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US Health Care System Performance & History and Overview of the Green Mountain Care Board

Jessica Holmes, GMCB Board member

Robin Lunge, GMCB Board member

April 12, 2023

The health care sector differs from other markets

- And its uniqueness may justify the extent of government oversight through laws and regulation:
  - Uncertainty
  - Asymmetric Information (i.e., one party has more information than another in a transaction)
  - Presence of Third-Party Payers
  - Externalities
  - Lack of competition

The uniqueness of the Health Care sector

- Most markets have a few common features

  - Most transactions involve only a buyer and a seller.
  - Sellers can freely enter and exit a marketplace
  - Buyers have full information about the quality of the product/service and the price they will pay.
  - Buyers pay sellers directly for the goods/services being exchanged.
  - Market prices help coordinate the decisions of market participants and lead to efficient outcomes.

Is the Health Care sector unique?

In the Health Care sector…

1. Most transactions involve only a buyer and a seller. NO!
   Presence of third parties in transactions—insurers and the government play a significant role in determining health care decisions.

2. Sellers can freely enter and exit a marketplace. NO!
   Provider Licensing, CON laws, High Fixed Costs create barriers to entry.

3. Buyers have full information about the quality of the product/service and the price they will pay. NO!
   Patients often don't know what they need and cannot evaluate the quality of their treatment. They often lack full information on quality and price.

Is the Health Care sector unique?

In the Health Care sector…

4. Buyers pay sellers directly for the goods/services being exchanged. NO!
   Health care providers are most often paid by third parties (private or government health insurance)…after the transaction has occurred.

5. Free market prices coordinate the decisions of market participants and lead to efficient outcomes. NO!
   The access and payment rules established by insurance companies and government payers largely determine the allocation of resources, and the resulting allocation may not be the most efficient.

Taking the pulse of the US Health Care system

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- Economists assessing the overall performance of a health care system focus on three key components (“Triple Aim”)
  - Access
  - Cost
  - Quality

Access: What % of the population has access to health care?

Access to the health care system is tied to access to health insurance.

> *"Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected."* ***Key Facts about the Uninsured Population, Kaiser Family Foundation.***

Access: The importance of health insurance

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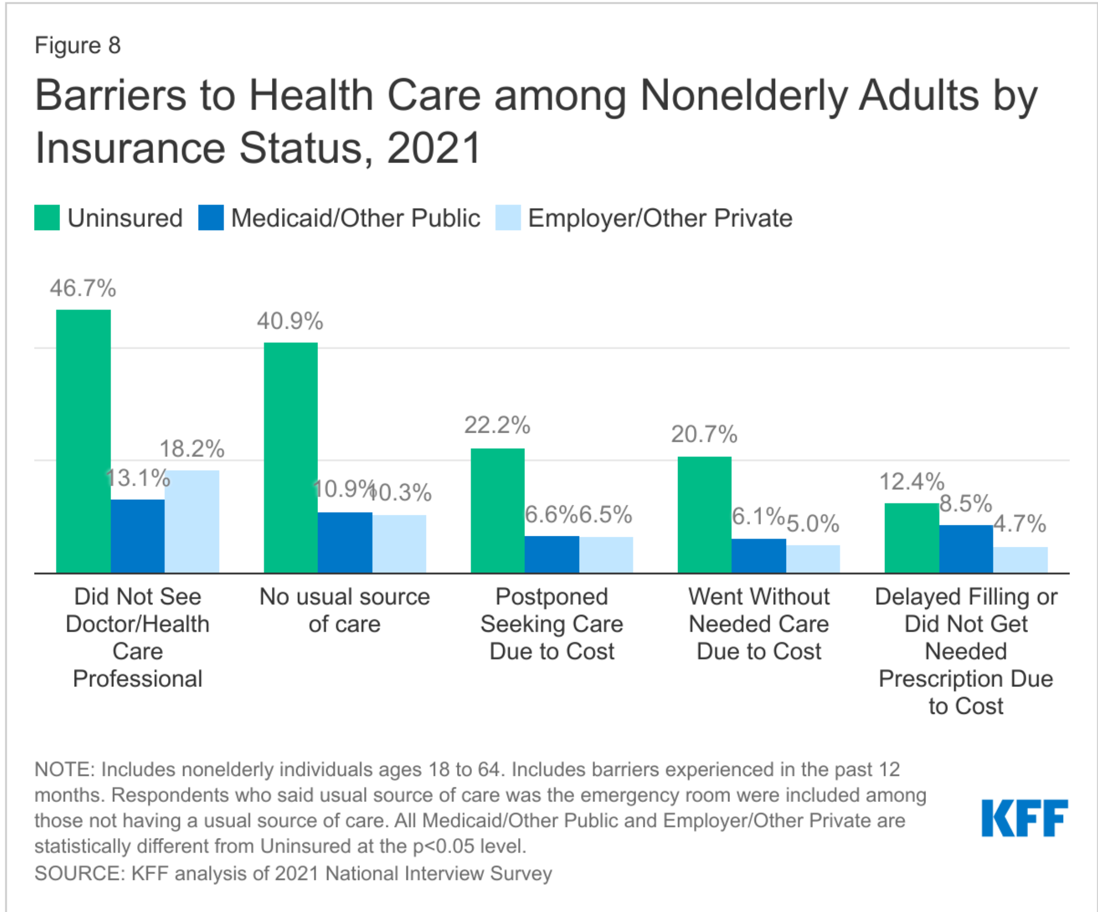

Access: The impact of the Affordable Care Act (2010)

- Landmark legislation whose primary focus was increasing access to health insurance. How?
  - Imposed an Individual and Employer Mandate
  - Provided Funding for Medicaid expansion
  - Limited the ability of insurance companies to deny coverage to consumers with pre-existing conditions; eliminated lifetime caps
  - Imposed limits on what insurance companies could charge for smokers, older people, etc.
  - Allowed young people to stay on family coverage until age 26
  - Introduced premium tax credits and cost-sharing subsidies for those who purchase insurance on the Exchange

