Cost Growth Target programs

New Hampshire Department of Insurance
Christopher F. Koller
Milbank Memorial Fund
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About The Milbank Memorial Fund

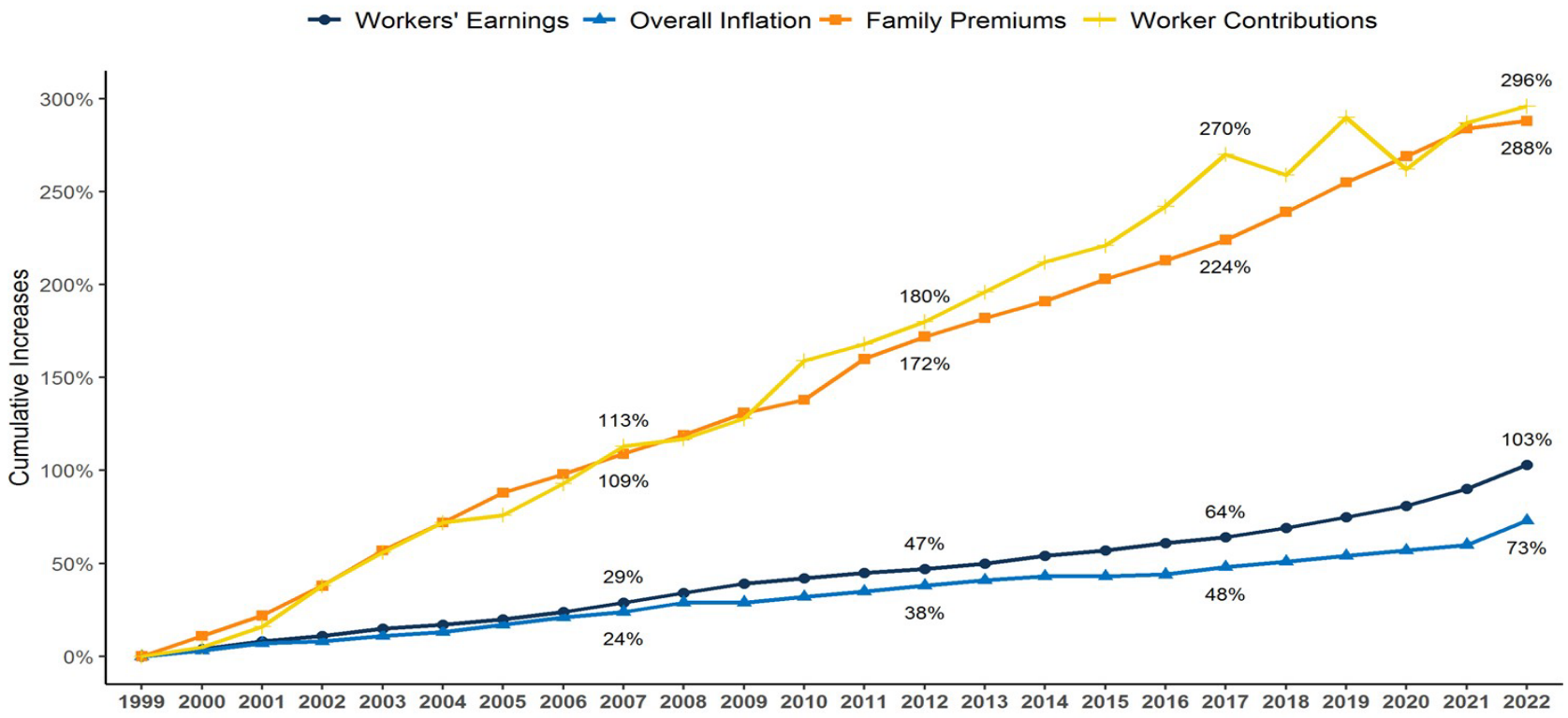
The Milbank Memorial Fund is an endowed operating foundation that works to improve population health and health equity by collaborating with leaders and decision-makers and connecting them with experience and sound evidence.

