Manatt Health
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February 2022 Edition

The Manatt State Cost Containment Update
February 1, 2022

Introduction

Welcome to the Manatt State Cost Containment Update, a digital publication produced with generous support from the Robert Wood Johnson Foundation and in collaboration with the Peterson-Milbank Program for Sustainable Health Care Costs. This Manatt series, to be released quarterly through 2022, shares the latest 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 feature a spotlight issue that speaks to how state benchmarking programs are collectively evolving to meet new regulatory or landscape needs. Below are our February updates.

February Spotlight

In each edition, Manatt will feature a "deep dive" topic that shares new cross-cutting benchmarking program developments as states seek to evolve and advance their cost growth benchmarking programs to meet new regulatory and landscape needs. In this issue, Manatt examines opportunities for states to leverage All Payer Claims Databases (APCDs) and other key data assets to supplement state benchmarking programs.

Leveraging APCDs and Other Data Assets

The takeaway. State benchmarking programs may leverage other data resources - including All Payer Claims Databases (APCDs), private claims databases, and federal and state survey data - to provide policy-makers, regulators, consumer advocates, and researchers with important context for findings (e.g., who bears burden of cost growth) and allow results to be as actionable as possible (e.g., specific providers or drugs contributing to cost growth).

What it is. State cost growth benchmarking programs are data-driven, transparency-focused cost-containment initiatives that measure resident health care spending growth in relation to established targets; payers and providers that exceed targets may be subject to public inquiry or penalty. States collect benchmarking data directly from public and private payers operating in their states, monitoring health care spending across all lines of business. Payers may be asked to segment spending data by service category, key populations or product types, attribute spending to providers who may influence patient service utilization, or supplement "core" reporting with contextual information such as premium cost growth, Alternative Payment Methodology (APM) adoption rates, and member cost-sharing growth to help states better understand cost drives across payers and populations. Payer submissions, typically delivered in a set of summative tables with aggregate data (i.e., not person-level information), are sourced from a combination of their administrative (claims/encounter) data and financial data (non-claims-based payments), to present a complete, timely, and verifiable accounting of health care spend. Payers may be required to have an accountable person at their organization (e.g., CEO, chief actuary) certify that the data presented is valid to the best of their knowledge.

States may also use All Payer Claims Databases (APCD) to better understand health care market cost trends. APCDs are large-scale databases that collect health care claims and encounter data from public

and private payers across most lines-of-business, with the notable exceptions of the private self-insured (unless voluntarily reported) and Medicare fee-for-service (unless manually integrated by the state from CMS files).[1] Claims/encounter data can be a rich source of information, including person-level detail on patient diagnosis, the service delivered, the provider delivering the service, and the amount paid for delivery, by both the payer and patient. APCDs also collect other administrative information from payers to supplement and contextualize claims data, including enrollee demographic characteristics (e.g., age, zip code), and characteristics of enrollees' coverage types and details (e.g., network characteristics, plan premiums). APCDs can provide health services researcher with large sample sizes, person-, provider-, and service-level detail, and the ability to following patient populations/panels over time (i.e., longitudinal information), making them valuable and powerful – if at times unwieldy – data assets.[2]

