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Strategies to Expand Transparency, Enhance Competition and Control Costs: A Toolkit for Insurance Regulators

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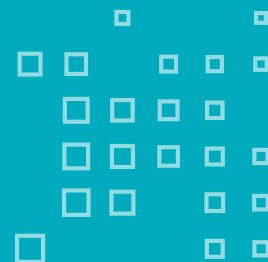


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Executive Summary

State insurance regulators play many roles in making health insurance more available and affordable to consumers. Two that stand out are enhancing transparency and promoting competition. Every state department of insurance (DOI) has a consumer complaint hotline and provides information to help consumers understand how health insurance works and what health insurance products are available in the local market. Transparency has always been part of the job, but in the fast-changing world of web sites and apps that make information readily accessible in ways unforeseen even a decade ago, there is more need than ever to enhance the flow of accurate information and more tools in the regulator's tool kit to accomplish that goal.

Similarly with competition, the role of DOIs in promoting competitive markets is becoming more complex. Much of traditional insurance regulation is designed to maintain a level playing field for fair competition, but health inflation and market consolidation have spawned market conditions that put issues like antitrust enforcement and cost control front and center on the agenda of many insurance regulators. In some cases, insurance regulators are fighting to have a bigger voice on questions such as what a provider or insurer consolidation will mean for the affordability of health insurance; in other cases, regulators are being asked to address issues beyond their traditional purview, such as how to regulate hospital and drug prices.

The purpose of this toolkit is to help insurance regulators understand the wide range of transparency and competition strategies available to them, including new and evolving strategies. We group the strategies into five categories and provide some leading examples and best practices for each category in the five major sections of this toolkit. We also identify important drawbacks or limitations associated with particular strategies, and provide resources for those who want to dig deeper on the featured strategies.

The five sections reflect a progression from basic transparency to targeted transparency to antitrust and other level playing field issues to targeted cost control strategies to systemic efforts to control costs and bend the cost curve. What follows is an overview of the issues covered in each section.

Chapter 1: Helping Consumers Select a Health Benefit Plan. The most consequential decision most consumers make is selecting a health benefit plan since 85-90 percent of consumers access specific services in the context of having commercial health insurance or Medicaid or Medicare coverage. As the residual market for people not covered by their employer or a public program, the individual market rightly gets out-sized attention as the market where consumer choice is most prominent. It also is the market where DOIs have their maximum authority to help consumers navigate their health insurance choices.

Topics covered include:

- **Consumer-friendly websites.** The technology and available data for facilitating consumer choice is steadily improving, offering states unprecedented opportunities to continually upgrade their websites and related consumer education. The best plan search tools allow consumers to rank and sort plans in multiple ways and get "total cost of care" estimates based on their inputs. Cost estimators will take a leap forward as consumers gain the ability to download their health data into apps that allow for more refined cost projections.

- **Provider directories and network adequacy.** Provider availability is the most important consumer concern after price. DOIs are uniquely positioned to improve the quality of provider directories by requiring accurate and timely information in machine readable formats that can be aggregated by states and third party app developers and used for multiple purposes, including network adequacy.
- **Formulary search and benefit design discrimination.** Formulary search reveals what drugs are covered by a plan, but pricing is complicated and utilization management adds more complexity. States can help improve drug search by requiring formularies to be more transparent and non-discriminatory against drugs tied to high cost health conditions.
- **Federal vs. state exchange.** Healthcare.gov has improved consumer choice in the 39 states that rely on this federal IT platform, but state-based exchanges (SBEs) offer more flexibility for states to enhance transparency and pursue innovative strategies not possible with Healthcare.gov. This section examines the reasons why states currently dependent on the federal IT platform might benefit from running their own state exchanges.

Chapter 2: Enhancing Transparency About the Price of Health Services. Once a consumer has selected a health benefit plan, the next step is enhanced transparency over the cost of actual health services. Health care prices are often displayed in generic transparency tools, such as a state-sponsored web site that displays average prices for common services. The problem with such tools is that no one pays the average price; a few people may pay a higher list price, but most people pay a discounted price tied to their insurer and they only pay a portion of that discounted price out of pocket tied to their cost sharing obligations under their benefit plan. Given these facts, the more promising transparency strategies focus on price trends and, even more important, price variability for a targeted set of services. The 14 states that have All Payer Claims Databases (APCDs) are much better positioned to conduct such studies, which is why another five states, including California, Florida, and New York, are in the process of developing APCDs.

Topics covered include:

- **Federal role in enhanced transparency.** HHS Secretary Alex Azar has championed transparency, with strong initiatives to require hospitals to disclose their master charges and drug companies to disclose their list prices. This section discusses the value and limits of this type of disclosure, and describes more recent HHS efforts to enhance transparency in broader ways, including a June 24, 2019 executive order that requires disclosure of discounted prices in a set of steps over the next year.
- **APCDs and generic price disclosure.** As APCDs become more common, states are well-positioned to develop websites that allow consumers to compare costs for common services. This section summarizes recent trends, including efforts to move beyond generic posting of average prices to more targeted studies of variations in discounted prices for hospital, drug, and other leading cost drivers.
- **Hospital pricing.** States have struggled to find meaningful ways to make hospital pricing more transparent to consumers. This section explores the challenges states face in moving beyond master charges to the discounted prices that most consumers pay.
- **Drug pricing.** Drug transparency requires manufacturers, PBMs, and others to expand public disclosures and report more information on drug pricing to the state. Strategies may be aimed at various parties, including manufacturers, pharmacy benefit managers, insurers, providers, and state agencies.

- **Cost driver reporting.** Cost driver reporting highlights specific areas of health system cost growth to inform targeted policy and regulatory action. Data for cost driver reporting is typically collected from public and private payers through APCDS or targeted data calls, and may cover the full market or be limited to particular market segments, populations, or services.
- **Data exchange.** New federal rules to promote interoperability and empower consumers to control their own health data have the potential to transform the health care marketplace and open up new potential for transparency.

Chapter 3: Enforcing antitrust laws and promoting competition. Antitrust enforcement is a critical tool for preserving competitive markets. All DOIs have oversight responsibilities when a merger would change control of a domestic insurer, many DOIs have actively reviewed the recent spate of high-profile horizontal and vertical mergers involving the five largest national for-profit insurers, and some DOIs have shown increasing concern about hospital mergers that, where successful, can give rise to insurer mergers in response. Regulators are taking a second look at the market impacts of laws that restrict competition, and some states have prohibited payer and provider contracting practices where they have anti-competitive impact. Complicating factors include that insurance regulators have limited leverage over provider consolidation and the impact of most contracting practices depend heavily on market specific conditions.

Topics covered include:

- **Horizontal mergers.** DOIs typically prefer more competitors to fewer, and often play an active role in antitrust cases, especially those involving domestic insurers, that reduce competition. At the same time, there are other regulators in the mix, including the U.S. Dept of Justice, that played the lead role in rejecting the high profile Aetna-Humana and Anthem-Cigna mergers. DOIs also share authority with state Attorneys General, and may not have any legal authority if the merger does not involve regulated insurance entities.
- **Vertical mergers.** Vertical mergers are more likely to pass muster under antitrust laws, as evidenced by the fact that four of the largest five national insurers are vertically integrated with their PBMs, including the recently approved Cigna-Express Scripts deal. However, a federal judge is holding hearings on the pending CVS-Aetna deal, and exploring various antitrust issues. In heavily consolidated health insurance markets, there may be more reasons than ever for closely examining vertical mergers.
- **Anti-competitive laws.** There are increasing calls for rolling back laws that may have outlived their usefulness such as certificate of need (CON), Certificate of Public Advantage (COPA), certain aspects of anti-kickback laws, and site specific payment policies. Other laws clearly serve important purposes, but should be carefully balanced to avoid becoming barriers to competition. This list includes scope of practice and licensure laws, as well as overly burdensome network adequacy rules and quality reporting requirements. The Trump Administration also considers some aspects of the ACA to be anti-competitive.
- **Payer and provider contracting.** Some states have banned the most egregious forms of anti-competitive contracting, including most favored nation clauses (MFNs), gag clauses, and all products clause. States also have broader concerns with anti-tiering and anti-steering contract terms, although a few states have enacted any willing provider laws, and the PA Attorney General is currently seeking to impose any willing insurer requirements on two large insurers, each with their own integrated health system.

Chapter 4: Targeted strategies to control hospital and drug costs. As health care prices continue to skyrocket, states are increasingly crafting strategies that move beyond transparency to take direct aim at cost control. Federal and state officials have both offered a wide range of ideas for controlling drug prices, and states are increasingly exploring reference pricing tied to Medicare or Medicaid reimbursement rates as a way to limit variation and control hospital prices. More broadly, states have generally allowed and even encouraged insurers to use narrow or value networks, particularly in the individual market, to give insurers more leverage over provider price increases.

Topics covered include:

- **Reference pricing for shopping.** CalPERS and other large purchasers have had success with setting prices for particular services, such as knee surgery, where there are wide price variations and reasonable potential for consumer shopping.
- **Reference pricing to control hospital costs.** A few states have experimented with using Medicare rates as a benchmark for setting hospital reimbursement rates for state employee health plans, and some states have looked at more expansive uses of Medicare-based reimbursement rates to reduce variations among hospitals and reduce rates.
- **Purchasing alliances and other efforts to control drug prices.** The most common strategy for controlling drug prices at the state level has been purchasing alliances to gain more negotiating leverage. Some advocates have called for Medicare to negotiate prices at the federal level. Federal and state policymakers have proposed a torrent of bills to control drug prices—from reference pricing based on international pricing to promotion of drug importation to caps on price increases. At the state level, many proposals envision a regulatory role for DOIs that may be outside the typical insurance domain, but are designed to leverage the insurance regulator’s familiarity with formularies and other pricing policies.
- **Tiered and narrow networks.** Insurers have long used pricing tiers in drug formularies to incent consumers to purchase generics and other lower-priced drugs, and this same strategy is becoming more popular with provider networks as well, including narrow networks that exclude high-priced facilities. One state has required insurers to offer at least one tiered or narrow network product with a mandatory price discount.

