



Brandeis University
The Heller School for Social Policy and Management

Health Care Cost Management in Massachusetts: A Discussion of Options

Meeting #3: Consumer-Focused Strategies

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Conference Report

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Health Care Cost Containment and Value-Based Insurance Design

Presenter: **Michael Chernew**, PhD, Professor, Department of Health Care Policy, Harvard Medical School

Overview

Most economists believe that medical technology is the largest driver of health spending growth, accounting for 50% or more of the overall growth rate over time. The challenge for policy makers is to continue benefiting from effective new technologies while reducing cost growth associated with those of marginal value. Managing costs associated with medical technology is complex and most cost containment strategies focus more broadly. Common approaches include expanding managed care, reducing provider payments, and increasing patient cost sharing. All have potential for controlling costs but also have important limitations.

Most consumer-focused strategies increase patient cost sharing. Cost sharing reduces spending, but consumers often respond by cutting back on valuable services as well as less effective care, which may have adverse health consequences. Value-based insurance design (VBID) reduces cost sharing for high value services (like treatments for chronic diseases) and has been successful with improving medication compliance. VBID is not a silver bullet for controlling costs, but it does support prevention and chronic disease management better than traditional cost sharing. Given the trend towards higher consumer cost sharing, VBID should be considered as part of an overall cost management approach.

Context

Michael Chernew, a professor and economist, discussed the major drivers of health care cost growth and presented the benefits and drawbacks of several cost-containment options including an important consumer-focused strategy, value-based insurance design.

Key Takeaways

- **Medical technology is the largest driver of health care spending growth.**

Dr. Chernew defines medical technology broadly to include new technologies as well as new knowledge that enables new applications of existing technology. Numerous academic studies using differing methodological approaches document the role of technology in driving costs, with one estimate suggesting that 50% of cost growth is related to technology.

The technologies driving cost growth change over time. In the 1950s and 1960s costs were driven by "small-ticket items" like lab tests and x-rays. In the 1970 and 1980s the primary drivers of cost growth were big-ticket items such as CABG, C-section, and cancer treatments. Beginning in the 1990s, new pharmaceuticals and biologics became a major factor driving cost increases.

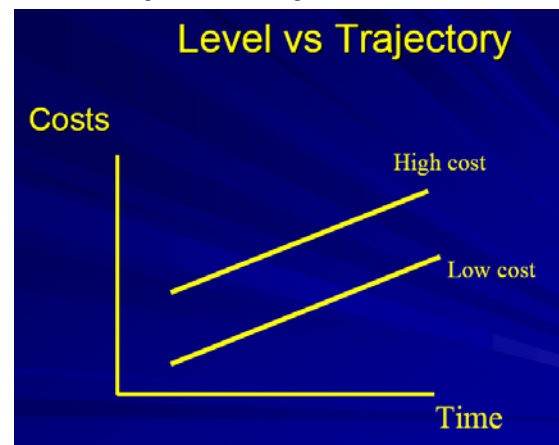
Other cost drivers include rising incomes, more generous insurance coverage, administrative and clinical inefficiency, inappro-

prate utilization, medical liability, and aging (which will become more important in the future).

General perceptions about the importance of certain "cost drivers" are often inconsistent with the actual evidence. For example, many believe obesity is an important driver of spending growth. In fact, the cumulative impact of rising obesity between 1987 and 2001 is about 1%-2% of real per capita spending. Similarly, Dr. Chernew stated that while price fluctuations can significantly impact costs over short time periods, it is unlikely that prices have had a major impact on spending growth over the long run.

- **A discussion on cost containment must consider both the level of costs and the rate of cost growth.**

Dr. Chernew presented the graphic below to distinguish between the level of cost (height of the curve) and the trajectory (how fast the rate of cost growth is rising).



Factors that contribute to the *level* of spending may be different than those affecting the *trajectory*. For example, inefficiency increases the level of costs and therefore pushes the curve up, but does not impact the growth rate. It is important to distinguish between whether a given cost-containment strategy will simply shift the curve down or bend its trajectory.

- **There are no "silver bullets" health care costs.**

Dr. Chernew presented four cost-containment strategies, each with its own challenges:

1. **Managed care:** Evidence shows that managed care can lower the level of costs and may modestly reduce cost growth. In the 1990s, managed care slowed but did not eliminate cost growth. Technology adoption was as rapid under managed care as under fee-for-service. Lower spending growth was seen in managed care-dominated areas with considerable provider competition. Yet even in those areas, health care cost growth still exceeded income growth.