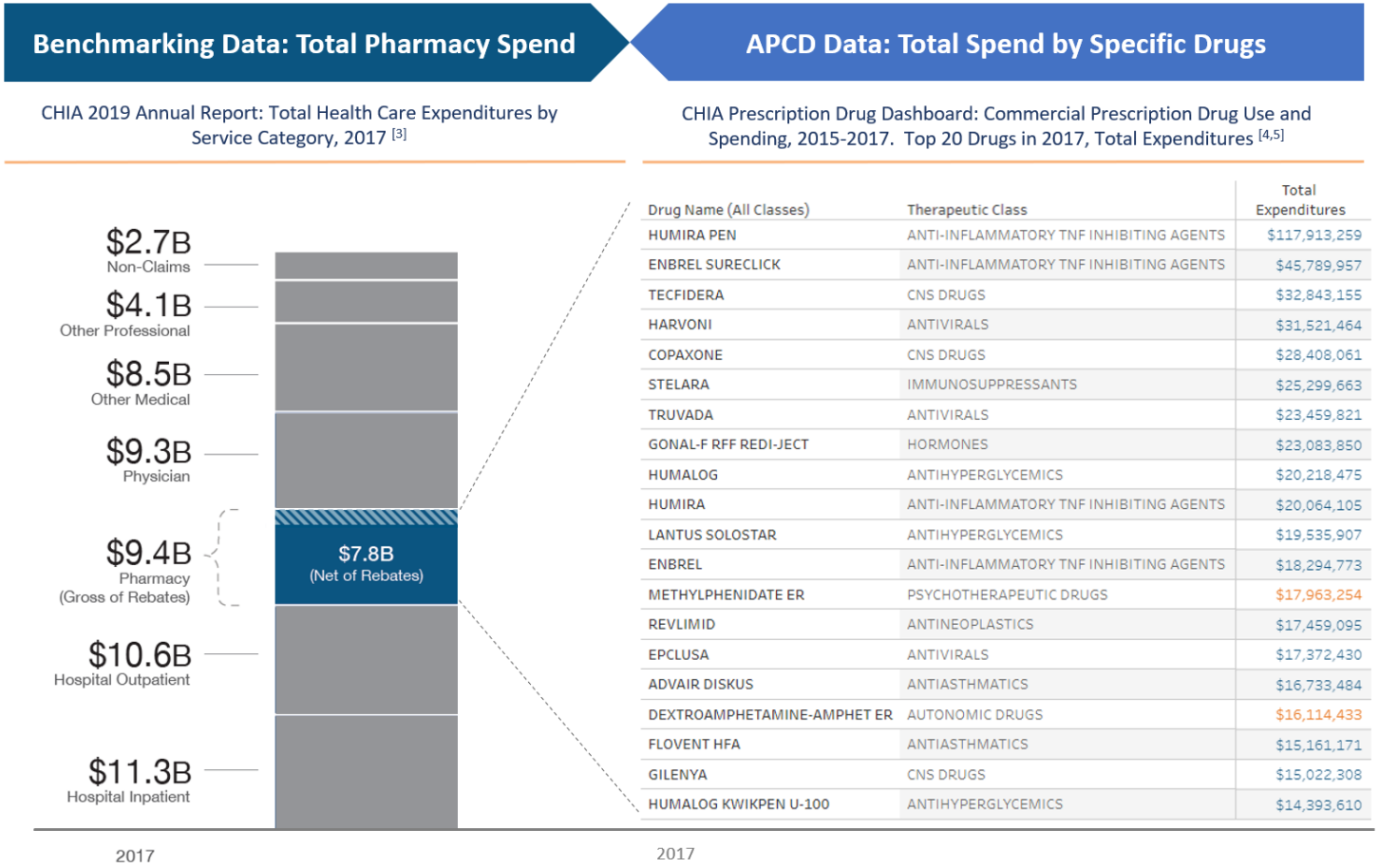
Unfortunately, **APCD data cannot replace payer benchmarking data reporting**, a common myth in health data circles, for reasons including that APCD data:

- Does not include non-claims payment information, which is of increasing importance as more payers and providers are paid under APMs;
- Does not include the vast majority of ERISA-preempted self-insured claims data (self-insured lives typically comprise over 60% of the employer-sponsored insurance market);
- Is not as timely as benchmarking data files, with calendar year benchmarking data received as soon as five months after year-end with payer-provided incurred but not reported (IBNR) estimates; and
- Does not have payer verification of results – or the methods used to derive them.

However, benchmarking and APCD data analyses can be paired to great effect: with benchmarking data uniquely capable of identifying cross-market concerns, while APCD data can be used to add context and detail to findings, making them that much more actionable for policy-makers, regulators, advocates, and researchers.

[1] APCD Council, FAQs. Available here: https://www.apcdcouncil.org/frequently-asked-questions
[2] "Overview of All-Payer Claims Databases," Agency for Healthcare Research and Quality. Available here: https://www.ahrq.gov/data/apcd/index.html

Figure 1. Benchmarking Data vs. APCD Data



Drug Name (All Classes)	Therapeutic Class	Total Expenditures
HUMIRA PEN	ANTI-INFLAMMATORY TNF INHIBITING AGENTS	$117,913,259
ENBREL SURECLICK	ANTI-INFLAMMATORY TNF INHIBITING AGENTS	$45,789,957
TECFIDERA	CNS DRUGS	$32,843,155
HARVONI	ANTIVIRALS	$31,521,464
COPAXONE	CNS DRUGS	$28,408,061
STELARA	IMMUNOSUPPRESSANTS	$25,299,663
TRUVADA	ANTIVIRALS	$23,459,821
GONAL-F RFF REDI-JECT	HORMONES	$23,083,850
HUMALOG	ANTIHYPERGLYCEMICS	$20,218,475
HUMIRA	ANTI-INFLAMMATORY TNF INHIBITING AGENTS	$20,064,105
LANTUS SOLOSTAR	ANTIHYPERGLYCEMICS	$19,535,907
ENBREL	ANTI-INFLAMMATORY TNF INHIBITING AGENTS	$18,294,773
METHYLPHENIDATE ER	PSYCHOTHERAPEUTIC DRUGS	$17,963,254
REVLIMID	ANTINEOPLASTICS	$17,459,095
EPCLUSA	ANTIVIRALS	$17,372,430
ADVAIR DISKUS	ANTIASTHMATICS	$16,733,484
DEXTROAMPHETAMINE-AMPHET ER	AUTONOMIC DRUGS	$16,114,433
FLOVENT HFA	ANTIASTHMATICS	$15,161,171
GILENYA	CNS DRUGS	$15,022,308
HUMALOG KWIKPEN U-100	ANTIHYPERGLYCEMICS	$14,393,610

