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Service Employees International Union, Local 49
SB 889
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Testimony to the Senate Committee on Health Care in support of SB 889

Chair Monnes Anderson and members of the Committee,

My name is Felisa Hagins and I am the Political Director for the Service Employees International Union, Local 49. SEIU Local 49 is comprised of healthcare and property service workers throughout Oregon and SW Washington. When combined with SEIU Local 503, we are the largest union in the state representing over 80,000 public and private sector workers. Our mission as a union is to achieve a higher standard of living for our members, their families, and dependents by elevating their social conditions and by striving to create a more just society.

I am here today to testify in support of SB 889. SEIU approaches health care policy from the perspectives of our members. This includes members who work in hospitals delivering critical care, members who collectively are significant purchasers privately and through PEBB, and of course SEIU members and their families who use the care system as patients. In each instance – as employees dealing with short staffing and cost constraints, as major purchasers via PEBB, and as direct patients - our members have been struggling for too long with the rising cost of health care. On behalf of them and all Oregonians who struggle to access affordable care, I am here today to testify in support of SB 889. This bill will address the unsustainable growth in health care expenditures that weighs on patients, communities, and the Oregon economy by setting an enforceable cost growth benchmark for the entire industry.

A balloon is often used as a metaphor to describe the health care industry; pressure to lower costs in one-part results in expanding costs in another. The idea behind SB 889's growth benchmark on total expenditures is to address the whole balloon at once to shrink, or at the very least contain the cost of, the entire industry. SB 889's growth benchmark on total expenditures is both necessary and important as the healthcare industry, left to its own devices, has engaged more in finger pointing than in making actual progress. We believe that a total expenditures growth benchmark would incentivize all parts of the health care system to control runaway costs.

THE PROBLEM

Oregon is headed in the wrong direction, with high and growing prices
In Oregon we have seen a rapid increase in patient expenditures on health care: growing 49 percent on a per capita basis from 2006-2014. Oregon's national ranking dropped from 15th lowest in 2006 to 23rd lowest in 2014, just barely below the US average.[1] In that same time period, hospital-specific healthcare expenditures in Oregon grew 52 percent, compared to national growth of 41 percent.[2]

Patient spending is measured by hospitals' net revenue, on the surface suggesting that hospitals might be increasing patient billing to cover rising expenses. But as it turns out, in aggregate, hospitals just billed a lot more. All acute care hospitals in Oregon had $564 million in operating profit in 2014, up from $300 million in 2006.[3]

We also know that relative to other markets measured by the Network for Regional Healthcare Improvement, Oregon's healthcare prices are the problem. As compared to Colorado, Maryland, Minnesota, Utah, and St. Louis, Missouri, Oregon's price index was 16 percent above the average and the highest in the group. But utilization was 10 percent below average, leading to a total cost index that was four percent higher than average and ranking it third out of the six regions.[4] In a different analysis of employer-sponsored insurance, Oregon's healthcare spending per person has increased 15 percent from 2013-2017, with prices driving that increase.[5]

Portland metro, arguably the most competitive health market in the state, ranked tenth out of 112 metros nationally on healthcare prices by the Health Care Cost Institute (HCCI).[6] While this is only one part of our state, the five counties on the Oregon side of this metro account for just over half of statewide hospital discharges.[7] Here inpatient prices specifically ranked 10 percent above the national average, and had grown by 24 percent in just five years (2012-2016).[8]

