

Introduction to Cost Growth Benchmarks

Nevada Patient Protection Commission Advisory Subcommittee

June 30, 2021

Topics

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Introduction to Health Care Cost Growth Benchmarks

Advisory Subcommittee Membership

Meeting Timeline

Massachusetts' Cost Growth Benchmark Program Experience

Nevada's Health Care Benchmark Program

- Nevada's health care benchmark program was initiated earlier this year when Governor Sisolak used his broad authority under the 2019 enabling PPC statute to direct creation of the benchmark program.
- The Governor did so in the context of Nevada being one of five states invited to participate in the Peterson-Milbank Program for Sustainable Health Care Costs.
- In a March 8, 2021 letter to the PPC the Governor requested assistance to:
 1. develop a statewide cost growth benchmark;
 2. calculate and analyze statewide health care cost growth, and
 3. analyze drivers of cost growth.

About the Peterson-Milbank Program for Sustainable Health Care Costs

- **Goal:** Advance state efforts to make health care more affordable for residents, employers, and states.
- **Strategy:** Provide technical assistance to five states to:
 - Develop targets for per-capita trends in total health care spending statewide;
 - Engage stakeholders and communicate about project activity, and
 - Analyze and collaboratively address the underlying drivers of cost growth.
- **Participating states:**
 - Connecticut
 - New Jersey
 - Nevada
 - Oregon
 - Washington

What is a cost growth benchmark and why pursue one?

- A health care cost growth benchmark is a per annum rate-of-growth target for health care costs for a given state.



**Per Capita Health Care
Cost Growth 2018-2019:
4.1%¹**

**GDP Growth
2018-2019:
4.0%²**

**Average Wage Growth
2018-2019:
3.3%³**

SOURCES:

- 1) Centers for Medicare & Medicaid Services, [National Health Expenditure Accounts](#), accessed February 17, 2021.
- 2) U.S. Bureau of Economic Analysis, Gross Domestic Product [GDP], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/GDP>, February 16, 2021.
- 3) U.S. Bureau of Labor Statistics, Average Hourly Earnings of All Employees, Total Private [CES0500000003], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/CES0500000003>, February 16, 2021.

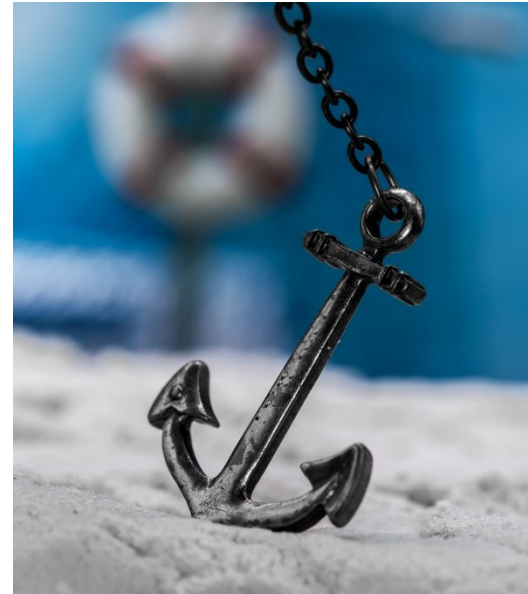
A note on terminology

- States use different terminology, with some using “benchmark” and others using “target.” They are treated in other states as synonyms.

