



Cross-Agency Strategies to Curb Health Care Costs: Leveraging State Purchasing Power

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Executive Summary

Rising health care costs appear to be an intractable problem in the United States, but states, faced with balanced budget requirements and growing voter concern, aren't waiting for a federal solution. Policymakers have long known that US health care costs are twice those of developed nations, yet our outcomes are poorer and that the prices paid are far higher than those paid in other countries.

A simple equation explains health care costs – price multiplied by quantity. States have been actively engaged on the quantity side of the health care equation. They are:

- Innovating with value-based purchasing, utilization and care management, especially addressing high-cost users of health care, and
- Launching numerous service and payment delivery reforms, with significant federal support.



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Yet, costs continue to outpace budgets. Variation in costs among providers, differing payment rates, and complexity are the watchwords of our health care system. Now, consolidation looms larger as a cost driver. Today, there is little competition in the health care market – 90 percent of hospitals have consolidated, which has led to price increases estimated at 20 to 40 percent. The promise that provider consolidation would improve quality and efficiency [has not been realized](#). Consolidation affects more than hospitals – 65 percent of specialty physicians, 57 percent of insurers, and 39 percent of primary care providers have consolidated, tipping the balance and creating a seller's market.

State dollars fund a significant share of health care in each state. As large purchasers, states have the potential to leverage better prices in an increasingly consolidated health care marketplace, yet they tend to purchase health care in silos rather than combining and fully deploying their collective buying power. Medicaid drives much of the discussion about public health care spending, but states provide care in corrections facilities and mental health and public hospitals and state dollars purchase health care for state, university, and municipal employees and teachers, as well as their dependents. Increasingly states are harnessing that purchasing power to achieve cost growth goals.

This paper highlights some of those collaborative purchasing approaches based on discussions with state leaders. It is not intended to be a comprehensive analysis of the state of the art, but is designed to highlight examples of approaches states might consider.

Organizing State Government to Better Leverage Purchasing Clout

The structure of health care purchasing in a state is rooted in its history and political priorities, but is not generally the result of a planned approach to purchasing. However, some states have done just that, moving to break down the silos of public health care purchasing and unite forces to better coordinate how public dollars are spent. This can be a complex undertaking as health benefits are often the subject of labor negotiations and differ by bargaining unit – university systems often have independent governance, municipalities within the same state may have different plans, and teachers may have their own plans. Some may have longstanding relationships with health plans and brokers they wish to sustain. Plans may be funded not just by state general revenue but also by local taxes. Enrollees, and the organizations that run their plans, raise concerns about losing benefits, raising rates, or compromising the integrity and “ownership” of those plans. The case needs to be made that combining forces can strengthen purchasing power and help lower the trajectory of rising costs.

Examining the amount of public dollars spent to support public health plans and the rising costs of those plans is a starting point, sometimes achieved by utilizing data from the plans or, where they exist, from state all-payer claims databases. States have worked to better coordinate public purchasers – some through task forces and multi-agency planning efforts, others by organizational changes, and still others by purchasing coverage across multiple public programs and covering all within one pool to maximize their buying power.

Collaboration: Connecticut established a Health Care Cabinet under a former governor to coordinate health policy and established the Office of Health Strategy to improve health, limit costs, and advance innovation across private and public sectors. The office consolidated oversight of the state’s All-Payer Claims Database, the State Innovation Models (SIM) initiative, the Office of Health Care Access (OHCA), and the state’s health information technology initiatives into one state [agency](#).

Colorado’s governor established, by [executive order](#), the Office of Saving People Money in Health Care. Led by the lieutenant governor, the office is charged – among other duties – with establishing a statewide inter-agency collaborative effort to develop common policies and strategies to reduce the cost of health care, and the order also creates a permanent Health Care Cabinet of key state agencies. Similar examples of collaborative planning exist in other states.

Coordination and Colocation: Seeking to organizationally align purchasing programs, the [Washington State Health Care Authority](#) administers both Medicaid and the public employees’ health plan. As a result, it is the largest health care purchaser in the state, covering about 30 percent of the state’s population. In 2020, the School Employees Benefits Board will be added to its purchasing pool. In 2009, the [Oregon Health Authority](#) (OHA) was established to expand purchasing power by combining the administration of public employees, educators, and Medicaid into the new agency. As a result, the OHA purchases health coverage for one of every three Oregonians.

In 2005, Kansas created a Health Policy Authority overseeing Medicaid’s medical benefit, the Children’s Health Insurance Program (CHIP), the State Employees Health plan, and workers’ compensation health plans. In 2011, the authority was eliminated as an independent agency and its duties transferred to the [Kansas Department of Health and Environment](#)’s Division of Health Care Finance. This division retains the responsibility for administering the health plans, while continuing the role for the State Employee Health Commission in overseeing that benefit program.

The Washington authority, like Oregon’s, maintains independent administration of the public employee plan

and Medicaid, but engages in collaborative planning, such as using health technology reviews to utilize evidence to guide conditions of coverage and covered services in both plans, and shares pharmacy reviews and expertise across both programs. A subcabinet group of agency medical directors was also convened and was the first to produce opioid guidance for chronic pain in 2008.

Washington enacted legislation, effective in 2020, to expand coverage by requiring any health plan that offers coverage to state employees or teachers to also offer an individual plan on Washington's health insurance exchange. Concerns have been raised about the viability of the plan and the state is now contemplating leveraging the state's purchasing power to:

- Contract with one or more commercial plans;
- Impose limits on provider reimbursement rates; and
- Possibly supplement current Affordable Care Act (ACA) subsidies for certain targeted enrollees to create an affordable statewide option for those without group coverage.

Another example of multi-agency coordination, while limited to drug costs, is California's multi-agency [Pharmaceutical Procurement Collaborative](#), housed in the Office of Pharmaceutical Acquisition Services. The collaborative includes the departments of corrections, veterans' affairs (CalVets), health and human services, finance, labor, and workforce development, and the Government Operations Agency. Other state and local government agency collaborative participants include the Department of Industrial Relations, state retirees (CalPERS), Association of Counties, State University System, Covered California (the ACA state exchange), the departments of Managed Care, State Hospitals, and Developmental Services, and the University of California system. The collaborative has a broad charge to coordinate payers and jointly purchase drugs and negotiate rebates.

Consolidated Purchasing: Joint planning and program administration are important steps to leverage state purchasing power, but states have taken the next step to more fully integrate public purchasing and pool covered lives across different employee groups to gain more buying clout and capitalize on their state employee health plans. About half of states allow cities, municipalities, and counties to [join their plans](#). The nation's largest public health plan, the California Public Employees Retirement Systems ([CalPERS](#)) plan, covers state employees, schools, and local government employees.

The [North Carolina State Health Plan](#) provides coverage to 727,000 members, including state, school, and university workers and employees of fire departments, medical transportation services, and some local governments. Charter schools may voluntarily join the State Health Plan so long as they make that decision within two years of the school's charter creation and are approved by the state and charter schools. Importantly, the North Carolina plan pools all covered lives and provides a standard, single preferred drug list across the plans to maximize its purchasing leverage.

These few examples, by no means exhaustive, outline approaches to improve collaboration to colocate programs, integrate purchasing, and share risk across a wider pool of enrollees. They suggest strategies states may undertake to strengthen their capacity to more effectively negotiate health care costs paid with taxpayer dollars:

- Identify a lead agency or individual to spearhead cross-agency planning.
- Inventory current health plans, enrollment, and costs by all public purchasers (state employees, corrections, university systems, municipalities, workers compensation, K-12 employees).
- Convene public purchasers to identify areas for potential collaboration and preventable redundancies.
- Develop strategies to collaboratively undertake activities to reduce costs through joint contracting, drug purchasing, standardizing performance and quality metrics.
- Join private-public purchasing coalitions to foster collaborative efforts to address costs.

Leveraging Medicare Pricing for State Employee Health Plans – Reference Pricing

The growth in insurance premium costs for state-sponsored employee health plans has outpaced private sector cost increases. Between 2010 and 2014, for example, the growth in state employee plans grew more than 14 percent faster than those of large, private sector firms. Public sector plans, under the scrutiny of budget officials, governors, state legislators, and the general citizenry, must be sensitive to making the best use of tax revenues as possible.

These plans face multiple challenges, including the demographic composition of their employees, who are generally more highly educated, older, married, and who are more likely to be female – all “risk” factors for higher use rates and thus, higher premium costs. The degree of unionization tends to be higher in public plans, which may contribute to the relative “richness” of benefits and lower deductibles and coinsurance, as compared to large, private sector plans. The public sector competes with the private sector for employees, as a result some states may find it easier to increase benefits rather than increase wages to compete. Whatever the factors, benefits for public employees generally equate to Platinum-level plans on the health insurance exchanges. Under the ACA, these plans must meet all of the requirements placed on large employer health plans, including actuarial value and affordability. These benefits will subject many state employee health plans to the “Cadillac tax” scheduled to begin in 2022.

