



**Wisconsin Public Health & Health Policy Institute  
State Forums Partnership Program**

## **State Policy Options: Health Costs and Financing**

*Better Health Through Informed Policy*



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# STATE POLICY OPTIONS: HEALTH COSTS AND FINANCING

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## PREFACE

This Information Paper is the inaugural product of the Wisconsin Health Policy Forums, a multi-state initiative funded in part by the Robert Wood Johnson Foundation and the University of Wisconsin Foundation. Our goal is to inform Wisconsin's health policy debates with the most accurate and timely evidence and thinking available. We strive to be comprehensive in our treatment of a topic, avoiding ivory tower theory and partisan considerations.

We address here the need for a system approach to policy, recognizing that changes in one element of a problem inevitably will have effects, intended and unintended, elsewhere. This contrasts with layers of policy patches often driven by the constituency that is the most vocal or well funded.

We promote the principle that policy development can be characterized as trying to do the best possible with what is presently known. To summarize what is known, our authors must liberally borrow ideas from "experts," even while recognizing that experts often disagree over the meaning of the same evidence. We believe it is the nature of policy development to try to reach some consensus working from incomplete and contradictory information. If the solutions to problems were clear, they would already be in place! The Forums projects, both state and nationally, focus on *what is known today* and how that knowledge applies to policy.

Our information papers heavily draw from published and peer-reviewed literature. They are written by and based on the work of observers that one could readily label academics and scientists. This sector is not our audience. Nor is our audience the consumer who regularly faces the health and health care issues that policy must address. Our audience is health policymakers: that small group of people whose job includes listening to all sides while developing equitable, financially responsible approaches when the parties affected may be competitive and their needs contradictory. In that sense the forums serve as knowledge and information brokers as well as a safe place for even partisans to engage in nonpartisan discussion.

It is not our intention to develop policy, but to draw attention to the widest range of policy options that current knowledge suggests. The rest is up to our readers.

Thank you for joining us.

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## **STATE POLICY OPTIONS: HEALTH COSTS AND FINANCING**

### **Introduction**

Growth in health care spending is a concern of payers, purchasers, providers, consumers and policymakers. Health care accounts for approximately 13% of GDP, the rate of increase in spending is calculated at 13.7%<sup>1</sup> for 2001, and national health expenditures are projected to double over the next ten years.<sup>2</sup>

Questions of health care costs and quality are in the headlines and the tone is that of crisis. In Wisconsin, Mercer Human Resource Consulting reported that health benefits for employees in Wisconsin rose 14.8% in 2002, which is 20% higher than nationally for businesses with 500 or more employees. Earlier in 2002, Mercer had reported that health care costs for Milwaukee employers are 55% higher than for comparable cities in the Midwest. Then, last April, the United Auto Workers and DaimlerChrysler in Kenosha released a report that health care costs there were three times higher than other DaimlerChrysler plants.

As this paper was being written (late in 2002) the National Academy of Sciences said that the United States health care system was "in crises"<sup>3</sup> and urged the Bush Administration to immediately begin testing possible solutions including universal insurance coverage and no-fault payment for medical malpractice. The Democrat's Al Gore endorsed the idea of a single payer system. Senator Bill Frist, the newly named Senate Majority Leader, plans to release an "initial blueprint" of a proposal for broad, long-term Medicare reform that would include the development of a new "health care infrastructure" which could include information and management systems to assess outcomes and allow physicians and patients to exchange information.<sup>4</sup>

Meanwhile, turmoil is growing in the industry. Health care providers face a projected 4.4% fee cut, threatening to further restrict participation in Medicare and access to care for Medicare recipients.<sup>5</sup> Health maintenance organizations are trying to block a class action on behalf of some 600,000 doctors over the issue of cutting physicians fees.

The CEO of Blue Shield of California has called for legislation that would provide public or private health coverage for every resident of California. In Wisconsin, the AFL-CIO is calling for a unified statewide system, financed by a payroll tax and run by a state commission, for all working residents and their families.

Health policy is largely shaped, intentionally or unintentionally, by the way resources are distributed among competing programs.<sup>6</sup> The question of benefits gained can be raised each time there is a change in resource allocation. Will one set of expenditures produce greater health and quality of life than another? Will cutting services to reduce costs result in lowered health status for Wisconsin citizens? Can we escape the ever-increasing cost cycles of health care and still maintain the length and quality of our lives? Why do we pay much more per capita than any other nation in the world and yet

our life expectancy and infant mortality rankings, among other health measures, fall short?

Policy responses are generally to increase or reallocate expenditures. In turn, health providers, purchasers and consumers follow the money (incentives). And, as noted by Thomas Scully, Director of the federal Centers for Medicare and Medicaid Services (CMS), "these incentives are all going in the wrong direction".<sup>7</sup>

The question, then, is how to alter the financial incentives that drive health care expenditures and access to care:

- *Who* should pay (government, employers, individuals).
- *How* much to pay.
- *How* to pay (Fee for service, managed care, benefit payments, taxes).
- *What* should be paid for (drugs, therapies, practitioners, locations of care).
- *What* to do when financing schemes fail (the uninsured, underinsured), or
- *When* financing become so burdensome that it threatens the business viability and government solvency.

Although receiving less public attention, policy discussion also includes:

- *What* results or benefits are we getting for expenditures.

The debate on health care expenditures has also included the role of values, responsibility and ethics. Indeed, government, employers, providers and individuals all have ethical and financial fiduciary responsibilities in health care. The health care cost debate raises deep underlying social issues. Polarizing questions emerge: Is health care a right, or a privilege? Should the delivery of health care be a business or a community benefit -- driven by profits or by people?

Even with good and broad information (still a rarity), policymakers must nevertheless make value judgments regarding whether current or projected expenditures (incentives) are either too high or not high enough. If we believe expenditures are too low, increasing them may drive up costs; if we believe they are too high, decreasing them often means someone must make do with less.

Policy and regulation also contribute to the cost issue. The regulatory climate serves as referee, rule-setter and sets incentives for the other players. Through policy incentives regulation strives to prevent excesses, fraud, and abuse of power; it creates safety nets and limits what may be requested, attempted or promised. Regulation also limits competition and restricts free trade through licensing and "credentialing". Further, regulation because it creates a static environment, may also prevent change and needed growth. Constituencies can become empowered or even enriched by legislative efforts<sup>8</sup>. Finally, regulations may at times restrict costs or at times add to costs.<sup>9</sup>

This paper differentiates "health care costs" (the expenditure of resources to produce health care services and products) from health care *prices* (costs + profit margin). Consumers and payers are usually focused on price, whereas health care providers focus on the cost of their inputs. Clearly costs, in part, drive prices. Nevertheless most of the public concern about "escalating health care costs" is about escalating prices and the reluctance to pay the price, not what went into developing that price. This would suggest that, once purchasers are satisfied with the provider markup between costs and price, there is considerable utility in working with providers to lower their own costs.

