

Profiles of Cost Containment Strategies

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Implement a Health Care Cost Growth Target

Cost Driver Targeted: Global spending

OVERVIEW

A health care cost growth target or benchmark establishes a shared expectation for a state's per capita health care cost growth each year. Several states — starting with Massachusetts in 2012, followed by Delaware, Connecticut, Nevada, New Jersey, Oregon, Rhode Island, and Washington — have established programs to slow health care spending growth based on a cost growth target. These programs aim to slow the rate of health care cost growth through public engagement, measurement, transparency, cost growth mitigation strategies, and accountability.

KEY STEPS IN DESIGN AND IMPLEMENTATION

Establish authority for the program. States have used executive orders or legislation to establish their cost growth targets. Executive orders can enable a nimbler response but are more limited in scope and sustainability. In contrast, legislation can create more permanent programs with a broader scope but can take longer to develop. Legislation is also vulnerable to opposition from stakeholders and may be less flexible.

Establish a governance body. States employ different approaches to govern their programs. Massachusetts created a new, quasi-independent agency, the [Health Policy Commission](#), to administer its health care cost growth target program. Other states have situated their target program within existing executive branch agencies; in states like Nevada and New Jersey, these programs were initially housed in the governor's office. In some cases, the governance bodies are “protected,” meaning they exclude industry stakeholders, while in others they do not. States also have sought public input through formal advisory bodies and informational presentations and meetings.



Set a benchmark. States have defined a health care cost growth target that brings health care cost growth in line with economic indicators, such as gross state product and wage growth. In most states, state agencies or stakeholder bodies define the target value. At present, annual health care cost growth targets range from 2.4 percent to 3.8 percent per capita and have been set for a minimum of four years. In conjunction with setting the target, it is important for states to decide exactly how to define health care costs and how and when to collect and report data.

Measure statewide health care cost growth and report performance against the target. Once policies governing the benchmark and data collection processes are established, states collect aggregate spending data from payers and then analyze the data to determine per capita health care cost growth. States publicly report performance against the health care cost growth target. Current policies call for performance reporting at the state, market (e.g., commercial, Medicare, and Medicaid), payer, and large provider entity levels, with some states also reporting by geographic region.

Conduct analyses to identify cost drivers. States supplement their performance measurement and reporting against the target with additional [data analyses](#) that focus on the factors driving cost growth. The analyses focus on three organizing questions:

- Where is spending problematic?
- What is causing the problem?
- Who is accountable for the problem?

To answer these questions, many states use data from all-payer claims databases (APCDs). States without APCDs use available claims data from public programs (e.g., Medicaid and state employee health benefit programs). Other data sources can be used to supplement the claims data to look at spend and trend by market, geography, health condition, and demographics. Analyses also can drill down into key cost drivers in a given state, such as pharmacy, market consolidation, or change in site of care. These analyses require significant analytics capacity, which may be available in-house and/or through the support of vendors, including university partners.

Implement strategies to achieve the target. Performance measurement and public reporting on their own may not be sufficient to slow cost growth over the long term. Data analysis and stakeholder engagement can identify cost growth mitigation strategies for implementation. In Rhode Island, the governance body recommended action on prescription drug prices after data analysis revealed pharmaceutical price growth was a significant contributor to spending growth. Oregon has a statewide effort underway to speed adoption of advanced value-based payment models.

Ensure accountability. States have various tools available to hold payers and providers accountable for meeting the cost growth target. All states emphasize public transparency as a key strategy for accountability. Massachusetts' law also gives the Health Policy Commission authority to require performance improvement plans from entities exceeding the cost growth target, while Oregon's law goes a step further and allows financial penalties for repeated unjustified growth above the target.

EVIDENCE OF IMPACT

The most data come from Massachusetts' program, which sets the cost growth target at or below the predicted growth rate of the state's overall economy.

- From 2013 to 2019, Massachusetts' health spending growth stayed below the target rate for three years and exceeded the target for four years. On average, this resulted in a growth of [3.6 percent over seven years](#).
- Before Massachusetts implemented its health care cost growth target, annual per capita cost growth in the commercial market consistently exceeded the national trend. Post-implementation, commercial spending growth dropped significantly, remaining below the national average from 2013 to 2018. This decrease translated to an estimated [\\$7.2 billion saved for employers and consumers](#). This evidence is observational and does not isolate the impact of the cost growth target from that of other policies.

Experience with cost growth target programs suggests that influencing payer-provider negotiations is a key mechanism for reducing health care cost growth.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

A health care cost growth target program is a collaborative, multistakeholder approach that primarily uses data and transparency to drive change. The strategy's impact will likely be greatest in the commercial market where there are few meaningful constraints on the primary cause of rising costs: price growth.

The strategy is best suited for states that:

- have resolute state leadership to create and implement the program
- have or are interested in building strong health care data analytic capacity
- are willing to engage stakeholders to build support and buy-in
- have one or more strong partners in the payer, provider, and/or employer communities.

Fairly significant resources are needed to stand up the engagement, data collection, and data analytic infrastructure required to launch a program. This strategy could be applied in both rural and urban areas, and several states pursuing this strategy have large rural regions.

Thus far, this strategy has been pursued in states with more progressive politics. However, the central concept behind it is not aligned with a particular political ideology.

EQUITY CONSIDERATIONS

An inherent challenge of health care cost growth target programs is that they apply a growth target to all entities, even though some payer and provider organizations are more costly at the outset. Unless targets are adjusted to allow for greater growth for providers that have historically been paid less (e.g., community hospitals serving lower-income communities) and lower growth for providers that have traditionally been paid more, these programs risk perpetuating payment inequities.

Additionally, it is important to make sure that a focus on health care cost containment does not have unintended consequences for people of color and other populations

that have historically had worse outcomes because of systemic racism, discrimination, and other factors. Some states, like [Connecticut](#), have built a strong focus on health equity into the design and implementation of their health care cost growth target programs. Stratified analyses to assess specific — and disparate — impacts of the target on groups that have been economically and socially marginalized (including people with disabilities, Black people, Indigenous people, and people of color) are important components of an equity strategy.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

Although there is no evidence yet to support the concern, there is a risk that provider actions taken in response to a state's cost growth target could restrict patients from receiving medically necessary services. Such actions could exacerbate existing disparities in health care access and quality.

To help prevent such unintended adverse consequences, states should provide oversight of their cost growth target programs, using such strategies as assessing utilization of preventive and chronic illness care, measuring patient experience, and monitoring for risk selection among payers or providers.

Another limitation of this approach is that it does not directly compel or result in cost savings. Some states have exceeded their targets, and enforcement of targets has been very limited to date.

RESOURCES

Joel S. Ario, Kevin Casey McAvey, and Amy Zhan, *State Benchmarking Models: Promising Practices to Understand and Address Health Care Cost Growth* (Manatt Health Strategies, June 2021).

Elsa Pearson and Austin Frakt, "Health Care Cost Growth Benchmarks in 5 States," *JAMA* 324, no. 6 (Aug. 11, 2020): 537–38.

Erin Taylor et al., *Rhode Island's Cost Trends Project. A Case Study on State Cost Growth Targets* (Milbank Memorial Fund, Jan. 2021).

Promote Adoption of Population-Based Provider Payment

Cost Driver Targeted: Global spending

OVERVIEW

Transitioning health care provider payment from fee-for-service to value-based payments (VBPs) tied to the quality of care provided has gained interest during the past decade. A population-based payment is a type of VBP that pays for a set of services for an individual's care during a given period or for a specific condition.

The Healthcare Payment Learning and Action Network has categorized different types of [value-based payment models](#), with population-based payments identified as the most advanced. Population-based payment models emphasize three features: they are prospective, based on a budget, and require providers to take on risk for costs of care that exceed the budgeted amount. Population-based payments give providers more flexibility to coordinate and optimally manage care for individuals and populations. These models also may incentivize providers to develop more innovative approaches to person-centered health care delivery by rewarding those that successfully manage care.

However, moving health care toward a population-based payment system is challenging. Population-based payment models require providers to fundamentally change the way they provide care, and these changes are not sustainable unless a critical mass of public and private payers adopt aligned approaches. These models also require provider organizations to take on greater financial risk than they have assumed under the traditional, fee-for-service payment system, a move that not all providers are prepared to make.

Several states have pursued strategies to move toward population-based payments across their health care markets. Although no state has moved fully into prospective, population-based payments, efforts to move along the continuum toward more advanced value-based payment models provide some lessons for interested states.



KEY STEPS IN DESIGN AND IMPLEMENTATION

Identify the payment model to be advanced. States can start by identifying the type of model or models they wish to promote. Rhode Island, for example, included a specific requirement for prospective payment for primary care. Some states, such as Arkansas and Ohio, have focused on episode-based payments, which could potentially become the foundation for population-based payments for certain conditions. Maryland has a unique model that includes a global (though not prospective) budget for hospitals, an approach that Pennsylvania also has adopted for its rural hospitals. Oregon doesn't focus on one specific model but rather has benchmarks organized around the Healthcare Payment Learning and Action Network's framework for alternative payment methodologies, which shifts provider payments into advanced models that involve more risk sharing.

Determine whether to use a voluntary or mandatory approach. Several states have taken voluntary approaches to promote population-based payments in the commercial market. When Arkansas developed episode-based payments in its Medicaid program, two of its largest commercial payers aligned their own payment methodologies. More recently, Ohio has convened commercial plans and the Medicaid agency to collaborate on a multipayer delivery system reform initiative that includes comprehensive primary care payment and episode-based payments. Oregon, which has pursued value-based payment in its Medicaid program, developed a voluntary compact to galvanize momentum toward value-based payment within the commercial market. More than 40 health care organizations [signed the compact](#) and committed to making a good faith effort to “participate in and spread” VBPs. They also committed to move from having 35 percent of payments under advanced VBP models in 2021 to having 70 percent of payments be value-based by 2024.

