



BERKELEY CENTER
FOR HEALTH TECHNOLOGY

Health Care Cost Trends and Employers' Cost Control Strategies

Kern County Economic Development Council
March 21, 2012

James C. Robinson

**Leonard D. Schaeffer Professor of Health Economics
Director, Berkeley Center for Health Technology
University of California, Berkeley**

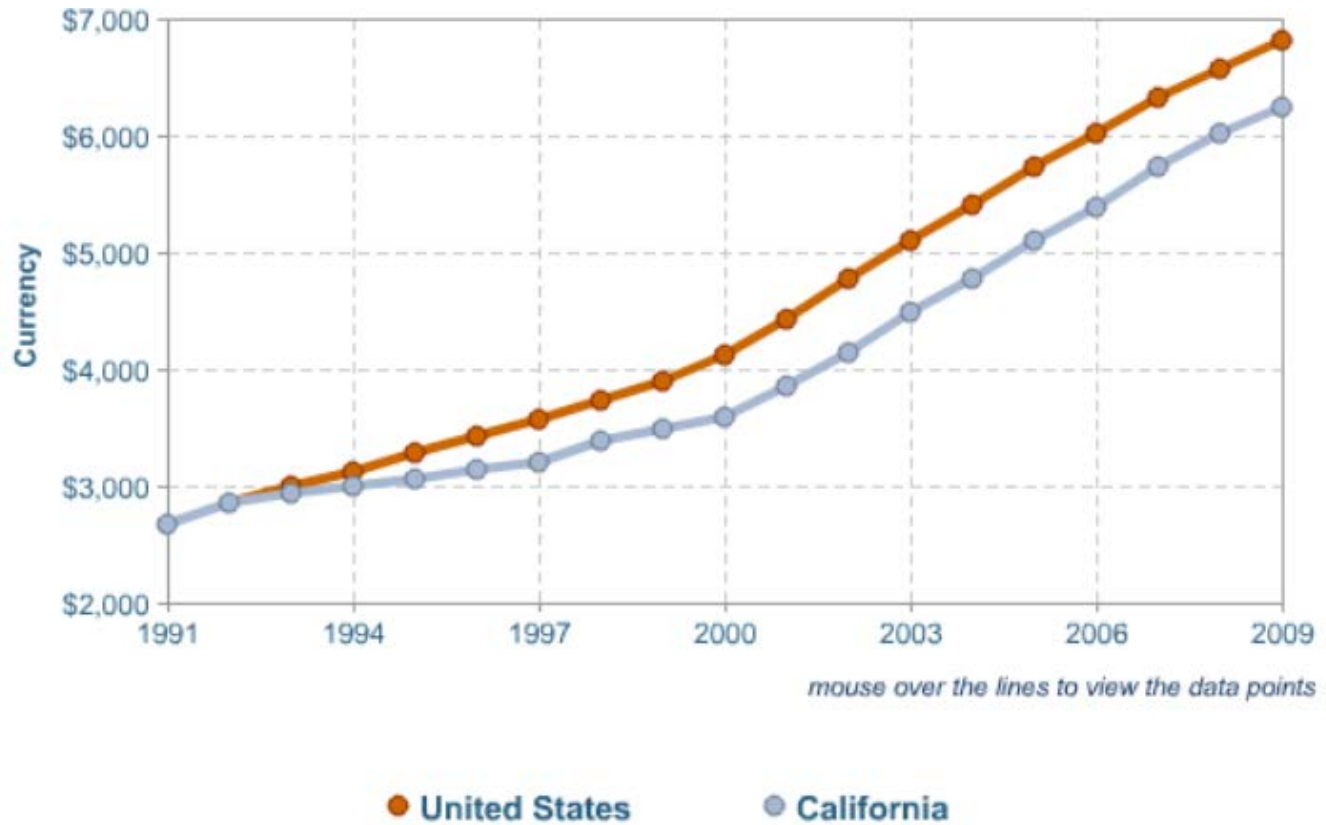


OVERVIEW

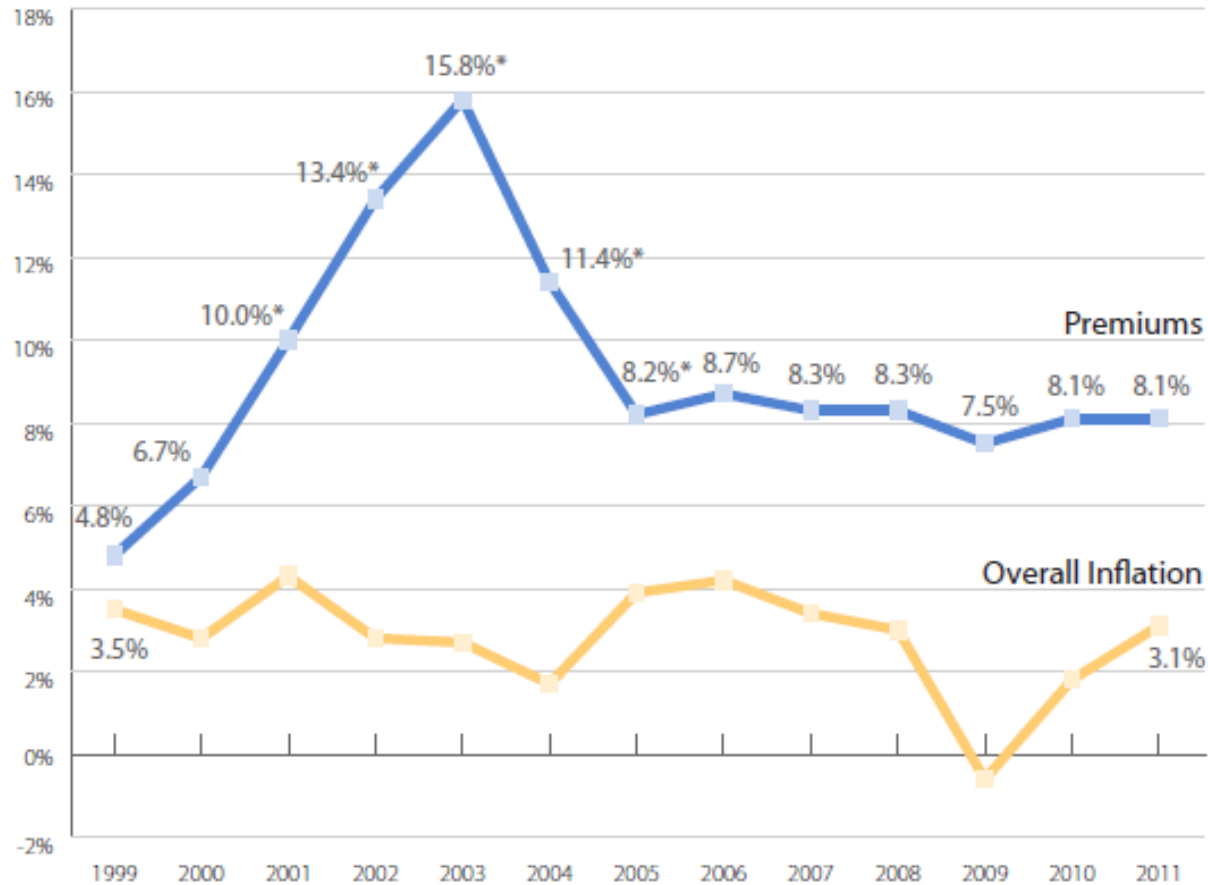
- Trends in health costs and coverage
- Why are costs so high?
- Employer strategies for managing health costs



