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What Can We Afford?

Aligning Office of Health Care Affordability spending target with Californians' ability to afford increases

by Laurel Lucia, Miranda Dietz, and Tynan Challenor

Executive summary

The California Office of Health Care Affordability (OHCA) will establish statewide and sectoral health care spending targets with the goal of achieving a more sustainable per capita rate of spending growth on health care provided by a range of health care entities including but not limited to hospitals, medical groups, health plans, and fully integrated delivery systems. Total health care expenditures will be compared against the spending target and a progressive enforcement process will begin in 2028.

California law outlines certain requirements for determining the statewide spending target, but the specifics of the methodology will be decided by the OHCA board in consultation with staff and with input from the advisory committee and the public. This policy brief discusses one major question the OHCA board will consider in determining the methodology for the statewide spending target: which economic indicator or combination of indicators will be used in setting the target?

Five economic indicators that could be used as the basis of a spending target are evaluated: growth in median wages, median household income, Consumer Price Index (CPI), gross state product per capita (GSP), and potential gross state product (PGSP, a forecasted measure of the long-run growth in the economy). These reflect the range of possible economic indicators described in state law, and, with the exception of CPI, these indicators have been used by health care cost commissions in other states.

The advantages and disadvantages of each economic indicator can be summarized as follows:

- Median wage and median household income growth are the best proxies for consumers' ability to afford health care spending increases, while GSP per capita and PGSP are the best proxies for state and local governments' ability to absorb health care spending increases using general funds which originate from broad-based taxes. CPI growth is a poor proxy for both consumers' and governments' ability to afford health care because it reflects changes in prices, not changes in resources available.
- A spending target set using growth in median wages, household income, or CPI would be likely to slow spending more than a target using GSP, based on historical spending trends in California over the last two decades. From 2002 to 2021, average annual CPI growth in California was 2.55%, median wage growth was 2.81%, median household income growth was 2.83%, and GSP growth per capita was 3.92%. Historical trends for California PGSP are not available.
- Data showing historical California growth rates for each economic indicator is readily available with a limited time lag for all indicators except PGSP. California-specific projections were only found for CPI-W, but projections should be possible to obtain for the other indicators.
- Historical data for all economic indicators show significant volatility from year-to-year, even when a rolling three-year average is used. To make a target more stable, OHCA may consider using long-term projections for the relevant economic indicators or historical averages that cover a long time period such as 20 years. These are approaches taken by other state health care cost commissions.
- Looking ahead to the possibility of geographic targets in the future, regional data availability could be an additional consideration. Historical data that could be aggregated by Covered California region is readily available for growth in median wages, household income, and GSP per capita, but not for CPI or PGSP.

In determining a methodology for setting the statewide target, a key question for the board will be how much weight to give to each of the two main goals: improving consumers' ability to afford health care and slowing spending growth for government and other sources of spending. Some board members have expressed an interest in centering consumer affordability in implementation decisions.

When considering the goal of improved consumer affordability, it is important to keep in mind a couple of factors related to job-based coverage, which remains the most common source of coverage in California. First, growth in premiums and out-of-pocket costs can have a range of negative consequences for households with job-based coverage including higher worker premium contributions and higher out-of-pocket costs, which can in turn threaten financial security and access to care. Rising health care costs can also lead to lower wages; since employer premium contributions are an important part of workers' overall compensation, there is a tradeoff between employer premium contributions and wages paid. Secondly, the financing of the worker share of job-based coverage is regressive, meaning that low-income households pay a significantly higher share of income on premiums and out-of-pocket costs than higher-income households.

We recommend that:

- If the board seeks to prioritize consumers' ability to afford health care spending growth, it should consider using median wage growth or median household income growth in setting the spending target.
- If the board seeks to proportionally address the affordability of health care for consumers and their employers on the one hand and state and local governments on the other hand, it should consider setting the spending target based on a blend of median wages or median household income, weighted 80%, and GSP per capita or PGSP, weighted 20%. This weighting would reflect the approximate proportion of California-based health care expenditures paid by households/employers and state/local governments respectively.

Prioritizing consumer affordability would not mean that state and local governments' interest in slowing health care spending growth would be disregarded. State and local governments' budgets would also benefit from the lower spending target that would be set if median wage growth or median household income growth was the focus.

Background on OHCA's charge

The California Legislature and Governor Newsom created the Office of Health Care Affordability (OHCA) in 2022 to analyze health care spending trends and cost drivers, set and enforce spending growth targets, make recommendations for slowing health care spending, assess market consolidation, and set standards for quality and equity, alternative payment models, primary care and behavioral health investments, and workforce stability. OHCA, housed within the Department of Health Care Access and Information, is currently being implemented.

State law requires that OHCA establish a statewide health care spending target. In addition, OHCA may establish "specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, except for fully integrated delivery systems." The health care spending targets are required to "promote a predictable and sustainable rate of change in per capita total health care expenditures." Historical trends and projections for economic indicators or population-based measures must be considered in setting a target percentage, and the targets must 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.¹

Health care entities subject to the targets include payers such as health plans and insurers, Medi-Cal, Medicare, third party administrators, and other entities that pay or arrange for the purchase of health care services; providers such as hospitals and other health facilities, physician organizations, clinics, ambulatory surgery centers, labs, and imaging facilities; and Kaiser Permanente, as the only current example of an integrated delivery system. The statewide spending target will be used to measure against growth in per capita total health care expenditures,² which will include all claims-based and non-claims-based payments for health care provided, cost sharing payments by patients such as deductibles and copayments, and the administrative costs associated with health coverage. The law

does not include other health spending such as workers' compensation or public health expenditures in the definition of total health care expenditures.

At their September 2023 meeting, the OHCA board will begin discussing a statewide spending target for 2025, with adoption of a final target to be completed by June 1, 2024. The 2025 target will be for reporting purposes only, and future targets will be enforced beginning with the 2026 target. By October 1, 2027, the OHCA board is required to define health care sectors and by June 1, 2028, the board will establish targets by health care sector which could include targets by geographic region, health care sector, and for individual health care entities.³

Scope of this brief

This brief is focused on evaluating which economic indicator(s) should be considered in setting the statewide spending target.

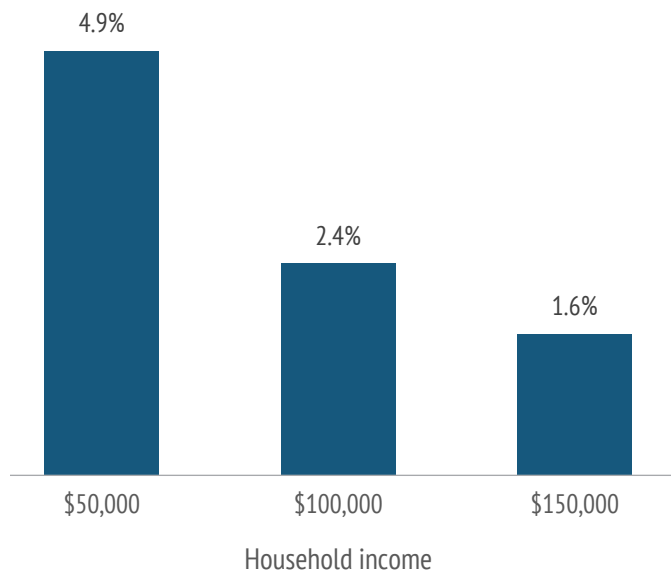
The board will likely discuss a number of other questions in determining the methodology for establishing the statewide target such as whether the target should be multi-year, how population-based measures (such as aging) will be used in setting the target, and what adjustments can or should be incorporated into the target and under which circumstances. Examples of possible adjustments include using add-on factors such as adding or subtracting 0.5 percentage points in certain years to phase-in the target or achieve other goals, determining conditions that warrant a potential adjustment to the target like a major change in the economy, making adjustments to improve accuracy and reliability when assessing performance, and directly adjusting the target for certain entities like Medi-Cal providers or entities with organized labor cost growth that exceeds the target.⁴