Other states have adopted a mandatory approach using regulatory or statutory requirements. In 2020, Rhode Island's Office of the Health Insurance Commissioner established [affordability standards](#) that require insurers to increase their use of alternative payment methods. They also specifically require insurers to adopt a prospective payment model for primary care, with payments through

these models accounting for 60 percent of covered lives by January 2024. In 2021, [Delaware enacted a law](#) that requires the state's Office of Value-Based Health Care Delivery to establish requirements for adopting innovative payment models.

In weighing whether to take a voluntary or mandatory approach, states may want to consider that legislation provides durable authority but will require navigating a legislative process. States also may plan for enforcement activities to make the legislation meaningful. In comparison, a voluntary approach emphasizes a collaborative, market-driven strategy, which can hold political appeal but does not enable enforcement.

Establish oversight for the initiative. Monitoring whether entities are meeting their goals is important for the success of these payment models. For states pursuing a mandatory approach, that oversight has fallen to the state insurance department, which has the ability to regulate insurance providers. In Rhode Island, the Office of the Health Insurance Commissioner oversees the requirement for prospective payments. In Delaware's legislation, responsibility for designing and overseeing the requirement for adopting payment innovations rests with the Office of Value-Based Health Care Delivery. Oregon's compact, which is voluntary, is overseen by a workgroup that is jointly convened by a governmental agency (the Oregon Health Authority) and the Oregon Health Leadership Council, a stakeholder body with leaders from health care organizations across the state.

EVIDENCE OF IMPACT

Evidence for cost savings with population-based payments is limited, though the evidence that fee-for-service payment drives spending through increased volume and intensity of services is strong. Most research has focused on evaluation of accountable care organization (ACO) models, which have some but not all of the features of population-based payment.

The Alternative Quality Contract, Blue Cross Blue Shield of Massachusetts' ACO program, has been shown to [improve quality and lead to savings](#). It is one of the only large-scale evaluations in the commercial market to date, although it initially involved HMO enrollees only.

In Medicare's Shared Savings Program, physician-led ACOs (compared with hospital-integrated ACOs) achieved **modest savings in total spending**. The **Next Generation ACO** program, which had more significant risk sharing, decreased Medicare Parts A and B spending by \$348.6 million relative to the comparison group, although this savings was offset by \$466.1 million in shared savings and beneficiary incentives.

Maryland's global budget for hospitals was found to slow total expenditure growth for Medicare beneficiaries by 2.8 percent relative to the comparison group, largely driven by 4.1 percent slower growth in total hospital expenditures. Commercial plan members had 6.1 percent slower growth in total hospital expenditures relative to a comparison group; however, growth in total expenditures did not abate.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

The Center for Medicare and Medicaid Innovation has a strong interest in partnering with states on new payment models, potentially creating new momentum for states to engage in this arena. A population-based payment strategy is likely most attractive to states with the following features:

- A delivery system landscape that is prepared to accept population-based payments. To be successful, providers need the infrastructure (people, technology, data, and processes) to facilitate care coordination, improve clinical care delivery, and track clinical and financial performance. The state can help providers by reducing barriers to payer adoption (e.g., aligning performance measures across insurers), considering infrastructure investments (e.g., health information exchange), and supporting learning collaboratives.
- The analytic capacity to define the payment model, solve for technical implementation issues (e.g., how patients are attributed to providers), and monitor uptake.
- If a voluntary approach is being considered for the commercial market, payer and provider partners who will support this effort on a sustained basis.

Population-based payment is a strategy with wide appeal and application across states, though states with stronger market orientations will likely shy away from mandatory approaches.

EQUITY CONSIDERATIONS

Alternative payment models such as population-based payments could potentially worsen health disparities in a number of ways. One concern is that they “bake in” historical disparities in access to care and utilization, resulting in baseline assumptions that could be predicated on underutilization. Another concern is that provider organizations might be inclined to pursue patients with fewer socioeconomic challenges. There also have been concerns raised about disparities in geographic access if ACOs are less likely to form in underserved areas and about the impact of financial penalties on safety-net providers.

Research has explored the extent to which these issues occur in current alternative payment models. Several descriptive, **cross-sectional analyses** suggest that **disparities in geographic access** may exist under Medicare ACOs, which are less likely to form in higher poverty areas with more racial minorities and poorly educated individuals, compared with more affluent areas. However, evidence is more mixed about whether providers in existing ACOs exacerbate disparities by selecting lower-complexity or less vulnerable patients. **Some studies** found that ACO-attributed patients were more likely to come from vulnerable populations while **other studies** suggested that patients with higher clinical risk scores were more likely to exit an ACO program.

To address concerns, researchers have **identified certain strategies** — such as assessing improvement (not just performance) and strengthening risk-adjustment models — that could help mitigate some of these impacts. Some programs also have set up initiatives to support providers caring for socioeconomically disadvantaged populations, such as the now-defunct **Accountable Care Organization Investment Model (AIM)**, which provided up-front and ongoing monthly payments to smaller providers in rural and underserved areas to enter the Medicare Shared Savings Program. Looking ahead, the Center for Medicare and Medicaid Innovation has identified equity as a top priority in its development of future models.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

ACOs could potentially incentivize consolidation of physician groups, with some studies finding an [increase in large practices](#) in areas with the greatest ACO penetration. Even short of consolidation, there is concern that ACOs could lead to price increases if participants jointly negotiate prices.

From a consumer perspective, population-based payments raise concern about stinting or undertreatment. Evaluating quality of care is one strategy to protect against stinting, but quality measures are not able to assess every aspect of care. Strong oversight mechanisms and consumer protections are therefore vitally important components of population-based payment programs.

RESOURCE

Caroline Picher et al., [State-Driven Initiatives to Support Moving to Value-Based Care in the Era of COVID-19](#) (National Governors Association Center for Best Practices and Duke-Margolis Center for Health Policy, Mar. 2021).

Cap Provider Payment Rates or Rate Increases

Cost Driver Targeted: Provider (primarily hospital) prices

OVERVIEW

Provider price growth is a leading driver of health care cost growth in the commercial market, and a number of states are implementing or considering strategies to directly address high provider prices or price growth. For example, Massachusetts' Health Policy Commission recommended a number of strategies, including capping provider prices and adopting a default out-of-network payment rate, in its [2021 Annual Health Care Cost Trends Report](#).

Oregon was one of the first states to cap hospital prices in its [public employee benefit program](#), limiting payments for in-network hospital services to 200 percent of the amount Medicare would pay for the services and limiting payments for out-of-network hospitals to 185 percent of the amount Medicare would pay. Building on these efforts, states have broadened their lens with a focus on addressing high prices across the commercial market.¹ Notably, Rhode Island has a cap on provider rate increases enforced through insurance rate review. Rhode Island's "[affordability standards](#)" for all commercial insurers in the state include annual price inflation caps equal to inflation plus 1 percent for both hospital inpatient and outpatient services. Delaware recently enacted a law that similarly caps price growth for nonprofessional services at hospitals for fully insured payers.



¹ Montana uses reference-based pricing in its public employee health plan, and North Carolina proposed to do the same. Although these reference-based pricing approaches are similar in that they limit reimbursement rates to providers, they are employed as purchasing strategies and are not geared toward influencing the commercial market as a whole.

KEY STEPS IN DESIGN AND IMPLEMENTATION

Determine whether to cap prices or price increases.

Capping prices (at a certain percentile of median price or based on Medicare rates) directly addresses provider price variation by limiting the amount that can be charged by the highest-cost providers. This approach can be politically difficult, however, as often these higher-priced providers have strong market and political clout. There is also a risk that lower-priced providers would increase their rates up to the cap, thus reducing the potential for savings. Alternatively, addressing price increases perpetuates baseline discrepancies in payment rates but has the advantage of potentially being less disruptive to existing pricing structures. Capping prices and capping price increases are not mutually exclusive, however, and a state could potentially use both approaches.

Define which prices to include. Rhode Island's and Delaware's initiatives to limit hospital rate increases have encompassed both hospital inpatient and outpatient prices. However, states could consider starting with a more limited (or, for that a matter, a broader) set of prices. For example, Oregon's initiative began with joint replacements in 2015 before expanding to all hospital payments in 2017. States also could apply price caps and/or price growth caps to professional services. Some proposals on capping out-of-network payments have focused on particularly costly services for consumers, such as pathology, emergency, anesthesiology, and radiology services.

Establish oversight for the program. Rhode Island's and Delaware's programs use insurance oversight as the regulatory mechanism for caps on price increases. Rhode Island's cap on rate increases is built into its health insurance affordability standards, which are enforced by its Office of the Health Insurance Commissioner through the rate review process. Similarly, Delaware's law uses the rate review process to implement its cap on rate increases. Having statutory authority for oversight as well as adequate staff capacity will help states effectively implement this type of strategy.

EVIDENCE OF IMPACT

Controlling prices and price increases has a direct effect on health care spending. The size of the effect will depend on the number of prices and price increases being capped, and the aggressiveness of the cap.

Oregon's program to cap payments in its public employee benefit program had an estimated initial savings of \$81 million, representing roughly 5 percent of total costs. A study of **Rhode Island's affordability standards**, which apply to the fully insured market, found a 2.7 percent decrease in total spending growth from 2010 to 2016 compared with matched controls in other states, with the effect more pronounced after three years following policy adoption. Utilization did not change significantly, suggesting that the decrease in spending was driven primarily by lower prices.

Nationally, many different proposals to institute price caps across the commercial market have been modeled, with all suggesting the possibility of significant savings. **Limiting out-of-network payments** to 125 percent of Medicare payments is estimated to yield a \$108 billion to \$124 billion reduction in nationwide hospital spending, whereas capping payments at 200 percent of Medicare payments is estimated to reduce hospital spending by \$56 billion to \$94 billion. Setting prices for all commercial payers at 100 percent to 150 percent of Medicare rates 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 that would cap commercial hospital prices 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 1.0 percent.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

This option is likely most attractive to states that:

- have a high degree of commercial price variability within their markets
- can obtain statutory authority to limit commercial insurer contractual rates and/or rate increases
- have adequate staff capacity to oversee and enforce caps
- are prepared and able to work through provider opposition.

