VERMONT'S AFFORDABILITY CRISIS

LOW ROAD? HIGH ROAD?

Elliott Fisher, MD, MPH
Professor of Health Policy, Medicine and Community and Family Medicine
The Dartmouth Institute

The Gist of the Argument

A crisis of affordability and access.

The largest driver? Vermont hospital inefficiency, made worse by primary care crisis

→ potential savings of $150m in near term, 25% or more in longer term

→ better access to primary, inpatient and specialty care

To make progress, we need to address the deeper causes

The Balloon Problem
Market Failure

Strong, effective and
aligned state agencies

Competition where possible
Regulation where necessary
Getting the incentives right

Vermont is well-positioned to be a national model

Vermont's Health Care Affordability Crisis

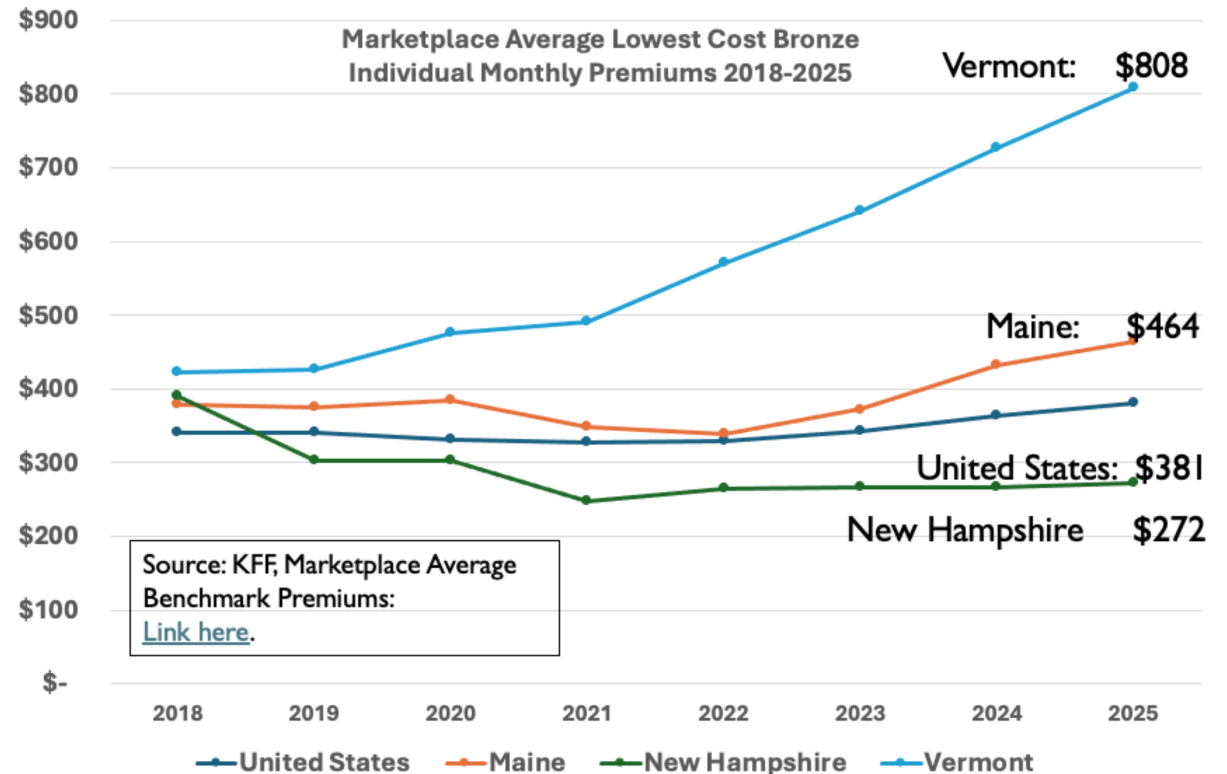
Public Comments: Act 167

"Vermonters are tapped out. Being a single dad of 3, I can't afford this"

"Vermont has made it nearly impossible for small business to do business here... Now the cost of business is too high to stay here."

