CHPRE Issue Brief #1

February 12, 2014

Enlisting States as Partners in Health Care Cost Savings

Stuart Butler, David Kendall, Len Nichols

GEORGE MASON UNIVERSITY
Center for Health Policy Research & Ethics
College of Health & Human Services
4400 University Drive, Fairfax VA 22030

Enlisting States as Partners in Health Care Cost Savings

Stuart Butler[1], David Kendall[2], and Len Nichols[3]

February 5, 2014

Abstract: State gain sharing is a strategy to enlist states as partners with the federal government to achieve health care cost savings for public and private payers and consumers. States can provide unique leadership in three ways: convening local stakeholders to design and advance reform and innovation, reforming the regulatory and legal environment that affects the cost of health care, and improving the efficiency of state and federal-state health care programs. Under this proposal, states would be rewarded for their effort with a share of the federal savings they help to achieve, while the federal government would be rewarded for actions that led to savings within a state. Savings would be measured against a baseline for federal, state and private spending. The savings to be shared with the states would be negotiated through an agreement between HHS and each state. The state would in turn share savings with private sector bodies that were partners in cost-saving reforms. The agreements in the proposal would also include patient protections to

[1] Heritage Foundation
[2] Third Way
[3] Director, CHPRE, George Mason University (703) 993-9490; lnichol9@gmu.edu

prevent savings from being achieved through arbitrary benefits cuts, lowering the quality of care, or limits on access to care.

Rising health care costs are the single largest contributor to long-term federal deficits. Yet more than half of the nation's health care costs are not actually under the federal government's direct control, and its policy instruments are blunted by this fact. When Washington tries to solve part of its health cost problem on its own by cutting Medicare payments to health care providers, for instance, the providers respond by trying to shift the costs of the federal "underpayment" onto private payers. Meanwhile, private payers acting alone face local provider market power and a lack of critical market share that diminish the effectiveness of their efforts.

The states can step into this breach from their unique policy platform. States set health care policies that affect all payers. For example, they are responsible for professional and facility licensure and quality regulation and thereby have a large -- if understated -- formative impact on local delivery system patterns and overall costs. Numerous laws and regulations—from scope of practice rules to medical malpractice laws—vary by state and limit the cost containment

possibilities of all other stakeholders, from Medicare to self-insured employers to consumers to would-be innovative providers themselves. Furthermore, employers, workers, physicians, and hospital CEOs all frequently interact with the state government over reimbursement rates, health plan regulations, and other ways through the buying programs they administer such as Medicaid and state employee health benefits. Indeed, states are often the single largest buyer providers face, when combining Medicaid, SCHIP, and state (and sometimes local) employee programs. State are increasingly forming all-payer claims data systems for evaluating and implementing cost-saving initiatives.[1] Thus a state government is in a unique position to convene the entire set of health care stakeholders in joint efforts to tackle cost growth reduction.

But whenever we seek to harness federal, state and private-sector players in a coordinated effort to slow the growth of costs, there is a challenge: how can we encourage one of these sectors to take action, if the main beneficiaries gaining from that action are or are perceived to be other sectors of the health system?

To establish states as the leaders of a multi-stakeholder cost restraint strategy that addresses this challenge, we propose a gain sharing approach. It would be a bottom-up process where

states identify potential efficiency gains from cooperative strategies among stakeholders at the local, state or regional level and secure an agreement with the federal government for distributing the gains from those strategies in order to facilitate value-enhancing changes among affected stakeholders. In other policy areas, such as welfare reform, this model has worked well, but it would have to be adapted for the special challenges and opportunities presented in health care.

States can provide unique leadership in at least three areas:

1) Convening private and/or public stakeholders to design and advance reform and innovation within their own states, and perhaps in conjunction with other states.

2) Reforming the regulatory and legal environment that affects much of the costs in health care within their borders (e.g., health care professions and facility licensing, tort law, and public health requirements), so that the federal, state and private sectors can deliver health care more efficiently.

