outpatient prescriptions in Medicaid were for chronic hepatitis c virus drugs.[8] The Food and Drug Administration recently approved new gene therapies for sickle cell disease that have the potential to provide life-altering care for nearly 100,000 people in the United States living with this painful, life-threating genetic disease. The cost of this therapy could be as high as $2-3 million per patient.[9] Further, even the prices of the most commonly used drugs are consistently increasing. For instance, one public health care system experienced price increases of 15-20% over the past year for common antibiotics – with one being over 650% – and has seen nearly a 20% increase annually in its pharmacy costs since 2022.

Patients should have access to technologies and medications that could transform their health status and well-being but if providers are forced to live under a spending target that does not take these costs into consideration, unintended consequences could arise, and access could be significantly diminished.

Inflation – There has been sky rocketing inflation in recent years, reaching 8.5% in 2022.[10] This type of broader economic impact also impacts health care costs. A recent analysis estimates the annual national health expenditure could be $370 billion higher by 2027 due to the impact of inflation compared with pre-pandemic projections.[11] Because many health care input factors (like labor contracts) are set a few years in advance, inflationary impacts in

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[4] Beauvais, B., Kruse, C. S., Ramamonjiarivelo, Z., Pradhan, R., Sen, K., & Fulton, L. (2023). An exploratory analysis of the association between hospital labor costs and the quality of care. *Risk Management and Healthcare Policy*, 16, 1075–1091. https://doi.org/10.2147/RMHP.S410296
[5] Lagasse, J. (2023). Hospitals' labor costs increased 258% over the last three years. *Healthcare Finance*. Retrieved from: https://www.healthcarefinancenews.com/news/hospitals-labor-costs-increased-258-over-last-three-years
[6] Nichols, L. (2002). Can defined contribution health insurance reduce cost growth? Available at SSRN: https://ssrn.com/abstract=318824
[7] Henry, B. (2018). Drug pricing & challenges to hepatitis c treatment access. *Journal of Health & Biomedical Law*, 14, 265–283.
[8] Barenie, R. E., Avorn, J., Tessema, F. A., & Kesselheim, A. S. (2021). Public funding for transformative drugs: the case of sofosbuvir. *Drug Discovery Today*, 26(1), 273–281. https://doi.org/10.1016/j.drudis.2020.09.024
[9] Bettelheim, A. (2023). New sickle cell gene therapies pose cost and access questions. *Axios*. Retrieved from: https://www.axios.com/2023/12/09/sickle-cell-gene-therapies-cost-access
[10] U.S. Bureau of Labor Statistics. (2022). Consumer price index unchanged over the month, up 8.5 percent over the year, in July 2022. *U.S. Bureau of Labor Statistics*. Retrieved from: https://www.bls.gov/opub/ted/2022/consumer-price-index-unchanged-over-the-month-up-8-5-percent-over-the-year-in-july-2022.htm
[11] Krishna, A., & Singhal, S. (2022). The gathering storm: The transformative impact of inflation on the healthcare sector. *McKinsey & Company*. Retrieved from: https://www.mckinsey.com/industries/healthcare/our-insights/the-gathering-storm-the-transformative-impact-of-inflation-on-the-healthcare-sector

health care are typically delayed.[12] It will be critical that OHCA and the board account for these impacts as they flow through the health care sector, at least in the early years of the target's implementation, and potentially in outer years as well.

Population level changes – As described, California's population is experiencing rapid growth in older adults. By 2030, one-third of California's population will be over 50 and the population of people over 65 will grow from 3.6 million to 8.9 million.[13] Over one million individuals are expected to be in the oldest of old adults group (85 and over) by that time.[14] Health care costs for seniors are five to nine times those for children and youth.[15, 16] And for those 85 years and over, the Centers for Medicare and Medicaid Services estimates per capita costs for this group are twice as high as than for those 65 to 84 years of age.[17] In California, the aging of our population alone is projected to increase health care spending by nearly 1% annually in future years as our older adult population grows and the under 18 population shrinks. The spending target methodology must factor in these types of population level changes to account for the level of services that will be needed to effectively care for our state's population.

Mass events and climate change – Unfortunately, it is only increasingly likely that California will face large-scale events in future years due to things like climate change or new diseases that could quickly escalate into epidemics or pandemics. Early research has found that the recent COVID-19 pandemic had significant financial impacts for hospitals. For example, drug expenses were estimated to have increased by 37% and medical supply expenses by 21% since pre-pandemic times.[18] Hospitals were also required to invest extra resources to train staff on new protocols, secure a large volume of personal protective equipment, quickly stand-up new facilities or reconfigure existing spaces to be able to accommodate care for a large number of patients, and to secure needed staff. One report indicates hospital expenses increased by 37% per patient from 2019 to 2022 because of the pandemic.[19]

Additionally, climate change has intensified extreme weather events like wildfires and floods. These impacts often disrupt patient care, may lead to poor outcomes, or increase the demand for services, and ultimately can lead to higher costs. Hospitals and health systems may experience damage to infrastructure, power outages, instability in the workforce,

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[12] ibid.

[13] Public Policy Institute of California. (2000). New analysis: California's aging population. *Public Policy Institute of California.* Retrieved from: https://www.ppic.org/press-release/new-analysis-californias-aging-population/

[14] State of California. California State Plan on Aging, 2027-2021. *California Department of Aging.* Retrieved from: https://www.aging.ca.gov/download.ashx?lE0rcNUV0zbUy1iwYmWKng%3D%3D#:~:text=By%202030%2C%20when%20all%20of,group%2C%20a%2070%20percent%20increase.

[15] Centers for Medicare and Medicaid Services. (2023). NHE fact sheet. *Centers for Medicare and Medicaid Services.* Retrieved from: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet#:~:text=NHE%20by%20Age%20Group%20and,%2Dage%20person%20(%249%2C154)

[16] Centers for Medicare and Medicaid Services. (2020). U.S. personal health care spending by age and sex: 2020 highlights. *Centers for Medicare and Medicaid Services.* Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/AgeandGenderHighlights.pdf

[17] Centers for Medicare and Medicaid Services. (2024). Age and sex tables. *Centers for Medicare and Medicaid Services.* Retrieved from: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet#:~:text=NHE%20by%20Age%20Group%20and,%2Dage%20person%20(%249%2C154)

[18] Li, K., Al-Amin, M., & Rosko, M. D. (2023). Early financial impact of the covid-19 pandemic on u.s. hospitals. Journal of Healthcare Management / American College of Healthcare Executives, 68(4), 268–283. https://doi.org/10.1097/JHM-D-22-00175

[19] Kauffman Hall. (2022). Reliance on contract labor during pandemic means higher hospital expenses. *Kaufmann Hall.* Retrieved from: https://www.kaufmanhall.com/news/reliance-contract-labor-during-pandemic-means-higher-hospital-expenses

crowding, supply chain disruptions and other impacts that could increase costs.[20] The spending target should allow for flexibilities in these types of response efforts that impact health care expenses through no fault of providers.

Access – At the local level, many of our members are dealing with pent up demand for health care services, particularly for primary care services. Some public health care systems are partnering with their health plans to address this demand, realizing that any solution to build capacity to improve access to care will impact health care costs and spending. Public health care systems are also experiencing challenges related to the provision of step-down care for patients requiring lower levels of care. This is due to the lack of placements available at facilities like skilled nursing facilities. Many of our members are operating at very high volumes (120-140%) right now and need significantly more resources (such as increased levels of registry staff) to ensure they are providing the best and safest care. Although some systems are exploring how to expand these types of facilities within their systems or support external efforts in the community, there are significant barriers due to the shortage of health care workers and it will take time to rebuild this workforce and the necessary infrastructure. OHCA and the board will need to provide enough flexibility in the spending target to account for experiences like this at the local level.

State-level policy decisions – California has recently enacted or is implementing a number of important state-level policy changes that will have significant impacts on health care spending. Examples include the new health care worker minimum wage law that will be implemented over the next several years that is estimated to increase spending by billions of dollars annually,[21] a requirement for hospitals to become compliant with new seismic safety standards by 2030 (estimated at upwards of $100 billion by that time),[22] and the recent expansion of coverage and addition of new benefits in the Medi-Cal program (e.g., the State is seeking expenditure authority of nearly $1 billion to cover CalAIM transitional rent services in 2025 and 2026).[23] Further, the Administration and the Legislature have recently acknowledged the longstanding inadequacy of provider rates in Medi-Cal and are seeking to correct this. In the coming years, there will be an infusion of billions of dollars in the Medi-Cal program to increase reimbursement rates to help expand access and stabilize Medi-Cal providers' financing. Policymakers have agreed that these changes are needed to improve the health and well-being of Californians. Providers that are working to comply with and/or implement these state policy goals should not be penalized for their efforts and the spending target must accommodate these new state policies.

**Considerations Must Be Made for Medi-Cal and The Health Care Safety Net**

As mentioned, public health care systems care for a disproportionate share of Medi-Cal members. We understand the Department of Health Care Services (DHCS) will be submitting baseline data to OHCA on behalf of the Medi-Cal managed care plans, and we appreciate that OHCA has been collaborating with DHCS to discuss how this data will be collected given the

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[20] Salas, R., Friend, T., Bernstein, A., & Jha, A. (2020). Adding a climate lens to health policy in the United States. *Health Affairs.* https://doi.org/10.1377/hlthaff.2020.01352

[21] Anderson, C. (2024). California health care workers won a path to $25 minimum wage. Now they fear a detour. *The Sacramento Bee.* Retrieved from: https://www.sacbee.com/article284846781.html#storylink=cpy

[22] Preston, B. L., LaTourrette, T., Broyles, J. R., Briggs, R. J., Catt, D., Nelson, C., Ringel, J. S., and Waxman, D. A. (2019). Updating the costs of compliance for California's hospital seismic safety standards. *RAND Corporation.* Retrieved from: https://www.rand.org/pubs/research_reports/RR3059.html

[23] California Department of Health Care Services. (2023). Proposed CalAIM Section 1115 Demonstration amendment to authorize transitional rent services as a new community support in Medi-Cal managed care. *California Department of Health Care Services.* Retrieved from: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Demo-Rent-Amendment-Public-Notice.pdf

complexity of Medi-Cal financing. We are also thankful that OHCA and DHCS have had initial meetings with us to share their early thinking. However, we hope that the progress of these discussions can accelerate. It is still unclear what Medi-Cal spending data will be collected, how the complexity of public health care system financing will be addressed (including how supplemental payments and provider self-financing will be treated), and how spending will be attributed to providers. Of equal concern is the minimal discussion that has occurred between OHCA and the board on these unresolved issues and the financial impact the proposed 3% spending target would have on Medi-Cal providers.

Applying a 3% target in Medi-Cal would be especially detrimental as it would assume Medi-Cal payments are adequate to begin with and it could lock in payment inequities in perpetuity. For example, public health care systems are facing a significant structural financing deficit of roughly $3-4 billion annually in immediate future years due to the inadequacy of Medi-Cal base rates and the role these systems play in self-financing the care they deliver in Medi-Cal. We are working with DHCS to try to right-size our payments and to develop solutions and strategies to stabilize our members' financing. This includes our members working with their managed care plans to increase their base rates, growing existing supplemental payments, and creating new performance requirements and incentive funds for achieving cost containment, productivity, efficiency, and access goals. However, it may take years to fully correct these underpayments and shore up public health care systems' financing. These systems should not be penalized as they work to achieve greater equity in payment. Further discussion is needed by OHCA and the board on how the spending target would apply in Medi-Cal and where flexibility can be provided to account for the historical underfunding of the health care safety net.

**Further Discussion Is Needed on Performance Adjustments**

As discussed briefly by the board, OHCA's enabling statute outlines adjustments that should be considered in evaluating providers' total medical expense and performance on the target. This includes potential adjustments for equity, quality, labor, and Medi-Cal. We would urge for these concepts to be developed further and for there to be continued discussions on them as they could significantly impact providers' performance on meeting the spending target. Without understanding how these adjustments could influence performance, stakeholders cannot fully understand the impact of the spending target proposal or effectively weigh in.

We appreciate that there has been significant discussion on, and an approach developed for risk adjustment. However, we echo the concerns raised previously by CHA on OHCA's decision against using a clinical risk adjustment methodology. As major safety net providers, public health care systems serve complex patient populations with multiple and co-occurring conditions, including the unhoused, those who are in or are transitioning from jail settings, and patients with significant behavioral health needs. Public health care systems also provide highly specialized services (like major organ transplants and trauma and burn care) that are not available elsewhere. Without considering the acuity level of a provider's patient population, providers like public health care systems may be unfairly penalized. Public health care systems may have to take on even more higher acuity patients if perverse incentives are created in the health care system that limit access for patients that are most in need. We would urge OHCA and the board to reconsider its approach to the risk adjustment methodology and at the very least, adopt CHA's recommendation to test a clinical risk adjustment methodology alongside the sex- and age-only risk adjustment methodology it intends to implement.

**Potential Impact of The Proposed Target**

We anticipate there will be significant unintended consequences for safety net providers if OHCA's proposal for a statewide health care spending target of 3.0% for 2025-2029 is adopted.

We surveyed our members on what a 3% spending target would mean in their ability to provide high value, high quality care to their patients, and heard several overarching concerns:

- Public health care systems are concerned that preventive and outpatient services would be reduced, exacerbating the access issues our communities are already experiencing;
- Providers and health systems may need to reduce staff in their ambulatory settings to keep costs down, which may result in increased wait times for outpatient visits, an inability to decompress specialty care demand at hospitals, and reduced ambulatory clinic hours;
- Emergency departments may become overburdened, reversing positive trends our members have achieved by reducing emergency department wait times; and
- Public health care systems may not be able to make needed infrastructure investments, such as creating physical spaces to ensure their facilities are functioning well for patient care and staff, or to make much needed enhancements in health information technology and electronic health records.

Beyond public health care systems, across Medi-Cal, existing issues could also worsen. For example, DHCS has reported that many members are lacking basic preventive and wellness services, which often results in more severe diseases when diagnosed, such as advanced cancers and uncontrollable diabetes. Medi-Cal members also experience higher rates of unnecessary emergency department visits and hospital readmissions.[24] These outcomes could be exacerbated under the current proposal as providers may increasingly seek to care for a healthier patient population or reduce preventive services to try to quickly cut back on costs, and it may undermine efforts like CalAIM. We would urge OHCA and the board to reconsider the proposal so that the health status of historically underserved and marginalized patients is not compromised.

**Target Cycle Length Should Be Reconsidered**

Given the outstanding questions and concerns described above and potentially harmful impacts that may result under the current proposal, we would urge OHCA and the board to reconsider the length of time currently being proposed for this target cycle. The timeline outlined in statute provides flexibility for the board to first set a non-enforceable target for 2025 by June 2024, the first enforceable target for 2026 by June 2025, and so on. Consequently, the board can take more time to deliberate on these complex issues and thoughtfully approach the spending target decision for future years beyond 2025. We would urge OHCA and the board to take advantage of the permitted timeline and adopt a one-year target cycle. Doing so would provide more time to fully consider all of the necessary design features of the spending target so that a meaningful and achievable spending target can be created to not only promote affordability, but also protect access to care in our state.

**Recommendations**

In summary, we recommend OHCA and the board:

1. Consider additional factors, such as other economic and population-based measures in the development of the spending target and not base it solely on the historical growth rate of median household income;
2. Consider health care cost growth drivers as part of the spending target methodology;
3. Articulate how spending will be measured and how the target will apply in the Medi-Cal program, and what considerations are being made for the health care safety net;

[24] California Department of Health Care Services. (2024). Medi-Cal minute: what is population health management? *California Department of Health Care Services.* Retrieved from: https://www.dhcs.ca.gov/CalAIM/Pages/What-is-Population-Health-Management.aspx

4. Provide more information on how spending performance will be adjusted for factors such as labor, Medi-Cal, quality, and equity, and reconsider the approach to risk adjustment; and
5. Consider a shorter, one-year target cycle length to allow for additional discussions to address these outstanding issues.

Thank you for the opportunity to provide comments and for your consideration. We would be pleased to discuss these recommendations with you further or answer any questions you may have. Please contact Haleigh Mager-Mardeusz, Associate Director of Policy, if you would like to follow up.

Sincerely,

Katherine Rodriguez

Katie Rodriguez
Vice President of Policy and Government Relations
[redacted]

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Members of the Health Care Affordability Board:
Dr. David Carlisle
Secretary Dr. Mark Ghaly
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Dr. Donald Moulds
Dr. Richard Pan

| | |
|---|---|
| **From:** | [redacted] on behalf of Caryn Cowin |
| **To:** | HCAI OHCA |
| **Subject:** | Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations |
| **Date:** | Wednesday, February 28, 2024 1:29:28 PM |

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[You don't often get email from c. Learn why this is important at https://aka.ms/LearnAboutSenderIdentification ]

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board,

Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. My employer in 2024 decreased their contribution towards health care coverage by at least 1/3 (more for people covering family members), the burden being placed on the employees to make up the difference to maintain the same coverage levels we had in 2023. This forced many people like myself to reduce our coverage levels.

This was a factor in my decision to take a new job with a company that provided better contributions to coverage. Many are not in a position to do what I was able to do, and is completely unfair.

This has to stop.

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Sincerely,
Ms Caryn Cowin

| | |
|---|---|
| **From:** | [redacted] on behalf of Catherine Vidal |
| **To:** | HCAI OHCA |
| **Subject:** | Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations |
| **Date:** | Saturday, February 24, 2024 1:20:45 PM |

[You don't often get email from [redacted]. Learn why this is important at https://aka.ms/LearnAboutSenderIdentification ]

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board,

I retired in 2020, however, Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

I finally decided to return to work. Never did I think that the reasons I mentioned above would necessitate my returning to the
classroom.