"As a small nonprofit employer….continuing increases are simply not sustainable for our institutional budgets, for our staff, or for our ability to continue to operate with staff here in Vermont"

"We are on a unsustainable path and it's going to lead to all young people in Vermont to consider moving out of state, strictly due to the health care cost."



Access: Hospital Sustainabilty

Four of Vermont's 13 rural hospitals are at risk

National analysis reported:

Of 13 Vermont rural hospitals

5 – not at risk

4 – at modest risk

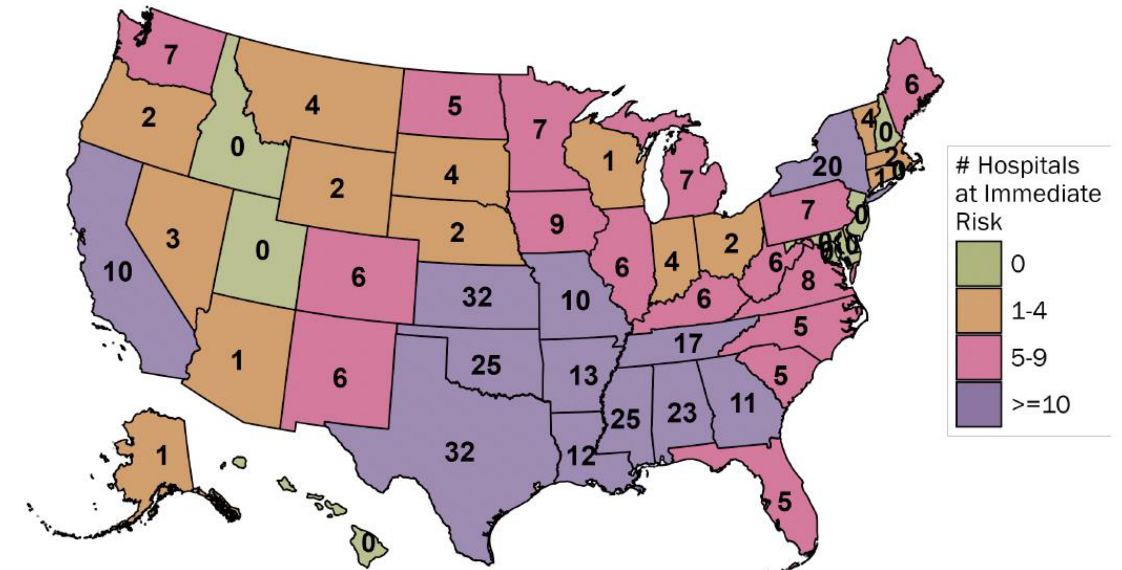
4 – at high risk of closure

Act 167 Report recommended closing inpatient units at 4 hospitals

Hospitals report runs into furor over 'major restructuring' recommendations

Peter D'Auria, Mountain Times, 11-6-2024

Rural Hospitals at *Immediate* Risk of Closing



RURAL HOSPITALS AT RISK OF CLOSING

November 2024: www.RuralHospitals.org

Primary Care is in Crisis

100 million Americans lack adequate local access to primary care*

United Health Care 2019 report**

- 2/3 of 27 million commercial patient ER visits could have been treated in primary care settings
- Average cost of these ER visits: **$2032**
- Primary care cost per visit: **$167 - $193**
- Potential savings: ($1800) **$32 B**

Vermont: 84,000 ER visits***

- Assuming UHG data: **$ 100 M**

* NACHC analysis – here.
** United Health Group analysis – here
*** Julie Wasserman, VT Digger -- here

