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POLICY & ACTION FROM CONSUMER REPORTS

Addressing Rising Health Care Costs

A Resource Guide for Consumer Advocates

November 10-12, 2013

The problem is that no one in charge seems willing to acknowledge that getting a handle on cost growth will also involve uncomfortable trade-offs.

Peter Neumann, NEJM, February 16, 2012

Table of Contents

CHAPTER 1: INTRODUCTION	1
Goals and Purpose of Resource Guide.....	1
Acknowledgements	2
Welcome from Consumers Union and Robert Wood Johnson Foundation	3
Are Rising Health Care Costs An Urgent Problem?.....	5
CHAPTER 2: HEALTH CARE COSTS 101	7
Ten Things You Need to Know	7
CHAPTER 3: HEALTH CARE COST DRIVERS	15
Introduction	15
Guide to the Evidence	18
<i>Spending Per Procedure or Product</i>	18
<i>Units of Service Consumed</i>	20
<i>Advances in Medical Treatment</i>	22
<i>Provider Market Power</i>	24
<i>Lack of Price Transparency</i>	25
<i>Population Health Status: Smoking, Obesity, and Chronic Disease</i>	26
<i>End-of-Life Care</i>	29
<i>Aging of the Population</i>	30
<i>Malpractice Spending and Defensive Medicine</i>	31
<i>Mandated Benefits</i>	31
<i>Administrative Costs</i>	33
<i>Direct-to-Consumer Advertising (Drugs)</i>	35
<i>Fraud and Abuse</i>	36
CHAPTER 4: COST CONTAINMENT STRATEGIES	38
Introduction and An Overarching Framework	38

CHAPTER 5: POLICY STRATEGIES41

Guide to the Evidence 41

Strategies that Target Consumers' Purchase of Health Care or Health Products . . . 41

Strategies that Target Consumers' Purchase of Health Insurance 51

Strategies that Target Providers of Care 53

Strategies that Target Providers of Products 75

Strategies that Target Insurers' Costs 76

Strategies that Improve Our Understanding of Spending Flows 80

**APPENDIX A: HOW DOES THE AFFORDABLE CARE ACT
ADDRESS COSTS?83**

APPENDIX B: HOW WILL PROGRESS BE MEASURED?89

APPENDIX C: GLOSSARY OF COST CONTAINMENT TERMS93

Chapter 1

Introduction

Goals and Purpose of Resource Guide	1
Acknowledgements	2
Welcome from Consumers Union and Robert Wood Johnson Foundation	3
Are Rising Health Care Costs An Urgent Problem?	5



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Introduction

Goals and Purpose of Resource Guide

On November 11 and 12, Consumers Union and the Robert Wood Johnson Foundation convened a working meeting for consumer advocates on the topic, “Addressing Rising Health Care Costs.”

The Resource Guide is intended to provide a road map to some of the key concepts and research findings that may help advocates work on this important policy issue. This guide is not meant to be exhaustive but is designed to serve as a starting point and a means of facilitating the conversation around health care costs.

Our focus in this document is identifying the major factors contributing to systemic increases in health care costs. While critically important, we aren’t confining ourselves to the more narrowly defined issue of Medicare or Medicaid budgets. Also important but not included is a discussion of the social determinants of population health and public health strategies.

This Guide is primarily trying to make sense of what the evidence says. The accumulated evidence on health care cost drivers and strategies is massive yet, at the same time, incomplete. Because the path forward is not clear cut, there are many views about how we should proceed. We want you in the conversation, and we hope this Guide will help you do that.

Introduction

Acknowledgements

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She had significant research assistance from Lisa Swirsky, Carolyn Kraemer, Sarah Melecki, Alex Gold and Rebecca Elwork. She is grateful for early review by Cathy Levine, Suzanne Delbanco, Bob Galvin, Linda Blumberg, Anne Weiss, Betsy Imholz, and Lisa McGiffert. She thanks David Adler, DeAnn Friedholm, and Stephen Finan for their review of the final draft.

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Introduction

Welcome from Consumers Union and Robert Wood Johnson Foundation

To our advocate attendees,

The health care system touches all of us. As patients, taxpayers, employers, employees, or beneficiaries, we all have a stake in how our health care system works.

In 2011, the United States spent \$2.7 trillion on health care, representing roughly 18 percent of gross domestic product (GDP). The Centers for Medicare & Medicaid Services (CMS) estimate that American health spending will reach nearly \$5 trillion, or 20 percent of GDP, by 2021. Yet for all those trillions of dollars, we are surprisingly uninformed about how much things cost and why. In fact, the very basic question about how much something costs is often unanswerable. What's more, we are often paying for things that don't work or may do harm. Quite simply, we can and must do better.

Most consumers on the ground may not realize the direct impact of rising cost of health care: Governments make tradeoffs to pay for Medicare and Medicaid, employers limit salary increases to pay for health coverage, and families across the country make tough choices every day about getting the care they need for themselves and loved ones.

Too many of the conversations about controlling health care costs take place without involving health care consumers, and that is a problem. At the end of the day, the health care system is meant to help the people who need it; therefore conversations about how to reform it must more fully include this primary audience. More importantly, any effort to control costs will only work if it makes sense for the people who use the system.

To bridge this gap among research, policy, and consumers, Consumers Union and the Robert Wood Johnson Foundation have organized this groundbreaking meeting for consumer advocates on the topic, "Addressing Rising Health Care Costs."

For years, most consumer advocates have shied away from this hot button topic, but that is no longer an option. In light of the predictable impact of rising costs on access to coverage and health, not to mention other social programs important to consumers, it is time to take on this issue with the same energy advocates have displayed on questions of coverage, access, and quality.

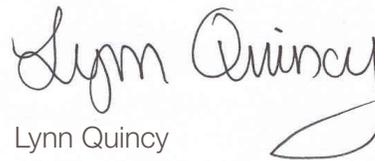
This meeting is an opportunity for us to hear from you about this important issue. Our goals for this meeting are simple:

1. Provide you this overarching framework and guide to the evidence. The field can be overwhelming and full of jargon. It's health care after all.
2. Create a new network that allows you to work more effectively in this policy area. Some of you have been deeply engaged with this issue and some of you are new to the topic. All of you were asked to come because you and your organizations may be able to contribute much to the coming debates on this issue.

We hope you find this meeting helpful to your work, and we expect it is only the beginning of a longer journey to make health care ever more accessible and affordable for everyone.



David Adler
Program Officer
Robert Wood Johnson Foundation



Lynn Quincy
Senior Policy Analyst
Consumers Union

Introduction

Are Rising Health Care Costs An Urgent Problem?

Yes. Health care spending consumes more than one of every six dollars we earn.

Growth in health care costs is wiping out almost all income growth. RAND sponsored an analysis that compared a family's health care cost burden in 1999 with that incurred in 2009.¹ The take-away message: Although family income grew throughout the decade, the financial benefits that the family might have realized were largely consumed by health care cost growth, leaving them with only \$95 more per month than in 1999.² Another study shows that the cost of health care has resulted in relatively flat real wages for 30 years.³

Lower income families are hit hardest by this phenomenon.⁴ If they are uninsured or buy insurance on their own, they directly pay these high health care costs, and go without when they can't afford it. If they have employer coverage, health premium increases (being a fixed expense) absorb a larger share of the low-income employee's compensation compared to a high-income employee. In one study, workers in the bottom-income group who are insured had a ratio of employer-paid premiums to household income of 20 percent.⁵ That compares with 3.3 percent for the top-income group. Hence, rising health care costs contributes to income inequality around the country.

Rising health care costs are an issue for middle-class families as well. A fifth of middle-income people under 65 report spending more than 10 percent of their incomes on health care expenses—up significantly from 2000.⁶ And as we all know, even families with insurance find they struggle to pay their share of the medical bills.⁷

¹ RAND, *How Does Growth in Health Care Costs Affect the American Family?*, 2011. http://www.rand.org/content/dam/rand/pubs/research_briefs/2011/RAND_RB9605.pdf OR David I. Auerbach and Arthur L. Kellermann. A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains For An Average US Family, *Health Affairs*, September 2011 30(9) 1630-1636. <http://content.healthaffairs.org/content/30/9/1630.full>

² Not adjusted for inflation.

³ Emanuel EJ, Fuchs VR. Who Really Pays for Health Care?: The Myth of "Shared Responsibility," *JAM*, 2008;299(9):1057-1059. doi:10.1001/jama.299.9.1057. <http://jama.ama-assn.org/cgi/content/full/299/9/1057>

⁴ Ketsche, PE; Adams, K; Wallace, S; Kannan, VD; Kannan, H. Lower-Income Families Pay a Higher Share of Income toward National Health Care Spending Than Higher-Income Families Do , *Health Affairs*, September 2011 30(9): 1637-1646; <http://content.healthaffairs.org/content/30/9/1637.full>

⁵ Auguste, Byron G.; Laboissière, Martha; and Lenny T. Mendonca. "How health care costs contribute to income disparity in the United States." McKinsey. http://www.mckinsey.com/insights/economic_studies/how_health_care_costs_contribute_to_income_disparity_in_the_us

⁶ Harriet Komisar. *The Effects of Rising Health Care Costs on Middle-Class Economic Security*, AARP's Public Policy Institute, January 2013.

⁷ Sara R. Collins, Ph.D., Ruth Robertson, M.Sc., Tracy Garber, M.P.H., and Michelle M. Doty, Ph.D. *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act*, April 26, 2013

Rising health care spending forces painful tradeoffs within household budgets but also in state and federal budgets. These are tradeoffs we'd rather avoid, like reducing spending on education or charging Medicare beneficiaries more for care.⁸

This economic pain is not necessary. As will be explored in more detail below, other developed countries provide health care for their citizens at a significantly lower cost.⁹

⁸ Triangle of Painful Choices: Policy Options for a Balanced Budget in 2035. (2012). *Altarum Center for Sustainable Health Spending (as cited in The Incidental Economist 2012)*. <http://theincidentaleconomist.com/wordpress/wp-content/uploads/2012/08/triangle-painful.png>

⁹ One claim about rising health care costs where we don't have consensus is whether rising costs undermine the ability of US businesses to compete abroad. See Semenova, Alla and Kelton, Stephanie. (2008). Are Rising Health Care Costs Reducing U.S. Global Competitiveness? *CFEPS*. <http://www.cfeps.org/health/chapters/pdf/Rising%20costs%20and%20US%20competitiveness.pdf>; Nichols, Dr. Len M. and Axen, Sarah. (2008). Employer Health Costs in a Global Economy: A Competitive Disadvantage for U.S. Firms. *The New America Foundation*. <http://www.newamerica.net/files/EMPLOYER%20HEALTH%20COSTS%20IN%20A%20GLOBAL%20ECONOMY.pdf>

Chapter 2

Health Care Costs 101



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Ten Things You Need to Know

(**Bolded blue terms** are included in our Glossary Appendix)

1. **Spending per capita or spending as a percentage of GDP are much better measures than overall health care spending.**

Although the straight numbers on American health care spending are impressively large—we spent \$2,700,000,000,000 (\$2.7 trillion) on healthcare in 2011—they provide little real information without more context. The important questions about health care costs are about whether we spend the right amount per person or whether an appropriate amount of our economy is devoted to health care.

The two most common ways of measuring health care costs are:

- **Spending per capita**—the amount of money spent per person in a year (\$8,187 in 2011).¹⁰ This automatically adjusts for the fact that some health care spending is simply due to the fact that our population is growing larger.
- **Spending as a percentage of GDP**—the amount of money spent as a portion of total spending on all goods and services in one year (17.9 percent in 2011).¹¹ This figure is the “opportunity cost” of health care spending, as any resources expended on health care cannot be used in some other way. It automatically adjusts for the fact that, all other things being equal, we would expect to spend more on health care as our nation’s economy grows. But health care spending as a share of GDP has been rising – and that’s a concern.

2. **Premiums are not a good substitute for more complete measures of health care spending trend.**

When the United States Department of Health and Human Services (HHS) measures our health care spending over time, they include all types of spending: payments to providers for care, consumers’ out-of-pocket costs for care, insurers’ administrative costs and more. And they do it for all Americans.

¹⁰ National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960-2011. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf>

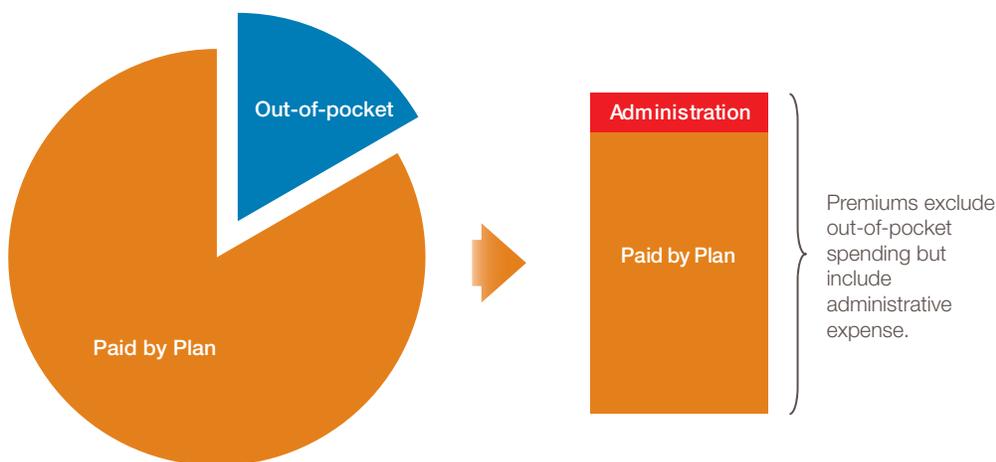
¹¹ National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960-2011. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf>

But not every estimate of health care spending trend fully reflects all our spending, the most common culprit being premium trend. While useful to know,¹² premiums provide only a partial view of what is happening with spending:

- **Premiums** only account for the portion of medical expenses that are reimbursed by health plans, plus the insurer's administrative expense and profit.
- Premiums don't include the spending that an insured person pays out-of-pocket when they go to the doctor or hospital in form of co-pays, co-insurance and deductibles.
- Premiums don't include consumer spending for health care that isn't covered by their plan.
- Premiums don't reflect the out-of-pocket costs of people with no insurance and they don't reflect trends experienced by the publicly insured population.
- Premium data may not even reflect the overall experience of the privately insured population as most data comes from large employers, often omitting the trends experienced by very small employers and individuals that buy on their own.
- Year-to-year changes in premiums can disguise real spending trends, due to the **underwriting cycle**.

Premium trends will often be reported in the media as the employer surveys that provide this information is much more timely than the National Health Expenditure Data from HHS.

Exhibit A: Premiums Provide Only a Partial View of Spending



¹² One oft cited survey is the well done Kaiser HRET annual survey of employer benefits. 2013 Employer Health Benefits Survey. (April 2013). *Kaiser Family Foundation*. <http://kff.org/private-insurance/report/2013-employer-health-benefits/>

National Health Expenditure Data from HHS are the gold standard for measuring overall health care trends over time.

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>

3. Current levels of spending are secondary to trends over time.

The United States has two problems:

- Our level of spending per person is significantly higher than any other developed country, with no corresponding improvement in outcomes. This persists even if health status and wealth differences are taken into account.¹³
- Our rate of spending growth, also higher than other nations,¹⁴ is eating up an unsustainable share of GDP.

Many health care economists believe that we need to focus on the rate of spending growth.¹⁵ If we lower the level of spending but don't alter the factors that lead to a high rate of growth, we'll eventually have high levels again. In other words, a one-time fix will not put us on a sustainable path. In particular, we would like the growth of health care costs to remain close to the growth rate of GDP.

Few would object to addressing both the level and the rate of growth but failing to focus on growth would be unwise.

4. Worry about the long run, not the short run.

Year-to-year cost trends can hide the larger picture. Particularly if you are looking at premium trend, the **underwriting cycle** can make it hard to interpret year-to-year changes. Furthermore, some interventions that save money in the short run may cost money in the long run, or vice versa.

¹³ McKinsey Global Institute, *Accounting For The Cost Of US Health Care: A New Look At Why Americans Spend More*, December 2008.

¹⁴ Kaiser Family Foundation. Snapshots: Health Care Spending in the United States & Selected OECD Countries, April 12, 2011 <http://kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/> and Chapin White Health Care Spending Growth: How Different Is The United States From The Rest Of The OECD?, *Health Affairs*, January 2007 vol. 26, no. 1 154-161.

¹⁵ Alliance for Health Reform. *High and Rising Costs of Health Care in the U.S.*, 2012 <http://thescanfoundation.org/alliance-health-reform-high-and-rising-costs-health-care-us>

5. Spending and prices are very different things.

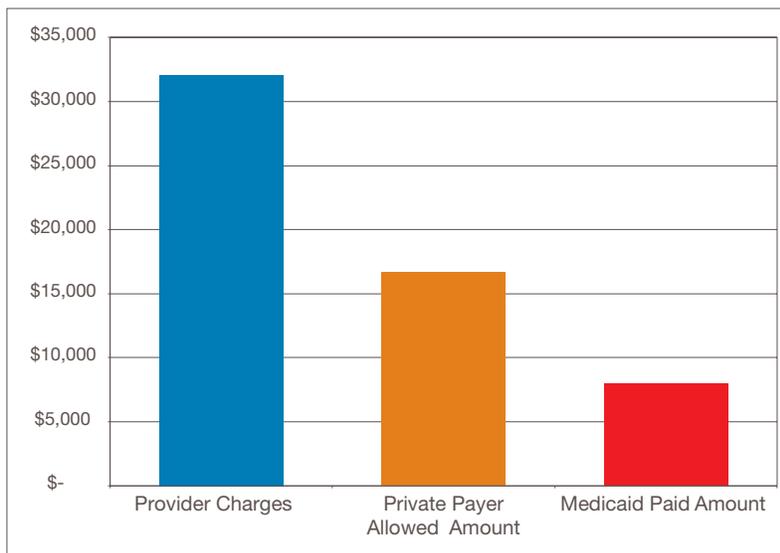
Even with the caveats highlighted above, counting up all of the money spent on health care products and services is a mathematically straightforward affair.

Health care “prices,” on the other hand, are not so straightforward. The quoted price for a product or service may be very different from what we actually pay. Furthermore, even getting a price quote for a hospital procedure is an exercise that would stymie most consumers.¹⁶

Something called the hospital charge master or **charge description master (CDM)** lists the off-the-shelf prices for hospital-provided health care products and services. However, almost nobody actually pays the price listed on the charge master. There is often little relationship between the cost to the hospital and the price listed on the charge master. Instead, the charge master prices are usually considered the opening bid in negotiations between the hospital and payers.

Unfortunately, the true prices that most private insurers pay for various procedures and products are actually shrouded in mystery. These amounts are the result of private negotiations between insurers and providers and the results are usually kept secret. **Medicare** and **Medicaid** payments are set differently, through the use of complicated formulas that adjust for geography, severity of condition, whether the hospital treats an inordinate number of low-income or uninsured individuals, and a variety of other factors.

Exhibit B: Average Maternal Costs, Cesarean Childbirth, 2010



Source: The Cost Of Having A Baby In The United States, Truven Health Analytics, 2013

¹⁶ Jaime A. Rosenthal; Xin Lu, MS; Peter Cram, MD, MBA. Availability of Consumer Prices From US Hospitals for a Common Surgical Procedure, *JAMA Intern Med.* 2013;173(6):427-432.

6. ...and neither price nor spending provide an accurate picture of the underlying cost to provide the service or product.

Health care prices, whatever they may be, have very little to do with the cost of the inputs into the product or service. What's more, we know very little about what these underlying input costs are.

In his recent article "Bitter Pill: Why Medical Bills Are Killing Us," Steven Brill speculates that a dose of a drug called Flebogamma for which a patient is charged \$2,135, cost the hospital \$1,500 to buy from the producer and cost the producer just \$300 to "collect, process, test and ship."¹⁷ But typically the cost to produce and ship a product would be unknowable to the general public or to policymakers. Medical devices and drugs have been singled out as being particularly difficult to unravel.^{18 19}

With little data on what health care *should* cost, it will be hard to know when we've arrived at the "right" level of spending.

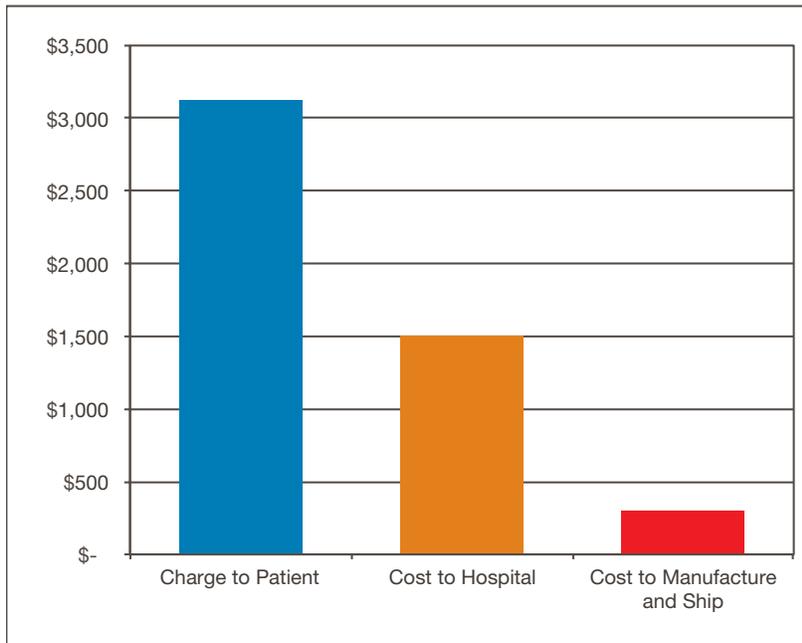
A partial exception is the way Medicare sets prices for how doctors are paid. The **Resource-Based Relative Value Scale** (RBRVS) system sets prices based on the physician's time needed for a procedure and the costs of maintain a practice. By federal law, those values are required to be based on the time and intensity of the procedures. But the process for maintaining these "values" from year to year falls to a committee of the AMA that meets confidentially. This process is not open to public scrutiny and has been criticized as overvaluing some services and not accurately reflecting how doctors practice.²⁰

¹⁷ March 4, 2013 edition of *Time* magazine. See also Elizabeth Rosenthal's three-part series, "Paying Till It Hurts" from the summer of 2013 in *The New York Times*, which examines why three different medical procedures are more expensive in the US than elsewhere.

¹⁸ U.S. Government Accountability Office, *Lack of Price Transparency May Hamper Hospitals' Ability to Be Prudent Purchasers of Implantable Medical Devices*, January 2012, GAO-12-126 <http://www.gao.gov/assets/590/587688.pdf>; Mark V. Pauly and Lawton R. Burns, Price Transparency For Medical Devices, Health Affairs, Nov 2008 <http://content.healthaffairs.org/content/27/6/1544.full>. And for fun, see: http://www.newyorker.com/archive/2004/10/25/041025crat_atlarge.

¹⁹ A 2002 study found that the thirteen largest U.S. pharmaceutical companies allocated their sales revenue as follows: cost of goods sold, 25.3 percent; selling and administration, 32.8 percent; R&D, 14 percent; taxes, 7.3 percent; and net after-tax profits, 20.6 percent. U.E. Reinhardt, "An Information Infrastructure for the Pharmaceutical Market," *Health Affairs* 23, no. 1 (2004).

²⁰ Haley Sweetland Edwards, The shadowy cartel of doctors that controls Medicare, *Washington Monthly*, July/August 2013. http://www.washingtonmonthly.com/magazine/july_august_2013/features/special_deal045641.php.

Exhibit C: “Cost” of a Dose of Drug Flebogamma

Source: Steven Brill, “Bitter Pill: Why Medical Bills Are Killing Us,” *Time*, March 4, 2013

7. Remember to account for value.

Value in health care can be increased by improving quality or reducing costs (or both at the same time), and it is essential to consider value in any conversation about health care cost containment. When costs decrease but quality also decreases, we’ve lost value and we need to reconsider the cost-reduction strategy.

In addition, we need to account for what we get when spending increases over time. Some spending yields extraordinary benefits in terms of longer life, improved quality of life, reduced suffering, etc. When improved health results in a longer life, this may increase costs because the person has more years to consume health care.²¹ But this may still be the right thing to do because there is value added by the increased spending.

The bottom line is we don’t want to examine cost-reducing strategies without accounting for the impact on consumers’ access to health care and quality of care.

²¹ The impact of health changes on savings from preventing disease and cost of living longer was examined in the US Medicare population between 1998 and 2004. The analysis showed that life extension costs cancel out savings from reducing morbidity. Gandjour A. Health care expenditures from living longer-how much do they matter. *International Journal of Health Planning and Management*, 2013 <http://www.ncbi.nlm.nih.gov/pubmed/23418021>.

8. Measurement is difficult.

Unfortunately, our tools for measuring costs, while controlling for quality, are pretty poor. It is difficult to measure the net savings of an intervention over the medium and long run while accounting for quality. Strong quality measures exist for some health conditions, but not others. For more on this, see the Appendix: How Will Progress Be Measured?

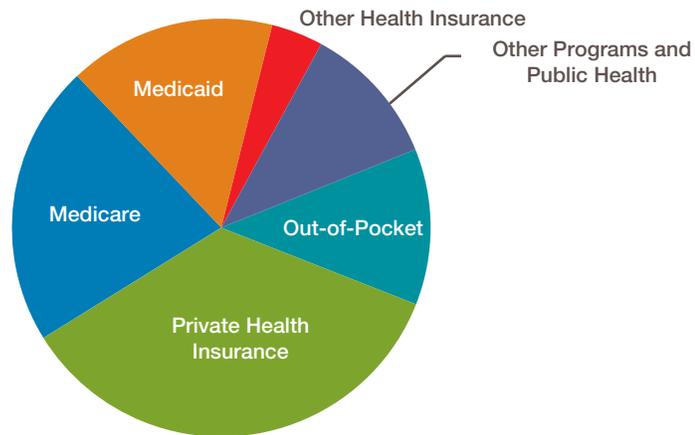
9. Some interventions just shift costs.

Some strategies for addressing health care costs are really cost-shifting, not cost-reducing. Strategies that merely increase the share of costs paid by consumers may reduce costs for one party, but they raise them for another—i.e., the total expenditure remains essentially the same. Similarly, strategies that simply pay providers less may temporarily address government budget issues, but not the underlying problem of rising health care costs. All proposed strategies should be critiqued to ensure they are not merely cost-shifting.

10. Become familiar with how overall spending is distributed among market segments.

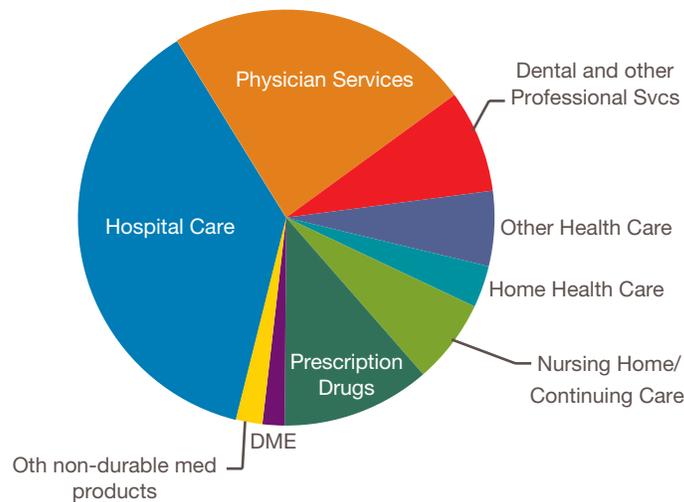
A lot of evidence is derived from just a segment of the health care sector, for example, studies based on Medicare claims data or interventions that target just hospital-delivered care. Become familiar with these market shares in order to have a context for the size of any projected savings.

Exhibit D: Spending Shares by Payer



Source: 2011 Data from National Health Expenditure Accounts, CMS Actuary

Exhibit E: Spending Shares by Type of Health Care



Source: 2011 Data from National Health Expenditure Accounts, CMS Actuary

Chapter 3

Health Care Cost Drivers

Introduction	15
Guide to the Evidence	18
Spending Per Procedure or Product	18
Units of Service Consumed	20
Advances in Medical Treatment	22
Provider Market Power	24
Lack of Price Transparency	25
Population Health Status: Smoking, Obesity, and Chronic Disease	26
<i>Smoking</i>	26
<i>Obesity</i>	27
<i>Prevalence of Chronic Disease</i>	28
End-of-Life Care	29
Aging of the Population	30
Malpractice Spending and Defensive Medicine	31
Mandated Benefits	31
Administrative Costs	33
Direct to Consumer Advertising (Drugs)	35
Fraud and Abuse	36



Health Care Cost Drivers

Introduction

In theory, if we had a solid understanding of what’s driving spiraling health care costs, we would know which policy interventions are most likely to bring the problem under control.

Unfortunately, there is no single way to look at health care cost drivers. Cost drivers can be approached from many directions, adding confusion to any discussion about rising costs.

