Transcript provided by the Kaiser Family Foundation[1]
(Tip: Click on the binocular icon to search this document)

CMS Estimates of State-by-State Health Expenditures
Kaiser Family Foundation
December 7, 2011

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

LARRY LEVITT: Good day. I'm Larry Levitt with the Kaiser Family Foundation. Today, the Office of the Actuary in the Federal Centers for Medicare and Medicaid Services is releasing new estimates of total healthcare spending state by state. The estimates are being published in the journal, *Medicare & Medicaid Research Review*, and they show how the almost $7,000 per person we spend in a year on healthcare varies throughout the country.

We're going to dissect that variation and explore what's behind it and why it matters. We're joined by Gigi Cuckler, an economist and author of the new report, and also for reaction, two highly-regarded experts in health policy and economics. John Holahan who directs health policy at the Urban Institute and Dan Crippen, former head of the Congressional Budget Office and now, executive director of the National Governors Association.

You can submit questions for our panel during the show by e-mailing them to ask@kff.org. Thanks to all of you for joining us. Gigi, let's start with you. One conclusion from the report is that spending does vary quite a bit from state to state. Give us a sense of that variation. Where is spending high; where is is low?

GIGI CUCKLER: Sure. When you look at overall spending for personal healthcare per capita in the nation, we see some

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

of the highest levels come out of the New England and mid-east regions with the highest level of spending in Massachusetts, which spent more than a third higher than the national average. On the other hand, some of the lowest levels of spending are in the Rocky Mountain region, including Utah which had the lowest level of spending, who spent more than a quarter below the national average.

Now, as you'd expect the trends are different for Medicare and Medicaid. For Medicaid — or for Medicare rather, we see only 14 states with above-average spending, most of those coming out of the eastern United States, including the state with the highest level of spending, New Jersey, which spent 15-percent above the national average.

On the other hand, in the western United States, you tend to see lower levels of Medicaid spending per enrollee generally speaking, including Montana which had the lowest level of spending. And of course for Medicaid, you see much broader variations. Instead of 14 states having above-average spending, you actually have 30 states with above-average spending with some of the highest levels coming in again in the New England and mid-east regions, the lowest levels coming in in the far west and the southeast regions.

The highest level of spending was actually in Alaska, though, which spent two-thirds higher than the national

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

average. Lowest spending came in in California, which spent more than a third below the national average.

LARRY LEVITT: And just to clarify here, we're talking about variations across the states, but we're not just talking spending of the states themselves or state governments themselves.

GIGI CUCKLER: Sure. Sure.

LARRY LEVITT: It's Medicaid; it's Medicare. It's people's out-of-pocket costs, what's paid for out of employer-provided health insurance, so really direct healthcare spending across the whole system.

GIGI CUCKLER: Yeah, it's total personal healthcare spending. When we look at all payers, that was sort of the first part that I discussed. That's total personal healthcare spending. And then we looked at the components of that for Medicare payer and the Medicaid payer.

LARRY LEVITT: Why? I mean if you had to point to two or three factors of why spending varies, what would those be?

GIGI CUCKLER: Well, broadly speaking for overall healthcare spending variation across the nation, we looked at some of the key characteristics among states with some of the highest levels of spending and some of the lowest levels of spending. So what we saw is states that had the highest level of spending tended to have higher per capita incomes. They also tended to have more elderly residents, whereas on the

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

other hand, we saw that states with some of the lower levels of spending tended to have younger residents, lower incomes and lower rates of health insurance coverage.

As you might expect, things are a little bit different in Medicare and Medicaid. For Medicare spending, we looked at states that had the highest levels of per-enrollee spending, and we saw that states that had higher spending tended to have higher shares of female enrollees, African-American enrollees, and relatively older beneficiaries.

Of course for Medicaid, which had even broader variation, we saw that incomes also played a role. We saw that states that had higher incomes also tended to have higher per-enrollee spending, but that's really more of a function of the economic availability of resources for those states.

We also looked at beneficiaries there and we found that states that had above-average spending tended to have above-average shares of enrollees that were blind or disabled or elderly. And of course since Medicaid is a state-specific program we saw that certainly policy differences and differences in benefit design are going to impact variation as well. There are really a complex mix of factors that help explain the variation.

LARRY LEVITT: Yeah, complex is certainly right [laughter]. And so the estimates you've been talking about are for 2009.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

GIGI CUCKLER: Yeah.

LARRY LEVITT: But you also looked back 10 years. And did you see variation in how fast spending has been growing? Has there been some movement around? Low-spending states become high-spending states? High-spending states become low-spending states over time?

GIGI CUCKLER: Well, yes, we did see that. We basically looked at growth over the last decade and the impact that growth has on the relative position of states or the ranking of states. And what we saw is that states — well, the fastest growths first of all for overall personal healthcare spending was in New England region. Some of the slowest spending was in the southeast region. And what we saw is that states that had some of the highest levels of spending historically actually grew faster than the national average, while states with some of the lowest levels of spending historically actually grew slower than the — or grew on par with the national average.

