**TABLE OF CONTENTS**

| Health Innovations (B) Working Group Summer National Meeting Minutes | 2 |
| Health Innovations (B) Working Group October 28 Conference Call Minutes | 4 |
| Presentation on Innovative Insurer Practices to Contain Health Care Costs - Migliori | 6 |
| Presentation on Innovative Insurer Practices to Contain Health Care Costs - Piatkowski | 23 |
| Presentation on Health Care Cost Data | 34 |
| Provider Perspective on Cost Containment Practices | 71 |
| Consumer Perspective on Cost Containment Practices | 80 |
The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in New York, NY, Aug. 3, 2019. The following Working Group members participated: Marie Ganim, Chair (RI); Martin Swanson, Vice Chair, (NE); Jacob Lauten (AK); Steve Ostlund (AL); Howard Liebers (DC); Andria Seip (IA); Alex Peck and Karl Knable (IN); Vicki Schmidt and Julie Holmes (KS); Angela Nelson (MO); Jon Godfread and Chrystal Bartuska (ND); Philip Gennace and Justin Zimmerman (NJ); Paige Duhamel (NM); David Cassetty (NV); TK Keen (OR); Katie Dzurec (PA); Rachel Bowden (TX); Jaakob Sundberg (UT); Molly Nollette (WA); Nathan Houdek and Jennifer Stegall (WI); and Joylynn Fix (WV). Also participating were: Michael Conway (CO); Fleur McKendell (DE); and Kevin Beagan (MA).

1. **Adopted its July 11 and Spring National Meeting Minutes**

   Mr. Ostlund made a motion, seconded by Mr. Lauten, to adopt the Working Group’s July 11 (Attachment __) and April 6 (see NAIC Proceedings – Spring 2019, Health Insurance and Managed Care (B) Committee, Attachment Six) minutes. The motion passed unanimously.

2. **Heard a Presentation on Prices Paid to Hospitals by Private Health Plans**

   Chapin White (RAND Corporation) presented the results of his research on the relative prices paid by private health plans and Medicare to hospitals for the same services. He showed that, on average, private plans pay roughly two and a half times Medicare’s rates. He shared the ratios for the states where there was sufficient data. He discussed market failures that lead to higher prices, and he described a range of policy options for limiting prices.

   Working Group members asked how the states were selected for the study, whether other states could be included in the future, and what else would be done differently in updates to the research. Mr. White responded that his team gathered data from those willing to provide it—large employers and some state all-payer claims databases. He said he continues to be in discussion with other employers and states about potentially contributing their data. He said in future studies, he would like to add professional service payments to the existing facility payment data and apply repricing to both. He would also like to obtain data that shows which payments are in versus out of network.

   Mr. Knable asked how changes in Medicare payments affect the ratio with payments from private plans. Mr. White responded that Medicare payments have been growing slowly, and increases are driven by out-patient costs.

   Working Group members discussed whether data like that analyzed by Mr. White can be used to understand the level of payments that cause a hospital to break even in balancing revenue and costs.

   Mr. Keen asked whether there are ways to encourage employers to shop for better hospital prices. Mr. White said employers do better when they collaborate. Even a large employer will represent only a small share of a hospital’s revenue, so they need to band together. He said they need to share data, educate themselves, get expert advice, and build clout to make a difference in their costs.

3. **Heard a Presentation on State Cost-Containment Initiatives**

   Joel Ario (Manatt Health) said the pendulum in health care debates is moving away from access and toward affordability. He said state insurance regulators cannot address cost issues themselves; instead, they have to work across state agencies. Even then, he said cost containment is difficult.

   Kathy Hempstead (Robert Wood Johnson Foundation—RWJF) said cost is a barrier to expanding coverage, taking up coverage by the uninsured, and accessing care for those with coverage. She said access to claims data is critical for policymakers to understand health care costs.
Mr. Ario said there are many uses that the data from an all-payer claims database can be put to. He referenced material he shared last year with NAIC working groups on this topic.

Mr. Ario briefly described four states’ efforts to contain health care costs. He mentioned Washington’s recently enacted public option legislation, New Mexico’s efforts to create a Medicaid buy-in, Rhode Island’s health care cost benchmarking, and Maryland’s initiative to set limits on prescription drug pricing.

Commissioner Conway asked whether cost containment would limit the resources pharmaceutical companies invest in research and development. Mr. Ario responded that mystery drives margins—companies have opportunities for larger profits when customers and policymakers do not know their true prices. He said more transparency is needed in drug pricing to know the true impact on research and the development of price limits.

4. Discussed State Approaches to Health Care Cost Targets

Health Insurance Commissioner Ganim provided information on Rhode Island’s cost growth target. She described the stakeholder steering committee and partnerships with a foundation and Brown University. She outlined the workstreams of setting a cost growth target, measuring cost drivers and growth trends, and using the data to improve health system performance.

