

Statewide Strategies to Control Health Care Costs

Discussion Draft

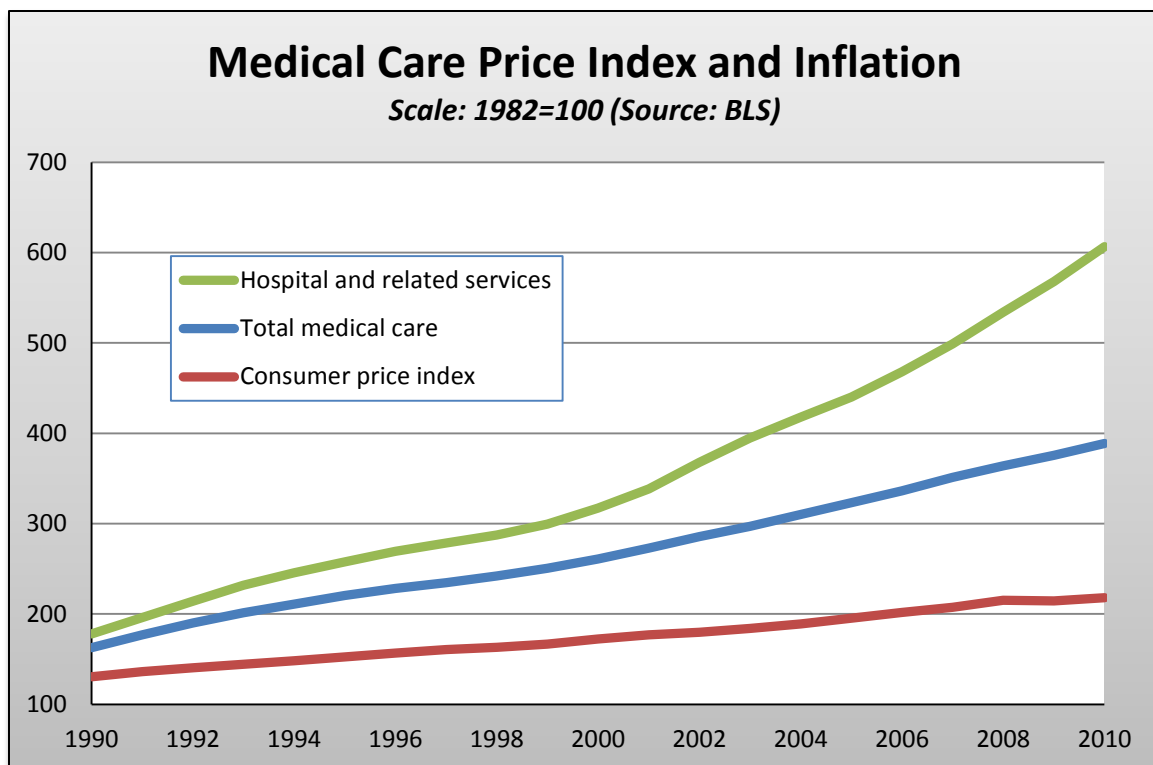
Introduction and Background

There is one inconvenient truth that most policymakers can agree with: America spends more on health care per person than any other nation, but receives only modest returns for this investment. In fact, although the United States ranks highest in the world on health care expenditures, it rates relatively low on the positive scale when it comes to measures such as longevity, obesity, chronic disease, and infant mortality.

America's health care spending growth is partly driven by increased utilization of services, but also by the high cost of U.S. health care in general, which continues to outpace inflation at mounting rates. These trends strain family budgets, reduce business competitiveness, and take away government resources from other priorities, such as education.

Strategies to change this country's upward trajectory in health care costs include improving care coordination, promoting the widespread use of electronic health records, employing evidence-based procedures, and altering how individuals pay for services. These are among the most promising ways to boost productivity in health care—if they can be brought to scale. But even though these changes hold potential, they have yet to curb the steady rise in health care spending as a share of the economy. The reason is simple: the U.S. spends more on health care than any other country because we pay higher prices and use more expensive procedures more often. We do not visit doctors more, we do not get better outcomes, we just spend more.

That is not to imply that high-quality care at reasonable expense cannot be obtained in the U.S. In fact, studies have shown that some integrated provider networks and hospitals are able to achieve



high-quality, coordinated care at lower cost than other provider systems. But these examples tend to be exceptions to the norm. Evidence also is mounting that hospital consolidation and provider network integration can enable health care entities to amass greater market power, which can be used to demand higher rates from insurance carriers. This market leverage has the potential to offset any savings obtained through care coordination, use of electronic records, or other practices designed to increase system efficiency and effectiveness. In short, there are no easy solutions to the price and spending problems in health care.