Focus Areas | News & Blogs | Publications | About Us | The Milbank Quarterly

FEBRUARY 28, 2024
REPORT

The Health of US Primary Care: 2024 Scorecard Report — No One Can See You Now

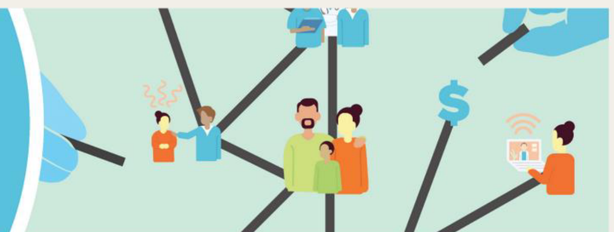
NATIONAL ACADEMIES Sciences Engineering Medicine

SEARCH

About Us | Events | Our Work | Publications | Topics | Engagement | Opportunities

Implementing High-Quality Primary Care

SHARE



The opportunity to do better

Hospitals make up over half of Vermont health care spending

Increasing commercial prices compared to peers

Excessive costs measured as percent of costs covered by Medicare payments: (100% is good, means you can break even on Medicare by keeping costs down)**

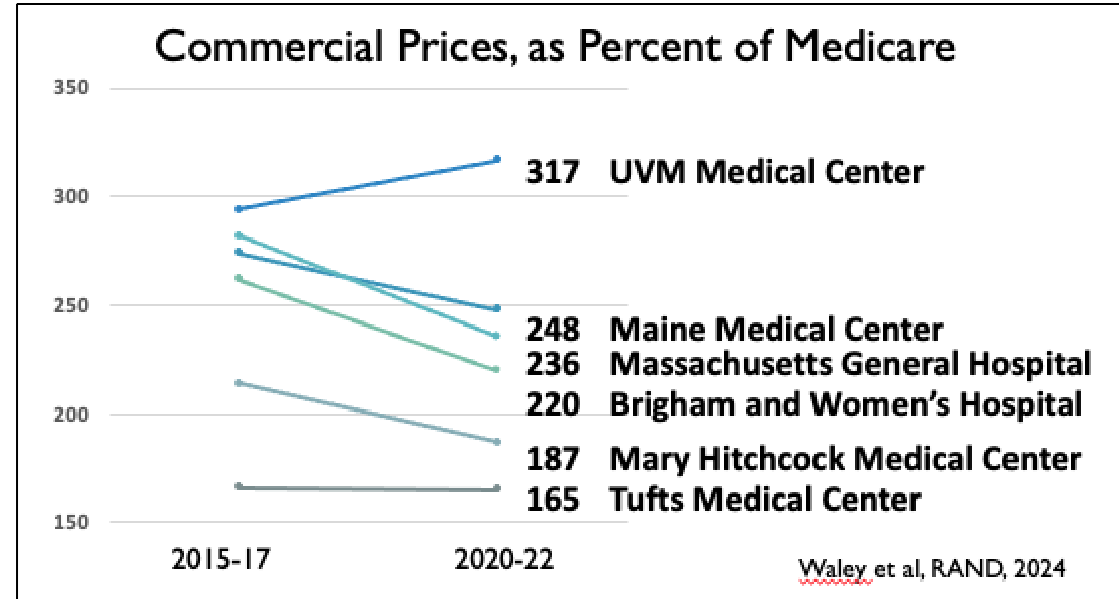
	2011	2022
Median VT non-critical access hospital	90%	73%
UVMMC	94%	72%

