CHCF Updates Medi-Cal Facts and Figures
The California HealthCare Foundation has published a detailed overview of Medi-Cal, California’s Medicaid program. Medi-Cal provides health coverage for one in five non-elderly Californians and one out of every three children in California, totaling 7.6 million people.

Medi-Cal is undergoing significant changes as it shifts most enrollees into managed care, as it absorbs the 850,000 Healthy Families Program beneficiaries, and as more than one million Californians become eligible for Medi-Cal under the Affordable Care Act next year.

Medi-Cal managed care covers 69% of the Medi-Cal population – having increased 50% in the past five years – but accounts for only 26% of Medi-Cal expenditures. Seniors and Persons with Disabilities account for 24% of Medi-Cal beneficiaries but nearly 70% of expenditures. Medi-Cal Managed Care is currently available in 30 of the 58 counties and will expand to the remaining 28 in September 2013.


Study Proposes $1 Trillion in Health Care Savings
A bipartisan report from the Brookings Institution aims to bend the health care cost curve by $1 trillion over the next 20 years, with $300 billion in federal savings over 10 years. The comprehensive proposal includes reforms to Medicare, Medicaid, and private health insurance as well as regulatory reforms to medical liability, antitrust rules, scope of practice laws, access to telemedicine, and certain licensing rules.

- Changes to Medicare include phasing out Medicare fee-for-service, capping Medicare out-of-pocket expenses, and increasing Medicare and Medicare Advantage payments in relation to per capita GDP growth.

- For Medicaid, the report recommends transitioning from waivers to “person-focused Medicaid,” allowing states that improve quality and reduce per capita costs to keep a disproportionate share of the savings, creating a stronger and permanent infrastructure for dual eligibles, and facilitating

Resources
All of CAHP’s publications and research, including the Research Review, are available online.

Contact
California Association of Health Plans
1415 L Street
Sacramento, CA 95814
916.552.2910

Contact Sunshine Moore, Policy Analyst/Writer, with any questions about the Research Review or to be added to the policy unit’s distribution list.
managed care plans to participate in state insurance exchanges to help mitigate churning.

- Reforms to the private health insurance market include capping the employer-provided health insurance tax subsidy, supporting employer efforts to reduce overall health care costs through ERISA, tiered benefit designs, narrow networks, employees’ ability to share in the savings, and promoting transparency by making standard measures of provider performance available from Medicare and Medicaid.

- The bipartisan group also supports regulations that would allow flexibility in plan choices with actuarially equivalent benefit designs in the state exchanges and regulations that would offset state-specific subsidy growth caused by state-benefit mandates that exceed the essential health benefits.

- To reduce adverse selection and encourage broad participation in the small group and individual markets, the report recommends default enrollment for individuals who are eligible for subsidies, limiting open enrollment periods to one or two months per year, limiting shifts from plans with relatively low actuarial value to higher value during open enrollment, relaxing the requirement for full community rating when consumers have not maintained continuous coverage, and allowing late enrollment penalties.


**Impact of the ACA on Premiums**

Three new reports assess the impact of the Affordable Care Act (ACA) on premiums in the individual market:

- A Milliman report commissioned by America’s Health Insurance Plans provides a comprehensive assessment of how the Affordable Care Act will affect premiums in the individual market in 2014. Similar to other such reports, it points to new taxes and fees, comprehensive benefits, and the elimination of preexisting conditions and other medical underwriting as factors that will raise premiums for some and lower premiums for others.

It also highlights premium and cost-sharing subsidies that will help offset the cost of higher premiums for millions of Americans. On average, these subsidies will pay for 40% of the total cost of premiums for a silver plan. For the lowest income subsidy-eligible population, premiums will be reduced by as much as 94% for a silver plan with many people paying nothing at all if they select a bronze plan. For the higher end of the subsidy-eligible population, the premium reduction decreases to about 13% for a silver plan, according to the report.
Milliman examined how the ACA will impact premiums for specific populations based on gender, age, and health status. For example, age- and gender-rating restrictions will likely increase premiums for younger, healthy males and healthy seniors while reducing premiums for less healthy females and less healthy seniors.


- The American Academy of Actuaries (AAA) issued an analysis of the ACA that cautions against average premium change projections by noting that actual premium increases or decreases will vary by person and by region. They say that average premium changes do not convey the full story and that the truth is more complicated.

Broadly, the effectiveness of the mandate in ensuring that younger individuals purchase coverage and temporary reinsurance payments to health plans could assuage the anticipated premium increases. Comprehensive benefits with lower out-of-pocket costs are also important considerations beyond the dollar amount changes to monthly premiums, according to their analysis.

Individuals could pay more or less than they do now based on their own health status, demographics, and state of residence. Premiums could be lower for older, less healthy people and women while premiums for younger, healthier individuals and men could go up. Premium changes will also depend on the degree to which current state laws already require community rating and guaranteed issue.

