

Trends in and Drivers of Health Expenditures in Idaho

Report by
University of Minnesota
State Health Access Data Assistance Center

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Idaho's Health Care Costs and Options to Improve Health Care Access

Report on Task 5: Trends in & Drivers of Health Expenditures in Idaho

Authors:

Lynn A. Blewett, Ph.D.

Nitika Malik, M.P.P.

Donna Spencer, M.A.

State Health Access Data Assistance Center
University of Minnesota School of Public Health
2221 University Avenue Suite 345
Minneapolis, MN 55414
shadac@umn.edu
612-624-4802

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EXECUTIVE SUMMARY

This report is one out of a series of five reports prepared for the Idaho Legislature, Office of Performance Evaluations (OPE) and Idaho Health Care Task Force as part of the project, “Idaho’s Health Care Costs and Options to Improve Health Care Access.” This report is on Task 5, a study of the trends in and drivers of health care expenditures in Idaho. The study focuses on trends in public and private health care spending in Idaho using the most recent data available. We rely on Idaho-specific data collected as part of Task 1 (Cataloging Public Health Expenditures in Idaho¹) and Task 2 (Estimating Private Health Expenditures in Idaho²), and supplement with national data when state-level data are not available.

The intent of this and the other reports is to establish baseline data that can be used to help frame the policy debate and to answer specific questions that may arise during discussions of health reform options in the state. These reports document many aspects of health care spending and trends to help inform the work of Idaho policy makers as they debate the regulatory and/or market-based approaches they will employ to addressing health costs, coverage, and access. In particular, the cost and cost growth issues addressed in this report may warrant additional discussion by policy makers.

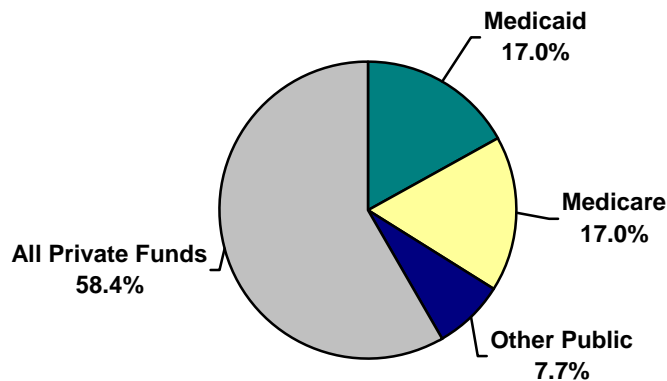
This summary describes Idaho’s health care expenditures and trends, discusses key cost drivers, and outlines a preliminary analysis of the Catastrophic Care Program. In the body of the report, detailed cost and trend data are used to compare Idaho to the nation and to its neighboring states.

Overview of Idaho’s Health Care Expenditures and Trends

- *Idaho spends a smaller share of its resources on health care than the nation as a whole.* Public and private health care spending in Idaho totaled \$5.6 billion or 13.0 percent of the gross state product in 2004. This is less than the share (13.3%) of the national gross domestic product spent on health care for the U.S. in that year.
- *A greater share of health care spending in Idaho is from private funds compared to the national average.* (See figure on next page.) Private funds (health insurance payments to providers, individual and employer premiums, other individual spending for health care services) covered more than half (58.4 percent) of all health care expenditures in Idaho in 2004, while nationally, private funds covered 55.4 percent.
- *Idaho’s annual average per capita health care spending growth rate of 7.1 percent is consistent with the national trend and lower than all six of Idaho’s neighboring state the period 2000-2004.* Taking population growth into account, Idaho’s overall per capita health care spending average growth rate of 7.1 percent is consistent with the national average per capita growth rate of (6.9 percent) and lower than all of its six neighboring states (ranging from 7.5 percent in Oregon to 8.2 percent in Nevada.)

