HealthRIght was established in 2007 with the following foundational principles:

1. **Healthy Lives:** The purpose of health care is to help all people to achieve healthier lives.
2. **Quality of Care:** All Rhode Islanders should receive health care that is high quality, timely, accessible and affordable.
3. **Consumer Choice and Protection:** The health care system should be designed to maximize consumer choice, protection and control.
4. **Aggregated Payment and Pooled Risk:** All public and private health care dollars should be consolidated into an aggregated public or not-for-profit purchaser of health coverage and/or health care services that pools risk across the state.
5. **Cost Containment:** Costs should be controlled by implementing a coordinated health planning process and restructuring delivery of health care to achieve more equitable and efficient allocation of health care resources in the public interest.
6. **Diversity of Stakeholders:** Involving multiple and diverse stakeholders is the best way to design a health care system that delivers high quality, accessible and affordable care for everyone.

Following eight years of health care conversations, HealthRIght is issuing three papers. These papers provide an overall view of the health care system; address health care cost containment strategies; and discuss access to health care in Rhode Island.

Together, these three papers raise critical questions and suggest possible paths or solutions to issues facing the health care system in Rhode Island. The following are over-arching themes of the recommendations throughout:

- It is critical that health care financing move away from fee-for-service payment models towards global budgets;
- Vigorous and meaningful health care planning must be at the foundation of the health care system;
- Strong, coordinated regulatory oversight of insurers and health care providers is necessary;
- Consolidated purchasing power, and increased negotiating strength, will be helpful to the three goals above.
Cost Containment - Executive Summary

No state, insurer, or government program has yet found a magic bullet to control health care costs or improve health outcomes. But as Rhode Island works towards those goals, there is still much to be learned from others. In this paper, HealthRIght analyzes six cost-containment approaches, drawing lessons from their implementation elsewhere:

- Total Health Care Spending Growth Cap (Massachusetts)
- Accountable Care Organizations (ACOs) (Medicare)
- All-Payer Hospital Rate Setting (Maryland)
- Active Purchaser Health Insurance Exchange (Covered California)
- High Utilizer Programs (Camden, NJ)
- Consumer Price Transparency (Massachusetts)

Americans (and Rhode Islanders) spend far more on health care than citizens of any other industrialized nation, yet our health care system achieves mediocre results. A number of factors prevent Americans from getting good value in return for high health care spending. Market fragmentation—Medicaid, Medicare, commercial, BlueCross, United, etc.—adds administrative costs, reduces the public's negotiating power, and makes rational resource planning difficult. Fee-for-service payments reward health care providers for increasing volume while providing no incentive for coordinating care or for keeping patients healthy.

The six approaches discussed in this paper approach the problem from different angles. None of these approaches, on its own, is likely to have a substantial impact on costs or outcomes in the short term. In the long term, the reforms most likely to contain costs and improve outcomes will be those that:

1. Transition away from fee-for-service payments, towards global budgets;
2. Include vigorous planning of health care infrastructure investments;
3. Provide strong regulatory oversight; and
4. Consolidate the purchasing power of rate payers and tax payers.

HealthRIght supports a health care spending growth cap, paired with an equally strong outcomes improvement plan. All-payer rate setting is also attractive, and should be seriously considered as a long term fallback option should the spending cap prove ineffective.
High Health Care Spending in America
America spends far more than any other industrialized country on health care.

Mediocre Outcomes for Quality, Outcomes and Access
Despite this high spending, the American health care system consistently ranks as mediocre or poor at measures of quality, outcomes, and access. For example, America’s life expectancy is similar to that of nations that spend less than half as much on health care.
Why the High Costs?

There are many potential explanations for this country’s high spending levels. It is helpful to start with two factors that are not the problem. First, American patients are not significantly sicker, on average, than those in peer nations. Second, American patients do not utilize significantly more health care services, on average, than patients in peer nations.

