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What's Working to Control Costs

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Without major changes in the way the U.S. pays for and delivers health care, total national health spending is projected to rise to $4.6 trillion—or nearly 20 percent of GDP—by 2020. This will further strain the budgets of federal and state governments, businesses, and families struggling with continual increases in health care costs.

Fortunately, as I outlined earlier this year, there is some evidence that health care spending growth is beginning to moderate in response to health reform initiatives. The Centers for Medicare and Medicaid Services' most recent projection of national health spending in 2020 is about $275 billion (5.6 percent) lower than estimates made before reform was enacted. Spending over the decade is now projected to be $1.7 trillion lower than estimated just two years ago. Projected Medicare spending is even further below original estimates, and provisions in the Affordable Care Act and other reform efforts play a major role in the new, lower numbers.

As policymakers continue to implement the health reform law and search for ways to generate additional savings, it will be important to "go where the money is," or focus on improving care for the sickest patients with multiple, high-cost conditions. The Commonwealth Fund Commission on a High Performance Health System recently released a report detailing a strategy that prioritizes the use of primary care, payment reform, and health information technology to lower overall health system spending and improve health outcomes for these complex patients simultaneously.

Policymakers also should consider promising public and private interventions that are already working to lower costs and improve care. Several state-based Medicaid initiatives have shown significant potential, including efforts in North Carolina and Vermont to create patient-centered medical homes. The Vermont Blueprint for Health, in particular, offers an example of successful collaboration among dominant private health insurers with public oversight. Under the program, Blue Cross Blue Shield of Vermont and CIGNA have become active participants in rolling out medical homes and community health teams across the state. Preliminary results suggest a 21 percent decrease in hospitalization and 31 percent decrease in emergency department use, leading to reduced health care expenditures per capita.

Similarly promising are several patient-centered medical home interventions initiated by private payers, including Geisinger Health System in Pennsylvania, Group Health Cooperative of Puget Sound in Washington, and HealthPartners in Minnesota. Evidence from Geisinger, on whose board of directors I serve, shows an 18 percent reduction in all-cause hospital admissions and a 36 percent reduction in readmissions among medical home participants. Both Group Health and HealthPartners also realized reductions in emergency department use among patients with medical homes, generating significant savings for plans. These are both health co-ops, owned and governed by members, so savings to plans are typically passed on to members.

Private insurers have found other ways to lower the cost of health care. Blue Cross Blue Shield of Massachusetts recently launched the Alternative Quality Contract, under which health care providers receive fixed payments for patient care delivered during a defined period, as well as bonuses of up to 10 percent if certain process, outcome, and patient experience targets are met. An early evaluation suggests that the Alternative Quality Contract slowed spending growth by encouraging practices to refer patients to physicians and hospitals that charge lower fees. The researchers wrote that such changes in referral patterns can pressure more expensive facilities to lower their fees.

Blue Cross Blue Shield of Michigan has deployed the Physician Group Incentive Program, which features bonus payments both for achieving benchmark levels of performance and showing improvement on outcome measures, as well as implementing patient-centered medical home care processes. Preliminary analysis indicates that the medical home component has led to more efficient resource use, including lower inpatient admissions for ambulatory care–sensitive conditions, fewer hospital readmissions within 30 days of discharge, and fewer overall visits to the emergency department.

Meanwhile, a preliminary Commonwealth Fund–supported analysis of the State Action on Avoidable Rehospitalizations (STAAR) program shows that the initiative is having a measurable impact on both quality and costs. A national survey of hospitals suggests that those participating in the STAAR program to reduce costly hospital readmissions are more likely to have adopted interventions such as enhanced assessments of patients before they leave the hospital, enriched patient education, and better contact with post–acute care providers prior to discharge. Over a four-year period, trends suggest statistically significant reductions in 30-day readmissions among STAAR participants in Massachusetts and Michigan.

Avoidable hospitalizations among elderly long-term care residents are costly and put potentially vulnerable patients at undue risk. Nursing homes participating in the INTERACT II (Interventions to Reduce Acute Care Transfers) project were able to safely reduce hospitalizations by 17 percent. The intervention involves training staff in the early identification and assessment of clinical risks (e.g., dehydration); providing care paths for the management of conditions that likely do not need hospital care (e.g., simple urinary tract infections); and improving advanced care planning. This model is so promising that the Vanderbilt University Medical Center recently received a Health Care Innovation Award from the Department of Health and Human Services for a program based on INTERACT that is projected to save an estimated $8.7 million.

Finally, several international innovations point to effective ways to lower health care spending. The German government is funding disease management programs for approximately 115 private insurers covering a range of chronic conditions, including diabetes and coronary heart disease. Recent analysis found that participating diabetic patients had lower rates of complications and overall costs. And an after-hours care program that covers more than 90 percent of the Dutch population has increased patient contact with primary care providers by 25 percent and lowered contact with emergency services by more than 50 percent.

As these examples make clear, it is possible to slow health spending and improve outcomes simultaneously. Innovations to date show promise of achieving savings through improved care management for high-cost patients, resulting in lower hospitalization and emergency room use. It will require a period of trial and error to learn what interventions work best for which patients, and the best incentive structure for providers and patients. Quick data feedback, assessment of impact, continuous quality improvement, and long-term commitment are all essential. Policymakers should capitalize on lessons from the many promising public and private interventions already under way in order to slow health spending—and improve health care—as quickly as possible.