February 22, 2024

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

Subject: **Comments on the January 2024 Health Care Affordability Board and Advisory Committee Meetings**
(Submitted via Email to Megan Brubaker)

Dear Dr. Ghaly:

California's hospitals and health systems share the Office of Health Care Affordability's (OHCA) goals of making health care more affordable while preserving and improving access to high-quality, equitable care and seek to partner with OHCA in pursuit of these worthwhile objectives. In service of these goals, the California Hospital Association recommends the following:

Reconsider OHCA's Spending Target Proposal

OHCA has an obligation to improve the affordability of health care **without sacrificing access to or the quality of health care**. While the office has shown clear commitment to improving affordability, its final recommendation for California's first statewide spending target misses the mark when it comes to preserving access, equity, and quality. *CHA urges the OHCA board to reconsider OHCA staff's proposed 3% target for 2025-29*, which would represent a sudden 40% drop in health care spending growth relative to long-term historical trends. The proposal:

- Fails to achieve the multiple objectives in state law related to the targets
- Ignores the drivers of health care spending, such as inflation and California's aging population
- Sets California apart as an outlier from other states, which have often failed to meet their higher spending targets
- Unnecessarily rushes toward the finalization of not only the initial, non-enforceable spending target, but also enforceable targets for 2026 and beyond

Take Time to Make a Thoughtful Decision. Setting a spending target is the most impactful decision the OHCA board will make. It will not only shape the growth trajectory of a $500 billion economic sector in California, but also affect Californians' ability to access cutting-edge, patient-centered, and life-saving care. When the legislation establishing OHCA was developed, lawmakers recognized this important responsibility and sought to develop a process that supported it in two ways:

- First, state law requires the board to balance multiple considerations: affordability, access, quality, equity, and workforce stability. To date, attention has focused almost exclusively on the first

consideration, leaving major gaps that must be addressed if the board is to meet its statutory mandate.

- Second, state law establishes rolling deadlines: June 2024 for the board to set an initial, non-enforceable target for 2025, June 2025 for the first enforceable target for 2026, and so on. This timeline allows for thoughtful deliberation and the drawing of lessons from the initial year's data collection. By proposing a multi-year target at this stage, OHCA is missing a critical opportunity to ensure the target is realistic, achievable, and supportive of hospitals' and other providers' efforts to improve the value of the care they provide.

Accordingly, the board should take the time needed to reach a thoughtful decision on the spending target, including taking seriously the feedback OHCA receives from regulated entities through the public comment process. *The board should consider using the March board meeting to deliberate this feedback, and return at a later date, within the time afforded in statute, to make this consequential decision.*

Obtain Meaningful Feedback from the Advisory Committee. Obtaining and taking time to consider the feedback of the health care field is all the more essential given deficiencies in how advisory committee input has been transmitted to the board to date. At the most recent advisory committee meeting, nearly six hours of discussion was boiled down to a verbal summary to the board lasting less than five minutes. Moreover, the summary papered over genuine disagreements and questions around OHCA's proposed spending target, creating a mistaken impression of near consensus. This raises process concerns that can and must be addressed through greater consideration of the diverse perspectives being aired on matters before the advisory committee.

Recognize the Drivers of Health Care Spending. OHCA's proposed target ignores the drivers of health care spending, instead focusing exclusively on a single economic indicator that bears little relation to the health care sector. Without changes that account for the true drivers, the spending target risks forcing health care providers to cut back on the care they provide, or face penalties for delivering the care their patients need. To avoid this, OHCA must recognize at least the following six essential components in setting a spending target:

- **Inflation.** Over the next five years, the Legislative Analyst's Office projects inflation to be 3.4% annually. In other words, OHCA's proposed spending target would dictate a decline in real health care spending of nearly a half a percentage point each year, assuming no change in utilization patterns despite the growing health needs of California's population and concerted efforts, in Medi-Cal and beyond, to improve access to care. Hospitals and other providers would find themselves not only unable to afford medical supplies and infrastructure updates, but also unable to compete with other states and sectors for workers.
- **Growing Health Needs of an Aging Population.** The oldest members of the baby boomer generation are entering their late 80s and 90s, while the youngest members are just now reaching retirement age. Health care costs for seniors are five to nine times those for children and youth. Under these demographic trends, aging alone is projected to increase health care spending in California by 0.7% annually, a far greater impact than what OHCA staff presented, and a factor unaccounted for in OHCA's proposed spending target.
- **Technological Change.** In health care, technological development often 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 lifetime. 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 manufacturers, intermediaries, or retailers. However, payers and providers are responsible under the target for any growth in these unregulated sectors. To rectify this contradiction, OHCA must recognize the cost of pharmaceutical and other innovation in the spending target to avoid punishing health care entities for factors beyond their control and protect against the rationing of new, life-saving treatments.

