

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

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National Conference of State Legislatures



NCSL

rev. 9/17/07

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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

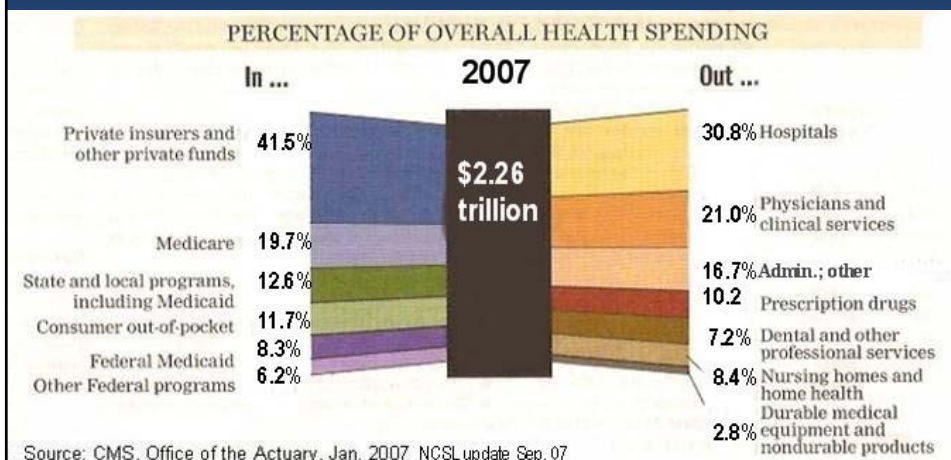
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The human side of health policy

- ◆ Accurate, up-to-date data is important, but...
- ◆ State Legislators care more about the human impact –
 - Will your constituents get the medical care they need?
 - Will they be able to afford it as a family?
 - The impact of one unnecessary death.
 - The cancer patient dropped from insurance.
 - The family that loses their home.
- ◆ Many state reform actions, from mandates to tax credits look to practical help for people.
- ◆ State solutions often combine “market-based” and “government regulation”

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National Health Expenditures with Services and Supplies by Category



Figures are projections. "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%

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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

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Annual Change in Total Health Benefit Cost

1990-2007

Cost growth levels off at 6.1%



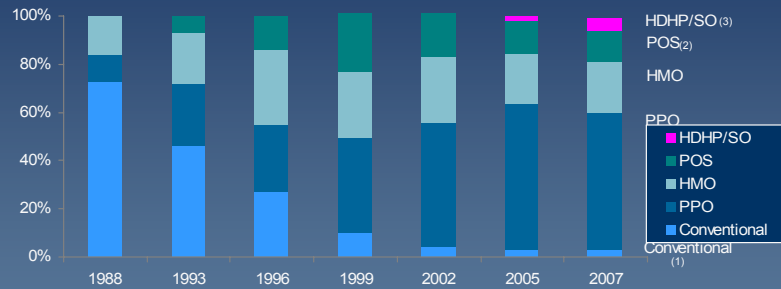
Note: Benefit costs includes all types of coverage for individuals and families. Results for 1990-1998 are based on cost for active and retired employees combined. The change in cost from 1998-2007 is based on cost for active employees only.

*Average increase projected for 2007 after changes to plan design

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

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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

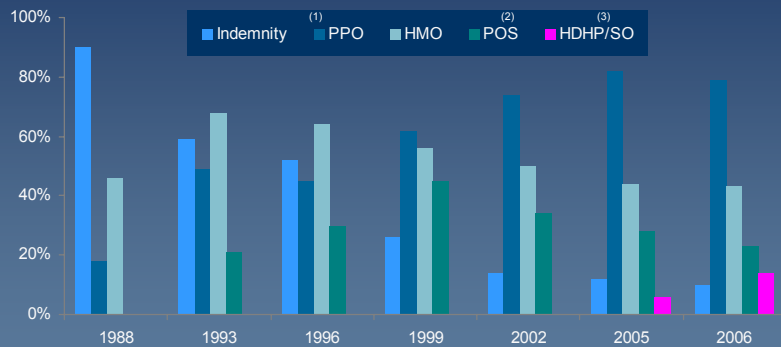
(1) Conventional plans refer to traditional indemnity plans.

(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).

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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.

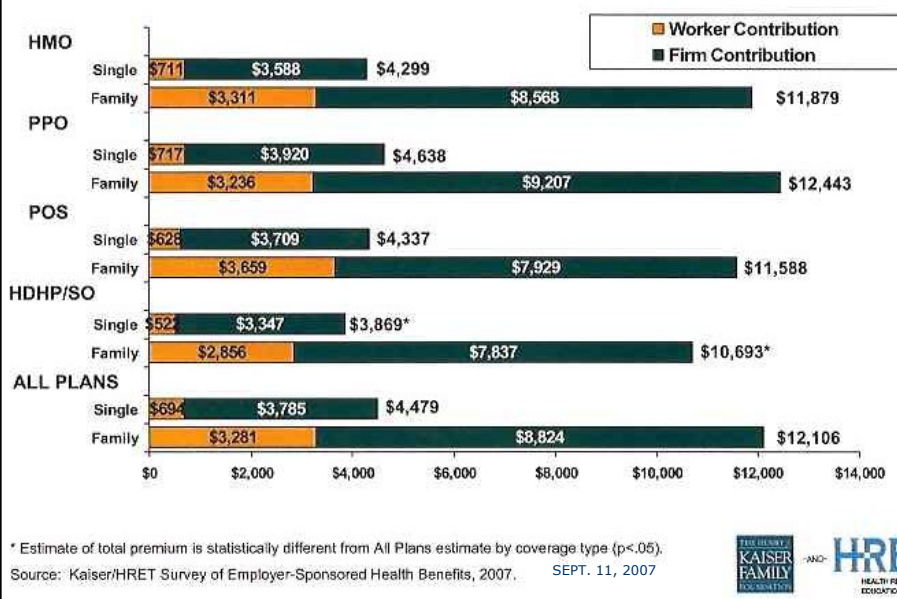
(1) traditional indemnity plans; also referred to as Conventional plans.

