Colorado Consumer Health Initiative

Comments for the Colorado Commission On Affordable Health Care
October 20, 2015

The Colorado Consumer Health Initiative (CCHI) is pleased to submit the following comments to the Colorado Commission on Affordable Health Care. CCHI is a statewide, non-partisan, non-profit coalition of organizational and individual members, representing well over 500,000 Coloradans. CCHI's mission is to advance the consumer perspective to improve health care for all Coloradans. Our vision is that all Coloradans can access high-quality, affordable and equitable health care.

We note that a few of our members, including the Colorado Foundation for Universal Health Care, have submitted their own responses to the Commission's survey.

1. What do you think are the fundamental cost drivers and why?

A September 2012 report from the Bipartisan Policy Center[1] identifies numerous drivers of health care costs, including fee for service, fragmented care delivery, population demographics and high unit prices of medical services, and notes that these drivers are complex and overlapping. Consumers Union[2] has characterized the various drivers as follows:

Table: Cost Drivers Take Many Forms

Type of Cost Driver	Description
Segment Drivers	Highlights segments of the health care industry where spending has been increasing, like outpatient care
Demographic Drivers	Measures of the population, society, and general economy that appear to result in more spending on health care, like the aging of the population or increases in per capita income.
Health Condition Drivers	Measures of illness or other health conditions that have changed over time in excess of general demographic trends, like the increasing prevalence of diabetes.
Line Item Drivers	Increasing amounts actually being spent by health care providers in their operating budgets, like increased spending on new medical technology.
Policy Drivers	Public policy and health system practice can contribute to the cost of health care, like allowing hospital consolidations that result in near monopolies.

Adapted from Doug Hall, *Will the Real "Cost Drivers" Please Stand Up? The Problem of Identification*, November 2004.

[1] Bipartisan Policy Center (2012). "What is Driving U.S. Health Care Spending?" http://bipartisanpolicy.org/wpcontent/uploads/sites/default/files/BPC%20Health%20Care%20Cost%20Drivers%20Brief%20Sept%202012.pdf

[2] Consumers Union. "Why is Healthcare so Expensive?" *Consumers Union Health Care Value Hub.* [http://www.healthcarevaluehub.org/cost-and-quality-problems/why-healthcare-so-expensive/]

A report released earlier this month by the Commonwealth Fund comparing US health care spending, utilization and prices to 13 other countries concludes that US spending is likely driven by greater utilization of medical technology and higher prices, rather than more frequent doctor visits or hospital admissions.[3] Compared to other industrialized nations, the U.S. pays "somewhere between one-third more to over twice as much for the same procedure or brand-name medication."[4] These high unit prices can be attributed to consumer preference, high market concentration, and a lack of price transparency.[5] The Commonwealth Fund report also referred to the growing body of evidence suggesting that "social services play an important role in shaping health trajectories and mitigating health disparities" and yet U.S. spending on social services is a relatively small share of the economy compared to other countries.[6]

Based on their research, Consumers Union identified the following take-aways when looking at costs[7]:

- Focus on the trend, or rate of spending, over the level of spending.
- Rising unit prices are driving spending growth; increased utilization is a less important factor.
- Important cost drivers include advances in medical technology, chronic disease prevalence, obesity, and provider market power.
- Other often-cited drivers, such as an aging population, mandated benefits, and malpractice expenses, account for a small share of spending and do not contribute to high trend.

