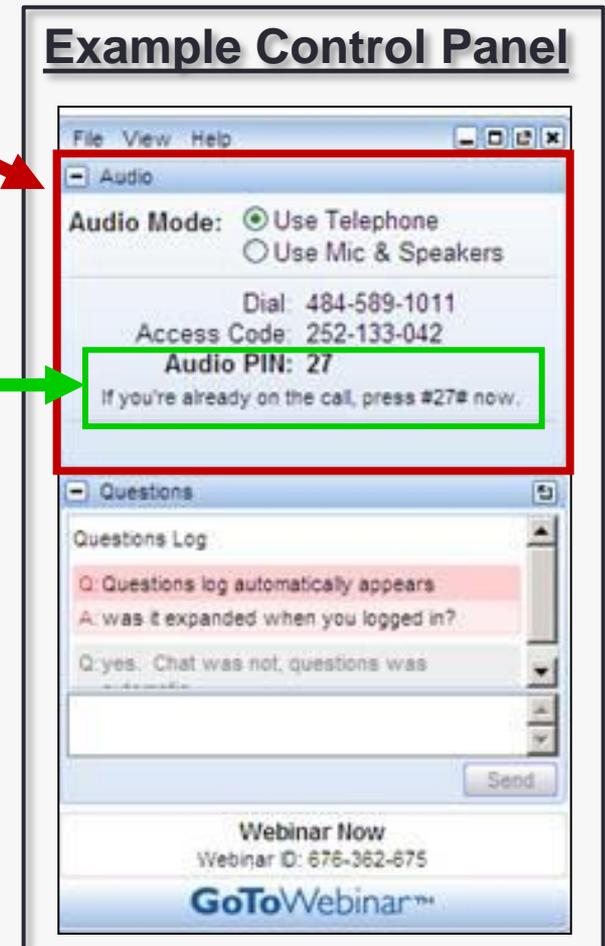


# Telephone Instructions

*Please note: This webinar is live*

1. To join the webinar using a telephone, change the Audio mode to “Use Telephone”
  2. Dial the telephone number provided.
  3. Enter the Access Code followed by the pound sign (#)
  4. Enter your Audio PIN followed by the pound sign (#)
- If you do not input your “Audio PIN” at the beginning of the Webinar, you can enter “#PIN#” anytime during the Webinar.
    - Example: #27#, see screenshot at right
  - Toll charges may apply.
  - ***Please remember to mute your phones***



# WELCOME

---

Task Force Co-Chairs

Diana Dooley, Secretary

California Health and Human Services  
Agency

Donald M. Berwick MD, MPP, FRCP



Let's Get Healthy California Task Force



# LET'S GET HEALTHY CALIFORNIA TASK FORCE

---

Task Force and Expert Advisor Group Meeting

Debbie Freund, PhD

President and University Professor  
Claremont Graduate University

Tuesday, August 21, 2012



# OVERVIEW OF TASK FORCE CHARGE AND TIMING

---

Patricia E. Powers, Director  
Let's Get Healthy California Task Force



Let's Get Healthy California Task Force



# Executive Order B-19-12

- Prepare a 10-year plan that will:
  - Improve the health of Californians
  - Control health care costs
  - Promote personal responsibility for health
  - Advance health equity
  - Not involve additional government spending
- Key Plan Components
  - Establish baselines for key health indicators and standards for measuring improvement over a 10-year period
  - Seek to reduce diabetes, asthma, childhood obesity, hypertension, sepsis-related mortality, hospital readmissions within 30-days of discharge, and increase the number of children receiving recommended vaccinations by age three
  - Identify obstacles for better health care



# The Charge

*“What will it take for California  
to be the healthiest state  
in the nation?”*

Diana Dooley, Secretary  
California Health and Human Services Agency  
June 11, 2012

