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State Options to Control Health Care Costs and Improve Quality

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Introduction and summary

The recent debate on health care reform has occurred mostly at the national level. The Affordable Care Act, or ACA, was a momentous change for the U.S. health care system. So far, 20 million people have gained health insurance coverage due to the ACA—a historic reduction in the number of uninsured people in the United States.[1]

The ACA also contained several tools designed to control health care costs. It created the Center for Medicare & Medicaid Innovation, or CMMI, which is authorized to test new payment and delivery methods in order to lower costs and improve quality for individuals who receive benefits from Medicare; Medicaid; or the Children's Health Insurance Program, or CHIP.[2] CMMI is currently testing and evaluating many different models, including accountable care organizations, bundled payments for hip and knee replacements, and primary care medical homes. The ACA also reduced Medicare payments to Medicare Advantage plans; to hospitals with poor quality measures; and to medical providers, which has had a spillover effect on private insurance.[3]

Partly due to the ACA, health care cost spending growth has slowed in recent years. Before 2014, there were five years of historically low growth, and 2011 was the first time in a decade that spending on health care grew slower than the U.S. economy.[4] Health care costs are still projected to grow faster than the overall economy, however, and health care spending already puts tremendous pressure on state and federal budgets and limits spending on other important services.[5] More needs to be done to sustain this slowdown in growth.

The current political environment makes it unlikely that reforms to control systemwide health care costs will be achieved at the federal level in the near future. States, however, are well-positioned to take the lead on implementing cost control and quality improvement reforms. Indeed, many states are already innovating and seeing positive results.

There are several advantages to implementing reforms at the state level. State-level reforms can be tailored to work best for each state, depending on the structure of its insurance markets, the size of the state, and its demographics. States also have considerable authority over the regulation of health insurance and the provision of health care within their borders. States control their own insurance markets: They run their Medicaid and CHIP programs and state employee plans, and certain states run the exchanges for individual health insurance. States also control the rate review process, scope-of-practice regulations, physician licensing, antitrust laws, and provider and insurer regulations. Lastly, states and governors have considerable convening power to bring together diverse stakeholders, making reform efforts more politically feasible.

The innovations that some states are implementing to reduce costs while maintaining or improving quality can and should be replicated by other states. This report lays out a comprehensive summary of options, as outlined in the following table, that states can choose from to improve the quality and sustainability of their health care systems. Generally, these options relate to implementing new payment models, increasing accountability and transparency, collecting more data, increasing the use of high-value services and practices, and removing barriers to effective practices.

We have included examples from some of the most pioneering states and other examples where states are instituting similar reforms, as well as details from these states' experiences and their strategies to make the reforms successful. These examples are not an exhaustive list of all the states that may be undertaking these reforms. Other ideas and strategies have not been used before. Importantly, these reforms are not mutually exclusive; in fact, states should adopt as many as possible.

All of these reform options would help states slow the growth of health care costs, improve the quality of their health care systems, and protect their residents.

Policy options and selected state examples

Establish a cost growth goal.
- Examples from Massachusetts, Maryland, and Rhode Island

Publish a health and cost outcomes scorecard.
- Examples from Maryland and Oregon

Adopt payment and delivery system reform goals.
- Examples from Massachusetts, Maryland, Rhode Island, and California

Implement bundled payments for all payers.
- Examples from Arkansas, Tennessee, Ohio, and Delaware

Institute global budgets for hospitals.
- Example from Maryland

Launch all-payer claims databases.
- Examples from Maine, Colorado, New Hampshire, and Washington

Expand evidence-based home visiting services.
- Examples from Minnesota and South Carolina

Improve price transparency.
- Examples from New Hampshire and Massachusetts

Integrate behavioral health and primary care.
- Examples from Oregon, Washington, and Colorado

Combat addiction to prescription drugs and heroin.
- Examples from Maryland, Florida, New York, and Rhode Island

Improve the delivery of long-term care.
- Examples from California, Maryland, Montana, Oregon, Texas, and Missouri

Align scope of practice with community needs.

Institute reference pricing in the state employee plan.
- Example from California

Expand the use of telehealth.
- Examples from Maryland, New York, Virginia, the District of Columbia, and Pennsylvania

Decrease unnecessary emergency room use.
- Examples from Georgia, New Mexico, Indiana, Minnesota, Washington, and Wisconsin

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