



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



Public Comments Submitted Regarding OHCA Proposed Spending Target

Part 2

Table of Contents

Children's Specialty Care Coalition	3
California Society of Pathologists	5
Danny Tascione	10
David Hann	11
Deborah Temple	12
Denise Walker	13
District Hospital Leadership Forum	14
Diana Mireles	20
Diego Gollas	21
Dignity Health- California Hospital Medical Center	22
Dignity Health- Inland Empire	24
Dignity Health- Dominican Hospital	26
D.Q. Neyhart	28
El Centro Regional Medical Center	29
Elena Santamaria	31
Ellen Wade	32
Emilia Ruiz	33
Emma Lenz	34
Eric Devezin	35
Ernest Villicana	36
Esther Zamora	37
Evette Betancourt	38
French Hospital Medical Center- Dignity Health	39
Gabrielle Swanberg	41

George Haslam- Ridgecrest Regional	42
Kristin Gershfield- Vituity Hospital	44
Glen Brunner	46
Graciela Valentin	47
Greg Light	48
Health Consumer Alliance	51
Health Access California	53
Helen Fahey	64
Helen Mlynarski	65
Hemophilia Council of California	66
Hitesh Shah	68
Irma Galindo	69
James Kawamura	70
James Suver- Ridgecrest Regional	71
Janet Heinle	73
Jason Pullen	74
Jessica Twitty	75
Jill B	76



Children's Hospital Los Angeles
Medical Group

California Association
of Neonatologists

ChildNet/Specialty Medical Group
Valley Children's Hospital,
Madera

Sutter Children's Center
Sutter Medical Center, Sacramento

Children First Medical Group,
Emeryville

Rady Children's Specialists of
San Diego

Department of Pediatrics
California Pacific Medical Center
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UCLA Mattel Children's Hospital
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UC San Diego School of Medicine

Stanford Children's Health
Stanford University School
of Medicine

Department of Pediatrics
UC Davis Children's Hospital

Department of Pediatrics
UCSF Benioff Children's Hospital
UC San Francisco School of Medicine

Department of Pediatrics
UC Irvine Medical Center

Department of Pediatrics
Loma Linda University Faculty
Medical Group, Inc.

Miller Children's and Women's
Hospital Long Beach

CHOC Children's Specialists, Orange
County

Cottage Children's Medical Center -
Santa Barbara

Shriners Hospitals for Children -
Northern California

Community Regional Medical Center,
Fresno

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

Re: Proposed Statewide Health Care Spending Target - CONCERNS

Dear Ms. Brubaker,

On behalf of the Children's Specialty Care Coalition, I am writing to express our concern regarding the proposed plan by the California Office of Health Care Affordability (OHCA) to set a 3% spending target beginning next year and extending through 2029, which threatens to have negative consequences for access to care for children and youth with medical complexity, a population that already struggles to receive timely care.¹ The potential consequences of OHCA's proposed 3% spending growth target appears to prioritize cost containment over patient access to high-quality care.

Although OHCA was established with the intention of curbing healthcare cost growth while ensuring continued access to high quality treatments and services, it is evident that the proposed spending target fails to strike a healthy balance between the two. The singular focus on aligning the growth target with median household income over the last 20 years fails to take into account the rampant inflation in recent years, rising labor costs, and high-cost drugs, among other factors. We are significantly concerned that new cost-reduction strategies have the potential to harm California's sickest children.

Children and youth with chronic and complex conditions are living longer than ever before due to advancements and breakthroughs in treatments. This includes recent high-cost drugs and therapies to treat conditions like hemophilia and sickle cell disease. New emerging treatments can cost hundreds of thousands of dollars, to upwards of \$2 million per dose. Pediatric specialty physicians at children's hospitals and medical centers provide life-enhancing and life-saving care to our state's sickest, and a 3% spending growth target would constrain their ability to provide these treatments to children who need them, without exceeding this arbitrary spending target.

At the same time, the pediatric specialty care workforce is also facing a growing crisis. Access to pediatric specialty care is rapidly deteriorating, with one third of families of children with special health care needs in California waiting over three months for a new specialty care appointment.²

¹ Fact Sheet: California's Children Need Access to Pediatric Subspecialists - <https://childrens-coalition.org/wp-content/uploads/2023/04/5.-Access-to-Care-Infographic.pdf>

² Fact Sheet: Access to Care in California The CYSHCN Family Experience - <https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Impacts-of-Delays-in-Care-Factsheet-24-0208.pdf>

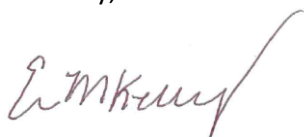
Moreover, there are concerning trends related to the pipeline of pediatric subspecialists with an increasing number of non-procedural based subspecialty fellowship slots going unfilled.³ These trends largely stem from low and stagnant Medi-Cal reimbursement rates, which are slowly eroding providers' ability to recruit and retain a sufficient workforce to meet the current demand. Recently prominent organizations, including the National Academies of Sciences, Engineering and Medicine, and the American Academy of Pediatrics have called upon state and federal governments to bring all pediatric rates at or above parity with Medicare.^{4,5} The OHCA recommendation does not take into consideration the inadequacy of Medi-Cal rates and the need to infuse more dollars into stabilizing this fragile network that has been underfunded for the last two decades.

By prioritizing cost containment over patient needs, OHCA risks setting a dangerous precedent that could further marginalize individuals, including children, with complex and chronic conditions. We are concerned that a focus on a 3% cost containment will harm this vulnerable patient population.

While we applaud OCHA for focusing on making health care more affordable, we urge the Board to reject the 3% target, and for OHCA to reconsider its approach in terms of this ambitious target and carefully consider the needs of children with rare diseases and their families in the target-setting process. It is imperative that any spending target be developed in close coordination with stakeholders to ensure it is based on the appropriate data which considers the underlying drivers of healthcare costs. By doing so, OHCA can ensure that California's healthcare system remains accessible, high-quality, and equitable for all residents.

CSCC represents over 3,000 pediatric subspecialty care physicians throughout California, and our mission is to ensure that children and youth with complex health care needs have access to equitable, timely and high quality care, provided by pediatric specialists who are able to thrive in California's health care environment, through strong leadership, education and advocacy. Thank you for considering our concerns.

Sincerely,



Erin M. Kelly, MPH
Executive Director
Children's Specialty Care Coalition

CC: David M. Carlisle, MD, PhD, Health Care Affordability Board Member
Sandra Hernández, MD, Health Care Affordability Board Member
Richard Kronick, PhD, Health Care Affordability Board Member
Ian Lewis, Health Care Affordability Board Member
Elizabeth Mitchell, Health Care Affordability Board Member
Donald B. Moulds, PhD, Health Care Affordability Board Member
Richard Pan, MD, MPH, FAAP, Health Care Affordability Board Member
Health Care Affordability Advisory Committee Members

³ Match Results Statistics Medicine and Pediatric Specialties – 2023 - <https://www.nrmp.org/wp-content/uploads/2023/11/2023-MPSM-Match-Results-Statistics-Report.pdf>

⁴ The Future Pediatric Subspecialty Physician Workforce: Meeting the Needs of Infants, Children, and Adolescents, September 2023 - <https://nap.nationalacademies.org/catalog/27207/the-future-pediatric-subspecialty-physician-workforce-meeting-the-needs-of>

⁵ AAP – Medicaid Payment - <https://www.aap.org/en/advocacy/state-advocacy/medicaid-payment/#:~:text=AAP%20Position&text=The%20AAP%20supports%20efforts%20at,least%20equivalent%20with%20Medicare%20rates>



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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 California Society of Pathologists (CSP), we appreciate 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. CSP 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 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 cost of providing health care when setting California's spending growth target. In the last CSP 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 health 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. CSP 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

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

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 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 consolidation³. 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 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,

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>

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 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 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

CSP 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.

CSP 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 the lobbyist for CSP, Ryan Spencer, at (916) - 396-9875 or rspencer@rgsca.com.

Sincerely,

A handwritten signature in black ink, appearing to read 'Emily Green', with a stylized flourish at the end.

Dr. Emily Green
President
California Society of Pathologists

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

From: [REDACTED] on behalf of [Danny Tascione](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Monday, February 12, 2024 2:14:56 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,
Mrs. Danny Tascione

[REDACTED]

From: [DAVID Hann](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Friday, February 16, 2024 10:32:14 AM

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board Members,

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

My health care costs entirely too much each 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,
DAVID Hann

[REDACTED]

United States

From: [REDACTED] on behalf of [Deborah Temple](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Monday, February 12, 2024 1:43:22 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,

Because I have ME/CFS (Myalgic Encephalomyelitis/Chronic Fatigue Syndrome), which is akin to Long Covid, I need specialty care, specialty lab tests. Most of this healthcare is provided by specialists who know more than the regular medical community about chronic, complex, infection-related illnesses. My illness caused me to lose my ability to work when I was 43, clearly robbing me of the life I was in & the future I had planned & hoped for.

Most of the specialists who can go the extra mile with these lesser known illnesses don't even take insurance. I'm very lucky to have quite good insurance, thanks to my 20 years serving as a specialist in the public schools. Why, as a life-long, still tax-paying, citizen, can't I seek out & get the life-enhancing medical & health care I need? In a country that takes pride in calling itself the best on the planet?