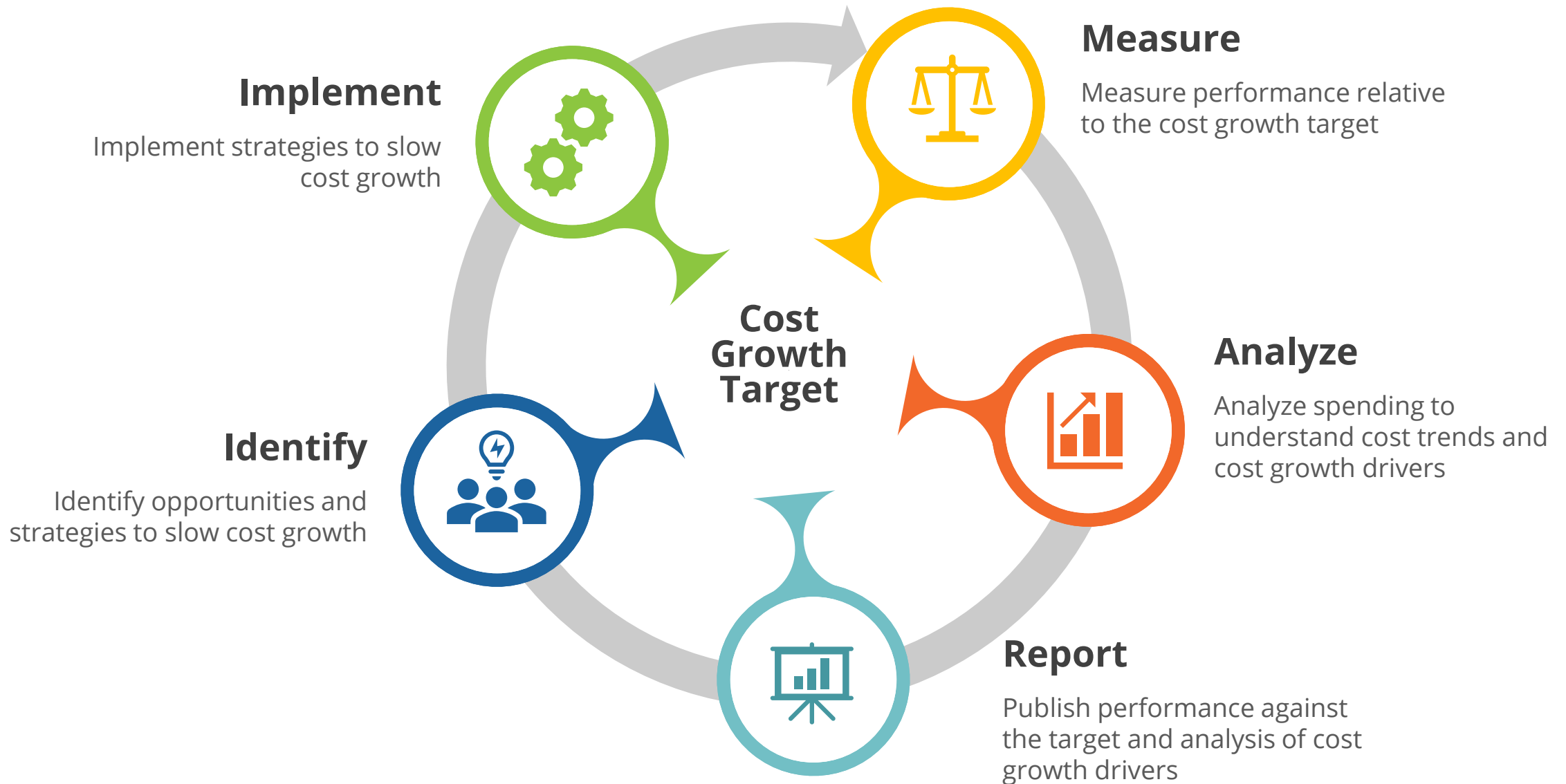
“Benchmark”	“Target”
<ul style="list-style-type: none">• Connecticut• Delaware• Massachusetts• Nevada• Washington	<ul style="list-style-type: none">• California• Oregon• Rhode Island

