California Legislature

SENATE COMMITTEE ON HEALTH

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Informational Hearing
Making Health Care Affordable: What's Driving Costs?
February 4, 2015 -- 1:30 p.m.
State Capitol, Room 4203

Purpose of the hearing

In March 2014, the Senate Committee on Health convened several health care experts to discuss factors that contribute to the growing cost of health care in California and efforts to make care more affordable. This is the second in a series of hearings on health care cost containment. This hearing will serve to educate members and the public about some of the cost drivers within the health care system, and provide a better understanding of why health care is so expensive. The Chair would like to identify cost drivers in an effort to understand if health care costs are appropriate and to keep focus on the need for affordable health care premiums.

Background on health care costs

According to a 2014 report by the California HealthCare Foundation, the rate of increase in health care costs has declined since 1981, and last year reached an historic low of 3.7 percent. Annual average health care spending has been in the single digits for the last two decades, influenced recently by the recession. However, health care still accounts for more than 17 percent of the U.S. Gross Domestic Product, and health care costs continue to consume significantly large percentages of federal, state, business, and personal budgets. According to a May 2014 report published by the Kaiser Family Foundation, the U.S. spends substantially more on health care than other developed countries.

The rising price of pharmaceuticals is often pointed to as a major driver for health care costs, but prescription drugs account for only nine percent of U.S. health care expenditures. By comparison, hospital and physician services account for over half of health care costs. Additionally, some researchers believe the U.S. pays more for health care because technology is more readily available, and Americans have greater rates of chronic disease.

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. A number of states have established All-Payers Claim Databases (APCDs) in order to make data available to consumers. An APCD typically includes data derived from medical, provider, pharmacy, and dental claims, along with eligibility and provider files, from private and public payers. APCDs seek to promote transparency by consolidating a range of data from multiple payers and other entities throughout the state and supporting efficient access to these data. In California, the California Healthcare Performance Information System (CHPI) is a voluntary 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 United Healthcare, 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.

In another similar project, the University of California, San Francisco is working with the California Department of Insurance (CDI) on a medical cost and quality transparency website. According to CDI, the website will report average prices paid for episodes of care or annual costs for chronic conditions, as well as quality measures where available. Prices will be aggregated across payers and providers, and shown at the regional level based on the 19 California rating regions (some regions may need to be consolidated pursuant to the terms of the data license agreement). The website is expected to provide price information for 95 to 99 episodes of care or conditions; and, five to 15 of those episodes or conditions will have both price and quality information as well as consumer education content created by Consumers Union. Quality information will consist of existing performance, appropriateness, and outcome measures.

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 price variation can be as high as 700 percent for selected services in some markets, and quality can differ significantly. The brief suggests price information must be available to those who make decisions or those who guide consumers in making decisions. Price transparency is a necessary element to controlling costs, but price transparency alone is not enough.

Company Consolidation

According to a 2012 policy brief from the Robert Wood Johnson Foundation, consolidation of health care companies and providers can make it easier for organizations to comply with federal reporting mandates and can make a health system more efficient. However, health care conglomerates can also drive up the cost of care by monopolizing geographical markets and limiting competition. This is especially relevant in rural areas with fewer health care options.

As an example, in 1999, Sutter Health-owned Alta Bates Hospital merged with one of its competitors, Summit Medical Center. The Federal Trade Commission reports that following the merger, prices increased 29 to 72 percent. Sutter Health has since acquired several surgical

centers and medical groups and operates 23 hospitals across northern California. In a 2011 community benefit report, the company stated that, "In many [of] Northern California's underserved rural locales, Sutter Health is the only provider of hospital and emergency medical services in the community". In comparison, southern California does not have a system with as large a market share, and prices for identical services often cost much less. A 2014 study published in the Journal of the American Medical Association demonstrated that patient expenditures were lower when medical groups were physician-owned and independent, as opposed to being owned by either local hospitals or large, multi-market systems. Research also demonstrates that consolidation of care does not necessarily lead to increased quality of care.

Blue Shield Insurance, which contracts with Sutter Health, claims the company is violating antitrust and competition laws, and is using its market power to increase prices and force disputes out of courts and into arbitration. United Food and Commercial Workers (UFCW) has also filed an anti-trust lawsuit against Sutter Health. If negotiations between Blue Shield and Sutter Health fail, it may mean that 270,000 Blue Shield customers across California would have to find new physicians. At this time, talks and lawsuits are ongoing.
Hospitals contend that the real cause of cost increases is not the lack of competition. An article published in Modern Healthcare in August 2012 pointed out that an increasing number of procedures are being done on an outpatient basis, leaving only the sickest and most costly patients to receive care in the hospital. Per patient, the average cost is going up, but the system is saving money by admitting fewer patients overall.

A study published in Health Affairs in May 2014 outlined strategies to stimulate price and quality competition. These strategies include disclosing price, quality, and efficiency data to the public, limiting provider consolidation through antitrust enforcement, limiting charges for out-of-network providers, and providing point of service incentives.

Technology
The rising cost and use of technology in the health care setting also contributes to increases in health care spending in the U.S. Some estimates show that 38 to 65 percent of spending increases can be attributed to new technology. For example, MRI machines are much more common in the U.S. than they are in comparable countries, and we perform more MRIs per patient than any other country. According to a 2012 international comparison of supply, utilization, prices, and quality conducted by The Commonwealth Fund, the cost of the MRIs is between 200 and 800 percent more expensive than in other comparable countries. Hospitals and doctors can be incentivized to overuse technology for a number of reasons. The first is "defensive medicine", in which a doctor will order more tests than may be necessary in order to defend against potential malpractice suits. The second is to increase profit; expensive imaging equipment can pay for itself in a year, despite having an operating life of ten years.

