California Hospital Association

DRAFT – MARCH 4, 2024

March XX, 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
OHCA@hcai.ca.gov

SUBJECT: CHA Comments on the Proposed Statewide Health Care Spending Target Recommendations to the Board

Dear Ms. Brubaker:

On behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) thanks the Office of Health Care Affordability (OHCA) for the opportunity to comment on the proposed statewide health care spending target recommendations. We look forward to working with the OHCA board and staff on the finalization of the most consequential decision OHCA will make this year.

Executive Summary

California's hospitals share OHCA's foundational goals of making health care more affordable while preserving and improving access to high-quality, equitable care. Setting a spending target and placing health care spending in California on a sustainable trajectory is perhaps the most important decision the OHCA board will make. At its essence, the board is responsible for deciding how much health care spending **should** be in the coming years. This is an incredibly complex, multifaceted, and important question, with the lives and livelihoods of millions of Californians at stake. Accordingly, the board and office must approach this decision with utmost care and base it on a clear and comprehensive understanding of the health care system and its cost drivers, with a strong rationale that integrates the multiple objectives of state law.

OHCA's proposed 3% spending target for the years 2025 through 2029 does not live up to these high but appropriate standards. It goes too far too fast, seeking an abrupt 40% reduction in the growth of health care spending within a single year, then compounds that reduction every year for five years, even as health care providers struggle to recover from the financial, operational, and morale shocks of the COVID-19 pandemic. By the end, OHCA would eliminate 10% of total health care spending in California within just five years.

OHCA proposes a methodology for the spending target based on the last 20 years of historical median household income growth, a period that includes the worst recession in a century since the Great Depression. The result is a proposed target value that is biased downward and fails to reflect reasonable expectations of median household income growth going forward.

Furthermore, the proposal narrowly focuses on just one of OHCA's objectives – that of affordability, ignoring the other objectives in state law. It fails to recognize the drivers that will affect health care spending over the next several years, like high inflation and the aging of California's population. It sets California apart from other states with spending target programs by failing to incorporate contemporary economic trends and a phase-in that allows health care entities to adapt to a changing regulatory environment. One state, Rhode Island, has since recognized that changing economic circumstances require a change in approach, and effectively doubled its target before gradually ramping it back down. The proposal does not incorporate the lessons from other states — which experience shows have set their targets at unattainably low levels. Finally, the five-year proposal unnecessarily rushes toward an enforceable target despite flexibility under state law and much work to be done in collecting data, setting the rules of enforcement, and properly evaluating the potential impacts of the spending target – work that should be done prior to setting an enforceable target.

Given these critical shortcomings, the proposed target would lack credibility by being unattainable, unsustainable, and ultimately unsupportive of efforts by health care entities to improve the value of health care, not just lower its costs. To address these and other concerns, this letter makes two key recommendations:

An Alternative Framework for a Sustainable Spending Target. We propose an alternative framework that incorporates commonly recognized drivers of health care spending, with a goal of ensuring that the target is attainable, sustainable, and fulfills OHCA's multiple objectives. The framework has at least three possible uses:

- For use as the spending target methodology
- To assess the reasonableness of a different spending target and methodology
- As a source for reasonable and appropriate adjustments to a spending target that relies on an alternative methodology.

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%**

Adoption of a One-Year Target. The timelines in OHCA's authorizing legislation were drawn to facilitate thoughtful deliberation and learning before enforceable spending targets are set for 2026 and beyond. While multiyear targets may eventually make sense, the board should reconsider the appropriateness of setting a multiyear spending target before critical outstanding issues have been resolved, including the following:

- Collection and analysis of total health care expenditure data reported by payers
- Consideration and promulgation of the rules of enforcement

- Meaningful analysis of the drivers of health care spending and potential impacts of the spending target

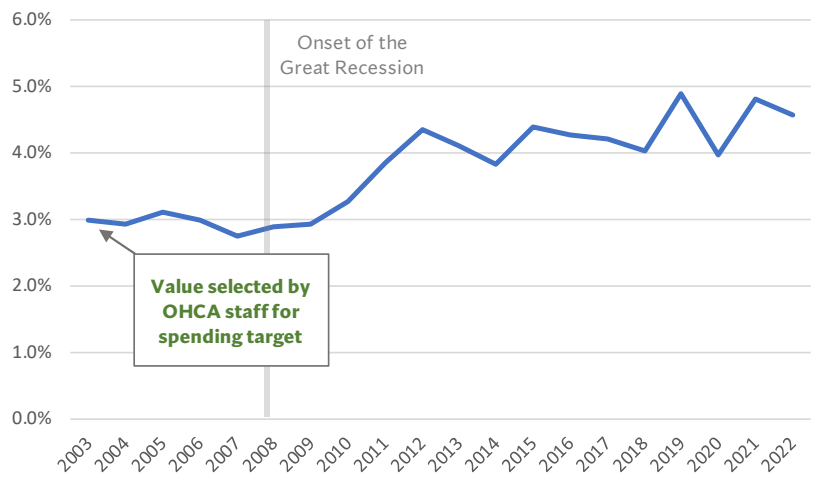
Proposed Methodology Has Clear Deficiencies

OHCA's proposed spending target is based on the annual growth of median household income in California. The rationale is that health care spending should not grow faster than families' incomes. While this methodology has a clear intuitive appeal, close inspection reveals serious deficiencies in the proposed approach.

Historical Period Used to Determine Median Household Income Growth Is Biased Downward. Given OHCA's stated rationale that health care should not grow faster than household income, it would have been reasonable for OHCA to propose a target based on **expectations** for median household income growth over the next five years. However, OHCA explicitly rejected the use of projections, and instead based its spending target methodology on a 20-year historical period that includes the worst recession in a century since the occurrence of the Great Depression. While no clear rationale has been given by OHCA for using 20 years of data, the implications of this decision are shown in the lefthand figure. The figure displays the average annual growth in median household income starting in 2022, going back each additional year to 2003.[1] By using the 20-year average, OHCA obtained a spending target value of 3%, close to the lowest value it could have selected based on up to 20 years of data. This value is over a percentage point lower than what the post-Great Recession years clearly predict will be the trajectory of median household income growth going forward.[2] Moreover, if projections of inflation from the Legislative Analyst's Office (LAO) hold true, median household income growth of 3% annually over the next several years would mean that **real** (inflation-adjusted) median household income is declining by 0.4% each year, trends not experienced since the Great Recession. One board member has recommended instead using a 10-year historical average of median household income growth, which these data clearly support over staff's recommendation for a 20-year series.

Historical Income Growth Is Biased Downward When the Great Recession Period Is Included

Average Annual Percent Change Starting in the Year Displayed, Ending in 2022



Note: 2019 median income adjusted downward by 2.8% to reflect OHCA staff's finding that income may have been overestimated that year by the Census Bureau.