Why the selection of economic indicator(s) matters

The economic indicator(s) that OHCA uses to set the target could affect the extent to which slower health care spending growth is achieved, and meaningfully slowing health care spending growth is important for access to care, financial security, and equity. In a survey of California adults in the Fall of 2022,⁵ more than half (52%) of Californians reported that they or a family member postponed or skipped care due to cost in 2022. An even higher percentage of Californians with low income (69%) skipped care. Black and Latino residents were more likely to say that they or a family member skipped a recommended medical test or treatment due to cost (28% and 34% respectively), compared to 19% of white and 13% of Asian residents. More than one in four (27%) Californians reported problems paying medical bills and 36% reported having medical debt, with these circumstances being more frequently reported by Black, Latino, and low-income Californians.

Among Californians with job-based coverage--the most common source of health coverage in the state--low- and middle-income families will reap the largest benefits from slowing spending on premiums and out-of-pocket costs. As a hypothetical example, total health care spending by a family of four and the policyholder's employer could reach \$27,000 in 2025, including premiums and typical out-of-pocket spending, based on projected health care spending growth.⁶ If combined premium and out-of-pocket costs grew by 5% annually in the absence of a spending target, spending per family with job-based coverage would grow to \$32,819 by the fifth year of the policy. If the growth rate slowed to 3% annually as a result of health care entities meeting the spending target, total spending per family would be \$30,389 in year five. Under the lower spending growth rate, the family and employer would save \$2,430 in the fifth year alone. If the savings are fully passed through by the employer to the worker, those savings could mean lower growth in worker premium contributions, lower growth in out-of-pocket costs, higher wages, improvements in non-health benefits, or some combination of those impacts. Annual savings of \$2,430 means a lot more to families on the lower end of the income scale because it makes up a higher percentage of income as shown in **Exhibit 1**.

Exhibit 1: Hypothetical annual savings for a family of four with job-based coverage in year five of spending target implementation, as a percentage of household income



Source: UC Berkeley Labor Center analysis of hypothetical scenario in which annual health care spending growth slows from 5% to 3% in the first five years of the spending target, saving \$2,430 for a typical family with job-based coverage in the fifth year alone if the savings are fully passed through by the employer.

Savings like this also matter to employers because health care benefits are an important part of workers' total compensation. When health insurance premiums are growing rapidly, employers often have less money to spend on wage increases and improvements to other benefits like retirement, important factors in recruitment and retention of workers.⁷ This is particularly of concern for small employers and employers with a high proportion of low- and moderate-wage workers.

Slowing health care spending growth also matters for state and local governments. Health care is a major part of state and local budgets; in the 2023-2024 state budget, Medi-Cal General Fund spending (\$37.5 billion) is projected to comprise 16.6% of total General Fund spending of \$225.9 billion.⁸ This spending is ultimately borne by state taxpayers, with the largest sources of revenues being state income taxes (56.6% of General Fund revenues), corporate taxes (20.2%), and sales and use taxes (16.0%).⁹ Health care spending growth rates also affect state tax revenues related to the deductibility of job-based coverage.

Criteria for evaluating economic indicators

As the OHCA board considers which economic indicators to use in setting the spending target, at least four criteria warrant consideration. An economic indicator or combination of indicators used as the basis for setting the target would ideally have the following characteristics.

1. The economic indicator(s) should lead to meaningful slowing of health care spending growth if the target is achieved. The gap between the growth in the economic indicator(s) and in total health care expenditures per capita should be significant enough that consumers and purchasers would perceive a meaningful improvement in how affordability is changing over time.
2. The economic indicator(s) should be reflective of changes in consumers' ability to pay for health care increases, and could potentially also reflect the ability of state/local governments to absorb health care spending increases. This criterion is dependent on how the board decides to weigh the interests of the sources of health care spending in the state, as discussed later.
3. The economic indicator(s) should exhibit relatively low volatility, or change from year-to-year, to support predictability for health care entities in meeting the spending target.
4. The data showing growth rates in the economic indicator(s) should be produced regularly with a limited time lag. Additionally, it would be preferable if the data can be compiled by Covered California region, given that OHCA is currently discussing collecting and reporting data by Covered California region with some possible modifications.

Economic indicators for consideration in setting OHCA spending target

In this brief, five economic indicators are evaluated using California-specific data: growth in median wages, median household income, Consumer Price Index - Wages,¹⁰ gross state product per capita, and potential gross state product (see **Exhibit 2**). These indicators are included to reflect the range of "established measures reflecting the broader economy, the labor markets, and consumer cost trends" described in California law.¹¹ With the exception of the Consumer Price Index, all of these indicators are used by at least one other state health care cost commission to set spending targets (**Appendix Exhibit A**).

When measuring changes in wages or household income it is important to use medians rather than averages because outliers on the high end of the wage or income scale drive up the average. Wage growth and income growth have disproportionately occurred at the top of the income scale in recent years.¹²

Exhibit 2: Economic indicators for OHCA consideration

Economic indicator	Source	Economic change reflected in indicator
California median wages	U.S. Census Bureau, Current Population Survey ¹³	The typical California worker's income
California median household income	U.S. Census Bureau, Current Population Survey ¹⁴	The typical California household's income including earnings, certain income and benefits from government programs, interest and dividends, and other income
California Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W)	California Department of Finance	Prices paid by California urban wage earners and clerical workers for a market basket of consumer goods and services
California gross state product per capita	U.S. Bureau of Economic Analysis estimates of GSP by state and California Department of Finance population estimates	The per capita value of all final goods and services produced and sold within California
California potential gross state product	Estimated by authors for 2025-2030 based on formula used by other state health care cost commissions	An estimate of the value of the output that the California economy would have produced if labor and capital had been employed at their maximum sustainable rates (often used in monetary policy)

Indicators of projected health care costs or spending are not included as potential indicators in this brief because using those indicators would be circular. The purpose of the spending target is to change the spending trajectory. Instead of directly using health care cost or spending trends in setting the target, health care cost factors driving spending growth can be considered in evaluating achievement of the spending target. For example, the Massachusetts Health Policy Commission considered the impact of the introduction of the Hepatitis C drug Sovaldi and other high-cost Hepatitis C drugs when evaluating health care entities' performance compared to the benchmark in 2014.¹⁵

Evaluation of criteria

Each economic indicator is evaluated based on the criteria outlined earlier in this brief.

