August 23, 2024

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

Subject: **CHA Comments on the August 2024 Health Care Affordability Board Meeting**
(Submitted via Email to Megan Brubaker)

Dear Dr. Ghaly:

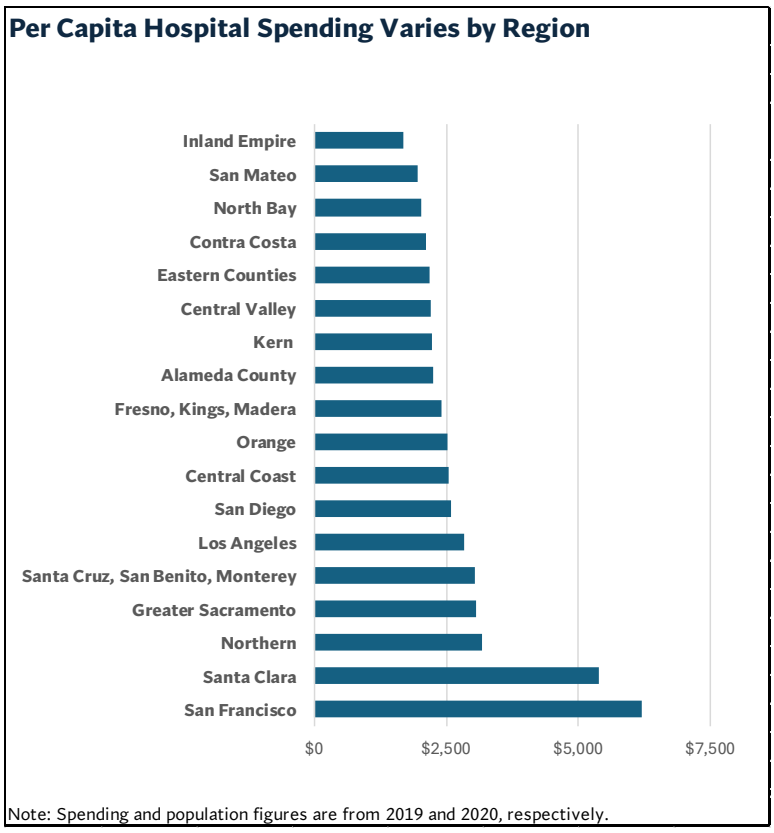
The Office of Health Care Affordability's (OHCA) success in fulfilling its mission of promoting affordability while improving health care access, quality, and equity depends on obtaining a clear understanding of the drivers of health care spending growth. Only then can OHCA appropriately employ its tools to address the real affordability challenges facing Californians while avoiding serious negative consequences. Investigating regional differences in health care costs, as well as their underlying causes, presents a promising approach for identifying these drivers.

On behalf of more than 400 hospital members, CHA encourages OHCA to carefully study the drivers of variation in health care spending across California, the United States, and the globe. Below are some findings related to hospital spending that may inform OHCA's approach to this important topic. Specifically, the letter acknowledges that hospital spending across the state does vary widely. The analysis then shows how this variation closely tracks demographic differences and variation in the general cost of living throughout California.

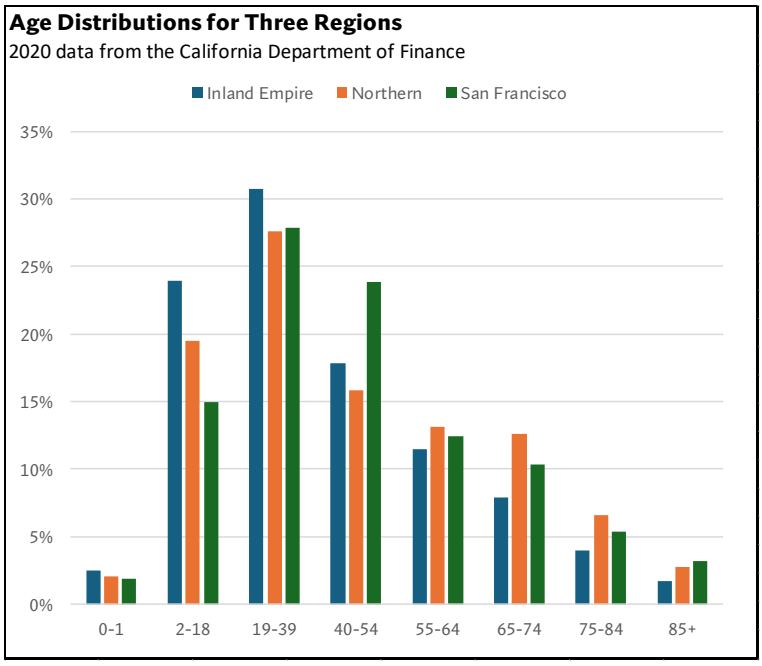
Hospital Spending Varies Significantly Throughout the State. As the figure on the next page shows, hospital spending is roughly $6,200 per resident of San Francisco, which is almost 130% higher than the statewide average of $2,719 per California resident.[1] By contrast, in the Inland Empire, hospital spending is roughly $1,700 per resident, 28% lower than the statewide average. Thus, per capita hospital spending in the most expensive region of the state is 3-to-4 times higher than spending in the least expensive region.

