Strategies other states are exploring to address health care cost growth drivers in the commercial market

Cost Growth Target Educational Webinar | April 2024

Oregon Health Authority

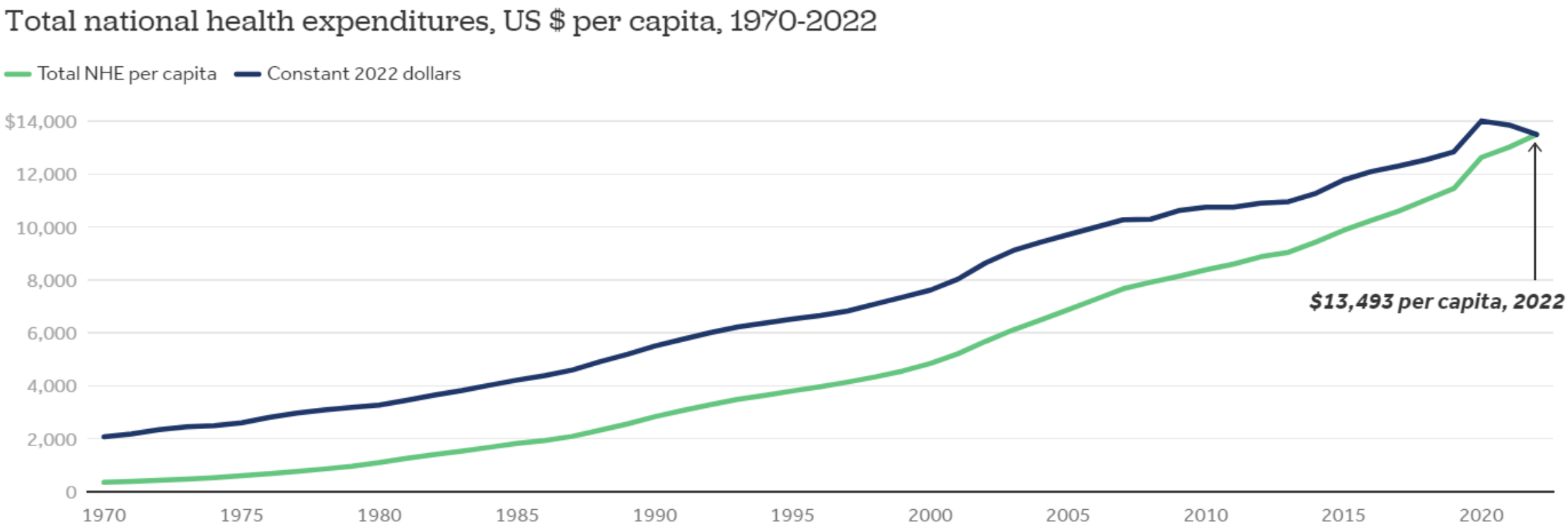
HEALTH CARE COST GROWTH TARGET

Agenda

- Background
- Environmental Scan of State Strategies
- Case Studies

Background

Health care spending is growing nationally



Note: A constant dollar is an inflation adjusted value used to compare dollar values from one period to another.

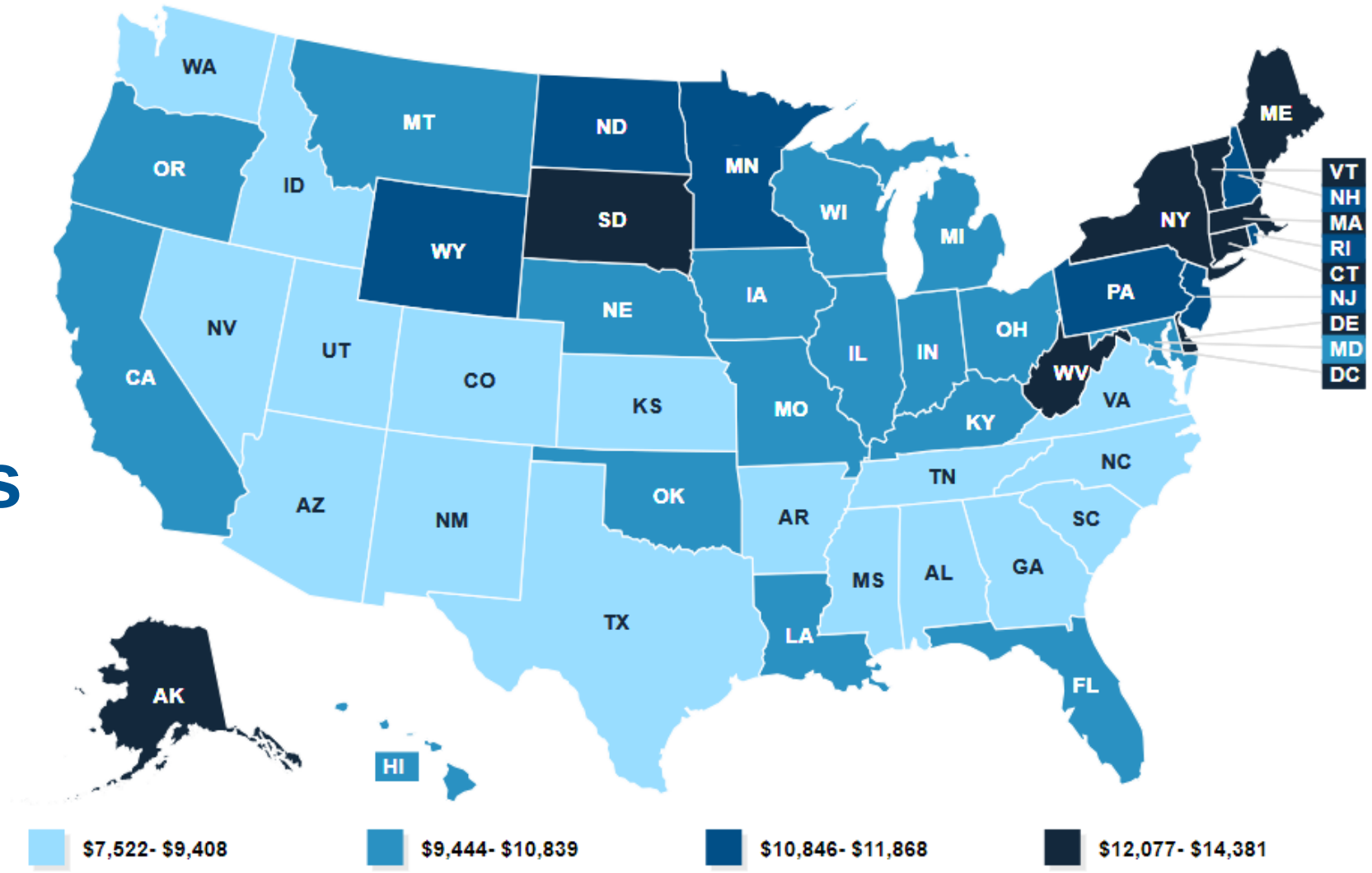
Source: KFF analysis of National Health Expenditure (NHE) data • Get the data • PNG

Peterson-KFF Health System Tracker

https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/

Health care spending varies a lot by state

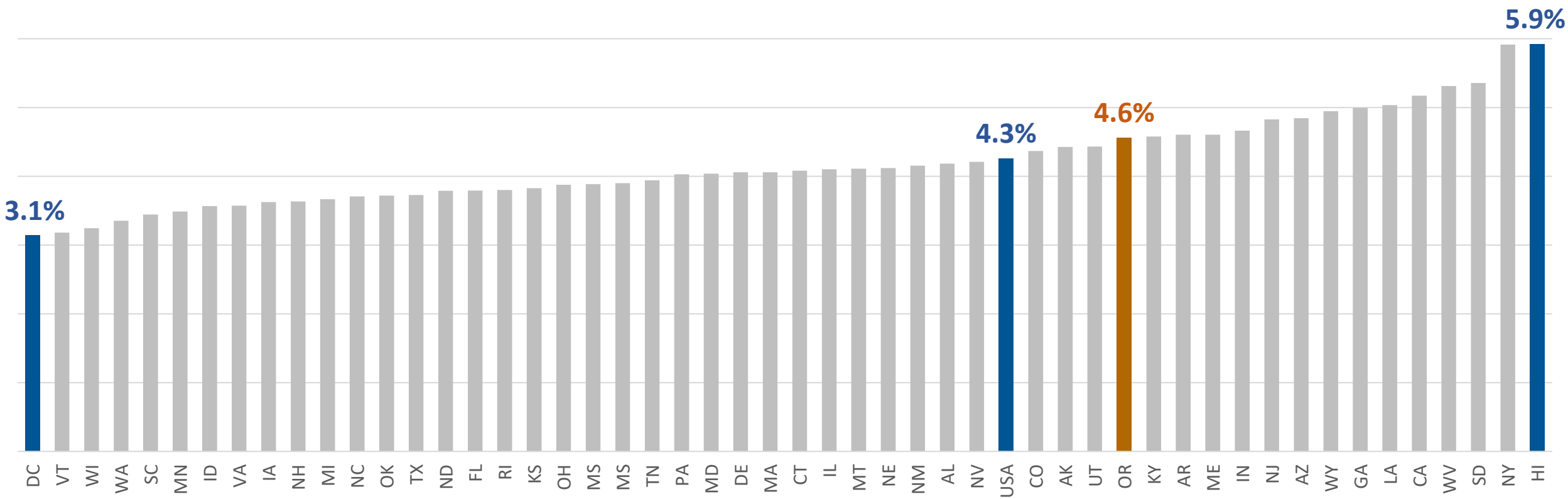
Health Care Expenditures Per Capita by State of Residence, 2020