So we actually saw a broadening in the gap between the states with the highest level of per capita spending and the states with the lowest level of per capita spending over time. For Medicare and Medicaid, we saw, of course, a slightly different trend. For Medicare, we saw that growth was fastest in the Plains and the Great Lakes regions, and slowest in the

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

far west. For Medicaid, we saw actually fastest growth in the southeast region and slowest growth in the mid-east region.

For Medicare and Medicaid, for both, we saw that over time, the gap between states with the highest level of per-enrollee spending and the states with the lowest level of per-enrollee spending narrowed somewhat. So despite this sort of narrowing for public payers on a per-enrollee basis over time, the gap between the highest and lowest spending states overall on a per capita basis broadened.

LARRY LEVITT: John, let me bring you in here. Gigi talked about the variation in Medicaid being larger than the variation in overall spending. Why do you think that is? Why would Medicaid spending vary more across states that overall spending?

JOHN HOLAHAN: Well, I think the main reason is the one she mentioned which is that those states tend to have a higher share of their population that's aged and disabled versus adults and children. That not only affects acute care costs quite a bit, but also long term care.

The states in the northeast and mid-west and some of the west just spend an awful lot more on Medicare and Medicaid dual-eligibles, on long-term care services and on acute care services for those populations. So I think that's by far the biggest —

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

LARRY LEVITT: And is this driven in part by demographics, just different — population looks different in different states or policy decision states are making about eligibility?

JOHN HOLAHAN: Well, it's that their populations are older and whereas states in the southeast and southwest, there's been a lot of migration towards those states of younger populations, but that wouldn't do it by itself. There needs to be policy decisions that are going to support big long-term care systems, and by and large, you've seen a lot more of that in the northeast and mid-western states.

LARRY LEVITT: We also — in these discussions, we often think of healthcare costs as being bad, high costs are bad, low costs are good. Is that the right way to look at this here? I mean is that the right way to look at this here? I mean is a state that has low spending automatically doing better than a state that has high per capita spending, whether in Medicaid or more broadly?

JOHN HOLAHAN: Well, as you know, that question's been debated. I have a very hard time believing that spending substantially less is gonna do you much good. You can get to the point where increased spending at the margin has a very low payoff, but my guess is that within that range, that there's — you're better off putting more resources into healthcare than not.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

LARRY LEVITT: And Dan, would you agree? Is there — how do we judge what the right level of spending here is?

DAN CRIPPEN: There's no way to make a — to talk about an optimal level, but it does come back to the health of the patients or the beneficiaries. And it's certainly not a great correlation to say that those who spend less have healthier citizens or beneficiaries. On the other hand, it's also pretty clear that spending more doesn't necessarily correlate with better health or better outcomes either, so there's no magic to the right level of spending.

I mean the longer-term trick, of course, to bring healthcare cost down is to have a healthier population. It is true that we tend to spend more on people who are less healthy and need more healthcare. So we can talk about inefficiencies and other things, but ultimately it's the health status of citizens that drive much of the per capita.

One other thing on Medicaid, by the way, is that the payment providers is one thing that states do have a significant control over at this point. You get somewhat anomalous results, like California having a low per capita of cost for Medicaid, but they also have notoriously low payments to providers. So it's another piece that comes in here.

There's going to be a change, of course, with the Healthcare Reform Act of last year where we'll have essentially a national standard for Medicaid eligibility. Heretofore, the

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

states have had a lot of say over who is eligible and what the benefit packages are. Some of that variability will come out and your next ten-year numbers will show a much different result, but a lot of it because of federal policy changes and coming to national standards.

LARRY LEVITT: See you think — let's tease that out a little bit. So looking at the effect of the Affordable Care Act, what — so it sounds like you were saying that that should narrow some of the variation across states. What's the mechanism? What are the factors that you think would cause that?

DAN CRIPPEN: Well, primary one is who is eligible for Medicaid benefit. Currently, states have before last year established much of that. In some states, it's less than 100-percent of the poverty level is the cutoff for eligibility. Other states, it's well above the poverty level. So who is eligible is going to become much more a national standard; at 133-percent, roughly, above the poverty level, you'll be eligible no matter what state you're in.

The second big variability is what benefits are covered. There'll be much more inclination for a standard benefit package, although we'll still have some variability, but the cost should be roughly the same. Two of the big pieces will be taken out. Two big pieces of variation will be taken out by the Health Reform Act.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

LARRY LEVITT: John, you agree looking ahead to 2014 and beyond that we should see the variation narrow?

JOHN HOLAHAN: Well, with one important caveat. All of this data as I read it was on a per-enrollee basis. So what will happen with health reform is more enrollees in states that now have relatively few. What will happen to per-enrollee spending is harder to tell. I suspect it will stay low. It hasn't really been growing at particularly rapid rates in Medicaid, so I guess I wouldn't see that.

I'd like to say one thing about this issue of provider payment rates. Yes, states can control that. But what I think we don't know is whether if you control, say, very low rates of physician payment, whether you have low acute care expenditures. In the data that I've looked at, and it's not terribly sophisticated what I've done, but you see very high rates of hospital admissions and expenditures in those states with low physician fees. In New Jersey or New York, people are very reliant on hospital systems for their care, and that's expensive.