Idaho's Total Personal Health Care Expenditures (PHCE) by Funding Source (2004)

Total Spending: \$5.3 Billion



Notes: Medicaid and Medicare from CMS State Health Expenditure Accounts, 2004. Other Public based on national estimate from CMS National Health Expenditure Accounts (NHEA), 2004. For other public cost components see Figure 5.1.1 in body of report. Percentages do not total 100 percent due to rounding.

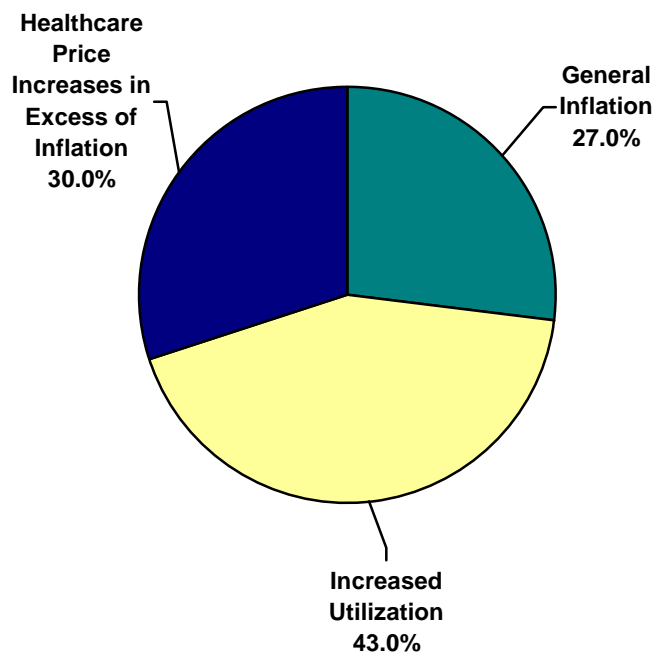
- *Idaho's population has been growing faster than four of its six neighboring states and the U.S. overall, which contributes to the overall health care expenditure growth rate of 9.0 percent.* When looking at increases in the rate of growth of health care spending it is important to take into account population growth. Between 2000 and 2004, Idaho's population grew 7.3 percent compared to the US population growth rate of 4.0 percent. Of its six neighboring states, only Nevada had a significantly higher population growth rate during this period (15.6 percent).
- *Idaho's private sector premiums continued to grow from 2002 through 2006.* Private sector premiums continue to grow for both the individual and group markets. Between 2002 and 2006, total premiums collected increased by a higher percentage than enrollment in both types of plan. Overall, total individual premiums grew by 34.0 percent during this five-year time span, whereas enrollment increased by 22.4 percent. For groups plans, total premiums grew by 59.7 percent, while enrollment in group plans increased only by 16.9 percent.

Contributing Factors to Increases in Idaho's Health Care Spending

The figure on the following page shows the national factors contributing to the 8.8 percent increase in health insurance premiums between 2004 and 2005. Health care expenditure

increases are determined by the price of goods and services, as measured by general inflation (Consumer Price Index-CPI), the price of health care services in excess of general inflation (Medical CPI), and service utilization. Utilization is a function of increased use and advances in technology, which includes new medical treatments (e.g., prescription drugs, medical devices) and improved diagnostic testing. Utilization is also driven by the aging of the population and increases in the population with chronic disease; the management of these issues is affected by lifestyle choices. In this section, we focus on both the trends in prices and in utilization and list key drivers below.

Factors Contributing to the 8.8 Percent Increase in Insurance Premiums (2004-2005)



Continued Increase in Public Program Enrollment

In general, public program per capita spending as well as administrative costs are relatively low when compared to private health care spending in Idaho. However, expenditures for public programs continue to grow as enrollment in both Medicare and Medicaid grows. Between 2001 and 2005 Medicare enrollment grew by 9 percent and Medicaid/SCHIP enrollment grew by 22 percent, driving much of the increased spending in Idaho’s public health care programs.

