Health Care Costs and State Cost Containment Strategies

March 11, 2020
House Health and Human Services Committee
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
TODAY’S AGENDA

1. Health insurance coverage
2. Insurance market characteristics
3. Health care costs
4. State policy approaches to contain health care costs
1. HEALTH INSURANCE IN KANSAS
HEALTH INSURANCE IN KANSAS 2018

2,870,610 Kansas Population

PRIVATE COVERAGE
1,792,340
- 1,546,358 Employment-Based
- 67,932 Military/TRICARE
- 178,050 Direct-Purchase
  Includes 67,975 Kansans with a marketplace plan.

PUBLIC COVERAGE
829,153
- 328,133 Medicaid/CHIP
- 75,395 Both Medicare & Medicaid
- 416,628 Medicare
- 8,997 Veterans Affairs (VA) Health Care

249,117 TOTAL UNINSURED

CHILDREN (0-18)
39,965
(Family income not available for 1,724 children)

ADULTS (19-64)
206,458
(Family income not available for 1,937 adults)

SENIORS (65+)
2,694
(Likely eligible for Medicare)

LEGEND
- Currently eligible for Medicaid and/or CHIP = 36,356
- Would qualify for Medicaid if expanded = 74,774
- Qualify for subsidies on the marketplace = 129,955
- Could purchase a marketplace plan without subsidies = 30,090

Federal Poverty Level (FPL) = Family of Four, 2018
- 38% of FPL = $9,530
- 100% of FPL = $25,100
- 138% of FPL = $34,261
- 240% of FPL = $66,240
- 400% of FPL = $100,400

Source: KHI analysis of data from the U.S. Census Bureau 2018 American Community Survey Public Use Microdata Sample and the Early 2018 Expanded Enrollment Snapshot Fact Sheet from the Center for Medicare and Medicaid Services.

KANSAS HEALTH INSTITUTE
Informing Policy. Improving Health.
December 2019
Kansas Ranked 33rd Among States for Insurance Coverage

Figure 1.1 Percentage of Uninsured Residents by State, 2018

Source: KHI analysis of data from the U.S. Census Bureau 2018 American Community Survey Public Use Microdata Sample files.
Favorable Advantage in Insurance Coverage for Kansas Has Disappeared

*Figure 1.3 Percentage of Uninsured Residents, Kansas and U.S., 2009-2018*

Source: KHI analysis of data from the U.S. Census Bureau 2009-2018 American Community Survey Public Use Microdata Sample files.
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

<table>
<thead>
<tr>
<th>Overall HHI*</th>
<th>Insurer 1</th>
<th>Share (%)</th>
<th>Insurer 2</th>
<th>Share (%)</th>
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</thead>
<tbody>
<tr>
<td>US 3464</td>
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<td>KS 2491</td>
<td>BCBS KS</td>
<td>41</td>
<td>Aetna</td>
<td>17</td>
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<td>CO 2008</td>
<td>United HealthGroup</td>
<td>26</td>
<td>Anthem</td>
<td>22</td>
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<tr>
<td>IA 3180</td>
<td>Wellmark (BCBS)</td>
<td>47</td>
<td>United HealthGroup</td>
<td>28</td>
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<tr>
<td>MO 1969</td>
<td>Anthem</td>
<td>26</td>
<td>United HealthGroup</td>
<td>24</td>
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<tr>
<td>NE 3296</td>
<td>BCBS NE</td>
<td>48</td>
<td>United HealthGroup</td>
<td>25</td>
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<tr>
<td>OK 3339</td>
<td>HCSC (BCBS)</td>
<td>53</td>
<td>United HealthGroup</td>
<td>18</td>
</tr>
</tbody>
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*Overall HHI includes all insurance types (HMO+PPO+POS+EXCH)
# OVERALL INSURANCE MARKET COMPETITIVENESS

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<th>Location</th>
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<tr>
<td>KS</td>
<td>2491</td>
<td>BCBS KS</td>
<td>41</td>
<td>Aetna</td>
<td>17</td>
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<tr>
<td>Lawrence</td>
<td>3226</td>
<td>BCBS KS</td>
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<td>Cigna</td>
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<td>Manhattan</td>
<td>5661</td>
<td>BCBS KS</td>
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<td>Aetna</td>
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<tr>
<td>Topeka</td>
<td>5370</td>
<td>BCBS KS</td>
<td>72</td>
<td>UnitedHealth Group</td>
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<tr>
<td>Wichita</td>
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<td>BCBS KS</td>
<td>43</td>
<td>Aetna</td>
<td>34</td>
</tr>
<tr>
<td>KC (MO+KS)</td>
<td>3307</td>
<td>BCBS Kansas City</td>
<td>52</td>
<td>UnitedHealth Group</td>
<td>17</td>
</tr>
</tbody>
</table>

*Overall HHI includes all insurance types (HMO+PPO+POS+EXCH)
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.

