Steve Sisolak
Governor

Richard Whitley
Director

State of Nevada

Department of Health and Human Services

9-21-22 Meeting

Patient Protection Commission

Helping people. It's who we are and what we do.

Agenda

1. Letters of Support for PPC Topics
2. Roadmap of Benchmark and Overview of CHESS findings
3. Benchmark Accountability Mechanisms
4. Options for Cost Growth Mitigation Strategies

Review, Discussion and Decision of PPC Letter of Support for Subject 1, Topic 1 and Subject 2, Topic 6

PPC Letters of Support

- **Subject 1, Topic 1**
  - Included as a PPC budget item for Special Consideration
  - Now included in **Medicaid ARPA request during October meeting of Interim Finance Committee**
  - Letter requesting Legislator support for this item.

- **Subject 2, Topic 6**
  - Letter is recommending as an item for a Legislator or Legislative Committee, etc. to bring forward for the 2023 Session.

- Discussion and Possible Action -

Overview and Roadmap of Nevada's Health Care Cost Growth Benchmark Program

Nevada's Health Care Cost Growth Benchmark Program (1 of 2)

Executive Order 2021-29

First step toward improving health care transparency and affordability in Nevada.

Phase 1 Cost Driver Analysis

Initial reports completed by DHHS, Office of Analytics (OOA) and Public Employees' Benefits Plan (PEBP) – **what is driving health care costs**.

Baseline Data Request from NV Insurers

Distributed **benchmark implementation** manual, held webinar training, and issued request.

Voted & Submitted BDR to Codify Executive Order

8/17/22 PPC voted to advance a bill draft request (BDR) to codify the Executive Order 2021-29.

Nevada's Health Care Cost Growth Benchmark Program (2 of 2)

Data Analysis and Assoc. Benchmark Strategies

- OOA/PEBP to complete analysis of Phase 2 cost drivers.
- Guest presenter from OR re: accountability strategies.
- Cost growth mitigation strategies.

Phase 2 Cost Driver Analysis

Publish and present findings on deeper dive health care cost driver analyses from OOA and PEBP.

Validate, Analyze, Review Baseline Benchmark Findings with Insurers

January – March 2023

Publish and Present Baseline Benchmark Findings with PPC stakeholders, and the public!

Highlights of Nevada Consumer Healthcare Experience State Survey (CHESS) Findings

Nevada Consumer Healthcare Experience State Survey (CHESS)

Altarum Healthcare Value Hub

- Offered a CHESS at no cost to Nevada.
- Surveyed over 1,130 Nevada adults statewide from 6/21 – 7/8, 2022.

3 Survey Briefs

1. Health care affordability
2. Prescription drug cost concerns
3. Hospital prices

With support from the Robert Wood Johnson Foundation, the Healthcare Value Hub provides free, timely information about the policies and practices needed to achieve health systems that are equitable, affordable, and focused on the goals and needs of the people the system is meant to serve. The Hub is part of Altarum, a nonprofit consulting and research organization that creates solutions to advance health of vulnerable and publicly insured populations.

Nevada CHESS Highlights (1 of 2)

Highlights from CHESS Briefs

- A substantial portion of Nevada respondents worry about **affording healthcare costs** both now and in the future, and many (65%) reported experiencing financial hardship due to hospital costs.
- Most NV respondents believe the major reason for high healthcare costs is **unfair prices** charged by powerful industry stakeholders such as hospitals, pharmaceutical industry, and health insurers.
- When asked about top 3 healthcare priorities the government should work on, NV residents most strongly supported **addressing high healthcare costs**, including prescription drugs.
- Over half (**59%**) of all respondents reported **delaying or going without healthcare** during the prior 12 months **due to cost**.

