California Legislature

SENATE COMMITTEE ON HEALTH

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Making Health Care Affordable: Exploring California Efforts
March 5, 2014, 1:30 p.m.
State Capitol, Room 4203

Purpose of hearing:

The Senate Committee on Health has convened health care experts to discuss initiatives underway in California directed at controlling the growth of health care costs. The hearing will serve to educate members and the public about potential state policy solutions to control health care costs as millions of Californians obtain coverage under the Affordable Care Act (ACA). The hearing should also provide a better understanding of why health care is so expensive and why there are significant variations in health care costs depending upon where a person lives or which hospital performs a procedure. The Chair would like to develop an action agenda for California policymakers to ensure California's health care costs are appropriate and health care premiums are affordable.

Background on health care costs:

While reports indicate that health care costs are increasing at a slower pace in recent years, health care still accounts for over 17 percent of the U.S. Gross Domestic Product and health care costs continue to consume significantly large percentages of federal, state and personal budgets. Whereas most sectors keep pace with the overall economy, health care continues to grow at higher rates than inflation. According to a 2013 Health Care Almanac report on health care costs published by the California HealthCare Foundation (CHCF), the average annual growth rate has declined since 1981 and has remained flat over the last three years at a historic low of 3.9 percent. Health spending in 2011 was only slightly higher than inflation. Annual average health care spending has been in the single digits (as compared to double digits) for the last two decades, influenced recently by the recession. However, some provisions of the ACA are expected to cause a one-time spike in growth.

According to a May 2012 Primer published by the Kaiser Family Foundation, the U.S. spends substantially more on health care than other developed countries. In 2009, U.S. spending was 90 percent higher than many other industrialized countries. Some researchers believe the U.S. pays

more for health care because prices are higher, technology is more readily available, and Americans have greater rates of chronic disease.

The CHCF report indicates that hospital and physician services, combined, account for just over half of U.S. health care expenditures. Prescription drugs account for another 10 percent.

Health care is paid for through insurance premium payments, out-of-pocket expenses, and payroll taxes, or by directing general taxes to health care. If amounts people pay in payroll taxes for Medicare are included, households and the government are the largest purchasers of health care. According to the CHCF report, approximately 78 percent of private business spending on health care consists of employer contributions to insurance premiums for workers. In contrast, household out-of-pocket spending consists largely of spending on premiums, copays, coinsurance, and items not covered by insurance.

Millions of people are expected to obtain health care coverage or switch to more comprehensive coverage because of the ACA. The ACA makes private insurance more available and affordable for many and includes a simplification and expansion of Medicaid for lower income populations including adults without children. The coverage expansions of the ACA should reduce the need for cost shifting where providers charge more to commercial coverage to make up for losses associated with patients without health coverage or those in underfunded public programs.

California initiatives:

State Health Care Innovation Plan

California, through the California Health and Human Services Agency (CHHS) and the "Let's Get Healthy California" Task Force, has developed a draft State Health Care Innovation Plan (SHCIP) with the support from a federal State Innovation Model (SIM) grant. This effort is referred to as Cal-SIM. The draft SHCIP offers some of the following insights into health care in California.

<u>In general, Californians are young and healthy.</u>

California is the most populous state, accounting for 12 percent of the U.S. population. California is the sixth youngest state, with a median age of 35 years compared to a national average of 37 years. California's population over 65 will nearly double over the next 20 years, a faster rate than the U.S. average. California has a lower infant mortality rate, more individuals meeting physical activity guidelines, fewer smokers, and fewer obese adults than the national average. California's per capita heath spending is below the national average and ninth lowest in the nation ($6,238 compared to $6,815 nationally in 2009). Medi-Cal per capita spending falls significantly below the national average ($4,569 compared to $6,826 nationally in 2009).

