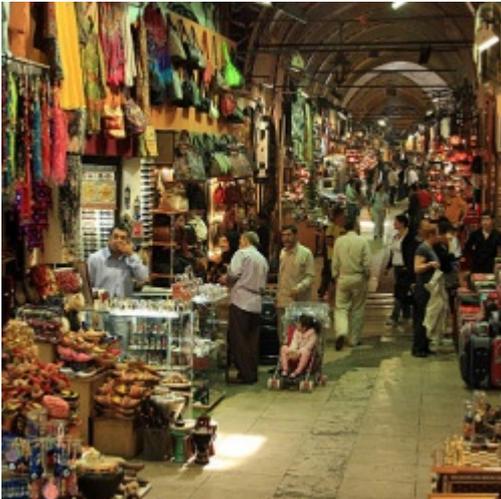


California's Legislation to Control Health Care Costs is Misguided



By Chuck Dinerstein — May 2, 2018



By Dmgultekin [1]

Today's labor negotiations frequently involve healthcare costs, employers, and labor tossing numbers back and forth, like the proverbial hot potato. Now two large purchasers of commercial healthcare insurance in California, the State's employees, and labor unions have introduced a bill (AB 3087) to cap costs and control further increases. It will be neither a panacea in managing their costs nor will it be the "end of times" pictured by the targets of this bill - hospitals, physicians and commercial, private insurers.

The legislation creates a new state commission to:

- Set a ceiling on payments to all the hospitals, physicians, laboratories, outpatient centers by private insurers as a percentage of what Medicare pays but no less than 100%.
- Set a global cap on California's health care spending.

The bill will not:

- Increase transparency since the insurance companies' negotiations with health plans and systems will remain confidential and proprietary.
- Effect Medicare and MediCal, California's Medicaid program, since it caps charges only for private insurance.
- Ensure that savings will trickle down to the actual purchasers.

The reporting from California notes the similarities and differences between this bill and Maryland's first in the nation global health care payment system. This reporting is misleading because the law creates the same market conditions that plague drug prices, benchmarks misused, secret

negotiations, pricing that favors some at the expense of others and special interests. AB 3087 will not end well despite its intentions.

Benchmarks

Medicare's allowable charge (MAC) is what Medicare actually pays providers, be they a clinician or health system. Medicare calculates allowable charges for all medical procedures based on a physician's effort and geographically adjusted costs for office expenses and malpractice. It is a readily understood calculation. AB 3087 uses the MAC to determine California's benchmark which can be no less than 100% of MAC but can be set higher. Most price negotiations already use this approach, calculating the commercial insurance payment as MAC multiplied by some percentage, say 20 to 50%. The bill merely formalizes the processes. For example, if Medicare's allowable charge was \$100, then a commercial insurer might pay Medicare + 20%, \$120. Drug pricing's benchmark is the drug's average wholesale price. It is a mystical number because no one can show you how it is calculated – but it represents costs, of manufacturing, distributing, advertising, research, development and the risk of innovation, along with a profit.

Secret, proprietary negotiations

California's "base rate" benchmark, is used only as a starting price in negotiations. In negotiations, size matters because it gives you leverage to get the best possible deal. In drug pricing, more purchasers (patients) results in leverage to lower prices; in health care services, providing care to more customers, termed "lives at risk," provides leverage resulting in higher payment. For a marketplace to properly function, price information needs to be widely known otherwise you may pay too high or ask too little. In econ terms, price signals value. The negotiated price for drugs is secret, proprietary information; the secrecy eliminates the price signal. It is unavoidable when prices are unknown that there is inequity - some people pay more, others less. AB 3087 explicitly maintains the secrecy of negotiated costs for health care services and therefore results in similar inequality, some health plans will pay more than others.

Pricing inequality results in winners and losers

Government, Federal or California's is the largest single purchaser of drugs and health services, so they make some exceptions for themselves. For drug pricing, the Department of Defense must be charged the lowest price available, including all the secret negotiated prices. On the other hand, Medicare's drug payments cannot be negotiated they are based solely on the average wholesale price. Exemption and special rules result in an uneven "playing field" where government declares some groups winners and others losers.

AB 3087 has identified its first winner, MediCal, their Medicaid program. MediCal wins because they are exempt from these health service price caps; they already pay roughly 10% less than Medicare's allowable charge.

The losers in drug pricing often try to make themselves "whole again," by shifting their losses onto others. Rising out-of-pocket expenses is a form of cost shifting. But there are other approaches. Because AB 3087 does not address the fee-for-service payment model, health systems and physicians can "cut their losses" by merely performing more services, like home care. In the first

three years of Maryland's payment reform, the rate of increase in hospital admissions tripled from the national average. We should expect an influx of less expensive mid-level providers; health cares "generic". They pay for themselves and perhaps return a small profit. So why not hire more of them as a substitute for more expensive physician labor?

If by some chance the price caps are set so that insurance companies face losses, expect higher out-of-pocket expenses. AB 3087 has no provision to control out-of-pocket costs. That is left to current federal and state guidelines limiting out-of-pocket payments to 40% of an individual's health care costs or about \$7,300 whichever is lower.

Special interests

The marketplace for drugs, because of benchmarks, price opacity and cost shifting requires intermediaries to navigate among the players and "grease" the wheels of commerce. Pharmacy benefit managers fulfill that intermediary role and are among the "villains" of high drug prices. AB 3087 creates intermediaries beginning with the commission itself. Paying for their additional oversight is to come from "the savings," but we all know that at some point the burgeoning bureaucracy will need more money. We should anticipate surcharges, a well-established revenue source, on healthcare services to plug any bureaucratic shortfalls. More importantly, the commission will use outside consultants and advisors to help formulate caps. And like pharmacy benefit managers they will be rewarded for the influence.

AB 3087 is also supposed to cap California's total health care expenditures. Maryland is the closest of any state to that goal. But to get there, Maryland ended fee-for-service, paying health systems a capitated rate irrespective of the insurer, and receiving a special exemption and financial support from the Federal government. AB 3087 has none of these necessary provisions and admits that no mechanism is in place.

Assembly Bill 3087 intent is admirable but moves in the direction of the dysfunctional market created around drug pricing. It has an explicitly calculated benchmark, but by allowing secret negotiations over costs, it will inevitably create winners and losers. The inequality will be exacerbated when the losers seek to shift their costs onto the actual payers, you and me. Just like in the market of drug pricing. Do we want more of that marketplace?

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