October 9, 2024

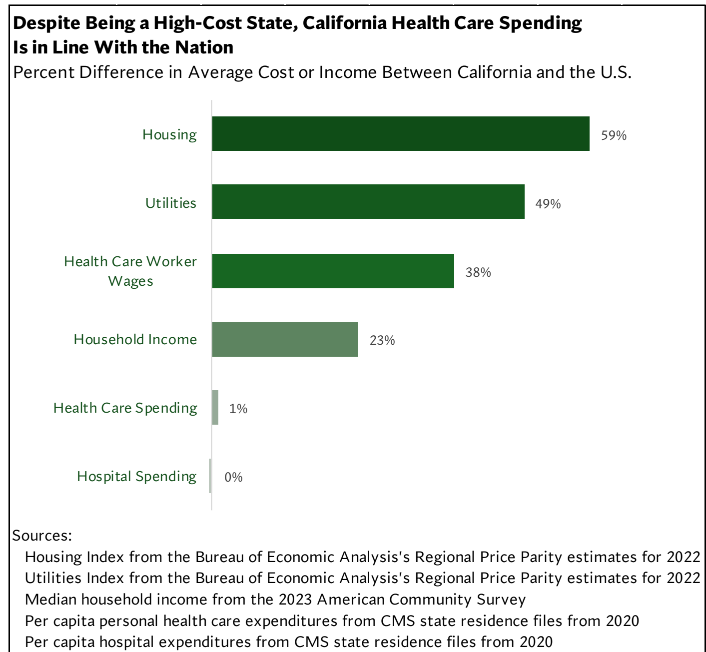
Health Care Affordability Board
2020 W El Camino Ave.
Sacramento, CA 95833

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

The California Hospital Association (CHA), on behalf of its more than 400 hospital and health system members, appreciates the opportunity to comment on the August 2024 Health Care Affordability Board meeting. The Office of Health Care Affordability (OHCA) has an historic opportunity to transform health care delivery in California, but it cannot achieve its goals of affordable, high-quality, equitable care delivery without a thorough understanding of the health care landscape. The August meeting focused on regional variation in health care spending throughout California and the United States, with a focus on hospital spending. The information presented showcased stark regional differences in health care spending throughout the state and assessments of their causes and consequences. However, certain perspectives, context, and analysis were missing. This letter aims to fill those gaps and offer alternative views on the matters under consideration. Moving forward, the office must ensure that the perspectives and information presented offer a complete and accurate picture.

Regional Comparisons of Hospital Reimbursement Lack Critical Context

The August board meeting included several presentations showing that California has higher health care costs than other states, and that certain regions like the Bay Area and regions to its south along the coast have especially higher costs. While most of this information was well grounded, it lacked critical context. Namely, that **almost everything is more expensive in California**, especially in certain regions. The question worth asking is whether health care is more expensive than would be expected given the state's and certain regions' extraordinarily high cost of living. The answer is no.



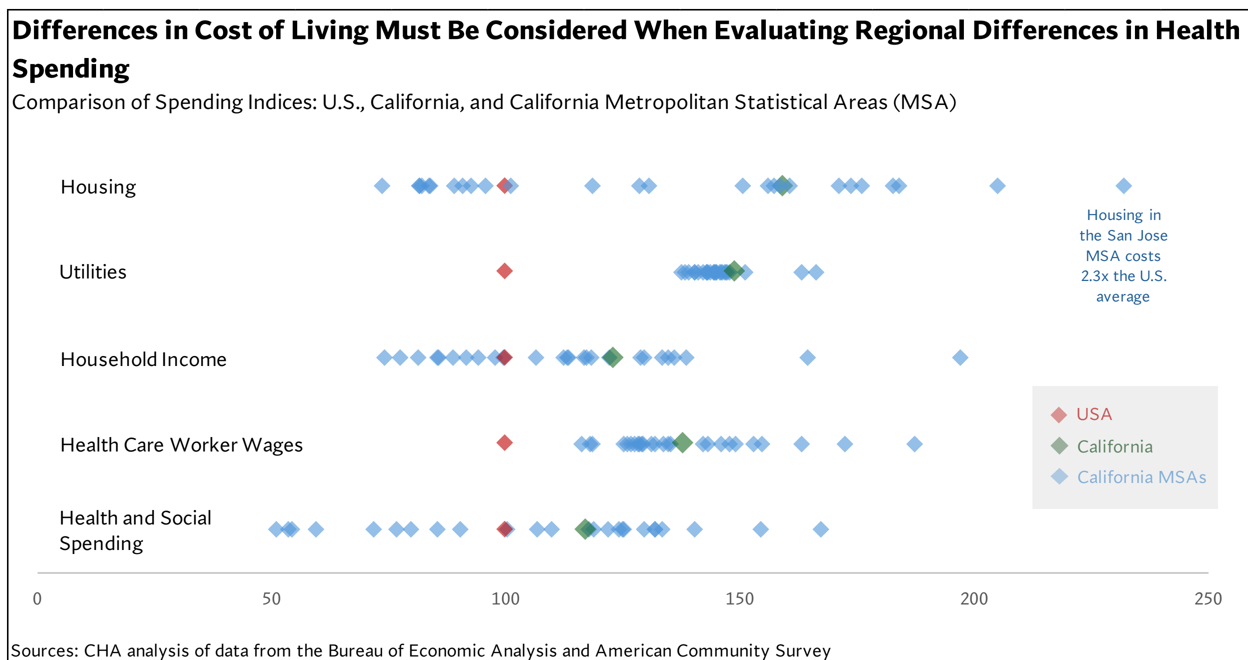
Costs Are High in California. Per capita spending on health care and hospital care in

