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# Implementing a Statewide Healthcare Cost Benchmark: How Oregon and Other States Can Build on the Massachusetts Model

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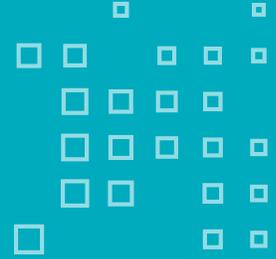
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## Executive Summary

State interest in healthcare cost containment has grown dramatically since Massachusetts enacted the nation's first statewide cost benchmarking program in 2012. At that time, most states were focused on coverage expansion through the Affordable Care Act (ACA). More recently, however, coverage gains have plateaued, and in some cases coverage has contracted, primarily because of affordability issues.

Seeking methods to better understand and control healthcare costs, states are assessing how to build on Massachusetts' benchmarking model, since adopted, in varying forms, by three other states: Delaware, Rhode Island, and Oregon. All four states share common elements of the program: establishing a statewide cost benchmark; collecting data to measure health spending against the benchmark; publishing health spending reports to identify systemic cost drivers; and using a variety of levers, including public hearings and performance improvement plans (PIPs), to enhance transparency and contain spending growth that exceeds the benchmark.

Two states that followed Massachusetts' lead—Delaware and Rhode Island—adopted streamlined benchmarking programs by executive order in 2018 and 2019, respectively. Also in 2019, the Oregon Legislature enacted a benchmarking program that rivals the Massachusetts program in its aspiration to use benchmarking as the state's leading strategy for improving system transparency and accountability. Oregon officials view benchmarking as part of a broader effort to align providers and payers around a common set of cost control strategies.

This Manatt Health white paper, written with support from the Robert Wood Johnson Foundation, examines the four state benchmarking programs and offers guidance for other states considering similar programs. The paper has four sections:

- I. **Massachusetts benchmarking program:** An overview of the program, its operational requirements, and what has been accomplished in the seven years since the landmark law was enacted in 2012
- II. **Oregon benchmarking program:** A summary of the 2019 law authorizing the benchmarking program and the opportunities and challenges the state will face in building on the Massachusetts model
- III. **Streamlined benchmarking programs (Delaware and Rhode Island):** An overview of the Delaware and Rhode Island benchmarking programs
- IV. **Key state considerations:** An analysis of seven areas that all benchmarking programs must address based on state goals, local market dynamics, and state resources

Oregon officials view benchmarking as part of a broader effort to align providers and payers around a common set of cost control strategies.

Benchmarking programs can vary significantly in scope and focus as each state pursues its own path.

The first three sections illustrate how benchmarking programs can vary significantly in scope and focus as each state pursues its own path to offer policymakers a new level of insight and transparency into their healthcare systems. The final section of the paper discusses seven areas that states should consider in developing their own benchmarking programs:

- **Market landscape.** The competitiveness of payer and provider markets varies significantly by state, creating different data reporting priorities. Designing data collection to help monitor these market variations, will better inform use cases, such as mergers that could lead to higher prices and therefore may merit more scrutiny by policy-makers.
  - **Example.** Collection of provider data, particularly around price variation, in Massachusetts has informed the state’s response to proposed provider consolidations.
- **State resources.** Benchmarking programs require resources to support data collection and report writing, and to engage stakeholders in addressing cost control issues. States should establish a benchmarking program commensurate with available resources and policy goals.
  - **Example.** Delaware and Rhode Island used executive orders and more streamlined infrastructure to support their benchmarking process, while Massachusetts used legislation to create two new state agencies.
- **Governance.** States have different traditions and philosophies of how programs should be governed, including when to use stakeholder boards. Broadly representative boards can be an effective way to increase stakeholder engagement and ensure agency accountability.
  - **Example.** Oregon named a blue ribbon implementation committee to make recommendations to an existing citizen-based policy board. Rhode Island’s program is guided by a steering committee co-chaired by the state’s health insurance commissioner and the CEOs of a leading insurer and provider organization.
- **Data collection for cost growth benchmarking.** Measuring total healthcare system expenditures relies on public and private payer data. States may want to phase-in data collection, starting with the largest payers, and be judicious about data segmentation to avoid overly-complex data collection requirements, at least initially.
  - **Example.** Massachusetts administers detailed data requirements and has years of experience with data collection, making its model a useful starting point for other states’ consideration.

Delaware and Rhode Island used executive orders and more streamlined infrastructure to support their benchmarking process.

Massachusetts administers detailed data requirements and has years of experience with data collection.

- **Supplemental data collection.** States may collect supplemental reports from payers, providers and others to provide context and depth to spending data. Massachusetts collected data on premiums, cost-sharing, provider price variation, and alternative payment method adoption from the start of its program and is considering enhancements to measure who is bearing the burden of cost growth and whether spending is being directed to the highest priority services.
  - **Example.** Oregon has collected extensive data on hospital and drug pricing under laws that pre-date the benchmarking law and will be considering how to incorporate that data into the state’s benchmarking process. Governor Kate Brown also has expressed interest in better understanding trends in consumer cost-sharing to address cost shifting to consumers.
- **Public process.** Benchmarking programs derive much of their leverage from the way in which benchmarking data is used to identify significant cost drivers across market segments and make recommendations to address them, including corrective action plans.
  - **Example.** Massachusetts has a rigorous annual schedule of data reports and public hearings, culminating in an annual policy report with actionable recommendations.
- **Enforcement.** Benchmarking programs are primarily a soft path to cost containment, relying on transparency to improve the behavior of market actors, but states may also choose to develop specific enforcement tools to enhance accountability.
  - **Example.** In Massachusetts and Oregon, insurers and providers who exceed the benchmark may be required to develop performance improvement plans (PIPs).

Oregon has collected extensive data on hospital and drug pricing under laws that pre-date the benchmarking law.

Massachusetts has a rigorous annual schedule of data reports and public hearings, culminating in an annual report with actionable recommendations.

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## Introduction

Seeking methods to better understand and control healthcare costs, many states are taking a careful look at a state-defined spending target, or “benchmarking” model, that originated in Massachusetts and has since been adopted, in varying forms, by three other states. The core elements of the Massachusetts model that are common to all four states are establishing a statewide cost benchmark; collecting data to measure health spending against the benchmark; publishing health spending reports to identify systemic cost drivers; and using a variety of levers, including public hearings and performance improvement plans (PIPs), to enhance transparency and contain spending growth that exceeds the benchmark.

### Common Elements in Benchmarking Programs

- Establishing benchmark
- Collecting data
- Reporting cost trends
- Holding public hearings

Massachusetts was the first state to adopt the benchmarking approach in sweeping legislation in 2012.<sup>1</sup> “Massachusetts has been a model for the nation for access to health care,” Governor Deval Patrick said at the program’s launch, “today we become the first to crack the code on costs.”<sup>2</sup> Massachusetts built its benchmarking program on the foundation of near-universal coverage, with policymakers knowing that coverage-sustainability was inextricably linked to affordability: for consumers, employers, and the state. Chapter 224 established a “cost growth benchmark,” a target growth ceiling against which the state (per capita) and payers and providers (per attributed member) would be measured, and a new data reporting infrastructure to—for the first time—provide healthcare stakeholders with a clear, objective view into the state’s healthcare cost-centers and cost-drivers. Massachusetts cost benchmarking program has since allowed the state to have data-informed and targeted conversations around prospective policy and program actions to contain costs. Massachusetts saw its commercial healthcare cost growth decline significantly after implementation of the program, from being among the fastest growing in the nation to growing at rates below the national average. Massachusetts’ Health Policy Commission (HPC) estimated that establishing the benchmark would save those paying into the Commonwealth’s healthcare system \$4.7 billion over five years.<sup>3</sup>

Two additional states—Delaware and Rhode Island—adopted streamlined benchmarking programs by executive order in 2018<sup>4</sup> and 2019,<sup>5</sup> respectively.

In 2019, Oregon became the fourth state to adopt a benchmarking program when the legislature enacted Senate Bill 889 to establish a sustainable target for annual growth in total healthcare costs and state performance metrics to be measured against that benchmark.<sup>6</sup> The Oregon program rivals the Massachusetts program in its aspiration to use benchmarking as the state’s leading strategy for improving system transparency and accountability. Oregon officials view benchmarking as part of a broader effort to align providers and payers around a common set of cost control strategies.

This white paper examines all four state benchmarking programs, but focuses primarily on how the Massachusetts program has evolved over the past seven years, how Oregon intends to implement its program, and key considerations for other states considering similar reforms. Manatt Health interviewed eight representative providers and payers in Oregon and more than a dozen state officials to understand their aspirations for Oregon's benchmarking program; the resources and process that the state will need to appropriately support the benchmark; the best method for engaging stakeholders in the program's design and implementation; and ultimately, how the benchmark can be used to drive transparency, accountability, and cost containment.

Manatt Health interviewed more than 20 stakeholders and state officials to understand their aspirations for Oregon's benchmarking program.

The white paper has four sections and three appendices:

- **Massachusetts benchmarking program:** An overview of the program, its operational requirements, and what has been accomplished in the seven years since the landmark law was enacted in 2012
- **Oregon benchmarking program:** A summary of the 2019 law authorizing the benchmarking program and the opportunities and challenges the state will face in building on the Massachusetts model
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- **Key state considerations:** An analysis of seven areas that all benchmarking programs must address based on state goals, local market dynamics, and state resources

**Appendix A**—Oregon interview table

**Appendix B**—Massachusetts data collection requirements

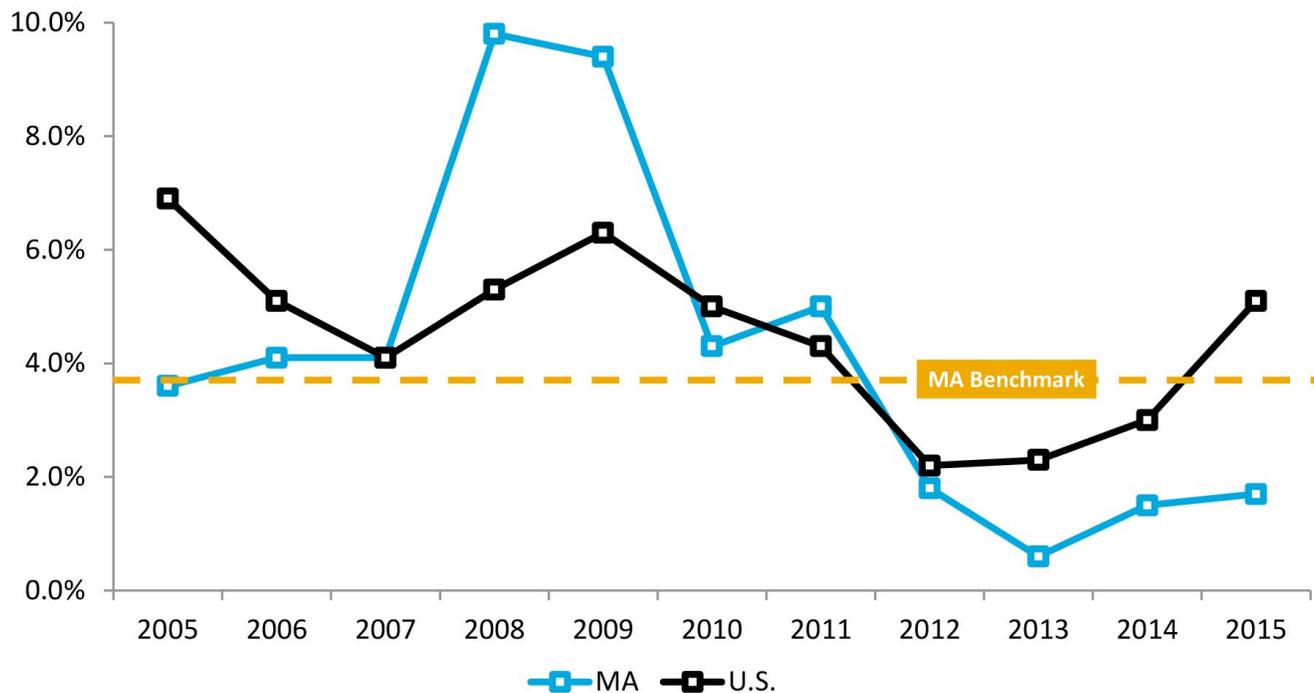
**Appendix C**—Massachusetts calculations of total spending

# I. Massachusetts Benchmarking Program

In 2012, Massachusetts implemented the country’s first statewide healthcare cost benchmarking program to better monitor and respond to cost drivers across the state’s healthcare ecosystem. The program established new data collection infrastructure and reporting requirements for public and private payers operating in the state, annually highlighting where the cost to care for attributed populations exceeded the state’s target (“benchmark”) and why. The program has added a new level of transparency and accountability across the healthcare system, and is touted as taming healthcare cost growth in the Commonwealth. Since the establishment of the benchmark in 2012, commercial spending growth in Massachusetts has fallen below national rates—a rarity in the state’s history—generating potentially billions of dollars in avoided spending.