We're in very big trouble.

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. Deborah Temple

[REDACTED]

From: [Denise Walker](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Thursday, February 15, 2024 10:40:22 AM

CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board Members,

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

My health care costs me more than \$2000 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,
Denise Walker

[Redacted Signature]

United States



DISTRICT HOSPITAL LEADERSHIP FORUM

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
Email: OHCA@hcai.ca.gov

Subject: DHLF Comments on the Proposed Statewide Health Care Spending Target Recommendations to the Board

Dear Ms. Brubaker:

On behalf of California's 33 district and municipal hospitals, the District Hospital Leadership Forum (DHLF) appreciates the opportunity to provide comments on the Office of Health Care Affordability (OHCA) staff recommendation for a proposed statewide health care spending target. **OHCA staff's recommendation does not adequately consider the factors driving health care spending growth, nor does it consider significant investments needed in health care (e.g., Medi-Cal program). Unfortunately, if the OHCA Board were to adopt the proposed staff recommendation of a 3% annual target over 2025-2029, underserved communities would experience reductions of essential health care services, potentially exacerbating health disparities and perpetuating inequality for low-income Californians.**

District and municipal hospitals, with publicly elected Boards of Directors, are proud to be local governments responsible for providing the health care needs of their communities. Over two-thirds are considered rural, and more than half have a critical access hospital (CAH) designation. On an annual basis, approximately 50% of their inpatient days are for services provided to Medi-Cal beneficiaries, collectively they deliver 20,000 babies, and provide over 3.5 million outpatient visits. They serve as the safety-net providers in their communities with few alternatives—providing health care services to significant levels of uninsured and Medi-Cal patients.

District and municipal hospitals are grateful for the Administration and Legislature's swift action in 2023 to establish the Distressed Hospital Loan Program (DHLP). **More than 30% of district and municipal hospitals qualified as distressed and received DHLP loans totaling more than 50% of the available funds in the program.** Given that district and municipal hospitals only represent 8% of hospitals statewide, qualifying for this level of support with short-term loans should provide a current financial status for these providers and the inherent risk of access to health care in the communities they serve. The concerns from our hospital leaders stated below are not intended to paint worst case scenarios—they are concerns founded on this reality for health care in many rural and underserved communities in our state.

OHCA's proposed 3% annual target fails to account for the impact to access and quality of health care for Californians—especially, those in underserved areas that district and municipal hospitals serve.

Feedback from district and municipal hospital leaders is clear—adopting a 3% annual target will have *dire effects* on the health of communities in which they serve. Fundamentally, if the OHCA Board adopts a 3% annual target they are assuming that all existing health care spending and investments occurring today are happening in the right place and at the right levels. That means, funding for programs like Medi-Cal—which provides health care to more than 1 out of 3 Californians or 1 out of 2 children in California—are at sustainable levels today.

As evident by the Governor himself with the most recent budget proposals, this could not be further from the truth. ***Significant new spending is needed to transform the Medi-Cal program and place it on a sustainable pathway moving forward.*** This is precisely why the Administration and Legislature passed AB 119 (Chapter 13, Statutes of 2023) which required the Department of Health Care Services (DHCS) to pursue the implementation of a new Managed Care Organization (MCO) Tax, raising more than \$32 billion off managed care plans over a 3.75-year period. The federal government approved the proposal in December, and now the Governor is proposing to use a portion of the new tax proceeds to support more than \$25 billion in new Targeted Provider Rate (TRI) increases for the Medi-Cal program. The Administration and DHCS have even acknowledged publicly, the proposed new TRI investments do not provide enough added resources to raise the level of Medi-Cal provider reimbursement for all, and instead are *targeting these investments in areas and for providers that need them the most.*

Adopting a statewide 3% annual target across all payers beginning in CY 2025, will effectively lock California into these existing inequities which will have irreversible and detrimental impacts to the future of health care in communities that need help the most. Proposed investments like TRI, or significant expansions to existing “self-financed” Medi-Cal supplemental payments, would be restricted and force providers into tough decisions as they evaluate whether they can afford to continue to maintain existing levels of participation in the Medi-Cal program. As result, our hospital leaders believe there will be a direct correlation in the implementation of an annual 3% spending target that does not acknowledge or allow for significant Medi-Cal investments and the reduction of essential health care services for underserved communities across the state. Specifically, it means scaling back on specialized care for chronic conditions, such as diabetes management or prenatal care, which are crucial for maintaining overall health and well-being for their communities. Any discretionary investments that happen today in community outreach programs and supportive services aimed at supporting the Governor’s CalAIM initiatives and addressing social determinants of health may be at risk of being slashed, further deepening the impact on these underserved populations.

Maintaining access to essential health care in many underserved communities across California relies heavily on public providers like district and municipal hospitals. ***They are the safety-net providers in their communities and provide more than just life-saving care.*** Even though many hospitals/health systems may have recovered from the COVID-19 pandemic—some large health systems even acquiring other hospitals—unfortunately, the district and municipal hospitals are not in that same position. Simply put, they have not fully recovered—they are experiencing

significant workforce challenges, and their current financial state is not sustainable as evident by the high proportion needing DHLP loans. The bottom line, capping overall growth in health care spending to 3% on annual basis, assumes health care spending in their communities is in the right place and currently is at satisfactory levels. The reality is this decision will force these communities to reevaluate what services can be provided. District and municipal hospitals will have to explore ways to reduce costs (e.g., new investments, staffing), and the concerns raised by leaders are, this will lead to an increased risk in hospital bankruptcies (e.g., Hazel Hawkins) and/or closures (e.g., Madera)—targeting those underserved communities in California that need help the most.

OHCA’s proposed methodology fails to consider known factors that influence health care spending (e.g., demographic factors, delivery system investments, medical inflation and pharmaceutical pricing, labor costs, and new health care policies) and the treatment of Medi-Cal supplemental payments.

The OHCA staff’s recommendation to base the annual growth target on the 20-year historical period of median household income in California, does not consider the statutory requirements when establishing a methodology defined in Health and Safety Code (HSC) 127502(d). More specifically, the methodology does not consider any of the provisions summarized below:

(d)(3)—Trends & COVID: Historical trends in Medi-Cal, Medicare, and Commercial Health Coverage. Differential treatment of 2020 and 2021 calendar years due to the impacts of COVID-19.

(d)(4)—Factors, including, but not limited to: health care employment cost index, labor costs, consumer price index for urban wage earners and clerical workers, impacts due to known emerging diseases, trends in the price of health care technologies, provider payer mix, state or local mandates such as required capital improvement projects, and any relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs.

(d)(5)(A)—Medi-Cal: the provision of nonfederal share associated with Medi-Cal payments.

(d)(5)(B)(i)—Medi-Cal: supplemental payments for Medi-Cal services and underinsured patients.

(d)(5)(B)(ii)—Medi-Cal: nonfederal share and fees (e.g., Hospital Tax 24% Fee for Children’s Coverage, 20% Administrative Fees on Intergovernmental Transfers).

(d)(5)(B)(iii)—Medi-Cal: health care-related taxes (e.g., MCO Tax, Hospital Tax)

(d)(5)(C)—Medi-Cal: Methodology that cannot jeopardize federal requirements for federal financial participation (e.g., actuarial soundness requirements when developing Medi-Cal capitations).

The Legislature carefully considered and ensured in the authorizing legislation these requirements for any OHCA annual target to take into consideration the interactions with the Medi-Cal program. Unfortunately, the OHCA staff’s recommendation completely disregarded the statutory required consideration of the Medi-Cal program and clearly did not acknowledge the specific importance of Medi-Cal supplemental payments and health care related taxes which serve to support the Medi-Cal program. Today, the Medi-Cal program accounts for roughly 30% of all health care spending in the state on an annual basis. In state fiscal year 2023-24, the Medi-Cal Program has an annual budget totaling more than \$150 billion, with nearly \$24 billion or **25% of the annual budget supported by non-federal sources that are not attributed to the state**

General Fund (e.g., MCO Taxes, Skilled Nursing Facility Fees, Ground Emergency Medical Transportation Quality Assurance Fees, Private Hospital Taxes, Public Hospital Certified Public Expenditures, or Intergovernmental Transfers, etc.)¹. The interaction this critical revenue source plays on the California health care market—supporting 15 million Californians—cannot be understated. ***It also means, when a district or municipal hospital receives funding for Medi-Cal services, that it is likely to be Medi-Cal revenue supported by the governmental entity rather than the state General Fund.*** When it shows up in the Medi-Cal budget or what the Medi-Cal managed care plans will report to OHCA later this year as total payments, for the provider, that's not actually the net patient revenue the hospital can count on—rather OHCA will be seeing it from a gross revenue perspective. This further adds to the importance and why the Legislature wrote into statute the requirement for the OHCA annual spending target methodology to take these factors into account.

Medi-Cal safety-net providers, including district and municipal hospitals who primarily provide services to Medi-Cal and Medicare beneficiaries (75%+ government payer mix), are concerned by how the proposed annual spending target will reconcile with anticipated spending growth over the next few years, which is projected for Medi-Cal to grow between 5-6% annually (projections by DHCS and the Legislative Analyst's Office²).