So what is a state purchaser to do? Over time, states have tried many different approaches to contain plan costs. States have relied on transferring risks to fully insured plans and have moved back to self-insuring their employee group. They have used health maintenance organizations (HMOs) and managed care organizations (MCOs), as well as designing benefit tiers for prescription drugs and providers or both. They have also tried narrow networks and have tried encouraging healthy behaviors through wellness incentives and programs and building value-based benefits structures, all with varying degrees of success.

Significantly, states are in a strong position to be change leaders, both in the employee health plan market and in the broader market as well. As very large employers with enrollee bases that touch all corners of their marketplace, states can command attention in the market. As the administrator of the Medicaid program, state employee health plans can move to consolidate purchasing clout and improve enrollee health by combining forces with the Medicaid programs in their states. Leveraging purchasing power is not a new idea, but there are ways in which states might consider marshalling the collective “lives” in their public sectors in innovative ways to alter marketplace dynamics and gain savings for state programs and residents.

State employee health plans, as noted earlier, face many challenges in trying to reduce costs. Like many other employers, they have relied on their contracted health plans or third-party administrators to bring to the table comprehensive networks of health providers with affordable rates. However, as providers increasingly consolidate, rate negotiation becomes more challenging.

Step One: Understanding the Fundamentals of Hospital Price Negotiation

Plan administrators negotiate contractual allowances against provider charges, with these charges serving as the starting point for the payment calculation, which generate “allowed amounts” for each type of provider charge.

The issue with this approach is the starting point for negotiation, which is the provider’s chargemaster. The chargemaster is a compilation of all of the items a provider can charge to a payer, be it a government insurer, a private insurance plan, or a self-paying patient. Providers are free to set their charges at whatever level they like and, although they ordinarily update chargemasters once a year, there is no prohibition against changing them more frequently. Although hospitals are required by federal law – and in some cases state law – to make their charges public, they may be updated at any time for changes in technology, changes in inputs, and more. Because there is no federal requirement that charges be reported in an accessible format, they may not be easily accessible.

As a result, a contract that calls for a contractual allowance equal to a percentage discount off charges can lead to payments that are relatively dynamic over time. Payers usually have a “default” discount rate for services that fall outside of their set fees for services or bundled care rates. This arrangement can impact a large percentage of the services a purchaser pays for.

The drawbacks to this approach are obvious. In most jurisdictions, providers are free to charge whatever the market will bear. In this era of increasing consolidation, providers can easily gain the upper hand in their respective markets, facing little or even no pressure from close competitors. There is ample evidence that in such markets, prices charged to payers rise. In contrast, payers, even very large payers, occupy an eroded negotiating position and have little ability to leverage a better deal through negotiation. In the best situations, the market for health care services is arguably compromised, but as market inequalities are magnified, providers have little incentive to constrain costs. Therefore, what is a state to do?

It is important in this discussion to be clear about the meaning of the terms “cost” and “price.” Providers think of cost as the expenses they incur to produce the health care services they deliver to their patients. Payers think of costs as the amounts they pay to providers for care provided. Patients think of costs as being the amounts they must pay out of pocket. For this discussion, the term cost refers to the underlying cost of the production of health care. These are the costs of inputs: labor, technology, overhead, etc. Price, in contrast, refers to the charges providers place on their services.

While prices or charges (less any applicable discounts) represent a payer’s costs, they do not necessarily bear any relationship to the underlying cost of production that the provider incurs. Intuitively, one would expect that costs and charges would have some close relationship, particularly in the case of a nonprofit organization. However, health care providers are complex organizations with many, many cost centers, many inputs to production, and myriad sources of payments and other revenues. Moreover, many large health care providers are part of extraordinarily complex, multifaceted systems that sell and purchase services from one another, further masking the relationship between costs and charges for services. Transparency into the [true cost](#) of production of health services is [challenging](#), at best.

Similarly, the manner in which providers set prices also lacks transparency. The public has a growing appreciation for the challenges inherent in understanding the costs of production of prescription drugs. There is also a growing understanding that the manner in which manufacturers price their products bears little, if any, relationship to the true cost of production. More and more frequently, products are simply priced at the level the market will bear. Service providers can take a similar tack given this pricing difficulty, most payers and users are often simply price takers, rather than effectively negotiating a discounted price that bears some rationale relationship to the cost of production. In addition, just like prescription drugs,

the producer can boost the “list price” of a service and grant a discount off that inflated price. The concept of discounting a list price is itself problematic as vendors are rewarded for getting better percentage discounts rather than getting the lowest net cost. In more competitive markets, there may be more incentives for health services providers (particularly hospitals and systems) to hold down their costs and their prices, so they may retain or grow market share.

At the same time, payers are facing increasing cost pressures themselves, and are searching for ways to address the cost of doing business. This may be particularly true for public purchasers, who must be sensitive to making the best use of tax revenues possible while providing attractive benefits to public employees. In an effort to contain costs, employers have turned to restructuring benefit packages. While these efforts include a range of “tools,” including increasing deductibles, copays, and coinsurance, they generally boil down to shifting costs away from the employer and/or health plan to the enrolled employee. They have also shifted costs to employees by requiring them to pay a greater proportion of the plan premium. Or, they have put in place narrow networks of providers with whom the employer-sponsored plan has negotiated what appear to be deep discounts. Still, plan costs keep rising.

Step Two: Reference Pricing – Why Medicare?

Public employers could consider adopting provider payment structures that are tied to Medicare payment rates. In other words, instead of negotiating discounts off charges, the payer instead ties its reimbursement to a known standard, in this case Medicare rates. In these payment arrangements, purchasers set reimbursement at Medicare plus some percentage load. That loading factor depends on a number of factors, including plan affordability and the ability to bring on key providers with the offered rate.

Basing reimbursement on Medicare rates offers several benefits. Most providers accept Medicare payments and are not only familiar with that system, but also are adept at using that payment system. The Medicare payment system is based on costs that have been audited by the federal government. This lends transparency and the knowledge that the purchaser is relying on a long-tested, tried and true method of payment. Instead of shifting costs to employees, this approach seeks to introduce more balance into the payer/provider market equation and enable the large purchaser to move away from the passive role of “price taker” to that of active “price setter.”

It is relatively easy to establish reimbursement rates using one of the many commercially available Medicare repricing services available on the market. This exercise involves running claims through the repricing software.

Health benefits plans serving a range of enrollees and their dependents will undoubtedly incur claims for services not covered by Medicare – obstetrical, neonatal, and pediatric care are good examples of such services. In these instances, payment rates must be developed.

One of the challenges inherent in adoption of a reference pricing strategy, such as this, is the predictably negative reactions it will generate from the provider community. Hospitals will almost undoubtedly argue that Medicare underpays for services, forcing them to shift costs to private payers. As Uwe Reinhardt explained, providers and private insurers, for that matter, often argue, “They are the victims of inadequate spending” on the part of public payers.

The notion of cost shifting is one that has intuitive appeal. It makes sense that a provider would seek to maximize profits by setting differential prices to payers, based on what they are able to get those payers to pay. If Payer A holds substantial leverage over what it will pay hospital either by virtue of the market power it wields or the force of law – as in the case of Medicare and Medicaid – it can pay less than the provider believes to be fair for the services purchased. Providers – acting as rational sellers – seek to maximize profits by demanding higher

payments from purchasers with less clout in the marketplace.

Importantly, there are [economists](#) and [health policy experts](#) who do not buy into the cost-shifting theory. This schism in the field highlights the complex nature of health services markets and the challenges that follow those trying to influence them.

MedPAC – the federal Medicare Payment Advisory Council – disagrees that Medicare pricing is, overall, inappropriate. In its March 2018 [report](#) to Congress, MedPAC examined the adequacy of Medicare payments – in this instance, hospital payments – in light of beneficiaries’ access to care. It examined the capacity and supply of providers serving Medicare patients and the volume of services delivered, the quality of care provided, providers’ access to capital markets, and Medicare payments relative to providers’ costs.

MedPAC has used these metrics over time, looking at them as a whole to get a more holistic view of a complex sector of health care. In the March 2018 report, it noted that hospitals have excess capacity, suggesting that beneficiary access to care is not impaired. The quality of care as indicated by hospital mortality and readmission rates are showing improvement, as has patient satisfaction. Hospitals have strong access to bond markets, demonstrated by a 48 percent increase in the value of bond offerings in 2016 over the prior year, and strong all-payer profit margins. In addition, across all services, the marginal profit rate in 2016 was about plus 8 percent.

Medicare hospital payments are built to meet the average costs of producing and delivering care at relatively efficient hospitals. Inefficient organizations will struggle in the face of such a system. MedPAC takes the position that the program’s payment policy should not be dictated by whatever the cost trend is for a particular type of provider, like hospitals. Just because costs grow does not mean that growth is reflective of effective provider operations. Instead, it can be easily driven by economic climates and a provider’s relative dominance (or lack thereof) in the marketplace.

