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The Forum for America's Ideas

Health Cost Containment and Efficiencies

NCSL Briefs for State Legislators

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June 2010

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

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 obvious and some 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 hopes, these reports present an objective appraisal, saying, for example, "Limited evidence is available ... " or "It is still too early to determine..."

NCSL will produce additional briefs on health cost containment in the coming year.

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

Federal Health Reform

Several cost containment approaches are included in the federal Patient Protection and Affordable Care Act, signed into law in March 2010.[1] 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

The latest information on this project is available at www.ncsl.org/?tabid=19920.

1. The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) was signed into law on March 23, 2010. On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010. It is widely termed The Affordable Care Act.

Health Cost Containment and Efficiency Strategies

Strategy and State/ Private Sector Examples	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.).	• 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.	• 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.	• 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.	• 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.	• 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.

The Cost of Doing Nothing

"The unrelenting rise in medical costs is likely to wreck havoc within the system and beyond it, and pretty much everyone will be affected, directly or indirectly."

—Reed Abelson
New York Times, Feb. 28, 2010

Strategy and State/ Private Sector Examples	Cost Containment Strategy and Logic	Target of Cost Containment	Evidence of Effect on Costs
6. Performance-Based Health Care Provider Payments	Payments to providers for meeting preestablished health status, efficiency and/or quality benchmarks for a group of patients.	• 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.
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.	• High health care prices. • Lack of price competition. • Significant provider costs to negotiate, track and process claims under multiple 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.	• 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: • Preferred drug lists, • Extra manufacturer price rebates, • Multistate purchasing and negotiations, and scientific studies on comparative effectiveness.	• 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.	• 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.

Growth in Health Care Costs

"If health care spending grows as projected under current law, future budget deficits will rise to levels that will seriously jeopardize long-term economic growth."

—Peter R. Orszag, Director
Congressional Budget Office, Jan. 21, 2008

About the Authors

Barbara Yondorf is the lead author and researcher for most briefs (1-7) in this series. She is president of Yondorf & Associates, a Denver-based health policy consulting firm. Yondorf & Associates researches policy issues, conducts feasibility studies, analyzes fiscal data, provides strategic planning services, facilitates meetings, and drafts legislation and grant proposals. The firm's clients include community nonprofits, health foundations, government agencies, associations and national health policy organizations. Before starting her own company, Barbara oversaw the health grant making program at Rose Community Foundation in Denver, Colorado. She has served in senior management positions at the Colorado Division of Insurance, National Conference of State Legislatures, and Colorado Department of Health. Barbara has also worked for the Colorado legislature's Joint Budget Committee. She has written extensively about health care policy.

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About this Project

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Administrative Simplification in the Health System

Cost Containment Strategy and Logic

Administrative simplification refers to efforts to streamline administrative functions in the current health system.[1] Administrative simplification includes programs that:

- Promote or require use of standardized, common electronic or paper forms (e.g., for billing and coding);
- Improve the efficiency of provider-insurer transactions in claims processing and payment;
- Institute a single process for verifying provider (for example doctors, specialists, nurses) experience and education that is recognized by all parties, as opposed to having separate processes for each health plan, hospital and practice that requires providers to verify their credentials before hiring or paying them;
- Give providers and patients instant access to a patient's insurance coverage information (e.g., services covered, required copayments and caps on benefits) using a magnetic swipe card;
- Standardize medical management policies (e.g., preauthorization procedures); and
- Streamline government regulations and compliance requirements.

By streamlining and standardizing routine business processes, administrative simplification can help to reduce unnecessary and duplicative transaction costs and thus reduce overall health care expenditures.

Target of Cost Containment

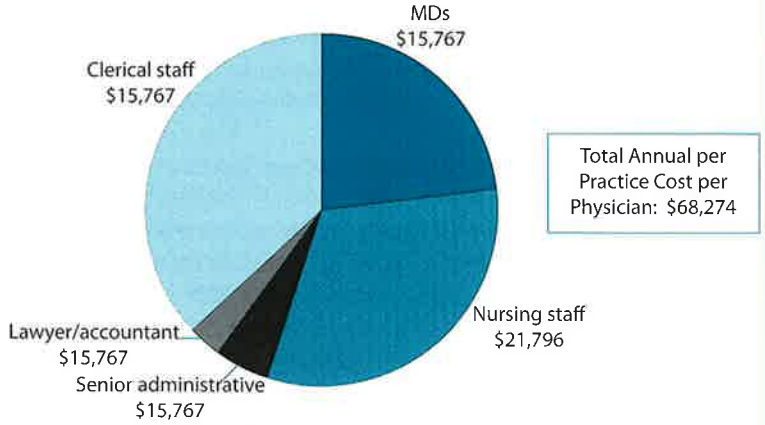
Evidence indicates that efforts to reduce administrative expenses have resulted in some efficiencies.

The primary goal of administrative simplification efforts is to lower costs by reducing duplication and unnecessary complexity in health care system operations. A 2009 report on improving health care purchasing in Minnesota observed, "Because routine administrative transactions such as checking patient eligibility for benefits, submitting bills for services, or making payments to providers occur every minute, every day, millions of times each year, even small inefficiencies add up to be significant costs and drags on health system productivity."[2]

Administrative simplification initiatives are aimed mainly at how health providers and insurers conduct business, especially with one another.

An example of administrative inefficiency concerns the way health care billings are processed. Studies suggest that paper billing—the traditional and still most widely used method—costs nearly twice as much ($1.58 per claim) as electronic billing ($.85 per claim).[3] Provider credential verification also typically is inefficient. One group has estimated that the average health plan spends approximately $500,000 annually on credentialing activities, and the average provider spends up to 6.5 hours annually.[4] Processing bills is another source of unnecessarily high administrative expenses. According to the American Medical Association, physician practices spend as much as 14 percent of their total collections to ensure accurate payment for services. This amounts to more than $68,000 per physician practice (Figure 1). Researchers estimate that provider and health plan administrative costs together account for 25 percent or more of the cost of private health insurance coverage.[5]

Figure 1. Total Annual Cost to U.S. Physician Practices for Interacting with Health Plans Is Estimated at $31 Billion*



*Based on an estimated 453,696 office-based physicians.
Source: L.P. Casalino et al., "What Does it Cost Physician Practices to Interact with Health Insurance Plans?" Health Affairs Web Exclusive, May 14, 2009, w533-w543.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, contains several administrative streamlining provisions. Examples include adopting a single set of operating rules for eligibility verification and claims status (effective Jan. 1, 2013); electronic funds transfer and health care payment and remit-

tances (effective Jan. 1, 2014); and health claims processing, enrollment and disenrollment, premium payments, and referral certification and authorization (effective Jan. 1, 2016).

State Examples

■ Several states have conducted studies to estimate the potential savings from various administrative simplification initiatives. For example, the Oregon Health Fund Board estimated that, over 10 years, developing and requiring all plans to use uniform forms and processes for administrative transactions could save $350 million in health-plan-related transaction costs. Limiting the allowable increase in the administrative portion of insurance premiums to a measure of general inflation could save as much as $1.4 billion over 10 years in health insurance premium costs. Minnesota's Center for Health Care Purchasing Improvement calculated that requiring providers and insurers to conduct all administrative transactions electronically using standard data and content could reduce overall costs in Minnesota's health care system (both public and private) by more than $60 million per year by 2013.

■ At least 15 states require or encourage use of a standard provider application for credentialing—a nationally recognized application and/or a state-specific one. West Virginia is among the most recent states to enact legislation that sets up a process designed to lead to a standard credentialing system.[6] In most cases, states have designated the standard provider application developed by the Council for Affordable Quality Healthcare (CAQH) as their required or acceptable provider credentialing form. Louisiana, New Jersey and Tennessee, for example, require or allow health plans to use either the standard CAQH application or a state-specific alternative. Vermont requires use of the CAQH application form.

■ An increasing number of states are encouraging or requiring health plans to provide enrollees with health insurance swipe cards. Swipe cards, which would replace paper ID cards, have magnetic strips that give patients and providers immediate access to information about a patient's health insurance benefits (e.g., deductibles and copayments). Most states are considering the uniform standards recommended by the Workgroup for Electronic Data Interchange (WEDI), a broad-based, national health care industry association. Utah enacted legislation in 2009 (HB 165) that moves the state toward a standardized swipe card and changes how hospitals and health care providers send information and billing to patients. Colorado's 2008 law (SB 08-135) requires health insurers to issue standardized, printed identification cards and authorizes the commissioner of insurance to adopt rules requiring insurers to use standard swipe cards or other appropriate technology in the future.

■ States are considering a standardized claims processing system for all payers. The Oregon Health Policy Commission recommended in its 2007 road map for health care reform that the state continue its efforts to create a statewide simplified and standardized claims processing system, using its influence as a purchaser and as a key regulator. Several states already require standard claims submissions. Maine, for example, requires providers to submit their claims to insurers in a standardized electronic format.

■ A 2005 Maine law was designed not only to reduce administrative costs, but also to ensure that savings are passed to health care purchasers.[7] The law establishes an administrative streamlining work group to "...facilitate the creation and implementation of a single portal through which hospitals can access and transmit member eligibility, benefit and claims information from multiple insurers." The work group is responsible for investigating ways to ensure that savings from implementation of the portal are passed to purchasers in the form of rate reductions by hospitals and other providers and by reductions in administrative costs by insurers and third-party administrators.

■ Several states have either passed a series of bills to streamline various administrative processes or have enacted comprehensive administrative simplification bills.

—A 2007 Minnesota law required all health care providers and payers to use a single electronic standard for the transmission, content and format of payment records, claims and eligibility verifications, beginning in 2009.[8] In 2009, the Legislature passed technology standards legislation (HF 384B) that prescribes a process for adopting rules to implement a standardized electronic swipe card all health plans must use.

—A 2008 Massachusetts law requires health insurers and providers to adopt statewide, uniform, consistent and standardized billing and coding processes by 2012.[9] The state is also considering ways to reduce duplicative or conflicting state regulatory requirements. State agencies that regulate health providers and plans are collaborating to consider the cost containment potential and feasibility of creating a uniform system and format for similar reports required by multiple state agencies. Examples of such filings include reports of injuries, adverse medical events, frequency of filing claims information and membership data. The Division of Insurance and the attorney general's office are responsible for holding hearings for insurance companies that submit rate increases above 7 percent, paying particular attention to the companies' administrative costs and executive compensation. The state also is considering moving health plan licensure from every year to every two years.

—Washington enacted comprehensive administrative streamlining legislation in 2009.[10] The Health Care Efficiency Act requires development and implementation of a uniform provider credentialing process; a uniform standard document and data set for electronic eligibility and coverage verification; code standardization; and common and consistent time frames for reviewing requests for medical management protocols (e.g., prior authorization and preadmission requirements).

■ Several states have established or are considering creating advisory groups or offices responsible for identifying ways to reduce administrative expenses. Maine established an Administrative Streamlining Workgroup authorized by a 2005 law.[11] In a 2008 report, the Oregon Health Fund Board recommended that the Division of Insurance convene a work group to develop uniform forms and processes for administrative transactions.[12]

Non-State Examples

■ A national group, the Committee on Operating Rules for Information Exchange, is working to build consensus among health care industry stakeholders on a set of operating rules for administrative interoperability between health plans and providers to streamline provider-plan transactions. It currently is working to develop rules for immediate electronic verification of patients' health plan coverage; determination of claims status; processing prior authorizations; and standard medical identification cards. Among the government agencies participating in CORE are Louisiana Medicaid and the Minnesota Department of Human Resources.

■ Humana Health launched a swipe card pilot program in two Florida cities in 2007. Since then, the project has spread statewide and to seven other states. United Healthcare also has adopted swipe card technology; more than 20 million of its members have electronic ID cards.

Several states have either passed a series of bills to streamline various administrative processes or have enacted comprehensive administrative simplification bills.

Evidence of Effectiveness

Limited evidence indicates that efforts to reduce administrative expenses have resulted in some efficiencies. Unfortunately, most of the literature on administrative streamlining focuses more on estimates of current administrative expenditures rather than on demonstrated savings from administrative simplification. Existing evidence comes mainly from the private sector; no studies of the results of state administrative simplification efforts were found. The results of three private sector initiatives are discussed below

■ IBM assessed the results achieved by health plans that adopted some initial CORE rules for administrative interoperability described previously. It found that electronic verification of patients' benefit coverage (e.g., deductible and copayments) took about seven minutes less than telephone verification, saving about $2.10 per verification.[13]

■ Blue Cross and Blue Shield of South Carolina's Web-based tool, My Insurance Manager Web Precert, allows providers to receive immediate resolution of some pre-certification requests, verifying member eligibility for procedures, medications and other services. In 2007, it reported that the system created efficiencies credited with savings of $1.4 million.[14]

■ UnitedHealthcare is testing immediate claims adjudication, which allows a claim to be submitted to an insurer and settled before a patient leaves the office. The company reported that a 10-physician Texas practice participating in the pilot program saved $14,000 in billing costs in a year. Another practice reduced accounts receivable by 13 percent and decreased the average time to collect insurer and patient payments from 45 days to six. For some practices, however, implementing real-time claims adjudication is complicated and can require a change in physician office billing and collections procedures.[15]

Although administrative streamlining appears to have resulted in some savings, for the most part it has not yet reduced costs for purchasers. A comprehensive research report concluded, "Evidence is lacking on whether improvements in the efficiency of insurance companies will be translated into reductions in premiums for their customers."[16] The report continued: "Similarly, it is uncertain whether improvements in hospital efficiency will be translated into reductions in charges for services." It found no evidence to prove that any specific interventions would reduce overall costs.

Challenges

■ Significant cost savings from administrative reforms have not been realized or appeared in the form of lower costs for purchasers for several possible reasons.

■ Many efforts to streamline administrative functions are relatively new and have not been widely enough adopted to realize overall savings.

■ Programs designed to reduce overhead often have significant front-end costs (e.g., new computer systems and training personnel). As a result, a net benefit may not be realized for several years.

■ It can be difficult for payers to capture the savings associated with efficiencies realized at the provider or plan level. Plans and providers may retain the savings rather than pass them along to payers.

■ Some targets of administrative simplification account for a relatively small part of health care costs. For example, a Washington report on administrative simplification found that, while "provider credentialing is a source of administrative variation and waste that generates provider frustration, it does not appear to be a major source of cost to providers, plans or hospitals."[17]

■ Some health policy analysts have argued that a greater overhaul of the system beyond simply streamlining current administrative functions is needed to realize savings. This might include substantially reforming the health care payment system, limiting the number of allowable benefit designs and prohibiting exclusion of preexisting conditions, or establishing a single payer system.

For More Information

Eibner, Christine, et al. *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, Option #13, "Reduce Administrative Overhead." Santa Monica: RAND Health, August 2009; http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_care_spending_rand_08-07-09.pdf.

Washington State Office of the Insurance Commissioner. *Report to the Governor and Legislature: Top Five Health Care Administrative Simplification Priorities and a Plan to Achieve Those Goals.* Olympia: WSOIC, Dec. 1, 2008; http://www.insurance.wa.gov/legislative/reports/SimplificationRpt.pdf.

NCSL has posted supplemental materials and 2010 updates on this topic online at http://www.ncsl.org/?tabid=19926.

Notes

1. Single payer systems, which involve a substantial restructuring of the health care payment and administrative systems, are the subject of another brief in this series.

2. "Center for Health Care Purchasing Improvement, *Annual Report: January 2008 – December 2008*, Minnesota (St. Paul, Minn.: CHCPI, May 2009); http://www.health.state.mn.us/divs/hpsc/chcpi/legrpt2009.pdf.

3. AHIP Center for Policy and Research, *An Updated Survey of Health Care Claims Receipt and Processing Times, May, 2006 (*Washington D.C.: AHIP Center for Policy and Research, May 2006; http://www.ahipresearch.org/pdfs/PromptPayFinalDraft.pdf.

4. Washington State Office of the Insurance Commissioner, *Report to the Governor and Legislature: Top Five Health Care Administrative Simplification Priorities and a Plan to Achieve Those Goals*, (Olympia: WSOIC, Dec. 1, 2008); http://www.insurance.wa.gov/legislative/reports/SimplificationRpt.pdf.

5. Healthcare Administrative Simplification Coalition, *Bringing Better Value: Recommendations to Address the Costs and Causes of Administrative Complexity in the Nation's Healthcare System* (Washington, D.C.: HASC, July 2009); http://www.ahima.org/dc/documents/HASCReport20090717.pdf.

6. 2009 W.Va. Acts, Chap. #110.

7. Maine 2005 Me. Laws, Chap. 394 (Laws of Maine); http://www.legislature.maine.gov/legis/bills_122nd/LD.asp?LD=1673.

8. Minn. 2007 Minn. Laws, Chap. 147.

9. 2008 Mass. Acts, Chap. 305.

10. 2009 Wash. Laws, Chap. 298.

11. 2005 Me. Laws, Chap. 394 (Laws of Maine).

12. Oregon Health Fund Board, *Aim High: Building a Healthy Oregon*, Final Report (Salem, Ore.: OHFB, November 2008); http://www.oregon.gov/OHPPR/HFB/docs/Final_Report_12_2008.pdf.

13. Council for Affordable Quality Healthcare, "Industry Collaboration: Simplifying Administrative Complexity," PowerPoint presentation, Institute of Medicine Public Meeting 10: The Healthcare Imperative: Lowering Costs and Improving Outcomes, Strategies that Work, Washington D.C., July 17, 2009; http://healthitextensionservice.igloocommunities.com/documents/instituteofmedicinehealthreform/industrycollaborationsimplifyingadministrativecomp.

14. Blue Cross and Blue Shield of South Carolina website; http://www.blueadvocacy.org/plans/view/blue_cross_and_blue_shield_of_south_carolina.

15. Victoria Stagg Elliott, "Practices See Slow Progress in Instant Claims Adjudication," *amednews*, Aug. 17, 2009; http://www.ama-assn.org/amednews/2009/08/17/bil20817.htm.

16. Christine Eibner et al., *Controlling Health Care Spending in Massachusetts: An Analysis of Options* (Santa Monica: RAND Health, August 2009),160; http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_care_spending_rand_08-07-09.pdf.