Access: The impact of the 2010 Affordable Care Act

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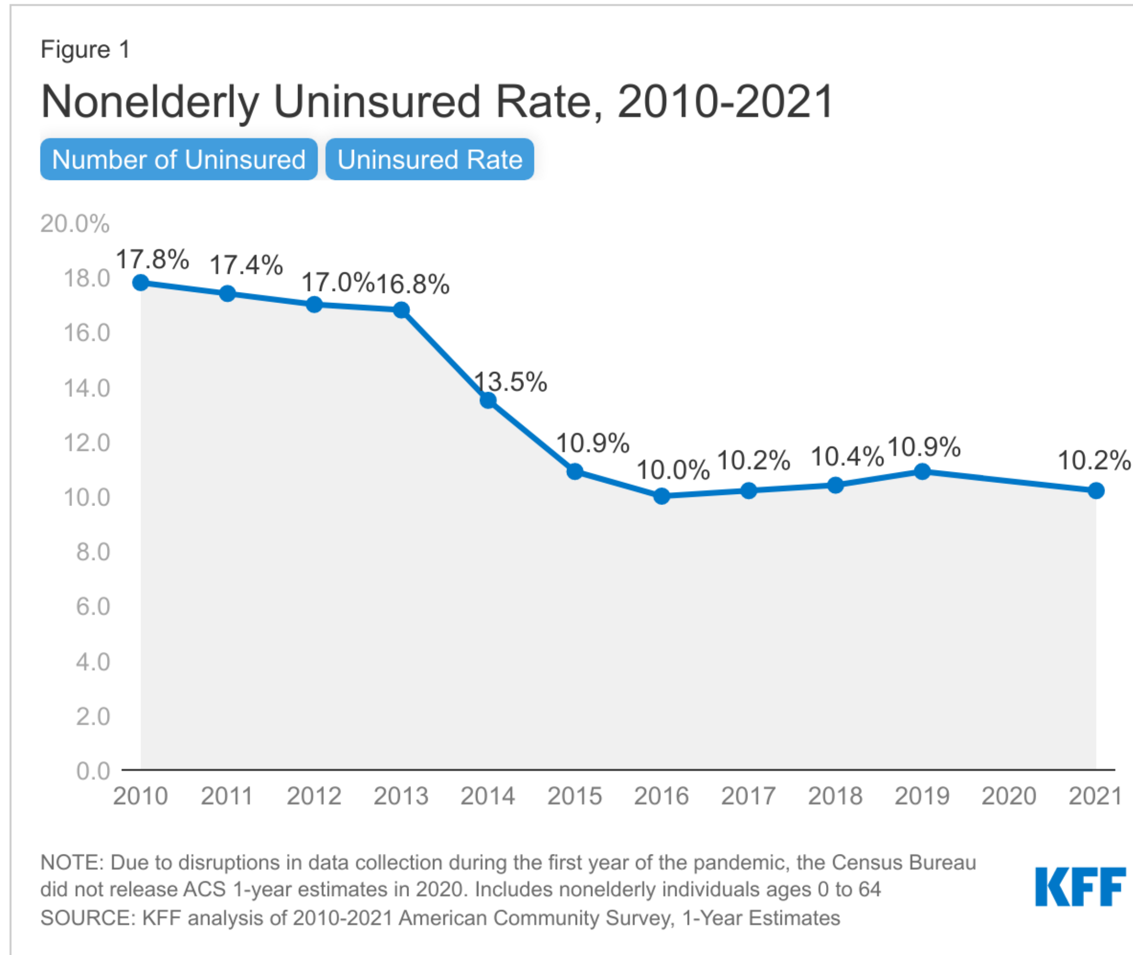
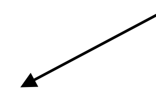


Most ACA Provisions took full effect by 2014



Access: Health Insurance access varies by state

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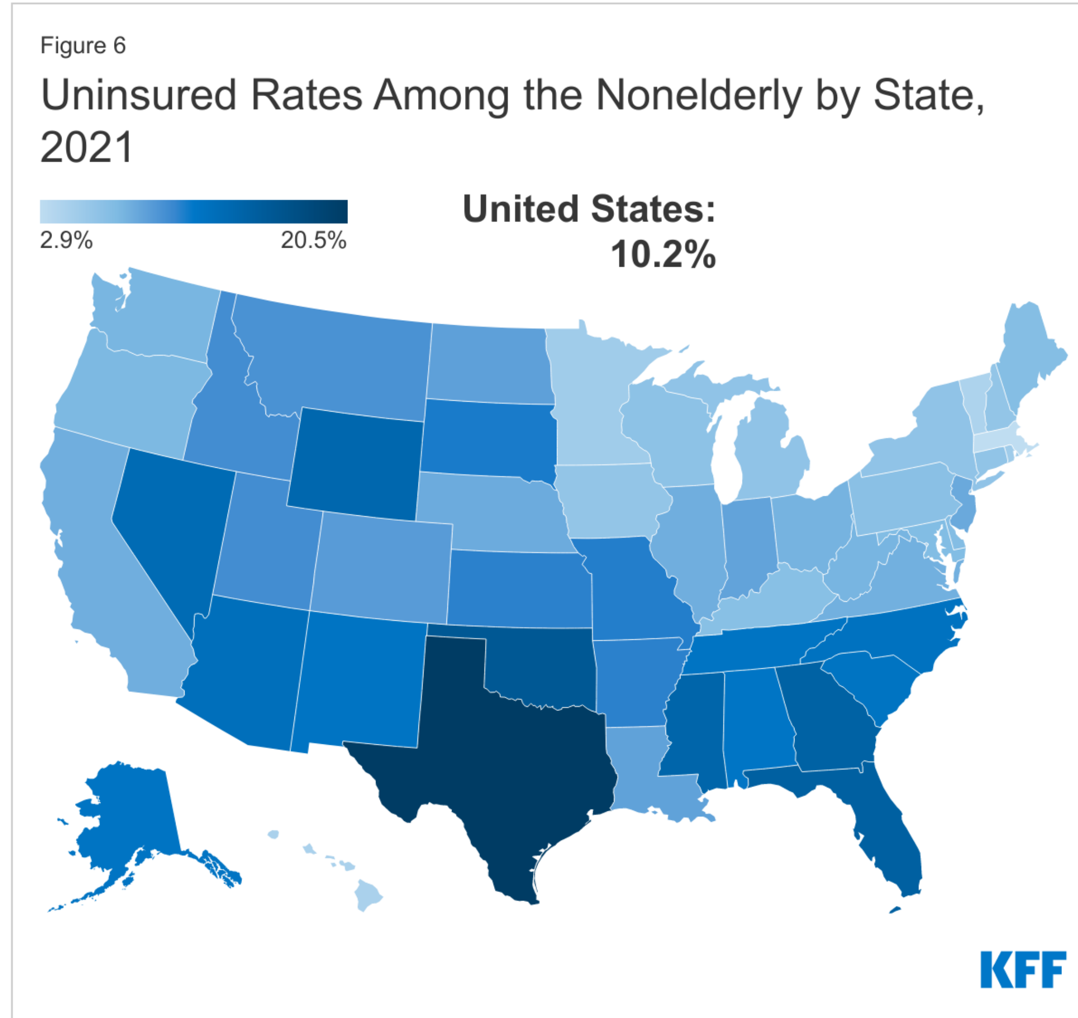