It is easy to make policy arguments about Medicare payment adequacy, and much harder to face down the political pressures providers like hospitals can bring to bear. Hospitals in particular, are formidable political adversaries. Often, they are one of the largest employers in any given community, providing many, many jobs, and providing services communities want and need for constituents of governors and legislators. However, those new jobs are funded by premiums or taxes.

This makes it especially challenging to take on a move to a reference price based on Medicare. It is prudent for purchasers to take a lesson from the experience of Montana’s state employee health plan, which made the decision to move to reference pricing several years ago. At that time, the state plan was facing losses and was projecting bankruptcy for the plan’s reserves in the not-too-distant future, prompting decisive action. In searching for strategies they might use to bring program costs under control, plan administrators examined price variation in hospital services across the state, as those costs comprised more than 40 percent of the plan’s costs. They found marked variation from one area to the next with regard to the prices they were paying for the same type of care, with no discernable difference in quality or outcomes.

They learned, too, that a high discount does not necessarily translate into a lower price paid for a service. As noted elsewhere, discounts off charges are relatively meaningless in a market where the provider has little incentive to hold down charges. By way of example, consider the Montana plan’s payment at two hospitals for a knee replacement:

Hospital A		Hospital B	
Hospital charge	\$115,000	Hospital charge	\$25,000
Discount	10%	Discount	7%
Cost to State Plan	\$103,000	Cost to State Plan	\$23,250

This example clearly illustrates that larger discounts do not always mean lower prices paid. The plan was looking for a way to introduce transparency into the equation along with some element of strict control over payment rates. They turned to reference pricing as their strategy, with Medicare as their point of reference. As the largest payer in the nation, Medicare's rates are a common reference point, familiar to every provider in the state. The payment rates used by Medicare recognize differences in geography, teaching status, and patient case mix. Moreover, the calculation of Medicare payment rates is a matter of public record.

Montana's Success at Reference Pricing

In considering implementation of a reference price system of payment, the Montana state employee plan knew that it did not want to introduce narrow networks for plan enrollees and, instead, wanted to include as many facilities as possible – ideally, all facilities would agree to participate. They wanted their payment system to include predictability in yearly payment rate increases and they wanted to preclude any balance billing by providers. These constraints presented a tall order, but plan administrators, faced with the certainty of depleted reserves in the next couple of years, decided to push ahead. Working with a contractor who repriced the plans' claims to Medicare, it became apparent that adoption of reference pricing held the opportunity for considerable savings, without generating undue friction between the plan and its enrollees. Therefore, with the backing of a staunch supporter in the administration, the plan set out to negotiate payment rates with hospitals at a reference point set at 234 percent of Medicare rates – high enough to attract providers into contracts and, simultaneously, allow for the provision of high-quality care and a profit margin.

Hospitals across the state, with one notable exception, accepted the new contract terms. After some pressure from patients, the remaining hospital holdout also moved into the network. Two years into the new payment system, the plan has seen a turnaround, generating savings of more than \$15 million and restoration of its reserve fund. Moreover, no hospital – rural or urban – has closed its doors. There is also no evidence that hospitals have increased utilization to offset lower rates. Most Montana hospitals use diagnosis-related group (DRG), a payment methodology based on the average resources used to treat a specific diagnosis, and in some cases there is evidence of lower utilization. The state also did not see any cost shifting to other payers, who at the same time were seeking to reduce their costs by narrowing networks and reducing rates.

The challenges in moving to reference pricing are considerable. Once a state has assessed the potential for savings using a reference-based system, be it keyed off Medicare or otherwise, it will need to identify the "sweet spot" – i.e., the Medicare-plus "factor" – that allows sufficient savings without disrupting the provider network in too material a manner. In addition, it will need to adopt methods to price non-Medicare services like maternity. In Montana, the plan with assistance from its third-party administrator used the usual, customary, and reasonable (UCR) rate, which is the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service,¹ to determine maternity and pediatric reimbursement rates.

The state will also need to be prepared for the political pushback that will certainly come in response to any such proposal. Rising prices in a state employee health plan translate into wage suppression for those employees and an increased need for tax revenue. In that sense, employee unions may be natural allies for this type of approach. In fact, unions were supportive of Montana's initiative and proved helpful in "selling" the initiative to their rank and file. Support of employees will help as a state works to garner support of the provider community – or at least to dampen the outcry by providers – which will help manage the politics of the activity. Given the considerable political sway hospitals hold, this will be important to counter push back that legislators might present.

North Carolina, Connecticut, and Washington State Advance Reference Pricing

Other states are picking up the reference pricing baton. North Carolina's State Health Plan covers 725,000 subscribers and their dependents, including active and retired public employees. The plan, by statute, includes not only state employees, but also employees of public school and higher education systems, fire departments, emergency medical service (EMS) squads, National Guard units, and non-profit charter schools.

This self-insured plan utilizes the services of a third-party administrator (TPA) – Blue Cross and Blue Shield – and a preferred provider organization network. The plan spends more than \$3 billion annually, with spending rising each year. Additionally, the plan faces a severe deficit in terms of funded reserves. Even before addressing the issue of unfunded liability, plan cost trends outstrip revenues. The state treasurer, who administers the State Health Plan, has made it a priority to address plan costs, and has proposed moving to reference pricing as a strategy in that effort. In setting goals for the overhaul of the plan's approach to contracting and payment, the administrator's priorities include enhancing transparency, ensuring quality and affordability, as well as supporting providers, particularly rural providers.

Plan administrators were particularly interested in reducing the use and payment variation for the same services across providers, and improving the predictability of payments and, therefore, total program expenditures, over time. Attuned to this variation, they turned to a claims analysis of waste and inefficiency in the North Carolina system, which identified system inefficiencies ranging from 10 to 70 percent. North Carolina – and other states including Washington – have used Milliman's MedInsight Waste Calculator to identify the prevalence and use of low-value services. This tool uses claims databases to assess the use of services as appropriate, likely wasteful, or wasteful. The algorithm used to categorize claims is derived from recommendations established by the ABIM Foundation's Choosing Wisely initiative, the recommendations of the US Preventive Services Task Force, and VBID Health and can provide a purchasing plan with persuasive evidence to address system inefficiencies. Oregon is launching a waste analysis as a joint project between the Oregon Health Authority and the Oregon Health Leadership Council, a health plan and system leadership collaborative.

The North Carolina plan used Medicare as a basis for a reference pricing, applying it to inpatient/outpatient hospital and professional charges. As with Montana, North Carolina's chose Medicare as a pricing base because:

- Medicare is the largest payer not only in the state, but also in the nation;
- The payment system provides standard, publicly-accessible reimbursement measures that adjust for important differences among providers; and
- The system is built on a platform that considers and covers providers' costs.

Analysis of the plan's claims – using repricing, software-enabled decision makers to identify a payment rate that, in the aggregate, is set at Medicare plus 77 percent. This level of reimbursement is expected to result in less payment variation across providers, with rural providers gaining in terms of payments at the expense of large health systems. With implementation scheduled for January 2020, savings under the system redesign for Year One are projected to be \$300 million for the state and \$68 million for plan enrollees.

The North Carolina State Health Plan rolled out its planned redesign in October 2018, generating substantial pushback from the provider community – particularly hospitals. The proposed plan is currently the subject of much debate in the media and in the statehouse. While plan administrators are passionate advocates for the change, it remains to be seen if the political forces that swirl around the health care industry in North Carolina are strong enough to derail the overhaul.

Connecticut provides health care coverage to approximately 47,000 active employees and 50,000 retirees. All

retiree costs and approximately 73 percent of active employee costs are paid by the state's general fund and totaled more than \$1.33 billion in FY 2019. Health care is also one of the general fund's major cost drivers – current projections reflect a \$235 million increase from health care expenditures by the end of the biennium.

Fee-for-service payments to providers account for the vast majority of the state's employee plan costs – well over 95 percent. Payments across providers vary significantly. For example, average costs paid for knee replacement surgery range from \$24,000 at one hospital to more than \$50,000 at another. Connecticut reports that the more than two-fold difference in cost bears no relationship to quality. Patients receiving knee replacements from the lower-cost hospital are less likely to experience an adverse event than at the high-cost hospital. The governor's budget proposes, in coordination with the Office of the State Comptroller, to limit this price variation by setting a ceiling on the maximum price the state health employee plan will pay for these services. The maximum price will be set as a percentage above the Medicare payment rate.

While this program is currently only a proposal in the governor's budget, the comptroller's office has begun evaluating implementation options and is requesting maximum flexibility in implementing the program. In an effort to collaborate with the provider community, the comptroller is seeking the ability to engage in negotiations with each hospital system to determine – together – the best way to meet the proportional savings target required by the governor's budget. The maximum price, as a reference to Medicare, will be used as a backstop to these negotiations and to achieve savings if alternatives do not materialize. According to state officials, conversations to date have been productive, and significant cost savings is not required until the second year of the biennium, which will give the comptroller time to negotiate with hospitals and provider groups to determine the best avenue to achieve the required savings.

