State Cost Containment Strategies

Sept. 12, 2019
Special Committee on Financial Institutions and Insurance
WHO WE ARE

- Nonprofit, nonpartisan educational organization based in Topeka
- Established in 1995 with a multi-year grant by the Kansas Health Foundation
- Funded by local and national foundations, state and federal agencies, NGOs
- Located directly north of the Kansas Statehouse
1. Health insurance coverage
2. Insurance market characteristics
3. Health care costs
4. State policy approaches to contain health care costs
HEALTH INSURANCE IN KANSAS
HEALTH INSURANCE IN KANSAS 2017

2,872,207 KANSAS POPULATION

PRIVATE COVERAGE 1,813,373

1,543,268 Employment-Based
70,978 Military/TRICARE
199,127 Direct Purchase

Includes 66,310 Kansans with a Marketplace plan.

PUBLIC COVERAGE 815,529

316,227 Medicaid/CHIP
73,261 Both Medicare & Medicaid
412,743 Medicare
13,298 Veteran Affairs (VA) Health Care

243,305 TOTAL UNINSURED

CHILDREN (0-18) 40,815
(Family income not available for 1,303 children)

ADULTS (19-64) 201,275
(Family income not available for 2,036 adults)

SENIORS (65+) 1,215
(Likely eligible for Medicare)

<241% FPL
25,623
Currently eligible for Medicaid/CHIP

>241% FPL
13,889
Not eligible for Medicaid/CHIP

400% FPL
9,948
Quality for subsidies on the marketplace

100-400% FPL
57,736
Quality for subsidies on the marketplace

100-138% FPL
120,239
Quality for subsidies on the marketplace

100-138% FPL
53,574
Quality for subsidies on the marketplace

<38% FPL
7,632
Currently eligible for Medicaid

<100% FPL
34,118
Do not qualify for Medicaid or subsidies on the marketplace

<3x-<100% FPL
16,006
Do not qualify for Medicaid or subsidies on the marketplace. Would qualify for Medicaid if expanded

>138-400% FPL
96,395
Quality for subsidies on the marketplace

>400% FPL
21,104
Could purchase a marketplace plan without subsidies

LEGEND
- Currently eligible for Medicaid and/or CHIP – 33,237
- Would qualify for Medicaid if expanded – 74,098
- Quality for subsidies on the marketplace – 130,317
- Could purchase a marketplace plan without subsidies – 25,075

Federal Poverty Level (FPL) — Family of Four, 2017
- 38% of FPL = $9,948
- 50% of FPL = $12,600
- 100% of FPL = $25,069
- 200% of FPL = $50,138
- 400% of FPL = $96,400

Source: This analysis is based on the 2017 American Community Survey Public Use Microdata Sample from the U.S. Census Bureau and the 2017 Effective Enrollment Snapshot Fact Sheet from the Centers for Medicare and Medicaid Services.
Uninsured Rate for Kansas and the United States, 2009-2018

2. THE INSURANCE MARKET IN KANSAS
WHAT IS A COMPETITIVE INSURANCE MARKET?

• Market concentration
  – Number of insurers
  – Share of market covered by largest insurers

• Barriers to market entry
  – State regulatory requirements (solvency, etc.)
  – Cost of network development, marketing, enrollment

• Types of insurance products offered – PPO, HMO, POS, EPO, HDHP
## OVERALL INSURANCE MARKET COMPETITIVENESS

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<th>Overall HHI*</th>
<th>Insurer 1</th>
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*Overall HHI includes all insurance types (HMO+PPO+POS+EXCH)
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*Overall HHI includes all insurance types (HMO+PPO+POS+EXCH)

AMA, Competition in Health Insurance, 2018 Update
3. HEALTH CARE COSTS
Note: Expenditure excludes investments, unless otherwise stated. 1. Australian expenditure estimates exclude all expenditure for residential aged care facilities in welfare (social) services. 2. Includes investments. Source: OECD Health Statistics 2017, WHO Global Health Expenditure Database
Since 1980, the gap has widened between U.S. health spending and that of other countries.

