

Cost Growth Benchmark Methodology

Nevada Patient Protection Commission

April 21, 2021

Beginning the Process of Defining the Benchmark Methodology

- During the March Commission meeting we reviewed how other states have:
 - designed and implemented health care cost growth benchmarks, and
 - complemented their benchmarks with data analysis in order to identify and address cost growth drivers.
- Today we begin a process that will span several meetings to design what Nevada's approach should be.
- We will sequentially work through a series of benchmark *design decisions*, sharing information about other state approaches, and asking you for your recommendations.

Design Decisions We Will Be Covering Today

1

Defining Total Health Care Expenditures (THCE)

2

Defining the Population for Whom Total Health Care Expenditures Are Being Measured

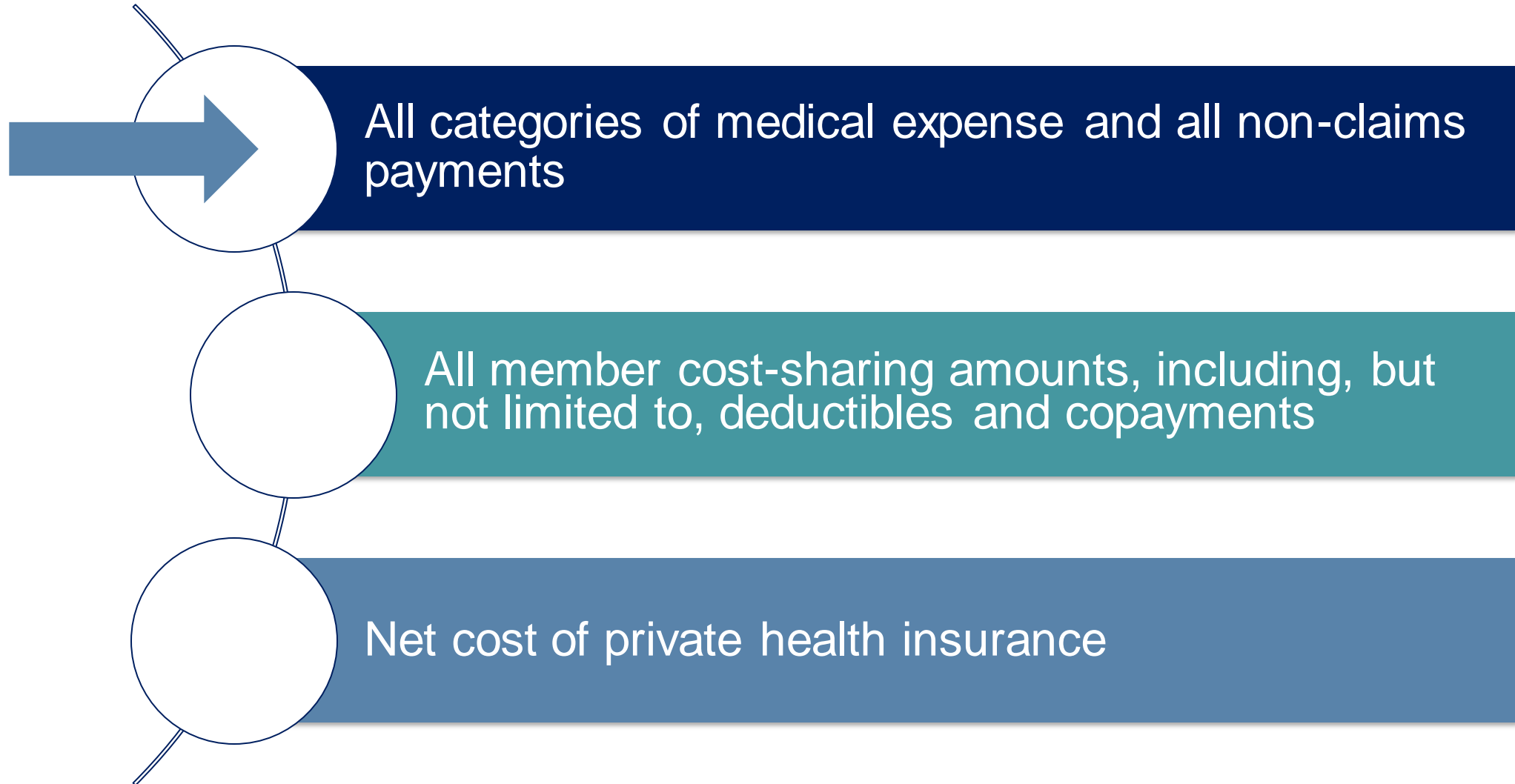
3

Establishing Criteria for Choosing an Economic Indicator

Defining Total Health Care Expenditures (THCE)