California is in line with the national average, despite everything else being far more expensive here. Many reasons underlay this surprising fact. Californians are relatively young, correspondingly healthier, and have enjoyed a long history of widely available, clinically integrated care. On the other hand, California health care providers face extraordinary cost pressures such as astronomical real estate costs, outsized energy bills, and an imperative to pay their workers high wages to match California's high cost of living, as shown in the figure on page 1.

Californians in Some Areas Face Astoundingly High Costs of Living. Californians' costs for housing and other necessities vary widely throughout the state. The figure below provides a snapshot of the incredible variation throughout the state in spending on housing and utilities, as well as household incomes, health care worker wages, and overall health and social spending. It shows extraordinarily high costs of living in Northern California areas like the Bay Area and regions to its south along the coast. These high regional costs of living are passed through to local hospitals, particularly through high labor costs.

Differences in Cost of Living Must Be Considered When Evaluating Regional Differences in Health Spending

Comparison of Spending Indices: U.S., California, and California Metropolitan Statistical Areas (MSA)



Sources: CHA analysis of data from the Bureau of Economic Analysis and American Community Survey

It Is Essential to Control for Regional Cost Differences When Evaluating Hospital Spending. Two comparisons between California hospital prices and national prices were presented at the August board meeting, both showing that hospital care is more expensive here than elsewhere. The first simply showed that California health care costs are higher, but included no adjustments to control for California's overall higher cost of living, creating a misleading impression that health care is uniquely expensive here.

The second compared hospital prices to what Medicare would have paid. Here, things become more complicated as this approach partially — **but ultimately inadequately** — controls for regional variation in underlying costs. Medicare rates vary geographically based on differences in the hospital labor costs, as determined by the area wage index. However, according to research out of Stanford and the University of Southern California, deficiencies in the area wage index result in significant and growing underpayment

from Medicare for California hospitals located in high-cost regions.[1] For example, while fee-for-service Medicare paid California hospitals in regions with low area wage index scores fairly close to at cost as of 2019, it underpaid hospitals with high area wage index scores by upwards of 50% or even 75%. This deficiency in Medicare payment policy inevitably makes hospitals in areas that are disproportionately undercompensated by Medicare appear more expensive, despite their higher commercial rates being necessary to sustain their operations. Accordingly, even using relative payment benchmarks, like comparing commercial payments to Medicare benchmark rates, can mislead due to deficiencies in how the underlying benchmark rates are determined.

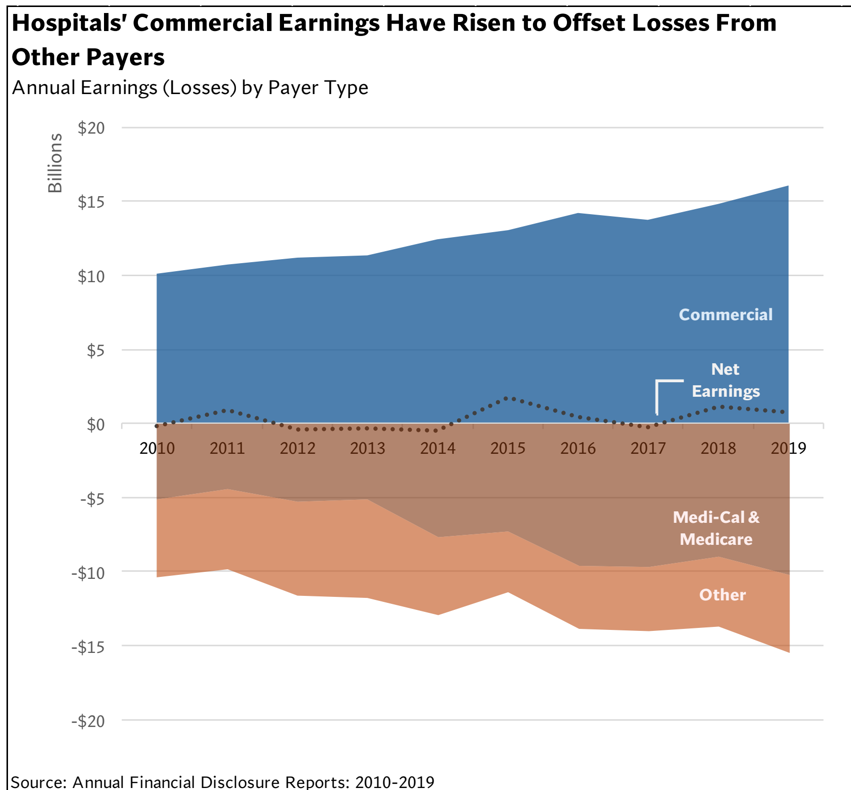
The Cost Shift Is Real, and Getting Worse

Cost shifting occurs when one entity underpays for a good or service, resulting in another entity overpaying for the good or service to ensure the producer's costs are covered. The phenomenon is commonplace in health care finance, where reimbursement shortfalls from government payers — namely Medicare and Medicaid — are cross subsidized by relatively higher payments from commercial insurers. Nevertheless, the concept is debated, with some (including one witness at the August board meeting) challenging whether cost shifting plays any role in hospital finance. However, it is difficult to see how this view squares with the data and overall landscape of the hospital field.

