National Trends in State Affordability and Sustainability Strategies

May 13, 2020

bailit health

Agenda

1. Welcome and Introductions
2. National Trends in State Affordability and Sustainability Strategies
3. Discussion and Public Comment

Welcome and Introductions

About Bailit Health

- Bailit Health is a Massachusetts-based health policy consulting firm that focuses on helping states maximize health system performance.
- We have supported over 40 states since our inception.
- Our work in Vermont began in 1997.
  - We first designed and helped implement health plan regulatory oversight for the former Banking, Insurance, Securities and Health Care Administration (BISHCA).
  - Between 2014 and 2017 we assisted the GMCB with the design and implementation of its ACO pilot.
  - Beginning in 2017, we assisted the GMCB with the design and implementation of an ACO regulatory strategy.

National Trends in State Affordability and Sustainability Strategies

Current National Trends

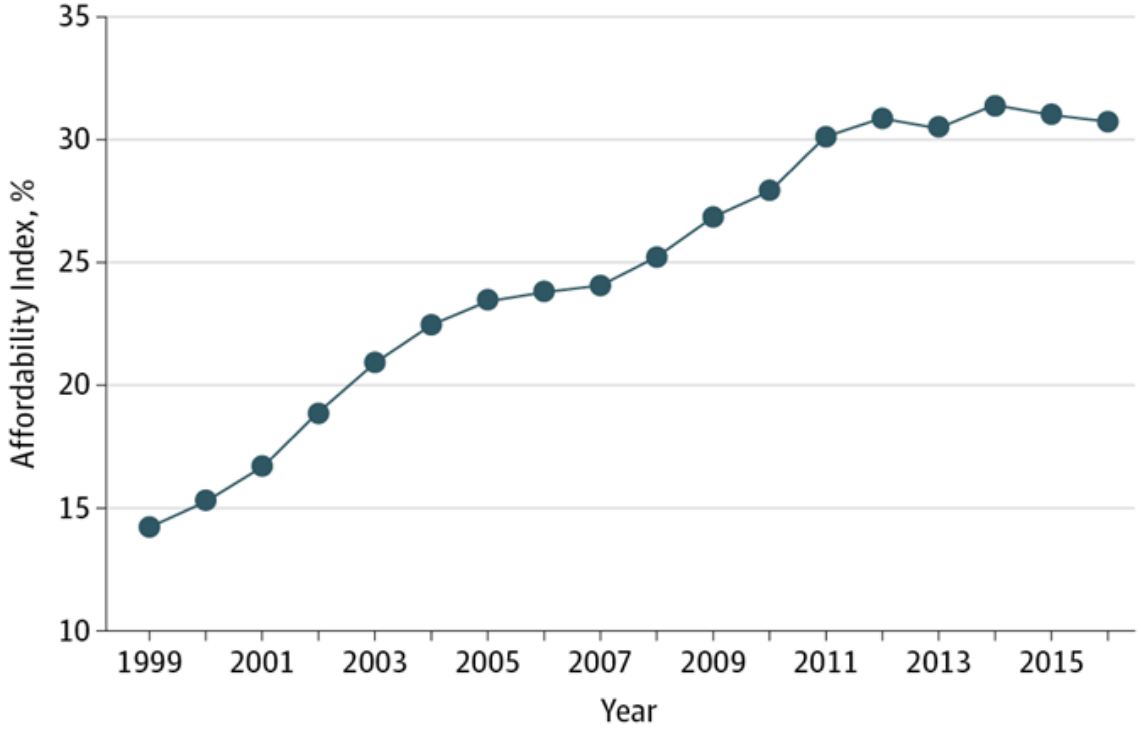
1. Affordability and sustainability: context and definition
2. Mechanisms other states are using to achieve affordability and sustainability
3. Considerations for Vermont

What Does "Affordable" Health Care Mean?

- Economic view
  - Normative: what people should be able to afford, given a certain income level
  - Behavioral: what most people in similar financial circumstances buy
  - Budget: how much room in the budget people have for necessities
- Purchaser view (public and private)
  - flat or decreasing % of tax expenditures or employee compensation devoted to health care coverage
- Consumer view
  - no cost barriers to needed care, delayed or skipped care due to cost, or high levels of medical debt

Health Care Affordability Over Time

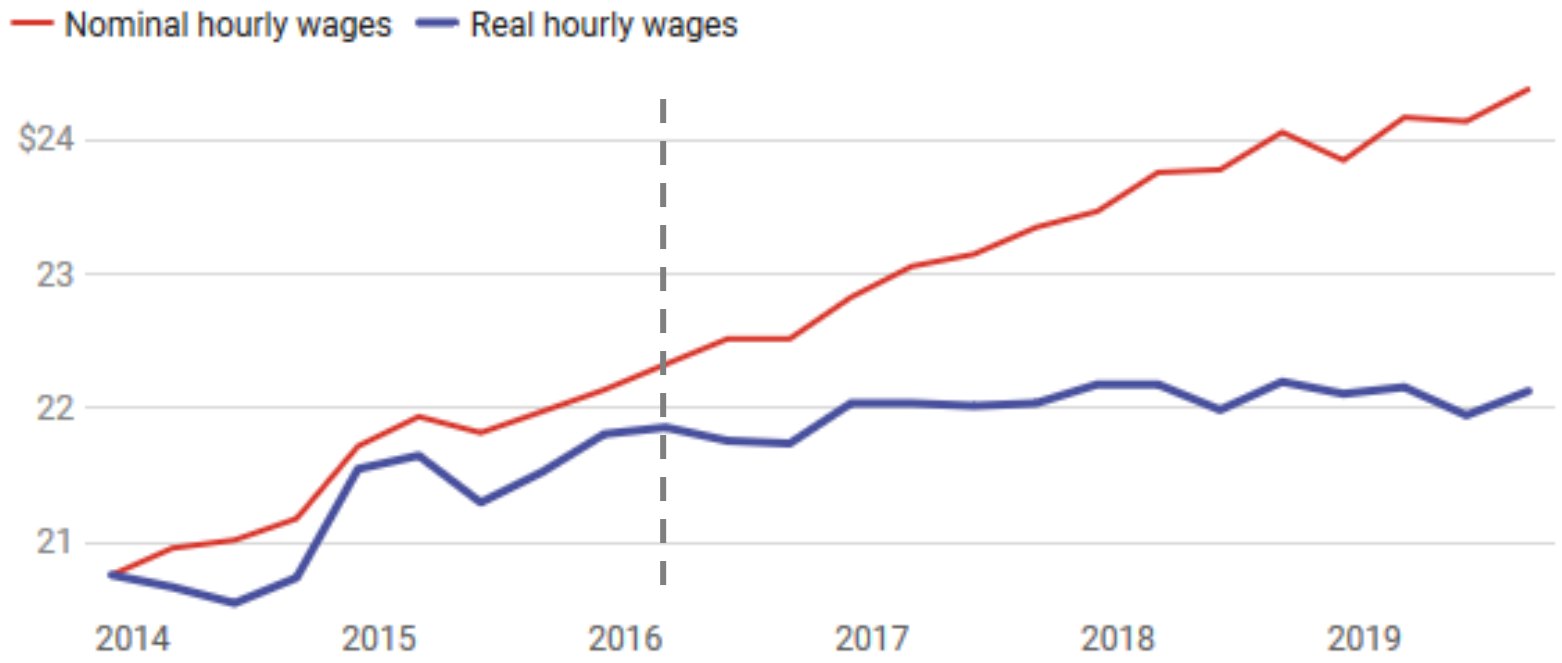
- Affordability index = ratio of health care costs to income
- Lower numbers means greater affordability