With these considerations in mind, CCHI highlights the following cost drivers for the Commission's consideration:

Lack of Focus on Disease Prevention: Preventable chronic diseases, such as type 2 diabetes and heart disease, affect 50 percent of the U.S adult population.[8] In 2011, 33 percent of adult Coloradans had at least two of eleven selected chronic diseases. The prevalence was higher among Coloradans aged 45-64 (44 percent) and even higher among Coloradans aged 65+ (70 percent).[9] According to one report, the high prevalence of chronic disease accounts for 86 percent of U.S health care costs.[10] The U.S health care system currently spends approximately $238 billion per year in "excess costs," which the

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[3] Squires & Anderson (2015). "U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices and Health in 13 Countries." *Commonwealth Fund Issue Brief,* pub. 1819, Vol. 15. [http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/oct/1819_squires_us_hlt_care_global_perspective_oecd_intl_brief_v3.pdf]

[4] Consumers Union. "Cost & Quality Problems." *Consumers Union Health Care Value Hub.* [http://www.healthcarevaluehub.org/cost-and-quality-problems/browse-cost-driverquality-issue/rising-unit-prices/].

[5] Ibid.

[6] Squires & Anderson (2015).

[7] Consumers Union. "Why is Healthcare so Expensive?"

[8] Bipartisan Policy Center (2015). "A Prevention Prescription for Improving Health and Health Care in America."

[9] Colorado Department of Public Health & Environment. "The Burden of Chronic Disease in Colorado." *Colorado Department of Public Health and Environment* (2013): 1-12.

[10] Bipartisan Policy Center (2015). "

Urban Institute defines as the difference between the cost of care for people with preventable chronic disease and those without.[11] Medicaid and Medicare finance more than half of these costs and by 2030, if these excess costs are left unchecked, costs are projected to rise to $466.5 billion; this means Medicaid and Medicare will finance nearly $294 billion of those costs.[12]

Obesity is one of the largest drivers of preventable chronic disease in the United States. It is estimated that the U.S spends $147 billion to nearly $210 billion per year on obesity-related medical treatments and disease.[13] Based on a two-year Medical Expenditure Panel study, being overweight and having obesity in childhood is associated with $14.1 billion in additional prescription drug, emergency room visit, and outpatient visit costs annually. The average total health cost for a child treated for obesity under Medicaid is $6,730 annually, while the average health cost for all children covered by Medicaid is $2,446.[14]

Market Power and Concentration: The Commission should consider both *insurer and provider market power and concentration* and its impacts on health care prices. While there may be conflicting data on whether carrier or provider consolidation has a bigger impact on costs, in either case, consumers ultimately bear the brunt of higher costs.

Insurance Companies: Both the American Hospital Association and the American Medical Association have highlighted the potential anti-competitive impacts of insurance company mergers. An American Medical Association study of the potential merger impacts indicates that insurer mergers could result in consumers paying higher-than-competitive premiums.[15]

Hospitals: Several reports have looked at the impact of provider power on health care costs. A 2010 investigation by the Massachusetts Attorney General found that prices correlated with the relative market position of the hospital or provider group, as compared to, for example, quality of care or the sickness of the population being served. [16] A 2012 report, "The Impact of Hospital Consolidation –Update,"[17], updated a 2006 study on hospital consolidations.[18] The 2012 update reviewed hospital concentration studies since

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[11] Waidmann, Ormond, & Bovbjerg (2011). "The Role of Prevention in Bending the Cost Curve." *Urban Institute Health Policy Center*.
[12] Ibid.
[13] Trust for America's Health (2013). "F as in Fat: How Obesity Threatens America's Future." *Trust for America's Health and Robert Wood Johnson Foundation Issue Report*.
[14] Ibid.
[15] "AMA Releases Analyses on Potential Anthem-Cigna and Aetna-Humana Mergers." *American Medical Association*. [http://www.ama-assn.org/ama/pub/news/news/2015/2015-09-08-analysis-anthem-cigna-aetna-humana-mergers.page].
[16] http://www.mass.gov/ago/news-and-updates/press-releases/2010/ago-releases-report-on-health-care-cost-drivers.html
[17] Gaynor & Town (2012). The Impact of Hospital Consolidation – Update. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261
[18] Williams, Vogt & Town (2006). "How has hospital consolidation affected the price and quality of hospital care?" http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056. That earlier report in suggested, based on data from the 1990's, that consolidation led to price increases of 5% or more