Chapter 5: Systemic Efforts to Control Costs. With systemic cost control unlikely to advance at the federal level, at least before the 2020 election, states are considering various models for taking action at the state level. Examples include a Maryland hospital rate-setting program to equalize reimbursements across public programs and commercial insurance in hospital reimbursement; a Massachusetts cost benchmarking approach that has been used both to constrain spending and to scrutinize consolidations; and most recently, a Washington law to leverage state purchasing power to design a public option with Medicare-based reimbursement rates to offer a more affordable individual market product.

Topics covered include:

- **Rate setting for hospitals.** Maryland’s Health Services Cost Review Commission has been setting rates for Maryland hospitals since the 1970s, and recently transitioned from a per-unit of service model to a global budget model. Other states adopted similar models in the 1970s, but Maryland’s model is the only one

to survive and adapt to the new payment reform focus on global budgeting. Pennsylvania has adopted a similar model for rural hospitals, but the challenges of rate-setting across public programs and commercial markets remain formidable.

- **Cost benchmarking for insurers and providers.** Massachusetts enacted a sweeping cost control program in 2012 that relies on a combination of data reporting, public hearings, and state reviews to hold payers and providers to a state-defined benchmark for annual health care spending. The program has been successful at holding spending below a 3.4 percent annual increase benchmark, which was recently lowered to 3.1 percent. Other states, including Delaware, Oregon, and Rhode Island are pursuing similar benchmarking strategies.
- **Public options and Medicaid buy-ins.** Washington enacted legislation in 2019 to leverage state purchasing power and other resources to establish a state-defined product (public option) that would offer more affordable insurance to individuals by using Medicare-based reimbursement rates for providers. The program faces many implementation challenges, but reflects a growing interest among the states in leveraging government bargaining power to offer a more affordable coverage option, whether through a Medicaid buy-in for targeted populations or a public option available in the individual market. Other states, including Colorado, Nevada, and New Mexico, enacted bills in 2019 to further study similar proposals.

Chapter 1. Helping Consumers Select a Health Benefit Plan

In this section, we do a deep dive on the single most important transparency tool for most consumers—a plan search tool that allows consumers to easily search their health plan options and find the best plan for them. A majority of consumers choose among options offered by their employers, who typically offer a limited number of standardized choices with web-based applications to compare those choices. Medicare and Medicaid offer web sites with information that is tailored to the standardized coverages offered in those programs, though one can find a wide range of private web sites offering help to seniors in sorting out their choices between Medicare Advantage options and traditional Medicare, including the cost sharing and prescription drug policies most consumers need to supplement traditional Medicare.

For state insurance regulators, however, the market to focus on for plan selection is the individual market and, to a lesser extent, the small group market. The ACA has transformed this market in many ways, some of which remain controversial. But nearly everyone has embraced the enhanced transparency that ACA marketplaces offer to consumers who fall into what is essentially a residual market for people not eligible for Medicare, Medicaid or employer-based coverage. In most states, individual shoppers have a wide range of benefit plan choices. This is especially true in a competitive market with multiple carriers, but even in single carrier markets, consumers generally have choices between low and high deductible plans similar to the choices an employee might have with an employer who “sole sources” health benefits through a single carrier offering multiple options.

Consumer-friendly Websites

Easy to use websites, which provide consumers with all the information they need to make an informed decision on purchasing health insurance, are an important enrollment channel for ACA compliant insurance. In particular for younger (and likely healthier) consumers, who are accustomed to shopping on sites like Amazon, an easy to use and attractive website may influence their decision to purchase insurance, as they may be discouraged by a clunky or slow website where it takes more time to shop. This is illustrated by the idea of the purchase funnel, a marketing concept which illustrates the consumer journey towards a decision to purchase a product or service. Marketers always want to keep the purchase funnel as simple and easy as feasible. For websites, this means making sure the website is easy to navigate and utilize. While individual preferences will influence what design is preferred, or which features are key, there are best practices in website design that inform what makes a website user friendly.

In Table 1 below, we briefly summarize the consumer tools that can help guide consumer decision-making, in order of priority for the average consumer: cost estimator, provider directory, drug directory, and quality ratings. We also discuss website navigation. DOIs have varying relationships with the ACA exchanges in their states, with more opportunity to enhance the consumer experience in the 11 states (plus DC) that run their own state-based exchanges, but also some options in the 39 states that rely on Healthcare.gov, the federal IT platform for states that have not established their own exchange.

There are many ways that DOIs can use their expertise about health insurance products and consumer education to address the issues identified in Table 1 and improve consumer access to affordable and high quality health insurance:

- **Improve and streamline access to data.** DOIs collect a veritable gold mine of data about benefits, premiums and cost sharing through the State Electronic Rate and Form Filing system (SERFF). As product offerings change by, for example, adding more tiers to drug formularies, regulators can work together through the NAIC to improve SERFF templates so that the data available to consumers and third party app developers is as accurate and comprehensive as possible. States that have not streamlined public access to SERFF data can also follow the lead of the many states that offer full access. The SERFF team at the NAIC has made this a simple and easy process for states.
- **Support consumer education and outreach.** All DOIs provide some educational information about health insurance on their websites, but most could improve their consumer information by updating it on a regular basis, doing more to promote the annual open enrollment periods for federally-subsidized individual coverage, and supporting consumer outreach through web-based and traditional agent-based channels.
- **Establish a state-branded web site in federal exchange states.** At least two federal exchange states, Illinois and Pennsylvania, have supplemented Healthcare.gov with state-branded websites to highlight consumer outreach events and state-specific information about health care options.
- **Consider a transition to a state-based exchange.** At least five of the 39 states currently dependent on Healthcare.gov are in the process of moving to their own IT platforms. As described later in this chapter, generally results in a cost savings to the state and creates more flexibility for the state on consumer outreach and public policy innovations that are not possible on Healthcare.gov.

The Future of Consumer Tools. How people shop for health insurance will continue to evolve, with many consumers largely dependent on their mobile devices for Internet access. Mobile apps, shopping on mobile-optimized sites, shopping by text, and shopping through new technology pathways such as using Alexa or Siri are all possibilities. Both public exchanges and private exchanges, including web brokers and other direct enrollment partners in Healthcare.gov states, have mobile-optimized sites that make it easy for users to access their websites from their mobile phones. This is anticipated to go a step further with the development of mobile apps for shopping for health insurance. Mobile apps are already well embedded in the healthcare sector with apps that enable consumers to track their own health at the forefront, and apps allowing communication between providers and patients increasingly available. Many health insurance companies already offer mobile apps for their enrolled consumers. Although shopping for health insurance by text message may seem far-fetched to some, text message based therapy services, which would have also been seen as improbable not too long ago, are now a reality through the company Talkspace. Direct enrollment partners are already thinking about these new technologies and how they can be leveraged to improve the customer experience shopping for health insurance. As Healthcare.gov is already behind the curve on developing consumer tools, and signs indicate an interest in pushing an increasing amount of responsibility to direct enrollment, it seems unlikely that Healthcare.gov or any other single site will offer the full range of new technologies.

Table 1. Best Practices for Consumer Plan Search

Function	Search Features
Plan search: easy to read displays of plan choices with ability to sort plans by key variables (e.g., rank from lowest to highest premium), and ability to filter plans (e.g. show only plans with deductible under \$2000).	Basic: sorting and filtering by price, doctors, drugs, quality. Enhancements include more ways to sort and filter, and simple displays of best options based on the consumer’s preferences. Can also have defaults to standardized plans or other “preferred” plans (with disclosure of the criteria for preferred plans).
Cost calculator: individualized estimates of expenses in a typical year, based on consumer inputs about health utilization. In future, consumers will be able to aggregate their health data through “data custodians” and use apps that base cost estimates on their own data. Consumer should always have choice as to how much to disclose or not disclose.	Basic: consumer inputs expected use (high, medium, low) or specific conditions. Enhancements include allowing consumer to input more elaborate list of health conditions, planned medical procedures, and drug usage. Default price should be “total cost of care” which combines premium and estimated cost sharing. Enhancements include adding more variables, such as costs in a worst year.
Provider search: search for doctors and facilities by plan. As machine readable provider filings are aggregated by exchanges and app developers, search can expand in areas such as provider availability for new patients, and information from different domains can be added, such as quality ratings.	Basic: auto-fill for names and allow unlimited entries. Enhancements include more information about doctors and integrating provider search into plan search so consumer who cares about particular doctors can input that before the ranking and sorting process.
Drug search: search for drugs, including dosage, by plan. Search is complicated by formularies that include complex cost sharing tiers with associated utilization management requirements. Search tools should improve as more transparency is required and potentially more standardization.	Basic: auto-fill for drug names and unlimited entries. Enhancements include information about formulary tiers, generic alternatives, cost estimates based on consumer inputs about usage, and integration of drug search into plan search so consumer who cares about particular drugs can input that before the ranking and sorting process.
Quality ratings: composite rating for each plan, usually with ability to access sub-ratings. Integrating quality ratings into other components of search, especially provider search, is a fast developing area.	Basic: one easy-to understand composite rating, typically on 1-5 scale. Enhancements include sub-ratings for member experience, medical care, and plan administration; also sub-categories such as access to care, maternal health, patient safety.

Provider Directories and Network Adequacy

After price, provider availability is the second most important consumer concern in plan selection and one that is difficult to manage because it requires cooperation between insurers and providers. Directories are helpful to consumers to the extent they provide up-to-date and accurate information on nearby providers accepting new patients. Many studies and audits have found that directories frequently fail to meet these standards.