Health Spending per Capita

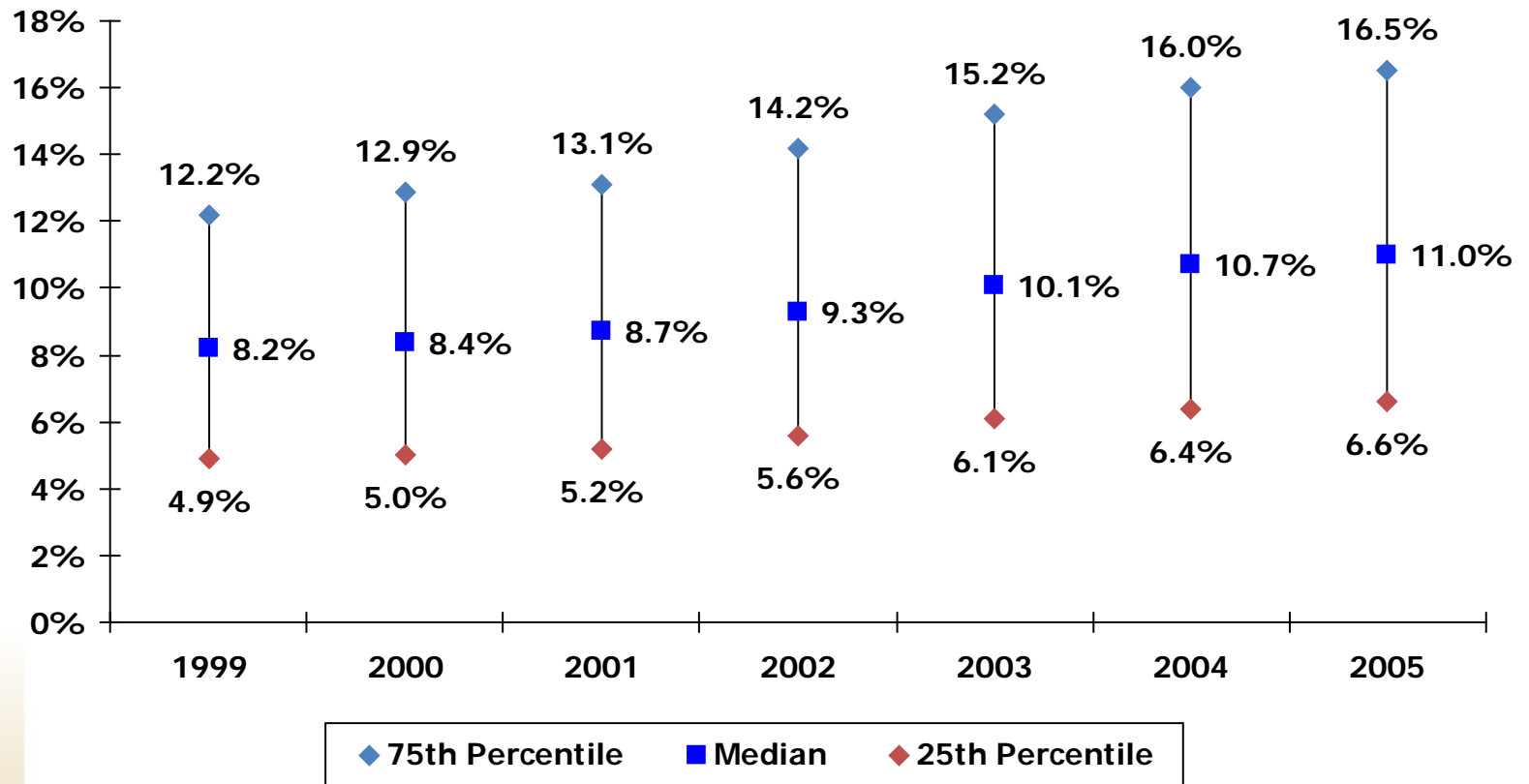


Health Care Premium Increases Compared to Inflation, Family Coverage, California