2006 and, based on that analysis, concluded that hospital consolidation generally results in higher prices; in concentrated markets, the price increases could exceed 20 percent.[19] Similarly, a 2013 study of prices in 13 metropolitan markets found that "the variation in hospital and specialist physician prices within communities underscores that some hospitals and physicians have significant market power to command high prices, even in markets with a dominant insurer."[20] Just this week, a study conducted by Harvard Medical School reported that costs increase when small doctors' practices join large hospitals, likely due to the negotiating clout of the hospitals.[21]

Physician Practices: A recent study on physician practices concludes that "more concentration among physician practices, which implies less competition, is associated with higher prices paid by private PPOs to physicians for most of the fifteen common and costly procedures . . . examined."[22]

Cost of Prescription Drugs: In a recent poll, 72% of the public viewed the cost of prescription drugs as unreasonable.[23] Spending on specialty drugs grew by 26.5% in 2014, reaching one-third of medicine spending.[24] The Health Care Cost Institute's Health Care Cost and Utilization Report found that in 2013, prescription spending accounted for 17.0 percent of health care spending and that rising prices, rather than utilization, was the driving factor in the spending growth for brand prescriptions.[25] As the cost share for drugs shifts toward consumers, IMS Institute for Health Care Informatics reports: "deductibles have had a proven negative effective on patient adherence particularly when out-of-pocket costs are over $125 per prescription."[26]

Fragmented Fee-For-Service System: The current fee-for-service system (FFS), which pays providers for volume rather than patient outcomes, incentivizes providers to perform more test and procedures. The FFS system does not encourage providers to coordinate a patient's care with other providers, resulting in an even greater fragmentation in the care

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[19] Gaynor & Town (2012). "The Impact of Hospital Consolidation – Update." http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261

[20] White, Bond & Reschovsky, (2013). "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power." *HSC Research Brief No. 27*. http://www.hschange.org/CONTENT/1375/#ib9.

[21] Mathews, Anna Wilde (2015, Oct. 19). "Outpatient Medical Care Prices are Rising Study Shows." *Wall Street Journal*. http://www.wsj.com/articles/new-study-on-hospitals-acquiring-doctor-practices-seen-fueling-debate-1445266894?utm_campaign=KHN%3A+Daily+Health+Policy+Report&utm_source=hs_email&utm_medium=email&utm_content=22993297&_hsenc=p2ANqtz--AiBAC59x0SlaYRdpUs5G9Cj4V_3h_gMIkKB_IvA5jT3wIwQcUTOELFbXZ_0AVRH2WnzvBurNzV-uO-DzpLeE5c5gGOqskOJwIQR-ysRCa9hFRSoI&_hsmi=22993297

[22] Austin & Baker (2015). "Less Physician Practice Competition is Associated with Higher Prices Paid for Common Procedures." *34 Health Affairs* 1753-60. [**doi: 10.1377/hlthaff.2015.0412].**

[23] DiJulio, Firth, & Brodie (2015). "Kaiser Health Tracking Poll: August 2015." *Kaiser Family Foundation*. [http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-august-2015/].

[24] IMS Institute for Healthcare Informatics (2015). "Medicines Use and Spending Shifts: A review of the Use of Medicines in the U.S. in 2014."

[25] Health Care Cost Institute (2014). "2013 Health Care Cost and Utilization." http://www.healthcostinstitute.org/files/2013%20HCCUR%2012-17-14.pdf

[26] IMS Institute for Health Care Informatics (2015), p. 24.

system. According to one estimate, overtreatment, due to lack of care coordination, costs the U.S. between $158 and $226 billion per year.[27]

2. What are the barriers to reducing cost?

The competing interests of different parties in the health care system are barriers to reducing cost. Instead of a system in which consumers are protected from unaffordable care, providers are reimbursed fairly for services, and carriers make rational profits while providing for members, we are faced with a structure that pits these groups against each other. Because of these entrenched interests and growing financial expectations, the health care system continues to become more complex, instead of becoming fair for all who participate.