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 on issues they identify as important, particularly in areas related to primary care transformation, sustainable health care costs, and aging, and
- Publishing high-quality, evidence-based publications and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy.

Growing Crisis in Health Care Affordability Tied to Economic Indicators

Cumulative Increases in Family Premiums, Worker Contributions to Family Premiums, Inflation, and Workers' Earnings, 1999-2022



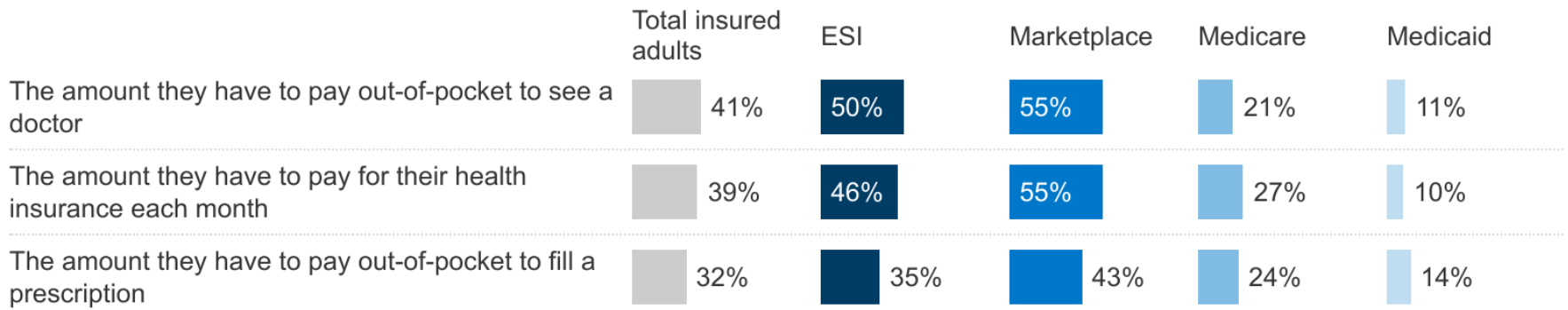
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017. B
Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 1999-2022; Bureau of Labor Statistics, Seasonally Adjusted Data
Current Employment Statistics Survey, 1999-2022.

Commercial health insurance is at center of affordability concerns

Figure 7

Large Shares Of Adults With ESI And Marketplace Coverage Rate Their Insurance Negatively When It Comes To Premiums And Out-Of-Pocket Costs

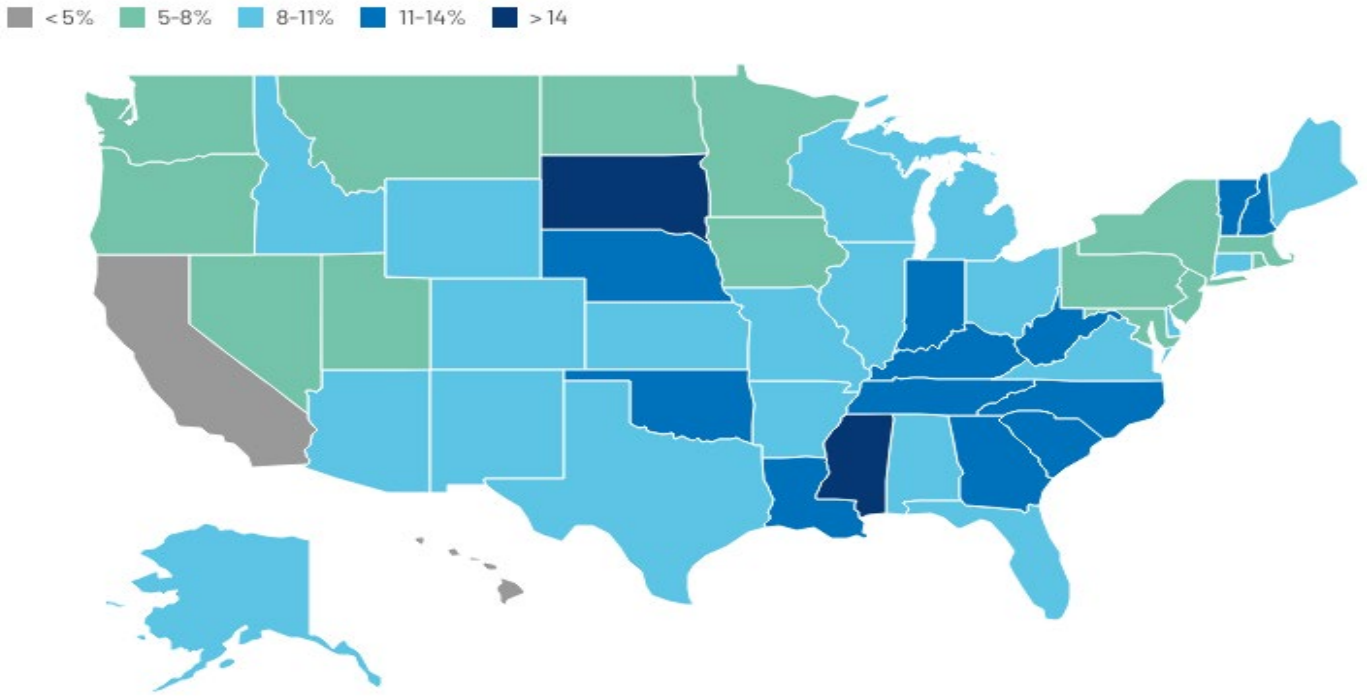
Percent who rate the following aspects of their current health insurance as either **fair** or **poor:**



