



April 19, 2024

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

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

Millions of Californians each year rely on hospitals for life-changing, life-saving care. California’s hospitals recognize that accessible, affordable care is out of reach for too many patients and stand ready to work with the Office of Health Care Affordability (OHCA) and other stakeholders to transform our health care system into one that best serves patients. To this end, and on behalf of more than 400 hospitals and health systems, the California Hospital Association (CHA) is grateful for the opportunity to comment on OHCA’s March Health Care Affordability Board and Advisory Committee meetings.

Modifications to the Proposed Spending Target Are Essential

Proposal Would Set Up Health Care Payers and Providers to Fail. A credible target is an achievable target that reflects the need to improve affordability for all Californians and the actual costs of providing essential health care services — not a false promise that commits to spending levels that economic, demographic, and public policy trends all show would be unattainable. A credible target must be one that payers and providers both recognize in their negotiations and strategic planning as an achievable goal — not one that condemns all payers and providers to failure.

Unfortunately, OHCA staff’s proposed 3% spending target ignores this precept. As has occurred in most other states, California health care spending is almost certain to blow past the target, raising doubts among health care entities and the public about OHCA’s efficacy while subjecting hundreds of health care entities to an opaque enforcement process that lacks any clear standards.

Fortunately, there is time to fix these deficiencies. Hospitals encourage the board to consider the adjustments summarized in the “Framework for a

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%

Sustainable Spending Target,” proposed in [CHA’s March 8 letter](#). These adjustments would place the spending target on a more attainable, sustainable, and credible path.

OHCA Should Adopt Two Board Member-Proposed Modifications.

In March, OHCA board members proposed two reasonable modifications to the proposed spending target, which CHA encourages the board to adopt:

- A demographic adjustment aimed at protecting access to care for California’s growing aging population
- A glide path to prevent shocks to the system and promote longer-term affordability and access, not the indiscriminate slashing of costs

A Demographic Adjustment Is Essential.

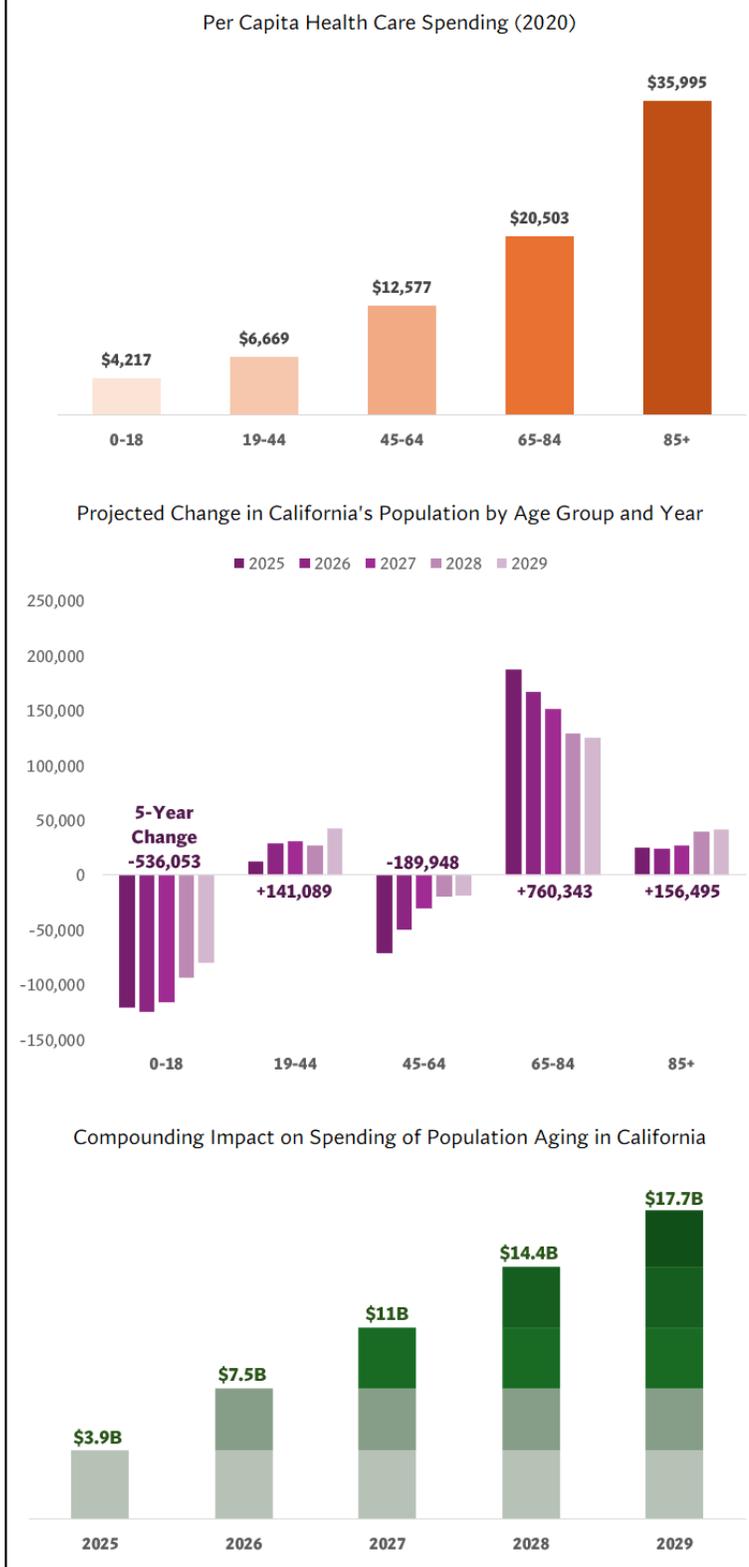
The figure on the right shows three trends that cannot be ignored:

- Health care spending on seniors is nearly 10 times that for children and youth.
- California’s 65+ population is projected to grow by over 900,000 over the next five years.
- These two factors will raise health care spending by nearly \$18 billion (3.5%) over 5 years.

The proposed spending target focuses solely on household earnings, entirely failing to acknowledge the growing health needs of this vulnerable population.

Population aging will increase the need for health care services due to growth in chronic disease and cancer prevalence. Between 2024 and 2029, [2 million additional Americans are projected to be diagnosed with cancer](#), a roughly 10% increase in just five years. According to the National Institutes of Health, cancer treatment [costs](#) over \$150,000 per

Aging Is Expected to Increase Health Care Spending in California by Nearly \$18 Billion Between 2024 and 2029

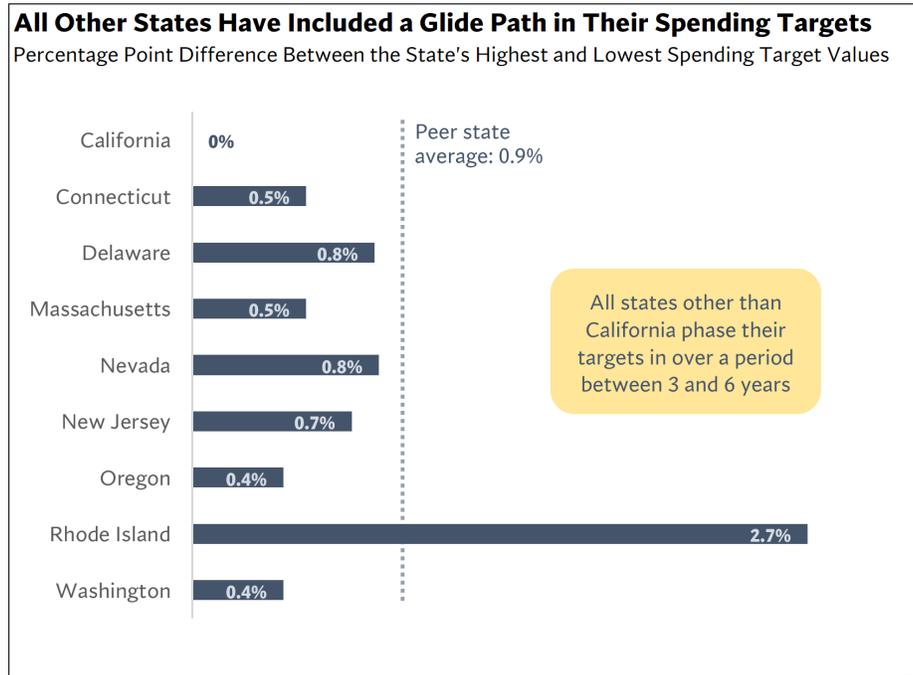


Source: Demographic projections from the California Department of Finance and per capita health care spending estimates from the Centers for Medicare and Medicaid Services' National Health Expenditures.

patient, more than 10 times that of general health care spending for the population as a whole. Unless unduly rationed, treatment for these additional cancer patients, and other aging Californians with growing health needs, would save millions of lives and come at a real — but entirely worthwhile — cost.