- **Total Health Care Expenditures** refers to the spending we will be measuring when assessing performance against the benchmark.
- We will start by reviewing the typical components adopted by other states, and then ask you how you think it should be defined.

Defining the Specific Components of THCE



Payments by Payers to Providers

Our first category of THCE includes payments to providers for all covered services and other related payments. This includes:

- **Claims-based payments:** all payments on providers' claims for reimbursement of the cost of health care provided
- **Non-claims-based payments:** all other payments not included on providers' claims

Note that the definition of covered services differs across commercial, Medicare, and Medicaid markets.

- For example, long-term care is covered by Medicaid, but not by commercial policies.

Typical Claims-Based Payments as Defined by Other States

- Hospital Inpatient
- Hospital Outpatient
- Professional: Primary Care
- Professional: Specialty Care
- Professional: Other
- Long-Term Care
- Retail Pharmacy¹
- Other (e.g., durable medical equipment, transportation)

¹ Most states capture medical pharmacy in the hospital inpatient and outpatient service categories

Design Decision: Claims-Based Spending



Does the Patient Protection Commission wish to define claims-based spending as all claims-based payments for covered services, consistent with the definition adopted by other states?

Typical Non-Claims-Based Spending: Six Categories

- 1. Prospective service payments:** Prospective payments to cover health care services (e.g., capitation, episode-based payments, case rates).
- 2. Performance incentive payments:** All payments made to providers for achievement relative to specific pre-defined goals for quality, cost reduction, or infrastructure development (e.g., pay-for-reporting and pay-for-performance payments). This includes shared savings distributions and shared risk recoupments.
- 3. Population health and practice infrastructure payments:** All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality, and control costs.

Typical Non-Claims-Based Spending: Six Categories (Cont'd)

- 4. Provider salaries:** All payments for salaries of providers who provide health care services not otherwise included in claims and non-claims categories.
- 5. Recoveries:** All payments recouped during the performance year as the result of a prior review, audit, or investigation, regardless of the time period of the initial payment. (Value is reported as a negative.)
- 6. Other payments:** All other payments pursuant to a payer's contract with a provider that were not made on the basis of a claim for a medical service and not classified in any of the other categories above (e.g., governmental payer shortfall payments, grants, or surplus payments).

Design Decision: Non-Claims-Based Spending



Does the PPC wish to use the definition of non-claims-based spending adopted by other states?

➤ Are there any modifications you wish to recommend?

1. Prospective service payments
2. Performance incentive payments
3. Population health and practice infrastructure payments
4. Provider salaries
5. Recoveries
6. Other payments

Prescription Drug Rebates

- Drug manufacturers commonly provide prescription drug rebates to pharmacy benefit managers and health insurers. These rebates can be quite substantial.
 - Nationally, Medicaid prescription drug spending in 2017 was cut in half after accounting for rebates.¹
 - In RI, pharmacy rebates accounted for 15% of commercial pharmacy spending in 2019.
- In MA, DE, RI, OR, and CT, payers must report prescription drug rebates received. Total Medical Expense (TME) is reported net of rebates.²

¹ Medicaid and CHIP Payment and Access Commission, “Medicaid Drug Spending Trends,” February 2019.

² States cannot access data on Medicare FFS rebates.