Rather than a sicker population or one too eager to seek care, America’s high spending is more likely explained by factors such as (1) high administrative costs associated with our fragmented private insurance model, (2) high unit costs of hospital services; (3) high unit costs of pharmaceuticals, and (4) high physician compensation.1
Price Measures

Spending on Health Insurance Administration per Capita, 2012
Adjusted for Differences in Cost of Living


Physician Incomes, 2008
Adjusted for Differences in Cost of Living


Pharmaceutical Spending per Capita, 2012
Adjusted for Differences in Cost of Living

Costs in the Ocean State

Rhode Island is no exception from this national problem. While the State’s costs are high by national standards, they are among the lowest in New England. The State’s recent preliminary release of data from an important study of cost of care shows costs in Rhode Island costs as nearly the same as in Massachusetts and well below those in Connecticut, though Rhode Island’s lower average per capita income may make these costs more difficult to bear. Rhode Island’s position on quality indicators is generally strong, as would also be expected of a New England state.

Cost Containment

Against this backdrop, Rhode Island is one of many States working hard to reduce health care spending growth while improving quality and outcomes. Many initiatives have now been battle-tested in Rhode Island and elsewhere over the course of several years. While some reform efforts are promising, no state has yet found a magic bullet. This paper analyzes six cost containment approaches.
Health Care Cost Containment

1: Total Statewide Health Care Spending Cap or Target

Description: The Raimondo administration is actively considering a statewide health care spending cap for Rhode Island. The concept is that a government agency could impose a strict limit on health care spending, then require industry participants—insurers, hospitals, and other providers—to work within its confines.

Massachusetts Example: Massachusetts established a similar framework in 2012. "Chapter 224," as the law is known, empowers the Massachusetts Health Policy Commission (HPC), a new quasi-public entity, to set a statewide health care spending growth "target." The target corresponds with the State's overall potential economic growth. For 2013 and 2014, the target per-capita growth rate was set to 3.6%. The law included other related reforms, including the encouragement of "alternative" (non fee-for-service) reimbursement models, increased price transparency for consumers, and a focus on health resource planning.

The "target" applies to all insurance carriers, hospitals, and large provider groups, who must now submit detailed data to the HPC and the Center for Health Information and Analysis (CHIA), another new entity. CHIA is charged with measuring and reporting on the growth in Total Health Care Expenditures (THCE) for each reporting entity. Beginning in 2015, the HPC can require entities exceeding the target to file and implement performance improvement plans, and can fine non-compliant entities up to $500,000. The HPC can also waive performance improvement plan requirements after considering factors such as an entity's health-status-adjusted total medical expenses, investments into efficiency, and whether the cost growth was within the entity's control.

In 2013, Massachusetts saw THCE growth of 2.4%. In 2014, that growth accelerated to 4.8%, exceeding the 3.6% target, though much of that growth was attributable to increased Medicaid enrollment following implementation of the Affordable Care Act (ACA). This was also a period of diminished health cost growth nationally. In short, it is too soon to tell how well the law is working.
Special Considerations for RI: Rhode Island already imposes more stringent limits on hospital cost growth: OHIC’s Affordability Standards cap growth in hospital rates in relation to a specific Consumer Price Index (CPI-Urban).8 In 2015, the capped rate of growth was 2.7%.9 OHIC’s standards differ from Chapter 224 in that they apply only to commercial insurers and their fully-insured products (so leave out Medicaid, Medicare, and self-insured plans). OHIC’s standard also differs in that it only applies to the price charged per service, rather than to total utilization. But given the similarity, any movement towards a Massachusetts-style spending growth target should include a careful assessment of the impact of the Affordability Standards.

Final Grade: The approach is a very promising improvement on the status quo. It increases transparency on costs, creates public entities with the authority to set targets and monitor progress, and properly views the health care system as a whole rather than fragmenting between programs.
Basic Description: Accountable Care Organizations (ACOs) are comprised of doctors, hospitals, and other health care providers who work together and are held jointly “accountable” for the cost, quality, and outcomes for their patients’ care. ACOs are designed to make providers sensitive to cost considerations, and to encourage the coordination of services.

