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Informational Hearing

Health Care Affordability: How to Control Costs in California?

Tuesday, October 27, 2020 - 1:30 – 5:00 PM
State Capitol, Room 437

BACKGROUND

Health care spending

In 2019, 32.7 million Californians had health insurance coverage, and most (18 million) obtained their health care coverage through their employers, 2.3 million were enrolled in small group coverage and over 10 million were enrolled in large group insurance.[1] In the individual market, over 289,000 consumers signed up for coverage through Covered California during the COVID-19 special enrollment period which ran from mid-March through August. Recent estimates indicate over 13 million Californians are enrolled in Medi-Cal, and part of this growth was brought on by the Patient Protection and Affordable Care Act's (ACA) Medicaid expansion to low-income adults. As a result of the ACA, California also had the largest reduction in its uninsured population compared to any other state.[2] With these coverage gains,[3] health care spending also grew. The most recent data available for California indicate that health care spending in the state totaled $292 billion in 2014, compared to $266 billion in 2012 or $253 billion in 2011. According to a report "Getting to Affordability: Spending Trends and Waste in California's Health Care System (Getting to Affordability)," per capita spending in California has grown steadily over time for all sources of coverage – employer-sponsored insurance, Medi-Cal, Medicare, and private health insurance. Most of the spending comes from inpatient hospital stays and office-based medical provider services ($60 billion each), followed by prescription drugs ($45.6 billion).[4]

Nationally, the trends are not much different and health care spending in the United States (U.S.) has grown faster than the rest of the economy. In 2018, U.S. health care spending reached $3.6 trillion or $11,172 a year per capita, accounting for 17.7% of the nation's Gross Domestic Product (GDP), up from 13.3% of GDP in 1998 and 16.3% of GDP in 2008. In 2027, U.S. health care

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[1] Katherine Wilson, 2020 Edition – California Health Insurance Enrollment, California Health Care Foundation, July 31, 2020.
[2] Laurel Lucia, Miranda Dietz, and Ken Jacobs, *California's Health Coverage Gains Under the Affordable Care Act: What's At Stake in California v. Texas*, UC Berkeley Labor Center, September 28, 2020.
[3] *Id*. This fact sheet highlights the key health coverage gains made in California with its implementation of the ACA since it was enacted over 10 years ago on March 23, 2010, and how overturning the ACA in *California v. Texas* could have devastating impact on health care coverage in the state.
[4] Christine Eibner, Christopher Whaley, Kandice Kapinos, et.al., *Getting to Affordability: Spending Trends and Waste in California's Health Care System*, California Health Care Foundation, January 2020.

spending is projected to grow to 19.4%, a total of $6 trillion, and will account for nearly one-fifth of GDP. Public health insurance, including Medicare and Medicaid (Medi-Cal in California), paid the largest share of spending (41%), followed by private health insurance (34%), and consumers' out-of-pocket spending (10%).

The rise in health care spending means families are also paying more for health care. According to the 2020 Kaiser Family Foundation Employer Health Benefits Survey, for job-based coverage, the average annual premium for single coverage rose 4%, to $7,470, and the average annual premium for family coverage also rose 4%, to $21,342. Covered workers, on average, contributed 17% of the cost for single coverage and 27% of the cost for family coverage. The average premium for family coverage has increased 22% over the last five years and 55% over the last 10 years.[5] In California, the Getting to Affordability report states that the average cost of family health insurance plan is $20,000 per year, or almost one-third of the state's median family income. Premiums for the average family health plan in the employer market increased by 133% since 2002.

These increases in health care costs have burdened many California families because wages have not kept pace with health care spending. The UC Berkeley Labor Center (UC Labor Center) points out that since 2008, premiums for job-based family health coverage in California have grown by 49% on average; but real median wages have remained stagnant. For example, single coverage premiums averaged $8,712 per year in 2018, equivalent to $4 per hour for someone working 40 hours per week and for family coverage, the average annual premium was $20,843 which is equivalent to $10 per hour work for a full-time worker, which is $2 less per hour than the current $12 minimum wage for employers with more than 25 employees. In addition to rising premiums, out-of-pocket costs exacerbate the financial burden of health care coverage. The average deductible for a family now exceeds $3,000.[6] A UC Labor Center blog post states that the average deductibles in California have increased 84% for single enrollees and 77% for those with family coverage since 2008, after accounting for inflation. These affordability challenges are causing financial difficulties for those struggling to pay premium or medical bills, deter enrollment in and retention of coverage, and decrease access to care.