Criteria 1: Meaningfully slowing health care spending growth

Evaluation based on historical data

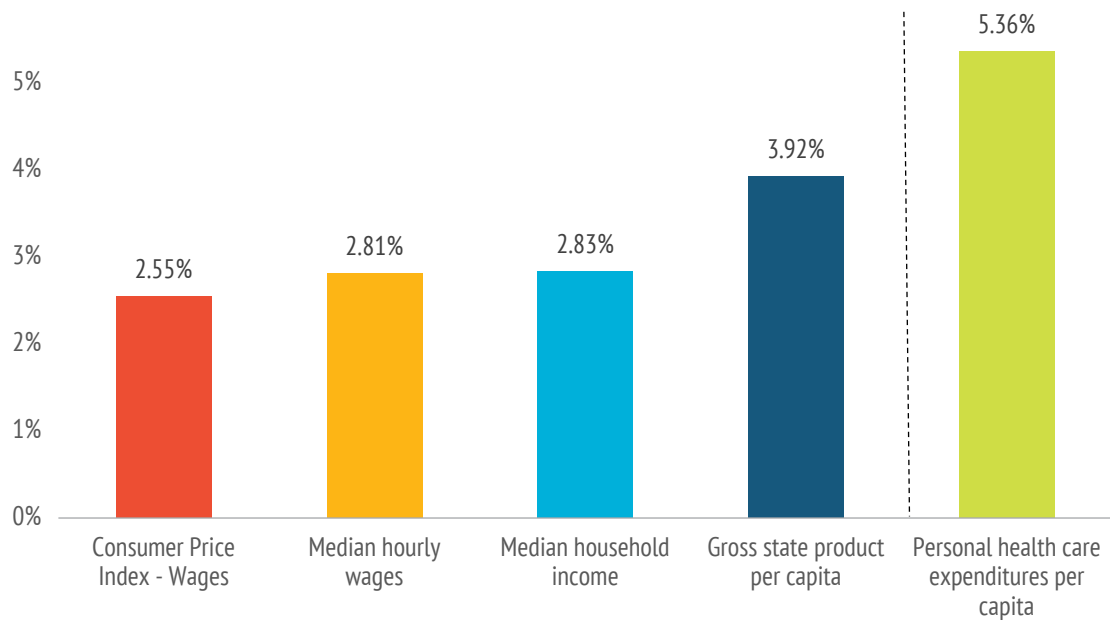
Examining California-specific data over the last two decades shows that median wages, median household income, CPI, and GSP per capita have all grown at a slower average annual rate than personal health care expenditures per capita. As a result, use of any of these economic indicators in setting the target is likely to achieve reduced spending on total health care expenditures if the target is met. However, median wages, median household income, and Consumer Price Index have grown at slower rates than GSP per capita and would result in a greater reduction in spending if the target is met.

In **Exhibit 3**, the growth in these economic indicators is reviewed against growth in personal health care expenditures per capita as a proxy for data on total health care expenditures per capita, which cannot be reported because it has not yet been collected. The biggest difference between personal health care expenditures as defined by the Center for Medicare and Medicaid Services¹⁶ and total health care expenditures as defined in California law is that personal health care expenditures do not include the cost of administering health coverage.

PGSP is not included in **Exhibit 3** because no source for historical estimates for California PGSP were found. Some health care cost commissions in other states use a formula to estimate PGSP on a forward-looking basis; we used that formula to estimate PGSP in California in 2025 through 2030, as discussed later in this section. However, it seems inappropriate to apply a forward-looking formula that is comprised of projected rates to historical data.

Exhibit 4 shows that between 2002 and 2021, personal health care expenditures per capita grew cumulatively by 163%, while GSP per capita grew by 110%, and CPI, median wages, and household income grew by between 61% and 72% depending on the indicator. Had spending growth been successfully limited to the growth rate of any of the economic indicators shown in the exhibit, the state and its residents would have achieved savings compared to spending growing at the rate of personal health care expenditures per capita. However, the hypothetical savings would have been more significant had spending growth been limited to growth in median wages, median household income, or CPI, compared to growth in GSP per capita.

Exhibit 3: Average annual historical growth rate of select economic indicators, California, 2002-2021

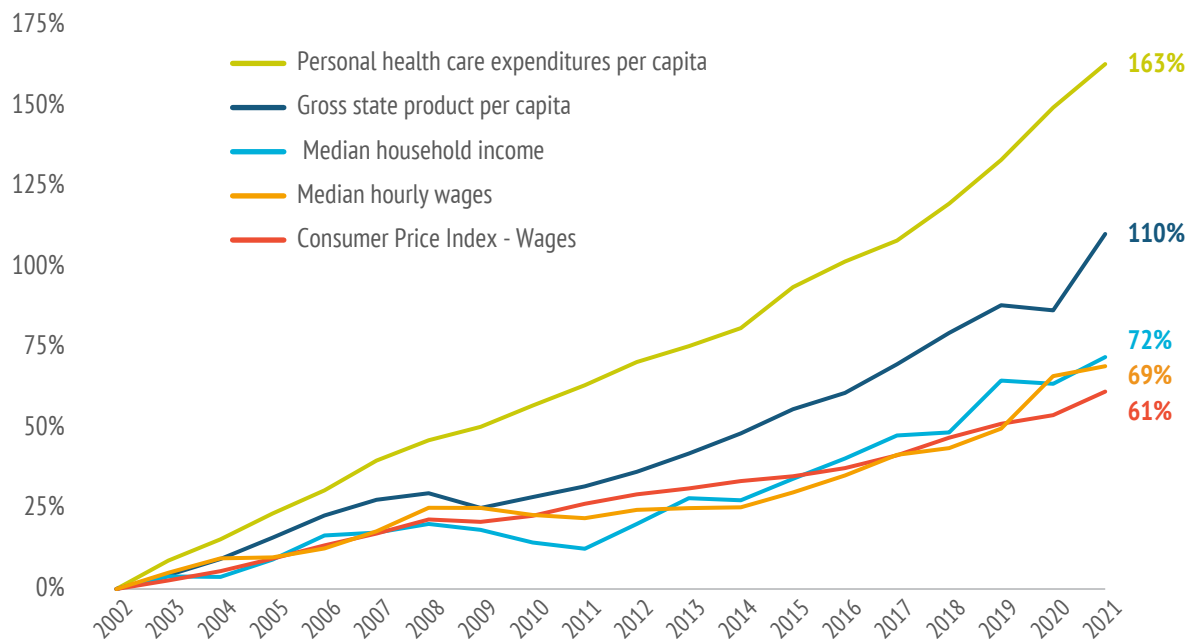


Min	-0.62%	-1.73%	-3.30%	-3.49%	2.85%
Max	4.75%	10.88%	10.80%	12.72%	8.82%

Notes: Personal health care expenditures per capita is included for comparison purposes as the closest available proxy for total health care expenditures per capita. An estimate of personal health care expenditures per capita was not available for California for 2021; U.S. data was used for that year.

Sources: UC Berkeley Labor Center analysis of data from Center for Medicare and Medicaid Services, U.S. Bureau of Economic Analysis, Economic Policy Institute analysis of U.S. Census Bureau Current Population Survey, Federal Reserve Bank of St. Louis analysis of U.S. Census Bureau Current Population Survey, California Department of Finance.

Exhibit 4: Cumulative historical growth rate of select economic indicators, California, 2002-2021



Notes: Personal health care expenditures per capita is included for comparison purposes as the closest available proxy for total health care expenditures per capita. An estimate of personal health care expenditures per capita was not available for California for 2021; U.S. data was used for that year.

Sources: UC Berkeley Labor Center analysis of data from Center for Medicare and Medicaid Services, U.S. Bureau of Economic Analysis, Economic Policy Institute analysis of U.S. Census Bureau Current Population Survey, Federal Reserve Bank of St. Louis analysis of U.S. Census Bureau Current Population Survey, California Department of Finance.

