

Cracking the Code on Health-Care Costs



CUTLER

The following is an excerpt from Cracking the Code on Health-Care Costs, a report by the State Health Care Cost Containment Commission. The full report is available at <http://millercenter.org/policy/commissions/healthcare>.

The cost of health care in the United States has reached a tipping point as spending by individuals, governments, and businesses has grown steadily for over five decades. In 1960, annual health-care costs per individual averaged \$147; by 2011, this figure had reached \$8,860. This is more than twice the average spent by all other developed countries in the Organization for Economic Cooperation and Development. Although there has been a recent lull in the growth of health-care spending, it is likely temporary. If current practices in health-care delivery and compensation remain the same, projected annual costs will reach \$14,103 per person by 2021.

Despite their massive investment in health care, Americans are far less healthy than their peers elsewhere in the developed world. U.S. health quality is average or below that of other countries on several important measures, including life expectancy, infant mortality, obesity, diabetes, chronic lung illnesses, and heart disease. Moreover, although some of the most advanced medicine in the world is practiced in the United States, surgical errors, medical mistakes, and poorly coordinated care are not uncommon.

Past trends do not necessarily dictate the future, however. The nation's health-care system is now entering a unique period of change. Over the next decade, millions more Americans will be enrolled in health insurance plans, which will encourage the creation and reorganization of health-care delivery systems to accommodate the newly insured. Health-care purchasers and many providers are becoming more cost conscious.

TRANSFORMATION IS POSSIBLE

Urged by health-care payers, which include federal and state governments, many provider organizations and hospitals are forming partnerships to improve the efficiency and quality of care. This is a positive trend that may lead to more cost-effective, higher-quality care in the future, but this trans-

formation is slow and not universal. Moreover, other trends such as the consolidation of hospitals and provider groups to gain market leverage may counter the positive aspects of this transformation.

Nevertheless, the opportunity exists to transform how health care is delivered. The State Health-Care Cost Commission believes that governors, along with key members of state cabinets and legislatures, are in the best position to lead that change.

The goal is straightforward but ambitious: Replace the nation's reliance on fragmented, fee-for-service care with comprehensive, coordinated care using payment models that hold organizations accountable for cost control and quality gains. Achieving this will take time. There is inertia in the current system and few incentives for changing it. However, the states are in a strong position to achieve meaningful reforms

and create the needed incentives, with the support of payers, providers, insurers, and consumers. As the nation's "laboratories of democracy," states can serve as a proving ground for new approaches that raise the efficiency and value of health care.

The opportunity exists to transform how health care is delivered.

WHAT DRIVES U.S. HEALTH-CARE COSTS

Health-care costs are high in the United States because of several interrelated factors:

- Physician, facility, and drug costs are high. Average unit costs for physicians, facilities, and drugs in the United States are almost universally the highest in the world. Even the lowest U.S. costs often exceed those in all other countries.
- Americans use a higher proportion of expensive medicine. Even though Americans visit doctors less frequently, enter hospitals less, and have shorter hospital stays than other OECD countries, they make up for it by using more expensive medical technologies and costly procedures. For example, although an average of 46.3 magnetic resonance imaging diagnostics are conducted per 1,000 individuals throughout the OECD, the U.S. rate is 97.7 — more than double the OECD average.
- Care is fragmented and uncoordinated, for the most part, with minimal clinical information transferred across care settings and infrequent consultation among provid-



ers treating the same patient. This contributes to unnecessary and redundant services, errors and hospitalizations, delays in treatment, patient dissatisfaction, and excessive expense.

- Consumers do not weigh costs when making health-care decisions.

Other than insurance premiums and out-of-pocket expenses, consumers pay little attention to the cost of care. In fact, numerous studies have shown that consumers generally equate high-cost treatment with high-quality care and will choose the most expensive treatment among options that are equal in quality but vary substantially in cost.

- The traditional fee-for-service payment model promotes fragmentation and higher spending. The most common payment model in the United States is fee for service, which compensates physicians for each service they deliver. For many experts, fee for service encourages providers to maximize the amount and cost of the services they deliver.
- Billing and insurance-related activities for health care in the United States are the most expensive in the world because of: 1) the complicated, numerous, and unique billing procedures employed by different insurance plans, and 2) a fragmented system in which each provider organization maintains its own administrative process and personnel.
- Unhealthy behaviors in the United States help cause chronic illnesses such as heart disease, stroke, cancer, diabetes, and arthritis. These ailments cause approximately 70 percent of all deaths in the United States and afflict one in every two adults, raising the cost of health-care treatment nationwide. Most believe that a large share of these conditions is avoidable.
- End-of-life care in the United States is expensive. Americans consume a significant share of their lifetime medical costs in their last year of their lives, often because of aggressive treatments and repeated hospitalizations that are unnecessary, unwanted, and inappropriate.
- Provider consolidation among and between hospitals and physician groups is rampant throughout the health-care industry, with a great deal of it focused on increasing market share. Although such consolidation can create orga-

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nizations that are more efficient and provide higher-quality care, it can sometimes create health systems that dominate markets, placing upward pressure on the price of services.