## Exhibit 1: Massachusetts Commercial Spending Growth Improvement (2005–2015)<sup>7</sup>

Annual growth in commercial health insurance premium spending from previous year, per enrollee (via Health Policy Commission)



## Program Overview

### The Program's Founding and Governing Statute

Massachusetts' cost benchmarking program was established as part of a sweeping compendium of health system reforms in Chapter 224 of the Acts of 2012.<sup>8</sup> Chapter 224 was developed through an extensive public and private stakeholder engagement process that involved legislative liaisons gathering information and generating buy-in from the state's largest payers and providers before moving the package through the legislature. The final bill, signed by Governor Deval Patrick, passed on a bipartisan basis with the support of the attorney general and state auditor, to whom it also assigns responsibilities for ensuring the program's requirements are implemented.<sup>9,10</sup>

### Agencies Responsible for Benchmark Implementation and Administration

Chapter 224 provides detailed guidance on how the legislature envisioned the benchmarking program being implemented and administered, providing a road map for the two new quasi-independent governmental agencies it created to do so:

- Center for Health Information and Analysis (CHIA), a new independent state data agency responsible for collecting and measuring health system performance against the benchmark
- HPC, responsible for enforcing the benchmark and developing program and policy recommendations to mitigate future cost growth

CHIA and HPC were given 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.

With the Commonwealth's FY2016 budget, the Oversight Council was established for CHIA to provide stronger linkages between the agency and its related state departments. The Oversight Council meets quarterly to guide CHIA's research and analytic priorities and manage the agency's budget. It is composed of ex officio state department/agency leadership (e.g., HPC Executive Director, DHHS Secretary, Commissioner of Insurance), and appointees of the Governor, Auditor, and Attorney General's Office who must represent and be qualified to speak about certain subject matter domains. Appointed members serve five-year terms, are eligible for reappointment, and must have no official affiliation with acute care hospitals, ambulatory surgery centers, or major payers in Massachusetts.

CHIA, the state's new independent data agency, was tasked with numerous responsibilities around the collection of data and information to directly support and otherwise inform the cost benchmarking process and subsequent policy development:<sup>11</sup>

- "Collect, analyze and disseminate healthcare information to assist in the formulation of healthcare policy and in the provision and purchase of healthcare services including, but not limited to, collecting, storing and maintaining" the state's All Payer Claims Database (APCD)

- “Provide an analysis of healthcare spending trends as compared to the healthcare cost growth benchmark”
- “Collect, analyze and disseminate information regarding providers, provider organizations and payers to increase the transparency and improve the functioning of the healthcare system”
- “Provide information to, and work with...[all state agencies, including HPC, Medicaid, and Division of Insurance] to collect and disseminate data concerning the cost, price and functioning of the healthcare system in the commonwealth and the health status of individuals”
- “Participate in and provide data and data analysis for [HPC’s annual cost trends hearings] concerning healthcare provider and payer costs, prices and cost trends.”

Each of these responsibilities is further detailed in the statute and supported by the authority to collect needed data from payers and providers.

HPC was established with complementary responsibilities to CHIA and overarching responsibility to administer the benchmark, and was also given institutional independence. HPC was established “within the executive office for administration and finance, but not under its control ... an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or policy subdivision of the commonwealth.”<sup>12</sup>

Among numerous responsibilities (many not directly related to the state’s benchmark program),<sup>13</sup> HPC was tasked with establishing and updating the state’s healthcare cost growth benchmark, and using CHIA data as well as its own investigative authority to develop recommendations to improve market competitiveness. HPC may also recommend to the attorney general that certain payers or providers develop PIPs should their cost growth systemically exceed the benchmark.<sup>14</sup> Though HPC has not officially and publicly required any payers or providers to complete a PIP, it has used its authority to negotiate market behavior changes and system changes. HPC also plays a broader market oversight role in the Massachusetts landscape, including reviewing provider transactions and material changes to provider ownership.

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HPC is overseen by an 11-member board of commissioners that, similar to the CHIA Oversight Council, includes ex officio state department/agency leadership and appointees of the Governor, state auditor, and attorney general’s office (AGO). Appointees must represent areas of particular subject matter expertise or constituencies. For example, the current chair of the board, Dr. Stuart Altman, was appointed by the Governor and was expected to represent “expertise in healthcare delivery, healthcare management at a senior level or healthcare finance and administration, including payment methodologies.”

The relative independence afforded to CHIA and HPC has allowed these agencies to serve as neutral brokers in the Commonwealth healthcare ecosystem.

The relative independence afforded to CHIA and HPC has allowed these agencies to serve as neutral brokers in the Commonwealth healthcare ecosystem, providing them with insulation from political shifts and allowing them to be nimble and responsive to market changes and transparency needs.

## Health System Data and Metrics

CHIA developed and annually calculates a statewide total cost metric for comparison against the benchmark. 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 CHIA data on premiums and cost-sharing, utilization, alternative payment method adoption, provider price variation, and quality for context. While much of this data is derived from summary-level files collected directly from payers through a manual request process, CHIA also stewards Massachusetts All Payer Claims Database (MA APCD), a centralized claims repository for the Commonwealth's public and private payers, which it uses to dig deeper into THCE trends by subpopulation, service category, payer, or provider following publication of the annual report.

For more information on THCE, please see Appendix C.

## Supplemental Reporting

Per its mandate, CHIA fields numerous other data requests from payers and providers that, while not directly contributing to THCE and the benchmark comparison, provide critical context and detail to further illuminate where and why cost growth is occurring within these broader categories. These reports include, but are not limited to:

- **Relative Price Reporting:** CHIA is required to “publicly report relative prices ... contractually negotiated amounts paid to providers by each private and public carrier for healthcare services, including non-claims-related payments and expressed in the aggregate relative to the payer’s network-wide average amount paid to providers.” This data includes the amounts reported by the ten largest payers in the commercial insurance category, as well as payers offering Medicare Advantage plans or MassHealth managed care organization (MCO) plans; information on prices paid to providers and health systems within a payer’s network and expressed as a measure that accounts for provider-specific patient acuity profiled by various breakouts (e.g., product type, provider type, service categories).<sup>15,16</sup>

### Insurer Calls for Benchmark Analyses of Hospital and Drug Spending

*“(W)ith hospital costs being a significant factor in total healthcare expenditure (THCE) growth, the state should add reasonable statutory or administrative tools to directly test hospital systems via a cost benchmark analysis specific to these hospitals and systems. ... (F) or another major THCE growth driver, pharmaceutical costs, we should enact strong transparency tools very similar to those already employed for health plans and providers. Comparable to the public reporting requirements of payers and providers, pharmaceutical companies should be required to submit data to the state and participate in the Annual Cost Trends Hearing with the HPC.”*

— 2019 Testimony from Blue Cross Blue Shield of Massachusetts

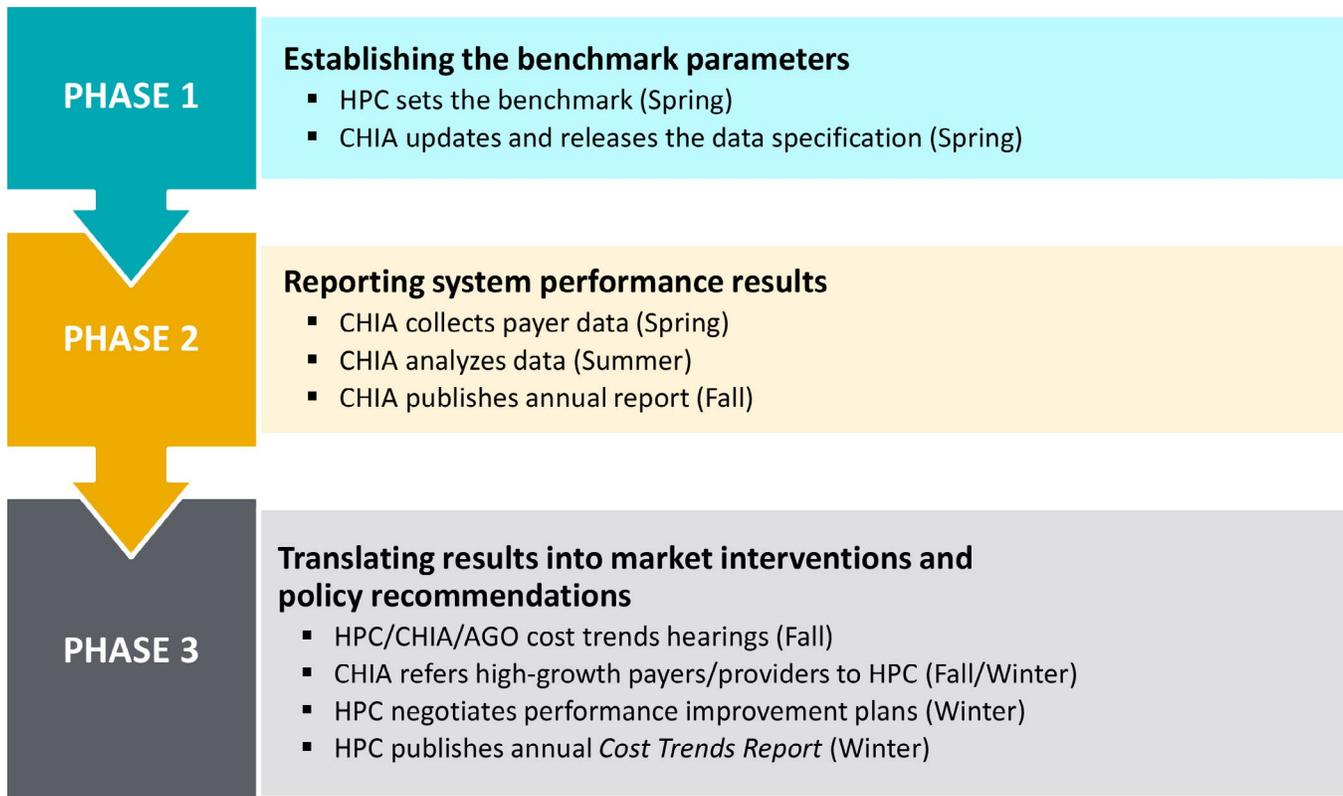
- **Premiums and Cost-Sharing Reporting:** CHIA is required to report on changes over time in Massachusetts' health insurance premiums, benefit levels, member cost-sharing, and product design (tiered network plans, limited network plans, high deductible health plans).<sup>17,18</sup>
- **Prescription Drug Rebate Data Submission:** CHIA is required to “consider the effect of drug rebates and other price concessions in the aggregate without disclosure of any product or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price” when detailing cost growth trends in its annual report.<sup>19,20</sup>

Chapter 224 provides explicit detail for the types of data CHIA would be required to collect, and in some cases, the methods it should employ for its collection and calculation. Model excerpts from the statute are included in Appendix A for reference.

## Annual Process

HPC and CHIA work in tandem throughout the year to confirm the benchmark, specify and collect the data required to measure the healthcare system against it, and then to report and engage the results, crafting program and policy action to stem identified cost pressures. Exhibit 2 illuminates the annual timeline.

### Exhibit 2: Annual Timeline<sup>21</sup>



## **Phase 1: Establishing the benchmark parameters**

### **HPC Sets the Benchmark**

HPC Board of Commissioners meets by April 15 each year to discuss and set the state's cost growth benchmark, against which costs for the next calendar year will be measured. From 2013 through 2017, the cost growth benchmark was set at the expected growth rate of potential gross state product (PGSP) of 3.6%.

For calendar years 2018 through 2022, HPC began to exercise its statutory flexibility to adjust the benchmark to an amount up to 0.5 percentage points less than the estimated growth in PGSP, lowering it to 3.1%.<sup>22,23</sup>

The benchmark is currently set within legislative parameters, though the commissioners may explore parameter-loosening by the legislature. Potential benchmark alterations may include:

- Lowering the rate to reflect slower healthcare growth nationally (and more aggressive targeting)
- Incorporating a "convergence factor" to help mitigate future cost growth of the Commonwealth's higher-priced providers, where higher-cost providers are held to a stricter cost growth benchmark than are lower-cost providers (after accounting for patient acuity and service mix)

### **CHIA Updates and Releases the Data Specification**

Starting in the fall of each year, CHIA determines whether any modifications to the following year's cost trends reporting are necessary to address the most pressing policy concerns in the Commonwealth. Highest-priority system transparency needs are translated into revised draft data specifications, which are then shared with payers for feedback. Payers provide input on the feasibility and level of effort of new requirements and often suggest alternative methods for data collection. For major changes in data collection scope, CHIA may determine it necessary to promulgate sub-regulatory guidance specifying the changes for public comment.

During the winter, CHIA finalizes and releases data specifications for the year, incorporating payer and stakeholder input, and discusses these new requirements on a series of payer Technical Advisory Group webinars.