Controlling U.S. health care costs—often referred to as “bending the cost curve”—will require a concerted policy response on several fronts. All stakeholders, including consumers, providers, payers, and government, will need to come together to address the problem.

The already growing state role in the health care marketplace will expand even more dramatically under the new federal health care law. Without a concerted effort to alter the cost curve for health care, the financial solvency of states will suffer and the competitiveness of the U.S. economy will be jeopardized.

With such a large stake in fixing the system, states and governors can provide the leadership to get a handle on health care costs. They can convene stakeholders who can help identify what is driving cost growth and chart a path to improve quality and productivity.

This paper describes how states can spearhead a cost-containment strategy for health care—one that seeks to address the costs that all payers face, both public and private. The paper first reviews the essential drivers of health care expenditures and concludes by presenting a set of policy responses states can take to put downward pressure on these costs.

“ . . . U.S. health care spending is high because U.S. health care prices are high. Americans don’t use more health services than their counterparts in other industrialized countries, nor is the quality of care they receive systematically higher. They just pay more per unit, and the people and companies who provide those services earn more, in general, than their foreign counterparts do.”

—Bruce Vladeck and Thomas Rice, “Market Failure and the Failure of Discourse: Facing Up To the Power of Sellers,” *Health Affairs* 28, no. 5, September/October 2009.

Cost Drivers of Health Care

Over the last four decades, per-capita health care spending in the U.S., as a share of the nation’s gross domestic product (GDP), has grown each year. It rose from 5.2 percent of GDP in 1960 to 16.2 percent of GDP in 2008.¹ This spending growth has far outpaced that of other industrialized countries. McKinsey & Company estimated that the U.S. spent \$650 billion more on health care in 2008 than should have been expected given the country’s wealth and the experiences of comparable member countries belonging to the Organisation for Economic Co-operation and Development (OECD). Two-thirds of the extra spending went to outpatient care (e.g., visits to physicians and one-day hospital treatments). The remaining one-third was equally split between drugs and administration and health insurance.²

What is behind the cost growth? It is not because Americans visit doctors or enter hospitals more than anyone else. In fact, we seem to engage the health care system less often than people in other countries. On average, the number of physician visits per capita in the U.S. (4.0) is lower than the

OECD median (6.4), the number of hospital discharges per 1,000 population is in the bottom quartile among OECD countries, and the average length of stay of acute care hospitalizations is one day shorter than the OECD median.³ What tends to drive up expenses is the fact that we utilize more services, drugs, and equipment than any other country whenever we engage “the system,” and we pay higher unit prices on everything we use.

Policymakers cite several reasons for this, including:

- A general shift in the delivery of care from lower cost general practitioners to more expensive specialists;
- Low patient out-of-pocket expenses—particularly for low-value services—making consumers relatively insensitive to treatment choices and cost;
- Widespread use of high-cost medical equipment (such as CT scanners) and advanced procedures (such as angioplasty, stenting, knee replacements, and dialysis); and
- Lack of good information on the cost and quality of services delivered by providers and hospitals, which prevents payers from easily determining how much other payers are charged for the same services and inhibits consumers from choosing the best value among providers.

Provider Leverage and Prices

In recent years, two other factors have been driving up health care costs in many market regions. The first is the trend of hospital consolidation, which accelerated in the mid-1990s (*see box*). The second is the aggregation of providers into integrated networks, which are sometimes aligned with hospitals.

For more than a decade, the trend among hospitals has been to consolidate and, in some instances, form integrated networks with providers to offer a wide array of services in both inpatient and outpatient settings. Most hospital consolidations sought to improve the financial position of the hospitals in the market region they served rather than bolster patient care. In fact, a large body of research—with only a few exceptions—has found that hospital consolidations tend to result in higher prices for hospital services, with little or no positive effect on quality of care.

Recently, policymakers have been encouraging physician groups to become more integrated and better aligned with hospitals to coordinate care through so-called accountable care organizations (ACOs). Policymakers pushed for these

By the mid-1990s, hospital merger and acquisition activity was nine times its level at the start of the decade. According to an analysis by the Robert Wood Johnson Foundation, hospital prices rose 10 percent or more after mergers.

Studies have found that consolidation raised prices by 5 percent to as much as 40 percent. Consolidation among hospitals that are closest together leads to the highest prices.