Meanwhile, the Washington State Legislature is currently debating Gov. Jay Inslee's public option proposal that would provide a new insurance plan through the Washington Health Benefits Exchange. The plan would provide a standardized benefit and lower rates by paying providers through a Medicare reference pricing strategy.

Leveraging Medicaid's Purchasing Power to Lower Prices for Non-Medicaid Populations

At the height of the Great Recession, Maine launched the Payment Equity Program to address hospital reimbursement. The effort addressed longstanding complaints by hospitals about inadequate Medicaid reimbursement rates and helped address the state's budget crisis. Reimbursement rates for the state employee health plan were reduced, creating savings that provided state funds to support a Medicaid rate increase. The program was short-lived in part because Maine's employee plan, unlike many across the country, did not include other publicly-funded health plans (e.g., teachers or municipal employees). As a result, the rate decreases disproportionately affected hospitals serving larger populations of state employees than Medicaid enrollees did. Nevertheless, the program is an example of the possibilities of public purchaser collaboration.

Maine was more successful in leveraging Medicaid to support efforts to make prescription medicine affordable to lower-income, non-Medicaid eligible residents in 2000. Leveraging Medicaid's power, the state created the [Maine Rx program](#). Maine Rx was designed to improve affordability and access to medications for Mainers who lacked prescription drug coverage. The program leveraged the state's purchasing power as a sponsor of Medicaid to demand that manufacturers extend negotiated rebates for Medicaid to Maine Rx members.

PhRMA immediately filed suit to stop the program's implementation, arguing that the new program both violated the federal Medicaid statute and the Commerce Clause because it interfered with interstate commerce. PhRMA won its Maine Rx case in federal court, but the decision was reversed by the First Circuit Court of Appeals. PhRMA appealed that decision to the US Supreme Court, which in May 2003 overturned the Appeals Court ruling and

upheld the program. The court found no merit in the Commerce Clause argument. It also found that as long as the US Department of Health and Human Services Secretary determines that the program provides a Medicaid benefit and presents no harm to Medicaid beneficiaries, the extension of discounts/rebates to the Maine Rx program are valid and allowable.

Maine Rx still exists today, now called [Maine Rx Plus](#), and the specifics of the program have been refined somewhat, but it remains materially the same as when it was challenged by the industry. While initially the program was theoretically open to any Maine resident without coverage, Maine Rx Plus now provides benefits to Mainers in households earning less than 350 percent of the federal poverty level, as well as those who have incurred extraordinary prescription drug or medical costs, as defined by statute and rule. The program runs in parallel to the state's Medicaid program and is a secondary payer to any "superior" prescription drug coverage an enrolled member may have.

Manufacturers are free to participate in the discount program, or not, and participating manufacturers may disenroll from the program at any time without jeopardizing their participation status in the state's Medicaid program. However, should a manufacturer decline to participate in Maine Rx Plus, all of that manufacturer's products covered by the Maine Medicaid preferred drug list will be subject to prior authorization requirements. Further, the state will release this information to prescribing providers and the public at large regarding the manufacturer's non-participation decision.

While this initiative required some investment in both real and political capital on the part of the state's administration, attorney general, and legislature, it was relatively easy to implement, produced tangible benefit to needy residents, and is an approach that could be easily replicated by other states.

Vaccines for Children – Possible Cost Savings for Children's Health Insurance Programs (CHIP)

The Vaccines for Children (VFC), a bulk-purchasing program, offers a different cost-savings model than Maine Rx. It provides opportunities for states that are interested in considering ways to adapt it for other populations. Here we examine how separate CHIP programs can leverage VFC to achieve savings. The VFC can also be a platform for bulk purchasing initiatives, described later in this paper.

The VFC program provides vaccines to children whose parents or guardians may not be able to afford them to help ensure that all children have a better chance at getting their recommended vaccinations on schedule. Vaccines available through the VFC program are recommended by the Advisory Committee on Immunization Practices to protect babies, young children, and adolescents from 16 diseases. Funding for the VFC program is approved by the Office of Management and Budget and allocated through the Centers for Medicare & Medicaid Services (CMS) to the Centers for Disease Control and Prevention (CDC). CDC buys vaccines in bulk at a discount on behalf of VFC grantees (i.e., state health departments and certain local and territorial public health agencies) and ensures the vaccines are distributed directly to private physicians' offices and public health clinics that are registered as VFC providers.¹

The VFC program covers children younger than age 19 who are Medicaid-eligible, uninsured, underinsured – meaning their health coverage does not include immunizations – and American Indian or Alaska Native. Children whose health insurance covers the cost of vaccinations are NOT eligible for the federal VFC program. However, states can create savings in separate CHIP programs by purchasing vaccines for children enrolled in those programs using their VFC contract with the CDC and/or use of CDC provider ordering/distribution mechanisms by defining and identifying these children as state-vaccine eligible under their state immunization program. Because children with CHIP coverage are not eligible for the federally-funded VFC Program, CHIP programs must pay for the

vaccines, but can benefit from the reduced, bulk purchase price achieved through their state's contract with the CDC.

According to 2014 federal guidance from CMS and CDC to states, CHIP programs must pay in advance on a quarterly basis for vaccines sent to providers that will be administered to separate CHIP children. The program is complex, but does leverage CDC funding to lower costs of vaccines in state-only CHIP plans. One state that covers approximately 41,000 children in its CHIP program estimates a savings of about \$1 million annually for vaccines purchased from the CDC.

Leveraging Buying Power across Agency and State Lines to Lower Drug Costs

States have a history of coordinating public purchases and extending their buying power to harness discounts through the bulk-purchase of drugs and medical supplies.² Interest in coordinating purchasing has been heightened by California Gov. Gavin Newsom's recent executive order requiring the state to pool its purchasing power to lower prescription drug costs.

Multi-State Purchaser Models

Since 1985, the [Minnesota Multistate Contracting Alliance for Pharmacy](#) (MMCAP) has worked with state procurement systems in all 50 states and serves as a purchasing cooperative to negotiate manufacturer and wholesaler discounts for governmental facilities and agencies. This is a bulk-purchasing program – not a program of negotiated rebates. There is no membership fee, eligible entities register with MMCAP and pay service or purchase-related administrative fees to MMCAP.³

MMCAP negotiates with wholesalers for certain discounts and negotiates directly with generic and brand-name drug manufacturers. Members can choose from three wholesalers for order fulfillment. Because members do not have to align their drug formularies, discounts are based on estimated volume. If members agree on a specific product over other products in a class, there can be greater discounts based on volume and moving market share to a preferred product. MMCAP has found that it is very difficult for different facilities and/or agencies to agree to a common formulary or to a list of preferred drugs within a category or class of drugs. MMCAP purchases a variety of supplies for health facilities in addition to drugs. For drugs, MMCAP contracts with wholesalers.⁴

Multi-State Rebate Negotiation Models

States across the country have historically joined together to negotiate higher drug rebates in their Medicaid programs. While these programs are exclusive to Medicaid, they showcase a vehicle for multi-state efforts to pool resources to increase purchasing clout. Participating states are generally those with smaller populations that may not have enough staff to manage a preferred drug list and contract negotiations. Because supplemental rebates are voluntary, pooling resources can increase their negotiating strength.

There are three multi-state supplemental rebate pools:

- The National Medicaid Pooling Initiative (NMPI) started in 2003 and has 10 states currently participating;
- Top Dollar (Top\$), initiated in 2005, has seven states currently participating; and
- Sovereign States Drug Consortium (SSDC), instituted in 2006, has 12 participating states.

These pools negotiate rebates based on volume of pooled lives. Pools do not negotiate based on an agreement

of the members to treat certain drugs similarly. For example, all members agree that a drug will be taken off their states' PDLs if there is no supplemental rebate. Discounts would likely be more significant if states would further aggregate their negotiating leverage. There is very little public information about the cost-savings associated with these programs, or what differentiates the two pools.

The Northwest Consortium – A Multi-State, Multi-Payer Approach to Drug Costs

In 2006, Oregon and Washington took a “next step” and established the Northwest Consortium to allow their state agencies, local governments, businesses, labor organizations, and uninsured consumers to pool their purchasing power to obtain better prices for prescription drugs. Administered by Moda Health and Ardon Health as the specialty pharmacy contractor, the multi-faceted consortium began with a discount card for point-of-service pharmacy discounts at participating pharmacies. This card enables an individual to obtain discounts at the pharmacy counter. Pharmacies participating in the program experienced higher customer traffic because of their participation.

Today, the Northwest Consortium has a group purchase organization (GPO) and a pharmacy benefit manager (PBM), which operate on behalf of purchasers and payers respectively.

Participating Oregon agencies include corrections, Medicaid, workers compensation, public employees/retirees and public school employees, and in Washington they include Medicaid, state employees/retirees, and workers compensation. Additionally, the consortium program has grown from a pharmacy-based discount card program and GPO, to a PBM for payers who negotiate price concession rebates with a role in the federal 340B program serving hundreds of safety net providers in the consortium.⁵

Participating employer groups enroll employees in the discount card program or use the Northwest Consortium PBM function to manage the pharmacy benefit for employer groups. The consortium's PBM provides 100 percent transparency – the manufacturers' rebates are passed through in full to payers in the consortium.

