California State Assembly

Committee on Health

Informational Hearing

Cost Containment: Considerations for California

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Commissioning Change:
How Four States Use Advisory Boards to Contain Health Spending

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State Level Health Care Cost Commissions

- Other states have created Health Cost Commissions/Offices to reduce excessive cost growth

- Properly designed, a similar agency in California could provide policymakers a mechanism to achieve important benefits to California:

  - Lower the costs of expanding health insurance coverage to uninsured

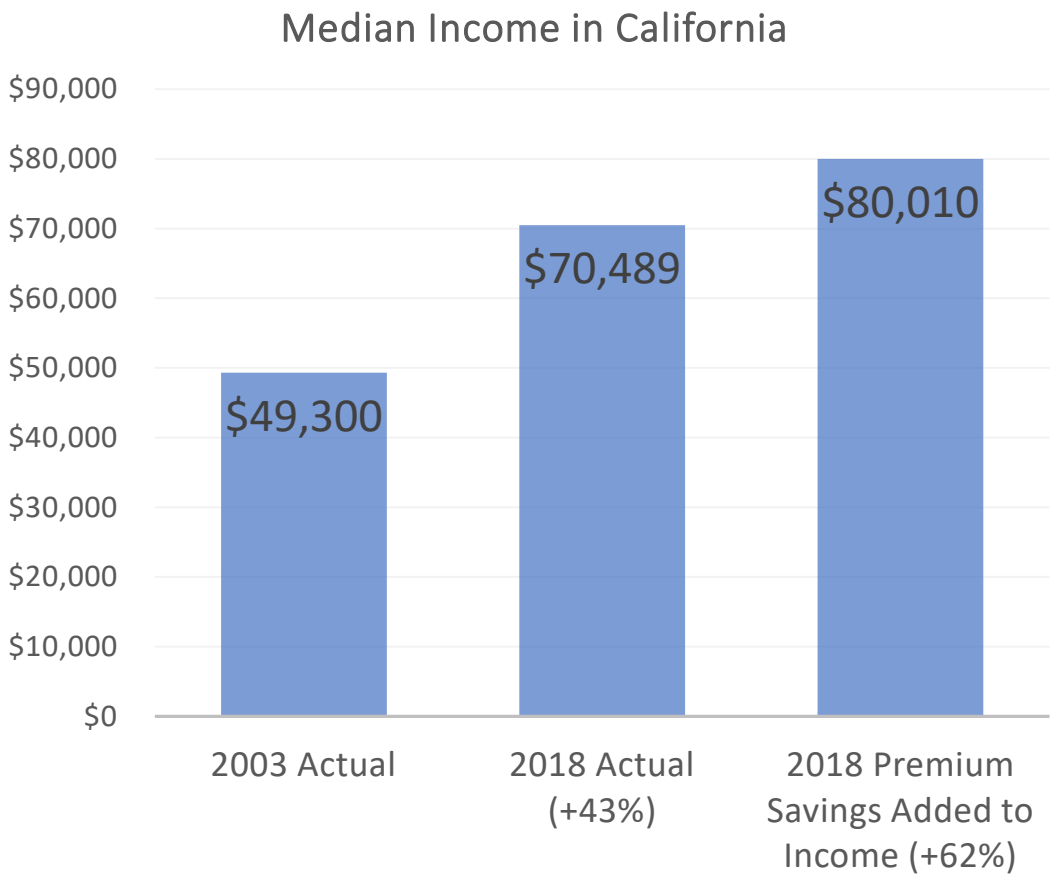
  - Provide relief to millions of Californians struggling with premiums and out of pocket costs

  - Provide California's policy makers with greater budgetary resources to support other, non-health care related programs and policies

  - Improve the economic well being California's workers and their families

If Premium Growth Equaled CA Economic Growth California Median Family Income Would be $9,500 Higher

#		2003 Actual	2018 Actual	$ Increase	% Increase
1	California GDP Per Capita	$51,780	$68,803	$17,023	33%
2	Total Premium - California Family	$8,504	$20,831	$12,327	145%
3	Total Premium - Tied to GDP Per Capita Growth	$8,504	$11,310	$2,806	33%
4	Premium Savings		$9,521		



A California Commission Could Identify and Target Multiple Problem Areas

- No simple solution to our health care cost conundrum
  - Problems in our system are multiple

- Policies are needed to:

  - Set enforceable targets that encourage and create meaningful competition
  - Ensure markets are open, transparent, and competitive
  - Provide appropriate regulation when markets fail