So it will be interesting in 2014; we're going to raise physician fees. Is that going to cost us a lot of money, or is it going to bring care out of hospitals?

LARRY LEVITT: So you think it's possible that raising physician fees could actually lead to — wouldn't necessarily lead to higher per-capita spending.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

JOHN HOLAHAN: It might not. It might not.

DAN CRIPPEN: We have history, too, of physicians and other providers being good at adjusting quantity around price. I mean obviously, it's P times Q to get the cost, and we've had lots of attempts to change or manage prices and still not have much effect, or at least not as much effect as we thought it would on cost.

LARRY LEVITT: Gigi, certainly we've been talking about Medicaid. The Affordable Care Act, people get coverage in multiple different ways. Notably, expanded eligibility for Medicaid, but also tax subsidies and exchanges to make private insurance more affordable. Looking currently now, how much of the variation across states can you pin on differentials in the number of people or the share of the population uninsured? If someone's uninsured, they use less services; how much does that factor in here?

GIGI CUCKLER: Well, the level of uninsured — first, I should just step back and say that since our estimates only go through 2009, we really haven't built in any effects of the Affordable Care Act, and we certainly haven't done any sort of supposition on what they would be by state.

Because we do notice that there's a high correlation between states with higher rates of uninsured, we would expect that those states would have more of an impact from the

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Affordable Care Act. But really beyond that, that's outside of the scope of what we looked at.

LARRY LEVITT: The other thing; looking at the timing of your estimates which are for 2009, it was as the recession was in full bloom. Give us a sense of what effect that had on state variations in spending.

GIGI CUCKLER: Sure. So what we saw with the recession, the effect on personal healthcare spending per capita was pretty notable. We saw a decline in overall spending growth from 2007 to 2008, and then continued slow growth in 2009. Our report really focused on three areas with the regional impacts of the recession.

What we saw is that the effects were most notable in the Great Lakes, New England and far west regions. For those regions, they experienced more substantial slowdowns in healthcare spending per capita. Really, what we saw when we kind of dug in a little bit is that those regions tended to have higher job losses and more losses in health insurance coverage. Of course, when we looked at health insurance coverage, we excluded Massachusetts from New England since it underwent health reform in 2006 to expand coverage.

The second area that we looked at was which states had the least impact related to the recession. So really, the southeast and the southwest region, while they slowed down —

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

their health spending overall slowed down in response to the recession, they didn't slow quite as much as the other regions.

That brings us into our key finding as well is that the severity and depth of this current recession caused health spending to slow rather immediately during the recession for every region across the United States, whereas in the previous recession in 2001, we saw that health spending actually accelerated during the recession.

So there was really more of a delayed effect of the recession on health spending the previous recession, where in the current recession, we just had an immediate slowdown, an immediate effect from the economic downturn.

LARRY LEVITT: Do you have any theories of why that might be the case? What was different here?

GIGI CUCKLER: Well, with this case, it was just the tremendous job losses as well as losses in insurance coverage. Because those were so severe relative to the last recession, it was a much quicker impact, and we also saw that in our recent health spending projections from 2010 to 2020 that we put out, through Office of the Actuary.

LARRY LAVITT: John, what would expect to happen after? Assuming we do pull out of the economic downturn [laughter], what would these numbers look like? Would you expect spending to then start to accelerate again?

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

JOHN HOLAHAN: Yeah, I guess I would, but I think we really don't understand why it's fallen off quite as much as it has. I think one difference between the two recessions is that prescription drug spending was really exploding back around 2000 and years right after that. That has slowed down a lot since then.

So that's probably one thing, but to the extent it is due to people losing jobs, incomes going down, less ability to spend, people losing health insurance, going on Medicaid which costs less on a parentally basis than private coverage, or becoming uninsured. We know people that are uninsured spend less. That's probably what's explaining it, and to the extent that turns around a bit, it will turn around health spending.

I suspect that an awful lot of the smaller firms that laid people off, or if they didn't lay people off, at least dropped health insurance, very well may not go back. In which case, let's talk about it before we get to 2014. It may not pick up — spending may not pick up to get back to the levels we were at before.

LARRY LEVITT: And Dan [interposing].

JOHN HOLAHAN: There may be other factors that are explaining what we're seeing in especially the states.

LARRY LEVITT: Wait, what other factors might those be?

DAN CRIPPEN: Well, the states have had a dramatic decline in revenue [inaudible] highpoint was 2008. They still

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

haven't recovered to literally the nominal level of revenues. At the same time Medicaid enrollment, of course, has gone up because of the recession, and states have taken continued actions to try to trim the per capita cost of Medicaid.

We have actually state legislators in special sessions even as we speak with some more Medicaid reductions on the table, so the state piece, at least, of Medicaid. There was of course the stimulus plan; it had an increased FMAP for a couple of years for the states. That has now of course completely expired. But in the meantime, the states have also been trying to better control Medicaid cost increases. So there's been a real impetus at least on doin that.

LARRY LEVITT: Broaden beyond Medicaid here. How much control do governors have over health spending outside of Medicaid? Is this something that governors are just playing the hand they're dealt, or are there other things they can do?

