

Bending the HealthCare Cost Curve:



(Part 2) Supplemental Charts to Live Presentation

(updated 10/16/16)

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**National Conference of State
Legislatures**

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HEALTHY CITIES.
BETTER LIVES.



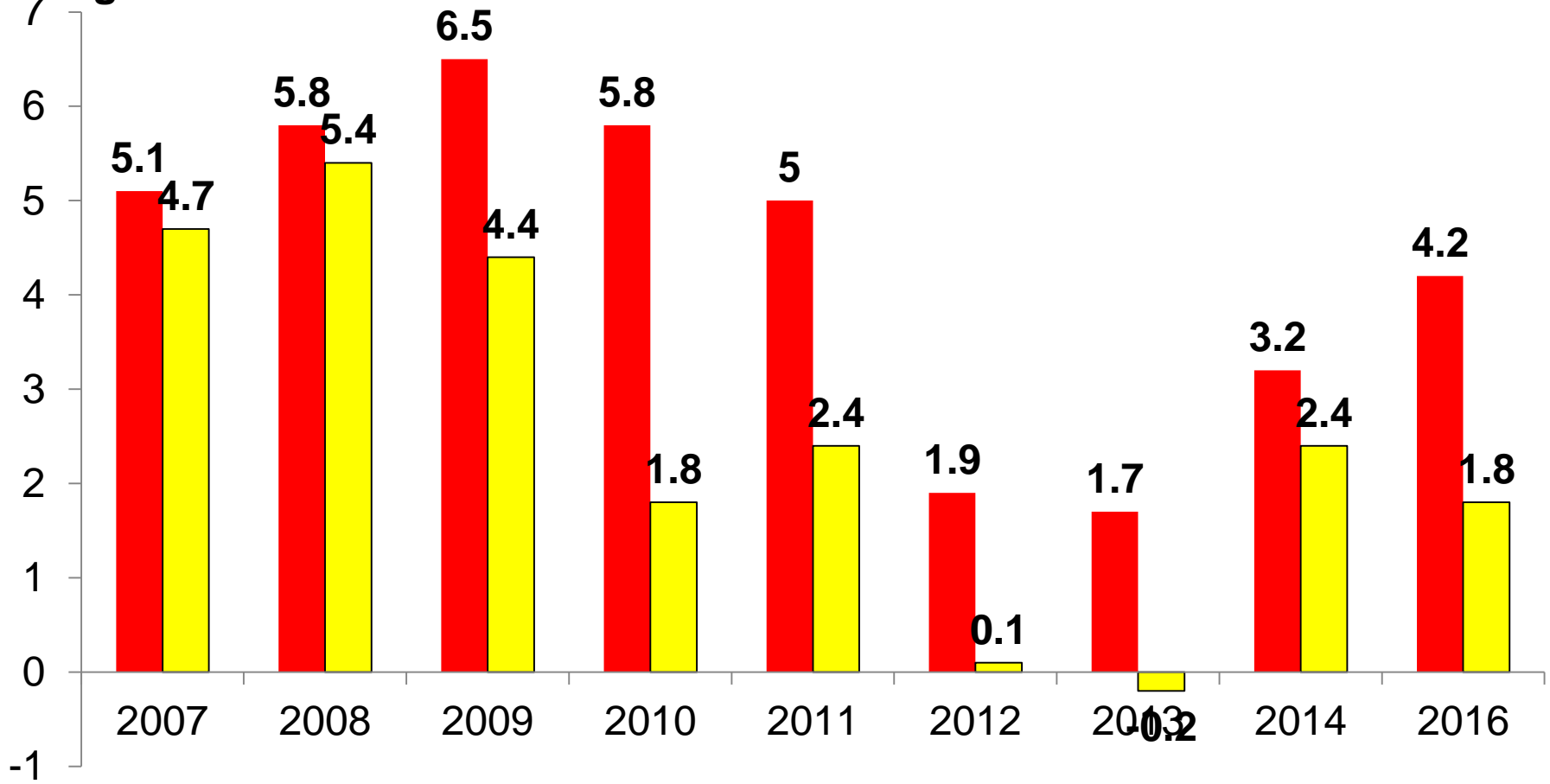
Supplemental Charts

- **Recent slow-down in rate of growth per person: private and public**
 - Medicare little to no growth: historic lows
- **Medicaid slow growth harder to see with growth in enrollment**
- **Premiums continue to rise faster than income in all states**
 - Affordability concerns for insured
 - Higher deductibles + cost-sharing = substantial share of income
 - Extra costs if go out of network
- **Price paid by private insurers have been driving claims costs**
 - Widely variations within markets reflect provider market power
- **Medicare data enables geographic comparisons**
 - Wide variation in potentially preventable hospital use
 - Private sector (higher/lower use) tend to track Medicare patterns
- **Readmission rate decline in Medicare benefits private sector and Medicaid**
 - States with the highest rates had the largest 2013 decreases