Exhibit F: Health Care Cost Drivers Come In Different Flavors

Type of Cost Driver	Description
Segment Drivers	Highlighting segments of the health care industry where spending has been increasing, like outpatient care ²²
Demographic Drivers	Measures of the population, society, and general economy that appear to result in more spending on health care, like the aging of the population or increases in per capita income.
Health Condition Drivers	Measures of illness or other health conditions that have changed over time in excess of general demographic trends, like the increasing prevalence of diabetes
Line Item Drivers	Increasing amounts actually being spent by health care providers in their operating budgets, like increased spending on new medical technology
Policy Drivers	Public policy and health system practice can contribute to the cost of health care, like allowing hospital consolidations that result in near monopolies

Adapted from Doug Hall, Will the Real “Cost Drivers” Please Stand Up? The Problem of Identification, November 2004.

²² A “segment” discussion can be viewed in this report: <http://nihcm.org/images/stories/NIHCM-CostBrief-Email.pdf>

Because the problem can be approached from different directions, multiple explanations for rising health care costs can be true simultaneously. For example, it is perfectly correct to say that rising costs are associated with increasing rates of obesity (condition driver), higher spending on new treatments (line item), and hospital market power (policy), but these explanations could all be referring to the same spending.

We chose to break it down this way:

- Price vs. volume—which is more important?
- Within each source of growth, what are the important and not-so-important causes?

As the next Chapter shows, the key take-away is that rising unit prices are driving our health care spending growth, and increasing utilization is a less important factor.²³ This distinction is important. If we adopt policy strategies that only address the utilization of services, we will still have unsustainable spending.

But “rising unit prices” isn’t specific enough to suggest the appropriate intervention. For both types of spending growth, it is important to look at the underlying drivers. While not all of the frequently cited drivers fit neatly into one category or the other (like fraud and abuse), we nonetheless attempt to categorize these drivers into “rising prices” or “increasing units consumed” (Exhibit G).

As the Exhibit shows, a “driver” can be a large portion of our spending, yet not account for very much of the year-to-year growth in spending. The reason that these two phenomena can coexist is that if a driver accounts for a lot of spending, but this spending isn’t increasing, then it isn’t explaining our rising health care cost trend.

In a 2010 report, the Institute of Medicine (IOM) concluded no single issue dominates health care spending growth, and that it is the result of multiple forces at play in a fragmented delivery system.²⁴ We agree.

²³ See discussion in Chapter 4

²⁴ Pierre Yong and Leigh Anne Olsen, “The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary,” Institute of Medicine, 2010.

Exhibit G: Varying Impact of Health Care Cost Drivers

Price vs. Volume	Cost Driver	An important share of spending <u>level</u> ?	An important driver of health spending <u>trend</u> ?*
Rising Unit Prices	Advances in Medical Technology	n/a	Major Driver
	Provider Market Power	n/a	Major, but depends on local market conditions
	Administrative Costs/ Profits	8% of spending***	Minor
	Mandated Benefits	.5% to 4% of premium costs; less of total spending	Not a driver
	Malpractice Expenses	.4% of spending	Not a driver
Units Consumed	Chronic Disease Prevalence	Up to 75% of spending	Medium Driver
	Obesity **	10% of spending	Evidence is mixed
	Waste	15-30% of spending	Minor
	End of Life Care	About 27-30% of Medicare spending	Minor
	Prevalence of Smoking**	4% of spending	Not a driver
	Defensive Medicine	2% of spending	Minor
	Aging of Population	n/a	Minor
	Direct-to-Consumer Advertising	<1% of spending	Minor
Difficult to Categorize	Fraud and Abuse	Unknown	Evidence inconclusive

Source: Summary of Chapter 3

* See discussion in next chapter.

** Smoking and Obesity often lead to chronic diseases, and that spending is included in the Chronic Disease category.

*** Excludes administrative burden on providers, employers, and consumers to deal with claims payments, for which we don't have strong estimates.

Health Care Cost Drivers

Guide to the Evidence

While not exhaustive, this summary reviews a significant amount of literature to identify robust studies that assess the significance of various cost drivers, noting areas where there seems to be some consensus.

While high health care cost trend remains the major concern, we tried to note the impact on both level of spending and trend, where possible.

Following the framework in Exhibit G (above), we first look at the evidence surrounding price vs. quantity, followed by a discussion of underlying cost drivers affecting these sources of spending growth. A discussion of strategies to address costs follows in Chapters 4 and 5.

Spending Per Procedure or Product

We find the evidence very strong that spending more per unit of health care (as opposed to consuming too many units of care) is the single most important reason that the U.S. spends so much more on health care, per person, than other developed countries. Health care spending per person has grown at about the same rate as other countries in the past decade, so our high level of spending reflects the fact that the U.S. was already spending more per capita in the 1990s.²⁵

Discussion

There is overwhelming evidence that the U.S. pays significantly more for procedures, devices, and physician fees than other OECD countries.²⁶ This finding shows up in both anecdotal evidence²⁷ and analyses that control for a country's wealth, health status, and difference in the utilization of services.²⁸ While estimates vary depending on the country of comparison and

²⁵ David Squires, "Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality," Commonwealth Fund Issues In International Health Policy, May 2012.

²⁶ The Organisation for Economic Co-operation and Development (OECD) is an international organization that collects and analyses data on various social and economic indicators. In this context, it refers to other wealthy, developed nations who provide comprehensive health care for their citizens via one mechanism or another.

²⁷ See also Elizabeth Rosenthal's three-part series, "Paying Till It Hurts" from the summer of 2013 in *The New York Times*, which examines why three different medical procedures are more expensive in the U.S. than elsewhere else.

the exact procedure, on average we pay somewhere between one-third more to over twice as much for the same procedure or brand name medication.

There is one important exception: the U.S. pays substantially less than other countries for generics. When combined with our overspending on brand name medicine, it is not clear that we pay an inordinate amount overall for medications as a proportion of total health care spending.

Studies that attempt to disentangle price vs. volume without reference to other countries reach the same conclusion. A detailed analysis of private payer claims data finds that for all major health care service categories, increases in prices drove spending growth.²⁹ A detailed study of physician fees finds “higher fees, rather than factors such as higher practice costs, volume of services, or tuition expenses, were the main drivers of higher U.S. spending, particularly in orthopedics.”³⁰

It is worth noting that within the U.S., provider payment is determined in two very different ways. Within Medicare and Medicaid, unit prices are dictated through a formal process that incorporates input from stakeholders. For private insurers, provider prices reflect the relative market power of the insurer and provider.³¹

As discussed in more detail below, the reasons for high unit prices in the U.S. appear to include factors like consumer preference for broad provider networks, lack of price transparency and high market concentration among providers that allows them to charge prices substantially above costs.

Some suggest that the higher prices in private insurance are a result of Medicare and Medicaid

²⁸ Gerard Anderson, Uwe Reinhardt, Peter Hussey, and Varduhi Petrosyan, “It’s the Prices, Stupid: Why the United States is So Different From Other Countries,” *Health Affairs*, vol. 22 no. 3, May 2003, 89-105; David Squires, “Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality,” Commonwealth Fund Issues In International Health Policy, May 2012; Chris Peterson and Rachel Burton, “U.S. Health Care Spending: Comparison with Other Countries,” CRS Report RL34175, Sept 2007; <http://nihcm.org/images/stories/NIHCM-CostBrief-Email.pdf>.

²⁹ The Health Care Cost Institute, *The Health Care Cost and Utilization Report*: 2011, September 2012.

³⁰ Laugesen, MJ; Glied, SA Higher Fees Paid To U.S. Physicians Drive Higher Spending For Physician Services Compared To Other Countries. *Health Affairs*, September 2011 30(9): 1647-1656. <http://content.healthaffairs.org/content/30/9/1647.full>.

³¹ Private insurer contracts often tie provider payment to what Medicare pays using a multiple, like 160 percent of the Medicare rate for a service. But the negotiation process can result in very different multiples being used for different providers in the same geographic area.

reimbursement rates that are too low. This is a matter of debate but even if true in some situations, it does not explain why the U.S. spends so much more in aggregate than other countries.

Units of Service Consumed

In some health care areas the U.S. consumes more services than other countries but in other areas less. At the same time, there is strong evidence that 15 percent or more of current consumption of health care is unnecessary. Reducing our consumption of services would reduce the level of spending by a significant amount. However, increases in utilization are not the major driver of our per capita spending trend.

Discussion: *Comparisons to Other Countries*

Compared to other countries, there is evidence that the US consumes more of some types of health care but not all types. Moreover, it is not clear whether care in the U.S. is more intense in aggregate or how this affects costs.³² We do have the highest use of advanced imaging techniques like MRI and CT scans and do more of some procedures (like knee replacements) but only an average amount of others (like hip replacements). On the other hand, we have fewer doctor consultations per capita.³³

Discussion: *Wasteful Spending*

There are a variety of estimates of how much health care utilization is “wasteful” (not including outright fraud) but there is general consensus that too large a share of our spending is unnecessary. Estimates of waste fall between 15 and 30 percent of spending.³⁴

One of the most in-depth studies, conducted by the Institute of Medicine (IOM), found wasteful spending in a number of broad categories.³⁵ The IOM used a unique 6-domain analytic model of waste—unnecessary services, delivery inefficiencies, high prices, unnecessary administrative costs,³⁶ missed prevention opportunities, and fraud. They found that spending is wasted on services with little or no evidence of effectiveness, services that are delivered inefficiently because of preventable mistakes, care fragmentation, or more cost-intensively than necessary

³² Chris Peterson and Rachel Burton, “U.S. Health Care Spending: Comparison with Other Countries,” CRS Report RL34175, Sept 2007.

³³ David Squires. *The U.S. Health System in Perspective: A Comparison of Twelve Industrialized Nations*, Commonwealth Fund, July 2011.

³⁴ Jules Delaune and Wendy Everett, Waste and Inefficiency in the U.S. Health Care System, New England Health Care Institute; Donald Berwick and Andrew Hackbarth, “Eliminating Waste in U.S. Health Care,” *JAMA* 2013, 307(14): 1512-1516.

³⁵ Pierre Yong and Leigh Anne Olsen, “The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary,” Institute of Medicine, 2010.

³⁶ Further discussion of administrative costs is below.

(e.g., in a hospital rather than an outpatient clinic), missed prevention opportunities, and unnecessary paperwork and administrative burden.

Another report distinguishes between *indirect* evidence of waste³⁷ and *direct* evidence of unnecessary tests and procedures.³⁸ A review of the literature on *direct* evidence of overutilization from 1979 to 2009 found that “the robust evidence about overuse in the United States is limited to a few medical services.”

One study estimated that eliminating redundant tests would save \$8 billion.³⁹

Discussion: Care that Causes Harm

A critically important area of excess spending and patient suffering is connected to care that is not only unnecessary but actually harms patients. Among other things, medical harm includes:

- Hospital Acquired Infections (HAI),
- medication errors, and
- surgical errors.

Within these categories, some errors are considered more serious than others. Called “serious reportable errors” or “never events,” these errors are defined as “adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.⁴⁰ While medical harm can occur in any setting, most of the research to date has examined harm that occurs in hospitals. Preventable readmissions—another source of wasteful spending—are different but often connected to Hospital Acquired Infections and other types of errors.⁴¹

While there is broad consensus that improving patient safety is the right thing to do, the exact breadth of the problem and potential for savings and improved quality is hard to pin down. There are no recent, high-quality, nationally representative data on the rates of adverse events in U.S. hospitals.⁴² As a result, the level of spending associated with medical harm is known to

³⁷ As an example of indirect evidence, researchers at Dartmouth authored an influential study examining Medicare spending in different regions of the country. They found the amount of spending on health care varies widely, often does not correlate with better outcomes, and that if each higher-cost region in the country reduced its spending to the level of the low-spending, high-quality regions, savings of 30 percent or more are possible. But see also: <http://www.kaiserhealthnews.org/Daily-Reports/2012/October/05/more-debate-health-care.aspx>

³⁸ Mike Alberti. Keeping the “best care” option out of the health spending equation, *Remapping Debate*, Feb. 27, 2013 <http://www.remappingdebate.org/article/keeping-%E2%80%9Cbest-care%E2%80%9D-option-out-health-spending-equation?page=0,1>

³⁹ Ashish K. Jha, David C. Chan, Abigail B. Ridgway, Calvin Franz and David W. Bates. Improving Safety And Eliminating Redundant Tests: Cutting Costs In U.S. Hospitals, *Health Affairs*, September/October 2009 <http://content.healthaffairs.org/content/28/5/1475.full>.

⁴⁰ A list of “never events” is maintained by the National Quality Forum. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69572>.

⁴¹ Research Activities, December 2012, No. 388. December 2012. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/news/newsletters/research-activities/12dec/1212RA11.html>; and Medicare.gov, “Readmissions, complications and deaths,” <http://www.medicare.gov/hospitalcompare/About/RCD.html?AspxAutoDetectCookieSupport=1>.

be large but is imprecise. A 2009 study estimated the annual direct cost of just HAIs as ranging from \$36 billion to \$45 billion.⁴³ Recent studies estimate that that one in four hospital patients are harmed⁴⁴ and that 210,000 to 440,000 of these patients die each year.⁴⁵

There is worry that at least some of these costs are increasing. As the instances of HAIs caused by antibiotic resistant organisms continue to grow, we expect the costs to treat them will also grow.⁴⁶

Discussion: Underutilization

It is important to note that evidence of over-utilization exists side-by-side with the problem of consumers who receive too little care. Underutilization is most acute among people that have no insurance and therefore have extremely limited financial access to medical care. Underutilization is also a serious problem in the insured population, especially as high cost-sharing provisions deter people from receiving beneficial care.⁴⁷

Advances in Medical Treatment

There is significant evidence and consensus that the growth in U.S. health care costs has been driven in large part by advances in medical technology that make care more expensive. The best evidence indicates medical technology accounts for one-half to two-thirds of spending growth.⁴⁸ Many advances have also been associated with improvements in care. This is an arena where it is absolutely critical to look at quality and cost information together, so that we can get increasing high value out of the health care system.

⁴² Ashish K. Jha, David C. Chan, Abigail B. Ridgway, Calvin Franz and David W. Bates. Improving Safety And Eliminating Redundant Tests: Cutting Costs In U.S. Hospitals, *Health Affairs*, September/October 2009. <http://content.healthaffairs.org/content/28/5/1475.full>.

⁴³ Patricia W Stone, PhD, FAAN, Economic burden of healthcare-associated infections: an American perspective. *Expert Rev Pharmacoecon Outcomes Res.* 2009 Oct 9.

⁴⁴ Three separate studies had similar findings: Department of Health and Human Services, Office of Inspector General, "Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries," Daniel R. Levinson Inspector General, November 2010, OEI-06-09-00090. Christopher P. Landrigan, M.D., M.P.H., Gareth J. Parry, Ph.D., Catherine B. Bones, M.S.W., Andrew D. Hackbarth, M.Phil., Donald A. Goldmann, M.D., and Paul J. Sharek, M.D., M.P.H. , "Temporal Trends in Rates of Patient Harm Resulting from Medical Care," *The New England Journal of Medicine*, November 25, 2010; 363:22. David C. Classen, Roger Resar, Frances Griffin, Frank Federico, Terri Frankel, Nancy Kimmel, John C. Whittington, Allan Frankel, Andrew Seger, and Brent C. James; "Global Trigger Tool' Shows That Adverse Events In Hospitals May Be Ten Times Greater Than Previously Measured," *Health Affairs*, April 2011, 30:4.

⁴⁵ James, John, "A New Evidence-based Estimate of Patient Harms Associated with Hospital Care," *Journal of Patient safety*, 9(3):122-128, September 2013.

⁴⁶ Interagency Task Force on Antimicrobial Resistance, "A Public Health Action Plan To Combat Antimicrobial Resistance," 2011 revision, <http://www.cdc.gov/drugresistance/pdf/public-health-action-plan-combat-antimicrobial-resistance.pdf>; US Department of Health and Human Services, Centers for Disease Control and Prevention, "Antibiotic Resistance Threats in the United States, 2013, <http://www.cdc.gov/drugresistance/threat-report-2013/>.

⁴⁷ High-Deductible Health Plans Cut Spending but Also Reduce Preventive Care, RAND Fact Sheet, 2011. http://www.rand.org/content/dam/rand/pubs/research_briefs/2011/RAND_RB9588.pdf.

⁴⁸ PB Ginsburg. *High and Rising Health Care Costs: Demystifying U.S. Health Care*, The Synthesis Project, Issue 16, 2008, <http://www.rwjf.org/pr/product.jsp?id=35368>.

Discussion

There is widespread agreement that technological growth accounts for a large share of our spending growth, perhaps as much as half of the increases in spending.⁴⁹

New advances can increase costs by simply substituting a less expensive technology for a more expensive one, like using an MRI when an X-ray could do the job. But there are other ways in which new advances contribute to costs. Technology often increases costs by extending the lives of sick individuals or by treating those who were not eligible for treatment in the past. For example, improvements in kidney dialysis has resulted in longer lives for those with advanced renal disease and also higher costs as they remain in treatment for a longer period of time. Other treatments, like bone marrow transplants, are found to be effective for broader groups of diseases than originally realized, and costs increase as more people are treated. In other cases, like coronary angioplasty, new technology enables patients formerly too ill to undergo treatment to undergo the procedure.

Some advances are unambiguously cost saving.⁵⁰ And some do not appear to improve value, as in the case where older therapies are replaced with newer ones that are only marginally more effective. But many advances are more costly and accompanied by improvements in the quality of care. Whether the cost increases are justified by the quality improvements is a debate that hasn't been settled.⁵¹ One thing that is certain is that the answer varies depending on the specific disease being treated.

Note: there is consensus around the contribution of medical advances to spending growth, but for the most part the role of medical advances to spending growth can't be directly measured. Many studies use a "residual method" where growth unexplained by other factors is assumed to be due to technology or medical advances. How strong this evidence is depends on how well the researchers have accounted for all other possible factors.

⁴⁹ Shelia Smith, Joseph Newhouse, and Mark Freeland, "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" *Health Affairs* 28(5), 2009: 1276-1284; A CBO Paper: Technological Change and the Growth of Health Care Spending, January 2008, <http://www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf>.

⁵⁰ Although specific examples can be hard to find, one example of a cost saving innovation is ultra-portable ultrasound units. These units are around the size of a cell phone from the early 2000s and cost under \$10,000—a drastic cut from the \$250,000 of the larger units from the 1990s. It is possible that wide adoption of the technology could increase the number of ultrasounds performed and offset the unit cost savings, but it is hard to imagine that the increase in volume could eclipse the huge price difference between the units.

⁵¹ <http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2008/Mar/Washington-Health-Policy-Week-in-Review---March-10--2008/Health-Care-Quality-Gains-Not-Keeping-Pace-with-Cost-Increases.aspx> ; <http://www.nber.org/aginghealth/2011no2/w16953.html> Cutler and McClellan, "Is Technological Change in Medicine Worth It?", 2001 <http://content.healthaffairs.org/content/20/5/11.full>.

Provider Market Power

While hard to quantify, there appears to be consensus that provider market power leads to higher prices, with most of the research focusing on hospital providers.

Discussion

There are several studies showing that greater hospital market concentration leads to higher hospital prices.⁵² One team of investigators found hospitals in concentrated markets charge significantly higher prices and earn significantly higher margins from private insurers than do hospitals in competitive markets.⁵³ Another study noted that when hospitals merge in markets that are already concentrated, the price increase can be significant—sometimes in excess of 20 percent.⁵⁴ The Massachusetts Attorney General used her authority to directly examine insurers' contracts with providers and found “[p]rice variations are correlated to market leverage as measured by the relative market position of the hospital or provider group.”⁵⁵ Her report concluded that the health care “market” in Massachusetts was not able contain health care costs.

Hospitals aren't the only culprit. Two of the five most profitable industries in America—pharmaceuticals⁵⁶ and medical devices—provide health products. Profit margins near 20 percent in those two industries suggest that insurers, who reported profit margins only one-tenth as high in 2009, are unable to bargain effectively with providers. Systems of hospitals, doctors and other providers (with integrated fee schedules) may also have significant economic impact in certain markets, but they have not been well studied.

There is some evidence that insurer market power can counteract hospital market power. One study found that hospital prices in the most concentrated health insurance markets were approximately two percent lower than in more competitive health plan markets.⁵⁷

⁵² <http://www.catalyzepaymentreform.org/2013-03-03-06-22-58/2013-03-04-03-29-59/market-power>; Academy Health, “Integration, Concentration, and Competition in the Provider Marketplace,” Research Insights, 2010, http://www.academyhealth.org/files/publications/AH_R_Integration%20FINAL2.pdf.

⁵³ Robinson, JC. Hospital market concentration, pricing, and profitability in orthopedic surgery and interventional cardiology, *American Journal of Managed Care*, 2011; 17(6): 241-8 <http://www.ncbi.nlm.nih.gov/pubmed/21756018>

⁵⁴ M Gaynor and R Town, “The Impact of Hospital Consolidation,” *Robert Wood Johnson Foundation, The Synthesis Project*, 2012 <http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/06/the-impact-of-hospital-consolidation.html>

⁵⁵ Further, the report found that price variations are not correlated to (1) quality of care, (2) the sickness of the population served or complexity of the services provided, (3) the extent to which a provider cares for a large portion of patients on Medicare or Medicaid, or (4) whether a provider is an academic teaching or research facility. Moreover, (5) price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities. <http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf>

⁵⁶ An older study found that from U.E. Reinhardt, “An Information Infrastructure for the Pharmaceutical Market,” *Health Affairs* 23, no. 1 (2004): 107–112, Exhibit) and a total prescription drug spend of \$263 billion in 2011 (CMS). In 2002 the thirteen largest U.S. pharmaceutical companies allocated their sales revenue to particular objects of expenditures and profits as follows: cost of goods sold, 25.3 percent; selling and administration, 32.8 percent; R&D, 14 percent; taxes, 7.3 percent; and net after-tax profits, 20.6 percent.

⁵⁷ Melnick GA, Shen YC, Wu VY. The increased concentration of health plan markets can benefit consumers through lower hospital prices, *Health Affairs*, 2011 Sep;30(9):1728-33. doi: 10.1377/hlthaff.2010.0406.

Lack of Price Transparency

While there is wide spread agreement that there is little price transparency in the US health care market, there is little direct evidence as to the contribution of this phenomenon to health care spending growth. At the same time, increased price transparency may be an important prerequisite to being able to design effective policies. It may also be a basic issue of fairness for consumers seeking to weigh the cost and value of alternative health care treatments.

Discussion

At every level—hospitals, physicians, prescription drug and medical devices—prices are masked in the United States so that consumers and policy-makers rarely see how one provider or treatment compares to the next. Economist Uwe Reinhardt describes hospital pricing in the US as “chaos behind a veil of secrecy.”⁵⁸

In the traditional consumer marketplace, price transparency is a powerful force in incentivizing producers to raise the quality and lower the price of their goods. But it is not at all certain whether these same rules apply in the US health care market.⁵⁹

- Many patients have little inclination, or motivation, to shop for health-care bargains as their share of the expense may not vary or may be relatively small under their plan’s cost-sharing provisions.
- Cost and quality are not perceived by consumers as being independent attributes. Instead, many patients assume that a higher price signals higher quality.⁶⁰
- Quality measures are often non-existent or required sophisticated knowledge to use them, so the typical consumer is not properly empowered.⁶¹
- Much of our nation’s health care spending is directed by physicians, not consumers.

⁵⁸ Cited by Andy Grove in “Peeling Away Health Care’s Sticker Shock,” Oct. 16, 2012 at the Wired Health Conference in partnership with the Robert Wood Johnson Foundation. <http://www.wired.com/business/2012/10/mf-health-care-transparency/>.

⁵⁹ Peter Ubel. How Price Transparency Could End Up Increasing Health-Care Costs, *The Atlantic*, Apr 9 2013. <http://www.theatlantic.com/health/archive/2013/04/how-price-transparency-could-end-up-increasing-health-care-costs/274534/>

⁶⁰ Roseanna Sommers, Susan Dorr Goold, Elizabeth A. McGlynn, Steven D. Pearson and Marion Danis. Focus Groups Highlight That Many Patients Object To Clinicians’ Focusing On Costs, *Health Affairs*, February 2013

⁶¹ Berenson RA, Pronovost PJ, and Krumholz HM. *Achieving the Potential of Health Care Performance Measures*, Robert Wood Johnson Foundation and the Urban Institute, May 2013.

Population Health Status: Smoking, Obesity, and Chronic Disease

A 2007 study by McKinsey Global found that higher spending in the United States (compared to other OECD countries) is not explained by a higher disease burden. The research shows that the U.S. population is not significantly sicker than the other countries studied, and where differences exist, they don't explain much of the cost difference. Furthermore, while extending people's lives through healthier living reduces suffering and increases our nation's productivity, it may not decrease costs as additional medical care is consumed in those extra years of life.

Improved population health is a worthy goal in and of itself, but for purposes of focusing our cost-containment resources, it is important to understand the role of disease prevalence. In short, factors such as obesity and smoking may have a profound impact on population health, but the impact on health care spending may have more to do with how much we are paying for health care than on the prevalence of disease. Furthermore, there are important differences underlying this spending. Smoking rates, which have declined in recent decades, probably contribute less to overall spending than obesity rates, which have been increasing.

Smoking

Although tobacco related health care costs run in the billions and the associated diseases cause suffering, smoking is not a major driver of overall health care costs.

Discussion

Tobacco use continues to be a significant contributor to a wide range of health problems, including cancer, respiratory and coronary diseases. The CDC estimates that tobacco-related health care costs are \$96 billion per year – about four percent of overall health spending.⁶²

Like many public health issues, policies and strategies to lower tobacco use have great merit for improving health status and quality of life.

However, tobacco related health care costs are *not a significant driver* of overall health care costs. The U.S. actually has lower rates of smoking than most other developed countries.

⁶² Centers for Disease Control and Prevention. Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 2000–2004. *Morbidity and Mortality Weekly Report*, 2008.

(Reductions in the rate of smoking in the U.S. are widely considered one of the greatest public health achievements of the past 50 years.) One study finds that spending on treatment of respiratory conditions has grown more slowly than GDP, despite increases in spending for the treatment of asthma.⁶³

Obesity

Several studies find that obesity and related diseases increase both the level and growth of U.S. health care spending—but there is disagreement over how much. Nonetheless, obesity in the U.S. population is and may be an important driver of growth in health care costs, and is certainly a growing health problem.

Discussion

There is no question that obesity is a serious and growing health problem. It is also undisputed that health spending by obese patients is higher than that of normal weight patients.⁶⁴ A 2009 study estimated that the annual medical burden of obesity amounted to roughly 10 percent of all medical spending.⁶⁵

The exact contribution of obesity to spending growth is a matter of debate. One study finds that rising rates of obesity explained 10 percent of the increase in total spending between 1987–2009 (10.4 percent), and increases in treatment intensity, a component of spending per treated case, accounted for a slightly larger share (11.9 percent).⁶⁶ Another study finds that most of the increase in spending is attributable to rising cost per case and only a small share due to the increase in rates of obesity.⁶⁷ A third study comes to a very similar conclusion—that the real difference is that we spend so much more to treat a given case, regardless of what type of case it is.⁶⁸

⁶³ Charles Roehrig and David Rousseau, "The Growth in Cost Per Case Explains Far More of U.S. Health Spending Increases Than Rising Disease Prevalence," *Health Affairs* 30(9), 2011: 1657-1663.

⁶⁴ Congressional Budget Office. *How Does Obesity in Adults Affect Spending on Health Care?*, September 8, 2010 http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/118xx/doc11810/09-08-obesity_brief.pdf

⁶⁵ Eric A. Finkelstein, Justin G. Trogon, Joel W. Cohen and William Dietz. Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific Estimates, *Health Affairs*, July 2009 <http://content.healthaffairs.org/content/28/5/w822.full.pdf>

⁶⁶ Kenneth E. Thorpe. Treated Disease Prevalence And Spending Per Treated Case Drove Most Of The Growth In Health Care Spending In 1987–2009, *Health Affairs* May 2013 <http://content.healthaffairs.org/content/32/5/851.full?sid=8bf0c53f-0fb0-493e-a63b-e9a11ea3fa29#F1>

⁶⁷ Charles Roehrig and David Rousseau, "The Growth in Cost Per Case Explains Far More of U.S. Health Spending Increases Than Rising Disease Prevalence," *Health Affairs* 30(9), 2011: 1657-1663.

⁶⁸ Carlos Angrisano, Diana Farrell, Bob Kocher, Martha Laboissiere, and Sara Parker, *Accounting for the Cost of Health Care in the United States*, McKinsey and Company, January 2007.

There are nuances to understanding the contribution of obesity to rising health care costs. In and of itself, obesity isn't that expensive to treat.⁶⁹ Although bariatric surgery and other treatments for obesity are increasing in popularity, in actuality these treatments remain rare. As a result, the medical costs attributable to obesity are almost entirely a result of costs generated from treating the diseases that obesity promotes.⁷⁰ Obesity is associated with increased risk for many chronic conditions, such as diabetes, hypertension, high cholesterol, cardiovascular disease, and cancer. (Chronic diseases are discussed in next section).

Also, the timing of these costs is important. The costs of treating the associated conditions peak around the age of entry into the Medicare program.⁷¹ In contrast, private insurers bear far less of these costs.

Many researchers speculate that obesity rates will continue to climb, worsening the problem in the future.⁷²

Prevalence of Chronic Disease

We find strong evidence that chronic disease accounts for a large share of spending, but the prevalence of chronic disease, while growing, explains just one quarter of overall growth in spending for patients with chronic disease. Most of the increase in spending for chronic disease is accounted for rising cost per case.

