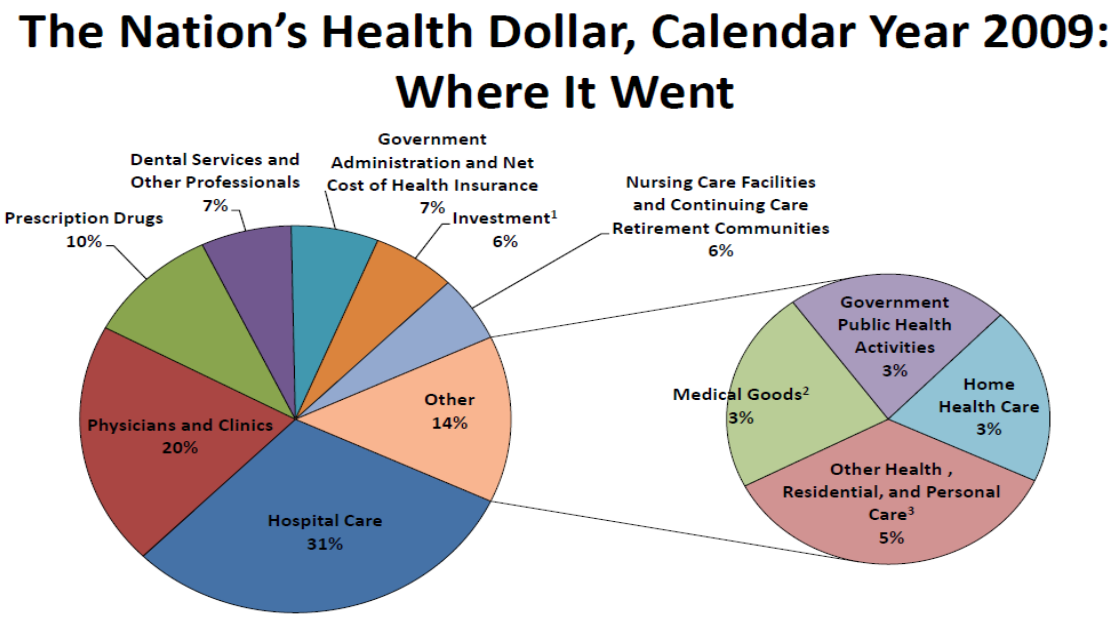
California Legislature

Joint Oversight Hearing of the
Assembly and Senate Committees on Health:
ESCALATING HEALTH CARE COSTS

March 15, 2011
1:30 P.M.
State Capitol, Room 4202

BACKGROUND

For many years, health spending growth has outpaced inflation. The United States spends a larger share of its gross domestic product (GDP) on health care than any other major industrialized country. Expenditures for health care represent 17% of the nation's GDP.[i] In 1960, health care expenditures accounted for about 5% of the GDP. By 2019, the federal Centers for Medicare and Medicaid Services (CMS) project health care expenditures will account for 19% of GDP.[ii]



[1] Includes Research (2%) and Structures and Equipment (4%).
[2] Includes Durable (1%) and Non-durable (2%) goods.
[3] Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.
Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

As costs have risen, health care coverage has become more unaffordable. The 2010 California Employer Health Benefits Survey (CEHBS) found health insurance premiums increased 8.1% in California in 2010.[iii] Other key findings from CEHBS were:

- Since 2002, premiums have increased 134.4%, more than five times the 25.4% rise in California's overall inflation rate.
- Single-coverage premiums in California were $5,463 annually, significantly more than the national average of $5,049. Premiums for family coverage were $14,396.
- California workers contributed $725 annually for single coverage in 2010, and $3,632 for family coverage. The contribution for single coverage is less than for workers nationally ($899), but increased from 12% of the premium in 2009 to 15% in 2010.
- Enrollment in plans with a deductible of $1,000 or more for single coverage has increased significantly for workers in small firms (at 27%, up from 7% in 2006).
- Twenty-eight percent of California firms either reduced benefits or increased cost sharing for employees as a result of the economic downturn in 2010, up considerably from the 15% who did so in 2009. Cost sharing may continue to increase for California workers. Just under half of large firms (200 or more workers) are "very" or "somewhat" likely to increase the amount workers pay for coinsurance or copayments in the next year. Sixty-eight percent are "very" or "somewhat" likely to raise the amount workers pay toward premiums.
- Four percent of California firms indicated they are "very likely" to drop coverage entirely in the next year. In 2008, only 1% of firms said this.