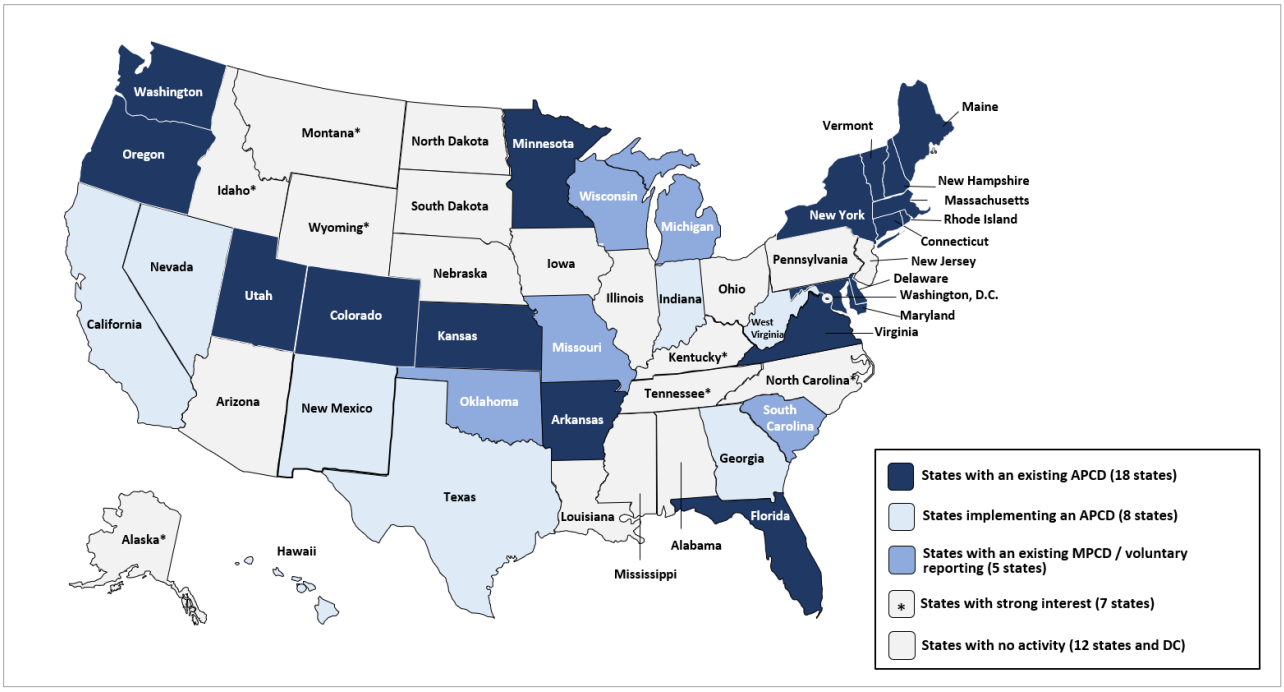
[3] "Annual Report on the Performance of the Massachusetts Health Care System (October 2019)," Massachusetts Center for Health Information and Analysis (CHIA). October 2019. Available here: https://www.chiamass.gov/assets/2019-annual-report/2019-Annual-Report.zip

[4] Interactive Dashboard, Top 20 Drugs in 2015: Total Expenditures. Commercial Prescription Drug Use & Spending, 2015-2017, Massachusetts Center for Health Information and Analysis (CHIA). February 2020. Available here: https://www.chiamass.gov/prescription-drugs/#prescription-dashboard

[5] CHIA data set used does not reflect the impact of prescription drug rebates. Also does not include spending for drugs or administration of drugs covered under a medical benefit.

What it means. While benchmarking data can provide important insights into aggregate, year-over-year cost growth trends by state, payer, provider (often), service category, and population group, states can derive additional insights by pairing benchmarking data and findings with analyses of other data assets, such as APCDs.[6] Six of the eight states that have a benchmarking program, or have one actively in development, also have an APCD - including Washington, Oregon, Massachusetts, Delaware, Connecticut and Rhode Island – though analytic coordination across the two data assets varies considerably.[7]

Figure 2. Current State of APCD Implementation as of February 2022



Massachusetts has used its APCD, as well as other data assets it stewards, such as the Massachusetts Health Insurance Survey (MHIS), to support the state's broader cost trends evaluations and hearings. For example, in 2021, the Massachusetts Health Policy Commission (HPC) used state benchmarking data to identify hospital outpatient spending as the fastest-growing service category for the commercial market, followed by spending on physician services and other professional services (Figure 3).[8,9]

The HPC then leveraged other available data to better understand the equity implications of cost growth: pairing service category trends with information on who bears the costs.