A cost growth target creates a platform for action

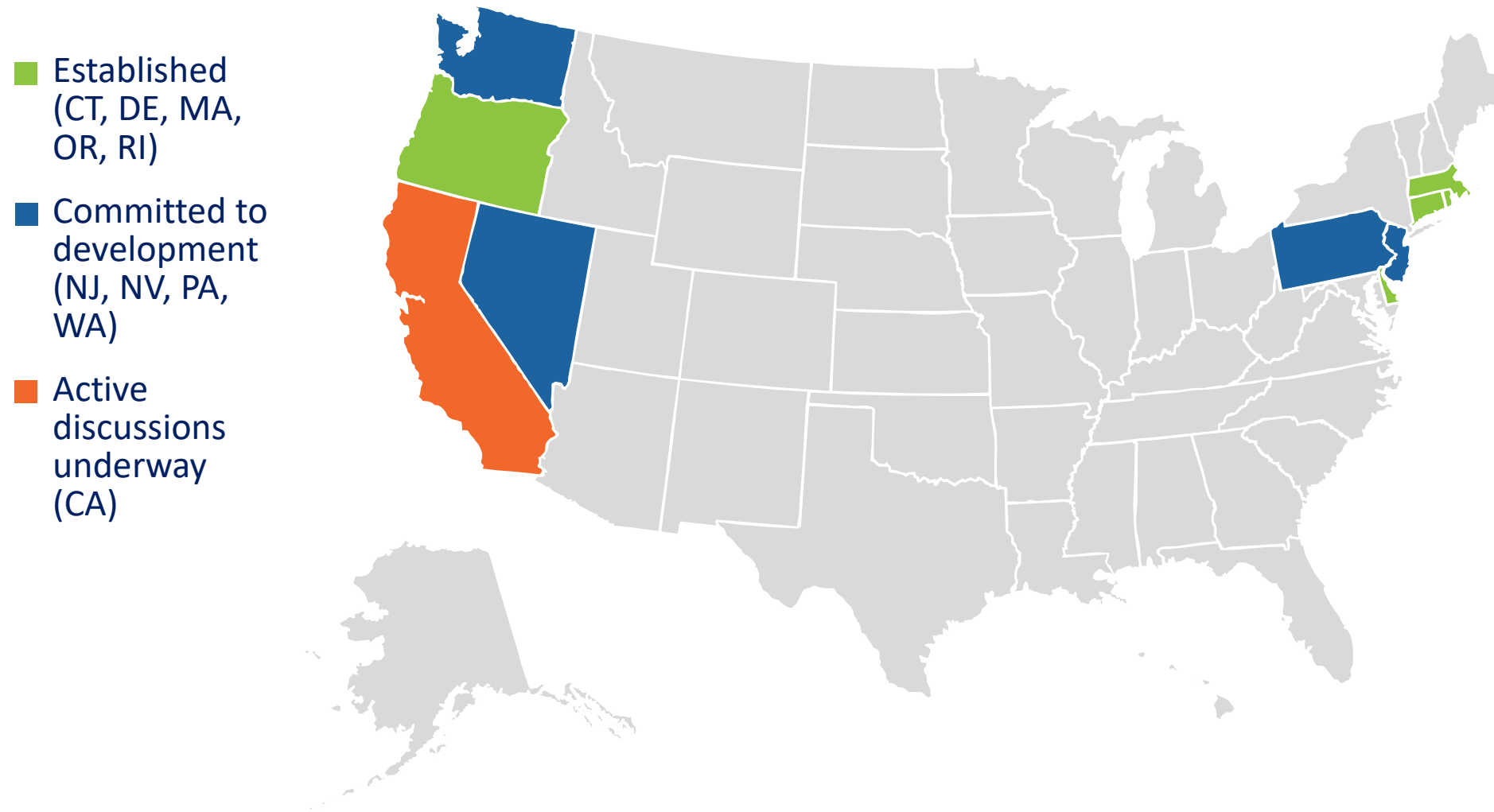
- Setting a public target for health care spending growth alone will not slow rate of growth.
- A cost growth target serves as an anchor, establishing an expectation that can serve as the basis for transparency at the state, insurer and provider levels.
- To be effective, it must be complemented by supporting strategies if it is likely to be effective.