Adding an aging adjustment would acknowledge the growing needs of California’s aging population and place the target on a more sustainable path. While CHA believes a 0.7-0.8% adjustment would

more accurately capture the anticipated impact of aging, hospitals support the inclusion of a 0.5% adjustment and urge the board to adopt this essential change.



A Glide Path Would Protect Against Sudden Reductions in Access and Quality. OHCA’s fundamental responsibility is to improve value without sacrificing access to, or the quality of, health care. This cannot be achieved overnight. Nevertheless, the current proposal would mandate, in a single year, a 40% reduction in spending growth. Such a radical change in the long-term trajectory of health care spending growth cannot be achieved without drastic measures that would have serious, negative consequences for patients, such as service line reductions; decreased investment in technology, workforce, and other critical needs; and slower innovation.

In stark contrast, raising the value proposition of health care depends upon delivering the right care, at the right time, and in the right place. It means preventing disease before acute care is needed, including through expanded access to primary care and behavioral health services.

Achieving OHCA’s underlying vision will require more investment at the outset, not immediate caps on spending that do not even keep up with general inflation. The benefits of improvements like expanded primary care can only be realized gradually, meaning divestment now will only make the transition to better care more difficult and fraught with unnecessary patient suffering.

A glide path also would recognize the state’s current efforts to increase equitable access to care and address health care workforce challenges, such as to expand Medi-Cal access or raise minimum wages for health care workers. These two policy changes alone, combined with other cost pressures, would make it impossible for the vast majority of health care entities to meet a 3% spending target starting as soon as next year. Accordingly, a glide path would move the spending target in the right direction by making it more realistic, attainable, and credible.

Every Other State Spending Target Program Includes a Glide Path. Every other state with a similar program has recognized the need to facilitate a planned transition to a lower spending growth environment, rather encourage a mad dash to lower spending at the expense of patient care. As such, every other state has phased its target down over time. On average, the eight other states started with

(or adjusted to) targets that initially are about 1 percentage point higher than their final targets, phasing them in gradually over three to six years. The figure on the right shows the difference between the other states' highest and lowest targets, showing by how much they phased their targets in over time. (See appendix 1 for more detail on each state's glide path and how states have performed against their spending targets to date.)

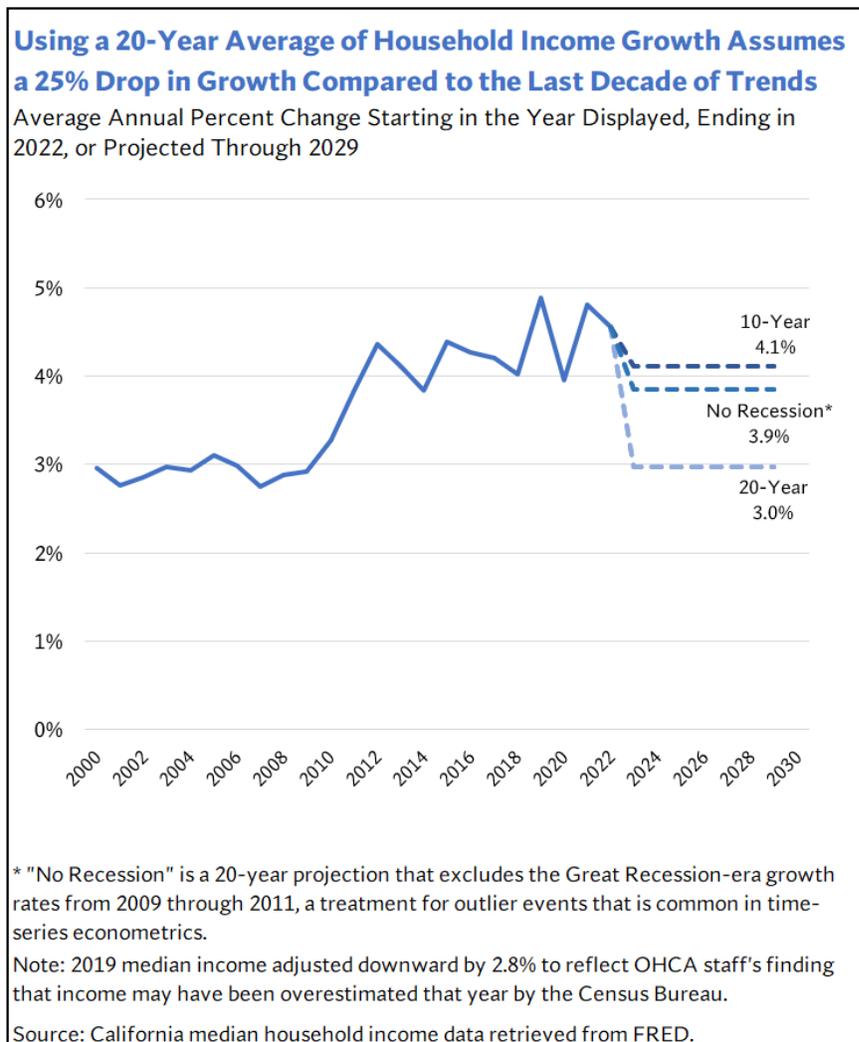
OHCA Board Must Adopt a Meaningful Glide Path. With the aim of ensuring attainability, preventing sudden deterioration in access and quality, and incorporating lessons from other states, the board should adopt a glide path that gradually reduces the spending target over five years. Based on other states' experience, starting about 1 percentage point above the final target value would be appropriate.

