

Improving the Bottom Line

Lawmakers, businesses and health care providers are trying an array of approaches to curb the long-term costs of health care.

Next month: Six more strategies to manage the rising cost of health care.

BY RICHARD CAUCHI,
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Spiraling health costs grab headlines, create budget shortfalls and plunge families into bankruptcy.

America spends \$2.6 trillion annually on health care and costs seem to rise inexorably. Every year, state lawmakers face tough choices as health costs eat up 25 percent to 30 percent of total budgets. Costs hit households, too, with family health insurance coverage now averaging \$15,073 a year.

At the same time, policymakers are teaming up with innovative local providers, business leaders and consumer advocates to find new and sustainable ways to hold down the cost of health care for the long term.

“Moving away from compensating the volume of care to providing better value is the way to cut costs without harming access or quality,” says Massachusetts Senator Richard Moore (D), chair of the legislature’s Joint Committee on Health Care

Financing. “Promoting prevention and wellness, along with improving quality and safety, are fundamental to cutting health care costs.”

In a nutshell, most medical experts agree medical care that does the right thing at the right time to the right people will help save money and improve Americans’ health. These actions, coupled with promoting prevention and personal responsibility, should help curb health costs.

“Taming rising health costs is one area where state governments have been out front and where reaching across the aisle has saved real money,” says Senate President Steve Morris (R) of Kansas, NCSL’s current president. “I am pleased that NCSL and state legislators across the country are tackling this complicated issue.”

No magic bullet exists. What works in one locale may not fit another. Yet, lawmakers continue to press for cost-effective strategies—in the individual home and at the state policy level.

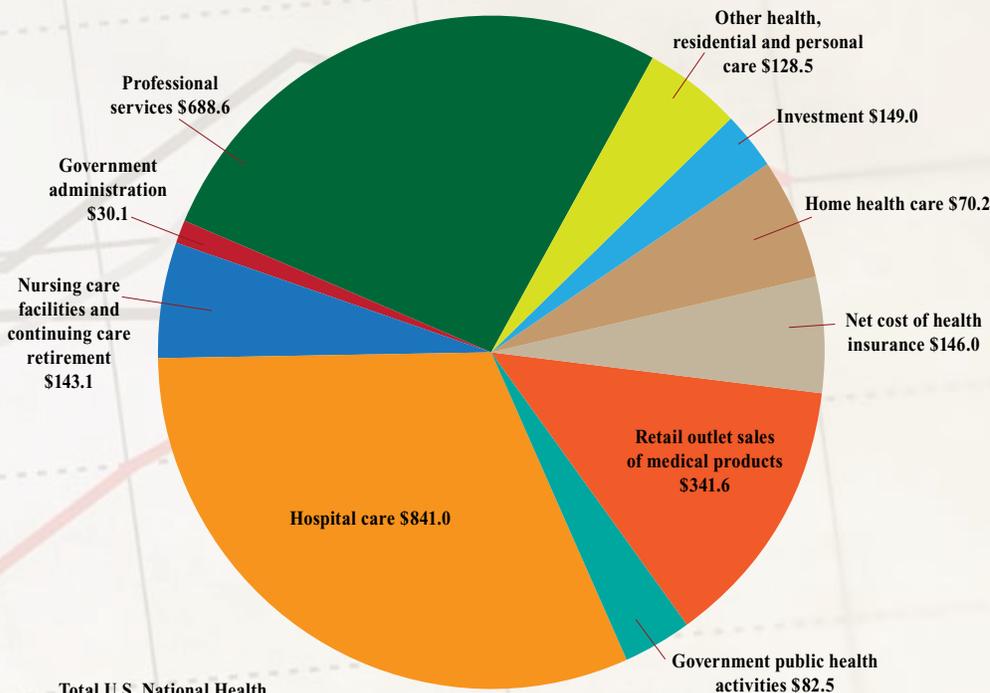
Health Systems That Work

Group Health Cooperative in Seattle, Rocky Mountain Health in Grand Junction, Colo., and Geisinger Health System in Pennsylvania have paved the way for documented cost savings.

Group Health houses its providers, clinics and hospitals under

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U.S. National Health Care Expenditures 2010 (billions)



Total U.S. National Health Care Expenditures in 2012 was \$2.6 trillion.

Source: Data released January 2012 the CMS Office of the Actuary and the National Health Expenditure Accounts Team; published in Health Affairs article, "Growth In US Health Spending Remained Slow in 2010; Health Share Of Gross Domestic Product Was Unchanged From 2009." Authors: Anne B. Martin, Dave Lassman, Benjamin Washington, Aaron Catlin

NCSL Briefs

NCSL's Cost Containment and Efficiencies project has published 16 issue briefs, each four to six pages in length. Go to www.ncsl.org/magazine to download a copy.