3) Improving state and federal-state programs in ways that will relieve budget pressures on federal, state, and local governments as well as on private payers, including consumers. This is largely about using state leverage as a buyer of health care and health insurance for large and diverse populations,

ranging from Medicaid and SCHIP recipients to state (and sometimes local) government employees. Since it buys from private sector insurers and providers for these beneficiaries and employees, just like other payers do, we are calling for strategic collaboration with other buyers, including Medicare, to incentivize cost growth reductions across the board.

State leadership is especially needed to bridge the gaps in care for patients enrolled in both Medicare and Medicaid. These so-called dual eligible patients have Medicare for most of their acute coverage and may also have Medicaid because of particular low incomes and/or for long-term care. With two separate sources of financing, care coordination often falls through the cracks. For example, states have no way to ensure that patients in state-paid nursing homes are getting all they can out of federally-paid health care that, if utilized wisely, could let patients return home, reducing costs to all governments while improving patient health and satisfaction.

To encourage states to take a lead role in health care innovation and efficiency we need to create incentives for states to develop and implement beneficial changes and cooperation even when there is no or little current direct financial benefit to state coffers, or where there may be state costs associated with savings that a state's actions may

achieve for other payers. As Alan Weil, Executive Director of the National Academy for State Health Policy points out, the enhanced federal match rates that Congress has used in recent years to encourage states to expand coverage under Medicaid and the Children's Health Insurance Program has reduced states' marginal incentive to reduce costs simply because states have less money at stake.[2] The federal government is sending a mixed signal because states nonetheless face growing fiscal pressure from the rising cost from older Medicaid coverage requirements that haven't been offset with higher federal match rates. Under the Affordable Care Act, states have increased responsibilities for coverage, which has caused both supporters and opponents of the ACA to make states an important health care policy battleground, as well as a **potential** laboratory for strategic cooperation. For those reasons, it is an opportune moment to examine gain sharing, which can capitalize on state leadership.

Gain sharing as we see it is a state-led partnership between the federal government, the private sector and the states wherein cooperation to achieve common savings objectives are jointly rewarded through an agreement that transcends and modifies current payment and reward systems. Gain sharing recognizes that cost savings in one sector may accrue because of actions and costs incurred by another sector. By addressing this, gain

sharing would turbocharge cooperation in situations where one party's actions would mostly or solely benefit another party under existing rules. As such it uses a federal-state-private coordination strategy to bring to scale similar gain sharing initiatives within sectors. For example, hospitals have successfully shared savings with cardiologists from centralized purchasing of stents and other supplies, which cardiologists would otherwise order individually at the hospital's expense.[3]

A gain sharing relationship between the federal government and states should be a partnership among equals. Unlike other federal-state relationships where the federal government essentially pays states to perform a service such as building highways or providing health care coverage to the uninsured, a gain sharing relationship would be based on the unique leadership and knowledge that each can bring to the table.

A start toward that kind of partnership can be found in Center for Medicare and Medicaid Innovation's State Innovation Models Initiative.[4] It is encouraging states to develop multi-payer and delivery models that deliver high-quality health care and improve health system performance. Unlike our gain-sharing proposal, however, states that compete and win participation are limited to a total of $275 million in up-front funding. Our proposal would enable a long-term relationship, made sustainable

through greater financing opportunities for all states, funded through the savings achieved over the long run.

