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State Strategies for Slowing Health Care Cost Growth in the Commercial Market

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TOPLINES

State policymakers can address rising health care costs in the commercial market with strategies targeting global spending, provider and drug prices, utilization, and administrative costs

Strategies that could have the greatest impact include implementing a cost growth target, adopting population-based payment, capping payment rates, and containing growth in drug prices

The Commonwealth Fund

INTRODUCTION

The American public has become increasingly concerned about rising health care costs. State policymakers also have become more focused on the issue of rising costs in the commercial market. In less than 20 years, from 2000 to 2019, premiums for employer-sponsored health insurance have more than tripled, far outpacing inflation; in 37 states, premium contributions and deductibles now consume 10 percent or more of the median income. High health care cost growth directly affects business profitability and worker wages, too. Meanwhile, rising health care costs for state employees, dependents, and retirees squeeze out other state budget priorities, such as education and social services.

In general, states have less power to address cost growth in the commercial health care market than they do in public programs like Medicaid that are directly funded by and administered by the state. Nonetheless, state policymakers have explored and implemented a range of cost-control strategies in recent years. Their experiences, along with ongoing research and evaluation, can inform the next wave of policy innovation.

In this brief, we provide practical guidance to state policymakers seeking to contain health care cost growth in the commercial market. We present an overview of 10 potential strategies, which we discuss in greater depth in the accompanying profiles. For each one, we describe:

- key design and implementation considerations
- empirical evidence on the strategy's potential to reduce health care cost growth
- the potential impact on health equity, including consequences for economically and socially marginalized groups
- contextual features, such as health care market conditions, state analytical and regulatory capacity, and stakeholder dynamics, that might make the strategy particularly attractive to certain states
- possible unintended consequences or limitations.

STRATEGY IDENTIFICATION AND SELECTION

To develop this set of options, we surveyed the peer-reviewed and grey literature and drew upon recent work by health economists at the Urban Institute, 1% Steps for Health Care Reform, and the American Enterprise Institute. We also examined recent state laws affecting health care cost growth and supplemented our research with our team's knowledge of current state activity on cost containment.

To select strategies for inclusion, we first employed "gating" criteria to determine whether a strategy should be given further consideration. These focused on whether the strategy:

- has been shown to reduce health care cost growth in the commercial market, or whether a strong argument exists that it could reduce cost growth
- could be implemented in a way that does not negatively affect low-income populations, including those served by Medicaid, or people of color.

A second set of criteria was applied to the group as a whole to ensure that the final list of strategies, even while parsimonious, would provide states with a diverse array of options. These criteria addressed whether the strategies:

- would appeal to states with a range of political dispositions
- could be applied in a variety of geographic settings
- would cover the leading drivers of high health care costs and cost growth
- could be implemented by states with varying levels of resources.

PROPOSED STRATEGIES

We identified the following 10 strategies for states to address health care cost growth in the commercial market. They are grouped by the resource requirements needed for implementation, with the most resource-intensive strategies listed first. Each strategy in the list links to a detailed overview providing information on design and implementation, evidence of impact, equity considerations, and other topics.

1. **Implement a health care cost growth target.** Establish a target, or benchmark, for per capita health care cost growth; measure performance against that target; hold entities accountable for meeting the target; and implement cost growth mitigation strategies to attain it.
2. **Promote adoption of population-based provider payment.** Encourage or require increased adoption of advanced alternative payment methodologies, particularly those that move provider payment toward meaningful risk sharing.
3. **Cap provider payment rates or rate increases.** Set a limit on prices paid or restrict provider price increases in state-regulated markets.
4. **Contain growth in prescription drug prices.** Establish prescription drug affordability boards, upper payment limits, international reference pricing, or penalties for "excessive" prices.
5. **Improve oversight of provider consolidation.** Reinforce states' ability to review and disapprove mergers and prohibit anticompetitive contracting terms to counter the impact of health care consolidation on provider prices.
6. **Strengthen health insurance rate review.** Use the insurance rate review process as a lever for health care cost containment.
7. **Adopt advanced benefit designs.** Promote strategies that encourage consumers to choose lower-cost providers, such as reference-based benefit design and "smart shopper" programs.
8. **Promote use of community paramedicine.** Enable emergency medical service providers to provide a range of services to patients without transport to an emergency department (ED) to reduce unnecessary emergency and inpatient care.
9. **Improve behavioral health crisis systems.** Expand behavioral health crisis services to reduce use of more costly ED and inpatient services, and leverage multipayer support for these programs.
10. **Reduce administrative waste.** Address product choices and administrative processes that contribute to waste by, for example, streamlining plan choices, health care utilization review, and billing functions.

As a whole, these strategies address a range of cost drivers and present options that could be attractive to many states. They also have been implemented or considered in different state environments.

The table below assesses each of the 10 strategies based on the cost driver that it addresses, the resource and analytic capacity needed to operationalize it, the degree of difficulty in enacting the strategy from a political and stakeholder perspective, and the political context in which the strategy might be successful. In addition, we make a broad assessment of their relative impact on slowing cost growth, dividing strategies into those with likely sizeable impact (++: on the order of magnitude of 1% or more of total health care spending), smaller but meaningful impact (+: on the order of magnitude of 0.1% of total health care spending), or unknown/highly variable impact (?). This assessment is described in greater detail in the appendix.