Evaluation based on projections

Comprehensively comparing these economic indicators based on projected rates of growth is not possible because projections for California median wages, median household income, and GSP per capita were not found. If the OHCA board were to decide to use projected median wage growth or projected median household income growth in setting the target, it is reasonable to expect that a state agency or a contractor could readily produce those estimates. The California Department of Finance already projects aggregate personal income in the state and average wages in the state for 2023 through 2026,¹⁷ but those estimates are not directly applicable here since the indicators should be based on medians not averages, as discussed earlier. In at least one state, Connecticut, forecasted median wage estimates were purchased from an outside vendor.¹⁸

Projections are currently available for two economic indicators:

- The California Department of Finance projects CPI-W growth at 2.9% in 2025 and 3.0% in 2026.¹⁹
- Published projections of California PGSP were not found, but we have estimated an average PGSP growth rate of 4.17% for 2025-2030²⁰ using the same formula as that used by health care cost commissions in several other states.²¹ It is important to note that health care cost commissions

in other states have generally developed long-term estimates of PGSP. For example, in Massachusetts PGSP was defined as 3.6% in statute for the first 10 years of the benchmark²² and in Connecticut the same value for long-term PGSP growth will be used for 2026 through 2030.²³

If projections are used, the board could consider periodically re-basing the target if there are sustained discrepancies between projected and actual growth.

Criteria 2: Relevance to consumer affordability or state/local government affordability

The California law establishing OHCA expresses the intent to improve affordability for consumers²⁴ and to address the impact that rising health care costs have on the state as a purchaser and in terms of tax impacts related to the tax deductibility of certain types of health coverage.²⁵

As the OHCA board sets a spending target, one overarching question will be how they intend to weigh the interests of each type of sponsor – employers, households, federal, state, and local governments – in determining the target-setting methodology. “Sponsor” is a term used by the Center for Medicare and Medicaid Services to categorize the sources of financing for health care expenditures, and has a different meaning than the term “payer.” For example, private health insurance plans are payers that pay claims on behalf of covered individuals, but employers, households, and governments are the sponsors of that private health insurance.²⁶

Should the interests of certain sponsors be prioritized, such as emphasizing affordability for consumers, or should the spending of consumers, employers, state, and local governments (all types of spending coming from within the state) be considered proportionally? Some board members have expressed an interest in centering consumer affordability, but the board has not yet discussed in-depth what that means in the context of setting the statewide spending target.

Growth in median wages or median household income has the most relevance to consumers’ ability to afford health care increases; an increase in resources is necessary for consumers with job-based coverage to be able to afford increases in premium contributions and out-of-pocket expenses for all types of insurance. A few conceptual considerations distinguish these indicators from each other:

- Median wage is a simpler indicator. It solely reflects changes in hourly wage levels, while household income reflects hours worked per week, weeks worked per year, number of household members working, and non-earned income.
- Household income would reflect changes in income for retired Californians or others who are not in the labor market, while median wages would not.
- Household income would likely better reflect changes in consumer affordability during times of recession. For example, in 2020 and during other recessions, median wages increased as lower-wage workers were more likely to lose their jobs, even as median household income decreased.²⁷ This consideration is most relevant if the target is set using historical data.

In spite of the conceptual differences between median wage and median household income, the two indicators have had a similar average growth rate over the last two decades, with the long-term average varying by only 0.02 percentage points (**Exhibit 3**). Either indicator would reflect consumers' ability to afford health care.

Growth in GSP per capita or PGSP has the most relevance for affordability for state and local government because it reflects growth in the total economy. Tax revenues collected by state and local governments are broad-based as they are collected from all state taxpayers including households and corporations.

Growth in CPI is not directly relevant to the ability of households or governments to afford health care spending increases because when CPI is high consumers often need to spend more on other essential items and government may spend more on other programs, making it harder to pay for health care.

California health care expenditures by sponsor

As shown in **Exhibit 5**, employer and household spending was projected to be the largest source of health care spending in the state in 2022 (\$222 billion, or 43% of total spending), according to an analysis conducted by the consulting team for the Healthy California for All Commission.²⁸ Employer and household spending included:

- premium contributions paid by private and public employers (\$113 billion);
- household out-of-pocket spending (\$51 billion);
- household premiums on job-based coverage (\$30 billion);
- workers' comp (\$7 billion); and
- all other household spending including premiums paid for other types of private insurance such as individual market insurance and Medigap plans (\$21 billion).

Employer spending was included in combination with household spending because the largest component of employer expenditures -- employer contributions to insurance premiums -- is part of workers' total compensation. Spending by both private and public employers was included in this category because government spending on employee health benefits is similar to private employer spending since in both cases any reduction or slowing of health spending can be redirected to another aspect of total compensation.

The next largest source of health care spending was federal spending (39% of total) on Medicare, Medi-Cal, In-Home Supportive Services, and Affordable Care Act Advance Premium Tax Credits. Medicare expenditures were the largest component here. Federal spending on Veterans Administration, Military Health System, and Indian Health Services was excluded from the Healthy California for All Commission analysis, but the spending on those federal programs was equivalent to approximately 2.8% of total California health expenditures from all sponsors.

State and local expenditures include Medi-Cal and In-Home Supportive Services expenditures. The “other” spending category includes public health expenditures, research spending, and a variety of other small programs.

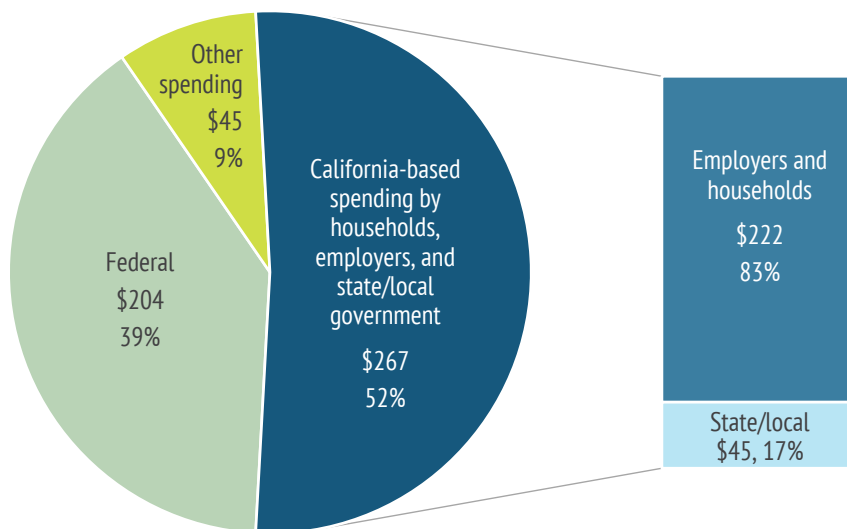
If the analysis conducted for the Healthy California for All Commission were revised using OHCA’s definition of total health care expenditures, the results would likely be similar.

Spending by employers, households, and state and local governments is most relevant to OHCA as it generally comes from within the state, with some exceptions such as spending on job-based coverage for California workers by employers based out-of-state. While a portion of federal spending ultimately comes from California taxpayers, the savings that would accrue to the federal government from California reducing the growth in total health care expenditures would not necessarily flow back to California taxpayers in the form of reduced tax contributions. OHCA also lacks direct control over Medicare expenditures, the largest component of federal spending. The \$45 billion for public health, investment, and other programs is spending that is generally not included in the definition of total health care expenditures spelled out in state law, though some board members have expressed an interest in OHCA collecting and reporting on data related to public health expenditures.