Overall Health Care Prices in U.S. Metros Relative to National Average, 2016

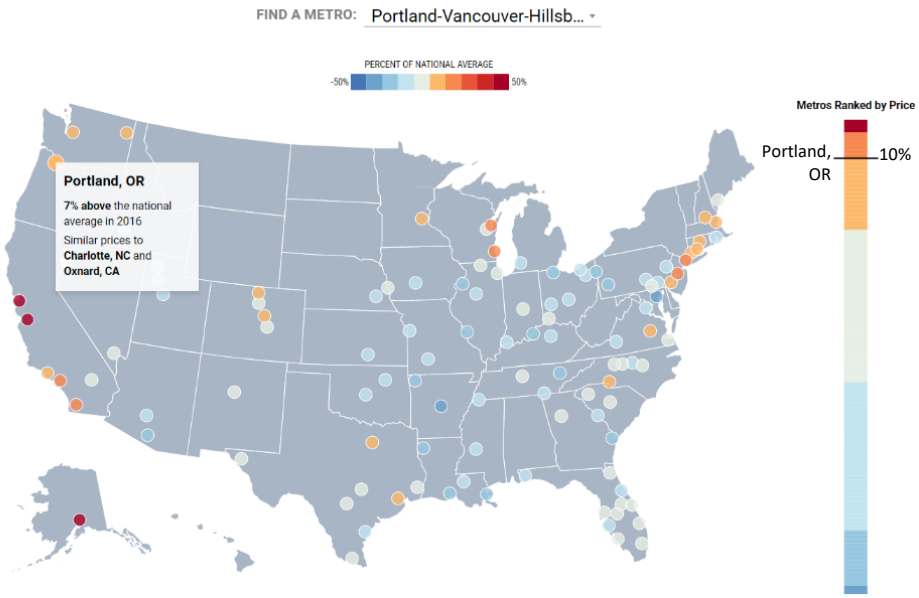


Figure above from Health Care Cost Institute

Finally, Oregon's all-payer-all-claims database shows that the median paid amount for inpatient procedures increased by 6.4% from 2015-16 (the most recent year of data).[9] That's a more than six percent increase *in just one year*. A very similar number, six percent, was what HealthNet projected its Oregon contractual provider increases to be for its 2019 rate renewal, in the absence of its own credible individual group.[10]

Cost of Insurance in Oregon is going up with employees bearing more of the cost

Of course, higher prices for care lead to higher prices for health insurance in the form of premiums and out-of-pocket spending on care. In Oregon, we've seen premiums grow steadily in recent years. On the

Oregon healthcare exchange, the premium for the benchmark silver plan has grown by 91 percent from 2014 to 2018, exceeding the growth of the US national average.[11]

From 2013-2017, employee-only coverage premiums increased slightly less than the US average at 12 percent, yet employee contributions to those premiums outpaced the US average and grew by 27 percent. Simply put, employees in Oregon are bearing a greater share of the rising cost of coverage.[12] The trend in Oregon is unsustainable and pointed in the wrong direction.

As premiums and cost-sharing have increased, workers' earnings have not kept pace. Over the past 20 years, working families nationwide have seen:[13]

- Family premiums increased 239 percent, while
- Workers' contributions to family premiums increased 259 percent, but
- Workers' earnings increased just 68 percent, and
- Inflation increased 51 percent.

Increased health care costs have negative consequences for patients, families, and communities
The negative effects of out-of-control healthcare costs manifest most immediately as medical debt, and in the long-term with deferred and foregone care. With rising deductibles, many patients are confronted with large expenses - $1,000 to $2,000 or more - before their coverage even kicks in.[14] This dynamic has real consequences: among people struggling to pay medical bills for themselves or someone else, the majority had insurance when the health problem and treatment began.[15]

Medical debt, even when small, can leave lasting and spillover damage on credit reports, affecting people's ability to obtain housing, jobs and more. More than 1 in 10 US consumers age 25-40 had a new medical bill sent to collections in 2016, for amounts ranging from about $500-650.[16] Indeed, other research finds that 4 in 10 U.S. adults could not easily pay an emergency $400 expense.[17]

It is not surprising then that more than 1 in 4 U.S. adults have skipped medical care in the past year because of costs;[18] that number more than doubles among people with health insurance who already had medical bill problems.[19] The "financial toxicity" of illness can lead to devastating consequences. Cancer patients, for example, can face staggering bills for treatment and are 2.65 times more likely to file for bankruptcy than their cancer-free counterparts of similar economic means.[20] Among patients with cancer, those who filed for bankruptcy had a 79 percent increased risk of early death.[21] Oregon has taken great strides to provide insurance to residents and improve the system, but health care reform has not come fast enough for many.

