Addressing the Current Crisis of Affordability and Access

The harms are worse than we think

Why haven't we been able to fix this?

You are well positioned to do so.

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 – and economic harm.

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

→ potential savings substantial: reduce – take back – unnecessary hospital costs.

→ better access to primary, inpatient and specialty care (improve health)

To make progress, we need to address the deeper causes

The Balloon Problem
Market Failure
Special interests show up

→

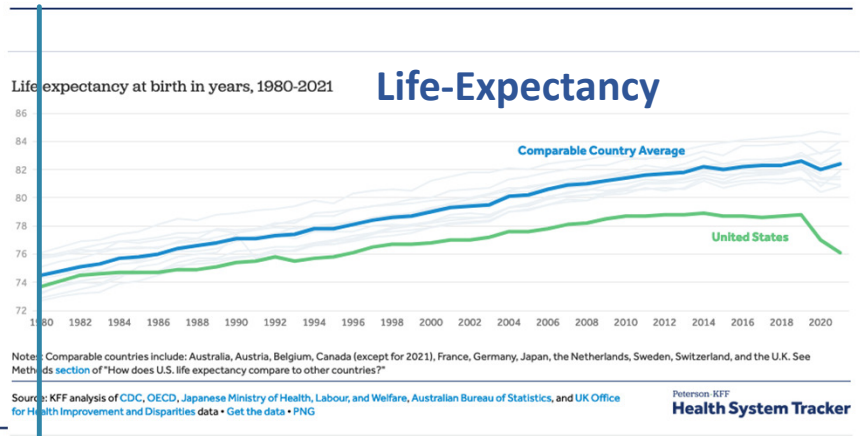
Strong, effective and aligned state agencies

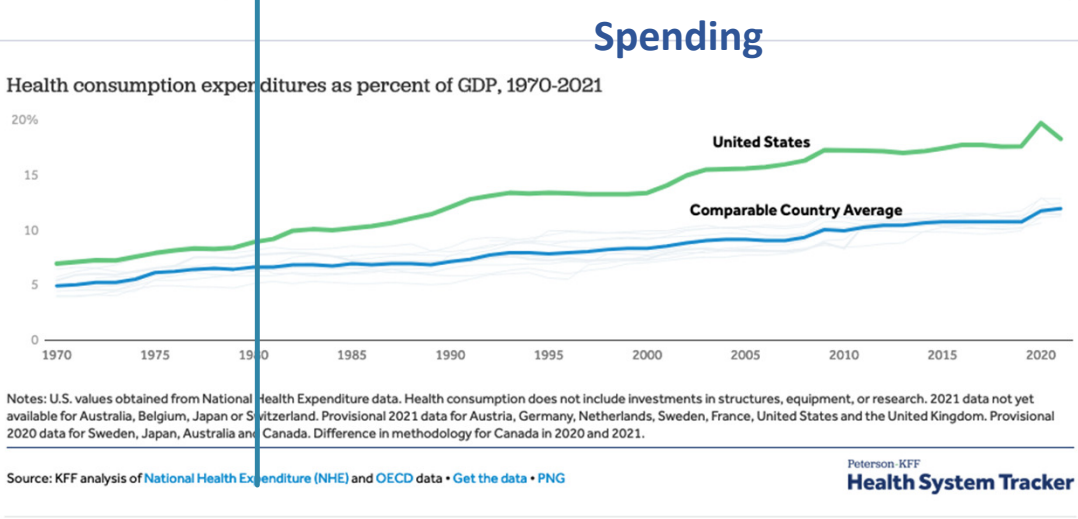
→

Planning and evaluation
Regulation where needed
Independence and accountability

HEALTH ECONOMICS 101 – ARE WE GETTING VALUE FOR MONEY?

COMPARED TO OTHERS -- WE PAY TWICE AS MUCH FOR WORSE OUTCOMES





A widening gap in life expectancy: across and within countries

A rising burden of chronic illness (lower productivity workforce)

↕ Potentially avoidable spending → waste?

Health Economics 101: Direct Harms

Direct Harms – affordability, access and suffering

Act 167 Public Comments

"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."