The AAA report also discusses the ACA’s impact in the individual market in relation to changes in employer-sponsored coverage caused by the ACA. If young, healthy employees lose coverage through their jobs and purchase coverage in the individual market, it could lower average premiums. If older employees with poor health status lose employer-sponsored coverage, it may increase premiums in the individual market. If low-income employees lose coverage, they may qualify for Medicaid and not enter the individual market.


- A report from Deloitte prepared for the New York State Department of Financial Services estimates the ACA could bring down average premiums in New York. Unlike most states, New York has required pure community rating and guaranteed issue since 1993, which have caused considerable premium increases. The ACA’s addition of a mandate for everyone to purchase coverage, along with subsidies, is expected to alleviate the cost pressures in New York by expanding the risk pool to younger, healthier individuals who currently may forgo
coverage. The analysts expect premiums to come down 13.9%, on average.


Debate Over Causes of Health Spending Growth Slowdown Continues
Four recent studies analyze whether the recent slowdown in health spending growth can be attributed to the recession and other economic forces, which may be temporary, or to structural changes in the health care delivery system, which could indicate a continuing trend:

• An analysis from the Kaiser Family Foundation finds that the historically slow growth rates in national health expenditures over the past four years – reaching its lowest point of 3.9% in 2009-2011 and estimated to remain low at 4.3% in 2012 – is mostly a temporary phenomenon.

Although some of the slow growth can be attributed to structural changes in the health system that may indicate a continued slower pace for health spending growth in the future, the researchers attribute 77% of the recent change to the recession. They predict that health expenditure growth will resume its previous pace as the economy recovers, reaching 7% by 2019.


• A Health Affairs study attributes at least 20% of the recent spending slowdown to changes in employer-sponsored health coverage plan benefit designs that increase consumers’ out-of-pocket costs. Even after controlling for this change, the researchers conclude that health spending would have declined regardless, suggesting other structural changes in the health system are at play, such as a reduced rate in the introduction of new health care technology.

Health Affairs. The Slowdown In Health Care Spending In 2009–11 Reflected Factors Other Than The Weak Economy And Thus May Persist. May 2013.

• A second Health Affairs study finds that 45% of the recent spending slowdown was caused by economic factors, including a one-time 37% reduction in overall expenditures due to the economy and 8% due to Medicare payment rate cuts. The researchers attribute the remaining 55% to less rapid development of imaging technology and new prescription drugs, increased patient cost-sharing, and greater provider efficiency. The study estimates that health care spending will be $770 billion lower than predicted if these trends continue over the next decade.
An analysis by the Robert Wood Johnson Foundation does not attribute the decline in health spending growth to any permanent trends and instead points out that health spending has recovered after every major cost containment effort to date. It names a decline in real incomes and shifts in the sources of health coverage as the drivers of lower health spending growth.


Recent Studies on Health Care Cost Drivers
A number of recent reports point to the growing need to address the underlying drivers of health care costs:

• An analysis in *JAMA Internal Medicine* finds that half of major medical societies do not consider costs when drafting clinical guidelines. The researchers examined publicly available guidelines from 30 medical societies with at least 10,000 members published from 2008 to 2012. Of the 30 groups, 17 addressed costs in their guidelines, four implicitly considered costs, three intentionally excluded cost analysis, and six did not mention costs at all. Of the groups that did consider costs, only nine had a formal system for cost-benefit analysis.

• *JAMA Internal Medicine*. Cost Consideration in the Clinical Guidance Documents of Physician Specialty Societies in the United States. May 2013. A report from the IMS Institute for Healthcare Informatics finds spending on prescription drugs in 2012 fell 1% to $325.8 billion – the first ever annual drop since tracking began in 1957. The researchers attribute the decline in large part to expiring patents on a number of important name brand drugs and the expanded use of generics.

• The IMS Institute estimates that spending on prescription drugs was almost $29 billion lower than it would have been because of new generic drugs. Among the brand name drugs losing patent protection last year were Lipitor for high cholesterol, Plavix for blood clots and strokes, Singulair for allergies and asthma, and Diovan for high blood pressure.

Still, average per person spending on prescription drugs was $898 last year. The researchers also note that more than half of total private health care expenditures is spent on just 5% of enrollees.

The American Heart Association (AHA) estimates that the costs to treat heart failure will more than double by 2030, from about $21 billion in 2012 to around $53 billion, even though the actual numbers of Americans with the condition is expected to rise only 46%. The reason is that people are living longer with the fatal condition thereby increasing total costs per person.

Declines in smoking and heart disease have been offset by increases in diabetes and obesity, which contribute to heart failure. The AHA estimates that total costs including lost productivity and wages could reach $70 billion, or an additional $244 for every taxpayer in the country by 2030. The health care system would also be strained by a lack of specialists, hospitals, and other providers.

American Heart Association. Costs to treat heart failure expected to more than double by 2030. April 2013.