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MARCH 2023

The Manatt State Cost Containment Update

Introduction

Welcome to the Manatt State Cost Containment Update, a digital publication produced with support from the Robert Wood Johnson Foundation and developed in coordination with the Peterson-Milbank Program for Sustainable Health Care Costs. This Manatt series shares updates on state cost growth benchmarking programs and other data-driven initiatives states are undertaking to contain health care cost growth. In each edition, we also spotlight issues that speak to how state health data organizations and programs are evolving to meet new policy and program priorities.

Spotlight

In this issue, Manatt provides a refresher on **California's new Office of Health Care Affordability** and an update on next steps for its newly elected Affordability Board, and also breaks down Congressman Don Beyer's **National All-Payer Claims Database Act of 2022**, which was introduced shortly after Manatt's December 2022 National All-Payer Claims Database Summit, renewing discussions on the Hill about the value of national health system transparency.

California Gets Rolling: Health Care Affordability Board Appointed and Set to Convene on March 21, 2023

The takeaway. In early March, California's Office of Health Care Affordability (OHCA) announced its Health Care Affordability Board members and set the date for the Board's first meeting: Tuesday, March 21, 2023. California's health care public and private industry leaders—many of whom have only become recently aware of OHCA's cost containment authorities—will be listening closely to understand the vision of the Office's new Deputy Director, Vishaal Pegany (previously an Assistant Secretary at CalHHS), for the state's benchmarking program and how the state's new spending targets will be set to account for the dynamics of the nation's largest, and potentially most complex, health care market. State leaders will not be the only ones listening. As America grapples with health care costs that continue to rise, comprising greater shares of household salaries and state budgets, state policymakers and regulators are looking to health care cost growth benchmarking programs as potential tools to better understand and address health care cost drivers.

With California's passage of the Health Care Quality and Affordability Act in 2022, ten states[1] have cost growth benchmarking programs in place or in development, covering over 70 million people—or one in five Americans. California's statewide cost growth benchmarking program aims to measure the market in new ways, as its leaders strive to identify and stem cost drivers, promote consumer affordability, improve health equity, and maintain high-

[1] Including California (in progress), Connecticut, Delaware, Maine (in progress), Massachusetts, Nevada, New Jersey, Oregon, Rhode Island, and Washington.

quality care. However, **much of the state's program remains undefined**, left to be designed through implementation. Stakeholders should be prepared to engage with OHCA through 2023 and 2024 as the Board sets key program parameters and definitions.

What it is. After years of negotiation between the California Legislature and health care organizations, in late June 2022, California's Governor Newsom signed the California Health Care Quality and Affordability Act (Senate Bill 184) to establish OHCA within the California Department of Health Care Access and Information (HCAI). OHCA is charged with creating a state strategy for controlling the cost of health care, establishing a state cost growth benchmarking program, and supporting other market oversight activities. Specific responsibilities of the Office include:

1. **Establishing Governance.** Within OHCA, an eight-member Health Care Affordability Board comprised of people appointed by the Governor, the Senate Committee on Rules, the Speaker of the Assembly, the Secretary of Health and Human Services, and the CalPERS Chief Health Director will serve as a key decision-making body for California's cost growth benchmarking program. The Board will also establish a Health Care Affordability Advisory Committee comprised of industry stakeholders, including representatives of consumer and patient groups, payers, fully integrated delivery systems, hospitals, organized labor, health care workers, medical groups, physicians, and purchasers. The Board may also choose to establish other technical/advisory committees to advise the Board's decision-making.
2. **Developing Cost Growth Targets.** The Health Care Affordability Board is charged with establishing a statewide cost target on total health care spending, as well as specific targets by health care sector, geographic region, and health care entity as appropriate. The statewide cost target will be determined by the Board and set annually beginning in 2025,[2] while specific targets by sector, by geographic region, and, potentially, by individual entity will be set beginning in 2028. Targets may incorporate economic or population-based measures; will account for baseline health care costs, historical trends, and other relevant data; and should be "predictable and sustainable" and set in accordance with a Board-approved, transparent methodology.
3. **Measuring System Performance.** OHCA will annually collect and analyze data from public and private payers to monitor health care spending across all lines of business in the state and assess statewide performance against established and approved cost growth targets. OHCA will supplement benchmarking data collection and measurement with additional HCAI data, such as hospital payment data, health care workforce data, hospital financial reporting data, and Health Care Payments Data (HPD, the state's APCD).

