Addressing and Reducing Health Care Costs in States: Global Budgeting Initiatives in Maryland, Massachusetts, and Vermont

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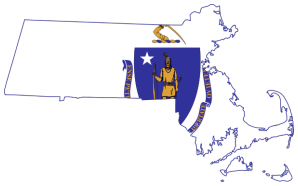
Introduction

In the five years since the passage of the Affordable Care Act (ACA), 17 states and the District of Columbia have created health insurance exchanges[1] and 30 states and the District of Columbia have expanded their Medicaid programs to cover low-income populations.[2] More than 16 million people are newly insured under the law.



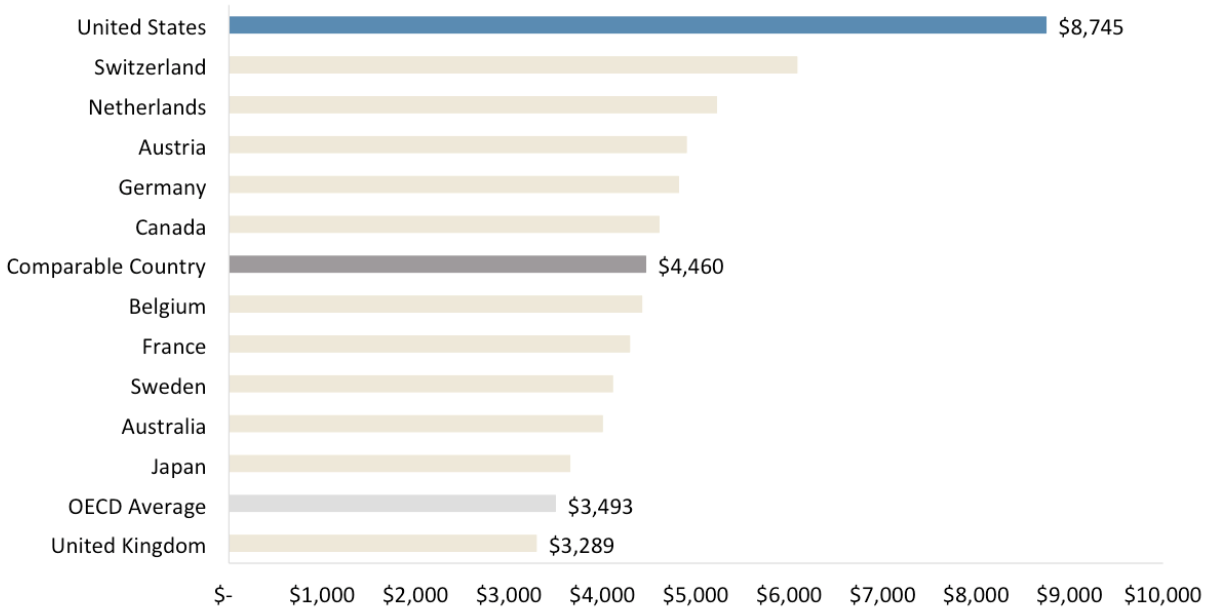
In addition to expanding health coverage, a number of states are also undertaking broad health care system transformation initiatives, which seek to achieve the Triple Aim: improve health and quality while lowering costs. The Centers for Medicare and Medicaid (CMS) Innovation Center has awarded nearly $4.8 billion to these efforts and states are undertaking scores of new demonstrations to reform payment and delivery systems.[3] Although health care spending has been growing at a slower rate in recent years, it is now projected to increase.

An important focus for states is the third "leg" of the Triple Aim—lowering costs. This paper highlights how Maryland, Massachusetts, and Vermont have adopted policies and are working to implement all payer models that set targets or global budgets for health care cost growth based on the total cost of care. These states have undertaken initiatives to try to slow the growth of health care spending in their states and the results of these experiments will be important to watch, but affordibility remains a challenge.

Why Pursue Global Budgets?