The major challenges in health care policy reflected in this paper are *costs, quality and coverage (i.e., the uninsured)*. These three are so fundamentally linked that any long-term effective solution must address all three. Historically, when one element of rising costs is targeted, it inevitably creates unintended consequences elsewhere. For example, efforts to contain prices paid to providers may reduce the amount of outpatient charity care available for uninsured persons and therefore increase the use of, and costs associated with, emergency-room care. The system is like a balloon that, when squeezed in one area, bulges elsewhere.

The U.S. has faced a problem with runaway health care costs, with only temporary relief since the Nixon Administration. Many market-based and regulatory solutions have been tested. Some remain, while others have fallen away. None yet have sustained their promise in the long term; we continue to face the fundamental and reoccurring challenge of rising costs.

### **A Brief History of Health Care Purchasing and Pricing**

Arguably, concern with health care costs began in 1929 when hospital insurance (and the beginning of Blue Cross) was devised as a means of helping employees who might face economic ruin as a result of illness. The Depression and wartime kept the issue nearly invisible until the late forties. Following the war, insurance coverage expanded from just hospitalization to include physician's fees and, ultimately, testing, pharmaceuticals and allied health services. Led by union contracts, major medical insurance soon became an integral part of employment benefits.

In 1943, the IRS made health coverage contributions a deductible expense, which changed the status of health benefits to a type of pre-tax compensation. Employees and their unions were quick to see that it was better to take the money as untaxed benefits rather than as taxed compensation. The employer became firmly entrenched as a group buyer, the purchaser of health care.

In 1965 the government began its assistance programs of Medicare and Medicaid, which removed payment as an obstacle to health care for the aged and a segment of the poor. It was clear in the seventies that the government programs were going to far exceed their cost estimates. Each succeeding administration attempted to do something about the escalating costs. Most efforts proved to be of little avail. By the 1980s large employers realized that they could predict their employees health care expenses as well

as or better than the insurers. Consequently, they moved to a self-funded or self-insurance model.

The Medicare and Medicaid programs for many years used cost-based and retrospective reimbursement. Cost pressures led these programs to innovate with such cost-control methods as Diagnostic Related Groups (DRGs) and the Prospective Payment System for outpatient charges. Most government efforts, and the efforts of newly formed employer purchasing groups, were aimed at controlling costs. Little serious effort was made to determine whether what was done was right or necessary. There was a large tolerance for errors and enormous practice variation among providers, and very little accountability, except for peer review in hospitals.<sup>10</sup>

Nevertheless, many purchasers, strongly encouraged by the medical community, felt that it was inappropriate for them to be involved in medical judgment and behavior. It was a curious argument since business people are famous for their willingness to specify the quality they demand from other types of suppliers.

In the early nineties several well-documented events occurred. First, employers began to band together in purchasing alliances. Second, many states passed small-group guaranteed access insurance legislation. This legislation opened the managed care markets for businesses with fewer than 50 employees. Then, in 1994, the Clinton administration attempted - and failed - to bring about large-scale system reform.

During the Clinton reform effort sectors of the health care industry, fearing loss of revenue, were able to attach their fears to the public's fear of loss of freedom of choice. Consequently, Congress heard the people's fear, backed up by hundreds of millions of dollars worth of industry-sponsored advertising and lobbying. More recently, the pharmaceutical industry has sought to tap into public distrust of the government, this time to avoid Medicare prescription drug benefits, and its price limits, in place of commercial insurance coverage.<sup>i</sup>

### **Managed Care: Great Expectations**

Managed care appeared to offer a market-based solution to the health care pricing and paying problems.<sup>11, 12</sup> Around 1970 Paul Ellwood coined the term "health maintenance organization" which as a concept greatly appealed to the Nixon administration and led to the HMO act of 1973. Enthoven<sup>13</sup> in 1978 further suggested that medical care could be reorganized to use objective, scientific knowledge about prevention, cost and effectiveness, thereby bringing about a more efficient and equitable health care system. This seemed to hold the potential to cut costs without cutting quality. Market theory

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<sup>i</sup> The drug industry, which has enjoyed a 40% increase between 1993 and 1998 in the average price per prescription, also attained the ability for direct-to-consumer (DTC) advertising. DTC appears to further drive up utilization of expensive brand-name drugs. Pharmaceutical company spending on direct-to-consumer marketing now exceeds their spending for research and development.

introduced a new force of cost-effectiveness into medical decision making, which had before, at least in theory, been purely clinical.

Through the eighties and nineties health maintenance organizations based on managed care principals grew rapidly across the country. Among the innovations HMO's swept in were pre-authorization for hospital stays, large case management, negotiation for rates, closed provider networks and intense scrutiny of covered services by purchasers. Such scrutiny often initiated public and legal debate of which procedures, drugs or conditions should be a part of the plan.

Managed care, with prospective and per-capita payment, may encourage the health industry to provide fewer services and procedures. With fee-for-service, the medical providers made more money by doing more; now, it makes more money by doing less. Their risk, of course, is that their members may develop something that if caught earlier would have been less expensive to treat, but if not caught till later is enormously expensive. Consequently managed care was initially heralded for, and provides some incentive for, preventive care.

Yet at the same time, consumers perceived that the "gatekeeper" function in managed care -- considered essential to controlling costs -- limited access to needed or desired specialty services. By 1999, 68% of Americans believed that their health plan's chief interest was in making a profit rather than the care their patients receive.<sup>14</sup>

Today, private sector efforts focus increasingly on making the consumer more sensitive to the price of health care. At the same time, the private sector has embraced prevention. Patient education, monitoring, and self-care have spawned a new sub-industry of disease management. Increasingly, industry executives and public policy makers seek ways to align financial incentives with the appropriate outpatient management, particularly of common and costly chronic conditions such as asthma, diabetes, cardiovascular disease, and depression.

### **Costs Continue their Climb**

Following about eight years where managed care appeared to contain health care costs (see Exhibit 1, page 17), business leaders and governments again in 2001 saw their health care spending increasing at a double-digit rate. Although many suspected as much in the nineties, business leaders and public policymakers knew that the big three health care challenges -- *costs*, *quality* and the *uninsured* -- were still with us and likely to get worse.