Source: California median household income data retrieved from FRED.

Proposed Methodology Was Changed After Updated Data Would Have Adjusted the Target Upward. In December 2023, OHCA released a preliminary spending target methodology that was also based on 20 years of median household income growth. This methodology correctly recognized that more recent data are a better predictor of the future than old data, and therefore weighted the most recent 10 years' data

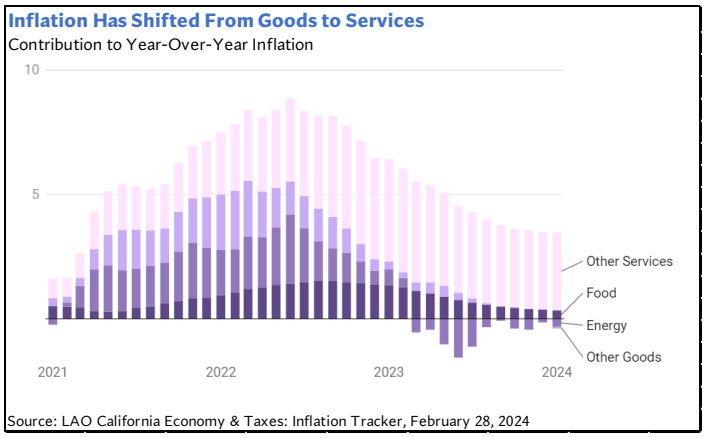
[1] Each year going back includes an additional year in the multiyear average.
[2] Economic forecasting principles typically recommend placing more weight on more recent years' data, such as in exponential smoothing models.

more heavily than the prior 10 years, resulting in a 3% target value. However, the original methodology cut the series off prematurely in 2021, despite 2022 data being available. Following suggestions from board members and stakeholders, OHCA incorporated the most recent 2022 data, but, at the same time, removed the weight on more recent years' data. The effect was to undo what would have been an upward adjustment to the target, and instead the updated methodology produced the same 3% value as previously. This unjustified change in the methodology raises serious questions about the arbitrariness of the proposed methodology.

Methodology Does Not Recognize Known Drivers of Health Care Spending. Health care is different than other sectors in the economy. Health care:

- Saves lives and cures and ameliorates debilitating diseases
- Is a frontier of innovation, with an incredible record of progress and enormous untapped potential
- Involves one person caring for another in serious need
- Evolves in demand over a person's lifespan
- Is subject to constant attention from policymakers enacting delivery and financing reforms to improve access and quality

Given these unique attributes, health care cannot be treated like any other sector in California's economy. Unfortunately, OHCA's proposed spending target methodology does just that by utilizing a single economic indicator disconnected from the realities of supporting California's health care system. Recognizing the key drivers of health care spending is essential if OHCA is going to fulfill its legislative mandate and prevent the erosion of access to high-quality health care — particularly in already underserved areas. The Legislature recognized this prerogative in subdivision (b) of Health and Safety Code section 127500.5 of OHCA's authorizing statute, declaring an intent for OHCA to take a *"comprehensive view of health care spending [and] cost trends"* to inform the pursuit of its multiple goals. Fulfillment of this responsibility must be done, now.



Spending Target Would Result in Cuts to Real Health Care Spending California is [currently experiencing economy-wide inflation] of almost 4%, twice the historical average of what other states experienced prior to setting their spending targets. What's more, inflation has shifted almost entirely from goods to services, showing it may persist in health care for longer than in other sectors, as shown in the first figure on this page. Over the next four years, the independent Legislative Analyst's Office projects inflation to be 3.4% — over 10% higher than OHCA's proposed target.[3] This means that OHCA's proposed spending target would dictate a

[3] Inflation projections are from the Legislative Analyst's Office's [The 2024-25 Budget: California's Fiscal Outlook].

Real Health Care Spending Would Decline by $13 Billion by 2029 Under a 3% Spending Target

Comparison of Spending Growth Under 3% Spending Target and Projected Spending If Health Care Grew at the Projected Inflation Rate

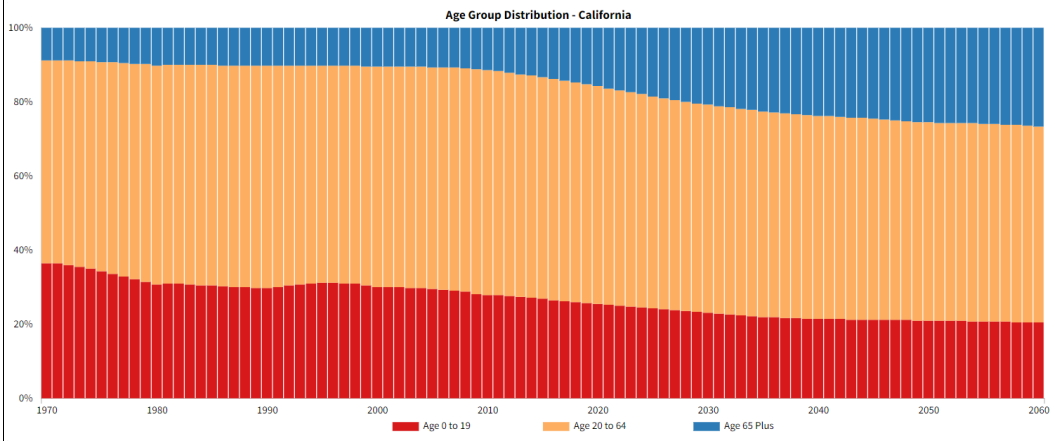
Source: LAO CPI-U projections under the 2024-25 Fiscal Outlook

decline in real health care spending of nearly a half a percentage point each year. The figure on the left shows this would result in a $13 billion cut in real health care spending by 2029. Real cuts of this magnitude would force hospitals and other providers to disregard the target, risking enforcement under an undefined process, or be left unable to afford to provide the care their patients need.

Proposed Target Ignores the Growing Health Needs of an Aging Population. The baby boomer generation is entering or advancing in their senior years. As the next figure shows, the elderly share of California's population is projected to roughly double between 2010 and 2040, with growth concentrated in 2020s. While average annual per capita health care spending for Americans under age 65 is around $7,500, it is over $20,000 for those age 65 or older, and over $35,000 for those age 85 and older. This will inevitably result in higher health care spending going forward. Ignoring it would place the health and longevity of aging Californians at risk.