In an ACO model, patients are “attributed” to an ACO based primarily on where those patients receive primary care. The total cost of caring for those patients is then measured, and compared to some benchmark. In most arrangements, the ACO receives a portion of the savings (“shared savings”). In other (more rare) arrangements, the ACO can also take “downside risk” and be forced to pay for a portion of any cost overruns. Most ACO arrangements base any shared savings distributions on the ACO’s achievement of measurable quality standards.

Medicare Example: In 2012, Medicare launched a massive national ACO demonstration project. Today, more than 400 provider groups are participating in a Medicare ACO, together caring for more than 7.3 million Medicare beneficiaries.10 An ACO’s patients continue to have equal access to any Medicare participating provider.11 Results have been mixed. In 2014, fewer than 1/4th of these ACOs achieved cost reductions sufficient to earn a “shared savings” bonus, and nearly half of the ACOs saw costs exceed benchmarks.12 That said, the data also indicate that the ACOs who got an earlier start are far more likely to have achieved savings, hopefully indicating that everyone’s results will improve with time.13 ACOs also showed improvements in quality and patient experience of care.14
**Special Considerations for RI:** There are already two Medicare shared savings ACOs operating in Rhode Island: Coastal Medical and Integra (a partnership between Care New England and RI Primary Care Physicians Corp.). Coastal is a standout performer, having achieved 7% savings in 2014 and earning a shared savings distribution of $3.3 million. Coastal also earned quality marks in the top 1% of all ACOs nationwide. (Integra is new, so no results are yet publicly available.)

The Rhode Island Medicaid program is also encouraging the creation of “Accountable Entities,” which are essentially the same as ACOs. The Executive Office of Health and Human Services (EOHHS) has announced a goal of having 25% of all Medicaid patients enrolled into an accountable provider network by 2018, and eventually for all Medicaid enrollees to be attributed to an accountable entity.

Rhode Island’s small size and fragmented provider landscape may present a problem. The state simply may not be large enough to sustain five or six ACOs, especially with separation of markets for Medicare, Medicaid, and commercial insurance.

**Final Grade:** ACOs are a fact, and the State must account for them. But there is little evidence, at least so far, that ACOs are likely to have a substantial impact on overall cost trends.

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**Advantages**

- Reduces perverse incentives of fee-for-service system
- Starts financially rewarding cost-conscious providers
- Encourage collaboration and coordination between health care providers
- Spurs IT and infrastructure investment likely to improve care
- First step down road towards global budgets

**Disadvantages**

- Little evidence ACOs actually reduce costs
- Require big IT and human resources investments
- May drive consolidation and mergers, thereby increasing costs
- Fragments markets and risk pools, potentially shifting costs rather than saving
- Essentially unregulated today, so savings could be achieved in harmful ways
Basic Description: Hospitals make up a large portion of health care spending and, together with pharmacy, a large portion of spending growth in recent years. Prices can vary widely between hospitals, and prices paid to a single hospital also vary between Medicare, Medicaid, and various commercial payers. These conditions foster a system where the hospitals getting paid the most are those with the most market power, rather than those demonstrating the best performance. The fragmentation of the payment systems also makes it very difficult for hospitals to be rewarded for a consistent set of quality standards. Against this backdrop, some states have taken a more active role in regulating, or even setting, hospital prices.

Maryland Example: Maryland has operated a unique all-payer hospital rate setting system since the late 1970s. Under this model, all health care payers—Medicaid, Medicare, and commercial—pay the same prices to any given hospital, and that price is set by the Maryland Health Services Cost Review Commission (HSCRC). Until recently, the rate set by HSCRC was a fee-for-service price, so hospitals still received more revenue based on increases in volume.