A number of studies also confirm that, for some procedures, an increase in hospital concentration reduces quality.

—Claudia H. Williams, William B. Vogt, and Robert Town, “How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?” Policy Brief (Princeton, NJ: Robert Wood Johnson Foundation, February 2006).

changes to more effectively manage patients' needs and more efficiently use resources. Indeed, a number of managed care organizational structures have generated these results.

But further consolidation and integration also can increase health care costs by strengthening the leverage of provider groups and hospitals in negotiating reimbursement rates with their health plans. If provider groups choose to use this leverage, they can bargain for higher rates than others that have less market clout. Data show this occurring in some areas that have experienced the horizontal integration of hospitals and the formation of joint hospital and physician groups.

A landmark examination of health care cost trends and drivers was conducted in 2010 by the Massachusetts Attorney General's Office. The office led a detailed review of insurer-provider contracts and financial data to learn the prices paid to providers and the contract provisions that accompanied them. The goal was to determine if price variations for particular services could be explained by differences in value, such as the quality or complexity of services.

The report painted a picture of a broken marketplace. Among the findings:

- Price variations are not correlated to the quality of care, the sickness of the population served or complexity of the services provided, the extent to which a provider cares for a large portion of patients on Medicare or Medicaid, or whether the provider is an academic teaching or research facility.
- Price variations are correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospital or provider groups within a geographic region (for example, the average price variation among large physician groups was 230 percent).
- Price increases, not increases in utilization, caused most of the rise in health care costs during the past few years in the state.
- Higher priced hospitals are gaining market share at the expense of lower priced hospitals, which are losing volume.

Other researchers (Berenson et al., 2010) reached similar conclusions in studies of different market regions of the country.⁴

The price pressures caused by provider clout have even caught the attention of federal regulators in some instances. The Federal Trade Commission (FTC) recently agreed to settle with a group of doctors and hospitals in southwestern Minnesota concerning alleged anticompetitive tactics related to consolidation. The Minnesota Rural Health Cooperative (MRHC) formed an integrated network of 25 hospitals and 70 doctors. The FTC complaint alleged that the MRHC used its market leverage to coerce a health plan into paying MRHC members 27 percent more than it was paying non-MRHC providers. If the plan did not agree, the FTC complaint said, the MRHC threatened to terminate its contract with the carrier.

As more providers and hospitals are encouraged to form ACOs to support health reform, the trend of consolidation is bound to continue. Although ACOs offer the potential of delivering better care at greater value, states will need to keep a close watch on them to ensure that such consolidations do not lead to price spikes from market distortions.

Along these lines, the Massachusetts Attorney General’s report recommended that the state take the following actions to keep health care costs under control:

- Increase transparency and standardization in both health care payment and health care quality;
- Adopt payment reform measures that address existing market dynamics and distortions; and
- Develop legislative or regulatory proposals to mitigate health care market dysfunction and price disparities.

“As accountable care organizations lead to more integrated provider groups that are able to exert market power in negotiations—both by encouraging providers to join organizations and by expanding the proportion of patients for whom provider groups can negotiate rates—private insurers could wind up paying more, even if care is delivered more efficiently.”

—Robert A. Berenson, Paul B. Ginsburg, and Nicole Kemper, “Unchecked Provider Clout in California Foreshadows Challenges to Health Reform,” Health Affairs 29, no. 4, April 2010.

Cost-Containment Strategies for States

States can use their substantial and growing role in the health care marketplace to fashion cost-containment strategies to tame market forces that might cause health care costs to rise, and devise policies that encourage consumers to recognize and choose value.

States play a large role in the health care marketplace, a role that will grow substantially in the future. States administer Medicaid, which covers about 60 million people and is the largest public health program in the U.S. (By comparison, the federally administered Medicare program covers less than 47 million people.) By 2014, when new federal Affordable Care Act eligibility rules take effect, Medicaid rolls will swell by at least 16 million.

States also provide health care coverage for an additional 3.4 million state government employees and retirees. When their covered dependents and family members are included, the total is about 7 million people.

Finally, the federal health care law gives states the option of establishing and running new state insurance exchanges, which will be centralized marketplaces where individuals and small businesses can find and purchase the most suitable health care plans from among several options. RAND estimates that approximately 68 million people will enroll in exchange-based coverage, a number that could grow to 139 million if the exchanges are opened up to businesses with more than 100 workers. A subset of this group—perhaps 20 million people—is eligible for federal subsidies, which are only offered in the exchanges. Thus, states choosing to run the exchanges will have a hand in shaping the health care policies, benefits, and options affecting a large number of plans, providers, and consumers.