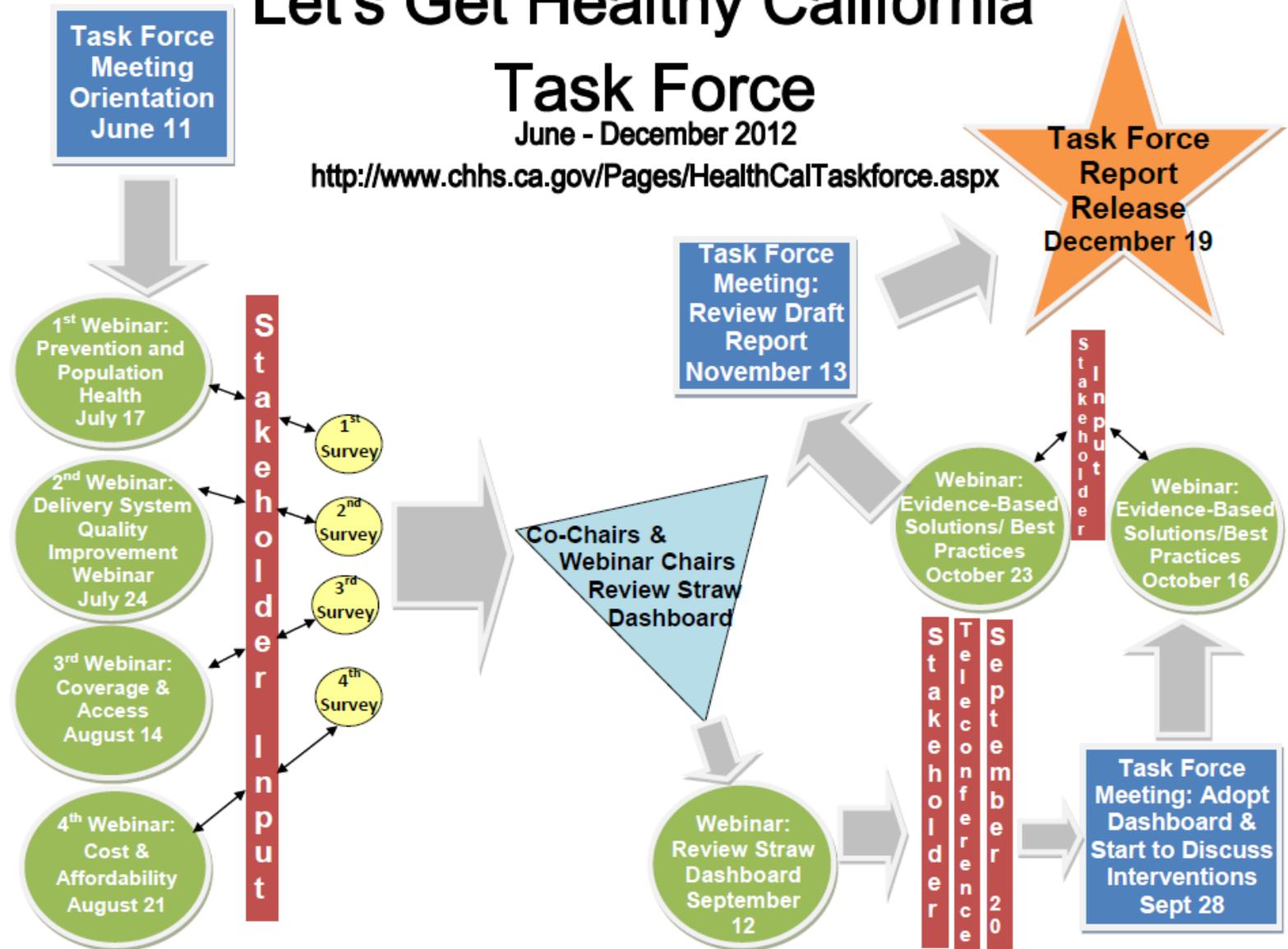


# Let's Get Healthy California

## Task Force

June - December 2012

<http://www.chhs.ca.gov/Pages/HealthCalTaskforce.aspx>



# Consensus Approach

- Majority rules
- Surveys will follow each webinar
- Staff to summarize Task Force/Expert Advisor priorities
  - Discuss on September 12<sup>th</sup> webinar
  - Present to Task Force to vote on September 28<sup>th</sup>



# GUIDING PRINCIPLES

---



Let's Get Healthy California Task Force



# HEALTHCARE AFFORDABILITY & COSTS

---

Richard Scheffler, Distinguished Professor of Health Economics & Public Policy  
*School of Public Health & the Goldman School of Public Policy, UC Berkeley*