17. Washington State Office of the Insurance Commissioner, *Report to the Governor and Legislature: Top Five Health Care Administrative Simplification Priorities and a Plan to Achieve Those Goals.*

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Global Payments to Health Providers

Cost Containment Strategy and Logic

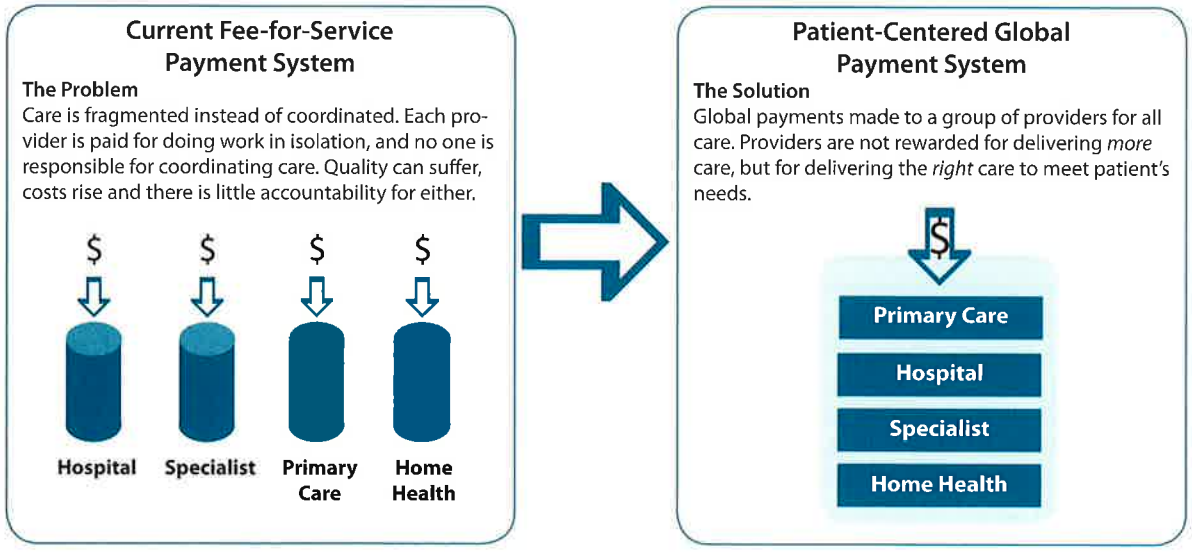
A global payment—a fixed prepayment made to a group of providers or a health care system (as opposed to a health care plan)—covers most or all of a patient's care during a specified time period. Global payments are usually paid monthly per patient over a year, unlike fee-for service, which pays separately for each service (Figure 1). In most cases, a global payment encompasses physician and hospital services, diagnostic tests, prescription drugs and often other services, such as hospice and home health care. Under a global fee arrangement, a large multispecialty physician practice or hospital-physician system receives a global payment from a payer (e.g., health plan, Medicare or Medicaid) for a group of enrollees. It is then responsible for ensuring that enrollees receive all required health services. Global payments usually are adjusted to reflect the health status of the group on whose behalf the payments are made. Entities that receive global payments sometimes are known as accountable care organizations (discussed in a separate brief) and can include both formally and loosely organized health care systems. Global payment provides an incentive for providers to coordinate and deliver care efficiently and effectively to hold down expenses.

Where providers are organized and have the data and systems to manage global payments, research indicates such payments can lower costs without affecting quality or access.

Some similarities exist between global and episode-of-care payments (discussed in a separate brief). In both cases, payment is bundled instead of made separately for each service. The major difference is that global payments are made on behalf of a group of patients (e.g., enrollees in a health plan) and cover all care for all conditions covered by the health plan. Episode-based payments cover an episode of illness or medical condition, such as a heart attack, hip replacement or diabetes.

The term global payment includes capitation, most frequently used to pay health maintenance organizations (HMOs) on a per-member, per-month basis for all care covered by the HMO plan. Some important differences exist between the current concept of global payments and traditional capitation, however. Today's global payments include incentives for patient access and quality improvement. They also include better ways to adjust payment for the overall health and specific chronic conditions (i.e., risk level) of patients covered by global payments. Further, they use more sophisticated, often electronic, systems to manage care.

Figure 1. Fee-for-Service versus Global Payment Incentives



Source: Massachusetts Special Commission on the Health Care Payment System, "Recommendations of the Special Commission on the Health Care Payment System," PowerPoint (Boston: SPHCP, July 16, 2009).

Global payments also are known as risk-adjusted capitation and bundled global payments.

Health economists and others are increasingly promoting global payments as an important strategy to slow growth of health care expenditures. A 2008 *New England Journal of Medicine* article examining health care cost control options concluded, "The most potent version of payment reform is budget-based capitation, or a global payment to cover all health care needs of a population of patients."[1]

Target of Cost Containment

Global payments are designed to:

- promote cost-effective prevention and early intervention;
- eliminate services of questionable value;
- reduce excess health care system capacity; and
- reverse the current incentive providers have under fee-for-service to provide more services to earn a higher income.

These goals are accomplished by holding multiple providers in multiple settings jointly accountable for the total cost of care through shared payments. In the current payment system, no incentive exists for providers to hold down total costs. With global payments, providers have greater net income when they hold down costs for their shared fixed global payments. They also have an incentive to maintain or improve a patient's health, prevent hospital admissions and coordinate care; their net income will be higher if they can lower care costs for a fixed payment. Global payments encourage formation of organized provider systems that can accept global payments and provide comprehensive care.

Health economists and others are increasingly promoting global payments as an important strategy to slow growth of health care expenditures.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, requires the secretary of Health and Human Services to establish the Medical Global Payment System Demonstration Project in up to five states, effective 2010 (section 2705). Under the project, participating states must use global capitation rather than fee-for-service to pay large safety net hospital systems. The pilot program period is FY 2010 through FY 2012. The act also authorizes tests of innovative Medicare and Medicaid payment and service delivery models "to reduce program expenditures while preserving or enhancing patient quality of care, effective Jan. 1, 2011" (section 3021). The secretary can select several models for testing, including direct contracting with groups of providers using "risk-based comprehensive payments" (i.e., global payments).

State Examples

- A 2008 Massachusetts law required creation of a Special Commission on the Health Care Payment System.[2] In July 2009, the commission recommended that all payers—both public and private—move to a system of global payments for providers no later than 2014. The Massachusetts Health Care Cost and Quality Council made a similar recommendation in October. In November, the Massachusetts Medicaid Policy Institute proposed testing global Medicaid payments "with a defined set of providers that includes high-volume Medicaid providers and providers currently participating in a global fee initiative with a commercial insurer."[3]

- In 2009, Maine passed "An Act to Protect Consumers and Small Business Owners from Rising Health Care Costs."[4] The act directed the Advisory Council on Health Systems Development to recommend payment reforms. A November 2009 draft of the council's report to the Legislature recommends pursuing several strategies, given the diversity of Maine's delivery system and needs, and highlights global payments as a key payment reform strategy.[5]

- Many states have Programs for All-Inclusive Care for the Elderly (PACE). These programs are paid a capitated rate to provide total care for frail patients who are eligible for both Medicare and Medicaid. Patients must have a disability and be eligible for nursing home care. PACE provider organizations are responsible for coordinating a wide range of services, including comprehensive primary medical care, prescription drugs, adult day care, meals and nutritional counseling, home health care, and hospital and nursing home care. According to the Centers for Medicare and Medicaid Services, 30 states have one or more PACE sites.[6]

- Several states require that, if a group of providers accepts risk (i.e., global payments) to ensure that a population of patients obtains all or most of their required care over a defined period of time, the group must be licensed. This is especially true for provider-sponsored organizations that accept capitation. A 1997 study found some states require HMO licensure if the organization, rather than an insurance plan, is the ultimate bearer of risk or assumes risk beyond that which its providers are themselves licensed to provide (e.g., California, Illinois and Pennsylvania).[7] Others require a special license or certificate (e.g., a limited service license in Colorado, a nonprofit health corporation license in Texas, and a community integrated service network license in Minnesota).

Non-State Examples

- Patient Choice is a program for self-funded employers in Minnesota, North Dakota and South Dakota. Created by Buyers Health Care Action Group in 1988, it currently is operated by Medica, a large HMO. The Patient Choice Care System Program works with groups of providers (including both hospitals and physicians) called care systems. Care systems submit bids based on the expected total (global) cost of care for a defined population of patients with the same health plan benefits. Reimbursement rates are driven by performance on quality measures and total care costs—also called "virtual capitation" or "capitation in drag."[8] Care systems' incentive to hold down

costs is competition for consumers who select among competing care systems based on total price and market share. Consumers pay the difference in the bid price if they select a care system in a higher cost tier.

- Blue Cross Blue Shield of Massachusetts offers providers an Alternative Quality Contract. Under this voluntary contract, providers can accept a condition-adjusted, fixed annual payment for each Blue Cross Blue Shield patient. The payment, which covers all care delivered by the provider, also includes incentives for quality, effectiveness and patient satisfaction.

- Some programs use partial capitation or partial global payments, for instance for primary care. One example is a pilot program of the Massachusetts Coalition for Primary Care Reform, a nonprofit organization comprised of health policy experts, leading primary care practices, payers, patient advocacy groups and government. Under the program, each participating primary care medical home practice[9] receives a global fee for all primary care services for each patient. Although the fee does not include hospitalization, lab tests or other services, participating practices are eligible for performance-based incentives based in part on reduced use of those services. Cost targets for the incentives include less use of high-cost imaging procedures; pharmacy use; and ambulatory-sensitive emergency room visits, admissions and readmissions. Thus, although they receive a global payment for primary care services only, practices have an incentive to hold down total patient care costs.

Evidence of Effectiveness

Research indicates global payments can result in lower costs without affecting quality or access. Existing evidence comes from experience with traditional capitation, which is a form of global payment.

- Several studies have shown that fully integrated health care systems that provide the full range of health care services and directly employ most or all their physicians have significantly lower spending and use through capitated managed care.[10] Examples of integrated health care systems are Cleveland Clinic in Ohio and Kaiser Permanente, based in California and operating in Colorado, Georgia, Hawaii, Maryland, Ohio, Oregon, Virginia, Washington and the District of Columbia.

- A 2004 report prepared by The Lewin Group reviewed 14 studies of savings achieved from Medicaid managed care programs using capitated payments.[11] It found clear evidence of cost savings, mainly from less use of inpatient services. Savings ranged from 2 percent to 19 percent compared to fee-for-service. Michigan's capitated, managed care program savings were 9 percent in 2001, 14 percent in 2002, 16 percent in 2003 and 19 percent in 2004. Kentucky's Region 3 Partnership program savings were 2.8 percent in FY 1999, 5.4 percent in FY 2000, 9.5 percent in FY 2001, 9.5 percent in FY 2002 and 4.1 percent in FY 2003. In FY 2002, inpatient costs decreased by 27 percent under Ohio's Medicaid managed care program, Premier Care. Many state Medicaid programs in the Lewin report used a global capitation fee that covered physical but not behavioral or long-term care services. Programs often excluded special populations such as people with disabilities. Based on evidence from the states that included some or all special populations and other types of care in their capitated contracts, Lewin concluded, "Real opportunities exist for states to benefit from expanding the Medicaid managed care model to eligibility categories and services heretofore largely excluded from managed care."

- 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 cost, compared with fee-for-service arrangements."[12] A 2008 article in *The New England Journal of Medicine* reported, "Experiments with capitation in commercially insured populations demonstrate reductions in cost."[13]

- Experience with Patient Choice (described previously) indicates the program "... has encouraged patients to select more cost-effective providers and has spurred providers to reduce their costs while maintaining or improving quality to attract more consumers."[14] Reimbursement rates under Patient Choice, which are driven in part by the total cost of care (although not the only factor accounting for these findings), appear to be a significant contributor.

- Not all researchers agree that the evidence shows clear cost savings from capitation. Some find the evidence inconclusive and have noted some problems provider-sponsored organizations have problems sufficiently integrating care among physicians, hospitals and other health professionals to control costs.[15] Others have found that, although capitation may lower cost growth, it is difficult to maintain the effectiveness.[16]

Challenges

A number of challenges are involved in implementing global payments on a broader scale than traditional managed care capitation arrangements. The types of care covered by a global payment must be clearly defined. The patient population must be stable because, as one payment reform expert notes, "If you don't have them long enough, you can't effectively manage and hold down the cost of care."[17] Risk adjustment is an important factor in ensuring global payments are high enough to manage the level of risk assumed by providers. However, risk-adjustment methodologies are imperfect and must be continually refined. Most providers are not organized to accept global fees. Where a global payment is made to loosely—rather than formally—integrated networks of providers, a system must be developed to handle receipts and payments (e.g., the local independent practice association or the hospital). States may want to regulate which entities can accept global payments and the types of clinical and/or insurance risks global payments can include.

Complementary Strategies

Global payments often are used with other methods of payment and health care programs. Examples include performance-based pay, medical homes and accountable care organizations. Using global payments in conjunction with these payment and program strategies (see other briefs in this series), may offer a greater level of cost containment than could be achieved by implementing a single strategy.

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About this Project

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Health Cost Containment and Efficiencies
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Episode-of-Care Payments

Cost Containment Strategy and Logic

Episode-based payments are at an early stage of development and use, but interest in them is growing. In contrast to traditional fee-for-service reimbursement where providers are paid separately for each service, an episode-of-care payment covers all the care a patient receives in the course of treatment for a specific illness, condition or medical event. Examples of episodes of care for which a single, bundled payment can be made include all physician, inpatient and outpatient care for a knee or hip replacement, pregnancy and delivery, or heart attack. Savings can be realized in three ways: 1) by negotiating a payment so the total cost will be less than fee-for-service; 2) by agreeing with providers that any savings that arise because total expenditures under episode-of-care payment are less than they would have been under fee-for-service will be shared between the payer and providers; and/or 3) from savings that arise because no additional payments will be made for the cost of treating complications of care, as would normally be the case under fee-for-service.

Episode-of-care payments also are known as case rates, evidence-based case rates, condition-specific capitation and episode-based bundled payments.

Episode-based payment creates an incentive for physicians, hospitals and other providers to work together to improve patient care related to an episode of illness or a chronic condition; providers do better financially when patient care is cost effective. Under episode-of-care reimbursement, for example, providers will have higher net income if they avoid unnecessary tests, reduce complications related to care, and shorten patients' hospital stay using better hospital discharge planning.

Research indicates cost savings for some conditions using episode-of-care payments, which are at an early stage of development.

Target of Cost Containment

Episode-of-care payments target unnecessary or duplicative care, avoidable hospitalizations, complications of care and inefficient care (e.g., providing high-cost care where less expensive care would be as effective). According to the Center for Healthcare Quality and Payment Reform, "An episode payment system reduces the incentive to overuse unnecessary services within the episode, and gives healthcare providers the flexibility to decide what services should be delivered, rather than being constrained by fee codes and amounts."[1] Episode-based payments are intended to strengthen incentives for providers to work together to offer more cost-effective care. Under the current fee-for-service system, no provider or group of providers is accountable for managing the quality and costs of a patient's care throughout the course of treatment for a condition or illness.

Figure 1. Massachusetts Annual Costs of Care for Medicare Beneficiaries with Three Chronic Conditions (Diabetes, Heart Failure and COPD), 2006

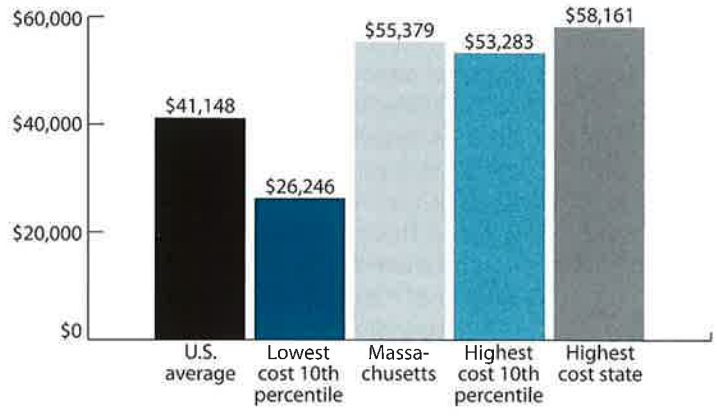

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Figure 1 uses Massachusetts data to illustrate the wide variation among the states in the annual cost to Medicare of providing care for three chronic conditions, reflecting various care practices and intensity of service. Episode-of-care payments are designed to reduce the average cost of these and other conditions and to reduce unwarranted variations in the cost of care.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, authorizes new Medicaid demonstration projects to test episode-of-care payments in up to eight states (section 2704). The payments are for integrated care for an episode of illness and must include a hospitalization. The effective date

for the demonstration projects is Jan. 1, 2012, through Dec. 31, 2016. The new legislation also establishes a national Medicare pilot program to develop and evaluate bundled payments for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge (section 3023). The Medicare pilot program will be effective Jan. 1, 2013.

State Examples

■ A Minnesota provision in comprehensive 2008 health reform legislation called for development of uniform definitions of at least seven "baskets of care" (e.g., asthma, low-back pain, obstetric care and total knee replacement).[2] These definitions are to form the basis for episode-based payments. Hospitals and providers will set a price for a package of care, allowing patients and payers to compare prices for bundles of care.

A Minnesota provision in comprehensive 2008 health reform legislation called for development of uniform definitions of at least seven "baskets of care" (e.g., asthma, low-back pain, obstetric care and total knee replacement) that will form the basis for episode-based payments.

■ Massachusetts enacted legislation in 2008 concerning cost containment, transparency and efficiency in delivery of health care.[3] After the legislation was enacted, the Massachusetts Division of Health Care Finance and Policy contracted with the RAND Corporation to assess a comprehensive menu of cost containment options. RAND estimated that cumulative savings from the widespread adoption of episode-of-care payments would be $685 million to $39 billion (0.1 percent to 5.9 percent of total health expenditures) for the period from 2010 to 2020.[4] Savings would result from using episode-of-care payments for four hospital conditions (e.g., knee and hip replacements) and six chronic conditions (e.g., diabetes and asthma).

■ The Maryland hospital rate-setting commission uses case rates (i.e., episode-of-care rates) for hospital services, ambulatory surgery, and clinic and emergency room services.

■ Many Medicaid programs pay for prenatal care and delivery using a single, risk-adjusted, bundled payment.

Non-State Examples

■ The Centers for Medicare and Medicaid Services (CMS) launched the Acute Care Episode (ACE) Demonstration in 2009. Under the demonstration, hospitals are paid a single fixed rate for all hospital, physician and ancillary services provided during an inpatient stay for orthopedic or cardiovascular procedures. The demonstration sites are in Albuquerque, Denver, Oklahoma City, San Antonio and Tulsa.[5]

■ UnitedHealth is testing use of episode-based payments to pay oncologists for several months of cancer care.