More than 80% of projected within-state health care spending in 2022 was by households and employers, and the remainder was by state and local governments (**Exhibit 5**).

Exhibit 5: Estimated California health care expenditures (\$ billions), 2022

Total = \$517 billion

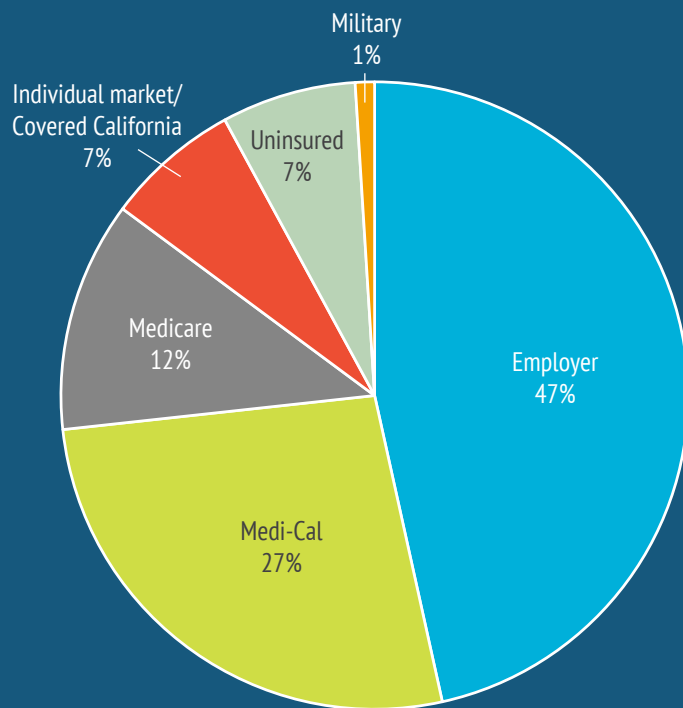


Source: Healthy California for All Commission, Analytic Findings, March 17, 2022, accessed <https://www.chhs.ca.gov/healthycforall/#analytic-findings>

Context on job-based coverage

Job-based coverage is the most common source of coverage for Californians (Exhibit 6). When seeking to improve consumer affordability, a couple of factors are important to keep in mind.

Exhibit 6: Health Insurance Coverage of Californians (All Ages), 2021



Note: Californians reporting Medi-Cal and Medicare are included in Medi-Cal.

Source: Kaiser Family Foundation analysis of American Community Survey data, State Health Facts, Health Insurance Coverage of the Total Population, 2021.

Growth in premiums and out-of-pocket costs can have a range of negative consequences for households with job-based coverage. Growth in health care costs can lead to higher worker premium contributions and higher out-of-pocket costs which threaten financial security and access to care.²⁹ Affordable access to care is increasingly a problem for Californians with job-based coverage due in part to

the growing prevalence and size of deductibles. The percentage of Californians with job-based coverage who had a deductible grew from 61% in 2012 to 77% in 2022, and the average individual deductible amount grew from \$1,151 in 2012 to \$1,808 in 2022, according to the Medical Expenditure Panel Survey Insurance Component.³⁰ Health care spending growth can also result in lower wages, as there is a tradeoff between employer premium contributions and wages.³¹ Many employers, including small employers that offer health benefits, share an interest in slowing health care cost growth so that more compensation can be directed towards wages, which will support recruitment and retention.

The financing of job-based coverage is regressive, meaning that low-income households pay a significantly higher share of income on premiums and out-of-pocket costs than higher-income households. For example, for a family of four with income of \$50,000, the total premium paid by the worker and the employer, along with the worker's out-of-pocket costs, is equivalent to 48% of income. For a household with \$150,000 in annual income, typical total health care costs are equivalent to 16% of income.³² Employer premium contributions are included in this example because they are an important part of workers' total compensation. While adults in higher-income households are more likely to have employment-based coverage, the regressive financing affects many low- and middle-income Californians given that nearly half (48%) of all Californians with job-based coverage are in households with income of \$100,000 or less.³³ While OHCA does not have the authority to change the underlying structure of job-based coverage financing, this problem with the current financing is important context to keep in mind as the target-setting methodology is determined.

Criteria 3: Limited volatility

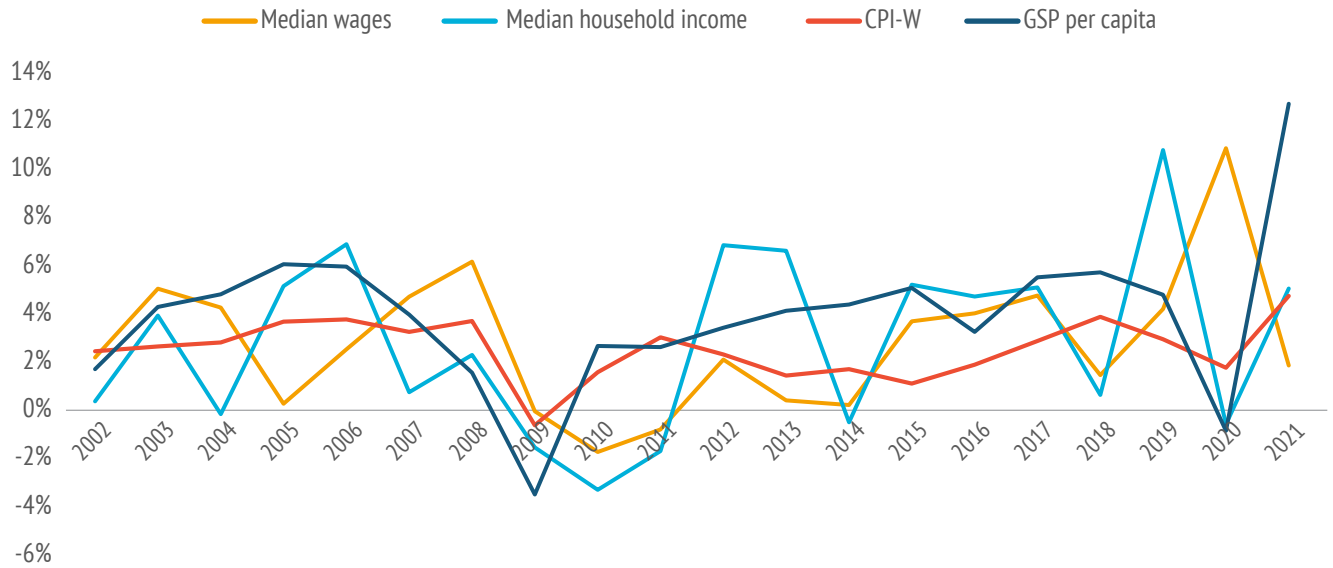
The economic indicators examined in this brief have historically had significant year-to-year variation, as shown in **Exhibit 7**. Minimizing volatility will promote predictability in the target, which will be important for health care entities subject to the target and for purchasers and consumers of health care.

If historical data were used as the basis for target-setting, a three-year rolling average would be recommended to attempt to smooth out volatility, as shown in **Exhibit 8**. However, significant volatility remains even with this smoothing—the gap between the lowest annual growth rates and the highest annual growth rates in 2002 to 2021 range from approximately 2.2 percentage points (CPI-W) to 7.7 percentage points (median household income).