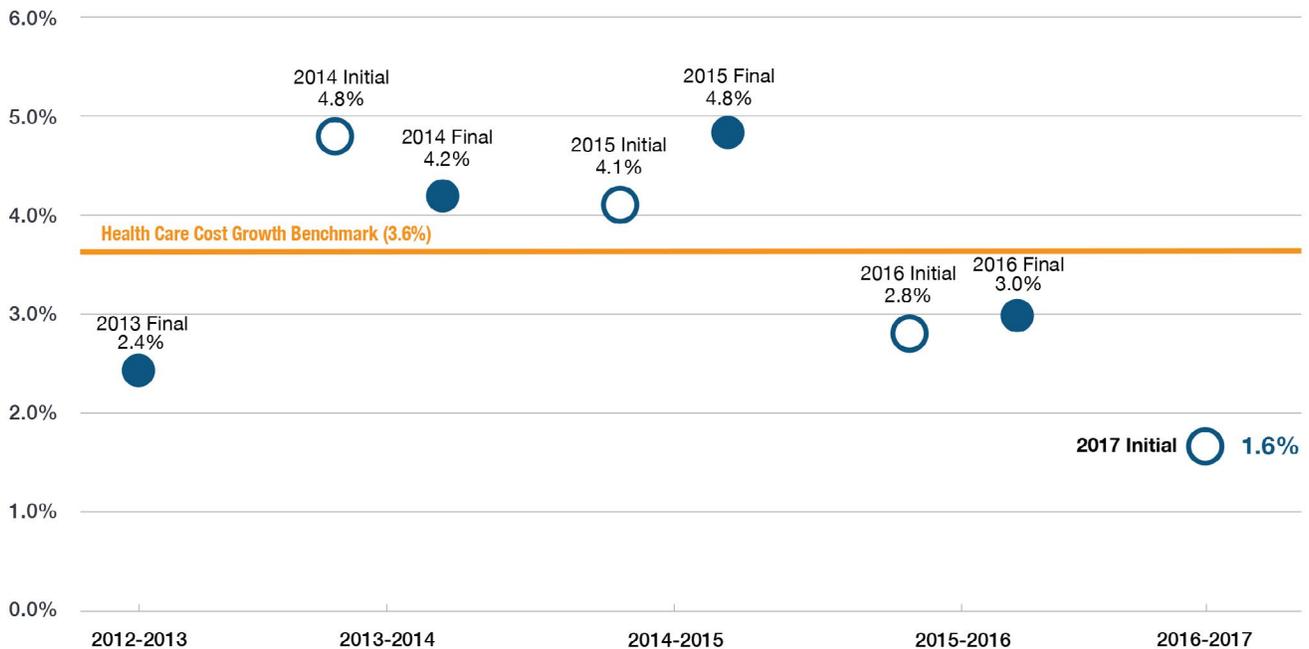
## **Phase 2: Reporting system performance results**

### **CHIA Collects Payer Data**

Each spring, CHIA engages payers in the data collection process, sharing finalized specifications along with detailed instructions on how payers should be populating these new fields. Payers must then provide data to CHIA by early summer. Payers have the option to submit data as part of formatted Excel-based workbook tabs/tables or as flat files, aligned with specifications. Depending upon the data request, two to three years of previous data are collected with each submission to ensure current and reliable trend analysis.

**Exhibit 3: CHIA Annual Report—Example Results<sup>24</sup> (September 2018)**

**Per Capita Total Health Care Expenditures Growth, 2013-2017**



**FINAL THCE PER CAPITA GROWTH WAS 3.0% IN 2016, BELOW THE HEALTH CARE COST GROWTH BENCHMARK.**

**CHIA Analyzes Data**

Throughout the summer, CHIA analysts and actuaries review submitted data for completeness and accuracy and analyze results for use in the annual report. Payer-submitted data undergoes rigorous quality checks upon submission. Data submissions are compared to those the payer submits to the National Association of Insurance Commissioners (NAIC), the Center for Consumer Information and Insurance Oversight (CCIIO), and the Massachusetts Division of Insurance; submissions are also checked against prior-year submissions, against other CHIA-based reporting (e.g., enrollment trends), and for internal consistency (e.g., checking enrollment and payment values and trends across required data submission files). Where data anomalies

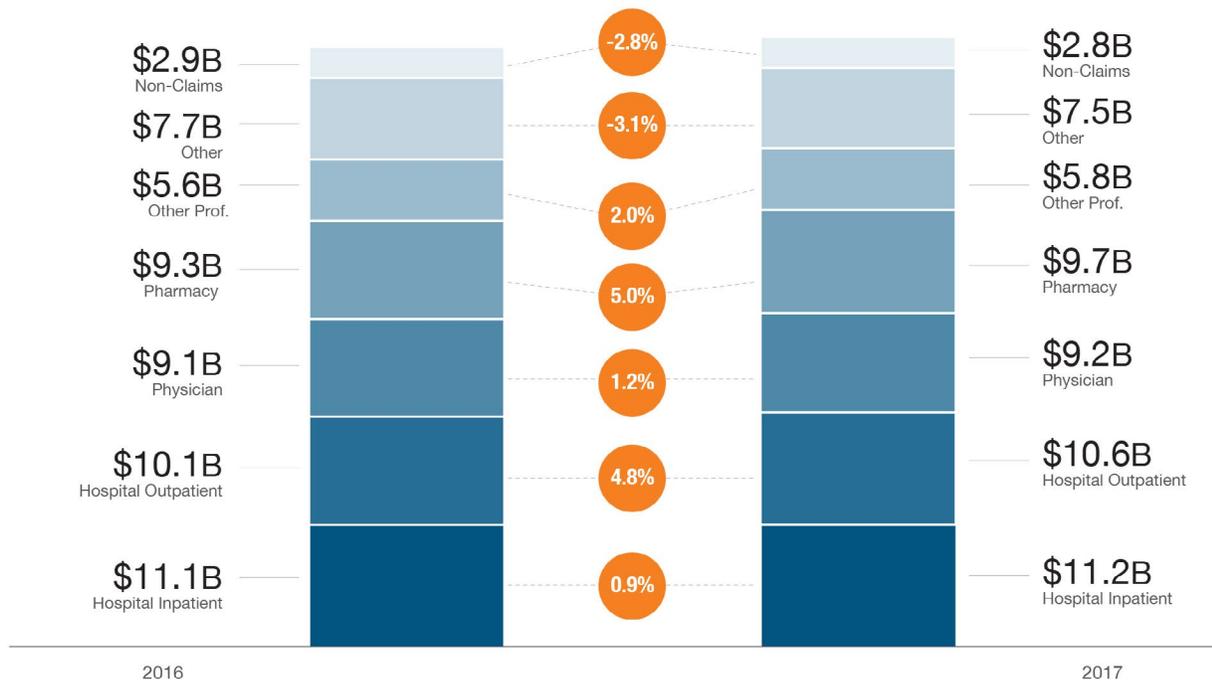
are identified, payers are engaged to help explain or resolve these issues with a file resubmission. Quality-checked data is then aggregated across submissions to allow for market-wide and cross-cutting analyses, which are presented in the annual report.

**CHIA Publishes Annual Report**

By early fall, CHIA translates the data it receives into an overarching, system wide report, *The Annual Report on the Performance of the Massachusetts Health Care System*. This voluminous, visually oriented report includes chapters that highlight overall market performance and spending growth, per capita, against the benchmark; commercially based growth in total medical expenses (TME); premium and cost-sharing growth; and quality. Additional chapters focused on topics of interest (e.g., pharmaceutical rebates) are inserted as new data is requested and incorporated into the reporting process.

**Exhibit 4: CHIA Annual Report—Example Results<sup>25</sup> (September 2018)**

**Total Health Care Expenditures by Service Category, 2016-2017**



**HEALTH CARE SPENDING INCREASED IN ALL BUT ONE CLAIMS-BASED SERVICE CATEGORIES, WITH THE HIGHEST GROWTH IN THE PHARMACY AND HOSPITAL OUTPATIENT SPENDING CATEGORIES.**

### Phase 3: Translating results into market interventions and policy recommendations

#### HPC, CHIA, and AGO Hold Annual Cost Trends Hearings

In the early fall, HPC, in coordination with CHIA and the Massachusetts AGO, hosts hearings where plans, providers, and other healthcare stakeholders are asked to publicly testify about the state of the Massachusetts healthcare system and various issues or concerns that emerged during the data collection process. Written testimonies are submitted in advance of the hearings and publicly posted. Testimonies include both broad policy recommendations, such as recommending new benchmark analyses of hospital and drug spending, and specific analyses of what the data indicate in key areas. Testimonies are followed by questioning from HPC commissioners. Payers and providers may also receive questionnaires, seeking specific information and impressions about key topic areas.

The hearings frequently make front-page news in Massachusetts, with the Governor and Attorney General regularly serving as morning headliners, emphasizing the importance of the process and how its results will benefit Massachusetts families and employers.

#### CHIA Refers High-Cost-Growth Payers and Providers to HPC

During early winter, CHIA sends documentation to HPC highlighting payers and providers that exceeded the benchmark based on that year's data collection. This includes **preliminary** results from the latest year and **final** results from the previous year, and context for HPC's consideration.

#### HPC Negotiates PIPs

After receiving high-growth results from CHIA, HPC engages benchmark-violating payers and providers to determine whether PIPs are necessary. PIPs are plans, agreed to by HPC and the organization, that outline concrete structural steps that the organization agrees to take to reduce its cost growth. While no PIPs have been publicly announced to date, HPC has privately engaged payers and providers to better understand the factors driving their cost growth and discuss how cost-driving factors will be addressed in the next reporting period. HPC has reported these "informal channels" have resulted in meaningful changes in payer and provider behavior.

#### HPC Publishes Annual Cost Trends Report

Through the remainder of the winter, HPC develops its annual *Cost Trends Report*. This report connects the data concerns elevated in CHIA's *Performance* report to broader themes that are more fully developed through the hearings and PIP processes, and makes explicit "Policy Recommendations." HPC's *Cost Trends Report* focuses on discrete market wide concerns (i.e., concerns cutting across payers and providers), such as pharmacy cost growth, to share a public narrative on the biggest concerns facing the Commonwealth, along with potential solutions.

#### Insurer Verifies Impact of Value-Based Contracts

*"TME trend of providers on a value-based contract is lower by 1.4 percentage points than providers not on a value-based contract, and providers on value-based contract have a 6.5- 8% lower risk adjusted TME than those not on value-based contract."*

— 2019 Testimony from Harvard Pilgrim

### HPC Encourages Tiered Networks

*“Employers and payers should continue to encourage employees to choose high-value providers, including through improved tiered and limited products, direct employer contracts with preferred providers, and/or financial incentives (e.g., reduced premiums, lower deductibles) for employees who choose primary care providers affiliated with high-quality, efficient provider groups.”*

## Next Steps

In October 2019, Massachusetts Governor Charlie Baker announced the introduction of House Bill 4134,<sup>26</sup> an act to improve healthcare by investing in value. The bill is designed to continue the Massachusetts drive for better healthcare at a lower cost by encouraging more investments in primary care and behavioral health services, requiring providers and insurers to increase spending on these services by 30% between 2019 and 2022. The bill also establishes a statewide “aggregate primary care and behavioral health expenditure target” that will be monitored by the existing CHIA and HPC process. With a mature cost driver benchmark reporting system, this initiative represents a new way to build on the Commonwealth’s data-based foundation to better understand **who is bearing the costs** of the healthcare system (e.g., consumers) within the spending total, and **whether spending is being appropriately targeted** to healthcare priorities (e.g., primary care, behavioral healthcare).

### HPC Encourages Review and Negotiations for High-Cost Drugs

*“Prescription drug and hospital outpatient department spending continued to be the highest growth areas in 2017. The Commonwealth should take action to reduce drug spending growth. Specific areas of focus should include authorizing the Executive Office of Health and Human Services to establish a process that allows for a rigorous review of certain high-cost drugs, increasing the ability of MassHealth to negotiate directly with drug manufacturers for additional supplemental rebates and outcomes-based contracts, increasing public transparency and public oversight for pharmaceutical manufacturers, medical device companies, and pharmacy benefit managers, addressing price variation in drugs provided under enrollees’ medical benefits, and encouraging providers and payers to use treatment protocols and electronic health record prescribing alerts to maximize value for patients.”*

Despite the mandated increased investment in primary and behavioral healthcare, healthcare entities will still be required to meet the existing benchmark (i.e., they will have to shift existing spending to services deemed to be of higher value). The bill also adds price and records disclosure requirements for manufacturers for high-cost drugs and pharmacy benefit managers (PBM), and adds potential penalties for excessive increases. As of this writing, the bill is being considered by the House Health Care Financing committee.

### **Massachusetts Attorney General Releases 2019 Examination of Healthcare Cost Trends and Cost Drivers<sup>27</sup>**

In tandem with HPC report, the AGO releases an annual report highlighting successes and challenges in the cost growth initiative. In recent years, the report has focused on the complexity and variation in payment methods between health insurers and providers, and the additional burden this variation places on administrative costs and consumers. The 2019 report recommends the following:

- Temper expectations that consumer-driven healthcare price transparency tools will reduce spending.
- Review provider incentives to direct patients to lower-cost care.
- Recognize provider incentives are hampered by health plan churn.
- Standardize patient attribution methods under alternative payment arrangements

## II. Oregon Benchmarking Program

Oregon has been a national leader in managing healthcare spending, including a landmark 2012 Medicaid waiver limiting Medicaid spending to a 3.4% annual cost growth benchmark over ten years. That Medicaid waiver, which applies to one million Medicaid lives in Oregon, has successfully set Oregon on a similar path to Massachusetts' with broader cost benchmarking. In 2019, Oregon extended its Medicaid benchmark to 300,000 state employees and teachers to encompass roughly one-third of the state's population.<sup>28</sup>

In 2019, Oregon extended its Medicaid benchmark to 300,000 state employees and teachers to encompass roughly one-third of the state's population.

