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Health Care Cost Growth and Cost Containment Initiatives

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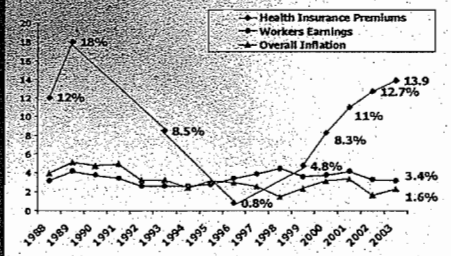
Overview

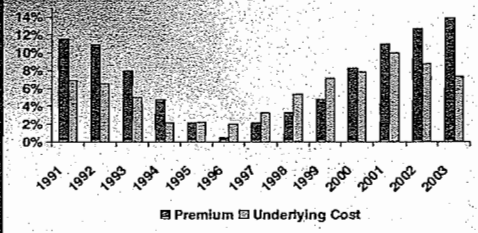
- Trends in Health Premiums and Spending
- Drivers of Growth: Levels of Analysis
- Efforts focused on containing growth of costs
  - Market structure
  - Technology
  - Demographics
  - Consumer and Provider Incentives
- Some concluding thoughts

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2003



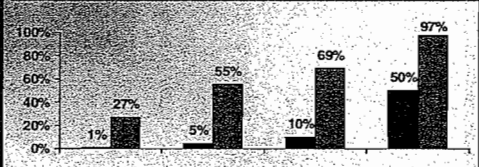
Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002,2003; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996.
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

Trend in Employer Health Insurance Premiums and Underlying Health Care Costs, 1991-2002



Source: Kaiser/HRET Survey of Employer-Based Health Plans

Concentration of Health Care Spending

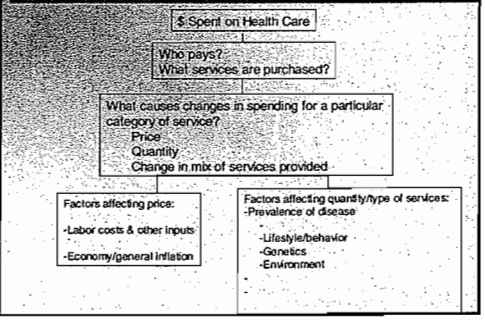


■ Most Expensive x% of the population

▨ Percent of Health Expenditures accounted for by the most expensive x% of the population

Source: Berk and Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs*, March/April 2001. Expenditure estimates for civilian non-institutionalized population.

Drivers of Health Care Spending: Many Levels of Analysis



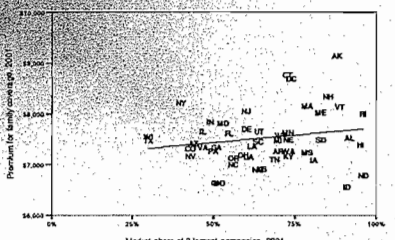
Factors Affecting Price: Market Structure

- Health plan/provider relationships
  - Managed care "backlash"
    - Relaxation of many managed care practices
    - Enrollees shifted to more permissive plans (PPO/POS)
    - As a result, focus on "patient protection" legislation has faded
  - Current emphasis on broad provider networks leads to:
    - Enhanced provider negotiating power
    - Lack of selectivity/ability to channel enrollees to higher quality, more cost-effective providers
- Post-"managed care" world
- Shift to "consumer driven" health care

Factors Affecting Price Market Structure: Health Plans

- Number of health plans
  - Health plan competition
    - More competitors = lower prices?
    - Or More competitors = less negotiating power?
- Evidence suggests that health plan markets are becoming more consolidated in the past several years

Market Concentration and Health Insurance Premiums, by State



Sources: Deborah Chollet et al., "Mapping State Health Insurance Markets, 2001: Structure and Change," Academy Health, September 2003; Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey Insurance Component 2001.

Notes: Required for regression line is .63

Factors Affecting Price Market Structure: Providers

- Provider consolidation in response to managed care and health plan consolidation
  - Hospitals, specialty groups
- Proliferation of specialty facilities
  - Cardiac care centers
  - Imaging facilities
- Certificate of need/capacity constraints
  - Avoids service duplication/excess capacity
  - But reduces competition between facilities
  - Is an administrative process more effective at containing costs than an imperfect marketplace?

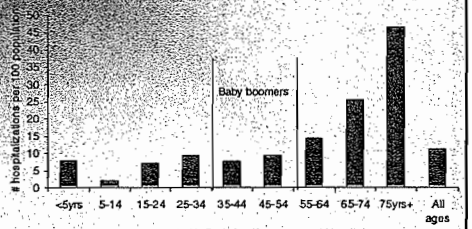
Factors Affecting Price and Quantity: Technology

- Most economists believe that advances in technology account for a majority of increases in health care spending
- Tradeoff: conditions can be treated more effectively, but often at higher cost
- Recently, we have seen renewed policy concerns about a "medical arms race"
  - Imaging technology, cardiac care advances, etc.
  - Also renewed interest in certificate of need (CON) or similar capacity and investment restrictions
- Available evidence suggests that the benefits from certain technological advances outweighed the costs of those advances

