



KEY COST CONTAINMENT METHODS IN FEDERAL HEALTH REFORM

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The House of Representatives recently released their merged healthcare legislation, HR 3962.¹ The 1,990-page document outlines a variety of ways to ensure affordable, quality health care for all Americans and to cut or slow the growth in health care spending.

The Exchange, the Public Option and Market Reforms

HR 3962 works to guarantee access to affordable, essential benefits to all Americans. It does this most notably by implementing a health insurance exchange inclusive of a public health insurance option and executing a series of market reforms.

The health insurance exchange would allow uninsured individuals who are currently ineligible for other public or private coverage to have access to a variety of approved insurance options. Premium assistance would be available on a sliding scale up to 400% of the federal poverty level with subsidies equivalent to the difference between the lowest premiums for basic plans and a percentage of one's income.² Aside from individuals, small employers would be permitted to participate in the first couple of years of operation; subsequently, larger employers (>100 employees) would be allowed to join. The exchange could be operated at the national or state-level or across several states, as approved; health insurance cooperatives may also be created. The exchange is structured so that subsidies are built on the average premiums of the three lowest cost plans, which assures strong cost conscious financial incentives for plan participants.

The public health insurance option will be made available only through the health insurance exchange and must meet all standards imposed on plans participating in the exchange. To ameliorate some of the controversy surrounding this plan's potential to unfairly compete in the insurance market, there is a protection against crowd out, i.e., retroactive reimbursement by employers who drop their previously covered employees. Additionally, this plan must not only follow the same rules as all the other plans in the exchange, but also its payment rates will be determined through direct negotiations with providers—rather than being defined as a percentage of Medicare rates; these rates will be no lower than current public program rates and no higher than the market average. Provider networks are likely to be similar to those in Medicare, although providers are given the opportunity to opt out of participating. Actual payment and care delivery mechanisms are designed to promote lowering costs through innovation, including using medical homes, accountable care organizations, value-based purchasing, bundling of services,

¹ United States House of Representatives. H.R. 3962. Retrieved November 2, 2009 from http://docs.house.gov/rules/health/111_ahcaa.pdf.

² Basic plans would be equivalent to 70% of the average benefits of employer-sponsored coverage, although comprised of hospital, clinic, and physician services including mental health and substance abuse services and maternity Care. The next level of plans, "enhanced" plans, will be similar to basic plans but offer lower cost sharing. "Premium" plans would offer even less cost sharing, while "premium-plus" plans would have the lowest cost sharing plus additional benefits.



differential payment rates, performance or utilization-based payments, capitation, and direct contracting with providers. In these ways, the public plan could seed innovation in both payment and delivery reforms.

Several insurance market reforms will put a strong emphasis on managing health costs as opposed to avoiding risk. These include guaranteed issue and renewal, age ratings that vary by no more than a 2:1 ratio, cost-sharing of no more than \$5,000/\$10,000 per individual/family per year, and the elimination of annual and lifetime limits on coverage. Also, processes for reviewing premium increases will be created and rescission abuses will be ended. Other reforms would also work to empower consumers by making insurance information, such as benefits, cost-sharing rules and grievance procedures, more transparent and available in plain language. Premiums in general will be kept lower by specifying a medical loss ratio of at least 85% in the group and individual insurance markets.

Shared Responsibility

Individuals will be required to have a basic level of coverage or they could be fined up to 2.5% of their income excluding hardship exemptions. Employers will need to provide coverage or help finance coverage for their employees by contributing up to eight percent of the average wages paid by the employer through the health insurance exchange.³ Employers providing coverage must pay no less than 72.5% of an individual's premium (65% for family coverage) for the lowest cost plan they offer. The effect of these requirements is to make all individuals and employers much more conscious shoppers in a marketplace where the prices and covered benefits of plans can be more readily compared.

Medicare and Medicaid Improvements

HR 3962 makes a series of enhancements to Medicare and Medicaid. This includes payment upgrades for certain providers and reductions for others and improvements in financial and enrollment assistance for beneficiaries. In this section is an explicit promotion of access to primary care, mental health, and coordinated care and a focus on prevention.⁴ Efforts under this section of the bill will also work to reduce waste, fraud and abuse. Further, some of the pilot reforms include: accountable care organizations, medical homes, payment for performance incentives, payment bundling, the inclusion of mental health, and other innovations to improve cost and quality.

Improvements also look to instill a series of quality and surveillance initiatives—many of which are key to cost containment. Some of the key provisions in this section under quality are summarized below, including comparative effectiveness, quality measurements, and sunshine on pharmaceutical payments to physicians. Also included in the bill but not analyzed here are nursing home transparency and public reporting of healthcare associated infections—the latter of which California has started taking successful steps towards controlling by passing both SB 158 (Flores) and SB 1058 (Alquist) in 2008.

³ Employers with annual payrolls of up to \$500,000 pay 0%; \$500,000-\$585,000 2%; \$585,000-\$670,000 4%; and \$670,000-\$750,000 6%.

