Sustainable Health Care Cost Growth Target
Health Insurer Frequently Asked Questions (FAQs)
February 14, 2020

Senate Bill 889 (2019) directs the Oregon Health Authority (OHA) to work with stakeholders and consumers to set a Sustainable Health Care Cost Growth Target that would apply to insurance companies, hospitals and health care providers, so that health care costs do not outpace wages or the state's economy. Through this program, OHA will also identify opportunities to reduce waste and inefficiency, resulting in better care at a lower cost.

The SB 889 Implementation Committee, selected by Governor Kate Brown and operating under the supervision of the Oregon Health Policy Board (OHPB), is a consumer and stakeholder-led body responsible for recommending steps to define and operationalize the cost growth target. This includes defining how to measure health care spending.

1. **What is a cost growth target?**
   The first step in containing costs is establishing an expectation and common goal that costs grow at a sustainable rate, not outpacing the economy or wages. A cost growth target, also known as a "benchmark," is a prospective target for annual per capita growth in total health care spending in a state. In each of the three states that have implemented a cost growth target, it is based on the state's potential gross state product (PGSP), which is a measure of the state's projected future economic growth.[1]

   - Massachusetts: The 2019 and 2020 benchmark is **3.1%.**
   - Delaware: The benchmark changes annually: 2019 – **3.8%**; 2020 – **3.5%**; 2021 – **3.25%**; 2022 – **3.0%**; 2023 – **3.0%**
   - Rhode Island: The benchmark is established for four years (2019-2022) at **3.2%.**

2. **Why is the Oregon Health Authority establishing a Sustainable Health Care Cost Growth Target?**
   The cost growth target is a strategy to bring annual health care cost growth to a sustainable level so it does not continue to outpace economic growth or income in Oregon. Since 2000, Oregon employer-sponsored insurance premiums have grown three times faster than personal income and average annual family deductibles have risen 77%.[2,3]

   The Legislative Assembly has been examining ways to contain health care cost growth. In 2017, the Joint Interim Task Force on Health Care Cost Review (SB 419) made

[1] In Delaware, the benchmark is PGSP plus an add-on factor that diminishes over five years to 0%.
[2] MEPS IC, Oregon and BEA
[3] "The Burden of Health Care Costs for Working Families." Penn LDI, April 2019.

recommendations to create a health care cost growth target and in 2019, the Legislative Assembly passed SB 889 with bipartisan support. The health care cost growth target will bring everyone to the table to work towards a common goal of holding down health care costs.

3. **What topics will the Implementation Committee discuss?**
   The Implementation Committee discussions will, at a minimum, address the following key focus areas:
   - What will be the methodology for setting the cost growth target?
   - How will growth in spending be measured?
   - What services will be included in total spending?
   - Whose spending will be measured?
   - What provider organizations will have their data publicly reported?
   - Will data be risk-adjusted to account for the differences in populations?

   OHA needs broad partnerships and support to make this program successful. Health insurers can play a key role in helping us figure out the information needed to understand health care spending, what's driving rising health care costs, and how to address it. Health insurers are encouraged to be involved in the process and may email HealthCare.CostTarget@state.or.us with any questions, comments or testimony.

   All Implementation Committee meetings will be public and recorded for online viewing as well as be open to public comment. You can stay up-to-date on the topics of discussion by viewing meeting agendas and presentations on the Health Policy and Analytics website: https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx.

4. **How long have cost growth targets been used?**
   In Oregon, Medicaid has been held to a 3.4 percent per capita growth rate since 2012, and the public employee health plans have since 2014. These programs provide health coverage to 1.3 million Oregonians or one-third of the state. The new health care cost growth target that will be developed by OHA in partnership with stakeholders and consumers will apply a uniform growth target statewide. This will help contain costs for Oregon families and businesses that purchase private health insurance. Other states are using them, too. Massachusetts has had a statewide health care cost growth target since 2012. Delaware and Rhode Island started similar programs in 2019. Starting in 2021, Connecticut will implement a health care cost growth and quality target program.

5. **How do we know this program will be successful in slowing health care spending growth?**
   There is compelling evidence from Massachusetts that their cost growth target has had a significant constraining influence on cost growth, particularly in the employer market. Massachusetts estimates that since the target was established it has saved an estimated $5.5 billion in avoided commercial health care spending.[4] That's the kind of savings that we want to create for Oregon businesses and families.