Access: Main Take-aways

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- Health Insurance is the ticket into the health care system.
- Uninsured people often postpone health care or forgo it altogether. This can lead to poor outcomes for those with preventable conditions and chronic diseases.
- The Affordable Care Act made huge strides in reducing the numbers of uninsured but there are still more than 27 million Americans without health insurance.
- Safety net providers, including hospitals, community health centers, rural health centers, FQHCs and free clinics provide care to many people without health coverage.

Costs: Growth in per capita health care spending over time

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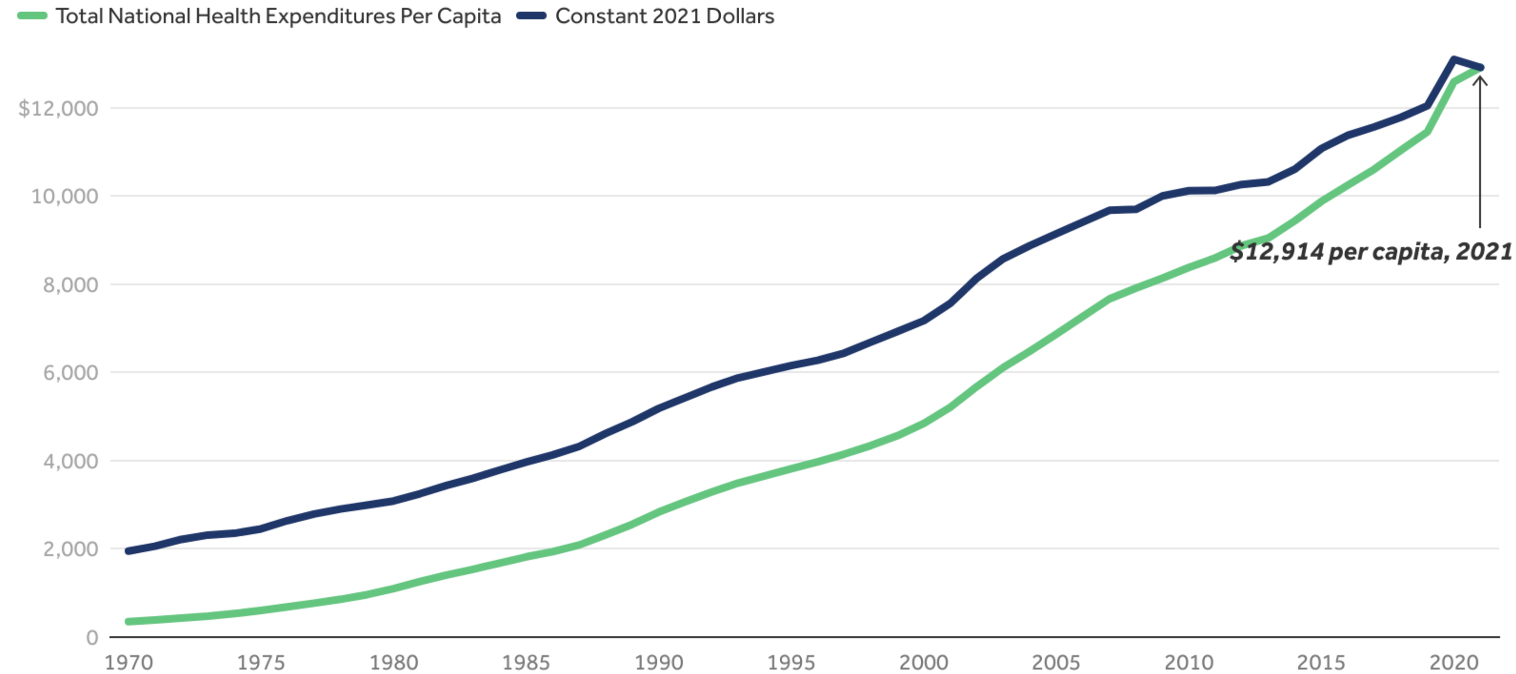