   OHCA will develop a baseline report by June 1, 2025 (using 2022 and 2023 calendar year data) and its first annual report (using 2024 and 2025 calendar year data) on health care spending trends and underlying cost drivers by June 1, 2027, along with policy recommendations to control costs, improve quality performance, and advance equity of the health care system. Recommendations will ensure access to care and high-quality jobs while preserving workforce stability. At least 30 days after posting the annual report, OHCA will present the report at a public meeting of the Board to inform policymakers and the broader public about its findings, including actionable recommendations for mitigating cost growth.
4. **Fostering Target Compliance.** Beginning in 2026, OHCA may start to take progressive actions against health care entities for failing to meet the cost targets. If entity-attributed cost growth is found to be in excess of the target, OHCA may provide technical assistance to the entity, require public testimony from the entity, require submission and implementation of a performance improvement plan (PIP), and/or impose administrative penalties "in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets."

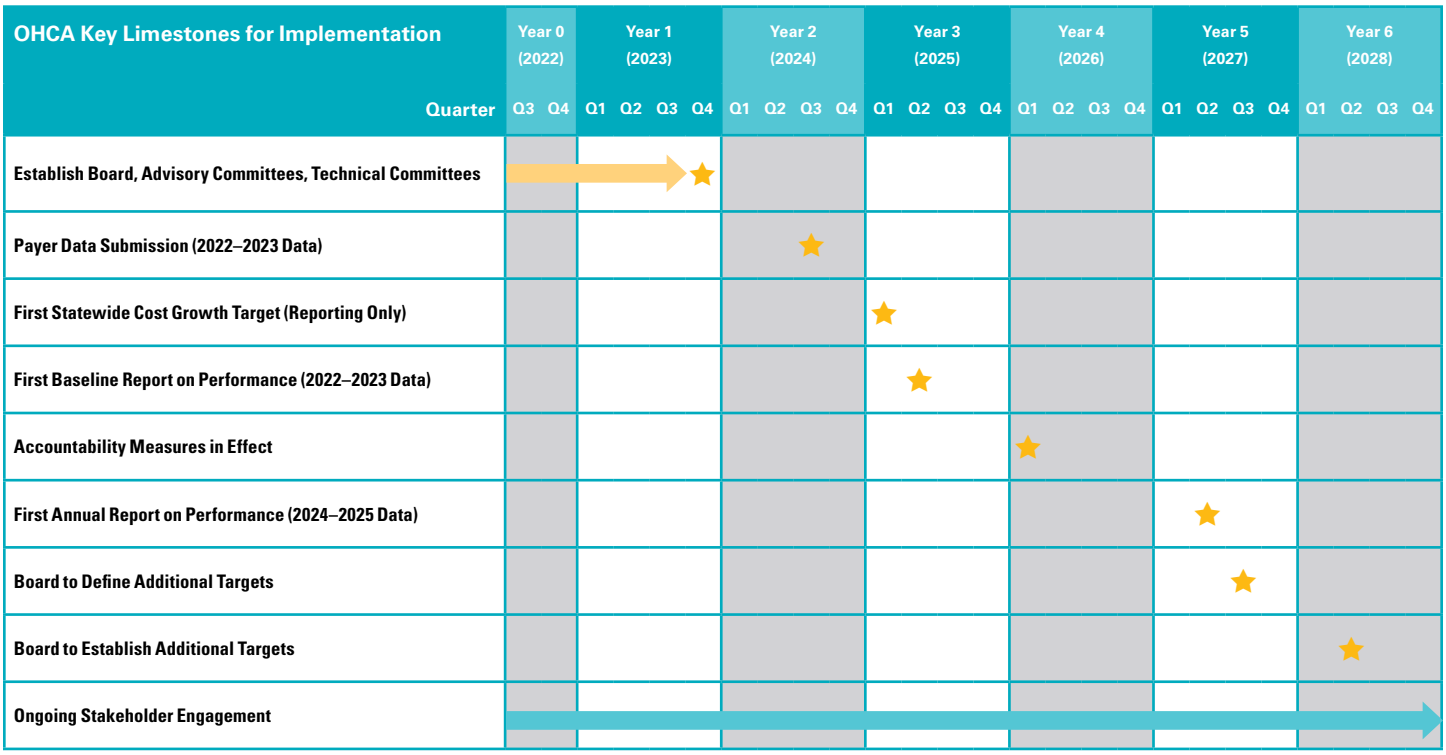
OHCA may also establish requirements for health care entities that wish to file for a waiver of enforcement actions due to circumstances that are outside the entity's control or for entities that provide other sufficient reasons for being unable to meet cost targets.

