Health Care Cost Transparency Board Retreat

February 9, 2024

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

HEALTH CARE COST TRANSPARENCY BOARD AGENDA

February 9, 2024
10:00 – 3:30 p.m.
Hybrid Meeting

Board Members:					
☐	Susan E. Birch, Chair	☐	Jodi Joyce	☐	Kim Wallace
☐	Jane Beyer	☐	Gregory Marchand	☐	Carol Wilmes
☐	Eileen Cody	☐	Mark Siegel	☐	Edwin Wong
☐	Lois C. Cook	☐	Margaret Stanley		
☐	Bianca Frogner	☐	Ingrid Ulrey		

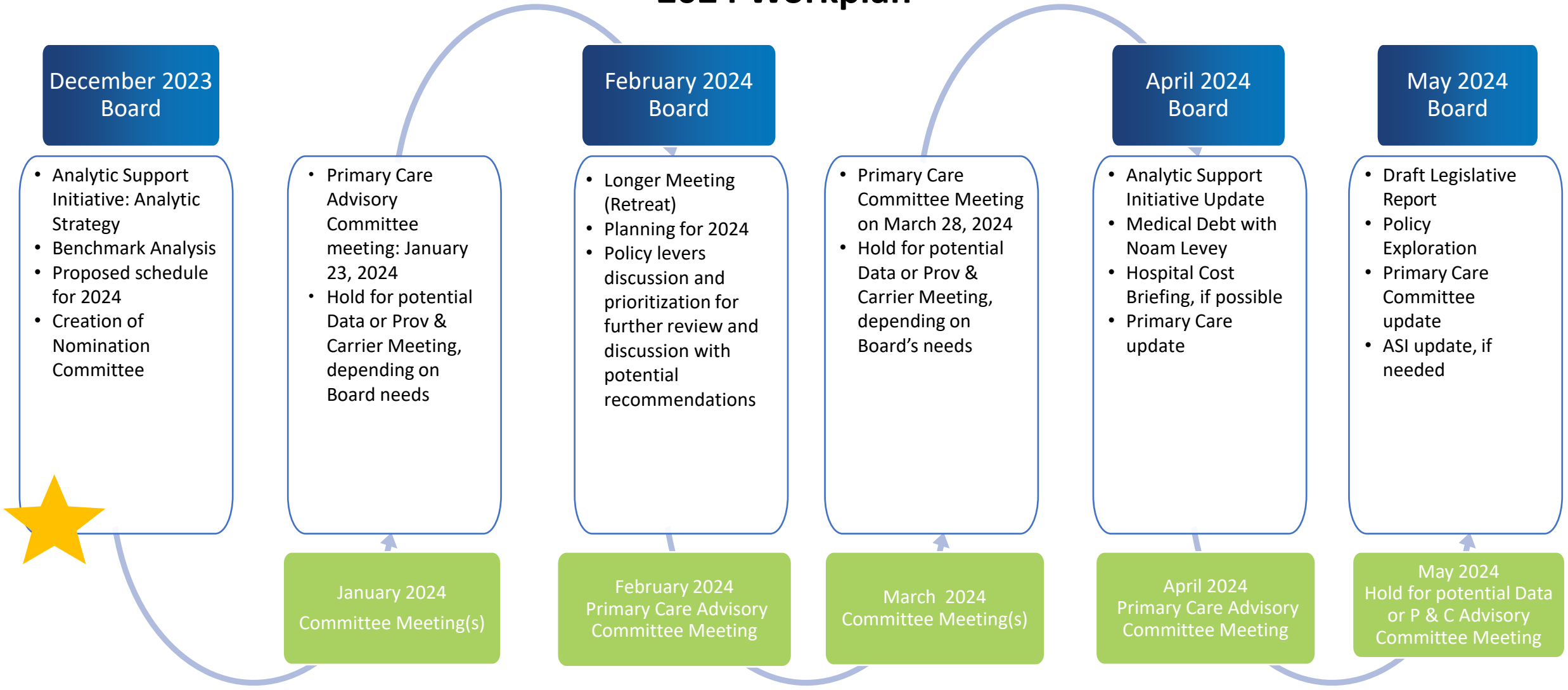
Time	Agenda Items	Tab	Lead
10:00 – 10:05 (5 min)	Welcome, roll call and new Board Member introduction	1	Sue Birch, Director Health Care Authority
10:05-10:15 (10 min)	Looking ahead • Introduction to Health Management Associates team	2	Sue Birch, Director Health Care Authority
10:15 – 10:20 (5 min)	Approval of the December Meeting Summary	3	Mandy Weeks-Green, Cost Board Director Health Care Authority
10:20 - 11:00 (40 min)	Affordability Reports • Office of the Insurance Commissioner • Office of the Attorney General	4	Jane Beyer, Office of the Insurance Commissioner Kelley Richburg, Office of the Attorney General
11:00 - 12:00 (60 min)	Individual Presentations and Panel Discussion from Cost Boards in Massachusetts, Oregon, and Rhode Island	5	David Seltz, Executive Director, Massachusetts Health Policy Commission Cory King, Rhode Island Office of the Health Insurance Commissioner Sarah Bartelmann, Oregon's Cost Growth Target Program Manager
12:00 - 12:15 (15 min)	Break		
12:15 - 12:30 (15 min)	Facilitated Discussion of Today's Presentations Over Lunch		Facilitators: Liz Arjun and Gary Cohen, Health Management Associates Theresa Tamura, Health Care Authority
12:30 – 1:00 (30 min)	Legislative Updates	6	Evan Klein & Mich'l Needham Health Care Authority
1:00 – 2:30 (90 min)	Creating the Board's Policy Priorities for 2024 Presentation and Discussion	7	Liz Arjun and Gary Cohen Health Management Associates
2:30 - 2:45 (15 min)	Break		

2:45 - 3:00 (15 min)	Committees and Charters Discussion	8	Liz Arjun and Gary Cohen Health Management Associates
3:00- 3:10 (10 min)	Updates on the Data Call for 2024	9	Sheryll Namingit, Health Research Manager Health Care Authority
3:10 – 3:25 (15 min)	Public comment	10	Sue Birch, Director Health Care Authority
3:25- 3:30 (5 min)	Wrap Up and Adjourn The Board's next meeting is April 10, 2024, 2-4 PM • Noam Levey will present on Medical Debt		Sue Birch, Director Health Care Authority

Unless indicated otherwise, meetings will be hybrid with attendance options either in person at the Health Care Authority or via the Zoom platform.

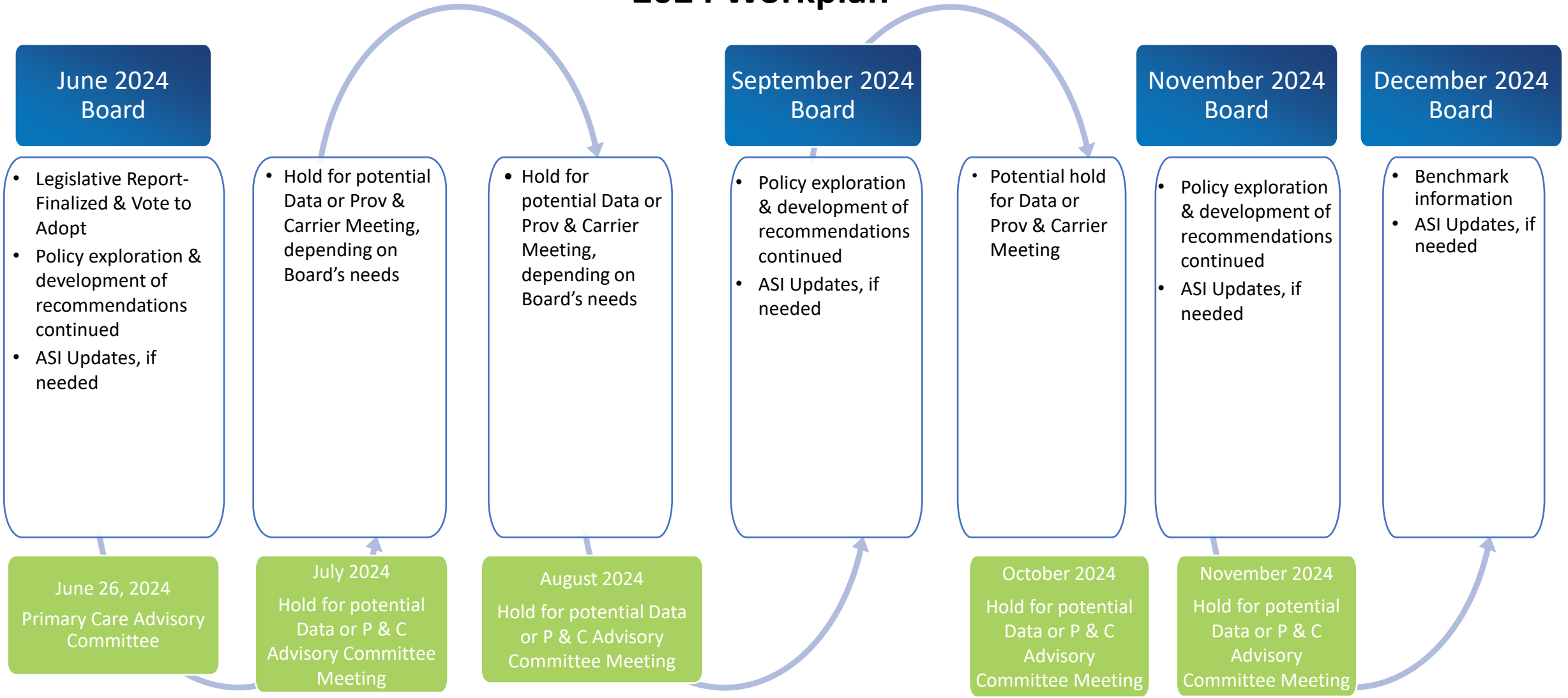
Tab 2

Health Care Cost Transparency Board
2024 Workplan



Workplan will change depending on progress made in each meeting

Health Care Cost Transparency Board
2024 Workplan



Workplan will change depending on progress made in each meeting

Tab 3

Washington State Health Care Authority

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Health Care Cost Transparency Board meeting summary

December 7, 2023

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
2–4 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the Board is available on the **Health Care Cost Transparency Board webpage**.

Members present

Sue Birch, Chair
Jane Beyer
Eileen Cody
Bianca Frogner
Margaret Stanley
Ingrid Ulrey
Kim Wallace
Edwin Wong

Members absent

Lois Cook
Jodi Joyce
Mark Siegel
Carol Wilmes

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Chair Sue Birch welcomed members of the Health Care Cost Transparency Board (the Board). She encouraged board members to read a New York Times article that explores how America spends more money as a proportion of its economy than any other advanced industrialized country. Chair Birch also pointed out a White House press release outlining its recent efforts by the White House to reign in health care costs and concluded by providing an overview of the meeting agenda.

Meeting summary review from the previous meeting

The Board voted by consensus to adopt the October 2023 meeting summary. There was feedback by board members regarding an updated format for the summary that included precise timestamps. Generally, these changes were accepted by members, but there was a preference for future summaries to provide a brief synopsis of discussion.

Public comment

Chair Sue Birch called for comments from the public. Jeb Shepard, of WSMA, provided public comment regarding challenges in the practician community, referencing recent articles from the Seattle Times and the Kitsap Sun. The Seattle Times article describes the recent closure of a Seattle-area OB/GYN due to high costs and low reimbursement for Medicare and Medicaid patient care, and that these pressures drive consolidation in Washington. The piece in the Kitsap Sun outlines investments made that, while raising costs, have improved access to quality care.

Katerina LaMarche, Washington State Hospital Association (WSHA), had questions regarding whether there would be a reconsideration or reaffirmation of the benchmark for 2024 given higher labor costs, citing data from the Bureau for Labor Statistics that showed a 33 percent increase in RN wages between 2013 and 2022. Additionally, Katerina LaMarche asked that meetings be set far in advance with set agendas to maximize participation and encourage feedback. Chair Birch responded that the workplan and key dates for 2024 would be shared near the end of the meeting.

Sharon Eloranta, Medical Director at the Washington Health Alliance, brought a report on the health waste calculator to the board's attention. With the newest iteration, data from the Washington All Payer Claims Database (APCD) was run through the calculator, along with poverty data from the Area Deprivation Index dataset to allow users to explore health waste in the context of socioeconomic challenges.

Written public comments can be found in the meeting materials.

2024 Analytic Strategy for the Analytic Support Initiative

Dr. Joseph Dieleman, Associate Professor at the University of Washington's Institute for Health Metrics and Evaluation (IHME)

Dr. Dieleman presented an analytic strategy based on discussions and feedback from the Board, Health Care Authority, the Board's Advisory Committee on Data Issues, and health care subject matter experts as a part of the Analytic Support Initiative (ASI). Three analyses were proposed, building on a foundation of IHME's Disease Expenditure Project (DEX), with a fourth optional analysis. The first three analysis included: 1) estimates of health care spending by disease, payer category, and age/sex group, 2) age and risk-standardizing those estimates, and 3) using the estimates to investigate cost drivers. All outputs would be presented by county, CMS Geographic Rating Area, and Accountable Community of Health. Maps, tables, and plots would be created as the primary outputs of the analyses. Dr. Dieleman presented a fourth analysis that would investigate price differentials as a function of sites of care. The presentation touched upon potential use cases for these data analyses and products that have been of interest to cost boards and legislatures in other states and concluded with a high-level timeline for delivery of the strategy. Comments from the board centered on whether the products included a dashboard or interactive data product, with a consensus to perform the first three analyses, but not perform the fourth in favor of working to build a dashboard output. This strategy was adopted into a motion and **passed unanimously** by the board.

Preliminary Spending Growth Benchmark of the Cost Board

Vishal Chaudhry, Chief Data Officer, HCA

Vishal Chaudhry presented preliminary results of the Washington Health Care Spending growth benchmark data. Prefacing the data, Vishal Chaudhry emphasized that there is still ongoing work to finalize results. The presentation began with a review of the reporting cycle timeline over the next five years, key terminology, and

which payers submitted data that went into the report. The context of the data and caveats of what data is still missing was communicated prior to presenting the State and Market levels results for 2017-2019. Total health care expenditures in Washington were $48B in 2019, reflecting a cost growth of 7.15 percent and 5.81 percent from 2017 and 2018 levels respectively. State Spending by Category (Claims, Non-Claims, Retail Rx, Long Term Care, Physician, Hospital Inpatient, and Hospital Outpatient) showed little change in proportion between 2017-2019. Medicaid showed Per Member Per Year (PMPY) yearly growth of 13.8 and 11.9 percent in that same period, with Sue Birch and Megan Atkinson, HCA Chief Financial Officer, offering policy-related context for the growth during this period. Much of the growth was a product of legislative directives that increased behavioral health spending, provider reimbursement rates, and expanded eligibility. Medicare spending PMPY grew slower than Medicaid in the same time period (6.2 and 7.0 percent), even while total Medicare spending is significantly higher than that of Medicaid. Commercial spending increased 4.5 and 4.0 percent between 2017 and 2019. Vishal Chaudhry concluded by discussing 2024 work that included finalization of this data, the next data call for 2021 and 2022, and exploration of cost containment strategies to recommend to the Legislature. The discussion included additional explanations of where specific spend categories appear in benchmark categories, how to handle age- and gender-adjustment, and working with data submitters to accurately capture primary care spending with an updated submission template.

Review of Broad vs. Narrow Definitions of Primary Care

Dr. Judy Zerzan-Thul, Chief Medical Officer, HCA

Dr. Judy Zerzan-Thul provided an update on the use of broad versus narrow definition of Primary Care for data categorization. In a prior meeting, the Board voted to move forward with the narrow definition. Using the narrow definition will require greater investment for organizations to achieve the 12 percent target of total health care spending and is in alignment with other states. A brief discussion by the board reviewed the rationale behind specific types of care categorized as falling under either the broad or narrow definition.

Nomination Committee for Board Vacancies

Sue Birch, Chair of the Health Care Cost Transparency Board

Chair Birch led discussion on a proposal to create a Nomination Committee for the specific function of identifying, vetting, and presenting qualified candidates for committees to the Board for approval. The context for the creation of the nomination committee is news that three members of advisory committees are stepping down. Previously, filling committee vacancies had fallen either to the Chair or staff, but the time was right to open the process up. Chair Birch specified that the Nomination Committee could also serve the function of identifying and vetting *Board-level* candidates for presentation to the Governor, who is charged with making the appointments. Finding general support among the Board, Chair Birch asked for a motion to approve the proposal and it was seconded, **passing unanimously**. Mandy Weeks-Green, HCA's Cost Board and Commissions Director, specified that membership in the Nomination Committee likely could not be delegated due to a lack of authority. To fill an existing vacancy, Board Member Eileen Cody moved to appoint Eric Lewis, the Chief Financial Officer of WHSA, to the Board's Advisory Committee of Health Care Providers and Carriers. The motion was seconded and **approved**. A proposal to send the remaining two committee vacancies to a new Nomination Committee was moved, seconded, and **approved unanimously**.

Nomination Committee for Board Vacancies

Mandy Weeks-Green, Board and Commissions Director at the Health Care Authority

The final discussion of the meeting was led by Mandy Weeks-Green, centering on a discussion of the workplan and calendar for 2024. The early part of the calendar is driven by the legislative mandate to submit a Legislative Report by August. The contents of this report must be reviewed, discussed, and ultimately approved by June. A February 9th Board Retreat was introduced to board members and other meeting dates in 2024 for the Board. There was a suggestion to have some flexibility on the in-person meeting date and a review of when the ASI outputs would be reviewed.

Washington State Health Care Authority

Adjournment

The meeting was adjourned at 4:04 p.m.

Tab 4

Washington State Health Care Authority

Preliminary Affordability Report

Presentation to Health Care Cost Transparency Board

Jane Beyer, Senior Health Policy Advisor

February 9, 2024

OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

Affordability challenges for Washingtonians

Health Care Affordability Growing Problem for All

Consumers: A 2022 survey in Washington found:

- 62% of people had experienced at least one health care affordability burden in the past year, including rationing prescriptions, delaying or going without necessary care and depleting their savings.
- 81% said they worried about affording health care in the future.

Employers: In 2022, OIC found health care costs for the commercial health insurance market in Washington increased by 13%, nearly double the rate of inflation of 7%, between 2016 and 2019.

State Budget: Washington state now spends more than 20% of its general fund budget on health care.

Legislative direction

Legislative direction

- 2023 Legislature directed the Office of the Insurance Commissioner and the Office of the Attorney General to evaluate policy options that could improve overall affordability for consumers, employers and taxpayers.
    - Preliminary Reports – December 1, 2023
    - Final reports – August 1, 2024

Components of Preliminary Reports

Office of the Insurance Commissioner report:

- The structure of Washington's current health care system, including information about vertical and horizontal consolidation of health insurers, hospitals and health care providers.
- Private equity investment trends in Washington.
- An overview of potential policy options to improve health care affordability, some already adopted to some degree in Washington.

Attorney General Office report:

- An overview of current enforcement of federal and state antitrust laws aimed at securing strong market competition.
- A review of how other states monitor and challenge health care consolidation (i.e. mergers and acquisitions).
- A review of non-compete agreements in health care and anti-competitive provisions in insurer/provider contracts.

Structure of Washington's health care system

Vertical and Horizontal Integration Among Hospitals

- 40 of the 101 hospitals in the state are part of the five largest hospital systems: Providence/Swedish, MultiCare, Virginia Mason Franciscan Health, UW Medicine, and PeaceHealth and another 15 are part of smaller multi-hospital systems.

- 79.51% of all licensed beds are part of multi-hospital systems.

- In 2022, 9% of hospital systems owned skilled nursing facilities (SNFs), 82% owned hospital-affiliated clinics, 28% owned freestanding clinics, and 13% own a home health agency.

- Approximately 50% of physicians are employed by hospitals and of these, 65.6% are employed by multi-hospital systems.

Vertical Integration Among Insurers

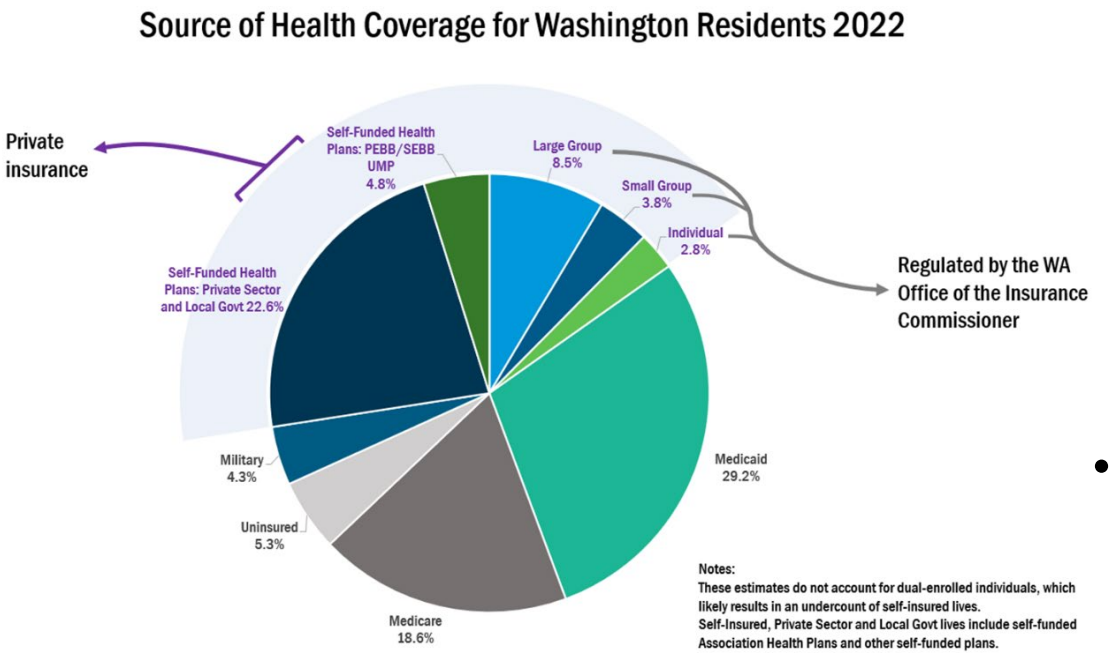
- Insurers actively purchasing physician groups and clinics- United HealthCare is reportedly the largest employer of physicians nationally.
- Insurers or their holding companies have integrated with other sectors including:
  - Pharmacy benefit managers (PBMs)
  - Pharmacy services,
  - Health care benefit managers
  - Third-party administrators
  - Data and analytics
- Beyond acting as health insurers, also involved in various aspects of the care that Washingtonians receive.

Private Equity

- Growing national trend – little public information available and some controversy about the impact on cost and quality of care.
    - Recent review of 55 studies: private equity ownership was most consistently associated with increased cost to patients/payers and mixed to harmful impacts on quality of care.
- Key investment areas: specialists (dermatology, ophthalmology, gastroenterology, primary care, OB/GYN, radiology, orthopedics, oncology, urology, and cardiology) and other health care facilities and services, e.g. hospice and home health care.
- From 2014–2023, 97 health care acquisitions in Washington State
- Private equity & physician staffing companies.
    - TeamHealth – 1 of 6 largest emergency medicine staffing companies nationally.
    - US Anesthesia Partners – Operates in 8 states; largest majority physician-owned + led anesthesia group in the PNW.

Affordability policy options

Several Sources of Coverage Require Different Policies to Address Affordability



- Washingtonians receive health coverage from different sources, each subject to different laws and regulations, with oversight by different state and federal authorities.
- Addressing affordability across these markets may require a combination of policy options.

Health Care Cost Growth Benchmarks

- Cost growth benchmarks establish targets for how much health care spending should grow each year. States set statewide benchmarks; some also apply these benchmarks to providers and payers.

- Established in nine states and have shown mixed results. Massachusetts, the most mature program, recently issued recommendations for improvement, including a need to focus on constraining provider prices.

- Washington's HCCTB, established in 2020, will issue its first report on baseline health care expenditures in Fall 2023.

- HCCTB lacks authority to take action against a provider or payer that exceeds the benchmarks, such as requiring Performance Improvement Plans.

Health Insurance Rate Review

- Process where state Insurance Departments (OIC in Washington), review proposed health plan rates and must approve them prior to their going into effect.

- 43 states have prior rate approval over the individual market, 38 states have prior rate approval over the small group market. Rhode Island imposes a cap on the amount hospitals can increase their prices each year and has a process for large group health plan rate prior approval.

- Under ERISA, states cannot require rate review for self-funded health plans.

- Washington requires prior rate approval only in the individual and small group markets.

Reinsurance

- Reinsurance programs lower premiums for consumers in the individual market by paying a portion of high-cost claims incurred by health insurers.

- 17 states have reinsurance programs that lowered premiums from 5% to 38% in 2022.

- Washington considered reinsurance in 2018 but did not enact it due to the potential cost to the state.

Reference-Based Pricing

- Establishes standard reimbursement rates that are tied to an already defined price standard, such as a percentage of Medicare, for a set of health care services.

- Montana and Oregon established this for their state employee programs (and school employees in Oregon) and realized significant savings as a result.

- Washington has implemented reference-based pricing for its public option plan, Cascade Select. Provider reimbursement is limited to 160% of Medicare in the aggregate. To date, premium increases have been lower than other plans on the Exchange.

All-Payer Model

- An All-Payer Model establishes rates for hospitals that are the same for all payers and sets global budgets for hospital revenue.

- Maryland only state will all-payer model. Has evolved over time 10+ years to a Total Cost of Care Model that expands all-payer rate setting from hospitals to include primary care and specialty providers and provides support and incentives for care redesign.

- Washington had a hospital rate-setting statute in the 1970's and '80s. It was repealed in 1989.

Facility Fee Reform

- Additional oversight and limitation of "facility fees" for care received in outpatient and physician office settings that are part of hospital system.

- Few other states have addressed. Those that have focus on limitations about when and where fees can be charged and additional reporting and transparency; Connecticut has been the most aggressive.

- Washington: Clinics charging facility fees must disclose that the clinic is part of a hospital system and that the patient may be charged a separate fee that could result in additional out-of-pocket expenses.

Medical Loss Ratio Requirements

- The ACA requires insurers in the individual and small group markets to pay 80% and insurers in the large group market pay 85% of the premium collected towards medical care or quality improvement efforts.

- Can be seen as a tool to reduce premiums by limiting administrative expenses and profits. Massachusetts has adopted a higher MLR of 88%.

- Washington uses the minimum MLR requirements established by the ACA.

Public Option Plans

- Public Option plans are designed to be the most affordable plans in the individual and small group markets

- Colorado established a public option plan that is intended to decrease premiums by 15% over three years. Too early to know if goal will be met.

- 2023 enrollment in Washington's public option plans (Cascade Select) at 11% of Washington Healthplanfinder individual market enrollment. Premium increases in public option plans lower than other plans offered on the Exchange. In 2024, Cascade Select will be the lowest cost silver plan in 31 counties.

- Nevada also in the process of implementing a public option.

State Exchange Subsidies

- State funds lower premiums and provide cost sharing assistance for consumers enrolled in Exchange plans.

- Eight states have implemented some form of state-based premium or cost-sharing assistance.

- Washington has a state-funded premium subsidy to Exchange consumers who enroll in Cascade Care silver or gold plans. Dedicated funding for subsidies for certain immigrant groups.

Prescription Drug Pricing Regulation

- Programs to increase transparency, cap out of pocket costs for prescription drugs and oversee Pharmacy Benefit Managers.

- Eight states have implemented programs to oversee and regulate prescription drug prices; insufficient experience to determine their effectiveness.

- Washington's Prescription Drug Affordability Board was established in 2022. Authorized to conduct up to 24 affordability reviews of drugs that have been on the market for 7 years. PDAB had its first meeting in October 2023.

Individual Mandate

- Requires individuals to participate in health insurance coverage to promote universal enrollment and a larger risk pool- penalties could be used to support affordability provisions.

- Five states have enacted individual mandates.

- Washington enacted an individual mandate as part of the 1993 Health Services Act, which was repealed in 1995.

Next Steps

- Perform in-depth economic and actuarial impact analysis on selected policy options and conduct key informant interviews.
- Principles in choosing options for analysis:
  - Amenable to actuarial and economic analysis
  - Mix of targeting price directly & addressing affordability through other means
  - Mix of impacting primarily carriers vs. primarily providers
  - Proviso requires feasibility of global hospital budget strategy in at least one county and/or region
- Findings in final report due August 2024.

Questions?

Jane Beyer

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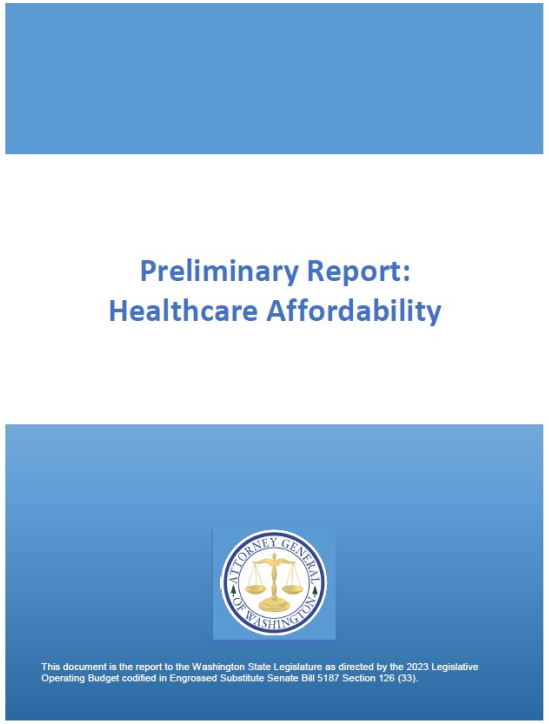
Healthcare Affordability Preliminary Report

HEALTH CARE COST TRANSPARENCY BOARD RETREAT

FEBRUARY 9, 2024

Topics

- Healthcare Transaction Notifications and Reviews
- Anticompetitive Contract Clauses



Available Online

Why Care about Consolidation?

It is linked to:

- Increased patient prices[1] without improvements in the quality of care[2];
- Impacts on healthcare labor markets, such as suppressed wage growth for hospital workers[3] and degraded working conditions.[4]

See final slide for citations.

Transaction Notice & Review

- Healthcare entities must notify states before completing a merger, acquisition, or other affiliation.
- Washington receives notice of a wide range of transactions and reviews for harms to competition.
- Some states also review transactions for impacts to affordability, access to services, and quality of care.
- Some states have statutory authority to approve, reject or impose conditions on transactions without going to court.

Washington Law

- ✓ Requires notice of transactions involving healthcare providers besides non-profit hospitals.
- ✓ Covers in-state transactions regardless of size and dollar thresholds (out-of-state entities are subject to the requirement if they generate at least $10 million or more in healthcare service revenue from Washington patients).
- ✓ Mandates reporting of contract affiliations between hospitals and groups of seven or more affiliated providers.
- ✓ Focuses on capturing anticompetitive transactions.
- ✓ Protects the confidentiality of information submitted to the AGO.

Washington Law

- ☒ Does not cover physician groups with fewer than seven providers.
- ☒ Does not direct the AGO to consider the impact of transactions on affordability, access to services, or quality of care.
- ☒ Does not authorize the AGO to administratively approve, reject or impose conditions on transactions without going to court.
- ☒ Does not provide for a public involvement process.

Other States

	California	Massachusetts	Oregon
Agency	Office of Health Care Affordability	Health Policy Commission, an independent state government agency	Oregon Health Authority
Year of First Review	2024	2013	2022
Factors for Review	Competition; consolidation; costs to payers, purchasers, or consumers; availability or accessibility of healthcare services; quality of care; labor market impacts	Impact to healthcare cost benchmark or competitive market	Competition; costs to consumers; access to services; health equity and healthcare quality

Other States

Information Available Online		
	Massachusetts	Oregon
Transaction notice	✓	✓
One-page summary of proposed transaction		✓
Preliminary review report	✓	✓
Public comments	✓	✓
Comprehensive review report	✓	✓

Oregon Health Care Marketplace Annual Report Available Online

Anticompetitive Contract Clauses

- Certain anticompetitive contract clauses can result in increased costs for patients.
- Some states are restricting or banning these clauses.
- Washington has not banned most anticompetitive contract clauses.
- Legislation can be more efficient and effective than litigation, which is reactive and resource-intensive.

Non-Compete Agreements

- **Non-compete agreements restrict workers' job mobility. In healthcare, they can impact provider-patient relationships.**
- **Washington restricts non-compete agreements for employees and independent contractors making below a certain amount – physicians and other healthcare workers often earn more.**
- **Other states restrict non-compete agreements outright or have specific restrictions on non-competes involving physicians and other healthcare providers.**

Related Legislation

- Senate Bill 5241 – Keep Our Care Act

- House Bill 2066 – addressing affordability through health care provider contracting

Questions?

Kelly Richburg, Kelly.Richburg@atg.wa.gov, 206-389-2130

Citations

[1]*See e.g.,*Karyn Schwartz *et al*., *What We Know About Provider Consolidation*, KAISER FAMILY FOUND. (Sept. 2, 2020); *see also*, DAVID DRANOVE & LAWTON R. BURNS, BID MED: MEGAPROVIDERS AND THE HIGH COST OF HEALTH CARE IN AMERICA (2021); Nicholas C. Petris Center at the School of Public Health, University of California, Berkeley, *Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums* 44 (2018); Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, 23 HEALTH AFFAIRS 175 (2004).

[2]Samuel M. Chang, et al., *Examining the Authority of California's Attorney General in Health Care Merger*, California Healthcare Found., (Apr. 2020).

[3]Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals* (Washington Ctr. for Equitable Growth, Working Paper, 2018) (finding evidence of negative wage growth among skilled workers following recent hospital mergers).

[4]For example, after a merger, providers may see more patients per day without an increase in wages. *See generally*, Carley Thornell, *Physicians report that organizational and technology changes are among the biggest burnout factors*, athenahealth, (July 2, 2021) (reporting on findings from 799 physician respondents between October and December 2020).

Tab 5

Washington State Health Care Authority

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Presenters do not have slides to share for this portion of the meeting.

However, they have shared several resources and materials that have been placed in the Appendix.

