Cost Containment Opportunities in the Roadmap to Coverage

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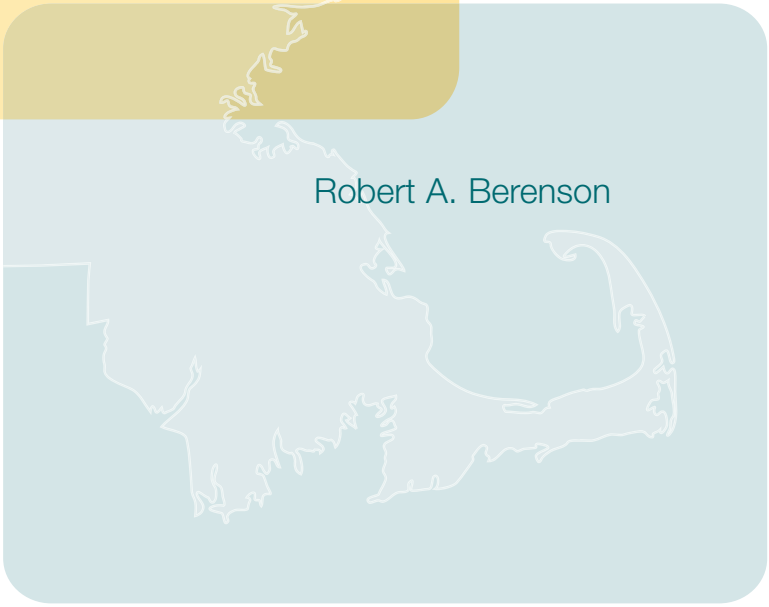

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TO COVERAGE

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Introduction

Although the main purpose of expanding health insurance coverage is to improve the health and well-being of the uninsured population and correct health system distortions created by uncompensated care and cost-shifting, the Roadmap to Coverage will only succeed if it can constrain health care cost growth to reasonable levels. The Roadmap estimates the costs of expanded coverage to be $2.0 to $2.2 billion, in addition to current spending on the uninsured.

Assuming that universal coverage would cost more net than the current situation is a prudent assumption. Most analysts agree that the new health benefits available to the uninsured through a universal coverage system would provide more care than the currently uninsured population receives now through uncompensated (charity) care in emergency rooms and hospitals—and that the additional cost of this care would not be totally offset by the substantial funds that would come in from amounts the uninsured would pay out of their own pocket, from worker's compensation payments for health care, and from charity care received.[1]

Further arguments can be made for why there might be additional expenditure-reducing strategies under universal coverage—including administrative efficiencies from insurance coverage in a large group purchasing pool, concentrated purchasing power to constrain inflationary cost increases, and health delivery system redesign to promote efficiency, e.g., various health information technology advances to enhance the timely retrieval of patient information. These are promising ideas, although there is as yet relatively little evidence as to what the effect of such cost strategies might be.

Thus, it would not be prudent to assume that moving to a coherent system of universal coverage such as represented by the Roadmap would completely offset the cost of enhanced coverage. Indeed, the Roadmap makes no such assumption. What the Roadmap does is to base its design of universal coverage on four components (building blocks) that in combination would be inherently cost-containing—a Medicaid expansion, health care tax credits, a purchasing pool, and a system of reinsurance for extraordinary health care costs. In addition to these specific building blocks, other cost containment strategies might be particularly promising within the context of universal coverage.

This paper begins by exploring why health care cost inflation matters and reviews alternative explanations for why these costs rise faster than general inflation. Next, the paper explores the health care cost containment landscape in Massachusetts—in

[1] Institute of Medicine. *Insuring America's Health: Principles and Recommendations.* Washington, D.C.: National Academies Press, 2004.

particular, the characteristics of the Massachusetts health care system that influence cost inflation and potential approaches to addressing costs. Next the paper presents the basic approach to cost containment related to the Roadmap's four building blocks, particularly the role of the purchasing pool. The paper concludes with a discussion of eight additional targets of cost containment opportunity that are available to complement the approaches related to the building blocks themselves.

Why Health Care Costs Matter and Why They Keep Rising

Increased spending on health care may be desirable, especially in a relatively affluent state such as Massachusetts.[2] In addition to any direct benefits in improved health, health care spending supports jobs and incomes, particularly in a place like Massachusetts, which is long recognized as an international leader in health care—in research, education, and provision of high quality "cutting edge" medicine. Already, one in seven jobs in Massachusetts resides in the health care sector. Expansion of the health care enterprise, while simultaneously improving the health for newly insured, surely is a worthwhile goal.

At the same time, employers and individuals (required to pay health insurance premiums rising faster than their wages) and taxpayers (asked to subsidize these premiums) have a reasonable expectation that costs will be managed prudently and over time not crowd out other legitimate uses for personal assets and public funds. Making the cost containment imperative even more persuasive is growing recognition that, in many parts of the system, health care is being provided at what health economist Victor Fuchs has called the "flat of the curve," that is, where additional spending provides no incremental health benefit to the recipients of the spending.[3]

The main culprits driving health care spending

The U.S. spent $5,267 per capita for health care in 2002—53% more than any other country.4 Although the problem of "skyrocketing health care costs" has been with us for decades, there is remarkable disagreement over the basic reasons why per capita health care spending is so high in the U.S. relative to other developed countries—and why it rises so much faster than inflation in the general economy (although, interestingly, not materially faster than health care cost inflation in other countries).5

There are many expert theories, supported by good data, pointing to different primary causes of high spending. For over three decades Dartmouth Professor Jack Wennberg has developed a large body of work on geographic variations in use and cost of care that all point to unnecessary service utilization—unnecessary because it

[2] Cutler, David M and Mark McClellan, Is Technological Change in Medicine Worth It? *Health Affairs* 2001; 20:11–29.

[3] Fuchs, Victor R, Health Care and the United States Economic System: An Essay in Abnormal Physiology, *Milbank Quarterly* 1972; 50(2): 211–237, Enthoven, Alain C, Stattuck Lecture – Cutting Cost without Cutting the Quality of Care, *New England Journal of Medicine* 1978; 298 (22):1229-1238.

[4] Anderson, Gerard F et al., It's the Prices Stupid: Why The United States Is So Different From Other Countries. *Health Affairs* 2003; 22: 89–105.

[5] Reinhardt, Uwe E, Peter S Hussey and Gerard F Anderson. Cross-National Comparisons of Health System Using OECD data, 1999, *Health Affairs* 2002; 21: 169–181.

improves neither quality of nor patient experience with care. He is describing flat of the curve medicine, a phenomenon resulting largely from high supply-induced demand for services—that is, providers creating the patient demand for services they then provide.[6]

Another set of studies find, in contrast, that on most measures of health services use, the U.S. is below the OECD mean. They assert that, rather than excessive use, higher prices for health care goods and services explain high U.S. spending. They find that higher U.S. prices reflect greater inputs used for providing hospital care in the U.S.—salaries, equipment, etc., and higher hospital service intensity, e.g., more stays in relatively costly critical care units. Further, physician incomes are much higher in the United States than in other developed countries.[7]

Yet others have recently challenged both the high price and high use explanations for U.S per capita health care costs. Rather, they find that the rise in the prevalence of common diseases, and not increased cost per case, is the primary factor responsible for growth in private health spending. They point specifically to the rising prevalence of obesity and to conditions such as diabetes mellitus that occur as a result of increased prevalence of obesity; and to new treatment approaches for many conditions (including pharmacological agents for mental disease) at earlier stages or with new treatment modalities.[8]

Many other analysts focus on new technology and new applications of old technology as the main driver of health care costs.[9] Victor Fuchs usefully distinguishes between baseline spending differences, which he asserts have various causes, and spending growth, which he attributes specifically to technology. He argues that changes in technology dominate the increase in expenditures in all high-income countries, which is why percentage rates of growth, rather than baseline spending, tend to be the same in all these countries, including the U.S.[10] Similarly, William Schwartz has long argued that reducing baseline expenditures has little impact on the factors responsible for the upward trend in real costs, in particular, technological innovation and diffusion.[11] But even accepting the importance of technology as a leading cause of health care cost growth, there has been a decades old dispute about whether a few "big ticket" technologies or thousands of "small ticket" tests and procedures are mostly responsible

[6] Fisher, Elliot S et al., The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care, *Annals of Internal Medicine 2003;* 138(4):273–287 and The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care. *Annals of Internal Medicine 2003;* 138(4): 288–298, Fisher, Elliot S et al., Variations in the Longitudinal Efficiency of Academic Medical Centers, *Health Affairs* Web Exclusive, 7, October 2004, assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.var.19v1.pdf.,Wennberg, John E, et al., Use of Medicare Claims Data to Monitor Provider-Specific Performance Among Patients with Severe Chronic Illness, *Health Affairs* Web Exclusive, 7 October 2004, assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.var.5v1.pdf.

