Milbank Memorial Fund

Using evidence to improve population health.

Health Care Affordability: Systemic State-Level Approaches

National Academy of Medicine/VISAC

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February 13 2020

About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by:

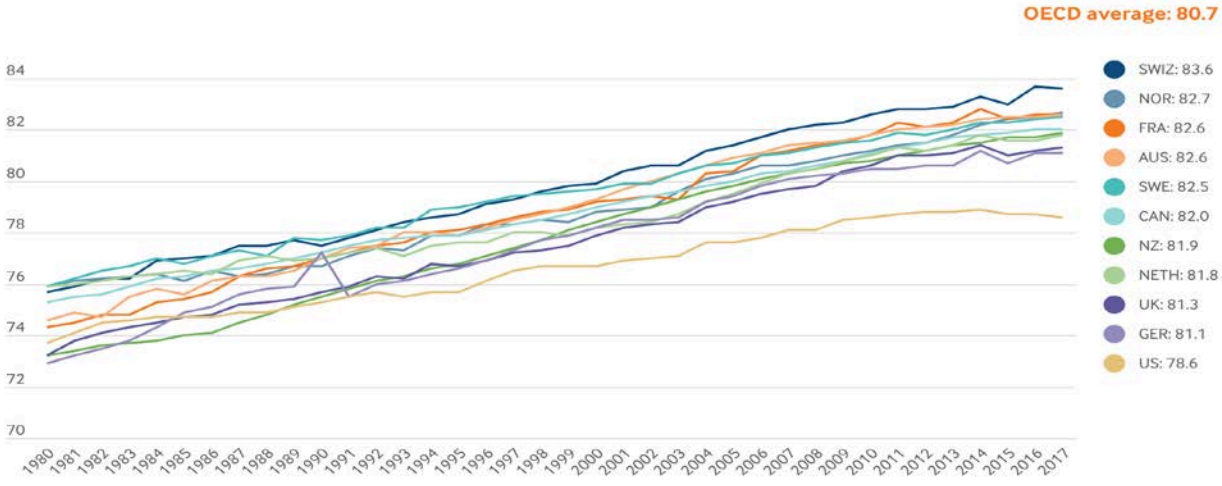
- publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly,* a peer-reviewed journal of population health and health policy;
- convening state health policy decision makers on issues they identify as important to population health;
- and building communities of health policymakers to enhance their effectiveness.

I have no conflicts but some biases...