ROLE OF THE STATES IN HEALTH CARE

States play a major role in influencing health care and its delivery system. Using numerous policy levers, they can influence how the system is organized and how it operates. They can motivate it to pursue greater efficiency and enhanced quality and discourage market behavior that results in wastefulness and unreasonable price increases. Notable policy levers include:

- *Government-sponsored health-care programs such as Medicaid or Children's Health Insurance Program, state employee health benefits, and health insurance exchanges.* States are a major market participant in health care, directing how dollars are spent for Medicaid/CHIP and for state (and often local) employee health benefits. States can use these investments to influence the health-care system toward organizational structures that are accountable for cost management and quality improvement. States can also influence the type of plans offered in their insurance exchange. Exchanges can encourage the participation of plans that focus on quality, price, and value. States can steer consumers to higher-value plans by assigning ratings or displaying the plans more prominently on the exchange website.
- *State laws and authorities governing insurance, scope of practice, provider rates, and medical malpractice.* States can use insurance premium rate review to identify provider costs that appear unreasonable. They can eliminate state-mandated benefits that do not reflect evidence-based medicine and contractual rules between insurers and providers that hinder more efficient care. Scope-of-practice rules can be changed to allow non-physician providers to practice independently and at their full level of competency. Medical malpractice policies can be altered in an attempt to lower defensive medicine costs. And, as they have done in the past, states can elect to regulate the prices that providers charge for specific services.
- *State laws promoting consumer choice through price and quality information and ensuring market competition through*

antitrust authority. States can require plans and providers to report information on prices and quality to encourage consumers to select high-quality, cost-efficient care. States also have their own antitrust authority, which can be used to discourage provider consolidation that leads to non-competitive behavior.

- *The authority to enact policies in schools and invest in public health initiatives designed to improve population health.* Such policies can promote healthy communities, improve the physical well-being of children, and encourage exercise and better nutrition, including establishing school nutrition and physical education standards, providing financial support to expand local bicycle and walking paths, increasing community access to healthy foods by supporting farmers' markets, and providing loans and grants to grocery stores that locate in underserved communities.
- *The power of governors, working with cabinet members and legislators, to engage stakeholders in major public policy issues and create a process for change.* Developing a consensus among all stakeholders to modify norms, such as health-care payment models, can often be as effective as new laws or regulations. In health care, governors and legislatures can create temporary or permanent commissions that bring together stakeholders to address rising health-care costs. States can also create supporting institutions to collect, analyze, and track information on health-care costs and quality over time.

FIXING THE PROBLEM

The members of the State Health-Care Cost Containment Commission offer the following seven recommendations, which are explained in greater detail in the body of the full report.

Recommendation 1: Create an Alliance of Stakeholders to Transform the Health-Care System. To move toward a more cost-effective health-care system, government must form an alliance with purchasers, the medical community, and other stakeholders to create a consensus and commitment for change. Changing how health care is delivered will require a comprehensive approach that can take many years. The state can lead this transition and provide institutional support, but it cannot succeed without the long-term commitment of all stakeholders, including payers, consumers, and providers.

A state alliance for transforming health-care delivery can take several forms, largely influenced by the culture and key players in the state. Some states may be able to effect change through temporary commissions, advisory groups, and volunteer efforts. Others may require more permanent and formal institutional structures, and enabling legislation or executive orders. Whatever approach the state chooses, it must be prepared to lead and support certain critical actions, including establishing goals for improving quality, curbing spending, and monitoring progress.

Recommendation 2: Define and Collect Data to Create a Profile of Health Care in the State. Working with their stakeholder alliances, states should establish a common definition of health-care spending, identify quality tracking measures, create a process for collecting cost and quality data, and conduct an initial analysis of where health-care spending is concentrated and outside national norms. The state should also conduct an inventory of the health-care delivery infrastructure.