2. **Capitation:** Capitation also can lower the level of costs and can control growth, particularly when global capitation is used rather than episode-based capitation. Maintaining slow growth in capitation rates, however, is challenging. At the provider level, physicians often exert upward pressure on capitated rates, which reduces the cost savings. At the system level, a great deal of political will is required to maintain the level of financial restriction required for capitation.
3. **Lower provider payments:** Paying providers less can result in reduced spending, but not without a downside. First, some evidence shows that physicians respond to lower payments by increasing volume, which diminishes cost savings. Second, access becomes a concern, particularly when there are payment differentials among payers. While conceptually, lower provider payments could affect both the cost levels and growth rates, there is scant evidence about appropriate thresholds for lowering payments.
4. **Patient cost sharing:** The theory behind cost sharing is that if people are charged more at the point of care, they will utilize fewer health care services and/or seek less expensive providers, thereby lowering costs. However, there are several drawbacks to cost sharing: individuals may forgo important clinical services if the costs of seeking care are too high; consumers may make poor provider choices; and health disparities across income groups may be exacerbated when consumers are asked to cover more costs.

Although it is unknown whether cost sharing can flatten the cost curve, Dr. Chernew believes it must be a component of any cost-containment plan.

"There's no way we can move forward without some sort of cost sharing to manage demand."

— Michael Chernew, PhD

▪ **Value-based insurance design is a potentially more effective—although still imperfect—approach to cost sharing.**

Value-based insurance design (VBID) recognizes that health care services are not all of equal value, and thus should not be subject to identical cost-sharing. VBID supports reducing copays for high-value services, such as maintenance therapy for diabetic patients, to encourage utilization.

"To control costs . . . we will have to be more clinically nuanced than just charging people a lot of money."

— Michael Chernew, PhD

VBID programs differ based on two key characteristics:

- *Targeting:* Targeted VBID programs identify a subset of patients to receive lower copays, while non-targeted programs offer lower copays to everyone.
- *Scope:* Some programs only lower copays for high-value services, while others also raise copays for low-value services.

The financial impact of VBID remains unclear. VBID increases costs due to greater use of high-value services, and may carry increased administrative costs (depending on design of the program). However, costs are mitigated by savings from increased use of preventive services and decreased emergency room and acute care visits.

How much these savings offset the costs of VBID is uncertain, as the literature currently offers little hard data. A simulation of prescription drug spending, however, addressed this question and found that in one specific program, non-drug spending for people adherent to their chronic disease medications would have to be 17% below that of non-adherent patients to offset aggregate (employer plus employee) drug spending associated with the program. If only employer spending is considered, non-prescription drug costs of adherent members would have to be 48% below those of non-adherent patients to achieve a complete offset. If productivity gains and disability savings were added in, the difference in costs between adherent and non-adherent patients needed for employers to break even could be lower. Moreover, programs that focus on different conditions or that target patient more effectively could break even with more modest adherence impacts.

"VBID cannot be perfect, but imperfect may be better than non-existent."

— Michael Chernew, PhD

Critics point out that implementing VBID for some conditions, such as back pain, will be extremely difficult. Yet that should not discourage payers from pursuing cost-sharing programs in areas where implementation is less challenging, such as diabetes and asthma.

Some VBID activities are showing promise. A small number of employers and payers have begun experimenting with VBID with positive results. For example, Blue Care Network of Michigan offers its members lower copays for asthma drugs and Pitney Bowes reports that its VBID program resulted in a 6% decrease in diabetes costs and generated over \$1 million in savings.



Consumer-Focused Strategies: Participant Roundtable

Presenters: **Bruce Bullen**, Chief Operating Officer, Harvard Pilgrim Health Care
John McDonough, DPH, Executive Director, Health Care For All

Overview

Health care leaders representing a wide range of organizations agree that cost sharing is only one component of a broader cost management strategy. Other important components that were discussed included payment reform, disease management, investments in information technology, and supply-side incentives. A range of opinions emerged as to which cost drivers are most important and which cost-containment strategies would be most effective. However, all parties concurred that Massachusetts can no longer afford inaction.

Context

Mr. Bullen offered his perspective on cost containment, cost sharing, and value-based insurance design. Dr. McDonough shared his views on the critical elements for health care payment reform. A roundtable discussion followed, surfacing viewpoints from employers, providers, health plans, and state government agencies.

Key Takeaways

Mr. Bullen's Comments:

- **Technology is only one of many drivers of cost growth in commercial markets.**

Mr. Bullen noted that in commercial markets, where cost growth is measured by increases in health insurance premiums, providers, plans, employers, and subscribers each have a unique view of what drives health care costs. Technology is an important factor, but certainly not the only factor driving premium increases. According to Mr. Bullen, other factors include:

- Utilization of medical services
- Administrative costs
- Demographics of populations covered
- Insurance purchasing choices
- Provider price increases due to provider consolidation
- Market dynamics and market rules
- Limited customer preference for closed provider networks
- Site of service decisions made by individual patients

"Many cost drivers in health care have little to do with the practice of medicine."