[6] Other informative data assets that states have used include hospital discharge data, payer expenditure reports, provider financial reports, and surveys of employers and households.
[7] Nevada is planning for APCD development, pending the release of federal funds to support establishment.
[8] "2021 Annual Health Care Cost Trends Report," Massachusetts Health Policy Commission (HPC). September 2021. Available here: https://www.mass.gov/doc/2021-health-care-cost-trends-report/download
[9] Other informative data assets that states have used include hospital discharge data, payer expenditure reports, provider financial reports, and surveys of employers and households.

Using commercial claims data from the Massachusetts APCD, the HPC found that individuals in the highest-income quintile had a higher proportion of their overall health care spending concentrated in hospital outpatient and professional services, whereas individuals in the lowest-income quintile had a higher proportion of their spending concentrated on prescription drugs, inpatient services, and emergency department (ED) services (Figure 4). These findings – made possibly only by linking benchmarking data with other available data resources - highlighted an important disparity in individuals' access and utilization of health care services by income for policymakers and regulators consideration.

Figure 3. Percentage annual growth in spending per commercial enrollee, 2016-2019.[10]

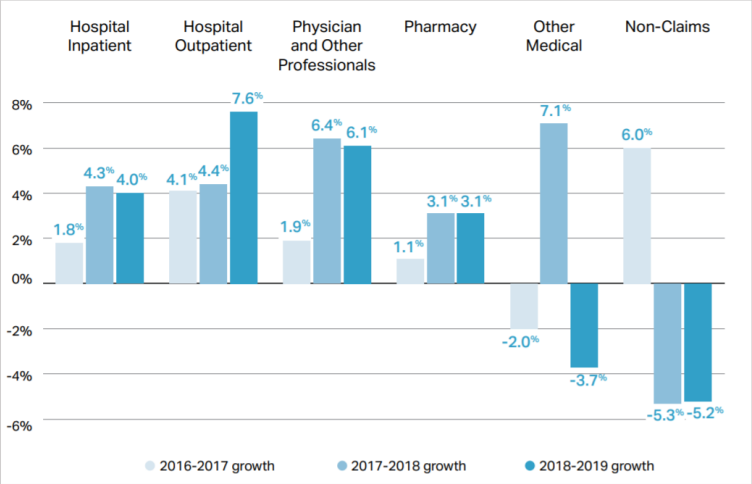
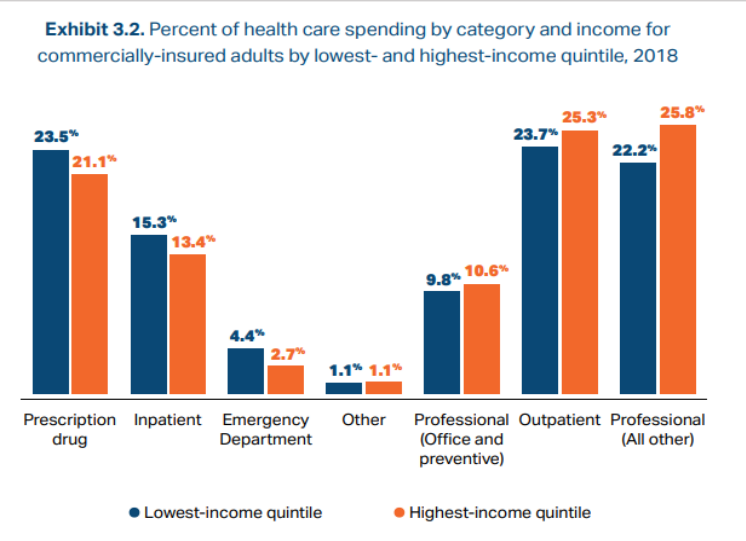


Figure 4. Percent of health care spending by category and income for commercially insured adults by lowest- and highest-income quintile, 2018. [11]



[10] Data source: Payer reported TME data to CHIA and other public sources; HPC analysis of data from Center for Health Information and Analysis Annual Report, March 2021.
[11] Data source: HPC analysis of Massachusetts APCD, 2018.