**I appreciate the input and contributions of the following people:**

**Liora Bowers, MBA, MPH**

Director of Health Policy & Practice

Petris Center on Health Care Markets & Consumer Welfare,

UC Berkeley SPH

**Debbie Freund, PhD**

President and University Professor

Claremont Graduate University



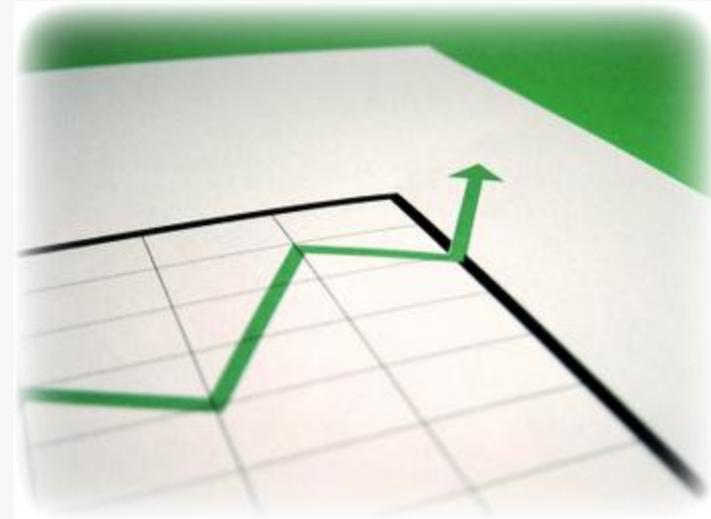
Let's Get Healthy California Task Force



# Recommended Framework

## Cost indicators:

- Health spending compared to economic growth

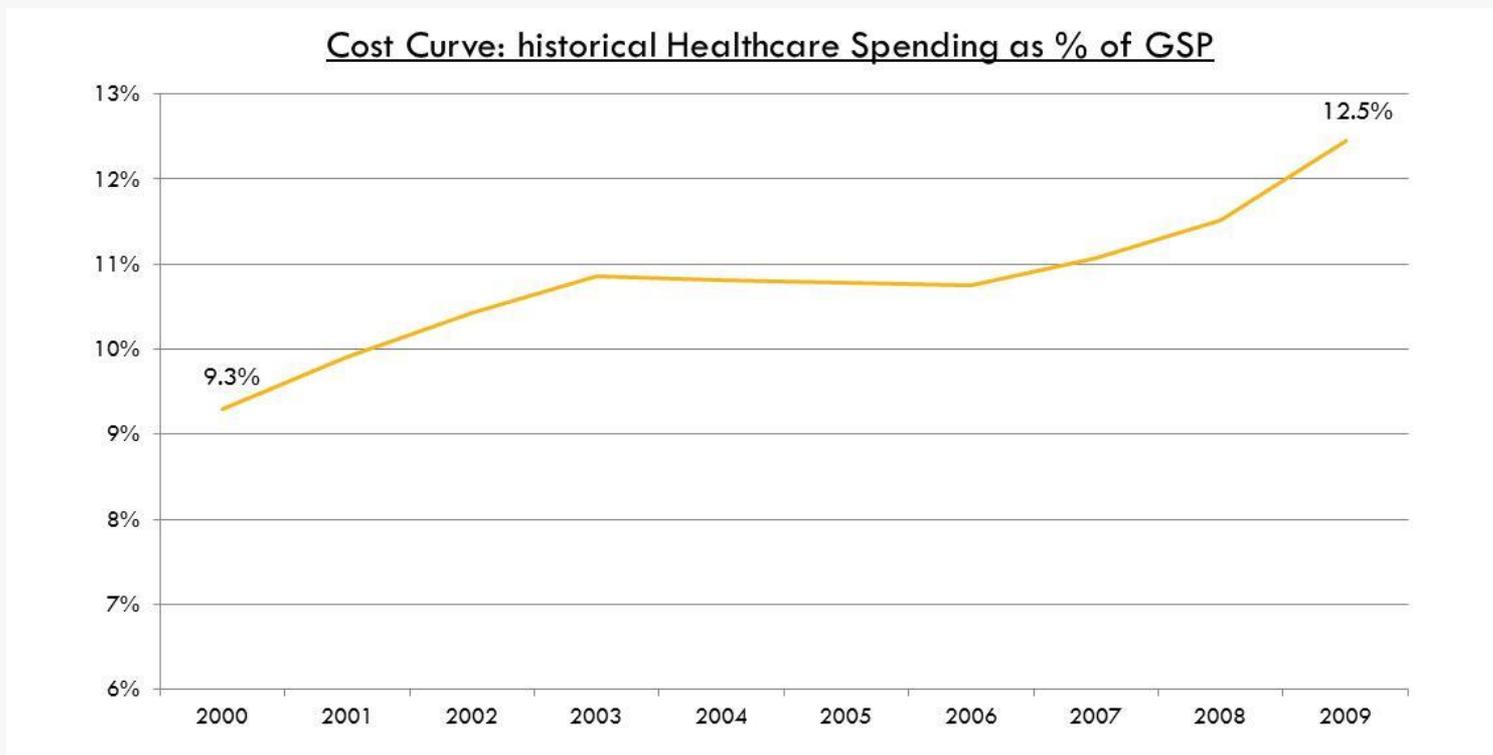


## Affordability indicators:

- Measures of premiums / out-of-pocket spending as a share of household income

# Priority #1: Health Spending - Aggregate

- 32% increase in GSP between 2000 – 2009
- 73% increase in healthcare spending in same time period



Healthcare spending in California is consuming an increasing share of the economy

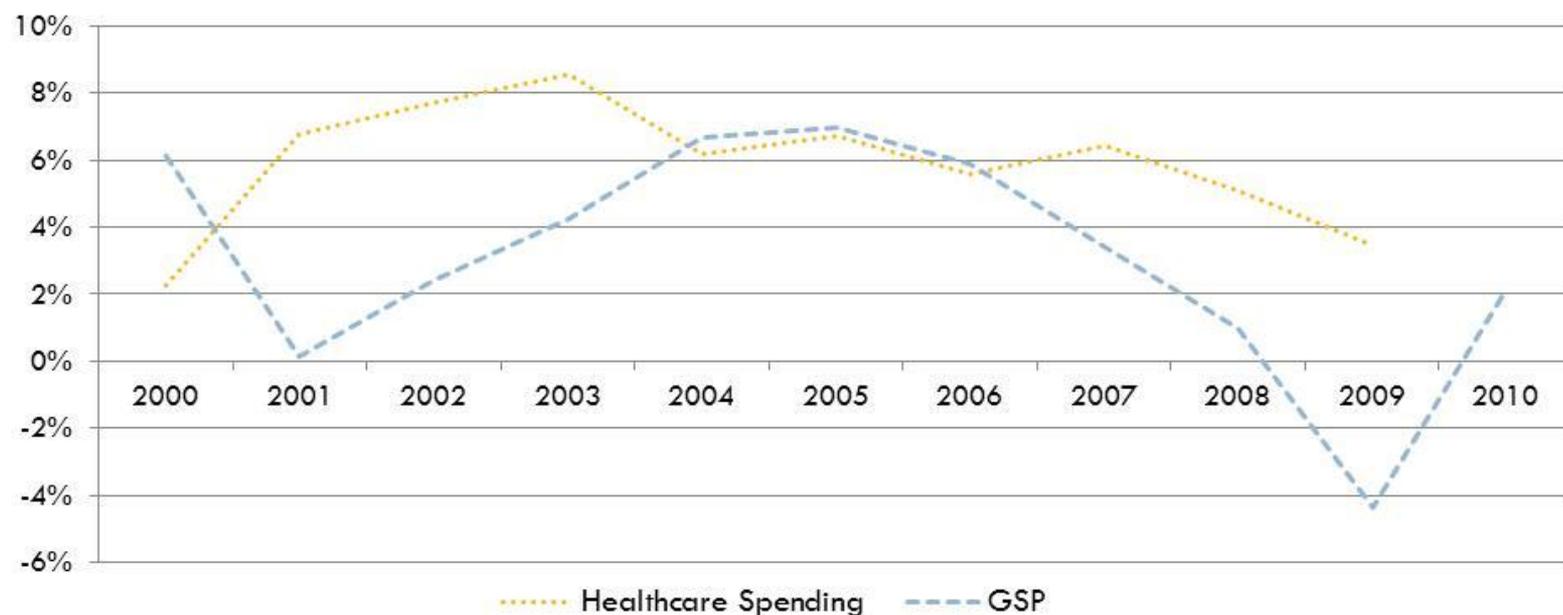
*\*Preliminary analyses*

*Data from CMS' State Health Expenditure Accounts (SHEA) and Bureau of Economic Analysis*

# Priority #1: Health Spending - Aggregate

On average between 2000 - 2009, health care costs grew 2.6% faster per year than did GSP

