Cost Containment in Healthcare

September 2015

CURATIO INTERNATIONAL FOUNDATION

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DEFINITION & CLASSIFICATION

What is a Cost Containment?

- Cost containment is a practice of maintaining expense levels to prevent unnecessary spending or thoughtfully reducing expenses to improve profitability without long-term damage.

- Almost all European countries have introduced and implemented **cost containment measures** that keep expenses in check.

Classification of sets of measures:

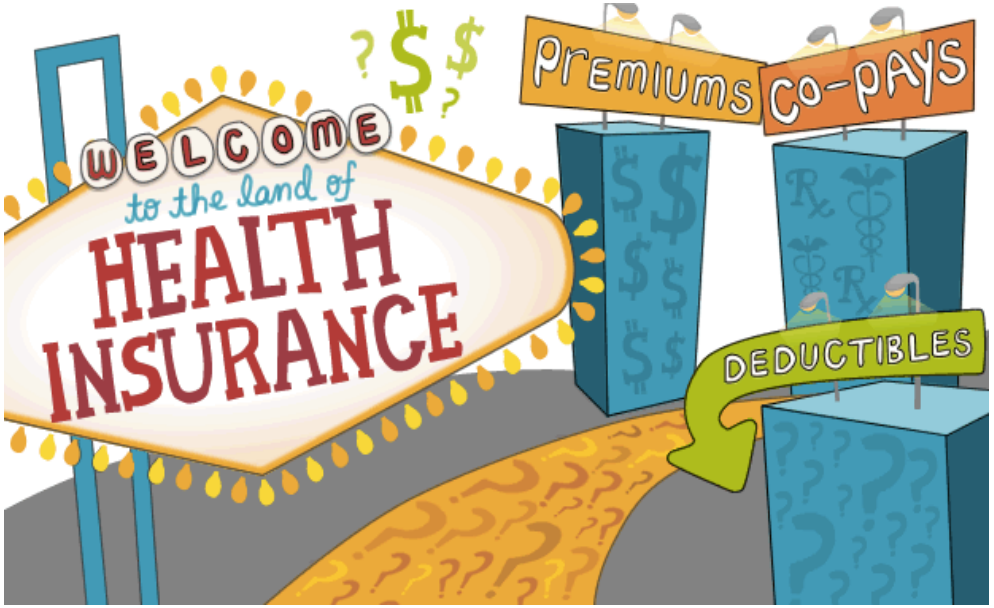
- ✓ *Budget shifting,*
- ✓ *Budget setting,*
- ✓ *Controls*,
- ✓ *Competition*.

Budget Shifting

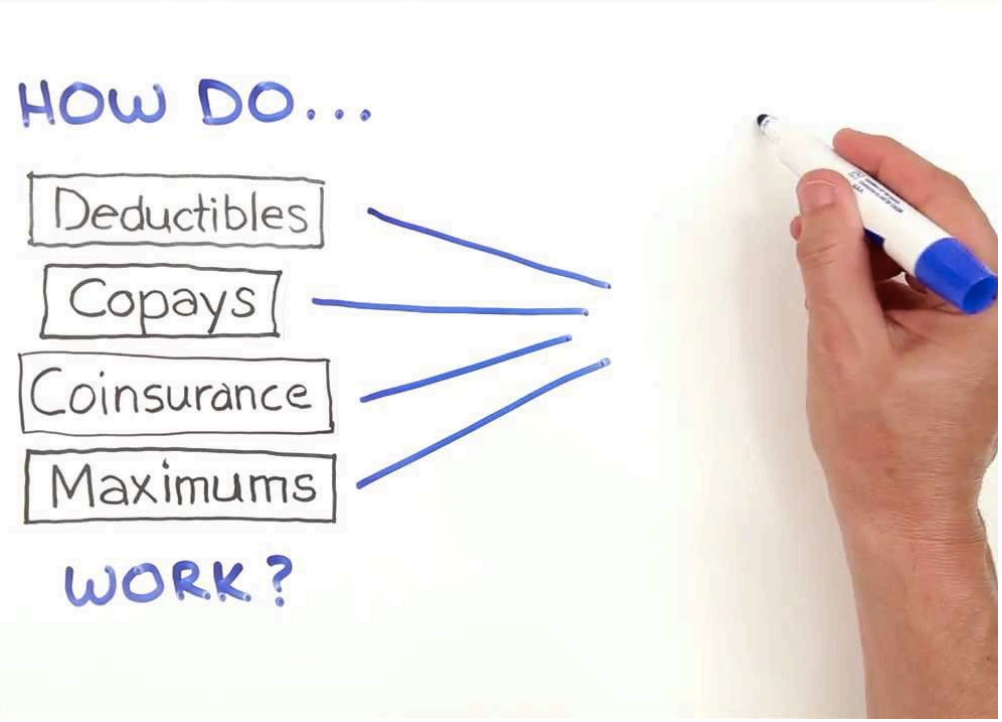
- Possibly the most common method of reducing health expenditure on one budget is to try to shift it on to some other budget, especially that of the patients themselves.

