California Legislature

SENATE COMMITTEE ON HEALTH

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Informational Hearing
Making Health Care Affordable: Impact on Consumers
March 18, 2015 -- 1:30 p.m.
State Capitol, Room 112

Purpose of the hearing

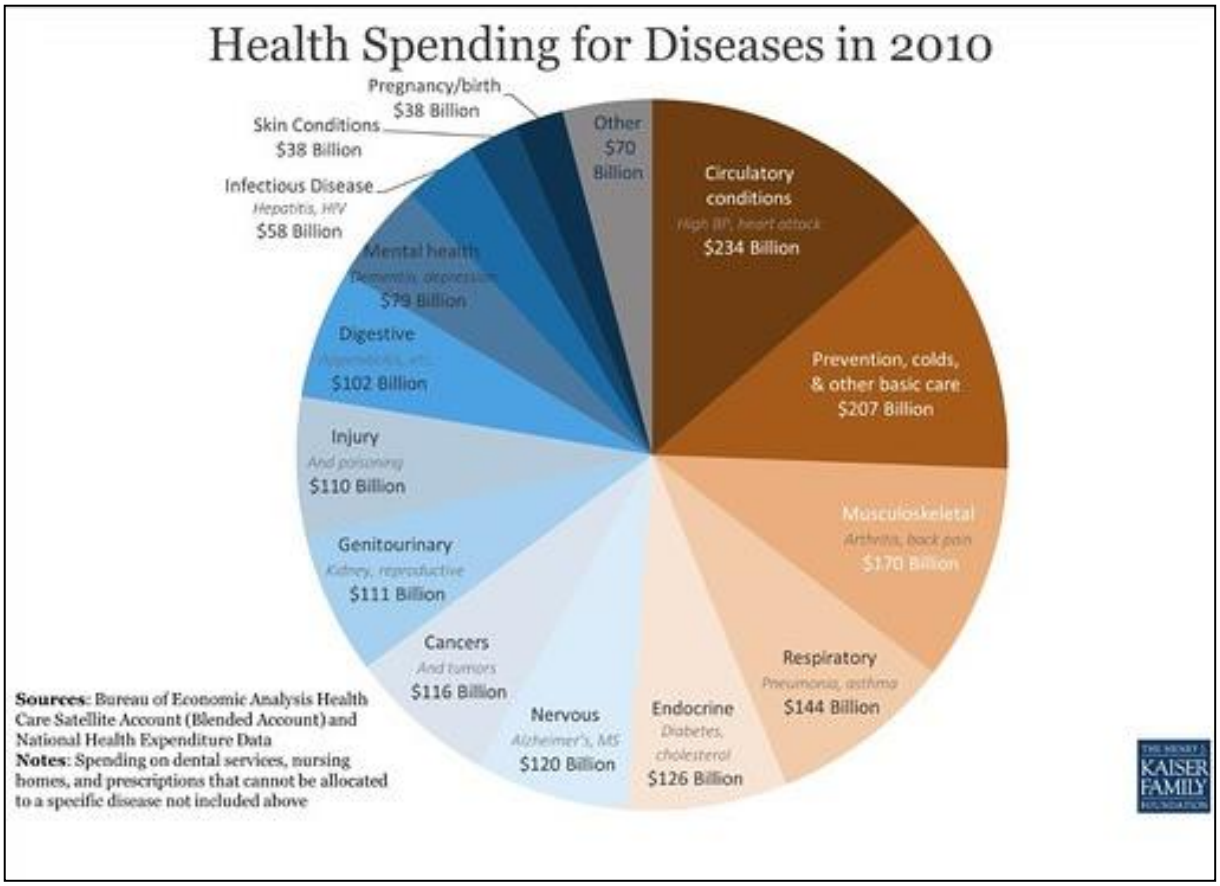
In March 2014, the Senate Committee on Health convened several health care experts to discuss factors that contribute to the growing cost of health care in California and efforts to make care more affordable. At a second hearing in February of this year, the Committee heard testimony related to some major cost drivers in the health care system, including pharmaceuticals, hospital costs, and the effects of geographic location on contracting. This hearing is the third in the series, and will serve to educate members and the public about the effect of health care costs on consumers. Consumers are impacted by high health care costs in a variety of ways including through the premium share they are required to pay as well as deductible, coinsurance copayment requirements, benefit designs, and access to broad or narrow provider networks. Patients with complex medical conditions can face higher financial burdens or less access to broader networks of providers.

