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Forum Brief

Kansas Health Policy Forums 2003

Health Care Spending Growth and State Policy Options

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212 SW Eighth Avenue, Topeka, KS • Lower Level Conference Room

A DISCUSSION FEATURING

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KANSAS HEALTH INSTITUTE
Healthier Kansans through informed decisions

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About the Forums

Kansas Health Policy Forums are a series of interactive sessions for policymakers examining a broad array of health issues. Forums present a wide range of national and local expertise on current health policy issues followed by facilitated discussion and dialogue in a non-partisan, off-the-record setting. Forum Briefs analyze issues, present relevant data and information, and are produced as background material for each Forum.

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Health Care Spending Growth and State Policy Options

SUMMARY

Increases in both private and public health care spending raise anxieties among consumers and policymakers alike, forcing difficult choices at both levels.

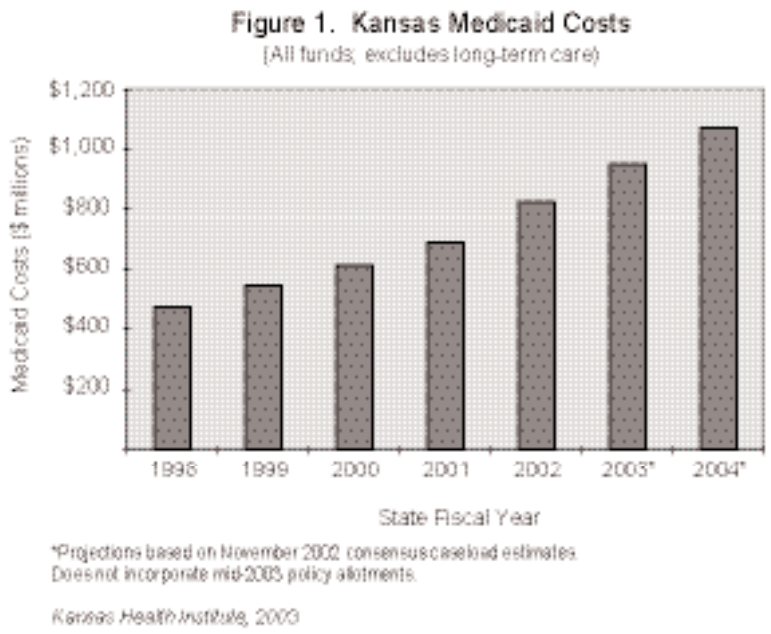
- Public and private health care spending has grown significantly over the past few years because of a sluggish economy and increased demand for health care.
- Private health insurance premiums are rising even more than covered health costs due to the insurance marketing/pricing cycle.
- While many Kansans can afford these increases, some may lose health insurance coverage, while others may forego care because of increased co-payments or deductibles.
- Policymakers may be faced with the difficult challenge of reducing Medicaid spending precisely when the state of the private insurance market is increasing demands on public insurance coverage.

Introduction

"Health insurance premiums are rising at double-digit rates," wrote Henry Aaron of the Brookings Institution recently. "Drug prices are skyrocketing. Employers are curtailing health insurance benefits and boosting the share of cost employees must shoulder. ...A genuine mess is in the making, and no one is doing anything about it."[1] Total spending on health care at the national level, which had plateaued as a percentage of Gross Domestic Product (GDP) during the 1990s, is once again on the rise and is projected to grow from 14.1 percent of GDP in 2001 to 17 percent of GDP in the next six years.[2,3] Of more direct concern to employers and consumers, however, is the recent and sometimes dramatic rise in private health insurance premiums at the large group, small group, and individual levels. Large groups, such as the Topeka public school system and Kansas state employees, are facing increases of 19 percent and 16 percent, respectively, for plan year 2003.[4] The state's major carrier of small group policies, Blue Cross Blue Shield of Kansas, anticipates that premium increases for small groups will average 30 percent to 35 percent for 2003 (Andy Corbin, personal communication, Jan. 8, 2003). A review of rate increases on record with the Kansas Insurance Department indicates that premiums for individual policies in the state are increasing by an average of about 16 percent for the 2003 plan year. There is also great concern over increases in government health spending, especially for the Medicaid program, which provides public health insurance to many poor, near-poor, and disabled Kansans. As in other states, Kansas has experienced consistent double-digit growth in Medicaid expenditures just as state revenues have been hit by a sluggish economy.