The United States spends more money on health care than any other developed country in the world. The average amount of health spending per person in comparable Organization for Economic Co-operation and Development (OECD) countries is roughly half that of the United States or $4,460 vs. $8,745. (See Chart 1.) Until the 1980s, the U.S. was relatively on pace with other countries. For example, in 1970 the U.S. spent about seven percent of its Gross Domestic Product (GDP) on health, similar to spending by several comparable countries.[4] Since 1980, however, the gap between spending in the U.S. and other nations has grown tremendously when health spending grew at a significantly faster rate relative to the GDP. In 2012, the U.S. spent 17 percent of its GDP on health, while the next highest country, the Netherlands, attributed 12 percent of its GDP to health.[5]

Chart 1. Total health expenditure per capita, U.S. dollars, adjusted per person, 2012



SOURCE: Kaiser Family Foundation analysis of 2013 OECD data: "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database). **Notes:** Because 2012 data was unavailable, 2011 were used for Australia and the Netherlands. Data for Canada and Switzerland are estimated values.

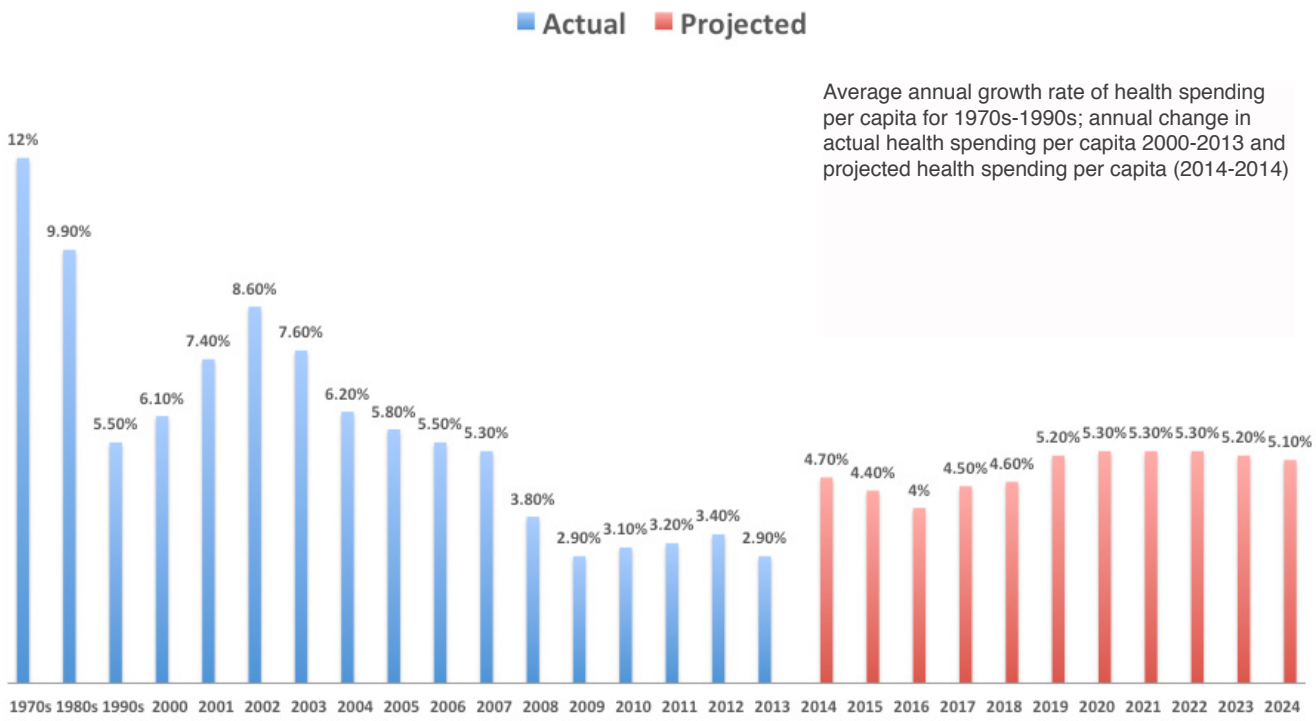
Health spending is growing and will continue to rise