Medicare Pays 75 Cents on the Dollar for Hospital Care. In 2019, hospitals provided more care to Medicare patients than Californians with any other type of health care coverage. That year, California's hospitals provided about $40 billion in care to Medicare patients. However, due to the growing inadequacy of Medicare reimbursement, California's hospitals were paid just $30 billion for this care, creating $10 billion in losses that hospitals were forced to make up elsewhere. This enormous shortfall, representing nearly 10% of statewide hospital expenses, grew significantly over the preceding decade because Medicare payment growth failed to keep up with the cost of providing hospital care. (Medi-Cal payments similarly fall short; in fact, Medi-Cal reimbursement is closer to the actual cost of care only because hospitals put up their own funding to draw down federal Medicaid dollars and thereby increase their net reimbursement.)

Hospitals' Commercial Earnings Have Risen to Offset Losses From Other Payers

Annual Earnings (Losses) by Payer Type



Source: Annual Financial Disclosure Reports: 2010-2019

Hospitals Turn to Commercial Payers to Keep Their Doors Open. As hospitals fight to keep providing patient care in the face of these massive losses from government payers, they have few good options

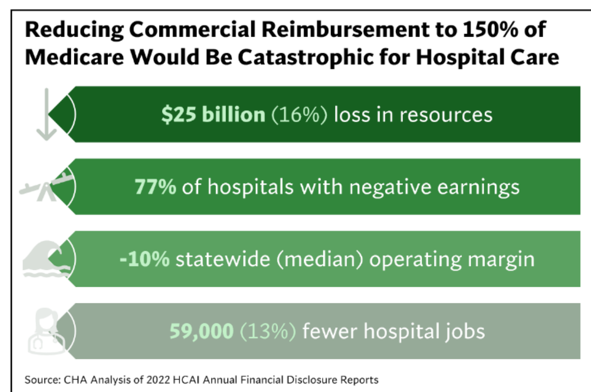
[1] Gaudette É, Bhattacharya J. California Hospitals' Rapidly Declining Traditional Medicare Operating Margins. Forum Health Econ Policy. 2023 Mar 7;26(1):1-12. doi: 10.1515/fhep-2022-0038. PMID: 36880485.

to ensure their costs are covered. Historically, the best approach to ensure hospitals can stay open has been to rely on commercial payers to make up for the losses from government payers. As the figure on the prior page shows, hospitals' commercial earnings are almost perfectly offset by losses from Medicare, Medicaid, and other payers. Moreover, this tight relationship holds throughout the nearly decade-long period, with every increase in commercial reimbursement offset by growing losses elsewhere, keeping earnings near zero. These results are corroborated by recent research on California's hospitals that show growing losses on Medicare fee for service since 2005, earnings growth for the commercially insured, and operating margins close to zero. Cost shifting predicts the consistency between these trends. A pure market power theory, by contrast, would allow higher commercial earnings to be retained as higher overall earnings.

Hospitals That Cannot Cost Shift Close or Merge. Hospitals do not unilaterally set their commercial prices. Rather, they do so through negotiation with their health plan partners. In many cases, one or two health plans may dominate a given area or market — and use their market power to restrain hospital payments, even in circumstances where higher payments are needed to offset declining government reimbursement. A 2021 study in *Health Affairs* showed what can happen when hospitals cannot recoup their losses through improved commercial payments: they close, or they merge with another hospital.[2] While mergers sustain access to care and jobs, closures sacrifice both, endangering the communities that rely on their local hospitals for their lives and livelihoods.

Losses from Government Payers Likely to Increase through the End of the Decade. Almost 300 elderly Californians are added to the Medicare rolls every day, a trend likely to continue for the foreseeable future. Most are retirees, meaning they are exchanging their commercial job-based coverage for Medicare the day they turn 65. This shift toward Medicare coverage will severely test hospital finances. The reason: the job-based commercial coverage for the 64-year-old hospital patient covers their cost of care, and more. By contrast, the 65-year-old patient's Medicare coverage pays 75% of the cost of care. Consequently, a one-day change in a patient's age, and therefore their type of coverage, lowers reimbursement for their hospital visit by half. As the relative share of Medicare-to-commercially-insured patients inexorably grows over the next decade, accompanied by further deterioration in the adequacy of Medicare payments, hospitals will have to balance growing financial losses through higher reimbursement from other payers, service reductions, closures, and other measures.

Reducing Commercial Reimbursement to 150% of Medicare Would Be Catastrophic. At the August board meeting, it was suggested that hospitals should be able to make do with commercial reimbursement no higher than 150% of what Medicare pays. The figure on the right shows what such a drop would do to hospital care in California. Resources for patient care would drop by tens of billions of dollars, nearly four in five hospitals would operate in the red, and hospitals would be forced to reduce their workforces by as many as 59,000 jobs. The impact on patients would be devastating, and would violate OHCA's charge to make care affordable while preserving access, equity, and quality.