Oregon's partial expenditure caps will fail until the whole industry is covered
The existing caps on PEBB and OEBB, and the OHP growth cap built into the waiver, have pushed progress in addressing cost drivers and promoting value-based care, but these cost containment efforts have also been incomplete. Within PEBB and OEBB, holes cost containment efforts allow costs to be pushed to consumers/patients rather than actually driving total expenditures down.[22]

Implementing a cap without accompanying power to curtail the actual costs of healthcare and incorporating all payers will ultimately be unsuccessful.

THE SOLUTION
The measures contained in SB 889 are an important first step to address the burden of high health care costs in our state. The legislature must explore how to responsibly adopt the recommendations of the

Health Care Cost Review Task Force and establish a spending growth benchmark that spans across the health care industry.

A total expenditure approach will place all Oregon payers and providers under the same cost growth benchmark

Oregon has implemented some interesting, and often successful, innovations related to health care. Working to operate the Medicaid system through a global budget and encouraging PEBB and OEBB to implement alternative payment structures is all laudable. But the commercial portion of the market is still significantly fee-for-service. It is difficult for providers and other actors in the industry to operate simultaneously under different incentive structures.

For Oregon to truly lower the cost of health care and turn our unsustainable trends around, we must apply incentive structures universally, uniting all payers and providers. This is why a total health care spending benchmark approach was recommended by the Health Care Cost Review Taskforce.

To be successful, we must curb unnecessary cost growth while protecting effective health investments

The old adage "penny-wise and pound-foolish" must be kept in mind when operating under a growth benchmark. We must meet quality expectations and allow for innovations that promote health and reduce future expenditures, even if this means incurring additional expenses today.

To do this, we must have a better understanding of, and agreement on, the drivers of cost and expenses in the system. We must distinguish necessary and good drivers from wasteful drivers. We would argue that a necessary cost driver is improving the wages and benefits of health care workers. Health care workers should not need coverage by the OHP for themselves: the latest data we've seen is that more than 3,000 hospital workers in Oregon needed OHP in 2017.[23] And two of the most common jobs in Oregon hospitals, food service and housekeeping/EVS, earned less than $15/hour in 2017.[24] It's true that raising the wage floor for thousands of workers will cost money yet so do the current multi-million dollar pay increases enjoyed by hospital executives. Investing in living wages is a *good* driver of costs as there is a strong association between income and health. Moreover, income also impacts all other social determinants of health, including food security and housing.[25]

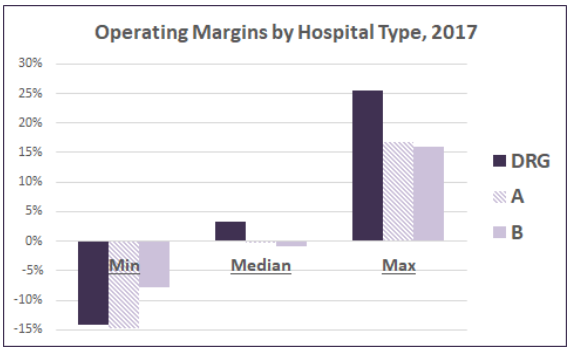
We also believe there are wasteful drivers of hospital expenses that have little to no impact on the actual health of people, like multi-million-dollar sponsorships of sports stadiums and fancy hospital lobbies.

Other drivers remain largely outside of the control of health care systems, like some pharmaceutical costs and medical devices.