<u>California has high rates of elective deliveries at some hospitals.</u>

Half of all births (506,023) are paid for by Medi-Cal. California has a statewide cesarean delivery rate of 33 percent but some hospitals have rates as high as 71 percent. Elective delivery rates are associated with increased risk to mothers and neonatal morbidity and longer hospital stays.

High costs are associated with the elderly and medically complex.

California Medicare per capita spending is higher than the national average. Across all payers, five percent of the population accounts for over half of expenditures in a typical year. Hospice utilization in California lags significantly behind the national average (16.8 versus 21 days of hospice in the last six days of life). Medicare per decedent reimbursements were $46,686 in 2010 in California compared to $43,728 nationally. Relative to the national average, California tends to have higher rates of care utilization in the last two years of life.

The state suffers from health workforce shortages in some areas and a lack of diversity.

Only 16 of 58 California counties meet the nationally recommended ratio of primary care physicians per capita; eight counties have fewer than half of the recommended number. Less than 25 percent of medical graduates go into primary care, leading to a reliance on foreign medical graduates who comprise a significant share of the state's primary care physician workforce. With regard to specialty care some areas exceed recommended supply while the Central Valley and Riverside-San Bernardino experience shortages. As a step towards addressing shortages in the region, California recently began enrollment at its first new medical school in 40 years at University of California, Riverside. More than 10 percent of the population lives in Office of Statewide Health Planning and Development designated mental health professional shortage areas. Additionally Latinos comprise 38 percent of the California population, but only account for five percent of physicians and eight percent of nurses.

SHCIP

According to the draft SHCIP, the plan balances the need to realize savings over the next three years with the longer-term goal of accelerating broader public and private sector health care transformations. A target has been set to bring California's health care expenditure growth rate in line with that of the gross state product by 2022, along with establishing targets for 38 health indicators. The SHCIP is projected to yield savings of $1.3 to $1.7 billion over three years – a return of over 20-fold on the potential $60 million SIM investment.

The SHCIP includes four initiatives:

1. Maternity Care – Promote safe, evidence-based deliveries to improve birth outcomes, promote maternal and infant health, and reduce unnecessary costs.

2. Health Homes for Complex Patients – Implement and spread care models, which include coordinated, team-based care, to improve the quality of care and outcomes for medically complex patients, and reduce costs associated with unnecessary emergency department visits and hospitalizations.

3. Palliative Care – Promote the use of palliative care, when appropriate and in line with patient preferences, by educating patients, training providers, and removing any structural or informational barriers to receiving care.

4. Accountable Care Communities – Support development of Accountable Care Organization (ACO) pilots that model how population health can be advanced through

collaborative efforts that promote shared responsibility.

The plan also suggests six building blocks to address data, transparency and accountability issues:

1. Workforce – Leveraging and advancing team-based culturally engaged health services and enhancing community-based health and other lower-cost workers, where appropriate.
2. Health Information Technology – Target high need entities and geographies, develop health homes, and support research and analysis.
3. Enabling Authorities – Identify and secure needed policy changes that remove barriers or create incentives to achieve the goals of SHCIP.
4. All-Payer Claims Database (APCD) – Build on current efforts to create integrated data systems to support data collection and analysis for comparisons of costs, performance, and outcomes across all populations, providers, and regions of the State.
5. Public Reporting – Enhance state efforts to make health care quality and cost data readily available and accessible to stakeholders and the public.
6. Payment Reform Innovation Incubator – Support an expanded forum to facilitate payers, providers and purchasers to build consensus related to payment reforms.

Price Transparency

Several state and national transparency initiatives have highlighted variation in health care costs based on geographic differences. Factors that can contribute to variation can include: market power and competition, payment methodology, technology, patient mix, and cost-shifting. With the proper data, purchasers, policymakers, and stakeholders can learn more about price and payment differences. According to a 2013 Action Brief by the Catalyst for Payment Reform, the single biggest driver of increases in health care spending is the increase in unit prices - the cost of hospital and physician services and medications in both inpatient and outpatient settings. The Action Brief states that with price variation as high as 700 percent for selected services in some markets and significant differences in quality, price information must be available to those who need to make decisions or who guide consumers in making decisions. Price transparency is a necessary element to controlling costs, but price transparency alone is not enough.