The Share of California's Elderly Population Is Doubling, with Growth Concentrated in the 2020s

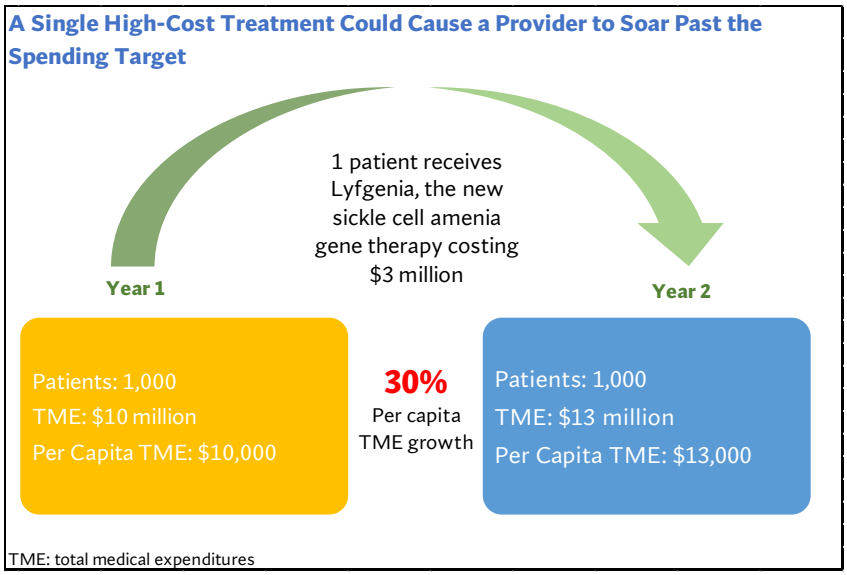
Population Shares by Age Group



Source: Department of Finance population estimates and projections: 1970 to 2060.

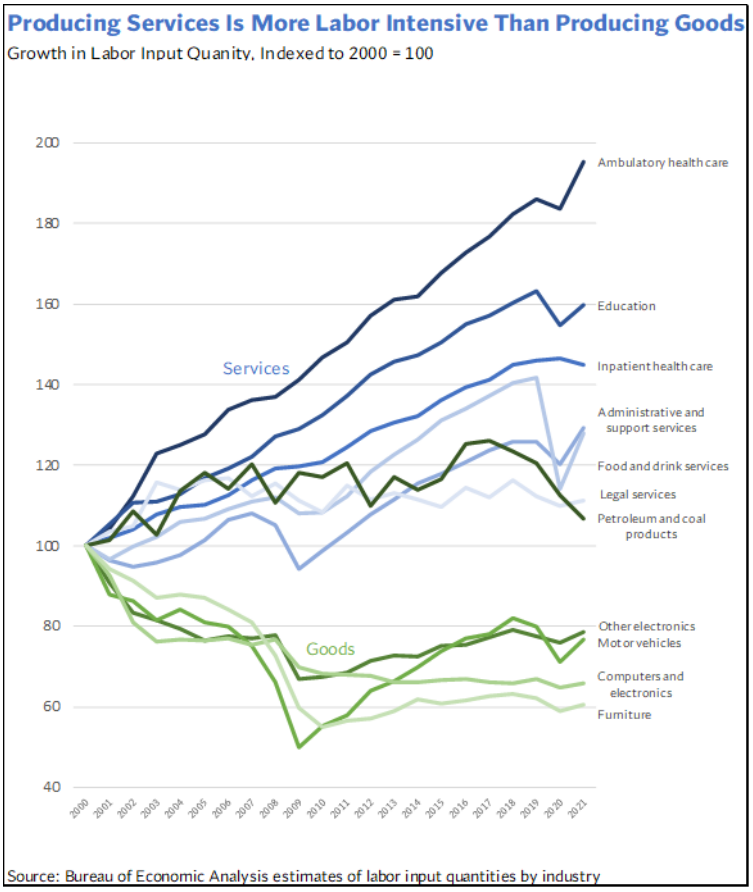
Proposed Target Would Force Payers and Providers to Eschew New Technologies. Technological development is different in health care and is treated differently under OHCA's authorizing statute. In health care, technological development often comes in the form of new and expensive drug therapies and medical devices, which often receive extended government-granted monopolies, suppressing price competition. Recent new drugs 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 called Lyfgenia that will cost up to $3 million, are on their way. As the next figure shows, having a single patient utilize this drug could cause a provider to soar past the proposed target.[4] OHCA does not

[4] The illustrative example in the figure shows the potential impact of a single patient from a 1,000-patient physician group being prescribed Lyfgenia. Assuming no other year-over-year changes in spending on the group's patients, spending attributed to the group would go up by 30% due to Lyfgenia's $3 million price tag. While offsetting savings would likely occur, these likely would only do so over the course of many years, and therefore not materially help the physician group avoid spending growth in excess of the target. For example, researchers found that it took 14 years for savings to offset the cost of Sovaldi.



regulate pharmaceutical manufacturers, intermediaries, or retailers. However, payers and providers are responsible under the target for any growth in these unregulated sectors. To address 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 prevent the rationing of new, life-saving treatments.

Target Proposal Fails to Recognize That Health Care Is a Labor-Intensive Sector. Broad economic indicators like median family income and inflation average out the fundamental differences between industries like health and manufacturing, making them ill-suited as a reference point for a health care spending target unless adjustments are made. Economists have long understood that sectors that are labor intensive tend to grow relatively more expensive over time, commanding a greater share of people's incomes. The figure to the right shows labor trends by industry, and features remarkably similar patterns to the overall inflation among these different industries. The reasons are that the service sectors do not benefit as much from cost-saving automation as other industries, like manufacturing, and generally are less exposed to national and international competition. To illustrate the principle, consider that the amount of time for a nurse to administer a drug or otherwise care for a patient has only been marginally reduced by technological change. Meanwhile, a roboticized car factory may only require an employee to keep the robots in working order, meaning the assembly line of workers previously needed in the factory can be deployed elsewhere in the economy. For exactly these reasons, the share of US workers in service-producing industries has increased by around 20% over the last 40 years.[5]



[5] Estimated based on data from the Bureau of Labor Statistics on workforce statistics in service-providing industries.

Spending Target Proposal Does Not Accommodate Policies Going Into Effect Policies adopted by the Legislature — including new investments in Medi-Cal to address longstanding payment shortfalls and improve access to care, the enactment of a new health care worker minimum wage, and the outstanding costs of complying with the state's 2030 seismic standards, will add billions of dollars in health care spending over the next several years. In percentage terms, just these three policy changes will add 3% in health care spending statewide over the next five years, amounting to 20% of total allowable growth under the proposed spending target. Failing to account for these and potentially other 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.

Relatedly, OHCA has not publicly shared how it would reconcile the differences between the anticipated growth in public health care programs and its proposed statewide, all-payer spending target. Over the next few years, the Department of Health Care Services and LAO project Medi-Cal to grow by between 5% or 6% annually, while the Centers for Medicare & Medicaid Services (CMS) projects Medicare to grow by 5.4% annually going forward. It is entirely unclear how payers and providers with high Medi-Cal and Medicare patient populations — for some, Medi-Cal and Medicare represent 75% or more of all their members or patients — would meet a 3% target.