The best leverage point to improve provider directories is for DOIs to sanction insurers who fail to provide accurate and timely information to members. The NAIC’s recently updated “Health Benefit Plan Network Access and Adequacy Model Act” offers a strong list of best practices for DOIs to require insurers to meet, including:

- Updating directories monthly
- Conducting periodic audits
- Monitoring consumer complaints
- Re-verifying providers who have not submitted claims in six months

Enforcing reporting requirements is critical, but it also is important for states to follow the lead of Healthcare.gov in requiring insurers to file their directories in versatile machine-readable formats that allow states and third party app developers to aggregate the information and make it searchable for multiple purposes:

- **Enhancing consumer search.** App developers can develop sophisticated tools that combine network filings with other data sources on providers to give consumers not only more information but also the ability to sort and filter the information using criteria such as which providers are taking new patients and how they rate on member satisfaction and other quality measures.
- **Enforcing network adequacy requirements.** Regulators can monitor network adequacy in real time in response to consumer complaints or other signals that access is a problem. Some states already use vendors who have their own provider-facing tools to streamline regulatory oversight and redeploy resources from comprehensive audits to targeted enforcement efforts. States with APCDs can also use claims data to better understand where issues like provider shortages are driving network adequacy problems. New Hampshire has been a pioneer in this area.
- **Facilitating research.** More transparent networks will allow researchers to answer questions about how network access differs across plans, regions, and market segments (individual, group, public programs) and could even help regulators decide where transparency is the best way to facilitate consumer choice and where tougher regulation is needed.

California example. In 2015, California passed SB137, requiring Covered California, Medi-Cal managed care, and most private plans to meet new standards for online directories, including updating directories weekly, making directories publicly available, and prominently displaying how to file a consumer complaint. Insurers are also responsible for out-of-network charges consumers face from providers erroneously listed as in-network. Providers not accepting new patients are required to notify plans within five days. Insurance regulators, led by the Department of Managed Health Care (DMHC), worked with leading insurers and provider groups to create a centralized provider directory. The directory may eventually be consumer-facing but is starting as a resource for insurers, provider groups, and others who have a long list of “use cases” for a statewide provider directory. Non-profit Integrated Healthcare Association (IHA) is developing the platform.

Formulary Search and Benefit Design Discrimination

Behind price and doctors, drug availability is the third highest consumer concern when selecting a plan. DOIs are again in the center ring since they regulate the insurers who establish the formularies that determine what drugs are covered, what level of cost-sharing applies, and whether there are prior authorization or other utilization management requirements that apply. There have been efforts to aggregate information in standardized ways to allow cross-plan comparisons but progress has been slow because formularies are

complex and pricing is notoriously variable with coupons and other discounting. The best strategies may be to require insurers to post their formularies and to do targeted studies of drug availability and cost for specific conditions.

Plans have multiple variations of their formularies and they change rapidly when, for example, a new drug, especially a generic one, comes online mid-year. In this context, transparency is an important goal and insurance regulators can play a lead role in making drug formularies more transparent and facilitating the work of app developers and researchers on multiple goals:

- Improving the form review process to ensure the process captures accurate and complete information on tiering/cost sharing and utilization management
- Ensuring that formularies provide adequate access and do not discriminate against populations with high drug needs
- Requiring insurers to provide information on cost and coverage restrictions (e.g., prior authorization) before the point-of-plan selection
- Developing search tools with state of the art search capability and cost information, at least for leading diseases with high cost drugs (e.g., HIV/AIDS)
- Developing case studies on key user groups such as medication assisted treatment (MAT) for patients with opioid use disorders

Federal vs. State Exchange

State options for improving the plan search process depend on how much control the state wants to exercise over its individual market. Most states initially opted for the federally-facilitated marketplace (FFM, otherwise known as Healthcare.gov), and many felt vindicated when technology failures hit both Healthcare.gov and state-based exchanges (SBEs). But that is changing as technology options have dramatically improved in both price and reliability. Indeed, Nevada is moving back to a state-based technology platform in 2020 both to save money on technology and to have greater control over regulatory and policy issues than is possible for states that are dependent on Healthcare.gov. New Mexico is following Nevada's path and recently hired an IT vendor to move to a state-based technology platform in 2022. Oregon has issued an RFI to gain more information on its options for moving back to a state-based IT platform.

In July 2019, New Jersey and Pennsylvania became the first states since 2014 to enact legislation to establish state exchanges and transition away from the FFM. In both cases, the rationale was partly to save some money for market stabilization initiatives, but also to control their own destinies from a policy perspective. Meanwhile, federal officials have been clear that many of the innovative ideas for Section 1332 consumer empowerment waivers cannot be accomplished in FFM states because of the relatively inflexible federal technology platform.

Every state is unique, and every state will evaluate policy flexibility from its own vantage point. Some states may want to counteract the policies of the current president; others may be worried about what the next president may do; still others will prefer to stay with Healthcare.gov, especially if it continues to stabilize. Whatever choice states make, they will have at least some opportunities to enhance the plan selection process and take other steps to improve their individual markets.

KEY TAKEAWAYS

Insurance regulators can help consumers select the best health benefit plan for their needs by leveraging their roles as a key source of consumer information and as a regulator of provider networks and drug formularies. Issues to consider include:

- Monitor best practices for consumer-friendly websites, and contribute to a culture of continuous improvement in your state
- Enforce network adequacy standards to ensure that provider directories are accurate and up to date, and that data is available in machine readable formats that can be aggregated and used by regulators, app developers, and researchers
- Review drug formularies to ensure they are not discriminatory and promote transparency initiatives that make it easier for consumers to understand the availability and cost of drugs by health plan
- Participate in discussions with state leaders as to the cost savings and policy flexibility to be gained by establishing a state-based exchange

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Chapter 2. Enhancing Transparency About the Price of Health Services

In this section, we look at what states are doing to shine a spotlight on hospital and drug prices—the two leading cost drivers in our system. State insurance regulators have been in the forefront of efforts to illuminate how hospital pricing works with charge master prices superseded by discounted prices for the vast majority of consumers who benefit from insurer discounts in the commercial market and regulated prices in Medicare and Medicaid. More recently, states have tended to give DOIs a lead role in state efforts to reign in drug prices through various transparency efforts. Finally, DOIs have been involved in state efforts to move from transparency to direct price control strategies.

Federal Role in Enhanced Transparency

HHS Secretary Azar has made bringing down drug prices one of his four top priorities, and the Administration has proposed a number of steps toward that goal. Some of those steps have involved price controls, such as tying US prices to international prices, but others have focused on enhanced transparency. In particular, in May 2019, HHS finalized the “Medicare and Medicaid Programs; Regulation to Require Drug Pricing Transparency” rule requiring pharmaceutical manufacturers to include the list price, defined as the wholesale acquisition cost (WAC), of a drug in all television advertisements. CMS hopes the price disclosures will encourage consumers to choose lower price drugs and manufacturers to lower their prices, thus reducing drug costs to the Medicare and Medicaid programs. The rule has been struck down by a lower federal court, though similar proposals are included in federal legislative proposals pending in the Congress.

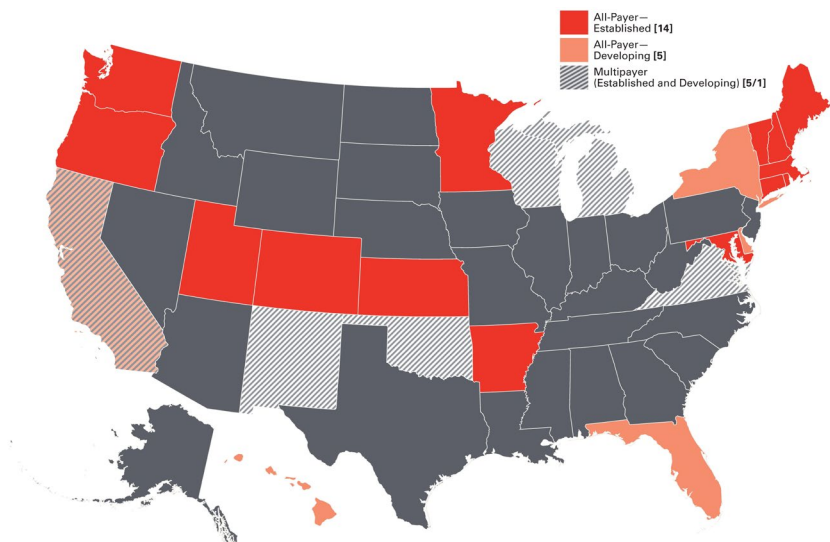
Similarly, starting in 2019, HHS now requires hospitals to post their charge master, or list prices, online in a downloadable format. The first iteration of published prices showed just how confounding hospital pricing can be, with many inexplicable pricing variations and varying levels of clarity and usability for patients. Nevertheless, the new requirement has set a tone of higher expectations on hospitals for their pricing policies—there will no doubt be fewer price anomalies next year—and it has led HHS to where most state insurance regulators have been: focused more on the discounted prices that insurers negotiate and how to shine more light on that process without undermining competition.

In March, the Office of the National Coordinator for Health Information Technology (ONC) released a notice of proposed rulemaking on interoperability that included a request for comments on price transparency. The request asked for additional information/comment about whether to include price information in the scope of publically-available electronic health information (EHI), including, but not limited to the amount charged to and paid for by the patient and the patient’s health plan, variation based on type of health insurance or payment structure, and whether future rulemaking should require health IT developers to create a mechanism for patients and providers to see price information. In June, the Administration followed up with an executive order requiring federal agencies to develop rules requiring hospitals to disclose discounted charges negotiated with payers, as well as requiring payers and providers to provide information to consumers on anticipated out-of-pocket costs.

APCDs and Generic Price Disclosure

From Utah and Oregon to Maine and Massachusetts, states across the country are exploring how All Payer Claims Databases (APCDs) can be used to support and enhance insurance regulation. APCDs are state-based datasets that comprise medical and dental health insurance membership and claims records for members across most insurance categories. Their unique breadth and depth of coverage make them an attractive resource for state policymakers, researchers, and other healthcare stakeholders for enhancing transparency; analyzing coverage, cost, and utilization trends; identifying access and use disparities; and conducting targeted research around distinct subpopulations. APCDs have the potential to be a key resource for a new generation of data-driven decision-making.

Maine established the country's first APCD in 2003, but was not alone for long. Kansas, Maryland, Massachusetts, and New Hampshire had early-stage APCDs by 2008, with Minnesota, Tennessee, Utah, and Vermont joining the movement by 2010. By 2018, according to Manatt Health's APCD Capacity Catalogue, there were 14 states operating APCDs; with five more, including three of the country's four largest states, in the process of building APCDs: California, Delaware, Florida, Hawaii, and New York. Six other states are either operating or establishing "multi-payer" claims databases, which are typically more limited and/or voluntary databases intended for similar use. APCDs are expected to hold data for more than 80 million people when the new APCDs come on line.