A strategy to forge a new, robust relationship involves three basic steps:

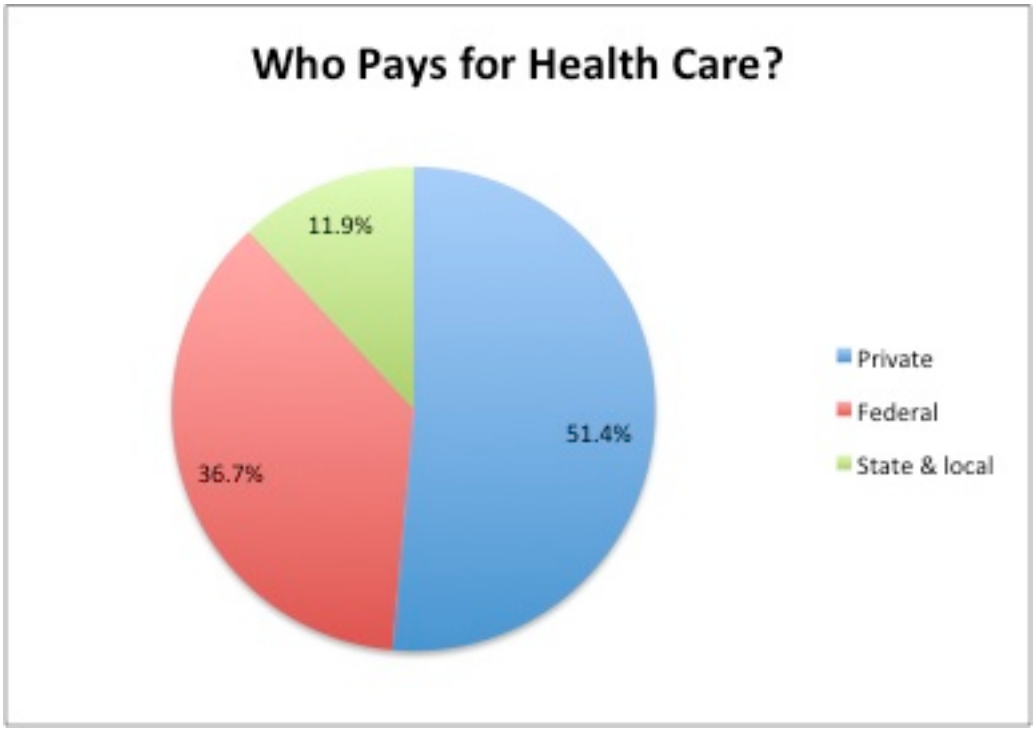
First, we need to establish a "default" baseline for the expected total health care spending (federal, state and private) within each state that would occur without state initiatives. This baseline would allow some measurement of the incremental savings due to state action.

Second, we need to measure differences in actual spending levels within the state, in order to identify the savings achieved when compared with the baseline.

Third, we need to design an operational system for sharing any savings achieved by the state with the state itself, the federal government, and private stakeholders, including patients, in ways that are generally considered equitable, and supportive of other important goals like quality and access.

The potential pot of money for gain sharing is substantial even if we limit it to federal savings that could accrue from state actions. As the Congressional Budget Office projects, the federal government will spend nearly $5 trillion on the major

health care programs over the next ten years. At the same time, estimates of health care spending that does not improve health show that roughly one of every three health care dollars are wasted.[5] When we consider that total national health spending in the United States is projected to rise from 17.9% to 19.6% of GDP, i.e., to almost $37 trillion over those 10 years, reaching $14,102 per person by 2021, it is clear that "excess" health care spending is far more than a government problem.[6]



Source: Centers for Medicare and Medicaid Services, National Health Expenditures, 2011

According to an analysis by Don Moran, if the states achieved cost reductions of 0.5% compounded annually, there would be

an estimated $220 billion in aggregate federal savings over 10 years (2012-2021) resulting from changes in both outlays and revenues.[7] This estimate is simply illustrative of the potential federal savings and would be different in practice.

In order to develop a workable proposal based on the three steps, several issues need to be addressed.