Mr. Keen presented on Oregon’s health care cost growth benchmark. He said Oregon considered Maryland’s all-payer rate setting model, but it decided instead to use Massachusetts’ cost growth benchmark model. He said many details are yet to be determined, but the benchmark is scheduled to go into effect in 2021, with reporting and enforcement beginning in 2022. The benchmark applies to all providers, payers, and health care entities in Oregon; and it will be measurable on a per capita, statewide, and health care entity basis.

Mr. Beagan spoke about Massachusetts’ health care cost growth target. He said state law created a Health Policy Commission, and the Division of Insurance does not serve on the Commission. The Commission sets an annual cost growth target, and it may require health care entities that exceed the target to file and implement performance improvement plans. He shared data on private health insurance premiums in the state before and after the Commission was established.

Ms. McKendell described Delaware’s health care cost growth target. She said it was created through an executive order by the governor in late 2018. It is implemented by the Delaware Department of Health and Social Services. Delaware has set a cost growth target for each year through 2023, and it will also measure progress against quality benchmarks, starting with eight in 2020.

5. Discussed Innovative Initiatives from Working Group Member States

Ms. Nollette provided information on Washington’s Cascade Care program. She said the state decided it did not want to pursue a Section 1332 waiver. Under Cascade Care, Medicaid will procure a fully insured product that fits into a standard plan design. It will be offered as a qualified health plan (QHP) through the state’s exchange. The program will cap payments to providers relative to Medicare amounts, excluding prescription drugs. The role of the insurance commissioner is only to ensure that the plan meets applicable requirements.

Having no further business, the Health Innovations (B) Working Group adjourned.
The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met via conference call Oct. 28, 2019. The following Working Group members participated: Marie Ganim, Chair (RI); Martin Swanson, Vice Chair, and Michael Muldoon (NE); Andrew Stolfi, Vice Chair, Cassie Soucy, Jesse O'Brien, Tasha Sizemore and Rick Barry (OR); Jacob Lauten (AK); Steve Ostlund and William Rodgers (AL); Andria Seip and Cynthia Banks-Radke (IA); Claire Szpara and Karl Knable (IN); Julie Holmes (KS); Amy Hoyt (MO); John Arnold (ND); Maureen Belanger (NH); Chanell McDevitt and Diana Sherman (NJ); Paige Duhamel and Renee Blechner (NM); Katie Dzurec (PA); Douglas Danzeiser (TX); Heidi Clausen (UT); Molly Nollette, Jane Beyer and Jennifer Kreitler (WA); Nathan Houdek, Jennifer Stegall, Barbara Belling, Sue Ezalarab, Diane Dambach, Mary Kay Rodriguez and Julie Walsh (WI); and Joylynn Fix (WV). Also participating were: Mary Boatright (AZ); Christopher Citko (CA); Adam Boggess (CO); Fleur McKendell and Leslie Ledogar (DE); Chris Struk (FL); Kathy McGill (ID); Ryan Gillespie and Sara Stanberry (IL); Melinda Domzalski-Hansen (MN); Bob Williams (MS); Ashley Perez, Michelle Scaccia, and Pam Koenig (MT); Robert Croom, Ted Hamby and Mike Wells (NC); Laura Miller (OH); Kendall Buchanan (SC); Jill Kruger (SD); and Bob Grissom and Yolanda Tennyson (VA).

1. **Discussed State Efforts to Address Prescription Drug Costs**

   Commissioner Stolfi and Ms. Soucy shared an overview of Oregon’s Prescription Drug Price Transparency program. Commissioner Stolfi described the requirements the program imposes on both prescription drug manufacturers and health insurers. He said health insurers must provide information on the top 25 highest cost drugs and the contributions of drug prices to premium increases. He reported that as of September, 300 manufacturers had filed 700 reports, which are available on a state website. The reports include price increases over the past five years and the prices the manufacturers charge in other countries. He said that Oregon plans to do more analysis of the reported data next year. He noted that fulfilling the consumer notice provisions of the law has been challenging, but his department has sent flyers to pharmacies. Ms. Soucy said that Oregon needed to identify the manufacturers that were required to report and that the Board of Pharmacy helped with a list. She said that education is needed to get the manufacturers to report correctly as many of them lack the specifics required to support their claims of trade secrets.

   Joel Ario (Manatt Health) described activity in other states around drug pricing. He said 33 states have passed 59 laws on prescription drugs, many of them related to transparency and volume-based pricing. He explained California’s test of bulk pricing. He said California’s pool has 13 million people and includes Medicaid enrollees in the state. He noted that California’s experience will show how effective this strategy can be. He also mentioned California’s law on pay for delay. Mr. Ario also described Maryland’s drug price reforms. He said the first effort was stopped in the courts and warned that drug companies will look to litigation on all of these types of laws. He said that Maryland’s drug cost board will review the entire pharmaceutical supply chain and issue a report by December 2020. The report will consider direct price controls, a reverse auction and bulk purchasing as in California. He said that Maine has also enacted a drug affordability board with a 2021 start date, and it will consider spending targets and moving to more direct price controls over time.