The logic model for a cost growth target



State activity on health care cost growth benchmarks



States pursued cost growth benchmarks to curb health care spending growth

- **MA:** State-purchased health care rose 40% over 12 years while spending on other services was reduced by 17% on average.
- **OR:** health insurance premiums cost 29% of a family's total income.
- **DE:** the State's per capita total health spending was the 3rd highest in the nation.
- **RI:** 7 of 10 health insurance filings in the large and small group market outpaced annual wage growth.
- **CT:** health care costs outpaced growth in the State's economy, with personal health care expenditures taking up a larger portion of the State's GDP.

Key design considerations

1. **Defining total health care expenditures**
 - What types of spending should be included?
 - What sources of coverage are included?
 - Include residents only or include non-residents covered by employers in the state?
2. **Establishing the benchmark methodology**
 - How to identify the benchmark value?
 - How often should the benchmark be modified?
3. **Measuring performance**
 - Whose performance should be assessed?
 - What are the criteria for reporting payer and provider performance?

What are total health care expenditures (THCE)?

- THCE has three components:
 - All **medical expenses** paid to providers by private and public payers, including Medicare and Medicaid
 - All **patient cost-sharing** amounts (e.g., deductibles and co-payments)
 - The **net cost of private health insurance** (e.g., administrative expenses and operating margins for commercial payers)
- THCE is a *per capita* measure.

Defining total health care expenditures

What types of spending should be included?

■ Claims-based payments

- Hospital inpatient
- Hospital outpatient
- Physicians
- Other professionals
- Home health
- Long-term care
- Dental (when covered as a medical benefit)
- Vision (when covered as a medical benefit)
- Retail pharmacy
- Durable medical equipment
- Hospice
- Other (e.g., hearing aids, optical services and transportation)

■ Non-claims-based payments

- Provider performance incentive payments
- Prospective payments for health care services (e.g., capitation)
- Payments that support care transformation and infrastructure (e.g., care manager payments, lump sum investments, PCMH)
- Payments that support provider services (e.g., DSH payments)

■ Cost sharing

- Copayments
- Deductibles
- Coinsurance

■ Net cost of private health insurance

Defining total health care expenditures

What sources of coverage are included?

- **Medicare**
 - Medicare FFS (Parts A, B, D)
 - Medicare Advantage
- **Medicaid**
 - MCO
 - Fee-for-service and other
- **Commercial**
 - Fully-Insured
 - Self-Insured
- **Veterans Health Administration**
- **FEHB**
- **TRICARE**
- **Correctional Health System**
- **Indian Health Services**

States have chosen to include various sources of coverage based on assessment of what data are accessible and represent the majority of the state spending.

Defining total health care expenditures

Residents only or include non-residents covered by employers in the state?

Residence of Patient

State Resident
State Provider

State Resident
Out-of-State Provider

Out-of-State Resident
State Provider

Out-of-State Resident
Out-of-State Provider

Used by CT,
DE, MA, OR,
and RI

Location of Care

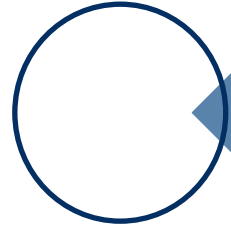
2021 benchmark values for other cost growth benchmark states

MA	DE	RI	OR	CT
3.1%	3.25%	3.2%	3.4%	3.4%
(PGSP-0.5%)	(PGSP+0.25%)	(PGSP)	(roughly...average annual change of nominal per capita gross state product and median wage over the last 20 years)	(20% PGSP/80% Median Income + 0.5%)

- MA previously dropped its benchmark from 3.6% to 3.1%.
- CT will drop to 2.9% by 2023.
- DE will drop to 3.0% by 2022.
- OR will drop to 3.0% by 2026.

