



## Bend the health care cost curve

Giving states incentives to reduce costs could gain bipartisan support

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In 2014, health care spending in the United States rose 5.3 percent to \$3 trillion, or \$9,523 per person. Although this cost burden affects all purchasers, it has particular impact on the budgets of federal and state governments, which together purchase more than 60 percent of health care services in this country.

Controlling health care costs is important to the long-term health of the United States' economy and its people. At the federal level, health care is the biggest driver of increases in federal budget deficits and outstanding public debt, which is now projected to reach \$24 trillion in 2025. Growing interest payments on this debt limit federal spending on existing and new programs and unfairly burden future generations. Growing deficits and increases in the public debt may put the domestic economy at higher risk of recessions due to volatility in international financial markets.

Moreover, the cost of health care programs hinders the ability to make other vital public investments in education, research and development, infrastructure, and other areas. This is particularly problematic for state governments, which currently allocate more than 40 percent of their total spending to public investments. Reductions in public investment will eventually lead to lower domestic economic growth, slower growth in real wages and incomes, and higher rates of long-term unemployment.

This is not a new problem. Over the past 30 years, the Consumer Price Index (CPI) for health care has grown about 4.9 percent per year, substantially above that of the average CPI. Even in 2009, in the depths of the Great Recession when the average CPI was -0.4 percent, the health care index increased 3.4 percent. Such above-average growth is likely to continue over the next decade.

Most federal health care spending is in four programs: Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and the insurance subsidies made available through the federal and state insurance exchanges. According to the Congressional Budget Office (CBO), these four programs will more than double between 2014 and 2025, growing from \$925 billion to \$1.9 trillion, until they represent 27 percent of all federal spending. This total does not include billions of other federal health care dollars spent by the U.S. Department of Veterans Affairs, federal employees, and active-duty personnel in the Armed Forces. Similarly, state Medicaid spending is projected to increase by 6.5 percent annually over the same 10-year period.

Bending the health care cost curve is not only important, it's doable.

Ultimately, an intergovernmental compact between federal and state governments can encourage state policymakers to make needed changes that reduce health care costs and improve overall economic health, which ultimately benefits the American people.

During the first year in office the new president should:

- Focus on health care cost containment, as this is the only way to avoid making major cuts in Medicare, Medicaid, and other federal health care programs or making major increases in taxes to reduce growing budget deficits.
- Recognize that most health care policy levers reside with states and that only by developing a proposal that incentivizes states to develop health care cost containment strategies would there be a path to bipartisan cooperation and eventual enactment of the president's proposal.
- Incorporate the cost and the potential saving of the proposal in the President's Budget for Fiscal Year 2018.

### **Incentivize State Health Care Cost Containment**

It is not politically feasible for the next president or Congress to set hospital and physician rates directly or for them to broadly preempt state authority to control health care costs. Rather, the best approach to cost containment is for the federal government to incentivize states to take the lead.

This approach could be effective and politically feasible for several reasons:

- Most health care policy levers currently reside at the state level. From insurance regulation to scope of practice to malpractice policies, the existing legal authority rests with state governments. Furthermore, in terms of driving delivery system change, each state's government is the dominant purchaser of health care in that state.
- The existing health care system is undergoing major structural change; therefore, allowing states to experiment with what works makes them the true "laboratories of democracy" as envisioned by U.S. Supreme Court Justice Louis Brandeis. States can tailor their approach to their respective health care markets and cultures. If a state finds that a policy is ineffective, it can quickly change strategies.
- When the more innovative states determine best practices, other, similar states will quickly adopt them. Numerous such historical examples exist, such as in welfare reform, where state-to-state adoption was rapid.

- The rate of return from such an approach is high: Every health care dollar saved generates an additional 30 cents in savings for the federal government. If this reduction is applied to just the four main federal programs—Medicare, Medicaid, SCHIP, and low-income subsidies in the exchanges—CBO projects a total potential base to calculate saving of \$867 billion in 2018.
- As shown by the recent signing into law of the Every Student Succeeds Act, which shifts responsibility for elementary and secondary education back to the states, such a federalism-based approach can often gain substantial bipartisan support.

