Milbank Memorial Fund

Using evidence to improve population health.

State Affordability Efforts

Christopher F. Koller
Milbank Memorial Fund

Vermont Senate Health and Human Services Committee

February 5, 2025

Today:

1. About Milbank
2. What's the Problem Here?
3. Barriers to State Level Health Reform
4. Policies to Address Rising Commercial Prices for Hospital Care
5. Addressing the Barriers in VT

About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve population health and health equity by collaborating with leaders and decision-makers and connecting them with experience and sound evidence.

We advance our mission by:

- Identifying, informing, and inspiring current and future state health policy leaders to enhance their effectiveness;
- Working with state health policy decision makers to advance primary care transformation and sustainable health care costs, leadership development and
- Publishing high-quality, evidence-based publications and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy.

What Problem Are We Addressing?

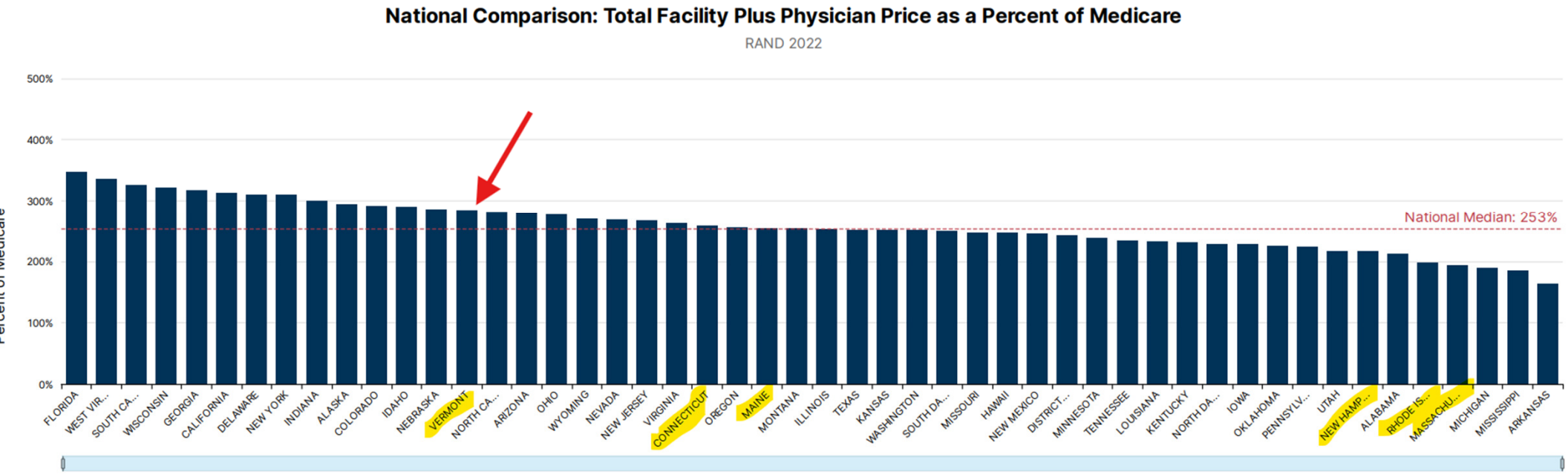
- Affordability?
  - Whose?
- Patient Access to Services?
- Provider Sustainability?
- Health Status?
- Quality of Care?

Lots of challenges and considerations to any problem, but knowing your priorities is key

What is the Priority in Vermont?

1. Rising costs of commercial insurance driven by rising provider prices – especially hospitals
   - See Presentation by Dr. Fisher; Supported by NASHP, RAND, BCBSVT analyses.
   - Found in other states too (Peterson Milbank program working with five other states: cost drivers are commercial hospital and RX prices
2. An unbalanced health care delivery system results in money spent on healthcare that could be better deployed elsewhere
   1. Public Health
   2. Education and Social Services (Health care costs driving district expenses)
   3. Citizens' wallets

VT has a commercial hospital price problem



https://dashboard.sagetransparency.org/

Milbank Memorial Fund

Two Barriers States Face to Taking on any Policy Challenge in Health Care

1. **Aligning Policies between payers** - Medicare, Medicaid and Commercial
   - Much easier to play hot potato and shift the problem,
   - Providers want alignment

2. Setting up **well resourced, durable structures and processes** for health system planning, policy implementation and oversight
   - Allocating limited resources in a sector where the market does not work
   - Saying no is hard. Sying no and sending money elsewhere (to rebalance the delivery system) is even harder

Policies to Address Rising Commercial Prices for Hospital Care

1. Publish data on hospital prices and price growth, and "name names"
2. Tie the terms of hospitals' certificate of need (CON) and cost and market impact review (CMIR) approvals to the cost growth target value
3. Take direct action on narrower hospital pricing policy issues (e.g. site neutral payments)
4. Create a complementary hospital price growth target
5. ***Set a hospital price cap ("reference-based pricing")***
6. ***Establish a hospital price growth cap***
7. ***Prospectively review and approve hospital revenue and/or price growth***

Reference-Based Pricing

- Index hospital prices to a percentage of Medicare
  - Can be applied to a narrow set of services or to a more comprehensive set.
  - States may exclude certain hospital types from caps or phase in their participation.
  - Can be applied to specific market segments only, such as within a public option program or a state employee health plan, or can be applied more broadly across the insurance market.
- Pros – low effort alignment with Medicare; address hospital market power
- Cons – possibility of utilization churn or price hikes elsewhere, no rebalancing of funds to building capacity for community-based services.