Price disparities

According to a policy brief entitled "The Sky's the Limit: Health Care Prices and Market Consolidation in California," California pays more for common health care services that the rest of the country. For example, the average price of childbirth across California was over $11,000 but neighboring Nevada and Arizona had average prices below $8,000. However, in addition to spending more for health care services than the rest of the country, there is wide price disparity in health care prices and premiums across the state. For example, vaginal delivery is 24% higher in Northern California than Southern California ($13,855 vs. $11,202); the average price of colonoscopy in Northern California is $1,007 while it is $887 in Southern California.[7] According

[5] Kaiser Family Foundation, *Employer Health Benefits 2020 Summary of Findings*, October 8, 2020.
[6] Christine Eibner, Christopher Whaley, Kandice Kapinos, et.al., *Getting to Affordability: Spending Trends and Waste in California's Health Care System*, California Health Care Foundation, January 2020.
[7] Richard M. Scheffler, Daniel Arnold and Brent Fulton, *The Sky's the Limit: Health Care Prices and Market Consolidation in California*, California Health Care Foundation, October 2019.

to a Petris Center report (Petris report), inpatient procedures were 70% higher in Northern California ($223,278) than Southern California ($131,586).[8] For outpatient procedures, Northern California prices were 17-55% higher than Southern California prices in 2014, depending on physician specialty. Additionally, premiums also vary widely across Covered California's 19 rating regions, with Northern California notably higher than Southern California. For example, a 50-year old individual would pay 19% more for an average bronze plan in Northern California than in Southern California.[9] However, premiums, hospital, and physician prices are not the only sectors where price disparities exists. Pharmacy costs range from an average of $650 per member per year in several locations, such as Alameda County, Central Valley North, Kern County, and much of the southeastern part of the state to $1,100 per member per year in San Francisco.[10]

One of the main reasons often cited for the price disparity and overall increases in health care cost is the pervasive consolidation in many healthcare markets, including hospital, physician, insurance, and pharmaceutical markets. Consolidation could come in several forms. Horizontal transactions merge two similarly-situated market participants, like hospitals or laboratories. Vertical transactions merge two entities at different levels of the same supply chain, for example a hospital acquiring a physician practice or a health care system acquiring a laboratory. Lastly, cross-market transactions occur when an entity in one market merges with or acquires another related market actor. [11]

During the last decade, approximately 800 healthcare transactions have occurred throughout the country, and the market for health care in the U.S. is more consolidated now. As of 2018, nearly 95% of hospital markets were highly concentrated, followed by markets for specialist physicians (77.5%), insurers (58.1%), and primary care providers (41.2%).[12] In California, the Petris report cited that of the 54 California counties with a hospital in 2016, 44 were highly concentrated, and six were moderately concentrated. For insurers, among the 58 California counties, 42 were highly concentrated and 16 were moderately concentrated. For the physician market, of the 57 counties analyzed, 12 counties were highly concentrated and 21 were moderately concentrated, 20 counties had highly concentrated orthopedic markets, 22 markets had highly concentrated cardiology markets, 24 counties had highly concentrated hematology/oncology markets, and 26 counties had highly concentrated radiology markets.[13]

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[8] Nicholas C. Petris Center for Health Care Markets and Consumer Welfare, *Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums*, University of California, Berkeley, March 26, 2018.
[9] Richard M. Scheffler, Daniel Arnold and Brent Fulton, *The Sky's the Limit: Health Care Prices and Market Consolidation in California*, California Health Care Foundation, October 2019.
[10] Christine Eibner, Christopher Whaley, Kandice Kapinos, et.al., *Getting to Affordability: Spending Trends and Waste in California's Health Care System*, California Health Care Foundation, January 2020.
[11] Jamie King, Samuel M. Chang, Alexandra D. Montague, et.al., *Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States*, Source on Healthcare Price and Competition, June 2020.
[12] *Id*.
[13] The Petris study used different data and methods in its analysis, primarily the Herfindahl-Hirschman Index (HHI), which is used by the U.S. Department of Justice and Federal Trade Commission to measure market concentration. The HHI measures market concentration on a range from 0 to 10,000. Markets with HHIs between 1,500 and 2,500 are considered to be moderately concentrated and those with HHIs higher than 2,500 points are considered to be highly concentrated.