5. **Providing Additional Market Oversight.** OHCA will seek to promote competitive markets in California by examining and analyzing the impact of market changes in a manner supportive of the efforts of the Attorney General (AG), the Department of Managed Health Care, and the California Department of Insurance. Beginning April 1, 2024, health care entities will be required to provide written notice of certain agreements or transactions 90 days in advance of the agreement or transaction taking place. OHCA is also granted oversight to prospectively examine and conduct cost and market impact reviews (CMIRs) of proposed consolidations and other similar transactions that may have "a risk of significant impact on market competitions, the state's ability to meet cost targets, or costs for purchasers and consumers." Upon CMIR completion, OHCA will issue a preliminary report of its findings, to which affected parties and the public can respond, and may refer findings to the AG for further review of unfair methods of competition, anticompetitive behavior, or anticompetitive effects.
6. **Encouraging Market Transformation.** SB-184 advances a comprehensive benchmarking program that extends beyond core expenditure measurement and reporting to include:
    a. **Quality and Equity.** SB-184 includes a specific emphasis on maintaining a quality and equity lens in carrying out the functions of OHCA and establishing a single set of standard measures to report on quality and equity performance across payers, fully integrated delivery systems, hospitals, and physician organizations.
    b. **Alternative Payment Models.** OHCA will promote a shift from fee-for-service to alternative payment models by adopting alternative payment model standards for use during payer-provider contracting by July 1, 2024. OHCA will establish benchmarks to increase the proportion of care delivered through alternative payment models.
    c. **Primary Care and Behavioral Health.** To measure and promote a sustained systemwide investment in primary care and behavioral health, OHCA will set spending benchmarks for primary care and behavioral health services and promote investments into models that integrate primary care and behavioral health services or that leverage alternative payment models to improve access, quality, and care coordination.
    d. **Health Care Workforce Stability and Training.** To ensure that the implementation of cost-reducing strategies does not negatively impact workforce stability, OHCA will develop health care "workforce stability" standards to incorporate into statewide cost growth targets by 2024.

What it means. Implementing SB-184 will require a multiyear process of defining and refining the benchmarking program's design and respective requirements. Stakeholder engagement will be central to advancing the bill's long-term goals, and stakeholders should keep in mind that:

- **SB-184 is a blueprint with much left to design and define.** SB-184 is a blueprint for OHCA and California's benchmarking program that leaves much to design (e.g., performance measurement methodology) and define (e.g., health care "sector").
- **Stakeholder engagement will be essential for program success.** With the Board officially appointed, expect OHCA to set up an accelerated schedule of public meetings to support program design and implementation.
- **Transparency is at the core of OHCA's design.** Public transparency is built into SB-184, requiring the establishment of a Health Care Affordability Board (to be run in accordance with Bagley-Keene requirements) and a Health Care Affordability Advisory Committee. Both the Board and the Committee are expected to be publicly consulted on crucial program development and market accountability decisions.
- **Benchmarking programs are about culture change.** Benchmarking programs seek to engage public and private stakeholders around a common goal and develop collective and clear pathways and expectations for reaching that goal.
- **Playing the long game.** Culture change—and benchmarking program development—takes time. Stakeholders should not expect major market reporting prior to the Baseline Report until mid-2025 or major system "accountability" actions (e.g., performance improvement plans) until the late 2020s, at the earliest.