State APCD Use Cases

APCDs have been used to support numerous use cases across the 18 states that presently host them. They may be used by policy-makers, regulators, consumer advocates, researchers, and other stakeholders to: better understand health care spending and utilization by payer, provider, and population group; answer specific policy and research questions (e.g., potential impact of Medicaid expansion); support public health monitoring, population health assessments, and cross-payer quality measurement initiatives; increase health system and cost transparency; and guide purchasers in decision-making.[12]

Massachusetts' HPC uses the state's APCD to expand upon benchmarking-related topics and issues, including to:[13]

- **Analyze out-of-pocket costs for commercial insured populations,**[14] including copayments, co-insurance, and deductibles for both medical and prescription spending among the commercially insured using APCD data. The HPC found that from 2015-2017, average annual OOP spending for the commercially insured grew about 20%, from $601 to $721. Within that average annual OOP spend, APCD data provided additional clarity on who faced the cost of increasingly high OOP spending by examining the distribution of the annual OOP spend: while half of all members spent $345 or less OOP annually, individuals at or above the 90th percentile of OOP spending in all three years spent nearly ten times more, or nearly $3,499 on average, in comparison.

- **Analyzing telehealth visits among commercially insured residents in 2015-2017,** [15] which examined telehealth visits using commercial claims data from the Massachusetts APCD. This analysis found that the rate of telehealth utilization among commercially-insured patients in Massachusetts almost doubled between 2015 and 2017, from 2.0 visits per 1,000 members in 2015 to 4.0 visits per 1,000 members in 2017 – even prior to the pandemic - a finding that mirrors trends observed in a similar national commercially-insured population. The investigation only added context to future benchmarking discussions around patient access, service utilization, and cost.

While having an APCD allows for more robust analyses of heath care trends, states may also use private claims data assets – such as data from the Health Care Cost Institute (HCCI) or FAIR Health - to better understand their health care spending trends.

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[12] D. McCarthy, "STATE ALL-PAYER CLAIMS DATABASES: Tools for Improving Health Care Value. Part 2: The Uses and Benefits of State APCDs," The Commonwealth Fund. December 2020. Available here: https://www.commonwealthfund.org/sites/default/files/2020-12/McCarthy_State_APCDs_Part2_v2.pdf

[13] Health Policy Commission (HPC) DataPoints Series. Available here: https://www.mass.gov/service-details/health-policy-commission-hpc-datapoints-series

[14] "DataPoints Issue 19: Persistently High Out-of-Pocket Costs Make Health Care Increasingly Unaffordable and Perpetuate Inequalities in Massachusetts," Massachusetts Health Policy Commission (HPC). Jan. 13, 2021. Available here: https://www.mass.gov/info-details/hpc-datapoints-issue-19-persistently-high-out-of-pocket-costs-make-health-care.

[15] "DataPoints Issue 16: The Doctor Will (Virtually) See You Now," Massachusetts Health Policy Commission. March 12, 2020. Available here: https://www.mass.gov/info-details/hpc-datapoints-issue-16-the-doctor-will-virtually-see-you-now

State-level survey data has been widely used by states to understand health care cost growth and consumer affordability, including Massachusetts, Oregon, and Connecticut. For example, **Connecticut** paired American Community Survey (ACS) data with APCD data to create the Connecticut Healthcare Affordability Index (CHAI), a tool for policymakers and consumers to better understand the growing burden of rising health care costs for Connecticut families. The CHAI used data from the Connecticut APCD to calculate out-of-pocket costs for families with employer-sponsored and individual marketplace insurance by town, county, age group, gender, and health risk score.[16]

