

# **Sustainable Health Care Cost Growth Target**

Implementation Committee Status Report to  
the Oregon Legislature

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Senate Bill 889 (2019)

September 30, 2020



# Executive Summary

## The Sustainable Health Care Cost Growth Target Program

### About the Program

In 2019, the Oregon Legislature passed Senate Bill 889, establishing the Sustainable Health Care Cost Growth Target Program, and convening an Implementation Committee under the direction of the Oregon Health Policy Board. The Committee is charged with designing the implementation plan for the Program and was directed to report its recommendations to the Oregon Health Policy Board and the Legislature no later than September 15, 2020. However, the Committee paused its work for several months during the COVID-19 public health emergency and is now slated to finish its recommendations by the end of 2020.

This report provides an overview of Implementation Committee progress. Final recommendations will be submitted to the Legislature in January 2021.

### How Cost Growth Targets Work

The cost of health care in Oregon is projected to continue growing faster than both the state's economy and Oregonians' wages. When the cost of health care grows faster than the economy and wages, it means that Oregonians are left paying a larger percentage of their income on health care. Rising health care costs also mean less money for investments in wages, retirement, and critical public services.

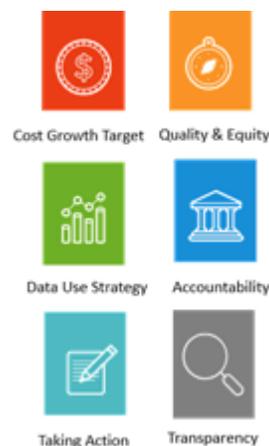
The health care cost growth target is intended to serve as a budget target for the annual per capita rate of growth of total health care spending in the state. Health insurance companies' and health care providers' health care spending will be compared to the cost growth target each year, and the Program will report on cost increase and drivers of health care costs annually. The cost growth target will bring everyone to the table to work towards a common goal of holding health care costs down.

### Committee Recommendations

The Implementation Committee has organized its implementation planning across six workstreams (see graphic). A description of the workstreams and recommendations to-date are summarized below; these recommendations may be modified or expanded before final recommendations are submitted in January 2021.

The Committee will address remaining topics (see below) in its October – December 2020 meetings.

### Committee Workstreams



## **COST GROWTH TARGET**

This workstream contains activities related to the development of a cost growth target and establishing an implementation timeline.

- The annual per capita health care cost growth target should be 3.4% for 2021-2025 and then 3.0% for 2026-2030.
- In 2024, a to-be-determined advisory body should review economic indicators and health system performance against the cost growth target to determine whether the annual 2026-2030 target was set appropriately and if adjustments are needed.
- The cost growth target will be measured at four different levels: (1) statewide, (2) market (Medicaid, Medicare, Commercial), (3) by payers, and (4) by provider organization. Which payers and which provider organizations will be included in the measurement will be finalized in fall 2020.
- The first performance year of the cost growth target should measure trend between calendar years 2020 and 2021. OHA will collect data for 2018 and 2019 to understand what health care cost growth in Oregon looked like prior to COVID-19, as well as understanding the impact of COVID-19 on health care spending.

## **DATA USE STRATEGY**

This workstream includes activities related to using Oregon's All Payer All Claims (APAC) data and other data sources to understand cost and cost drivers relative to the cost growth target.

- The Implementation Committee adopted Data Use Strategy Goals and Principles to guide planned analyses, data requirements, and transparent reporting for the Program.
- Payers will submit data measuring performance relative to the cost growth target. Additional analyses to understand health system performance cost drivers, unintended consequences, and unjustified variation in cost growth will be conducted using Oregon's APAC data and other data sources.

## **TRANSPARENCY**

This workstream includes activities related to public reporting and sharing of information.

- Program information will be shared through three primary mechanisms:
  1. Development and publication of public-facing reports,
  2. Publication of data files, and
  3. Public hearings.

- Public hearings will be held annually, after the publication of the annual health care cost trend report, to discuss performance and strategies to improve performance. Smaller stakeholder convenings could occur during the year to address specific strategies.

## **TAKING ACTION**

This workstream includes activities related to strategies required to lower the growth in health care costs by payers, providers, and the state. This includes identifying opportunities for lowering costs, improving the quality of care, and improving the efficiency of the health care system by using innovative payment models, and determining the technical assistance and support necessary to help payers and providers achieve the cost growth target.

- The Implementation Committee is currently reviewing draft principles for accelerating the adoption of advanced value-based payment models across the state.

## **Remaining Decisions**

The Implementation Committee will address the Quality & Equity and Accountability workstreams in their meetings before the end of the year.

Remaining topics for Quality & Equity include: principles for measuring the quality of care and how to address equity and cost containment. Remaining topics for Accountability includes: future governance for the Program, accountability and enforcement mechanisms, and supports payers and providers need to meet the cost growth target.

## **For More Information**

Please contact [HealthCare.CostTarget@dhsosha.state.or.us](mailto:HealthCare.CostTarget@dhsosha.state.or.us)

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## Acknowledgements

Staff at the Oregon Health Authority prepared this publication on behalf of the Implementation Committee.

Please cite this report as follows:

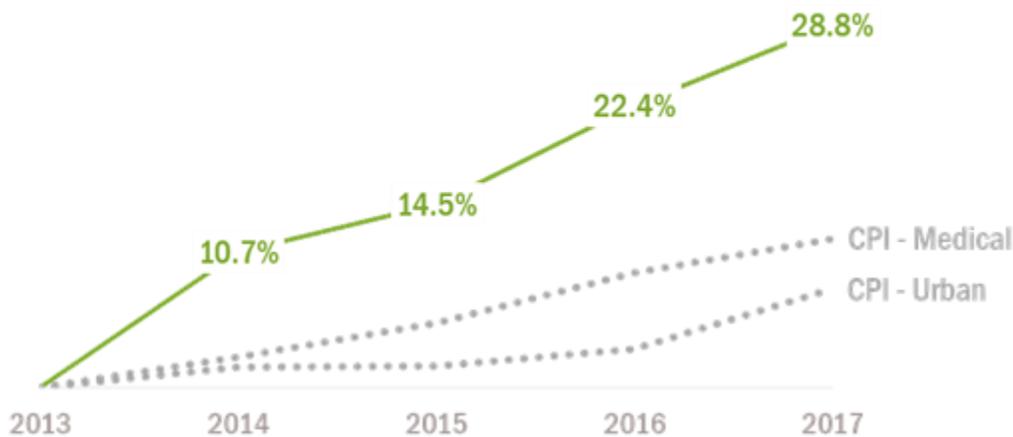
Oregon Health Authority. SB 889 (2019). Sustainable Health Care Cost Growth Target Implementation Committee Status Report to the Legislature. Salem, OR. September 2020.