Other sources of unnecessary spending

It should be noted that although health care industry consolidation plays a huge factor in health care costs and pricing variation, there are other sources of unnecessary spending. The Getting to Affordability report outlines six contributors of wasteful and unnecessary spending, including:

A. Overtreatment. Nationally, overtreatment accounts for up to $76 to 101 billion in health spending annually. Duplicate tests, prescribing treatment that have little or no value and ordering a high-cost treatment when a lower-cost treatment could have resulted in equivalent or superior quality of care all contribute to overtreatment;

B. Failures of care delivery and inadequate prevention. It is estimated that the U.S. spends $102 to $166 billion each year of all avoidable health spending treating conditions that are preventable, unnecessary, or avoidable; and,

C. Administrative complexity or administrative expenses. Nationally, high administrative expenses contribute about $266 billion in overspending. A 2005 analysis of administrative costs for private insurers, physician groups, and hospitals in California found that commercial insurers in the state spend about 10% of revenue on administration, physician groups spend about 27% of revenue on administration, and hospitals spend about 21% on administration.

Impact on consumers

The continuous year to year growth of health care spending is taking a toll on consumers. According to the 2020 Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey, conducted by the California Health Care Foundation (CHCF), Californians are worried about many types of health care costs, including unexpected medical bills and out-of-pocket expenses. Due to affordability issues, many residents reported delaying or skipping medical treatment or medications, including cutting pills in half or skipping doses. Additionally, 24% of those surveyed reported that they or someone in their family had problems paying for or were unable to pay medical bills within the past 12 months, and as a result, they have cut back on basic household needs like food and clothing, used up their savings, increased their credit card debt, taken on extra work, borrowed money from friends or relatives, or taken money out of their savings accounts. Although disturbing, the survey results are not surprising. Many Californians are also acknowledging the need for long-term solutions. Of those surveyed by CHCF, eight out of 10 residents (84%) rate making health care more affordable as an "extremely important" or "very important" priority for the Governor and Legislature to address in 2020.

State actions

Recognizing the need to control health care spending, Governor Newsom, in his 2020-21 Budget, proposed the creation of a cost containment entity called the Office of Health Care Affordability (OHCA). OHCA will be charged with increasing quality and price transparency, developing specific strategies and cost targets for the different sectors of the health care industry,

and imposing financial consequences for entities that fail to meet these targets. According to the Governor's announcement, the goal of the OHCA is to return savings to consumers directly impacted by increasing health care costs. Due to the COVID-19 pandemic, the Governor did not pursue this proposal.

This year, AB 2817 (Wood) was introduced to establish the OHCA to, among other functions, analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs, and create a strategy to control health care costs. Due to the COVID-19 pandemic, AB 2817 did not move but the author has expressed his intent to reintroduce this legislation next year.

The Legislature also passed AB 80 (Committee on Budget), Chapter 12, Statutes of 2020, a budget trailer bill, which establishes California's Health Care Payments Data System within the Office of Statewide Health Planning and Development (OSHPD), which would collect health care data submitted by health care service plans, health insurers, a city or county that offers self-insured or multiemployer-insured plans, and other specified mandatory and voluntary submitters. Among other provisions, AB 80 requires OSHPD to use the above-described data to produce publicly available information, including data products, summaries, analyses, studies, and other reports, to support goals that include improving public health, reducing disparities, and reducing health care costs.

Purpose of this hearing

The COVID-19 pandemic coupled with the severe recession illustrates the importance of having health insurance. Now more than ever, health insurance coverage is critical. However, Californians deserve affordable, accessible and quality health care that is financially sustainable. As the Legislature continues to evaluate efforts to control the growth of health care spending, this hearing is intended to provide background on health care costs, the drivers of health care spending, data needed to advance cost containment efforts, health care industry consolidation, and how affordability concerns are hindering care for many Californians. Options to control costs in California will also be included in the discussion.