Increased Spending and Rising Premiums Do Not Necessarily Result in Higher Value. Despite spending more for health care, higher payments do not necessarily result in higher benefits or quality. This is partly because a portion of health spending that is paid through premiums is spent to compensate for costs in other parts of the health system or to compensate for inefficient delivery of care. Specifically:

- *Care for the uninsured shifts costs to payers of health coverage through increased premiums*. Federal and state laws require hospital emergency rooms to provide care to stabilize patients, regardless of their ability to pay. Emergency rooms become the provider of last resort for many uninsured and underinsured individuals. However, hospitals and physicians who provide emergency care are generally not fully compensated for these costs, since the uninsured and underinsured often cannot afford to pay. As a result, providers look elsewhere to recover these uncompensated costs. One method used to recover costs is to charge higher prices to those with health insurance. One report estimated that 10% of California premiums can be attributed to the cost-shift due to caring for the uninsured and underinsured. The report estimated the cost-shift results in families paying an additional $1,186 in premiums and individuals paying an additional $455 in premiums.[iv]

- *Payments are used to compensate inefficient delivery of care*. Per capita health expenditures in the United States are about twice those of the median industrialized nation.[v] However, recent surveys comparing quality, efficiency, access, and equity among industrialized nations' health systems have found relatively poor U.S. performance.[vi] Despite spending more on health care than other countries, an international survey found that the United States lags behind on important measures of access, quality, and use of health information technology (HIT).[vii] In fact, research has shown that much of the current health care spending is unnecessary or inappropriate, due to medical errors, lack of preventive or appropriate care, and lack of HIT.[viii]

Cost Containment Has Been Difficult in California.
Due to market structures, provider payment mechanisms, unmet health care needs, and lack of data, cost containment has been difficult to achieve. Reasons include:

- *California continues to have a large number of uninsured persons*. The large number of uninsured persons means that the cost for their care continues to be shifted to commercial payers. Twenty-four percent of the non-elderly population in California (8.2 million people) were uninsured during at least some part of 2009.[ix] Studies also show that, compared to persons with health insurance, people without insurance are more likely to postpone seeking needed care because of cost. This leads to poorer health outcomes, which can lead to more expensive care later.[x]

- *Structure of health plan and provider relationships lowers business incentives for health plans and providers to invest in quality*. In California there is widespread use of the delegated model, under which the HMO contracts with medical groups or independent practice associations, pays a capitated monthly rate for every enrollee, and retains some percentage of the premium for administrative costs and profit. In effect, the HMO delegates financial risk and utilization management responsibilities to physician groups. Also, in California most of the major medical groups and hospitals contract with most of the major HMOs. In other words, provider groups do not contract exclusively with any single plan. For example, in California, physician groups typically contract with 15 different managed care plans, each of which may establish its own requirements. These relationships lessen the business case for health plans or providers to invest in quality measures if the benefits or savings accrue to others.

  For example, since provider groups contract with different health plans, the health plans may be reluctant to invest in electronic medical records if they know it will benefit other plans. Providers may be reluctant to invest in electronic medical records, due to the upfront investment costs and because the resulting benefits of higher quality care might accrue to payers through lower premiums, rather than as revenue to providers.

  Under an integrated delivery system, such as Kaiser, the health plan and providers work together to strategize on financing and delivery of care because benefits could accrue to both health plans and providers. This is different from the HMO delegated model, where health plans and provider groups have business incentives to shift costs to one another. Kaiser, for example, has implemented evidence-based practice guidelines for its providers. One study of physician groups in California found that the Permanente Medical Group, which contracted exclusively with the Kaiser Foundation Health Plan, allowed for efficiencies that improved the ability to deliver quality care management processes, compared to other physician groups. Integrated delivery systems, however, are not common in California.

- *Churning of health plan enrollees lowers incentives for employers and health plans to make long-term investments*. Some employers and plans have invested in cost-containing measures that target utilization of services, such as disease management or preventive care. For example, Kaiser has implemented strategies to manage chronic conditions, such as diabetes and cardiovascular disease, and strategies for smoking cessation and prevention.

However, the savings from these programs generally accrue over time (as an enrollee's health outcome improves) and are greater when more enrollees participate.[xi] In many cases, though, employees enroll and disenroll from health plans when they switch jobs. This churning of enrollees makes it difficult for employers and health plans to realize the savings from their investments. As a result, there are lower incentives, especially for smaller employers, to make long-term investments.