Tab 6

Washington State Health Care Authority

ESHB 1508 - H AMD **799**
By Representative Macri

Strike everything after the enacting clause and insert the following:

"Sec. 1. RCW 70.390.040 and 2020 c 340 s 4 are each amended to read as follows:

(1) The board shall establish an advisory committee on data issues and ((~~an~~)) a health care stakeholder advisory committee ((~~of health care providers and carriers~~)). The board may establish other advisory committees as it finds necessary. Any other standing advisory committee established by the board shall include members representing the interests of consumer, labor, and employer purchasers, at a minimum, and may include other stakeholders with expertise in the subject of the advisory committee, such as health care providers, payers, and health care cost researchers.

(2) Appointments to the advisory committee on data issues shall be made by the board. Members of the committee must have expertise in health data collection and reporting, health care claims data analysis, health care economic analysis, ((~~and~~)) actuarial analysis, or other relevant expertise related to health data.

(3) Appointments to the health care stakeholder advisory committee ((~~of health care providers and carriers~~)) shall be made by the board and must include the following membership:

(a) One member representing hospitals and hospital systems, selected from a list of three nominees submitted by the Washington state hospital association;

(b) One member representing federally qualified health centers, selected from a list of three nominees submitted by the Washington association for community health;

(c) One physician, selected from a list of three nominees submitted by the Washington state medical association;

(d) One primary care physician, selected from a list of three nominees submitted by the Washington academy of family physicians;

(e) One member representing behavioral health providers, selected from a list of three nominees submitted by the Washington council for behavioral health;

(f) One member representing pharmacists and pharmacies, selected from a list of three nominees submitted by the Washington state pharmacy association;

(g) One member representing advanced registered nurse practitioners, selected from a list of three nominees submitted by ARNPs united of Washington state;

(h) One member representing tribal health providers, selected from a list of three nominees submitted by the American Indian health commission;

(i) One member representing a health maintenance organization, selected from a list of three nominees submitted by the association of Washington health care plans;

(j) One member representing a managed care organization that contracts with the authority to serve medical assistance enrollees, selected from a list of three nominees submitted by the association of Washington health care plans;

(k) One member representing a health care service contractor, selected from a list of three nominees submitted by the association of Washington health care plans;

(l) One member representing an ambulatory surgery center selected from a list of three nominees submitted by the ambulatory surgery center association; ((~~and~~))

(m) Three members, at least one of whom represents a disability insurer, selected from a list of six nominees submitted by America's health insurance plans;

(n) At least two members representing the interests of consumers, selected from a list of nominees submitted by consumer organizations;

(o) At least two members representing the interests of labor purchasers, selected from a list of nominees submitted by the Washington state labor council; and

(p) At least two members representing the interests of employer purchasers, including at least one small business representative, selected from a list of nominees submitted by business organizations. The members appointed under this subsection (3)(p) may not be directly or indirectly affiliated with an employer which has income from health care services, health care products, health insurance, or

other health care sector-related activities as its primary source of revenue.

Sec. 2. RCW 70.390.050 and 2020 c 340 s 5 are each amended to read as follows:

(1) The board has the authority to establish and appoint advisory committees, in accordance with the requirements of RCW 70.390.040, and shall seek input and recommendations from ((~~the~~)) relevant advisory committees ((~~on topics relevant to the work of the board~~)).

(2) The board shall:

(a) Determine the types and sources of data necessary to annually calculate total health care expenditures and health care cost growth, ((~~and to~~)) establish the health care cost growth benchmark, and analyze the impact of cost drivers on health care spending, including execution of any necessary access and data security agreements with the custodians of the data. The board shall first identify existing data sources, such as the statewide health care claims database established in chapter 43.371 RCW and prescription drug data collected under chapter 43.71C RCW, and primarily rely on these sources when possible in order to minimize the creation of new reporting requirements. The board may use data received from existing data sources including, but not limited to, publicly available information filed by carriers under Title 48 RCW and data collected under chapters 43.70, 43.71, 43.71C, 43.371, and 70.405 RCW, in its analyses and discussions to the same extent that the custodians of the data are permitted to use the data. As appropriate to promote administrative efficiencies, the board may share its data with the prescription drug affordability board under chapter 70.405 RCW and other health care cost analysis efforts conducted by the state;

(b) Determine the means and methods for gathering data to annually calculate total health care expenditures and health care cost growth, and to establish the health care cost growth benchmark. The board must select an appropriate economic indicator to use when establishing the health care cost growth benchmark. The activities may include selecting methodologies and determining sources of data. The board shall ((~~accept~~)) solicit and consider recommendations from the advisory committee on data issues and the health care stakeholder advisory committee ((~~of health care providers and carriers~~)) regarding the value and feasibility of reporting various categories of information under (c) of this subsection, such as urban and rural,

public sector and private sector, and major categories of health services, including prescription drugs, inpatient treatment, and outpatient treatment;

(c) Annually calculate total health care expenditures and health care cost growth:

(i) Statewide and by geographic rating area;

(ii) For each health care provider or provider system and each payer, taking into account the health status of the patients of the health care provider or the enrollees of the payer, utilization by the patients of the health care provider or the enrollees of the payer, intensity of services provided to the patients of the health care provider or the enrollees of the payer, and regional differences in input prices. The board must develop an implementation plan for reporting information about health care providers, provider systems, and payers;

(iii) By market segment;

(iv) Per capita; and

(v) For other categories, as recommended by the advisory committees in (b) of this subsection, and approved by the board;

(d) Annually establish the health care cost growth benchmark for increases in total health expenditures. The board, in determining the health care cost growth benchmark, shall begin with an initial implementation that applies to the highest cost drivers in the health care system and develop a phased plan to include other components of the health system for subsequent years;

(e) Beginning in 2023, analyze the impacts of cost drivers to health care and incorporate this analysis into determining the annual total health care expenditures and establishing the annual health care cost growth benchmark. The cost drivers may include, to the extent such data is available:

(i) Labor, including but not limited to, wages, benefits, and salaries;

(ii) Capital costs, including but not limited to new technology;

(iii) Supply costs, including but not limited to prescription drug costs;

(iv) Uncompensated care;

(v) Administrative and compliance costs;

(vi) Federal, state, and local taxes;

(vii) Capacity, funding, and access to postacute care, long-term services and supports, and housing; ((~~and~~))

(viii) Regional differences in input prices; ((~~and~~ ~~(f)~~)) (ix) Financial earnings of health care providers and payers, including information regarding profits, assets, accumulated surpluses, reserves, and investment income, and similar information;

(x) Utilization trends and adjustments for demographic changes and severity of illness;

(xi) New state health insurance benefit mandates enacted by the legislature that require carriers to reimburse the cost of specified procedures or prescriptions; and

(xii) Other cost drivers determined by the board to be informative to determining annual total health care expenditures and establishing the annual health care cost growth benchmark; and

(f) Release reports in accordance with RCW 70.390.070.

Sec. 3. RCW 70.390.070 and 2020 c 340 s 7 are each amended to read as follows:

((~~(1) By August 1, 2021, the board shall submit a preliminary report to the governor and each chamber of the legislature. The preliminary report shall address the progress toward establishment of the board and advisory committees and the establishment of total health care expenditures, health care cost growth, and the health care cost growth benchmark for the state, including proposed methodologies for determining each of these calculations. The preliminary report shall include a discussion of any obstacles related to conducting the board's work including any deficiencies in data necessary to perform its responsibilities under RCW 70.390.050 and any supplemental data needs.~~

~~(2) Beginning August 1, 2022~~)) By December 1st of each year, the board shall submit annual reports to the governor and each chamber of the legislature. ((~~The first annual report shall determine the total health care expenditures for the most recent year for which data is available and shall establish the health care cost growth benchmark for the following year.~~)) The annual reports may include policy recommendations applicable to the board's activities and analysis of its work, including any recommendations related to lowering health care costs, focusing on private sector purchasers, and the establishment of a rating system of health care providers and payers.

NEW SECTION. **Sec. 4.** A new section is added to chapter 70.390 RCW to read as follows:

(1) At least biennially, the board shall conduct a survey of underinsurance among Washington residents.

(a) The survey shall be conducted among a representative sample of Washington residents. Analysis of the survey results shall be disaggregated to the greatest extent feasible by demographic factors such as race, ethnicity, gender and gender identity, age, disability status, household income level, type of insurance coverage, geography, and preferred language. In addition, the survey shall be designed to allow for the analyses of the aggregate impact of out-of-pocket costs and premiums according to the standards in (b) of this subsection as well as the share of Washington residents who delay or forego care due to cost.

(b) The board shall measure underinsurance as the share of Washington residents whose out-of-pocket costs over the prior 12 months, excluding premiums, are equal to:

(i) For persons whose household income is over 200 percent of the federal poverty level, 10 percent or more of household income;

(ii) For persons whose household income is less than 200 percent of the federal poverty level, five percent or more of household income; or

(iii) For any income level, deductibles constituting five percent or more of household income.

(c) Beginning in 2026, the board may implement improvements to the measure of underinsurance defined in (b) of this subsection, such as a broader health care affordability index that considers health care expenses in the context of other household expenses.

(2) At least biennially, the board shall conduct a survey of insurance trends among employers and employees. The survey must be conducted among a representative sample of Washington employers and employees.

(3) The board may conduct the surveys through the authority, by contract with a private entity, or by arrangement with another state agency conducting a related survey.

(4) Beginning in 2025, analysis of the survey results shall be included in the annual report required by RCW 70.390.070.

NEW SECTION. **Sec. 5.** A new section is added to chapter 70.390 RCW to read as follows:

(1) No later than December 1, 2024, and annually thereafter, the board shall hold a public hearing related to discussing the growth in

total health care expenditures in relation to the health care cost growth benchmark in the previous performance period, in accordance with the open public meetings act, chapter 42.30 RCW. The agenda and any materials for this hearing must be made available to the public at least 14 days prior to the hearing.

(2)(a) Except as provided in (b) of this subsection, to the extent data permits, the hearing must include the public identification of any payers or health care providers for which health care cost growth in the previous performance period exceeded the health care cost growth benchmark.

(b) Provider groups with fewer than 10,000 unique attributed lives shall be exempt from identification under (a) of this subsection.

(3) At the hearing, the board:

(a) May require testimony by payers or health care providers that have substantially exceeded the health care cost growth benchmark in the previous calendar year to better understand the reasons for the excess health care cost growth and measures that are being undertaken to restore health care cost growth within the limits of the benchmark;

(b) Shall invite testimony from health care stakeholders, other than payers and health care providers, including health care consumers, business interests, and labor representatives; and

(c) Shall provide an opportunity for public comment.

NEW SECTION. **Sec. 6.** A new section is added to chapter 43.71C RCW to read as follows:

Information collected pursuant to this chapter may be shared with the health care cost transparency board established under chapter 70.390 RCW, subject to the same disclosure restrictions applicable under this chapter.

Sec. 7. RCW 70.405.030 and 2022 c 153 s 3 are each amended to read as follows:

By June 30, 2023, and annually thereafter, utilizing data collected pursuant to ((~~chapter~~)) chapters 43.71C, 43.371, and 70.390 RCW, ((~~the all-payer health care claims database,~~)) or other data deemed relevant by the board, the board must identify prescription drugs that have been on the market for at least seven years, are dispensed at a retail, specialty, or mail-order pharmacy, are not

designated by the United States food and drug administration under 21 U.S.C. Sec. 360bb as a drug solely for the treatment of a rare disease or condition, and meet the following thresholds:

(1) Brand name prescription drugs and biologic products that:

(a) Have a wholesale acquisition cost of $60,000 or more per year or course of treatment lasting less than one year; or

(b) Have a price increase of 15 percent or more in any 12-month period or for a course of treatment lasting less than 12 months, or a 50 percent cumulative increase over three years;

(2) A biosimilar product with an initial wholesale acquisition cost that is not at least 15 percent lower than the reference biological product; and

(3) Generic drugs with a wholesale acquisition cost of $100 or more for a 30-day supply or less that has increased in price by 200 percent or more in the preceding 12 months."

Correct the title.

EFFECT: Removes the requirement that the Health Care Cost Transparency Board (Board) seek input from advisory committees prior to major votes or decisions. Removes the Board's authority to require reporting and collection of data from payers and health care providers and to levy civil fines on payers and health care providers that violate data submission requirements. Removes the Board's authority to use data from nonspecified sources. Allows the Board to use publicly available information filed by insurance carriers. Removes requirements of the Board to adopt risk adjustment methodologies for use in analyzing total health care expenditures and health care cost growth.

Changes the due date of the Board's annual report to December 1st each year, rather than August 1st. Removes the requirement that the annual report include information about testimony and public comments received during the annual public hearing on growth in total health care expenditures.

Eliminates the study of costs to the state related to nonprofit health care providers and nonprofit payers that are not included in the calculation of total health care expenditures.

Changes the annual survey of underinsurance to a biennial survey. Directs the Board to conduct a biennial survey of insurance trends among employers and employees.

Removes the Health Care Authority's authority to support activities and decisions of the Board, such as data collection and analysis, technical assistance, and the enforcement of performance improvement plan submissions and the payment of fines. Eliminates the requirements that the Board's analyses be performed by individuals with relevant expertise.

Requires the Board's public hearing on growth in total health care expenditures to occur once a year, rather than at least once a year, and does not require that it be held concurrent with the issuance of the annual report. Requires the Board to make materials for the public hearing available at least 14 days prior to the public

hearing, rather than seven days prior. Requires the Board to provide at least 21 days' notice to payers or health care providers that are required to testify. Exempts provider groups with fewer than 10,000 unique attributed lives from public identification as having exceeded the health care cost growth benchmark.

Eliminates the Board's authority to require payers and health care providers to establish performance improvement plans or pay civil fines.

Removes legislative findings and intent. Removes the null and void clause.

--- END ---

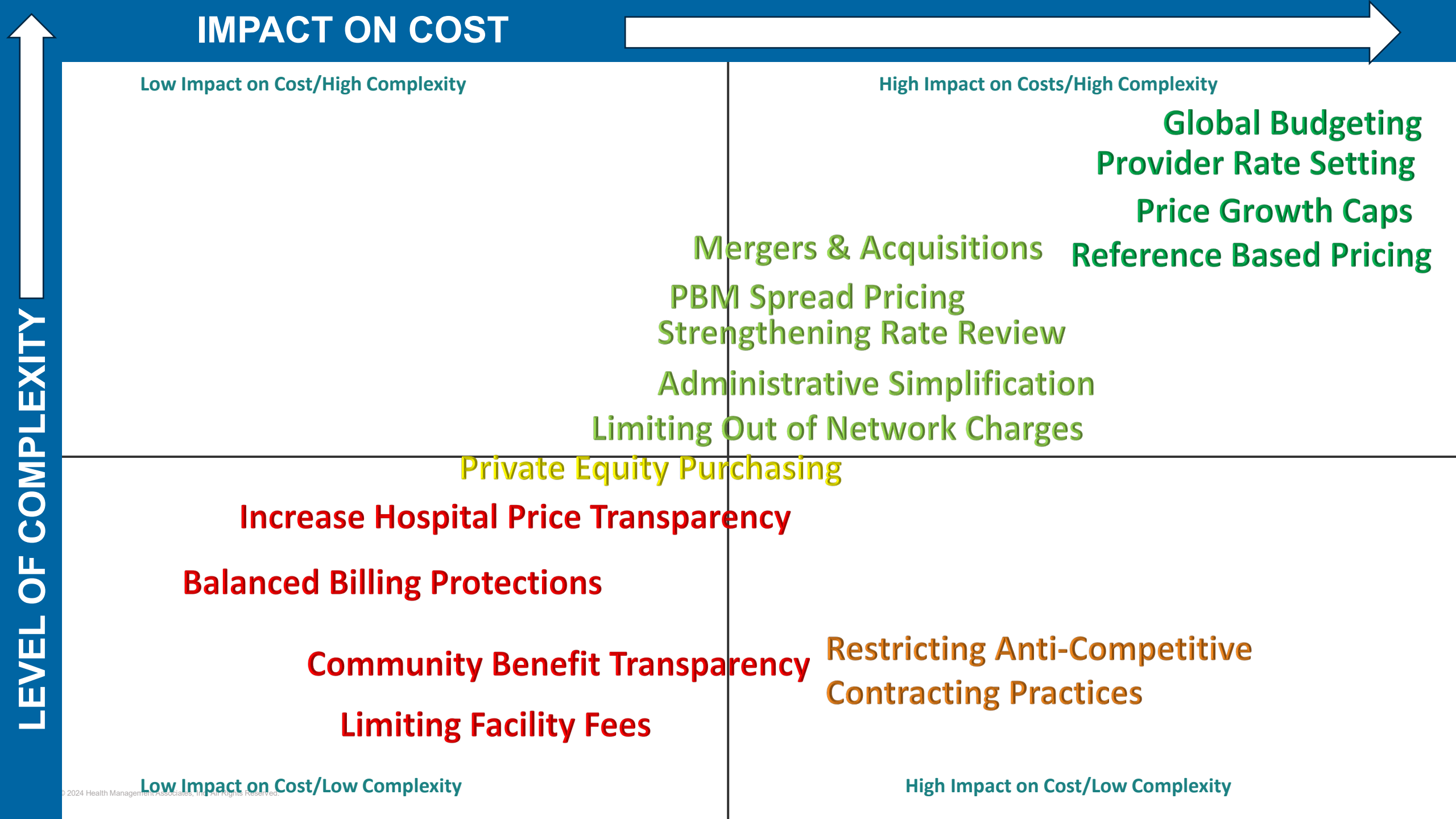
Tab 7

Washington State Health Care Authority

POLICY OPTIONS TO LOWER HEALTH CARE COSTS AND IMPROVE AFFORDABILITY

GOALS FOR THIS DISCUSSION

- Understand the landscape of potential policy options that the Cost Board might consider to address growing health care costs and affordability.
- Identify the top 5 (ideally) policies that the Cost Board would like to investigate during 2024 to develop recommendations to the Legislature.



SHORT-TERM OR SHORT-TO-MEDIUM TERM POLICY OPTIONS

Short-Term:

- ❑ Limiting Facility Fees
- ❑ Address Services Not Covered by the Balanced Billing Protection Act

Short-to-Medium Term:

- ❑ Restricting Anti-Competitive Clauses in Health Care Contracting
- ❑ Increased Hospital Transparency
- ❑ Community Benefit Transparency

LIMITING FACILITY FEES: BACKGROUND

- Designed to compensate hospitals for “stand-by” capacity required for emergency departments and inpatient services.
- Increasingly being added to bills for diagnostic testing and other routine services and are raising health care costs.
- Generally unregulated and are set through contract negotiations.
- Medicare is looking at this issue; states have increased efforts to regulate facility fees and foster transparency around the issue in the interest of limiting facility fee charges, curbing price growth, and educating consumers.
- Washington State Law
  - Requires provider-based clinics that charge a facility fee to post and disclose to patients that the clinic is licensed as part of a hospital and that the patient may be charged a separate facility fee that could result in additional out-of-pocket expenses.
  - Requires hospitals with provider-based clinics to include in their year-end financial reports to the Department of Health (DOH) information about facility fees Washington State Legislature.

Source: RCW 70.01.040: Provider-Based Clinics that Charge a Facility Fee—Posting of Required Notice—Reporting Requirements. Available at: https://app.leg.wa.gov/RCW/default.aspx?cite=70.01.040&pdf=true.

LIMITING FACILITY FEES

Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway
❑ Lower impact on underlying costs ❑ Potentially significant for purchasers ❑ Significant impact to consumers	❑ Low	❑ Short-term	❑ Included in OIC's Preliminary Report ❑ Currently related legislation: HB 2378 Concerning facility fees charged by certain affiliated health care providers.

ADDRESS SERVICES NOT COVERED BY THE BALANCED BILLING PROTECTION ACT

- Surprise billing happens because some medical providers and or facilities may not be contracted with an individual's health insurer even though they provide services at a hospital or facility that is in the health insurer's provider network.
- This leads to affordability concerns for many consumers; 2 in 3 adults say they worry about unexpected medical bills, more than the number worried about affording other health care or household expenses. Surprise bills can number in the millions each year.
- This could potentially result in improved affordability across coverage markets because this protects against uncovered expenses when providers unexpectedly bill for what insurance doesn't cover.

ADDRESS SERVICES NOT COVERED BY THE BALANCED BILLING PROTECTION ACT

Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway
❑ Low impact on underlying costs ❑ Significant impact on consumers	❑ Lower to medium due to existing protections in federal and state law	❑ Short-term	❑ Currently related legislation: SB 5986 concerning protecting consumers from out-of-network health care services charges.

RESTRICTING ANTI-COMPETITIVE CONTRACTING PRACTICES: BACKGROUND

- Dominant providers raise prices is through anti-competitive health plan contracting in which provider groups and health systems utilize their market power to demand terms in their contracts with health insurance plans.
- When health care markets become consolidated, that health system may control multiple hospitals, multi-specialty physician practices, clinics, and ancillary service providers.
- These health systems can use all-or-nothing negotiations to raise prices for all of their affiliated providers by threatening to prevent any of their providers from participating in the insurer's network unless the insurer accepts the prices and terms set by the health system.

RESTRICTING ANTI-COMPETITIVE CONTRACTING PRACTICES

Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway
❑ Significant impact on costs/controlling health care spending and spending increases	❑ Low to medium	❑ Short-term	❑ Included in AG's Preliminary Report ❑ Related legislation: SB 2066: "Addressing affordability through health care provider contracting."

INCREASE HOSPITAL PRICE TRANSPARENCY: BACKGROUND

- Lays the foundation for a patient-driven health care system by making hospital standard charges information available to the public.
- One strategy that has been proposed to help consumers identify and select lower-priced health care providers and services.
- Use of existing price transparency websites remains low.

INCREASE HOSPITAL PRICE TRANSPARENCY

Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway
❑ Medium ❑ Medium impact to consumers	❑ Low to medium	❑ Short to medium-term (depends on policy)	❑ Federal policies require hospitals to publish prices ❑ Unclear how many are compliant ❑ CMS updating enforcement mechanisms

COMMUNITY BENEFIT TRANSPARENCY

- Nonprofit hospitals are exempt from paying most federal and state taxes, can issue tax-exempt bonds, and can receive tax-deductible contributions, with the expectation that they will direct proceeds to community benefit.
- There is growing concern that some nonprofit health systems are reducing staff, demanding payment from patients who qualify for charity care, and shifting services from low-income to high-income neighborhoods, while increasing profits.
- Previous research has found that 86 percent of nonprofit hospitals did not provide more charity care than the value of their tax exemption.

COMMUNITY BENEFIT TRANSPARENCY

Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway
❑ Medium impact on consumers ❑ Does not address underlying health care costs	❑ Low	❑ Short-term to Medium	

MEDIUM TERM POLICY OPTIONS

- Mergers and Acquisitions
- Limiting/or Capping Out-of-Network Charges by Providers
- Strengthen Rate Review Authority
- Administrative Simplification
- Prohibition on spread pricing across markets / Pharmacy Benefit Managers (PBM) regulatory reform.
- Private Equity Purchasing of Health Care Providers

MERGERS & ACQUISITIONS: BACKGROUND

- Research has shown that provider consolidation, including both horizontal and vertical integration, limits options for purchasers and carriers and leads to higher health care prices and increased health care costs as well as limiting options.
- OIC report covers the state of health care consolidation in Washington.
- Some states have adopted policies that include additional reporting requirements and options to review of proposed mergers and acquisitions.

MERGERS & ACQUISITIONS

❑ Significant	❑ Medium	❑ Medium-term	❑ Included in AG's Preliminary Report ❑ Related legislation: SB 5241 (Keep Our Care Act).
Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway

LIMITING OUT-OF-NETWORK CHARGES: BACKGROUND

- Caps the total amount that hospitals can be paid when they are not in-network and prevents providers from billing patients for a balance.
- In addition to limiting surprise medical bills, out-of-network payment caps would reduce a hospital's leverage during contract negotiations by shifting the threat-point of out-of-network services from its self-imposed charges to the level of the legal payment limit. .

LIMITING OUT-OF-NETWORK CHARGES

Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway
❑ Moderate impact on underlying costs ❑ Significant impact for purchasers ❑ Significant impact to consumers by limiting out-of-network charges	❑ Medium	❑ Medium-term	❑ Builds on balance billing efforts in the state.

STRENGTHENING RATE REVIEW AUTHORITY: BACKGROUND

- Process by which insurance regulators (OIC) review health carriers' proposed insurance premiums to ensure they are based on accurate, verifiable data and realistic projections of healthcare costs and utilization.
- May include assumptions about medical trend and utilization, changes in enrollment volume and health status of enrollees, and compliance with state and federal changes to policies, regulations, or law.
- OIC requires insurers to provide documentation justifying the proposed increase or, in limited cases, decrease to demonstrate they are adequate, reasonable, and non-discriminatory
- Closer scrutiny can uncover duplication, faulty assumptions and errors in the rate filings

STRENGTHENING RATE REVIEW

❑ Medium impact on costs and reduced spending. ❑ Medium impact for purchasers. ❑ Impact to consumers will be seen in lower rates.	❑ Medium to High	❑ Medium-term	❑ Included in OIC's Preliminary Report
Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway

ADMINISTRATIVE SIMPLIFICATION: BACKGROUND

- Administrative costs comprise up to one-third of total health care costs of which billing and insurance-related (BIR) costs are the largest. component. These activities include eligibility determination, claims management, clinical documentation and coding, prior authorization, sales and marketing, quality measurement, and credentialing.
- One example of this is that as healthcare costs have risen, so has insurers' use of prior authorization.
- A specific focus has been to reform and streamline prior authorization to minimize complexity for providers, promote access for consumers and potentially reduce spending administrative costs.

ADMINISTRATIVE SIMPLIFICATION

Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway
❑ Medium impact	❑ Medium	❑ Medium-term	❑ Being studied by the Universal Health Care Commission in 2024 ❑ CMS recently issued a final rule to expand access to health information and improve the prior authorization process. ❑ There are several legislative proposals on this topic.

PROHIBITION ON SPREAD PRICING ACROSS MARKETS / PHARMACY BENEFIT MANAGERS (PBM) REGULATORY REFORM.

- Spread pricing is when PBMs reimburse pharmacies less than what they are reimbursed by plans for a drug and retain the “spread” as profit, resulting in an overpayment by the plan.
- Banning spread pricing ensures that plans, employers, and patients are not overpaying for prescription drugs.
- Several states have taken actions to prohibit spread pricing in Medicaid managed care programs and others seek to expand those actions across markets.
- This is currently in place in the UMP Moda contracts.

PROHIBITION ON SPREAD PRICING ACROSS MARKETS / PHARMACY BENEFIT MANAGERS (PBM) REGULATORY REFORM.

Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway
❑ Medium impact on lowering health care costs ❑ Significant impact for employers and purchasers	❑ Medium	❑ Medium-term	❑ Currently related legislation: SB 5213 concerning Pharmacy Benefit Managers ❑ Prescription drug prices are being examined by the Prescription Drug Affordability Board.

PRIVATE EQUITY PURCHASING OF HEALTH CARE PROVIDERS

- Significant evidence shows that private equity ownership increases prices. PE firms aim to secure high returns on their investments which can conflict with the goal of delivering affordable, accessible, high-value health care.

- Increased transparency could make it clear who owns private, for-profit health care organizations. However, greater transparency rules alone is unlikely to slow private equity's penetration of health care markets.

- Another option is to reform antitrust laws to open the future sale of local physician practices to scrutiny.

PRIVATE EQUITY PURCHASING OF HEALTH CARE PROVIDERS

❑ Lower impact ❑ Doesn't address underlying costs	❑ Medium	❑ Medium term	
❑ Magnitude of Impact	❑ Complexity for Board Development and Agency Implementation	❑ Short, Medium or Long-Term Goal (time intensity)	❑ Policy efforts already underway

LONG-TERM POLICY OPTIONS

- Provider Rate Setting Policies
- Price growth caps and/or and price caps
- Global Budgeting
- Reference based pricing
- Further consolidate and expand state purchasing

PROVIDER RATE SETTING: BACKGROUND

- Establishes payment levels to control the rate of growth of those payment levels over time.
- Could lower costs by reducing or eliminating the administrative burden of negotiating multiple payer contracts and streamline claims processing.
- Could provide a platform for payment reforms to promote improvements in the quality and equity of care to the extent that incentives are built into the uniform payment rates.
- Could also provide better price and quality transparency for consumers.

PROVIDER RATE SETTING

Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway
❑ Significant impact on costs and future increases to health care spending. ❑ Potentially significant for purchasers. ❑ Impact to consumers further out by lowered rates.	❑ High	❑ Longer-term	❑ Included in OIC's Preliminary Report

PRICE GROWTH CAPS: BACKGROUND

- Limits the maximum price providers can charge for a given service or set of services without setting the exact payment amount.

- Market forces (and market-based policies) can still influence prices underneath the caps and allowing prices to continue to vary (to some extent) across providers and health plans.

PRICE GROWTH CAPS

Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway
❑ High impact overall ❑ Significant impact to purchasers ❑ Significant impact to consumers	❑ High	❑ Longer-term	❑ Included in OIC's Preliminary Report ❑ Cascade Care is Washington's current vehicle that uses price growth caps

GLOBAL BUDGETING: BACKGROUND

- Providers are paid a fixed amount for treating a patient population over a defined period, instead of being paid for each service piecemeal.
- By constraining total provider revenue, global budgets create an incentive for delivering more efficient care.
- Shifts financial risk from payers to providers, reducing payer uncertainty which is helpful for state budgeting purposes.

GLOBAL BUDGETING

❑ Significant impact on controlling costs and health care spending.	❑ High	❑ Longer-term	❑ Included in OIC's Preliminary Report
Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway

REFERENCE-BASED PRICING: BACKGROUND

- Similar to how Medicare sets uses a reference point to set rates, the state would set a price range or cap prices for each health care service instead of negotiating the prices with providers for whom it purchases coverage.

REFERENCE-BASED PRICING

❑ Significant	❑ High	❑ Longer-term	❑ Included in OIC's Preliminary Report
Magnitude of Impact	Complexity for Board Development and Agency Implementation	Short, Medium or Long-Term Goal (time intensity)	Policy efforts already underway

FURTHER CONSOLIDATE AND EXPAND STATE PURCHASING: BACKGROUND

- Consolidate and expand state purchasing power to leverage better prices for a potentially broader population.

FURTHER CONSOLIDATE AND EXPAND STATE PURCHASING

- ❑ Significant
- ❑ Magnitude of Impact

- ❑ High
- ❑ Complexity for Board Development and Agency Implementation

- ❑ Longer-term
- ❑ Short, Medium or Long-Term Goal (time intensity)

- ❑ Policy efforts already underway

DISCUSSION

Are there other factors that should be considered as we consider priorities?

What other data do you need to make recommendations?

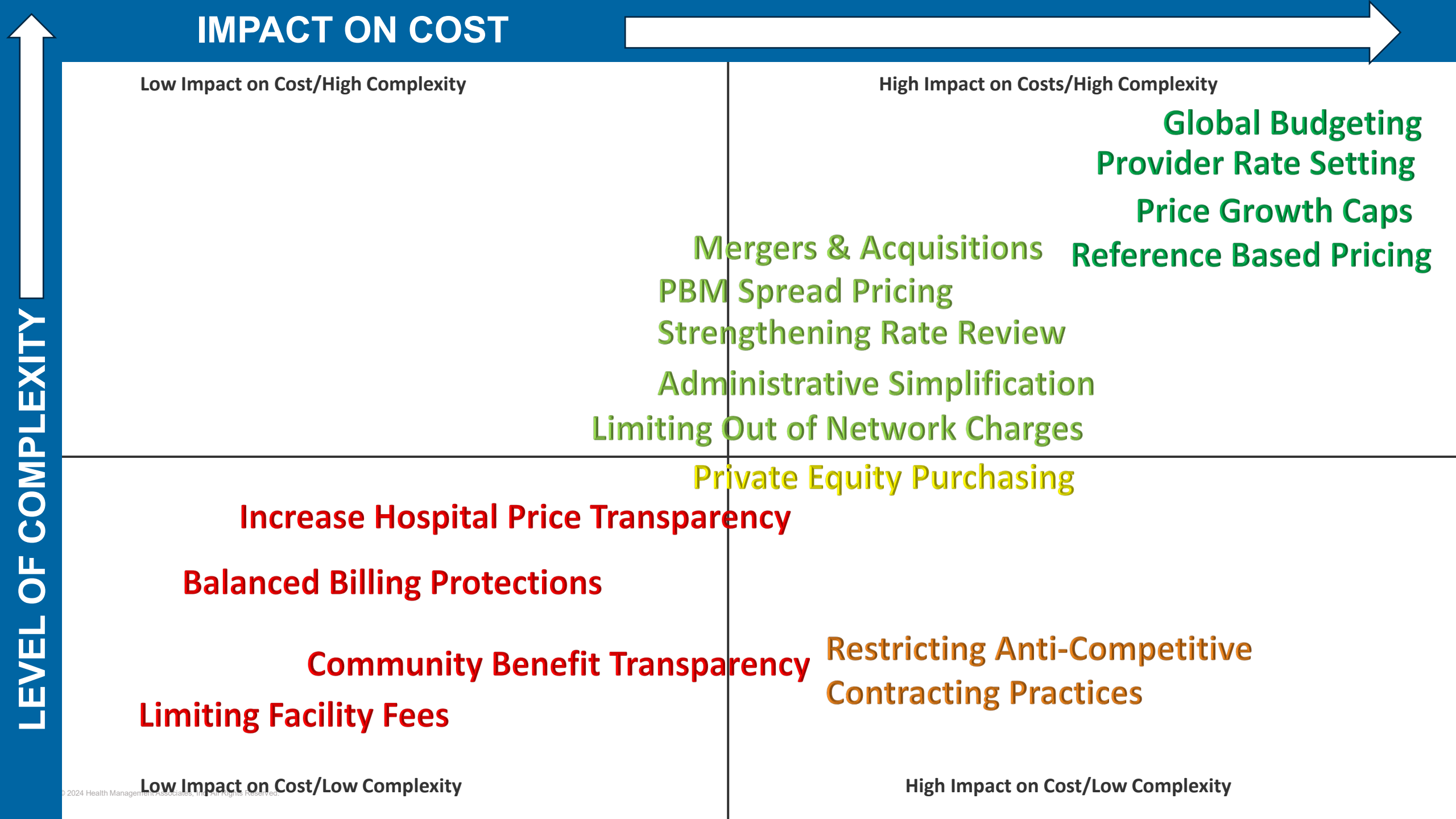
What matters to you?