Health consumption expenditures as percent of GDP, 1970 - 2017

Notes: U.S. values obtained from National Health Expenditure data. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of OECD and National Health Expenditure (NHE) data • Get the data • PNG
A Different Trajectory After 1980

In most countries, more health spending coincided with much longer lives. But the U.S. diverged from peer nations around 1980. Each dot below represents one year in a country between 1970 and 2003.

Source: Our World in Data
WHAT DRIVES HEALTH CARE SPENDING?

Total Spending = Number of people \times \text{Volume of services per person} \times \text{Price per service}
WHOSE HEALTH CARE COSTS DO WE CARE ABOUT?

State and Federal Government  816,000
Military/Tricare              71,000
Employees and employers      1,543,000
Individuals                  199,000
Uninsured                    250,000

Kansas Total                2,900,000
WHAT DO WE SPEND IT ON?

Relative contributions to total national health expenditures, 2017

Hospitals 33%
Other Health 27%
Physicians & Clinics 20%
Prescription Drugs 10%
Nursing Care 5%
Dental 4%
Home Health Care (5%)

Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data • Get the data • PNG
WHAT DRIVES INCREASES IN HEALTH CARE SPENDING?

Factors
- Population size
- Population age
- Disease prevalence or incidence
- Service utilization
- Service price and intensity
- Total change

Change in Spending Associated With Each Factor, 1996-2013, $ Billions

Average annual premiums for single and family coverage, 1999–2018

November 2018 37:11 Health Affairs, data from KFF and HRET’s Employer Health Benefits Survey, 1999–2017
Cost of Health Care Rising Faster Than Workers’ Wages and Inflation

Cumulative increases, 2008-18

Reproduced from Kaiser Family Foundation 2018 Employer Health Benefits Survey; Note: Average general annual deductibles are for single coverage; Chart: Axios Visuals
Monthly Premiums on ACA Marketplace Also Rising

Figure 2. Average and Range of Premiums, Before APTC, for Benchmark Plan for Family of Four

EXPENDITURES BY SERVICE LINE, KANSAS (IN MILLIONS)

STATE POLICY OPTIONS TO CONTAIN HEALTH CARE COSTS
WHAT STATES HAVE DONE TO CONTROL HEALTH CARE COSTS AND IMPROVE QUALITY

- Establish cost growth goal
- Public health and cost outcomes scorecard
- Adopt payment and delivery system reform goals
- Implement bundled payments for all payers
- Institute global budgets for hospitals
- Launch All Payer Claims Databases (APCD)

Emanuel, E., et. al., Health Affairs Blog, April 28, 2016
WHAT STATES HAVE DONE TO CONTROL HEALTH CARE COSTS AND IMPROVE QUALITY (CONT.)

• Expand evidence-based home visiting services
• Improve price transparency
• Integrate behavioral health and primary care
• Combat addiction to prescription drugs and heroin (and methamphetamine)
• Improve the delivery of long-term care
• Align scope of practice with community needs

Emanuel, E., et. al., Health Affairs Blog, April 28, 2016
WHAT STATES HAVE DONE TO CONTROL HEALTH CARE COSTS AND IMPROVE QUALITY (CONT.)

- Institute reference pricing in the State Employee Health Plan
- Expand the use of telehealth
- Decrease unnecessary emergency room use

Emanuel, E., et. al., Health Affairs Blog, April 28, 2016
AEI/BROOKINGS RECOMMENDATIONS

• Improve incentives for cost-effective private insurance
  – Limit the tax exclusion of employer-sponsored insurance
  – Ensure effective anti-trust enforcement
  – Create pathway to the development of APCDs
• Remove state regulatory barriers to provider market competition
  – Repeal any willing provider laws
  – Certificate of need reform
  – Surprise billing reform

• Improve choice environment for (buying insurance)
  – Comprehensive plan-finder tools that give consumers better information on the likely cost of enrollment options
OTHERS?

• Right to Shop
• Direct patient care models
• Reinsurance programs/high risk pools
• Association Health Plans/Short Term Limited Duration Insurance
THANK YOU

Any questions?

You can connect with us at:

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Average Annual Family Premium for Employer-Based Health Insurance in Kansas