- *Lack of information on quality and performance means purchasers and consumers of health care may be paying for medical errors or inappropriate care*. Many purchasers and consumers select plans based on cost rather than quality. Also, health plans generally do not pay providers based on quality. This is largely due to the lack of information on quality and performance, especially at the provider level. Health plans and providers do not generally have incentives to share information on performance, partly due to disagreement on how to track and measure performance. Recent efforts to promote payment based on quality include attempts to collect quality and outcome data and to implement pay-for-performance strategies. Despite efforts by various groups to collect quality and performance information, there is still a gap in information needed by purchasers and consumers to make decisions.

- *Better assessment of new technologies needed*. Research suggests that, although managed care slows health care cost growth, the effects are not large enough to slow the continued rise in health spending, due to the diffusion of technology.[xii] While innovation and new technology (including prescription drugs) are desirable, there may be overuse or underuse of a particular product, due to lack of information on its relative effectiveness. For example, information regarding alternative technologies or adverse events associated with a product could help physicians in deciding which technologies to use, especially given consumer demands for the latest technology. Although larger health plans conduct value assessments of new technology, these activities may not be widespread or may require more information (such as tracking adverse events) to be more useful.

- *Employer coverage offerings do not maximize competition based on efficiency and quality*. Many small- and medium-sized employers offer only a single carrier and delivery system. This may be partly because smaller employers find it administratively burdensome to offer choices. Also, carriers may insist that a high percentage of the employees must select their plans. This means that competition among plans happens at the employer level rather than the employee level.[xiii]

- *Some employee cost-sharing arrangements may discourage use of preventive or appropriate care*. Employers have increased consumer cost-sharing through out-of-pocket payments (such as copayments and deductibles) as a way to contain costs. For example, some employers may require tiered-cost sharing formulas for prescription drugs, in order to encourage use of generic drugs. Also, employers are offering different types of tax-favored health savings accounts, which employees can use to pay for preventive care. Some cost-sharing arrangements, however, may discourage consumers from seeking appropriate care due to cost barriers.[xiv] For example, high-deductible plans that do not exempt primary care may result in cost barriers for some individuals seeking preventive care. (Note: The

recently enacted federal health care reform law, discussed below, requires no cost sharing for preventive services.)

- *Much is spent on administrative costs*. One study estimated that billing and insurance-related administrative activities (including claims, marketing, and underwriting) account for 8.4% of commercial plan premiums in California.[xv] Overall, the study estimated that 19.7% to 21.8% of spending on physician and hospital services in California, that are paid for through private insurance, is spent on billing and insurance-related administration.

Patient Protection and Affordable Care Act.
On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act; Public Law (P. L.) 111-148, as amended by the Health Care and Education Reconciliation Act of 2010; P. L. 111-152, (collectively PPACA). Among other provisions, the new law makes statutory changes affecting the regulation of and payment for certain types of private health insurance. The law also significantly expands health care coverage to currently uninsured individuals through public program expansions, a mandate to purchase coverage, a temporary high-risk pool program, and by requiring guaranteed issue of coverage. Millions of currently uninsured people in California will obtain coverage under the provisions of PPACA. This expansion of coverage to uninsured individuals will help to reduce the portion of existing premiums that are spent to pay for care for the uninsured.

Additionally, there are a number of other provisions contained in the new law that are meant to reduce costs. The PPACA calls for new initiatives that challenge health plans and providers to focus on quality improvement and value. Specifically, the PPACA contains provisions that:

- Reduce demand for the most expensive plans (which some argue encourage overuse of medical care) by making them less attractive through a "Cadillac" insurance tax;
- Implement pilot programs to test various approaches to revamping provider-payment incentives and organizational structure;
- Invest hundreds of millions of dollars in new comparative-effectiveness research; and,
- Implement pilot programs to assess the impact of various reorganizations of the medical malpractice process.