Experience in the 1990s has shown that there was much about health care pricing, economics and accounting that cried out for fixing. The problem with free market theory was that in health care the patient and the payer are rarely the same. The dissatisfied consumer can not withhold payment, nor can consumers change plans or providers at will; consumers can not "vote with their feet."<sup>15</sup>

Few Americans (besides a handful of researchers, academics and business leaders) were paying much attention to outcomes and quality systems for pricing. Some of this inattention was a result of the paucity of accessible health care information. Medical systems costing models and data systems were often nearly unchanged from what they had been at the turn of the century. Information technology had barely penetrated the real economic business of health care. In 2002, information technology constitutes only about 3% of health industry expenditures, while other industries spend three-to-five times more.<sup>16</sup> Tom Scully, the Director of the federal Centers for Medicare and Medicaid Services (CMS), notes that today hospital information systems are 25 years behind the times.<sup>17</sup>

The health care functions and the billing and pricing functions in health organizations were only loosely connected. Physicians often had no idea what the care they provided cost, what was actually being paid, or who paid it. Purchasing organizations often became more knowledgeable about the cost, price and payment business of health care than the industry itself.

Yet, since with managed care there is no direct billing of services to outside payers, the administrative record of transactions has been removed from outside scrutiny. Only providers and their management are now in a position to know exactly what was done and its price. With managed care, purchasers know even less about the industry's pricing and costs structures and actions, than they did before. The yearly costs are more predictable, but the value purchased has receded even further from investigation.

Through the nineties a lucrative, but cost escalating, industry of so-called "third party administrators" developed to handle health care billing and payment. Yet billing and payment methods, while the most technically advanced of all medical information systems, remain primitive compared to other industries. Medicare and Medicaid did promote some degree of standardization in billing, still there remains significant variation among private insurers.

### **The Quality - Price Connection**

Policymakers, in their efforts to constrain expenditures, try to balance social and fiduciary responsibility against often-contradictory constituency demand. Purchasers want more services and lower prices. Providers and suppliers, in order to lower prices, must lower their own costs or reduce their profit margins. Lowered costs and margins often mean a reduction in offered services. In attempting to balance the push and pull of these forces, policymakers need an ally.

One such ally is the ongoing national and international efforts to determine what value the costs and prices of health care actually deliver. This agenda asks: what health care services are value-added and what can we do to move resources and incentives to value.<sup>18</sup>

Many observers<sup>19,20</sup> now seek to focus on the relationship between costs and outcome. Often referred to as value-purchasing<sup>21,22,23</sup> this concept links cost containment to the measuring and purchasing of quality in order to achieve a healthier population. Fundamentally, value purchasing requires explicit decisions on the relative costs and benefits involved in purchasing health services. And such explicit decisions cannot be made without a strong data infrastructure.<sup>24</sup>

The value that is purchased in a health care transaction is measured by the outcome / result of that transaction in relation to the price paid. Many observers suggests that shifting to purchasing health care based on value -- including consideration of both price and outcome -- rather than on price alone will help re-align incentives within the industry and should help override the power of more superficial cost drivers.<sup>25</sup> Toward this end, policy that supports the information resources necessary for quality / outcomes based purchasing will enable:

- Monitoring & Evaluation: of the effects of health care policies we enact,
- Purchasing & Financing: Calculation of the value of our health purchases,
- Program Evaluation: Measurement of the outcomes of our medical efforts, and
- Health Services Research: Determination of the results / effectiveness of choices made.

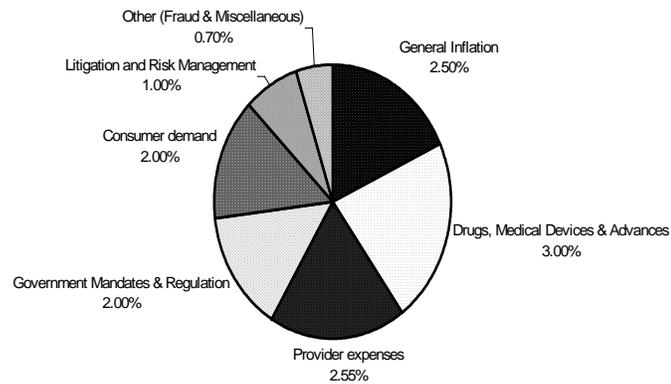
## **Factors Behind Rising Health Care Costs**

The shift to outcome- or quality-based purchasing will take time. While that shift occurs, it may be possible to address some of the underlying factors (“drivers”) behind rising costs. Analysts generally agree that health care cost drivers include the following:

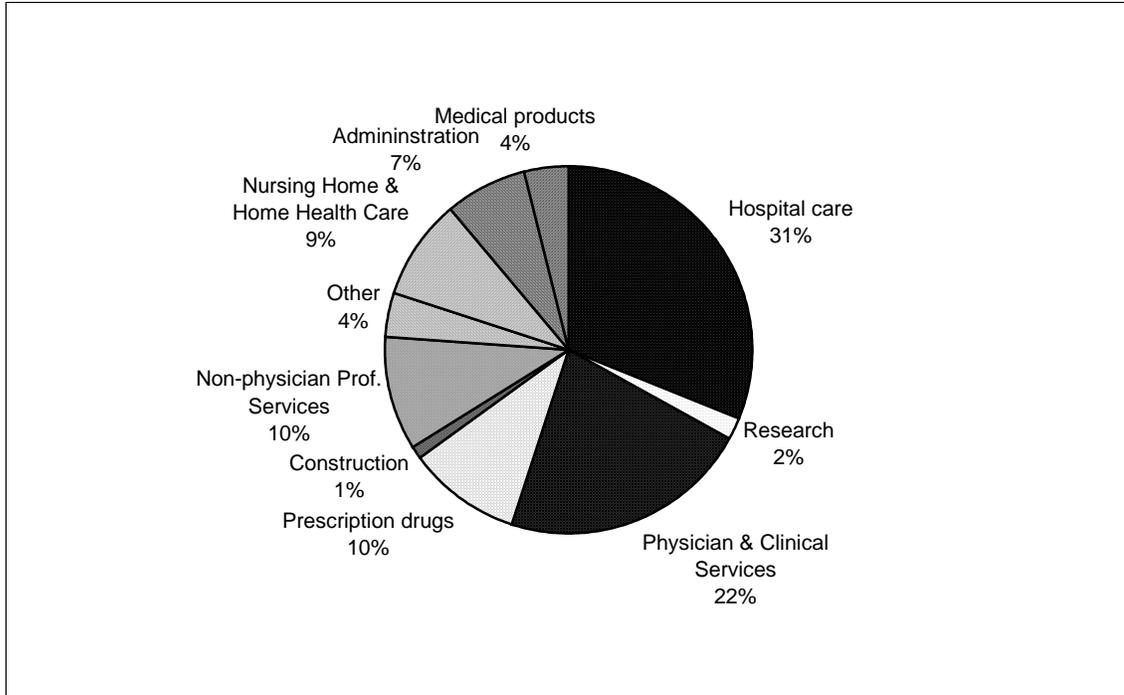
- Consumer demand.
- Costs of training, hiring and retention of a health care labor force.
- Drugs - both disease and life style oriented.
- Emergency medical response (mobile & within hospitals).
- End of life and chronic care.
- General inflation.
- Government mandates and regulations.
- Hospital care.
- Medical research.
- Medical supplies.
- Outpatient care.
- Defensive actions (litigation & risk management).
- Public education / advertising.
- Technology.