[1] This analysis compares the OHCA region a hospital is in and the residents of that region. The only variance with the OHCA regions is that it aggregates the Los Angeles regions into a single one.

Regions With Older Populations Feature Higher Hospital Spending. A person's chance of visiting the hospital and having a lengthy stay increases dramatically as they age. Therefore, one might expect that regions with older populations would have higher hospital spending. The data bear this out, as regions with older populations also have higher per capita hospital spending. For example, while 16% of California's population is over the age of 64, 22% of the Northern region's population is over 64. By contrast, less than 14% of Inland Empire's residents are over 64. Only knowing the regions' senior population percentage, per capita hospital spending can be predicted to be nearly $850 (33%) higher in the Northern region than in the Inland Empire. Fine-grained differences in age distributions matter as well. San Francisco has the highest population proportion aged 85 and older — this alone predicts per capita hospital spending in San Francisco to be more than $1,200 higher than the state average.



If differences in need drive these differences in spending, data would show that higher spending regions have more hospital utilization. Again, the 2019 data bear this out. For example, San Francisco hospitals have 25% more utilization than the statewide average, as judged on an inpatient-days-per-resident basis. Meanwhile, Inland Empire hospitals have 18% lower utilization than for California residents overall, contributing to the lower spending in the region.



In addition to age, regional differences in disease prevalence, socioeconomic needs, access to primary care, and other factors likely drive differences in per capita spending and deserve further exploration.

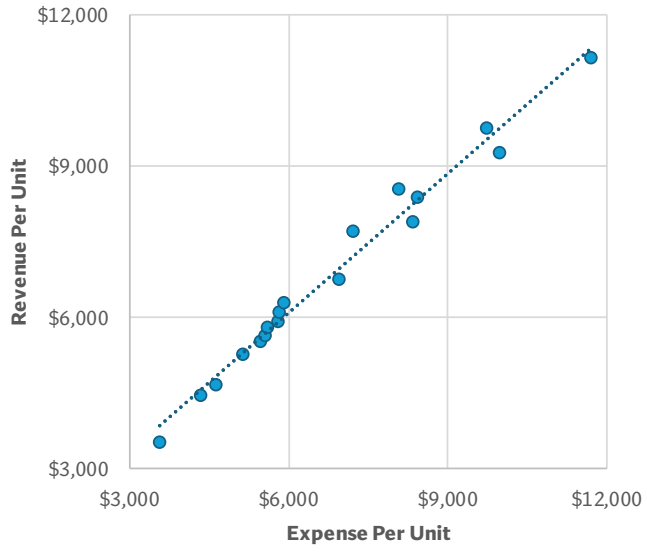
Variation in Reimbursement Levels Explain a Portion of the Difference in Per Capita Hospital Spending. While population health needs explain a large part of the differences in hospital spending across the state,

reimbursement levels play an important role too. It is true that hospitals are paid more in certain regions of the state, like the Bay Area, even after largely controlling for patient acuity and service mix. By contrast, hospital reimbursement is relatively low in the Inland Empire, Central Valley, and in Eastern Counties. However, as shown below, higher reimbursement tracks higher expenses, which are driven by differences in the cost of living across California's different regions.