As in Other States, OHCA Should Phase in Its Spending Target OHCA must consider a phase-in factor that would help health care entities adapt to a lower spending growth environment. To meet the spending targets without sacrificing quality, equity, or access, health care entities will need to make new investments and make changes to their care processes to shift toward value-based care. Such investments will not bear fruit immediately. For example, better management of chronic conditions will require higher up-front expenditures, with savings only to be realized over the years or decades that follow (often by payers and providers other than those who made the improvements). Failing to incorporate a phase-in factor would leave health care entities with no choice but to scramble to cut their spending growth in faster and more concrete ways, such as by reducing service lines, rightsizing their staffing, not providing high-cost yet high-value services, and taking steps to protect themselves against sharp shifts in the risk profiles of their members. Adding a phase-in factor would avoid these problems and 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 before reaching their longer-term levels.

Drivers Must Be Incorporated Now, Not Left to Selective Enforcement. OHCA staff have conveyed a preference for setting an aggressive target now, without a demonstrated interest in whether it is achievable,[6] while potentially retaining maximum discretion around whether to enforce against health care entities that miss the target. In this way, OHCA would decide whether to recognize external drivers like inflation or policy changes as justification for missing the target under a retrospective process that has yet to be defined and likely would never be clear to regulated entities. This approach is incredibly problematic. Laying down unattainable standards and then granting selective and esoteric forgiveness later would be antithetical to good governance, and we ask the board to not endorse this approach.

[6] The only relevant analysis OHCA has provided is that other states set similar targets. However, as discussed later, other states have missed their targets more often than not and typically phased their targets in, only reaching OHCA's proposed level after several years of the targets being in place.

Moreover, setting an unattainable target would cause it to be ignored in contract negotiations between payers and providers,[7] which would only serve to expand the possibility of arbitrary and capricious enforcement as described above. Finally, this approach would inevitably lead to unintended consequences. The purpose of the spending target is not limited to identifying and enforcing against individual entities that miss the target. Rather, the purpose is to affect negotiations between payers and providers. Thus, payers would look to meet the target by suppressing reimbursement levels and placing more stringent utilization management controls on providers, which would be most effective against providers with the least leverage to push back against the demands of their oligopolistic payers. Small, independent, rural, and safety-net hospitals and other small providers would be hit the hardest, endangering their survival and exacerbating the access challenges already faced by too many vulnerable California residents today.

An Alternative Framework for a Sustainable Spending Target

While OHCA staff's recommended methodology simply recognizes a single measure of consumer affordability, a target that is credible, achievable, and sustainable must actually recognize the factors that influence how much Californians spend on health care. To this end, we propose an alternative framework for a sustainable spending target. It includes factors that account for inflation, the aging of California's population, trends in the costs of technology and labor that are specific to the health care sector, and the impacts of three major policies that will implement over the next five years. The framework has three potential uses:

- For use as the spending target methodology
- To assess the reasonableness of a different spending target and methodology
- As a source for reasonable and appropriate adjustments to a spending target that relies on an alternative methodology.

Framework for a Sustainable Spending Target

	2025	Average 2025 - 2029
1) Economy-Wide Inflation	**3.3%**	**3.4%**
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A) Health Care Worker Minimum Wage	0.4%	0.2%
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Totals	**6.3%**	**5.3%**

The following bullets summarize the independent factors included in the framework:

- **Economy-Wide Inflation.** A spending target that is less than inflation risks penalizing health care entities simply for keeping up with what it costs to hire workers, buy supplies, and make facility improvements. To prevent this, the OHCA board should either use economy-wide inflation as an economic indicator in the spending target or adjust the target upward as appropriate. The inflation value in the framework is the LAO's projection for inflation for 2025 through 2028 (a 2029 inflation projection is not available).[8] To more properly reflect the dynamics of the health care sector, the OHCA board could alternatively consider using a measure of inflation that is lagged by two years, given that inflation often ripples through health care two years after it hits the broader economy, as asserted by OHCA's principle consultant on the spending targets.

[7] In Medi-Cal managed care and delegated provider models, actuaries would likely have no choice but to disregard the target if it is inconsistent with their duties to set reasonable and attainable capitated rates.
[8] Inflation projections are from the Legislative Analyst's Office's The 2024-25 Budget: California's Fiscal Outlook.

- **Aging.** California's population is aging rapidly, a factor that must be accounted for in determining how much health care spending should grow in the coming years. According to data from the California Department of Finance[9] and CMS' Office of the Actuary,[10] California health care spending will grow by around $3.5 billion every year from 2025 through 2029 due to population aging alone. This translates to an annual increase of 0.7% and is not recognized in OHCA's proposal. The appendix displays the detailed results of these projections.
- **Technology.** Failing to account for the costs of new technology would bring undue restrictions in access to the latest life-changing treatments. 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%).[11] The value in the framework is the incremental impact in percentage terms of the higher growth above the 3% proposed spending target in these two service categories.
- **Labor.** As a service industry, health care spending cannot be expected to grow at the same rate as sectors like car and TV manufacturing, or composite measures that average out the differences among industries. Accordingly, an adjustment is needed to reflect the greater labor intensity of health care, relative to other industries. The adjustment provided in the framework accounts for higher expected growth in health care spending due to labor dynamics unique to the sector. It is derived from an economic model developed in the *Journal of Health Economics* and incorporates California-specific trends in wages, employment, and gross state product.[12,13]
- **Major Policy Impacts.** 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. The following major policy impacts cannot be ignored and have been incorporated into the framework.
    - **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 projected inflation (3.5%) due to the implementation of this new law.[14]
    - **Investments in Medi-Cal.** Largely starting in 2025, the MCO tax will support about $6 billion in increased Medi-Cal provider reimbursement annually, which on its own will reflect a 1.1% increase in total health care spending in California.[15] Additionally, Medi-Cal will be increasing payments to private hospitals under a new hospital quality assurance

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[9] Aggregated from the California Department of Finance's population projections.
[10] Reflects personal health care expenditures stratified by age and sex, taken from CMS's national health expenditure data.
[11] 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.
[12] 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."*
[13] 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.
[14] Estimate is based on CHA's 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*.
[15] 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.

fee program and to designated public hospitals under an Enhanced Payment Program expansion.

- **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 $160 billion in capital improvements over the next six years to comply with the state's rules.[16] By and large, hospitals will borrow to pay for these capital improvements. The value in the framework assumes hospitals will utilize bond financing at 30-year terms at interest rates of 5.5%, which translates into incrementally higher expenditures of around $500 million, or 0.1% of statewide health care spending.

This framework results in a value that is achievable and promotes patient-centered care. Notably, it also is closely aligned with the target recently approved in Rhode Island, which raised its target to 6% (decreasing annually thereafter) after the state reevaluated its initial target of 3.2% in light of more recent economic trends.