Among these factors, analysts focus on several trends: efficiency and effectiveness, advancements in technology, the labor shortage, hospital consolidation, and the easing of managed care restrictions.

Medical costs increased 13.7% in 2001. The rates contributing to the medical inflation rate vary from year to year and among analysts. Nevertheless, PriceWaterhouseCooper<sup>26</sup> in a widely cited estimate, reports the 2001 cost driver contributions to the total medical inflation as illustrated in Figure 1:



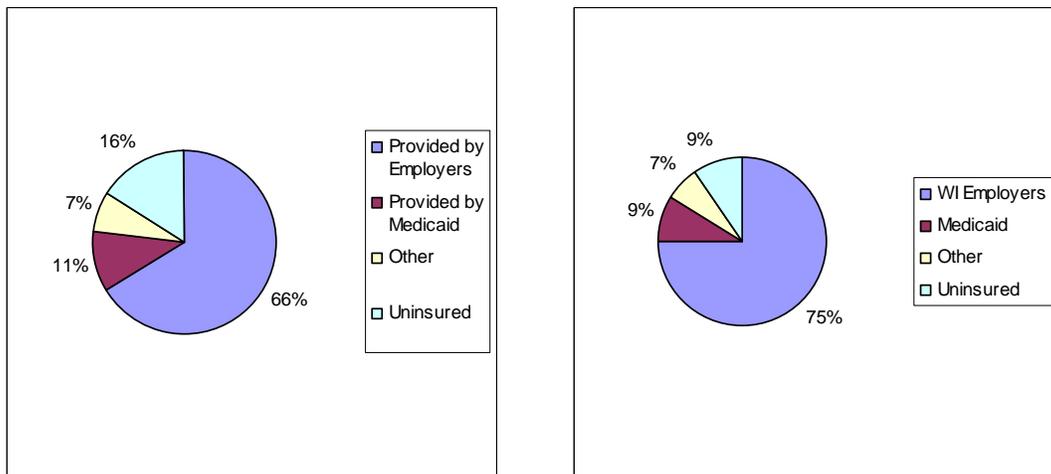
Increases in *provider costs and drugs*, followed by *government mandates and increased consumer demand* accounts for 70% of the total increase in premiums. Reviewing these costs by service sector, the Centers for Medicare and Medicaid Services<sup>27</sup> projected, expenditures in 2002 as follows:



There continues to be evidence that growth in health care spending is the collective result of inefficiencies in the provision of health services; continued large returns to providers (and their suppliers); and investment in new technology.<sup>28</sup> Further, the rate at which these basic drivers push costs are increasingly influenced by consumer demand and policymaker's efforts to balance conflicting constituency needs through mandates and regulations.

### Who Bears the Cost of Health Insurance?

Sources of Health Insurance of Non-Elderly population US and Wisconsin.<sup>29</sup>



While Wisconsin's numbers vary from national figures, the manner in which our state, or any state<sup>ii, 30</sup> finances its health care related purchases is very similar. The majority of people under age 65 have their health care expenses paid for, either in whole or part, by their employers. In Wisconsin,<sup>31</sup> about 73% of the all uninsured persons are either workers themselves or live in households that include a full-time employed worker. They either have not enrolled in a plan offered by their employers or were not offered coverage by their employers and were not able to obtain it from another source.<sup>32</sup>

A significant part of the health care cost discussion, as much as the price of insurance, is the issue of being insured or not. Health service research published in the past 25 years makes a compelling case that having health insurance or using more medical care improves health. Further, a mid-range estimate of the effect of extending health insurance coverage to all would be a 10-15% reduction in mortality rates of the uninsured.<sup>33</sup>

A minimum amount of health care access will generate real improvements in morbidity, mortality and disability. Just as surely, there is also an upper bound on the amount of improved health more medical care can provide<sup>34</sup> - more money or more health care providers, above some minimum level, does not generate more health.

### **The Aging Population: A Cost Driver that Isn't**

It is a rare policy analyst that does not mention how the "graying of America" may overwhelm Medicare and the health system. Their analyses are based on baby boomers reaching retirement age and is compared to the health care costs for previous generations as they reached the same ages. Noting that the baby boomers numbers in the ages between 55 and 59 will grow 24% between 2001 and 2005 and 41% between 2001 and 2010, it is assumed that this population is currently a major driver of increased costs for those under 65. This assumption is apparently incorrect.

The Center for Studying Health System Change<sup>35</sup> recently reported that differences in spending by age are not large enough and the U.S. population is not aging quickly enough to make ageing a major cost driver for the under-65 population. Their calculations show that aging contributed less than 10% of the total increase in per capita health care spending for people under 65. So while aging may contribute to overall expenditures within the economy and the per capita spending for the population as a whole, it does not itself substantially contribute to the underlying cost of inputs.

By 2011, the first wave of the estimated 76 million baby boomers will turn 65 and begin shifting their employment-based insurance over to the Medicare program. Indeed, Medicare costs will increase significantly, but that will be as a result of the sheer numbers of baby boomers and thus more aggregate spending.

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<sup>iii</sup> A ballot initiative in the State of Oregon in 2002 sought to have the state adopt a single payer model, but failed overwhelmingly with the support of providers and insurers.

## Policy Options and Regulatory Tools

Policy cannot change the age structure of the population, but it can address the underlying costs of inputs that drive insurance premiums. Federal and state governments have initiated a range of cost containment policies, some of which focus on the market and others on regulation (Chart 1).<sup>36</sup> Most have worked for a limited time and could be implemented, or re-implemented, in Wisconsin at least on a temporary basis.

**Chart 1. Approaches to Containing Costs**

<b>Market Force Approaches</b>	<b>Regulatory Approaches</b>
Co-payments	Provider Rate Setting
Deductibles	Insurance Rate Banding
Defined Contribution	Coverage Mandates and Restrictions
Managed Care	Prescription Drug Formulary
Risk Pooling	Certificate of Need
Capitation	Medicare DRGs, RBRVS
	Oregon-type "Rationing"
	Preventive Policies (e.g. tobacco taxes)

The State of Wisconsin is a major purchaser of health care services, through its role as an employer and as a provider of coverage through Medicaid, BadgerCare, SeniorCare, HIRSP, and other safety net programs. The State clearly has an interest in containing these costs. As well, states seek solutions to rising insurance premiums in the private sector, as these are a burden on business profitability and growth. And if businesses drop insurance coverage for their workers, these people will become uninsured or will seek coverage through publicly-supported programs, for which the State ultimately bears the costs.