https://www.kff.org/other/state-indicator/health-spending-per-capita

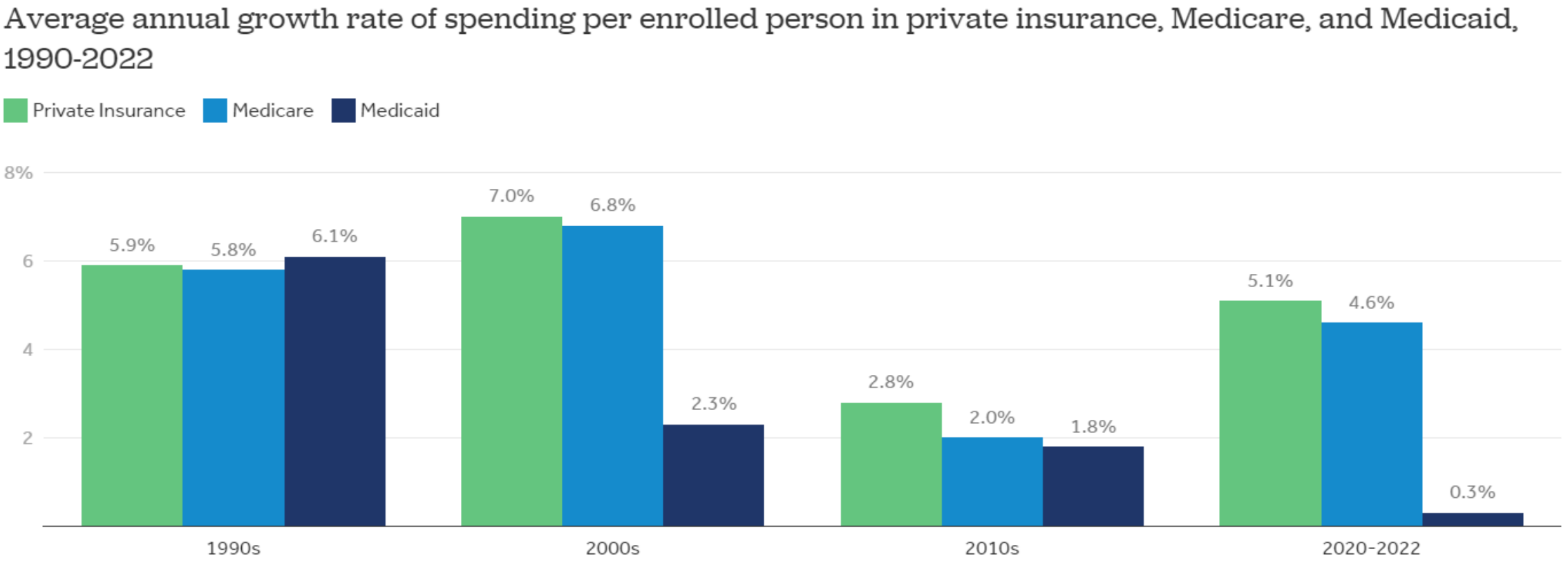
So does health care spending growth

Average Annual Growth in All Payers Per Person Estimated Spending - Personal Health Care, by State of Residence, 2013-2020



SOURCES: U.S. Census Bureau; and Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

Health care spending growth varies by market



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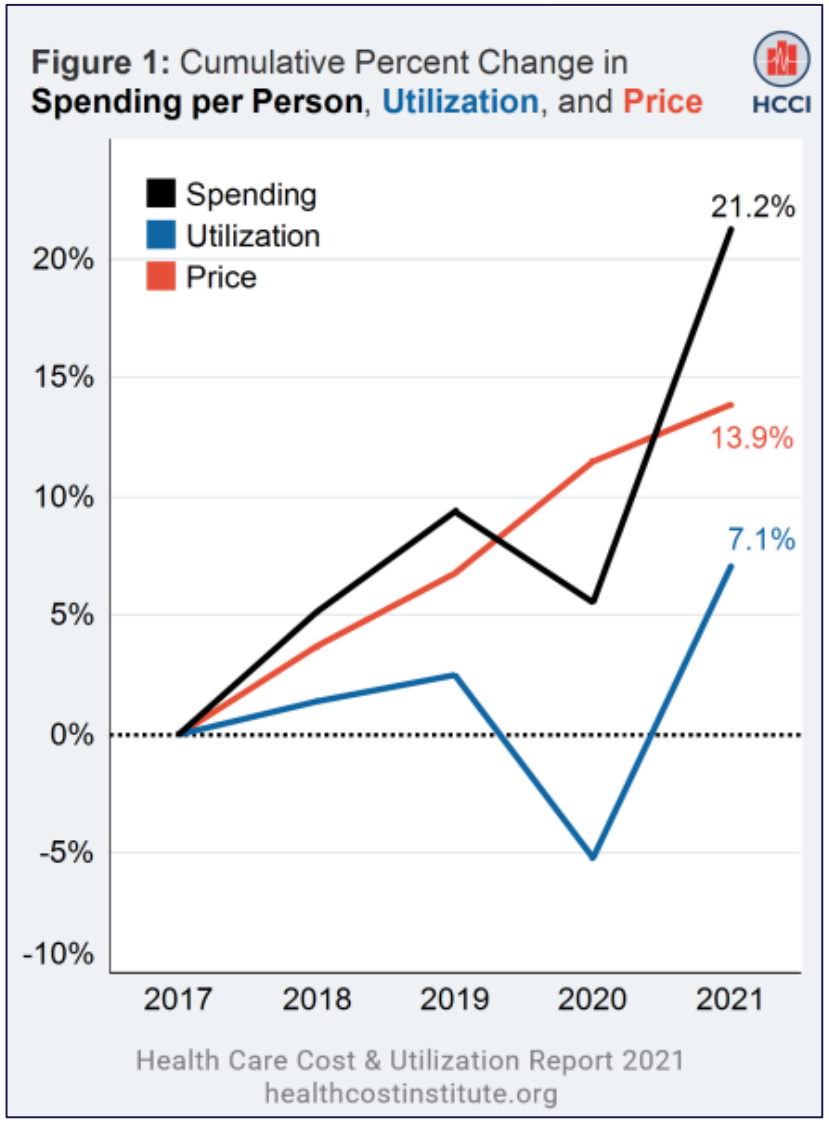
Peterson-KFF Health System Tracker



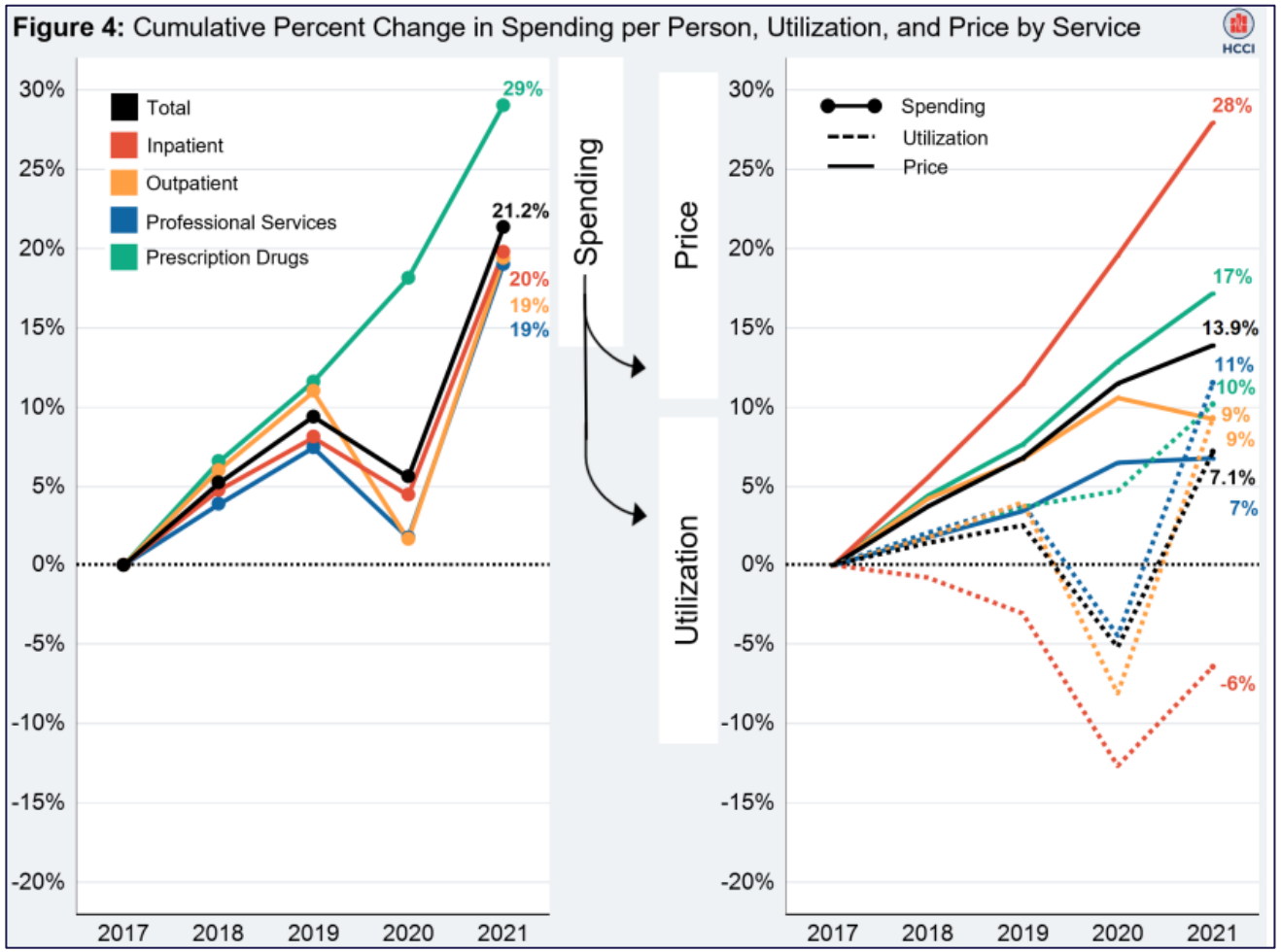
Price, not utilization, has driven commercial spending growth

The Health Care Cost Institute found that from 2017 to 2021, growth in commercial spending was driven by **increasing unit payments**.

