California becomes latest state to try capping health care spending

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California's Office of Health Care Affordability faces a herculean task in its plan to slow runaway health care spending.

The goal of the agency, established in 2022, is to make care more affordable and accessible while improving health outcomes, especially for the most disadvantaged state residents. That will require a sustained wrestling match with a sprawling, often dysfunctional health system and powerful industry players who have lots of experience fighting one another and the state.

Can the new agency get insurers, hospitals, and medical groups to collaborate on containing costs even as they jockey for position in the state's $405 billion health care economy? Can the system be transformed so that financial rewards are tied more to providing quality care than to charging, often exorbitantly, for a seemingly limitless number of services and procedures?

The jury is out, and it could be for many years.

California is the ninth state—after Connecticut, Delaware, Massachusetts, Nevada, New Jersey, Oregon, Rhode Island, and Washington—to set annual health spending targets.

Massachusetts, which started annual spending targets in 2013, was the first state to do so. It's the only one old enough to have a substantial pre-pandemic track record, and its results are mixed: The annual health spending increases were below the target in three of the first five years and dropped beneath the national average. But more recently, health spending has greatly increased.

In 2022, growth in health care expenditures exceeded Massachusetts' target by a wide margin. The Health Policy Commission, the state agency established to oversee the spending control efforts, warned that "there are many alarming trends which, if unaddressed, will result in a health care system that is unaffordable."

Neighboring Rhode Island, despite a preexisting policy of limiting hospital price increases, exceeded its overall health care spending growth target in 2019, the year it took effect. In 2020 and 2021, spending was largely skewed by the pandemic. In 2022, the spending increase came in at half the state's target rate. Connecticut and Delaware, by contrast, both overshot their 2022 targets.

It's all a work in progress, and California's agency will, to some extent, be playing it by ear in the face of state policies and demographic realities that require more spending on health care.

And it will inevitably face pushback from the industry as it confronts unreasonably high prices, unnecessary medical treatments, overuse of high-cost care, administrative waste, and the inflationary concentration of a growing number of hospitals in a small number of hands.

"If you're telling an industry we need to slow down spending growth, you're telling them we need to slow down your revenue growth," says Michael Bailit, president of Bailit Health, a Massachusetts-based consulting group, who has consulted for various states, including California. "And maybe that's going to be heard as 'we have to restrain your margins.' These are very difficult conversations."

Some of California's most significant health care sectors have voiced disagreement with the fledgling affordability agency, even as they avoid overtly opposing its goals.

In April, when the affordability office was considering an annual per capita spending growth target of 3%, the California Hospital Association sent it a letter saying hospitals "stand ready to work with" the agency. But the proposed number was far too low, the association argued, because it failed to account for California's aging population, new investments in Medi-Cal, and other cost pressures.

The hospital group suggested a spending increase target averaging 5.3% over five years, 2025–29. That's slightly higher than the 5.2% average annual increase in per capita health spending over the five years from 2015 to 2020.

Five days after the hospital association sent its letter, the affordability board approved a slightly less aggressive target that starts at 3.5% in 2025 and drops to 3% by 2029. Carmela Coyle, the association's chief executive, said in a statement that the board's decision still failed to account for an aging population, the growing need for mental health and addiction treatment, and a labor shortage.

The California Medical Association, which represents the state's doctors, expressed similar concerns. The new phased-in target, it said, was "less unreasonable" than the original plan, but the group would "continue to advocate against an artificially low spending target that will have real-life negative impacts on patient access and quality of care."

But let's give the state some credit here. The mission on which it is embarking is very ambitious, and it's hard to argue with the motivation behind it: to interject some financial reason and provide relief for millions of Californians who forgo needed medical care or nix other important household expenses to afford it.

Sushmita Morris, a 38-year-old Pasadena resident, was shocked by a bill she received for an outpatient procedure last July at the University of Southern California's Keck Hospital, following a miscarriage. The procedure lasted all of 30 minutes, Morris says, and when she received a bill from the doctor for slightly over $700, she paid it. But then a bill from the hospital arrived, totaling nearly $9,000, and her share was over $4,600.

Morris called the Keck billing office multiple times asking for an

itemization of the charges but got nowhere. "I got a robotic answer, 'You have a high-deductible plan,'" she says. "But I should still receive a bill within reason for what was done." She has refused to pay that bill and expects to hear soon from a collection agency.

The road to more affordable health care will be long and chock-full of big challenges and unforeseen events that could alter the landscape and require considerable flexibility.

Some flexibility is built in. For one thing, the state cap on spending increases may not apply to health care institutions, industry segments, or geographic regions that can show their circumstances justify higher spending—for example, older, sicker patients or sharp increases in the cost of labor.

For those that exceed the limit without such justification, the first step will be a performance improvement plan. If that doesn't work, at some point—yet to be determined—the affordability office can levy financial penalties up to the full amount by which an organization exceeds the target. But that is unlikely to happen until at least 2030, given the time lag of data collection, followed by conversations with those who exceed the target, and potential improvement plans.

In California, officials, consumer advocates, and health care experts say engagement among all the players, informed by robust and institution-specific data on cost trends, will yield greater transparency and, ultimately, accountability.

Richard Kronick, a public health professor at the University of California-San Diego and a member of the affordability board, notes there is scant public data about cost trends at specific health care institutions. However, "we will know that in the future," he says, "and I think that knowing it and having that information in the public will put

some pressure on those organizations."