

# Health Cost Containment & Efficiencies

Presentation to  
NCSL Fall Forum. December 11, 2009



NATIONAL CONFERENCE of STATE LEGISLATURES

*The Forum for America's Ideas*



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Denver, Colorado

rev 12/8/09



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## Overview of Presentation

- Health costs – huge issue, dollars and debate
- New NCSL Health project – a fresh look at state cost containment strategy options
  - Plans and schedule for 2010
- An advance look today: the first 7 topics
- Q & A + existing resources



## Health costs: A major issue for states

**U.S. Health costs \$2.5 trillion  
in 2009.\***

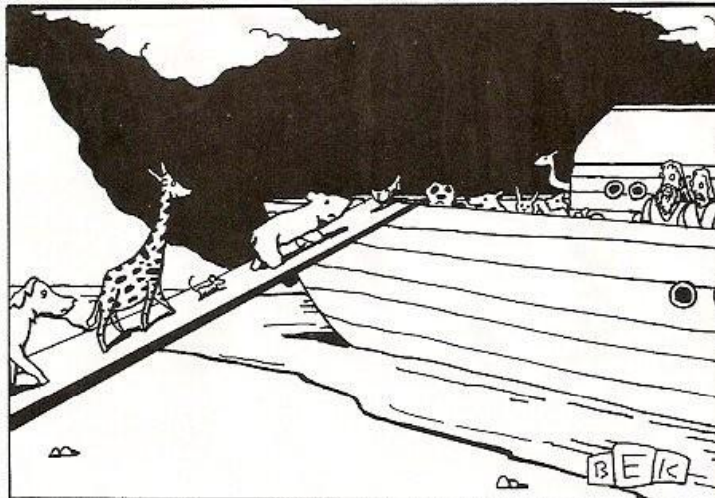
**Health premiums “unaffordable”  
heading up for 2010**

**Chronic disease costs US  
\$280 billion in treatment;  
\$1 trillion lost productivity**

**ARRA temporary federal  
Medicaid help, ends 2011?**

**Impact of federal changes?**

\* CMS Office of the Actuary, in Health Affairs, 2/09



"I know we have to cut costs but is bringing only one of each a good idea?"

© 2009 BEK /New Yorker



# Health as a major factor in state budgets

29.7% of total state FY 2009 budget  
Estimated 50-state averages

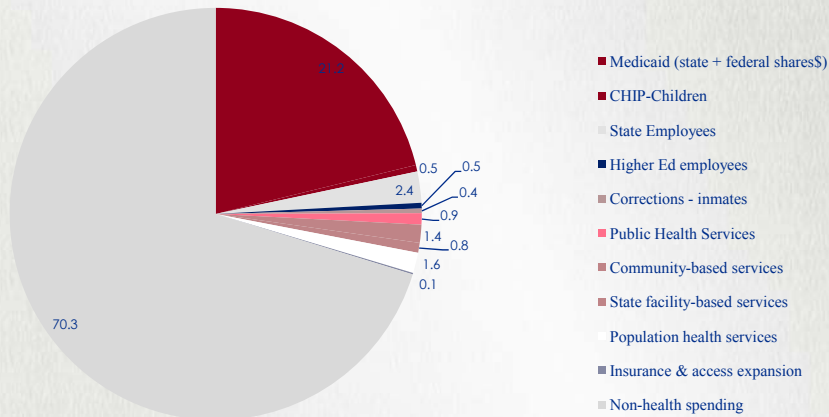
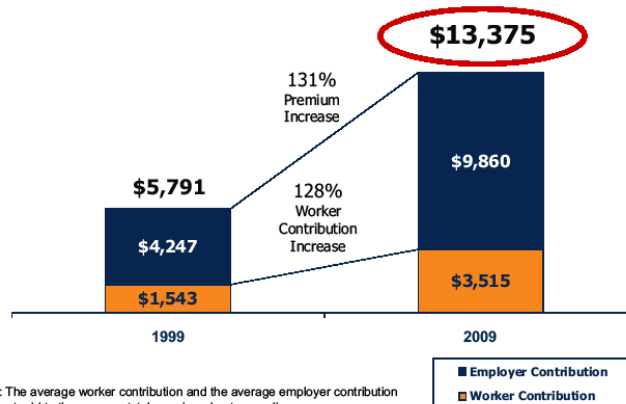


Figure 1  
**Average Health Insurance Premiums and Worker Contributions for Family Coverage, 1999-2009**



Note: The average worker contribution and the average employer contribution may not add to the average total premium due to rounding.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.