OPTIONS TO ADDRESS HEALTH CARE COSTS AND IMPROVE AFFORDABILITY

	Being Addressed Elsewhere	Not Being Addressed
May Impact but not Targeted at Costs	Administrative Simplification 🟡 (2)	Private Equity 🔴 (2)
Consumer and Purchaser Cost Protections	Balance Billing 🔴 (1)	Limiting Facility Fees 🔴 (1) Limiting or Capping Out of Network 🟡 (2)
Transparency Tools for Consumers and Regulators		Increased Hospital Price Transparency 🟡 (1) Community Benefit Transparency 🟡 (1)
High Costs	Global Budgets 🟢 (3) PBM Spread Pricing 🟡 (2)	Reference Based Pricing (Public Option) 🟢 (3) Consolidated State Purchasing 🟢 (3) Price Growth Caps 🟢 (3) Provider Rate Setting 🟢 (3)
Enhanced Regulatory Authority	Rate Review Authority 🟡 (2) Mergers and Acquisitions 🟢 (2)	Restricting Anti-Competitive Clauses in Health Care Contracting 🟢 (1)

🟢 = *High Impact*
🟡 = *Medium Impact*
🔴 = *Low Impact*

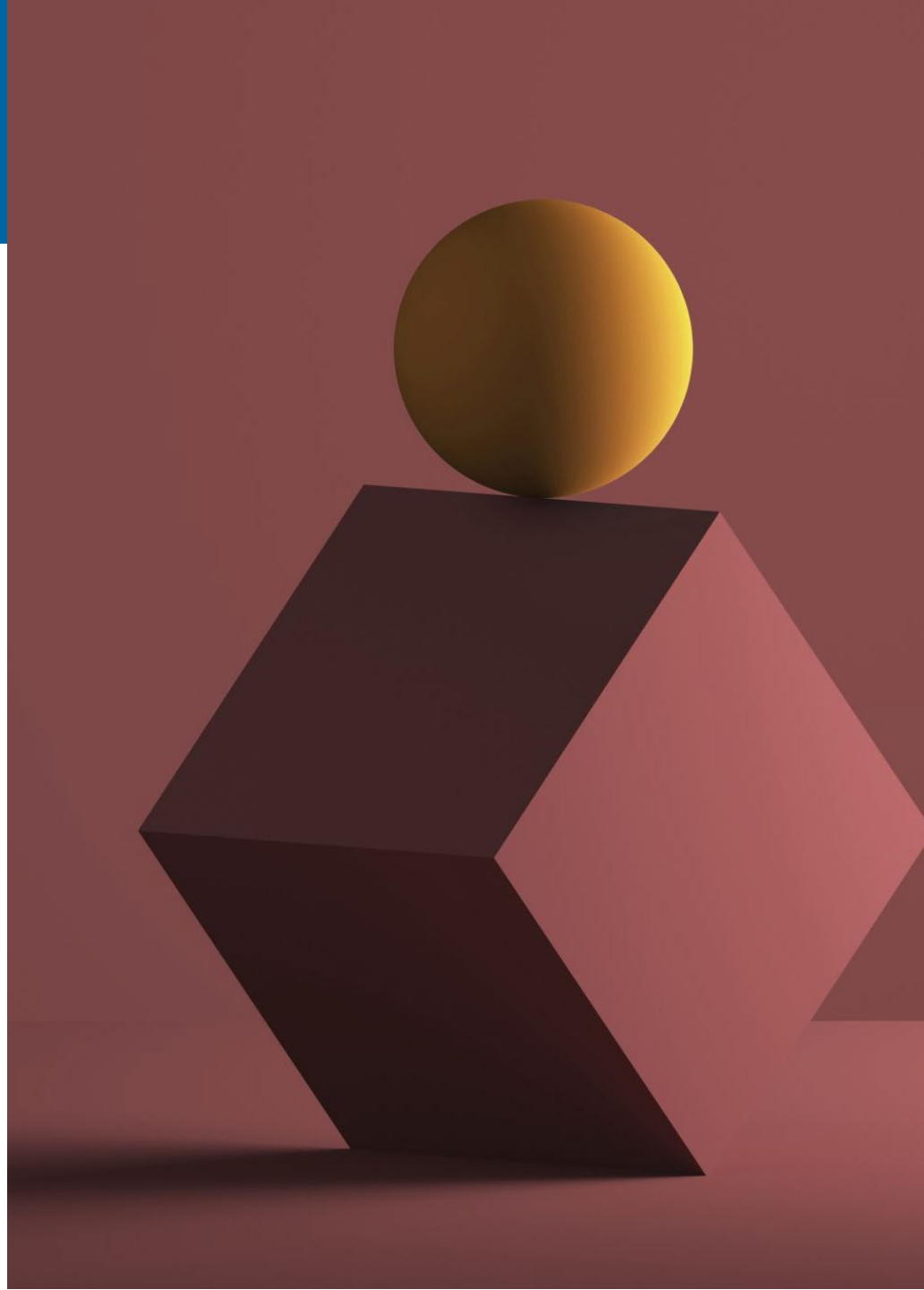
(1) = *Short Term*
(2) = *Medium Term*
(3) = *Long Term*



ESTABLISH THE 5 (IDEALLY) POLICIES THAT THE COST BOARD WOULD LIKE TO STUDY IN 2024 TO DEVELOP RECOMMENDATIONS TO THE LEGISLATURE

1) “Fist to Five” to identify the lowest five policies

2) “Ranking with Dots” to identify the top five of the remaining



DISCUSSION

Now that you have identified the top 5 policies, what information do you need to be able to provide recommendations to policymakers about them?

Tab 8

Washington State Health Care Authority

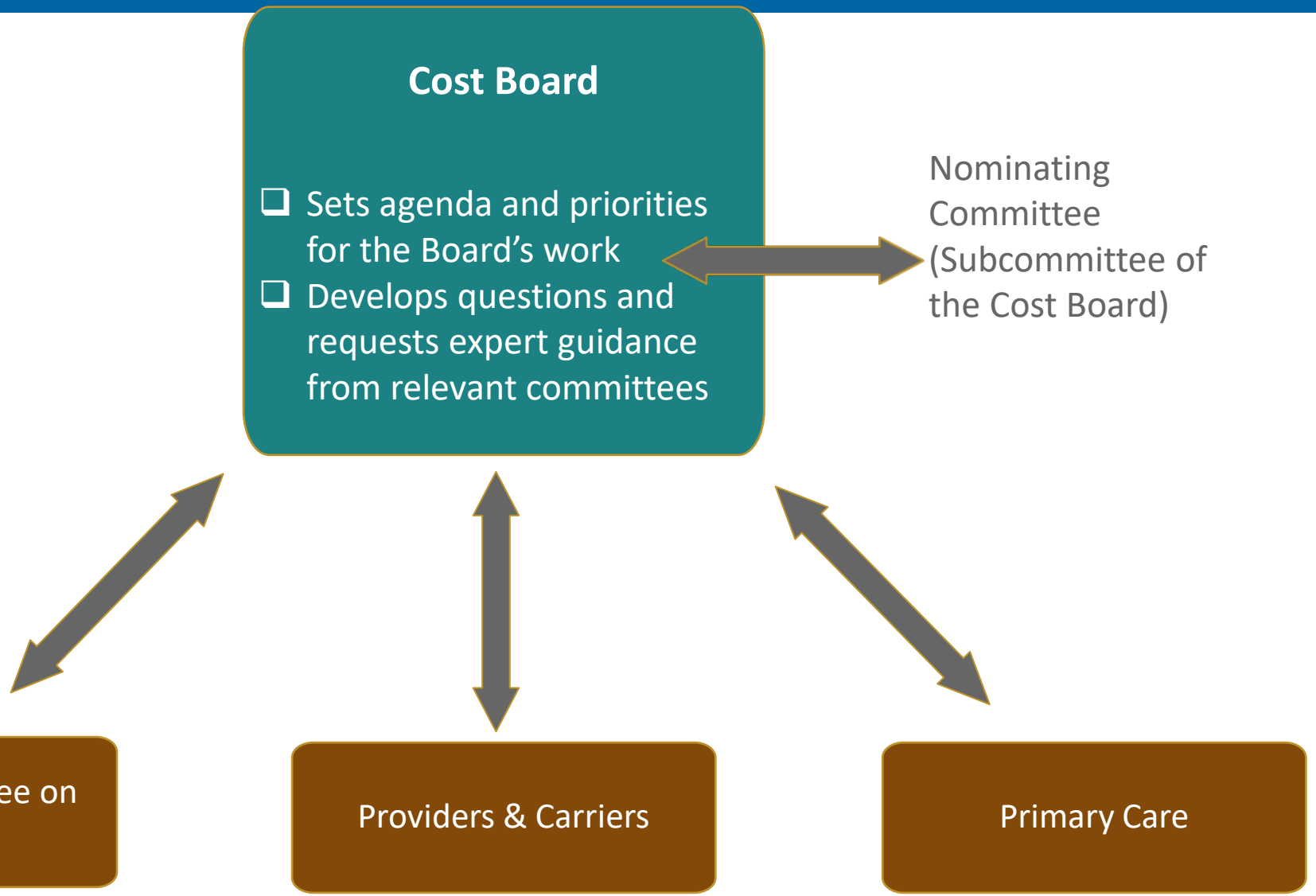
COMMITTEES, CHARTERS, EXPECTATIONS: ENSURING EFFECTIVE SUPPORT AND GUIDANCE TO THE BOARD'S MISSION

BACKGROUND

- While the Board was established and chartered, some of the committees were not chartered.
- This could lead to unclear expectations for committee members.
- Moving into this new phase now that the benchmark has been established and the first review complete, the Board may wish to continue to utilize the expertise of committee members to the extent possible.
- With the new focus of the Board, important to ensure alignment and synergies to maximize the expertise available in committees.

THE BOARD AND ITS COMMITTEES

- The role of the committees is to provide expert guidance in response to the questions and direction of the Cost Board.
- Committee chairs will be established to bring information to Committees from the Board and back to the Board from the Committees



DISCUSSION

- Concerns about the proposed approach and charters?
- Feedback on the Charters will be due by the end of February.
- Please contact Rachelle or Mandy if you are interested in being Chair to an Advisory Committee.

HEALTH CARE COST TRANSPARENCY BOARD'S

Advisory Committee on Data Issues

What is the Purpose of the Advisory Committee on Data Issues?

The role of the Advisory Committee on Data Issues is to assist the Health Care Cost Transparency Board ("Board") by providing subject matter expertise and support to the Board on data calls and in the analysis of existing data sources. The Advisory Committee on Data Issues will also assist with the Board's efforts by proving subject matter expertise on other data issues as identified by the Board.

Membership:

As indicated in House Bill 2457, section 4 and related RCWs, the Advisory Committee of Data Issues will be appointed by the Board. Members of the Advisory Committee must have expertise in health data collection and reporting, health care claims data, analysis, health care economic analysis, and actuarial analysis.

Member Responsibilities:

Members of the Advisory Committee on Data Issues are responsible for:

- Providing subject matter expertise in relation to the growth benchmark, including understanding for outliers or unexplained trends with the cost growth and benchmark data analysis.
- Collaborating with the Board and HCA staff to help create buy-in across the various markets and organizations and offering suggestions that may help with the data collection and analysis.
- Serving as a liaison between the Board and health care community by relaying essential information and bringing forth feedback as needed to the Board to ensure all parties involved have an opportunity to address how to slow cost growth and to address growing affordability concerns for the state of Washington at various levels.

- Attendance and participation in Advisory Committee meetings. This includes reviewing meeting materials in advance of the scheduled meeting, coming prepared to engage with other members, working collaboratively with other members and the Board, being sensitive to the impact that high health care spending growth has on Washingtonians, and providing input to help the conversation continue moving forward.
- If a member cannot attend a meeting, they are requested to advise HCA before the meeting and contact staff for a recording of the meeting.
- Members will adhere to the requirements of the Open Public Meets Act and Public Records Act. Records related to the Advisory Committee on Data Issues are public records.

Meetings:

The Advisory Committee on Data Issues will meet as needed (likely no more than six times annually) to fulfill its mandate to the Board by providing subject matter expertise and support to the Board.

Quorum:

A majority of the Advisory Committee on Data Issues members constitutes a quorum for a meeting of the committee. If a meeting does not have a quorum of members present or does not maintain a quorum, the meeting may be cancelled or rescheduled so that there are sufficient members to fulfill the Advisory Committee's responsibilities.

Accountability and Reporting:

The Advisory Committee on Data Issues is accountable to the Board and to report its activities and to provide subject matter expertise at the request of the Board or to follow up on requests of the Board.

HEALTH CARE COST TRANSPARENCY BOARD'S

Advisory Committee of Health Care Providers and Carriers

What is the Purpose of the Advisory Committee of Health Care Providers and Carriers?

The role of the Advisory Committee of Health Care Providers and Carriers is to assist the Health Care Cost Transparency Board ("Board") by providing subject matter expertise, and support to the Board regarding the cost growth benchmark. The Advisory Committee of Health Care Providers and Carriers will also help the Board identify opportunities to slow cost growth, address growing affordability concerns for the state of Washington at various levels (state, market, carriers, and large provider entities), and assist with other areas proving subject matter expertise as identified by the Board.

Membership:

As indicated in House Bill 2457, section 4 and related RCWs, the Advisory Committee of Health Care Providers and Carriers will be appointed by the Board.

Appointments to the Advisory Committee of Health Care Providers and Carriers must include the following membership:

a) One member representing hospitals and hospital systems, selected from a list of three nominees submitted by the Washington State Hospital Association;
b) One member representing federally qualified health centers, selected from a list of three nominees submitted by the Washington Association of Community Health Centers;
c) One physician, selected from a list of three nominees submitted by the Washington State Medical Association;
d) One primary care physician, selected from a list of three nominees submitted by the Washington State Academy of Family Physicians;

e) One member representing behavioral health providers, selected from a list of three nominees submitted by the Washington Council for Behavioral Health;
f) One member representing pharmacists and pharmacies, selected from a list of three nominees submitted by the Washington State Pharmacy Association;
g) One member representing advanced registered nurse practitioners, selected from a list of three nominees submitted by ARNPs United of Washington State;
h) One member representing tribal health providers, selected from a list of three nominees submitted by the American Indian Health Commission;
i) One member representing a health maintenance organization, selected from a list of three nominees submitted by the Association of Washington Health Care Plans;
j) One member representing a managed care organization that contracts with the Health Care Authority to serve medical assistance enrollees, selected from a list of three nominees submitted by the Association of Washington Health Care Plans;
k) One member representing a health care service contractor, selected from a list of three nominees submitted by the Association of Washington Health Care Plans;
l) One member representing an ambulatory surgery center selected from a list of three nominees submitted by the Ambulatory Surgery Center Association; and
m) Three members, at least one of whom represents a disability insurer, selected from a list of six nominees submitted by America's Health Insurance Plans.

Member Responsibilities:

Members of the Advisory Committee of Health Care Providers and Carriers are responsible for:

- Providing subject matter expertise in relation to the growth benchmark and benchmark, including understanding for outliers or unexplained trends with the cost growth data analysis.
- Collaborating with the Board and HCA staff to help create buy-in across the various markets and provider organizations and offering suggestions that may help streamline the data collection process.
- Serving as a liaison between the Board and health care community by relaying essential information to carriers and providers and bringing forth feedback from carriers and providers to the Board to ensure all parties involved have an opportunity to address how to slow cost growth and to address growing affordability concerns for the state of Washington at various levels.
- Attendance and participation in Advisory Committee meetings. This includes reviewing meeting materials in advance of the scheduled meeting, coming prepared to engage with other members, working collaboratively with other members and the Board, being

sensitive to the impact that high health care spending growth has on Washingtonians, and providing input to help the conversation continue moving forward.
- If a member cannot attend a meeting, they are requested to advise HCA before the meeting and contact staff for a recording of the meeting.
- Members will adhere to the requirements of the Open Public Meets Act and Public Records Act. Records related to the Advisory Committee of Health Care Providers and Carriers are public records.

Meetings:

The Advisory Committee of Health Care Providers and Carriers will meet as needed (likely no more than six times annually) to fulfill its mandate to the Board by providing subject matter expertise and support to the Board.

Quorum:

A majority of the Advisory Committee of Health Care Providers and Carriers members constitutes a quorum for a meeting of the committee. If a meeting does not have a quorum of members present or does not maintain a quorum, the meeting may be cancelled or rescheduled so that there are sufficient members to fulfill the Advisory Committee's responsibilities.

Accountability and Reporting:

The Advisory Committee of Health Care Providers and Carriers is accountable to the Board and to report its activities and to provide subject matter expertise at the request of the Board or to follow up on requests of the Board.

Tab 9

Washington State Health Care Authority

DATA CALL 2024

Washington State Health Care Authority

1

Feb 12:
Launch data call

2

April 15:
Receive data submission

3

Apr - Jul:
Conduct data validation

4

Aug - Oct:
Conduct analysis & generate carrier/provider reports

5

Nov - Dec:
Report analysis to the Cost Board

Tab 10

Washington State Health Care Authority

Public Comment

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board

Written Comments

Received Since Last Meeting

Written Comments Submitted by Email

No written public comments have been received since the last meeting.

Comments Received at the December Meeting

The Zoom video recording is available for viewing here:
https://www.youtube.com/watch?v=Yz4lKNESq70

Tab 11

Washington State Health Care Authority

2023

ANNUAL HEALTH CARE COST TRENDS REPORT

POLICY RECOMMENDATIONS

MASSACHUSETTS
HEALTH POLICY COMMISSION

SEPTEMBER 2023

2023 HEALTH CARE COST TRENDS RECOMMENDATIONS

This year marks a critical inflection point in the Commonwealth's ambitious journey of health care reform which has made it a national policy leader. As documented in this 10th annual HPC report, there are many alarming trends which, if unaddressed, will result in a health care system that is unaffordable for Massachusetts residents and businesses, including:

- Massachusetts residents have high health care costs that are consistently increasing faster than wages, exacerbating existing affordability challenges that can lead to avoidance of necessary care and medical debt, and widening disparities in health outcomes based on race, ethnicity, income, and other factors. These high and increasing costs are primarily driven by high and increasing prices for some health care providers and for pharmaceuticals, with administrative spending and use of high-cost settings of care as additional drivers.
- Massachusetts employers of all sizes, but particularly small businesses, are confronting ever-rising premiums by shifting costs to employees through high deductible health plans. As a result, many employees are increasingly at risk of medical debt, relying on state Medicaid coverage, or are becoming uninsured, an alarming signal of the challenges facing a core sector of the state's economy.
- Many Massachusetts health care providers across the care continuum continue to confront serious workforce challenges and financial instability, with some providers deciding to reduce services, close units (notably pediatric and maternity hospital care) or consolidate with larger systems. The financial pressures faced by some providers are driven, in part, by persistent wide variation in prices among providers for the same types of services (with lower commercial prices paid to providers with higher public payer mix) without commensurate differences in quality or other measures of value.

It is imperative that the state take action to enhance our high-quality health care system in Massachusetts such that it is also an affordable and equitable one. In this report, the HPC has outlined several areas of excess spending related to unreasonably high prices, avoidable use of high-cost care settings, and services that confer little to no benefit to patients – all of which have the potential to reduce total health care spending while maintaining the quality that residents deserve. A renewed commitment by all stakeholders is needed to redirect resources away from unwarranted excess spending that benefits the few and towards efforts to revitalize the health care system that benefit the many, consistent with the Commonwealth's values and goals.

The **nine policy recommendations** below reflect a comprehensive approach to reduce health care cost growth, promote affordability, and advance equity. The HPC further recommends that legislative action in 2023 and 2024 prioritize modernizing and evolving the state's policy framework, necessary to chart a path for the next decade.

POLICY RECOMMENDATIONS

1. MODERNIZE THE COMMONWEALTH'S BENCHMARK FRAMEWORK TO PRIORITIZE HEALTH CARE AFFORDABILITY AND EQUITY FOR ALL
2. CONSTRAIN EXCESSIVE PROVIDER PRICES
3. ENHANCE OVERSIGHT OF PHARMACEUTICAL SPENDING
4. MAKE HEALTH PLANS ACCOUNTABLE FOR AFFORDABILITY
5. ADVANCE HEALTH EQUITY FOR ALL
6. REDUCE ADMINISTRATIVE COMPLEXITY
7. STRENGTHEN TOOLS TO MONITOR THE PROVIDER MARKET AND ALIGN THE SUPPLY AND DISTRIBUTION OF SERVICES WITH COMMUNITY NEED
8. SUPPORT AND INVEST IN THE COMMONWEALTH'S HEALTH CARE WORKFORCE
9. STRENGTHEN PRIMARY AND BEHAVIORAL HEALTH CARE

1. MODERNIZE THE COMMONWEALTH'S BENCHMARK FRAMEWORK TO PRIORITIZE HEALTH CARE AFFORDABILITY AND EQUITY FOR ALL.

The state's health care cost growth benchmark, first established in 2012, is a measurable goal for moderating total spending growth and easing the burden of health care costs on government, households, and businesses in Massachusetts. Building on this approach which has successfully moderated cost growth in Massachusetts and which other states have adopted and expanded upon, the Commonwealth can establish a more comprehensive framework for setting goals and tracking progress on other priorities, such as affordability and health equity. A modernized, aligned framework should:

a. Strengthen the Health Care Cost Growth Benchmark. As recommended in past years, the Commonwealth should strengthen and improve the mechanisms for holding health care entities responsible for health care spending performance to support the Commonwealth's efforts to meet the health care cost growth benchmark. These collective fixes to the benchmark and its accountability mechanisms are critically necessary to establish a more effective process to constrain excessive spending. Specifically, the Legislature should strengthen the existing health care cost growth benchmark framework by:

i. Directing CHIA to use metrics in addition to growth in health status adjusted total medical expense (HSA TME) to refer entities to the HPC for review and a potential performance improvement plan (PIP). Such a change would enable CHIA to refer entities other than payers and providers with primary care networks (e.g., hospitals and specialists) to the HPC and would ensure that real dollar spending increases are not masked by medical coding efforts that reduce growth rates in health status adjusted measures;

ii. Directing CHIA to develop referral standards that recognize that health care entities vary considerably in their baseline spending levels, pricing levels, and populations served, and that reflect that spending growth may be more or less concerning for a given entity based on these contextual factors;

iii. Requiring that referrals of entities to the HPC for review and a potential PIP be made public; and

iv. Strengthening the PIP process to allow the HPC to set savings target expectations and identify the types of strategies that should be included in a PIP, to give the HPC greater oversight tools to ensure that any PIP results in meaningful improvement on the most important factors driving spending for a given entity, and to further deter excessive spending by allowing the HPC to apply tougher, escalating financial penalties for above-benchmark spending or non-compliance, similar to efforts in other states with health care growth targets.

These collective fixes to the benchmark and its accountability mechanisms have been detailed in previous Cost Trends Reports and are critically necessary to establish a more effective process to constrain excessive health care spending and allow resources to be directed to other important priorities that also impact the health and well-being of Massachusetts residents.

b. Establish New Affordability Benchmark(s). While health care spending by public and private health care payers moderated in the years following the enactment of Massachusetts' health care cost growth benchmark, health insurance premiums and cost-sharing by individuals and families have frequently increased in excess of the benchmark. To both complement and bolster the health care cost growth benchmark, the Commonwealth should develop an accountability framework for affordability of care for Massachusetts residents. As part of a strategy that tracks improvement on indicators of affordability, including the differential impact of both health plan premiums and consumer out-of-pocket spending by income, geography, market segment, and other factors, an affordability index should be measured annually in a benchmark-like process. To enable public transparency and accountability, the state's performance on the affordability index and other measures should be incorporated into CHIA's Annual Report and the HPC's Annual Cost Trends Hearing. Such targets should inform the development of new health plan affordability standards at the Division of Insurance (DOI) that play a central role in DOI's review and approval of health plan rates.

c. Establish New Health Equity Benchmark(s). To further embed the goal of advancing health equity in the state's policy framework, the Commonwealth should undertake a coordinated effort across state agencies and sectors, both in health care and in other key sectors that influence health and well-being such as education, housing and social services, to identify high-priority areas of health inequities, set measurable goals for improvement, develop a framework for accountability, and report annually on progress. To enable public transparency and accountability, the state's performance on health equity benchmark(s) and other measures should be incorporated into CHIA's Annual Report and the HPC's Annual Cost Trends Hearing.

2. CONSTRAIN EXCESSIVE PROVIDER PRICES. Prices continue to be a primary driver of health care spending growth in Massachusetts, and the significant variation in prices between Massachusetts providers for the same sets of services (without commensurate differences in quality) continues to divert resources away from smaller and/or unaffiliated community providers, many of which serve vulnerable patient populations toward generally larger and more well-resourced systems. These high and variable prices have been highlighted in more than a decade of work by the HPC and other state agencies. Past market initiatives (e.g., tiered and narrow network products, price transparency efforts, risk contracting) have failed to

meaningfully restrain provider price growth or reduce unwarranted variation in provider prices in Massachusetts, and many states (e.g., Rhode Island, Oregon, Colorado, and Maryland) are similarly recognizing that some level of price regulation, rather than market initiatives alone, may be necessary to ensure an equitable and affordable health care system. Accordingly, the HPC recommends the following actions:

a. **Limit Excessive Provider Prices.** The Legislature should take action to limit excessive commercial provider prices beyond reasonable benchmark amounts, as illustrated in this report. Such limits could target prices with the greatest impact on spending, as well as annual price growth. Such price limits—targeted specifically at the highest-priced providers and those services for which competitive forces are not likely to meaningfully constrain prices —would be an important complement to the health care cost growth benchmark. Such limits would reduce unwarranted price variation and promote equity by ensuring that future price increases can accrue appropriately to lower-priced providers including many community hospitals, community health centers, and other providers that care for populations facing the greatest health inequities, ensuring the viability of these critical resources.

b. **Require Site-Neutral Payment.** Many routine health care services are safely provided in both hospital outpatient departments and non-hospital settings such as physician offices. Commercial prices and patient cost-sharing are generally substantially higher (often twice as high or more) at hospital outpatient sites due to the addition of a hospital payment component or "facility fee." In many cases, patients may not realize that pricing can be substantially higher at some sites (those licensed as hospital outpatient departments), and face higher costs as a result. To limit higher prices related to hospital/physician consolidation and enhance consumer protections, policymakers should take action to require site-neutral payments for certain ambulatory services that are commonly provided in office-based settings (e.g., office visits, lab tests, basic imaging and diagnostic services, and clinician-administered drugs). Additionally, remaining outpatient sites that charge facility fees should be required to disclose this fact conspicuously and clearly to patients prior to delivering care, and payers and providers should include the location where the visit occurred, including whether it was an on-or off-campus hospital outpatient department, on claims submitted to payers and reported to CHIA's Massachusetts All-Payer Claims Database.

c. **Adopt Default Out-of-Network Payment Rate.** To further constrain excessive provider prices, the Legislature should enact the default out-of-network payment rate for "surprise billing" situations recommended by the Executive Office of Health and Human Services in its 2021 report. Data from early implementation of the arbitration process established by the federal No Surprises Act (to resolve out-of-network provider payment disputes) demonstrate significant administrative challenges and disadvantages of relying on the federal arbitration process. The Commonwealth should join other states that have enacted a default rate for the fully insured market, with a potential opt-in for self-insured plans. A default rate would provide predictability, transparency and simplicity, and reduce health care spending in Massachusetts. Establishing a default out-of-network rate is also a critical component of a policy response to unwarranted provider price variation.

3. ENHANCE OVERSIGHT OF PHARMACEUTICAL SPENDING.

Retail drug spending has become one of the fastest areas of spending growth in the Commonwealth, growing at an annualized rate of 7.5% between 2019 and 2020. This is largely driven by escalating prices for the highest cost branded prescription drugs. Some patients who need high-cost branded drugs are experiencing steep increases in their out-of-pocket expenses as health plans design benefit packages that shift rising pharmacy costs back to patients in the form of specific medication deductibles or specialty tiers with coinsurance or high co-pays, or face barriers to prescribed care due to utilization management designed to limit access to treatments. Without any additional oversight or regulatory tools, high drug prices will continue to shape patient access through barriers related to health plan benefit designs, and pharmacy costs will continue to steadily increase, driving individuals and employers to purchase more restrictive plans that aggressively manage pharmacy spending through cost sharing and utilization management. Accordingly, the HPC recommends the following actions:

a. **Enhance Oversight/Transparency and Data Collection.** At minimum, the Commonwealth should take action to increase both transparency of drug price growth and spending and oversight of the key stakeholders responsible for setting drug prices and establishing the policies that influence how patients access critical medications. The Commonwealth should add pharmaceutical manufacturers and pharmacy benefit managers explicitly into the HPC's oversight responsibilities, and authorize CHIA to collect data on pharmaceuticals from payers and pharmacy benefit managers (PBMs), including the average cost of pharmaceuticals

after all discounts and rebates; prices on average charged by PBMs to health plans and paid to pharmacies by drug; and gross and net spending for drugs administered in provider offices and hospital outpatient departments, including through the 340B drug pricing program.

b. PBM Oversight. The state should also require licensure of PBMs in order to monitor their business practices with pharmacies and health plans, and their impact on patients.

c. Expand Drug Pricing Reviews. The Commonwealth should build on MassHealth's successful process by exploring expansion of the HPC's drug pricing review authority to other state and commercial payers such as the Group Insurance Commission in order to strengthen price negotiations by creating the pathway for a public escalation in negotiations that ultimately results in an investigation by the HPC if negotiations are unsuccessful.

d. Limit Out-of-Pocket Costs on High-Value Drugs. Finally, the Commonwealth should cap monthly out-of-pocket costs for high value prescription drugs that are widely recognized to improve health outcomes for patients with no or minimal impact on health care spending.

4. MAKE HEALTH PLANS ACCOUNTABLE FOR AFFORDABILITY. As both health insurance premiums and the use of higher deductibles increase, further squeezing families in Massachusetts, the Commonwealth should require greater accountability of health plans for delivering value to consumers and ensuring that any savings that accrue to health plans (e.g., from provider price caps as described above or reduced use of high-cost care) are passed along to consumers.

a. Enhance Scrutiny of Drivers of Health Plan Premium Growth. State affordability targets should inform the DOI's oversight of health plans and should be a key factor in the DOI's review and approval of health plan rate filings. The Legislature should equip DOI with dedicated tools and resources to analyze drivers of health plan premium growth across market segments, including provider rate increases and administrative expenses, such as broker fees and contributions to reserves. The DOI should consider the need for additional reporting requirements and coordination with CHIA and the HPC and other agencies.

b. Facilitate Small Business Enrollment in Massachusetts Connector Plans. The small group market continues to shrink due, in part, to increasingly unaffordable premiums that outpace wage growth, leading to higher premiums, and higher rates of employee enrollment in MassHealth or uninsurance. The HPC recommends further steps to facilitate enrollment of small business groups in plans via the Massachusetts Health Connector's Health Connector for Business platform. These steps could include additional savings on premiums through enhanced Health Connector offerings, additional promotional efforts, reduction of enrollment barriers such as percentage-of-group participation requirements, and administrative facilitation such as automatic opt-out enrollment for the smallest employee groups in the Massachusetts small group market.

c. Improve Health Equity Through Premium Support for Employees with Lower Incomes. As the number of Massachusetts consumers with high-deductible health plans (HDHPs) has sharply increased, the HPC has documented increasing challenges to affordability, equitable access, and experience of care, particularly for employees with lower incomes. Total health care spending, including premiums and cost-sharing, consumes more than 20 percent of total compensation for middle class families, squeezing household budgets. Employers and health plans could improve health equity by reducing premium contributions for lower wage workers via tax credits or wage-adjusted contributions.

d. Alternative Payment Methods (APMs). Health plans should continue to promote the increased adoption and effectiveness of APMs (e.g., increased use of primary care capitation, APMs for preferred provider organization populations, episode bundles, and two-sided risk models), especially in the commercial market where expansion has stalled. Plans should leverage multi-payer alignment opportunities, to unify APMs across MassHealth, Medicare, and commercially-insured populations for participating practices.

5. ADVANCE HEALTH EQUITY FOR ALL. A recent study by the Blue Cross Blue Shield of Massachusetts Foundation estimated that the economic burden of health inequities experienced by Black, Hispanic/Latino, and Asian populations in Massachusetts totaled $5.9 billion each year, and that "about one-quarter of this burden, is associated with avoidable health care spending, which translates to approximately 2.2 percent of total medical spending in Massachusetts." Achieving health equity for all will require focused, coordinated efforts among policymakers, state agencies, and the health care system to ensure that the Commonwealth addresses inequities in both the social determinants of health (SDOH) and in health care delivery, as well as the impacts of those inequities on residents. As such, all stakeholders should have both a role in and accountability for efforts to achieve health equity for all.

a. **Address Social Determinants of Health.** Recognizing that the Commonwealth's health equity goals will be difficult to achieve without addressing inequities in the SDOH, policymakers must continue to prioritize investments in such areas as affordable housing, improved food and transportation systems, and climate change reduction and mitigation strategies. Health care providers can contribute meaningfully to these efforts as anchor institutions, supporting community-led initiatives to respond to these and other social determinants.

b. **Use Payer-Provider Contracts to Advance Health Equity.** Payers and providers should continue adopting and building on current efforts to create accountability for health equity via payer-provider contracts, including by requiring stratification of performance data by race/ethnicity and tying payment to performance on health equity targets. APM contracts, in particular, offer opportunities to align incentives to motivate investments in services and infrastructure (e.g., care coordination, integrated technology, and performance reporting) aimed at addressing health inequities within patient populations.

c. **Improve Data Collection.** To implement these health equity goals, policymakers, providers, and payers should commit to the adoption of the data standards recommended by the Health Equity Data Standards Technical Advisory Group of the EOHHS Quality Measurement Alignment Taskforce. Universal adoption of these standards would enable efficient and consistent collection of reliable, standardized patient data on race, ethnicity, language, disability status, sexual orientation, gender identity, and sex to inform the integration of equity considerations into quality improvement, cost-control, and affordability initiatives.

d. **Support Investment in Innovative Strategies to Address Health Equity.** To support providers in developing innovative solutions to achieving health equity, the Legislature should expand the approved uses of the Distressed Hospital Trust Fund and Payment Reform Trust Fund to include supporting innovative initiatives focused primarily on addressing inequities in health and health care.

e. **Reduce Inequities in Maternal Health.** Despite the Commonwealth's strong overall performance in measures of maternal health, recent data indicate significant, persistent inequities in maternal health outcomes. As part of a broader effort to address these outcomes, the Commonwealth should ensure that efforts to address health care workforce challenges encompass investments to expand and diversify the workforce of doulas and midwives.