Figure 1. Timeline and Key Milestones for OHCA Implementation



What happens next. California's benchmarking program is more comprehensive and complex than any benchmarking program that has come before it. OHCA's charge is sweeping, but much of its program was left to design through implementation. Stakeholders should be prepared to engage with OHCA through 2023 and 2024 as the Health Care Affordability Board sets key program parameters and definitions. **Stakeholders should also remember that technical and seemingly small decisions can have major implications for benchmarking program design, implementation, and impact, and stakeholders should engage their associations and subject matter experts accordingly.**

For more information, please see Manatt Health's webinar A New Era of Accountability: Lessons From the CA Health Care Quality and Affordability Act or contact Kevin McAvey at kmcavey@manatt.com.

Manatt All-Payer Claims Database Summit Renews Congressional Interest in a National APCD

The takeaway. On December 7, 2022, with support from the Robert Wood Johnson Foundation (RWJF) and the Peterson Center on Healthcare, Manatt hosted the National All-Payer Claims Database (APCD) Summit, where public and private health care stakeholders offered support for the recommendations in Manatt's report "Realizing the Promise of All Payer Claims Databases: A Federal and State Action Plan," including the establishment of a national APCD and enhancing State Health Data Organizations (HDOs) funding. Following the Summit, Congressman Donald Beyer introduced the National All-Payer Claims Database Act of 2022 (H.R. 9644), which codified many of the paper's recommendations—and renewed discussions on the Hill about the value of national health system transparency.

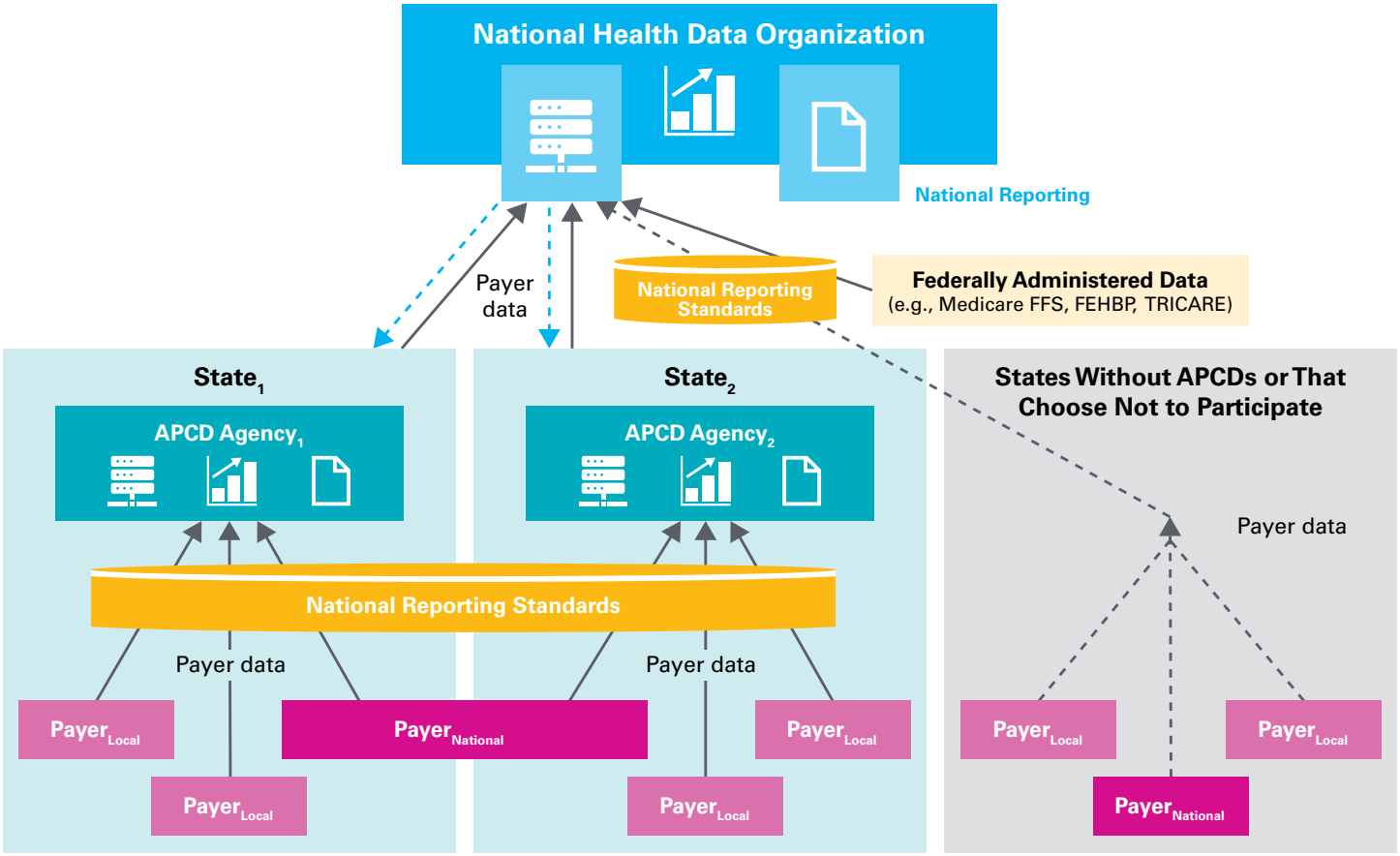
What it is. State APCDs are marketwide repositories of public and private payer health care claims and encounter data, including records of health care service payments that provide contextual information about the individuals served and their diagnosed conditions. State APCDs can provide users with broad and longitudinal cross-payer insights into health system performance and changing population health, and they are used by policymakers to inform health care and payment reform design as well as support market transparency.