3. Can you list up to three things that you are doing to address cost that are unique?

An important tenet of CCHI's work is to educate consumers about coverage and increase Coloradans' health insurance literacy. Most notably, CCHI created CoveredU.org (SeguroTU.org in Spanish) to serve as an educational tool about health insurance and health insurance concepts for consumers and as a tool for enrollment assisters (health coverage guides). CoveredU.org is a website that contains basic insurance terminology and uses interactive scenarios to help explain health insurance concepts with the goal of improving health insurance literacy, helping consumers use coverage more efficiently, and providing basic information about plan types. This project was a direct response to feedback from community partners that their clients and patients were struggling to understand insurance to make good purchasing decisions and to use their benefits once enrolled.

As a health care consumer organization, CCHI has advocated for policies to ensure that health care costs are affordable for consumers and has submitted comments to DOI about proposed health insurance rate increases.

4. Is there any supporting data that demonstrates a reduction in cost?

We are not aware of studies evaluating the relationship between health insurance literacy and health care costs, however there have been studies suggesting a correlation between a higher level of patient engagement and activation and cost reductions.[28] Also, see the study by Karaca-Mandic et al. (footnote 37) regarding the impact of rate review on premiums.

5. Where do you see waste in the system?

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[27] "What Is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth."

[28] Greene et al. (2015). "When Patient Activation Levels Change, Health Outcomes and Costs Change, Too." 34 *Health Affairs:* 431-437.

A December 2012 Health Affairs brief, "Reducing Waste in Health Care,"[29] provides an overview of the types of waste in health care. Those categories include (1) failures of care delivery, failures of care coordination, overtreatment, administrative complexity, pricing failures, and fraud and abuse. According to that analysis, the estimated ranges of costs associated with each of these types of waste are as follows:

EXHIBIT 1

Estimates of Waste in US Health Care Spending in 2011, by Category

	Cost to Medicare and Medicaid[a]			Total cost to US health care[b]		
	Low	Midpoint	High	Low	Midpoint	High
Failures of care delivery	$26	$36	$45	$102	$128	$154
Failures of care coordination	21	30	39	25	35	45
Overtreatment	67	77	87	158	192	226
Administrative complexity	16	36	56	107	248	389
Pricing failures	36	56	77	84	131	178
Subtotal (excluding fraud and abuse)	166	235	304	476	734	992
Percentage of total health care spending	6%	9%	11%	18%	27%	37%
Fraud and abuse	30	64	98	82	177	272
Total (including fraud and abuse)	197	300	402	558	910	1,263
Percentage of total health care spending				21%	34%	47%

SOURCE Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," *JAMA* 307, no. 14 (April 11, 2012):1513–6. Copyright © 2012 American Medical Association. All rights reserved.
NOTES Dollars in billions. Totals may not match the sum of components due to rounding. [a]Includes state portion of Medicaid. [b]Total US health care spending estimated at $2.687 trillion.

6. What are the principal barriers to transparency?

Much of the Cost Commission's discussion around price transparency focused on its ability to impact consumer behavior. However, as the Commission recognizes, it is also important to consider the value of price transparency for other audiences, including providers, employers, health plans, and policymakers. The West Health Policy Center article, "Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending" highlights possible interventions focused on each of these audiences.[30] For example, there is some indication that, at the provider level, transparency can impact behavior.[31] At the policymaking level, the availability of price data at an aggregate level can promote discussion about how the healthcare market should be organized and regulated. Price transparency would allow policymakers to compare prices with the costs of producing

[29] "Reducing Waste in Health Care" (2012). *Health Policy Brief.* [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=82]
[30] White, Chapin, et al (2014). "Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending." *West Health Policy Center*.
[31] Ibid.

medical services and to assess whether public and private mechanisms for determining prices are operating appropriately.[32]

From a consumer perspective, at the outset, it is important to recognize that only about 10% of health spending is both out of pocket and shoppable for consumers. Consumers' knowledge imbalance vis-à-vis health care professionals is also a disadvantage. Moreover, a key problem with the existing price tools is that they do not provide meaningful, actionable data. The confusion around terminology – price v. costs v. charges for example – is particularly challenging.