In 2017, the Northwest Consortium served more than 1 million covered lives and administered \$800 million in volume.⁶ The consortium is currently looking for ways to expand participation.

Sole-State, Multi-Agency Drug Purchasing Models

The [Washington State Health Care Authority](#), the largest purchaser of health care in the state, administers the Washington Prescription Drug Program (WPDP). The program coordinates the pharmacy benefit for Medicaid, state employees/retirees, school employees, and the workers compensation program. These state agencies also participate in the Northwest Consortium. All agencies use a unified preferred drug list, or formulary, called the Washington Preferred Drug List. The Medicaid Drug Utilization Review Board serves as the program's pharmacy and therapeutics (P&T) committee. P&T committees generally review drugs to determine if they should be covered and can make recommendations addressing how they should be covered – only for certain conditions, or with prior authorization, for example. In addition to managing costs for multiple health coverage programs through negotiating manufacturer, wholesaler or pharmacy discounts, the program also develops treatment and prescribing protocols to optimize care and treatment as well as manage costs. The treatment protocols apply to participating state programs and are widely available to providers in the community.

California operates both purchaser and payer drug programs. These programs are run by several state departments and local governmental programs. The Department of General Services (DGS) and the Department of Health Care Services are tasked with responding to the Governor's Executive Order N-01-19. The Department of Health Care

Services will move the Medi-Cal (Medicaid) pharmacy benefit out of individual managed care organizations into its fee-for-service program and negotiate supplemental rebate agreements with manufacturers based on a larger group of covered lives.⁷ Prior to implementation of the governor's order, Medi-Cal lives were distributed among Medi-Cal contracting MCOs, and each MCO negotiated separately for manufacturer rebates or relied on MCO-specific PBM contractors to obtain drug rebates.

Part of the governor's charge was placed on the DGS, in consultation with the California Pharmaceutical Collaborative (CPC). DGS coordinates the multi-agency CPC, which acts as a statewide workgroup of the DGS Statewide Pharmaceutical Program California. The CPC is tasked with the following responsibilities:

- Coordinate best-value clinical treatment protocols among collaborative members.
- Leverage state, local, and other government efficiencies and methodologies to achieve best-value procurement, purchasing, and negotiation with manufacturers for discounts on pharmaceuticals.
- Establish and monitor performance and quality standards for protocols, guidelines, and contracts created for member agencies.
- Work with member departments to track state expenditures on specific high-cost drugs to inform the budget process.
- Recommend high-cost pharmaceuticals for cost-value review by independent research organizations.
- Track new pharmaceuticals under US Food and Drug Administration (FDA) review, those likely to come out onto the market in the near future, and those that may become high-cost drugs.
- Act as a discussion forum where pharmaceutical issues of interest can be identified and addressed.

The executive committee of the collaborative includes the departments of Corrections, Veterans' Affairs (CalVets), Health and Human Services, Finance, as well as the Government Operations Agency, and the Labor and Workforce Development Agency.

Other state and local government agency collaborative participants include the Department of Industrial Relations, Association of Counties, State University System, Covered California (the ACA Exchange program), Department of Managed Care, Department of State Hospitals, Department of Developmental Services, University of California system, and state retirees (CalPERS). By law,⁸ the departments of corrections and rehabilitation (California Correctional Health Care Services and Division of Juvenile Justice), state hospitals (psychiatric), and developmental services must participate in a joint purchasing program. Other state and local governmental agencies can participate voluntarily. Other agencies that have elected to participate include the State University System, the Department of Public Health, and the Emergency Medical Services Authority.

Available information indicates that the collaborative purchases drugs for participating agencies at 63 percent to 69 percent off "suggested wholesale price," which is the price at which manufacturers suggest that wholesalers sell to retail pharmacies. The participating agencies then dispense directly to their patients.

All participants (except corrections) employ a unified formulary – the participants agree to use the products that are part of the procurement. Unified formularies and a commitment to prefer the use of certain drugs over therapeutic alternates are important to assure a drug wholesaler or manufacturer that a certain level of volume or market share will be utilized by the CPC. Guaranteeing a certain level of market share is what motivates the wholesaler or manufacturer to offer better discounts than would occur in the absence of any attempt by the group of purchasers to buy and use quantities of a product independently.

DGS uses a group purchasing organization (GPO) vendor, (currently Managed Health Care Associates) as a broker for generic and some branded prescription products. Additionally, the state negotiates purchase contracts directly with wholesalers and manufacturers and participating state departments purchase desired quantities at the negotiated contract price directly from the supplier (similar to the MMCAP program). Program volume

was \$300 million in 2013.⁹ DGS also contracts with PBMs that negotiate rebates from manufacturers on behalf of many covered lives.

Participating departments conduct a joint procurement for a PBM service that manages claims processing, and other routine PBM functions on behalf of health plan payers. The current PBMs are Magellan and InMedRx. These PBMs provide full pharmacy services to the California Department of Corrections and Rehabilitation (CDCR) adult parolee program and re-entry program, and offer alternative fill services for CDCR's Juvenile Justice and Adult Operations and CalVet homes. The Office of AIDS' AIDS Drug Assistance Program also coordinates with DGS to procure PBM services for their clients. Contracts are either bid or negotiated, per DGS authority.¹⁰

Massachusetts was the first statewide initiative to privatize, standardize, and consolidate multiple pharmacy care entities within a state to improve cost-effectiveness while retaining state oversight, control, and accountability. Established in 1992, the [Massachusetts State Office of Pharmacy Services](#) (SOPS) administers pharmacy services for about 50 state facilities for the departments of Public Health, Corrections, Developmental Services, and Mental Health, sheriffs, and soldiers' homes. SOPS contracts with CompleteRx to operate the pharmacy services, which includes drug purchasing. This office also runs a naloxone purchasing and payer discount program for state offices and agencies, including local law enforcement.

Like Massachusetts, many states have a designated agency that coordinates the purchase of drugs to greater or lesser extents – particularly for state run-facilities. There are also some states where opioid reversal agents are purchased (or contracted for discounts) from an agency other than a state's pharmacy procurement agency.

Louisiana's health department is partnering with its Department of Corrections in a unique procurement¹¹ [process](#) exclusively for hepatitis C drugs. The state plans to contract for the direct purchase of one or more new hepatitis C treatments at a discounted price from one or more manufacturers. The procurement budget will be equal to what the state currently spends on hepatitis C treatment for its Medicaid and corrections populations (gross costs before rebates). The Medicaid part of the initiative will be handled through rebates on drugs dispensed, following the normal Medicaid rebate process. In a year when the spending cap is exceeded, all products dispensed after the cap is met are rebated at 100 percent. The corrections portion will run through the 340B program and the unit price of the product may have to be lowered if and when corrections reaches its budgeted spending limit. About 16 states already access 340B pricing for their corrections departments through agreements with state-operated 340B clinics or hospitals. The winning contractors will also support the states' efforts to increase the number of people treated each year through expanded community outreach and provider training, in addition to other strategies. The states describe this concept as a subscription model similar to Netflix – for a set fee, a state can use as much hepatitis C drugs products to treat as many people as needed in a month.

While Louisiana's program specifications are not yet finalized, the goal is to procure as much product as possible to treat as many people as possible at what would essentially be a bulk-purchase price. Three manufacturers have submitted bids and one has been selected. The state is implementing the program, which does not require federal Medicaid waivers.

Leveraging Public and Private Payers to Limit Health System Cost Growth

The strategies laid out in this paper identify ways that states can break down the silos of purchasing power to work collaboratively to negotiate or establish better prices for health care services and prescription drugs. However, states also bear responsibility, primarily through their legislatures and departments of insurance, to protect consumers who buy coverage in the commercial market.

Unrelenting growth in health care costs means increases in insurance premiums, not just state spending. About one-third of states operate their own health insurance exchanges, working to provide affordable coverage for enrollees. States also play critical roles as bully pulpits, conveners, and regulators and can work to achieve statewide policies to address costs across all payers – public and private. States join or partner with business purchasing collaboratives and related groups and they enact legislation to advance more global approaches to cost containment. The earliest examples include hospital all-payer rate-setting commissions, which once operated in several states and still exists in Maryland. Newer iterations include establishing “global budgets” or expenditure caps for all state health care spending.

