



Washington State Health Benefit Exchange Program

Issue Brief #6: Cost Containment Opportunities

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Introduction and Overview

A key issue for states implementing the Patient Protection and Affordable Care Act (ACA), and essential to the states' ultimate success, is how to realize the potential for a reorganized market to control health care cost growth. Individual premiums are estimated to increase due to the market offering benefit designs of greater value. Early estimates also anticipate a small near-term reduction in employer premium trends and an even steeper reduction in consumer premiums for individual coverage if the estimate excludes the significant improvement in individual benefits.¹ These changes are due to greater scrutiny of insurance rates and limits on nonmedical costs in private insurance, as well as changes in the insured population. However, "bending the cost curve" over time is arguably a greater challenge than obtaining small immediate reductions in premium trend—and the ACA offers important opportunities to drive cost growth below the very high rates that are projected absent more efficient health insurance, higher-value health care, and improvements in population health.

The ACA's opportunities for states to bend the cost curve fall into at least five broad categories:

- Provisions to create more effective competition among private insurers
- Provisions to heighten regulatory oversight of insurance

¹ Early estimates from the U.S. Congressional Budget Office projected a drop in average small- and large-group premiums of as much as a 2 to 3 percent in 2016 associated with the health care reforms as enacted in the ACA. Individual premiums were projected to increase 10 to 13 percent due entirely to improvements in benefits: for the same coverage and population, individual premiums are projected to drop 7 to 10 percent in 2016, compared with the amount under current law. Changes in the insured population, with many low-risk individuals becoming insured, are projected to reduce average individual premiums for the same coverage another 7 to 10 percent. See: Congressional Budget Office, An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, November 30, 2009 [<http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf>].

- Provisions to improve the efficiency of insurance transactions, including electronic eligibility and claims processes
- Provisions to improve the value of health care services
- Provisions to improve population health

The following sections review many of the ACA's provisions in each of these categories. The state's initiatives to begin implementation of these provisions where activity has already started are described briefly, as are selected ongoing initiatives in Washington State that are broadly consistent with those envisioned in the ACA.

Finally, opportunities for Washington State's Exchange to help contain cost are reviewed. These include selective purchasing to promote competition, engaging in delivery system changes, developing "value purchasing" premium assistance schedules to reward high-quality plans, disseminating health information, and encouraging healthy behaviors.

1. Competition

The ACA charts two general paths intended to constrain the growth of health care costs directly: greater competition among health insurers and more effective regulatory oversight of health insurance rates.

To improve competition among health insurers, the ACA addresses the need for better consumer information about plans offered through the state's Health Benefit Exchange, it offers the potential for greater choice among health plans, and it provides incentives to increase the number and type of insurers that compete in the market.

Health Insurance Consumer Information. In implementing ACA, the U.S. Department of Health and Human Services (HHS) developed an Office of Consumer Information and Insurance Oversight (OCIIO). Within OCIIO, the Office of Consumer Support developed an internet portal that provides consumers with information and assistance to understand and compare the insurance options available to them.²

In addition, the Health Benefit Exchanges that will become operational by 2014 must offer information to help consumers compare their health plan options in ways that historically have been largely impossible. Each exchange will develop an internet portal through which consumers and employers can access information for comparing the relative quality of care and the price of coverage for each health plan offered through the Exchange; these comparisons will use a standard rating system to be developed by HHS. The exchange also must provide

² OCIIO also administers grants to states to help strengthen and enhance ongoing consumer protection efforts. In Washington State, with grant funding under the ACA, the Office of the Insurance Commissioner has initiated a program to educate consumers about the Affordable Care Act, help consumers resolve health care related issues and facilitate referrals for help with the resolution of disputes, develop an online toolkit (in English, Chinese and Spanish) to assist with health plan appeals, and assist consumers with appeals by providing support through the process.

information about enrollee satisfaction, helping consumers to easily compare enrollee satisfaction levels among otherwise comparable plans.

The Exchange will offer all of this information in a standard format available to anyone who might want to purchase health insurance through the Exchange. In addition, the Exchange will offer an on-line calculator to help consumers determine their actual cost of coverage for each plan option - after applying any premium tax credit or reduction in cost-sharing for which they may be eligible.

Finally, the ACA requires Exchanges to establish a “Navigator” program to help employers, employees, and individuals enroll in qualified health plans. Navigators may include trade, union, professional, and consumer organizations, as well as licensed agents and brokers. Navigator responsibilities will include (among other activities) conducting public education about the availability of qualified health plans, distributing fair and impartial information about qualified plans, and facilitating enrollment in qualified plans.

