Health Care Costs & Spending: Latest State Strategies

Presentation for the
Iowa Legislative Commission on Affordable Health Care Plans for Small Businesses and Families

September 19, 2007

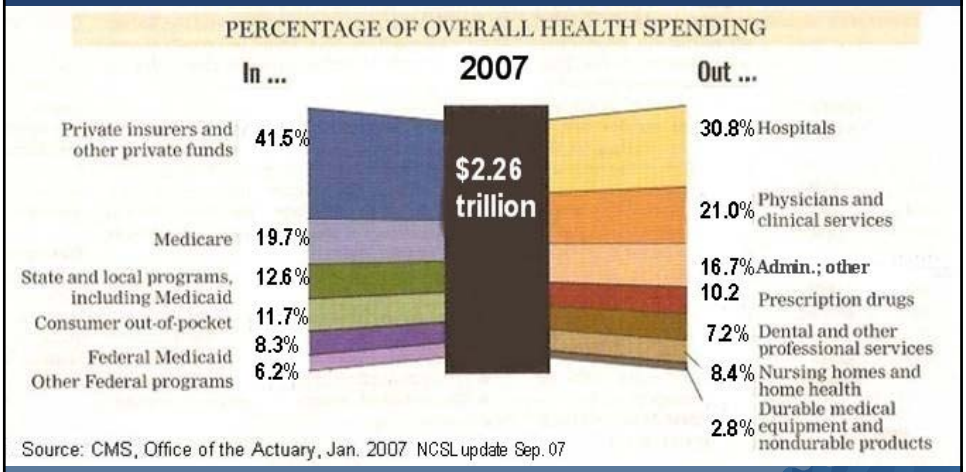
By Richard Cauchi
Director, Health Program - Denver
National Conference of State Legislatures

rev. 9/17/07

Overview

- Increasing health costs: where & why
- Insurance: costs versus coverage
  - Traditional conflicting strategies; now merging
- Finances: current realities + latest ideas
- Checklists: states' mix and match solutions
  - Cost containment and expanded coverage combined in reform legislation
  - Quality, disclosure and wellness in the mix
  - A multi-year process in most states

National Health Expenditures with Services and Supplies by Category



"Other" includes administration, the net cost of insurance and government public health activities; Other "personal health care" adds another 2.9 to the "Out" side%

Long term cost drivers: 2 economists' views:

- Medical technology
  - New research, knowledge
    - Radiation, imaging, chemotherapy
    - Pharmaceuticals, biotech
- Prices
- Unhealthy behavior
- Aging population
- More generous coverage
- Inefficiency
- Inappropriate use; overuse; under use
- End-of-Life interventions
- Liability

-based in part on Dr. Michael Chernew, Harvard Medical School, and Brent James, MD, Institute for HealthCare Delivery Research, at NCSL, Aug. 7, 2007

- No clear agreement among economists

Annual Change in Total Health Benefit Cost

1990-2007

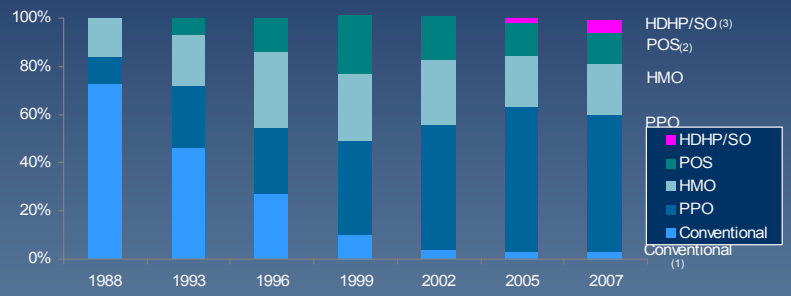
Cost growth levels off at 6.1%

Note: Benefit costs includes all types of coverage for individuals and families. Results for 1990-1998 are based on cost for active and retired employees combined. The change in cost from 1998-2007 is based on cost for active employees only.