[7] Anderson, Gerard F et al., It's the Prices Stupid: Why The United States Is So Different From Other Countries. *Health Affairs 2003*; 22: 89–105, Reinhardt, Uwe E, Peter S Hussey and Gerard F Anderson. Cross-National Comparisons of Health System Using OECD data, 1999, *Health Affairs 2002;* 21: 169–181.

[8] Thorpe, Kenneth E et al., The Rising Prevalence if Treated Disease: Effects on Private Health Insurance Spending, *Health Affairs* Web Exclusive, 27 June 2005, assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.317v1.pdf

[9] Newhouse, Joseph P, Consumer-Directed Health Plans And The RAND Health Insurance Experiment, Health Affairs 2004; 23(6): 107–113, Fuchs Victor R, Editorial: Health Care Expenditures Reexamined. *Annals of Internal Medicine, 2005;* 143(1) 76–78.

[10] Fuchs Victor R, Editorial: Health Care Expenditures Reexamined. *Annals of Internal Medicine, 2005;* 143(1) 76–78.

[11] Schwartz, William B, The Inevitable Failure of Current Cost-Containment Strategies. Why They Can Only Provide Temporary Relief, *Journal of the American Medical Association* 1987; 257(2):220-224.

for technology-related cost increases and thus where to concentrate cost containment efforts.[12] Still others have their own favored explanation for high health care spending. Some point to the problem of "moral hazard," that is, people seeking more care when some one else, i.e., third party coverage, picks up the tab on their behalf.[13] Thus, consumer-directed health plan advocates would have consumers paying much more directly out of pocket, reserving insurance only for "catastrophic" costs. A former President of the Robert Wood Johnson Foundation has called specialty care "the invisible driver of health care costs," and there are ample data to support that contention.[14]

Many, including the author of this paper, have emphasized the costs associated with patients with multiple chronic conditions, not only in Medicare but in other insurance programs as well.[15] Actuaries point to particular service areas that at any particular time make a disproportionate contribution to rising health care costs, e.g., prescription drugs, and would focus cost containment strategies on addressing those particular services. And we have only scratched the surface of favorite cost drivers, not least of which is the public's perennial favorite—fraud, waste and abuse.

It is not the purpose of this paper to attempt to reconcile these apparently divergent viewpoints on the main drivers of health care spending and spending increases, although it should be pointed out that these culprits do not represent mutually exclusive categories. What seems apparent is that there actually are many causes of high health care spending and of spending inflation, with perhaps too much time spent disputing causes and not enough time trying solutions that directly or indirectly address the many causes of excessive spending.[16] Further, the specific approaches to adopt to contain costs depend very much on the characteristics of the local markets where health care is delivered. In the case of the Roadmap, cost containment approaches need to be tailored to the particular characteristics of the Massachusetts health care market.

Flat of the curve medicine or unmet need?

One important question in considering the role of cost containment in the Roadmap is whether the relevant population is susceptible to flat of the curve medicine or, rather, has substantial unmet need such that additional health care spending would provide substantial incremental benefit. The population that would be covered in the purchasing pool would likely include both (a) those who currently have employer-based insurance or no group coverage but find that the pool offers better economic

[12] Moloney, Thomas W and David E Rogers, Medical Technology—a Different View of the Contentious Debate Over Costs. *New England Journal of Medicine 1979;* 301(26): 1413–1419.

[13] Pauly, Mark V, The Economics of Moral Hazard American Economic Review, 1968; 58: 231–237, Pauly, Mark V. Competition and New Technology, H*ealth Affairs 2005,* forthcoming

[14] Schroeder, Stephen A and Lewis G Sandy, Editorial: Specialty Distribution of U.S. Physicians—The Invisible Driver of Health Care Costs, N*ew England Journal of Medicine 1993*; 328(13):961–963., Starfield Barbara et al., The Effects of Specialist Supply on Populations' Health: Assessing the Evidence. Health Affairs Web Exclusive, 15 March 2005 assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.97v1.pdf, Welch, W. Pete, et al. Geographic Variation in Expenditures for Physicians' Services in the United States *New England Journal of Medicine* 1993; 328(9): 621–627.

[15] Berenson, Robert A. and Jane Horvath, Confronting The Barriers to Chronic Care Management in Medicare, *Health Affairs,* Web Exclusive, 22 January 2003 assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.37v1.pdf, Wolff, Jennifer, Barbara Starfield and Gerard Anderson, Prevalence, Expenditures and Complications of Multiple Chronic Conditions in the Elderly, *Archives of Internal Medicine, 2002;* 162: 2269-2276.

[16] Berenson, Robert A, Getting Serious About Excessive Medicare Spending: A Purchasing Model. *Health Affairs* Web Exclusive, 10 December 2003 assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.586v1.pdf

value and (b) those who are newly insured and may have unmet health care needs. About 80% of the uninsured in the Commonwealth are adults, mostly falling in the 19–54 age group, but a full 8% percent are between 55 and 64.17 A significant percentage of the newly insured would be 30–50 year-old men in this cohort, some with long-standing behavioral health and problems that need to be addressed.

About 73% of the uninsured come from low and moderate income families, so may also have unmet needs related to primary and secondary prevention for chronic conditions that begin in early adulthood, including hypertension, diabetes mellitus, and hyperlipidemia. For this population, improvements in access to care might incrementally increase ambulatory and prescription drug costs related to secondary prevention, but can be expected in the long run to realize health care cost reductions deriving from prevention activities that would result in reduced cardiac events, strokes, renal disease, etc.

In considering self-reported health status, the uninsured fall between those on Medicaid and those with employer or other private coverage. Six percent of the Massachusetts uninsured report fair or poor health status, compared with 20% for those covered by Medicaid but only 4% for those with private insurance coverage.[18] Thus, there is an opportunity to use new health plan and provider based techniques that address high cost patients—including disease management and high cost case management approaches to improving adherence to evidence-based practice guidelines, care coordination for those with multiple chronic conditions, teaching patient self-management, etc.

In short, it appears that the newly covered population under the Roadmap would have some unmet need, particularly in the areas of behavioral health and primary and secondary prevention, which could increase costs, at least in the short run. At the same time, there will be a substantial number of patients already well covered that surely would be subject to flat of the curve expenditures. For these groups, developing health plan and provider-based approaches to cost control should pay off.

Characteristics of Massachusetts Health Care Delivery

Although Massachusetts generally, and Boston hospitals specifically, score near the top on national measures of quality of care,[19] albeit with plenty of room for improvement, the Commonwealth is a relatively high spending state when considering per capita spending. However, there are Massachusetts-specific explanations and cost containment activities underway that suggest a more complex picture of health spending in the state. For example, an analysis by Partners HealthCare of 2002 data indicates that after adjusting for differences in wages, research and teaching costs, Massachusetts hospital costs per capita are only about 11% higher than the U.S. average.[20] In another example, data from 2003 on the average cost of employment-based

[17] Roadmap to Coverage: Health Insurance Coverage and the Uninsured in Massachusetts, prepared by Alison Cook, The Urban Institute, June 2005.

[18] Roadmap to Coverage: Health Insurance Coverage and the Uninsured in Massachusetts, prepared by Alison Cook, The Urban Institute, June 2005.