- **Labor Intensity.** Health care is a labor-intensive sector. For hospitals, labor expenses make up nearly 60% of total costs. Sectors that are labor intensive tend to grow relatively more expensive over time, commanding a greater share of people's incomes, as they do not benefit as much from cost-saving automation seen in other industries, like manufacturing, which — unlike health care — is more subject to national and international competition. Broad economic indicators like median family income and inflation average out these fundamental differences between industries, making them ill-suited as a reference point for a health care spending target, unless adjustments are made. Consistent with findings from the Centers for Medicare and Medicaid Services' Office of the Actuary, OHCA should recognize this important factor in setting the spending target.
- **Health Care Policies that Drive Up Costs.** Policies adopted by the Legislature — such as the dedication of new tax revenues to raise Medi-Cal reimbursement rates and the enactment of a new health care worker minimum wage — will add billions of dollars in health care spending. In fact, these two recent policy changes, on their own, will raise health care spending by 2.5% in tandem over the next three years. The proposed spending target does not accommodate these or any other changes enacted by policymakers.
- **Facilitation of Thoughtful, Meaningful Change.** To make care more affordable without harming access, quality, or equity, health care entities will need to make new investments and change their processes to shift toward value-based care. While this has the potential to lead to long-term cost savings, it requires significant up-front investment and will not produce cost savings overnight. By setting a flat, multi-year target, OHCA has failed to recognize the time needed to truly improve the value proposition of health care. Instead, in effect, OHCA is encouraging the hasty slashing of costs. Patients would bear the brunt, as health care entities would be left scrambling to cut their spending growth in the fastest ways possible: closing service lines, reducing workforce, not offering the latest drugs and medical technologies, and curtailing investments in their infrastructure and care processes.

Other States Have Struggled to Meet Their Targets. Spending target programs have been implemented in eight other states — and more often than not, states have missed their targets. As the figure below shows, other states have missed their targets in 10 out of a possible 17 years, or six out of a possible nine years when only considering the pre-COVID-19 period. On average, other states have missed their targets by 1 percentage point, showing they set their targets 20%-25% lower than they reasonably should have.

Other States Have Missed Their Spending Targets More Often Than Not								
	All Years				Pre-COVID-19			
	Average Performance	Average Target	Years Target Missed	Years in Place	Average Performance	Average Target	Years Target Missed	Years in Place
Connecticut	6.1%	3.1%	1	1			0	0
Delaware	5.3%	3.3%	2	3	5.8%	3.8%	1	1
Massachusetts	3.5%	3.4%	5	9	3.6%	3.5%	4	7
Nevada		2.8%	0	0			0	0
New Jersey		3.1%	0	0			0	0
Oregon	3.5%	3.3%	1	1			0	0
Rhode Island	1.5%	3.3%	1	3	4.1%	3.2%	1	1
Washington		3.8%	0	0			0	0
Averages/Totals	**4.0%**	**3.0%**	**10**	**17**	**4.5%**	**3.5%**	**6**	**9**

Nevertheless, OHCA Has Proposed a Target Even Lower Than Other States. California's proposed target is lower than that of all other states when considered on a multiyear basis. In fact, while the other states set their targets to exceed the historical growth in their economies by about 1 percentage point (or 45% higher) on average, OHCA's proposed target would be nearly 2 percentage points (39%) lower than California's historical economic growth rate. Moreover, inflation in the year prior to the other states setting their target averaged a mere 1.8%, whereas for California, prior year inflation came in at 4.2% — a factor entirely unrecognized in OHCA's proposal.

Importantly, other states' targets are higher than OHCA's proposal because all other states phase their targets in, typically over four to five years. Rhode Island, which had a flat 3.2% target in place for four years, had been the lone exception. However, the state subsequently revised its approach and set its target at 6% in 2023 and 5.1% in 2024, then incrementally lowering it thereafter to 3.3%.

OHCA's aberrantly low proposed target would mean that even health care entities making strides toward improving affordability would miss the spending target in at least one of the next five years, exposing them to the largely undefined yet potent enforcement tools at the office's disposal.