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.

Armed with health insurance, consumers may be surprised to by their own financial burden when diagnosed with a specific disease. According to a March 3, 2015, op-ed in the Wall Street Journal, the Bureau of Economic Analysis (BEA) has contributed to making health spending more comprehensible for consumers by analyzing health spending and price growth

by common diseases and diagnoses such as cancer, heart disease, diabetes, and even the common cold. The BEA analyzed health spending by disease from 2000 to 2010, sorting diseases and diagnoses into categories. Illustrated by the chart below, circulatory conditions like high blood pressure and heart attacks accounted for $234 billion dollars of America's health care spending, which is more than the cost of care for cancer, infectious diseases, pregnancy, and birth combined. Arthritis and back pain cost $170 billion, whereas diabetes and high cholesterol only cost $126 billion.



Employer-Based Coverage

Employer-based coverage is the leading source of health insurance in California as well as nationally. However, as the prices of health care services have risen, employers have taken steps to contain costs, either by increasing employee contributions in the form of higher copays and deductibles or sharing in the cost of premiums, or by limiting or eliminating coverage altogether. According to the Kaiser Family Foundation/Health Research & Educational Trust (HRET) 2014 Employer Health Benefits Survey, between 2006 and 2014, the percentage of employer-covered workers that had to pay a deductible went from 55 percent to 80 percent. At the same time, the average size of the deductible for a single person increased from $584 to $1217. Over the last

decade, the average premium for family coverage has increased 69 percent, with 81 percent of that increase shouldered by the family. In 2014, the average annual premium for employer-sponsored health insurance was $6,025 for single coverage and $16,834 for family coverage, a two percent and three percent increase, respectively, over the previous year. During the same period, workers' wages increased 2.3 percent and inflation increased two percent. Increased premiums are eventually passed on to the employee in the form of decreased wages. A study in the Journal of Labor Economics found that a 10 percent increase in health premiums results in a decrease in wages by 2.3 percent.

Children with Special Health Care Needs

Children with special health care needs (CSHCN) are children who have a chronic physical, developmental, behavioral, or emotional condition and who require health services of a type or amount beyond that required by other children. CSHCN use more health care services than other children and consequently have higher health care expenditures. Data from the 2009-2010 National Survey of Children with Special Health Care Needs show that 10.6 percent of children in California qualify as having special health care needs. The survey also showed that families of CSHCN experiencing high out-of-pocket expenses (exceeding five percent of family income) were approximately 11 times more likely to be from households with incomes below 200 percent of the federal poverty level (FPL) than to be from families with incomes at or above 400 percent FPL. Insurance plays an important protective role for families of CSHCN, but it still provides incomplete protection because specialty services and therapies are not covered by some plans.

Tiering

Health plans are structuring benefit cost sharing arrangements in ways to impact consumer utilization of high-cost, often lower quality providers and high-cost specialty drugs. As described in a paper on tiering arrangements published in September 2007 by the Department of Health Policy at George Washington University Medical Center, physician tiering typically appears to be targeted at specialized, selected high-cost procedures. Tiering techniques and methods may be tied to physician performance against evidence-based guidelines and consensus standards specified by the plan, with actual performance calculated via proprietary algorithms.

With regard to drugs, a report in the Wall Street Journal published on March 10, 2015, states that growth in drug spending had been relatively modest in recent years because of the introduction of generic versions of mass-market drugs like Pfizer's cholesterol-lowering drug Lipitor, which lost patent protection in 2011. From 2009 through 2013, annual drug spending by commercial health plans rose by an average of 4.2 percent, according to an annual report from Express Scripts Holding Co., which is based on a sample of the roughly 85 million people who receive prescription-drug benefits through them. However, new specialty medications for diseases like hepatitis C and multiple sclerosis contributed to a sharp increase in spending last year. The drugs treat relatively small numbers of patients, but can cost between $50,000 and $100,000 annually per patient. A number of stakeholders in California, including health plans, the Administration, and consumer advocates, have expressed concern with such high -cost drugs, which contributed to a sharp increase in spending last year. According to the Wall Street Journal article, spending

on specialty medications in 2014 rose by an average of 38 percent across Medicare, Medicaid and commercial insurance plans in the U.S.