•Average increase projected for 2007 after changes to plan design

•SOURCE: MERCER HEALTH & BENEFITS -2/8/2007 Proprietary and confidential

Distribution of Employer-sponsored Health Insurance Enrollment by Type of Plan: '88-'07



Source: The Kaiser Family Foundation and Health Research and Educational Trust. Data Released 2007. *Employer Health Benefits*: 1999, 2002, 2005, and 2007.

Link: http://www.kff.org/insurance/7527/upload/7527.pdf. Slide design by Avalere Health

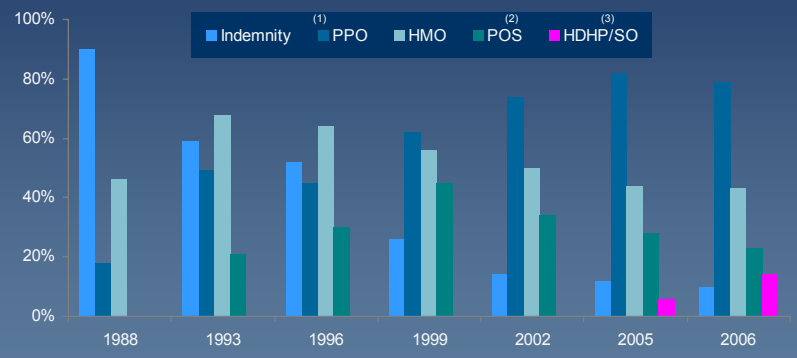
KPMG Survey of Employer-Sponsored Health Benefits: 1988- 1996. HDHP highlighted, **adjusted by NCSL**

(1) Conventional plans refer to traditional indemnity plans.

(2) Point-of-service plans not separately identified in 1988.

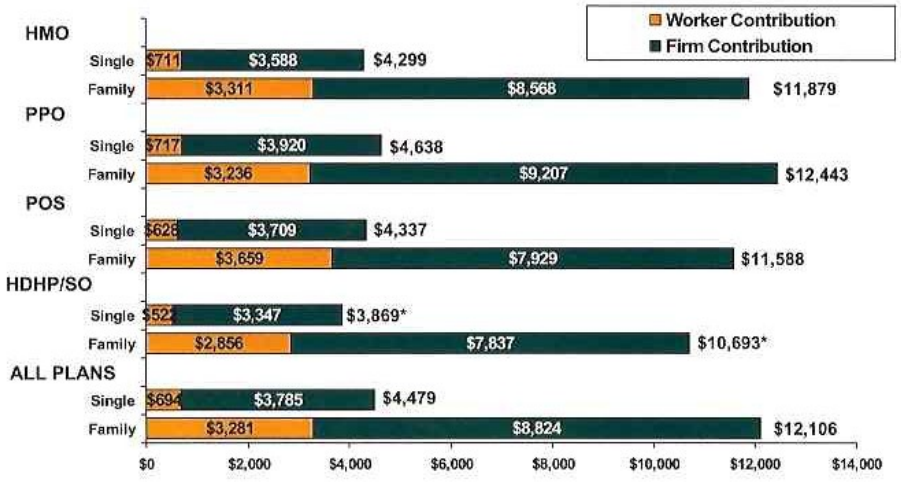
(3) In 2006, the survey began asking about HDHP/SO, **high deductible health plans** with a **savings option (HSA/HRA).**

Employees with Employer-based Coverage Who Can Choose Types of Plans, 1988 – 2006



Source: The Kaiser Family Foundation and Health Research and Educational Trust. Data Released 2006.
Employer Health Benefits: 1999, 2002, 2005, and 2006. Link: http://www.kff.org/insurance/7527/upload/7527.pdf.
Adopted from Avalere Health presentation, 2007/ HDHP data added by NCSL
KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996.
(1) traditional indemnity plans; also referred to as Conventional plans.
(2) Point-of-service plans not separately identified in 1988.
(3) In 2006, the survey began asking about HDHP/SO, high deductible health plans with a savings option.

Average Annual Premiums for Covered Workers, by Plan Type, 2007



* Estimate of total premium is statistically different from All Plans estimate by coverage type (p<.05).
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007.

