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March 11, 2024

Secretary Mark Ghaly, M.D.
Chair, Health Care Affordability Board
Department of Health Care Access and Information
202 West El Camino, Suite 800
Sacramento, CA 95833

Re: Proposed Statewide Health Care Spending Target - Opposition to Current Recommendation

Dear Secretary Ghaly and Members of the Health Care Affordability Board:

On behalf of the California Radiological Society (CRS), we appreciate the opportunity to provide comments regarding the Office of Health Care Affordability (OHCA) staff recommendation of an annual 3% statewide health care spending growth target for 2025-2029.

This staff recommendation is based on the single economic indicator of the median household income growth from 2002 – 2022, which is unrelated to the increasing cost of practicing medicine. Adopting a 3% health care spending growth target, which most physician practices and health care entities will be unable to meet, will negatively impact access to health care for Californians, particularly for communities that have historically lacked equitable access to quality health care. CRS urges the Health Care Affordability Board (Board) to take the time to explore alternatives to the unrealistic staff proposal before casting the most important vote you are charged with making.

The Cost of Providing Health Care and Historical Health Care Spending Growth Should Be Factored into the Target

In December 2023, the Centers for Medicare and Medicaid (CMS) projected that the increase in the Medicare Economic Index (MEI) – the cost to practice medicine - will be 4.6% in 2024. It is critical to consider, rather than ignore, the cost of providing health care when setting California's spending growth target. In the last CRS survey of members, the majority of physician practices in this state were still worried about their financial health after the height of the pandemic was behind us. Setting a spending growth target that disregards the rate of inflation, increasing labor costs and those for necessities such as medical supplies and utilities is more likely to drive smaller practices to be acquired by larger, more costly health care systems than it is to save consumers money.

If the Board sets a target lower than the actual cost of providing health care, providers will be pressured to deliver less medically necessary health care. If Californians cannot access care, patients, their employers and taxpayers will be paying for insurance coverage they cannot use. Affordability is only meaningful if there is access to care.

Moreover, if the state's spending growth target is unrelated to the cost of providing health care, it will be difficult to get buy-in from the health care entities subject to the cost targets to make changes that are within their power without coming at the expense of quality patient care.

Further, the average annual growth in per capita health care spending should be considered when setting a spending growth target. According to CMS for California, the 10-year average annual change in per capita health care spending from 2010-2020 was 4.7%, and the 20-year average annual change in per capita heath care spending from 2000-2020 was 5.4%. It is unfeasible to meet a 3% health care spending growth target considering that CMS estimates the cost to practice medicine in 2024 will grow by 4.6% and the average annual change in per capita health care spending was no less than 4.7% in the 20 years from 2000 – 2020.[1]

As has been mentioned by many witnesses testifying before you and by members of the OHCA Advisory Committee, the rate of household income growth is unrelated to the factors driving cost increases in health care. Additionally, the choice by OHCA staff to use the median household income over 20 years (with years that include the greatest recession since the 1920s) would result in a 3% target that is artificially low. If the Board continues down the questionable path of using median household income as the sole factor in determining the spending growth target, it would be more appropriate to look at the median income over the last ten years, which is 4.1%, and the current projection for median household income growth for 2026, which is 3.6%.

Access to Care Needs to Be Considered Along with Affordability

Health care affordability is a concept that does not and should not exist in a vacuum. SB 184, Chapter 47, Statutes of 2022 that created the Office of Health Care Affordability specifically names "Access, Quality and Equity of Care" among its goals. These three priorities coupled with affordability are the quadruple aim of the Office of Health Care Affordability. Currently, many Californians already have difficulty getting timely access to health care. Covered California's narrow provider networks were recently raised as a concern by an OHCA board member, followed by the statement from another Board member that those with large employer coverage are also having trouble getting timely appointments with specialists. A 3% target put in place for 5 years will undoubtedly result in longer wait times for most California patients.

Health Care Growth Spending Targets in Other States

The statements that have been made at your Board meetings that could lead one to believe that California is simply replicating what has worked in other states omit most of the relevant facts. CRS strongly encourages you to look at the health care spending growth targets that were initially adopted in other states, what factors informed their decisions, and how those targets have been modified since initial adoption. No other state has set its initial spending growth target as low as 3%. For example, in 2013 in Massachusetts, the health care spending growth target was set at 3.6%, based on the state's estimated potential growth state product (PGSP). Then it was lowered to 3.1% in 2018 (PSPG -.5%), and then the target was increased to 3.6% in 2023.[2] PGSP is comprised of several economic factors, including the expected growth in

national labor force productivity, state labor force, national inflation and state population growth. Delaware set its benchmark for 2019 to 3.8% via Executive Order. Oregon's benchmark was determined by the state's Sustainable Health Care Cost Growth Target Implementati

Committee. It considered PSPG, wage and personal income growth and set its cost growth target at 3.4% for 2021–2025 with a planned reduction to 3.0% for 2026–2030. Connecticut set a 3.4% cost growth benchmark that is a blend of the growth in per capita PGSP and the forecasted growth in median income of state residents, with a recommended reduction to 3.2% for 2022 and 2.9% for 2023–2025. And as mentioned by OHCA's consultant at the February

[1] State Health Expenditure Accounts by State of Residence, 1991-2020, Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trendsand-reports/national-health-expenditure-data/state-residence.