■ PROMETHEUS Payment Inc., a nonprofit corporation with board members from several national employers, is developing a payment system designed to cover all care delivered by a provider for a specific condition (e.g., heart failure, chronic obstructive pulmonary disease, hypertension). Called an evidence-informed case rate, this payment approach is being tested in Minneapolis, Philadelphia and Rockford, Ill.

Evidence of Effectiveness

Limited evidence is available concerning the effect of episode-of-care payments on overall health expenditures. Existing evidence indicates that, for some conditions, episode-of-care payments can improve efficiency and generate cost savings.[6] Mathematica Inc. reviewed the available evidence on episode-of-care payments. It showed scant evidence of the effects of episode-based payment approaches on cost and quality, although some programs indicate decreased costs of care.[7]

Most evidence concerning the effect of episode-based payments comes from federal and private sector pilot programs. (Several examples are included below.) Research for this brief did not uncover any assessments of cost savings from state programs that use episode-of-care payments.

■ **Coronary artery bypass graft surgery** (CABG). In the early 1990s, Medicare sponsored the Participating Heart Bypass Center Demonstration. Under this program, Medicare paid a single, negotiated, risk-adjusted amount for inpatient CABG patients. The payment covered both inpatient hospital and physician charges and any related readmissions. Medicare spending through 90 days post-discharge was found to be 10 percent lower than for patients who were not in the demonstration. The average length of stay in pilot program hospitals declined by between 14 percent and 32 percent.[8] In the private sector, the Geisinger Health Plan, a Pennsylvania-based, integrated health care delivery system, currently accepts risk-adjusted episode-of-care payment for all care related to CABGs. The single payment includes hospital care, hospital readmissions within 72 hours and care for the following 90 days. Geisinger reports that its average hospital length of stay for CABGs is down 16 percent, and mean costs have been reduced by 5.2 percent.[9]

■ **Bundled payment for hospital care based on diagnosis.** Since 1983, Medicare has paid hospitals a fixed-rate-per-hospitalization based on diagnosis at the time of discharge. This diagnosis-related group reimbursement covers only the hospital's expenses; it does not cover physician care. Researchers have found this type of episode-based payment has resulted in a "substantial and sustained reduction in Medicare hospital spending"[10] and "significant overall reduction in the rate of Medicare spending growth."[11] Several Medicaid programs use a similar system for paying hospitals.

■ **Arthroscopic surgery**. A two-year study of a program that used a bundled payment for knee and shoulder arthroscopic surgery indicated that the health maintenance organization that made the bundled payment saved in excess of $125,000.[12] Savings came from less radiography and physical therapy, shorter hospital stays, and fewer complications and hospital readmissions.

Challenges

While episode-based payments can help control costs for certain acute illnesses and chronic conditions, several caveats should be noted. Some have suggested that, unless they are properly structured, episode-of-care payments may create an incentive for providers to provide more episodes or avoid patients with complicated diagnoses in order to maximize income. Defining the boundaries of an episode can be difficult. The effect of episode-based payments may be dampened if payers use different definitions of an episode of care. Episode-of-care payments may require providers to set up new care arrangements. Providers may encounter administrative complications as they develop joint arrangements for accepting and dividing episode-of-care payment among themselves. Despite these difficulties, the trend among payers is toward increased use of episode-based payments.

Complementary Strategies

Episode-of-care payments can be used with other cost containment strategies. Examples include disease management programs, medical homes and care coordination programs. Using episode-based pay in conjunction with these strategies (which are the subject of other briefs in this series), may offer a greater level of cost containment than could be achieved by implementing a single strategy.

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Collecting Health Data: All-Payer Claims Databases

Cost Containment Strategy and Logic

In recent years, several states have established databases that collect health insurance claims information from all health care payers into a statewide information repository. Known as "all-payer claims databases" or "all-payer, all-claims databases," they are designed to inform cost containment and quality improvement efforts. Payers include private health insurers, Medicaid, children's health insurance and state employee health benefit programs, prescription drug plans, dental insurers, self-insured employer plans and Medicare (where it is available to a state). The databases contain eligibility and claims data (medical, pharmacy and dental) and are used to report cost, use and quality information. The data consist of "service-level" information based on valid claims processed by health payers. Service-level information includes charges and payments, the provider(s) receiving payment, clinical diagnosis and procedure codes, and patient demographics. To mask the identity of patients and ensure privacy, states usually encrypt, aggregate and suppress patient identifiers.

Some states are using all-payer claims databases 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.

Table 1. Benefits of All-Payer, All-Claims Data Collection Programs

Businesses
- Helps businesses know where they stand with respect to their coverage's costs and included services.
- Provides access to information that gives businesses a better negotiating position.
- Allows businesses to choose insurance products for employees based on price and quality.

Consumers
- Provides consumers with access to information to help them make informed decisions with their health care providers so they can determine which providers and treatments are most effective and efficient.

Providers
- Supports provider efforts to design targeted quality improvement initiatives.
- Enables providers to compare their performance with that of their peers.

Policymakers
- Enables [the state] to identify communities that provide cost-effective care and learn from their successes.
- Allows targeted population health initiatives.
- Allows reform efforts to be evaluated so successful initiatives can be identified and replicated.
- Allows identification of opportunities for further reform.

Source: Oregon Health Fund Board, "Aim High: Building a Healthy Oregon—Final Report," November 2008, http://www.oregon.gov/OHPPR/HFB/docs/Final_Report_12_2008.pdf.

All-payer claims databases alone are not a means of controlling costs. Rather, they provide detailed information to help design and assess various cost containment and quality improvement efforts. By collecting all claims into one data system, states gain a complete picture of what care costs, how much providers receive from different payers for the same or similar services, the resources used to treat patients, and variations across the state and among providers in the total cost to treat an illness or medical event (e.g., a heart attack or knee surgery). In turn, businesses, consumers, providers and policymakers can use the information to make better-informed decisions about cost-effective care (Table 1). All-payer claims databases also are an important source of information for designing and implementing payment and delivery system reforms, such as pay-for-performance, episode-of-care payments, global payments, medical homes and accountable care organizations (all of which are discussed in other briefs in this series).

Target of Cost Containment

Studies confirm the United States spends significantly more on health care than other countries but, on the whole, does not produce better results for patients; it does not receive equivalent value for each health care dollar. Researchers estimate that up to 30 percent of spending on health care is wasted.[1]

Without comprehensive data on costs, components, results and demographics of care, it is difficult to identify and eliminate waste. Without reliable information about how and where health care dollars are spent and how patients move through the system, states cannot design effective programs to address both unnecessary and inadequate care to realize health care

system savings. In some cases, all-payer claims databases can be used to identify the most cost-effective providers and methods of care. They also can provide valuable information to assess the relationship between total care costs, prices, use and service intensity, on the one hand, and quality and results of care for different providers, treatments and populations, on the other. Due to data limitations, not all these applications may be possible.

State Examples

■ As of December 2009, all-payer claims databases were operating or under development in Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Oregon, Tennessee, Utah and Vermont. The all-payer claims databases in Maine, Maryland and New Hampshire were established partially in response to escalating health care costs and premiums.

■ Most state all-payer claims databases have a governing board or advisory committee that administers or provides recommendations on the operation of, and reports to be generated from, the databases. The committees usually include directors of state health agencies and representatives of key stakeholder groups, such as health insurers, hospitals, physicians, employers and consumers. Some states out-source data management and analytics. Others conduct all or some of the activities in-house. Efforts are under way to standardize data collection processes to make it easier for insurers that operate in more than one state to participate and allow for cross-state data applications and analyses.

As of December 2009, all-payer claims databases were operating or under development in Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Oregon, Tennessee, Utah and Vermont.

■ States that require payers to submit claims data often have statutory penalties for failure to do so in a timely manner (e.g., $1,000 for each week of delay in Massachusetts, $500 per day in Oregon and $100 per day in Tennessee).

■ Legislation enacted in 1995 established the Maine Health Data Organization (MHDO).[2] Maine is one of 30 states where health data organizations collect and disseminate health care data for policy and market uses. As with other state data organizations, Maine's reporting systems consist of hospital financial and organizational data (including inpatient, outpatient and emergency department data); non-hospital ambulatory service data; and quality data. In 2003, Maine became the first state to require all payers to report claims data.[3]

Today, MHDO has nine full-time-equivalent employees and an annual budget of about $1.8 million. Several studies have used MHDO data to identify areas of the health care system that could benefit from specific cost containment efforts. One study, for example, used MHDO data to identify significant unwarranted variation in use and costs of care across the state.[4] It concluded that, if potentially avoidable inpatient use and high-cost, high-variation outpatient use were reduced by 50 percent, medical spending by commercial health payers could be reduced by 11.5 percent, and Medicaid spending could be reduced by 5.7 percent. A second study showed Maine uses 30 percent more emergency services than the national average.[5] Researchers estimated health care payers in Maine could save $115 million annually by reducing avoidable emergency department use. Maine plans to use its claims database "to identify specific inefficiencies to start working with stakeholders on levers to reduce waste."[6]

■ A 2003 New Hampshire law created the New Hampshire Comprehensive Health Information System (CHIS),[7] which consists of claims and eligibility data from Medicaid and commercial payers. A website, New Hampshire HealthCost, uses CHIS data to provide comparative information to consumers and employers about the estimated amount a hospital, surgery center, physician or other health care professional receives for its services. HealthCost provides information specific to an insured person's health benefits coverage and also shows health costs for uninsured patients. Employers can use the website's Benefit Index Tool to compare carriers' health plan premiums and benefits. CHIS data are used to produce health care cost, quality and use reports. One report, for example, found that Medicaid members who received primary care in 2006 incurred $4.1 million for outpatient emergency department visits for conditions more appropriately treated in a primary care setting.[8] A second, related report found that Medicaid patients who were frequently treated in the emergency department often were seen for conditions that probably could have been treated in a primary care office or clinic.[9] An estimated $2.1 million could have been saved if each frequent emergency department user had made just one less outpatient emergency room visit during 2006.

■ A 1993 Maryland law created the Maryland Medical Care Data Base,[10] which includes health care practitioner claims (e.g., physician, podiatrist, nurse practitioner) and pharmacy services. Payers that collect more than $1 million in health insurance premiums annually must submit claims data. Medicare claims also are part of the database. Although the program has access to Medicaid claims, they are not part of the database. The Maryland Health Care Commission uses claims data to report costs and use of professional health services, including variations in charges. A November 2009 report, for example, analyzed expenditures for professional services by privately insured patients between 2006 and 2007.[11] The report found average professional services expenditures grew 3 percent in 2007, mainly as a result of increases in the number of services per user as opposed to increases in health care prices.

■ Several states are using their all-payer claims databases for specific cost containment-related initiatives. Utah plans to use claims data to compare the cost of caring for newborns whose mothers had limited or no prenatal care to mothers who had the recommended number of prenatal visits. Kansas intends

to use data from its all-payer claims system to develop cost-saving initiatives in its Medicaid or state employee health plan by the summer of 2011.

Non-State Examples

- The Wisconsin Health Information Organization (WHIO), a private nonprofit organization, is comprised of multiple payers that voluntarily submit claims data to the WHIO Health Analytics Exchange. The organization was incorporated in late 2006 by insurers, employers and providers (e.g., Anthem Blue Cross Blue Shield of Wisconsin, Humana, Greater Milwaukee Business Foundation on Health, Wisconsin Medical Society and Wisconsin Hospital Association). In 2007, the Wisconsin Department of Health and Family Services and Wisconsin Department of Employee Trust Funds became members. Currently, WHIO receives data from 29 percent of health care claims in the state and has commitments from Medicaid and other health plans for submission of claims data that will bring the total to more than 50 percent of the population in 2010. WHIO's goal is to use data to improve the quality, affordability, safety and efficiency of health care delivered to patients in Wisconsin.

- The U.S. Department of Health and Human Services plans to build a nationwide all-payer claims database consisting of a representative sample of the population. The data will be used to analyze and compare the effectiveness of medical treatments for various conditions. The department posted a pre-solicitation in December 2009 for "a targeted design study to inform the creation of such a database and supporting services, methods, and skills."[12]

Effectiveness of Cost Containment Approach

It is still too early to assess how effectively state all-payer claims databases can help states control costs. Most programs have not been in use long enough to determine their effectiveness in shaping successful cost containment efforts. To date, all-payer claims database programs have not focused on cost containment per se. Rather, the focal point has been using claims information to investigate statewide variations in costs and health care use and publishing data that allow the public to compare health care prices and quality. Some states (e.g., Massachusetts and New Hampshire) have used claims data to identify potential areas for cost savings.

- At least one state—New Hampshire—has used its all-payer claims database to assess the effect on prices over time of publishing comparative health service prices. The analysis was intended to determine the effect of the state's HealthCost website on prices for health care procedures shown on the website. Before HealthCost was launched, some suggested it could encourage price competition and help slow price increases for procedures listed on the website. Others said higher prices could result due to provider access to their competitors' rates. Still others said prices could become more consistent as providers with high rates lowered them and providers with low rates moved to the mean. In fact, the analysis found no demonstrable effect on providers' prices over time.[13]

- Evidence exists that analyses of claims data can help evaluate programs that are designed to control costs. A private sector study published in 1989 used claims data to assess the effect on costs of using primary care physicians as gatekeepers in managed care programs.[14] Although researchers did not have access to an all-payer claims database, they used four years of claims data from a large insurer to conduct their study. They found gatekeeping resulted in lower costs during the first year, primarily due to reduced use of specialists, but costs rose during the second year to just below indemnity (i.e., fee-for-service) plan levels.

Challenges

Several challenges exist to setting up all-payer claims databases.

- Providers may object to payers reporting data about their practices. They may be concerned about how the data will be used, whether it will accurately reflect prices and quality, and if it will account for variations in the complexity of their cases.
- Consumers may be concerned about the privacy and security of their information, although this often is explicitly addressed in state authorizing legislation and regulations.
- Large, multi-state insurers, concerned about administrative costs of complying with various state database requirements, may lobby for states to harmonize rules and procedures.
- A state may not be able to obtain data from employers that have self-insured health plans unless the information is available from the third-party administrators of such plans. Some employers, however, may voluntarily submit claims data, since it is in their interest to compare the prices they pay with what others pay. Information about all users of the health system should be—but often is not—in the database to provide a complete picture of health care use and cost. For the most part, states do not have access to claims data for Medicare patients and have either no or limited data about uninsured patients.
- The cost of establishing and maintaining an all-payer claims database and publishing and analyzing database information can be significant. Vermont estimated start-up costs for its database would be approximately $500,000 for FY 2009. The Utah Legislature appropriated $625,000 in 2008 to launch its all-payer claims database; annual costs are projected to be $1 million, paid for primarily with state and Medicaid matching funds. In 2008, the Oregon Health Fund Board suggested investing $400,000 in state funds and $300,000 in federal funds to establish a database.

Complementary Strategies

All-payer claims databases provide valuable information for structuring and evaluating a number of cost containment strategies. Strategies include payment reforms, such as episode-of-care and global payments; and delivery system reforms, such as medical homes, care coordination, chronic disease management and broad-scale health information technology projects (which are the subject of other briefs in this series).

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About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple 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, with Barbara Yondorf as lead researcher.

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Accountable Care Organizations

Cost Containment Strategy and Logic

An accountable care organization (ACO) is a local, provider-led entity comprised of a wide range of collaborating providers. ACOs monitor care across multiple or all care settings (e.g., physician practices, clinics and hospitals) and are accountable to health care payers (e.g., Medicaid, Medicare or private insurers) for the overall cost and quality of care for a defined population. They provide an overarching structure for coupling health care delivery system reforms (e.g., medical homes and electronic medical records) and new forms of provider payment (e.g., global and episode-of-care payments) (Figure 1). The ACO concept envisions direct contracting by payers with provider organizations without reliance on a health plan intermediary such as a managed care plan.

In and of themselves, ACOs are not a cost containment strategy. Rather, they are a vehicle for implementing comprehensive payment reform and health care system redesign in order to control the growth in health care costs and obtain better value for each health care dollar.

The following example illustrates how an ACO might work to control health care costs, developed by health policy expert, Steven Shortell. Health care providers sign an agreement to participate with the ACO. Spending targets are set based on past years' data. If total spending comes in under target, providers share the savings. Savings come from better chronic care management, compliance with preventive care guidelines and better care coordination among ACO. providers.

Accountable care organizations, a relatively new concept, have not been fully tested. Existing evidence indicates that fully integrated ACOs can provide higher-quality, more efficient care than smaller, more loosely organized ones.

ACOs are a relatively new, largely untested concept. As a result, the exact definition of what constitutes an accountable care organization varies. Common elements and variations in an ACO definition are described below.

- According to the Medicare Payment Advisory Commission, "The defining characteristic of ACOs is that a set of physicians and hospitals accept joint responsibility for the quality and cost of care received by the ACO's panel of patients."[1]

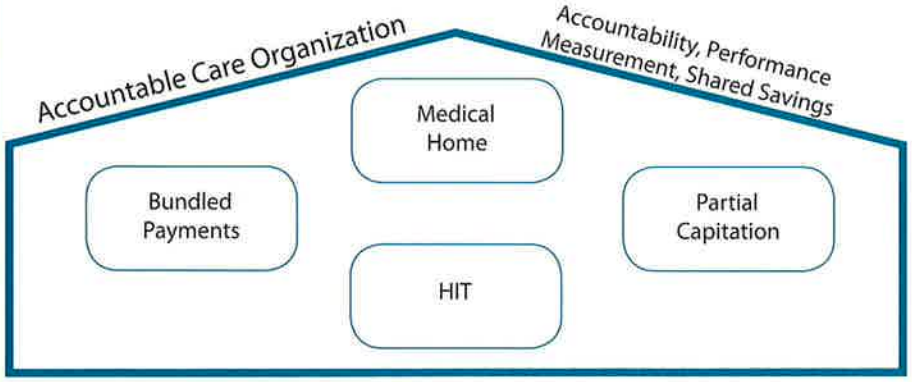
- ACOs serve a patient population (e.g., Medicaid recipients or health plan enrollees) in a defined medical service area. A medical service area (sometimes called a hospital referral area) includes most or all the health care services needed by patients living in the area. The ACO concept may allow for only one or for several competing ACOs in a medical service area.