Strive for a Transparent and Standardized Data Collection Process

While CHA has been supportive of OHCA's overall approach to data collection, the revised regulations fail to make improvements to ensure transparency, standardization, and clarity, including for how a quarter of the state's health care spending, that under Medi-Cal, will be treated.

- **Lack of Transparency.** Inaccurate or manipulated data will threaten the credibility of the spending target program. It is troubling that neither providers nor the office itself will have line of sight into the spending that payers attribute to providers due to there being no validation process. Such processes exist as part of other health care financing programs — like the Maryland All-Payer Model and the California Hospital Quality Assurance Fee Program — and must be included in OHCA's data collection process.
- **No Standardization.** OHCA's data collection rules lack clear and consistent standards for how health plans and insurers must attribute their members to providers when assignment is not clearly determined by contractual arrangement. Rather, the only requirement is that payers use a "[payer]-developed, rules-based approach." This is concerning as it will:
    - Increase the incidence of misattributing patients to providers
    - Result in the attribution of patients to providers that do not meaningfully influence a patient's utilization patterns and costs
    - Create apples-to-oranges comparisons of spending across payers and providers

- Open the door for data to be used in ways OHCA didn't intend

While the next couple of years can and should be used to learn about which approaches to patient attribution do and do not work in California, reasonable guardrails should be established now to ensure the collection of credible and consistent data.

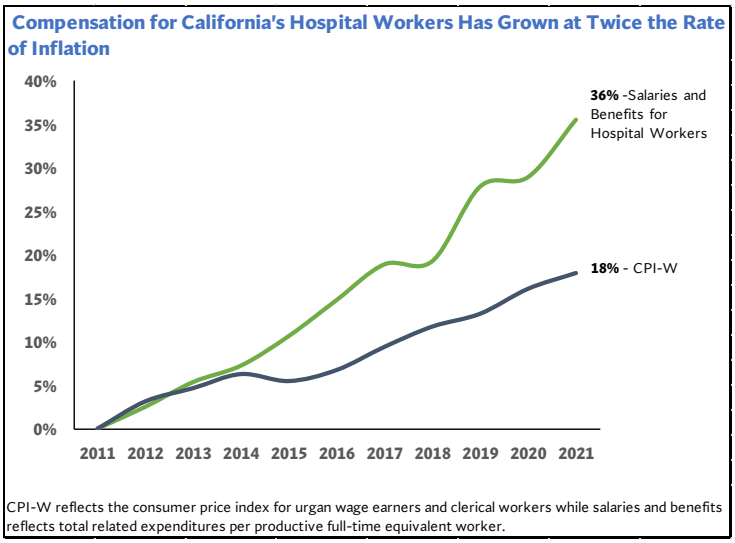
- **Clarity on Medi-Cal Spending.** Medi-Cal financing is enormously complex, so getting the data collection and analysis pieces right will take time. Apart from establishing that the Department of Health Care Services (DHCS), in lieu of the health plans, will initially provide the Medi-Cal spending data, the proposed guidance largely sidesteps related issues. We look forward to working with OHCA and DHCS to stand up an effective Medi-Cal data collection process.

Reconsider Hospital Spending Methodology

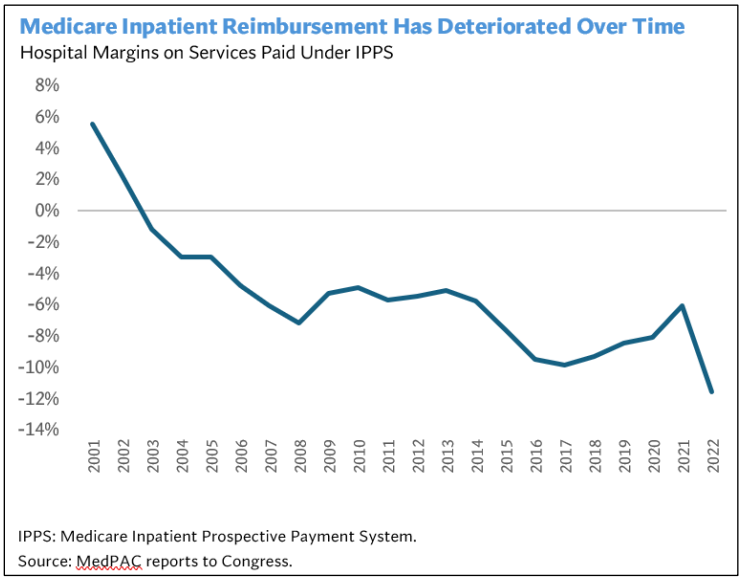
In January, OHCA introduced a new effort to assess hospital spending, citing hospital costs and prices as a driver of the lack of affordability. This focus on hospital spending unfairly targets a single provider type, despite health care being a vast network, of which hospitals are one piece. Moreover, it comes at a time of unprecedented financial distress, with 52% of hospitals experiencing negative operating margins according to data collected and analyzed by OHCA's parent department. This misplaced focus occurs as health insurance companies — four of which effectively control the entire commercial market in California — are earning billions and engaging in practices that undermine access to patient-centered care.