Source: Manatt Health APCD Capacity Catalogue

APCDs are best known for supporting price transparency through their public-facing consumer websites such as New Hampshire's HealthCost or Washington's HealthCareCompare. These websites are designed to help consumers understand price variations for procedures and services across providers for the purposes of healthcare "shopping." While organizations such as Catalyst for Payment Reform have aggressively promoted such initiatives, "failing" the vast majority of states in its annual Report Card for not adequately pursuing these goals, most state policy-makers believe these generic websites provide little value to consumers (though third party developers may find their underlying data useful).

States more effectively leverage their APCDs to provide transparency in a different form: using the datasets to shine light provider price variation and identification of leading cost-drivers. In August 2018, for example, Minnesota used its APCD to show how “a patient undergoing one of four hospital procedures may pay between two to nearly seven times as much as another patient at the same hospital...mean[ing] a price difference from about \$7,000 to nearly \$70,000.”

As more governors and legislatures appreciate the value of APCDs to highlight price variation and cost drivers, state agencies will be called upon to play a leading role in cost containment. Indeed, many of the state initiatives that focus on cost drivers give insurance departments a lead role in enforcing reporting requirements and promoting price transparency in areas such as:

- Pharmaceutical pricing transparency, wherein manufacturers, pharmacy benefit managers, or insurers may be compelled to disclose drug price variation and changes, net of rebates;
- Hospital charge transparency, wherein hospitals may be required to publicly disclose their charge-masters or average negotiated prices with insurers;
- State cost-driver transparency, wherein insurers and public payers submit aggregated data that outlines health care spending and spending trends by market population, service category, and providers, allowing for health system performance monitoring and cost-driver identification.

For more information on how APCDs can be used to support states’ price transparency agendas, see Manatt’s November 2018 report, “Enhancing the Value of Coverage through Transparency: How APCDs Can Support Insurance Regulation.”

Hospital Pricing

Hospital transparency requires hospitals to expand public disclosures and report information on their pricing to the state. Hospital transparency encompasses a wide variety of strategies used by states to better understand hospital pricing and make the relationship between list prices (rarely charged and even more rarely collected) and actual charges more transparent. Strategies may be aimed at various prices:

- **List prices.** Some states have focused on disclosure of “charge master” prices, but insurance regulators are well-positioned to help other state officials understand that these prices have limited value since they are rarely charged and even more rarely connected. List prices do, however, play an important role as a starting place for many efforts to negotiate discounts.
- **Discounted rates.** These are the rates that insurers negotiate with providers and generally pass on their customers, though there can be complex and confusing relationships between insurer discounts and the out of pocket charges or cost sharing that consumers pay directly to providers. These deductibles, copays, and other out of pocket costs that the consumer are typically but not always based on the discounted rates tied to their health insurance IF the service was provided by an in-network provider.
- **Out-of-network charges.** Consumers who use out-of-network providers could end up paying the provider’s full list price, but there are an increasing set of situations in which federal or state law regulates prices, including emergency services and “surprise bills” where an in-network provider arranges for certain

services to be provided by an out-of-network provider. When charges are regulated for out-of-network services, they can be set in any number of ways, from arbitration to a Medicare-based price to a network-based price.

As this over-simplified summary makes clear, hospital pricing is anything but clear, and insurance regulators are well-positioned to help consumers sort out what charges apply to specific services and to advocate for new laws and regulations, such as surprise billing laws, where those charges are not fair or reasonable. These issues are destined to become more prominent as increases in deductibles and other consumer cost sharing continues to expose more consumers to large and confusing bills.

Florida and Hospital Price Transparency

In April 2016, Florida renewed its commitment to healthcare price transparency with the passage of two pieces of legislation: HB1175, “An act relating to transparency in health care,” and HB221, “An act relating to health insurance coverage for emergency services.” HB1175 required hospitals, ambulatory surgery centers, and healthcare practitioners to share personalized estimates of services charges with consumers, and required insurers and HMOs to create online methods for consumers to use those estimates to understand their out-of-pocket costs. HB1175 also required providers to publicly disclose their average payments and payment ranges for various services, and authorized the Agency for Health Care Administration (AHCA) to establish a state all payer claims database (APCD) to support future price and quality transparency efforts.

HB221, meanwhile, focused on mitigating the consequences of opaque service pricing, placing limits on “surprise” billing, where patients may unknowingly receive services from out-of-network providers while at in-network facilities. HB221 also required insurers to publicly disclose their network providers, and providers to publicly disclose their contracts with plans.

These bills furthered Florida’s transparency agenda, rooted in the state’s 2004 “Affordable Health Care for Floridians Act.” The Act required providers and insurers to submit performance, utilization, cost (charge), and financial data to AHCA, and required AHCA to make much of this information publicly available on what would become FloridaHealthFinder.gov. This website would expand to include data from the state’s licensure database, inspection and patient safety data, national data (e.g., CMS Star Ratings), and to include new provider types (e.g., nursing homes). With the implementation of HB1175, it now also includes average statewide costs—and price ranges—for 295 care bundles, and cost comparisons with national averages.

Florida continues to advance consumer transparency by bolstering consumer protections and disclosure requirements, and by making strategic investments in new data reporting requirements and data asset development. The state continues to seek ways of joining facility- and service-specific price data with quality information, and is exploring new efforts to leverage transparency to lower healthcare costs, particularly for state employees.

Drug Pricing

Drug transparency requires manufacturers, PBMs, and others to expand public disclosures and report more information on drug pricing to the state. Drug transparency encompasses a wide variety of strategies used by states to better understand drug pricing trends and highlight pricing decisions with the goal of reducing price increases. Strategies may be aimed at various parties:

- **Manufacturers.** Price increases, list prices, pricing policies.
- **Pharmacy Benefit Managers (PBMs).** Rebates, other roles.
- **Insurers.** Formularies, cost sharing for brand and generic drugs, utilization management techniques that restrict access.
- **Providers.** Price markups.
- **State agencies.** Drug expenditures and usage trends.

Oregon established a “fair pricing” legislative task force in 2018 (HB 4005) that has developed more than a dozen recommendations for further work, including state agency reporting on the 10 most expensive drugs and the 10 with the highest price increases; manufacturer justification of high prices; insurer explanation of formulary practices; provider disclosure of markups; and evaluation of PBM rebates.

Maine also enacted a law in 2018 (LD 1406) requiring the state’s APCD to annually report on the price of the state’s most frequently prescribed and costliest prescription drugs, and to develop a plan for the collection of cost and pricing information from drug manufacturers.

Nationally, 44 states have filed bills to address drug costs during the 2019 legislative session, including 51 bills on pricing transparency and eight bills related to volume purchasing.

Cost Driver Reporting

Cost driver reporting highlights specific areas of health system cost growth to inform targeted policy and regulatory action. Data for cost driver reporting is typically collected from public and private payers through data calls or APCD filings, and may cover the full market or be limited to particular market segments, populations, or services. Cost driver reporting may be tied to a state-set benchmark for cost growth with cost outliers identified and examined through a public hearing process with testimony from relevant parties. Policy-makers and stakeholders may use results to craft policy or regulatory solutions, which can be applied market-wide or be targeted to certain market segments or services as appropriate.

A 2012 Massachusetts law (Chapter 224) established a new cost containment strategy that uses the state’s APCD to collect insurer and provider data to identify cost trends which exceed the state’s benchmark for cost growth. In 2016, the state identified pharmacy growth in excess of 25% between 2013 and 2015 and its APCD was able to identify the biggest individual drug cost drivers by subpopulation. This information was used in public hearings to develop carefully targeted policy and regulatory solutions.

Data Exchange

Data “protectionism” can stifle marketplace competition between providers. Providers continue to view patient data as a key **private**, strategic asset, allowing them to know and manage their population’s health—while helping them to simultaneously steer them to in-network facilities. Sharing that insight, whether through data-sharing collaboratives (e.g., external health information exchanges), direct requests from other providers, or with the patients themselves, is frequently met with resistance, despite a number of laws that prohibit such “information blocking” and in direct violation of HIPAA’s patient right of access.

The recently proposed HHS “interoperability” rules—CMS’ “Interoperability and Patient Access” (CMS-9115-P) and ONC’s “21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program”—only promise to place new pressure on payers and providers to share patient data with one another, and back with patients for their own use within third party applications. To the extent that state regulators can monitor and elevate/discourage information blocking behavior in alignment with federal goals (e.g., tying payment to data-sharing), the more consumers—and markets—will benefit.

KEY TAKEAWAYS

Insurance regulators bring valuable expertise to the challenge of making hospital and drug pricing more transparent, and can also lend critical support to APCDs and other systematic efforts to collect data and use it to highlight cost variations. Issues to consider include:

- Help policy-makers understand the complexities of hospital and drug pricing, especially the wide disparities between list prices and the discounted prices that insured consumers pay
- Consider how best to leverage data available through rate and form review and other insurance regulatory processes to enhance transparency
- Support APCDs and other efforts to collect and publish information on the wide variations in discounted prices, which creates pressure to reduce unwarranted variations
- Look for opportunities to bridge the gap between list prices and discounted prices in other contexts, such as determination of “fair prices” in surprise billing cases

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Chapter 3. Enforcing Antitrust Laws and Promoting Competition

Consolidation in provider and insurer markets drives a range of problems from higher prices to uneven quality to lack of innovation. State insurance regulators occasionally play a major role in addressing consolidation, such as when two larger insurers in a state propose to consolidate, but the lead role in most antitrust reviews rests with federal regulators at the Federal Trade Commission (FTC) for providers, at the Department of Justice (DOJ) for insurers, and in most states, with the Attorney General. The exception to the rule is where a merger involves a “change of control” for a domestic insurer, in which case the state DOI has a major role to play.

In state markets where consolidation is a key dynamic, there may be reasons for DOIs to take a more active interest in antitrust reviews and scrutiny of market practices that can promote or undermine competition. In this section, we look at key issues impacting competition and what tools are available to DOIs to address those issues. On antitrust reviews, it may be difficult to play a prominent role in provider mergers, though there is a clear pattern of provider-approved mergers leading insurers to react with their own merger proposals. For a DOI that is interested in being more proactive on the provider side, this section provides an overview of two areas—anti-competitive laws and provider contracting—that may be a useful point of entry to the broader competition arena.