Some have raised the point that the potentially discriminatory nature of high-cost specialty tiers is in conflict with the Affordable Care Act (ACA), which prevents denial of health care coverage on the basis of pre-exiting conditions. A January 2015 study in the New England Journal of Medicine found evidence that insurers may be using alternative methods to keep high-cost patients from enrolling. For example, some plans have put all HIV drugs, including generics, in the top tier of their formularies, making patients pay 30 percent or more of the cost out of pocket. The study suggests that this "adverse tiering" dissuades HIV and AIDS patients from joining certain health plans.

Physician Self-referral

Consumers can face higher costs and potentially unnecessary risk in some cases where financial incentives or convenience may drive inefficient use of services. Generally, "physician self-referral" occurs when a physician refers patients to places where he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation). A March 2015 report on the subject by the Governmental Accountability Office (GAO) found that:

*1. Self-referrals cost taxpayers and pose serious risks to patients***.** In 2010, health care providers who self-referred for advanced imaging likely made 400,000 more referrals for advanced imaging services than they would have if they were not self-referring. The cost of those additional referrals to Medicare was estimated to be $109 million. GAO adds: "To the extent that these additional referrals were unnecessary, they pose unacceptable risks for beneficiaries, particularly in the case of CT services, which involve the use of ionizing radiation that has been linked to an increased risk of developing cancer."

2. The pace of doctors referring patients to places where they have a financial stake is increasing more quickly than referrals to an independent health care provider. The GAO found that "the number of self-referred MRI services increased over this period by more than 80 percent, compared with an increase of 12 percent for non-self-referred MRI services." Doctors who self-refer tend to recommend extra care more frequently. If doctors have a stake in a MRI service, they recommend it about twice as frequently as providers who do not self-refer. The GAO reported that its analysis suggests "that financial incentives for self-referring providers were likely a major factor driving the increase in referrals."

3. Once a doctor starts to self-refer patients, the rate at which they refer goes up quickly. When physicians with prostate cancer patients did not have a financial stake, they referred a smaller percentage of their patients to Intensity-Modulated Radiation Therapy (IMRT) services, about 37 percent. When those same physicians switched to self-referrals, that fraction grew to 54 percent.

Price Transparency

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. 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.

All-Payers Claim Databases (ACPDs)
A number of states have established APCDs in order to make pricing 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.

UCSF and CDI: Cost and Quality Transparency Website
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. 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.

Participatory Medicine
According to The Society for Participatory Medicine, "participatory medicine" is a movement in which networked patients are encouraged to be more involved in their health and health care management, and in which providers value patients as full partners. The Society for Participatory Medicine is a not-for profit organization that seeks to bring together all the stakeholders in healthcare (patients, caregivers, healthcare professionals, payers, and others) to foster provider/patient engagement, patient empowerment and education. Clearhealthcosts.com is a member group of the Society for Participatory Medicine. The website provides a search engine

that combines data from providers, patients, and databases, and informs prospective patients what they may pay at different facilities. Clearhealthcosts.com says their product is especially helpful for people who are uninsured or on high-deductible plans. In 2014, ClearHealthCosts and its partners, KQED public radio in San Francisco and KPCC/Southern California Public Radio in Los Angeles, launched a new project called PriceCheck, a crowd-sourced database of health prices in California. Using the tool, consumers can enter in the prices for their medical bills, and the aggregated data provides cost comparisons between and among facilities. According to Clearhealthcosts.com, "Armed with price information, consumers will be able to use cost (as well as other factors) to choose a doctor, choose a hospital, budget for a medical expenditure, or argue with the insurance company. An informed consumer can make better, more thoughtful choices about insurance…" In late February, ClearHealthCosts launched a similar partnership to build a community-created database of health prices in Philadelphia, with WHYY public radio, to build on the California partnership and other work in the New York area and Texas.

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. Despite the passage of the ACA, consumers continue to feel the financial burden of health care costs. 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 and to keep health services and insurance premiums affordable.