In this time, unit payments grew at an average of **3.5% annually**, while utilization increased annually by an average of 1.8%.

Note: HCCI holds data for over 55 million commercially fully insured and self-insured covered lives in all 50 states and DC. Payers whose data are included in HCCI's analyses are: Blue Cross Blue Shield plans, Aetna, Kaiser Permanente, and Humana. https://healthcostinstitute.org/images/pdfs/HCCI_2021_Health_Care_Cost_and_Utilization_Report.pdf

Nationally, prices have risen fastest for hospital inpatient and retail pharmacy services



Between 2017 and 2021, commercial prices for each service category increased.

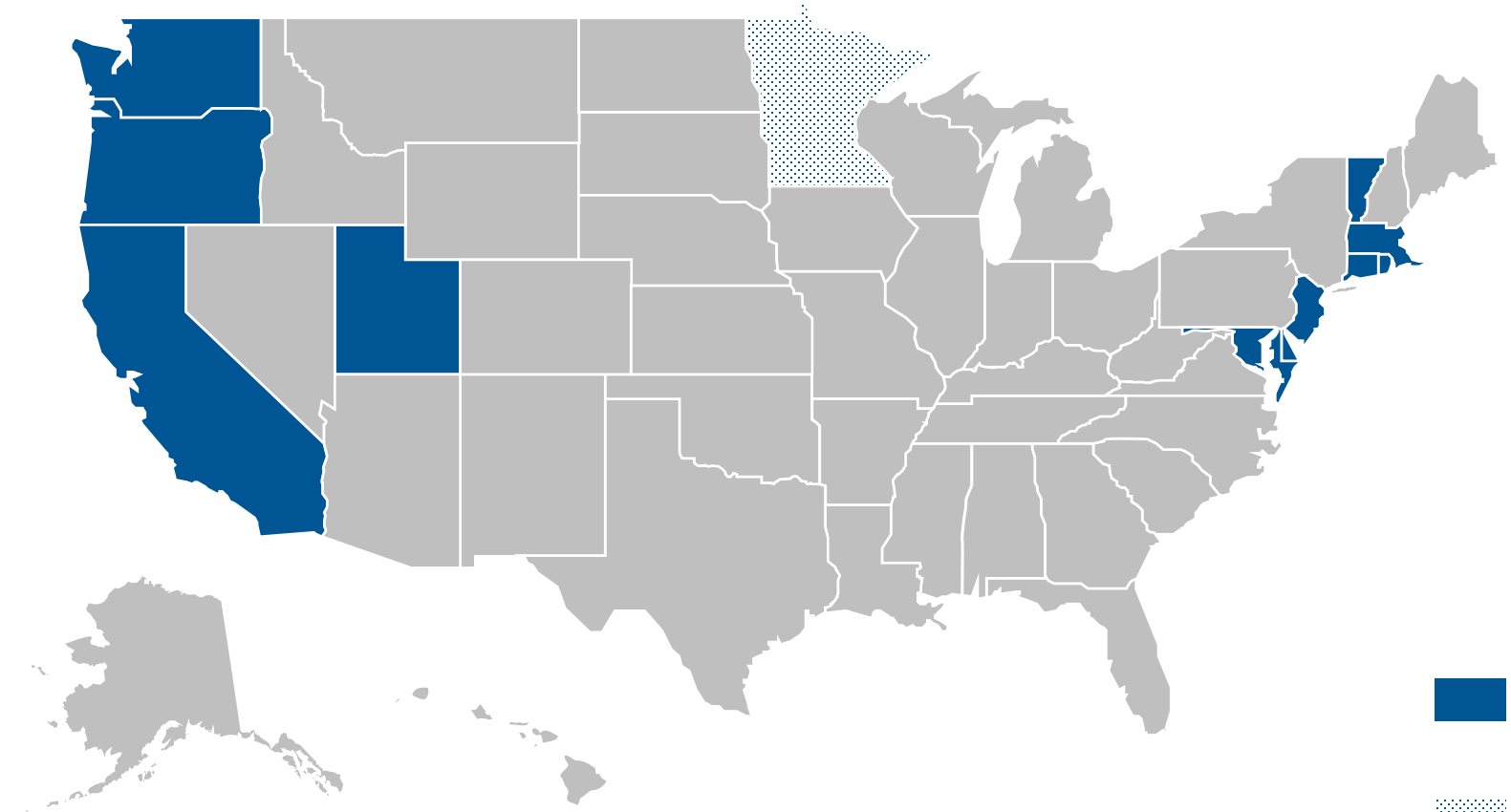
For most service categories, increased spending was largely driven by increases in prices.

- The exception was outpatient hospital, where utilization and price grew at the same rate in this period.

 Source: https://healthcostinstitute.org/images/pdfs/HCCI_2021_Health_Care_Cost_and_Utilization_Report.pdf

States are pursuing a variety of strategies to address health care costs

A growing number of states are using a cost growth target to address health care affordability



Vermont
Massachusetts
Rhode Island
Connecticut
Delaware
Maryland
New Jersey

States with a cost growth target program

States that are considering a cost growth target

Setting a cost growth target will not slow the rate of growth by itself.

A cost growth target is a catalyst for implementing cost growth mitigation strategies.

In this presentation

- Share summary information about other strategies states are pursuing to address cost growth drivers in the commercial market

- Share specific strategies emerging from other cost growth target states / cost growth target advisory committees