PGSP = potential gross state product, a forecast of state economic growth years 5-10 into the future

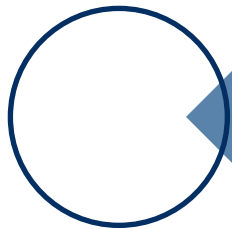
Topics



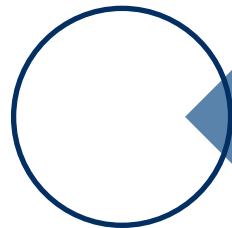
Introduction to Health Care Cost Growth Benchmarks



Advisory Subcommittee Membership



Meeting Timeline



Massachusetts' Cost Growth Benchmark Program Experience

Membership in the Advisory Subcommittee

27 members representing:

- Culinary Union
- Health Plans
- Hospitals and hospital systems
- Nevada Department of Health and Human Services
- Nevada Governor's Office of Economic Development
- Pharmacy
- Physicians
- Regional Interests
- Special Interest Groups

Topics

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3 Meeting Timeline

Massachusetts' Cost Growth Benchmark Program Experience

Meeting Timeline

Meeting Number	Meeting Date	Key Topics
Advisory Subcommittee Meeting #1	June 30, 2021	<ul style="list-style-type: none">• Introduction, orientation to cost growth benchmarks• Review role vis-à-vis the PPC• Review detailed meeting plan• Review landscape of similar activity in other states, and data on existing growth trends
Advisory Subcommittee Meeting #2	Date TBD	<ul style="list-style-type: none">• Review PPC deliberations on measurement of total health care expenditures and cost growth benchmark methodology• Gather feedback to share with the PPC
Advisory Subcommittee Meeting #3	Date TBD	<ul style="list-style-type: none">• Review PPC deliberations on benchmark methodology and values, and on performance assessment• Gather feedback to share with the PPC
Advisory Subcommittee Meeting #4	Date TBD	<ul style="list-style-type: none">• Review PPC deliberations on performance assessment, and on authority and governance of benchmarks• Gather feedback to share with the PPC

Meeting Timeline

Meeting Number	Meeting Date	Key Topics
Advisory Subcommittee Meeting #5	Date TBD	<ul style="list-style-type: none">• Overview of the goals and purpose of a data use strategy• Review PPC deliberations on transparency and accountability, and on data use strategy goals and potential analyses• Gather feedback to share with the PPC
Advisory Subcommittee Meeting #6	Date TBD	<ul style="list-style-type: none">• Overview of cost growth mitigation strategies to ensure the benchmark strategy is successful• Gather feedback to share with the PPC
Advisory Subcommittee Meeting #7	Date TBD	<ul style="list-style-type: none">• Review draft Commission recommendations• Review PPC discussions of the benchmark implementation strategy• Gather feedback to share with the PPC

Topics

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4 Massachusetts' Cost Growth Benchmark Program Experience



Massachusetts' Health Care Cost Growth Benchmark Program



Enabling legislative, regulatory or administrative requirements

- Chapter 224 of the Acts of 2012 established health care cost growth benchmarks as part of sweeping health system reforms.
- Chapter 224 created two entities:
 - Health Policy Commission (HPC) to set and enforce the benchmark
 - Center for Information and Analysis (CHIA) to collect and measure health system performance against the benchmark.



Cost growth benchmark values and methodology

- Benchmarks are set in statute and pegged to Potential Gross State Product (PGSP), a forecasted average growth rate of the state's economy, according to the following rules:
 - 2013 – 2017: equivalent to PGSP (calculated at 3.6%)
 - 2018 – 2022: PGSP minus 0.5% (or 3.1%), unless the HPC votes that an adjustment is warranted (requires 2/3 majority)
 - 2023 and beyond: equivalent to PGSP, with authority for the HPC to adjust it to any value



Assessment of performance against the benchmark

- Measured using Total Health Care Expenditures (THCE) by and for MA residents from public and private sources, which consist of:
 - **Total Medical Expense (TME)** spending on all medical services for all MA residents regardless of where care was provided, including non-claims-related payments to providers;
 - **Patient cost-sharing**; and
 - **Net Cost of Private Health Insurance (NCPHI)**, a measure of the costs to MA residents associated with administration of private health insurance (including Medicare Advantage and Medicaid managed care).