There are a set of well-known policy and regulatory tools that have been implemented in other states, some of which have already been tested in Wisconsin. The National Academy for State Health Policy (NASHP)<sup>37</sup> notes that the various approaches have focused on 1) the supply of services, 2) the demand for services, and 3) the pricing of services. Below is a brief summary of the approaches that have been tried or are currently being considered. These tools have been well described elsewhere (see NASHP), so will here only be reviewed briefly. The discussion will then focus on trade-offs involved with a variety of proposed system changes.

### **Constraining Supply of Services**

- **Certificate of Need (CON):** State-level review process to decrease service duplication and investment in excess capacity in facilities and/or technology.

CON requires that certain facilities, usually hospitals, obtain state approval for substantial changes in their scope of services or for capital investments. The limits are intended to hold down the volume and the intensity of services, and thereby reduce cost associated with over-utilization. Although discontinued and largely discredited in Wisconsin, 38 states continue to operate CON systems. Existing data on the efficacy of CON does not support that it helps curb overall health care costs.

- **Regionalization of Services:** Explicitly designating and steering patients toward centers of excellence for selected, high volume or high risk services, based on evidence that a provider's high volume of procedures are associated with better outcomes. CON may be useful in promoting regionalization of services, but such could occur separate from a comprehensive CON system.

### **Constraining Demand for Services**

- **Managed care:** HMO and Preferred Provider Organization (PPO) plans for state employees and expanded enrollment for those populations for which the State now provides Medicaid and BadgerCare coverage. Managed care does appear to contain costs, but at the expense of enrollee freedom of choice.
- **Limiting the range of covered services:** Limiting coverage, particularly within the Medicaid program, for optional Medicaid services, or adopt a more overt priority-setting process like that used by the State of Oregon.<sup>38</sup> This involves assessing cost-effectiveness of various services, and assigning relative priority among these. Services are covered up to the level of resources available.
- **Safety net services:** Programs, often government supported, that provide health care to those without insurance or the ability to pay. These programs may increase the demand for primary care services, but successfully direct the uninsured away from more costly emergency care and, by promoting early and timely care, reduce the later need for specialty services.
- **Cost sharing, limited benefits and defined contribution:** These strategies by employers shift a greater proportion of premium and service costs to the employee, and thereby increase the consumer's cost- and price-sensitivity. These include tiered-pricing of plans and services, consumer-driven design of plan coverage, and the adoption of medical savings accounts combined with high-deductible plans in place of comprehensive coverage. These private-sector tools may be available to Wisconsin in its role as an employer and purchaser of coverage.

### **Constraining Pricing of Services and/or Insurance Prices**

- **Insurance Purchasing Pools:** Large insurance purchasing pools for low-wage workers and small employers. The larger the pool, the more leverage the pool has in negotiating insurance prices. States may also leverage the buying power of their Medicaid programs and allow buy-in by private purchasers.
- **Hospital and other provider rate-setting:** Strategies to control the rate of cost increases and returns to providers. This has been tried in Wisconsin and largely discredited, but may still merit consideration in more targeted form. For example, provider prices could be reported in relationship to a standard fee schedule to promote comparisons and uniform pricing.
- **Prescription drug purchasing:** Joint purchasing, formularies, alternative therapies, tiered-benefits, pharmacy benefit management, manufacturer reimbursement strategies, or limiting number of prescriptions or days of supply.
- **Insurance regulation:** Policies such as rate banding; expansion of who is eligible for insurance pools; damage caps; tort reforms and limits to malpractice awards and contingency fees; and no-fault systems.

More recently, the private sector has adopted measures to address the quality of services, improve efficiency, and thereby contain the underlying costs of inputs. These include:

- **Patient safety initiatives:** Reducing medical errors and their associated costs. Currently, these focus on three high priority areas selected by a coalition of large employers known as the “Leapfrog Group”: 1) Adopt computerized order entry systems to avoid paperwork mistakes in hospitals; 2) Increase use of hospital-based specialists (“Intensivists”) in the intensive care unit; and 3) Direct patients to hospitals where a high volume of procedures are performed.
- **Disease Management (DM):** The use of evidence-based guidelines, structured patient education and case management to reduce the costs and improve the health status of patients. DM ranges from physician guidelines or patient education to nurse case management and sophisticated system changes. DM program often focus on populations with chronic conditions, particularly diabetes, asthma, heart disease, or depression. Some programs target individual patients with high cost conditions.
- **Evidence-Based Medicine:** A broader approach than Disease Management, EBM involves monitoring an entire population, working to improve provider compliance with guidelines and best practices, and measuring outcomes.

### **Cost-Shifting: Public to Private, Federal to State**

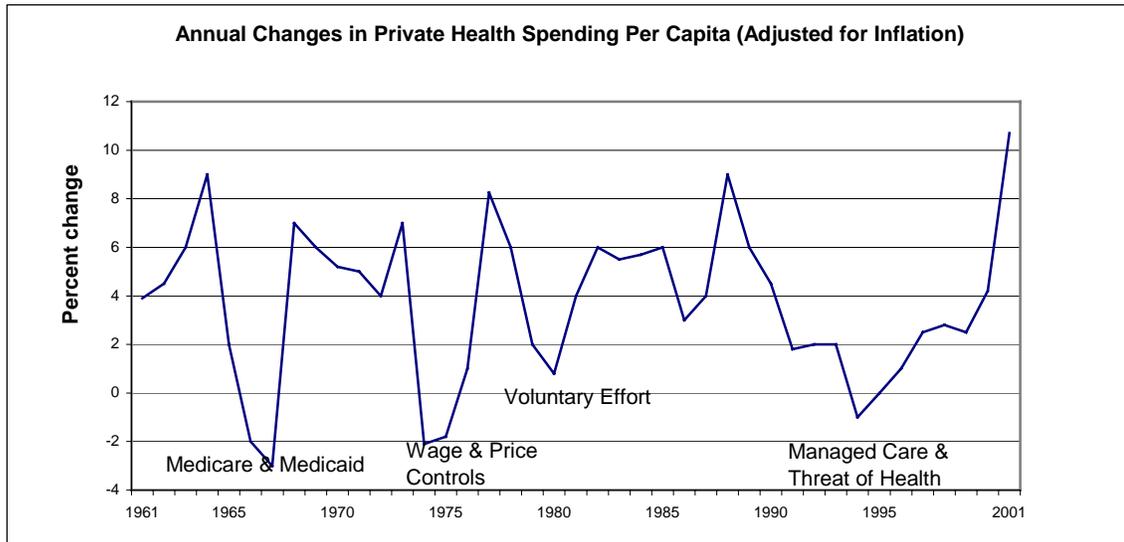
Other approaches seek to move the cost burden from the private sector or the state to the federal government. This does not actually reduce the cost burden to the economy as a whole, but certainly may reduce the costs borne by interested parties within the

state. Such approaches include leveraging additional federal Medicaid dollars to reduce the burden on the state budget, and increasing Medicare payments to state providers:

- Explore opportunities to expand Medicaid coverage to additional eligibility groups, and thereby leverage federal financial participation. However since federal Medicaid dollars must be matched by state dollars, it must be remembered that more federal dollars increases state expenditures.
- Work with Congress to change the low reimbursement rates in Medicare and Medicaid payment formulas, which result in cost-shifting to the private sector, but of course increased costs at the federal level.