Proposed Spending Target Methodology Continues to Contain Major Flaws

CHA's March 8 letter revealed several significant flaws with the proposed spending target methodology and value, including to the use of a 20-year lookback at household income growth and additional ways in which OHCA's proposed target is an outlier compared to other states. These flaws must be addressed before a target is finalized.

Using a 20-Year Lookback for Household Income Growth Mistakenly Assumes a Massive Drop in Growth Going Forward.

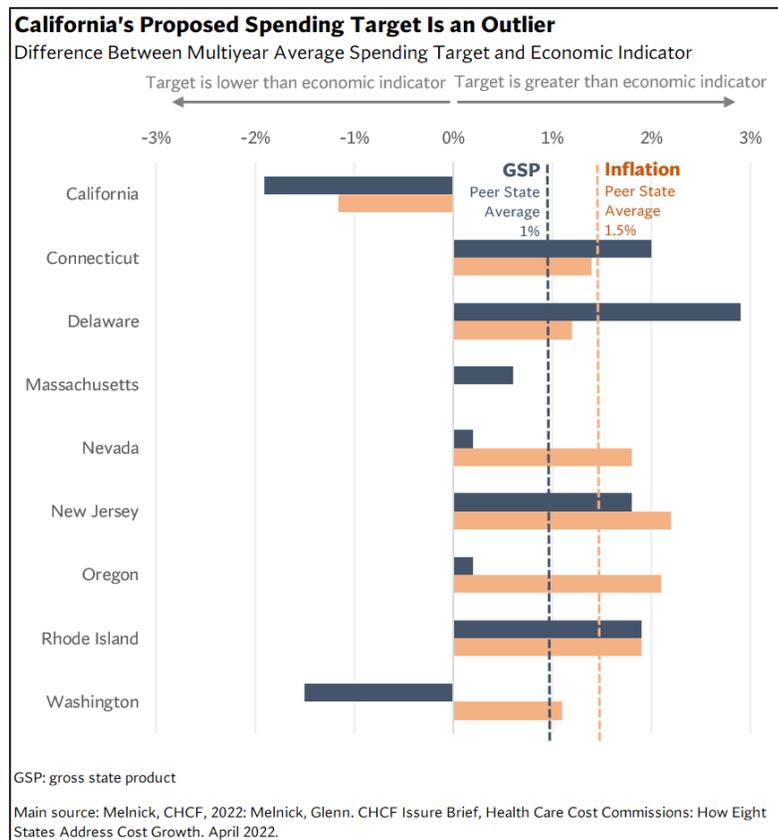
OHCA's stated rationale is that health care spending should not grow faster than household income. However, OHCA's estimate of household income growth is biased by using old data that includes the worst recession in a century. As the figure on the right shows, OHCA's estimate effectively assumes a more than 25% drop in household income growth compared to the last decade's trend. This is driven by the inclusion of the Great Recession period between 2009 and 2011, when growth was negative. The Great Recession was, by definition, an outlier event. Economists and professional forecasters, when analyzing trends over time, generally exclude outlier events from their projections, effectively assuming events that occur once in a hundred years will not occur again in the next several



years. In addition to showing how a 10-year average is more reasonable than a 20-year average, the graph above shows that using a 20-year trajectory that removes the outlier years results in a multiyear average of 3.9%. Moreover, this methodology has limited volatility and has been more predictively accurate of

household income growth than other approaches. The board should consider modifying the proposed household income methodology to remove the effect of the Great Recession.