The volatility that remains even when using a rolling three-year average highlights the potential need to use long-term projections or to average historical data over decades. An example of the application of long-term projections comes from Connecticut, which uses a blend of forecasted median household income growth for 2026-2030 (weighted 80%) and forecasted long-term 2026-2030 per capita PGSP (weighted 20%) in setting their health care spending target.³⁴ Only two state health care cost commissions use historical data in setting their targets. Oregon considers historical GSP and historical median wage in a non-formulaic way, examining the average over the last 20 years.³⁵ Washington considers historical median wage (weighted at 70%), calculated as an average from 2000-2019.³⁶

PGSP is not shown in **Exhibits 7** and **8** because historical estimates are not available. Potential gross domestic product (PGDP, or the national version of PGSP) is not necessarily an inherently stable indicator; Congressional Budget Office estimates of PGDP show significant volatility in recent and upcoming years, with the annual rate of change moving from 3.2% in 2020 up to 8.9% in 2022, then gradually down to 3.9% in 2025, where it levels off at 3.9% through 2030. This volatility primarily reflects fluctuation in the actual/projected inflation rate.³⁷ Some state health care cost commissions have estimated a single PGSP value over the long term, which supports stability in the targets.

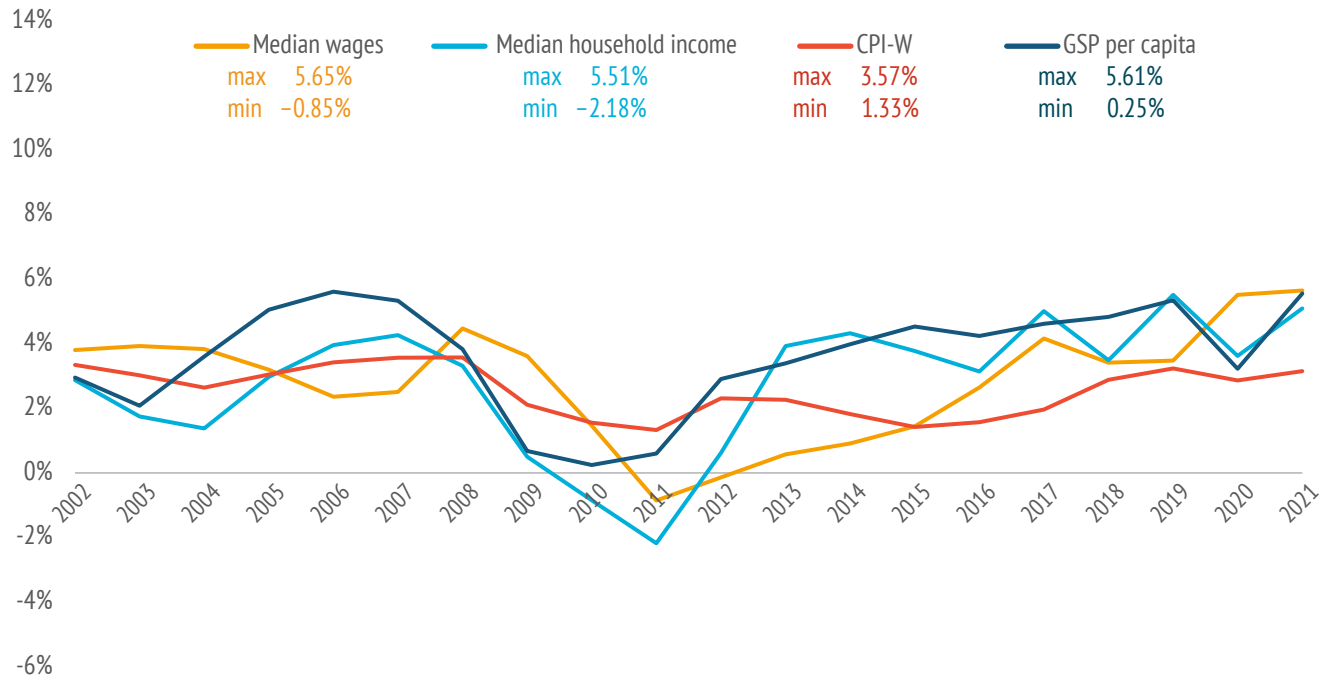
Exhibit 7: Annual growth rate, select economic indicators, California, 2002-2021



	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18	'19	'20	'21
Wages	2.2	5.0	4.3	0.3	2.5	4.7	6.2	0.0	(1.7)	-0.8	2.1	0.4	0.2	3.7	4.0	4.8	1.5	4.2	10.9	1.9
Income	0.4	3.9	(0.2)	5.2	6.9	0.8	2.3	(1.5)	(3.3)	(1.7)	6.9	6.6	(0.5)	5.2	4.7	5.1	0.6	10.8	(0.6)	5.1
CPI	2.5	2.6	2.8	3.7	3.8	3.3	3.7	(0.6)	1.6	3.0	2.3	1.4	1.7	1.1	1.9	2.9	3.9	2.9	1.8	4.7
GSP	1.7	4.3	4.8	6.1	6.0	4.0	1.6	(3.5)	2.7	2.6	3.4	4.1	4.4	5.1	3.3	5.5	5.7	4.8	(0.8)	12.7

Sources: UC Berkeley Labor Center analysis of data from U.S. Bureau of Economic Analysis, Economic Policy Institute analysis of U.S. Census Bureau Current Population Survey, California Department of Finance.

Exhibit 8: Annual growth rate smoothed using three-year rolling average, select economic indicators, California, 2002-2021



Note: The minimum and maximum smoothed annual growth rate is shown for each economic indicator.

Sources: UC Berkeley Labor Center analysis of data from U.S. Bureau of Economic Analysis, Economic Policy Institute analysis of U.S. Census Bureau Current Population Survey, California Department of Finance.

Criteria 4: Data availability

Data showing historical California growth rates for each economic indicator is readily available with a limited time lag for all indicators except PGSP. California-specific projections were only found for CPI-W, but projections should be possible to develop for median hourly wages and median household income. PGSP could be estimated based on the formula used by other state health care cost commissions.

Growth rates for median wages, median household income, and GSP per capita could be compiled by Covered California region if the board wished to do so for the purpose of regional targets; this will be discussed in the future. CPI-W historical data is available only for certain Metropolitan Statistical Areas (Los Angeles, Riverside, San Diego, and San Francisco). PGSP estimates by region are not currently available and it is unknown what formula would be used to estimate PGSP by region and whether those estimates would be reliable.

Conclusion and Recommendations

The board's selection of an economic indicator or combination of indicators will in part depend on how they decide to prioritize the needs of the different sponsors of spending.

If the board seeks to prioritize consumers' ability to afford health care spending growth, they could consider using median wage growth or median household income growth in setting the spending target. Both economic indicators would slow health care spending in a meaningful way if the target is achieved and would be fitting proxies for changes in consumers' ability to afford health care spending growth. Historical median wage growth and median household income growth data is readily available and projected growth rates seem possible to develop. Both indicators could be analyzed by Covered California region if OHCA sets regional targets in the future.

