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COUNCIL ON HEALTH CARE SPENDING & VALUE

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A Road Map For Action:

Recommendations Of The Health Affairs Council On Health Care Spending And Value

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A Road Map For Action: Recommendations Of The Health Affairs Council On Health Care Spending And Value

The Health Affairs Council on Health Care Spending and Value is a nonpartisan, multidisciplinary, expert working group charged with recommending ways that the United States can take a deliberate approach to moderating health care spending growth while maximizing value.

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I. Introduction

For more than forty years, questions about health care spending levels and growth have been an important focus of *Health Affairs*. In the words of the journal's founding editor, John Iglehart, "From our very launch in 1981, costs and how they may be responsibly restrained have been a driving theme of Project HOPE's eclectic journal."[1]

Recently, the journal announced a first-of-its-kind project intended to build on its rich history of scholarship on health care spending.[2] The Health Affairs Council on Health Care Spending and Value was charged with recommending ways that the United States can take a deliberate approach to moderating health care spending growth while maximizing value.[3] The council is a nonpartisan, multidisciplinary, expert working group under the leadership of cochairs William Frist and Margaret Hamburg.

This report contains the council's recommendations and is the culmination of a multiyear process during which the twenty-two council members studied the literature and consulted with experts on drivers of US health care spending and a wide variety of proposed interventions.

This, the council's final report, accomplishes two goals: through its supporting research, it synthesizes literature about how much the US spends on health care, the value of that spending, and the likely impact of various interventions; and it provides recommendations to public and private stakeholders on how to achieve higher-value health care spending and growth in the US.

A. The Health Care Spending Problem And The Council's Goal

For decades, the level and growth of US health care spending have diverged from both international and domestic norms, leading many to characterize rising health expenditures as "unsustainable."[4] The Organization for Economic Cooperation and Development (OECD) estimates that total health care spending averaged 8.8 percent of gross domestic product (GDP) among its member countries in 2019 compared with 16.8 percent in the US.[5]

In addition, health care spending growth has far outpaced growth in the US economy as a whole. Between 1970 and 2019, total US health care spending grew from 6.9 percent to 17.7 percent of GDP.[6,7] Then, in 2020, amid unique strain on the health care system and a dramatic economic downturn due to the COVID-19 pandemic, this figure jumped to 19.7 percent of GDP, or nearly one-fifth.[8] It remains to be seen how the pandemic will affect the long-term trajectory of health care spending.

High levels of and growth in health care spending are not, in and of themselves, problematic. Researchers have sought to quantify the health gains resulting from increased US health care spending over time. There have been significant improvements in morbidity and mortality, particularly for specific disease categories.[9] In addition, health care is a major driver of the US economy, accounting for twenty-two million jobs (or 14 percent of all jobs) in 2019.[10]

However, the high level and growth rate of US health care spending raises concerns about Americans' continued ability to pay for all other goods and services at both the macro (government) and micro (employers, families) levels. This has led some experts to call for the stabilization of the rate of health care growth as a percentage of GDP.[11] At the same time, comparisons with health care spending in other developed nations with equal or better health outcomes[12] lead us to ask whether we could be doing much better for our money.

In addition, the current de facto distribution of health care spending by race and ethnicity[13]—a legacy of the structural marginalization of specific

populations—results in significant disparities in access to and quality of care. In fact, some research draws a connection between health inequity and excess spending driven by delayed care, access challenges, missed diagnoses, and lack of preventive services.[14,15]

> "The goal of the recommendations in this report is to achieve higher-value health care spending and growth in the US."

The US is an outlier among nations not only in how much is spent on health care but also in the absence of any mechanism to make collective decisions about what services should be covered or available and for whom, or to restrain how much is spent. Although it is unclear what percentage of GDP would represent the ideal level to devote to health care, the council believes that the current expenditure and rate of growth are higher than they should be, as they are disproportionate to the health and equity they produce and represent a significant burden on families, employers, employees, and government. The corollary is that there are likely actions that could reduce the health care spending growth rate with little effect on health or other benefits consumers value.

With all of this in mind, the goal of the recommendations in this report is to achieve higher-value health care spending and growth in the US.

The mechanism for achieving this goal involves four levers:

- price, or paying the most efficient price for care;
- volume, or ensuring the appropriate quantity of care;
- mix, or ensuring the appropriate types of services for given patients and populations; and
- growth, or growing the price and volume sustainably and maintaining an appropriate mix over time.

Collectively, recommendations must address all four levers. If they do not, then improvements in one area could be counteracted by changes in another, resulting in no change to overall spending or growth. Although no single intervention is a silver bullet, the council offers a set of recommendations that, both alone and in concert with specific existing efforts, will lead to improvements in all four areas.

B. Council Process And Areas Of Focus

The council examined literature and received input from experts regarding key drivers of US health care spending and growth. These included administrative waste, excess prices, clinical waste, regulatory burden, supply-chain profits, clinician earnings, and fraud and abuse. These factors were chosen on the basis of staff review of literature and are consistent with the way many researchers have examined health care spending drivers in the past several decades. Summaries of literature the council reviewed regarding administrative waste, excess prices, and clinical waste are available as Health Affairs Research Briefs.[16-18] A bibliography of literature the council reviewed on health care spending and growth by sector and as it relates to several additional spending drivers is included in appendix A. (Also see section IV, "Supporting Research," at the end of this report.)

The council focused on spending drivers that met the following criteria: a meaningful amount of money is potentially at stake, it is likely feasible to address the spending driver through policy intervention, and the council, drawing

> "The council offers recommendations in… administrative streamlining, price regulation and supports for competition, spending growth targets, and value-based payment."

on the unique expertise and perspectives of its members, can make a powerful contribution to the debate about the given spending driver.

On the basis of these criteria, the council offers recommendations in four priority areas:

- administrative streamlining,
- price regulation and supports for competition,
- spending growth targets, and
- value-based payment.

Exhibit 1 illustrates how these four sets of recommendations map to the four levers for achieving high-value spending and growth. Conceptually, it may be helpful to think of the sets of recommendations as falling into two categories: targeted interventions that pull only one or two of the levers, and systemic interventions that pull several levers at once. Both types of actions are likely needed.

Several additional points provide context about the council's process. First, multiple factors went into the recommendations, including evidence, judgment, and values. Where evidence regarding the efficacy of proposed interventions was inconclusive, the council relied on its values and judgment as a group of experts about what is most promising. In some cases, the council endorses experimentation that will help develop better evidence.

Second, the council provides a range of recommendations that are designed to be compatible with various political environments and views about the role of government.

Third, there is a significant focus on states, given the great variability in needs and

EXHIBIT 1

Levers addressed by Council on Health Care Spending and Value recommendations

	Levers to achieve high-value health care spending and growth			
Council recommendations	Price	Volume	Mix of services	Growth
Administrative streamlining	✓		✓	
Price regulation and supports for competition	✓			
Spending growth targets	Potentially can address any of these if stakeholders set goals around them			✓
Value-based payment	✓	✓	✓	✓

SOURCE: Authors' analysis.

priorities across the country. Highly networked, multistakeholder efforts at the state level can be powerful in driving change. The council hopes to harness the power of states as policy laboratories, with the federal government providing support and coordination to facilitate states' efforts and add a sense of urgency to the process.

Fourth, the council did not focus explicitly on individual sectors of the health care ecosystem. For example, recommendations are not presented separately for physicians versus hospitals—or for providers versus payers or public versus private sectors—because of the deeply intertwined nature of spending across these categories. Although some recommendations require more significant action from some stakeholders than others, on balance, a set of interventions that involves all sectors will be most effective.

Finally, the council did not have a formal consensus process. For one set of recommendations, a minority report is provided (see recommendations C1–C4). In all other cases, readers may assume that all council members expressed at least some level of support for the recommendation (see section III, "Putting it All Together," for more details).

The recommendations are presented in a spirit of optimism and humility. The council acknowledges that the country's health care spending problems cannot be solved in a single stroke and concedes that there are several important issues in health care spending that this report does not address. Nevertheless, the extent of the problem must not lead to inaction. To paraphrase social justice advocate Arthur Ashe, stakeholders must start where they are, with the tools currently available, and move forward.[19] The council's recommendations contain a road map for doing so.

C. What This Report Is Not

The council's first task was to define its scope and to understand what issues would not be covered in depth or, in some cases, at all. In doing so, members identified three issues that are not included in this work but are nevertheless significant in health care spending. It is important to provide readers with insight into the council's decisions not to delve deeply into these three areas.

SOCIAL DETERMINANTS OF HEALTH

In accepting their charge, the council members first grappled with the well-established concept that health care accounts for only a small portion—perhaps only as much as one-fifth—of the modifiable contributors to health.[20] The rest is attributable to factors that are largely outside the control of the health care system. These are the social determinants of health (SDOH) or, in the framework of the World Health Organization, the "conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life...[including] economic policies and systems, development agendas, social norms, social policies and political systems."[21,22]

Although social determinants clearly shape health, it is less well understood how they shape health care spending. Logic suggests that more spending to address social determinants would eventually result in more efficient health care spending and slowed growth. If people were better fed, housed, and supported socially, financially, and politically, it stands to reason that health care dollars might go farther. This question is difficult to study, however, and there is limited evidence to support or rebut these assumptions. In practice, researchers have found that among OECD countries, those that spend more on social services (a very rough proxy for SDOH) also spend more on health care.[23]

Nevertheless, an SDOH framework has informed the careers of many of the council members. For some, there was an immediate instinct to go "upstream" in thinking about how to improve the value of health care spending. Ultimately, and with guidance from Health Affairs staff, the council decided to focus instead on spending drivers and interventions that are primarily within the health care sector, thereby drawing on the specific expertise of the council members. The council's hope is that improvements in the value proposition of the health care sector itself will lay groundwork for that sector becoming more effective at reaching beyond its walls to address SDOH.