Key actions include:

- States should create a common measure of health-care spending that allows identification of a baseline and permits year-to-year tracking of spending growth. The commission recommends that each state use a formula that calculates the total cost of medical care divided by the population in the state (i.e., per-capita spending).
- The state must establish a means of collecting detailed information on medical spending throughout the state. This information should be used to establish an initial baseline, analyze changes and trends on a yearly basis, and provide information on costs among providers, services, and regions.



- The state should calculate baseline costs for various sub-components of health care to determine current spending patterns. The state should compare state baselines to national averages, costs in different geographic regions, and costs across different providers and plans.
- The state should identify a set of quality measures that all health-care organizations in the state consistently report.
- Most states have already established a process to gather, analyze, and report trends in key population health statistics, such as death, cancer, heart disease, obesity, diabetes, alcohol and tobacco use, infant mortality, and immunization status. Such data are often broken down by race, gender, and geographic location. Collecting and tracking such data should help the state, providers, and other institutions set priorities for improving population health.
- The state should work with its alliance to conduct an inventory of the state's health-care infrastructure. The inventory should identify the type and number of health-care insurers and provider organizations in the state and the process through which care is delivered and compensated.

Recommendation 3: Establish Statewide Baselines and Goals for Health-Care Spending, Quality, and Other Measures as Appropriate. The state and its alliance should establish appropriate targets for cost growth and quality improvements in the health-care system. They should collect timely and accurate data annually and report to the public and policymakers on progress in meeting goals. Such annual reports should be used to inform the development of policies to assist in meeting the goals.

Key actions include:

- The state should establish specific goals or limits on the annual percentage increase of per-capita total health-care expenditures over at least the next five years. The commission recommends that the state set the target as some fraction of state economic growth, such as a percentage of gross state product.
- To ensure that cost management does not come at the expense of health-care quality, the state should establish annual benchmarks for quality improvement and overall quality performance for each measure providers report for the next five years.

Although there has been a recent lull in the growth of health-care spending, it is likely temporary. If current practices in health-care delivery and compensation remain the same, projected annual costs will reach \$14,103 per person by 2021.

- The state should set long-term goals for tracking improvements in population health. This information can be used to focus on public health policies and draw attention to care delivery needs.
- Each year, the state should review the most up-to-date spending and quality data.

Recommendation 4: Use Existing Health-Care Spending Programs to Accelerate the Trend toward Coordinated, Risk-Based Care. States should use health spending programs they administer or oversee to support formation of high-performing coordinated care organizations that accept risk-based, global payments. Programs that states can use for leverage include Medicaid, the state employee health program (which can be combined with local government employee health programs for increased influence), and health insurance exchanges.

Key actions include:

- States should create a standard definition of what constitutes a high-performing coordinated care organization that manages costs and promotes quality using risk-based payments. Such a definition would establish goals for all health-care organizations in the state and allow payers to identify plans that deliver the best care and value.
- States have been steadily increasing their use of Medicaid managed care to cover a large share of their population, particularly children and adults. Seventy-four percent of all Medicaid enrollees are already in some form of managed care, and a large portion of these plans already uses risk-based payments. After states create a definition for high-performing, risk-based coordinated care, they should begin urging their Medicaid managed care plans to upgrade to meet the state definition.
- To better manage costs and improve outcomes, states have been encouraging delivery systems to build the capacity to serve the disabled and dual-eligible population through coordinated care using risk-based payments. This transition has begun in some states and should continue.
- As in the Medicaid program, states should negotiate contracts with health-care providers and insurers to provide coordinated, risk-based care to serve state employees. To increase

their market influence, states should work with local governments and create common benefit plans for state and local employees. Doing so would accentuate the purchasing power of both governments.

- Exchanges can be used to encourage consumers to choose certain types of plans. For example, exchanges can display cost and quality information, including out-of-pocket costs, to help customers compare plan value. Exchanges can also encourage plans to incorporate payment reforms such as global budgeting to encourage greater cost management.

Recommendation 5: Encourage Consumer Selection of High-Value Care Based on Cost and Quality Data, and Promote Market Competition. States can help ensure that consumers are given the information they need to consider cost in their health-care decisions and that adequate competition exists in the health-care marketplace. States can make the cost and quality of health-care services more transparent by reporting such information on a statewide basis and requiring plans to publish such information for their members. Antitrust authority can be used proactively and reactively to ensure that consolidation of health-care providers achieves greater efficiency, not market leverage over prices.