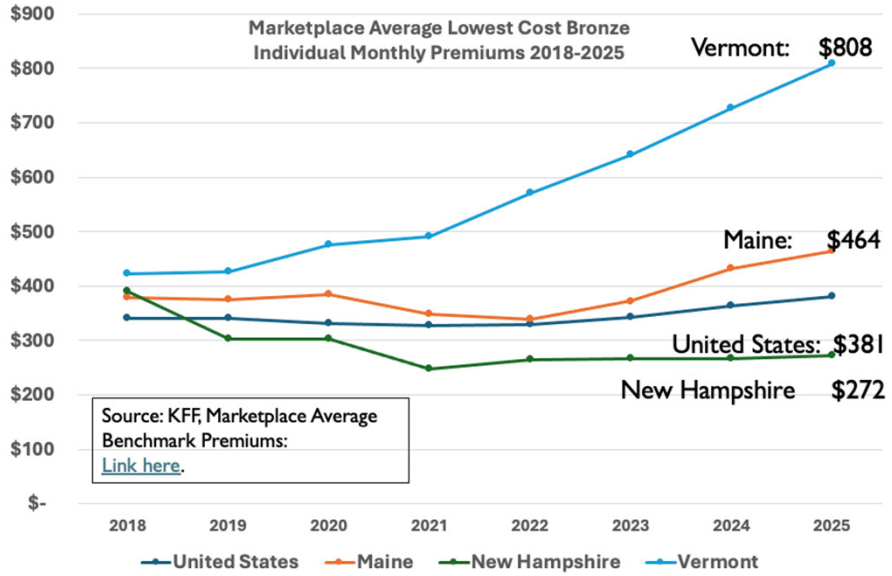
National Data

100 million Americans lack adequate access to primary care. (twice the rate as in 2014)

1 in 4 have debt due to medical care;
For 40% of these-- a visit to the ER was the cause.

74% of Americans worry about being able to afford care.

Vermont



HEALTH ECONOMICS 101: INDIRECT HARMS

PROFOUND IMPACTS ON LOCAL ECONOMIES

Economic harms of rising prices

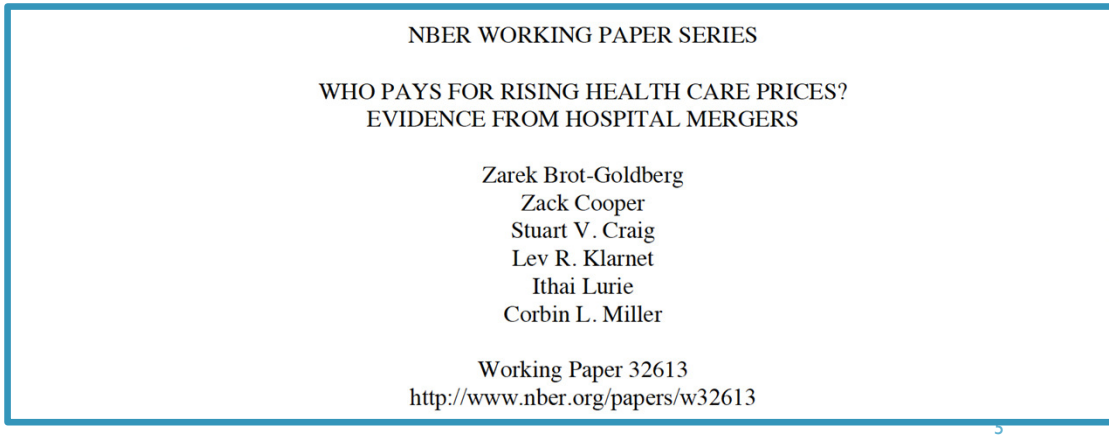
1% increase in health care prices →

- 0.4% decrease in private payroll and employment
- 0.3% decrease in county-level income
- 1% increase in county unemployment
- 1 additional suicide/overdose per 100,000

Most of the impact falls on lower and middle income people

"In this paper, we have shown that Employer Sponsored Insurance (ESI) creates a pathway through which rent-seeking and inefficiency in the health care industry can cause immense harm to local economies."

