Bending the HealthCare Cost Curve: Challenges and Opportunities

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Background Chart Pack

National Conference of State Legislatures

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Confronting Cost while Improving Access and Health Outcomes

• US highest costs in the world
  – Yet, often poor access and quality/safety concerns
  – Rising prices, not use, have driven spending increases
  – Evidence of wasteful spending & high administrative costs

• Costs a shared concern
  – Despite 4 years of slow growth, up faster than income
  – Projected to accelerate without targeted policies

• Potential for State action
  – Purchasers; Market oversight; and Regulatory authority
  – Opportunities and examples

• Aim: Lower costs with better access & outcomes

Average spending on health per capita ($US PPP)

- US
- NOR
- SWIZ
- GER
- CAN
- FR
- JPN
- UK

Total health expenditures as percent of GDP

- US
- FR
- SWIZ
- GER
- CAN
- JPN
- NOR
- NOR

Note: PPP = Purchasing power parity.

Data Source: OECD Health Data 2015: National Health Expenditure Accounts.
### U.S. Prices Higher: Total Hospital and Physician Costs, Selected Countries, 2012

<table>
<thead>
<tr>
<th>Procedure</th>
<th>AUS</th>
<th>FRA</th>
<th>NETH</th>
<th>NZ</th>
<th>SPA</th>
<th>SWIZ</th>
<th>UK</th>
<th>US (avg)</th>
<th>US (95th %ile)</th>
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<tbody>
<tr>
<td>Appendectomy</td>
<td>$5,467</td>
<td>$4,463</td>
<td>$4,498</td>
<td>$5,392</td>
<td>$2,245</td>
<td>$4,782</td>
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<td>Hip Replacement</td>
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<td>9,574</td>
<td>11,889</td>
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<td>Bypass Surgery</td>
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<td>22,844</td>
<td>14,061</td>
<td>26,432</td>
<td>17,437</td>
<td>17,729</td>
<td>14,117</td>
<td>73,420</td>
<td>150,515</td>
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</tbody>
</table>

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

Medicaid as Share of State Budgets, 2013

- Medicaid: 24.5%
- Elem/Secondary: 15.1%
- Higher ED: 0.0%
- All other: 25.0%

State Funded Budget: $1.2 Trillion

Total State Budget*: $1.8 Trillion

* Includes federal funds. Federal Medicaid = 13.9% state total budget.
Medicaid (including federal funds) as percent of Total State Expenditures, 2014*

*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

Recent Rapid Increase in Prescription Drug $

National Health Spending Growth Rate Forecast to Accelerate

Annual Rate Change

Source: CMS National Health Expenditures, Historical and Projected July 30, 2015
# National Health Expenditures by Source

## Actual and Projected to 2025

<table>
<thead>
<tr>
<th>Year</th>
<th>Federal Government</th>
<th>State and Local Government</th>
<th>Private Employers (+ other private)</th>
<th>Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>27%</td>
<td>16%</td>
<td>28%</td>
<td>29%</td>
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<tr>
<td>2012</td>
<td>26%</td>
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<td>2014</td>
<td>28%</td>
<td>17%</td>
<td>27%</td>
<td>28%</td>
</tr>
<tr>
<td>2025</td>
<td>30%</td>
<td>17%</td>
<td>25%</td>
<td>27%</td>
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</table>

### Projected $5.6 Trillion

<table>
<thead>
<tr>
<th>Year</th>
<th>Federal Government</th>
<th>State and Local Government</th>
<th>Private Employers (+ other private)</th>
<th>Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>2025</td>
<td>30%</td>
<td>17%</td>
<td>25%</td>
<td>27%</td>
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</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>% GDP</th>
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<tr>
<td>2009</td>
<td>17.4%</td>
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<tr>
<td>2012</td>
<td>17.4%</td>
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<td>2014</td>
<td>17.5%</td>
</tr>
<tr>
<td>2025</td>
<td>20.1%</td>
</tr>
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</table>

Note: GDP = gross domestic product. Source: Centers for Medicare and Medicaid Services, Office of the Actuary. Historic and projected National Health Expenditure data as of July 2016. Table 16.

U.S. average total family premium = $17,322


Single-Person Deductibles, 2015
Average $1,000 or more in all but 3 States

Confronting Costs

• Excess prices
• Broad evidence of waste and inefficiency
• Poorly coordinated, duplicative, unsafe care
• Administrative complexity =
  ➢ Overhead costs for providers
  ➢ Paperwork, time, hassle for patients
Keys to Rapid Progress: Payment, Information, and Care System Innovation

Payment Reform: Prices, Incentives & Value

Teams

Care System Innovation

Population Health

Information Systems

On a Foundation of Access
Strategic Policy Areas to Confront Costs

• Payment reform
  – Payment methods and price levels
  – More “bundled” payment; shared savings
  – Spur care system innovation with access and quality

• Insurance reforms
  – High value choices; informed choice
  – Reduce administrative costs