THE HENRY J. KAISER FAMILY FOUNDATION -AND- HRET HEALTH RESEARCH & EDUCATIONAL TRUST

What Does *Affordable* Insurance Mean?

An analysis published April '07 for Massachusetts and beyond, aimed at universal coverage.

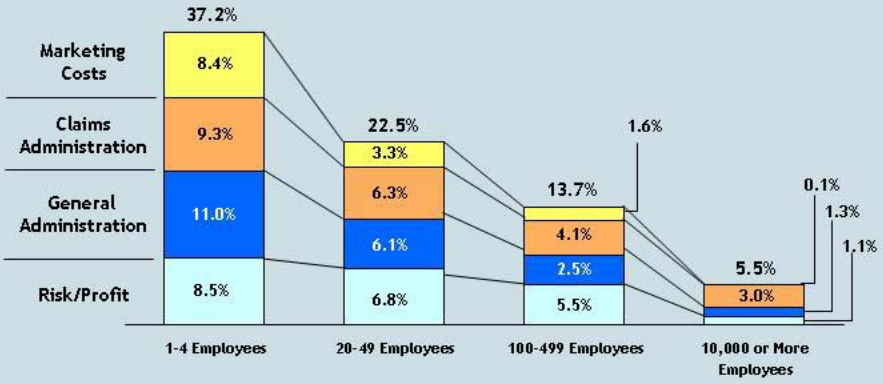
- People with low incomes can pay only small amounts toward health care.
- The "upper bound" of affordability should be set at about **8.5% of income** (for income at $61,000+/year)
- A sliding scale of affordability is needed. For people between 300% - 600% FPL, create progressive sliding scale from 4% to 8.5% of income.
- What is affordable may not be available.

Lewin model uses **7.5% of income** (Colorado example).

NCSL observation: Other economists will disagree with details, but it is important to do an in-state analysis and set standards and goals.

Insurance is More Costly to Administer for Small Groups

% of typical insurance costs



Source: Lewin presentation on "Cost and Coverage Impacts" to Colorado Commission, August 23, 2007

The Lewin Group – Ingenix

441556

Checklist of Use of Specific Care Management Programs

Currently offered to employees enrolled in medical plans

	Small employers	Large employers	Jumbo employers
Health website	60%	77%	87%
Health risk assessment	21%	53%	68%
Targeted behavior modification	15%	30%	45%
Nurse advice line	42%	67%	80%
Health advocate services	21%	35%	43%
Complex case management	19%	63%	82%
Catastrophic case management	22%	63%	81%
End-of-life case management	15%	40%	41%

SOURCE: **MERCER HEALTH & BENEFITS -2/8/2007** Proprietary and confidential

"Affordable Checklist" of state strategies for moderating health costs

1. Move People into Coverage Status
2. Consumer Driven Plans- Health Savings Accounts
3. Examine Insurance Mandates
4. Certificate of Need Reviews
5. Expanded use of "Cafeteria Plans"
6. New Purchasing Coalitions
7. "Value-Driven" Health Purchasing
8. Evidence-based Practices
9. Focus on Wellness and Prevention
10. Cost Transparency & Disclosure
11. Uniform Quality and Reporting Requirements
12. Reverse Poor Quality and Waste

Strategies for moderating health costs: **Move population into coverage status**

- Reduce uncompensated care costs (often high-cost emergency room services) -by moving everyone (possible) into coverage status.
- Larger risk pool = more stable, predictable (not always cheaper, unless more healthy are included)
- Covering the uninsured endorsed by insurers-AHIP, doctors-AMA, hospitals-AHA, etc.
  - *"Moderating costs is only possible if everyone is in the pool."*

    - Jon Kingsdale, Executive Director, Commonwealth Connector Authority. July 2007
- **Laura Tobler's presentation to follow**

Strategies for moderating health costs: **Consumer Driven** Health Savings Accounts (HSAs)