The Congressional Budget Office has estimated that the PPACA will produce a net reduction in the federal deficit of $124 billion over the next nine years.[xvi] According to an analysis of a CMS actuary report, although the PPACA will increase medical spending somewhat, its incremental impact on spending will decrease over time (from 2% in 2016 to 1% in 2019), which implies that by the second decade of implementation, the PPACA will have reduced national health care spending.[xvii]

Health Information Technology for Economic and Clinical Health Act.
Congress passed, and President Obama signed the American Recovery and Reinvestment Act (ARRA) in February 2009, that contained the Health Information Technology for Economic and Clinical Health (HITECH) Act, which seeks to improve patient care through the creation of a secure, interoperable nationwide health information network. The HITECH Act includes roughly $41 billion for national HIT investments over the next four years to implement wide-scale sharing of electronic medical records (EMR) and patient health information by providing

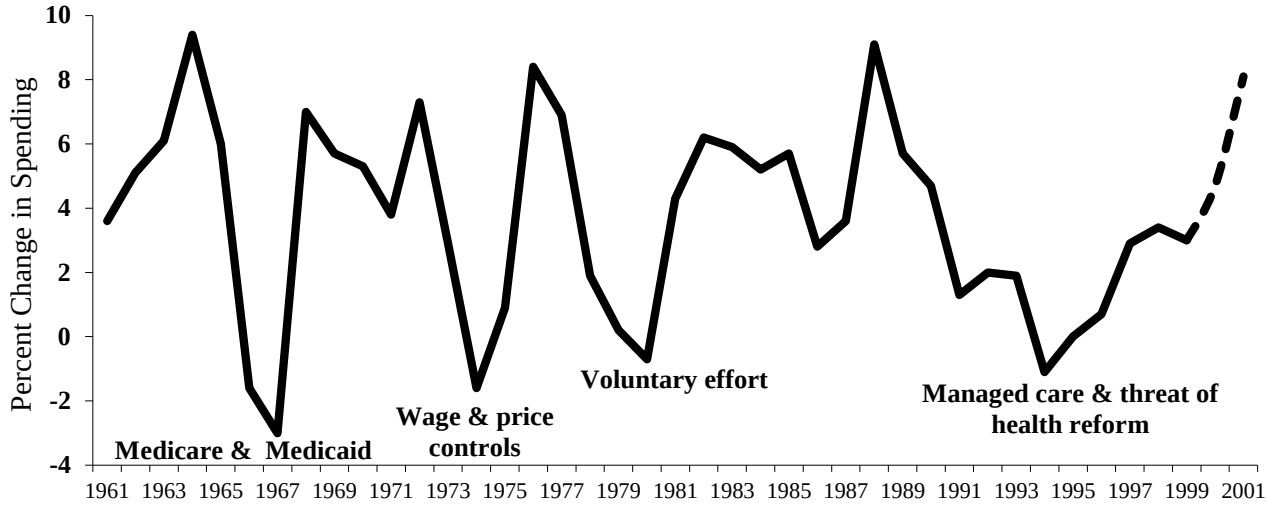
incentive payments to providers to purchase and use HIT and EMRs to improve care coordination. California is estimated to receive $4 billion.

These federal actions have served as a catalyst for California to build HIT infrastructure that will encourage sharing of electronic health information across providers. Since the passage of the HITECH Act, California established a statewide strategic plan to develop HIT infrastructure, began the development of a statewide health information exchange, established regional extension centers to provide technical assistance and support to providers, and established workgroups to address issues around medical privacy and security through the California Privacy and Security Advisory Board. The Department of Health Care Services is expected to establish an incentive payment program for Medi-Cal physicians and hospitals to implement and use EMRs; payments are expected to begin in 2011.

Where Do We Go From Here?

Despite the promise of PPACA, a 2002 article in the journal *Health Affairs* entitled, "The Sad History of Health Care Cost Containment as Told in One Chart" shows that efforts to curtail health care costs have a long and generally unsuccessful history.[xviii] Public and private efforts to rein in health care costs through wage and price controls, voluntary efforts, managed care, and the threat of health care reform have triggered declines in spending growth, but these periods of decline have always been temporary and have been followed by a rapid growth in costs.

The Sad History of Health Care Cost Containment as Told in One Chart
Annual Change in Private Health Spending Per Capita
(Adjusted for Inflation), 1961-2001



The authors conclude:

> In sum, neither regulation, voluntary action by the health care industry, nor managed care and market competition have had a lasting impact on our nation's health care costs. Some might argue that we were not serious or comprehensive enough about any one of these approaches for them to have had a lasting impact. On the other hand, it could be argued

that the point is academic; we were only as serious as public and political support for any one approach would allow.