[4] Massachusetts Health Policy Commission, Hearing on the Potential Modification of the Health Care Cost Growth Benchmark. March 28, 2018.
https://www.mass.gov/files/documents/2018/04/03/Benchmark%20Presentation.pdf

6. **How will total spending be measured and reported in Oregon, and how is it done in other states?**
   How total spending is measured and reported are key decisions that the Implementation Committee will consider. OHA's goal is to maximize available data and minimize new data collection.

   In Massachusetts, Delaware and Rhode Island, total spending is measured by using data reported by commercial, Medicaid and Medicare Advantage insurers. In addition, the state collects data from Medicare and Medicaid for their fee-for-service (FFS) programs and collects data for other populations not reported by insurers.

   In Massachusetts, Delaware and Rhode Island, total spending is reported by the insurers to the state agency that operates the program. Data are publicly reported by the state agency that operates the program at the state level, the market level (i.e., Medicare, Medicaid and commercial), the insurer level and the large provider level. For an example of how data are reported in Massachusetts see: http://www.chiamass.gov/annual-report/

7. **How will insurers in Oregon determine spending that is associated with large providers, and how is it done in other states?**
   The Implementation Committee will consider the different ways in which spending can be attributed to large providers and what the definition of a large provider is. In Massachusetts, Delaware and Rhode Island state residents are attributed by their insurer to a primary care provider using the insurer's own attribution methodology. All spending incurred by each resident member (with little exception) is attributed to the individual's primary care provider. That spending is then rolled up to the provider organization level based on primary care provider affiliation.

8. **Will the performance of an individual insurer be reported?**
   Yes. SB 889 requires spending to be measured statewide on a per capita basis and by health insurers and providers. OHA anticipates that reporting will also be done at the market level (e.g. Medicare, commercial, Medicaid). Massachusetts, Delaware and Rhode Island report (or will report) health insurer performance by market.

9. **Is the performance of individual health care providers reported?**
   No. Reporting is done at the provider organization level and not at the clinician level. Examples of provider organizations are clinics, hospitals and hospital systems that employ or are otherwise formally affiliated with primary care clinicians. Massachusetts, Delaware and Rhode Island have established a minimum number of attributed patients any given provider organization must have for the organization to have its performance publicly reported. For large provider organizations reporting may occur at the parent organization level when components of the organization are not large enough for public reporting.

10. **If spending is attributed to primary care providers, will hospital performance be measured in Oregon?**
    The Implementation Committee will make recommendations on if and how hospital performance will be reported. In Massachusetts, Delaware and Rhode Island, inpatient hospital spending is reported by large provider organizations for patients attributed to

those organizations through affiliated primary care providers. Each state tracks the growth in inpatient hospital spending over time.

11. **What will happen in Oregon if a health insurer exceeds the cost growth target? How are the other states holding insurers accountable?**
    The Implementation Committee will make recommendations on how insurers and providers that exceed the target will be held accountable. Regardless of those recommendations, OHA will publish cost growth trends and compare performance to the target to raise public awareness and transparency of cost growth in the state. The goal of the cost growth target is long-term stability of our health care system, not penalizing insurers or providers.

    In Massachusetts, Delaware and Rhode Island, no specific action plans have been formulated for health insurers that exceed their respective cost growth targets, but all states do or intend to publish performance as a means of accountability.

12. **Will Oregon's All Payer All Claims (APAC) database be used to report on spending against the cost growth target?**
    Given the experience of other states, OHA is likely to collect data from insurers to report on spending against the target and use the APAC for other related analyses. For example, the APAC could be used to validate insurer-reported data, as well as provide supplemental and targeted analyses on drivers of cost growth. In Massachusetts, Delaware and Rhode Island, each state collects summary-level data on spending from the insurers (not individual health care claims-level data) and either does or plans to utilize its claims database to provide supplemental analyses to support its benchmark program.

13. **What type of data might health insurers need to report and how?**
    The Implementation Committee is tasked with identifying the data that providers and insurers will report for the program. In Massachusetts, Delaware and Rhode Island insurers are reporting summary-level data on spending categorized by common health care services, like inpatient hospital and professional physician services. Insurers also report summary-level data on non-claims-based spending that may be expended through alternative payment arrangements. In addition, insurers report risk-adjustment scores using their own risk-adjustment software. OHA anticipates developing a detailed data request template to ensure that all insurers and/or providers required to submit are submitting data using the same methodology.

14. **How will the cost growth target help Oregonians understand why health care costs are growing?**
    In addition to publishing information related to the performance of insurers and providers against the target, OHA anticipates that data will be published annually that explores the reasons why health care costs are growing and provide drill-down analyses to help Oregonians understand the true drivers of health care cost growth. In addition, OHA plans to provide data analysis that may help providers improve cost and quality performance.