The proposed methodology also fails to consider known factors that influence health care spending (e.g., demographic factors, delivery system investments, medical inflation and pharmaceutical pricing, labor costs, and new health care policies).

Aging population—Not only does the proposed methodology lock in existing spending inequities, but also fails to consider an aging population in California. While California's overall population has stagnated recently (~40 million people), the Department of Finance projects the proportion of Californians aged 65+ will continue to grow relative to the under 65-year-old populations. Our leaders are shocked to see this important demographic factor completely omitted. Health care spending in an aging society will place more of a burden on the health care system which will apply more pressure on annual per capita spending, especially over an extended period (e.g., 2025-2029). The trend of aging populations choosing to move/retire in more rural communities due to housing affordability, is something that has been happening for the past several decades and will disproportionally impact the communities in which district and municipal hospitals serve. Additionally, DHCS also expects significant changes in the low-income dual eligible populations with the implementation of a D-SNP requirements for all Medi-Cal managed care plans by 2027. For the reasons stated above—aging societal demands on health care system especially in underserved communities and the changing dual-eligible market dynamics going live soon—hospital leaders do not understand how any credible target chooses to ignore these factors.

Medical inflation and pharmaceutical pricing—Absent from the proposed methodology, are adjustments for well-known factors and uncontrollable medical inflation—pharmaceuticals, medical devices, and new technologies. According to the U.S. Department of Health and Human Services³, pharmaceutical prices for essential medications increased by 15.2% over the period between January 2022 to January 2023. Unfortunately, these significant increases place a heavy

¹ November 2023 Medi-Cal Local Assistance Estimate ([Link](#))

² December 2023 Legislative Analyst Office Medi-Cal Fiscal Outlook ([Link](#))

³ October 2023 Report, Assistant Secretary for Planning and Evaluation (ASPE), HHS ([Link](#))

burden on patients and the health care systems who cannot control these prices. This does not include other significant increases in costs for medical devices such as prosthetics or implantable devices, or other advancements in medical technology. Unlike payers (HSC 127500.2(o)), full integrated delivery systems (HSC 127500.2(h), providers (HSC 127500.2(q), physician organizations (HSC 127500.2(p), and health care entities (HSC 127500.2(k), pharmaceutical and medical device manufactures, and technology industry, are not subject to any oversight or enforcement under the current purview of the OHCA. Not only will this create a division across the industry as we collectively strive to improve health care affordability for the consumers of California, but leaving out this factor or ignoring the rapid growth in the annual spending targets will force the entities subject to enforcement actions by OHCA to cut other “controllable” areas of spending (e.g., services, staffing, new investments). Effectively, it will create a race to the bottom and areas of investment, or “*good spending*” will suffer.

Labor costs and new health care policies—The proposed methodology also fails to consider other required adjustments contemplated carefully by the legislature (*HSC 127502(d)(4)*) which would account for the rising labor costs and other state or legislatively-required health care policies. District and municipal hospitals are no different than the rest of the hospital industry—a sizable portion of their overall cost structure is attributed to salaries and wages for their staff. For our critical access district hospitals (CAHs), that staff may also include physicians who are employed. The collective impact from recent statutory requirements like Senate Bill 525 (Chapter 890, Statutes of 2023) which increases health care worker minimum wage and the outstanding costs of complying with the state’s 2030 seismic standards, cannot be ignored. Statewide, these policy decisions will add *billions* in new health care spending over the next few years, and for district and municipal hospitals the impact will be significant. The proposed methodology fails to consider these realities and other state mandated policies. Without clear acknowledgment and consider of these factors in the first annual spending target, leaders are worried this will create a precedent that sends a message to the Legislature that similar actions that increase future health care costs do not impact spending.

Legislation allows for the OHCA Board to adopt a single year target—there is no requirement to adopt a five-year target.

It is not clear to district and municipal hospital leaders why the OHCA staff believe a five-year recommendation fixed at 3% is best for “*improving health care affordability, access, and equity of health care for Californians (HSC 127500.5)*.” Especially, when OHCA staff’s recommendation will enact irreparable harm to underserved communities by failing to comply with statutory requirements, ignoring the importance of Medi-Cal and the necessary investments proposed by the Governor, and lastly failing to consider factors outside the control of those being regulated by this new office.

We urge the OHCA Board—a Board that the Legislature envisioned would be independent—to evaluate the timelines within the authorizing legislation and not rush towards creating enforceable spending targets without a data-driven and more credible target-setting process. This important decision by the OHCA Board to establish the first annual spending target will create precedence for years to come and should not ignore critical factors that influence health care spending.

We urge the OHCA Board to specifically consider the following:

- Use the March 27th OHCA Board meeting to publicly review and discuss with OHCA staff the feedback collected through this public comment process. Be transparent!
- Return the recommendation back to OHCA staff and have them revise the methodology only to assume CY 2025. This work to revise the methodology can be done between the March 27th and April 24th OHCA Board meetings. In April, request for OHCA staff to return with a revised CY 2025 recommendation that satisfies the statutory requirements, adjustments for factors that influence spending, and intent of the legislation.
- Approve only a CY 2025 target during the May 22nd OHCA Board meeting. Additionally, request the OHCA staff present their proposed workplan for developing the CY 2026 target and request they take into account the actual data that will be collected by the Office later this year.

We appreciate the opportunity to provide our comments and stand ready to assist the OHCA staff in developing a thoughtful, data-driven approach to establishing spending target that does not sacrifice the delivery of health care in underserved communities across California.

Sincerely,



Ryan Witz
Senior Vice President, Finance Policy

Cc:

Elizabeth Landsberg, Director, Department of Health Care Access and Information (HCAI)
Vishaal Pegany, Deputy Director, HCAI OHCA
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

Michelle Baass, Director, Department of Health Care Services (DHCS)
Lindy Harrington, Assistant Medicaid Director, DHCS
Sarah Brooks, Chief Deputy Director, Health Care Programs, DHCS
Rafael Davtian, Deputy Director, Health Care Financing, DHCS

From: [Diana Mireles](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Friday, March 1, 2024 12:28:20 PM

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 about equitable access to healthcare. Although I recognize that I am coming from a place of privilege in being afforded employment sponsored healthcare and my monthly premiums can be considered low for my family of 5 I am part of an HMO group in central California. The doctors participating in this medical group are the worst that I have encountered. From optometrists to internists I have experienced limited options, hours, no urgent care and instead only emergency services. This HMO foundation offered better services expanded services in the Bay Area but very limited in central California valley. Not what I would expect from a healthcare that aims to put an end to healthcare disparity specially in a region that is in high needs of equitable access to healthcare.

Sincerely,
Diana Mireles

[REDACTED]

United States

From: [Diego Gollas](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Thursday, February 15, 2024 10:16:18 AM

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CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board Members,

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

My health care costs me more than \$ __480__ 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,
Diego Gollas

[REDACTED]

United States



March 6, 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:

We hope this letter finds you well.

You are familiar with our hospital- Dignity Health- California Hospital Medical Center in downtown Los Angeles. 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.**

You may be aware that California Hospital Medical Center and Dignity Health's 30 other hospitals in California are the largest provider of Medi-Cal services, making up a significant portion of the state's safety net. Three fourths of all patients that come to Dignity Health have either Medi-Cal or Medicare. Unfortunately, Government reimbursement has not kept pace with the rising costs of labor, supplies and drugs leading to a loss of over \$245 million last fiscal year for Dignity Health. We are deeply concerned that the current proposal will have a disproportionate impact on all safety net providers.

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, like minimum wage and seismic mandates; 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.

The proposed target falls well below our current lived experience. Hospitals are a critical part of our state's first response to disaster and we welcome everyone, regardless of their ability to pay. As we work toward our financial recovery from COVID, Dignity Health and other health systems operating in the red will be penalized under this target.

For California Hospital Medical Center, 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. We operate many services at a loss such as Maternal Health, our Ambulatory Surgery Center and outpatient Women's Clinic. It is these very services that would be put at risk for closure or reducing access to stay within our given targets. Restricted access will not reduce overall health care spending, but rather defer it until more critical and more costly.

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,


Alina Moran, MPA, FACHE, FAB
President

February 28, 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:

Dignity Health Inland Empire (Community Hospital of San Bernardino and St. Bernardine Medical Center) stands 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.**

Community Hospital of San Bernardino and St. Bernardine Medical Center, as well as, Dignity Health's 30 other hospitals in California are the largest provider of Medi-Cal services, making up a significant portion of the state's safety net. Three fourths of all patients that come to Dignity Health have either Medi-Cal or Medicare. Unfortunately, Government reimbursement has not kept pace with the rising costs of labor, supplies and drugs leading to a loss of over \$245 million last fiscal year for Dignity Health. We are deeply concerned that the current proposal will have a disproportionate impact on all safety net providers.

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, like minimum wage and seismic mandates; 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.

The proposed target falls well below our current lived experience. Hospitals are a critical part of our state's first response to disaster and we welcome everyone, regardless of their ability to pay. As we work toward our financial recovery from COVID, Dignity Health and other health systems operating in the red will be penalized under this target.