Historical per capita GSP & Healthcare Spending annual growth rates

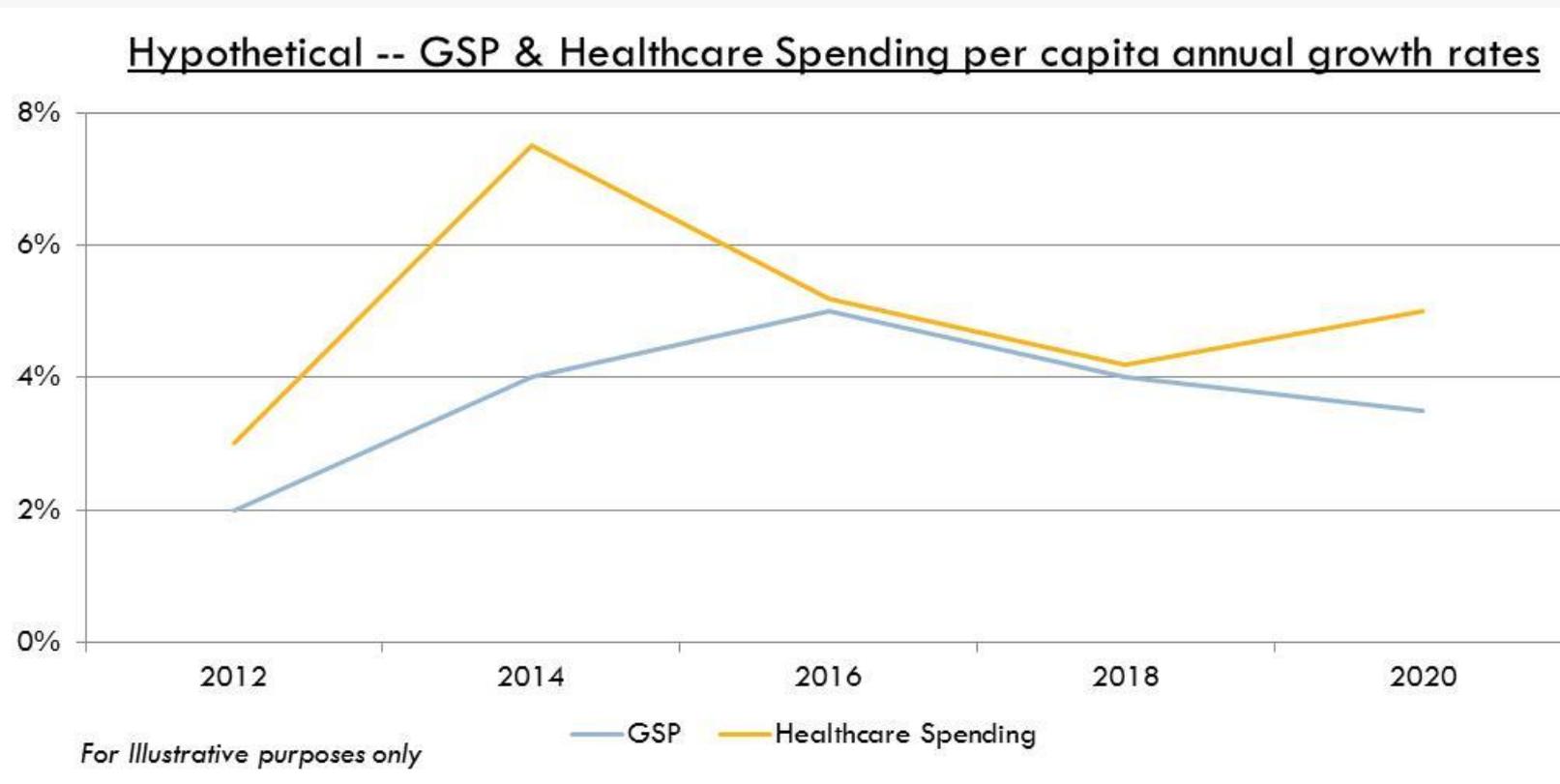


Because of cyclical fluctuations, it is important to consider health care spending's share of the economy over an extended period of time – e.g. 10 years

\*Preliminary analyses

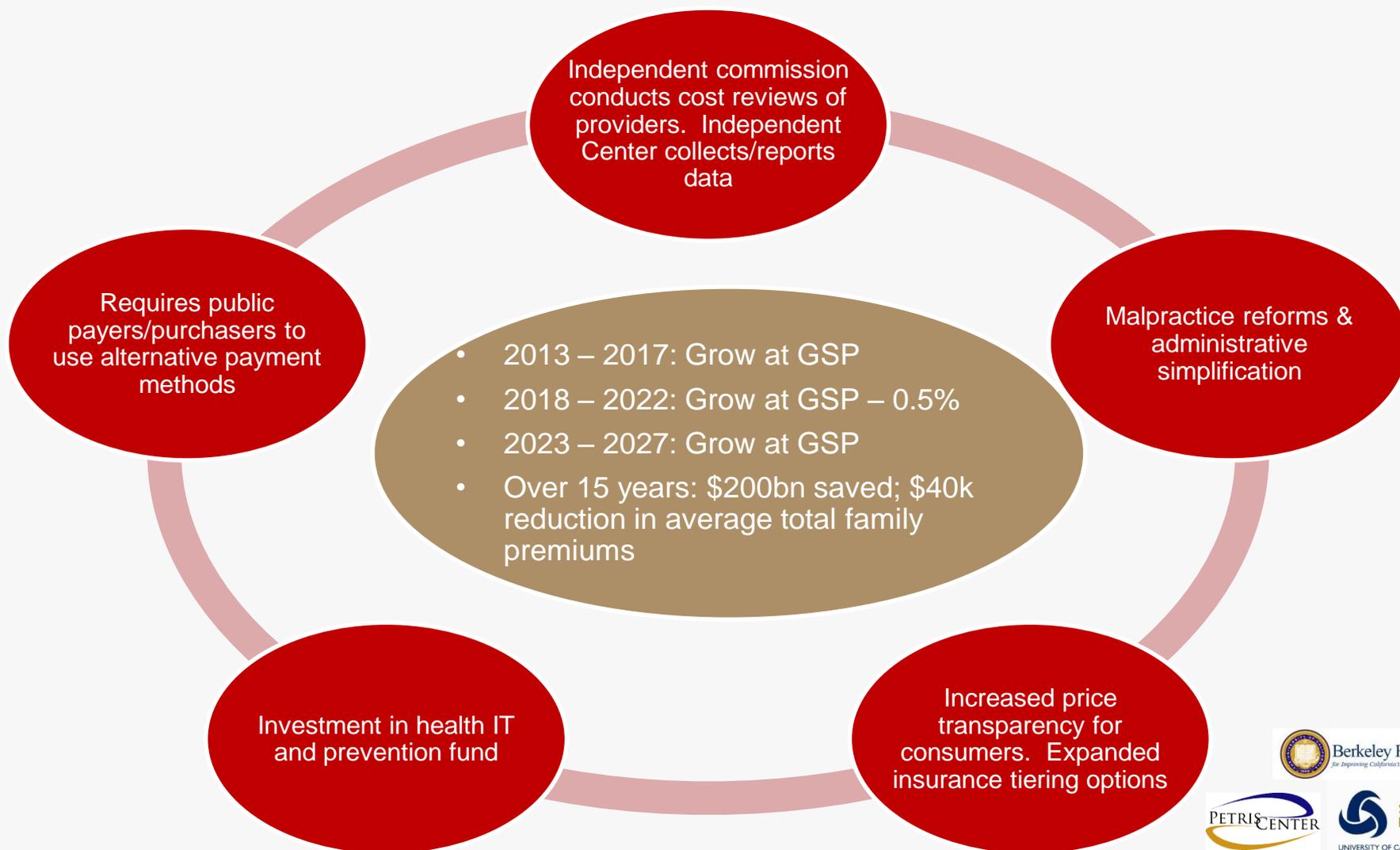
Data from CMS' State Health Expenditure Accounts (SHEA) and Bureau of Economic Analysis