INTERVENTIONS TO REDUCE LOW-VALUE CARE

As illustrated in exhibit 1, the council focused on four priority areas: administrative streamlining, price regulation and supports for competition, spending growth targets, and value-based payment. The group also considered a potential fifth area of focus: efforts to reduce the use of low-value care. Low-value care, also referred to as overtreatment, has been described by Donald Berwick and Andrew Hackbarth as "the waste that comes from subjecting patients to care that, according to sound science and the patients' own preferences, cannot possibly help them."[24] Examples of low-value care include cervical cancer screening for women older than age sixty-five, brain computed tomography or magnetic resonance imaging for uncomplicated headaches, and spinal injection for lower back pain.[25] Notably, low value is not usually inherent in a given procedure but, rather, in the provision of that procedure to a specific patient who is unlikely to benefit from it because of their clinical status or other factors. Estimates of the cost of overtreatment with low-value care range from about $76 billion to $226 billion per year.[24,26]

The council does not present formal recommendations in this area but, rather, defers to the work of expert groups that have a long-standing focus on interventions that address low-value care directly. For example, Choosing Wisely, a voluntary initiative of clinicians, identifies low-value care processes and works to reduce or eliminate their use by educating clinicians and consumers on avoiding them.[25] Others promote the use of benefit design to discourage use of low-value care. The council puts forth its recommendations with the assumption that these important interventions will be ongoing.

In addition, although the council does not make recommendations that address low-value care directly, its systemic recommendations have the potential to do so indirectly. Value-based payment, in particular, provides incentives for delivery systems to identify and reduce the use of low-value care. Similarly, concerted efforts to meet statewide health care spending growth targets could lead stakeholders to choose low-value care as an area of policy focus.

PHARMACEUTICAL PRICES AND SPENDING

A third and very different issue not addressed directly in this report is a detailed discussion of pharmaceutical spending. Given the dominance of pharmaceutical issues in the public policy sphere, it is important to clarify why the report does not include recommendations regarding this category of spending.

As noted, the council chose not to focus explicitly on individual sectors of the health care spending ecosystem. Pharmaceutical spending is an integral part of that ecosystem and will be affected directly and indirectly through the council's recommendations regarding administrative streamlining, prices (particularly hospital prices), target setting for overall spending growth, and value-based payment.

This does not suggest a lack of concern on the council's part about many aspects of pharmaceutical pricing and spending, including seemingly unwarranted high prices and increases in price for some vital drugs (such as

insulin) and for branded specialty drugs. The council also recognizes that high-price, physician-administered specialty drugs are often a significant cost driver for hospitals and payers and a burden for patients. Nevertheless, solutions to these very specific problems go beyond the council's scope.

In addition, pharmaceutical markets behave differently from markets for most other health care services. The former are unique because competition is governed by federal patents and exclusivity periods intended to encourage innovation. Pharmaceutical markets are also affected by a complex supply chain involving manufacturers, pharmacy benefit managers, wholesalers, pharmacies, and health plans.[27] These markets are further complicated by significant consolidation in the supply chain (with the top three pharmacy benefit managers controlling more than 75 percent of the market nationwide, by some estimates[28]) and contracting practices that are opaque. Accordingly, a detailed set of recommendations about these very specialized markets was also beyond the council's scope.

However, the council acknowledges the critical importance of additional work to understand the causes, benefits, and consequences of increased spending on pharmaceuticals. The Inflation Reduction Act of 2022, containing major provisions related to pharmaceutical pricing, had been signed into law but not yet implemented as the council completed its work. Without taking a position on that law, the council notes that its rollout, particularly the provision allowing Medicare to negotiate prices for specific drugs, will provide important evidence regarding market interventions intended to reduce pharmaceutical spending. The council looks to the research community to explore key questions such as the law's impact on drug prices in Medicare and commercial markets and whether savings will be passed through to patients.

D. An 'Unprecedented' Context For The Council's Work

The council's work began just before the start of the COVID-19 pandemic and concluded as the public health emergency entered its third year. These circumstances changed the council's process but not its fundamental goal, which remained to achieve higher-value health care spending and growth in the US. However, the pandemic did have profound effects on the policy environment into which the recommendations would eventually be introduced.

First, the pandemic shone a harsh light on persistent inequities in health care access and delivery and how lack of attention to SDOH can enhance these inequities and their attendant costs. The council's work also took place during a time of increasing racial unrest in the US, spurred by events such as the killings of Eric Garner and George Floyd, heightening the public's and policy makers' understanding that systemic racism is embedded in major institutions, including health care.[29] These events have highlighted the critical importance of applying an equity lens to evaluate all potential interventions presented by the council.

Second, the pandemic revealed significant stakeholder willingness to spend more on health care when the value feels incontrovertible, suggesting that a council seeking to moderate spending growth was "in the right place at the wrong time." However, recent projections from the Centers for Medicare and Medicaid Services (CMS) indicate that, despite a few anomalous years of spending related to the pandemic, the trajectory has not changed significantly.[30] Concerns about rising costs of employer-based coverage, patients' out-of-pocket spending, inflation, and the expected 2028 insolvency of the Medicare Part A Trust Fund remain.[31] Furthermore, the pandemic arguably lent more urgency to the call to shift spending away from fee-for-service payment, a model that was

challenged to support the health care delivery system during the public health emergency.

Third, COVID-19 resulted in significant attention at all levels of government to earning and keeping public trust. Whether deserved or not, many early public responses to COVID-19 created distrust in public institutions. At the same time, these responses brought to light (for many) the critical role and power of state- and local-level policy making.

Fourth, the pandemic exacerbated chronic health care staffing shortages and contributed to rising wages, both of which will shape the feasibility of spending-related interventions in the future. According to an October 2021 survey, nearly one in five health care workers had quit their jobs since mid-February 2020, although this does not necessarily mean that they had left health care.[32] More recent data suggest that the overall health care workforce is down 2.7 percent from February 2020, which is a substantial reduction, and it is unclear when or whether this trend will reverse.[33] The pandemic has also taken a heavy toll on health care workers' mental health, and there is growing awareness of the risk among clinicians of dying by suicide and of facing depression, anxiety, and posttraumatic stress disorder.[34,35]

Although the council does not offer specific recommendations to address each of these factors, a desire to see improvement (or, at a minimum, to "do no harm") in these areas guided the council's choices about high-priority areas for intervention. In addition, these considerations must be placed at the center of implementation efforts related to the council's recommendations.

Finally, and on a more positive note, the pandemic experience has demonstrated that the health care system can change rapidly, despite perceptions to the contrary. Perhaps the most striking example of this rapid change is the pivot to telehealth. This extraordinary shift was made possible not only by health care institutions moving resources and changing priorities but also by the rapid loosening of regulatory restrictions that had previously limited the spread of this modality. The pandemic response also led to closer coordination between public health agencies and health care systems, including improved data sharing. This flexibility and quick response by health systems and policy makers bodes well for future willingness to implement change when a crisis is perceived.

II. Recommendations

The council offers recommendations in four priority areas:

- administrative streamlining,
- price regulation and supports for competition,
- spending growth targets, and
- value-based payment.

Individual recommendations are listed in exhibit 2 and discussed in detail in the sections that follow. There are synergies among the recommendations, so that some smaller-benefit solutions may produce a greater impact in combination with others.

A. Administrative Streamlining

Administrative waste is a meaningful detractor from health care value, accounting for several hundred billion dollars per year.[36-38] These dollars could likely be better spent on improved health care access or quality or even in another sector of the economy altogether.

Experts have been working to reduce health care administrative waste for decades, with limited success. However, now may be a uniquely relevant time to consider reforms in this area. The COVID-19 pandemic has arguably increased all stakeholders' level of comfort

EXHIBIT 2

Council on Health Care Spending and Value recommendations to achieve higher-value health care spending and growth in the US

Administrative streamlining
A1: Standardization of four key "between" and "seismic" processes
A2: Longer-run harmonization of quality measures
Price regulation and supports for competition
B1: Increased state and federal monitoring of market competitiveness and scrutiny of proposed mergers
B2: Limited price regulation in markets that cannot be competitive
B3: Performance improvement plans and conditional price regulation in markets that could potentially be competitive
B4: Additional supports for competition in markets that are currently competitive
Spending growth targets
C1: Data-supported spending growth target setting
C2: Data-supported monitoring of spending growth
C3: Data-supported enforcement of spending growth targets
C4: Federal support for data infrastructure
Value-based payment
D1: Continued evolution of value-based payment models

SOURCE: Authors' analysis.

with digital tools, and automated technology is improving rapidly. The pandemic has also demonstrated that many processes previously considered to be impossible (for example, making a vaccine available for a novel disease in less than a year) are, in fact, possible. The council, therefore, believes that there is reason for optimism in this area now.

Estimates of US administrative spending range from about 15 percent to more than 30 percent of total national health spending.[39] However, experts estimate that at least half of administrative spending is ineffective or wasteful.[36-38] Accordingly, 7.5–15 percent of national health spending is likely administrative waste.[40] A summary of literature the council reviewed regarding administrative spending and waste is available as a Health Affairs Research Brief (also see section IV, "Supporting Research," at the end of this report).[16]

The council's goal is not to reduce administrative spending to a level comparable to those of peer nations with single-payer systems. Researchers have estimated that if the US had a Canadian-style single-payer system, administrative spending could be reduced by more than $600 billion, or about 17 percent of national health spending at the time of the study.[36] Another study suggests that from one-third to one-half of billing- and insurance-related costs could be eliminated in the US under a Medicare-for-all single-payer system.[41] However, much of the administrative spending in the US supports choices that many Americans value—choice of benefits, insurers, providers, treatments, and so on—all of which

are enabled by a multipayer system. The council therefore presents recommendations that can be actionable within that system, where research suggests that significant savings are possible.