Content from environmental scan conducted by Bailit Health

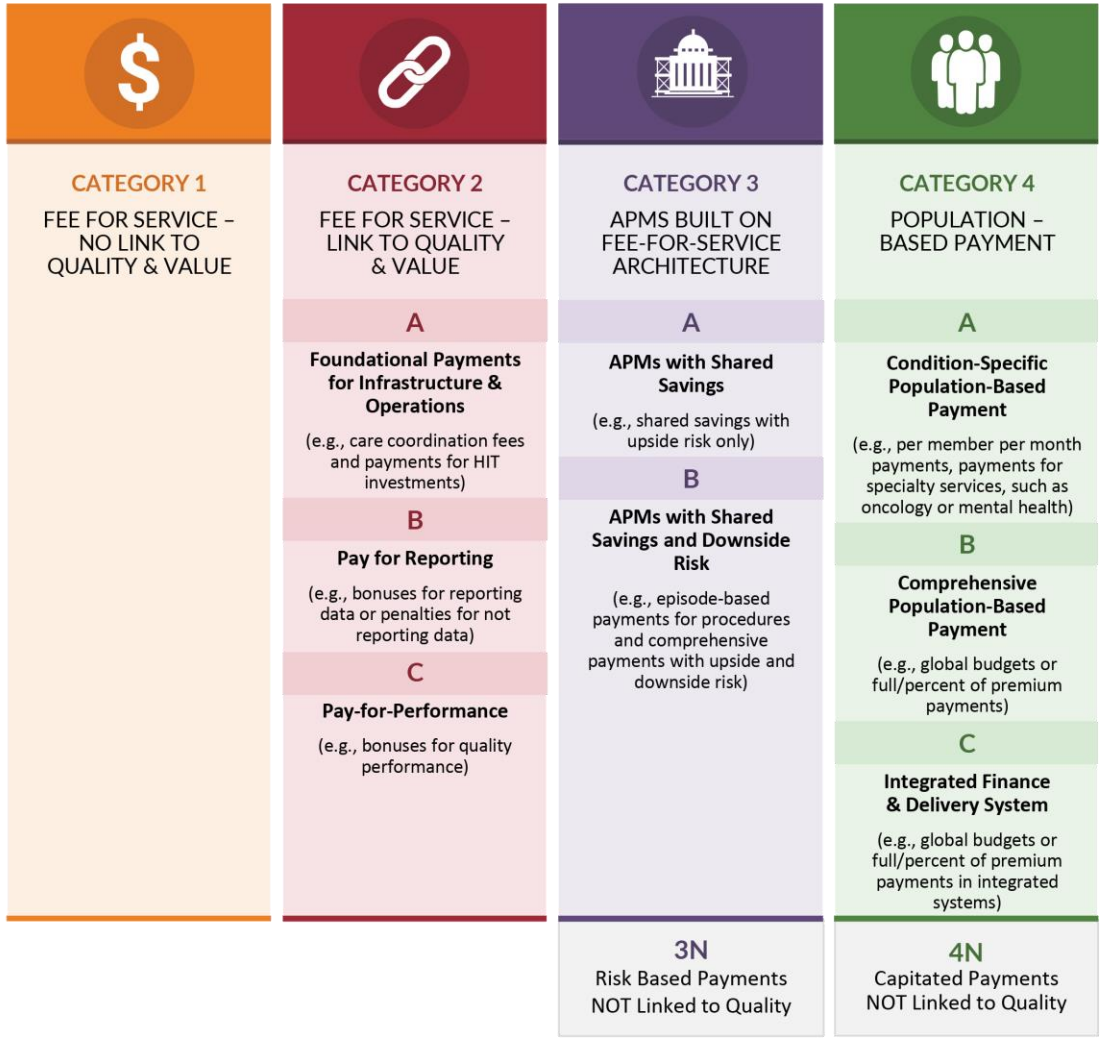
Strategies

Promote Adoption of Population-Based Provider Payment

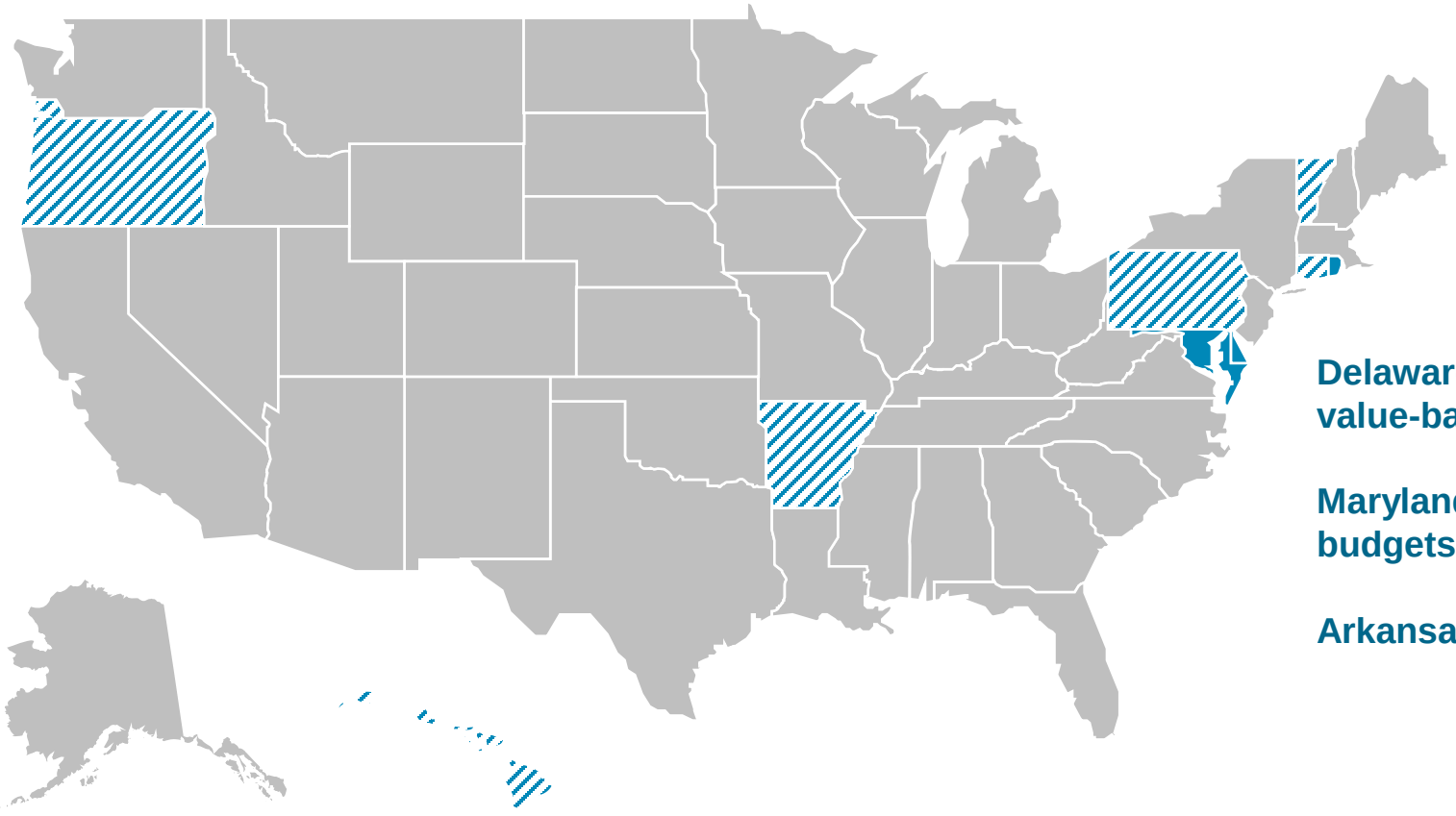
What is a population-based payment model?

The Healthcare Payment Learning and Action Network has categorized different types of value-based payment models. Population-based payment models emphasize three features:

1. They are prospective
2. They are based on a budget
3. They require providers to take on risk for costs of care that exceed the budgeted amount



Who is working on this?



Oregon VBP Compact

Vermont All-Payer ACO Model

Rhode Island Affordability Standards and VBP Compact

Delaware commercial payer participation in value-based models

Maryland and Pennsylvania hospital global budgets

Arkansas condition-specific bundled payments

Regulatory population-based payment models

Voluntary population-based payment models

Cap provider payment growth and/or provider prices

How to limit provider price increases?

Provider price increases are a leading driver of health care cost growth in the commercial market. There are two main strategies:

Limiting Price Growth

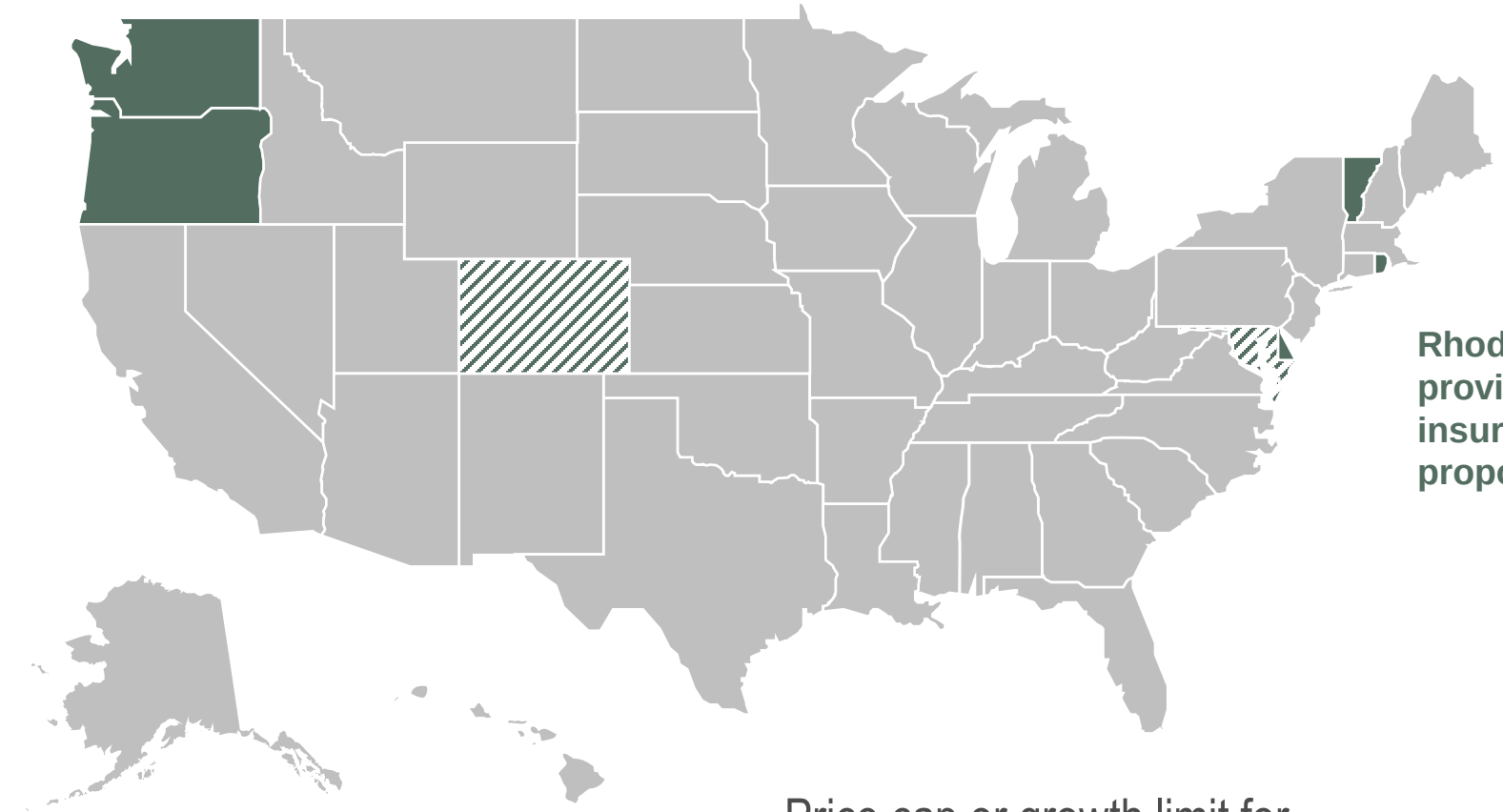
- Usually tied to economic indicators like the Consumer Price Index
- Can be applied in aggregate across all of a payer or provider's contracts or for each contract
- For example: payer cannot increase rates in provider contract by more than CPI + 1%.