For our two hospitals, 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. Our two hospitals operate many services at a loss such as Maternal Child Health, NICU, and some outpatient services. It is these very services that would be put at risk for closure or reducing access to stay within our given targets. Restricted access will not reduce overall health care spending, but rather defer it until more critical and more costly.

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,

A handwritten signature in black ink, appearing to read 'Dan Murphy', with a stylized flourish extending from the end.

Dan Murphy
Vice President and CPO

CC: June Collison, President, Community Hospital of San Bernardino
Doug Kleam, President, St. Bernardine Medical Center



Dignity Health™
Dominican Hospital

1555 Soquel Drive
Santa Cruz, CA 95065
direct 831.462.7700
dominicanhospital.org

February 28, 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:

Dignity Health Dominican Hospital stands 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.**

Dominican Hospital and Dignity Health's 30 other hospitals in California are the largest providers of Medi-Cal services, making up a significant portion of the state's safety net. Three fourths of all patients that come to Dignity Health have either Medi-Cal or Medicare. Unfortunately, Government reimbursement has not kept pace with the rising costs of labor, supplies and drugs leading to a loss of over \$245 million last fiscal year for Dignity Health. We are deeply concerned that the current proposal will have a disproportionate impact on all safety net providers.

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, like minimum wage and seismic mandates; 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.

The proposed target falls well below our current lived experience. Hospitals are a critical part of our state's first response to disaster and we welcome everyone, regardless of their ability to pay. As we work toward our financial recovery from COVID, Dignity Health and other health systems operating in the red will be penalized under this target.

For Dominican Hospital, 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. 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,

A handwritten signature in blue ink, appearing to read "Nanette", followed by a stylized flourish or second name.

Nanette Mickiewicz, MD
President & CEO

From: [REDACTED] on behalf of [D.Q. Neyhart](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Thursday, March 7, 2024 9:36:47 AM

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CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board,

My health care costs come out of the Social Security check. It is a large percentage. Recently I moved to Kaiser where I am receiving superior health care but at a marginally superior price.

One concern that is not adequately addressed is why are people in the medical field not happy, why do they retire or leave soon, and why are ever fewer of them committed until their 70s and 80s? So many of the people who study hard try and get out as soon as they can. Why is that? What can we do to make it more pleasant for them to stay and be productive and happy about it?

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. D.Q. Neyhart

[REDACTED]

February 26, 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, like minimum wage and seismic mandates; 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 El Centro Regional Medical Center, 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. Delaying reinvesting in nurse call upgrades, which allow our patients to notify nursing staff of needs. We would also be unable to meet necessary infrastructure upgrades such as air conditioning units, purchase MRI and CT machines to replace old and outdated equipment, update/upgrade computer systems to meet both demand of new IT infrastructure as well as mitigate cyber threats.
- Considering ways to reduce current staff or hire fewer staff in the future, including offering fewer retention or recruitment bonuses. ECRMC would be unable to offer market wage increases needed to stabilize staff and rely less on nurse registry companies. El Centro is already in a health care shortage area, funds are desperately needed to attract specialists to our areas to offset travel demands faced by many patients. These patients, without specialists in the Imperial Valley, are forced to travel several hours for treatment.
- Uncertainty over our ability to meet state mandates like seismic requirements. While El Centro Regional has planned construction projects currently ongoing, the cost to meet these requirements place a significant toll on dwindling revenues.

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:

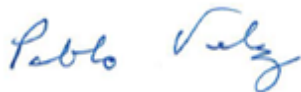
- Collected data to inform the establishment of a credible, attainable target
- Promulgated rules around how these data would be analyzed
- Laid out the rules for how entities would be held accountable for the targets

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,



Pablo Velez, PhD, RN, Chief Executive Officer
El Centro Regional Medical Center

From: [Elena Santamaria](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Tuesday, February 13, 2024 2:28:18 PM

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Dear Office of Health Care Affordability Board Members,

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

Over 10 years ago, a medical emergency impacted my family and we were left with medical bills in the hundreds of thousands of dollars. My sister's emergency care alone was \$150,000 and the life surgery she needed was \$250,000. These costs crippled my family at the time and left me to navigate a way to find help. No family should have to experience what we went through.

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,
Elena Santamaria
[REDACTED]

United States

From: [REDACTED] on behalf of [ellen wade](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Tuesday, February 13, 2024 10:13:43 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,
Ms. ellen wade

[REDACTED]

From: [Emilia Ruiz](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Wednesday, March 6, 2024 7:42:15 AM

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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 300.00 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,
Emilia Ruiz

[REDACTED]

United States

From: [Emma Lenz](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Wednesday, March 6, 2024 7:42:21 AM

You don't often get email from [REDACTED] org. [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 \$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,
Emma Lenz

[REDACTED]

United States

From: [REDACTED] on behalf of [Eric Devezin](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Wednesday, February 14, 2024 10:56:59 AM

[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.

California, the land of sunshine and opportunity, feels more like a land of crushing expenses lately. Like many Californians, I'm drowning in the high cost of living, and healthcare feels like a luxury I can barely afford. It's a constant battle every month: rent versus groceries, car payment versus medications. Choosing between keeping a roof over your head and caring for your health should be easy.

Last year, I had to put off seeing a specialist for a nagging health issue because the copay would have blown my budget. It meant months of worry and sleepless nights, hoping it wasn't something serious. It wasn't fair, and it shouldn't be anyone's reality.

This isn't just about me. I see the strain on my neighbors, friends, and family. People skip checkups, ration medications, or put off procedures because the cost is simply out of reach. It's heartbreaking and takes a toll on everyone's well-being.

But I refuse to give up hope. We deserve better, and California deserves better. We need real solutions, not empty promises. We need leaders who understand everyday Californians' struggles and are willing to fight for affordable healthcare for all.

So, I'm raising my voice, sharing my story, and urging others to do the same. We can't stay silent while our health and wallets are squeezed. Together, we can demand change and build a California where everyone can thrive, not just survive.

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. Eric Devezin

[REDACTED]

From: [Ernest Villicana](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Wednesday, March 6, 2024 7:42:18 AM

You don't often get email from [REDACTED] rg. [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 \$220 for myself only 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,
Ernest Villicana

[REDACTED]

United States

From: [REDACTED] on behalf of [Esther Zamora](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Monday, February 12, 2024 6:57:01 PM

[You don't often get email from [REDACTED] m. 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,
Ms. Esther Zamora

[REDACTED]

From: [Evette Betancourt](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Wednesday, March 6, 2024 7:44:22 AM

You don't often get email from civinput@newmode.org. [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 2000 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,
Evette Betancourt

[REDACTED]

United States

February 28, 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:

French Hospital Medical Center stands 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.**

French Hospital Medical Center and Dignity Health's 30 other hospitals in California are the largest provider of Medi-Cal services, making up a significant portion of the state's safety net. Three fourths of all patients that come to Dignity Health have either Medi-Cal or Medicare. Unfortunately, Government reimbursement has not kept pace with the rising costs of labor, supplies and drugs leading to a loss of over \$245 million last fiscal year for Dignity Health. We are deeply concerned that the current proposal will have a disproportionate impact on all safety net providers.

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, like minimum wage and seismic mandates; 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.

The proposed target falls well below our current lived experience. Hospitals are a critical part of our state's first response to disaster and we welcome everyone, regardless of their ability to pay. As we work toward our financial recovery from COVID, Dignity Health and other health systems operating in the red will be penalized under this target.

For French Hospital Medical Center, 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. French Hospital Medical Center operates many services at a loss such as labor & delivery, pulmonary and cardiac rehabilitation services. It is these very services that would be put at risk for closure or reducing access to stay within our given targets. Restricted access will not reduce overall health care spending, but rather defer it until more critical and more costly.

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,

A handwritten signature in black ink, appearing to read 'Patrick Caster', with a long, sweeping horizontal line extending to the right.

Patrick Caster
President & CEO
French Hospital Medical Center

From: [REDACTED] on behalf of [Gabrielle Swanberg](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Monday, February 12, 2024 4:27:47 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,

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. Gabrielle Swanberg

[REDACTED]



March 4, 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, like minimum wage and seismic mandates; 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 Ridgecrest Regional Hospital, meeting the proposed target will mean we will have to further cut more services. We have already made the painful decision to suspend OB services as well as certain clinic services. Further cuts will be necessary if the 3% target is put in place.

Also, we have recently gone through a 10% layoff as a result of our poor financial condition post Covid. Further cuts will only lead to more reductions. We also are having to delay replacing badly needed patient care and diagnostic equipment because cash reserves are so low.

Further, the 3% cuts will only exacerbate and create more uncertainty over meeting state mandates such as seismic retrofitting. Mandated seismic retrofitting will cost this hospital over \$25 million dollars. Spending cuts will make it more difficult if not impossible to make these renovations.