# Introduction

## Health Care Costs in Oregon

The cost of health care in Oregon is projected to continue growing faster than both the state's economy and Oregonians' wages. When the cost of health care grows faster than the economy and wages, it means that Oregonians are left paying a larger percentage of their income on health care. Rising health care costs also mean less money for investments in wages, retirement, and critical public services.

**Total paid amounts per person in Oregon increased 6.5 percent per year on average from 2013-2017.**



Data sources: Oregon's All Payer All Claims database. Includes only claims-based payments for all lines of business. Non-claims payments such as value-based payments or alternative payment methodologies are not included. Carriers' profit margin and administrative overhead not included. Compared to Consumer Price Index (CPI) for All Urban Consumers and Medical Care, U.S. Bureau of Labor Statistics.

There are many factors that affect health care costs, but the Centers for Medicaid and Medicare Services attribute 50% of projected spending growth to a rise in prices; 33% of projected spending growth is due to use and intensity of services, and only 17% is due to demographics.<sup>1</sup>

A 2018 study comparing Oregon to four other states (Maryland, Minnesota, Colorado and Utah) found that Oregon has higher prices and lower utilization.<sup>2</sup> More recent research from the Health Care Cost Institute found that Oregon's average Commercial service prices are almost 170% of Medicare prices (third highest in the country).<sup>3</sup>

<sup>1</sup> Sisko et al, "National Health Expenditure Projections, 2018-2027: Economic and Demographic Trends Drive Spending and Enrollment Growth." *Health Affairs*, 2019.

<sup>2</sup> Healthcare Affordability; Untangling Cost Drivers, Network for Regional Healthcare Improvement, 2018.

<sup>3</sup> Comparing Commercial and Medicare Professional Service Prices, Health Care Cost Institute, 2020.

## Why did Oregon pursue a cost growth target approach?

The idea for a health care cost growth target in Oregon came from Senate Bill 419 (2017) – the Joint Interim Task Force on Health Care Cost Review. The 419 Task Force was convened to study the feasibility of creating a hospital rate-setting process in Oregon modeled on the process used in Maryland. After studying Maryland as well as payment reform models in Massachusetts, Pennsylvania, and Vermont, the Task Force recommended moving forward with a health care cost growth target program similar to Massachusetts’ cost containment approach.<sup>4</sup>



To respond to Oregon’s health care cost challenges, we are recommending a new approach to achieving a sustainable health care system. This is an Oregon solution, a plan to control total health care expenditures across – *all payers and providers* – by establishing a health care spending benchmark: a statewide target for the annual rate of growth of total health care expenditures.

This solution supports accountability for total costs of care applied to all payers, public and private, and builds on Oregon’s existing health care reform efforts around cost containment and payment reform. A foundational underpinning for these efforts is ensuring the long-term affordability and financial sustainability of Oregon’s health care system, for patients and providers.”

Health care cost growth targets are intended to serve as a budget target for the annual per capita rate of growth of total health care spending in the state. A health care cost growth target brings payers and providers to the table to work towards a common goal of holding health care costs down. Taking a total cost of care approach allows payers and providers to shift from volume to value-based approaches, rather than focusing on just one aspect of health care spending such as high prices.

Health care cost growth targets are intended to ensure that health care costs do not outpace other economic growth, such as general inflation or wages, and health care cost growth target programs create transparency by studying and publishing the reasons for cost growth. Health insurance companies’ and health care providers’ health care spending will be compared to the cost growth target each year, and the health care cost growth target program will report on cost increase and drivers of health care costs annually.

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<sup>4</sup> Senate Bill 419 Joint Interim Task Force on Health Care Cost Review Report to the Oregon Legislature, September 2018. <https://olis.leg.state.or.us/liz/201711/Downloads/CommitteeMeetingDocument/150143>

## Establishing Legislation

Senate Bill 889 passed in the 2019 legislative session with broad bipartisan support, building on the 419 Task Force recommendations to establish the health care cost growth target program and a Committee appointed by the Governor to design an implementation plan for the cost growth target program.<sup>5</sup>

The health care cost growth target program will expand the existing per capita cost growth target programs already in place for the Oregon Health Plan and public employee health insurance programs statewide, holding the entire health care system accountable for sustainable cost growth.

## Governor's Directive

In her October 2019 letter to the Oregon Health Policy Board appointing members of the Implementation Committee<sup>6</sup>, Governor Brown further directed the Committee to ensure:

- A target rate of growth is selected that provides an aggressive restraint to cost growth so that health care costs grow at a sustainable rate for families and businesses in Oregon.
- Transparency of cost drivers is prioritized, and the program provides meaningful information – utilizing Oregon's All Payer All Claims (APAC) database and other data sources – to identify and report publicly on areas of high cost, cost growth drivers, and variation in price and utilization.
- The program provides information on cost drivers and savings opportunities to other programs within the Oregon Health Authority and the Department of Consumer and Business Services to support respective roles in setting, negotiating, or approving affordable health plan rates.
- Health care quality is a key component of the program, with a focus on inequities and reducing disparities in health care.
- Robust enforcement and accountability tools are recommended to hold health insurance carriers and providers accountable for meeting the target, including presenting a legislative concept for the 2021 Legislative Session for authority needed to implement the recommendations.

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<sup>5</sup> Senate Bill 889, Enrolled. <https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB889/Enrolled>

<sup>6</sup> <https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Governor-Appontment-Letter-10-18-2019.pdf>

## Implementation Committee

The Implementation Committee was first convened in November 2019 to review their charge and begin the work. The Committee adopted a charter in December, including the following guiding principles.<sup>7</sup>

### The Committee's recommendations will:

- Support the establishment of a cost growth target by January 1, 2021
- To the extent practical, be inclusive of all populations and all categories of spending
- Recommend a stable target upon which payers, providers, and policymakers can rely for several years at a time
- Develop target and reporting methods that are statistically robust
- Be sensitive to the impact that high health care spending growth has on Oregonians
- Align recommendations with other state health reform initiatives to lower the rate of growth of health care costs
- Promote collaboration across payers and providers, and encourage collective action to meet the cost growth target
- Be mindful of state financial and staff resources required to implement recommendations, and
- Focus on the charges delegated to the Committee by SB 889 and the Governor and avoid topics and recommendations that are beyond the Committee's assignment.

The Implementation Committee agreed to address all aspects of their charge from SB 889 and the Governor's Directive by organizing their specific tasks into several areas of activity (see description of each Workstream on the next page) and by learning from other states' cost growth target programs where applicable. The Committee also committed to a robust stakeholder engagement process.

The Committee is supported by agency staff, with subject matter expertise provided by Bailit Health.<sup>8</sup>

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<sup>7</sup> Implementation Committee Charter, adopted December 2019.