NOTE: See topline for full question wording.
SOURCE: KFF Survey of Consumer Experiences with Health Insurance (Feb. 21-Mar. 14, 2023)

KFF

Share of Adults Who Have Medical Debt, by State, 2019-2021



Note: This chart aggregates SIPP data from 2019 through 2021

“First National Scorecard Reveals a Sector in Peril”

The Health of US Primary Care:

A Baseline Scorecard Tracking Support for High-Quality Primary Care

BY YALDA JABBARPOUR, STEPHEN PETTERSON, ANURADHA JETTY, AND HOON BYUN, ROBERT GRAHAM CENTER

FINDINGS

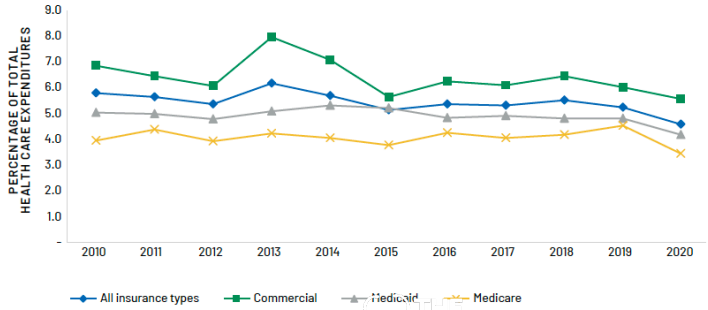
I. **Financing:** The United States is underinvesting in primary care.

From 2010 to 2020, the percentage of total health care spending allocated to primary care has been low, and little progress has been made over time. US primary care spending for all insurance types over the decade varied from 6.2% in 2013 to 4.6% in 2020. By comparison, Organization for Economic Co-operation Development (OECD) nations spent 7.8% of total health care expenditures on primary care in 2016, according to the NASEM report.

“Primary care spending” depends on payers’[7,8] and states’[9] definitions of primary care.[10] For this report, primary care spending was defined as the proportion of total health care expenditures being spent on outpatient and office-based visits to primary care clinicians (Figure 1). This “narrow” definition is restricted to outpatient and office-based expenditures to primary care physicians (PCPs), defined as family physicians, general pediatricians, general internal medicine physicians, and geriatricians. A “broad” definition adds spending for office-based care from nurse practitioners (NPs), physician assistants (PAs), behavioral health clinicians, and obstetricians/gynecologists. (Appendix B provides additional data using the broad definition, as well as information on how each of the specialties in the broad category contributes to primary care spending.)