### How Effective Are These Approaches?

Historical experience, reflected in Exhibit 1<sup>39</sup>, suggests that the cost containment attempts in the last fifty years have failed to provide lasting long-term relief.



Direct price regulation in general and managed care in the 1990s did hold down costs, but for relatively short periods of time. The promise of managed care has waned in the face of consumer, and often provider, backlash against its restrictions. Some of the large consolidated systems spawned by managed care have come to face financial difficulties. Some analysts argue that the early benefits of managed care were one-time savings. Where “fee-for-service” may have encouraged excess service, managed care eliminated the financial incentive for such “over-utilization.”

Whatever the future of managed care, it remains true that powerful drivers of cost -- technology, consumer demand, provider returns, mandates and regulations and pharmacy costs -- remain. Further, the number of uninsured and underinsured

continues to climb. Price distortions inevitably result as providers seek to shift the costs of uncompensated care onto its commercial payers.

The National Academy for State Health Policy, in its comprehensive review<sup>40</sup> of cost containment options, concludes:

"The key lesson we can take from the past is that a haphazard approach to cost containment will not achieve or sustain its objectives. Policymakers need methods to integrate supply, price, and demand.... Such a comprehensive approach to health care cost containment may well require a re-thinking of the entire health care delivery system to assure that clear goals are set and that incentives are properly aligned to reach them."

The possibility of such systems change seems more likely now than in the past. Certainly the recent calls for single payer systems and statewide risk pools in Wisconsin and elsewhere are not business as usual.

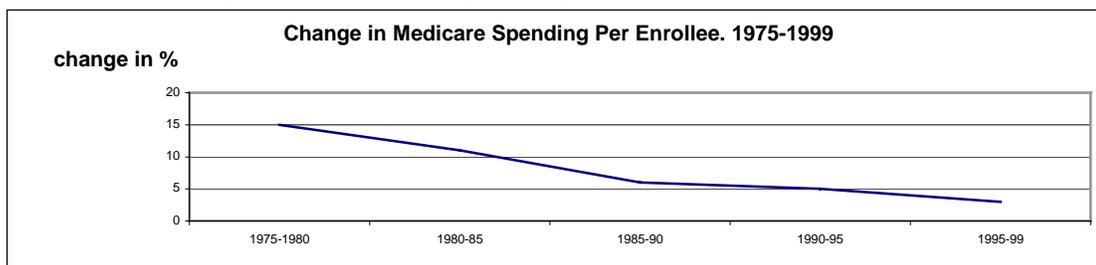
### **Are there Lessons from Medicare?**

Medicare, in many respects, does appear to work. Using such regulatory efforts as prospective payment, volume performance standards and reforms within the Balanced Budget Act Medicare has successfully slowed its rate of expenditure growth (See Exhibit 2).<sup>41</sup> The program itself has grown along with the population reaching 65 years of age, but adjusting for inflation, annual increases in Medicare spending per capita dropped from 11.2 % in 1975-1980 to 1.8% for 1995-1999.<sup>42</sup> Medicare's projected future growth rate is expected to be around 6%--much lower than the double-digit increases projected for the rest of the health care system.

Those who favor universal single-payer programs cite the success of Medicare--in essence a single payer system--in containing cost increases and maintaining relatively low administrative expenses (less than 2% of total expenditures<sup>43</sup>).

However, many Medicare providers argue that those savings occur only because Medicare shifts the administrative burden to the provider. Moreover, Medicare payment may not cover the true costs of care nor expected profits, which is then shifted to the private sector. In other words, the private sector may actually subsidize the apparent Medicare savings. And Medicare, which does not cover outpatient prescription drugs, has avoided these significantly increasing costs.

## Exhibit 2: Changes in Medicare Spending Per Enrollee. 1975-1999



### Containing Prices: Insurance Regulation and Purchasing Pools

Both public and private employers use large purchasing pools to attain more favorable prices, either through negotiating lower commercial insurance rates or by directly contracting with physician organizations for lower prices based on larger pools of insured.

Pooling does hold down the price per individual, and thereby makes insurance coverage more attainable. This has been shown in strategies such as the creation of large purchasing pools for employees, low-income consumers (i.e., Medicaid), or those over 65 (i.e., Medicare). But pooling does not directly address health care costs. Instead, pooling spreads risk and financing across more people, while most of the underlying factors affecting cost remain firmly in place.

Controlling the costs of insurance through various mechanisms may reduce the prices paid by specific purchasers (government and/or industry), but not address the actual underlying cost of care. The market power of payers often leads to the negotiation of contractual discounts with providers. This dynamic has led various sectors to seek, through pooled purchasing, the advantages currently enjoyed by larger purchasers. However, such advantage may in effect shift costs to other, less strategically positioned, purchasers.

Although state-sponsored small employer purchasing pools hold promise, they also face several challenges. Insurance purchasing pools, if voluntary, could attract smaller and higher risk groups, and thereby face the costs of adverse selection. This potential has led some observers to argue the need for tighter rate-banding regulations that would diminish the insurance industry's opportunity for underwriting. Indeed, purchasing pools in other states that have demonstrated success have rate-bands no greater than 10%.<sup>44</sup> Yet rate-banding itself may discourage participation in the pool by lower-risk groups, who could potentially attain better insurance prices on its own rather than taking on the risk profile of the larger pool.

Many states, including Wisconsin, are now considering play-or-pay models that require employers to provide insurance or buy into state-sponsored coverage pools. Yet such mandates may encourage more businesses to opt to self-insure, thereby gaining federal ERISA protections from state regulation. This, in turn, would again lead to adverse

selection -- leaving higher risk groups, and their higher insurance costs, within the state pool.<sup>45</sup>

Assume, however, that purchasing pools or regulatory approaches succeed in containing the price of insurance. Insurers, in turn, would seek to extract savings from their contracted providers. Providers ultimately must cover the costs of operating their practices, which includes the expense associated with any un-reimbursed or under-reimbursed care. This includes care for the uninsured, as well as care for beneficiaries within Medicare, Medicaid, and other publicly-sponsored programs, for which providers generally receive payment for a fraction<sup>46</sup> of their usual retail charges. In Wisconsin, providers receive 77% of what they spend on Medicare patients.<sup>47</sup>

Under the current system, the private sector indirectly subsidizes these otherwise un-reimbursed expenses and providers may also expense these actions on their taxes. As commercial payers leverage greater discounts, the resources diminish for charity and other under-compensated care. Indeed, research<sup>48</sup> demonstrates that managed care and other price-restricted contracting that emerged in the 1990s also led to reductions in charity care and increased pressure on safety net providers.