• Market wide policies
  – Better, transparent information
  – Confront drug price increases while protecting value
  – Accountability: balance market power of consolidated systems and insurers
  – Other: malpractice; licensure

• Alignment across public and private payers
Wide Spectrum of Potential Targeted State Actions

**Insurance Design**
- Value-based cost-sharing design
- Narrow networks
- Consumer protection: surprise bills

**Purchasing Power**
- Bundled payment with accountability
- Medicaid
- Public employee health plans
- Multi-payer initiatives

**Market reforms**
- Transparency
- Anti-trust: market power
- Multi-payer
  - Administrative costs
  - Payment rates+
- Licensure
- Convene to collaborate
Insurance Design with Patient Protections

• **Value based insurance benefit design**
  – Lower cost-sharing for effective care (including RX) or high-value providers
  – Examples with evidence cost and quality
    • CAL PERS (public employee): reference pricing
    • Connecticut State Employees: focus on chronic conditions
    • Mass Blues AQC: tiered variable cost-sharing

• **Narrow networks**
  – Aim to reduce prices; accelerate care system integration
  – Require access and consumer protection

• **Consumer protection: NY Surprise Bill Example**

  2015: Protects against out-of-network if not informed or emergency
Payment Reform

• Payment reforms aim to provide incentives to:
  – Focus on patients
  – Coordinate and integrate care across continuum
  – Hold care systems accountable for outcomes and costs

• Range of approaches with accountability for outcomes
  – Pay for performance: FFS with adjustment for outcomes
  – Primary care: medical homes and health homes
    • Extra monthly payment for teams + coordinated care
    – “Bundled” payments for episodes of care
  – Shared savings across care systems
  – Global budget/capitation: risk and accountability
Accessible Patient-Centered Primary Care Foundation - Connected to Care System
Multiple Models of “Medical Homes” and Teams
Examples Bundled Payment Initiatives

Where: Arkansas

What’s New: Medicaid and state’s two largest private insurers pay per “episode of care”
• Incentive for better quality at lower costs

What’s New: Medicare bundled payment demonstrations; Mandatory for hip/knee joint in 67 metro areas April 2016

Examples: Albuquerque, Oklahoma City, Tulsa, San Antonio
• Bundled payment for hospital and physician services for inpatient orthopedic and cardiovascular procedures
• Share savings with providers and beneficiaries
Focus on High-Cost Patients - Care Continuum

Sickest 10% of United States account for two-thirds of total costs

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 2009

- U.S. population: 100%
  - Health expenditures: 97%
  - 97% of health expenditures account for 50% of total costs
  - 90% of health expenditures account for 10% of total costs

Source: Agency for Healthcare Research and Quality analysis of 2009 Medical Expenditure Panel Survey.
- 744 accountable care organizations in the U.S.
- 23.5 million lives covered.

Variation in Asthma Admission Rates within a Single County, Cincinnati

**County neighborhoods**

- Highest tertile
- Middle tertile
- Lowest tertile

- Neighborhood in the highest tertile (n=18)
- Neighborhood in the middle tertile (n=21)
- Neighborhood in the lowest tertile (n=54)
Federally Supported Statewide Innovation Initiatives

• State Innovation Model (SIM) Awards 2013/2014
  – Multi-payer: value-based payment
  – Accountability for quality and costs
  – Improve population health
  – Align payment & measures
    Ø Streamline and provide coherent incentives

• Delivery System Reform Incentive Payment
  Medicaid waivers (DSRIP): 7 states
  – $ for providers to restructure care systems
  – Improve care and lower costs Medicaid
  – Contingent on targets/goals
States with State Innovation Model (SIM) Testing Awards (17) as of 2014

Source: CMS https://innovation.cms.gov/initiatives/state-innovations/
TeleHealth and Electronic Communication: Access and Teams

Multiple States: enabling legislation and amend practice laws
  – Mississippi leader in pay for Telehealth 2015

- Veteran’s Administration Home Telehealth by 2012, reached 119,535 veterans; annual savings of $1,999 per patient

- U. Tennessee Memphis: Remote specialist consultations with patients, local clinicians; 3 state region
  – Reduce heart failure admission and readmissions by 80%

- New Mexico project Echo: enable teams high-need, high-cost

- Primary care to Specialist e-consultations and referral
  – Mayo, SF General, Group Health Puget Sound

- Emory University, Georgia: Innovation Grant for Tele-ICU to support critical care teams in rural hospitals (10,000 patients)
Transparency and Information Systems

- Price, cost, and quality/outcomes
- Inform and guide
- Enable targets and benchmarks
- Essential for care system and markets
- Resource for policy and system leaders
What is the Cost? All-Payer System Payment Variation in New Hampshire

Range of Private Insurer Payments Across New Hampshire for Selected Procedures

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Emergency Room Visit—Medium</th>
<th>MRI—back (Outpatient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$444 - $2,071</td>
<td>$940 – $3,245</td>
</tr>
<tr>
<td>B</td>
<td>$431 - $1,099</td>
<td>$797 – $3,146</td>
</tr>
<tr>
<td>C</td>
<td>$410 - $1,290</td>
<td>$635 – $3,586</td>
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</table>

Medicare and Employer Health Spending Per Beneficiary

Correlation of Public and Private Total Spending Per Beneficiary: 0.140

Note: Data on Medicare from the Dartmouth Atlas. Spending on private enrollees includes all inpatient, outpatient, and physician claims. HCCI data.