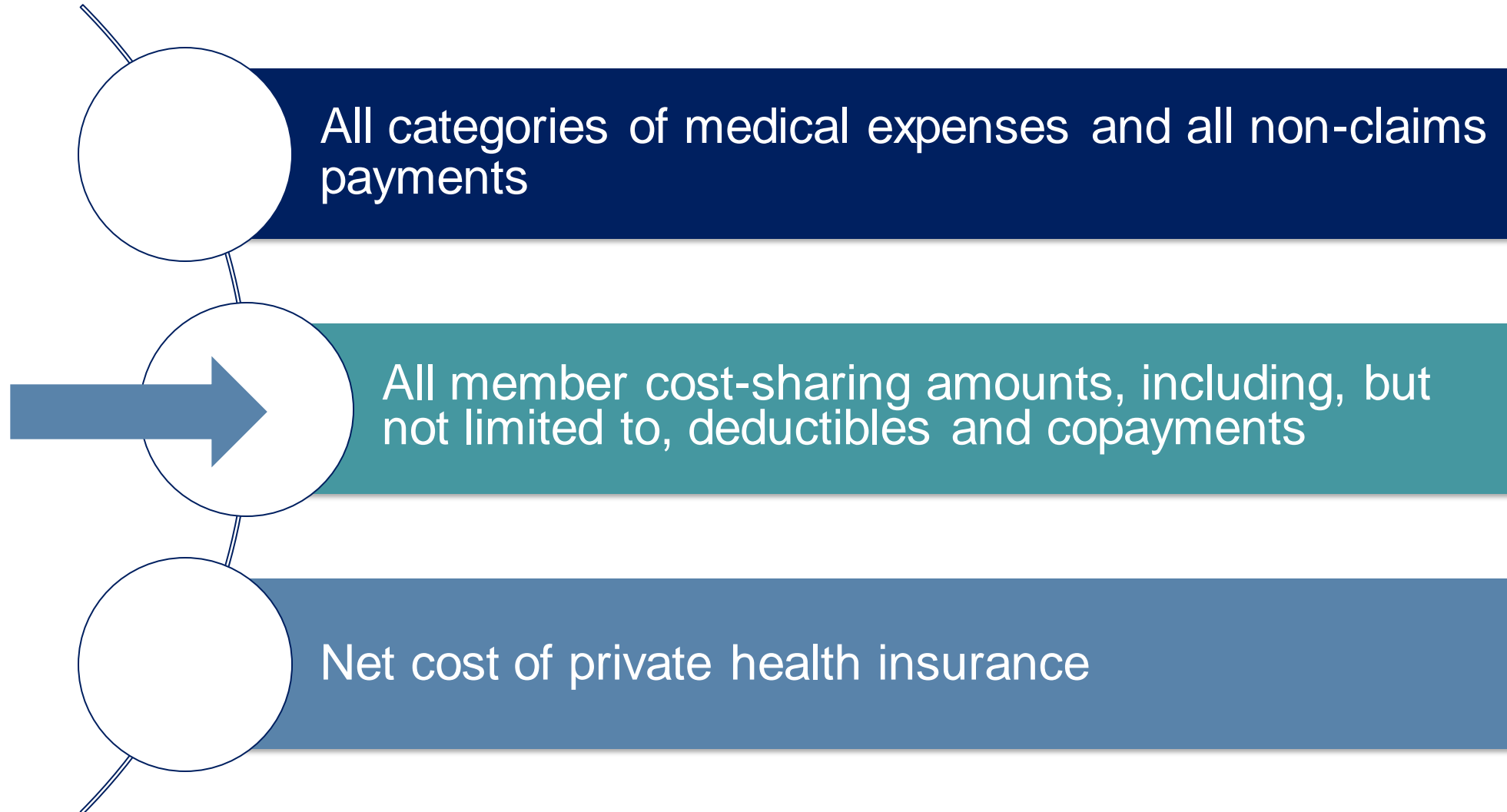
Advantages and disadvantages of reporting provider payments net of pharmacy rebates

	Advantages of Including	Disadvantages of Including
Pharmacy rebates	<ul style="list-style-type: none">• Provides a more accurate picture of actual pharmacy spending.	<ul style="list-style-type: none">• Pharmacy rebate amounts are highly confidential and difficult to validate.

Design Decision: Pharmacy Spending

Does the Patient Protection Commission wish to measure Total Medical Expense (TME) net of pharmacy rebates?