Marked Slow-Down in Medicare and Private Spending Growth Per Enrollee

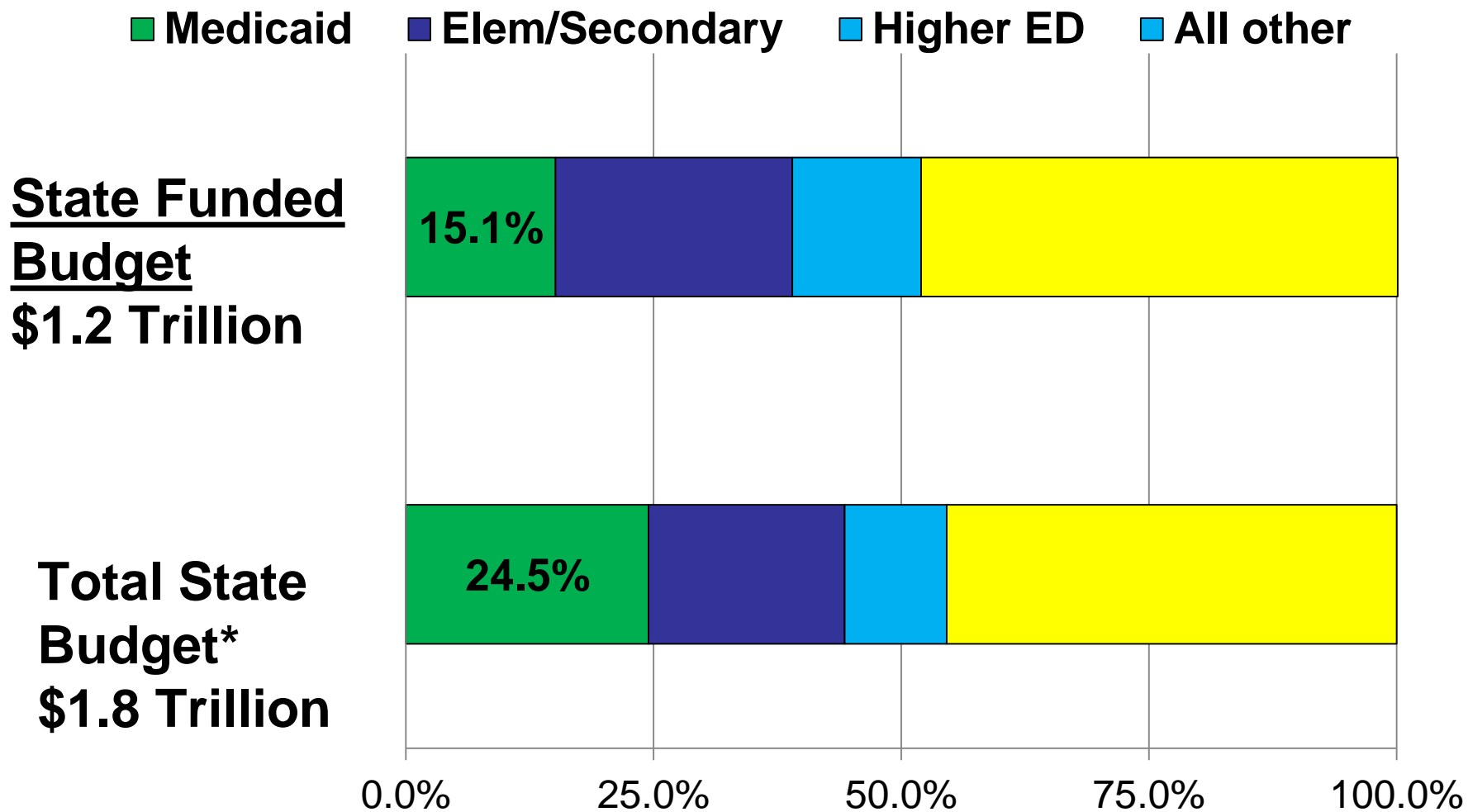
Annual percent change

■ Privately Insured ■ Medicare



Source: CMS Office of the Actuary Table 17, July 2016 – with projections 2016.

Medicaid as Share of State Budgets, 2013

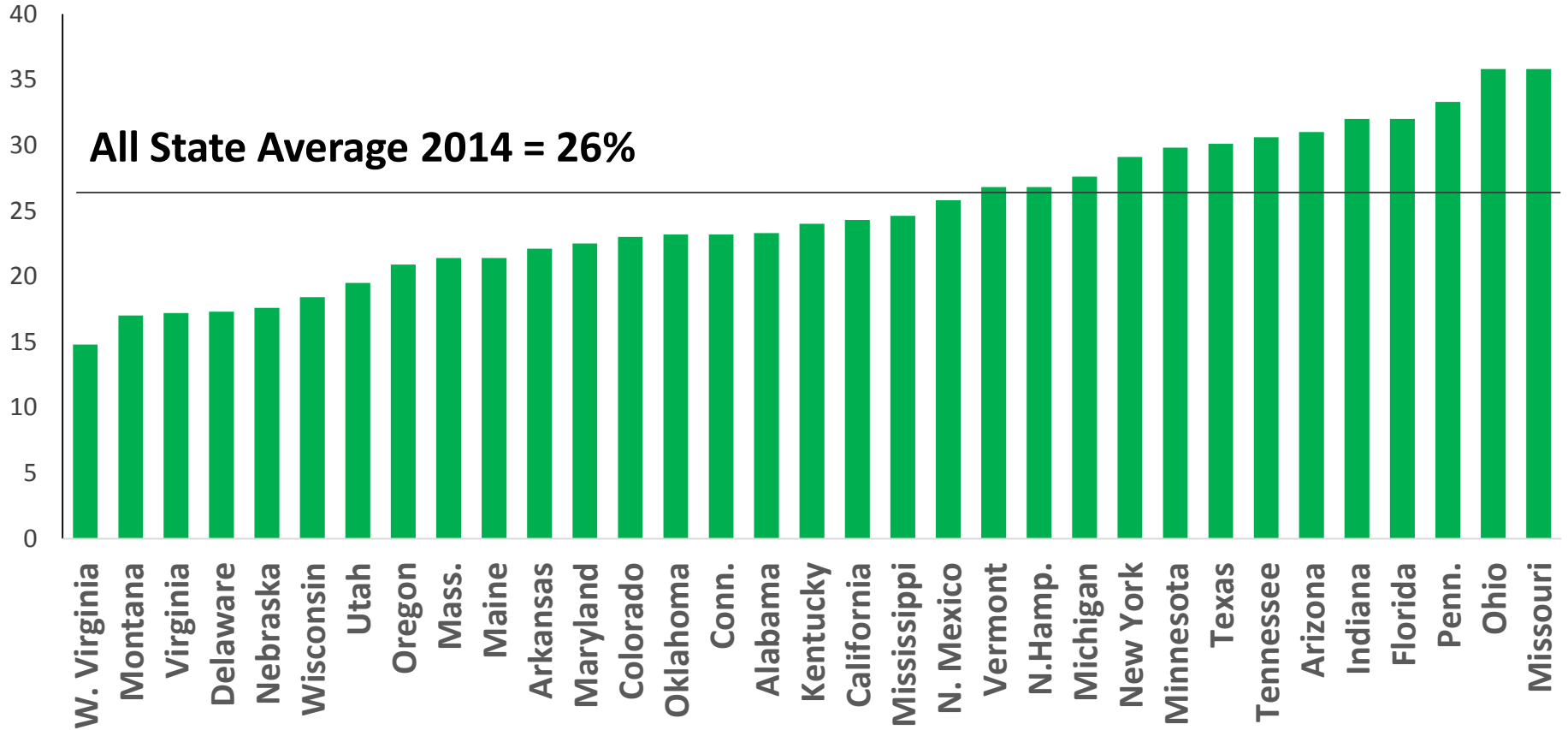


* Includes federal funds. Federal Medicaid = 13.9% state total budget.