I feel cheated out of a well-deserved retirement due to soaring health costs and the continually rising cost of living.

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Sincerely,
Ms. Catherine Vidal

1215 K STREET, SUITE 1930
SACRAMENTO, CA 95814
916.552.7111
www.ccha.org

March 11, 2024

Megan Brubaker
Department of Health Care Access and Information
Office of Health Care Affordability
2020 West El Camino Avenue
Suite 1200
Sacramento CA 95833

Submitted Via Email: OHCA@hcai.ca.gov

**SUBJECT: Office of Health Care Affordability Recommendation to the California Health Care Affordability Board: Proposed Statewide Cost Growth Target of Three Percent**

Dear Ms. Brubaker:

The Office of Health Care Affordability (OHCA) seeks to improve health care affordability without sacrificing access to, or the quality of, health care, and the California Children's Hospital Association (CCHA) stands ready to collaborate with you to achieve those shared goals. Unfortunately, OCHA staff's recommendation for California's first statewide cost growth target does not adequately consider the factors driving health care spending growth, particularly for tertiary providers like children's hospitals, and in doing so has the potential to jeopardize access to lifesaving and life-extending care for the state's sickest and most vulnerable children.

**I. General Considerations**

First, we would like to align ourselves with the broader comments provided by the California Hospital Association (CHA). Specifically, we share CHA's concerns with the underlying methodology of the statewide cost growth target, which in no way reflects recent or expected trends in health care cost growth, does not acknowledge that providers have little to no control over many cost-drivers, and makes no attempt to accommodate for policies and advances in technology that will cause providers to exceed the target. Instead, the recommended statewide cost growth target is unrealistically low, virtually ensuring that most providers will not meet it without providing guidance to those providers about what OCHA staff and the board might consider acceptable reasons for exceeding it. Furthermore, we believe it is premature to establish a static target for five years. Instead, the initial target should be for a one-year period, to enable to OCHA staff and the board to reassess it as data begins rolling in next year.

In addition, the approach recommended by OCHA staff makes it the sole responsibility of each provider to reduce health care cost growth to no more than three percent, without regard to that provider's ability to exert control over such growth. We believe the statewide cost growth target should be viewed as one important tool to help the state identify outliers and encourage efficient and effective health care cost spending. However, state policymakers, Congress, federal regulators, health plans, drug and device manufacturers, and advocates all have a role to play, too. It is unreasonable to hold providers accountable for cost growth that happened at the

direction of the state legislature, such as the cost growth that will result from the new state health care minimum wage law. Similarly, it is unreasonable to penalize children's hospitals for cost growth that exceeds the statewide target due to administering lifesaving breakthrough treatments, such as the new therapies for sickle cell disease that cost $2-3 million per patient. The only way we will ever achieve truly equitable and sustainable affordability is through a comprehensive effort, with every stakeholder making the most of their unique role.

For these reasons, we urge the board to consider adjusting the statewide cost growth target to more accurately capture the underlying drivers of health care costs and more narrowly focus in on those costs that are within a provider's ability to control. We also ask the board to consider setting the target for a single year to allow future statewide cost growth targets to reflect all the information that OCHA will gather during that baseline year.

**II. Children's Hospital-Specific Considerations**

While the target currently being considered is a statewide, industrywide cost growth target, individual providers will still be called upon to justify their costs should they exceed it. We are concerned that children's hospitals are apt to exceed a target that is set unreasonably low, given their unique roles in the health care delivery system. As such, we wish to proactively highlight several significant cost drivers for children's hospitals that may lead their costs to grow faster than average.

*Changing Care Patterns.* One major trend that is driving cost growth for children's hospitals is the national shift of pediatric inpatient capacity and higher acuity patients from community hospitals to regionalized, freestanding children's hospitals. According to a 2021 article in Pediatrics, pediatric inpatient beds and PICU beds are becoming increasingly concentrated in children's hospitals[1]. Researchers found that the total number of pediatric inpatient units nationwide decreased by 19.1% between 2008-2018, and the total number of pediatric inpatient beds available nationally decreased by 11.8%. During that same period, however, inpatient beds at children's hospitals increased by 12.1%, and those hospitals' share of inpatient beds increased from 21.5% to 27.4%. The overall number of PICU beds nationwide grew by 16% during that 10-year period, but most of that growth happened at children's hospitals, with the share of PICU beds at children's hospitals growing from 26.7% of all PICU beds to 33.7%.

What is driving this change? There are likely several factors, but one significant reason is that pediatric care is costly to provide and poorly reimbursed – more poorly reimbursed than care for adults because Medicaid is the primary payer of care for children. As a result, many community hospitals have found it increasingly difficult to support pediatric inpatient care beds, and around the country, pediatric units in community hospitals are closing.

Another recent study of freestanding children's hospitals across the country found that, between 2012 and 2020, children with medical complexity with 2 or 3+ complex chronic conditions (CCCs) had a rapid increase in the number of annual "discharges (3.0% per year for 2 CCCs, 5.5% for 3+ CCCs, $p < .001$), hospital days (2.2% per year for 2 CCCs, 7.6% for 3+ CCCs, $p < .001$), and costs (2.2%

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[1] Cushing A M, Bucholz E M, Chien A T, et al. Availability of pediatric inpatient services in the United States. *Pediatrics*. 2021;148(1):e2020041723 https://doi.org/10.1542/peds.2020-041723

per year for 2 CCCs, 7.0% for 3+ CCCs, p < .001)" compared to children with no complex chronic conditions or only one.[2]

These studies show that the cost of care for the most medically complex children is growing more rapidly than the cost of care for other children, and that care for the most medically complex children is increasingly occurring at freestanding children's hospitals. If these trends continue, which we believe they will, costs for children's hospitals will continue to grow faster than costs for the average community hospital, making children's hospitals more likely to exceed the statewide cost growth target and appear as outliers, unless OHCA adjusts the target to account for acuity.

*High-Cost Therapies.* Even without the centralization described above, pediatric specialty care has always been more regionalized than adult specialty care. Adult specialty care tends to focus on a narrow range of conditions, such as heart disease or diabetes that affect a substantial number of adults, whereas pediatric specialty care encompasses a very heterogeneous range of conditions, many of which, like cystic fibrosis or heart abnormalities, affect relatively small numbers of children. Since maintaining a high-quality pediatric specialty care network requires adequate patient volume, pediatric specialty care is centralized at a small number of hospitals around the state.

This regionalization of care is even more pronounced when it comes to treatment with new gene, cell, and tissue-based therapies, which can only be administered by qualified treatment centers that meet specific criteria. One of our member hospitals that is a qualified treatment center for many new gene, cell, and tissue-based therapies has estimated that if, in 2025, they are able to treat all medically eligible children referred to them for these types of medications, the hospital's pharmacy spend will grow by over 60%. A three percent statewide cost growth target with no adjustments poses a real challenge for hospitals like this one, whose specialization results in a faster cost growth percentage. If the care it provided were spread out across hundreds of other hospitals in the state, the rate of cost growth would appear lower, but the degree of regionalization that currently exists in California's pediatric specialty care system means that a small number of hospitals will disproportionately share the increased cost growth burden of new, life-saving gene, cell, and tissue-based therapies as they enter the market.

*High-Medi-Cal Providers.* California's children's hospitals are uniquely and disproportionately dependent upon the Medi-Cal program as a payer. On average, two-thirds of California's children's hospitals' patients are covered by Medi-Cal. Medi-Cal has historically and consistently under-reimbursed children's hospitals for the care that they provide. In fact, over the past decade, reimbursement to children's hospitals has remained flat or been reduced, despite inflation, increasing labor costs, and the influx of high-cost therapies entering the market. As a result, our members have spent the last 10 years struggling to find ways to cut costs and operate as efficiently as possible, leaving them with little to cut back on in the face of a 3% target. We are very concerned that there is no adjustment proposed for high Medi-Cal providers.

*Teaching Hospitals.* California's children's hospitals are teaching hospitals that train 50% of the state's pediatricians and 10% of all fellows regardless of their specialty. Children's hospitals are also major contributors to the training of other providers, including family medicine physicians

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[2] Hall M, Berry JG, Hall M, et al. Changes in hospitalization populations by level of complexity at children's hospitals. *J Hosp Med*. 2024;1-4. https://doi:10.1002/jhm.13292.

and emergency room doctors. This is because these physicians-in-training must complete a pediatric rotation as part of their residency and children's hospitals are frequently the only sites with a sufficient volume of pediatric patients to enable such training.

Despite being significant providers of medical training, children's hospitals receive significantly less public funding than other teaching hospitals. This is largely because children's hospitals do not receive Medicare GME, which is the largest funder of graduate medical education in the U.S. Instead, the bulk of public financing for pediatric residency programs comes from the federal Children's Hospital Graduate Medical Education (CHGME) program. Funding from this program is substantially less overall and per resident than what is provided to hospitals eligible for Medicare GME. Specifically, Medicare GME payments to general acute hospitals are on average twice as large as the funding that children's hospitals receive through the CHGME program – $153,000 per full-time equivalent for Medicare GME compared to $75,000 per full-time equivalent for CHGME.

Further, neither state nor federal GME funding supports the training rotations that children's hospitals provide for other primary care physicians. So, for example, as the state works to grow the number of family medicine physicians in California, the state is increasing an unfunded cost burden on the children's hospitals that provide pediatric rotations for these doctors-in-training.

According to the California Children's Specialty Care Coalition (CSCC), children's hospitals will need to train many more pediatricians than they currently do if state policymakers hope to address growing wait times and ensure equitable access to pediatric specialty care in the coming years. CSCC recently found that nine pediatric subspecialties had an average recruitment time of at least one year, with many of that organization's members reporting recruitments times of two years or longer for certain subspecialties. Not surprisingly, CSCC's recent family survey also found that 25% of families experienced wait times of more than three months for new appointments, and for some subspecialities, the wait times were much longer[3].

Training the pediatricians and pediatric specialists of tomorrow, and supporting the pediatric rotations needed by other doctors-in-training, is a critical responsibility, but it is also an expensive one. Arguably, children's hospitals should be encouraged to grow the capacity of their residency programs to help alleviate existing shortages and prevent those shortages from worsening. To this end, the national Children's Hospital Association is currently spearheading an effort to nearly double the size of the federal CHGME program, and state lawmakers are considering allocating $75 million annually of MCO Tax revenues to help grow residency programs throughout the state. If these efforts are successful, they would help California's children's hospitals address critical pediatric healthcare workforce needs, but they would also increase the rate of health care cost growth for children's hospitals beyond that of their non-teaching hospital peers.

**III. Summary**

For all of these reasons, we ask the board to:

- Adjust the statewide cost growth target to more accurately capture the underlying drivers of health care costs.

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[3] California Children's Specialty Care Coalition, Access to Pediatric Specialty Care in California: Results of the Children's Specialty Care Coalition 2022 Member Survey, https://childrens-coalition.org/wp-content/uploads/2023/04/4.-Access-Survey-Final-Report.pdf

- Focus on those costs that are within a provider's ability to control and explicitly recognize that some providers, like children's hospitals, will have unique cost drivers.
- Include an acuity adjustment in the target to account for cost growth that is attributable to caring for sicker patients.
- Set the target for a single year to allow future statewide cost growth targets to reflect all the information that OCHA will gather during that baseline year.

Thank you for the opportunity to provide comment on the proposed statewide cost growth target. Please feel free to contact me at mmorton@ccha.org or (916) 203-0488 if you have any questions.

Sincerely,

Mira Morton
Vice President of Government Affairs

**Thomas M Priselac**
President and CEO

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310.423.5711
TMP@cshs.org

cedars-sinai.org

February 19, 2024

Mark Ghaly, MD
Chair, Health Care Affordability Board
2020 West El Camino Avenue
Suite 1200
Sacramento CA 95833

Submitted via email to Megan Brubaker at: OHCA@hcai.ca.gov

**Subject: Protect Access to Health Care, Reject 3% Cost Growth Target**

Dear Dr. Ghaly:

The Office of Health Care Affordability (OHCA) seeks to improve health care affordability and must do so without sacrificing access to or the quality of health care. We stand ready to collaborate with OHCA to achieve our shared goals of improved affordability and access to high-quality health care. **Unfortunately, office staff's recommendation for California's first statewide spending target does not adequately consider the factors driving health care spending growth, and in doing so jeopardizes patient care.**

This target, which is based solely on the historical growth in household income, is overly narrow and fails to account for myriad factors that impact health care spending. To be credible, a target must not only consider but actually **reflect** these known factors: inflation; demographic factors, such as California's aging population; trends in labor and technology costs, such as the high costs of new pharmaceuticals and medical devices; policy changes that raise spending; and the up-front investments hospitals make to improve the value of the care they provide, which — over the long term — reduce the cost of care.

For Cedars-Sinai, meeting the proposed 3% target would mean:

- Reevaluating the services we provide, and other investments we hope to make to improve our community's health.
- Compromising our ability to meet essential needs of the community as we strive to meet state mandates like the 2030 hospital seismic mandates. As the State works to hold health care costs in check, it must consider the impact tens of billions in infrastructure spending will have on this effort. Hospitals will need to divert funds from patient care for construction, which delays progress towards health access and health equity in communities everywhere. The seismic mandate will cost $4 billion for Cedars-Sinai alone.

On top of these challenges, OHCA staff's five-year target recommendation seeks to prematurely establish an enforceable spending target by proposing to do so before OHCA has:

- Collected data to inform the establishment of a credible, attainable target
- Promulgated rules around how these data would be analyzed
- Laid out the rules for how entities would be held accountable for the targets

Given these outstanding issues, we question the prudence of adopting a five-year target before data become available and critical decisions have been made.

Making health care more affordable requires thoughtful, long-term planning. For example, a comprehensive focus on health equity has the potential to lead to long-term cost savings but requires significant up-front investments and reorganization of delivery models. Ultimately, allowing for an opportunity to conceive and implement these improvements will allow the health care system to transform into one that California patients need and deserve — a system that supports timely access to high-quality, person-centered care.

Unfortunately, this proposal would do the opposite — it would force cost-cutting measures at patients' expense. We ask the board to reject the OHCA staff proposal, and instead adopt a data-driven spending target that truly reflects the resources needed to provide life-saving care.

Sincerely,

Thomas M. Priselac

March 8, 2024

Megan Brubaker
Department of Health Care Access and Information
Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833
OHCA@hcai.ca.gov

**SUBJECT: CHA Comments on the Proposed Statewide Health Care Spending Target Recommendations to the Board**

Dear Ms. Brubaker:

Millions of Californians each year rely on hospitals for life-changing, life-saving care. More than half a million Californians devote their careers to ensuring hospital care is there for patients in need. Unfortunately, accessible, affordable care is out of reach for too many Californians. The causes of these challenges are many, ranging from soaring pharmaceutical costs, to record insurance premiums and rising inflation. California hospitals stand ready to work with the Office of Health Care Affordability (OHCA) and other stakeholders to transform our health care system into one that best serves patients. To these ends, and on behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) is grateful for the opportunity to comment on OHCA's proposed statewide health care spending target recommendations.

## Executive Summary

California's hospitals share OHCA's goals of making health care more affordable while preserving and improving access to high-quality, equitable care. Setting a spending target and placing health care spending in California on a sustainable trajectory is perhaps the most important decision the OHCA board will make. At its essence, the board is responsible for deciding how much health care spending **should be** in the coming years. This is an incredibly complex, multifaceted, and important question, with the lives and livelihoods of millions of Californians at stake. Accordingly, the board and office must approach this question with utmost care. The decision must be data driven, based on a clear and comprehensive understanding of the health care system and its cost drivers, and have a strong rationale that integrates the multiple and sometimes competing objectives of state law.

OHCA's proposed spending target does not live up to these lofty but appropriate standards. The 3% proposed target for 2025 through 2029 goes too far, too fast; narrowly focuses on just one of OHCA's objectives; ignores the drivers of spending; and unnecessarily rushes toward an enforceable target despite flexibility under state law. It seeks an abrupt 40% reduction in the growth of health care spending

within a single year, then compounds that reduction every year for five years. In doing so, OHCA would eliminate 10% of total anticipated health care spending in California within just five years.

Moreover, these deficiencies strain the credibility of the spending target program. At 3% for five years despite high inflation, an aging population, and widespread provider financial distress, the proposed target would prove unattainable, unsustainable, and unsupportive of health care entities' efforts to improve the value of health care, not just lower its costs. To address these and other concerns, we make two key recommendations.

**Consider an Alternative Framework for a Sustainable Spending Target.** CHA proposes an alternative framework that incorporates commonly recognized drivers of health care spending, with a goal of ensuring that the target is both credible and fulfills OHCA's multiple objectives.