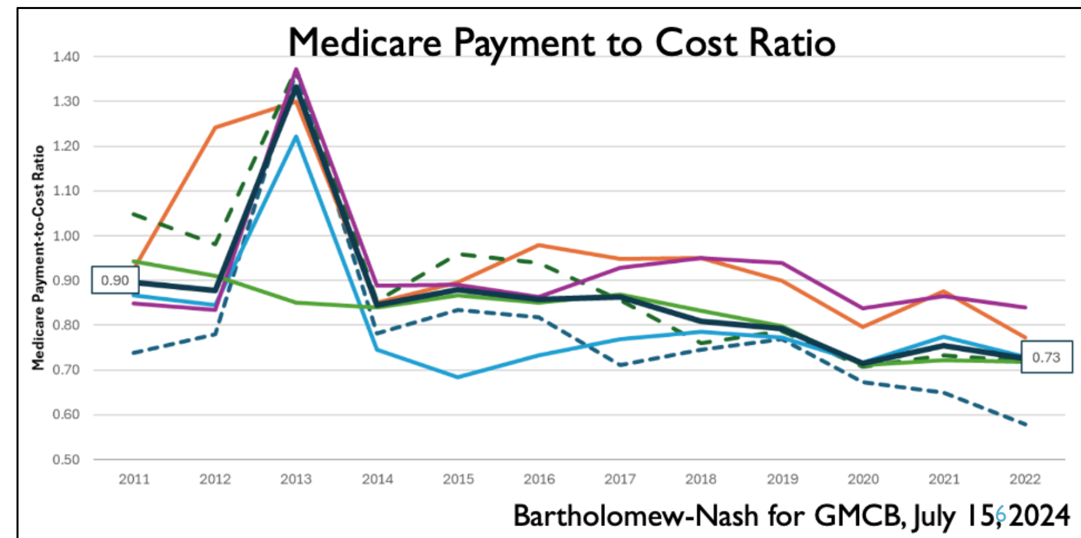
Physician productivity lower than peers***

36% of specialties in bottom quartile
79% of specialties in bottom half

Magnitude of potential savings is substantial

VHC 911 analysis*	$170m per year (UVM)”
Large savings? Perhaps:	25% to 50% in longer term



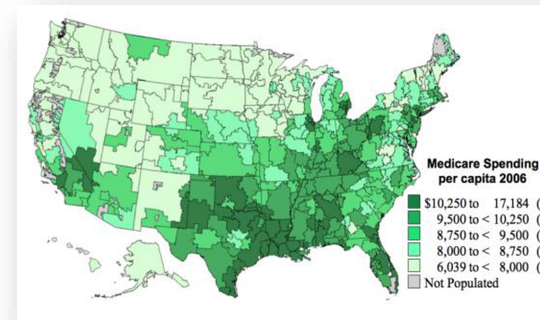


*VHC911 White Paper, Jan 29, 2025
** Nash-Bartholomew
*** GMCB budget order, 2024

The Bigger Picture

The Longer Term Opportunities are Substantial

Discretionary utilization accounts for 20+ percent of Medicare spending, with no detectable benefit from higher spending.



(1) Fisher et al. Ann Intern Med: 2003; 138: 273-298; (2)) Fisher et al. Health Affairs, Nov 16, 2005; (3) Skinner et al. Health Affairs, Feb 7, 2006; (4) Sirovich et al. Ann Intern Med: 2006; 144: 641-649; (5) Fowler et al. JAMA: 2008; 299: 2406-2412.

Pricing differences explain half of the US variation in commercial spending across the U.S. (but quantity explains the rest.

JOURNAL ARTICLE

The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*

Zack Cooper, Stuart V Craig, Martin Gaynor, John Van Reenen

The Quarterly Journal of Economics, Volume 134, Issue 1, February 2019, Pages 51–107, https://doi.org/10.1093/qje/qjy020

Payment reform can lead to dramatic improvements in health and care → savings.

A system focused on improvement can achieve dramatic impact – **James estimated 50% savings.**