2. **Discussed State Laws and Regulations That Pertain to Telehealth**

   Health Insurance Commissioner Ganim said that telehealth is an innovative practice with the potential to reduce costs. She said that in Rhode Island, insurers are contracting with providers to provide telehealth services, but the providers may be from a national network and are not part of the patient’s medical home. She said that pediatricians in the state want to be the contracted entity to provide telehealth services to their patients to improve continuity of care. She said that in her state, state law is very general and only says that insurers must pay for telehealth.

   Ms. Bartuska spoke about North Dakota’s laws. She said that the law defines facility and provider, and providers must meet the standards for medical professionals. Health insurance policies must cover telehealth and provide the same coverage for services delivered in person. However, she said that not all services are allowed via telehealth, and a carrier may define medical necessity. Ms. Sizemore said that Oregon grappled with the same questions about payment parity but that many of the questions have sorted themselves out without new laws or regulations. Ms. Bartuska added that North Dakota protects...
consumers from disparate co-pays for telehealth but does not get involved in payment amounts between carriers and providers. Commissioner Ganim asked whether North Dakota requires any invested in infrastructure, and Ms. Bartuska responded that that was not necessarily something the department of insurance (DOI) would be aware of. Ms. Hoyt and Ms. Duhamel said Missouri and New Mexico have parity laws, as well. Ms. Duhamel said that New Mexico has Project ECHO, which allows providers to consult with other providers via telehealth.

Erika Melman (federal Centers for Medicare & Medicaid Services—CMS and Center for Consumer Information and Insurance Oversight—CCIIO) asked how states define telehealth and whether it can include communications like phone or email. Ms. Sizemore said Oregon law requires two-way synchronous communication; other states said they have similar requirements. Ms. Melman asked whether providers provide the site with the remote connection. Ms. Sizemore responded that providers might, but not issuers, and that senior centers or libraries can also provide sites. Runi Shukla (CMS–CCIIO) asked how telehealth affects network adequacy measures such as time and distance. Ms. Duhamel said it is hard to count telehealth providers as an addition to a plan’s network because providers already have full panels and cannot add more patients through telehealth. She said there is some advantage in provider-to-provider consultations, though. Ms. Sizemore said that in Oregon, insurers use telehealth to allow patients in areas with booked clinics to see providers in areas where clinics are not as busy. Ms. Melman asked where issuers provide access through telehealth to providers licensed in another state. Ms. Bartuska said some carriers allow for consultations with out-of-state providers, but only when the provider has a contract with an in-state hospital. Other states said they have similar arrangements.

Having no further business, the Health Innovations (B) Working Group adjourned.
The ROI of Being Healthy

Dr. Richard Migliori
EVP, Medical Affairs & Chief Medical Officer

UNITEDHEALTH GROUP
30% of Overall Budget

- $210B Unnecessary Services
- $130B Inefficiently Delivered Services
- $105B Prices that are Too High
- $191B Excessive Administrative Costs
- $75B Fraud
- $55B Missed Prevention Opportunities
Commercial Market Subsidizes the Rest of the System

**Payer View**
Relative Reimbursement Rates for Hospitalizations

- **Medicaid**: 78%
- **Medicare**: 100%
- **Commercial**: 189%
  - 2x Medicare
  - 2.5x Medicaid

**Provider View**
Hospital Payment to Cost Ratio

- **Commercial**
  - Breakeven: 87%
  - 145%

**Commercial Market Subsidizes the Rest of the System**
Even Commodity Services Like MRIs Have a Wide Range of Costs

$740_{\text{AVG.}}$
Range: $300-1,400$
Transforming From Managed Care to Organized Care

1980
Indemnity Health Plans

1990
Gatekeeper HMO Plans

2000
Consumer Driven Health Plans

2020
Organized Systems of Care

Redesign the care system around top-performing providers and better equip them to engage our members.
Total Cost Of Care
COST TRENDS
AGING
TECHNOLOGY
VALUE-BASED PAYMENT
CHRONIC DISEASE
RETAIL MINDSET
Obesity – Defined via Biometrics and Rally Survey

- Healthy Weight: 29%
- Overweight: 30%
- Obese: 29%
- Morbidly Obese: 11%
- Underweight: 1%
Obesity – Prevalence of Diabetes and Pre-Diabetes

*Pre-diabetic data based on glucose screenings out of biometric and Rally survey self-reported data*
Obesity – Knee Replacement Admits

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<th>Admits</th>
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<td>Healthy Weight</td>
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<tr>
<td>Underweight</td>
<td>0</td>
</tr>
<tr>
<td>Overweight</td>
<td>0.9</td>
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<tr>
<td>Obese</td>
<td>3.4</td>
</tr>
<tr>
<td>Morbidly Obese</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1.8</td>
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Financial incentives may help contribute to lower net deductibles than traditional plans

<table>
<thead>
<tr>
<th>Example plan design</th>
<th>Traditional</th>
<th>Traditional with Motion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$3,000</td>
<td>$3,500</td>
</tr>
<tr>
<td>Potential earned incentive</td>
<td>—</td>
<td>$1,095</td>
</tr>
<tr>
<td>Net deductible</td>
<td>$3,000</td>
<td>$2,405</td>
</tr>
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</table>
Health Activation Index (HAI)