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one roof. The group receives a monthly capped payment from insurers to manage each patient's care. Its methods include physician consultation by phone and secure email for patients. Washington analysts writing for the health policy journal Health Affairs have estimated that Group Health has saved more than \$10 per client per month within this model of care.

In Grand Junction, the average per capita Medicare spending was 24 percent lower than the national average in 2007. Since it was founded in 1974, the Rocky Mountain Health communitywide system has expanded preventive care, including free prenatal care, and treated

diabetes and asthma with a comprehensive case management approach. It also provides in-home follow up by nurses and other health professionals. Observers have suggested the cooperative spirit shown by providers, hospitals and health plans helps lower costs.

These promising methods include a payment system that involves equal reimbursement for care of Medicare, Medicaid and private insurance patients; limits on expensive resources, such as hospital beds and specialists; and comprehensive end-of-life care, which has led to 50 percent fewer deaths occurring in hospitals by emphasizing hospice and at-home services.

Pennsylvania's Geisinger Health System is widely celebrated for focusing on coordinating care among providers, peer-review and easy access for patients to routine care. Geisinger motivates providers to use only health care approaches that research has demonstrated are effective, such as team work and peer review. Patients' ability to schedule same-day appointments has increased from 50 percent to 95 percent since 2002. Using a medical home model, Geisinger has reduced overall medical costs by 4 percent—while costs have risen in most plans—

Health Care By the Numbers

\$2.6 trillion

U.S. annual health spending.

\$421 billion

Total spent by state and local governments.

\$8,402

Average spent per person annually on health.

6.6% to 3.9%

Drop in annual growth of health spending from 2007 to 2010.

17.9%

Health share of gross domestic product.

\$72.5 billion

Estimated annual cost of insurance fraud.

75%

Share of all health care spending that goes to treat chronic conditions.

\$19.5 billion

Estimated annual cost of medical errors.

200%

Cost to treat someone with diabetes compared with a nondiabetic.

\$15,073 a year

Average cost of a family health insurance policy.

Source: 2010 National Health Expenditures, Department of Health and Human Services, published 2012.



Senate President
Steve Morris (R)
Kansas

and has seen a 29 percent reduction in hospital readmissions overall. For diabetic patients, the system has reduced hospital admissions by 25 percent and days spent in the hospital by 43 percent.

Medical Homes

Poor coordination of health care services can lead to serious problems. A person who needs a specialist doesn't know how to find one. Another patient must undergo unnecessary medical tests because a specialist doesn't have access to her medical records. A man who can't get an appointment to see his primary care physician goes to the emergency room instead.

Medical homes can avoid many of these problems, while also avoiding unnecessary costs and improving patients' health.

Medical homes, especially for those with complex medical needs, are a way of organizing and delivering health care that is coordinated, comprehensive, efficient and personalized. A medical home provides patient education, resources and referral assistance, while integrating the individual's needs whether medical-surgical, rehabilitative, psychological or supportive services. As of July 2010, at least 29 states had enacted medical home legislation addressing such things as certification, authorization for Medicaid pilot programs, appropriations for care coordination fees, the creation of advisory panels and anti-trust protections.

Initial results from pilot projects indicate they can save money. Community Care of North Carolina covers more than 950,000 Medicaid enrollees. Between 2007 and 2010, preventable hospital admissions declined by 12.5 percent among the 71 percent of patients who were enrolled in the pilot program, but increased by 25.9 percent among patients who were not. A 2011 report calculated that Community Care saved Medicaid nearly \$1.5 billion over three years.

Medical home pilot programs sponsored by WellPoint, a health benefits company and licensee of the Blue Cross and Blue Shield Association, have experienced as much as an 18 percent decrease in acute inpatient admissions and a 15 percent decrease in emergency room visits.

Health Savings Accounts

Health savings accounts can help reduce health costs and give people greater engagement in and control over their health issues, according to backers of the accounts.

"A health savings account provides consumers and employers a practical alternative to combat high-cost medical coverage," says Wisconsin Senator Mary Lazich (R), chair of the legislature's Committee on Public Health, Human Services, and Revenue. "During an era of skyrocketing medical expenses, HSAs allow and encourage cost-conscious consumers to seek pricing information and shop for competitive services."

The accounts are similar to personal savings accounts, but

account holders can use the money only for health expenses. Most also enroll in high-deductible plans paid for with pretax dollars from employers. This allows them to pay for routine health care from the account, but provides them with insurance in the event of a major illness. Most reports of their success come from insurance industry sources.

An Aetna study found members with the accounts used the emergency room less frequently and had 9 percent lower annual medical costs than those without the savings accounts. In 2010, Cigna found its health savings account enrollees reported better control of and engagement in treatment of their health issues than did non-HSA enrollees, such as a 21 percent higher likelihood of participating in disease management programs. A 2010 study by the University of Illinois School of Public Health reported those with HSAs spent 5 percent to 7 percent less than enrollees without them.