## Project on Containing Health Costs and Realizing Efficiencies

- o NCSL Health Program will research and analyze policy strategies that might make health costs –
  - “Smarter,” more efficient, cost effective
  - “Bend the health cost curve” – change the pattern for the long-term or “one-time” savings rather than just shifting costs to someone else
  - Avoid waste, duplication, excessive payments
- o Focusing on real examples from states
- o Emphasis on documented savings/efficiencies, not vague estimates or wishful press releases
  - Will include effects on health outcomes
  - Will not include “slash & burn” cuts in eligibility or benefits
  - Will not cover expansion-only or special population health programs



## 25 Strategies for States

- o Each strategy: 3 to 4-Page reports
  - Description of strategy
  - Cost containment target 
  - Examples from states and other markets
  - Evidence of savings or effectiveness
  - Reliable or expert sources for more information
- o 15-month project – 3-part publications in 2010
  - **Health system financing, organization and administration** — Structural strategies aimed at improving the efficiency and effectiveness of the health care system.
  - **Efficient and effective practice of medicine**
  - **Benefits and health choices**



## Today: Preview of **Seven** Selected Strategies

- **New Payment Strategies**
  - Pay-for-performance
  - Episode-of-care payments
  - Global payments
- **Administrative Simplification**
- **Prescription Drug Strategies**
  - Increase use of generic drugs
  - Expand negotiated prescription drug purchasing
- **Consolidated Multi-agency Purchasing**



## Strategy: Pay-for-Performance

- **Rewards providers for meeting quality, efficiency benchmarks**
  - Rewards based on demonstrated performance
  - Types of rewards: bonuses, more patients, enhanced fees
  - Often used for high-cost conditions & preventive care; also used with other types of payment
  - Benchmark examples: diabetics' blood sugar level, fewer avoidable hospitalizations, immunization targets





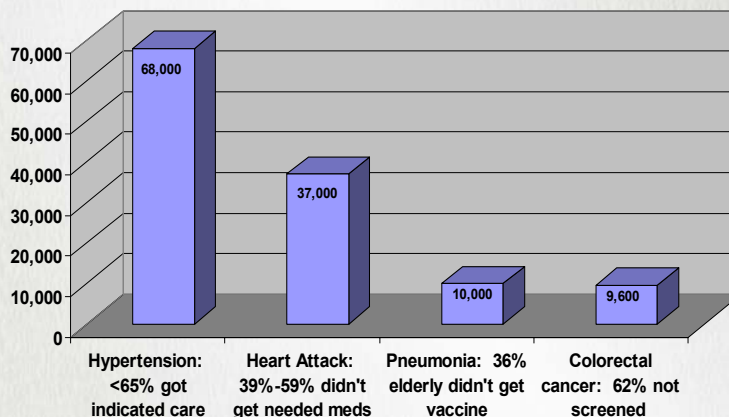
## Cost Containment Target



- Insufficient value for health care dollar
  - Under-utilization of cost-effective, preventive care
  - Inadequate management of patients with chronic conditions
  - Failure to provide quality care, follow evidence-based guidelines
- Main target: improved quality of care