Since 2008, health care spending in the U.S. has grown at historically low levels, which is likely attributable to the economic downturn, slow recovery, and structural changes to the health system, including lower Medicare and Medicaid payments to providers. This slow growth continued through 2013 when costs grew at just 3.6 percent.[6] In 2014, overall health spending grew by 5.3 percent,[7] and projections suggest it will continue to grow. In its most recent projections, CMS estimates that health spending will grow an average of 5.8 percent per year through 2024, to a total of $5.4 trillion or 19.6 percent GDP.[8] (See Chart 2.)

The main factors leading to the 2014 spending growth include health coverage gains under the ACA, as well as new specialty drugs, like pharmaceuticals to treat Hepatitis C, cancer, and multiple sclerosis, which carry high price tags and have contributed to higher spending.[9] In 2014, prescription drug spending grew to 12.2 percent,[10] but experts predict that growth will moderate to 7.6 percent in 2015 and 6.6 percent in 2016.[11]

As the Medicaid population grows and the baby boomer generation ages and becomes eligible for Medicare, it is projected that nearly four out of every 10 health care dollar will be spent on people enrolled in one or both of these two government-funded programs between 2014 to 2024.[12] As a result, national health spending growth rates are projected to be highest (above six percent) during the latter years of this period, and the share of total health expenses paid for by federal, state, and local governments is projected to increase to almost half of all national health expenditures.[13]

Chart 2. U.S. health care spending per capita 1970s-2013, projected spending per capita 2014-2024



SOURCE: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of Actuary, National Health Statistics Group.

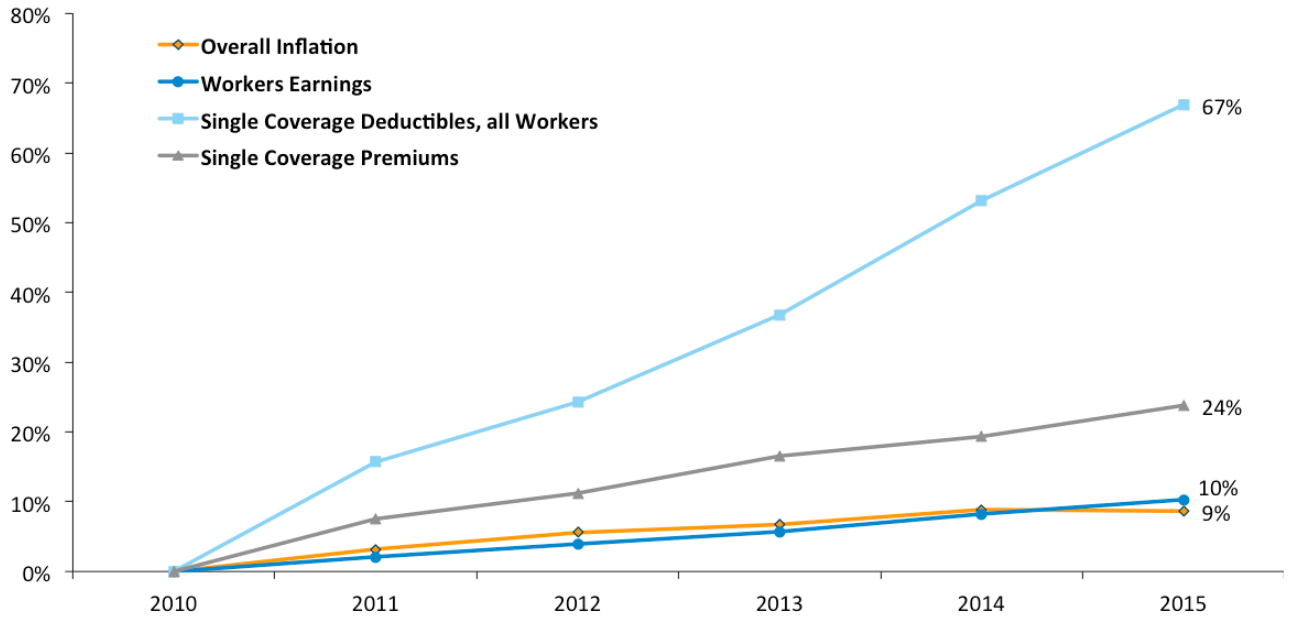
Increases in consumer health care costs continue