Nevada CHESS Highlights (2 of 2)

Selected Survey Statements/Questions	Total Percent of Respondents in Favor
The government should cap out-of-pocket costs for life-saving medications, such as insulin.	90%
The government should require hospitals and doctors to provide up-front cost estimates to consumers.	92%
The government should set limits on health care spending growth and penalize payers or providers that fail to curb excessive spending growth.	81%
The government should require a minimum amount of spending that payers and providers in the state must devote to services that keep people healthy, such as primary care.	81%

Findings from a Study of Massachusetts' Cost Growth Benchmark Accountability Mechanisms

Background: The Massachusetts Health Care Cost Growth Benchmark

- In **2012**, Massachusetts adopted legislation establishing the cost growth benchmark, which sets a target for the annual rate of increase in health care spending statewide.
- The legislation also established the Health Policy Commission (HPC) and gave it the authority to monitor compliance with the benchmark through a set of accountability mechanisms.

Mathematica Study Goals & Methods

- **Study goals:**
  - To examine how the MA benchmark and the HPC's accountability mechanisms influenced the motivation and actions of state agencies, payers, and providers to control health care cost growth.
  - To identify lessons and considerations for other states implementing similar initiatives about the design and use of accountability tools.
- **Data and methods:**
  - Collection, review and catalogue of documents by the HPC, Center for Information and Analysis, other state agencies, payers, providers, and other organizations.
  - Structured interviews with ~ 50 key stakeholders between November 2021 and March 2022.

The Benchmark: Stakeholder Perspectives

Strengths

- Widespread agreement that the benchmark has helped constrain the rate of cost growth over time by creating a focal point for conversations among leaders about trends in health care spending.
- During its initial years, the benchmark influenced contract negotiations between payers and providers, and reportedly increased providers' willingness to participate in accountable care organizations and value-based payments, which reward improved quality and lower costs.

Weaknesses

- Not all providers agreed that the benchmark influenced their business decisions. Some providers said the benchmark had little direct influence on their organizations' internal decision-making.
- Other stakeholders highlighted a key limitation of the benchmark: by focusing on cost growth, it ignores the individual providers' *level of spending* (the product of price times utilization).

Cost Trends Hearings: Stakeholder Perspectives

The HPC convenes annual **Health Care Cost Trends Hearings** to focus public attention on health care cost growth.

Strengths

- The hearings are an important venue for making health care costs and spending trends transparent, and for shining a spotlight on how major payers and providers are trying to address key cost drivers.
- Several respondents conveyed that the entities called to testify take the hearings seriously and invest substantial time in preparing their remarks.

Limitations

- Many respondents believe that public attention, including media coverage of the hearings, has waned over time.
- Some respondents believed that witnesses were able to evade tough questions, particularly as time passed. Other respondents believe that the HPC board members do not ask tough enough questions.
- Many respondents were skeptical the hearings provide strong public accountability, as they do not have a lasting influence on entities' behavior.

Cost Trends Report: Stakeholder Perspectives

The HPC develops annual **Health Care Cost Trends Reports** to assess overall health care spending growth patterns, analyze key cost drivers, and make policy recommendations for payers and providers to restrain cost growth.

Strengths

- Respondents commended the HPC for presenting data and trends about health system performance in a manner that makes complex information more easily understood.
- Recommendations are "on point," focusing on solutions to major cost drivers.
- State policymakers and agency respondents said they use the recommendations regularly to inform their policy decisions.

Limitations

- Relatively few of the policy recommendations have been adopted, raising questions about their influence on the policy process.
- The lag of almost two years between the data used to identify spending trends and key cost drivers, and the HPC's analysis and recommendations sometimes diminishes their relevance.

Performance Improvement Plans: Stakeholder Perspectives

Individual payer and provider entities with an annual rate of spending growth considered excessive may be required to develop and implement a **Performance Improvement Plan (PIP)**. The PIP follows a confidential review of the reasons and whether they are within the entity's control.

Strengths

- Provides deeper insight into payer and provider spending performance.
- Encourages entities to keep spending growth below the benchmark by raising the risk of having to submit a formal PIP.

Limitations

- With only one formal PIP requirement, despite many PIP referrals each year, the current PIP process may not be an effective accountability mechanism.
- Entities subject to the PIP process do not include some that are responsible for major cost growth, such as pharmaceutical companies and hospital spending for non-affiliated primary care providers.
- Criteria for PIP referrals focus on spending growth, and not on levels of spending.
- Fine for PIP non-compliance is low and unrelated to spending levels.