Source: Ezekial Emanuel, Aaron Glickman and David Johnson. Measuring the Burden of Health Care Costs on US Families: The Affordability Index. *JAMA.* 2017;318(19):1863-1864. Available at: https://jamanetwork.com/journals/jama/fullarticle/2661699.

A Closer Look at Income – Wages

- Both nominal and inflation-adjusted real hourly wages were rising from the end of 2013 through 2016
- After that, real wages (inflation-adjusted) have remained flat as inflation picked up, increasing 0.42% from Dec 2016-Sep 2019
  - *Nominal* wages rose 6.79% from $22.83 to $24.38 during the same time

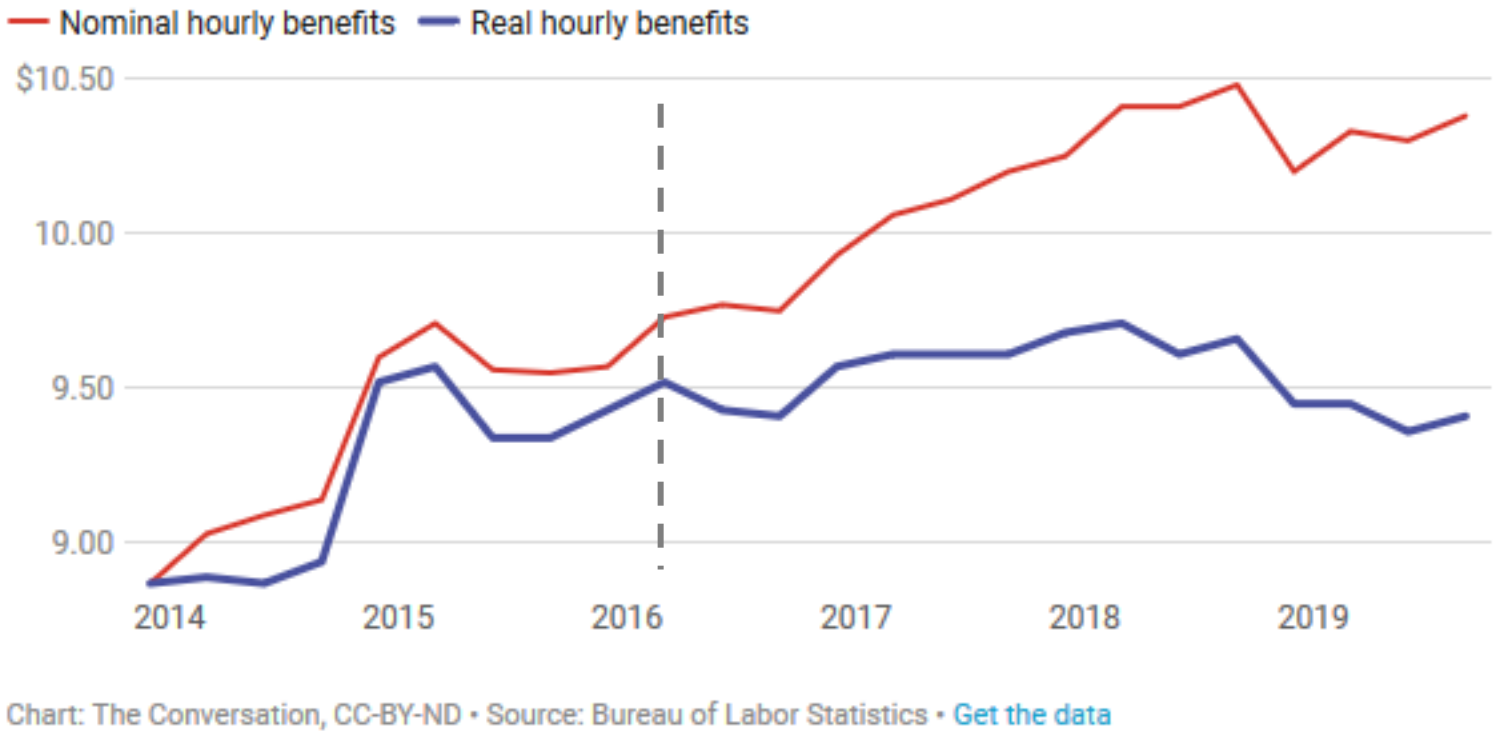


Real numbers adjusted to December 2013 values.