For these reasons alone, states should think seriously about leading an effort to control health care costs for all payers in the state. Doing so not only can relieve cost pressures on state government, but also lower future costs for families, businesses, and individuals who are self-employed.

There are six key steps to implementing a statewide strategy for curbing the growth in health care costs:

- **Collect data on medical claims from all payers in the state.** This is imperative. Without an understanding of the cost of medical services reimbursed by all payers (e.g., insurance carriers, Medicare and Medicaid, private entities, and individuals), it is almost impossible to implement effective cost-containment. Indeed, all of the strategies described in this paper rely on such data.
- **Analyze the data and publicize cost and quality information.** Collecting information of the cost of health care services is important, but it means nothing if the data cannot be analyzed and sorted to produce information useful to the public, policymakers, and state regulators. The public needs information to make informed decisions concerning the quality and cost of health care services; payers, such as insurance carriers and large employers, need to know what others are being charged; and state policymakers and regulators need information on major price disparities and the reasons for those disparities.
- **Establish a statewide cost growth goal with stakeholders.** Governors should bring the major plans, private payers, and large hospital and provider groups together to establish a statewide cost containment goal for health care. The goal should be simple, easy to measure, and understandable to the public—for example, holding health care costs in the state to the rate of inflation or to inflation plus a certain percent. Creating a goal helps anchor all subsequent efforts.
- **Encourage consumers to purchase value.** States should work with their plans and providers to publish good information on health care service costs and quality. Plans should be urged to use financial incentives and care management practices to drive consumers toward high-value, low-cost interventions. For example, plans should be allowed to charge higher co-pays or co-insurance to patients who choose more expensive providers over those with a similar quality rating. They also should provide incentives to use preventative care services that are known to lower costs.
- **Work with plans and providers on systemwide improvements that lower cost.** States can work with their plans and providers to pursue actions that lower cost and improve quality throughout their health care system. Such steps include reducing hospital re-admissions, hospital-acquired infections, and avoidable emergency room (ER) visits.
- **Conduct provider price reviews and negotiate payment reforms.** By collecting and analyzing payment data, states will be able to see what is driving cost growth in the state. States should review this data on an ongoing basis (at least yearly) to identify cost outliers and negotiate changes or payment reforms that help bring these costs in line.

Collect Data on Medical Claims from All Payers

A state cost-control strategy must begin with developing a firm knowledge of what health care services actually cost in the state. States interested in collecting such data typically establish what is termed an all-payer claims database (APCD). Using information from medical insurance claim payments made to providers, an APCD can help identify the following items:

- The cost of medical interventions charged by individual providers, provider networks, and hospitals;
- The quality of some services and procedures; and
- The quantity of services used in different regions, in different networks, and by type of patient.

To be as comprehensive as possible, an APCD should collect claims information from all payers in the state—insurance carriers, Medicare, Medicaid, private entities, and individuals. Currently, most state APCDs collect information from commercial carriers, third-party administrators, and Medicaid (if data are available). Three states—**Maine**, **Maryland**, and **Minnesota**—include Medicare data from the Centers for Medicare & Medicaid Services (CMS) and most other APCD states are endeavoring to include this data in their systems.

As of September 2010, 13 states had established APCDs and all but one of them had enacted laws to implement comprehensive reporting requirements.⁵ Because the data are generated automatically for every medical encounter in a standardized format, it can be relatively inexpensive for plans to provide this information if the state’s reporting format is similar to the plan’s format.

The start-up costs to create an APCD and collect the data appear to be around \$1 million, but states also must provide annual resources to analyze the data through fees or other means. The following table shows how much states have spent to create APCDs to date:

State	APCD Costs ⁶
Kansas	\$1.3 million per year
Maine	\$4 million–\$5 million since 2002
Maryland	\$1 million per year
Massachusetts	\$1 million
New Hampshire	\$3 million since 2005
Oregon	\$700,000 (over two years)
Tennessee	\$500,000 per year
Utah	\$800,000 per year
Washington	\$1.5 million (total investment)
West Virginia	\$200,000 per year
Wisconsin	\$4 million (total investment)

It may be a small price to pay, however, to obtain a better picture of what drives health care spending in a state. For example, the **Oregon** Office of Health Policy and Research estimated an initial investment of about \$1 million to establish and run an APCD, but suggested that this cost was relatively small in comparison to the \$20 billion spent on health care in the state each year.⁷

The most effective APCDs are established through legislation that provides authority to enforce its provisions, such as penalties for failing to report data. Typically, APCDs require reporting only by payers above a certain market share or total annual premiums.