Bias One: We Are All in the Life Expectancy Business and We Are Not Doing Well

The U.S. Has the Lowest Life Expectancy

Years
Legend shows 2017 data



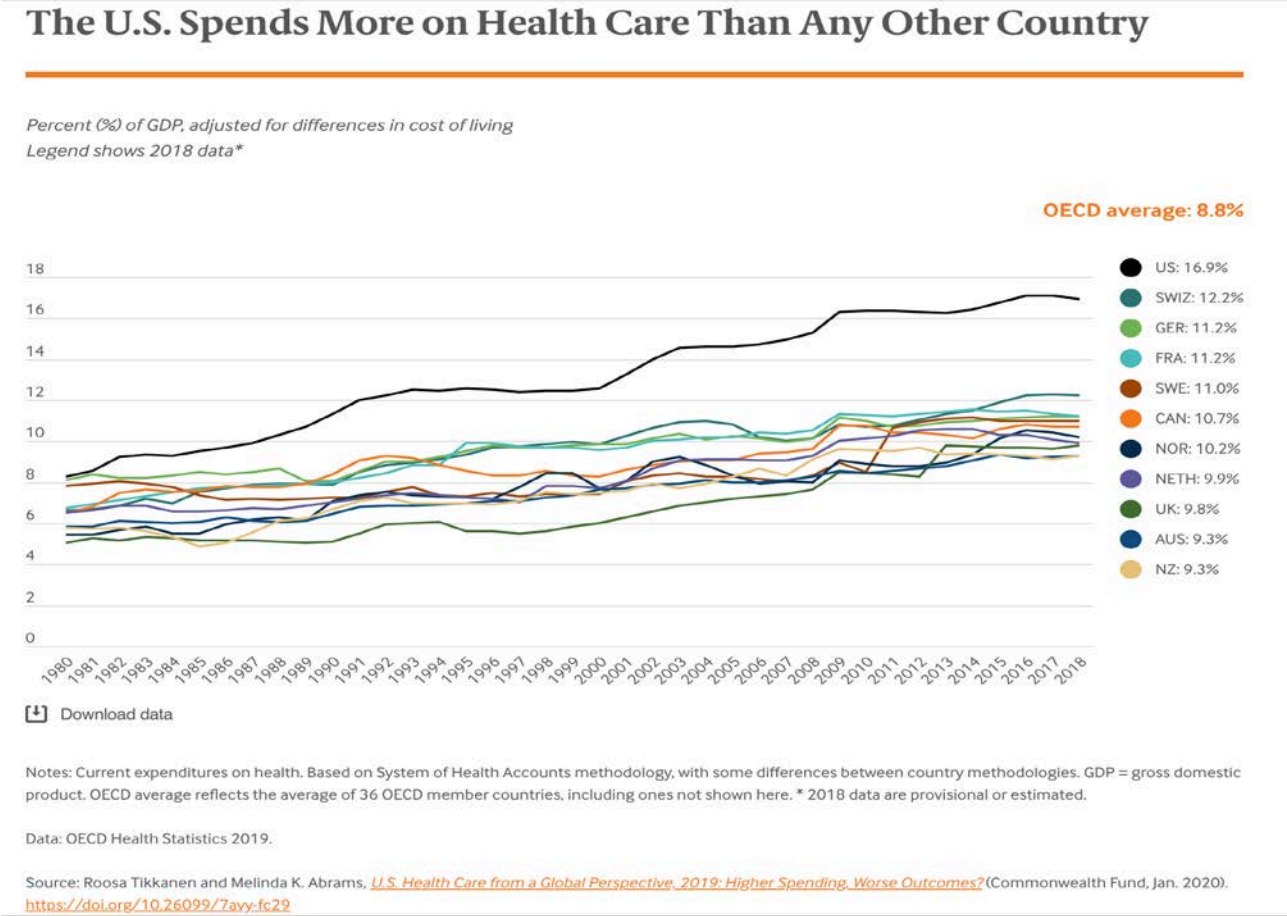
Download data

Note: OECD average reflects the average of 36 OECD member countries, including ones not shown here.

Data: OECD Health Statistics 2019.

Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?* (Commonwealth Fund, Jan. 2020). https://doi.org/10.26099/7avy-fc29

Bias Two: The Simultaneous Diversion of US Cost and Health Performance from Other Countries is not Coincidental.



Defining Affordability Systemically: as PMPM Cost and Trend, by Three Major Payer Categories.

EXHIBIT 5

Per enrollee Medicare, Medicaid, and private health insurance (PHI) personal health care spending and average annual percentage change, by region and state of residence, calendar year 2014

		Personal health care spending			Average annual change, 2010–14		
Region	**State**	**Medicare**	**Medicaid**	**PHI**	**Medicare**	**Medicaid**	**PHI**
United States		$10,986	$ 6,815	$4,551	1.2%	0.0%	3.3%
New England	Connecticut	11,964	8,058	5,187	1.6	–5.7	2.5
	Maine	9,325	7,504	5,015	1.5	–1.1	4.2
	Massachusetts	11,899	8,922	5,302	1.2	–5.6	3.9
	New Hampshire	9,397	9,129	4,880	1.8	–2.3	1.3
	Rhode Island	10,901	10,934	4,620	1.5	0.2	1.6
	Vermont	9,231	7,917	5,313	1.7	2.4	3.9
Mideast	Delaware	11,460	6,921	4,806	2.0	1.1	2.7
	Dist. of Columbia	11,814	8,998	8,831	1.0	–3.4	2.8
	Maryland	12,000	7,677	4,343	1.1	–1.9	2.4
	New Jersey	12,614	8,049	5,081	1.2	–5.4	5.2
	New York	12,179	9,803	5,338	1.0	–1.5	3.3
	Pennsylvania	11,243	9,407	4,634	1.2	3.2	4.2