- ACOs receive financial incentives to contain costs and improve quality through the collaborative efforts of the providers in their networks. Incentives are based, in part, on the extent to which providers in the ACO meet or fail to meet efficiency and quality goals. Goals are set by, or negotiated with, payers.

- ACOs provide support services to providers to help them achieve quality and efficiency goals. Support services include care coordination, health information technology support, performance feedback and assistance with practice redesign.

- ACOs can include a wide continuum of providers and services in their networks, but usually include at least physicians, specialists and one or more hospitals.

Figure 1. The ACO is the overarching structure within which other reforms can thrive



Source: John Bertko, "Delivery System Reform: Developing Accountable Care Organizations," PowerPoint presentation to the State Quality Improvement Institute meeting, Denver: May 27, 2009; www.academyhealth.org/files/SQII/Bertko.pdf.

■ The ACO itself can be an independent nonprofit organization formed specifically to serve as an ACO, an independent practice association, a multi-specialty group, a hospital-medical staff organization or a physician-hospital organization. It also could be a fully integrated health care system that provides the full range of health care services and employs most or all the physicians in the system. Examples include the Cleveland Clinic in Ohio, the Mayo Clinic based in Rochester, Minn., and Denver Health in Colorado.

■ Under some models, ACOs receive a per-member, per-month fee for overseeing and supporting the care delivered by network providers. In this case, providers often are paid a fee for each service minus an amount withheld that is paid out based on attainment of benchmark goals. Under other models, the ACO may receive a global per-member, per-month payment that it distributes to participating providers to yield the most efficient care overall. Funds are distributed based in part on the costs incurred by each provider and in part on the success of the entire organization in meeting quality and cost goals. In either case, providers in the ACO share some financial risk for meeting or exceeding performance goals across all providers and patients and may earn less if benchmark goals are not met.

The primary target of ACOs is lack of accountability for the overall cost and quality of care.

Target of Cost Containment

The primary target of ACOs is lack of accountability for the overall cost and quality of care. ACOs are designed to address fragmentation of care, current financial incentives that encourage clinically unwarranted higher volumes of care and intensity of services, unnecessary growth (e.g., more hospital beds and diagnostic equipment than needed), lack of care coordination, use of higher-cost providers where lower-cost ones (e.g., nurse practitioners) would be as effective, and insufficient attention to ensuring that patients receive timely primary and preventive care. ACOs address these problems by organizing, supporting and paying providers so they have financial incentives and a mutual interest in holding down costs and improving care quality across all providers, for all patients.

The Congressional Budget Office has estimated that potential savings to Medicare from promoting ACOs could amount to $5.3 billion between 2010 and 2019, although net savings would not begin to be realized until 2013.[2] The savings would be realized as providers reduce the volume and intensity of services delivered to their patients.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, authorizes Medicaid and Medicare ACO pilot programs. The Medicaid program allows pediatric medical providers organized as ACOs to share in cost savings, effective Jan. 1, 2012, through Dec. 31, 2016 (section 2706). The Medicare pilot program authorizes Medicare providers organized as qualifying ACOs that voluntarily meet quality goals to share the cost savings they achieve with the program, beginning Jan. 1, 2012 (section 3022).

State Examples

■ Vermont enacted legislation in 2009 that included ACO provisions.[3] The state's Commission on Health Reform is to convene a work group to support an application by at least one Vermont provider network to participate in a national ACO state learning collaborative. The intent is to implement at least one ACO project in Vermont by July 1, 2010. The legislation addresses possible federal anti-trust issues that may arise when providers join to deal with cost and shared savings issues. The law states the General Assembly's intent to ensure sufficient state involvement in design and implementation of ACOs to comply with federal anti-trust provisions "by replacing competition between payers and others with state regulation and supervision." The law envisions that the state's Medicaid program, Children's Health Insurance Program (CHIP) and Health Access Program could contract with the ACO and recapture a portion of anticipated savings from the state participation.

■ Oregon passed the Healthy Oregon Act in 2007,[4] which established the Oregon Health Fund Program and directed it to develop a comprehensive health reform plan. The law also established a set of committees to develop recommendations on specific aspects of the plan. The Delivery Systems Committee has developed recommendations concerning accountable care districts. Recommendations call for the state to define accountable care districts "that will allow for meaningful comparisons of quality, utilization and costs between districts" and test new payment models in the accountable districts.

■ A 2008 Massachusetts law required creation of a Special Commission on the Health Care Payment System.[5] A July 2009 commission report recommended that the state make the transition from the current fee-for-service payment system to global payments[6] over a period of five years. It also recommended creating an entity to guide implementation of the new payment system. Among other things, the entity would be responsible for defining and establishing risk parameters for ACOs, which will receive and distribute global payments. ACOs will assume risk for clinical and cost performance.

■ Programs in at least two states—Colorado and North Carolina—use networks of providers that, while not true ACOs, have the potential to develop. The programs in both states focus on primary care for Medicaid enrollees and rely on provider-led local networks that are responsible for improving care, quality and efficiency for the patients served by the networks.

• Community Care of North Carolina consists of 14 independent, nonprofit, care-coordination networks.[7] The regionally organized networks consist of participating physicians that receive per-member, per-month fees for serving as a medical home for Medicaid patients. The networks receive a $2.50 per-member, per-month fee to coordinate patient care and help primary care providers improve care using local nurses and other case managers.

• The Colorado Accountable Care Collaborative, set to launch in 2010, is designed to be a "primary care-based health care reform for full body, mind and mouth."[8] Regional Care Coordination Organizations (RCCOs) will develop and organize the provider network in their regions. They will provide technical assistance on such things as medical home practice redesign and implementation of new health information technologies. They also will help coordinate care and care transitions between health care settings and be accountable for specific population health measures within each region. Each RCCO will be paid a per-member, per-month case management fee. Primary care medical providers that meet medical home standards also will be paid a per-member, per month fee. A portion of total funding will be withheld from the RCCOs and the primary care medical providers to support a potential incentive payment.[9]

■ Several states regulate ACO-like entities called provider-sponsored organizations, which accept risk for ensuring that a population of patients receives necessary care. A 1997 study examined how nine states regulate provider-sponsored organizations.[10] It found that some states require HMO licensure if the organization, rather than an insurance plan, is the ultimate bearer of risk or assumes risk beyond that which its providers are licensed to offer themselves (e.g., California, Illinois and Pennsylvania), especially where the organizations receive capitated or global payments. Others require a special license or certificate (e.g., a limited service license in Colorado, a nonprofit health corporation license in Texas, and a community integrated service network license in Minnesota).

Non-State Examples

■ Patient Choice is a program for self-funded employers in Minnesota, North Dakota and South Dakota. Created by the Buyers Health Care Action Group in 1997, it is operated today by Medica, a large HMO. The Patient Choice Care System Program works with groups of providers (including both hospitals and physicians) called care systems that function like ACOs. Care systems submit bids based on their expected total cost of care for a defined population of patients who have the same benefits. Reimbursement rates are driven by performance on quality measures and the total cost of care, or what has been called "virtual capitation" or "capitation in drag."[11]

■ In the Physician Group Practice (PGP) Demonstration, a Medicare pilot program started in 2005, 10 large, multi-specialty physician groups receive a share of the savings they achieve in caring for Medicare patients and meeting documented quality improvement targets. Physician groups that are able to meet quality benchmarks and reduce their total expected Medicare spending by more than 2 percent can share in the savings they generate for Medicare. Although the demonstration does not meet all the criteria of a true ACO—for instance, there is no penalty for failure to meet efficiency and quality benchmarks—Medicare plans to expand the PGP model to more closely resemble an ACO pilot program.

■ Health systems in five states will be part of an ACO pilot program sponsored by two health policy groups, the Engelberg Center for Health Care Reform at the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice. The systems, in Arizona, Iowa, Kentucky, Vermont and Virginia, are scheduled to begin in 2010.

Evidence of Effectiveness

Because it is a relatively new concept that has not been fully tested, there is insufficient evidence to determine the effectiveness of true ACOs in containing costs. According to a recent report to Congress on Medicare, "...any projections of savings from the formation of ACOs are subject to a high degree of uncertainty."[12] What evidence exists is mixed.

■ Evaluations of the early results of several Medicare ACO-like pilot programs have led researchers to different conclusions. Some have reported that the Medicare Physician Group Practice Demonstration described previously has resulted in lower costs and improved quality.[13] They note that four of 10 demonstration sites had low enough growth in their risk-adjusted costs to qualify for bonuses. In contrast, the Medicare Payment Commission reports that, "It is questionable whether the PGP demonstration has saved money."[14] The commission notes that, after two years, five of the PGP sites had absolute (non risk-adjusted) cost growth that was materially higher than their comparison groups, four had roughly equal cost growth and only one had lower cost growth.

■ During the 1990s, a number of provider-sponsored organizations assumed responsibility from managed care plans for coordinating the care and managing the costs of care for groups of patients. Examples of such organizations included independent practice associations and physician-hospital organizations. Although these arrangements do not exactly match the ACO definition, they bear many similarities. A 2001 study of 64 risk-bearing, provider-sponsored organizations found that some experienced serious financial problems, some were dealing with tension between themselves and hospital partners due to concern about payment adequacy and fairness, and some were simply unable to manage costs.[15] Proponents of ACOs note that many of these problems are being addressed in current models. ACOs receive payments that are risk-adjusted, and they are better equipped to track quality-of-care and costs. They have better data support, their risk assumption is limited to that they directly control, and quality and efficiency incentives are more fine-tuned.

■ Experience with the Minnesota Patient Choice system indicates that the program "...has encouraged patients to select more cost-effective providers and has spurred providers to reduce their costs while maintaining or improving quality to attract more consumers."[16] Although the competing, ACO-like care systems that participate in Patient Choice are not the only factor that accounts for these findings, they appear to contribute significantly.

■ Several studies have found that more fully integrated ACOs provide higher-quality, more efficient care than smaller, more loosely organized ones.[17]

Challenges

A number of challenges exist to successful implementation of ACOs. Formation of ACOs may raise anti-trust issues when an ACO dominates the market. The ACO and participating providers must resolve organizational and professional liability arrangements. ACOs must have systems in place to capture, analyze and share clinical information with providers across care settings and to track costs. Payers and ACOs will need to agree on how patients will be assigned to a particular ACO and what happens when patients use a non-ACO provider—is the ACO still accountable for the total costs of that patient's care? Experience suggests it takes many years to establish a successful ACO, particularly where formal arrangements among providers do not already exist. Finally, states will want to decide whether and how to regulate ACOs—at what point do ACOs accept so much risk that they should be regulated as insurers?

Complementary Strategies

ACOs provide an organizational framework for implementing, coordinating and enhancing payment and delivery system reforms. Examples of such reforms include medical homes, episode-of-care and global payments, partial capitation, care coordination, chronic disease management and broad-scale health information technology projects. These are discussed in separate papers in this NCSL cost containment series.

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Performance-Based Health Care Provider Payments

Cost Containment Strategy and Logic

Pay-for-performance is a system of payment that rewards health care plans and providers for achieving or exceeding preestablished benchmarks for quality of care, health results and/or efficiency. Pay-for-performance is most often used to encourage providers to follow recommended guidelines or meet treatment goals for high-cost conditions (e.g., heart disease) or preventive care (e.g., immunizations). A physician might, for example, receive a year-end $25 bonus for every 2-year-old on the physician's panel if at least 80 percent have received recommended immunizations. A hospital may receive a performance payment for reducing the rate of avoidable hospital readmissions or ensuring that patients receive appropriate discharge medications. Performance awards can take many forms, including bonuses, enhanced fee schedules and directing more enrollees to high-performing providers and health plans.

Pay-for-performance is sometimes called value-based purchasing, quality-based purchasing or performance-based contracting. It usually is abbreviated "P4P."

The main goal of pay-for-performance systems is to improve health care results by ensuring that patients receive timely, cost-effective care—especially preventive and chronic care. Pay-for-performance also is intended to reduce costs. With improved quality of care, patients should remain healthier longer, the incidence of complications of care should decline, and the use of less-expensive but equally effective treatments should increase.

Target of Cost Containment

Research indicates that, for some conditions, pay-for-performance can lead to higher-quality, lower-cost care but, by itself, may not slow overall cost growth.

Pay-for-performance is designed to address health care underuse (e.g., inadequate preventive care) and overuse (e.g., unnecessary medical tests). It pays for value—efficient and effective care. Studies have shown that, in many cases, providers fail to provide care or follow guidelines that could both avoid the need for future more expensive care and save lives (Table 1). This is due in part to the fact that the current fee-for-service system does not reward quality or efficiency. With fee-for-service—where each completed test, treatment or product is billed and reimbursed as a coded line-item—providers may actually earn less by delivering cost-effective care if it means fewer services for which they can bill. Pay-for-performance is designed to address this negative incentive.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, directs the secretary of Health and Human Services to develop a "payment modifier" to allow for differential Medicare fee-for-service payments based on quality and efficiency measures (section 3007). It also establishes pay-for-performance pilot programs for psychiatric, rehabilitation, long-term care, and cancer hospitals and hospice programs that treat Medicare enrollees (section 10326).

Table 1. Performance Shortcomings in Treating Certain Medical Conditions

Condition	Shortfall in Care	Avoidable Toll if Recommended Care Guidelines Were Followed by All Providers in the U.S.
Diabetes	Average blood sugar not measured for 24% of patients	2,600 blind; 29,000 kidney failures
Hypertension	Less than 65% received indicated care	68,000 deaths
Heart Attack	39% to 55% did not receive needed medications	37,000 deaths
Pneumonia	36% of elderly didn't receive vaccine	10,000 deaths
Colorectal Cancer	62% not screened	9,600 deaths

Source: S.H. Woolf, "The Need for Perspective in Evidence-Based Medicine," Journal of the American Medical Association 282 (1999): 2358-2365.

State Examples

- In 2009, more than 250 pay-for-performance programs existed nationwide; almost half targeted hospital care. State Medicaid departments sponsored 18 percent of these, health insurers 66 percent, employers 11 percent and Medicare 5 percent.[1] Estimates are that, by 2011, 85 percent of state Medicaid programs will operate some type of pay-for-performance program.[2] Seventy percent of current Medicaid performance-based payment programs operate in managed care or primary care case management environments. Some involve nursing homes or behavioral health providers. Most focus on preventive health services and children's, adolescents' and women's health issues. Several states participate in multi-payer, pay-for-performance programs (e.g., the regional, multi-payer, pay-for-performance and quality reporting program operated by the Indiana Health Information Exchange).

- Several states link pay-for-performance to hospital reimbursement rates. The Maryland Health Services Cost Review Commission, which sets hospital reimbursement rates for all payers, rewards hospitals that score well on specified quality-of-care measures (e.g., surgical infection prevention, following evidence-based heart attack treatment guidelines) as part of its Quality-Based Reimbursement Initiative. The authority for this program comes from state law that allows the commission, in determining if rates are reasonable, to consider objective standards of efficiency and effectiveness.[3] A 2006 Massachusetts law provides that Medicaid hospital rate increases be contingent upon quality measures.[4]

Several states have either passed a series of bills to streamline various administrative processes or have enacted comprehensive administrative simplification bills.

- In 2008, Minnesota passed comprehensive health reform legislation that, among other provisions, requires the commissioner of human services to implement quality incentive payments for enrollees in state health care programs.[5] The law requires development of a payment system that rewards high-quality, low-cost providers. Minnesota's Medicaid and state employee health benefits programs also are partnering with nine private sector employers in a statewide pay-for-performance program.

- Maine's Medicaid program includes a Physician Incentive Program that ties 30 percent of a performance bonus to appropriate reductions in emergency department use.[6]

- A 2007 Texas law directed the Health and Human Services Commission to investigate outcome-based performance measures and incentives in all Medicaid contracts with health maintenance organizations (HMOs). If the commission determines that performance incentives are feasible and cost-effective, it is authorized to develop and implement a pilot project in at least one health care service region. Legislation is intended to improve access to care and strengthen the link between reimbursement and hospital-based programs that can reduce the cost of care for Medicaid enrollees.

- Several states have estimated likely savings from implementing pay-for-performance programs. The Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program, estimated the cost of and projected savings from implementing a physician incentive program to provide optimal care to patients and ensure full immunization of all 2-year-olds. It estimated that, over three years, the program would cost $4.6 million but would save the state $10.1 million.[7] Despite these projections, the Arizona Legislature did not approve a 2008 request to fund the program, due to budget shortfalls and the need to make a significant up-front investment before any savings would be realized. In 2009, Massachusetts estimated that implementation of pay-for-performance standards called for in the state's FY 2010 budget would save the state $62 million.[8]

Non-State Examples

- Under Medicare's Physician Group Practice Demonstration Project, physician groups are eligible for performance payments if the growth in Medicare spending for the population assigned to the physician group is less than the growth rate of Medicare spending in their local market by more than two percentage points. Performance payments are based on meeting efficiency and quality targets.

- A number of large employers and health plans use pay-for-performance systems.

  - More than half of commercial HMOs include performance-based incentives in their provider contracts. Collectively, these HMOs manage 81.3 percent of the nation's commercial HMO enrollees.[9]

  - Bridges to Excellence is an employer-led, national initiative to improve health care quality and hold down costs. Participants include large employers (e.g., General Electric, Proctor and Gamble, and UPS), health plans (e.g., Aetna, Humana and several Blue Cross Blue Shield plans) and physician groups. Bridges to Excellence focuses on improving diabetes and cardiovascular disease care and patient care management systems.

  - The California Integrated Healthcare Association launched a pay-for-performance initiative in 2003. It includes seven major health plans and 225 physician groups that care for 46.2 million people.

Evidence of Effectiveness

Little research exists on the effect of performance-based pay on health care costs. Most research focuses on improvements in quality of care rather than on cost savings. Research for this

brief did not uncover any assessments of cost savings from state pay-for-performance programs. Existing evidence, mainly from the private sector, has produced mixed results. Some have found that, for certain conditions, pay-for-performance can lead to higher-quality, lower-cost care. Others have found that, for the most part, performance-based pay does not yield net savings but can improve care quality.

- Bridges to Excellence reports that physicians who are recognized by the program for providing high-quality and more efficient care deliver it at 10 percent to 15 percent lower cost than nonparticipating physicians. The average annual cost of care for diabetes patients, for example, is $1,400 with recognized physicians versus $1,600 with others.