[19] Jha, Ashish Ket al., Care in U.S. Hospitals – The Hospital Quality Alliance Program, *New England Journal of Medicine* 2005; 353(3): 265-274, Jencks, Stephen F, Edwin D. Huff and Timothy Cuerdon, Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001, *JAMA* 2003; 289(3):305–312.

heath insurance showed that Massachusetts ranked in the middle (25th) among the 51 states on premiums for singles but 10th highest for family coverage, with premiums about 7 percent above the national average. On Medicare per capita spending, Massachusetts was 6th nationally in 2001, with spending about 14 percent above the national mean. Yet, on the annual increase in all private and public health care spending between FY 1980 through FY 2000, the Massachusetts annual increase of 8.3% was below the national average (8.7%).[21]

Overall, Massachusetts is clearly in the upper tier of costly states. But it is also a relatively affluent state, with very active research and education programs that are not accounted for in national comparisons. And cost containment efforts already seem to be having some impact, with a number of new activities underway.

In considering strategies for containing costs, it is important to recognize certain Massachusetts characteristics that are facilitators of and barriers to effective approaches to cost containment. These characteristics need to be kept in mind in developing the specific cost containment approaches and targets of opportunity discussed in subsequent sections of the paper.

1. Massachusetts has a strong commitment to and reliance on academic health centers (AHCs) to provide a disproportionate amount of health care, not only in Boston (with the Harvard, Boston University, and Tufts affiliated AHCs), but also in other parts of the state (with the Leahy Clinic outside Boston and the University of Massachusetts network, based in Worcester). For historical and cultural reasons, these tertiary care hospitals also serve particular populations for primary and secondary care. It is common for people to drive by local community hospitals and ambulatory centers to seek care from these relatively expensive AHCs, despite their ongoing efforts to encourage care in affiliated local facilities. Another asset of the prevailing delivery system is a relatively strong safety net, based on Boston Medical Center and the Cambridge Health Alliance and buttressed by a broad network of community health centers that are positioned to expand to provide primary care for a newly insured population.

2. By national norms, Massachusetts has a high supply of physicians, which could be viewed as a driver of health care costs, given increasing acceptance of the importance of supply-induced demand for discretionary medical services. The Boston area, in particular, has 50% more physicians per population than other metropolitan areas—2.7 per 1000 population, compared with 1.9 per 1000.[22] However, this "over-supply" may be more apparent than real, in that many of the physicians affiliated with AHCs are heavily involved in research and education and, therefore, spend relatively little time in clinical practice. Indeed, there are indications that, because of factors such as the high cost of malpractice premiums and the relatively high cost of living,

[20] Mechanic, Robert E. What Will Become of the Medical Mecca? Health Care Spending in Massachusetts, *Health Affairs,* 22(6):134.

[21] Kaiser Family Foundation, State Health Facts, assessed at http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?

[22] Center for Studying Health System Change, Health Care Market Stabilizes, but Rising Costs and State Budget Woes Loom in Boston Community. Report No. 12, Fall 2003, assessed at http://www.hschange.org/index.cgi.

Massachusetts actually is having difficulty recruiting physician graduates of training programs to stay in the state and also difficulty retaining early and mid-career physicians. The Massachusetts Medical Society, for example, reports statewide shortages in a number of specialties, and the situation seems to be getting worse.

Accordingly, the relevant issue for cost containment might actually not be physician oversupply, but rather concerns about continuity and timeliness of care provided by part-time clinicians. Consistent with this concern, the managed care technique of assigning patients to a "gatekeeper" physician, which has been abandoned in other markets, continues to play a role in many insurance products in commercial and Medicaid insurance products in Massachusetts, and would seem appropriate for those who would be covered in the Roadmap purchasing pool.

3. Physicians typically are organized either into large multi-specialty group practices (e.g., the AHC-based practices, Fallon Clinic, Leahy Clinic) or still in small solo and small group practices. For the most part, Massachusetts has been spared the development of large single specialty medical groups that have been organized elsewhere both to exert contracting leverage on negotiating fees with health plans and to develop large enough scale to own and refer to lucrative ambulatory services—including ambulatory surgery centers, advanced imaging services such as MRI and PET scans, and an array of other diagnostic testing items. The state's physician practice structure, particularly multi-specialty practice and close alignment with hospitals, serves to facilitate certain new approaches to cost containment, such as pay for performance and rapid expansion of health information technology.

4. There is active competition among large commercial health plans in Massachusetts. In the eastern part of the state, three major plans—Blue Cross Blue Shield, Harvard Pilgrim, and Tufts Health Plan—compete aggressively. Other carriers, such as Fallon Health Plan, are important elsewhere in the state. In addition, there are three active Medicaid health plans in the Boston area—Neighborhood Health Plan, the Boston Medical Center Health Net plan, and the Cambridge Health Alliance's Network Health plan. The latter plans have developed expertise in caring for a population with similar health needs to those of the uninsured population in the state. In contrast to other states, Massachusetts generally is not served by large, national health insurers, although United Health Care and Aetna, for example, do serve parts of the state. The dominance of state-based plans has created a problem for self-insured employer business and has produced some affiliations—Tufts and CIGNA, Harvard Pilgrim and United. However, the target population for the Roadmap is locally based and would not suffer from the lack of national plans.

   Thus, on the one hand, the large commercial plans and the Medicaid-only plans together already in the state provide the basis for a managed competition approach to cost containment based around the purchasing pool sponsor, as discussed below. On the other hand, a strong purchasing pool providing a structure for aggressive price competition among insurers for the large population covered under the pool might be a magnet for entry of strong national carriers.

In recent years, because of hospital mergers and consolidations as well as increasing capacity constraints facing hospitals in the state, health plans have been less able to obtain favorable pricing from hospitals. In fact, although hospital costs are relatively high, hospital margins in Massachusetts are relatively lean. Given the importance of these institutions to their communities, cost containment strategies based on aggressive pricing policies may not offer much promise, although the new purchasing pool, with an estimated 1.4–1.7 million individuals, could provide plans new leverage in negotiating over hospital prices.

5. On the service use side, health plans have recently focused on innovative approaches to utilization management to address cost inflation. In Massachusetts, the HMO model, including gatekeeper primary care physicians and basic prior authorization and concurrent stay review, has continued and over time has become reasonably well accepted in the provider and patient communities. Newer approaches based on an HMO-type platform, e.g., restricted "high performance networks," would likely be appropriate for the particular population to be served, and are surely innovations that health plans can adopt. In recent years, plans have focused on various approaches to disease management and high-cost case management targeted to the small percentage of the insured population responsible for a highly disproportionate percentage of spending. The larger health plans have also adopted pay-for-performance approaches targeted to overuse and are exploring the possibility of tiered networks, based on cost and quality considerations.

   In contrast, communities in other states are seeing a rapid movement to insurance products relying on increased patient cost-sharing, e.g., PPOs and, now, consumer-directed health plans that feature high deductibles. Whatever one's views on the merits of relying more on individuals to face cost-sharing obligations to discipline spending at the point of service, the particular population that would be served by the insurance expansion in the Roadmap pool lacks the financial resources to pay much at the point of service. For that reason, the pool is designed to offer low-cost-sharing plans. (However, many of the newly insured will buy coverage outside the pool and have available plans with higher cost-sharing.) In summary, given their reasonably successful experience with medical management approaches, Massachusetts-based health plans are positioned to compete not only on service, but also on how successful they are applying predominantly supply-side interventions to hold down health care spending.

6. Massachusetts benefits from strong provider leadership to address problems of cost, quality, and access. Further, for the most part, provider organizations have shown willingness to collaborate with each other and with health plans and other important parties to promote innovation. Collaboration is ongoing on health information technology (HIT) generally and on discrete HIT activities, such as computerized physician order entry systems, "eprescribing," regional connectivity, and electronic medical records. Indeed, on HIT and other cutting edge issues, Massachusetts is providing national leadership. In addition, Massachusetts providers and researchers based in AHCs are on the cutting edge in such areas as

pay for performance, malpractice liability system reform, and quality improvement. Examples of broad-based collaborations that offer the promise of improved care include the Healthcare IT Collaborative, the Massachusetts eHealth Collaborative, and the Massachusetts Health Quality Partnership.