- **Care Setting**: 51.55% / N=80,974
- **Other Conditions**: 65.06% / N=14,148
- **Clinical Prevention**: 56.13% / N=72,978
- **Resources Engagement**: 33.12% / N=21,221
- **Clinical Wellness**: 56.24% / N=36,114
- **Resources Participation**: 39.91% / N=89,584
- **Diabetes**: 62.25% / N=19,008
- **CAD**: 75.94% / N=2,876
- **Asthma**: 68.86% / N=2,219
HSA Norm Trend reflects observed performance for UHC National Accounts for full replacement HSA plans in years 1 and 2 (relative to a year 0 where PPO type plans were in place. Norms are adjusted to reflect client demographic and plan richness changes. Market trend from industry consultant surveys. Client adopted 100% CDHP in 2012.

HAI Client Trend Performance

Cost Per Member Per Year (normalized for age/gender and richness)

- Market Norm (5-6%)
- Client

Health Activation Index

- 2011: 56%
- 2012: 56%
- 2013: 58%
- 2014: 61%
- 2015: 64%
- 2016: 67%
- 2017: 69%

18% Lower

HSA Norm Trend reflects observed performance for UHC National Accounts for full replacement HSA plans in years 1 and 2 (relative to a year 0 where PPO type plans were in place. Norms are adjusted to reflect client demographic and plan richness changes. Market trend from industry consultant surveys. Client adopted 100% CDHP in 2012.
Better Decisions Drive Better Health and Productivity

**Health Metrics**

*Diabetes and CAD** Onset is Slowing*

915 Fewer Members Diagnosed with Diabetes/CAD
$11M in savings

**Health Metrics**

*Diabetes / CAD disease onset rate for 93,000 continuously enrolled adults.*

**Business Metrics**

- *Injury Rate*: 18% Lower
- *Baggage Mishandling*: 16% Lower
- *Airport NPS*: 21% Higher
- *On Time Departures*: 7% Higher
THANK YOU

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Executive Vice President, Medical Affairs
Chief Medical Officer, UnitedHealth Group
(952) 936-7291
richard.migliori@uhg.com

www.unitedhealthgroup.com
ADVANCING THE QUADRUPLE AIM: MEDICA’S EXPERIENCE WITH ACOS

John Piatkowski, M.D., MBA
Senior Director, Provider Engagement
ABOUT MEDICA | Overview

Minnesota
founded in 1975

1,550 employees
for community focus and investments in the right areas

Not-for-profit

$5 billion
expected revenue for 2019

1 Foundation
for charitable grant-making

9 states

9 states

Nearly 1 million members

185,000
Individual and Families

150,000
Medicare/Medicaid

610,000
Commercial

13
Accountable Care Organization Partnerships

4/4.5
Star Rating

4/4.5
Star Rating

200+
Products / market solutions

MEDICA | Medica Business Confidential
Our mission
To be the trusted health plan of choice for customers, members, partners and our employees.

Our vision
To be trusted in the community for our unwavering commitment to high-quality, affordable health care.
Accountable Care Organizations

- Medica and health systems partner on shared vision for affordable care
- Defined populations via a point of enrollment model
- Optimized care through improved predictive modeling, data sharing and collaborative management throughout the member’s health continuum

**Table:**

<table>
<thead>
<tr>
<th>IMPROVE QUALITY</th>
<th>IMPROVED SERVICE</th>
<th>LOWER COSTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased focus on preventive care</td>
<td>Simplified member service experience</td>
<td>Unique point of enrollment models (with risk sharing)</td>
</tr>
<tr>
<td>Increased member participation in programs</td>
<td>Integrated care, leveraging payer and provider data and analytics</td>
<td>Reduce duplication of services (as appropriate)</td>
</tr>
<tr>
<td>Measurable through quality metrics, outcomes and experience surveys</td>
<td>Assist member in navigating system; from billing to finding the right provider</td>
<td>Claim cost savings average 15% compared to open access network</td>
</tr>
</tbody>
</table>
Assessing ACO partner performance

- Work together to align on an assessment of ACO’s capabilities and gaps
- Quarterly benchmarking and joint clinical operations meetings
- Best practice sharing
  - Annual ACO Summit
  - Clinical opportunities as indicated

### ACO ASSESSMENT RATING

<table>
<thead>
<tr>
<th>Category</th>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td>Organizational Culture</td>
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</tr>
<tr>
<td>Population Management</td>
<td>1.9</td>
</tr>
<tr>
<td>Population Health</td>
<td>1.6</td>
</tr>
<tr>
<td>Member Experience</td>
<td>1.9</td>
</tr>
<tr>
<td>Outcome Measurement</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Data-driven opportunity identification
- Leveraging each organizations strengths
- Collaboration on specific goals
- Execution rigor and iteration
MEDICA ACCOUNTABLE CARE ORGANIZATIONS | Provider Partnerships