Consumer Choice. The ACA’s provisions governing Health Benefit Exchanges are intended to help consumers compare available health insurance options and choose more knowledgeably among competing plans. However, the ACA also offers the opportunity for employees of small businesses to enjoy greater choice among health plan options. Small business employers who purchase coverage through the Exchange or through a Small Business Health Options Program (or SHOP) will select a level of coverage (bronze, silver, gold, or platinum) within which employees may choose among available health plans. This approach is similar to that which the Massachusetts Connector developed.³

New Nonprofit Insurers. The ACA establishes a new “Consumer Operated and Oriented Plan” (or CO-OP) program to foster the creation of qualified non-profit health insurance plans available to both individuals and small employers. The CO-OP program is authorized to provide loans to help such plans start up, as well as repayable grants to help the plans meet the state’s solvency requirements. Preference for these loans and grants will be given to organizations able to offer qualified health plans statewide. In addition, HHS may encourage qualified nonprofit health plans licensed in another state to expand into any state where no nonprofit health insurance company applies to offer a qualified health plan.

2. Insurance oversight

The ACA also calls for greater regulatory oversight of health insurance premiums nationally, although not necessarily greater oversight than currently exists in some states—including Washington State, which already reviews individual and small group premiums before they become effective. The ACA requires the Secretary of HHS, in consultation with the states, to establish a process for annual review of premium increases. In addition, it requires health

³ Washington State’s Health Insurance Partnership (HIP), which begins enrollment in January 2011, offers employer choice, but does not allow for employee choice among alternative coverage options. The HIP program has recently begun to discuss how to offer individual choice of health plans.

insurers to justify to HHS premium increases that HHS views as unreasonable and post this information prominently on their websites.

The ACA also authorizes grants to state insurance departments to bolster their oversight processes; in Washington State, the Office of the Insurance Commissioner (OIC) has received such a grant to make information technology (IT) system upgrades, improving the collection, analysis, standardization, and reporting of data to the rate filing system. In addition, the OIC will create a "Consumer Care" website to increase the public transparency of the health insurance premium review process and changes to premiums, and to raise consumer awareness about the cost and quality of health care as a strategy to bring long-term improvement to the health care system.

3. Efficient insurance transactions

The ACA requires HHS to develop operating rules for electronic transactions that will be uniform nationwide—standardizing billing and requiring health plans to begin adopting and implementing rules for the secure and confidential electronic exchange of health information. These measures are intended to reduce paperwork and administrative burdens, cut costs, reduce medical errors, and improve the quality of care.

HHS will adopt operating rules for electronic health plan eligibility and claim status transactions not later than July 1, 2011, to become effective by January 1, 2013. These processes may allow for the use of a machine-readable identification card to support verification of eligibility and claims status electronically. Similarly, HHS will develop operating rules for electronic funds transfers and health care payments and remittance advice transactions not later than July 1, 2012, to become effective by January 1, 2014. Finally, HHS will develop operating rules for health claims and encounter information, health plan enrollment and disenrollment, health plan premium payments, and transactions certifying or authorizing referrals. The ACA requires the Secretary to conduct a biennial series of hearings, reports, and public comment periods to develop these operating rules, and to review and amend them over time.

In turn, all health plans must certify compliance with the applicable standards and operating rules. By December 31, 2013, all health plans must certify to HHS that they have operational data and information systems for electronic funds transfers, verification of health plan eligibility and health claims status, and health care payment and remittance advice that comply with the applicable standards and operating rules. By December 31, 2015, all health plans must certify that their data and information systems also comply with all applicable standards and operating rules for health claims or encounters, enrollment and disenrollment, premium payments, and referral certification and authorization.

4. Health care value

The ACA seeks to improve health care value in a number of ways: by establishing standards for the health plans to be offered through state Exchanges, supporting patient-centered

medical homes, establishing new rules and models to improve the value of Medicare services, and launching strategic national quality initiatives.

Qualified Health Plans. The ACA establishes a system of “qualified health plans” that may be offered through the state’s Health Benefit Exchange. Exchanges may offer only qualified health plans, and low- and middle-income consumers may qualify for reduced premiums and cost-sharing only by purchasing through an Exchange.

In addition to various requirements intended to improve competition, qualified health plans must be accredited with respect to local performance on clinical quality measures—such as those contained in the Healthcare Effectiveness Data and Information Set (HEDIS)—as well as on patient experience ratings, consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs. In addition, qualified health plans must have in place a “pay for performance” (generally called P4P) quality improvement strategy that provides increased reimbursement or other incentives for improving health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors, implementing wellness and health promotion activities, and reducing health and health care disparities.