Some believe that we will not get a handle on health care costs as a nation until we are ready to make tough decisions about rationing medical care. An equally plausible scenario is that the apparent failure of all approaches reflects the American people's uncontainable desire for the latest and best health care, and that what we will do in the future is try small things that will work at the margin, complain a lot, but ultimately pay the bill. Whichever view is right, the historical data, while certainly open to different interpretations, show that managed care is not alone in its failure to solve the health care cost problem. Indeed, history suggests that it may be folly to expect that there are any easy or magic answers to this problem. When it comes to controlling health care costs, reformers should not overpromise.

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[i] Centers for Medicare and Medicaid Services. National Health Expenditures 2009 Highlights. September 2010.

[ii] Centers for Medicare and Medicaid Services. National Health Expenditure Projections 2009-2019. September 2010.

[iii] California HealthCare Foundation and National Opinion Research Center. *California Employer Health Benefits Survey*. December 2010.

[iv] Peter Harbage and Len M. Nichols, "A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System," New America Foundation, December 2006. According to the report, the $1,186 and $455 amounts represent the total amount of the insurance premium (both the employer and employee share) that is the result of cost-shifting.

[v] Chapin White, "Health Care Spending Growth: How Different Is the United States From the Rest of the OECD?" *Health Affairs*, Vol. 26, No. 1, January/February 2007, p. 154-161.

[vi] Commonwealth Fund, "Why Not the Best? Results from a National Scorecard on U.S. Health System Performance," September 2006.

[vii] C. Schoen, R. Osborn, M. M. Doty, D. Squires, J. Peugh, and S. Applebaum, A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences, *Health Affairs* Web Exclusive, Nov. 5, 2009, w1171–w1183.

[viii] Commonwealth Fund, "2006 International Health Policy Survey of Primary Care Doctors," October 2006; Commonwealth Fund, "2005 International Health Policy Survey of Sicker Adults," November 2005; and Commonwealth Fund, "2004 International Health Policy Survey of Adults' Experiences with Primary Care," October 27, 2004; RAND, "Assessing the Appropriateness of Care," Research Highlight, RB-4522 (1998); Elizabeth A. McGlynn, et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, June 26, 2003, Vol. 348, No. 26, p. 2635-2645; and Institute of Medicine, "Crossing the Quality Chasm: A New Health System for the 21st Century," March 2001.

[ix] SA Lavarreda, ER Brown, L. Cabezas, DH Roby. *Number of Uninsured Jumped to More*

Than Eight Million from 2007 to 2009. Los Angeles, CA: UCLA Center for Health Policy Research, March 2010.

[x] Kaiser Commission on Medicaid and the Uninsured, "Sicker or Poorer: The Consequences of Being Uninsured," May 2002, and American College of Physicians, "No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health," 2000.

[xi] Diane R. Rittenhouse, et al., "Physician Organization and Care Management in California: From Cottage to Kaiser," *Health Affairs,* 2004, Vol. 23, No. 6, p. 51-62.

[xii] Michael Chernew, et al., "Managed Care and Medical Technology: Implications for Cost Growth," *Health Affairs,* Vol. 16, No. 2, 1997, p. 196-206, and Michael Chernew, et al., "Barriers to Constraining Health Care Cost Growth," *Health Affairs,* November/December 2004, Vol. 23, No. 6, p. 122-128.

[xiii] Alain C. Enthoven, "Employment-Based Health Insurance Is Failing: Now What?" *Health Affairs,* May 28, 2003.

[xiv] Between 1971 and 1982, the RAND Health Insurance Experiment studied cost-sharing and its effect on service use, quality of care, and health. Also see Karen Davis, et al., "How High Is Too High? Implications of High-Deductible Health Plans," Commonwealth Fund, April 2005. And Goldman DP, Joyce GF, Zheng Y. "Prescription drug cost sharing: associations with medication and medical utilization and spending and health." *Journal of the American Medical Association* 2007;298:61-69.

[xv] James G. Kahn, et al., "The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals," *Health Affairs,* November/December 2005, Vol. 24, No. 6, p. 1629-1639.

[xvi] Congressional Budget Office. Final Cost Estimate of the PPACA, P. L. 111-148; and, following that, the Health Care and Education Reconciliation Act of 2010 (H.R. 4872).

[xvii] Gruber, J., "The Cost Implications of Health Care Reform." *The New England Journal of Medicine*: p. NEJMp1005117.

[xviii] D Altman and L Levitt. "The Sad History Of Health Care Cost Containment As Told In One Chart" *Health Affairs* web exclusive at http://www.healthaffairs.org/. January 23, 2002.