- Fairview HealthEast
- St. John Medical Center
- CHI Health
- North Memorial Health
- Essentia Health
- Mayo Clinic
- Saint Luke’s Hospital of Kansas City
- UnityPoint Health
- Altru Health System
- Park Nicollet
- Ridgeview Community Network
- LifeCare Health Services
- Nebraska Health Network

MEDICA | Medica Business Confidential
RESULTS
Rate of successful blood sugar control nearly doubled in first 8 months of initiative

RESULTS
52% decline in ED utilization rate/1,000 members
2018 Risk-Adjusted Allowed PMPM Cost (Relative to Open-Access Network)

Medica ACO Members

Average number of members per ACO
2015 – 4,551
2019 – 12,952
• How to encourage payer / provider collaboration
  - Incentivize the creation and use of effective ACOs
  - Open lines of communication with insurers
• Health information exchange standards and capabilities
• “Any willing provider” laws can be barriers
• Surprise billing
  - Surprise services and billing usually originate at in-network facilities or in emergency situations
  - It is not every out-of-network service or bill
MEDICA ACCOUNTABLE CARE ORGANIZATIONS | Summary

- Right care, right place, right time
  - Reduced overall and unnecessary ER utilization
  - Reduced hospital readmissions
  - Higher utilization of primary care

- Clinical outcomes
  - Improvement in diabetes care, asthma care, cancer screenings and experience

- Claim cost savings: 15% overall ACO average

- Member satisfaction
  - 97% of commercial and 81% of IFB members renewed into an ACO plan
  - 91% of surveyed ACO members say their ACO provides them with medical care that meets their needs
Its Still The Prices Stupid: Observations on Health Care Spending in the US

Niall Brennan
CEO, HCCI
@N_Brennan
November, 2019
HCCI’s Mission

HCCI’s mission is to get to the heart of the key issues impacting the U.S. health care system — by using the best data to get the best answers.

Our values are simple:

▪ Health care claims data should be accessible to all those who have important questions to ask of it.

▪ Health care information should be transparent and easy to understand.

▪ All stakeholders in the health care system can drive improvements in quality and value with robust analytics.

HCCI reports cost trends and facilitates informed debate about the less-understood commercially-insured population.
HCCI 1.0 Data Holdings

Commercial Claims
- Years: 2008-2017
- All 50 states and D.C.
- Updated annually
- De-identified, HIPAA and anti-trust compliant

Medicare Fee-For-Service Claims
- National Qualified Entity (QE)
- Years: 2012-2017
- 100% Parts A & B & D

ESI 42M

FFS Medicare 40M
HCCI 2.0 Data Holdings

Commercial Claims
- Years: 2012-2018
- All 50 states and D.C.
- Updated annually
- De-identified, HIPAA and anti-trust compliant

Medicare Fee-For-Service Claims
- National Qualified Entity (QE)
- Years: 2012-2018
- 100% Parts A & B & D
HCCI Governance

Independent Board

- **Bob Town, UT-Austin, Chair**
- Mike Chernew, Harvard
- Leemore Dafny, Harvard
- Dale Yamamoto, Independent Actuary
- Aneesh Chopra, Entrepreneur, former White House CTO
- Chuck Phelps, University of Rochester (retired)
- Almeta Cooper, Morehouse University (retired)
- Aaron McKethan, Duke/NC HHS
- Stephanie Carlton, McKinsey
- Amy Finkelstein, MIT
- Marshall Votta, Nautic Partners
Enabling World Class Research

HCCI’s current research partners include:

- Dartmouth
- MD Anderson Cancer Center
- Northwestern
- University of Minnesota
- Penn
- The Commonwealth Fund
- The Pew Charitable Trusts
- Laura and John Arnold Foundation
- Robert Wood Johnson Foundation
Share of GDP Spent on Health Care

National Health Expenditure as a Share of Gross Domestic Product, 1960-2017

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group
US Health Care Employment 1998-2018

Shaded areas indicate U.S. recessions

Source: U.S. Bureau of Labor Statistics
myf.red/g/IC8E
Health Care Reform Efforts in the US
Some Observations on the Status Quo

• Americans are indefatigable when it comes to optimism and new ideas about controlling health care costs
• BUT
  • NOTHINGS WORKING
    • And that optimism means everyone thinks reform can be achieved without hurting them / hurting anyone
• Quality!
• Patient Responsibility!
• Value-based Care!
• Transparency!
• Disruption!
• Innovation!
It’s The Prices, Stupid: Why The United States Is So Different From Other Countries

Higher health spending but lower use of health services adds up to much higher prices in the United States than in any other OECD country.

by Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan
In 2017, per-person spending reached a new all-time high of $5,641. This total includes amounts paid for medical and pharmacy claims; drug spending reflects discounts from wholesale/list prices but not manufacturer rebates.

Spending per-person grew at a rate above 4% for the second year in a row, rising 4.2% from 2016 to 2017 - slower than the 2015 to 2016 rate of 4.9%.

The overall use of health care changed very little over the 2013 to 2017 period, declining 0.2%. In 2017, utilization grew 0.5% compared to 2016.

