

Health Cost Containment and Efficiencies

NCSL Briefs for State Legislators

May 2011

A series examining options for containing or reducing health costs and improving efficiency in health – expanded for 2011

The cost of health and health care in the United States for years has been a highly visible topic of discussion for consumers, employers, state and federal policymakers, and the media.

Innovations and Experiments

Policymakers, especially at the state level, have spent a good deal of time and energy considering—and sometimes passing—laws and budgets aimed at controlling or even cutting selected health expenditures. In recent years, a variety of health policy innovations and experiments have been put into place to improve quality, control cost and expand coverage. Many new approaches, already established in parts of the private, commercial market and in state and public sector programs, promise savings or improved affordability.

Some health cost controls have medical consequences; some are obvious and some are unintended. During budget crises, for example, health programs may reduce coverage, shift costs to enrollees or phase out programs for special populations.

Successes and Potential

This series of briefs takes a fresh approach by describing a number of health cost containment and cost efficiency ideas. Emphasis is on documented and fiscally calculated results, along with results that affect budgets, coverage, quality, prevention and wellness. Each brief describes 1) *cost containment strategy and logic*; 2) *the target*; 3) *relation to the federal health reform law*; 4) *state and non-state examples*; 5) *evidence of effectiveness*; 6) *challenges and complementary approaches* and 7) *best sources for more information*. Where the results do not meet the intended goals, these reports present an objective appraisal, saying, for example, “Limited evidence is available ...” or “It is still too early to determine...”

The Topics for Series I: Payment and Purchasing Reforms

1. *Administrative Simplification in the Health System*
2. *Global Payments to Health Providers*

3. *Episode-of-Care Payments*
4. *Collecting Health Data: All-Payer Claims Databases*
5. *Accountable Care Organizations*
6. *Performance-Based Health Care Provider Payments*
7. *Equalizing Health Provider Rates: All-Payer Rate Setting*
8. *Use of Generic Prescription Drugs and Brand-Name Discounts*
9. *Prescription Drug Agreements and Volume Purchasing*
10. *Pooling Public Employee Health Care*

The Topics for Series II: Delivery System and Health Promotion Reforms

11. *Combating Fraud and Abuse*
12. *Medical Homes*
13. *Employer-Sponsored Health Promotion Programs*
14. *Public Health and Cost Savings*
15. *Health Care Provider Patient Safety*
16. *Medical Malpractice (Forthcoming)*

Federal Health Reform

Several cost containment approaches are included in the federal Patient Protection and Affordable Care Act, signed into law in March 2010. Some federal provisions build upon programs already used by some states. Other sections of the law provide new options, challenges and grant opportunities for states that choose to create a new policy or program in future years. These examples are described in each brief where applicable.

Future Updates and Forthcoming Briefs

The latest information and published material for this project is available at www.ncsl.org/?tabid=19200. NCSL will continue intermittent publications of briefs in this series; new editions and recent developments will be posted online.

NCSL takes no position for or against any state law or proposed legislation. Materials and descriptions included in these briefs do not constitute the opinion of NCSL, its members or staff.



Health Cost Containment and Efficiency Strategies

Strategy	Cost Containment Strategy and Logic	Target of Cost Containment	Evidence of Effect on Costs
1. Administrative Simplification in the Health System	Streamlining administrative functions in the current health system (e.g., standardized forms and processes, streamlined claims processing, reduced and/or coordinated government regulations, etc.).	<ul style="list-style-type: none"> • High health care system administrative costs. • Administrative inefficiencies associated with complex, uncoordinated, often duplicate regulatory and administrative requirements. 	Studies are limited and indicate that efforts to reduce administrative expenses have resulted in some efficiencies.
2. Global Payments to Health Providers	A fixed prepayment made to a group of providers or health care system (as opposed to a health care plan) for all care for all conditions for a population of patients.	<ul style="list-style-type: none"> • Lack of financial incentives for providers to hold down total care costs for a population of patients. • Inefficient, uncoordinated care. • Not enough attention to management of chronic conditions. • Prevention and early diagnosis and treatment. 	Research indicates global payments can result in lower costs without affecting quality or access where providers are organized and have the data and systems to manage such payments.
3. Episode-of-Care Payments	A single payment for all care to treat a patient with a specific illness, condition or medial event, as opposed to fee-for-service.	<ul style="list-style-type: none"> • Lack of financial incentives for providers to manage the total cost of care for an episode of illness. • Inefficient, uncoordinated care. 	Research is limited and shows cost savings for some conditions. Payment mechanism is at an early stage of development.
4. Collecting Health Data: All-Payer Claims Databases	A statewide repository of health insurance claims information from all health care payers, including health insurers, government programs and self-insured employer plans.	<ul style="list-style-type: none"> • Inability to identify and reward high-quality/low-cost providers. • Lack of data to enable consumers to compare provider prices and care quality. 	It is too early to determine whether all-payer claims databases can help states control costs.
5. Accountable Care Organizations (ACOs)	A local entity comprised of a wide range of collaborating providers that is accountable to health care payers for the overall cost and quality of care for a defined population.	<ul style="list-style-type: none"> • Lack of a locus of accountability for overall health care costs and quality for a population of patients. • Fragmented care. 	Because it is a relatively new concept that has not been fully tested, there is insufficient evidence to assess the effect on costs. Existing evidence is mixed.
6. Performance-Based Health Care Provider Payments (P4P)	Payments to providers for meeting pre-established health status, efficiency and/or quality benchmarks for a group of patients.	<ul style="list-style-type: none"> • Providers not financially rewarded for providing efficient, effective preventive and chronic care. • Unnecessary care. 	Research is limited and indicates some improvements in quality of care but little effect on costs.