[2] Chernew, Michael E., et al. "Public Payment Rates for Hospitals and the Potential for Consolidation-Induced Cost Shifting." *Health Affairs*, vol. 40, no. 8, 1 Aug. 2021, pp. 1277–1285, https://doi.org/10.1377/hlthaff.2021.00201.

Hospital Revenues Support Patient Care

CHA's August 2024 letter to the OHCA board showed that hospital revenues line up almost perfectly with the cost of providing care. However, certain information presented at the August board meeting left a mistaken impression that California hospitals' revenues often support other purposes. This is far from the truth.

Data Presented to OHCA Misrepresented Hospitals' Current Financial State. At the August board meeting, a witness presented data showing that California's hospitals, taken together, enjoyed a healthy operating margin of 11.1% in 2022 (with the national figure being even higher at 13%). Both state and federal data show that excess returns are not, however, a driver of hospital costs. Rather, these data reveal that the data presented at the August board meeting are highly suspect and out of line with other analyses of the same and similar data. The Medicare Payment Advisory Commission (MedPAC) recently analyzed the same data presented at the board meeting for hospitals nationally, finding that their all-payer operating margin averaged 2.7% in 2022, one-fifth of the 13% figure shared at the board meeting. A Milliman analysis corroborated the MedPAC estimate. Meanwhile, state data also contradict the data presented at the board meeting. For 2022, California hospitals reported an operating margin of just 1.04% to the Department of Health Care Access and Information, far below the 3% level that credit agencies deem necessary for hospitals to meet their financial obligations. Contrary to the story conveyed at the board meeting, California's hospitals continue to struggle to financially recover from the COVID-19 pandemic, seeking partnerships and state loans to obtain basic operating capital, eliminating unsustainable service lines, and taking various other actions just to keep their doors open.

Eliminating Hospital Earnings Would Imperceptibly Change Health Care Costs, While Jeopardizing Patient Care. For the entire period from 2010 to 2019, California's hospitals barely broke even. Collectively, their margins when comparing their direct (net) patient revenues to their expenses were just 0.41%, a wholly unsustainable margin were it not for other sources of revenue keeping hospitals afloat. Total margins, including all sources of revenue, tell a largely similar story. Most recently in 2022, hospitals' total margins, including all sources of income, were just 1.3% percent on a statewide basis; again, far below what credit ratings agencies understand is necessary to sustain services.

These margins translate into $1.7 billion in earnings on roughly $130 billion of expenses. The earnings reflect roughly 0.4% of total health care spending in California. Accordingly, OHCA could eliminate all hospital margins and total health care spending would go down by roughly $4 per person per month — a virtually imperceptible difference. Meanwhile, hospital care would crumble from a lack of resources to maintain physical infrastructures, invest in new technologies and treatments, recruit and retain their workforce, and expand capacity to meet the growing needs of California's aging population.

Nonsupervisory Labor Costs Are Hospitals' Largest Expense. Roughly half of California hospitals' expenses go toward labor. If physician payments and salaries are included, the share increases to almost 60%. What's more, this spending overwhelmingly is for direct patient care and support, with 85% of total labor expenses going to nonsupervisory workers in the form of wages and benefits. Most of the remainder goes to direct staff supervisors, such as nursing supervisors. Of all hospital spending on worker wages and salaries, just 1.7% went to high-level hospital administrators in 2021. Removing all these expenses on high-level hospital administrators would reduce statewide health care spending by roughly two-tenths of 1%, saving Californians less than $2 per person per month.

There Are Many Drivers of Hospital Spending, Not Simply Market Concentration

Hospital spending is driven by a variety of factors, including:

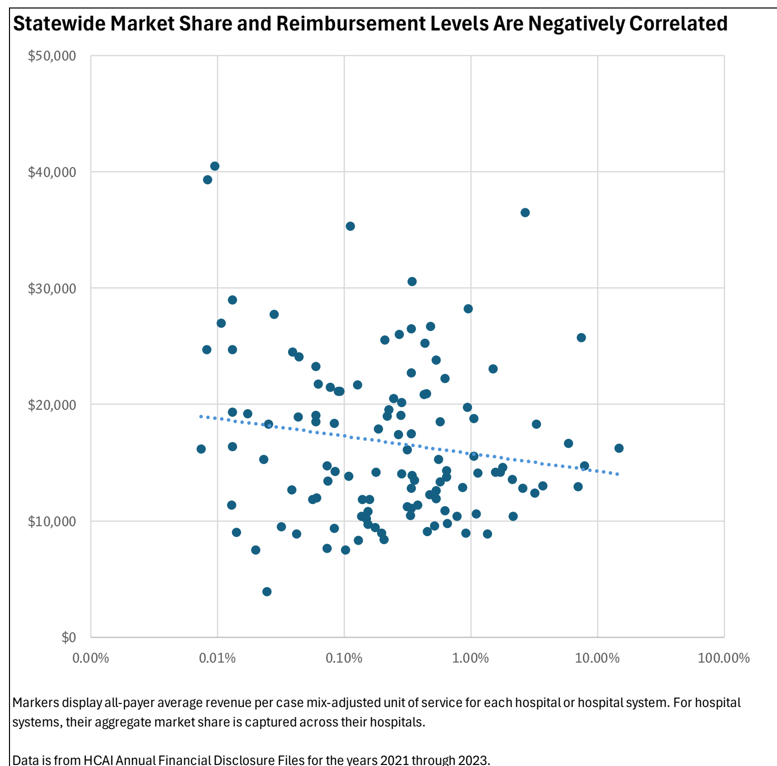
- Regional differences in the cost of living and their effect on labor costs (hospitals' highest category of expense)
- Differences in population health needs, such as the age of a hospital's surrounding population
- Differences in utilization levels that spread the fixed costs of running a hospital across higher or lower numbers of patients
- Idiosyncratic patterns of profitable service and payer lines cross-subsidizing losses elsewhere
- The provision of highly specialized care for patients with the most complex, severe conditions
- Differing levels of investment in clinical training