Higher Reimbursement Does Not Predict Better Financial Performance. It would be reasonable to guess that hospitals in regions with high reimbursement levels perform better financially, such as by having the highest margins. However, the opposite is true. Regions with the highest average reimbursement levels tend to have the lowest operating margins. This surprising relationship is due to the experience of Bay Area hospitals, which collectively lost money over an entire decade from 2010 through 2019 even though their reimbursement levels tended to be higher than in other parts of the state.

Hospital Expenses and Revenues Track Each Other Nearly Perfectly

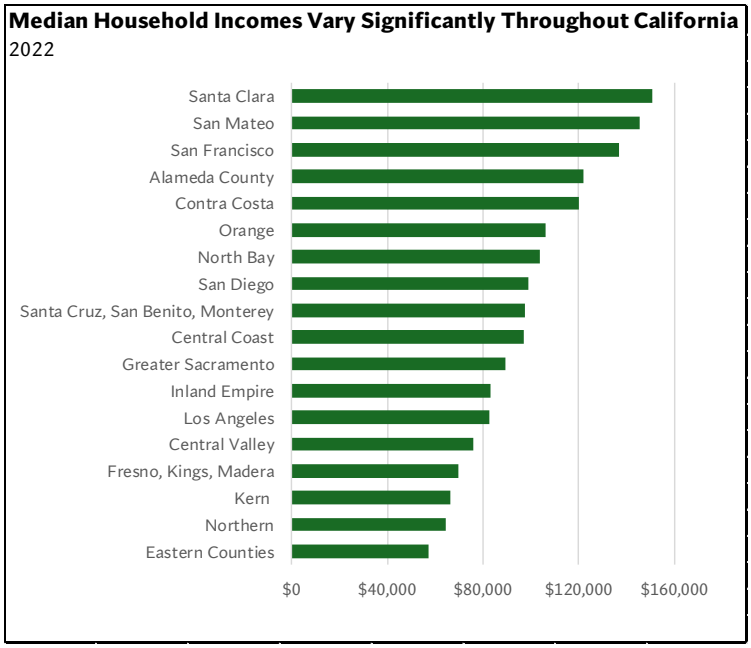
Net Patient Revenue and Operating Expense Per Unit of Service, by OHCA Region, 2010-2019



Hospital Expenses Closely Track Their Revenues. The reason that hospital reimbursement does not predict better financial performance is that for every $1 increase in patient care revenue, operating expenses increase by the same amount, if not slightly more. As a result, cutting hospital spending, from a consumer or purchaser perspective, is not a simple exercise of trimming margins. Rather, to achieve spending reductions, hospitals would have to find ways to cut back on underlying costs, with potential serious negative ramifications for access, quality, and workforce stability.

Hospitals' Largest Expense Is Labor, Which Varies Regionally. Statewide, hospital labor expenses comprise about 50% of total expenses.[2] In certain regions, this share is higher, with hospitals in the Santa Cruz, San Benito, and Monterey region having labor expenses that represent nearly 60% of total expenses. Variation in hospital labor expenses ultimately drives differences in the cost of care, making it no coincidence that Bay Area counties have the highest reimbursement levels *and* the highest labor costs on a per-unit-of-service basis. In contrast, the Inland Empire, Central Valley, and Eastern Counties receive lower reimbursement corresponding almost exactly to their lower labor costs. For example, hospitals in