US primary care spending for all insurance types over the decade varied from 6.2% in 2013 to 4.6% in 2020.

Figure 1: Primary Care Spending (Narrow Definition) from 2010 to 2020



Data Source: Analyses of Medical Expenditure Panel Survey (MEPS), 2010-20. MEPS was redesigned in 2013; data on ambulatory care expenditures derived from the consolidated, office-based, and outpatient event files. See Appendix B for details.

Notes: The primary care narrow definition is restricted to primary care physicians only. The primary care specialties included family medicine, general practice, internal medicine, pediatrics, geriatrics, and osteopaths.

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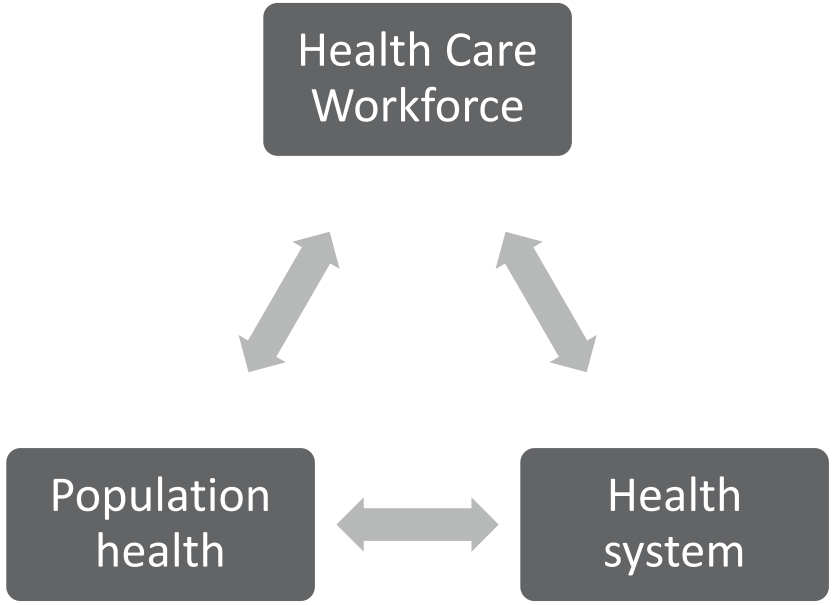
Beyond just affordability - Health care system problems are interconnected



Need to consider solutions in holistic context

Reducing rate of cost growth necessary to rebalance investments in health care (Strong primary care as a critical foundational component) and other more productive uses of those funds

What is a health care cost growth target (CGT)?

- Determine what is a “sustainable” level for overall cost growth
- May also be called benchmark, spending growth target
- Key variables:
  - Blend of state economic growth and household income growth used to set target – rates fixed for period of years; possible adjustments can be formula based or predetermined percent
  - Performance against target measured by total health care spending growth, reported at one or more of the following:
    - Aggregate statewide/system level
    - Aggregate market/payer categories
    - Large health plans and provider systems

Elements of a Cost Growth Targets Model

- Commission chartered
- Set target for Average Per Capita Growth in Health Care Costs in state (growth across all payers)
- Measure performance against target by payer type, (sometimes payer and delivery system)
- Measure growth by service type and by price and utilization
- Disseminate findings
- Generate discussion about policy responses

The Fundamental Principle:

"You Can’t Lose Weight Without a Scale”