⁴ This includes the use of health information technology, such as telehealth to enhance access to care for those in rural areas.



Comparative Effectiveness

Under this section of HR 3962, a Center for Comparative Effectiveness Research will be created within the Agency for Healthcare Research and Quality. The Center will determine what prevention, diagnosis, treatment, and disease management activities work best. This includes conducting, supporting and analyzing empirical research on a wide variety of medical procedures and interventions, pharmaceuticals and medical devices. Under quality and surveillance, additional steps will be taken to identify current best practices and to develop, disseminate information on, implement, and evaluate new ones. Specified are activities relating to healthcare-associated infections, surgery, emergency room use and design, obstetrics, and pediatrics.

A clinical perspective advisory panel and an established Comparative Effectiveness Research Commission will determine research priorities, i.e., research questions, methods and evidence gaps that are clinically relevant and can be used to improve health outcomes.⁵ National priorities will be based on disease incidence, prevalence and burden; evidence gaps in clinical outcomes; variations in practice, delivery and outcomes including health disparities; the presumed potential for new evidence in a given area; and the input of stakeholders—but without “inappropriate” (p. 752) political or stakeholder influence.⁶

Based on research recommendations, the Center shall conduct research with full access to data from any United States department or agency. In addition, when the Center does not conduct research itself, it will have the ability to award grants to public or private entities to conduct this research. The Center will work to continuously improve its study methods with the guidance of stakeholders and experts including the Institute of Medicine and National Academy of Sciences.

The Center will submit reports based on its research and activities to the Comparative Effectiveness Research Commission, the Secretary, and Congress. Subsequently, this data shall also be released to the public in a format that can be easily understood. In particular, this data should be presented in a way that helps support patients in making better health care decisions and clinicians in incorporating new evidence into their practice of medicine.⁷

The Center shall also encourage the development and use of clinical registries and research data networks through which to electronically share data collected from various sources including electronic health records and post marketing drug and medical device surveillance data.

The Center will periodically be subject to audits and will be evaluated on the quality of its research, its expenditures, and its backlog of approved but unfunded research projects. Funding will be allocated to the newly established Comparative Effectiveness Research Trust Fund in the

⁵ This Commission will be composed of a variety of stakeholders. Members of the Commission and the advisory panel will not be able to participate either as voting or nonvoting members on a particular matter when they have a conflict of financial interest with limited exceptions.

⁶ United States House of Representatives. H.R. 3962. Retrieved November 2, 2009 from http://docs.house.gov/rules/health/111_ahcaa.pdf.

⁷ This does not authorize any federal official or employee to supervise or control the practice of medicine, nor allow the research to be used to deny or ration care.



following amounts: \$90 million for fiscal year (FY) 2010, \$100 million for FY 2011, \$110 million for FY 2012; future years will be funded by revenues from fees on health insurance and self-insured plans, subject to other conditions.⁸

All processes and data⁹ from the development of research priorities and methods to the dissemination of the outcomes and research limitations will be publicly documented and transparent so that all stakeholders have the opportunity to review and comment on these processes.

Quality Measurement

The Secretary will determine national priorities for performance improvement in areas of health care delivery that have a large burden of disease (high prevalence and/or cost) and have the greatest potential to reduce morbidity, mortality and variations in care (including health disparities) and to improve performance, affordability and patient-centeredness. There will also be a focus on priorities that have the potential for rapid improvement. The Secretary will establish these priorities with the help of stakeholders, including the public at-large, and the recommendations of a contracted entity with technical expertise in health quality measurement.

Measures will look at the performance of providers and improvements in population health. They will look at health outcomes, impairment levels and functional status, the continuity and coordination of care, the patient experience and level of patient engagement, the safety, effectiveness and timeliness of care, health disparities, and the efficiency of care. Measures must be collected using health information technology with a minimal administrative burden on the collectors (e.g., providers) and with maximum protection for privacy of personal health information.

Before measures are put into use (or once they are outdated), they will be tested by qualified entities. Each year, the Secretary will make a public list of measures that are being considered for use. In an effort to maintain a transparent process, stakeholders will have the opportunity to comment on this list. The Secretary will finalize the selection of measures in conjunction with these recommendations and the endorsements of a contracted entity, indicating how the choice was made in line with, against, or in addition to those recommendations or endorsements.

Data should be made available in the form of reports to Congress and the Secretary and free of charge and in a usable form to users, such as patients and providers. Other direct or indirect costs to users shall be monitored.

To establish national priorities, \$2 million will be allocated for each year from FY 2010-2014. To develop the measures, \$25 million will be allocated for each year between FY 2010-2014. To ensure stakeholder input, \$1 million will be allocated for each year of FY 2010-2014. The GAO shall periodically evaluate data collection processes for quality measurement, ensuring that data

⁸ This includes the fair share per capita amount determined by the Secretary multiplied by the average number of individuals entitled to benefits during the year. For additional computation rules, see Section 1802 of HR 3962.