- *While the private sector accounts for more health care spending in Idaho, spending on public programs (Medicare and Medicaid/SCHIP) is growing.* The share of total health care spending for public programs increased from 39.2 percent of total spending in 2000 to 41.6 percent in 2004. The private share of Idaho’s health care spending decreased from 60.8 percent to 58.4 percent in that same time period.

- ***Public program cost increases are tied to enrollment more than to per person spending.*** Idaho's low per person spending on public health care programs has helped to limit the increases in overall per capita health care spending. Between 2000 and 2004, the per person increases in Medicaid spending were 4.2 percent compared to a per capita increase of 9.5 percent for state employee health benefits.

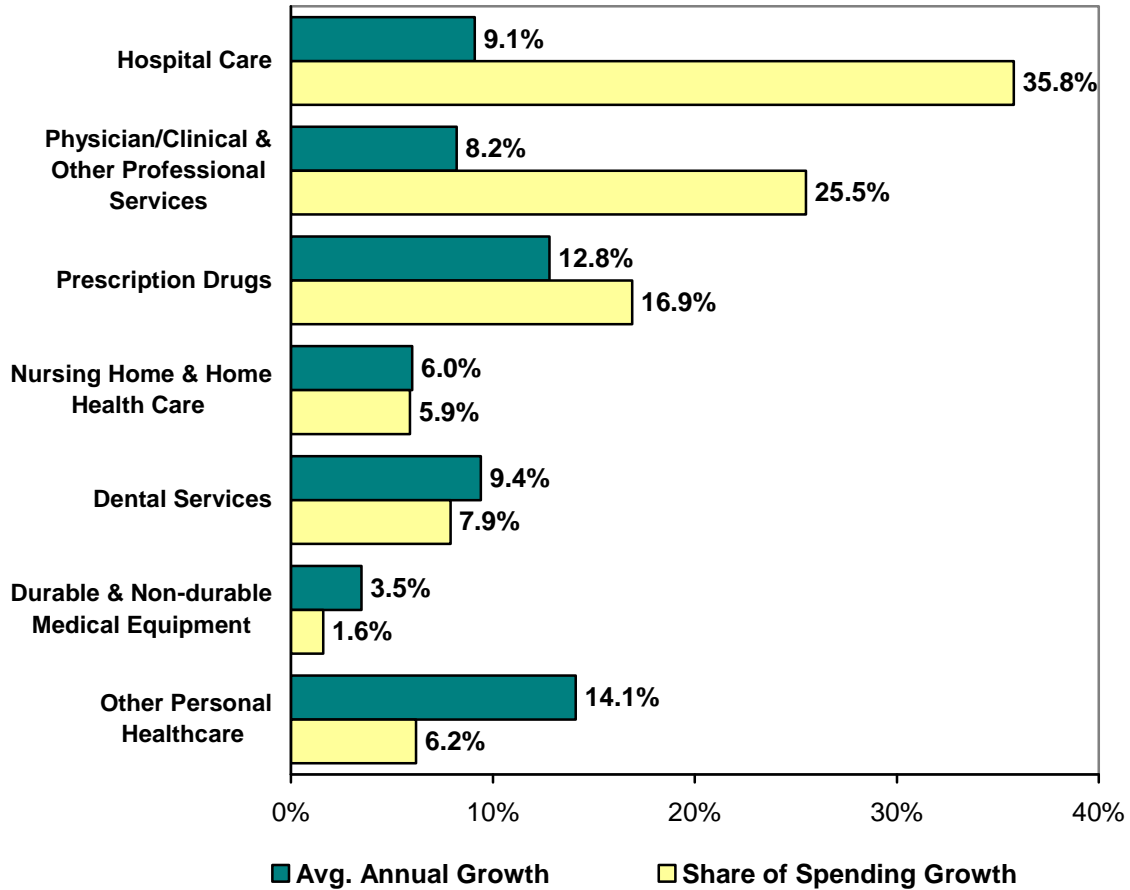
Spending on Hospital and Physician Services

Hospitals and physician, clinical and other services represent key spending drivers and comprise almost two-thirds (63.1 percent) of health care spending in Idaho. Understanding trends in health care spending over time may require ongoing monitoring of utilization and costs.