Assessment of performance against the benchmark

- THCE does not include:
 - Non-medical spending made by payers (e.g., gym membership);
 - Vision or dental care not otherwise covered by a medical plan; or
 - Expenditures recorded by providers, but not insurers (e.g., spending for uninsured residents).



Assessment of performance against the benchmark

- Commercial insurers submit TME summary-level information, including:
 - “Allowed amount” expenditures made on behalf of MA residents, which includes patient cost-sharing
 - Fully-insured and self-insured plans
 - Medicare Advantage, Medicaid MCOs, and dual eligible products
 - Payer completion factor adjustment to estimate costs that have been incurred but not reported (IBNR)
- For carved-out services (behavioral health, pharmacy), CHIA makes actuarial adjustments.



Assessment of performance against the benchmark

- CHIA also collects medical expenses for other payers that don't report TME, including:
 - Medicaid primary care case management program and other fee-for-service data from the Medicaid agency
 - Medicare Part A and/or B and stand-alone Part D membership and expenditure data from CMS
 - Other sources of health spending (e.g., Veterans Health Administration)



Accountability and enforcement of the benchmark

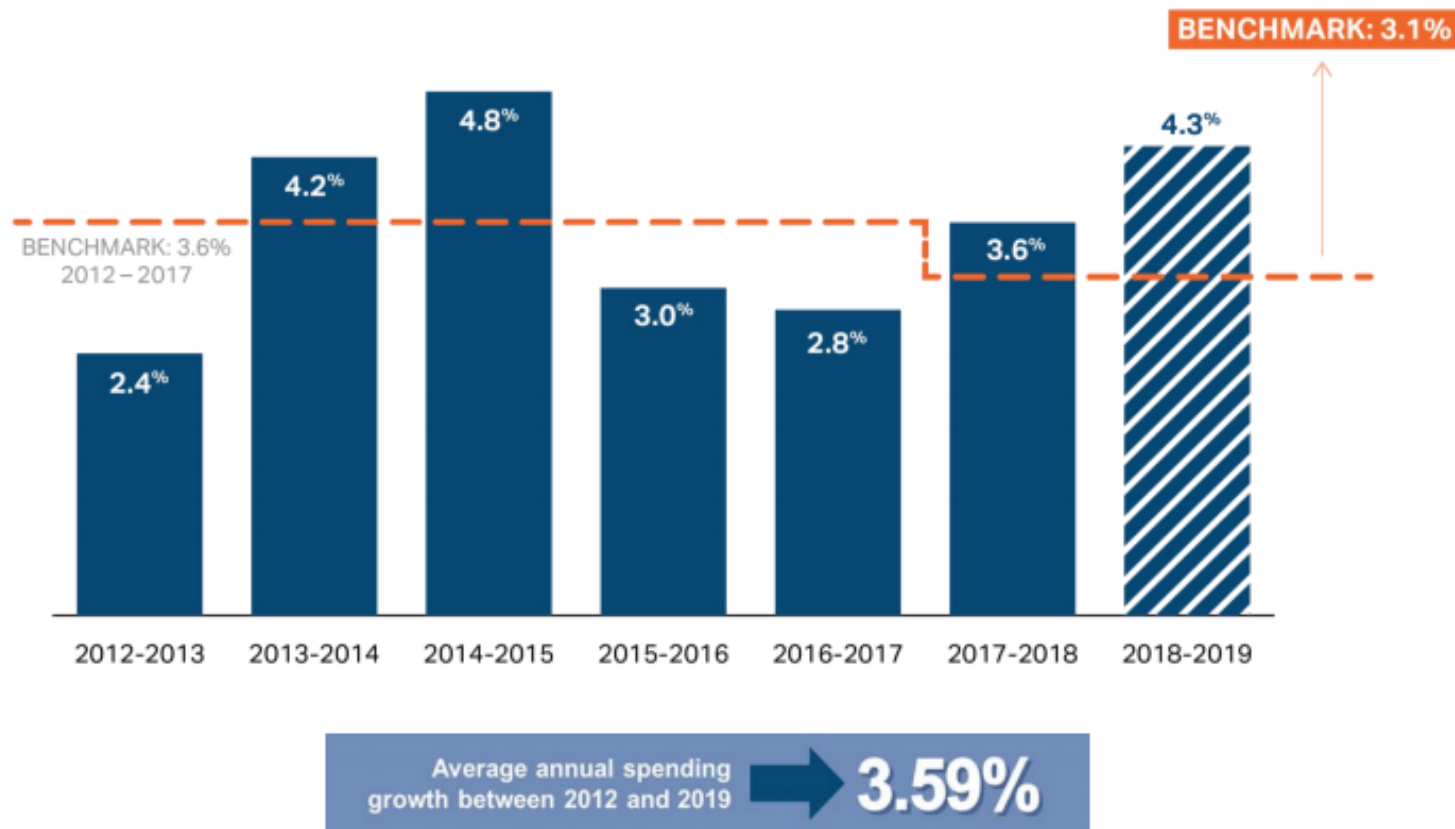
- On an annual basis, CHIA publicly reports performance at four levels:
 - State
 - Market (i.e., Commercial, Medicare, Medicaid)
 - Payer or insurer
 - Provider entity