Defining the Specific Components of THCE



Member Cost-Sharing

- Insured individuals pay out-of-pocket costs dictated by their insurance product's benefit design:
 - Copayments
 - Deductibles
 - Coinsurance
- Other states exclude from their definition of member cost-sharing any out-of-pocket spending for:
 - Non-covered services (e.g., non-medical cosmetic surgery);
 - Non-health care services using discounts offered by an insurer (e.g., gym membership), and
 - Health care spending by individuals who are uninsured.
 - Why? Because there is no systematic means of capturing such spending.

Approaches to Capturing Member Cost-Sharing

- To measure performance against the benchmark, other states require payers to submit claims-based costs using “allowed amounts.”
 - This means the amount a payer paid to a provider for a covered health care service, plus any required member cost-sharing.
 - In these states, cost-sharing is not separately reported and therefore cannot be separately analyzed.*
 - “Allowed amounts” exclude out-of-pocket spending on non-covered services, non-medical services, and costs incurred by the uninsured.
 - By measuring “allowed amounts” states assume that members always pay their required cost sharing. We know, however, that this is not always the case.

*It can, however, be assessed via APCD analysis.

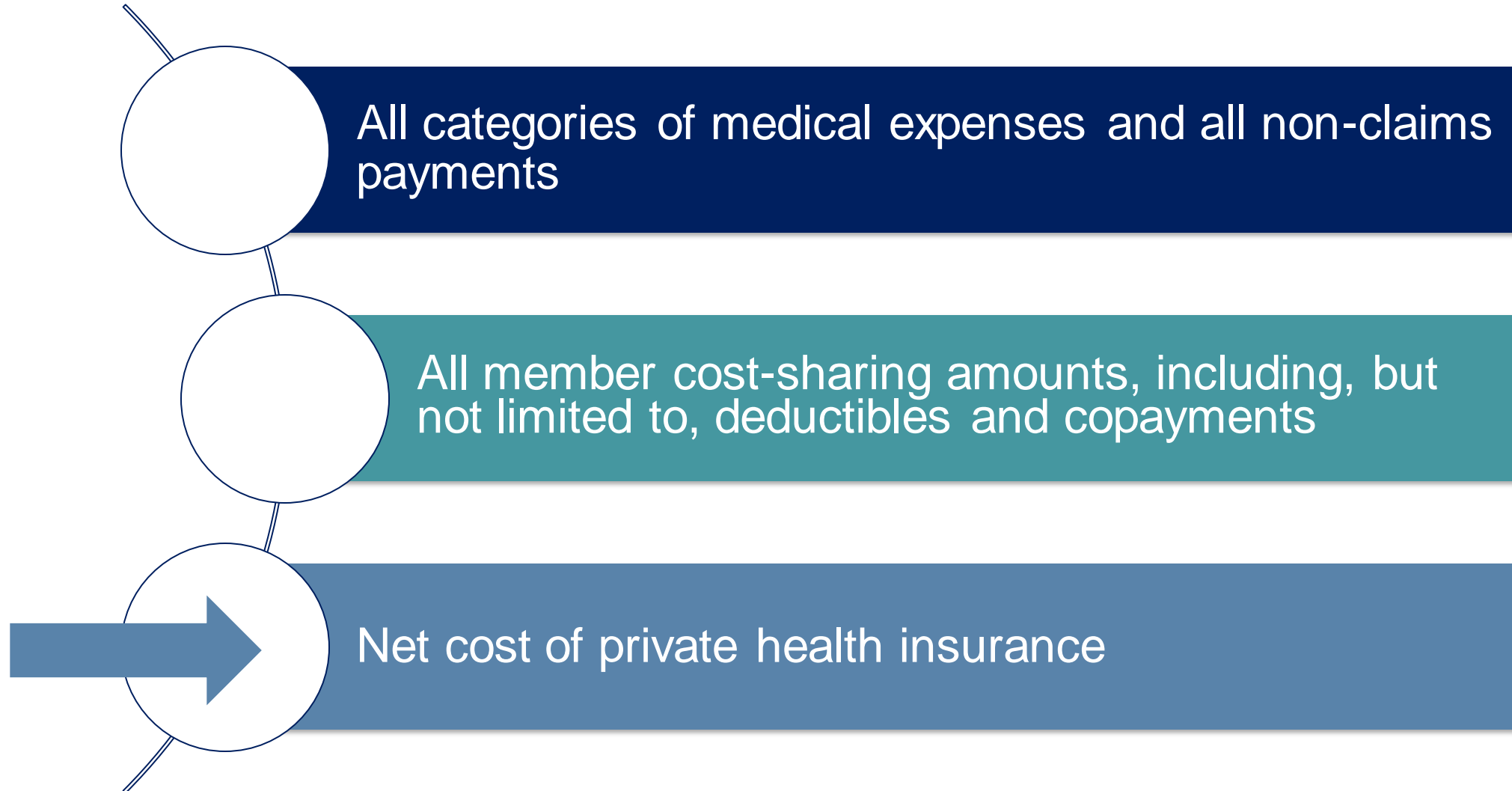
Design Decision: Cost-Sharing Spending



Does the Patient Protection Commission wish to adopt the definition of cost-sharing spending used by other cost growth benchmark states?

- Are there any modifications you wish to recommend?

Defining the Specific Components of THCE



Net Cost of Private Health Insurance (NCPHI)

- NCPHI captures the cost associated with the administration of private health insurance. It is the difference between health premiums earned and benefits incurred.
- It consists of insurers' costs related to:
 - Paying bills
 - Advertising
 - Sales commissions
 - Other administrative costs
 - Premium taxes and other fees
- It also includes insurer profits¹ and/or losses.

¹ For not-for-profit insurers, profits are referred to as “contribution to reserves.”

Other State Approaches to Measuring NCPHI

- MA, DE, RI, OR, and CT all define and measure NCPHI in the same way.
- Each state collects information related to NCPHI from carriers on the self-insured market, and through federally mandated financial reporting forms. NCPHI is calculated on a PMPM basis for each market segment:
 - Individual
 - Small group, fully insured
 - Large group, fully insured
 - Student markets
 - Medicare Advantage
 - Medicaid MCO
 - Self-insured market

Design Decision: Net Cost of Private Health Insurance