This set of recommendations adopts Nikhil Sahni and colleagues' categorization of administrative interventions.[42,43] "Within" interventions improve processes that are controlled and implemented by individual organizations. Examples include automating repetitive manual tasks in human resources and finance. "Between" interventions improve processes that require agreement to act between organizations but not broader, industrywide change—for example, implementing a payer-provider communication platform to automatically share information about in-network specialists. "Seismic" interventions address industrywide processes and require the participation of public and private decision makers and broad collaboration across the health care industry. Examples include adoption of a centralized, automated claims clearinghouse and harmonized quality reporting requirements.

RECOMMENDATION A1: STANDARDIZATION OF FOUR KEY 'BETWEEN' AND 'SEISMIC' PROCESSES

The council identified certain "between" and "seismic" processes as the highest-priority areas for intervention on the basis of their likely immediate effects on consumers' and clinicians' experience. The clinician perspective is especially critical now, in a post-COVID-19 environment, where health care workers have been particularly hard hit by stress and burnout.[44-47] One national organization representing physicians ranked "onerous administrative/paperwork burdens" as the top reason driving clinicians to retire early or leave the profession.[48]

Although some of the reforms detailed here would admittedly produce relatively small savings on their own, these actionable steps can help build momentum for taking additional, and larger, steps in the future.

In the immediate term, the council recommends the standardization and streamlining of four high-cost processes for all payers and all providers. These primarily include processes that payers control, although the council recognizes that providers and other stakeholders must play a role in advocating for and participating in standardization efforts.

Collection Of Data For Provider Directories

To comply with state and federal law, health plans must provide members with directories that generally include in-network providers' practice locations, ability to accept new patients, office hours, and other information. CAQH estimates that maintaining provider directories costs US physician practices up to $2.76 billion each year.[49] CAQH further estimates that if providers used a single platform to exchange directory information, they could save $396 per practice, per month on average. Nationally, using a standardized platform for maintaining provider directories could save US physician practices at least $1.1 billion per year. There are no available estimates of health plans' potential savings related to such a data collection platform, but any savings would be above and beyond those estimated for physicians.

Collection Of Data To Support Credentialing Of Providers

CAHQ defines credentialing as the "regulated process of assessing the qualifications of specific types of providers."[50] Credentialing is performed by both health plans and hospitals and ensures that all providers are up to date on education and licensure. The information that providers share with health plans and hospitals for credentialing is similar to the information used for provider directories. According to CAQH, clinical practices using a single platform to facilitate credentialing with multiple health plans report spending, on average, $1,250 per month to do so, or almost 40 percent less than the $2,068 spent per month by those that used multiple approaches.[49]

Claims Processing

A centralized claims clearinghouse would standardize the electronic transmission of billing information across providers and payers. This system could be modeled after the banking industry's automated clearinghouse, which moves money among institutions while ensuring security.

Council member David Cutler proposes that an entity such as CAQH would promulgate operating standards for electronic submission of billing information and that a second entity, a clearinghouse, would receive batches of claims from multiple payers and providers, routing them to the correct counterparty for each payment.[51] The clearinghouse would serve as a fraud detector and confirm that submitted information was compliant with privacy and security standards. Cutler estimates that implementing a centralized clearinghouse and standardized billing information could save approximately $300 million per year, which may be a conservative estimate. Another study by David Scheinker and colleagues finds that standardization of billing across provider and payer contracts, which is another feature of Cutler's proposed clearinghouse, could save 27 percent of billing- and insurance-related costs,[41] which may themselves account for about 13–17 percent of total national health spending each year.[40]

> "In the immediate term, the council recommends the standardization and streamlining of four high-cost processes for all payers and all providers."

Notably, clearinghouses are used voluntarily by some providers and payers today. However, there is a disincentive to invest in compliance with any given clearinghouse's requirements, which may be changed at any time. Therefore, despite the council's general preference for voluntary approaches, mandatory designation of one or a few clearinghouses across the industry would ensure that stakeholder investments in compliance were protected.

Collection Of Data To Support Prior Authorization

Prior authorization is used by nearly all insurance plans, including Medicare Advantage plans, to manage costs and ensure appropriate use, and it can be particularly burdensome for clinicians. A first important step would be for all prior authorization processes to be conducted electronically, rather than on paper or by telephone or fax. Payer support may be needed to assist the most disadvantaged clinical practices in complying with such a requirement. CAQH estimates that transitioning to a fully electronic system for prior authorization could save $417 million annually.[52] Standardizing the data elements needed to complete the prior authorization process would help support full automation, which a number of stakeholders have called for.[53-55]

A proposed rule to streamline prior authorization was advanced by the Trump administration but appears to have been withdrawn by the Biden administration in 2021.[56] Some states are taking steps on their own: A newly formed payer and provider coalition in Massachusetts seeks to automate prior authorization functions in that state in a manner similar to the banking and travel industries,[57] and Michigan recently mandated the use of standardized prior authorization methods.[58]

Summary Of Recommendation A1

The goal of this set of recommendations is to standardize the data flow, not to standardize

the decision-making criteria or the outcome. For example, information used for credentialing would be centrally collected, but organizations would make their own choices about whom to credential.

Standardization of these processes will require transparency and significant collaboration among public and private stakeholders, and an entity will need to take the lead in facilitating that collaboration. The council recommends that CMS play the convening role, leaning heavily wherever possible on existing efforts in states and in the private sector.

With the exception of the claims clearinghouse, the council does not recommend mandating use of standardized processes initially; rather, it expects that if CMS and several large private payers agree to use them—particularly if there are federal implementation grants available as an incentive—others will follow suit voluntarily. The council supports such federal assistance for these efforts, as they will require significant investment on the part of payers and providers.

RECOMMENDATION A2: LONGER-RUN HARMONIZATION OF QUALITY MEASURES

Few stakeholders would argue with Cutler's understated assertion that "quality assessment is hampered by the diversity of metrics."[51] In the longer run, the council strongly supports ongoing and additional work to harmonize quality measures across payers. This will be impactful in terms of clinician and patient experience, as well as potential savings, although it is by no means simple to achieve. CMS uses more than 2,200 metrics across its programs alone, and state and local agencies and private payers add hundreds more.[51] Although harmonization among these metrics has widespread industry support, large-scale testing of such initiatives would require coordination among many stakeholders and has therefore been limited. As a result, savings estimates are scarce. Lawrence Casalino and colleagues estimate that quality reporting costs providers $15 billion per year.[59] On the basis of this figure, Cutler suggests that use of a standard set of measures for all payers could save up to half of such costs, or about $7 billion annually.[51]

CONCLUSION

An important consideration in reducing payers' and providers' administrative burden is ensuring that at least some portion of the savings accrues to individuals, employers, or the health care system writ large. For example, administrative reforms that reduce providers costs' should also lower providers' prices, which in turn could reduce employers' or individuals' premiums or cost sharing. Administrative savings could also be redirected to increase the value of care delivered.

B. Price Regulation And Supports For Competition

There is compelling evidence that relatively high US private-sector prices are an important driver of relatively high US health care spending.[60-62] Also compelling is a lack of evidence linking consolidation-induced higher prices within the US to higher-quality care.[63] A summary of literature that the council reviewed regarding prices and their contribution to overall spending is available as a Health Affairs Research Brief (also see section IV, "Supporting Research," at the end of this report).[17]

In theory, competition in markets helps ensure that prices of goods and services reflect market conditions, including the cost of supplying them and consumers' ability and willingness to pay for them. In competitive markets, prices convey meaningful information to suppliers and consumers. High prices relative to costs should entice providers to enter markets and innovators to find cost-saving strategies, and they should encourage consumers to demand fewer services. Low prices send the opposite set of signals. This kind of competitive outcome does not appear to characterize many health care markets.

This set of recommendations focuses on negotiated health care prices in the private sector, rather than on administered prices in the public sector, given evidence pointing to the former as an important health care spending driver.[17] Administered prices have historically grown more slowly than commercial prices and are generally much lower than the latter across a range of services.[64-66] Nevertheless, many stakeholders believe that, at least in hospital markets, cost shifting from public to private payers is indeed a factor in private-sector prices. The empirical work, however, does not support this direct connection, and where it has been observed, the effect is small.[67-69]

In considering recommendations to address private-sector prices, the council weighed the benefits of regulatory and administrative approaches versus market-based interventions. The former likely would have more immediate impacts than the latter, but they also entail a potentially high cost of compliance and enforcement and run a high risk of regulators "getting it wrong," further distorting the market while trying to fix it.

Nevertheless, the council believes that it is important to open the door to regulating some provider prices in some settings. Price regulation is not optimal in all types of markets. Accordingly, these recommendations include regulatory and nonregulatory approaches that are focused on three categories of markets. (Hospital care is used as an illustrative example, but a similar framework could be applied to markets for other health care goods and services, with some modifications.)