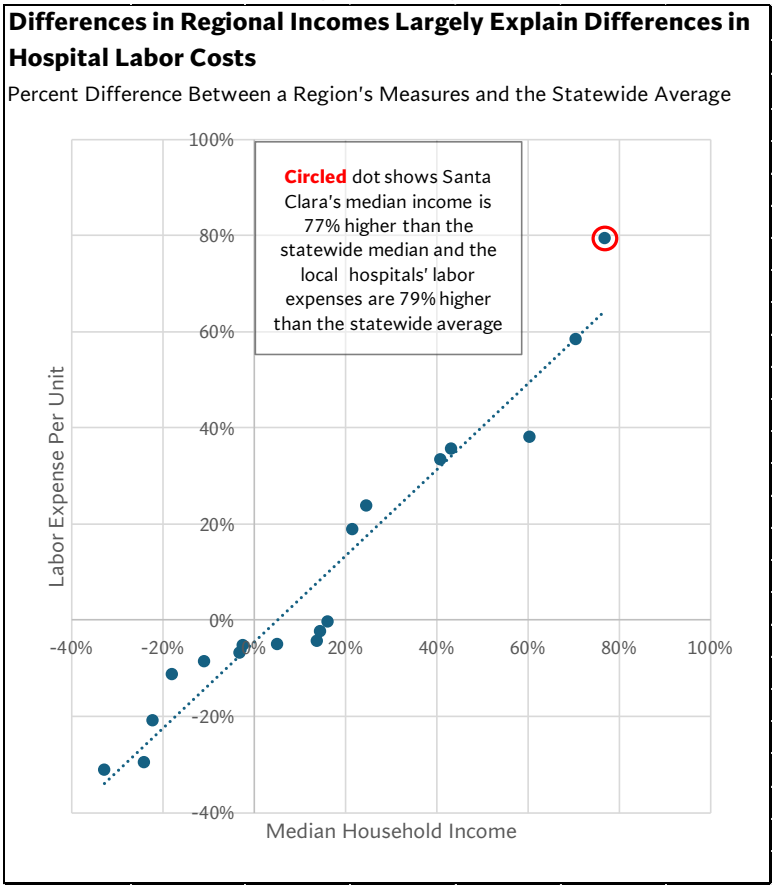
[2] This figure does not include what hospitals pay physicians. When added, hospitals spend closer to 60% of their total expenses on labor.



the Central Valley are paid, on average, 30% less than California hospitals as a whole. They also have labor costs per service that are 30% less than hospitals statewide.

These differences cannot be explained away by higher management salaries. Rather, it is higher non-supervisory worker wages that disproportionately drive the higher labor costs in more expensive regions of the state. Hospitals in regions with lower labor costs dedicate 17% of their salary expenses to manager salaries — compared to 16% in regions with high overall labor costs ("high" and "low" simply compare regions above and below the state average and management is defined broadly, for example, to include direct staff supervisors).

High Area Wages Lead to Higher Hospital Labor Costs. To attract workers, hospitals, like other organizations, must offer wages and benefit packages that consider local economic conditions, including cost of living. One key measure, median household income, varies hugely throughout California. As shown in the figure above, in San Francisco, San Mateo, and Santa Clara, median household income in 2022 was between $136,000 and $150,000. Statewide, median household income was $85,300, while some counties have median incomes between $50,000 and $70,000. Unsurprisingly, hospitals in the above three Bay Area counties have correspondingly high costs, and the opposite is true where household incomes are lower. This tight relationship between hospital labor costs and median household income is shown in the figure to the right, which demonstrates that the need to provide competitive salaries drives differences in hospitals' labor costs.



Higher Cost of Living Is Similarly Tied to Higher Hospital Costs. As with incomes, cost of living is anything but

homogenous across California. According to a measure called the regional price parity index, a $200 doctor's visit, restaurant meal, or purchase from a local home goods store in San Francisco could be expected to cost $170 in the Eastern Counties or $191 in Los Angeles. Regional cost of living is closely tied to the local wage levels, real estate prices, and the prices of other necessities and amenities. As expected, hospital expenses track differences in the cost of living throughout California. For every 1% increase in the cost of living for a given region, the cost to provide hospital services increases by around 4%. Predictably, cost of living ties most closely to hospitals' labor expenses, which are determined by local labor market conditions far more than, for example, hospitals' supply costs (including pharmaceuticals), which are more influenced by national pricing trends.

Conclusion

Hospital spending varies significantly throughout the state, whether viewed on a per-capita or per-service basis. This is driven by varying population health needs, as well as differences in the cost of living and the price of attracting a highly skilled and increasingly scarce workforce. Higher reimbursement is not a simple matter of hospitals charging and earning more. Ultimately, this analysis reveals that structural issues related to health needs and the cost of providing care must be explored as OHCA seeks to improve health care affordability for all Californians.

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
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Dr. Sandra Hernández
Dr. Richard Kronick
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