Oregon must be careful not to advantage those who are over-charging

SB 889 is silent on the baseline for growth, which absent any review, risks being placed where prices and expenses are now. Given what we already know about prices and price growth in Oregon, this omission could essentially lock in existing disparities in efficiency and profiteering. For example, the operating profit margins at Oregon hospitals vary dramatically across all hospital types.[26]

Of the 13 hospitals with at least a 10 percent operating margin, seven are DRG, five are type B and one is type A. Without a closer look we don't know if these hospitals are being operated with exceptional efficiency, and/or if their prices are exceptionally high. SB 889, Section 4(2)(h)(A-B) includes



consideration of "unjustified price variation", but it is unclear if as currently written this would relate solely to setting and assessing the growth benchmark, or would also extend to assessing any given provider's baseline. As an example, it is difficult to imagine how to justify a statewide range that results in a $5,000 to $12,000 difference in the median price paid to a hospital for a mother to give birth without complications.[27]

The broad inefficiencies in the U.S. health care system are well-documented.[28] Yet at a basic level, most hospitals and health systems do not understand their own costs, the actual itemized expenses, of delivering care. The University of Utah Health Care System has grabbed headlines for its use of software to track every item, including clinician's time, while it simultaneously tracks patient outcomes.[29] The Utah system claims to have made extraordinary strides in lowering costs and maintaining or improving patient care. Efforts like these will be necessary in order for providers and policymakers to understand appropriate baselines and benchmarks.

All of this points to why Oregon needs a deeper examination of cost drivers, while extending the expenditure benchmark broadly so that all payers and providers operate under similar constraints and market incentives.

Oregon can build on its successes and current structures, and can look to examples from other states

We are supportive of the Taskforce's decision to build on structures already in place within Oregon's health care system. Expanding on the growth caps already in place within PEBB, OEBB and OHP will not only help those programs to be more successful but bring the remainder of the industry along.

Fortunately, Oregon can learn from experts and visionaries both within and outside our own state. Massachusetts has operated under a growth benchmark for many years, and Rhode Island has seen its affordability standards (which include a hospital price inflation cap) slow growth in healthcare spending.[30] And as Oregon ventures down this path, we will walk with Delaware and Rhode Island as they consider similar approaches to addressing out of control costs.

We urge you to address Oregon's unsustainable growth in health care costs, give patients and communities hope for a healthier future, and eliminate conflicting incentives for payers by passing SB 889.

Thank you for the opportunity to testify. I would be happy to answer any questions.

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Endnotes

[1] Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, made available through the Kaiser Family Foundation: https://www.kff.org/statedata/ "Health Care Expenditures per Capita by State of Residence."
[2] Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, made available through the Kaiser Family Foundation: https://www.kff.org/statedata/ "Health Care Expenditures per Capita by Service by State of Residence."
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[5] See the Health Care Cost Institute's Health Care Cost and Utilization Report 2017 data interactive, https://healthcostinstitute.org/research/hccur/2017-health-care-cost-and-utilization-report.
[6] See here to plug in Portland-Vancouver-Hillsboro, the methodology, and the raw data: https://www.healthcostinstitute.org/research/hmi/price-index. For an analysis of Portland hospitals' inpatient prices in 2014 and 2015 relative to statewide prices, see K. John McConnell's presentation to the Oregon Joint Interim Task Force on Health Care Cost Review, "Health Care Spending & Pricing Overview," Mar. 9, 2018, pp. 21-22, https://olis.leg.state.or.us/liz/2017I1/Downloads/CommitteeMeetingDocument/148190, accessed March 1, 2019.
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[13] See Kaiser Family Foundation Employee Health Benefits Survey 2018 chart pack, slide 6: https://kaiserfamilyfoundation.files.wordpress.com/2018/10/2018-ehbs-release-slides.pptx, accessed January 25, 2019.
[14] Over half of all U.S. workers now have single-coverage with a deductible of at least $1,000, and 26 percent face a deductible of $2,000 or more. Kaiser Family Foundation, Employer Health Benefits Survey 2018, summary of findings, https://www.kff.org/report-section/2018-employer-health-benefits-survey-summary-of-findings/, accessed January 25, 2019.
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