Taming Health Costs: New Solutions, New Challenges For States

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This Presentation at a Glance

- The United States face a number of health and health care challenges – and much of the burden and responsibility falls on states

- Pursuit of the Triple Aim: Challenges in health, health care and health care costs

- A quick overview of what states are doing

- Introductions of our panel
The Triple Aim

- Better health
- Better health care
- Lower cost
- Core principle now at heart of major U.S. payment and delivery system reform efforts

Donald Berwick, MD
Former Administrator
Centers for Medicare and Medicaid Services

Better Health

Fans line up outside Paula Deen's The Lady and Sons restaurant,
Savannah, Georgia, June 2013
Institute of Medicine Study, January 2013

- “For many years, Americans have been dying at younger ages than people in almost all other high-income countries.”

- “Not only are their lives shorter, but Americans also have a longstanding pattern of poorer health that is strikingly consistent and pervasive over the life course – at birth, during childhood and adolescence, for young and middle-aged adults, and for older adults.”

FIGURE: Causes of Death for U.S. Men Before Age 50, Compared with Average of Peer Countries, 2006-2008

NOTE: CVD is cardiovascular disease

Rising Mortality, Declining Life Expectancy For Many


- Female mortality rates increased in 42.8 percent of counties, while male mortality rates increased in only 3.4 percent.

- Several factors, including higher education levels, not being in the South or West, and low smoking rates, were associated with lower mortality rates.

- Source: DA Kindig, ER Cheng, “Even As Mortality Fell In Most US Counties, Female Mortality Nonetheless Rose In 42.8 Percent Of Counties From 1992 To 2006.” Health Affairs, March 2013


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Change in Female Mortality Rates From 1992–96 To 2002–06 in US Counties.


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Rising Female Mortality

- Medical care variables, such as proportions of primary care providers, were not associated with lower rates.
- Findings suggest that “improving health outcomes across the United States will require increased public and private investment in the social and environmental determinants of health—beyond an exclusive focus on access to care or individual health behavior.”

Source: DA Kindig, ER Cheng, “Even As Mortality Fell In Most US Counties, Female Mortality Nonetheless Rose In 42.8 Percent Of Counties From 1992 To 2006.” Health Affairs, March 2013

What are we doing about these challenges?

- Good news: some efforts to tackle child obesity, for example, seem to be working
- Mississippi: obesity and overweight rate fell from 43 percent in the spring of 2005 to 37.3 percent in the spring of 2011 among Mississippi public school students in grades K-5, a 13.3 percent decline.
How Mississippi succeeded

- Set nutrition standards in 2006 for food sold in school vending machines
- Passed legislation setting requirements for physical education, health education, wellness policies, and school meals, snacks, and drinks;
- Began participating in 2010 in Safe Routes to School’s state network project to secure funding to make streets safer for walking and bicycling
- Implemented Move to Learn in 2012, an initiative that encourages teachers to lead students in physical activity breaks
- Has a growing movement within faith-based communities to encourage families to prepare healthy meals and integrate physical activity into everyday life.

Source: 3-Year Report, Center for Mississippi Health Policy, at http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/05/year-three-report.html

Cultural Clash

Mississippi passes 'anti-Bloomberg bill,' banning local limits on portion sizes and requirements to post calorie counts

The bill was authored by state Sen. Tony Smith, a Republican who owns the Stone碾’s BBQ chain, who said government shouldn’t tell people what they cannot eat.
Maryland’s State Health Improvement Process

- 39 state objectives for health improvement
- Include life expectancy, obesity
- 18 local health improvement coalitions
- toolkits

Objective 30: Increase the Proportion of Adults at a Healthy Weight

Percentage of Adults At a Healthy Weight (Not Overweight or Obese), 2008-2010:

- 40.8% - 47.7%
- 33.9% - 40.7%
- 26.5% - 33.8%
- Maryland Baseline: 34.0%

Source: Maryland’s Health Improvement Process (SHIP) Review
For more information, please visit: https://www.marylandship.org/SHIP/ReportsAndData/30-C1228.pdf

Maryland’s Health Improvement Process (SHIP)
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Better Health Care

The Health Effects Of Not Having Health Insurance

- 18,000 die prematurely each year
- Acutely ill receive fewer and less timely services; 8 million chronically ill receive fewer services and have higher morbidity and worse outcomes
- 41 million uninsured adults and children less likely to receive preventive and screening services
- 60 million uninsured individuals and families have less financial security and increased life stress
- People living in communities with a higher than average uninsured rate are at risk for reduced availability of health care services
- All Americans