December 2024



NBER WORKING PAPER SERIES

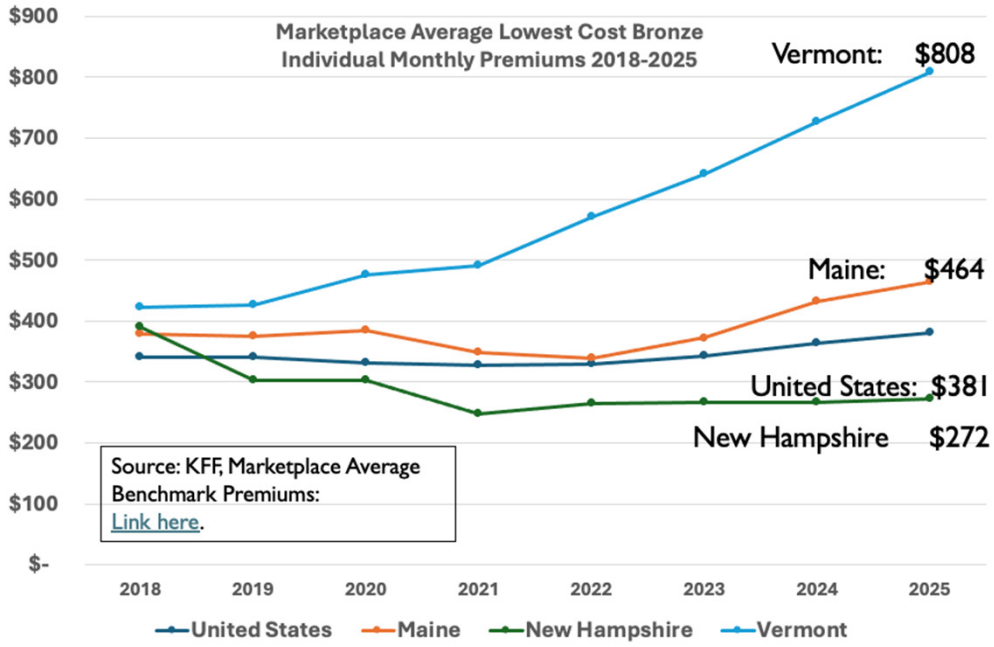
WHO PAYS FOR RISING HEALTH CARE PRICES?
EVIDENCE FROM HOSPITAL MERGERS

Zarek Brot-Goldberg
Zack Cooper
Stuart V. Craig
Lev R. Klarnet
Ithai Lurie
Corbin L. Miller

Working Paper 32613
http://www.nber.org/papers/w32613

HEALTH ECONOMICS 101

VERMONT SHOULD BE ABLE TO REDUCE OUR SPENDING --



Source: KFF, Marketplace Average Benchmark Premiums: Link here.

Potentially avoidable spending → waste
About $400 per month; $4800 per year

Health Economics 101: Harm and Waste

Often referred to as "defects" that can be addressed through improvement.

Worse health

Failures of Care Delivery, Care Coordination and Overtreatment cause
- Unnecessary progression of disease
- Complications
- A lower productivity workforce

Avoidable waste

Administrative complexity

Pricing failures

Fraud and abuse

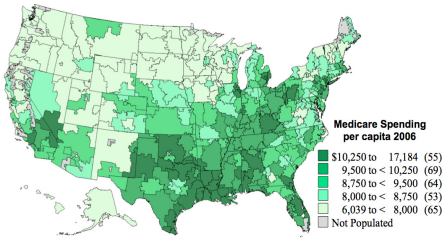
Category	Berwick and Hackbarth[T1]	Shrank, Rogstad & Parekh[T2]
Failures of Care Delivery: Waste due to poor execution or failure to adopt known best practices	3.8% – 4.8%	2.7% – 4.3%
Failures of Care Coordination: Waste from fragmented care	0.9% –1.3%	0.7% – 2.0%
Overtreatment: Waste from care that, according to known science, cannot help patients	5.9% – 7.1%	2.0% – 2.6%
Administrative Complexity: Waste from inefficient rules, such as failure to standardize forms.	4.0% – 9.2%	7.0%
Pricing Failures: Waste from prices that migrate far from those expected in efficient markets	3.1% – 4.9%	6.0% – 6.3%
Fraud and Abuse: Waste that comes as fraudsters issue fake bills and run scams	3.0% – 6.6%	1.3% – 2.2%
Overall Percent of Spending	*20.7%–33.8%*	*19.9%–24.5%*
Total Spending on Waste	*$558B–$910B*	*$760B–$935B*

Source: Fisher, ES. The Single System Solution NEJM Catalyst 2020

AVOIDABLE?

