Title

Measuring Consumer Affordability is Integral to Achieving the Goals of the California Office of Health Care Affordability

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Measuring Consumer Affordability is Integral to Achieving the Goals of the California Office of Health Care Affordability

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Executive summary

Consumer health care affordability has deteriorated over the past two decades in California due to rising premiums along with increasingly common and increasingly large deductibles for job-based coverage. Taken together, these trends in premium and deductible growth result in health care taking up a larger and larger share of household income. This has consequences for Californians' health and financial well-being: a significant portion of California adults—with any type of insurance including those without insurance—reported that in the last 12 months they or a family member had delayed or postponed care due to cost (52%), had problems paying or couldn't pay any medical bills (27%), or had some type of medical debt (36%).

The California Office of Health Care Affordability (OHCA) is tasked with controlling the growth in per capita spending on health care and ensuring that consumers benefit from this reduction in the rate of growth. To these ends, we suggest OHCA monitor consumer affordability metrics related to the cost of coverage, the cost of care, and the consequences of unaffordable coverage and care for both health and financial well-being. There are two types of sources for these data: administrative data sources that can be used to annually assess consumer affordability; and survey data that can be used to investigate and monitor longer-term trends and equity impacts. OHCA has access to existing, state-specific data sources and more can be developed over time. OHCA should monitor trends and report on consumer metrics in their annual reports, starting with statewide trends in the 2025 baseline report and as part of annual reports thereafter.

Introduction

In the last two decades the cost of job-based coverage—still the main source of coverage for most Californians under age 65—along with the size and prevalence of deductibles have outpaced growth in workers' wages and household incomes, with harmful consequences for both health and financial well-being. More than half of Californians (with all types of health coverage including no coverage) say that they or a family member have skipped or delayed care due to cost in the past year. The problems are particularly acute for lower- and moderate-income families, and problems like delaying or postponing care, trouble paying for medical bills, and medical debt are significantly more prevalent for Black and Latino Californians.

California created the Office of Health Care Affordability (OHCA) in response to this affordability crisis. OHCA will establish health care spending targets with the goal of achieving a more sustainable per capita rate of spending growth on health care that is provided by hospitals, medical groups, fully integrated delivery systems (like Kaiser), and other health care entities. The office must also monitor and ensure that slower spending growth does not come at the expense of quality and equity. The founding statute also establishes a goal that consumers benefit from reductions in the rate of growth in health care spending.[1] Such an outcome is by no means guaranteed; in Massachusetts, the first state to set total health care expenditure benchmarks, success in moderating spending growth has *not* always translated into premium

and cost sharing trends below the benchmark.[2] OHCA has the obligation to monitor consumer affordability trends and determine whether and how slowing spending growth is translating to consumers.

OHCA's efforts to collect data on total health care expenditures are well underway; expenditures by all payers will be compared against the spending target, which will be set in 2024. The law also mandates that OHCA's spending target be incorporated into the state's annual health insurance rate review process, done by the Department of Managed Health Care and the Department of Insurance, which analyses the reasonableness of premium rate changes for the 14 million Californians with state-regulated job-based and individual market health insurance.[3] It will also be important for OHCA to develop and annually evaluate consumer affordability metrics to assess how California health care consumers are faring. California consumers with job-based coverage have faced increasing premiums and higher deductibles over the past two decades. Given this history, OHCA should monitor trends and report on consumer metrics in their annual reports, starting with statewide trends in the 2025 baseline report and as part of annual reports thereafter. In 2024 the OHCA Board will need to discuss and subsequently select which metrics to use to assess consumer affordability and prepare to include them in a June 2025 report.

1. Health care affordability has eroded in job-based coverage

Health care affordability challenges exist for Californians with any type of health insurance, as well as the uninsured. This brief focuses on metrics related to the affordability of health care for Californians with commercial coverage, primarily those with job-based insurance, which is still the largest source of coverage in the state. Data from employer surveys, consumer surveys, and administrative data all tell the same story of worsening affordability for Californians with job-based coverage over the past 10 to 20 years. Health care affordability has improved for the millions of Californians who have gained Medi-Cal with the progressive expansion of the program. In addition, those who over the last 10 years have received premium subsidies for individual market coverage through Covered California as a result of the Affordable Care Act (ACA) have experienced affordability improvements, though the ACA overall has had only limited impacts in mitigating the longer-term downward trend in affordability of job-based insurance.[4]

Below we explore two major trends in the last two decades in California job-based coverage: rising premiums, and increasingly common and increasingly large deductibles. Had rising premiums been coupled with more generous coverage, or had larger deductibles been a trade-off for lower premiums, the consequences could have been more mixed. Instead, these trends in higher premiums and in more and larger deductibles have resulted in a serious erosion of job-based coverage affordability.

Higher premium costs are increasingly borne by workers

For most people with job-based coverage, the largest health-related expenditure in any given year will be the cost of premiums. The total premium cost is usually split between the employer and the worker; on average in 2022 California workers paid 30% of the cost of family coverage and employers paid 70%.[5] Despite this nominal division of costs, economic theory posits that workers pay the entire cost of premiums in forgone wages, and in practice the entire cost of coverage is included when calculating workers' total compensation.[6]

As health care premiums have increased, so has the amount workers pay for their coverage. Not only has the dollar amount increased, but employers have also increased the premium share paid by workers. In 2002, California workers in the private sector paid 15% of the cost of single premiums ($446 on average) and 24% of the cost of family premiums ($4,193 on average). In 2022, private-sector workers paid both higher amounts and a higher share of the premium: an average of 19% of the cost of single coverage ($1,448) and 30% of the cost of family premiums ($6,755).[7] Single premiums at private sector firms in California grew an average of 4.9% every year from 2002 to 2022, while the worker contribution to that single premium grew at 6.8%, according to the Medical Expenditure Panel Survey Insurance Component (MEPS-IC). Family premiums grew an average of 5.1% per year over those two decades, while the worker contribution to family premiums at California private sector firms grew 6.6% every year on average according to MEPS-IC (see Figure 1).