6. **REDUCE ADMINISTRATIVE COMPLEXITY.** Administrative complexity that does not add value permeates the Massachusetts health care system, from the wide array of plan options that are not easily comparable by consumers and employers, to non-standard contract terms and differing rules for provider credentialing, claims submission, and utilization management which consume significant provider time and resources. Prior authorization, often a multi-step, manual process, is particularly burdensome for providers and can result in patient challenges and delayed care, particularly for those with fewer resources. Standardizing among plans and streamlining processing can ease the administrative burden for providers, payers, and patients, and allow for the reallocation of health care resources to higher value tasks and improve equity.

a. **Require Greater Standardization in Payer Processes.** The Legislature should require standardization in payer claims administration rules and processes. In particular, the standardization requirements should focus on uniform medical necessity criteria and a uniform set of limited services appropriate for prior authorization.

b. **Automate Prior Authorization.** When prior authorization can be warranted to protect patient safety and avoid overuse, automation could streamline the prior authorization process by reducing uncertainty about prior authorization requirements and decreasing the time between prior authorization submission and decision. Efforts to automate prior authorization are already underway for certain public payers, as the proposed federal rule from the Centers for Medicare and Medicaid Services (CMS) would require certain public payers to automate their prior authorization processes by January 2026. The Legislature should build upon this momentum and mandate that others in Massachusetts, including commercial payers, automate their prior authorization processes according to a statewide roadmap, with technical and financial assistance, to support successful implementation.

c. **Mandate Adoption of the Aligned Quality Measure Set.** While the Quality Measure Alignment Taskforce has achieved substantial voluntary adoption of its standard, aligned quality measure set for use in global budget-based risk contracts, payer adherence remains variable, even after several years. To promote alignment and mitigate the reporting burden for providers, the Legislature should mandate adoption of the aligned measure set, as further refined by the Taskforce, and approved by the Secretary of Health and Human Services.

7. STRENGTHEN TOOLS TO MONITOR THE PROVIDER MARKET AND ALIGN THE SUPPLY AND DISTRIBUTION OF SERVICES WITH COMMUNITY NEED. Recent health care market activity implicating both access and cost, including both closures and proposed expansions, have highlighted the need for a better understanding of the allocation of health care resources across the Commonwealth and its implications for quality, affordability, and equity of care. In addition, there is an opportunity to enhance the current regulatory framework to ensure equitable distribution of health care resources to address need. The HPC recommends enhancing regulator tools as follows:

a. Conduct Focused Assessments of Need, Supply, and Distribution. The Commonwealth should conduct focused, data-driven assessments of supply and distribution of services based on identified needs or disparities in outcomes. Such targeted assessments would identify specific provider types or service lines that warrant examination (e.g., obstetrics, outpatient substance use disorder treatment, inpatient pediatric care, oncology, etc.) and relevant regions and incorporate other factors in the public interest, such as populations served. Formal findings of an assessment could include designating a specific set of services or class of providers as critical to the proper functioning of the Massachusetts health care system, identifying barriers impacting accessibility of available supply by specific populations, and/or making recommendations to address misalignment of need, supply, and distribution.

b. Strengthen Tools to Monitor and Regulate Supply of Health Care Services. Massachusetts' existing frameworks for monitoring and regulating provider supply and distribution, including its Determination of Need (DoN) Program, Essential Services Closures process, and Material Change Notice (MCN) process can be strengthened as follows:

i. Better Equip the State to Monitor and Respond to Essential Service Closures. The Essential Services process could be improved with enhanced financial monitoring of providers who may be at risk, earlier confidential notice of potential reduction in services or closure, broadening the scope of services covered, and allowing for sensitive information to be provided confidentially to better inform regulator response.

ii. Strengthen the Review of Proposed Expansions to Ensure Alignment with State Cost Containment and Health Equity Goals. The DoN program should be updated to align with the focused assessments of need, cost growth, affordability, and health equity goals. In addition, given the significant potential for impacts on health care spending, quality, access and equity of market expansions, the existing material change notice and review process should be amended to require notice to the HPC before a provider substantially increases capacity.

c. Enhance the HPC's Market Oversight Authority of For-Profit Investment. The requirement that providers and provider organizations file notices of material change before engaging in certain transactions should be updated to reflect the increasing role of private equity and for-profit investment in health care. All new and significant for-profit investments in a provider or provider organization, including private equity investment, should require a material change notice filing.

8. SUPPORT AND INVEST IN THE COMMONWEALTH'S HEALTH CARE WORKFORCE. The Massachusetts health care workforce continues to experience substantial disruption, with high turnover and shortages of care providers in many roles throughout the care continuum, especially in behavioral health care and long-term care. The COVID-19 pandemic exacerbated pre-existing challenges such as stress, inflexibility, and administrative burden – and with a tighter labor market, many care providers have left their roles seeking higher pay (e.g., at comparatively well-resourced organizations, in different health care settings, or in contract roles), have redirected their careers away from patient care to administration or research, or have left health care altogether. These trends have impeded patient access, interrupted care continuity, and resulted in patient access issues and bottlenecks, threatening the Commonwealth's efforts to advance health care affordability, access, and equity. Building on substantial new investments by the Healey-Driscoll Administration and the Legislature in the fiscal year 2024 budget, such as $140.9 million in loan repayment for primary care and behavioral health workers and free community college education for all nursing students, there are opportunities for both the Commonwealth and the health care delivery organizations that employ care providers to stabilize and strengthen the health care workforce.

a. Public Investments and Policy Change. The Commonwealth should provide upfront support to alleviate the financial burden of education and training, including for advanced degrees and for the period between education and licensure for licensed roles, and should otherwise reduce barriers to entry. The Commonwealth should also consider

policy changes supporting enhanced wages for under-resourced sectors. Finally, Massachusetts should join 41 other states (including most New England states) and jurisdictions across the country by adopting the Nurse Licensure Compact to facilitate permanent hires from other states.

b. **Health Care Delivery Organizations Should Invest in their Workforces.** Health care delivery organizations should invest in their workforces and implement care delivery innovations to provide attractive schedules, improved work environments, and career advancement opportunities. As part of this investment, care delivery organizations should focus on job quality and retention, especially for roles with high turnover, with improvements in areas including mentoring and professional development, schedule flexibility, and compensation.

c. **Ensure Adequate Compensation for Non-Clinical Workforces.** Innovative, evidence-based care models for primary and behavioral health care frequently integrate non-clinical staff workforces – e.g., community health workers, community navigators, and peer recovery coaches – whose lived experience confers significant value to patients. These workers frequently assume significant operational and emotional responsibility, particularly in caring for patients with complex health and social needs but are often not compensated commensurate with that responsibility. Efforts to address compensation should also encompass increased spending on these important workforce types.

d. **Support Workforce Diversity.** Research shows that clinician diversity improves care for patients of color. Increasing the diversity of health care professionals and leaders requires concerted efforts by secondary and higher educational institutions, medical and nursing schools, and health care providers. Outreach and recruitment efforts to encourage students of diverse backgrounds to become health care providers should be supported by upfront funding for education and training, including the development of clear and accessible career ladders, and with improved mentoring and leadership training to support retention. Care delivery organizations should prioritize targeted recruitment and retention efforts that will create a more diverse and reflective workforce.

9. STRENGTHEN PRIMARY AND BEHAVIORAL HEALTH CARE.

There is considerable evidence that health care delivery systems oriented toward primary care tend to have lower costs, higher quality, and a more equitable distribution of health care resources. Better management of behavioral health conditions has also been found to lower overall health care spending and improve quality of life. Specific areas of focus should include:

a. **Focus Investment in Primary Care and Behavioral Health Care.** Payers and providers should increase resources devoted to primary care and behavioral health while adhering to the Commonwealth's total health care cost growth benchmark. These investments should prioritize non-claims based spending such as capitation, infrastructure, and workforce investments. CHIA and the HPC should continue to track and report on primary care and behavioral health care spending trends annually.

b. **Increase Access to Behavioral Health Services.** In response to the critical need for behavioral health services—in particular among children, young adults, and people of color — payers and providers should take steps to increase access to behavioral health services appropriate for and accessible to these populations. The Commonwealth can advance these goals by continuing to implement the Executive Office of Health and Human Services' Roadmap for Behavioral Health Reform: Ensuring the right treatment when and where people need it, including increasing inpatient beds for behavioral health patients (including pediatric patients), investing in community-based alternatives to the emergency department, and aligning the behavioral health workforce with current needs, by increasing reimbursement to behavioral health providers, developing targeted recruitment and retention strategies, and using telehealth and innovative care models to extend capacity and ensure that patients have equitable access to the appropriate level of care based on their needs.

c. **Improve Access to Treatment for Opioid Use Disorder.** Recent studies have documented both rising rates of opioid overdose among Black and Hispanic populations and disparities in access to treatment for opioid use disorders (OUD). In response to these troubling data, payers and providers should use RELD (race, ethnicity, language, disability) data to identify inequities in access to Medication for Opioid Use Disorder (MOUD). Based on those findings, providers should undertake focused efforts to close any access gaps by engaging with community-based organizations and people with lived experience to tailor interventions to identified communities.

PRESS RELEASE

HPC REPORT FINDS MASSACHUSETTS RESIDENTS AND BUSINESSES FACE UNSUSTAINABLE GROWTH IN HEALTH CARE COSTS, CALLS FOR POLICY ACTION

The HPC's 10th annual Health Care Cost Trends Report urges updates to advance cost containment, affordability, and health equity

FOR IMMEDIATE RELEASE:
9/13/2023

Massachusetts Health Policy Commission

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BOSTON — Today, the Massachusetts Health Policy Commission (HPC) voted to issue the 2023 Health Care Cost Trends Report and comprehensive policy recommendations (/doc/2023-health-care-cost-trends-report/download). The HPC reports that the average expense of employer-based private health insurance in 2021 climbed to $22,163, outpacing growth in wages and salaries. Including copayments, deductibles, and out-of-pocket spending, health care costs for Massachusetts families neared $25,000 annually. The HPC found that 72% of small business health insurance plans featured deductibles exceeding $2,800 for families (or $1,400 for individuals) in 2021, with annual family premiums simultaneously surging from $16,000 to $23,000 since 2012. The report highlights the unequal burden of these trends, finding persistent disparities across income and racial/ethnic groups with nearly 1 in 5

lower-income residents having high out-of-pocket spending, for example, and significantly higher infant mortality rates and rates of premature deaths from treatable causes among Black and Hispanic residents compared to other residents. To address these complex and interrelated challenges, the HPC calls for urgent action to update the state's policy framework to more effectively contain cost growth, alleviate the financial burden of health care costs on Massachusetts families, and promote equity in access to care and outcomes for all residents. The **presentation materials from the Board meeting** (/info-details/hpc-board-meetings) and a **recording of the meeting** (https://www.youtube.com/watch?v=JwzwT4YI7bQ) are available on **the HPC's website** (/orgs/massachusetts-health-policy-commission).

"The 2023 Health Care Cost Trends report makes clear how we must do more in Massachusetts to provide more affordable and equitable access. Policymakers do not have to choose between high quality care and affordability," said Deb Devaux, HPC Board Chair. "We have tremendous opportunities for transformative action to support patients and employers."

Among the report's findings were that, on average from 2019 to 2021, total health care spending increased 3.2% per year, higher than the 3.1% health care cost growth benchmark. Commercial spending grew by 5.8% per year, far outpacing the national average in a reversal of prior years of relatively slower growth. Commercial expenditures for prescription drugs and hospital outpatient care grew the fastest; the average price per prescription for branded drugs exceeded $1,000 in 2021, up from $684 in 2017 while the average commercial price for hospital outpatient services grew by 8.4% from 2019 to 2021. The average price for many common hospital stays also increased, with most growing by 10% or more over the same period. The HPC estimates that by eliminating excessive spending due to unreasonably high prices, overuse of high-cost sites of care, and overprovision of care, the Commonwealth could see systemwide savings of nearly $3.5 billion annually.

With the report, the HPC announces nine policy recommendations for improving oversight and accountability and promoting affordability and equity in the health care system.

"The residents of the Commonwealth deserve a policy framework equal to the novel challenges facing our health care system today," said David Seltz, HPC Executive Director. "The recommendations in this report provide a roadmap for policymakers to equip the state with the tools it needs to constrain health care cost growth equitably and sustainably in a manner that meaningfully addresses existing disparities in access and outcomes."

2023 HEALTH CARE COST TRENDS REPORT – POLICY RECOMMENDATIONS

The HPC recommends reforms to reduce health care cost growth, promote affordability, and advance equity, with an emphasis on modernizing the state's nation-leading benchmark framework.

1. **Modernize the Commonwealth's benchmark framework to prioritize health care affordability and equity for all**. As recommended in past years, the Commonwealth should strengthen the accountability mechanisms of the benchmark such as by updating the metrics and referral standards used in the performance improvement plan (PIP) process and enhancing transparency and PIP enforcement tools. The state should also modernize its health care policy framework to promote affordability and equity including through the establishment of affordability and equity benchmarks.
2. **Constrain excessive provider prices**. As found in previous cost trends reports, prices continue to be the primary driver of health care spending growth in Massachusetts. To address the substantial impact of high and variable provider prices, the HPC recommends the Legislature enact limitations on excessively high

commercial provider prices, require site-neutral payments for routine ambulatory services, and adopt a default out-of-network payment rate for "surprise billing" situations.

3. **Enhance oversight of pharmaceutical spending**. The HPC continues to recommend that policymakers take steps to address the rapid increase in retail drug spending in Massachusetts with policy action to enhance oversight and transparency. Specific policy actions include adding pharmaceutical manufacturers and pharmacy benefit managers (PBMs) under the HPC's oversight, enabling the Center for Health Information and Analysis (CHIA) to collect comprehensive drug pricing data, requiring licensure of PBMs, expanding the HPC's drug pricing review authority, and establishing caps on monthly out-of-pocket costs for high-value prescription drugs.
4. **Make health plans accountable for affordability**. The Division of Insurance (DOI) should closely monitor premium growth factors and utilize affordability targets for evaluating health plan rate filings. Policymakers should promote enrollment through the Massachusetts Connector and the expansion of alternative payment methods (APMs). Lower-income employees should be supported by reducing premium contributions through tax credits or wage-adjusted contributions.
5. **Advance health equity for all**. To address enduring health inequities in Massachusetts, the state must invest in affordable housing, improved food and transportation systems, and solutions to mitigate the impact of climate change. Payer-provider contracts should promote health equity via performance data stratification and link payments to meeting equity targets. Payers should commit to the adoption of the **data standards** (/info-details/eohhs-quality-measure-alignment-taskforce#health-equity-data-standards-and-accountability-framework-recommendations-) recommended by the Health Equity Data Standards Technical Advisory Group, and efforts should be made to ensure that the health care workforce reflects the diversity of the state's population.
6. **Reduce administrative complexity**. The Legislature should require standardization in payer claims administration and processing, build upon the momentum from recent federal initiatives to require automation of prior authorization processes, and mandate the adoption of a standardized measure set to reduce reporting burdens and ensure consistency.
7. **Strengthen tools to monitor the provider market and align the supply and distribution of services with community need**. The HPC recommends enhanced regulatory measures including focused, data-driven assessments of service supply and distribution based on identified needs and updates to the state's existing regulatory tools such as the Essential Services Closures process, the Determination of Need (DoN) program, and the HPC's material change notice (MCN) oversight authority.
8. **Support and invest in the Commonwealth's health care workforce**. The state and health care organizations should build on recent state investments to stabilize and strengthen the health care workforce. The Commonwealth should offer initial financial assistance to ease the costs of education and training, minimize entry barriers, explore policy adjustments for improved wages in underserved areas, and adopt the **Nurse Licensure Compact** (https://www.nursecompact.com/) to simplify hiring from other states. Health care delivery organizations should invest in their workforces, improve working conditions, provide opportunities for advancement, improve compensation for non-clinical staff (e.g., community health workers, community navigators, and peer recovery coaches) and take collaborative steps to enhance workforce diversity.
9. **Strengthen primary and behavioral health care**. Payers and providers should increase investment in primary care and behavioral health while adhering to cost growth benchmarks. Addressing the need for behavioral health services involves measures such as enhancing access to appropriate care, expanding inpatient beds, investing in community-based alternatives, aligning the behavioral health workforce to

current needs, employing telehealth, and improving access to treatment for opioid use disorder particularly in places where existing inequities present barriers.

The full text of all nine **policy recommendations can be found in the report** (/doc/2023-health-care-cost-trends-report-policy-recommendations/download).

2023 HEALTH CARE COST TRENDS REPORT – KEY FINDINGS

Prices continue to be the primary driver of health care spending growth in Massachusetts.

In the report, the HPC identifies price, rather than utilization, as the primary driver of the increase in spending. Commercial prices grew substantially from 2018 to 2021, with an 8.8% increase for office-based services, a 12.1% rise for hospital outpatient services, and a 10.2% uptick for inpatient care. Total payment per hospital discharge for commercially insured patients grew by 23% between 2017 and 2021, primarily driven by a 34% price increase for non-labor-and-delivery discharges.

HPC's analyses of excess spending found that, private insurers paid providers more than twice what Medicare would have paid for nearly 40% of all lab tests and imaging procedures in 2021. Taken together, commercial spending on lab tests, imaging procedures, inpatient hospital stays, clinician-administered drugs, endoscopies, prescription drugs, and certain specialty services accounted for 45% of commercial spending. Among this spending, 27% was in excess of double what Medicare would have paid (or 120% of international drug prices), equivalent to approximately $3,000 annually for a family with private insurance.

Other findings include:

- **Excessive spending from unnecessary use of care**. Unnecessary utilization of care, such as procedures that could be performed in more cost-effective ambulatory surgery centers (ASCs), care that provides no clinical benefit to patients, and low-risk births in academic medical centers (AMCs) that are reimbursed at higher rates than those in community hospitals, contribute to excessive spending.
- **Administrative spending**. Administrative spending of both hospitals and insurers has increased substantially, with hospital administrative costs nearly doubling from 2011 to 2021, and insurers experiencing growth in administrative spending for both small and large group coverage.
- **Price trends**. Escalating price trends are evident from 2018 to 2021, with commercial prices increasing for various services including: office services, hospital outpatient care, and inpatient services. Payments for inpatient hospital care grew by 23%, driven primarily by non-labor-and-delivery discharges.
- **Provider organization performance variation**. Variation in provider organization performance continues, with medical spending differing widely between major provider groups, and the rate of avoidable visits and imaging utilization varying significantly.
- **Hospital utilization**. Massachusetts maintains the highest hospital utilization rate for Medicare beneficiaries among all states, and higher statewide rates of inpatient stays, outpatient visits, and emergency department visits. The Commonwealth also ranks among the highest in the nation in preventable hospitalizations and readmission rates.
- **Primary care**. Between 2017 and 2021, primary care spending grew more slowly than other medical spending, leading to a decrease in primary care's share of total commercial spending; significant disparities in access to primary care between low and high-income communities persist.

- **Behavioral health**. Behavioral health trends show a substantial increase in psychotherapy visits and mental health prescriptions among young adults, alongside a rise in the proportion of patients admitted to acute care hospitals for mental health conditions. While opioid-related hospitalizations declined overall, Black non-Hispanic residents experienced persistent increases until 2020.

The **full report** (/doc/2023-health-care-cost-trends-report/download) and **policy recommendations** (/doc/2023-health-care-cost-trends-report-policy-recommendations/download), **five chartpacks** (/doc/2023-health-care-cost-trends-report-chartpack/download), and an **interactive Cost Trends Report dashboard** (/info-details/2023-cost-trends-report-interactive-overview-and-dashboard) are available on **the HPC's website** (/orgs/massachusetts-health-policy-commission).

The findings and recommendations of the report will be discussed during the HPC Cost Trends Hearing on November 8, 2023, at Suffolk University Law School in Boston. Register to attend the HPC Cost Trends Hearing in person at tinyurl.com/CTH23reg or watch via **livestream** (https://www.youtube.com/channel/UCGZknspI63TdBuHLf3IrrKQ).

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Massachusetts Health Policy Commission

The Massachusetts Health Policy Commission (HPC) is an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform. The HPC's mission is to advance a more transparent, accountable, and equitable health care system through its independent policy leadership and innovative investment programs. The HPC's goal is better health and better care – at a lower cost – for all residents across the Commonwealth.

RELATED

Annual Cost Trends Report (/info-details/annual-cost-trends-report)

STATE OF RHODE ISLAND
Office of The Health Insurance Commissioner
Department of Business Regulation

High and Increasing Prices Drive Prescription Drug Spending

The Problem

Spending on prescription drugs is high in Rhode Island.

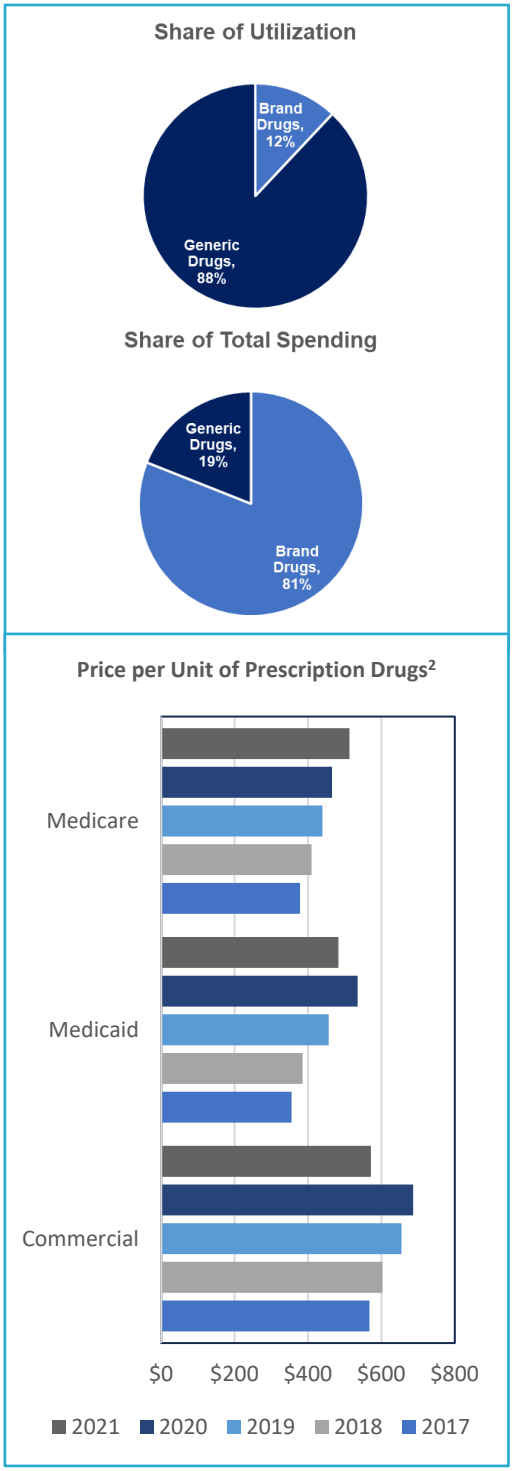
- Statewide retail prescription drug spending per person amounted to $1,223 in 2021, representing 15% of total medical spending.[1]

Price increases for brand name drugs are driving growing prescription drug spending in Rhode Island.

- In 2021, brand name drugs made up only 12% of all drugs dispensed but accounted for 81% of drug spending.
- Prices for these drugs steadily increased from 2017 to 2020, while utilization remained flat or decreased.[2]

Certain brand drugs have had VERY HIGH prices *and* have also had high rates of annual price growth.

- A prescription drug may enter the market at a very high per unit price and become even more costly over time.
    - For example, the Humira (Cf) pen was introduced into the market in 2019 at a price of **$68,880 per year**.[3]
    - After two years on the market, in 2021, the price of this drug had increased 19% to nearly **$82,000 per year**.



Why This Matters

Rhode Islanders cannot afford their life-saving prescription medications.

- Many residents use prescription drugs, and a significant portion of the elderly and those with chronic conditions rely on them to manage their conditions.
- Too many Americans have reported not filling a prescription at the pharmacy, skipping doses, or cutting pills in half because of the high prices of their medications.[5]
- For those who do fill their prescriptions, paying for these medications means less income going toward necessities like food or housing.

Research on national prescription drug spending data shows that, over time, the average launch prices of prescription drugs have increased by 20% annually.[4]

OHIC Promotes Transparency into State Health Care Spending Patterns

The Rhode Island Office of the Health Insurance Commissioner can leverage the state's All-Payer Claims Database (HealthFacts RI) to better understand patterns in health care spending and spending growth. Users can conduct analyses using these data in the interactive dashboards available on the OHIC Data Hub. These data can inform provider organizations, payers, purchasers, policymakers, and state residents interested in improving the affordability of health care in Rhode Island.

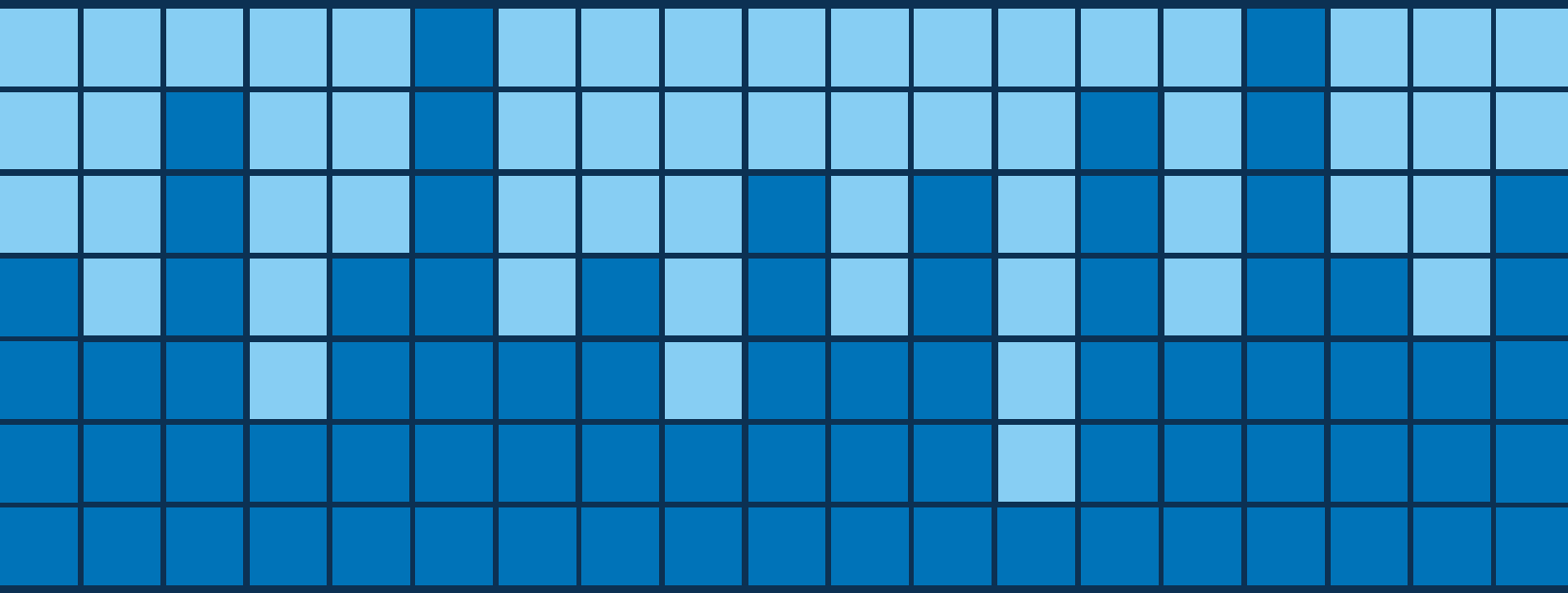
1. OHIC's analysis of total medical expense data from insurers, the Centers for Medicare & Medicaid Services (CMS), and the Rhode Island Executive Office of Health and Human Services (EOHHS).
2. Price trend for 2021 did not follow this pattern due to high utilization of COVID-19 vaccines, which were largely subsidized and made available at very low per unit prices. It is likely that without these vaccines, this pattern of growing average price would have persisted for 2021.
3. Health plans often negotiate with drug manufacturers – either directly or through pharmacy benefit managers (PBMs) – to receive discounts on prescription drugs. However, manufacturers and PBMs do not disclose the amount of the rebates on a drug-specific basis. Annual cost is based on the price per unit (PPU) for a 30-day supply multiplied by 12.
4. https://jamanetwork.com/journals/jama/article-abstract/2792986
5. https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/

The Rhode Island Office of the Health Insurance Commissioner (OHIC) was established through legislation in 2004 to broaden the accountability of health insurers operating in Rhode Island. The Office is dedicated to: protecting consumers, encouraging fair treatment of medical service providers, ensuring solvency of health insurers, and improving the health care system's quality, accessibility, and affordability.

ANNUAL REPORT

Health Care Spending and Quality in Rhode Island

2023



STATE OF RHODE ISLAND
Office of The Health Insurance Commissioner
Department of Business Regulation

Index of Acronyms

ACO	Accountable Care Organization
AE	Accountable Entity
AHRQ	Agency for Healthcare Research and Quality
APCD	All-Payer Claims Database
BCBSRI	Blue Cross Blue Shield of Rhode Island
BVCHC	Blackstone Valley Community Health Care
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease of 2019
EOHHS	Executive Office of Health and Human Services
GDP	Gross Domestic Product
HEDIS	Healthcare Effectiveness Data and Information Set
ICER	Institute for Clinical and Economic Review
IHP	Integrated Healthcare Partners
MEPS-IC	Medical Expenditure Panel Survey Insurance Component
MMP	Medicare-Medicaid Plan
MY	Measurement Year
NA	Not Applicable
NCPHI	Net Cost of Private Health Insurance
NHPRI	Neighborhood Health Plan of Rhode Island
NR	Not Reported
OHIC	Office of the Health Insurance Commissioner
PCHC	Providence Community Health Centers
PCTL	Percentile
PGSP	Potential Gross State Product
PMPM	Per Member Per Month
PMPY	Per Member Per Year
PQIP	PCP (Primary Care Physician) Quality Incentive Program
RI	Rhode Island
THCE	Total Health Care Expenditures
THP	Tufts Health Plan
THPP	Tufts Health Public Plans
TME	Total Medical Expense
UHC	UnitedHealthcare
UHCCP	UnitedHealthcare Community Plan

Annual Report: Health Care Spending and Quality in Rhode Island (2023)

The Rhode Island Office of the Health Insurance Commissioner (OHIC) was established through legislation in 2004 to broaden the accountability of health insurers operating in Rhode Island. The Office is dedicated to: protecting consumers, encouraging fair treatment of medical service providers, ensuring solvency of health insurers, and improving the health care system's quality, accessibility, and affordability.

Contents

CHAPTER 1

Introduction

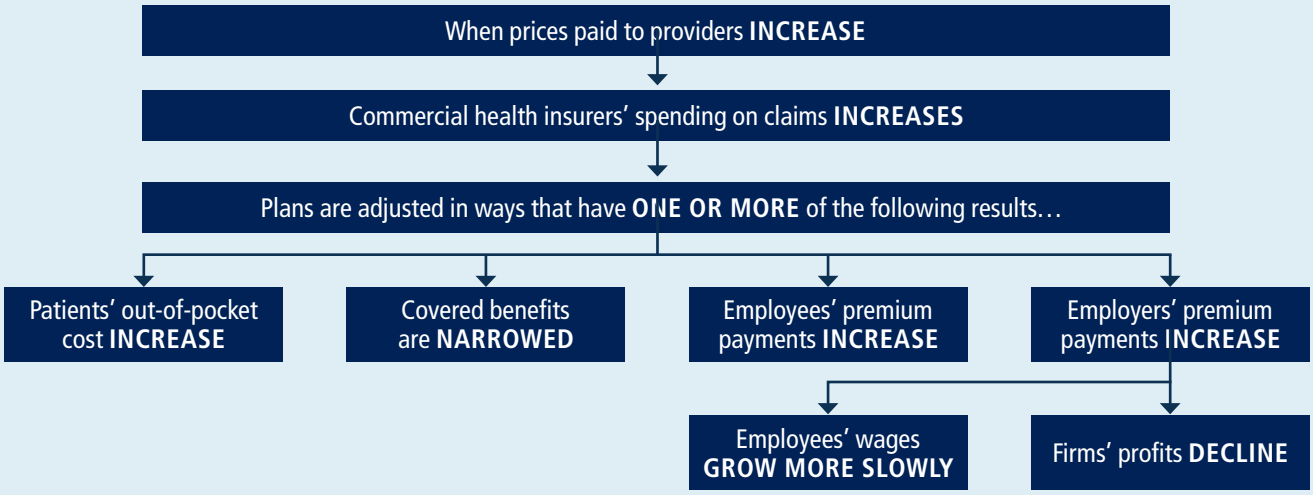
Over the last two decades, per person spending on health care in Rhode Island has grown faster than the state economy and personal income, consuming a significant and increasing proportion of household income, business revenue, and state and municipal budgets. Since 2000, per capita health care spending in Rhode Island has increased at an average annual rate of 4.6 percent,[1] compared to an average annual growth of 2.9 percent in state gross domestic product (GDP)[2] and 3.5 percent in personal income.[3] Today, per person spending on health care is 2.45 times higher than it was in 2000.

High and rising health care spending has led to dramatic increases in premiums for employer-sponsored insurance, putting a significant strain on employers and their workers. Employer-sponsored insurance is the predominant form of insurance coverage in the state, with half of Rhode Islanders obtaining coverage through an employer in 2021.[4] From 2001 to 2021, the average employer-sponsored family premium in Rhode Island grew nearly three times, from $8,023 to $22,381 per year.[5] Whether the employer funds employee health care expenses directly on a self-insured basis (as is common among large companies and municipal and state employee health benefit plans) or purchases a fully insured group plan from a commercial health insurer, these premium increases are having a significant impact on employers' costs and profitability.

High and rising health care spending has led to dramatic increases in premiums for employer-sponsored insurance, putting a significant strain on employers and their workers.