Consumers are are feeling the pinch of rising health care costs. Health care premium and out-of-pocket costs exceed both wage growth and inflation. From 2010 to 2015, deductibles increased 67 percent, and premiums increased 24 percent, while wages and inflation increased at a much lower rate—only 10 and nine percent, respectively.[14] (See Chart 3.) From 2003 to 2013, premiums for those with employer-sponsored health insurance rose by 73 percent, while family income only increased by 16 percent during the same time period.[15] In 2013, family premiums were 23 percent of median family income, up from 15 percent of family income in 2003. Deductibles and other cost-sharing have also increased steadily—the average deductible for a single person doubled from 2003 to 2013.[16]

Affordability is an issue for consumers shopping for marketplace coverage. Fifty-seven percent of people who visited the marketplaces in the last open enrollment period but failed to sign up said they could not find an affordable health plan.[17] Of those who enrolled in marketplace coverage, larger shares of adults had per-person deductibles of $1,000 or more compared with adults in employer-sponsored plans (43 percent compared to 34 percent). In an analysis of 2015 marketplace plans in states using the federal marketplace, the average deductible for silver-level plans was $2,559.[18]

The causes of health care cost growth are many and cut across all payers. Just as efforts are underway in states to change how care is delivered to all who receive it, states have also begun to consider how to realign incentives across all who pay for care to achieve comprehensive approaches to reduce health care cost growth.

Chart 3. Cumulative increases in health insurance premiums, general annual deductables, inflatio, and worker's earnings, 2010-2015



NOTE: Average general annual deductible is among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010-2015. Bureau of Labor Statistics, Consumer Price Index,

States Pursuing Global Budgets

Three states, Maryland, Massachusetts, and Vermont, are testing varied approaches to establishing annual limits on health care expenditure growth on an all payer basis. Each of these states has a different approach: some are doing so through regulatory action that imposes a global budget for total health care spending, while others are relying on increased cost transparency and consensus targets to move markets.[19]

Maryland

Maryland has a long history of hospital rate setting. A Medicare waiver approved in 1977 authorized an all payer system to regulate hospital payment rates. Under this system the Health Services Cost Review Commission (the Commission), established in 1971 by state legislation, sets hospital rates for all payers, including Medicare and Medicaid.[20] This is estimated to have saved the state over $45 billion and lowered the rate of cost growth from 25 percent above the U.S. average to three percent above the average.[21]

Due to changes to the state's hospital system over time Maryland's waiver needed to be modernized. In order to continue the original waiver, the state had to demonstrate that its Medicare costs per case were growing more slowly than the rest of the country. Maryland's model only measured inpatient services per case, however, and as hospitals nationwide began to shift treatment from inpatient services to less expensive outpatient services the state's hospital spending growth did not compare as favorably to the rest of the country.[22]

In 2013, Maryland submitted a waiver request to CMS to revise its Medicare payment system for a five-year period. CMS approved the application and the waiver implementation began January 1, 2014. The state's new model, referred to as the All-Payer Model, limits growth in total hospital all payer costs per capita and provides for savings to Medicare. In order to secure the performance needed and to limit expenditure growth, Maryland regulators and hospitals implemented a hospital global budget payment system in which all payers (Medicare, Medicaid, and private insurers) in aggregate pay hospitals a fixed annual amount for inpatient and outpatient services, adjusted for quality and irrespective of hospital utilization.