Rather than confronting such complexities head on, one factor was singled out at the August board meeting as driving variation in health care spending: market concentration. The analysis below shows that market concentration is not major driver of differences in hospital spending.

Statewide Market Share Is Not Linked to Higher Reimbursement. If market concentration is a primary driver of differences in reimbursement levels, hospitals and systems with greater market shares should translate their dominant market position into higher reimbursement. However, the figure to the left shows this is not the case — hospitals with greater statewide market shares have, on average, lower reimbursement than other hospitals. (Hospitals that are part of a system are treated as a single entity.) Clearly, other factors are driving these differences in hospital reimbursement.

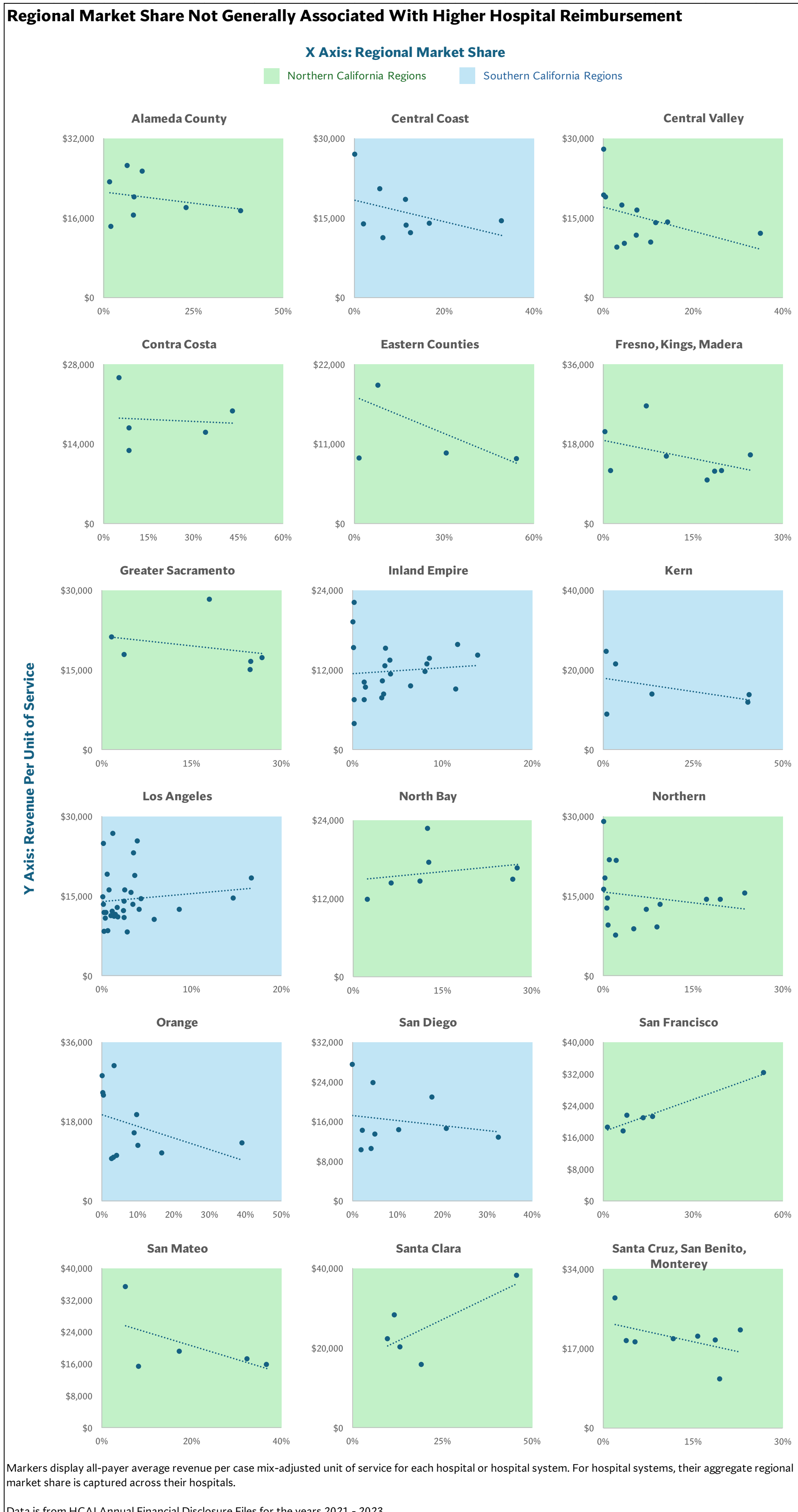
Regional Market Share Is Not Associated with Higher Reimbursement. Statewide market share may represent the wrong measure of concentration since most hospital care is delivered to local residents. Instead, the question should be looked at regionally. The figure on the next page shows the relationships between hospitals and hospital systems' regional market shares and their reimbursement levels. In 13 of the 18 regions, hospital reimbursement trends downward as their regional market share increases, indicating that market power is not a primary determinant of local differences in hospital reimbursement. To the contrary, this and the statewide result indicates that other factors — such as greater efficiency through economies of scale — may be influential drivers.