National Estimates by the Institute of Medicine, 2003
Simplified Structure of Affordable Care Act

- Coverage expansion to projected 30 million more Americans -- “stretching our security blankets”

- Roughly 15 million to be able to buy private health insurance coverage through state exchanges with assistance of federal subsidies

- Roughly 15 million to obtain coverage through expanded Medicaid program - but depends on how many states ultimately go along

- Individual and employer mandates – latter now delayed for a year

- Insurance market reforms to broaden and stabilize private coverage, including ban on preexisting condition restrictions (broadens group of insured; spreads risks)

To Date, 20 States & DC Plan to Expand Medicaid Eligibility, 14 Will Not Expand, and the Remainder Are Undecided
“Amenable mortality:”
US falling further behind Europe

- Amenable mortality = deaths that should not occur in the presence of timely and effective health care

- Comparison of amenable mortality in the United States compared to those in France, Germany, and the United Kingdom between 1999 and 2007.

- Overall, amenable mortality rates among men from 1999-2007 fell by only 18.5 percent in the United States compared to 36.9 percent in the United Kingdom.

- Among women, the rates fell by 17.5 percent and 31.9 percent, respectively.

- US deaths from circulatory conditions—mainly, cerebrovascular disease and hypertension—were the main reason.

Source: Nolte et al, Health Affairs, September 2012

Vermont Blueprint for Health: System of Medical Homes for Chronically Ill in State

Hospitals

Advanced Primary Care

Specialty Care & Disease Management Programs

Social, Economic, & Community Services

Mental Health & Substance Abuse Programs

Healthier Living Workshops

Community Health Team
- Nurse Coordinator
- Social Workers
- Nutrition Specialists
- Community Health Workers
- MCAD Care Coordinators
- Public Health Specialist

Public Health Programs & Services

Total 422,000 patients in state now served

106 primary practices

90 Community health Teams

Health IT Framework

Evaluation Framework
**Early evidence on VT Blueprint**

![Chart showing percentage change in total expenditures per capita (adjusted); commercially insured, 18-64 years old.](http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%2002_14_13_FINAL.pdf)

Source: 2012 Annual Report, Vermont Blueprint for Health, at


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**Lower Costs**
International Comparison of Spending on Health, 1980–2008

Average spending on health per capita ($US PPP)

Source: OECD Health Data 2010 (June 2010).

“'It’s the Prices, Stupid:’
International Cost Comparisons

2012 Total Hospital and Physician Cost: Hip Replacement

Source: International Federation of Health Plans, 2013
Exchanges: The Theory

- State-based exchanges or marketplaces to spur competition among insurers
- Consumers will be able to comparison shop for price, cost sharing, networks and coverage once options are standardized
- States can be active purchasers and set quality standards on plans; have rate review authority
- Early evidence suggests the theory is proving out in a number of states

All-Payer Claims Data Bases

- Large-scale databases created by state mandate
- Typically include data from medical, pharmacy and dental claims
- Public and private payers
- Promotes transparency about delivery and pricing of health care
- Supports delivery transformation efforts
- Supports insurer rate review
State Innovation Models under Center for Medicare and Medicaid Innovation

State Innovation Models Initiative: General Information

The State Innovation Models Initiative is providing up to $600 million to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. The projects will be broad-based and focus on people enrolled in Medicare, Medicaid and the Children’s Health Insurance Program (CHIP).

The Participating States

Examples:

• Arkansas: majority of population in patient-centered medical homes (PCMHs)
• Minnesota: majority of population in ACO’s, including long-term services and supports
• Oregon: “Coordinated Care Organizations”

Medicaid transformation: ACO’s, CCO’s, health homes

• E.g., Oregon providing integrated package of health care services through local coordinated care organizations (CCO’s)
• Global payment based on value and outcomes to provide for all services, including mental health and dental
• Applies to Medicaid and dual-eligibles
• Annual budget capped
• Goal: reduce Medicaid spending by nearly $300 million over two years
“There has never been a better time to be an innovator in health care.”

--Don Berwick, former administrator, CMS
January 2011

“Those who say it can’t be done are usually interrupted by others doing it.”

--the late James Baldwin, American novelist, essayist and playwright