Increases in health care spending raise anxieties among consumers and policymakers alike, forcing difficult choices at both levels and leading to a number of important questions addressed in this Forum Brief.

- Why is health care spending rising so quickly?
- When will these rapid increases end?
- Are high health care costs really a problem? For whom?
- What can policymakers do about rising health care costs?



Why is health care spending rising so quickly? To address the question, it may be helpful to think of health care spending in terms of three main components:

- Prices paid for health care goods and services
- Utilization, which represents the quantity of goods and services that individuals receive
- The number of individuals receiving services

The recent rise in health care spending is the combined effect of increases in each of these three components.

Medical prices

Price increases have often been blamed for increases in health care spending. For example, hospital prices are rising partly because of the increased wages that hospitals must pay in competition for a dwindling supply of nurses and other health professionals.[5,6] Historically, prescription drug prices have received attention for their role in overall health spending. However, since the early 1990s, prescription drug prices have increased at only a modest increment over general medical prices. Overall, medical prices appear to be rising faster than general inflation, but only by a small amount,[7] and new research casts doubt on even these reported levels of medical price inflation. Many informed observers suggest that existing indices overstate increases in health care prices because they do not fully account for increases in the quality or effectiveness of health care.[8] In any event, annual medical inflation of 4 percent to 5 percent (or less) could not, by itself, explain double-digit growth in health insurance premiums and Medicaid costs.

Utilization of health care

If there is skepticism about the role of price inflation as a cause of the recent increase in health care spending, there appears to be general agreement about the prominent role of technology and individual utilization of health care goods and services. Over the 1999-2002 period, average utilization of health care services on a per-person basis rose more than health care prices.[9] Normally, higher prices will lead consumers to purchase fewer items. How, then, can recent increases in both health care utilization and spending be explained? Common sense suggests, and research confirms, that consumers have a very high demand (willingness to pay) for health care.[10] Prevailing levels of co-payments and deductibles enhance demand for health care even further, prompting consumers to spend more than they would if they didn't have insurance. Indeed, there is a long list of deficiencies in the market for health care that may lead consumers to purchase more health care than they would otherwise, not least of which is the option that many employees have to purchase job-based health insurance using pre-tax dollars. These deficiencies, however, are longstanding and do not explain the recent and continued growth in both prices and utilization. Prices and quantities of health care purchased could increase together only if consumer demand increases, or if the goods and services being compared change over time.

Both dynamics may be affecting the market for health care. Many analysts believe, for example, that consumer demand for prescription drugs has increased due to the introduction of direct-to-consumer marketing. In addition, new medical technologies that result in potentially better care often prove to be in great demand by consumers.[11,12] These new technologies, in effect, expand the definition of health care and present consumers with another opportunity to spend more on health care and less on other things.

Rising Medicaid enrollments

Part of the recent growth in Medicaid spending is attributable to increases in the number of participants. Enrollments in Medicaid are subject to a "counter-cyclical" pattern, which means that they tend to increase when the economy is doing poorly, since it is during these times that the greatest number of individuals will meet the program's income eligibility criteria. Increasing enrollment, however, may not be the driving force behind increasing Medicaid expenditures. Enrollment increases have been concentrated among low-income women and children, while Medicaid directors across the country attribute most of the current increases in Medicaid spending to elderly and disabled enrollees.[13] The factors driving these costs appear to be the same as those affecting private health costs: increased consumer demand leading to higher utilization and, to a lesser extent, higher prices. In particular, spending on prescription drugs is rising due to increases in both reimbursement and demand.

While increases in medical prices and Medicaid enrollment help to explain recent increases in health care spending, increased consumer demand for health care has had the most significant effect on private and public health care expenditures.