# Priority #1: Health Spending - Aggregate



Preliminary forecasts suggest that healthcare spending growth will continue to outpace economic growth through 2020

# Recent MA Legislation on Cost Control (signed into law on August 6, 2012)



# Recommended Cost Indicator

Indicator	Data Source	CA (2009)
Healthcare spending as % of GSP / GDP	<p><i>Healthcare Spending:</i> CMS State Health Expenditure Accounts (SHEA), by State of Residence</p> <p><i>Gross State Product:</i> Bureau of Economic Analysis</p>	<ul style="list-style-type: none"> <li>• Health Exp per capita: \$6,225</li> <li>• GSP per capita: \$49,972</li> <li>• <b>Indicator<sup>1</sup>: 12.5%</b></li> </ul>

1) In 2009, overall US healthcare spending as a % of GDP was 14.8% (based on \$6,807 in health spending per capita; \$45,989 in GDP per capita). Dollar figures are unadjusted for cost of living.

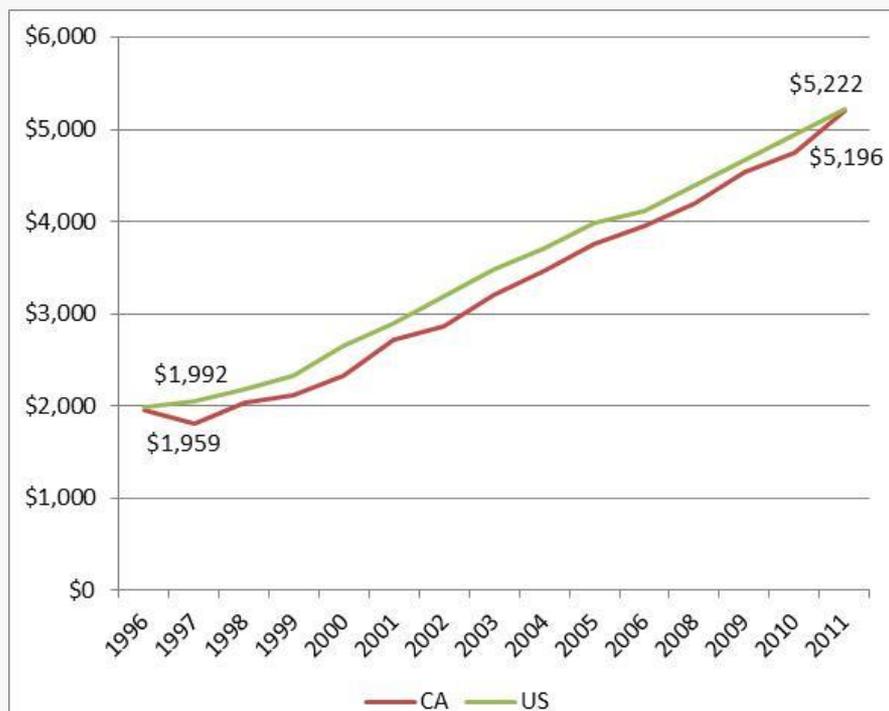
\*Preliminary analyses

# Polling Question

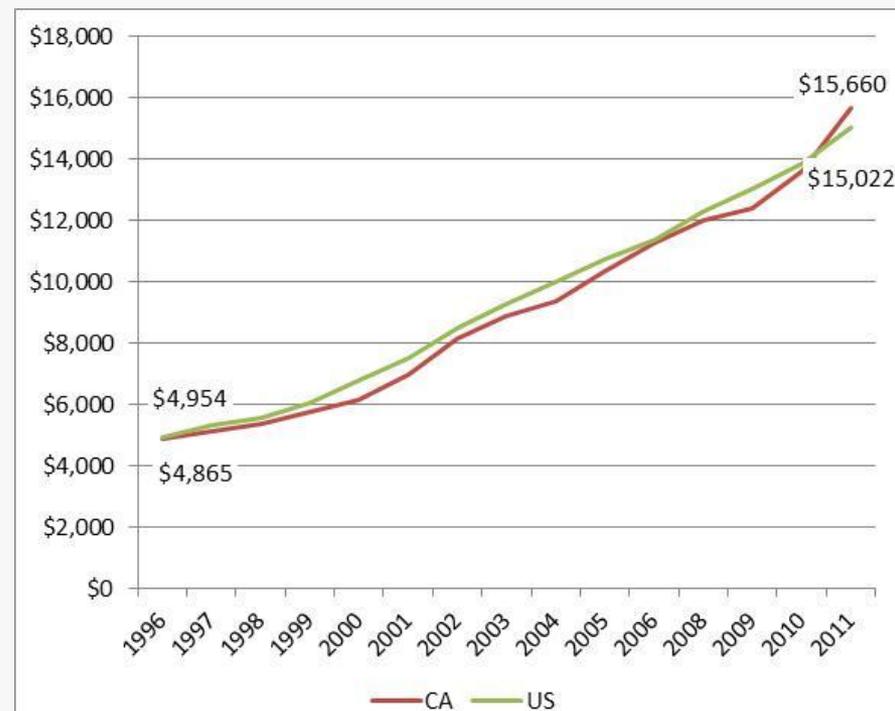
- 1) Do you support linking health spending in California to growth in the Gross State Product?
  - Yes
  - No