Creating the Best Baseline

There are significant conceptual and practical challenges in creating a baseline against which we could measure savings. Policymakers faced similar challenges in the design of the landmark 1996 welfare reform legislation (Temporary Assistance for Needy Families, or TANF). Among other things the legislation sought to induce states to find better ways of moving welfare recipients towards independence, and to reward the states that did so. But how to gauge what would have happened without a state initiative? The approach used for measuring incremental savings in public assistance costs was relatively crude but also effective. To calculate a baseline, state funding for Aid to Families with Dependent Children (AFDC) and other smaller programs that became the new TANF-based approach was frozen at 1994 or 1995 levels in nominal dollars. Since these years were considered funding peaks, the states were

generally content since they expected those costs to fall anyway in subsequent years. So in the short term they were assured extra money, while any savings they achieved when compared with this baseline were shared with the federal government.

To be sure, while the welfare reform case shows one way to establish a baseline for certain kinds of programs, there are limits in its applicability to the challenge we have set. For one thing, our approach makes the case for measuring total health spending, while the AFDC/TANF baseline budget was government spending only. For another, there was widespread policy agreement by 1996 that reducing the welfare rolls was both feasible and desirable, while today there is a fear among many that budget rules and baselines could become a way to throw beneficiaries off the Medicaid and even Medicare rolls. Therefore it is important to devise a total health spend baseline so that there is no incentive to meet a baseline and claim savings in one sector by shifting people and costs to another.

Can we devise such a baseline for all health care that states would find an agreeable platform from which to measure the impact of their efforts and calculate their share of any gain?

Answering that question requires us to ponder some second level questions. One is whether the baseline should attempt to distinguish changes in spending that are not related to state-specific cost reduction strategies (such as an influx of retirees or regional differences in disease outbreaks)? Another is how to design a baseline that does not simply encourage states to engage in cost shifting to patients, employers or the federal government.

In our view it is important not to let the perfect be the enemy of the good. Attempting to design a baseline and measurement of future actual costs that distinguishes the impact of state action with great precision would be enormously difficult – if not impossible – and likely would lead to endless disputes over causality. Better, then, to focus on devising a baseline that distinguishes between state, federal and private future costs with a reasonable degree of accuracy and probability, so that incentives for states to cost-shift are minimized while accepting that states may end up being rewarded for improvements for which they were not responsible.

Fortunately, we do have the tools to do this. CMS/OACT computes state spending, on both state of residence and state of provider bases (which adjusts for border crossing), every 5 years. With some additional resources this could be yearly with projections

(derived from same NIPA accounts that drive annual NHE data).[8] In this way, a baseline and what happens to each of the three sectors individually would be available, not just the total. And each sector would have an interest in helping the other sectors reduce spending if they shared the gains proportionally. But in addition, by adjusting the baseline annually, based on national and perhaps regional trend rates, states would be rewarded more for savings that are greater than the national trend.

Calculating State Rewards

There are several ways of calculating the share of any savings that would go to the state. One would be to legislate a formula (much like the formula determining how Medicaid costs – or savings achieved – are to be shared between the federal government and the state). Another would be for the Department of Health and Human Services to make the determination, based on a number of factors.

We favor a different route. Under our proposal, there would be a formal, prospective gain sharing agreement proposed by the state and agreed upon between the state and the federal government, based on a state plan to achieve savings. As part of its role in this process, the state would convene a

commission of stakeholders, including patient organizations, providers, employers and plans, to develop the plan on how state savings would be distributed among the sectors within the state. The reason we prefer the negotiation approach is that different savings rates should go with different degrees of state effort in pursuit of common state-federal-private objectives.

As partners in the final agreement, the state and federal government would negotiate key features of a federal-state gain sharing agreement. One would be the proportion of savings to accrue to the federal government and to the state and its stakeholders. This would reflect any up-front associated planning and other costs to be incurred by the state or the federal government. It would also reflect the degree to which the savings would be likely to affect federal programs, such as Medicare. Another feature would be an agreed-upon process to calculate future savings, to avoid later confusion and disputes. Still another would be any federal waivers or other administrative actions to help facilitate the innovation plan put forward by the state. We would not rule out mutually agreeable temporary statutory changes as part of the plan – one of us co-authored a proposal in an article designing a mechanism for state innovations involving temporary statutory changes for a specific state engaged in an agreed federal-state plan to

improve coverage.[9]

Creating an Operational System

How would this basic structure be turned into an operational system? In our view the procedure would involve the following steps.