## Shortfalls in Care Have Serious Consequences Avoidable Deaths per Year, U.S.



S.H. Woolf, JAMA, Vol. 282, 1999



## Pay-for-Performance: Examples

- 250 P4P programs around country, 18% Medicaid
- TX requires outcome-based performance measures in all Medicaid-HMO contracts
- MA Medicaid, MD rate setting commission—P4P for hospitals
- MN—2008 law re quality incentive pay, rewards in state health programs for high-quality, low-cost providers
- ME Physician Incentive Program: 30% bonus for reduction in avoidable ER use
- Private sector—More than half of HMOs use P4P



## Pay-for-Performance: Cost Evidence

- Very little research: savings for diabetes care
  - One study: Higher-performing physician cost/diabetic patient = \$1,400 v. \$1,600 per year
  - Second study: Program in Upstate NY found return on investment of 2.5
- Some reasons for limited cost effect: admin. costs, inconsistent payer P4Ps, quality is focus, not cost
- Studies show P4P can improve health care quality



## Strategy: Episode-of-Care Payments

- Main elements:
  - Single payment for all providers treating a specific illness, condition or medical event
  - One payment per episode instead of multiple payments for each service
  - Episode examples: knee and hip replacements, heart attack, pregnancy and delivery
- Trend among payers is episode-based pay



## Cost Containment Target

- Unnecessarily expensive care for an episode of illness
  - Duplication of services
  - Avoidable hospitalizations
  - Unnecessary tests, procedures
  - Complications of care
  - High-cost care where less expensive care is as effective
  - Failure to provide preventive care or early intervention
  - Lack of incentives to provide efficient care



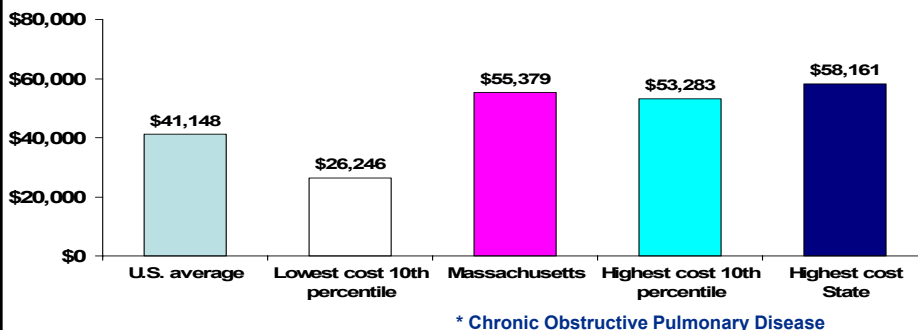


## Costs Vary Widely Among States for Same Condition

### AVOIDABLE HOSPITAL USE & COSTS

#### State Variation: Annual Costs of Care for Medicare Beneficiaries with Three Chronic Conditions (Diabetes, Heart Failure, and COPD), 2006

##### Average annual cost



DATA: Medicare SAF 5% Data from the Chronic Condition Data Warehouse (CCW)

SOURCE: Analysis by G. Anderson and R. Herbert, Johns Hopkins University.



## Episode-Based Pay: Examples

- MN—2008 law called for development of “baskets of care”
- MD—hospital rate setting commission uses case rates that bundle hospital, ambulatory surgery, clinic, ER care
- TX—considered, did not pass, bill for retirement system pilot
- Medicaid programs—many use for obstetrical care
- Private sector—UnitedHealth testing with oncologists for cancer care
- Medicare—Acute Care Episode Demonstration for all inpatient care for orthopedic, cardiovascular procedures
- Federal reform bills—Authorize Medicaid demos in 8 states



## Episode-Based Pay: Cost Evidence

- Limited evidence: savings for some conditions

### Examples:

- Medicare bypass surgery demo—10% lower mean costs and 14% to 32% shorter hospital lengths-of-stay
- Arthroscopic surgery for knee and shoulder surgery—\$125,000 savings over 2 years in small HMO pilot
- Hospital payments per diagnosis in Medicare and state Medicaid programs—reduced rate of growth in hospital expenditures



## Strategy: Global Payments

- Elements:

- Fixed pre-payment to provider group/system(s) for all patient care for a specified time period
- Incentives for access and quality
- Payment adjusted based on health of patients
- Need an entity to receive and distribute payment-- accountable care organizations