The Case for Capitation

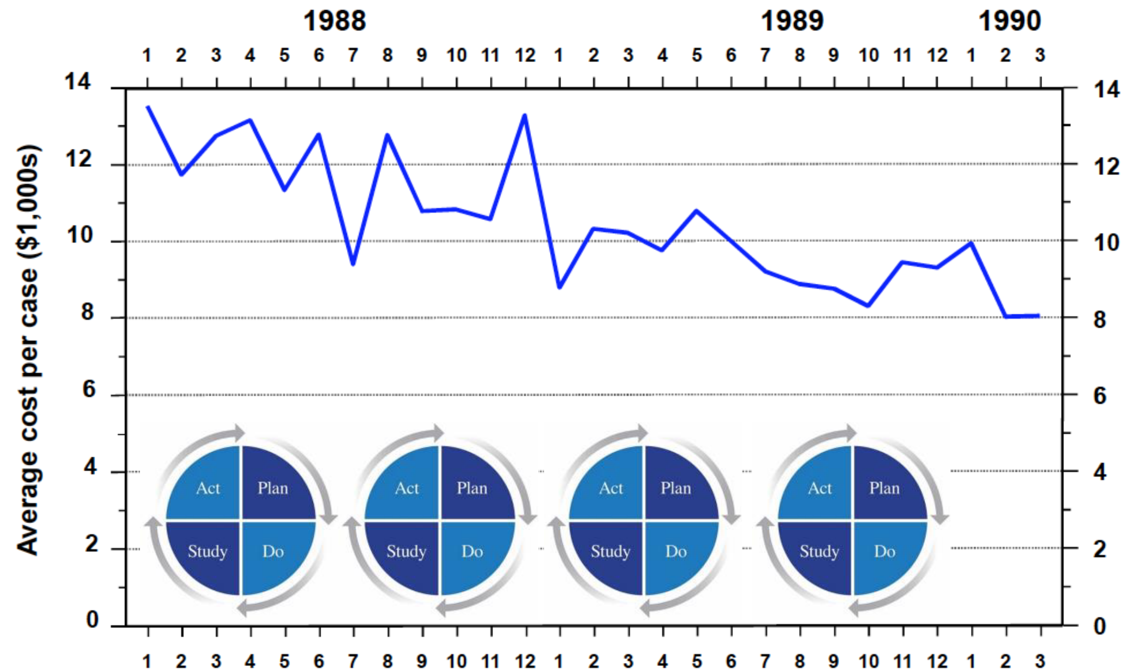
It's the only way to cut waste while improving quality.

James and Paulsen
Harvard Business Review, 2016

A Path Forward:

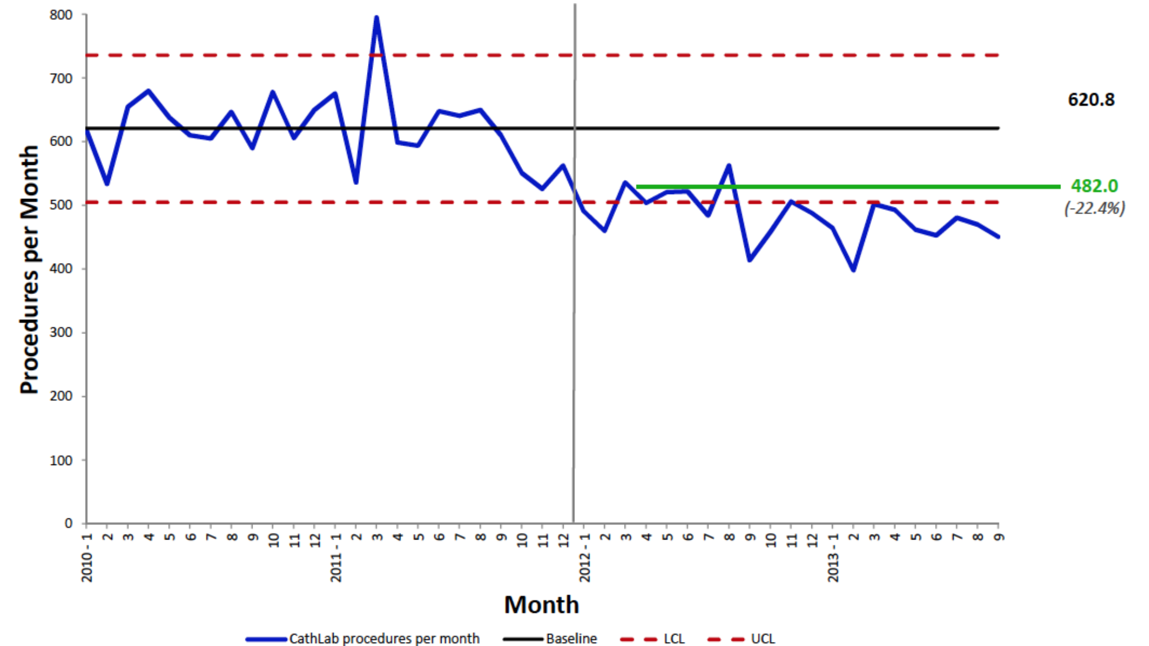
Creating a learning health system – at Intermountain's Practice Levels

