State Policy Options: Health Costs and Financing

By Wisconsin Public Health - Health Policy Institute

This paper begins by summarizing the major issues driving the increasing costs and price of health care, including the patchwork of cost containment policy remedies that are commonly used. It then reviews the cost-impact of various insurance models, including the potential of purchasing pools, universal coverage, and single payer systems, to leverage lower prices and reduce cost shifting. This paper concludes with a discussion of the relationship between prices and quality, and the long-term potential of value purchasing to control health care costs.

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

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

Many observers now seek to reframe the questions, focusing on the relationship between costs and outcome. Often referred to as value-purchasing, this concept links cost containment to the measuring and purchasing of "quality" in order to achieve a healthier population. Fundamentally, value-purchasing requires explicit decisions on the relative costs and benefits involved in purchasing health services.

What Factors Are Behind Rising Health Care Costs?

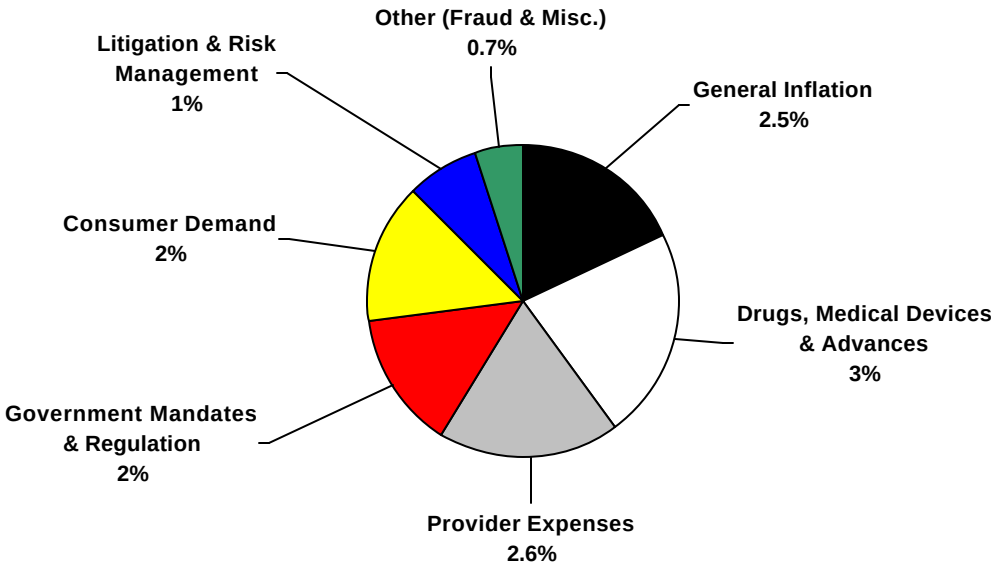
The shift to outcome- or quality-based purchasing will take time. More immediately, options are available to address the underlying factors ("drivers") behind these costs. Analysts generally agree that these cost drivers include the following:

- Consumer demand.
- Costs of training, hiring and retention of a health care labor force.
- Drugs—both disease- and lifestyle-oriented.
- Emergency medical response (mobile & within hospitals).

- End of life and chronic care.
- General inflation.
- Government mandates and regulations.
- Hospital care.
- Medical research.
- Medical supplies.
- Outpatient care.
- Defensive actions (litigation & risk management).
- Public education/advertising.
- Technology.

Medical costs in the U.S. increased 13.7% in 2001. The rates contributing to the medical inflation rate vary from year to year and among analysts. Nevertheless, PriceWaterhouseCooper, a widely cited source, estimates the 2001 contributions to the total medical inflation as illustrated in Figure 1:

Figure 1. Factors Contributing to Health Care Inflation Rates in 2001



What Policies Have State and Federal Governments Used to Contain Costs?

In response to these drivers, federal and state governments have initiated a range of cost containment policies, some of which focus on the market and others on regulation (see Chart 1). Most have worked for a limited time and could be implemented, or re-implemented, in Wisconsin at least on a temporary basis.