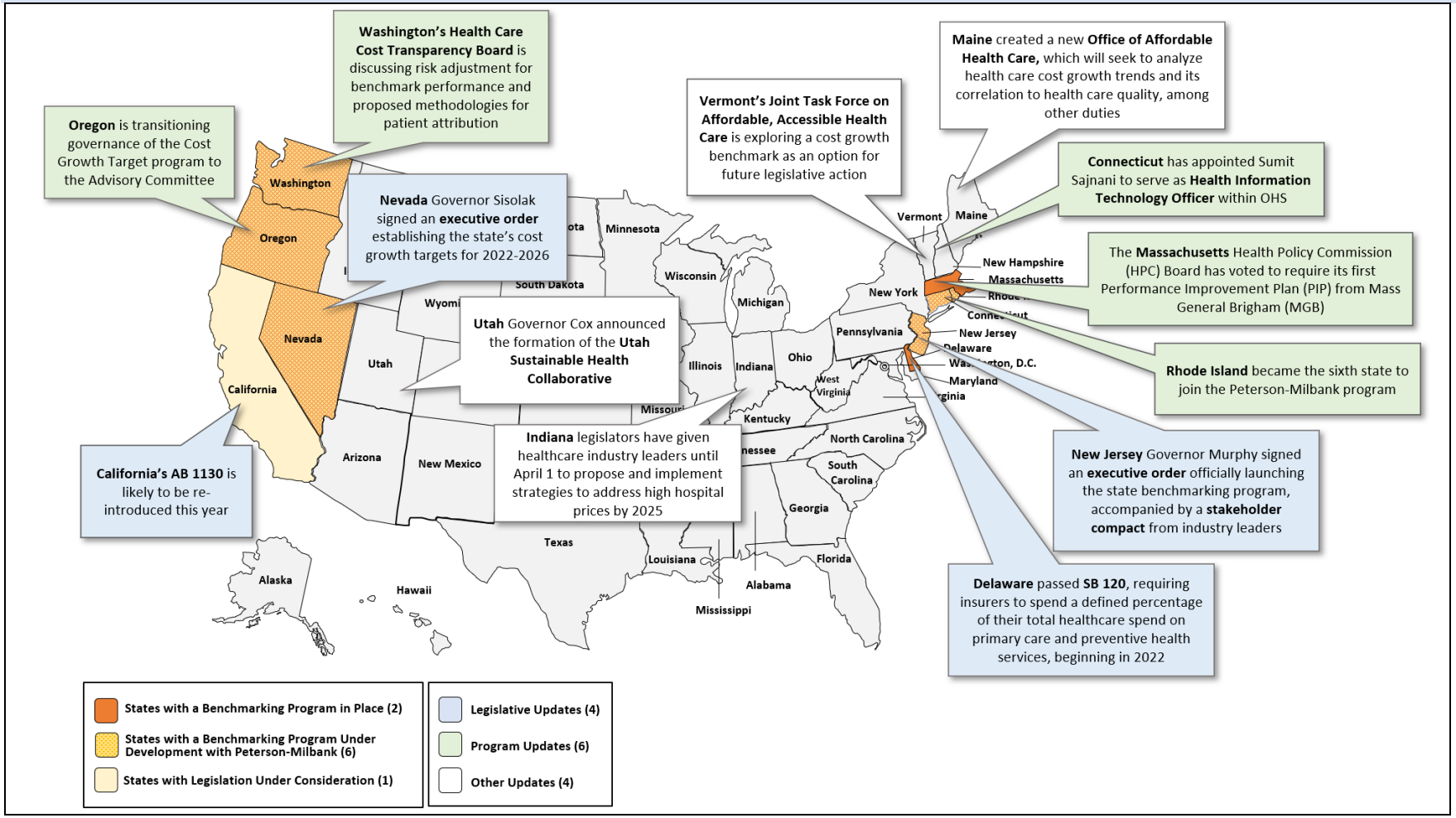
States may also use the Medical Expenditure Panel Survey (MEPS) Insurance Component (IC), which fields questionnaires to private and public sector employers to collect data on the number and types of private health insurance plans offered, benefits associated with these plans, annual premiums, annual contributions by employers and employees, eligibility requirements, and employer characteristics.[17] For many states that do not have health insurance premium reporting as part of their benchmarking data collection process, the MEPS-IC provides similar premium cost growth data – though with a lag of at least two years – that provides insight into how employees and employers are directly confronting cost growth in local markets.

What happens next. As benchmarking programs continue to proliferate and mature, additional opportunities will emerge to examine how states are pairing their data with other assets to reinforce findings and other, novel use cases.

[16] L. Manzer and D. M. Pearce, "Connecticut Healthcare Affordability Index," prepared for the Connecticut Office of Health Strategy and Connecticut Office of the State Comptroller. December 2020. Available here: https://portal.ct.gov/-/media/OHS/CT-Healthcare-Affordability-Index/CHAI/CT-Healthcare-Affordability-Index.pdf

[17] The Medical Expenditure Panel Survey, Insurance/Employer Component. Agency for Healthcare Research and Quality. Accessed December 22, 2021. Available here: https://meps.ahrq.gov/survey_comp/Insurance.jsp

The State of Play: Cost Growth Benchmarking Programs (as of February 1, 2022)