<https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Approved%20Implementation%20Committee%20Charter.pdf>

<sup>8</sup> <http://www.bailit-health.com/>

## Implementation Committee Workstreams



### **Cost Growth Target**

Activities related to the development of a cost growth target, including the methodology to establish the cost growth target, selecting the target values, identifying the data that payers and providers shall report to the program and which payers and providers are required to report, and establishing an implementation timeline.



### **Quality & Equity**

Activities focused on the measurement of quality of care, in alignment with the Health Plan Quality Metrics Committee approaches, with a strong focus on inequities and disparities in health care.



### **Data Use Strategy**

Activities related to using Oregon's All Payer All Claims (APAC) data and other data sources to understand cost and cost drivers relative to the cost growth target, including a system to identify unjustified variations in prices or in health care cost growth, and the factors that contribute to unjustified variation.



### **Taking Action**

Activities related to strategies required to lower the growth in health care costs by payers, providers, and the state. This includes identifying opportunities for lowering costs, improving the quality of care, and improving the efficiency of the health care system by using innovative payment models, and determining the technical assistance and support necessary to help payers and providers achieve the cost growth target.



### **Accountability**

Activities including recommending accountability and enforcement processes, as well as future governance for the program.



### **Transparency**

Activities related to public reporting and sharing of information for each of the above areas.

## Implementation Committee Members

Committee Member	Title and Organization
Jack Friedman, Chair	Former Chief Executive Officer, Providence Health Plan
Kevin Ewanchyna, Vice-Chair	Vice President and Chief Medical Officer and President, Samaritan Health Services and Oregon Medical Association
Patrick Allen	Director, Oregon Health Authority
Kraig Anderson	Senior Vice President and Chief Actuary, Moda Health
Kathryn Correia	President and Chief Executive Officer, Legacy Health
Angela Dowling	President and Chief Revenue Officer, Regence BlueCross Blue Shield of Oregon
Jessica Gomez	Chief Executive Officer, Rogue Valley Microdevices
Felisa Hagins	Political Director, SEIU Local 49
Ruby Haughton-Pitts	State Director, AARP Oregon
K. John McConnell	Director, Center for Health Systems Effectiveness, OHSU
Mark McMullen	State Economist, Oregon Office of Economic Analysis
William Olson	Chief Financial Officer, Providence Health & Services
Jordan Papé	Chief Executive Officer, The Papé Group
Ken Provencher	President and Chief Executive Officer, PacificSource
Shanon Saldivar	Co-Owner and Agent, Chamness Saldivar Agency, Vice-Chair of the Marketplace Advisory Committee
Andrew Stolfi	Director, Department of Consumer and Business Services; Insurance Commissioner
Jenny Smith <sup>9</sup>	Chief Financial Officer, Kaiser Foundation Health Plan
Jennifer Welander	Chief Financial Officer, St. Charles Health System

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<sup>9</sup> Jenny Smith left Kaiser in spring 2020 and was replaced on the Implementation Committee by William (Bill) Ely, Vice President, Actuarial Services.

# Committee Progress

This section summarizes Committee discussion and recommendations in each of the key areas they have addressed to date. Recommendations in each section are indicated by an icon.

## Cost Growth Target

### SELECTING THE COST GROWTH TARGET

In their January meeting, the Implementation Committee agreed on two criteria to help select the cost growth target:

1. The cost growth target should be a predictable target based on an economic indicator
2. The cost growth target should rely on objective data sources with transparent calculations (conducted by an entity that does not have a conflict of interest).

The Implementation Committee reviewed multiple economic indicators that the cost growth target might be based on, including forecasted and historic Gross State Product (GSP) and Potential Gross State Product (PGSP), as well as median wage and income data.<sup>10</sup>

#### Economic Indicators

		Historic (1999-2019)	Forecast (2025-2029)
Economy	GSP/PGSP	3.5% (GSP)	3.8% (PGSP)
Wage	Median	2.7% (2001-2018)	3.9%
Income	Median	3.1%	3.5%

The Committee also considered the current cost growth target for the Oregon Health Plan (Medicaid) and for public employee plans, the consumer price index (inflation), and stakeholder encouragement to set an aggressive target that will reduce the level of health care spending relative to the rest of the economy, not merely maintain spending at its current level.<sup>11</sup> The Committee also considered how many years it should set the cost growth target for and determined that establishing the target for a 10-year period would help payers and providers plan for future contracting and rate setting.



The Implementation Committee recommended that the annual per capita health care cost growth target should be 3.4% for 2021-2025, and then 3.0% for 2026-2030.

Oregon’s initial annual per capita health care cost growth target of 3.4% is similar to the initial health care cost growth targets selected by other states, including Massachusetts (3.6% for the first five years, then 3.1%), Rhode Island (3.2% for the first four years), Connecticut (3.4% in 2021, with annual reductions to 2.9% in 2023-2025), and Delaware (3.8% in the first year, with annual reductions down to 3.0% in the fourth year). For comparison, national health care

<sup>10</sup> [https://www.oregon.gov/oha/HPA/HP/HCCGBMeetingDocs/2.12.20%20Presentation%20Slides\\_updated.pdf](https://www.oregon.gov/oha/HPA/HP/HCCGBMeetingDocs/2.12.20%20Presentation%20Slides_updated.pdf)

<sup>11</sup> <https://www.oregon.gov/oha/HPA/HP/HCCGBMeetingDocs/2.12.20%20Public%20Testimony.pdf>

spending increased 4.6% between 2017 and 2018.<sup>12</sup> See the Context Setting section below for additional information on national health care spending.

### ADJUSTING THE COST GROWTH TARGET

The Implementation Committee is charged with specifying the “frequency and manner” in which the target should be reevaluated and updated and so considered the various mechanisms other state health care cost growth target programs have adopted for revisiting their targets and making any necessary modifications.

#### State mechanisms for adjusting targets

State mechanisms for adjusting targets	
Massachusetts	The Health Policy Commission can vote to modify the target in the second five years of the program; after the first 10 years, the Health Policy Commission can adjust the target to any value.
Delaware	The State Finance Committee reviews the target methodology annually and can make changes if the Potential Gross State Product (PGSP) forecast has changed in a “material way.”
Rhode Island	Only “highly significant” changes in the economy will trigger revisiting the target; this has not been defined. The Committee elected not to make any changes despite the economic impact of COVID-19.



In 2024, a to-be-determined advisory body should review 20-year historic values of Oregon’s per capita gross state product trend, median wage trend and health system performance against the target to determine whether the annual 2026-2030 target is set appropriately.<sup>13</sup>

After reviewing the data, the to-be-determined advisory body should make a recommendation to the Oregon Health Policy Board to keep the target at 3.0%, or to increase or decrease the target from 3.0% for 2026-2030.