Table 2 makes a compelling case that the trend toward consolidation in health insurance markets is matched or exceeded by similar consolidation in other closely related health care markets. This has implications both for horizontal and vertical merger proposals. Indeed, consolidation has reached the point in some states where price controls compete with more traditional antitrust remedies. In Massachusetts, for instance, the Attorney General recently approved a major provider consolidation with long term price controls on the new provider system as an alternative to rejecting the merger. Despite the fact that price controls are difficult to enact on state by state basis and also difficult to administer, the imperative to control hospital and drug prices is driving states in this direction.

Table 2. Consolidation Across Health Care Markets

Commercial Insurance	<ul style="list-style-type: none"> • 69% of insurance markets highly concentrated. • In half of all markets, 2 largest insurers have >70% of the market. • The share of the largest four insurers increased from 74% to 83% from 2006 to 2014.
Pharmacy Benefit Management	<ul style="list-style-type: none"> • Three largest PBMs control approximately 70% of the national market.
Physician Services	<ul style="list-style-type: none"> • 65% of MSAs have highly concentrated specialty markets; 39% have concentrated primary care markets. • Hospital employment of primary care physicians grew from 28% to 44% between 2006 and 2016.
Retail Pharmacies	<ul style="list-style-type: none"> • The two largest chains control 50–75% of the drug stores in the nation’s 14 largest markets.
Hospitals	<ul style="list-style-type: none"> • 90% of inpatient acute care hospital markets are highly concentrated. • Many large metropolitan markets, e.g., Boston, Pittsburg, San Francisco, are dominated by one or two hospitals.

Horizontal Mergers

The American Medical Association (AMA) publishes a report each year that shows most health insurance markets are highly concentrated and others have done similar analyses. In half of local markets, the top two insurers have more than 70% of the market and often substantially more. Where insurers propose horizontal mergers, DOIs often play a lead role. In 2009, for instance, the Pennsylvania Insurance Department (PID) held its own hearings after the federal DOJ approved a proposed consolidation of the Commonwealth's two largest insurers; the insurers eventually withdrew their proposal after the PID made preliminary findings that the consolidation would violate the Pennsylvania Insurance Holding Companies Act requirements that the deal "not substantially lessen competition" and "not be likely to be hazardous or prejudicial to the insurance buying public." (See box.) More recently, a number of state DOIs were involved in the review and ultimate rejection by DOJ of two large mergers that would have consolidated the nation's five largest for-profit health insurers into three companies.

As these examples illustrate, antitrust enforcement remains a powerful tool against horizontal mergers among health insurance companies, and DOIs can play an important, even lead role, in using state insurance codes to address competition concerns.

In 2007, Pennsylvania's two largest health insurers, Highmark BCBS and Independence Blue Cross (IBC), proposed to "consolidate" and form the sixth largest health insurer in the country with a dominant market position in Pennsylvania. The transaction was approved by the U.S. DOJ, but the Pennsylvania Insurance Department (PID) subsequently exercised its authority under the Pennsylvania Holding Companies Act to hold hearings across the state and build a record over 18 months that led the PID to conclude the transaction violated the Holding Company Act absent certain conditions. The most important condition was that the new company sell either the Blue Cross or Blue Shield mark in Philadelphia to another Blue-affiliated company to preserve the potential for Blue-on-Blue competition in Philadelphia similar to what existed (and continues to exist) in central Pennsylvania between Highmark and Capital Blue Cross. The insurers chose to withdraw their proposal rather than meet this condition. Although Blue Cross and Blue Shield companies compete with each other in multiple states, including California and Washington, the Blue Cross Blue Shield Association has vigorously opposed antitrust challenges seeking to rollback restraints on Blue-on-Blue competition.

Vertical Mergers

While vertical mergers are typically allowed without much scrutiny under current antitrust doctrine, there is growing criticism of at least two types of vertical mergers in the health arena. The first type involves hospitals buying physician practices, which has become more common under the ACA's incentives for collaboration to achieve population health goals, but can have detrimental impacts on competition and other

counterproductive consequences. DOIs may encounter these concerns across a variety of issues, from price increases for services provided in a hospital setting to consumer confusion over cost sharing at in-network facilities that utilize out-of-network providers, leading to “surprise bills.” It also bears reiteration that DOIs have a clear stake in provider consolidation since it can change the playing field and fuel the case for insurer consolidations to rebalance bargaining power over provider rates.

A second type of vertical merger that is getting more attention involves an insurer merging with a non-insurance entity, such as, for example, vertical mergers between insurers and PBMs. As indicated in Table 2, both the insurer and the PBM markets are heavily consolidated, and the two markets are also intertwined with the largest insurers matching up with their own PBMs. With the possible exception of the CVS-Aetna merger, which is still under review, insurer-PBM consolidations have not been restrained. The insurer-PBM mergers could end up providing an ideal test case for the proposition that vertical mergers do not undermine competition. Critics have argued that vertical mergers merit more scrutiny when they carry the potential for exclusionary practices, such as raising prices or otherwise imposing disadvantageous terms on independent insurers. In the case of insurer/PBM mergers, anti-competitive practices could include the PBM developing formularies that do not include important drugs or distribution channels for rival insurers, which could reduce competition in insurance markets. DOIs may want to watch the insurer-PBM market closely so that the impact of recent consolidations on health insurance markets is fully explored and addressed as needed.

Anti-competitive Laws

Antitrust advocates have long argued that certain scope of practice laws and related limitations on who can provide health services which ostensibly protect consumers are, in fact, anti-competitive restraints on trade. In 2015, the U.S. Supreme Court held that a state licensing board regulating dental practice in North Carolina was not entitled to immunity from antitrust law unless it was “actively supervised” by the state. The FTC and other federal and state antitrust regulators have become more aggressive in scrutinizing state licensing laws and other restrictions on trade, such as limits on telehealth, that increase health care costs by restricting the supply of health care services. In a comprehensive report, *Reforming America’s Healthcare System through Choice and Competition*, three leading federal agencies called on federal and state lawmakers to “allow all healthcare providers to practice to the top of their licenses.” The same report also called on states to revisit certificate of need (CON) and certificate of public advantage laws (COPA) laws.

- **Certificate of Need (CON).** Many states adopted CON laws to control costs by requiring providers to obtain state permission to construct new facilities, expand existing ones, or offer certain services. While well-intentioned, the laws have not proven effective and at least 15 states have eliminated their CON requirements after finding that they did not contain costs or improve healthcare quality (see fn 171 on the 15 states).
- **Certificate of Public Advantage (COPA).** States have adopted COPA laws to protect providers against antitrust enforcement when they enter into cooperative agreements to obtain benefits such as population health improvements, preservation of hospital resources, and expanded access to care. COPA laws also have a dubious record of success and raise the question of whether insulating providers from antitrust enforcement to achieve beneficial results for consumers may actually hurt consumers by depriving them of the benefits they would reap from a more competitive market.

In a 2017 report, *Making Health Care Markets Work: Competition Policy for Health Care*, the authors offer a wide range of additional prescriptions for reducing barriers to entry and enhancing the competitiveness of health markets. The list includes a “parsimonious” set of quality measures and a national claims data repository to “enable [network] tiering and facilitate network formation,” promoting entry into Medicare Advantage markets, and ramping up regulatory scrutiny of “anti-tiering, anti-steering, and gag clauses.”

As these examples illustrate, insurance regulators concerned about anti-competitive dynamics in their marketplaces can find a wealth of analyses identifying myriad laws and regulations that merit scrutiny as to their potential detrimental impact on consumers and competition. In the next section, we offer three specific examples where insurance regulators could take action to create a more level playing, though befitting the variation in local markets, each case identifies specific insurer-provider contracting terms that could stifle competition depending on local market conditions.

Payer and Provider Contracting

Certain contracting practices between payers and providers can impede competition when a dominant insurer or provider leverages its market power unfairly to undermine competition. We will focus on cases where a dominant insurer attempts to impede competition since those are the cases where DOIs are the most relevant regulator, but note that dominant providers can engage in similar practices and also that these practices are not necessarily anti-competitive since much depends on specific market conditions.

With these caveats, examples of potentially anti-competitive contracting practices include:

- **All products clauses.** Insurers offering multiple lines of business may use “all products” clauses, which tie provider participation in one line of business or one provider network to participation in other lines of business or other provider networks. These tying arrangements, which can include future products as well as current ones, can suppress competition by allowing an insurer with dominant market power in one line of business to force providers to accept lower reimbursement rates or other unfavorable terms in other lines of business. As insurers increasingly participate in Medicare Advantage and Medicaid managed care in addition to offering commercial products, all products clauses can force providers into products that present much different business propositions. Public coverage programs, in particular, can change quickly as program requirements are altered by state and federal regulations. Protecting the ability of providers to selectively contract could enhance competition by preserving free and open competition in each line of business. Depending on market conditions, however, the result could be a lack of competition in certain lines of business, with insurers constrained in their ability to form adequate networks across multiple lines of business. In other words, there are competing arguments about what exactly “free and open competition” is and should be in heavily regulated health care markets.
- **Most-favored nation clauses.** Dominant insurers can use “most favored nation” (MFN) clauses in provider contracts to ensure their provider rates are as low, or in some cases a specified percentage lower, than any rate offered to a competing insurer. MFN clauses can be anti-competitive depending on market circumstances; states that have prohibited them have generally done so to prevent dominant insurers from using their market power to prevent competing insurers from obtaining favorable rates. MFN clauses can take many forms and may include complexities such as audit rights or an enforcement mechanism that

automatically adjusts rates. Eliminating these clauses could free up providers to negotiate preferential agreements with non-dominant insurers as a way to create a more competitive market and enhance provider bargaining power in the long term. On the other hand, restricting the bargaining power of a dominant insurer will not guarantee that other competitors will enter or expand their market position, and could end up simply raising premiums.

Ohio enacted an all products law in 2008 which started with a sweeping prohibition: “no contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider provide services for all of the products offered by the contracting entity.” However, the law then qualifies the prohibition by allowing financial incentives or other forms of consideration specified in the health care contract to encourage participating providers to provide health care services under all of the contracting entity’s products.