Source: MacPac analysis of National Association of State Budget Officers, 2014.

Medicaid (including federal funds) as percent of Total State Expenditures, 2014*

Percent

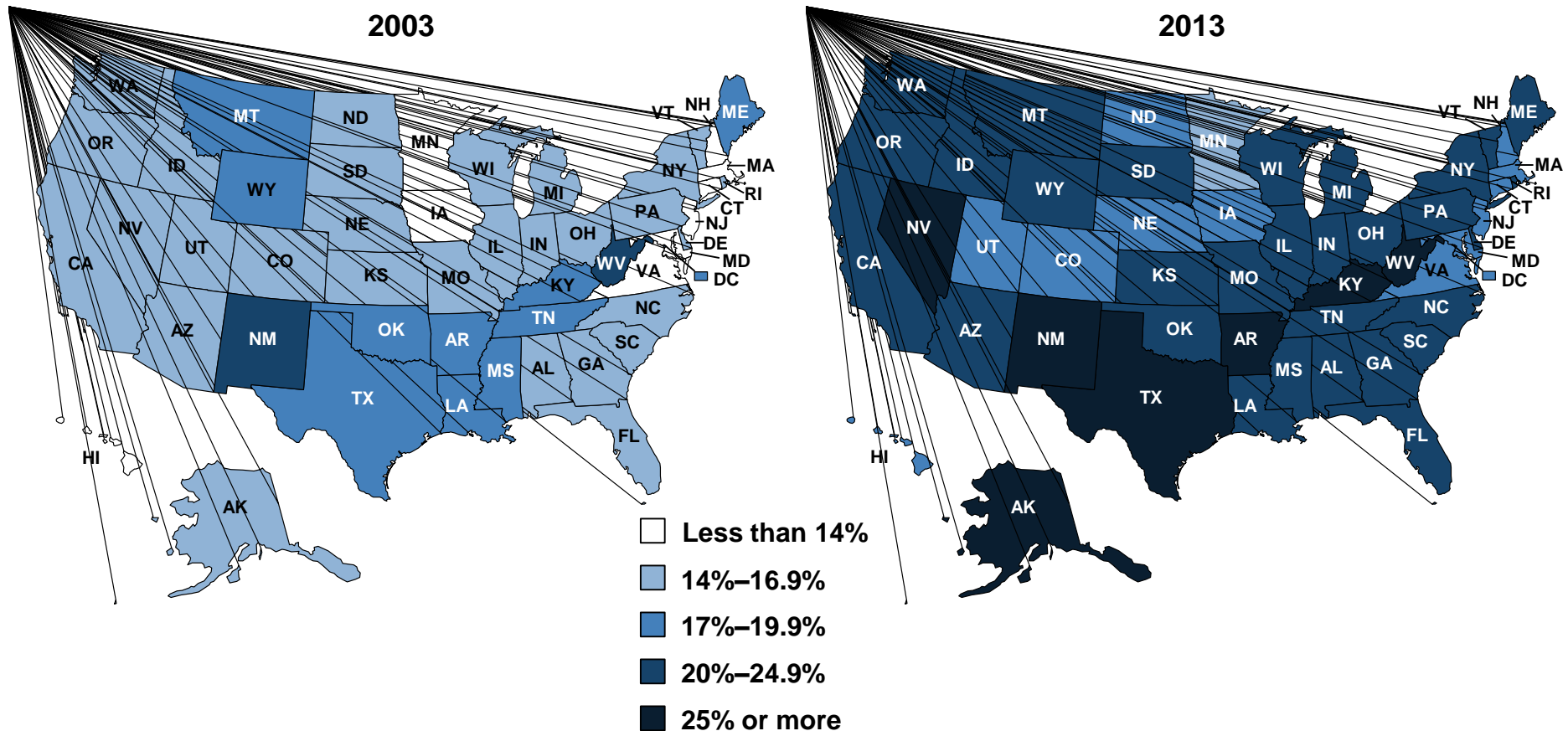


*Includes federal and state funds for Medicaid and total state spending from all sources. Federal \$ average 58% of Medicaid. Range from lows of under 50% in high income states such as MA and CT to more than 70% in low-income states such as WV, Mississippi, New Mexico

Source: NASBO, State Expenditure Report, 2013- 2015, Fall 2015. www.nasbo.org

Costs a Shared Concern: Total Premiums Increase Faster than Median Income in All States