Source: Lassman et al Health Affairs, 2017

Why are Some States Getting More Engaged in Systemic Affordability Issues?

- Medicaid sustainability
- Public employees purchasing
- Individuals facing high deductibles and looking for solutions (more bone than skin in the game)
- Employers educated on high hospital commercial prices, variations based on size and never ending cost shifting battle.
- The logical tension of a "Meds and Eds" economic development strategy

Challenge One: My Expense Is Your Revenue

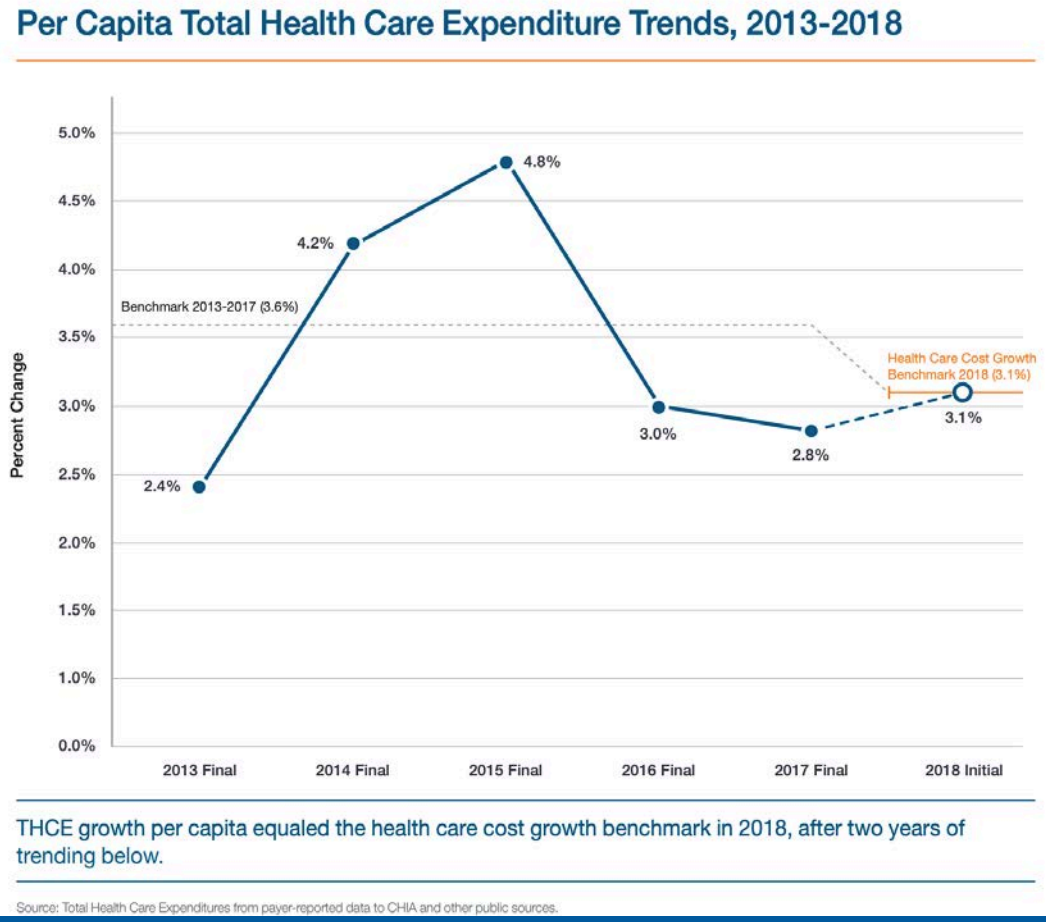
Challenge Two: It's Easier to Shift Costs than to Reduce Them

Challenge Three: Leadership and Skepticism: Is this even a role for State Government?