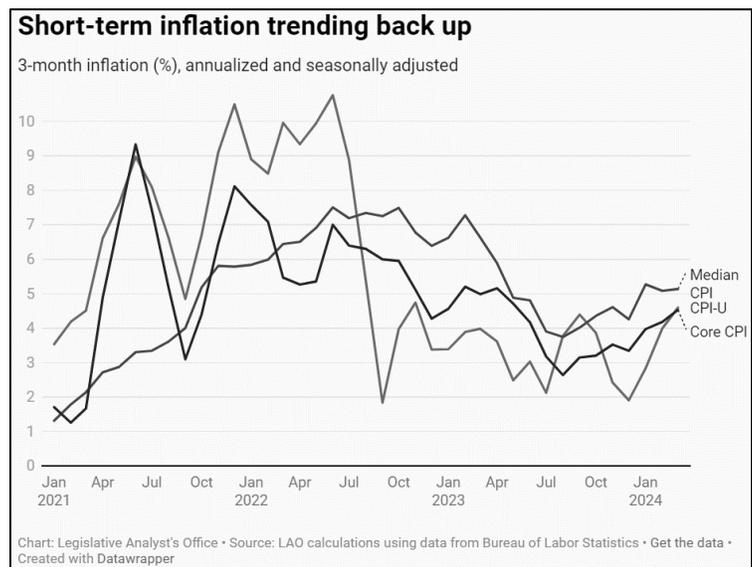
OHCA’s Proposal Is Inconsistent with Other States’ Approaches. OHCA’s proposed target is the most aggressive in the nation, and not just because it fails to include a glide path.



Only one other state has set a health care spending target that is less than its historical economic growth: Washington, which has a nonbinding target. On average, other states set their targets to be about 1 percentage point **higher** than their recent historical economic growth. In contrast, OHCA has proposed a target that is nearly 2 percentage points lower than California’s recent economic growth. The same holds true for inflation: all other states set their targets higher than recent historical inflation (1.5 percentage points above, on average). OHCA’s proposed target is more than 1 percentage point less than recent inflation. The figure on the left illustrates just how much of an outlier California’s spending target would be in relation to other states on these two key economic indicators. No justification has been given for why California’s target should

stand alone in these critical respects.

Inflation Ticking Up, Not Down. Health care spending is driven by broader economic conditions, like inflation and economic growth. And yet, the proposed spending target ignores the primary economic trend of the last two years: sky-high inflation that is proving anything but transitory. While inflation averaged less than 2% in the year leading up to when other states set their spending targets (averaging 3.3%), inflation came in at over 4% in the year leading up to California setting its target. Despite moderation toward the end of 2022 that led to hopes that it would return to its targeted level of 2%, high inflation has not only persisted, but, in fact, grown worse, prompting the Federal Reserve to [signal](#) that interest rate cuts will be delayed to later in the year at the earliest. As of March, short-term inflation stands at an annual rate of 4.6% (more than 50% higher than the proposed spending target). Moreover, inflation is concentrated almost entirely



within the service sector — which includes most of the health care sector. The OHCA board must recognize that the spending target is being set in economic conditions that did not apply when other states set their target, and that an adjustment is needed if the target is not to be ignored due to being wholly disconnected from the cost of patient care.

Integrated Healthcare Association (IHA) Data Do Not Demonstrate That a 3% Target Is Achievable.

At the March board meeting, OHCA presented publicly reported total cost of care data from IHA in an effort to demonstrate that its spending target is achievable. OHCA's contention was that growth of 3% among reporting health maintenance organizations (HMO) between 2017 and 2021 showed that 3% spending growth is an attainable goal. However, while the IHA data represent an invaluable source of information on health care spending and quality, CHA understands that the publicly reported data used by OHCA excluded certain high-cost patients' spending growth from the dataset, resulting in understated spending growth in the HMO line of business. Once revised, we understand that IHA estimates growth over this period was closer in line with the 5% annual growth in health care spending that California and the nation have experienced over the long term.