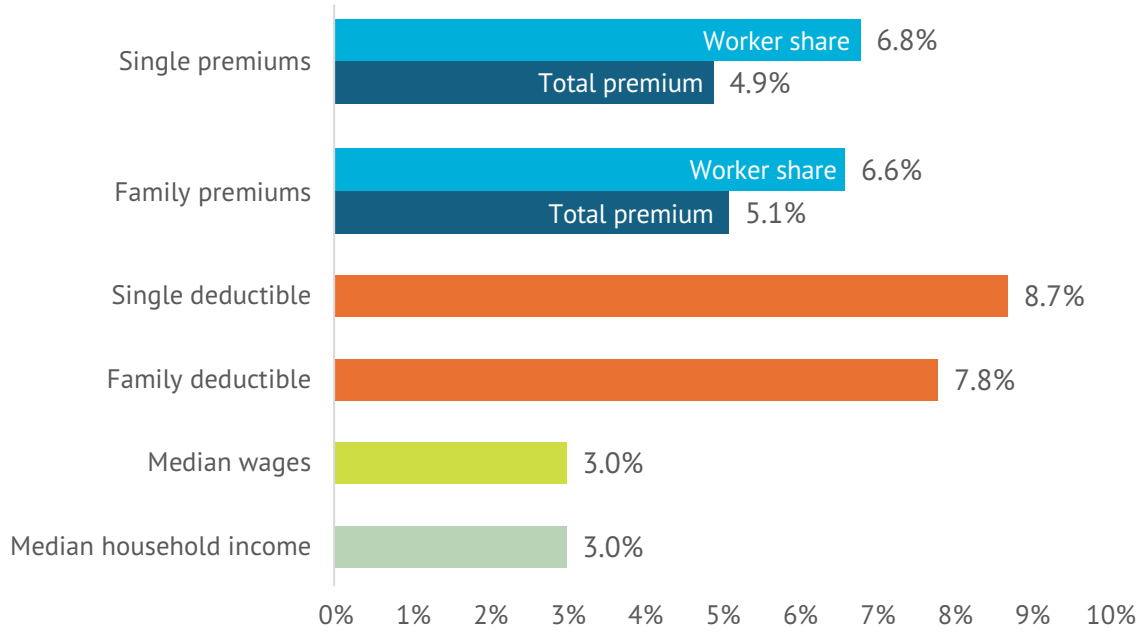
While the problem of rising health care costs is often framed in terms of health care expenditures taking up an increasing share of gross domestic product, that statistic is most relevant for government spending because it reflects growth in the total economy and the tax revenues collected by governments from both households and corporations. Consumer affordability, on the other hand, is most closely connected to median wages and median household income.[8] Growth in median wages or median household income reflects the change in consumers' resources that is necessary to afford health care cost increases. From 2002 to 2022, median wages grew by an average of 3.0% per year and median household income grew by 3.0% on average (see Figure 1).[9] Deductibles, which will be discussed more fully below, have seen even higher rate increases than premium costs for consumers.

Deductibles have become more common and larger in size

Even with insurance, many consumers face costs at the point of care. A plan's out-of-pocket costs can take many forms, from copays, to coinsurance, to meeting a deductible, to all three.

Increases in out-of-pocket costs add to the actual cost of care and can ultimately deter access to care. To promote access to preventative health care, the ACA mandated that health insurance plans cover certain preventive services without any patient cost-sharing. But patients know that even free trips to the doctor can lead to costly follow up tests, specialty care visits, and prescriptions. Further, management of chronic conditions from asthma to diabetes to hypertension is not counted as "preventive care" in the law—even though such management

Figure 1. Average annual growth rates for premiums and deductibles for private-sector workers; median wages; and median household income in California 2002-2022

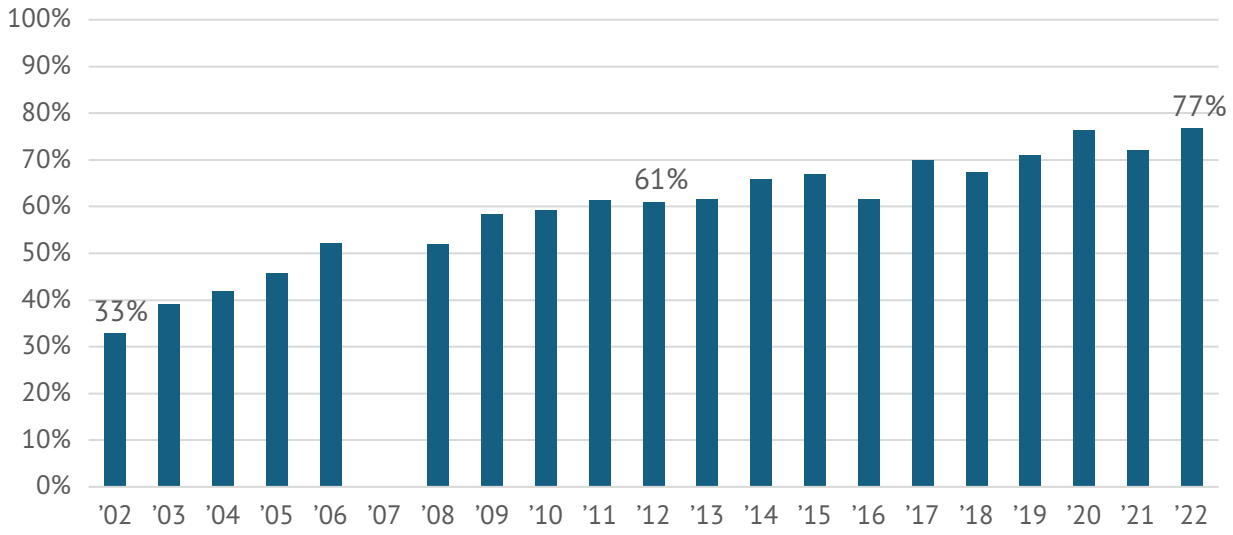


Source: MEPS-IC California 2002-2022; US Census Current Population Survey[10]

is to prevent the worst outcomes of such diseases. Increasing consumers' exposure to health care prices has not been found to have the hoped-for effect of limiting the use of low-value or unnecessary care (that is, services that have little to no benefit for patients or may even harm them); instead, it leads to reductions in all types of care, including needed and high-value care.[11] The high costs of care limit access.