Discussion

Spending to treat chronic disease accounts for an enormous share of American health care spending. Approximately 75 percent of U.S. health care spending is on chronic disease.⁷³ Among the elderly, four of the five conditions most expensive to treat are chronic (heart disease, cancer, mental disorders, and pulmonary conditions).⁷⁴ The only non-chronic condition to make the list is trauma.

⁶⁹ Carlos Angrisano, Diana Farrell, Bob Kocher, Martha Laboissiere, and Sara Parker, *Accounting for the Cost of Health Care in the United States*, McKinsey and Company, January 2007.

⁷⁰ Eric A. Finkelstein, Justin G. Trogon, Joel W. Cohen and William Dietz. Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific Estimates, *Health Affairs*, July 2009. <http://content.healthaffairs.org/content/28/5/w822.short>

⁷¹ Finkelstein EA, Trogon JG, Brown DS, Allaire BT, Dellea P, Kamal-Bahl S. The lifetime medical cost burden of overweight and obesity: Implications for obesity prevention. *Obesity*, 2008; 16(8):1843–1848.

⁷² Trust for America's Health. *F as in Fat: How Obesity Threatens American's Future*, Sept 2012. <http://www.healthymamericans.org/assets/files/TFAH2012FasInFatFnlRv.pdf>

⁷³ Centers for Disease Control and Prevention. *The Power to Prevent, The Call to Control: At A Glance 2009 (2009)* <http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm>

⁷⁴ Anita Soni and Marc Roemer. *Top Five Most Costly Conditions among the Elderly, Age 65 and Older, 2008: Estimates for the U.S. Civilian Noninstitutionalized Adult Population*, AHRQ, July 2011

US spending is concentrated among patients with multiple chronic conditions. A person's risk of having more than one chronic condition, henceforth referred to as multiple chronic conditions or MCC, increases with age: 62 percent of Americans over 65 have MCC.⁷⁵ Among high-cost Medicare beneficiaries (e.g., the 25 percent of beneficiaries accounting for 85 percent of programmatic costs), about 30 percent had four co-occurring chronic illnesses: coronary artery disease, diabetes, congestive heart failure, and chronic obstructive pulmonary disease.⁷⁶

However, recent research finds it is not the increasing number of people being treated for chronic disease ("treated prevalence") that causes high spending growth but rather the rise in cost per case.⁷⁷ Examining populations with a given disease (treated or not), the authors found that overall three-fourths of the increase in spending was attributed to growth in cost per case and just one-fourth due to increases in treated prevalence. Authors conclude that efforts to reduce disease prevalence—while worthy for other reasons—are unlikely to reduce the overall rate of health care cost growth. Instead, they recommend a focus on reining in cost per case.

End-of-Life Care

While there is strong evidence that end-of-life care represents a significant portion of spending for the Medicare sector, it is not growing and thus not contributing the overall growth in health care spending. Nonetheless, the potential for savings are believed to be present.

Discussion

It is clear that the US spends a lot on end-of-life care, both through public safety net programs and private expenditures. Medicare has devoted about 27-30 percent of total spending to end of life care.⁷⁸ This percentage has remained stable over the last two decades, and many of the trends that determine it are likely to persist, such as an aging population and the prevalence of chronic diseases including cancer, coronary artery disease, renal failure, diabetes, chronic liver disease, and dementia.⁷⁹

⁷⁵ Christine Vogeli, Alexandra E. Shields, Todd A. Lee, Teresa B. Gibson, William D. Marder, Kevin B. Weiss, and David Blumenthal. Multiple Chronic Conditions: Prevalence, Health Consequences, and Implications for Quality, Care Management, and Costs, *J Gen Intern Med*. 2007 December; 22(Suppl 3): 391–395. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2150598/>

⁷⁶ Christine Vogeli, Alexandra E. Shields, Todd A. Lee, Teresa B. Gibson, William D. Marder, Kevin B. Weiss, and David Blumenthal. Multiple Chronic Conditions: Prevalence, Health Consequences, and Implications for Quality, Care Management, and Costs, *J Gen Intern Med*. 2007 December; 22(Suppl 3): 391–395. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2150598/>

⁷⁷ Charles Roehrig and David Rousseau, "The Growth in Cost Per Case Explains Far More of U.S. Health Spending Increases Than Rising Disease Prevalence," *Health Affairs*, 30(9), 2011: 1657-1663.

⁷⁸ Samantha Smith, Aoife Brick, Sinead O'Hara, and Charles Normand, "Evidence on the Cost and Cost-Effectiveness of Palliative Care: A Literature Review," *Palliative Medicine*, July 2013; Gerald Riley and James Lubitz, "Long-Term Trends in Medicare Payments in the Last Year of Life," *Health Services Research*, vol. 45 issue 2, April 2010, 565-576.

⁷⁹ "Key Issues: End of Life Care." (2013). The Dartmouth Atlas of Health Care, <http://www.dartmouthatlas.org/data/topic/topic.aspx?cat=184>

Nevertheless, substantial geographic variation in the cost of end-of-life care suggests that reductions in cost may be possible. This variation is not explained by health outcomes, patient preferences,^{80, 81} or hospital characteristics such as cancer center designation or for-profit status.⁸² Instead, it correlates most strongly with the availability of medical services. That is, patients are more likely to be admitted to the hospital in regions with more hospital beds per capita, and more likely to visit medical specialists when more specialists are available.⁸³

Other research adds to the conclusion that provider financial incentives play an important role in determining care for end-of-life patients. A study assessing the effects of Medicare's 2005 and 2006 reductions in reimbursement for chemotherapy on chemotherapy use during a patient's last two weeks of life found that use dropped sharply in physicians' offices, where drugs generate a high proportion of revenue, but remained relatively stable in hospital outpatient settings, where drug reimbursements are less important to total revenue.⁸⁴

Aging of the Population

We find strong evidence that the aging of the population is a minor driver of health care cost growth.

Discussion

Older people use more care, and they are increasing as a greater proportion of the population. But, because the average age of the population goes up so slowly, this phenomenon explains very little of the overall trend in rising health care prices per person.⁸⁵ The main driver of per capita health spending growth is the growth in spending per capita within each age group, not growth in the share of the population in older age groups.

⁸⁰ Jonathan Skinner and John E. Wennberg. "How Much is Enough? Efficiency and Medicare Spending in the Last Six Months of Life," *National Bureau of Economic Research*, April 1998, Working Paper 6513. http://www.nber.org/papers/w6513.pdf?new_window=1

⁸¹ Wennberg J, Fisher E, Goodman D, Skinner J. Tracking the Care of Patients with Chronic Illness. The Dartmouth Atlas of Health Care 2008. Hanover, NH: The Dartmouth Institute for Health Policy and Clinical Practice, 2008. http://www.dartmouthatlas.org/downloads/atlas/2008_Chronic_Care_Atlas.pdf

⁸² Nancy E. Morden, Chiang-Hua Chang, Joseph O. Jacobson, Ethan M. Berke, Julie P.W. Bynum, Kimberly M. Murray, and David C. Goodman, "End-Of-Life Care For Medicare Beneficiaries With Cancer Is Highly Intensive Overall And Varies Widely," *Health Affairs*, April 2012, vol. 31 no. 4 786-796. <http://content.healthaffairs.org/content/31/4/786.abstract>

⁸³ Goodman, D.C., et al, *Trends and Variation in End-of-Life Care for Medicare Beneficiaries with Severe Chronic Illness*, The Dartmouth Institute for Health Policy & Clinical Practice, April 12, 2011.

⁸⁴ Carrie H. Colla, PhD, Nancy E. Morden, MD, MPH, Jonathan S. Skinner, PhD, J. Russell Hoverman, MD, PhD, and Ellen Meara, PhD. "Impact of Payment Reform on Chemotherapy at the End of Life," *Journal of Oncology Practice*. May 2012 vol. 8 no. 3S e6s-e13s <http://jop.ascopubs.org/content/8/3S/e6s.full.pdf+html>

⁸⁵ Uwe E. Reinhardt, "Does The Aging Of The Population Really Drive The Demand For Health Care?," *Health Affairs*, November 2003 vol. 22 no. 6 27-39; and Dale H. Yamamoto, "Health Care Costs--From Birth to Death", Health Care Cost Institute, Independent Report 2013-1, 2013.

Malpractice Spending and Defensive Medicine

We find strong evidence that spending related to malpractice is not a driver of health care spending growth. Due to measurement issues, the evidence is mixed as to the size and importance of the practice of defensive medicine, but it is still thought to be a minor driver.⁸⁶

Discussion

Malpractice premiums and legal awards are believed to be less than half a percent of our nation's health spending.⁸⁷ Further, payments have been stable or falling in recent years, further suggesting that Malpractice spending is not driving health care spending growth.⁸⁸

Estimates of spending on defensive medicine are difficult to measure but thought to be small. One frequently cited report calculated that this spending accounted for 2.4 percent of annual health care spending.⁸⁹ Other reports also find small shares of spending attributable to defensive medicine.

Mandated Benefits

While the presence of mandated benefits varies from state to state, the evidence is fairly strong that mandated benefits account for a modest amount of spending (.5 percent to four percent of premium costs at the margin; less in terms of overall spending).⁹¹ We found no evidence that state mandated benefits are an important driver of health care cost growth. We do expect a one-time jump in premium costs in the non-group market from newly mandated benefits required as part of the ACA's essential health benefit requirement.

Discussion

Mandated benefits are services that a carrier is required by its licensing or other statute to include in its health plan. State mandates can also refer to categories of providers (like

⁸⁶ PB Ginsburg *High and Rising Health Care Costs: Demystifying U.S. Health Care The Synthesis Project In.*, Issue 16, 2008 <http://www.rwjf.org/pr/product.jsp?id=35368>

⁸⁷ Michelle Mello, Amitabh Chandra, Atul Gawande, and David Studdert, "National Costs of the Medical Liability System," *Health Affairs*, vol. 29 no. 9, 2010, 1569-1577.

⁸⁸ Medical Malpractice Insurance: Stable Losses/Unstable Rates 2007, Americans for Insurance Reform, March 28, 2007. More recent analysis from the AMA seem to indicate continued low rates of growth: http://www.ama-assn.org/ams/pub/amawire/2013-january-09/2013-january-09-general_news3.shtml

⁸⁹ Michelle Mello, Amitabh Chandra, Atul Gawande, and David Studdert, "National Costs of the Medical Liability System," *Health Affairs*, vol. 29 no. 9, 2010, 1569-1577.

⁹⁰ Hermer LD, Brody H. Defensive medicine, cost containment, and reform, *J Gen Intern Med*, 2010 May 9.

⁹¹ <http://www.mass.gov/chia/docs/r/pubs/13/comprehensive-mandate-review-report-2013-1-10.pdf>. See also: Alan Monheit and Jasmine Rizzo, "Mandated Health Insurance Benefits: A Critical Review of the Literature," Prepared for the State of New Jersey Department of Human Services, January 2007.

chiropractors) that must be included in the plan.

Critics of mandated benefits often make the implicit (and sometimes, explicit) argument that mandated benefits are unnecessary and wasteful—i.e. consumers would not want or need the benefits if they were not mandated. The reality is usually very different. Many studies drastically overstate the impact of mandating benefits by calculating the total cost of the mandated benefit rather than the marginal cost of the mandate. In other words, how much would costs go down if the mandate were removed? Because a majority of mandated benefits would be offered anyway, the cost reduction from removing mandates is very small.

The most reliable studies examining the marginal effect find real but small impacts on premiums—in the range of 0.5 to four percent of premiums, and much of the result of a few specific mandates such as mental health, substance abuse, and maternity.⁹² Note this is a small subset of spending. For the most part, these premiums reflect just the premiums of fully insured products. Further, premiums reflect a subset of all health care spending (see Chapter 2).

The mandated benefits issue can provoke intense arguments, but a review of the literature finds that there is no compelling evidence that mandated benefits are a significant driver of increasing health care costs.

Until the Affordable Care Act, few benefit mandates originated at the federal level. But beginning in 2014, the ACA broadens the minimum benefits package that must be included in individual and small group health plans, known as Essential Health Benefits (EHBs). Researchers agree that richer benefits will cause premium costs to go up, particularly in the non-group market,⁹³ but aggregate spending will increase by a smaller amount as the sums that consumers pay out-of-pocket may go down. Little impact is expected in the small group market, as these benefits are for the most part already covered by small group policies.⁹⁴

⁹² Compass Health Analytics, *State-Mandated Health Insurance Benefits and Health Insurance Costs in Massachusetts*, January 2013 <http://www.mass.gov/chia/docs/ir/pubs/13/comprehensive-mandate-review-report-2013-1-10.pdf>. See also: Alan Monheit and Jasmine Rizzo, "Mandated Health Insurance Benefits: A Critical Review of the Literature," Prepared for the State of New Jersey Department of Human Services, January 2007.

⁹³ In 2009, the Congressional Budget Office estimated that federally required improvements in covered benefits might increase non-group premiums by up to 30 percent. Note that many other features also influence the final price that consumers see, making it unlikely that many consumers will experience that precise increase in premium costs. See: Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, November 30, 2009 and Gary Claxton, Larry Levitt, Karen Pollitz and Anthony Damico, *Why Premiums Will Change for People Who Now Have Nongroup Insurance*, Kaiser Family Foundation, February 06, 2013.

⁹⁴ Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, November 30, 2009.

⁹⁵ Mike Alberti, *Health Insurance Maze A Major Financial Burden On Hospitals, Doctors, Businesses, Remapping Debate*, June 2012. <http://www.remappingdebate.org/article/health-insurance-maze-major-financial-burden-hospitals-doctors-businesses>

Administrative Costs

The U.S. spends more on administrative costs than any other country, reflecting the complexity of our multi-payer system.⁹⁵ Several studies show that, with structural reforms, these costs could be significantly reduced.⁹⁶ Administrative costs have been increasing faster than the overall rate of spending, suggesting that they may be a minor driver of spending trend.⁹⁷

Discussion

The Centers for Medicare & Medicaid Services (CMS) estimates that in 2011 our country spent \$156 billion on administrative costs (including profits) associated with private health insurance plans and \$32.5 billion on the administration of government coverage programs—about eight percent of total personal health care spending.^{98, 99}

The administrative costs of private health plans cover costs such as marketing, provider and medical management, account and member administration, and corporate services.¹⁰⁰ Many of these aspects of insurance administration are “fixed” costs. As a result, administrative spending is a greater proportion of the premium costs faced by small firms and individuals. And a comparatively smaller portion of large programs like Medicare.

While some administrative spending is necessary, there is general consensus that a portion of this spending is “excessive.” One study looked at administrative spending in 2008 and found that approximately 11 percent (\$42 billion) of total fully-insured commercial health insurance premiums as being consumed by payer administrative activities such as claim processing, customer service, medical management, and sales and marketing, as well as corporate overhead and external broker commissions. If the average payer administrative expense level for fully insured commercial products were reduced to approximately eight percent of premiums—an expense level exhibited by “best practice” payers—the study suggested that total payer administrative expense for these products would be reduced to approximately \$29 billion, thereby generating a savings of approximately \$14 billion; for the self-insured market, the

⁹⁶ Institutes of Medicine. *The Healthcare Imperative: Lowering Costs and Improving Outcomes - Workshop Series Summary*, Chapter 4, February 24, 2011.

⁹⁷ National Health Expenditures Accounts data from Centers for Medicare & Medicaid Services, Office of the Actuary <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>

⁹⁸ National Health Expenditures Accounts data from Centers for Medicare & Medicaid Services, Office of the Actuary <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>

⁹⁹ In the national health expenditure accounts, these costs are: net cost of private health insurance which is the difference between health premiums earned and benefits incurred. The net cost consists of insurers' costs of paying bills, advertising, sales commissions, and other administrative costs; net additions to reserves; rate credits and dividends; premium taxes; and profits or losses.

¹⁰⁰ American Academy of Actuaries, Administrative Expenses, September 2009. http://www.actuary.org/files/publications/admin_expenses_sept2009.pdf

study estimated an additional savings of \$6 billion to \$9 billion could be realized. More robust structural changes would likely be associated with larger savings.¹⁰¹

It is important to note that drivers of administrative costs for private insurers are changing. The ACA capped non-medical spending by insurers for non-group and small-group plans to 20 percent of the premium. Large groups are capped at 15 percent. Further, in 2014 the ACA eliminates medical underwriting and streamlines the factors that can be used to determine premium rates in the non-group and small-group markets. In theory, these changes should lower the level of administrative spending.

Estimates of Medicare administrative costs are often criticized as understating true administrative spending by excluding the costs of CMS administrative staff, office space, and the collection of Medicare premiums and payroll taxes. After accounting for these costs, however, the administrative costs of Medicare are estimated to be just five percent of premiums, compared with 12 percent and up for private plans.¹⁰² Even after adjusting for the fact that Medicare's costs are spread over larger enrollment, the program's costs are still lower than in private plans.¹⁰³ A separate study directly compared the administrative costs of private health plans participating in Medicare (Medicare Advantage) with those of the traditional Medicare program and found that administrative expenses of the private plans to be five times as high.¹⁰⁴

This discussion understates our true spending on claims administration by failing to include the administrative costs incurred by doctors and hospitals as they address the burden of getting paid under a fragmented multi-payer financing system. A 2010 IOM report tallied these expenses at \$361 billion,¹⁰⁵ but a primary author of the report now states they should be revised to \$400 billion.¹⁰⁶ The IOM report noted that physicians spend a reported 43 minutes per day on average—the equivalent of three hours per week and nearly three weeks per year—on administrative interactions with health plans and not on patient care.¹⁰⁷ It was also noted that one assessment found surgical nurses spending about a third of their time on documentation needs rather than clinical care.¹⁰⁸

¹⁰¹ See discussion of uniform payment systems in Chapter 5.

¹⁰² John Holahan and Linda Blumberg. *Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?* Urban Institute, 2008. http://www.urban.org/UploadedPDF/411762_public_insurance.pdf

¹⁰³ John Holahan and Linda Blumberg. *Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?* Urban Institute, 2008 http://www.urban.org/UploadedPDF/411762_public_insurance.pdf

¹⁰⁴ Congressional Budget Office, *Designing a Premium Support System for Medicare*, November 2006.

¹⁰⁵ Institutes of Medicine, *The Healthcare Imperative: Lowering Costs and Improving Outcomes - Workshop Series Summary*, Chapter 4, February 24, 2011.

¹⁰⁶ Mike Alberti. *Health Insurance Maze A Major Financial Burden On Hospitals, Doctors, Businesses*, Remapping Debate, June 2012. <http://www.remappingdebate.org/article/health-insurance-maze-major-financial-burden-hospitals-doctors-businesses>

¹⁰⁷ Casalino et al., 2009

¹⁰⁸ Smith, 2009

A separate estimate places the administrative costs paid by employers at \$37 billion.¹⁰⁹

No study seems to have attempted to quantify the administrative burden borne by consumers as they sort through claims payments forms and bills.

Direct-to-Consumer Advertising (Drugs)

Evidence of direct-to-consumer (DTC) advertising is somewhat dated. This older evidence suggests that DTC advertising can increase drug costs, sometimes by increasing utilization and sometimes by increasing unit price but there is little evidence to suggest DTC advertising is a major driver of health care cost trend. The direct spending associated with DTC advertising is less than one percent of overall health spending, but that doesn't include the spending associated with increased sales.

Discussion

Direct-to-consumer (DTC) advertising increases spending on both the advertised drug itself and on other drugs that treat the same conditions. Spending on DTC advertising has increased more than 330 percent from 1996 (when a regulatory change made DTC advertising more attractive) to 2005, but it made up only 14 percent of total promotional expenditures in 2005.¹¹⁰ These direct expenditures add less than one percent to our nation's health care bill¹¹¹ but don't account for inappropriate drug use that may result from the ads.

One study of 64 drugs found a median increase in sales of \$2.20 for every \$1 spent on DTC advertising.¹¹² An older study found an even higher ratio: sales increased \$4 for every \$1 in spending on DTC advertising. More research may be needed to understand the mechanism by which this occurs. An analysis of a single drug, clopidogrel, found that direct-to-consumer advertising was not associated with an increase in use, *but instead an increase in cost per unit*.¹¹³

¹⁰⁹ Mike Alberti. *Health Insurance Maze A Major Financial Burden On Hospitals, Doctors, Businesses*, Remapping Debate, June 2012. <http://www.remappingdebate.org/article/health-insurance-maze-major-financial-burden-hospitals-doctors-businesses>

¹¹⁰ Julie M. Donohue, Marisa Cevasco, Meredith B. Rosenthal. A Decade of Direct-to-Consumer Advertising of Prescription Drugs, *N Engl J Med* 2007 <http://www.nejm.org/doi/full/10.1056/NEJMsa070502>.

¹¹¹ Author's calculation based on an overall promotion budget of 25.3 percent (from U.E. Reinhardt, "An Information Infrastructure for the Pharmaceutical Market," *Health Affairs* 23, no. 1 (2004): 107–112, Exhibit) and a total prescription drug spending of \$263 billion in 2011 (CMS). In 2002 the thirteen largest U.S. pharmaceutical companies allocated their sales revenue as follows: cost of goods sold, 25.3 percent; selling and administration, 32.8 percent; R&D, 14 percent; taxes, 7.3 percent; and net after-tax profits, 20.6 percent.

¹¹² David Gascoigne and John Busbice, *DTC ROI: The Latest Findings*, presented at the DTC National Conference, Washington, D.C., Apr. 26, 2006.

¹¹³ Michael R. Law, Stephen B. Soumerai, Alyce S. Adams, Sumit R. Majumdar, Costs and Consequences of Direct-to-Consumer Advertising for Clopidogrel in Medicaid, *Arch Intern Med*. 2009.

About 10 years ago, the FDA completed a comprehensive survey of patients' and physicians' experiences with direct-to-consumer advertising.¹¹⁴ Consumer surveys show a nearly universal awareness of DTC advertising, with 81 percent reporting exposure to broadcast or print promotion in 2002. The survey found that exposure to this advertising increased the likelihood that consumers would ask their physicians about the drugs. More scholarship is needed to evaluate the impact of new social marketing tools on direct-to-consumer advertising.

An analysis by GAO suggests that while DTC advertising increases prescription drug spending and utilization, it can have both positive and negative effects on consumers.¹¹⁵ These ads encourage consumers to talk to their doctors about previously undiagnosed conditions, but they also lead to increases in prescriptions. The surveys GAO reviewed found that between two and seven percent of consumers who saw DTC advertising requested and ultimately received a prescription for the advertised drug.

Physicians reported an increase in the frequency of patient questions about health care topics during the last five years in all areas except over-the-counter drugs. The most frequently asked questions were about drug treatments, with 85 percent of physicians reporting that their patients asked about prescription drugs frequently (“often/all the time”) and 62 percent reporting that their patients asked about generic drugs frequently.

Despite evidence on the effectiveness of DTC advertising in driving sales, there is no direct evidence this is a major contributor to health care cost trend, due to the small share of overall spending represented by DTC advertising.

Most other countries ban the use of direct-to-consumer advertising.

Fraud and Abuse

The impact of fraud and abuse on both the level of health spending and growth in spending is difficult to assess.

Discussion

It is difficult to know how much fraud is occurring in health care—though it appears to be very significant—and even harder to understand how it influences spending trend. Estimates of fraud

¹¹⁴ *Patient and Physician Attitudes and Behaviors Associated With DTC Promotion of Prescription Drugs - Summary of FDA Survey Research Results* <http://www.fda.gov/Drugs/ScienceResearch/ResearchAreas/DrugMarketingAdvertisingandCommunicationsResearch/ucm151498.htm>

¹¹⁵ GAO, *FDA Oversight of Direct-to-Consumer Advertising Has Limitations*, October 2002. <http://www.gao.gov/assets/240/236204.pdf>

in the health care system range from around two to 10 percent of annual health care costs.¹¹⁶ The most credible sources lament that there are no reliable estimates of the magnitude of fraud in health care. Part of the problem is that some figures only address activity that is illegal while others count waste of various sorts.

We found no evidence to suggest whether or not fraud and abuse is contributing to health care cost trend.

Evidence does indicate that fraud is not primarily practiced by patients but by those who earn their incomes from health care. Medical facilities (such as medical centers, clinics, and practices) and durable medical equipment suppliers were the most frequent subjects of criminal fraud cases in Medicare, Medicaid, and CHIP.¹¹⁷ Although there have been some large and very public fraud cases in recent years,¹¹⁸ it is hard to know what the overall size and impact of fraud is on health care costs.

¹¹⁶ David A. Hyman, "Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust 'Reposed in the Workmen'," *Journal of Legal Studies*, vol 531, 2001;

¹¹⁷ Kathleen M. King, "Health Care Fraud: Types of Providers Involved in Medicare Cases, and CMS efforts to Reduce Fraud," GAO Testimony, 2012 and <http://www.nhcaa.org/news/what-does-health-care-fraud-look-like.aspx>

¹¹⁸ For example, Richard A. Serrano, "Doctor charged in nation's largest healthcare fraud scam," *LA Times*, February 29, 2012. <http://articles.latimes.com/print/2012/feb/29/nation/la-na-medicare-fraud-20120229>

Chapter 4

Cost Containment Strategies

Introduction and An Overarching Framework 38



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POLICY & ACTION FROM CONSUMER REPORTS

Cost Containment Strategies

Introduction and An Overarching Framework

Policies that effectively rein in spending are tough to identify and even tougher to implement. One person's savings is another person's income. And the people that we are talking about can be politically powerful. For that reason, many cost saving approaches may get traction for their political expediency rather than their effectiveness in saving money.

As with all policy discussions, the devil is in the details. It isn't always self-evident what will save money or even how we should be measuring "success."

This section summarizes the evidence around proposed cost control strategies, leaving the political feasibility discussion aside (and reflecting the fact that what is politically feasible may vary across states and municipalities). We call these "strategies" because not every approach has enough evidence to firmly anchor it under the moniker "solution."

There are many, many strategies being discussed. To help you make sense of them, we've created a framework for thinking about strategies. First, we look at the intended target of the intervention (consumers, providers, or insurers). Second, within those categories, we group the strategies by type of intervention:

- **Transparency:** Does the strategy seek to change purchasing or practicing patterns exclusively through providing better information to consumers, providers, or insurers?
- **Financial:** Are financial incentives/price signals used to change purchasing or practicing patterns?
- **Structural:** Does the strategy include changes of a more structural nature?

Finally, we briefly describe some strategies that may not directly reduce spending but may be needed to provide that foundational information that allows policy-makers and purchasers to be more precise when designing cost containment policy, like all payer claims datasets.

Exhibit H: A Framework for Thinking About Cost Strategies

Primary Target of Intervention	Approach	Strategy Examples*
Consumers' Purchase of health care/products	Transparency	Published prices for medical services Provider quality reports
	Financial Incentives	High Deductible Health Plans Consumer Directed Health Plans Value-Based Insurance Design Reference Pricing Wellness Incentives Tiered Drug Formularies
Consumers' Purchase of insurance	Transparency	Summary of Benefits and Coverage
	Structural	Reducing variation in plan designs through actuarial value tiers and Essential Health Benefits
Providers of Care	Transparency	Pricing Data Quality Reports, including reports on medical harm
	Financial incentives	Bundled Payments Capitation Hospital Rate Setting Reference Pricing Relative Value Units Pay for Performance No payment for "never events"
	Structural	Disease Management Case Management Global Budgets Determination of Need Accountable Care Organizations (ACOs) Medical Homes Health Information Technology (HIT) Selective Contracting Tiered Provider Networks More/Different Provides (scope of practice) Fraud and Abuse measures

Primary Target of Intervention	Approach	Strategy Examples*
Providers Of Products	Structural	Generic Pathway for Biologics
Insurers	Financial	Medical Loss Ratio Cadillac Tax
	Structural	Public Option Improved Rate Review
Strategies that Improve Our Understanding of Spending Flows		All Payer Claims Datasets Standard Reporting on Medical Harm Comparative Effectiveness Research

* These strategies are defined in the Glossary and discussed in Chapter 5.

As already noted, we couldn't include public health strategies in this Guide, but we acknowledge that interventions that deliver more value-per-dollar-spent for "sick care" are different from transforming the system to one that is focused on health. While there is a great need for the latter, we focused on the former to keep the volume of information manageable. We also did not include really comprehensive structural changes like single payer approaches.¹¹⁹

There have been several comprehensive reviews of cost containment approaches.¹²⁰ A few big ideas that these compilations agree on:

- There are no "silver bullets" that alone would reduce the rate of growth in health spending to that of GDP.
- A combination of strategies is likely needed.
- The amount of savings for each approach is highly uncertain, reflecting the fact that few approaches have a proven history of reducing spending and savings from implementing multiple policy options are not likely to be additive. In many cases, employing more than one option would save less than the sum of the individual options would suggest.

¹¹⁹ Hsiao WC, Knight AG, Kappel S, Done N. What Other States Can Learn From Vermont's Bold Experiment: Embracing A Single-Payer Health Care Financing System, Health Affairs, July 2011.