Employers have responded to increased health care costs in various ways, such as by increasing employees' premium contributions, increasing cost-sharing, reducing employment, or limiting wage growth (see Exhibit 1.1).[6,7] Data show that in Rhode

Exhibit 1.1: Effects of Higher Prices on Health Insurance Premiums and Benefits, Out-of-Pocket Costs, and Wages



Source: Congressional Budget Office, *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services*, January 20, 2022, https://www.cbo.gov/publication/57422.

1 KFF State Health Facts, *Health Expenditures per Capita by State of Residence*, accessed March 29, 2023, https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
2 United States (US) Bureau of Economic Analysis (BEA), *Gross Domestic Product: All Industry Total in Rhode Island*, retrieved from Federal Reserve Economic Data (FRED), Federal Reserve Bank of St. Louis, accessed March 27, 2023, https://fred.stlouisfed.org/series/RINGSP.
3 US BEA, *Per Capita Personal Income in Rhode Island*, retrieved from FRED, Federal Reserve Bank of St. Louis, accessed March 27, 2023, https://fred.stlouisfed.org/series/RIPCPI.
4 KFF State Health Facts, *Health Insurance Coverage of the Total Population*, accessed March 29, 2023, https://www.kff.org/other/state-indicator/total-population/.
5 Agency for Healthcare Research and Quality (AHRQ), *Average Total Family Premium (in Dollars) per Enrolled Employee at Private-sector Establishments that Offer Health Insurance by Total, Rhode Island, 1996 to 2021*, Medical Expenditure Panel Survey Insurance Component (MEPS-IC), accessed March 27, 2023, https://datatools.ahrq.gov/meps-ic?type=tab&tab=mepsich3ps.
6 Laurel Lucia and Ken Jacobs, *Increases in Health Care Costs are Coming Out of Workers' Pockets One Way or Another: The Tradeoff Between Employer Premium Contributions and Wages*, UC Berkley Labor Center Blog, January 29, 2020, https://laborcenter.berkeley.edu/employer-premium-contributions-and-wages/.
7 Daniel Arnold and Christopher M. Whaley. , RAND Corporation, 2020, https://www.rand.org/pubs/working_papers/WRA621-2.html.

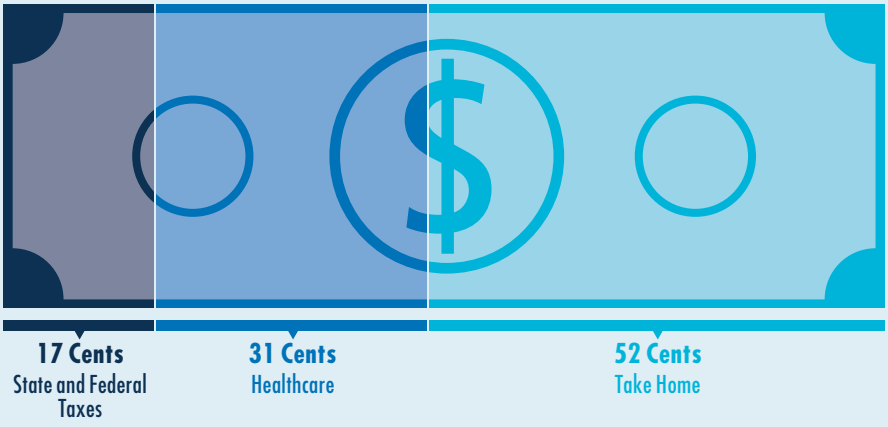
Island, employers have shifted a greater proportion of the costs of employer-based health care to employees in the form of higher premium contributions and cost-sharing. In 2001, Rhode Island workers' average premium contribution for family coverage was $1,703, or 21 percent of the entire premium. This has since increased to $6,216, or 28 percent of the entire premium, in 2021.[8] In addition, the percent of employees enrolled in a health insurance plan that has a deductible increased from 31.8% in 2003 to 94.6% in 2021. Over this same period the average annual deductible for a family plan quadrupled from $885 to $3,662.[9]

As employers turn towards plans with large deductibles and higher cost-sharing to manage the cost of providing health care to their workers, underinsurance – where individuals who have medical coverage are still exposed to financial risk – is becoming increasingly common. A survey of Rhode Islanders' insurance status, experience getting care, and use of medical services showed that 28.1 percent of Rhode Islanders were underinsured in 2022.[10] On average, Rhode Islanders spend more than $2,500 a year out-of-pocket on health care, with some spending much more to obtain care because they have coverage that requires far greater cost-sharing and/or they have significant health care needs.[11]

As a result of rising premiums and cost sharing, an estimated 31 cents of every additional dollar earned by Rhode Island families between 2017 and 2019 went to health care, leaving fewer resources for other daily needs such as housing, education, and savings (see Exhibit 1.2). In 2022, 14.9% of survey respondents had problems paying medical bills, with some being unable to pay for necessities like food, heat or rent, and others using up savings to pay for medical bills or incurring debt. Some even had to file for bankruptcy (see Exhibit 1.3).

As a result of rising premiums and cost sharing, an estimated 31 cents of every additional dollar earned by Rhode Island families between 2017 and 2019 went to health care, leaving fewer resources for other daily needs such as housing, education, and savings.

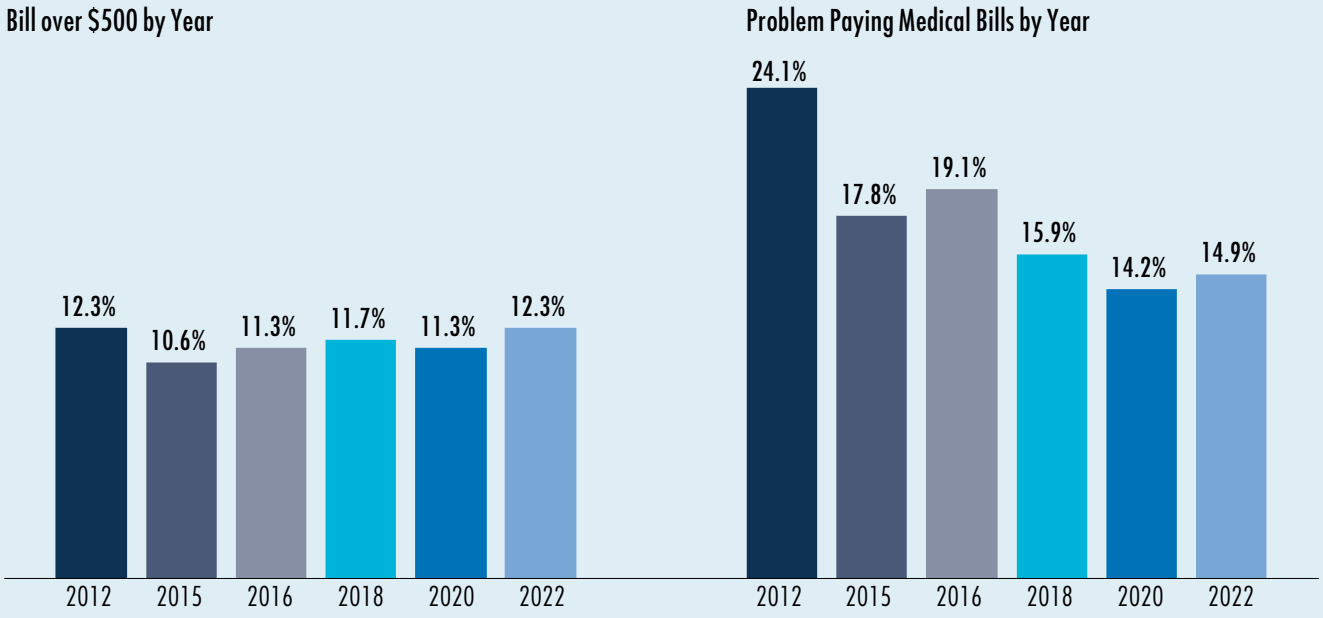
Exhibit 1.2: Allocation of the Increase in Monthly Compensation Between 2017 and 2019 for a Median Income Rhode Island Family with Health Insurance Through an Employer

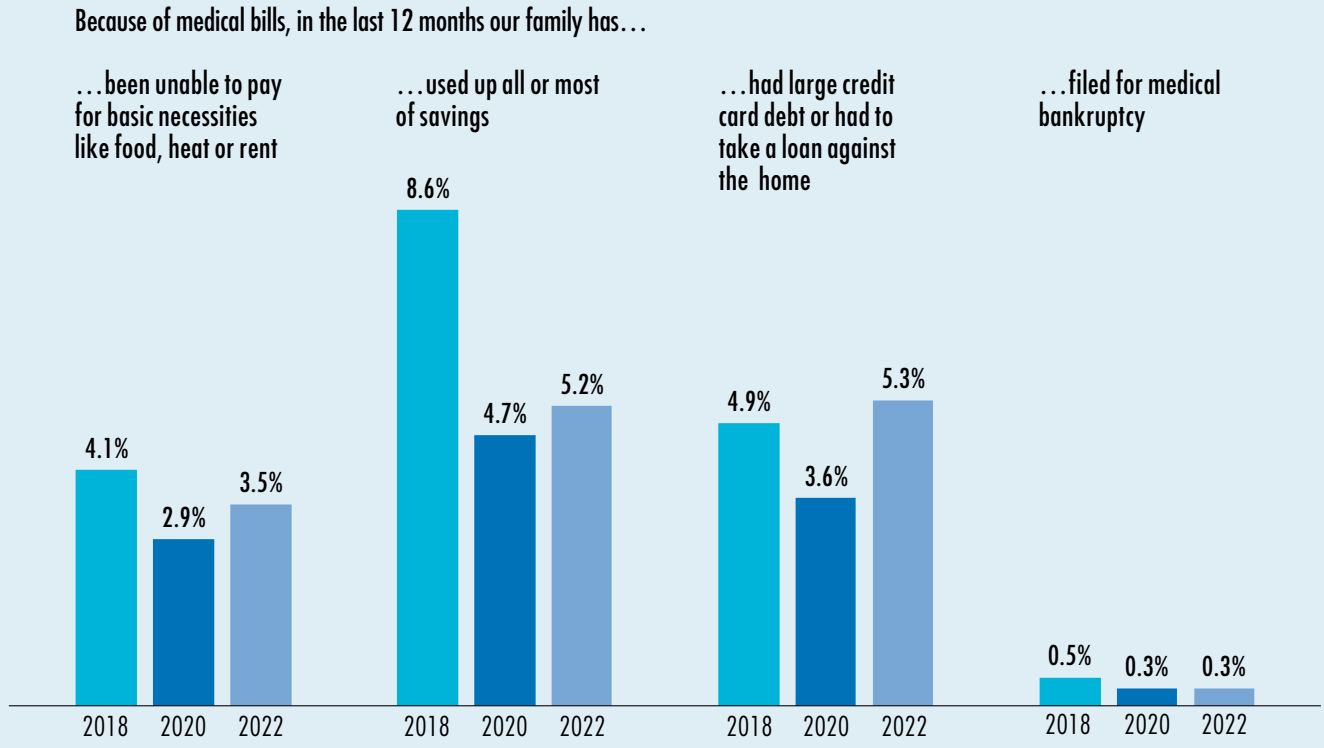


Source: OHIC analysis of AHRQ's MEPS-IC, the American Community Survey 1-year files, and the Current Population Survey. Data represent Rhode Island families who obtain private health insurance through an employer.

8 Office of the Health Insurance Commissioner (OHIC) analysis of MEPS-IC for Rhode Island private-sector establishments that offer health insurance.
9 AHRQ, MEPS-IC.
10 The 2022 Health Information Survey categorizes individuals as underinsured if: (1) their out-of-pocket costs over the past 12 months, excluding premiums, for families with incomes of 200% FPL or greater, was equal to at least 10% of household income; (2) their out-of-pocket costs over the past 12 months, excluding premiums, for families with incomes lowers than 200% FPL, was equal to at least 5% of household income; or (3) their deductible was at least 5% of household income. See: HealthSource RI, *2022 Rhode Island Health Insurance Survey*, accessed March 27, 2023, https://healthsourceri.com/surveys-and-reports/.
11 HealthSource RI. Results include all policy holders, not just those with private insurance.

Exhibit 1.3: Problems Paying Medical Bills and Financial Consequences for Rhode Islanders





Source: HealthSource RI, *2022 Rhode Island Health Insurance Survey*, accessed March 27, 2023, https://healthsourceri.com/surveys-and-reports.

An even more sobering picture emerges when looking at how medical bills have impacted certain racial groups. While 14.9 percent of the overall Rhode Island population had problems paying medical bills in 2022, a much higher percentage of Black or African American Rhode Islanders (23.6 percent) experienced this issue. Black or African American Rhode Island families also reported being unable to pay for necessities like food, heat or rent at higher rates (5.9 percent) than all Rhode Island families (3.5 percent).[12]

Against this backdrop, Rhode Island took on the challenge of slowing spending growth in 2018 when it became the third state to design a statewide target for health care spending growth. The target was implemented and became effective on January 1, 2019. Rhode Island engaged leaders in the state's health care industry to develop the target, demonstrating their shared commitment to providing Rhode Islanders with high-quality, affordable health care through greater cost transparency and increased accountability.

This report presents the findings from the Office of the Health Insurance Commissioner's (OHIC) activities to better understand and monitor the factors affecting health care spending growth in the state in 2021. **Chapter 2** presents 2021 state and market level performance against the cost growth target (insurer and provider performance are included in the Appendices). **Chapter 3** examines retail pharmacy spending and utilization patterns based on analysis of the state's All-Payer Claims Database (APCD). **Chapter 4** describes the Rhode Island health care system's performance on quality metrics. **Chapter 5** concludes with a call to action for health care leaders in public and private sectors to take all reasonable and necessary steps to keep annual spending growth below the target while maintaining high standards for quality and access.

Rhode Island engaged leaders in the state's health care industry to develop the target, demonstrating their shared commitment to provide Rhode Islanders with high-quality, affordable health care through greater cost transparency and increased accountability.

What is the Health Spending Accountability and Transparency Program?

The Rhode Island Legislature authorized OHIC to establish the Health Spending Accountability and Transparency Program in July 2022 to improve affordability and facilitate access to high-quality health care for all Rhode Islanders. The program builds on **voluntary efforts** initiated by the Rhode Island Cost Trends Steering Committee to curb health care spending growth and achieve the following goals:

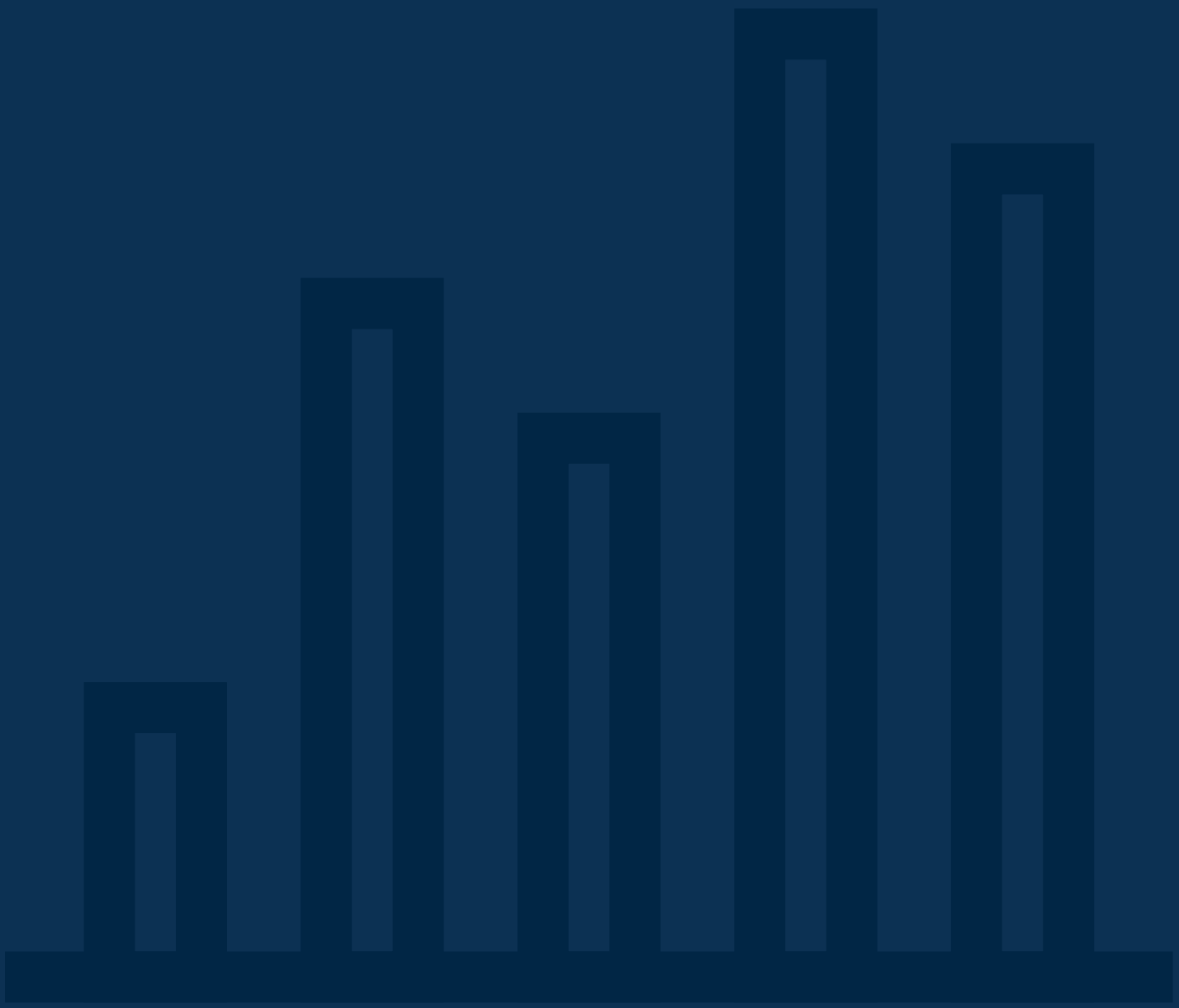
- Understand and create transparency around health care spending and the drivers of spending growth
- Create shared accountability for health care spending and spending growth among insurers, providers, and government by measuring performance against a spending growth target tied to economic indicators
- Lessen the negative impact of rising health care spending on Rhode Island residents, businesses, and government

The program seeks to achieve these goals by collecting and analyzing health care spending data to inform meaningful actions that will slow spending growth.

12 HealthSource RI.

CHAPTER 2

Trends in Health Care Spending



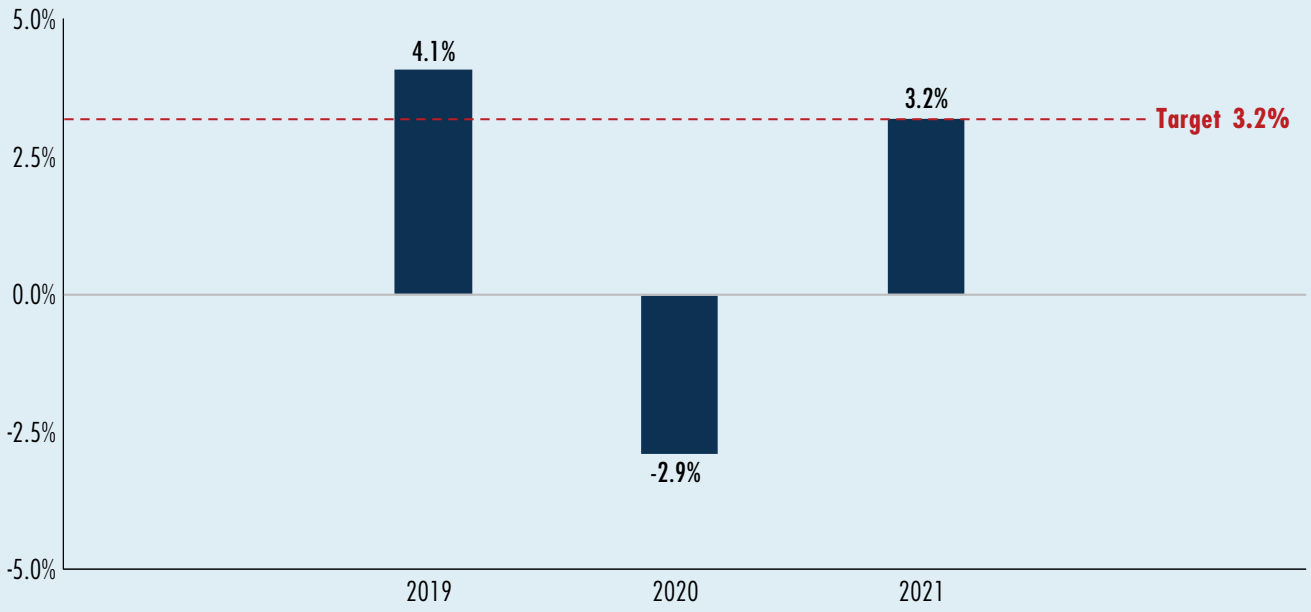
OHIC began analyzing health care spending growth in 2020 after the Rhode Island Cost Trends Steering Committee established a voluntary compact in 2018 to restrain the growth in per capita spending on health care to no more than the level of projected state economic growth. For 2019 to 2022 the state set an annual health care cost growth target of 3.2 percent, equivalent to the long-term forecasted growth in Rhode Island's Potential Gross State Product (PGSP). This chapter examines 2021 state and insurance market performance against the cost growth target. It also examines 2021 health care spending patterns based on OHIC's annual Cost Trends data collection.[1]

COVID-19 restrictions caused an abrupt reduction in the use of in-person health care, which led to a sharp drop in per capita spending in 2020. Utilization rebounded in 2021, although not to pre-pandemic levels, resulting in a 3.2 percent growth in THCE, which was equal to the target.

Statewide Spending and Spending Growth

OHIC assesses statewide health care spending growth against the cost growth target by calculating the annual change in Total Health Care Expenditures (THCE) for covered residents. THCE represents health care expenditures for Rhode Island residents who received coverage from commercial insurance (including employers that self-fund), Medicaid, and Medicare. It includes all categories of claims and non-claims payments to providers for covered services[2] delivered to insured individuals (also referred to as Total Medical Expense, or TME), and the cost of administering private health insurance (referenced as the Net Cost of Private Health Insurance, or NCPHI). OHIC measures THCE using aggregate data submitted by insurers in the state, as well as state and federal government data.

Exhibit 2.1: Statewide Performance Against the Cost Growth Target, 2019–2021



Source: OHIC analysis of TME data from insurers, the Centers for Medicare & Medicaid Services (CMS), and the Rhode Island Executive Office of Health and Human Services (EOHHS).

1 For details on the data collection and analysis methodology, see OHIC, *Rhode Island Health Care Cost Growth Target and Primary Care Spend Obligation Implementation Manual*, August 26, 2022, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-08/RI%20Implementation%20Manual_CY%202020%20-%20CY2021_final%20v8.1.pdf.

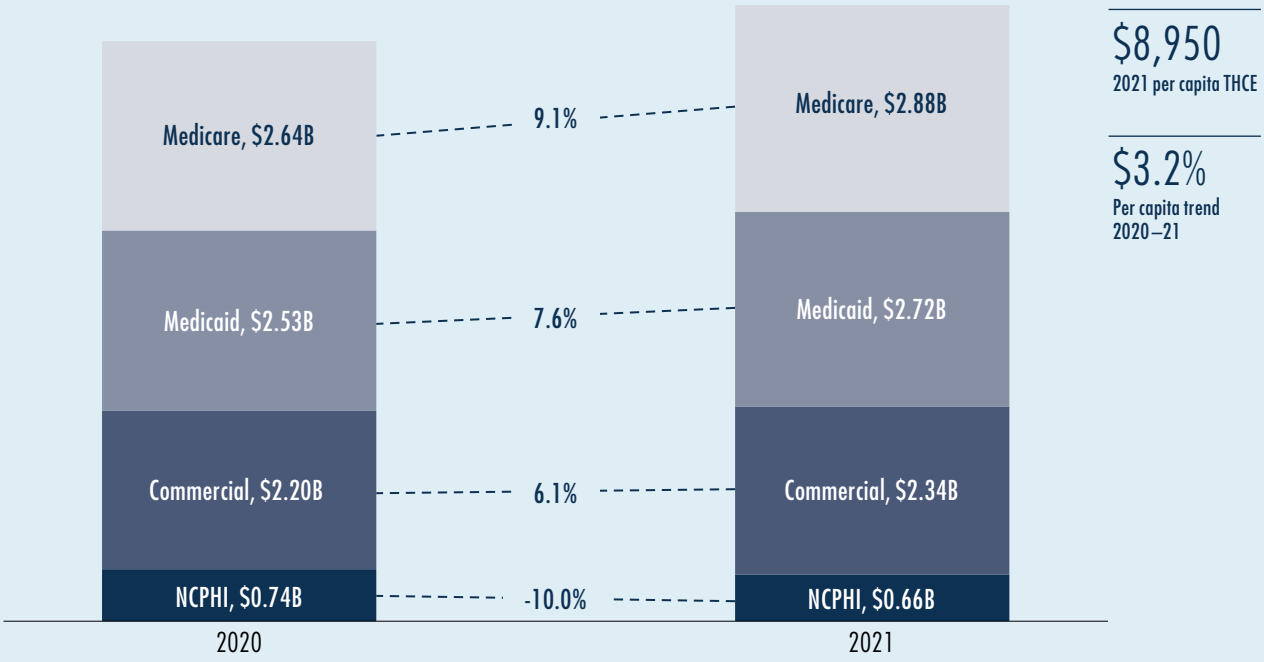
2 Some non-claims payments are not for covered services but are for incentives or infrastructure payments intended to support care delivery (e.g., electronic health record infrastructure payments and other data analytics payments).

As previously reported by OHIC, Rhode Island's per capita growth in THCE exceeded the state's target of 3.2 percent in 2019.[3] COVID-19 significantly altered health care utilization and spending in 2020. In particular, COVID-19 restrictions caused an abrupt reduction in the use of in-person health care, which led to a sharp drop in per capita spending in 2020.[4] Utilization rebounded in 2021, although not to pre-pandemic levels, resulting in a 3.2 percent growth in THCE, which was equal to the target (see Exhibit 2.1). State-level performance in 2021 was heavily influenced by a decline in Medicaid per capita spending, which may have been an artifact of federal action during the Public Health Emergency.[5]

Trends in Statewide Spending by THCE Component

Aggregate spending in the commercial market was $2.3 billion in 2021, comprising 27 percent of state THCE (see Exhibit 2.2). Combined with a commercial market enrollment decrease of 3.4 percent, this yielded a per capita spending level of $6,171, which represents a 9.7 percent increase over 2020 (see Exhibit 2.3). This increase, while far above the cost growth target, is below that of neighboring states with cost growth targets for 2021.[6]

Exhibit 2.2: Aggregate Statewide Spending Growth by THCE Component, 2020–2021



Source: OHIC analysis of TME data from insurers, CMS, the Rhode Island EOHHS, and publicly available insurer regulatory filings.

3 OHIC, *Performance Year 2020 Cost Trends Report*, April 27, 2022, https://ohic.ri.gov/policy-reform/health-spending-accountability-and-transparency-program.

4 Federal relief payments, including to Rhode Island providers, caused national health care spending to increase in 2020. Those relief payments are not available for capture in OHIC's analysis, however.

5 2021 per capita statewide spending was depressed as a result of negative Medicaid per capita trend (see Exhibit 2.3). This may be partially attributed to enrollees with extended Medicaid coverage due to the suspension of Medicaid eligibility redeterminations, some of whom obtained and utilized commercial insurance but remained enrolled in Medicaid. OHIC is unable to quantify the number of individuals affected.

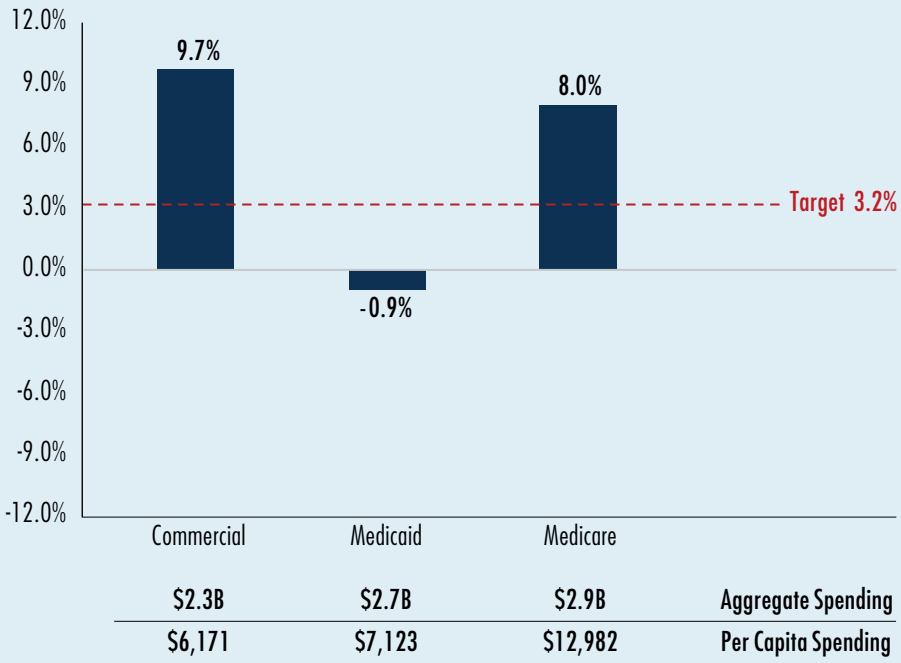
6 In 2021, Massachusetts' per capita TME for the commercial market increased by 11.6 percent. For more information, see: Massachusetts Health Policy Commission, *Hearing to Determine the 2024 Health Care Cost Growth Benchmark* (slide 6), March 15, 2023. https://www.mass.gov/doc/national-context-and-affordability-implications-of-massachusetts-trends-dr-david-auerbach/download. Connecticut's per capita TME for the commercial market increased by 18.8 percent in 2021. For more information, see: Connecticut State Office of Health Strategy, *Healthcare Cost Growth Benchmark Steering Committee Meeting*, March 27, 2023. https://portal.ct.gov/-/media/OHS/HBI-Steering-Committee/March-27-2023/Steering-Committee-meeting-3-27-23-Final-slides.pdf. Delaware reported for 2021 a per capita increase in THCE of 16.5% in the commercial market (note that at the market level Delaware only reports THCE and not TME). For more information, see: Delaware Department of Health and Social Services, *Calendar Year 2021 Results: Benchmark Trend Report* (slide 23), April 6, 2023. https://dhss.delaware.gov/dhcc/files/de_cy_2021_benchmarkreport.pdf. Oregon's per capita TME for the commercial market increased 12.1% from 2020 to 2021. For more information, see: *Oregon Health Authority, Health Care Cost Growth Trends in Oregon, 2020–2021: 2023 Sustainable Health Care Cost Growth Target Annual Report* (slide 17), May 9, 2023. https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2023-Oregon-Cost-Growth-Target-Annual-Report.pdf.

Medicare spending was to $2.9 billion in 2021, representing 34 percent of state THCE. Per capita spending on Medicare increased 8.0 percent to $12,982, while enrollment increased 1.0 percent.

Medicaid spending totaled $2.7 billion, accounting for 32 percent of state THCE in 2021. On a per capita basis, Medicaid spending decreased 0.9 percent to $7,123. Enrollment in Medicaid increased 8.7 percent, in part due to federal requirements to maintain continuous coverage during the COVID-19 public health emergency. It is likely that some of those with continuous coverage obtained private employer-based coverage prior to or during 2021 and did not incur Medicaid spending, therefore causing decline in the Medicaid growth rate.

Aggregate spending on NCPHI totaled $661.1 million in 2021. NCPHI represents the administrative costs of providing private health insurance and accounted for 8 percent of THCE in 2021. On a per capita basis, NCHPI decreased 12 percent from 2020. During the height of the pandemic in 2020, insurers saw a large increase in NCPHI due to decreased health care utilization (and therefore, decreased medical expenses). In 2021, utilization patterns returned to anticipated levels, which drove NCPHI spending down from its previously elevated levels (for more information on NCPHI, see the sidebar).

Exhibit 2.3: Aggregate TME, Per Capita TME, and Growth in Per Capita TME by Market, 2020–2021



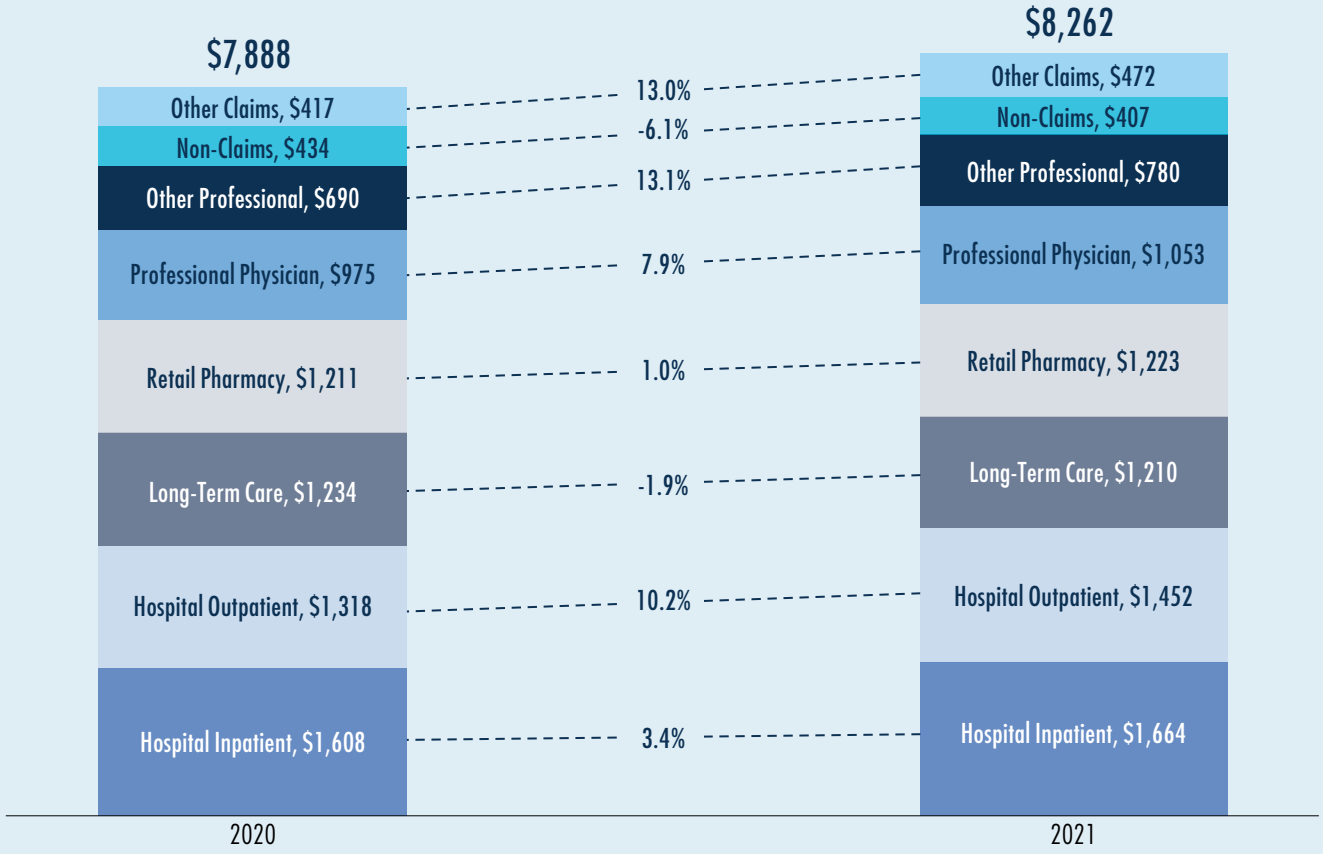
Source: OHIC analysis of TME data from insurers, CMS, and the Rhode Island EOHHS.