Referenced-based Pricing - Results

- Montana's (state employee health plan) - for hospital inpatient and outpatient services from 2016 to 2022. (220%–225% of Medicare rates for inpatient services and 230%–250% for outpatient services with transition period to come down, The program generated an estimated savings of $47.8 million over the three state fiscal years from 2017 to 2019.
- Oregon (public employees) as of 2017 prohibits hospitals from charging the state employee plan more than 200% of Medicare rates for in-network hospital facility services and 185% of Medicare rates for out-of-network prices. (Rural or critical access hospitals or certain sole community hospitals excluded) In the first 27 months of implementation savings of 4% of plan spending. All remained in network and did not increase their prices for the non-state-employee commercial population to compensate for revenue losses.
- OR and WA considering legislation to apply to all commercial insurance

Hospital Price Growth Caps

- Compel Insurers to limit the year over year change in the prices they pay to providers
- Results:
  - In place in RI since 2010; Multiple studies confirm significantly lower commercial premium growth in RI than any other New England state;
- Pros
  - Simple to implement and administer, Politically easier than take aways but savings compound over time
- Cons
  - Preserves existing inequities in commercial pricing between hospitals, does not build community capacity; limited alignment with Medicare, unclear impact on self insureds (administrator dependent),

Hospital Global Budgets

- Set total or per capita budgets for hospital services; adjustments for shifts in populations, risk mix etc,
- Two state models referred to nationally – Maryland and Vermont.
  - Maryland most mature – evolved from all payer inpatient rate setting to per capita growth limits for institutions; latest iteration being implemented as part of the AHEAD model

- Vs Accountable Care Organizations.
  - Focus of Hospital Global Budgets is on existing institutions, not as in ACOs on attributing populations to entities for broad accountability and broader incentives

Hospital Global Budgets (cont'd)

- Pros
  - Direct alignment with Medicare and self insured. Shifts incentives for hospitals from fee for service; makes rebalancing within institutions conceivable; a guaranteed future for hospital
- Cons
  - GMCB experience is relevant:
    - Complex; significant analytical lift
    - Does not necessarily build capacity of community services
    - Alignment with Medicaid
    - Building and maintaining political will
    - Possible in theory to take costs out of budgets but strong forces to take existing costs as fixed. (See UVM discussion)

Back to Our Two Barriers States Face to Taking on any Policy Challenge in Health Care

1. Aligning Policies between payers - Medicare, Medicaid and Commercial
   - ***AHEAD is heavy alignment and lift; Reference Pricing is light touch; Growth Caps even lighter***

2. Setting up well resourced, durable structures and processes for health system planning, policy implementation and oversight
   - ***What has been learned from Blueprint for Health and GMHCB?***

Rebalancing the Delivery System to Emphasize Primary Care and Community Services

- Primary Care in VT and US is under siege. VT has a head start (strong Community Health Centers, cultural commitment to Primary Care).
- **VT Blueprint for Health**
  - Used supplemental Medicare, Medicaid and Commercial Funds to build primary care capacity ("Medical Homes")
  - Challenges: allocating limited funds; establishing priorities.
  - Successes: Advanced primary has been backbone of Opioid and Covid responses, some aging services.
  - Eclipsed by One Care model – theory was that at risk health system would redistribute within itself to build community capacity. Has not proven to be case.
  - Primary Care-based Accountable Care Organizations are best successes in Medicare. Could build in VT, alongside Hospital Global Budgets

What has been learned From GMCB Experiment?

From Dr. Fisher: Effective State Agencies charged and resourced to improve health and care

A learning system

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


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

When the Market Fails – Who does the work? Learning from the Past and from Other Sectors

Learning System Elements	Education	Public Utilities	Vermont – Health	Maryland - Health
Evaluation, Planning and Policy Dev't	State Agency	Com-mission	State - Dispersed across agencies and legislature	Maryland Health Care Commission
Policy Implementation (Financing and Programs)	Locals	Com-mission	GMCB + DOH + Medicaid + Public Employees (+Medicare?)	Maryland Health Services Cost Review Commission + DOH
			GMCB+ VT Connect	Insurance Regulation+ Exchange
Measurement and Monitoring	Locals and State with Legislative oversight	Com-mission with Legislative oversight	GMCB + Medicaid + DOH + VT Connect	Maryland Health Services Cost Review Commission + Medicaid+ DOH+ Insurance Regulation+ Exchange

Pro-viders

Payers

Challenges for Legislature

- What is your priority problem?
  - Commercial provider prices
  - Cost reduction is hard – containing growth less so
- Acting on lessons on structure and process learned from GMCB grand experiment
  - Get alignment with Medicare
  - Greater alignment with other state agencies on planning and implementation
  - Adequate resources for health system planning and monitoring functions – In GMCB?
  - More explicit strategy for delivery system rebalancing (Blueprint 2.0?)
  - Legislature: firm oversight, and accountability for performance - not policy mechanics

Final thoughts