States that have pursued caps on rate increases in the commercial market have tended to be more progressive states that feel comfortable taking a regulatory approach.

EQUITY CONSIDERATIONS

Strategies that cap price increases, rather than prices, inherently perpetuate underlying disparities in payment rates and could potentially harm provider organizations that care for underserved or low-income communities. Pursuing such a strategy will require carefully monitoring and mitigating the impact on rural, safety-net, and other providers that might have lower commercial payer reimbursements. Rhode Island incorporated a one-time adjustment for hospitals with the lowest prices to address this issue.

However, bringing up low rates without an offsetting decrease or slowed increase to high rates will reduce savings. Capping rates may cause lower-priced providers to raise their prices up to the cap; although this would lead to more equitable payment rates, it would negate the potential for cost savings.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

States that cap payment rates only in certain programs (e.g., state employee health benefit programs or public option plans) may inadvertently dissuade providers from participating. This has been a challenge for Washington's public option, which caps provider payment rates at 160 percent of Medicare rates.

If caps are applied more broadly across the market, downward pressure on hospitals' prices would ultimately reduce margins. Hospitals might try to increase volume to compensate, and states would need to monitor for this effect. Decreased margins also could put pressure on hospitals to close unprofitable service lines or to close entirely, which could affect access to care. Hospitals could hypothetically also reduce staffing or investments in quality, making it important for states to monitor for access and quality effects.

RESOURCE

Aaron Baum et al., "Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers," *Health Affairs* 38, no. 2 (Feb. 2019): 237–45.

Contain Growth in Prescription Drug Prices

Cost Driver Targeted: Drug prices

OVERVIEW

States have sought to constrain prescription drug prices by implementing legislation that would have a direct impact on the reimbursement rates for prescription drugs. Some states have established prescription drug affordability boards (PDABs) to identify higher-priced drugs and to develop and oversee solutions.

[Maryland created](#) the first state prescription drug affordability board in the nation, which employs a phased approach that could eventually establish upper payment limits (UPLs) for drugs across all payers in the state, including in the commercial market. In 2021, [Colorado passed legislation](#) that would enable UPLs to apply to “all purchases of and payer reimbursements for a prescription drug that is dispensed or administered to individuals in the state in person, by mail, or by other means . . .” Legislation creating PDABs is pending or will likely be introduced in the upcoming session in a number of states.

States that wish to implement UPLs without creating the infrastructure of a PDAB can reference prices paid in other countries, where prescription drug prices are much lower. In 2020, the National Academy for State Health Policy (NASHP) developed [model legislation](#) for instituting international reference pricing for public plans, state-regulated plans, and federally regulated (ERISA) plans. Six states (Hawaii, Maine, North Carolina, North Dakota, Oklahoma, and Rhode Island) have proposed legislation based on NASHP’s model. [Massachusetts](#) and [Connecticut](#) proposed but did not succeed in passing legislation that would penalize drug manufacturers with price increases that exceed the consumer price index plus 2 percent each year.

The basic premise of this set of interrelated strategies is to establish or designate an entity to review the prices or price increases of certain drugs and to implement policies to mitigate those high prices or price increases. However, states have chosen to implement these programs in different ways.



KEY STEPS IN DESIGN AND IMPLEMENTATION

Set criteria for which drugs will have their prices reviewed. Defining which drugs' prices will be subject to review and possibly limits is an important initial step. Maryland's law includes drugs that have price increases over a certain threshold, as well as drugs with high wholesale costs. Colorado's law includes criteria for price (\$30,000 per year or per treatment course if less than a year) and price increases (10% per year). Colorado's law also includes provisions for biosimilar and generic drugs that have high prices or price increases. Some proposals include exemptions: for example, Connecticut's proposed legislation exempted drugs deemed to be in short supply.

Determine what action will be taken. The range of remedies applied by states varies. Colorado's Prescription Drug Affordability Review Board can establish UPLs, which apply to all transactions in the state. The board will develop the methodology for establishing those upper payment limits, and for the first three years of the program the strategy is limited to 12 medications. Payments in excess of the UPL are prohibited. Recognizing the analytic work necessary to define and establish a UPL, the NASHP international reference pricing proposal would employ international drug prices as reference prices and prohibit payments in excess of those reference prices. The Massachusetts and Connecticut proposals, and [NASHP model legislation](#) based on these proposals, do not prohibit sales but instead levy civil penalties against manufacturers based on the difference between the sales price and the benchmark price.

Create a governance structure. Many states have established new boards or commissions to carry out this work. Maryland created a Prescription Drug Affordability Board as an independent unit of state government, with appointees by the governor, the Senate president, the speaker, and the attorney general. Colorado similarly created an independent board, appointed by the governor and confirmed by the Senate. NASHP's model legislation sites authority with the superintendent of insurance.

EVIDENCE OF IMPACT

Analyses in multiple states and [at the national level](#) show that pharmaceutical spending is a large and growing component of health care spending in the commercial market. Strategies to lower prices or slow price increases would logically decrease pharmaceutical spending, but the magnitude of the impact would depend on how stringent the limits are, how broadly they are applied, and assumptions about utilization and substitution effects.

Savings estimates developed for a federal proposal (H.R. 3) that would institute reference pricing at the national level suggested [\\$256 billion in reduced costs](#) for employer-sponsored insurance and \$36 billion in reduced premiums and cost sharing in the Affordable Care Act marketplaces over a six-year period.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

The strategy is likely best suited for states that have:

- the political will to take on the pharmaceutical industry
- a strong coalition of payer, provider, business, and consumer organizations
- the willingness to create the analytic capacity to identify high-cost drugs or drugs with significant cost increases
- resources to administer the program.

Addressing prescription drug costs has broad appeal, and proposals have advanced in states with a range of political environments.

EQUITY CONSIDERATIONS

In general, lowering the cost of prescription drugs, particularly those treating conditions such as diabetes that are disproportionately prevalent among communities of color, has the potential to improve the accessibility and affordability of care for people of color and those living in low-income communities. However, proposed laws will need to be evaluated carefully for their health equity impacts to ensure that they do not decrease access to treatments for specific conditions, particularly those that are uncommon or for which there are relatively few treatment options.

States could proactively include provisions that look at equity as part of the criteria when evaluating affordability and setting rates. With all proposals that cap prices or price increases, it will be important to monitor availability of medications to consumers in a state, particularly for uncommon diseases or conditions with few therapeutic options.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

Limits on price increases are most readily applicable to drugs that are already on the market and may not be able to restrain high initial prices. Colorado's legislation does include a specific provision applying to drugs that have an initial wholesale acquisition cost of \$30,000 or more. An additional consideration is that states would likely face legal challenges to upper payment limit and reference pricing laws from the drug industry. NASHP's model legislation includes guidance on ways to minimize this risk. Finally, because these initiatives are new, states would likely face implementation issues as they stand up these programs.

RESOURCES

- Daniel A. Ollendorf, Patricia G. Synnott, and Peter J. Neumann, *External Reference Pricing: The Drug-Pricing Reform America Needs?* (Commonwealth Fund, May 2021).
- National Academy for State Health Policy, "Comparison of State Prescription Drug Affordability Board Bills," NASHP, Mar. 15, 2021.
- "NCSL Prescription Drug Policy Resource Center," National Conference of State Legislatures, Jan. 19, 2021.

Improve Oversight of Provider Consolidation

Cost Driver Targeted: Provider prices

OVERVIEW

State oversight of provider consolidation focuses primarily on preventing horizontal consolidation (between the same type of organization, e.g., hospitals) and vertical consolidation (across different types of organizations, e.g., hospitals and physician practices) that could make markets less competitive and raise provider prices. In some cases, approaches could include “conduct remedies,” which require or restrict certain actions by the postmerger entity to maintain competition. They also may include Certificate of Public Advantage (COPA) agreements involving requirements on the transactional parties prior to state approval, with penalties for the providers or unwinding provisions should the consolidation lead to undesired price increases and/or other anticompetitive behavior. Because of extensive provider consolidation activity in recent decades, states may also need to develop robust policies to address anticompetitive contract language and behavior between provider systems and health plans. In limited cases, states may also need to consider unwinding mergers or having entities divest certain assets to recreate a competitive environment.

Five states proposed legislation targeting provider consolidation during the 2021 session. Two states, Oregon and Nevada, successfully enacted new legislation. Nevada has passed two bills requiring [notice of “material changes”](#) and [prohibiting antitiering and antisteering clauses](#), two types of anticompetitive contract terms. [Oregon’s legislation](#) requires parties to provide the Department of Consumer and Business Services or the Oregon Health Authority with at least 180 days’ advance written notice of any “material change transaction.” Transactions that are found to “have a negative impact on access to affordable health care” are subject to disapproval or conditional approval.



KEY STEPS IN DESIGN AND IMPLEMENTATION

Determine level of authority. All state attorneys general (AG) already have some authority, mostly from statute but also from state constitutions or common law, to oversee health care mergers and acquisitions involving health care providers. This authority exists within one or more divisions in the AG office, such as the charities, antitrust, or the consumer protection divisions. Some states' AG offices have created health care divisions to respond more comprehensively to issues that arise from provider consolidation. Some states have additional statutory authority to review potential mergers and acquisitions or to prohibit anticompetitive contract terms. Moreover, some states may block transactions that they deem anticompetitive.

Consider including other agencies. One option for states is expanding other agency (besides the AG) involvement in this activity. Currently, 35 states have some Certificate of Need authority within a state agency that could contribute to the review of certain transactions and analyze potential impacts of mergers and acquisitions.² Some states have assigned new authority to an existing agency or created a new agency to assist with reviews. In Massachusetts, the Center for Health Information and Analysis (CHIA) and the Health Policy Commission (HPC) provide additional data and analytical capacity for reviewing transactions. In Rhode Island, the AG receives notice of nonprofit hospital transactions only, while the Rhode Island Department of Health receives notice of all hospital transactions.