- ***Hospital volume has increased over time and more of the growth is concentrated in the Boise area.*** The number of hospital discharges increased by 7.2 percent between 2001 and 2005 from 130,822 to 140,229 in 2005. Boise metropolitan statistical area (MSA) hospitals accounted for 45.8 percent of discharge activity in 2005 and the greatest increase in discharges between 2001 and 2005 (11.2 percent). Discharges for non-Boise MSA hospitals grew by only 3 percent during this same time period.
- ***Population changes can account for some of the increases in hospital discharges.*** While Idaho's population continues to grow, the Boise area has seen the greatest population increase, growing 12.3 percent between 2000 and 2004 compared to 5.8 percent for the remainder of the state.
- ***Boise-area hospitals had higher average net revenue per Medicare discharge in 2005 at \$13,917 per discharge compared to \$11,244 for non-Boise MSA hospitals.*** While it might reflect the complexity of cases treated in Boise-area hospitals, this difference is not consistent with the average net revenue for other payers. Medicaid net revenue per discharge was approximately \$9,300 for Boise and non-Boise area hospitals. Private pay net revenue per discharge was \$17,658 for all hospitals in the state, with Boise MSA hospitals just slightly lower (\$17,445) and non-Boise MSA hospitals slightly higher (\$17,897).
- ***Increases in the utilization of hospital services, technology and other hospital capital expansions are drivers of health care spending in Idaho.*** While the State of Idaho does not collect data on or regulate capital spending in the health care arena, there is some information on facility construction and expansion drawn from recent newspaper articles and provider system web sites. From these sources, we estimate that over \$350 million in hospital expansion projects are underway in Idaho.

- ***Medicare pays the lowest reimbursement rates compared to other payers but represents almost half of all spending in non-Boise area hospitals.*** In the Boise area, the private sector is the primary payer for hospital services. Outside of Boise, Medicare makes nearly half of all hospital payments. States are not empowered to shape Medicare payment rates and hospitals with a high volume of public program patients have limited ability to cost-shift to other payers. Another issue for policy makers to monitor is the balance in non-Boise hospitals between financial viability and maintaining adequate access to needed care.
- ***Idaho has Medicare discharge rates higher than the national average for back surgery and hip replacement.*** In general, Idaho's Medicare costs for the last two years of life are well below the national average, suggesting lower cost and lower utilization per Medicare beneficiary in Idaho. However, specific procedures and certain hospital service areas (Twin Falls and Lewiston) show significantly higher rates of back, knee, and hip procedures. There is considerable variation in a few procedures that may warrant discussion with local hospital and physician groups to address best practices and procedures and target areas where procedures should either be decreased or perhaps increased.
- ***Growth in Idaho's physician spending was consistent with the national average, but lower compared to its six neighboring states.*** The average annual growth rate, between 2000 and 2004, for spending on physician services in Idaho (8.2 percent) was the same as the growth rate for the U.S. overall (8.2 percent) and slightly lower than the growth rate for all six neighboring states – from a low of 9.1 percent in Wyoming to a high of 13.5 percent over this time period.
- ***Prescription drugs have one of the fastest rates of growth of all health services in Idaho (12.8 percent between 2000 and 2004) but accounted for a relatively small share of total spending.*** Yet, prescription drug expenditures represented only a small portion, 8.4 percent of total personal health care spending in 2004. As shown in the figure below, they contribute 16.9 percent of the share of average annual growth in Idaho's spending. In addition, Idaho's per capita utilization of prescription drugs (8.6 prescriptions per capita) was lower than the national prescription drug utilization rate of 10.6 prescription drugs per capita.