In 2017, the Oregon Legislature charged a task force with considering next steps in cost control.<sup>29</sup> The Senate Bill 419 (SB 419) Joint Task Force on Health Care Cost Review took a comprehensive look at several models, including Maryland's Health Services Cost Review Commission for setting hospital rates, and concluded that the Massachusetts cost benchmarking model was a better fit for Oregon.<sup>30</sup>

The Oregon Legislature agreed and enacted Senate Bill 889 (SB 889) in 2019 to enhance the state's benchmarking process and extend it to all state healthcare spending.<sup>31</sup> SB 889 closely tracks the Massachusetts model in many respects, but also differs in important ways, including that it is a relatively short law that leaves many implementation details to the Health Care Cost Growth Benchmark Implementation Committee. The Implementation Committee is charged with setting the initial benchmark and making other recommendations for state agency implementation, with only one issue expressly reserved for further legislative review: defining "escalating enforcement actions when a provider or payer fails to remain at or below the healthcare cost growth benchmark."<sup>32</sup>

### Exhibit 5: Trends in Healthcare Expenditures in Oregon

Health Care Expenditures for Oregon Residents, per capita, 2009–2014



Analysis of Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Data: Health Expenditures by State of Provider, June 2017.

## Program Overview

SB 889 establishes a Health Care Cost Growth Benchmark program that follows the Massachusetts model in several key areas:

- **Setting the benchmark:** The benchmark must be based on a leading economic indicator and periodically reviewed.
- **Data reporting:** The program has broad authority to require payer and provider data submission to support the program.
- **Annual reports:** The program must publish an annual report that identifies cost drivers and makes recommendations for addressing them.
- **Annual public hearings:** The program must hold public hearings on total expenditures and cost growth in the previous year.
- **PIPs:** The program must identify providers and payers who exceed the benchmark and, “if appropriate,” require a performance improvement action plan.

SB 889 also charts a unique path for Oregon in other respects:

- **More delegation:** The Implementation Committee is given broad and flexible authority over issues, such as recommending a governance structure and defining what data to collect, that are otherwise addressed in more prescriptive statutory language in Massachusetts.
- **No new agencies:** Unlike in Massachusetts, where two new agencies were created, Oregon chose to leverage two existing agencies—the Oregon Health Authority (OHA) and the Department of Consumer and Business Services (DCBS)—to administer the law and for the Oregon Health Policy Board (OHPB) to provide policy oversight.
- **Transparency on steroids:** Oregon’s historical leadership on hospital cost transparency and the more recent prescription drug task force give Oregon a head start on building a data collection operation with the potential to fuel an unprecedented level of transparency.
- **Delivery system reform:** The statute highlights quality of care and innovative payment models, offering stakeholders a unique opportunity to fashion a benchmarking program that accelerates value-based payment (VBP) adoption and other delivery system reforms.

### Stakeholder Perspectives

Manatt’s interviews with providers, insurers, and state officials found widespread enthusiasm for SB 889 as the next logical step in Oregon’s ongoing efforts to control health costs. Interviewees, many of whom were part of the SB 419 Task Force, were generally positive about Oregon’s benchmarking experiences with Coordinated Care Organizations (CCOs) and the Public Employees Benefit Board (PEBB)/

Stakeholders have a unique opportunity to fashion a benchmarking program that accelerates value-based payment (VBP) adoption and other delivery system reforms.

Oregon Educators Benefit Board (OEBB) and were ready to extend the approach to the entire healthcare marketplace. That said, there also were significant differences among stakeholder groups as to expectations and how to handle specific implementation issues.

- Providers tended to see benchmarking as a way to bring everyone to the table to push “real” improvements rather than “arbitrary caps.” Rural hospitals were acutely aware of their relatively small share of health spending and very concerned about urban-rural divides, with the latter getting left behind.
- Providers uniformly expressed a clear preference for benchmarking over other cost containment strategies, and worried that reference pricing in PEBB/OEBB would be counterproductive and could dilute interest in benchmarking.<sup>33</sup> Hospitals had some concerns about the CCO benchmarking process being too payer-centric and wanted a stronger provider role in the benchmarking process, including the use of provider data.
- Insurers were more interested in specific cost drivers and how to target them, including hospital cost variation, drug spending, and facility redundancy. Some insurers were concerned that the implementation of benchmarking could lose focus if stakeholders tried to incorporate too many issues into the process. Insurers preferred Massachusetts-style public hearings for benchmarking and thought that the insurer rate review process in DCBS should not be used as a forum for pursuing benchmarking goals given the actuarial focus of rate review. Some insurers were concerned about sharing VBP models and other intellectual property, while others thought the CCO rate-setting process with heavy actuarial involvement and anonymous FAQs had worked to facilitate robust data sharing.
- Insurers generally did not see consolidation as a cost driver, though there was some concern about out-of-state acquisition of doctor practices that may impede community-by-community adoption of VBP arrangements.
- More generally, there was strong interest in how benchmarking could promote VBP with both insurers and providers ready to extend CCO and Medicare Advantage models to the commercial market. Insurers were generally comfortable with the CCO process for expanding VBP and acknowledged slow progress in the commercial market, while hospitals suggested more provider involvement in the process.
- On data collection, there was broad agreement that Oregon’s All Payer All Claims (APAC) database’s usefulness has limits both because it is claims-based in a world that is shifting to VBP and because it has to be supplemented to get at cost drivers. Providers were concerned about insurer-centric reporting models, where they cannot control or provide context to data, and where data may not fully highlight operational costs of greatest concern to them (e.g., staffing, infrastructure investments).
- On stakeholder engagement, there were mixed views as to who should be driving the process—senior leadership who may not be as engaged versus hands-on experts with limited authority. Some would like a focused table that operates independent of other cost containment initiatives such as reference pricing in PEBB/OEBB and the Medicaid buy-in/single payer study. Others would like benchmarking to be the central table, with a coordinated approach as to other initiatives.
- Finally, there was broad support for a “carrots first, sticks later” approach (as SB 889 envisions), with some support for continuing to use public payers as a testing ground, and universal concern about who will pay for the program.

## Key Implementation Issues

### Governance and Role of State Agencies

SB 889 establishes the Health Care Cost Growth Benchmark program to be administered by OHA in collaboration with DCBS “subject to the oversight of the OHPB.”<sup>34</sup> The law directs the Implementation Committee to “recommend the governance structure for the program”<sup>35</sup> and directs OHA and DCBS to implement the recommendation.<sup>36</sup> The Implementation Committee could recommend that the benchmarking program have an independent or quasi-independent governing board, perhaps a broadly representative board analogous to the Implementation Committee. Presumably, the Implementation Committee also could recommend that OHA and DCBS, with oversight by OHPB, implement the benchmarking program under their existing authority to implement and manage state programs.

Under either approach, there will be two overarching questions. First, who decides what data is to be collected each year. In Massachusetts, the legislature provided substantial direction on data collection, but also entrusted CHIA with significant data gathering responsibilities.

The second question is who determines how the data is to be used in public hearings and in other decision-making processes related to implementing and enforcing the benchmark. In Massachusetts, HPC fulfills this role with leadership provided by commission members, including several major thought leaders across the healthcare sector. Oregon will need a similar leadership strategy to drive coordination between OHA and DCBS as the benchmark is extended from Medicaid and state employees to the commercial market.

### Competitive Landscape

The Implementation Committee may want to consider whether market consolidation trends merit collecting from providers data similar to what Massachusetts collects for HPC review. While SB 889 does not call out payer or provider consolidation as a leading issue, and Oregon stakeholders generally did not report consolidation as a major factor driving healthcare costs during our interviews, recent consolidation trends may spark the need for future policy oversight. At least one well-respected local economist has raised concerns about provider consolidation.<sup>37</sup>

Oregon has six major insurers and one of the more competitive insurance markets in the country, but the provider market is consolidating in the Portland area. Four of the six insurers have close relationships with major provider-based health systems: Kaiser and Providence are provider-sponsored health plans, and Moda and PacificSource have established partnerships with the Oregon Health Sciences University (OHSU) and Legacy. Vertical integration does not typically raise the same concerns as horizontal mergers, though some antitrust experts argue that these mergers could merit more scrutiny as they carry the potential for exclusionary practices such as raising prices or otherwise imposing disadvantageous terms on independent insurers.

#### Major Oregon Insurers (2019)

- BlueCross and BlueShield companies (Cambia, Regence, Bridgespan)
- Centene (Health Net)
- Kaiser Foundation Health Plan of the NW
- Moda Health Plan
- PacificSource Health Plans
- Providence Health Plan

Recent developments in the Portland area have raised some of these concerns. For example, Centene has alleged exclusionary practices in recent litigation about its efforts to secure CCO contracts with Portland-area health systems.<sup>38</sup> The proposed partnership between the Providence health system and Care Oregon (a leading Medicaid plan) is also sparking concerns about the market impact of consolidation.<sup>39</sup> Another area of concern could be the ownership of provider practices by national firms that may not have the same incentives to expand VBP arrangements that locally owned practices that routinely participate in insurer networks have.

### Setting the Benchmark

SB 889 directs the Implementation Committee to establish the initial benchmark and “specify the frequency and manner in which the benchmark should be reevaluated and updated” as part of the Committee’s responsibility for designing the benchmark program.<sup>40</sup> The statute creates a number of parameters for the benchmarking process, including:

- The benchmark must be based on “an economic indicator adopted by the OHPB, such as the rate of increase in the state’s economy or of the personal income of residents of this state,” that will “promote a predictable and sustainable rate of growth for total health expenditures.”
- The benchmark must apply to “all providers and payers in the healthcare system” and be measurable on a statewide, per capita, and healthcare entity basis.
- The methodology for calculating cost growth must be risk-adjusted for both providers and payers to account for differences in health status. Massachusetts does use risk adjustment, though plans are not required to follow one standard model.

Unlike the Massachusetts law, which currently has the benchmark set at 3.1%, the Oregon law does not set any floor or ceiling for the benchmark. Oregon currently has a 3.4% benchmark for its Medicaid CCOs and for PEBB and OEBC, though the Medicaid benchmark expires in 2022.

The methodology for calculating cost growth must be risk-adjusted.

### Applying the Benchmark to Commercial Spending

Both insurers and providers recognize the value of extending the benchmark to commercial spending, though both groups are wary of using the DCBS rate review process as the forum for doing so. The top reason for that wariness is that providers are not at the table in commercial rate review, so it can become a one-sided effort to restrain insurers without addressing the role that providers play in driving up premiums. A second reason was that rate review applies only to the individual and small-group markets, leaving out the biggest segments of the commercial market: large-group insurance and self-insurance. DCBS officials also pointed out that commercial rate review is an actuarially based process that would be difficult to reconcile with a benchmarking process. DCBS officials suggested that a better approach may be for them to contribute to the benchmarking process what they learn from rate review and, conversely, use data and information from the broader benchmark process to inform their review of rates. Examples include exchanging data on individual plan-reported cost drivers by service categories, membership trends, and premium rates for all market segments.

## Data Reporting—Benchmarking

SB 889 requires the Implementation Committee to “establish requirements for providers and payers to report data and other information necessary to calculate healthcare cost growth” at the statewide level, on a per capita basis, and for each provider and payer. Unlike in Massachusetts, the statute does not prescribe what data to collect, which means this will be a key issue to address with stakeholders early in the implementation process. SB 889 gives the Implementation Committee broad authority to collect the necessary data for benchmarking from payers and providers.

What data to collect will be a key issue to address with stakeholders.

As a starting point, Oregon can look to the detailed reporting required of insurers in Massachusetts. Section 10 of Chapter 12C requires insurers and third-party administrators to report data on premiums, cost-sharing and other plan design issues, provider payments, risk-adjusted TME by provider, and other information on alternative payment contracts, among other data. CHIA is charged with developing templates and other specifications to ensure standardized data reporting.

While provider data is not collected by CHIA to implement its benchmark-related duties, CHIA separately collects provider financial reports and HPC does collect provider data related to organizational structure to carry out its duties related to monitoring and making recommendations on consolidation trends.