Overall Influence of the MA Health Care Cost Growth Benchmark

- The HPC achieved early success through effective use of its accountability tools and authority, persuading health care entities to hold spending growth below the benchmark.
- However, the influence of the benchmark on payers and providers has waned over time, as stakeholders realized the limits of the scope and authority of the HPC's accountability mechanisms.
- To address these limitations, most respondents recommended stronger enforcement and "more teeth" going forward.

Consider Potential Accountability Mechanisms for Nevada

Accountability Mechanisms in Other States (1 of 2)

California

- Recently passed cost growth benchmark legislation in 2022.
- Requires public reporting and annual public meetings.
- Progressive enforcement of compliance with cost growth benchmarks, beginning with technical assistance and increasing over time to include required testimony at public meetings, performance improvement plans, and assessment of escalating financial penalties.

Accountability Mechanisms in Other States (2 of 2)

Oregon

- Passed cost growth target legislation in 2021; accountability procedures not yet applied.
- Requires public reporting and annual public hearings.
- Requires performance improvement plans from any payer or provider organization that unreasonably exceeds the benchmark any year.
- Fines are assessed for late or incomplete submission of data and/or performance improvement plans.
- Payer or provider organizations that exceed the benchmark in any three out of five years are subject to a financial penalty that varies based on the amount of excessive spending.

Next month the PPC will hear a presentation from Oregon on its cost growth benchmark program.

Considerations for Nevada

- The NV cost growth benchmark BDR includes public reporting and an annual informational public hearing on health care cost trends and the factors contributing to such costs and expenditures.
- Following next month's presentation from OR, the PPC may choose to consider whether Nevada should pursue other accountability mechanisms for the cost growth benchmark.

Provider Price Caps and Provider Price Growth Caps

Provider Prices Have Been a Key Contributor to Health Care Cost Growth

- Trends in national health care spending from 2016 – 2020 show that provider **prices**, as opposed to utilization, are leading drivers of spending growth for individuals with employer-sponsored insurance. (Health Care Cost Institute 2020 Report)
  - Overall spending per person increased 9.3%, while utilization decreased a cumulative 5.4%. Over the same period, prices increased 15.8%.
  - Growth in spending was driven by increasing prices across all service categories: inpatient, outpatient, professional services, and prescription drugs.

What is a Provider Price Growth Cap?

It is a regulatory limit on the % by which insurer payments to providers can grow annually.

Price Growth Cap

- Limits the amount provider prices can grow each year.
  - Can be applied to just certain classes of providers where price growth has been problematic.
- Enforced through insurance regulation.

What is a Provider Price Cap?

It is a regulatory limit on the absolute level of provider prices.

Price Cap

- Can be applied in one or more of these ways:
  - Broadly across the commercial insured market
  - For out-of-network payments
  - Within PEBP
  - Within a public option
- Implemented through purchasing authority and/ or through insurance regulation.

Implement Provider Price Growth Caps and/or Price Caps (1 of 2)

Why do it?

- **Cost containment**: Provider prices are the primary factor driving health care spending growth.
- **Consumer affordability:** High prices hurt consumers, in the form of out-of-pocket costs as well as premiums, and harm access to care.
- **Transparency:** The market for provider pricing is non-transparent. It is also dysfunctional, with a high degree of price variation.
- **Resource reallocation**: Option to redirect spending to under-resourced sectors of health care as part of a broader policy agenda.

Implement Provider Price Growth Caps and/or Price Caps (2 of 2)

What is the evidence?

- **Rhode Island Price Growth Cap:** Spending decrease of 8% vs. control group of other states (Baum, *Health Affairs*, 2019)
- **Montana Price Caps**: Beginning in 2016, the state employee health plan limited hospital prices to a multiple of what Medicare pays. In the first two years, this initiative generated an estimated savings of $47.8 million across inpatient and outpatient services.
- **Oregon Price Caps:** Legislation passed in 2017 caps in-network and out-of-network hospital provider payments for the public employee benefit program at up to a specified percentage of the Medicare rate, with some hospitals exempted.

