Title
Financing and Delivery of Health Care: California Trends

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SOLUTIONS-ORIENTED CONVERSATIONS IMPROVING HEALTH POLICY

Sixty percent of Americans and the majority of Californians receive their health insurance through employer-based benefits. Approximately 20% are covered through public insurance programs such as Medicaid (Medi-Cal), Medicare and S-CHIP (Healthy Families). The private individual health insurance market covers approximately 5% of the population, while the uninsured account for approximately 16%.[1] In 2003, an estimated 6.6 million Californians were uninsured.[2]

Health care premiums rose in California and the nation at double-digit rates from 2001 through 2004. While health care inflation has slowed from its height of nearly 16% in 2003, the 2005 rate of 8.2% is still more than double the overall rate of inflation in California during the same period (3.9%).[3]

California has lower per capita expenditures and lower employer premium costs compared to the rest of the nation. Nationally, on average, in 2005 employer premiums cost $335 per month for single coverage and $907 a month for family coverage, compared to $321 and $858, respectively, in California.[4]

Following the Dollars

The U.S. spent $1.9 trillion on health care in 2004[5], or about $6,300 per person. While the majority of the population is covered by private health insurance, only 35% of all health care expenditures are paid for by private health insurance, with an additional 13% financed through out-of-pocket costs paid for by patients. In contrast, public insurance programs cover only about 20% of the population, but account for 46% of all health care payments. Medicare accounts for 17%, while Medicaid and S-CHIP account for 16%, with other public programs paying for an additional 13%.[6]

The majority of all health care dollars are spent on hospitals (30%) and physician services (21%). Prescription drugs account for 10% of outlays, while nursing homes account for 6%.[7] Over the last 12 years there has been a shift in the mix of services purchased.[8, 9] The share of expenditures for hospitals has fallen from 36.5% in 1992 to 30% in 2004. In contrast, the share spent on prescription drugs increased from 5.8% to 10% over this same time.[10, 11]

Causes of Cost Increases

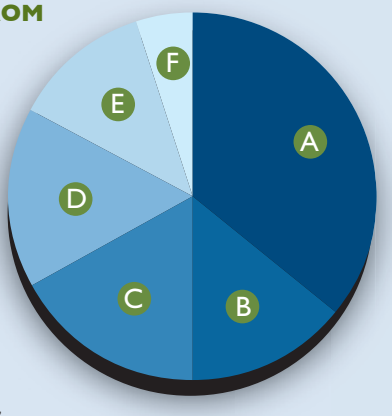
There are a number of factors responsible for rapidly rising health care costs. These include the aging of the population, new treatment technologies, the growing numbers of uninsured and under-insured, and changing reimbursement incentives.[12]

THE NATION'S HEALTH DOLLAR

Year 2004

WHERE IT CAME FROM

A. *Private Insurance 35%*
B. *Out of Pocket 13%*
C. *Medicare 17%*
D. *Medicaid and SCHIP 16%*
E. *Other Public* 13%*
F. *Other Private** 7%*



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; available at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/PieChartSourcesExpenditures2004.pdf

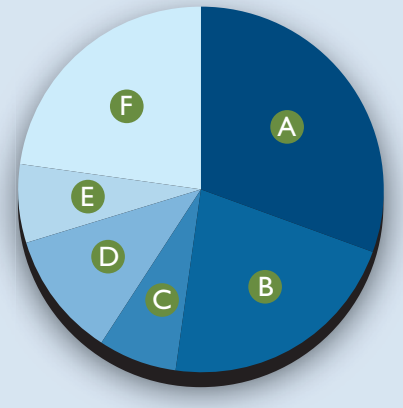
* "Other Public" includes programs such as worker's compensation, public health activity, Dept. of Defense, Dept. of Veterans Affairs, Indian Health Service, and State and local hospital subsidies and school health.

** "Other Private" includes industrial in-plant, privately funded construction, and non-patient revenues, including philanthropy.

Note: Numbers shown may not add to 100% because of rounding

WHERE IT WENT

A. *Hospital Care 31%*
B. *Physician Services 21%*
C. *Nursing Home 6%*
D. *Rx Drugs 10%*
E. *Program Admin 7%*
F. *Other Spending* 25%*



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; available at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/PieChartSourcesExpenditures2004.pdf

* "Other Spending" includes dental services, other professional services, home health care, durable medical products, over-the-counter medicines and sundries, public health activities, research and construction.

Nationwide, Medicaid is consuming a growing share of state expenditures. Factors contributing to increased Medicaid costs include growth in the eligible population, intensive and long-term care services, provider payments, and increased survival of low birth-weight babies.[13]

However, California's Medicaid program spends less per recipient on medical care than most other states in the country. The 2003 national average Medicaid expenditure per recipient was $4,307. New York spent more than double that at $8,961 per recipient, whereas California spent about half of the national average ($2,386).[14] While California offers its Medicaid recipients one of the most comprehensive benefit packages in the country, it ranks 48th nationwide in Medicaid spending per recipient and last among the 10 most populous states.[15] Low Medicaid payment rates reduce provider incentives to serve Medicaid patients, thus limiting their access to care.

California's Health Care Market

California's health care market has evolved to look quite different from that of the rest of the nation. A higher percentage of Californians are in Health Maintenance Organizations (HMOs) but the rate has been recently declining; California HMO premiums are lower than the national average. In contrast, the proportion of Californians enrolled in Preferred Provider Organizations (PPOs) is lower but rapidly increasing, while premium costs for PPOs in California are higher than the national average.

In an effort to control and reduce health care costs, employers in many parts of the country have chosen to self-insure for the health care costs of their employees, thus directly bearing the financial risk. This has two advantages for employers: they can design health benefits that cost less than group market plans; and they are subject to federal regulation only.