The Committee also suggested revisiting the health care cost growth target prior to 2024 to more closely understand the impact of COVID-19 and potential implications for the Health Care Cost Growth Target Program as part of the governance conversations later this fall.

<sup>12</sup> <https://www.cms.gov/files/document/highlights.pdf>

<sup>13</sup> Trend is calculated by determining the flat average annual percent change of the nominal per capita gross state product and median wage over the last 20 years.

## DEFINING THE COST GROWTH TARGET

### Defining Total Health Care Expenditures

The intent of the health care cost growth target is to measure the annual per capita rate of growth for total health care expenditures in the state. The Implementation Committee considered what types of spending should be included in Oregon’s definition of total health care expenditures.



The Committee recommended that Total Health Care Expenditures should be defined as the “allowed amount”<sup>14</sup> of claims-based spending from an insurer to a provider, all non-claims-based spending from an insurer to a provider, pharmacy rebates, and the net cost of private health insurance (calculated as premiums minus claims).

### Whose Total Health Care Expenditures are being measured?

Given SB 889’s directive to include all payers and providers, and the Committee’s previously adopted definition for Total Health Care Expenditures to include all payments made to providers and cost sharing by Oregon residents, the Committee focused on including health care spending for all Oregonians.



Total Health Care Expenditures should be inclusive of spending on behalf of Oregon residents who are insured by Medicare, Medicaid or commercial insurance, or are self-insured for commercial coverage, and receive care from any provider in or outside of Oregon.

Spending by the Indian Health Services for Oregon residents and for Oregonians incarcerated in a state correctional facility will be included in Total Health Care Expenditures to the extent the Oregon Health Authority determines their data are accessible, comparable and collection of the data can be replicated over time.

The Oregon Health Authority estimates that over 90 percent of Oregonians are captured in the Total Health Care Expenditure calculation. The commercial population consists of all group and individual coverage, TRICARE and the Federal Employees Health Benefit Plan (FEHBP), as well as the Public Employee Benefit Plan and Oregon Educators Benefit Plan (PEBB/OEBB). Medicaid includes all of the Oregon Health Plan and Cover All Kids, through Coordinated Care Organizations (CCOs) or Fee For Service (FFS).

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<sup>14</sup> “Allowed amounts” refers to the price paid by the insurer to the provider and the patient liability owed directly to the provider, regardless of whether the patient actually paid the owed amount.

## Populations included in the Total Health Care Expenditure calculation



State corrections and Indian Health Services each represent less than 1 percent of Oregonians. The Committee also considered whether Oregon residents seeking care outside of Oregon and out-of-state residents seeking care inside of Oregon should be included in the calculation.



Out-of-state residents who receive care from Oregon providers may be included should the data be reportable, consistent across insurers, and replicable over time. This will be determined in the final technical measurement specifications.

### APPLYING THE COST GROWTH TARGET

Oregon's health care cost growth target is calculated and applied at four different levels:

1. Statewide
2. Market Level (Medicare, Medicaid, Commercial)
3. Payer Level (Medicare Fee-For-Service; Medicare Advantage; Medicaid Fee-For-Service; Medicaid Coordinated Care Organizations; and Commercial insurers, including self-insured)
4. Provider Organization level (large provider organizations reported on individually, smaller provider organizations reported on in aggregate, and spending for members who could not be attributed to specific provider organizations).

To address SB 889's directive that the cost growth target should apply to all payers and providers in the state, the Implementation Committee looked at considerations for measuring cost growth at the insurer and provider levels.

#### Cost growth at the payer level

Payers offering comprehensive medical benefit can appropriately be held to a cost growth target, but the Committee needs to determine how many members (in Oregon) a payer must have to be held accountable to the cost growth target. Member size is important to be able to detect accurate and reliable change in annual per capita total health care expenditures.

The Implementation Committee has not finished this discussion, pending the results of Oregon Health Authority and Department of Consumer and Business Services’ analysis of insurers and their covered lives in Oregon.

### Cost growth at the provider level

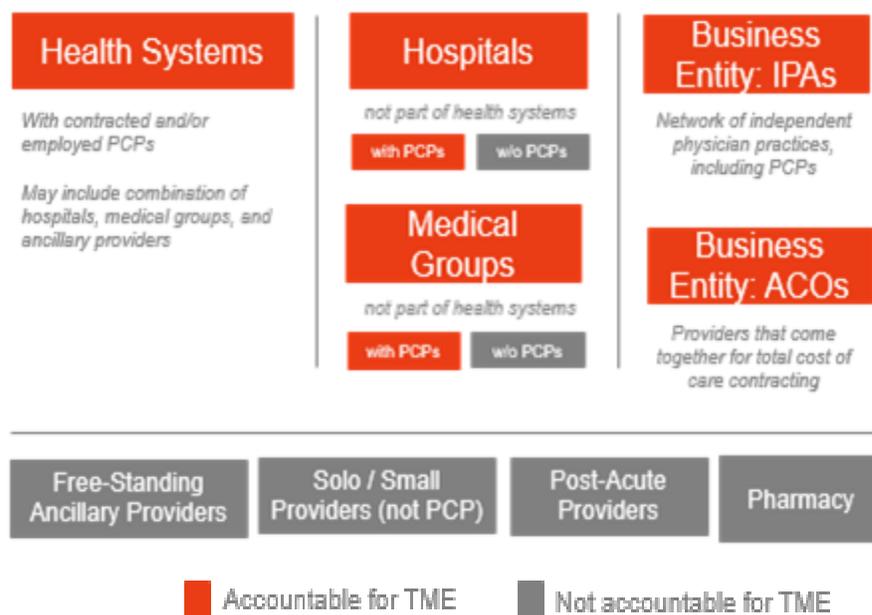
When measuring total cost of care at the provider level, not all of the elements included in the agreed upon definition for Total Health Care Expenditures (above) are appropriate. To measure provider cost growth, the Implementation Committee recommended removal of the net cost of private health insurance and pharmacy rebates to look at Total Medical Expenditures (TME).

Next, the Implementation Committee focused on defining which types of provider entities should be held responsible to the cost growth target. Not all provider entities can be held accountable for Total Medical Expenditures, as TME accountability typically applies to provider entities that could in theory take on contracts where they are responsible for the total cost of care because they:

- Include primary care providers who direct a patient’s care and/or
- Can exert some influence over where a patient receives care

The Implementation Committee considered which types of provider entities could have TME accountability using the above criteria. See chart below for a conceptual model; however, more technical definitions will need to be developed and tested as part of the baseline data collection process in 2021.