### **The Next President's Proposal to Contain Health Care Costs**

The next president could use his or her FY 2018 budget proposal to outline a “Containing Federal Health Care Spending” strategy that would have four major provisions:

- All states would be provided strong incentives to negotiate voluntary shared savings agreements, receiving yearly performance bonuses based on their ability to slow the rate of health care spending relative to an agreed-upon baseline. These bonuses would be funded by an increase in the federal match rate for state Medicaid spending.
- All states would be required to use the same metrics and data sources specified in the legislation to measure total health care spending in the state and the potential savings to federal and state governments.
- Quality metrics would have to be included in all agreements to ensure that states do not sacrifice quality for savings. Initially, agreements would include the 33 quality measures that Medicare Accountable Care Organizations (ACOs) use, but the plan would allow modifications of the measures through the Centers for Medicare & Medicaid Services' (CMS) rulemaking process as more information becomes available.
- The key components of the agreements are a projected baseline for total health care spending in the state for three years and the bonus amount for each \$1,000 in total federal savings. In addition to the bonuses from the federal government, states would also accrue savings directly through their own Medicaid, SCHIP, and health plans for state workers. Individuals and businesses also would reap savings, although they would not participate in the agreements.

Another potential benefit of this approach is that it may reduce incentives for cost shifting between states and the federal government. For example, the federal government and states today often shift Medicaid costs back and forth in an attempt to reduce their own government costs. States try to move as much of their health care costs as possible to Medicaid so that the federal government pays a share, and the federal government makes states pay Medicare premiums for their low-income individuals. A final benefit under this new approach is that most governors will work with the health care stakeholders in their state to attain a consensus for developing cost-control strategies. This means there will be ownership and thus the new policy should be sustainable.

### **Potential State Strategies to Contain Costs**

Currently, states have robust tools to help them comprehensively reduce the rate of increase in health care costs. Not only do they directly purchase health care for the 70 million

individuals in Medicaid and for more than 3 million state workers, some also purchase for local government employees. In addition, states clearly influence how individuals and businesses purchase health care through the state exchanges. States oversee the scope-of-practice regulations for a broad spectrum of non-physician health care workers, such as physician assistants and nurse practitioners. They also enact medical malpractice laws and are responsible for overseeing health insurance companies. Many states do not exercise their full authority over approval of health insurance rate increases, but this could change with proper incentives. Some states could enhance competitiveness by requiring all providers to produce timely information about price and quality and by providing greater antitrust enforcement.

That said, some states could follow a regulatory approach. For example, Maryland sets hospital rates for all purchasers, including Medicare. Below is a summary of the broad strategic approaches that states could use to reduce the rate of total health care spending growth as promoted by the new president's proposal.

### *Use Health Care Spending Programs to Drive Delivery System Reform*

States can strongly influence how the delivery system is organized and operated. They can use the spending programs that they administer—Medicaid, SCHIP, and health care purchased for state employees and by individuals through state insurance exchanges—to support the formation of high-performing coordinated care organizations that accept risk-based fixed fees. By 2018, enrollees in all these programs could total more than 80 million. Most states will likely start by creating a state definition of an ACO. To date, nine states have already done this, and another 10 are in the process. States have already increased their use of managed care, particularly for women and children, in the Medicaid program. In fact, well over 75 percent of all Medicaid recipients are currently in managed care. Each state will then urge its Medicaid managed care plans to upgrade their care to meet its definition of ACO so that it can transition its women and children to the new plans. Simultaneously, each state can transition its employees to these plans. Then, it can work with its providers to create the capacity to offer risk-based coordinated care for the state's disabled and dual-eligible population. Finally, states can encourage risk-based coordinated providers to offer their plans through state exchanges.

### *Encourage Consumers to Select High-Value Care*

States can adopt policies to ensure that plans and providers make available consumer-friendly, accurate, and timely data on prices and quality. Consumers need this information to make more informed health care choices. It is also important for states to use state action and their antitrust powers to promote beneficial consolidation, which increases efficiency but blocks consolidation if it would increase market prices and reduce competition.

### *Specify Fees Charged by Hospitals and Physicians*

Although most states will likely pursue strategies that involve enhancing competition in the health care marketplace, others may prefer to follow a more regulated approach similar to that adopted by Maryland. There, a state agency—the Health Services Cost Review Commission—establishes the rates that hospitals can charge. Seven volunteer commissioners appointed by the governor run the commission, which is legally and politically independent. The staff consists of 30 individuals who have expertise in hospital finance, accounting, and public policy. The commission’s goal is to restrain the growth in hospital costs while ensuring access, quality of care, financial stability, and public accountability. In 1976, when the commission was created, hospital costs were 26 percent above the national average; by 2007, costs were about 2 percent below the national average. The system focuses on costs, not profits, and requires that hospitals and payers provide timely, accurate information so that the commission can develop payment methodologies that are consistent with market principles.