Detailed State Updates as of February 1, 2022

State	Update	Detail
CA	**Legislative**	California's 2022-2023 proposed state budget proposes to allocate $30 million for a new Office of Health Care Affordability. The legislature is expected to re-introduce benchmarking legislation (AB 1130) this year.
CT	**Benchmarking Program**	In November 2021, Connecticut appointed Sumit Sajnani to serve as Health Information Technology Officer within the Office of Health Strategy (OHS). OHS presented pre-benchmark cost growth trend data for 2018-2019 at its January 24th meeting. All OHS Health Benchmark Initiative (HBI) Meeting Materials are available here.
DE	**Legislative**	In October 2021, Delaware Governor John Carney signed Senate Bill No. 120 into law, requiring insurers to spend a defined percentage of their total health care spend on primary care and preventive health services, such as annual check-ups and management of chronic care. In 2022, carriers will be required to spend at least 7 percent of their total cost of medical care on primary care, followed by 8.5 percent in 2023; 10 percent in 2024; and 11.5 percent in 2025.
IN	**Other Activity**	In January 2022, Indiana state leaders have distributed letters to health care industry leaders in the state giving them until April 1 to propose and implement specific measures to bring Indiana hospital prices down to "at least the national average" by 2025. If the industry is unable to provide a viable plan for doing so by April 1st, the legislature promises to pursue legislation to statutorily reduce prices through to-be-determined methods.
MA	**Benchmarking Program**	During the Massachusetts HPC January 2022 Board Meeting, the HPC Board announced it has voted to require a Performance Improvement Plan (PIP) from Mass General Brigham (MGB), finding that the systems' spending performance "raises significant concerns" and has likely already impacted the state's ability to meet the health care cost growth benchmark. Within 45 days of receiving the PIP notice, MGB will be required to file either: a PIP proposal; a request for a waiver; or, a request for an extension. MGH will be subject to ongoing monitoring by the HPC during the 18-month implementation process, and if needed, a fine of up to $500,000 may be assessed as a last resort.
ME	**Other Activity**	In July 2021, Maine established a new Office of Affordable Health Care with the passage of LD 120. Duties of the new Office include: • Analyzing health care cost growth trends and correlation to the quality of health care; • Monitoring the adoption of alternative payment methods in this State and other states that foster innovative health care delivery and payment models to reduce health care cost growth and improve the quality of health care; • Developing proposals for consideration by the legislative oversight committee on potential methods to improve consumer experience with the health care system, including the provision of a consumer advocacy function on health care matters not addressed by the Health Insurance Consumer Assistance Program. Maine is seeking an Executive Director for the new Office.

NJ	**Legislative**	In December 2021, Governor Phil Murphy signed an Executive Order officially launching the New Jersey Health Care Cost Growth Benchmark Program. The program launch is bolstered by a stakeholder compact organized by the Murphy Administration consisting of advocacy groups, hospitals and health care providers, insurers, a union, employers and other stakeholders across New Jersey. The compact reflects a shared goal for stakeholders and the State to work toward constraining the growth of health care costs over time. The state's benchmark targets are built from a 75%/25% blend of forecasted median income and potential gross state product (PGSP). The benchmark target will be implemented for 2023-2027, starting at 3.5% and gradually declining to 2.8% in 2027, following an initial "transition" year for reporting in 2022, in which providers and payers would begin reporting data to the state without accountability measures in place. More information on the state's benchmarking program is available here.
NV	**Legislative**	In December 2021, Governor Sisolak issued an Executive Order establishing a benchmark for health care cost growth beginning in 2022. The cost growth targets are generated from a blend of median wage and gross state product each year, resulting the following targets: • 3.19% for 2022 • 2.98% for 2023 • 2.78% for 2024 • 2.58% for 2025 • 2.37% for 2026 The Patient Protection Commission will work with the Division of Insurance, the State Based Health Exchange and the Department of Health and Human Services to monitor progress to ensure that payors and providers are meeting these goals.
OR	**Benchmarking Program**	The Oregon Health Authority (OHA) is transitioning governance of the Cost Growth Target program to the Advisory Committee beginning in 2022, which will oversee ongoing program implementation processes established by the previous Implementation Committee. The Advisory Committee will include industry representatives; non-industry representatives; ex-officio members; and subject matter experts in health care financing, administration, economics, and equity. In early 2022, OHA intends to publish state and market level trends data from CY 2018 and 2019 using payer-submitted benchmarking data, once data validation is complete. This will be the first public report released by OHA using data collected by the state's Cost Growth Target program. More information on the state's Cost Growth Target Program activities and working program timeline is available here.

RI	**Benchmarking Program**	In November 2021, Rhode Island became the sixth state to join the Peterson-Milbank Program for Sustainable Health Care Costs. In an interview with Milbank Memorial Fund, Rhode Island Insurance Commissioner Patrick Tigue discusses Rhode Island's progress on cost containment and next steps for the program.
UT	**Other Activity**	In November 2021, Utah Governor Cox announced the formation of the Utah Sustainable Health Collaborative, which will be focused on reducing health care costs and improving health outcomes for Utahns. In a December 2021 interview, Rich Saunders, chief innovation officer and senior advisor to Gov. Spencer Cox, discusses the purpose, partners, and future plans for the Utah Sustainable Health Collaborative.
VT	**Other Activity**	Vermont's Joint Task Force on Affordable, Accessible Health Care is examining a number of policy considerations to improve consumer affordability of health care, including a cost growth benchmark as an option for future legislative action
WA	**Benchmarking Program**	As of mid-November 2021, the Washington Health Care Cost Transparency Board was actively discussing: • Risk adjustment for determining benchmark performance at the carrier and provider levels (raised Massachusetts and Rhode Island's experiences with rising risk scores) • Patient attribution to clinicians and organizing clinicians into large provider entities

To return to the Manatt Cost Containment Update Home Page, please click here.

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.