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

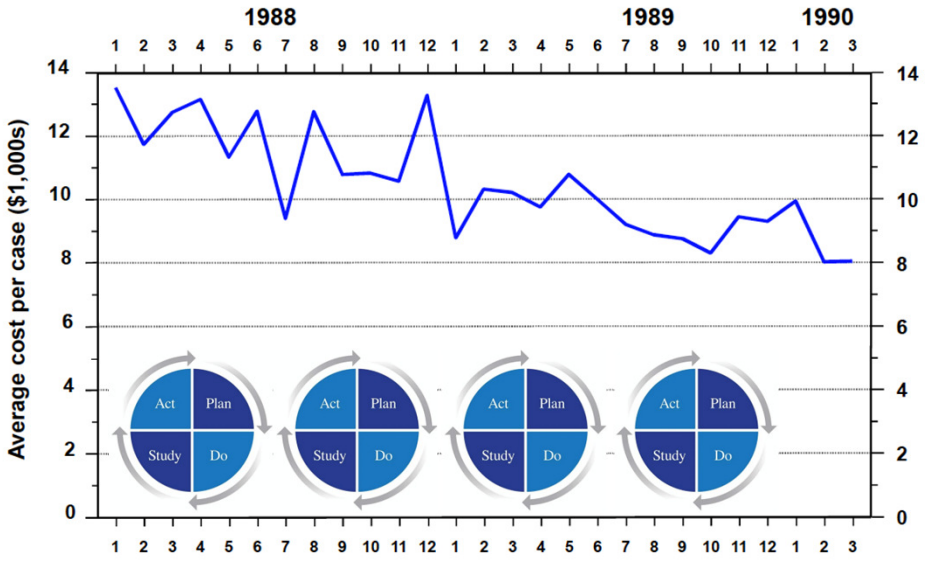
It's the only way to cut waste while improving quality.

James and Paulsen
Harvard Business Review, 2016

AVOIDABLE?

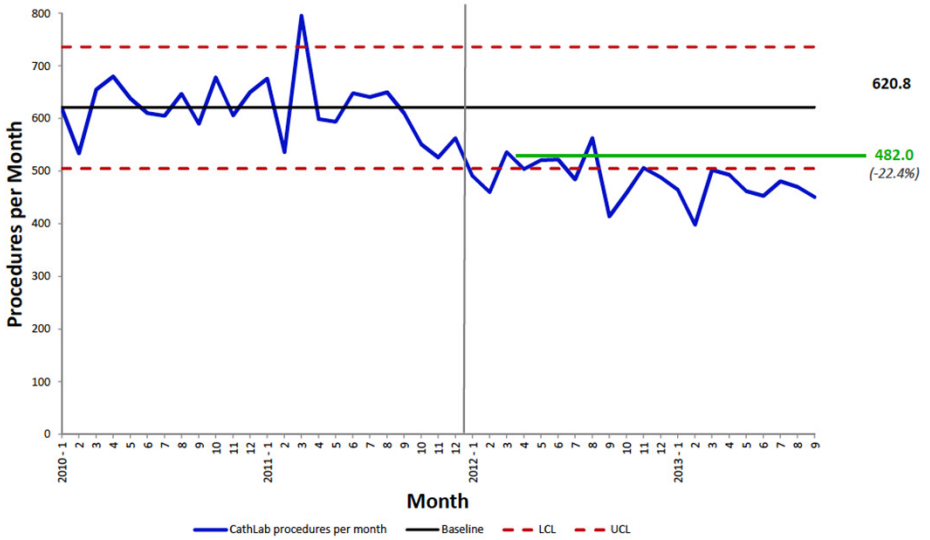
CREATING A LEARNING HEALTH SYSTEM – AT INTERMOUNTAIN'S PRACTICE LEVELS

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



AVOIDABLE?

