Reducing Health Care Costs in CT

There is near universal agreement that the rising costs of health care are unsustainable and do not reflect rising quality of care. There is, however, a great deal of disagreement about the best ways to "bend the cost curve."

What's been tried?

Employers have employed a number of mechanisms to reduce health benefit costs over the last twenty years, with varying levels of success.

Managed care – All the rage in the 1980's and 90's, "managed care" involved changing consumer and provider incentives to favor less costly health care options, and to reduce escalating provider fees. Techniques included requiring prior authorization for treatments, reducing hospital lengths of stay, selective contracting with networks of providers, and increasing cost sharing on patients (see below). While it is generally agreed that managed care did reduce the rate of increase in health care costs for a time in the 1980's, it has failed to sustainably rein in long term costs, succeeded only in reducing prices paid to providers and not waste, and created a significant public backlash.[i]

Raising cost sharing A series of studies, most prominently a large insurance experiment by researchers at RAND from 1974 to 1982, found that consumers who do not pay the full cost of their health care services are likely to consume more health care treatment, as they are not liable for the full costs of their health care decisions.[ii] Economists labeled the incentives "moral hazard"; employers argued that consumers needed "more skin in the game." Consequently throughout the 1980's and 90's, employers shifted more of the costs of care onto beneficiaries in the form of increasing copays, coinsurance and deductibles[iii].
Subsequent research found that while increasing patients' cost sharing does reduce health care service use, it does so indiscriminately. Patients are as likely to reduce essential preventive and maintenance care as they are other health services. The effect is particularly strong for low income patients. Increased cost sharing has also been associated with increases in more expensive forms of care such as emergency rooms and hospitalizations.[iv]

Consumer-directed health plans In the late 1990's and early in this decade, a new concept gained ground among businesses eager to reduce skyrocketing health costs. Consumer-directed health plans (CDHPs) combine high-deductible health plans with tax-sheltered health savings accounts to create a new set of incentives for consumers to reduce health care spending. Premiums for the high deductible plans are lower than for comprehensive coverage. Tax exempt health savings accounts, to which workers contribute directly, are designed to make patients more cost-conscious thereby reducing health care spending overall. Early evidence found however, that CDHPs attracted healthier and wealthier workers, led to more missed health care due to cost, decreased patient satisfaction with health care, and did nothing to impact the rate of uninsurance.[v]

So how can we "bend the cost curve" in CT?

National health reform and our state-based reform, SustiNet, have numerous pilots designed to test promising initiatives to reduce the rate of growth in health care spending. Some proposals from the CT Health Policy Project have included:[vi]

1. **Implement PCCM statewide for the HUSKY program**. Committing attention and resources to ensure a robust program that attracts providers and consumers, is accountable for outcomes, serves as honest competition to the HUSKY HMOs (motivating them to perform) and saves money. PCCM not only saves money but invests in primary care and care coordination, sorely needed capacity in Connecticut.

   PCCM has been implemented and is saving money in thirty states. To date, Connecticut has implemented this important program in Waterbury and Willimantic only. The state has also set several artificial barriers to participation for both consumers and providers, including a failure to devote resources equal to those committed to HUSKY HMO, and an unwillingness to accept assistance from advocates with recruiting providers and consumers.

2. **Recover the $50 million annual overpayments to HUSKY HMOs revealed in the Comptroller's audit of HUSKY rates.** These savings were proposed by the Governor for the FY 2010 and 2011 budgets, approved by the General Assembly and are included in the final budget. However, DSS has yet to reduce HMO capitation rates to reflect the savings.

3. **Provide coverage for smoking cessation medications and counseling in Medicaid.**

4. **Limit HMO administrative costs.** Other states have passed legislation limiting medical loss ratios to 75 percent (insurers may only spend up to 25 percent of premiums on administration and profit). Enforcement of a similar law by the state of Maine resulted in the return of millions in premium overpayments to residents of that state. The House version of national health reform limits insurers' medical losses to 85 percent.