Idaho's Personal Health Care Expenditures (PHCE): Growth Rates and Shares of Total Growth by Service Type (2000-2004)



Source: Personal Health Care Expenditures (PHCE), All Payers 1980-2004, CMS Office of the Actuary, National Health Statistics Group. Data are as of February 2007.

Notes: Shares of spending growth do not total 100.0%

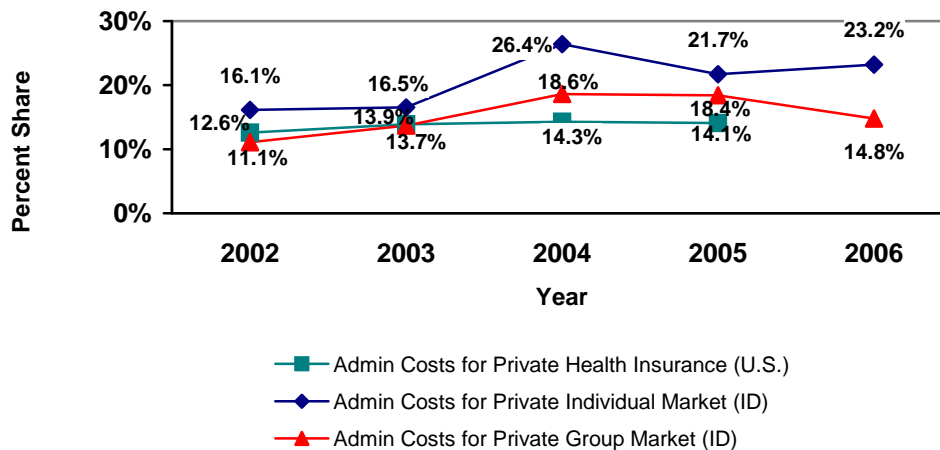
Consolidation of Payer and Provider Markets

A competitive market needs a sufficient presence of both supply (providers) and demand (payers) to ensure a successful functioning market. Consolidation in either the supply of or the demand for health care can disrupt the market equilibrium by shifting market power on one side or the other. While consolidation of the payer market is not unique to geographically large frontier states with relatively small populations, the consolidation can contribute to increases in private health care spending.

- *Consolidation of private payer market limits competition to keep premium costs down.* Idaho has two primary insurers, Regence Blue Shield and Blue Cross of Idaho, which enroll approximately 96 percent of the private individual and group market in the state. The broader networks used by these plans and the market concentration of enrollees may reduce competition.

- **Consolidation of the private payer market has led to increased discussions about consolidation of the provider market.** The consolidation situation also raises concerns about dominant market power in both the payer and provider sectors of a competitive market for health care services. There are tensions between a consolidated payer market and increased incentives for physicians and other providers to consolidate to position themselves in a dominant payer market.
- **Compared to its neighbors, Idaho's private group market is slightly more concentrated and its individual market is similar.** While it is not unusual for a few large payers to emerge in states with large geographic areas and relatively small populations, for the latest year (2001) when comparable data are available, the largest three insurers in Idaho held 91 percent of the market. By contrast, the highest consolidation in a neighboring state is in Montana where the three largest insurers had 76 percent of the market. In the individual market, Idaho's three largest insurers had 92 percent of the market compared to Utah where the three largest insurers had 100 percent of the individual market and Wyoming where the three largest insurers had 87 percent of the market.¹
- **Net costs of Idaho's individual and group markets are higher than for the nation as a whole.** The net cost of insurance is the difference between benefits and premiums. This difference includes administrative costs and, in some cases, additions to reserves, rate credits and dividends, premium taxes, and profits or losses. For the latest year of comparable data Idaho's administrative costs in the individual and group markets (21.7 percent and 18.4 percent) were well above the national average of 14.1 percent.