A challenge moving forward is to standardize the type and format of data collected from all payers across all states. Underway now are efforts involving the National Association of Health Data Organizations (NAHDO), the All-Payer Claims Data Council (APCDC), health plans, and other stakeholders to develop consistent rules on data reporting and specifications across states. The NGA Center, which is helping move this process forward, this year will issue a draft interim report on how states can implement APCDs that are consistent across states. A standardized framework for APCDs will allow comparisons of prices with other states, permit the sharing of applications to analyze the data, and allow health plans that operate in multiple states to comply with one set of standards. Standardization also will make it easier for states to create new APCDs by eliminating the need to renegotiate new requirements and formats with the insurance industry.

What Are All-Payer Claims Databases?

“Databases created by state mandate that typically include data derived from medical claims, pharmacy claims, eligibility files, provider files, and dental claims from private and public payers. In states without a legislative mandate, there may be voluntary reporting of these data.”

—As defined by the National Association of Health Data Organizations and the All-Payer Claims Data Council

Analyze the Data and Publicize Cost and Quality Information

Collecting the data through an APCD is only the first step. To be useful to consumers and policymakers, state resources must be dedicated to analyzing and organizing the data to address state goals.

Although they vary by state, the NGA Center estimates that annual costs associated with supporting APCD activities range from \$500,000 to \$1.3 million. Most states with legislatively mandated APCDs fund database operations through general funds, fees from providers or insurers, or a combination of these sources. Some states also use a portion of Medicaid matching funds to pay start-up costs and operations. Because the costs of submitting the claims in the correct format are incurred by the payers, annual support for the APCD mostly goes to system maintenance and data analysis.

Through analysis, the data can provide information on the following items:

- Which provider networks and hospitals have the highest payments for certain services;
- Which providers meet safety and quality guidelines;
- What are the utilization rates for certain services in provider groups and hospitals; and
- Which hospitals have the highest readmissions for certain treatments.

A fully functioning APCD can become a critical tool to understand and benchmark health care costs and utilization in the states and provide greater public transparency on prices and a limited set of quality measures. For example, the **Maine** and **New Hampshire** APCDs give consumers the ability to compare the cost of services for particular procedures across provider networks. **Maryland** has used the data to analyze cost trends for health care services and to inform the Health Services Cost Review Commission, which sets hospital rates for all payers in the state

(Maryland is the only state to do so). New Hampshire has used its APCD to study carrier discount arrangements with providers.

Despite these examples, APCDs are still in their infancy and state efforts to provide useful price comparisons are limited and varied. A number of states do not even post price comparisons; the few that do require a committed and savvy consumer to navigate through the information. Current transparency efforts need to be vastly improved to make a difference in how consumers choose providers.

Establish a Statewide Cost Growth Goal with Stakeholders

Governors should bring the major plans, private payers, hospitals, and provider groups together to establish a statewide voluntary cost containment goal for health care. The goal should be one that the public can understand and relate to, such as holding health care expenditure growth to no more than the rate of inflation or a percent of the annual growth rate of the state economy (the gross state product, or GSP).

Any chosen goal should be achievable but ambitious. Health care costs have been rising twice as fast as the rate of inflation over the last three years, and so it may take three to five years to bring health care spending in line with general inflation. Although challenging, this goal is one that most people can understand and want to reach because they know the state fiscal position and business climate would significantly improve.

Recently, **Washington** Governor Christine Gregoire proposed holding the annual growth rate of health care spending in the state to between 4 percent and 5 percent by 2014, which would reduce total spending by \$26 billion over 10 years. In a similar vein, the National Commission on Fiscal Responsibility and Reform recently proposed holding total federal health care expenditures to a cost-growth target of GDP plus 1 percent after 2020, and reviewing such costs every two years.

Encourage Consumers to Purchase Value

An effective cost-control strategy must encourage consumers to opt for value when selecting health care services, just as they do when they buy a car or a computer. However, this is very difficult, chiefly because the majority of expenses (85 percent on average) are borne by third parties (the insurance plan) and not the user, and consumers are given little information and few financial incentives to select care on the basis of value.

Clearly, good data on cost and quality are a critical first step. For some consumers, the information alone may drive them to choose the best value provider (i.e., the one with the lowest cost) among those of equal quality. More often than not, however, consumers will choose the highest cost provider within a similar quality rating band as long as the payments are covered by insurance and they are not penalized by their choice. For this reason, it is important to give consumers a financial incentive to choose value.