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,

George Haslam – Board Director
Ridgecrest Regional Hospital

Kristin Gershfield, M.D.
Vituity Hospitalist
Sequoia Hospital
170 Alameda de las Pulgas
Redwood City, CA. 94062

February 28, 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:

I, Kristin Gershfield, M.D., 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 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 me, 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. Kristin Gershfield

From: [REDACTED] on behalf of [Glen Brunner](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Wednesday, February 14, 2024 10:48:54 AM

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CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board,

Perhaps your limited focus on "increasing costs of healthcare" doesn't cover my situation as a retired Californian on Original Medicare. But for the record, during the first 8 years of my Medicare coverage, I received cash Social Security benefits of \$331 per month...since every increase in benefits was taken back by increases in Medicare premiums.

I eventually dropped my Medi-Gap plan (covering only half of the 20% not covered by Medicare) because the two were about to take 50% of my monthly Social Benefits...even though I rarely ever used Medicare coverage. Our healthcare system is BROKEN. Costs are outrageous; services are limited or nonexistent; and capitalism doesn't work well where lives are at risk. Medical bankruptcies and denial of care are the evidence of this--especially in the "Medicare Advantage" programs. So "affordability" is only one small aspect of this huge, dysfunctional problem. We need

"Healthcare for All" in California....and across the country. Nothing short of that will solve this problem.

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. Glen Brunner

[REDACTED]

From: [Graciela Valentin](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Wednesday, February 28, 2024 3:32:53 AM

You don't often get email from [REDACTED] g. [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,
Graciela Valentin

[REDACTED]

United States

From: [Greg Light -CA](#)
To: [HCAI OHCA](#)
Subject: Protect Access to Health Care, Reject 3% Cost Growth Target
Date: Monday, March 11, 2024 3:36:21 PM

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CAUTION: This email originated from outside of the organization.

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 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 Dignity Health Medical Foundation Medical Groups, 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,

Greg Light, Pharm.D.

System Director Ambulatory Care Pharmacy
Dignity Health Medical Foundation

Greg Light, Pharm.D.

System Director, Ambulatory Care Pharmacy Services

Pharmacy Enterprise

CommonSpirit Health

[REDACTED]

[REDACTED]

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Caution: This email is both proprietary and confidential, and not intended for transmission to (or receipt by) any unauthorized person(s). If you believe that you have received this email in error, do not read any attachments. Instead, kindly reply to the sender stating that you have received the message in error. Then destroy it and any attachments. Thank you.



1764 San Diego Avenue, Suite 200 San Diego, CA 92110

Phone 619-471-2606 Statewide Toll Free 888-804-3536 HealthConsumer.org

Submitted Via Email

March 11, 2024

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

RE: Proposed Statewide Spending Target

Dear Ms. Brubaker:

On behalf of the Health Consumer Alliance (HCA), I am writing to provide our feedback on the Office of Health Care Affordability (OHCA) January 16 recommendations for a proposed statewide health care cost target. The HCA is a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, which includes: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Community Legal Aid SoCal, Greater Bakersfield Legal Assistance, Legal Aid Society of San Diego, Inland Counties Legal Services, Legal Aid Society of San Mateo, Legal Services of Northern California, Neighborhood Legal Services of Los Angeles County, the Western Center on Law and Poverty, and the National Health Law Program. HCA has decades of experience defending the health rights of low-income and underserved Californians, and we understand the vital importance of ensuring that health care is affordable for all Californians. The HCA strongly supports the proposed OHCA targets for up to 3% cost growth annually for the next five years.

At a time when over half of Californians skip or delay doctor visits or prescriptions because of costs—and their condition then worsens because of this lack of care—any increases in the cost of care will only exacerbate problems of access, equity, and public health. These cost increases and the further lack of access, affordability, and equity fall especially hard on Black, Indigenous, and other People of Color (BIPOC), the uninsured, those with disabilities and chronic medical conditions, immigrant populations, and those with lower-incomes.



1764 San Diego Avenue, Suite 200 San Diego, CA 92110

Phone 619-471-2606 Statewide Toll Free 888-804-3536 HealthConsumer.org

With median family coverage now costing an eye-popping \$24,000 and the family share of employer coverage and deductible costing \$10,600 or more, medical costs are a main driver in California's affordability crisis. Nationwide, an average worker would have had \$125,000 more in wages if not for inflated health care costs over the last three decades. Family incomes have climbed by 3% per year while premiums go up 5% and deductibles rise 8% in California.

Affordability is a particular concern for very low-income Californians. As a result of the COVID-19 Public Health Emergency Unwinding process many Californians who are newly ineligible for Medi-Cal after the last several years are now having to purchase private coverage. While the subsidies available to help people purchase Covered California insurance are enormously important, increases in cost could seriously strain budgets for very low-income Californians, including people whose income is just above the threshold for Medi-Cal eligibility.

The OHCA staff proposal of a cost growth target of up to 3% each year is not a reduction, nor a freeze, but a goal that the health care industry must compete within the same constraints as a median California family does. In a highly consolidated health system where consumers have little ability to shop around or say no, and where prices have little relation to the cost or quality of care, or patient outcomes, OHCA has a responsibility to set a target that would at least prevent care and coverage from becoming even more unaffordable.

OHCA has the opportunity to meet its mission of setting affordability targets grounded in the lived experiences and realities of Californians. We support the proposal for a cost growth target to be 3% or lower, to provide real relief for California consumers and communities.

Please feel free to reach out to Abbi Coursolle of the National Health Law Program (310-736-1652; coursolle@healthlaw.org) if you have any questions about our comments. Thank you for your consideration.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Abbi Coursolle', is written over a faint, light blue circular stamp that contains the text 'NATIONAL HEALTH LAW PROGRAM'.

Abbi Coursolle, Senior Attorney, National Health Law Program

On behalf of the Health Consumer Alliance



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Sonya Young
California Black Women's Health Project

Anthony Wright
Executive Director

Organizations listed for
identification purposes

March 11, 2024

Mark Ghaly, M.D., Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability
Department of Health Care Access and Information

2020 W. El Camino, Suite 1200
Sacramento, CA 95833

Re: Office of Health Care Affordability Proposed Spending Target

Dear Dr. Ghaly, Ms. Landsberg and Mr. Pegany,

Health Access California, the statewide health care consumer advocacy coalition committed to quality, affordable health care for all Californians, supports the proposed spending target of 3% over the five years from 2026 to 2029 as well as the proposed methodology which relies on median household income rather than the wealth of the economy.

The Office of Health Care Affordability was established to address the crisis caused by the lack of affordability of health care in California, to provide new insight into what is driving health care cost growth and for the first time and give consumers and other purchasers who pay the bills a seat at the table where those costs are decided. Without the Office, consumers and other purchasers have little or no voice in influencing health care costs. The Office was created to change the status quo of ever-escalating costs that are largely unrelated to improving access, quality, or equity. The target should not simply codify the existing cost trends that led to today's crisis of affordability where low- and middle-income families choose between getting care and paying for housing and other necessities. The target and the other important elements of the law are designed to foster structural and systemic change that improves outcomes, quality and equity while slowing the growth in health care costs.

Consumers Want To Stop Paying More to Get Less The Current System Means Less Care, Less Access, Less Quality, Less Equity

Californians, especially those with employer-based coverage are paying more and getting less: less care, less access to care, lower quality in terms of managing chronic conditions and less health equity.

- From 2002 to 2021, in California, premiums grew 163% while incomes grew only 72%¹. During these years, as premiums got bigger, so did cost sharing.
- Deductibles proliferated and got bigger for Californians who rely on employer-based coverage²:
 - In 2002, about a third of California workers had a deductible.
 - By 2022, almost 80% had a deductible.
 - By 2022, median deductible for family coverage was \$3,700.
- By 2022, the median working family spent \$10,400 on their share of premium plus deductible while median income was about \$85,000.³
- The result: half of Californians report skipping or delaying care. And it's worse for lower income consumers and people of color⁴.
- Health care costs growing at 3% instead of 5%-6% means consumers stop paying more to get less care. Limiting the growth in health care costs will prevent further crowding out of other necessities and over time, will make health care more affordable compared to incomes.

Executive Summary

Health Access supports a 3% target based on a 20-year lookback on median household income for the five years from 2025 to 2029. In summary, we support this for the following reasons:

- The cost of obtaining care is today the greatest barrier to access.
- Lack of affordability impairs quality because consumers skip or delay going to the doctor, filling prescriptions, and getting other necessary care.
- Inequity is worse, both in terms of race, ethnicity and sexual orientation and gender identity as well as income and wealth disparities for low- and middle-income consumers.
- California should lead, not lag, other states.
- Inflation has abated and by 2025, the initial target year for reporting, is likely to be in the rearview mirror. Because of this, the recent spate of inflation will already be built into the baseline, and not need to further influence the growth target.
- The health care workforce grew, and wages increased in Massachusetts, the state with the longest experience with growth targets.
- We reject alternative approaches based on cherry-picking facts, including:
 - Use of random years to describe target levels in other states.
 - Use of more volatile economic indicators such as five or ten years of data.
 - Basing the target on the wealth of the economy instead of the ability of consumers to afford the health care they need.

¹ <https://laborcenter.berkeley.edu/what-can-we-afford/> September 2023

² <https://laborcenter.berkeley.edu/measuring-consumer-affordability/> January 2024

³ <https://laborcenter.berkeley.edu/measuring-consumer-affordability/> January 2024

⁴ [The 2024 CHCF Health Policy Survey](#)

- Asking that spending to be adjusted by “age” both in the target and in the performance of specific entities or regions against the target, essentially seeking a double discount for aging.
- A “glide-path” or “phase-in” of as-yet-unspecified parameters that allows industry to grow that much further, prolonging the pain of consumers and other purchasers beyond the intent of the long-debated law, and allowing industry more time to undercut the need for change.