⁹ Data that would violate the privacy of research participants will not be shared.



is relevant and credible, in addition to minimizing the administrative burden and cost on those required to collect the data.

Physician-Pharmaceutical Payments Sunshine Provision

Under this provision, the financial relationships between manufacturers and distributors of drugs, devices, biologicals, and medical supplies¹⁰ and physicians and other health care entities¹¹ will be more transparent. Each manufacturer or distributor must report to the Secretary information on the recipient of their product including demographic information, the value of the exchange,¹² and a description of the exchange including such information as the product exchanged and the date of the exchange.¹³ Yearly, the aggregate amount of payments or other transfers of value will be required to be reported, except under limited circumstances.¹⁴

Hospitals or other healthcare entities that bill Medicare must additionally report ownership shares of physicians who either directly or indirectly earn interest from these entities. Distributors must share similar information, including any ownership or investment interest held by the immediate family member of a physician. Such information includes the amount invested, the value and terms of the investment, any payments or other transfers of value, and any other relevant information. Those entities that fail to report their information inadvertently or knowingly will be penalized.

Collected information will be submitted to Congress and made available, except under certain circumstances,¹⁵ through the Internet in a searchable, clear and user-friendly format that can be easily aggregated and downloaded. To ensure accuracy, those who are the subject of the report(s) can submit corrections to the reporting entity to submit to the Secretary.

Under this section of HR 3962, a study will be conducted to determine the influence of physician self-referral arrangements on the cost of advanced diagnostic imaging and radiation oncology services to Medicare beneficiaries.

¹⁰ Other than wholesale pharmaceutical manufacturers. This includes only those drugs, devices, biologicals, and medical supplies covered under Medicare, Medicaid or CHIP.

¹¹ This includes a physician group practice, pharmacy or pharmacist, health insurer or group plan, hospital, medical school, patient advocacy group, biomedical researcher, and similar organizations.

¹² This includes payment or value in the form of gifts, food, entertainment, travel, tips, honoraria, research funding or grants, education or conference funding, consulting fees, and ownership or investment interest and royalties or license fees. This excludes other specified transfers of value, such as those to patients or used for charity care.

¹³ This excludes the disclosure of a payment or other transfer of value to a physician from a self-insured health plan.

¹⁴ For example, for those providing services for drug development, the report may be submitted the earlier of two years after the transfer of value or by the date of the drug's approval.

¹⁵ For example, information related to drug samples or national provider identifiers cannot be made public. This and similarly protected information can be used by the Secretary for research and business purposes, however, outside of the Department of Health and Human Services.



Additional parts of this section look at nursing home transparency and the public reporting on healthcare-associated infections. Related to cost containment, other sections of the bill outline the health insurance exchange, the public health insurance option, and individual affordability benefits as outlined above.

Public Health, Workforce Development and Indian Health

Final sections of the bill look at public health and workforce development and Indian health care improvement. The former section attends to shortages in the health care workforce by modifying loan repayment mechanisms and scholarships or otherwise allocating funds to designated areas of need (e.g., primary care, the National Health Service Corps, nursing programs, and the public health workforce). This section also encourages the development of a prevention and wellness strategy and research activities and grants to improve health outcomes and strengthen the public health infrastructure.

Final Thoughts

Scarce in HR 3962 but critical to health care reform discussions are details about what federal health care reform might offer in terms of ways to further reform payment systems including aligning public and private funding streams and facilitating greater provider and insurer accountability. The bill mentions intentions to use innovative payment systems through the public option and within pilots for Medicare and Medicaid, such as value-based purchasing; these innovations should be encouraged across the health system at large.¹⁶ Additionally, the final bill will leave open significant implementation challenges—particularly surrounding the health insurance exchange and public option. In question is the level of negotiating power of the exchange and public option. With little power, the cost savings may be minimal.

Health care policies with potential in the future might best be subject to fast track, up-or-down votes in Congress to ensure that future policies in health care reform are given enough time for input but pass through Congress more quickly. The closest thing to this in HR 3962 is the Institute of Medicine's and National Academy of Science's reporting on proposed geographic Medicare payment changes; these recommendations must be submitted to each house of Congress and must be acted on in joint session. President Obama's Independent Medicare Advisory Council Act of 2009 additionally seeks to influence Medicare payments by providing the President with yearly recommendations on payment changes.¹⁷ The President can approve or disapprove these recommendations as a whole; if approved, Congress has 30 days to act before the changes are implemented.¹⁸

¹⁶ Antos, J. et al. (2009). Bending the curve: Effective steps to address long-term health care spending growth. Retrieved September 14, 2009 from

http://www.brookings.edu/~media/Files/rc/reports/2009/0826_btc/0826_btc_fullreport.pdf.

¹⁷ Office of Management and Budget. Independent Medicare Advisory Council. Retrieved November 4, 2009 from

http://www.whitehouse.gov/omb/assets/legislative_letters/IMAC_bill_071709.pdf.

¹⁸ Ibid.