CREATING A LEARNING HEALTH SYSTEM – AT HEALTH SYSTEM LEVEL

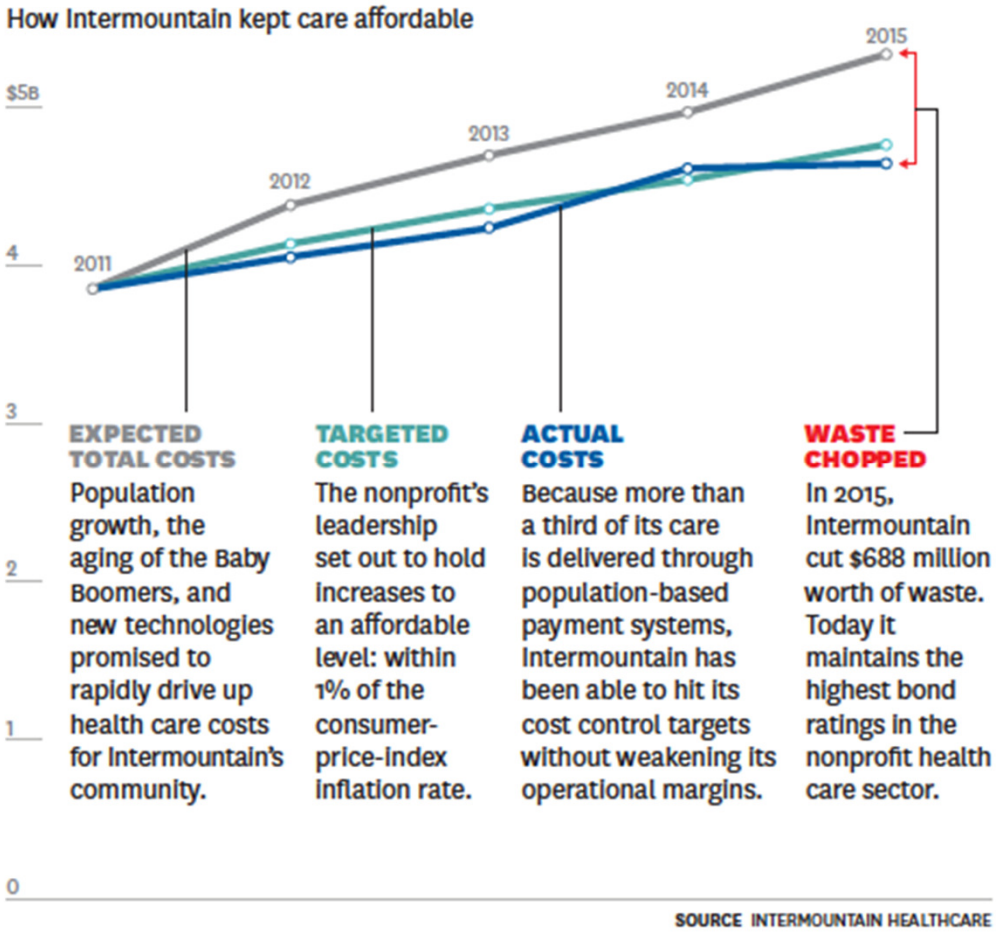
CEO Charles Sorenson established a goal of keeping care affordable: a target of CPI plus 1%.

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

It worked.

Achieved strongest bond-ratings among US non-profits.

→ On lower total revenues



AVOIDABLE:

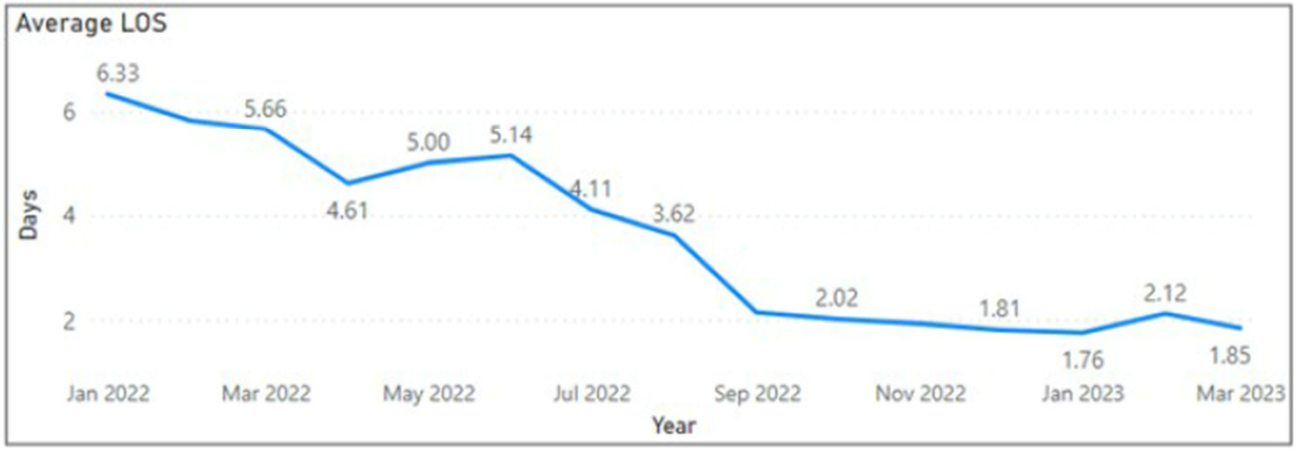
CREATING A LEARNING HEALTH SYSTEM – AT UNIVERSITY HOSPITALS CLEVELAND

Surgical Length of Stay – an important and available measure of hospital costs
Note how long this took

System ERAS LOS
January 2022-March 2023

Reduce Cost Per Visit/Discharge

January 2022 January 2023



Peter Pronovost: Presentation to Green Mountain Care Board, March 5, 2025

How States Can Lead

Effective State Agencies charged and resourced to improve health and care

A learning system

Aim: affordable, accessible care

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
- Primary care investment to enable team-based care.
  (ensuring all receive evidence-based care → reduced costs quickly)

All-payer oversight, payment reform and regulation
- In near term: reference-based pricing; tighter oversight
- Hospital Global Budgets: enforceable, incentives to improve
- Physician incentives to improve care, lower costs
- Can create a virtuous cycle


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

But why so hard? Why only a few hospitals?

A Strong State Agency can Address all Three

The Balloon Problem:

Pressure to reduce costs in one area is easily avoided by shifting costs or raising prices

Market Failure

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

Lack of competition allows hospitals to be inefficient, ignore quality, raise prices, shift resources

The power of special interests

Powerful interests show up and have multiple ways of influencing decisions

The public does not

Set Total Cost of Care Targets and hit them

Evaluation – to identify drivers of avoidable cost and harm.

Planning – to provide guidance on how to address these over time

Strengthen incentives, address market failure

Regulatory structures that promote competition where possible, create incentives to improve (quality measures), and set limits on pricing power and growth in the wrong places.

Independence, transparency, accountability

Oversight and coordination by a public agency that independent, transparent and accountable to the public limits the capacity of special interests to secure special treatment

QUESTIONS TO CONSIDER

Strengths of Senate Bill

- A compelling and well-articulated purpose.
- Duties of GMCB oversee the development and implementation and evaluate the effectiveness of payment and delivery system reforms"
- Regulate as needed – including reference-based pricing, global budgets , new payment models (by both AHS & GMCB)
- Strengths of the bill…
- Hospital duties to provide data; strengthened budget review
- Establishes statewide health care delivery plan, total cost of care and primary care spending targets
- Integration of health care data to support planning and improvement

Some thoughts and questions about the current bill

- Primary responsibility should rest with one agency
- If so, what principles should guide the choice? Perhaps: independence, transparency, track record of meeting deadlines, vulnerability to political influence.
- Tighter Timing? Consider framing the plan as continually evolving with annual recommendations on regulatory and legislative changes needed to strengthen the system.
- Where is primary care?

The elephant in the room: the current crisis.

- Collapse of BCBS is unthinkable but possible; provider closures seem likely; federal cuts will make things worse.
- Track one: emergency planning is starting
- Consider track two: accelerating transformation before the market or federal cuts foreclose better options.
- How might the legislature help with both?