The framework has at least three possible uses:

- For use as the spending target methodology
- To assess the reasonableness of a different spending target and methodology
- As a source for reasonable and appropriate adjustments to a spending target that relies on an alternative methodology

**Framework for a Sustainable Spending Target**

| | 2025 | Average 2025 - 2029 |
|---|---|---|
| **1) Economy-Wide Inflation** | **3.3%** | **3.4%** |
| **2) Aging** | **0.8%** | **0.7%** |
| **3) Technology and Labor:** | **0.6%** | **0.6%** |
| A) Drug and Medical Supplies | 0.4% | 0.4% |
| B) Labor Intensity | 0.2% | 0.2% |
| **4) Major Policy Impacts:** | **1.6%** | **0.6%** |
| A) Health Care Worker Minimum Wage | 0.4% | 0.2% |
| B) Investments in Medi-Cal | 1.1% | 0.3% |
| C) Seismic Compliance | 0.1% | 0.1% |
| **Totals** | **6.3%** | **5.3%** |

**Adopt a One-Year Target.** The timelines in OHCA's authorizing legislation were drawn to facilitate thoughtful deliberation and learning before enforceable spending targets are set for 2026 and beyond. While multiyear targets may eventually make sense, the board should reconsider the appropriateness of setting a multiyear spending target before critical outstanding issues have been resolved, including:

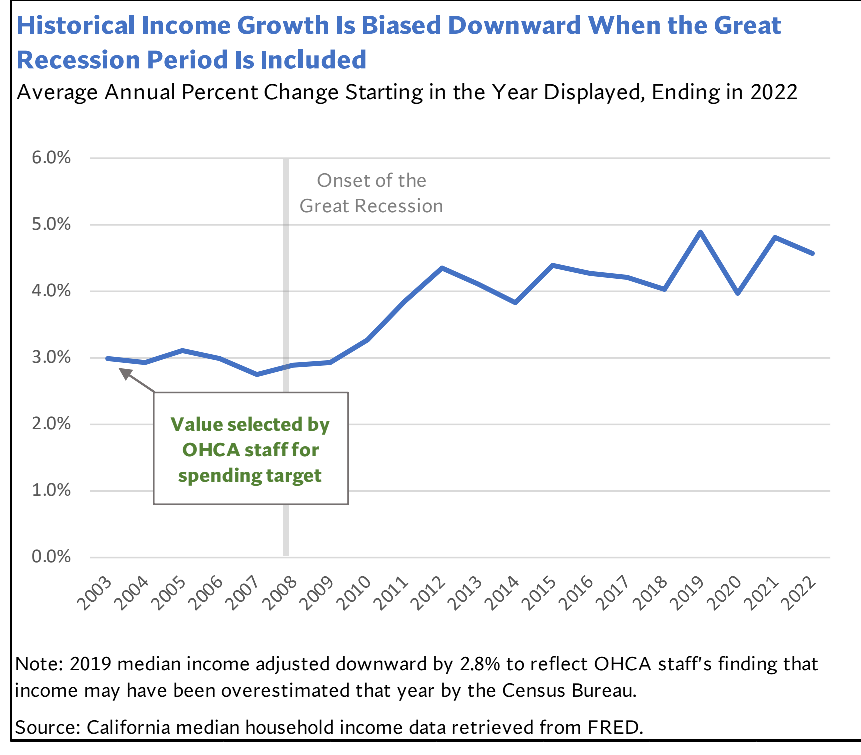
- Collection and analysis of total health care expenditure data reported by payers
- Consideration and promulgation of the rules of enforcement
- Meaningful analysis of not only the drivers of health care spending, but also the spending target's potential impacts

California's hospitals look forward to working with OHCA and the board in the adoption and implementation of a spending target that is reasonable and achieves meaningful improvements in affordability without sacrificing access to high-quality, equitable care.

## Proposed Methodology Has Clear Deficiencies

OHCA's proposed spending target is based on the annual growth of median household income in California. The rationale is that health care spending should not grow faster than families' incomes. While this methodology has a clear intuitive appeal, close inspection reveals serious deficiencies in the proposed approach.

**Historical Period Used to Determine Median Household Income Growth Is Biased Downward.**




Given OHCA's stated rationale that health care should not grow faster than household income, it would have been reasonable for OHCA to propose a target based on **expectations** for median household income growth over the next five years. However, OHCA explicitly rejected the use of projections, and instead based its spending target methodology on a 20-year historical period that includes the worst recession in a century since the Great Depression. While OHCA has provided no clear rationale for using 20 years of data, the implications of this decision are shown in the lefthand figure. The graph displays the average annual growth in median household income starting in 2022, going back each additional year to 2003.[1] By using the 20-year average, OHCA obtained a spending target value of 3%, close to the lowest value it could have selected based on up to 20 years of data. This value is over a percentage point lower than what the post-Great Recession years clearly predict will be the trajectory of median household income growth going forward.[2] Moreover, if projections of inflation from the Legislative Analyst's Office (LAO) hold true, median household income growth of 3% annually over the next several years would mean that **real** (inflation-adjusted) median household income is declining by 0.4% each year, trends not experienced since the Great Recession. One board member has recommended instead using a 10-year historical average, which these data clearly support over staff's recommendation.

**Proposed Methodology Was Changed After Updated Data Would Have Adjusted the Target Upward.**
In December 2023, OHCA released a preliminary spending target methodology that was also based on 20 years of median household income growth. This methodology correctly recognized that more recent data are a better predictor of the future than old data, and therefore weighted the most recent 10 years' data more heavily than the prior 10 years, resulting in a 3% target value. However, the original methodology cut the series off prematurely in 2021, despite 2022 data being available. Following suggestions from board members and stakeholders, OHCA incorporated the most recent 2022 data, but, at the same time, removed the weight on more recent years' data. The effect was to undo what would have been an upward adjustment to the target, and instead the updated methodology produced the same 3% value as previously. This unjustified change in the methodology raises serious questions about the arbitrariness of the proposed methodology.

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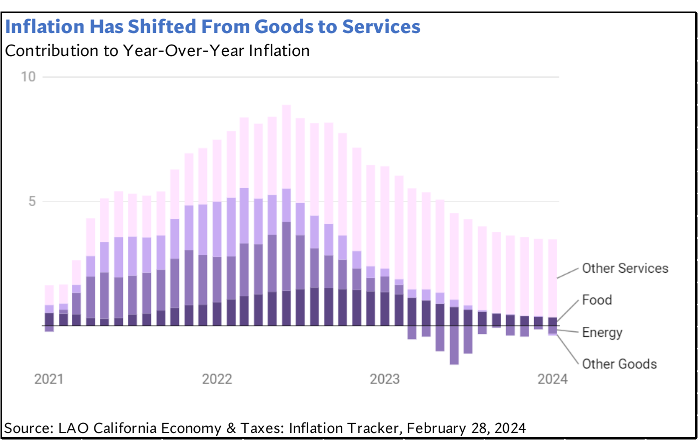
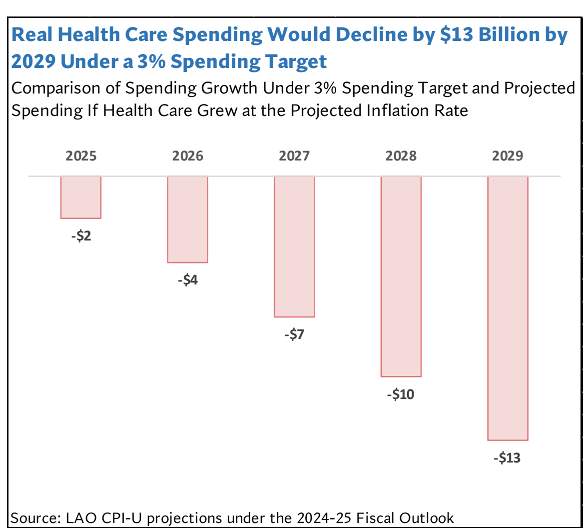
[1] Each year going back includes an additional year in the multiyear average.
[2] Economic forecasting principles typically recommend placing more weight on more recent years' data, such as in exponential smoothing models.

**Methodology Does Not Recognize Known Drivers of Health Care Spending.** Health care is different than other economic sectors. Its professionals save lives and cure diseases every single day, caring for people in times of greatest need. Health care is a frontier of innovation, with an incredible record of progress and enormous untapped potential. Patients' needs for health care services evolve considerably over their lifetimes. And the sector is subject to constant attention from both state and federal policymakers seeking to improve access and quality.

Given these unique attributes, health care cannot be treated like any other sector in California's economy. Unfortunately, OHCA's proposed spending target methodology does just that, utilizing a single economic indicator disconnected from the realities of supporting California's health care system. Recognizing the key drivers of health care spending is essential if OHCA is to fulfill its legislative mandate and prevent the erosion of access to high-quality health care — particularly in already underserved areas. The Legislature recognized this prerogative in subdivision (b) of Health and Safety Code section 127500.5 of OHCA's authorizing statute, declaring an intent for OHCA to take a *"comprehensive view of health care spending [and] cost trends"* to inform the pursuit of its multiple goals. Fulfillment of this responsibility must be done, now.




**Spending Target Would Result in Cuts to Real Health Care Spending.**
California is [currently experiencing economy-wide inflation]() of almost 4%, twice the historical average of what other states experienced prior to setting their spending targets. What's more, as the first figure shows, inflation has shifted almost entirely from goods to services, showing it may persist in health care for longer than in other sectors. Over the next four years, the independent LAO projects inflation to be 3.4% — over 10% higher than OHCA's proposed target.[3] This means that OHCA's proposed spending target would dictate a decline in real health care spending of nearly a half a percentage point each year.

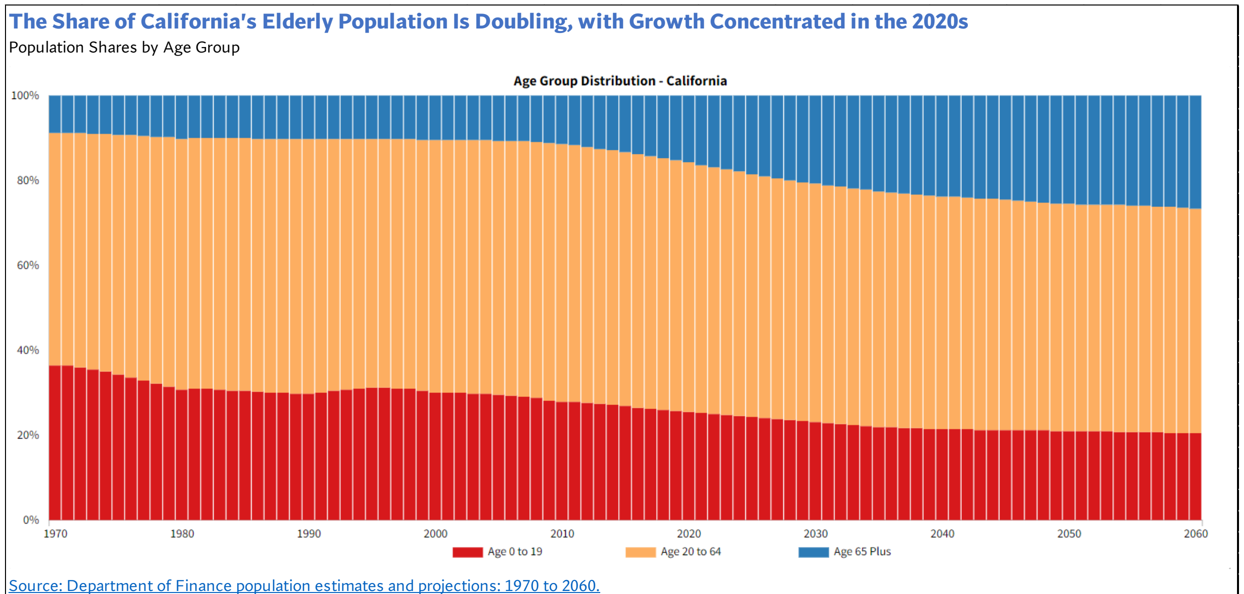



The second figure shows this would result in a $13 billion cut in real health care spending by 2029, the magnitude of which would force hospitals and other providers to disregard the target, risking enforcement under an undefined process, or be left unable to afford to provide the care their patients need.

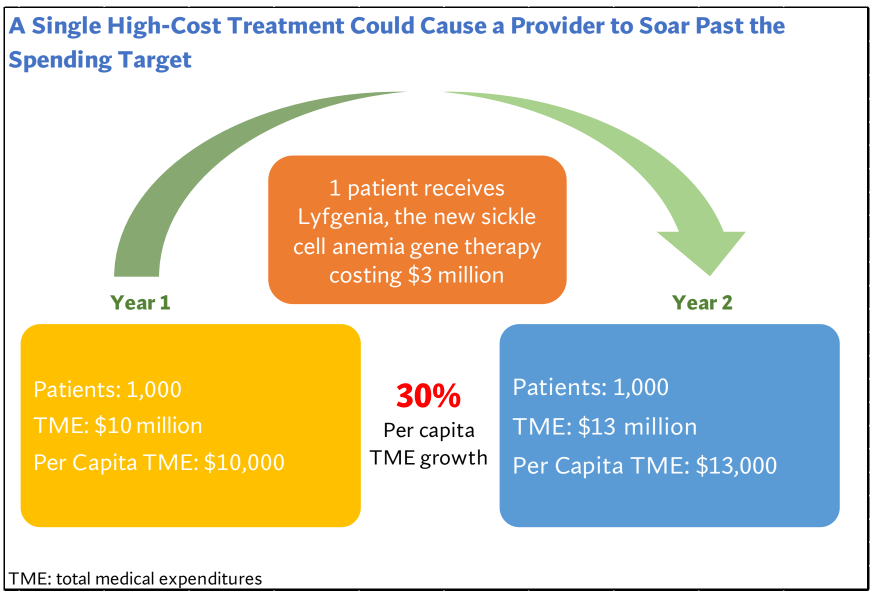
**Proposed Target Ignores the Growing Health Needs of an Aging Population.** The baby boomer generation is entering or advancing in its senior years. As the figure on the next page shows, the elderly share of California's population is projected to roughly double between 2010 and 2040, with growth concentrated in the 2020s. While average annual per capita health care spending for Americans under age 65 is around $7,500, it is over

[3] Inflation projections are from the Legislative Analyst's Office's [The 2024-25 Budget: California's Fiscal Outlook]().

$20,000 for those between the ages of 65 and 84, and over $35,000 for those age 85 and older. This will inevitably result in higher health care spending going forward. Ignoring it would place the health and longevity of aging Californians at risk.



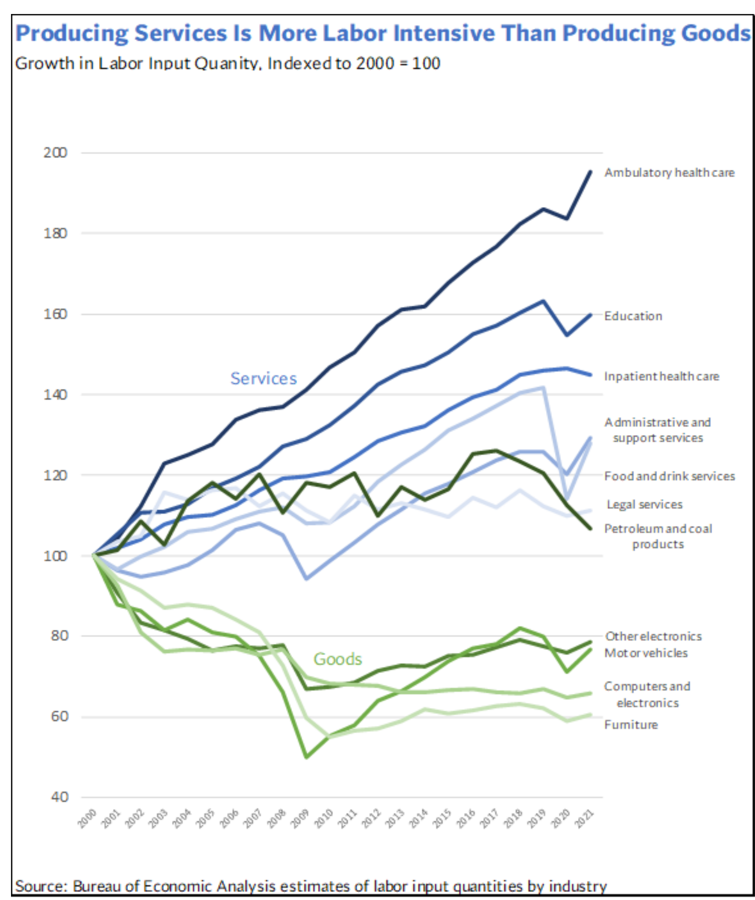

**Proposed Target Would Force Payers and Providers to Eschew New Technologies.** Technological development is different in health care and is treated differently under OHCA's authorizing statute. In health care, technological development often comes in the form of new and expensive drug therapies and medical devices, which often receive extended government-granted monopolies, suppressing price competition. Recent new drugs include Sovaldi, a hepatitis C drug that debuted at a price of $84,000 per treatment, and Ozempic, a popular diabetes and weight loss drug that costs over $10,000 per year and is intended for use over a patient's lifetime. Further novel therapies, like a new gene therapy for sickle cell anemia that will cost up to $3 million, are on their way. As the following figure shows, having a single patient utilize this drug could cause a provider to soar past the proposed target.[4]




OHCA does not regulate pharmaceutical manufacturers, intermediaries, or retailers. However, payers and providers are responsible under the target for any growth in these unregulated sectors. To address this contradiction, OHCA must recognize the cost of

[4] While offsetting savings are likely to occur, they likely would only do so over the course of many years, and therefore not materially help an entity avoid spending growth in excess of the target. For example, researchers found that it took 14 years for savings to offset the cost of Sovaldi.

pharmaceutical and other innovation in the spending target to avoid punishing health care entities for factors beyond their control and prevent the rationing of new, life-saving treatments.



Source: Bureau of Economic Analysis estimates of labor input quantities by industry

**Target Proposal Fails to Recognize That Health Care Is a Labor-Intensive Sector.** Broad economic indicators like median family income and inflation mask the fundamental differences between industries like health and manufacturing, making them ill-suited as a reference point for a health care spending target unless adjustments are made. Economists have long understood that sectors that are labor intensive tend to grow relatively more expensive over time, commanding a greater share of people's incomes. The figure to the right shows labor trends by industry and features remarkably similar patterns to the overall inflation among these different industries.