Share of Administration Costs (Net Costs) of the Private Health Insurance for U.S. NHE, Idaho's Private Individual and Group Markets



¹ Chottet, D. et al. (2003). Mapping State Health Insurance Markets, 2001: Structure and Changes. State Coverage Initiatives. Academy for Health Services Research and Policy. Available at <http://statecoverage.net/pdf/mapping2001.pdf>

Other Lifestyle Factors

Health care costs related to factors including aging, chronic disease, smoking and obesity may be amenable to public health and primary care interventions. While aging is not a personal choice, healthy aging and healthy lifestyles certainly are.

- *The aging population will spur increased health care spending in Idaho similar to other states and the U.S. overall.* Idaho's share of the population 65 years and older is projected to increase by 15 percent to 18.3 percent of the total projected population by 2030.
- *On a positive note, Idaho has one of the lowest rates of adult smokers in the US.* Idaho showed a reduced level of smoking, from a high of 20.6 percent of the population in 1990 to 16.8 percent in 2006. Idaho ranked third across the states in having the lowest smoking rate. Health care costs for smokers are as much as 40 percent higher than for non-smokers.
- *Obesity rates continue to rise and contribute to increased costs of health care.* Currently Idaho has an obesity prevalence of 24.1 percent of the adult population, which is slightly lower than the national rate of 25.1 percent. Obesity-related health spending is estimated to account for 27 percent of inflation-adjusted per capita health spending in the U.S. including increased costs of heart disease and diabetes related care.

Estimated Expenditures due to Lack of Routine Preventive Care

Idaho's County Medical Indigency Program and the state Catastrophic Health Care Cost Program provide financial assistance for episodic, catastrophic care for indigent uninsured Idaho residents. We used data from the state Catastrophic program to assess whether some of these hospitalizations could have been avoided with better primary and preventive services. In fiscal year (FY) 2006 these programs combined spent \$36.7 million in medical and related administration expenses, serving 5,249 cases across the state. In FY 2006 the state Catastrophic program alone spent approximately \$22.8 million for indigent care services.

- *In fiscal year 2006, an estimated 20 percent of state Catastrophic payments (\$4.6 million) were for events that might have been avoided had better primary and preventive care services been available.* This estimate was developed using the construct of ambulatory care sensitive conditions including appendectomies, coronary-related diagnoses and diabetes.
- *If mental health related hospitalizations are considered potentially avoidable given better routine preventive services, this would add 4 percent in savings, or \$911,000, in fiscal year 2006.*
- *Combining the ambulatory sensitive conditions and the mental health and substance abuse diagnoses, we estimate that approximately 24 percent of the state Catastrophic*

expenditures of \$22.8 million in FY 2006 (representing approximately \$5 million) might have been avoided with improved access to routine preventive and primary care.

It might be of interest to policy makers to consider the implications of using a portion of the state/county funding to develop a pilot demonstration to more formally assess the potential of better access to primary care and preventive services as a means to prevent costly treatment of episodic care that likely includes hospitalization.

Conclusion

While Idaho is unique in its culture, heritage and approaches to public policy, it faces many of the same health reform issues that are confronting other states. These issues include the rising health care costs, growing number of uninsured adults, an increase in an elderly population and growing number of people considered obese.

There does not appear to be a lot of waste in the health care system in Idaho. In relation to the national average or neighboring states, there may be some opportunities for improved access in primary and prevention care through the Catastrophic Care Program. This program has grown out of historical indigent care program and serves an important component of the safety net for coverage for the uninsured. It is however, primarily focused on treatment as opposed to primary care and prevention. We estimate that at least a portion of these costs may be preventable and a pilot project in one or more counties to demonstrate a different approach might be considered.

We hope this data can be used to help frame the debate and answer specific questions that arise during continued discussions of health reform. While we have documented many different aspects of health care spending and the trends in spending, it will be important for Idaho policy makers to work together and set priorities in terms of regulatory and market-based approaches to the increasing coverage and access and constraining costs.