Chart: The Conversation, CC-BY-ND • Source: Bureau of Labor Statistics • Get the data

Now Add Fringe Benefits

- Real fringe benefits began to stagnate at the end of 2015 and have been declining in the past couple of years
- Inflation-adjusted (real value) of fringe benefits declined 1.7% from Dec 2016 – Sep 2019
- Total real compensation (wages and fringe) was down 0.22%



Health Care Issues in Governors' Addresses

- Health care issues mentioned in 42 State of the State addresses given in 2020

How Many Governors Are Talking About:	# of States
Health Care Costs	21
Prescription Drug Costs	12
Medicaid Program Operations	8
Medicaid Expansion	6
Health Care Coverage	19
General Behavioral Health	29
Heroin and Opioid Abuse	19
Health Care Workforce	10
Miscellaneous Health Issues	34

Source: National Academy for State Health Policy. *How Governors Addressed Health Care in their 2020 State of the State Addresses.* Available at: https://nashp.org/how-governors-addressed-health-care-in-their-2020-state-of-the-state-addresses/.

Financial Sustainability

- Health care provider financial sustainability, i.e., the ability of providers to remain financially solvent, has been a concern for rural hospitals in Vermont and elsewhere in recent years.
- Financial sustainability concerns intensified and spread rapidly with COVID-19, as dramatic drops in service utilization created an immediate financial crisis for health care providers, especially those with little funds reserve.
- Facing reduced tax revenues and another recession and having experienced a pandemic, there is heightened national recognition that health care needs to be affordable *and* sustainable.

Financial Sustainability *(cont'd)*

- Among many other things, COVID-19 has laid bare another deleterious effect of fee-for-service payment.
- Linking payment to service delivery places health care providers in the same position as restaurants, movie theaters and bowling alleys.
- While we tolerate the prospect of those businesses going under during an economic downturn, most don't want the same to befall physicians, therapists, hospitals and nursing facilities.

State Strategies to Improve Affordability and Promote Sustainability

1. Payment-based models
   a. Growth caps (RI)
   b. Global budgets (MD and PA)
   c. Prospective payment
   d. Rate setting
2. Cost growth targets (DE, MA, OR, RI)
3. Public option (WA, CO)
4. Other

State Strategies

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Payment-Based Models: Growth Caps

- In 2010 Rhode Island's Office of the Health Insurance Commissioner established a set of "**affordability standards**" - requirements for commercial insurers to follow in their efforts to improve the affordability of their products
- The Commissioner uses her rate review process to assess whether the insurer has taken steps to increase affordability, as well as conducts other reviews to assess compliance.

Rhode Island's Affordability Standards

Starting in 2010, RI's Affordability Standards have required:

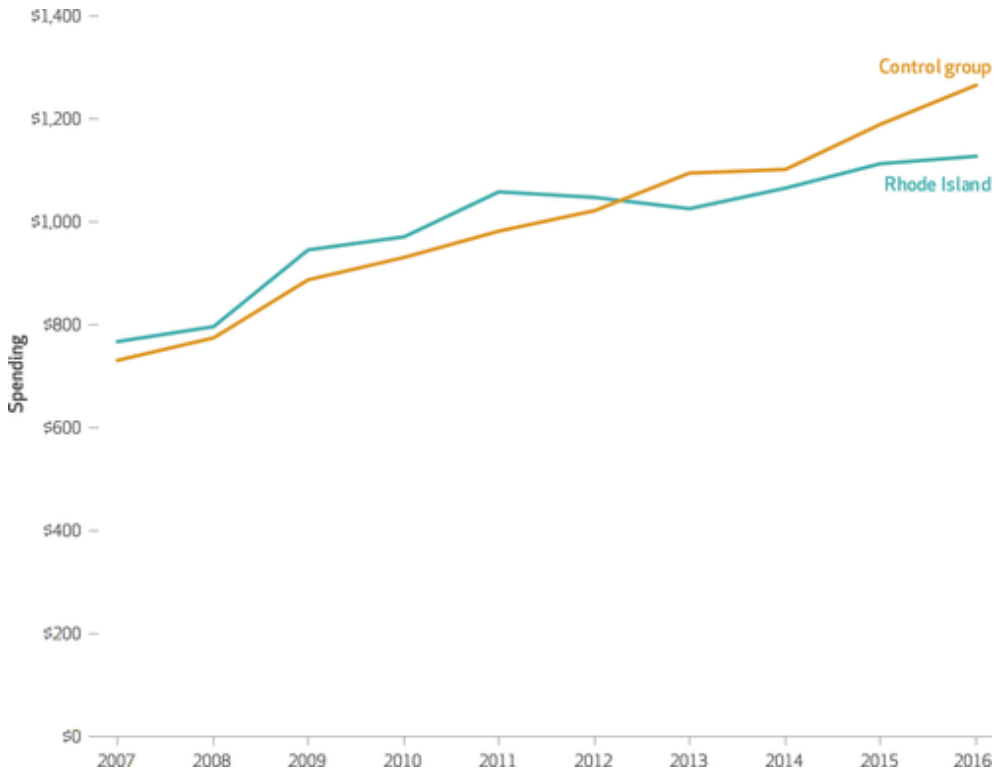
1. **annual price inflation caps on insurer hospital rates and on ACO budgets**
2. unit-of-service payment for inpatient and outpatient services, derived from nationally utilized payment practices other than fee-for-service
3. commercial insurers to roughly double the percentage of medical payments to primary care as a percentage for total spending and then maintain that level
4. increased adoption of value-based provider contracting, **with primary care prospective payment new in 2020**
5. increased adoption of the PCMH model
6. adoption of a common incentive aligned measure set

Rhode Island's 2019 Price Caps

- Hospital rate growth: CPI-U plus 1.0%
- ACO per capita budget growth: CPI-U plus 1.5%

Impact on Health Care Cost Growth

Quarterly per enrollee fee-for-spending in Rhode Island declined after the implementation of affordability standards compared to the control group



Source: Aaron Baum, Zirui Song, Bruce Landon et al. Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers. *Health Affairs*, Vol 38, No 2, February 2019. Available at: www.healthaffairs.org/doi/10.1377/hlthaff.2018.05164.