Michigan phased in its MFN law, first prohibiting MFN clauses not approved by the director of insurance in 2013, then prohibiting MFN clauses for major medical contracts in 2014, then extending the prohibition to nonprofit dental contracts in 2017. The Michigan law is quite precise about what is prohibited, perhaps because the issue was contentious with a dominant insurer in the state. The Michigan prohibition applied to a contract clause that prohibits a provider from contracting with another insurer at a lower rate, requires the provider to disclose its contracted rates with other insurers, or requires the provider to adjust its rates for the dominant insurer if the provider contracts with other insurers at lower rates.

- **Contract Amendments.** Contracts negotiated between health care providers and insurers can contain clauses that permit the insurer to amend the contract on notice, in its discretion. Many providers lack the power or sophistication to object to these clauses. These amendments by notice clauses can prevent providers from meaningfully negotiating terms and conditions. Even when providers are able to negotiate specific terms in a contract, an insurer can simply amend that term away by notice once the contract is signed. Establishing legal ground rules on the right of insurers to amend contracts by notice could restore the balance of power between insurers and providers, and promote fair negotiation that yields actual agreement between the parties on terms.

Ohio has regulated amendments to provider contracts since 2008. The Ohio law distinguishes “material amendments” as those that decrease the participating provider’s payment or compensation, change the administrative procedures in a way that may reasonably be expected to significantly increase the provider’s administrative expenses, or add a new product. It does not include certain changes to fee schedules or edits, prior authorization, or other requirements that do not increase administrative expense. Material amendments require at least 90 days’ written notice from the insurer to the provider, and allow either party to terminate the agreement with 60 days’ notice. Non-material amendments require at least 15 days prior notice before they take effect. The Ohio law permits contracts to be amended by operation of applicable state or federal law.

Market Oversight in Massachusetts

The Massachusetts Health Policy Commission (HPC) serves two major regulatory roles in the Commonwealth: as a facilitator of health system transparency (see “Massachusetts and Cost Benchmarking”) and as an overseer and enforcer of market competitiveness. The HPC pursues its market oversight responsibilities through three mechanisms:

- **Payer and Provider Performance Improvement Plans:** Massachusetts’ Center for Health Information and Analysis (CHIA) is required to provide HPC with a list of payers and providers whose cost growth is “excessive” and may “threaten” the state’s ability to stay below the cost growth benchmark. The HPC may require the identified payers and providers to file a Performance Improvement Plan (PIP) that outlines meaningful steps they will take to reduce their spending. While the HPC did not officially require the development of any PIPs in 2016, 2017, or 2018 (despite 20 to 33 entities being referred to the HPC for consideration each year), its authority to do so resulted in coordinated and purposeful changes in market behavior.
- **Cost and Market Impact Reviews:** The HPC tracks proposed material changes to the structure or operations of provider organizations (e.g., consolidations) and conducts cost and market impact reviews (CMIRs) of transactions that may have a significant impact on healthcare costs or market functions in the Commonwealth. CMIRs provide another layer of transparency and accountability for market actors, beyond—but often informing the actions of—state and federal antitrust agencies. Proposed market changes cannot be completed until 30 days after the HPC has issued its final report, which may then be referred to the state’s Attorney General for further investigation. As of December 2018, the HPC has issued six CMIRs covering nine transactions, including the proposed merger of Beth Israel Deaconess Medical Center and Lahey Health. In its review, the HPC reported to the Attorney General that the merger would result in healthcare cost increases of up to \$251 million per year. While the Attorney General ultimately approved the consolidation, she cited the HPC’s report as key to extracting concessions, including: \$71.6 million in services to support

low-income and underserved communities; participation in the Massachusetts Medicaid program; and a seven year price cap that would guarantee that the combined entity would keep cost growth below the state's benchmark.

- **Providing Input for Other State Reviews (e.g., Determination of Needs and Essential Services):** The HPC provides input into Determination of Need (DoN) applications filed with the state's Department of Public Health when providers make significant changes in their services, capital expenditures or other operational adjustments. It also provides input on Essential Service Filings, when hospitals file an intent to close or eliminate services. HPC is able to share its market knowledge through these opportunities to comment, while staying connected to the latest market developments.

Since the HPC was established in 2012, commercial spending trends have shifted significantly in Massachusetts—from seven years of spending growth near or above national averages to five straight years below—resulting in billions of dollars in potential healthcare savings.

KEY TAKEAWAYS

Insurance regulators have multiple roles to play in preserving competitive markets from direct authority in mergers involving domestic insurers to regulatory cooperation when broader consolidations impact local markets to public policy leadership when it comes to anti-competitive practices. Issues to consider include:

- Keep a watchful eye on both horizontal and vertical mergers since the latter tend to get less attention but can have a powerful impact on local market choices and prices.
- Participate in state and federal debates about the fine line between protecting consumers in areas such as network adequacy and quality improvement and over-regulating in ways that create barriers to entry or otherwise impede competition.
- Monitor provider contracting practices, especially when dealing with a dominant insurer or provider who may be leveraging their position in anti-competitive ways.

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Chapter 4. Targeted Strategies to Control Hospital and Drug Costs

With increasing prices driving affordability problems, states have begun to look past transparency and competition strategies to policies that more directly control costs. We address three such strategies in this section: reference pricing, price restrictions on drugs, and selective or tiered networks.

Reference Pricing for Shopping

Reference pricing can be used to target certain high cost services, such as knee operations, or it can be a broader strategy, such as paying hospitals a “Medicare plus” rate. When it is targeted, it can send powerful price signals to consumers though it also is fraught with consumer protection issues. In targeted reference pricing, consumers who choose services that cost less than the insurer’s reference price pay less in cost-sharing, and those who select higher priced services pay more. Reference pricing sends a powerful price signal, but it must meet several criteria to be fair to consumers:

- Services must be “shoppable” and paired with search tools that allow comparison shopping
- Must be adequate network of service providers at or below reference price
- Needs of vulnerable populations must be considered

In 2011, the California Public Employees’ Retirement System (CalPERS) instituted a reference-based pricing model for a select list of “shoppable” services, including joint-replacement surgery, cataract surgery, and colonoscopies. For knee and hip replacements, CalPERS reported that reference pricing saved it over \$6 million in its first two years, as lower-price hospitals gained market share, and higher-priced hospitals reduced their prices to compete. Prices for the procedure fell by an average of 20 percent. CalPERS is currently weighing a pilot to expand its reference pricing model to include select prescription drugs.

Reference Pricing to Control Hospital Costs

Aggressive forms of reference pricing (insurer will only cover the cost of lowest priced providers and use of any other providers requires the consumer to pay the difference) require careful groundwork to be laid with consumers and providers. But broader forms of reference pricing (insurer will only pay Medicare rates and consumer can go to any provider that accepts this rate and pay whatever difference the provider bills) may become increasingly powerful. Montana is the most successful state to date in implementing reference-based pricing in its state employee plan. North Carolina is pursuing a similar strategy, though the state’s hospitals have uniformly resisted the effort. Colorado proposed to use reference pricing for high-priced claims and use the savings to fund a reinsurance program, but the effort encountered resistance from federal regulators and the state legislature. As more data becomes available on wide variations in hospital rates, such as a recent Rand study, it is likely that more states will explore reference pricing in various ways.

CalPERS and Reference-based Pricing

In 2011, the California Public Employees' Retirement System (CalPERS) instituted a reference-based pricing model to bolster market competition and mitigate healthcare cost growth. The model, which started by benchmarking prices for a few procedures, had an immediate impact on the market. For knee and hip replacements alone, CalPERS reported that reference-based pricing saved it over \$6 million in its first two years as lower-priced hospitals gained market share, and higher-priced hospitals reduced their prices to compete; one study estimated price reductions of 34 percent. CalPERS now uses reference-based pricing for a dozen "shoppable" procedures.

Reference-based pricing is when a healthcare purchaser—such as an insurer or self-insuring employer (like CalPERS)—sets a limit to what it will pay towards the cost of a particular healthcare service or procedure, with the consumer paying the remainder. Varying out-of-pocket costs by provider creates a new incentive for consumers to shop for services, instigating provider competition. CalPERS realized the potential such a program could have on its spending after getting to know its own spending: where it was coming from, who it was going to, and how much those prices varied for the exact same service. In the years before instituting the program, CalPERS leadership spent time analyzing its claims data, identifying cost-centers and -drivers, and modeling how even small consumer behavior changes could have large impacts on future cost growth.

Paired with tools to help consumers navigate to lower cost, high quality providers (Castlight), CalPERS' reference-based pricing program has lowered its healthcare spending and increased consumer engagement in their healthcare decisions. CalPERS is now exploring how to introduce reference-based pricing to its pharmaceutical spending, with a potential pilot including prescriptions for inhaled corticosteroids, thyroid agents, and oral estrogen under consideration.

State of Montana Benefit Plan and Reference-Based Pricing

In July 2016, with its reserves dwindling, Montana's employee health benefit plan—the state's largest self-funded plan with over 31,000 total lives—switched from paying for hospital facility services using rates negotiated by its Third Party Administrator to rates it independently established against those paid by Medicare. Setting its payment rates against a common, nationally-accepted schedule allowed the plan to avoid difficult individual negotiations with health systems and hospitals, each with varying charge masters and billing practices, while still allowing for case mix and geographic variation. The strategy was risky, with several major hospital protesting the move. However, through a concerted public information campaign and data-driven advocacy, the plan was able to retain all 10 of the state's largest hospitals and 41 of the 48 state's smaller hospitals in its network. The reimbursement strategy is estimated to have saved the plan over \$30 million since its inception, without having a significantly adverse impact on its participating hospitals.

The plan's shift to using Medicare rates for its pricing reference also dramatically reduced the variation in the facility service rates it was paying at hospitals across the state. In 2014, the plan paid blended hospital inpatient and outpatient contract rates that varied by over 270 percent.

Within one year of plan implementation, this variation fell to around 57 percent, before narrowing to less than 30 percent in 2018.