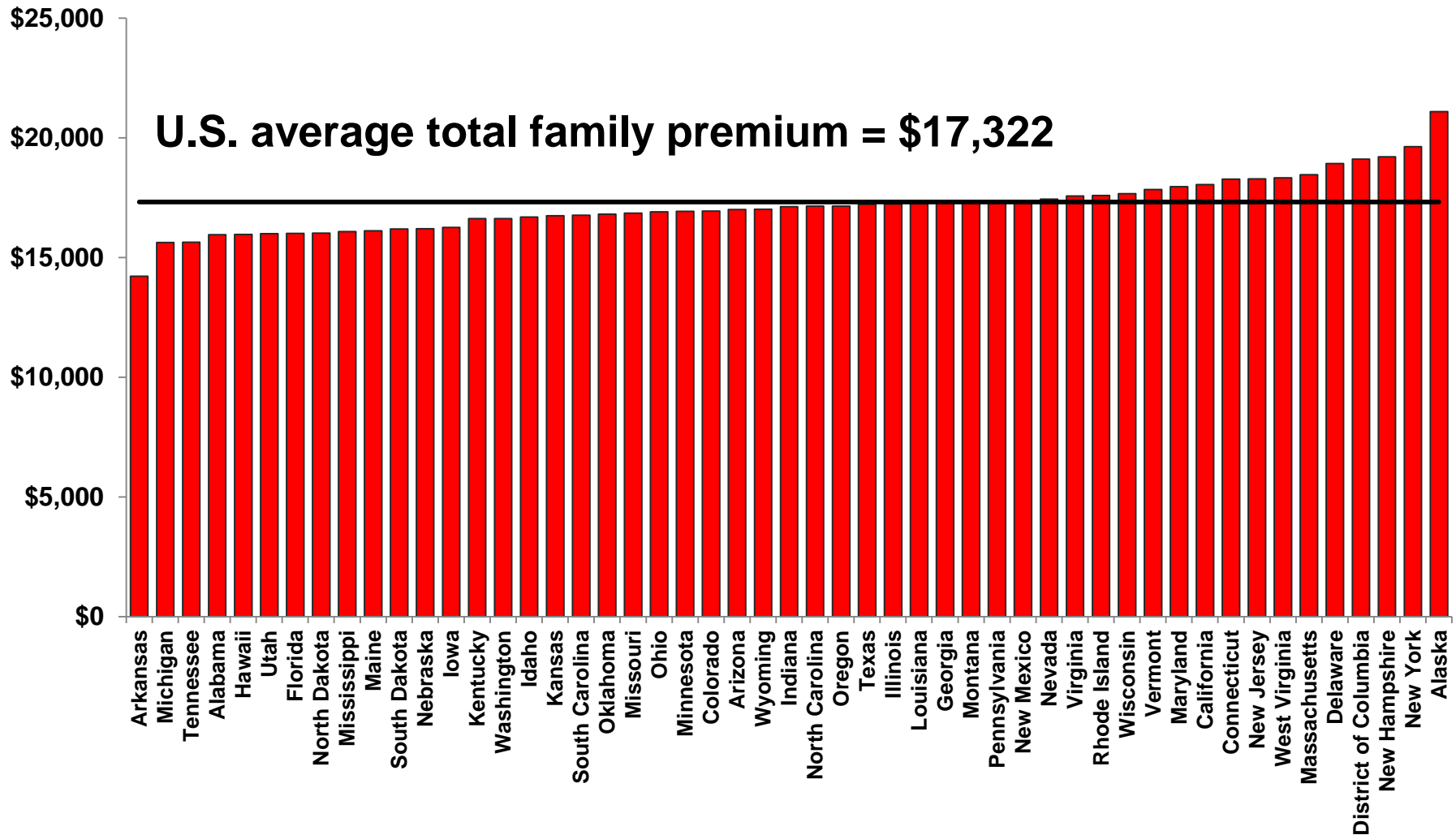
82 percent of under-65 population in live where total premiums amount to 20 percent or more of median income



Data: 2003 and 2013 Medical Expenditure Panel Survey—premiums for employer-based health plans. Median Income 2003–04 and 2013–14 Census CPS under-65 population.

Source: Schoen, Radley, Collins, *State Trends Employer Premium and Deductible, 2003-2013*. Commonwealth Fund Jan. 2015

Insurance Expensive No Matter Where you Live: Insurance Premiums for Family Coverage 2015



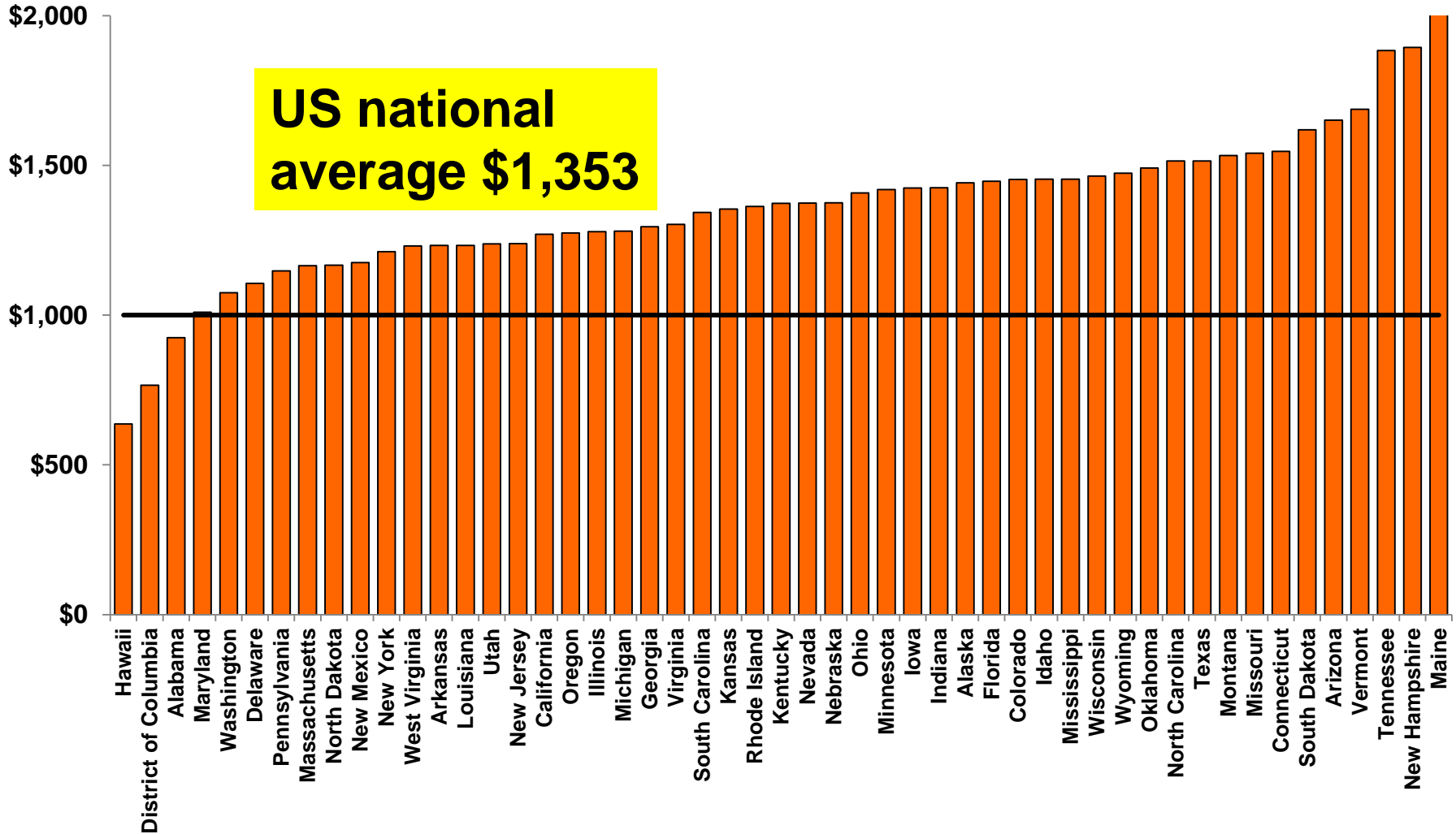
Data source: 2015 Medical Expenditure Panel Survey—Insurance Component Private-Employer Sponsored Plans..