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Payment-Based Models: Hospital Global Budgets

- Effective July 1, 2014 in Maryland
- Requires hospitals to only accrue a budgeted amount of revenue from all payers, with the goal of limiting hospital volume and shifting care to less costly settings
- Sets an all-payer global budget for each hospital using historical baseline revenue and volume data
- Each year, the budget can be adjusted for: (1) inflation; (2) volume; (3) quality; and (4) uncompensated care
- Also implemented with rural hospitals in PA

Hospital Global Budgets: Results from Maryland

- RTI International's final evaluation of the 2014-2018 demonstration found the following:
  - Maryland's All-Payer Model **reduced both total expenditures and total hospital expenditures for Medicare beneficiaries**; however, only total hospital expenditures declined for commercial plan members.
  - **Reduced expenditures for outpatient hospital services** drove Medicare hospital cost savings.
  - The Model reduced expenditures for hospital services **without shifting costs** to other parts of the health care system outside of the global budgets, although site of care changed slightly for Medicare beneficiaries.
  - Maryland hospitals were able to operate within global budgets without adverse effects on their financial status.

Hospital Global Budgets: Sustainability Impact

- Hospital global budgets are attractive from a sustainability perspective, especially if they involve *prospective* payments, because they untether volume and payment in the short term.
  - OneCare currently pays each hospital a fixed prospective monthly amount per attributed life associated with historical hospital and hospital-based physician spending for residents in the hospital's HSA.
- Prospective payment models need to consider provider capital needs.

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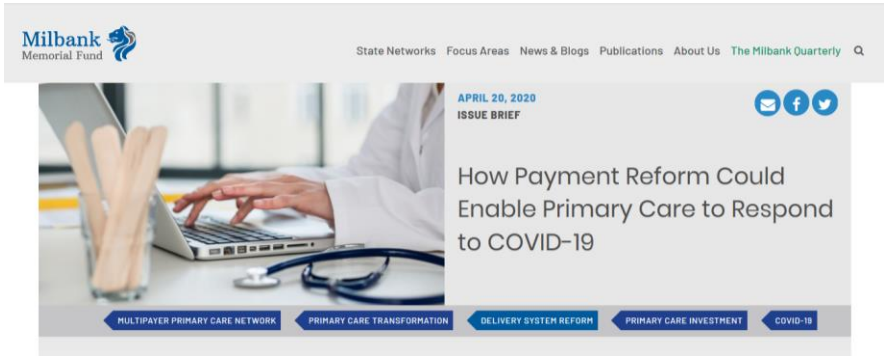
Prospective Payment

- COVID-19, and the cash flow crises it created for many providers across the U.S. due to decline in service volume, has kindled interest in expanded use of prospective payment.
- Prospective payment can address both affordability and sustainability objectives.



Prospective Payment

- Historically, few states have pursued strategies to advance prospective payment.
  - RI's updated 2020 "Affordability Standards" will do so, but only for primary care
- It is likely that there will be increased state activity in this area in the next two years.
- In Vermont, OneCare has utilized prospective payments with some hospitals and with primary care practices participating in a pilot.

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Payment-based Models: All-Payer Rate Setting

- Defined as all payers using one price for each medical procedure
  - Reduces administrative inefficiencies associated with determining price to charge each payer
  - Medicaid and Medicare prices  while commercial 
- Mainly used for hospital inpatient and outpatient services
- Attempted by about a dozen states in 1970s and 1980s, one of which was the forerunner to the Medicare Prospective Payment System
- Largely abandoned in the 1980s with the rise of HMOs...but not in Maryland!

Maryland's All-Payer Rate Setting Experience

- Began in 1976 when MD hospital admission cost was 25% higher than national average per case
  - By 1993, MD cost per admission was more than 11% *lower than the* U.S. average
- Between 2001-2008
  - MD admissions grew at 2.4% per year, compared to only 0.8% nationally
  - MD outpatient volumes grew 4.7% per year compared to 3.4% per year in the previous decade
- Total hospital operating costs grew to average annual rate of 8.4% compared to 4.8% in previous decade
- This is why Maryland moved to global budgets

Payment-based Models: Review and Key Takeaways

- RI affordability standards
  - policy lever to apply with commercial insurers
  - imposes price controls (inflation caps on hospital rates and ACO budgets; payment caps on inpatient / outpatient services) on contracts between commercial insurers and providers
  - promotes increased spending on primary care
- Prospective payment, including prospectively paid global budgets, offer a more predictable revenue stream for providers & budget control
  - Prospective payment can also be applied in non-global payment
- All-payer rate setting holds all payers to a single price for a medical procedure, typically inpatient and outpatient services
  - Experience has shown this leads to increased utilization; also high risk of regulatory capture

Payment-based Models: Opportunities for Vermont

1. Require movement toward adoption of prospective payment to support sustainability and affordability
2. Invoke provider rate regulation authority
   - Establish a cap on provider rate increases in commercial contracts

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Cost Growth Targets

- In 2012, MA set a target for controlling the growth of total health care spending across all payers, set at the state's projected long-term economic growth rate:
  - 2013-2017 – potential gross state product (PGSP) (3.6%)
  - 2018-2022 – PGSP minus 0.5% (3.1%) - can be modified with 2/3 vote if reasonably warranted
  - 2023 – PGSP (3.6%) - can be adjusted to any value
- Cost growth is defined as the per capita change in total health care spending from public and private sources and includes:
  - All categories of medical expenses and all non-claims related payments to providers
  - All patient cost-sharing amounts
  - Net cost of private health insurance (i.e., insurer admin and margin)