### **Universal Insurance Coverage and Single- and Multi-Payer Systems**

Research suggests that, under the current decentralized system, providers incur significant additional costs associated with caring for the uninsured. Providers often seek to recoup their charity care "losses" by shifting costs to private insurance, thereby increasing the costs to the commercial and employer insurance sectors.

Universal coverage, some argue, would itself reduce health care costs by promoting timely and effective primary and preventive care. This should in turn reduce the costs associated with delayed interventions, treatment of more complex or advanced disease, and use of emergency departments as points of entry into the health care system.

Universal coverage could be pursued through either a single-payer or a multi-payer model. By definition, universal coverage implies that the uninsured are no longer, whether or not payment is managed centrally.

From a cost-containment perspective, universal coverage as well as single payer systems, remain important options to consider and are being studied in a number of states. Both California<sup>49</sup> and Maryland<sup>50</sup> have recently completed extensive studies of the costs and impacts of adopting different payer models for reform. Several options are available that maintain the pluralistic medical care system that allows consumers choice of providers and plans.

Single- and multi-payer universal health care models are logical extensions of pooling. Each model has intrinsic benefits, but also several drawbacks. Many powerful sectors of the economy would be impacted and some would resist change. Many proposals would require major changes in the American market system, although the extent of

such restructuring may range from modest to radical. One commonly proposed measure involves taxing employers and paying providers from a central state fund. Such a fund could still support a multi-payer system, contracting with a variety of commercial health plans that compete for contracts on the basis of price and quality.<sup>51</sup>

### **Can We Reduce Administrative Costs?**

Supporters of a single-payer system see cost containment failures as strong evidence of failure of the market-based system and push to nationalize the health care system. They argue that the multi-payer commercial insurance system diverts resources to profits, excess employees and administration, and inappropriate medical interventions.

A single-payer system could potentially reduce these costs and use the savings to expand coverage to currently uninsured persons. Such cost savings, however, would only occur through central possibly government administration and regulation. Even then, many argue that despite the private sector's perceived excesses, potential advantages of public administration would be offset by the oft-presumed inefficiency of government.

Systems in countries like Germany, Japan, Canada and the U.K. have successfully slowed health care cost increases. Twenty-four of the 29 Organization for Economic Cooperation and Development countries have addressed health care payment issues by covering more than 99 percent of their citizens basic health insurance coverage through government programs.<sup>52</sup> Indeed, the United States is alone among industrialized countries in lacking a national health care system.

A centralized approach does not mean, of course, that these countries don't also face increasing health care costs. However, many of their costs are of a different order of magnitude than in the U.S. Comparisons<sup>53</sup> with Canada's program are often made, for example: in the U.S. private insurers take, on average, 13% of premium dollars for overhead and profit and as much as 40% in some large managed care plans. In contrast, overhead consumes less than 1% in Canada's program.

Canada's system uses fewer people to administer to its 27 million citizens than Blue Cross employs to administer coverage to about 2.5 million New Englanders<sup>54</sup>. (Blue Cross covers roughly 1 in 3 Americans.<sup>55</sup>)

Centralized government management and regulation would require dismantling a huge sector of the U.S. economy. There is certainly opportunity for success between unregulated health care markets and centralized government control. Indeed, a widely held goal is to contain costs while retaining a pluralistic health care system.

### **When Restricting Supply becomes Rationing**

Rationing is not a popular concept. Nevertheless, the current American system rations health care in many covert ways including cost-shifting among payers. Uncompensated and under-compensated care is subsidized through increased charges to commercial payers, and those without coverage face restricted access to vital services. Physicians,

medical and insurance administrators, employers and government officials regularly make decisions about where limited health care resources will be allocated. Consumers may tacitly take part in these decisions by selecting an insurance or HMO policy or employer. Or consumers may not be made aware of health and therapy options that are simply not offered or made available.

National health systems in Europe, Japan and Canada do sometimes result in long waits for non-emergency care.<sup>56</sup> These systems also reflect the individual cultural and health / medical expectations of each country although there is little evidence that, outside of non-emergency waiting, overall quality is less than in America -- indeed the opposite is apparently true.<sup>57</sup> At times, however, such systems have also demonstrated an ability to contain some costs and reduce inequities in health care. Even in European countries that rely on employer contributions to a central pool, however, governments are facing spiraling costs and insurance contributions have become onerous to employment growth.<sup>58</sup>

Finally, some analysts argue that, with universal coverage, consumer demand (a powerful health cost driver) would also soar<sup>59</sup> and that many quality providers would simply limit their practices to the wealthy. Further, the current supply of primary care physicians and nurses, particularly in more rural areas, may be inadequate to meet such expanded demand.<sup>60</sup> This could raise the specter of overt rationing.

On the other hand, evidence suggests that an oversupply of specialty physicians in itself drives utilization and costs although determining whether physician supply or demand came first is not an easy analysis.<sup>61</sup> If you have clinics, waiting rooms and hospital beds there is much incentive to fill them.<sup>62</sup>

This conundrum has led to attempts to measure the relative cost-effectiveness of various services, and assign explicit priority and rank in covering these services. The State of Oregon has pioneered this approach in its Medicaid program, which overcame considerable skepticism and opposition to become a widely cited model of innovation.<sup>63</sup>

### **Reducing Demand: Defined Contributions and Consumer-Driven Plans**

The private sector continues to look for ways to encourage employees to take both personal and financial responsibility for their health. Better employee health is a cost saving measure. Most recently, private employers, under the banner of consumer driven purchasing,<sup>64</sup> have used the concepts of defined contributions,<sup>65</sup> high deductibles, co-payments, and after-tax savings and pre-tax spending accounts as a means to share the increasing burden of payment with employees.

Employers and insurers are now experimenting with varying levels of cost-sharing, each with a different employee price tag based on the employee's willingness and ability to pay. These tools could be more widely adopted by the public sector. However, substantial changes might be required in existing union-negotiated contracts.

Despite the popularity of this trend, there are significant concerns that “consumer-driven purchasing” may further segment the market and erode the broad risk-sharing advantages of pooling. That is, younger, healthier, lower risk purchasers would opt for minimal coverage plans, while older, sicker or higher risk patients would still need to purchase broad-based coverage. These less healthy people would then find themselves further priced out of the insurance market.<sup>66,67</sup>

Indeed, the Agency for Health Care Research and Quality (AHRQ)<sup>68</sup> recently concluded that cost sharing, while successful in making consumers more sensitive to the price of health care, “may impose disproportionate burden on vulnerable groups such as the poor and those with multiple chronic conditions.”