Last year, Maryland announced major reforms to its rate setting program. Going forward, the system will drive towards “global budgeting.” In early years, hospitals will receive only a fraction of revenue for increases in volume, and may also retain a portion of savings associated with decreased volume. Eventually, hospitals will receive a fixed amount of revenue in any given year and will be held responsible for caring for a defined population. Quality and outcomes incentives are also set on a system-wide basis. The incentive to increase volume will be reduced and then eliminated, hopefully spurring investments and collaborations that will drive down hospital utilization and keep people healthy. Results from the first year have been impressive, with all-payer hospital spending growing only 1.47%, reduced readmission rates, and drastically reduced hospital-acquired infection rates.

Advantages
- Alignment between payers
- Creates single set of quality, efficiency goals
- Improves transparency and accountability
- Eliminates “cost-shifting” from public payers to commercial insurance market
- Public control over spending
- Global budgeting creates predictability for hospitals and for public
- Incentives for hospitals to reduce utilization

Disadvantages
- May limit market experimentation with payment models
- Does not address other drivers of spending, especially pharmacy
- To avoid hospital revenue cut, may require increase in Medicaid reimbursement
**Special Considerations for RI:** Implementing such a system in Rhode Island would require a federal waiver from Medicare rules, which may not be fast or easy to obtain. Disparities between hospital rates exist in Rhode Island, but not nearly at the levels seen in other states (especially Massachusetts). The “cost-shifting” to private payers in Rhode Island also appears muted: Medicaid rates, on average, are actually higher than Medicare rates; and commercial rates are only about 35% higher, on average, than Medicare rates. These special characteristics of the Rhode Island system may also present an opportunity, because transition to an all-payer model would not be as difficult.

**Final Grade:** All-payer rate setting is an extremely promising long-term strategy. It would take several years to implement, but the return on investment—in terms of shifting away from fee-for-service, rationalization of planning, and alignment between payers and programs—could be substantial.
Basic Summary: In Rhode Island’s Medicaid program, the most expensive 6% of enrollees account for 65% of spending. This pattern is not at all unusual: Nationally, the most expensive 5% of patients account for about 50% of spending.

This pattern has encouraged a multitude of efforts to identify savings within this population of “high utilizers.” Most of these efforts include extensive care coordination services to ensure that medications are taken as prescribed and that appointments are not missed. Many models also include extra supports to address the “social determinants of health” such as lack of food, housing, and transportation that can reduce the impact of traditional health care interventions.
**Camden Model:** This model of “hot spotting” and addressing the needs of high utilizers was made famous by Dr. Jeffrey Brenner with a pilot project in Camden, NJ. Dr. Brenner analyzed local data, identified frequent hospital and emergency room visitors, and connected these patients with intensive support. In the initial group of 62 patients, his team succeeded at reducing hospital costs from a monthly total of $1.2 million to just over $500,000. As the model was scaled up, results, though still promising, were less obviously impressive.

**Special Considerations for RI:** Rhode Island already has several such programs in operation, and these programs are minimally coordinated. For example, there are times when a Medicaid-funded community health worker stationed at a provider site cannot work with a commercially insured patient. At other times, multiple community health workers have overlapping “jurisdiction” over the same patients.

**Final Grade:** Programs focusing resources to high utilizing populations are valuable and important, but unlikely to have substantial impact on health care costs. Rhode Island needs to make more efforts to coordinate these programs so that resources are deployed efficiently.

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**High Utilizer Programs**

**Advantages**
- Primary focus on improving care coordination
- Brings resources and supports to needy populations

**Disadvantages**
- Results mixed as programs scale up
- Lack of randomized studies to validate model
- Some high utilization is unavoidable—car accidents, cancers, etc.
Basic Summary: The Affordable Care Act created health insurance “exchanges” (sometimes called “marketplaces”) in each state. On these exchanges, consumers can view available health plans and prices, make “apples-to-apples” comparisons, and enroll into coverage. Rhode Island’s exchange is called HealthSource RI (HSRI).