CCHI asked some consumers to informally test seven different price transparency tools; the feedback we received was that the tools left them more confused than before using the tools. First, some of the websites require a fair amount of knowledge of medical procedures (such as understanding different medical codes) in order for *average* prices to be accurate. In addition, many websites provided ranges of prices for one procedure, which made it difficult for consumers to make any conclusions about the actual cost of care. For transparency tools to change consumer decision-making, the data should be presented in a way that allows consumers to easily draw comparisons for different treatment options and providers. It is also important that tools provide quality data, *relevant to consumers,* as well as price to drive value-based decision-making.

The APCD is a good starting point on price transparency, but its value for consumers is currently limited to four procedures. We concur with the Cost Commission's recommendation to support the work of CIVHC in expanding the APCD, and suggest the recently released California website, with its data on cost and quality, may be a useful tool to consider. However, given the relatively small margin of influence that price transparency may have on consumer behavior, it is also important to consider the value of price transparency as an important policymaking tool.

7. What would you change to make things better related to cost?

Increase Investment in Disease Prevention and Health Promotion: Colorado can reduce health care spending by keeping the population healthy. Investing in upstream disease prevention efforts is a cost-effective strategy to reduce individuals' risk of developing chronic diseases and to reduce downstream treatment costs. The Urban Institute study, "The Role of Prevention in Bending the Cost Curve," estimates that cutting the growth rate of chronic disease by 5 percent would save Medicare and Medicaid $5.5 billion per year by 2030; cutting the rate of chronic disease growth by 25 percent would save these programs $26.2 billion per year.[33]

We encourage particular attention be paid to obesity and behavioral health. The Trust for America has made several recommendations to reduce obesity including improving

[32] Ibid.
[33] Waidmann, Ormand & Bovbjerg (2011).

nutrition and activity in school settings and limiting the marketing of unhealthy food. [34] With respect to behavioral health, we support the work of the State Innovation Model to integrate behavioral and physical health and encourage the Commission to support efforts to reduce barriers to integration.

Encourage Investment in Social Interventions: According to one study, medical care accounts for only about 10 – 20% of health as compared to other determinants of health, such as genetics and behavior.[35] Early childhood intervention can play a significant role in improving health.[36]Likewise, the Trust for American report referred to above discusses the importance of childhood intervention to address obesity. Other types of interventions that support social determinants of health should be explored and considered as part of new payment models to help address the factors that may limit a person's ability to be healthy.

Use Rate Review to Drive Cost Containment: According to a recent study, "states with prior approval authority and loss ratio requirements constrained health insurance premium increases."[37] States with such authority had adjusted premiums approximately $100 less than those with no rate review authority or only file-and-use regulations.[38] A Families USA Issue Brief entitled "States Making Progress on Rate Review," goes as far as to say that "[rate review] is arguably the key element keeping the costs of premiums from skyrocketing out of control."[39] Colorado has a strong rate review process in place that, in 2013, saved consumers $62,674,703.[40] However, there is opportunity to expand the rate review process to drive cost containment and quality improvement, such as integrated care. Rhode Island, for example, includes consideration of health system cost containment efforts in the rate review process. [41]

Evaluate Provider and Carrier Market Power. We believe it is important for the Commission to consider how the changes in the market are impacting costs. In addition to provider and carrier consolidation, Colorado is seeing a proliferation of freestanding

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[34] Trust for America's Health (2015). "The State of Obesity: Better Policies for a Healthier America." http://healthyamericans.org/assets/files/TFAH-2015-ObesityReport-final.22.pdf; see also http://healthyamericans.org/reports/stateofobesity2015/