As California Considers Creating a Health Cost Commission or Office

- Opportunity to learn from and building on what other states have done will ensure our efforts help bring about an affordable health care system that works for all of us.
  - Extremely fortunate to have leaders from two other states to provide the Committee with first-hand knowledge of their models and advice for California
    - Massachusetts and Oregon
    - Well developed cost commissions
  - Later, I will provide overviews of the Commissions in Maryland and Rhode Island

Notable Success Factors Common to Other States

- **Explicit Benchmarks**
  - Quantitative benchmarks
  - Measurable with reliable, agreed upon data
  - Cost growth tied to growth of the State's economy

- **Authority to collect and analyze detailed data**
  - Further transparency
  - Understand major cost drivers
  - Improve market performance
  - Monitor performance relative to benchmark

- **Independent authority and stakeholder collaboration**

- **Enforcement mechanisms if targets are not met**

Part 2

Cost Commissions - Two Other States

- Maryland
- Rhode Island

Legislative History and Commission Structure

	MARYLAND	RHODE ISLAND
Year Formed	1972	2004
Year - Most Recent Update	2018	2019
Government Agency or Independent	Government Agency	Government Agency
Commission/Implementing Agency	Maryland Health Services Cost Review Commission (HSCRC)	Office of the Health Insurance Commissioner (OHIC)
Commissioners	Appointed by: Governor	Appointed by: Governor
Number of Commissioner Members	Seven (7) Members	One (1), State Health Insurance Commissioner
Commission Member Representation	Independent Experts, Payors, Providers, and Consumers	State Official, Supported by Working Groups
External/Supplemental Data Collection and Support	Yes	Yes
Medicare/CMS Waivers	All Payor CMS Waiver - includes Medicare and Medicaid	None

Maryland: All-Payer Global Revenue Budgets for Hospitals

- Sets Global Revenue Budgets for All Hospitals
  - Effectively controls spending for the largest component of health care costs for all payers
  - Sets statewide target for total spending for all payers
- Transitions Rural Hospitals from Cost-Based Reimbursement to Global Budgets
  - Provides predictable, stable revenue and cash flows for rural hospitals
- Provides Financial Incentives for Prevention and Population Health

Maryland: All-Payer Global Revenue Budgets for Hospitals – Some Limitations

- Sets Global Revenue Budgets for All Hospitals
  - Limited to hospitals only
  - Patient population and attribution difficult under hospital global budgeting
- Transitions Rural Hospitals from Cost-Based Reimbursement to Global Budgets
  - Accounting for factors outside hospital control
  - Adjusting for “leakage” of care from hospital to nonhospital settings
- Maryland has a unique CMS/federal waiver that is likely not to be available to other states

Rhode Island Model: Health Insurance Premium Regulation + Affordability Standards

- Review and Approve Health Insurance Premium Rates
  - Establishes a Global Health Spending Cap for Rhode Island Tied to Economic Growth
  - Ties 80% of Health Care Payments to Quality
  - Develops a Next-Generation Health Information Technology System for providers Health Care Payments to Quality

Rhode Island Model: Health Insurance Commissioner Leverages Affordability Standards

- Law allows Commissioner to Review and Approve Health Insurance Rates

- In addition -- Rhode Islands broad ***Affordability Language*** Allows Commissioner to:
  - Go beyond health insurance premiums
  - to underlying factors driving cost growth
  - both fully insured and self-insured plans

- Commissioner implemented a set of affordability standards (in 2010) for **all commercial insurers** in the state
  - Price controls on providers -- including annual price inflation caps for both inpatient and outpatient services (equal to the Medicare price index plus 1 percentage point)
  - Require contracts include value-based payments to hospitals
  - Require increased spending on primary care services -- by 1 percentage point per year without raising consumer premiums -- to support development the patient-centered medical home model
  - Mandate adoption of electronic health records and statewide health information exchange to support care coordination and quality

Closing Comments

Fundamental Building Blocks – Comprehensive Data

- Our current system lacks transparency
  - Effective markets need information and transparency
  - Proper public policy needs information and transparency

- Slowing cost growth will be very difficult
  - Without good data -- likely impossible
  - Difficult decisions will be required
  - The policy debates should focus on policy trade-offs and ***not*** on whether we have the right data to measure important policy parameters

- Good news - California has a history, experience and momentum with collecting needed health system data
  - Need to build on our experience and support development the essential APCD project
  - But, should not wait until we have everything
  - Need to make the data widely and easily available to the public and researchers to leverage the analytical resources within California health services research community

Fundamental Building Blocks – Benchmarks and Governance

- Develop and track progress against benchmarks
  - Measure and track *affordability* from multiple perspectives – not just total aggregate spending
    - Households
    - State government
- Provide Commission with independence (and data) to make difficult decisions
  - Our current system can be vastly improved
  - Competitive markets determine these outcomes in consumers interests
  - Intervention sometimes needed to ensure markets function properly