More Work Needed Before Setting an Enforceable Spending Target

The timelines in OHCA's authorizing legislation were drawn to facilitate thoughtful deliberation and learning before enforceable spending targets are set. Unfortunately, OHCA's proposal unnecessarily rushes toward an enforceable spending target in 2026 and beyond. While multiyear targets may eventually make sense, the board should reconsider the appropriateness of setting a multiyear spending target before critical outstanding issues have been resolved.

Board Has Flexibility on Whether to Adopt a Single- or Multiyear Target. State law requires the OHCA board to adopt the statewide non-enforceable spending target for 2025 on or before June 1 of this year. While statute authorizes the adoption of multiyear spending targets, the board is not obligated to set the 2026 spending target — the first enforceable target — until June of next year. Nevertheless, OHCA has proposed a statewide target for five years, through 2029.

Collect and Analyze Data First, Set Enforceable Targets Second. A credible target-setting process will make **data-driven** decisions. Pursuant to statutory timelines, OHCA will not collect any health care spending data comparable to what will be used for the spending targets until September 2024. This makes it impossible for the board to meet its June 1 deadline and make a decision on 2025 spending target based on data collected by OHCA. However, this is not the case in 2026 and beyond. Following the collection of data in September 2024, the office will have up to nine months to analyze the data and release a report comparing 2022 and 2023 health care spending by June 1, 2025 — the same deadline for the board to set the 2026 spending target. Accordingly, the timeline for data collection and analysis presents the board with the opportunity to inform its decision on the first enforceable spending target in 2026 based on 2022 and 2023 spending data collected by OHCA.[17]

Establish Rules of Enforcement First, Set Enforceable Targets Second. The February 2024 board meeting featured essentially the first extended discussion of the enforcement process. Still, this discussion only recapitulated the requirements under statute. Accordingly, no progress was made toward

[16] 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.

[17] Doing so could require a modest acceleration of OHCA's work analyzing and reporting the September 2024 data, potentially in preliminary form.

ironing out critical components of the process that state law left to rulemaking. For example, no rules have been established around what factors OHCA will use to determine whether growth in excess of the target was justifiable, whether performance will be judged based on one year or multiple years, whether entities will be judged across all their business lines or within each one, or what the financial penalties will be. This lack of clarity around key aspects of enforcement will make it impossible for health care entities to properly plan and prepare to comply with the spending target.

These challenges are exacerbated by the fact that OHCA has proposed a target at a level that few, if any, health care entities would be able to consistently achieve. Among hospitals over the last five years, over 95% had net patient revenue growth in excess of 3% in at least one year. Would OHCA subject all such hospitals to enforcement? If not, how would it pick among the hundreds that had growth in excess of the target? These challenges are avoidable should the board opt to set a single-year target at this time, giving it ample opportunity to make progress in outlining the enforcement process over the next year prior to the deadline for adopting the 2026 target. Doing so should be a prerequisite to adopting an enforceable target.

Learn More About Drivers of Affordability Challenges and Potential Impacts of the Target First, Set Enforceable Targets Second. This letter raises numerous deficiencies in the analytical process undergirding OHCA's proposed spending target. Information presented and discussed has been one-sided, contrary information has not received meaningful attention, and the intent and requirements of state law have not been fully met. While the board has up to three scheduled meetings before the deadline for setting next year's target, this does not provide sufficient time to meaningfully resolve the outstanding issues. Accordingly, the board should consider deferring the adoption of enforceable targets for 2026 and beyond until the various shortcomings of the process, as carried out thus far, can be addressed.

Additional Shortcomings of the Proposed Spending Target, Methodology, and Supporting Analysis

OHCA Has Proposed a Target Even Lower Than Other States. Spending target programs have been implemented in eight other states. The figure below shows that California's proposed target is lower than all other states' when considered on a multiyear basis. 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. Finally, California's proposal ignores important differences in economic trends compared to other states. So while the other states set their targets to exceed the historical growth in their economies by about 1 percentage point (45%) higher on average, OHCA's proposed target would be nearly 2 percentage points (39%) lower than California's historical economic growth rate.

Importantly, other states' targets are higher than OHCA's proposal because all other states have elected to 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, 5.1% in 2024, then incrementally lowering it thereafter to 3.3%.

California's Spending Growth Target Would Be the Lowest in the Nation Despite Higher Inflation and a Faster Growing Economy

State	Year Target Was Set	Prior Year Inflation	Average Target[1]	GSP Growth[2]	Difference (Target - GSP)	Phase-in Period (Years)[3]	Phase-in Value[3]
California	**2024**	**4.2%**	**3.0%**	**4.9%**	**-1.9%**	**0**	**0.0%**
Massachusetts	2012	3.1%	3.1%	2.5%	0.6%	6	0.5%
Nevada	2021	1.3%	3.1%	2.9%	0.2%	4	0.8%
Connecticut	2020	1.8%	3.2%	1.2%	2.0%	3	0.5%
Rhode Island	2021	1.3%	3.8%	1.3%	2.5%	4	2.7%
Washington	2018	2.1%	3.2%	4.7%	-1.5%	5	0.4%
Delaware	2018	2.1%	3.3%	0.4%	2.9%	4	0.8%
Oregon	2021	1.3%	3.4%	3.2%	0.2%	6	0.4%
New Jersey	2021	1.3%	3.5%	1.7%	1.8%	4	0.7%
Peer State Average		**1.8%**	**3.3%**	**2.2%**	**1.1%**	**4.5**	**0.9%**

[1] Average Target = average growth in the health care growth target 2021-23. Source: Melnick, CHCF, 2022.
[2] GSP: average gross state product for the period 2016-2019. Source: Melnick, CHCF, 2022.
[3] Phase-in value is the distance between the maximum and minimum spending target values. For all states except Rhode Island, the maximum value is the first year's value. Rhode Island revised its target upward to account for contemporary economic trends. Phase-in period is the number of years it takes for target to be reduced from its maximum to minimum value.

Melnick, CHCF, 2022: Melnick, Glenn. CHCF Issure Brief, Health Care Cost Commissions: How Eight States Address Cost Growth. April 2022.

Other States Have Struggled to Meet Their Targets. More often than not, other states have missed their targets. As the next figure 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 up to 1 percentage point (depending on the period), showing they set their targets around 20% lower than they reasonably should have even without considering current inflationary pressures.