Sharp Community Medical Group

Sharp provides a case study comparing fee-for-service (volume-based) and accountable coordinated care (value-based), through the story of two patients, Margaret and Donna. The medical treatment of these two patients with the same congestive heart failure condition is compared to show how a volume-based system produced a negative patient outcome at a cost of $172,000 and a value-based system achieved a beneficial treatment outcome at a cost of $42,000.

Integrated Healthcare Association

The Integrated Healthcare Association (IHA) is a statewide, nonprofit multi- stakeholder leadership group that promotes quality improvement, accountability, and affordability of health care in California. IHA convenes health care stakeholders across sectors and incubates pilot projects. One such project is the California Payment for Performance (P4P) program on behalf of eight health plans: Aetna, Anthem Blue Cross, Blue Shield of California, Cigna Healthcare of California, Health Net, UnitedHealthcare, Western Health Advantage, and Kaiser Permanente (public reporting only), representing 9 million enrollees. Through this project, quality and, more recently, cost reporting is being conducted on 35,000 physicians in nearly 200 physician groups.

Additionally, through this project a Total Cost of Care marker has been developed. Total Cost of Care is the total amount paid to a physician group to care for a population for one year. The Total Cost of Care includes professional facility (inpatient and outpatient), pharmacy, ancillary costs, capitation, fee-for-service, member cost share, and administrative adjustments collected from Health Maintenance Organizations (HMO) and Point of Service (POS) plans. The data is adjusted for risk and geographic variation.

According to a September 2013 IHA Issue Brief, physician organizations are highly engaged in understanding their Total Cost of Care results because they have clear and complete information on their cost performance relative to their peers. Initial results show risk-adjusted Total Cost of Care, on a per member per year basis ranges from under $2,300 to approximately $5,500 for 2012. The physician groups at the high end are more than twice as costly without strong correlation to quality.

California Healthcare Performance Information System

The California Healthcare Performance Information System (CHPI) is a physician performance database with statistical analysis that will eventually publish information online. According to the CHPI website, output will be an analysis of claims data aggregated from more than 12 million patients enrolled in CHPI's three participating California health plans—Blue Shield, Anthem Blue Cross and UnitedHealthcare, as well as Medicare. CHPI was federally certified to include data from Medicare's five million California beneficiaries, and became the first Qualified Entity to receive Medicare data.

CHPI will initially cover primary care physicians and some specialists, including cardiology and endocrinology. Physicians' performance scores will be based on evidence-based indicators vetted and used by standard setting organizations such as the National Quality Forum and National Committee for Quality Assurance. CHPI will include efficiency and resource use metrics, such as whether the physician prescribed generic drugs as opposed to more expensive brands. In a few years, CHPI hopes to add data on the *allowed* cost of care paid by health plans. With this new information, CHPI will make public the Total Cost of Care for many conditions or episodes side-by-side with quality care data.

California Public Employees Retirement System

A December 2013 Research Brief by the Center for Health Systems Change describes a strategy California Public Employees' Retirement System (CalPERS) adopted in 2011 referred to as

"reference pricing," which guides enrollees to hospitals that provide hip and knee replacements below a certain price threshold. According to the brief, the use of reference pricing for inpatient hip and knee replacements by CalPERS is among the most prominent examples of reference pricing in the United States. After reviewing quality and cost information, CalPERS set a threshold of $30,000 for hospital payments for both procedures and designated certain hospitals where enrollees could get care at or below that price. Enrollees who have surgery at designated hospitals pay their plans' standard deductible and coinsurance up to the out-of-pocket maximum. Enrollees can go to other in-network hospitals for care but are responsible for both the standard cost sharing and all allowed amounts exceeding the $30,000 threshold, which are not subject to an out-of-pocket maximum. CalPERS saved $2.8 million for CalPERS and $300,000 in cost sharing for enrollees in 2011 without sacrificing quality, according to a study published in Health Affairs in August of 2013. According to the December 2013 brief, questions remain about the ability of other employers, particularly those with less leverage, to achieve similar savings through reference pricing.