Hip Replacement Cost



James, B.C. Quality Management for Health Care Delivery (monograph). Chicago, IL: Hospital Research and Educational Trust (American Hospital Association), 1989.

Cardiac Cath Lab Procedures



Used with permission from Intermountain Healthcare.
©2016 Intermountain Healthcare. All rights reserved.

A Path Forward

Creating a learning health system – at Health System Level

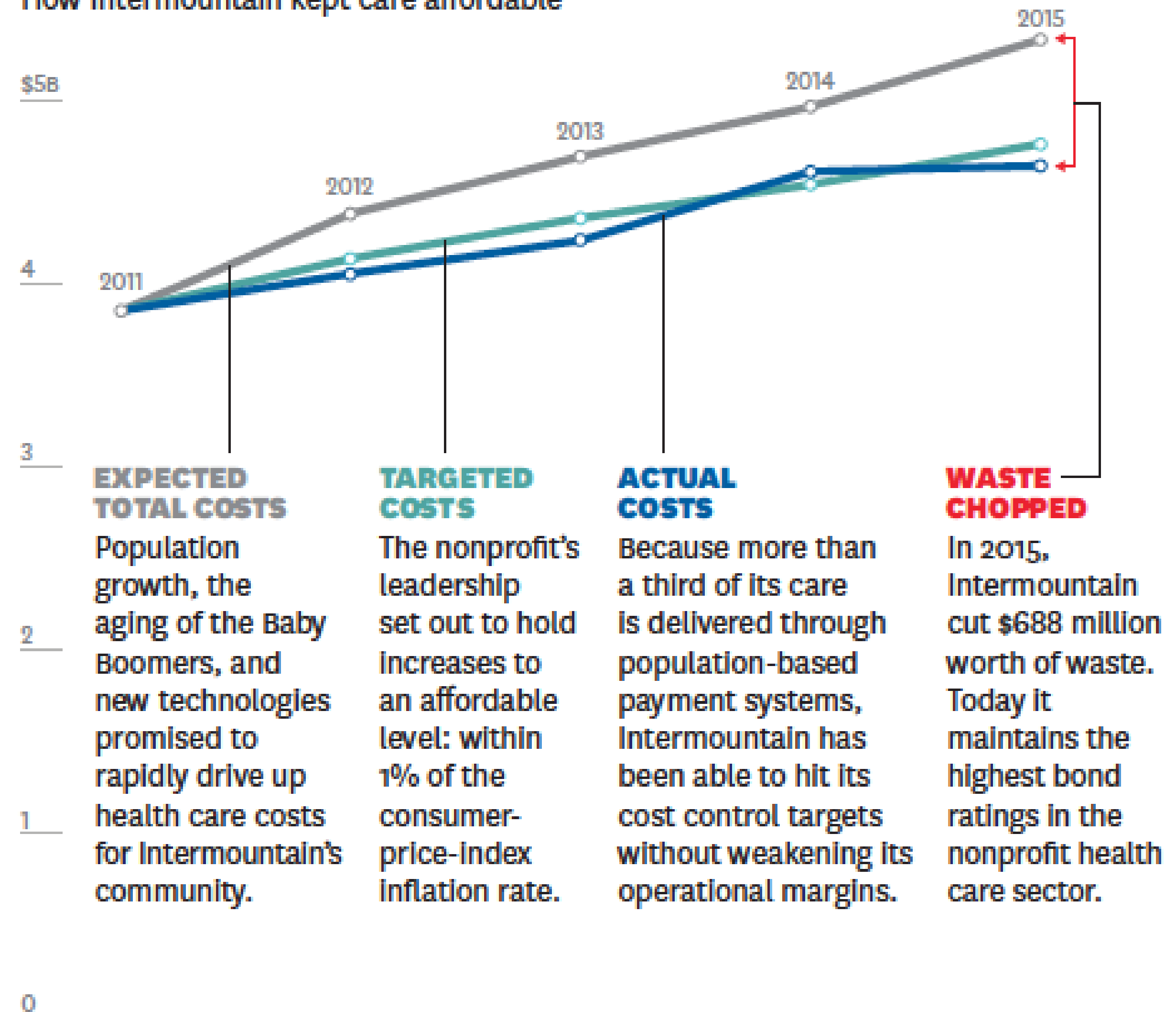
CEO Charles Sorenson established a goal of keeping care affordable: a target of CPI plus 1%.