DAN CRIPPEN: Well, they often do play the hand they're dealt which could be tough politically and otherwise within a state. But there are two pieces, I think, that are important to note. One is that all governments now provide and pay for about 50-percent of all healthcare before you even talk about tax exclusion. So governments were at large, federal, state, local have a big stake in this and therefore, a big influence.

I think we do look at state employees, state retirees; many states have the local employees, teachers and others in

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

retirement systems that are statewide. So there are big impacts of healthcare on the whole state. They in theory, of course, have control over some of those costs. One thing states don't recognize as much as they might is that often states, whether it's governors or not, have a lot of control over the supply of healthcare.

They determine the number of slots in medical schools, what the curriculum is, how many hospital rooms in many states, whether there are certificates of need for imaging machines, but equally importantly, what can the healthcare professionals do? It's called scope of practice, but if you let nurse practitioners or physician assistants perhaps do more things like have a limited range of prescribing powers just as an example, you might be able to expand the supply of healthcare which we don't talk about much.

We talk about prices. We talk a lot about demand and utilization, but not much about supply. So I think states and governors need to think more about supply, especially anticipating we're adding some 30 million people through Medicaid and the exchanges to the healthcare system. We want them to use healthcare. That's the idea behind this, but we have to make sure we have enough supply to absorb those incoming beneficiaries.

LARRY LEVITT: Gigi, do you see or have you looked at variations in supply now? I mean physicians per capita,

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

hospital beds; how much of that might drive some of the variation we already see?

GIGI CUCKLER: Sure. We actually did look at some supply side factors, number of hospital beds and physicians, and we did see a positive association with those factors on some higher levels of health spending. But one thing to keep in mind is that the reasons why there might be higher rates of them also may be related to relatively higher incomes per capita as well, which would attract more physicians. So we did look at it, and it was — we did find that it was common for some of the highest-spending states to see higher rates of physicians and specialists, in particular.

LARRY LEVITT: And to table full of economists, I think it makes intuitive sense to you that higher incomes lead to higher spending. I'm not sure it makes intuitive sense to everyone. John, why would it be that a higher-income state would necessarily have a higher healthcare spending than a lower-income state?

JOHN HOLAHAN: Well, I think if people have higher incomes, they're going to want more of most things. Health is valued greatly, and people will spend more. Usually, when people say we spend more when we have higher incomes, they're controlling for health status. I think if higher-income people are healthier, and you don't control [inaudible] health status,

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

you may not see that strong an effect. But I think most of the time, people do that.

LARRY LEVITT: So this is almost a state-by-state variant of what we see with international comparisons where higher income countries spend more on healthcare as well.

JOHN HOLAHAN: I think in their regression analysis, they see a pretty strong —

DAN CRIPPEN: It was one of the strongest.

JOHN HOLAHAN: — relationship.

LARRY LEVITT: We have some questions from the audience, and let's move on to one. One is about the state variation in cost of living differences across states. Gigi, when you looked at factors, how much does that play in, the fact that it just costs more to do everything in some states than others?

GIGI CUCKLER: Sure. Well, you've actually touched upon one of the most challenging parts of our analysis. You would think that would be a relatively easy adjustment, but when you look at incomes, you can find state-by-state — data sources for state-by-state per capita income. On the other hand, there's not really a good data source for health sector prices on a state-by-state basis.

Really, income captures two effects. It captures the relative ability of residents in states to spend on healthcare, but it also reflects a measure of cost of living. So the

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

higher the incomes tend to be in a state, the higher the costs of living tend to be in a state. So that's really the way the pricing plays into and how we accounted for it in our analysis.

LARRY LEVITT: So it's sometimes hard to tease out the difference between the —

GIGI CUCKELER: Absolutely.

LARRY LEVITT: — fact that higher income people spend more on lots of things, and that costs are higher in those places.

GIGI CUCKLER: Sure. Sure.

LARRY LEVITT: We've been talking a lot about Medicaid. Not surprisingly, because we're talking about variation across states, but obviously, the private insurance side represents a substantial portion of spending as well. Dan, how much — looking at state-by-state variations, how much would you expect differences in the private insurance market to play in here? Are there differences between what private insurers in California do versus what private insurers in Alaska or North Dakota, wherever?

DAN CRIPPEN: Sure, there are a lot of variations. The states still regulate much of the health insurance market. Part of that variation can be attributable to differences in that regulation. Whether there are community rating rules for example that you can only have so much variation among your premiums; what the benefit packages are.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Probably more significant is the historical patterns of use of healthcare. We have the example of, of course, Kaiser, and where it had provided healthcare and what effects that had over the long term. That's very regional if not state. So there's lots of variation due to state regulation as well as tradition and practice patterns that are embodied in the state regulation.

LARRY LEVITT: John, turning back to the Affordable Care Act and health insurance exchanges that come into play, how would you see that changing the health insurance market and then playin out in turn in some of these spending trends?

JOHN HOLAHAN: It'll vary a lot by state. States with high — with lower-income populations and higher uninsured rates now are going to really see very large increases in coverage. A lot of other states really won't see that much. That should put more pressure on the system, and it'll lead to higher overall expenditures because you have more people with insurance, but to the extent it causes price increases that will add to it.