Challenge Four: The Self Insured are half of the commercial market and want nothing to do with states

Challenge Five: Data and Analytics

Approach One – Health Cost Growth Targets (MA)



Established Health Policy Commission with authority to:

- Set targeted rate of growth for per capita health care expenses
- Monitor statewide performance
- Assess effects of mergers and consolidations

So Far Four States Following Suit…

Approach Two: Facilitate Community-based Accountable Care (OR)

- Consolidate Medicaid and state employee purchasing
- Establish Medicaid ACOs with federal per capita budget
- Create state health policy commission
- Strongly commit to primary care statewide
- Next up:
  - Moving public employees into coordinated care organizations
  - Developing health care cost growth targets

Approach Three – Medicare Waivers (MD and VT)

Medicare waivers to align with commercial market and Medicaid

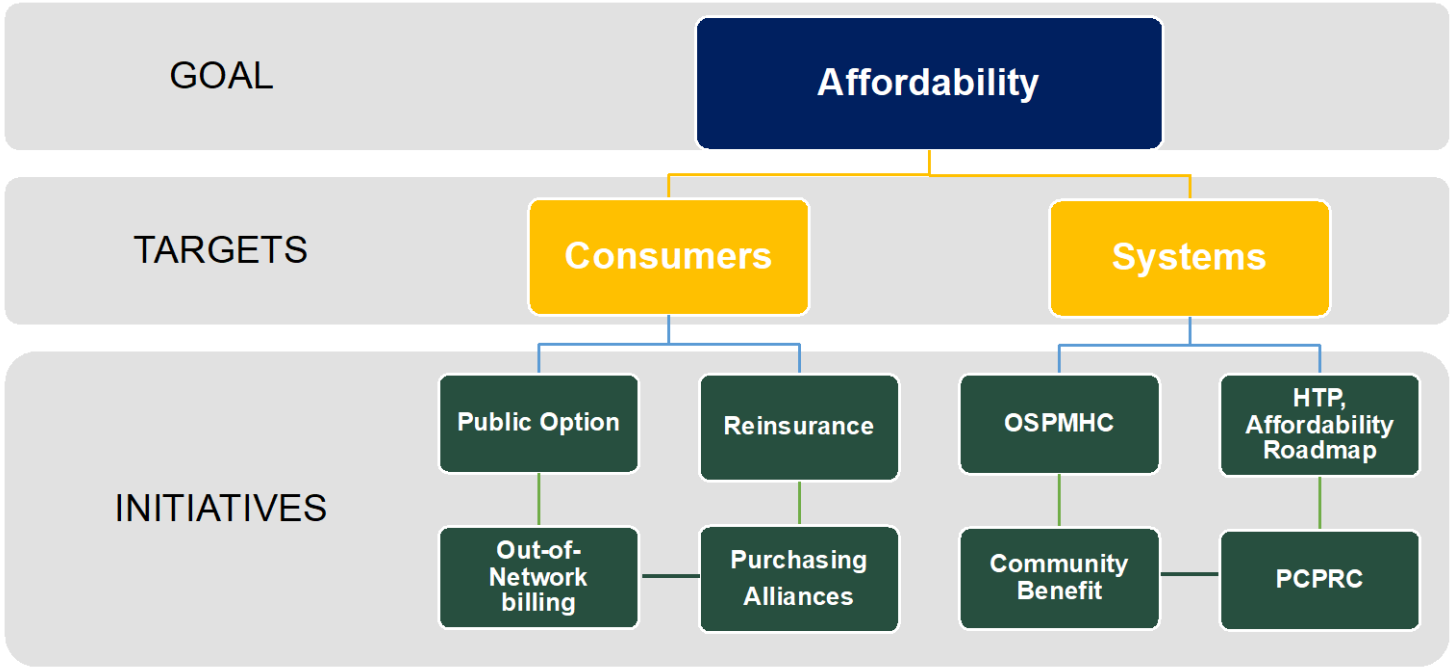
Maryland: "Payment Reform Systematized"