## Priority #2: Affordability – Total Premium (ESI)

**Total Employer-Sponsored  
Single Coverage Premium**  
(adjusted for CPI)<sup>1</sup>



**Total Employer-Sponsored  
Family Coverage Premium**  
(adjusted for CPI)<sup>1</sup>



While adjusted single and family employer-sponsored premiums in California have tracked US premiums since 1995, they have increased faster in recent years

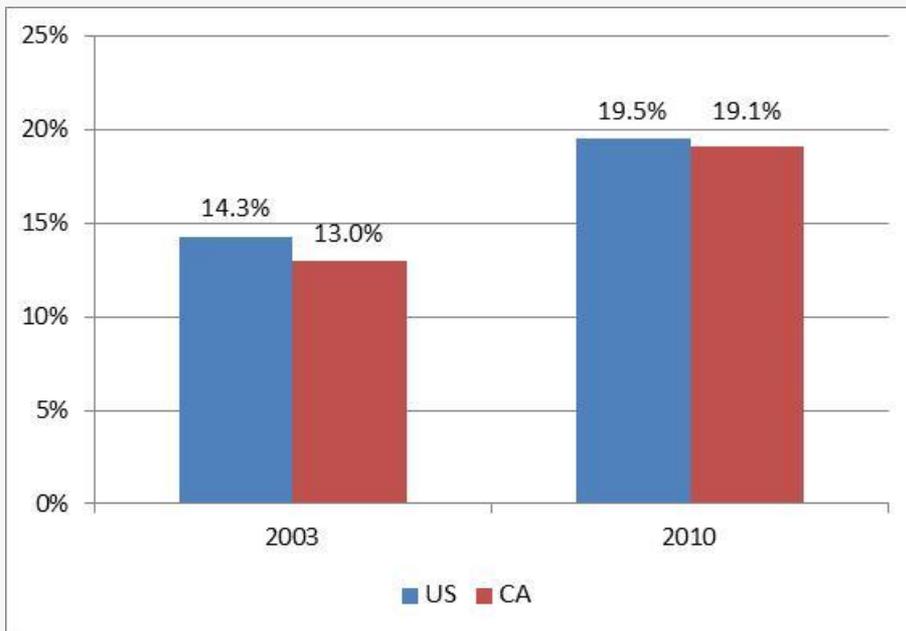
1) Total premium includes both employee and employer share and represents average premium in CA / US. Premiums are adjusted by CPI (CA adjustment based on West Region CPI)

\*Preliminary analyses. Data from MEPS Insurance Component State files

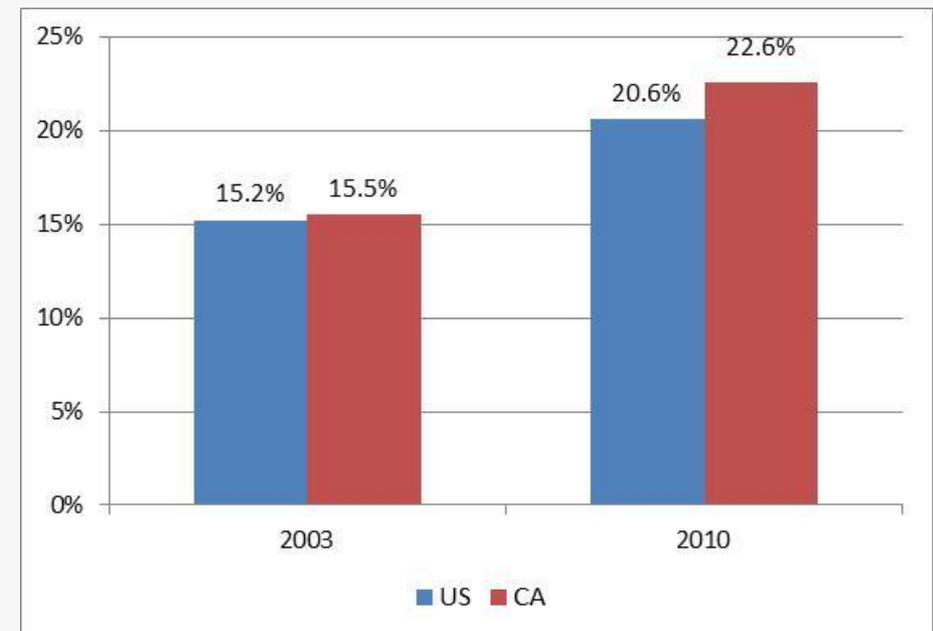
ESI = Employer-Sponsored Insurance

## Priority #2: Affordability – Total Premium (ESI)

Total Single Coverage Premium as % of Median Household Income<sup>1</sup>



Total Family Coverage Premium as % of Median Household Income<sup>1</sup>

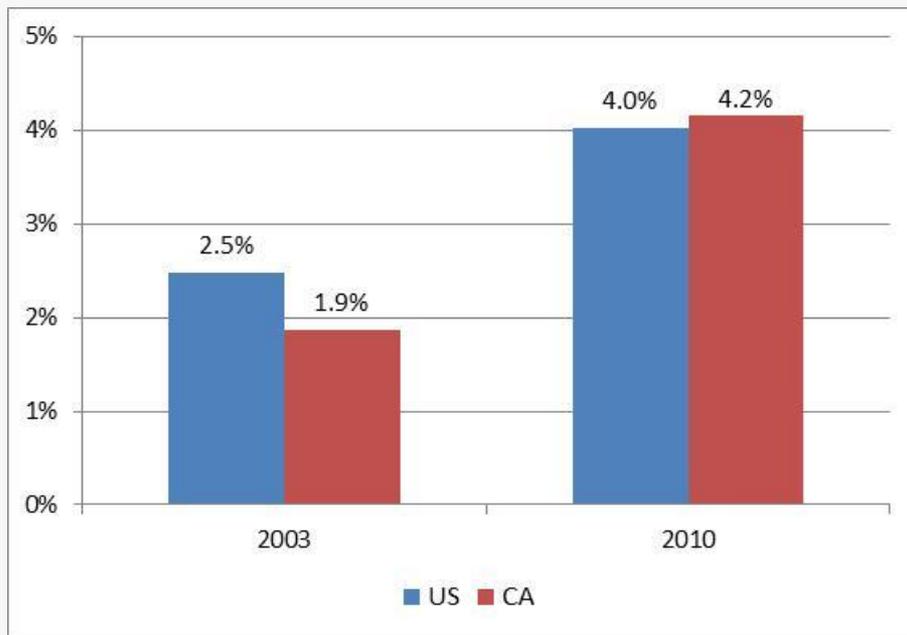


Percent of median household income spent on total employer-sponsored premiums has increased faster in CA versus the US