- A 2007 study examined the results of a pay-for-performance program in Rochester, N.Y.—the Excellus/Rochester Individual Practice Association Rewarding Results Initiative. It reported a 5-to-1 return on investment for the initiative's diabetes and coronary artery disease programs.[10]

- A 2008 report to the Texas Legislature found that, "Despite the broad application of P4P programs across commercial insurance, Medicaid and Medicare in programs across the country, there is limited evidence of clinical effectiveness and no evidence of cost effectiveness."[11]

- A 2008 study of health care quality and value published by The Bipartisan Policy Center reported, "Most pay-for-performance experiments to date have shown some evidence of small improvements in measured quality of care, but little evidence of cost savings."[12]

- A study published in 2009 concluded that pay-for-performance is good for rewarding improved use of underused services (e.g., colonoscopy screenings and mammograms) but does not reduce overused services.[13]

- With respect to quality, several studies have found that pay-for performance programs can improve health care quality, as measured by such things as cervical cancer screening and mammogram rates, frequency of well-baby visits, percent of women receiving appropriate postpartum care and childhood immunization rates.[14] Others have found little evidence to support the effectiveness of paying for quality.[15]

Researchers have suggested several reasons for the apparently limited effect of performance payments on overall costs.

- The cost of, and administrative expenses associated with, incentive payments may offset any savings from reductions in preventable complications and unnecessary services.

- The various ways different payers structure and target their performance incentives may dampen the effect as providers attempt to respond to incentives.

- Incentive payments may account for only a fraction of a provider's patients.

- Programs have not been implemented on a large enough scale or for long enough to demonstrate net savings.

- Performance pay programs tend to focus on rewarding improvements in quality-of-care measures but not on improved efficiency or cost of care.

Challenges

Several challenges exist to implementing a performance-based payment system that can both control costs and improve quality. One is determining how large a performance incentive is necessary to affect physician behavior. Another is deciding how savings will be measured—will they be based on costs under the program compared to a control group, trend or a baseline measure of cost? Also, will the effect on overall costs be measured (e.g., annual expenditures for children on Medicaid) or only the effect on costs associated with the targeted, performance-based incentive (e.g., reduction in emergency room use by asthmatic children)? Other challenges include 1) consolidating enough payers that use the same pay-for-performance incentives to ensure program impact and 2) securing sufficient front-end funding to implement a pay-for-performance program (e.g., establishing a system for reporting, collecting and analyzing performance data and appropriating funds to pay performance bonuses).

Complementary Strategies

Performance-based pay often is used in conjunction with other payment methods and health care programs. Examples include global payments (i.e., risk-adjusted capitation programs), disease management programs, medical homes and care coordination programs. Combining pay-for-performance with these strategies, which are the subject of other briefs in this series, may result in a greater level of cost containment than could be achieved by implementing any one by itself.

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Equalizing Health Provider Rates

All-Payer Rate Setting

Cost Containment Strategy and Logic

All-payer rates are payment rates that are the same for all patients who receive the same service or treatment from the same provider. "All payers" include patients, private health insurance plans, large employer self-insured plans and people without insurance; it also may include Medicaid and Medicare (under an approved waiver from the federal government). Rates may be set per service or per case (e.g., hospital care for a heart attack). Rate setting has mainly been used for hospital inpatient and outpatient services.

Under a system of all-payer rates, the reimbursement a provider receives for a given service is the same regardless of who pays. Different payers would not pay different rates for the same service, as is the case today. Currently, although virtually all patients are charged the same amount on paper (i.e., list price), actual payments vary widely based on negotiated discounts. A hospital, for example, may receive reimbursements from more than a dozen different health insurers and health plans, each with its own payment schedule. In addition, Medicare and Medicaid have their own rules for paying hospitals. Minnesota has described all-payer rates as a pricing system in which "charge = price = reimbursement."[1]

The two types of all-payer rate programs are:

- State-determined rates. This is the traditional approach to rate setting under which a state authority sets rates, most often for hospital services. It is similar to public utility regulation.

- Provider-set rates. This approach, which is sometimes called "uniform pricing," allows providers to set their own rates but requires rates to be the same for all payers. A state can establish rate setting parameters but does not set the actual rates. A variation of this approach applies only to uninsured patients who are not eligible for charity care. In this case, providers are prohibited from billing uninsured patients more than Medicare or health plans that have negotiated discounted rates.

Both approaches are designed to contain health care costs by fostering price competition and reducing or eliminating the cost to negotiate and administer multiple reimbursement schedules with multiple payers. State rate setting programs also reduce costs by limiting payment rates to the minimum necessary to cover a provider's operating expenses.

Evidence is mixed, but indicates that, properly structured, state all-payer rate setting can slow price increases but not necessarily curb overall cost growth.

Interest in all-payer rates as a cost containment tool declined significantly since its heyday in the 1970s, but all-payer rate setting and uniform pricing have received renewed attention for several reasons.

- In recent years, mergers and acquisitions have led to increased hospital and health care system market concentration. According to one health policy expert, the disproportionate bargaining power providers have in markets where they are dominant makes cost control extremely difficult.[2] All-payer rate setting addresses this problem.

- Health care costs continue to increase much faster than general inflation. Frustrated by the apparent inability of the market (including managed care) to control spiraling health care costs, policymakers want to improve market competition by making it easier for health care purchasers to compare prices. They also want to reduce administrative costs associated with multiple, complicated reimbursement schedules.

- More sophisticated data systems, advances in health information technology and improvements in risk-adjustment methodologies make it easier to set rates that accurately reflect provider costs and include incentives for cost containment.

In addition to cost containment, other reasons exist for renewed interest in all-payer rates.

- Advocacy groups are concerned about "discriminatory pricing"—the practice of billing full charges ("list price") to uninsured patients who are not eligible for charity care. These charges often may be at least twice those of commercially insured or Medicare patients.

- Providers are concerned about the disproportionate bargaining power large health insurers have in some states, particularly where one or two insurers dominate the market.

Target of Cost Containment

The primary target of all-payer rates are uneven and high health care prices, especially for inpatient and outpatient hospital care. Numerous studies show the main reason per capita health care expenditures are so much higher in the United States than in other countries is higher medical prices.[3] Between January 1988 and January 2009, the consumer price index (CPI) rose 82 percent, while the medical component of CPI rose 175 percent.

All-payer rates are intended to promote provider price competition, reduce health plan and administrative costs and, when combined with quality incentives, reward high quality/low cost providers. All-payer rates also are designed to address significant mark-ups in provider charges that, in the current system, are needed to cover deeply discounted rates for some payers. Hospital mark-ups average 187 percent of costs and range as high as 400 percent of costs.[4]

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, creates a Center for Medicare and Medicaid Innovation (CMI).[5] The act directs CMI to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing quality of care. It allows states to test and evaluate systems of all-payer payment reform for the medical care of residents of the state, including individuals who are eligible for both Medicare and Medicaid. In selecting models to test, the Secretary of Health and Human Services must give preference to models that improve the coordination, quality, and efficiency of health services.

State Examples

- Maryland established an all-payer hospital rate setting program in 1971 that still operates today.[6] The program's goals include constraining hospital costs; providing financial stability for hospitals; providing efficient and effective care; and financing growing levels of hospital uncompensated care. The program is administered by the Health Services Cost Review Commission, a government agency with broad authority to set hospital rates. The rates take into account each hospital's reasonable costs, level of charity care and severity of patient illness. They also include quality and efficiency incentives. The commission sets only hospital rates, not physician fees. Maryland's rate-setting program applies to fully insured and employer self-funded health plans, Medicaid and, under a federal waiver, Medicare. Rates are set per-diagnosis (e.g., all hospital care for a pancreas transplant, as opposed to per-service, separate charges for sutures, ultrasound, etc.) to encourage hospitals to control the cost of each episode of care.

- A Minnesota provision in comprehensive 2008 health reform legislation calls for creation of a work group to make recommendations on "the potential impact of establishing uniform prices that would replace current prices negotiated individually by providers with separate payers."[7] The work group has developed an "evolving concept of uniform pricing in practice" that includes three elements, cited in its report as:
  1. Services (individual and bundled) are defined.
  2. Providers set an accepted reimbursement payment price. There is no requirement about how prices are set; each provider could offer a different price.
  3. Price = payment = what insurance plan pays + what the consumer pays.[8]

- Oregon does not have an all-payer rate system but is considering limits on provider rate increases that would apply to all payers. The Oregon Health Fund Board, established by the Oregon legislature in 2007,[9] issued a November 2009 report that examined a number of health care reform strategies, including "authorization of an appropriate state agency to establish annual maximum limits ("ceilings") on price increases charged by health care providers in a similar class (e.g., licensed health care facilities)."[10] It suggested two ways to establish ceilings: limit increases to a fixed multiplier of the Medicare reimbursement rate (e.g., 130 percent) or limit them to no more than a fixed percentage from a base year (e.g., consumer price index + 1 percent).

- Massachusetts examined potential savings from of a variety of cost containment strategies, including a rate setting program similar to Maryland's. An independent report estimated hospital all-payer rate setting could reduce health spending in Massachusetts by between 0.1 percent and 3.9 percent between 2010 and 2020.[11] Rate setting ranked second, behind global payments, in its predicted ability to save costs. (A global payment is a fixed prepayment made to a group of providers or a health care system that covers most or all of a patient's care during a specified time period; global payments are discussed in another brief in this series.)

- To bring them more in line with other payers' rates and make care for the uninsured more affordable, several states have capped the rates hospitals can charge uninsured individuals. Although the caps do not establish all-payer rates, they move a step closer to rate equalization. A 2008 New Jersey law, for example, limits to 115 percent of Medicare rates the amount hospitals can bill certain uninsured patients.[12] The cap in Illinois is 135 percent of Medicare rates.[13] Massachusetts now requires hospitals to charge self-payers the same rates as third-party payers.[14] Under a 2005 agreement with Minnesota's attorney general, hospitals give the same discounts as insurance companies to uninsured Minnesota patients with annual family incomes under $125,000. According to a Families USA brief, "This can mean a 40 – 60 percent price reduction in services."[15]

- States are looking not only at the rates uninsured patients pay, but also at the rates they pay for their own programs.
  - Colorado legislation enacted in 2010 (SB 10-020) authorized CoverColorado—the state's high-risk pool for the uninsured—to set its own health provider reim-

bursement rates instead of paying commercial rates. A 2008 report to the Colorado General Assembly noted that the program could save millions of dollars by moving to a fee schedule based on a multiplier of Medicare rates.[16]

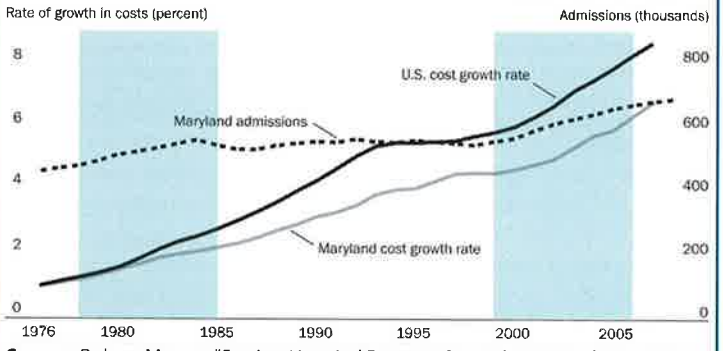
- A February 2010 North Carolina state audit found that, on average, providers of inmate hospital services bill the Department of Correction 4.5 times the applicable Medicare/Medicaid reimbursement rates.[17]

Evidence of Effectiveness

Evidence is mixed but indicates that, properly structured, state all-payer rate setting can slow price increases but not necessarily curb overall cost growth. It also suggests state rate-setting can be administratively complicated, difficult to sustain and, in some cases, politically unpopular. Uniform pricing strategies that allow providers to set all-payer rates are too new to assess their effect on costs.

- Evidence shows Maryland's rate setting program has consistently held hospital cost growth per admission to below the national average (Figure 1). Between 1976 and 2007, Maryland had the second lowest rate of increase in costs per admission in the country. According to the executive director of the Maryland Health Services Cost Review Commission, "Had Maryland costs grown at the national rate from 1976 to 2007, hospital spending would have been cumulatively $40 billion higher than what resulted under rate setting."[18]

Figure 1. Indexed Growth Rates in Hospital Cost Per Adjusted Admission, Maryland and United States, 1976–2007



Source: Robert Murray. "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience." *Health Affairs*, 28, no. 5 (2009); http://content.healthaffairs.org/cgi/content/full/28/5/1395.

Maryland attributes its success controlling per admission costs to several factors. They include the Health Services Review Commission's broad statutory authority that allows flexibility in its approach to cost control; the state's Medicare waiver; and the commission's political, legal and budgetary independence.[19] Although Maryland has slowed per admission cost growth, the same cannot be said for the growth in admissions, outpatient visits or overall spending per capita. In large part this is because, as with other hospital rate setting programs, Maryland does not control admission rates. To address this problem, the Cost Review Commission is instituting pay-for-performance incentives and episode-based hospital rates (discussed in other briefs in this series) to encourage reductions in both hospital use and costs.

- Evidence exists that rate setting can "temper excessive use of cost-increasing technologies" but does not reduce their availability.[20]

- At one time, more than 30 states had hospital rate setting or budget review programs. By 1990, most had been discontinued, and Maryland is the only state that still has a program. Several factors contributed to the dismantling of rate setting programs. Among them were the increased use of managed care to control costs; growing hospital dissatisfaction with the rate-setting process; a public policy shift from a regulatory to a more market-oriented approach to cost control; mixed cost containment results; and the inability to sustain reductions in cost growth over the long term, even in states where efforts were initially successful.[21]

- A 2009 RAND Health report examined the literature on states' experiences with hospital rate setting programs during the 1970s and 1980s.[22] It found mixed evidence of cost savings. Some studies reported as much as a 2 percent annual reduction in hospital spending growth in certain states; most studies found no effect. At least one study suggested rate setting may actually have increased per capita spending in some states. Where cost growth reductions occurred, evidence suggests that, in most cases, it may not have been sustainable.

Challenges

Establishing an effective program of state-determined or provider-set all-payer rates presents a number of challenges.

- Medicaid and Medicare may resist participating. Medicaid programs may be concerned that an all-payer rate program will increase their reimbursement rates. Medicare will not participate unless a state can demonstrate that Medicare's costs will not increase more rapidly under all-payer rates than they would if Medicare did not participate.

- To slow overall cost growth, states need to control not only health care prices but also health care use (i.e., the volume and intensity of health services).

- Where all-payer rates apply to one type of health care provider only (e.g., hospitals), care—and thus the costs of care—may simply be shifted to other providers (e.g., free-standing surgery centers).

- Provider-set all-payer rates will not spur price competition unless there is a place (e.g., a website) where purchasers can compare providers' rates not only for individual services but also for the total cost of care for a condition (e.g., knee replacement surgery).

- State all-payer rate setting programs present additional challenges. Some major challenges are listed below.
  - Setting appropriate rates is difficult. They must be set to avoid incentives for providers to provide too many or too few services and ensure financial viability without paying for inefficient care.
  - Presently, there appears to be little support for a highly regulated rate-setting structure.[23] Instead, the focus is on payment incentives to improve quality and efficiency and on organized systems of care that can manage total patient care costs.
  - The cost to operate a rate-setting system can be substantial. Maryland's hospital rate setting program has 30 staff and a $4.9 million annual operating budget.

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Future Updates

The latest information on this topic is available in an NCSL online supplement at www.ncsl.org/?tabid=19928.

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About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple 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, with Barbara Yondorf as lead researcher.

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Use of Generic Prescription Drugs and Brand-Name Discounts

Prescription Drugs: An Overview

Pharmaceuticals, an integral part of medical treatment, keep patients healthier and extend or save lives. More than half of Americans take prescription drugs regularly. In many situations, proper pharmaceutical use is documented to save money by avoiding costly hospitalization, emergency room use, moving to a nursing home or repeat visits to specialists. Millions of patients with high blood pressure, high cholesterol, chronic pain, arthritis, sleep disorders or mild depression depend on one or two daily pills, for example.

Drugs, both brands and generics, can be the cost-effective choice. The math sometimes may be complex, but savings through use of pharmaceuticals can be irrefutable when compared to other treatments:

- A simple aspirin, costing less than 1 cent, can ward off a first or a second heart attack. After warning symptoms occur, aspirin prevents further damage from small blood clots that have formed. For the long-term, it acts as an anti-inflammatory.
- Heart failure will cost the United States $39.2 billion in 2010, according to the Centers for Disease Control and Prevention. One example of a widely used medication for mild-to-moderate heart attack, Lanoxin® (digoxin), at $20 per 30 day supply, keeps the heart rate slow or well-controlled in most situations.[1]

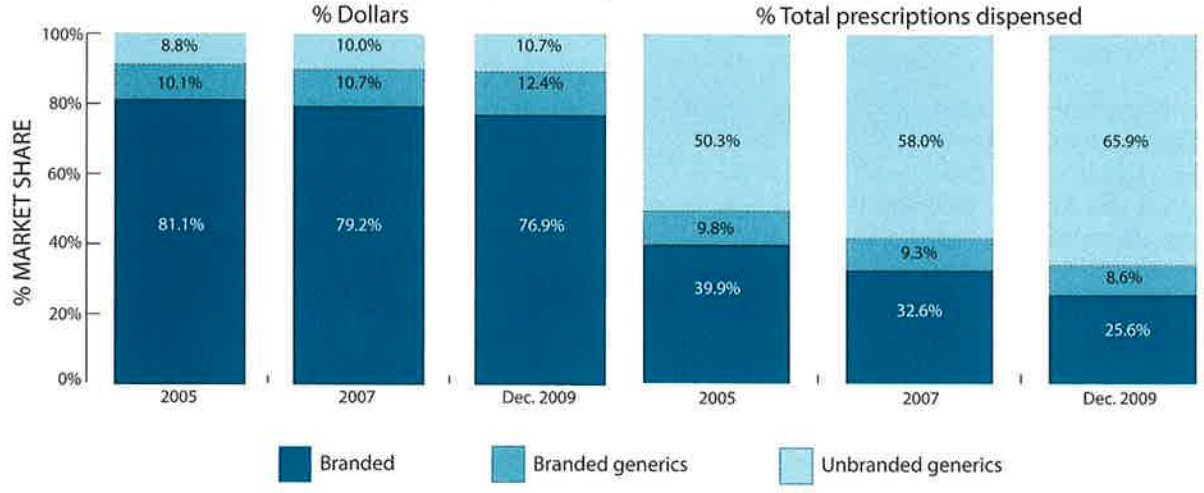
Pharmaceutical use is documented to save money by avoiding costly hospitalization, emergency room use or nursing home placement.