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%	3.8%	1	3	4.1%	3.2%	1	1
Washington		3.8%	0	0			0	0
Averages/Totals	**4.0%**	**3.3%**	**10**	**17**	**4.5%**	**3.5%**	**6**	**9**

Ensure Target Meets the Multiple Objectives of State Law. OHCA's proposed target falls short of meeting the spirit, if not the letter, of state law by narrowly focusing on just one of its statutory objectives — that of affordability — neglecting to appropriately recognize OHCA's other foundational goals. In its findings and declarations in section 127500.5 of the Health and Safety Code, the state legislature declares its intent to:

> *"**Have a comprehensive view of health care spending, cost trends**, and variation to inform actions to reduce the overall rate of growth in health care costs while maintaining quality of care,*

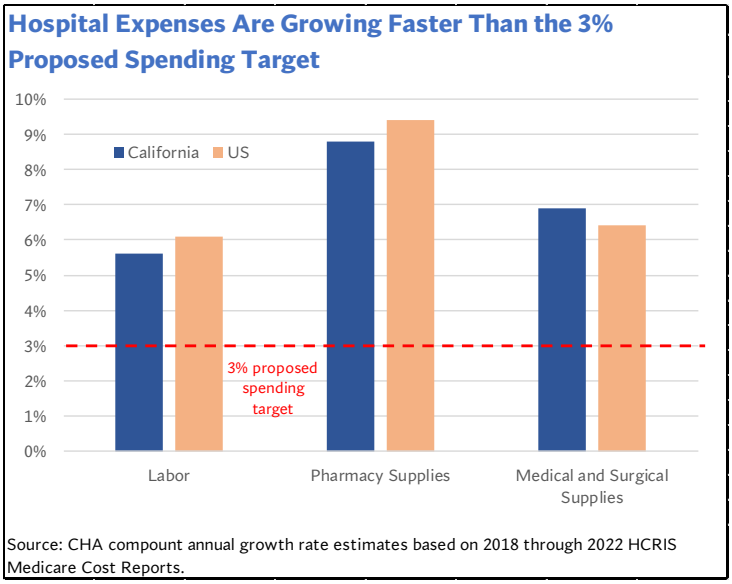
> ***with the goal of improving affordability, access, and equity of health care for Californians.*** *" **[emphasis added]***
>
> *"Encourage policies, payments, and initiatives that improve the affordability, quality, equity, efficiency, access, and value of health care service delivery, with a particular focus on ensuring health equity and reducing disparities in care, access, and outcomes across California.*

State law specifically extends these principles to the spending target and associated methodologies in Health and Safety Code section 127502, requiring that they:

> *"Promote the goal of improved affordability for consumers and purchasers of health care, while* ***maintaining quality and equitable care, including consideration of the impact on persons with disabilities and chronic illness.*** *" **[emphasis added]***
>
> *"Promote a predictable and* ***sustainable rate of change*** *in per capita total health care expenditures. **[emphasis added]***
>
> *"Be based on a target percentage, with consideration of economic indicators or population-based measures, and be developed based on a methodology that is available and transparent to the public. Economic indicators may include established measures reflecting the broader economy, the labor markets, and consumer cost trends.* ***Population-based measures may include changes in the state's demographic factors that may influence demand for health care services, such as aging." [emphasis added]***
>
> ***Promote the stability of the health care workforce****, including the development of the future workforce, such as graduate medical education teaching, training, apprenticeships, and research.* ***[emphasis added]***

OHCA Has Not Performed a Serious Analysis of the Impacts of the Target on Access, Quality, Equity, or Workforce Stability. While OHCA has prepared and presented analyses of the potential impacts of a 3% spending target on health care spending growth, it has avoided any equitable discussion and analysis of the impacts of its proposal on access, quality, or equity. Furthermore, OHCA has rejected the use of any and all population-based measures without sufficient justification and potentially based on a severe underestimate of the influence demographics have on health care spending (estimates published by OHCA estimated that aging increases health care spending by 0.1% to 0.2% annually, in contrast to the 0.7% estimate derived from the Department of Finance and CMS). Similarly, OHCA has not performed sufficient analysis of the trends in health care labor costs, the potential impacts of a 40% drop in health care spending growth on workforce stability, or the effects of negative **real** spending growth on access and quality. Without performing and publicly presenting this work, it is unclear how OHCA can defensibly attest to fulfilling its responsibilities under statute related to the spending target.[18]

[18] Recent developments at the board demonstrate the office's shortcomings in ensuring balance around which perspectives receive consideration. Since proposing the 3% target, OHCA staff received two requests from OHCA board members to analyze the impacts of the target on the labor market. One request was to look at the effect of health care affordability challenges on general employment outcomes, while the other focused on the implications of the proposed 3% spending target for employment *within* the health care sector. OHCA staff promptly fulfilled the former request at the February board meeting, showing higher premiums are associated with lower wages and lower labor force participation. Meanwhile, OHCA declined to fulfill the latter request, betraying a consistent and



Source: CHA compount annual growth rate estimates based on 2018 through 2022 HCRIS Medicare Cost Reports.

A Balanced Analysis of Potential Target Impacts Would More Carefully Identify Where Savings Could Be Achieved Without Unacceptable Tradeoffs. It is incumbent upon OHCA to do more to analyze where cost growth can be reduced to meet the spending target without harming patients. However, no such analysis has been done. Looking specifically at hospitals, expenses have grown at over 5% in the long run — roughly 70% higher than OHCA's proposed target. Recently, costs have grown even faster, as shown in the figure to the left. To meet a 3% spending target, hospitals would have to significantly scale back their workforce and operations, such as service lines and bed capacity. To illustrate, we estimated the revenue impacts if hospitals had been subject to a 3% spending target for the years 2018 through 2022. Across these five years, over $60 billion in resources for patient care would have been eliminated for hospitals alone. To balance their expenses with their lower revenues, by 2022, hospitals would have had to reduce their total expenses by 14%. Achieving this proportionate cut to their labor expenses would have required California's hospitals to reduce their full-time equivalent-worker count by 58,000 — 14% of their workforce. Alternatively, hospitals would have had to suppress wages by an equivalent percentage or rely on a combination of wage and force reductions. How hospitals could have achieved such reductions while meeting the public health and workforce crises brought by COVID-19 is not clear.

Impacts on Quality Must Be Accounted for and Minimized. Despite the fact that OHCA's proposed spending targets would likely force negative growth in inflation-adjusted reimbursement rates, OHCA has not presented an analysis of the potential impacts of its proposed target on health care quality. This is contrary to good policymaking and the requirements of statute. To meet its legislative mandate, OHCA must demonstrate that its spending target proposal would avoid such impacts. In doing so, OHCA must offer reasonable assurances that the following consequences would not result from a spending target designed to eliminate around 10% of statewide health care spending within a period of just five years. Below are some examples of research that show that the tradeoffs between spending and quality are real.