Understanding the Net Cost of Private Health Insurance

NCPHI captures the cost of administering private health insurance for Rhode Island residents. It is broadly defined as the difference between the premium revenue health plans receive on behalf of Rhode Island residents and the spending incurred for covered benefits for those same members. NCPHI includes insurers' costs of paying bills, advertising, sales commissions, and other administrative costs. Because plan premiums are set prospectively based on historical claims data and actuarial assumptions, NCPHI can vary significantly from year to year depending on how closely actuarial projections match actual spending on health care services.

Statewide Spending Trends by Service Category

Exhibit 2.4. Per Capita State TME by Service Category



Source: OHIC analysis of TME data from insurers, CMS, and the Rhode Island EOHHS.

A deeper look at spending by service categories shows that per capita spending on Long-Term Care and Non-Claims payments at the state level decreased in 2021, whereas spending on all other service categories increased (see Exhibit 2.4). Hospital services represent the largest portion of health care spending, with Hospital Inpatient and Outpatient services accounting for 38 percent of per capita TME. Service categories that experienced the most significant growth were Other Professional, Other Claims, Hospital Outpatient, and Professional Physician Services.

The significant increase in Hospital Outpatient and Professional Physician spending represents a rebound in utilization for those services that were delayed, avoided, or canceled in 2020 at the height of the COVID-19 pandemic. The increase in Other Professional spending, which includes behavioral health services delivered by non-physician practitioners, may have been influenced by the pandemic's profoundly negative effects on mental health. The increase in Other Claims was driven by COVID-19 testing and vaccine administration.

Per capita spending on Retail Pharmacy remained high in 2021. In contrast to previous years, however, spending growth for this service category increased only slightly. Retail Pharmacy grew by only 1.0 percent in 2021, compared to 6.9 percent in 2019 and 8.3 percent in 2020.[7] Pharmacy rebates, which totaled $420 million in 2021, had a significant impact on lowering the annual growth in Retail Pharmacy spending (see sidebar for more information on pharmacy rebates).[8] Without accounting for rebates, per capita growth in Retail Pharmacy spending was 3.9 percent.

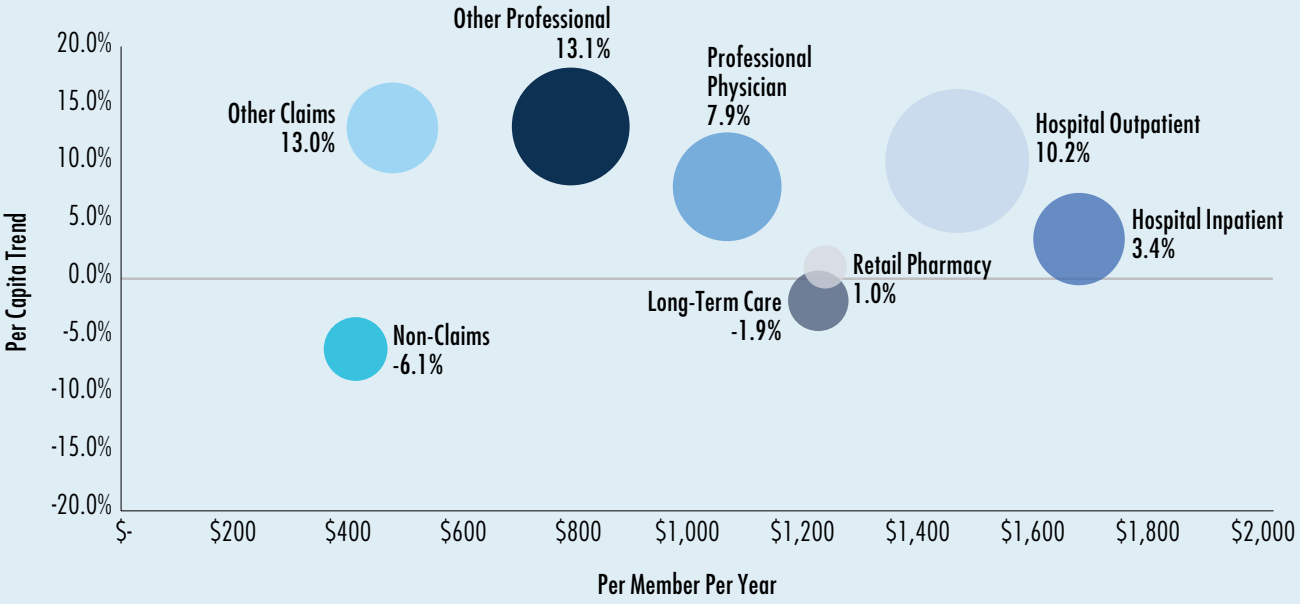
Drivers of Statewide Spending Growth

Two factors determine a particular service category's contribution to overall spending growth – the level of per capita spending for the service category, and its annual rate of growth.[9] At the state level, growth in Hospital Outpatient and Other Professional spending drove overall spending growth in 2021 (see Exhibit 2.5). Per capita spending on Hospital Outpatient services – which was already high – grew significantly in 2021, making it the largest contributor to overall spending growth. Per capita spending on Other Professional services was moderate, but increased significantly, making this service category a second significant cost driver for 2021.

Drug Rebates

Health plans often negotiate with drug manufacturers – either directly or through pharmacy benefit managers – to receive discounts on prescription drugs. These discounts or rebates are paid to the plan after a drug has been dispensed, effectively reducing the cost of the drug. Manufacturers use these rebates as a negotiation tool to earn favorable placement on the insurer's preferred drug list or formulary, which increases the drug's market share.

Exhibit 2.5: State Level Service Category Contribution to Growth, 2020–2021



Source: OHIC analysis of TME data from insurers, CMS, and the Rhode Island EOHHS.

Data are unadjusted. Retail and medical pharmacy rebates are accounted for in the reporting of Retail Pharmacy spending. Data do not include NCPHI. The width of the bubbles represents contribution to growth.

7 For more information on 2019 spending growth performance see: OHIC, *Rhode Island Cost Trends Steering Committee* (slides 9-47), April 29, 2021. https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/2021/April/Cost-Trends/steering-committee-meeting-2021-4-29-for-sharing.pdf. For more information on 2020 spending growth performance, see: Office of the Health Insurance Commissioner, *Performance Year 2020 Cost Trends Report*.

8 The timing of rebate payments may be irregular, which may cause modest distortions in the total amount of rebates in a given year.

9 Contribution to overall spending growth was calculated by taking the absolute difference in per capita spending between 2020 and 2021 for each service category and dividing it by the sum of the absolute differences in per capita spending between 2020 and 2021 for all service categories.

CHAPTER 3

Trends in Prescription Drug Spending

Prescription drug spending has been a significant driver of overall spending growth in Rhode Island and across the United States. OHIC's analysis of Cost Trends data showed that in 2021, statewide per capita spending on Retail Pharmacy amounted to $1,223, representing 15 percent of TME (see Exhibit 2.4). To further explore statewide trends in Retail Pharmacy spending, OHIC analyzed claims data from 2017 through 2021 that are available through the Rhode Island All-Payer Claims Database (APCD), HealthFacts RI. This chapter presents the results of these analyses.

Drivers of Per Capita Spending Growth on Prescription Drugs

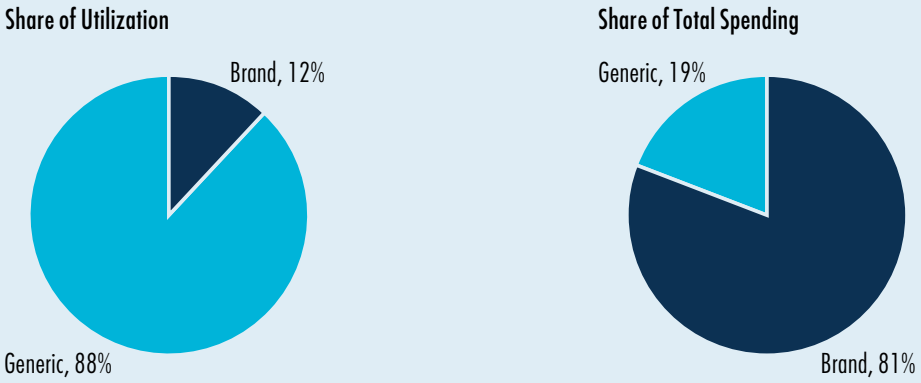
From 2017 to 2021, spending on prescription drugs for those with commercial insurance, Medicaid, and Medicare coverage in Rhode Island increased an average of 4.4 percent annually, from $120 per member per month (PMPM) to $142 PMPM. This growth was fueled by spending on brand name drugs. Between 2017 and 2021, PMPM spending on brand name drugs grew by 28 percent. By comparison, PMPM spending on generic drugs decreased 9 percent over the same time frame (see Table 3.1). In 2021, brand-name drugs represented only 12 percent of all drugs dispensed, but account for 81 percent of drug spending (see Exhibit 3.1).

Table 3.1: Per Member Per Month Spending on Retail Pharmacy for Rhode Island Residents with Commercial Insurance, Medicaid, or Medicare Advantage Coverage

	All Drugs	Brand Drugs	Generic Drugs
2017	$120	$90	$30
2018	$129	$99	$31
2019	$129 18.7%	$100 27.8%	$29 -9.2%
2020	$139	$109	$29
2021	$142	$116	$27
Average Annual Growth	**4.4%**	**6.4%**	**-2.3%**

Source: OHIC analysis of HealthFacts RI data. Medicare fee-for-service data are excluded.

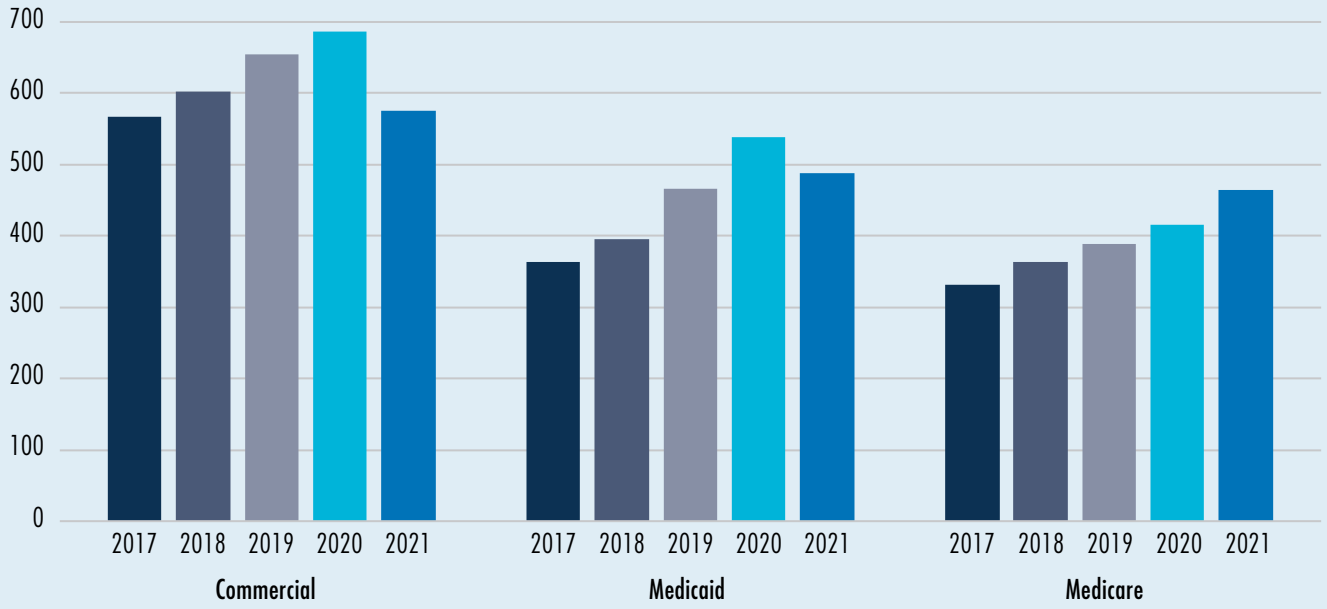
Exhbit 3.1: 2021 Utilization and Spending on Brand and Generic Drugs for Rhode Island Residents with Commercial Insurance, Medicare, or Medicare Advantage Coverage



Source: OHIC analysis of HealthFacts RI data. Medicare fee-for-service data are excluded. Units are defined as 30-day equivalent prescriptions.

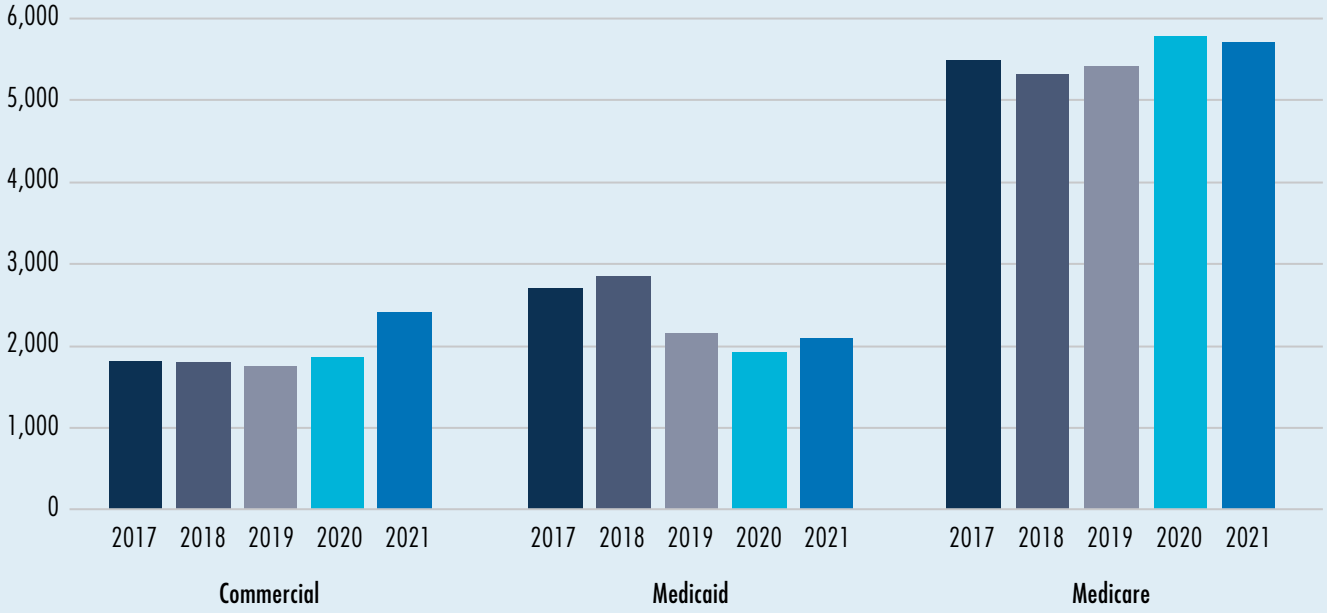
Further analysis shows that price increases drove growth in PMPM spending on brand name drugs. Across all markets, branded drug prices increased steadily between 2017 and 2020 (see Exhibit 3.2), while utilization remained relatively flat or decreased (see Exhibit 3.3).

Exhibit 3.2: Price per Unit of Prescription Drugs



Source: OHIC analysis of HealthFacts RI data. Medicare fee-for-service data are excluded. Units are defined as 30-day equivalent prescriptions.

Exhibit 3.3: Utilization of Prescription Drugs (Units per 1,000 Members)



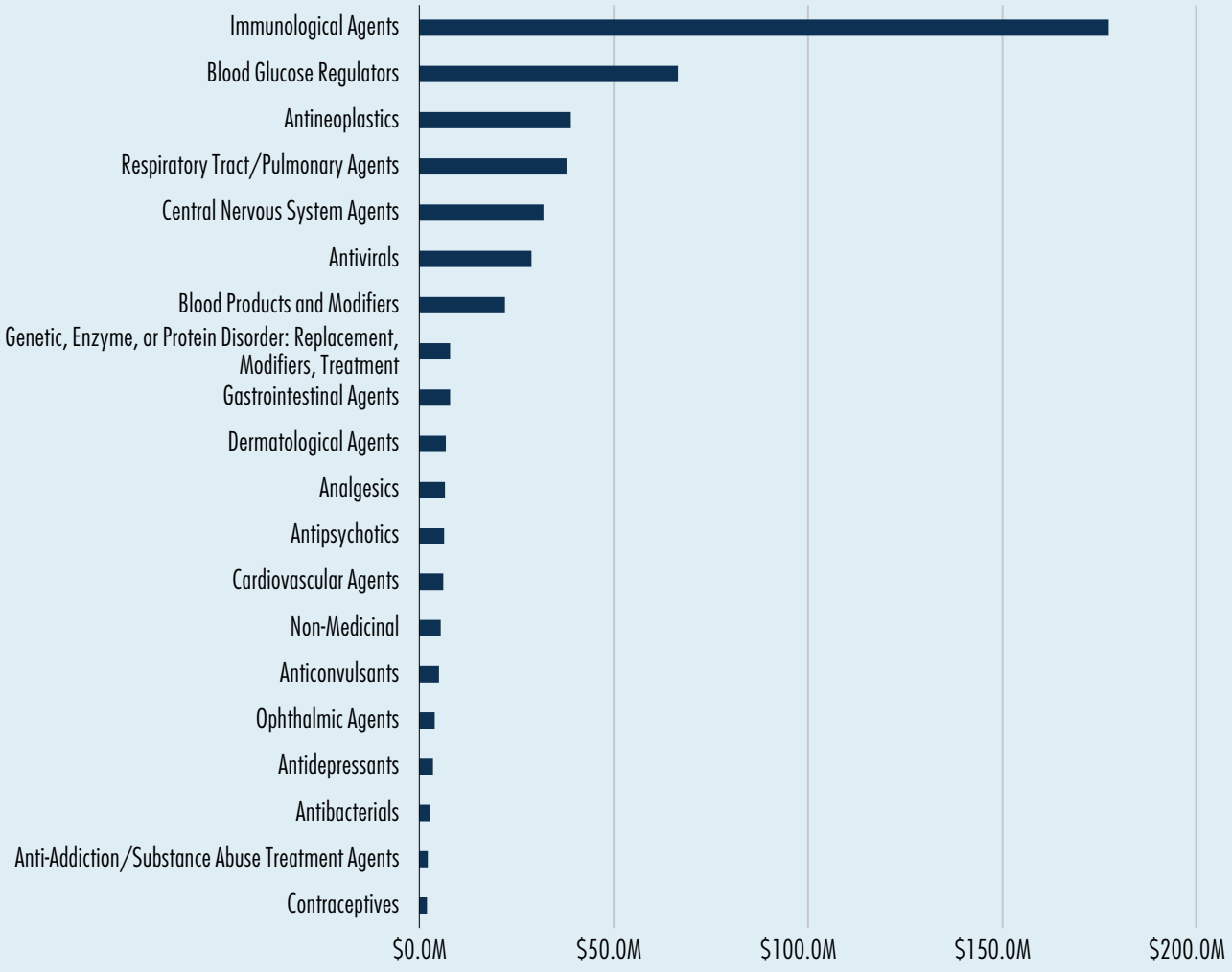
Source: OHIC analysis of HealthFacts RI data. Medicare fee-for-service data are excluded. Units are defined as 30-day equivalent prescriptions.

Trends for 2021 did not follow this general pattern due to the high utilization of COVID-19 vaccines that were subsidized and made available at very low per unit prices. The Pfizer, Moderna, and Janssen COVID-19 vaccines were three of the four most prescribed immunological agents in 2021, with unit prices of approximately $40. Without the COVID-19 vaccines, per unit prices of brand name drugs would have certainly increased in 2021 as well.

Leading Contributors to Prescription Drug Spending in the Commercial Market

To gain a better understanding of what is driving prescription drug spending in the commercial market, OHIC reviewed the seven categories of drugs accounting for almost all of 2021 spending on brand name drugs. Immunological agents topped the list with spending at $177 million (see Exhibit 3.4). A deeper look at leading immunological agent brand drugs shows that per unit prices and annual increases

Exhibit 3.4: Commercial Spending for the Top 20 Brand Name Drug Categories in 2021



Source: OHIC analysis of HealthFacts RI data. Medicare fee-for-service data are excluded.

in per unit prices for these drugs are very high, especially for drugs that have growing market share (see Table 3.2). For example, the Humira (Cf) Pen – a version of a leading anti-inflammatory drug used to treat auto-immune conditions – was introduced into the market in 2019 at a price of $5,740 per unit. Two years after entering the market, the price for the drug increased by 19 percent. The rapid introduction of new and expensive brand name drugs into the market raises significant concerns around affordability for employers and consumers.

Furthermore, research shows that there is often not enough clinical evidence to justify substantial price increases for some major drugs. In 2021, the Institute for Clinical and Economic Review (ICER) reviewed 13 drugs that significantly contributed to growth in U.S. drug spending and found that 10 of them had price increases that were unsupported by new clinical evidence.[1] In previous years, ICER consistently categorized Humira – the highest spend drug in Rhode Island – as a drug with unsupported price increases.[2]

Table 3.2: Change in Commercial Price and Utilization for the Three Leading Immunological Agent Brand Name Drugs

Drug	2017		2021		Change from 2017–2021	
	PRICE PER UNIT	UNITS/1000	PRICE PER UNIT	UNITS/1000	CHANGE IN PRICE PER UNIT	CHANGE IN UNITS/1000
Humira	Not on the market	NA	$6,828	18	19% (since 2019)	80% (since 2019)
Stelara	$9,604	2	$14,624	5	52%	150%
Enbrel Sureclick	$4,431	8	$5,817	7	32%	-13%

Source: OHIC analysis of HealthFacts RI data. Medicare fee-for-service data are excluded.

Prescription drugs are vital to maintaining or improving health. At least half of U.S. individuals and 69 percent of adults aged 40–79 use prescription drugs, and a significant portion of the elderly and those with chronic conditions rely on them to manage their conditions.[3] The high and rising cost of these drugs is putting a financial strain on families, employers, and government. Moving forward, addressing prescription drug costs will be a vital issue for Rhode Island, as the state continues to recover from the pandemic and turns its attention toward containing health care costs over the long term.

1 Institute for Clinical and Economic Review (ICER), *Unsupported Price Increase Report: Unsupported Price Increases Occurring in 2021*, December 6, 2022. https://icer.org/wp-content/uploads/2022/04/UPI_2022_National_Report_120622.pdf.

2 ICER has categorized Humira as a drug with price increases that were not supported by clinical evidence in 2019 and 2020. See: ICER, *Unsupported Price Increase Report: 2019 Assessment*, Updated November 6, 2019, http://icerorg.wpengine.com/wp-content/uploads/2020/10/ICER_UPI_Final_Report_and_Assessment_110619.pdf; and ICER, *Unsupported Price Increase Report: 2020 Assessment*, January 12, 2021. https://icer.org/wp-content/uploads/2020/11/ICER_UPI_2020_Report_011221.pdf.

3 Craig M Hales et al, *Prescription Drug Use Among Adults Aged 40–79 in the United States and Canada*, NCHS Data Brief 347 (2019):1-8, https://pubmed.ncbi.nlm.nih.gov/31442200/.

CHAPTER 4

Quality

To offer a balanced perspective on health system performance, the Rhode Island Cost Trends Steering Committee recommended that OHIC begin reporting quality data to complement annual public reporting of spending growth. Examining quality of care, in conjunction with efforts to aggressively control spending growth, is critical for a comprehensive picture of health system performance.

Since 2017, OHIC has required commercial insurers to use core measures from OHIC's Aligned Measure Sets in any contract with a financial incentive tied to quality.[1,2] In addition, Rhode Island Medicaid's Accountable Entities (AE) program requires measurement and reporting of AE quality performance using the Medicaid AE Common Measure Slate, which EOHHS voluntarily aligns with the OHIC Accountable Care Organization (ACO) Core Measure Set, to inform the distribution of any shared savings earned under total cost of care contracts. For these reasons, and because ACOs and AEs are assessed against the cost growth target, the Cost Trends Steering Committee recommended using OHIC's existing ACO Core Measure Set to monitor quality alongside spending growth.[3]

Starting with the 2021 performance year, OHIC is reporting commercial and Medicaid quality performance data for the Core Measures in OHIC's ACO Aligned Measure Set. This chapter presents these findings.

2021 ACO Core Measure Set

The 2021 ACO Core Measure Set contained the following nine measures addressing three domains: chronic illness, behavioral health, and preventive care:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Comprehensive Diabetes Care: Eye Exam
- Comprehensive Diabetes Care: HbA1c Control (<8.0%)
- Developmental Screening in the First Three Years of Life
- Follow-Up After Hospitalization for Mental Illness (7-Day)
- Weight Assessment and Counseling – BMI Percentile
- Weight Assessment and Counseling – Counseling for Nutrition
- Weight Assessment and Counseling – Counseling for Physical Activity

OHIC obtains commercial performance on the ACO Core Measure Set measures directly from insurers as part of the cost growth target data collection.[4] The Rhode Island EOHHS provides the data to calculate Medicaid performance on the ACO Core Measure Set measures.[5]

1 Rhode Island Code of Regulations, *230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner*, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-03/230-ricr-20-30-4-final-sos.pdf.

2 For OHIC's guidance for insurers related to the implementation of its Aligned Measure Sets required under 230-RICR-20-30-4.10(D)(5), see: Office of the Health Insurance Commissioner, *Updated Guidance on Use of Aligned Measure Set*, October 11, 2022, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-10/Aligned%20Measure%20Set%20Interpretive%20Guidance%202022%2010-11.pdf.

3 For details on the data collection and analysis methodology, see: OHIC, *Rhode Island Quality Reporting Implementation Manual*, September 21, 2022, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-09/RI%20Quality%20Implementation%20Manual_CY2021%20v1.0.pdf.

4 For more information on commercial ACO Core Measure Set data reporting requirements, see: Office of the Health Insurance Commissioner, *Rhode Island Quality Reporting Implementation Manual*, September 1, 2022, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-09/RI%20Quality%20Implementation%20Manual_CY2021%20v1.0.pdf.

5 For more information on the AE Common Measure Slate data reporting requirements, see: Rhode Island Executive Office of Health and Human Services, *Rhode Island Accountable Entity Program: Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities: Implementation Manual*, September 1, 2022, https://eohhs.ri.gov/media/36616/download?language=en.

Statewide Commercial Performance on the ACO Core Measure Set

Rhode Island scored above the national 75th percentile for the commercial market on all the measures, and exceeded the national 90th percentile on all but one of the measures, Comprehensive Diabetes Care: HbA1c Control (see Table 4.1).

Table 4.1: Statewide Commercial Performance on ACO Core Measure Set

Measure	National Benchmarks		Statewide Performance	
	75TH PCTL	90TH PCTL	ABOVE 75TH PCTL?	ABOVE 90TH PCTL?
Breast Cancer Screening	73%	75%	Yes 84%	Yes 84%
Colorectal Cancer Screening	66%	70%	Yes 79%	Yes 79%
Comprehensive Diabetes Care: Eye Exam	54%	60%	Yes 68%	Yes 68%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	60%	64%	Yes 62%	No 62%
Developmental Screening in the First Three Years of Life	57%	65%	Yes 85%	Yes 85%
Follow-Up After Hospitalization for Mental Illness (7-Day)	53%	59%	Yes 69%	Yes 69%
Weight Assessment and Counseling – BMI Percentile	77%	83%	Yes 92%	Yes 92%
Weight Assessment and Counseling – Counseling for Nutrition	72%	78%	Yes 90%	Yes 90%
Weight Assessment and Counseling – Counseling for Physical Activity	69%	75%	Yes 89%	Yes 89%

Source: OHIC analysis of quality performance data submitted by commercial insurers in Rhode Island. Statewide commercial performance is based on a weighted average of insurer performance using membership from the insurers' cost growth target data submissions, rather than performance for the full population, because multiple insurers submitted population samples.

What Are OHIC's Aligned Measure Sets?

Insurers often provide financial incentives to providers for meeting targets and/or demonstrating improvement on a set of quality measures as a way of encouraging high-quality health care. However, requirements for providers to report their data to multiple insurers who each use a distinct set of measures creates significant provider administrative burden. It also risks diluting the impact of payer incentives by spreading provider attention over a large number of measures. To mitigate these adverse effects, Rhode Island stakeholders undertook a collaborative effort in 2015 to identify a common set of quality measures for use in contracts between insurers and providers.

The Rhode Island State Innovation Model Test Grant supported the initial measure alignment process by convening a work group comprising stakeholders representing insurers, providers, and consumers to develop the measure sets. OHIC now convenes the OHIC Measure Alignment Work Group annually to review and update the Aligned Measure Sets as necessary. OHIC currently maintains aligned measure sets for use in primary care, ACO, acute care hospital, behavioral health hospital, outpatient behavioral health, and maternity care contracts. Each of the measure sets include Core Measures that insurers must use in applicable provider contracts; Menu Measures that are for optional use; and Developmental Measures that need further refinement and/or testing before measure set adoption.

Statewide Medicaid Performance on the ACO Core Measure Set

For 2021, the AE Common Measure Slate did not include Colorectal Cancer Screening, therefore Medicaid performance could only be reported on eight of the nine ACO Core Measures. Rhode Island exceeded the national 75th percentile for the Medicaid market on five measures and exceeded the national 90th percentile on one of the measures (see Table 4.2). Medicaid performance was better for the chronic illness and behavioral health measures than the preventative care measures (with the exception of *Developmental Screening in the First Three Years of Life*). Although the national benchmarks were higher for the Medicaid market than for the commercial market for some measures, Rhode Island's overall performance relative to national benchmarks on the ACO Core Measures was poorer for the Medicaid market than the commercial market, suggesting greater inequity between the two markets in Rhode Island than in other states.

Table 4.2. Statewide Medicaid Performance on ACO Core Measure Set

Measure	National Benchmarks		Statewide Performance	
	75TH PCTL	90TH PCTL	ABOVE 75TH PCTL?	ABOVE 90TH PCTL?
Breast Cancer Screening	57%	61%	Yes 60%	No 60%
Colorectal Cancer Screening	NA	NA	NA	NA
Comprehensive Diabetes Care: Eye Exam	57%	64%	Yes 63%	No 63%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	54%	58%	Yes 54%	No 54%
Developmental Screening in the First Three Years of Life	57%	65%	Yes 79%	Yes 79%
Follow-Up After Hospitalization for Mental Illness (7-Day)	46%	55%	Yes 54%	No 54%
Weight Assessment and Counseling – BMI percentile	84%	86%	No 83%	No 83%
Weight Assessment and Counseling – Counseling for Nutrition	81%	84%	No 76%	No 76%
Weight Assessment and Counseling – Counseling for Physical Activity	78%	81%	No 74%	No 74%

Source: OHIC analysis of quality performance data of Rhode Island Medicaid managed care organizations obtained from EOHHS. Medicaid performance represents the full population for the measure because EOHHS requires that insurers submit performance for their full population.

CHAPTER 5

Conclusion

Understanding the complicated factors driving health care spending trends is important if Rhode Island is to meet its cost growth target. Three years after OHIC first started analyzing data and reporting on health care spending, a clearer picture is emerging about where health care spending is high and growing quickly, and how COVID-19 has affected trends over the last few years.

The transparency created by collecting, analyzing, and publishing health care spending trends has shone a light on what is driving spending and spending growth in Rhode Island. The data show that pharmaceutical and hospital services represent a significant and fast-growing portion of per capita spending on health care, where the greatest opportunities exist to slow spending growth and thereby improve affordability. In the coming years, addressing pharmacy and hospital spending will be key priorities for OHIC and the Rhode Island Health Care Cost Trends Steering Committee.

That Rhode Island has met the cost growth target in the last two years largely due to the disruptions caused by COVID-19 illustrates the challenges in containing spending growth. Meeting this challenge will require sustained commitment from all stakeholders – including state and local governments, insurers, providers, businesses, and consumers – to implement new and creative approaches to deliver and pay for care in a way that enhances the value of health care. All parties must share accountability for making health care more affordable. Now is the time for all health care stakeholders in the state to commit to action and do our part to take all reasonable and necessary steps to keep annual spending growth below the target while maintaining high standards for quality and access.

Containing spending growth… will require sustained commitment from all stakeholders… to implement new and creative approaches to deliver and pay for care in a way that enhances the value of health care.

