TAMING HEALTH COSTS: NEW SOLUTIONS, NEW CHALLENGES

A Report from Utah
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NCSL 2013 Legislative Summit, August 14, 2013

[Slide 1: Title] Health reform is a challenge, isn't it? Today, I'll highlight three initiatives from Utah, each of which is still in the early implementation or development phases, but is far enough along to show promise of making a meaningful impact on *value* by constraining costs *and* improving quality.

I. APCD

First, Utah has been one of the pioneers in the development of a statewide all-payers health insurance claims database, or APCD. From the beginning, our goal with the APCD has been to empower consumers by putting into their hands actionable data that will allow them to shop for health care based on real value. We see a day when consumers will be able to identify meaningful differences in treatment costs and quality and act on that information. This will ensure that consumers get better, more affordable care and that higher-cost, lower-quality providers get the message that they need to either lower their charges or improve their services in order to remain competitive in an increasingly consumer-driven marketplace.

Although we've used our APCD to analyze claims data and publish some initial results, we are still in the construction phase, as are most of the 14 other pioneering states. At this moment, we are acquiring a new technology vendor and beginning an in-depth audit of our data quality.

We are also assessing what it would take to make the APCD the foundation of a state-based risk adjustment program under the Affordable Care Act. If we can run risk adjustment the way *we* want to run it, carriers will get information sooner and uncertainty will decrease. As a result, rates should be lower than they otherwise would be. This is also cost containment, though not in a way we normally think of. Once we deal with risk adjustment, we plan to focus on analyzing high-cost, high-volume procedures for things like pregnancy and orthopedic conditions. Again, we want to promote cost consciousness by getting actionable information into the hands of both consumers and providers.

II. PUBLIC EMPLOYEES COST AND QUALITY TOOLS

What we hope to one day provide to *all* consumers with our all-payer claims database, we are already providing in some measure to our public employees. In April, our Public Employees Health Insurance Program, PEHP, made available to all of its enrollees cost and quality tools that will allow some of the very comparisons I've been discussing. **[Slide 2: Outpatient vs. In-office]** In this slide, you can see how some of these online tools work. In this example, an individual is able to compare the price for cataract repair in either an in-office or outpatient facility setting and by either an in-network or out-of-network provider. As shown by the numbers in large, green type, the difference in out-of-pocket cost to the enrollee is substantial—about $2,200 vs. $400. Importantly, these cost differences are not theoretical or based on the experiences of other states or other insurance companies. Instead, they are derived from actual PEHP claims paid over the most recent 36 months.

[Slide 3: Doctors Compared] This next slide also illustrates how enrollees can compare out-of-pocket and other costs across specific providers.

We have other tools as well, which I won't discuss at this point, but which are part of our same overall strategy of empowering both consumers and providers by giving them data to identify and act on value.

At this point, it is still too early to quantify the impact of PEHP's new tools. But I can tell you we are learning some important lessons. First, that for procedures performed in hospitals and similar facilities, there is a wide variation in cost. Second, compared with hospitals and similar facilities, free-standing surgical centers are able to perform the same procedures at a much lower cost. Third, the doctor's office is an even more economical delivery setting. And fourth, treating a condition in the emergency room costs 11 times as much as it does to provide the same treatment in an urgent care setting—$1,400 vs. $128.

We realize, of course, that data alone aren't sufficient to motivate consumers to choose care providing the highest value at the lowest cost. For that reason, we have been restructuring plan designs over several years so that enrollees recognize both the negative and the positive consequences of their choices on their own out-of-pocket expenses. This restructuring has included the offering of high-deductible plans and changes to deductibles, copays, and coinsurance. I expect cost sharing will be refined even further, depending on how enrollees respond to the cost and quality tools discussed. Further refinement may also be needed to ensure that enrollees recognize the consequences of their choices, even after their normal out-of-pocket maximum has been reached.

III. cHIE

In addition to creating comparative data that hasn't been available in the past, we are also working to improve the flow of data that already exists. For several years now we have been building a health information exchange—a statewide system to facilitate the electronic exchange of *clinical* health information.

How does this relate to cost containment? We hope that someday when a provider sits down with a patient—even a patient from a different health care system—the provider will have the ability to electronically access the patient's full medical record, or at least that portion for which the patient has given consent. The advantages of this are pretty obvious—improved information about a patient leads to better diagnosis and treatment, which in turn leads to lower costs. This kind of information also has the potential to reduce duplicative testing and ensure that vital information is available to a provider in less usual situations, like when a patient shows up in the ER, receives care far from home, or is unconscious.

As health care moves toward value-based payment systems, clinical health information exchanges like the one we're creating will become increasingly important to providers as a tool for improving care and assisting patients.

In Utah, only a small percentage of our state's citizens have given consent for their medical records to be shared through the exchange, but when we ask them, 97% agree to participate. Because asking three million people one at a time is a big job, we may revisit the question of whether Utah, like many other states, should become an"opt-out" state, where you're *in* the information exchange unless you elect to opt out. If we do become an opt-out state, I expect use of our exchange will increase dramatically and its benefits will become more apparent.

IV. Summary

[Slide 4: List of Three Initiatives] To wrap up, I believe each of the initiatives I've discussed today—the all-payers claims database, cost and quality comparison tools for public employees, and the electronic exchange of clinical health information—have put Utah on the road to constraining costs and improving quality—in short, to improving value.