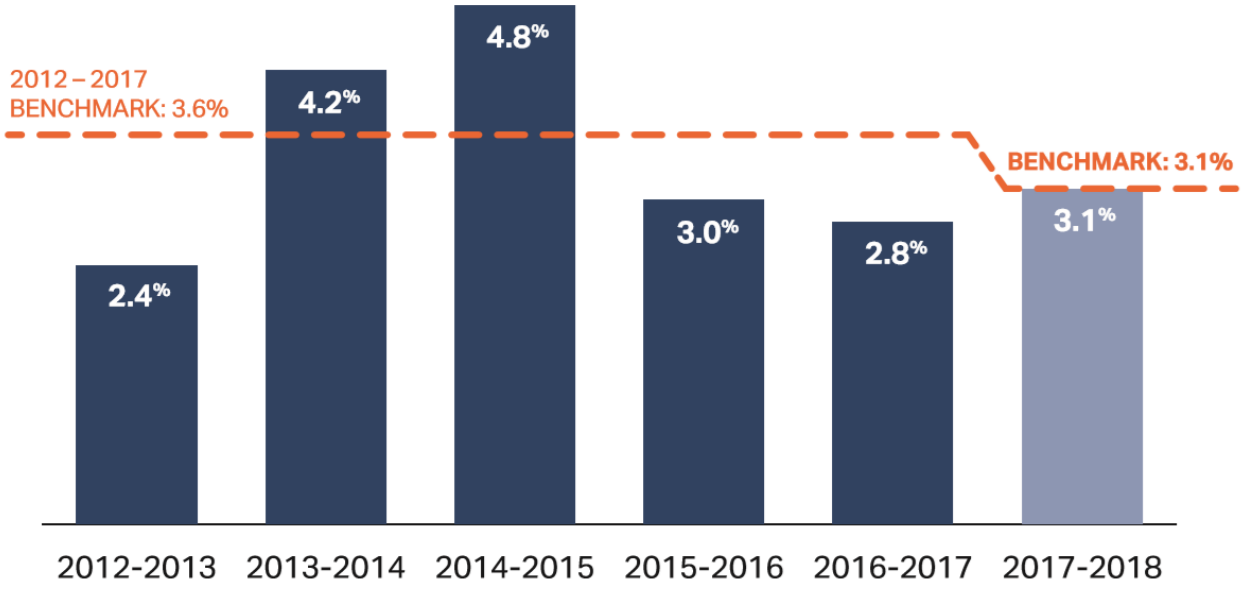
Cost Growth Targets

- In MA, if an organization exceeds the target:
  - The Health Policy Commission *may* require it to submit a performance improvement plan (PIP)
  - A fine of up to $500,000 can be imposed for failure to submit, implement, or report on the PIP
- If the benchmark strategy does not work

  "The commission may submit a recommendation for proposed legislation to the joint committee on health care financing if the commission determines that further legislative authority is needed to achieve the health care quality and spending sustainability objectives of this act, assist health care entities with the implementation of performance improvement plans or otherwise ensure compliance with the provisions of this section."

Massachusetts' Experience To Date

Annual Growth in Total Health Care Expenditures Per Capita in Massachusetts



Notes: 2017-2018 spending growth is preliminary.

Sources: Center for Health Information and Analysis Annual Report, 2019

Massachusetts' Experience To Date

- "Payer and provider rate negotiations are now conducted in light of the 3.6% target." (State Auditor study)
- "With an expected utilization increase of about 2%, payers and providers generally agree on annual price increases of about 1.5%." (David Cutler, HPC member)
- "The [cost growth benchmark] does mean something. It sets the bar upon which most activities in the health system are judged. It's more than just a symbol, it's become an operational component of how our health system works." (Stuart Altman, HPC Chair)
- Yet...commercial premiums and out-of-pocket costs have continued to rise at rates above the cost growth target, so additional levers may be necessary.

Other Cost Growth Target Efforts

- Delaware
  - Set at 3.5% for CY 2020, 3.25% for CY 2021, and 3.0% for CY 2022 and 2023
- Oregon
  - Set at 3.4% through 2025, and then 3.0% through 2030
- Rhode Island
  - Set at 3.2% through 2022
- Other states currently pursuing cost growth targets: CA, CO, CT, WA