The effect of new technology on overall spending depends on a number of factors. If the technology leads to treatment of previously untreatable conditions, improves the capacity to treat more patients, broadens the ability of diseases to be diagnosed, requires hiring additional staff to run new equipment, or extends the life of patients that will use more services in the future, costs may go up. However, if new technology reduces staff time, enables procedures to be done on an outpatient basis, or decreases future complications, costs may go down.

Pharma and Biotech

Federal regulations prohibit the U.S. government from setting the price of pharmaceuticals, and patents on drugs, in effect, void competition, at least initially. Countries without these restrictions generally buy drugs for a fraction of the U.S. price. Pharmaceutical companies argue that high drug prices are justified because of the enormous cost and risk associated with bringing a drug to market and that payment for current drugs funds future innovation. Developing a new drug costs an average of $1.2 billion and takes 10 to15 years. When a new drug provides a cure for a disease, as opposed to only treating symptoms, drug companies claim that a high upfront cost is mitigated by not having to treat symptoms indefinitely. The current controversy over the Hepatitis C drug Sovaldi demonstrates these principals.

Hepatitis C treatment: A Case study

Hepatitis C is a liver disease caused by the Hepatitis C virus (HCV) and usually spreads through blood. Hepatitis C can range in severity from a mild illness lasting a few weeks to a lifelong illness. About 80 percent of patients who have an HCV infection develop a chronic infection. According to the Centers for Disease Control and Prevention (CDC), millions of Americans have Hepatitis C, but most don't know it because people often have no symptoms and can live with an infection for decades without feeling sick.

Hepatitis C is a leading cause of liver cancer and the leading cause of liver transplants. According to data from 1999 to 2008, about three-fourths of U.S. patients with HCV infection were born between 1945 and 1965. The most important risk factor for HCV infection is past or current intravenous drug use. According to the CDC, there were an estimated 16,000 new cases of HCV infection in 2009 and an estimated 15,000 deaths in 2007.

In December 2013, the federal Food and Drug Administration (FDA) approved a drug produced by Gilead Sciences called Sovaldi for the treatment of HCV. Sovaldi represents a significant advance in therapy for HCV as it provides a higher cure rate, allows for a shorter duration of treatment, has fewer adverse effects, and opens up treatment options for individuals with comorbid conditions for which traditional treatments are contraindicated. While the drug has been found to be remarkably effective (curing 90 percent or more of patients over the course of 12 weeks, according to the FDA), Gilead Sciences has come under heavy fire for the price of the drug treatment. Sovaldi is priced at $1,000 per pill, which brings the cost associated with a 12-week treatment regimen to $84,000. Gilead Sciences reported it sold $2.27 billion worth of Sovaldi in the first quarter of 2014, a number that beat Wall Street estimates by $1 billion, according to an April 23, 2014 article in Bloomberg. However, a 12-week regimen of Sovaldi doesn't cost $84,000 everywhere. According to a 2014 article in the San Francisco Chronicle, Gilead prices the treatment at $57,000 in the United Kingdom and $66,000 in Germany. In Egypt and other developing countries, the treatment costs $900, which is 99 percent less than the U.S. cost.

In his 2015-16 Budget, Governor Brown included $300 million in additional funds to cover HCV treatment over the next two years. By law, Medi-Cal has to cover all drugs that are approved by the Food and Drug Administration (FDA). The price of treating HCV will affect California's budget, as over 70,000 Medi-Cal patients have a chronic infection. Sovaldi is also of particular

interest for both the prison population and the AIDS community, as the rate of HCV infection among prisoners is significantly higher than the general population, and 33 percent of AIDS patients are coinfected with HCV. According to the CDC, in the general population, one to 1.5 percent of people are infected with HCV, compared with 16 to 41 percent among prisoners. A recent study put the cost of treating HCV in the Medi-Cal and prison population at $6.6 billion. As of October 2014, only 162 California prison patients, out of more than 17,000 that are infected with HCV, have been treated with Sovaldi. According to California Correctional Health Care Services, prison health care systems are staying within their budgets by prioritizing patient need, and only treat those patients with advanced disease.

Whereas the government does not set the price of a drug, private insurance companies and government agencies are able to negotiate prices. In late December 2014, the FDA approved an HCV drug regimen called the Viekira Pack, made by AbbVie. Insurance companies now had an HCV treatment option comparable to Sovaldi, and the competition has led to deals between drug companies and insurance companies. Soon after Viekira Pak's approval, AbbVie made an agreement with Express Scripts, which negotiates drug prices for a number of large insurance companies. Express Scripts was able to secure Viekira Paks at an undisclosed rate; in return, insurance providers loosened restrictions on which care givers are able to write prescriptions for Viekira Paks, and how ill patients had to be in order to receive treatment. Express Scripts also promised exclusivity for Viekira Paks if both it and Sovaldi were viable options.

Alternately, CVS Health has contracted with Gilead to make Sovaldi the preferred treatment, and will only cover Viekira Paks in exceptional circumstances. U.S. Veterans Affairs has also negotiated a 40 percent price break with Gilead, and has added Sovaldi to its own list of prescribable drugs.

Conclusion and Next Steps

Data show that the cost of health care has been rising at a slower pace in the last few years, but health care costs take up a growing portion of private and public funds. Changes in health care business practices and advances in technology and pharmaceuticals will continue to influence the price of health care in the future. Variation in prices also needs to be better understood. Biotech companies, hospitals, health plans, health care providers and the government will have to work together to insure the best care for the highest number of Californians.