(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.

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



What Does *Affordable* Insurance Mean?

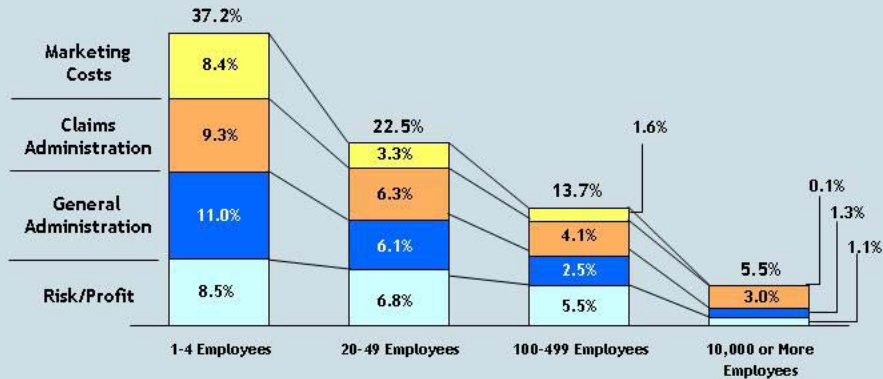
An analysis published April '07 for Massachusetts and beyond, aimed at universal coverage.

- ◆ 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
INSUREX

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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

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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**

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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.

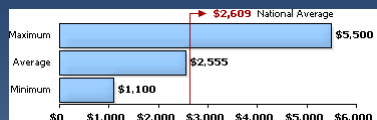
Growing enrollment and use; Premium savings: HDHP total premium about 16 to 20% lower. (ave. \$640 below HMO for an individual; \$1,700 for family)

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

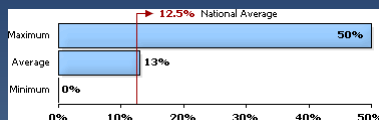
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High Deductible Health Plans + HSA Plans Iowa compared with National Averages

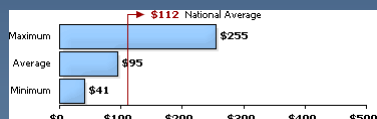
HDHP Annual deductibles



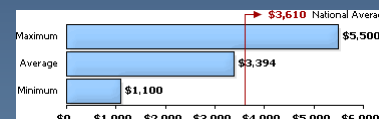
HDHP Co-Insurance



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

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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.

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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 clinics.
- **Iowa**: In FY 2006, 19 applications seeking \$81 million; of which 14 worth \$37.5 million approved.

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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.

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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*²⁰

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.

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"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

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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

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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.

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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

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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.**

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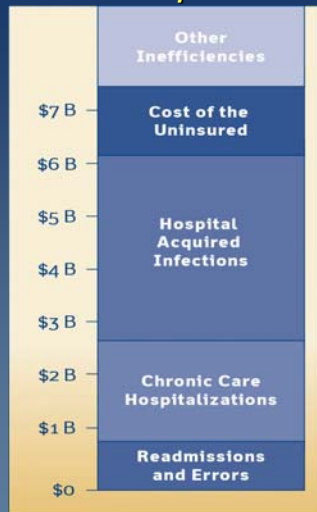
11 Uniform Quality Measures and Reporting Requirements

- ◆ 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

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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>

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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>

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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

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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.

<p>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</p>	<p>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</p>
<p>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.</p>	<p>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</p>

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)

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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

Latest headlines:

How existing spending may affect future reform

– NY Times, Sep 18, 2007, using CMS Office of the Actuary data from 2004

States Differ Widely in Spending On Health Care, Study Finds

By ROBERT PEAR

WASHINGTON, Sept. 17 — A new federal study shows huge variations in personal health spending among states, ranging from an average of nearly \$6,700 a person in Massachusetts to less than \$4,000 in Utah.

The study, published on Monday in the Web edition of the Journal Health Affairs, said that Mas-

per capita spending on hospital care than any other state, while Maine spends more than other states on home and community-based care. Maine had the second highest level of spending on doctors' services, after Alaska.

Utah had the lowest per capita spending on doctors and hospitals.

Sara Rosenbaum, a professor

- ◆ Iowa falls just above average in personal spending per capita.

IA \$5,380 /yr | US \$5,283

Average annual growth:

IA 6.3% | US 6.3%

Medicaid annual growth:

IA 6.2% | US 3.4%

IA uses more health care than it produces (105.4%)

"The variations help explain why some states can achieve health care reform on their own, without a huge infusion of federal money, while others cannot." – Sara Rosenbaum, GWU

"States that spend more per capita often have a lower quality of care." – Karen Davis, Commonwealth Fund

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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.

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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>

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