Maryland’s All-Payer Rate Setting – Moving to Total Cost of Care

On Jan. 1, 2014, Maryland and CMS entered into a new initiative to improve quality of care and reduce costs for all payers by restructuring Maryland’s 30-plus year-old, unique all-payer rate-setting system for hospital services. The state converted its hospital payment system from traditional fee-for-service to a global system, in which hospital total revenue for all payers is set at the beginning of the year. The premise behind global hospital payments is simple – providing fixed, predictable revenues gives hospitals flexibility to invest in care and health improvement activities that reduce avoidable utilization and improve value for consumers and purchasers.¹²

Maryland’s Health Services Cost Revenue Commission (HSCRC), the state’s hospital rate-setting authority, helped lead the state’s all-payer model in setting global hospital payments for this payment reform initiative. HSCRC set the annual hospital cost growth rate ceiling for all payers at 3.58 percent, which is equal to the long-term growth rate for the state’s economy. The actual growth was much lower – 1.47 percent in 2014 and 2.31 percent in 2015.¹³ The state was also able to achieve its promised \$330 million in Medicare cost savings ahead of the originally forecasted five years. Although the initiative targeted hospital costs, the state also monitored non-hospital costs and saw those costs rise. Hospitals shifted some patients to home health care services or skilled nursing facilities, however, an evaluation of the initiative found that hospital cost savings exceeded non-hospital cost increases, so payers did save money overall.

Maryland’s all-payer model successfully reduced unnecessary readmissions and hospital-acquired conditions, while decreasing the growth in hospital cost per capita. However, its focus was limited to hospitals and an evaluation indicated that the model did not sufficiently provide for comprehensive coordination across the entire health care system. Because of this limitation, CMS required Maryland to develop a new model that encompasses all of the health care that patients receive in a community, both inside and outside hospitals.¹⁴

In launching the new, broader-scoped model designed to address Total Cost of Care (TCOC), Maryland needed to align incentives to encourage non-hospital provider participation. The state negotiated an amendment to its agreement with CMS to qualify the model as an Advanced Alternative Payment Model (AAPM) under the CMS Quality Payment Program, which was established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Providers who participate in Maryland’s Care Redesign Programs became eligible for an incentive payment from the federal government beginning in 2018.

Building on its success in achieving quality improvements while reducing hospital costs and armed with MACRA incentives for non-hospital providers participating in the state’s TCOC model, Maryland launched this next phase in January 2019. The following key elements of the TCOC model are designed to achieve a patient-centered system:

- Care will be coordinated across both hospital and non-hospital settings, including mental health and long-term care.
- The model will invest resources in patient-centered care teams and primary care enhancements.
- Maryland will set a range of quality and care improvement goals. Providers will be paid more when patient

outcomes are better.

- Maryland will set a range of population health goals addressing opioid use and deaths, diabetes, and other chronic conditions.
- State flexibility will facilitate programs centered on the unique needs of Marylanders, the provider community, geographic settings, and other key demographics.

The Vermont Green Mountain Care Board

Vermont has a long history of advancing public-private collaboration to address health care and rein in costs. Initially piloted in 2003, the Blueprint for Health, launched a primary care medical home model that included a 2007 mandate requiring private payers to participate in the model, and an agreement negotiated with CMS to include Medicare.¹⁵ Today, Medicare, Medicaid, commercial payers, and some self-funded plans participate in the Blueprint and over 90 percent of Vermont's primary care practices receive per-member-per-month payments to participate in the model.¹⁶ Vermont has documented a significant reduction in cost growth under the Blueprint, while expenditures have risen at a rate of 3 percent annually for non-attributed populations, the rate increase has held at 2.4 percent for those attributed to the Blueprint.¹⁷

In 2011, Vermont created the Green Mountain Care Board (GMCB) – an independent, public agency established to improve population health, reduce health care spending, improve patient experiences, and simplify health care financing and delivery. The GMCB is governed by five members appointed by the governor and legislature to six-year terms, and now has 27 staff.¹⁸

When the GMCB was created, Vermont was searching for solutions to increase access to care, but with health care costs escalating at an annual rate of 6.5 to 8.5 percent, the state also recognized that it must address cost if any access improvements were to be sustainable.¹⁹ In this context, the GMCB was established under Chapter 220 and granted broad authority over many aspects of Vermont's health care system in order to control cost growth. The legislation authorizes the GMCB to:

- Set provider payment rates;
- Develop, implement, and evaluate the effectiveness of payment and delivery system reforms;
- Develop and maintain a system for evaluating health care performance and quality;
- Promulgate rules to achieve payment reform and cost-containment; and
- Review and approve health information technology and workforce development plans.²⁰

The GMCB's work falls into four buckets:

- Health insurance rate review;
- Review of certificate of need submissions;
- Review of hospital and accountable care organization (ACO) budgets; and
- Advancement of health system reform efforts designed to promote cost containment and value over volume.

The board works diligently on these tasks, for example, in 2018, the GMCB reduced insurer premium increases by \$21.4 million for plan year 2019. The GMCB also issued reports examining the primary drivers of pharmaceutical spending in the state and one that examines health care expenditures across Vermont's Medicare, Medicaid, and commercially-insured populations.²¹

Much of the GMCB's recent attention has focused on implementation of an all-payer ACO model that includes Medicare, Medicaid, and commercial payers. The goal of the model is to maintain average annual cost-growth at 3.5 percent per capita, with a 4.3 percent growth ceiling. In addition, the state is committed to maintaining cost growth for Medicare beneficiaries at 0.2 percent below the national average. The all-payer model is currently being implemented in one ACO and involves Medicare, Medicaid, and individual market products sold by Blue Cross Blue

Shield of Vermont (the state's largest commercial insurer). Vermont expects to grow the model over a five-year span and anticipates that 70 percent of its population will be attributed to an all-payer ACO by 2022.

Act 113, enacted in 2016, mandates that the GMCB conduct certification and regulation of ACOs, with the authority to review and approve the budget of any ACO with more than 10,000 attributed lives. Under the all-payer model, payers and the GMCB set a population-based payment rate with payments made prospectively to participating ACOs, and reconciled at the end of each year. The payment calculation also includes a calculation to mitigate any actions Vermont may take to address cost shift caused by low Medicaid payments. While some economists have made the case that refutes cost shifting, Vermont's policy recognizes the potential for cost shifting if and when providers divert uncompensated or under-compensated care costs to payers with a more robust reimbursement structure. The all-payer model discounts any increases in Medicaid to address payment differentials from the ACO's financial cap. The GMCB must report on cost shifts, including any effects of the all-payer model on cost shift in the state.²²

In addition to advancing cost growth targets under the all-payer model, the GMCB works closely with Vermont's 12 hospitals to set an annual growth target. The target is based on the net patient revenue received by a hospital, calculated in terms of all hospital revenue minus costs of uncompensated care and patient "discounted" prices as negotiated with payers. If any hospital cannot sufficiently justify growth in excess of these targets, the GMCB has authority to issue court orders or to place an assessment on those hospitals with unreasonable costs. Since 2015, annual targets have ranged from an average of 1.7 percent growth in 2017 to 6.8 percent in 2015. For 2019, targets range from 2.3 to 5 percent, averaging 2.7 percent across all hospitals.²³

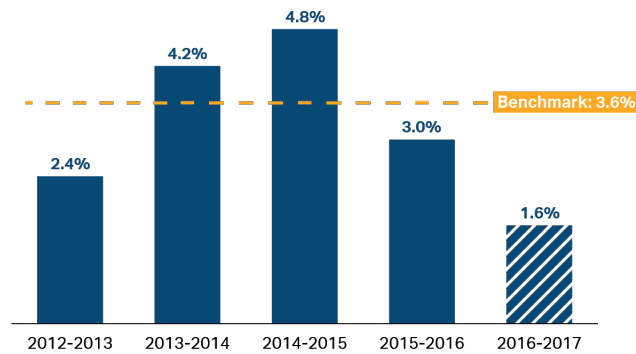
The GMCB's broad authority puts it in a unique position to leverage its powers to advance comprehensive cost containment strategies coordinated across payers, providers, and health reform initiatives. The GMCB itself has suggested that its work related to implementation of an all-payer ACO model serve as a means to better integrate its "core regulatory responsibilities," including hospital budget review and insurance rate review,²⁴ recognizing that aggressive regulation of both is necessary to understand and achieve its cost targets. Ultimately, the GMCB envisions that its efforts will help draw connections between disparate aspects of health care spending in the state.

Massachusetts – All-Payer Cost Growth Targets

In 2012, a Massachusetts law (Chapter 224 of the Acts of 2012) was enacted to provide a framework to control health care spending, which included establishing a health care cost growth benchmark – a statewide target for the rate of growth of total health care expenditures (THCE). Chapter 224 also created two independent agencies – the Health Policy Commission (HPC) and its sister agency the Center for Health Information and Analysis (CHIA) – charged with monitoring and enforcing health care costs trends, price variation, cost growth at individual health care entities, and scrutinizing health care market power.

The goal of setting a THCE cost growth benchmark was to keep health spending across payers and providers in line with the state's long-term economic growth rate. Without intervention, the THCE was expected to out-pace the state's overall economic growth rate. Chapter 224 set the health care cost benchmark for the first five years at 3.6 percent, equal to the state's potential gross state product rate (PGSP), which was established by state leadership with input from outside economists. For Years 6 through 10, the law established the health care cost benchmark at PGSP minus 0.5 percent or 3.1 percent and gave HPC authority to adjust the benchmark up to 3.6 percent. For later years (10-20), the benchmark established by the legislature at PGSP, though HPC has authority to modify it to any amount. Data shows that from 2012 through 2017, the annual growth averaged 3.2 percent, which is below the state's THCE benchmark of 3.6 percent during that time period. Notably, early data indicates total health care spending from 2016-2017 was 1.6 percent, which is significantly below the benchmark.