Costs: Cross-country comparison of expenditures per capita

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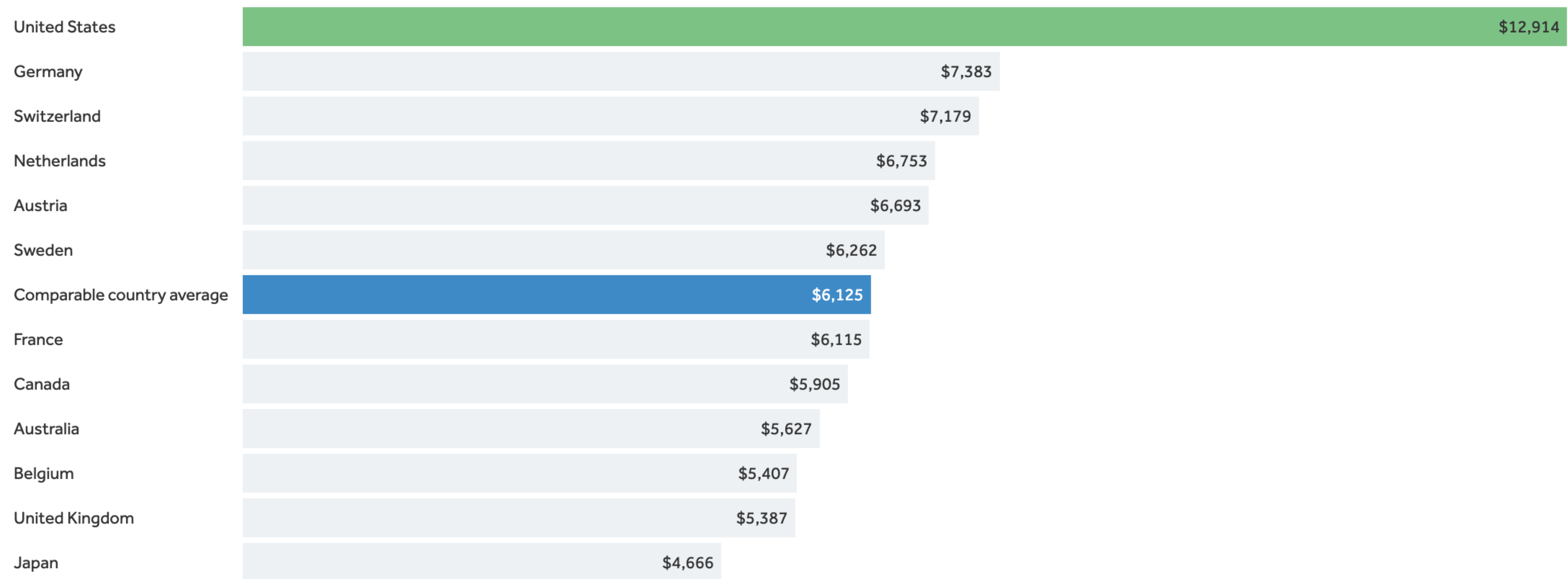

Costs: Health Expenditures as a share of US GDP over time

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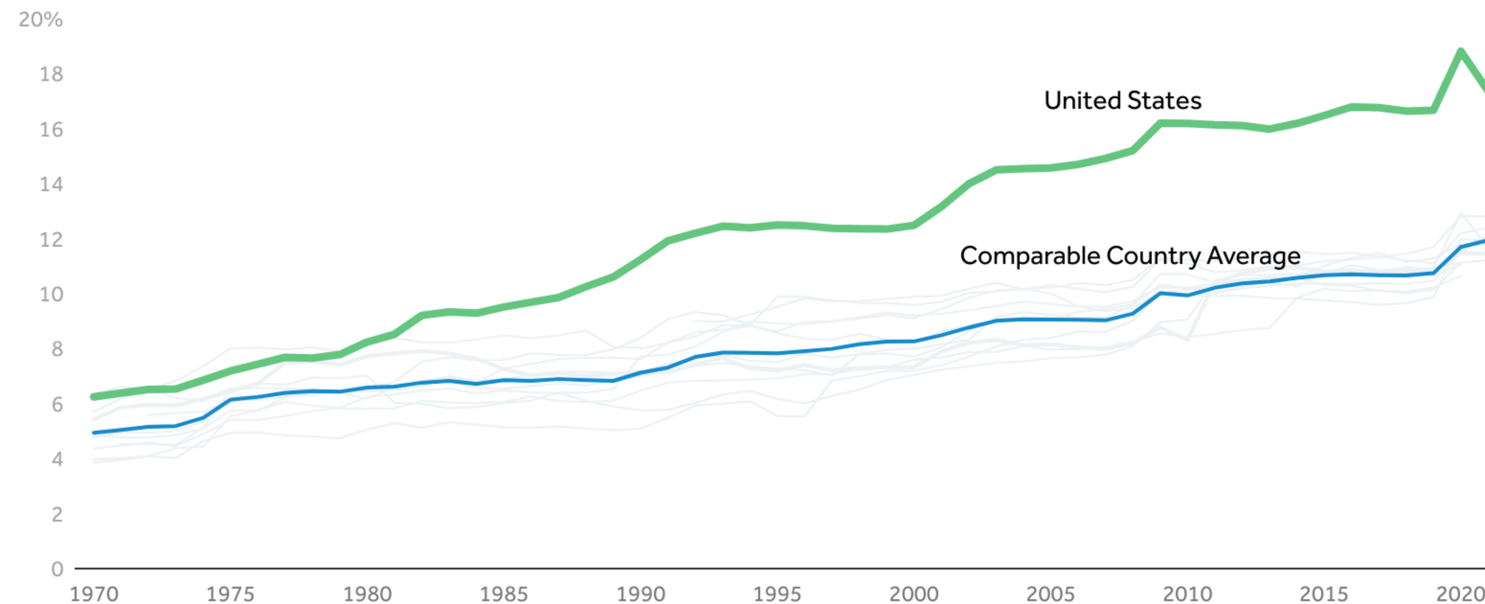

Notes: U.S. values obtained from National Health Expenditure data. Health consumption does not include investments in structures, equipment, or research. 2021 data not yet available for Australia, Belgium, Japan or Switzerland. Provisional 2021 data for Austria, Germany, Netherlands, Sweden, France, United States and the United Kingdom. Provisional 2020 data for Sweden, Japan, Australia and Canada. Difference in methodology for Canada in 2020 and 2021.