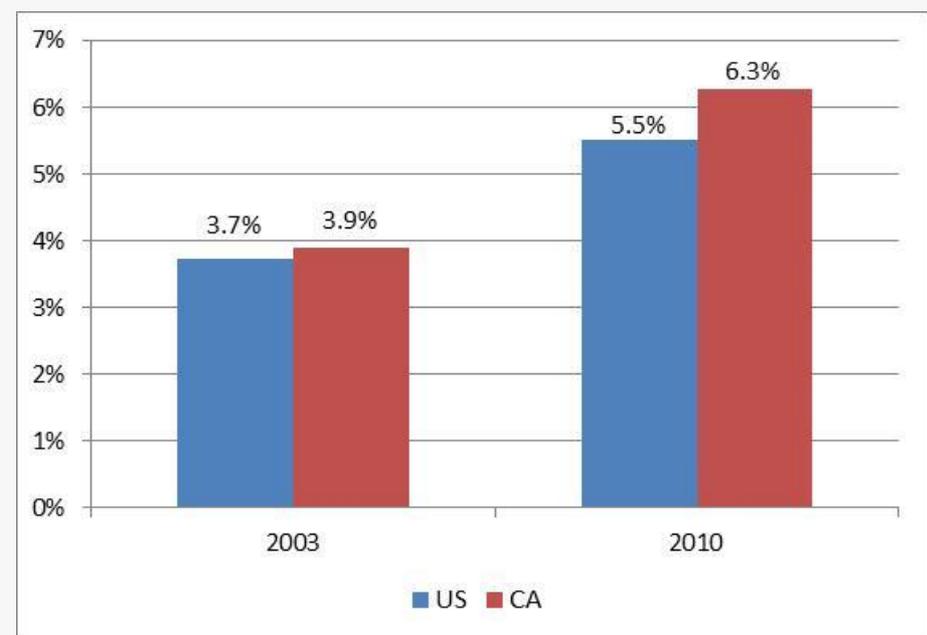
1) Total premium includes both employee and employer share and represents average premium in CA/ US. Data from Commonwealth Fund's "State Trends in Premiums and Deductibles, 2003–2009", which uses MEPS for premiums and Current Population Survey for income data  
ESI = Employer-Sponsored Insurance

## Priority #2: Affordability – Individual Cost Burden (ESI)

Employee Share of Single Coverage Premium as % of Median Household Income<sup>1</sup>



Employee Share of Family Coverage Premium as % of Median Household Income<sup>1</sup>



Percent of median household income spent on the employee share of employer-sponsored premiums has increased faster in CA versus the US

1) Includes only employee share of premiums and represents average premium in CA/ US.  
 Data from Commonwealth Fund's "State Trends in Premiums and Deductibles, 2003–2009", which uses MEPS for premiums and Current Population Survey for income data  
 ESI = Employer-Sponsored Insurance

## Priority #3: Affordability – Individual Cost Burden

- CA has a relatively high HMO penetration: 77% of covered employees in CA have the choice of an HMO vs. only 39% in the US
  - HMOs tend to offer more comprehensive coverage and lower cost-sharing
- Aside from premiums, co-pays and deductibles affect overall affordability of health care:
  - For example, in 2011, the median HMO office visit co-pay was \$15 in CA, an increase from \$10 in 2005
  - Similarly, the average deductible for PPOs increased 43% between 2005 and 2011, going from \$348 to \$499

It is important to monitor how cost-sharing and benefit design change over time to allow for a comprehensive analysis of affordability

1) Based on PPO plans with deductibles (84% of PPO plans in CA). Co-pay and deductible figures are nominal (unadjusted for CPI)

\*Preliminary analyses. Data from CHCF – California Employer Health Benefits Survey



# Recommended Affordability Indicators

Indicator	CA <sup>1</sup>	US <sup>1</sup>
2010 Percent of household income spent on Total <sup>1</sup> Healthcare <sup>2</sup> (Single)	To be analyzed	17.6%
2010 Percent of household income spent on Total <sup>1</sup> Healthcare <sup>2</sup> (Family)	To be analyzed	23.4%
2010 Percent of household income spent on Employee / Exchange participant contribution to Healthcare <sup>2</sup> (Single)	To be analyzed	6.7%
2010 Percent of household income spent on Employee / Exchange participant contribution to Healthcare <sup>2</sup> (Family)	To be analyzed	9.6%

*Using MEPS data, the California analysis could be conducted on a granular level based on education level, ethnicity, or income level. However, MEPS does not allow for a sub-geographic analysis within the state.*

**Recommend considering Affordability based on total spending on healthcare – including premiums, deductibles and copays – as percent of household income**

- 1. “Total “ refers to both employee and employer contribution (ESI). The California Health Benefits Exchange could similarly track both the individual contribution plus subsidies for Exchange participants to track “Total” premiums*
- 2. “Healthcare” refers to sum of: all premiums + co-pays + deductibles within a household. An individual household is defined as 1 member, a family is defined as 2+ members.*
- 3. Refers to only the employee contribution. The California Health Benefits Exchange could similarly track only the individual contribution portion for Exchange participants (not including subsidies)*

*\*Preliminary estimates. Data from MEPS Insurance Component State files*

# Discussion

- 2) Do you support measuring affordability by looking at Total Premiums (employee + employer) as % of household income
- Yes
  - No
- 3) Would you also be interested in considering total health care spending (including copays & deductibles) as % of household income
- Yes
  - No

# Drivers of Healthcare Spending

## Factors<sup>1</sup>

## Illustrative examples

Population Aging  
(2%)

- Population distribution

Increase in personal income  
(11 – 18%)

- Wage rates
- Employment rates

Changes in 3<sup>rd</sup> party payment  
(10%)

- Insurance mandates
- Coverage expansion
- Benefit design

Prices  
(11 – 22%)