— Bruce Bullen

- **The effectiveness of cost-sharing programs depend on how well they are designed.**

Harvard Pilgrim Health Care's experience with cost-sharing programs has been encouraging. For instance, a well-constructed three-tiered drug formulary has increased use of less expensive, generic medications without causing patients to forego medication. Mr. Bullen noted that the Pitney Bowes experience referenced by Dr. Chernenow is promising, but complicated. While cost sharing and VBID can support disease management efforts, these programs yield long-term rather than short-term benefits. Therefore, employers must be willing to take a longer-term view on cost containment, which requires patience, focus, and some investment in infrastructure. The downstream benefits, including healthier employees, go beyond cost savings alone.

- **Cost sharing should be just one component of a more complex health care plan.**

Evidence suggests that when copays are dropped to zero, patients still forego valuable health services. Thus, other interventions, including information technology and disease management are important. These interventions must be complementary with the benefit design to improve the health care system.

In addition, any broad cost management strategy will need both supply-side (provider) incentives and demand-side (patient) incentives if it is to succeed.

Dr. McDonough's Comments:

- **Massachusetts health care has reached a turning point where a new payment system is necessary.**

Dr. McDonough suggested that like 1975 and 1991, when health care leaders recognized the need to devise a better health system, we are now on the precipice of dramatic change. Although everyone agrees that change needs to occur, a new set of system concepts must be accepted and understood before the existing system can be abandoned.

"We are at a pivotal moment in Massachusetts health care policy . . . but we need something to turn to."

— John McDonough, DPH

While no one knows exactly what the new financing system should look like, Dr. McDonough believes it should include the following four elements:

1. **Transparency:** Capitation failed in Massachusetts in the 1990s due to a breakdown of trust, which occurred because decisions were non-transparent. Moving forward, payment systems and performance data must be entirely transparent to all parties.



"The era of private deals between hospital systems and insurers has to end . . . No more secret deals."

— John McDonough, DPH

2. **Accountability:** Health care purchasers (government, business, and insurers) must refuse to pay for substandard care, including "never events," preventable infections, and preventable readmissions. Purchasers should also examine the relationships between drug companies and providers, ensuring that doctors and hospitals do not act as "paid agents" for pharmaceutical companies. Insurers must also work collaboratively under the aegis of the Attorney General and Division of Insurance to eliminate administrative waste.
3. **Responsibility:** The new system must make strategic system investments in public health, primary care, and chronic disease management.
4. **Payment Reform:** Massachusetts must move towards prospective payment for all levels of health care encounters—outpatient as well as inpatient care. This will help create a level playing field and reduce payment variation..

Participant Comments:

- **Achieving cost management will depend on not only building an IT infrastructure, but using it effectively.**
A number of participants raised the importance of IT in controlling health care costs. Administrative simplification could be achieved through greater connectivity among players. Personal health records would improve access to information, allowing consumers to more actively manage their own care and make better health care decisions. Dr. Chernew cautioned that investments in IT alone will not reduce costs; savings are predicated on how effectively the information provided by these systems is utilized.
- **Emphasis on primary care can lower costs, but may not control cost growth.**
Overuse of specialty care is a major contributor to excess spending in the United States. Health systems in nations with strong primary care tend to have lower costs and are more efficient. That said, early data suggest that cost growth is no different in markets that are more primary care intensive.
- **Capitation, while difficult to execute, is an effective lever for cost control.**
One participant noted that there are currently only two remaining primary care groups in Massachusetts that are fully capitated. However, among these two groups, capitation is work-

ing. These groups deliver lower costs and the physicians make more money. He cautioned, however, that finding an adequate number of physicians willing to participate in capitation remains a challenge.

- **Supply-side incentives must be considered along with demand-side incentives.**

A number of participants reiterated Mr. Bullen's comment that patient cost-sharing must be considered alongside other cost management approaches. In particular, greater emphasis needs to be placed on reforming the provider payment system—creating the right set of incentives to promote efficiency among providers.

Other Important Points

- **Technology for patients or for profits?** Dr. McDonough sees two distinct types of new technology: technology that leads to improved health and technology that leads to profit maximization. He cited his opinion that the former accounts for 20% of new technology, while the latter accounts for 80%. Participants agreed that future discussions of health care cost containment should focus more specifically on reducing use of technology that yields little or no health benefit.

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Additional materials are available at:

www.heller.brandeis.edu/costmanagement