- HSAs allow for tax-free accumulation of savings.
  - Tax free contribution; Tax free accumulation.
  - Tax free withdrawals for health care services, COBRA and Long Term Care Ins. premiums, retiree health premiums for Medicare-eligible retirees.
- Must have qualified **"High Deductible Health Plan"**
  - Self-only: Minimum $1,100 annual deductible, $5,500 Out-of-Pocket max. (all 2007 requirements)
  - Family coverage: Minimum $2,200 deductible, $11,000 Out-of-Pocket max.
- Contributions
  - Self-only: limited to level of deductible, up to $2,850.;
  - Family: limited to level of deductible, up to $5,650 max.

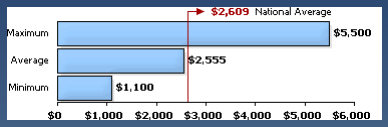
Growing enrollment and use; Premium savings: HDHP total premium about 16 to 20% lower. (ave. $640 below HMO for an individual; $1,700 for family)

Who pays high deductible portion, employer or individual, makes a big difference in the economic appeal of HSAs.

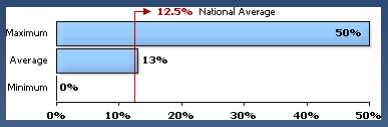
High Deductible Health Plans + HSA Plans

Iowa compared with National Averages

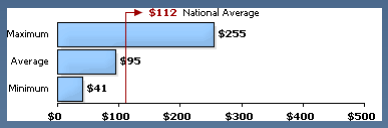
HDHP Annual deductibles



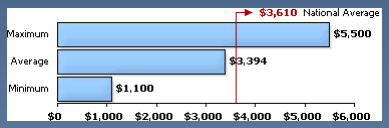
HDHP Co-Insurance



HDHP Monthly premiums, individual policy



HDHP Out-of-Pocket Maximum



Source: "Qualified High Deductible Health Plan (HDHP) Atlas VIMO comparison shopping for health" - online August 2007

Strategies for moderating health costs:

#3 **Examine Insurance Mandates**

- State coverage mandates add to costs, but repeals do not assure cheaper premiums.
  - No simple answers.
  - Most existing state mandate laws are stable.
  - New mandates have virtually disappeared.
- Required mandate reviews, now in 18 states
  - MA universal law retains, freezes mandates, old & new.
  - Mandate exemptions for defined groups growing. HSAs.
- Iowa study a useful example in contrasts
  - Chiropractors add 1.49% but may save on surgery or bone specialists?
  - Diabetes self-management adds 3.63% but may be a major savings v. hospitalization.

Strategies for moderating health costs: #4 **Certificate of Need Reviews**

- Requires review of the state's need for more facilities and specialty equipment.
- "CON" laws used in 36 states including Iowa.
- Provides a structure to restrict, halt or just disclose potentially duplicative or less needed health services.
- Challenges: surgical centers, retail clinincs.
- **Iowa**: In FY 2006, 19 applications seeking $81 million; of which 14 worth $37.5 million approved.

Strategies for moderating health costs: #5 Expanded use of "**Cafeteria Plans**"

- Expand or require use of federal IRS (Section 125) "cafeteria plans" that allow full tax deduction for health premiums.
  - **Employee can save 26%**
    Employers will save 1.86% *(Mass. Calculation, 2007)*
    Employee earning $50,000 in employer's Plan has annual tax savings of $796; employer saves $161 in annual FICA taxes.
  - **RI:** stand-alone, requires all employers of 50+ workers to have a plan; no employer $$ required. (2007 law)
  - **MA** Universal plan requires "125 plans" be offered
  - **WA:** Partnership for small business employers; participants required to offer "125 plans." (2007 law)
  - **MO:** includes similar "125" requirement for employers.