Source: KFF analysis of OECD and National Health Expenditure (NHE) data

Peterson-KFF
Health System Tracker

Costs: Main Take-aways

- We spend more per capita for health care than any other country in the world.
- Our health care expenditures are growing faster than the economy which means health care is taking up more and more of our household, state and federal budgets.
- The gap in expenditure growth between the US and other countries has grown over time.

Costs: What is driving up health care spending?

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- Growth of third-party payers (people shielded from true cost of care demand more care – "moral hazard")
  - Fee for service reimbursement system (incentivizes volume not value)
- Technological growth
- More specialization
- Consolidation
- Aging of population

Quality: We are spending more…are we getting more?

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- Not so much…..

Quality: We are spending more...are we getting more?

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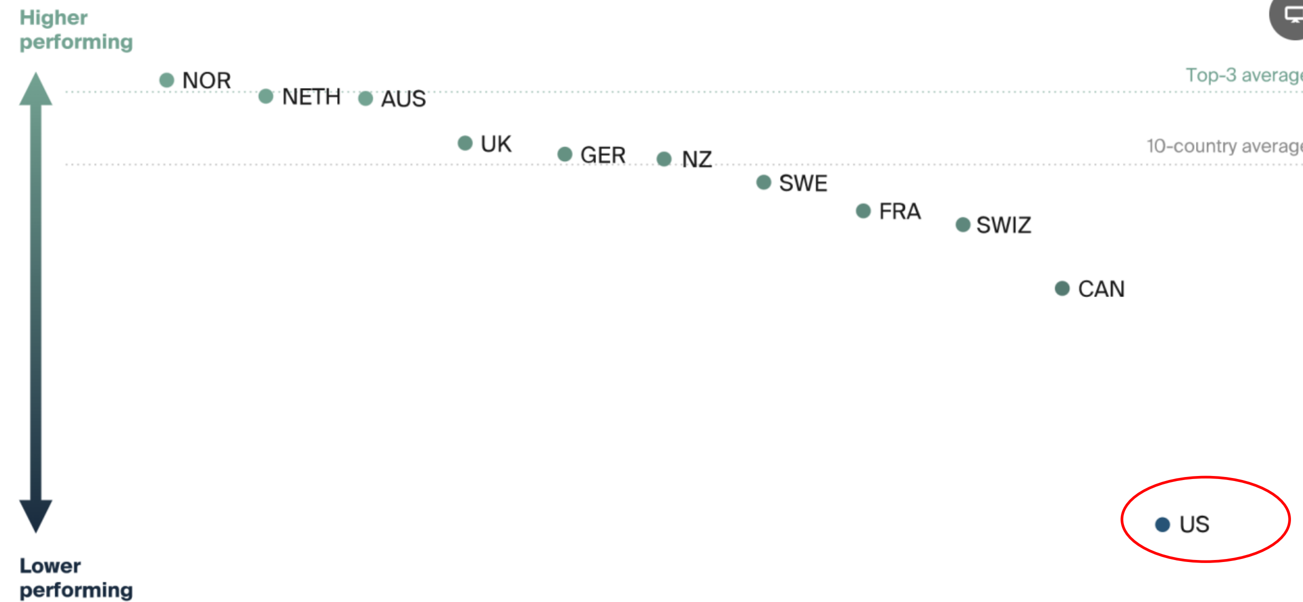

Quality: We are spending more...are we getting more?

- The US performs poorly on basic health measures such as child and infant mortality and life expectancy at birth.
  - From 2001-2010, the risk of death in the US was 76% greater for infants and 57% greater for children than the average across 20 high income nations. Thakrar et al.(2018) *Health Affairs*
  - In 2016, the US ranked last in life expectancy at birth among 18 high income countries. The gap between the highest performer and the US was almost 6 years for women and 5 years for men. Ho (2018) *British Medical Journal*
  - In 2018, there were 17 maternal deaths for every 100,000 live births in the U.S. — a ratio more than double that of most other high-income countries (e.g., the ratio was three or fewer per 100,000 in the Netherlands, Norway, and New Zealand). *Commonwealth Fund Report* (2020).

Quality: We are spending more…are we getting more?

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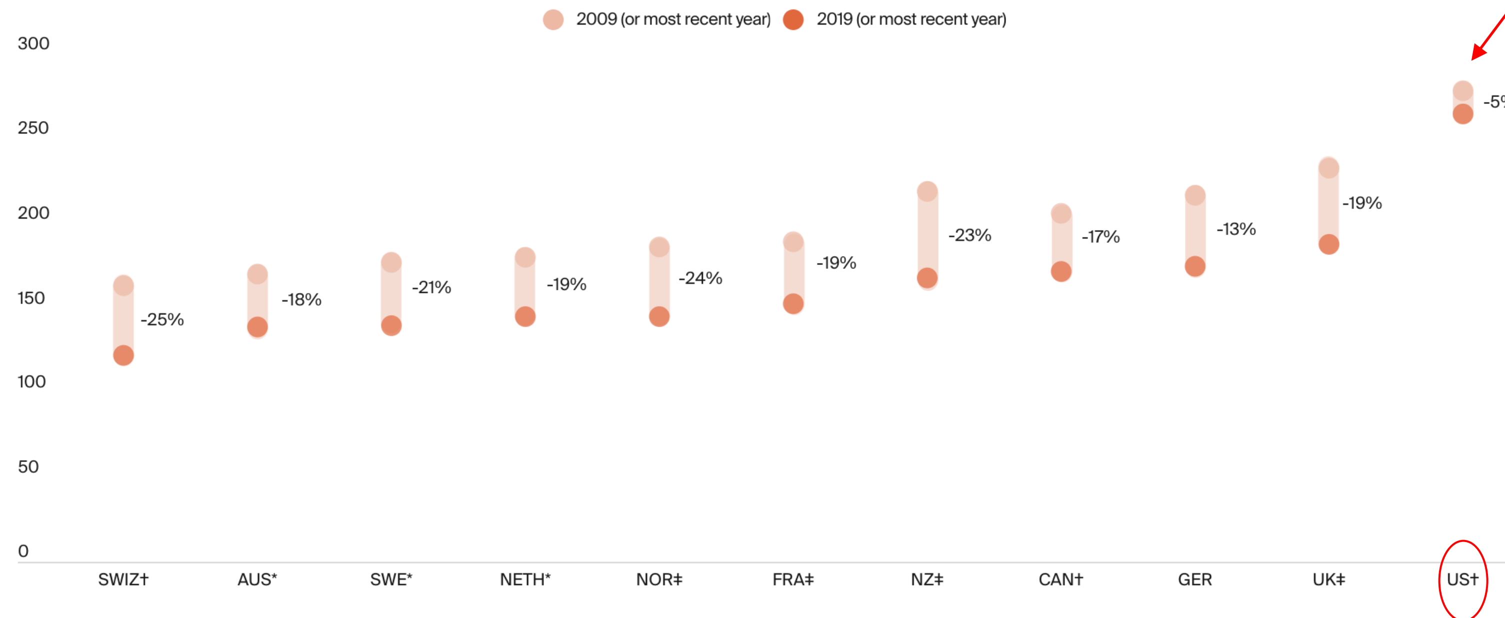