## Supplemental Data Reporting

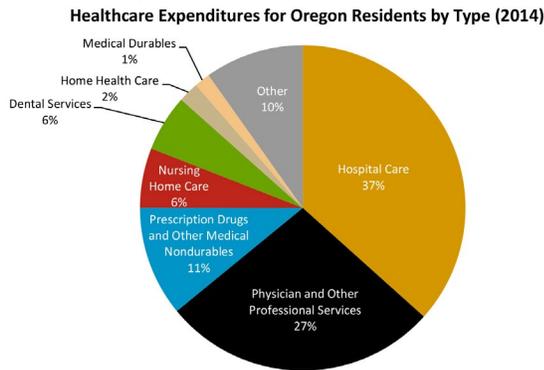
Oregon’s long-standing commitment to transparency creates opportunities for the Implementation Committee to supplement the Massachusetts approach with additional data collection and analysis in several areas. More specifically, drug pricing has become a much more salient issue since 2012; there is increasing scrutiny of hospital pricing, including average rates that are 240% or more higher than Medicare rates for employer-sponsored coverage; and rising cost-sharing for consumers that raise questions about whether consumers are bearing an unfair portion of the burden for holding aggregate spending down. Oregon’s benchmark data collection process may be supplemented to collect usable data to monitor concerns in each of these areas.

## Hospital and Drug Costs

For hospital and drug costs, the Implementation Committee will have a rich tapestry of data sources and approaches to collecting data that it can use to fashion a customized data collection strategy for Oregon.

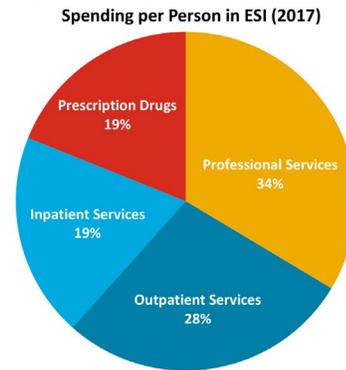
In 2014, the last year state-specific aggregate data is available, hospital and prescription drug costs accounted for 48% of Oregon resident healthcare spending—37% for hospital care and 11% for drugs and other nondurables.<sup>41</sup> These numbers include some drug spending in the hospital care category and likely understate overall hospital and drug spending, as indicated by more recent national data on spending per person in employer-sponsored insurance. That data indicates that hospital and prescription drugs may account for nearly two-thirds of total spending for individuals under age 65: 19% for inpatient care, 28% for outpatient care, and 19% for prescription drugs.<sup>42</sup>

### Exhibit 6: Oregon Healthcare Expenditures, by Service Type



Analysis of Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Data: Health Expenditures by State of Provider, June 2017.

### Exhibit 7: Estimates of Average Spending per Person in Employer-Sponsored Insurance



Source: Health Care Cost Institute. 2017 Health Care Cost and Utilization Report. February 2019.

Oregon has a long history of collecting and analyzing hospital cost data, including a 2007 effort by the Insurance Division to collect data from insurers to show the average discounted rates paid by insurers for leading services and a 2015 law<sup>43</sup> requiring OHA to annually compile and post to its website the median prices for the 50 most common inpatient procedures and the 100 most common outpatient procedures.<sup>44</sup> These reports served as a precursor to a more recent RAND study showing that in 24 states (not including Oregon), hospitals were paid an average of 241% of Medicare rates for commercial business in 2017, up from 236% in 2015. The study showed wide variation among states, facilities, and services. Hospital systems also see wide variation in their prices, from 150% to over 400% of Medicare, and in general, outpatient services have higher relative prices than inpatient care services.<sup>45</sup>

On drug pricing, Oregon established a “fair pricing” legislative task force in 2018 (HB 4005<sup>46</sup>) that has developed more than a dozen recommendations for further work, including state agency reporting on the 25 most expensive drugs and the 25 with the highest price increases, manufacturer justification of high prices, insurer explanation of formulary practices, provider disclosure of markups, and evaluation of PBM rebates. The task force’s first annual report will be available on December 15, 2019.

#### Top 10 Most Costly Drugs in Oregon (2018)

1. Humira (AbbVie) for Rheumatoid Arthritis/Crohn’s Disease/Plaque Psoriasis
2. Enbrel (Amgen) for Rheumatoid Arthritis/Crohn’s Disease/Plaque Psoriasis
3. Tecfidera (Biogen) for Relapsing-Remitting Multiple Sclerosis
4. Truvada (Gilead) for HIV Treatment
5. Stelara (Janssen Biotech/J&J) for Rheumatoid Arthritis/Crohn’s Disease/Plaque Psoriasis
6. Remicade (Janssen Biotech/J&J) for Rheumatoid Arthritis/Crohn’s Disease/Plaque Psoriasis
7. Herceptin (Genentech/Roche Holding AG) for Breast Cancer
8. Rituxan (Genentech/Roche Holding AG & Biogen) for Non-Hodgkin’s Lymphoma
9. Cosentyx (Novartis) for Plaque Psoriasis
10. Genvoya (Gilead) for HIV treatment

Oregon's commitment to making hospital and prescription drug spending more transparent will be an asset in the benchmarking process, though there will be issues with some collected data remaining proprietary, and prescription drug costs may be difficult to separate from other services. There also may be questions about the limits of data collection given litigation in California and elsewhere about state authority to collect more information on pharmaceutical cost drivers.<sup>47</sup> Although SB 889, on its face, gives broad latitude to collect any and all data relative to assessing benchmark progress, an efficient and successful stakeholder process may require setting priorities.

### **Provider Data**

Oregon providers have noted the focus on insurer data in Massachusetts and are interested in having their data play a bigger role—not as a replacement for insurer data but rather as a parallel perspective on key trends. The combination of insurer data on spending trends and provider data on care delivery and the costs to support it could provide a “bifocal” perspective on healthcare spending and where savings can be found. Oregon providers are seeking strong representation from hospitals and physicians in the data collection process to help inform its results.

### **All Payer All Claims (APAC) Data**

Oregon is fortunate to have APAC, a relatively mature APCD that dates back to 2009. APAC has had a lead role in prior cost control efforts and will be able to provide claims-level data to look deeper into the spending trends identified through the benchmarking process, similar to how Massachusetts uses its nation-leading APCD.

### **Value-Based Purchasing**

Stakeholders saw the expansion of VBP as a critical strategy for lowering costs and praised SB 889 for requiring identification of opportunities for using “innovative payment models” that “do not use a per-claim basis for payments.” Most of the providers and insurers Manatt interviewed were familiar with OHA's efforts to expand VBP in the CCO program, partly to meet the 3.4% benchmark applicable to that market. There was broad support for expanding VBP in the commercial market, where it is currently used less, though there were some concerns about how willing insurers and providers would be to share data about proprietary VBP strategies, and there will be questions about how much VBP strategies should be part of the benchmarking discussion. On that score, the Implementation Committee may consider building on Massachusetts' alternative payment method (APM) adoption reporting, a supplemental series reporting on cost drivers, while ensuring the data collection reflects its own priorities and definitions. Oregon's long-standing effort to expand the role of primary care through its Patient-Centered Primary Care Home Program (PCPCHP) initiative may also deserve attention. As noted in section I, Massachusetts Governor Baker recently highlighted primary care and behavioral health as important areas to shift spending toward without increasing overall spending.

Oregon's long-standing effort to expand the role of primary care through its Patient-Centered Primary Care Home Program initiative is a critical cost control strategy.

## Quality Reporting

Putting cost containment in the context of the quality of care provided is a critical goal of any benchmarking program but is a challenge states are still trying to address. Massachusetts includes quality measures in its annual reports, but this data has not played a major role in the Commonwealth's benchmarking program, with measures not proving an effective differentiator among payers and providers. Newer metrics emphasizing customer satisfaction may prove stronger and more compelling, as they have in other industries. The Implementation Committee should review these previous experiences and determine how it can meaningfully profile quality data in the context of cost data to support healthcare value for Oregonians.

## Annual Report

SB 889 requires an annual "cost trends report" on services provided, sorted by provider organization; services paid for, sorted by payer; variations in cost, sorted by service; and affordability based on prices, premiums, and type of payment. The report must include the factors impacting costs and spending, make recommendations to improve efficiency, and analyze the causes of providers and payers not meeting the benchmark.

The annual report will provide an opportunity to add a new level of transparency to Oregon's healthcare system. One question unanswered by the statute is who is responsible for defining reporting format and ensuring compliant reporting. The Implementation Committee should consider which of the program's governing organizations will hold this responsibility, among the many others, in maintaining a benchmarking program.

## Public Hearings

SB 889 requires the program to hold public hearings on the annual report, though detailed requirements for what to cover and who might be ready to reveal their findings are not specified. The Implementation Committee will need to shape these important forums to reflect Oregon's priorities, and educate the media on why these are critical events to cover and how to report on their findings accurately.

## Performance Improvement Plans

SB 889 prescribes Massachusetts-like PIPs for payers and providers who exceed benchmark targets, but the legislature expressly retains the responsibility to determine in 2021 how to enforce such plans. Oregon stakeholders agreed with delaying the enforcement discussions, supporting a "carrots first, sticks later" approach, but several stakeholders expressed dissatisfaction with the fact that Massachusetts has relied on private negotiations and has yet to publicly announce a performance plan has been enacted. With Oregon's strong commitment to transparency, the Implementation Committee will have to find a balance that works for the state.

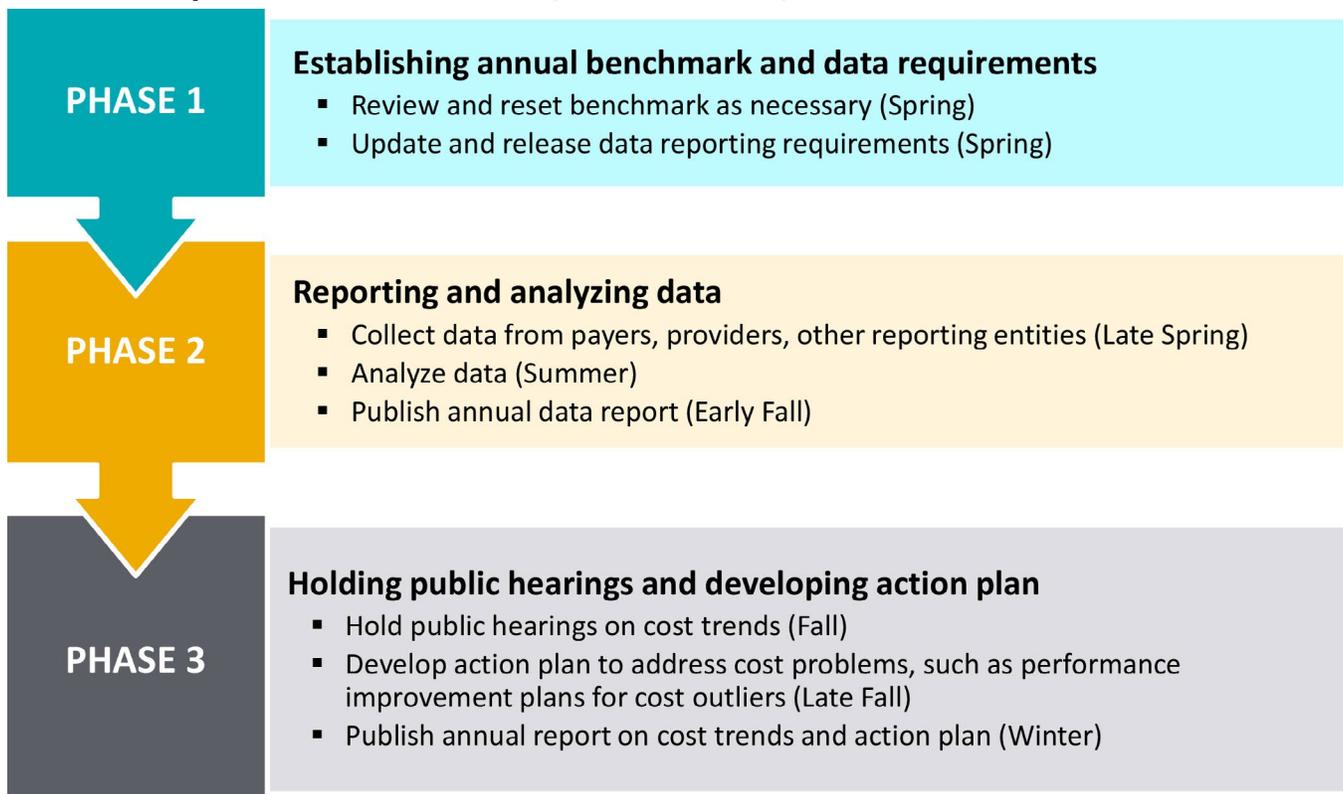
Oregon can enhance the Massachusetts model by adding more comprehensive data on the two largest cost drivers (hospital and drug pricing), utilizing the state's pioneering work in these areas.

## Next Steps

Oregon should consider the following priorities as it moves forward with an implementation plan that builds on the Massachusetts model:

- **Transparency on steroids.** Oregon can enhance the Massachusetts model by adding more comprehensive data on the two largest cost drivers (hospital and drug pricing), utilizing the state’s pioneering work in these areas. Oregon could also feature more “delivery”-oriented service categories, such as “primary care” and “behavioral healthcare,” as it looks to use the data collection model to support its core healthcare priorities.
- **High-profile public/stakeholder process.** Oregon can build on the Massachusetts model in developing an annual process that uses data to generate reports and hold public hearings with all major stakeholders at the table and each one obligated to do their part to control costs in the areas where data shows the need for better cost control. See Exhibit 8 for a sample annual timeline with annotations as to what could happen at key junctures each year.