Factors Affecting Quantity Demographics

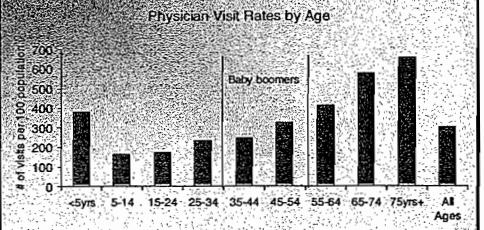
- The upcoming aging of the population is well-documented
  - Some aging has occurred, but will accelerate as the baby-boomers age
- To date, population aging has had a small and limited effect on health spending increases
- As the boomer wave advances in higher health need years, it's likely the health spending will increase as a result
- Will also strain capacity in the system, if current models of care continue

Hospitalizations will likely increase substantially in the next 20 years as the baby boom generation ages...



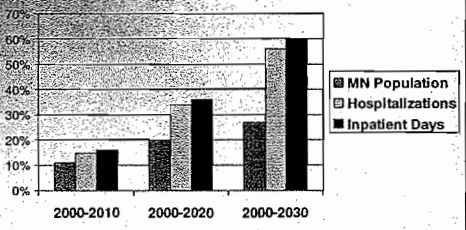
Sources: National Center for Health Statistics (2000 National Hospital Discharge Survey); U.S. Bureau of the Census

...And Use of Physician Services Will Increase Too



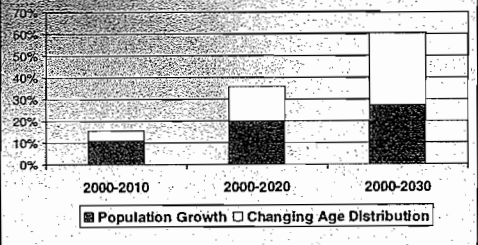
Source: National Center for Health Statistics, National Ambulatory Medical Care Survey, data for 2000.

Projected Growth in Minnesota Hospital Utilization



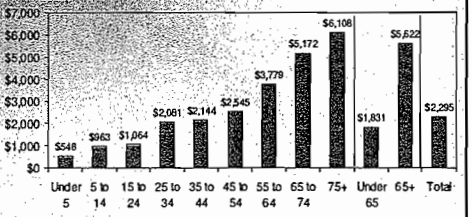
Source: Minnesota Department of Health, Health Economics Program

Sources of Growth in Projected Minnesota Hospital Utilization Example: Inpatient Days



Source: Minnesota Department of Health, Health Economics Program

Variation in Health Care Spending by Age

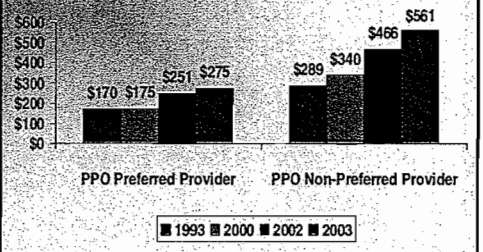


Source: Agency for HealthCare Research and Quality, Medical Expenditure Panel Survey, data for per capita spending by age group in the Midwest, inflated from 1999 to 2000.

Consumer and Provider Incentives: Benefit Design Changes

- The past several years have seen the introduction of:
  - Higher deductibles, copays, and conisurance
  - Employers previously paying the full premium began requiring employees to pay some portion
  - Employers with modest copayments in their benefit design increased them
    - ED copayments increased substantially
  - Those with larger copayments switched in some cases to coinsurance

Average Annual Deductible for Single Coverage in PPO Plans, selected years



Source: Kaiser/HRET Survey of Employer Sponsored Health Benefits: 2000, 2002, 2003. KPMG Survey of Employer Sponsored Health Benefits: 1993.

Consumer Driven Health Plans

- Much recent focus on benefit design has been on a shift to "consumer driven" health plans
  - High deductible insurance plans
  - Personal account funded in various ways to pay for care
  - Gap between the annual amount put into the account
  - Internet-based decision support
- Larger choice of providers, but also greater out of pocket exposure
- HSAs
- Remember skewed distribution of spending

Consumer/Provider Incentives

- Higher deductibles, copays, coinsurance
  - Efforts to make consumers more cost conscious in health care decisions
    - Consumer need more information to be able to make informed decisions
    - Evidence from RAND health insurance experiments
  - Potential to increase risk segmentation in markets – reduce costs for some, raise for others
- Information may not yet be sophisticated or user-friendly enough on either cost *or* quality for effective use by consumers
- Remember skewed distribution of spending

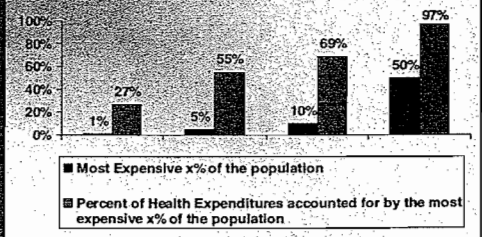
Tiered Networks

- Tiered benefit level is very common with prescription drug benefits
- Becoming increasingly common for physician clinics, and sometimes hospitals
- Future may involve even more sophisticated and service-specific tiering
- Decisions about which tier to place a provider in should be adjusted for risk selection, and should consider quality as well as cost
- To work well, consumers need good info on cost/quality differences, and price differences between tiers need to be large enough to influence choices.