For trends: Schoen, Radley, Collins, *State Trends Employer Premium / Deductibles, 2003-2013*. Commonwealth Fund 1/2015

Single-Person Deductibles, 2015

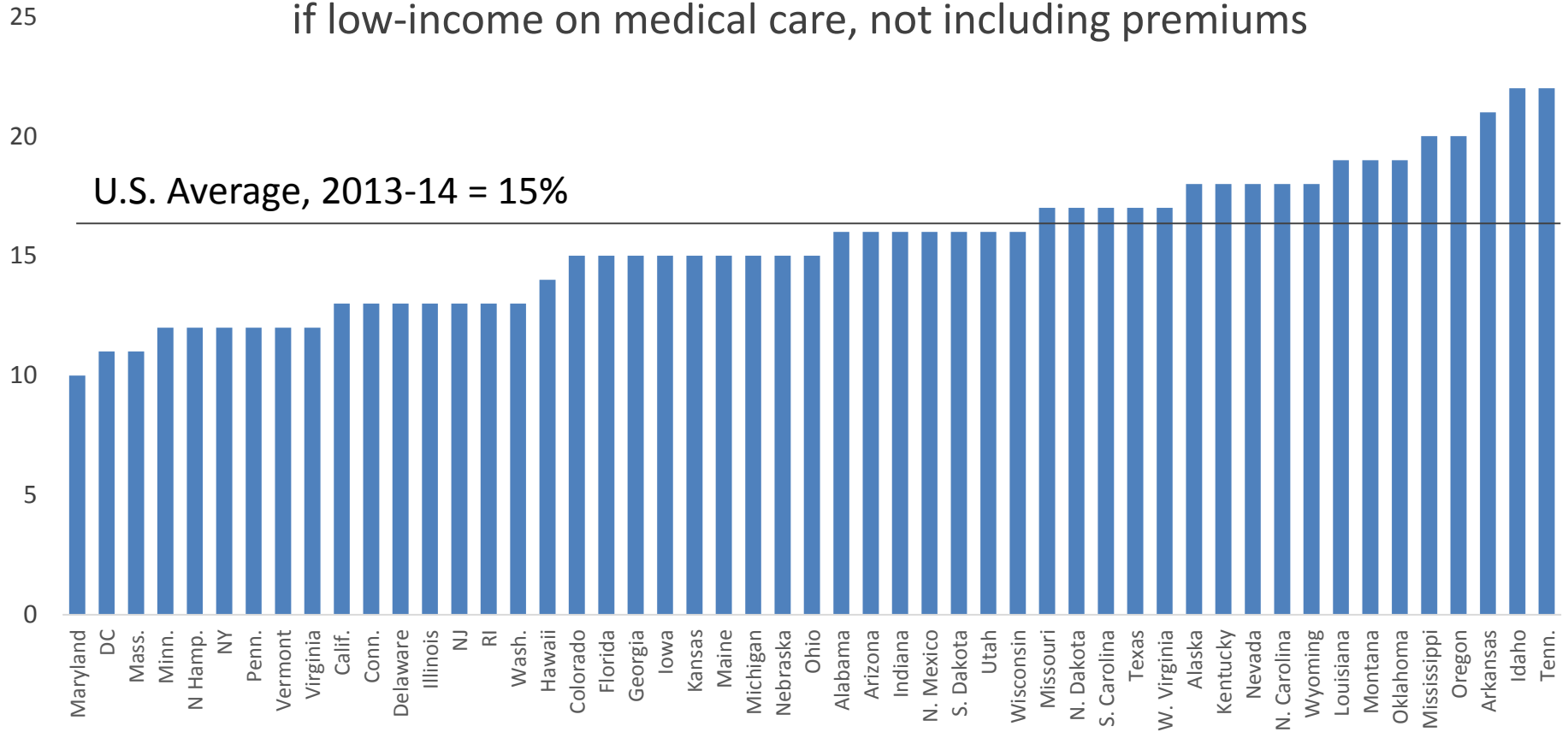
Average \$1,000 or more in all but 3 States

Dollars



Affordability Concerns: Out-of-Pocket Medical Spending, 2013-14

Percent of under age 65 population spending 10% or more of income or 5% if low-income on medical care, not including premiums



Low income is below 200% of the federal poverty level. State estimates average of the two years.

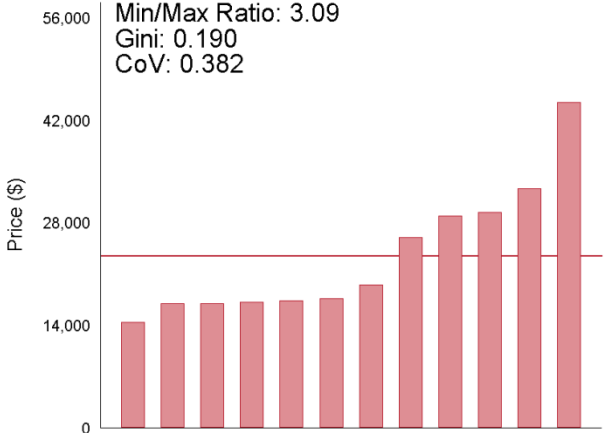
Data: U.S. Census Bureau, Current Population Survey Annual Social and Economic Supplement, March 2014 and March 2015. Analysis by C. Roman-Solis, New York University, Wagner School of Public Policy.