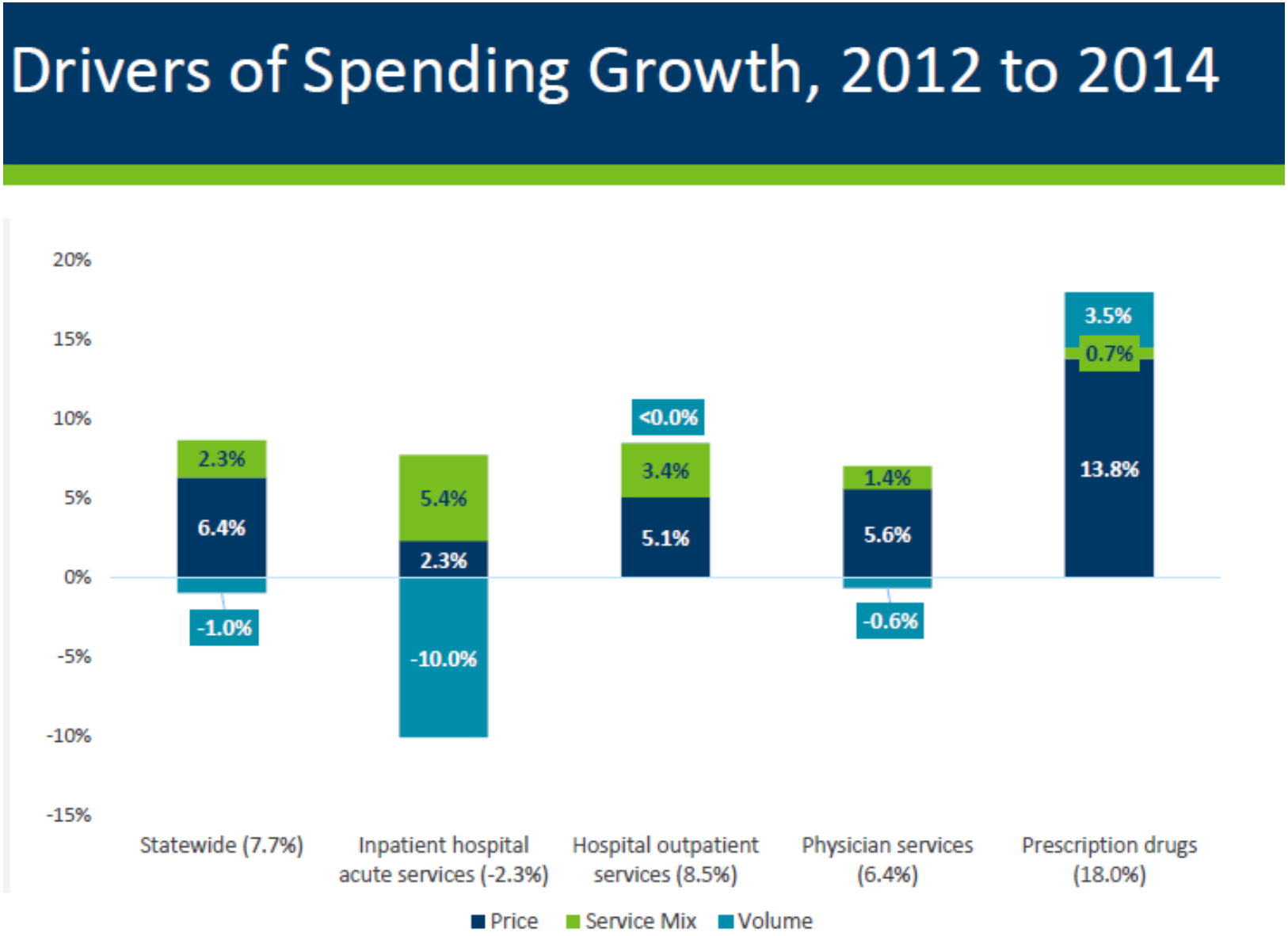
It's Not Just a Target

- RI and OR are developing complementary strategies, including:
  - Public reports that identify performance of insurers and large providers relative to the cost growth target
  - Public reports that highlight drivers of cost and cost growth in order to inform provider, insurer, state and collaborative cost growth reduction efforts
  - Facilitating of collaborative multi-stakeholder work

Identification of Cost Growth Drivers

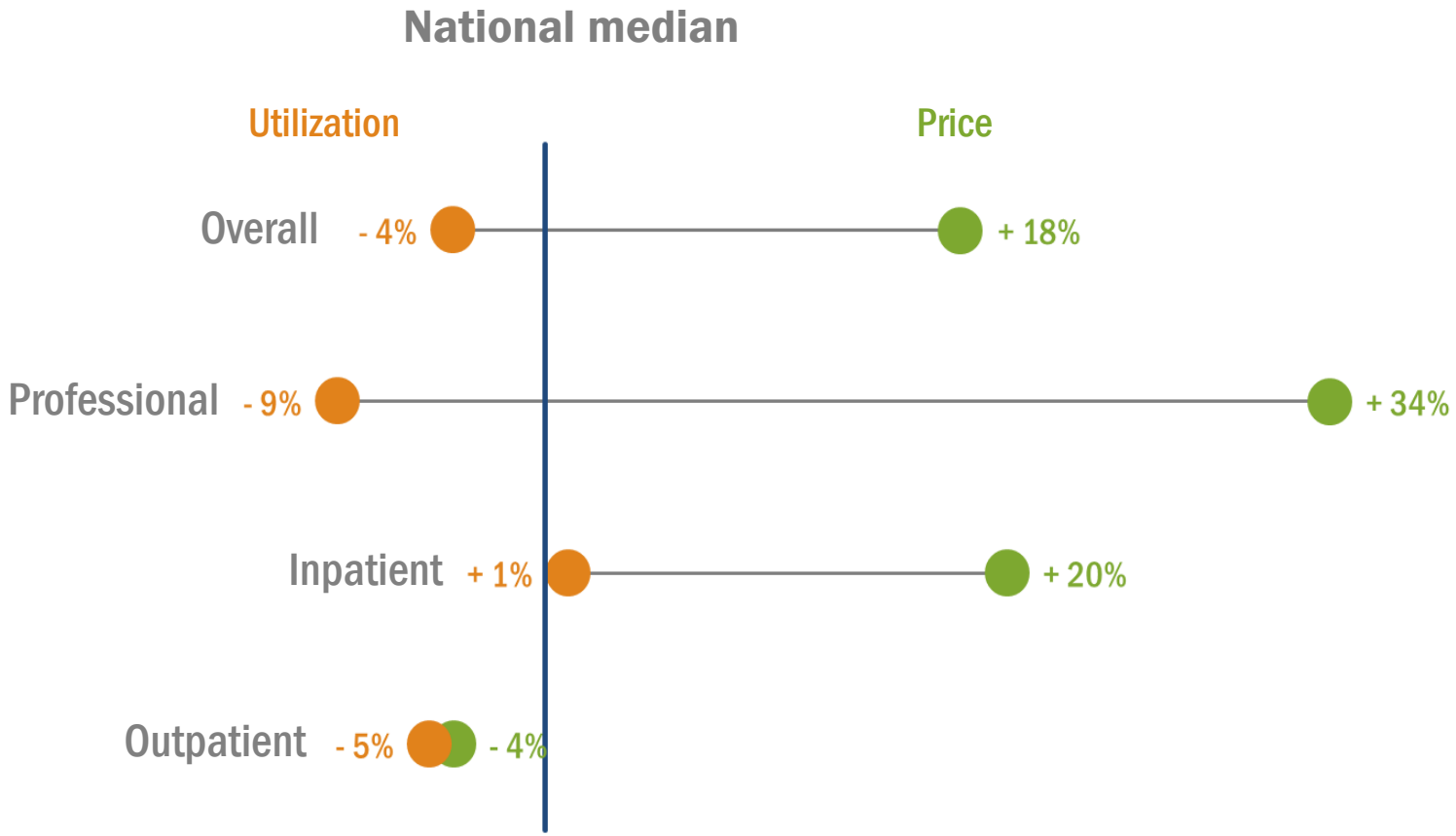
- Rhode Island – with input from a committee of providers, payers and consumers – is considering leveraging its all-payer claims database (APCD) to:
  - produce and publish structured analyses of a set of defined metrics
  - perform ad hoc analyses focusing on discrete topics of interest to the State and to Rhode Island stakeholders
- Rhode Island will generate reports that isolate what is driving underlying cost and what is driving cost growth.
- Oregon is commencing a process to do the same.