Strategies for moderating health costs: #6 **New Purchasing Coalitions**

- **Early voluntary purchasing pools (1990 ~ 2000)**
  Usually based on small businesses. Not subsidized.
  Results: Limited use, not popular, costs did not drop.
- **New Purchaser Coalitions:**
- groups of public and private purchasers working together to standardize demands on suppliers and share value-driven strategies.
- reaching agreement among purchasers with different priorities can be challenging, but
- coalitions can leverage greater market share and wield more influence with suppliers.
  Minnesota Smart Buy Alliance = 60% of state residents.
  Washington's Puget Sound = 1 million+ lives; 140 org's.

- **Connectors & Partnerships:** Pooled negotiation and marketing. *See Laura Tobler's presentation. MA & WA laws*

Strategies for quality & moderating health costs: #7 **"Value-Driven Health Purchasing"**

- Recent state public/private partnerships have built into their purchasing contracts
  - evidence-based medicine,
  - new information technology and e-records; good data collection,
  - tiered premiums,
  - pay-for-performance incentives & measures,
  - Designating high-performance providers as "centers of excellence"
- Minnesota - Smart Buy Alliance
  Washington -Puget Sound Health Alliance,
  a broad group of public and private health care purchasers, providers, payers (health plans), and consumers, working to develop public performance reports on health care providers and evidence-based clinical guidelines.

"Value-Driven Health Purchasing" Example:
Minnesota Smart Buy Alliance

- Created Nov. 2004 - evolved from earlier efforts
  - Large self-insured employers (BHCAG)
- Includes state agencies (Human Services with Medicaid, SCHIP, public employees), coalitions of businesses and labor unions.
- Represents 60 percent of residents = 3 million.
- Using common quality standards; pay-for-performance.
- One early financial "payoff":
  - State employees had 0% premium increase in 2006; those who pay the premiums got a 4.4% reduction

See: "Case Study of MN" by Commonwealth Fund, August 2007

Strategies for quality & moderating health costs:
Evidence-based Practice (A)

- Ideally use objective science to link quality and cost effectiveness
- Public, academic and private sector efforts.
- Initiative and federal funding within HHS:
  - Agency for Healthcare Research and Quality (AHRQ)
  - Sponsors 13 "Evidence-Based Practice Centers (EPCs)
  - "EPCs review all relevant scientific literature on clinical, behavioral, and organization and financing topics to produce evidence reports and technology assessments."
  - The resulting evidence reports and technology assessments are used by Federal and State agencies, providers, payers, others.
  - Reports accessible: www.ahrq.gov/clinic/epcindex.htm

Strategies for quality & moderating health costs:
Evidence-based Practice (B)

Drug Effectiveness Review Project (DERP)

- 13 states, "joined together to provide systematic evidence-based reviews of the comparative effectiveness and safety of drugs in many widely used drug classes."
- Based in Oregon; initiated by former Gov. Kitzhaber
- Reports are public; anyone may use them.
- Not tied to "rationing;" not binding on any agency.
- may facilitate understanding of generics and brand name Rx.

- DISPUTES ABOUT APPROACH:
  "DERP decision to ignore cost-effectiveness considerations reveals a society still unable to consider economic factors openly in evidence reviews.
  -Neumann, Health Affairs June 2006
  Rx manufacturers disagree with some results.

Strategies for quality & moderating health costs:
#9 **Focus on Wellness & Prevention**

- An estimated $300~$600 billion of health spending goes to treatment of disease and injury that might have been preventable.
  - Traditional insurance focused on treatment, plus a few low cost screenings for early detection.
  - Now, a growing trend toward voluntary, educational campaigns for wellness, exercise, healthy diet.
- State reforms can be a vehicle for new features:
  - Direct financial incentives for weight loss, non-smoking, BMI improvement; early treatment of preventable diseases.
  - Indiana-Personal Wellness Responsibility Account, $1,100 HSA.
  - Rhode Island created a "wellness health benefit plan."
  - Other state examples: AR, AZ, DE, HI, KS, OK, ND, OH, TX, VT
  - NCSL Wellness page
    www.ncsl.org/programs/health/WellnessOverview.htm

Strategies for quality & moderating health costs: #10 **Cost Transparency & Disclosure**

Cost, price and quality information is deemed a critical component of Value Based Purchasing and consumer-driven approaches. The initiatives involved collecting data from providers and health plans, and applying quality, efficiency, and "value" measures (a combination of quality and cost) to present comparative information.