California has a much smaller proportion of its population in self-insured employer plans than the rest of the country, due to the early penetration of and enrollment in HMOs in the state. In the U.S., 54% of employees are enrolled in self-insured employer plans, compared to 25% of California employees.[16] As a result, a much greater proportion of California's insured population is in health plans that are subject to state regulation.

Private Market Response

The response of the private health insurance market to high costs and the growing number of uninsured is to create new products that provide less protection but are offered at a lower cost. This trend is known as consumer driven health care.[17] Under consumer driven health care, the consumer is given greater responsibility in deciding where to go for care, assessing the quality of care, and paying for their medical care. In addition, some insurers have begun offering products with reduced benefits such as non-coverage of prescription drugs or maternity care. Even HMOs have begun adding deductibles to their products to make premiums more affordable.

The consumer driven health insurance products that have emerged take on several general forms. The single feature shared by all of them is a high deductible, below which acute care is generally not covered. Many of these high deductible

Approximately 29% of HMO enrollees and 9% of PPO enrollees do not have any limits on single coverage out-of-pocket costs they pay each year.

Source: California HealthCare Foundation & Center for Studying Health System Change 2005. Survey of Employer Sponsored Health Benefits: 2005. (Oakland, CA: California HealthCare Foundation).

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plans—recognizing the importance of preventive care and timely primary care—will exempt up to four office visits from the deductible. Another frequent element of consumer driven health care is a personal account to pay for care that is not covered under the high deductible plan.[18] These accounts take the form of a health reimbursement arrangement (HRA) or a health savings account (HSA).

In 2005, 20% of all firms in California offered their employees a high deductible plan, with 2% offering it with an HRA and 3% offering it with an HSA.[19]

Public Program Response

Medicaid and Medicare have also increased participant cost-sharing and restricted benefits. In 2005, 47 states froze or reduced provider payments and 14 put cost controls on pharmacy spending. In addition, nine states plan to reduce eligibility, nine states plan to reduce or restrict benefits, and nine states plan to increase co-payments.[20]

The new Medicare Part D Prescription Drug Program is a recent example of giving consumers more responsibility for their care, such that elderly beneficiaries who spend more than $2,250 on drugs in a year, face a "gap" (the equivalent of a large deductible) of $2,850 (referred to as the donut hole) before coverage resumes.[21]

Getting Value for Expenditures

While spending more per capita on health care than any other industrialized nation,[26] the U.S. covers a smaller proportion of its population. Japan, France and Canada spend 30% less on health care than the U.S. measured in terms of the percentage of GDP[27] and yet, they report significantly better health status including lower rates of infant mortality, and higher rates of life expectancy at birth and at age 65.[28]

Another important factor in the value equation is the quality of the medical care that Americans receive. A recent study found that, on average, patients receive less than half of the medical care that is recommended for their condition and the quality of the care they receive varies significantly by condition.[29] For example, while 78% of U.S. women with breast cancer receive recommended care, fewer than half of all persons with diabetes, pneumonia or hip fractures receive the care.[30]

The Institute of Medicine (IOM) in its 2001 report, *Crossing the Quality Chasm*, concluded that Americans often cannot get the medical care they need and that health care resources are presently not being used in an effective or efficient way.[31] In addition, safety problems in the delivery of care are common and include medical errors as well as hospital-acquired (nosocomial) infections. The report identified six aims for improvement to achieve a health care system that is safe, effective, efficient, equitable, timely, and patient centered.[32]

Consequences of Rising Costs and Reduced Benefits

The major consequence of rising costs and reduced benefits are decreased affordability and access to care, which have significant public health and economic impacts. Affordability is the main reason most uninsured Californians do not have health insurance. The uninsured and underinsured—those with reduced benefits and higher cost sharing—are more likely to postpone care due to costs, not fill prescriptions, and not get medical care for a serious condition.[22, 23] In addition, they are more likely to report that they have been contacted by a collection agency for payment of their medical care bills and suffer significant economic losses that have a major impact on the quality of their lives.[24, 25]

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Policy Recommendations

The IOM series of reports on quality and insurance recommend *systems change* to improve Americans' health and health care. There are numerous policies California could implement to achieve these goals; the following recommendations provide examples consistent with preceding information and IOM research.

Value

- **Expand state public reporting on quality.** While the California Office of the Patient Advocate currently reports health plan and some medical group performance measures, these can be expanded to include performance of hospitals, physicians, clinics, pharmacists, etc. Such information can be tailored for enrollees in state-buying programs, as well as the public at large.
- **Implement pay-for-performance (P4P).** State-buying programs, such as Medi-Cal, CalPERS, and Healthy Families, can create a financial incentive that rewards providers for the provision of high quality care. The program can be revenue neutral.

Financing

- **Expand health insurance coverage and improve access.** The Legislature and Administration could create an acceptable approach to expanding coverage in line with the IOM principles: universal, continuous and affordable.

Information

- **Create efficiencies through standardized electronic information.** Improving state information systems can increase policymakers/managers' ability to gauge the effectiveness of health programs, as well as facilitate coordination for clients receiving services from multiple agencies. Furthermore, the state can expand existing systems, such as public health surveillance, to better capture diseases and detect medical errors.

Although the following recommendation is not from the IOM, it is a relatively recent trend deserving of state oversight:

- **Monitor effect of increased out-of-pocket costs on consumers.** Both the Department of Insurance and the Department of Managed Care can monitor the prevalence and effect of new plan designs so that policymakers are aware of the impact on Californians, as well as the uninsured rate.

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