Capping Prices

- Can be implemented through rate setting, contract negotiations, or fee schedule
- Directly limit prices, usually as a % of Medicare
- For example: payer cannot pay provider more than 200% of Medicare rate for hospital inpatient services.

Who is working on this?

Oregon has price caps for public employee health plans; Washington has price caps for its public option plan.



Vermont sets annual caps for charge increases for each hospital

Rhode Island and Delaware limit annual provider price increases in commercial insurer contracts. Connecticut has proposed similar legislation.

Price cap or growth limit for some market(s) and services

Authority to use rate setting for hospital prices

Contain growth in prescription drug prices

How to limit prescription drug prices?

Prescription drug spending represents a significant portion of total health care spending. It is growing rapidly due to expensive new drugs, and high annual price increases.

States cannot set drug prices because of federal law (Commerce Clause) but can *influence* prescription drug prices.

Capping Payments

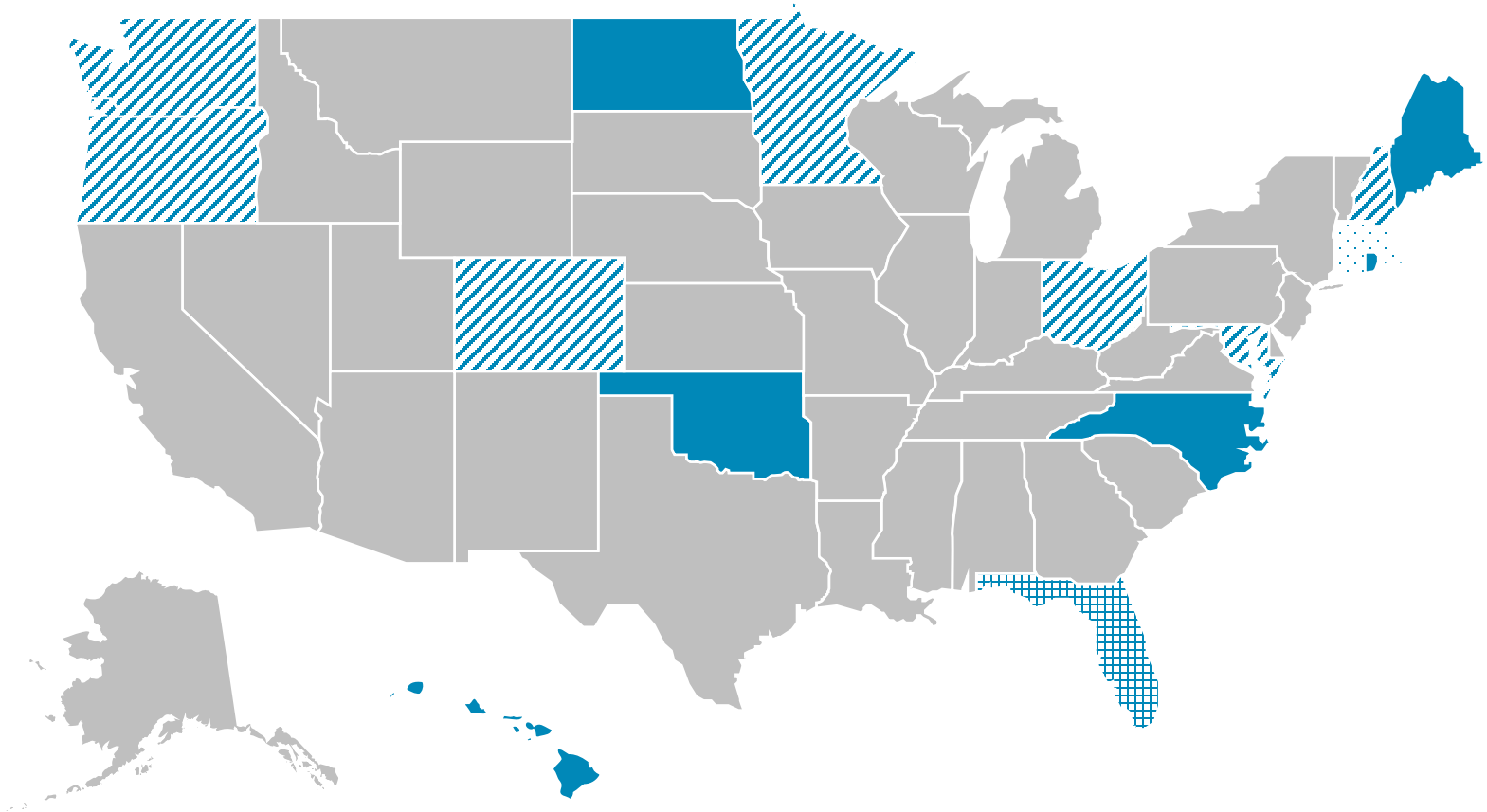
- A limit on what purchasers pay for some or all prescription drugs.
- Can use affordability reviews or external benchmarks to establish payment limits.

Limiting Price Growth

- Penalize drug manufacturers for sales of drugs with excessive price increases (based on an economic benchmark and/or clinical outcomes).

Other

Who is working on this?



6 states have proposed legislation for international reference pricing
HI, ME, NC, ND, OK, RI

8 states have Prescription Drug Affordability Boards (5 with authority for UPLs)

MA and CT previously pursued legislation that would limit price growth

FL is the first state approved to import prescription drugs from Canada

Improve oversight of provider consolidation, including mergers & acquisitions

How to improve oversight of provider consolidation?

State oversight focuses on preventing horizontal consolidation and vertical consolidation that could make markets less competitive and raise prices.

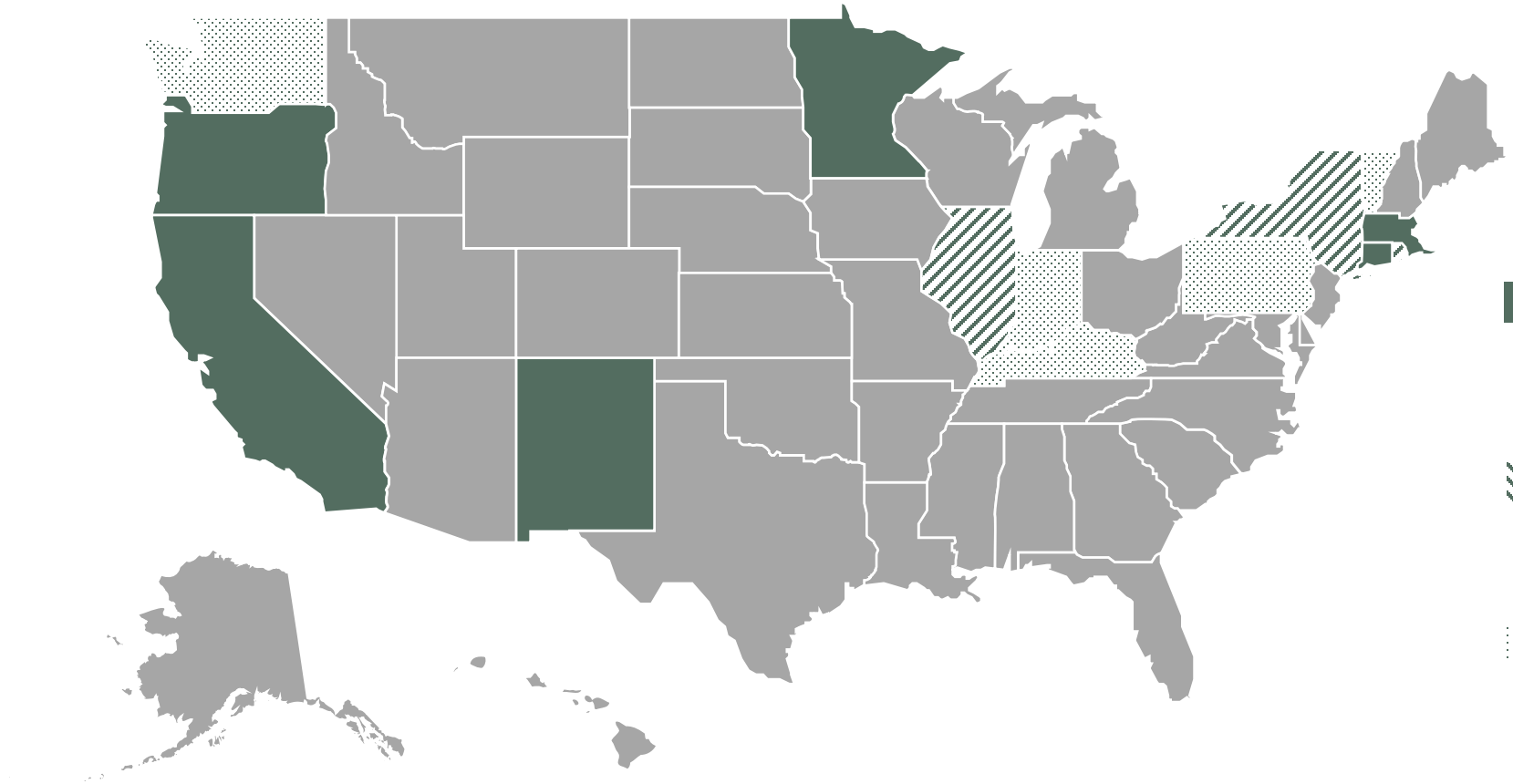
A variety of state authorities may be involved, including existing:

- State AG oversight over anti-trust, non-profits, or consumer protections
- Certificate of Need / Certificate of Public Advantage

Strategies

- Require state notice or review of mergers and acquisitions before they happen
- Address private equity transactions
- Post-merger “conduct remedies” to maintain competition
- Restrict or ban anti-competitive practices
- Authority to block transactions or impose conditions

Who is working on this?