The current state APCD operating model has several limitations that can constrain the use and usefulness of APCDs. Drawbacks include:

- **Missing data for key populations and services.** Federal regulations limit the ability of state APCD agencies to collect data from self-insured plans covered by the Employee Retirement Income Security Act (ERISA) and from federally managed health care programs, creating data gaps for up to a third of state residents.
- **Inconsistent data collection and access requirements.** Each state APCD agency has its own protocols for how it collects, curates, and releases data, impeding cross-state data access and analytic comparisons.
- **Need for sustainable and adequate funding for state health data capacity.** State APCDs are often underinvested in resources and lack the level of sustained and reliable federal and state funding required to hire and retain top-flight talent and to invest in the foundational data, data management, and analytic infrastructure required to demonstrate their full capabilities.

With support from the RWJF and the Peterson Center on Healthcare, Manatt Health engaged more than 40 federal and state policymakers, regulators, researchers, and other health data leaders to design and propose a new, national APCD model that would build on the existing state-based APCD infrastructure to strengthen national health system transparency. The proposed "Federally Facilitated State Data Partnership" model (see Figure 2) was presented at the December 2022 National APCD Summit.

Figure 2. Manatt Health's Proposed National APCD Model: Federally Facilitated State Data Partnership



Key features of the Manatt-proposed model were included in Congressman Donald Beyer's National All-Payer Claims Database Act of 2022 (H.R. 9644), introduced on December 21, 2022.

What it means. If reintroduced and advanced in the House, Congressman Beyer's bill would create new national health data capacity to support system transparency and decision-making, including:

1. **Creating a National Health Data Organization (HDO) and National APCD.** The bill directed the Secretary of Health and Human Services to contract with a nonprofit organization to establish and maintain a national health care claims database in accordance with federal data privacy laws as well as protections set by the HDO's governing board. The National HDO would be housed within the Agency for Healthcare Research and Quality (AHRQ) and would collect data from participating state APCDs before filling data gaps with direct payer reporting. The National HDO would also be responsible for:
   - Establishing national APCD data standards, which would allow states to fill their largest data collection gap: data for ERISA-preempted, self-insured health plan members, which comprise approximately one-third of state lives.[2]
   - Facilitating the collection and distribution of federally administered health care data back to participating state APCDs, including data for individuals served by Medicare, TRICARE, and the Federal Employee Health Benefit Plan (FEHBP).
   - Releasing aggregate data to the public at no charge and making more detailed data available to patients, states, providers, payers, and researchers at cost and to the extent allowed by federal law and National HDO privacy protections.
   - Reporting on national, cross-state, and regional trends in health care access, utilization, and costs.
   - Responding to state, federal, and congressional requests relating to data in the database.

The National HDO would be governed by a board that comprises representatives from the federal government, participating states, employers, patient advocacy organizations, and academia who have data privacy and security expertise. The National HDO would be funded at $50 million annually.