First, Congress enacts legislation to establish the process and to allow savings accruing to the federal government as part of a federal-state-private sector agreement to be shared with other sectors.

Second, the federal government develops a projected baseline for federal, state and private expenditures in each state, and lays out broad areas of policy innovation it would like states to pursue

Third, a state wishing to take part in the gain sharing program convenes a local commission of stakeholders and develops a plan of action by the state intended to produce health care savings. The state commission negotiates and agrees on how the savings produced by the plan, if successful, will be divided between the state, the other stakeholders in the state, and the federal

government. The commission also identifies the federal actions, including waivers from regulations, upfront federal investments, and any federal statuary changes that would be necessary for the plan. As part of the plan, the state identifies the statutory (if any), regulatory or program commitments it is willing to make. HHS would provide general grants for the initial planning of any course a state wants to take, as long as it is generally consistent with the goals we have outlined, establishing commissions, and ensuring participation of patients and consumers who, unlike other stakeholders, often do not have a source of funding for participation. This is similar to the process envisioned in section 1332 of the ACA, wherein states are invited to present alternative methods of achieving ACA coverage and cost goals, starting in 2017 (though Arkansas and Iowa [at least] have gotten a head start).

Fourth, the state, on behalf of the commission, presents the plan to the federal Administration with its estimates of the savings to each sector. The state and the Administration negotiate the details of the state plan affecting the federal government and the proposed savings to the federal government that require federal action. We propose a new Office of State Partnerships in the Department of Health and Human Services, with the Director reporting directly to the Secretary devoted to

encouraging state innovation and outside of the normal waiver authority process. This new office would build upon the work of the State Innovation Models Initiative at the Center for Medicare and Medicaid Innovation and the Medicare-Medicaid Coordination Office, which has launched state demonstration programs to improve care for dually eligible beneficiaries.

These negotiations are intended to achieve agreement on several issues:

An agreement on the goals and timetable for savings and in particular the goals for savings to the federal government that accompany the state action and any proposed commitments from the federal government. There would be no national formula for the proportion of savings that would accrue to the federal government or for the proportion going to state and private sector stakeholders. In contrast, Alan Weil's state gain-sharing proposal would set a single, national rate for splitting the savings.[10] Given the wide variety of possible cost saving initiatives, it would be impossible to select **a priori** the one rate that would balance rewarding the degree of effort involved with the need to protect the federal interest. (Thus the agreed proportions should differ according to the degree of difficulty for achieving savings and other factors that HHS would identify.

Further, such flexibility would allow the federal government to adjust the gain sharing over time in order to gain more state participation.

Any required federal administrative waivers. The federal government would grant them simultaneously.

Any federal commitment of funds. For example, the federal government could provide additional planning grants or loans, both of which would be repaid from the savings, and the timing of such funds.

Any changes in federal law required to enable the agreement to be fully implemented or to continue the program past the pilot period. These would be sent to Congress by the Administration.

An agreed verification procedure to measure whether the proposal does indeed reach its goals.

Fifth, to the extent that state action successfully yielded the proposed results, and these were verified by the chosen third-party, the gains would be distributed according to the formula agreed by the state commission and in the agreement with the federal government.

Anticipating Concerns

We recognize that our gain sharing proposal raises a number of issues. . Here are ways to address the main ones:

Patient Protections: Whenever a state, or a health plan, is given an incentive to reduce costs, there is the worry that the state will do so by reducing the quality or availability of health services below an acceptable level. So there needs to be a mechanism to protect the interests and perspective of patients. The concern is not just that there may be a risk to beneficiaries of state-administered programs or patients, but also that state actions to reduce total health care costs may pose risks to patients in federal programs operating within the state, such as Medicare, and patients receiving services under private sector plans.