Expenditure can be shifted on to patients either

1. Directly through introducing **charges** or **co-payments** for the use of medical services or
2. Indirectly through **restricting the range of services** covered by the health insurer.



Co-payments



The co-payment could either take the form of

- **a percentage contribution** (each patient pays x% of the total cost of a given course of treatment)

or

- **a fixed deductible** (the patient pays the first $x of the cost)

- In theory, co-payments should be able to keep down the costs of treatment through discouraging the so- called ‘frivolous’ use of health services.

Co-payments

Problem

- Data from the U.S. RAND Health Insurance Experiment and other studies looking at the effects of co-payments on drug consumption have found small price elasticities: very little effect on consumption of increases in co-payments. Moroever, **the co-payments are usually set too low significantly to discourage use.**

- In the US the 22% who spent $2,000 or more on health care accounted for 77% of health spending.

Answer to this problem

- **To raise the co-payment.**

- But if co-payments are raised to a level high enough to affect use, the individuals concerned are likely to take out further health insurance to cover the cost, with the consequence that the charges or deductible have little impact on use.

- In France, 83 % of the population have private insurance that pays all or part of patients' share of the costs, thus virtually eliminating any impact on demand.

Funding restrictions

- **Restricting the number and type of treatments that are funded by the insurer can lead to a 'one-off' reduction in health care costs.**

The restrictions could be based on an examination of evidence concerning

- effectiveness,
- cost-effectiveness,

and/or

- whether the treatment is largely cosmetic.

Funding restrictions

Restrictions can take the form of positive or negative lists.

- ✓ **A positive list** details the treatments that will be funded by the insurer;
- ✓ **A negative list** details those that will not.

- ✧ Most European states have introduced positive or negative lists for pharmaceuticals. These have usually been quite effective in creating at least a one off reduction in costs.
- ✧ However, their impact was often reduced by a shift in prescribing patterns towards reimbursable drugs.

Funding restrictions

- The UK has set up the National Institute of Clinical Effectiveness (NICE), with the brief of assessing the suitability of drugs and treatments for public funding under the National Health Service.

- The principal criterion is cost-effectiveness, with a rough cut-off point of £30,000 per QALY. That is, any treatment that NICE assesses as costing more than £30,000 for each extra year of life, adjusted for quality, that it delivers should not be funded.

- But it does not take account of affordability: that is, the impact on the NHS budget or the opportunity cost of adopting its recommendations.

- In consequence, most of its activities so far seem to be approving drugs that meet its cost per QALY criterion, but are so expensive to buy that some commentators view it more as an instrument for cost-enhancement than cost-containment.