Example Analyses of Cost and Cost Growth Drivers



Example Analyses of Cost and Cost Growth Drivers *(cont'd)*

- Overall prices in the Portland, Oregon metro area are 18% above the national median
  - High prices are not offset by low utilization.

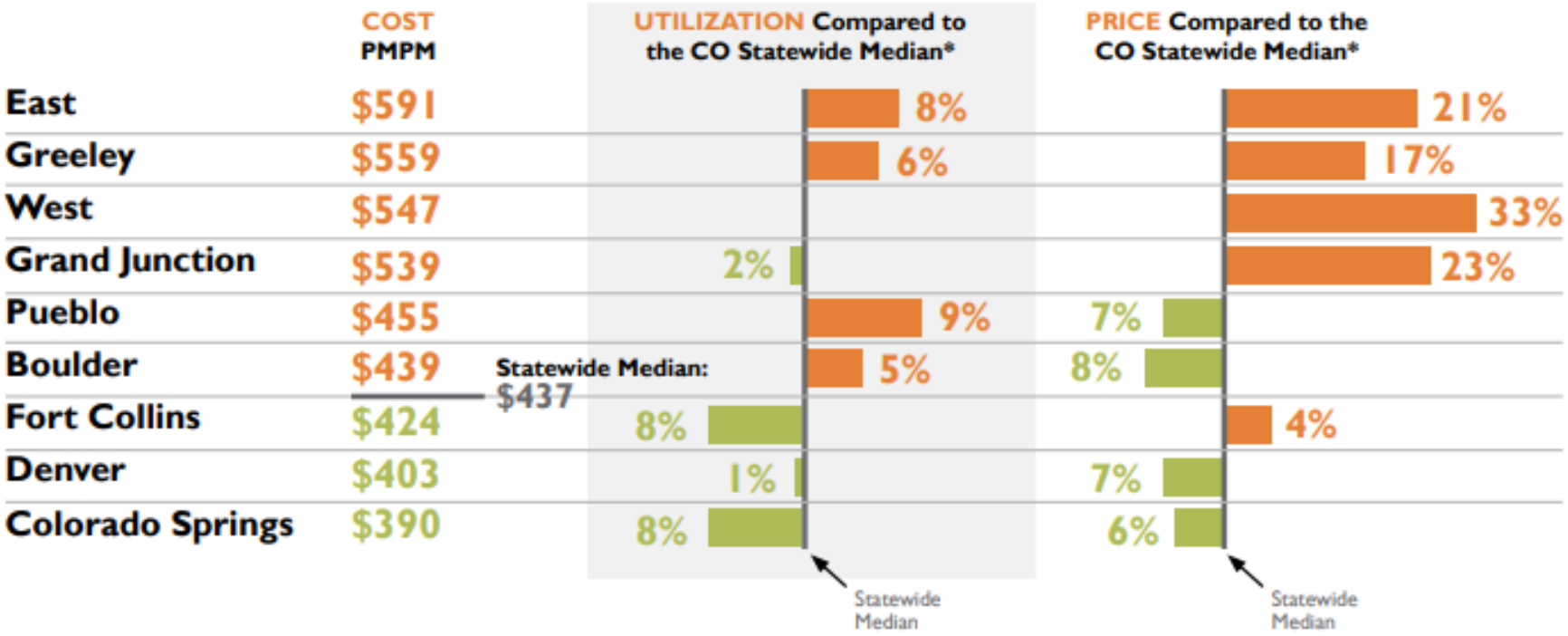


Source: Health Care Cost Institute, 2016

Example Analyses of Cost and Cost Growth Drivers *(cont'd)*

- Drivers of Cost by Region

Table 3. Total (Inpatient, Outpatient, Professional, Pharmacy) Median Risk-Adjusted Per Member Per Month (PMPM) Cost by CO Division of Insurance Region



*Statewide medians only reflect results for the 102 adult primary care practices included in the 2015 Colorado All Payer Claims Database study

Cost Growth Targets: Review and Key Takeaways

- Cost growth targets are a mechanism to slow the growth of health care spending *(affordability strategy)*
  - Set a budget for total health care costs
  - Promotes alignment among providers and payers around a common goal for reducing health care costs
  - Utilizes transparency through public reporting to promote accountability
- Combined with a data use strategy, cost growth targets can identify cost drivers, target interventions, and facilitate collaborative action

Cost Growth Targets: Opportunities for Vermont

1. Pursue a “data use strategy” for deeper analyses into costs, cost growth drivers, and cost variation.
2. Develop measures of cost accountability at the provider level (below TCOC) to look at price and utilization variation across specialists.

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Public Option

- A “public option” is a state-organized plan that competes with other private health insurance company products. It could be:
  - Self-sustaining and paid solely through premiums
  - Subsidized by taxes
- Generally, states have proposed contracting with a plan administrator(s) rather than operating the plan itself, as the concept was initially envisioned.
- It is viewed by some as a first step towards a single-payer system, but certainly need not be.

State Efforts to Stand Up Public Option Plans

- Washington (passed legislation)
  - Available starting January 2021
  - Administered by insurers, overseen by state
  - Provider reimbursements capped at 160% of Medicare
  - Minimum reimbursement of 135% of Medicare for primary care, and 101% of allowable costs for care in critical access and sole community hospitals
- Colorado (legislation being considered)
  - Administered by insurers, overseen by state
  - Most savings to come from paying hospitals less (155% of Medicare)
  - Projects enrollment of 4,600 to 9,200 in first year

Public Option: Key Takeaways

- Offers more choices for consumers and introduces additional competition in the market
- Mechanism to implement price controls
  - Enables states to establish minimum amounts payers must pay providers
  - Imposes price caps on some providers
- WA and CO designs stray from the original concept of a public option whereby a public purchaser would administer the public plan

Public Option: Opportunities for Vermont

1. A public option may not be needed given the existing regulatory levers that the GMCB is able to apply to the commercial market

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Other

- Some states have pursued additional strategies to advance affordability and sustainability objectives, including:
  A. Market Stabilization
  B. Prescription Drug Policies
- Because Vermont has already addressed many opportunities in these areas, we will not review them.
- Additional information about those strategies is contained in the Appendix