Mandated Benefits

- 2 types of proposals around mandates:
  - Reduce/repeal mandated benefits
  - Allow for sale of no-mandate plans (e.g., Association Health Plans)
- Studies indicate mandated benefits account for perhaps 5 to 8% of total spending
  - Many people would have coverage even in absence of mandate
  - One-time savings from repealing mandates
- No-mandate plans: concerns about increasing risk segmentation in insurance markets
  - Some may see savings, but costs will rise for others

Concentration of Health Care Spending: A Small Share of the Population Accounts for Most Health Care Spending



Source: Berk and Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs*, March/April 2001. Expenditure estimates for civilian non-institutionalized population.

Incentives for Quality: Disease Management

- Skewed spending distribution
- Disease management focuses on high-cost cases or people with conditions at risk of becoming high-cost
  - Better management of these conditions can avoid complications and reduce costs
- Factors limiting use of this strategy – difficulty making the "business case":
  - Long time to payoff
  - Difficulty capturing benefits of investment

Incentives for Quality: Evidence-based Medicine

- Research studies have shown large variation in patterns of care, but more care does not necessarily lead to better outcomes
  - Example: Medicare enrollees in high-spending regions received 60% more care but did not have better quality or outcomes of care
- Underuse exists as well (McGlynn, et al.)
- Potential for cost savings by reducing variation in care practices – by one estimate, Medicare savings could be close to 30%*
- In Minnesota, measurement of diabetes care shows that patients in the best performing clinics receive care to the practice guidelines only about a quarter of the time

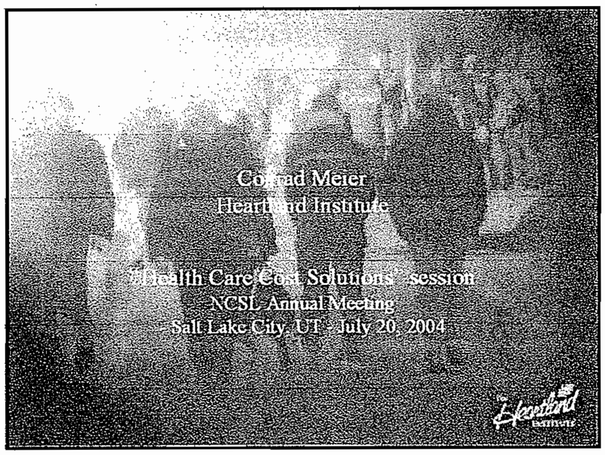
*"Geography and the Debate Over Medicare Reform," John E. Wennberg et al., *Health Affairs*

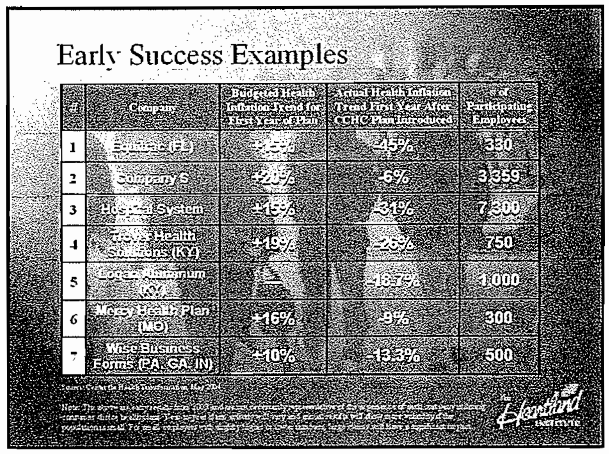
Incentives for Quality: Value-Based Purchasing

- Value-based purchasing represents an attempt to create incentives that reward quality and cost-effective care
- Examples:
  - Oregon rx drug initiative
  - California's Integrated Healthcare Association's P4P
  - BCBS of Michigan Participating Hospital Agreement Incentive Program
  - Centers of Excellence – channel patients to providers that use best practices (high-quality, cost-effective care)

Conclusions

- Many factors that are driving increased costs are not within the control of policymakers, but opportunities to reduce cost growth do exist
- Need to focus on activities that contain costs rather than shifting them around (to other services or to other payers)
- Consumers need to play a role in cost containment, but need more and better information in order to make better decisions
- Opportunities exist within the current system with a greater focus on value, evidence-based medicine, and pay-for-performance initiatives





#	Company	Budgeted Health Inflation Trend for First Year of Plan	Actual Health Inflation Trend First Year After CCHC Plan Introduced	# of Participating Employees
1	Equitrac (FL)	+15%	-45%	330
2	Company S	+20%	-6%	3,359
3	Hospital System	+15%	-31%	7,300
4	Trover Health Solutions (KY)	+19%	-26%	750
5	Logan Aluminum (KY)	—	-18.7%	1,000
6	Mercy Health Plan (MO)	+16%	-9%	300
7	Wise Business Forms (PA, GA, IN)	+10%	-13.3%	500