Alternative Framework for a Sustainable Spending Target

OHCA Staff Recommendation. The Office of Health Care Affordability (OHCA) staff have recommended an annual statewide spending target of 3% for 2025 through 2029. The recommended target is based exclusively on the long-term historical trends of a single economic indicator, median household income, which was chosen as a measure of consumer affordability.

Current Recommendation Misses the Mark. OHCA's goal is to improve affordability by implementing a spending target that ensures sustainable growth in health care spending. However, the current proposal misses the mark. Specifically, the proposed target:

- Fails to strike a balance between promoting affordability and maintaining access to high quality, equitable care
- Ignores external factors that influence health care costs, such as inflation and California's aging population
- Sets California apart as an outlier from other states that, despite higher spending targets, have struggled to meet them
- Sprints toward an enforceable target despite the fact that the rules of the road have not been established and there is no statutory mandate to set an enforceable target at this time

An Alternative Framework for a Sustainable Spending Target. The following table summarizes an alternative framework for setting a sustainable spending target. While OHCA staff's recommended methodology exclusively considers a measure of consumer affordability, this framework incorporates the major independent drivers of health care spending growth, which is essential for preventing the erosion of access to high-quality health care — particularly in already underserved areas.

Framework for a Sustainable Spending Target

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

Economy-Wide Inflation. California is currently experiencing inflation of around 4%, twice the historical average of what other states experienced prior to setting their spending targets. The spending target methodology should account for growth in prices for all goods and services in the economy. Failing to do so would leave the state's health care system unable to afford medical supplies, upgrades to its physical and technological infrastructure, and compete with other states and sectors for workers.

Economy-wide inflation is incorporated into this framework using projections from the independent Legislative Analyst's Office, which projects the California consumer price index to be 3.4% between 2025 and 2028 (0.4 percentage points higher than the target proposed by OHCA staff).[1]

Aging. The youngest members of the baby boomer generation are entering retirement age, while its oldest members are entering their 80s and 90s. This will put enormous strain on health care delivery and financing over the next decade, given the size of this generation and that health care spending on the elderly is three to four times that of an average American. Failing to incorporate an accurate aging adjustment would ignore the growing health care needs of California's aging population, endangering their health and longevity.

Population aging will add 0.7% (around $3.5 billion) annually to health care expenditures over the next five years. This projection marries two authoritative datasets on per capita health care expenditures and population projections: for expenditures, the National Health Expenditures data from the Centers for Medicare & Medicaid Services (CMS), which stratifies per capita health expenditures by age group;[2] and for population trends, projections applicable to 2025 through 2029 developed and published by the California Department of Finance.[3]

Technology and Labor. Technology and labor costs affect health care differently than other sectors and are treated differently under OHCA's authorizing statute. Adjustments must be included to incorporate the unique impacts these factors have on the health care sector.

- **Technology.** In health care, technological development typically comes in the form of new and expensive drug therapies and medical devices. Recent examples include Sovaldi, a hepatitis C drug that debuted at a price of $84,000 per treatment, and Ozempic, a popular diabetes and weight-loss drug that costs over $10,000 per year and is intended for use over a patient's remaining lifespan. Further novel therapies, like a new gene therapy for sickle cell amenia that will cost up to $3 million, are on their way. OHCA does not regulate pharmaceutical spending due to the carve out of pharmaceutical manufacturers and intermediaries. Similarly, OHCA does not have jurisdiction over durable medical equipment makers and sellers. As a result, it will not be able to control prices in these industries. Payers and providers should not be forced to absorb these cost increases, which would only lead to restrictions in access to these life-changing medications and technologies.

  To account for future expected growth in pharmaceutical and medical supply spending, an estimate of the portion of per capita health care expenditures going to these products should be added and grown according to historical trends (around 5.5%).[4] Identified in the chart above is the incremental impact in percentage terms of the higher growth above the 3% proposed spending target in these two service categories.

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[1] Inflation projections are from the Legislative Analyst's Office's The 2024-25 Budget: California's Fiscal Outlook.
[2] Reflects personal health care expenditures stratified by age and sex, taken from CMS's national health expenditure data.
[3] Aggregated from the California Department of Finance's population projections.
[4] Estimates come from CMS' estimates of health expenditures by state of provider, supplemented with estimates from Altarum on the proportion of drug expenditures that are billed via provider, rather than pharmacy, claims.