Out-of-pocket spending per-person increased 2.6% in 2017. The growth was slower than total spending, so OOP costs made up a smaller share of spending by 2017.

Prices increased 3.6% in 2017. Year-over-year price growth decelerated throughout the five-year period, rising 4.8% between 2013 and 2014 and slowing to 3.6% in 2016 and 2017, reflecting slowed growth of in drug prices.

*2018 coming soon!
Annual Spending per-person

Spending per Person in 2017

- **Professional Services**
  - $1,898
  - 33.6%

- **Inpatient**
  - $1,097
  - 19.5%

- **Outpatient**
  - $1,580
  - 28.0%

- **Prescription Drugs**
  - $1,065
  - 18.9%

Total $5,641

Note: Prescription drug spending is amount paid on pharmacy claim, which reflects discounts from wholesale price, but not manufacturer rebates paid in separate transactions.
Cumulative Change in Spending per-person, Utilization, and Average Price since 2013

Note: Except for prescription drugs, utilization reflects volume and service-mix intensity. Thus, the prices presented factor out changes in the mix of services used for these three categories. Additionally, prescription drug spending is the amount paid on the pharmacy claim, which reflects discounts from the wholesale price, but not manufacturer rebates paid in separate transactions.
TX Ranked 13th Highest State, Spending $6,057 per Person in 2017
Spending Growth in TX was higher than the National Average

Cumulative Growth in Spending per Person by State since 2013

**Texas** saw an increase of 18.5% in spending between 2013 and 2017.
TX had slightly higher spending growth than neighboring states

Outpatient spending also increased faster than the national average in neighboring state NM and OK

TX had higher outpatient spending growth than the national average
TX 2017 Outpatient Spending $1,750 per person, 19th highest state
Project Overview:

- Compare how local health care markets function throughout the country
  - Analyzed over 1.8 billion commercial claims from 2012-2016

- Develop, publicly report a standard set of replicable measures:
  - Service Price, Service Use, Hospital Market Competition

- For each measure: interactive web articles, dashboards, public use files
  - Explore trends across 112 metro areas in 43 States
    - Including 8 metros within the state of Texas
Wide Variation in Prices Across U.S.

Overall Health Care Prices in U.S. Metros Relative to National Median, 2016

FIND A METRO: Dallas-Fort Worth-Arlington...

-50% ≤ PERCENT DIFFERENCE FROM NATIONAL MEDIAN ≤ 50%

Dallas, TX
16% above the national median in 2016
Similar prices to Bridgeport, CT and Boston, MA

Corpus Christi, TX
4% below the national median in 2016
Similar prices to Augusta, GA and Dayton, OH
Prices Growing Almost Everywhere

Comparing Overall Price and Use Changes, 2012 - 2016

FIND A METRO: San Antonio-New Braunfels...

HIGHLIGHT A SERVICE TYPE: Overall Inpatient Outpatient Professional

Change in Price by Metro

San Antonio-New Braunfels, TX

Change in Price: +20%
However, Use Declining Largely Everywhere

Comparing Overall Price and Use Changes, 2012 - 2016

FIND A METRO: San Antonio-New Braunfels...

HIGHLIGHT A SERVICE TYPE: Overall, Inpatient, Outpatient, Professional

San Antonio-New Braunfels, TX
- Change in Price: +20%
- Change in Use: -12%

Change in Price by Metro

Change in Use by Metro
All 8 metro areas in Texas experienced a growth in prices & decline in use

- **Prices**
  - El Paso (+11%) lowest growth rate, San Antonio (+20%) highest

- **Use**
  - Houston (-9%) smallest decline, Corpus Christi (-18%) largest

<table>
<thead>
<tr>
<th>Metro Area</th>
<th>% Change in Price</th>
<th>% Change in Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin-Round Rock</td>
<td>+15%</td>
<td>-16%</td>
</tr>
<tr>
<td>Beaumont-Port Arthur</td>
<td>+13%</td>
<td>-15%</td>
</tr>
<tr>
<td>Corpus Christi</td>
<td>+17%</td>
<td>-18%</td>
</tr>
<tr>
<td>Dallas-Fort Worth-Arlington</td>
<td>+15%</td>
<td>-12%</td>
</tr>
<tr>
<td>El Paso</td>
<td>+11%</td>
<td>-10%</td>
</tr>
<tr>
<td>Houston-The Woodlands-Sugar Land</td>
<td>+15%</td>
<td>-9%</td>
</tr>
<tr>
<td>McAllen-Edinburg-Mission</td>
<td>+13%</td>
<td>-17%</td>
</tr>
<tr>
<td>San Antonio-New Braunfels</td>
<td>+20%</td>
<td>-12%</td>
</tr>
</tbody>
</table>
Prices and Use Varied by Service Category Within Metros

**Price and Use Levels Within Metro Areas by Service Categories, 2016**

**El Paso, TX**

<table>
<thead>
<tr>
<th>Category</th>
<th>Use</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>-14%</td>
<td>+9%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>+2%</td>
<td>-31%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>-16%</td>
<td>+37%</td>
</tr>
<tr>
<td>Professional</td>
<td>-21%</td>
<td>-10%</td>
</tr>
</tbody>
</table>
Compare Health Care Prices, Use Levels and Growth in Select Metros

