Assembly
California Legislature
ASSEMBLY COMMITTEE ON HEALTH
JIM WOOD, CHAIR
ASSEMBLYMEMBER, SECOND DISTRICT

Informational Hearing
Cost Containment: Considerations for California
February 25, 2020
9:00 AM – 12:00 PM
State Capitol, Room 4202

BACKGROUND

INTRODUCTION

Health care spending in the United States (U.S.) has grown faster than the rest of the economy. According to the most recent data, U.S. health care spending reached $3.6 trillion in 2018 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 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 most recent data available for California indicate that health care spending in the state totaled $292 billion in 2014. According to a California Health Care Foundation (CHCF) report entitled, *"Getting to Affordability: Spending Trends and Waste in California's Health Care System* (*Getting to Affordability*)," per capita spending has grown steadily over time for all sources of coverage – employer-sponsored insurance, Medi-Cal, Medicare and private health insurance. Private health insurance coverage faced the highest growth rates at 4% per year. The report points out that 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).

According to the 2020 *Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey*, conducted by CHCF on how California residents view health care policy and their experiences with the health care system, 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. This survey also paints a picture of Californians worried about many types of health care costs, including unexpected medical bills and out-of-pocket expenses. Due to these 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.

More than half of Californians and their families (58%) obtain their health coverage through their employer, but wages have not kept pace with health spending. According to the UC Berkeley Labor Center (UC Labor Center), 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 premium costs, consumers are also facing higher out-of-pocket spending. The *Getting to Affordability* report points out that from 2000 to 2016, annual out-of-pocket patient spending increased by almost 36% for those with employer-sponsored coverage or an average annual increase of 2% per year while those with private, individual market coverage had an annual average growth rate of around 4%. The UC Labor Center states that 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.

COST CONTAINMENT

The growth in health care spending and affordability challenges are not unique to California; many states are exploring multiples ways to control spending, and one method is through the creation of cost containment commissions. According to a January 2020 CHCF report entitled *Commissioning Change: How Four States Use Advisory Boards to Contain Health Spending*, cost-containment commissions establish targets to make health care more affordable to consumers and improve the delivery of care. For example, the Maryland Health Services Cost Review Commission, established in 1972, is the oldest commission of its kind in the U.S. Maryland's commission was initially focused on setting payment rates for hospital services but its scope has been expanded to include total hospital budgets and targets for total statewide spending per capita. In 2012, the Massachusetts Health Policy Commission was established to monitor health care spending growth in Massachusetts and provides data-driven policy recommendations regarding health care delivery and payment system reform. Although the Oregon Health Authority is working on establishing a statewide growth benchmark for health care costs, since 2009, it has been focused on controlling costs for the state's Medicaid program and premium costs for state employee health plans, and in 2012 received a federal waiver to cap its Medicaid cost growth to 3.4% per year, which was eventually applied to state employee health plans.

According to the National Conference of State Legislatures, other options for containing or reducing health care costs and improving efficiency in health care include: administrative simplification; global or fixed prepayment to health providers; public health promotion; medical homes; combating health care fraud and abuse; prescription drug agreements and volume purchasing; use of generic prescription drugs and brand-name discounts; all-payer rate setting; performance-based health care provider payments; and establishing an all-payer claims database. The *Getting to Affordability* report explored six areas of cost containment that target unnecessary spending in California: overtreatment; failures of care delivery and inadequate prevention; failures of care coordination; administrative complexity; pricing and market inefficiencies; and, fraud and abuse.

PURPOSE OF THIS HEARING

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.

As the Legislature evaluates efforts to control the growth of health care spending, including the proposed OHCA and its structure, regulatory authority and scope, this hearing is intended to provide background on how state cost containment commissions, like those established in Massachusetts and Oregon, measure, monitor, and establish targets to control health care cost increases while improving the quality of health care. The drivers of health care spending, including health care industry consolidation, and other cost containment considerations and approaches will be included in the discussion.