Further questions abound related to whether these data justify the OHCA staff proposal. First, using a historical series of spending growth that ends in 2021, the middle of the COVID-19 pandemic, undoubtedly biases the resulting growth figures unless artificially corrected. Second, while the spending data are risk-adjusted, this risk adjustment does not eliminate the systemic difference in the risk profiles of HMO versus preferred provider organization (PPO) members. Despite an apparent anomaly in the 2021 public data, these data otherwise make clear that PPO members have higher health needs than those in HMOs, driving higher growth in this insurance product type.

Cost-Reducing Strategies Hold Promise, But Will Take Time to Bear Fruit. OHCA has sought to learn from health care entities about strategies to bend the cost curve and improve the value of California's health care system. To date, one health plan and two health systems have presented to the board their successful strategies. Health systems emphasized investments in integrated, whole-person care with aligned value-based financing arrangements as fundamental drivers of success. At the same time, they acknowledged that the widespread penetration of the HMO model in California means that future opportunities to generate savings from expanding this care model are more limited in California than elsewhere. Further, CHA has presented opportunities to improve the value of patient care, such as improving the care transition process so that patients can move to lower levels of care as soon as their conditions permit, streamlining utilization management and payment processes that divert time and resources from clinical care, and other policies that promote whole-person, integrated care.

While there are known and promising opportunities to improve the value of care, the realizable savings that can be generated by implementing new policies and strategies is uncertain, unlikely to materialize quickly, and [smaller than the roughly 10% cut](#) in health care spending that a 3% spending target would impose compared to longstanding growth trends over a five-year period.

Medi-Cal and Medicare Payers and Providers Must Be Subject to Consistent Enforcement Standards

In March, OHCA staff presented its intent to provide a blanket exemption from enforcement against the spending target for payers for growth in their Medi-Cal and Medicare lines of business. As justification, staff cited the fact that public payer spending is regulated by other state and federal agencies. However, OHCA does not propose to extend this blanket exemption to providers. Instead, staff declared an intent to determine whether to enforce spending against the target within providers' public lines of business on a case-by-case basis.

The proposed inequitable treatment of payers versus providers has no justification. In Medi-Cal, the Department of Health Care Services (DHCS) reviews historical pricing and utilization data coming from plans that are equally constitutive of what is paid to providers. DHCS and its actuaries ultimately certify the reasonableness of these reported pricing and utilization levels, with adjustments to account for trends, policy changes, and other factors. For these purposes, the spending data going into the DHCS review are simply two sides of the same coin for payers and providers.

The following example illustrates the incoherence of the proposed approach. Imagine that DHCS certifies a year-over-year capitated rate increase of 5% to protect and promote access in Medi-Cal. Unless plans were to keep the entire increment of the capitated rate increase above, for example, a 3% spending target for their own administrative functions and profit, their providers' year-over-year revenue growth would be above the spending target. Punishing providers for "excess" growth would disregard DHCS' decision to raise capitated rates above the target and create a double standard where providers, but not payers, could be punished by one regulatory body (OHCA) for decisions made by another (DHCS). To prevent such a circumstance, OHCA should treat providers according to the same standard it proposes for payers, rather than subjecting them to enforcement against the target for spending in public programs.

OHCA's Approach on Workforce Stability Is Reasonable; Including Physicians Would Make the Effort Even More Comprehensive

In March, OHCA unveiled a comprehensive and workable approach to measuring workforce stability. The proposed approach appropriately aims to not only look at performance at the individual entity level, but at the statewide and geographic levels as well as a means of identifying and helping policymakers address systemic workforce challenges impeding access to affordable care. The approach relies on existing, extensive reporting by health care entities and other organizations, rather than imposing new burdens. It recognizes both the learning that the office must do in this novel effort and the distinct ways that health care entities track and promote their performance on workforce development.

One change should be considered. As multiple OHCA advisory committee members noted, the proposed approach forgoes a promising opportunity for OHCA to comprehensively assess health care workforce stability. Specifically, OHCA has declared an intent to not include the physician workforce in its analyses. Given the extent of primary care and other physician shortages and the resulting access barriers, as well as the opportunity to be a comprehensive source of information on the health care workforce, OHCA should include this set of professionals in its work.