Over the past two decades, deductibles have become increasingly common in California, though they remain less common here than in the rest of the country. In California, 77% of private-sector workers enrolled in coverage through their job had a deductible in 2022, up from 61% in 2012 and just 33% in 2002 (Figure 2). Deductibles are less common in HMO plans; this type of plan is more common in California than elsewhere in the country, which partly explains why the national rate of private-sector enrollees with a deductible is even higher, at 89%.[12] Deductibles are also less common for public-sector workers; the latest California Employer Health Benefits Survey looks at all workers in California, not just those in the private sector, and finds that 62% had a deductible in 2022.[13]

Figure 2. Growth in the share of private-sector workers enrolled in coverage with deductibles in California, 2002-2022



Source: MEPS-IC California, 2002-2022 (no data available for 2007).

For private-sector workers with deductibles, the size of those deductibles has grown 380% since 2002 for single plans, or an average of 8.7% growth every year; for family plans the size of deductibles has grown 332% or 7.8% annually, according to MEPS-IC. As noted previously, median wages grew by an average of 3.0% per year from 2002 to 2022 and median household income grew by 3.0% on average (Figure 1).[14] In 2022, the average deductible was $1,808 for single coverage and $3,659 for family coverage among enrollees at private-sector establishments. However, some deductibles can be even higher; of employees enrolled in family coverage with a deductible, 10% had deductibles of $6,900 or more.[15] These data on deductibles indicate that even as the cost of coverage has grown over the last twenty years, the generosity of that coverage has declined: California workers are paying more and getting less.

High-deductible health plans—which covered 17% of California workers in 2022[16]—can be coupled with Health Savings Accounts (HSAs), which allow workers and employers to contribute pre-tax to a savings account that can be used to pay the deductible or other qualified medical expenses. However, these accounts are most likely to benefit high-income workers. In practice, only half of Americans enrolled in high-deductible health plans have HSAs set up. An analysis of IRS data revealed that the prevalence of HSA contributions declined as income declined, and tax returns reporting between $200,000 and $1 million in income were the most likely to report employer contributions. These tax-sheltered accounts do little to help low- and moderate-income workers who struggle to afford premiums and do not have the means to contribute to HSAs.[17]

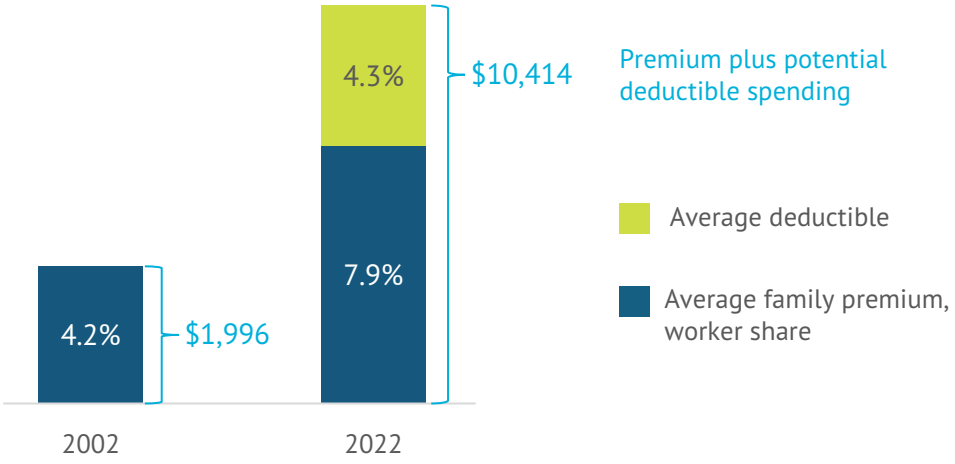
High deductibles are particularly problematic for lower- and moderate-income families, especially given the large share of families with limited liquid assets. A $3,659 average deductible may be manageable for some families, but completely out of reach—and may

render access to health care likewise out of reach—for the 42% of U.S. families with private coverage who have less than $4,000 in liquid assets[18] and for those who are already struggling to make ends meet in our high-cost state. A national survey found the median balance in transaction accounts (like checking and savings accounts) in 2022 was almost six times as great for households with a white respondent ($12,000) as for households with a Black or Latino respondent ($2,110 and $2,100 respectively).[19] These stark differences in assets by race and ethnicity undoubtedly lead to differences in the impact of increasing presence and size of deductibles, but data sources to explore the issue are currently limited.

Combined impact of higher premiums and deductibles

Taken together, these trends in premium and deductible growth mean that health care is taking up a larger and larger share of household income. In 2002, a median-income household was earning $47,400 and paying an average of $1,996 for family coverage premiums (4.2% of income), likely without a deductible. In 2022, the median household income was $85,300, but family coverage premiums averaged $6,755 (7.9% of income). Despite this higher price, a 2022 family plan was likely to have a deductible, which on average was $3,659—another 4.3% of median income if they hit the full deductible. All together, these average expenses comprised 12.2% of median household income. A California family with typical job-based coverage faced as much as $10,400 in annual health care costs if they had a serious medical need that caused them to hit their deductible. If they had to reach into their own pocket for behavioral health or other costs of a disabling illness like multiple sclerosis, they would spend even more. Not every family hits their deductible every year, but anyone with this kind of typical family plan is exposed to the real risk of paying a significant amount for medical care, despite having health insurance.

Figure 3. Typical private-sector family coverage premium and potential deductible spending as a share of median household income, 2002 and 2022



Sources: Current Population Survey; MEPS-IC California 2002, 2022.

Note: Typical plans in 2002 did not have a deductible; 33% of private-sector enrollees did have a deductible, and the average amount was $847 or 1.8% of median household income in that year. By 2022, 77% of private-sector worker enrollees had a deductible.