The reasons are that the service sectors do not benefit as much from cost-saving automation as other industries, like manufacturing, and generally are less exposed to national and international competition. To illustrate the principle, consider that the amount of time for a nurse to administer a drug or otherwise care for a patient has only been marginally reduced by technological change. Meanwhile, a roboticized car factory may only require an employee to keep the robots in working order, meaning the assembly line of workers previously needed in the factory can be deployed elsewhere in the economy. For exactly these reasons, the share of U.S. workers in service-oriented industries has increased by around 20% over the last 40 years.[5]

**Spending Target Proposal Does Not Accommodate Policies Going Into Effect.** Policies adopted by the Legislature — including new investments in Medi-Cal to address longstanding payment shortfalls and improve access to care, the enactment of a new health care worker minimum wage, and the outstanding costs of complying with the state's 2030 seismic standards — will add billions of dollars in health care spending over the next several years. In percentage terms, just these three policy changes will add 3% in health care spending statewide over the next five years, amounting to 20% of total allowable growth under the proposed spending target. Failing to account for these — and other potential policy changes — would leave health care entities unable to afford the higher associated costs or, in other cases, even realize the investments intended by state policymakers.

Relatedly, OHCA has not publicly shared how it would reconcile the differences between the anticipated growth in public health care programs and its proposed statewide, all-payer spending target. Over the

[5] Estimated based on data from the Bureau of Labor Statistics on workforce statistics in service-providing industries.

next few years, the Department of Health Care Services and LAO project Medi-Cal to grow by between 5% and 6% annually, while the Centers for Medicare & Medicaid Services (CMS) projects Medicare to grow by 5.4% annually going forward. It is entirely unclear how payers and providers with high Medi-Cal and Medicare patient populations — for some, Medi-Cal and Medicare represent 75% or more of all their members or patients — would meet a 3% target.

**As in Other States, OHCA Should Phase in Its Spending Target.** OHCA must consider a phase-in factor that would help health care entities adapt to a lower spending growth environment. To meet the spending targets without sacrificing quality, equity, or access, health care entities will need to make new investments and make changes to their care processes to shift toward value-based care. Such investments will not bear fruit immediately. For example, better management of chronic conditions will require higher up-front expenditures, with savings only to be realized over the years or decades that follow (often by payers and providers other than those who made the improvements). Failing to incorporate a phase-in factor would leave health care entities with no choice but to scramble to cut their spending growth in faster and more concrete ways, such as by reducing service lines, not providing high-cost yet high-value services, or taking steps to protect themselves against sharp shifts in the risk profiles of their members. Adding a phase-in factor would avoid these problems and harmonize California's approach with those of other states, which on average have elected to gradually phase down their spending targets by nearly 1 percentage point over a period of four to five years before reaching their longer-term levels.

**Drivers Must Be Incorporated Now, Not Left to Selective Enforcement.** OHCA staff has conveyed a preference for setting an aggressive target now, without a demonstrated interest in whether it is achievable,[6] while potentially retaining maximum discretion around whether to enforce against health care entities that miss the target. In this way, OHCA would decide whether to recognize external drivers like inflation or policy changes as justification for missing the target under a retrospective process that has yet to be defined and likely would never be clear to regulated entities. This approach is incredibly problematic. Laying down unattainable standards and then granting selective and esoteric forgiveness later would be antithetical to good governance, and we ask the board to not endorse this approach.

Moreover, setting an unattainable target would cause it to be ignored in contract negotiations between payers and providers,[7] which would only expand the possibility of arbitrary and capricious enforcement, as described above. Finally, this approach would inevitably lead to unintended consequences. The purpose of the spending target is not limited to identifying and enforcing against individual entities that miss the target. Rather, the purpose is to affect negotiations between payers and providers. Thus, payers would look to meet the target by suppressing reimbursement levels and placing more stringent utilization management controls on providers, which would be most effective against providers with the least leverage to push back against the demands of their oligopolistic payers. Small, independent, rural, and safety-net hospitals, and other small providers, would be hit the hardest, endangering their survival and exacerbating the access challenges already faced by too many vulnerable California residents today.

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[6] The only relevant analysis OHCA has provided is that other states set a similar target. However, as discussed later, other states have missed their targets more often than not and typically phased their targets in, only reaching OHCA's proposed level after several years of the targets being in place.

[7] In Medi-Cal managed care and delegated provider models, actuaries would likely have no choice but to disregard the target if it is inconsistent with their duties to set reasonable and attainable capitated rates.

## An Alternative Framework for a Sustainable Spending Target

While OHCA staff's recommended methodology simply recognizes a single measure of consumer affordability, a target that is credible, achievable, and sustainable must actually recognize the factors that influence how much Californians spend on health care. To this end, CHA proposes an alternative framework for a sustainable spending target. It includes factors that account for inflation, the aging of California's population, trends in the costs of technology and labor that are specific to the health care sector, and the impacts of three major policies that will be implemented over the next five years.

The framework has three potential uses:

- For use as the spending target methodology
- To assess the reasonableness of a different spending target and methodology
- As a source for reasonable and appropriate adjustments to a spending target that relies on an alternative methodology

**Framework for a Sustainable Spending Target**

| | 2025 | Average 2025 - 2029 |
|---|---|---|
| **1) Economy-Wide Inflation** | **3.3%** | **3.4%** |
| **2) Aging** | **0.8%** | **0.7%** |
| **3) Technology and Labor:** | **0.6%** | **0.6%** |
| A) Drug and Medical Supplies | 0.4% | 0.4% |
| B) Labor Intensity | 0.2% | 0.2% |
| **4) Major Policy Impacts:** | **1.6%** | **0.6%** |
| A) Health Care Worker Minimum Wage | 0.4% | 0.2% |
| B) Investments in Medi-Cal | 1.1% | 0.3% |
| C) Seismic Compliance | 0.1% | 0.1% |
| **Totals** | **6.3%** | **5.3%** |

The following bullets summarize the independent factors included in the framework:

- **Economy-Wide Inflation.** A spending target that is less than inflation risks penalizing health care entities simply for keeping up with what it costs to hire workers, buy supplies, and make facility improvements. To prevent this, OHCA should either use economy-wide inflation as an economic indicator in the spending target or adjust the target upward as appropriate. The inflation value in the framework is the LAO's projection for inflation for 2025 through 2028 (a 2029 inflation projection is not available).[8] To more properly reflect the dynamics of the health care sector, the OHCA board could alternatively consider using a measure of inflation that is lagged by two years, given that inflation often ripples through health care two years after it hits the broader economy, as asserted by OHCA's principle consultant on the spending targets.
- **Aging.** California's population is aging rapidly, a factor that must be accounted for in determining how much health care spending should grow in the coming years. According to data from the California Department of Finance[9] and CMS' Office of the Actuary,[10] California health care spending will grow by around $3.5 billion every year from 2025 through 2029 due to population aging alone. This translates to an annual increase of 0.7% and is not recognized in OHCA's proposal. The appendix displays the detailed results of these projections.
- **Technology.** Failing to account for the costs of new technology would bring undue restrictions in access to the latest life-changing treatments. To account for future expected growth in pharmaceutical and medical supply spending, an estimate of the portion of per capita health care expenditures going to these products should be added and grown according to historical trends

[8] Inflation projections are from the Legislative Analyst's Office's The 2024-25 Budget: California's Fiscal Outlook.
[9] Aggregated from the California Department of Finance's population projections.
[10] Reflects personal health care expenditures stratified by age and sex, taken from CMS's national health expenditure data.

(around 5.5%).[11] The value in the framework is the incremental impact in percentage terms of the higher growth above the 3% proposed spending target in these two service categories.

- **Labor.** As a service industry, health care spending cannot be expected to grow at the same rate as sectors like car and TV manufacturing, or composite measures that average out the differences among industries. Accordingly, an adjustment is needed to reflect the greater labor intensity of health care, relative to other industries. The adjustment provided in the framework accounts for higher expected growth in health care spending due to labor dynamics unique to the sector. It is derived from an economic model developed in the *Journal of Health Economics* and incorporates California-specific trends in wages, employment, and gross state product.[12,13]
- **Major Policy Impacts.** A handful of recently enacted or long-standing policies are expected to raise health care spending by between $10 billion and $20 billion in the coming years. The following major policy impacts cannot be ignored and have been incorporated into the framework.
    - **Health Care Worker Minimum Wage.** In 2023, the state approved a new $25 health care worker minimum wage, which will be implemented gradually over the next several years. At full implementation, this new law is expected to raise health care spending by nearly $8 billion, or 1.5% compared to existing statewide health care spending. This estimate reflects incrementally higher costs above projected inflation (3.5%) due to the implementation of this new law.[14]
    - **Investments in Medi-Cal.** Largely starting in 2025, the MCO tax will support about $6 billion in increased Medi-Cal provider reimbursement annually, which on its own will reflect a 1.1% increase in total health care spending in California.[15] Additionally, Medi-Cal will be increasing payments to private hospitals under a new hospital quality assurance fee program and to designated public hospitals under an Enhanced Payment Program expansion.
    - **Seismic.** California's hospitals have been subject to seismic compliance for a number of years. The next major deadline to meet the state's seismic standards arrives in 2030, requiring hospitals to make around $160 billion in capital improvements over the next six years to comply with the state's rules.[16] By and large, hospitals will borrow to pay for these capital improvements. The value in the framework assumes hospitals will utilize bond financing at 30-year terms at an interest rate of 5.5%, which translates into

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[11] Estimates come from CMS' estimates of health expenditures by state of provider, supplemented with estimates from Altarum on the proportion of drug expenditures that are billed via provider, rather than pharmacy, claims.
[12] Estimate is based on 10 years of historical economic data and the model developed by L.J. Bates and R.E. Santerre in their 2013 article in the Journal of Health Economics: *"Does the U.S. healthcare sector suffer from Baumol's cost disease? Evidence from the 50 states."*
[13] CMS' Office of the Actuary similarly recognizes that health care labor productivity increases at a slower rate than labor productivity in the general economy.
[14] Estimate is based on CHA's analysis of the Department of Health Care Access and Information's Hospital Annual Financial Disclosure Report with input from Capitol Matrix's *Economic and Fiscal Impacts of SB 525*.
[15] This estimate does not include the more than $6 billion in higher annual taxes that MCOs will pay and report as total health care expenditures.
[16] CHA analysis of the Department of Health Care Access and Information's Hospital Building Data file. Analysis assumes bond financing and a 50-50 split between hospitals choosing to retrofit non-compliant buildings or rebuild them.

incrementally higher expenditures of around $500 million annually, or 0.1% of statewide health care spending.

This framework results in a value that is achievable and promotes patient-centered care. Notably, it also is closely aligned with the target recently approved in Rhode Island, which raised its target to 6% (decreasing annually thereafter) after the state reevaluated its initial target of 3.2% in light of more recent economic trends.

## More Work Needed Before Setting an Enforceable Spending Target

The timelines in OHCA's authorizing legislation were drawn to facilitate thoughtful deliberation and learning before enforceable spending targets are set. Unfortunately, OHCA's proposal unnecessarily rushes toward an enforceable spending target in 2026 and beyond. While multiyear targets may eventually make sense, the board should reconsider the appropriateness of setting a multiyear spending target before critical outstanding issues have been resolved.

**Board Has Flexibility on Whether to Adopt a Single- or Multiyear Target.** State law requires the OHCA board to adopt the statewide non-enforceable spending target for 2025 on or before June 1 of this year. While statute authorizes the adoption of multiyear spending targets, the board is not obligated to set the 2026 spending target — the first enforceable target — until June of next year. Nevertheless, OHCA has proposed a statewide target for five years, through 2029.

**Collect and Analyze Data First, Set Enforceable Targets Second.** A credible target-setting process will make **data-driven decisions**. Pursuant to statutory timelines, OHCA will not collect any health care spending data comparable to what will be used for the spending targets until September 2024. This makes it impossible for the board to meet its June 1 deadline and make a decision on the 2025 spending target based on data collected by OHCA. However, this is not the case in 2026 and beyond. Following the collection of data in September 2024, the office will have up to nine months to analyze the data and release a report comparing 2022 and 2023 health care spending by June 1, 2025 — the same deadline for the board to set the 2026 spending target. Accordingly, the timeline for data collection and analysis presents the board with the opportunity to inform its decision on the first enforceable spending target in 2026 based on 2022 and 2023 spending data collected by OHCA.[17]

**Establish Rules of Enforcement First, Set Enforceable Targets Second.** The February 2024 board meeting featured essentially the first extended discussion of the enforcement process. Still, this discussion only recapitulated the requirements under statute. Accordingly, no progress was made toward ironing out critical components of the process that state law left to rulemaking. For example, no rules have been established around the factors OHCA will use to determine whether growth in excess of the target was justifiable, whether performance will be judged based on one year or multiple years, whether entities will be judged across all their business lines or within each one, or what the financial penalties will be. This lack of clarity around key aspects of enforcement will make it impossible for health care entities to properly plan and prepare to comply with the spending target.

These challenges are exacerbated by the fact that OHCA has proposed a target at a level that few, if any, health care entities would be able to consistently achieve. Among hospitals over the last five years, over 95% had net patient revenue growth in excess of 3% in at least one year. Would OHCA subject all such

[17] Doing so could require a modest acceleration of OHCA's work analyzing and reporting the September 2024 data, potentially in preliminary form.

hospitals to enforcement? If not, how would it pick among the hundreds that had growth in excess of the target? These challenges are avoidable should the board opt to set a single-year target at this time, giving it ample opportunity to make progress in outlining the enforcement process over the next year prior to the deadline for adopting the 2026 target. Doing so should be a prerequisite to adopting an enforceable target.

**Learn More About Drivers of Affordability Challenges and Potential Impacts of the Target First, Set Enforceable Targets Second.** This letter raises numerous deficiencies in the analytical process undergirding OHCA's proposed spending target. Information presented and discussed has been one-sided, contrary information has not received meaningful attention, and the intent and requirements of state law have not been fully met. While the board has up to three scheduled meetings before the deadline for setting next year's target, this does not provide sufficient time to meaningfully resolve the outstanding issues. Accordingly, the board should consider deferring the adoption of enforceable targets for 2026 and beyond until the various shortcomings of the process can be addressed.

## Additional Shortcomings of the Proposed Spending Target, Methodology, and Supporting Analysis

**OHCA Has Proposed a Target Even Lower Than Other States.** Spending target programs have been implemented in eight other states. The figure below shows that California's proposed target is lower than all other states' when considered on a multiyear basis. Moreover, inflation in the year prior to the other states setting their target averaged a mere 1.8%, whereas for California, prior-year inflation came in at 4.2% — a factor entirely unrecognized in OHCA's proposal. Finally, California's proposal ignores important differences in economic trends compared to other states. So, while the other states set their targets to exceed the historical growth in their economies by about 1 percentage point (or 45% higher) on average, OHCA's proposed target would be nearly 2 percentage points (39%) lower than California's historical economic growth rate.

Importantly, other states' targets are higher than OHCA's proposal because all other states have elected to phase their targets in, typically over four to five years. Rhode Island, which had a flat 3.2% target in place for four years, had been the lone exception. However, the state subsequently revised its approach and set its target at 6% in 2023, 5.1% in 2024, then incrementally lowering it thereafter to 3.3%.

**California's Spending Growth Target Would Be the Lowest in the Nation Despite Higher Inflation and a Faster Growing Economy**

| State | Year Target Was Set | Prior Year Inflation | Average Target[1] | GSP Growth[2] | Difference (Target - GSP) | Phase-in Period (Years)[3] | Phase-in Value[3] |
|---|---|---|---|---|---|---|---|
| **California** | **2024** | **4.2%** | **3.0%** | **4.9%** | **-1.9%** | **0** | **0.0%** |
| Massachusetts | 2012 | 3.1% | 3.1% | 2.5% | 0.6% | 6 | 0.5% |
| Nevada | 2021 | 1.3% | 3.1% | 2.9% | 0.2% | 4 | 0.8% |
| Connecticut | 2020 | 1.8% | 3.2% | 1.2% | 2.0% | 3 | 0.5% |
| Rhode Island | 2021 | 1.3% | 3.8% | 1.3% | 2.5% | 4 | 2.7% |
| Washington | 2018 | 2.1% | 3.2% | 4.7% | -1.5% | 5 | 0.4% |
| Delaware | 2018 | 2.1% | 3.3% | 0.4% | 2.9% | 4 | 0.8% |
| Oregon | 2021 | 1.3% | 3.4% | 3.2% | 0.2% | 6 | 0.4% |
| New Jersey | 2021 | 1.3% | 3.5% | 1.7% | 1.8% | 4 | 0.7% |
| **Peer State Average** | | **1.8%** | **3.3%** | **2.2%** | **1.1%** | **4.5** | **0.9%** |

[1] Average Target = average growth in the health care growth target 2021-23. Source: Melnick, CHCF, 2022.
[2] GSP: average gross state product for the period 2016-2019. Source: Melnick, CHCF, 2022.
[3] Phase-in value is the distance between the maximum and minimum spending target values. For all states except Rhode Island, the maximum value is the first year's value. Rhode Island revised its target upward to account for contemporary economic trends. Phase-in period is the number of years it takes for target to be reduced from its maximum to minimum value.

Melnick, CHCF, 2022: Melnick, Glenn. CHCF Issure Brief, Health Care Cost Commissions: How Eight States Address Cost Growth. April 2022.

**OHCA Has Neglected to Learn from Other States That Have Struggled to Meet Their Targets.** More often than not, other states have missed their targets. As the next figure shows, other states have missed their targets in 10 out of a possible 17 years, or six out of a possible nine years when only considering the pre-COVID-19 period. On average, other states have missed their targets by up to 1 percentage point (depending on the period), showing they set their targets around 20% lower than they reasonably should have even without considering current inflationary pressures.