¹²⁰ Eibner C, Hussey P, Ridgely MS, and McGlynn EA, Controlling Health Care Spending in Massachusetts: An Analysis of Options, RAND Corporation, 2009, available at http://www.rand.org/pubs/technical_reports/TR733/. John Holahan, Linda J. Blumberg, Stacey McMorrow, Stephen Zuckerman, Timothy Waidmann, and Karen Stockley, Containing the Growth of Spending in the U.S. Health System, Urban Institute, October 2011, <http://www.urban.org/uploadedpdf/412419-Containing-the-Growth-of-Spending-in-the-US-Health-System.pdf>

Chapter 5

Policy Strategies

Guide to the Evidence	41
Strategies that Target Consumers' Purchase of Health Care or Health Products	41
<i>Revealing the Prices in the Marketplace</i>	41
<i>Revealing Quality/Value in the Marketplace</i>	43
<i>Increasing Consumers' Responsibility for Cost</i>	44
<i>Setting Consumer Price Signals to Achieve Specific Outcomes</i>	46
Strategies that Target Consumers' Purchase of Health Insurance	51
<i>Tools that Help Consumers Understand Plan Value</i>	51
Strategies that Target Providers of Care	53
<i>Transparency Aimed at Providers</i>	53
<i>Provider Payment Reforms</i>	55
<i>Provider Treatment Oversight</i>	62
<i>Global Budgeting</i>	63
<i>Better Coordinated Care</i>	65
<i>Restricting Provider Networks to High Value Providers</i>	70
<i>Encouraging More/Different Providers</i>	72
<i>Tort Reform</i>	73
<i>Combating Fraud and Abuse</i>	74
Strategies that Target Providers of Products	75
<i>Biosimilars: The Generic Pathway for Biologics</i>	75
Strategies that Target Insurers' Costs	76
<i>Rate Review/Rate Regulation</i>	76
<i>Medical Loss Ratio (MLR)</i>	78
<i>The Cadillac Tax</i>	79
<i>Public Insurance Option</i>	80
Strategies that Improve Our Understanding of Spending Flows	80
<i>All-Payer Claims Database</i>	81
<i>Systematic Reporting of Medical Harm</i>	81
<i>Research on Comparative Effectiveness</i>	82



Policy Strategies

Guide to the Evidence

Given the challenge of accurately predicting savings, in this overview we identify evidence of savings from implemented interventions as opposed to projected savings that have been modeled for untested approaches.

Strategies that Target Consumers' Purchase of Health Care or Health Products

While many strategies target consumers' purchase of health care or insurance plan, it is important to remember that consumers themselves direct a minority of our health spending. Consumers' out-of-pocket spending for health care goods and services totals about 13 percent of our nation's health care bill.¹²¹ But the actual amount of spending they direct may be far less. Because consumers are unable to judge the relative merits of different treatment options, they defer many health care purchasing decisions to their providers.

Another limitation of consumer directed strategies is the fact that much of our spending is concentrated among a small group of Americans who suffer from chronic or severe conditions that are costly to treat. Five percent of Americans—those with the most serious health problems—drive nearly half of health care spending.¹²² Many in this group are too ill or too overwhelmed by the complexity of our delivery system to shop around for a better deal. Further, their personal stake in the costs is properly absorbed by insurance at these high levels of spending.

Revealing the Prices in the Marketplace

It is widely understood that true health care prices are typically obscured or unattainable for consumers. Policy analysts speculate that better price transparency, particularly when combined with information on quality, could inject cost-lowering competition into the marketplace. To date, there is little evidence that price transparency alone can significantly lower health spending.

¹²¹ National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960-2011. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

¹²² National Institute for Health Care Management (NIHCM) Foundation, Understanding U.S. Health Care Spending, NIHCM Foundation Data Brief, Washington, D.C., July 2011. <http://nihcm.org/images/stories/NIHCM-CostBrief-Email.pdf>

In 2010, Americans spent \$2.6 trillion on health care, but understanding the price a consumer paid for an individual service within the system is still widely unknown.

-Michael Berger, *Healthcare Price Transparency: A State and Federal Approach*, Costs Of Care, March 2013

The Evidence

In the traditional consumer marketplace, price transparency is a powerful force in incentivizing producers to raise the quality and lower the price of their goods. Policy analysts speculate that better price transparency, particularly when combined with information on quality, could inject cost-lowering competition into the marketplace, as well as encourage consumers to avoid unneeded services. A second mechanism is that exposing prices to “sunshine” will highlight disparities, inequities, and the irrationality of our pricing system in a way that will spur self-correction or build public will for regulatory approaches to achieve efficiency and fair pricing.

However, to date no peer-reviewed studies have been conducted to assess the impact of better price transparency on health care spending trends.^{123, 124} And there is consensus that consumers of health services appear to react very differently to price data for health care, compared to other goods and services.

In 2007, New Hampshire began releasing price information on things like MRIs, as part of its health care price transparency efforts. But in the twelve months following that bill, prices haven’t changed.¹²⁵ Factors that limit the value and availability of health care price transparency include: the difficulty of determining in advance precisely which procedures a patient will need; consumers’ limited ability to choose hospitals or other providers due to insurance policy network, geographic, and cost restrictions; and dulled consumer incentives to shop based on “value” due to third-party payments.¹²⁶ In addition, some suggest that armed with price information, consumers will gravitate toward the “higher priced spread” on the assumption that higher price means better quality.¹²⁷

¹²³ Deloitte Center for Health Solutions, *Health Care Price Transparency: A Strategic Perspective for State Government Leaders*, 2007 http://www.deloitte.com/assets/dcom-UnitedStates/local%20Assets/Documents/us_chs_pricetransparency_031307.pdf

¹²⁴ Anna D. Sinaiko and Meredith B. Rosenthal, “Increased price transparency in Health Care—Challenges and Potential Effects,” *NEJM*, March 2011.

¹²⁵ Anna D. Sinaiko and Meredith B. Rosenthal, “Increased price transparency in Health Care—Challenges and Potential Effects,” *NEJM*, March 2011.

¹²⁶ Chapter 1: *Does Health Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector*. Health Care Policies. 2008.

¹²⁷ Waber RL, Shiv B, Carmon Z, Ariely D. *Commercial Features Of Placebo And Therapeutic Efficacy*. *JAMA* 2008; 299:1016-1017

There is a general consensus that without extensive quality information to pair with it, price information is of limited value.¹²⁸

Current state health price transparency laws are spotty and widely considered inadequate to the task of helping consumers shop. Thirteen states have “All-Payer Claims Databases” (APCDs), primarily through enacted legislation, for that purpose. (See further discussion of All-Payer Claims Databases below.)

Revealing Quality/Value in the Marketplace

Most stakeholders agree that consumers should not shop for health care (or health insurance) based solely on price but rather by examining overall value. While some researchers have demonstrated success in an experimental setting, there is little real world evidence of consumers using quality reports to become value oriented shoppers or that such activities have lowered spending.

Discussion

Research has shown that consumers are more likely to speak with friends, family, or a physician when selecting a provider than they are to use published quality reports.¹³⁰

The largest U.S. test of public reporting, called the Medicare Premier Hospital Quality Incentive Demonstration, showed little or no impact on the value of care received for important clinical conditions; the demonstration neither reduced patient mortality nor cost growth.¹³¹

Myriad barriers have been identified: patients are often not aware that the quality information is available, the information provided in public reports is not what they need or value, the information is outdated, the information is not always available when they need it or the information is not presented in an easily understandable way.¹³² Low rates of trust in their health plans’ quality designations has also been identified as a barrier to quality signals.¹³³

¹²⁸ Id.

¹²⁹ Catalyst for Payment Reform, “Price Transparency: An Essential Building Block for a High-Value, Sustainable Health Care System” undated Action Brief, <http://www.leapfroggroup.org/media/file/PriceTransparencyActionBrief.pdf> and Farrell KS, Finocchio LJ, Trivedi AN, Mehrotra A., Does Price Transparency Legislation Allow the Uninsured to Shop for Care?, *Journal of General Internal Medicine*, 2010.

¹³⁰ “National Survey on Americans as Health Care Consumers: An Update on the Role of Quality Information” Kaiser Family Foundation/Agency for Healthcare Research and Quality, 2000.

¹³¹ Berenson R, Pronovost P, Krumholz H, *Achieving the Potential of Health Care Performance Measures: Timely Analysis of Immediate Health Policy Issues*, Urban Institute, May 2013.

¹³² Julia James, *Public Reporting on Quality and Costs*, *Health Affairs*, March 2012, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=65

¹³³ Anna D, Sinaiko and Meredith B. Rosenthal, “Increased price transparency in Health Care—Challenges and Potential Effects,” *NEJM*, March 2011.

A fundamental barrier is that the typical consumer doesn't have a good working definition of "value" as it pertains to health care. Even when price and quality information are readily available, consumers need better information regarding whether recommended treatments and procedures are clinically necessary or appropriate.¹³⁴

While there is little real world evidence that consumers are using quality reports, in experimental conditions researchers have found that if they are given easy-to-understand information on price and quality, consumers will choose a high-quality provider (defined as lowest price with best quality) 80 to 90 percent of the time.¹³⁵

Increasing Consumers' Responsibility for Costs

Consumer Directed Health Care

Several studies have found first year savings from health plans with deductibles greater than \$1,000. While these plans do attract healthier participants, savings persist after controlling for this favorable selection. Several studies show that both low value and high value care are being reduced, and there is little evidence that consumers become more careful shoppers. Further, longer term savings have not been identified.

Discussion

Consumer Directed Health Plans (CDHPs) are intended to reduce health care spending by exposing consumers to the financial implications of their treatment decisions. These plans typically feature a high deductible and may be accompanied by a tax advantaged savings account designed to encourage consumers to reduce their use of unnecessary health services in order to build up the balance in the account.

A 2012 RAND study found that Consumer Directed Health Plans resulted in significant cost savings. RAND found families enrolling in a higher-deductible health plan (HDHP) for the first time spent an average of 14 percent less in the first year than similar families in traditional health plans.¹³⁶ The analysis examined plans with a range of deductibles but found cost savings of significance only for enrollees in plans with a deductible of at least \$1,000 per person. Other studies have also found first year savings. More research also needs to be done to assess long term savings, if any.^{137, 138}

¹³⁴ Elizabeth Q. Cliff, Kathryn Spangler, Suzanne Delbanco, Nicole Perelman, A. Mark Fendrick. Aligning Quality, Price Transparency, Clinical Appropriateness and Consumer Incentives, Sept 2013. <http://www.sph.umich.edu/vbidcenter/publications/pdfs/CPR%20Aligning%20quality-clinical%20appropriateness%202013.pdf>

¹³⁵ Hibbard JH, Greene J, Sofaer S, Firminger K, Hirsh J. *An Experiment Shows That a Well-Designed Report on Cost and Quality Can Help Consumers Choose High-Value Health Care*. Health Affairs. March 2012; 31(3), 560-8.

¹³⁶ Melinda Beeuwkes Buntin, Amelia M. Haviland, Roland McDevitt, Neeraj Sood *Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans*, RAND, The American Journal of Managed Care, v. 17, no. 3, Mar. 2011.

CDHPs generate greater spending reductions among low- or medium-risk enrollees than among high-risk enrollees and spending reductions are concentrated among outpatient services and pharmaceuticals.¹³⁹

Some researchers have found evidence of modest favorable health selection accounting for some of the observed savings, but this appears to be an issue that needs more research.¹⁴⁰ In the RAND study cited above, the researchers estimated that CDHP enrollees spent about 25 percent less than those who decided not to enroll in the CDHP.¹⁴¹

The data does not suggest that consumers become more careful shoppers, however. A recent RAND study finds little evidence that consumers engage in more price shopping.¹⁴² Further, RAND'S findings also show that participants in high deductible plans use high value services—such as preventive services—less frequently. The drop in preventive care occurred even though most preventive testing is fully covered under consumer-directed plans. Another recent study has similar findings.¹⁴³

Researchers find greater information about prices, quality, and treatment choices will be critical if CDHPs are to achieve the goals of more value conscious shopping. The lack of price transparency in most situations stymies consumers' ability to be a careful shopper, no matter how great the financial incentive.

In the midst of a medical problem...patients are even less likely than usual to adhere to economists' standard assumptions about rational choices.

-AHRQ "Implementing Consumer Financial Incentive Programs"

¹³⁷ RAND Research Highlight, *Skin in the Game: How Consumer-Directed Plans Affect the Cost and Use of Health Care*, 2012. http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9672.pdf

¹³⁸ Commonwealth of Massachusetts, A report on consumer-driven health plans: A review of the national and Massachusetts, Literature. <http://www.mass.gov/anf/docs/hpc/health-policy-commission-section-263-report-vfinal.pdf>

¹³⁹ Kate Bundorf, Consumer Directed Plans: Do They Deliver? October 2012 <http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf402405>

¹⁴⁰ Barry CL, Cullen MR, Galusha D, Slade MD, Busch SH. *Who Chooses a Consumer-Directed Health Plan?* Health Affairs. 2008;27(6):1671-1679.

¹⁴¹ Haviland AM, Marquis MS, McDevitt RD, and Sood N, "Growth of Consumer-Directed Health Plans to One-Half of all Employer-Sponsored Insurance Could Save \$57 Billion Annually," Health Affairs, Vol. 31, No. 5, May 2012.

¹⁴² Neeraj Sood, Zachary Wagner, Peter J. Huckfeldt, Amelia M. Haviland. *Price Shopping in Consumer-Directed Health Plans*, RAND 2013. http://www.rand.org/pubs/external_publications/EP51397.html

¹⁴³ Mary E. Reed, Ilana Graetz, Vicki Fung, Joseph P. Newhouse and John Hsu. In *Consumer-Directed Health Plans, A Majority Of Patients Were Unaware Of Free Or Low-Cost Preventive Care*, Health Affairs, December 2012 <http://content.healthaffairs.org/content/31/12/2641.full>

Setting Consumer Price Signals to Achieve Specific Outcomes

Of interest, a review by AHRQ finds there is no specific evidence from health services research to address whether consumer financial incentives should be structured as rewards, penalties, or a combination of the two.¹⁴⁴ In economic situations other than health care, it has been shown that people are less responsive to potential financial gains than they are to potential financial losses, even when the gains and losses are of equal dollar amounts. It is likely that both penalties and rewards can be used in creating incentive programs.

Reducing Consumer's Cost for Preventive Care

While it would seem like lowering the cost of preventive services would always save money, the evidence shows that isn't always the case. Some services save money but in the aggregate encouraging the use of preventive services save lives at little or no cost but also produces little net savings.

The Evidence

Several studies find that some preventive measures save money while others do not, although they may still be worthwhile because they confer substantial health benefits relative to their cost.^{145, 146} Whether a particular preventive measure represents good value depends on factors such as population targeted, such measures are often good value if there are focused on higher risk or age appropriate populations. Careful analysis of the costs and benefits of specific interventions is critical. It is not possible to generalize about preventive interventions as though they were all alike.

A 2010 study found greater use of preventive services in U.S. health care could save lives at little or no cost, but also produced little net savings. Authors calculated that if 90 percent of the U.S. population used proven preventive services (more than do now), it would save only 0.2 percent of health care spending.¹⁴⁷

Value-Based Insurance Design (VBID)

The evidence on whether VBID can achieve real health care savings is inconclusive.

¹⁴⁴ AHRQ, Consumer Financial Incentives: A Decision Guide for Purchasers, 2007 <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/value/incentives/incentives4.html>

¹⁴⁵ J.T. Cohen, P.J. Neumann, and M.C. Weinstein, Perspective—Does Preventive Care Save Money? Health Economics and the Presidential Candidates. *N Engl J Med*, February 14, 2008. 358(7): 661-663

¹⁴⁶ Russell LB. Prevention's potential for slowing the growth of medical spending. Washington, DC: National Coalition on Health Care, October 2007.

¹⁴⁷ Michael V. Maciosek, Ashley B. Coffield, Thomas J. Flottemesch, Nichol M. Edwards, and Leif I. Solberg Greater Use Of Preventive Services In U.S. Health Care Could Save Lives At Little Or No Cost, Health Affairs, September 2010.

Discussion

Value-based insurance design (VBID) ties cost-sharing to the expected benefit of the health care service being consumed. By lowering the cost of preventive care, wellness visits and treatments such as medications to control blood pressure or diabetes at low to no cost, health plans may save money by reducing future expensive medical procedures. Benefit plans may create disincentives as well, such as high cost-sharing, for health care choices that may be unnecessary or repetitive, or when the same outcome can be achieved at a lower cost. Although VBID could be applied to any health care service, it is commonly considered in the context of pharmaceutical co-payments. To decide what procedures are the most effective and cost efficient, insurance companies may use evidence-based data to design their plans.

There is strong evidence that consumers respond to price incentives when making health care choices. Studies show that consumers respond to the differential cost-sharing in part by switching to drugs in the preferred tiers and reducing demand for non-preferred drugs.¹⁴⁸ There is also evidence that lower co-payments lead to better medication adherence among chronically ill patients.¹⁴⁹ But these consumer responses aren't the same as demonstrating cost savings.

VBID savings depend on whether the cost reductions in one area outweigh the increase costs that results from lower co-payments in another area. Further, VBID may require up-front investments that would have to be recouped before savings are realized. An assessment by RAND found limited evidence for savings from VBID.¹⁵⁰ Similarly, a guide by the National Business Coalition on Health (NBCH) notes that the currently available research evidence documenting a positive short- or long-term “return on investment” from VBID initiatives is “limited, preliminary and mixed.”¹⁵¹ The NBCH Guide notes that VBID may not be worthwhile in places:

- With high employee turnover—especially given that high-value services take several years to realize savings.¹⁵²
- In companies with fewer than 5,000 employees—the administrative costs may be too high to realize savings. (NBCH notes that most experience with VBID is in companies with 10,000 or more employees.)

¹⁴⁸ Goldman DP, Joyce GF, Zheng Y. “Prescription Drug Cost-Sharing: Associations with Medication and Medical Utilization and Spending and Health.” *Journal of the American Medical Association*, 298(1):61-9, 2007.

¹⁴⁹ D.P. Goldman et al. “Prescription Drug Cost-Sharing: Associations with Medication and Medical Utilization and Spending and Health,” *JAMA*, 2007. Conversely, this study found increasing patient cost-sharing was associated with declines in medication adherence, which in turn was associated with poorer health outcomes. Michael T. Eaddy, Christopher L. Cook, Ken O’Day, Steven P. Burch, and C. Ron Cantrell, *How Patient Cost-Sharing Trends Affect Adherence and Outcomes*, P T. 2012 January; 37(1): 45–55.

¹⁵⁰ Eibner C, Hussey P, Ridgely MS, and McGlynn EA, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, RAND Corporation, 2009, available at http://www.rand.org/pubs/technical_reports/TR733/.

¹⁵¹ Citing Hunt S, Maerki S, and Rosenberg W., *Assessing Quality-Based Benefit Design*, Prepared for the California HealthCare Foundation and Pacific Business Group on Health, April 2006.) Houy, M., *Value-based Benefit Design: A Purchaser’s Guide*, National Business Coalition on Health (January 2009), p. 4.

¹⁵² Longer-term savings are still of value in curbing our overall cost trend, but other means of achieving them may need to be found if there is not ROI for an individual employer.

Reference Pricing

A well-designed study found savings from reduced utilization of the procedure and from provider price reductions when reference pricing was introduced by CalPERS, a large payer in California. It's unclear if scaling it to hundreds of procedures is feasible or if smaller payers can extract the payment concessions from providers that CalPERS has achieved.

Discussion

Reference pricing establishes a standard price for a drug, procedure, or service and then generally asks health plan beneficiaries (consumers) to pay the charges beyond that amount—essentially a “reverse deductible.” Thus, consumers have an incentive to choose a provider at or below the reference price to avoid having to pay out-of-pocket for the difference.¹⁵³ Choice is preserved, but at a cost.

There is strong evidence that reference pricing can produce savings, at least for selected procedures, without harming quality. The California Public Employees' Retirement System's (CalPERS) implemented reference pricing for knee and hip replacement surgery after observing a five-fold variation in prices for these two procedures, with no measurable difference in outcome quality across California hospitals. CalPERS designated hospitals with procedure prices below \$30,000, acceptable quality, and sufficient geographic dispersion as Value-Based Purchasing design (VBPD) facility.¹⁵⁴ Employees who went to a non-VBPD facility were required to pay the difference between \$30,000 and the actual price charged by the hospital, in addition to the regular cost-sharing.

A major study examined the impact of reference pricing from 2008 to 2012. The researchers found savings from reduced utilization of the procedure and from provider price reductions. In the first year after implementation, surgical volumes for CalPERS members increased by 21.2 percent at low-price facilities and decreased by 34.3 percent at high-price facilities. There was a decline of 5.6 percent in prices charged to CalPERS members at low-price facilities and a decline of 34.3 percent at high-price facilities. In 2011 alone, reference pricing accounted for \$2.8 million in savings for CalPERS and \$0.3 million in lower cost-sharing for CalPERS members.¹⁵⁵

It could be an effective cost containment tool in instances when there are equivalent therapeutic options available. It's unclear if scaling it to hundreds of procedures is feasible

¹⁵³ Catalyst for Payment Reform, From Reference Pricing to Value Pricing, http://catalyzepaymentreform.org/images/documents/CPR_Action_Brief_Reference_Pricing.pdf

¹⁵⁴ CalPERS, Hips and Knees Reference Based Pricing Evaluation, June 18, 2013. <http://www.calpers.ca.gov/eip-docs/about/committee-meetings/agendas/pension/201306/item-7.pdf>

¹⁵⁵ James C. Robinson, and Timothy T. Brown, Increases In Consumer Cost-Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery, <http://content.healthaffairs.org/content/32/8/1392.full>

or if smaller payers can extract the payment concessions from providers that CalPERS has achieved. This strategy needs to be informed by good data on quality and the comparative effectiveness of treatment options so that quality of care doesn't suffer.

Wellness Incentives

A meta-analysis by RAND concluded that there is good evidence that wellness programs can positively impact behavior. However, it found little evidence that these programs lowered costs.¹⁵⁶

Discussion

Wellness incentives—typically introduced by employers—attempt to get employees to make health changes in behavior, targeting lifestyle risks such as tobacco, alcohol and drug use, as well as chronic health risks such as cancer, diabetes, high blood pressure and heart disease. There are different approaches:

- Participation-based incentives reward employees with cash or a health insurance premium reduction simply for participating in, say, an annual health risk assessment or biometric screening.
- Outcome-based incentives take it a step further and reward employees who achieve and maintain specific health goals for things such as body mass index and cholesterol and blood pressure levels.
- Progress-based incentives reward employees for the progress they make toward specific health goals, whether they reach them or not.

A meta-analysis by RAND concluded that there is good evidence that wellness programs can positively impact behavior; however, it found little evidence that these programs lowered costs.¹⁵⁷ Specifically, RAND found statistically significant, meaningful improvements in exercise frequency, smoking, and weight control, but not cholesterol. The improvements were sustainable over four years and simulation analyses suggest cumulative effects.

Authors note there is wide variation in programs, and not all positively impacted behavior. Formal guidelines or standards for such programs generally do not exist yet. Furthermore, they report that only half of employers have actually evaluated the impact of their programs and only two percent report actual savings estimates.

¹⁵⁶ Soeren Mattke, Hangsheng Liu, John P. Caloyeras, Christina Y. Huang, Kristin R. Van Busum, Dmitry Khodyakov, Victoria Shier. Workplace Wellness Programs Study Final Report, RAND, 2013. http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.sum.pdf

¹⁵⁷ Soeren Mattke, Hangsheng Liu, John P. Caloyeras, Christina Y. Huang, Kristin R. Van Busum, Dmitry Khodyakov, Victoria Shier. Workplace Wellness Programs Study Final Report, RAND Health, 2013. http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.sum.pdf

A second study had similar findings, noting that employers should expect to invest in wellness for several years before achieving a positive ROI, if at all.¹⁵⁸ Authors note there are many challenges in accurately capturing ROI or alternative measures of impact, and because wellness programs are often implemented simultaneously with other benefit changes, isolating the impact of wellness programs on an employer's cost trends may not be possible.

Many consumer advocates are concerned that workplace wellness programs may bring health status underwriting in through the back door; the ACA had otherwise promised to eliminate such underwriting.

Promoting Generic Drug Substitution

Despite high levels of generic substitution today, some researchers find additional savings may still be realized.¹⁵⁹

The Evidence

Policies to promote generic substitution can take several forms, including lowering the price of the generic drug and requiring substitution of generic for brand, or making it the default unless the physician requests otherwise. Such policies have been in place for a long time and there is evidence that substantial savings have been realized for the health system. An analysis by ASPE finds current levels of generic drug use are fairly high. There is potential for increased savings from generic drug use both through increased availability of generic drugs and through increased substitution, particularly therapeutic substitution.¹⁶⁰ Some researchers find additional savings may still be realized.¹⁶¹

Note: Studies of savings from Medicaid are uncertain due to rebates Medicaid receives from manufacturers. By law, Medicaid receives a larger rebate for branded than for generic drugs.

¹⁵⁸ Ha T. Tu, Ralph C. Mayrell, Employer Wellness Initiatives Grow Rapidly, but Effectiveness Varies Widely, NIHCR Research Brief No. July 2010. <http://www.nihcr.org/Employer-Wellness-Initiatives.html>

¹⁵⁹ Congressional Budget Office, Effects of Using Generic Drugs on Medicare's Prescription Drug Spending, September 15, 2010, <http://www.cbo.gov/publication/21800>

¹⁶⁰ Expanding the Use of Generic Drugs, ASPE, December 1, 2010. <http://aspe.hhs.gov/sp/reports/2010/genericdrugs/ib.shtml>

¹⁶¹ William H. Shrank, Niteesh K. Choudhry, Jessica Agnew-Blais, Alex D. Federman, Joshua N. Liberman, Jun Liu, Aaron S. Kesselheim, M. Alan Brookhart, and Michael A. Fischer, State Generic Substitution Laws Can Lower Drug Outlays Under Medicaid, *Health Affairs*, 29, No. 7 (2010): 1383–139; and J Hoadley, K Merrell, E Hargrave, and L Summer. In Medicare Part D Plans, Low or Zero Copays And Other Features To Encourage The Use of Generic Statins Work, Could Save Billions. *Health Affairs*. October 2012: 31 (10): pp. 2266-2275.

Tiered Formularies

There is strong evidence that tiered formularies are associated with reduced use of medicines. Whether tiered formularies impacts quality needs more research.¹⁶²

Discussion

A tiered formulary divides drugs into groups, based primarily on cost. A plan's formulary might have three, four or even five tiers. If a plan negotiates a lower price on a particular drug, then it can place it in a lower tier and pass the savings on to its members. In general, the lowest-tier drugs are the lowest cost.

Strategies that Target Consumers' Purchase of Health Insurance

The point at which consumers shop for coverage is another place where health care spending can be targeted, at least indirectly. Unlike using shopping for health care treatments, products or providers, consumers can be much more dispassionate about health plans. While selecting between health plans has historically been very difficult,¹⁶³ new requirements included in the Affordable Care Act are reducing the complexity of the task.

While a better marketplace certainly helps consumers make selections that are right for their families, whether or not this can be leveraged to put downward pressure on costs remains to be seen. As the discussion in Chapter 3 shows, it isn't clear how much control insurers themselves can exert on prices.

Tools that Help Consumers Understand Plan Value

When premium is the only understandable component of consumers' health plan options, low premiums can reflect skimpy coverage, favorable selection into the risk pool, or very limited provider networks. When the other dimensions of coverage, such as quality, become understandable to consumers, insurers have more of an incentive to provide value and negotiate aggressively with their providers as means of lower premiums. The Affordable Care Act took a number of important steps toward increasing consumer awareness and understanding of health plans.

¹⁶² Steve Morgan, Gillian Hanley, and Devon Greyson. Comparison Of Tiered Formularies And Reference Pricing Policies: A Systematic Review, *Open Med.* 2009; 3(3): e131–e139. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3090119/>

¹⁶³ L. Quincy, *What's Behind the Door: Consumers' Difficulties Selecting Health Insurance*, *Consumers Union*, January 2012. http://consumersunion.org/wp-content/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf

Actuarial Value Tiers and Standard Benefits

There is no direct evidence that greater clarity on the coverage offered by a plan will reduce health spending. However, there is evidence that providing consumers with more easily understandable information can help them be better shoppers.

Discussion

“Actuarial value” measures the percentage of expected medical costs that a health plan will cover, on average. It can be considered a general summary measure of health plan generosity. As such, it can help consumers make sense of their health plan options by providing an overall measure of coverage in addition to discrete information on deductibles, co-payments, and co-insurance, etc. (Note: actuarial value reflects what would be paid across a standard population; an individual’s specific cost-sharing can vary greatly from this average.)

The Affordable Care Act requires plans sold in the nongroup and small group market to conform to one of four different coverage tiers: Bronze, Silver, Gold and Platinum (with actuarial values of 60 percent, 70 percent, 80 percent and 90 percent, respectively). This requirement is joined by a requirement to cover a standard list of services, known as Essential Health Benefits. Together, these two requirements should significantly reduce the variation between health benefit designs in the nongroup and small group market. The policy goal is to better enable consumers to judge the adequacy of their coverage options.

There is limited research showing that grouping health plans into coverage tiers provides an intuitive and easy-to-use way for consumers to navigate their choices by providing a sense of the relative value of one plan compared to another.¹⁶⁴

Summary of Benefits and Coverage (SBC)

Despite experimental data showing that consumers prefer and respond to standard disclosures that allow them to compare health plans “apples-to-apples,” there is no direct evidence that these tools will reduce health spending.