Budget Setting

- If budgets are allocated to the relevant agents, and
- Those agents have a strong incentive to spend within their budget, through
  - ✓ penalties for overspending,
  - ✓ rewards for under-spending,
  - ✓ or both

Cost pressures can be contained

The budgets can take different forms:

- **"Hard" budgets**, that is, with penalties for overspending and perhaps also rewards for under-spending.
- **"Soft" (target) budgets**, where a record is kept of the costs of the transactions undertaken by the agent concerned, who is made aware of any overspending or underspending, but where no immediate penalties are applied and overspending is automatically met.
  - ◆ Such budgets are less likely to be effective instruments of cost containment than hard budgets

Ways of Budget Setting

- For agents serving a fixed population they can be set on **a capitation basis**:
- That is, the agent receives a fixed amount per person covered, regardless of the actual use made of the system.

- **Historical spending** or **activity levels:**

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  - Unless those levels are an accurate reflection of needs, both now and in the future, this may simply perpetuate past inefficiencies in resource allocation.

Problems associated with Budget Setting

Budgets do have their problems as instruments of cost containment:

1. Hard budgets with penalties for overspending but no rewards for underspending encourage agents to spend up to their limit.

2. Most types of budget setting offer incentives for cream skimming and for budget shifting; that is, for agents to select the people covered by their budget so as to favor those who will make the least demands on the budget and to shift other, more expensive patients on to other budgets.

3. If budgets are successful in containing costs, then they are likely to create a need for rationing and waiting lists may develop, which can create political problems.

Successful examples of Budget Setting (1)

1. Countries with national health systems such as the United Kingdom have always operated with budgets at some (usually most) levels of the system; and these are often countries with historically low levels of spending.

2. In France the introduction of budgets for hospitals in 1984 played a significant role in reducing their share of overall health expenditure. They did so by reducing the volume of services, with the relative price of these services remaining constant.

Successful examples of Budget Setting

3. In Ireland a significant fall in the average length of stay in hospitals (28% from 1980 to 1993) was attributed to the efficiency pressures on hospitals resulting from tight budgetary allocations.

4. In Germany the introduction of budgets for sectors and individual providers, although of various forms and efficacy, were generally more successful in containing costs than any other measure. Moreover, since those budgets were abolished in 1997, Germany again has experienced upward cost pressures.

Controls

Insurers can try to affect health care costs through controls on the way in which providers supply health care.

- Fees or payments made to providers can be controlled, and, in state systems, the prices of pharmaceuticals and other medical supplies can be regulated, as can the profits of pharmaceutical companies or other medical suppliers.

- The utilization of procedures can be controlled by insurers, as with much managed care.

- Also, in state systems at least, the ‘inputs’ into the system can be regulated, with governments imposing restrictions on capital investments or on the supply of medical personnel.

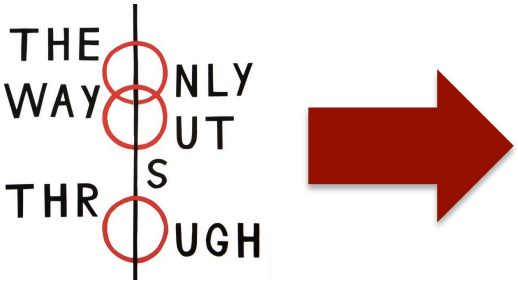
Controls – difficulties associated to it

Both doctors and patients resent controls on procedure utilization.

This can encourage costly efforts to evade the controls.

- There may be a 'balloon' effect, with the compression in one part of the system leading to expansion elsewhere.
  - One element of expenditure is controlled, but others are not.

- *E.g. the prices of pharmaceuticals are kept low, the demand for drugs expands, the quantity purchased increases and total expenditure on pharmaceuticals may increase.*



❖ **Control several elements simultaneously (price and quantity, wages and employment, technology and volume) to have an influence in the right direction.**

Reference price – new approach of control

- In a reference price system a group of similar products is given a specific reference price that is fully covered by insurance, subject to co-payment.

- The use of a reference price as a reimbursement benchmark implies that the insurer will only pay that particular price.
- Any excess above the reference price has to be paid by the insured person.
- The objective is to make the consumers more fiscally aware and to trigger price competition in the reference-priced part of the market.