Consumers today spend roughly 15 percent of their out-of-pocket costs on health care, down sharply from the average of 47 percent spent in 1960.⁸ While low out-of-pocket costs make it easier to access health care, they fail to discourage spending on unnecessary services or providers that charge more than others who deliver the same quality care. In fact, in the absence of any financial penalty, most consumers will assume that higher costs are a proxy for higher quality, even though no such correlation exists. To change this behavior, plans need to include incentives—either positive or negative—to steer consumers to purchase services based on value.

Some plans are beginning to do just that by:

- Designing benefits so that consumers are encouraged to use primary and preventive care (e.g., by eliminating co-pays for primary care services and offering rebates for certain preventive care);
- Establishing value-based benefits that minimize cost sharing for proven, cost-effective services while increasing cost sharing for less effective or optional services (*see box*); and
- Creating tiered providers and structuring cost-sharing (co-pays and co-insurance) that guide enrollees to the most efficient (low-cost, high-quality) provider and/or that exclude low-value providers from the network altogether.

These plans also typically use primary care physicians as care coordinators (the “Medical Home” concept). Consumers are encouraged to use primary care through lower co-pays or incur penalties for failing to consult their primary care provider before engaging a specialist. Care coordination helps avoid the use of unnecessary services and can guide the patient to the most effective care needed for a particular ailment.

Work With Plans and Providers on Systemwide Improvements

In addition to encouraging the consumer to choose value, states also can work with their health plans and providers to focus on common quality improvements that reduce costs throughout the system. As with other initiatives, APCD data can provide key information to set baselines and measure progress toward a goal. Practices that can and should be targeted include:

- **Avoidable readmissions.** The estimated cost of unnecessary hospital readmissions in 2004 accounted for \$17.4 billion of the \$102.6 billion in total hospital payments made by Medicare that same year, according to an article in the *New England Journal of Medicine*. States can take practical steps to measure and report avoidable readmissions and create incentives for plans and/or providers to prevent avoidable readmissions.

Oregon’s Tiered Benefit Program

The Oregon Health Leadership Council developed a three-tiered benefit system that encourages consumers to adhere to high-value treatments over low-value health care services:

- Level-one benefits, provided at no charge to the individual, include generic medications and labs and other ancillary services for individuals with chronic conditions.
- Level two, which carries a standard deductible and co-pay/co-insurance, encompasses the majority of benefits.
- Level-three benefits require double the standard deductible and co-insurance and include overused or low-value services such as knee and hip replacement, spine surgery for pain, and unnecessary emergency room visits (such costs are waived if individuals are admitted).

The Public Employee Benefits Board is offering the plan to state employees. In addition, several insurers and large employers are offering or will begin to offer the benefit product soon. The Oregon Health Leadership Council, comprised of health plans, hospitals, and physicians, works to create solutions that maximize efficiencies throughout the health care system.

- **Hospital-acquired infections (HAIs).** HAIs exact a heavy toll on life and costs. Working with their plans and provider networks, states can target these events through a range of activities. In addition, federal law now requires Medicare and Medicaid to penalize hospitals with high HAI rates.
- **Avoidable ER visits.** ER use due to lack of appropriate primary care can be reduced through a number of strategies, including holding alternative office hours, expanding the scope of practice for nurse practitioners, and making improvements in care coordination. By working with their plans and providers, states can help reduce this type of utilization.
- **Overused and high-cost services and procedures.** States can work with their plans and providers to discourage unnecessary use of high-cost services such as lower back surgery (often no more effective than physical therapy and time); advanced imaging (often providing redundant information to less expensive imaging); and many hysterectomies. Incentive programs, provider education, and reporting efforts can be useful supplements to these efforts.

States also can work with their providers and plans to ensure that electronic health records are deployed and connected through an electronic information exchange and that the data is used (with privacy safeguards) to analyze the quality of clinical care in the state. Over time, as APCD data become more integrated with clinical data from electronic health records, more quality improvement initiatives that lower costs can be identified and acted on.

Conduct Provider Price Reviews and Negotiate Payment Reforms

A crucial component of an effective cost-control strategy is regular analysis of APCD data to identify major expenditures that are preventing the state from reaching its cost-containment goal. Such reviews help determine price and quality trends and identify hospitals or provider groups that appear out of line with their peers that deliver services of similar quality. The reviews can be structured to assess the following factors:

- High-cost outliers, both in terms of certain services as well as providers;
- Major price disparities for the same procedures across regions;
- High utilization of certain expensive services, such as imaging; and
- Major disparities in quality.