Annual growth in total health care expenditures per capita in Massachusetts



Notes: 2016-2017 spending growth is preliminary.

Sources: Center for Health Information and Analysis Annual Report, 2018

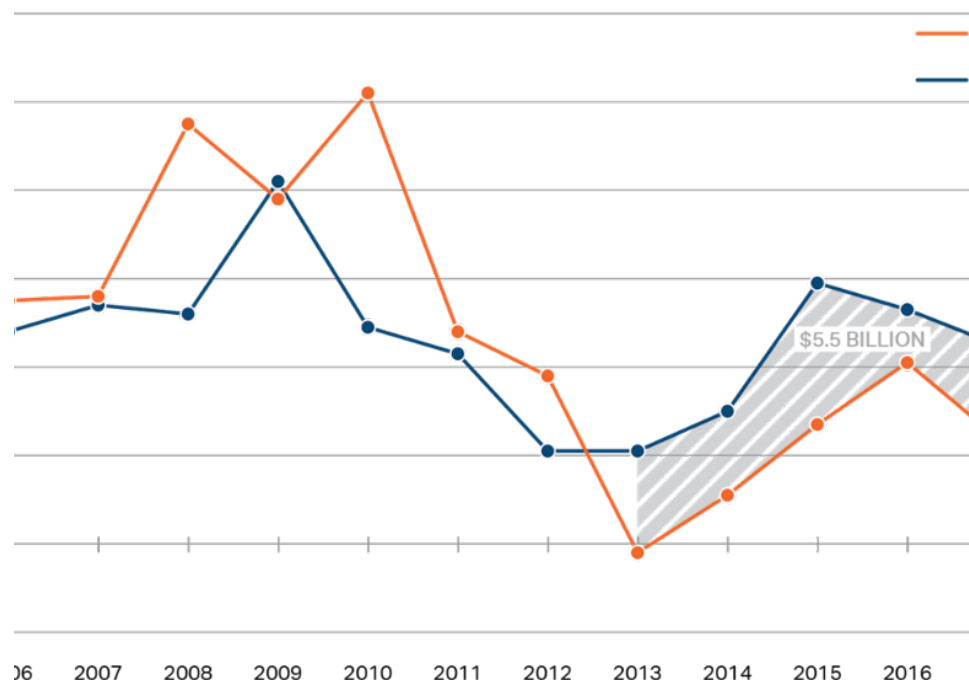
The law provides tools for monitoring and oversight. CHIA collects and analyzes spending data from Massachusetts payers and publishes the state's THCE from the previous year's performance against the benchmark in an annual report. This report contributes toward the information shared during the state's Annual Health Care Cost Trends Hearing that is convened by HPC and cohosted with CHIA and the state's Attorney General's Office. HPC has authority to compel the executives representing hospitals and health plans to testify under oath during the public hearing on their efforts to meet the benchmarks. These public hearings, initiated by the governor, have become an annual "check in" to assess the states performance on the THCE collectively.

Following the initial report and the public hearing, CHIA, having collected and analyzed more payer information, is able to provide HPC with a confidential list of providers and payers that have exceeded the cost growth benchmark. HPC follows up with the named entities to obtain more information, such as contracts and utilization trends, to better understand why spending may have been high to decide if the entity is excessively contributing to cost growth. By law, HPC can require a public performance improvement plan that gives entities determined to be excessively contributing to the cost growth 18 months to get their spending in line. To date, HPC has not had to use this enforcement tool. Payers and providers identified with higher spending have participated in private negotiations with HPC and taken actionable steps to get their cost growth in line.

Also within the scope of monitoring health system performance, HPC reviews payer and provider mergers and consolidations. Although HPC does not have regulatory authority, nor can it block a transaction, the agency can conduct a complete review of the potential implications of a merger based on overall health cost and quality. To obtain a more complete picture on behalf of the public's interest, HPC can compel entities seeking to merge to share information, such as a board reports, internal data analyses, and more. If the agency's review raises concerns, HPC can refer its report to the state's attorney general to specify conditions for a merger, including price cap restrictions. Short of that, sometimes HPC's review can prompt targeted questions that require merging entities to develop specific goals with actionable measures for quality or population health that they may not have done otherwise.

In addition to ensuring that the average annual growth of THCE stays below the state's benchmark, data shows that commercial spending growth in Massachusetts has been below the national rate since 2013, which correlates with Chapter 224's enactment. Slowing the rate of commercial health care cost increases has generated billions in avoided spending. Massachusetts residents have benefited from a 2 percent wage increase that – without slowing the health care cost rate increase – would have resulted in residents losing wages (by 1 percent) by spending more on health care. Residents' increased wages have also meant an additional \$350 million to the state through its income tax.

Annual growth in commercial spending per enrollee, MA and the United States, 2006-2017



Notes: US data includes Massachusetts. US and MA figures for 2017 are preliminary.

Sources: Centers for Medicare and Medicaid Services, National Health care Expenditure Accounts Personal Health Care Expenditures Data (U.S. 2014-2017) and State Health care Expenditure Accounts (U.S. 2000-2014 and MA 2000-2014); Center for Health Information and Analysis Annual Report TME Databooks (MA 2014-2017).

Oregon – Moving to All-Payer Cost Benchmarks

Oregon is seeking to follow Massachusetts's lead and establish a statewide cost benchmark program for all payers, but so far has only done this for the state's coverage programs. In 2010, the Oregon Health Authority (OHA), in collaboration with its nine-member oversight entity, the Oregon Health Policy Board (OHPB), produced Oregon's Action Plan for Health,²⁵ which not only identified goals for improving health and increasing quality of care, but also for lowering the rise of health care costs. One of the action plan's strategies requires the state to "align public purchasing, reduce administrative costs, and change how we pay, establish value-based payments, and set budgets." With broad political and stakeholder support, Oregon reorganized agencies to align and consolidate its health care programs — including Medicaid, public health, behavioral health, and Public Employee Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) — under the OHA. As a result, OHA is responsible for purchasing health care services for one in three Oregonians, which laid the foundation for additional reforms.

Oregon designed and in 2012 launched its Coordinated Care Model (CCM) to serve Medicaid enrollees with the goals of streamlining and integrating delivery of care, further emphasizing primary care and prevention, and reducing

Oregon Health Authority purchases health care services for:

- 1 million enrolled in the Oregon Health Plan (Medicaid)
- 150,000 state and university employees/families (PEBB)
- 150,000 K-12 and community college employees/families (OEBB)

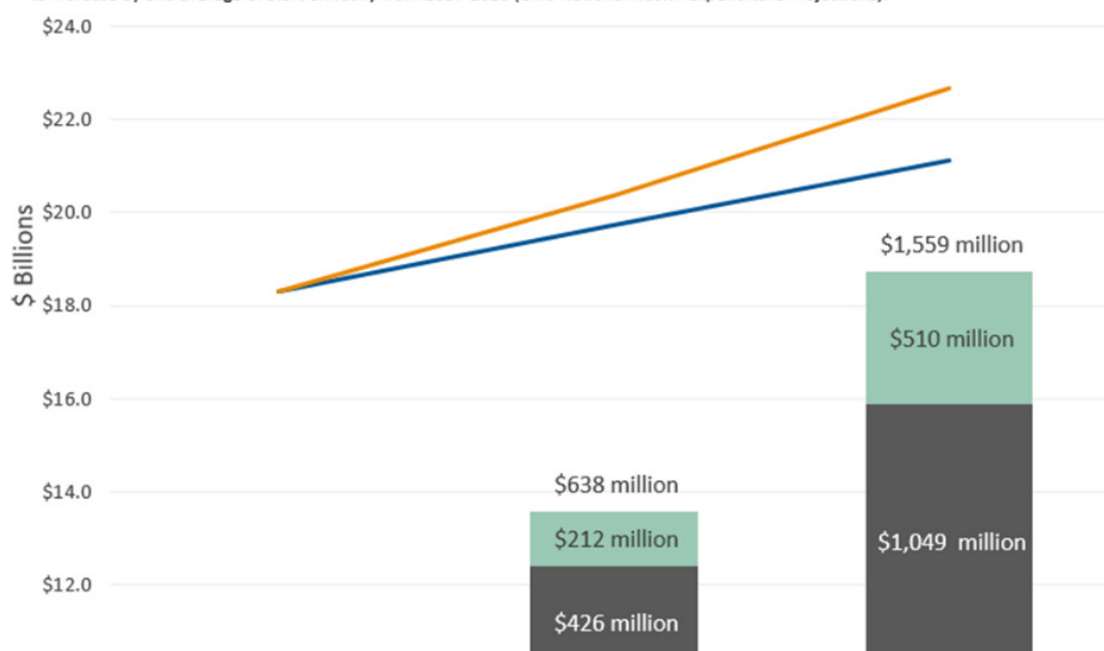
Source: OHA Data, Feb. 1, 2019

the growth rate in health care spending. Through its Section 1115 Demonstration waiver that supports CCM transformation, the state committed to a 3.4 percent per capita annual growth rate in Medicaid and reported a savings of \$2.2 billion between 2012- 2017.²⁶ From 2013 through 2017, OHA also based PEBB and OEGB budgets on a 3.4 percent per capita growth rate cap. The graphic below shows that Oregon expects to save \$700 million in general funds over the next two biennia by holding the per capita growth rate to 3.4 percent as compared to the projected US health care growth rate of 5.5 percent. The state legislature incorporated the growth rate cap into statute, with an effective date of 2020 for all payers – public and private. In 2018, building on the success of OHA's capped growth rate, a state legislative task force recommended creating a statewide benchmark program to move to a total cost of care focus and establish a cost growth target across all markets, expanding beyond state programs.