Comparison of Selected Strategies for Health Care Cost Containment

Strategy	Cost driver targeted	Resources required	Political difficulty	Political context	Potential magnitude of impact
Implement a health care cost growth target	Global spending	High	Medium	Not associated with a particular political ideology, though mostly adopted in more progressive states	++
Promote adoption of population-based provider payment	Global spending	High	Medium	Has appeal across the ideological spectrum	++
Cap provider payment rates or rate increases	Provider (primarily hospital) prices	Medium	High	Mostly applied in states willing to take a regulatory approach	++
Contain growth in prescription drug prices	Drug prices	Medium to high	High	Has broad appeal across the ideological spectrum	++
Improve oversight of provider consolidation	Provider prices	Medium to high	High	Has broad appeal across the ideological spectrum because it focuses on improving how well markets function	?
Strengthen health insurance rate review	Global spending	Medium to high	Medium	Mostly applied in progressive states that have sought to expand this regulatory authority	?
Adopt advanced benefit designs	Provider prices	Low to medium	Low to medium	Has appeal in more conservative states	+
Promote use of community paramedicine	Inpatient/ED utilization	Low	Low to medium	Has broad appeal, particularly in rural areas	+
Improve behavioral health crisis systems	Inpatient/ED utilization	Low	Low	Has broad appeal, including in rural and conservative states	+
Reduce administrative waste	Administrative costs	Low	Variable	Has broad appeal	?

Data: Authors' analysis.

ADDITIONAL STRATEGIES FOR CONSIDERATION

In developing a concise list of strategies for this brief, we could not include several other worthy approaches. Many of these may still be of interest to state policymakers, and we expect that evidence and experience with these strategies will continue to expand and evolve. We briefly review these approaches below.

Several states have implemented initiatives to increase **investment in primary care.** Primary care is an essential component of health care and a key contributor to quality outcomes. Although observational studies have linked higher primary care spending to lower levels of health care spending, the key question for policymakers is whether *increasing* primary care spending at the state level would slow the growth of total health care spending. To date, causal evidence for increasing primary care spending to reduce spending growth is lacking. It is possible that primary care investment coupled with other interventions that transform care delivery could be beneficial, particularly over the longer term. Evaluation of current state efforts to increase primary care spending will be helpful for understanding the impact of these initiatives and what features are most important to health care cost containment in the long run.

Policymakers have expressed tremendous interest in **addressing social factors** that can contribute to poor health outcomes, particularly lack of housing, healthy food, and transportation. At the state level, many Medicaid programs have launched initiatives to encourage health plans and providers to screen for and address social needs. In the commercial market, social and economic factors can also affect how individuals access care, but there are fewer data on specific interventions and their potential for cost savings. Research to characterize effective interventions for a commercially insured population will be important for understanding potential cost savings and the time horizon in which those savings could be achieved.

Integrating primary care and behavioral health care has many benefits. It can help expand access to needed mental health services and can help decrease stigma and discrimination, while improving overall health outcomes. Integration also can help address the adverse outcomes faced by those with serious behavioral health conditions. Although there are promising models for achieving better outcomes and cost effectiveness through integration, the evidence for cost savings in a commercially insured population is less clear. Even though behavioral health integration could be part of broader payment and delivery system reforms, particularly given its positive effect on health outcomes, it is not included as a stand-alone strategy for cost containment in this brief.

Value-based insurance design, an approach to benefit design that modulates cost sharing to incentivize high-value care (for example, eliminating copayments for medications for treating diabetes) was not included in this brief. Although research suggests it has benefits in terms of outcomes and cost *effectiveness,* there is little evidence to date that it is cost *saving.*

Centers of excellence programs encourage enrollees to use specific providers for certain services. These programs generate savings primarily through lower prices (although they may provide some additional quality benefit by ensuring guideline-based care). As such, this strategy overlaps with the reference-based benefit design approach that is discussed in this brief.

Policymakers have also been interested in tackling **low-value care.** Specific forms of low-value care have been identified and studied (such as reducing unnecessary preoperative testing). However, successful strategies that states could implement to decrease low-value care more broadly have not been well studied, apart from approaches that address low-value care through alternative payment models.

Alternative sites of care (such as **telehealth or urgent care centers**) were not included. Although they might substitute for more costly sites of care, they also may increase utilization (and thus increase net costs). This effect makes it difficult to put them forward as cost-saving measures without further research and refinement.

Some policy organizations have advocated for changing **scope of practice** to increase use of nonphysician providers (such as nurse practitioners, physician assistants, and nurse anesthetists). Issues concerning scope of practice encompass many factors beyond cost containment. From a purely cost-containment perspective, the potential cost savings are difficult to

generalize, as they would depend on provider supply, impact on utilization, and payment rates. Each state's specific circumstances are likely to be different, making it difficult to create a generalized approach or strategy.