II. Unaffordable coverage and care have negative consequences for health, financial well-being, and equity

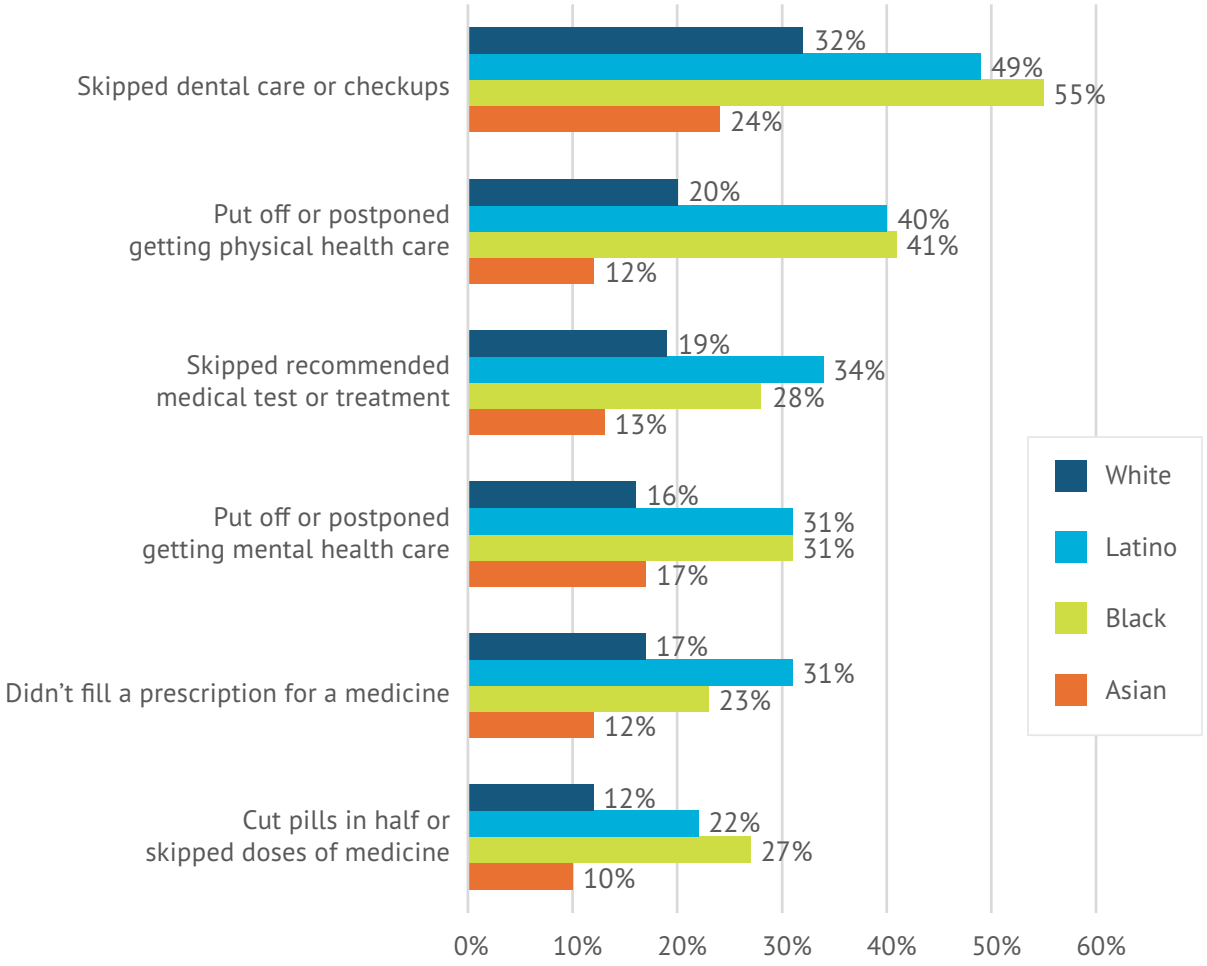
Increasing premium and out-of-pocket costs that grew faster than wages and income explains, in part, why some workers and their families who have access to employment-based coverage decline that coverage, leaving uninsured an estimated 570,000 Californians who have access to job-based coverage.[20] In addition to the implications for coverage, these cost increases have consequences for Californians' health and financial well-being. The California Health Care Foundation's Health Policy Survey has been particularly useful for measuring the effects.[21] Their findings apply to all California adults, both those with job-based insurance and individual market insurance, as well as those with Medicaid, Medicare, or other public coverage, and the uninsured.

- About half (52%) of California adults say that they or a family member skipped or postponed care due to cost. These delays have health consequences: of those who skipped care, 50% said that it made their condition worse. These data also include estimates of the percentage of California adults skipping or delaying specific types of care (dental, physical, or behavioral health, prescription drug, etc.; see Figure 4).
- More than one in four adults in California (27%) said that they or a family member had problems paying or couldn't pay medical bills in the last 12 months.
- Approximately one in three Californians (36%) have some type of medical debt: debt owed to a lender, medical bills put on a credit card, debt owed to a provider that is being paid off over time, bills that are past due or that they are unable to pay, or debt owed to a family member or friend.

Disparities by race, ethnicity, and income were evident across all three of these metrics, with higher prevalence for those with lower incomes (under 200% of the federal poverty level or $25,760 for a single person in 2022) and among Black and Latino Californians. Monitoring how these disparities in prevalence change over time will be important.

Medical debt can have pernicious effects on financial well-being and health. A KFF national survey of those with medical debt found that it often resulted in people cutting spending on food, clothing, or basic household items (63%) and depleting most or all savings (48%), as well as other serious consequences like delaying college or changing a housing situation.[22] Medical debt can decimate credit scores, which in turn can affect the ability to buy or rent a house or secure employment. There are also health consequences, as those with medical debt are more likely to report delaying or skipping care due to cost, as well as being denied care by providers due to unpaid bills.[23]

Figure 4. Share of California adults reporting that they or a family member skipped or delayed the following in the past 12 months due to cost, by race/ethnicity (2022)



Source: CHCF California Health Policy Survey, 2023

III. OHCA can measure California's consumer affordability trends with administrative and survey data

What can OHCA do to directly address the health care affordability challenges that Californians face? The founding statute recognizes the goal that consumers benefit from reductions in the rate of growth in health care spending and requires that the slower growth be reflected in the rate review process for state-regulated coverage. To maintain a focus on consumer affordability, OHCA should monitor a robust set of statewide measures of consumer affordability trends, starting with the initial annual report in 2025.