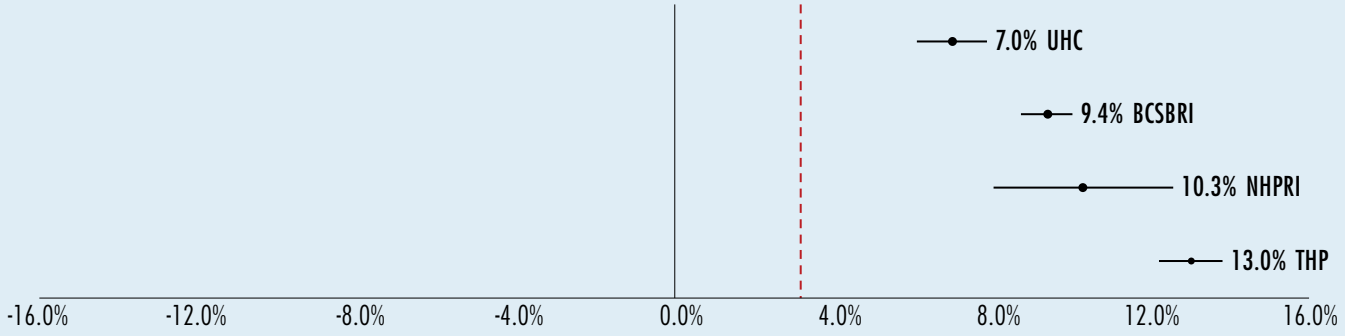
Appendices: Insurer and Provider Cost Growth Target and Quality Performance

Appendix A: Insurer Level Spending Growth

Commercial Insurers' Performance Against the Cost Growth Target

All four commercial insurers exceeded the 3.2% cost growth target for the 2021 performance period. Tufts Health Plan (THP) and Neighborhood Health Plan of Rhode Island's (NHPRI) spending growth exceeded 10% (see Exhibit A.1).

Exhibit A.1: Commercial Insurers' 2021 Performance Against the Cost Growth Target



Source: OHIC analysis of TME data from insurers. Target performance is calculated using TME data, after applying truncation and age/sex risk adjustment. Data represent spending on fully insured and self-insured products, including the Federal Employee Health Benefits Program.

Medicare Advantage Insurers' Performance Against the Cost Growth Target

Both Medicare Advantage insurers exceeded the cost growth target for the 2021 performance period. Spending growth in the commercial and Medicare Advantage markets for both Blue Cross Blue Shield of Rhode Island (BCBSRI) and UnitedHealthcare (UHC) were comparable in 2021; UHC's Medicare Advantage spending growth was higher than its growth in the commercial market, while BCBSRI's Medicare Advantage spending growth was lower than its commercial market growth (see Exhibit A.2).

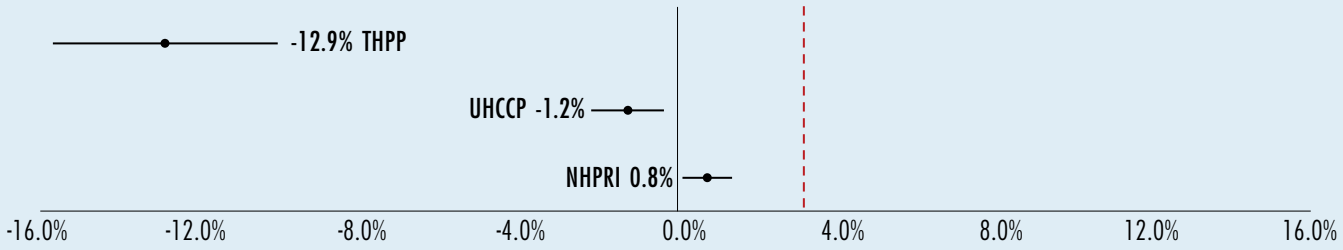
Exhibit A.2: Medicare Advantage Insurers' 2021 Performance Against the Cost Growth Target

Source: OHIC analysis of TME data from insurers. Target performance is calculated using TME data, after applying truncation and age/sex risk adjustment.

Medicaid Insurers' Performance Against the Cost Growth Target

Unlike in the other markets, all Medicaid insurers met the cost growth target. NHPRI was the only Medicaid insurer to experience growth in 2021. UnitedHealthcare Community Plan (UHCCP) and Tufts Health Public Plans' (THPP) PMPM costs decreased, which we suspect were attributed to growth in members as a result of the public health emergency continuous coverage requirement for Medicaid, and the fact that some of those continuously enrolled likely gained commercial coverage. Continuous enrollment had a more dramatic effect for THPP because its membership was comparatively low, magnifying the impact of a large influx of members in 2021. THPP saw a 45 percent increase in membership, while UHCCP and NHPRI's membership grew at approximately 11 percent (see Exhibit A.3).

Exhibit A.3: Medicaid Insurers' 2021 Performance Against the Cost Growth Target



Source: OHIC analysis of TME data from insurers. Target performance is calculated using TME data, after applying truncation and age/sex risk adjustment.

Medicare-Medicaid Plans' Performance Against the Cost Growth Target

Through CMS' Financial Alignment Initiative, Rhode Island provides coverage to individuals who are dually eligible for Medicare and Medicaid through a combined Medicare-Medicaid Plan (MMP). NHPRI was the only insurer to offer such a product in 2021. Target performance is calculated using TME data, after applying truncation. MMP spending is not risk-adjusted, as risk-adjustment is not performed at the market level and NHPRI's population represents the entire population of individuals enrolled in this market.

For the 2021 performance period, NHPRI's MMP spending growth was 4.5 percent, which exceeded the target. MMP enrollees tend to have more complex health care needs and, as a result, higher health care spending per capita.[1] This population may have also experienced more adverse consequences from having to delay care during COVID-19, resulting in higher spending growth.

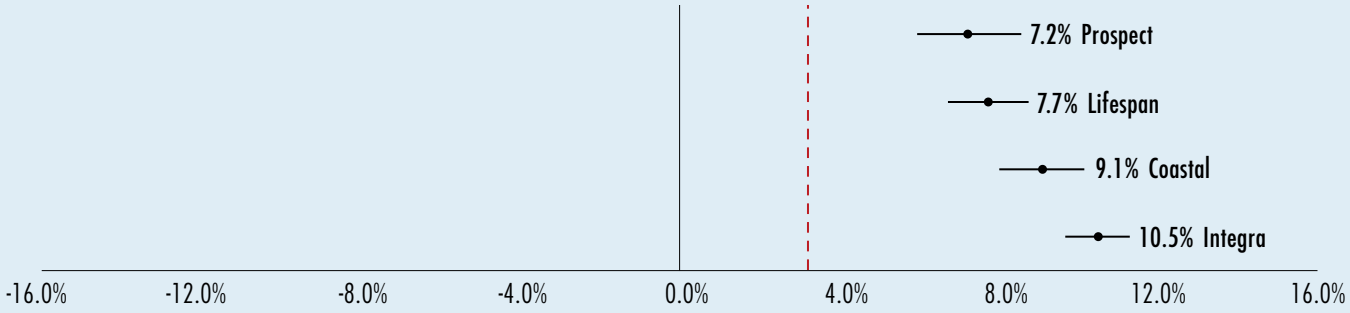
1 For more information on Integrity, see: Neighborhood Health Plan of Rhode Island, *Neighborhood INTEGRITY (Medicare-Medicaid Plan)*, accessed March 27, 2023, https://www.nhpri.org/medicare-medicaid/.

Appendix B: Provider Level Spending Growth

ACOs' Commercial Market Performance Against the Cost Growth Target

2021 commercial growth is not published for Blackstone Valley Community Health Care (BVCHC), Integrated Healthcare Partners (IHP), Providence Community Health Centers (PCHC), or Thundermist Health Center (Thundermist) because they did not have the minimum number of commercial attributed lives required for public reporting.[1] Among the four ACOs that had sufficient attributed lives for performance to be publicly reported, all exceeded the cost growth target for the 2021 performance period (see Exhibit B.1). The range of spending growth of ACOs in the commercial market is similar to that of commercial insurers (7–11 percent for ACOs, 7–13 percent for insurers).

Exhibit B.1: ACOs' 2021 Commercial Market Performance Against the Cost Growth Target

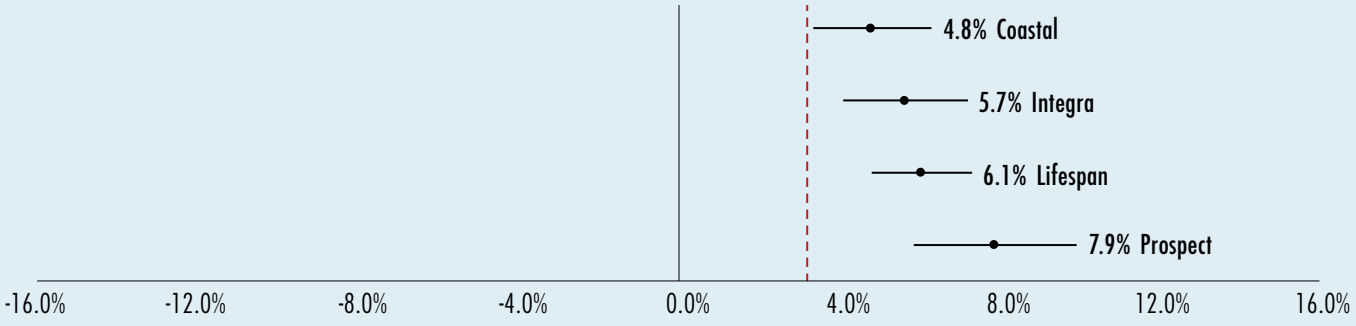


Source: OHIC analysis of TME data from insurers. Target performance is calculated using truncated and age/sex risk-adjusted spending.

ACOs' Medicare Advantage Market Performance Against the Cost Growth Target

2021 Medicare Advantage spending growth is not published for BVCHC, IHP, PCHC, and Thundermist because they did not have the minimum number of Medicare Advantage attributed lives required for public reporting. Among the four ACOs that met the minimum for reporting – which were the same four ACOs that met the threshold for reporting in the commercial market – all exceeded the cost growth target for the 2021 performance period. The range of the ACOs' Medicare Advantage spending growth was similar to the range of their commercial spending growth.

Exhibit B.2: ACOs' 2021 Medicare Market Performance Against the Cost Growth Target



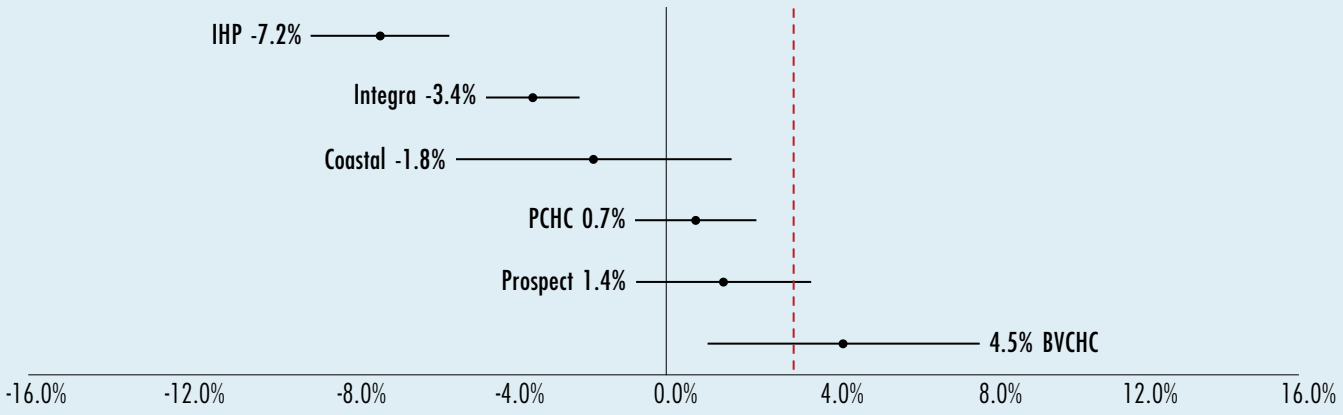
Source: OHIC analysis of TME data from insurers. Target performance is calculated using truncated and age/sex risk-adjusted spending.

1 Insurers and providers must have a minimum of 5,000 attributed lives in the applicable market for their spending growth to be publicly reported.

AEs' Medicaid Market Performance Against the Cost Growth Target

2021 Medicaid spending growth is not presented for Lifespan because it did not hold a total cost of care contract with any Medicaid insurer in 2021. Medicaid spending growth is not presented for Thundermist because it did not have sufficient Medicaid attributed lives in both 2020 and 2021 to meet the minimum required for public reporting. Performance for two AEs (BVCHC and Prospect CharterCARE [Prospect]) could not be assessed based on statistical testing because their confidence interval intersected with the cost growth target. The four remaining AEs met the cost growth target.

Exhibit B.3: AEs' 2021 Medicaid Market Performance Against the Cost Growth Target



Source: OHIC analysis of TME data from insurers. Target performance is calculated using truncated and age/sex-risk adjusted spending.

Appendix C: Insurer Level Performance On Quality

Commercial Insurers' Performance on the ACO Core Measure Set

The three commercial insurers (BCBSRI, THP, and UHC) performed well on the prevention, screening and behavioral health measures but not as well on the diabetes care measures. The three insurers were above the National 75th percentile for all measures, except THP for *Comprehensive Diabetes Care: HbA1c Control (<8.0%).* The insurers were above the 90th percentile for all measures except UHC for *Comprehensive Diabetes Care: Eye Exam* and all three insurers for *Comprehensive Diabetes Care: HbA1c Control (<8.0%)*. BCBSRI's performance compared favorably to the other insurers on three measures: *Breast Cancer Screening, Colorectal Cancer Screening*, and *Comprehensive Diabetes Care: Eye Exam*.

Table C.1: Commercial Insurers' Performance on the ACO Core Measure Set

Measure	National Benchmarks		Above 75th Pctl?			Above 90th Pctl?		
	75TH PCTL	90TH PCTL	BCBSRI	THP	UHC	BCBSRI	THP	UHC
Breast Cancer Screening	73%	75%	Yes 86%	Yes 84%	Yes 78%	Yes 86%	Yes 84%	Yes 78%
Colorectal Cancer Screening	66%	70%	Yes 81%	Yes 73%	Yes 75%	Yes 81%	Yes 73%	Yes 75%
Comprehensive Diabetes Care: Eye Exam	54%	60%	Yes 71%	Yes 63%	Yes 60%	Yes 71%	Yes 63%	No 60%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	60%	64%	Yes 62%	No 48%	Yes 64%	No 62%	No 48%	No 64%
Follow-Up After Hospitalization for Mental Illness (7-Day)[1]	53%	59%	NA	Yes 75%	Yes 68%	NA	Yes 75%	Yes 68%
Developmental Screening in the First Three Years of Life[2, 3]	57%	65%	Yes 85%	NA	NA	Yes 85%	NA	NA
Weight Assessment and Counseling – BMI percentile	77%	83%	Yes 92%	Yes 88%	Yes 91%	Yes 92%	Yes 88%	Yes 91%
Weight Assessment and Counseling – Counseling for Nutrition	72%	78%	Yes 90%	Yes 87%	Yes 89%	Yes 90%	Yes 87%	Yes 89%
Weight Assessment and Counseling – Counseling for Physical Activity	69%	75%	Yes 89%	Yes 87%	Yes 88%	Yes 89%	Yes 87%	Yes 88%

Source: OHIC analysis of quality performance data submitted by commercial insurers in Rhode Island.

Note: NA = Not Applicable. Insurer did not submit performance on this measure. NHPRI is not included here because it does not have total cost of care contracts with ACOs for their commercial members.

1 BCBSRI did not include *Follow-Up After Hospitalization for Mental Illness* in its 2021 PQIP Program, thus no data were reported for 2021.
2 THP was unable to report a MY 2021 rate for *Developmental Screening in the First Three Years of Life*. THP is working with a vendor and will report this measure for MY 2022.
3 UHC explained to OHIC that they could not report *Developmental Screening in the First Three Years of Life* at the plan level because it is not a HEDIS measure.

Medicaid Insurers' Performance on the ACO Core Measure Set

Medicaid insurers' performance on the ACO Core Measure Set was better for the chronic illness and behavioral health measures than for the preventative care measures. The two Medicaid insurers (NHPRI and UHCCP) were both above the national 75th percentile for *Breast Cancer Screening, Comprehensive Diabetes Care: Eye Exam, Follow-Up After Hospitalization for Mental Illness and Developmental Screening in the First Three Years of Life*. The insurers were above the 90th percentile for only one measure – *Developmental Screening in the First Three Years of Life*.

Table C.2: Medicaid Insurers' Performance on ACO Core Measure Set

Measure	National Benchmarks		Above 75th Pctl?		Above 90th Pctl?	
	75TH PCTL	90TH PCTL	NHPRI	UHCCP	NHPRI	UHCCP
Breast Cancer Screening	57%	61%	Yes 61%	Yes 58%	No 61%	No 58%
Colorectal Cancer Screening	NA	NA	NA	NA	NA	NA
Comprehensive Diabetes Care: Eye Exam	57%	64%	Yes 63%	Yes 61%	No 63%	No 61%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	54%	58%	Yes 55%	No 53%	No 55%	No 53%
Follow-Up After Hospitalization for Mental Illness (7Day)[4]	46%	55%	Yes 54%	Yes 54%	No 54%	No 54%
Developmental Screening in the First Three Years of Life[5,6]	57%	65%	Yes 80%	Yes 79%	Yes 80%	Yes 79%
Weight Assessment and Counseling – BMI percentile	84%	86%	No 82%	Yes 85%	No 82%	No 85%
Weight Assessment and Counseling – Counseling for Nutrition	81%	84%	No 75%	No 79%	No 75%	No 79%
Weight Assessment and Counseling – Counseling for Physical Activity	78%	81%	No 73%	No 78%	No 73%	No 78%

Source: OHIC analysis of quality performance data of Rhode Island Medicaid managed care organizations obtained from the Rhode Island EOHHS.

Note: NA = Not Applicable. Insurer did not submit performance on this measure. EOHHS does not collect quality data from THPP due to its small population size.

4 BCBSRI did not include *Follow-Up After Hospitalization for Mental Illness* in its 2021 PQIP Program, thus no data were reported for 2021.
5 THPP was unable to report a MY 2021 rate for *Developmental Screening in the First Three Years of Life*. THPP is working with a vendor and will report this measure for MY 2022.
6 UHCCP indicated to OHIC that they could not report *Developmental Screening in the First Three Years of Life* at the plan level because it is not a HEDIS measure.

Appendix D: Provider Level Performance On Quality

ACO Commercial Performance on the ACO Core Measure Set – 75th Percentile

Two ACOs (Coastal Medical [Coastal] and Lifespan) exceeded the 75th percentile for commercial performance for all of the ACO Core Measure Set measures. Integra Community Care Network (Integra) exceeded the 75th percentile for all but one measure – *Comprehensive Diabetes Care: HbA1c Control*. PCHC, Prospect, and Thundermist exceeded the 75th percentile for between one and four measures. BVCHC did not exceed the commercial 75th percentile for any measures. Only one ACO/AE (Integra) had a commercial denominator size large enough (> 30) to report performance on *Follow-Up After Hospitalization for Mental Illness*.

Table D.1: ACO Commercial Performance on the ACO Core Measure Set – 75th Percentile

Measure	National 75th Pctl	Above 75th Pctl?							
		BVCHC	COASTAL	INTEGRA	IHP	LIFESPAN	PCHC	PROSPECT	THUNDERMIST
Breast Cancer Screening	73%	No 64%	Yes 89%	Yes 82%	NA	Yes 89%	Yes 75%	Yes 82%	No 72%
Colorectal Cancer Screening	66%	No 50%	Yes 85%	Yes 78%	NA	Yes 81%	No 61%	Yes 77%	No 53%
Comprehensive Diabetes Care: Eye Exam	54%	No 40%	Yes 75%	Yes 64%	NA	Yes 70%	Yes 57%	Yes 68%	No 53%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	60%	No 40%	Yes 66%	No 51%	NA	Yes 62%	No 48%	No 60%	No 23%
Follow-Up After Hospitalization for Mental Illness (7Day)	53%	NA	NR	Yes 67%	NA	NR	NR	NR	NA
Developmental Screening in the First Three Years of Life	57%	NR	Yes 95%	Yes 82%	NA	Yes 85%	Yes 73%	Yes 67%	Yes 73%
Weight Assessment and Counseling – BMI percentile	77%	No 64%	Yes 94%	Yes 91%	NA	Yes 90%	No 13%	No 44%	No 37%
Weight Assessment and Counseling – Counseling for Nutrition	72%	No 8%	Yes 93%	Yes 90%	NA	Yes 91%	No 9%	No 38%	No 26%
Weight Assessment and Counseling – Counseling for Physical Activity	69%	No 8%	Yes 92%	Yes 89%	NA	Yes 84%	No 6%	No 27%	No 19%

Source: OHIC analysis of quality performance data submitted by commercial insurers in Rhode Island.

Note:
1. NA = Not Applicable. Insurers did not submit performance on this measure for the ACO/AE.
2. NR = Not Reported. The ACO/AE did not meet the minimum denominator size required for public reporting.

ACO Commercial Performance on the ACO Core Measure Set – 90th Percentile

Only one ACO (Coastal) exceeded the national 90th percentile for commercial performance for all of the ACO Core Measure Set measures. Integra and Lifespan both exceeded the 90th percentile for all but one measure – *Comprehensive Diabetes Care: HbA1c Control*. Prospect exceeded the 90th percentile for all measures except *Comprehensive Diabetes Care: HbA1c Control* and the *Weight Assessment and Counseling* rates. PCHC and THC only exceeded the 90th percentile for *Developmental Screening in the First Three Years of Life*. BVCHC did not exceed the commercial 90th percentile for any measure.

Table D.2: ACO Commercial Performance on the ACO Core Measure Set – 90th Percentile

Measure	National 90th Pctl	Above 90th Pctl?							
		BVCHC	COASTAL	INTEGRA	IHP	LIFESPAN	PCHC	PROSPECT	THUNDERMIST
Breast Cancer Screening	75%	No 64%	Yes 89%	Yes 82%	NA	Yes 89%	No 75%	Yes 82%	No 72%
Colorectal Cancer Screening	70%	No 50%	Yes 85%	Yes 78%	NA	Yes 81%	No 61%	Yes 77%	No 53%
Comprehensive Diabetes Care: Eye Exam	60%	No 40%	Yes 75%	Yes 64%	NA	Yes 70%	No 57%	Yes 68%	No 53%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	64%	No 40%	Yes 66%	No 51%	NA	No 62%	No 48%	No 60%	No 23%
Follow-Up After Hospitalization for Mental Illness (7-Day)	59%	NA	NR	Yes 67%	NA	NR	NR	NR	NA
Developmental Screening in the First Three Years of Life	65%	NR	Yes 95%	Yes 82%	NA	Yes 85%	Yes 73%	Yes 67%	Yes 73%
Weight Assessment and Counseling – BMI percentile	83%	No 64%	Yes 94%	Yes 91%	NA	Yes 90%	No 13%	No 44%	No 37%
Weight Assessment and Counseling – Counseling for Nutrition	78%	No 8%	Yes 93%	Yes 90%	NA	Yes 91%	No 9%	No 38%	No 26%
Weight Assessment and Counseling – Counseling for Physical Activity	77%	No 8%	Yes 92%	Yes 89%	NA	Yes 84%	No 6%	No 27%	No 19%

Source: OHIC analysis of quality performance data submitted by commercial insurers in Rhode Island.

Note:
1. NA = Not Applicable. Insurers did not submit performance on this measure for the ACO/AE.
2. NR = Not Reported. The ACO/AE did not meet the minimum denominator size required for public reporting.

AE Medicaid Performance on the ACO Core Measure Set – 75th Percentile

Two AEs (Coastal and PCHC) exceeded the national 75th percentile for Medicaid performance for all the ACO Core Measure Set measures. BVCHC exceeded the 75th percentile for all the measures except for *Comprehensive Diabetes Care: Hba1c Control* and two of the *Weight Assessment and Counseling* rates. Integra and Prospect exceeded the 75th percentile for four of the measures, with worse performance for the *Weight Assessment and Counseling* rates and the diabetes measures. IHP and Thundermist exceeded the 75th percentile for two and three measures, respectively. All ACOs/AEs exceeded the 75th percentile for *Follow-Up After Hospitalization for Mental Illness* and all but one ACO/AE exceeded the 75th percentile for *Developmental Screening in the First Three Years of Life*.

Table D.3: AE Medicaid Performance on the ACO Core Measure Set – 75th Percentile

Measure	National 75th Pctl	Above 75th Pctl?							
		BVCHC	COASTAL	INTEGRA	IHP	LIFESPAN	PCHC	PROSPECT	THUNDERMIST
Breast Cancer Screening	57%	Yes 59%	Yes 75%	Yes 58%	No 51%	NA	Yes 64%	Yes 62%	No 53%
Colorectal Cancer Screening	NA	NA	NA	NA	NA	NA	NA	NA	NA
Comprehensive Diabetes Care: Eye Exam	57%	Yes 67%	Yes 73%	No 56%	No 51%	NA	Yes 73%	Yes 60%	Yes 58%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	54%	No 52%	Yes 62%	No 49%	Yes 64%	NA	Yes 57%	No 51%	No 54%
Follow-Up After Hospitalization for Mental Illness (7-Day)	46%	Yes 56%	Yes 64%	Yes 55%	Yes 51%	NA	Yes 54%	Yes 50%	Yes 51%
Developmental Screening in the First Three Years of Life	57%	Yes 91%	Yes 93%	Yes 75%	No 56%	NA	Yes 82%	Yes 78%	Yes 78%
Weight Assessment and Counseling – BMI percentile	84%	Yes 87%	Yes 94%	Yes 85%	No 76%	NA	Yes 87%	No 53%	No 73%
Weight Assessment and Counseling – Counseling for Nutrition	81%	No 72%	Yes 89%	No 77%	No 56%	NA	Yes 81%	No 51%	No 71%
Weight Assessment and Counseling – Counseling for Physical Activity	78%	No 70%	Yes 89%	No 76%	No 55%	NA	Yes 81%	No 38%	No 70%

Source: OHIC analysis of quality performance data of Rhode Island Medicaid managed care organizations obtained from the Rhode Island EOHHS.

NA = Not Applicable. Insurers did not submit performance on this measure for the ACO/AE.

AE Medicaid Performance on the ACO Core Measure Set – 90th Percentile

Only one AE (Coastal) exceeded the national 90th percentile for Medicaid performance for all the ACO Core Measure Set measures. BVCHC and PCHC exceeded the 90th percentile for half of the measures. Integra and Prospect exceeded the 90th percentile for two measures each. IHP and Thundermist exceeded the 90th percentile for one measure each (*Comprehensive Diabetes Care: HbA1c Control and Developmental Screening in the First Three Years of Life*, respectively). All but one AE exceeded the 90th percentile for *Developmental Screening in the First Three Years of Life*.

Table D.4: AE Medicaid Performance on the ACO Core Measure Set – 90th Percentile

Measure	National 90th Pctl	Above 90th Pctl?							
		BVCHC	COASTAL	INTEGRA	IHP	LIFESPAN	PCHC	PROSPECT	THUNDERMIST
Breast Cancer Screening	61%	No 59%	Yes 75%	No 58%	No 51%	NA	Yes 64%	Yes 62%	No 53%
Colorectal Cancer Screening	NA	NA	NA	NA	NA	NA	NA	NA	NA
Comprehensive Diabetes Care: Eye Exam	64%	Yes 67%	Yes 73%	No 56%	No 51%	NA	Yes 73%	No 60%	No 58%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	58%	No 52%	Yes 62%	No 49%	Yes 64%	NA	No 57%	No 51%	No 54%
Follow-Up After Hospitalization for Mental Illness (7Day)	55%	Yes 56%	Yes 64%	Yes 55%	No 51%	NA	No 54%	No 50%	No 51%
Developmental Screening in the First Three Years of Life	65%	Yes 91%	Yes 93%	Yes 75%	No 56%	NA	Yes 82%	Yes 78%	Yes 78%
Weight Assessment and Counseling – BMI percentile	86%	Yes 87%	Yes 94%	No 85%	No 76%	NA	Yes 87%	No 53%	No 73%
Weight Assessment and Counseling – Counseling for Nutrition	84%	No 72%	Yes 89%	No 77%	No 56%	NA	No 81%	No 51%	No 71%
Weight Assessment and Counseling – Counseling for Physical Activity	81%	No 70%	Yes 89%	No 76%	No 55%	NA	No 81%	No 38%	No 70%

Source: OHIC analysis of quality performance data of Rhode Island Medicaid managed care organizations obtained from the Rhode Island EOHHS.

NA = Not Applicable. Insurers did not submit performance on this measure for the ACO/AE.

STATE OF RHODE ISLAND
Office of The Health Insurance Commissioner
Department of Business Regulation

As Health Care Costs Rise, Employee Wage Growth Declines

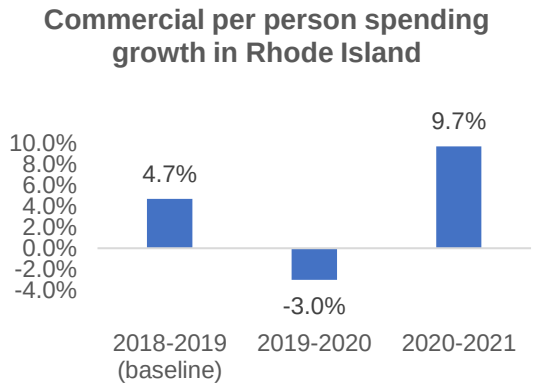
The Problem

Consumers and employers face growing health care costs in Rhode Island.

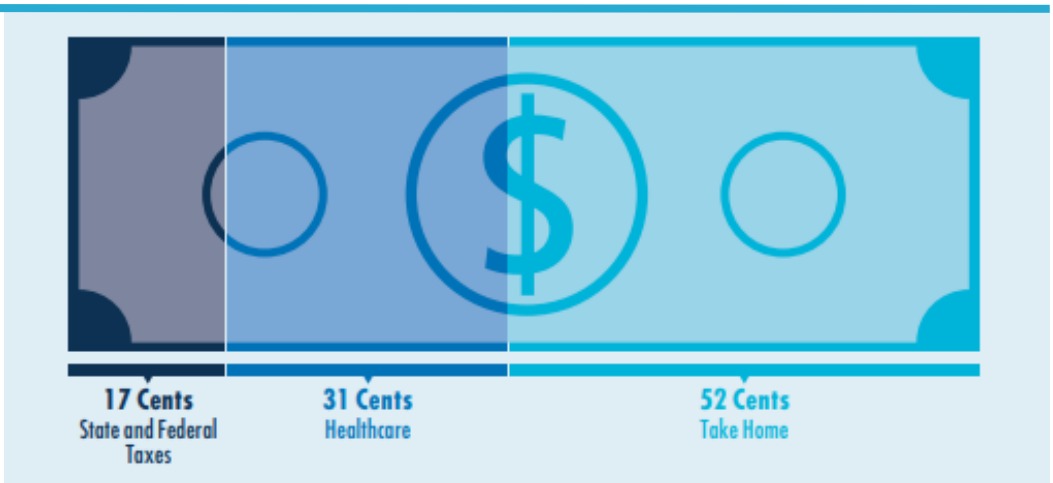
- In 2019, the state established its annual cost growth target of 3.2%.
- Commercial health care spending growth has exceeded the target two out of three years since it was established.
- Commercial spending per person grew nearly 10% from 2020 to 2021.[1]
- When Rhode Island met its target for commercial spending growth in 2020, it was only because of reduced health care utilization and spending due to the pandemic.[2]

Health care in Rhode Island is very expensive.

- In 2022, the average health insurance premium for a family plan was $22,955 in Rhode Island[3] – nearly the average cost of a new compact car ($23,839).[4]



According to a household survey from 2022, too many Rhode Island families reported problems paying their medical bills, being unable to pay for necessities like food or rent and using up savings to pay for medical bills.[5]



An estimated 31 cents of each additional dollar earned by Rhode Island families between 2017 and 2019 went to health care.

This includes the employer's share of the premium, the employee's share of the premium, and estimates of out of pocket payments for deductibles, copays, and coinsurance.

Why This Matters

High and rising commercial health care costs reduce employee wage growth.

- Employers and employees split the cost of health insurance.
- Employers have a finite pool of money to fund both health insurance and wages.
- As health care spending goes up, there is less money available for cash compensation increases.[6]

High and rising health care costs reduce available income for household use.

- As a result of rising premiums and cost sharing, an estimated 31 cents of each additional dollar earned by RI families between 2017 and 2019 went to health care costs.[7]
- The average family deductible has quadrupled in the last 20 years.[8]
- Rising health care costs take money out of Rhode Islander's paychecks and pocketbooks.

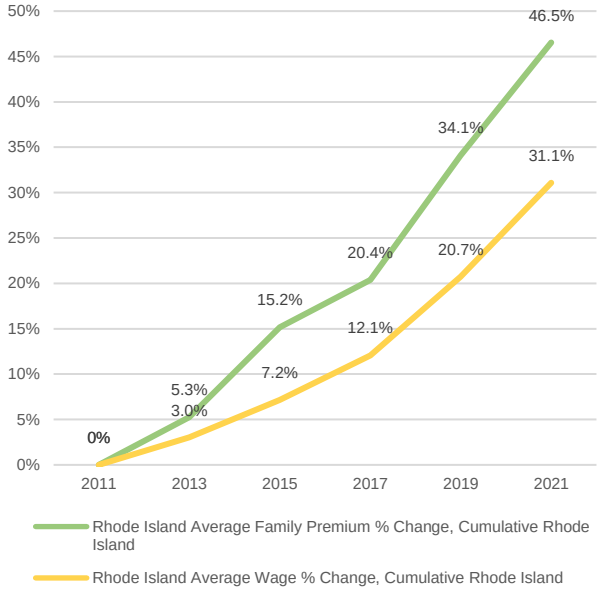
Rhode Islanders are unable to access necessary care.

- Many state residents cannot afford large out-of-pocket medical expenses, so they defer, or worse, avoid necessary care.

OHIC Tracks Spending Growth

We cannot improve what we cannot measure. In 2022, the Rhode Island Office of the Health Insurance Commissioner established the Health Spending Accountability and Transparency Program to improve affordability and facilitate access to high-quality care for all Rhode Islanders. OHIC measures health care spending against the state's cost growth target and is currently analyzing data for the 2021-2022 reporting cycle. OHIC will report its findings and policy recommendations in the spring of 2024.

Cumulative Average Family Premium and Wage Growth[9] in Rhode Island, 2011 - 2021



Health insurance premiums have outpaced wage growth over the last decade.

Rhode Islanders rely on wages to fund housing, food, utilities, childcare, transportation, and build their personal wealth.