Require notification of health care mergers or acquisitions. The federal government, via the Federal Trade Commission and the Department of Justice, receives notice of transactions exceeding \$92 million as required by the 2021 Hart–Scott–Rodino Antitrust Improvements Act (HSR). However, most transactions fall below this threshold, never facing review unless the state requires it. States will likely want to set their own standards for notice to capture transactions below the HSR level. Several important criteria for states to consider include:

- *Organizations required to report:* States may choose to include for-profit providers and/or investors in addition to the standard nonprofit authority of the AG. Because of the increase in vertical mergers and acquisitions, states also may want to include organizations other than hospitals. Connecticut, for example, requires hospitals and group medical practices to provide the AG with 30 days' notice of [merger or affiliation agreements](#).
- *Types of transactions that are reportable:* Instead of trying to anticipate the myriad possible transactions or the dollar amount needed to trigger noticing, one option for states is using “material change” language, which can then be defined and updated through state guidance or regulation. Washington recently passed legislation requiring notice for any “material change” to a provider organization, which is currently defined to include a merger, acquisition, or contracting affiliation between two or more hospitals, hospital systems, or provider organizations. States may want to include language regarding contracting affiliation, as those relationships can have the same impact on price and competition as mergers and acquisitions.
- *Length of notice period:* When determining the length of the notice period, states have selected options ranging from 30 days to 180 days before the effective date of the transaction. However, some states have flexibility in extending the period if additional time is needed to assess the transaction and to coordinate a response.

Request data and conduct analysis. States may predetermine the standard data and documents needed to adequately review the potential impacts of the transaction. They also may consider adding authority to request supplementary documentation if needed. States with all-payer claims databases and analytical capacity will be better positioned to analyze price and market conditions before the transaction and estimate changes that may occur.

² Of note, the impact of Certificate of Need programs themselves on health care expenditures is mixed. See Christopher J. Conover and James Bailey, “Certificate of Need Laws: A Systematic Review and Cost-Effectiveness Analysis,” *BMC Health Services Research* 20, no. 1 (Aug. 14, 2020): 748.

Determine action. Some states have the authority to block certain transactions without court action. For example, Rhode Island's Hospital Conversions Act grants state officials the authority to reject mergers that will decrease competition. Without this authority, states have the choice of pursuing legal action or compelling the entities to meet certain requirements under ongoing state oversight. States can impose conditions in several ways. States with authority can approve transactions subject to specific conditions. States with COPA authority can protect hospitals from the enforcement of state and federal antitrust action by putting in place a framework for active oversight. COPA agreements and state oversight continue indefinitely. Finally, states without either authority can seek court approval to impose conditions through negotiated consent decrees. No matter which mechanism is used, states can impose numerous conditions on the behavior of the merged entity, such as limiting cost growth and requiring that health systems keep certain services in operation. Taking legal action and monitoring terms of agreements can require substantial resources for the state and are not always vigorously pursued. Moreover, some oversight approaches are time-limited and provide no assurance that the entity won't pursue anticompetitive behavior once the oversight ends.

Develop strategies to prohibit noncompetitive contract terms between payers and providers. Because more than 90 percent of U.S. health care markets are already considered anticompetitive, states may need to focus their efforts on developing strategies to restrict anticompetitive contract terms between payers and providers. These terms include "all-or-nothing" clauses, antitiering or antisteering clauses, "most favored nation" exclusive contracting, anti-incentive clauses, and gag clauses. Several states, including Massachusetts, have restricted anticompetitive contract clauses through legislation, and the National Academy for State Health Policy has developed [model legislation for states](#). Some states have also focused on capping high prices or price increases, as described separately in these profiles.

EVIDENCE OF IMPACT

There is significant [research](#) documenting that [more concentrated health care markets](#) have higher commercial prices and that both [horizontal](#) and [vertical](#) consolidation [increase prices](#). Therefore, it is logical to expect that by preventing mergers that would reduce competition in a particular market, states would be able to maintain lower commercial prices in that market.

There also are numerous examples where states have put in place requirements on transactions to ensure continued access, cap price increases, or constrain anticompetitive behavior. However, most of these agreements have been time limited, and we were unable to find evidence of sustained impact on improving the competitiveness in a market for the long term. More recent efforts by states to enact stronger, more comprehensive legislation are new and have not been evaluated.

In terms of the effect of banning noncompetitive contract terms, the Congressional Budget Office and the Joint Committee on Taxation [recently found](#) that banning antitiering and antisteering clauses in markets with a dominant health care provider and no single dominant insurer would have a modest effect, decreasing premiums by approximately 0.05 percent.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

The strategy is likely best suited for states that have:

- provider systems with significant market share
- the willingness to take on large provider systems
- significant data analysis capacity within the AG office or elsewhere in the state.

Although states with comprehensive legislation in this area have tended to have more progressive political climates, this strategy is already being pursued in AG and Certificate of Need offices in states with a wide range of political dynamics. Legislation was proposed (although not passed) during the 2021 legislative sessions in both Florida and Indiana, suggesting significant interest across political contexts. For those states desiring market-based approaches to health care, ensuring the market is functioning as it should is important and cannot be ignored.

EQUITY CONSIDERATIONS

In general, a strategy that increases competition in a marketplace should reduce health care costs and improve access and quality for all. However, there is some concern that as hospitals aim to maximize profits, they could eliminate services that have a disproportionate share of patients associated with low reimbursement. States could mitigate such outcomes by incorporating specific provisions to assess and improve access and equity for low-income patients. For example, states could require provider commitments to enhance community services, participate in Medicaid programs, or ensure that behavioral health or other services with lower reimbursement continue to serve underserved communities in their approvals of mergers.

In Massachusetts, an agreement that allowed [Beth Israel Deaconess Medical Center and Lahey Health](#) to merge included a “good faith effort” to enroll Medicaid and CHIP beneficiaries and “to make over \$70 million in investments over eight years to improve access to health care for low-income and underserved communities, with a focus on financial support for community health centers, safety-net hospitals, and behavioral health.” When Ballard Health was established in rural Tennessee and Virginia, the [COPA agreement](#) included a commitment to invest more than \$300 million to expand access to behavioral health, address population health services specific to the community, and direct funds toward children’s and rural health.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

A limitation with this strategy is that many markets already have a high degree of consolidation, particularly among hospitals. While it may still make sense to employ a noticing requirement, states may need to focus on the anticompetitive behavior of existing large health systems. These systems may already have significant political clout within a state, making it more difficult to direct policy at those organizations alone. Therefore, other strategies (e.g., cost growth targets and price caps) may be more effective overall. In addition, if states implement agreements in lieu of legal action, they may be forestalling but not preventing price increases and other anticompetitive behavior by the merging entities. There are [several state examples of COPAs](#) that initially worked well at achieving policy goals but were later discontinued when state legislatures repealed their COPA laws, leaving the mergers unsupervised.

RESOURCES

Robert A. Berenson et al., *Addressing Health Care Market Consolidation and High Prices: The Role of the States* (Urban Institute, Jan. 2020).

Erin Fuse Brown, “[State Policies to Address Vertical Consolidation in Health Care](#),” National Academy for State Health Policy, Aug. 7, 2020.

Katherine L. Gudiksen et al., *Preventing Anticompetitive Contracting Practices in Healthcare Markets* (The Source on Healthcare Price & Competition and Petris Center, Sept. 2020).

Alexandra D. Montague, Katherine L. Gudiksen, and Jaime S. King, *State Action to Oversee Consolidation of Health Care Providers* (Milbank Memorial Fund, Aug. 2021).

Strengthen Health Insurance Rate Review

Cost Driver Targeted: Global spending

OVERVIEW

Rate review allows state regulators to evaluate, and in some cases, disapprove or modify, proposed health insurance rate increases that are deemed excessive. As such, rate review can be a helpful lever for states to bring down the cost of insurance in state-regulated health insurance markets.

Federal rate review regulation in the Affordable Care Act requires insurance carriers to file and publicly justify the reasonableness of proposed rate increases of 10 percent or more. To varying degrees, states have additional statutory and regulatory authority to regulate health insurance rates. [Past studies of states' rate review authority](#) found that about half of states had prior approval authority, which gives the state insurance commissioner the authority to approve, reject, or reduce proposed rate increases, usually through negotiation with the insurer. Under prior approval authority, carriers cannot use a rate until it is approved by the state's health insurance commissioner. There is usually a deadline after which the rate is deemed approved if the state takes no action. In contrast, under "file-and-use" regulations, premium rates automatically go into effect after a certain amount of time without approval from an insurance department, though states can take action later if the rates are found to be unreasonable.

States also vary in what criteria they can use when determining whether to approve or disapprove a proposed rate increase. Some states are able to disapprove "unreasonable" or "excessive" rate increases. Typically, states can look at carrier reserves, medical trends, rate history, and medical loss ratios (i.e., the proportion of an insurance carrier's premium revenues that it spends on medical expenses.) Some pioneering states, notably Rhode Island, have moved beyond traditional standards of financial solvency and consider affordability as a standard for rate review.



States also have demonstrated wide variation in how they wield their authority. For example, states vary in the percentage of rates they approve, and their staff capacity and historical practices may influence whether they maintain a culture of active review. Reviewing rates requires nuanced judgment calls, which can be challenging without sufficient capacity and expertise. The rigor and thoroughness that [states bring to rate review](#) can vary widely from state to state, depending on motivation, resources, and staff capacity.

KEY STEPS IN DESIGN AND IMPLEMENTATION

Assess statutory authority and consider legislation to establish prior approval authority and a mandate for affordability. Establishing prior approval authority may be an option for states that do not already have it. Another option is including broader authority for insurance commissioners to disapprove rates on the basis of affordability. For example, in approving, disapproving, or modifying an insurer's proposed rate, Vermont's [Green Mountain Care Board](#) must determine whether a rate is "affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State." Several states, including Oregon and Washington, have the ability to deny increases that are not "reasonable."

Rhode Island uses the rate review process to advance broader goals around insurance affordability. The [statute for rate review](#) requires plans to establish "that the rates proposed to be charged are consistent with the proper conduct of its business and with the interest of the public." To carry out that responsibility, Rhode Island has adopted a series of standards that define whether products are affordable to individuals and whether the insurer has implemented strategies to improve affordability. In this way, rate review expands from a strategy that is focused on reducing rates in the short term to one that can be used to align payer strategies for long-term cost mitigation.