The promise of these high visibility initiatives to reduce health care cost inflation still needs to be tested. However, as discussed more in the section below on the purchasing pool, a strong purchaser with large market share can help direct the focus of provider and plan efforts to assure attention to cost containment, whether by requiring health plans to engage providers through purchaser RFP/contracting process or by convening providers directly. The main point is that compared with most other states, providers in Massachusetts are creative and interested in redesigning health care to be more effective and should respond positively to thoughtful initiatives.

A remaining barrier to innovation is payment systems that create a so-called "negative business case" barrier to innovation. For example, under prevailing fee for service payment approaches, physicians are not rewarded for coordinating care, even though such coordination could reduce downstream health spending. And hospitals have no incentive to invest in post-hospital disease management programs that, among other consequences, should reduce subsequent hospitalizations.[23] Current pay-for-performance initiatives could be expanded to address the fundamental disincentives to more active care management by physicians, hospitals and other providers.

7. Massachusetts health plans have demonstrated some willingness to come to the table to work together and with providers to solve problems, without compromising their competitive positions. Collaboration is desirable because the competitive model breaks down in some particular areas. Health plans often do not get "first mover advantage" by innovating and sometimes are actually at a disadvantage by adopting a unique program to address particular segments of the population. For example, a particular health plan might be subject to unfavorable adverse selection if it put into place programs for patients with particular high cost health conditions. In addition, in a market place such as most of Massachusetts, where most providers are in most health plan networks,[24] plans may be concerned that their competitors would become free riders if they were to support enhanced provider capability as part of a health system redesign effort.[25] This concern surely is a consideration in whether plans help provide HIT hardware and software to physicians to support electronic billing and ehealth approaches.

   As a result of these market characteristics, collaboration among plans and providers might be appropriate to improve quality and reduce costs in particular

[23] Leatherman, Sheila et al., The Business Case for Quality: Case Studies and an Analysis, *Health Affairs,* 2003; 22(2): 17–30.

[24] Fallon Clinic recently split off from Fallon Health Plan

[25] Berenson, Robert A, Bringing Collaboration into the Market Paradigm

areas. For example, plans and providers might agree on using common metrics and approaches on defining quality measures that can be the basis for plan-specific pay for performance programs. A large purchaser, such as the envisioned purchasing pool, can play an important role in bringing the various parties to the table and promoting collaboration in those areas where plans and providers share a collective interest in addressing rising health care costs.

An example of a program that might be facilitated by plan collaboration is academic counter-detailing of prescription drugs.[26] This approach has been shown to reduce inappropriate and often needlessly expensive prescription drugs, but requires a fairly sophisticated and costly administrative structure that might be supported by spreading the costs across all the covered lives in an insurance program. A strong purchaser can bring the parties to the table to promote this kind of collaboration.

8. The Massachusetts market accepts certain forms of government regulation that, when carefully applied, can help address rising health care costs. Disagreement on the right mix of market forces and government regulation to address leading causes of health care inflation is inevitable. However, other states have abandoned certain regulatory approaches, such as certificate of need (CON), without substituting strong market forces to address inflationary causes, such as increased system capacity. Massachusetts has a relatively weak CON program, covering relatively few services and subject to a high capital threshold.[27]

   Because of relatively good relationships between physicians and hospitals in Massachusetts, the state has not had to invoke its Determination of Need authority to address the proliferation of physician-owned specialty hospitals and ambulatory centers that are creating unnecessary capacity and self-referral opportunities that result from physician ownership. Similarly, the state has been willing to legislate in areas of patient rights in managed care, physician self-referral, and medical record confidentiality. More than in most states, Massachusetts would likely be willing to legislate in areas that are not amenable to individual health plan or purchaser initiative but rather require policies that apply in a multi-payer context. In short, the potential exists that the purchasing pool itself could be an active, direct purchaser of care—bypassing health plans, and performing such activities as rate setting and prescription drug purchasing.

[26] Soumerai, Stephen. B and Jerry Avorn Principles of Educational Outreach ('Academic Detailing') to Improve Clinical Decision Making, *JAMA* 1990; 263: 549–556.

[27] Choudhry Sujit, Niteesh K. Choudhry, and Troyen A. Brennan. Specialty Versus Community Hospitals: What Role For The Law? *Health Affairs* Web Exclusive, 9 Aug 2005, assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.361v1.pdf.

The Building Blocks For Universal Coverage—and Cost Containment

Under the Roadmap, both the purchasing pool and the public reinsurance program would provide structural bases for containing costs while also assuring insurance coverage for most of the population. The new purchasing pool, in particular, would provide a strong cost containment platform, preferably as a strong purchaser that successfully organizes competition on price, quality and service among health plans interested in serving the large population of individuals covered in the pool. As a fall back, if costs rise unacceptably, the purchasing pool could also negotiate directly with providers.

The Purchasing Pool

The purchasing pool would have a number of administrative responsibilities related to enrollment, administration of tax credits, and assuring portability of coverage as people change jobs. In carrying out these functions, a large purchasing pool would immediately reduce the administrative cost of coverage in the individual and small group insurance market. In addition, the purchasing pool would become a mechanism for creating the administrative structure to support health plan competition to restrain premium growth.

In the Roadmap model, the purchasing pool would set a benchmark premium based on actual premium bids plans submit based on their estimate of their costs for providing the standard benefit package specified for an average enrollee covered by the pool. (Plans might be allowed to alter modestly their actual benefit packages, but, by using actuarial adjustments on their benefits, would still submit a premium bid for a standard package provided to an average person.)

The benchmark could be set at the median bid premium, the enrollment-weighted average bid, or other measure that relates the benchmark contribution the pool sets to actual bids health plans make. This approach to developing equal dollar payments made to any participating plan is a key to promoting price competition. Individuals covered by the pool would have an incentive to select the lowest cost health plan that meets their needs, because they would have to pay extra for selecting plans whose premiums were higher than the established benchmark premium. They could also receive a rebate or extra benefits for selecting a plan that was less costly than the benchmark. It is important to recognize that, in this approach, an individual's sensitivity to price comes in the selection of their health plan, made annually—not on their selection of individual provider services at the point of service, which is the prominent feature of consumer-directed health care.

Whether covered individuals would pay dollar for dollar for selecting plans with premiums above the benchmark premium, and how they would benefit from selecting health plans that bid below the benchmark amount, are important design features that would have to be determined. In any case, the important principle that is key to this form of plan competition is to provide covered individuals with incentives such

that they have a financial interest in their selection of health plan. For their part, the plans would enroll more individuals if they are able to keep their premiums below those of their competitors, and thus should want to adopt a range of activities that address the price and use of health care services in order to have competitive premiums that attract enrollment.

This approach also differs importantly from a strict, defined contribution approach, by relating the benchmark to the actual bids plans make rather than to some external measure of inflation. External measures typically do not accurately capture the growth in health care inflation, which exceeds measures of general inflation. Thus, under this approach, a variation of what are generally labeled "premium support" plans are better able to submit bids that reflect their own costs, rather than in relation to an arbitrary benchmark fixed to an external growth factor, such as the increase in the general consumer price index.

One merit of the premium support approach is that it recognizes the actual costs plans bear in providing the required benefit package while at the same time requiring them to bid without knowing ahead of time the level of their competitors' bids. That uncertainty provides an incentive for more aggressive bidding. A premium support approach also assures that enough plans are affordable at no extra cost for individuals who have little disposable income. In contrast, a stricter, defined contribution approach, with the benchmark pegged to an external measure of inflationary growth, would more strictly limit the public subsidies for coverage. But it could also expose covered individuals to much greater out of pocket payments to cover the full insurance premium.

Under any model of competition among many health plans, it is natural for plans to try to obtain enrollees who are healthier than average, even under modified community rating schemes that adjust premiums for age and gender, which have been shown to be very weak predictors of health spending.[28] Thus, a major function of the purchasing pool would be to guard against both intentional and inadvertent selection into health plans—not only by limiting marketing practices designed to attract healthy individuals, but also by administering a "risk adjustment" mechanism that modifies the actual payments plans receive for the health status of the actual individuals that enroll in each plan.

