Special California Assembly Hearings Provide Insights and Solutions to Increasing Healthcare Costs

After the public outcry following last year's tabling of SB 562 (Lara), which would have created a single-payer program in California, a special California Assembly committee was formed. The Assembly Select Committee on Health Care Delivery Systems and Universal Coverage began hearings in late October 2017 and adjourned on February 7th, 2018. While much of the hearings was a crash course on health insurance, some of them addressed high healthcare prices. This month, we will summarize two of the hearings that focused on understanding the origins of high healthcare pricing as well as ways to control them.

State Cost Containment Efforts

On December 11, 2017, the Assembly Select Committee on Health Care Delivery Systems and Universal Coverage held a very grueling (8 hours and 8 minutes long) informational hearing titled "Universal Coverage and Cost Containment Efforts in the United States." We summarize here the latter part, "Cost Containment Efforts in Other States," as it pertains to how states have attempted to control healthcare prices.

A. Maryland's All-Payer Hospital Payment System and Global Budget Model

Sule Calikoglu Gerovich, Ph.D., senior researcher at Mathematica Policy Research, explained that Maryland had set the same hospital rate for all payers since the late 1970s. Because Maryland requires that all payers pay the same rate, Medicare and Medicaid, which normally pay lower rates, pay more in Maryland than in other states, while private payers and the uninsured, which normally pay higher rates, pay less in Maryland than they would in other states. Though rates differ from hospital to hospital, all payers pay the same rate at a particular hospital. Yet, Gerovich stated

that even though Maryland solved the price problem, it still had a cost problem. She explained that while Maryland controlled the price, hospitals increased utilization to gain revenue. As such, the state must address both price and utilization together to solve the cost problem.

To address increased utilization, Maryland introduced the global budget model, which set each hospital's budget or revenue to a fixed amount. Consequently, the global budget model prevented hospitals from increasing utilization to increase their revenue. Instead, it incentivized hospitals to reduce utilization and costs to gain maximum profit from the fixed budget. Gerovich clarified that the model was adjusted for medical inflation, utilization growth, and other factors that lead to change in costs. Under the model, Maryland saved money for payers while maintaining "healthy" profit levels for hospitals. But, Gerovich explained that success and sustainability of the global budget model requires (a) connecting hospitals with other providers, (b) focusing on high needs patients, (c) creating more effective care coordination with emergency rooms and transitions, (d) creating new performance metrics, (e) investing in infrastructure like health information exchanges, and (f) having an effective administrative structure.

B. Massachusetts' 2012 Cost Containment Law

Dr. Paul A. Hattis MD, JD, MPH of Tufts University Medical School stated that high health care spending in Massachusetts resulted from higher prices charged by providers and larger utilization. Dr. Hattis added that provider price variation, mergers and consolidations, out of network costs, and drug prices were additional challenges to containing costs.

The need for reform led to the passage of Chapter 224, a 2012 bill which created two independent state agencies, Centers for Health Information and Analysis (CHIA) and Health Policy Commission (HPC), which work together to contain cost. CHIA, or the "truth tellers" as Dr. Hattis calls it, collects data relating to premiums and costs, while HPC takes that data and provides a policy view. Dr. Hattis clarified that HPC is not a regulatory agency. Instead, HPC writes research reports on healthcare topics, brings together stakeholders to act on a problem, partners with community hospitals to transform them, and serves as a watchdog to monitor and intervene. In summary,

Massachusetts uses the G.P.S. formula: (G)lobal payments, which, like Maryland, incentivize hospitals to change from volume-based (higher utilization) to value-based (lower utilization)|(P)rice transparency, (P)erformance of cost and market impact reviews, which the HPC does to see if consolidations or alignments have a "significant" impact on health care costs or market share|and (S)pending growth targets, which limit the growth of health care entity expenditures and subject these entities to strict monitoring and implementation of performance improvement plans.

C. What California Could Do

Given the experience of other states, Larry Levitt, Senior Vice President of Kaiser Family Foundation, proposed the following to contain costs in California: (a) greater transparency mechanisms for healthcare costs combined with an enforceable mechanism to address the cost, (b) simplifying payment administration by moving to a uniform payment system, (c) paying for value instead of volume of services, (d) addressing consolidation via antitrust actions, and (e) greater government control via regulated rates (such as all-payer rate setting, global budget, public option insurance plan, or single payer program). But, Levitt noted that health care cost containment is difficult and that any cost containment strategy requires federal government (specifically Medicare) and employer buy-in.

Overall, this hearing provided insight on the increasing burden of health care costs, the causes of increased health care costs, and how to address it. This hearing provided examples of ways California could control its cost whether it'd be through global budget or cost transparency.

Understanding and Addressing High Prices

On January 17, 2018, the Assembly Select Committee on Health Care Delivery Systems and Universal Coverage held a less lengthy (4 hours and 30 minutes long) informational hearing titled "Achieving Better Access and Greater Value in California's Health Care System." We summarize here the second part, "Understanding and Addressing High Prices," as it pertains to healthcare competition and prices.

Larry Levitt first opened up by discussing the fragmentation of the health care system. He stated that it results from a "balkanized approach" of different formularies, different prices paid to health care providers, and different networks of physicians and hospitals based on the patient's insurance. On top of that, Levitt pointed out that there is no central agency to control costs. Without central oversight, he noted that there is a "water balloon" effect, which means that cost control in one part of the health care system may show up as cost in a different part.

Additionally, a fragmented system without central oversight leads to rising administrative costs and lack of accountability in pricing. Levitt noted that health insurance administrative expenses have increased as a percentage of health spending and that administrative expenses equaled 20-27% of California hospitals and provider groups' revenues. Administrative costs include marketing, care and benefits management, and claims payment. Erin Trish, Associate Director of Health Policy for the University of Southern California's Schaeffer Center for Health Policy and Economics, added that other factors for high administrative costs come from providers trying to negotiate, keep up, and reconcile multiple payment structures with differing types of incentives.

To reduce fragmentation, Levitt offered solutions like all payer rate settings where all plans pay the same rates to the same providers, or a uniform pricing mechanism where providers and plans use similar pricing structures. Trish cautioned that while a uniform pricing mechanism could address high healthcare prices and simplify administrative costs, such a mechanism could stifle innovation in pricing approaches and could be difficult to implement because stakeholders may disagree on which pricing structure is appropriate.

On the flip side, Laurence Baker, Ph.D., Professor and Chair of Stanford University's Health Research and Policy, stated that consolidation and merger of hospitals and providers is an example of market failure that leads to improper healthcare pricing. While consolidation of insurers may lead to lower pricing, consolidation of hospitals and physicians generally leads to increased prices, since insurers seek to rein in costs while hospitals and physicians seek higher rates. Baker also noted that other factors for high healthcare prices include high cost structures for physicians, new and costly treatments, and lack of knowledge by consumers, which translates to less

pressure to lower prices. He proposed that states (a) review consolidation using metrics like the Hirschman-Herfindahl Index (HHI) or the Concentration Ratio, (b) limit out-of-network pricing, (c) encourage individual purchase of insurance which would give power to insurers to bargain for lower prices, and (d) regulate prices like Maryland's All-Payer rate.

Together, these two hearings provide a broad overview of what is causing high healthcare prices and how the state of California can address it. While these hearings were done in the context of determining new delivery systems for California, they are helpful in giving the public a crash course on how California can tackle rising health care costs and what types of expenses California should focus on.