It is our hope that a 3% benchmark will require all parties to recognize the need for change and to begin the hard work of making that change over time. We, as Californians, have done this before, committing not only to implementing the Affordable Care Act but improving on it and expanding coverage to all Californians through Health4All. This goal was broadly shared by all those who care about health care, from consumers and labor to all the major players in the health care industry. Looking the other experience of other nations and other states, those that have achieved some version of universal coverage find that addressing cost, quality and equity becomes a shared goal once it is no longer possible to simply deny people the right to care as was done for so long in this state and this nation.

Comments at greater length follow.

Consumers’ Ability to Afford Care, Not the Wealth of the Economy

Health Access California supports the target methodology proposed by the Office of Health Care Affordability and the target proposed by the Office of Health Care Affordability staff. The Board has discussed at length basing the critical importance of basing the spending growth targets on median household income which reflects the ability of consumers to afford both health care and coverage rather than the wealth of the California economy as reflected in measures such gross domestic product (GDP).

Median household income better reflects the lived experiences of Californians. A cost growth target grounded in household income is also a better test of whether Californians’ health costs, in premiums, cost-sharing, and other costs, are becoming more unaffordable. Given the extreme wealth inequality in California, and the structure of our economy, economic measures such as gross domestic product—which includes how well movie studios do and how many iPhones sold—is not suited for this purpose of evaluating consumer affordability.

If California had a system of financing health care that was based on the wealth of the economy such as a single payer system based on progressive taxation of wealth and income, basing the growth of health care costs on the wealth of the California economy would make sense to us. California does not. Instead, about half of all Californians rely on employer-based coverage which is regressively financed through lost wages--lost wages that are spent on health benefits instead of take-home pay. So long as Californians rely on regressive financing of employer coverage, consumer affordability must drive the discussion rather than the wealth of the economy.

Consumer affordability is at the core of our perspective.

- In California today, those who can afford health care the least pay the most as a proportion of their income while those who are in the upper 20% of the income scale, above \$200,000 a year, pay the least as a fraction of their income.
- Those who need care the most, such as those with MS, HIV/AIDS, or a serious disability, also pay the most in terms of out-of-pocket costs.
- Consumer spending on health care comes in the form of worker share of premium, deductibles and other out of pocket costs as well as lost wages spent on the employer share of health benefits. These costs are proliferating and escalating.

What is the result? A health care system in which today Californians lack access, inequity abounds, and quality suffers, all because of lack of affordability. The Board has heard from a broad range of Californians facing a crisis of affordability: teachers, hotel workers, people with MS, small business owners and there are many more Californians out there with similar stories.

Lack of Affordability Means Lack of Access Today

Californians with job-based health coverage face substantial affordability challenges and cannot afford the care they need. Because of high health care costs, Californians lack access today:

- Over half of Californians (53%) skip or delay doctor visits or prescriptions because of costs⁵.
 - About half of these Californians got worse because they did not get the care they needed.
- Families spend almost \$10,600 including both the family share of premium and median deductible⁶.
 - \$10,600 for health care paid out of \$85,300 median family income. How does anyone afford that while still paying for other needs?
 - Family coverage is 12.2% of median income for share of premium and median deductible for a family with a median income of \$85,300.
 - And even more in lost wages for the employer share of coverage as employer pay the employer share of premiums.
- Deductibles have proliferated and gotten worse⁷:
 - In 2002, only 1 in 3 Californians with employer coverage had a deductible.
 - In 2022, almost 8 in 10 (77%) do—and some deductibles are over \$7,000.
- Lost wages due to health care costs amount to \$125,000 nationally over the last 33 years⁸.

People don't get care today because they can't afford to go to the doctor, pick up their prescriptions or get other necessary care. High health care costs deny Californians access to care today.

⁵ The 2024 CHCF Health Policy Survey: <https://www.chcf.org/wp-content/uploads/2024/01/2024CHCFHealthPolicySurvey.pdf>

⁶ <https://laborcenter.berkeley.edu/measuring-consumer-affordability/> January 2024

⁷ <https://laborcenter.berkeley.edu/measuring-consumer-affordability/> January 2024

⁸ [Employer Health Coverage and Its Association with Earnings Inequality, Hager et al, Jan. 25, 2024,](#)

Today's Lack of Affordability Makes Inequity Worse

- High health care costs are worse for Black, Latino/x and Multiracial Families⁹
- Black, Latino/x and multiracial Californians are more likely to be worried about being able to afford health care, including out of pocket costs and premiums.
- Black (53%), Latino/x and multiracial Californians (46%) are more likely to report difficulty paying medical bills as well as medical debt.
- Health premiums are almost 20% of income for Black and Latino/x workers¹⁰. And deductibles are on top of that.
- The wage penalty is also greater for workers of color as a proportion of income:
 - By 2019, health care premiums were almost 20% of earnings for Asian, Black and Hispanic families while they were only 13.8% for White families.¹¹

Quality Depends on Access to Care

Good health outcomes depend on regular access to care—and high health care costs stand in the way of regular care because consumers fail to go to the doctor, take their prescriptions, get necessary tests or follow up care, all because of lack of affordability.

- Twelve of the 13 equity and quality measures adopted by DMHC for use across all lines of business, including both Medi-Cal and commercial coverage, depend on going to the doctor and taking your prescriptions¹².
 - Childhood immunizations, diabetes control, high blood pressure, asthma, depression screening: these measures and more depend on consumers being able to afford doctor visits and their medications.
 - The same is true for most of the measures adopted by DHCS for Medi-Cal managed care.
- Even measures associated with hospitalization or emergency room use are associated with lack of affordability:
 - People end up in the emergency room with ambulatory sensitive conditions because they cannot afford the doctor's visit, the medications or other follow-up care.
 - People bounce back into the hospital through a readmission because of the lack of access to adequate supports post-hospitalization, much of which is related to income, ability to pay for care and generosity of benefits.

Without regular care, patients get worse and end up in the emergency room sicker: it is a vicious cycle too often caused by lack of affordability.

California Should Lead, Not Lag, Targets in Other States

⁹ <https://www.chcf.org/wp-content/uploads/2024/01/2024CHCFCAHealthPolicySurvey.pdf>

¹⁰ [Employer Health Coverage and Its Association with Earnings Inequality, Hager et al, Jan. 25, 2024](#)

¹¹ [Employer Health Coverage and Its Association with Earnings Inequality, Hager et al, Jan. 25, 2024,](#)

¹² [DMHC Equity and Quality Measures, 2022:](#) and [2022 Health Equity and Quality Committee Recommendation Report](#)

Other states with cost growth targets have targets for 2024-2027 in the range of 2.8%-3.3%, putting the staff recommendation of 3.0% squarely in the same range as other states. A target of 3.5% or 4% would be far higher than the targets in other states¹³.

One commenter, largely relying on a report published in 2022 which used data from as early as 2012, pointed to a somewhat higher average target of 3.3% while pointing to California's GDP (or gross state product) in 2024¹⁴. This commenter fails to mention that targets in the other states for the years after 2022 are consistently lower.

After years of conversations and now implementation of this new Office of Health Care Affordability, Californians should not have to settle for a target that is less ambitious than what Washington, Oregon, Massachusetts, and other states around the country are using for a goal in the next several years.

Inflation Abating

The round of inflation that occurred post-pandemic is abating, and that inflation will be built into the base of spending for the 2025 target and the years beyond. Inflation that occurs prior to the year 2025 will be built into the base of spending and does not need to be double-counted in the cost growth target as well. The 2025 target will be reported in 2027. By then, the inflation of 2022 and 2023 will be years in the rearview mirror. If there is a reversal of trend, the Board has the flexibility to review the target then.

Including inflation, particularly inflation that occurred in prior years, might well contribute to an inflationary cycle. The point of OHCA is not simply to reflect the existing cost structures of hospitals or other health care entities but rather to transform the system.

The same commenter who relies on an outdated report on cost growth targets for other states selectively picks inflation projections, relying on a Legislative Analyst Office estimate from last fall which is higher than those of the California Department of Finance or the Congressional Budget Office---or the observations of the Federal Reserve in 2024.