Develop the analytic capacity to review rate filings. To effectively review rates, states' departments of insurance need sufficient staff capacity to review actuarial analyses, determine "reasonableness" of rates, and assess whether

carriers are meeting additional requirements, such as participation in strategies to improve health care affordability. Historically, lack of resources, coupled with short deadlines for prior approval, have limited departments' ability to meaningfully exercise their regulatory authority. Ensuring sufficient staffing can help states review filings within statutorily established deadlines; they also may wish to draw on application fees to support the cost of this review.

Educate consumers about and build public support for the rate review process. States can proactively design their rate review processes to allow for extensive public education and input. Connecticut's insurance department, for example, posts all health insurance filings on its website and makes them available to the public. During the rate review process, consumers may comment about the rates under review. They also can sign up for e-alerts so that they are notified when rate filings are posted. Individual policyholders also receive prior notification from their insurance company when a proposed rate increase is filed with the insurance department. Similarly, Oregon's rate review program posts carriers' justifications of rate increases on the [Oregon Insurance Division's website](#), and the public has opportunities for input through public comments and hearings.

EVIDENCE OF IMPACT

One [peer-reviewed study](#) found that states with stronger rate review policies had lower individual market premiums. From 2010 to 2013, adjusted premiums in the individual market in states that had prior-approval authority coupled with loss-ratio requirements were lower than premiums in states with no rate review authority or that had only file-and-use regulations (\$3,489 compared with \$3,617; this study period preceded federal loss-ratio requirements that took effect in 2014). Additionally, adjusted premiums declined modestly (from \$3,526 in 2010 to \$3,452 in 2013) in prior-approval states with loss-ratio requirements, while premiums increased (from \$3,422 to \$3,683) in states with no rate review authority or file-and-use regulations only.

Vermont's Green Mountain Care Board [commissioned a study](#) that found that for rates effective from 2012 to 2016, the total premium adjustments made in the rate review

process saved Vermonters approximately \$66 million, or about 3 percent. Additional assessments by advocacy organizations also have documented savings related to rate review in [California](#) and [Oregon](#), but these results do not report savings as a percentage of total spending across the market.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

States with a wide range of political dispositions have worked to strengthen rate review authorities. To date, the states that have expanded standards for review to broadly encompass health insurance affordability have tended to be more progressive states that are comfortable using this regulatory approach.

For states to have more leverage in rate review negotiations, some degree of competition in the insurance marketplace is needed. In addition, states will likely be most successful if they have:

- statutory authority backed up with the analytic capacity to review rates and to negotiate with carriers
- ability to align their approach to rate review with related efforts to constrain provider prices or price increases, and/or advance payment and delivery system reforms.

EQUITY CONSIDERATIONS

Design, implementation, and oversight of rate review programs should take into consideration their impact on affordability and access to low-income and underserved populations. Specifically, there is a hypothetical risk of losing access to carriers (especially in rural areas or other areas where there are not many carriers to begin with) and to specific higher-cost providers in network. Monitoring trends in insurance availability, affordability, and coverage by income, race/ethnicity, geography, and other characteristics at the state level is beneficial. Connecticut's [affordability index](#) is an example of a tool that helps to define affordability and the impact of policymaking on health care affordability across the state. States that are expanding their rate review processes to address affordability could consider assessing equitable access to care within their review.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

Rate review processes become a negotiation between the regulators and carriers and are predicated on a symbiotic relationship: the state needs carriers to offer plans to cover all regions of the state, and carriers want to offer these plans. For rate review to be effective, there needs to be sufficient competition in the market to create a healthy “push–pull” between regulators and carriers. States will need to monitor to ensure they continue to have robust competition and participation.

Regulators also need the independence to properly execute their oversight responsibilities. This independence can be threatened when regulated interests dominate the agencies that are meant to be overseeing them. Regulators also will need to be alert to gaming, where plans may submit higher rates knowing those rates will be negotiated downward.

Given the downward pressure on rates applied through rate review, plans could theoretically respond by decreasing access to care. To help avoid this, states can monitor indicators such as carrier networks, appeals and grievances, and quality performance.

RESOURCES

“Resources: Using Rate Review to Address Healthcare Affordability,” Altarum Health Care Value Hub, n.d.

Pinar Karaca-Mandic et al., “States with Stronger Health Insurance Rate Review Authority Experienced Lower Premiums in the Individual Market in 2010–2013,” *Health Affairs* 34, no. 8 (Aug. 2015): 1358–67.

Adopt Advanced Benefit Designs

Cost Driver Targeted: Provider prices

OVERVIEW

Advanced benefit designs employ price transparency and shopping tools that enable enrollees to shop for high-quality, lower-cost providers and services. In return for using lower-cost providers, beneficiaries pay less out of pocket and/or share in the savings with the insurer. Examples of the designs discussed here include reference pricing and enrollee “right-to-shop,” or “smart shopper,” programs.

Reference-Based Benefits

Reference pricing is a payment scheme in which an insurer or employer determines a price that it is willing to pay for certain “shoppable” health care services based on an average or percentile of market-based prices (e.g., 60th percentile). As variations on the approach have evolved, this specific approach is now referred to as “reference-based benefits.”³ Enrollees who obtain care from a provider with a price at or below the reference price pay only the normally required cost sharing. Enrollees obtaining care from a higher-priced provider pay the normally required cost sharing and the difference between the reference price and the allowed charge.

³ The term “reference-based benefits” is used to distinguish these benefit design approaches from other forms of reference pricing, such as that used by Montana’s state employee health plan. The approaches are similar in one aspect: a payer sets a price it is willing to pay for a service. However, in the approach employed by Montana, the price is tagged to a normative price (e.g., a multiple of Medicare rates), instead of market-based prices. Moreover, the consumer is not involved in “shopping” for lower cost providers per se, although in some cases they may be subject to balance billing if they use a provider who has not agreed to the reference-based price. Finally, the reference prices typically apply to all services within a category (e.g., all hospital services), rather than specific services.

Smart Shopper

A “right-to-shop,” or “smart shopper,” program is a strategy whereby an enrollee uses an online or mobile platform or a call center to locate lower-cost providers for certain predetermined services. Typically, these include laboratory services; advanced diagnostic imaging; outpatient surgery; and speech, occupational, and physical therapy. These services are considered shoppable because they are offered by multiple providers with comparable quality and have significant price variation in the market. Enrollees that choose a lower-cost provider receive an incentive payment, thus sharing in the savings. These incentives can range anywhere from \$25 to \$500, depending on the service and the provider selected.

KEY STEPS IN DESIGN AND IMPLEMENTATION

Determine level of state involvement. Thus far, states have adopted advanced benefit designs primarily in state employee plans, but they could expand their efforts to other types of plans. For example, states could require one or more of these approaches be offered in state-based marketplace plans. They also could encourage or compel insurers to offer one or more of these products across their fully insured markets. [Virginia, for example](#), requires health insurers in the small-group market to develop a smart shopper program that provides enrollees with direct cash, gift cards, or lower out-of-pocket costs as incentives to seek more affordable care. Florida enacted legislation [authorizing but not requiring](#) insurers participating in the individual and small-group market to develop smart shopper programs for enrollees. Through brokers and employer associations, states also can play an important role in educating employers, including those that are self-insured, about these options.

Oversee contracts between payers and providers to prevent anticompetitive terms. States interested in encouraging the growth of these strategies will likely need to strengthen their oversight of anticompetitive contract terms between payers and providers. Antitiering or antisteering provisions in contracts can limit the ability of purchasers to require higher cost sharing for some higher-cost providers with market power, and states may seek legislative authority to prohibit these terms.

Develop robust price and quality transparency tools and provide consumer education. States may wish to develop their own price and quality tools to help consumers choose high-quality providers. New Hampshire was the first state to develop a [price transparency website](#). States with all-payer claims databases may be in a better position to create such tools. States also can work with vendors to develop transparency tools but will still require pricing data from insurers. States also have an important role to play in educating consumers about the use of these tools, as the evidence suggests that uptake is very limited. In addition, states will likely need to provide significant consumer education around price variability and the fact that they cannot equate higher prices with higher-quality care.

EVIDENCE OF IMPACT

Reference-Based Benefits

Reference-based benefits used in both the California Public Employees’ Retirement System (CalPERS) and in the Safeway grocery store chain have been formally evaluated. Both organizations found their strategies resulted in significant savings as enrollees switched to lower-cost providers. In the [Safeway program](#), savings ranged from 10.5 percent (for MRI imaging) to 32 percent (for diagnostic lab testing) while the percentage of enrollees moving to lower-cost providers ranged from 9 percent to 29 percent. Savings in the [CalPERS program](#) ranged from 17 percent (for shoulder arthroscopy) to 21 percent (for colonoscopy). Moreover, with CalPERS, prices charged among higher-priced hip and knee replacement providers dropped by an [average of 34 percent](#).

Although the use of reference-based benefits to date has focused on a small number of procedures and services, some researchers have suggested that broader use is possible. [One study](#) proposed 350 shoppable services (about 35% of total health care spending) that would be amenable to price shopping. They estimated that spending for these services could be reduced by 14 percent, potentially curbing total health care spending by about 5 percent.

Smart Shopper

Smart shopper programs have been used in several state employee programs and are becoming more popular in commercial insurance products. [Kentucky's smart shopper program](#) for state employees saved \$13.2 million during its first three years, with employees earning \$1.9 million in shared savings. A [large insurer's "Member Rewards" program](#), which allowed employees from 29 employers to shop for 135 elective services, reduced prices by 2.1 percent for certain services in its first 12 months. Although these savings are small, this evaluation was conducted using the program's first year of data, and most programs have shown larger savings after several years.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

These strategies are best suited for states that have:

- significant price variability of services within a market
- urban markets with adequate numbers of competing lower-cost, high-quality providers
- the data resources to create or assist with the development of a price-comparison tool
- the resources and willingness to support consumer education and engagement around use of price transparency tools
- an interest in market-based approaches.