5. **Implement payment reform for all state health care purchasing and support all-payers initiatives to reduce overutilization and pay for quality.** This includes a variety of initiatives implemented in other states such as pay-for performance for both providers and managed care plans, paying for episodes, or bundles, of care in one payment across the care continuum rather than paying fees for each service, and eventually making global care payments for individuals, risk adjusted to account for varying levels of need.

6. **Implement patient-centered medical homes for every member of state coverage plans**. Medical homes coordinate fragmented services and give patients the tools and support they need to improve and maintain their own health status. Medical homes reduce the need for specialty care, improve access, reduce duplicate tests, reduce unnecessary and conflicting medications, keep patients out of emergency rooms, and improve patient safety by strengthening the patient-provider relationship and by emphasizing primary care and prevention.

7. **Promote and require the use of health information technology tools,** including provider electronic medical records and consumer personal health records, for all state coverage

8. **Use transparency and market forces to improve cost effectiveness of care by providing consumers with comparative quality and cost data, using successful models from other states**.

9. **Reduce prescription drug costs with a provider education campaign,** on the relative costs and effectiveness of medications; limit gifts to providers from drug companies; require disclosure of all financial ties between providers and suppliers; and prohibit data mining, or the purchase of consumer prescription records, for marketing and commercial purposes.

10. **Expand public health programs that give patients tools to take responsibility for their health** including care coordination, disease management, risk assessments, disease screenings and immunizations on a community level to prevent disease and manage chronic illness. Connecticut's program providing free nicotine replacement therapies was overwhelmed and had to be shut down early because demand outstripped the budget. Vermont's Blue Print for Health can serve as a template for Connecticut.

11. **Build all-payer data systems** that monitor quality, support care coordination, reduce duplication of services and medical errors. Support providers in using their data to improve performance and support payers in using the data to reward value and efficiency.

12. **Assess areas of over and under capacity in the health care workforce**, develop a strategic plan to address shortages and surpluses. The nursing shortage has been a significant driver of hospital costs, in particular, while there is evidence that an over-abundance of physicians in an area can increase costs. As our population ages, chronic diseases multiply, and the practice of medicine changes, it is critical that Connecticut monitor and regulate its health care workforce.

13. **Create a shared-savings plan for all state coverage plans to engage consumers** in both identifying and reporting fraud, waste and abuse and in generating ideas for innovation. Use the "wisdom of crowds" and the network of hundreds of thousands of consumers to drive improvement.

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[i] D. Cutler et. al., How Does Managed Care Do It?, RAND J Economics, 31:526-548, 2000, Kaiser Family Foundation polling

[ii] R. Brook, et. al., The Effect of Coinsurance on the Health of Adults, RAND Health Insurance Experiment Series, 1984, http://www.rand.org/pubs/reports/2006/R3055.pdf.

[iii] Copays are set fees paid by patients for each service, coinsurance is a set percentage of the cost of each treatment paid by patients, deductibles is a fixed amount of spending in a given time period (generally each year) patients must spend toward their health costs before insurance will begin paying bills.
[iv] L. Ku & V. Wachino, The Effect of Increased Cost-sharing in Medicaid, Center on Budget and Policy Priorities, July 2005, H. Huskamp, et.al., The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending, New England J Med., 349:2224-2232, 2003, S. Zuckerman, et. al., Missouri's 2005 Medicaid Cuts: How did they Affect Enrollees and Providers? Health Affairs Web Exclusive, 2/18/09, D. Goldman, et. al., Pharmacy Benefits and the Use of Drugs by the Chronically Ill, JAMA 291:2344, 2004.

[v] P. Frontsin and S. Collins, 2nd Annual Consumerism in Health Care Survey 2006, EBRI/Commonwealth Fund, December 2006.
[vi] Thirteen Ways to Save Money in CT's State Budget, CT Health Policy Project Issue Brief, November 2009.