Oregon Medical Plans Expenditures and Savings

(Oregon Health Plan, Public Employees' Benefit Board, Oregon Educators Benefit Board)

As part of Oregon's Medicaid demonstration, the state agreed to limit annual per capita expenditure growth to 3.4%, while maintaining standards of access and quality. Similarly, Oregon statute requires PEBB and OEGB to limit annual budget growth to 3.4%. U.S. health spending is projected to increase by an average of 5.5% annually from 2017-2026 (CMS National Health Expenditure Projections).



Oregon officials credit their cost growth rate with creating alignment around a goal and multiple programs working in a common direction with a shared context for decision-making. The growth rate cap helps to force analysis and conversations across payers to understand what is driving costs and has helped to lead to a better understanding of data and identify additional data needs. To date, the cost growth cap has also encouraged Oregon's CCOs to agree on a 2.7 percent general fund increase and those with advanced hospital alternative payment methodologies have even lower trends, including two CCOs that had negative trends. The state is looking forward to the statewide cost growth benchmark to encourage broader alignment across other public entities, local governments, and individual and small group markets.

Delaware Health Care Cost Commission

Delaware is consistently ranked high among states for health care spending — with health care costs 27 percent higher than national averages. To address growing concerns over this cost trend, the legislature passed a joint resolution in September 2017 granting authority to the Secretary of the Department of Health and Social Services (DHSS) to study and plan for the establishment of an annual growth rate for total costs of care in Delaware.²⁷ In February 2018, the governor further supplemented this work with the creation of an advisory committee to discuss the establishment of health care spending and quality benchmarks.²⁸ After a series of reports, stakeholder meetings, and solicitation of public feedback, their work culminated in the recommendation that Delaware establish an annual target growth rate for payers and providers tied to the potential gross state product (PGSP) as well as a series of benchmarks to monitor quality of health care services.

Following these recommendations, the governor issued an executive order in November 2018 codifying the growth rate target with a spending benchmark tied to PGSP to be monitored across all payers and providers in the state. The order set the benchmark at 3.5 percent, 3.25 percent, 3 percent, and 3 percent for 2020, 2021, 2022, and 2023 respectively, though the order also allows for annual review and modification of the benchmark pending major unanticipated changes to economic factors, such as dramatic shifts in the labor market or the state's economy. Cost growth will be measured based on an assessment of the total medical expenses incurred by Delaware residents for all services and the net cost of private health insurance. The order also established a subcommittee under the Delaware Economic and Financial Advisory Council (DEFAC) to oversee the benchmark and to advise the governor on current and projected trends in health care. In addition, the order tasks the Delaware Health Care Commission (HCC), an independent public instrumental, with setting a series of quality benchmarks designed to promote affordable, quality health care in the state. These benchmarks include measurement of:

- Emergency department utilizations;
- Opioid-related overdoses;
- Residents per 1,000 with overlapping opioid and benzodiazepine prescriptions;
- Prevalence of adult obesity and tobacco use; Physically active high-school students;
- Statin-therapy for those with cardiovascular disease; and
- Persistence of beta blockers for post-heart attack treatments.

The order requires the DHCC to issue an annual report on both the spending and quality benchmarks, with data broken down by insurance markets (e.g., commercial, Medicare, and Medicaid), individual payer, and by large provider groups (defined as providers with a minimum of 5,000 Medicare lives or a minimum of 10,000 Medicaid or commercial lives).^{29,30} Legislation gives DHCC the necessary authority to monitor cost trends and collect data to support any of its initiatives.³¹ As part of its evaluation, payers are expected to report summary data documenting member attribution to primary care facilities, non-claims spending (e.g., capitated provider payments) and spending on major service categories including hospital inpatient and outpatient, primary care, specialty care, long-term care, retail pharmacy, and other professional services.

Payer data will be collected from the state's largest insurers (Aetna, AmeriHealth Caritas, Cigna, Highmark Blue Cross Blue Shield, and United Healthcare), CMS, and the US Department of Veterans Affairs, with supplemental data provided by CDC to aid in assessment of quality benchmarks related to obesity, physical activity, opioid deaths, and tobacco use. The first public spending and quality benchmark reports from DHCC are expected to be published in fall 2020. While current law does not enable the assessment of penalties when benchmarks are not met, the state plans to use public reporting of payer and hospital performance against the cost and quality benchmarks to facilitate additional discussion about the direction of health care in the state.

Rhode Island Health Care Costs Trends Project and Spending Growth Targets

Supported by a grant from the Peterson Foundation, Brown University's School of Public Health recently released a study of cost trends in the state, developed with an 18-member steering committee of public and private stakeholders jointly led by the state's health insurance commissioner, the CEO of the state's largest insurer, and a provider CEO. The state's all payer claims database provided key information about cost and utilization drivers to inform the work. The steering committee has signed a compact committing to containing health care spending.

On the heels of the study's release, RI Gov. Gina Raimondo signed an executive order establishing a 3.2 percent growth target for health care spending. The executive order charges the state's Office of Health Insurance and the Executive Office of Health and Human Services to engage providers, insurers, and community partners and issue annual reports to track the state's progress in meeting health spending targets.

Conclusion

States are increasingly looking beyond individual agencies and programs to harness the significant potential of their collective buying power. State dollars fund Medicaid, state employee health plans, health services in mental health facilities, public hospitals, and corrections, and fund health coverage for employees of university systems, municipalities, and schools. Combined, that collective buying power can be a powerful tool to negotiate better prices in an increasingly consolidated health care system. But in many states today, each program is administered separately. Crossing these organizational silos – while respecting individual organizational cultures and priorities – can be challenging. Some states have taken on that challenge by establishing new administrative structures to increase collaboration, coordination, and co-location of services and consolidate purchasing.

State employee health benefit plans are leveraging Medicare prices by advancing strategies to base hospital pricing on Medicare's well-established rates. Following Montana's success, North Carolina, Connecticut, and Washington State are proposing reference-based approaches. Other states, including Maine, are leveraging Medicaid's drug rebates to provide an affordable prescription drug option for low-income, non-Medicaid-eligible residents.

California's newly elected governor has raised the profile of multi-agency collaboration by proposing to consolidate prescription drug purchasing of public payers and ultimately allow local governments and the private sector to buy into the program. Multi-state collaboratives have long negotiated rebates on behalf of Medicaid programs and the Northwest Consortium has expanded that model to provide lower prescription drug prices for state agencies, local governments, businesses, labor unions, and uninsured residents. In Washington State, public agencies work together through a unified drug formulary to lower drug prices, coordinating drug-purchasing programs for Medicaid, state employee health plans, schools and workers' compensation programs through a single agency. Since 1985, the Minnesota Multistate Contracting Alliance for Pharmacy has purchased drugs and other medical supplies in bulk on behalf of public health facilities in all 50 states.

Based on these experiences – and faced with continuously rising health care costs – state leaders are conducting re-energized discussions about how to think and act across traditional agency boundaries to harness their collective purchasing power to lower the health care price trajectory. Several states have gone further, establishing mechanisms to control all health care spending in a state.

- Maryland has a long-standing, all-payer hospital rate-setting commission.
- Vermont's Green Mountain Care Board was an early leader in consolidating state regulatory functions and setting growth limits.
- The Massachusetts Health Policy Commission sets and monitors statewide health care cost growth targets, and Delaware, Rhode Island, and Oregon have followed with similar strategies.

This work represents a new and important wave of state activity designed to curb costs by harnessing all the public dollars spent on health care and by coordinating public and private payers to limit cost growth. The National Academy for State Health Policy will continue to work with state leaders to build on this momentum and advance meaningful state-based reforms to address health care costs.

Next Steps: NASHP invites state reviewers to submit comments to NASHP Executive Director Trish Riley at triley@nashp.org.

Notes

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17. Maryland's All-Payer Model <https://www.healthaffairs.org/doi/10.1377/hblog20170131.058550/full/>
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Acknowledgements:

The National Academy for State Health Policy (NASHP) thanks the many state officials who participated in its summit on health care costs and for their review and comments on this paper. NASHP also thanks Kaiser Permanente for its support of the summit. Any errors or omissions are the authors'.

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