Strategy	Cost Containment Strategy and Logic	Target of Cost Containment	Evidence of Effect on Costs
7. Equalizing Health Provider Rates: All-Payer Rate Setting	Payment rates that are the same for all patients receiving the same service or treatment from the same provider. Rates can be set by a state authority or by providers themselves.	<ul style="list-style-type: none"> • High health care prices. • Lack of price competition. • Significant provider costs to negotiate, track and process claims under many reimbursement schedules. 	Evidence is mixed but indicates that, properly structured, state all-payer rate setting can slow price increases but not necessarily overall cost growth.
8. Use of Generic Prescription Drugs and Brand-Name Discounts	Buying more generic prescription drugs instead of their brand-name equivalents and purchasing brand-name drugs with discounts can significantly reduce overall prescription drug expenditures.	<ul style="list-style-type: none"> • State government-funded pharmaceutical purchasing, including Medicaid, state-only programs and some private-market pharmaceutical purchasing. 	Expanded use of generic drugs is documented to save states 30 percent to 80 percent on certain widely used medications, reducing expenditures by millions of dollars annually.
9. Prescription Drug Agreements and Volume Purchasing	States use combinations of approaches to control the costs of prescription drugs including: <ul style="list-style-type: none"> • Preferred drug lists, • Extra manufacturer price rebates, • Multistate purchasing and negotiations, and • Scientific studies on comparative effectiveness. 	<ul style="list-style-type: none"> • Helps state government public sector programs operate more efficiently and cost effectively. • Holds down overall state pharmaceutical spending, but does not deny coverage or services to individual patients. 	State Medicaid programs are using preferred drug lists, supplemental rebates and multi-state purchasing arrangements to save between 8 percent and 12 percent on overall Medicaid drug purchases.
10. Pooling Public Employee Health Care	Programs that pool or combine health insurance purchasers across or beyond traditional jurisdictions or associations, including public employee health coverage pools and private sector health purchasing alliances.	<ul style="list-style-type: none"> • High administrative costs as a proportion of small and mid-sized employer premiums. • Limited ability of small and mid-sized groups to negotiate lower health care prices or premiums or benefit. 	Evidence indicates arrangements may benefit small groups that join large state pools but have not slowed overall insurance premium increases.
11. Combating Fraud and Abuse	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 current collections.	Medicaid expenditures for fraudulent claims cost states billions of dollars each year.	It appears the more anti-fraud tools a state has at its disposal, the greater likelihood of fewer unwarranted payments and larger recoveries.
12. Medical Homes	Some studies show significant medical home savings. Others have found minimal or no overall savings but report other benefits, such as improved quality of care, fewer medical errors and enhanced health care access.	Medical homes are designed to address several shortcomings in the current health care system, especially uncoordinated care. Poor care coordination is associated with duplicate procedures, conflicting treatment recommendations, unnecessary hospitalizations and nursing home placements, and adverse drug reactions.	Most studies that support medical homes' potential to reduce overall spending have not assessed a complete version of the approach.

Strategy	Cost Containment Strategy and Logic	Target of Cost Containment	Evidence of Effect on Costs
13. Employer-Sponsored Health Promotion Programs	Evidence indicates that well-designed worksite wellness programs can reduce health expenditures and reduce absenteeism, at least for large employers, including state government.	The main targets of worksite wellness programs are chronic diseases, such as diabetes, chronic obstructive pulmonary disease and heart disease.	Research for this brief did not uncover any studies of the effectiveness of state laws to encourage more employers to offer, or more employees to participate in, worksite wellness programs.
14. Public Health and Cost Savings	Evidence indicates public health programs improve health, extend longevity and can reduce health care expenditures.	Public health programs protect and improve the health of communities by preventing disease and injury, reducing health hazards, preparing for disasters, and promoting healthy lifestyles.	Extensive research documents the health benefits of more Americans exercising, losing weight, not using tobacco, driving safely and engaging in other healthy habits. Less clear is the effect on total health care costs.
15. Health Care Provider Patient Safety	Medical errors are the eighth leading cause of death in the United States, higher than motor vehicle accidents, breast cancer or AIDS. Each year, between 500,000 and 1.5 million Americans admitted to hospitals are harmed by preventable medical errors.	The estimated annual cost of additional medical and short-term disability expenses associated with medical errors is \$19.5 billion. Longer hospital stays and the cost of treating medical error-related injuries and complications are the two major expenditures associated with medical errors.	Examples of patient safety initiatives that improve patient care and reduce costs exist, but evidence of overall savings is limited. Recent strategies include E-prescribing, non-payment for "never events," regulating medical work conditions and error reporting.

About this project

NCSL's Health Cost Containment and Efficiency Series describes various alternative state policy approaches, with an emphasis on documented and fiscally calculated results. The project is housed at the NCSL Health Program in Denver, Colorado. It is led by Richard Cauchi (program director) and Martha King (group director); Barbara Yondorf is lead researcher. Katie Mason and Leann Stelzer provide editorial review and publication management.

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