Private health insurance premiums

The single most important health care expenditure for most consumers is their health insurance premium. As documented above, health insurance premiums have risen significantly over the last few years. Part of these increases result directly from increased spending on health care. However, premiums have risen faster than covered health care costs due to a recurring pattern called the "underwriting cycle." Even after taking account of changes in underlying health costs, health insurance premiums periodically fall as insurers seek to increase market share and then rise as they attempt to generate profits on the resulting client base. For much of the 1990s, health insurance premiums did not keep pace with underlying health care costs. This "soft" marketing phase of the underwriting cycle was followed by the current period of accelerated growth in premiums, during which premium increases have exceeded growth in underlying health costs by as much as 3 to 4 percentage points in a single year.[14]

When will the rapid increases end?

Two of the current primary spending pressures — the economic downturn and the private insurance premium cycle — are cyclical in nature and should be expected to subside relatively soon, while the fundamental impetus of new technology is not expected to go away.[15] The Center for Studying Health System Change in Washington, D.C., predicts possible premium rate relief as soon as the 2004 plan year. However, government actuaries predict that health care spending will continue to rise as a percentage of GDP for several years to come. In addition, both national experts and the state's Consensus Caseload Estimates suggest that Medicaid costs may continue to grow at unusually high rates through at least 2003.[16]

What do higher costs mean for Kansas?

Whatever the reasons, many Kansans have been faced with significant increases in health care spending, and the state itself is facing a budget crisis due in part to double-digit increases in Medicaid spending. Already in state fiscal year 2003, there have been emergency reductions in Medicaid benefits to help address the current

budget crisis. A large budget gap remains to be filled, and Medicaid benefits may be targeted for additional reductions. Medicaid cutbacks could have both short- and long-term effects on beneficiaries' health and access to care. For example, programmatic changes intended to help meet a short-term budget shortfall may remain in place indefinitely if the Legislature does not take positive action to restore benefit levels when the budget crisis subsides.

What impact might health care cost increases have on Kansans who do not participate in Medicaid? Will increases in private health insurance premiums and reductions in employer-sponsored insurance benefits have a significant impact on access to health care services? We may not know the full implications of these cost increases until after the fact, when data on health insurance rates and access become available. However, John Knack, president of Blue Cross Blue Shield of Kansas, contends that the number of uninsured Kansans is already on the rise due to the increase in premiums[17] and a continued economic slowdown could further increase the ranks of the uninsured.

Not every Kansan is at equal risk for becoming uninsured or losing access to health care. If the driving force behind health care spending has been consumer demand for new technologies and treatments, then many, if not most, consumers are apparently both willing and able to spend more on health care. Most Kansans will continue to be insured, even if their out-of-pocket costs increase. A minority of Kansans, however, may not be able to afford access to the growing menu of expensive health care technologies. Some may lose health insurance coverage, while others may forego care because of increased copayments or deductibles.

What can policymakers do?

State policymakers face two interrelated problems: 1) Medicaid spending increases that have contributed to the state's current budget crisis, and 2) increases in private health spending that are associated with a rise in numbers of uninsured and reductions in access to health care for those least able to pay.

Addressing high Medicaid costs

With projections of double-digit growth until at least 2004 [see Figure 1], policymakers are considering further Medicaid spending reductions as they attempt to bring the state into fiscal balance. Potential mechanisms for reducing the growth in Medicaid spending include reducing payments to providers, restricting Medicaid eligibility, increasing cost sharing, or limiting coverage of certain types of care.

For each of these savings mechanisms, there are a number of practical, legal, and political considerations that must be taken into account. Federal rules limit Medicaid's ability to require cost-sharing by beneficiaries and specify coverage for many specific health care services. Also, while the state Medicaid program usually pays providers directly and, to a degree, can impose price constraints, this ability is limited. Providers are not obliged to contract with the state and may refuse Medicaid clients if state payments do not meet their expectations. The low number of providers willing to accept Medicaid is already an issue in many areas of the state. The state might also consider reducing enrollment by tightening Medicaid eligibility criteria. However, families who have recently enrolled because of job loss are generally the healthiest and least costly. Reduced enrollment of higher cost elderly and disabled beneficiaries would produce more significant savings, though at a potentially high cost to beneficiaries and their families.