If the board seeks to proportionally reflect the ability of consumers and their employers next to state and local governments to afford health care spending growth, they could consider setting the spending target based on a blend of median wage or household income growth, weighted 80%, and GSP per capita or PGSP growth, weighted 20%. This weighting would reflect the approximate proportion of California-based health care expenditures paid by households/employers and state/local governments respectively. This weighting would be similar to those used by health care cost commissions in other states, including Connecticut, Nevada, New Jersey, Rhode Island, and Washington. These states are all currently using or moving towards using median wages or median household income at a weight of 70-80% with the remainder based on PGSP (**Appendix A**).

Deciding to prioritize consumer affordability would not mean that state and local governments' interest in slowing health care spending growth is ignored. State and local governments' budgets would benefit from the lower spending target that would be set if median wage or median household income growth was the sole economic indicator used in setting the target.

Using either of these recommended approaches to set the statewide target would result in meaningful slowing of health care spending growth if the target is achieved.

Appendix A: Economic indicators considered in other state health care cost commissions' target setting

States with health care cost commissions have tied targets to one economic indicator or a combination of indicators, including median household income (projected), median wages (historical and/or projected), gross state product, and potential gross state product. Spending target values in other states ranged from 2.8 to 3.8% for 2018-2022, roughly 2 percentage points less than average annual state health care spending growth over the prior decade.³⁸

Appendix Exhibit A: Economic indicators considered in other state cost commissions' target setting

State	Methodology	Add-on or subtraction factors
Connecticut	Blend of projected median household income (weighted 80%) and PGSP (weighted 20%)	+0.5% in 2021, +0.3% in 2022, 0.0% in 2023-2025
Delaware	PGSP	+0.25% for 2021, +0.0% for 2022-2023
Massachusetts	PGSP	-0.5% in 2018-2022
Nevada	Blend of forecasted median wage and PGSP (weighted 20% median wage/80% PGSP in 2022, shifting gradually to 80%/20% by 2026)	N/A
New Jersey	Blend of median projected household income (weighted 75%) and PGSP (weighted 25%)	+0.3% for 2023, +0.0% for 2024, -0.2% for 2025, -0.4% for 2026-2027
Oregon	Non-formulaic consideration of: historical GSP, historical median wage, CMS waiver, and legislative growth caps applied to the state's Medicaid and publicly purchased programs	N/A
Rhode Island	Blend of PGSP (weighted 75%) and projected median household income (weighted 25%) in 2023-2027	N/A
Washington	Blend of historical median wage (weighted 70%) and PGSP (weighted 30%) with a downward adjustment starting in 2024	N/A

Sources: Michael Bailit, [Presentation to OHCA Board](#), March 21, 2023. Connecticut Healthcare Benchmark Initiative, [Implementation Manual](#) Version 2.2, November 18, 2022. Rhode Island Health Care Cost Trends Steering Committee, [Compact](#) to Reduce the Growth in Health Care Costs while Improving Health Care Access, Equity, Patient Experience, and Quality in Rhode Island, 2022.

Endnotes

- 1 State of California Health and Safety Code Division 107, Part 2, Chapter 2.6, Section 127502.
- 2 “Total health care expenditures” means all health care spending in the state by public and private sources, including all of the following: (1) All claims-based payments and encounters for covered health care benefits. (2) All non-claims-based payments for covered health care benefits, such as capitation, salary, global budget, other alternative payment methods, or supplemental provider payments pursuant to the Medi-Cal program. (3) All cost sharing for covered health care benefits paid by residents of this state, including, but not limited to, copayments, coinsurance, and deductibles. (4) Administrative costs and profits. (5) Pharmacy rebates and any inpatient or outpatient prescription drug costs not otherwise included in this subdivision. State of California Health and Safety Code Division 107, Part 2, Chapter 2.6, Section 127500.2.
- 3 State of California Health and Safety Code Division 107, Part 2, Chapter 2.6, Section 127502.
- 4 Michael Bailit, Presentation to Health Care Affordability Advisory Committee, June 21, 2023, accessed September 4, 2023, <https://hcai.ca.gov/document/health-care-affordability-advisory-committee-presentation/>.
- 5 “The 2023 CHCF California Health Policy Survey,” California Health Care Foundation, accessed August 25, 2023, <https://www.chcf.org/publication/2023-chcf-california-health-policy-survey/>.
- 6 The average total premium for a family job-based coverage plan in California was \$22,818 in 2022. Median annual spending on out-of-pocket costs for households with job-based coverage was \$500 in 2016–2017. The projected total spending in 2025 would be nearly \$27,000 using national CMS projections for private health insurance and out-of-pocket expenditures. “California Employer Health Benefits: Cost Burden on Workers Varies — 2023 Edition,” California Health Care Foundation (blog), accessed September 4, 2023, <https://www.chcf.org/publication/2023-edition-california-employer-health-benefits/>. “How Much U.S. Households with Employer Insurance Spend on Premiums and Out-of-Pocket Costs: A State-by-State Look,” May 23, 2019, <https://doi.org/10.26099/s50f-rs05>. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2015–2031.
- 7 Laurel Lucia and Ken Jacobs, “Increases in Health Care Costs Are Coming out of Workers’ Pockets One Way or Another: The Tradeoff between Employer Premium Contributions and Wages,” UC Berkeley Labor Center (blog), accessed August 25, 2023, <https://laborcenter.berkeley.edu/employer-premium-contributions-and-wages/>.
- 8 California Department of Health Care Services, May 2023 Medi-Cal Estimate, accessed September 4, 2023, <https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/default.aspx>. State of California, 2023–24 State budget, accessed September 4, 2023, <https://ebudget.ca.gov/budget/2023-24EN/#/BudgetSummary>.
- 9 State of California, 2023–24 State budget, accessed September 4, 2023, <https://ebudget.ca.gov/budget/2023-24EN/#/BudgetSummary>.

10 An alternate indicator, Consumer Price Index – Urban, was also considered but not included in this brief. CPI-U also reflects prices paid for a market basket of consumer goods and services but in this case prices paid by “almost all residents of urban or metropolitan areas, including professionals, the self-employed, the poor, the unemployed, and retired people, as well as urban wage earners and clerical workers.” CPI-W is a better measure of affordability for families than CPI-U and is what the Labor Center typically uses when inflating wages or estimating future wage growth. CPI-U and CPI-W are often relatively similar in value—CPI-W and CPI-U varied by no more than 0.3 percentage points in most but not all years between 2002 and 2021.

11 State of California Health and Safety Code Division 107, Part 2, Chapter 2.6, Section 127502.

12 For example, California workers with wages at the 95th percentile saw 55% growth in real wages between 2014 and 2021, compared to 12% growth for workers with median wages. Even for workers with wages at the 90th percentile, real wage growth was more similar to the median— 16% between 2014 and 2021. “Low-Wage Work in California Data Explorer,” UC Berkeley Labor Center (blog), accessed September 4, 2023, <https://laborcenter.berkeley.edu/low-wage-work-in-california-data-explorer/>.

13 California median wage estimates in this brief reflect Current Population Survey data analyzed using the hourly wage variable derived by the Economic Policy Institute. <https://www.epi.org/data/methodology/>

14 California median wage estimates in this brief reflect Current Population Survey data analyzed by the Federal Reserve Bank of St. Louis. <https://fred.stlouisfed.org/series/MEHOINUSCAA646N>

15 Commonwealth of Massachusetts Health Policy Commission, 2015 Cost Trends Report, accessed September 4, 2023, <https://www.mass.gov/doc/2015-cost-trends-report-1/download>.