- The first scheme of this type was introduced by **New Zealand**. In Europe, **Germany** was the first to introduce a reference price system. It is also used in
- the Netherland
- Denmark
- Sweden
- Italy

Weakness of reference price systems

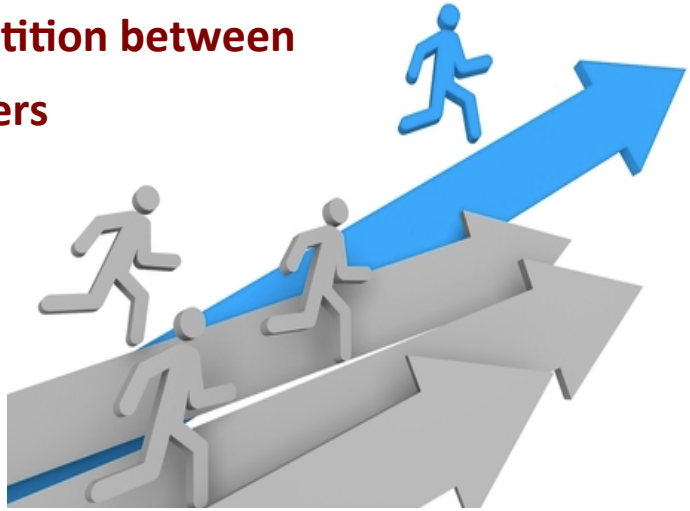
- From the governments' point of view, the weakness of reference price systems, *as the experience of the Netherlands and Germany has shown,* is that their introduction does not necessarily decrease the drug budget.

- The reference price system stimulates the pharmaceutical industry to make major efforts to promote drugs that are not covered by the scheme.

- As a result the market share of these expensive products increases, and firms may raise the prices of these products further to recover losses caused by the reference price system.

Competition

- **Competition between insurers**
- **Competition between providers**



- Between insurers it will keep down premiums,
- while between providers it will keep down hospital and other medical costs.

The empirical evidence concerning **the impact of competition is mixed**.

- In the United States, hospital competition in the 1980s appears to have led to higher costs and, in some cases, worse health outcomes.
- In the 1990s, in contrast research found competition leading to reductions in costs and improved health outcomes.

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HEALTH COST CONTAINMENT AND EFFICIENCY STRATEGIES

Strategies

Strategy	Cost Containment Strategy and Logic	Target of Cost Containment	Evidence of Effect on Costs
Global Payments to Health Providers	A fixed prepayment made to a group of providers or health care system (as opposed to a health care plan) for all care for all conditions for a population of patients.	• Lack of financial incentives for providers to hold down total care costs for a population of patients. • Inefficient, uncoordinated care. Not enough attention to management of chronic conditions. • Prevention and early diagnosis and treatment.	Research indicates global payments can result in lower costs without affecting quality or access where providers are organized and have the data and systems to manage such payments.
Episode-of-Care Payments	A single payment for all care to treat a patient with a specific illness, condition or medial event, as opposed to fee-for-service.	• Lack of financial incentives for providers to manage the total cost of care for an episode of illness. • Inefficient, uncoordinated care.	Research is limited and shows cost savings for some conditions. Payment mechanism is at an early stage of development.
Performance-Based Health Care Provider Payments (P4P)	Payments to providers for meeting pre-established health status, efficiency and/ or quality benchmarks for a group of patients.	• Providers not financially rewarded for providing efficient, effective preventive and chronic care. • Unnecessary care.	Research is limited and indicates some improvements in quality of care but little effect on costs.

Strategy	Cost Containment Strategy and Logic	Target of Cost Containment	Evidence of Effect on Costs
Collecting Health Data: All-Payer Claims Databases	A statewide repository of health insurance claims information from all health care payers, including health insurers, government programs and self-insured employer plans.	• Inability to identify and reward high-quality/low- cost providers. • Lack of data to enable consumers to compare provider prices and care quality.	It is too early to determine whether all-payer claims databases can help states control costs.
Equalizing Health Provider Rates: All-Payer Rate Setting	Payment rates that are the same for all patients receiving the same service or treatment from the same provider. Rates can be set by a state authority or by providers themselves.	• High health care prices. • Lack of price competition. • Significant provider costs • to negotiate, track and process claims under many reimbursement schedules.	Evidence is mixed but indicates that, properly structured, state all-payer rate setting can slow price increases but not necessarily overall cost growth.
Use of Generic Prescription Drugs and Brand-Name Discounts	Buying more generic prescription drugs instead of their brand-name equivalents and purchasing brand-name drugs with discounts can significantly reduce overall prescription drug expenditures.	• State government-funded pharmaceutical purchasing, including Medicaid, state-only programs and some private-market pharmaceutical purchasing.	Expanded use of generic drugs is documented to save states 30 percent to 80 percent on certain widely used medications, reducing expenditures by millions of dollars annually.