### Exhibit 8. Sample Annual Timeline for Oregon Benchmarking



- **Aligning payers and providers on key strategies.** Oregon can build on the way CCOs and PEBB/OEBB already use benchmarking to drive payment reform, bringing the commercial carriers on board to take similar actions in the commercial market (insured and self-insured). Key areas for progress include expanding use of VBP and taking other actions to control spending in targeted areas, such as addressing price sustainability, waste and inefficiency, and low-value care.
- **Providing framework for health policy.** With the legislature considering over 500 healthcare-related bills each session, Oregon's benchmarking program can provide legislators with a comprehensive framework and base of data to understand the current state of healthcare costs, including the cost centers and cost drivers that are impacting their constituents. This information will provide a solid reference point for picking priorities and considering policy changes.
- **Addressing all markets.** Benchmarking can inspire a new level of creativity in containing costs and improving value across the entire healthcare system, including parts of the system with which states typically do not engage as much (e.g., self-insured, Medicare). While national healthcare debates continue to play out and the long-range shape of national health policy remains rather opaque, new initiatives such as statewide cost benchmarking show how states can take their purchasing, policymaking, and regulatory power to a new level, and utilize the state's influence to help control costs for all individuals and businesses regardless of where they get their insurance.
- **Highlighting consumer cost-sharing.** Governor Kate Brown recently highlighted the increasing cost-sharing burden on consumers as a major concern in Oregon.<sup>48</sup> By establishing a benchmark focused on consumer spending and how it is changing over time, the state could gain insight into how that burden varies by product type (e.g., high deductible health plan (HDHP), HMO, PPO); how much of the burden results from non-covered services; and how effective new initiatives, such as surprise billing laws, are in reducing the consumer burden. Collecting cost-sharing data by key service categories (e.g., inpatient services, pharmacy spending) could further enable policymakers to understand what is driving higher rates of consumer cost-sharing.

Collecting cost-sharing data by key service categories (e.g., inpatient services, pharmacy spending) could further enable policymakers to understand what is driving higher rates of consumer cost-sharing.

## III. Streamlined Benchmarking Programs

Delaware and Rhode Island have adopted streamlined benchmarking programs that include some but not all of the elements found in the Massachusetts and Oregon programs. These programs offer a model for states, especially smaller states with limited resources, to initiate benchmarking programs that are more focused on specific types of spending than are the broader Massachusetts and Oregon programs.

### Delaware Benchmarking Program

In September 2017, the Delaware Legislature passed House Resolution 7, to establish and plan for the monitoring and implementation of an annual healthcare benchmark.<sup>49</sup> After subsequent development of a public and private all-payer cost-benchmarking program by the Delaware Department of Health and Social Services and establishment of an “advisory group” of Delaware healthcare leaders,<sup>50</sup> Delaware Governor John Carney issued an executive order in November 2018 to formally establish a healthcare quality and spending benchmark across the state.<sup>51</sup>

#### Exhibit 9: Delaware Levels of Public Reporting Required<sup>52</sup>

Level	Reporting Detail
State level	<ul style="list-style-type: none"> <li>Aggregate spending and per capita</li> <li>Compare per capita rate of change against benchmark</li> </ul>
Commercial market	<ul style="list-style-type: none"> <li>Aggregate spending and PMPY</li> <li>Compare PMPY rate of change against benchmark</li> </ul>
Medicare market	<ul style="list-style-type: none"> <li>Aggregate spending and PMPY</li> <li>Compare PMPY rate of change against benchmark</li> </ul>
Medicaid market	<ul style="list-style-type: none"> <li>Aggregate spending and PMPY</li> <li>Compare PMPY rate of change against benchmark</li> </ul>
Insurer level (e.g., Highmark, AmeriHealth), by line of business (including Medicare Advantage, Medicare fee-for-service and Medicaid managed care organization)	<ul style="list-style-type: none"> <li>PMPY</li> <li>Compare PMPY rate of change against benchmark</li> </ul>
Large provider group	<ul style="list-style-type: none"> <li>PMPY; however, a more limited set of spending data than reported elsewhere</li> </ul>

#### Agencies Responsible for Benchmark Implementation and Administration

The program is overseen by the Delaware Health Care Commission and the Delaware Economic and Financial Advisory Council (DEFAC) Health Care Spending Benchmark Subcommittee. The subcommittee is responsible for setting the healthcare spending benchmark and advising DEFAC, the Governor, and relevant state agencies on the spending benchmark. Specifically,<sup>53</sup> it is tasked with:

- Reviewing the PGSP methodology and recommending to DEFAC whether the forecast PGSP growth rate has changed in such a material way that it warrants a change in the spending benchmark, and if so, how and why the spending benchmark should be modified
- Starting January 1, 2024, reviewing the methodology of the spending benchmark periodically for possible updates or modifications to the methodology for the performance year

- Facilitating the public comment process around the benchmark and incorporating feedback into its recommendations
- Advising the Governor and DEFAC on current and projected trends in healthcare and the healthcare industry

### **The Benchmark**

The state's healthcare spending target is set at 3.8% for 2019, with the goal of reducing it to 3.0% by 2023, which is in line with the state's PGSP. The state has also set quality metrics for ongoing reference in its annual benchmarking program. Measures relate to emergency department utilization rates, opioid-related metrics, adult obesity and tobacco use, physical activity among high school students, statin therapy, and beta-blocker treatment post-heart attack.

### **Health System Data and Metrics**

The executive order requires annual reporting on performance relative to the spending and quality benchmarks for the prior calendar year.<sup>54</sup> Insurers will be responsible for reporting per member per year (PMPY) TME (i.e., the amount the insurer paid plus any member cost-sharing) for lines of business in Delaware. Insurers must also attribute members to a primary care provider so that all member spending can be attributed to one physician group, as in Massachusetts.<sup>55</sup> There are eight categories of claims data to be submitted, all with specific definitions: hospital inpatient; hospital outpatient; professional claims (including primary care physicians, specialty physicians, and providers other than a physician); retail pharmacy; long-term care; and other claims for medical services not otherwise included in other categories. The annual data reporting will include variation in costs and quality of high-volume, high-cost, and high-value episodes of care (identifying the causes of variation, including mix of services used, unit price variation, and provision of low-value care.) For 2019, medical and quality data was due to the commission on August 1.

## **Rhode Island Benchmarking Program**

Rhode Island has a history of evaluating healthcare spending and affordability in the state. In 2010, the Rhode Island Office of the Health Insurance Commissioner implemented healthcare "affordability" standards for commercial health insurers; specifically, the standards require issuers to expand and improve primary care infrastructure, spread the adoption of the patient-centered medical home, support the state's health information exchange, and work toward comprehensive payment reform across the delivery system.<sup>56</sup> These standards increased investment in the primary care system, capped spending growth for hospitals, and encouraged the adoption of new payment models to reduce healthcare spending growth.<sup>57,58</sup> A 2019 evaluation showed the standards reduced per capita health spending, compared with a control group.<sup>59</sup>

Building on the success of this program, in August 2018, Rhode Island Governor Gina M. Raimondo launched the Rhode Island Health Care Cost Trends Project to create a statewide all-payer cost growth target "to provide Rhode Island citizens with high-quality, affordable healthcare through greater transparency of healthcare performance and increased accountability by key stakeholders." Following initial work by the committee, Governor Raimondo signed an executive order in February 2019 establishing a target for healthcare spending growth in Rhode Island. The project consists of three work streams:

- Develop a methodology for a healthcare cost growth target for operationalization in 2019.
- Conduct a data analysis to measure healthcare system cost performance and identify cost drivers.
- Create a data use strategy to leverage the Rhode Island APCD, HealthFacts RI, on an ongoing basis in identifying cost drivers and sources of cost growth variation to improve healthcare system performance.

### **Agencies Responsible for Benchmark Implementation and Administration**

The project is a joint initiative between the Office of Governor, the Office of the Health Insurance Commissioner (OHIC), and the Executive Office of Health and Human Services (EOHHS). An 18-member steering committee—composed of payers, providers, and business and community representatives, and led by the state’s health insurance commissioner, the CEO of the state’s largest insurer, and a provider CEO—guides the project. The executive order charges the state’s OHIC and EOHHS to engage providers, insurers, and community partners and issue annual reports to track the state’s progress in meeting health spending targets.<sup>60</sup>

### **The Benchmark**

In December 2018, the steering committee and an executive order established the state per capita cost growth target at 3.2% annually for 2019–2022. The benchmark will be re-evaluated thereafter. The target is based on the PGSP.<sup>61</sup>

### **Health System Data and Metrics<sup>62,63</sup>**

Data will be calculated and reported from Medicare, Medicaid, and all major insurers to assess performance against the cost growth target at the state, insurance market, insurer, and large-provider organization levels, while adjusting for annual changes in population clinical risk.

The cost growth target will be calculated using payer-reported information for the first two years, as the state’s APCD continues to develop.<sup>64</sup>

### **Exhibit 10: Rhode Island Data Methodology Considerations**

<b>Methodological Consideration</b>	<b>Included</b>	<b>Excluded</b>
<b>Payer Populations<sup>65</sup></b>	<ul style="list-style-type: none"> <li>• Commercial (both fully insured and self-insured populations)</li> <li>• Medicaid</li> <li>• Medicare</li> </ul>	<ul style="list-style-type: none"> <li>• Correctional Health</li> <li>• TRICARE</li> <li>• Veterans Health Administration (VA)</li> </ul>
<b>State of Residence and Locations of Care</b>	<ul style="list-style-type: none"> <li>• Rhode Island residents with Rhode Island providers</li> <li>• Rhode Island residents with out-of-state providers</li> </ul>	<ul style="list-style-type: none"> <li>• Out-of-state residents with Rhode Island providers</li> <li>• Out-of-state residents with out-of-state providers</li> </ul>
<b>Types of Spending</b>	<ul style="list-style-type: none"> <li>• Claims-based spending</li> <li>• Non-claims-based spending</li> <li>• Pharmacy carve-outs</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral health carve-out contracts<sup>66</sup></li> </ul>

Source: Rhode Island Health Care Cost Trends Steering Committee. Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island. November 2018.

## IV. Key Considerations for Benchmarking Programs

State cost benchmarking programs offer policymakers a new level of insight and transparency into their healthcare systems. However, as shown by the four states that have implemented such programs, programs can vary significantly in scope and focus. States considering developing their own benchmarking programs should consider the following factors when shaping its design:

- 1. Market landscape.** The competitiveness of states' payer and provider markets varies significantly, creating different benchmark reporting priorities. If payer or provider markets lack an appropriate level of competition, as in Massachusetts, the benchmarking program may prioritize collecting data that helps policymakers understand the potential impact of proposed consolidations.
- 2. State resources.** States vary in their financial capacity and political will to support a benchmarking plan. Benchmarking programs require staff resources to support data collection and report writing, as well as the political will to engage key stakeholders and ensure they participate in addressing the identified cost control issues. States should establish a benchmarking program commensurate with available resources. Massachusetts, a state with a long and storied history of major reforms, created two new state agencies to implement its law, while Delaware and Rhode Island used executive orders and less sweeping mandates to institute more streamlined infrastructure to support their benchmarking process. The Oregon Legislature enacted a law similar to the Massachusetts law, though more details were left to a blue-ribbon implementation committee.

States should establish a benchmarking program commensurate with available resources.
- 3. Governance.** States have different traditions and philosophies of how programs should be governed, especially as to when stakeholder boards should have policy oversight over state agencies. States should consider a governance structure and composition that would best serve the scope of their benchmarking program and generate the most stakeholder support. Governance composition could be an effective way to engage key industry stakeholders to generate buy-in, subject matter experts to guide program development and interpret results, and governmental leadership to ensure accountability through appropriate regulation. The governance structure may include empowering an existing policy board (e.g., Oregon), creating a new board or commission (e.g., Delaware, Rhode Island), or vesting governance in new or existing state agencies (e.g., Massachusetts).

The governance structure may include empowering an existing policy board, creating a new board or commission, or vesting governance in new or existing state agencies.

### Measuring the Consumer Cost-Sharing Burden

Cost benchmarking programs have been successful in measuring the total cost of healthcare for various segments of the market, but to date, data collection has not focused on how costs are spread across different stakeholder groups and how those burdens may be shifting. Understanding how consumer costs change over time has become a paramount priority for state policymakers as out-of-pocket liabilities continue to grow, placing members at increasing financial risk. Consumer cost-sharing was a leading issue in this year's benchmarking hearings in Massachusetts and was also identified as a major issue in Oregon by Governor Kate Brown in her news release announcing the membership of the benchmarking implementation committee.

While Massachusetts implemented "supplemental" reports to the benchmark that capture premium, cost-sharing, plan benefit, and plan type adoption changes (e.g., HDHP, tiered network adoption) for the state's population, no core "consumer burden" indicators have been implemented to specifically measure how that burden has shifted over time. States may advance this priority by developing a single indicator that displays not just how per capita healthcare costs are changing over time, but also who is most directly bearing the burden of those costs.