### Conceptual Map of Provider Entities



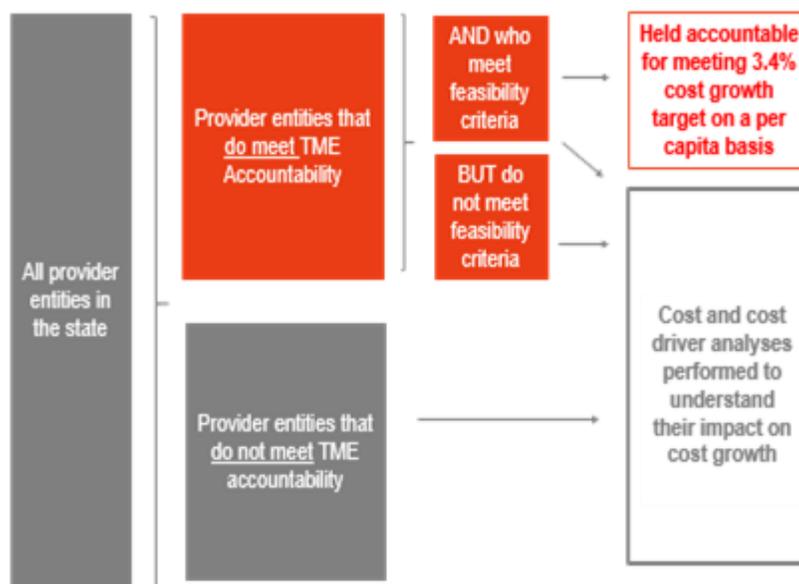
In addition to whether or not a provider entity has TME accountability, the size of the provider entity (i.e. the number of patients they have in a given year) is also an important consideration.

Provider entities must have sufficient patient volume to be able to detect accurate and reliable changes in annual per capita total medical expenditures, and to help prevent situations where smaller provider organizations may exceed the health care cost growth target due to a few unusually complex and expensive patients.

Not all provider entities that have TME accountability will be large enough to hold accountable for meeting the 3.4% cost growth target on a per capita basis (see chart).

The Committee agreed that OHA and DCBS should conduct an analysis to determine how large provider entities should be to be held accountable and will finalize this recommendation in the fall.

### Provider entities with and without TME accountability



## CALCULATING THE COST GROWTH TARGET

### Data Source



Performance relative to the cost growth target will be calculated using data supplied by payers.

Each year, payers who meet the criteria for data submissions will submit health care cost data to OHA using the specified templates. Payers will report on provider entities who meet criteria. This data will be used to calculate performance relative to the cost growth target.

Criteria will be finalized in subsequent meetings, and templates and data submission process will be developed with a technical group later this fall / early 2021.

See Data Use Strategy section below for the types of analysis possible with this data, and other data sources that will be used to understand what is driving health care cost growth.

## Attribution

To measure Total Medical Expenditures for provider entities, Oregon residents must be attributed to a specific provider entity. The Committee considered various approaches for attribution, including whether a common attribution methodology could be adopted.



Payers will use their own attribution methods for assigning Oregon residents to a provider. Payers will need to share the attribution methodology with OHA.

OHA will assess the commonalities between attribution methodologies and consider adjusting how attribution is performed in future years.

## Risk Adjustment

A payer or provider entity's population – including its clinical risk profile – may change over the course of a year. Some of these changes will have an impact on spending growth, e.g. a population that is sicker than last year would be expected to have higher spending. Performance relative to the cost growth target needs to be risk adjusted for provider entities and for the payers, but not at the market or statewide levels, since these populations are large enough to be stable over time.

The Committee considered whether each payer should use their own methodology, or whether a common risk adjustment methodology could be adopted statewide.



In order to account for changes in population health over time, each payer will use its own risk adjustment methodology.

Payers will report to OHA on which risk adjustment methodology they used, and if they change risk adjustment methodologies, will submit the previous year's data with the new methodology to ensure accurate year-over-year comparisons.

## IMPLEMENTATION TIMELINE

The Implementation Committee agreed that it will be important to understand what health care cost growth in Oregon looked like prior to COVID-19, as well as to understand the impact of COVID-19 on health care spending.



OHA should collect data from insurers starting with calendar year 2018.

OHA will initially collect data from insurers for calendar years 2018, 2019. This will help ensure data submission templates and validation processes are worked out, and provide context leading into the first performance year of the cost growth target. OHA will also initially collect data for calendar year 2020; this will allow Oregon to be able to report pre, during, and post

pandemic health care spending and cost growth.



The first performance year of the cost growth target should measure trend between calendar years 2020 and 2021.

Performance against the cost growth target for 2020 and 2021 (at minimum) should be reported with enough context for the public to understand the effect the pandemic had on spending.

See discussion at the end of this report (The Potential Impact of COVID-19 on Health Care Costs) for additional considerations.

**Timeline**

Calendar Year	What	Proposed Reporting
2018	Practice year, test data submission and validation processes	State and market only
2019		
2020	Practice year, first look at impact of COVID-19	State and market only
2021	First performance year	State, market, insurer, provider entity, regional
2022	Second performance year	
2023...	Third performance year...	

## Data Use Strategy

The Data Use Strategy is a planned approach for understanding the impact of the health care cost growth target and the factors contributing to health care cost and cost growth in Oregon. The Data Use Strategy guides the planned analyses, data requirements, and commitment to transparency for the Health Care Cost Growth Target Program.

The Implementation Committee's conversations included all of the following:

- Identifying unjustified variation in prices, cost, cost growth, and contributing factors
- Identifying what types of data OHA should collect and annually report on relative to the Cost Growth Target Program, including types of analyses and key audiences.
- Informing recommendations for public reporting and public hearings (see Transparency section below)

### USE STRATEGY GOALS & PRINCIPLES

To guide these conversations, the Committee first adopted the following Data Use Strategy Goals and Principles.

#### Principles



1. OHA (in collaboration with DCBS) should assume responsibility for the design, production and public distribution of routine, all-payer statistical analyses that:
  - Assess cost growth attainment;
  - Examine health care cost and cost growth drivers;
  - Provide access and quality measure analysis for the purposes of assessment of, including, but not limited to the possible adverse impacts of cost-focused actions, including on health disparities; and
  - Provide information on cost drivers and savings opportunities to other programs within OHA and DCBS and to other health care purchasers to support their respective roles in setting, negotiating, or approving affordable health plan rates.
2. OHA should involve external stakeholders in the design of analyses.
3. The methodologies employed in OHA statistical analyses should be fully transparent.

4. OHA analyses of health care cost and cost growth drivers should identify:
  - Payers and large providers, when it is statistically valid to do so, and
  - Opportunities for improved cost management
  
5. OHA should continue to support using APAC data for:
  - Research and evaluation activities, and
  - Provider, consumer and employer purchaser efforts to improve health care access, equity, quality or cost management

including for increased publication of APAC data and making APAC data available at a reasonable cost, within constraints of state and federal laws and regulations.
  
6. OHA should employ a data strategy framework that supports multi-sector collaboration to help achieve the cost growth target.