Does the Patient Protection Commission wish to adopt the definition of NCPHI used by other cost growth benchmark states?

- Are there any modifications you wish to recommend?

Topics

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Establishing Criteria for Choosing an Economic Indicator

Total Health Care Expenditures for Whom?

- We need to be specific with the definition of “for whom.” We will walk through a series of questions to help define the coverage status of individuals whose health care spending is being measured.
- Data access may play a role in which coverage groups can be included.

Primary Sources of Health Care Coverage

- Medicare
 - Fee-for-service
 - Medicare Advantage
- Medicaid
 - Fee-for-service
 - Managed Care
- Medicare & Medicaid “Duals”
- Commercial
 - Fully-insured
 - Self-insured



All cost growth benchmark states include these sources of coverage.

Other Sources of Health Care Coverage

- Veterans Health Administration (VA)
- State Correctional Health System
- Indian Health Service (IHS)

States vary on inclusion of these sources of coverage.

We will review the considerations of including each of these sources.

Note: TRICARE is not presented for separate consideration, as we assume that spending will be captured in the data request to commercial carriers.

Total Health Care Expenditures for Which Sources of Coverage?

	Advantages of Including	Disadvantages of Including
Veterans Health Administration (MA, DE and CT)	<ul style="list-style-type: none">• Including VHA would make NV's definition comprehensive. In 2019 1.7% of NV residents were covered through the VHA or other military coverage (e.g., TRICARE).	<ul style="list-style-type: none">• Data are limited and not measured in using a directly comparable methodology.
State Correctional Health System (OR and CT)	<ul style="list-style-type: none">• Including state correctional health system health care spending would make NV's definition more comprehensive. In 2016, 20,200 individuals were incarcerated in NV, which was approximately 0.7% of the state population.	<ul style="list-style-type: none">• Some inpatient costs are already included under Medicaid (in certain circumstances).• State spending for corrections is disaggregated and may not be obtainable using a directly comparable methodology.
Indian Health Service (OR)	<ul style="list-style-type: none">• Including spending by the Indian Health Service would make NV's definition more comprehensive. 0.9% of NV's population identify as "American Indian / Alaska Native," though not all are likely served by the IHS.	<ul style="list-style-type: none">• Data are extremely difficult to collect and require consent from all tribes.