To better assess this value, states may supplement data collection to include denied claims, providing insight into how much of the consumer cost-sharing burden results from non-covered services, including out-of-network services. As surprise billing laws are implemented, data could show how much of the consumer cost-sharing burden is eliminated by various approaches to holding consumers harmless for out-of-network charges incurred at in-network facilities. States may also build on the Massachusetts data collection framework to collect cost-sharing data by key service categories (e.g., inpatient services, pharmacy spending) to better understand what is driving higher rates of consumer cost-sharing. Depending on how important the issue of consumer cost-sharing burdens is for policymakers, it may be advisable to set benchmarks around some or all consumer spending.

4. **Data collection for cost benchmarking.** Measuring total healthcare system expenditures relies on data submitted directly from public and private payers, which have access to claims-based and non-claims-based payments made on behalf of their fully insured and self-insured members, and which have unique insight into where the dollars come from and the types of providers and services they go to. States have several options on how best to pursue this data to balance data submission burdens with data needs:

- **Data submission thresholds:** States may alter reporting thresholds to require only the biggest state payers to submit data, acknowledging that these entities are best positioned to bear the reporting burden. However, if high thresholds are pursued, states should consider how much of the market they

States may initially collect limited data and then expand data collection as the reporting infrastructure matures.

would be leaving uncaptured and whether there is reason to believe members of smaller payers may have a different experience than those enrolled with larger payers. States may also choose to start the benchmark process by collecting data from only select payers during its first year of implementation, and expanding data collection in subsequent years as the data collection and reporting infrastructure matures.

- **Scope of data submitters:** Payers are uniquely positioned to supply benchmark data on aggregate spending trends. However, states relying solely on a payer-driven data submission model will be naturally limited in their understanding of potential provider-centric cost drivers (i.e., payers may be able to pinpoint higher-cost providers and which of their members receive which services there, but they do not have direct insight necessarily into **why** those costs are higher). States considering the development of robust benchmark models may consider whether companion provider-based reporting may help to create a bifocal view of the health system.
- **Scope of data request:** Benchmark data requests can grow exponentially with each new membership breakout-of-interest introduced. For example, a payer’s responsibility to submit data on its total spending on behalf of its members in a given year may change from one data point to eight when a state asks for that data by group size: individual (subsidized), individual (unsubsidized), small group, midsize group, large group, jumbo group, association health plan, and student health plan. Reports may further double in size by classifying whether those members, by those group sizes, are fully insured or self-insured. And with each new breakout, the opportunity for definition misinterpretation increases. States should work with payers to understand reporting burden introduced with each breakout requested; as is the case with thresholds, states may also choose to introduce new requirements as the program matures and payers develop initial systems to provide more basic data in an accurate and timely manner. States may also need to work directly with public payers whose data is not reflected in that available to commercial payers (e.g., Medicaid fee-for-service, Medicare Part A/B) in order to collect data that reflects their full markets; keeping those requests simple will maximize the chances requests are able to be fulfilled in a timely manner.

States collecting both payer and provider data may help to create a bifocal view of the health system.

5. **Supplemental data collection.** Beyond data collected directly to inform the benchmark program, states may also collect companion or “supplemental” reports from payers and others to provide context and depth to results. Massachusetts, for example, regularly collects data on consumer premiums and cost-sharing (see below), quality, APM adoption, and provider price variation, with many of these metrics bound to benchmark data by referencing the same populations (i.e., denominators). Supplemental data can be more consequential than the core benchmarking data, illuminating factors that either aggravate or mitigate the impact of cost drivers. For example, in Massachusetts, while benchmark data may not highlight a particular health system for excessive cost growth, the state’s provider price variation reporting could reveal it to be the highest-cost

Supplemental data can be more consequential than the core benchmarking data, illuminating factors that either aggravate or mitigate the impact of cost drivers.

network in the state, adding important context to the policy conversation. States with APCDs may also leverage these databases to expand their mission in these areas, and states without APCDs may want to establish them.

6. **Public process.** Benchmarking programs derive much of their leverage from the way in which benchmarking data is publicly profiled: identifying cost drivers across market segments; and making recommendations to mitigate them, including corrective action plans for payers and providers whose spending is exceeding the benchmark. Massachusetts has a rigorous annual schedule of data reports and public hearings, culminating in an annual report with actionable recommendations. The Oregon statute envisions a similar public process; other states may want to adopt a similar process in whole or in part. The extent to which states are willing to engage all stakeholders, the media, and ultimately the public in the benchmarking process will influence the level of impact the process has on outcomes.

Benchmarking programs derive much of their leverage from the way in which benchmarking data is publicly profiled: identifying cost drivers across market segments; and making recommendations to mitigate them.

7. **Enforcement.** Benchmarking programs are primarily a soft path to cost containment, relying on transparency to improve the behavior of market actors (i.e., Hawthorne effect), but states may also choose to develop specific enforcement tools to enhance accountability. In Massachusetts, payers and providers who exceed the benchmark may be required to develop PIPs, though no such plans have been publicly ordered yet. The Oregon Legislature authorized full implementation of the state's benchmarking program—pending only the enforcement of PIPs for further legislative consideration. States will vary in their use of explicit enforcement mechanisms to ensure accountability to benchmark goals.

States will vary in their use of explicit enforcement mechanisms to ensure accountability to benchmark goals.

## Appendix A: Interview Table

Industry Shareholders			
Interviewee	Title	Organization	Interview Date
Jenn Welander	Chief Financial Officer	St. Charles Health System	July 18, 2019
William Olsen	Vice President of Finance Operations	Providence Health & Services Oregon	July 22, 2019
Maggie Hudson	Director of Operations and Finance	Santiam Memorial Hospital	July 23, 2019
Daniel Field	Executive Director of Community Health	Kaiser Permanente	July 26, 2019
Amy Fauver	Director, Government Relations	Kaiser Permanente	July 26, 2019
Vince Porter	Director, Oregon Government Affairs	Cambia Health Solutions	July 30, 2019
Kraig Anderson	Senior Vice President	Moda Health Plan, Inc.	August 1, 2019
Kevin Ewanchyna	Chief Medical Officer	Samaritan Health Services	August 1, 2019
Ken Provencher	President & CEO	PacificSource Health Plans	August 7, 2019
Mark Florian	Vice President, Actuarial and Underwriting	PacificSource Health Plans	August 7, 2019

State Officials			
Interviewee	Title	Organization	Interview Date
Cameron Smith	Director	Department of Consumer and Business Services (DCBS)	August 19, 2019
Andrew Stolfi	Insurance Commissioner and Administrator	DCBS Division of Financial Regulation	August 19, 2019
TK Keen	Deputy Administrator	DCBS Division of Financial Regulation	August 19, 2019
Chiqui Flowers	Administrator	DCBS/Oregon Health Insurance Marketplace	August 19, 2019
Tina Edlund	Senior Health Policy Advisor	Office of Governor Kate Brown	August 27, 2019
Jeremy Vandehey	Director, Health Policy and Analytics	Oregon Health Authority	August 27, 2019
Trilby de Jung	Deputy Director, Health Policy and Analytics	Oregon Health Authority	August 27, 2019
Lori Coyner	State Medicaid Director	Oregon Health Authority	August 27, 2019
Ali Hassoun	Director	Public Employees Benefit Board (PEBB) /Oregon Educators Benefit Board (OEBB)	August 27, 2019
Shaun Parkman	PEBB Chair	Public Employees Benefit Board	August 27, 2019
Geoff Brown	OEBB Chair	Oregon Health Authority	August 27, 2019
Karen Hampton	Program Manager, APAC	Oregon Health Authority	August 27, 2019
Steven Ranzoni	Hospital Policy Adviser	Oregon Health Authority	August 27, 2019
Zachary Goldman	Health Policy and Analytics	Oregon Health Authority	August 27, 2019

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State Officials			
Interviewee	Title	Organization	Interview Date
JP Jones	Deputy Administrator	DCBS Division of Financial Regulation	August 28, 2019
Rick Blackwell	Manager, Policy	DCBS Division of Financial Regulation	August 28, 2019
Tashia Sizemore	Manager, Life & Health Product Regulation	DCBS Division of Financial Regulation	August 28, 2019
Michael Sink	Actuary	DCBS Division of Financial Regulation	August 28, 2019
Rick Barry	Operations Policy Analyst	DCBS Division of Financial Regulation	August 28, 2019
Jesse O'Brien	Senior Policy Advisor	DCBS Division of Financial Regulation	August 28, 2019
Michael Schopf	Senior Policy Advisor	DCBS Division of Financial Regulation	August 28, 2019
Gayle Woods	Senior Policy Advisor	DCBS Division of Financial Regulation	August 28, 2019

Other Stakeholders			
Interviewee	Title	Organization	Interview Date
Kirsten Isaacson	Research Coordinator	SEIU Local 49	September 11, 2019

## Appendix B: Massachusetts Data Requirements

### Excerpts From MA General Laws Chapter 12C, Section 10

(a) The center shall promulgate regulations necessary to ensure the uniform reporting of information from private and public health care payers, including third-party administrators, that enables the center to analyze:

- (1) changes over time in health insurance premium levels;
- (2) changes in the benefit and cost-sharing design of plans offered by these payers;
- (3) changes in measures of plan cost and utilization; provided that this analysis shall facilitate comparison among plans and between public and private payers; and
- (4) changes in type of payment methods implemented by payers and the number of members covered by alternative payment methodologies; provided, however, that this analysis shall facilitate comparison among plans and plan types, including the self-insured. The center shall adopt regulations to require private and public health care payers to submit claims data, member data and provider data to develop and maintain a database of health care claims data under this chapter.

(b) The center shall require the submission of data and other information from each private health care payer offering small or large group health plans including, but not limited to:

- (1) average annual individual and family plan premiums for each payer's most popular plans for a representative range of group sizes, as further determined in regulations, and average annual individual and family plan premiums for the lowest cost plan in each group size that meets the minimum standards and guidelines established by the division of insurance under section 8H of chapter 26;
- (2) information concerning the actuarial assumptions that underlie the premiums for each plan;
- (3) summaries of the plan and network designs for each plan, including whether behavioral, substance use disorder and mental health or other specific services are carved-out from any plans;
- (4) information concerning the medical and administrative expenses, including medical loss ratios for each plan, using a uniform methodology and collected under section 21 of chapter 176O;
- (5) information concerning the payer's current level of reserves and surpluses;
- (6) information on provider payment methods and levels;
- (7) health status adjusted total medical expenses by registered provider organization, provider group and local practice group and zip code calculated according to the method established under section 51 of chapter 288 of the acts of 2010;
- (8) relative prices paid to every hospital, registered provider organization, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider, with hospital inpatient and outpatient prices listed separately and product type, including health maintenance organization and preferred provider organization products and determined using the method established under section 52 of chapter 288 of the acts of 2010;

- (9) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology;
- (10) the annual rate of growth, stated as a percentage, of the average relative price by provider type and product type for the payer's participating health care providers, whether that rate exceeds the rate of growth of the applicable producer price index as reported by the United States Bureau of Labor Statistics and identified by the commissioner of insurance and whether that rate exceeds the rate of growth in projected economic growth benchmark established under section 7H<sup>1</sup>/<sub>2</sub> of chapter 29; and
- (11) a comparison of relative prices for the payer's participating health care providers by provider type which shows the average relative price, the extent of variation in price, stated as a percentage, and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20 per cent below the average relative price.

(c) The center shall require the submission of data and other information from public health care payers including, but not limited to:

- (1) average premium rates for health insurance plans offered by public payers and information concerning the actuarial assumptions that underlie these premiums;
- (2) average annual per-member per-month payments for enrollees in MassHealth primary care clinician and fee for service programs;
- (3) summaries of plan and network designs for each plan or program, including whether behavioral, substance use disorder and mental health or other specific services are carved-out from any plans;
- (4) information concerning the medical and administrative expenses, including medical loss ratios for each plan or program;
- (5) where appropriate, information concerning the payer's current level of reserves and surpluses;
- (6) information on provider payment methods and levels, including information concerning payment levels to each hospital for the 25 most common medical procedures provided to enrollees in these programs, in a form that allows payment comparisons between Medicaid programs and managed care organizations under contract to the office of Medicaid;
- (7) health status adjusted total medical expenses by registered provider organization, provider group and local practice group and zip code calculated according to the method established under section 51 of chapter 288 of the acts of 2010; and
- (8) relative prices paid to every hospital, registered provider organization, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider, with hospital inpatient and outpatient prices listed separately, and product type and determined using the method established under section 52 of chapter 288 of the acts of 2010;
- (9) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology;

- (10) the annual rate of growth, stated as a percentage, of the average relative price by provider type and product type for the payer's participating health care providers, whether that rate exceeds the rate of growth of the applicable producer price index as reported by the United States Bureau of Labor Statistics and identified by the commissioner of insurance and whether that rate exceeds the rate of growth in projected economic growth benchmark established under section 7H<sup>1</sup>/<sub>2</sub> of chapter 29; and
- (11) a comparison of relative prices for the payer's participating health care providers by provider type which shows the average relative price, the extent of variation in price, stated as a percentage and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20 per cent below the average relative price.