## Goals



- Ensure timely and accurate measurement of performance relative to the cost growth target at the state, insurance market, insurer/CCO, and large provider levels
- Produce routine analyses that pinpoint leading opportunities to reduce health care spending by the state, payers, purchasers, and Oregonians in a manner that will not harm patients
- Interpret health care spending analyses and link findings with recommended actions for the State, policymakers, insurers/CCOs, providers and employer purchasers.
- Produce routine public reporting and communication products to share progress, challenges, and opportunities with consumers.

## DATA SOURCES

The Health Care Cost Growth Target Program will use multiple data sources.

Data Source	Purpose
Data submitted by payers	Measuring performance relative to the cost growth target
Data from Oregon's All Payer All Claims (APAC) database and other sources	Measuring health care system performance, including understanding cost drivers, looking at unjustified variation, and monitoring for unintended consequences of the target.

# Transparency

Transparency is a key component of Oregon’s Health Care Cost Growth Target Program and it cuts across all of the Implementation Committee’s focus areas. Transparency will help us understand cost drivers and opportunities for lowering costs.

Committee discussion and recommendations to date have focused on transparency of performance relative to the cost growth target and data use strategy analyses.

The Committee will continue to discuss transparency as it relates to quality, equity, accountability, and governance in upcoming meetings.

## Transparency Mechanisms



The Implementation Committee agreed on three primary mechanisms for sharing information from the Cost Growth Target Program: development and publication of reports, publication of data files, and public hearings.

## PUBLIC REPORTING

The primary mechanisms for transparency will be the development of public facing reports that will be used to inform all audiences, consistent with the goals of the Data Use Strategy.

- Reports will meet all state and federal data privacy laws.
- Reports may be static or interactive, and may involve supplemental material
- Reports will likely evolve over time (new analyses, ad hoc topics, etc.)
- Reports will be published on OHA’s website.

## Annual health care cost trend report

The annual health care cost trend report should include both performance relative to the cost growth target and information about health care system performance. The tables below describe potential analyses that can be included in the annual report.

### *Performance relative to the cost growth target*

<b>Description</b>	Annual per capita growth rate for Oregon’s total health care spending, expressed as the percentage growth from the prior year’s per capita spending
<b>Analyses</b>	<ul style="list-style-type: none"><li>• Success in achieving the health care cost growth target*</li><li>• Per capita growth over time*</li><li>• Per capita growth over time as compared to growth in selected comparison states</li><li>• Per capita growth over time compared to other economic indicators</li></ul>

\*required per SB 889

*Health care system performance: underlying cost trends*

<b>Description</b>	Analyses of cost drivers <i>and</i> cost growth drivers, highlighting where targeted stakeholder action is needed to restrain cost growth.
<b>Analyses</b>	<ul style="list-style-type: none"> <li>• Geographic, demographic and/or condition-specific variation</li> <li>• Utilization</li> <li>• Service intensity</li> <li>• Price variation</li> <li>• Low-value care</li> <li>• Potentially preventable services</li> </ul>

*Health care system performance: impact of the cost growth target*

<b>Description</b>	Analyses targeting the impact of the cost growth target, including, but not limited to, understanding any unintended adverse consequences.
<b>Analyses</b>	<ul style="list-style-type: none"> <li>• Premium growth</li> <li>• Benefit levels</li> <li>• Consumer out-of-pocket spending</li> <li>• Quality of care (process, outcome, patient experience)</li> <li>• Access to care</li> <li>• Health care disparity and health care inequity</li> <li>• Employer spending</li> <li>• Clinician satisfaction</li> <li>• Workforce impacts</li> <li>• Consolidation impacts</li> </ul>

It will take time to develop all of these analyses and incorporate them into the annual health care cost trend public report. The Implementation Committee agreed to phase in public reporting:

	<b>First Public Report</b>	<b>Impact of COVID-19 Report</b>	<b>First Performance Report</b>
<b>Release Date (est.)</b>	2021	2021	2022
<b>Years</b>	2018-2019	2018-2020	2018-2021

	First Public Report	Impact of COVID-19 Report	First Performance Report
<b>Performance relative to the cost growth target</b>	<i>Change 2018-2019</i> <ul style="list-style-type: none"> <li>• State level</li> <li>• Market level</li> </ul>	<i>Change 2019-2020</i> <ul style="list-style-type: none"> <li>• State level</li> <li>• Market level</li> </ul>	Change 2020-2021 <ul style="list-style-type: none"> <li>• State level</li> <li>• Market level</li> <li>• Insurer level</li> <li>• Provider level</li> </ul>
<b>Underlying cost trends</b>	Initial look at cost drivers	Impact of COVID-19 on cost drivers	Deeper look at cost drivers and price variation
<b>Impact of the cost growth target</b>	Baseline analysis of premiums, quality, access, and consumer spending	Impact of COVID-19 on premiums, access, quality, and consumer spending	Deeper look at impacts and adverse consequences

**Audiences for Public Reporting**

 Publicly reported data analysis should be performed for providers, payers, purchasers, policy makers, public health and the general public, with a particular interest on actionable information for providers.

Implementation Committee members have also noted the importance of ensuring cultural and regional sensitivity when reporting out on this work to the public.

**Publication of Data Files**

Data files can be made available for researchers and other interested parties to perform their own analysis. This could be as simple as posting Excel files with the summary data used to develop publicly reported analyses on OHA’s website, consistent with how OHA currently publishes Hospital Payment Report data.

Any data files posted will meet all applicable privacy laws. This is in addition to the existing public release and data request processes for APAC data.

## PUBLIC HEARINGS

The purpose of public hearings is to report out on performance relative to the cost growth target and to foster open dialogue around challenges and opportunities for improving care and reducing costs.

### Frequency



The Implementation Committee recommends holding annual public meetings, after the publication of the annual health care cost trend report, to discuss performance against the cost growth target and strategies to improve performance.

Smaller stakeholder convenings could occur during the year to address specific strategies.

### Format

The Implementation Committee reviewed the format and content used in Massachusetts' public hearings, including request for pre-filed testimony from payers and providers; a report on performance against the cost growth target; testimony from executive and/or legislative branches; testimony from a cross-section of the health care market on challenges and opportunities for improving care and reducing costs; and public comment.



The Implementation Committee recommends including the elements used by Massachusetts in their public hearings, in a formal but collaborative approach.

Public hearings should include invited presentations from:

- Payers and providers performing at or below the target
- Payers and providers performing above the target
- Employer purchasers
- Consumer advocates
- Executive and legislative branch representatives

Public hearings should ensure participation of an appropriate cross-section of stakeholders and geographies.

Public hearings should also make space for public comment.

## Taking Action

Taking Action refers to the steps that the state, payers and providers can take to reduce cost growth and the work required to improve affordability and advance equity, as directed by SB 889 and Governor Brown. It also includes opportunities informed by the state’s experience with COVID-19.