A number of purchasers, particularly public purchasers, that offer multiple choice of plans to covered individuals have successfully implemented risk adjusted payments to plans. And several risk adjustment tools, which typically rely on analysis of administrative data that health plans routinely collect, are available. These would need to be reviewed and/or adjusted, to ensure that they adequately predict the costs associated with those who would be covered in the Roadmap purchasing pool, particularly those with untreated behavioral health problems.

[28] Whenever insurance pools the experience of individuals with different health needs, whether commercial insurance, Medicaid, or Medicare, a small percentage of patients generate a highly disproportionate percentage of health care spending. As rules of thumb, 20% of covered individuals are responsible for 80% of spending and 50% of individuals for 5%. Berk, Mark L and Alan C Monheit, The Concentration of Health Care Expenditures, Revisited, *Health Affairs,* 2001; 20(2): 9–18.

Although health status is a far better basis for risk adjustment than one using demographic information alone, it still predicts a relatively small percentage of health spending. Thus, one objective of the public reinsurance building block, discussed in more detail below, is to mitigate the effects of the risk selection that is sure to occur for individuals who obtain insurance both inside and outside the purchasing pool.

A particular objective in risk adjusting payments to the health plans is to assure transparency, so that plans and providers are able to negotiate a "pass-through" of risk adjusted payments to providers where appropriate. For particular populations in need of unique expertise, the risk adjuster should reward plans and providers for selective channeling of patients to those providers best able to care for patients with those needs. Although paying providers on the basis of capitation logically supports the objective of passing through risk-adjusted payments, other payment approaches, including pay for performance (which is being adopted in Massachusetts as a replacement for capitation), can be used to reward such demonstrated expertise.

In addition to conducting the bidding process and implementing a system of risk adjusted payments to discipline the nature of the price competition plans could engage in, the purchasing pool would have other important functions related to promoting cost containment. For example the pool should oversee basic data collection and consumer education and information programs to support the expectation under this form of plan competition that covered individuals would make informed choices of the health plans and providers they select. On all these approaches to supporting plan competition, the purchasing pool shares an interest with employers, MassHealth, and the state employees program (the Group Insurance Commission) to engage in data sharing and analysis of findings to inform patient choices.

Finally, because the Roadmap purchasing pool would cover about 1.5 million individuals, it clearly would have clout to directly negotiate with providers over prices or impose a payment schedule for plans to adopt, setting up a form of all-payer rate setting for the large population covered in the pool. Given the relatively large negotiating clout that some providers in Massachusetts have, it may well be that the best countervailing pressure would be for the purchasing pool to use its consolidated market share to counteract provider power.

Even so, there are good reasons to reserve this more active role for use only in the event that health plan price competition fails to achieve cost containment goals. First, if the purchasing pool negotiated rates directly with providers, health plans would be required to use the pool-established payment rates for one segment of its covered population, while paying differently in other products. Plans may have good reason to vary network configurations, payment levels and other operational policies for different policies, but they maintain control over these variations. Pool-imposed payments, thus, may be disruptive to both plans and providers.

Second, relying on market power to impose payment rates may produce payment distortions and replicate the kind of cost shifting that now occurs because of MassHealth's payment rates, which are widely acknowledged to be lower than cost.

In effect, it might be too easy for the pool to ratchet down on payment rates, which in turn would stimulate increased service use, a problem currently being faced in Medicare with physician payments. Finally, it is important to remember that a purchasing pool commitment to the imposition of rates or direct contracting with providers does not represent a full, all-payer strategy because commercial payers, Medicaid, and Medicare would still be excluded.

Allowing the purchasing pool to adopt a more active role on pricing, if necessary, is a potential fall-back activity that should serve to discipline the competitive bidding process that would provide the fundamental approach to price competition under the building block structure. One could envision relying on the pool to establish or negotiate prices with providers, while health plans compete over alternative approaches to restrain service use. In addition, the size of the purchasing pool would give it market power to directly negotiate prescription drug prices with pharmaceutical and medical device manufacturers, again relying primarily on health plans to influence the use of prescription drugs and other technology. Although not the first choice, such a role for the purchasing pool might actually have spillover benefits for the rest of the health system, as health plans serving individuals in their traditional insurance products work to prevent providers from successfully cost-shifting to them in the face of an aggressive pool purchaser.

Public Reinsurance

The Roadmap would make public reinsurance available to coverage purchased inside the purchasing pool and to coverage provided by employers with fewer than 100 workers purchasing private insurance. Reinsurance spreads the cost of high cost cases across the insurance market and therefore reduces the substantial reserves insurers otherwise would have to maintain; without reinsurance, premiums would have to be much higher than otherwise needed because of the risks associated with catastrophic costs. Unfortunately, for insurers with small risk pools the private reinsurance market does not provide efficient protection for primary insurers. By decreasing uncertainty and, therefore, the level of reserves that must be reflected in current premiums, public reinsurance not only transfers the cost of high cost cases to the public fund but also permits both private insurers and the public pool to maintain premiums below what they otherwise would be. In short, public reinsurance itself should produce modest reduction in the total cost of insurance coverage.

Having a population of high cost patients potentially offers an opportunity for the pool to engage in direct cost containment for those who spend into reinsurance. With the recognition that health care spending is heavily skewed to those extraordinarily high expenses, public and private insurers have targeted this population for special attention and targeted interventions.[29]

[29] Lieberman, Steven M Lieberman, et al., Reducing The Growth Of Medicare Spending: Geographic Versus Patient-Based Strategies, Health Affairs Web Exclusive 10 December 2003, assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.603v1.pdf

Currently, a number of approaches to high cost case management are being explored in most insurance plans—public and private. Given that health plans compete over their ability to adopt effective disease management and related activities, the Roadmap's public reinsurance program has been designed to reimburse eligible insurers for 75 percent, rather than 100 percent, of an individual's cost incurred above $35,000 each year. This is because maintaining a 25% liability for high cost patients would still leave insurers with an interest in managing the patients generating these high costs, rather than shifting both the liability and responsibility for them to the public reinsurer. Relying on competition among plans, then, the purchasing pool might not itself have to develop disease and case management capabilities.

It might be wise to do so, however, because the public reinsurer would be bearing the risk for small private insurers, as well as those in the pool. In addition, some plans might wish to defer to the pool to manage the costs for covered individuals who exceed the catastrophic cost threshold. Thus, the pool might need to develop the capacity to contract for disease management and case management services from available vendors, or to develop internal capacity to perform important disease management and case management activities. .

Additional Cost Containment Opportunities

As discussed above, the primary route of cost containment would be through the purchasing pool's creation of price competition among competing health plans. In addition there are complementary activities that could be initiated or enhanced to achieve some measure of cost containment. Here, we present a short list (culled from many possible cost containment opportunities) of some of the most promising approaches that could be tried in Massachusetts.[30] Some initiatives belong logically with health plans in a managed competition approach to price competition. Others are primarily provider-based approaches, which might be fostered by collaboration among health plans or by the purchasing pool directly. Still others involve broader state law and regulation because they would apply across the entire Massachusetts health system. (I do not comment on initiatives that are best addressed at the federal level, whether in Medicare or elsewhere, but do point out places where state-based activity can attempt to correct for an absence of federal activity.)

1. High cost case management

Plans emphasize their commitment to various approaches to disease management and case management, using predictive modeling to target interventions on patients with a clinical condition, or more commonly, multiple conditions that would benefit from aggressive patient education, monitoring of compliance with medications, early detection of acute or chronic complications, facilitation of social services support, and care coordination. Although there are many models used by health plans, disease management vendors, and, occasionally, providers, for purposes of this discussion disease management programs as a group target individuals who have a specific

[30] Berenson, Robert A, Getting Serious About Excessive Medicare Spending: A Purchasing Model. Health Affairs Web Exclusive, 10 December 2003 assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.586v1.pdf.

chronic disease, such as asthma, diabetes mellitus, or congestive heart failure. As disease management programs have matured, they have also increasingly addressed common comorbidities often associated with the primary condition.