Finally, a handful of states have passed legislation enacting a **public option,** including Washington state. We do not include this as a separate strategy because the key lever for savings in the public option is constraining provider prices, which is already included in this brief.

CONCLUSION

Addressing health care cost growth in the commercial sector is not easy, but it is critically important to the health and economic security of Americans across the country. State policymakers have the opportunity to build on an array of strategies that are being pioneered and refined in states across the country. These strategies can serve as practical tools for tackling this important challenge.

APPENDIX. ESTIMATE OF COST GROWTH REDUCTION

The selected strategies vary in their estimated impact on cost growth. To provide a sense of relative potential cost avoidance, we have grouped strategies into three categories: those with sizable impact, those with meaningful but smaller impact, and those whose impact is unknown or highly variable. We recognize that actual cost avoidance will depend greatly on how policies are implemented. Strategies that impact only the fully insured market would by definition have a smaller impact across the commercial market as a whole. Thus, these estimates are intended to provide only an "order of magnitude" for potential impact.

Sizable Cost Growth Impact (++)

Each of these strategies could potentially reduce total health care spending by approximately 1 percent or more.

Implement a health care cost growth target. The stated goal of health care cost growth targets is to reduce per capita cost growth. These targets are generally set at several percentage points below expected trend. Although available data are only observational, experience from Massachusetts suggests these targets can reduce spending growth by 0.6 percent when compared with national trends.

Promote adoption of population-based provider payment. Evaluation of the Alternative Quality Contract (AQC), an accountable care initiative implemented by Blue Cross Blue Shield of Massachusetts in the commercial market, found net savings. For example, in the 2011–2012 cohort, average adjusted medical claims savings in the first and second halves of the contract were 4.7 percent and 2 percent, respectively. Incentive payments in the first and second halves were 2 percent to 3 percent and 1 percent to 2 percent, respectively. Results from Medicare accountable care organization models have been mixed, with the most recent data from the Next Generation ACO Model showing reductions in medical spending but an increase in net Medicare spending because of performance payouts.

Cap provider payment rates or rate increases. This strategy directly addresses a key component of health care costs and cost growth. Studies of Rhode Island's affordability standards, which include hospital price growth caps, suggest reduction of 2.7 percent of total spend. Modeling by RAND of federal proposals to limit provider rates implies substantial savings, depending on the aggressiveness of the cap. Setting prices at 100 percent to 150 percent of Medicare rates for all commercial payers could reduce hospital spending by $61.9 billion to $236.6 billion, equivalent to a 1.7 percent to 6.5 percent reduction in national health spending. Another proposal, which would cap commercial prices for hospital care at five times the 20th percentile price, is estimated to save $38 billion, reducing commercial health care spending by about 3.2 percent and total health care spending by about 1 percent.

Contain growth in prescription drug prices. A federal proposal (H.R. 3) that would institute reference pricing and government negotiation of drug prices at the national level was estimated to result in sizeable savings to the commercial market. Depending on how the government-negotiated drug prices would be applied to the commercial market, projections for savings range from 3 percent to 9 percent.

Smaller Impact (+)

These strategies may result in meaningful savings in specific sectors or services, but their impact on total health care spending is small (about 0.1%, from an order of magnitude perspective).

Adopt advanced benefit designs. Evidence from CalPERS' experience with reference pricing suggests savings of $5.5 million over two years against an annual spend of nearly $7 billion. Kentucky's Smart Shopper program estimated savings of $13.2 million over three years, against approximately $1.4 billion a year in spending.

Promote use of community paramedicine. Researchers have estimated the total potential savings from community paramedicine at $283 million to $560 million for Medicare each year, using data from 2005 to 2009. Conservatively estimating Medicare spending at the 2005 level ($336.4 billion), savings potential is on the order of 0.1 percent.

Improve behavioral health crisis systems. Although there are little data in this regard, the number of potentially divertible emergency room visits and inpatient admissions for behavioral health crises is likely a subset of those estimated for community paramedicine. As such, cost savings are likely to be a fraction of the estimate above.

Unknown or Highly Variable (?)

At this time, the impact of these strategies on total health care spending is unknown or highly variable.

Improve oversight of provider consolidation. Even though research consistently demonstrates that prices increase as markets consolidate, it is not yet clear if reducing further consolidation would result in lower price growth. The Congressional Budget Office and the Joint Committee on Taxation have estimated that a nationwide ban on antitiering and antisteering clauses would reduce total employment-based health care costs by 0.05 percent after the effects of the ban are fully realized.

Strengthen health insurance rate review. Rate review strategies are highly variable in their application. More traditional application of rate review strategies can result in decreases of a few percentage points on specific proposed premiums, but as these rate reductions affect a small fraction of the total commercial market, their impact on the market as a whole is likely small.

Reduce administrative waste. Administrative waste is a large component of reducible health care expenditures, and modeling has suggested that comprehensive national reforms, such as implementing real-time claims adjudication, could decrease costs by more than 1 percent. However, the most sweeping changes would not be readily applied at the state level, and states' efforts in this arena have been more limited.

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