Corpus Christi, TX
2016 Overall Levels:
Price: -4% below median
Use: -27% below median

Overall growth since 2012:
Price: +17%, Use: -18%

El Paso, TX
2016 Overall Levels:
Price: 9% above median
Use: -14% below median

Overall growth since 2012:
Price: +11%, Use: -10%

San Antonio-New Braunfels, TX
2016 Overall Levels:
Price: Same as median
Use: -3% below median

Overall growth since 2012:
Price: +20%, Use: -12%
Majority of Inpatient Hospital Markets were Highly Concentrated

Inpatient Hospital Market Concentration in U.S. Metros, 2016

Click or mouseover a group above to highlight on the map. Hover over a city below to see more.

Where else did patients get care?

PERCENT OF ADMISSIONS

0-10%  10-20%  20%+

Austin, TX

RANK  2016 HHI
31  0.3847

PATIENT DESTINATION

94.5%  5.5%
Within Metro  Outside Metro

MAJOR DESTINATIONS
San Antonio, TX
Most Hospital Markets Became More Concentrated Over Time

Change in Hospital Market Concentration

Change in HHI from 2012–2016 by U.S. Metro

<table>
<thead>
<tr>
<th>City, TX</th>
<th>HHI 2012</th>
<th>HHI 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaumont</td>
<td>0.2436</td>
<td>0.3015</td>
</tr>
<tr>
<td>Houston</td>
<td>0.1691</td>
<td>0.2605</td>
</tr>
<tr>
<td>El Paso</td>
<td>0.4691</td>
<td>0.4778</td>
</tr>
</tbody>
</table>

HHI INCREASED  HHI DECREASED
Inpatient Hospital Concentration in U.S. Metros, 2016

Houston-The Woodlands-Sugar Land, TX
2016 HHI: 0.2605
Change in HHI since 2012: +0.0915

El Paso, TX
2016 HHI: 0.4778
Change in HHI since 2012: +0.0087

Corpus Christi, TX
2016 HHI: 0.3731
Change in HHI since 2012: +0.0130
Price Levels Don’t Necessarily Capture Variation in Prices of Different Services Within Areas
Price Levels Don’t Necessarily Capture Variation in Prices of Different Services Within Areas

Blood Test
Distribution of Metro Area Median Service Prices, 2016

Blood Test
Range of Service Prices for Select Metro Areas, 2016

They Want It to Be Secret: How a Common Blood Test Can Cost $11 or Almost $1,000
10 Years of ER Spending – prices and coding

Spending per Person more than doubled in 10 years

Overall ER Use did not change over the 10 years, but the mix of CPT codes billed did.
Median increase in point-of-sales prices for common insulin products between 2012 and 2016 was 92%
Individuals enrolled in CDHPs have more dramatic month-to-month fluctuations in OOP spending on insulin.
Monthly cap on OOP spending on insulin would vary by health plan type and month.

Share of Enrollees with Monthly Out-of-Pocket Spending on Insulin Above Dollar Thresholds in TX 2017

<table>
<thead>
<tr>
<th>State</th>
<th>TX</th>
</tr>
</thead>
</table>

- **CDHP Enrollees**
- **Non-CDHP Enrollees**
How do rising drug prices affect cost of care for people with MS?

Studying the implications of price changes of the most common drugs taken by people with MS.
Health care is the only sector of the American economy where you can lose market share and gain revenue.
Putting Patients First While Containing Cost

Debra Patt, MD
Chair, Council on Legislation, Texas Medical Association
President elect, Texas Society Clinical Oncology
Executive Vice President, Texas Oncology
Reducing Administrative Waste:
Worsening Prior Auth. Burden Harming Patients

Care delays associated with PA

Q: For those patients whose treatment requires PA, how often does this process delay access to necessary care?

- Always: 11%
- Often: 36%
- Sometimes: 44%
- Rarely: 7%
- Never (0%)
- Don't know (%)

91% report care delays

Abandoned treatment associated with PA

Q: How often do issues related to the PA process lead to patients abandoning their recommended course of treatment?

- Always (2%)
- Often (53%)
- Sometimes (21%)
- Rarely (75% report that PA can lead to treatment abandonment)
- Never (1%)
- Don't know (4%)

In your experience, has the PA process ever affected care delivery and led to a serious adverse event (e.g., death, hospitalization, disability/permanent bodily damage, or other life-threatening event) for a patient in your care?