Cost and Market Impact Reviews / Health Care Market Oversight

Require notification prior to some health care transactions

Pending legislation

35 states have active Certificate of Need programs (not shown)

Require Site Neutral Payments

What is a site-neutral payment?

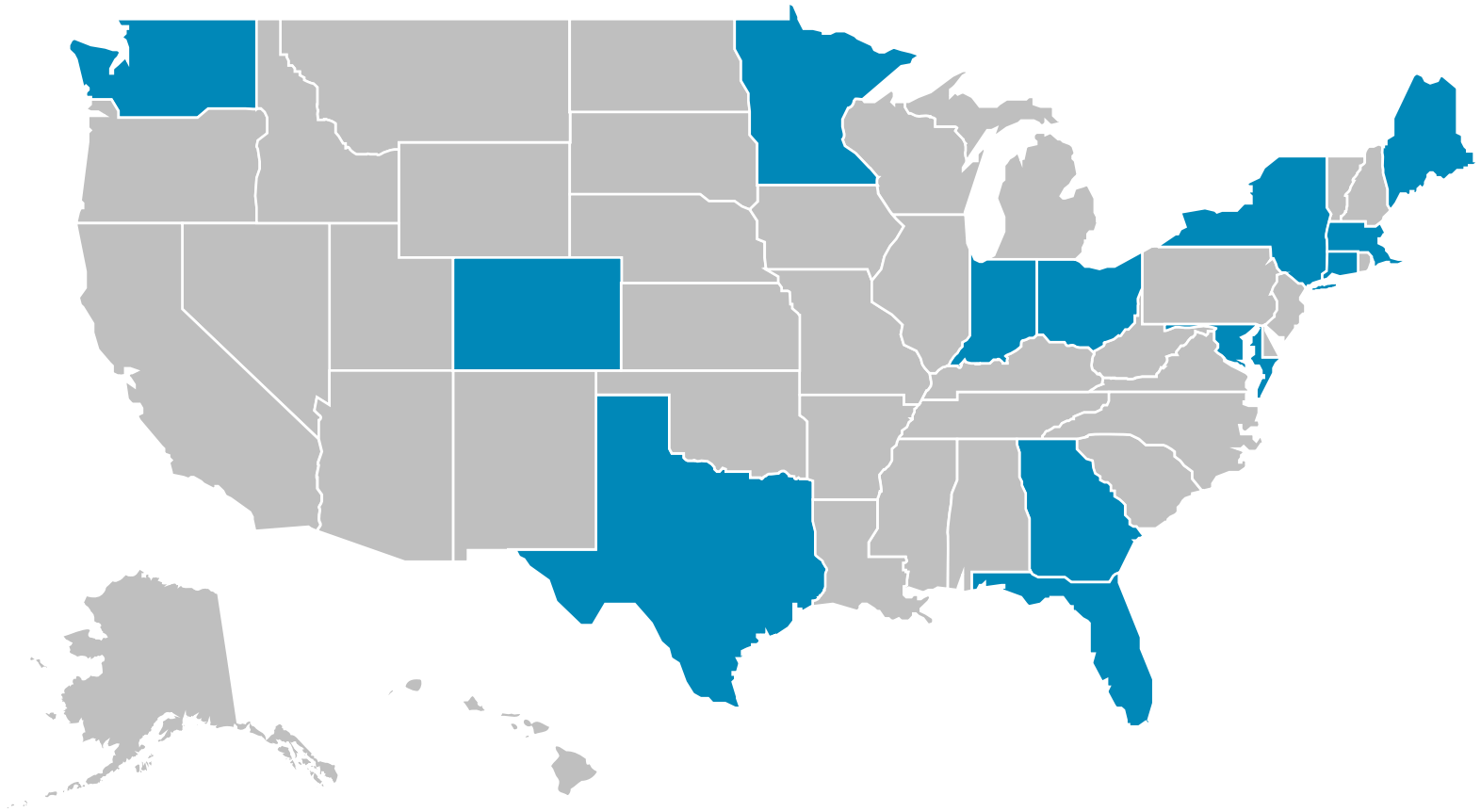
Under “site-neutral” payment policies, the payment for a service provided to a patient is the same regardless of the setting where the service is provided.

This is often focused on hospital outpatient and non-hospital settings like physician offices.

Strategies

- Require site-neutral payments for certain services that are commonly provided in office-based settings.
- Prohibit hospital or health system from charging “facility fees” for certain services at certain locations.
- Require providers to give patients notice / post information about facility fees.

Who is working on this?



States with existing facility fee reform laws

Strengthen Health Insurance Rate Review

What is rate review?

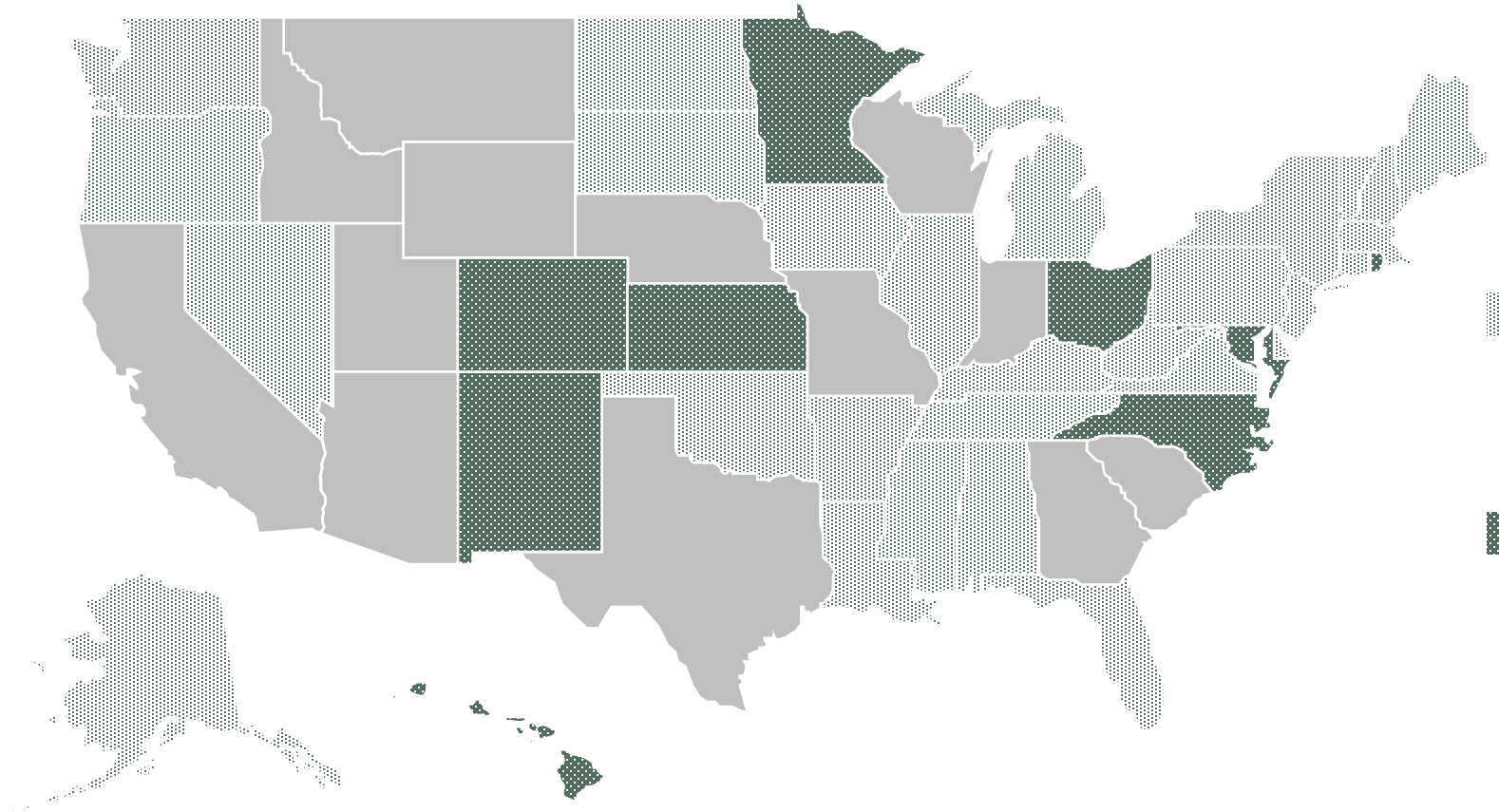
Under the Affordable Care Act, health insurers are required to file their proposed rates (premiums) for individual and small-group health plans with state regulators every year.

Rate review gives state regulators the opportunity to review and disapprove or modify proposed health insurance rate increases to protect consumers.

Strategies

- Expand rate review to large group plans.
- Explicitly consider affordability in assessment of premium rate increases.
- Require health plans adopt strategies to improve affordability or contain costs.

Who is working on this?