Categories and sources for consumer affordability metrics

We find it useful to consider three categories of consumer affordability metrics: the cost of coverage, the cost of care, and the consequences of unaffordable coverage and care for both health and financial well-being. To construct these metrics, we consider two types of data sources: administrative data that can be used to annually assess consumer affordability; and survey data that can be used for monitoring longer-term trends and to investigate and monitor equity impacts. OHCA has access to existing, state-specific data sources and more can be developed over time.

Figure 5. Suggested metrics for monitoring change in consumer affordability in California

	Cost of coverage	Cost of care	Health and financial consequences of unaffordable coverage and care
Administrative data for annual assessments	☑ Total premiums	☑ Consumer responsibility portion of total health care expenditures ☑ Actuarial value	☐ N/A
Survey data for longer-term monitoring	☑ Worker share of premiums ☑ Offer rate by firm size ☑ Take up rate among workers	☑ Deductible ☑ Maximum out-of-pocket ☑ Copays / coinsurance	☑ Skipped or delayed care due to cost ☑ Trouble paying medical bills ☑ Prevalence of medical debt
Survey data for equity impacts	☐ Premium by income and race	☐ Deductible as share of income	☑ All of above by income and race/ethnicity

Notes: Cost of coverage and cost of care metrics primarily focus on the commercial market. The consequences of unaffordable coverage and care metrics include effects on Californians with any type of insurance or no insurance.

Empty checkbox indicates data not currently available.

OHCA can use administrative data to measure yearly changes in commercial health care costs for consumers. (The commercial market includes both job-based coverage and the individual market. While individual market cost trends have a different history from job-based coverage, they are also state regulated and important to track going forward.) These data include:

- Premium growth rates collected by the Department of Managed Health Care (DMHC) from fully insured large group, small group, and individual market plans (combined this included about 14 million Californians with coverage in 2022, or 70% of the commercial market);
- Changes in plan actuarial value (AV), which is the average share of medical expenses that the plan will pay and is thereby a measure of the generosity of a plan, using data collected from fully insured large group, small group, and individual market plans by DMHC, as well as data collected by OHCA from commercial payers; and
- Growth in average per person out-of-pocket spending, a component of total health care expenditures data that OHCA is in the process of gathering.

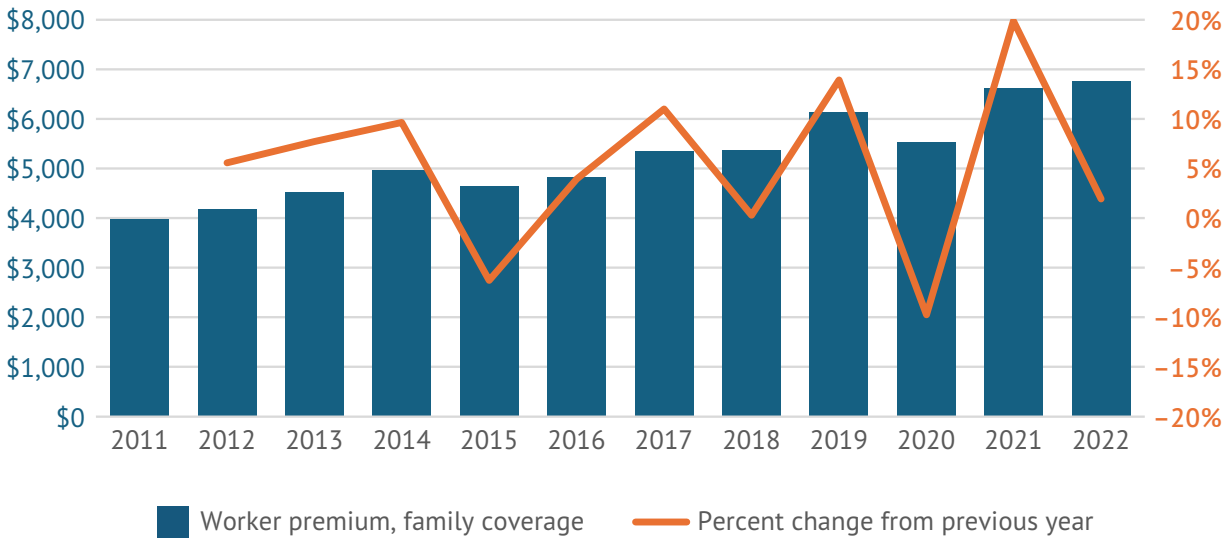
To supplement the available administrative data, OHCA can use survey data to understand the big picture of consumer affordability in the state, monitoring trends over multiple years and investigating inequities by race, ethnicity, and income. One-year trends from survey data must be interpreted carefully given confidence intervals around annual point estimates. Even with reliable survey methods, the volatility year-to-year makes it difficult to draw conclusions based on one-year trends, but longer-term trends can be meaningfully revealed (see Figure 6). Surveys remain the best source for some key trends that cannot currently be captured by administrative data. Surveys include:

- The California Employer Health Benefit Survey (CEHBS), which has recently undergone methodological improvements that make it an excellent source going forward but limit its use in looking at historical trends prior to 2022;
- The Medical Expenditure Panel Survey Insurance Component (MEPS-IC), which has historical state-specific data on job-based coverage as reported by private-sector establishments;
- The California Health Care Foundation Health Policy Survey, a consumer survey of California adults; and
- Other surveys such as the California Health Interview Survey that may be helpful to investigate specific trends and questions.

Figure 6 illustrates the potential complexity with using volatile year-over-year survey data but the usefulness of these data in showing a clear long-term trend. MEPS-IC shows average worker contributions to family premiums in California rose from 2012 to 2022, but year-over-year changes in survey estimates were volatile. For example, from 2016 to 2017 estimated premiums rose 11%, but then were fairly flat 2017 to 2018, rising only 0.3%. The two-year average estimated growth rate (5.5%) is in line with administrative data on the overall premium growth

rates in the large group market during those years (4.5% and 5.7%),[24] but it seems unlikely that most workers faced a double-digit increase in contributions in 2017 and no increase in contributions in 2018. Additionally, standard errors estimated by MEPS-IC (approximately $250 in each of these three years) indicate that the estimates derived from the survey sample can vary significantly from the actual average worker premium contribution value that would result if data were available from the entire population.