The Committee began by considering a menu of possible pathways for Taking Action and discussing which are most important for lowering health care cost growth that can be pursued now or in the near future.

### Possible pathways for Taking Action



“All activities related to supporting payers, providers and the State in meeting the cost growth target, including technical assistance and Alternative Payment Model development”

-Senate Bill 889

1	State, payer and provider options to increase use of value-based payments (VBP)
2	State, payer and provider options to rebuild a resilient delivery system based upon COVID-19 lessons, and contribute to lower cost growth
3	State-facilitated options to assist payers/providers in meeting the cost growth target
4	Collaborative work to reduce cost growth jointly pursued by multiple private sector organizations
5	Other Implementation Committee ideas to support reduced cost growth

The Implementation Committee’s discussion focused primarily on increasing the use of value-based payments (VBP). While there was strong interest in this pathway, the Committee expressed concern that stakeholders have been talking about increasing VBP for years, without seeing much change. The Committee was clear that simply endorsing VBP would not be sufficient and explored voluntary and collaborative ways to expand VBP across all lines of business.

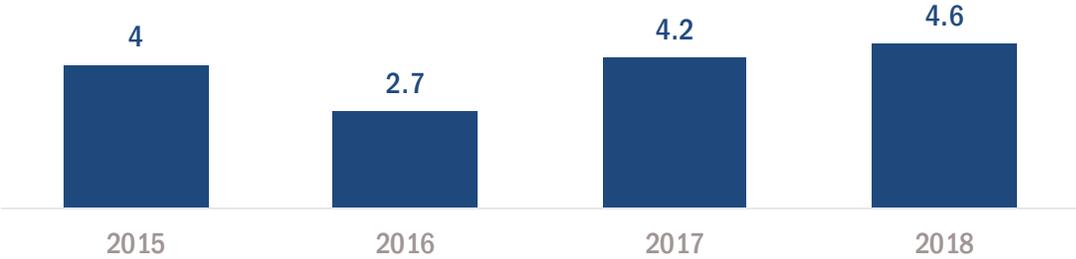
The Committee is currently reviewing draft principles for accelerating the adoption of advanced value-based payment models across the state.

# Context Setting

## National Health Expenditures

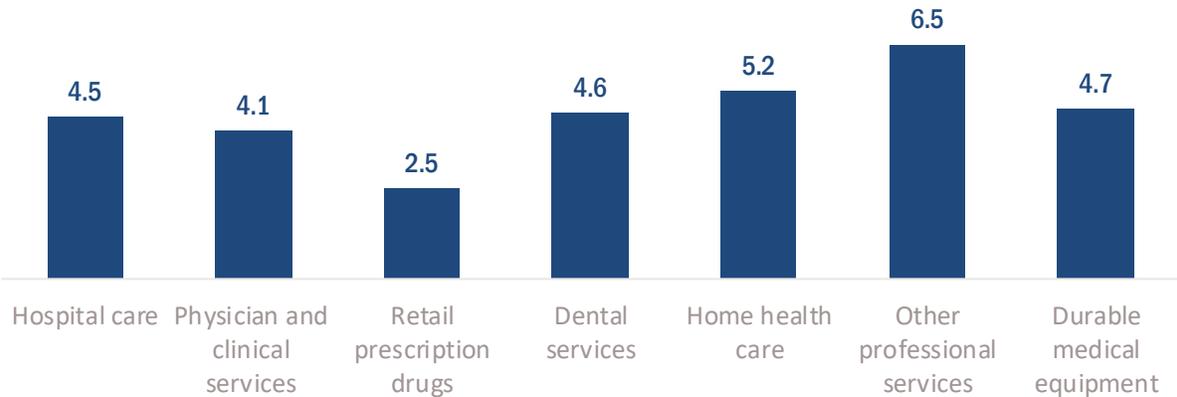
Health care spending continues to increase. The most recent national data show that US health care spending increased 4.6% in 2018.<sup>15</sup>

Annual increase in national health care spending, reported as the percent increase from the previous year



The increase in national health care spending varied by type of service, with the fastest rate of growth for Other Professional Services, a category which includes independent health practitioners (except physicians and dentists) that primarily provide services such as physical therapy, optometry, podiatry, or chiropractic medicine.<sup>16</sup>

National health care spending, percent increase between 2017 and 2018 by type of service



On a per capita basis, national health care spending has increased drastically over the last five decades, from \$1,832 in 1970 to \$11,172 in 2018, in constant 2018 dollars.<sup>17</sup>

<sup>15</sup> <https://www.cms.gov/files/document/highlights.pdf>

<sup>16</sup> *ibid*

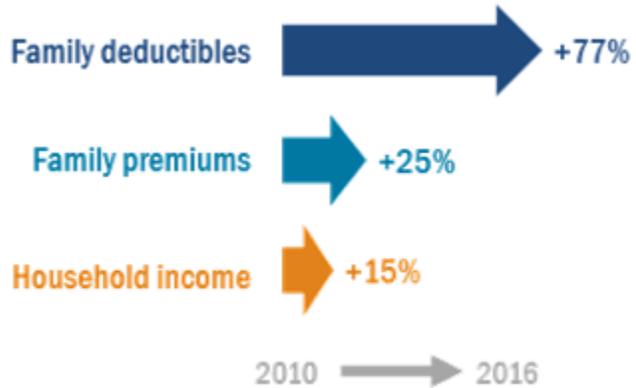
<sup>17</sup> [https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-nhe-trends\\_total-national-health-expenditures-as-a-percent-of-gross-domestic-product-1970-2018](https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-nhe-trends_total-national-health-expenditures-as-a-percent-of-gross-domestic-product-1970-2018)

## Impact of Costs on Oregon Consumers

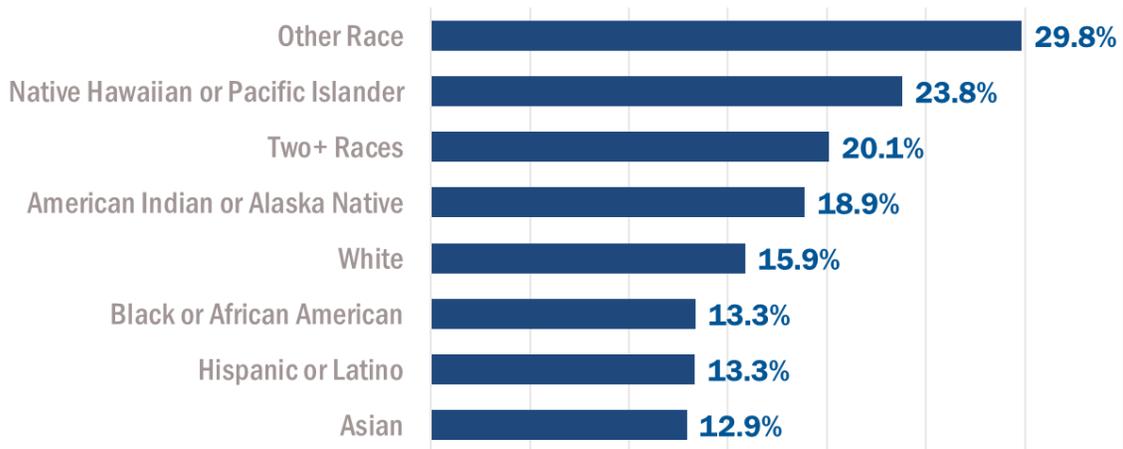
The burden of health care costs is high on Oregon families. In 2016, Oregon premiums equated almost a third of a family’s total income and deductibles and premiums grew faster than household income between 2010 and 2016 (77% and 25% growth respectively, compared to 15% growth in income).<sup>18</sup>