- Category 1 is markets that likely cannot be competitive (natural monopolies). These are markets with smaller populations (for example, below 400,000 residents) for analysis of hospital markets.
- Category 2 is markets that are not competitive now but could potentially be competitive with some intervention. These markets have a population size greater than the maximum threshold for category 1 and have an Herfindahl-Hirschman Index above 2,500, which is the Federal Trade Commission's (FTC's) threshold for moderately concentrated markets.[70]
- Finally, category 3 is markets that are currently competitive. These markets have both a population size greater than the maximum threshold for category 1 and a Herfindahl-Hirschman Index below 2,500. A Herfindahl-Hirschman Index of 2,500 or lower cannot be achieved with fewer than four hospitals.

Exhibit 3 shows the number of markets and the share of US population in each category of hospital market. This analysis was performed by council member Sherry Glied, using 2015 data provided by the Petris Center at the University of California Berkeley, as described by Brent Fulton.[71] A summary of Glied's methods and expanded findings, including for physician markets, is included as appendix B.

RECOMMENDATION B1: INCREASED STATE AND FEDERAL MONITORING OF MARKET COMPETITIVENESS AND SCRUTINY OF PROPOSED MERGERS

In all markets there is a need for increased monitoring of competitiveness, even in the absence of proposed mergers, as well as additional scrutiny of proposed mergers. These activities can be undertaken by the states and the FTC or Department of Justice (DOJ) and should ideally be done collaboratively by state and federal entities. State all-payer claims databases and efforts to increase price transparency to state regulators would support these activities.

This recommendation is in line with an October 2021 executive order from President Biden, which states that federal antitrust enforcement should focus in particular on markets for labor, agriculture, and health care (which includes

the prescription drug, hospital, and insurance markets) and on the tech sector.[72]

State and federal budgets must prioritize these activities. In March 2022 President Biden proposed increasing the DOJ Antitrust Division's funding by $88 million in 2023[73] (on a base of about $200 million[74]) and the FTC's funding by $139 million (on a base of about $375 million).[75] Following suit, the House Appropriations Committee's draft fiscal year 2023 funding bill increases the FTC's funding by $113 million.[75] Additional state-level antitrust enforcement funding could be provided by broad-based assessments on market participants or through user fees paid to state regulators by the parties proposing to merge.

RECOMMENDATION B2: LIMITED PRICE REGULATION IN MARKETS THAT CANNOT BE COMPETITIVE (CATEGORY 1)

In markets where competition is not feasible because smaller populations will not support multiple competitors, the council makes its strongest case for government intervention on price. For hospital markets, 249 Metropolitan Statistical Areas (MSAs) and all non-MSAs in the US fall into this category, accounting for just over 28 percent of the population (exhibit 3).

In these markets the council supports states in setting all-payer price maximums. Such maximums could be calculated one of many ways—for example, as a percentage of Medicare or of demographically adjusted price levels in chosen benchmark markets. The council does not recommend a specific benchmarking method. Advantages and disadvantages of various methods are explored in the literature.[76,77]

As shown in exhibit 3, non-MSAs, which can be considered rural, account for about half the population in this category, requiring special consideration in price regulation. Here, policy makers must balance the competing priorities of geographic access and affordability. One proposal for balancing these needs is a two-part tariff that encourages the monopolist rural hospital to engage in marginal cost pricing. Operationally, this could take the form of all-payer rate setting in these areas, with all payers contributing to a pool used to provide a fixed payment to local hospitals to cover their fixed costs (based on their market share), with insurers negotiating marginal cost prices.

EXHIBIT 3

Number and share of markets and US population in each market category, hospitals (400,000 population cutoff for markets that cannot be competitive)

Market category	Markets	Share of MSAs (excludes non-MSA areas), %	Population	Share of population, %
1: Cannot be competitive	249 MSAs and all non-MSA areas	65	91,023,879 (includes 45,482,635 in non-MSA areas)	28
2: Potentially competitive	95 MSAs	25	80,500,166	25
3: Currently competitive	38 MSA	10	149,111,118	47

SOURCE: S. Glied, based on 2015 data provided by the Petris Center at the University of California Berkeley, as described Brent Fulton and colleagues.[71] See appendix B.

NOTE: MSA is Metropolitan Statistical Area, as defined by the Census Bureau.

Policy makers will need to choose whether to establish price maximums for all services or limit them to specific services for which the local market is not competitive, given that the geographic market areas for all services are not the same—for example, the geographic market for neurosurgery is much larger than that for primary care.

The council recommends state, rather than federal, intervention in these markets. States differ in their markets and circumstances and are more likely than federal actors to be aware of particular rural access issues. In addition, states already have regulatory authority over hospitals and physician practices, and this would be an extension of that role.

RECOMMENDATION B3: PERFORMANCE IMPROVEMENT PLANS AND CONDITIONAL PRICE REGULATION IN MARKETS THAT COULD POTENTIALLY BE COMPETITIVE (CATEGORY 2)

For hospital markets, ninety-five MSAs fall into this category, accounting for about one-quarter of the population (exhibit 3). In these MSAs the population size is sufficient to support at least moderate competition. This can be accomplished by increasing the number of competitors, either by inducing more market entrants or by breaking up existing combinations in service lines where there could be more sellers of efficient size. The former is likely more palatable than the latter in most states and may be supported or encouraged by legislation that prohibits specific anticompetitive contracting clauses that are common in health care. These include most-favored-nation, anti-steering, anti-tiering, all-or-nothing, and gag clauses. Although most states currently ban most-favored-nation clauses, fewer ban the other types of clauses, with Massachusetts being a prominent exception.[78] In 2021 legislation was passed in Nevada, Washington, and New York to prohibit these types of clauses. These new laws provide an opportunity for continued research to determine more definitively whether they are effective in improving competition.

Another category of state law and regulation that could be modified to support competition in these markets, at least with respect to clinicians, is licensure. For example, the Interstate Medical Licensure Compact provides a streamlined pathway for physicians to be licensed to provide telemedicine in states other than the one in which they are physically located. Today, thirty-seven states are included in this compact.[79] In addition, the Department of Veterans Affairs allows licensed providers to practice in any of its facilities, regardless of the state in which they are licensed.[80] States could consider entering into these compacts or similar arrangements as a targeted way to increase the number of competitors in clinician markets.

In addition, policy makers may choose to authorize performance improvement plans on firms that are engaging in anticompetitive behavior in these markets. Such plans may require firms to divest facilities or take actions that enable new entrants. If competitiveness does not improve in a specified period, whether by the action of such firms or for exogenous reasons, states should move on to maximum price setting, as described in recommendation B2. Enhanced evaluation of competitiveness, as described in recommendation B1, will allow for price maximums to be removed if competitiveness improves.

In addition to the above, states and the federal government should give extra scrutiny to proposed mergers in these markets.

RECOMMENDATION B4: ADDITIONAL SUPPORTS FOR COMPETITION IN MARKETS THAT ARE CURRENTLY COMPETITIVE (CATEGORY 3)

Compared with the other market types described above, there are fewer hospital markets in this category—just thirty-eight MSAs—although they are home to 47 percent of the US population (exhibit 3). These markets are currently competitive, but if current consolidation

trends hold,[71,81] they are nevertheless at risk of becoming less competitive because of future mergers and acquisitions, including those that are cross-market or backed by private equity.

In these markets the council does not recommend regulation of prices, but rather increased FTC and DOJ or state monitoring of competitiveness and merger activity, supported by appropriate funding, as described in recommendation B1.

In addition, as in recommendation B3, states should consider limiting or prohibiting anticompetitive contracting practices in these markets.

CONCLUSION

This set of recommendations addresses negotiated prices paid to providers by insurers. However, these are not the same as the prices that most people pay. The latter vary depending on each person's premium and out-of-pocket cost-sharing obligations. Because of these insurance coverage issues, there is not a perfect correlation between changes in providers' negotiated prices and changes in consumers' costs. The council did not consider specific recommendations about benefit design. Nevertheless, it is the council's hope that, particularly given medical loss ratio requirements and new price transparency rules for hospitals and health plans,[82-84] payers will pass along to consumers at least a portion of reductions in negotiated prices. Without such behavior, the recommendations presented here would still likely result in price reduction, but they might also lead to people dropping coverage or forgoing needed care, both of which would contribute to health inequity.

C. Spending Growth Targets

A missing ingredient in US efforts to moderate health care spending growth is a locus for collective action. The council therefore encourages states, with federal support, to convene stakeholders to engage in data collection, analysis, and discussion about health care spending, which may lead to the establishment, monitoring, and enforcement of spending growth targets that are calibrated to growth in the overall economy.

Examples of this kind of multistakeholder work include Maryland's all-payer global budgeting system and Massachusetts's all-payer spending growth target setting.[85,86] High-level results from these two initiatives are described in appendix C. In addition, California, Connecticut, Delaware, Nevada, New Jersey, Oregon, Rhode Island, and Washington are all in various stages of considering or actively implementing health care cost commissions to engage in target setting.[87-89]

To the extent that these types of efforts are successful in stabilizing the ratio of health care expenditures to GDP, there could be significant savings. Jonathan Skinner and colleagues estimate that if health care's share of the GDP beginning in 2022 could be stabilized at the 2019 level (18 percent), then total health care expenditures between 2022 and 2031 would be $3 trillion lower than if health care's share of the GDP continues to grow at the same rate that it has since 1980.[11]

Although target-setting work is led by states today, there are advantages and disadvantages to state versus federal leadership in this area. States are an advantageous locus for these activities because of wide variability in needs and priorities and because states are laboratories for testing multiple approaches when we are not yet certain what works best. In addition, many states have significant momentum to address this issue, and their ongoing work should be encouraged.

However, if this set of recommendations is implemented only by states, some states will decline to participate, potentially exacerbating existing health and socioeconomic disparities among states. In addition, this work is data intensive (as described below), and many states

will not have sufficient resources to develop and analyze the needed data. Furthermore, for payers and providers operating in multiple states, a plethora of home-grown, state-level data requirements will be burdensome.