  - Also, evidence from modeling of federal proposals.

Key Components: Select Prices Subject to the Cap (1 of 2)

- Consider contribution to spending and spending growth.

  Examples include:

  - Hospital inpatient
  - Hospital outpatient
  - Professional services
  - Pharmacy (retail, medical)
  - Accountable Care Organization budgets

Key Components: Select Prices Subject to the Cap (2 of 2)

- Determine whether to apply within a specific program or more broadly.
  - Public employees
  - Public option
  - All out-of-network care
  - Broadly across commercial market

Key Components: Determine Level of Cap

Price Growth Cap

- Can tie to an economic indicator, such as Consumer Price Index (CPI), Core CPI, Personal Consumption Expenditures (PCE) or a Medicare market basket.

Price Caps

- Determine whether to peg to Medicare or a commercial standard.
- Determine at what percentile the cap should be set.
- Determine whether to set a floor.

For both, consider whether to modify over time and whether to include a transition period.

Key Components: Apply at Individual vs. Aggregated Level

- Price growth caps could be applied to each provider contract individually or across all of a given payer's contracted providers.
- Price caps could be applied to individual services or in aggregate across all services.

Summary and Challenges

- Provider price caps and price growth caps: *highly* effective in slowing cost growth…but not for the faint of heart!
- Expect intensive provider opposition because it will reduce the ability of providers to grow their commercial revenue.

Questions and Discussion

1. Should Nevada consider pursuing:
   - Provider price caps?
   - Provider price growth caps?
2. What is your rationale?
3. Do you require any additional information as you consider this policy option?

Please note, we are *not* asking for a recommendation (or vote) today. We may revisit this pair of strategies after we consider other strategy options during future meetings.

Prescription Drug Affordability Strategies

Why Focus on Pharmaceutical Spending?

- Pharmaceutical spending growth in Nevada is *significant*.
  - According the phase 1 cost driver analysis for Nevada Medicaid, pharmacy spending was among the top two categories of spending growth from 2016-2019 at 27%.
  - For PEBP, pharmacy spending grew an average of 16% per year from 2017-2020.
- According to a recent survey of Nevada residents, over half of respondents reported concern about prescription drug costs, with nearly 1 in 3 respondents reporting hardship over the past 12 months, such as skipping medications or not filling a prescription due to cost. Respondents across party lines expressed a strong desire for policymakers to enact solutions.
- While modest progress has been made at the federal level, states can take further action to control pharmaceutical spending.

NV Prescription Drug Transparency Laws

Existing prescription drug transparency laws include:

- DHHS is required to compile a list of prescription drugs essential for treating diabetes (Essential Diabetic Drugs), and a list of those drugs and other medications that had a significant price increase and cost more than $40 per course of therapy (NRS 439B.630)
- All manufacturers of the Essential Diabetes Drug List must submit to DHHS a report with data outlining drug production costs, profits, financial aid, and other drug-specific information and pricing data (NRS 439B.635). For drugs with a recent significant price increase, manufacturers must submit a report providing a justification for these price increases (NRS 439B.640).
- Pharmacy Benefit Managers (PBMs) must submit reports regarding rebates negotiated with manufacturers for drugs on both the Diabetic Essential Drug List and the Over $40 Drug List (NRS 439B.645).
- DHHS is required to maintain a registry of pharmaceutical sales representatives that market prescription drugs in Nevada (NRS 439B.660).

Pending Prescription Drug Legislation

The Nevada Joint Interim Standing Committee on Health and Human Services included the following BDRs for the 2023 legislative session:

- Licensing of Pharmaceutical Sales Representatives
  - Proposed legislation requires DHHS to license and regulate pharmaceutical sales representatives who are operating within the state. Any fees collected from the licensure must only be used to cover the costs of the program and for improving transparency of prescription drug costs.
- Licensing and Regulation of PBMs
  - Requires a PBM operating in NV to obtain a license from DHHS.
  - Prohibits PBMs from using spread pricing.
  - Requires PBMs to allow clients full audit rights for compliance.
  - Establishes a fiduciary duty for a PBM to a third-party payer.
  - Prohibits PBMs and certain health plans from reimbursing less for prescription drugs purchased under the 340B program.