16 “Personal Health Care expenditures (PHC) represent all revenue received by health care providers and retail establishments for medical goods and services as well as all non-patient and non-operating revenue, grants, subsidies, and philanthropy received by health care providers.” Center for Medicare and Medicaid Services, National Health Expenditure Accounts: Methodology Paper, 2021, Definition, Sources, and Methods, accessed September 4, 2023, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical>.

17 California Department of Finance, Economic Forecasts, U.S. and California, accessed September 4, 2023, <https://dof.ca.gov/wp-content/uploads/sites/352/Forecasting/Economics/Documents/California-Economic-Forecast-MR-2023-24.xlsx>.

18 Connecticut Healthcare Benchmark Initiative, Implementation Manual Version 2.2, November 18, 2022, accessed September 4, 2023, <https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/Guidance-for-Payer-and-Provider-Groups/Posted-11-21-22/CT-OHS-Implementation-Manual-v22-2022-11-18.pdf>.

19 California Department of Finance, Economic Forecasts, U.S. and California, accessed September 4, 2023, <https://dof.ca.gov/wp-content/uploads/sites/352/Forecasting/Economics/Documents/California-Economic-Forecast-MR-2023-24.xlsx>.

20 California PGSP was estimated for 2025-30 using the formula described in the next endnote. Projections in the growth of the California labor force were only available through 2026 so an average of the projected growth rate in 2025-26 was used for 2027-2030. National projections are from the Congressional Budget Office and California projections are from the California Department of Finance. Congressional Budget Office, February 2023 Baseline Economic Forecast, accessed September 4, 2023, <https://www.cbo.gov/system/files/2023-02/51135-2023-02-Economic-Projections.xlsx>. California Department of Finance, Economic Forecasts, U.S. and California, accessed September 4, 2023, <https://dof.ca.gov/wp-content/uploads/sites/352/Forecasting/Economics/Documents/California-Economic-Forecast-MR-2023-24.xlsx>. California Department of Finance, State Population Projections, accessed September 4, 2023, <https://dof.ca.gov/forecasting/demographics/projections/>.

21 The formula used by Connecticut, Delaware, and Massachusetts is PGSP per capita = (expected growth in national labor force productivity + expected growth in the state's labor force + expected national inflation) – expected state population growth. Connecticut Healthcare Benchmark Initiative, Implementation Manual Version 2.2, November 18, 2022, accessed September 4, 2023, <https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/Guidance-for-Payer-and-Provider-Groups/Posted-11-21-22/CT-OHS-Implementation-Manual-v22-2022-11-18.pdf>.

22 Massachusetts Health Policy Commission, "Health Care Cost Growth Benchmark | Mass.Gov," accessed September 4, 2023, <https://www.mass.gov/info-details/health-care-cost-growth-benchmark>.

23 Connecticut Healthcare Benchmark Initiative, Implementation Manual Version 2.2, November 18, 2022, accessed September 4, 2023, <https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/Guidance-for-Payer-and-Provider-Groups/Posted-11-21-22/CT-OHS-Implementation-Manual-v22-2022-11-18.pdf>.

24 For example: "It is the intent of the Legislature, therefore, to establish a single entity within state government charged with doing all of the following: (1) Developing a comprehensive strategy for cost containment in California, including measuring progress towards reducing the rate of growth in per capita total health care spending and ultimately lowering consumer spending on premiums and out-of-pocket costs, while maintaining quality, access, and equity of care, as well as promoting workforce stability and maintaining high-quality health care jobs." State of California Health and Safety Code Division 107, Part 2, Chapter 2.6, Section 127500.5.

25 For example: "The State of California has a substantial public interest in the price and cost of health care coverage. California is a major purchaser through the Public Employees' Retirement System, the State Department of Health Care Services, the Department of General Services, the Department of Corrections and Rehabilitation, and other entities acting on behalf of a state purchaser. The government also provides major tax expenditures through the tax exclusion of employer-sponsored coverage and tax deductibility of coverage purchased by individuals, as well as tax deductibility of excess health care costs for individuals and families." State of California Health and Safety Code Division 107, Part 2, Chapter 2.6, Section 127500.5.

26 Center for Medicare and Medicaid Services, National Health Expenditure Accounts: Methodology Paper, 2021, Definition, Sources, and Methods, accessed September 4, 2023, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical>.

- 27 This example is illustrated in Exhibit 7.
- 28 Note: The authors were part of the consulting team to the Healthy California for all Commission. Healthy California for All Commission, Analytic Findings and Methods and Assumptions, accessed September 4, 2023, <https://www.chhs.ca.gov/healthycaforall/>.
- 29 The Labor Center’s blog series outlines these problems in more detail. “Rising Health Care Costs in California: A Worker Issue,” UC Berkeley Labor Center (blog), accessed September 5, 2023, <https://laborcenter.berkeley.edu/rising-health-care-costs-in-california-a-worker-issue/>.
- 30 “MEPS-IC Data Tools – Medical Expenditure Panel Survey (MEPS) Insurance Component (IC),” accessed September 5, 2023, <https://datatools.ahrq.gov/meps-ic/>.
- 31 Laurel Lucia and Ken Jacobs, “Increases in Health Care Costs Are Coming out of Workers’ Pockets One Way or Another: The Tradeoff between Employer Premium Contributions and Wages,” UC Berkeley Labor Center (blog), accessed August 25, 2023, <https://laborcenter.berkeley.edu/employer-premium-contributions-and-wages/>.
- 32 Analysis is based on premium contributions in 2022 from California Health Care Foundation and median out-of-pocket spending for California households with job-based coverage in 2016-2017 from Commonwealth Fund, inflated based on CMS estimates/projections for premiums and out-of-pocket spending. “California Employer Health Benefits: Cost Burden on Workers Varies — 2023 Edition,” California Health Care Foundation (blog), accessed September 4, 2023, <https://www.chcf.org/publication/2023-edition-california-employer-health-benefits/>. Commonwealth Fund, “How Much U.S. Households with Employer Insurance Spend on Premiums and Out-of-Pocket Costs: A State-by-State Look,” May 23, 2019, <https://doi.org/10.26099/s50f-rs05>. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2015-2031.
- 33 Authors’ analysis of data from California Health Interview Survey 2020-2021.
- 34 Connecticut Healthcare Benchmark Initiative, Implementation Manual Version 2.2, November 18, 2022, accessed September 5, 2023, <https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/Guidance-for-Payer-and-Provider-Groups/Posted-11-21-22/CT-OHS-Implementation-Manual-v22-2022-11-18.pdf>.
- 35 Oregon Health Authority, Sustainable Health Care Cost Growth Target Implementation Committee Recommendations, Final Report to the Oregon Legislature, Senate Bill 889 (2019), January 2021, accessed June 6, 2023, <https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf>
- 36 Washington’s Health Care Cost Benchmark Program, Technical Manual, July 7, 2022, accessed June 6, 2023, <https://www.hca.wa.gov/assets/program/benchmark-data-call-manual-july-2022.pdf>
- 37 Congressional Budget Office, February 2023 Baseline Economic Forecast, accessed September 4, 2023, <https://www.cbo.gov/system/files/2023-02/51135-2023-02-Economic-Projections.xlsx>.
- 38 Michael Bailit, Presentation to OHCA Board, March 21, 2023, accessed September 4, 2023, <https://hcai.ca.gov/document/health-care-affordability-board-meeting-presentation-3-21-23/>.

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