[2] Joel Ario, Kevin McAvey, and Amy Zhan, State Benchmarking Models: Promising Practices to Understand and Address Health Care Cost Growth, Manatt Health, June 2021.

2024 Board meeting, these other states set their targets before the current inflationary situation and there is little optimism about states meeting the targets set for 2023 and 2024.

Based on a review of five other state spending targets, it appears that California is contemplating setting an overly ambitious and unobtainable target at the outset, rather than where other states set their initial targets. As you begin your work with health care entities to attempt to meet spending growth targets, we urge you to consider the increasing cost of providing care. Your initial spending growth target should be one that health care entities can achieve without reducing access to quality care. Instead of starting at an unrealistic place, we suggest that the Board set the spending growth target for 2025 at a level that considers the increased costs of providing care and then you can lower the percentage over time. Additionally, given that the Board has currently only considered one option and California has no experience with this yet, we think that setting spending targets for five years is ill-advised.

Consolidation Implications

According to a 2019 California Health Care Foundation Report, prices for both inpatient and outpatient services increase when there is more market concentration or consolidation[3]. If the Board sets the health care growth spending target too low, high-cost outliers will continue to be just that – high-cost outliers, and smaller entities will give up and be swallowed up by larger, often more expensive systems. Setting the targets too low will drive the very consolidation that leads to increased health care costs that you hope to prevent.

Implications of SB 525 and MCO Tax Should Be Considered

Last year, the Governor signed SB 525 (Durazo) which will increase the minimum wage for health care workers to $25 an hour over a series of years depending on the health care setting. For integrated healthcare systems with 10,000 employees or more and dialysis clinics, or county-operated health care facilities with a population of more than 5 million by January 1, 2023, the minimum wage will increase to $23 an hour beginning June 1, 2024, increase to $24 an hour on June 1, 2025, and to $25 an hour on June 1, 2026. For hospitals with a high governmental payor mix, an independent hospital with an elevated governmental payor mix, a rural independent covered health care facility, or a covered health care facility that is operated by a county with a population of less than 250,000 as of January 1, 2023, the minimum wage for covered health care employees shall be $18 per hour from June 1, 2024 and must increase incrementally to $25 per hour beginning June 1, 2033. Regardless of the exact timeline of SB 525 implementation, state law ensures that health care entities will have increased labor costs going forward and this fiscal reality should be taken into consideration when adopting a health care spending growth target.

In addition, a new Managed Care Organization (MCO) Tax was enacted in 2023 and will provide much needed rate increases for Medi-Cal providers for the first time in thirty years to increase access to care for the one in three Californians who are enrolled in Medi-Cal. The Coalition to Protect Access to Care worked with the Administration and the legislature to make this historic investment in the Medi-Cal system a reality. Over $1 billion annually of this spending will be new investment in primary care, aligned with the call in OHCA statute for increased investment in primary care. All of the new revenue from the MCO tax that will be invested in Medi-Cal and workforce expansion will help to increase access to care, particularly for low-income Californians. Failing to account for this critical new spending that will improve access to care for Californians when setting the spending growth target undermines all of the work we are collectively doing to improve patient care in the Medi-Cal system.

Putting Cost Targets in Place for Five Years Before Any Data Available

[3] Richard Sheffler, Daniel Arnold, Brent Fulton, Health Care Prices and Market Consolidation in California, California Healthcare Foundation, October 2019. https://www.chcf.org/publication/the-skys-the-limit/#market-concentration

The proposal to keep a 3% target in place for five years is too long a timeframe for an initial spending target. California's lack of experience with collecting the data and calculating Total Health Care Expenditures for the state, let alone setting and maintaining a spending growth target, is among the arguments for setting targets that last for no more than two or three years. While predictability is important, it is critical that the Board gain information and employ some of the flexibility that was discussed during the Senate Rules Confirmation hearings and in your

February Board meeting to adjust targets when appropriate. Sector-specific targets may be warranted, and if so, the Board should begin work on those for as early as 2026.

Revise Proposal: Consider Economic Factors That Impact the Cost of Health Care Delivery

CRS strongly recommends that the Board reject the staff's recommendation of a 3% annual statewide health care spending growth target because it is both unrealistic and does not take into consideration critical factors such as the actual cost of providing health care such as labor costs, supply costs, medical equipment costs and inflation.

We urge the Board to set a cost target for 2025 that considers the economic realities of today, and the next 18 months, rather than reaching back to the Great Recession that lasted from 2007-2009 and including household income growth during that period to arrive at an artificially low spending growth target unrelated to costs today.

The Board's cost target should be set at a level that is attainable for most health care entities without patient care suffering as a result, rather than creating a situation where health care providers universally fail to meet the cost target and the state moves no closer toward achieving the goals that led to the creation of OHCA.

CRS urges the Board to consider the spending target's impact on more than just the hope of affordability. This spending target will have real-life impacts on patient access and quality of care. It would be counterproductive to sacrifice quality and access to care.

We look forward to working with you on this and other critical issues before the Office of Health Care Affordability Board this year and beyond. For more information or questions, please contact our lobbyist, Ryan Spencer, at (916) 396-9875 or rspencer@rgsca.com.

Sincerely,

Matthew Peralta, CAE
California Radiological Society, Executive Director

cc: Elizabeth Landsberg, Director of the Department of Health Access and Information