The ACA identifies a number of strategies that qualified health plans must adopt to improve the quality and value of health care, including:

- Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives that may include the medical home model
- Comprehensive hospital discharge programs, including patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional
- Appropriate use of best clinical practices, evidence-based medicine, and health information technology
- Use of language services, community outreach, and cultural competency training for health care providers.

In addition, the ACA authorizes, but does not require, qualified health plans to contract with hospitals (with more than 50 beds) that use an approved patient safety evaluation system and ensure that each patient receives comprehensive hospital discharge services, as described above.

Patient-Centered Medical Homes. The ACA requires HHS to establish a program of grants and contracts either to establish community-based interdisciplinary, inter-professional teams (called health teams) that support primary-care patient-centered medical homes, or to provide capitated payments to primary care providers in support of patient-centered medical homes. States or state-designated entities, as well as Indian tribes or tribal organizations, are eligible for grants under this program. Qualified health teams may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers, chiropractors, other licensed practitioners, and physicians’ assistants. Both the health teams

and patient-centered medical homes must meet a number of requirements focused on better integration of clinical and preventive services for patients, especially related to prevention and management of chronic disease.

New Medicare Payment and Service Delivery Models. Since its implementation, Medicare has broadly led many of the changes in health care financing that have become common features of private insurance—such as diagnosis-related prospective payment for hospital stays. In that light, it is important also to consider the ACA’s provisions to improve the value of Medicare services by changing how they are delivered and paid for.

The ACA establishes value-based purchasing for both hospital and physician services (as well as skilled nursing facilities and home health agencies). For hospitals, effective in fiscal year 2013, the ACA establishes a program of value-based incentive payments to be made to hospitals that meet the performance standards related to at least five specific procedures or conditions: acute myocardial infarction (heart attack), heart failure, pneumonia, surgeries, and healthcare-associated infections. In addition, hospitals must meet standards related to consumer satisfaction and measures of efficiency—the latter including risk-adjusted spending per beneficiary. The ACA also requires HHS to implement two hospital payment adjustments to provide a financial incentive for hospitals to reduce rates of hospital acquired conditions and readmissions, respectively. Specifically, the ACA requires:

- By January 1, 2012, a 1-percent reduction in Medicare payments to hospitals that have high rates of hospital-acquired conditions—specifically, the 25 percent of hospitals with the highest risk-adjusted rates of hospital-acquired conditions among all hospitals nationwide
- In fiscal year 2013, 1-percent reduction in Medicare payments to hospitals with high risk-adjusted rates of readmission, rising to 3 percent in fiscal year 2015 and subsequent years. Excess readmissions will be defined as the difference between actual rates of readmission (to any hospital, excluding readmissions unrelated to the original admission) and the expected rate of readmission adjusted for patient diagnosis and the severity of the patient’s condition.

For physician care, the ACA establishes a payment modifier for physician services as of fiscal year 2015, adjusting the fee schedule for physicians to account for differences in the quality and cost of care they deliver. The quality of physician care will be measured using composite measures that may include patients’ health outcomes adjusted for risk. The cost of physician care (independent of geographic adjustments) also will be measured on a risk-adjusted basis, taking into account patients’ socioeconomic and demographic characteristics, ethnicity, and health status.

In addition to these purchasing strategies, the ACA establishes a number of programs and national pilots intended to improve the value of Medicare-financed health care. For example:

- By January 1, 2012, HHS must establish a shared savings program to promote the development and management of “accountable care organizations” (ACOs). Under the law, ACOs may be group practice arrangements, networks of individual practices,

partnerships or joint ventures between hospitals and medical professionals, hospital-employed health professionals, or other appropriate groups of health care providers and suppliers that accept responsibility for the quality, cost, and overall care of a Medicare fee-for-service patient population and coordinate hospital, physician, and other services under Medicare Parts A and B. The shared savings program will encourage ACOs to invest in infrastructure and redesigned care processes to achieve high quality and efficient care delivery. Subject to performance on measures of quality, ACOs will be allowed to retain a percentage of the difference between the ACO's actual expenditures (adjusted for beneficiary characteristics) and the estimated average per capita Medicare expenditures in a year.

- By January 1, 2013, HHS must establish a pilot program to pay for integrated care during episodes of care that include a hospitalization. This program will make bundled, "episode based payments" to qualified health care organizations for care related to a hospitalization for one or more of ten conditions to be selected by the Secretary. Care related to an episode will include acute care inpatient services, in-hospital and other physician services, outpatient hospital services (including emergency department services), post-acute services such as home health care, skilled nursing care, and long-term care hospital services, and other services as may be appropriate. The program will continue for at least five years.