Rate review with prior approval authority for both small group and individual group rates

Rate review with prior approval authority over small, individual AND large group rates

Authority to consider affordability in rate review / Affordability Standards RI, DE, VT, CO

https://georgetown.app.box.com/v/looking-under-the-hood

Reduce Administrative Waste

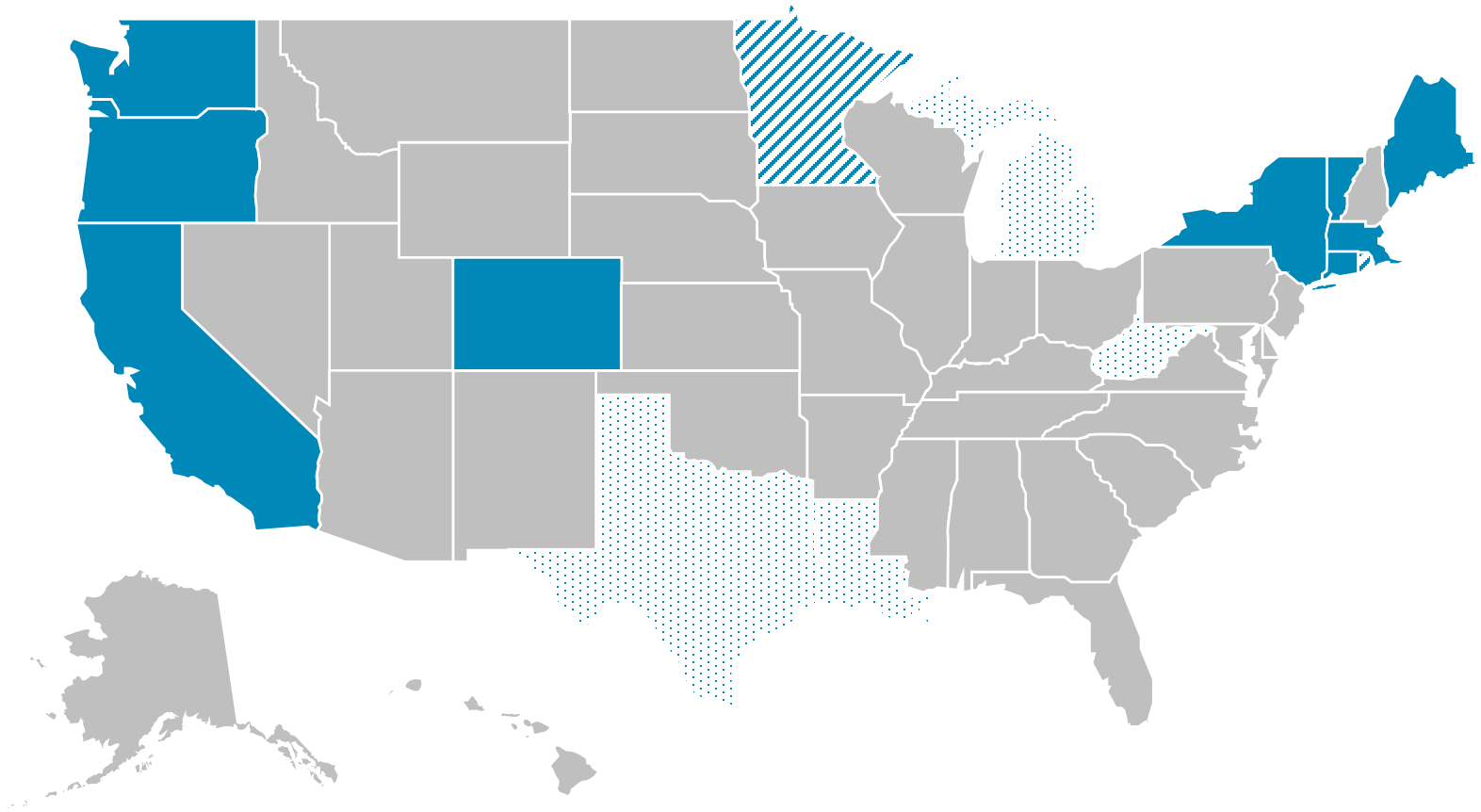
What is administrative waste?

In the US, administrative costs are estimated to comprise up to 1/3 of total health care costs, especially billing and insurance-related costs like eligibility determination, prior authorization, quality measurement, and claims management.

Strategies

- Simplifying and standardizing insurance choices
- Aligning quality metrics
- Reforming the prior authorization process
- Amending Medical Loss Ratio (MLR) requirements to further limit the percentage of spending on admin expenses
- Other (e.g. standardizing billing forms and processes)

Who is working on this?



Simplifying insurance choices
CA, CO, CT, ME, MA, NY, VT, OR, WA

Aligning quality metrics
CT, ME, MA, MN, OR, RI, VT, WA

Reforming prior authorizations
TX, VT, LA, MI, WV

Increasing MLR requirements
MA, WA

Offer a Public Option

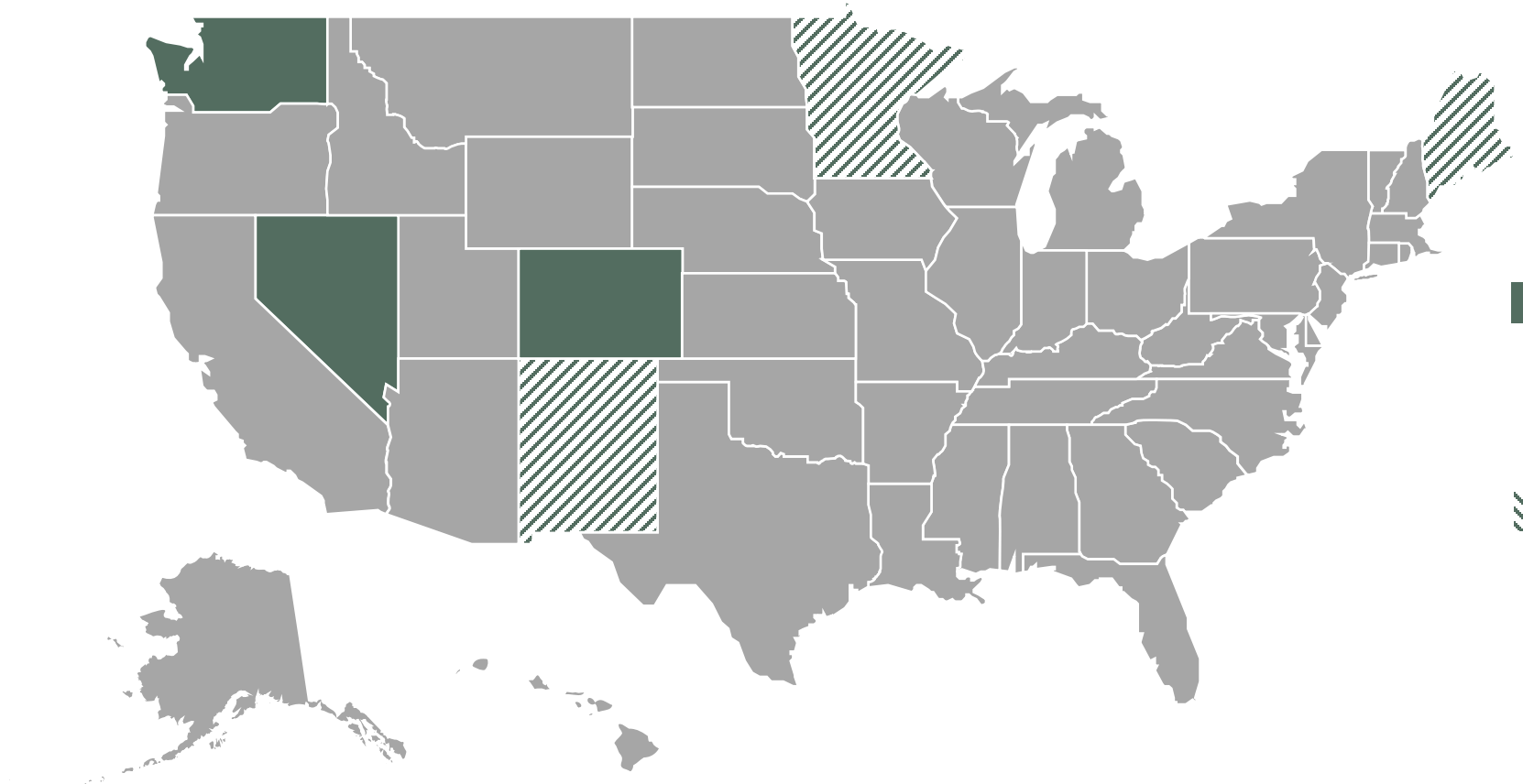
What is a public option?

“Public option” is an insurance product that provides an alterative to traditional commercial coverage for individuals and small businesses, usually offered by private insurers with requirements set by government

Public option plans can:

- Increase competition and plan choice for consumers
- Expand access to coverage for underserved populations
- Help contain health care costs by putting downward pressure on health care prices and administrative costs

Who is working on this?