Chart 1: Several Policy Options Exist for Containing Care

Market Force Examples	Regulation Examples
Co-payments	Rate Setting
Deductibles	Insurance Rate Banding
Defined Contributions	Medicare Physician Fees
Managed Care	Generic Drugs
Risk Pooling	Certificate of Need
Capitation	Medicare DRGs, RBRVS
	Oregon-type "Rationing"
	Preventive Policies (e.g., tobacco taxes)

**These as well as other terms are fully defined in the accompanying paper and glossary produced by the Wisconsin Public Health and Health Policy Institute, through the Health Policy Forums project.*

Policy Options

The following policy and regulatory tools have been implemented by other states. Some have already been tested in Wisconsin.

- **Insurance purchasing pools.** Large insurance purchasing pools for low-wage workers and small employers. The larger the pool, the more leverage the pool has in negotiating insurance prices.
- **Certificate of need and hospital rate-setting.** Strategies that have been tried in Wisconsin and largely discredited, but may still merit consideration in a more targeted form.
- **Safety net services.** Programs, often government supported, that provide health care to those without insurance or the ability to pay, thereby directing the uninsured towards primary and preventive care, and away from more costly, emergency care.
- **Cost sharing, limited benefits, and defined contribution.** Private-sector tools that may be available to Wisconsin in its role as an employer and purchaser of coverage.
- **Disease management.** The use of evidence-based guidelines, structured patient education, and case management to reduce the costs and improve the health status of patients with chronic conditions
- **Prescription drug purchasing.** Joint purchasing, formularies, alternative therapies, pharmacy benefit management, manufacturer reimbursement strategies, or limiting number of prescriptions or days of supply (see Family Impact Seminar Briefing Report, "Designing a State Prescription Drug Benefit: Strategies to Control Costs.")
- **Insurance regulation.** Policies such as rate banding; expansion of who is eligible for insurance pools; damage caps; tort reforms and limits to malpractice awards and contingency fees; and no-fault systems.

- **Managed care.** HMO and PPO plans for state employees and expanded enrollment for those populations for which the State now provides Medicaid and BadgerCare coverage.
- **Patient safety initiatives.** Reducing medical errors and their associated costs.
- **Limiting the range of Medicaid-covered services.** Limiting coverage for optional Medicaid services, or adopt a more overt priority-setting process like that used by the State of Oregon**.**

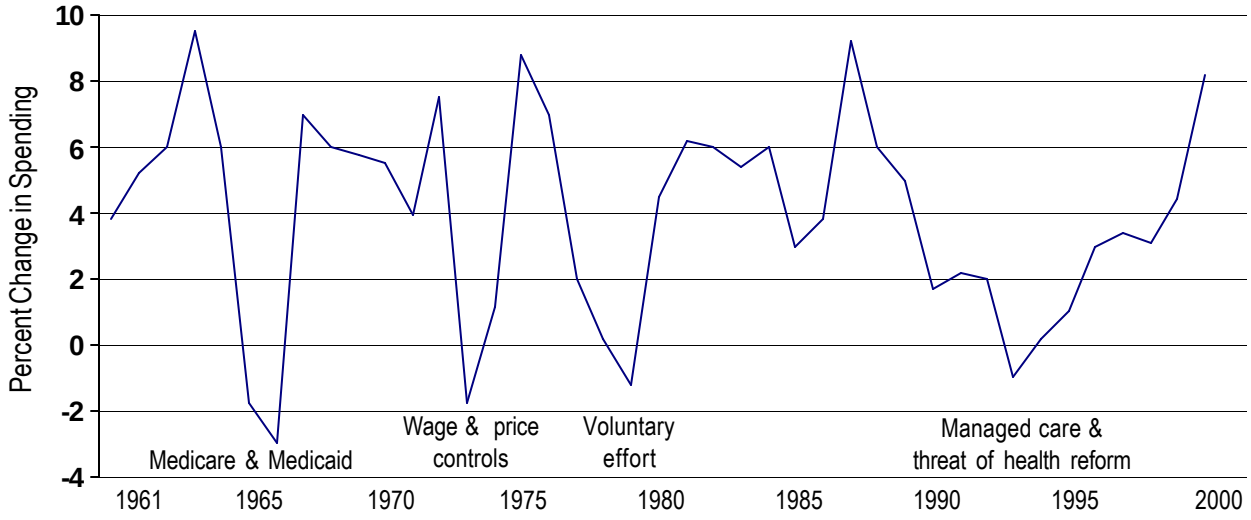
Other approaches include leveraging additional federal Medicaid dollars to reduce the burden on the state budget:

- Explore opportunities to expand Medicaid coverage to additional eligibility groups, and thereby leverage federal financial participation**.**
- Work with Congress to change the low reimbursement rates in Medicare and Medicaid payment formulas, which result in cost-shifting to the private sector.

Will These Policies Work?

Research shows little evidence that most "fixes" will limit cost increases for any length of time. Nearly all would require increased administrative resources. Historical experience, reflected in Figure 2, suggests that cost containment attempts have failed to provide long-term relief (see Figure 2).

Figure 2: Annual Private Health Spending Per Capita 1961-2001 Has Ebbed and Flowed (Adjusted for Inflation)



Drew Altman, Health Affairs, 2002. Used with permission.

Direct price regulation in general and managed care in the 1990s did hold down costs, but for relatively short periods of time. The promise of managed care has waned in the face of consumer backlash against its restrictions. Some analysts argue that the early benefits of managed care were one-time savings. Where "fee-

for-service" may have encouraged excess service, managed care eliminated the financial incentive for such "over-utilization." Yet more powerful drivers of cost—technology, consumer demand, mandates and regulations, and pharmacy costs—remain.

The National Academy for State Health Policy, in its exhaustive review of the options, concludes:

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

Purchasing Pools: Better Prices and Lower Costs?

Common responses to rising prices include (a) regulating payments to doctors and hospitals and (b) creating larger insurance purchasing pools by expanding opportunity for various sectors and populations to participate. Both public and private employers use these large purchasing pools to combat prices, either through negotiating lower commercial insurance rates or by directly contracting with physician organizations for lower prices based on larger pools of insured.

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

Single- and Multi-Payer Systems and Universal Insurance Coverage: How Do These Relate to Cost?

Pooling does hold down the price per individual, as has been shown by contemporary solutions such as single-payer, universal insurance, and aggregated pools whether of employees, the poor (Medicaid), or those over 65 (Medicare). But pooling does not directly address health care costs. Rather pooling spreads risk and the financing across more people while most of the cost drivers remain firmly in place.

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Single-payer and multi-payer universal health care systems are logical extensions of pooling. Each model has intrinsic benefits, but also several drawbacks. Single-payer, in particular, would require major changes in the American market system. Many powerful sectors of the economy would resist such change.

Some observers argue that the multi-payer commercial insurance system diverts resources to profits, excess employees and administration, and inappropriate medical interventions. A single-payer system could potentially reduce these costs and use the savings to expand coverage to currently uninsured persons. Such cost savings, however, would only occur through central, possibly, government

administration and regulation. Even then, many argue that despite the private sector's perceived excesses, potential advantages of public administration would be offset by the oft-presumed inefficiency of government.

Those who favor universal single-payer programs cite the success of Medicare—in essence a single payer system—in containing cost increases and maintaining relatively low administrative expenses. However, Medicare providers argue that those savings occur only because Medicare shifts the administrative burden to the provider. Moreover, Medicare payment may not cover the true costs of care nor expected profits, which is then shifted to the private sector. In other words, the private sector may actually subsidize the apparent Medicare savings. And Medicare, which does not cover outpatient prescription drugs, has avoided these significantly increasing costs.

Universal coverage could be pursued through either a single-payer or a multi-payer model. Research suggests that providers incur significant costs associated with caring for the uninsured. Providers currently cover the costs of providing charity care by shifting costs to private insurance, thereby increasing the costs to the commercial insurance sector. Universal coverage, some argue, would itself reduce health care costs by promoting timely and effective primary and preventive care, and reducing the costs associated with delayed interventions and use of emergency rooms.