Importantly, states may have little leverage to influence certain factors in health care spending, particularly the actions of self-insured employers and trusts protected under the Employee Retirement Income Security Act (ERISA) of 1974. In addition, although states have jurisdiction over some aspects of drug prices,[90,91] such as how insurers pass on manufacturer rebates to patients, they cannot change federal laws and regulations that affect drug prices nationwide. These include federal patent law and regulations around the drug approval process.

For these reasons, the council generally supports states taking the lead in this area, but with significant federal coordination and support to ensure the robustness and interoperability of state efforts and to ease participation for stakeholders that are active in multiple states.

RECOMMENDATION C1: DATA-SUPPORTED SPENDING GROWTH TARGET SETTING

All states, either individually or in concert with other states or the federal government, are encouraged to develop a mechanism to establish health care spending growth targets relative to the size of the economy and in the context of other state goals concerning equity, affordability, and access. One such mechanism would be to create a dedicated commission, similar to those implemented in Massachusetts and Maryland. States may find other ways to accomplish the same goal with existing structures.

The governance of a target-setting entity must be multistakeholder, including providers, payers, and patients, and it must have a process that is transparent to the public. Data needed for target setting are readily available. To date, the states that have established spending growth targets have calibrated them to be slower than the growth rate of a key economic indicator, such as the gross state product, household income, wages, or Consumer Price Index. Growth targets established by the eight states currently undertaking this work range from 3.1 percent to 3.5 percent for 2021–23.[87]

RECOMMENDATION C2: DATA-SUPPORTED MONITORING OF SPENDING GROWTH

States that choose to set spending growth targets should develop a mechanism to monitor performance relative to the target through analysis and public reporting. The Peterson-Milbank Program for Sustainable Health Care Costs, which supports states in implementing spending growth targets, recommends that states focus not only on high spending but also on spending variation and high growth rates.[89] Analysis should disaggregate high spending or growth to determine whether it is caused by outlier prices, practice patterns, population characteristics, or other factors. Analysis should also identify specific stakeholders experiencing high spending or growth.

The monitoring entity must have power, granted through legislation or executive action, to compel stakeholders to share necessary data, either with the state or with a centralized, federally led data collection entity, as described under recommendation C4. Data needed for monitoring spending growth might not be the same as those used for target setting. Although thirty states already have all-payer claims databases in existence or development,[92] these might not provide data in a timely fashion, nor in a granular enough fashion to support this type of monitoring. In addition, many all-payer claims databases collect data on hospital discharges only, which is insufficient for this purpose.

Instead, monitoring entities may need payer-reported aggregate data. According to a recent report, the best practices in collecting such data are set by Massachusetts, Delaware, Oregon, and Rhode Island.[87] Data used by these states include medical expenses paid to providers by

private and public payers and any non-claims-related payments; all patient cost-sharing amounts, such as deductibles and copayments; and net cost of private health insurance, which includes administrative expenses and operating margins for commercial payers. Payers from which these data should be collected include commercial insurers, Medicare Advantage, traditional Medicare, Medicaid managed care organizations, fee-for-service Medicaid, state employee health plans, state correctional facilities, the Indian Health Service, and other federal entities such as the Department of Veterans Affairs. Data collection from entities protected under ERISA is discussed under recommendation C4.

> "The governance of a target-setting entity must be multistakeholder...and it must have a process that is transparent to the public."

Additional data collected at the subpayer level can be used to analyze spending drivers.[87] Such data may include hospital discharges, payer expenditure reports, provider financial reports, surveys of employers and households, consumer premiums, cost sharing, plan types, and prescription drug costs.

Importantly, data collection strategies should be designed, whenever feasible, in a way that supports states' efforts to detect health care disparities across population subgroups.[93]

RECOMMENDATION C3: DATA-SUPPORTED ENFORCEMENT OF SPENDING GROWTH TARGETS

States that have established spending growth targets and are actively monitoring progress against them should develop a mechanism to enforce them. The party to which the enforcement action would apply, whether a payer, a health system, or some other entity, will depend on analysts' understanding of what is driving excess spending growth. The type of enforcement action that might be feasible or desirable in any given state will vary. Such actions lie along a spectrum from simple transparency (public reporting of data), to public justification of prices or spending, to performance improvement plans, to direct fines or other penalties. In Massachusetts the state Health Policy Commission has relied primarily on a "naming and shaming" strategy, hoping that publicly calling out health systems and payers for outlier spending will encourage corrective action.[94] Some observers believe that the threat of this public shaming did have a sentinel effect on providers in the first few years of the program.[95] However, a waning of that effect may help explain the uptick in spending growth in the past two years. In response to that change, the Health Policy Commission required a performance improvement plan from one large provider, Mass General Brigham, in early 2022. The plan was formally approved several months later and includes the providers' commitment to cut prices by millions of dollars over the course of an eighteen-month implementation period that had just begun as the council completed its work.[96]

All states should formally evaluate the efficacy of enforcement mechanisms and adjust as needed.

RECOMMENDATION C4: FEDERAL SUPPORT FOR DATA INFRASTRUCTURE

Collecting and analyzing state-level, payer-reported aggregate spending data is costly and requires expertise. For example, in 2020 the Massachusetts initiative, including both the commission and the agency charged with performing data analysis, supported eleven commissioners and sixty professional staff with an annual budget of more than $36 million.[95] The council therefore recommends federal support for states undertaking this type of work. In addition to providing direct financial

support, the federal government can help states share learnings through meetings and dissemination of best practices.

As more states gather these data, there is a need for national-level minimum, common data standards to support comparability across states and to ease the administrative burden on payers and providers operating in multiple states. Furthermore, states acting on their own cannot compel data from self-insured employers and trusts protected by ERISA, but they may request such information. Standardized data requirements across states will make it easier for ERISA plans to comply with such requests.

A national-level entity should convene immediately to determine what data are required to support this work, how to leverage the efforts of states already collecting these data, and how to create an ongoing mechanism for states to learn from one another. Ideally, CMS could play a lead role in convening stakeholders for this purpose.

The council identified several important questions that the national entity and its stakeholders must answer:

- Should the national entity set standards for state data collection, or should it serve as the data collector itself? The former offers states flexibility, but the latter may be necessary to reduce redundancies, ensure a basic level of data quality, and ease the process for multistate employers and payers.
- If the national entity is designed as a centralized data collector, will states engaged in target setting be required to participate in such efforts, or will they be able to opt out and maintain their own data? What financial or technical assistance incentives could be offered to encourage states to participate?
- What data could or should be collected from states that do not engage in target setting?
- How will the entity make the data available to researchers and the public to allow outside analysis and transparency?

MINORITY REPORT: SPENDING GROWTH TARGETS

Five council members had specific reservations about supporting this set of recommendations and offer a minority report (see page 19).

CONCLUSION

The mechanisms described in this section are primarily designed to address health care spending growth. However, once established, the multistakeholder entities described here could be used, if desired, to set other priorities—for example, around payment models, health care workforce issues, or market conditions. In Massachusetts the Health Policy Commission is charged with accelerating the adoption of public and private value-based payment models.[95] Thus, spending growth target setting may provide a foundation for stakeholder collaboration to further other shared health system goals.

D. Value-Based Payment

In this report, *value-based payment*—often called advanced Alternative Payment Models (APMs)—refers to a variety of arrangements, all of which are best defined by what they are not: open-ended fee-for-service payments. Value-based payment models can exist at multiple levels within the health care system and can be used to compensate payees such as the health plan, the delivery system (here used to include institutional providers, such as hospitals, physician groups, or combinations thereof), or the individual clinician. For example, Medicare may use these models to pay private health plans with which it contracts (as in Medicare Advantage), health plans may use them with delivery systems, and delivery systems may use them with individual clinicians. The focus of this report, and much of the research on value-based payment, is those models that are used to pay delivery systems.

Minority Report: Spending Growth Targets

Five council members offer this minority report regarding recommendations C1–C4. These members believe that it would be prudent to look to the states that are already engaged in target setting to generate evidence that is needed to either support or reject these recommendations.

Each state's health care market is unique, and states have differing perspectives on whether there are problems in those markets and how to intervene, or not, to address them. During 2013–19, growth in health care spending across states ranged from 1.0 percent to 4.2 percent.[i] States at the lower end of this range might not want or need to make the investments in data infrastructure, staffing, political capital, and other resources necessary to support the recommendations of the council. The influence of state politics and the varying political perspectives of governors and state legislators should not be overlooked, either. The council should not presume that federal financial support or data infrastructure will be enough to spur states to adopt growth targets if they are otherwise not inclined to interfere in private markets.

In addition, there is little to no evidence that growth targets will produce savings for employers, consumers, and other payers. Only Maryland and Massachusetts have significant experience with setting growth targets, and their experience is unlikely to closely predict that of most other states. They are both small, liberal, eastern states, each with only three hospital referral regions and a small number of dominant health systems driving higher-than-average per capita costs.[ii,iii] In addition, Massachusetts has one of the lowest rates of uninsurance in the nation.[iv]

Massachusetts's experience has been mixed in terms of meeting the state's benchmarks, with the rate of growth exceeding the benchmark in four of the seven years between 2013 and 2019, including the two most recent years not affected by the COVID-19 pandemic.[v] Although Massachusetts's spending trend was below the national growth rate from 2013 to 2018,[vi] it is not clear whether that should be credited to the state's growth targets or to higher spending growth in other states, driven by coverage expansions under the Affordable Care Act, whereas Massachusetts's coverage expansions—and the associated spike in spending—occurred in 2006–07.