Strategy: improve care (keep people healthy) and eliminate waste.

Key element: aligned incentives for 30% of their patient population – savings were sufficient for them to maintain margins while reducing utilization for all payers.

Achieved strongest bond-ratings in non-profit sector.

(on lower total revenues)



Why so hard at the larger system level?

Two Deeper Causes can only be addressed by Policy Makers

Market Failure

90% of US hospital markets are too consolidated to support meaningful competition

Fulton, Health Affairs, 2019

Lack of competition allows hospitals to:

(1) be inefficient,

(2) ignore quality,

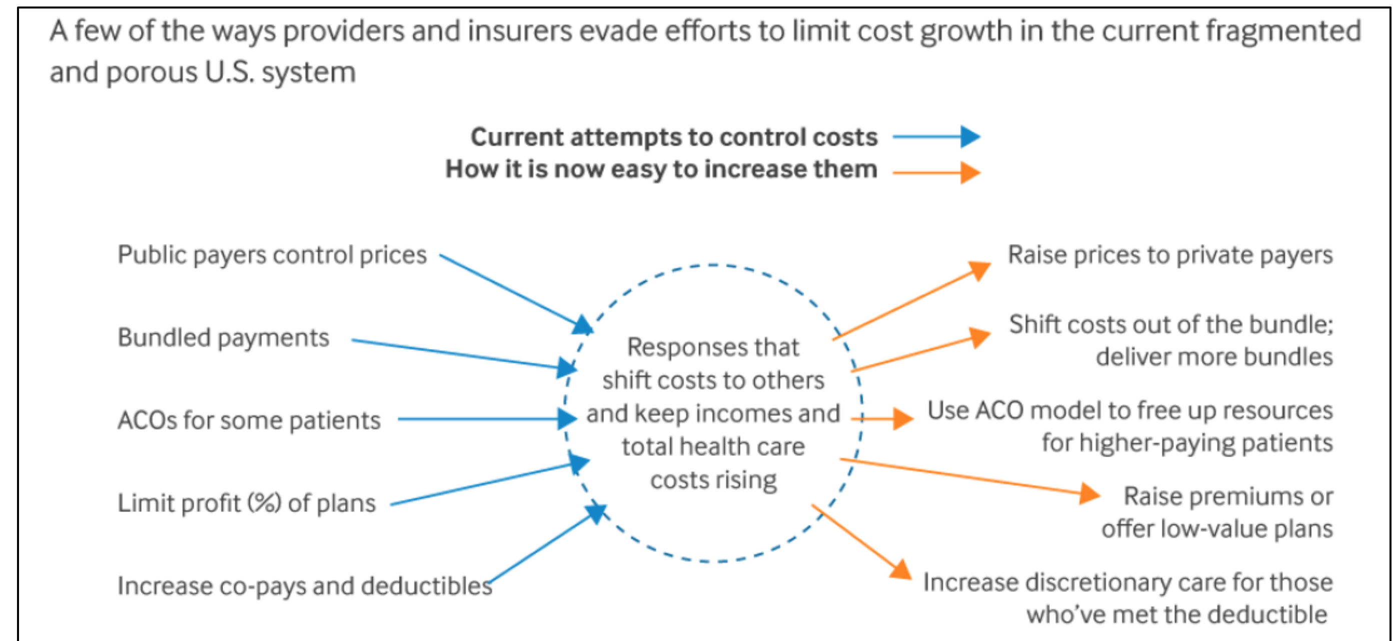
(3) raise prices.

