



Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Statewide Spending Target

The Office of Health Care Affordability’s Mission and Purpose

In 2022, the California Health Care Quality and Affordability Act (SB 184, Chapter 47, Statutes of 2022) established the Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI). Recognizing that health care affordability has reached a crisis point as health care costs continue to grow, OHCA’s enabling statute emphasizes that it is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal.

Health care spending in California reached \$10,299 per capita and \$405 billion overall in 2020, up 30% from 2015.¹ Californians with job-based coverage are facing higher out-of-pocket costs, with the share of workers with a large deductible (\$1,000 or more) increasing from 6% in 2006 to 54% in 2020.² For the third consecutive year, the 2023 California Health Care Foundation reports that more than half of Californians (52%) – and more than two-thirds (69%) of those with lower incomes (under 200% of the federal poverty level) – reported skipping or delaying at least one kind of health care due to cost in the past 12 months.³ Among those who reported skipping or delaying care due to cost, about half reported their conditions worsened as a result. Further, high costs for health care disproportionately affect Black and Latino Californians who report they had problems paying or could not pay medical bills (36% and 40%, respectively, compared to White Californians at 20%).³

OHCA has three primary responsibilities to achieve its mission of improved consumer affordability:

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>.

² Whitmore, H., & Satorius, J. (2021, August). *California Health Care Almanac, California Employer Health Benefits: Are Workers Covered?* California Health Care Foundation. <https://www.chcf.org/wp-content/uploads/2021/08/CAEmployerHealthBenefitsAlmanac2021.pdf>

³ Bailey, L. R., Catterson, R., Alvarez, E., & Noble, S. (2023, February 16). *The 2023 CHCF California Health Policy Survey*. California Health Care Foundation. <https://www.chcf.org/wp-content/uploads/2023/02/2023CHCFCAHealthPolicySurvey.pdf>

1. Slow health care spending growth through collection and reporting on total health care expenditure data and enforcing spending targets set by the Board.
2. Promote high value system performance; and
3. Assess market consolidation.

OHCA proposes a spending target methodology and target value before the Board's adoption of a final spending target value.

Background

As described in the OHCA enabling statute and summarized here⁴, the methodology for the spending target should:

1. Be available and transparent to the public.
2. Be based on a review of historical health care cost trends and projections (forecasts) of economic and population-based measures.
3. Be based on a review of historical cost trends, with differential treatment for COVID-19 years.
4. Consider potential factors to adjust future targets, including but not limited to, the health care employment cost index, labor costs, the 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.
5. Consider several criteria related to Medi-Cal, including but not limited to the non-federal share of spending, maintaining federal requirements to ensure full federal financial participation and health care related taxes or fees provided by the non-federal share.
6. Allow the Board to adjust targets downward, when warranted, for health care entities that deliver high-cost care that is not commensurate with improvements in quality.
7. Allow the Board to adjust targets upward, when warranted, for health care entities that deliver low-cost, high-quality care.
8. Require the Board to adjust targets, as appropriate, for a provider or a fully integrated delivery system to account for actual or projected nonsupervisory employee organized labor costs.

Statutory requirements 4, 6, 7 and 8 above are reserved for potential future adjustments after the Board sets an initial target and OHCA receives data to inform those adjustments. OHCA considered statutory requirement 5 through discussions with the Department of Health Care Services (DHCS). OHCA continues to collaborate with DHCS to ensure total health care expenditure data collection and proposed spending

⁴ These criteria are summarized from Article 3. Health Care Cost Targets [Health and Safety Code §127502].

targets consider the complexity of Medi-Cal financing and payments. This methodology document focuses solely on the discussion and decisions on the first three requirements.

OHCA Recommendations

OHCA recommends the adoption of a 3.0% statewide spending target for 2025-2029. This recommendation centers affordability for consumers by using median household income as the basis to inform the value. A 3.0% target places California on the path of a more sustainable, affordable, and equitable health care system, slowing the trajectory of growth and improving affordability for all.

This recommendation is based on the following methodology:

1. Using historical per capita health care spending data to inform the spending target.
2. Using historical median household income as the sole indicator to inform the target percentage.
3. Not adjusting the target for population-based measures or technology-related factors.

The subsequent sections provide the supporting rationale for this recommendation:

Historical Per Capita Health Care Spending Data and Economic Indicators

Table 1 below reviews publicly available historical per capita health care spending data from the Centers for Medicare and Medicaid Services (CMS) for California and shows the annual growth rates over the last 20 years.⁵

Table 1: Average Annual Growth in Per Capita Health Care Spending by Time Period

| Time Period | Average Annual Change (%) in Per Capita Health Care Spending |
|----------------------------|---|
| 5-year change (2015-2020) | 5.2% |
| 10-year change (2010-2020) | 4.7% |
| 15-year change (2005-2020) | 4.8% |
| 20-year change (2000-2020) | 5.4% |

Note: Health care spending refers to personal health care spending, which excludes public health activities, net cost of health insurance, government administration, and investment.

⁵ 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>.

To promote improved consumer affordability and achieve the goal of slowing the rate of health care spending growth, multiple stakeholders – including representatives of the Board and Health Care Affordability Advisory Committee – asserted it was important to establish a statewide spending target lower than the state’s long-term health care spending growth rate of 5.4%. OHCA agrees with these stakeholders.