- A leading brand product for depression and obsessive-compulsive disorder costs $100 per 30 pills, or about $1,200 per year.[2] This compares with $4,500 to $8,100 for a typical one-episode stay in a psychiatric hospital.[3] The "return on investment" varies, but combined with the medical and societal benefits, particular drugs are a widely accepted treatment choice for certain patients.
- About 76 million Americans take Lisinopril, to lower blood pressure. It costs $4 to $5 per month, but is rarely advertised or promoted.

Total annual U.S. pharmaceutical purchases were $244 billion in 2008.[4] Although this figure is huge, it represents just over 10 percent of the overall national health expenditure of $2.4 trillion.

Prescription drug policies remain contentious, with strong economic competition between brand-name companies and generic manufacturers. Experts and interest groups also seek

Figure 1. Prescription Drug Sales and Market Shares



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market advantage, including those employed by government agencies, insurers, employer benefit managers, medical societies, consumer advocates, professional associations representing pharmacies, pharmacy benefit managers (PBMs), and the manufacturers and distributors of brand-name, generic, over-the-counter and herbal or vitamin supplements.

Cost Containment Strategy and Logic

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.

Brand-name products include the unique patent-protected products that usually are available only from a single manufacturer.[5] Generic drugs, typically no longer protected by patents, are produced and sold by multiple, competing manufacturers at much lower costs.

Generics. The federal Food and Drug Administration (FDA), which approves all drug products sold legally in the United States certifies the "safety and suitability of generic drugs and encourages their use." All generic drugs must meet the same strict quality guidelines and have exactly the same active ingredients as brand-name drug equivalents.[6]

- In 2007, the average retail price for a generic prescription was $34.34, while the average retail price for a brand-name prescription was $119.51, a 71 percent difference.[7]
- The generic substitution rate in the United States in 2009 was 75 percent; generic medicines accounted for more than 2.6 billion of the approximately 3.9 billion prescriptions dispensed. The total number of generic prescriptions dispensed increased 5.9 percent in 2009, while the number of brand-name prescriptions dispensed declined 7.6 percent.[8] This compares to approximately 1.2 billion brand-name prescriptions dispensed annually in the United States.
- Generic drugs represented 22 cents of every $1 spent on prescription drugs.
- Fifty-two percent of FDA-approved prescription products are available in a generic form.[9]
- According to the PhRMA, "The volume of generic drugs dispensed affirms that formularies and generic substitution are the major forces in determining whether a patient receives a newer brand medicine or an older generic medicine."[10]

Brand-Name Drugs. Approximately 48 percent of prescription products are available only in a brand-name product, most of which are available only from a single manufacturer. The highest-priced medications are brand-names, which means generic drugs are not available for some key medical conditions and categories of patients unless a doctor decides a different form of medication is appropriate. Potentially life-saving drugs—such as the latest anti-depressants, anti-psychotics, and cardiovascular products—often remain predominantly brand-name; their sales total approximately $127 billion annually. Each dose of a leading colon cancer drug, for example, costs $10,000 a month and a lung cancer drug about $8,800 per month.[11] If a physician feels that a brand-name product is beneficial for a patient, he or she may request "brand medically necessary" on the prescription especially prevalent for conditions such as HIV/AIDS, organ transplants and mental illness.

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.

Target of Cost Containment

States already are one of the largest purchasers of prescription drugs, making decisions and signing agreements worth billions each year. Their buying decisions, set by law, contracts and negotiations, are aimed primarily at cost-effective purchasing based on the needs of the patient populations, not on individual patients' benefits or treatment. Large national corporations, including health insurers and pharmaceutical benefit management companies, already vie for the least expensive prices. Patients' access to treatment usually is addressed by separate requirements, such as Medicaid guidelines that require no "medically necessary" prescription drugs be excluded from coverage and through use of simplified prior authorization steps that allow use of "non-preferred" as well as "preferred" drugs.

- Between 2000 and 2005, the annual increase for drug spending was the highest of any health service or product—11.6 percent in 2000 and 10.6 percent in 2005. This annual increase slowed dramatically by 2008 to 3.2 percent. Medicaid prescription drug spending actually decreased by 1.8 percent in 2007; 31 states reported spending less in 2007 than in 2006. The slowdown in costs does not mean the prescription drug market is shrinking or unimportant. It does demonstrate the clearest numerical examples of cost containment within the American health system.
- In late 2009, prescription drug prices were reported to be increasing. For example, Anthem Blue Cross in California claimed it was experiencing 13 percent annual increases for key drug products.[12] AARP reported 9.3 percent increases on several widely used brand products.
- A report by the National Association of Chain Drug Stores states, "Medicaid programs generally have a good generic dispensing rate, but greater savings could be achieved by encouraging or mandating more aggressive prescribing of generics. Most states spend between 7 percent and 8 percent of their Medicaid drug budget on higher-cost brand-

name drugs that have lower-cost generic equivalents."[13] However, states generally provide a good balance of brand-name and generic drug access.

- A 2009 U.S. Government Accountability Office report examining price changes from 2008 to 2009 reported that "lack of therapeutically equivalent drugs and limited competition may contribute to extraordinary price increases."[14]

- A 2010 report released by Express Scripts, one of the largest pharmaceutical benefit management companies, calculated that "potential savings of $18 billion were missed in the commercially insured market alone from use of brand-name drugs instead of chemically or therapeutically equivalent lower cost generics." "Extrapolating to the U.S. population, including those enrolled in Medicare, Medicaid and other public insurance programs, Express Scripts estimated that 'missed saving opportunities' amounted to over $42 billion."[15]

- States also can provide incentive payments to pharmacies and to physicians who promote generic drug use.[16]

The complex U.S. pharmaceutical market includes more than 10,000 distinct FDA-approved medicines. Therefore, large purchasers need systematic programs that are constantly updated to ensure both maximum appropriate savings and the best medical effectiveness.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, significantly increases the federal Medicaid drug rebate on brand-name drugs by 8 percent, from 15.1 percent to 23.1 percent and the generic drug rebate by 2 percent, from 11 percent to 13 percent. The new rebates apply only to the federally paid portion of Medicaid, not the state portion. The law also extends the prescription drug rebate to Medicaid managed care plans, payable to Medicaid programs retroactively, effective Jan. 1, 2010. The Congressional Budget Office calculated that this change would save a total of $420 million in 2011, $710 million in 2012 and $790 million in 2013.[17] Brand drug manufacturers will be responsible for $2.8 billion in added federal excise taxes annually for the 10-year period between 2010 and 2019.[18]

State Examples

- Thirteen states—Florida, Hawaii, Kentucky, Massachusetts, Minnesota, Mississippi, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Washington and West Virginia[19]—and Puerto Rico require licensed pharmacists to dispense the FDA-approved generic equivalent when available. All other states permit, but do not require, licensed pharmacists to dispense the generic equivalent. These state laws generally apply to all patients and all payers.

- In every state, physicians and other licensed prescribers can specifically order the use of a brand by name and block a generic substitution. A group payer—either a public agency or private sector company—can control the reimbursement rules. South Dakota's state employee health plan, for example, pays only the generic price if enrollees choose a brand-name drug that is not "medically necessary" when a generic could be used. The employee will pay the $9 generic copayment plus the difference in cost between the generic drug and brand-name drug.[20]

- In 2006, Washington launched a three-agency joint purchasing project. The three agencies reported "that on average each one percent increase in generic use can decrease pharmacy spending by an equivalent one percent."[21]

- An analysis of annual generic, brand-name and total annual spending in state Medicaid programs showed the following examples of spending and projected savings for the period from July 2008 to June 2009 (Table 1).

- West Virginia law requires substitution of generic drugs when appropriate and further requires that pharmacies pass on to purchasers the entire savings realized from use of generic drugs. In August 2009, the state sued major pharmacies in the state for overcharging retail consumers.[22]

- Under Medicaid, nine states pay a tiered reimbursement to pharmacies as an incentive to dispense generics. Illinois, for example, pays a $4.60 pharmacist dispensing fee for generics and a $3.40 fee for branded products. North Carolina pays $5.60 for generics and $4.60 for branded products.[23]

Table 1. State Medicaid Prescription Drug Use, Cost and Projected Savings*

State Medicaid	Total Rx Scripts (million)	Total Rx Spending ($ in millions)	Brand Average Cost	Brand % Total Dollars	Generic % Total Dollars	Generic Use Savings if 1% Change (state share)
Arkansas	4.5	$359	$172	79%	20%	$1.8 mil.
Connecticut	3.4	$313	$194	79%	20%	$2.8 mil.
Kentucky	9.9	$533	$147	76%	23%	$3.8 mil.
Maine	2.4	$168.	$149	89%	11%	$1.2 mil.
New Jersey	5.4	$547	$203	79%	20%	$4.5 mil.
National Total	289	$23,040	$191	82%	17%	

*Savings figures are a projection based on an assumption of a 1 percent change, not actual savings.
A 50-state version of this information is available online. The column headed "Generic utilization if 1% change (state share)" calculates only the state portion of Medicaid payment, ranging from 50 percent to 24 percent of total costs, and excludes the federal share of savings (FMAP share).
Source: National Association of Chain Drug Stores, *National Brand and Generic Prescription (Rx) Medicaid Drug Utilization and Expenditures by State in 2008Q3 - 2009Q2.*

Non-State Examples

- The U.S. Food and Drug Administration described the financial result of using generics as follows.
  - An IMS National Prescription Audit shows that a typical formulary now charges $6 for generic medications, $29 for preferred branded drugs and $40 or more for non-preferred branded drugs.[24]
  - National chains—including Wal-Mart, Walgreen's, Target, Kroger Supermarkets and others—have established $4 generic pricing for a 30-day supply and $10 for a 90-day supply of several hundred popular drugs. Wal-Mart, for example, reports that it "has provided customers in 10 states with nearly $997 million in savings, if compared to purchasing the brand-name equivalent drugs." When compared to regular pharmacy generic pricing, the savings are far more modest ($2 to $10 per refill) but are significant for some patients. (A complete state-by-state breakdown is available at www.livebetterindex.com.)

Complementary Strategies

For medicines that have no generic equivalent, several other purchasing options exist to reduce overall costs and expand access.

Many states already use a combination of cost containment approaches to control the costs of prescription drugs. Under some global payment programs, pharmaceutical costs are bundled into the payment, creating an incentive for providers to prescribe the more cost effective medicines.

When it comes to price, there is a big difference between generic and brand-name drugs. On average, the cost of a generic drug is 80 percent to 85 percent lower than the brand-name product (before rebates are deducted).

—Source: US FDA, Oct. 13, 2009.

Selecting Brand-Name Products.

- Some brand-name drugs cost less than generics. With discounts and marketing a particular brand product can be obtained for the same or less than a generic. Acknowledging this, several state required generic substitution laws have a blanket exception for products sold at a lower price.
- Some brand-name drugs have proven to be more effective, causing fewer side effects or requiring fewer doses per week. Thus, state-sponsored preferred drug lists almost always include selected brand-name products for "preferred" status.
- Extra discounts agreed to by manufacturers (supplemental rebates) make some products competitive by price, especially in the Medicaid pricing structure.
- The federal 340B Drug pricing program allows 14,500 approved clinics, hospitals and other entities located in all 50 states and the territories to purchase and provide many costly brand-name products at deep discounts, frequently below the established Medicaid price. Regular outpatients of the approved clinics and hospitals are eligible for the 340B prices, including the uninsured and Medicaid or Medicare patients. A leading brand-name cancer drug, for example retails at $6,000 per month (100 percent), while a 340B community health clinic or hospital pharmacy can purchase the same product for $3,060 (51 percent) or less.[25] Some states achieve savings by having some Medicaid enrollees obtain their drugs from the 340B-eligible clinics and pharmacies. (Find more information about using the 340B pricing program online at "States and the 340B Drug Pricing Program," http://www.ncsl.org/default.aspx?tabid=14469.)
- The major brand-name pharmaceutical manufacturers offer free and reduced-cost pharmaceutical assistance programs nationwide, some with state-identified branches. The Partnership for Prescription Assistance (PPA Rx), for example, helps qualifying patients who do not have prescription drug coverage obtain free or low-cost medications, including 2,500 products offered by 200 brand-name manufacturers and 275 other assistance sources. Started in April 2005, PPA and its Help Is Here Express bus tour had helped 6 million patients as of October 2009.[26] Together RX provides a similar nationwide service free or at a discount.[27]

Evidence of Effectiveness

Purchasing generic pharmaceuticals instead of their brand-name equivalent drugs can provide substantial savings, not only for state and local governments and Medicaid programs, but also for health insurers, employers, employees, and direct-pay patients and consumers.

- Among all purchasers, the total cost of using generic pharmaceuticals nationwide was $121 billion less compared to the purchase price of brand-name equivalents.[28] In 2008, for all drugs except specialty products, overall use of brand-name drugs decreased by 10.9 percent, and generic drug use increased by 7.5 percent. As a result, the cost was lowered by 2.3 percent to $12.70 per prescription for these drugs, according to the annual survey conducted by Express Scripts. Decreased brand-name drug use also was influenced by the slowing economy, over-the-counter sales, drug safety concerns and expiring patent protections.[29]
- Massachusetts adopted a mandatory Medicaid generic substitution process in 2002, when its generic use rate was 47 percent. By 2007, it had increased generic use to 70 percent. Total prescription drug spending was $464.9 million, of which approximately 20 percent was spent on generic drugs ($92.8 million). The average cost of the generic drugs dispensed was $17, compared to an average cost of $167 for a prescription filled with a brand-name product in

2007, the latest data reported. Each 1 percent increase in generic drug use generated state savings of $7.4 million.[30]

- Arizona's Medicaid managed care health plans require generic drug use when available. According to Director Anthony Rogers, the overall state agency dispensing rate average for generic drugs is 70 percent. When generic drugs are available, health plans average a 98 percent generic dispensing rate. Arizona has found it is more cost effective to use generic drugs than to use brand-name drugs and receive a rebate.[31]

- New York's Medicaid Mandatory Generic Drug Program, enacted in 2002, requires doctors to prescribe the generic version of a drug unless they obtain prior approval for a brand-name drug. For FY 2008-2009, the state program showed a decrease in use and spending on most products requiring drug review and a 50 percent reduction in total payments for switched drugs. Annual cost reduction was estimated to be $22,918,665.[32]

- Washington's drug discount card program for uninsured residents reported that the average percentage of generic prescriptions was 86 percent as of January 2010, an increase from 81 percent in 2008. The program filled 483,000 prescriptions in its three years of operation, saving card members $19 per prescription—39 percent—and a total of $10,396,000 among 133,000 enrolled residents (as of Jan. 31, 2010).[33]

- Fifty-seven percent of the total nationwide cost reduction from use of generic drugs between 1999 and 2008—totaling some $420 billion—were realized in cardiovascular, psychiatric and neurological disease medications. Generic metabolism and anti-infective drugs combined accounted for an additional 19 percent of the savings. Nationwide, overall reduced cost from use of generic drugs in these five major therapeutic categories totaled approximately $561 billion (an average of $56 billion annually).[34]

Challenges

- Treatment for some of the most serious and costly medical conditions—including life-threatening and chronic diseases—may require prescribing brand-name products because no generic drugs are available for a particular condition.

- With thousands of FDA-approved brand-name and generic drugs available, it is difficult for legislators and other elected policymakers to understand, monitor or play a direct role in an arena where physicians and pharmacists traditionally make all decisions.

- At least two case studies of state prior authorization programs found the programs "can lead to bureaucratic and communication problems among enrollees, providers, and pharmaceutical benefit management firms under contract to the state, which in turn can lead to delays and other problems with prescription drug access."[35, 36]

- Brand-name pharmaceutical manufacturers make a high-visibility, frequently presented case that continued use of brand-name products is good both for patients and the overall economy. They state, "Brand medicines bear the cost of research and development needed to achieve treatment advances and to prove that a new medicine is safe and effective. Over time, these innovative medicines transition to cheaper generics, which piggyback on the brand's research and development."[37]

- People may react differently to medications. A published story of one very ill patient who is denied a particular treatment can lead to reversal of otherwise well-established or scientific-based prescription drug programs.

- People's perceptions of generic drugs can present a challenge. A national survey of a random sample of commercially insured patients with prescription drug coverage found that patient perception of generic drugs generally is positive, When asked whether they "prefer" generics, however, only 38 percent agreed. Few patients reported concern about the safety or side effects of generic drugs, only a minority believe that brand-name drugs are more effective than generics, and most believe that generics are a better "value" than brand-name drugs. As a result, respondents overwhelmingly agreed with the statement, "More Americans should use generics."[38]

For More Information

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Future Updates

The latest information on this topic is available in an NCSL online supplement at www.ncsl.org/?tabid=19934.

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About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple 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, with Barbara Yondorf as lead researcher.

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Health Cost Containment and Efficiencies
NCSL Briefs for State Legislators
No. 9 June 2010

Prescription Drug Agreements and Volume Purchasing

Preferred Lists, Rebates, Multi-State Purchasing and Effectiveness Review of Medicine

Cost Containment Strategy and Logic

Medicaid programs spent at least $24 billion to purchase prescription drugs in 2009. Many states now use a combination of approaches to control the cost of prescription drugs. States typically draw from a menu of four purchasing options that feature negotiation, evaluation and volume buying:

1. Expanded use of preferred drug lists,
2. Expanded use of manufacturer price rebates,
3. Multistate purchasing and negotiations, and
4. Use of scientific studies on comparative effectiveness of products.[1]

Expanded use of preferred drug lists (PDLs). Preferred drug lists provide a consistent method for public programs—such as Medicaid, public employee benefits or state-only subsidy programs—to define which prescription products are covered automatically by insurance or benefit programs as "preferred" and which other products for the same medical conditions are "non-preferred." The non-preferred drugs often require an extra approval step or a higher patient copayment. In the public sector, the lists are developed by publicly designated committees, using medical research to judge the effectiveness of drugs and, in some cases, their cost effectiveness. One goal is to encourage physicians to increase the use of preferred drugs. While 45 states already use PDLs, about half have "carved out" or protected, from PDLs, entire classes of medical conditions such as mental health, HIV/AIDS and cancer. Because many of these drugs have high per-patient costs, several states have recently expanded PDL requirements to allow evaluation of products to treat these diseases and conditions.