One way to deal with concern would be for the federal government to regulate state gain sharing agreements with detailed a priori requirements to meet or exceed specified performance measures, including such indicators as specific levels of patient outcomes, access to care, patient satisfaction, benefits levels, out-of-pocket expenses, and medical error rates, and to achieve these in-state results for health care in the state, federal and private sectors. But this would be both a major expansion of

federal regulation and a considerable disincentive for the state and its stakeholders to take part.

We favor instead that each state gain sharing commission agreement include an agreed set of patient protections including publicly available standards and performance reporting. In addition, the federal government during the discussion of the plan would be expected to specify that the state must achieve an agreed level of performance for the state to receive its share of savings. The state commission of stakeholders would be primarily responsible for proposing the metrics for these protections for the gain sharing agreement which must include concrete plans to generate and track publicly transparent data, which the federal government would have to agree reflect the goals and risks of the initiative in question. Thus the federal government would, as it does today in Medicare and Medicaid waiver discussions, confine itself mostly to assuring existing federal requirements are met and also, as a condition for the state receiving gain sharing funds, that the protections set out by the stakeholder commission were achieved.

Opportunity Costs: Another concern is that a state-based approach might crowd-out other, non-state based cost control efforts that potentially might be more successful (such as a reform of federal health care tax policy or the methodology for

Medicare doctor payments). In particular, the proposed plan might turn out to conflict with existing or future cost control initiatives.

The issue of existing cost control measures would be addressed during the discussion stage between the state and the federal government. It is possible of course the state-initiative might leverage the federal pilot (extending medical home arrangements to all payers comes to mind). The federal government also would not approve a state-initiated plan if it conflicted with federal policies or statutes – unless the administration provided a waiver or agreed to request from Congress a change in the law. Existing demonstrations (e.g., for dual eligibles) would continue or be folded into a gain-sharing initiative with the approval of the state.

Regarding the potential impact of future federal action on a gain sharing agreement, one way to address this would be to allow the federal government to honor established gain sharing arrangements for a minimum fixed period of 10 years, but beyond a set time period or for new arrangements, the federal government and the states would both be free to propose different terms and time periods for the arrangement or subsequent agreements.

Achieving Significant Savings: Several major studies have concluded that roughly one-third of U.S. health care spending is wasteful.[11] This waste comes from various sources ranging from poor quality care to excessive pricing to unnecessary administrative costs. It is such a large amount that if states worked for the next ten years chipping away at less than one-fifth of the waste, they would save the federal government $220 billion. That assumes the states reduce the rate of annual growth rate of health care spending by one-half of one percent, according to the Moran analysis.[12] The federal savings would include reductions in Medicare, Medicaid, exchange subsidies, the tax exclusion for employment-based coverage and other federal programs.

The key to achieving significant savings is to align the interests of key stakeholders with a concerted strategy. Individually, each payer may not have the leverage to affect large-scale changes. Public payers acting by themselves risk shifting costs onto the private sector. Gain sharing would blend together potential cost savings from public payers and private payers (as represented through the tax exclusion). States would be the platform for organizing an agreement over how the payers could achieve cost savings and for how to share the gains. Although the actual cost savings from this approach

are difficult to predict, there are few, if any, alternatives that have as much potential.

Encouraging State Participation: Another concern is that if the procedures in the gain sharing system are too onerous, or if the resources required to produce a proposal are beyond the discretionary resources of many states, few or no states will come forward with a plan. States might also be concerned that an incentive for success today could become a requirement for success tomorrow. A related question is whether gain sharing needs to be a 50-state effort or will action and success in a few states lead to scaled-up efforts elsewhere?

We believe the procedures we have proposed will be sufficient for several states to agree to develop a gain sharing plan that involves federal actions and savings. Nevertheless, we do believe that prior to the announcement of the initiative the federal government should identify a handful of likely early adopter states. With these states the federal government could forge model agreements for gain sharing programs and provide additional early planning money to the states willing to take the lead. It is hard to determine what the "critical mass" would be for a gain sharing initiative. That would depend on both the scale and level of innovation in proposals. Even a handful of significant and successful state proposals in the

early years could induce many more states to copy the proposals, leading to a widespread adoption of gain sharing proposals over the years.