Benefits of CGT model

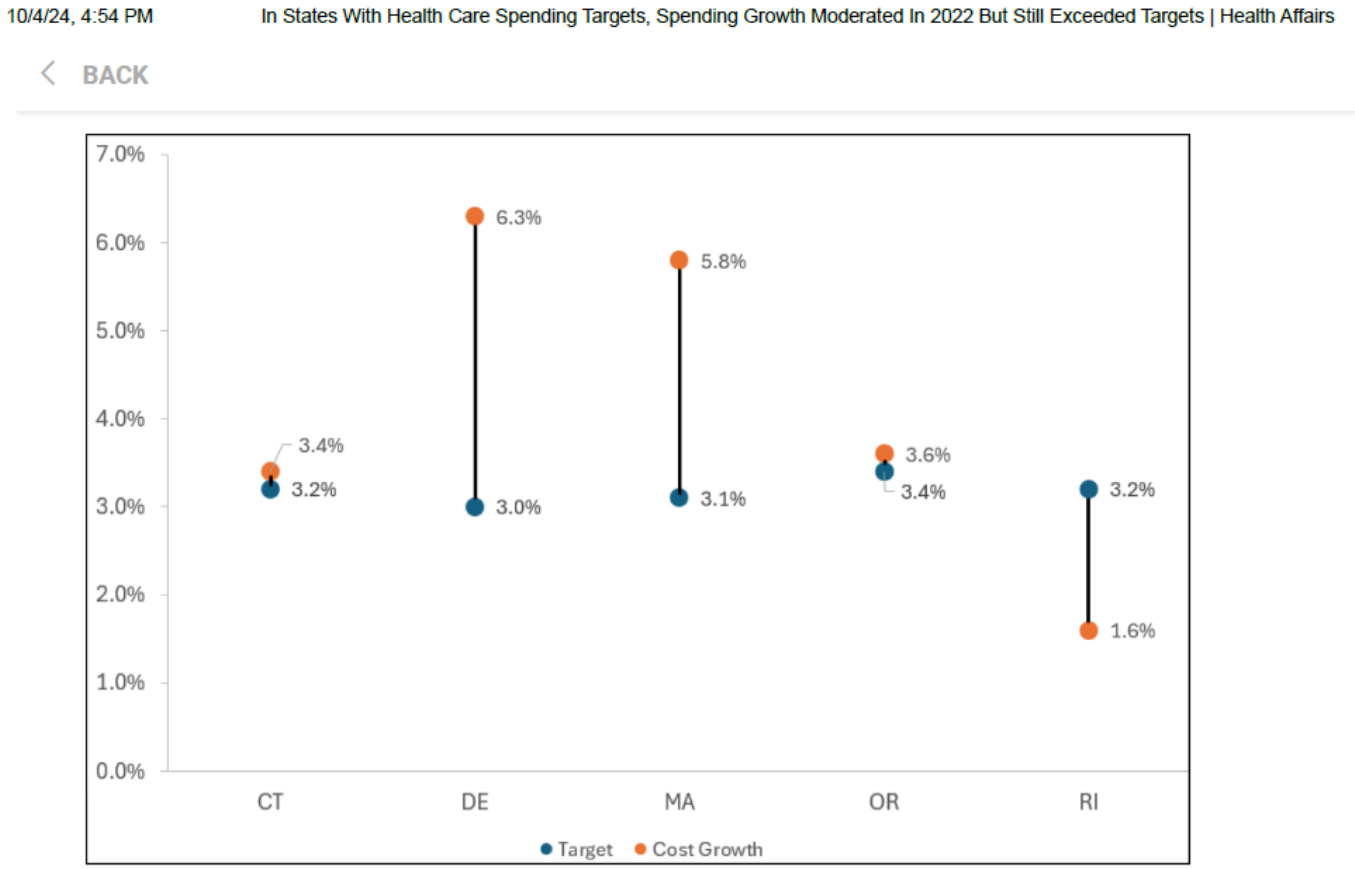
- CGTs create a platform for the information, public-private engagement, and leadership that is necessary for improving statewide cost growth.
- They provide a complete picture of total health care spending across their markets and pinpoint cost drivers.
- CGTs promote a clear goal for the development of capabilities required to monitor health care costs, provide a business case to fund the associated data and policy infrastructure, and act as a motivator for stakeholder participation.
  - We have a better understanding now that this is a long-term process and only a few states have gotten to this point

Peterson-Milbank Program

- Rhode Island
- Connecticut
- New Jersey
- Oregon
- Washington
- “Friends and family” invited to program events – Massachusetts, Delaware, California, Maine, Minnesota, Utah, Vermont