**Other States Have Missed Their Spending Targets More Often Than Not**

| | All Years | | | | Pre-COVID-19 | | | |
|---|---|---|---|---|---|---|---|---|
| | Average Performance | Average Target | Years Target Missed | Years in Place | Average Performance | Average Target | Years Target Missed | Years in Place |
| Connecticut | 6.1% | 3.1% | 1 | 1 | | | 0 | 0 |
| Delaware | 5.3% | 3.3% | 2 | 3 | 5.8% | 3.8% | 1 | 1 |
| Massachusetts | 3.5% | 3.4% | 5 | 9 | 3.6% | 3.5% | 4 | 7 |
| Nevada | | 2.8% | 0 | 0 | | | 0 | 0 |
| New Jersey | | 3.1% | 0 | 0 | | | 0 | 0 |
| Oregon | 3.5% | 3.3% | 1 | 1 | | | 0 | 0 |
| Rhode Island | 1.5% | 3.8% | 1 | 3 | 4.1% | 3.2% | 1 | 1 |
| Washington | | 3.8% | 0 | 0 | | | 0 | 0 |
| **Averages/Totals** | **4.0%** | **3.3%** | **10** | **17** | **4.5%** | **3.5%** | **6** | **9** |

**OHCA Has Not Ensured Its Target Meets the Multiple Objectives of State Law.** OHCA's proposed target falls short of meeting the spirit, if not the letter, of state law by narrowly focusing on just one of its statutory objectives — that of affordability — and neglecting to appropriately recognize OHCA's other foundational goals. In its findings and declarations in section 127500.5 of the Health and Safety Code, the state Legislature declared its intent to:

> *"**Have a comprehensive view of health care spending, cost trends**, and variation to inform actions to reduce the overall rate of growth in health care costs while maintaining quality of care, **with the goal of improving affordability, access, and equity of health care for Californians**." **[emphasis added]***

> *"Encourage policies, payments, and initiatives that improve the affordability, quality, equity, efficiency, access, and value of health care service delivery, with a particular focus on ensuring health equity and reducing disparities in care, access, and outcomes across California.*

State law specifically extends these principles to the spending target and associated methodologies in Health and Safety Code section 127502, requiring that they:

> *"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]***

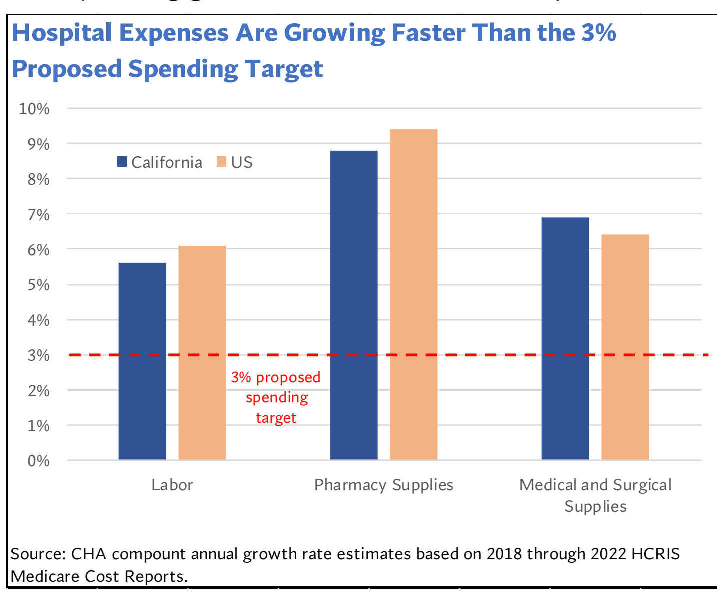
> *"Promote a predictable and **sustainable rate of change** in per capita total health care expenditures. **[emphasis added]***

> *"Be based on a target percentage, with consideration of economic indicators or population-based measures, and be developed based on a methodology that is available and transparent to the public. Economic indicators may include established measures reflecting the broader economy, the labor markets, and consumer cost trends. **Population-based measures may include changes in the***

***state's demographic factors that may influence demand for health care services, such as aging." [emphasis added]***

***Promote the stability of the health care workforce****, including the development of the future workforce, such as graduate medical education teaching, training, apprenticeships, and research.* ***[emphasis added]***

**OHCA Has Not Performed a Serious Analysis of the Impacts of the Target on Access, Quality, Equity, or Workforce Stability.** While OHCA staff has prepared and presented analyses of the potential impacts of a 3% spending target on health care spending growth, it has avoided any fair discussion and analysis of the impacts of its proposal on access, quality, or equity. Furthermore, OHCA has rejected the use of any and all population-based measures without sufficient justification and potentially based on a severe underestimate of the influence demographics have on health care spending (estimates published by OHCA estimated that aging increases health care spending by 0.1% to 0.2% annually, in contrast to the 0.7% estimate derived from the Department of Finance and CMS). Similarly, OHCA has not performed sufficient analysis of the trends in health care labor costs, the potential impacts of a 40% drop in health care spending growth on workforce stability, or the effects of negative **real** spending growth on access and quality. Without performing and publicly presenting this work, it is unclear how OHCA can defensibly attest to fulfilling its responsibilities under statute related to the spending target.[18]

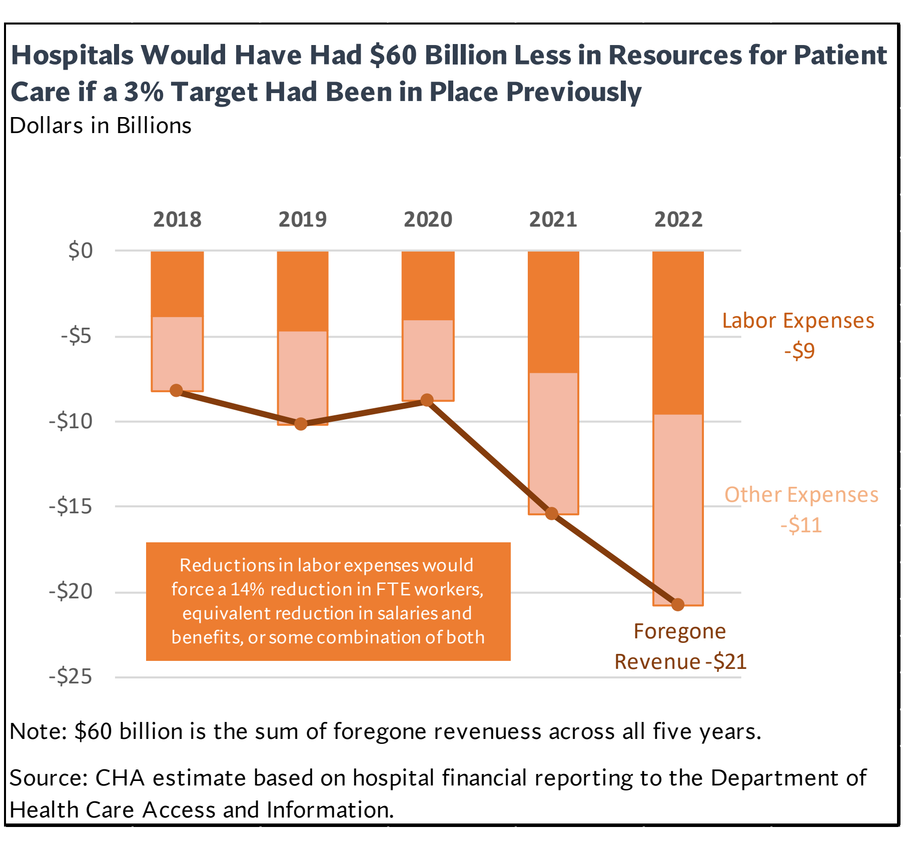


Source: CHA compound annual growth rate estimates based on 2018 through 2022 HCRIS Medicare Cost Reports.

**OHCA Must Conduct a Balanced Analysis of Potential Target Impacts to More Carefully Identify Where Savings Could Be Achieved Without Unacceptable Tradeoffs.** It is incumbent upon OHCA to do more to analyze where cost growth can be reduced to meet the spending target without harming patients. However, no such analysis has been done. Looking specifically at hospitals, expenses have grown at over 5% in the long run —

[18] Recent developments at the board demonstrate the office's shortcomings in ensuring balance around which perspectives receive consideration. Since proposing the 3% target, OHCA staff received two requests from OHCA board members to analyze the impacts of the target on the labor market. One request was to look at the effect of health care affordability challenges on general employment outcomes, while the other focused on the implications of the proposed 3% spending target for employment *within* the health care sector. OHCA staff promptly fulfilled the former request at the February board meeting, showing higher premiums are associated with lower wages and lower labor force participation. Meanwhile, OHCA declined to fulfill the latter request, betraying a consistent and troubling lack of balance in what information and questions receive analysis and presentation.[18] The staff's rationale for answering one question but not the other was a lack of academic research specifically on the effect of spending targets on health care employment outcomes, a constraint that did not prevent them from relying on literature *unrelated* to spending target programs to discuss general employment impacts in response to the other question from the board. Moreover, despite no published research to rely upon, OHCA has presented projections of the impacts of the spending target on total and per capita health care spending, with the purpose of showing affordability improvements they anticipate, again revealing a worrisome double standard.

roughly 70% higher than OHCA's proposed target. Recently, costs have grown even faster, as shown in the figure on the previous page. To meet a 3% spending target, hospitals would have to significantly scale back their workforce and operations, such as service lines and bed capacity. To illustrate, as the figure below shows, CHA estimated the revenue impacts if hospitals had been subject to a 3% spending target for the years 2018 through 2022. Across these five years, over $60 billion in resources for patient care would have been eliminated for hospitals alone. To balance their expenses with their lower revenues, by 2022, hospitals would have had to reduce their total expenses by 14%. Achieving this proportionate cut to their labor expenses would have required California's hospitals to reduce their full-time equivalent-worker count by 58,000 — 14% of their workforce. Alternatively, hospitals would have had to suppress wages by an equivalent percentage amount, or rely on a combination of wage and force reductions. How hospitals could have achieved such reductions while meeting the public health and workforce crises brought by COVID-19 is not clear.




Note: $60 billion is the sum of foregone revenuess across all five years.

Source: CHA estimate based on hospital financial reporting to the Department of Health Care Access and Information.

**OHCA Must Account for and Mitigate Impacts on Quality.** Despite the fact that OHCA's proposed spending targets would likely force negative growth in inflation-adjusted reimbursement rates, OHCA has not presented an analysis of the potential impacts of its proposed target on health care quality. This is contrary not just to good policymaking, but also to statutory requirements. To meet its legislative mandate, OHCA must demonstrate that its spending target proposal would avoid such impacts. In doing so, OHCA must offer reasonable assurances that the following consequences would not result from a spending target designed to eliminate around 10% of statewide health care spending within a period of just five years. Below are some examples of research that show that the tradeoffs between spending and quality are real.

- **Higher Medicare Payments Lead to Better Outcomes.** As Jonathan Gruber, a key architect of the Affordable Care Act, and others note, differences in health and socioeconomic status among the patients served by different hospitals seriously complicate the study of the relationship between reimbursement and costs and quality. That said, significant research indicates that quality would suffer at hospitals from reimbursement cuts brought about by the spending target program. Gruber and coauthors find that hospitals that received higher reimbursement under Medicare produced better patient outcomes — specifically, that a 10% increase in reimbursement is associated with a 2.4 percentage point lower mortality rate.[19] In this study, higher

[19] Gruber et al.

reimbursement was driven by increased treatment intensity, as captured in coding under Medicare's diagnosis-related group payment methodology, showing that higher reimbursement owed to higher levels of care and produced superior patient outcomes. Unfortunately, to adhere to the extremely low proposed spending target, payers would almost certainly increase their reliance on practices like downcoding and steering patients away from high-cost, high-quality hospitals, helping their performance on the spending target but at the detriment of their members' health.

- **Medicare Payment Reductions Under the Balanced Budget Act (BBA) of 1997 Led to Increases in Mortality.** In 1998, due to concerns that Medicare was overpaying providers, Medicare inpatient reimbursement rates were slashed by the largest amounts in recent history. After profit margins for 35% of hospitals turned negative as a result of the cuts, Congress swiftly enacted legislation partially reversing them. Unfortunately, the reversal came too late. While no effects on patient outcomes were detected in the first three years of implementation of the BBA rate cuts, all-cause mortality shot up over the next several years at hospitals most exposed to the BBA rate cuts. Researchers ultimately concluded that a 1% reduction in Medicare payment rates induced a 0.4% increase in mortality, driven by staffing reductions and hospitals' other efforts to lower operating costs.[20] Similar effects could result from OHCA spending targets that constrain provider revenues below what it costs to provide high-quality patient care.
- **Reduced Access to Emergency Services Could Lead to More Deaths.** Over 50% of hospitals had negative operating margins in 2022, leaving many on the brink of closure. OHCA's proposed target is barely more than half of both recent and long-term hospital cost growth, which inevitably would exacerbate hospitals' existing financial challenges. Any resulting closures and reductions in emergency and other hospital services, particularly in but not limited to rural areas, would endanger residents' health by increasing the amount of time it takes to get proper emergency care. This is strikingly shown in a study of the effect of road closures during marathon events on emergency transport times and the resulting mortality rates for hospitalized patients.[21] The authors found that emergency transport times increased by 4.4 minutes during marathons, leading to a 3.3 percentage point higher mortality rate among affected patients. Similar increases in emergency transport or access times could result from hospital closures or service reductions, a factor that OHCA must consider in the spending target development process.

**Proposed Spending Target Would Eliminate Resources for Patient Care.** OHCA has largely relied upon a single piece of research showing there is waste in the U.S. and California health care systems to demonstrate that spending can be eliminated without negative consequences for patients. This research comes from an article titled "Waste in the US Health Care System: Estimated Costs and Potential For Savings," from the *Journal of the American Medical Association* (JAMA). Without question, there are opportunities in health care to improve efficiency, as in all sectors of the economy. However, even this study relied upon by OHCA cannot support the magnitude of spending reductions proposed by OHCA nor the claim that it would not negatively affect patient care.

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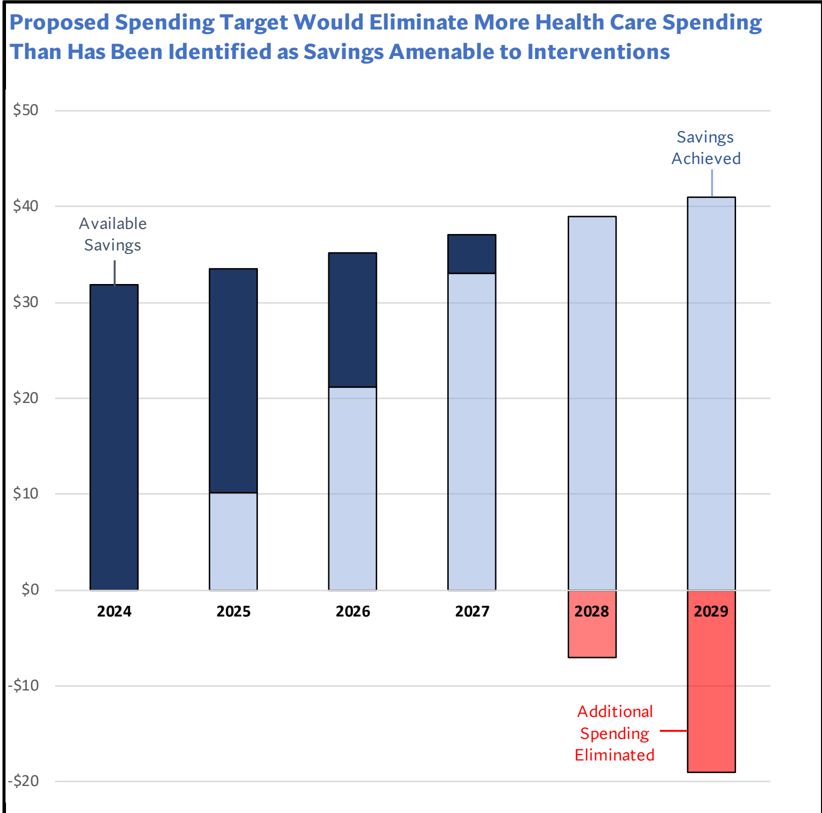
[20] Wu and Shen

[21] Jena et al.

The JAMA article concludes that between 20% and 24% of total U.S. spending on health care reflects waste, and that a quarter of this waste reflects potential savings from identified interventions proven to improve efficiency without harming patient care. Interventions suggested include the integration of behavioral and physical health, transitional care programs, drug pricing changes, and hospice expansion. Applied to California's health care system, the JAMA article suggests that there are $30 billion to $40 billion in savings that could be realized via changes in care delivery and financing. Problematically, however, OHCA's proposed target would eliminate $60 billion in annual health care spending by 2029 (as compared to growth under existing trends). This implies that nearly $20 billion in spending on medically necessary patient care would have to be eliminated to meet the proposed spending target, assuming California achieved **all** the theoretical savings amenable to intervention identified in the JAMA article.