That's complicated because it really depends on the ability of insurers to control their rates of payment and other payers to control rates of payment. It's not a simple demand and supply. Demand goes up, prices are going to go up, but it isn't that simple in healthcare.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

I think one of the things that we're seeing more and more as a big factor in cost growth is the consolidation among hospitals where you have big systems that are developing and buy up smaller hospitals and then negotiate as one. It's very hard for insurers to negotiate with them. So where you have states that are really dealing with that, it is very difficult for their insurers, to control their premium growth.

LARRY LEVITT: Dan, from a governor's perspective, is that an issue that they're looking at, facing, have any control over?

DAN CRIPPEN: Well, they may have some control through local standards and state antitrust laws, but more they rely on the federal antitrust mechanisms, especially when you have these larger systems who are across state lines. So again, that's not something they have thought about a lot, antitrust initiatives of their own, but the state attorney generals who often get together on various things have had some discussions about it. I don't anticipate anything coming of that yet, but it's certainly something that they could take on and try and prod more antitrust kinds of considerations.

LARRY LEVITT: So we've talked about Medicaid. We've talked about private insurance. Medicare is obviously the third big piece. Gigi, you talked about the variation in Medicare. If you could just turn back to them. Medicare is a national program with less variation in policy across states,

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

but there is still variation in spending. What drives that variation in Medicare spending across states —

GIGI CUCKLER: Sure.

LARRY LEVITT: — even though it's the same program everywhere?

GIGI CUCKLER: Well, in this case, we really saw that there was a lot of variation in the beneficiary populations by state, and we did notice that states with above-average spending tended to have higher shares of female enrollees. Likely, they're also older since women have a longer life expectancy, so that's not really surprising.

In addition, we did find that higher shares of African-American beneficiaries were also associated with higher levels of spending. This is a case where we saw looking at several studies that show when that population is under 65, they have higher rates of uninsured. They also tend to be less healthy. So when they finally get into the Medicare program, they do tend to have higher levels of spending on a per-enrollee basis. that's consistent with other analysis that we've done within the office.

In addition to that, we also looked at the break-out of age groups within the beneficiary population, and certainly beneficiaries that are relatively older tend to spend more. That's related to that end-of-life spending that we see in

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Medicare that's very notable and there's been a plethora of research on.

LARRY LEVITT: John, how about on the provider side? There certainly is, as Dan pointed out earlier, spending is P times Q, price times quantity or price times utilization in this case. You certainly see differences in utilization, even in a uniform program like Medicare across the country. How much of that — do you have a sense how much that drives these differences in expenditures?

JOHN HOLAHAN: Well, there are differences in prices as you know because we adjust for geographic costs of differences. I think there are clearly differences in utilization that are driven by the availability of providers, particularly specialists and teaching hospitals certainly have some effect.

It's also — Gigi alluded to the health status differences, and they differ quite a bit. That's related to demographics, incomes, poverty the percentage of say a state's population that's really low income. And I think all of those things will —

DAN CRIPPEN: And not to divert back to Medicaid too far, but as John observed, there are interrelationships. You pay providers less under Medicaid, then they tend to use hospitals more. So for dual-eligibles who are eligible for both Medicaid and Medicare, the programs are bifurcated.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Medicaid doesn't have to pay for most of the acute care hospitalizations for a dual-eligible. So you may pay doctors less under Medicaid, and if John's hypothesis is right, you drive more into hospitals which Medicare pays for. Some of the variation may actually be a function of the Medicaid program as well.

LARRY LEVITT: We got a question from one of our viewers about dual-eligibiles, people eligible for both Medicare and Medicaid and what states might be doing to control costs there. Is that a topic on the minds of lots of governors right now?

DAN CRIPPEN: It is very much. It hasn't been heretofore, but because of the increased costs and reduced resources, they're looking at lots of things. One of the facts is that the dual-eligibles tend to spend a significant amount of money in both programs, both Medicaid and Medicare. So it is one way of thinking about treating the whole patient, of getting rid of some of these adverse incentives between the two programs and hold someone accountable more for the whole patient and the whole spending.

It's assumed by most governors that if we did a better job of taking care of those folks, there would be some savings. One of the discussions has been about how we share those savings between the Medicare program and the Medicaid program, state versus federal.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

LARRY LEVITT: [Interposing] have a view on that.

DAN CRIPPEN: Well, we do. There's nothing magic about it. There should be some shared savings and I think that's our view, and the specific formula yet to be negotiated, but duals are certainly a population that spent a lot of money, are some of our sickest citizens. If we did a better job of coordinating between the two programs, we'd probably give them better health and we hope as an artifact of that save money.

LARRY LEVITT: John, give us a sense. For this group of dual eligibles, what kind of spending levels are we talking about compared to, let's say, other groups in the Medicaid program.

JOHN HOLAHAN: There are some numbers I don't carry around in my head. I would say $10 to $30, up to $30,000 or $40,000 and then on up for a very small share. They are far and away the most expensive populations for Medicaid when we look at Medicaid data. That doesn't count the Medicare spending.