Nonetheless, some analysts argue that consumer demand (a powerful factor affecting health costs) would soar and that physician capacity could not accommodate such demand. Higher quality providers, it is argued, may opt out of the system and limit their practices to those able to pay for care out-of-pocket or through alternative mechanisms. In some countries, single payer or national health systems result in long waits for care, inadequate access to the latest technology, and questions about overall quality. And Americans appear uncomfortable with systems that rely on overt "rationing." At times, however, such systems have demonstrated an ability to contain some costs and reduce inequities in health care. From purely a cost-containment perspective, single payer systems, along with universal coverage, remain options to consider and are being studied in a number of states.

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Private Sector Experiments: Shouldn't Consumers Bear More Responsibility?

The private sector continues to look for ways to encourage employees to take financial responsibility for their health and promote better employee health as a cost saving measure. Most recently, private employers, under the banner of consumer-driven purchasing, have used the concepts of defined contributions, high deductibles and after-tax savings and pre-tax spending accounts as a means to share the increasing burden of payment with employees. Employers and insurers are now experimenting with varying levels of cost-sharing, each with a different employee price tag based on the employee's willingness and ability to pay.

These tools could be more widely adopted by the public sector. However, substantial changes might be required in existing union-negotiated contracts.

However, there are significant concerns that "consumer-driven purchasing" may further segment the market and erode the broad risk-sharing advantages of pooling. That is, younger, healthier, lower-risk purchasers would opt for minimal coverage plans, while older, sicker or higher-risk patients would still need to purchase broad-based coverage. These people would then find themselves further priced out of the insurance market.

The trend toward consumer-driven plans reflects a broader intent: to make consumers more responsible for their health status and more aware of the relative costs and benefits of various services. All of the reforms mentioned above, nevertheless, focus almost exclusively on price as the mediator of value. They are limited in their ability to promote value based on quality, which many observers argue is essential to the cost-benefit analysis.

Doesn't Price Relate to Quality and Value?

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

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

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Both the private and public sectors promote the use of data [Health Plan Employer Data and Information Set (HEDIS), for example] as a step towards measuring quality. Large corporate payers are spearheading national efforts, most notably through the "Leapfrog Initiative," which examines the relationship between price, quality, and value.

Many public and private organizations, both in and outside of medicine, have become increasingly skilled at using data to analyze the quality of health care practices and outcomes. Such efforts have provided some definite conclusions, as noted in the Dartmouth Atlas and recently published Institute of Medicine studies:

- Medical practice varies greatly, both among physicians and between and within hospitals.
- Errors and poor practices are widespread and not limited by reputation, credentials, or geography.

- There are significant regional variations in prices for identical services, as has been noted in the recent studies of comparing Milwaukee to other metropolitan areas.

What Role Can Government Play In Increasing Quality and Value?

A decade ago, Wisconsin led the nation in initial efforts to acquire critical health care data.

A decade ago, Wisconsin led the nation in initial efforts to acquire critical health care data. Since then, politics, stakeholder resistance, administrative barriers, and falling state revenues have diminished this promising effort.

Various options are available to invigorate and expand state and private initiatives to acquire, analyze, and publicly disseminate health and outcomes data. These could allow statewide comparisons across provider and payer systems. Effective and tested methods for evaluating and reporting medical outcomes are available, relatively easy to understand and, through Internet-based technologies, relatively inexpensive.

Such a data infrastructure requires that government and the private sector collaborate, such that all purchasers of health care might understand and make comparative judgments about the available health care "products." Success in this undertaking requires health data collection and analysis to work in a flexible and neutral environment.

Where Do We Start?

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

This chapter is excerpted from a more complete issue brief with full references by the same title that will also be distributed to participants of the January, 2003 Seminar/Forum. The full text is available from David Austin, Coordinator, Wisconsin Health Policy Forums, 760 WARF, 610 Walnut Street, Madison, WI 53726 (608.263.8298) and on our website: www.medsch.wisc.edu/pophealth/StateForums

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