Figure 6. Average worker premium contribution for family coverage and percent change from previous year, covered workers in private establishments in California 2011-2022



Source: MEPS-IC California, 2011-2022

No single metric can fully capture consumer affordability trends in health care. For example, flat employee premiums could be offset by a reduction in actuarial value (the percentage of medical costs paid by insurance); lower actual out-of-pocket spending could mean that care is so expensive that people are avoiding it. Likewise, relying solely on administrative data would ignore trends in the worker share of premiums that may differ from trends in premiums overall, as well as ignore whether there are changes in consumers skipping or delaying care due to cost. The story of the last several decades of affordability of employer coverage is that workers and their families are paying higher premiums, both as a share of the total premium and an absolute dollar amount, while cost sharing, particularly deductibles, have proliferated in frequency and increased in dollar amount and thus actuarial value has likely fallen. Fully understanding how consumer affordability is changing will require keeping track of several key elements to uncover whether and which consumers benefit from reductions in the rate of growth in health care spending.

Administrative data can be used for annual monitoring of cost of coverage and cost of care

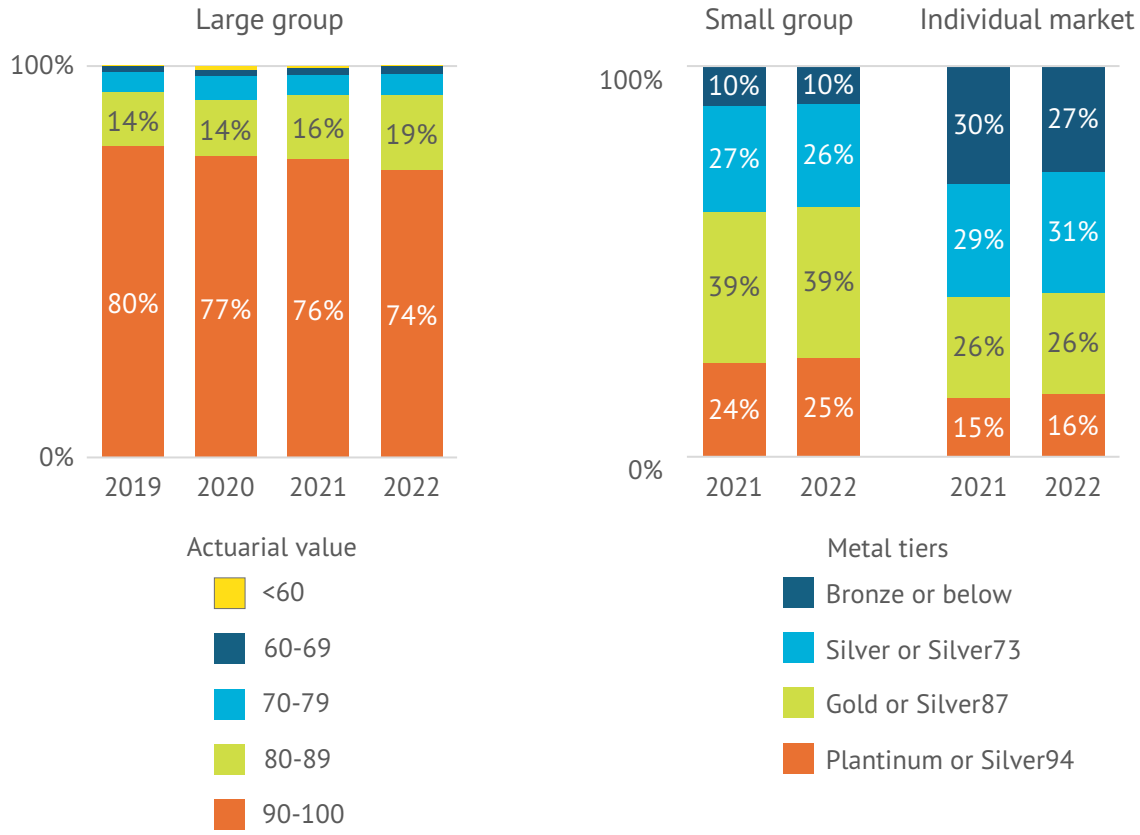
Annual data already submitted by fully-insured health plans to DMHC and data that will be submitted by most payers to OHCA can provide solid evidence on annual premium and out-of-pocket trends for certain markets. For example, DMHC data show that between 2021 and 2022, per member per month premiums increased 4.1% for fully-insured large group plans, 3.4% for fully-insured small group plans, and 1.5% for individual market plans (see Figure 8).[25] When OHCA begins collecting total health care expenditures data it will include data on the member responsibility portion of expenditures, which can be used to calculate the growth rate in the average consumer out-of-pocket spending amount per member per month.[26] These premium and out-of-pocket spending growth rates could then be compared to the statewide and sectoral OHCA spending targets.

Additionally, DMHC collects data on actuarial value (AV), the average share of medical expenses that the plan will pay, a measure of the generosity of a plan. DMHC presents actuarial value data for the individual and small group markets in terms of enrollment in metal tier plans as defined by Covered California, with higher metal tier plans covering a higher percentage of medical expenses: Bronze (covering about 60% of medical expenses), Silver (70%), Gold (80%), or Platinum (90%). For the large group market, DMHC presents data categorically—the number of enrollees with plans covering 90-100% of costs, etc. OHCA could more holistically compare the change in actuarial value year-to-year if DMHC were able to present the data it collects from plans as an average actuarial value by market.

Existing DMHC data show that in 2021 and 2022, approximately three-quarters of fully-insured large group enrollees were in plans covering 90% to 100% of expenses on average (see Figure 7). A majority of small group enrollees were in Gold plans or better, covering 80% of expenses or better on average. (The lower AV in the small group market is evident in the higher cost-sharing amounts that small firms consistently report in employer surveys.)