Nonetheless, some have come to challenge the social contract whereby those who are healthy, whether through their own efforts or by chance, help to pay for those who are not.<sup>69</sup> And the Institute of Medicine reports that about 15-25 conditions account for the majority of health care expenditures, and nearly all of these are chronic.<sup>70</sup> Employers and consumers question their role and responsibilities in paying for these, perhaps preventable, health services.

Ultimately, however, these costs are unavoidable. With increased cost-sharing, more employees choose to forego coverage and services.<sup>71</sup> The number of uninsured persons increases, as does the level of uncompensated care. This increases cost shifting onto the private sector and further burdens safety net providers and programs.

Apart from these concerns, the trend toward consumer-driven plans reflects a broader intent: to make consumers more responsible for their health status and more aware of the relative costs and benefits of various services.

### **Value Purchasing: Assessing Inputs and Measuring Outputs**

The Agency for Health Care Policy and Research now AHRQ initially defined “value purchasing” in 1997.<sup>72</sup> It explained the premise that “buyers should hold providers of health care accountable for both cost and quality of care.” In simplest terms, value purchasing means “getting the best care for the best price.” The tools of this approach include technology assessment, cost-benefit analysis, and disease management, as well as continuous collection and reporting of data on health outcomes.

All of the reforms mentioned thus far focus almost exclusively on price as the mediator of value. They are limited in their ability to promote value based on quality, which many observers argue is essential to the cost-benefit analysis.

The literature defines value as quality divided by expenditures. As currently practiced, consumer-driven purchasing does not promote the underlying goal of value-purchasing, because:

- 1) There is limited opportunity for purchasers to acquire the information needed to judge providers' quality or outcomes.
- 2) Currently, the dollar amount employees actually spend or have at risk on their insurance may be too small to motivate consumers to shop around for the best value. In 2001, consumers paid, on average, less than 15% of the premium for a single person, 27% for family coverage, and single-digit percentages for employees in the public sector.
- 3) Even where data are available, some analysts question the ability of consumers or the willingness of purchasers to sort through the data to make informed decisions.

Today, fewer people question that health care quality<sup>73</sup> is, and must be, a major part of discussions of cost. But the term "quality" needs further definition. Two major types of health care quality are usually discussed: one is service quality and the other is clinical quality. Measures that fall under service quality include such things as patient satisfaction with waiting times, facility presentation, hours of operation and provider attentiveness. Clinical quality is more concerned with physician behavior, that is the procedures and methods that are employed, given a specific diagnosis.

A third measure -- "outcomes" -- is more of a blend of the two. Outcomes include not only how the consumer experienced his/her medical interaction and whether the physician did the right thing at the right time, but further, to what extent did the patient's health status improve.

### **Quality, Outcomes and Data**

Both the private and public sectors promote the use of data (HEDIS -- Health Employers Data Information Set, for example) as a step towards measuring quality. The HEDIS data set provides a reasonable audited window on whether best practices, clinical tests and procedures, have been performed and whether certain disease states are being effectively monitored and treated.

Large corporate payers are also spearheading national efforts, most notably through the "Leapfrog Initiative," which examines the relationship between price, quality and value particularly in hospital settings.<sup>74</sup> For its part, the federal Agency for Healthcare Research and Quality (AHRQ) supports original quality research and disseminates a range of health related quality information.

Such pursuits extend to the public sector. Last year, the Milwaukee Task Force on Health Care Cost Control recommended, among other things, providing consumers more information on costs, improving ways to measure quality and reduce medical errors, and coordinating a community wellness initiative. As well, these themes are reiterated through expert testimony submitted at several Governor's Listening Sessions and legislative hearings last year.

Many public and private organizations, both in and outside of medicine, have become increasingly skilled at using medical record and claims data to analyze the quality of

health care practices and outcomes. Such efforts have provided both definite and troublesome conclusions, as documented in the Dartmouth Atlas<sup>75</sup> and recently published Institute of Medicine reports<sup>76</sup>:

- Medical practice and ability varies greatly, both among physicians and between and within hospitals.
- Errors and poor practices are widespread and not limited by reputation, credentials, or geography.
- There are significant regional variations in prices for identical services, as has been noted in the recent studies<sup>77</sup> comparing Milwaukee to other metropolitan areas.

These findings give cause to the observed effect of increasing health care costs overall and significant differences in practices, costs and pricing across and within geographic areas. Consequently, a complexity of policy development is that while government may recognize a national or state problem, influential purchasers, providers or consumers may not be experiencing these same issues locally. The local groups often strongly resist policy aimed at fixing a problem they aren't experiencing. Health care is local, whereas policy tends to be general - adequate data can connect the two.

### **Government Role in Promoting Cost-Efficiency, Quality, and Value**

The policy road to value lies through information and data--although often that data are difficult to obtain. As noted by the HHS Secretary Tommy Thompson, grocery stores have better data and information systems than do hospitals!<sup>78</sup> Even so, a decade ago Wisconsin led the nation in initial efforts to acquire critical health care data. Since then, politics, stakeholder resistance, administrative barriers, and falling state revenues have diminished this promising effort.

At the national level, leading health care experts are promoting technology assessment, quality reporting, and public access to data and information systems.<sup>79</sup> Providers, researchers, and elected leaders seem to agree that if it were a readily accessible option, health care purchasers would pursue *value*, rather than *price* alone. Purchasers increasingly share this sentiment. The largest private insurer (Blue Cross/Blue Shield) and the largest public insurer (CMS), and one of the largest employers (Honeywell) all recently agreed that the "value quandary"<sup>80</sup> must be solved; that the system might self-correct if we could measure performance and quality; and the key was to reduce costs while increasing quality.

Various options are available to invigorate and expand state and private initiatives to acquire, analyze and publicly disseminate health and outcomes data. These could allow statewide comparisons across provider and payer systems. Effective and tested methods for evaluating and reporting the health status of populations are available<sup>81</sup>. Such instruments measure current health status with appropriate adjustments made for age, sex, race and geography. They are a good metric for judging the success of medical interventions and thus medical outcomes. They are available, relatively easy to

understand and, through Internet-based technologies, relatively inexpensive to regularly monitor.

Developing outcome measurement capability and utilizing the health care value information it will provide requires an accessible data infrastructure. Such a data infrastructure requires that government and the private sector collaborate, such that all purchasers of health care might understand and make comparative judgments about the available health care “products.” Success in this undertaking requires health data collection and analysis to work in a flexible and neutral environment.

### **WHERE DO WE BEGIN?**

Policymakers can work on more immediate containment of the health care cost drivers, while also working to build systems for collecting outcome and quality data. The available strategies to contain cost may buy some financial breathing room. Ultimately, cost and prices remain rooted in quality, outcomes measurement, and value purchasing. To make it all work, public and private purchasers will need to collaborate in unprecedented economic, programmatic, and political ways.<sup>82</sup>

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