Design Decision: Sources of Coverage to Include



What sources of coverage does the Patient Protection Commission wish to include?

- Medicare (FFS and Medicare Advantage)
- Medicaid (FFS and managed care)
- Commercial (fully- and self-insured)
- Veterans Health Administration
- State Correctional Health System
- Indian Health Service

Are there any other sources of coverage to consider for inclusion?

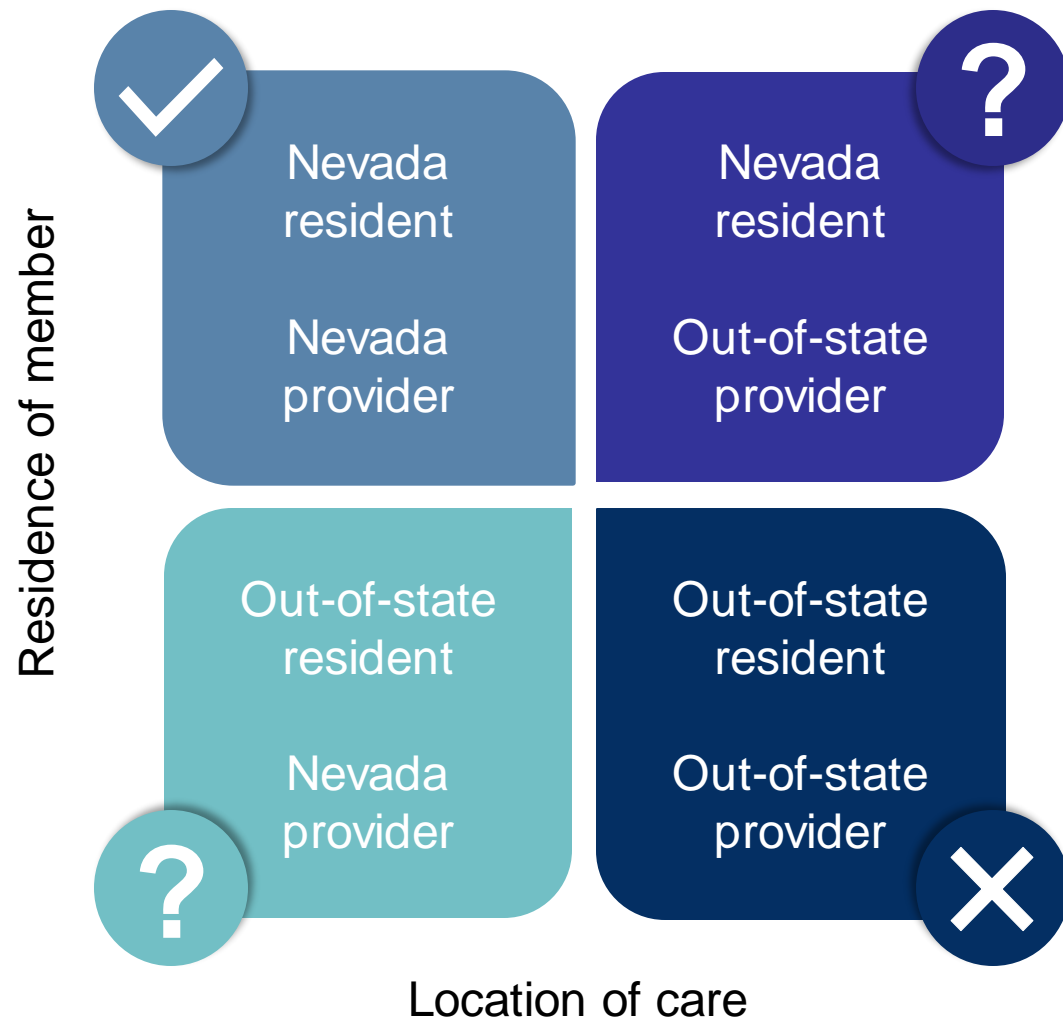
Whose THCE Should Be Measured?