Analysis to Inform Strategic Efforts

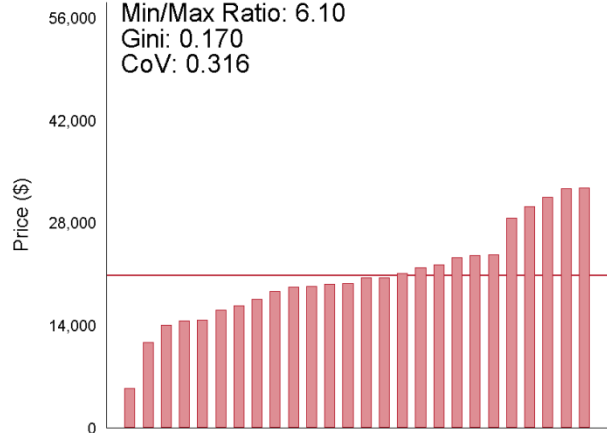
- **Payment reform**
 - Payment methods and price levels
 - Incentives across a care continuum
- **Value oriented Insurance benefits**
 - Information on price variation for benefit design
 - Transparency for patients before access care
- **Market wide policies**
 - Better, transparent information
 - Medicare data on variations may provide insights
 - Accountability: balance market power of consolidated systems and insurers
 - Other: malpractice; licensure
- **Alignment across public and private payers**