The impact of COVID-19 on per capita spending in California may become evident in the 2020 to 2021 growth rate; however, using the 20-year average likely mitigates any COVID-19-related anomalies and results in an upper limit value of approximately 5.4%.

Of the eight states that have health care spending targets, all have tied their targets to one or more economic indicators, including state economic growth and indicators of income growth. The economic indicators OHCA evaluated for California were similar and are shown in Table 2 below:

Table 2: Historical and Forecasted Changes for Economic Indicators⁶

| Indicator | Historical | Forecast |
|--|-----------------------|----------------|
| Median Household Income | 3.0% (2002 – 2022) | 3.6% (2026) |
| Median Wage | 3.0% (2002 – 2022) | 2.6% (2026) |
| Gross State Product | 4.2% (2002-2022) | N/A |
| Potential Gross State Product ⁷ | N/A | 4.0% |

Historical Median Household Income

To promote consumer affordability, OHCA recommends historical median household income over median wages because it captures retirees and others not in the labor market and better reflects changes in affordability during times of recession. In addition, this is consistent with the Board’s preference for using a consumer-centric indicator to inform the target value.

⁶ U.S. Bureau of Economic Analysis. (2023, June). *California State Gross Domestic Product (GDP), 1963 to 2022*. State of California Department of Finance. <https://dof.ca.gov/forecasting/Economics/economic-indicators/gross-state-product/>; Economic Policy Institute. (2023). Current Population Survey Extracts, Version 1.0.47. <https://microdata.epi.org>; U.S. Census Bureau. (2023, September 12). *Median Household Income in California [MEHOINUSCAA646N]*, retrieved from FRED. Federal Reserve Bank of St. Louis. <https://fred.stlouisfed.org/series/MEHOINUSCAA646N>

⁷ Seven of the eight states included PGSP (except Oregon); however, this measure is not widely used in California nor forecasted for a sufficient number of outyears, so it was not recommended for inclusion.

Although some other states have blended indicators to arrive at a target value, OHCA recommends using historical median household income as a single economic indicator because it is simpler to publicly communicate and understand. There was strong support from the Board and stakeholders at the October 2023 Board meeting that consumer affordability be the basis for selecting an indicator in California, and agreement that using the average annual change in historical median household income correlates strongly with what consumers can afford.⁸

Using the 20-year average growth rate of historical median household income data reduces the volatility in year-to-year variation. This approach better reflects long-term patterns rather than relying on uncertain forecasting methods. In California, the unweighted average annual change in median household income for the 20-year period from 2002-2022 is 3.0%, which is 2.4 percentage points below the 20-year average annual change in per capita health care spending.⁹

Adjustments to the Target

As required by statute, OHCA reviewed population-based measures, and at the Board's request, also reviewed trends in the price of health care technologies. OHCA recommends against making adjustments to the target based on both of these.

OHCA discussed population-based measures at the October and December 2023 Board meetings and found adjustments based on age / sex, disability status, and prevalence of chronic conditions appear to be small and correlated with one another and potentially other economic indicators.¹⁰ OHCA also found there is limited data available to forecast the impact of some population-based indicators on future spending growth. Additionally, no other states with spending target programs have incorporated population-based adjustments.

OHCA reviewed potential adjustments to the target based on technology-related factors mentioned in the statute. OHCA found that technology is a driver of health care spending, but that it also can reduce health care spending. To adjust the target for technology factors affecting health care spending, OHCA would need to predict the net impact of new technology on health care spending in advance of market entry because the target is set in advance of the performance year. Further, broadly applying a technology adjustment would assume uniform adoption by all health care entities, which is inconsistent with practice and existing academic research.¹¹ For these reasons,

⁸ October (2023) Health Care Affordability Board Meeting. <https://hcai.ca.gov/wp-content/uploads/2023/10/October-2023-Board-Meeting-Presentation-1.pdf>

⁹ U.S. Census Bureau. (2023, September 12). *Median Household Income in California [MEHOINUSCAA646N]*, retrieved from FRED. Federal Reserve Bank of St. Louis. <https://fred.stlouisfed.org/series/MEHOINUSCAA646N>

¹⁰ See Board meeting presentations for [October 2023](#) and [December 2023](#).

¹¹ Garthwaite, C., Ody, C., & Starc, A. (2020 June). "Endogenous Quality Investments in the U.S. Hospital Market." National Bureau of Economic Research (NBER) Working Paper Series. <https://www.nber.org/papers/w27440>

OHCA recommends no adjustment to the target to account for trends in the price of health care technologies.

Rather than making prospective adjustments for uncertain technology impacts, other states provide context for drivers of spending when reporting unusual or infrequent events that have an outsized impact on spending growth (e.g., introduction of Sovaldi to treat Hepatitis C).

Multi-Year Target

A multi-year target provides payers and providers long-term predictability. Knowing the target value in advance allows the target to influence negotiations for health plan contracting and to inform strategic planning for health plan and provider operations. All other states with health care spending targets have established multi-year targets, with most settling on a five-year duration.

OHCA Recommendation

OHCA's final recommendation is adoption of a five-year, single fixed-value statewide spending target of 3.0% for 2025-2029, based on the average change in median household income for the 20-year period from 2002-2022.

Considerations for Revisiting the Target

In the event of extraordinary circumstances, including highly significant changes in the economy or the health care system, the Board may consider changes to the target. OHCA recommends that the Board meet annually to consider any needed updates to the target, including adjustments for unforeseen circumstances.