- **Higher Medicare Payments Lead to Better Outcomes.** As Jonathan Gruber, a key architect of the Affordable Care Act, and others note, differences in the health and socioeconomic status among the patients served by different hospitals seriously complicate the study of the relationship between reimbursement and costs and quality. That said, significant research

troubling lack of balance in what information and questions receive analysis and presentation.[18] Their rationale for answering one question but not the other was a lack of academic research specifically on the effect of spending targets on health care employment outcomes, a constraint that did not prevent them from relying on literature *unrelated* to spending target programs to discuss general employment impacts in response to the other question from the board. Moreover, despite no published research to rely upon, OHCA has presented projections of the impacts of the spending target on total and per capita health care spending, with the purpose of showing affordability improvements they anticipate, again revealing a worrisome double standard.

indicates that quality would suffer at hospitals from reimbursement cuts brought about by the spending target program. Gruber and coauthors find that hospitals that received higher reimbursement under Medicare produced better patient outcomes — specifically, finding that a 10% increase in reimbursement is associated with a 2.4 percentage point lower mortality rate.[19] In this study, higher reimbursement was driven by increased treatment intensity, as captured in coding under Medicare's diagnosis-related group payment methodology, showing that higher reimbursement owed to higher levels of care and produced superior patient outcomes. Unfortunately, to adhere to the extremely low proposed spending target, payers would almost certainly increase their reliance on practices like downcoding and steering patients away from high-cost, high-quality hospitals helping their performance on the spending target but at the detriment of their members' health.

- **Medicare Payment Reductions Under the Balanced Budget Act (BBA) of 1997 Led to Increases in Mortality.** In 1998, due to concerns that Medicare was overpaying providers, Medicare inpatient reimbursement rates were slashed by the largest amounts in recent history. After total margins for 35% of hospitals turned negative as a result of the cuts, Congress swiftly enacted legislation partially reversing them. Unfortunately, the reversal came too late. While no effects on patient outcomes were detected in the first three years of implementation of the BBA rate cuts, all-cause mortality shot up over the next several years at hospitals most exposed to the BBA rate cuts. Researchers ultimately concluded that a 1% reduction in Medicare payment rates induced a 0.4% increase in mortality, driven by staffing reductions and hospitals' other efforts to lower operating costs.[20] Similar effects could result from OHCA spending targets that constrain provider revenues below what it costs to provide high-quality patient care.
- **Reduced Access to Emergency Services Could Lead to More Deaths.** Over 50% of hospitals had negative operating margins in 2022, leaving many on the brink of closure. OHCA's proposed target is barely more than half of both recent and long-term hospital cost growth, which inevitably would exacerbate hospitals' existing financial challenges. Any resulting closures and reductions in emergency and other hospital services, particularly in but not limited to rural areas, would endanger residents' health by increasing the amount of time it takes to get proper emergency care. This is strikingly shown in a study of the effect of road closures during marathon events on emergency transport times and the resulting mortality rates for hospitalized patients.[21] The authors found that emergency transport times increased by 4.4 minutes during marathons, leading to a 3.3 percentage point higher mortality rate among affected patients. Similar increases in emergency transport or access times could result from hospital closures or service reductions, a factor that OHCA must consider in the spending target development process.

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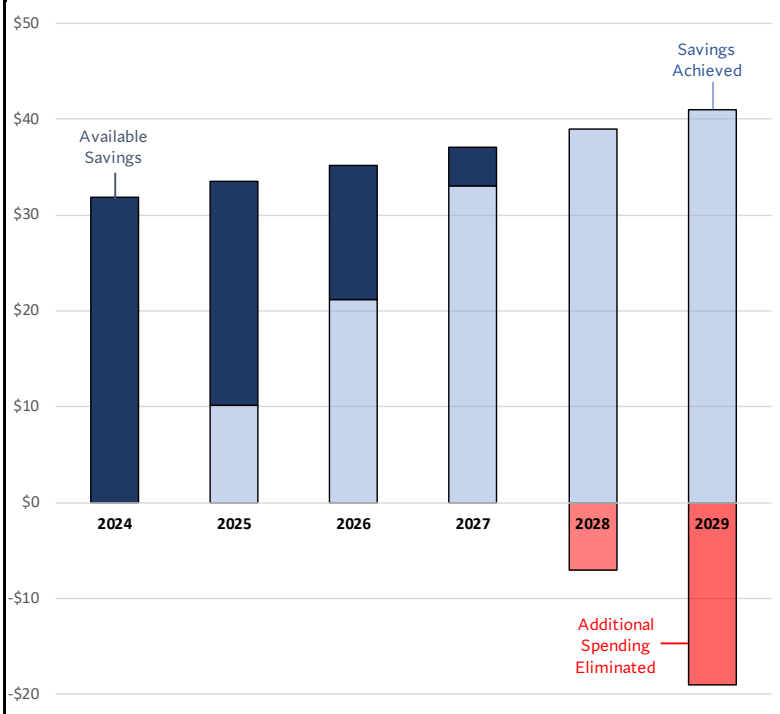
[19] Doyle, Joseph J., et al. "Measuring Returns to Hospital Care: Evidence from Ambulance Referral Patterns." *Journal of Political Economy*, vol. 123, no. 1, Feb. 2015, pp. 170–214, https://doi.org/10.1086/677756. Accessed 14 June 2020.

[20] Wu, Vivian Y., and Yu-Chu Shen. "Long-Term Impact of Medicare Payment Reductions on Patient Outcomes." *Health Services Research*, vol. 49, no. 5, 20 May 2014, pp. 1596–1615, https://doi.org/10.1111/1475-6773.12185.

[21] Jena, Anupam B., et al. "Delays in Emergency Care and Mortality during Major U.S. Marathons." *New England Journal of Medicine*, vol. 376, no. 15, 13 Apr. 2017, pp. 1441–1450, https://doi.org/10.1056/nejmsa1614073. Accessed 28 Mar. 2020.

Proposed Spending Target Would Eliminate Resources for Patient Care. OHCA has largely relied upon a single piece of research showing there is waste in the U.S. and California health care systems to demonstrate that spending can be eliminated without negative consequences for patients. This research comes from an article titled "Waste in the US Health Care System: Estimated Costs and Potential For Savings," from the *Journal of the American Medical Association* (JAMA).[22] Without question, there are opportunities in health care to improve efficiency, as in all sectors of the economy. However, even this study relied upon by OHCA cannot support the magnitude of spending reductions proposed by OHCA nor the claim that it would not negatively affect patient care.

Proposed Spending Target Would Eliminate More Health Care Spending Than Has Been Identified as Savings Amenable to Interventions



A 2019 article in the Journal of American Medicine estimated that between 5% and 7% of American health care spending reflects waste that could be eliminated by known interventions. This percentage (6%, the average of the range) is applied to California's health care spending, starting at roughly $500 billion in 2024, to estimate the dollar amount of available savings that could theoretically be achieved by the interventions identified in the JAMA article. This shows a spending target of 3% would reduce nominal spending by nearly 10% compared to current trends (5% annual growth) over a 5-year period, resulting in the elimination of more spending than has been identified as savings amenable to policy intervention.