Accountability and enforcement of the benchmark

- The HPC can require providers whose cost growth exceeds the benchmark to:
 - Implement a performance improvement plan (PIP); and
 - Levy penalties of up to \$500,000 for noncompliance with the PIP.
- In years when the State exceeds the benchmark, the HPC may conduct a review of one or more provider entities.
- To date, there have been referrals, but *no PIPs*.

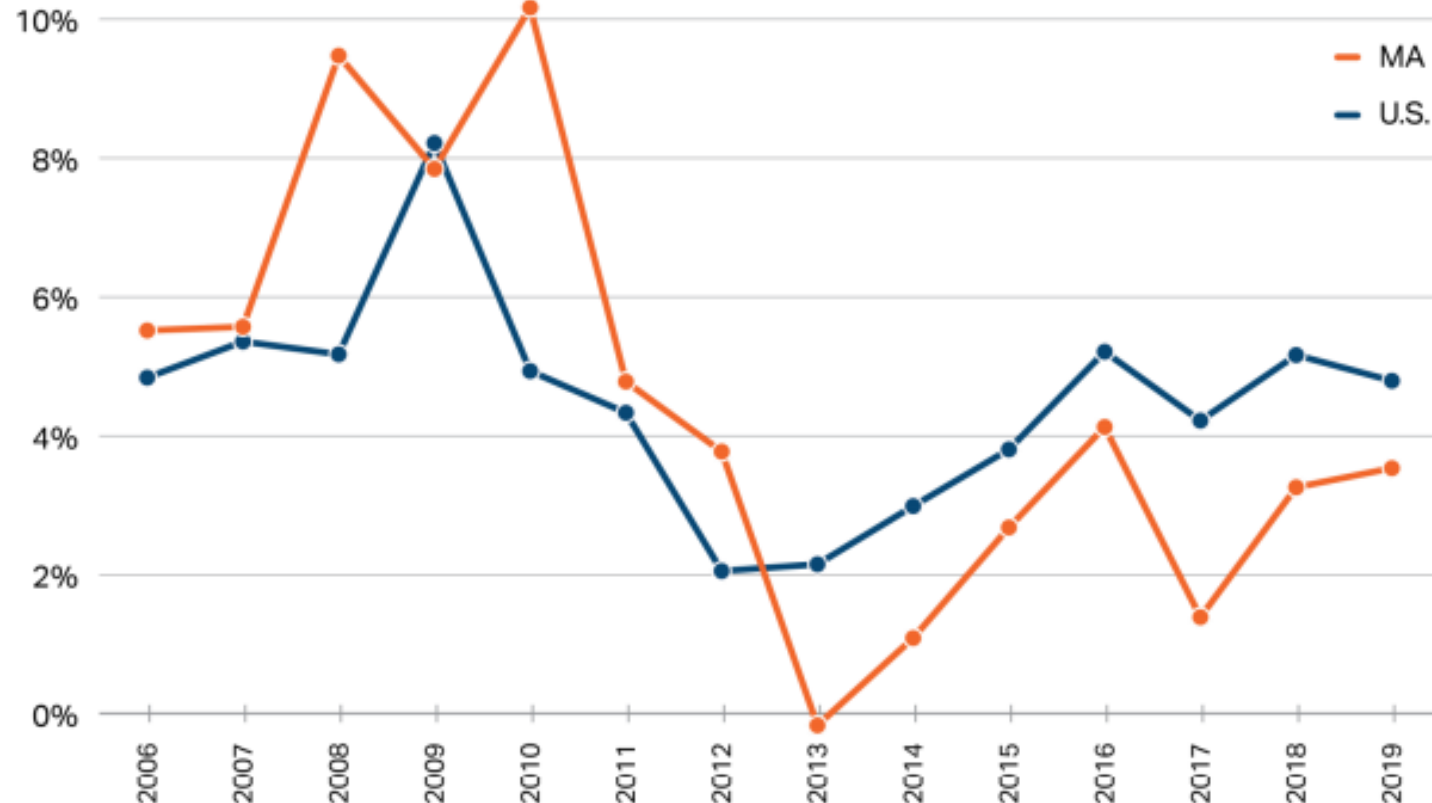
Massachusetts' cost growth benchmark experience