What's more, the information presented by OHCA on hospital spending misled more often than it clarified. Factors this presentation ignored include:

- **Hospitals Provide Services, Not Goods.** The inflation rates displayed in the chart from the American Enterprise show a clear pattern — service sectors like health care, education, and child care have experienced high inflation, while goods like clothing, cars, toys, and TVs have seen low inflation. The drivers of these differences are as previously discussed: the former are labor-intensive industries not subject to labor-saving technological change or significant international competition; the latter are not.
- **Advancements in Health Care Often Skew Measures of Inflation.** Measurements of inflation frequently struggle to appropriately reflect changes in the quality of goods and services over time, a challenge that is only more true in health care. Research by David Cutler and the Bureau of Economic Analysis reveals that the failure to appropriately reflect quality improvements in health care leads to a vastly overstated picture of medical inflation. **In fact, when properly accounted for, medical inflation shifts from being a half percentage point above economy-wide inflation to over a percentage point below.** A similar phenomenon applies specifically to hospital services, which the Bureau of Labor Statistics has found to be overstated by roughly a quarter of a percentage point. Incorporating this adjustment reduces aggregate price inflation for hospitals services to be roughly in line with that of educational services and motor fuels over the past 23 years.
- **Hospital Labor Expenses Outpace Inflation.** Hospital prices are growing because hospital expenses are growing. For example, labor expenses for hospitals grow in excess of 5% in a typical year — significantly higher than inflation. Over 90% of this growth is for non-supervisory workers and the majority is due to higher wages. The figure below shows that hospital worker compensation has been twice that of broader inflation.



- **California Hospital Prices Are No Higher Than Differences in Cost of Living and Labor Expenses Would Indicate.**The OHCA slides show commercial prices for hospital inpatient and outpatient services to be higher than average national prices by 8% and 40% respectively. The presentation neglected to provide important context for why California hospital prices may differ from those in other states — namely, that compensation for nurses, hospitals' largest group of workers, is 33% higher than the national average *after* accounting for the fact that California's cost of living is nearly 13% higher than for U.S. residents as a whole.
- **Commercial Reimbursement Covers Public Payer Shortfalls.** OHCA's presentation shows that reimbursement levels are higher for commercial coverage than Medicare. On its face, this can lead to a false understanding that commercial reimbursement levels are excessive. In reality, commercial payers play a pivotal role in covering growing shortfalls in reimbursement from public payers. As the figure below shows, inpatient reimbursement in Medicare now covers just 88 cents for every dollar spent on patient care. This shortfall is only increasing, compounded by a growing shift from commercial to government coverage under Medicare and Medi-Cal.



- **Over Half of Hospitals Are Operating in the Red.** Fifty-two percent of California's hospitals had negative operating margins in 2022, according to HCAI data, meaning the prices they are charging are insufficient to cover their expenses.

Request Close Consultation with the Hospital Field. As this effort to measure hospital spending moves forward, OHCA must lean heavily on experts with current, real-world experience in hospital finance. Otherwise, OHCA risks developing a methodology that fails to appropriately capture the full realities and complexities of how hospitals fund the care they provide to California's patients.

Conclusion

Plan for the Health Care System Californians Need and Deserve. California's health care system provides world-leading, life-saving care to millions of patients every year. A poorly considered, hastily developed spending growth target would have dire consequences for millions. CHA is committed to helping the office develop a thoughtful, data-driven approach. We are grateful for the opportunity to comment, and look forward to continuing to work closely with OHCA staff and its board to craft policies that meaningfully address affordability challenges while protecting access to health care.

Sincerely,

Ben Johnson
Vice President, Policy

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