Some exchanges take a more “active” role than others in negotiating with participating carriers. Under an “active purchaser” model, the exchange can work to bring down prices, standardize plans to make comparisons easier, and/or encourage plans to engage in payment reforms to transition away from fee-for-service reimbursements.

Covered California: Covered California is the most prominent active purchaser exchange. The exchange directly negotiates with carriers on price, network, and quality. It also excludes carriers and products that do not measure up, giving it leverage in negotiations and creating a more limited (some say more manageable) set of choices for shoppers. For example, residents of Los Angeles had only seven “silver” plan options from which to choose, while residents of Miami and Denver each had 35 silver plan options.

From 2015 to 2016, Covered California plans increased in price by an average of just 4%, indicating some measure of success. Further, the exchange has enrolled 68% of subsidy-eligible enrollees, putting it among the top ten in the country in penetration.

Much of the success at rate control, though, has been achieved through narrow network plans that offer access to a very limited menu of doctors and hospitals. Of the 16 networks available on Covered California, 12 have been deemed “extra-small” or “small” by an independent study. California has the 4th highest prevalence of narrow networks, and the highest among any state-based exchange.
**Special Considerations for RI:** HSRI and OHIC together already have the authority to work under an active purchaser model, and a significant amount of negotiation does in fact take place between HSRI and carriers about what plans will be available. HSRI has also already had some success at restraining premium growth, probably even more so than Covered California. From 2014 to 2015, the price of the benchmark silver plan actually decreased by 12%. From 2015 to 2016, the price of the benchmark silver plan increased only 1.5%. Enrolling State and municipal employees and larger businesses into HSRI would substantially increase its negotiating power.

**Final Grade:** HSRI can and should take an active role in negotiating with health plans, but that is unlikely to have a substantial impact on health care costs until HSRI has far more enrollees. HSRI could achieve higher enrollment through increasing penetration in the small group market, or opening up to larger employers or public workers.

### Advantages
- Tool to leverage buying power of public
- Price/Quality pressure on carriers can also impact providers
- Infrastructure in RI already in place (HSRI)
- No new statutory or regulatory authority needed

### Disadvantages
- HSRI has little room to exclude any willing carrier (only three in market)
- HSRI market small—only 35,000 enrollees, with little penetration in the group market
- No new statutory or regulatory authority needed
- Limited networks are constraining and difficult for consumers to navigate
- Frequent changes to plan options disrupt consumer experience and patient care
**Basic Summary:** It is nearly impossible to determine the cost of a particular health care service, making comparison shopping extremely difficult. This lack of public pricing information (1) reduces the need for providers to compete on price and quality, and (2) makes life difficult for the large and growing share of consumers covered by plans with high deductibles.

Many states have attempted to address this problem by requiring providers or insurers to provide more price information to consumers.33

**Consumer Price Transparency in Mass. Ch. 224:** Chapter 224, discussed above with respect to its health care spending growth target, also included several provisions designed to bring price transparency to the health care marketplace. Massachusetts insurers are now required to offer a toll-free phone number and website through which enrollees can learn the out-of-pocket cost for a proposed admission, procedure or service. The cost quoted is binding, at least for the procedure codes covered by the estimate.34

Early reports indicate major weaknesses with these transparency measures. One analysis graded the efforts of Massachusetts’ three major carriers, and none scored higher than a “C.” Among the many problems, no carrier provided information on the cost of prescription drugs (a major cost concern for consumers), two of the three carriers provided no information on the cost of behavioral health services, and two of the three carriers included no information on the cost of inpatient procedures (three of the most commonly identified drivers of health care cost growth). In the end, very few members reported they would be likely to use the tool in the future.35
Special Considerations for RI: Rhode Island has already dabbled in price transparency rules, through a 2013 initiative of OHIC. OHIC requires carriers to provide price information to network providers, helping them to make cost-conscious referral decisions. OHIC also requires carriers to make a plan for making price information available to consumers. Most carriers (including BlueCross and United, the two largest in the commercial market in RI) already have tools to allow enrollees to look up costs and compare across providers.