2. **Increasing Funding for State Health Data Organizations**. The bill proposed the appropriation of $40 million annually—or $200 million over five years[3]—to provide states with funding to build health data capacity and test innovative approaches to health data use (Health Data Innovation Grants). State health data capacity funding of up to $36 million annually would be available to states to support the maintenance, establishment, or utilization of state APCDs. State Health Data Innovation Grants of no less than $4 million annually would also be provided to states to support state APCD analyses of potential national interest (e.g., analyses to support opioid use disorder responses or to test behavioral health network adequacy). Funding would be available to states participating in national database development.
3. **Establishing National Health System Data Protections**. The bill outlined data privacy and security requirements for the National HDO and its activities, including:
   - Required compliance with HIPAA and other federal data privacy laws when collecting, transmitting, and releasing data.
   - Establishment of clear and public data use and release policies, developed with the Governing Board.
   - De-identification of data prior to release while retaining the ability to link data longitudinally for research purposes and allow for risk adjustment and geographic analysis.

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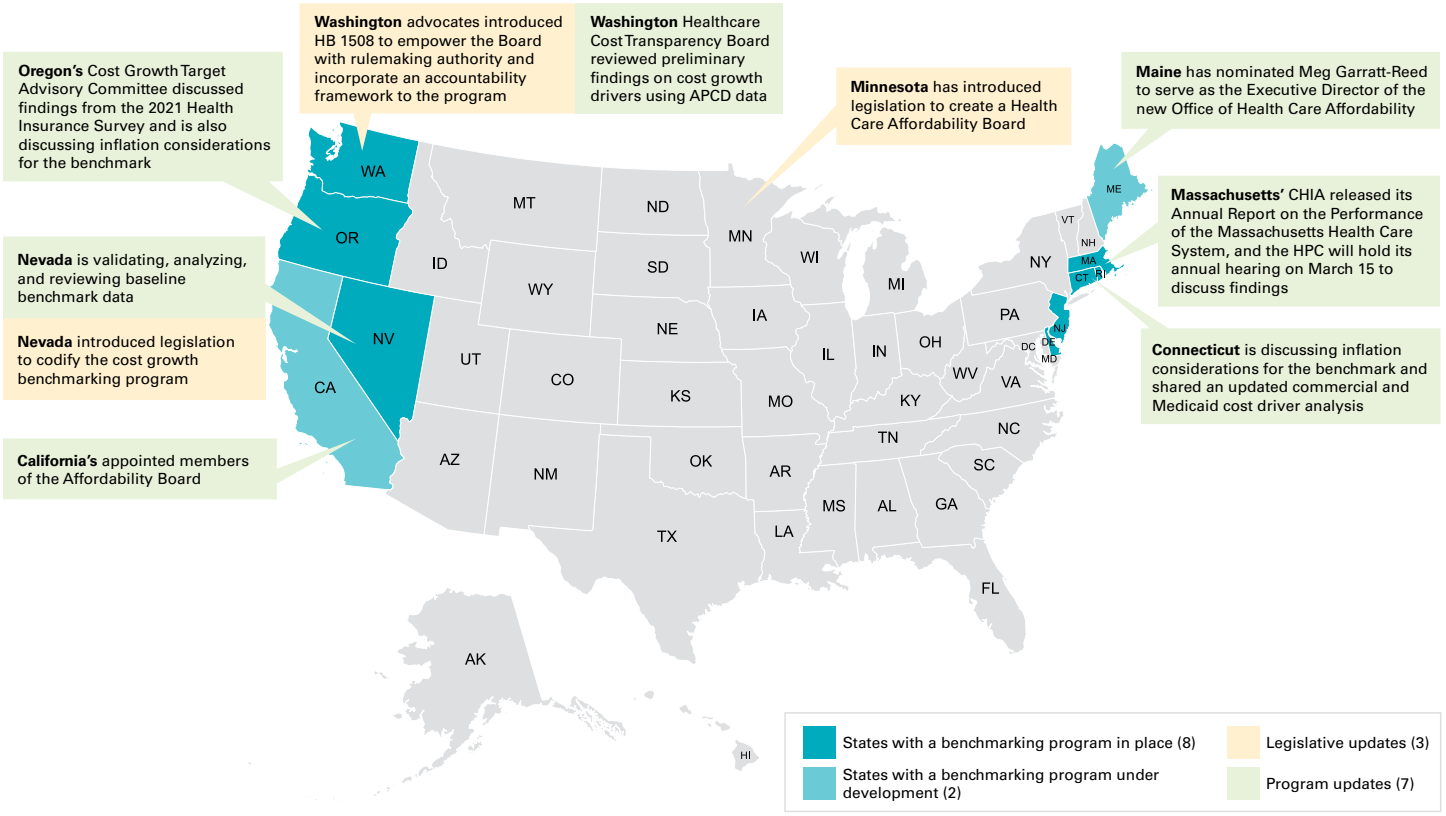
[2] Half of Americans are covered by employer-sponsored insurance (ESI), and nearly two-thirds (64%) of those are covered through self-insured plans. For more information, see "Health Insurance Coverage of the Total Population," Kaiser Family Foundation. 2019. Accessed July 25, 2022. Available here. See also, "Employer Health Benefits: 2021 Annual Survey," Kaiser Family Foundation. 2021. Accessed July 25, 2022. Available here.