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

Total Spending = Number of people X Volume of services per person X Price per service
<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
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<tbody>
<tr>
<td>State and Federal Government</td>
<td>829,000</td>
</tr>
<tr>
<td>Military/Tricare</td>
<td>68,000</td>
</tr>
<tr>
<td>Employees and employers</td>
<td>1,546,000</td>
</tr>
<tr>
<td>Individuals</td>
<td>178,000</td>
</tr>
<tr>
<td>Uninsured</td>
<td>249,000</td>
</tr>
<tr>
<td><strong>Kansas Total</strong></td>
<td><strong>2,900,000</strong></td>
</tr>
</tbody>
</table>
WHAT DO WE SPEND IT ON?

Relative contributions to total national health expenditures, 2017

- Hospitals: 33%
- Physicians & Clinics: 20%
- Other Health: 27%
- Prescription Drug: 10%
- Nursing Care: 5%
- Dental: 4%
- Home Health Care: 5%

Source: Kaiser Family Foundation analysis of National Health Expenditure 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

- +212% Deductibles
- +55% Family premiums
- +26% Workers’ earnings
- +17% Inflation

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 Monthly Premium, Before APTC, for the Silver Benchmark Plan on the Kansas Marketplace, 2014-2020 Plan Years

Note: Premium, before application of Advance Premium Tax Credits (APTC). The amounts shown are the actual average monthly premiums for the “benchmark plan,” a middle-of-the-road plan in terms of covered benefits and cost among the plans available on the marketplace. Technically, the benchmark plan is the second-lowest-cost silver plan (SLCSP).

EXPENDITURES BY SERVICE LINE, KANSAS (IN MILLIONS)

STATE POLICY OPTIONS TO CONTAIN HEALTH CARE COSTS
WHAT STATE LEGISLATURES HAVE DONE IN 2020 TO ADDRESS HEALTH CARE COSTS

• Prescription drug benefit (PBM) regulation
  – Enhanced oversight, transparency requirements, prohibitions on some business procedures
  – 35 states, including KS, CO, IN, IA, MO, NE, OK

• Importation of prescription drugs
  – Directing the state to develop an importation program that complies with federal law
  – 24 states, including KS, CO, IN, MO, OK

National Academy of State Health Policy, www.nashp.org, accessed March 9, 2020
WHAT STATE LEGISLATURES HAVE DONE IN 2020 TO ADDRESS HEALTH CARE COSTS

• Transparency requirements
  – Prescription drug pricing; price increase justification
  – 24 states, including CO, IN, IA, NE, OK

• Cost Review
  – Prescription drug costs and increases
  – Determination of state spending targets and goals
  – 14 states, including IL, MO

National Academy of State Health Policy, www.nashp.org, accessed March 9, 2020
WHAT STATE LEGISLATURES HAVE DONE IN 2020 TO ADDRESS HEALTH CARE COSTS

• Coupons/Cost Sharing
  – Cost sharing limits on prescription drugs
  – Require inclusion of rebates in calculation of cost sharing amounts
  – Prohibition on offer or use of manufacturers coupons or discounts to induce purchase of branded drugs when generic is available
  – 31 states, including KS, IN, IA, MO, OK

National Academy of State Health Policy, www.nashp.org, accessed March 9, 2020
WHAT STATE LEGISLATURES HAVE DONE IN 2020 TO ADDRESS HEALTH CARE COSTS

- Volume Purchasing
  - Coordination of purchasing by state and local government entities for prescription drugs
  - Establish bulk pharmaceutical purchasing processes for state and local government, as well as private purchasers, including small businesses, health benefits plans, and self-insured entities and individuals, to benefit from state bulk pharmaceutical purchasing agreements
  - Partnering with other states to manufacture generic drugs

National Academy of State Health Policy, www.nashp.org, accessed March 9, 2020
WHAT STATE LEGISLATURES HAVE DONE IN 2020 TO ADDRESS HEALTH CARE COSTS

• Studies
  – Pharmacy benefits
  – Cost sharing limits
  – Prescription drug pricing, costs and affordability
  – Reimbursement rates
  – Insurance benefits design
  – Eight states, including GA, KY, MI, TN

National Academy of State Health Policy, www.nashp.org, accessed March 9, 2020
AMERICAN ENTERPRISE INSTITUTE / 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 all-payer claims databases (APCDs)

A response to Chairman Alexander and the Senate HELP Committee, March 2, 2019
AMERICAN ENTERPRISE INSTITUTE / BROOKINGS RECOMMENDATIONS

• 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

• 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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