# Health Care Affordability

## Market Forces, Flexibility in Benefit Design Among Key Elements

Health care accessibility is a primary concern for everyone. Politicians have various ideas about how to ensure each person has access to quality health care; however, all theories lead to one main issue: affordability. Concerns about affordability are ubiquitous amongst Californians regardless of whether they obtain health care coverage through an employer-sponsored plan or a public exchange.

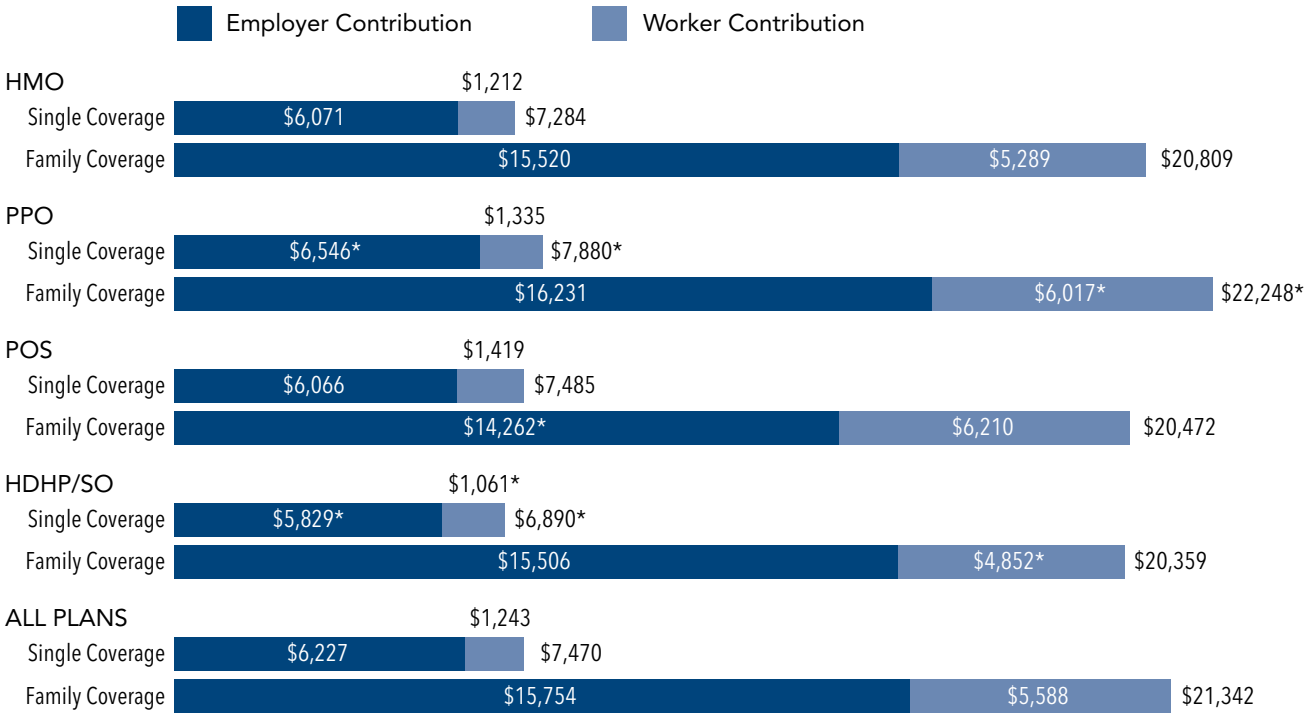
Many Californians are enrolled in an employer-sponsored health plan, meaning ever-increasing premiums are of the utmost concern. What's causing premiums to rise and addressing overall health care cost increases will likely be a fundamental component of California's 2021 legislative package.

### HEALTH CARE COVERAGE AND SPENDING

According to the California Health Care Foundation, 18 million of 32.7 million insured Californians had health care coverage through an employer-sponsored health plan in 2019. Clearly, health care coverage is obtainable in our state. However, is it affordable?

California employers and employees spent $144 billion on health care in 2019—$27 billion was spent by employees on

### AVERAGE ANNUAL WORKER AND EMPLOYER PREMIUM CONTRIBUTIONS




*Estimate is statistically different from All Plans estimate within coverage type ($p < .05$).
Source: Kaiser Family Foundation Employer Health Benefits Survey, 2020

CalChamber

# Agenda for California Recovery

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premiums while $100 billion was spent by employers on premiums. The average premium for family coverage has increased 22% over the last five years and 55% over the last 10 years. Since 2002, premiums for the average family health plan in the employer market have increased 133%. The 2020 Kaiser Family Foundation Employer Health Benefits Survey indicated that, for job-based coverage, the average annual premium for single coverage rose 4% in the last year, to $7,470. The average annual premium for family coverage also rose 4% in the last year, to $21,342, which is nearly one-third of the state's median family income.

California pays more for common health care services than the rest of the United States and price disparities abound within the state itself. When doing a national analysis, the average price of childbirth in California was more than $11,000. Nevada and Arizona had average prices below $8,000.

When attention is turned to California's intrastate spending, prices vary geographically. For example, a vaginal delivery on average is $13,855 in Northern California while it's $11,202 in Southern California. That is a 24% difference. A colonoscopy in Northern California, on average, is $1,007 while it is $887 in Southern California. Inpatient spending differences are even more dramatic when comparing Northern and Southern California. Inpatient procedures, on average, are $223,278 in Northern California while they are $131,586 in Southern California—a 70% difference.