Discussion

The Affordable Care Act calls for a new, standardized method of communicating health

¹⁶⁴ Quincy, Early Consumer Testing of the Actuarial Value Concepts, Consumers Union and Kleimann Communication Group, September 2011 and Health Reform Toolkit Series: Resources from the Massachusetts Experience, Determining Health Benefits Designs to be offered on a State Health Insurance Exchange, November 2011. <https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/MassachusettsExperienceBenefitDsignsToolkit.pdf>.

coverage information to consumers. This new document is called the “Summary of Benefits and Coverage” (SBC).

Since the SBC was only required beginning September 2012, there is no direct evidence yet whether it will affect consumer decisions or lower health spending overall. However, there is evidence from consumer testing showing that consumer-friendly, comparative information can help consumers understand their coverage,¹⁶⁵ which may enable consumers to make better selections and incent insurers to compete on value.

A survey conducted by Consumers Union in the fall of 2012 on the SBC showed that people who saw the SBC though it was helpful.¹⁶⁶ Over 50 percent of those who viewed were very or completely satisfied with the specific features of the SBC, with very few expressing any dissatisfaction. When asked to rate the helpfulness of the SBC against other common sources of health plan information, the SBC was rated as helpful most often, followed by employer provided health plan comparisons (for those shopping for employer coverage). A second study simulated health plan coverage for different medical scenarios, for example, breast cancer, heart attacks, and diabetes.¹⁶⁷ The researchers concluded that standardized health plan comparison tools helped consumers better understand the types of medical events for which health insurance could be needed and understand the financial impact of these events under different policies.

Strategies that Target Providers of Care

Health care providers drive the bulk of our nation's health spending through their purchasing and treatment decisions. Many strategies have been designed to motivate providers to deliver better care at lower cost.

Transparency Aimed at Providers

Price Transparency

While there is evidence that providers are often unaware of the cost of devices and treatments, there is little evidence on whether more ready price information would alter their practice patterns so as to lower spending.

¹⁶⁵ Quincy, *Early Consumer Testing of the Coverage Facts Label: A New Way of Comparing Health Insurance*, Consumers Union and Kleimann Communication Group, 2011. http://consumersunion.org/wp-content/uploads/2013/03/CU_CFL_Report_FINAL.pdf

¹⁶⁶ Quincy, *Early Experience with a New Consumer Benefit: The Summary of Benefits and Coverage*, Consumers Union, February 2013. <http://consumersunion.org/pdf/Early%20Experience%20With%20the%20SBC%20Report.pdf>

¹⁶⁷ Karen Pollitz et al. *Coverage When It Counts: What Does Health Insurance In Massachusetts Cover And How Can Consumers Know?*, Robert Wood Johnson Foundation, <http://www.rwjf.org/content/dam/web-assets/2009/05/coverage-when-it-counts>

Discussion

Surprisingly, many providers are themselves unaware of what health care costs. Physicians rarely have comparative data on specific charges for medical procedures.¹⁶⁸ A recent study found that only 16 percent of surveyed U.S. hospitals were able to provide an estimate for the cost of a hip replacement.¹⁶⁹

Some researchers express concern that transparency of price information will actually have the perverse, unintended effect of raising hospital and other provider prices; once providers see what is being paid to their “competitors,” the theory goes, those with lower prices will raise prices because now they know what the market will bear.¹⁷⁰

Other point out that the health care industry still has a number of distinctive characteristics that limit transparency’s price effects—low competition in many markets, complex products, and multiple agents involved in purchasing decisions.

Quality Transparency

There is evidence that hospitals increase their quality improvement activities in response to public reporting of provider performance data, but no evidence of impact on spending trend.¹⁷¹

Discussion

Hospital executives report that quality reports and hospital comparisons help them focus their quality efforts.¹⁷² The evidence suggested that individual clinicians and organizations respond to public reporting in positive ways, including adding services, changing policy, and increasing focus on clinical care.¹⁷³ Few studies have tried to demonstrate that quality reporting saves money, however.

The evidence seems to be mixed with respect to the impact of mandating hospitals to report HAI rates publicly. The intended consequence of these policies is that hospitals increase

¹⁶⁸ Collins, Sara, & Davis, Karen. *Transparency In Health Care: The Time Has Come*. The Commonwealth Fund. March 15, 2006.

¹⁶⁹ Jaime A. Rosenthal; Xin Lu, MS; Peter Cram, MD, MBA. *Availability of Consumer Prices From US Hospitals for a Common Surgical Procedure*, JAMA Intern Med. 2013;173(6):427-432.

¹⁷⁰ David Cutler and Leemore Dafny. “Designing Transparency Systems for Medical Care Prices”, NEJM, March 2011 364;10, p. 894

¹⁷¹ Fung CH, Lim YW, Mattke S, Damberg C, Shekelle PG. “Systematic Review: The Evidence That Publishing Patient Care Performance Data Improves Quality of Care.” *Annals of Internal Medicine* 148(2):111-23, 2008.

¹⁷² Mary Laschober, Ph.D., Myles Maxfield, Ph.D., Suzanne Felt-Lisk, M.P.A., and David J. Miranda, Ph.D. *Hospital Response to Public Reporting of Quality Indicators*, Health Care Financing Review, Spring 2007, Volume 28.

¹⁷³ AHRQ, *Public Reporting as a Quality Improvement Strategy Closing the Quality Gap: Revisiting the State of the Science*, http://www.effectivehealthcare.ahrq.gov/ehc/products/343/1198/Evidencereport208_CQG-PublicReporting_ExecutiveSummary_20120724.pdf

efforts to decrease infection rates. One study concludes this impact is unknown¹⁷⁴ but other evidence finds reductions in HAI in response to reporting. The Center for Disease Control (CDC) has documented significant decreases in the types of infections covered by state reporting programs. In 2011, CDC reported a 41 percent decrease of central line associated bloodstream infections in ICU patients compared to 2008—a specific measure required by most states with infection reporting laws.¹⁷⁵ The same CDC report indicated a 17 percent reduction of surgical site infections¹⁷⁶ and a seven percent decrease in catheter associated urinary tract infections.¹⁷⁷ Annual reports from states have also demonstrated declines in reported HAIs.¹⁷⁸

Worth noting: despite consumers beliefs to the contrary, there is strong evidence that price does not correspond with quality.¹⁷⁹

Provider Payment Reforms

There is widespread agreement that payment policies must change to motivate providers to focus on outcomes and deliver value (broadly defined as health benefits per dollar spent) rather than volume of services (the number of examinations, tests, procedures, and treatments). A meta-analysis by RAND¹⁸⁰ found that only two provider payment strategies showed promise of savings:

- Bundled Payments
- Hospital Rate Setting

Bundled Payments

Several researchers view bundled payments as a promising strategy but the quality of the evidence to date is rated “low.”

¹⁷⁴ Patricia W Stone, PhD, FAAN, Economic burden of healthcare-associated infections: an American perspective. *Expert Rev Pharmacoecon Outcomes Res.* 2009 Oct;9 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2827870/>

¹⁷⁵ Centers for Disease Control, 2011 National and State Healthcare-associated Infections Standardized Infection Ratio Report, Feb 2013; <http://www.cdc.gov/hai/national-annual-sir/index.html>

¹⁷⁶ 2011 compared to 2008 data; most of the CDC data during this period came from the numerous states that required reporting of selected surgical infections.

¹⁷⁷ 2011 compared to 2009 data; the hospital acquired condition payment program, which included this type of HAIs (CAUTIs), began during this time period.

¹⁷⁸ Consumers Union Safe Patient Project list of links to state reports on HAIs, <http://safepatientproject.org/tags/state-disclosure-reports>

¹⁷⁹ <http://www.californiahealthline.org/articles/2013/7/23/report-hospital-list-prices-often-do-not-match-quality-of-care> and <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf>

¹⁸⁰ Eibner C, Hussey P, Ridgely MS, and McGlynn EA, Controlling Health Care Spending in Massachusetts: An Analysis of Options, RAND Corporation, 2009, available at http://www.rand.org/pubs/technical_reports/TR733/. Summary available: http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9690z1.pdf

Discussion

In a bundled payment methodology, a single, “bundled” payment covers services delivered by two or more providers during a single episode of care or over a specific period of time.¹⁸¹ For example, if a patient has cardiac bypass surgery, rather than making one payment to the hospital, a second payment to the surgeon and a third payment to the anesthesiologist, the payer would combine these payments for the specific episode of care (i.e., cardiac bypass surgery). This approach, in theory, gives strong incentives for the providers to coordinate care and determine the best overall approach—i.e., bundle of services—to treatment and care.

A meta-analysis by RAND researches examined 58 studies and found that the introduction of bundled payment was associated with:

1. Reductions in health care spending and utilization, and
2. Inconsistent and generally small effects on quality measures.¹⁸²

They concluded that there is weak but consistent evidence that bundled payment programs have been effective in cost containment without major effects on quality. Reductions in spending and utilization relative to usual payments were less than 10 percent in many cases. The findings were consistent across different bundled payment programs and settings, but the strength of the body of evidence was rated as “low” – indicating that there is low confidence that the evidence reflects the trust effect, due mainly to concerns about bias and residual confounding.

The best evidence to date (2009) for bundled payment is from Medicare demonstration projects, which have shown a 10 percent reduction in a project bundling payment for coronary artery bypass graft surgery.

Capitation

The evidence is mixed with respect to capitation’s ability to hold down costs. While some researchers have found that capitation can limit spending, not all researchers agree that the evidence shows clear cost savings from capitation.

Discussion

Capitation is a payment mechanism in which a provider is paid a fixed rate per person per

¹⁸¹ Catalyst for Payment Reform, Implementing Bundled Payment, http://catalyzepaymentreform.org/images/documents/CPR_Action_Brief_Bundled_Payment.pdf

¹⁸² Hussey PS, Mulcahy AW, Schnyer C, Schneider EC. Bundled Payment: Effects on Health Care Spending and Quality. Closing the Quality Gap: Revisiting the State of the Science. Evidence Report/Technology Assessment No. 208. AHRQ Publication No. 12-E007-EF. Rockville, MD: Agency for Healthcare Research and Quality. August 2012. www.effectivehealthcare.ahrq.gov/reports/final.cfm.

month, usually prospectively, to cover all care within a specified set of services without regard to the actual number of services provided.

Evidence of cost saving is mixed.¹⁸³ Not all researchers agree that the evidence shows clear cost savings from capitation. These studies found savings:¹⁸⁴

- A 2004 report prepared by The Lewin Group reviewed 14 studies of savings achieved from Medicaid managed care programs using capitated payments. It found clear evidence of cost savings, mainly from less use of inpatient services. Savings ranged from two to 19 percent compared to FFS.
- Mathematica Inc., a policy research firm, conducted a comprehensive review of the evidence and found that “Payment approaches involving risk-sharing with providers – including global payment or capitation – are associated with lower service use and costs, compared with fee-for-service arrangements.
- A 2008 New England Journal of Medicine reported, “Experiments with capitation in commercially insured populations demonstrate reductions in cost.”

Hospital Rate Setting

In Maryland (the most frequently cited example), the state’s Health Services Cost Review Commission has set hospital rates for all payers, including Medicare and Medicaid, since 1977. Well documented studies show Maryland has consistently had the lowest markup of charges over cost of any state, but extra steps needed to be taken to control the volume of admissions. Several meta-analyses suggest this can be an effective strategy.¹⁸⁵

Discussion

Several researchers have concluded that rate-setting can be successful in controlling the rate of increase in hospital costs.¹⁸⁶ However, its success depends on the way in which rate setting is carried out, as well as regulators’ ability to enforce the rates and impose penalties for noncompliance. Hospital care represents 31 percent of overall national health care spending. Even a modest decrease in hospital expenditures – on the order of five percent, a level that was

¹⁸³ National Conference of State Legislatures, Health Cost Containment and Efficiencies: NCSL Briefs for State Legislators. May 2011. <http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf>

¹⁸⁴ Ibid.

¹⁸⁵ Eibner C, Hussey P, Ridgely MS, and McGlynn EA, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, RAND Corporation, 2009, available at http://www.rand.org/pubs/technical_reports/TR733/. Summary available: http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9690z1.pdf and Atkinson, Graham, *State Hospital Rate-Setting Revisited*, The Commonwealth Fund, October 2009. http://www.commonwealthfund.org/-/media/Files/Publications/Issue%20Brief/2009/Oct/1332_Atkinson_state_hospital_ratesetting_revisited_1015.pdf

¹⁸⁶ Eibner C, Hussey P, Ridgely MS, and McGlynn EA, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, RAND Corporation, 2009, http://www.rand.org/pubs/technical_reports/TR733.html.

met or exceeded in most states adopting hospital rate regulation – would achieve an annual savings of \$35 billion, based on 2007 expenditures.

In Maryland, the state has achieved great success in holding down the cost per admission.¹⁸⁷ However, hospital admissions and overall hospital volume has not been well controlled. During the period of 2001-2007, admissions grew at an annual average rate of 2.7 percent in Maryland versus an average annual rate of one percent nationally. From 1978-2001 and then again in 2008, fixed/variable cost adjustments to payment rates were enforced due to volume of hospital admissions. In 2008, growth in admissions dropped to one percent per year.

One researcher suggests the following as to why Maryland’s system has endured:

1. The enabling legislation was drafted by the Maryland Hospital Association, an organization that was run by hospital trustees and the hospital industry has continued to support it
2. The rate-setting system severely restricts the discounts that payers, including HMOs, can receive. Allowing unrestricted discounting to HMOs greatly contributed to the dissatisfaction of hospitals with rate-setting in other states.
3. Medicare and Medicaid pay the rates set by the HSCRC.

Reference Pricing Revisited

The reference pricing strategy appears to lower costs by changing consumers purchase decisions, as discussed above, but also by inviting a price response from hospitals that were initially priced higher than the reference price.

Discussion

As discussed in the consumer directed Chapter 3, high price hospitals in the CalPERS reference pricing effort responded by lowering their prices.¹⁸⁸ It isn’t clear if this was a net lowering of spending by these hospitals, or if the lost revenue was made up by increasing the price of other services.

The RAND meta-analysis explored a strategy that used a reference price approach to institute rate regulation for academic medical centers (AMCs).¹⁸⁹ This policy would limit reimbursement for non-tertiary care provided at academic medical centers (AMCs) to the average community-hospital reimbursement rate through a regulatory strategy.

¹⁸⁷ Ibid.

¹⁸⁸ James C. Robinson, and Timothy T. Brown, Increases In Consumer Cost-Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery, <http://content.healthaffairs.org/content/32/8/1392.full>

¹⁸⁹ Eibner C, Hussey P, Ridgely MS, and McGlynn EA, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, RAND Corporation, 2009, available at http://www.rand.org/pubs/technical_reports/TR733/.

Relative Value Units (RVU) Approaches

While the Relative Value Units used by Medicare to pay doctors were originally designed to ensure that payments adhered to input costs and trend over time was controlled, there is evidence that this strategy is not working as intended.

Discussion

In 1992, the federal government implemented the Resource-Based Relative Value Scale (RBRVS), a system used to determine physician's services payment. RVU approaches try to establish the relative value of medical procedures by looking at inputs such as the time and intensity of the procedures. This system is used by Medicare, and is governed by a committee of the American Medical Association (AMA)¹⁹⁰ that meets confidentially every year to come up with values for most of the services a doctor performs.¹⁹¹ The values, in turn, determine what Medicare and most private insurers pay doctors.

There is some question over whether the current system of RVU weights, as maintained by the AMA committee, are accurately measuring doctor inputs. Over time, the RVU updating system has placed an increasing importance, as evidenced by RVU weights, on procedures, scans, and other technical services that fix certain ailments or problems.¹⁹² This has resulted in an emphasis on volume over value and the maintenance of silos in health care, which may have eroded quality of care.

There also seems to be insufficient scrutiny of these AMA recommendations. According to a study conducted by Health Affairs, CMS takes the AMA recommendation 87.4 percent of the time. According to this study, these RVU recommendations have widened the income gap between primary and specialty care providers.

A separate issue is sustainable growth rate (SGR). The conversion factor updates payments for physician services every year according to a formula called the sustainable growth rate (SGR) system. This formula is intended to keep spending growth (a function of service volume growth) consistent with growth in the national economy. However, in the last ten years, Congress has specified an update outside of the SGR formula.

¹⁹⁰ The RBRVS is based on these three factors: physician work, practice expense, and malpractice expense. CMS is responsible to adjust the RBRVS in accordance with any changes in the Current Procedural Terminology (CPT) book, or procedures annually. To determine the relative value of the "physician work" component, CMS has to determine the time, work, and effort physicians invest in that particular service. In light of this, the American Medical Association (AMA) offered to create an expert panel to provide them with recommendations addressing the RBRVS changes. CMS accepted, and in 1991, the AMA created the Specialty Society Relative Value Service Updating Committee (RUC) for the purpose of providing recommendations to the CMS.

¹⁹¹ Haley Sweetland Edwards, *The shadowy cartel of doctors that controls Medicare*, Washington Monthly, July/ August 2013. http://www.washingtonmonthly.com/magazine/july_august_2013/features/special_deal045641.php

¹⁹² Statement By Kavita Patel Md, Ms Hearing on "Using Innovation to Reform Medicare Physician Payment," Committee on Energy and Commerce Subcommittee on Health, United States House of Representatives, July 18, 2012 <http://www.brookings.edu/~media/research/files/testimony/2012/7/18%20medicare%20innovation%20patel/18%20medicare%20innovation%20patel.pdf>

The following revisions have been recommended for our current system:¹⁹³

1. Payments must incentivize coordination between providers and across different provider settings. Up to \$45 billion dollars in health spending each year are attributed to failures in coordination, up to \$226 billion in overtreatment and up to \$389 billion in administrative complexity.
2. Payments must inject flexibility into physician practices and clinical processes to remove the sole reliance on the provision of services, tests, and drugs as sources of income.
3. Payments must be tied to appropriate performance and quality measures and embedded into continuous quality improvement programs.

Pay-For-Performance

Pay-for-performance (P4P) initiatives have generally been designed to improve the quality of medical care, and there appears to be insufficient investigation of the effect of P4P on medical spending. While some studies have found savings, a recent meta-analysis concluded that “evidence on the efficiency of P4P is scarce and inconclusive.” P4P efficiency could not be demonstrated. The small number and variability of included studies limit the strength of our conclusions. More research addressing P4P efficiency is needed.”^{194, 195}

No Payment for “Never Events”; Medical Errors

Evidence from the literature establishes that “Hospital Acquired Conditions” (HACs) are avoidable. Other evidence establishes that providers respond to financial incentives. But direct evidence of the cost and quality impact of policies that don’t pay for “never events” or other types of errors must still missing.

Discussion

As noted above, medical harm, including Hospital Acquired Infections (HAI), prescription errors, and “never events,” is connected to significant additional costs and avoidable readmissions.

Until recently, the costs associated with treating the medical results of these errors were routinely paid by insurers, including private payers, Medicare and Medicaid. As a result, hospital leaders did not have strong economic incentives to avoid these medical errors to improve patient safety.¹⁹⁶

¹⁹³ Ibid

¹⁹⁴ Emmert M, Eijkenaar F, Kemter H, Esslinger AS, Schöffski O. *Economic evaluation of pay-for-performance in health care: a systematic review*. Eur J Health Econ. 2012 Dec;13(6):755-67.

¹⁹⁵ Mehrotra A, Sorbero ME, Damberg CL. *Using the lessons of behavioral economics to design more effective pay-for-performance programs*. Am J Manag Care. 2010 Jul;16(7):497-503.

In 2008, CMS began withholding payments to hospitals for care needed after patients suffer from HACs. The regulations included protections to prevent hospitals from billing patients when Medicare payments were withheld and to minimize hospital's effort to avoid admitting patients perceived to be at risk for these conditions. Under the ACA, hospitals will experience a reduction in payments to account for preventable readmissions for certain conditions beginning Oct. 1, 2012. In early 2013, CMS charged a total of 2,213 hospitals about \$280 million in readmission penalties and \$227 million in fines are expected in the second year, according to one analysis.¹⁹⁷

While several studies find savings from prevention of HAI generally, the impact of non-payment for never events has yet to demonstrate a significant impact in terms of quality or savings.¹⁹⁸ A limited number of studies looked at CMS's 2008 payment policies, but not the broader efforts implemented recently. One study found that the financial incentive associated with just six conditions might be too small to have much impact, but the public attention it has attracted may lead to improved quality.¹⁹⁹ Other evidence establishes that HACs are avoidable and that providers respond to financial incentives,²⁰⁰ although one researcher called this evidence "sparse" with respect to the impact on quality of care.

More generally, one study estimated that, for 2007, the benefits of HAI prevention range from a low of \$5.7 to \$6.8 billion (20 percent of infections preventable) to a high of \$25 to \$31.5 billion (70 percent of infections preventable).²⁰¹ New York estimated savings from reducing HAI between 2007 and 2011 as ranging from \$21 million to \$75 million²⁰² and Pennsylvania estimated that a minimum of \$34 million in direct health care costs that would have been associated with HAIs was saved in 2010 and 2011.²⁰³

One report pointed out that HACs, "never events" and readmissions are less common in the employed population, and savings could be offset by ensuring care is appropriate in the first place.²⁰⁴ However, another researcher speculates that any strategies used by hospitals to

¹⁹⁶ M. M. Mello, D. M. Studdert, E. J. Thomas, et al., "Who Pays for Medical Errors?: An Analysis of Adverse Event Costs, the Medical Liability System, and Incentives for Patient Safety Improvement," *Journal of Empirical Legal Studies*, Dec. 2007 4(4):835–60.

¹⁹⁷ Rau, Jordan, "Armed With Bigger Fines, Medicare To Punish 2,225 Hospitals For Excess Readmissions," *Kaiser Health News*, Aug 2 2013; <http://www.kaiserhealthnews.org/Stories/2013/August/02/readmission-penalties-medicare-hospitals-year-two.aspx>

¹⁹⁸ Julie Appleby Study: CMS Penalties Don't Change Hospital-Acquired Infection Rates, October 10th, 2012, <http://capsules.kaiserhealthnews.org/index.php/2012/10/study-cms-penalties-dont-change-hospital-acquired-infection-rates/> See also: [http://www.ajicjournal.org/article/S0196-6553\(11\)01253-3/abstract](http://www.ajicjournal.org/article/S0196-6553(11)01253-3/abstract); <http://www.sun.org/resources/journal/article331Epub1.pdf>

¹⁹⁹ Peter D. McNair, Harold S. Luft and Andrew B. Bindman. *Medicare's Policy Not To Pay For Treating Hospital-Acquired Conditions: The Impact*, *Health Affairs*, September/October 2009.

²⁰⁰ Eibner C, Hussey P, Ridgely MS, and McGlynn EA, Controlling Health Care Spending in Massachusetts: An Analysis of Options, Santa Monica, Calif.: RAND Corporation, TR-733-COMMASS, 2009

²⁰¹ R. Douglas Scott, *The Direct Medical Costs Of Healthcare-Associated Infections In U.S. Hospitals And The Benefits Of Prevention*, CDC, March 2009.

²⁰² New York Department of Health, "Hospital-acquired infections, New York State, 2011," p.5.

²⁰³ 2011 Report: Healthcare-Associated Infections (HAI) in Pennsylvania Hospitals; p 8; http://www.portal.state.pa.us/portal/server.pt/community/healthcare_associated_infections/14234/hai_annual_reports/1403644

reduce the incidence of avoidable complications (rather than just creative coding) in response to the CMS policy will probably benefit private health insurers through hospital wide initiatives.²⁰⁵

Provider Treatment Oversight

Disease management strategies have been in use for many years, and more recently, case management strategies. Both approaches to managing care include additional oversight of treatment decisions for complex or high cost cases.

Disease Management

The evidence is inconclusive with respect to the ability of disease management programs to reduce spending trends.

Discussion

The concentration of health care expenditures in subpopulations with chronic conditions has led to the widespread proliferation of disease management programs. However, several studies cast doubt on the capacity of disease management programs to reduce costs.²⁰⁶ Recent analyses have found that cost savings and return on investments varied by diagnosis.²⁰⁷

Most disease management programs focus on management of a single chronic condition. This raises concerns about whether they may undermine coordination of care for patients with multiple chronic conditions, possibly introducing new inefficiencies and potential threats to quality of care.²⁰⁸ Furthermore, by focusing on a single illness, programs fail to account for the synergistic impact of chronic conditions occurring in combination.

²⁰⁴ Catalyst for Payment Reform, Improving Fee-for-Service Payment, http://catalyzepaymentreform.org/images/documents/CPR_Action_Brief__ImprovingFFS.pdf

²⁰⁵ Peter D. McNair, Harold S. Luft and Andrew B. Bindman. *Medicare's Policy Not To Pay For Treating Hospital-Acquired Conditions: The Impact*, Health Affairs, September/October 2009.

²⁰⁶ Congressional Budget Office. An Analysis of the Literature on Disease Management Programs.; 2004 October 13; and Short AC, Mays GP, Mittler J. Disease Management: A Leap of Faith to Lower-Cost, Higher-Quality Health Care. HSC Issue Brief, 2003;No. 69

²⁰⁷ Christine Vogeli, Alexandra E. Shields, Todd A. Lee, Teresa B. Gibson, William D. Marder, Kevin B. Weiss, and David Blumenthal. *Multiple Chronic Conditions: Prevalence, Health Consequences, and Implications for Quality, Care Management, and Costs*, J Gen Intern Med. 2007 December; 22(Suppl 3): 391–395. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2150598/>

²⁰⁸ Christine Vogeli, Alexandra E. Shields, Todd A. Lee, Teresa B. Gibson, William D. Marder, Kevin B. Weiss, and David Blumenthal. *Multiple Chronic Conditions: Prevalence, Health Consequences, and Implications for Quality, Care Management, and Costs*, J Gen Intern Med. 2007 December; 22(Suppl 3): 391–395. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2150598/>

Case Management

There is too little evidence to date to assess the ability of case management strategies to reduce spending trend while controlling for quality.

Discussion

Intensive case management programs are aimed at high-risk patients with multiple complex conditions, often using predictive modeling applications to identify members whose past utilization suggests they are likely to generate high health care costs in the future.²⁰⁹ These initiatives may need to be highly customized to the specific disease combinations.

One researcher concludes “far more research is needed to understand the clinical impact of the clustering of chronic illness and to incorporate this more refined understanding into targeted quality improvement and clinical management strategies.”²¹⁰

Global Budgeting

Global budgets are intended to constrain both the level and rate of increase in health care costs by limiting them directly. Global budgets are compatible with any basic payment model—FFS, episode-based payments, or global payments. However, it implies an available enforcement mechanism—usually, regulation of provider payments and/or premiums, and the ability of providers to manage patient queues.²¹¹

No systematic studies have examined the effect of global budgets on cost and patient outcomes.²¹² Comparisons of the U.S. and Canada have suggested that global budgets can constrain the rate of cost growth with little or no effect on aggregate measures of health.

According to one observer, effective cost control requires strong government leadership to set targets or caps for spending in the various sectors of medical care (hospital, pharmaceutical, and physicians), either directly or through insurers.²¹³ The targets may not always be binding, and these caps would be on total expenditures, not services. But without explicit targets and continual efforts to enforce them, no health care system can control costs.

²⁰⁹ Christine Vogeli, Alexandra E. Shields, Todd A. Lee, Teresa B. Gibson, William D. Marder, Kevin B. Weiss, and David Blumenthal. *Multiple Chronic Conditions: Prevalence, Health Consequences, and Implications for Quality, Care Management, and Costs*, J Gen Intern Med. 2007 December; 22(Suppl 3): 391–395. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2150598/>

²¹⁰ Ibid.

²¹¹ Mathematica, Inc. Global Budgets For Health Care, 2009. <http://www.mass.gov/chia/docs/pc/2009-03-13-global-budgets-final-c5.pdf>

²¹² Mathematica, Inc. Global Budgets For Health Care, 2009. <http://www.mass.gov/chia/docs/pc/2009-03-13-global-budgets-final-c5.pdf>

²¹³ Theodore Marmor, PhD; Jonathan Oberlander, PhD; and Joseph White, PhD. The Obama Administration’s Options for Health Care Cost Control: Hope Versus Reality, Ann Intern Med. 2009;150(7):485-489. <http://annals.org/article.aspx?articleid=744428>

Determination of Need (DON) & Certificate of Need (CON))

The empirical evidence is mixed but seems to suggest that Determination of Need (DON) and Certificate of Need (CON) regulations implemented in the past have not reduced spending.

Discussion

Roemer's Law, a widely cited principle in health care policy, states that hospital beds that are built tend to be used. The validity of this "law" has implications for the status of supply-driven demand as a potential driver of higher health care costs. This study examined a state system of hospitals and population, evaluating over one million inpatient admissions.²¹⁴ The study found compelling evidence that a positive, statistically significant relationship exists between hospital bed availability and inpatient hospitalization rates. This study provides evidence that variations in hospitalization rates have origins in the availability of hospital beds. This relationship is found to be robust across geographic scales of analysis.