Recent research shows that rising health care costs reduce employee wage growth and push greater cost sharing onto workers.[10]

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6. Congressional Budget Office (2022), p.9 and https://www.rand.org/pubs/working_papers/WRA621-2.html
7. Allocation of the increase in monthly compensation between 2017 and 2019 for a median income Rhode Island family with employer-sponsored insurance. See Exhibit 1.2, p. 6 of the Annual Report: Health Care Spending and Quality in Rhode Island.
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9. Average Annual Wages (All Occupations) by State. Data from Occupational Employment and Wage Statistics (OEWS) Survey Data, State XLSX Files
10. See footnote 6.

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Office of The Health Insurance Commissioner
Department of Business Regulation

The Rhode Island Office of the Health Insurance Commissioner (OHIC) was established through legislation in 2004 to broaden the accountability of health insurers operating in Rhode Island. The Office is dedicated to: protecting consumers, encouraging fair treatment of medical service providers, ensuring solvency of health insurers, and improving the health care system's quality, accessibility, and affordability.

STATE OF RHODE ISLAND
Office of The Health Insurance Commissioner
Department of Business Regulation

The High Costs of Brand-Name Drugs

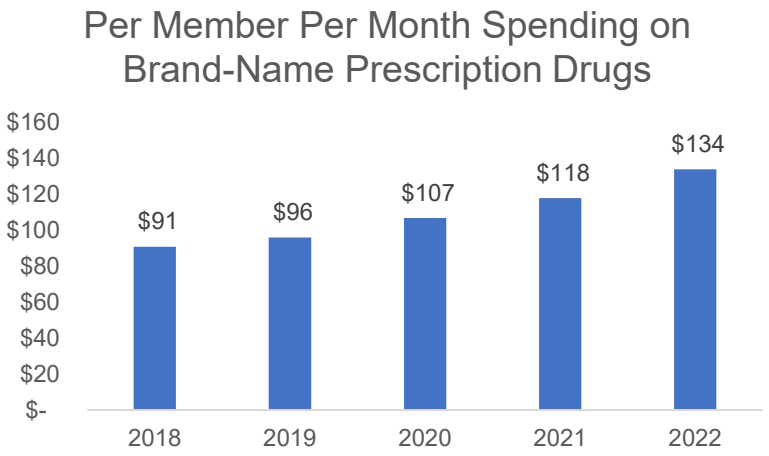
The Issue

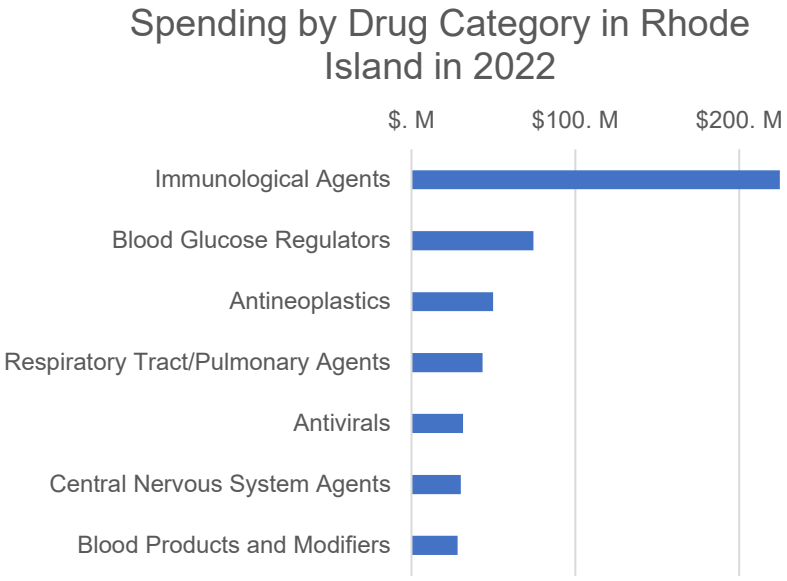
Spending on brand-name drugs has grown at an unaffordable rate in Rhode Island.

- From 2018 to 2022, spending for commercially insured residents on brand-name medications grew at an average annual rate of 10.2%.[1]
- Meanwhile, median household income in the state grew at an average annual rate of only 3.3%.[2]

In 2022, most spending (nearly $225M) on brand-name prescription drugs for residents with commercial coverage was on immunological agents.

- Immunological agents are drugs that modify the body's immune system response.
- The two immunological agents with the highest spend in 2022 were Humira (Cf) ($54.3M) and Stelara ($34.5M).[3]
- These drugs are used to treat arthritis, Crohn's disease, and psoriasis, among other conditions.





- In 2022, an annual supply of Humira cost **$90,564** and an annual supply of Stelara cost **$149,952**.[4,5]
    - These drugs were prescribed frequently in 2022. More than 7,000 prescriptions for Humira and nearly 3,000 prescriptions for Stelara were dispensed to Rhode Islanders with commercial coverage.

	# of 30-Day Equivalents	Total Spend	PPU
Humira	7,193	$54.3M	$7,547
Stelara	2,760	$34.5M	$12,496

Why This Matters

Prescription drugs are becoming increasingly unaffordable for Rhode Islanders.

- In 2022, Rhode Islanders reported delaying filling a prescription due to cost at a higher rate than delaying medical or mental health care due to cost.[6]
- Large deductibles and high drug prices lead some patients to skip doses.[7]

Dollars spent on these brand-name prescription drugs could have been used for other purposes if prices were lower.

- For example, the cost of a year's supply of Stelara is approximately equal to **1,119 primary care visits.**[8]

Updates to the OHIC Data Hub Coming Soon

OHIC now has access to 2022 data in the state's All-Payer Claims Database (HealthFacts RI). OHIC will make these data available soon in the interactive dashboards available on the OHIC Data Hub. OHIC plans to roll out new dashboards on additional topics in the coming weeks and months.

1. OHIC's analysis of data from HealthFacts RI, which is the state's All-Payer Claims Database (APCD). The spending in the APCD represents approximately 80% of commercial spending in the state due to the absence of data from some self-insured employers.
2. https://fred.stlouisfed.org/series/MEHOINUSRIA672N.
3. These drugs treat different types of arthritis.
4. These were calculated by OHIC using data from HealthFacts RI, and exclude manufacturer rebates. Rebate data are considered proprietary by manufacturers, making it impossible for OHIC to determine the actual price of individual drugs. Analysis of 2021 data submitted by Rhode Island insurers, the Rhode Island Executive Office of Health and Human Services, and by the Centers for Medicare and Medicaid Services found that pharmacy rebates equaled 25% of total commercial retail pharmacy spending.
5. Annual prices were calculated by multiplying the price of a 30-day supply by 12.
6. 2022 Health Insurance Survey. https://healthsourceri.com/surveys-and-reports/
7. https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/
8. Primary care visits were priced using the 2022 Medicare reimbursement for CPT code 99214: $133.93.

Health Care Market Oversight

2023 Annual Report

January 4, 2024

Oregon Health Authority

What is the Health Care Market Oversight program?

In 2021, the Oregon Legislature passed HB 2362 to oversee health care consolidation, creating the Health Care Market Oversight (HCMO) program. This law directs the Oregon Health Authority (OHA) to review business deals involving health care entities, such as hospitals, health insurance companies, and provider groups. HCMO assesses the impact of these deals on healthcare costs and reliable access to high quality care, particularly for communities that experience inequities. The HCMO program launched March 1, 2022.

Why health care market oversight matters

Health care consolidation is when two or more health care companies – such as hospitals, insurers, clinics, or health systems – combine or affiliate. In Oregon and nationwide, health care consolidation has become increasingly common, resulting in more markets being dominated by large, national companies and fewer independent and local health care providers.

Health care consolidation often happens through confidential business deals, so communities and state agencies have little visibility into major changes to the health care system. This lack of transparency means that communities may be unaware of impacts and have little opportunity to take action to try to mitigate negative consequences for patients and consumers.

While not all consolidation is bad, the Oregon Legislature created the HCMO program to address potential negative impacts of health care consolidation. Research points to some key concerns about health care consolidation:

- **When health care companies combine, it may lead to higher prices.**[1] While health care companies can find savings by consolidating, those savings often don't result in lower prices for patients and consumers.[2]
- **Consolidation may make it harder to access health care services, particularly in rural areas.** Research has shown that consolidation involving rural hospitals can result in those hospitals ending some onsite services, such as imaging and obstetric services.[3]
- **Consolidation may worsen health inequities.** For example, when hospitals consolidate, more resources may be invested in areas with more privately insured patients – and these areas also tend be more urban, White, and wealthy. Facilities that largely serve low-income communities, people living in rural areas, or people of color may receive fewer resources, leading to lower quality care.[4]
- **Consolidation may lead to worse quality in markets with little competition.** Studies looking at health care consolidation have shown that health outcomes and quality of care do not improve when health care companies combine – and in markets with little competition (i.e., few companies providing similar services), quality of care may get worse.[5]

How the program works

Through the HCMO program, OHA reviews proposed heath care transactions to make sure they support statewide goals related to cost, equity, access, and quality. Here's how it works:

1. Health care companies file a notice that they are planning a transaction
2. OHA examines the potential impacts of the transaction on prices, quality, equity, and access to services
3. OHA may consult with community members or other experts to get input
4. OHA issues a decision to approve, approve with conditions, disapprove, or exempt the transaction

OHA has 30 days to complete a preliminary review. Some transactions may also receive a more in-depth comprehensive review, which must be completed within 180 days of filing. Prior to and throughout the review process, OHA provides technical assistance and guidance to companies that are planning a transaction. OHA publicly posts online notices of proposed transactions and gathers public, community member, and other expert input about the potential impacts of a transaction. One, two, and five years after approving a transaction, OHA conducts a follow-up review to understand the effects of the transaction. OHA also monitors statewide trends and produces reports about consolidation in Oregon.

2023 Highlights

In 2023, HCMO entered its second year. Highlights include:

Transaction reviews

OHA received 11 material change transaction notices in 2023. The program launched its first comprehensive reviews and follow-up reviews. All review materials are posted to the HCMO website.

Public engagement

HCMO sought input from the public to inform all of its transaction reviews. Staff conducted outreach via email, newsletters, social media posts, and media to inform communities about transactions in their areas. We received written and verbal public comments, held two public listening sessions, and started recruiting members for HCMO's first community review board.

Collaboration

HCMO has developed a network of state agency and external subject matter experts to advise staff and support transaction reviews. We've built relationships with staff of state programs that regulate health care entities, including the Department of Justice Antitrust and Charitable Activities Sections, the Department of Consumer and Business Services, and OHA's coordinated care organization (CCO) Form A and Certificate of Need programs. HCMO also works closely with OHA's External Affairs and Government Relations teams.

News Highlights & Media Coverage

The HCMO program has been covered by media and research and policy institutes. Media coverage has helped increase public awareness of the program and drive public engagement.

- The Milbank Memorial Fund published the report, "A Step Forward for Health Care Market Oversight: Oregon Health Authority's Health Care Market Oversight Program," which highlights Oregon as a national leader in the space and provides a roadmap for how other states can replicate what Oregon has done
- The Source on Healthcare Price & Competition wrote an overview of the legal challenge to the HCMO program brought by the Hospital Association of Oregon.
- OHA's approval of Adventist's purchase of Mid-Columbia Medical Center was covered by State of Reform, Portland Business Journal, and The Lund Report.
- Multiple news outlets have covered OHA's review of the of the proposed combination of SCAN and CareOregon, including The Lund Report, The Oregonian, and KDRV ABC. Former Governor Kitzhaber also weighed in.
- HCMO's review of the planned merger between Kroger and Albertsons was covered by the Portland Business Journal and The Oregonian.

By the numbers: HCMO to date

As of December 2023, the HCMO program has worked on 21 transactions:

16 Transactions filed notices

2 Transactions requested a determination and were not subject to review

3 Transactions requested technical assistance, but did not file

As of December 2023, the HCMO program has undertaken:

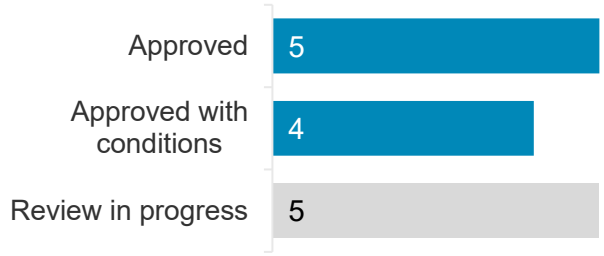
15 Preliminary reviews

2 Comprehensive reviews

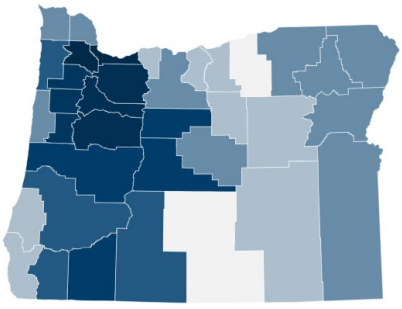
2 Follow-up reviews

We've received **more than 180** public comments voicing support, opposition, and potential impacts related to transactions.

Most reviewed transactions were approved.



HCMO reviewed transactions that impact 34 counties in Oregon.



Darker color indicates more transactions in the area

Reviewed transactions have the potential to impact at least:

2 hospitals

56 provider locations

4,800 health care workers

100,000 patients

500,000 health plan members

HCMO transactions involved a range of entity types.

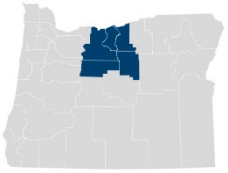
- 11 transactions with national entities
- 5 transactions with hospice and home health agencies
- 4 transactions with private equity firms
- 6 transactions with hospitals and health systems
- 4 transactions with primary care providers
- 3 transactions with insurance companies

Transaction Details

OHA received 11 complete notices of material change transaction between December 1, 2022 and December 31, 2023. The table below summarizes HCMO transactions during this time, with additional detail in the following paragraphs and maps showing counties served by entities involved in transactions.

ID	Entities	Review Type	Transaction Type	Decision Date	Status
006	Adventist; Mid-Columbia Medical Center	Preliminary	Acquisition	4/14/23	Approved with conditions
007	RadiaPS; Medford Radiological Group	Preliminary	Acquisition	3/9/23 (revised 12/22/23)	Approved with conditions
008	SCAN Group; CareOregon	Comprehensive	Affiliation	--	In progress
009	Samaritan Health; Norco	Preliminary	Acquisition	5/4/23	Approved
010	Option Care; Amedisys	Preliminary	Merger	N/A	Withdrawn
012	PeaceHealth; Northwest Surgical Specialists	Preliminary	Acquisition	8/16/23	Approved with conditions
013	Kroger; Albertsons	Comprehensive	Acquisition	--	In progress
014	UnitedHealth Group; Amedisys	Preliminary	Acquisition	--	In progress
015	Envision Healthcare	Preliminary	Ownership change	10/30/23	Approved
017	Agility; Keiper Spine	Preliminary	Acquisition	--	In progress
018	Optum; The Corvallis Clinic	Preliminary	Acquisition	--	In progress

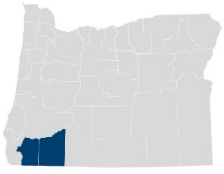
006 Adventist-MCMC



Adventist submitted a completed notice about its plans to acquire MCMC on January 24, 2023. MCMC operates a hospital and health clinics in and around The Dalles. Adventist is a faith-based health system that operates hospitals and clinics in California, Hawaii, Oregon, and Washington.

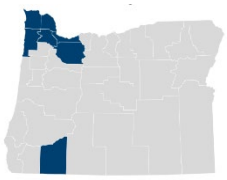
During its preliminary review, OHA received 50 public comments related to this transaction. OHA found that the transaction was warranted to ensure the financial stability of MCMC. The transaction was approved with conditions on April 13, 2023 and closed on June 1, 2023.

007 Radia-MRG



Radia, a radiology group based in the state of Washington, notified HCMO it was planning to purchase Medford Radiological Group (MRG), another radiology group based in Medford. OHA approved the transaction with conditions on March 9, 2023. In October, the companies informed OHA that the deal terms had changed significantly. After assessing these changes, OHA issued a modified order on December 22, 2023 with revised approval conditions.

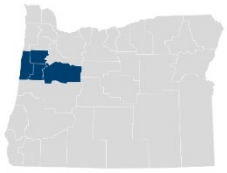
008 SCAN Group-CareOregon



SCAN Group submitted a notice on January 12, 2023 describing plans to combine with CareOregon. CareOregon is the largest provider of Oregon Health Plan benefits in the state, operating two CCOs and affiliated with a third. SCAN Group is based in California and offers Medicare Advantage plans in Arizona, California, Nevada, New Mexico, and Texas.

OHA completed a preliminary review and determined that the transaction warranted a comprehensive review. This transaction is also subject to OHA's CCO Form A review and the Department of Consumer and Business Services domestic insurer Form A review. OHA expects to complete the comprehensive review by mid-January 2024. For this review, HCMO will issue a recommendation to DCBS, rather than issuing a standalone decision. DCBS will issue the final decision.

009 Samaritan Health-Norco

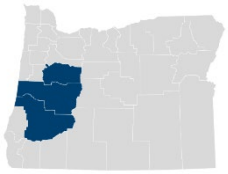


OHA accepted a completed notice from Samaritan Health on April 6, 2023, describing plans to sell its durable medical equipment business to Norco. Samaritan is a non-profit health system that operates hospitals, health plans, and clinics in Oregon. Norco is a home medical equipment supplier based in Idaho and operating in several western states. OHA completed a preliminary review and approved the transaction on May 4, 2023.

010 Option Care-Amedisys

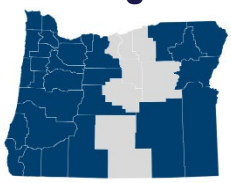
Option Care and Amedisys filed a notice of material change transaction in May 2023. Amedisys, however, accepted a competing offer from UnitedHealth Group (see transaction 014 below) and terminated the agreement with Option Care. Option Care and Amedisys withdrew their notice on June 28, 2023.

012 PeaceHealth-NWSS



PeaceHealth, a non-profit Catholic health system operating in the northwest, filed a notice regarding plans to purchase assets and hire staff of Northwest Surgical Specialists (NWSS). OHA reviewed the transaction and approved it with conditions on August 16, 2023. The transaction closed on August 18, 2023.

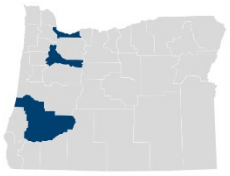
013 Kroger-Albertsons



Kroger and Albertsons, two large grocery store chains, are planning to merge. The companies collectively operate 159 pharmacies in Oregon in Fred Meyer, QFC, Albertsons, and Safeway stores. OHA conducted a preliminary review of this transaction. Due to the large footprint of this transaction, potential for anti-competitive effects, and potential to impact equity, OHA determined that it requires a comprehensive review. OHA is currently in the midst of conducting a comprehensive review and is recruiting members to join a community review

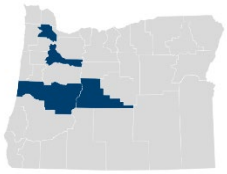
board. The community review board will provide a recommendation about whether to approve the transaction.

014 UnitedHealth-Amedisys



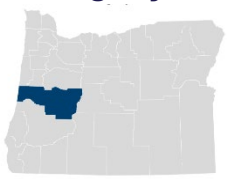
On December 4, 2023, OHA accepted a completed notice from UnitedHealth Group describing plans to purchase Amedisys. UnitedHealth Group is one of the largest companies in the U.S., offering health insurance and providing health care services nationwide. Amedisys provides hospice, home health, and palliative care services in 38 states. OHA is currently conducting a review of this transaction.

015 Envision



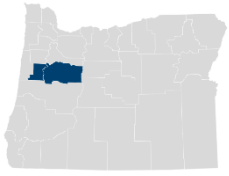
Envision Healthcare Corporation is a national company that employs physicians and owns ambulatory surgical centers. Envision filed a notice describing their chapter 11 bankruptcy, which includes a restructuring plan that would change the ownership of some of its Oregon surgery centers. OHA completed a preliminary review and approved this transaction on October 30, 2023. The bankruptcy concluded on November 3, 2023.

017 Agility-Keiper Spine



As described in its submitted notice, Agility Podiatry MSO, LLC, a management services organization (MSO) proposes to acquire the non-clinical assets of KeiperSpine, PC, a physician practice offering neuro-spine care, as well as a majority ownership stake of Spine Surgery Center of Eugene, LLC, an ambulatory surgery center. Agility Podiatry MSO is majority owned by a private equity firm. Both KeiperSpine and Spine Surgery Center of Eugene are located in Eugene, Oregon. HCMO is currently reviewing this proposed transaction.

018 UnitedHealth/Optum-Corvallis Clinic



Optum Oregon MSO submitted a notice describing plans to purchase The Corvallis Clinic, which operates 11 specialty clinics and one ambulatory surgery center in Oregon. Optum Oregon MSO is owned by UnitedHealth Group, one of the largest health insurance and health care companies in the nation. HCMO is currently reviewing this transaction.

Public engagement and outreach

The HCMO program aims to ensure that people are aware of health care business deals that affect their communities. Public input is also crucial to HCMO reviews. Information from public comments informs OHA's analysis, provides insight into potential impacts, surfaces inequities, and highlights populations that may be most affected by a transaction. The table below outlines how OHA engages the public in HCMO's work.

Transparent and accessible materials	The HCMO program makes information about health care transactions public, ensuring that individuals and communities have transparent access to information. Health care transaction materials, however, can be complex, involving lots of jargon and many legal documents. OHA strives to produce plain language materials with accessible and inclusive language. HCMO staff create summaries of each transaction that include key details presented in an easy-to-understand way. As applicable, HCMO translates summaries into multiple languages. HCMO staff may also ask entities to provide plain language summaries as part of their submissions.
Outreach	For each transaction, HCMO staff develop a plan to notify affected communities about transactions. We reach out to communities via OHA newsletters, media contacts, social media posts, and existing connections with community groups.
Public comment	OHA accepts public comments for every transaction. Comments are posted to the HCMO website and sometimes included in review reports and materials. If appropriate, OHA may hold public listening sessions to collect verbal input about a review. HCMO staff may schedule multiple meetings at different times to ensure that people with different schedules can attend.
Community review boards	OHA may convene a community review board for a comprehensive review. Community review boards consist of people who live in communities affected by a transaction, including patients, consumers, advocates, health care experts, and health care providers. Community review boards provide a recommendation about whether OHA should approve a transaction. OHA plans to convene its first community review board in early 2024 for the Kroger-Albertsons review.

What's next for HCMO

In 2024, the HCMO program will continue to receive notices of material change transactions, conduct transaction reviews, and monitor health care consolidation in Oregon.

Expected upcoming reviews

In August 2023, OHSU and Legacy Health announced their plans to combine. HCMO has not yet received a notice submission for this transaction. After OHSU and Legacy submit a notice, HCMO will begin a review and post materials related to the transaction to the HCMO website.

Completing follow-up reviews

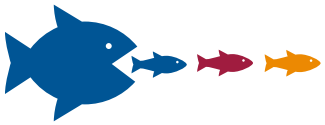
As directed by ORS 415.501(19), OHA conducts follow-up reviews for approved transactions one, two and five years after the transaction closes. Follow-up analyses assess entities' compliance with approval conditions, cost trends and cost growth. OHA may also examine any areas of concern surfaced in the initial review. To support follow-up reviews, OHA may request data and information from entities and solicit public comments.

In 2024, OHA plans to conduct follow-up reviews for multiple transactions:

- One-year follow-up reviews for 003 UnitedHealth-LHC, 005 Amazon-OneMedical, 006 Adventist-MCMC, 009 Samaritan-Norco, 012 PeaceHealth-NWSS, and 015 Envision.
- Two-year follow-up reviews for 002 Falcon Hospice and 004 SDB.

Monitoring consolidation in Oregon

In addition to conducting transaction and follow-up reviews, OHA monitors consolidation more generally, looking for patterns and trends in mergers and acquisitions of health care entities. OHA tracks information about non-filed transactions in Oregon, stays abreast of the latest research and evidence related to health care consolidation, monitors policy changes that could impact consolidation activity, and compiles insights and learnings for inclusion in the statutorily mandated 2026 study of the state of consolidation in Oregon. Some notable trends are listed below.



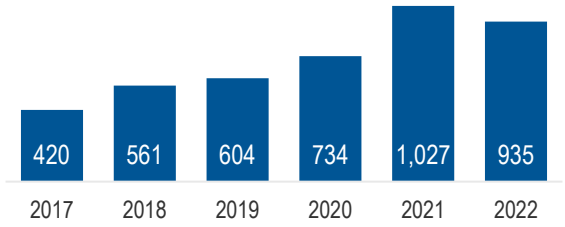
Serial transactions

Some companies engage in multiple transactions that can collectively impact the market. Even a series of small transactions can cumulatively result in increased consolidation over time.

Private equity acquisitions

The private equity business model, with its focus on short-term profitability, has been widely reported in media and research as being associated with lower quality of care, increased consolidation, and higher health care spending.[6] In 2023, two transactions – 015 Envision and 017 Agility – involved a private equity firm. OHA

Health care deals involving private equity in the U.S.



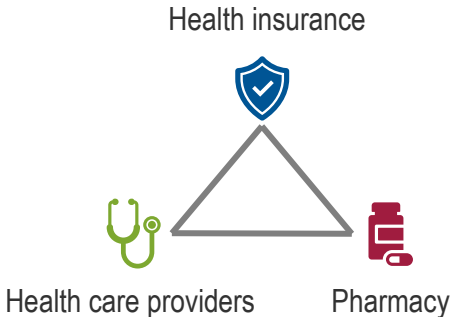
Source: Pitchbook Q2 2023 Healthcare Services Report

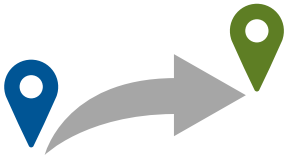
will continue tracking which transactions involve private equity.

Vertical consolidation

Vertical consolidation involves entities that offer different goods or services. For example, one growing trend is insurance company acquisition of provider groups such as primary care practices and in-home care providers.[7]

Another trend is for health care companies to seek to create an "iron triangle" that combines insurance, health care services, and pharmacy benefits management to generate profits and leverage power.[8]





Cross-market consolidation

Cross-market consolidation occurs when companies combine that do not directly compete in the same geographic markets. Recent studies have shown that cross-market consolidation can lead to higher prices and harm competition.[9]

Partial acquisitions

Partial acquisitions happen when one company buys or takes over some, but not all of the assets, rights, and obligations of another company. Both companies continue to exist. An example of a partial acquisition is LabCorp's acquisition of Providence's laboratory services. Partial acquisitions are often not subject to review by HCMO under current rules and statutes.

Impact of actions by large, national companies on Oregon's health system

Mergers or acquisitions among large national health care players have the potential to affect care delivery in Oregon, particularly if entities provide health care services to many communities or offer services with few alternatives.

Incorporating updated federal merger guidelines

In December 2023, the Federal Trade Commission (FTC) and U.S. Department of Justice (DOJ) released new Merger Guidelines to replace previous guidelines from 2010.[10] These guidelines are intended to inform the public, businesses, and courts about the federal agencies' framework for assessing whether proposed mergers comply with antitrust law. HCMO uses parts of this framework to analyze how transactions can affect consolidation and competition in Oregon's health care markets.

The new guidelines discuss how to analyze newer and more complex forms of consolidation, including serial acquisitions, cross-market mergers, vertical consolidation, and transactions involving private equity firms. As noted above, these trends are increasingly affecting Oregon, and the methods outlined will inform OHA's approach to reviewing such transactions. Additionally, the new guidelines recognize that mergers and acquisitions can reduce competition in labor markets, potentially leading to lower wages and worse working conditions.

In health care, this could mean doctors or nurses leaving their jobs at large provider organizations, or lower care quality. Where applicable, OHA intends to consider such impacts going forward.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact us by email at hcmo.info@oha.oregon.gov or by phone at 503-385-5948. We accept all relay calls.

Connect with us to learn more about the Health Care Market Oversight program:

- Visit our website
- Email us at hcmo.info@oha.oregon.gov
- Sign up to receive program updates

Appendix: Summary Data Table

Submissions Received	2022*	2023	Program to date
Notice of Material Change Transaction	5	11	16
Emergency Exemption Request	-	-	-
Determination of Covered Transaction Status		2	2
Transaction Reviews			
Initiated Preliminary Reviews	4	11	15
Completed Preliminary Reviews	4	8	12
Initiated Comprehensive Reviews		2	2
Completed Comprehensive Reviews	-	-	-
OHA Transaction Decisions			
Approved	3	2	5
Approved w/ conditions	1	3	4
Disapproved	-	-	-
Emergency exemption	-	-	-
Other exemption	1	-	1
Withdrawn	-	1	1
Community & Public Engagement			
Public comment periods	4	11	15
Public comments received	39	149	188
Community review boards convened	-	-	-

*The HCMO program launched March 1, 2022.

Appendix: Transaction Details

ID	Filing Entity	Other Entities	Description	Notice Date*	Decision Date	Status
001	Advantage Dental (dental care organization)	Sun Life Assurance (non-health care entity)	Advantage Dental's parent organization (DentaQuest) became a wholly owned subsidiary of Sun Life.	3/1/2022	3/9/2022	Exempt
002	Falcon Hospice (portfolio company of CD&R)	• Humana (insurance and health care provider) • Kindred at Home (hospice provider) • CD&R (private equity firm)	Humana divested a 60% stake in Kindred at Home's Hospice and Personal Care Divisions to Falcon Hospice, L.P., a portfolio company of CD&R, a private equity firm. Kindred at Home operates two locations in Oregon in Lake Oswego and Salem. This transaction closed 8/11/22.	6/14/22	7/14/22	Approved
003	UnitedHealth Group (insurance and health care provider)	LHC Group (hospice and home health provider)	UnitedHealth (through its Optum subsidiary) acquired LHC Group. LHC operates nine hospice and home health services locations in Oregon.	8/2/22	9/1/22	Approved
004	Specialty Dental Brands (dental support organization)	• TSG Consumer Partners (private equity firm) • Leon Capitol Group (private equity firm)	SDB and Leon Capitol Group sold an ownership stake in the business to TSG Consumer Partners, a private equity firm. SDB owns SDB MTN West Partners, LLC and SDB Partner Aggregator, LLC, two dental support organizations that provide management and administrative services to dental practices in multiple states, including Oregon. This transaction closed 9/16/22.	8/9/22	9/9/22	Approved
005	Amazon (technology and retail company	One Medical (primary care company, aka1Life Healthcare, Inc.)	Amazon is acquired One Medical, which operates five primary care locations in Oregon.	11/29/22	12/29/22	Approved with conditions
006	Adventist Health System	Mid-Columbia Medical Center	Adventist Health System purchased Mid-Columbia Medical Center, which operates a hospital and health care clinics in and around The Dalles, Oregon.	1/24/23	4/14/23	Approved with conditions
007	Radia Inc., PS	Medford Radiological Group	Radia, radiology group based in the state of Washington, plans to purchase Medford	1/31/23	3/9/23 (revised 12/22/23)	Approved with conditions

ID	Filing Entity	Other Entities	Description	Notice Date*	Decision Date	Status
			Radiological Group (MRG), another radiology group based in Medford.			
008	SCAN Group	CareOregon	CareOregon, the largest provider of Oregon Health Plan benefits in the state, is planning to combine with SCAN Group, a California company that offers Medicare Advantage plans and service for older adults.	1/12/23	1/12/24	In progress
009	Samaritan Health	Norco	Samaritan Health, a regional health system, sold its durable medical equipment to Norco, a provider of industrial and medical equipment.	4/6/23	5/4/23	Approved
010	Option Care	Amedisys	OptionCare sought to acquire Amedisys. Amedisys abandoned this deal to accept an offer from UnitedHealth Group.	6/20/23	N/A	Withdrawn
012	PeaceHealth	NWSS	PeaceHealth sought to purchase assets and hire staff from Northwest Surgical Specialists.	7/17/23	8/16/23	Approved with conditions
013	Kroger	Albertsons	Kroger and Albertsons, two large grocery store chains, are planning to merge. Together, the companies operate 159 pharmacies in Oregon.	8/8/23	--	In progress
014	UnitedHealth Group	Amedisys	UnitedHealth Group, one of the largest companies in the U.S., plans to acquire Amedisys, a hospice and home health provider.	12/4/23	--	In progress
015	Envision		Envision, a company that operates surgery centers and provides physician staffing services, pursued bankruptcy and a corporate restructure.	10/19/23	10/30/23	Approved
017`	Agility Podiatry MSO	KeiperSpine, PC & Spine Surgery Center of Eugene, LLC	Agility Podiatry plans to acquire non-clinical assets of KeiperSpine and majority share of Spine Surgery Center of Eugene.	12/18/23	--	In progress
018	Optum Oregon MSO	The Corvallis Clinic	Optum Oregon MSO, a subsidiary of UnitedHealth Group, seeks to acquire The Corvallis Clinic, which operates primary and specialty care clinics.	12/28/23	--	In progress

*Notice Date is the date OHA accepted and publicly posted a complete Notice of Material Change Transaction. This is also the date OHA's 30-day review period begins.

References

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[3] Claire O'Hanlon, et al. "Access, Quality, And Financial Performance of Rural Hospitals Following Health System Affiliation." Health Affairs, Dec 2019. See also Rachel Mosher et al. "Access to Obstetric, Behavioral Health, and Surgical Inpatient Services After Hospital Mergers in Rural Areas," Health Affairs, Oct 2021.

[4] Alan Kaplan and Daniel O'Neill. "Hospital Price Discrimination Is Deepening Racial Health Inequity." NEJM Catalyst, Dec 2020.

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[7] "Insurer 'FOMO' Driving Healthcare Bidding Wars," Modern Healthcare, Oct 3, 2022.

[8] Zirui Song, "Privatization in Health Care," Presentation to Oregon Legislature Senate Interim Committee on Health Care, Sep 27, 2023.

[9] Leemore Dafny, Kate Ho, Robin S. Lee. "The price effects of cross-market mergers: theory and evidence from the hospital industry." The RAND Journal of Economics, April 2019. See also Brent D Fulton et al. "The Rise of Cross-Market Hospital Systems and Their Market Power in the US." Health Affairs, Nov 2022.

[10] US. Department of Justice and the Federal Trade Commission, Merger Guidelines, December 18, 2023.

Thank you for attending the Health Care Cost Transparency Board Retreat.

Washington State Health Care Authority