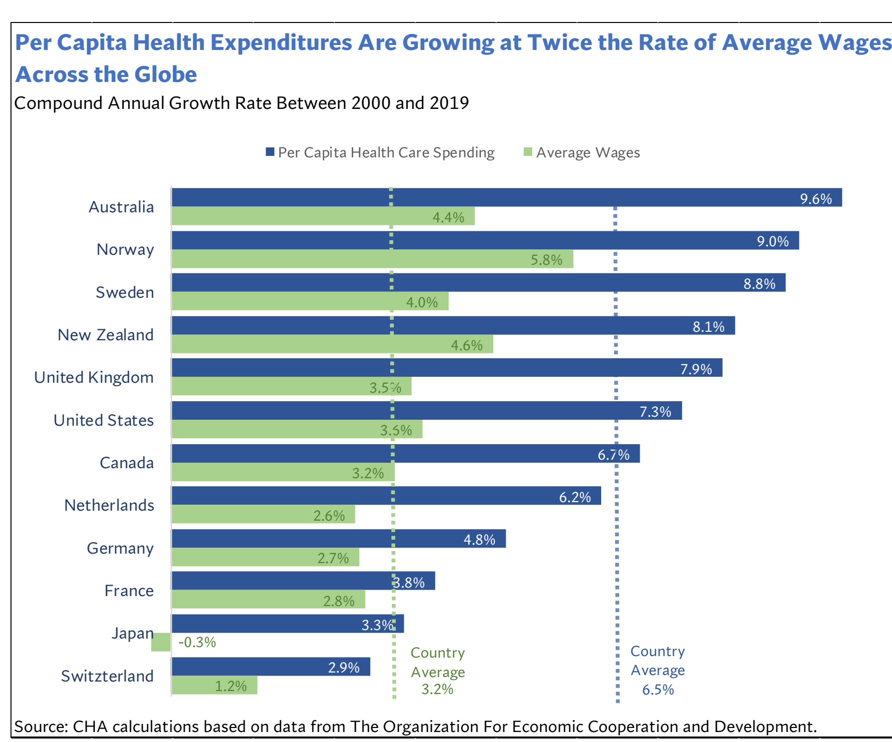
**Proposed Spending Target Would Eliminate More Health Care Spending Than Has Been Identified as Savings Amenable to Interventions**




A 2019 article in the Journal of American Medicine estimated that between 5% and 7% of American health care spending reflects waste that could be eliminated by known interventions. This percentage (6%, the average of the range) is applied to California's health care spending, starting at roughly $500 billion in 2024, to estimate the dollar amount of available savings that could theoretically be achieved by the interventions identified in the JAMA article. This shows a spending target of 3% would reduce nominal spending by nearly 10% compared to current trends (5% annual growth) over a 5-year period, resulting in the elimination of more spending than has been identified as savings amenable to policy intervention.

**Per Capita Health Expenditures Are Growing at Twice the Rate of Average Wages Across the Globe**

Compound Annual Growth Rate Between 2000 and 2019




Source: CHA calculations based on data from The Organization For Economic Cooperation and Development.

**Health Care Spending Trends Across the Globe Call Into Question Whether the Proposed Target Is Attainable.** If a proposed spending growth target based on a measure like median income were attainable, the U.S.'s peer countries likely would achieve it. However, as the figure shows, none of the following 11 peer countries have experienced per capita health spending growth anywhere near average wages (over the last 20 years in California, average wage growth has equaled median household income growth). In fact, over the last 20 years, the growth rate for per capita health

spending was roughly double that for average wages among this sample of economically developed countries. The consistent trends among countries with diverse health care systems demonstrate that this divergence is not simply due to differences in how different countries finance, organize, and regulate their health care systems.[22] Instead, it shows that underlying economic and demographic factors are key drivers of the higher growth in health expenditures and that limiting health care spending growth to a measure like wage growth would risk seriously undermining the capacity of California's health care system to provide the health care its residents need.

It must be recognized that, despite middling growth in per capita health care spending compared to its peer countries, the U.S. does have higher starting levels of per capita spending — a fact that has been a foundational assumption in OHCA's work. However, this fact alone does not demonstrate that reduced spending can be achieved without detrimental impacts for patients. Rather, careful analysis is needed of the drivers of health care spending differences between the U.S. (and California specifically) and its peer countries if OHCA is to understand how and how far California can go to achieve the lower spending levels of our peer countries without sacrificing OHCA's other objectives. Some relevant differences between the U.S. and its peer countries include:

- **Higher Patient Needs.** Americans suffer from chronic conditions at overwhelming rates compared to their peers in other, economically advanced countries. Obesity rates are higher (37% versus 25%), as are diabetes rates (11% versus 6%) and schizophrenia rates (40% higher than in peer countries).[23] Individuals with chronic diseases have health care costs as high as nine times that of other individuals, which means that even small differences in underlying risk factors can lead to large differences in health care spending. While chronic conditions are amenable to interventions from within the health care system, they also are significantly influenced by drivers outside of the health care system, like socioeconomic status, education levels, and environmental conditions. While improved care coordination and access to primary and behavioral health care could yield significant improvements in these areas, the extent of such improvements is uncertain, likely would take significant time to materialize, and may never close the gap between the U.S. and its peer countries.
- **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. The JAMA paper previously discussed 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. OHCA does not have authority over drug manufacturers, wholesalers, or retailers, making it unrealistic that improvements would be made in this area.
- **Administrative Inefficiencies.** Different payers, like Medi-Cal, Medicare, or Blue Shield, often impose different service coverage and payment rules on providers. This 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 Congressional Budget Office recently estimated the provider administrative savings that could be realized from a harmonization of payer administrative

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[22] Among the listed countries, Canada, New Zealand, Norway, Sweden, and the United Kingdom have single-payer systems. Australia, France, Germany, and the United States have public-private insurance systems. The Netherlands and Switzerland have private health insurance systems.
[23] All figures compare the U.S. to the same peer countries listed in the figure on the previous page. Data comes from the Organization for Economic Cooperation and Development.

policies (in this case through the adoption of a single-payer program, present in certain 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. OHCA does not have authority to require payers to standardize and streamline their utilization management and payment rules, diminishing the prospects of significant improvements in this domain.

## Conclusion

OHCA must plan for the health care system Californians need and deserve. California's health care system provides world-leading, life-saving care to millions of patients every year. A poorly considered, hastily developed spending growth target would have dire consequences for millions. CHA is committed to helping the office develop a thoughtful, data-driven approach. We are grateful for the opportunity to comment and look forward to continuing to work closely with OHCA staff and its board to craft policies that meaningfully address affordability challenges while protecting access to health care.

Sincerely,

Ben Johnson
Vice President, Policy

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Secretary Dr. Mark Ghaly
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan

## Appendix: Projected Impact of Aging on Health Care Spending Growth in California

**Aging Alone Projected to Increase Per Capita Health Care Expenditures by 0.7% Annually Over Next 5 Years**

| Age Group | Per Capita Expenditures* | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2024-2029 Average Annual Change | 2024-2029 Cumulative Change |
|---|---|---|---|---|---|---|---|---|---|---|
| | | DOF CA Population Projections** | | | | | | | | |
| 0-18 | $4,217 | 9,387,507 | 9,257,741 | 9,136,538 | 9,011,830 | 8,896,039 | 8,802,023 | 8,721,688 | -107,211 | -536,053 |
| 19-44 | $6,669 | 13,495,609 | 13,526,301 | 13,538,344 | 13,567,196 | 13,598,149 | 13,624,816 | 13,667,390 | 28,218 | 141,089 |
| 45-64 | $12,577 | 9,237,634 | 9,144,358 | 9,073,143 | 9,022,731 | 8,992,291 | 8,972,917 | 8,954,410 | -37,990 | -189,948 |
| 65-84 | $20,503 | 5,980,125 | 6,151,700 | 6,339,232 | 6,505,789 | 6,657,485 | 6,786,964 | 6,912,043 | 152,069 | 760,343 |
| 85+ | $35,995 | 889,612 | 911,621 | 936,797 | 960,535 | 987,815 | 1,027,084 | 1,068,116 | 31,299 | 156,495 |
| All | | 38,990,487 | 38,991,721 | 39,024,054 | 39,068,081 | 39,131,779 | 39,213,804 | 39,323,647 | 66,385 | 331,926 |
| **Age Group** | **Per Capita Expenditures*** | **DOF CA Population Projections* - Annual Percent Change** | | | | | | | **Average Annual Change** | **Cumulative Change** |
| 0-18 | $4,217 | | -1.4% | -1.3% | -1.4% | -1.3% | -1.1% | -0.9% | -1.2% | -5.8% |
| 19-44 | $6,669 | | 0.2% | 0.1% | 0.2% | 0.2% | 0.2% | 0.3% | 0.2% | 1.0% |
| 45-64 | $12,577 | | -1.0% | -0.8% | -0.6% | -0.3% | -0.2% | -0.2% | -0.4% | -2.1% |
| 65-84 | $20,503 | | 2.9% | 3.0% | 2.6% | 2.3% | 1.9% | 1.8% | 2.4% | 12.4% |
| 85+ | $35,995 | | 2.5% | 2.8% | 2.5% | 2.8% | 4.0% | 4.0% | 3.2% | 17.2% |
| All | | | 0.0% | 0.1% | 0.1% | 0.2% | 0.2% | 0.3% | 0.2% | 0.9% |
| | | **Total Expenditures (In Millions)** | | | | | | | | |
| 0-18 | $4,217 | $39,587 | $39,040 | $38,529 | $38,003 | $37,515 | $37,118 | $36,779 | -$452 | -$2,261 |
| 19-44 | $6,669 | $90,002 | $90,207 | $90,287 | $90,480 | $90,686 | $90,864 | $91,148 | $188 | $941 |
| 45-64 | $12,577 | $116,182 | $115,009 | $114,113 | $113,479 | $113,096 | $112,852 | $112,620 | -$478 | -$2,389 |
| 65-84 | $20,503 | $122,611 | $126,128 | $129,973 | $133,388 | $136,498 | $139,153 | $141,718 | $3,118 | $15,589 |
| 85+ | $35,995 | $32,022 | $32,814 | $33,720 | $34,574 | $35,556 | $36,970 | $38,447 | $1,127 | $5,633 |
| All | | $400,403 | $403,197 | $406,622 | $409,924 | $413,352 | $416,957 | $420,711 | $3,503 | $17,514 |
| | | **Per Capita Expenditures** | | | | | | | | |
| All | | $10,269 | $10,341 | $10,420 | $10,493 | $10,563 | $10,633 | $10,699 | $72 | $358 |
| | | **Per Capita Expenditures - Annual Percent Change** | | | | | | | | |
| All | | | 0.7% | 0.8% | 0.7% | 0.7% | 0.7% | 0.6% | 0.7% | 3.5% |

*Reflects 2020 personal health expenditures estimates by age group from CMS' National Health Expenditures data.
**Aggregated from Department of Finance's projections of California's population by age.

**From:** [redacted] on behalf of cheryl mcgrady
**To:** HCAI OHCA
**Subject:** Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
**Date:** Tuesday, February 13, 2024 12:26:56 PM

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[You don't often get email from c[redacted]. Learn why this is important at https://aka.ms/LearnAboutSenderIdentification ]

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board,

Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.
I have been type I diabetic for 57 years. I was diagnosed at the age of 13. My family's health insurance ws military as my dad ws a U.S. Marine. Prescriptions were free. That carried me until I graduated from college and began working. I then had employer based health insurance. I knew to work for a large group as individual health insurance would not be affordable. Later in my adulthood, my son developed type I diabetes. He was uninsured as his employer did not provide health insurance. In order to save his life, I let him use my insulin. Sometimes we ran out. It was by grace that my health provider added number of vials of insulin to my prescription to allow my son treatment.

Now , my son's health insurance through his employer does not pay for lab work. How can a type I diabetic manage his diabetes without lab work. It is not possible. He received a bill for $500.00 for just one blood test- a Hgb A1c. He could not pay the bill and until the bill was paid, he could not receive health care.

Now I am retired using Medicare and supplemental insurance. I have additional health issues. I was recently diagnosed with a lung condition call bronchiectasis. It is a progressive lung disease but can be managed with inhaled steroids. My first prescription cost me $475.00. How is a person supposed to continually pay that. Now, after not having a medication paid for under my insurance for several weeks, my copay is $75.00. a month. with insurance. This is a ridiculous amount to charge a senior citizen on a fixed income. I take many other medications as we... I was not gifted with healthy genes. My health issues are all auto immune based. I have tried to be healthy my whole life. I am changing my grocery shopping methods, cutting recreational activities, cutting any travel for vacations, just to pay for health care. Corporations are making too much money at the people's expense. This needs to change.

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Sincerely,
Ms. cheryl mcgrady

**From:** Ayala, Luis
**To:** HCAI OHCA
**Subject:** Children"s Hospital Los Angeles Comments: Spending Target Methodology
**Date:** Tuesday, January 23, 2024 10:10:53 AM

You don't often get email from [redacted] Learn why this is important
CAUTION: This email originated from outside of the organization.

Dear Members of the Health Care Affordability Advisory Committee:
On behalf of the Children's Hospital Los Angeles, I'd like to submit a few comments for the record as we move forward with this process.
First, thank you for your time and dedication to this very important issue of health care affordability. Children's Hospital Los Angeles (CHLA) is an unparalleled pediatric health resource that serves as a safety net provider for California's children. CHLA is the largest provider of care in California for children insured by Medi-Cal requiring complex care, accounting for:

- 53% of complex pediatric discharges in Los Angeles County
- 26% of complex pediatric discharges in Southern California
- 17% of complex pediatric discharges in the state of California
- CHLA's medically complex pediatric Medi-Cal care for the state comprises 34% of solid organ transplants, 23% of cardiac discharges, 18% of orthopedics discharges, 17% of cancer discharges and 14% of neurological discharges.
- 74% of CHLA patient days support children covered by Medi-Cal and Medi-Cal Managed Care.
- 54% of all patient days are for care provided for CCS patients.

While we appreciate the efforts of California's newly formed Office of Health Care Affordability to create a system to rein in health care cost growth, we want to ensure that we do not **sacrifice access to care or the quality of care**. We'd like to encourage you to consider how your work will affect health care access and quality.
There are at least four essential components to consider in setting spending target: inflation; the aging of California's population; the cost of health care policies adopted by the Legislature that add to cost; and the need to phase in any reductions in rate of growth to prevent harming access to care for Californians. An early proposal of a 3% growth target is well below even standard inflation projections and would remove $4 billion annually (and at least that much every year going forward) from California's health care system. This approach ignores much-needed investments in behavioral health care, health equity, rural health care, and more, and puts California's most vulnerable residents at risk.
We encourage you to make decisions based on data and analysis and account for the underlying drivers of health care costs to develop achievable spending targets that will not inadvertently result in negative consequences. Please consider the following:

- Incorporate inflation expectations into California's target. This not only renders the state's health care system unable to afford medical supplies and upgrades to its

physical and technological infrastructure, but also hampers hospitals' ability to compete with other states and sectors for workers.

- Consider the costs of state and federal mandates — such as seismic, minimum wage, or health information exchange in your calculation.
- Consider that by proposing an unadjusted target based on median family income growth, OHCA has set a target lower than recent years' GDP growth, making California an outlier when compared to the eight other states with similar health care cost growth targets.

OHCA's proposed 3% target would have detrimental impacts on health care quality, access, and equity. To meet this target and maintain it year over year, hospitals will have no choice but to reduce services or, in some cases, close certain service lines entirely and exacerbate an already difficult health care workforce shortage and diminish the outlook for those seeking careers in health care.

OHCA has an opportunity to transform California's health care system in a meaningful way to progress toward the health care system Californians need. To do this, it must clarify how its initial proposal balances the spending target with the need to create a modern system that addresses the social determinants of health that contribute to health disparities. A systemwide focus on health equity has the potential to lead to long-term cost savings but requires significant up-front investments and reorganization of delivery models. In its haste to develop an initial spending target, OHCA has crafted a proposal that could cost the state billions in economic activity. California hospitals, which currently generate more than $343 billion in economic output, will be forced to curtail investments so that they can meet the spending target, resulting in dire consequences across the state.

**Luis Ayala, M.Ed.**
Vice President of Government Relations & External Affairs
Children's Hospital Los Angeles (CHLA)

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**From:** Christine Braid CA-Citrus Heights
**To:** HCAI OHCA
**Subject:** Protect Access to Health Care, Reject 3% Cost Growth Target
**Date:** Monday, March 11, 2024 12:35:33 PM

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# MEMORANDUM

To: Megan Brubaker; OHCA@hcai.ca.gov

From:Christine Braid, DO

Subject: Protect Access to Health Care, Reject 3% Cost Growth Target

I stand ready to collaborate with OHCA to achieve our shared goals of improved affordability and access to high-quality health care. Unfortunately, office staff's recommendation for California's first statewide spending target does not adequately consider the factors driving health care spending growth, and in doing so jeopardizes patient care.

I am concerned that this unrealistic target will impact patient wait times which are already longer than acceptable. It will penalize physicians who care for complex patients with disabilities and chronic diseases. The most vulnerable of patients might not be able to find physician practices or medical groups able to take them and meet targets. Running a practice or medical group is already a daunting challenge given overall inflation rates, staffing shortages which drive up labor cost, supply costs and the cost of operating and maintaining our clinics. Government reimbursement has not not kept pace with inflation leading to difficult financial losses for many practices. I am deeply concerned that the current proposal will have a disproportionate impact on our ability to maintain access and provide high-quality care.

This target, which is based solely on the historical growth in household income, is overly narrow and fails to account for myriad factors that impact health care spending. To be credible, a target must not only consider but actually reflect these known factors: inflation; demographic factors, such as California's aging population; trends in labor and technology costs, such as the high costs of new pharmaceuticals and medical devices; and the overall cost of practicing medicine. In January, CMS projected the increase in the cost to practice medicine would be 4.6% in 2024 (Medicare Economic Index).

The proposed target falls well below current lived experience. Physicians are a critical part of our state's health care system and I am concerned that those operating in the red

will be penalized under this target. For CommonSpirit Health, meeting the proposed 3% target would mean reevaluating the services we provide, as well as care expansions and other investments we hope to make to improve our community's health and uncertainty over our ability to meet state mandates.

On top of these challenges, OHCA staff's five-year target recommendation seeks to prematurely establish an enforceable spending target by proposing to do so before OHCA has:

- Collected data to inform the establishment of a credible, attainable target
- Promulgated rules around how these data would be analyzed
- Laid out the rules for how entities would be held accountable for the targets

Given these outstanding issues, we question the prudence of adopting a five-year target before data become available and critical decisions have been made.

Making health care more affordable requires thoughtful, long-term planning. Maintaining access to care and equity must be considered when looking to set these spending growth targets. For example, a comprehensive focus on health equity has the potential to lead to long-term cost savings but requires significant up-front investments and reorganization of delivery models.