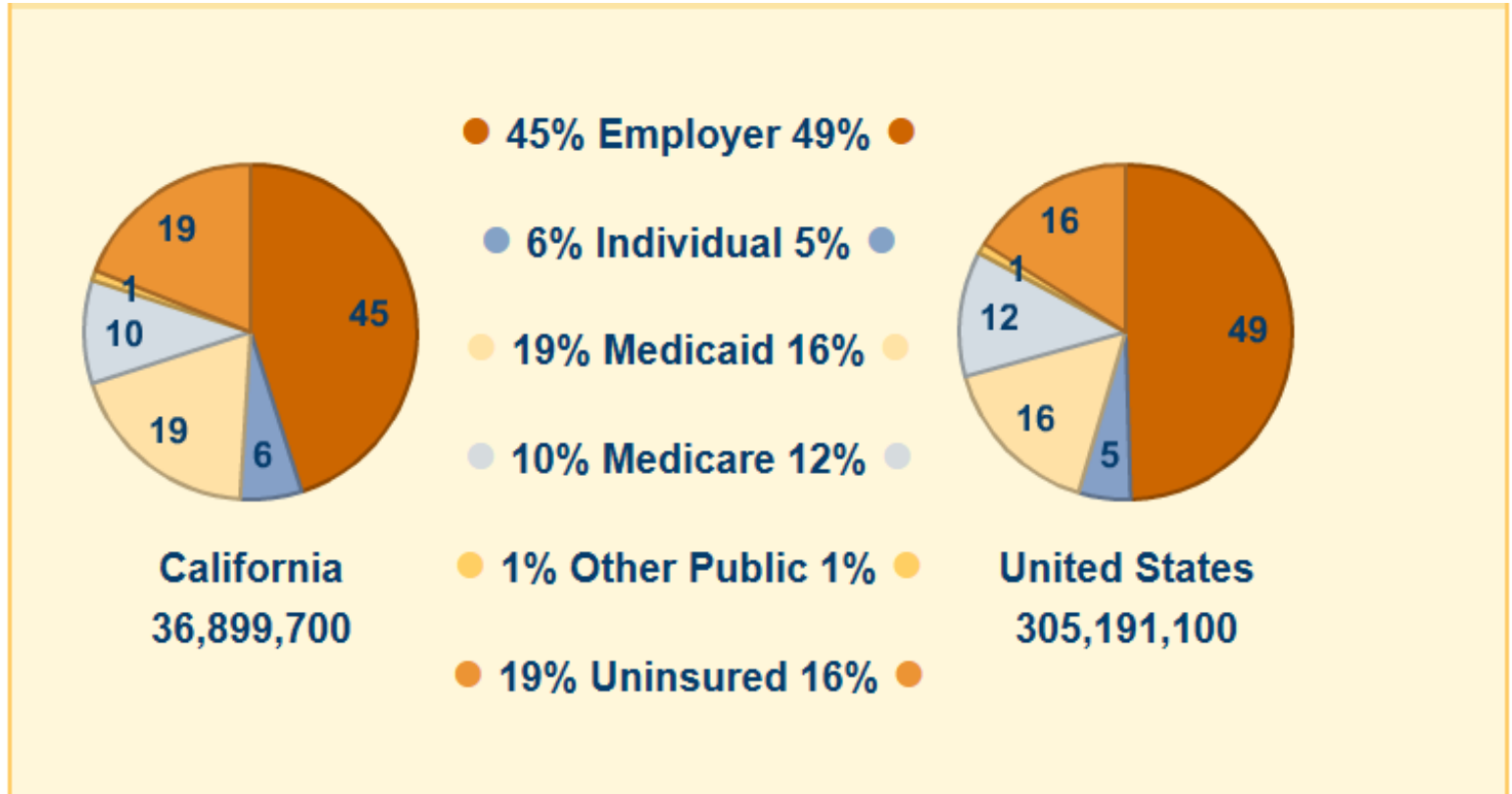


Source: California HealthCare Foundation and NORC California Employer Health Benefits Survey