LARRY LEVITT: And many of these are folks in long-term care and nursing homes.

JOHN HOLAHAN: A lot of them are in long-term care, but there are a lot of people who are quite expensive who are not in long-term care facilities. I think one of the things that is an interesting issue — and yeah, we are moving towards trying to figure out ways to manage the care, and there's been

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

a lot of grants given to states and new authorities to put people into managed-care plans and manage the care of all the services across both programs. It's largely thought to be a Medicaid responsibility.

Most of the studies that show that if you really manage the care, where are the savings going to be, they're really going to be in things that Medicare pays for. We've gone through a long period of time in which Medicare hasn't taken on that responsibility.

Now, we're going to have states manage it and be able to keep some of the savings on what would have been Medicare expenditures. So we'll have to see how this plays out. We don't — we're not as successful in the demonstration programs at saving money on the long-term care side of things as we are in acute care.

LARRY LEVITT: One of the other Medicare and Medicaid issues that played out over the period the actuary looked at was the implementation of the drug benefit in Medicare part D, which took a lot of people who were previously having their drugs paid for in the Medicaid program and shifted it to Medicare. Get a sense how that played out in these numbers, how that shift —

JOHN HOLAHAN: Well, one of the things you see in there in the actuary's numbers are that the growth rate in Medicare

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

spending of the 2004 to 2009 period actually goes up, whereas in Medicaid it goes down.

The question is if you had taken the drugs out of that altogether, what would those growth rates have looked like? I suspect that Medicare's growth rate probably would've gone down a little bit. Medicaid's probably would've gone down quite a lot in the recession primarily because so many of the new enrollees are people coming in because they're losing jobs, and they're adults and children and we're not probably adding that many of the more expensive aged and disabled.

So there's a compositional shift within Medicaid towards a less-expensive population. I think if the — I would really encourage you to try to do that because you'll really get a better picture of what's happening to those underlying growth rates on a parenterally basis.

LARRY LEVITT: Gigi, is that something you all looked at?

GIGI CUCKLER: We actually did. We looked sort of between the 2004 and 2009 period, and if you excluded which grew on a parenterally basis at 2.3-percent, so that seems like it's below the inflation rate —

JOHN HOLAHAN: That's Medicaid, right?

GIGI CUCKLER: In Medicaid per enrollee.

JOHN HOLAHAN: Okay.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

GIGI CUCKLER: But if you remove prescription drug spending and you just take the per-enrollee calculation without prescription drug spending, that goes up to 4.0-percent which is pretty close, at least much closer, to the overall personal healthcare spending per capita growth which was 4.7-percent during that time.

LARRY LEVITT: And how about in Medicare [interposing].

GIGI CUCKLER: In Medicare, I actually don't have that number with me [laughter]. We'd be happy to get that for you later on.

DAN CRIPPEN: One of the things we've seen in Medicaid that underlies some of the trend you teased out was a more rapid substitution in generic drugs than we anticipated. So we're getting 80-, 85-percent substitution in many states for drugs that have generics, which is faster than we thought. Part of that — some of that's happening in the part D benefit as well, but much more [interposing].

LARRY LEVITT: What's driving that? Is that state policy, different changes or —

DAN CRIPPEN: Some of it's state policy. Some of it's the managed care companies who are running many, for the moms and kids in particular, who are running the programs have figure out how to incent. We've got some differential co-pays like they do in the commercial populations of a dollar or two difference between generics and others, and just state policy

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

at some places who states won't pay for or will only pay a small part of a brand-name if there is a generic substitute available.

LARRY LEVITT: Let's turn it — one of the challenges in looking at state variation, and Gigi, let me just clarify, this is not spending that occurred in a state, but it's spending on behalf of residents of that state and that presumably requires some complicated adjustments in the data you have. Can you give us a sense of how that changes the numbers? Do you — how does that — how often are people in one state using services and in another state?

GIGI CUCKLER: I can give you a broad sense of what we do. We start off with looking at provider revenues by state and we get that data from the economic census which is released every five years. Then what we do is we look at utilization patterns for Medicaid — Medicare beneficiaries, rather, and also for some private insurance enrollees. Then what we do is based on their utilization patterns crossing states, we adjust our provider data so that the final data that we have is more of a reflection of spending that takes place in a given state, rather by a state's residents, rather than the state — just the revenues that occur within a state.

You mentioned an example before, we see a lot of that type of behavior definitely around Washington, DC, and certainly it's more common in areas with larger urban

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

populations. Generally, that's the feel for how it affects the adjustment and where we saw a notable adjustment.

LARRY LEVITT: I want to turn back to some questions from the audience; they've been coming in rapidly. One of the concerns — we were talking about the effect of the recession earlier on healthcare spending. The question is are there other factors? For example, higher cost-sharing that patients are facing that may have pre-dated the recession, may have occurred at a similar time to the recession. John, do you have a sense how much of this, if you can, how much of this might be the recession? How much might be more permanent changes in the kind of cost-sharing that patients are facing?

JOHN HOLAHAN: I think it's a really good question, and I think it's hard to tease it out of this data right now. It could be having some effect, but I suspect the declines in incomes, losses of jobs going to — losing insurance is really affecting private spending quite a big more. I certainly wouldn't rule that out that it's one of the factors for sure.