(d) The center shall require the submission of data and other information from public and private health care payers which utilize alternative payment contracts, including, but not limited to:

- (1) if applicable, the negotiated monthly or yearly budget for each alternative payment contract in the current contract year;
- (2) any applicable measures of provider performance in such alternative payment contracts; and
- (3) if applicable, the average negotiated monthly or yearly budget weighted by member months for each geographic region of the Commonwealth as further defined in regulations promulgated by the center.

For purposes of this subsection, payers shall report the negotiated budget assuming a neutral health status score of 1.0 using an industry accepted health status adjustment tool and shall, if applicable, separately report the budget allowances for: all medical and behavioral, substance use disorder and mental health care at both in and out-of-network providers; pharmacy coverage allowance; administrative expenses such as data analytics, health information technology, clinical program development and other program management fees; the purchase of reinsurance or stop-loss; and quality bonus monies, unit cost adjustments or other special allowances as may be required in regulations promulgated by the center. If out-of-network care, behavioral, substance use disorder and mental health, stop-loss insurance or any other clinical services are carved out of any global budget, bundled payments or other alternative payment methodologies such that there is no allowance included in the budget for those services, payers shall report actual claims costs of these items on a per member per month basis for the year immediately prior to the current contract year.

(e) Except as specifically provided otherwise by the center or under this chapter, insurer data collected by the center under this section shall not be a public record under clause twenty-six of section 7 of chapter 4 or under chapter 66.

## Appendix C: Massachusetts Benchmark Data Detail

**Total Health Care Expenditures (THCE)** payer data consists of data collected directly from commercial payers and public payers, supplemented with public actuarial estimates.

- **Total Medical Expenses (TME) data is collected from commercial payers** with segmentations by product type (HMO, PPO, Other) and ZIP code, product type and managing physician group, and category of service including:
  - Amounts reported by the ten largest payers in the commercial insurance category, as well as payers offering Medicare Advantage plans or MassHealth MCO plans
  - Aggregated medical expenditures for healthcare services, inclusive of patient cost-sharing and non-claims-related provider payments (e.g., performance payments)
  - Additional measures that include member months, health status adjustment score, unadjusted TME per member per month (PMPM), and health-status-adjusted TME PMPM
- Medical expenses obtained for other payers not reporting TME, generally collected through summary table-based requests of membership and expenditure data. CHIA develops and refines these requests with each stakeholder (MassHealth, CMS, VA) and distributes the agreed-to template annually for collection.
  - **“Non-commercial” Medicaid data** is requested and received directly from MassHealth, including data for its Fee-for-Service PCC Plan, Senior Care Options, and PACE plans, data for its One Care dual demonstration, and data otherwise unavailable through commercial payers (e.g., select ACO data).
  - **Medicare Part A and/or B and stand-alone Part D** membership and expenditure data is collected annually from CMS. This data fills significant “gaps” in the states assessment of aggregate healthcare expenditures.
  - **VA** reports summary data to CHIA through a request process similar to that of CMS.<sup>67</sup>
  - Data for **commercial payers that do not meet reporting thresholds** is estimated using publicly available CCIO or NAIC reporting.
- Commercial payers also report data for portions of their population for which they may only have **“partial claims”** (e.g., behavioral health or pharmacy services may be “carved out” or otherwise provided separately from the other medical services and are unaccounted for in total expenses). To estimate the full expenditure values, CHIA requests that this data be submitted separate from the “full claims” population and applies actuarial adjustments to the submitted data to estimate “full claim” values. For more information on CHIA’s estimation techniques in this area, please see its THCE/TME/APM Technical Appendix.<sup>68</sup>

- **Net cost of private health insurance (i.e., administrative costs) (NCPHI)**, which is calculated from the Medical Loss Ratio Reports from the Massachusetts Division of Insurance, the Annual Statutory Financial Statement and Supplemental Health Care Exhibit from the NAIC), and the Medical Loss Ratio Reports from the CCIO. Notably, NCPHI does **not** include administrative costs for public programs.

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<sup>1</sup> An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation. [Mass. Gen. Laws Ch. 224](#) (2012).

<sup>2</sup> LeBlanc, S. [Patrick signs health care cost containment bill](#). Associated Press. August 2012.

<sup>3</sup> Massachusetts Health Policy Commission. [Hearing on the Potential Modification of the Health Care Cost Growth Benchmark](#) (March 2018).

<sup>4</sup> [Delaware Executive Order No. 25](#) (2018).

<sup>5</sup> [Rhode Island Executive Order No. 19-03](#) (2019).

<sup>6</sup> [S.B. 889, 2019 Legislative Session](#) (Or, 2019).

<sup>7</sup> Massachusetts Health Policy Commission. [Introduction to the Health Policy Commission](#) (June 2017). U.S. data includes Massachusetts. Center for Health Information and Analysis data are for the fully-insured market only. Sources: Centers for Medicare and Medicaid Services, State and National Healthcare Expenditure Accounts, Private Health Insurance Expenditures and Enrollment (U.S. and MA 2005–2009); Center for Health Information and Analysis Annual Reports (MA 2009–2015).

<sup>8</sup> Mass. Gen. Laws Ch. 224, § 12C (2012).

<sup>9</sup> LeBlanc, S. [Patrick signs health care cost containment bill](#). Associated Press. August 2012.

<sup>10</sup> Anthony, B., Segel, C., & Toher, H. (2018). [Beyond Obamacare: Lessons from Massachusetts](#). *J. Health & Biomedical L.*, 14, 285.

<sup>11</sup> Mass. Gen. Laws Ch. 12C (2012).

<sup>12</sup> Mass. Gen. Laws Ch. 6D § 2a (2018).

<sup>13</sup> “The commission shall monitor the reform of the healthcare delivery and payment system in the commonwealth under this chapter. The commission shall: (i) set healthcare cost growth goals for the commonwealth; (ii) enhance the transparency of provider organizations; (iii) monitor the development of ACOs and patient-centered medical homes; (iv) monitor the adoption of alternative payment methodologies; (v) foster innovative healthcare delivery and payment models that lower healthcare cost growth while improving the quality of patient care; (vi) monitor and review the impact of changes within the healthcare marketplace and (vii) protect patient access to necessary healthcare services.”

<sup>14</sup> Mass. Sess. Laws Ch. 224, § 9 §13A (2012).

<sup>15</sup> Center for Health Information and Analysis (CHIA). [Payer Data Reporting: Relative Price](#).

<sup>16</sup> [Mass. Gen. Laws Ch. 12C, § 8](#) (2015).

<sup>17</sup> CHIA. [Payer Data Reporting: Premiums Data](#).

<sup>18</sup> Mass. Gen. Laws Ch. 12C, § 10 (2015).

<sup>19</sup> CHIA. [Prescription Drug Rebate Data Submission](#).

<sup>20</sup> Mass. Gen. Laws Ch. 12C, § 16(a) (2015).

<sup>21</sup> Massachusetts Health Policy Commission. [Hearing on the Potential Modification of the Health Care Cost Growth Benchmark](#) (March 2018).

<sup>22</sup> *Ibid.*

<sup>23</sup> Massachusetts Health Policy Commission. [HPC Sets Health Care Cost Growth Benchmark at 3.1% for 2020](#). Press Release. February 2020.

<sup>24</sup> CHIA. [Performance of the Massachusetts Health Care System: Annual Report](#). September 2018.

<sup>25</sup> Ibid.

<sup>26</sup> [H. 4134, 191st Legislative Session](#) (Mass, 2019).

<sup>27</sup> Massachusetts Office of the Attorney General. [Examination of Health Care Cost Trends and Cost Drivers](#). October 2019.

<sup>28</sup> [S.B. 1067 § 27, 2017 Reg. Legislative Session](#) (Or, 2017).

<sup>29</sup> [S.B. 419, 2017 Reg. Legislative Session](#) (Or, 2017).

<sup>30</sup> Oregon Joint Interim Task Force on Health Care Cost Review. [Senate Bill 419 Report to the Oregon Legislature](#). August 2018.

<sup>31</sup> [S.B. 889, 2019 Legislative Session](#) (Or, 2019).

<sup>32</sup> S.B. 889, 2019 Legislative Session, § 5 (Or, 2019).

<sup>33</sup> [S.B. 1067 § 31, 2017 Reg. Legislative Session](#) (Or, 2017).

<sup>34</sup> S.B. 889, 2019 Legislative Session, § 2.2 (Or, 2019).

<sup>35</sup> S.B. 889, 2019 Legislative Session, § 4.2(a) (Or, 2019).

<sup>36</sup> S.B. 889, 2019 Legislative Session, § 5.2 (Or, 2019).

<sup>37</sup> McConnell, K.J. [Health Care Spending & Price Overview](#). Oregon Health and Science University. March 2018. For more information, also see: Fulton, B. D. [Health care market concentration trends in the United States: evidence and policy responses](#). *Health Affairs*, 36(9), 1530–1538. September 2017.

<sup>38</sup> [Trillium Community Health Plan v. Legacy Health, et al.](#), United States District Court, 2019.

<sup>39</sup> Bolante, A. [Two Oregon health care giants join forces in Medicaid](#). *Portland Business Journal*. August 2019.

<sup>40</sup> S.B. 889, 2019 Legislative Session, § 4.2(a) (Or, 2019).

<sup>41</sup> Kaiser Family Foundation. [Distribution of Health Care Expenditures by Service by State of Residence: Oregon](#). June 2017.

<sup>42</sup> Health Care Cost Institute. [2017 Health Care Cost and Utilization Report](#). February 2019.

<sup>43</sup> [Oregon. Gen. Laws Ch. 845](#) (2015).

<sup>44</sup> Oregon Health Authority. [Hospital Reporting Program](#). Office of Health Analytics. 2018.

<sup>45</sup> White, C., & Whaley, C. (2019). [Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely](#). RAND Corporation. May 2019.

<sup>46</sup> [Oregon. Gen. Laws Ch. 7](#) (2018).

<sup>47</sup> Similar legislation in California (SB-17), which requires pharmaceutical manufacturers to justify certain price increases and provide state payers with 60 days' notice before raising prices, has faced a free speech rights and the constitutional Commerce Clause challenge in *Pharmaceutical Research and Manufacturers of America (PhRMA) v. David et al.* (Case No. 2:17-cv-02573).

<sup>48</sup> Oregon Governor's Office. [Governor Brown Announces Committee to Address Rising Health Care Costs](#). Press Release. October 2019.

<sup>49</sup> [House Joint Resolution 7](#), 149th General Assembly (Del, 2017).

<sup>50</sup> Delaware Health and Human Services (DHSS). [Report to Governor Carney on Establishing a Health Care Benchmark](#). August 2018.

<sup>51</sup> [Delaware Executive. Order No. 25](#) (2018); DHSS. [Health Care Spending Benchmark](#), 2019.

<sup>52</sup> DHSS. [Delaware Health Care Spending and Quality Benchmarks Implementation Manual Version 1.0](#). January 2019; DHSS. [Delaware Health Care Spending and Quality Benchmarks Implementation Manual Version 2.0](#). May 2019.

<sup>53</sup> Ibid.

<sup>54</sup> Ibid.

<sup>55</sup> DHSS. [Delaware Spending and Quality Benchmarks, Insurer Technical Briefing](#). May 2019.

<sup>56</sup> Rhode Island Office of the Health Insurance Commissioner. [The Affordability Standards: A Summary](#). October 2012.

<sup>57</sup> The Milbank Memorial Fund. [Compact to Slow Health Care Spending Growth Signed in Rhode Island](#). February 2019.

<sup>58</sup> Rhode Island Office of the Health Insurance Commissioner. [The Affordability Standards: A Summary](#). October 2012.

<sup>59</sup> Baum, A., Song, Z., Landon, B.E., Phillips, R.S., Bitton, A., & Basu, S. [Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers](#). *Health Affairs*, 38(2), 237–245. February 2019.

<sup>60</sup> [Rhode Island Executive Order No. 19-03](#) (2019); [Rhode Island Health Care Cost Trends Steering Committee](#). Meeting materials. August 2018.

<sup>61</sup> Rhode Island Health Care Cost Trends Steering Committee. [Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island](#). November 2018.

<sup>62</sup> State Health & Value Strategies. [Leveraging Multi-Payer Claims Databases for Value](#). Webinar. March 27, 2019.

<sup>63</sup> State of Rhode Island. [Leveraging HealthFacts RI for Value: Analysis and Recommendations](#). Stakeholder Meeting May 2019.

<sup>64</sup> State of Rhode Island. [Rhode Island Healthcare Cost Growth Target, Implementation Manual](#). July 2019.

<sup>65</sup> Provider resources applied in the delivery of care for uninsured Rhode Islanders are excluded from calculations of healthcare spending because they are technically not “spending” as defined by the Steering Committee.

<sup>66</sup> Most behavioral healthcare coverage in Rhode Island is provided through the insurer. Behavioral health carve-out is small and the trend is stable.

<sup>67</sup> Based on latest Technical Notes.

<sup>68</sup> CHIA. [2018 Report on the Performance of the Massachusetts Health Care System](#). Technical Appendix. September 2018.

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