Communities of color are more likely to be impacted by high health care costs.<sup>19</sup>

Oregonians who report other race, two or more races, or Native Hawaiian/Pacific Islander race are more likely to have delayed any type of care in the past year because of costs.



## Percent of Oregonians who reported they delayed any type of care in the past year because of cost, by race/ethnicity

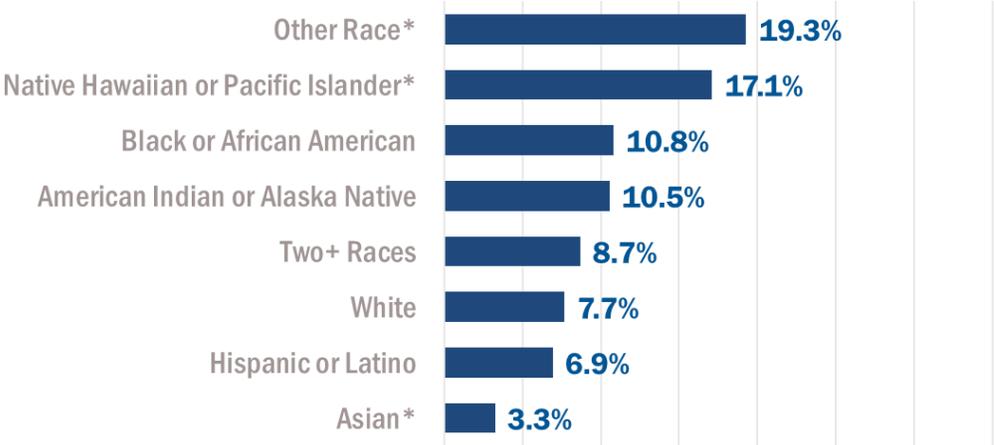


<sup>18</sup> The Burden of Health Care Costs for Working Families. April 2019. <https://ldi.upenn.edu/brief/burden-health-care-costs-working-families>

<sup>19</sup> Oregon Health Insurance Survey data, 2019

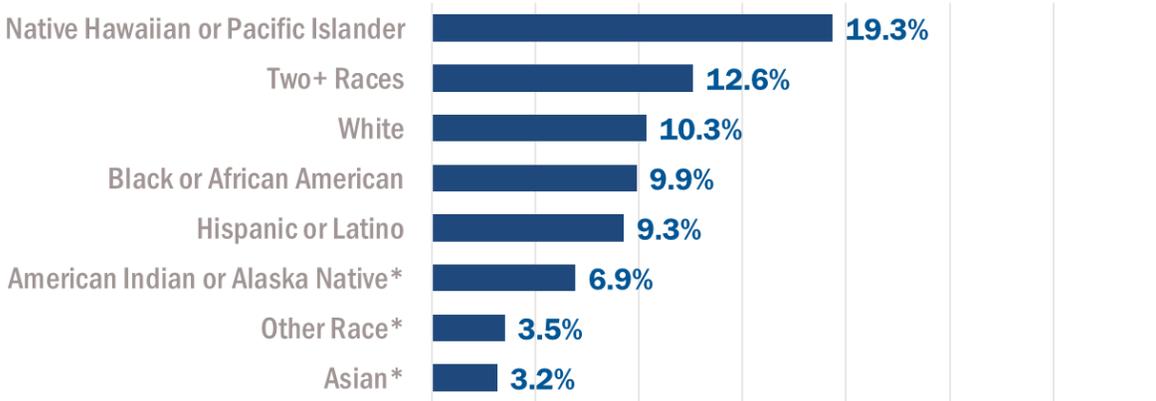
Black/African American and American Indian/Alaska Native Oregonians are more likely to report they were unable to pay medical bills in the past year, and Native Hawaiian/Pacific Islander Oregonians or Oregonians reporting two or more races are more likely to report difficulty paying medical bills over time.

### Percent of Oregonians who reported they were unable to pay medical bills *in the past year*, by race/ethnicity



\* Interpret data with caution. Sample sizes are small for this group.

### Percent of Oregonians who reported problems paying off medical bills *over time*, by race/ethnicity



\* Interpret data with caution. Sample sizes are small for this group.

# Next Steps

## Remaining Committee Meetings

Over the next three months, the Implementation Committee will finish developing their recommendations, including finalizing those for Taking Action, Quality and Equity, and addressing Governance and Accountability.

Committee meetings are scheduled for October 6, November 24, and December 16. Agendas and materials will be posted online at [www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx](http://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx).

## Final Recommendations Report

The Implementation Committee will submit their final recommendations to the Oregon Health Policy Board and the Legislature no later than January 31, 2021.

## The Potential Impact of COVID-19 on Health Care Costs

We know the COVID-19 pandemic will affect health care costs in 2020 and 2021, although we don't know how much or to what extent.

Some predict savings from fewer patient visits while others predict increase from COVID hospitalizations and costs for testing and future treatments, as well as coding changes.<sup>20</sup> Provider closures, premium rebate requirements, and the amount of pent up demand that might drive future health care spending also create uncertainty.

The Health Care Cost Growth Target Program will provide critical monitoring to help understand the impact of COVID-19 on health care costs.



*“As the coronavirus spreads rapidly across the United States, private health insurers and government health programs could potentially face higher health care costs.*

*However, the extent to which costs grow, and how the burden is distributed across payers, programs, individuals, and geography are still very much unknown.”*

– Peterson-KFF Brief (April 2020)

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<sup>20</sup> <https://www.healthaffairs.org/doi/10.1377/hblog20200518.567886/full/> and <https://www.healthsystemtracker.org/brief/how-health-costs-might-change-with-covid-19/>

# Supplemental Materials

The Implementation Committee charter and all agendas, minutes, and meeting materials are available online at: <https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx>



HEALTH POLICY AND ANALYTICS

Office of Health Policy

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