The All-Payer Model also aims to improve quality through two of the waiver's requirements: (1) reductions in the aggregate Medicare 30-day readmission rate to the national rate over five years; and (2) reductions in the state's all payer aggregate rate of 65 potentially preventable conditions by 30 percent over the five years of the waiver. These goals incentivize the hospitals to improve care delivery and work with other providers to prevent unnecessary hospitalizations and readmissions.

The growth in total hospital revenue is subject to two constraints. First, the all payer per capita hospital revenue growth is limited to a fixed 3.58 percent per year, which is the ten-year compound annual growth in the state's Gross State Product (GSP). Second, the Medicare per beneficiary total hospital cost growth over five years should be at least $330 million less than the national Medicare per capita total cost growth over five years.[23]

The All-Payer Model agreement contains triggering events that could result in termination of the model, such as failure to meet the per capita limits. The agreement also provides opportunities for the state to submit corrective action plans if such triggering events occur. If the agreement is not extended, but is instead terminated, it allows for a two-year period for hospitals to transition to standard Medicare payments.[24]

In the model's third year, the state is required to submit a proposal for a new model that will limit, at a minimum, the Medicare beneficiary total cost of care growth rate expanding the focus beyond hospitals to all health services for the state's residents. This plan would go into effect in 2019.[25]

In the first year of the model's implementation all hospitals moved to global budgeting. The hospital's budget is set at the beginning of the year, so each hospital knows what revenue it can expect to receive. Hospitals cannot exceed their budget, and unit rates, which are set by the Commission, must be maintained. Payers are billed on a fee-for-service basis using rates set by the Commission and those rates are increased or decreased systematically to achieve the fixed budget.[26]

Hospitals must monitor their performance on a monthly basis and corrective action must be taken to decrease rates concurrently if the budget is exceeded. Any amount not adjusted by the end of the rate year is corrected in the following year's budget. Hospital global budgets are also adjusted at least annually for shifts of service between hospitals.[27]

After the first year of the demonstration project, Maryland reported promising cost results. In 2013, the state committed to limiting annual growth of per capita hospital costs for all payers to 3.58 percent, which was the historical rate of the GSP. For calendar year 2014, there was a 1.47 percent

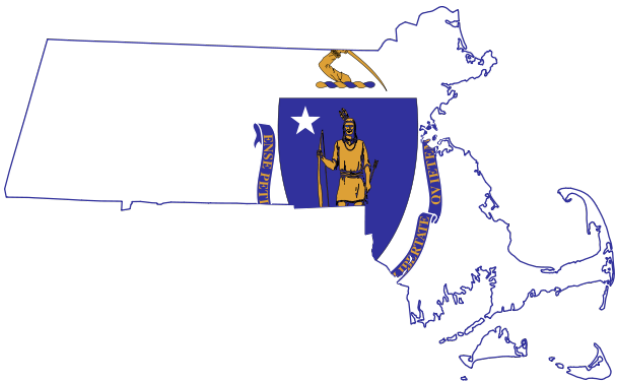
growth increase per capita or 2.11 percentage points lower than the capped limit.[28] The state and CMS believes this is due to a combination of lower-than anticipated growth in adjusted costs per admission and changes in care delivery under the model. Furthermore, the model saved Medicare $116 million, well on its way toward the target of $330 million in savings by 2019.[29]

The state also saw promising results in reducing potentially avoidable hospital admissions as a measure of improving quality. Maryland was able to reduce the rate of potentially preventable conditions by 26.3 percent between 2013-2014. The state also shrank its rate of all-cause readmissions among Medicare patients, bringing it toward the goal of reaching the national rate.[30] The Commission receives monthly abstracts for every inpatient discharge and outpatient encounter from hospitals, derived primarily from uniform billing data. It prepares reports and feeds back data on potentially avoidable utilization to hospitals to transform delivery and improve quality in ways that will reduce hospitalizations.[31]