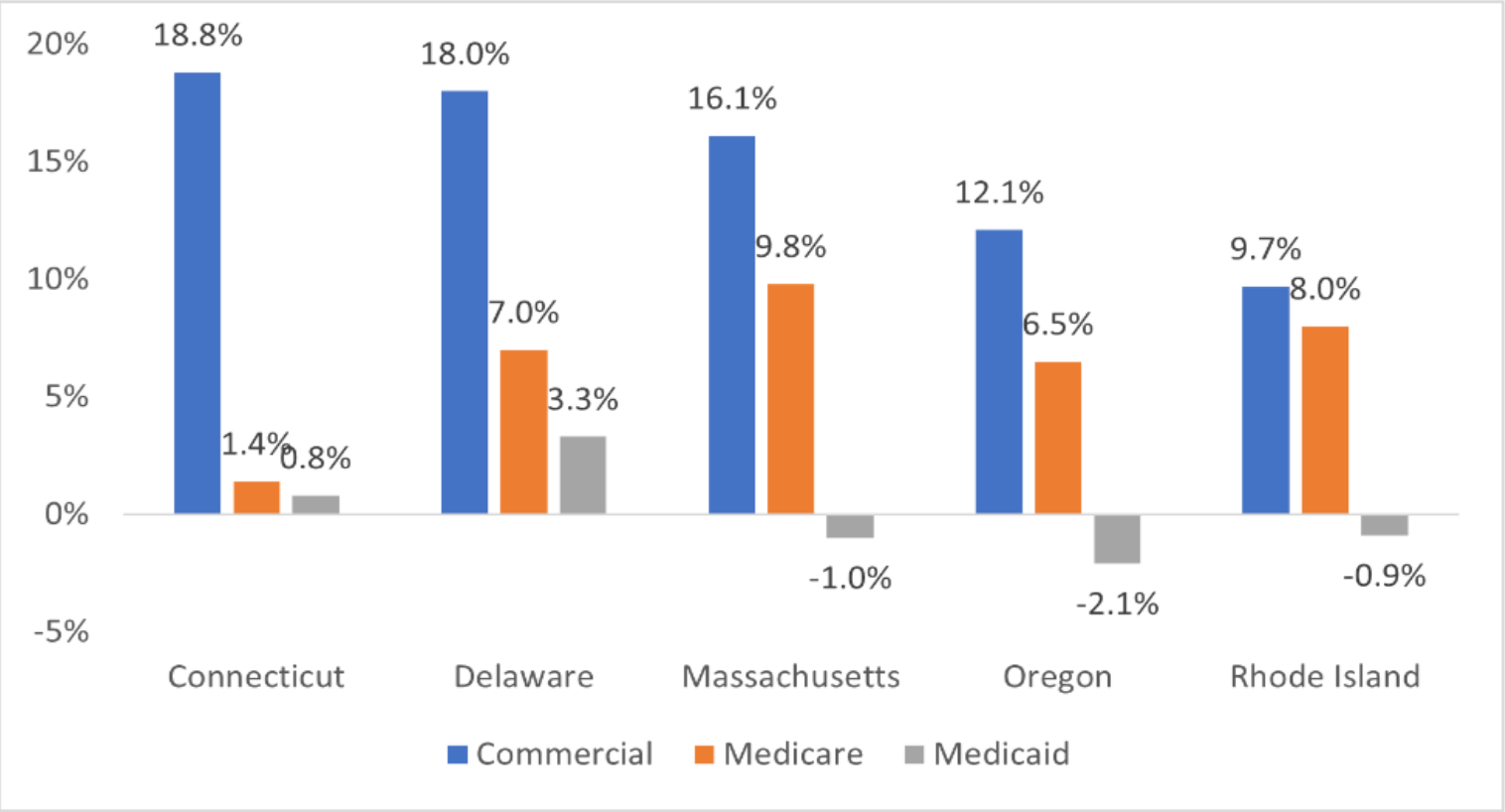
- Principal focus is providing technical assistance – combination of state-specific and group discussion on policy, technical and communications priorities
- Regular schedule of publications to highlight state experience and feature in-depth policy analysis
  - Health insurance affordability standards
  - Policies for hospital cost and price growth accountability
  - Balancing cost growth target with primary care investment target