Quality: We are spending more…are we getting more?

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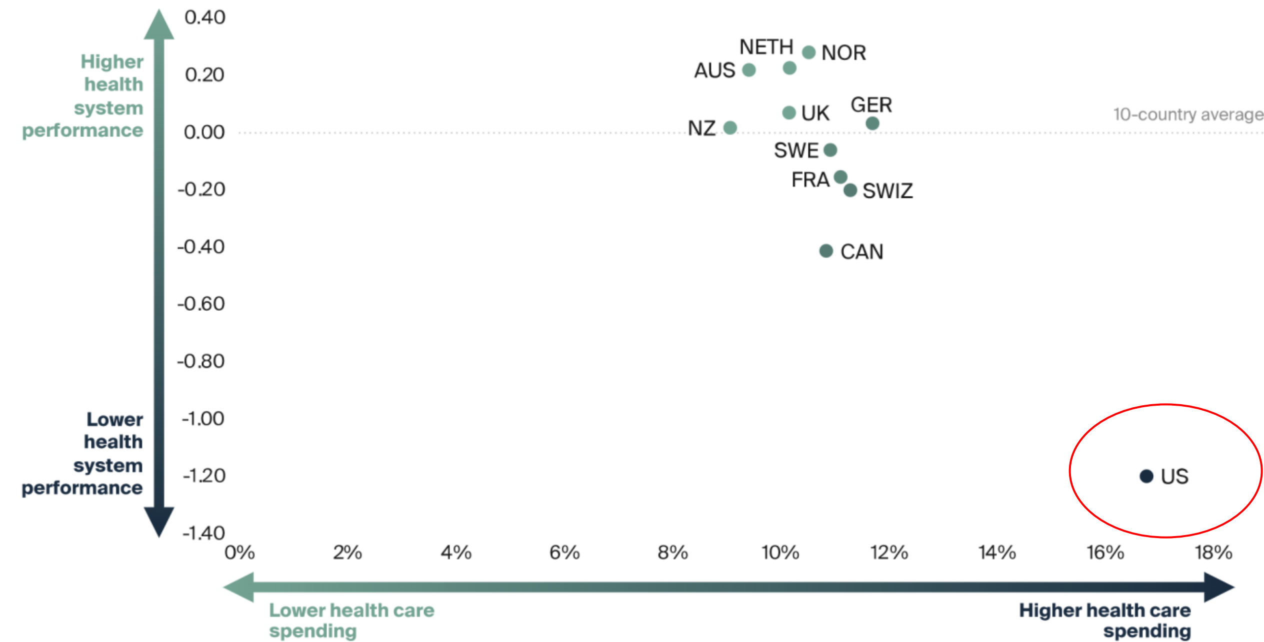

Note: Health care spending as a percent of GDP. Performance scores are based on standard deviation calculated from the 10-country average that excludes the US. See How We Conducted This Study for more detail.

Data: Spending data are from OECD for the year 2019 (updated in July 2021).

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 – Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/01DV-H208