- Since establishing the cost growth benchmark in 2012, annual all-payer health care spending growth has averaged the cost growth benchmark level.
- Growth in total health care spending accelerated the past two years and exceeded the benchmark in 2018 and 2019.

Commercial spending growth in Massachusetts since implementation of the benchmark

Annual growth in Massachusetts (full-claims only) and national commercial health care spending per member, 2006-2019



- *Commercial* medical spending growth in MA has been below the national rate every year since 2013.

The cost growth benchmark's impact in Massachusetts



Common goal

Payers and providers have aligned on a common target for reducing health care cost growth.



Total cost of care approach

The benchmark is consistent with a TCOC contracting approach which has become the common contracting structure.



Influence on negotiations

Negotiations between payers and providers have been influenced by the benchmark, thereby tempering price growth.



Transparency

Reasons for cost growth have been studied and publicized, keeping the policy and its consequences in the public eye.

Policy experts' assessment of the cost growth benchmark's impact in MA

“With an expected utilization increase of about 2%, payers and providers generally agree on annual price increases of about 1.5%”

- David Cutler,
HPC member

“The [cost growth target]...sets the bar upon which most activities in the health system are judged. It's more than just a symbol, it's become an operational component of how our health system works.”

- Stuart Altman, HPC Chair

“Payer and provider rate negotiations are now conducted in light of the 3.6% target”

- State Auditor study

State Cost Growth Benchmarks

- **Connecticut:** <https://portal.ct.gov/OHS/Content/Cost-Growth-Benchmark>
- **Delaware:** <https://dhss.delaware.gov/dhcc/global.html>
- **Massachusetts:** <https://www.mass.gov/info-details/health-care-cost-growth-benchmark>
- **Oregon:** <https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx>
- **Rhode Island:** <http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php>

Other Resources

- **Cross-Agency Strategies to Curb Health Care Costs: Leveraging State Purchasing Power – NASHP:** <https://nashp.org/wp-content/uploads/2019/04/States-Leverage-Purchasing-Power.pdf>
- **Health Care Cost Growth Benchmarks in 5 States – JAMA Forum:** <https://jamanetwork.com/channels/health-forum/fullarticle/2767017>
- **Implementing a Statewide Healthcare Cost Benchmark - Manatt:** <https://www.manatt.com/insights/white-papers/2019/blueprint-for-building-an-effective-statewide-heal>