[3] H.R. 9644 appropriates $40 million annually for fiscal years 2023 through 2028. While no single state will be eligible to receive more than $10 million in grant funding in any year, multiple states seeking to jointly establish a regional APCD would not be subject to this grant funding limit.

The National HDO, as proposed in Manatt's paper but not explicitly called out in the bill, may also choose to require minimum data privacy and security standards of participating states, elevating APCD data protections nationally.

What happens next. Congressman Beyer's bill would need to be reintroduced in the new Congress for further action to occur. However, its introduction has renewed federal (congressional and executive), state, and private sector interest in establishing a national APCD (or similar). Manatt will continue to track discussions and future legislative action. For more information, contact Kevin McAvey at kmcavey@manatt.com.

The State of Play: Cost Growth Benchmarking Programs (as of March 20, 2023)



Detailed State Updates as of March 20, 2023

State	Update	Detail
CA	**Benchmarking Update**	Members of California's Office of Health Care Affordability's Affordability Board have been appointed by state leadership. The Board will begin regular meetings through 2023 and will soon begin appointing members to the Health Care Affordability Advisory Committee.
CT	**Benchmarking Update**	The Office of Health Strategy (OHS) Healthcare Benchmark Initiative Steering Committee met in February to discuss the state's approach to considering inflation in the state's cost growth benchmark, discuss benchmark timeline and performance reporting, and present updated commercial and Medicaid cost driver analyses. The Committee also engaged in cross-state dialogue with other cost growth benchmarking states (including Rhode Island and Oregon) around their strategies for addressing pharmaceutical costs, advancing value-based payment models, and accountability measures.
MA	**Benchmarking Update**	On March 13, the Massachusetts Center for Health Information and Analysis (CHIA) published its Annual Report on the Performance of the Massachusetts Health Care System, which examines state trends in costs, coverage, and quality indicators. Key findings include: • Total health care expenditures (THCE) totaled $67.9 billion in 2021. From 2019 to 2021, THCE per resident increased at an annualized rate of 3.2%. THCE per capita increased 9.0% in 2021 to $9,715 per resident, following a 2.3% decline in 2020. • From 2019 to 2021, pharmacy spending increased at an annualized rate of 7.5% net of rebates and 9.6% gross of rebates, resulting in the fastest rate of three-year service category growth in Massachusetts. • In 2021, spending on behavioral health (BH) services comprised 6.6% of total health care spending for commercial members, 15.9% for Medicaid MCO/ACO-A members, and 1.9% for Medicare Advantage members. On March 15, the Massachusetts HPC will hold the annual hearing on the potential modification of the health care cost growth benchmark. The hearing will feature a presentation from the HPC on the Health Care Cost Growth Benchmark modification process, national health care spending trends, and affordability implications for Massachusetts residents. Staff from the Center for Health Information and Analysis (CHIA) will also present its Annual Report on the Performance of the Massachusetts Health Care System.
ME	**Benchmarking Update**	Gov. Janet Mills has nominated Meg Garratt-Reed to serve as the Executive Director of the state's new Office of Affordable Health Care. Garratt-Reed currently leads the state's office of the Health Insurance Marketplace.
MN	**Legislative Update**	Minnesota has introduced legislation to create a health affordability board that would establish health care spending targets for hospitals and providers, measure and publish health care system performance, develop accountability mechanisms, and collaborate with state agencies using APCD data to analyze and understand specific drivers of health care cost growth.
NV	**Benchmarking Update**	From January through March of 2023, the Patient Protection Commission (PPC) will be validating, analyzing, and reviewing baseline benchmark findings with Nevada insurers who responded to the State's request for the aggregated baseline benchmark data in late 2022. Additionally, the Commission will be working to further develop cost growth mitigation strategies.
NV	**Legislative Update**	Nevada's Gov. Lombardo has stated he will not support proposed legislation to establish into law the executive order former Governor Steve Sisolak signed in 2021, which created the state's health care cost growth benchmark program.
OR	**Benchmarking Update**	The Oregon Cost Growth Target Advisory Committee met in January to discuss findings from the 2021 Oregon Health Insurance Survey, review 2013-2019 cost growth data, and discuss state approaches to incorporating inflation into state cost growth benchmarking accountability measures.
WA	**Benchmarking Update**	The Washington Healthcare Cost Transparency Board met with the Advisory Committee on Data Issues at a public meeting on February 7 that included a presentation on preliminary findings from a study on cost growth drivers in the state using APCD data and an update on the WA multi-payer Primary Care Model Framework.
WA	**Legislative Update**	Washington advocates introduced HB 1508 to empower the Health Care Cost Transparency Board (HCCTB) and incorporate an accountability framework into the state's cost growth benchmarking program.