Final Grade: Price transparency is important, and consumers with high deductibles have the right to know what health care services will cost in advance. But transparency efforts layered on top of a confusing and fragmented system are unlikely to have substantial impact on patient behavior or cost trends.

"Imagine a department store whose customers are blindfolded before entering. A shopper might enter the store seeking to buy an affordable dress shirt and a tie, but exit it with a pair of boxer shorts and a scarf. Sometime later, he would receive an invoice, whose details would be incomprehensible to him, save for one item: a dollar amount in a framed box with the words: "Pay this amount."

Broadly speaking, and with few exceptions, this is the kind of "market" that our "market approach" has bestowed on American health care consumers (formerly "patients")."

Uwe E. Reinhardt, Princeton Health Economist, NY Times
(http://economix.blogs.nytimes.com/2013/12/12/health-care-prices-move-to-center-stage/)
Conclusion

The six cost containment approaches discussed in this paper all show potential to reduce the growth in health care spending, but no single approach is a panacea. In the long term, the reforms most likely to contain health care costs and improve outcomes will be those that:

1. Transition away from fee-for-service payments, towards global budgets;
2. Include vigorous planning of health care infrastructure investments;
3. Provide strong regulatory oversight;
4. Consolidate the purchasing power of rate payers and tax payers; and

HealthRight supports a health care spending growth cap, paired with an equally strong outcomes improvement plan. All-payer rate setting is also attractive, and should be seriously considered as a long term fallback option should the spending cap prove ineffective.
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1. Uwe E. Reinhardt et al., *It's the Prices, Stupid: Why the United States is So Different From Other Countries*, Health Affairs (2003), available at http://content.healthaffairs.org/content/22/3/89.full.pdf (add more recent cite too).


4. For 2012-2017, the target is set to correspond to the State's potential gross state product (PGSP), a measure of the State's potential economic growth if not for recessions. For 2018-2022, the target is set to the PGSP minus 0.5%. From 2023 onwards, the target returns to the full PGSP, but may be modified.


7. THCE includes "(i) all categories of medical expenses and non-claims related payments to providers, ... (ii) all patient cost-sharing amounts, such as, deductibles and copayments; and (iii) the net cost of private health insurance." Massachusetts Center for Health Information and Analysis (CHIA), *Performance of the Massachusetts Health Care System: Annual Report September 2015*, available at www.chiamass.gov/assets/2015-annual-report/2015-Annual-Report.pdf.

8. OHIC Regulation 2, Section 10(d)(3)(E), at www.ohic.ri.gov/documents/2_Adopted%20Regulation%202%20Amendments.pdf. Growth in hospital rates is allowed to exceed CPI-Urban by 1% in the second half of 2015, .75% in 2016, .5% in 2017, .25% in 2018, and 0% thereafter.


Health Care Cost Containment

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23 Robert Wood Johnson Foundation, A Coalition Creates a Citywide Care Management System (June 13, 2014), at www.rwjf.org/en/library/research/2011/01/a-coalition-creates-a-citywide-care-management-system-.html. The initiative identified 269 patients eligible for intervention, but only 146 enrolled in program. Of those 146, only 80 were enrolled six months out. Among those 80, there was a 46% reduction in hospital admission rates, but there was no control group to determine whether this was merely regression to the mean or the result of starting with a non-representative sample.


25 A recent study in Colorado found that only 28% of “high utilizers” at a hospital remained in that group after 12 months. Tracy L. Johnson et al., For Many Patients Who Use Large Amounts of Health Care Services, The Need is Intense Yet Temporary, Health Affairs (Aug. 2015), available at http://content.healthaffairs.org/content/34/8/1312.abstract?right.

Health Care Cost Containment

Works Cited


32 In 2015, HSRI had only seven sliver plan options available – the same “limited” set offered in California – without excluding any willing participant.