LARRY LEVITT: And Gigi, is that something you're able to look at in your estimates.

GIGI CUCKLER: Well, so this is one of the limitations of the state estimates is that it really — if you look at total personal healthcare for all payers, that's including PHI or private health insurance, that's including out-of-pocket expenses, and that's including Medicare or Medicaid, other

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

public. So we really can't tease out an on a state level out-of-pocket expenditures.

When you remove Medicare, Medicaid from our total personal healthcare spending, you don't really get a measure of, say, just private. It's really kind of amalgam, but looking at it more from a broad basis at the national level, in our most recent healthcare projections through the next ten years that our office puts out, we did note a trend in increased cost-sharing expectation and higher out of pocket expenditures. So that was something we did see at least nationally.

LARRY LEVITT: We have another question that's back at you, and it references an earlier discussion we had about price versus utilization and how much that is driving. The question is specifically about Medicare. As John was talking about, the prices do vary across areas in Medicare, but based on a more formulaic basis, utilization varies as well. Can you tease out how much of the variation in Medicare is price and how much is utilization?

GIGI CUCKLER: Well, in our analysis, since we are really working more with overall revenues and benefits, it's really more difficult for us to tease out price and utilization. That's really a challenge that we have, so it's very difficult to say with a precise measure, what level of utilization caused the variation.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

We can generally look at trends and we look at research, the kind that helps guide us in our analyses, but in general, based on the way that the analysis done using revenues and using benefits, it's very difficult to break out.

LARRY LEVITT: Got it. Okay. Let's talk about looking ahead for the next few years. I know your estimates don't address projections; they address history, but start with John and Dan. What are a couple things we should be watching out for over the next couple years? We come out of the recession, the Affordable Care Act gets implemented. What if we were looking at two or three things and came back to these estimates two or three years from now. What would you expect to see?

JOHN HOLAHAN: I guess I would expect to see continued slow growth in spending until we're well out of the recession because I think the slowdown that we've seen really is related to job loss, loss of insurance, loss of incomes. So I think until those things turn around, I think it'll have its effect on health spending. I mean we're talking about health spending falling. Remember, it's still — GDP has fallen more, so health spending as a percentage of GDP is actually going up. At least it was the last time I looked.

So I think those kinds of economic effects will dominate for a while. Then we'll get closer to 2014, assuming the ACA is still around. Then there'll be coverage expansions and other things that will become the new drivers. If the

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

economy is stronger and recovering [inaudible], then I expect to see health spending to start going up.

LARRY LEVITT: Dan?

DAN CRIPPEN: I agree with John. As he said it's more complex then supply and demand, but one piece of this is we're going to give access to 30 million more people to some kind of insurance, and presumably, they'll use more health resources which is the point of the policy. We want more people to have access so that just the raw look at demand and we're not, as I suggested earlier, probably doing enough analysis or more changes on the supply side. We're going to have cost pressures develop, and states continue to try and somehow cut — stand in the face of those pressures.

I expect that we'll see costs — and as John said, after the recession, go back, continue in a more historic or recent historic trends of being higher than they are now and well above increases in economic growth or any other factors we can think of. So I think the inexorable increases in healthcare costs that affect all of our budgets, federal, state, personal, will be back at the fore.

As many of the folks who have promoted increased access understand fully, it may be an empty promise if we don't do something about the cost side of the equation; whether people who now have access can first get to a doctor or other provider, but more importantly, can they afford it and all the

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

consequences of that. The whole discussion will come back, I think, in the next few years to changes of cost. Cost-containment, whatever you want to call it, but more work on the cost side of the equation.

LARRY LEVITT: Speaking as a policy-maker, what should these numbers tell me? What lessons do I take from these estimates?

DAN CRIPPEN: I don't know that it — other than what we've already talked about, that this particular set of data tell you a lot that we haven't discussed. I do think it's important to understand we still have a confounded more often then not on what are the real causality of both cost and increase in cost. It really is the increase we need to focus on, and as John said, we can take some solace in that decline because many other countries who spend less than we do for — and maybe get better care, but also are suffering some of the same increases and patterns of increases.

The base is only part of it. It's the rate of increase that is the worrisome part if you will for our future. So how we can analyze these differentials in increases I think is an important piece of research that as we've all said we need to keep working on and tease out the causality and know more about why these rates are changing, why they're different, why they're different between states.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

LARRY LEVITT: And Gigi, is that something you've looked at? We've talked about the factors behind the variation, less so about the factors behind why one state might be increasing faster than another. Can you point to a couple things you've seen in the data that might suggest —?

GIGI CUCKLER: Well, I would say our analysis was really based on more of an association, so this is a more technical aspect of the analysis, but the actual — it's a much stronger statement to say that any of these factors that we've pointed to cause higher health spending. We haven't really established that with the analysis that we've done here. We've mainly pointed out the characteristics of state that's tended to have higher spending.