The benefit plan's use of reference-based pricing, using Medicare as a benchmark, helped it to reduce its healthcare cost growth and service price variation, and provided it with a more transparent and predictable method for estimating—and planning for—future cost increases. The program's success led the plan's leadership to explore other areas where new payment approaches could result in additional savings. The plan recently identified that its pharmacy benefit manager (PBM) was retaining the “spread” between what the plan was initially told a prescription cost and what it actually cost, after negotiated rebates and other deals the PBM may acquire, a common industry practice. After pressing the issue, the plan hired a new PBM that agreed to eliminate any spread and pass along all rebates to the plan. The following year, the plan saved nearly \$16 per prescription, with spread and rebate savings exceeding \$5 million. The plan's move gained national attention and was later considered for statewide adoption, regulating PBMs through the insurance commissioner's authority.

Purchasing Alliances and Other Efforts to Control Drug Prices

Efforts to control drug prices include purchasing alliances and various other strategies aimed at the following parties:

- **Manufacturers.** For the disclosure of price increases, list prices, pricing policies.
- **Pharmacy Benefit Managers (PBMs).** For rebate and vendor practices and other roles other roles as part of the drug supply chain.
- **Insurers.** For disclosure of formularies, cost sharing for brand and generic drugs, and/or utilization management techniques that restrict access.
- **Providers.** For information or restrictions on billing price markups.
- **State agencies.** For disclosure of drug expenditures and usage trends and potential for pooled purchasing power.

State may use intrastate programs, where in-state purchasers pool their negotiating power, or interstate efforts, with cost-state alliances, to negotiate and control drug prices. California has a purchasing pool with 13 million Medicaid lives and a number of other state agencies involved.

California Intrastate Purchasing. California has taken the most aggressive approach to intrastate pooling with a proposal to allow various state purchasers to negotiate lower prices. In January 2019, Governor Gavin Newsom (D) signed Executive Order N-01-19 to create the nation’s single largest prescription drug purchaser. The order directs the Department of General Services (DGS) and Department of Health Care Services (DHCS) to combine the state’s pharmaceutical purchasers—including the existing, multiagency California Pharmaceutical Collaborative (CPC) with 15 member agencies including the corrections health services, the California Veteran’s Associations, and the state university system—with efforts to negotiate prescription drug purchasing on behalf of all 13 million Medi-Cal beneficiaries. As part of the program, the Governor’s 2019-2020 budget proposes transitioning pharmacy services for Medi-Cal managed care to a fee-for-service benefit to allow the State to negotiate on behalf of more Medi-Cal recipients. The combined purchasing proposal is estimated to result in hundreds of millions of dollars in annual savings starting in FY 2021-2022. While initial planning is under way, specific plans have yet to be announced, and, depending on design, California may need to pursue legislation, a Medicaid state plan amendment, and/or a Section 1115 waiver to implement all of the proposed changes.

Several states have introduced interstate purchaser models, including the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP), which negotiates discounts for government agencies across the county; and the Northwest Consortium, a group that allows government agencies, unions, businesses and individual consumer members in Oregon and Washington to pool resources as part of a group purchasing organization, PBM and discount card program.

Oregon established a “Task Force on the Fair Pricing of Prescription Drugs” in 2018 (under HB 4005, the Prescription Drug Price Transparency Act). Over six months, the task force developed and analyzed a transaction and transparency survey, conducted national research on pharmaceutical transparency and strategies, and defined relevant supply chain and cost factors to produce fourteen recommendations. The recommendations were developed with a series of evaluation considerations in mind, including the ability to monitor progress, potential cost reductions, cost-effectiveness, and enforceability. Ultimately, the task force developed fourteen recommendations to address price transparency for consumers and assist future price negotiations. These recommendations are summarized in Table 3.

Table 3. Overview of Oregon Task Force Transparency Recommendations

Manufacturer— Brand, Generic, and Biopharmaceutical	<ul style="list-style-type: none"> • Disclosure of total and average spending on patient assistance programs from manufacturers. • Inclusion of the monthly Wholesale Acquisition Cost (WAC) of a drug in direct-to-consumer advertising within the state of Oregon. • Require manufacturers to report on new drugs with list price exceeding the list price of other drugs within the therapeutic class.
Pharmacy Benefit Manager	<ul style="list-style-type: none"> • Evaluation of the utilization of rebate pass-through or fee-only PBM vendors for state-sponsored health plans.
Insurance Company	<ul style="list-style-type: none"> • Notice to insurance enrollees about a change in formulary, utilization management rules, or formulary tier placement with increased transparency on availability of brand and generic drugs, grievance and appeals processes, rates, and appeal denials. • Disclosure of the lesser of the health plan’s cost-share amount or the pharmacy usual and customary (cash) price to current or prospective enrollees.
Hospital and Medical Provider	<ul style="list-style-type: none"> • Disclosure of hospital and medical provider markups on patient bills.
State Government Entity	<ul style="list-style-type: none"> • Annual report from state agencies on the 10 highest expenditure, 10 highest increased cost paid, and 10 most prescribed drugs purchased. Identification of and manufacturer report on any prescription drug for which the cost of treatment is at least \$10,000 in the Medicaid program. • External audits for state government receipt and use of pharmaceutical rebates.
Coordinated Care Organization	<ul style="list-style-type: none"> • Require CCOs to provide information on accurate formulary, prior authorization, and use of point-of-prescribing electronic health records modules.
Consumer	<ul style="list-style-type: none"> • Disclosure of funding for nonprofit organizations advocating, outside of patient care, on issues regarding pharmaceutical treatment.
Multiple Supply Chain Entities	<ul style="list-style-type: none"> • Reporting—Require PBMs to report specified information on rebates, fees, and reimbursements. Require insurers to report specified information on price, fees, reimbursements, and impact of rebates. • Pharmacy—Promote PBMs and insurers to engage in practices that may increase the availability of lower-cost pharmaceuticals for consumers at pharmacies. • Rebates—Disclosure of total financial incentives that flow among manufacturers, PBMs, and commercial health insurers for entities that have a direct transactional relationship. Requires certification of commercial health insurance companies’ percentage of rebates applied to minimize consumer premiums or out-of-pocket costs.

Source: Legislative Policy and Research Office.

Tiered and Narrow Networks

Select or narrow networks have been a prominent feature of ACA exchange markets, which offer many more HMO products than PPO products. Select networks are often criticized for limiting choice, but broad brush critiques miss the fact that some of the highest quality products are offered by integrated insurer-provider plans that can better manage costs and quality by keeping networks to a manageable size. In another variation, tiered networks give consumers access to a broader network but they pay more to use “in-network” providers that are not on the lowest tier of cost sharing. Tiered networks are similar to drug formularies in creating incentives for consumers to be price conscious shoppers in choosing providers on the lowest cost sharing tier. Tiered networks have become more popular in the individual market as the ACA has increased the prevalence of narrow networks. Tiered networks raise a series of issues:

- Transparency to the consumer
- Potential discrimination against vulnerable populations
- Reasonable criteria for provider placement on tiers
- Actuarially sound cost differentials

Massachusetts' cost benchmarking law included a requirement that insurers offer tiered or selective networks with a premium rate discount of at least 12%. The law also allowed "smart tiering," defined as products that offer differences in cost sharing based on services rather than the facilities providing services. The law includes various consumer and provider protections, and the requirements are further defined in detailed regulations promulgated by the Division of Insurance. The law has worked reasonably well with take up rates higher for tiered than selective or limited networks.

While the Massachusetts law has been well-received, New Jersey regulators have encountered more backlash for approving tiered networks in that state. In 2016 Horizon Blue Cross Blue Shield of New Jersey (BCBSNJ) introduced a two-tier network in its OMNIA health plans that higher-tiered hospitals challenged in court and some legislators opposed. While the product survived, now with 400,000 members, there continues to be concerns about transparency and discriminatory impact. A recent court ruling required Horizon to release its original tiering methodology to the state.

The NAIC Network Adequacy Model highlights several issues with tiered networks that require more regulatory judgment than a typical one-tier network.

KEY TAKEAWAYS

Insurance regulators are well-positioned to regulate select or tiered networks in a manner that takes account of multiple conflicting factors in making contextual judgments, and are often called upon to address reference pricing models and drug pricing restrictions as well. Issues to consider include:

- Take a balanced approach to network adequacy regulation that ensures consumer access and flexibility for insurers in network formation
- Ensure full transparency to the consumer so they can understand and respond to price signals
- Pay careful attention to vulnerable populations to prevent discriminatory impact
- Emphasize the importance of addressing both cost and quality in developing an effective cost reduction program
- Use market data to determine whether cost variations are actuarially-based

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Chapter 5. Systemic Efforts to Control Costs

An increasing number of states are looking at systemic strategies to control costs. Two models that stand out are Maryland's long-standing hospital rate setting program and Massachusetts' cost benchmarking program. We profile both of them in this chapter, as well as Washington's public option enacted in 2019 as part of a wave of proposals that were variously described as "public options" or "Medicaid buy-ins." to ensure a level playing field across public programs and commercial insurance in hospital reimbursement. More recently, the goal has shifted toward cost control through payment reform in what had been a fee for service (FFS) approach. Massachusetts enacted a cost benchmarking approach in 2012 and has used it both to identify cost drivers and to scrutinize consolidations.

Rate Setting for Hospitals

Maryland has been a national leader in hospital rate setting going back to 1971, when the Maryland Health Services Cost Review Commission (HSCRC), an independent State agency, was given authority to set rates for Maryland's hospitals.

For much of its history, the HSCRC set rates according to a per-unit of service model, but in 2014 the Commission transitioned to a Global Budget Revenue (GBR) payment model to contain per capita, total hospital payments across payers. Under the GBR model, the HSCRC establishes an annual global budget, or allowed revenues, for each hospital in the state. The annual budget is built from allowed revenues during a base period (2013), and adjusted for future years using a number of hospital-specific and industry-wide factors. The hospital's global budget is updated each year to reflect cost inflation; approved volume changes based on changes in population demographics and market share; and additional adjustments related to reductions in potentially avoidable utilization, quality performance, uncompensated care, and changes in various adjustments, like user fees. This adjustment provides hospitals with predictable and limited annual inpatient and outpatient revenue increases, adding incentives to improve population health.