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Knee Replacement facility prices vary widely within markets.

**Denver, CO**
- Min/Max Ratio: 3.09
- Gini: 0.190
- CoV: 0.382

**Atlanta, GA**
- Min/Max Ratio: 6.10
- Gini: 0.170
- CoV: 0.316

**Manhattan, NY**
- Min/Max Ratio: 2.10
- Gini: 0.125
- CoV: 0.260

**Columbus, OH**
- Min/Max Ratio: 2.77
- Gini: 0.121
- CoV: 0.262

**Philadelphia, PA**
- Min/Max Ratio: 2.94
- Gini: 0.162
- CoV: 0.292

**Houston, TX**
- Min/Max Ratio: 5.42
- Gini: 0.167
- CoV: 0.304

**Note:** Each column is a hospital. Prices measured from 2008 – 2011, presented in 2011 dollars.

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Colonoscopy facility prices 3-6 fold variation within markets

**Denver, CO**
- Min/Max Ratio: 3.33
- Gini: 0.199
- CoV: 0.370

**Atlanta, GA**
- Min/Max Ratio: 5.76
- Gini: 0.232
- CoV: 0.449

**Manhattan, NY**
- Min/Max Ratio: 3.50
- Gini: 0.186
- CoV: 0.406

**Columbus, OH**
- Min/Max Ratio: 4.50
- Gini: 0.230
- CoV: 0.441

**Philadelphia, PA**
- Min/Max Ratio: 5.03
- Gini: 0.180
- CoV: 0.339

**Houston, TX**
- Min/Max Ratio: 4.41
- Gini: 0.159
- CoV: 0.320

*Note: Each column is a hospital. Prices are regression-adjusted, measured from 2008 – 2011, and presented in 2011 dollars.*

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US High Administrative Costs Insurance and Providers

**F R A G M E N T E D P A Y E R S**

**+**  **C O M P L E X I T Y**

**H I G H T R A N S A C T I O N C O S T S**

- Insurance overhead adds at least $100 billion per year*

- Billions more in provider administrative costs
  - Variation benefits, payment, reporting
  - Time and people expense for doctors and hospitals


**Spending on Health Insurance Administration per Capita, 2011**

- **US**: $606
- **FR**: $277
- **SWIZ**: $266
- **GER**: $237
- **NETH**: $199
- **CAN**: $148
- **AUS**: $70

*Source: 2013 OECD Health Data (June 2013)
States Can Contribute to Bending the Cost Curve with Better Health Care and Health

- Market-wide policies
  - Address market power and prices
  - Oversight providers and insurers
    - Licensure, anti-trust, other regulatory authority

- Leverage own purchasing power

- Partner with other payers, including Medicare
  - Standardize to reduce administrative costs

- Support transparency and information systems

- Combine public health and care system innovation

- Convene and build consensus
What if National Health Spending grew at same rate as the economy? $ Trillion Question

2014-2024 $42.4 Trillion if GDP growth rate, compared to $45.3 T with CMS NHE projections.

Actual

Based on CMS NHE Projection

IF NHE Growth at same rate as GDP

19.6% of GDP

Cumulative Difference: $2.9 T

17.4% of GDP

Tackling Costs: Opportunities for State Action to Pull Together

Triple Aim of Slower Cost Growth, Better Population Health and Better Care
For Further Information


• Commonwealth Fund Scorecards

• CMS Tracking Federally Supported Initiatives and Medicare
  – Medicare bundled payments and primary care

• NASHP: primary care medical homes, health homes, accountable care http://nashp.org/category/primary-care-and-medical-homes/
Extra

• Despite slow down, premiums continue to rise faster than income in all states

• Affordability concerns for insured: higher deductibles and cost-sharing can add up to a substantial share of income
  – This includes extra costs if go out of network

• Medicare data enables geographic comparisons
  – Wide variation in potentially preventable hospital use
  – Private sector patterns (higher or lower use) tend to track Medicare patterns

• Readmission rate decline in Medicare also benefit private sector and Medicaid
  – States with the highest rates had the largest 2013 decreases
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


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

U.S. Average, 2013-14 = 15%

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

Potentially Avoidable Hospital Use Among Medicare Beneficiaries Varies Widely

30-Day Hospital Readmission, 2013

Potentially Avoidable ED Visits, 2013

Per 1,000 beneficiaries

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

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

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, December 2015
30-Day, All-Condition Medicare Readmission Rates