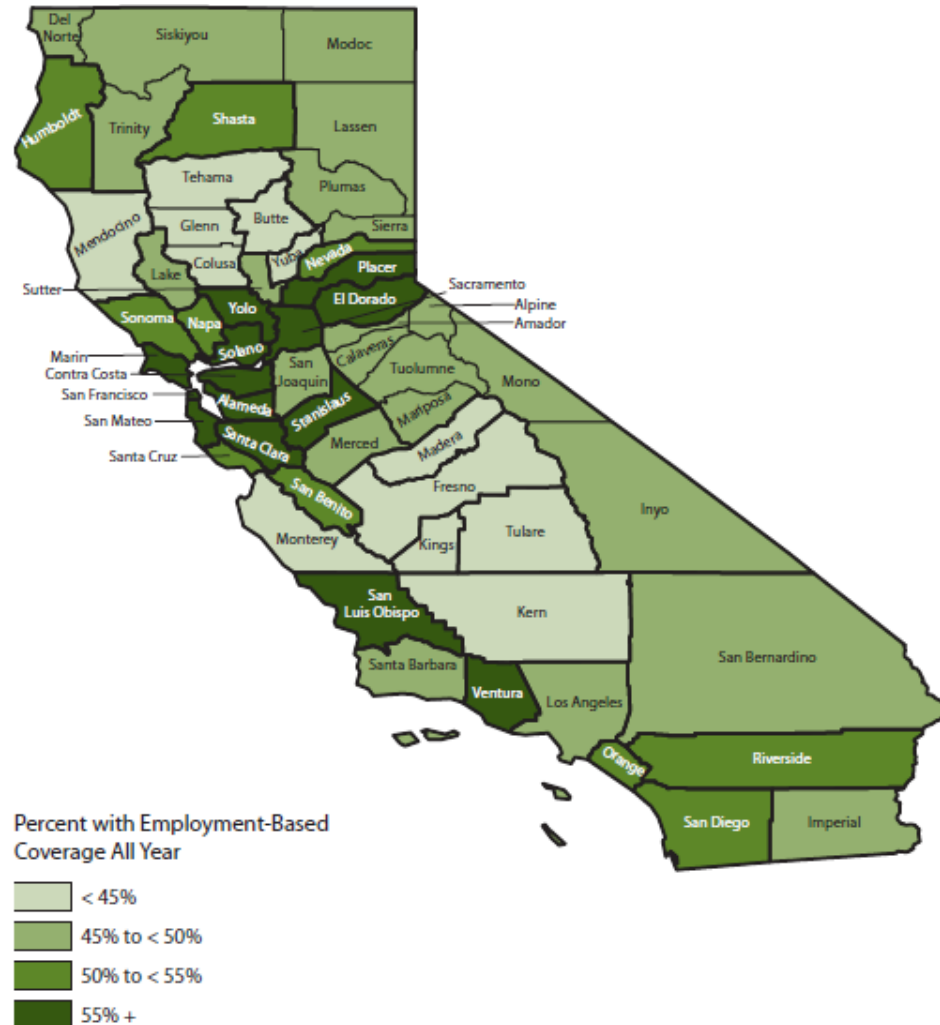
Health Insurance Costs as a Percentage of Payroll



Sources of Health Insurance Coverage



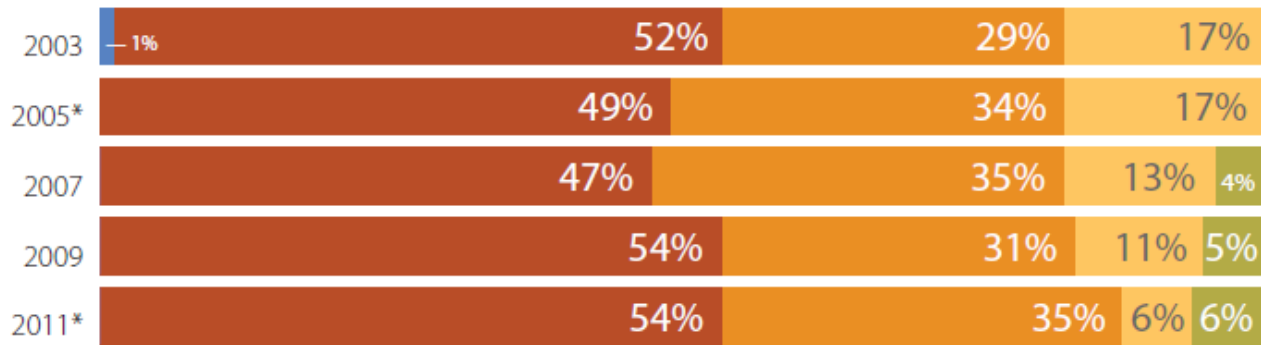
Percent with of Non-Elderly Persons with Private Health Insurance in California, 2009



Continuing Importance of HMOs in California

■ Conventional
 ■ HMO
 ■ PPO
 ■ POS
 ■ HDHP/SO

California



United States



Why is the Health Care System So Costly?