- Global budgets for hospitals (price and utilization)
- Five years in – Formal evaluation yield results similar to good ACO's - but across all payers and hospitals
- Next up – primary care transformation supported by statewide health information exchange and inclusion of specialists

Vermont

- Hospital budgeting and health plan rate setting
- Single statewide ACO with Medicare, Medicaid, and commercial participation
- Slow take up by providers

Approach Four: Focus on Commercial Market Oversight (CO and RI)



COLORADO
Department of Regulatory Agencies
Division of Insurance

Rhode Island: Insurer Affordability Standards

Implemented in 2010 by Office of the Health Insurance Commissioner (OHIC)

- Require increasing investment in primary care, from 5.5% of total spend to 10.5%
- Encourage patient-centered medical home transformation
- Promote health information technology adoption (EHR and health information exchange)
- Encourage payment reform/cost reduction (Alternative Payment models)
    - First stage: Encourage payment reform
    - Second stage: Rate increase caps on hospitals in insurer contracts

Primary Care Investment Leads to Improved Infrastructure

"Insurers responded by spending more on patient-centered medical homes, accountable care organizations (ACOs), performance incentives, and "common good" services such as health information technology, practice transformation, and loan repayment programs."

The NEW ENGLAND JOURNAL of MEDICINE

Primary Care Spending Rate — A Lever for Encouraging Investment in Primary Care

Christopher F. Koller, M.P.P.M., M.A.R., and Dhruv Khullar, M.D., M.P.P.

Why doesn't the United States invest more in primary care? A large body of evidence suggests that greater investment in primary care is good for patients and health systems. Greater use of primary care has been associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality.[1] Within the United States, health care markets with a larger percentage of primary care physicians (PCPs) have lower spending and higher quality of care.[2]

Despite this evidence, the United States continues to undervalue primary care. A recent Commonwealth Fund analysis identified underinvestment in primary care as one of four fundamental reasons that the U.S. health system ranks last among high-income countries.[3] Compared with peer countries, the United States has fewer primary care clinicians than specialists — along with larger income disparities between the two groups — and provides fewer services in the primary care setting.[3,4] Although the Affordable Care Act introduced a number of payment and regulatory changes that offer incentives to invest in primary care, they have not been