28% reported PA led to a serious adverse event
Growing Administrative Practice Burden

Taking Physicians Away from their Patients and Driving Costs

Change in PA burden over last five years

- 50% increased significantly
- 38% increased somewhat
- 10% no change
- 88% report PA burdens have increased over the last 5 years

On average, practices complete

- 31 PAs per physician, per week
- More than 1 in 3 physicians have staff who work exclusively on PA

Physicians and their staff spend an average of almost

- 36% of two business days (14.9 hours) each week completing PAs
Prescription Drug Costs:
Prescription drug costs have increased significantly over the past several decades.
Prevention and Care for Chronic Conditions
Stabilizing Health Insurance Markets
Meaningful Delivery Reform that Rewards Outcomes (alternative payment models)
Addressing Consumer Health Care Cost Concerns

Claire McAndrew, Director of Campaigns and Partnerships
Health Innovations (B) Working Group
NAIC Austin Meeting
December 7, 2019
Families USA is a leading nonpartisan, national voice for health care consumers. We work to ensure the best health and health care are equally affordable and accessible to all.

Visit us at: www.familiesusa.org
Health Care Costs are a Top Concern for Consumers

CBS News/ SSRS Poll Conducted September 26 – October 2, 2019
Consequences of Health Care Costs for Consumers

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had problems paying medical bills</td>
<td>43%</td>
</tr>
<tr>
<td>Gone without medical treatment</td>
<td>38%</td>
</tr>
<tr>
<td>Not filled a prescription/cut pills in half</td>
<td>31%</td>
</tr>
</tbody>
</table>
Consequences of Health Care Costs for Consumers

At least one of four access problems because of cost

- Insured all year, not underinsured
- Insured all year, underinsured
- Insured now, had a coverage gap
- Uninsured now

Notes: *Includes any of the following because of cost: did not fill a prescription; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic; did not see a specialist when needed. “Underinsured” refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 3% or more of income. “Insured now, had a coverage gap” refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. “Uninsured now” refers to adults who reported being uninsured at the time of the survey.

Data: Commonwealth Fund Biennial Health Insurance Survey (2018).

Increasing Prices Drive Increasing Costs

Cumulative Change in Spending Per Person, Utilization, and Average Price Since 2013

The solution must target the problem

States Address High and Rising Prices
Key Cost Concern for Consumers: Prescription Drugs

The consequences of increased drug costs on consumers

<table>
<thead>
<tr>
<th>Action</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not fill a prescription</td>
<td>30%</td>
</tr>
<tr>
<td>Declined a medical test or procedure</td>
<td>27%</td>
</tr>
<tr>
<td>Put off a doctor’s visit</td>
<td>26%</td>
</tr>
<tr>
<td>Switched to a supplement, over-the-counter drug or nondrug treatment.</td>
<td>20%</td>
</tr>
<tr>
<td>Spent less on groceries</td>
<td>32%</td>
</tr>
<tr>
<td>Spent less on family</td>
<td>32%</td>
</tr>
<tr>
<td>Used credit card more often</td>
<td>31%</td>
</tr>
<tr>
<td>Postponed paying other bills</td>
<td>21%</td>
</tr>
</tbody>
</table>

Source: Consumer Reports nationally representative survey of 1,180 adults who currently take prescription medication.
https://www.consumerreports.org/drug-prices/how-to-pay-less-for-your-meds/
Prescription Drug Solutions that Target the Problem

- Affordability Board
- Anti-Price Gouging
- Transparency
- Pharmacy Benefit Managers
Key Cost Concern for Consumers: Surprise Bills

More than 4 in 10 have experienced a surprise medical bill, half of those say the bill totaled more than $1000, and most found it difficult to pay.

Q: Have you or a family member ever received a surprise out-of-network medical bill after getting care in an emergency room, hospital, or clinic?

- Yes: 44%
- No: 45%
- Not sure: 11%

IF YES: What was the amount of the surprise medical bill you received? (n=451)
- $2,000+: 29%
- $1,001-$2,000: 19%
- $501-$1,000: 28%
- < $500: 23%

48% had to pay more than $1000 in surprise bills.

68% + 11% said it was difficult to pay this amount.

10% said they were unable to pay the bill.
Principles for Surprise Bill Solutions that Target the Problem

**Principle One: Hold Consumers Harmless**
- Balance billing should be completely prohibited in any care situation where consumers cannot ensure they will see an in-network provider or visit an in-network facility, including in emergencies, at in-network facilities, and for air and ground emergency transit.
- For out-of-network care that individuals incur due to no fault of their own, they should pay no more than in-network cost-sharing (including copayments, co-insurance, and deductibles).
- Out-of-pocket spending should count towards a consumer’s in-network out-of-pocket maximum.

**Principle Two: Hold Down Health Care Costs for Everyone**
- To ensure that insurance premiums aren’t unfairly increased, a reasonable payment level between insurers and out-of-network providers for surprise bill situations must be established.
- A reasonable payment level should be based on actual costs for care and not be inflationary (e.g., should not be based on billed charges, which almost always do not accurately reflect price).
Two Pitfalls to Avoid in Controlling Health Care Costs

- **Misdirecting responsibility for cost control on consumers:**
  - With prices driving cost growth, restricting consumer access to care or shifting more costs to consumers will harm consumer health and finances without fixing cost problems.

- **Falling into fads that lack evidence:**
  - Wellness programs designed to lower employer costs through employee lifestyle management (stopping smoking, addressing obesity, etc.)
Contact

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@claire_mcandrew