- All the incentives promote development and adoption of new and better services, without regard to cost
- Purchasers do not purchase based on value, and therefore providers do not provide value
- Employers are fragmented and risk-averse
- Consumers face little cost sharing incentive to use more efficient and effective providers
- There exists very little data on comparative clinical and economic performance of drugs, devices, tests, procedures
- Provider financial incentives are misaligned
- Most physician and hospital organizations are fragmented and internally conflicted



Absence of Value Purchasing

- Employers are fragmented and risk-averse
- Consumers face little cost sharing incentive to use more efficient and effective providers
- There exists very little data on comparative clinical and economic performance of drugs, devices, tests, procedures
- Provider financial incentives are misaligned
- Most physician and hospital organizations are fragmented and internally conflicted

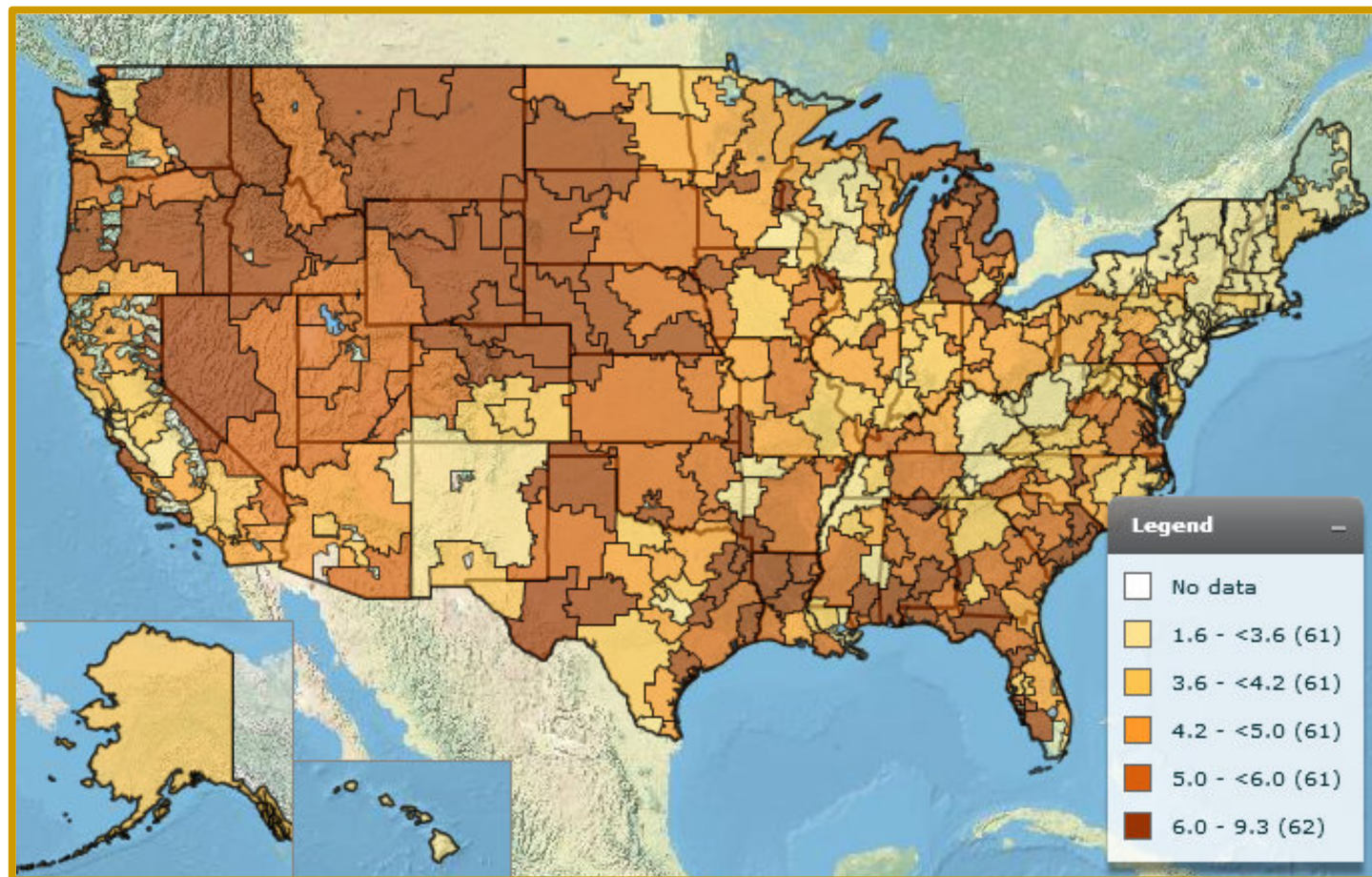


Social Costs of Weak Value Purchasing

- Unjustified variation in rates of procedures
- Unjustified variation in costs
- Unjustified variation in patient outcomes