Strategies

Strategy	Cost Containment Strategy and Logic	Target of Cost Containment	Evidence of Effect on Costs
Prescription Drug Agreements and Volume Purchasing	States use combinations of approaches to control the costs of prescription drugs including: • Preferred drug lists, • Extra manufacturer price • rebates, • Multistate purchasing and • negotiations, and Scientific studies on comparative effectiveness.	• Helps state government public sector programs operate more efficiently and cost effectively. • Holds down overall state pharmaceutical spending, but does not deny cover- age or services to individual patients.	State Medicaid programs are using preferred drug lists, supplemental rebates and multi-state purchasing arrangements to save between 8 percent and 12 percent on overall Medicaid drug purchases.
Pooling Public Employee Health Care	Programs that pool or combine health insurance purchasers across or beyond traditional jurisdictions or associations, including public employee health coverage pools and private sector health purchasing alliances.	• High administrative costs as a proportion of small and mid-sized employer premiums. • Limited ability of small and mid-sized groups to negotiate lower health care prices or premiums or benefit.	Evidence indicates arrangements may benefit small groups that join large state pools but have not slowed overall insurance premium increases.
Public Health and Cost Savings	Evidence indicates public health programs improve health, extend longevity and can reduce health care expenditures.	Public health programs protect and improve the health of communities by preventing disease and injury, reducing health hazards, preparing for disasters, and promoting healthy lifestyles.	Extensive research documents the health benefits of more Americans exercising, losing weight, not using tobacco, driving safely and engaging in other healthy habits. Less clear is the effect on total health care costs.