A right-to-shop or smart shopper strategy is a "carrot" approach that relies on the power of the market to reduce health care prices without penalizing consumers. States may find it more difficult to implement reference-based benefits, as this "stick" approach potentially exposes consumers to significant additional costs. States may also find providers to be less wary of shopping strategies, compared with reference-based benefits.

EQUITY CONSIDERATIONS

These approaches may have a negative impact on health equity if states (or others) do not implement them carefully. With reference-based benefits, individuals may face higher costs if they see certain providers, and it will be important to ensure that lower-income individuals in particular do not forgo needed care because of concerns about costs. It also will be important to limit these strategies to routine health care procedures that can be scheduled well in advance to allow consumers time to conduct the shopping comparisons required.

Having an adequate number of lower-cost providers (including those able to meet the cultural and linguistic needs of diverse enrollees across all geographic regions, especially rural or underserved areas) is also important. States can also be mindful of the impact on individuals with highly complex care needs, who may be less able to shop (because of the complexity of their needs) and are the most impacted by cost sharing. States could consider mitigating this by including an appeals process, allowing for exemptions, or creating a cap on the amount enrollees are required to pay. However, some of these mitigation strategies make program implementation more complex.

Using price-comparison tools also can be challenging for patients with low English proficiency or limited technology access. States can encourage the development of price transparency tools that are as easy to use as possible and available on multiple platforms. They also may require a call-in center to assist patients without access to the internet or who need assistance because of low English-language proficiency, low health literacy, disability, or other reasons.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

Advanced benefit designs have several limitations. In general, they create significant administrative burden to implement and require extensive consumer education and engagement.

Another concern is more specific to markets that are already consolidated with a prominent provider system. Hospitals within these systems may include restrictive language in their contracts that limits insurers' ability to steer consumers to lower-priced competitors. When such contractual provisions are in place, states may find it difficult to implement reference pricing or smart shopper strategies.

Another issue is the uncertainty around whether the higher out-of-pocket costs that consumers would face by using a provider above the reference price counts toward their plan's deductible or out-of-pocket limit. Although [joint guidance](#) from the U.S. Departments of Labor, Treasury, and Health and Human Services indicates that these payments can be excluded from out-of-pocket limits, the guidance is somewhat vague, and reporting requirements and oversight may be burdensome.

Additionally, the impact on cost savings is limited by the number of shoppable services. The limited scope raises the concern that providers could simply offset savings on these services by raising prices elsewhere.

Finally, there is nothing that requires employers to choose these programs or for consumers to use them. Without sizeable uptake of these products, they are less likely to influence provider behavior.

RESOURCES

Suzanne F. Delbanco et al., *Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care* (Urban Institute, Apr. 2016).

Brian Blase, *Transparent Prices Will Help Consumers and Employers Reduce Health Spending* (Galen Institute and Texas Public Policy Foundation, Sept. 27, 2019).

Promote Use of Community Paramedicine

Cost Driver Targeted: Inpatient/emergency department utilization

OVERVIEW

Decreasing unnecessary emergency department (ED) visits has been an important health policy goal as a result of the high cost of emergency services and how they contribute to unnecessary inpatient utilization. To achieve this goal, some state policymakers are rethinking how emergency medical services (EMS) providers could expand their role to deliver the “right care, in the right place, at the right time.” In most traditional EMS models, the primary responsibility of EMS providers is to stabilize patients in crisis and then transport them to EDs for treatment. Community paramedicine, a component of mobile integrated health, is an emerging model in which EMS providers deliver health services without transporting individuals to EDs. In this model, EMS providers work in partnership with public health and health care systems to deliver care. They might assess a patient’s condition, deliver treatments in the home or in the field, or conduct screenings and other services.

Taos, New Mexico, implemented one of the first community paramedicine programs in the United States in the 1990s. Since then, community paramedicine has been increasing in popularity nationally and internationally. As of 2018, more than 200 [community paramedicine programs](#) were operating in the United States, with many of them located in rural areas.

Community paramedicine programs have been found to decrease health care spending by preventing use of more costly and unnecessary services, such as inpatient or ED care, while achieving high satisfaction ratings from patients. In recent years, many states have started to explore and implement approaches to support more widespread use of community paramedicine as part of mobile integrated health solutions.



KEY STEPS IN DESIGN AND IMPLEMENTATION

Identify and resolve statutory barriers to community paramedicine. Some states restrict the role of EMS providers in a way that prevents them from delivering community paramedicine services. Other states, including [Minnesota](#) and [Wisconsin](#), have enacted legislation that broadly defines and enables community paramedicine services. Maine amended its statute in 2012 to allow the state EMS board to establish [12 pilot community paramedicine programs](#) before making community paramedicine programs [permanent in 2017](#). In California, the Health Workforce Pilot Project Program temporarily waived sections of the health and safety code to allow community paramedicine pilots.

States can review their existing laws and regulations to see whether they restrict or prohibit community paramedicine. If so, they can decide whether to pursue a broad “fix” or a narrower exemption (e.g., to allow for a pilot program).

In addressing statutory barriers to community paramedicine, key steps for states include reviewing where oversight of these programs should reside (e.g., within a licensing authority) and considering whether they should delineate a scope of practice or allow for delegated practice under a physician’s medical license.⁴

Determine areas of focus. Community paramedicine can be applied in a number of different ways. For example, states might choose to focus on postdischarge care or newborn assessments. Some programs have focused on specific chronic conditions, whereas others may address alternative transport sites (e.g., primary care, urgent care, or detoxification centers). Training and supervision, including requirements for who serves as medical control for the community paramedicine program, should be tailored to the area of focus. A needs assessment can identify significant gaps in existing health care services, which populations most frequently use EMS, the most frequent conditions requiring hospital readmission, and the greatest health care needs, from the perspective of providers, patients, and other stakeholders. This can help prioritize focus areas and support the most strategic use of resources.

Determine how community paramedicine services will be reimbursed. In many cases, payers reimburse EMS providers only when the patient is transported to the ED. The lack of reimbursement for care other than transport has been a major barrier to sustaining community paramedicine initiatives, but in recent years, support for reimbursing community paramedicine services has increased. Medicare recently launched the Emergency Triage, Treat, and Transport (ET3) model, which gives more flexibility to ambulance care teams to address the emergency health care needs of Medicare fee-for-service beneficiaries following a 9-1-1 call. At the state level, there has been significant progress in increasing opportunities for reimbursement, with commercial and Medicaid reimbursement [now occurring in a number of states](#).

Options for state policymakers to support community paramedicine services include:

- *Pilot or grant funding:* However, this approach has the obvious drawback of not providing for a sustainable, ongoing funding stream.
- *Medicaid reimbursement:* A number of state Medicaid agencies (notably in Arizona, Georgia, Minnesota, Nevada, and Wyoming) reimburse for community paramedicine services, and 14 states provide some reimbursement for EMS treatment without transport. Medicaid reimbursement can be an important first step that facilitates future commercial reimbursement, such as by establishing fee schedules and billing codes.
- *Commercial reimbursement:* After Medicare, commercial carriers are the [second-largest payer](#) by volume for EMS transports. Many commercial insurers have launched community paramedicine programs. For example, Blue Cross Blue Shield of New Mexico has [a program with Albuquerque’s ambulance services](#) to visit members within 72 hours following an ED visit or hospital discharge. In 17 states, commercial insurers reimburse for community paramedicine programs. States could grow commercial carrier reimbursement by addressing regulatory barriers; leading by example by advancing reimbursement in public programs and initiatives; facilitating multipayer alignment; and requiring plans regulated by the state to include community paramedicine services (although we are not aware of states that have done so).

⁴ For example, Minnesota’s Community Paramedic Toolkit details issues related to certification and scope of practice. See Minnesota Department of Health, [Community Paramedic Toolkit](#) (MDH, Dec. 2016).

- *Provider partnerships:* As providers are increasingly paid through financial models that make them accountable for patients' outcomes, they may be more interested in forming partnerships with community paramedicine programs to extend their reach to care for patients in the home. Colorado's Eagle County Ambulance District has had a [shared savings arrangement](#) with an area hospital to recoup a portion of the savings that results from preventing readmissions. Some hospitals operate their own EMS, which can facilitate coordination between health care providers and the EMS system. In addition to health systems, hospice and home health providers also can be important potential partners. States could support provider partnerships with community paramedicine by facilitating connections between health care and EMS providers, and by easing regulatory barriers.

EVIDENCE OF IMPACT

Community paramedicine programs have been found to decrease ED and inpatient utilization in multiple studies, while achieving [high patient satisfaction and improved health outcomes](#). Studies of several programs — including ones focused on a [Medicare Advantage population](#), a [small rural community](#), and a [large city](#) (Houston) — suggest that community paramedicine may have a positive return on investment. [Case studies](#), such as the [MedStar Mobile Health Program](#) in Texas, for example, have demonstrated savings from avoiding ED and inpatient admissions.

Although these studies have not specifically focused on commercially insured populations, a number of studies involved geographically defined populations that presumably included commercially insured individuals. [REMSA in Nevada](#) has reported savings in different populations, including the commercially insured.

Researchers have estimated the total potential savings from community paramedicine at [\\$283 million to \\$560 million for Medicare each year](#); this could double if private payers instituted similar policies.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

This approach is likely to have broad appeal across states with different political environments. It may be of particular interest to states that:

- are interested in improving access to care in rural areas
- have EMS providers who are interested in developing community paramedicine initiatives
- have a payer or provider who could serve as a partner in moving this initiative forward.

Some community paramedicine programs have encountered opposition because of concerns about the scope of practice of community paramedicine providers vis-à-vis nurses and other health professionals. Engaging with community members and stakeholders throughout the process can help clarify roles and address concerns.