The Commission is continuing to focus on quality improvement efforts and paying for value over volume. Hospitals are partnering with post-acute and long-term care providers to focus on and reduce avoidable hospital admissions, improve care coordination for high needs patients together with community providers, and enhance chronic care along with primary care providers. While hospitals are already connected in real time, the focus is to bring more information to community providers at the point of care to focus on improving care for high needs patients and improving population health.[32]

Massachusetts

Following the implementation of Chapter 58, the Massachusetts health reform law enacted in 2006, the state legislature enacted Chapter 224 of the Acts of 2012. This new law sought to contain costs and bring health care spending growth in line with growth in the state's overall economy. The law established the health care cost growth



benchmark, a statewide target for the rate of growth of total health care expenditures (THCE).[33] The Health Policy Commission (HPC), responsible for regulating costs and setting annual limits on health care cost growth among all providers and payers, was also established through this law.

THCE is a per capita measure of the total state health care spending growth, including: (1) all medical expenses paid to providers by private and public payers, including Medicare and Medicaid (MassHealth); (2) all patient cost-sharing amounts; and (3) the net cost of private insurance. THCE is calculated on a per capita basis to control for increases in health care spending due to population growth.[34] By including public and private payers in the measure, Massachusetts hopes to reduce the likelihood of cost-shifting among different payer types and ensure that gains are shared with both public and private purchasers.

THCE is calculated annually by the Center for Health Information and Analysis (CHIA), an independent agency that serves as Massachusetts' primary hub for health care data and a key source of health care analytics that support policy development, including management of the Commonwealth's all payer claims database (APCD). CHIA collects aggregate data from payers to compare growth with the health care cost growth benchmark, as set by the HPC, while CHIA and other agencies use the APCD data to analyze spending trends in detail. Chapter 224 established that from 2013-2017 the benchmark for the rate of growth of the THC would be equivalent to growth in the state's economy, from 2018-2022, the benchmark

is equivalent to 0.5 percent less than the state economic growth rate, bending the cost curve over time. For 2013-2014, the benchmark was set at 3.6 percent.[35]

The Health Policy Commission monitors the health care market and develops a range of policies in an effort to create a more sustainable and affordable health care system, including monitoring the impact of health care market changes on costs, quality and access to care; investing in community hospitals; promoting the adoption of new care delivery and payment models; researching health care cost drivers; and requiring testimony on health care cost trends from health care providers and payers. Beginning in 2016, the HPC also has the authority under Chapter 224 to require health care entities—providers, including hospitals, physician groups, and integrated delivery systems, and insurance carriers—with excessive cost growth and who threaten the health care cost growth benchmark to implement performance improvement plans and submit to ongoing monitoring.[36] These plans will be posted on the HPC website and must report factors that led to excessive cost growth and identify specific cost savings activities in which the entity will engage to lower costs. The HPC may institute fines of up to $500,000 for entities that fail to submit, implement or report on these plans in good faith.[37]

This approach differs from Maryland's model in that the HPC does not have the authority to set rates for commercial payers. According to the HPC Executive Director, David Seltz, Massachusetts is, in part, using transparency to try to steer the market, and, ultimately, contain health care costs.[38]

In September 2014, CHIA released the first report measuring Massachusetts's performance under the 2013 health care cost growth benchmark. The report found that statewide health care spending increased to $50.0 billion (or $7,550 per resident) and that THCE in the Massachusetts increased by 2.3 percent, or 1.3 percentage points below the 2013 benchmark.[39]

In the second year of reporting, CHIA found that health care expenditures in Massachusetts grew at a higher rate than the cost growth benchmark. In 2014, THCE was $54 billion, or $8,010 per capita, representing a 4.8 percent increase from 2013 and exceeding the health care cost growth benchmark by 1.2 percentage points. The HPC found that approximately two-thirds of this growth was mainly due to a 19 percent increase in spending in MassHealth, the state's Medicaid program. The growth in MassHealth spending was primarily a one-time increase in the level of spending arising from increased enrollment due to the implementation of the ACA's Medicaid expansion.[40] Approximately one-third of spending growth resulted from rapid growth in prescription drug spending consistent with national trends.[41] Although the cost growth benchmark was not met in 2014, to date, no health care entities have been required to implement performance improvement plans.