Statewide Market Share and Reimbursement Levels Are Negatively Correlated

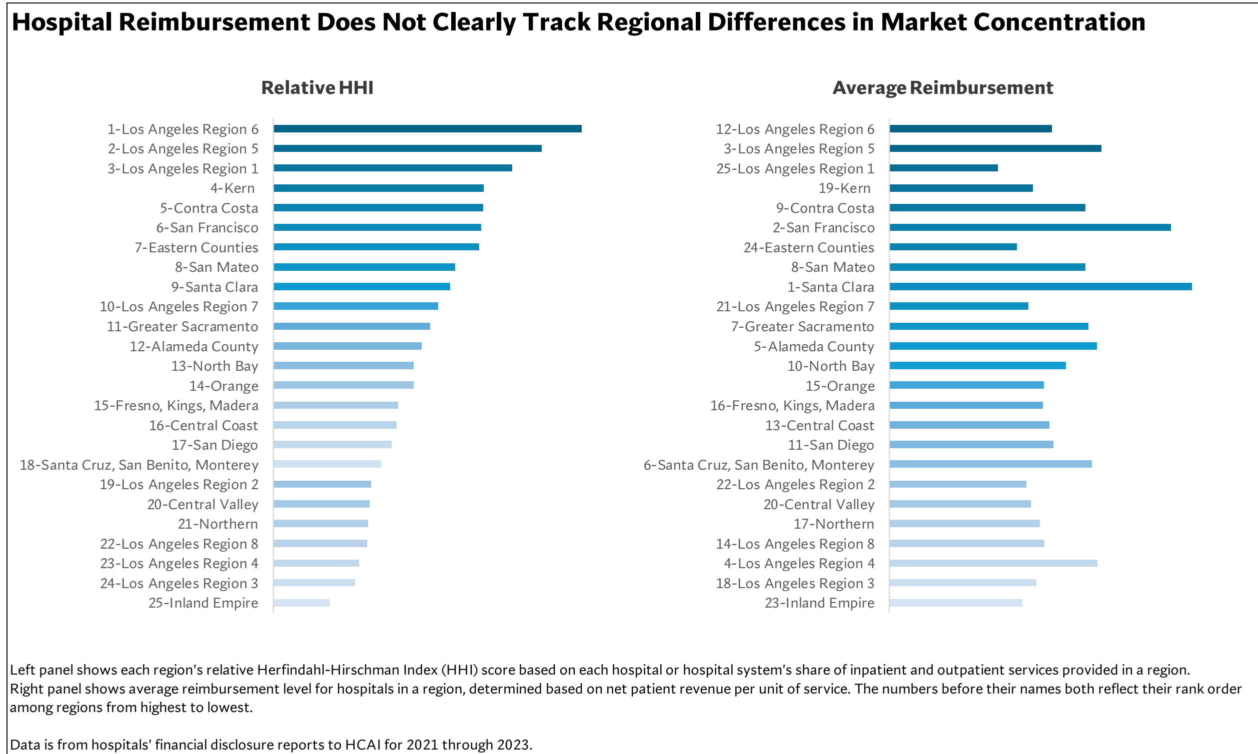


Markers display all-payer average revenue per case mix-adjusted unit of service for each hospital or hospital system. For hospital systems, their aggregate market share is captured across their hospitals.

Data is from HCAI Annual Financial Disclosure Files for the years 2021 through 2023.


Regional Market Share Not Generally Associated With Higher Hospital Reimbursement
X Axis: Regional Market Share
Northern California Regions
Southern California Regions
Y Axis: Revenue Per Unit of Service
Alameda County
Central Coast
Central Valley
Contra Costa
Eastern Counties
Fresno, Kings, Madera
Greater Sacramento
Inland Empire
Kern
Los Angeles
North Bay
Northern
Orange
San Diego
San Francisco
San Mateo
Santa Clara
Santa Cruz, San Benito, Monterey
Markers display all-payer average revenue per case mix-adjusted unit of service for each hospital or hospital system. For hospital systems, their aggregate regional market share is captured across their hospitals.
Data is from HCAI Annual Financial Disclosure Files for the years 2021 - 2023.