EQUITY CONSIDERATIONS

Community paramedicine holds particular promise for improving access and outcomes for individuals with high needs as well as for those in rural or underserved areas. It will be important to support research to better understand patient satisfaction and health outcomes by race/ethnicity, as well as to monitor for adverse effects.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

Under these types of programs, community paramedicine providers will need training appropriate to the services they will be providing. Some states stipulate training requirements, and some require formal recognition after training, such as licensure, certification, approval, or endorsement. States should be prepared to define and oversee such requirements.

As with initiatives that introduce alternative settings of care (e.g., urgent care and retail clinics, for example), monitoring is important to ensure that community paramedicine service volume does not grow so much as to increase overall utilization and erase the potential for cost avoidance. Similarly, it is important to avoid duplication of services. From a practical standpoint, ensuring that community paramedicine providers are communicating effectively (e.g., through a shared electronic health record) with a patient's regular provider is important to prevent fragmentation of care.

States should also monitor patient outcomes carefully to ensure that patients are receiving appropriate care and being appropriately triaged to EDs when warranted.

RESOURCES

Janet Coffman and Connie Kwong, *Left Behind in California: Comparing Community Paramedicine Policies Across States* (California Health Care Foundation, Nov. 2019).

"Rural Community Paramedicine Toolkit," Rural Health Information Hub, 2020.

National Association of Emergency Medical Technicians, *Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey* (NAEMT, 2018).

Improve Behavioral Health Crisis Systems

Cost Driver Targeted: Inpatient/emergency department utilization

OVERVIEW

The United States has created an organized system of care to meet the needs of those experiencing a physical health crisis. Individuals may call a dedicated national number (9-1-1) that will dispatch an ambulance to take them to a hospital emergency department (ED), where a team of clinicians will be activated to immediately address their needs. The current system, however, often fails to serve those experiencing a behavioral health crisis. In this case, an individual may call 9-1-1 or one of hundreds of other behavioral crisis lines and may end up “boarded” in an ED or sent to a crowded jail. Either path often sustains or escalates the behavioral health crisis for the individual. This is not only harmful and ineffective but also unnecessarily costly.

As a better option, states could create a crisis response system for behavioral health that is as robust and effective as our physical health emergency response system. Congress has recently taken a series of legislative actions that create new opportunities for states to improve the behavioral health crisis infrastructure at the state level, including:

- In 2020, Congress designated 9-8-8 as the universal telephone number for the national suicide prevention and mental health crisis hotline system. This number will go live in July 2022.
- Also in 2020, Congress set aside 5 percent of the Mental Health Block Grant to advance crisis care in states, resulting in the recent award of \$75 million to states for this purpose.



- As part of the American Rescue Plan Act (ARPA) in 2021, Congress authorized an enhanced federal medical assistance percentage (FMAP) of 85 percent for Medicaid funding of mobile crisis response teams. Additionally, the Centers for Medicare and Medicaid Services (CMS) awarded \$15 million in grants to states to develop their mobile response capacity.
- The ARPA also increased funding for home- and community-based services that could be used by states to support crisis services development.

As a result, there is an extraordinary alignment of policies and investments to create a meaningful, functioning behavioral health crisis system. State efforts to strengthen behavioral health crisis systems have the potential to improve the patient experience of care, advance population health, and bend the cost curve for all state residents, including the commercially insured population. Although behavioral health crisis services have been financed primarily by public sources to date, privately insured individuals account for substantial proportions of [inpatient discharges for behavioral health conditions](#) (26.9% of discharges from community hospital psychiatric units and 30.2% of discharges from “scatter beds,” referring to beds serving patients with behavioral health conditions on general medical/surgical units). Privately insured individuals also comprise an estimated [34.5 percent of people](#) with serious mental illness, suggesting that commercially insured individuals make up a substantial portion of the population that would likely benefit from a crisis system.

As states design and implement programs to meet the emergent behavioral health needs of their residents, they should design programs [following guidelines](#) from the Substance Abuse and Mental Health Services Administration (SAMHSA). The guidelines were developed to serve anyone, anywhere, at any time, regardless of payer. They define the three major components for a crisis system, which include:

- regional crisis call center capacity that is clinically staffed 24/7 and can provide risk assessment, engage individuals at imminent risk of suicide, and coordinate crisis care in real time

- a crisis mobile response team that can provide emergency mental health evaluation and crisis services in the field
- crisis stabilization facilities that can provide short-term (under 24 hours) observation and stabilization services in a nonhospital environment.

KEY STEPS IN DESIGN AND IMPLEMENTATION

Secure sustainable, multipayer financing. Historically, states have braided different public funding sources to develop and operate the crisis infrastructure. These resources typically included some combination of SAMHSA funds, Medicaid, local dollars, and private funds, with Medicare and commercial payers conspicuously absent. As of May 2021, bills had been [introduced in 20 states](#) to fund local crisis hotlines in the 9-8-8 network. [In Utah, legislation](#) was recently enacted requiring the Medicaid agency to submit a waiver or state plan amendment to allow payment for 9-8-8 services provided to Medicaid enrollees. As states develop their crisis system plans, they will need to evaluate strategies to include other payers, such as commercial plans, to support the infrastructure. This would help supplement federal block grant funds, which are very limited. (Nationally, only \$75 million of crisis care funding has been allocated for the first year. In comparison, Arizona alone had an annual funding commitment of \$163 million in 2019.)

Define program and policy requirements for a comprehensive crisis infrastructure. States provide the key guidance around payment policy and licensure to create viable crisis infrastructure. Leveraging key elements like peer supports and other nontraditional provider types are important in creating a viable structure. Such is the case with Arizona’s crisis program, which is frequently cited as a model of a comprehensive program. Arizona’s behavioral health crisis system is operated by the state Medicaid agency and administered by three regional behavioral health authorities that contract directly with community behavioral health providers. Crisis services include three regional 24-hour hotlines, mobile crisis response teams, and facility-based crisis stabilization. The state delineates the services provided and requirements for payments through its [provider billing manual](#).

Ensure stakeholder engagement. A successful crisis infrastructure depends on support from consumers, advocates, law enforcement, providers, and policymakers. The state of Washington recently enacted [comprehensive legislation](#) that provides funding for crisis call centers and 9-8-8 implementation. The legislation creates a Crisis Response Improvement Strategy Committee with broad stakeholder representation to provide recommendations to implement and monitor the progress of the 9-8-8 crisis hotline and to improve behavioral health crisis response and suicide prevention services statewide.

EVIDENCE OF IMPACT

The costs of implementing a behavioral health crisis infrastructure are significant, but these services can lead to cost savings by reducing inpatient hospital and ED use, diverting individuals from the criminal justice system, and fostering more appropriate use of community-based behavioral health care. Apart from direct cost savings, delivering care in the most effective setting is important in its own right, an imperative underscored during the COVID-19 pandemic. Components of a comprehensive crisis system have been shown to improve outcomes and decrease cost. Most recently, the crisis system in Maricopa County, Arizona, which includes all three core components, was estimated to [reduce inpatient spending by \\$260 million](#) and to decrease ED boarding.

[Prior studies](#) have suggested that community-based mobile crisis services result in a lower rate of hospitalizations than hospital-based interventions. This was also found by a study of [mobile crisis services](#) in DeKalb County, Georgia, which estimated savings for mobile crisis services compared with police interventions. A small study of [crisis intervention services located at a single hospital](#) also found that intervention services reduced costs associated with inpatient hospitalization by approximately 79 percent in a six-month follow-up period after the crisis episode. Another study examining [mental health crisis stabilization programs in the east metropolitan area of the Minnesota Twin Cities region](#) assessed the costs associated with reduced inpatient hospitalization and found a return of \$2.16 for every dollar invested.

The previous studies did not primarily focus on commercially insured populations and, with the exception of the Twin Cities study that used Medicaid

claims data because of a lack of commercial claims data, did not specify the insurance coverage for the individuals served. As crisis services expand to serve all in need, additional research will be helpful to measure the impact on commercially insured individuals specifically.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

To successfully develop comprehensive behavioral health crisis systems, states may opt to tackle each of the three major areas highlighted above: financing, policy, and stakeholder engagement. Ultimately, states need a financing strategy that can support the level of need in the state. Policymakers should assess how all payers should contribute to a strong crisis system that serves everyone in the state.

This approach is likely to have broad appeal across states with different political environments. It may be of particular interest to states that have:

- consensus about the need to improve behavioral health crisis services
- support from a lead payer-partner and/or a strong multistakeholder coalition on behavioral health issues.

EQUITY CONSIDERATIONS

A comprehensive crisis system can be a very effective tool in addressing disparities in care and access to treatment for mental health or substance use disorders. A strong crisis system creates a different access point other than an ED or jail, avoiding the negative repercussions of these pathways.

Expanded crisis capacity also may reduce the stigma associated with behavioral health issues and further break down cultural barriers to behavioral health treatment that may exist in communities. The establishment and rollout of a national behavioral crisis telephone number will likely create educational and promotional opportunities that are often limited and fragmented today.

Thoughtful stakeholder engagement in the design and implementation of a comprehensive crisis system is important to ensure that these programs meaningfully improve access and outcomes for diverse populations.

Virginia's [Marcus-David Peters Act](#) is one example. The act takes a comprehensive approach to responding to behavioral health emergencies and has several specific goals related to equity, including analyzing and decreasing race-based and other health disparities in crisis services; cultivating a statewide, Black-led crisis coalition; and supporting additional projects to ensure that equity is a central consideration in the planning, oversight, and evaluation of the crisis system.

POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

Ideally, a well-designed system would fully cover the state in both rural and urban areas, develop sustainable funding streams, and ensure continuity of care to create a clear path for the individual in crisis. The following examples illustrate potential unintended consequences that stem from design challenges:

- *Regional limits:* Some county leaders have developed a crisis infrastructure at the local level. Although creating local capacity is important, there may be challenges with how those local networks support individuals outside the county line. An approach that is too local can and will be fragmented and less effective.
- *Operational funding:* This is one of the most critical aspects that determines long-term viability. Often communities or states are eager to utilize new, but time-limited, resources. To have a sustainable infrastructure, it is essential to identify and secure permanent funding.
- *Continuum capacity:* As the crisis system evolves, having end-to-end visibility into system capacity is critical. Individuals may move from the call center to mobile response to stabilization and then to a poststabilization need. Managing this flow is important to care continuity and community support. Without it, stakeholders and the community may view the system as incapable of meeting their needs. For example, if significant effort is made to work and coordinate with law enforcement but they find inadequate access or responsiveness, they will begin to limit their use of the system.