In addition, this regulated approach limits cost shifting and allows prices to approximate costs, which helps maintain the correct incentives. Furthermore, the cost of uncompensated care is recognized prospectively in payments to hospitals. By pooling uncompensated care costs, hospitals that have large pools are not disadvantaged in the system.

The Maryland system is dynamic and constantly adjusting to innovations and changes in the health care system. Recently, the commission moved toward bundled payments for outpatient services and away from fee for service. It has also been experimenting with pay for performance, including incentives to reduce preventable hospital readmissions. Maryland has a waiver from CMS so that Medicare is fully integrated into the system. The president’s proposal could offer a similar waiver to any state that wants to set hospital rates.

### *The ACA, ACOs, and Cost Control*

The federalism-based approach discussed in this paper builds on the delivery system changes piloted by the Patient Protection and Affordable Care Act (ACA). For insight into this paper’s recommendations, here is a brief summary of the ACA and one of its key cost-control provisions: the expansion of ACOs.

Enacted in 2010, the ACA was designed to expand access to health care primarily by extending Medicaid to individuals who earn up to 140 percent of the Federal Poverty Level (FPL) and providing direct subsidies on a sliding scale for families that earn between 140 percent and 400 percent of the FPL and purchased coverage through state or federal insurance exchanges. Originally, the ACA mandated that states had to expand Medicaid, but in *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court made that expansion optional. As of January 2016, 31 states had expanded the program.

The ACA did less to control the cost of health care, although it took several steps in this direction. One provision that could have a major long-term impact on costs was the funding of ACO pilots. An ACO is a new type of provider that delivers more integrated, coordinated care and is based on value purchasing rather than fee for service, which incentivizes providers based on the volume of health services they supply. The ACO model also creates the potential for shared savings between the provider and consumer by establishing 33 quality standards that providers must meet and benchmarks to measure shared savings. Payments are capitated, so risks are shared. To date, although the results of this

### ***Reform Health Care Regulations to Promote System Efficiency***

States can review and streamline all the state health care requirements and mandates that insurance departments enforce, including contractual rules between plans and providers, rules for provider access, and essential benefits. The review could examine whether the rules and mandates unnecessarily add to the cost of health care services or inhibit the expansion of risk-based, coordinated care. Although states have continued to revise their malpractice laws, they could accelerate those reviews and modify the provisions that add substantial direct and indirect costs to the system. The drive toward greater care coordination and a growing population will strain the supply of skilled providers in many areas, particularly those involved in primary care. To help meet this demand, states can allow skilled non-physician practitioners at all levels to use the full range of their competencies. States could also grant reciprocity to providers licensed in other states.

### ***Promote Better Population Health and Personal Responsibility***

States can use education and the governor's bully pulpit, wellness programs for state employees, and public health initiatives to promote population health and encourage individuals to take personal responsibility for their health care decisions. In addition, they can educate citizens about the importance of lifestyle choices and assist schools and community organizations in adopting more aggressive policies for healthy living.

### **Conclusion**

The next president's "Containing Federal Health Care Spending" plan outlined above builds on some of the structural changes currently unfolding in the health care market. Clearly this is the next step in health care legislation for two reasons. First, the ACA was primarily about expanding access, not reducing costs. Despite implementation issues, it should lead to universal care over time. Second, after a few years of slower growth, the rate of increase in federal health spending is back on an unsustainable growth trend. Essentially, it is time to focus on costs as it was not an integral part of the ACA and it is the major health care problem now. The president's proposal lets states to take the lead in developing strategies for health care cost control that are consistent with an individual state's health care market and culture. It also leverages states' nimble nature in correcting ineffective policies and presents fewer risks of unintended consequences. Most importantly, it is the type of proposal that could gain substantial bipartisan support for a new president in the first year. Put another way, it is likely to become law.

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This essay is part of [First Year 2017](http://First Year 2017), a project of the nonpartisan Miller Center at the University of Virginia focusing on the key issues the next president must confront, viewed through the clarifying lens of history and amplified with actionable advice from leading scholars, former administration officials, and policy experts.