If the reviews find wide variations in charges that are not explained by quality differences, states can work with the appropriate plans and their providers to address the issues. States also can share the information with plans, businesses, and the public to create pressure to bring costs in line. Finally, states and payers can ask providers and plans to implement new payment models to curb cost growth of certain services or episodes of care. The following types of payment reforms should be considered:

- **Bundling.** Bundling involves paying a combined fee for an entire episode of care. Plans, working with providers, can identify procedures suitable for bundling. In one Medicare demonstration, a single payment rate for a coronary bypass procedure, for both physicians and inpatient services, saved more than 15 percent over the normal fee-for-service arrangement.
- **Capitated rates for managed care organizations.** Capitated rates can be used to suppress cost growth and encourage efficiency in managed care settings. In fact, this is an

approach suggested for accountable care organizations (ACOs), which provide all services to their enrollees using a coordinated care model, often in a closed, integrated system. Capitated rate payments encourage ACOs to invest in efficiency across the organization and to use coordinated care to manage individual patient costs.

- **Pay for performance.** Under a pay-for-performance (P4P) model, providers are compensated for delivering higher quality, cost-effective care. This approach can be used with fee-for-service or capitated models. Providers that deliver superior service are rewarded with additional compensation, and poor performers can be penalized. These models tend to work best when consumers also are given incentives to choose high-quality providers.

The success of these approaches depends on the cooperation of the stakeholders, whether enough large payers are involved to exert market leverage, and—to some extent—the willingness of the state to consider other actions, such as limiting “certificates of need” for new equipment or hospital expansions or disallowing certain provider rates if other measures fail to hold down costs.

States can consider benchmarking rates on certain procedures in hospitals and doctors’ offices. **Maryland** has done this for more than two decades for its hospitals by setting state-approved rates for particular episodes of care. All payers in the state are then charged the same rate, which eliminates charge disparities across plans. The Maryland Health Services Cost Review Commission (HSCRC), which has broad powers to set hospital rates, also has negotiated a waiver to require Medicare to pay state-approved rates. This cost-control system includes some bundled payments and pay-for-performance incentives for certain clinical categories.

The Maryland hospital payment system—established in 1971—has a long track record of success in controlling costs. In 1976, the cost of a Maryland hospital admission was 26 percent above the national average. In 2007, the average hospital cost per case was 2 percent *below* the national average, a level not exceeded since 1980.⁹

State review of hospital rates is not new. As late as 1980, More than 30 states employed some form of hospital rate-setting. However, as a result of several factors—including conflicts with the growth of managed care in the 1980s—rate-setting fell into disfavor so that only Maryland and West Virginia set rates today¹⁰.

Using State-Run Exchanges in a Cost-Control Strategy

In addition to implementing a statewide strategy on cost containment, states can instill complementary cost-control principles in their health insurance exchanges (if they decide to run them). This approach has the best chance of success in areas with a big insurance market, a diverse hospital and provider network, and multiple insurance carriers. It also requires the ability for the exchange to include benefit designs that encourage consumers to choose high-quality, low-cost services.

State insurance exchanges provide a centralized marketplace where large numbers of individuals and small businesses can find and purchase the most suitable health care plans from among several options. As mentioned previously, RAND estimates that approximately 68 million people will enroll in exchange-based coverage, a number that could grow to 139 million if the exchanges are opened up to businesses with more than 100 workers.

Exchanges will be successful only if they keep insurance costs affordable. The individuals and businesses that purchase through the exchange will be highly price-sensitive because they will be paying at least a portion of the plan premiums. Insurance plans will want to offer affordable policies, but they may face limitations if providers are able to negotiate high prices. For these reasons, state strategies that hold down costs *at the provider level* through consumer incentives to choose value or other means should be pursued. If that is accomplished, competition among plans in the exchange should keep premiums low, and attract a large market share of purchasers.

Exchanges offer several opportunities for states to drive cost containment at the provider level:

- First, states can use the exchange web portal to post comprehensive information on cost and quality of all participating providers, hospitals, and plans themselves (collected and analyzed using the state's APCD).
- Second, states can require plans and providers that participate in the exchange to pursue systemwide quality improvements that save money for all payers.
- Third, states can encourage health plans to create incentives (through benefit design) for consumers to seek low-cost, high-quality providers.
- Finally, states can use their authority to certify plans to review the rates of participating providers and hospitals and determine if market distortions or price outliers exist. States then can decide how to address excessive costs in hospitals or provider networks using several options, including negotiating payment reforms or even instituting targeted price controls.