Maryland's pathway and experience is somewhat different than that of Massachusetts: It grew out of the state's hospital all-payer rate setting process, established in 1977. From 2014 to 2018 the state moved to a global budget revenue model, with a target for hospital revenue growth of less than 3.58 percent annually; although this was achieved, it is limited to hospital spending growth.[vii] In 2019 Maryland moved to a total cost of care model, but it would not be prudent to assess the health system's performance under this model yet.

Finally, there is no evidence that limiting spending growth will not harm patients by limiting access to new technology or cutting wages and employment in the health care sector. Given the lack of evidence that these initiatives always do more good than harm, there is a material risk that states' efforts to intervene in the private market will be misguided at best and damaging at worst. This is particularly true in markets that are currently functioning competitively and in which the council recommends no active intervention on prices (see recommendation B4). Even in states with currently uncompetitive hospital markets, policies to improve competition should be tried before turning to spending targets.

Furthermore, these recommendations come with substantial administrative costs, at odds with the council's recommendations A1 and A2, aimed at reducing administrative waste. As one example, California has budgeted for fifty-nine staff members and $15.5 million in personnel and operations costs for its new target-setting entity in 2022–23, rising to 142 staff members and $31.6 million by 2024–25.[viii] This is just for the state's costs—it does not include any investments that health insurers, employers, and other affected entities must make to comply.

Minority Report: *continued*

In conclusion, this minority believes that the council should not encourage all states to "develop a mechanism to establish health care spending growth targets," nor should the federal government create infrastructure to support them. Nevertheless, there are already a small number of states moving forward. It seems most prudent to look to these first movers to generate the needed evidence in support or rejection of setting targets so that the remaining states can learn from their experience.

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Conceptually, value-based payment runs the gamut from fee-for-service with bonuses for quality to the more advanced models, including bundled payment and accountable care organizations (ACOs), and to full global capitation. Models vary in the extent to which they maintain an element of fee-for-service payment and in the degree of clinical and financial risk borne by the payee.

The Health Care Payment Learning and Action Network (LAN) has developed a widely used framework for categorizing payment models that allows for tracking and promotion of those that are considered value-based (exhibit 4).[97] The council's focus is primarily on the LAN's category 3 and 4 models, which it calls "advanced." These encourage delivery system accountability for total cost and quality and do not reward volume.

Value-based payment is a systemic intervention that can potentially pull all four of the levers of high-value spending and growth identified by the council (price, volume, mix of services, and growth; see exhibit 1). Delivery systems paid

under value-based payment have an incentive to provide care in the most efficient setting and to reduce input costs where feasible, with ripple effects on prices. They also have incentives to increase use of high-value care, decrease use of low-value care, and improve administrative efficiency. Finally, limits on growth in value-based payment models year over year, by definition, limit growth in spending.

EXHIBIT 4

The Alternative Payment Model Framework

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
Fee-for-service: no link to quality and value	**Fee-for-service: link to quality and value**	**APMs built on fee-for-service architecture**	**Population-based payment**
	2A	3A	4A
	Foundational payments for infrastructure and operations For example, care coordination fees and payments for health information technology investments	**APMs with shared savings** For example, shared savings with upside risk only	**Condition-specific population-based payment** For example, per member per month payments or payments for specialty services, such as oncology or mental health
	2B	3B	4B
	Pay-for-reporting For example, bonuses for reporting data or penalties for not reporting data	**APMs with shared savings and downside risk** For example, episode-based payments for procedures and comprehensive payments with upside and downside risk	**Comprehensive population-based payment** For example, global budgets or the full or a percent of premium payments
	2C		4C
	Pay-for-performance For example, bonuses for quality performance		**Integrated finance and delivery systems** For example, global budgets or the full or a percent of premium payments in integrated systems
		3N	4N
		Risk-based payments not linked to quality	Capitated payments not linked to quality

SOURCE: Health Care Payment Learning and Action Network (the LAN), 2017, used with permission and adapted for this report (see note 98 in the text).

NOTES: Subcategories labeled with "N" indicate "no quality considerations." These models are not considered by the LAN to represent true payment reform and are not tracked as part of measuring the achievement of the LAN's goals.

Importantly, under value-based payment, decisions about which levers to pull, and how aggressively, are left to the discretion of the entity placed under the spending constraint. These decisions have implications for quality of and access to care, so it is crucial that payment models have safeguards in those areas built into their design.

Despite compelling theory, use of prominent value-based payment models—the advanced APMs put forth by the Center for Medicare and Medicaid Innovation (CMMI)—has not resulted in significant savings to payers, providers, or patients. A summary of literature the council reviewed regarding savings from value-based payment is available as a Health Affairs Research Brief [98] (also see section IV, "Supporting Research," at the end of this report). Estimates of savings attributable to ACOs in Medicare have ranged from less than 1 percent to more than 6 percent of total per person spending. Savings from bundled payment models have been slightly higher, particularly for bundles related to joint surgery, but the outcomes are widely varied and depend heavily on the details of a specific episode.

"The council believes that continued experimentation with value-based payment is needed."

The fact that savings have been more modest than initially expected may primarily be a consequence of design and implementation challenges rather than fundamental flaws in this approach to payment reform. Experts within and outside of CMS have identified the following challenges.

First, according to CMS Administrator Chiquita Brooks-LaSure and colleagues, the voluntary nature of delivery system participation "limit[s] the potential savings and full ability to test an intervention, because participants opt in when they believe they will benefit financially, and opt out (or never join) when they believe they are at risk for losses."[99]

Second, Michael Chernew and colleagues have noted that the plethora of models "can create program fatigue, complicate incentives, add to administrative costs, and distract from the challenges of broader health care system transformation."[100]

Third, there is insufficient support for, or incentive to accept, downside risk. Some evidence[101] suggests that delivery systems facing downside risk perform better than those in upside-only contracts, although this is not universally true (for example, in the case of the early Pioneer ACO model).[100] Nevertheless, it is well understood that many delivery systems need additional tools to be able to accept downside risk, including waivers, data, and support for transforming care, particularly for vulnerable populations.[99]

Fourth, fee-for-service continues to dominate the payment landscape. Value-based payment represents only a small slice of the health care spending landscape, limiting delivery systems' ability to respond to the inherent incentives with significant changes in practice. There could be a greater impact on spending through a "spillover" effect on practice if a critical mass of spending fell under value-based payment models.

Finally, there are financial incentives related to both benchmark setting and risk adjustment that experts believe undermine many models' effectiveness.[99,100,102,103]

These challenges notwithstanding, the council believes that continued experimentation with value-based payment is needed; these models have the potential to be a chassis supporting the council's other sets of recommendations regarding administrative streamlining, competitive pricing, and spending growth targets by making the right thing easy to do.

There are reasons to be optimistic that continued experimentation with value-based payment will yield positive results. Notably, there is strong CMMI support for addressing many of the criticisms that experts have identified in Medicare's rollout of APMs.[99,103-105]

In addition, there is great potential to expand value-based payment models further into the private sector, where uptake of the more advanced models has been lower than in Medicare.[106] Private-sector value-based payment models may be more effective in addressing health care prices than Medicare models have been, given that prices are negotiated in commercial markets but administered in Medicare.

RECOMMENDATION D1: CONTINUED EVOLUTION OF VALUE-BASED PAYMENT MODELS

The council strongly supports continued development, evaluation, and evolution of value-based payment models in both the public and private sectors, focusing on the following elements:

- Fewer models and better alignment among payers. The council supports CMMI's move to limit the number of models and also encourages more public and private collaboration, particularly on a regional basis, to choose and implement only a limited number of models.
- Stronger incentives for patients to obtain care from accountable delivery systems. Payers and payees should consider models that allow patient "lock-in" to a specific delivery system that is accountable for their care.
- Increased levels of financial risk (that is, the proportion of savings or losses that can accrue to payees) and clinical risk (that is, the breadth of services for which payees are at financial risk, such as physician services only or both physician and hospital services). This will give delivery systems more flexibility in determining how to treat and manage patients in terms of what services are provided, where, and how.
- Exploration of incentives for addressing health-supporting social needs. Some payers and health systems are experimenting with providing support for patients to access services such as housing, food, and transportation assistance. A recent review of such programs called the evidence of their impact on health care use and spending "nascent," although often promising.[107] One challenge in developing these models is a lack of data on patients' access to nonclinical health-supporting services. This data gap has led some experts to call for the development of standardized measures of the "social drivers of health," defined as "person-level measure[s] of food insecurity, housing instability, transportation problems, utility assistance needs, interpersonal safety, and other social needs that impact health."[108] CMS has signaled support for adopting such measures, notably by incorporating them, for the first time ever, into proposed rules on inpatient hospital payment and in new requirements for ACOs participating in the Realizing Equity, Access, and Community Health (REACH) model.[109,110] The council supports ongoing experimentation in this area, recognizing that improved measurement is a critical first step.

CONCLUSION

In reviewing research regarding value-based payment, council members were disappointed with the lack of substantial savings to date. However, during the council's multiyear process, there was strong support for the general notion that fee-for-service cannot be the future of a health care system capable of controlling spending levels and growth. In fact, incentives inherent in fee-for-service are a cause of many of the problems addressed by the council's recommendations. The council believes that a refined approach to value-based payment could not only generate cost savings and improve quality but also help create a foundation on which to build additional reforms.

III. Putting It All Together

The overarching goal of the recommendations in this report is to achieve higher-value health care spending and growth in the US. The mechanisms for achieving this goal involve paying the most efficient price for the right quantity of care for the right patients and populations and growing the price and volume sustainably and maintaining an appropriate mix over time. With this as the goal, the council offers recommendations in four priority areas:

- administrative streamlining,
- price regulation and supports for competition,
- spending growth targets, and
- value-based payment.