For the services covered by the recommended payers, what should be the:

1. **Residence of the individual?**
2. **Location of the provider?**

State of Residence and Care Location



It's clear that we should:

- *Include* Nevada residents who received care from Nevada providers
- *Exclude* out-of-state residents who received care from out-of-state providers

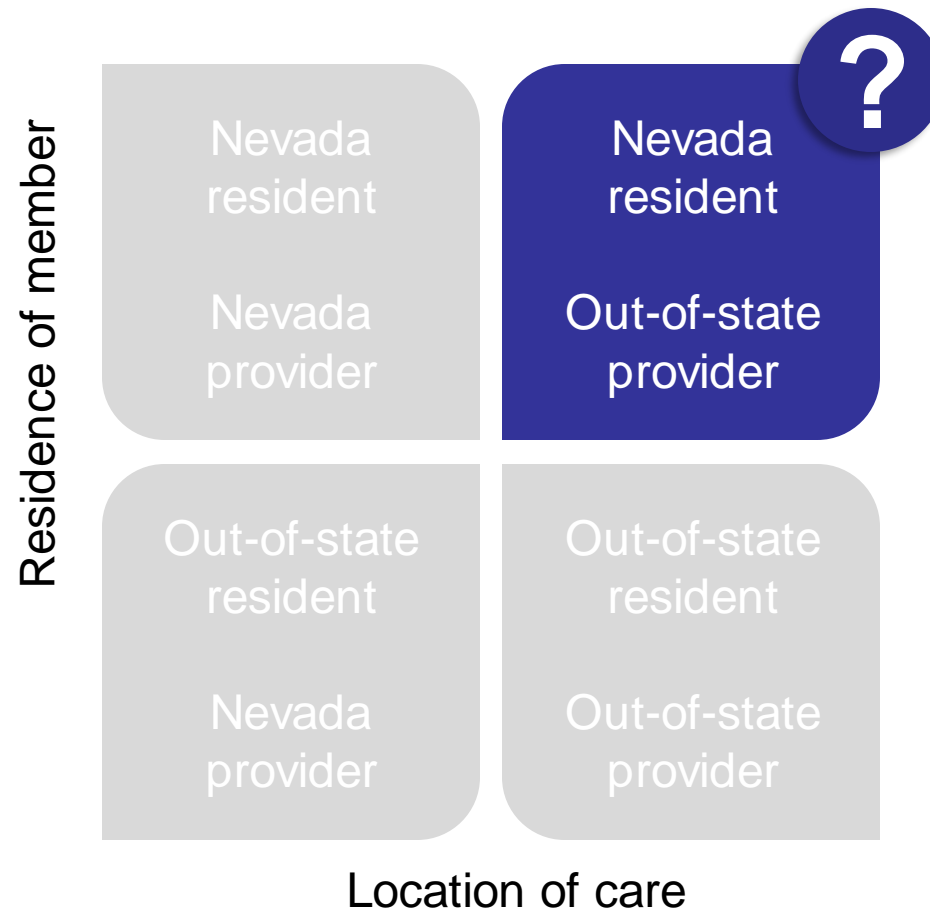
Considerations Around Spending on Care Received by State Residents from Out-of-State Providers

- Some state residents will receive some of their health care out of state.
 - For illness or injury incurred when traveling or temporarily living out of state
 - If they live near the state border and have provider relationships across the border
- MA, DE, RI, OR and CT include spending for state residents who received care from out-of-state providers in the numerator for their cost growth benchmarks.

Design Decision: State of Residence and Care Location



Should we include health care spending on Nevada residents that were incurred out-of-state?