Before enacting spending reductions, legislators may want to take into account the impact of potential cuts on those affected by the stagnant economy and the concurrent rise in private health costs. Were it not for the state budget crisis, policymakers might otherwise have consid-

ered proposals to expand public health insurance programs in an attempt to reach out to those affected by the economy and rising health costs.

Addressing private health costs

Increases in private health spending have put some Kansans at risk of losing their insurance and, potentially, their access to needed care. Policymakers could respond to the problem through interventions that attempt to control expenditures or through policies that cushion the effects of rising health cost on those losing private sources of coverage. Alternatively, policymakers could decide not to intervene and thus to allow the private health care market to find its own equilibrium.

To control expenditures, policymakers might consider explicit market interventions that affect the supply or demand of services or that limit prices directly. Price controls have not been applied on a widespread basis since President Nixon's Economic Stabilization Program during 1972-1974. The federal government has gained significant experience in its administration of regulated prices under the Medicare program. However, policymakers may worry about the potential for unintended consequences. Price controls at the state level could, for example, threaten the supply of health care providers willing to do business in the state. Furthermore, since health care prices haven't been the principal driver behind the recent increase in health spending, price controls might not be the most effective way to reduce spending in the short run.

One option to reduce utilization of private health services is to relax insurance regulations that mandate certain types of benefits. However, since the original basis for enacting mandates was political pressure by constituents, there is no assurance that relaxed mandates would reduce premiums, since policy holders might continue to demand that insurers offer policies that cover currently mandated benefits.

States might also try to control the supply of private health services by regulating health care capital investment through certificate of need regulation or by cutting back on the supply of medical professionals through reductions in training slots or tightened certification requirements. Such regulation would have few short-term effects on costs since it would be difficult to divert resources from capital projects that are already underway and from trainees in the midst of their education. Moreover, limiting the supply of health care services without a concurrent decrease in demand creates the risk of shortages, which could drive up future prices. If the state were more concerned about the lack of access among those least able to pay, it could instead attempt to expand the supply of medical services by relaxing licensure requirements or by expanding the license of existing providers such as nurse practitioners who might administer a wider range of health services. However, concerns about quality may limit how far these requirements should be relaxed.

To reduce the health cost burden on vulnerable constituents, expanded eligibility for public insurance programs, subsidized private insurance premiums or cost sharing for individuals or small groups, or mandated community rating to spread the impact of increasing premiums may each hold some promise. However, these policy interventions would themselves be costly and may risk distorting the private insurance market by reducing efficiency and increasing prices for other consumers.

Policymakers might ultimately decide to extend or reform public involvement in the health care system to address its many shortcomings. Among the most commonly discussed reforms are those that provide health insurance to the otherwise uninsured. Nevertheless, controlling health costs and addressing other weaknesses of the current system may not be a matter of flipping a switch, passing a new law, or changing a

few rules. Even countries that have nationalized their health care system have found that maintaining a balance between cost, quality, and access is an ongoing challenge. Such systems resolve these trade-offs in the political realm, where providers plead for more resources, consumers request reduced waiting times for care and greater access to technology, and the overall tax burden for the system is still contentious.

Conclusion

Public and private health care spending has grown significantly over the past few years because of a sluggish economy and an increased demand for health care services. Potential solutions involve complex choices among options with significantly different impacts on various groups of Kansans. In particular, policymakers may be faced with the difficult challenge of reducing Medicaid spending precisely when the state of the private insurance market is increasing demands on public insurance coverage. Policy discussions may ultimately focus on wider health system reforms, especially when tax revenues increase, but the demands placed on policymakers to maintain balance between cost, quality, and access will be ongoing.

Endnotes

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