Discussion and Public Comment

APPENDIX

Market Stabilization

- The ACA adopted reforms aimed at addressing failings of the individual health insurance market which focused on risk selection and segmentation
- Strategies to stabilize the individual market largely focus on:
  - Increasing or maintaining marketplace enrollment to allow broader risk pooling
  - Keeping insurers from exiting the individual market

Market Stabilization *(cont'd)*

- Efforts to stabilize markets include:
  1. Reinsurance programs
  2. Individual mandates
  3. Enhanced subsidies
  4. Limiting non-ACA-compliant plans
- Afford some protection and certainty to payers (e.g., reinsurance, individual mandate), and can reduce commercial premiums
- Can also support and protect consumers
  - Reinsurance may lower premiums
  - Enhanced subsidies make coverage more affordable
  - Limiting options that are not compliant with ACA

Action previously taken or considered by Vermont.

Market Stabilization Strategies

- Reinsurance programs
  - Partially reimbursing insurers for certain high-cost claims allows insurers to lower premiums for all ACA-compliant plans
  - AK, MN and OR's reinsurance programs led to lower premium increases and kept insurers from exiting marketplaces
- State individual mandate requirements
  - Without the mandate penalty, young, healthy adults may drop coverage, thereby driving up premiums
  - CA, DC, MA, NJ, RI, VT enacted state individual mandate requirements after Congress eliminated the penalty for being uninsured

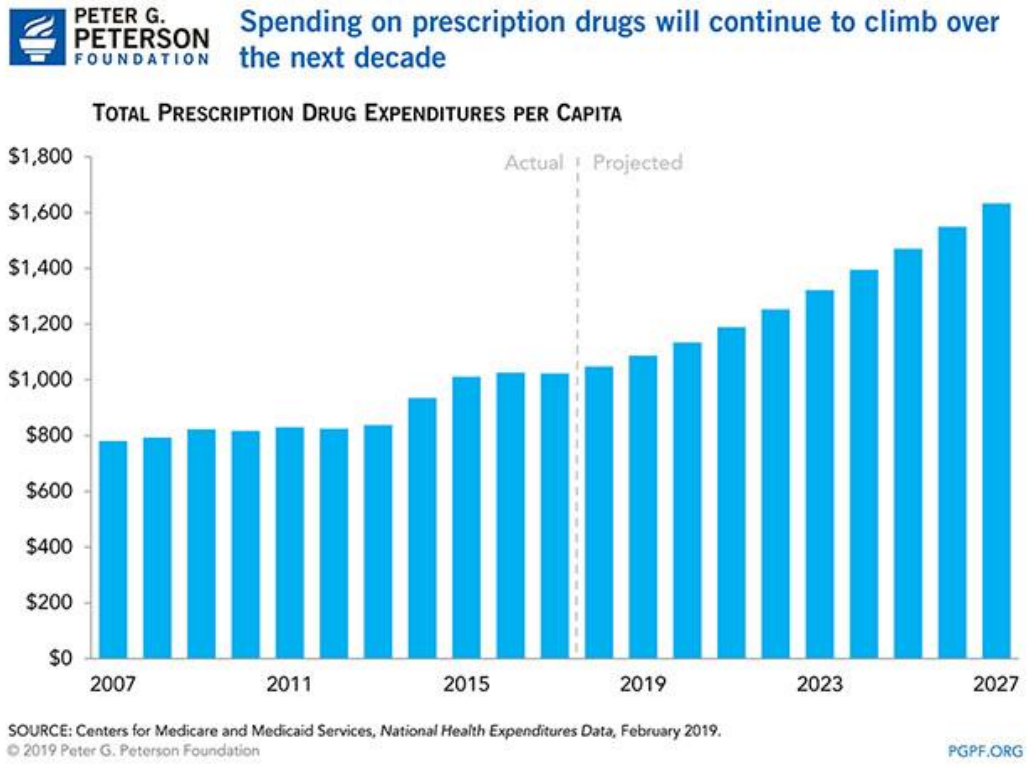
Market Stabilization Strategies *(cont'd)*

- State-funded enhanced subsidies
  - Subsidies that wrap around federal premium tax credits
  - MA and VT provide additional premium and cost sharing subsidies to people with income up to 300% FPL
- Limiting the availability of short-term and non-ACA-compliant transitional or "grandmothered" plans
  - 9 states limit short-term plans
  - 14 states and DC limit short-term plans to no more than six months and prohibit grandmothered plans

Controlling Prescription Drug Spending

58 million adults have experienced “medication insecurity,” defined as the inability to pay for prescribed medication at least one time in the past 12 months.

- Source: Gallup-West National Healthcare Study, September 2019.



Controlling Pharmacy Costs

- 2020 State Legislative Action to Lower Pharmaceutical Costs

Bills Introduced to Address Pharmacy Costs	Number
Regulations or restrictions on pharmacy benefit managers	140
Importation	38
Transparency	51
Volume purchasing	7
Affordability review	21
Price gouging	4
Coupons/cost-sharing	60
Study/evaluation	11
Other	31

8 State Strategies to Control Pharmacy Costs

1. Regulate pharmacy benefit managers (PBMs), such as banning of spread pricing, requiring to pass through of rebates to payers or patients
2. Create state-administered programs for wholesale prescription drug importation
3. Require drug companies to provide information on drug prices and planned price increases
4. Create intrastate or interstate purchasing pools to increase market leverage

Action previously taken by Vermont.

8 State Strategies to Control Pharmacy Costs

5. Establish drug affordability review board that can take action against excessive, unjustified price increases
6. Place caps on consumer co-pays for specific treatments or under certain conditions
7. Prohibit discount coupons for drugs for which a lower cost generic drug is covered
8. Explore alternative Medicaid payment models, such as outcomes-based contracts with drug manufacturers

Prescription Drugs: Opportunities for Vermont

- Vermont may wish to evaluate the impact of its action to control prescription drug spending and make modifications as appropriate
- For example, the state may consider assessing
  - Reports / actions from the drug affordability review board
  - Wholesale drug importation