Expanded use of manufacturer price "supplemental rebates." All Medicaid programs receive a basic, standardized rebate from drug manufacturers for both brand-name and generic products. As of 2003, however, states can directly negotiate with pharmaceutical manufacturers and companies classified as drug relabelers for additional or "supplemental" Medicaid rebates. These extra state rebates often are applied to brand-name "preferred products" because of their generally higher sales volume. Although the state supplemental and federal unit rebate amounts are confidential and cannot be disclosed, they can be as high as 25 percent above the basic federal rebate, reducing state costs by tens of millions of dollars. In 2005, for example, 30 states reported collecting a total additional $1.3 billion in state supplemental rebates.

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 (savings to states nationwide average $1.8 billion annually).

Multi-state purchasing and negotiations. Twenty-seven state Medicaid programs have voluntarily joined a multi-state "buying pool," primarily as a cost containment and efficiency strategy that influences buying and bargaining power with manufacturers. In Louisiana, New York and Washington, Medicaid has pooled administrative efforts with other in-state agencies such as public employee and workers' compensation programs.

Use of scientific-based comparative effectiveness evaluation for product selection. Several states have formally combined resources as members of the Drug Effectiveness Review Project (DERP), housed in Oregon.[2] Reviewers comb through drug studies to help policymakers purchase the most effective—sometimes less expensive—medicines. Member states pay approximately $75,000 per year for three years to fund the research and access project findings. The project's published "head-to-head comparisons" of medicines are based on science, not spending; however, states use the results to manage parts of their annual drug budgets. Non-member states can examine or apply the research results without paying to become partners.[3,4]

Target of Cost Containment

All four purchasing approaches are designed to help state government public-sector programs operate more efficiently and cost effectively. They aim to reduce overall state spending, but not deny coverage or services to individual patients. Some approaches, such as multi-agency buying or multi-state PDLs, can be shared with other large purchasers such as local governments or private employers. In some cases, savings can be passed indirectly to individual patients in the form of reduced copayments or coinsurance (Table 1).

Table 1. Percentage of Total National Prescription Drug Expenditures by Type of Payer, 2002-2010					
Type of Payer	**2002**	**2004**	**2006**	**2008**	**2010**
Public funds	25%	28%	34%	37%	40.2%
Private health Insurance	50	48	44	42	40.2
Consumer out-of-pocket	26	25	22	21	19.6

Source: CMS Office of the Actuary, *National Health Expenditures*, January 2010; 2010 figures are projections.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 2010, includes significant financial changes to Medicaid prescription drug rebate policy. As a result, every state will need to recalculate costs, savings and purchasing arrangements for current and upcoming fiscal years. The new law:

- Increases by 8 percent (to a total of 23.1 percent of average manufacturer price [AMP]) only the federal portion of manufacturer rebates for brand-name covered outpatient drugs in Medicaid.
- For brand drugs approved exclusively for pediatric use or for clotting factors, minimum rebates increase to 17.1 percent of AMP.
- Manufacturers of generic drugs used by outpatients are subject to a 2 percent increase (to a total of 13.1 percent of AMP) in required rebates.
- Also, for the first time, the federal law extends the prescription drug rebates to outpatient drugs dispensed to enrollees of Medicaid managed care organizations (Sections 1206 and 2501).

The changes, retroactive to Jan. 1, 2010, will generate more revenue for Medicaid nationwide. The Congressional Budget Office calculated that requiring rebates on drugs used in managed care settings would save a total of $420 million in 2011, $710 million in 2012 and $790 million in 2013[5] With about 33 million (or 71 percent) of the overall Medicaid population enrolled in managed care arrangements, the new application of manufacturer rebates required to be paid to each Medicaid program for their managed care population will be a significant net savings or cost reduction for most states. However, the state Medicaid share of revenue from existing state-negotiated supplemental rebates will be reduced; exact amounts have not yet been determined and are subject to future negotiations with manufacturers.

Comparative Effectiveness Review (CER). While the Drug Effectiveness Review Project (DERP) has operated under state jurisdiction since 2003, federal health reform included a new provision titled "Patient-Centered Outcomes Research." It includes are variety of medical practices beyond pharmaceuticals and emphasizes that informing patients and clinicians is an important focus of CER. Furthermore the legislation stipulates that findings from CER cannot, by themselves, determine Medicare coverage policy. Controversy still exists about the role of federally-funded research findings and expert conclusions in narrowing patient care options. These future federal efforts are beyond the scope of the information in this report.

State Examples

- At least 45 states have implemented one or more of these strategies. Table 2 (page 4) indicates combinations of strategies that are applicable to Medicaid and other state purchasing programs.
- As of mid-2010, three multi-state Medicaid bulk buying pools and one state-based pool were operating (see below). Each uses common preferred drug lists and obtains supplemental rebates from manufacturers. All lists include selected brand-name products. Use of generics is emphasized but not required for some conditions. Patient treatment decisions remain in the hands of physicians and state agency pharmacy officials.
- Nationwide, Medicaid buying pools included states with about 32 percent of enrolled beneficiaries (18 million) and 38 percent of the nation's Medicaid pharmaceuticals spending.[6] The pools include:
  - The "National Medicaid Pooling Initiative" (NMPI) started in 2003 and serves 11 states.
  - Top Dollar Program (TOP$)[SM] was started by Provider Synergies and serves seven states.
  - The Sovereign States Drug Consortium (SSDC) is a seven-state nonprofit structure; 100 percent of all supplemental rebate revenues are returned to member states. Vermont currently hosts program administration.
- The Northwest Prescription Drug Consortium (NPDC), started in 2007, combines non-Medicaid state pharmaceutical programs in Oregon and Washington.
- Medicaid directors report that a "significant majority of states impose prior authorization on certain drugs. Only 3.4 percent of Medicaid prescription drug claims required prior authorization." This means 96.6 percent of patient prescriptions did not require such authorization. Those that do account "for 7.5 percent of total Medicaid prescription drug spending."[7]

Non-State Examples

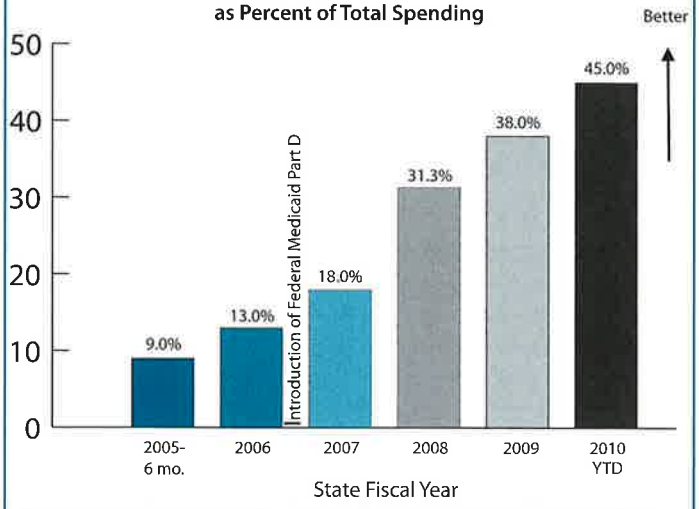
Several peer-reviewed studies that consider the effectiveness of formularies focus on incentives such as prior authorization or charging a higher or "tiered" copayment for brand-name drugs "used to steer utilization to drugs" on the lists. For example, Medco Health claimed an 11 percent savings in a 2005 *Health Affairs* article.[8]

Evidence of Effectiveness

The combined use of preferred drug lists, supplemental rebates, selected prior authorization for non-preferred drugs and multi-state purchasing arrangements is saving some states an estimated 8 percent to 12 percent on overall Medicaid drug purchases. States also report savings in state-only non-Medicaid programs. In most cases, the savings represent only state money and are ongoing over several years. Specific examples include the following.

- Iowa Medicaid reported saving "nearly $100 million in state dollars over four years after implementing a PDL in 2005; an average of 21 percent of the drug budget." The use of supplemental rebates has yielded more than $37 million annually (Figure 1).[9]

Figure 1. Iowa Medicaid Prescription Drug Savings as Percent of Total Spending



Source: Iowa Department of Human Services, Medicaid (quarters are cumulative, April 8, 2010.

- For FY 2009, the seven states in the Sovereign States Drug Consortium represented 1.2 million eligible Medicaid patients and more than $1.3 billion in state expenditures. Iowa's share of savings was "nearly $35 million."[10]

- Texas Medicaid estimated that its PDL resulted in savings of 6.6 percent ($116 million) in FY 2007, up from $108 million in FY 2006. The 59 drug classes on the Medicaid PDL represent approximately 68 percent of all Medicaid pharmacy expenditures, which totaled $1.76 billion in FY 2007.[11]

- Georgia's Department of Community Health in 2008 calculated it saved at least $20 million a year because doctors gave patients a different, lower-cost drug after seeking prior approval.[12]

- Vermont reported that, for FY 2008, the state received an additional 4.7 percent ($5.3 million) in state-negotiated supplemental rebates, using the Sovereign States Drug Consortium and the Vermont PDL. That amount was in addition to the standard federal Medicaid formula rebate, based on an $112.4 million pharmaceutical budget.

- Utah's Medicaid PDL, in its first year (2008), reduced spending by $546,000. Savings fell short of original estimates, however, because the initial law allowed physicians to write "dispense as written" on prescriptions without authorization, thereby eliminating a pharmacist's discretion to substitute generic products. In 2009, the law was expanded to include all drug classes; this is expected to reduce Medicaid drug spending by more than $1 million by 2010.[13]

- New York documented Medicaid savings on prescription drugs of $82.5 million for 2007. Of the savings, $80.5 million were the result of multi-state negotiated supplemental rebates. The remaining savings, $1.95 million, were due to a shift in use from more expensive non-preferred drugs to less expensive preferred drugs for a given medical treatment. Use of preferred ACE Inhibitors (for controlling blood pressure), for example, increased from 72 percent to 98 percent, and the market share for preferred beta blockers increased from 54 percent to 84 percent. [14,15]

- Indiana saved approximately $29.81 million through Sept. 30, 2007, based on cumulative estimated savings from the Medicaid PDL. Supplemental rebate savings after five years of operation totaled an additional $31.54 million.[16]

- In 2006, Washington launched a "joint purchasing project" for three agencies: the Medicaid, workers' compensation and state employee health plan programs. All three agencies agreed that, "on average each one percent increase in generic fill rate can decrease pharmacy spending by an equivalent one percent." Within the first two years of PDL program implementation, state officials reported savings of $20 million to $24 million annually in fiscal years 2005 through 2007. The results represent savings of about 5 percent of prescription drugs costs. The Medicaid fee-for-service program alone saved $13.7 million in 2006.[17]

- The federal Centers for Medicare and Medicaid Services have supported state-created PDLs and multi-state pooling, stating that "these pooling plans will help lower drug costs for the states involved."[18]

- Officials at the Veteran's Administration "use Drug Effectiveness Review Project reviews to inform decisions about drug coverage." The federal Agency for Healthcare Research and Quality (AHRQ) funds DERP's parent organization to assist in "stakeholder outreach."[19]

KEY: Multi-State Definitions

DER = Drug Effectiveness Review Project
DER# = Former member in '06 to '09
MED = Medicaid Evidence-based Decisions Project
NMPI = National Medicaid Pooling
##= Former member of pool
NWDC = Northwest Rx Consortium
SSDC = Sovereign States Drug Con.
TOP$ = Top Dollar Rx Purchasing

Exempt Conditions

CAN = Cancer treatment drugs
Hep-C = Hepatitis drugs
IMM = Immunosuppressive drugs (v)
HIV = HIV and AIDS drugs
MH = Mental health treatment drugs

Notes:
Not all features may be in operation in individual states
(i) Arizona uses a capitated managed care payment structure for almost all Medicaid enrollees and therefore does not pay for individual prescription drugs. Virtually all the Medicaid managed care companies use a preferred drug list.
(ii) New York's FY'10 budget discontinues participation in the National Medicaid Pooling Initiative, "allowing the state to negotiate supplemental rebates directly with manufacturers."
(iii) North Carolina launched a PDL and joined NMPI in April 2010.
(iv) Wisconsin's PDL includes Senior Care pharmaceutical assistance program and Badger Care children's health program.
(v) Immunosuppresives are used to inhibit or prevent activity of the immune system to treat conditions including arthritis, MS, lupus and organ transplants.

Table 2. State Prescription Drug Cost and Efficiency Strategies

State/ Jurisdiction	PDL-Medicaid Date Started	Examples of Exempt Conditions	PDL-State-Only Programs	State-Negotiated Supplemental Rebate	Multi-State Pool	Comparative Effectiveness Reviews
Alabama	✓ '03	MH/HIV		✓ '03		✓ MED
Alaska	✓ '04			✓ '04	✓ NMPI	✓ DER #, MED
Arkansas	✓ '04			✓ '04	✓ NMPI##	✓ DER, MED
Arizona	✓ (i)					
California	✓ '88	HIV/CAN		✓ '88		✓ DER #
Colorado	✓ '07	MH/HIV/CAN		✓ '08		✓ DER
Connecticut	✓ '02	MH/HIV	✓	✓ '04		
Delaware	✓ '05			✓ '05	✓ TOP$	
Florida	✓ '01	MH/HIV/CAN		✓ '01		
Georgia	✓	MH/	✓	✓ '09	✓ NMPI##	
Hawaii	✓ '04	MH/ HIV/ Hep-C/ IMM		✓ '04	✓ NMPI##	
Idaho	✓ '05			✓ '03	✓ TOP$	✓
Illinois	✓ '02	MH/HIV	✓	✓ '02		
Indiana	✓ '02	MH/	✓ CHIP	✓ '04		
Iowa	✓ '03	MH/HIV/CAN		✓ '04	✓ SSDC	
Kansas	✓ '02	MH/CAN		✓ '02		✓ DER #
Kentucky	✓ '02			✓ '04	✓ NMPI	
Louisiana	✓ '00	MH/HIV/CAN	✓ agencies	✓ '02	✓ TOP$	
Maine	✓ '00	MH	✓	✓ '03	✓ SSDC	
Maryland	✓ '03			✓ '03	✓ TOP$	✓ DER
Massachusetts	✓ '02	MH		✓ '04		
Michigan	✓ '01	MH	✓	✓ '03	✓ NMPI	✓ DER #
Minnesota	✓ '02			✓ '04	✓ NMPI	✓ DER #, MED
Mississippi	✓ '04	MH		✓ '06		
Missouri	✓ '02			✓ '04		✓ DER, MED
Montana	✓ '06			✓ '04	✓ NMPI	✓ DER
Nebraska	✓			✓ '09	✓ TOP$	
Nevada	✓ '03	MH/HIV		✓ '04	✓ NMPI	
New Hampshire	✓ '02			✓ '04	✓ NMPI	
New Jersey						
New Mexico	✓ Y '02			✓ '02		
New York	✓ Y '05	MH/HIV	✓ agencies	✓ '06	✓ NMPI (ii)	✓ DER, MED
North Carolina	✓ '10 (iii)			✓ '10	✓ NMPI	DER #
North Dakota						
Ohio		MH/HIV		✓ '03		
Oklahoma				✓ '03		✓ MED
Oregon	✓ '01	MH/HIV/CAN	✓	✓ '09	✓ SSDC, NWDC	✓ DER, MED
Pennsylvania	✓ '06			✓ '05	✓ TOP$	
Rhode Island				✓ '07	✓ NMPI	
South Carolina	✓ '04		✓ '05	✓ '07	✓ NMPI	
South Dakota			✓			
Tennessee	✓ '03		✓	✓ '03	✓ NMPI##	
Texas	✓ '03		✓	✓ '03		
Utah	✓ '07	MH, IMM	✓	✓ '07	✓ SSDC	
Vermont	✓ '01	MH case-by-case	✓ [all]	✓ '06	✓ SSDC	
Virginia	✓ '04		✓	✓ '04		
Washington	✓ '01	MH/HIV/CAN	✓ '03	✓ '02	✓ NWDC	✓ DER, MED
West Virginia	✓ '02	MH	✓	✓ '02	✓ SSDC	✓ MED
Wisconsin	✓ '03		✓ (iv)	✓ '05	✓ TOP$	✓ DER, MED
Wyoming	✓ '03			✓ '08	✓ SSDC	✓ DER
District of Columbia	✓			✓	✓ NMPI	

Sources: NCSL research, 2009, 2010; NASMD; National Association of Chain Drug Stores; CMS Medicaid Pharmacy Supplemental Rebate Agreements, March 2010.

Complementary Strategies

- **Prescriber Education Programs.** At least six states have established prescriber education programs or "academic detailing" initiatives to distribute scientific and clinical data about the effectiveness and costs of pharmaceuticals and medical devices. Programs operate in Maine, Massachusetts, New York, Pennsylvania, South Carolina, Vermont and the District of Columbia; pilot programs are under way in Idaho and Oregon. Pennsylvania's Independent Drug Information Services program is the largest, operating as a partnership between the state and Harvard Medical School. Under the program, state-employed pharmacy experts visit prescribers to explain the range of products, comparative patient results and pricing. Medicaid, public employee health benefits and the state-subsidized pharmaceuticals program (PACE) for seniors and people with disabilities use the program. Studies of existing state programs indicate that every $1 invested in these programs results in a $2 return on investment.[20] A 2010 analysis of the programs notes that states with a preferred drug list and a prescriber education program should coordinate to ensure that their preferred drug list and the evidence-based recommendations of the prescriber education program are in line.[21]

- **Step Therapy.** Some major purchasers, including commercial insurers and Medicaid programs, have imposed a strategy to shift patients to alternative prescription drugs, requiring an enrollee to try one drug before the plan will pay for another drug. Step therapy (and Fail First requirements) aims to control costs by requiring that enrollees use more common drugs that usually are less expensive. Progression to a new medication is based upon failure of the former medication to provide symptomatic relief or cure—hence "fail first." Step therapy currently is used in approximately 28 percent of employer programs, in all 50 state Medicaid programs and in many Medicare Part D programs. Cost containment results depend upon the individual products and treatment categories subject to step therapy.

Challenges to Cost Containment

- Medicaid programs generally are required to cover the costs of "all medically necessary" prescription drugs; treating physicians have the final say more than 90 percent of the time.