Rate of Back Surgery per 1,000 Medicare Enrollees, by Hospital Referral Region, 2007 (Dartmouth Atlas)

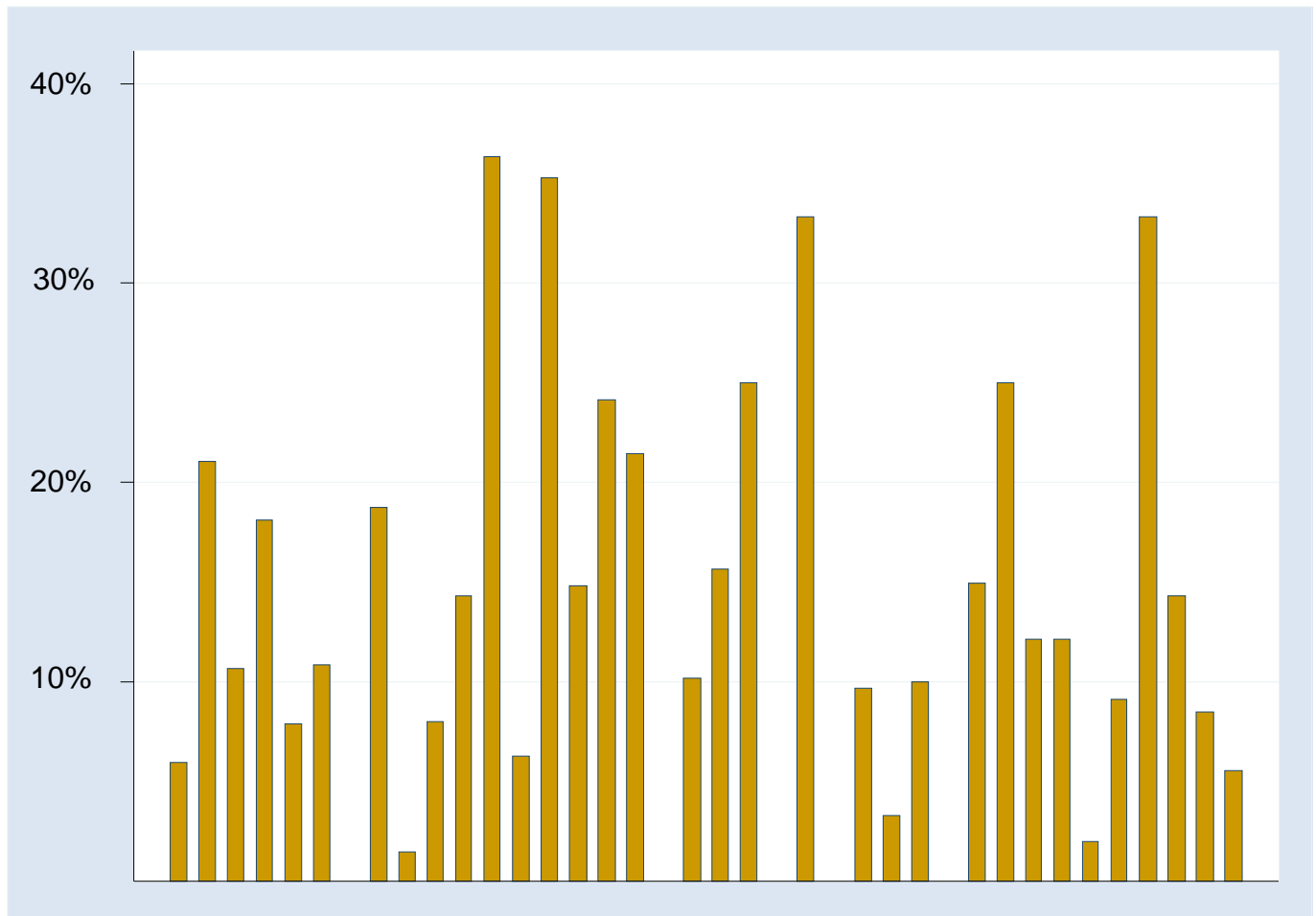


Costs and Reimbursements for Lumbar Fusion Surgery in California Hospitals, 2008

	Device Cost	Total Surgical Cost	Device Cost as % of Medicare FFS Reimbursement	Device Cost as % of Commercial HMO/PPO Reimbursement
1 st Percentile	\$3,239	\$12,318	3.6%	3.2%
25 th Percentile	\$7,077	\$20,630	18.0%	25.5%
Median	\$8,695	\$26,175	31.0%	32.8%
75 th Percentile	\$12,868	\$29,469	43.5%	52.0%
99 th Percentile	\$37,323	\$51,049	97.3%	2365%
Number of Hospitals	38			
Number of Patients	6,848			



Lumbar Fusion Surgery In-Hospital Complication Rate, California 2008



Purchasing Strategy: Highlighting Key Choices that Should be Cost-Conscious

1. Choice among **therapeutic alternatives**
 - Medical v. surgical (appropriateness)
2. Choice among **sites of care**
 - Inpatient v. outpatient v. freestanding ASC
3. Choice among **provider organizations**
 - Where should it be performed?
4. Choice among **clinical inputs**
 - Drugs, devices, diagnostics, imaging