Overview of Approaches Being Considered by Other States

Control prices and costs

1) Upper payment limits
2) Reference pricing
3) Prohibition of unsupported price increases
4) Penalization of excessive price increases

Use purchasing power

1) State purchasing pool

Promote use of less expensive drugs

1) Generic substitution
2) Academic detailing
3) Importation

Enhance transparency

1) Reporting of drug spending
2) Regulating PBMs

Focus for Today's Discussion

- Discuss strategies states have proposed or enacted to control costs and bring down overall pharmaceutical spending.
  - Excludes strategies that are focused solely on consumer affordability (i.e., out-of-pocket costs).
- Focus on the commercial market
  - Medicaid and state employee health plans have additional levers within their programs as purchasers.
- Many of these efforts are recent, so experience, especially with implementation, is limited to date.

Why Not Just Set Drug Prices?

- Federal preemption issues related to patent law
  - Any state that seeks to limit industry profits is allegedly violating federal patent rights, which triggers the Supremacy Clause. This clause claims that federal law is "supreme" and will always supersede state law.
- Commerce clause
  - The Dormant Commerce Clause prohibits states from passing laws that discriminate against out-of-state commerce, unduly burden interstate commerce, or regulate commerce occurring outside the state.

How to Lower Prices Without Setting Prices?

Two proposed approaches to date:

1) Regulate payments, not prices
   - Pro: Directly reduces spending.
   - Con: Cannot be mandated in the self-insured market.
2) Tax excess prices
   - Pro: Applies to all sales, not just those paid for by fully insured plans.
   - Con: Does not directly reduce spending. Taxes may go to general revenue or a fund focused on helping consumers, but the impact on spending is indirect.

Price Control Strategies (1 of 2)

Strategy	Description	State Examples	Comments
1. Upper Payment Limits (UPLs)	• Identify drugs subject to the UPL • Determine the UPL • Prohibit payments in excess of the UPL • Usually adopted in conjunction with creation of a Prescription Drug Affordability Board	CO, WA, maybe MD	Applies to relatively few drugs; significant effort to implement/ administer
2. International Reference Pricing	• Identify drugs subject to the reference rate • Determine reference rate (e.g., Canadian pricing) • Prohibit payments in excess of the reference rate	Passed in ME (2022); Bills introduced in HI, NC, ND, OK, and RI	Using international reference prices may be simpler than establishing upper payment limits

Price Control Strategies (2 of 2)

Strategy	Description	State Examples	Comments
3. Prohibition of Unsupported Price Increases	• Imposes penalty on manufacturers of drugs with "unsupported" price increases, as identified by ICER	Bills introduced in HI, ME and WA	Applies to drugs identified in ICER's assessment; has not yet passed in any state
4. Penalization of "Excess" Prices	• Impose a penalty on manufacturers for selling drugs at prices that grow faster than inflation	Proposed by Governors of CT and MA	Applies to drugs whose prices grow faster than the target rate; has not yet passed in either state

Discussion

1. Should Nevada consider pursuing prescription drug affordability strategies in addition to the Prescription Drug Affordability Board?
2. What is your rationale?
3. Do you require any additional information as you consider these policy options?

Please note, we are *not* asking for a recommendation (or vote) today. We may revisit these strategies after we consider other strategy options during future meetings.

Acronyms

- ARPA – American Rescue Plan Act
- IFC –Interim Finance Committee
- DHHS – Department of Health and Human Services
- OOA – Office of Analytics
- PEBP – Public Employees' Benefits Plan
- BDR – Bill Draft Request
- WNTR - Winter
- CHESS - Consumer Healthcare Experience State Survey
- HPC – Health Policy Commission
- ICER – Institute for Clinical and Economic Review