For these reasons, Determination of Need (DON) and Certificate of Need (CON) policies are regulatory strategies that require health care institutions to seek permission to make substantial capital expenditures (e.g. build new or expanded facilities, purchase high-cost technologies). The intent of the policy is to reduce the volume of utilization by constraining the supply of available resources. As such, they are a form of global budgeting.

An overview of current research finds mixed results. Some studies find that CON regulations appear to raise the volume of procedures and average costs for specific services like cardiac and cancer care, while other research indicates that states with CON laws have lower hospital prices and flat or reduced procedure volume for certain elective surgical procedures and cardiac care.²¹⁵ These researchers also find that effectiveness can be undermined by politics. Studying CON in six states, they find that in five of the states, the CON approval process can be highly subjective and tends to be influenced heavily by political relationships rather than policy objectives.²¹⁶

²¹⁴ Delamater PL, Messina JP, Grady SC, WinklerPrins V, Shortridge AM. Do more hospital beds lead to higher hospitalization rates? A spatial examination of Roemer's Law. *PLoS One* 2013;8(2):e54900. Epub 2013 Feb 13. <http://www.ncbi.nlm.nih.gov/pubmed/23418432>

²¹⁵ Tracy Yee, Lucy B. stark, Amelia M. Bond and Emily Carrier Health Care Certificate-of-Need Laws: Policy or Politics? National Institute for Health Care Reform: Research Brief. May 2011, No. 4.

²¹⁶ Tracy Yee, Lucy B. stark, Amelia M. Bond and Emily Carrier Health Care Certificate-of-Need Laws: Policy or Politics? National Institute for Health Care Reform: Research Brief. May 2011, No. 4.

Better Coordinated Care

Accountable Care Organizations (ACOs)

No evidence yet exists that establishes the potential cost savings from ACOs.

The Evidence

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, working together to manage and coordinate care for a defined population of patients, across the entire spectrum of care. ACOs are touted as a way to help fix an inefficient payment system that currently rewards more, not better, care.

ACOs are new and no one is sure that they can deliver major cost savings, especially right away.²¹⁷ A promising development is the closely watched Medicare pioneer ACO program, which finished its first year with modest cost savings and evidence of higher quality care.²¹⁸ However, some economists warn ACOs could lead to greater consolidation in the health care industry, which could allow some providers to charge more.²¹⁹

Medical Homes

The evidence is mixed with regard to the cost saving potential of medical homes.²²⁰ Some studies show significant medical home savings. Others have found minimal or no overall savings but report other benefits (i.e. improved care quality, reduced medical errors, higher patient satisfaction, enhanced health care access and fewer health disparities).

Discussion

A medical home is a cultivated partnership between the patient, family, and primary provider in cooperation with specialists and support from the community.²²¹ The patient/family is the

²¹⁷ Arthur L. Kellermann, Mary E. Vaiana, Peter S. Hussey, Ramya Chari, David Lowsky, and Andrew Mulcahy. Flattening the Trajectory of Health Care Spending, RAND Health research, 2012 http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9690z1.pdf; and Catalyst for Payment Reform, Implementing Accountable Care Organizations, http://catalyzepaymentreform.org/images/documents/CPR_Action_Brief_ACO.pdf

²¹⁸ <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html>

²¹⁹ <http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx>

²²⁰ National Conference of State Legislature, Health Cost Containment and Efficiencies: NCSL Briefs for State Legislators. May 2011. <http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf>

²²¹ Catalyst for Payment Reform, Establishing Medical Homes, http://www.catalyzepaymentreform.org/images/documents/CPR_Action_Brief_PCMH.pdf

²²² National Conference of State Legislature, Health Cost Containment and Efficiencies: NCSL Briefs for State Legislators. May 2011. <http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf>

focal point of this model, and the medical home is built around this center. The primary focus of medical homes is quality of care improvement, not cost containment.

The evidence of impact on costs is mixed:²²²

- Several studies have examined the cost-effectiveness of the Community Care of North Carolina (CCNC) program. Mercer found that for every year examined (2003-2007), CCNC achieved savings relative to an estimate of what the state would have spent under its previous primary care case management program. In 2007, estimated savings were between \$135 and \$149 million.²²³ However, these savings did not net enhanced payments to participating providers and network fees.
- Geisinger Health System calculated its medical home pilot practices reduced overall health care costs by four percent in 2006 and seven percent in 2008.
- Group Health Cooperative compared quality and costs of care for patients enrolled in a medical home pilot to a control group. After 21 months, it reported increased costs for specialty care (\$5.80 more per member per month) and primary care (\$1.60 more) but reduced costs for ED and urgent care visits (\$4 less) and inpatient admissions (\$14.18 less). Adjusting for severity of health conditions of patients in the pilot and control groups, this produced overall net savings of \$10.30 per member per month – a result that “approached statistical significance.”
- Long-running, randomized trials demonstrate that care coordination programs targeting high-risk, high-severity patients with chronic illnesses generate savings.
- A 2008 report by Deloitte Center for Health Solutions found no documented evidence of return on investment from medical home programs.

Researchers have suggested several reasons for the limited evidence of medical home savings:

1. Full-fledged medical homes have not been implemented on a large enough scale or for long enough to demonstrate savings.
2. Experts estimate it takes two-to-five years to fully transform from a traditional practice to a medical home.
3. The primary focus of medical homes is quality of care improvement, not cost containment.
4. In most medical homes, the initial focus is on getting recommended care for people who have not had it.

States may initially find their overall costs actually increase as a result of enhanced payments, new care coordination costs, and more services delivered to patients who were previously

²²³ *Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid*, Kaiser Family Foundation, May 009, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7899.pdf>. See also: <http://www.nashp.org/med-home-states/north-carolina>

underserved (i.e. immunizations were not up to date). It may take several years to realize cost savings, if any.

New Ways of Treating End-Of-Life Care

Strong evidence exists for variation in spending at the end of life across different geographic regions, but the evidence associated with specific approaches to reducing spending is relatively weak because the studies have had methodological problems.²²⁴

Discussion

There is strong evidence that end-of-life care is not meeting patients' needs. Currently, Medicare devotes a majority of spending on end-of-life care to inpatient services, as opposed to hospice or outpatient care. The hospital setting is not aligned with patient's preferences.²²⁵ Further, pain and other kinds of distress that commonly occur among dying patients are frequently undertreated in the U.S.²²⁶

These concerns, combined with wide geographic variations in spending, has led many researchers to explore the costs and benefits of alternate approaches to care, such as increased use of community hospitals and hospice care settings, as well as programs to encourage doctors to talk about palliative care and to consider less-intensive treatments for patients nearing the end of life. Related options include paying physicians an established fee in exchange for discussing end-of-life care with patients; requiring hospitals to provide palliative care services; and changing eligibility requirements for hospice care, which currently restrict admissions to six months prior to death, to reflect patients' conditions and needs instead of predictions about timing of death, which can be unreliable.²²⁷

²²⁴ Eibner C, Hussey P, Ridgely MS, and McGlynn EA, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, Santa Monica, Calif.: RAND Corporation, TR-733-COMMASS, 2009.

²²⁵ IOM, *Approaching Death*, 1997

²²⁶ IOM, *Approaching Death*, 1997

²²⁷ Ezekiel Emanuel. "Better, if Not Cheaper, Care." *The New York Times*, Jan 3, 2013, http://opinionator.blogs.nytimes.com/2013/01/03/better-if-not-cheaper-care/?_r=2

²²⁸ Baohui Zhang, MS; Matthew E. Nilsson, BS; Holly G. Prigerson, PhD. *Factors Important to Patients' Quality of Life at the End of Life*, *Archives of Intern Medicine* 2012;172(15):1133-1142, <http://archinte.jamanetwork.com/article.aspx?articleid=1212631>

²²⁹ Fried TR, van Doorn C, O'Leary JR, Tinetti ME, Drickamer MA. "Older persons' preferences for site of terminal care," *Annals of Internal Medicine*, 1999 Jul 20;131(2):109-12. <http://www.ncbi.nlm.nih.gov/pubmed/10419426>

²³⁰ Tang, Siew Tzuh RN, DNSc. When Death Is Imminent: Where Terminally Ill Patients With Cancer Prefer to Die and Why, *Cancer Nursing*, June 2003 - Volume 26 - Issue 3 - pp 245-251.

²³¹ Joan M. Teno, MD, MS; Brian R. Clarridge, PhD; Virginia Casey, PhD, MPH; Lisa C. Welch, MA; Terrie Wetle, PhD; Renee Shield, PhD; Vincent Mor, PhD. *Family Perspectives on End-of-Life Care at the Last Place of Care*. *JAMA*, 2004;291(1):88-93, <http://jama.jamanetwork.com/article.aspx?articleid=197944>

Approaches like these have intuitive appeal, because they also have the potential to improve quality of life for patients and their families. Patients who have fewer hospitalizations and stay out of the intensive care unit experience better quality of life during end-of-life care.²²⁸ Additionally, terminally ill and elderly patients often prefer to receive end-of-life care at home as opposed to in a hospital setting,^{229, 230} and families of patients who received end-of-life care in hospice settings expressed higher levels of satisfaction than those whose relatives received care in hospitals.²³¹

However, evidence on the cost-saving potential of these strategies is limited. Hospices have been expected to reduce health expenditures since their addition to the US Medicare benefit package in the early-1980s, but the literature on their ability to do so is mixed.²³² Documenting savings is difficult in part because the potential for cost reduction varies based on the type of hospice and patient type.²³³ Additionally, hospice expenditures have risen in recent years as utilization has increased, and this trend has not entirely been explained by increased utilization or overall increases in health care costs.²³⁴

Nevertheless, some studies have documented cost savings,²³⁵ and efforts are underway to evaluate new initiatives that seek to reduce costs while improving quality of life. The Advanced Illness Coordinated Care Program, an initiative that helps patients with severe illnesses who have not yet qualified for hospice care understand their illnesses, communicate with providers, and obtain palliative care and support, has been shown to effectively reduce hospital and emergency room visits and to improve patient quality of life.²³⁶ Other initiatives with similar

²³² Taylor DH Jr, Ostermann J, Van Houtven CH, Tulsy JA, Steinhauer K. *What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program?* Soc Sci Med. 2007 Oct;65(7):1466-78. http://hospiceactionnetwork.org/linked_documents/get_informed/policy_resources/DukeCostStudy.pdf; and Julie Fralich, Jennifer Lenardson, Hillary Skillings, A Review of the Literature on End-of-Life Care: Setting a Research Agenda for Maine, Muskie School of Public Service, University of Southern Maine, October 2007.

²³³ Barbara Gage, Ph.D., Susan C. Miller, Ph.D., MBA, Kristen Coppola, Ph.D., Jennie Harvell, M.Ed., Linda Laliberte, JD, MS, Vincent Mor, Ph.D., and Joan Teno, M.D., MS. "Important Questions for Hospice in the Next Century," Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 2000, <http://aspe.hhs.gov/daltcp/reports/impques.pdf>

²³⁴ Kirsten Colello, Janemarie Mulvey, Amanda Sarata, Erin Williams, and Kenneth Thomas. *End-of-Life Care: Services, Costs, Ethics, and Quality of Care*, Congressional Research Service, 2009, http://assets.opencrs.com/rpts/R40235_20090223.pdf

²³⁵ Jonathan Bergman, MD; Christopher S. Saigal, MD, MPH; Karl A. Lorenz, MD, MSHS; Janet Hanley, MS; David C. Miller, MD, MPH; John L. Gore, MD; Mark S. Litwin, MD, MPH. *Hospice Use and High-Intensity Care in Men Dying of Prostate Cancer*, Archives of Internal Medicine, 2011;171(3):204-210. <http://archinte.jamanetwork.com/article.aspx?articleid=416419>

²³⁶ Counseling and Care Coordination for Patients With Advanced Illness Lead to More Patients Completing Advance Directives and Less Use of Inpatient Care. Agency for Healthcare Research and Quality Innovations Exchange, 2010, <http://www.innovations.ahrq.gov/content.aspx?id=2746>

²³⁷ Comprehensive, Integrated Palliative Care Reduces Costs and Improves Satisfaction Among Patients and Their Families Within a Large Health System, Agency for Healthcare Research and Quality Innovations Exchange, 2008, <http://www.innovations.ahrq.gov/content.aspx?id=263>

²³⁸ *House Calls to Frail Elders Reduce Costs, Hospital Use, and Nursing Home Placements*. Agency for Healthcare Research and Quality Innovations Exchange, 2008, <http://www.innovations.ahrq.gov/content.aspx?id=262>

²³⁹ In-Home Palliative Care Allows More Patients to Die at Home, Leading to Higher Satisfaction and Lower Acute Care Utilization and Costs. Agency for Healthcare Research and Quality Innovations, 2009, <http://www.innovations.ahrq.gov/content.aspx?id=2366>

²⁴⁰ System-Integrated Program Coordinates Care for People With Advanced Illness, Leading to Greater Use of Hospice Services, Lower Utilization and Costs, and High Satisfaction. Agency for Healthcare Research and Quality Innovations, 2012, <http://www.innovations.ahrq.gov/content.aspx?id=3370>

objectives have improved the quality of life of patients and family members and produced cost savings.^{237, 238, 239, 240}

Administrative Simplification – Electronic Health Records (EHRs) /Adopting Health Information Technology (HIT)

Little empirical evidence exists to prove that HIT saves money but these investments may improve the quality of care.²⁴¹

Discussion

HIT is an enabling technology that may allow other cost-containment strategies to be implemented (e.g. better claims transaction processes, more efficient management of patients within systems, reduction of unnecessary utilization through more clinically detailed criteria for matching patients with interventions).

Two studies, one by the RAND Corporation and one by the Center for Information Technology Leadership, report estimates of the potential net benefits that could arise nationwide if all providers and hospitals adopted HIT and used it appropriately. Both studies estimated annual net savings to the health care sector of about \$80 billion (in 2005 dollars). Both studies attempted to measure the potential impact of widespread adoption of HIT, not the likely impact. The CBO concluded that both studies appear to overstate the savings for the health system as a whole significantly.²⁴² However, the Veterans Health Administration's experience suggests that HIT can contribute to the improvement of medical quality.²⁴³

The end goal of Electronic Health Records (EHR) integration has long been to improve workflow efficiency and accuracy and increasing patient safety and engagement, alongside other advancements.

Adopting an EHR system appears to be money-losing proposition for most physicians, even with the availability of federal bonuses for meaningful use of the technology.²⁴⁴ The study accounted for both one-time costs of the pilot such as the cost of the EHR system and ongoing costs such as the salary of an information technology expert. These were set against benefits of EHR adoption, which broke down into revenue increases and avoided costs.

²⁴¹ Eibner C, Hussey P, Ridgely MS, and McGlynn EA, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, Santa Monica, Calif.: RAND Corporation, TR-733-COMMASS, 2009.

²⁴² CBO, *Evidence on the Costs and Benefits of Health Information Technology*. May 2008. <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/91xx/doc9168/05-20-healthit.pdf>

²⁴³ Oliver A. The Veterans Health Administration: an American success story? *Milbank Q.* 2007; 85:5-35.

²⁴⁴ Julia Adler-Milstein, Carol E. Green, David W. Bates *A Survey Analysis Suggests That Electronic Health Records Will Yield Revenue Gains For Some Practices And Losses For Many*, Health Affairs, March 2013.

²⁴⁵ Ibid

A key reason why an EHR system is often a poor investment for a practice is that the physicians fail to make the operational changes required to realize benefits.²⁴⁵ For example, nearly half of the practices failed to save money on paper medical records because they continued to keep paper charts on hand even after they turned on their EHR systems.

Restricting Provider Networks to High Value Providers

Insurers have long tried to steer patients to high value providers as a means of controlling costs. In contrast to the mid-1990s, however, when HMOs directed patients to particular providers by using closed networks, health plans today are increasingly likely to channel patients through value-based network designs.²⁴⁶

Allow Selective Contracting by Insurers

States that have “any willing provider” laws, which limit insurers’ ability to choose which providers they have in their network, appear to have higher prices.

Discussion

“Any Willing Provider” (AWP) and “Freedom of Choice” laws restrict the ability of managed care entities, including pharmacy benefit managers, to contract selectively with providers. Several studies have found that state adoptions of such laws are associated with cost increases.²⁴⁷ A recent study found that spending was at least three percent higher when AWP) laws are enacted.²⁴⁸

An older study examined the effects of selective contracting on California hospital costs and revenues over the 1983-1997 period.²⁴⁹ They concluded that the more competitive the hospital’s market, the more hospitals had to lower the rate of increase in costs. A similar pattern exists with regard to hospital revenues. Both of the trends appear to result from the growth of selective contracting. It is not clear to what extent the cost reductions were the result of increased efficiency or of reduced quality. Previous studies had shown that hospitals in

²⁴⁶ Anna D. Sinaiko, *Tiered Provider Networks as a Strategy to Improve Health Care Quality and Efficiency*, February 2012. <http://nihcm.org/images/stories/EV-Sinaiko-2012.pdf>

²⁴⁷ Jonathan Klick and Joshua D. Wright, *The Anti-Competitive Effects Of “Any Willing Provider” Laws*, *Washington Legal Foundation*, Legal Backgrounder, March 23, 2012. http://www.wlf.org/upload/legalstudies/legalbackgrounder/3-23-12KlickWright_LegalBackgrounder.pdf

²⁴⁸ Klick, Jonathan and Wright, Joshua D., “The Effect of Any Willing Provider and Freedom of Choice Laws on Health Care Expenditures” (2012). Faculty Scholarship Paper 438 http://scholarship.law.upenn.edu/faculty_scholarship/438/

²⁴⁹ Michael G. Vita, *Regulatory Restrictions On Selective Contracting: An Empirical Analysis Of “Any-Willing-Provider” Regulations*, *Journal of Health Economics*, 20 (2001) 955–966. http://www.ftc.gov/be/healthcare/wp/17_vita_any-willing-provider.pdf

²⁵⁰ The Effect of Selective Contracting on Hospital Costs and Revenues, Jack Zwanziger, Glenn A. Melnick, and Anil Bamezai, *HSR: Health Services Research* 35:4 (October 2000). 849-867.

more competitive markets tended to have had higher costs in the period preceding selective contracting. They ultimately concluded that it was not just selective contracting – but selective contracting in conjunction with vigorous competition – that is important in obtaining cost containment.²⁵⁰

The National Conference of State Legislatures maintains a list of states with AWP laws.²⁵¹ AWP (and closely related Freedom of Choice laws) vary from state to state. Some laws narrowly focus on a single provider class such as optometrists or pharmacists. Other state laws define covered providers much more broadly.

Narrow Provider Networks/Tiered Networks

Tiered networks and narrow networks show promise, particularly when combined with other approaches such as reference pricing, but the evidence is still in the early stages.

Discussion

Tiered provider networks attempt to steer consumers towards high value providers, while maintaining consumer choice of provider. This benefit design reflects the lessons learned from the managed care backlash against restricted provider choice and has been enabled by improvements in recent years in measuring Individual provider performance.²⁵² In addition to encouraging individual consumers to seek high-value providers, tiered networks also hold the potential to improve the value of the health care system overall as lower-performing providers work to enhance the quality or efficiency of their care in order to improve their ranking.

While evidence suggests that hospitals increase their quality improvement activities in response to public reporting of provider performance data, there are no formal studies of how providers respond specifically to tiered networks and little empirical work on consumers' behavioral responses.

Consumer behavior research suggests that the office visit co-payment differences will have to exceed \$25 to counteract recommendations for lower-rated physicians from friends, family and other physicians.²⁵³ For that reason, narrow networks (which do not provide the option to go to a lower value provider) may be more effective, but they may also create a potential financial risk if a critical service, such as treatment for a rare form of cancer, is not covered by providers in the narrow network and the consumer/patient has to go out of network for necessary care.

²⁵¹ <http://www.ncsl.org/issues-research/health/managed-care-state-laws.aspx#access1>

²⁵² Anna D. Sinaiko, *Tiered Provider Networks as a Strategy to Improve Health Care Quality and Efficiency*, February 2012. <http://nihcm.org/images/stories/EV-Sinaiko-2012.pdf>

²⁵³ *Ibid.*

Many insurers have developed narrow networks in response to demands from employers seeking low-cost options that do not sacrifice quality. The spending and quality impacts must still be evaluated. As discussed above, CalPERS realized significant savings when they combined narrow networks with reference pricing for selected procedures but it is unknown how this would play out more broadly.

There are only so many levers health plans and plan sponsors can pull if they want to change plan designs. One study that examined consumer preferences found that narrow networks were preferred over other methods of achieving a limited health care budget, such as higher cost-sharing or fewer cover services.²⁵⁴ However, while participants were willing to tolerate fewer choices to control costs, they required that the narrow network be comprised of high quality providers.

Physicians question the reliability of the profiling methods and the lack of transparency in health plans' measurement methodologies. The public nature of physician tier-rankings has resulted in several prominent legal challenges.

Nonetheless, these approaches are gaining traction. Massachusetts requires insurers that cover more than 5,000 lives in the individual and small group market to offer at least one tiered network option costing at least 12 percent less than their most comparable non-tiered option.²⁵⁵ The New York Attorney General's inquiry into tiering practices of the major commercial providers in that state resulted in establishment of standards to ensure accuracy and transparency in tiering programs.

Encouraging More/Different Providers

Encourage Greater Use of Nurse Practitioners (NP) and Physician Assistants (PA)

Scope-of-practice laws establish the legal framework that controls the delivery of medical services. These state laws can encompass the full range of health disciplines—ranging from physicians and physical therapists to podiatrists and dental hygienists—and govern which services each discipline is allowed to provide and the settings in which they may do so.²⁵⁶

²⁵⁴ Personal conversation with Dr. Marge Ginsburg, October 9, 2013. See also: Marjorie Ginsburg, Susan Dorr Goold, and Marion Danis, *(De)constructing 'Basic' Benefits: Citizens Define The Limits Of Coverage*, Health Affairs, November / December 2006.

²⁵⁵ Anna D. Sinaiko, *Tiered Provider Networks as a Strategy to Improve Health Care Quality and Efficiency*, February 2012. <http://nihcm.org/images/stories/EV-Sinaiko-2012.pdf>

²⁵⁶ The National Conference of State Legislatures maintains a database of state laws: <http://www.ncsl.org/issues-research/health/scope-of-practice-legislation-tracking-database.aspx>

²⁵⁷ Eibner C, Hussey P, Ridgely MS, and McGlynn EA, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, Santa Monica, Calif.: RAND Corporation, TR-733-COMMASS, 2009.

Studies have shown that NPs and PAs provide care that is comparable to that of Primary Care Physicians (PCPs) in certain settings. As these professionals are usually paid less, substitution has the potential to decrease costs. Literature suggests that this policy option is promising, although savings are uncertain.²⁵⁷

States with more restrictive scope-of-practice laws are associated with more challenging environments for NPs to bill public and private payers, order certain tests, and establish independent primary care practices. One researcher suggests that to ensure effective use of NPs in primary care settings, policy-makers may want to consider regulatory changes beyond revising scope-of-practice laws, such as explicitly granting NPs authority as primary care providers under Medicaid or encouraging health plans to pay nurse practitioners directly.²⁵⁸

Promote growth of retail clinics as alternative to emergency departments (ED) and urgent care clinics.

Another approach is to encourage patients to substitute routine care from retail clinics for more expensive urgent care clinics and emergency departments. Evidence on the effect of retail clinics on spending is limited. RAND has extensively studied one such innovation, nurse practitioner-staffed retail clinics, and found that the treatment they provide is of comparable quality and significantly lower cost than treatment of the same condition in an emergency department or doctor's office. Prices are lower at retail clinics, but it is unclear whether or at what rate retail clinics substitute for utilization at higher-price settings (EDs) or if they create demand for care that would not have occurred otherwise.

Tort Reform

The empirical evidence on the effect of changing medical liability laws on spending is mixed.

Discussion

Tort reform efforts represent a movement to reduce the volume and associated costs of tort litigation in the judicial system, often through legislation that, among other things, may restrict the legal theories that can be used to support plaintiff claims or cap damage awards (especially with respect to the awarding of non-economic and punitive damages).

²⁵⁸ Tracy Yee, Elyn R. Boukus, Dori Cross, Divya R. Samuel, Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies, NIHCR Research Brief No. 13, February 2013.

²⁵⁹ Mehrotra A et al., "Health Care on Aisle 7: The Growing Phenomenon of Retail Clinics," Santa Monica, Calif.: RAND Corporation, RB-9491-1, 2010. http://www.rand.org/pubs/research_briefs/RB9491-1/index1.html

²⁶⁰ Ibid.

²⁶¹ Eibner C, Hussey P, Ridgely MS, and McGlynn EA, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, Santa Monica, Calif.: RAND Corporation, TR-733-COMMASS, 2009.

²⁶² J. William Thomas, Erika C. Ziller and Deborah A. Thayer. *Low Costs Of Defensive Medicine, Small Savings From Tort Reform*, Health Affairs, September 2010.

²⁶³ http://www.rand.org/content/dam/rand/pubs/monographs/2004/RAND_MG234.pdf

The empirical evidence on the effect of changing medical liability laws on spending is mixed, likely because of differences in study methodologies.²⁶¹ One study found the savings associated with a 10 percent reduction in medical malpractice premiums would be just 0.132 percent.²⁶² Caps on non-economic damages have been studied most frequently. In one study, caps in California were shown to reduce the average payout per claim but whether it lowered spending more overall was not studied.²⁶³

The costs of defensive medicine have been difficult to estimate, and there is no empirical evidence that shows changes in malpractice laws lead to changes in physician practice.

Combating Fraud and Abuse

While there is uncertainty about the exact amount of fraud, evidence shows concerted anti-fraud and abuse efforts save millions—and in some cases billions—of dollars each year. There appears to be significant room to cost-effectively increase collections, particularly in the Medicaid program.

Discussion

About 72 percent of health care fraud is committed by medical providers, 10 percent by consumers and the balance by others, including insurers and their employees.²⁶⁴

Among the 28 federal programs examined by the U.S. Government Accountability Office (GAO) in 2007, Medicaid had the highest number of improper payments.²⁶⁵ Fraud and abuse account for three to ten percent of Medicaid payments nationwide, yet the average state recovery rate is .09 percent.

Evidence shows concerted state anti-fraud and abuse efforts save states millions—and in some cases billions—of dollars each year and states potentially could double or even triple their collections.²⁶⁶ It appears that the more anti-fraud tools a state has at its disposal, the greater likelihood of fewer unwarranted payments and larger recoveries. Experts generally agree the following are among the most effective for combating fraud:

- State false claims acts that include whistleblower protections,
- Electronic data mining systems, and
- Enhanced staffing of state anti-fraud agencies.

²⁶⁴ National Conference of State Legislatures, Health Cost Containment and Efficiencies: NCSL Briefs for State Legislators. May 2011. <http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf>.

²⁶⁵ U.S. Government Accountability Office. *Opportunities to Reduce Potential Duplication in Government Programs Save Tax Dollars and Enhance Revenue*, GAO-11-714T, June 1, 2011. http://www.gao.gov/modules/ereport/handler.php?1=1&path=/ereport/GAO-11-318SP/data_center_savings/Health/Preventing_billions_in_Medicaid_improper_payments_requires_sustained_attention_and_action_by_CMS

²⁶⁶ National Conference of State Legislatures, Health Cost Containment and Efficiencies: NCSL Briefs for State Legislators. May 2011. <http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf>.

Strategies that Target Providers of Products

Biosimilars: The Generic Pathway for Biologics

A biosimilar is a product that has the same general qualities of expensive biologic drugs; sometimes labeled the “generic” version of a biologic. Only recently was an approval pathway for biosimilars initiated so there is no direct evidence of savings.

Discussion

Biologics are complex products made from living organisms that are considered a cutting-edge form of medicine, revolutionizing treatments for cancer, arthritis, multiple sclerosis, and other conditions. Although these drugs can sustain and improve the quality of life for many patients, they are expensive—sometimes costing \$100,000 or more annually. The U.S. had \$59 billion in sales in biologics in 2008.²⁶⁷ Biological drugs, regulated under the Public Health Service Act, are not eligible for the abbreviated approval pathway for generic drugs under the Hatch Waxman Act.

A biosimilar is a product that has the same general qualities of a biologic. Conceptually, a biosimilar is sometimes—incorrectly—said to be a “generic” of a biologic. A biosimilar does not have the precise replication of a biologic that a generic has for a chemical drug. No biosimilar has been approved in the U.S., but one expert predicts they will be priced from 10 percent to 30 percent lower than their reference products.²⁶⁸

An area for potential cost savings is the creation of an abbreviated pathway for approval of biosimilar drugs.²⁶⁹ The ACA created this new pathway but ensured that brand name biologic manufacturers are protected from this new competition for at least 12 years.²⁷⁰ Some advocates recommend a shorter period of patent protection.

In 2008, the CBO estimated a generic pathway for biologics could save the federal government \$5.9 billion over 10 years (2009-2018) and would reduce total expenditures on biologics in the United States by about \$25 billion over the same period (roughly 0.5 percent of national

²⁶⁷ ASPE ISSUE BRIEF: Expanding the Use of Generic Drugs, December 1, 2010, <http://aspe.hhs.gov/sp/reports/2010/genericdrugs/ib.shtml#Pathways>.

²⁶⁸ McKesson. *Time to Take Your Biosimilar- Manufacturers ready the market for new meds that promise same benefits at lower costs*, September 3, 2013. <http://betterhealth.mckesson.com/2013/09/time-to-take-your-biosimilar/>.