Market Trends

- Insurers and employers are raising cost sharing
 - High-deductible health plans
 - Reference pricing
- Changes in benefit design and cost sharing are being accompanied by changes in network design and payment
 - Payment methods for doctors and hospitals
 - Integration of doctors and hospitals

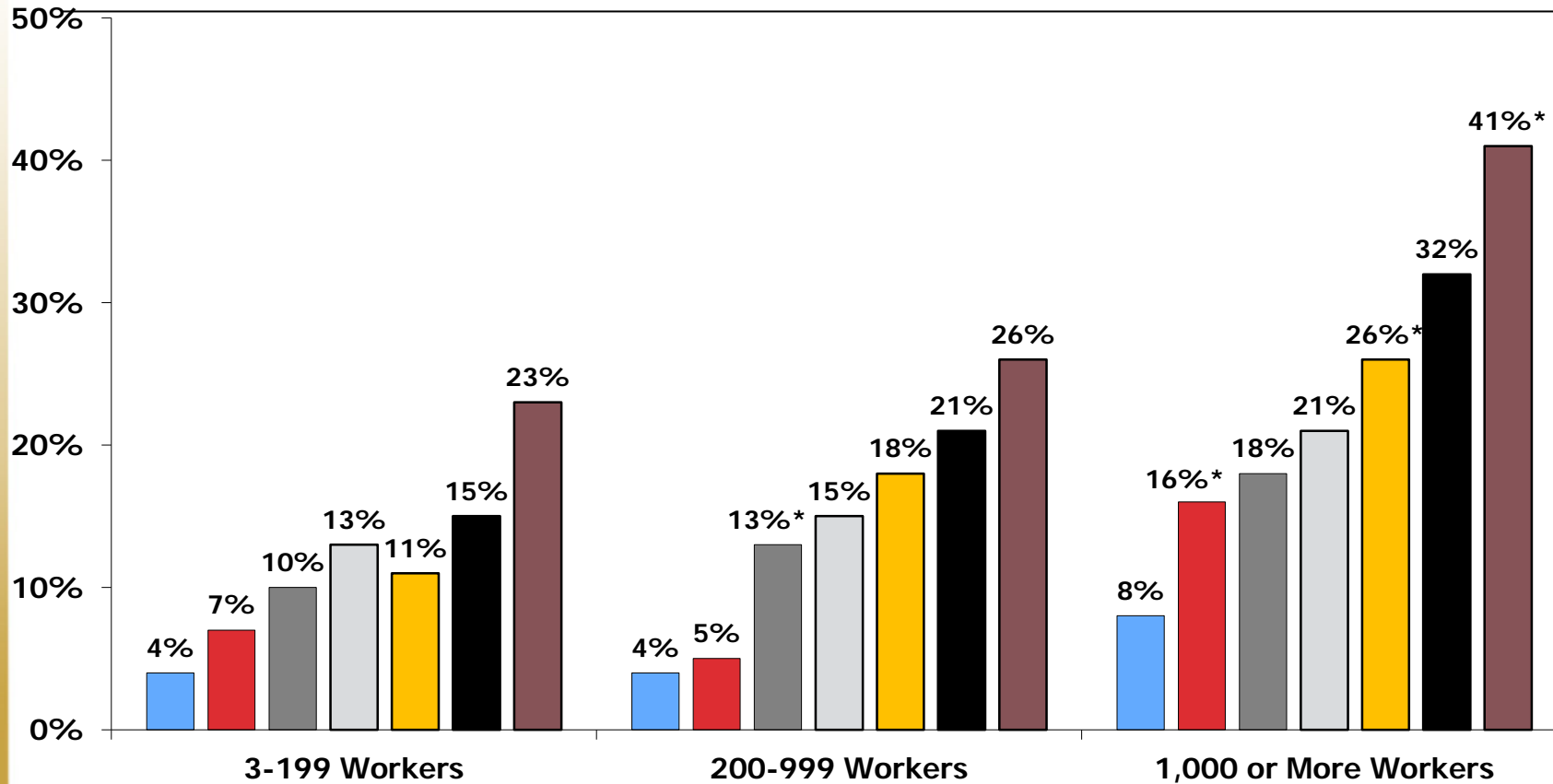


High-Deductible Health Plans (HDHP)