Vermont

Vermont enacted legislation in 2011 that created the Green Mountain Care Board (GMCB), which is composed of five members appointed by the Governor, and serves as a regulator of the state's health care system. Act 48 of 2011 gave the GMCB the authority to address health care costs, quality, and access including setting rates for all providers, administering the certificate of need program (CON), and health insurance premium regulation. The legislation also gave the GMCB authority to undertake payment reform pilot projects, including establishing a global health care budget across all payers for the state.[42]

In 2013, the GMCB developed guidance and implemented principles to govern the hospital budget review process for fiscal years 2014-16. The GMCB set a target rate for increases in hospital net patient revenue (NPR) of three percent for FY 2014 through 2016, allowing for an investment in health reform. In 2014, for the second year, the GMCB enforced its NPR rate target, which resulted in modest growth. In 2015, five hospitals in Vermont submitted a budget to the state that reflects a negative rate of increase, as negotiated between the state and hospitals.[43]

In 2014, the state implemented its Shared Savings Programs (SSP) in Medicaid and the commercial insurance markets. SSPs are formal arrangements between insurers and Accountable Care Organizations (ACOs) in the state that require any savings to be shared which are the result of improvements in cost, quality, and access for people who are served by participating providers and covered by participating insurance products. In September 2015, the state announced that the SSP in Medicaid helped to avoid $14.6 million in health care costs.[44]

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Building on these initial payment reform efforts, the GMCB is considering an all payer global model to include the set of services currently in the SSP: inpatient, outpatient, and employed physician and net revenues. The model would shift from fee-for-service to a value-based capitation-style payment for an ACO. Al Gobeille, the Chair of the GMCB, has called it "population-based rate setting for an accountable care model."[47] The plan would establish a fixed limit on total hospital revenue regardless of the level of patient service activity or operating cost experienced by the hospital in a given year. The hope is that fee-for-service incentives that reward hospitals for expansion and increased service volumes would be replaced with a strong incentive to economize and eliminate inefficiencies in the system.[48] By starting with hospitals, the state is able to regulate and try to reduce costs in a large share of the state's health care system, as 65 percent of physicians in Vermont are employed by hospitals.[49] Currently the state is in waiver negotiations with the federal government to include Medicare in a potential all-payer model. So far, hospitals and providers have been very willing to work with the state on the global budget plan.[50]

Next Steps

All three states are utilizing data from state Medicaid programs and APCDs, as well as other sources to generate total cost and cost trend measures. But the they are finding that these sources are not enough for the work they wish to do. Massachusetts would like to use quality information, which is very limited in claims systems, and detailed claims information is only available with substantial lag time. Maryland collects data from hospitals each month to gather quality information. The state is hoping to move further and use their health information exchange to get quality data, and build tools such as care profiles that move with the patient, helping to identify gaps in a person's health and hold providers accountable for improving outcomes.[51]

It is still very early in each of these initiatives to say whether these approaches are working to contain cost growth as well as transform the health care delivery system. Vermont's plan is still a work in progress. Maryland's hospital rate setting budget shows great promise in its first year. Massachusetts' met its goal in the first year, only to exceed it's growth target in year two. Its enforcement mechanism is untested, so whether imposing performance improvement plans will bring cost growth down in subsequent years is yet unknown. Moreover, while work to date has focused primarily on hospitals, each of these states has the authoirty to address cost growth across all providers. As U.S. health care spending is projected to rise in the future all eyes will be on these states and NASHP will continue to report on their progress.

End Notes

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