The federal government should also require a new HHS Office of State Partnerships to work directly with such state organizations as the National Governors Association and the National Council of State Legislatures to pave the way for state involvement. We envision this office also establishing a clearinghouse for sharing (but not determining) best practices among the states, and reporting to Congress on successful efforts for federal consideration.

Ensuring employer and insurer participation: Employers and private insurers would have a strong incentive to participate in a state initiative because they already have a financial stake in lowering costs. An additional reason is the inclusion in the baseline for gain sharing of the "tax expenditure" incurred through the tax exclusion for employment-based coverage. If states hope to achieve savings in the private sector baseline, they will have to find ways to engage employers and insurers in the initiative in return for a share of the health system's savings. But they might hold back if they have anti-trust concerns. These concerns can arise with changes in payment systems coordinated by multiple payers. If the changes

affect providers disparately or might exclude some providers, regulators or the courts might view the coordination as collusion. The possibility of anti-trust action as well as the threat of an anti-trust lawsuit needs to be addressed upfront in order to ensure broad participation by employers and insurers.

As part of the authorizing legislation, Congress should authorize the Federal Trade Commission to grant anti-trust exemptions. For the purposes of this proposal such exemptions would be limited only to participants in HHS-approved agreements with states and only to activities within the initiative. The FTC would rule on whether the benefits of the state initiative outweigh the risks of collusion. It would also conduct periodic follow-up reviews of the initiative as spelled out in the agreement. States may also provide "state action" anti-trust relief themselves as they have with multi-payer initiatives for medical homes.[13]

Another concern of employers – especially multi-state employers – with state-based efforts generally is the affect on ERISA, the federal law that sets a uniform, federal legal structure for employer-provided benefits. Under ERISA, employers must deal with health care market conditions that vary by state. State gain sharing would enable employers to target their efforts in states where they see the biggest potential gains from reforms.

As such, ERISA provides the flexibility for state action without any legislative or regulatory changes to ERISA.

Once fully engaged in a system of gain sharing, employers and insurers may be an additional source of upfront financing. For example, they may help fund upfront investment costs that pertain to their employees and enrollees in order to spread the costs over multiple payers as they have in multi-payer medical home initiatives.[14] Although employers and insurers may receive some gain even if they do not participate in the upfront costs of gain sharing initiatives, that fact should not serve as a reason for the federal government to compel their participation or exclude them from the part of savings that would accrue naturally and spillover to these employers. Innovation on the part of employers and insurer will require the same voluntary and enthusiastic commitment to change as it will with the states.

Encouraging provider participation. As with any cost-saving initiative, providers who stand to lose financially lack an incentive to participate. For example, hospitals may face lower admission rates if patients can manage their chronic conditions and avoid the need for acute care in the hospital.

States would have at least two tools at their disposal to overcome resistance to provider participation. One method would be to share some of the federal gain sharing saving with providers to offset a portion of their losses. Another would be to simply proceed with an initiative regardless of the cooperation of providers. If all the payers in a state agreed to pursue a uniform approach to payment reform, for instance (without going as far as violating anti-trust laws by setting prices collectively), then providers would face a clear choice: either agree to the new incentive structure or leave the state. Although the intent of gain sharing is to engender cooperation among all stakeholders, the underlying threat of having to face an organized group of payers should be a powerful motivator for provider participation and negotiation to set those incentive structures.