- **"How To Get Health Data Infrastructure Right For This Moment Of Medicaid Transformation," Health Affairs. January 18, 2022.** Claudia Williams, CEO of Manifest MedEx, California's leading health data network, and a former senior adviser for health innovation and technology at the White House, outlines three principles states can follow to make bold and achievable progress toward building smart data infrastructure to support Medicaid transformation.

- **"Improving Data on Race and Ethnicity: A Roadmap to Measure and Advance Health Equity," Grantmakers In Health (GIH). December 2021.** In a new report, GIH, in collaboration with the National Committee for Quality Assurance (NCQA), discuss race and ethnicity data collection in federally administered health programs and outlines several recommendations for improving that data. These findings and recommendations build upon a previous report from October 2021 that examines the barriers and opportunities to improving the completeness, accuracy, and usability of race and ethnicity data at the state and federal levels.

- **"The Colorado Health IT Roadmap," Colorado Office of eHealth Innovation (OeHI), November 2021.** Colorado released a new report that outlines a series of recommendations for "harnessing and expanding the digital tools and services that support the health of all Coloradans." The three primary goals of the roadmap are to: ensure stakeholders share data and have equitable access to needed health and social information; facilitate access to high-quality, in-person, virtual and remote health services; and, to improve health equity through inclusive and innovative use of health IT and digital health solutions.

- "State All Payer Claims Databases Advisory Committee Report with Recommendations Under Section 735 of the Employee Retirement Income Security Act Of 1974," **October 2021.** Under ERISA section 735, the SAPCDAC was charged with advising the Secretary of Labor regarding the standardized reporting format for the voluntary reporting by group health plans to State All Payer Claims Databases. Recommendations on data standardization from the SAPCDAC report include:
  - Using the APCD Common Data Layout (APCD-CDL) as the basis for standard reporting for submitting self-funded plan data to APCDs;
  - Working collaboratively with states to capture non-claims payments and other data needed to support cost and utilization analyses;
  - Creating a detailed data dictionary for the elements included in the APCD-CDL data layout

  The report also outlines additional recommendations for data submission; data privacy, security, and release; voluntary data submission; and more.

- "The History, Promise and Challenges of State All Payer Claims Databases," Background Memo for the State All Payer Claims Database Advisory Committee to the Department of Labor, **RAND Health Care. June 2, 2021.** Using an APCD-focused literature review, environmental scan of APCD websites, and several key informant interviews, RAND recaps several key findings on the state of APCDs today and the events that have led to their development and use.

To return to the Manatt Cost Containment Update Home Page, please click here.

Other Cost Containment Resources

- Office of Health Strategy (OHS) Roadmap for Strengthening and Sustaining Primary Care, **Connecticut Office of Health Strategy (OHS). Draft of as November 2021**. In collaboration with the state Department of Social Services (DSS), OHS has released a primary care roadmap to strengthen and sustain primary care in Connecticut, as required under Governor Lamont's Executive Order No. 5. The roadmap outlines four key steps to advance this goal:
  - Establish core functional expectations of primary care practice teams;
  - Apply resources and supports to help practice teams master the core function expectations;
  - Develop methods to assess and recognize practice team performance; and,
  - Make available voluntary primary care alternative payment models, beyond fee-for-service (FFS), to reimburse primary care.

- **The Toxic Impacts of High Health Care Costs on Coloradans, Colorado office of Saving People Money on Health Care (OSPMHC), October 2021.** This report by the OSPMHC highlights the impacts of high health care costs on Coloradans, and discusses the need to address underlying drivers of high health care costs and reduce out-of-pocket expenses for patients; the burden Coloradans face in navigating a complex and inaccessible health care system; and the barriers patients face in accessing care.

- **Rhode Island Market Summary based on 2022 Rate Filing Submissions as of October 15, 2021, Office of the Health Insurance Commissioner (OHIC) and Gorman Actuarial. October 15, 2021.** using 2022 rate filing data, OHIC examined trends in health insurance market membership, membership characteristics, market share by insurer, premium and cost-sharing trends over time, and more.

- **How ACA Marketplace Premiums Are Changing by County in 2022, Kaiser Family Foundation (KFF). December 7, 2021.** A KFF analysis of rate filings, state exchange websites, and Healthcare.gov finds that for the fourth consecutive year, premiums for ACA Marketplace benchmark silver plans are decreasing, on average, nationally, with many enrollees qualifying for additional, temporary American Rescue Plan Act (ARPA) subsidies that further improve health insurance affordability for 2022.

- **How Price Regulation Is Needed to Advance Market Competition, Health Affairs, January 2022.** In a new Health Affairs policy insight, Robert A. Berenson and Robert B. Murray re-examine traditional assumptions around price regulation and competition in the US health care market, and urge policymakers to consider regulations that limit out-of-network provider prices and establish flexible hospital budgets to address high and rising provider prices in the US.

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