Workforce Impacts: Observations, Experience of Massachusetts

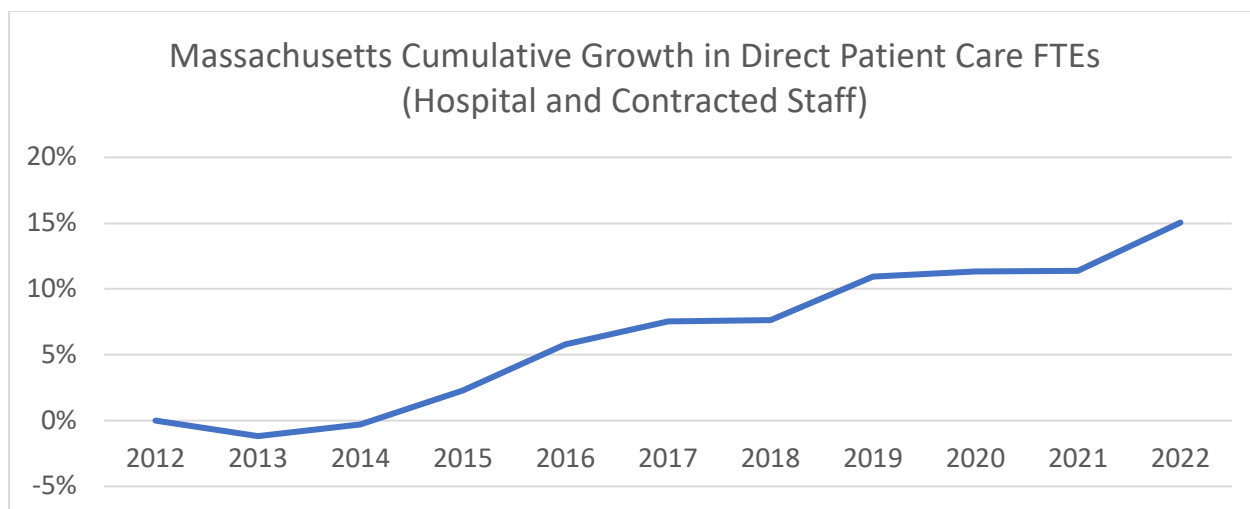
First, we look to Massachusetts that has the longest experience with a cost growth target:

- Direct care FTEs in hospitals, both employed and contracted, grew 15% from 2012 to 2022¹⁵

¹³ [Slide 132](#):

¹⁴ [December OHCA Written Public Comment](#) December 2023.

¹⁵ Hospital Cost Tool Dataset. Release date: December 15, 2023



- The rate of employment of health care workers per 1,000 in Massachusetts grew from 2014 until the pandemic year of 2020 and has rebounded since¹⁶.
- Wages for health care workers in Massachusetts have also grown over this period¹⁷.

Some have asserted that cost *growth* target will result in a smaller health care workforce. This assertion appears to rest on the false assumption that health care targets constrain net patient revenue in the aggregate rather than per capita spending. Put simply, if the population grows or if more people are insured or both, the per capita spending adjusts to reflect that. This was an important insight that is already reflected in the language of the law.

There is simply no evidence in the academic literature that a cost growth target means fewer health jobs or other negative workforce impacts.

The goal of OHCA is to reconfigure the delivery of care to achieve better outcomes and improved equity through measures such as alternative payment models as well as increased access to primary care and integrated behavioral health. Reconfiguration means change.

In a health care market where consumers have a limited ability to refuse care, or even to shop around and compare costs and quality, a cost growth target provides a spur for innovation, for providers to compete to find new ways to provide quality care efficiently and meet the target while ensuring that some of the savings goes to consumers, rather than profits and reserves. Other industries thrive on finding efficiency, savings, and innovations. We hope the cost growth target helps supercharge those efforts to find value for consumers in the health care sector.

¹⁶ US Bureau of Labor Statistics, Current Employment Statistics Survey, computed by UC Berkeley Labor Center.

¹⁷ <https://www.mass.gov/doc/health-care-workforce-trends-and-challenges-in-the-era-of-covid-19/download> slide 26.

We note that members of the advisory committee who are front-line workers and supervisors rather than senior administrators, have spontaneously pointed to the waste caused by excessive overhead in many health organizations. Existing law recognizes the need to limit administrative overhead and profits for carriers. There is also proposed legislation in California to assure that the vast majority of nursing home spending goes to care, not overhead and profits. There are no similar measures for hospitals, health systems, and large physician organizations. How many billions of dollars of administrative overhead, reserves, and available capital are hiding in health systems that are being spent on consolidation and expansion? We do not know. We should.

Finally, as noted by Board Member Mitchell, spending that does not go to health care cost growth is available to other parts of the economy, starting with the wages of workers who do not work in health care but also for other purposes of employers.

Alternative Approaches, Alternative Facts

Median Household Income: Ten-Year Lookback:

Several health plan commenters have proposed using median household income for the last ten years from 2013 to 2022 rather than the 20 years from 2002 to 2021 or 2003 to 2022. This would raise the target from the proposed 3% growth rate to a growth rate of 4% or 4.2%. But a ten-year lookback is far more volatile than a twenty-year period. A ten-year lookback would have yielded a target of 1.1% in 2011 and as much as 4.4% in 2021. A five-year lookback creates even greater swings. A longer lookback period creates more stable spending growth over time and provides a steadier foundation to which the health care industry can sustainably and structurally adjust.

Glide Path:

A “glide path” approach seems similar to a multi-year phase-in. Again, the OHCA statute already provided a multi-year phase-in: OHCA was enacted in 2022, two years ago, after being proposed over several years in the Governor’s Budgets. The first target is not in effect until 2025 with the first enforcement year in 2026. That is a five-year phase-in (the years 2022, 2023, 2024, 2025, and 2026). Do those who propose a glide path want a decade long phase-in? Or do they ever intend to lower the rate of cost growth?

Consumers are hurting now. Waiting longer only makes the damage worse. It means the already high base of health care spending climbs further. It sends the message to the health care industry that the targets are not serious and can be ignored, evaded or delayed.

Single Year Target? Multiple Years but Fewer than Five?

Other hospital system commenters have suggested a shorter time frame for the target, perhaps as short as one year. We are puzzled as to how this would work operationally: the data on 2025 spending will be collected in 2026 and reported in 2027 with further action possible in 2028 for the 2029 target year. What then happens for the years 2026, 2027, and 2028? Is there

no target for these years? It seems implausible that this is their suggestion. But in 2026 we will not know the result of the 2025 target. More importantly, if the purpose of the spending target is to encourage health systems to manage toward the triple aim of lower costs, better outcomes and improved equity, a knowable and predictable target is essential to that effort. How will health systems manage their spending toward prioritizing primary care and behavioral health if their spending target is unknown and unknowable? Other commenters have proposed fewer than five years but often without specifics. The same concerns apply.

Setting a five-year target allows the Board the flexibility to adjust the target if necessary. The target could be adjusted up or down, depending on actual circumstances such as an extraordinarily expensive new drug or cost savings due to widespread adoption of technology or other efficiency improvements.

Medi-Cal and Timing:

Other commenters for whom Medi-Cal patients account for more than half of their patients have raised concerns about the lack of clarity about which Medi-Cal revenue streams will count toward the spending target. Is it only the revenue from Medi-Cal managed care plans and fee-for-service payments? What about the plethora of Medicaid supplemental funding streams which some hospitals receive? What about supplemental payments or revenue arrangements specific to county hospitals?

We support greater clarity about how the Medi-Cal funding streams will be counted. Medi-Cal covers one out of three Californians, and those Californians are more likely to need hospital inpatient care: hospitals that have less than one third Medi-Cal bed days are not doing a proportionate share of Medi-Cal. A more rigorous accounting of hospital utilization of Medi-Cal enrollees compared to commercial lives might even raise that proportion.

Double-Counting Aging

Some commenters have repeatedly asked that the statewide spending target be adjusted for “aging”. But the OHCA staff has already proposed that when the target is applied to specific entities, it will be adjusted for age and sex by market segment. For example, if a health plan signs a mega employer group with very stable employment and thus many workers in their 50s and 60s, the target for that health plan’s commercial business would be adjusted by age (and sex if there is a particular gender bias in the industry of the newly signed employer). Similarly, a hospital system that opens pediatric units would have a different age mix than a hospital that closed its pediatric units as well as limiting labor and delivery. Counting “aging” in the statewide target is effectively double counting its impact. It is not clear if this is what is intended.

Workability Concerns: The Evidence

A recent presentation by the Integrated Healthcare Association to the Financial Solvency Standards Board of the Department of Managed Health on “total cost of care” and the differences between integrated and non-integrated health systems found that for HMOs, costs increased 3.12% for the five years from 2017 to 2021 while for PPOs and fee-for-service, costs

increased 9.93%¹⁸. The difference in out-of-pocket costs for consumers is equally enormous: those in risk-bearing systems pay \$250-\$300 a year out of pocket while those in fee-for-service pay over \$700, more than twice as much. The same study found quality on four key measures (high blood pressure, diabetes, colorectal cancer and childhood immunizations) higher as well.

Experts in Consumer Affordability—and the Damage the Lack of It Causes Today.

Some commenters have ignored the vivid testimony of consumer advocates, labor representatives and purchasers at the Advisory Committee about the damage being caused today by the worsening lack of affordability. In one particularly appalling moment, an individual employed by a health plan threatened that if the growth target was 3%, consumers might be denied medically necessary care, specifically high-cost prescription drugs, an action that if taken, would violate longstanding California law requiring coverage of all medically necessary care, including prescription drugs. Even hearing such a threat was troubling from a consumer perspective.

We support the OHCA targets of 3% for the five years from 2025 to 2029.

The proposed Office of Health Care Affordability targets of 3% will slow the rate of growth. Over time, consumers will spend less as a share of income on premiums, copays and deductibles and will be better able to afford care and coverage.