Regional Variation in Hospital Market Concentration Does Not Clearly Tie to Higher Reimbursement. Instead of an individual hospital or system's market share being the determining factor, hospital pricing could depend on overall regional market dynamics. Here, under the market concentration theory, hospital reimbursement levels should vary according to how concentrated a region's hospital market is. However, the data once again do not clearly bear this out. The figure below shows no clear relationship between hospital reimbursement levels and the degree to which an OHCA region has a concentrated hospital market, as measured by each region's Herfindahl-Hirschman Index (HHI) score (HHI is a widely accepted measure of market concentration).



Why Do These Findings Differ from Other Results? The analysis above fails to find consistent and clear positive relationships between market power and reimbursement levels. This finding contrasts with some, but not all, research on this topic. Key features of CHA's analysis, which may illuminate why these findings differ from others, include:

- Inclusion of reimbursement from all payers, rather than just a relatively small set of commercial payers (as in the RAND analysis presented at the August board meeting)
- Use of publicly available data for all California general acute care hospitals, as opposed to non-public data samples that are difficult to validate
- Regional delineation consistent with OHCA's regions, rather than using, for example, metropolitan service areas (MSAs) or Medicare core-based statistical areas
- A simplified approach that considers how one variable (concentration) relates to a second (reimbursement levels for all payers, adjusted to account for volume, service mix, and patient acuity), instead of the sometimes-complicated quantitative methods used in other studies that are difficult to assess for reasonableness

These differences between CHA's approach and others are discussed in greater detail in the Appendix at the end of the letter.

Premature to Adopt Sector Targets

OHCA's founding statute was intentionally crafted to facilitate iterative learning and process improvement. Data collection and analysis comes first. Spending targets follow. The spending target initially is statewide and unenforceable. Later, OHCA is to enforce the spending target and differentiate the health care field into sectors. Enforcement is to start with conversations with health care organization leaders and technical assistance, then move to performance improvement plans and, potentially, financial penalties.

The August board meeting featured calls to push ahead toward sector targets, contravening the clear intent in statute to learn from experience under the statewide spending target before applying different targets to different types of health care entities or regions. To answer such calls, at this point, would be premature, coming before OHCA has analyzed even baseline spending data, finalized a multipronged data collection plan, implemented the state's first spending target, or set any rules for enforcement. Moreover, OHCA has yet to consider how different sector targets for different components of the health care industry would interact. Before moving ahead, OHCA must consider whether a lower spending target for providers would allow payers to retain the resulting savings as higher earnings — or whether those savings must be passed through to consumers in the form of correspondingly lower payer targets Clearly, more groundwork is needed before moving forward.

Opportunities to Bend the Cost Curve for Hospital Care

Hospitals strive to make care more affordable for all Californians. Below are some areas for OHCA to explore to meaningfully improve affordability without sacrificing equitable access to high-quality care.

- **Improve the Care Transition Process.** Every day, thousands of patients are stuck in hospitals with nowhere to go. Their acute care needs have subsided, but coordination problems arise, resulting in delayed transitions to less costly and more appropriate post-hospital care. Addressing the problems in the care transition process, which have exploded since the onset of the COVID-19 pandemic, could bring substantial savings while simultaneously ensuring that patients are treated in the most appropriate setting for their conditions.
- **Help Health Care Professionals Do What They Do Best – Care for Patients.** Clinicians spend ever-increasing time on administrative work rather than treating patients. Every year, hospitals must hire more and more staff to navigate the opaque and evolving thicket of health plan policies and procedures that increasingly serve as barriers to appropriate care. OHCA should explore these issues and encourage policies and practices to improve the care authorization process.
- **Grow the Workforce.** Recruiting and retaining a highly skilled workforce is a longstanding challenge for hospitals and other health care providers, only made worse by the wave of departures from the health care workforce under the stresses of the COVID-19 pandemic. Researchers from the University of California San Francisco project nursing shortages until almost the end of the decade. Workforce shortages raise the price of labor, often forcing hospitals to rely on expensive contract labor (travelers), increasing costs while reducing access to care. OHCA should investigate ways to expand the health care workforce both throughout the state and in underserved areas by studying and supporting efforts to expand the education pipeline, ensure health care workers are able to practice at the top of their license, and that incentives are in place for practitioners to work where they are most needed.
- **Improve Access to Primary and Preventive Care.** Preventing disease onset and stopping its progression before it becomes acute is both better and more cost-effective care. Access to primary and specialty care is inadequate for too many Californians, resulting in expensive hospital stays for conditions that could have been treated earlier. OHCA is setting goals aimed at

encouraging greater investment in primary and behavioral health care. Going forward, OHCA must ensure these goals become a reality and yield tangible improvements in access for all Californians.