In the individual market, four out of ten enrollees were in Gold plans or better (including those in Silver94 and Silver87 plans, which respectively cover close to 94% and 87% of medical expenses on average). Although the most common metal tier in the individual market is Silver 70 or 73, Silver tier coverage leaves a high share of medical costs for the consumer—on average about 30% of the cost of care. Discussions of consumer affordability in Covered California have suggested increasing actuarial value for middle-income enrollees, including with increased cost-sharing reduction subsidies that will be available starting in 2024.[27]

Figure 7. Actuarial value by market, plans regulated by DMHC



Source: DMHC Large Group Aggregate Rates and Prescription Drug Cost Reports and Individual and Small Group Aggregate Premium Rate Reports, available at https://www.dmhc.ca.gov/AbouttheDMHC/DMHCReports/PublicReports.aspx.

Individual market actuarial value is supplemented by data from Covered California Active Member Profiles for June 2021 and June 2022, available at https://hbex.coveredca.com/data-research/

DMHC group plan data only includes fully-insured employer plans

The DMHC data include plans in the fully-insured large group market (9.5 million people—covering workers and their family members at firms with 100+ enrollees), the fully-insured small group market (2.3 million people—covering workers and their family members at firms with fewer than 100 enrollees), and the individual market (2.2 million people—enrolled through Covered California or purchasing coverage directly from insurers). DMHC data do not include the approximately 5.8 million people with job-based coverage where the employer is self-insured (sometimes categorized as "administrative service only" coverage or ASO).[28] While average premium amounts and actuarial values likely vary between job-based coverage that is fully-insured and self-insured,[29] limited California-specific data is available to help understand how the growth in premium and out-of-pocket spending might vary.[30] Nationally, Kaiser Family Foundation concluded that the average family premium growth in fully-insured plans between 2018 and 2022 (13%) was similar to that of self-insured plans (18%).[31]

To supplement its understanding of actuarial value trends based on DMHC data, OHCA could use the data it collects from payers to track over time the share of total medical expenditures that comes from payers as opposed to consumers. This would enable the monitoring of a single metric that is similar in concept to actuarial value and encompasses the entire commercial market including self-insured plans. It would not allow for differentiation between large group, small group, and the individual market, so OHCA should look at this data alongside DMHC actuarial value data.

We recommend that OHCA populate Figure 8 for the latest available years and continue to do so in all OHCA annual reports starting in 2025.

Figure 8. 2021-22 annual administrative data metrics

	2021	2022	Change	Source
Premiums—Average per member per month				
Large group	$533.70	$551.94	+4.1%	DMHC
Small group	$532.90	$558.28	+3.4%	DMHC
Individual market	$550.95	$562.46	+1.5%	DMHC
Actuarial value*				
Large group	76% Platinum	74% Platinum	-2 percentage points	DMHC
Small group	53% Gold	54% Gold	+1 percentage point	DMHC
Individual market	41% Gold	42% Gold	+1 percentage point	DMHC
Commercial market	% (to be collected by OHCA for 2022 and beyond)			OHCA**
Consumer out-of-pocket spending—Average per member per month				
Commercial market	$ (to be collected by OHCA for 2022 and beyond)			OHCA**

* Large group and small group AV data from DMHC excludes self-insured plans; commercial market data from OHCA does not disaggregate by market but does include self-insured plans.

Source: DMHC Large Group Aggregate Rates and Prescription Drug Cost Reports and Individual and Small Group Aggregate Premium Rate Reports, available at https://www.dmhc.ca.gov/AbouttheDMHC/DMHCReports/PublicReports.aspx

**OHCA data is not yet collected.

Another source of administrative data we considered was medical debt on credit reports. Rules currently under consideration by the Consumer Financial Protection Bureau would remove medical bills from credit reports and stop creditors from using medical bills for underwriting decisions.[32] Given this change, credit reports are not a recommended source of data.

Medical debt is a significant contributor to bankruptcy, especially among consumers with chronic illness or injuries requiring extensive hospitalization.[33] However, there is controversy in

the literature over the definition and prevalence of bankruptcy *specifically caused by* medical debt. Overall bankruptcy rates have been decreasing over time in California and nationwide, but it may be difficult to distinguish the role of medical debt in those bankruptcy rates. As such, bankruptcy may not be a useful metric to track.

Survey data are vital to monitoring consumer trends and consequences of unaffordable coverage and care, including inequities

As discussed above, survey data are vital for measuring the consequences of unaffordable coverage and care for health and financial well-being: how many Californians are postponing or delaying care due to cost, having trouble paying medical bills, or dealing with medical debt? Given the current limitations in data gathering, surveys are especially important to get at the big picture of the impact of unaffordable care on consumers. The OHCA board and staff have recognized concerns about growing spending on out-of-network care for behavioral health and other services, as well as spending on non-covered services. Developing data that measure these trends directly and capture them as part of the total cost of health care will be important, but in the meantime consumer survey measures such as delaying or skipping care and trouble paying medical bills are even more vital to track.

In addition, survey data on health insurance can be useful to disaggregate consumer affordability metrics by race, ethnicity, and income. In the future, DMHC and OHCA may have administrative data that track some of these variables but that is some years away. Finally, survey data are also useful for monitoring other trends in consumer affordability that cannot currently be measured using administrative data. For instance, as discussed above, survey data on worker share of employer premiums and deductibles can supplement administrative data on premiums, actuarial value, and out-of-pocket costs. Below we discuss other metrics related to the cost of coverage and cost of care that are important to track to monitor trends over time and to understand the bigger picture of consumer affordability of job-based coverage in the state. In Figure 9 we list the available survey data measures we recommend, including data from the past five years.

Premiums by income

Job-based coverage is funded regressively; the lowest-paid workers can pay as much for coverage as the highest-paid workers in a firm. Only 11% of firms in California that offer health insurance have reduced premium contributions for low-wage workers.[34] Trends across firms may exacerbate the regressivity: the California Employer Health Benefit Survey indicates that firms with few high-wage workers (those earning $70,000 or more) require *higher* average premium contributions than firms with more high-wage workers.[35]

Offer rates

The share of California employers offering coverage has been fairly stable since the major provisions of the ACA were implemented in 2014, according to MEPS-IC. Offer rates generally increase by firm size, with nearly all employers with 50+ workers offering health insurance coverage to at least some of their employees. About one in three (34%) California private-sector small firms with fewer than 50 employees offered coverage in 2022, identical to the offer rate when the ACA began in 2014, but lower than the small employer offer rate of 45% in 2002. The long-term decline in offer rates is likely related to increasing premiums.