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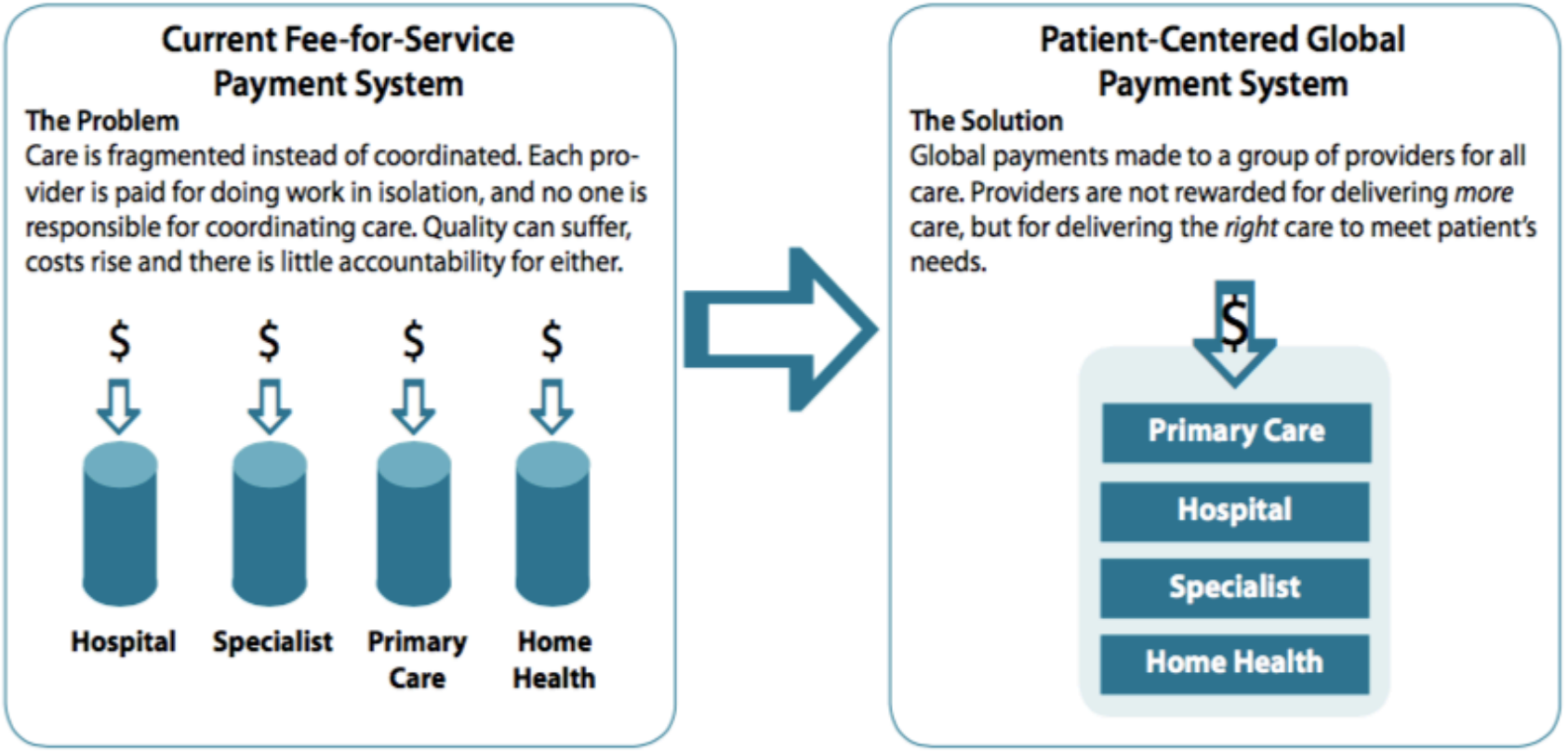
Health Care Provider Patient Safety	Medical errors are the eighth leading cause of death in the United States, higher than motor vehicle accidents, breast cancer or AIDS. Each year, between 500,000 and 1.5 million Americans admitted to hospitals are harmed by preventable medical errors.	The estimated annual cost of additional medical and short- term disability expenses associated with medical errors is $19.5 billion. Longer hospital stays and the cost of treating medical error-related injuries and complications are the two major expenditures associated with medical errors.	Examples of patient safety initiatives that improve patient care and reduce costs exist, but evidence of overall savings is limited. Recent strategies include E-prescribing, non-payment for “never events,” regulating medical work conditions and error reporting.

Global Payments to Health Providers

- Health economists and others are increasingly promoting glob- al payments as an important strategy to slow growth of health care expenditures.