Posting Cost and Quality information

State exchanges could significantly advance transparency by serving as a centralized information source on the costs and quality of all participating plans and providers. The exchange web portal could aid consumers by publishing easy-to-understand information on provider cost and quality all in one place and in one format. Prices could be calculated to represent a total cost for episodes of care rather than simply posting fees for specific services. Cost ratings also could be adjusted so that providers who serve patients with chronic or more complex health needs are not adversely affected. The information could be used in both deciding what plan to purchase and, once purchased, in choosing a provider for a particular service.

The exchange also could provide information on overall plan quality and value. States even could create a reference or seal of approval for high-quality, low-cost plans—or allow only high-value plans into exchanges to further influence consumer choice.

Work with Stakeholders to Pursue Systemwide Quality Improvements

The exchange provides a natural forum to work with plans and providers on systemwide quality improvements. As a condition for their plans to be certified (and allowed to be sold on the exchange) the carriers (with their provider networks) all could agree to pursue certain key improvements that lower costs for all. These include targeting some of the areas mentioned earlier, such as avoidable readmissions, hospital-acquired infections, avoidable ER visits, and overused and high-cost services and procedures. Because all plans would pursue the same measures, neither the plans nor their provider networks would face competitive disadvantages.

As experience grows in pursuing systemwide improvements, exchange plans could agree to pursue additional measures over time. This is how many hospital groups and associations achieve quality improvements today.

Allow Benefit Design to Encourage Value Purchasing

Exchange managers could encourage or even require that certified plans contain mechanisms to spur value purchasing by the consumer, using the information posted on the exchange. This would likely entail letting plans reward consumers that choose low-cost, high-quality providers. Conversely, it also might mean allowing plans to penalize consumers that choose higher cost providers if lower cost providers of equal quality are available. The likely mechanism for administering these incentives would be adjustments to co-pay and co-insurance rates.

Encouraging consumers to consider the cost and quality of health care services would stimulate competition among all providers in the exchange, and help curb market leverage of particular provider networks or hospitals. Even within plan networks, it would encourage shopping for providers based on value, which some plans offer now. However, the exchange also would give consumers information on the value of provider networks outside their plan and could influence what insurance they purchase in the future.

Conduct Provider Cost Reviews

States can use participation in the exchange as an opportunity to conduct price reviews of the providers contained in plan contracts. States could set benchmark rates for providers that wish to participate in the exchange and hold plans and providers accountable for meeting a statewide goal for cost containment. Plans or provider networks that exceed the benchmarks or do not meet the goal for one or more years could be denied access to the exchange and its market.

Regulation of provider rates may seem like an extreme response, but the fact that it has been used before may bring stakeholders to the table to negotiate other approaches for solving the problem.

Conclusion

The relentless rise of health care spending in the U.S. strains federal and state government budgets and threatens the economic competitiveness of the nation. No easy solutions are on the horizon, but a concerted effort among states, providers, businesses, and consumers may be able to bring about change. To be successful, states will need to lead these efforts and conduct the following activities:

- Collect and analyze information on the costs of health care charged to all payers in the state;
- Convene payers, providers, and other stakeholders to establish a statewide goal for cost control;
- Provide incentives to drive consumers (patients) to choose the highest quality, lowest cost option;
- Require plans and providers to implement a basic set of systemwide improvements that lowers costs for everyone; and

- Periodically review the prices of health care services and negotiate payment reforms with plans and providers to ensure that overall costs meet the state goal.

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³ Gerard Anderson and David Squires, “Measuring the U.S. Health Care System: A Cross-National Comparison,” (New York, NY: The Commonwealth Fund, June 2010).

⁴ Robert A. Berenson, Paul B. Ginsburg, and Nicole Kemper, “Unchecked Provider Clout in California Foreshadows Challenges to Health Reform,” *Health Affairs* 29, no. 4, April 2010.

⁵ Dennis Love et al., “All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency,” (New York, NY: The Commonwealth Fund, September 2010).

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⁸ McKinsey & Company, “Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More,” December 2008,

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⁹ Robert Murray, “Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience,” *Health Affairs* 28, no. 5, September/October 2009.

¹⁰ J. E McDonough, “Tracking the Demise of State Hospital Rate Setting,” *Health Affairs* 16, no. 1 (1997).