- **Transparency and Public Reporting.** At least 12 states have enacted price disclosure laws and have state web material:
- **California, Florida and Maryland** have state-run consumer web sites on hospitals' charges and readmission rates.

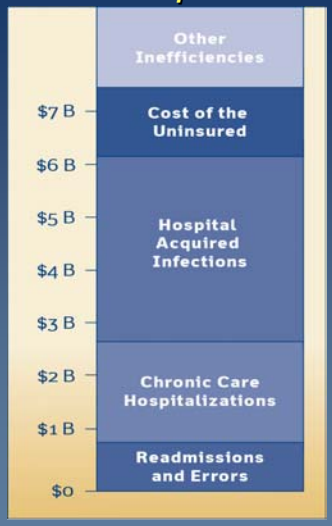
- Purchasing coalitions are working to build more universal repositories of data that would be available to and used by the wider public and all employer/purchasers. Used in **WA, WI, MA**.

11 Uniform Quality Measures and Reporting Requirements

- This strategy involves multiple purchasers joining together to establish uniform quality measures, which are translated into standard data requirements for health plans or providers.
- The intent is to:
  - reduce the burden on suppliers of varied reporting requirements from purchasers (thereby enhancing cooperation);
  - reduce confusion to employers and consumers when purchasing health care;
  - and allow providers to focus on improving quality measures that reflect evidence-based medicine.
- State Employee Benefit plans in MA, WA, WI are in the lead on these policies.

Source: Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve, Commonwealth Fund, 8/15/07.
http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=515778

Use savings from current waste & inefficiency *Pennsylvania example:* A Cost analysis -



Source: "Prescription for Pennsylvania" (2007) Governor Edward G. Rendell, State of the State, January 17, 2007

http://www.gohcr.state.pa.us/prescription-for-pennsylvania/Rx-for-Pennsylvania-Presentation.pdf

Make Small Business Insurance More Affordable: **Insure Montana:**

- Small Business Health Care Affordability Act
  - 1) For small businesses with 2-9 employees that are currently providing health insurance , they are eligible for refundable tax credits.
  - 2) For businesses previously unable to afford health insurance for their employees, provides health insurance coverage through a small business purchasing pool.
  - Pool insurance is subsidized on a sliding scale basis.
  - Over 1,550 small businesses are enrolled as of August 2007; there is now a waiting list due to funding constraints.
  - **Funding**: by a **new tobacco tax.**
- Other states working on this goal with different plans: NY, WV, TN, NM, OK [June '07 law] , AR, AZ.
  Visit http://www.ncsl.org/programs/health/business.htm

Small Business: Healthy Indiana Plan"

- A 50% small business wellness program tax credit aimed at 103,000 businesses employing 815,000 workers.
- Requires insurance companies to allow parents to keep children on a family insurance plan up to the age of 24.
- Allows companies to use pre-tax dollars to pay for employee health insurance coverage. Part of the program also includes both a federal and state income tax deduction for employees.
- Expected to help 132,000 Hoosiers earning up to 200 percent of the poverty level.
- Expansion of the state's children's health insurance program to cover up to 39,000 additional needy children.
- Increased eligibility for pregnant women on Medicaid, estimated 17,000.
- **Funding: cigarette tax increase** per pack to fund various health related expenses. The law will increase cigarette tax collections by an estimated $187.2 M in FY 2008 and $206.5 M in FY 2009.
- - signed into law by Gov. Daniels May 10, '07

Cover Tennessee

- A market based public/private partnership plan for small employers and uninsured workers with incomes below 250 percent of FPL. ($25.5k /yr for 1; $51.6k for family of 4)
- Cover Tennessee is guaranteed access to basic, major medical coverage for $150 a month with the cost shared equally by the individual, employer, and state government.
- **Funding:** Tennessee tripled its tax on cigarettes to produce $239 million in new revenue for FY 2008.
- Cover Tennessee is not an entitlement — "it is voluntary health insurance coverage, affordable to participants and to the state."