Unfortunately, this proposal would do the opposite — it would force cost-cutting measures at patients' expense. We ask the board to reject the OHCA staff proposal, and instead adopt a data-driven spending target that truly reflects the resources needed to provide life-saving care.

Sincerely,

**Dr. Christine Braid**

System VP, Physician Operations, Integration & Optimization

Medical Director of Billing and Coding, DHMF
Physician Lead E-Fill Pharmacy, DHMF

**CommonSpirit Health™**

*Executive Assistant: Michelle McBay*

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1500 East Duarte Road
Duarte, CA 91010-3000
Phone 800-826-HOPE
Fax 800-555-5555
CityofHope.org

March 1, 2024

Secretary, Dr. Mark Ghaly
Chair, Health Care Affordability Board
California Department of Health Care Access and Information
Sacramento, CA

To Dr. Ghaly:

On behalf of City of Hope, we thank you for the opportunity to submit comments regarding the growth targets being established by the board for the California Office of Health Care Affordability (OHCA). For the past 111 years City of Hope has been fiercely committed to the patients served each day. As one of the largest cancer research and treatment organizations in the United States, we ensure that leading-edge research, treatment, and care are accessible to patients, families, and communities throughout California and the nation. We work to close the gap between the innovations created and delivered at leading academic cancer centers and the needs of patients and families who frequently cannot benefit from these breakthroughs. City of Hope recently received the highest rating possible from the National Cancer Institute (NCI), the federal government's principal agency for cancer research and training. City of Hope is the only freestanding NCI-designated Comprehensive Cancer Center in California that is not affiliated with a university. The Centers for Medicare and Medicaid Services (CMS) recognizes the uniqueness and value of such independence and focus on oncology and has designated COH as one of only 11 prospective payment system (PPS)-exempt specialty cancer centers in the entire United States.

We deliver value to patients, communities, and society by unifying the branches of biomedical research, treatment, and academia to create innovations that save lives across the continuum and across this country. We iteratively advance the state-of-the-art in cancer care through our laboratory and clinical research. Beyond our principal NCI CCC cancer research hospital, we also have 34 locations throughout our five-county (Los Angeles, Orange, San Bernardino, Riverside, and Ventura counties), southern California service area. We have also invested more than $1 billion in the creation of the only cancer-focused research and clinical care hospital in Orange County, which will open in late 2025. As one of the birthplaces of biotechnology, City of Hope research is the basis for numerous breakthrough cancer medicines, as well as human synthetic insulin and monoclonal antibodies. City of Hope is a leader in blood and bone marrow stem cell transplantation; our program is now the largest in the nation with more than 19,000 transplants performed to date. Our center has the best record in the nation for serial high performance in the Stem Cell Therapeutic Outcomes Database's (SCTOD) annual transplant center survival outcomes report.

While we share and embrace OHCA's concerns regarding increasing health care costs, we are also deeply concerned by the potential, unintended, adverse consequences of the cost targets proposed by this board. When it comes to innovative cancer treatments and patients' optimal care needs, the plain truth is cancer care is different. Unlike other chronic conditions, cancer is not one disease but hundreds, with a uniquely vulnerable population of patients who navigate potentially lethal illnesses while having multifaceted care needs, including psychological and social. For Californians with cancer, the expertise, treatment options, supportive care services, and clinical trials available at academic cancer centers and the state's eight NCI CCCs may give them their best opportunity for survival.

We believe the board should consider how the broad application of cost targets to the state's NCI CCCs may undermine quality of care, exacerbate issues of access and thwart the development of new treatments that save lives. As a non-profit organization, City of Hope depends entirely on appropriate reimbursement and philanthropy to provide optimal care and discover future cures. Reduced revenues would force City of Hope and other academic cancer centers to potentially reduce investments in cancer research, differentiated services and advanced treatment technologies that turn cancer from a fatal illness into a manageable condition for so many Californians, especially while the costs of medical supplies and labor increase dramatically.

Cancer care is different in several ways. The following are several unique characteristics and attributes of CCCs that need to be considered when pursuing policies that are intended to augment the value of medical care:

**We make significant investments in creating the infrastructure and delivery systems for advanced care technologies which improve patient outcomes.** These include genomics and precision medicine which help to identify relevant biomarkers so that we effectively align patients with the optimal treatments or clinical trials. Between 2020 and 2023, COH invested $36 million (the vast majority of which was uncompensated) in its Center for Precision Medicine (CPM). The investment was designed to identify new targets for anti-cancer therapy, improve patient survival outcomes, and more effectively serve unmet cancer care needs. Through the CPM, City of Hope identifies new, impactful biomarkers so we can more effectively align patients with optimal treatments, life-saving clinical trials, and avoid treatments that we know would not be effective. Patients are therefore able to receive a level of care that would otherwise be unachievable without these investments.

In addition to developing diagnostics, another crucial role of centers like City of Hope is that they lead the development, implementation, and early adoption of new care technologies and discoveries. Our investment in these new clinical approaches subsequently translates into information and standards of care that will ultimately help community physicians throughout California in bringing these new technologies to their patients. Our impact therefore extends far beyond the boundaries of our campuses, improving access for patients who live outside the direct service areas of the Comprehensive Cancer Centers.

**We provide a breadth of services, including Supportive Care Medicine, that humanize the cancer patient's experience.** These services include pain and patient distress management, psychological support and family distress management, identification of goals of care, advanced directives support, end-of-life and hospice care transitions, and holistic/integrative treatments. In addition, we provide a broad set of non-reimbursable patient and family services that include multilingual health care literacy education, interpreter services, support groups, nutritional services, care resource navigation, child life programs, grief and bereavement support, couples counseling and education.

**We support a clinical trials enterprise that speeds access to care innovation, improves equity in care access, and advances therapeutic knowledge that will impact future patients throughout California.** City of Hope provides a portfolio of more than 400 interventional trials that include first-in-human, phase I, phase II, and phase III trials across the breadth of cancer types and unmet patient clinical needs. We are working to improve equity in clinical trials enrollment. City of Hope's trial enrollment data show a predominance of women enrolled on our therapeutic interventional trials and nearly half of patients enrolled in these trials are Asian, Black, or Latino. These exceed the benchmarks seen in many communities throughout this country. The data obtained from more equitable trial enrollment will result in reduced cancer care disparities in the future for all Californians.

**Should the OHCA board adopt the proposed 3% growth cap, then, we respectfully request that our state's eight NCI CCCs and leading academic cancer centers NOT be included under these caps.**

The state's eight NCI CCCs and leading academic medical centers are essential innovation hubs that are not just about cancer care delivery; they serve Californians through their deep investments in clinical research, therapeutic development, clinical trials, and early adoption of advanced care technologies that will eventually save the lives of patients throughout the state. Advances like chimeric antigen receptor (CAR) T-cells, bispecific T-cell engagers, targeted treatments for lung cancer and leukemia, and robotic surgery began their initial development and clinical use at these academic centers. These represent the first centers to develop treatment protocols and complication management strategies that are used by community physicians throughout the state. The cost of care at our essential innovation centers should not be subject to the same 3% proposed cost increase limits that might apply to the broader delivery system. The importance and impact of these CCCs should not be underestimated and they should not be considered only as hospital delivery systems; the full impact can only be understood when one recognizes their leadership role in the development and implementation of innovative, emerging, and advanced care technologies. While there is significant cost to some of the new discoveries, there is also cost saving, avoidance of ineffective drugs and lives saved. In the intermediate term, prices will come down for these treatments due to competition and improvement in science, and the broader delivery system will eventually deliver these life-saving therapies at a lower price point.

In addition, as our centers become referral centers for some of the most complex and advanced care technologies in existence, including gene therapies and next generational cellular therapeutics (like NK cells), it makes little practical sense to cap these centers' ability to make these therapies available to those in need. If these centers are capped, many innovations may sit on shelves as there are no centers able to take them on, stunting the speed of discovery. Further improvements in patient survival outcomes will depend upon patient access to emerging therapeutics based upon these core technologies as well as the next-generation biotherapies. The state's NCI CCCs and academic cancer centers are creating the means through which these new treatments will become available to all Californians.

Thank you once again for your consideration of our comments and for your efforts in shaping a healthcare system that fosters affordability, excellence, and compassion. We look forward to continued collaboration with creating a brighter future for greater healthcare equity in our nation.

Sincerely,

Harlan Levine, MD
President, Health Innovation and Policy

Joseph Alvarnas, MD
Vice President of Government Affairs
Professor, Department of Hematology & Hematopoietic Cell Transplantation

Peter Mackler
Executive Director, Healthcare Policy, and Advocacy

**CC: Members, Health Care Affordability Board**

March 11, 2024

Secretary Mark Ghaly, M.D.
Chair, Health Care Affordability Board
Department of Health Care Access and Information
202 West El Camino, Suite 800
Sacramento, CA 95833

**Re: Proposed Statewide Health Care Spending Target - Opposition to Current Recommendation**

Dear Secretary Ghaly and Members of the Health Care Affordability Board:

On behalf of our nearly 50,000 physician and medical student members, the California Medical Association (CMA) appreciates the opportunity to provide comments regarding the Office of Health Care Affordability (OHCA) staff recommendation of an annual 3% statewide health care spending growth target for 2025-2029.

This staff recommendation is based on the single economic indicator of the median household income growth from 2002 – 2022, which is unrelated to the increasing cost of practicing medicine. Adopting a 3% health care spending growth target, which most physician practices and health care entities will be unable to meet, will negatively impact access to health care for Californians, particularly for communities that have historically lacked equitable access to quality health care. CMA urges the Health Care Affordability Board (Board) to take the time to explore alternatives to the unrealistic staff proposal before casting the most important vote you are charged with making.

**The Cost of Providing Health Care and Historical Health Care Spending Growth Should Be Factored into the Target**

In December 2023, the Center for Medicare and Medicaid (CMS) projected that the increase in the Medicare Economic Index (MEI) – the cost to practice medicine - will be 4.6% in 2024. It is critical to consider, rather than ignore, the cost of providing health care when setting California's spending growth target. In the last CMA survey

of members, the majority of physician practices in this state were still worried about their financial health after the height of the pandemic was behind us. Setting a spending growth target that disregards the rate of inflation, increasing labor costs and those for necessities such as medical supplies and utilities is more likely to drive smaller practices to be acquired by larger, more costly health care systems than it is to save consumers money.

If the Board sets a target lower than the actual cost of providing health care to our aging population, providers will be pressured to reduce their provision of medically necessary care. If Californians cannot access care, patients, their employers, and taxpayers will be paying for insurance coverage they cannot use. Affordability is only meaningful if there is access to care. Moreover, if the state's spending growth target is unrelated to the cost of providing health care, it will be difficult to get buy-in from the health care entities subject to the cost targets to make changes that are within their power without coming at the expense of quality patient care.

Further, the average annual growth in per capita health care spending should be considered when setting a spending growth target. According to CMS for California, the 10-year average annual change in per capita health care spending from 2010-2020 was 4.7%, and the 20-year average annual change in per capita heath care spending from 2000-2020 was 5.4%. It is unfeasible to meet a 3% health care spending growth target considering that CMS estimates the cost to practice medicine in 2024 will grow by 4.6% and the average annual change in per capita health care spending was no less than 4.7% in the 20 years from 2000 – 2020.[1]

As has been mentioned by many witnesses testifying before you and by members of the OHCA Advisory Committee, the rate of household income growth is unrelated to the factors driving cost increases in health care. Additionally, the choice by OHCA staff to use the median household income over 20 years (with years that include the greatest recession since the 1920s) would result in a 3% target that is artificially low. If the Board continues down the questionable path of using median household income as the sole factor in determining the spending growth target, it would be more appropriate to look at the median income over the last ten years, which is 4.1%,

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[1] State Health Expenditure Accounts by State of Residence, 1991-2020, Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trendsand-reports/national-health-expenditure-data/state-residence.

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and the current projection for median household income growth for 2026, which is 3.6%.

### Access to Care Needs to Be Considered Along with Affordability

Health care affordability is a concept that does not and should not exist in a vacuum. SB 184, Chapter 47, Statutes of 2022 that created the Office of Health Care Affordability specifically names "Access, Quality and Equity of Care" among its goals. These three priorities coupled with affordability are the quadruple aim of the Office of Health Care Affordability. Currently, many Californians already have difficulty getting timely access to health care. Covered California's narrow provider networks were recently raised as a concern by an OHCA board member, followed by the statement from another Board member that those with large employer coverage are also having trouble getting timely appointments with specialists. A 3% target put in place for 5 years will undoubtedly result in longer wait times for most California patients.

### Health Care Growth Spending Targets in Other States

The statements that have been made at your Board meetings that could lead one to believe that California is simply replicating what has worked in other states omit most of the relevant facts. CMA strongly encourages you to look at the health care spending growth targets that were initially adopted in other states, what factors informed their decisions, and how those targets have been modified since initial adoption. No other state has set its initial spending growth target as low as 3%. For example, in 2013 in Massachusetts, the health care spending growth target was set at 3.6%, based on the state's estimated potential growth state product (PGSP). Then it was lowered to 3.1% in 2018 (PSPG -.5%), and then the target was increased to 3.6% in 2023.[2] PGSP is comprised of several economic factors, including the expected growth in national labor force productivity, state labor force, national inflation and state population growth. Delaware set its benchmark for 2019 to 3.8% via Executive Order. Oregon's benchmark was determined by the state's Sustainable Health Care Cost Growth Target Implementation Committee. It considered PSPG, wage and personal income growth and set its cost growth target at 3.4% for 2021–2025 with a

[2] Joel Ario, Kevin McAvey, and Amy Zhan, State Benchmarking Models: Promising Practices to Understand and Address Health Care Cost Growth, Manatt Health, June 2021.

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planned reduction to 3.0% for 2026–2030. Connecticut set a 3.4% cost growth benchmark that is a blend of the growth in per capita PGSP and the forecasted growth in median income of state residents, with a recommended reduction to 3.2% for 2022 and 2.9% for 2023–2025. And as mentioned by OHCA's consultant at the February 2024 Board meeting, these other states set their targets before the current inflationary situation and there is little optimism about states meeting the targets set for 2023 and 2024.

Based on a review of five other state spending targets, it appears that California is contemplating setting an overly ambitious and unobtainable target at the outset, rather than where other states set their initial targets. As you begin your work with health care entities to attempt to meet spending growth targets, we urge you to consider the increasing cost of providing care. Your initial spending growth target should be one that health care entities can achieve without reducing access to quality care. Instead of starting at an unrealistic place, we suggest that the Board set the spending growth target for 2025 at a level that considers the increased costs of providing care and then you can lower the percentage over time. Additionally, given that the Board has currently only considered one option and California has no experience with this yet, we think that setting spending targets for five years is ill-advised.

## Consolidation Implications

According to a 2019 California Health Care Foundation Report, prices for both inpatient and outpatient services increase when there is more market concentration or consolidation[3]. If the Board sets the health care growth spending target too low, high-cost outliers will continue to be just that – high-cost outliers and smaller entities will give up and be swallowed up by larger, often more expensive systems. Setting the targets too low will drive the very consolidation that leads to increased health care costs that you hope to prevent.

## Implications of SB 525 and MCO Tax Should Be Considered

Last year, the Governor signed SB 525 (Durazo) which will increase the minimum

[3] Richard Sheffler, Daniel Arnold, Brent Fulton, Health Care Prices and Market Consolidation in California, California Healthcare Foundation, October 2019. https://www.chcf.org/publication/the-skys-the-limit/#market-concentration

wage for health care workers to $25 an hour over a series of years depending on the health care setting. For integrated healthcare systems with 10,000 employees or more and dialysis clinics, or county-operated health care facilities with a population of more than 5 million by January 1, 2023, the minimum wage will increase to $23 an hour beginning June 1, 2024, increase to $24 an hour on June 1, 2025, and to $25 an hour on June 1, 2026. For hospitals with a high governmental payor mix, an independent hospital with an elevated governmental payor mix, a rural independent covered health care facility, or a covered health care facility that is operated by a county with a population of less than 250,000 as of January 1, 2023, the minimum wage for covered health care employees shall be $18 per hour from June 1, 2024 and must increase incrementally to $25 per hour beginning June 1, 2033. Regardless of the exact timeline of SB 525 implementation, state law ensures that health care entities will have increased labor costs going forward and this fiscal reality should be taken into consideration when adopting a health care spending growth target.

In addition, a new Managed Care Organization (MCO) Tax was enacted in 2023 and will provide much needed rate increases for Medi-Cal providers for the first time in 30 years to increase access to care for the one in three Californians who are enrolled in Medi-Cal. The Coalition to Protect Access to Care worked with the Administration and the legislature to make this historic investment in the Medi-Cal system a reality. Over $1 billion annually of this spending will be new investment in primary care, aligned with the call in OHCA statute for increased investment in primary care. All of the new revenue from the MCO tax that will be invested in Medi-Cal and workforce expansion will help to increase access to care, particularly for low-income Californians. Failing to account for this critical new spending that will improve access to care for Californians when setting the spending growth target undermines all of the work we are collectively doing to improve patient care in the Medi-Cal system.

### Putting Cost Targets in Place for Five Years Before Any Data Available

The proposal to keep a 3% target in place for five years is too long a timeframe for an initial spending target. California's lack of experience with collecting the data and calculating Total Health Care Expenditures for the state, let alone setting and maintaining a spending growth target, is among the arguments for setting targets that last for no more than two or three years. While predictability is important, it is critical that the Board gain information and employ some of the flexibility that was discussed during the Senate Rules Confirmation hearings and in your February

Board meeting to adjust targets when appropriate. Sector-specific targets may be warranted, and if so, the Board should begin work on those for implementation in as early as 2026.