²⁶⁹ IMS Health, *Shaping The Biosimilars Opportunity: A Global Perspective On The Evolving Biosimilars Landscape*, 2011, http://www.imshealth.com/ims/Global/Content/Home%20Page%20Content/IMS%20News/Biosimilars_Whitepaper.pdf

²⁷⁰ Brian J. Malkin and Andrew S. Wasson. *Biosimilars Are a Reality: Key Features of the Biologics Price Competition and Innovation Act*, 2010. <http://www.flhlaw.com/files/Publication/adee8a07-6084-4a22-86d6-01ee24840061/Presentation/PublicationAttachment/c0a87134-503a-4ae2-b0ee-046d0e7966a5/FDLI%20Update%20Biosimilars%20Are%20a%20Reality%20%2800779677%29.PDF>

spending on prescription drugs, valued at wholesale prices).²⁷¹ More recently, a 2013 report found that estimated saving over a 10-year period for just California residents would total approximately \$27.6 billion.²⁷² Authors conclude “[i]t warrants regulatory and legislative consideration at both federal and state levels.”

The FDA is currently working to implement the generic pathway. The European Union is ahead of the United States, having already developed both a legal pathway and an abbreviated approval process for biosimilars.

Strategies that Target Insurers’ Costs

Insurers can directly control their administrative costs, with the exception of taxes. Insurers can also influence costs indirectly, through their provider contracting. Exactly how much pressure they can bring to bear is a matter of debate, and almost certainly related to the relative market power of the insurer, the providers, and the purchasers (consumers and employers). Insurers also control key data that could help us unlock the reasons why costs are so high, through greater transparency of their claims datasets and provider contracts. This information is generally not available to policy-makers and others today.

Rate Review/Rate Regulation

There is good evidence that a robust state authority to review and, if needed, deny proposed premium increases helps ensure that the increases are justified and transparent. Two studies find savings from increased review of rates, but there are no studies showing the long term impact on health care costs.

Discussion

Premium rate review refers to the scrutiny of proposed premium rates by state health insurance departments, or occasionally the federal government. It is intended to constrain premium increases helping to ensure that insurers’ rates are based on accurate, verifiable data and realistic projections.

There has been a recent uptick in activity around rate review thanks to the Affordable Care Act. HHS has awarded about \$159 million in rate review grants to 46 states and the District of

²⁷¹ Congressional Budget Office Cost Estimate, S.1695 Biologics Price Competition and Innovation Act of 2007, June 25, 2008, www.cbo.gov/ftpdocs/94xx/doc9496/s1695.pdf.

²⁷² Sharon Glave Frazee Susan Garavaglia Jonah Houts, Steve Miller, *Ten-Year Potential Savings from Biosimilars in California*, Express Scripts Research Report, http://www.gphaonline.org/media/cms/Biosimilars_CA_white_paper_092613.pdf.

Columbia, much of which has funded five key activities, including expanding the scope of rate review programs.²⁷³ Further, the law requires any proposed rate increase by individual or small group market insurers at or above 10 percent to be reviewed by the state insurance department or the federal government to make sure it is justified. If a state does not have an effective rate review program, the federal government conducts the reviews, though it does not have the authority to prevent insurers from implementing “unreasonable” rates.

At least in the first year, stepped up rate review seems to have curtailed some premium increases. The Kaiser Family Foundation examined rate filings from 32 states and DC (all with effective rate review programs) and found that one in five (20 percent) resulted in a lower premium increase than the insurer initially requested (either because the rate was modified during review by the state or the insurer, or the request was denied or withdrawn and not resubmitted).²⁷⁴ On average, the rates that went into effect were about one-fifth (20.1 percent) lower than rates initially requested by insurers, although there was considerable variation around that average.

An analysis by the HHS Assistant Secretary for Policy and Evaluation (ASPE) also found savings. Their report concluded that insurers were much less likely to request rate increases of 10 percent or more in 2012 than previously, knowing that hefty hikes would be scrutinized closely by state regulators and HHS.²⁷⁵ In 2012, 26 percent of rate increases in the individual market exceeded 10 percent, compared to 43 percent of rate hikes proposed in 2011. In the small group market, “high” (over 10 percent) rate change requests dropped from 16 percent in 2011 to 9.7 percent in 2012. HHS estimates that total savings may have added up to \$1.2 billion. Past reviews have turned up instances of double counting and mathematical errors.²⁷⁶

As already noted, HHS cannot deny high rate increases, no matter how unjustified. And many states also lack adequate authority.²⁷⁷ Laws in 31 states give insurance commissioners little or no authority to block unduly large premium hikes from going into effect in the individual and/or small group markets.²⁷⁸

The Kaiser Family Foundation found that states with prior approval authority over rates appear

²⁷³ U.S. Government Accountability Office. HHS’s Process for Awarding and Overseeing Exchange and Rate Review Grants to States, May 2013. <http://www.gao.gov/assets/660/654994.pdf>.

²⁷⁴ Kaiser Family Foundation, *Quantifying the Effects of Health Insurance Rate Review*, October 2012, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8122.pdf>.

²⁷⁵ U.S. Department of Health and Human Services, *Rate Review Annual Report*, September 2013. http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.pdf.

²⁷⁶ Chris Rauber, *Anthem Blue Cross withdraws huge California rate increases*, San Francisco Business Times, Apr 29, 2010.

²⁷⁷ Kaiser State Health Facts, *State Statutory Authority to Review Health Insurance Rates, Small Group Plans* <http://kff.org/other/state-indicator/rate-review-small-group/>

²⁷⁸ Until the mid-1990s, most states required their insurance departments to review proposed rate changes for individuals and small businesses to ensure that insurance companies did not profiteer by raising rates far beyond the actual cost of medical expenses. Scot J. Paltrow. *The Case for a Stronger Federal Role in Insurance Regulation, Weak State Regulation Highlights the Need for Federal Oversight of Health Premiums*, Center for American Progress, June 25, 2010.

to be better positioned to negotiate reductions in rate requests filed by carriers. In states that do not have this type of authority, it generally takes an egregious and unjustified rate increase for them to ask for reductions.²⁷⁹

Medical Loss Ratio (MLR)

The MLR rule requires insurers to spend at least 80 percent of premium dollars on medical claims and quality improvement. There is some limited evidence that shows that the MLR rule has caused insurers to reduce their administrative spending but the effect is unlikely to permanently reduce our spending trend.

Discussion

The MLR rule (sometimes called the 80/20 rule) is a provision in the ACA that went into effect in 2012 and requires insurers to spend at least 80 percent of premium dollars on medical claims and quality improvement. Insurers in the large group market must pay out 85 percent in medical claims. The policy objective of the MLR was to improve value for consumers by requiring insurers to provide a fair amount of return on premium dollar in health care and reduce excessive administrative costs.

There is some limited evidence that shows the MLR rule has, in fact, caused insurers to adjust administrative costs in respond to the rule. This effect has been mainly in the individual market (which exhibited the highest levels of administrative spending) and has been more pronounced among for-profit insurers.²⁸⁰ HHS reports that 77.8 million consumers saved \$3.4 billion up front on their premiums in 2012.²⁸¹ However, it should be noted that it is difficult to disentangle the impact of the MLR on premiums from other ACA provisions such as rate review and other factors.²⁸²

Over time we expect that insurers will adjust administrative costs to meet the requirements of the rule, and premium reductions and rebates will moderate. In fact, rebates dropped from \$1.1 billion in the first year of MLR requirements to \$500 million in the second year.

²⁷⁹ Kaiser Family Foundation, Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable, December 2010, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8122.pdf>.

²⁸⁰ Michael Mccuel, Mark Hall and Xinliang Liu, *Impact of Medical Loss Regulations on the Financial Performance of Health Insurers*, Health Affairs, September 2013, vol. 32 no. 9.

²⁸¹ Health and Human Services, Press Release, Consumers saved \$3.9 billion on premiums in 2012, June 2013. <http://www.hhs.gov/news/press/2013pres/06/20130620a.html>.

²⁸² Cynthia Cox, Gary Claxton and Larry Levitt, *Beyond Rebates: How Much Are Consumers Saving from the ACA's Medical Loss Ratio Provision?* June 6, 2103, <http://kff.org/health-reform/perspective/beyond-rebates-how-much-are-consumers-saving-from-the-acas-medical-loss-ratio-provision/>.

The Cadillac Tax

No evidence exists to date on the spending impact of the “Cadillac” Tax.

Discussion

What’s the largest tax break in the federal tax code? If you guessed the home mortgage deduction, you’d be wrong. It is the tax break for employer provided health benefits.²⁸³

Beginning in 2018, this tax deduction will be curtailed for so called “Cadillac” health plans. A 40 percent excise tax will be assessed on the cost of employer sponsored insurance plans that exceed \$10,200 for individual coverage and \$27,500 for family coverage. The tax threshold increases over time at the general rate of inflation. If health inflation continues to outpace general inflation, more and more plans will be hit with the tax over time. Proponents of the tax believe that overly generous coverage plans (Cadillac plans) create an incentive for high spending by enrollees. The policy objective behind the tax was to slow the rate of growth in health spending by creating incentives to limit “Cadillac” plans and reduce overspending in health care.

Recent analysis shows that the impact of the tax on health spending may be lower than previously expected. The Congressional Budget Office projects the tax will generate \$80 billion in revenue for the ACA.²⁸⁴ This is down \$58 billion from a previous CBO estimate, due to slowing inflation in premium growth.²⁸⁵ If premium growth stays low, fewer plans will hit the amount that triggers the tax.

The excise tax will not go into effect until 2018. Employer surveys suggest that employers are already making changes to their health plans in response to the excise tax.²⁸⁶ But assessments of the impact are merely projections at this point, based on past experience with increased cost-sharing for consumers and economic theory about the relationship of coverage to increased health spending, often referred to as “moral hazard.”

Of concern is the possibility that the tax will lead to a cost shift to consumers rather than a slowing in the rate of spending growth. Further, some researchers express concern that the Cadillac tax is too blunt, and may target necessary health spending rather than the “excessive” health spending proponents of the tax intended to curb. This is particularly worrisome for

²⁸³ <http://www.npr.org/blogs/health/2012/12/04/166434247/the-huge-and-rarely-discussed-health-insurance-tax-break>.

²⁸⁴ Congressional Budget Office, Effects of Affordable Coverage on Health Insurance, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf.

²⁸⁵ Congressional Budget Office, Updated Projections Fiscal Years 2013-2023, <http://www.cbo.gov/sites/default/files/cbofiles/attachments/44172-Baseline2.pdf>.

²⁸⁶ International Foundation of Employee Benefit Plans cited and in Health Affairs Health Policy Brief, Excise Tax on “Cadillac Plans,” September 12, 2013.

individuals with expensive chronic conditions who stand to benefit from generous coverage and will see their out-of-pocket costs go up under less generous coverage.

Public Insurance Option

No direct evidence of savings is available. Savings are likely to be quite specific to local market conditions and the specifics of how the public option is structured.

Discussion

A public insurance option was considered but ultimately rejected as a cost saving measure during the legislative debate over the ACA. However, nothing prevents a state from adopting this strategy within its own borders.

The public plan, essentially a voluntary Medicare equivalent for Americans younger than 65 years, theoretically could save money in three ways. First, it could take advantage of the lower administrative costs of government programs, such as Medicare. Second, the public plan could use its substantial market power to restrain the prices of the medical care it finances. The extent of savings would depend in part on the size of the public plan's enrollment; a larger plan would have more purchasing power to control costs. Savings would, of course, also depend on the political willingness to reduce payments to medical providers. Finally, the combination of marketing regulation and competition from the less expensive public plan could also prompt private insurers to innovate in ways that lowered costs.

During the ACA debate, the Congressional Budget Office estimated that the public plan's premiums would be five to seven percent lower, on average, than the premiums of private plans offered in the exchanges, but the estimates were subject to a high degree of uncertainty.²⁸⁷ The estimate did not include any savings from private insurers lowering their costs in response. It may be worth noting that in the Medicare realm, having private Medicare Advantage plans compete side by side with a public option (traditional Medicare) does not appear to have resulted in more efficient private plans.

Strategies that Improve Our Understanding of Spending Flows

There is general agreement that comprehensive data is necessary to allow the analysis across

²⁸⁷ Douglas W. Elmendorf letter to Honorable Fortney Pete Stark, Chairman Subcommittee on Health, Committee on Ways and Means, July 22, 2010 http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/116xx/doc11689/stark_letter-hr_5808-07-22.pdf

markets to monitor and assess trends, measure market pressure, and establish accountability goals.²⁸⁸ Several strategies can help supply that data, although they don't save money directly.

All-Payer Claims Databases

All-payer claims databases provide detailed information from both public and private payers to help design and assess various cost containment and quality improvement efforts.

To date, all-payer claims database programs have not focused on cost containment per se. Some states, like MA and NH, are using all-payer claims data-bases to identify potential areas for cost savings. It is still too early, however, to determine how effective databases are in helping states shape successful cost containment efforts.²⁸⁹ Most programs have not been in use long enough to determine their effectiveness in shaping successful cost containment efforts. Several studies have used Maine Health Data Organization data²⁹⁰ to identify areas of the health care system that could benefit from cost containment efforts.

Efforts to harmonize data collection standards are being coordinated by organizations such as the Commonwealth Fund and the APCD Council in order to streamline data collection and facilitate comparison across states.

Systematic Reporting of Medical Harm

As noted above, medical harm includes things like Hospital Acquired Infections (HAI), prescription errors, “never events,” and avoidable readmissions.

There are no recent, high-quality, nationally representative data on the rates of adverse events in U.S. hospitals.²⁹¹ Many advocates believe that documenting where and when HAIs occur is an essential component to prevention²⁹² and provides the data needed to track prevention efforts.

Documenting harm can be administratively burdensome because it requires retrospective review since claims data may be inadequate.

²⁸⁸ See All-Payer Claims Databases: An Overview for Policymakers, State Coverage Initiatives (May 2010).; and Catalyst for Payment Reform, Action Brief, “Price Transparency: An Essential Building Block for a High-Value, Sustainable Health Care System” http://www.catalyzepaymentreform.org/images/documents/CPR_Action_Brief_Price_Transparency.pdf;

²⁸⁹ National Conference of State Legislatures, Health Cost Containment and Efficiencies: NCSL Briefs for State Legislators. May 2011. <http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf> http://www.ncsl.org/portals/1/documents/health/ALL-PAYER_CLAIMS_DB-2010.pdf

²⁹⁰ <https://mhdo.maine.gov/>

²⁹¹ Ashish K. Jha, David C. Chan, Abigail B. Ridgway, Calvin Franz and David W. Bates *Improving Safety And Eliminating Redundant Tests: Cutting Costs In U.S. Hospitals*, Health Affairs September/October 2009 <http://content.healthaffairs.org/content/28/5/1475.full>

²⁹² Centers for Disease Control, “Media statement: Public Reporting of Healthcare-Associated Infections,” Feb 2 2012; <http://www.cdc.gov/media/pressrel/2010/s100202.htm>

Research on Comparative Effectiveness

Comparative effectiveness research answers questions about how well alternative medical treatments work.²⁹³ Clinical Evidence, a project of the British Medical Journal, recently combed through the 3,000 medical treatments that have been studied in controlled, randomized studies. They found, for half of those, we have no idea how well they work.²⁹⁴

Undertaking comparative effectiveness research alone does not necessarily save money; the savings depend on the uncertain effect such research has on insurers' coverage decisions for medical technologies and on changes in medical practice.²⁹⁵

Despite the language in the Affordable Care Act that restricts the use of cost-effectiveness analysis in Medicare's coverage decisions, backers of comparative effectiveness research say it could lead to making better use of the nation's health care dollars. If there's more clarity about which treatments work best—and for which types of patients—there's potential for shifting money to those interventions and away from less effective treatments.

²⁹³ Comparative Effectiveness Research, Health Affairs Health Policy Brief, October 8, 2010 http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=28

²⁹⁴ <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/24/surprise-we-dont-know-if-half-our-medical-treatments-work/>

²⁹⁵ Neumann PJ. Using Cost-Effectiveness Analysis to Improve Health Care: Opportunities and Barriers. New York: Oxford Univ Pr; 2005.

Appendix A
**How Does the Affordable Care Act
Address Costs?**



Robert Wood Johnson Foundation

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POLICY & ACTION FROM CONSUMER REPORTS

Appendix A

How Does the Affordable Care Act Address Costs?

While there is agreement that the Affordable Care Act—by itself—will not solve our health care cost problem, it isn't true that the ACA is silent on health care costs. Significantly, in 2011, 272 of America's top economists wrote to the House Budget Committee that the ACA "contains essentially every cost-containment provision policy analysts have considered effective in reducing the rate of medical spending."²⁹⁶

The tally below lists initiatives included in the ACA that appear promising for reducing overall health care costs. We exclude ACA components that reduce the cost of a service to consumers, but don't alter costs on a systematic level (for example: tax credit subsidies that lower the price that consumers pay for insurance).

We also note for the record that the ACA does increase total health care spending. A significant portion of the population will gain much better coverage, and (even after accounting for what they paid out of pocket before the major reforms) they are likely to spend more on health care than they did in the past. But at least for some consumers, this will merely be getting them to the right level of spending, as they were consuming too little health care before.

²⁹⁶ <http://www.americanprogressaction.org/wp-content/uploads/issues/2011/01/pdf/budgetcommitteefinal.pdf>

Exhibit I: How the Affordable Care Act Addresses Costs

Primary Target of Intervention:		What's In the ACA?	Who is Affected?	Description
Consumers	Purchase of health care/ products	Free preventive services	All	In some but not all cases, better adherence to recommended preventive services saves money down the road.
		Measures to inform patients about the quality of medical care	Consumers shopping in the Marketplace	While roll out has been delayed, the law includes new quality measures which may incentives for insurers to offer better value.
	Purchase of insurance	Summary of Benefits and Coverage	Consumers in private plans	This new standard form allows consumers to more easily compare any private plans from any carrier. Since studies show that many consumers fail to enroll in the “best” option when confronted with a confusing array of choices, this may help consumers play their role in encouraging competition in the marketplace.

Primary Target of Intervention:	What's In the ACA?	Who is Affected?	Description
Providers of Care	Accountable Care Organization (ACO)	Medicare	Encourages health care providers to band together to better coordinate services for a group of patients, resulting in higher quality care at lower costs. The ACO bears responsibility jointly for the cost and quality of care delivered to a subset of traditional Medicare beneficiaries. ³
	Penalties for high rates of hospital acquired conditions	Medicare	Under the HAC (Hospital Acquired Condition) Program, hospitals that rank in the lowest-performing quartile of hospital-acquired conditions will be paid 99 percent of what otherwise would have been paid under IPPS (Inpatient Prospective Payment System), beginning in FY 2015. ⁷
	Bundled payments	Medicare	Redesigns payment to incentivize care coordination. Bundled payments offer providers four patient-centered episode-of-care models to choose from, allowing providers the flexibility to choose the conditions they believe make sense to bundle; decide how best to work together to deliver high-quality, coordinated episodes-of-care; and, in some cases, determine participating providers' share of payment. ⁴
	Penalties for high rates of readmissions	Medicare	A hospital's readmission rate for certain conditions (ex: heart attack/failure and pneumonia) will be compared to its expected readmission rate and, beginning October 2012, the hospital will be subject to a reduction in Medicare payments for its "excess readmissions." ³
	Partnership for patients	All	A nationwide effort to reduce patient infections and hospital readmissions by helping innovations spread.

Primary Target of Intervention:	What's In the ACA?	Who is Affected?	Description
Providers of Care (Continued)	Independent Payment Advisory Board (IPAB)	Medicare	From 2014-2017, any year in which the Medicare per capita growth rate exceeds the average growth in the consumer price index (CPI) and medical care CPI, the IPAB will be required to recommend Medicare spending reductions. In 2018 and after, the target is pegged at per capita GDP growth plus one percentage point. ³
	Value-Based Purchasing	Medicare	Starting October 1, 2012, hospitals will be rewarded for how well they perform on a set of quality measures as well as on how much they improve in performance relative to a baseline. The law also requires CMS to develop Value-Based Purchasing programs for home health agencies; skilled nursing facilities; ambulatory surgical centers; specialty hospitals, such as long-term care facilities; and hospice programs. ⁷
Providers of Products	Medicare Bidding Program	Medicare	CMS implemented a competitive bidding program in 2011 for durable medical equipment and other supplies in nine metropolitan areas. ⁴
	"Generic" Pathway for Biologic Drugs	All	The Affordable Care Act created an approval pathway for generic versions of biologic drugs, or biosimilars, but ensured that brand name biologic manufacturers are protected from this new competition for at least 12 years.

How Does the Affordable Care Act Address Costs?

Primary Target of Intervention:	What's In the ACA?	Who is Affected?	Description
Private Insurers Private Payers	Simplified and uniform rating factors/ Elimination of medical underwriting	Individual and small group consumers with private coverage	Eliminate variation in premiums charged to individuals and small businesses based on health status and gender; age and tobacco use rating are limited. This simplification should reduce the administrative costs connected with rate development and review. ³
	Medical Loss Ratio (MLR)	Primarily consumers with non-group or small group coverage	Private insurers must issue consumer rebates if they don't reduce profit and administrative costs to less than 20% of premium dollars (15% in the large group market). MLR encourages insurers to manage their administrative costs so that they do not have to issue rebate checks. ⁷
	Improved rate review	Individual and small group market consumers	Rate review is intended to constrain unjustified premium increases through a comprehensive review process that helps ensure that insurers' rates are based on accurate, verifiable data and realistic projections. ¹
	Competition in Exchanges	Individual and small group market consumers	Since consumers now have a shot at comparing health plans "apples-to-apples" insurers have more incentive to compete based on value, instead of flashy marketing and low premiums that may or may not translate into inadequate coverage. Furthermore, requiring subsidized enrollees to pay the full difference between higher-cost plans and the benchmark plan should lead to strong competition among insurers. ²
	Excise tax on high-cost employer-sponsored insurance plans	Consumers in employer sponsored plans	40% excise tax on employer-sponsored plans costing more than a threshold premium level. ¹ Individual premiums cannot exceed \$10,200 and family premiums cannot exceed \$27,500. ³

Primary Target of Intervention:	What's In the ACA?	Who is Affected?	Description
Public Insurance – Medicare and Medicaid	Waste, fraud, and abuse	Medicare and Medicaid	The government's ability to monitor and punish those who commit fraud or abuse the Medicare and Medicaid programs is significantly increased. ⁴
Strategies that Improve Our Understanding of Spending Flows	Patient-Centered Outcomes Research Institute (PCORI)	All	The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions and improve health care delivery and outcomes by producing and promoting high integrity, evidence-based information that comes from research guided by patients, caregivers and the broader health care community. ⁵
	CMS Innovation Center	Medicare	The Innovation Center is charged with streamlining the testing of new models of care so that care is more coordinated, resources are used more efficiently, and the health care system works better for patients, families, and providers and rapidly expanding successful models across the program. ⁴

Sources:

1. Quincy and Silas. *The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making*. Consumers Union, November 2012.
2. Stephen Zuckerman and John Holahan. "Despite Criticism, The Affordable Care Act Does Much to Contain Health Care Costs," October 2012, <http://www.urban.org/UploadedPDF/412665-Despite-Criticism-The-Affordable-Care-Act-Does-Much-to-Contain-Health-Care-Cost.pdf>
3. Robert Wood Johnson Foundation. "How Does the ACA Control Health Care Costs?," July 2011, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71451
4. Centers for Medicare & Medicaid Services. "The Affordable Care Act: Lowering Medicare Costs by Improving Care," 2012, <http://www.cms.gov/apps/files/aca-savings-report-2012.pdf>
5. Patient-Centered Outcomes Research Institute. "Update on the Patient-Centered Outcomes Research Institute," December 2012, <http://acd.od.nih.gov/PCORI-Presentation-tagged-SB.PDF>
6. Centers for Medicare & Medicaid Services. "CMS Final Rule to Improve Quality of Care During Hospital Inpatient Stays," August 2013, <http://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2013-fact-sheets-items/2013-08-02-3.html>
7. Pay-for-Performance, *Health Affairs Health Policy Brief*, October 11, 2012, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78

Appendix B

How Will Progress Be Measured?

What Metrics Do We Need?	89
What Metrics Do We Have?	90



Appendix B

How Will Progress Be Measured?

Measuring, reporting, and comparing outcomes are perhaps the most important steps toward rapidly improving outcomes and making good choices about reducing costs.²⁹⁸ Accurate, reliable, and valid measurements are a prerequisite for achieving and assessing improvements in value and efficiency. Without metrics that are consistent and accurate, it is impossible to assess whether costs have been reduced or merely shifted from one stakeholder to another, or to evaluate the effects of cost control on patient outcomes and quality of life. In short, we need a way to measure cost savings over time while controlling for quality of care and patient outcomes.

Unfortunately, health care costs are difficult to measure for a variety of reasons including the decentralized nature of relevant data and the many stakeholders involved. Charge and payment data are tracked by public and private payers and providers, but often this information is not publicly available. An added challenge is that it is difficult to understand the true cost of care as opposed to prices that result from provider-specific negotiations.²⁹⁹ Current measures of quality place too much emphasis on the convenience of process measures and rely too little on outcome measures.

What Metrics Do We Need?

According to Dr. Porter at the Harvard Business School, the only way to accurately measure value is to track patient outcomes and costs longitudinally.³⁰⁰ Costs, like outcomes, should be measured around the patient over a patient's entire care cycle.

During the Institute of Medicine's 2013 workshop on "Core Measurement Needs for Better Case, Better Health, and Lower Costs," participants agreed that an effective set of metrics should "present a unified picture of progress" on quality of care and population health as well as health care costs.³⁰¹ For health care costs, participants suggested that basic metrics should include:

²⁹⁷ Quincy and Silas. *The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making*. Consumers Union, November 2012.

²⁹⁸ Michael E. Porter, *What Is Value in Health Care?*, N Engl J Med 2010; <http://www.nejm.org/doi/full/10.1056/NEJMp1011024>

²⁹⁹ Painter, Michael W. and Chernen, Michael E. (March 2012). "Counting Change: Measuring Health Care Prices, Costs, and Spending." Robert Wood Johnson Foundation, <http://www.rwjf.org/content/dam/web-assets/2012/03/counting-change>

³⁰⁰ Michael E. Porter, *What Is Value in Health Care?*, N Engl J Med 2010; <http://www.nejm.org/doi/full/10.1056/NEJMp1011024>

- Resources and expenditures, such as per capita spending and federal government health care spending as a percentage of total government spending;
- Utilization, such as emergency room use, imaging services, and other specific services; and
- Affordability, a metric based on percentage of household spending on health care.³⁰²

Additionally, metrics must capture enough detail to aid key goals such as determining which areas of health care are most costly and inefficient and developing policies to address them. Each area will require additional “subset” measures to categorize different types of expenditures, establish “episodes of care” that are comparable across geographic locations and over time,³⁰³ and delineate units of time.

What Metrics Do We Have?

Numerous measures exist in the form of billing requirements and claims data, as well as public and private reporting requirements and independent initiatives to develop frameworks. Unfortunately, costs today are measured for departments or billing units rather than for the full care cycle over which value is determined, and process measures are often substituted for outcomes.

Currently, several classification systems for health care services, diseases, and episodes are used by different stakeholders. Diagnosis Related Groups, or DRG’s, were created as part of an effort to control Medicare costs in 1982. DRG’s group services typically needed to treat specific diseases into “bundles” on which to base Medicare’s reimbursements to hospitals.³⁰⁴ Other widely used coding systems include Current Procedural Terminology (CPT), a list of five digit alphanumeric codes³⁰⁵ used for billing purposes that represent individual services such as a preventive exam, a flu shot, or a specific type of biopsy. Finally, the International Classification of Diseases (ICD) numerically lists diseases classified by cause and affected area.³⁰⁶

In practice, quality usually means adherence to evidence-based guidelines, and quality measurement focuses overwhelmingly on care processes. In the 78 Healthcare Effectiveness Data and Information Set (HEDIS) measures for 2010, the most widely used quality measurement system, all but five are process measures.

³⁰¹ “Core Measurement Needs for Better Care, Better Health, and Lower Costs: Counting What Counts – Workshop Summary.” (2013). Institute of Medicine. p. 43.

³⁰² Ibid, p. 88.

³⁰³ Ibid, p. 44.