(4) And, if non-profit, allocate resources without regard to their public mission

Gaynor, Senate Judiciary Committee, 2021

The Balloon Problem

In health care, pressure to reduce costs in one area is easily avoided by shifting costs or raising prices



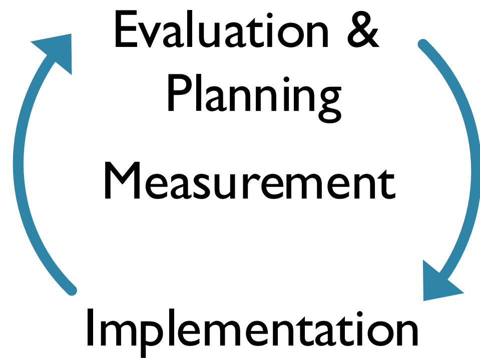
Fisher, 2020, NEJM Catalyst

How States Can Lead

Effective State Agencies charged and resourced to improve health and care

A learning system

Aim: affordable, accessible care



PERSPECTIVE ADDRESSING HEALTH CARE COST GROWTH

Addressing Health Care Cost Growth — Why and How States Should Lead

Elliott S. Fisher, M.D., M.P.H., Carrie Colla, Ph.D., Christopher F. Koller, M.P.P.M., M.A.R., and Alena Berube, M.S.

NEJM, October 25, 2024

Better data, transparent evaluation

- audited financial data from hospitals and others
- real-time quality measures – for improvement and policy.
- use data to identify drivers of poor performance;

Strengthen planning, implementation (engaging all parties)

- develop a state strategic plan
- align hospital strategic plans → system transformation
- clarify who does what: legislature, agencies, providers, payers

All-payer oversight, payment reform and regulation

- Hospital Global Budgets: enforceable, incentives to improve
- Physicians: Global payment to primary care focused organizations
- Regulatory system to manage balloon problem, market failure

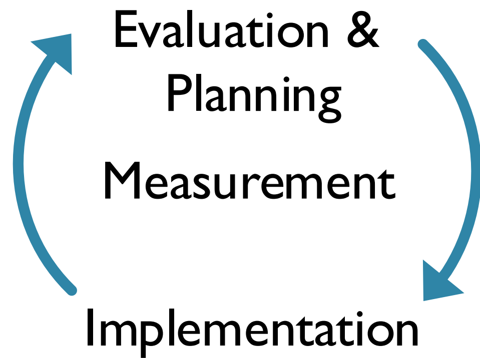
Measure impact

CONCLUDING THOUGHTS

URGENCY AND OPPORTUNITY

A learning system

Aim: affordable, accessible care



We can't wait another year

- With or without AHEAD, we must act
- Shortfalls in funding for primary care, community services loom.

The opportunity for near term savings is real

- Can we start now to advance global budgets? How quickly?
- Build noe on existing strengths in quality improvement
- Prioritize high impact initiatives (why wait?)
  - Administrative and other costs
  - Emergency room and primary care alternatives
  - Pregnancy and newborn care
  - Cardiology

Which road will we take?