[35] "The Relative Contribution of Multiple Determinants to Health Outcomes" (2014). Health Affairs. Aug. 2014. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf

[36] Campbell et al. (2014). "Early Childhood Investments Substantially Boost Adult Health." *Science* 343, 1478 doi: 10.1126/science.1248429

[37] Karaca-Mandic, Fulton, Hollingshead, & Scheffler (2015). "States With Stronger Health Insurance Rate Review Authority Experienced Lower Premiums In The Individual Market In 2010-13." 34 *Health Affairs* 1358-1367.

[38] Ibid.

[39] Families USA (2011). "Issue Brief: States Making Progress on Rate Review." *Families USA.*

[40] Colorado Division of Insurance (2014). "Health Insurance Cost Report to the General Assembly."

[41] Corlette, Lucia & Keith (2012). "Monitoring State Implementation of the Affordable Care Act in 10 States: Rate Review." *Urban Institute.* [http://www.urban.org/research/publication/monitoring-state-implementation-affordable-care-act-10-states-rate-review]

emergency rooms, with 20 reportedly opening in the state since 2014[42]. Their impact should also be considered in analyzing market impacts on costs.

Reform the Payment and Delivery System: The current fee for service (FFS) system drives quantity over quality. CCHI encourages efforts to improve care coordination of both medical and non-medical needs for consumers. As the Commission explores alternative structures, it is imperative that users of the system are engaged in those discussions and that reforms are designed to ensure the best outcomes for consumers.

Increase Drug Transparency and Affordability: Several states have explored ways to address issues related to drug costs. For example, several states have all looked at limiting cost-share structures for specialty drugs by, for example, requiring co-pays rather than co-insurance and capping the amount of the monthly co-pay. A study by the Colorado Division of Insurance indicates that a $150.00 co-pay on specialty drugs would only minimally impact overall premium (0.7%-1.3%).[43] Proposed legislation in Massachusetts, SB 1048, would require drug companies to disclose information about the pricing of their drugs, such as total production costs and research and development costs, and allows for the state to set a maximum allowable price for prescription drugs deemed "significantly high."[44]

Control Out-of-Network Charges: A consumer may attend an in-network facility but receive care from an ancillary out-of-network provider. While Colorado law requires health plans to hold consumers harmless, often times, consumers do not know that they are protected from paying these charges, causing them to pay the unnecessarily high medical bills. According to one report based on an analysis in New Jersey, these high out-of-network provider charges also cost "the industry hundreds of millions of dollars a year, driving up premiums in a sector where reigning in costs is a national concern."[45] Out of the 5,500 providers that were out of the particular network studied in New Jersey, the carrier reported that 200 of those providers bill some services at 1,000 percent of what is allowed under Medicare.[46] Several states (including Colorado) have or are exploring a state mediation or dispute resolution process to address surprise out-of-network bills, which would allow carriers and providers to negotiate a reasonable price without placing the consumer in the middle.

In conclusion, CCHI appreciates this opportunity to provide our perspective on health care costs and we look forward to continued engagement with the Cost Commission on this important issue.

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[42] Olinger, D. (2015, Sept. 25). "Free-standing ERs abound in affluent Colorado neighborhoods." *Denver Post.* [http://www.denverpost.com/news/ci_28874739/freestanding-ers-abound-affluent-colorado-neighborhoods]

[43] Lewis & Ellis (2015, Apr. 1). "Colorado Pharmacy Cost Study." *Colorado Division of Insurance.*

[44] MA Senate Bill 1048. https://malegislature.gov/Bills/189/Senate/S1048.

[45] Burd, J. (2015). "Bringing out-of-network costs into the light." *NJ Biz Magazine*. [http://www.njbiz.com/article/20150309/NJBIZ01/303069999/bringing-outofnetwork-costs-into-the-light].

[46] Ibid.