Lesson One: This is Doable
Can Set Targets, Measure Growth in Per Capita Health Care Expense by State and Compare



Mar, Angeles, Health Affairs Forefront, August 8, 2024

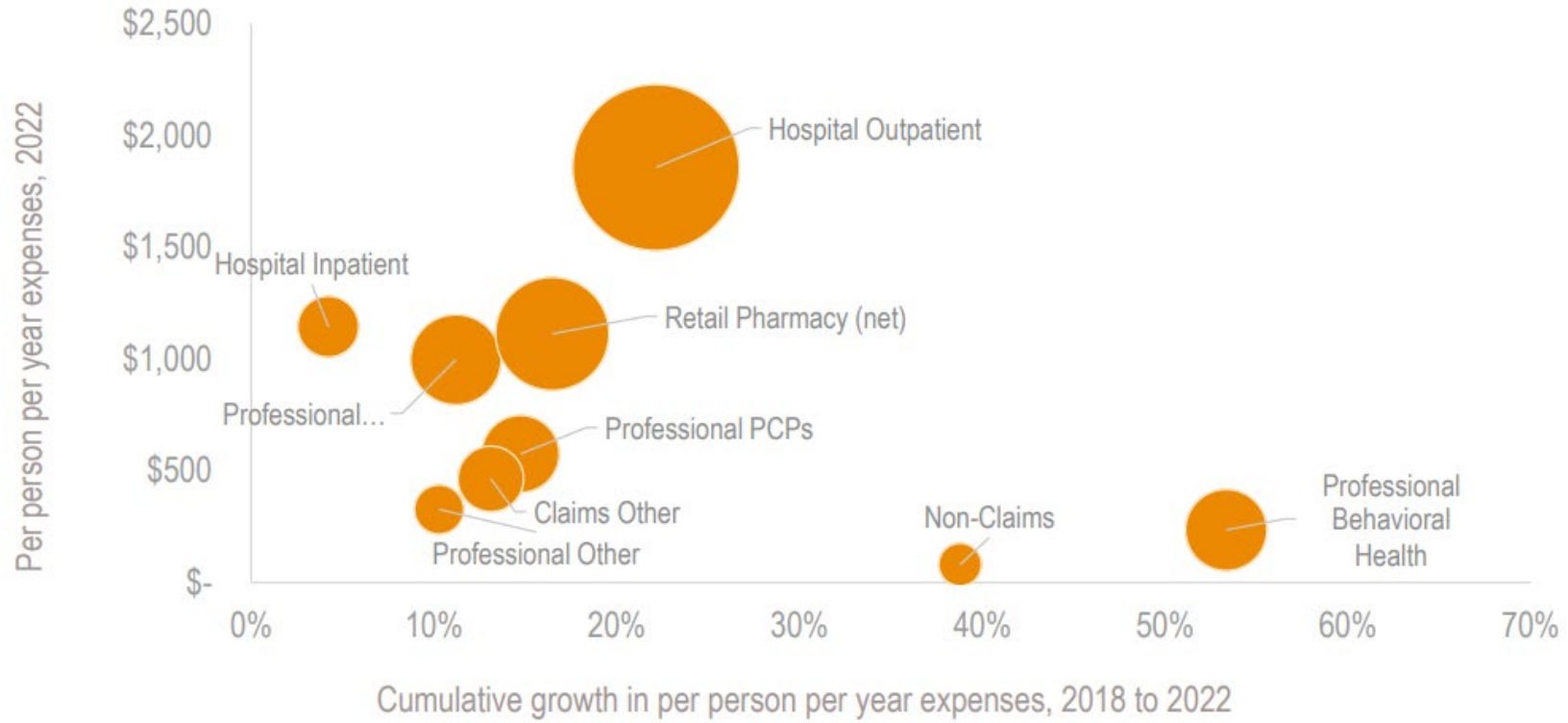
Lesson Two: All the Growth is in Commercial Insurance Expenses



Source: Angeles J. States Setting Health Care Spending Growth Targets Experienced Accelerated Growth in 2021. Health Affairs Forefront. June 29, 2023.