- One national consumer advocacy organization concludes that "many PDLs are ineffective. PDL committees may be biased by inaccurate information, or prescribing rules may not be properly enforced."[22]

- A study by the National Pharmaceutical Council of preferred-drug lists in 47 Medicaid programs concluded, "Savings in the drug budget appear to be completely offset by increased expenditures elsewhere in the system."[23] Another industry-funded study concluded, "A comprehensive review of the research found that the preponderance of studies showed an actual *increase* in overall health-care costs."[24]

- State supplemental rebates on brand-name drugs can have the unintended effect of lowering rates of generic use in many Medicaid programs below that of private insurers.

- Supplemental rebates can be available from and negotiated with generic drug manufacturers, but are less commonly used by some states.

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Future Updates

The latest information on this topic, including major changes in Medicaid manufacturer rebates for 2010 and beyond, is available in an NCSL online supplement at www.ncsl.org/?tabid=19934.

Notes

1. A companion brief, *Use of Generic Prescription Drugs and Brand Name Discounts*, addresses the related strategies of brand-name and generic prescription drug use.

2. The Drug Effectiveness Review Project (DERP) members as of June 2010 include Arkansas, Colorado, Idaho, Maryland, Missouri, Montana, New York, Oregon, Washington, Wisconsin and Wyoming. Other recent members were Kansas ('09), Maryland ('09), Michigan ('08), Minnesota ('08) and North Carolina ('08).

3. DERP is a nonprofit multi-state project of the Oregon Evidence-Based Practice Center *Project* headed by former Oregon governor John Kitzhaber. It provides reports but does not purchase prescription drugs.

4. In 2006, 38 states reported that drug comparative effectiveness reviews (CERs) are useful when developing Medicaid pharmacy policy. This includes 12 of the 15 states participating in the Drug Effectiveness Review Project.

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6. Not every product is purchased through the multi-state pools—certain specialty and rarely used drugs may be exempt. Managed care contracts may also include drugs purchased through large or multi-state private insurance contracts.

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12. "Augusta News," *The Augusta Chronicle*, Sept. 5, 2008; http://chronicle.augusta.com/stories/090508/met_472033.shtml.

13. Advisory Board Company and Kaiser Family Foundation, "Utah Preferred Prescription Drug List Savings Less Than Projected," *Medical News Today*; www.medicalnewstoday.com/articles/122282.php.

14. According to the 2007 New York Medicaid Annual Report of the drugs subject to the PDP, 97.7 percent of claims were for preferred drugs that did not require prior authorization (Appendix 9). This extremely high percentage is attributable to the wide selection of preferred drugs within a class, prescriber familiarity with PDLs used by other insurance programs and prescriber awareness of the Medicaid PDP. The remaining 2.3 percent (105,286 claims) were for non-preferred drugs that required prior authorization. These claim counts include both the initial prescription and refills, which do not require another prior authorization so the number of claims is greater than the number of PA requests. Of the total PA requests, 20.3 percent were for beta blockers used primarily for cardiovascular indications, 17.7 percent were for antihistamines used to treat allergies and 16.7 percent were for long acting narcotics used to treat moderate to severe pain. All other classes comprised 14percent or less of the total number of PA requests. When prescribers were asked why they were ordering a non-preferred drug, they most often cited contraindications preventing transition of a patient to a preferred drug, patient specific adverse reactions to the preferred drug and prescriber preference. In 2.8 percent of calls, the prescriber agreed to change the prescription to the preferred drug after consultation with CCC staff.

15. New York Department of Health, *Medicaid: Letter to Pharmacy Providers* (New York: NYDH, Aug. 1, 2008); http://www.emedny.org/info/newsletter/Pharmacy_Provider_Letter_Signed.pdf.

16. Savings do not count federal rebates and are calculated before administrative costs are deducted. Felice R. Slaughter and Mark Sutcliffe, "Evaluation of the Indiana Medicaid Preferred Drug List (PDL) Program," no.8 (Indianapolis: ACS Health Management Solutions, July 18, 2008).

17. Ray Hanley, interview with author, Jan. 8, 2009, and C. Silow-Carroll, et al., *States in Action: A Quarterly Look at Innovations in Health Policy* (New York: The Commonwealth Fund, Spring 2006); http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=362631&#washington.

18. U.S. Department of Health and Human Services, "HHS News Release," May 27, 2005.

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Pooling Public Employee Health Care

Cost Containment Strategy and Logic

Pooled public employee health benefit programs refer to efforts to merge or combine state employee health insurance with that of other public agencies and programs. About half the states have opened participation in their state employee health benefit plans to other public-sector employers, such as school districts or cities and counties. Two states have piloted programs to allow private sector employers to join their state employee pools.

Some public purchasers regularly try to lower overall administrative costs and negotiate lower prices from providers and insurers using their large numbers of enrollees as a bargaining tool. Health costs are controlled by using size, volume purchases and professional expertise to:

- Minimize and combine administrative and marketing costs;
- Facilitate negotiations with health insurers for more favorable premium rates and broader benefit packages; and
- Relieve individual employers of the burden of choosing plans and negotiating coverage and payment details.

In addition to cost containment and simplification, multi-agency purchasing arrangements also can give employees more choices of health benefit plans. This option often is not available if each smaller agency were to obtain coverage independently.[1]

Small public employer groups often benefit the most from purchasing pools and alliances. As Figure 1 illustrates, the larger the employer group, the lower the percentage of the health premium devoted to administrative costs versus medical care payments.

Target of Cost Containment

Small and medium-sized employers are at a decided disadvantage compared to the much larger state governments. Smaller groups that join existing state pools or join to form a purchasing alliance may be able to obtain coverage at a lower cost than if they purchased it through the open market. Proponents of public employer health purchasing pools note that small local governments and local public entities (fire districts or school districts, for example) often lack the volume and personnel expertise to obtain favorable rates.

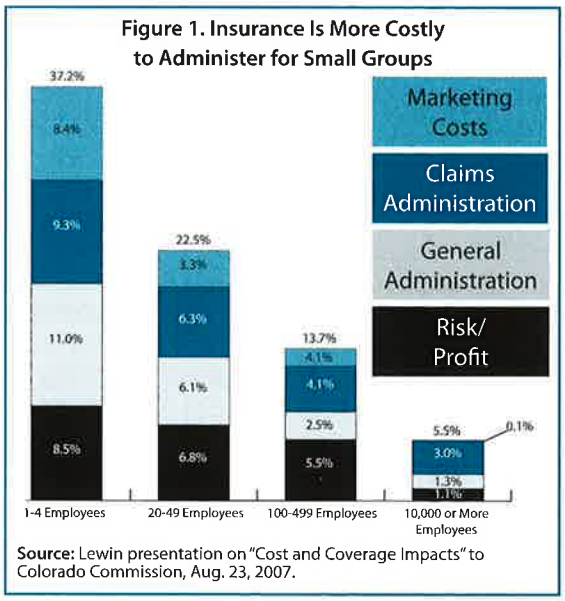
In the past three years, for example, policy leaders in Connecticut, Michigan, New Jersey and Washington have sought to create large-scale health insurance employee pools as a major element of health cost containment.

Combining small employer groups into large state employee pools can save up to 15 percent in administrative costs for small employers that join. Direct savings by states is not widely documented.

State employee health benefit programs already command a significant and relatively stable segment of the health insurance market; several benefit programs are the largest employers in their states. The programs have high-level, qualified personnel managers and negotiators and can take advantage of their size and expertise to negotiate rates and work with multiple insurers. The combined state-plus-local pooled programs can also use their large enrolled population to negotiate establishing innovative health programs such as wellness and prevention, tobacco cessation plans, electronic health records and provider incentive copayments. These prevention and modernization programs also aim to contain health costs, leading to an ideal of dual or multiple savings within the pooled programs.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 2010, includes several new federal insurance rules that take effect starting in October 2010 or later, at the start of an ex-



isting insurance plan year. The rules include prohibiting insurers from imposing lifetime limits on benefits and restrictions on the use of annual limits. Unmarried children will be able to remain on their parents' health plan until they reach age 26. Existing public employer plans can seek "grandfathered" plan status, which locks in certain benefits and out-of-pocket charges. Creation of health exchanges by 2014 also may affect public employee health plans. Because states have special status as employers, there are legal issues that affect which federal reform provisions apply to state government. Future information and guidance will be posted online by NCSL (http://www.ncsl.org/?tabid=19932).

State Examples

At least 24 states currently authorize other public employees to combine with state employees and retirees to create a larger insurance pool (Table 1). Of these, 11 states pool all members for health status or "rating" to spread premium costs among all or most employers and employees. Local public employer participation is optional in all but two states. In practice, some municipalities or local agencies join, while others choose to find their own coverage. California, Louisiana, New Jersey, New Mexico, North Carolina, South Carolina, Utah, Washington and West Virginia have substantial combined enrollment, adding 20 percent or more of local workers to the pooled total.

Table 1. State Employee Health Plans that Include Local Governments

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

R = State and local government employees are pooled for insurance premium rating purposes.
Sources: NCSL research (2007-2010); Connecticut Office of Legal Research (2008).

California attributes $40 million in annual premium savings for the overall plan to local participation.

- California: The California Public Employees' Retirement System (CalPERS) provides both health and retiree benefit services and manages health benefits for nearly 1.3 million members. Thirty-one percent of enrollees are state employees, 38 percent are school employees and 31 percent are local public agency employees. CalPERS reported that "local participation greatly increases the state's buying power."[2]

- New Jersey: Although local participation is optional, about 50 percent of the state plan's 780,000 enrolled members work for municipal employers.

- West Virginia: West Virginia's Public Employees Insurance Agency (PEIA), which covers both local jurisdictions and state employees,[3] has a public/private partnership with insurance companies that choose to offer the plan. Results are described below under "Evidence of Effectiveness."

State Proposals not Enacted

- In 2009-10, Michigan House leaders proposed a comprehensive multi-agency pooled plan aimed at covering all local and school public employees. The Michigan House published *An In-Depth Look at the Michigan Health Benefits Program* in September 2009 as part of an evaluation of the benefits and cost savings of pooling all public employees into a single program. The report indicated an estimated potential annual savings of $200 million due to pooling and further savings from quality initiatives.

- Connecticut's Health Partnership Act (House Bill 5536), passed in 2008 and 2009 but vetoed twice by the governor, would have allowed municipalities, certain municipal service contractors, nonprofit organizations and small businesses to provide coverage for their employees and retirees by joining the state employee health insurance plan. With consent of the State Employees' Bargaining Agent Coalition, all new employees would have been pooled with state employees in the state insurance. The act would have required the agency to provide insurance for employers that seek to cover all their employees or retirees.[4] Program features would have been similar to those for Medicaid and children's health "HUSKY" enrollees.

Evidence of Effectiveness

It is not clear whether purchasing pools have slowed the growth in premium costs overall; the evidence is mixed. It appears that including small employer groups in large state employee pools may benefit the small employers that join.

A 2008 study by the Lewin Group noted, "Given that state governments are typically the largest employer group in any given state, state employee health plans (SEHPs) are responsible for a

large volume of health care purchasing. This can yield considerable influence in negotiations with participating health plans and provider groups, in terms of encouraging their participation in quality improvement, cost containment, and related initiatives. In addition, SEHPs may be in a position to combine their quality improvement activities and strategies with other large public and private sector purchasers, including Medicaid, other public programs, and private health plans and employer groups. The combined market leverage of such coalitions can enhance SEHPs' purchasing advantage and help to coordinate state-level quality promotion activities."[5]

- Some documented evidence shows modest and, in at least one case, substantial cost savings to small and medium employers by combining a large number of in-state agencies and entities into a single administrative and insurance purchasing pool covering from 100,000 to 1.6 million enrollees.

- In 42 states, the state pool is "self-insured," which can save between 5 percent and 6 percent in administrative costs, compared to benefits that are fully insured through outside companies. A better negotiating position sometimes can result in modestly better benefits (such as a lower office visit copayment), although most states have not seen lower premium costs.

- California evaluated how local government membership in the state program affects costs. California Public Employees Retirement System (CalPERS) officials indicate that adding 490,000 local government employees reduced the state plan's annual premium costs by approximately $40 million per year.

- The West Virginia Public Employee Insurance Agency (PEIA) sets its own provider reimbursement rates, which are approximately 20 percent to 25 percent lower than private market rates. The program's total administrative expenses were 5 percent for FY 2008; medical and pharmaceutical expenses represented 95 percent of total expense. A non-pooled town or district with 200 employees would expect to pay administrative costs of 12 percent to13 percent. The savings apply to 602 local and regional public agencies with a total of 52,000 employees plus other dependents.

- West Virginia also created a Small Business Plan. According to its 2010 website, "Participating insurance carriers use PEIA payment rates for doctors and other health care providers; this is the key to making Small Business Plan premium rates lower than standard rates, typically ranging between 17 percent and 22 percent less than regular small business rates;" however, they caution, "rates and discounts will depend on the profile of each small business."

- Utah's Public Employee Health Plan (PEHP) includes approximately 52 percent of eligible local governments, including service districts, counties and public schools; the fact that they joined voluntarily indicates favorable terms and savings.[6]

- Massachusetts enacted legislation in 2007 that allowed all municipalities to combine with state workers to purchase insurance. Statewide savings of $225 million were estimated by FY 2010 and of $750 million by FY 2013. As of August 2009, however, only 17 of 351 towns were participating. Savings statewide have not yet been documented.

- South Carolina law requires state employees and retirees plus public school districts and public colleges and universities to obtain coverage through the state health plan; as a result nearly 10 percent of the state's population is covered by the plan.

- North Carolina is the largest example of mandatory combined local and state participation, covering 667,000 state and local employees and retirees.

Complementary Strategies

- Several states have created a combined health care purchasing agency that includes Medicaid, state employees and other agencies. Examples include the Kansas Health Policy Authority in 2005, the Oklahoma Health Care Authority in 1993 and the Georgia Department of Community Health. Although state and local employees are not "pooled" with Medicaid, the joint administration under one management structure results in "combining the state's purchasing power."[7]

- Some state employee programs have become leaders in demanding quality and efficiency in purchasing insurance. Examples of state plan innovations include promoting provider adherence to clinical guidelines and best practices, publicly disseminating provider performance information, implementing performance-based incentives, developing coordinated care interventions, and participating in multi-payer quality coalitions.[8]

- Louisiana, South Carolina and Washington review the claims history of local entities that seek to join with state employee programs and, if the risk history is higher than the existing pool, the new local member is charged a higher rate (usually for a limited period) to cover the risk. Although this approach is a cost shift, not savings, it illustrates how states can protect against higher charges.[9]

Challenges

- Lower-than-expected participation rates by local governments were examined in a nationwide analysis in 2008. The results pointed to a number of reasons, including:
  - Local governments had other affordable coverage options;
  - State plan requirements made it difficult for some local governments to join;

- Some municipalities would rather have a less comprehensive (and less expensive) plan than that offered by the state;
- Some local governments prefer keeping local control of their health plans; and
- One state placed a moratorium on new members.[10]

- Existing state employer programs may be concerned that having local agencies as members could result in "adverse selection" that could lead to higher premiums if employees are older or sicker than original pool members.

- Traditions of local autonomy and collective bargaining can mean less willingness to change or opposition to formation of multi-employer pools.[11]

For More Information

Cauchi, Richard. *State Employee Health Benefits*. Denver: NCSL, 2010.

Commonwealth Fund. "What Public Employee Health Plans Can Do to Improve Health Care Quality: Examples from the States." Washington, D.C.: Commonwealth Fund, 2008; http://www.commonwealthfund.org/usr_doc/McKethan_whatpublicemployeehltplanscando_1097.pdf?section=4039.

Connecticut Office of Legislative Research. "Impact of Pooling State and Local Employee Health Insurance In Other States." Hartford: Connecticut Office of Legislative Research, Aug. 29, 2008; http://www.cga.ct.gov/2008/rpt/2008-R-0463.htm.

NCSL will post supplemental materials and 2010 updates on this topic online at http://www.ncsl.org/?tabid=19932.

Notes

1. Another type of multi-employer purchasing arrangement is the state purchasing alliances for small business employers. These are discussed in another NCSL publication: Richard Cauchi, *Purchasing Alliances and Cooperatives for State Health Insurance* (Denver: National Conference of State Legislatures, Nov. 12, 2009); http://www.ncsl.org/default.aspx?tabid=18905.

2. Connecticut Office of Legislative Research, *Impact of Pooling State and Local Employee Health Insurance in Other States* (Hartford: Connecticut Office of Legislative Research, Aug. 29, 2008); http://www.cga.ct.gov/2008/rpt/2008-R-0463.htm.

3. As of mid- June 2008, West Virginia PEIA provided health coverage to 119 state agency divisions with approximately 21,000 primary participants (not including dependents), 55 county school boards with approximately 32,000 primary participants, 524 local government entities with approximately 10,000 primary participants, and 23 college and university entities with approximately 10,000 primary participants. Approximately 88,000 dependents also participated in PEIA health plans. West Virginia Public Employee Insurance Agency, *Comprehensive Annual Financial Report 2008* (Charleston, W.V.: West Virginia Public Employee Insurance Agency, 2008); http://www.peia.wv.gov/forms-and-downloads/Documents/financial%20reports/cafr/Comprehensive_Annual_Financial_Report_2008.pdf.

4. An earlier Connecticut law (Public Act 03-149 of 2003) authorized the agency "To allow small employers and all nonprofit corporations to obtain coverage under the state employee health plan and to provide that such coverage be exempt from the state insurance premium tax." S 353 was signed into law in June 2003.

5. Commonwealth Fund, *What Public Employee Health Plans Can Do to Improve Health Care Quality: Examples from the States* (New York: Commonwealth Fund, 2008); http://www.commonwealthfund.org/usr_doc/McKethan_whatpublicemployeehltplanscando_1097.pdf?section=4039.

6. Connecticut Office of Legislative Research, *Impact of Pooling State and Local Employee Health Insurance in Other States.*

7. State Coverage Initiatives, "Value-Based Purchasing and Consumer Engagement Strategies in State Employee Health Plans – A Purchaser Guide (Washington, D.C.: State Coverage Initiatives, May 13, 2010); http://www.statecoverage.org/node/2335.

8. Commonwealth Fund, *What Public Employee Health Plans Can Do to Improve Health Care Quality: Examples from the States.*

9. Ibid.

10. Ibid.

11. For example, the Michigan multi-agency pooled plan was formally opposed by local school employees and associations.

About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple 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, with Barbara Yondorf as lead researcher.

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