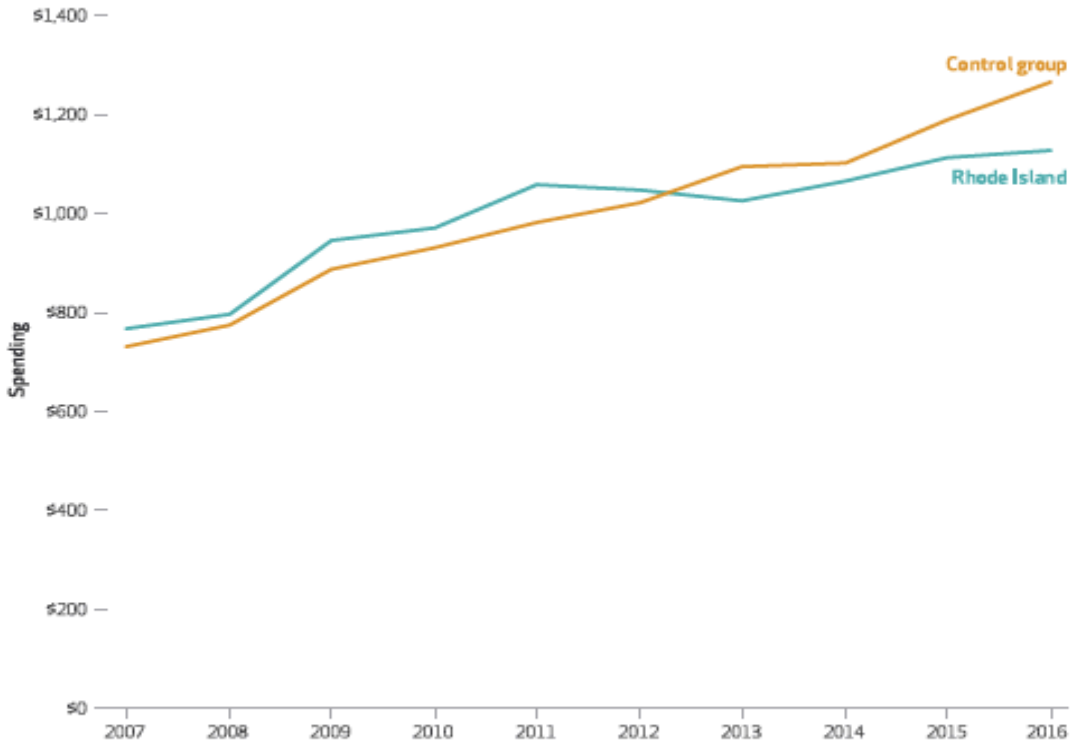
N ENGL J MED 377;18 NEJM.ORG NOVEMBER 2, 2017 1709

Eight states have implemented laws or regulations to measure and/or increase primary care spend rates.

Results – bending the Commercial Trend

EXHIBIT 2

Quarterly per enrollee fee-for-service spending in the Rhode Island and control-group cohorts, 2007–16



SOURCE Authors' analysis of data for 2007–16 from the Truven MarketScan Commercial Claims and Encounters database. **NOTES** The cohorts are explained in the notes to exhibit 1. All values were adjusted to a standardized ninety-day quarter. Dollar amounts were inflation adjusted to 2015 dollars. Rhode Island's affordability standards were implemented in 2010.

"Price inflation caps and diagnosis-based payments… drove a broad and sustained reduction in commercially insured health care spending growth. Furthermore, combining price control measures with a requirement to markedly increase funding to primary care practices led to a redistribution of spending toward primary care without net losses to payers."
—Baum et al. *Health Affairs* 2019

Increasing Savings For Employers and Consumers

Decomposition by FFS Spending Major Category

	2010-2016	2013-2016
Total	-$76	-$128
P Value	0.004	< 0.001
Insurer net spend	-$38	-$66
P Value	0.007	0.002
Patient cost share	-$37	-$63
P Value	0.037	0.004
Primary care	-$4	-$4
P Value	0.001	0.011
Specialist	-$9	-$13
P Value	0.518	0.512
Professional	-$16	-$29
P Value	0.001	< 0.001
Facility	-$8	-$14
P Value	0.437	0.334

Source: Baum et al

Where Is Rhode Island Going?

- Affordability Standards Evolution. Health Plans must:
  - Maintain primary care spend at 10+ percentage point levels
  - Accelerate implementation of downside risk APMs.
  - Institute primary care APMs (more or less primary care capitation)
  - Support primary care transformation collaborative
  - Explore specialist APMs (bundles)
  - Keep hospital price increase caps in place
- Setting health care cost growth targets overall growth rates (ala Massachusetts)
- Long-term collaborative planning on population health and social determinants

Lessons from State-based Systemic Approaches to Affordability

1. Government leadership essential
2. Commercial prices are a black box and opening them creates conversation
3. Insurers need public oversight and accountability for common good improvements
4. But they are the gas station, not the gas - and often they are buying from OPEC. Need help.
5. Need (more) affordability measures and goals: "Can't lose weight without a scale"
6. Modest expectations and early wins to keep people engaged.

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