These four sets of recommendations are intended to work together. This final chapter of the report provides analysis of important interactions among the sets of recommendations and offers concluding thoughts to guide implementation efforts.

A. Interactions

In many cases the sets of recommendations enable one another. However, in a few cases they could create countervailing pressures. Exhibit 5 describes major interactions among the sets of recommendations.

ADMINISTRATIVE STREAMLINING

Meaningful standardization of administrative processes, as outlined in recommendations A1 and A2, could support the council's recommendations around price regulation and supports for competition. Such standardization could help eliminate differing administrative burdens as a potential driver of high price variation across markets, allowing regulators to zero in on more likely drivers such as competitive dynamics.

In addition, to the extent that standardization results in reduced administrative spending, it could also be one element of a strategy to meet health care spending growth targets. Standardized administrative processes could also enable

EXHIBIT 5

Interactions among council recommendations

	Effect of recommendation category on other categories (enabling, countervailing, or neutral)			
Recommendation category	Administrative streamlining	Price regulation and supports for competition	Spending growth targets	Value-based payment
A1–A2: Administrative streamlining		Neutral Enabling	Neutral Enabling	Neutral Enabling
B1–B4: Price regulation and supports for competition	Neutral		Enabling	Neutral
C1–C4: Spending growth targets	Enabling Countervailing	Enabling		Neutral Enabling
D1: Value-based payment	Enabling Countervailing	Countervailing	Enabling	

SOURCE: Authors' analysis.

more streamlined collection of data to monitor progress relative to targets. For example, a state could gather much of the required data from a centralized claims clearinghouse, if one is present, instead of collecting data from individual payers.

The council's longer-run recommendation to harmonize quality measurement across payers would likely support implementation of value-based payment, as quality measurement is a key component of these models.

PRICE REGULATION AND SUPPORTS FOR COMPETITION

Improved analysis of market competitiveness, as outlined in recommendations B1–B4, would be an important input to any federal or state entity tasked with setting and monitoring overall spending growth targets. Such information will help these entities identify likely root causes of any observed outlier spending or prices.

SPENDING GROWTH TARGETS

Federal or state entities tasked with setting, monitoring, and potentially enforcing spending growth targets, as outlined in recommendations C1–C4, could engage in various initiatives that would dovetail with efforts recommended by the council. For example:

- In support of administrative streamlining, such entities could review state regulation of clinicians and insurers to identify administrative processes that are duplicative or unnecessarily burdensome.
- As noted, monitoring entities will need to disaggregate high spending or growth to determine whether it is caused by outlier prices, practice patterns, or population characteristics. This type of analysis, especially to the extent that it involves examination of prices, would naturally support the work of state and federal regulators working to monitor and improve competition. In Massachusetts the Health Policy Commission, whose primarily responsibility is to set and enforce spending growth targets, is also tasked with making recommendations to the state's attorney general regarding antitrust enforcement, illustrating that target-setting entities and antitrust regulators can benefit from working closely with one another. Doing so will also potentially reduce regulatory compliance burdens on payers and providers if requests for data can be coordinated.
- Target-setting entities would also be well suited to bring together stakeholders to agree on a limited number of value-based payment models to implement if a state chooses to do so.

However, setting, monitoring, and enforcing spending growth targets will likely add administrative costs to the health system, thus working against the council's recommendations on administrative streamlining. Whenever possible, data requirements from entities involved in target setting should build on existing efforts. Nevertheless, it is likely that the council's recommendations around target setting will lead to a net increase in administrative spending. This increase, although necessary to achieve other goals, makes even more urgent the need to streamline the administrative processes identified by the council as first priorities in recommendation A1.

VALUE-BASED PAYMENT

Value-based payment models (recommendation D1) can also impose heavy administrative costs. In particular, many value-based payment models rely on risk adjustment, which is normally based on claims data, thus creating incentives for providers to invest resources in coding. At the same time, however, value-based payment models could incorporate features that would allow for the elimination of some costly administrative processes. For example, a payer could design a value-based payment plan such that providers consistently meeting spending and quality goals are exempt from some prior authorization.

Significant penetration of value-based payment in a state could also affect both price transparency efforts and analysis of the effects of consolidation on prices, as it will be more difficult to disentangle individual prices from bundled and capitated payment arrangements. In addition, there is some concern that pressure on providers to accept value-based payment contracts has led, and will continue to lead, to increased consolidation. Regulators examining proposed consolidation that is related to value-based payment should carefully consider whether these arrangements permit entities to exercise market power. It will be important for regulators to discern when consolidation is truly needed to achieve the value-based payment aim or whether contractual arrangements among parties can achieve the same effect.

B. Concluding Thoughts

As noted, the council did not have a formal consensus process, although staff strove to craft language that could be supported by most, if not all, members. Where this was not feasible, a minority report is provided (see recommendations C1–C4). In all other cases, readers may assume that all council members expressed at least some level of support for the recommendation. To better understand that level of support, members rated their confidence, based on the empirical evidence, that individual recommendations

EXHIBIT 6

Key attributes of recommendations of the Council on Health Care Spending and Value

Recommendation	Member confidence that recommendation can produce savings or slowed growth (high [H] or medium [M])	Level of resources and difficulty of implementation (high or medium)	Expected magnitude of $ impact if successful (high or medium)
A1: Standardization of four key "between" and "seismic" processes	M	M	M
A2: Longer-run harmonization of quality measures	H	H	H
B1: Increased state and federal monitoring of market competitiveness and scrutiny of proposed mergers	H	H	H
B2: Limited price regulation in markets that cannot be competitive	M	H	H
B3: Performance improvement plans and conditional price regulation in markets that could be competitive	M	H	H
B4: Additional supports for competition in markets that are currently competitive	M	M	M
C1: Data-supported spending growth target setting	M	M	$ impact as yet unknown
C2: Data-supported monitoring of spending growth	M	M	
C3: Data-supported enforcement of spending growth targets	M	M	
C4: Federal support for data infrastructure	M	M	
D1: Continued evolution of value-based payment models	M	M	M

SOURCE: Authors' analysis.

would either produce savings or slow growth. As shown in exhibit 6, all of the recommendations clustered together. Average confidence ratings were in the "medium" range, with the exception of two outliers for which members had "high" confidence. These were recommendation A2 (longer-run harmonization of quality measures) and recommendation B1 (increased state and federal monitoring of market competitiveness and scrutiny of proposed mergers).

Exhibit 6 also rates the recommendations on two additional factors: level of resources needed and difficulty of implementation, and the expected dollar magnitude of impact if successful. Ideally, recommendations would be low cost and high impact, but this is not the case with respect to the council's recommendations—greater impact will require greater effort. This finding highlights a maxim that members knew when they began this work: If ensuring high-value health care spending and growth were easy, it would already have been done.

> "The council hopes to provide a strong starting point for action."

The level of collaboration and compromise that will be required to implement these recommendations is significant. However, in steering policy makers and other stakeholders toward a set of recommendations that has been vetted and supported by a diverse group of experts with divergent interests, the council hopes to provide a strong starting point for action. As noted previously, stakeholders must start where they are, with the tools currently available, and move forward. These recommendations contain a road map for doing so. They are offered in a spirit of optimism and humility and in the belief that success in any or all of these areas may open the door to even more impactful actions in the future.

IV. Supporting Research

This report was informed by the council's review of an extensive body of literature regarding key drivers of US health care spending and growth and the likely effects of various interventions. Much of this research is reflected in the report's endnotes.

Additional sources can be found in the following documents:

- Appendix A. Supplemental Bibliography: Health Care Spending and Growth by Sector; Key Drivers of Health Care Spending Growth
- Appendix B. Supplemental Analysis of Market Concentration and Health Services
- Appendix C. Health Care Spending Growth Targets in Massachusetts and Maryland
- Health Affairs Research Brief: The role of administrative waste in excess US health spending. Washington (DC): Health Affairs; 2022 Oct 6.[16]
- Health Affairs Research Brief: The role of prices in excess US health spending. Washington (DC): Health Affairs; 2022 Jun 9.[17]
- Health Affairs Research Brief: The role of clinical waste in excess US health spending. Washington (DC): Health Affairs; 2022 Jun 9.[18]
- Health Affairs Research Brief: Value-based payment as a tool to address excess US health spending. Washington (DC): Health Affairs; 2022 Dec 1.[98]

V. Appendices

Appendix A. Supplemental Bibliography: Health Care Spending And Growth By Sector; Key Drivers Of Health Care Spending Growth

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Appendix B. Supplemental Analysis Of Market Concentration And Health Services

Sherry Glied for the Council on Health Care Spending and Value

We estimate the share of areas and populations in the US that have noncompetitive, potentially competitive, and currently competitive markets for three types of health services: inpatient hospital and specialist and primary care. We define a market as a Metropolitan Statistical Area (MSA). An MSA is defined by the Census Bureau as an area that comprises a substantial core population (an urbanized area with a population of at least 50,000) and also includes neighboring communities that are integrated with that core (as measured by commuting patterns). Areas with populations below 50,000 that do not share substantial commuting ties to any MSA are classified by the Census Bureau as non-MSA areas. Using data from the Census Bureau and from the Nicholas C. Petris Center at the University of California Berkeley (as described by Brent Fulton and colleagues; see reference 71 in the text), we calculate that about 45,500,000 Americans, or 14 percent of the US population, live in non-MSA areas.