National Quality Initiatives. The ACA's provisions to improve the value of health care services nationwide are supported by initiatives to improve quality and develop valid quality measures. The ACA requires the Secretary of HHS to establish a national strategy by January 1, 2011 to improve the delivery of health care services, patient health outcomes and population health. Using a transparent and collaborative process, and coordinating with state Medicaid agencies, HHS will establish priorities for improvement that (among other goals):

- Offer the greatest potential for improving health outcomes, efficiency, and patient-centeredness for all populations
- Offer potential for rapid improvement in the quality and efficiency of patient care
- Address health care for high-cost chronic diseases
- Address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures.

The national strategy will include a comprehensive plan to achieve these priorities, including federal inter-agency coordination and strategies to align public- and private-payer efforts to improve health care quality and patient safety.

The ACA also requires the Secretary of HHS to identify gaps in quality measures and develop grants or contracts to develop, update, or improve quality measures. This program will give priority to measures that allow assessment of (among other quality concerns):

- Health outcomes and patients' functional status

- The management and coordination of episodes of care and care transitions across providers, health care settings, and health plans
- The experience, quality, and use of information provided to patients and caregivers to inform decision making about treatment options
- The safety, effectiveness, appropriateness, timeliness, and efficiency of care
- The equity of care and health disparities.

5. Provisions to improve population health

Besides the many provisions noted above that focus on health outcomes, the ACA includes many provisions that are intended to address serious problems of population health and health care access. These include (but are not limited to) fostering school-based health programs, oral health, and community efforts to improve health.

School-Based Health Care. The ACA establishes a grant program to establish and support the operation of school-based health centers that provide, at a minimum, comprehensive primary care services during school hours to children and adolescents, and a 24-hour on-call system and backup providers to ensure year-round access to services.⁴ All care must be provided by health professionals in accordance with established standards, community practice, and state laws.

Oral Health. Subject to Congressional appropriations, the ACA establishes a five-year national public education campaign focused on oral healthcare prevention and education, as well as grants to demonstrate the effectiveness of research-based disease management with respect to dental carries (cavities). Community-based providers of dental services—including federally qualified health centers, state hospital clinics, state or local departments of health, and Indian Health Service or tribal organizations—are eligible for these grants, as are private providers, various healthcare educational institutions, and national organizations that seek to improve children’s oral health.

Healthier Communities. The ACA also establishes a grant program to support state and local government agencies and community-based organizations (including Indian tribal organizations) that implement, evaluate, or disseminate evidence-based community preventive health activities to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence base of effective prevention programs. Activities funded by this program may focus on (but may not be limited to):

⁴ Comprehensive care includes both physical and mental health care services. Physical health care services must include comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions; and referrals to, and follow-up for, specialty care and oral and vision health services. Mental health services must include mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs. School-based health centers may not perform abortions.

- Creating healthier school environments—including healthy food options, physical activity opportunities, promotion of healthy lifestyle, emotional wellness, prevention curricula, and activities to prevent chronic disease
- Creating the infrastructure to support active living and access to nutritious foods in a safe environment
- Developing and promoting programs to increase access to nutrition, physical activity, and smoking cessation; improve social and emotional wellness; enhance safety in the community; or address any other community priority related to chronic disease
- Assessing or implementing worksite wellness programs and incentives
- Addressing special population needs, including those among individuals with disabilities or who reside in rural or frontier areas.

Additional grants will be made available to state and local health departments and Indian tribes for designing and implementing five-year community-based pilot programs to provide public health community interventions, screenings, and necessary clinical referrals for adults aged 55 to 64.⁵ These efforts are expected to forge relationships, as necessary, with relevant health agencies, health care providers, community organizations, and health insurers; and they must identify a community-based clinical partner (such as a community health center or rural health clinic).

Current efforts in Washington State

In addition to Washington State’s ongoing efforts to improve insurance oversight and consumer information as described above, a number of efforts are underway that mirror the concerns and goals of the ACA with respect to controlling cost and improving the value of health care services. For example, the Puget Sound Health Alliance—including employers, physicians, hospitals, patients, health plans in King, Kitsap, Pierce, Snohomish and Thurston counties—publishes an on-line Community Checkup report that measures the quality of care provided by hospitals, clinics, health plans and other health care providers in the Puget Sound region. The Alliance also offers on-line information and tools to support consumer decisions about health care and health improvement, as well as a tool kit to help health care providers understand and address health disparities.