**Revise Proposal: Consider Economic Factors That Impact the Cost of Health Care Delivery**

CMA strongly recommends that the Board reject the staff's recommendation of a 3% annual statewide health care spending growth target because it is both unrealistic and does not take into consideration critical factors such as the actual cost of providing health care such as labor costs, supply costs, medical equipment costs and inflation.

We urge the Board to set a cost target for 2025 that considers the economic realities of today, and the next 18 months, rather than reaching back to the Great Recession that lasted from 2007-2009 and including household income growth during that period to arrive at an artificially low spending growth target unrelated to costs today.

The Board's cost target should be set at a level that is attainable for most health care entities without patient care suffering as a result, rather than creating a situation where health care providers universally fail to meet the cost target and the state moves no closer toward achieving the goals that led to the creation of OHCA.

CMA urges the Board to consider the spending target's impact on more than just the hope of affordability. This spending target will have real-life impacts on patient access and quality of care. It would be counterproductive to sacrifice quality and access to care.

We look forward to continuing to work with you on this and other critical issues before the Office of Health Care Affordability Board this year and beyond. For more information or questions, please contact us at (916) 551-2560.

Sincerely,

Tanya W. Spirtos M.D.

Tanya W. Spirtos, M.D.
President
California Medical Association

CALIFORNIA MEDICAL ASSOCIATION

cc: Elizabeth Landsberg, Director of the Department of Health Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Megan Brubaker, Engagement and Governance Manager, Office of Health Care Affordability

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To: The Honorable Dr. Mark Ghaly, MD, Chair HCAI Board
Members, HCAI Board
Members, HCAI Advisory Board
Re: Proposed Emergency Regulations re statewide spending target
Date: February 25, 2024

Dear Chair and Members,

On behalf of the California Orthopaedic Association, I write with respectful concerns about the proposed 3% statewide spending growth target.

This target is based on expected wage growth for health care consumers, rather than on the actual cost drivers of health care. We fear that this focus on affordability without simultaneously considering access will potentially make our access issues even worse than they are now.

We suggest that the statewide spending growth target come after careful review of the actual drivers of health care cost in California – the cost of health care salaries, the cost of prescription medicines, the cost of technologies, the cost of hospital care, and so on. De-linking cost drivers from spending growth targets will not make sound public policy.

We are also concerned that keeping the 3% growth target for five years is too long for a new program with a new target and would suggest reviewing it after two years to adapt to potentially changing situations.

We urge reconsideration.

Sincerely,

Kim Stone

Kim Stone
Lobbyist, Stone Advocacy for COA

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January 24, 2024

***Via Email and U.S. Mail***

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

Re: ***Proposed Spending Target – January 24 OHCA Board Meeting***

Dear Dr. Ghaly:

The Office of Health Care Affordability Board is considering the first ever Statewide Spending Target under SB 184. In its proposal OHCA states its preference to tie this target to a consumer-centric indicator such as the unweighted average annual change in median household income. Certainly, this sounds like a reasonable approach—if consumers are impacted by rising healthcare costs, looking at household incomes is an indicator of one data point.

Section 127502(d)(4) of the Health and Safety Code provides that OHCA should also consider:

> The healthcare employment cost index, labor costs, the consumer price index, impacts due to known emerging diseases, trends in the price of healthcare technologies, provider payer mix, state or locate mandates such as required capital improvement projects and any relevant state and federal policy changes impacting benefits, provider reimbursement and costs.

The 3% proposal considers none of these factors.

Over the next five years, the Legislative Analyst's Office projects inflation to be 3.5% annually. OHCA's proposed spending target would dictate a decline in real health care spending of 0.5% over time. If this target is approved, hospitals and other providers will find themselves not only unable to afford medical supplies and infrastructure updates, but also hamstrung in their ability to compete with other states and sectors for workers.

There are many external factors that directly impact cost of care that hospitals and other health care providers cannot control. Here are some examples:

1. **Wages for healthcare workers:** As reimbursements have declined, historic pandemic-related inflation exponentially (and unexpectedly) increased our costs of operation. With the unprecedented shortage of healthcare workers, especially in Santa Barbara County, staffing costs have increased dramatically. Since 2019, our labor costs have increased 21%. As just one example, in 2022 our cost for temporary nurses (travelers) increased by 56%--following three years of double-digit increases. SB 525 established a new minimum wage for healthcare workers. Governor Newsom's office estimates that this will increase costs by $4 billion. For Cottage Health, this represented approximately $4 million in additional costs in the first year alone. These increases far exceed the 3% spending target.

2. **Technology Costs:** Technology is an imperative for healthcare providers. State and federal regulations require healthcare providers to have electronic medical records. The state of California recently implemented data sharing regulations that require hospitals to have systems and technology that are both secure but also facilitate ready sharing of information with other healthcare providers. All of these mandated systems drive healthcare costs. Approximately 7% of the Cottage Health budget is allocated to technology costs, which is an increase from prior years.

3. **Operational Costs:** Inflation did not let up in 2023. In *January 2023 alone*, our utility expenses were $1.2 million higher than the prior year. Gas accounted for $468,000 of these costs. These unanticipated cost increase were not forecast in our budget for the year.

4. **Unfunded Seismic Compliance Mandate:** Cottage Health has spent more than $1 billion on construction upgrades to its hospitals to comply with California seismic compliance requirements. The state did not provide any funding to hospitals to meet these seismic requirements. This is yet another cost that hospitals do not control.

We understand that the Board has requested additional data from OCHA to evaluate the proposed spending target, but that this data has yet to be provided. Specifically, we understand that data was requested about how the spending target will take into account rising labor costs. This important data is critical to understanding the impact of a spending target on the state's healthcare system and whether providers will be able to continue to operate in a constrained environment. Furthermore, a spending target divorced from the costs of care (e.g., labor costs and technology costs specifically) does not comply with SB 184.

California hospitals are taking a close look at the grim financial reality and determine whether to reduce, restructure or eliminate services. Most hospitals in our state are facing similar financial challenges and some are even considering closure. None of us anticipated the closure of Madera Community Hospital in December 2022, which was devastating for Madera County. A 2023 report by the national consulting firm Kaufman Hall affirmed that there are many other hospitals facing the same fate. This is not a theoretical threat. Therefore, any spending target must account for the increased cost of providing healthcare, especially labor, construction and supplies (and pharmaceuticals). Looking exclusively at the unweighted average annual change in median household income does not adequately reflect external drivers of cost.

Cottage Health urges the OHCA Board to carefully consider the proposed spending target and to ensure that all factors driving hospital costs are taken into consideration. We would welcome an opportunity to meet with you and share more about Cottage Health's commitment to our community and the financial challenges we are experiencing.

Very truly yours,

Stacy Bratcher
Senior Vice President & Chief Legal Officer/Government Relations
Cottage Health

**From:** [redacted] on behalf of Covell Meyskens
**To:** HCAI OHCA
**Subject:** Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
**Date:** Monday, February 12, 2024 2:54:14 PM

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CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board,

Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.

I support the Office of Health Care Affordability's suggested statewide spending target of at most 3% without any further delays and without population or new technology adjustments. This target makes sure that health care costs don't outpace what every day Californians like myself can afford. I hope this board keeps my story in mind while making their decisions so Californians can better afford the health care we need to thrive.

Sincerely,
Mr. Covell Meyskens

March 11, 2024

Health Care Affordability Board
Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833

**RE: Proposed Statewide Health Care Spending Target**

*Sent via email to OHCA@hcai.ca.gov*

Dear Health Care Affordability Board Members,

On behalf of our nearly 1,300 community health centers (CHCs), the California Primary Care Association (CPCA) would like to thank you for considering comments on the Office of Health Care Affordability (OHCA) staff recommendation of an annual 3 percent statewide health care spending growth target for 2025-2029. CHCs provide high-quality, comprehensive, coordinated, accessible, equitable, patient-centered care to more than 7.7 million Californians and to 1 in 3 Medi-Cal patients. CHCs also provide care to California's diverse populations, with about 68 percent of CHCs patients at or below 138 percent of the Federal Poverty Level (FPL) and more than 70 percent of patients being people of color.

CPCA supports ensuring health care is accessible and affordable for all Californians, particularly given that by their very mission, CHCs provide culturally and linguistically diverse services to low income and non-English speaking communities. However, we urge the Board to provide clarity on how the following areas will be taken into account in the statewide health care spending target.

**Investments in Primary Care**

It is unclear from the proposal how the statewide spending target will be applied to individual providers. Clarity on the methodology is especially critical for primary care providers given the historic underinvestment in primary care and the statewide efforts to increase primary care spending. Decades of research have consistently proven that greater investment in primary care services are associated with more equitable outcomes, lower total cost of care, and better quality of care, including lower mortality, fewer hospitalizations, and enhanced patient satisfaction.[1] Despite this strong investment, California spends from 6.1 percent to 10.8 percent on primary care, while the average among OECD countries is 14 percent.[2] Moreover, the COVID-19 pandemic further strained an already overwhelmed and understaffed

[1] Barbara Starfield, Leiyu Shi, and James Macinko, "Contribution of Primary Care to Health Systems and Health," The Milbank Quarterly 83, no. 3 (Sept. 2005): 457–502.
[2] Investing in Primary Care: A State-Level Analysis, Patient-Centered Primary Care Collaborative and Robert Graham Center (July 2019), available at https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019.pdf.

primary care system.[3] As a result, there have been numerous statewide efforts to increase primary care spending. For instance, one of the responsibilities of this Board is to promote high value system performance, which includes allocating greater spending upstream to primary care and other preventive services. Medi-Cal and Covered California have also recognized the need to strengthen primary care to improve access and quality of care received by Medi-Cal and Covered California enrollees, respectively. The Department of Health Care Services (DHCS) made prevention and primary care the foundation of its recently adopted five-year quality and equity strategy. Both DHCS and Covered California require plans to report on primary care spending as a percentage of total spending and will explore setting targets for minimum primary care spending.[4] To further promote, greater investment in primary care, last year the Legislature passed AB 118, partially codified in Welfare & Institutions Code sections 14105.201 and 14105.202, requiring rate increases for primary care, obstetric (including doula), and non-specialty mental health services for Medi-Cal providers. We urge the Board to clarify how these increased investments in primary care will be taken into account in the statewide health care spending target.

**Medicare Economic Index (MEI)**

Under federal law, Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, and Rural Health Centers (RHCs) are paid based on a Prospective Payment System (PPS). Under PPS, FQHCs, Look-Alikes, and RHCs are paid a predetermined rate that encompasses reimbursement for all services provided during a single visit, and it is adjusted annually by the percentage increase in the MEI applicable to primary care services. In 2023, the MEI was 3.8 percent and in 2024 it is projected to be 4.5 percent, which is above the proposed statewide spending target. As mentioned above, it is unclear how the statewide spending target will be applied to individual providers and how the annual MEI adjustments to PPS rates will be taken into account in the target.

**Medi-Cal Expansion and New Medi-Cal Benefits and Services**

Beginning January 1, 2024, California will allow adults ages 26 through 49 to qualify for full-scope Medi-Cal, regardless of immigration status. The State estimates 700,000 individuals will become newly eligible for Medi-Cal. Given that CHCs provide care to 1 in 3 Medi-Cal patients, costs for providing care will increase for CHCs. In addition, California has added several new benefits and services for Medi-Cal enrollees. Some of them are part of California Advancing and Innovating Medi-Cal (CalAIM), and others are new Non-Specialty Mental Health Services (NSMHS). Implementation by CHCs of these new benefits and services for Medi-Cal patients will increase also costs for CHCs. It is unclear from the proposal how these increased costs due to Medi-Cal Expansion and new Medi-Cal benefits and services will be factored into the statewide spending target.

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[3] Melissa K. Filippi et al., "COVID-19's Financial Impact on Primary Care Clinicians and Practices," Journal of the American Board of Family Medicine 34, no. 3 (May 2021): 489–97.

[4] Comprehensive Quality Strategy (PDF), Department of Health Care Services, 2022; Attachment 1 to Covered California 2023-2025 Individual Market QHP Issuer Contract: Advancing Equity, Quality, and Value (PDF), Covered California, 2023-2025.

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Thank you for the opportunity to provide comments on the proposed statewide health care spending target. We look forward to working with the Board and other stakeholders to ensure we achieve our collective goal of ensuring health care is accessible and affordable for all Californians while also ensuring we are continuing to provide greater investments in primary care. For clarification or additional information regarding CPCA's comments, please contact me at lsheckler@cpca.org.

Respectfully submitted,

Dennis Cuevas-Romero
Vice President of Government Affairs
California Primary Care Association

ACCESS
REPRODUCTIVE JUSTICE

ARI
Community
Services

CALIFORNIA IMMIGRANT
POLICY CENTER

California Pan-Ethnic
HEALTH NETWORK

The Cambodian Family

Chispa

Korean
Community
Center
of the East Bay

Nourish
California

SAN DIEGO REFUGEE COMMUNITIES COALITION

SEARAC

March 11, 2024

Dear OHCA Board Members –

The undersigned organizations write to you on behalf of millions of Californians ***in strong support of the 3% cost growth target for health care spending for five years from 2025 to 2029 as proposed by the Office of Health Care Affordability.***

For too long, communities of color have been left out of health care, unable to access even basic health insurance or preventive care. The Affordable Care Act (ACA) significantly helped to close the coverage gap, cutting uninsurance rates by more than half for Asian Americans and Blacks between 2013 and 2015 and reducing rates for Latine at slightly lower rates.[i] In January 2024, California moved us even closer as a state to achieving universal coverage, by authorizing all income-eligible individuals to access Medi-Cal, regardless of immigration status.

**Rising health care costs are threatening access to care:** While we applaud these critical steps, rising healthcare costs have negatively impacted access to critical healthcare services even for those with insurance. On average, health care spending by families has increased twice as fast as wages.[ii] About one in four Californians (27%) say they or someone in their family had problems paying at least one medical bill, such as a bill for doctors, dentists, medication, or home care in the past 12 months; Latine Californians are most likely to experience problems paying for medical bills (40%), followed by people who are Black (36%), White (20%), or Asian (17%).[iii]

**Lack of affordability has resulted in poorer health outcomes, particularly for communities of color:** A 2022 survey, for example, found that half of Californians (52%), reported skipping or delaying health care due to cost in the past 12 months. People who are Black (67%) or Latine (53%) were more likely to skip or delay care than those who are White (47%) or Asian (35%). Of those who skipped or delayed care, half of them (50%) say their condition got worse as a result. [iv]

This is an enormous problem for the individuals and families we represent including community members who can't afford to pay for their rising premiums, are unable to pay for emergency room visits or for preventative, life-saving medications like insulin. We have heard these and other stories of community members who have to work three jobs just to pay for cancer treatments or simply forgo health care or health insurance only to wind up thousands of dollars in debt.

**Medical Costs are the Main Driver of our Health Care Affordability Crisis:** Over the past ten years, health care spending in California shot up 60%, reaching $405 billion or $10,299 per person in 2020. This in turn has led to higher premiums and deductibles, which have risen faster than family incomes. Between 2010 and 2018, health insurance premiums for job-based coverage increased more than twice the rate of growth for wages. More specifically, median

household income grew an average of 3% each year, while health care premiums and deductibles rose an average of 7% and 9% each year, respectively.

**California must improve health care affordability NOW:** OHCA's proposed 3% cost growth target is desperately needed TODAY to help California families who are insured be able to use their health insurance. This includes the majority (close to 90%) of Covered California enrollees who receive health care subsidies and are people of color.

*The proposed spending target is not a reduction or a freeze on spending.* It would simply require the healthcare industry to compete within the same constraints as a median California family does. This is especially critical given the concentration of California's health care market, which makes it impossible for average consumers to shop around or say no, while allowing industry leaders to set prices with little relation to the cost or quality of care, or patient outcomes.

*OHCA's 3.0% spending target, puts California squarely in the same range as other states*. Other states with cost commissions have targets for 2024-2027 in the range of 2.8%-3.3%. A target of 3.5% or 4% would be far higher than the targets in other states.

OHCA has a responsibility to set a target that would at least prevent care and coverage from getting even more unaffordable. We urge the Board to stand with consumers and vote in support of OHCA's January 2024 recommendation for a 3% spending target. This target will help California strengthen health care quality and achieve more equitable care.

Thank you for your consideration of these comments.

Sincerely,

Access Reproductive Justice

Asian Resources Inc.

California Immigrant Policy Center (CIPC)

California Pan-Ethnic Ethnic Health Network (CPEHN)

Chispa

Korean Community Center of the East Bay (KCCEB)

Nourish CA

San Diego Refugee Coalition

Southeast Asia Resource Action Center (SEARAC)

The Cambodian Family

[i] "Federal Health Care Reform Generated Broad Coverage Gains Through 2015," but These Gains Are Now in Jeopardy". November 2016. Center on Budget & Policy Priorities. http://calbudgetcenter.org/resources/federalhealth-care-reform-generated-broad-coverage-gains-2015gains-now-jeopardy/

[ii] "Tracking the rise in premium contributions and cost-sharing for families with large employer coverage," Kaiser Family Foundation, August, 14. 2019. https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/#Percent%20of%20total%20family%20health%20spending%20contributed%20by%20worker,%202008%20and%202018

[iii] The 2023 CHCF California Health Policy Survey, February 2023: https://www.chcf.org/wp-content/uploads/2023/02/2023CHCFCAHealthPolicySurvey.pdf

[iv] The 2023 CHCF California Health Policy Survey, February 2023: https://www.chcf.org/wp-content/uploads/2023/02/2023CHCFCAHealthPolicySurvey.pdf

[v] "Is California breaking its promise to cut health care costs?" by Kristen Hwang, CalMatters, February 21, 2023. https://calmatters.org/health/2023/02/health-care-costs/