- **Labor.** Health care is a labor-intensive industry. For hospitals, labor expenses comprise about 60% of total costs. Industries that are labor intensive tend to grow relatively more expensive over time, as they do not benefit as much from cost-saving automation as other industries, like manufacturing (an industry that, unlike health care, is further subject to national and international competition).

  An adjustment is needed to reflect the greater labor intensity of health care, relative to other industries. The adjustment provided above is derived from an economic model developed in the *Journal of Health Economics* using state data on wages, employment, and gross state product.[5,6]

Major Policy Impacts. Federal, state, and local policymakers regularly approve policies with major impacts on health care spending. While dozens of laws are approved on an annual basis that raise spending by amounts that are relatively small or difficult to quantify within the context of the state's $500 billion health care system, just a handful of recently enacted or long-standing policies are expected to raise health care spending by between $10 billion and $20 billion in the coming years. This does not even include policies that will be enacted over the coming years that will further raise health care costs, likely in the latter years of the proposed spending target. Failing to account for policy changes would leave health care entities unable to afford the higher associated costs or, in other cases, even realize the investments intended by state policymakers. Examples of state legislation with significant financial impacts include:

- **Health Care Worker Minimum Wage.** In 2023, the state approved a new $25 health care worker minimum wage, which will be implemented gradually over the next several years. At full implementation, this new law is expected to raise health care spending by nearly $8 billion, or 1.5% compared to existing statewide health care spending. This estimate reflects incrementally higher costs above standard inflation (3.5%) due to the implementation of this new law.[7]
- **Investments in Medi-Cal.** In 2023, the state reauthorized the managed care organization (MCO) tax and dedicated a significant portion of the revenue to improving payments to Medi-Cal providers in an effort to address long-standing deficiencies in access due inadequate reimbursement. Largely starting in 2025, Medi-Cal reimbursement is set to increase by about $6 billion annually, which on its own will reflect a 1.1% increase in total health care spending in California.[8]
- **Seismic.** California's hospitals have been subject to seismic compliance for a number of years. The next major deadline to meet the state's seismic standards arrives in 2030, requiring hospitals to make over $100 billion in capital improvements over the next six years to comply

[5] Estimate is based on 10 years of historical economic data and the model developed by L.J Bates and R.E Santerre in their 2013 article in the Journal of Health Economics: *"Does the U.S. healthcare sector suffer from Baumol's cost disease? Evidence from the 50 states."*

[6] The Centers for Medicare and Medicaid Services' Office of the Actuary similarly recognizes that health care labor productivity increases at a slower rate than labor productivity in the general economy.

[7] CHA analysis of the Department of Health Care Access and Information's Hospital Annual Financial Disclosure Report with input from Capitol Matrix's *Economic and Fiscal Impacts of SB 525*.

[8] This estimate does not include the more than $6 billion in higher annual taxes that MCOs will pay and report as total health care expenditures.

with the state's rules.[9] By and large, hospitals will borrow to pay for these capital improvements. An estimate of impact assumes hospitals will utilize bond financing at 30-year terms at interest rates of 5.5%, which translates into the annual growth in expenses of around $500 million, or 0.1% of statewide health care spending.

Phase-In Factor. In addition to the factors identified in the table, OHCA must consider a phase-in factor that would help health care entities adapt to a lower spending growth environment. California's health care system cannot shift to a lower growth rate overnight without significant reductions in the numbers of workers and access to care. Health care entities will need to make new investments and make changes to their care processes to shift toward value-based care if they are to meet the spending targets without sacrificing quality, equity, or access. Such improvements will not bear fruit immediately. For example, better management of chronic conditions often requires higher up-front expenditures, with savings only to be realized over the years or decades that follow. Failing to incorporate such a factor would result in health care entities scrambling to cut their spending growth in faster and easier ways, such as by reducing service lines, not providing high-cost yet high-value services, and taking steps to protect themselves against sharp shifts in the risk profiles of their members. What's more, adding a phase-in factor would harmonize California's approach with those of other states, which on average have elected to gradually phase down their spending targets by nearly 1 percentage point over a period of four to five years.

[9] CHA analysis of the Department of Health Care Access and Information's Hospital Building Data file. Analysis assumes bond financing and a 50-50 split between hospitals choosing to retrofit non-compliant buildings and rebuild them.