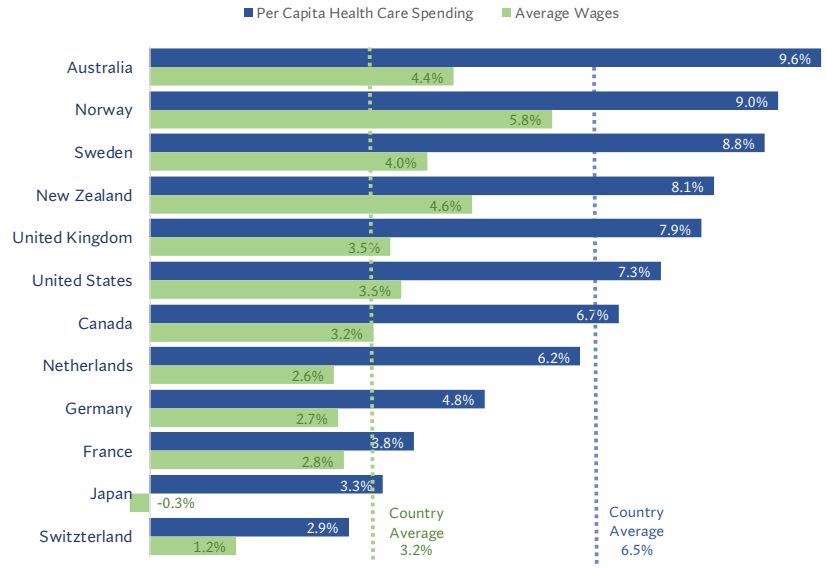
The JAMA article concludes that between 20% and 24% of total U.S. spending on health care reflects waste, and that a quarter of this waste reflects potential savings from identified interventions proven to improve efficiency without harming patient care. Interventions suggested include the integration of behavioral and physical health, transitional care programs, drug pricing changes, and hospice expansion. Applied to California's health care system, the JAMA article suggests that there are $30 billion to $40 billion in savings that could be realized via changes in care delivery and financing. Problematically, however, OHCA's proposed target would eliminate $60 billion in annual health care spending by 2029 (as compared to growth under existing trends). This implies that nearly $20 billion in spending on medically necessary patient care would have to be eliminated to meet the proposed spending target, assuming California achieved **all** the theoretical savings amenable to intervention identified in the JAMA article.

[22] Shrank, William H., et al. "Waste in the US Health Care System." Journal of the American Medical Association, vol. 322, no. 15, 7 Oct. 2019, jamanetwork.com/journals/jama/fullarticle/2752664?utm_source=The+Dispatch&utm_campaign=09e7060f28-Dispatch041&utm_medium=email&utm_term=0_6d0e869d45-09e7060f28-41071053, https://doi.org/10.1001/jama.2019.13978.

Health Care Spending Trends Across the Globe Call into Question Whether the Proposed Target Is Attainable. If a proposed spending growth target based on a measure like median income were attainable, the U.S.'s peer countries likely would achieve it. However, as the figure shows, none of the following 11 peer countries have experienced per capita health spending growth anywhere near average wages. (Over the last 20 years in California, average wage growth has equaled median household income growth, while nationwide the measures have tracked closely.) In fact, over the last 20 years, the growth rate for per capita health spending was roughly double that for average wages among this sample of economically developed countries. The consistent trends among countries with diverse health care systems demonstrates that this divergence is not simply due to differences in the how different countries finance, organize, and regulate their health care systems.[23] Instead, it shows that underlying economic and demographic factors are key drivers of the higher growth in health expenditures and that limiting health care spending growth to a measure like wage growth would risk seriously undermining the capacity of California's health care system to provide the health care its residents need.

Per Capita Health Expenditures Are Growing at Twice the Rate of Average Wages Across the Globe

Compound Annual Growth Rate Between 2000 and 2019



Source: CHA calculations based on data from The Organization For Economic Cooperation and Development.

It must be recognized that, despite middling growth in per capita health care spending compared to its peer countries, the U.S. does have higher starting levels of per capita spending — a fact that has been a foundational assumption in OHCA's work. However, this fact alone does not demonstrate that reduced spending can be achieved without detrimental impacts for patients. Rather, careful analysis is needed of the drivers of health care spending differences between the U.S. (and California specifically) and its peer countries if OHCA is to understand how and how far California can go to achieve the lower spending levels of our peer countries without sacrificing OHCA's other objectives. Some relevant differences between the U.S. and its peer countries include:

- **Higher Patient Needs.** Americans suffer from chronic conditions at overwhelming rates compared to their peers in other, economically advanced countries. Obesity rates are higher (37% versus 25%), as are diabetes rates (11% versus 6%), and schizophrenia rates (40% higher than in peer countries).[24] Individuals with chronic diseases have health care costs as high as nine times that of other individuals, which means that even small differences in underlying risk factors can lead to large differences in health care spending. While chronic conditions are amenable to

[23] Among the listed countries, Canada, New Zealand, Norway, Sweden, and the United Kingdom have single-payer systems. Australia, France, Germany, and the United States have public-private insurance systems. The Netherlands and Switzerland have private health insurance systems.

[24] All figures compare the U.S. to the same peer countries listed in the figure on the previous page. Data comes from the Organization for Economic Cooperation and Development.

interventions from within the health care system, they also are significantly influenced by drivers outside of the health care system, like socioeconomic status, education levels, and environmental conditions. While improved care coordination and access to primary and behavioral health care could yield significant improvements in these areas, the extent of such improvements is uncertain, likely would take significant time to materialize, and may never close the gap between the U.S. and its peer countries.

- **High Pharmaceutical Prices.** The U.S. is an outlier in the prices its residents pay for pharmaceuticals, paying roughly 150% more for drugs than peer countries. The JAMA paper previously discussed reveals that pricing failures in this area produce $170 billion in waste in health care expenditures in the U.S., reflecting over 4% of total U.S. spending on health care. OHCA does not have authority over drug manufacturers, wholesalers, or retailers, making it unrealistic that improvements would be made in this area.
- **Administrative Inefficiencies.** Different payers, like Medi-Cal, Medicare, or Blue Shield, often impose different service coverage and payment rules on providers. This patchwork of payer policies related to utilization management, payment, and reporting rules introduces enormous inefficiencies into the U.S. health care system. More troublingly, it takes time away from providing patient care. The Congressional Budget Office recently estimated the provider administrative savings that could be realized from a harmonization of payer administrative policies. In effect, the cost of the administrative inefficiencies that they identify would translate into $10 billion to $20 billion in annual savings in California alone and reflects another factor behind the U.S.'s flagging performance in terms of cost effectiveness. OHCA does not have authority to require payers to standardize and streamline their utilization management and payment rules, diminishing the prospects of significant improvements in this domain.

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