Health Data Corner

The Health Data Corner compiles the latest state health care data capacity innovations and policy developments and showcases select novel data use cases emerging from states.

- Indiana selected OnPoint to serve as the administrator for the state's new All-Payer Claims Database (APCD) following the Governor's 2020 "Next Level Agenda," which called for the creation of an APCD to increase health care price transparency for consumers.
- Massachusetts CHIA released a new report examining hospitalwide adult all-payer readmissions from 2011 to 2021, a key indicator of health system performance. Among other findings, this report found that Medicare and Medicaid patients had higher hospital readmission rates (18.2% and 17.0%, respectively) than did commercially insured patients (10.3%). This report is accompanied by a detailed databook and technical appendix.
- KFF released a new report on Health Insurer Financial Performance in 2021 using financial data reported by insurance companies to the National Association of Insurance Commissioners (NAIC). The report finds that by the end of 2021, gross margins in the individual and group markets were lower than pre-pandemic levels and Medicaid margins were higher than pre-pandemic levels. Medicare Advantage plans have nearly double the per-person gross margins seen in other markets in 2021.

Other Cost Containment Resources

- The recommendations in Health Affairs' new report, "A Road Map for Action: Recommendations of the Health Affairs Council on Health Care Spending and Value" (February 2023), span four priority areas: administrative streamlining, price regulation and supports for competition, spending growth targets, and value-based payment.
- A new Health Affairs *Forefront* series, "Provider Prices in the Commercial Sector," funded by Arnold Ventures, features analyses and discussions of physician, hospital, and other health care provider prices in the private-sector markets and their contribution to overall spending. Submissions will be accepted here on a rolling basis through 2023. Recent releases include:
  - Seven Burning Questions Related To Commercial Prices For Health Care Services (January 2023)
  - Private Sector Health Care Prices—Defining The Terms Of The Policy Debate (January 2023)
  - Insurer Price Transparency Rule: What Has Been Disclosed? (February 2023)
- A new report from Catalyst for Payment Reform, "Combinations of State-Based Health Care Policies to Constrain Commercial Prices and Rebalance Market Power," provides a framework for states to consider "menus" of policy options to address rising health care costs.
- A new blog post from Georgetown Center of Health Insurance Reforms (CHIR), "Can Employer-sponsored Insurance Be Saved? A Review of Policy Options: Price Regulation," assesses the evidence for the regulation of provider prices and options for policymakers. This piece is the second of a CHIRblog series that examines proposed policy options designed to improve the affordability of ESI, the state of the evidence supporting or refuting the proposed policy change, and opportunities for adoption. The first piece, available here, examines the primary drivers of the erosion occurring in ESI.

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Our diverse team of more than 180 attorneys and consultants from Manatt, Phelps & Phillips, LLP, and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions and lead health care into the future. For more information, visit https://www.manatt.com/Health.

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