- Hottest “new” payment strategy—similar to capitated managed care



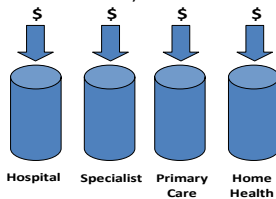
## Fee-for-Service versus Global Payment Incentives Massachusetts Special Commission Report

### Special Commission's Recommendation

#### Current Fee-for-Service Payment System

##### The Problem

Care is fragmented instead of coordinated. Each provider is paid for doing work in isolation, and no one is responsible for coordinating care. Quality can suffer, costs rise and there is little accountability for either.



#### Patient-Centered Global Payment System

##### The Solution

Global payments made to a group of providers for all care. Providers are not rewarded for delivering *more* care, but for delivering the *right* care to meet patient's needs.



Government, payers and providers will share responsibility for providing infrastructure, legal and technical support to providers in making this transition.



## Cost Containment Target



- Lack of accountability for total cost, quality of care for patients
  - Fragmented, uncoordinated care
  - Poor financial incentives for cost-effective care for people with multiple conditions
  - High administrative costs of processing multiple claims for each patient from multiple providers



## Global Payments: Examples

- MA payment system commission recommended all payers use global payments by 2014
- MN—Program launched by Buyers Health Action Group involves provider groups that bid for total care cost for a patient population
- Long history of public, private payments to integrated care systems (e.g., Kaiser, Mayo Clinic)
- Most Medicaid programs pay a bundled payment for primary care for mothers and kids; now being combined with pay-for-performance



## Global Payments: Evidence

- Research mainly from capitation experience: can lead to lower costs without affecting quality
  - State Medicaid savings from managed care = 2% to 19%
  - Works best with integrated delivery systems, especially mature ones  
e.g., Geisinger Health System in PA; Denver Health)
  - Savings come mainly from fewer hospitalizations, lower prescription drug expenditures
- Caveat: Most newly-formed, risk-bearing provider groups of the 1990s failed

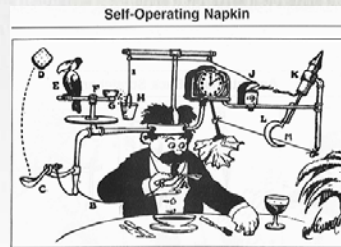


## Strategy: Administrative Simplification\*

### ○ Main elements:

- Common forms for billing, coding
- More efficient claims, prior-approval processes
- Single provider credentialing process
- Swipe cards for patient coverage information
- Streamlined government processes

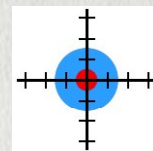
\* In current system



## Cost Containment Target

### ○ Administrative inefficiency

- Duplication of administrative processes
- Unnecessary complexity
- Antiquated administrative systems





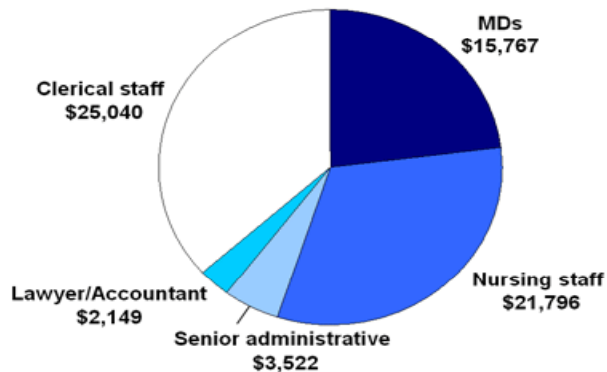
## Administrative Costs Eat Up a Significant Portion of the Health Care Dollar

- Although some administrative costs are necessary and add value (e.g., quality, fraud monitoring)...
  - Administration = 25% or more of premiums
  - Paper billing = \$1.85 per claim; electronic billing = 85¢ per claim
  - Physician practice cost = 14% total collections, average of \$68,274 per practice



### Total Annual Cost to U.S. Physician Practices for Interacting with Health Plans Is Estimated at \$31 Billion<sup>1</sup>

Mean Dollar Value of Hours Spent per Physician per Year on All Interactions with Health Plans



Total Annual per Practice Cost per Physician: \$68,274

<sup>1</sup> Based on an estimated 453,696 office-based physicians.