The Role of Building Consensus: *Example:* **Colorado's Commission**, 2006-07

- Bipartisan 27-member Blue Ribbon Commission, convened by Legislature and Republican Governor, continued by Democratic Governor.
- Issued a public "RFP" seeking reform plans - received 31 proposals in May; narrowed to four in June. Lewin analysis.
- Will issue a report this fall to the '08 legislature.

Better Health Care for Colorado Medicaid-funded insurance subsidies under 300% FPL Basic benefit package through large pool with annual benefit cap; individuals can use subsidy to purchase employer-sponsored insurance Medicaid reform, including managed care, P4P, consumer-directed home care	**Solutions for a Healthy Colorado** Individual mandate-all must have insurance. Guaranteed issue of a core benefit plan for individual insurance; modified community rating Subsidies for those up to 250% FPL
A Plan for Covering Coloradans Individual mandate- must have insurance or pay assessment if they do not "Pay or play" for employers- either contribute to employee coverage or pay assessment Purchasers pool to negotiate with providers; Subsidies up to 400% FPL and small businesses.	**Colorado Health Services Program** Single-payer program governed and administered like a public utility Premiums charged through income tax or payroll deductions Consumers may choose any licensed health care provider in the state

The Role of Accurate Data: Using a sound simulation model

Good, current health data is critical, but hard to find and compare.

Effective examples: 1) David Lind Associates- today

2) The Lewin Group estimates using the Health Benefits Simulation Model.

Provide precise FY 2007-08 estimated figures.

Examples provided by Lewin Group

John Sheils & Mark Zezza for the CO Blue Ribbon Commission

- Colorado 2006 population estimate is 4,753,377.
- Iowa 2006 population estimate is 2,982,085 (62.7% the size of CO)

Projected In-state Spending by Type of Service: FY 2007-2008 (in millions) *[Colorado example]*

Type of Service	CY 2000	Average Annual Growth Rate 2000-2004	CY 2004	Projected Average Annual Growth Rate 2004-2007	Provider Estimate FY07-08	Resident Estimate FY07-08
Hospital	$5,598	9.1%	$7,926	8.1%	$10,426	$10,438
Physician	$4,719	8.7%	$6,599	6.9%	$8,343	$8,563
Dental	$1,168	7.8%	$1,577	7.2%	$2,013	$2,065
Other Professional	$738	7.0%	$967	6.6%	$1,208	$1,240
Home Health	$305	4.6%	$365	5.6%	$442	$435
Prescription Drugs	$1,335	8.4%	$1,846	4.6%	$2,163	$2,163
Medical Durables	$372	4.8%	$449	4.6%	$526	$540
Nursing Home	$938	6.2%	$1,192	6.1%	$1,464	$1,434
Other Personal Care	$538	13.3%	$885	10.5%	$1,254	$1,254
Total	$15,711	8.5%	$21,806	7.1%	$27,838	$28,130

Source: Lewin Estimates using data from Centers for Medicare & Medicaid Services. For CO Task Force, 6/07

The LEWIN GROUP an INGENIX company

0

In Summary…. Key cost themes

- Cost solutions paired with coverage expansion. (within most passed 2006-07 laws)
- Premium affordability is a core feature or goal in most state activity this year.
- Public-private partnerships embraced by most.
- Role and impact within small business.
- "Political" successes most common after all stakeholders are at the table; bi-partisan endorsers.
- "Economic" successes can be measured in different ways - still fairly early to judge.

Massachusetts: Signing of the Health Reform Law, 2006

NCSL Resources

- Richard Cauchi, Program Director, Health-Denver
  303 856-1367 dick.cauchi@ncsl.org
- WEB: Insurance - www.ncsl.org/programs/health/healthmc.htm
- Health Finance - www.ncsl.org/programs/health/finance.htm
- Critical Health Areas Project - http://www.ncsl.org/programs/health/forum/chap/index.htm