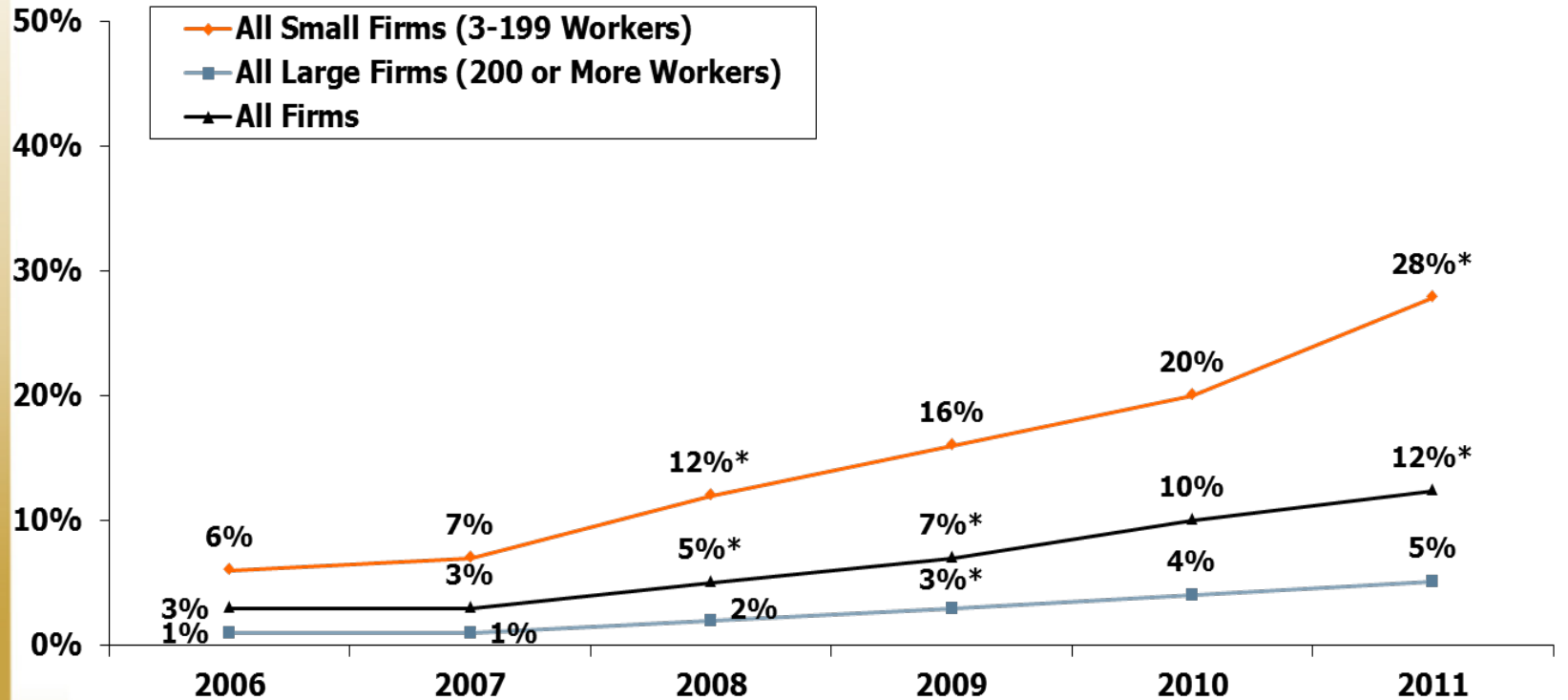
- Impact of deductible on use (and shifting responsibility for payment to patient) has encouraged employers and insurers to offer higher deductibles of \$2500 - \$15000, at much lower premiums
- “Consumer driven health plans” (CDHP)
- Enrollees can invest in tax-favored savings plans for non-insured uses
- Some HDHP are offering first dollar coverage for effective drugs and preventive services
- “Value-based insurance design”



Percentage of Firms that Offer Insurance Benefits Which Offer High Deductible Health Plan



Percentage of Covered Workers Enrolled in a Plan with an Annual Deductible of \$2,000 or More for Single Coverage,



Reference Pricing

- Insurer (employer) establishes benefit maximum it will pay for selected services
- Is designed for services and products with wide range in prices but narrow range in quality
 - Orthopedic surgery, advanced imaging, lab tests
- Patient is given list of providers whose charges are below the reference limit
- If patient goes to low-priced provider, no copay is charged. If goes to high-priced provider, patient must pay entire difference between benefit limit and price
- Example: PERS set \$30,000 limit for knee/hip replacement as charges ranged \$20K to \$120K. If employee picks hospital charging \$50K, he pays 10% of \$30K (coinsurance) plus 100% of difference (\$20K), for total of \$23K in cost sharing



Market Trends: Network Design

- Deductible-based PPOs are seeking to adopt network designs from HMO (narrow network, capitation, prior authorization)
- HMOs are developing very narrow networks to reduce premium while retaining lower copays
- Centers of Excellence are being developed for high cost acute services with high variance in performance (orthopedics, cardiology)



Policy Trends

- State has numerous mandated benefits, with pressure to limit cost sharing on them
- Health insurance exchange is pondering “qualified health plans” and “bronze” benefits
- Federal government will be imposing more benefit mandates and limits on cost sharing as part of Obamacare
 - Preventive services must be free
- IOM and “essential health benefits”



Conclusion

- Drivers of cost growth remain strong
- Employers increasingly are turning to consumer cost sharing and less generous benefits
- Public policymakers are imposing more regulation but fear undermining market incentives
- The public is not ready for the reality of cost containment, but, rather, want to interpret costs as due solely to waste and profiteering (rather than due also to innovation and rising quality)
- In addition to leading on benefit re-design, employers need to lead on policy reform and public education