Source: L. P. Casalino, S. Nicholson, D. N. Gans et al., "What Does It Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs* Web Exclusive, May 14, 2009, w533-w543.





## Administrative Simplification: State Examples

- Standard application for provider credentials verification -- LA, NJ, TN, WV and at least 9 other states
- Standard health insurance swipe cards—UT, CO laws
- Uniform electronic claims submissions—ME law
- Comprehensive administrative streamlining laws or series of laws—ME, MN, WA Health Care Efficiency Act
- Special task forces or offices—ME, OR Health Fund Board recommendation
- Federal reform bills include comprehensive simplification provisions



## Administrative Simplification: Cost Evidence

- Limited evidence: some efficiencies, not yet overall savings
  - Electronic v. phone benefit verification: \$2.10 saved/call
  - BCBS of SC real-time resolution of prior authorizations, patient coverage: \$1.4 million saved in 2007
- Why not more savings
  - Efforts are new, not adopted on wide enough scale
  - High front-end costs; providers, plans retain savings
  - May need greater system overhaul



## Overview: Prescription Drugs (Rx)

- Pharmaceuticals are integral part of medicine - keep patients healthier and save lives
- More than half of Americans take prescription drugs regularly
- Proper pharmaceutical use saves \$ by avoiding hospitalization, emergency rooms, nursing homes
- Overall market includes "brand name" or "innovator" products + generic or multi-source drugs + over the counter (OTC) non-prescription products
- U.S. Rx total purchases = \$244 billion annually



## Strategy: Use of generic drugs

A generic drug is identical, or bioequivalent to a (specified) brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. [U.S. FDA definition]

- In 2005 51% of all US prescription drug "scripts" +were generics
- In 2008-09 67% of all "scripts" or purchases are generics.
  - Generics ave. price \$32; Brand names ave. \$111.
  - Generics = 20% of all sales in dollars, or \$58 billion
- "Life-saving" drugs, anti-depressants, anti-psychotics, cardiovascular often remain predominantly brand name; totals ~ \$127 billion.



## Cost Target: Generic Use



- o **A 50-state analysis of Medicaid purchases for FY 2008 documents each state's comparative use of generics** – “National Brand and Generic Medicaid Utilization and Expenditure by State”
- o Average cost of brand Rx is \$191; predominate with 82% of total \$ spent
- o Average cost of generics \$21; 17% of total spent but states vary from 9% (OK) to 29% (UT)
- o 1% shift to generics reduces 50-state cost share by \$207 million/yr.
- o **The likely Legislative role:** Review your state agency processes: Most say there is no "right" percentage. States balance patient need, medical protocols, physician requests, approvals versus denials.
- o Source: Data is from the Centers for Medicare and Medicaid Services (CMS)



## Cost Target: Brand-Name Use



- o **Some brand name drugs can cost less than generics.**
- o Some brand name drugs are proven more effective - fewer side effects, fewer doses per week. Selected by state for "preferred status."
- o Manufacturer extra discounts (supplemental rebates) make some products competitive.
- o Average cost of brand Rx is \$191; predominate with 82% of total \$ spent
- o **The likely Legislative role:** See next section, **"Expand Negotiated Pharmaceutical Purchasing"**