Figure 1. Fee-for-Service versus Global Payment Incentives

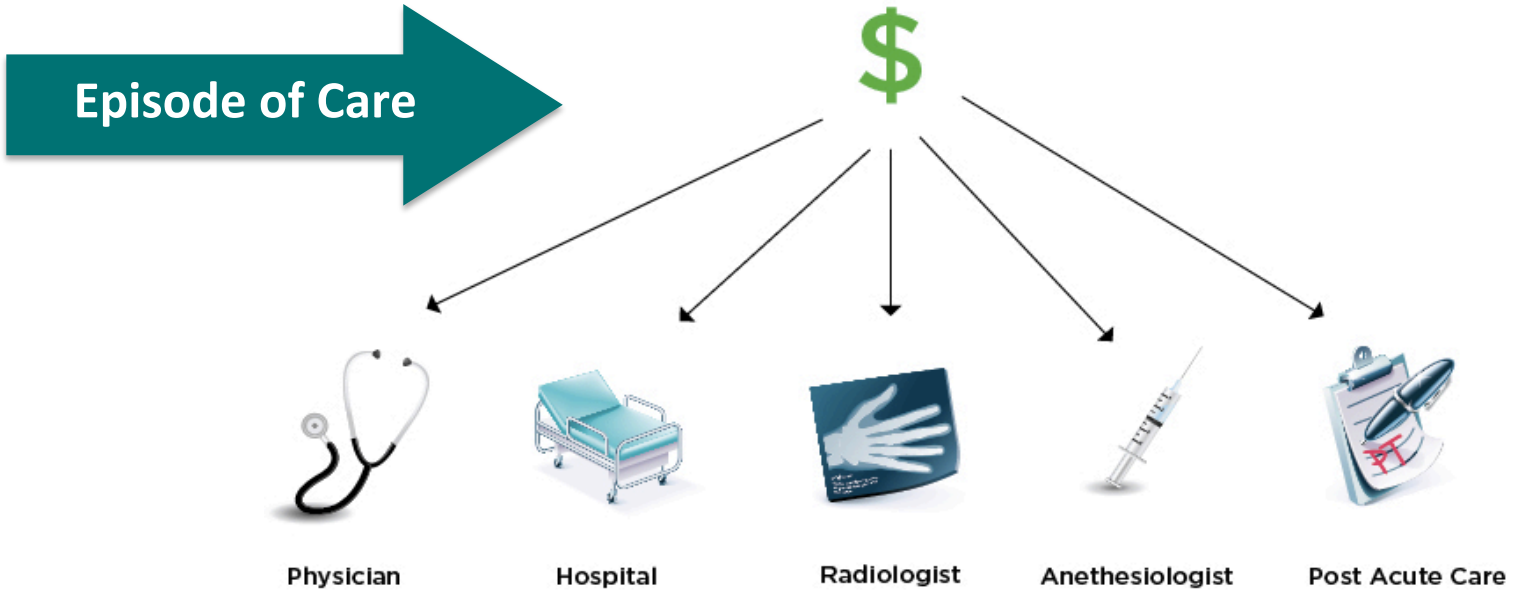


Source: Massachusetts Special Commission on the Health Care Payment System, "Recommendations of the Special Commission on the Health Care Payment System," PowerPoint (Boston: SPHCP, July 16, 2009).

Episode-of-Care Payments

With episode-of-care payments Savings can be realized in three ways:

1. By negotiating a payment so the total cost will be less than fee-for-service;
2. By agreeing with providers that any savings that arise because total ex- penditures under episode-of-care payment are less than they would have been under fee-for-service will be shared between the payer and providers;
3. From savings that arise because no additional payments will be made for the cost of treating complications of care, as would normally be the case under fee-for-service.



Performance-Based Health Care Provider Payments

- Pay-for-performance is used to encourage providers to follow recommended guidelines or meet treatment goals for high-cost conditions (e.g., heart disease) or preventive care (e.g., immunizations)

- Pay-for-performance is designed to address health care underuse (e.g., inadequate preventive care) and overuse (e.g., unnecessary medical tests)

- Research indicates that for some conditions, P4P can lead to higher-quality, lower cost care, but by itself may not slow overall cost grow.

Use of Generic Prescription Drugs and Brand-Name Discounts

- Proper pharmaceutical use is documented to save money by avoiding costly hospitalization, emergency room use, moving to a nursing home or repeat visits to specialists.

- Millions of patients with high blood pressure, high cholesterol, chronic pain, arthritis, sleep disorders or mild depression depend on one or two daily pills, for example.

- **Buying more generic prescription drugs instead of their brand-name equivalents and purchasing brand-name drugs with discounts can significantly reduce overall prescription drug expenditures.**

Pooling Public Employee Health Care

- Pooled public employee health benefit programs refer to efforts to merge or combine state employee health insurance with that of other public agencies and programs.

Public purchasers try to lower overall administrative costs and negotiate lower prices from providers and insurers using their large numbers of enrollees as a bargaining tool. Health costs are controlled by using size, volume purchases and professional expertise to:

- Minimize and combine administrative and marketing costs;
- Facilitate negotiations with health insurers for more favor- able premium rates and broader benefit packages; and
- Relieve individual employers of the burden of choosing plans and negotiating coverage and payment details.

Premiums that health care consumers pay go into the pot

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