Knee Replacement facility prices vary widely within markets

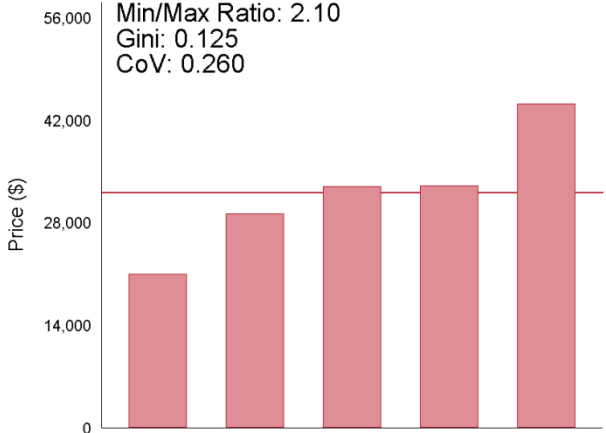
Denver, CO



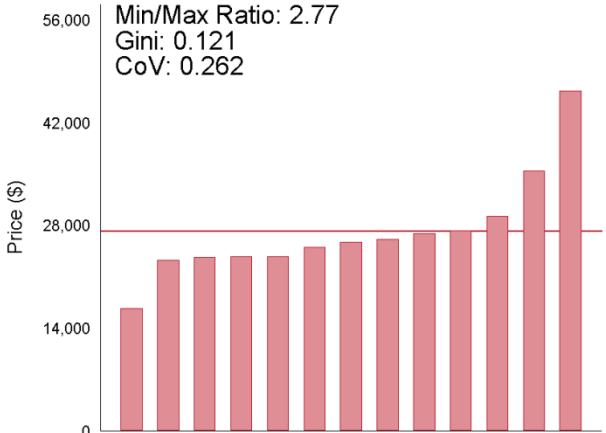
Atlanta, GA



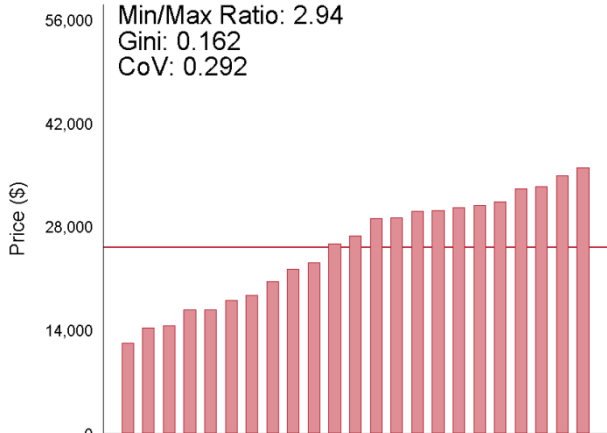
Manhattan, NY



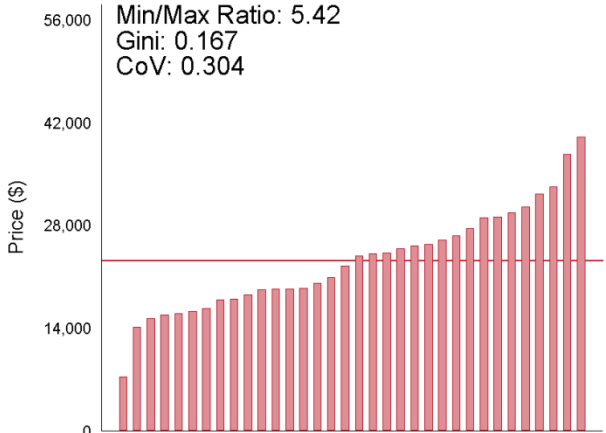
Columbus, OH



Philadelphia, PA



Houston, TX

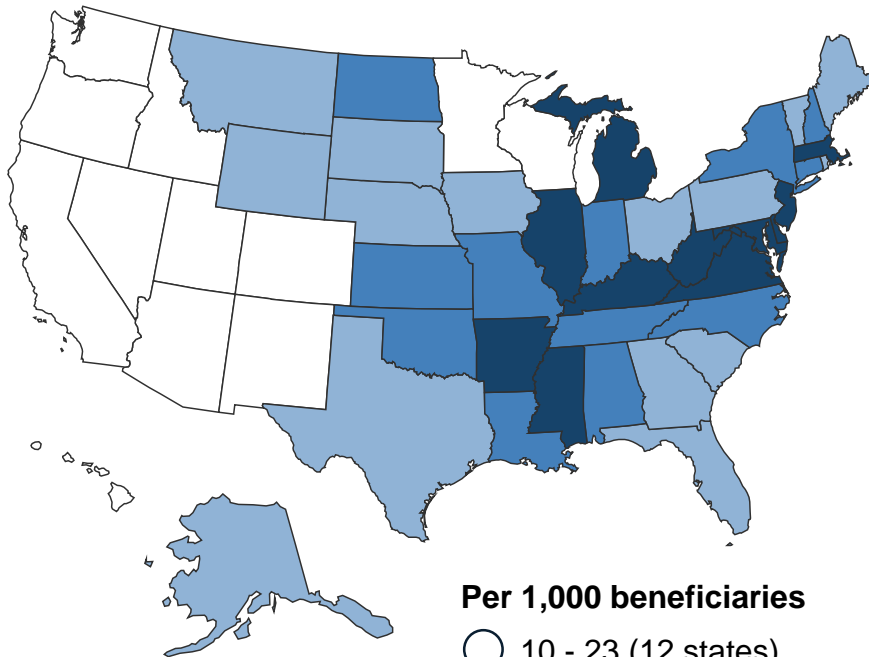


Source: Z. Cooper et al. The Price Ain't Right. Hospital Price and Health Spending on Privately Insured. NBER December 2015.

© Cooper, Craig, Gaynor, and Van Reenen

Potentially Avoidable Hospital Use Among Medicare Beneficiaries Varies Widely

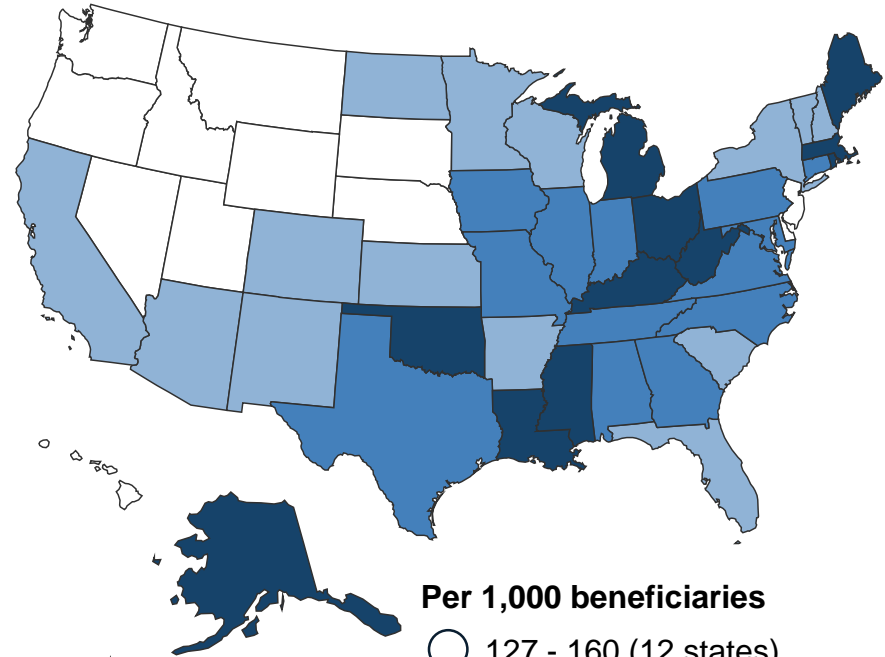
30-Day Hospital Readmission, 2013



Per 1,000 beneficiaries

- 10 - 23 (12 states)
- 24 - 30 (15)
- 31 - 35 (12)
- 36 - 48 (11 + DC)