Public option plan implemented
WA, NV, CO

New legislation with intent to pursue public option
ME, MN, NM

Increase Investment in Primary Care and Behavioral Health

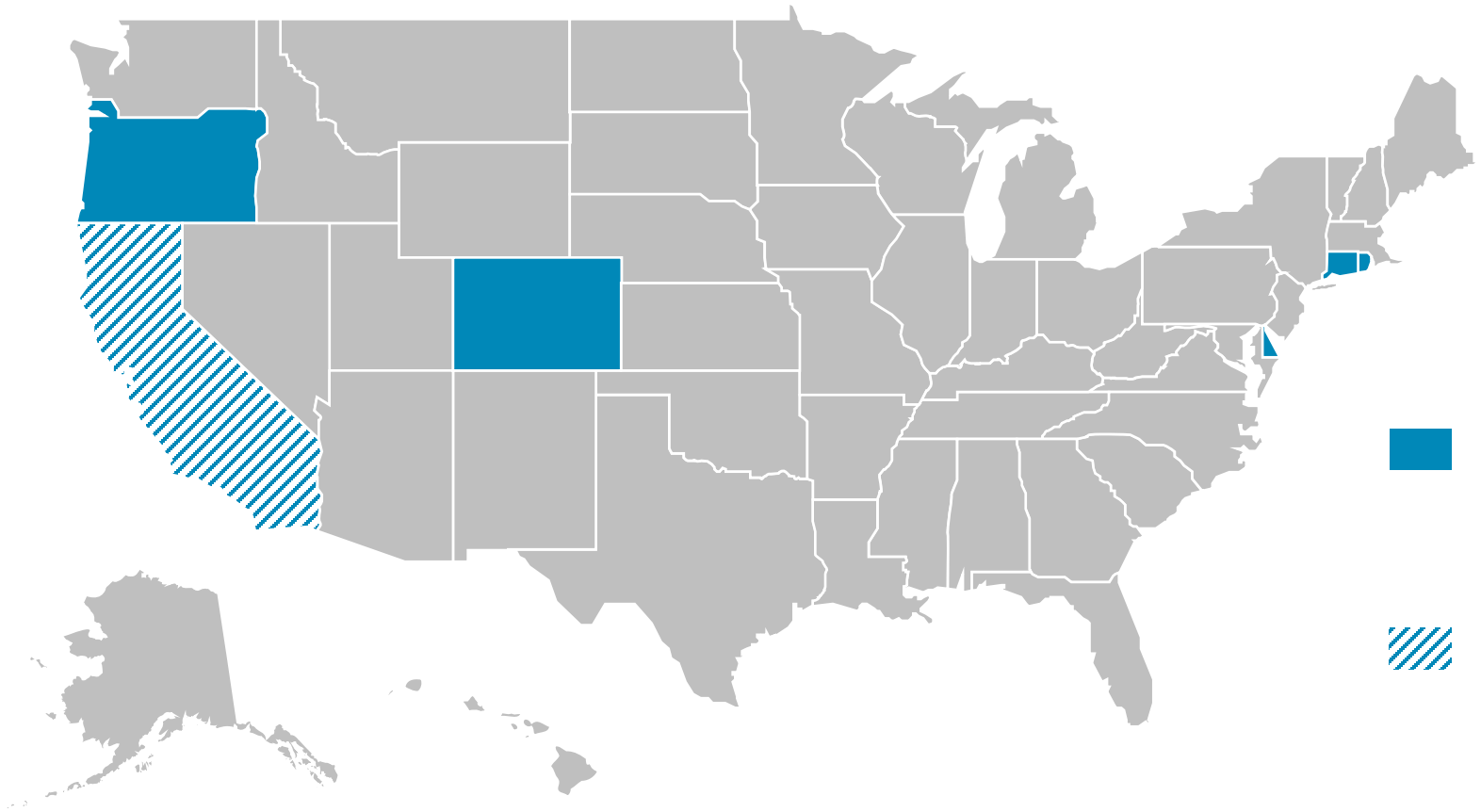
Why increase investment in PC and BH?

Primary care and behavioral health including vital services that can meaningfully shape patient outcomes, improve population health, and potentially decrease avoidable health care costs in the long-term.

Strategies

- Voluntary or regulatory targets for increasing primary care and/or behavioral health spending

Who is working on this?



Primary care spending target
CO, CT, DE, OR, RI

Behavioral health spending target
CA, RI

Questions?

Case Studies:
Connecticut and Rhode Island

Connecticut

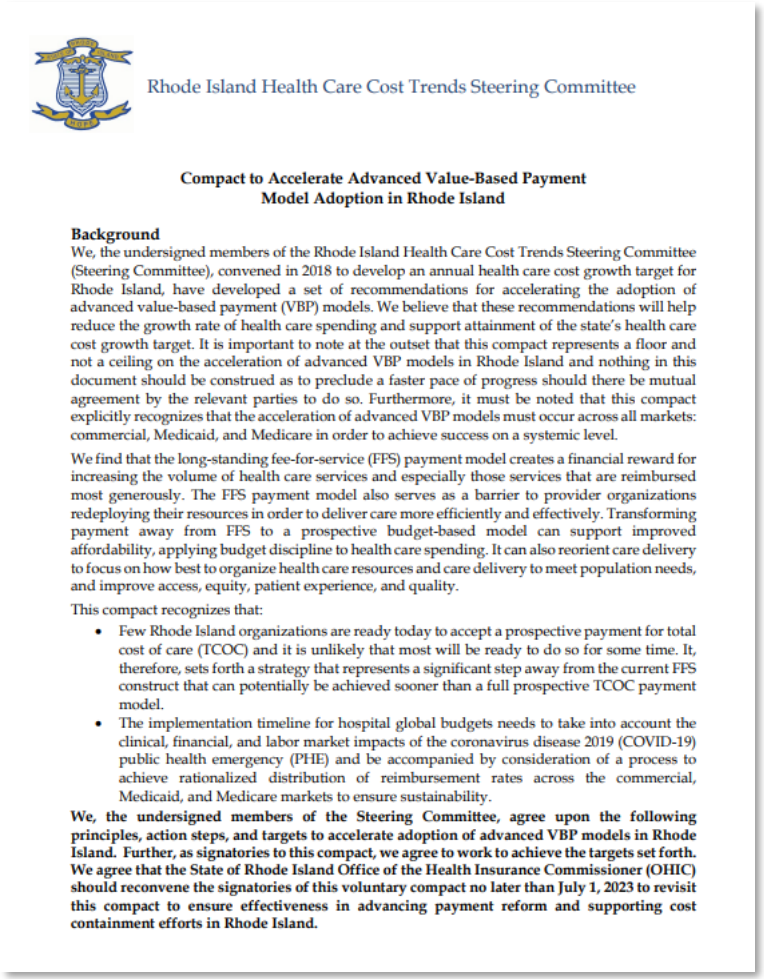
- CT's advisory committee reviewed the factors driving spending growth in the state and identified **pharmacy** as a top priority to address in 2022.

- A stakeholder-led work group reviewed a wide range of strategies to address pharmacy price growth and recommended a subset of them to the advisory body, which, in turn, recommended them to the State.

- Governor Lamont adopted some of the legislative recommendations and made them part of his 2023 legislative proposal.

Rhode Island

- RI's advisory committee agreed that expanded adoption of value-based payment should be a primary strategy to slow spending growth and thereby improve affordability.
- A subcommittee met for several months and in April 2022 signed a VBP compact committing the signatories to a range of actions, including development of a **hospital global budget** payment model.
- A hospital global budget work group met during 2022 and 2023 before settling on the parameters of a hospital global budget design. This design set the stage for RI to apply for Cohort 3 of CMMI's new AHEAD model in 2024.



Rhode Island Health Care Cost Trends Steering Committee

Compact to Accelerate Advanced Value-Based Payment Model Adoption in Rhode Island

Background

We, the undersigned members of the Rhode Island Health Care Cost Trends Steering Committee (Steering Committee), convened in 2018 to develop an annual health care cost growth target for Rhode Island, have developed a set of recommendations for accelerating the adoption of advanced value-based payment (VBP) models. We believe that these recommendations will help reduce the growth rate of health care spending and support attainment of the state's health care cost growth target. It is important to note at the outset that this compact represents a floor and not a ceiling on the acceleration of advanced VBP models in Rhode Island and nothing in this document should be construed as to preclude a faster pace of progress should there be mutual agreement by the relevant parties to do so. Furthermore, it must be noted that this compact explicitly recognizes that the acceleration of advanced VBP models must occur across all markets: commercial, Medicaid, and Medicare in order to achieve success on a systemic level.

We find that the long-standing fee-for-service (FFS) payment model creates a financial reward for increasing the volume of health care services and especially those services that are reimbursed most generously. The FFS payment model also serves as a barrier to provider organizations redeploying their resources in order to deliver care more efficiently and effectively. Transforming payment away from FFS to a prospective budget-based model can support improved affordability, applying budget discipline to health care spending. It can also reorient care delivery to focus on how best to organize health care resources and care delivery to meet population needs, and improve access, equity, patient experience, and quality.

This compact recognizes that:

- Few Rhode Island organizations are ready today to accept a prospective payment for total cost of care (TCOC) and it is unlikely that most will be ready to do so for some time. It, therefore, sets forth a strategy that represents a significant step away from the current FFS construct that can potentially be achieved sooner than a full prospective TCOC payment model.
- The implementation timeline for hospital global budgets needs to take into account the clinical, financial, and labor market impacts of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) and be accompanied by consideration of a process to achieve rationalized distribution of reimbursement rates across the commercial, Medicaid, and Medicare markets to ensure sustainability.

We, the undersigned members of the Steering Committee, agree upon the following principles, action steps, and targets to accelerate adoption of advanced VBP models in Rhode Island. Further, as signatories to this compact, we agree to work to achieve the targets set forth. We agree that the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) should reconvene the signatories of this voluntary compact no later than July 1, 2023 to revisit this compact to ensure effectiveness in advancing payment reform and supporting cost containment efforts in Rhode Island.

https://ohic.ri.gov/policy-reform/health-spending-accountability-and-transparency-program

Wrap Up

Thank you!