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

OECD average: 80.7

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

https://doi.org/10.12409/7aw-tc29
Bias Two: The Simultaneous Diversion of US Cost and Health Performance from Other Countries is not Coincidental.

The U.S. Spends More on Health Care Than Any Other Country

Percent % of GDP, adjusted for differences in cost of living
Legend shows 2018 data

OECD average: 8.8%
- US: 16.9%
- SWI: 12.2%
- GER: 11.2%
- FRA: 11.2%
- SWE: 11.0%
- CAN: 10.7%
- NOR: 10.2%
- NETH: 9.9%
- UK: 9.5%
- AUS: 9.3%
- NZ: 9.3%

Notes: Current expenditures on health. Based on System of Health Accounts methodology, with some differences between country methodologies. GDP = gross domestic product. OECD average reflects the average of 36 OECD member countries, including ones not shown here. * 2018 data are provisional or estimated.

https://doi.org/10.1002/hcf.hc29
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

<table>
<thead>
<tr>
<th>Region</th>
<th>State</th>
<th>Personal health care spending</th>
<th>Average annual change, 2010–14</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medicare</td>
<td>Medicaid</td>
</tr>
<tr>
<td>United States</td>
<td></td>
<td>10,986</td>
<td>6,815</td>
</tr>
<tr>
<td>New England</td>
<td>Connecticut</td>
<td>11,964</td>
<td>8,058</td>
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<td></td>
<td>Maine</td>
<td>9,325</td>
<td>7,504</td>
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<td></td>
<td>Massachusetts</td>
<td>11,899</td>
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<tr>
<td></td>
<td>New Hampshire</td>
<td>9,397</td>
<td>9,129</td>
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<tr>
<td></td>
<td>Rhode Island</td>
<td>10,901</td>
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</tr>
<tr>
<td></td>
<td>Vermont</td>
<td>9,231</td>
<td>7,917</td>
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<tr>
<td>Mideast</td>
<td>Delaware</td>
<td>11,460</td>
<td>6,921</td>
</tr>
<tr>
<td></td>
<td>Dist. of Columbia</td>
<td>11,814</td>
<td>8,998</td>
</tr>
<tr>
<td></td>
<td>Maryland</td>
<td>12,000</td>
<td>7,677</td>
</tr>
<tr>
<td></td>
<td>New Jersey</td>
<td>12,614</td>
<td>8,049</td>
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<tr>
<td></td>
<td>New York</td>
<td>12,179</td>
<td>9,803</td>
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<td></td>
<td>Pennsylvania</td>
<td>11,243</td>
<td>9,407</td>
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</table>

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…

Per Capita Total Health Care Expenditure Trends, 2013-2018

THCE growth per capita equaled the health care cost growth benchmark in 2018, after two years of trending below.

Source: Total Health Care Expenditures from payer-reported data to CHA and other public sources.
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)

**GOAL**

Affordability

**TARGETS**

Consumers

Systems

**INITIATIVES**

Public Option

Reinsurance

HTP, Affordability Roadmap

Out-of-Network billing

Purchasing Alliances

OSPMHC

Community Benefit

PCPRC
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.”

Eight states have implemented laws or regulations to measure and/or increase primary care spend rates.
Results – bending the Commercial Trend

“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

<table>
<thead>
<tr>
<th>Category</th>
<th>2010-2016</th>
<th>2013-2016</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>-$76</td>
<td>-$128</td>
<td>0.004</td>
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<tr>
<td>Insurer net spend</td>
<td>-$38</td>
<td>-$66</td>
<td>0.007</td>
</tr>
<tr>
<td>Patient cost share</td>
<td>-$37</td>
<td>-$63</td>
<td>0.037</td>
</tr>
<tr>
<td>Primary care</td>
<td>-$4</td>
<td>-$4</td>
<td>0.001</td>
</tr>
<tr>
<td>Specialist</td>
<td>-$9</td>
<td>-$13</td>
<td>0.518</td>
</tr>
<tr>
<td>Professional</td>
<td>-$16</td>
<td>-$29</td>
<td>0.001</td>
</tr>
<tr>
<td>Facility</td>
<td>-$8</td>
<td>-$14</td>
<td>0.437</td>
</tr>
</tbody>
</table>

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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