Understanding the Social Determinants of Health

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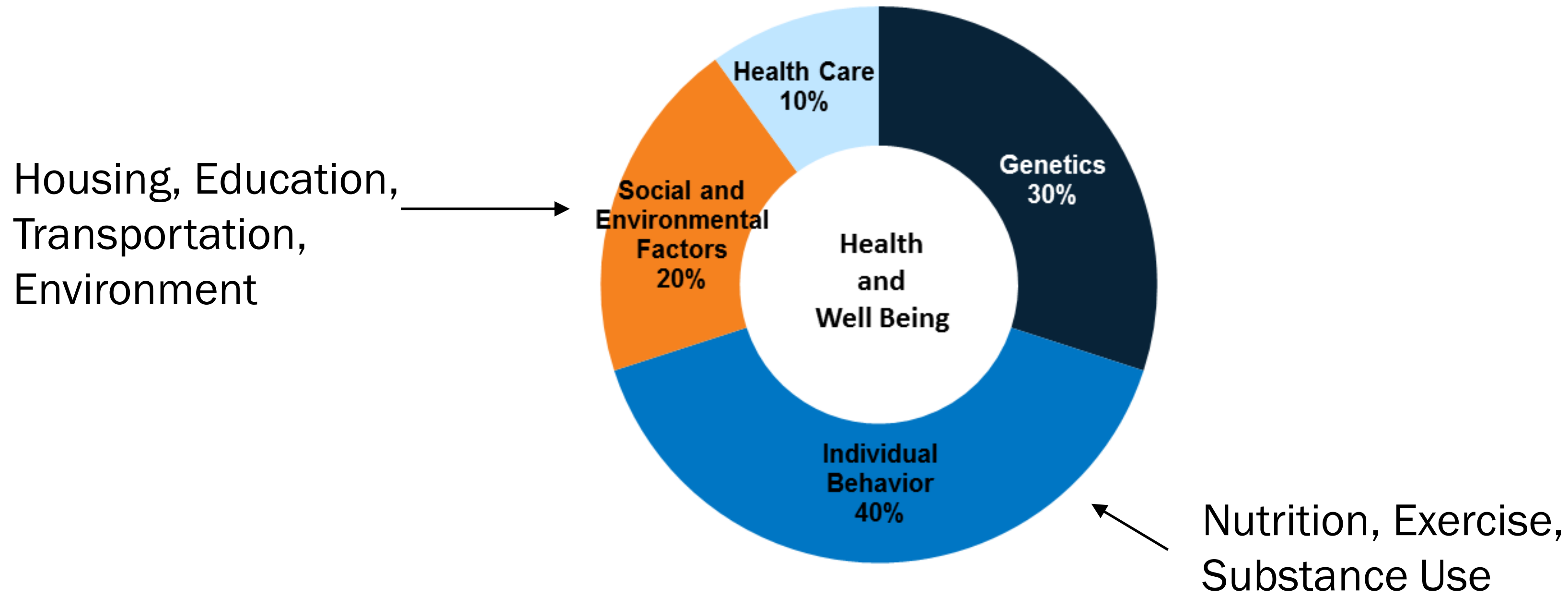
Figure 2

Impact of Different Factors on Risk of Premature Death



SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

KFF
HENRY J KAISER FAMILY FOUNDATION

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Regulation and the History of GMCB

Purposes of Government Policy & Regulation

- Access Examples
  - public coverage programs for the low-income, elderly and children (AHS)
  - support to buy private insurance coverage for the middle income (AHS)

- Cost Containment Examples
  - limit costly duplication of services through Certificates of Need (GMCB)
  - regulate hospital budgets (GMCB)
  - increase competition or reduce monopoly power through antitrust laws (US DOJ/FTC; Vermont AG)

- Consumer Experience/Quality
  - "health and safety" by limits on supply of professionals through licensing (Sec of State; VDH)
  - quality reporting by providers (various fed agencies; VDH)

Policy can be created by each branch

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- Legislative Branch
  - Laws & Oversight (hearings, briefings)
  - Appropriations/Money
  - House/Senate

- Executive Branch
  - Executive Orders, Regulations/statutory interpretations
  - Budget proposals, Waivers
    - President/Governor; agencies

- Judicial Branch
    - Legal decisions and opinions
    - Court systems

Federal and State Roles in Health Policy & Regulation

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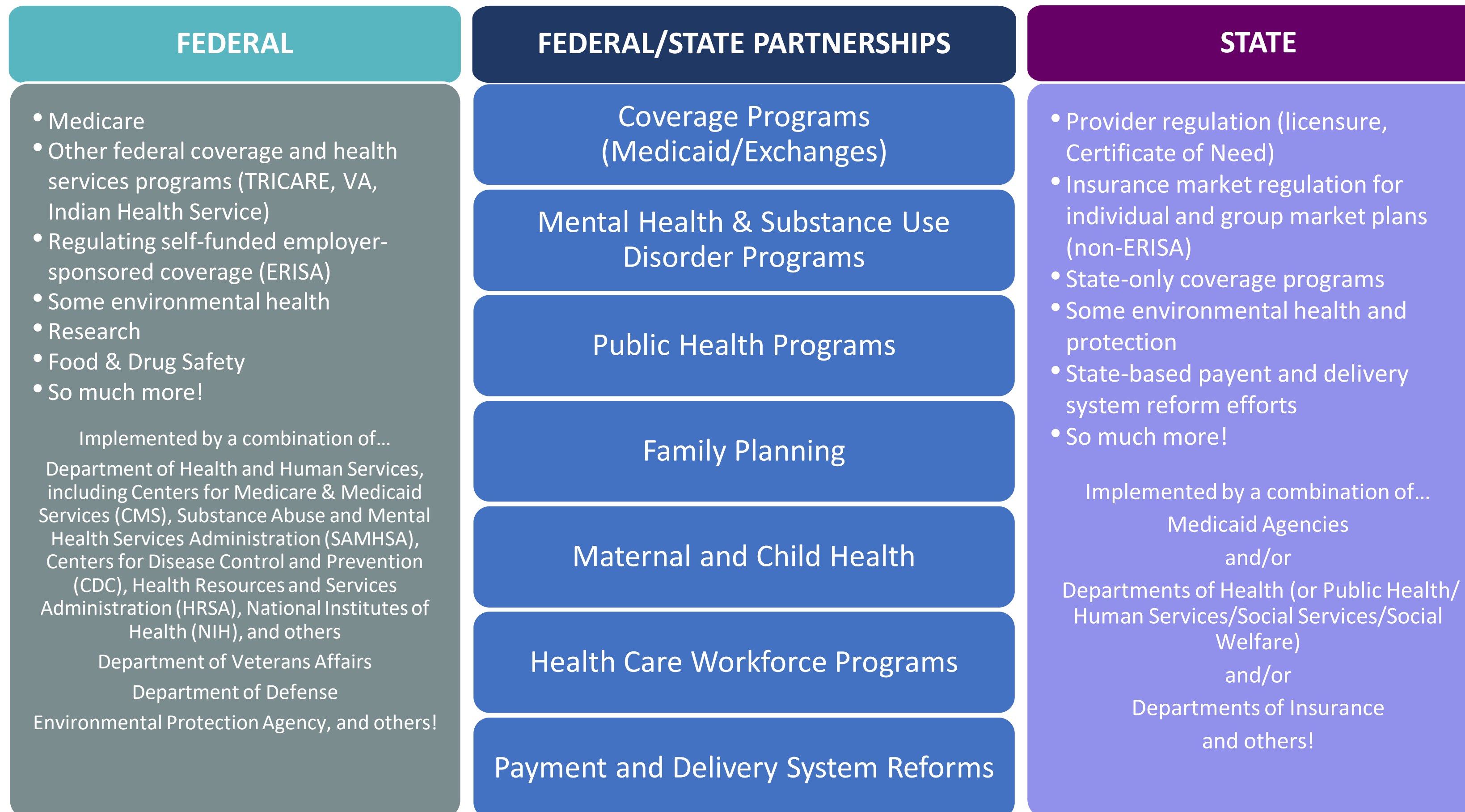

The Commonwealth Fund
A Century of Advancing Health Care for All

NEWSROOM TO THE POINT LOG IN SEARCH

Affordable, quality health care. For everyone.