## Generics: Cost Evidence

- Rx spending changes have been labeled a "success" by federal agency and industry analysts:
- CMS Actuaries: Annual increase in overall Rx spending:
  - 11.8% increase in 2006, but dramatic slow-down ...
  - 3.5% increase in 2008; **4.0% increase in 2009**
  - Due to "patients willing to switch from brand name to cheaper generics" + recession + # Rx filled slowed. - CMS, Health Affairs 2/24/09
- "... greater use of generics when available since 2003 has resulted in 22% lower pharmaceutical spending in 2007."
  - IMS Health in Health Affairs, Dec 16, 2008, page w158
- NY Medicaid reported 54% reduction in use of 1 product with a corresponding 55.2% reduction in total payments (Sept 2006)



## Rx Cost Challenges

- Many current brand name drugs have no generic equivalent and cannot safely be substituted unless the patient's physician identifies a different treatment.
- Drugs are not typical commodities - every patient is different. Role of orphan drugs, rare conditions.
- The status of individual drugs as unique brand products may eventually shift to generic or even over-the-counter, but states and legislatures cannot change this process; only the FDA (or courts) can.
- Legislators may be asked to mandate a particular product or category of coverage. Do they have the medical expertise to decide? Role of your state P & T Committee.\*
- \* Medicaid Pharmaceutical & Therapeutics Committee, usually created by statute.



Strategy:

## Expand Negotiated Pharmaceutical Purchasing

Many states use a strategic combination of up to 4 policies to control the costs of prescription drugs.

### 1 Use of preferred drug lists (PDLs)

- State list delineates which prescription products are preferred and covered automatically;
  - non-preferred drugs often require an extra approval step or a higher patient co-payment;
  - goal to influence the prescribing habits of physicians;
  - result usually is a significant increase in the use of generic drugs and designated brands instead of all possible brands and products;
- Target:** 45 states have PDLs; process requires regular review.
- half the states have protected or "carved out" classes of medical conditions such as mental health, HIV/AIDs and cancer. These products are large % of Rx budgets.



2

### • Expanded use of manufacturer price "supplemental rebates"

- state Medicaid can directly negotiate additional or "supplemental" rebates. Up to 25% beyond federal price arrangement.
- often tied to "preferred products"; may have increased sales volume.

3

### • Multi-state purchasing and negotiations

- 3 Multi-state buying groups now cover 26 states.
- Each uses combined strategies.
- Each state retains final decision-making.



## State Examples: Medicaid Rx Buying Pools

- National Multi-state Pooling Initiative has 12 states
- "TOP Dollar" Rx purchasing group has 7 states
- "Sovereign States Drug Consortium" has 7 states

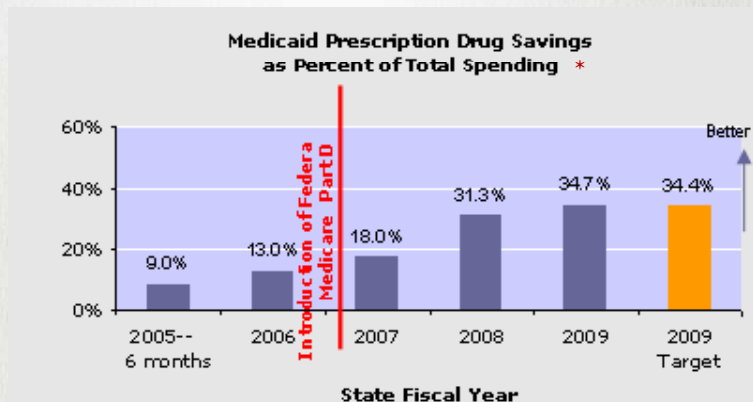
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- o Each pool uses common Preferred Drug List, plus gets supplemental rebates from manufacturers.
- o 2 pools have a management company: 100% pass-thru.
- o "Sovereign States" is non-profit, run directly by states.
- o Emphasize generics but do not require use.

Medicaid nationwide, buying pools cover 32% of enrollees (18 million) and 38% of the spending in 2008.



## Funds saved through the Pharmaceutical Preferred Drug List + 7-state buying pool (Iowa Medicaid)



\* For 2008, the total Rx savings were \$63 million, of a total drug expenditure of \$191 million.