Case management programs, in contrast, serve a more select group of frail, disabled patients at risk for recurrent, adverse medical events that often defy clear clinical demarcation.[31] It is not uncommon for patients, especially those with one or more serious chronic conditions, to be transferred from disease management to case management as their overfull functioning deteriorates, with this evolution particularly evident in the Medicare population.

It is especially difficult to document savings interventions in this area because spending for any high cost patient is subject to "regression to the mean." That is, individuals who are specifically selected because they have high spending in one period tend to spend less in subsequent periods as their health returns to baseline, even if that baseline spending is above average. The observed reduction in spending may inappropriately be attributed to the disease management intervention, rather than to the expected regression to the mean. The better way to study the impact of disease management and case management interventions would be randomize high spending individuals and then look for differences between those receiving the intervention program and those receiving usual care. Those studies have not been performed, which is why the Congressional Budget Office concluded that it could not determine whether disease management, and, by implication, case management, actually save money.[32]

Yet, virtually every plan is using variants of disease management and case management—sometimes contracting out to third party vendors, sometimes developing in-house capacity—seem convinced that the interventions are useful, not only to improve quality but also to reduce cost increases. What has been missing, outside staff and group model capitated health plans, has been an ability to engage physician offices and hospitals in what have been mostly plan-subscriber interactions, which tend to "work around" the medical professionals patients see. Some, including the author, have called for major modifications in the prevailing physician and, possibly, hospital payment systems to promote provider engagement in improving care coordination for complex patients.[33] The Roadmap would give health plans, possibly convened by the purchasing pool, an opportunity to modify prevailing payment methods to better promote provider engagement in disease and case management.

2. Promotion of health information technology (HIT)

Massachusetts is a leader in promoting a range of HIT initiatives to improve quality and reduce costs. The state has had significant experience in creating interoperability

[31] Chen, Arnold Chen et al., "Best Practices in Coordinated Care," Report to the Health Care Financing Administration, Contract no. HCFA 500-95-0048 (04) (Washington: Mathematica Policy Research, 22 March 2002).

[32] Congressional Budget Office, An Analysis of the Literature on Disease Management Programs, October 2004, assessed at http://www.cbo.gov/showdoc.cfm?index=5909&sequence=0 .

[33] Berenson, Robert A. and Jane Horvath, Confronting The Barriers to Chronic Care Management in Medicare, Health Affairs, Web Exclusive, 22 January 2003 assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.37v1.pdf., Bodenheimer, Thomas, High and Rising Health Care Costs. Part 3. The Role of Health Care Providers. Annals of Internal Medicine 2005; 142: 996–1002., Bodenheimer, Thomas,. High and Rising Health Care Costs. Part 4 Can Costs be Controlled While Preserving Quality? *Annals of Internal Medicine* 2005; 143: 26–31.

networks for exchange of clinical and financial information, which are prototypes for the federal government approach to creating Regional Health Information Organizations (RHIOs). In the Healthcare IT Collaboration in Massachusetts, for example, a range of parties, including health plans and provider organizations, have been actively involved in a collaborative effort to promote the objectives of interoperability and related HIT enhancements, including broad dissemination of electronic health records and movement toward ehealth approaches to care.[34] Organizations in Massachusetts have also evolved to provide the standards, policies, education, infrastructure, and implementation required to achieve community connectivity.

Reliable and timely transfer of information in the fragmented health care system could plausibly reduce the error, duplication, delays, lack of coordination, and other inefficiencies that currently exist in the absence of electronic exchange of information. HIT experts based at Partners HealthCare , for example, recently projected substantial, national, systemwide savings from one key element of an HIT strategy—electronic health information exchange and interoperability (HIEI), i.e., the flow of electronic data between providers and other providers, and between providers and five health system stakeholders with whom they most commonly exchange information: independent laboratories, radiology centers, pharmacies, payers, and public health departments. [35]

The Partner's experts' model of savings from implementation of a fully standardized HIEI projected savings of $78 billion nationally once fully implemented, about 5% of health care costs. On top of HIEI, other HIT initiatives—such as electronic medical records, computerized physician order entry systems, clinical decision support software and related tools—all potentially could reduce medical errors and streamline care. These projections may be overoptimistic, given known HIT implementation problems on the ground.[36] But even a fraction of the projected amount would signify substantial progress.

Presumably, the cost containing potential of HIT activities in the state could proceed regardless of the Roadmap. But the costs for patients covered in the purchasing pool presumably would be affected positively by these ongoing activities, and the pool itself should be in a position to further support them.

3. Reduction of Medical Errors

Although the main impetus for focus on reduction of medical errors is naturally to improve patient safety and well-being, some have estimated substantial savings (ranging from $5–$10 billion to $17 billion nationally) from eliminating preventable errors during hospitalization.[37] One prominent example of an error-reduction intervention is computerized physician order entry systems in the inpatient hospital setting, pioneered at Boston academic health centers. As is the case with disease and case

[34] Halamka, John et al., Healthcare IT Collaboration in Massachusetts: The Experience of Creating Regional Connectivity, J Am Med Inform Assoc. 2005; 0: 18661

[35] Walker, Jan et al., The Value of Health Care Information Exchange and Interoperability, Heath Affairs, Web Exclusive, 19 January 2005 assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.10v1.pdf

[36] Baker, Laurence C, The Benefits of Interoperability: A Closer Look at the Estimates, Health Affairs, Web Exclusive, 19 January 2005 assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.22v1.pdf.

[37] Bodenheimer, Thomas,. High and Rising Health Care Costs. Part 4 Can Costs be Controlled While Preserving Quality? *Annals of Internal Medicine* 2005; 143: 26–31.

management, some argue that the current, dominant payment systems provide poor incentives for providers to improve patient safety. Under these hospital per diem, case rate, and percentage of charges payments and fee for service physician payments, providers are paid full amounts for readmissions or returns to the operating room, even when the additional services resulted directly from errors.

Although surely there are strong professional reasons to reduce medical errors, current payments systems do not support the needed investment in systematic efforts at the hospital system or medical group level. Further, to date, pay-for-performance approaches nationally have tended to address underuse of appropriate services, rather than misuse (medical errors) or overuse (excess spending). Massachusetts health plans have initiated efforts to address overuse. But payment systems still "reward" providers for medical errors. As discussed in more detail below when discussing payment reform, there is a real opportunity to modify prevailing payment approaches to promote patient safety and reduce costly medical errors.

4. Medical Malpractice Reform

The possibility of malpractice liability generates two types of costs. The first consists of the direct costs, and associated legal representation and administrative costs, associated with medical malpractice liability experienced by physicians, hospitals, and other providers. These costs are not a major contributor to health care spending or spending increases—estimated by the Congressional Budget Office, for example, at less than 2 percent of health care spending and increasing only modestly faster than health care inflation.[38] The second type of costs generated by the threat of malpractice liability consists of the practice of "defensive medicine," that is, a deviation from sound medical practice induced by a threat of liability. All experts agree that defensive medicine is common, although its costs are in great dispute. Defensive medicine can produce additional services, such as unnecessary lab tests and imaging studies and specialty referrals. But it can also produce reduced or deflected care, such as referral of high-risk pregnancies to specialized centers, which might actually reduce health care costs.[39] Plaintiff attorneys argue that potential liability leads to more careful care, although it appears that the liability system generally fails to deter substandard care.[40] In short, there are plausible arguments that malpractice liability leads to substantially greater health care costs, modestly increased costs, or little or no increased costs. Similarly, the evidence that traditional tort reforms, such as caps on non-economic damages, reduce defensive medicine is not strong.[41] From a theoretical perspective, it is hard to see how physicians and other providers would practice very differently simply because limits on liability reduced claims payouts by a modest amount. They still face the uncertainty associated with the current tort system and substantial liability for economic damages.

[38] Congressional Budget Office, Limiting Tort Liability for Medical Malpractice, 8 January, 2004, assessed at http://www.cbo.gov/showdoc.cfm?index=4968&sequence=0

[39] Studdert, David M et al., Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment, *JAMA,* 2005; 293(21): 2609–2617.

[40] Mello, Michelle M, and Troyen A Brennan, Deterrence of Medical Errors. Texas Law Review 2002; 80:1595–1637.