We categorize markets in each MSA into one of three categories on the basis of population size and Herfindahl-Hirschman Index. We define an area as being noncompetitive if its population is not large enough to support four or more competing hospitals or—in some of our analyses—medical groups (that is, large enough to achieve a Herfindahl-Hirschman Index below 2,500). The population cutoff for each category of service varies. For hospital markets, we assume a population size cutoff of 400,000 (areas with populations below 400,000, including all non-MSA areas, are defined as noncompetitive). There are currently zero MSAs with a population size of fewer than 400,000 people for which the hospital Herfindahl-Hirschman Index is below 2,500, lending support to our population size cutoff. We use a cutoff of 200,000 for specialist physician markets. Of 163 MSAs with a population size of fewer than 200,000 people, only eleven have a specialist market Herfindahl-Hirschman Index below 2,500. We use a population cutoff of 50,000 for primary care markets, so all MSAs have a population size above the cutoff. We do not have Herfindahl-Hirschman Index estimates for non-MSA areas, so we cannot estimate how many non-MSA areas currently have competitive primary care markets despite their low population size. A potentially competitive market is one in which the population size is above the noncompetitive threshold but the current Herfindahl-Hirschman Index in a given category is above 2,500. We define a competitive market as one with a Herfindahl-Hirschman Index below 2,500.

In the four tables below, data on market Herfindahl-Hirschman Indexes and population size by MSA are drawn from the 2015 estimates provided by the Petris Center. Market shares for hospitals were calculated on the basis of inpatient admissions. For specialists, separate specialist Herfindahl-Hirschman Indexes for cardiologists, oncologists and hematologists, radiologists, and orthopedists were aggregated and weighted by the number of physicians in the specialty.

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APPENDIX B TABLE 1

Number and share of markets and US population in each market category, hospitals (400,000 population cutoff for markets that cannot be competitive)

Market category	Markets	Share of MSAs (excludes non-MSA areas), %	Population	Share of population, %
1: Cannot be competitive	249 MSAs and all non-MSA areas	65	91,023,879	28
2: Potentially competitive	95 MSAs	25	80,500,166	25
3: Currently competitive	38 MSA	10	149,111,118	47

NOTE: MSA is Metropolitan Statistical Area—an urbanized area with a population of at least 50,000 that includes neighboring communities that are integrated with that urban core, as measured by commuting patterns.

APPENDIX B TABLE 2

Number and share of markets and US population in each market category, hospitals (200,000 population cutoff for markets that cannot be competitive)

Market category	Markets	Share of MSAs (excludes non-MSA areas), %	Population	Share of population, %
1: Cannot be competitive	163 MSAs and all non-MSA areas	43	67,094,611 (includes 45,482,635 in non-MSA areas)	21
2: Potentially competitive	181 MSAs	47	104,429,434	33
3: Currently competitive	38 MSAs	10	149,111,118	47

NOTES: MSA is Metropolitan Statistical Area—an urbanized area with a population of at least 50,000 that includes neighboring communities that are integrated with that urban core, as measured by commuting patterns. Percentages may add up to more than 100 percent because of rounding.

APPENDIX B TABLE 3

Number and share of markets and US population in each market category, specialist physicians (200,000 population cutoff for markets that cannot be competitive)

Market category	Markets	Share of MSAs (excludes non-MSA areas), %	Population	Share of population, %
1: Cannot be competitive	163 MSAs and all non-MSA areas	43	67,094,611 (includes 45,482,635 in non-MSA areas)	21
2: Potentially competitive	111 MSAs	29	47,978,994	15
3: Currently competitive	108 MSAs	28	207,367,658	65

NOTES: MSA is Metropolitan Statistical Area—an urbanized area with a population of at least 50,000 that includes neighboring communities that are integrated with that urban core, as measured by commuting patterns. Percentages may add up to more than 100 percent because of rounding.

APPENDIX B TABLE 4

Number and share of markets and US population in each market category, primary care physicians (50,000 population cutoff for markets that cannot be competitive)

Market type	Markets	Share of MSAs (excludes non-MSA areas), %	Population	Share of population, %
1: Cannot be competitive	All non-MSA areas	0	45,482,635 (all residing in non-MSA areas)	14
2: Potentially competitive	156 MSAs	41	59,770,843	19
3: Currently competitive	226 MSAs	59	215,381,685	67

NOTE: MSA is Metropolitan Statistical Area—an urbanized area with a population of at least 50,000 that includes neighboring communities that are integrated with that urban core, as measured by commuting patterns.

Appendix C. Health Care Spending Growth Targets In Massachusetts And Maryland

To address health care spending that was historically higher than the national average, Massachusetts established a Health Policy Commission in 2012. The commission sets a benchmark that represents a shared commitment among all payers in the state to keep health care cost growth at pace with overall economic growth. From 2013 to 2017, growth in Massachusetts averaged 3.4 percent, which is below the benchmark of 3.6 percent.[i] In the next two years, however, growth exceeded the benchmark, which had been lowered to 3.1 percent by statute, coming in at 3.6 percent in 2018 and 4.1 percent in 2019.[ii] Detailed analysis of the 2019 spending drivers has prompted the commission to undertake enforcement action against a specific provider in the state; it is not yet clear what effect this will have on trends.

In Maryland, a state governing body sets annual global budgets for all hospitals in the state. Hospitals must adjust prices and negotiate with all payers on the basis of projected volumes to stay within this budget. A 2019 CMS report on a five-year span of the program found that Medicare spending for all types of care grew by 2.8 percent less than in a matched comparison group of hospital markets in other states, including 4.1 percent slower for total hospital expenditures.[iii] The additional reduction in total Medicare spending was due to savings on professional (physician) services in hospital settings and postacute care—areas that are not subject to the global budgets. Commercial payers also saw a slowing of growth in hospital expenditures, but unlike Medicare, they did not see such slowing in overall per capita spending growth because of increases in spending on professional services.

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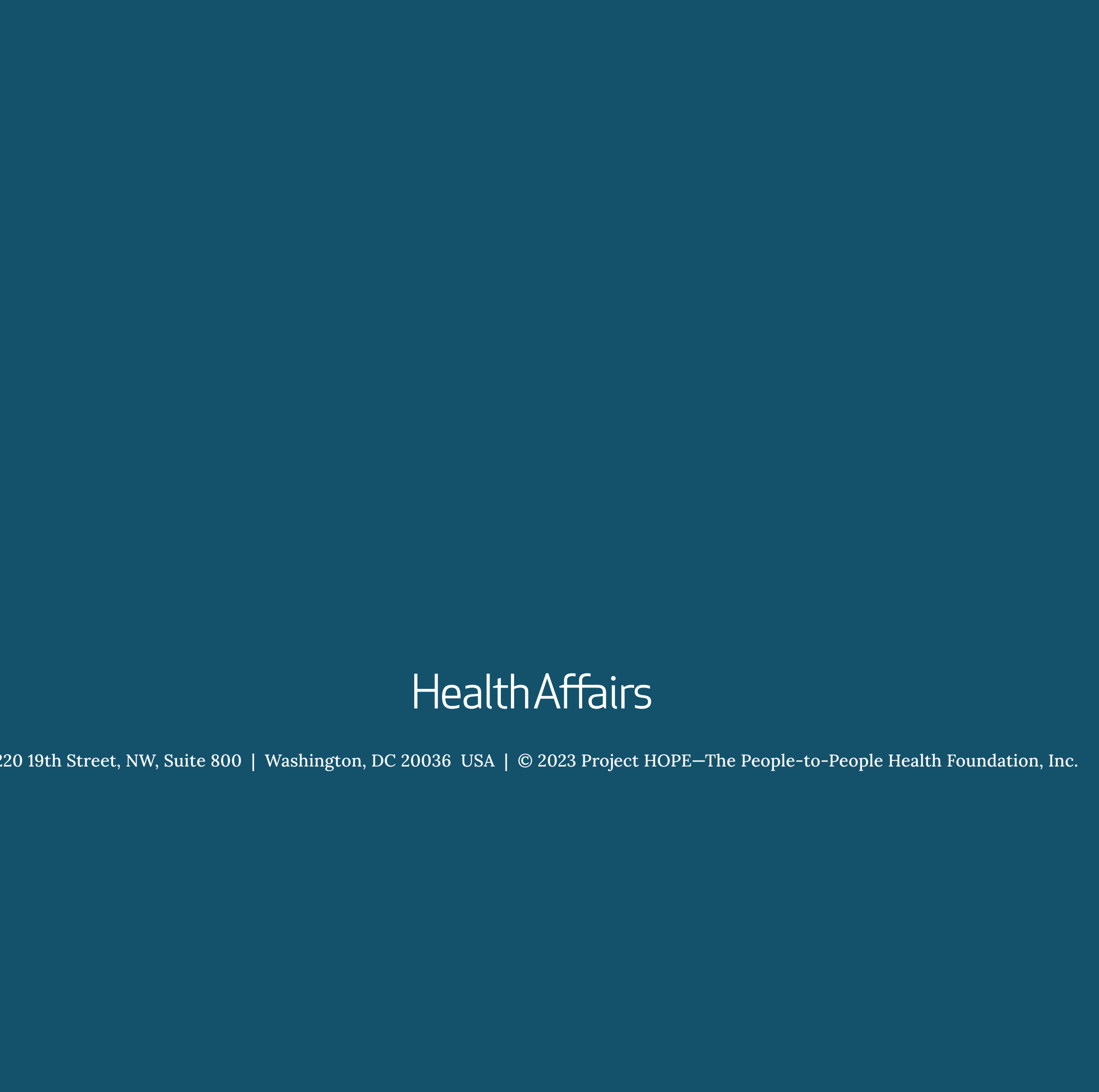

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