- **Further Protect Patients from the Financial Risks of Medical Conditions and Emergencies.** Health care spending is far from evenly distributed. A person may go decades with minimal health care use, only to need thousands of dollars in care following a medical emergency or serious diagnosis. Unfortunately, these costs increasingly are pushed onto patients in the form of higher deductibles and coverage denials. The end result: healthy people pay marginally less for coverage while the sick incur sometimes outsized medical expenses, creating disparities in the costs of care based on health status. OHCA should examine health insurance companies' marketing of plans that shift costs onto patients and encourage efforts to ensure that health care coverage is meaningful for those who need it most. Ultimately, coverage is not just a means to improve people's health — it is a critical financial protection. This was the most eye-popping finding of this century's landmark study on the effects of coverage expansion. While the study, known as The Oregon Experiment, found somewhat minimal effects of expanded coverage on short-term health outcomes, it found that the expansion virtually eliminated catastrophic out-of-pocket medical expenses, showing the potential for comprehensive coverage to protect against the downside financial risks of serious health conditions and medical emergencies.
- **Encourage Care Delivery Innovations.** To fulfill Californians' health needs, the care provided tomorrow cannot be the care provided today. New care delivery models are needed to treat patients in the least restrictive setting possible, such as under Hospital at Home and the nursing home diversion efforts under CalAIM. New technologies must be embraced, such as whole genome sequencing under Project Baby Bear to diagnose and treat newborns with serious health conditions. High-cost but potentially high-value treatments, like semaglutide (Ozempic and Wegovy) to reduce obesity and diabetes, should be available to patients who need them. More resources should go to underserved Californians to address longstanding inequities in access and care. All these improvements will require upfront investment. By capping the resources available to health care entities, OHCA risks obstructing, rather than encouraging, such innovations, locking in the health care system of today at enormous cost to the patients of tomorrow. To avoid this, OHCA must encourage new ways of providing care. To do so concretely, spending on improving access and quality cannot be penalized under the spending targets. And separately, OHCA and its board should encourage evidence-based practice transformations that ultimately improve patients' experiences and outcomes.

Urge Greater Balance in the Information and Perspectives Considered

OHCA has tremendous authority to shape the future of health care delivery and financing in California. To wield this power effectively — without serious unintended consequences for patients — a strong understanding of the workings of the health care sector is needed. OHCA board meetings present an incredible opportunity to build common understanding and work through the complexity of the questions and tasks before us. Unfortunately, the lack of balance offered at the August board meeting challenged, rather than supported, this prerogative — at times painting a misleading and reductive picture of the obstacles to providing affordable care for Californians. Going forward, hospitals urge the OHCA board to renew its commitment to inclusivity and balance in the issues, perspectives, and information that are explored.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

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

Appendix

The analysis shared in this letter found no positive relationship between market concentration and hospital reimbursement levels. The findings differ from other studies. Below are some of the ways this analysis differs from others, which may shed light on the benefits and drawbacks of this versus other approaches of studying this important question:

- **Which payers are included?** The analysis above includes the three major payers: commercial, Medi-Cal, and Medicare. Other analyses focus on commercial payers, ostensibly because prices are universally negotiated as well as highest in the commercial space. However, while there are unique considerations and constraints, pricing negotiation is present in Medi-Cal and Medicare managed care, through which more than 90% of all Medi-Cal beneficiaries and around 50% of Medicare participants receive coverage. Moreover, using the major payers captures overall reimbursement for hospitals, thereby accounting for differences in hospitals' revenue generating strategies and capacities. For example, high Medicare Advantage hospitals may focus their negotiating efforts on obtaining relatively higher prices from Medicare Advantage plans, with less emphasis on their commercial book of business.
- **What data is used?** The above analysis relies on comprehensive financial reporting from hospitals to the Department of Health Care Access and Information. It covers:
    - All general acute hospitals operating in California
    - Total net patient revenue for all inpatient and outpatient services for the three major payers divided by the sum of discharges for inpatient and discharge-equivalents for outpatient, risk-adjusted using the case mix index
    - The years 2021 through 2023 to smooth out annual anomalies often present in these data.

  Other analyses use other sources of data. For example, the analysis presented by Dr. Whaley at the August board meeting used a dataset for California comprising voluntarily reported commercial pricing data covering, at most, 10% to 15% of Californians.
- **How are regions delineated?** This analysis looks at market concentration regionally based on the OHCA regions, with the lone exception of Los Angeles being consolidated into a single region. For more densely populated areas, the regions are counties. For less dense areas, groups of counties are aggregated into a single region. Other similar analyses break geography up differently, such as by metropolitan service area (MSA) or hospital referral region. Ultimately, researcher decisions on how to delineate geography may have major implications on the results. To test this, CHA instead performed an identical HHI analysis by MSA, obtaining the same result showing no positive relationship between concentration and reimbursement.
- **What are the studies' methodologies?** Different studies use different approaches for identifying the influence of market concentration on prices. CHA's analysis looked simply at the basic two-way relationship between these factors, finding no evidence that the former is determinative of the latter. However, other factors like household incomes, age patterns, and population density may influence this relationship. Some approaches aim to account for these other factors, such as by incorporating demographic information or alternatively controlling for overall differences across regions. Unfortunately, the methods of such studies can quickly get complicated, are often the end result of significant experimentation by researchers when it comes to model specification, and sometimes are not transparent, ultimately making it impossible to ascertain the reasonableness of the methods' assumptions and specifications.[3] Sometimes, simple is better.

[3] See, for example, the dearth of detailed information provided on the methods used to estimate the relationship between prices and market share (page 17) in the RAND Research Report: Prices Paid to Hospitals by Private Health Plans, Findings from Round 5 of an Employer-Led Transparency Initiative (link).