From a consumer and purchaser perspective, lowering costs more and sooner would be even better. Other states have adopted even more aggressive cost targets and have lowered their cost targets in recent years¹⁹. OHCA proposes a gradual approach that allows doctors, hospitals, and insurers time to adjust and adapt to the new cost targets.

The OHCA statute and the work of the Office today includes many provisions to improve equity and quality while reducing costs:

- Emphasis on primary care and prevention
- Behavioral health targets
- Measures of consumer affordability
- Alternative Payment Model standards

The goal is to replace the vicious cycle of lack of affordability leading lack of access to care resulting in higher cost care in ERs and hospitals with a virtuous circle of lower costs, better quality and improved equity where Californians can afford their share of premiums and the cost to go to the doctor or get a prescription.

¹⁸

https://www.dmhc.ca.gov/Portals/0/Docs/DO/FSSBFeb2024/AgendaItem5_HealthCareandQualityAtlas.pdf

¹⁹ <https://hcai.ca.gov/wp-content/uploads/2024/01/January-2024-Board-Meeting-Presentation-3.pdf>
p. 132.

The first step in changing health care costs is setting a target that for the first time reflects the voice of consumers and other purchasers rather than just letting the health care industry charge whatever it can, no matter how unaffordable for consumers and other purchasers. For these reasons, we support the proposed target.

Thank you for your consideration. Please contact us with any questions.

Sincerely,



Beth Capell, Ph.D.
Policy Consultant



Anthony Wright
Executive Director

CC: Members of the Health Care Affordability Board
Assemblymember Robert Rivas, Speaker of the Assembly
Senator Mike McGuire, Senate President Pro Tempore
Assemblymember Mia Bonta, Assembly Health Committee Chair
Senator Richard Roth, Senate Health Committee Chair
Assemblymember Akilah Weber, M.D., Budget Subcommittee on Health Chair
Senator Caroline Menjivar, Senate Budget Subcommittee on Health and Human Services
Chair
Richard Figueroa, Assistant Cabinet Secretary, Governor's Office
Mary Watanabe, Director, Department of Managed Health Care

From: [REDACTED] on behalf of [Helen Fahey](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Monday, February 12, 2024 4:04:26 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.

We need universal healthcare!

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 Helen Fahey

[REDACTED]

From: [REDACTED] on behalf of [Helen Mlynarski](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Friday, February 23, 2024 12:23:08 PM

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Dear Office of Health Care Affordability Board,

My name is [NAME] and I am [DESCRIBE YOURSELF]. I work [DESCRIBE OCCUPATION, VOLUNTEER WORK, FAMILY OBLIGATIONS, AND/OR SIGNIFICANT DRAWS ON TIME]. Californians like myself, with numerous responsibilities and expenses, cannot afford the ever-escalating costs of the current health care system.

I have [DESCRIBE ANY MENTAL, EMOTIONAL, OR PHYSICAL HEALTH ISSUES] and I face [EXAMPLES OF HIGH COST OF YOUR CARE]. Because of these expenses, [DESCRIBE THE CONSEQUENCES OF EXPENSIVE CARE].

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 Helen Mlynarski

[REDACTED]



March 8, 2024

Secretary Mark Ghaly, MD, MPH
California Health and Human Services
Chair, Health Care Affordability Board
1215 O St. Sacramento, CA 95814

Re: Proposed Statewide Health Care Spending Target - CONCERNS

Dear Secretary Ghaly,

On behalf of the Hemophilia Council of California (HCC) and the California Rare Disease Access Coalition, and the thousands of patients we represent throughout the state, I am writing to express our concern regarding the proposed plan by the California Office of Health Care Affordability (OHCA) to set a 3% spending target, which threatens to have significant adverse effects on rare and chronic disease patients. The potential consequences of OHCA's proposed 3% spending growth target appears to prioritize cost containment over patient access to high-quality care.

Although OHCA was established with the intention of curbing healthcare cost growth while ensuring continued access to high quality treatments and services, it is evident that the proposed spending target fails to strike a healthy balance between the two. Considering OHCA has not been receptive to feedback from the patient community, we are significantly concerned that new cost-reduction strategies will discriminate against the sickest of us.

By prioritizing cost containment over patient needs, OHCA risks setting a dangerous precedent that could further marginalize individuals with rare diseases. We are concerned that a focus on a 3% cost containment will harm people living with rare diseases. Rare conditions cost 3 to 5 times more per person per year than common health conditions. Lack of available treatments is linked to a 21.2 percent increase in total costs per person per year and 373 of the 7,000 known rare diseases cost about \$2.2 trillion per year.ⁱ

While we applaud OHCA for focusing on making health care more affordable, we are concerned that the focus on a 3% cost containment target will harm rare disease patients who often experience a long diagnostic odyssey. It is estimated that rare disease patients face an average of four to five years to receive an accurate diagnosis.ⁱⁱ

We urge OHCA to reconsider its approach and prioritize the needs of rare disease patients in the target-setting process. It is imperative that any spending target be developed in close coordination with patients to ensure it is based on data and analysis and considers the underlying drivers of healthcare costs. By doing so, OHCA can ensure that California's healthcare system remains accessible, high-quality, and equitable for all residents.

Thank you for considering our concerns. I look forward to discussing with your office further.

Sincerely,

Lynne Kinst
Executive Director
Hemophilia Council of California

CC: David M. Carlisle, MD, PhD, Health Care Affordability Board Member
Sandra Hernández, MD, Health Care Affordability Board Member
Richard Kronick, PhD, Health Care Affordability Board Member
Ian Lewis, Health Care Affordability Board Member
Elizabeth Mitchell, Health Care Affordability Board Member
Donald B. Moulds, PhD, Health Care Affordability Board Member
Richard Pan, MD, MPH, FAAP, Health Care Affordability Board Member
Health Care Affordability Advisory Committee Members

ⁱ See Andreu P, Karam J, Child C, Chiesi G, Cioffi G. The Burden of Rare Diseases: An Economic Evaluation. Chiesi Global Rare Diseases. Available at https://chiesirarediseases.com/assets/pdf/chiesiglobalrarediseases.whitepaper-feb.-2022_production-proof.pdf. Accessed 6/10/2022. See also Tisdale A, Cutillo CM, Nathan R, et al. The IDeaS initiative: pilot study to assess the impact of rare diseases on patients and healthcare systems. *Orphanet J Rare Dis*. 2021;16(1):429. doi:10.1186/s13023-021-02061-3.

ⁱⁱ See Marwaha S, Knowles JW, Ashley EA. A guide for the diagnosis of rare and undiagnosed disease: beyond the exome. *Genome Med*. 2022 Feb 28;14(1):23. doi: 10.1186/s13073-022-01026-w. PMID: 35220969; PMCID: PMC8883622.

From: [Hitesh Shah](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Thursday, February 15, 2024 10:16:22 AM

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Dear Office of Health Care Affordability Board Members,

My name is Hitesh Shah 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,
Hitesh Shah

[REDACTED]

United States

From: [REDACTED] on behalf of [Irma Galindo](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Monday, February 12, 2024 3:10:46 PM

[You don't often get email from galindo195913@everyactioncustom.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,
Mrs. Irma Galindo

[REDACTED]

From: [REDACTED] on behalf of [James Kawamura](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Monday, February 12, 2024 3:08:52 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,
Mr. James Kawamura

[REDACTED] [REDACTED]



March 4, 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, like minimum wage and seismic mandates; 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 Ridgecrest Regional Hospital, meeting the proposed target will mean we will have to further cut more services. We have already made the painful decision to suspend OB services as well as certain clinic services. Further cuts will be necessary if the 3% target is put in place.

Also, we have recently gone through a 10% layoff as a result of our poor financial condition post Covid. Further cuts will only lead to more reductions. We also are having to delay replacing badly needed patient care and diagnostic equipment because cash reserves are so low.

Further, the 3% cuts will only exacerbate and create more uncertainty over meeting state mandates such as seismic retrofitting. Mandated seismic retrofitting will cost this hospital over \$25 million dollars. Spending cuts will make it more difficult if not impossible to make these renovations.



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,

James Suver, CEO/President
Ridgecrest Regional Hospital

From: [REDACTED] on behalf of [Janet Heinle](#)
To: [HCAI OHCA](#)
Subject: Public Comment on Initially Proposed OHCA Statewide Spending Target Recommendations
Date: Monday, February 12, 2024 1:09:28 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. Janet Heinle

[REDACTED]

From: [Jason Pullen](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Wednesday, February 28, 2024 4:01:06 AM

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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 \$85 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,
Jason Pullen

[REDACTED]

United States

From: [Jessica Twitty](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Thursday, February 15, 2024 10:16:36 AM

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CAUTION: This email originated from outside of the organization.

Dear Office of Health Care Affordability Board Members,

My name is Jessica Twitty 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,
Jessica Twitty

[REDACTED]

United States

From: [Jill B](#)
To: [HCAI OHCA](#)
Subject: Health care costs too much, Trust me I know
Date: Thursday, February 15, 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 Jill and I am writing to you today to share my health care story.

My health care costs me more than \$1000 per month in 2023 and increased by \$200 January 1st!

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. 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,
Jill B

[REDACTED]

United States