Federalism in Health Care: Identi
for Federal and State Partners

August 6, 2014 | Mike Stanek

ment collectively manage billions of dollars through
c employee benefit programs. Yet to bring about
ate and federal policymakers will need to
ore effectively. With the support of The
tional Academy for State Health Policy (NASHP)
h-level federal and state officials between May 2013
how to align their key policy goals.

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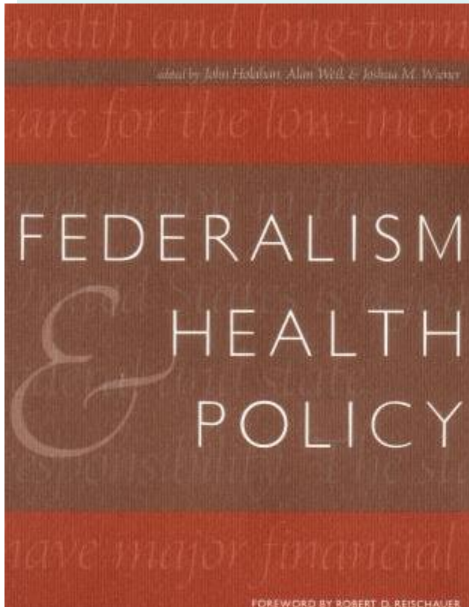
have all taken advantage of an Agency for



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Stanford Law Review

Volume 70 June 2018

ARTICLE

What Is Federalism in Healthcare For?

Abbe R. Gluck & Nicole Huberfeld*

Abstract. The Affordable Care Act (ACA) offers a window into modern American
dern American nationalism—in action. The ACA's federalism is
tion between state and federal, but rather by a national structure that
ementation. As it turns out, that structure was only a starting point
namic and adaptive implementation process that has generated new
ments. States move back and forth between different structural
federal government; internal state politics produce different state
compete, and cooperate with each other; and negotiation with federal
r constant. These characteristics have endured through the change in
presidential administration.

This Article presents the results of a study that tracked the details of the ACA's federalism-related implementation from 2012 to 2017. Among the questions that motivated the

HealthAffairs

HEALTH AFFAIRS > VOL. 24, NO. 6: RETHINKING HEALTH REFORM

Federalism And Health Policy

Richard P. Nathan

Federalism in Health Policy: Dual sovereignty, with power shared by federal and state governments

Who is who in Vermont Health Law & Regulation?

- Legislative Branch
  - Senate Health & Welfare; Finance; Appropriations
  - House Health Care; Human Services; Appropriations

- Executive Branch
  - Reports to the Governor
    - Agency of Human Services
    - Dept of Vermont Health Access (Medicaid)
    - Vermont Dept of Health
    - Dept of Disabilities, Aging, & Independent Living
    - Department of Financial Regulation
  - Independent, Public Body
    - Green Mountain Care Board

About Us
Green Mountain Care Board

- Established in 2011
- 5 Board Members
- 6-Year Staggered Terms

THE BOARD & EXECUTIVE DIRECTOR

Owen Foster, JD
GMCB Chair

Jessica Holmes, PhD
GMCB Member

Robin Lunge, JD, MHCDS
GMCB Member

David Murman, MD
GMCB Member

Thom Walsh,
PhD, MS, MSPT
GMCB Member

Susan Barrett, JD
GMCB Executive Director

GMCB Quick Facts

Quick Facts

- Established in 2011
- [5 Board Members]
- Appointed by the Governor to staggered, six-year terms

Vision A sustainable and equitable health care system that promotes better health outcomes for Vermonters.

Core Values Independent; Transparent; Data-Driven; Holistic; Collaborative; Accountable

Mission Drive system-wide improvements in access, affordability, and quality of health care to improve the health of Vermonters.

Regulate major areas of Vermont's health care system

Serve as a transparent source of information and analysis on health system performance

Advance innovation in health care payment and delivery

Brief History of Hospital Budget Oversight

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1992

Vermont Health Care Authority

Merged Health Policy Council, Health Data Council, and Certificate of Need Review Board

1995

Banking, Insurance, Securities, and Health Care Administration (BISCHA)

Established authority to limit hospital budgets

2011

Green Mountain Care Board

BISHCA renamed to Dept of Financial Regulation

GMCB Regulatory Processes

- Hospital Budget Review (evolving)
- Accountable Care Organization Oversight
- Provider Rate Setting (currently only implemented as part of Hospital Budget Review)
- VTAPM-Related Regulatory Duties (Medicare ACO benchmark)
- Health Insurance Premium Rate Review (and related insurance regulatory duties)
- Certificate of Need
- Review and approve state HIT Plan, Workforce Strategic Plan
- Data: Steward Vermont's APCD and hospital discharge dataset

GMCB Regulation - Scope

- GMCB regulatory decisions impact areas the GMCB does not directly regulate

Financial Scope

- $3.3B in system wide hospital net patient revenue* (FY23)
- ~$700M in health insurance premiums (FY23)
- $49.3M in approved CON applications
- Over $1B in Total Cost of Care managed by ACOs (FY22)

*Net patient revenue includes fixed prospective payments