Critics argue the plans are successful because they enlist people who are younger, healthier, better educated and wealthier than the general population.

Prescription Drug Purchasing

More than one-half of Americans take prescription drugs regularly, at a total cost of \$260 billion, or just under 10 percent of overall health spending in 2010.

In 2005, the annual increase for all U.S. drug spending was the highest of any health service or product—10.6 percent. Yet, by 2010 this increase had slowed dramatically, to a record low of just 1.2 percent.

Why? In January, actuaries at the Centers for Medicare and Medicaid Services reported "a continued increase in the use of generic medications and an increase in Medicaid prescription drug rebates" as leading causes of slowed spending. Eighty percent of all dispensed prescriptions in 2011 were FDA-certified generic drugs—up from just 67 percent in 2007. In 13 states, pharmacists are required to dispense the generic equivalent when available. In every state, physicians have the authority to order use of brand name drugs—and block a generic substitution—when beneficial to a particular patient.

Preferred drug lists, now used by 48 states for Medicaid and many state-run plans, allow public programs to dispense both generic and brand products and also allow physician discretion to meet individual needs. Especially for the most serious illnesses, unique brand-name or "innovator" drugs remain a key treatment choice, accounting for \$200 billion—77 percent—of U.S. market sales.

Global Payments

Global payment systems allow insurers to pay a fixed amount to a group of providers or a health care system to cover most or all of a patient's care during a specified time period.



Senator
Richard
Moore (D)
Massachusetts



Senator
Mary Lazich (R)
Wisconsin

In 2009, the largest insurer in Massachusetts, Blue Cross Blue Shield, established a program called the Alternative Quality Contract, which combined global payments with sizeable quality bonuses for medical groups. The groups agreed to an annual budget that included financial incentives if there were improvements in the quality of patient care. Within the first two years, the program included more than a quarter of the primary care physicians practicing in Boston. Together, these practices cared for more than 470,000 Blue Cross Blue Shield patients. Stuart Altman, a professor of health policy at Brandeis University, and colleagues wrote in 2009 that “global payment has the greatest potential for encouraging shifts in health care resource use from low-value to high-value services.”

Other examples of successfully integrated systems include the Cleveland Clinic in Ohio and Kaiser Permanente, which is based in California and operates in Colorado, Georgia, Hawaii, Maryland, Ohio, Oregon, Virginia, Washington and the District of Columbia.

Thirty states operate Programs for All-Inclusive Care for the Elderly, which pay a capped rate to provide total care to frail patients covered by Medicare and Medicaid. California, Kansas, Massachusetts, Rhode Island and Vermont are among the states that have or are considering applying for federal waivers to allow global payments. Health economists and others are increasingly promoting global payments as an important strategy to slow growth of health care expenditures. Using global payments in conjunction with performance-based pay, medical homes and accountable care organizations may help control costs better than using a single strategy.

Early Detection and Treatment

What you don't know can hurt you.

When it comes to your health, early detection and treatment can save your life and reduce your health care costs substantially.

Numerous health problems benefit from early intervention: From counseling for problem drinking to tuberculosis screening in high-risk populations, from smoking cessation counseling to STD screening for teens.

Promising new methods of diagnosing and treating early Alzheimer's disease alone could save Medicare and Medicaid a substantial amount of money, in part by delaying nursing home placements. “The future of this disease is to intervene decades before someone becomes symptomatic,” says Dr. Mark Sager, director of the Wisconsin Alzheimer's Institute. “This analysis says you can save literally billions of dollars in long-term care costs if you can intervene at an earlier stage.”

Early detection and treatment rates improve when insurance coverage is required, public education campaigns are employed and public providers are given incentives. Experts disagree about the frequency and usefulness of certain screenings, such as breast, prostate and cervical cancer. But most other screenings have broad support among health care practitioners.

The federal Patient Protection and Affordable Care Act requires health plans to cover certain screenings—high blood pressure, alcohol misuse, colorectal cancer—with no deductibles or copayments. At least 14 states require insurance coverage for osteoporosis-related diagnostic and treatment services.



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Primary care providers who participate in the Illinois Primary Care Case Management Program are eligible for an annual bonus based, in part, on meeting or exceeding benchmark screening rates for developmental disabilities, breast cancer and lead. Utah's colorectal cancer social marketing campaign warns the physical symptoms of colon cancer don't appear early on and that people age 50 and older should be tested regularly. 

Editor's note: This is the first of a two-part story on efforts in the states to hold down health care costs while improving quality. The second part of the story, to appear in the July/August issue of State Legislatures, will include information about patient safety, drug monitoring programs, medical malpractice reform, wellness in the workplace, and approaches to help patients make healthy choices and good medical decisions.

SL ONLINE

Learn more about state efforts to curb health costs at www.ncsl.org/magazine.