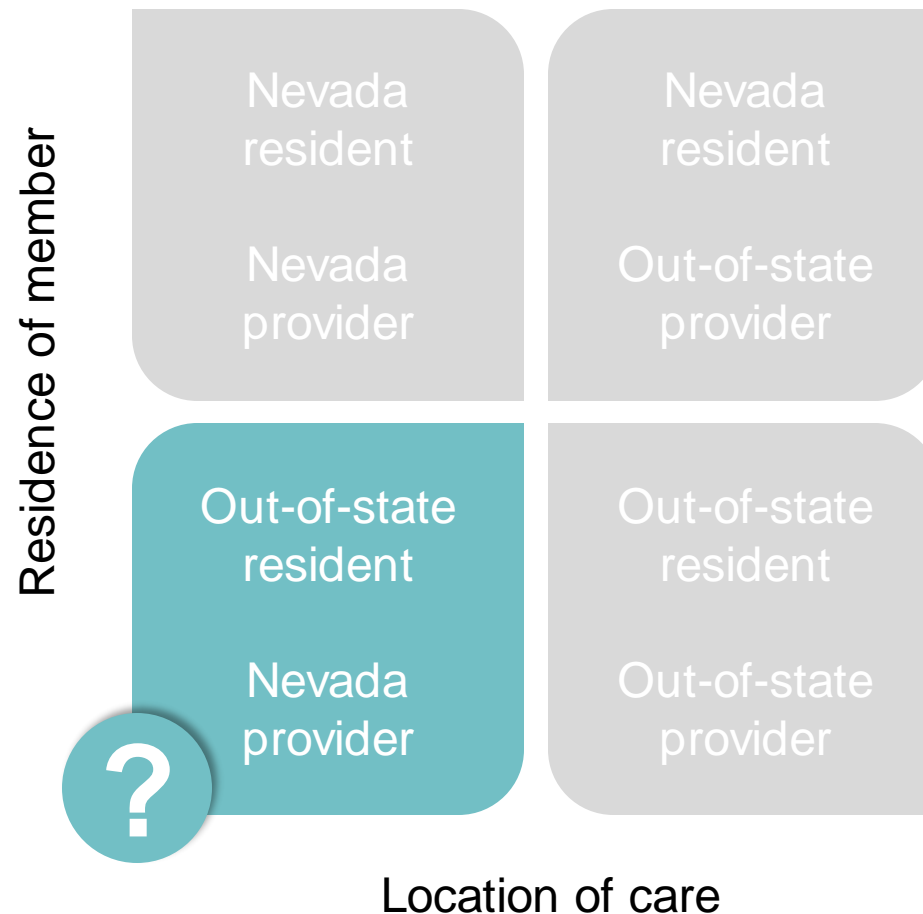
Considerations Around Spending on Care for Non-State Residents by In-State Providers

- Bodies like the PPC in other states have debated whether to include spending associated with non-state residents.
 - State employees and other workers may commute into the state for work and receive their health care in the state. This spending represents an expense for Nevada employers.
- These dollars can only be captured from those insurers required to report; insurers not licensed in the state are less likely to report.
- Do we care about this spending since it is not spending on behalf of Nevada residents?
- MA, DE, RI, OR and CT do not include these expenditures.

Design Decision: State of Residence and Care Location



Should we include non-state residents who receive care from in-state providers?



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Why Use an Economic Indicator?

- The primary reason for establishing a health care cost growth benchmark is that high and rising health care costs have been having a harmful impact on consumers and the non-health care economy.
- Using an economic indicator as the basis of the benchmark would link health care spending growth to state economic wellbeing.
- While all of the other states have elected to consider economic indices when setting their benchmark values, the PPC can consider other means for doing so if it desires.

Establishing Criteria for Choosing the Economic Indicator

- Should the PPC have interest in our doing so, during the next meeting we will share economic indicator options to inform the value of the cost growth benchmark.
- Determining which one is a matter of preference – there is no objective right or wrong answer.
- Identifying decision-making criteria may help facilitate the process, however. We therefore offer three criteria suggestions.

Suggested Criteria

1. Provide a stable, and therefore, predictable target.
2. Rely on independent, objective data sources with transparent calculations.
3. Lower health care spending growth.

Design Decision: Economic Indicator Criteria



Does the Patient Protection Commission wish to adopt the following criteria for choosing an economic indicator for the benchmark?

1. Provide a stable, and therefore, predictable benchmark.
2. Rely on independent, objective data sources with transparent calculations.
3. Lower health care spending growth.

Does the Commission wish to add other criteria for consideration?

Wrap-Up and Next Steps

- At our next meeting we will provide contextual information on historical health care cost growth in Nevada.
- The Commission will also deliberate on the cost growth benchmark methodology, including:
 - Economic indicators that could be used to set a benchmark;
 - Use of historical vs. forecasted values, and
 - Possible adjustments to the benchmark