[41] Congressional Budget Office, Limiting Tort Liability for Medical Malpractice, 8 January, 2004, assessed at http://www.cbo.gov/showdoc.cfm?index=4968&sequence=0

That is why the type of reform being promoted by Troy Brennan and colleagues at the Harvard School of Public Health offers the potential for changing defensive medicine practices. Under this reform, avoidable adverse events would be adjudicated administratively outside the adversarial tort system, with the goal of increasing consistency, predictability, timeliness in both decision-making and payment amounts.[42] If successful, this kind of malpractice system reform, which is being discussed in Massachusetts, could dampen the defensive medicine instinct that now exists among many medical professionals and institutional providers and that may contribute to health care cost inflation.

In the meantime, some physician defensive behavior does not actually help in protecting against suits. Health plans—in consultation with expert risk managers, such as those at Harvard's risk management foundation, Controlled Risk Insurance Company (CRICO), Ltd—might play a larger role, perhaps in pay-for-performance initiatives, in trying to modulate some misguided physician defensive behavior that actually does not serve to protect providers against medical injury liability but is rewarded in fee for service reimbursement.

5. Appropriate patient cost-sharing

Consumer-directed health care (CDHC) has received recent attention as a way of addressing health care costs by using high out of pocket spending to make patient/consumers smarter shoppers. These ideas are quite controversial, because of concerns that patients faced with large deductibles and copayments would choose to forgo necessary care along with discretionary, marginally necessary, or even unnecessary care.[43] But even if it did work to make consumers more cost conscious, as envisioned by advocates, the cost-containment potential of CDHC is limited because of the skewed distribution of health care spending, with a small minority of patients accounting for a large majority of spending.[44] Presumably, in any insurance program, these high cost individuals would be relieved of any cost-sharing individuals as they exceed reasonable annual limits on out of pocket spending. Thus, the preponderance of health care expenditures would still be for services above the annual out of pocket maximums and covered by insurance.

In the context of the Roadmap, relying on substantial cost-sharing should have little role, in any case, because of the low and middle income population that would make up the newly insured—even though some individuals could meet their obligation to purchase insurance by purchasing available high deductible plans outside the pool. That said, there is room in health plan benefit offerings for variable coinsurance, to provide better incentives for choosing lower cost items and services in certain circumstances. Multi-tiered pricing for biologically or functionally equivalent prescription drugs can surely be used even with a low-income population, to promote lower cost generic or

[42] Studdert, David M and Troyen A. Brennan, Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States *American Journal of Law and Medicine* 2001; 27(2–3):225–252.

[43] Newhouse, Joseph P, Consumer-Directed Health Plans And The RAND Health Insurance Experiment, *Health Affairs* 2004; 23(6): 107–113.

[44] Berk, Mark L and Alan C Monheit, The Concentration of Health Care Expenditures, Revisited, *Health Affairs,* 2001; 20(2): 9–18.

discounted brand drugs. And there may be other opportunities for variable cost-sharing to promote consumer cost consciousness. Nevertheless, consistent with the Massachusetts delivery system that is based in group practices and physician-hospital organizations, to be maximally effective, the orientation of cost containment efforts should primarily engage providers.

6. Rationalizing the Use of New Technology

A recent editorial in The New England Journal of Medicine asked the following question, "How can a drug that is associated with higher rates of both renal dysfunction and death than placebo—and that costs 50 times as much as standard therapies and for which there are no meaningful data on relevant clinical end points—be given to more than 600,000 patients and be promoted throughout the United States for serial outpatient use, an indication not listed on the label? The editorial answered the question with regard to the drug Neseritide, a treatment for highly prevalent congestive heart failure, and concluded that there is a need to improve procedures to eliminate indiscriminate use of drugs when there is not proper evidence of safety.[45] He might have added medical devices, new surgical procedures and other new technologies, or new applications of existing technologies to the list, and could also have added evidence of clinical effectiveness to the concern about safety. The fact is that many technologies add new costs to the health care system without improving quality and sometimes compromising safety.

Although the primary approach to cost containment in the Roadmap would involve price competition among qualified health plans, health plans have not been able to affect the delivery system for certain, important cost drivers. One such area is the use of new technology and new applications of existing technology. Health plan executives acknowledge that the adoption of medical innovation is driven mostly by factors outside their control, including physician and consumer demand, and manufacturers' marketing strategies. Their own internal strategies to influence adoption have been only marginally effective.[46]

Prominent advocates of market competition believe that, because of the importance of technology as a cost driver, health plans should actively compete by developing clearly different philosophies and policies regarding the use of technology.[47] (In one formulation of the vision, Mark Pauly would like plans to distinguish themselves by their reluctance to use cutting-edge innovation: "We offer last year's technology, at last year's prices.") Especially in a state like Massachusetts, such competition seems unlikely. Health plans would not want to be known as the plan that scrimped on quality-enhancing technology to save a buck, and providers would be reluctant to practice last year's medicine.

Given their own difficulties addressing the coverage and application of new technology, health plans might welcome a broader effort, convened either by the purchasing pool, or possibly at the state level, to try to influence the pace and direction of technological

[45] Topol, Eric J,. Neseritide—Not Verified, New England Journal of Medicine 2005; 353(2): 113–116.

[46] Chernow, Michael E et al., Barriers to Constraining Health Care Cost Growth, Health Affairs 2004; 23(6): 122–128.

[47] Havighurst, Clark C, Health Care Choices: Private Contracts as Instruments of Health Reform (Washington: AEI Press, 1995), Pauly, Mark V. Competition and New Technology, Health Affairs 2005, forthcoming

change. The proper place for initiative in this area is federal. Victor Fuchs and Allan Garber have presented a strong case for creation of an independent organization to assess the benefits and costs of technologies and to make the information readily accessible to health plans, providers, and the public.[48] Their center would develop and disseminate information on comparative effectiveness of alternative technologies and treatment modalities, and introduce considerations of cost-effectiveness into health plan coverage policies.

It would not be possible for the Commonwealth to sponsor a center to carry out all that their proposed center envisions. (They suggest a $1 billion budget financed by a small—less than one-tenth of 1 percent levy on health spending.) Nevertheless, given the broad range of expertise both within health plans and within academic health centers in Massachusetts, a version of such an independent center could be established, financed by a small allocation from insurance premiums. Given the Neseritide example, there is good reason to believe such a center would pay for itself many times over through reduction in provision of high cost services, relying often on off-label use of established technologies.

7. Provider Payment Reform

Another area where plans have demonstrated an inability to innovate to improve quality and save money is in provider payment policy, especially with regard to physician payment. Research demonstrates a negative relationship between the state-level supply of primary care physicians and death from stroke, infant mortality and low birthweight, and all-cause mortality[49] and confirms that an increase in general practitioners is associated with an increase in quality and a reduction in costs per Medicare beneficiary.[50] Perhaps more germane for this discussion, research also shows that the higher the ratio of specialists per population, the higher the surgery rates, performance of procedures, and expenditures, with no advantage on scores of quality or outcomes of care.[51]

Health plans now typically base their payments on the Medicare Resource Based Relative Value Scale (RBRVS), originally developed for Medicare by William Hsaio and colleagues at the Harvard School of Public Health. For a number of technical reasons related to how CPT codes are developed and approved, how relative values are set and updated, and how values are converted into prices, the RBRVS-based payment system is skewed to favor specialists and disfavor generalists, including primary care physicians.[52] The result is that typical fee for service payment systems do not recognize and pay for the physician activities from which patients with chronic illness

[48] Fuchs, Victor R and Alan M. Garber. Health and Medical Care. In: Arroe, Lindsay, Nivola, eds. Agenda for the Nation. Washington DC: The Brookings Institution Press; 2003: 145–181.

[49] Starfield Barbara et al., The Effects of Specialist Supply on Populations' Health: Assessing the Evidence. Health Affairs Web Exclusive, 15 March 2005 assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.97v1.pdf

[50] Baiker, Katherine and Amitabh Chandra, Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care Health Affairs Web Exclusive, 7 April, 2004 assessed at http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.184v1.pdf.