Ensuring successful negotiations between the states and federal government. For historical reasons including contentious debates involving accusations of inflexible federal Medicaid requirements, unrealistic baseline spending projections, and states' gaming of federal matching funds, both sides have plenty of historical reasons to mistrust each other. Although there are no guarantees of success, both sides have a substantial and common interest in restraining costs. To build a successful

federal-state relationship for cost restraint, the key is to "trust but verify." Negotiations based on trusting each other's intentions are a necessary first step that needs to be followed with verification of results. Federal savings to the states would not be distributed to the states until the results were verified. The disposition of any upfront federal or state investments in the case of failure would have to be part of the negotiated agreement. Some have proposed a penalty for states that don't achieve a national target for cost savings with Medicaid for instance.[15] That approach is based on a winners and losers approach to federal-state relations while our approach is based on finding win-win situations, which require negotiated agreements. Settling on the terms for success or failure will thus be the most critical step in determining the ultimate outcome of the partnership, but negative financial consequences from failure to reach agreed-upon goals, i.e., accountability, will likely be part of any sustainable agreement.

Conclusion

States can provide critical momentum towards less costly, higher quality health care for the nation. Gain sharing would expand their current efforts to save health care dollars. Instead of working with only their existing slice of health care spending, we propose they be tasked with working on behalf of employers,

consumers, and federal programs all at once. The combined leverage from multiple payers has the potential to capture at least some if not most of the savings identified in studies of unproductive health care spending. The experience of states would also inform national action to achieve health care cost savings.

---

[1]. All-Payer Claims Databases. National Conference of State Legislatures (Washington, DC). 2013. May. Available from: http://www.ncsl.org/research/health/collecting-health-data-all-payer-claims-database.aspx.

[2] Weil, Alan, Promoting Cooperative Federalism Through State Shared Savings, Health Aff (Millwood). 2013: 32 (8):1493–1500.

[3] Ketcham JD, Furukawa MF. **Hospital-physician gainsharing in cardiology.** Health Aff (Millwood). 2008; 27(3):803-812.

[4] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. State Innovation Models Initiative [Internet]. [cited 2012 Sept 12]. Available from: http://www.innovations.cms.gov/initiatives/state-innovations/index.html .

[5] Mark, M, Saunders R, Stuckhardt L, McGinnis JM, editors. Institute of Medicine. **Best Care at Lower Cost: The Path to Continuously Learning Health Care in America** [Internet]. Washington (DC); National Academies Press. Prepublication copy. 2012. p. 3-10. Available at: http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx.

[6] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary. **NHE Projections: 2011-2021** [Internet]. Baltimore (MD): CMS; 2011 Jan [cited 2012 Sept 12]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

[7] The Moran Company, **Assessing the potential budgetary effects of health benefits shared savings programs for states.** Arlington (VA). 2011 January. 6 p.

[8] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary. **Health Expenditures by State of Residence, 1991-2009** [Internet]. Baltimore (MD): CMS; 2011 Jan [cited 2012 Sept 13] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-

Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html.

[9] Henry J. Aaron and Stuart M. Butler. **How federalism could spur bipartisan action on the uninsured.** Health Aff (Millwood). 2004 Mar 31.

[10] [same as endnote 1-Weil]

[11] [same as endnote 3-IOM]

[12] [Same as endnote 5-The Moran Co.]

[13] Barbara Wirth and Mary Takach. State Strategies to Avoid Antitrust Concerns in Multipayer Medical. Commonwealth Fund (New York). 2013 July. 7 p. Available from: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/Jul/1694_Wirth_state_strategies_avoid_antitrust_ib.pdf.

Home Initiatives

[14] Jason Buxbaum and Mary Takach, State Multi-Payer Medical Home Initiatives and Medicare's Advanced Primary Care Demonstration. National academy for State Health Policy (Washington, DC). 2010. February. 8 p.

[15] Mark McClellan. Moving Forward On Medicaid Reform: Shared Savings In Medicaid, And How To Do It, Health Aff (Millwood). 2013. Sept. 5. Available at: http://healthaffairs.org/blog/2013/09/05/moving-forward-on-medicaid-reform-shared-savings-in-medicaid-and-how-to-do-it/.