Increased Focus on Health Plan Profits and Practices is Essential

OHCA's success will depend wholly on whether payers translate lower growth in medical expenditures into lower premiums and cost-sharing requirements. To date, OHCA has paid scant attention to the practices of health plans that have impacted — and will continue to impact — Californians' ability to afford health care. Increased scrutiny of the practices and finances of the state's \$240 billion health plan industry is essential for progress on OHCA's mission. Below are just a few of the ways health plans drive affordability problems and the steps OHCA can take to address them:

- **Special Oversight of Health Plan and Insurer Premiums Is Needed.** OHCA's work will be to no avail unless health plans and insurers translate the savings from constrained growth in health care spending to lower premiums and cost-sharing requirements. Accordingly, OHCA must incorporate into its analysis data on premium spending and out-of-pocket costs. While OHCA has proposed using the Medical Expenditure Panel Survey to assess the latter, no attention has been paid to the former. Fortunately, data are readily available on premiums since health plans and insurers currently report this information to state regulators. OHCA should gather this premium

data and report on how premium growth compares to OHCA's own measures of health care spending growth. This will be essential for actually holding payers accountable under the spending target and evaluating whether OHCA is achieving its stated goal.

- **Spending Target Must Apply to Health Plan and Insurers' Administrative Spending and Profits.** Within the next two months, OHCA will establish the first statewide spending target. This will apply to all health care entities, including payers. Paragraph (h)(1) of Health and Safety Code Section 127502 requires that "*Targets set for payers shall also include targets on administrative costs and profits.*" Despite this clear statutory requirement that spending targets applicable to payers explicitly extend to their administrative costs and profits, OHCA has not proposed how it will do so. At an upcoming board meeting, OHCA should present on how specifically it intends to fulfill this critically important provision in law that aims to prevent health plans and insurers from profiting while at the same time limiting access to care for their members.
- **Severe Lack of Competition.** Just three health plans control over [75% of the commercial market](#), meaning premium purchasers have almost nowhere to turn to obtain better rates and benefits. This troubling lack of competition allows health plans to collect outsized profits without providing real value to their members. OHCA should use its substantial resources and analytical capacity to shed light on the limited choices health care consumers have when selecting coverage and encourage meaningful competition.
- **Vertical Consolidation.** When health plans pay for care, they often are simply paying their own subsidiaries. This is because health plans increasingly own or are [affiliated](#) with the medical groups, pharmacy benefit managers, and other intermediaries through which their members must access care. What's more, patients' options are regularly limited via steering by plans to affiliated providers. As with the overall lack of competition among health plans, OHCA should use its authority to investigate vertical integration among health plans and their affiliates and the negative consequences for affordability and patient care.
- **Benefit Design.** Previous OHCA board meetings have featured compelling data and stories of the impact high out-of-pocket costs have on patients' financial well-being, willingness to seek care, and perceptions of health care affordability. High out-of-pocket expenditures stem from two conditions: uninsurance and underinsurance. While the state has made remarkable progress lowering the uninsured rate, addressing underinsurance has proven far more challenging. The reason is excessive marketing of high-deductible, narrow network products by health plans, which effectively transfer payment responsibility to patients at the point of care. OHCA should scrutinize these products for the negative impacts they are having on consumer affordability and identify and promote policy innovations that can increase enrollment in comprehensive, low cost-sharing products, such as those available through Covered California.

Conclusion

OHCA must plan for the health care system Californians need and deserve. It is imperative that the state address affordability challenges while at the same time meaningfully and measurably improving access to high-quality, equitable, and innovative care. CHA is committed to helping the office develop a thoughtful, data-driven approach to achieving its multiple objectives. 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 address affordability challenges while protecting access to health care.

Sincerely,



Ben Johnson
Vice President, Policy

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability

Members of the Health Care Affordability Board:

David M. Carlisle, MD, PhD

Secretary Dr. Mark Ghaly

Dr. Sandra Hernández

Dr. Richard Kronick

Ian Lewis

Elizabeth Mitchell

Donald B. Moulds, Ph.D.

Dr. Richard Pan

Appendix 1

Under the Current Proposal, California Would Be the Only State Not to Include a Glide Path