[51] Fisher, Elliot S et al., The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care, Annals of Internal Medicine 2003; 138(4):273–287 and The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care. *Annals of Internal Medicine 2003;* 138(4): 288–298.

[52] Hsiao, William C. et. al Resource-based Relative Values. An Overview, *JAMA* 1988; 260(16): 2347–2353.

and disabilities benefit and which reduce costs associated with duplication of services and medical errors are reduced. Additionally, because primary care incomes substantially lag those of specialists, plans' inability to address the income disparities across specialties will serve to hasten the shortage of primary care physicians, which itself is a predictor of increased costs.

Pay for performance (P4P) refers to payment arrangements that offer financial rewards to providers, including physicians and hospitals, meeting such goals as improved services for preventive and chronic care, patient satisfaction, development of information technology (IT) and cost containment.[53] In essence, P4P provides marginal bonus payments in the range of 1–10% on top of the base payment that providers receive. Nationally, P4P for physicians typically has been focused primarily on a few measures of clinical under-service representing suboptimal quality of care. It has not been tried extensively to address overuse, inefficiency, and inflationary physician-generated spending, and there are theoretical reasons to doubt its potential in a predominantly fee-for-service system that rewards increases in volumes of services provided. That said, it is noteworthy that plans in Massachusetts are attempting to use P4P approaches focused on overuse of services, often as a replacement payment approach for capitation.

Even state of the art P4P programs address only a few percent of marginal payments, while ignoring the 100 percent payment incentives that are embedded in basic provider payment policies and thus influential in determining provider behavior. Only significant changes to these underlying payment methods would address the perverse incentives inherent in current payment approaches. So far, Medicare and private health plans have deferred to the American Medical Association committees to define services eligible for reimbursement and to place relative values on those services. Although plans have taken the initiative in a few targeted areas to address deficiencies in the standard payment methodology, such as establishing a limited reimbursement for web-based medical consultations, much more fundamental reform of payment methodology would support other approaches to improving quality and reducing costs. Presumably, health plans under the Roadmap would still want to maintain authority for negotiating payment levels. However, they might want to collaborate with provider groups, under the auspices of either the purchasing pool administrator or the state, to modify the basic payment methods used to pay physicians.

8. Supporting Patient Decision-Making in the Last Months of Life

The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) showed, in a large sample of severely hospitalized patients, that physicians were largely unaware of patients' preferences regarding end-of-life care.[54] Further, patients, family members and surrogates, and other caregivers were often dissatisfied with the health care provided to dying patients, who often experienced severe pain and other clinical symptoms of distress and depression,

[53] Rosenthal, Meredith B et al., Providers' Incentives for Quality Improvement, *Health Affairs 2004;* 23(2): 127–141.

[54] SUPPORT Principal Investigators, A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), *JAMA* 1995: 271(20): 1591-1598.

and who underwent life-sustaining treatments while expressing a preference for a treatment plan focused on comfort care.[55] In recent studies of variations in costs for Medicare patients in the last six months of life, a major difference in care patterns was attributed to different reliance on hospitalization and to higher use of intensive care beds and specialty consultations for hospitalized patients.[56] Although surely a problem for Medicare, the lack of adherence to patient wishes and resulting costs associated with the end of life is also important for a younger population. Hospice referrals for cancer patients and patients with other terminal illnesses come late, for example, with a median length of stay in 2000 of only 25 days.[57]

Any activities in this area must assure that there be no arbitrary rationing of end-of-life care. However, the evidence finds that patients themselves seek less intensive care in many end-of-life situations. Thus, in better understanding and responding to patients' true wishes, costs would also be reduced. Many have proposed specific improvements to the health system designed to provide alternatives to intensive care, including the need to increase currently scarce palliative care and to provide specific reimbursement mechanisms for palliative care. Problems with coverage of and eligibility for end-of-life services are similar in most commercial health plans and traditional Medicare.[58] A recent study documented that "ethics consultations" reduced the use of life-sustaining treatments delivered to patients who did not survive to hospital discharge when treatment conflicts arose in the intensive care unit.[59] Others would introduce approaches to assure that patients are encouraged to complete and have available appropriate living wills and durable powers of attorney that reflect their end-of-life wishes.

In short, a range of potential improvements support patient preferences for how they want to spend the last days and weeks of a terminal illness. Respecting patients' wishes would also reduce expenditures. In this area, primary leadership probably lies with providers, especially hospitals. Yet, health plans and purchasers can be supportive as well in their benefits and reimbursement policies. The Roadmap purchasing pool could use the RFP approach to plan participation in the pool to assure that health plans address these issues in their provider contracts, leaving the primary responsibility for actually accomplishing enhanced attention to these topics with the physician-patient relationship.

[55] Lynn, Joanne et al., Retrinking Fundamental Assumptions: SUPPORT's Implications for Future Reform, Study to Understand Prognoses and Preferences and Risks of Treatment, *Journal of the American Geriatrics Society 2000* 48(5) supp.: S214–S221.

[56] Fisher, Elliot S et al., The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care, Annals of Internal Medicine 2003; 138(4):273–287 and The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care. *Annals of Internal Medicine* 2003; 138(4): 288–298.

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Conclusion

This paper has identified just a few of the many cost containment targets of opportunity. Already health plans have an interest in using their contracting authority to work on these areas to limit health care cost inflation. However, in the face of the managed care backlash of the late 1990s, the growing leverage providers have achieved in contract negotiations over prices, and the reality that plans are able to pass on high substantial cost increases to employers in the form of increased premiums and increased patient cost-sharing, health care costs in Massachusetts have been rising at high, possibly unsustainable rates. Although the Roadmap would inherently generate some savings to offset the increased cost of coverage, it is essential in addition that explicit attention be paid to achieving reasonable control over costs.

Three kinds of cost containment opportunities are associated with the Roadmap. The first type is approaches inherent in the design of the building blocks. The second type is approaches that are optional but facilitated by the presence of changes made as part of the Roadmap. The third type includes a number of additional steps that could be undertaken without the presence of the Roadmap, but deserve consideration within that framework.

Plan competition for individuals covered in the purchasing pool would be the primary structural mechanism to accomplish significant cost containment. Plans that are able to provide the specified benefit package for lower costs than their competitors would be rewarded by gaining market share of the 1.4–1.7 million population that would receive care through the pool. Supported by other tools of managed competition, including risk adjusted payments to plans, publicly available quality information, and the public reinsurance pool, the purchasing pool administrator would be in a stronger position than most employers or purchasing coalitions to actually implement a disciplined system of managed competition in Massachusetts.

In addition, in certain specific areas plans on their own are not well positioned to achieve cost savings. For these cost containment opportunities, collaborative action by plans, providers, purchasers, and, in some cases, the state, could succeed where plans themselves cannot. In some cases, the purchasing pool could act as a catalyst to get the relevant parties to the table to develop collaborative initiatives, such as with technology. In other cases, the purchasing pool could directly intervene with providers if plans fail, such as with rate setting.

In short, there are many ways to address inflationary health care spending in Massachusetts. What has been lacking is the will to proceed. The hope is that the Roadmap's important goal of achieving successful expansion of health insurance to bring about universal coverage will generate the requisite political will to introduce systematically available approaches to containing health care cost inflation.

About the Author

Robert A. Berenson, M.D., F.A.C.P., joined the Urban Institute as a Senior Fellow in November 2003. His areas of expertise include Medicare operational policies; physician payment policy, including fee schedule development and methods for placing physicians at risk; the policies and procedures of managed care; malpractice reform; and the politics of health care reform. He has authored articles on these topics in nationally recognized journals, including the New England Journal of Medicine, the Annals of Internal Medicine, and Health Affairs. With Walter Zelman he co-authored The Managed Care Blues & How to Cure Them, a review and critique of health maintenance organizations in 1998. From April 1998 until October 2000, he was Director of the Center for Health Plans and Providers (CHPP) in the Health Care Financing Adminstration (now the Centers for Medicare and Medicaid Services). He then became Acting Deputy Administer of HCFA, and for the last five weeks of the Clinton Administration was the senior official in the agency.