Potentially Avoidable ED Visits, 2013

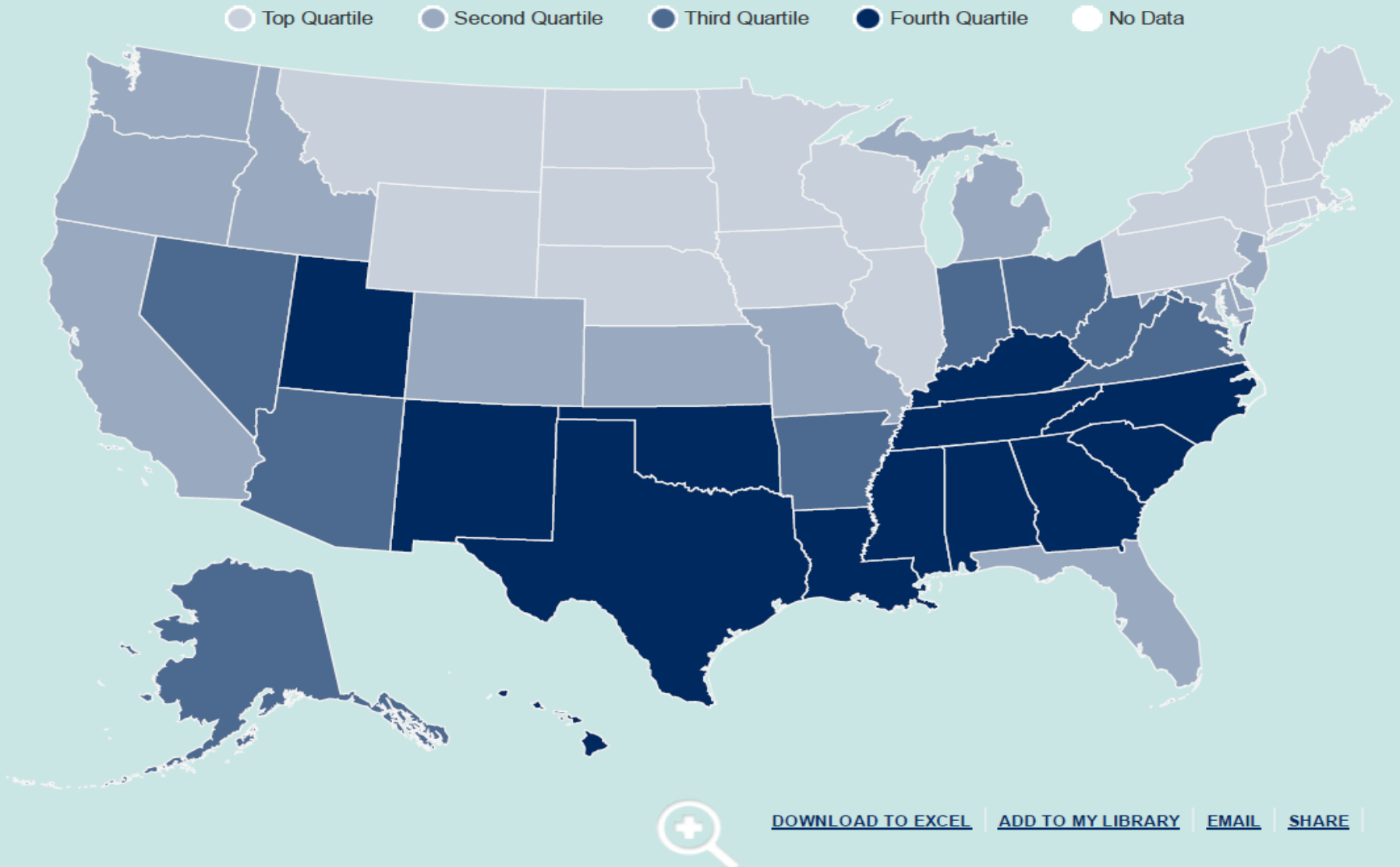


Per 1,000 beneficiaries

- 127 - 160 (12 states)
- 163 - 178 (14)
- 179 - 192 (13)
- 196 - 251 (11 + DC)

Note: Potentially avoidable emergency room (ED) visits are treatment was not required within 12 hours, or urgent but primary-care treatable, could have been provided in a primary care setting. Data: Analysis of Medicare Claims

Unsafe Prescribing: Medicare beneficiaries with drugs should avoid in elderly: 2012 Range from 9% to 24%



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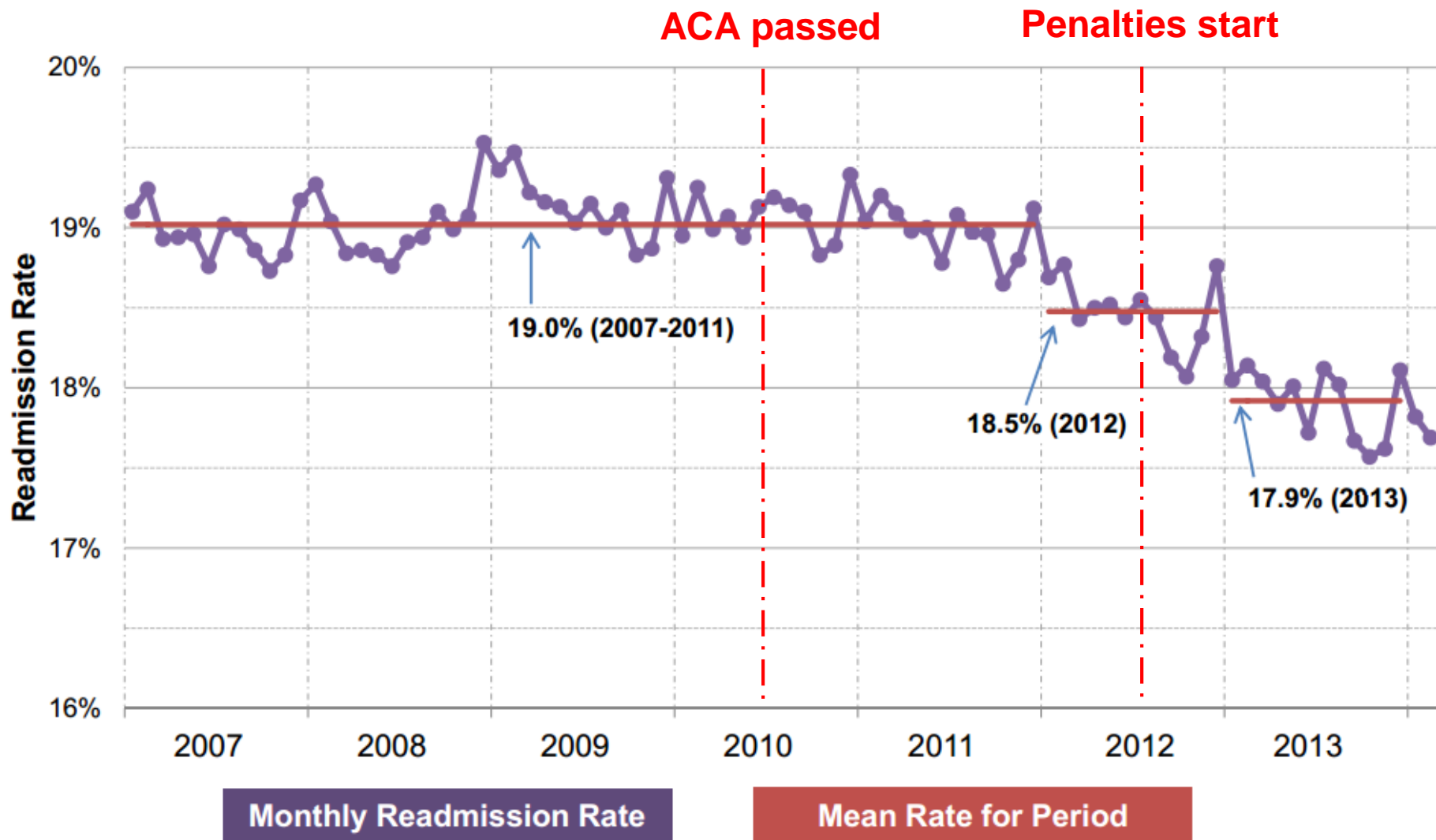
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Source

D. McCarthy, D. C. Radley, and S. L. Hayes. [Aiming Higher: Results from a Scorecard on State Health System Performance, 2015 Edition](#). The Commonwealth Fund, December 2015.

30-Day, All-Condition Medicare Readmission Rates



Source: Niall Brennan, Centers for Medicare and Medicare Services, "Findings from Recent CMS Research on Medicare," Presentation at AcademyHealth Annual Research Meeting session on The Centers for Medicare and Medicaid Services Data and Information Products, June 9, 2014. Available at <http://www.academyhealth.org/files/2014/monday/brennan.pdf>