- Cost of inputs
- Site of care
- Market structure

Administrative costs  
(3 – 10%)

- Billing, claims
- Regulatory burdens

Technology-related changes  
(38 – 62%)

- New treatments & procedures
- New drugs, devices
- Broader application of existing technologies

Drivers of healthcare spending include both healthcare-specific as well as demographic and economic factors

1) Data from: Sheila D. Smith, Stephen K. Heffler, and Mark S. Freeland, "The Impact of Technological Change on Health Care Cost Increases: An Evaluation of the Literature" (working paper, 2000)

*This work was supported in part by the Berkeley Forum for Improving  
California's Healthcare Delivery System  
School of Public Health, UC Berkeley*

# APPENDIX

---

# Current Performance on Affordability Indicators

Indicator <sup>1</sup>	Source	CA (2010)	USA (2010)
<p><b><u>Total<sup>3</sup>:</u></b> Total commercial premiums as % of median household income</p>	<p><u>Employer<sup>1</sup>:</u> Commonwealth Fund</p> <p><u>Exchange:</u> Proposed collection by Exchange</p>	<p><u>Employer:</u></p> <ul style="list-style-type: none"> <li>• Single: 19.1%</li> <li>• Family: 22.6%</li> <li>• Overall<sup>2</sup>: 21.5%</li> </ul> <p><u>Exchange:</u> NA</p>	<p><u>Employer:</u></p> <ul style="list-style-type: none"> <li>• Single: 19.5%</li> <li>• Family: 20.6%</li> <li>• Total<sup>2</sup>: 20.3%</li> </ul> <p><u>Exchange:</u> NA</p>
<p><b><u>Individual share<sup>3</sup>:</u></b> Employee / Exchange participant share of commercial premiums as % of median household income</p>	<p><u>Employer<sup>1</sup>:</u> Commonwealth Fund</p> <p><u>Exchange:</u> Proposed collection by Exchange</p>	<p><u>Employer:</u></p> <p>Single: 4.2%</p> <p>Family: 6.3%</p> <p><u>Exchange:</u> NA</p>	<p><u>Employer:</u></p> <p>Single: 4.0%</p> <p>Family: 5.5%</p> <p><u>Exchange:</u> NA</p>

1. Data from Commonwealth Fund's "State Trends in Premiums and Deductibles, 2003–2009", which uses MEPS for premiums and Current Population Survey for income data
2. Weighted by distribution of family/single premiums within the state / US
3. Note: "Total Premiums" or "Employee / Exchange Participant Premium" can be based on employer-sponsored insurance or Exchange-based insurance (taking into account government premium subsidies).

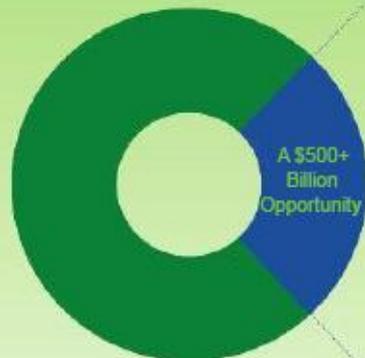
# Other Sample Cost & Affordability Indicators

Indicator	CA <sup>5</sup>	US <sup>5</sup>
2009 Total healthcare expenditure per capita <sup>1</sup>	\$6,225	\$6,807
2010 Total <sup>2</sup> premium <sup>3</sup> (single) <sup>4</sup>	\$4,811	\$4,940
2010 Total <sup>2</sup> premium <sup>3</sup> (family) <sup>4</sup>	\$13,819	\$13,871
2010 Employee / Exchange participant premium <sup>4</sup> contribution: (single) <sup>5</sup>	\$1,048	\$1,021
2010 Employee / Exchange participant premium <sup>4</sup> contribution (single) <sup>5</sup>	\$3,845	\$3,721

1. Data from CMS' State Health Expenditure Accounts (SHEA)
2. "Total" refers to both: 1) employee and employer contribution (ESI)
3. "Total Premiums" or "Employee / Exchange Participant Premium" is based on employer-sponsored insurance
4. Data from Commonwealth Fund's "State Trends in Premiums and Deductibles, 2003–2009", which uses MEPS data for premiums and Current Population Survey for income.
5. Data is unadjusted. However, for any dollar figure indicators, we recommend an adjustment based on cost of living / CPI in CA vs. US. Regional CPI is available (West) as is CPI for specific urban areas (e.g. SF, LA, San Diego)

# BEND THE CURVE

## A Health Care Leader's Guide to High Value Health Care



- Reducing Emergency Department Overuse
- Reducing Antibiotic Overuse
- Improving Patient Medication Adherence
- Reducing Vaccine Underuse
- Preventing Hospital Readmissions
- Decreasing Hospital Admissions for Ambulatory Care Sensitive Conditions
- Preventing Medication Errors



# TASK FORCE AND EXPERT ADVISOR DISCUSSION

---

Please use the hand raise  
feature.



# OPPORTUNITY FOR STAKEHOLDER COMMENT

Please type comments into the  
“Questions” feature and click  
the Send button.

A screenshot of the GoToWebinar interface. The top window is titled 'Audio' and contains the following text: 'Audio Mode:  Use Telephone  Use Mic & Speakers', 'Dial: 484-589-1011', 'Access Code: 252-133-042', 'Audio PIN: 27', and 'If you're already on the call, press #27# now.'. Below this is a window titled 'Questions' which is highlighted with a red border. It contains a 'Questions Log' section with the following text: 'Q: Questions log automatically appears', 'A: was it expanded when you logged in?', and 'Q: yes. Chat was not, questions was'. At the bottom of the 'Questions' window is a 'Send' button. Below the 'Questions' window, the text 'Webinar Now' and 'Webinar ID: 676-362-675' is visible, along with the 'GoToWebinar™' logo at the bottom.

# Contact information:

- Website:

<http://www.chhs.ca.gov/Pages/HealthCaITaskforce.aspx>

- Email:

[SRobinso@chhs.ca.gov](mailto:SRobinso@chhs.ca.gov)

- Comments

- Please submit any additional priorities or indicators to Sonia Robinson by **August 23, 2012**