RESOURCES

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Substance Abuse and Mental Health Services Administration, *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* (SAMHSA, 2020).

Ashley Traube, Patricia Boozang, and Jocelyn Guyer, *American Rescue Plan Provides a New Opportunity for States to Invest in Equitable, Comprehensive and Integrated Crisis Services* (State Health and Value Strategies, Apr. 30, 2021).

National Association of State Mental Health Program Directors, *Financing Mental Health Crisis Services* (NASMHPD, Aug. 2020).

Reduce Administrative Waste

Cost Driver Targeted: Administrative costs

OVERVIEW

In the United States, administrative costs comprise up to one-third of total health care costs, a much larger proportion than in other comparable countries in the Organisation for Economic Co-operation and Development (OECD). These costs are often attributed to the complexity of the largely private, multipayer system operating in the U.S. However, many other countries with lower administrative costs (including Switzerland, France, and Germany) use multipayer systems. These countries also have highly regulated, standard payment rates across payers, which reduces the administrative complexity of billing. However, there are other strategies to address the complexity of the U.S. system that do not require adopting standard payment rates.

Billing and insurance-related (BIR) costs are the largest component of administrative costs. Included in this category are eligibility determination, claims management, clinical documentation and coding, prior authorization, sales and marketing, quality measurement, and credentialing. The [Council for Affordable Quality Healthcare \(CAQH\) reports](#) that moving from manual to fully electronic transactions would yield the greatest savings per transaction for claim status inquiries (\$11.71), although prior authorization (\$9.64) and eligibility and benefit verification (\$8.64) also present large opportunities for savings.

Administrative costs are an attractive target for cost reduction, as they are potentially low-hanging fruit and not directly related to patient care. However, a comprehensive approach to reducing administrative costs has not been implemented at the federal or state level. [Congress has shown some interest](#) in efforts to reduce administrative costs, although legislation has stalled.

We focus here on strategies states can employ to reduce BIR costs, including simplifying and standardizing insurance choices, streamlining the billing process, harmonizing quality metrics, and reforming the prior authorization process.



- Simplifying and standardizing insurance choices:** Myriad insurance plans exist in the individual and group markets within each state. Many of these plans differ in negligible ways yet contribute significantly to the complexity of the system. This strategy would reduce the number of plans in the market to highlight those that are meaningfully different and provide greater standardization. As a result, consumers (both individuals and employers) may better understand the differences and maximize their choices. Standardization not only reduces complexity but can promote competition as well. In the employer market, this strategy also lowers the cost of negotiating and drafting contracts, decreases sales and marketing activities, and alleviates switching costs. In the nongroup market, individuals can more easily navigate their choices in the Affordable Care Act marketplaces, which offer **fewer, more structured choices**.
- Streamlining the billing process:** A proposed **national approach** for significant paperwork reduction would involve developing a centralized claims clearinghouse in the U.S. to allow providers to submit all claims to a single entity, as they do in Germany. Although this ambitious approach could not be implemented at the state level, there are strategies states could employ to streamline commercial claims processing. For example, states could require the interoperability of data across systems, further standardize and automate billing forms and processes, provide incentives for real-time adjudication of claims, and more fully realize the potential of prospective, value-based payments to reduce the need for billing and adjudication.
- Harmonizing quality metrics:** **A little more than half (53%)** of all commercial dollars in the medical system have some value-based component, either tied to performance or designed to improve efficiency. Thousands of quality metrics are in use in the health system, and physician practices spend **more than \$15 billion annually** to report quality measures. This strategy would involve determining a core set of quality measures and requiring insurers in the state to use them in value-based contracts with providers. With a new focus on equity measures, there may be an opportunity for states to harmonize efforts across payers.
- Reforming the prior authorization process:** As health care costs have risen, so has insurers' use of prior authorization. According to a **survey by the American Medical Association**, physicians estimate they complete about 40 prior authorization requests each week. State strategies that have been implemented via legislation include requiring fully automated prior authorization processes, fast turnaround (within 48 hours) of prior authorization requests, and exclusion of some services from prior authorization. In June 2021, **Texas adopted a new law** that contains a provision referred to as "gold carding" clinicians. Under the new law, if a clinician orders a medical service such as a medication or service at least five times in a six-month period, and at least 90 percent of the prior authorization requests are approved, then the clinician is exempt from requirements for prior authorization for that medical service for the next six months. Additionally, some insurers are considering waiving prior authorization requirements for providers who take downside risk.

KEY STEPS IN DESIGN AND IMPLEMENTATION

Decide which administrative functions to address. States could employ a comprehensive approach to reducing administrative costs or choose to start with one or more strategies. Several states (including Connecticut, Maine, Massachusetts, Minnesota, Oregon, Rhode Island, Vermont, and Washington) have worked on harmonizing quality improvement metrics across insurers, with the process initiated as part of their CMS State Innovation Model (SIM) grants. Through legislation passed in 2008, Minnesota has aligned quality metrics, although insurers are not limited to using measures in the aligned set in their contracts with providers. In 2015, Rhode Island used its SIM grant funding to support a process to align quality measures and convene a group of stakeholders including insurers, providers, and consumers. In 2017, the function transitioned to the Office of the Health Insurance Commissioner, and regulations were promulgated requiring that all commercial payers use the aligned measure sets in any contract with a financial incentive tied to quality. The workgroup meets annually to review the measure sets and recommend changes.

Determine type of state involvement. States could legislate that insurers use streamlined administrative functions or they could work collaboratively with stakeholders to achieve one or more of these goals. A state's choice of approach will depend on policymaker and stakeholder interest, the political environment, insurance and provider markets, and state resources.

Assess legal and market barriers. States will need to research the environment and determine the extent to which the market has harmonized and automated BIR functions. In addition, some strategies may require assessing legal barriers that may exist, including but not limited to state and federal data sharing and data privacy laws. Some efforts will likely require legislation to compel insurers to adopt certain reforms.

Convene a working group. These working groups may include representatives from major insurers and provider organizations, as well as consumer advocates and employers. Depending on the strategy pursued, state agencies (including the department of health, the insurance commissioner, the Medicaid agency, and others) could be involved. Alternatively, a state-based nonprofit entity or collaborative could help convene the stakeholders.

Monitor effectiveness of the intervention and ensure administrative savings are shared. Most of the strategies discussed here have not been implemented or evaluated. By evaluating the impact of their strategies, states can ensure that any waste eliminated from the system is captured and results in lower costs for purchasers and consumers.

EVIDENCE OF IMPACT

In general, evaluation data from implemented initiatives are lacking. A [recent report](#) used an analysis of profit and loss statements and categorized administrative simplification strategies into efforts limited to within an organization, those requiring partnership between two or more organizations, and those requiring wholesale changes to the health care industry. The authors found that the first two types of strategies could save those organizations \$210 billion annually without an impact on access or quality.

In another report, CAQH recently found that a manual health care transaction costs \$4.40 more on average than an electronic transaction and that completing all health care transactions electronically would yield **\$11.1 billion in savings annually**.

In addition, economists have modeled potential reforms of various administrative activities and report that substantial savings could be realized. In a recent simulation, Scheinker et al. found that significant reforms to physician billing and BIR could result in **savings ranging between 27 percent and 63 percent**, although these savings were projected on a national level. Cutler's estimates range from **\$50 billion to \$75 billion annually** for a series of reforms implemented nationally. The modeling for individual approaches has important but smaller projected impacts. For example, the modeling around limiting choice of insurance products, conducted only for the individual market, found savings of approximately **1.3 percent of commercial spending**, while implementing real-time adjudication of claims had a somewhat larger impact of 3.6 percent of commercial spending, or **\$45 billion annually**.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

These strategies are best suited for states that have:

- fewer insurers
- a history of collaborative private–public partnerships around health care reform
- a willingness to dedicate resources to a convening activity.

Smaller states with several insurers may find it easier to either pass legislation in this area or work collaboratively with stakeholders to determine the best strategies. States with a history of collaborative work with insurers will be better positioned to play a convening role, and insurer stakeholders will be more likely to want to participate.

Convening workgroups and establishing standards for the various administrative tasks requires significant time and resources. Coordinating with the federal government will likely also take time and may not be feasible for some of the strategies. However, the more encompassing the approach, the greater the savings.

EQUITY CONSIDERATIONS

In general, consumers are not well served by the complexities of our health care system. Streamlining many of these administrative functions will improve access to care for individuals, especially those with low health insurance literacy. These administrative simplification approaches likely have very little negative impact on equity and could improve access to services for certain populations, depending on the strategy.

For example, in considering prior approval reforms, 21 states currently have laws [prohibiting the use of prior authorization](#) for medication-assisted treatment for either public or private insurers or both. In addition, most consumers have difficulty navigating the choices they have for health insurance, whether through an employer plan or in the individual marketplace. Implementing greater standardization and reducing choice of insurance products will likely help consumers in making better decisions for themselves and their families.

In addition, there is some evidence that states can also improve equity with [greater standardization](#). One area where states may want to proceed carefully is around the harmonization of quality measures. In an effort to seek common ground, states could lose measures that are more focused on underrepresented populations.

POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

No state has implemented a comprehensive strategy to reduce administrative waste, so any state wishing to do so will be charting new territory and will need to overcome the reluctance of insurers (particularly national insurers) as it does so. Some pioneer states have already aligned quality measures and passed legislation to [streamline prior authorization](#).

In addition, ensuring that these strategies result in actual cost savings to purchasers and consumers is important. For example, if prior authorization reform decreases the need for administrative employees at provider organizations and compliance staff at insurers, states will need to consider how to capture these savings. They may need to implement caps or reductions, or both, on provider rates and insurer premiums in conjunction with action in this area.

RESOURCES

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