While prices vary across the state, health care spending in and of itself has increased over the last 10 to 15 years. This includes spending on prescription drugs, office-based care, and inpatient care. From 2014 to 2018, total health care spending increased 18.4% for employer-sponsored enrollees. Interestingly, while spending has increased, hospital utilization has decreased.

Hospital commercial patient volume decreased 15% from 2008 to 2018, according to the California Office of Statewide Health Planning and Development (OSHPD). During that same timeframe, total hospital spending for commercial patients rose 283%.

According to OSHPD data, recently extracted by Dr. Glenn Melnick, as of 2016 California hospitals were, on average, billing patients $19,649 per day. Of that billed amount, hospitals received, on average, $7,900. Compare that figure to 2008 when billed charges per day averaged $12,453 with a net of $4,400.

The cause of increased health care costs for employer-based plans is likely due to multiple factors, including high health system concentration, government mandates, increased administrative costs, California hospitals being required to retrofit—the costs of which are passed onto patients, and an aging population. To address these growing costs, the Legislature has introduced various proposals, including a few set forth below.

### ATTORNEY GENERAL OVERREACH WILL NOT REIN IN COSTS

During the 2020 legislative session, Senator Bill Monning (D-Carmel) authored SB 977 in an effort to control health system affiliations and manage large health system pricing by enhancing the Attorney General's power over market activity. The California Chamber of Commerce was part of a large and diverse coalition that opposed this bill.

The legislation would have required a health care system, private equity group, or hedge fund to provide written notice to, and obtain the written consent of, the Attorney General before a change in control or an acquisition between the entity and a health care facility or provider. Under the bill, health systems would have had to demonstrate that their proposed market activity would result in "in a substantial likelihood of clinical integration, a substantial likelihood of increasing or maintaining the availability and access of services to an underserved population, or both." If this prerequisite was not met, then the market activity would be denied. Thus, the bill created the presumption that all market activity was anti-competitive unless and until health systems proved otherwise.

While the author argued that the bill was intended to address increasing health care costs, opponents argued otherwise. The bill would have bestowed unprecedented power upon the Attorney General while characterizing all health system market activity as anticompetitive from the start. Further, the Attorney General already has a panoply of laws to utilize when regulating this market activity. This power was put on full display when the Attorney General entered into a $575 million settlement agreement with Sutter Health in relation to consolidation claims in October 2019.

Additionally, it must be noted that health system consolidation is only a piece of health care cost increases.

Last, imposing burdensome regulations on health system consolidation during a pandemic could actually harm patients and providers. Before the surge at the end of 2020, COVID had caused a substantial decrease in the number of hospital patients. Admissions were down 9.7% while emergency department visits had declined 22.5 (presentation to Assembly Health Committee, October 27, 2020, slide 14). California will likely see health system affiliations, consolidations, mergers and acquisitions in the next year as a result of reduced patient

census causing financial strain on these systems. This market activity will certainly be necessary for care to continue in certain communities.

### SINGLE-PAYER HEALTH CARE: NOT THE AFFORDABILITY ANSWER

Some legislators and even Governor Gavin Newsom have identified the single-payer model as an answer to affordability issues. However, this system is convoluted and expensive. Personal freedom and choice are precluded in a single-payer system, forcing every resident to use an assigned system or physician rather than a health plan or physician of their choosing. Additionally, a single-payer health care system can result in decreased quality of care because competition is eliminated and rates are set by the government. Under such a system, each type of health care provider is designated a set payment amount; thus there is no incentive to provide higher quality of care or be innovative in the care provided.

In 2017, the Senate Appropriations Committee's analysis on SB 562 (Lara; D-Bell Gardens), a bill that would have created a single-payer system in California, found the cost would be approximately $400 billion. This estimate is uncertain, however, as federal waivers would have to be obtained for all federal programs that provide funds for payment of health care services, such as Medicare, Medicaid and others. Even if all current employer and employee spending on health care were shifted over to a single-payer system, there still would be a shortfall of $100 billion.

To address this significant cost, the Legislative Analyst's Office identified a 15% payroll tax increase as the most likely source of funding for a single-payer health care system. Vermont attempted to enact a single-payer system in 2011, but the efforts were derailed when an 11.5% payroll tax on businesses and an individual income tax increase of up to 9.5% were proposed.

A payroll tax increase to finance single-payer health care would not only have a detrimental impact on businesses in California, but it would likely discourage companies from locating and establishing businesses here. Additionally, payroll tax increases would likely lead to job layoffs as existing businesses and employers would be forced to cut costs to sustain the added new tax burden.

### CALCHAMBER POSITION

Californians need to have access to affordable, quality health care. The cause of health care cost increases is multifactorial and addressing the issue requires a holistic approach. Coverage mandates, cost sharing caps, cumbersome administrative requirements, and Attorney General overreach are not the answer. Affordable health coverage requires market forces playing a predominant role, allowing employers flexibility in benefit design, giving health plans and insurers an opportunity to offer more affordable coverage to employers by controlling the size of their provider networks, and allowing for price transparency at the point of care.

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