Maryland's payment innovation has been implemented under a series of CMS waivers since the beginning of the HSCRC. In 2014, The State and CMS agreed to memorialize their evolving partnership in the All-Payer Model. Under the new waiver, the State agreed to achieve aggregate savings in Medicare spending equal to, or greater than, \$330 million over five years; limit the annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58%; shift at least 80% of hospital revenue to a population-based payment structure (e.g., GBR); and achieve quality targets related to readmission and hospital-acquired conditions reductions. In exchange, CMS agreed to continue participation in Maryland's all-payer rate setting methodology, with a 6% rate differential. Under the All-Payer Model, the State moved 100% of revenue to population-based payment, saved Medicare \$538 million through 2016, and held cost growth below the required targets in all years of the model test.

Building on the success of the All-Payer Model, Maryland and CMS announced the Total Cost of Care (TCOC) Model, which began in January 2019. The new model contains these several additional elements:

- Increased Maryland's Medicare cost savings commitments to CMS to \$300 million per year by 2023; with savings in the TCOC model are measured against all Part A and Part B expenditures for fee-for-service enrolled beneficiaries and include the cost of non-claims-based payments, such as savings payments to participants in Accountable Care Organizations (ACOs) or bundled care models
- Ties hospital Medicare revenue, in part, to the total cost of all care for attributed beneficiaries, or Medicare Performance Adjustment. Starting in 2020, hospitals could experience a +/- 0.5% shift based on performance.
- Encourages new initiatives focused on primary care transformation and episodic bundled payments, thus expanding the model into physician payments
- The new model maintains the hospital cost growth per capita for all payers must not exceed 3.58% per year (may be adjusted with federal review)

Pennsylvania is pursuing a similar program targeted at rural hospitals. In a 2017 effort to stabilize vulnerable rural hospitals, CMS and the Pennsylvania Department of Health announced the "Pennsylvania Rural Health Model." The voluntary model introduces an all-payer hospital global payment system and hospital care delivery transformation plan requirements for select rural hospitals in the state. In March 2019, the state announced the first five participating hospitals and payers. The goal is for at least 30 participating hospitals before the end of the model in CY 2024 and Pennsylvania has committed to achieve at least \$35 million in Medicare savings and no more than 3.38% hospital expenditure growth per year.

Cost Benchmarking for Insurers and Providers

In 2012, Massachusetts passed Chapter 224, "An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation," which established two new quasi-governmental agencies with statutory authority to collect data to measure health system performance against a cost growth benchmark, and to propose health system reforms where issues were identified.

The Center for Health Information and Analysis (CHIA), the state's new healthcare data agency, was tasked with developing, collecting data for, and annually calculating a measure of statewide healthcare expenditures that could be meaningfully compared to the benchmark. The measure, known as Total Health Care Expenditures (THCE), captures healthcare spending by and for Massachusetts residents from public and private sources, including all categories of medical expenses (as paid by the payer **and** patient), non-claims-based payments to providers, and the cost of administering private health insurance. Broken out by payer, service category, and managing physician group, THCE highlights system cost drivers, and is frequently paired with other data CHIA on utilization, alternative payment method adoption, provider price variation, and quality for context. While much of these data are derived from summary-level files collected directly from payers through a manual request process, CHIA also stewards the state's All Payer Claims Database (MA APCD), which it uses to dig deeper into THCE trends by sub-population, service category, payer or provider.

The Health Policy Commission (HPC), established simultaneously with CHIA, has complementary responsibilities. HPC was tasked with establishing and updating the state's health care cost growth benchmark, and using CHIA data (i.e., THCE), as well as its own investigative authority, to develop recommendations to improve market competitiveness. Its recommendations are informed by testimony from its Cost Trends Hearings, which are held approximately two months after CHIA's THCE results are released, and comprise public and private healthcare leaders speaking to—and answering questions about—the state's most pressing healthcare concerns before the HPC's Board of Commissioners. HPC's recommendations, released approximately four months thereafter, include delivery and payment system changes that span populations and programs, and are used by legislators, advocates, and other system actors to craft and implement specific system reforms.

HPC may also recommend to the Attorney General that certain payers or providers develop Performance Improvement Plans (PIPs) should their cost growth systemically exceed the benchmark. Though HPC has not officially required any payers or providers to complete a PIP, it has used its authority to do so to negotiate market behavior changes and system changes. (Note: HPC also plays a broader market oversight role in the Massachusetts landscape, including reviewing provider transactions and material changes, which is discussed in the "Market Oversight in Massachusetts" box on page page 31.)

The independence afforded to CHIA and the HPC has allowed these agencies to serve as "neutral brokers" in the Commonwealth healthcare ecosystem, providing them insulation from political interests, and allowing them to be nimble and responsive to market changes—particularly those identified through the annual cost growth benchmark process—and keep health system cost growth well below levels previously experienced in the Commonwealth.

At least three states—Delaware, Oregon, and Rhode Island—are pursuing cost benchmarking similar to the Massachusetts model.

Public Options and Medicaid Buy-ins

This session, legislators in twelve states introduced bills to implement or study opportunities to leverage government bargaining power to offer a more affordable coverage option to state residents. The concepts—commonly referred to as Medicaid buy-in or public options—built off of existing programs like Medicaid, state employee health plans (SEHP), or offering a public option on the state Marketplace.

While designs will vary significantly depending on state dynamics and health policy goals, two models are emerging for state consideration:

- **State Medicaid or SEHP Buy-in:** Under this model, the state makes coverage available to consumers who are not eligible for Medicaid or the SEHP as a state-sponsored buy-in plan with a premium contribution. Most commonly this design is considered to be offered outside the individual market or Marketplace.
- **Public Option:** The state offers a state-sponsored qualified health plan (QHP) on the Marketplace leveraging Medicaid infrastructure; potentially in partnership with an existing managed care plan (if applicable).

Despite differences in their design, these models have a common set of mechanisms that enable them to lower costs and achieve savings that can be passed to consumers and/or the government, including administrative efficiencies from existing government infrastructure and potentially reduced tax and profit obligations; reduced provider reimbursements, typically proposed as pegged to a percentage of Medicare rates; increased competition, theoretically influencing existing payers to adjust their pricing and purchasing behavior to compete with a state-sponsored product; and improvements in the individual market risk pool from new entrants with a healthier risk profile.

The state could choose to make eligibility for the plan open to a broad or targeted population and could finance the program through consumer premium contributions, general fund contributions, federal pass-through funding obtained through a Section 1332 federal waiver, or some combination of these sources.

To date, Washington is the only state to enact a public option. In 2019, New Mexico, Colorado, Oregon, and Nevada successfully passed bills to study future implementation of a buy-in or public option in their states. Lessons from Washington and other leader states will influence future state activity and could serve as an example for future federal reform.

Washington State Enacts First-in-the-Nation State Public Option

In April, Washington State became the first state to enact a public option. Under the law, the Washington Health Authority will negotiate and contract with insurers to provide state-sponsored silver and gold-level plans on the Marketplace starting in 2021 (with the goal of state-wide plan availability by 2022).

To insure affordability, the public option plans will be subject to an aggregate provider reimbursement cap of 160% of Medicare rates for all medical services, except pharmaceuticals. Certain provider reimbursements have set minimums, like primary care providers at 135% of Medicare reimbursement to ensure adequate payments and participation. The legislation includes exceptions from the reimbursement cap for contracted plans if the cap will raise premiums; if plans can achieve 10% premium reductions, compared to the previous year, through other means; and/or plans are unable to form adequate networks given the reimbursement restrictions. Today, State officials estimate individual market reimbursement rates are 175% of Medicare; they expect the cap and other design provisions to result in 5–10% premium savings.

The legislation also required the introduction of standardized plan parameters (deductibles, cost-sharing, etc.) for bronze, silver, and gold tiers that will be required for all Marketplace plans and commissioned a study on using state funds to limit premiums to 10% of income for enrollees whose incomes are less than 500% of the federal poverty levels. Implementation requires a high degree of coordination between the state insurance regulator, the umbrella agency for Medicaid and the state employee plan, and the state's ACA exchange.

KEY TAKEAWAYS

Systemic cost control requires insurance regulators to work in coordination with other state agencies, such as Medicaid, state exchanges, state employee programs and other purchasing agencies. Issues to consider include:

- Help state officials understand the similarities and differences between insurance rate review and rate-setting processes used in Medicaid, state purchasing programs, and provider rate-setting
- Highlight the need for providers and other stakeholders to be at the table with insurers in cost benchmarking programs
- Work closely with other state agencies to delineate roles and assess cross-market impacts when developing public option or Medicaid buy-in programs
- Emphasize the importance of including self-insured employers, typically the largest market segment, in systemic cost control efforts

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Interviews

Interviewee(s)	Organization	Date
Terry Bequette	Independent Consultant/HHS	2/6/19
Linda Borths, Chief Operating Officer	Quest Analytics	1/31/19
Michael Caljouw, Vice President	Blue Cross Blue Shield of Massachusetts	5/9/19
Kathy Donneson, Chief, Health Plan Division	CalPERS	12/27/18
Andrew Duff, Director of IT Coordination	Consumer Checkbook	11/26/18
Eric Ellsworth, Director of Health Care Strategy	Consumer Checkbook	11/26/18, 11/27/18
Jonah Frohlich, Managing Director of Manatt Health Strategies	Manatt/BS of CA Consultant	12/10/18
Thomas Greaney, Visiting Professor at Law	UC Hastings	1/18/19
Nikole Helvey, Bureau Chief	Florida Agency for Healthcare Administration	2/14/19
Amy Killelea, Director Health System Integration	NASTAD	11/27/18
Diana Moss, President	American Antitrust Institute	1/29/19
Robert Murray, Former Executive Director	Maryland Health Services Cost Review Commission	5/21/19
Kate Scarborough Mills, Director of Policy for Market Performance	Massachusetts Health Policy Commission	12/4/18, 12/10/18
David Seltz, Executive Director	Massachusetts Health Policy Commission	12/4/18
Andrew Stolfi, Insurance Commissioner	Oregon Department of Consumer and Business Services (DCBS)	4/6/19
Erika Wilkinson, Senior Policy Advisor, Government & Regulatory Affairs	Blue Cross Blue Shield of Massachusetts	5/9/19

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