Another CalPERS initiative was profiled in a September 2012 Health Affairs article. The article describes an alternative payment and delivery accountable care pilot between Blue Shield of California and health care providers that used an annual global budget for total expected spending under which risk and savings were shared among partners providing health care. The patient population consisted of members of CalPERS. According to the article, the model shows early promise for its ease of implementation and effectiveness in controlling costs. During the two year period, the total compound annual growth rate for per-member per-month cost was approximately three percent, which is less than half the rate at which premiums rose over the past decade. Some of the savings stemmed from declines in inpatient lengths-of-stay and 30-day readmission rates. The article states that results suggest that the approach can achieve considerable financial savings in as little as one year and can gain wide acceptance from reform-minded providers.

San Diego Electrical Health and Welfare Trust

As described in the May 2013 issue of Benefits Magazine, the San Diego Electrical Health and Welfare Trust, responsible for 5,000 members, has slowed growing health care costs without reducing benefits. Over the last three years, the hourly cost to fund its health plan has declined by 0.5 percent. Over the last 10 years, the trust's cost has increased an average of 3.8 percent annually; whereas, the average monthly claims cost per employer has declined over the previous three years. This has been done by utilizing tiered physician networks, not only offering, but incentivizing, expert validation of diagnosis and treatment plans, disease management, dependent verification, and screening for fraud, waste, and abuse.

California Department of Insurance

In September 2013, the California Department of Insurance (CDI) was awarded approximately $5.2 million as part of the U.S. Department of Health and Human Services Cycle III Rate Review Grant awards to review unreasonable rates and enhance the transparency of health care costs. In November 2013, CDI posted a solicitation requesting information regarding contracting with a vendor to collect, analyze, and publish health care cost information. The request for

information solicits information and suggestions from qualified service providers as part of a market research effort for the CDI's health care price transparency project. The bid period closed in early December.

Conclusion and next steps:

Experts seem to suggest that identifying actual health care costs is the first step toward reigning in rising health care costs. Additional steps include incentivizing quality, payment reforms, selective contracting and guiding consumers to providers who meet certain standards. Some researchers have recommended oversight and intervention in situations of consolidations and excess market power. The Committee plans to continue learning about successful initiatives to control health care costs, while ensuring quality health care for Californians.

Resource List

Health Care Costs: A Primer: Key Information on Health Care Costs and Their Impact. The Henry J. Kaiser Family Foundation, May 2012

California Health Care Almanac: Health Care Costs 101: Slow Growth: A New Trend? California HealthCare Foundation, September 2013

Draft State Health Care Innovation Plan, State of California, October 10, 2013

Action Brief: Ensuring Competitive Markets for Health Care Services. Catalyst for Payment Reform, November 2013

Health Systems Change Research Brief Number 30: The Potential of Reference Pricing to Generate Health Care Savings: Lesson from a California Pioneer. December 2013

Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery. James C. Robinson and Timothy T. Brown. *Health Affairs*, 32, no.8 (2013):1392-1397

A Global Budget Pilot Project Among Provider Partners And Blue Shield Of California Led To Savings In First Two Years. Paul Markovich. *Health Affairs*, 31, no.9 (2012):1969-1976

What's Working: Cost Containment Efforts Paying Off. Chris Vogel. *Benefits Magazine.* Volume 50. International Foundation of Employee Benefit Plans. May 2013

California Healthcare Performance Information System: Producing the Information Californians Need to Identify the Best Doctors: Program Summary. Pacific Business Group on Health, December 31, 2013

California Pay for Performance. Integrated Healthcare Association. www.iha.org/p4p_california.html