Data Source: Department of Human Services, Iowa Medicaid Enterprise - Updated August 19, 2009



# Evidence: Savings in bulk purchasing

(Multi-state plans, Medicaid programs)

## Multi-state bulk pools **alone**

- o Nevada saved \$4.3 million in 2005. (3.2% of \$134 million)
- o Maryland saved \$19 million in 2006 (4% of \$490 million)
- o West Virginia expect saving \$16 million in 2006 (4% of \$400 mil.)

## Bulk + Preferred Drug List + extra rebates

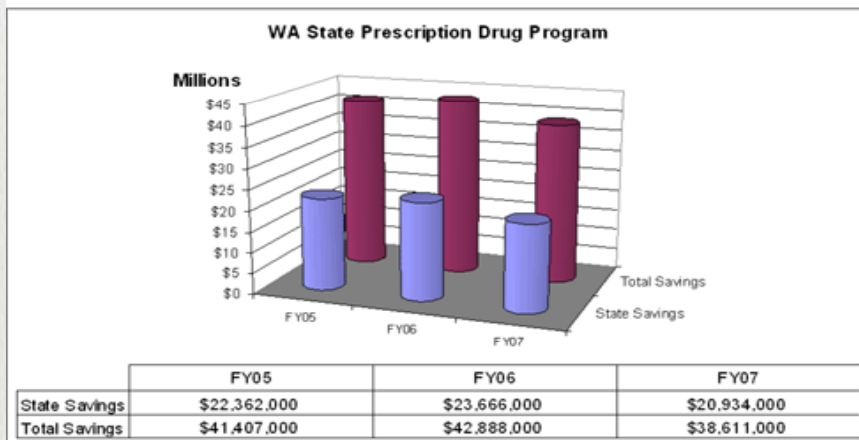
- o Vermont reported 4.7% (\$5.3 million) savings in 2008.
- o Kentucky reported \$19.8 million from supplemental rebates alone, 2006 \*
- o New York estimated \$392 million savings, 2007. (of \$4 billion)  
Actual audited total gross savings for the PDP was \$82.5 million.
- o Texas reports PDL savings of \$116 million general revenue in FY2007
- o Wyoming Medicaid PDL saved 6.8% in the first year, 2005.

**All savings are state-initiated in addition to federal maximum price and rebate formulas.**

\* see handout 12/11/09



Figure 2. Washington State Prescription Drug Program Savings, State Fiscal Years 2005-07



### Savings Projected for 2006 through 2007 (including Medicare Part D impact)

Source: Washington State Prescription Drug Program, presentation by Duane Thurman and Ray Hanley to the Washington State House Appropriations Committee Work Session on Evidence-Based Medicine, January 19, 2006. Reproduced with permission of authors.



## Strategy: Consolidated Multi-Agency Purchasing

- 1) Expanding the state employee pool to include other public agencies, or even private sector.
- 2) Pooling small employers into cooperatives or alliances
  - o "The idea has intuitive appeal, and it has been supported by thoughtful health analysts and politicians with widely different philosophical perspective." - CA analysis, 2006

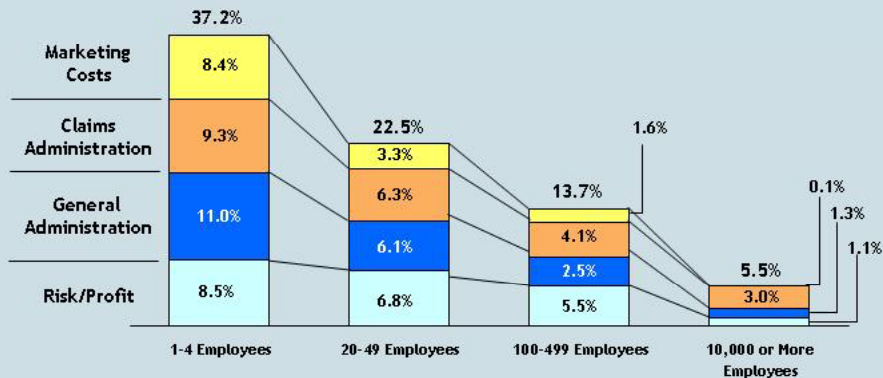
### Target:

- o Gain bargaining strength; minimize administrative costs.
- o Get better prices on premiums and health services through size

**Challenge:** For small employers "experiments with the concept have proved less successful than expected." - CA analysis, 2006



## Insurance is More Costly to Administer for Small Groups



Source: Lewin presentation on "Cost and Coverage Impacts" to Colorado Commission, August 23, 2007



## Examples: State Health Plans

30+ states Combine or Pool State Employees & Retirees with political subdivisions and education



- **Cities, towns, counties**  
permitted in at least 22 states  
includes: CA, NY, NJ, MO, IL, MA
- **K-12 schools**  
permitted in at least 15 states  
includes 11 southern states; NJ, NY, MA, WA
- **Higher Education**  
Required or permitted in about 30 states
- **Some participation rates are small % of program.**

24 States	Many Local Government Employees Covered by State Employee Plan
Arkansas	School employees. (since 2003)
California	Municipal, some school employees. (since 1967)
Delaware	Municipal employees.
Florida	School employees.
Georgia	Municipal and school employees
Hawaii	Municipal and school employees.
Illinois	Municipal employees.
Kentucky	School employees.
Louisiana	School employees. (since 1980)
Maryland	Municipal employees.
Massachusetts	Municipal employees. (since summer 2007)
Mississippi	School employees.
Missouri	Municipal and school employees.
Nevada	Municipal and school employees.
New Jersey	Municipal and school employees. (since 1964)
New Mexico	Municipal employees.
New York	Municipal and school employees. (since 1958)
North Carolina	School employees.
South Carolina	Municipal and school employees.
Tennessee	Municipal and school employees.
Utah	Municipal and school employees. (since 1977)
Washington	Municipal and school employees.
West Virginia	Municipal and school employees. (since 1988)
Wisconsin	Municipal employees.

Major state pool programs, as compiled by CT Legislature



## Multi-Agency: Evidence of Effectiveness

- o There is evidence of modest cost savings by combining a large number of in-state agencies and entities into a single administrative and insurance purchasing pool (covered lives of 100,000 - 1 million+).
- o The combined pool usually (in 84% of states) will be "self-insured," which saves about 5%-6% compared to fully-insured through outside insurers.
- o Better negotiating position = better benefits, modest savings.
  - One MI university saved \$400,000 by joining the MI Univ. Coalition on Health.
  - U-MI prescription drug program generated over \$55 million in savings by using the Medicaid pooling structure (about \$9 million per year)
  - MA: 2007 law added municipalities, calculated to save \$225 mil. by FY 2010, actually only 17 towns out of 351 have signed up. (Aug. 2009)

### Challenges:

- o Most pools are optional for all except the state employee agencies; Mandatory participation is much less widespread 2 – 3 states.
- o Traditions of local autonomy & collective bargaining can mean slower change or opposition
- o Smaller towns & units benefit most. Centralized state govt. less or none?



## Observations on How Far, How Fast?

- o **Comprehensive, multi-pronged, cost containment strategies likely hold the most promise. Examples:**
  - Maine
  - Massachusetts
  - Minnesota
  - Vermont
- o **Incremental changes can work if large enough**
  - Delaware: DelaWELL – Public employee wellness + prevention
  - Grand Junction, CO - "highest quality, lowest cost care"
  - Multi-state drug buying pool – track record of savings



## Cost Containment Project Supporters

- A cross-cutting project - partly responding to NCSL Executive Committee priorities from 2008
- Funded by two Colorado foundations, but national scope of research/reporting



The Colorado Health Foundation™



- Advisory group of Health Committee officers and Colorado members selected by leadership



## NCSL Health Costs Resources

- Numerous reports available – single state, national, single topic.
- Online material for some instant answers
- Health staff available for consultation.



- Dick Cauchi  
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- Barbara Yondorf