Key actions include:

- Consumers need accurate, timely, and comparative information on cost and quality within and across plans to make more informed choices on health treatment options. To reach this level of detail, states should require each health plan to report quality ratings and cost of procedures, including out-of-pocket expenses, for all hospitals and providers within the plan.
- States can use their antitrust powers to encourage consolidation as a means of reorganizing the system into more efficient care, or they can attempt to block it if it leads to market leverage in setting prices.

Recommendation 6: Reform Health-Care Regulations to Promote System Efficiency. State health-care regulations affecting insurance, scope of practice, and medical malpractice can influence health-care costs. The state should review these policies to determine whether they promote cost efficiency or present obstacles to expanding the availability of risk-based, coordinated care.

Key actions include:

- States should review their current lists of state regulations and benefit mandates enforced by insurance departments, including contractual rules between plans and providers,

rules on provider access, and essential benefits. The review should examine whether the rules and mandates unnecessarily add to the cost of health services or inhibit the expansion of risk-based, coordinated care.

- For more than a decade, states have been taking actions to reduce the costs of medical malpractice. States should review their medical malpractice policies and modify those that have substantial direct and indirect costs to the system.
- The drive toward greater coordination in care delivery and a growing population covered by insurance will strain the supply of skilled providers in many areas, particularly those involved in primary care. To help meet this demand, states should support policies that allow skilled non-physicians at all levels to practice at the full range of their competencies, including the ability to bill independently. States should also consider granting reciprocity to providers licensed in other states as practiced by states in the Nursing Licensure Compact.

Recommendation 7: Help Promote Better Population Health and Personal Responsibility in Health Care. States can use education and the bully pulpit, wellness programs for state employees, and public health initiatives to promote population health and encourage individuals to take more personal responsibility for their health-care decisions. In addition, states can make it easier for individuals to make informed end-of-life treatment choices that reflect their personal wishes.

Key actions include:

- Educate citizens about the importance of lifestyle choices and the value of maintaining a healthy lifestyle. Governors in particular can play a key role in these efforts, and most states today have a gubernatorial initiative designed to promote a “healthier state.” Most of these actions require minimal resources and often rely on volunteer efforts.
- Adopt more aggressive policies that promote healthy lifestyles in schools and communities. These policies often require some state resources and either legislation or executive orders to implement.
- Work with state employees to make better lifestyle decisions. Typically the largest single employer in the state, state governments can use their employee benefit plans to encourage and promote healthier lifestyles among a large portion of the workforce.
- Educate citizens on the value of creating instructions for end-of-life care. States can assist in ensuring that patients are given the opportunity to make informed end-of-life decisions, including palliative and hospice care.

THE FEDERAL ROLE

The federal government has a role to play in helping states transform the health-care delivery system. A major positive step is its effort to encourage the use of accountable care organizations in Medicare. ACOs are helping move the Medicare system away from fee-for-service to integrated and coordinated care, with financial incentives to manage costs and improve quality.

In addition, the report highlights several areas in which federal regulations or laws could be changed to strengthen states in their quest for higher-quality, cost-effective care. These run the spectrum from providing states with timely Medicare and Medicaid claims data to supporting more research and demonstration initiatives to help states test new cost control policies.

CONCLUSIONS

Bringing down the growth rate in health-care spending will take time and vigilance. The goal in each state should be to lower the growth rate of the cost of care per individual to a level that approximates the state's economic growth rate. Accomplishing this will require a long and sustained commitment by all major health-care stakeholders in the state. The strategies proposed in this report largely rely on transparency, purchasing power, payer and provider cooperation, persua-

sion, and "soft" regulatory pressure to spur the transition to more efficient, quality care. Over time, however, the state may need to consider additional corrective action for some high-cost outliers. States have many levers at their disposal to encourage compliance with state goals.

The time for state action is now. The health-care system is already moving toward payment reforms and more coordinated care in response to pressure from purchasers and, to some extent, incentives in the Patient Protection and Affordable Care Act. However, many of these changes are slow and tentative. States can accelerate change and create additional incentives for large-scale reforms.

Controlling the rise in health-care spending offers substantial future benefits to individuals, families, businesses, and governments. Health-care costs already consume 18 percent of the nation's output, as measured by the gross domestic product. Even small reductions in the growth rate will improve wage growth, business competitiveness, and the opportunity for governments to invest in programs that spur prosperity, such as education, infrastructure, and research. But failing to act will have consequences. Without systemic reforms, health-care expenses will continue to consume an ever-larger share of the nation's wealth, eventually threatening its economic future. ■

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