Most recently, Governor Gregoire has tasked her health care team with generating and considering bold actions that the state can take between now and 2014 to improve health care access, quality, and affordability within the state government’s capacity and resources. To date, many of these ideas are consistent with initiatives embraced in the ACA. These ideas include (but are not limited to):

⁵ Intervention activities may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among adults aged 55 to 64. Community preventive screenings must include screening to identify risk factors for cardiovascular disease, cancer, stroke, and diabetes; and may also include screening for mental health, behavioral health, and substance abuse disorders, as well as physical activity, smoking, and nutrition.

- Collaboration with private payers to promote organized health care systems, bundled payments, and performance-based contracts
- Selective contracting with providers that meet specific performance standards for cost of care and health outcomes
- Redesigning payment systems to allow redirection of funds from treatment to prevention and public health, in order to promote population health, address chronic illness, improve outcomes, and reduce cost
- Reinforcing and expanding prohibitions on payment for healthcare-acquired conditions
- Moving toward the delivery of fully integrated medical and behavioral health services through organized health care systems, including ACOs that bear financial risk
- Joining with other large employers to collectively purchase employee health coverage focused on organized systems of care including ACOs and patient-centered medical homes
- Designating Centers of Excellence for specific conditions, treatments and procedures (including knee and hip orthopedics, transplants, back pain, and complex mental health conditions) based on demonstrated high performance on quality and cost-effectiveness
- Applying evidence-based design strategies consistently across all public coverage, including use of an evidence-based prescription drug formulary and evidence-based payment for new drugs, devices, procedures, and therapies
- Promoting consumer health plan and health care literacy, as well as patient understanding and self-management of chronic disease.

Such initiatives could help the State and local governments, providers, employers, insurers, and community organizations transition into implementation of the ACA's requirements and programs to improve the efficiency and value of health care. They might also offer opportunities to test the feasibility and effectiveness of alternative approaches to improving health care systems and population health status that are tailored to community needs and to state and community health care priorities.

Opportunities for the Exchange to contain cost

The ACA offers Health Benefit Exchanges important opportunities to help contain cost. First, as described earlier, the ACA requires Exchanges to provide consumer information that will help them to compare health plans on cost and quality criteria—including a ranking of plans based on a system to be developed by HHS. In addition, Health Benefit Exchanges are invited to be selective purchasers. That is, they can set criteria for participating qualified plans that may include meeting minimum standards for quality of care and enrollee satisfaction, development of ACO and medical home options, and/or low premium growth. Such standards could

encourage competition not only on price, but on quality and innovation to improve the value of care.

In addition, Washington State’s Health Benefit Exchange could be an important voice in the development of system improvements statewide. At minimum, the Exchange could participate in the Puget Sound Health Alliance, partnering with other large payers to develop information and consistent incentives for health system improvements. However, the ACA may open additional avenues for Exchanges, as the structure for a significant share of health care purchasing statewide, to improve health system value. For example, the ACA requires the Secretary of HHS to report to Congress on the effectiveness of wellness programs, the impact of premium-based and cost-sharing incentives on participant behavior, and the effectiveness of different types of rewards. This effort could help inform the development of premium cross-subsidies in the Exchange (independent of income-related premium and cost sharing reductions) to encourage enrollment in high-value plans by reducing the premium for those plans relative to premiums for lower-value plans.⁶

Finally, the Exchange can be an important catalyst for improving population health. The Exchange could disseminate consumer information to support improvements in health status, extending and reinforcing information that enrollees may obtain from their own health plans—and guiding consumers to information and resources available from their plans—with respect to timely use of preventive care, counseling and treatment for addictive behaviors, and management of chronic conditions.

The ACA offers other ways to encourage healthy behaviors that the Exchange might consider as well. For example, the ACA requires the Centers for Disease Control and Prevention (CDC) to provide employers—potentially including small employers that might purchase through the Exchange—technical assistance, consultation, tools, and other resources to evaluate employer-based wellness programs. This effort might be centered in an Exchange, facilitating the expansion of evidence-based wellness programs for workers in small firms that otherwise have rarely had the resources to develop wellness programs for their workers.

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⁶ Generally called “value-based purchasing,” such strategies have had mixed results to date, suggesting the need for exchanges to focus on best practices when developing value-based purchasing systems. See: J. Bernstein, D. Chollet, and S. Peterson, Financial Incentives for Health Care Providers and Consumers. Reforming Health Care, Mathematica Policy Research Issue Brief No. 5, May 2010 [http://www.mathematica-mpr.com/publications/PDFs/Health/reformhealthcare_IB5.pdf].