Eligibility and take-up rates

Across California private sector firms of any size that offer coverage, about 80% of workers are eligible for coverage and 73% of eligible workers were enrolled in 2022, according to MEPS-IC. Workers may not be eligible for coverage if they work part time or have joined the firm only recently. Even if eligible, they may choose not to enroll because they have coverage available through Medicaid or through the employer of a spouse or parent, or because they find that coverage is too expensive. Affordability of coverage is a common reason provided by those who may forego work-based coverage and go uninsured.[36]

Copays and coinsurance

Copays in general have grown modestly in the past two decades according to MEPS-IC, with physician office visit copays averaging 3.1% annual growth from 2002-2022 for enrolled California private sector workers with copays. About 64% of covered private sector workers have copays for office visits, averaging $27 for doctor visits and $37 for specialist visits in 2022.

Coinsurance is common for hospital stays and specialty drugs, and is becoming more common for office visits to a physician and non-specialty prescription drugs. If insurance designs continue to move away from copays and toward coinsurance, consumers will be more and more exposed to the increases in underlying prices.

Maximum out-of-pocket

While very few enrollees will hit a plan's maximum out-of-pocket in any given year, this plan feature is an important way of limiting consumers' costs in the event they do use significant medical care during the year. Limits on maximum out-of-pocket costs are set federally every year ($17,400 for family coverage in 2022, up from $12,700 in 2014), but many plans have lower maximums; the average in California was $8,318 in 2022 for family plans and $4,439 for single plans, according to MEPS-IC. The average maximum out-of-pocket for single plans among private sector workers in California has grown modestly from $3,821 in 2016, or about 2.6% per year.

Figure 9. Survey data measures of consumer affordability

Metric	2018	2019	2020	2021	2022	Notes/source
Cost of coverage						
Single premium	$6,542	$6,939	$7,173	$7,574	$7,547	MEPS-IC Private-sector workers
Worker share	18%	19%	17%	22%	19%	
Family premium	$19,567	$20,788	$21,137	$21,830	$22,272	
Worker share	28%	30%	26%	30%	30%	
Offer rate by firm size						
50+	97.0%	97.3%	96.0%	98.6%	97.4%	
<50	34.0%	31.2%	34.6%	35.6%	33.5%	
Take up rate among eligible workers	71.0%	71.7%	74.6%	69.1%	72.8%	
Cost of care						
Average deductible						MEPS-IC Private-sector workers
Single	$1,680	$1,675	$1,718	$1,698	$1,808	
Family	$3,231	$3,329	$3,420	$3,643	$3,659	
Maximum out-of-pocket						
Single	$4,066	$4,099	$4,455	$4,253	$4,439	
Family	$7,953	$8,073	$8,305	$8,300	$8,318	
Copays						
Office visit	$25	$27	$25	$29	$27	
Specialist visit	$36	$40	$40	$45	$41	
Consequences of unaffordable coverage and care						
Skipped or delayed care due to cost (by race/ethnicity)	44%	51%	51%	49%	52%	See Figure 4 for trends by race and ethnicity for each type of care. CHCF California Health Policy Survey
Trouble paying medical bills						CHCF California Health Policy Survey
Total	20%	24%	20%	25%	27%	
Asian	8%	NA	10%	17%	17%	
Black	30%		30%	40%	36%	
Latino	28%		26%	32%	40%	
White	16%		17%	21%	20%	
Prevalence of medical debt						Not available for prior years. CHCF California Health Policy Survey
Total					36%	
Asian					27%	
Black					48%	
Latino					52%	
White					28%	

Sources: MEPS IC California: https://datatools.ahrq.gov/meps-ic/

CHCF Health Policy Surveys: https://www.chcf.org/collection/the-chcf-california-health-policy-survey/

OHCA should explore and develop other data sources

OHCA should continue to explore and develop other sources of administrative data. Data on consumers expenditures on out-of-network care and non-covered health services will be important to develop to get a fuller picture of total health care spending. Analyzing premiums as a share of income would help the state understand if premium trends are reducing or exacerbating the regressivity of job-based coverage. Currently these data are not easily available, but tax data utilizing W2 box 12DD could allow for analysis of total premiums as a share of household income. Additionally, the state's Health Payments Database (HPD) may soon be a useful source for tracking increases in the consumer share of claims and allowed amounts across various services, including trends in out-of-pocket costs for prescription drugs. HPD analysis may also be useful in getting finer-grained analysis by geography, by geographic proxies for socioeconomic status, or by race and ethnicity. Job-based coverage premiums and deductibles by income or income group and by race and ethnicity would be useful to track and will require exploration to find or create a useful source.

As the office gains experience tracking these data points and monitoring trends, no doubt other data needs will arise. The important work of shining a light on how consumers are faring is an important first step in finding ways to move the system toward more sustainable, affordable growth in health care costs for the people of California.

Conclusion

California workers and their families have faced two decades of worsening health care affordability; premiums and deductibles have risen faster than wages, taking up a larger and larger share of household income. For OHCA to achieve its goal of reducing the rate of growth in health care spending in a way that helps consumers, the office should track consumer affordability metrics from the start. No single measure will suffice since improvements in one area can come at the expense of another. Fortunately, California has both administrative and survey data that can be used to track changes in the cost of coverage, the cost of care, and the consequences of unaffordable health care for health and financial well-being. While administrative data is best suited to the specific purpose of comparing against a target on an annual basis, survey data are still important to completing the picture and understanding the multi-year trends and equity impacts. Over the longer term, California should also seek to expand and improve the available administrative data so that a broader range of health care affordability trends can be reliably compared against the spending target each year.

California has the opportunity to learn from Massachusetts, the state with the longest track record of setting targets and tracking the rate of spending growth in health care. They found that even as spending growth moderated, premiums and cost sharing for consumers often grew in excess of the target; as a result, Massachusetts is now embarking on efforts to track consumer affordability annually.[37] California has the opportunity to track these important measures from the beginning, starting with the first annual report in 2025.

Endnotes

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12 MEPS-IC California, 2002-2022.

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15 MEPS-IC.

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