Lesson Three: Outpatient Hospital and RX are Usually Biggest Contributors (data from OR)

Total Medical Expenses – Cumulative growth in spending per person per year from 2018-2022 and spending in 2022 with absolute dollar change (bubble size) from 2018-2022, by service category, Commercial*



Historically: Price, not Utilization driving increases

Lesson Four: Providers Are Often Not Pleased With This Transparency and Accountability

- Contest the Data
- Cite Alleged Underpayments by Public Payers
- Cite Labor Costs

Lesson Five - Growth in CGT policy uses Varies by State's Politics and Culture

System Oversight and Transparency	Value-based care transition	Price negotiation, regulation and all-payer budgets	Insurance Rate Review and Antitrust	Government funded health plans
1. Annual hearings on cost trends (all CGT states)	1. Value-based care compacts (OR, RI)	1. Global all-payer budgets (OR)	1. Insurance rate review (RI)	1. Unified health care financing system design (CA, OR, WA)
2. Report on cost drivers, solutions (all CGT states)	2. Primary care spending targets (CT, OR, WA)	2. Rate setting/Price Caps (RI)	2. Antitrust enforcement - market oversight programs or state AGs (OR, MA)	2. Public option design (NV, WA)
3. Performance Improvement Plans (OR, MA)				

States Can Lead: A Systemic Approach to Affordability

State Policies That Could Collectively Slow Cost Growth and Improve Health and Care.

Policy	Justification
Comprehensive oversight and spending-growth targets: Each state should establish and adequately fund a state agency to track systemwide cost and quality performance, set spending-growth targets, identify drivers of cost growth and opportunities for improvement, and implement or recommend needed reforms.	Systemwide oversight, sound data, and understanding of state-specific drivers of cost growth provide the foundation for effective policy. Having the statutory authority to achieve spending-growth targets makes agencies' actions more likely to withstand legal threats from groups and organizations that resist reform.
Hospital global budgets: States should work with Medicare to establish all-payer hospital global budgets that ensure both adequate local and regional access to needed facilities and services and their financial viability, gradually shifting resources to primary care and population health improvement, as possible.	All-payer hospital global budgets shift incentives by rewarding health improvements, reductions in avoidable utilization, and increased efficiency rather than volume growth for high-margin services. Implemented properly, they can strengthen safety-net and rural facilities while reducing duplication in overserved markets.
All-payer accountable care organizations: All payers should be required to adopt aligned global payment models for physician-led organizations that can deliver comprehensive, coordinated primary and specialty care with accountability for quality and the total cost of care.	Still the predominant payment model, fee-for-service payment rewards overuse and locates accountability at the level of the clinician, resulting in fragmented care. Clinicians and health care organizations that receive global payments for all their patients have powerful incentives to improve care and the necessary freedom to innovate.
Pricing power limited by means of effective regulation: States should adopt policies to preserve competition wherever possible. Where it is not possible, they should establish regulatory bodies authorized to review cost structures and effectively regulate prices as needed.	Consolidation and barriers to entry have led to decreased competition, lower quality of care, and monopoly pricing, especially for hospital services and prescription drugs. In such cases, regulation is essential for improving affordability and access to care.

Fisher et al. New England Journal of Medicine, October 10, 2024

In summary

- "Health care is the **tapeworm of our economy"** (Warren Buffett) Restraining cost growth and rebalancing health spending are public goods and require urgent attention
- Health Care Providers **behave to preserve their interests** – including gaining economic and political power,
- **Affordability of healthcare will get worse**. We cannot cost shift or subsidize our way out of the challenge

In summary (cont'd)

- **The market will not fix itself**. Meaningful action will require sustained and coordinated leadership at multiple levels – government, industry, consumers and employer/purchasers
- Cost Growth Targets provide transparency, structure and process to monitor performance and design and advance a policy agenda that **considers the state's health care system needs holistically** in light of rest of state's economy and values.