³⁰⁴ Gottlober, Paul. (Aug 2001). “Medicare Hospital Prospective Payment System: How DRG Rates Are Calculated and Updated.” Office of Inspector General, Office of Evaluation and Inspections, Region IX, CMS. <http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf>

³⁰⁵ *What is CPT?* (2013). AAPC. <http://www.aapc.com/resources/medical-coding/cpt.aspx>

Nonprofit and private organizations have proposed metrics for tracking health care costs in a way that integrates quality. The National Quality Forum (NQF), a coalition of public and private sector health care experts, is working to develop a “standardized system of evidence-based performance measurement and reporting” that integrates measures of health care quality and efficiency. To do so, NQF evaluates and endorses measures that facilitate informed comparisons of services and providers and promote accountability.³⁰⁷ One of these, “Resource Use Measures,” seeks to create a unit of measurement that is more specific than “expenses per capita” and more general than “expenses per medical incident.” To do so, it “counts the frequency of defined health system resources—such as allowable charges, paid amounts, or standardized prices—to each resource use unit.”³⁰⁸ NQF has also developed a method for defining and measuring a “generic episode of care” that would facilitate quality, costs, and outcomes comparisons across providers.³⁰⁹

On a national level, the U.S. Department of Health and Human Services maintains a variety of surveys that measure Americans’ health care costs and outcomes. For example:

- The Agency for Healthcare Research and Quality (AHRQ) conducts the **Medical Expenditure Panel Survey (MEPS)**, which gathers information on utilization of specific health services and the cost of these services as well as how they are paid for from stakeholders including families and individuals, their medical providers, and their employers.³¹⁰
- The Center for Medicare and Medicaid Services’ **National Health Expenditure Accounts (NHEA)** provide official estimates of total health care spending in the United States by “type of service or product”; categories include hospital care, physician and clinical services, and home health care.³¹¹

The MEPS and NHEA provide extensive data on health care use and cost that can be used to evaluate aspects of the health care system’s quality and efficiency. For example, MEPS tracks individual participants over several years, which allows researchers to track how changes in health, income, and employment status might relate to eligibility for public and private insurance coverage, use of services, and payment for care.³¹² Tools like these are helpful when seeking

³⁰⁶ It is updated regularly and in 2014, the U.S. will transition from ICD-9-CM to ICD-10. “What is ICD-9-CM?” AAPC. <http://www.aapc.com/resources/medical-coding/icd9.aspx>

³⁰⁷ “Improving Healthcare Quality.” (2013). The National Quality Forum, http://www.qualityforum.org/Setting_Priorities/Improving_Healthcare_Quality.aspx

³⁰⁸ “Endorsement Summary: Resource Use Measures.” (April 2012). National Quality Forum, <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69883>

³⁰⁹ “Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care.” (2009). National Quality Forum, http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx

³¹⁰ “Medical Expenditure Panel Survey: Survey Background.” (21 Aug 2009). Agency for Healthcare Research and Quality, http://meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp

³¹¹ “National Health Expenditures 2011 Highlights.” (1 Jan 2013). Centers for Medicare and Medicaid Services, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>

to understand trends and patterns in health care spending. However, their ability to track health care costs over time is limited in two ways. First, while they collect payment information for a variety of actors, they do not gather “input prices” for medical services for each market transaction. For example, while the MEPS measures both what health care providers charge and what insurance companies and individuals ultimately pay, it does not collect data on the cost of the resources devoted to each service. Second, they do not offer a normative framework for comparing different providers and insurance companies based on quality or value.

States and a growing array of nonprofit entities are also working to gather health care cost data.

- Some states have created **All Payer Claims Databases (APCDs)**, which are “large-scale databases that systematically collect health care claims data from a variety of payer sources which include claims from most health care providers.”³¹³ States vary in terms of their reporting requirements, and are at different stages of implementation. However, the effort to gather claims data from private payers, which has not been available to the public in the past, represents an important effort to understand real prices paid for services.
- Private and nonprofit consumer-facing tools have also been created in response to increasing demands for health care cost transparency. Services such as Healthcare Blue Book and FAIR Health use detailed claims data from private payers and providers to calculate price estimates for common health care services from x-rays to cosmetic surgery procedures. Their goal is to empower consumers to demand or seek out reasonable prices.

Claims-based tools such as state APCDs provide the detailed data needed to identify areas of excess spending or outlier prices. But these tools also suffer from the absence of information on input costs and the lack corresponding quality metrics.

In a nutshell, we have not yet developed scientifically sound or accepted approaches to defining or measuring either patient-centered outcomes of care, or—surprisingly—the costs of producing those outcomes.³¹⁴

³¹² “Medical Expenditure Panel Survey: Survey Background.” (21 Aug 2009). Agency for Healthcare Research and Quality, http://meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp

³¹³ “APCD Council Frequently Asked Questions: What are All-Payer Claims Databases? (APCD’s)?” (2013). APCD Council. <http://www.apcdouncil.org/apcd-council-frequently-asked-questions>

³¹⁴ <http://blogs.hbr.org/2013/09/getting-real-about-health-care-value/>

Appendix C

Glossary of Cost Containment Terms



Robert Wood Johnson Foundation

ConsumersUnion[®]

POLICY & ACTION FROM CONSUMER REPORTS

Glossary of Cost Containment Terms

Term	Acronym	Definition
Accountable Care Organization	ACO	Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers working together to manage and coordinate care for a group of patients, across the entire spectrum of care. Physicians and providers in the ACO are financially rewarded if they meet cost and quality benchmarks. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. Primary care doctors are put at the hub of coordinating patient care.
Actuarial value	AV	Actuarial value measures the percentage of covered medical services that a health plan will cover for a standard population. AV can be considered a general summary measure of health plan generosity, and it is used to categorize plans sold on individual and small group markets into coverage tiers. However, it is important to note that an individual patient may be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on actual health care needs and the terms of the insurance policy.
Affordable Care Act	ACA, PPACA	The comprehensive health care reform law that passed in March 2010, also known as "Obamacare."
All Payer Dataset or All Payer Claims Database	APD or APCD	Typically implemented by a state, All Payer Claim Datasets collect claims data from payers including private insurance companies, state employee health benefit programs, and, in some cases, Medicare and Medicaid. Claims data contains charges and payments, provider information, clinical diagnosis and procedure codes, and patient demographics.
Allowed amount		The amount on which payment is based for covered health care services. This may be also called "eligible expense," "payment allowance," or "negotiated rate."

Term	Acronym	Definition
Annual limits		The maximum amount an insurance plan will provide in benefits in a year. The health law no longer allows plans to have annual <u>dollar</u> limits, but service limits are still permitted. Some grandfathered plans may still be allowed to have annual limits, and annual limits are still permitted for “nonessential benefits” such as dental care.
Anti-trust enforcement		Anti-trust enforcement is the process by which a more competitive environment is created through the prohibition of certain practices deemed illegal by antitrust laws. When it comes to insurance companies, special rules apply. The McCarran-Ferguson Act exempts the business of insurance from most federal regulation, including federal antitrust laws to a limited extent.
Balance billing		When you receive services from a doctor or hospital that does not participate in your insurer’s network, that provider is not obligated to accept the insurer’s payment as payment in full and may bill you for the unpaid amount. This is known as “balance billing.” Some states prohibit providers from billing consumers under certain circumstances, for example for emergency services.
Benefit design		Benefit design is term that incorporates several features of a health plan, like patient cost-sharing, scope of coverage services, service limits (e.g., number of visits) or subscriber incentives to use network providers.
Biologics		Complex products made from living organisms that are considered a cutting-edge form of medicine, revolutionizing treatments for cancer, arthritis, multiple sclerosis and other conditions. Although these drugs can sustain and improve the quality of life for many patients, they are expensive—sometimes costing \$100,000 or more annually.
Biosimilars		A biosimilar is a product that has the same general qualities of a biologic. Conceptually, a biosimilar is sometimes—incorrectly—said to be a “generic” of a biologic. A biosimilar does not have the precise replication of a biologic that a generic has for a chemical drug.

Term	Acronym	Definition
Bundled payment		In a bundled payment methodology, a single, “bundled” payment covers services delivered by two or more providers during a single episode of care or over a specific period of time. For example, if a patient has cardiac bypass surgery, rather than making one payment to the hospital, a second payment to the surgeon and a third payment to the anesthesiologist, the payer would combine these payments for the specific episode of care (i.e., cardiac bypass surgery).
“Cadillac” benefit plans		A high-cost policy is usually defined by the total cost of premiums, rather than what the insurance plan covers or how much the patient has to pay for a doctor or hospital visit. Though premiums are high, people who have Cadillac plans often have low deductibles and excellent benefits that cover even the most expensive treatments.
Capitation		Payment mechanism in which a provider is paid a fixed rate per person per month, usually prospectively, to cover all care within a specified set of services and administrative costs without regard to the actual number of services provided.
Care coordination		The coordination of services provided by different members of the health care team, including good communication between them. In the absence of care coordination, patients may get duplicate or otherwise unnecessary tests, receive medications that are contraindicated by other aspects of the treatment regimen, fail to obtain services that each of the treating physicians thought had been provided by one of the other members of the health care team, etc.
Certificate of Need	CON	Certificate of Need programs are aimed at restraining health care facility costs and allowing coordinated planning of new services and construction. Laws authorizing such programs are one mechanism by which state governments seek to reduce overall health and medical costs. Less common now, many “CON” laws initially were put into effect across the nation as part of the federal “Health Planning Resources Development Act” of 1974.

Term	Acronym	Definition
Children's Health Insurance Program	CHIP	A federal/state program that offers low-cost health coverage to children up to age 19 who are U.S. citizens or eligible immigrants. This program is usually restricted to low-income children in families with incomes too high to qualify for Medicaid.
Co-insurance		The consumer's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service.
Co-payment		A flat-dollar amount that an insured person pays when accessing a service. A patient might be charged a co-pay when visiting a doctor, filling a prescription, or having an x-ray done.
Cost-sharing		Charges for medical care that a patient is responsible for under the terms of a health plan, such as deductibles, co-insurance and co-payments. The amount paid in premiums is not part of cost-sharing.
Comparative effectiveness research		Systematic research comparing different interventions and strategies to prevent, diagnose, treat and monitor health conditions. The purpose of this research is to inform patients, providers, and decision-makers, responding to their expressed needs, about which interventions are most effective for which patients under specific circumstances.
Competitive bidding		Suppliers submit bids to provide certain medical equipment and supplies at a lower price than what Medicare now pays for these items. Medicare uses these bids to set the amount it will pay for those equipment and supplies under the competitive bidding program. Qualified, accredited suppliers with winning bids are chosen as Medicare contract suppliers.
Consumer Directed Health Plan	CDHP	These plans typically feature a high deductible, and may be accompanied by a tax advantaged savings account. These accounts are intended to encourage consumers to reduce their use of unnecessary health services in order to build up the balance in the account.
Deductible		The amount that a patient must pay for health care services each year before the insurer will begin paying claims under a policy. Deductibles are part of an enrollee's cost-sharing. Certain services, such as preventive care, may be exempt from the deductible.

Term	Acronym	Definition
Defensive medicine		Defensive medicine occurs when doctors order tests, procedures, or visits, or avoid high-risk patients or procedures, primarily (but not always solely) to reduce their exposure to malpractice liability.
Diagnosis Related Group	DRG	A single payment for services related to a specific diagnosis and not the actual level of services required for a particular patient. DRGs are used by Medicare and many other payers to reimburse hospitals for patient visits.
Direct to Consumer advertising	DTC advertising	Any unsolicited promotional endeavor by a pharmaceutical company or other provider of medical services presenting information about medicine or medical services to the public through the popular media. It includes television and radio advertisements, newspaper and magazine advertisements, billboards, and direct mailings. Another class of materials that is sometimes considered to be direct-to-consumer advertising is the brochures that drug companies supply for physicians to give to patients. Although these brochures are provided to patients “indirectly” through physicians, they may have a marketing component and sometimes make claims about drug benefits and risks.
Essential Health Benefits	EHB	A package of ten benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services. The health law requires that all health insurance plans sold to individuals and small businesses after March 2010 include Essential Health Benefits.
Exchange		Another term for Health Insurance Marketplace.
Flexible Spending Account	FSA	A benefit that may be offered by an employer, allowing employees to put money aside on a pre-tax basis for health and/or dependent care expenses in the coming year. Generally, the FSA will be funded from the employee’s own income, although employers may opt to contribute. Employees choose how much to contribute, up to a maximum of \$2,500 per year. Contributed funds not used for eligible expenses during the year are forfeited.

Term	Acronym	Definition
Formulary		The list of drugs (medicines) covered fully or in part by a health plan. Formularies often include both brand name and generic drugs, and are used to manage drug costs. Under the ACA, health plans must include choices within commonly prescribed drug categories and classes in their formularies.
Fraud and abuse		Fraud and abuse take on many forms, but generally include intentional misrepresentation for the purpose of receiving greater reimbursement from a public or private payer. There is no precise measure or definition of health care fraud and abuse.
Gag Clause		A provision that may be incorporated in a physician's contract with managed care organizations, which prevents the physician from being open with his or her patients about the terms of the patient's coverage and therapeutic options.
Generic pathway		An approval pathway for "generic" versions of biologic drugs, or biosimilars. The ACA created this new pathway but ensured that brand name biologic manufacturers are protected from this new competition for at least 12 years.
Global budgeting		Global budgets are budgets or expenditure targets for health care spending. A global budget can be established at a national level, a state level or for other subsets of spending. Specific definitions vary depending on the types of services covered and the systems to which the budgets are applied. Global budgets are intended to constrain both the level and rate of increase in health care cost by limiting them directly.
Grandfathered plan		A plan that was in existence before March 23, 2010, the date the new health law was signed, and hasn't changed substantially since that time. Grandfathered plans are not be required to incorporate all of the consumer protections mandated by the ACA. For a complete list of consumer protections from which grandfathered plans are exempted, see https://www.healthcare.gov/what-if-i-have-a-grandfathered-health-plan/ .
Health Insurance Marketplace		The new Health Insurance Marketplaces help individuals and small businesses to find qualified insurers to provide coverage. Marketplaces also help individuals learn if they qualify for help paying for health insurance. People can also apply for Medicaid through the marketplace.

Term	Acronym	Definition
Health Maintenance Organization	HMO	A type of health plan that provides health care coverage through a network of hospitals, doctors and other health care providers. Typically, the HMO only pays for care that is provided from these in-network providers.
High Deductible Health Plan	HDHP	A type of health insurance plan that, compared to traditional health insurance plans, has higher deductibles although premiums may be lower. These plans are often a component of Consumer Directed Health Plan approaches.
Hospital charge master (Charge Description Master)	CDM	A hospital charge description master contains the prices of all services, goods, and procedures for which a separate charge exists. It is used to generate a patient's bill. But relatively few patients pay this amount. Insurers negotiate discounts from these charge master rates.
Hospital Rate Setting		Sets limits on the rates or budgets of hospitals. Some rate setting programs use a formula-based approach, some review rates or budgets of hospitals individually, and some use a mix of these two approaches.
Health Reimbursement Arrangement	HRA	An HRA is a tax advantaged account that may be used to pay premiums or unreimbursed medical expenses. An HRA must be funded by an employer—it cannot be funded from the employee's salary. An HRA may be offered with other health plans, including FSAs.
Health Savings Account	HSA	A way of saving for medical bills available to taxpayers enrolled in a qualified high-deductible health plan. The funds contributed to the account are not subject to federal income tax at the time of deposit. Funds roll over and accumulate year to year, if not spent.
In-network		If you use the services of hospitals and doctors who have contracted with the health plan, this is called going in-network. When you use in-network providers, you won't face extra costs over and above the cost-sharing specified in your policy.
Insurance		In exchange for a fixed premium, health insurance helps you pay for medicine, visits to the doctor or emergency room, hospital stays and other medical expenses. Because it can protect you from large, unexpected expenses, health insurance can provide you with significant financial protection and access to services that may otherwise be unaffordable.

Term	Acronym	Definition
Independent Payment Advisory Board	IPAB	The Independent Payment Advisory Board (IPAB) is a new executive-branch entity created by the Affordable Care Act. It consists of a 15 member board of medical providers, health care experts, and consumers who will serve paid six year terms. Starting in 2015, IPAB will make “binding recommendations” to decrease Medicare spending if per beneficiary growth in spending exceeds target growth rates. The recommendations will be sent to Congress, which must agree to them or pass alternative cuts of the same size within the year. Alternately, a supermajority in the Senate can amend IPAB’s proposed cuts. Proponents say that the board is a vital mechanism for controlling Medicare spending, since Congress and the executive branch have historically been unwilling or unable to do so. Opponents argue that the law cedes too much authority to an appointed panel and budget cuts might lead to reductions in the quantity or quality of health care services. The ACA limits what the board can do: “The proposal shall not . . . ration health care, raise revenues or Medicare beneficiary premiums . . . increase Medicare beneficiary cost-sharing . . . , or otherwise restrict benefits or modify eligibility criteria.”
Mandated benefits		A health service or category of health service provider that a carrier is required by its licensing or other statute to include in its health plan.
Market share		The percentage of an industry or market’s total sales that is earned by a particular company over a specified time period.
Medicaid		Medicaid is free or low-cost health coverage for people with low incomes, covering hospital stays, drugs, physician visits and more. It is financed jointly by the states and the federal government, but is administered by the states. The ACA includes a very significant expansion of Medicaid eligibility, but some states have chosen not to participate in that expansion.
Medical harm		Unintended physical injury resulting from, or contributed to by, medical care that requires additional monitoring, treatment or hospitalization, or that results in death.

Term	Acronym	Definition
Medical home		An approach to comprehensive primary care that features a partnership between the patient, family, and primary provider, in cooperation with specialists and support from the community. The patient/family is the focal point of this model, and the medical home is built around this center. The medical home is a concept first introduced by the American Academy of Pediatrics in 1967.
Medical Loss Ratio	MLR	MLR measures the proportion of premium revenues spent on clinical services and quality improvement. The ACA requires insurers to issue rebates to enrollees if this percentage does not meet minimum standards of 85% (large group plans) or 80% (nongroup and small group plans) of premium dollars on medical care.
Medical malpractice		Medical malpractice occurs when a health care provider's negligence or incompetence results in patient harm. Medical malpractice lawsuits are a relatively common occurrence in the United States. The injured patient must show that the physician acted negligently in rendering care, and that such negligence resulted in injury. Money damages, if awarded, typically take into account both actual economic loss and noneconomic loss, such as pain and suffering.
Medical tourism		Organized travel outside one's natural health care jurisdiction for the enhancement or restoration of the individual's health through medical intervention.
Medicare		Medicare is a federally financed and administered insurance program for seniors 65 and older and younger people with disabilities, as well as people with end stage renal disease, Amyotrophic Lateral Sclerosis ("Lou Gehrig's Disease"), and, in some cases, Multiple Sclerosis. Almost all Americans over age 65 receive coverage through Medicare.

Term	Acronym	Definition
Medicare Advantage (Medicare Part C)		An alternative to traditional Medicare that lets beneficiaries choose to receive their Medicare benefits through a private insurance company. Plans contract with the federal government and are required to offer at least the same benefits as traditional Medicare, but may follow different rules and may offer additional benefits, including lower cost-sharing. Unlike traditional Medicare, enrollees may be restricted to only certain “in-network” providers, or may be required to pay higher costs if they choose an out-of-network provider.
Medicare Part D		The prescription drug benefit provided under the Medicare program.
Medicare Payment Advisory Commission	MedPAC	An independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission’s statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare’s traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.
Medicare supplement (Medigap) insurance		Optional, private insurance policies that can be purchased to “fill-in” Medicare’s coverage gaps, like deductibles and co-insurance not covered by traditional Medicare (Part A and Part B). Some people obtain Medicare supplements through an employer, while others buy these policies independently. Individually purchased policies must conform to one of the federally mandated benefit designs.
Monopoly		A company or group having exclusive control over a commercial activity.
Most Favored Nation Clause	MFN	An agreement between a buyer and a seller that guarantees the buyer the lowest price for a product or service during the contract period. In the health care industry, for example, a payer such as an insurer) may incorporate an MFN clause in its agreement with a provider such as a hospital. If another insurer negotiates a lower rate with the hospital for a specific service, the first insurer is guaranteed to receive the same rate.

Term	Acronym	Definition
Negotiated rate		The fee a provider charges a health plan and its members for a specified medical service based on negotiations between the provider and insurance company.
Network provider		A doctor or hospital who has a contract with a given health insurance company. These hospitals and doctors agree to the plan's rules and fee schedules and agree not to charge or "balance bill" patients for amounts beyond the agreed upon fee.
Never events		Compiled by the National Quality Forum, this list includes 28 occurrences that are defined as "adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability."
Out-of-network		Doctors, pharmacies, hospitals, and other health care providers who have not contracted with a given health plan are "out-of-network." This means that the insurance company has not negotiated rates with them, and may limit coverage of services by these providers. Using out-of-network providers often results in higher out-of-pocket costs for patients.
Out-of-pocket limit		Annual limits on cost-sharing that patients have to pay under a health insurance plan. This limit does not apply to premiums, balance-billed charges from out-of-network health care providers or services that are not covered by the plan.
Patient-Centered Outcomes Research Institute	PCORI	The Patient-Centered Outcomes Research Institute (PCORI) is authorized by Congress to conduct research to provide information about the best available evidence to help patients and their health care providers make more informed decisions. PCORI's research is intended to give patients a better understanding of the prevention, treatment and care options available, and the science that supports those options.
Pay for Performance	P4P	A reimbursement scheme in which providers are rewarded for quality of health care services.
Preauthorization		Approval given by an insurer for a service before it is provided. This is sometimes known as prior approval or precertification. The need to obtain preauthorization varies from plan to plan, and not all services or health plans require it.

Term	Acronym	Definition
Preferred provider		A doctor or hospital with a contract with your health insurance company. Preferred providers are often described as “in-network.” These hospitals and doctors agree to the plan’s rules and fee schedules and agree not to charge or “balance bill” patients for amounts beyond the agreed upon fee.
Preferred Provider Organization	PPO	A type of health plan that provides health care coverage through a network of providers. Typically the PPO requires you to pay higher costs if you seek care from out-of-network providers.
Premium		The amount you pay, often on a monthly basis, to maintain insurance coverage. Failure to pay premiums can result in loss of coverage.
Premium support		A premium support plan would replace Medicare’s defined health insurance benefit with a defined contribution (or voucher) to purchase health insurance. Proponents argue that this system will harness the power of the marketplace to help solve Medicare’s fiscal problems by giving beneficiaries the incentive to choose low-cost plans and giving plans the incentive to compete for beneficiaries by controlling costs.
Preventive services		Services that are intended to prevent disease or to identify disease while it is easily treatable. Under the ACA, insurers are required to provide coverage for certain preventive benefits without deductibles, co-payments or other cost-sharing, unless grandfathered.
Primary Care Physician	PCP	A general or family practitioner who is your personal physician and often first contact within the health care system. The PCP will usually direct the course of your treatment and refer you to other doctors and/or specialists in the network if specialized care is needed.
Provider reimbursement		Payments to providers such as doctors or hospitals for patient care from insurance companies, Medicare, or Medicaid.
Public option		A publicly operated health care plan that operates alongside private plans in the marketplace. This approach was considered during the legislative debate on the Affordable Care Act but ultimately not included.

Term	Acronym	Definition
Qualified Health Plan	QHP	A health insurance plan that is sold through the Marketplace (Exchange) and has been certified as meeting minimum standards required by the exchange and by law.
Rate Review		The scrutiny of proposed premium rates by state health insurance departments, or occasionally the federal government. This scrutiny is intended to help moderate premium hikes and lower costs for individuals, families, and businesses that buy insurance in these markets. The Affordable Care Act requires that any proposed rate increase by individual or small group market insurers at or above 10% be reviewed to make sure it is justified. If a state does not have an effective rate review program, the federal government conducts the reviews, though it does not have the authority to prevent insurers from implementing “unreasonable” rates.
Reference pricing (Reference-based pricing)	RBP	Reference-based pricing is a health care benefit design through which employers or insurers seek to address price variation by placing a cap (or reference price) on clinical services.
Real costs or Real spending		Spending that has been adjusted for the impact of inflation over time.
Relative Value Scale Update Committee	RUC	The AMA created the Specialty Society Relative Value Service Updating Committee (RUC) in 1991 for the purpose of providing recommendations to the CMS on the relative values it assigns to the Current Procedural Terminology (CPT), which play an integral part of the RBRVS. On an annual basis, this expert panel provides CMS with recommendations for RBRVS changes.
Scope of practice laws		Scope of practice laws establish the legal framework that controls the delivery of medical services. These laws can encompass the full range of health disciplines—ranging from physicians and physical therapists to podiatrists and dental hygienists—and govern which services each discipline is allowed to provide and the settings in which they may do so.
Self-referral		The referral by a physician to a health facility—eg, imaging center—in which he/she has a financial interest.

Term	Acronym	Definition
Sin taxes		A popular term for any tax levied on ‘pleasure poisons’—eg, alcohol, tobacco, sugary or fatty foods.
Single payer		A system that finances the costs of delivering universal health care for an entire population using a single insurance pool. In many industrialized nations, this kind of publicly-managed health insurance is typically extended to all residents.
Summary of Benefits and Coverage	SBC	The Summary of Benefits and Coverage is a new standard form that describes the coverage offered by a health plan. Because all private plans use the same format, it is intended to make it easier to compare them on an apples-to-apples basis.
Sustainable Growth Rate	SGR	Enacted as part of the Balanced Budget Act of 1997, the sustainable growth rate formula determines how much Medicare pays for services that physicians provide. Under the SGR, cumulative Medicare spending on physicians’ services is supposed to follow a target path that depends on the rates of growth in physicians’ costs, Medicare enrollment, and real gross domestic product per person. If spending in a given year exceeds the SGR target for that year, then the amounts paid to physicians for each service they provide are supposed to be reduced in the following year to move total spending back towards the target path. The SGR is flawed because it attempts to limit payments without addressing the volume or complexity of services and the formula is rarely followed. In every year since 2003, Congress has prevented the full cuts required by the SGR from going into effect.
Tax credits		Tax credits lower the amount of income tax you owe. In the case of the tax credits created by the Affordable Care Act, some low and middle income people can get tax credits that lower the cost of health insurance purchased through the new Marketplaces.

Term	Acronym	Definition
Tiered network		Tiered provider networks categorize hospitals or physicians into tiers (typically two or three) using cost or some combination of cost and quality metrics. Members in plans with tiered providers pay higher cost-sharing amounts to use the higher cost or less efficient providers in the network. They pay lower cost-sharing amounts with the lower cost or more efficient providers. These networks are essentially a variation of a long-standing practice of providing one level of benefits to enrollees who use in-network providers and lower level of benefits for use of out-of-network providers.
Tiered formulary		A tiered formulary divides drugs into groups, based primarily on cost. A plan's formulary might have three, four or even five tiers. Plans negotiate pricing with drug companies. If a plan negotiates a lower price on a particular drug, then it can place it in a lower tier and pass the savings on to its members through lower enrollee cost-sharing requirements (e.g. lower co-payments).
Tobacco surcharge		A tobacco surcharge is an extra charge tacked onto insurance premiums based on a policyholder (or dependent's) tobacco use. Starting January 1, 2014, insurers in many states will be able to charge tobacco users up to 50 percent more in premiums.
Tort reform		Tort reform efforts represent a movement to reduce the volume and associated costs of tort litigation in the judicial system, often through legislation that, among other things, may restrict the legal theories that can be used to support plaintiff claims or cap damage awards (especially with respect to the awarding of non-economic and punitive damages).
Triple Aim		The Triple Aim is a framework for optimizing health system performance: improve the health of the population; enhance the patient experience of care (including quality, access, and reliability); and reduce, or at least control, the per capita cost of care.

Term	Acronym	Definition
Underwriting		The process used by insurers to determine a person's health-insurability using information on health status, health risk, and prior use of medical care. Prior to 2014, the underwriting process was used to set premiums, decide whether to issue a policy, and decide benefits to be offered. Medical underwriting was eliminated by the ACA for coverage that starts January 1, 2014 or later.
Underwriting cycle		The business cycle in the insurance sector. In the underwriting cycle, insurers compete with each other for clients, resulting in falling premiums and low underwriting standards. Eventually, insurers begin charging higher premiums to ensure adequate reserves, completing the cycle. The underwriting cycle can cause premium trend to diverge from the underlying growth in health care costs.
Utilization management		The process of evaluating the medical necessity, appropriateness, and efficiency of health care services. Utilization management describes proactive procedures, discharge planning, concurrent planning, precertification, and clinical case appeals. It also covers processes, such as concurrent clinical reviews and appeals introduced by the provider, payer, or patient.
Value-Based Insurance Design	VBID	Value-Based Insurance Design aims to increase health care quality and decrease costs by using financial incentives to promote use of cost efficient health care services by consumers. By lowering the cost of effective high-value treatments, health plans can encourage efficient patterns of care. VBID may include disincentives as well, such as high cost-sharing, for health services that may be ineffective or repetitive, or when the same outcome can be achieved at a lower cost using a different approach. To decide what procedures are the most effective and cost efficient, insurance companies may use evidence-based data to design their plans.
Value-Based Purchasing	VBP	Purchasing practices that reward quality of care through payment incentives to providers. These approaches hold providers accountable for the quality and cost of the health care services they provide. Approaches largely fall into two categories: (1) measuring and reporting comparative performance; and (2) paying providers differentially based on performance.

Term	Acronym	Definition
Voucher		A check from the government to a recipient for a single purpose, in this case paying for health insurance. In the case of a proposed change to Medicare, also known as premium support, the check would have to be used in one of two ways. It could be signed over to an insurance company to buy private insurance. Or, if the plan allows it, the voucher can be returned to the government to pay for traditional Medicare. The voucher approach is intended to cap Medicare's growth in spending.
Wellness incentives		Wellness programs try to promote health through incentives. Wellness incentives typically come as 'carrots' or 'sticks'. In the 'carrot' format, they reduce net insurance costs by a certain amount, provided you engage in healthy behaviors. 'Sticks' impose a net-increase if you don't.