It's a much stronger statement to say higher incomes causes higher levels of health spending per capita. We certainly looked at some studies that tried to get at that and we've noted that in our article. That definitely is sort of the golden egg [laughter] and it's very, very challenging to really make that stronger statement.

LARRY LEVITT: And when Dan talked about the rates of growth in spending — give us a sense of what kind of variation? Did one state — did a high-gross state, let's say, grow one percentage point a year faster than a low-gross state? What's the [interposing] range of —?

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

GIGI CUCKLER: Looking more recently, we saw New England grew I believe it was around a percentage point faster than the national average. Just in the national average, I believe between 2004 and 2009 was around 5.5 on a per capita basis. So just kind of broadly speaking, but you really can — depending on which payer you're looking at, depending on whether or not you're looking at an amalgam, you could see some sort of broader variation. When you look at all payers, you're looking at higher levels of aggregated data. So when you do that, you swamp the differences across the regions.

LARRY LEVITT: We also had another question from the audience about prescription drugs. Looking particularly at not so much the effect of the part D Medicare benefit, but how prescription drug spending grew in general across all bayers [misspelled? 00:48:14] and how that compared to previous years. How much of the increase we've seen over recent years is due to prescription drugs, and is that different from earlier periods?

GIGI CUCKLER: Well, there's a few things going on as we discussed with prescription drugs. We had the implementation of part D and for part D, we saw that we — there was really more of a one-time impact on overall spending per capita on prescription drugs, so basically, for all payers on prescription drugs. So we saw a one time bump in 2010, and mostly, that occurred in the western half of the country.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So there was that aspect, but in general, we also saw that if you look back earlier in the decade, compare that to later on the decade, there's really a broader adoption of generic drugs that we see. And that comes into lowering growth over the period from — I think it was over 12-percent down to below 6-percent.

Really, a big part of that is generic drug adoption. So you don't see — with Medicare part D, that's really more of a one-time shift rather than an overall shift. That's it, basically.

LARRY LEVITT: Thinking about more specifically the services that people use, and Dan talked earlier about some efforts to increase supply, what effect increasing access to primary care might have. How — do you — have you looked at and kind of drilled down and looked at how states might vary not so much in overall expenditures, but also what types of services people use? Do some states you see using more hospital care versus primary care?

GIGI CUCKLER: Well, it — there's certainly a broad variation in the services [laughter] as well. In our report, we really focused more on some of the variations we saw, and the services on a growth basis looking at more recently because there has just been so many things that have gone on. So as we said, we looked at prescription drugs.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

We also looked at some of the variation growth and physician payment growth, or rather, physician spending growth. There, we did see faster growth in New England and again, in Massachusetts, and really, we thought that that was related to health reform in Massachusetts. We've seen that when you have expansions of coverage, there can be increase in demand of physician services, more so relative than some of the other services.

We also looked at hospital spending growth, too, in the latter half of the decade. We did see that hospital spending growth, again, varied a little bit or quite a bit. We did see that that was fastest. Again, let me just — I would probably just want to briefly check, but I believe it's New England.

LARRY LEVITT: Okay. John, you talked earlier about how physician services expanding, for example due to Health Reform Massachusetts, might not necessarily lead to overall increases in expenditures, that there might be offsets. Looking ahead to the Affordable Care Act being implemented nationwide, how much do you expect that to change the composition of spending?

JOHN HOLAHAN: I guess that I off the top of my head would expect to see more use of physician services, particularly where the capacity is there to provide it, and probably fewer unnecessary hospital admissions. Maybe more

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

drug use because of the access to doctors, but I think that would be the main expectations that I have.

LARRY LEVITT: Dan, is that consistent with what you might expect to see changing?

DAN CRIPPEN: Yeah [interposing] we suspect the same in Medicaid as it expands into this population as well as — and there are things of course in the Affordable Care Act that tried to shift things away from hospitalization, some unnecessary or avoidable hospitalizations, payment changes, accountable care organizations, medical homes for Medicaid. There was a conscious effort to shift services more to physicians as John said and hopefully avoid more expensive and unnecessary hospitalization.

JOHN HOLAHAN: You're going to see a lot of variation. There are states where there is significant movement on the part of hospitals to buy up physician practices or to align with physicians. There are certain reasons why that's not attractive to doctors, but one reason it is is because they have, particularly the stronger systems, have a lot of bargaining power. This will give them more so doctors could do better.

If that's where the expanded use of primary cares services comes from, then you'll see more use in hospitals, and I suspect faster growth in those kinds of states. If it's outside, and we're able to expand primary care practices, and

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

they're able to use physician assistants and nurses efficiently, you may not see the cost pressure.

I think a lot depends on how that deliver system changes, and I don't think right now — we know, and I think if we know anything, it's not going to be the same everywhere.

LARRY LEVITT: Well, that's certainly been the theme here [laughter] is that things are not the same everywhere. We're coming to the end of the hour and I want to thank all of you. I think particularly with economic volatility right now and with implementation of the Affordable Care Act proceeding, coming back here a few years from now when — Gigi, I won't make you commit to when you're going to redo these estimates, but it might be a very good time to revisit some of these issues. So thank you, and thanks to everyone for joining us.

GIGI CUCKLER: Thank you for having us.

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.