HEALTH INNOVATIONS (B) WORKING GROUP
2019 SUMMER NATIONAL MEETING
SATURDAY, AUGUST 3, 2019
NEW YORK, NEW YORK

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Draft: 4/15/19

Health Innovations (B) Working Group
Orlando, Florida
April 6, 2019

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Orlando, FL, April 6, 2019. The following Working Group members participated: Marie Ganim, Chair (RI); Martin Swanson, Vice Chair, and Laura Arp (NE); Andrew Stolfi, Vice Chair (OR); Sarah Bailey (AK); Steven Ostlund (AL); Howard Liebers (DC); Andria Seip (IA); Alex Peck and Karl Knable (IN); Julie Holmes (KS); Carrie Couch (MO); Jon Godfread and Chrystal Bartuska (ND); Philip Gennace (NJ); Paige Duhamel (NM); Alison Beam (PA); Raja Malkani (TX); Jaakob Sundberg (UT); Molly Nollette (WA); and Olivia Hwang, Nathan Houdek and Jennifer Stegall (WI). Also participating were: Lucy Jabourian and Perry Kupferman (CA); Michael Conway and Peg Brown (CO); Paul Lombardo (CT); Jennifer Reif (IL); Kevin Dyke (MI); Grace Arnold (MN); Troy Oechsner (NY); Jill Kruger (SD); and Mike Humphreys (TN).

1. Reviewed its Charges

Health Insurance Commissioner Ganim welcomed members and attendees and provided an overview of the Working Group's charges, which the Working Group approved March 21 by e-vote.

2. Heard a Presentation on Governors' Initiatives on Health Innovations

Caroline Picher (National Governors Association—NGA) discussed governors' efforts on federal Affordable Care Act (ACA) Section 1332 waivers, value-based purchasing, prescription drug pricing and surprise billing.

Mr. Swanson asked what governors believe to be the greatest hinderance to the states adopting Section 1332 waivers. Ms. Picher replied that the 2015 guidance released by the federal Centers for Medicare & Medicaid Services (CMS) was strict in its interpretation of the waiver guardrails. Mr. Swanson inquired whether the NGA is working to address this, and Ms. Picher explained that the NGA issued a statement when the guidance was first released, and it continues to work with the states on the issue.

Health Insurance Commissioner Ganim asked what reactions governors have had to the pass-through amounts under Section 1332 waivers. Ms. Picher said governors have had concerns with some of them when they came in below projections. She said, in general, governors want to get as much pass-through funds for their state as they can.

Mr. Oechsner asked whether the states that have taken steps to address prescription drug prices have been able to measure the impact of their efforts. Ms. Picher replied that a different team at the NGA works on prescription drug pricing, and she would have to get back to the Working Group.

3. Reviewed State Activity on Section 1332 Waivers

Joe Touschner (NAIC) provided context around state activity on Section 1332 waivers. He relayed that a majority of the states have taken legislative or executive action to consider a Section 1332 waiver, even if only eight states had made it through to approval of a waiver. He shared statistics on the seven approved reinsurance waivers, showing the percentage by which they are estimated to reduce individual market premiums, as well as the share of total program funding provided by the states.

4. Discussed a Reinsurance Proposal from Colorado

Mike Brown (Lewis & Ellis) shared the results of actuarial modeling of Colorado's original plan to reprice high claims based on Medicare rates and use the savings as the state funding for a reinsurance program. He briefly reviewed the methodology for the modeling, then he gave a pricing example for a high annual claim amount. He summarized the model results and provided potential reinsurance payment parameters.

Commissioner Conway explained that repricing will be removed from the plan due to concerns about federal approval of the waiver, but he said he expects to move ahead with state funding coming from an assessment on hospitals. He also explained that repricing would have required insurers to write new provisions into their contracts with providers, although some existing contracts had provisions that would make it work.

5. Discussed State Approaches to Section 1332 Waivers

Health Insurance Commissioner Ganim asked Working Group members to describe their states' experience with Section 1332 waivers, whether approved or in development.

Commissioner Stolfi described Oregon's waiver as more of a traditional reinsurance program. He noted the payment parameters. He cited as difficult the length of time between when a funding commitment is needed for the waiver application and when the money is actually paid. He had to tell carriers in the second quarter of 2017 how much they would receive for plan year 2018, but they would not be paid until 2019. This makes cash flow a mess and goes across state budgeting cycles.

Ms. Bohn said Minnesota got a lot of help from CMS in writing its application, but because much of the state's application was not approved, the state is revisiting its approach. She corrected an earlier reference to the state share of funding, saying the state will put up around $10 million. She said the states that do not have a Basic Health Program (BHP) would not have the same problems in establishing reinsurance.

Ms. Seip asked whether the states with reinsurance had seen an increase in enrollment. Ms. Bohn said Minnesota had not seen a significant increase, and Commissioner Stolfi said Oregon had difficulty in measuring, but reinsurance may have slowed the state's decline in enrollment.

Ms. Bailey described Alaska's reinsurance program and cited the detailed reporting and auditing requirements related to the receipt of federal funds as a difficulty.

Mr. Gennace explained New Jersey's reinsurance waiver. He said the CMS has been active in the implementation, and he pointed out that, unlike other states, the law allows the state to appropriate funds the year after the plan year.

Commissioner Stolfi asked whether the law established a limit on what the state would pay. Mr. Gennace said there is no limit, but the law has a target for the amount of premium reduction.

Ms. Bohn pointed out that Minnesota gets funds from the federal government the year before the plan year, noting that it may be because of the guarantees in the state's appropriations law. She said the state was surprised when the federal government based payments on her initial projections for the state's waiver application. She recommended clarifying expectations on this point.

Mr. Dyke said Michigan is in the midst of an actuarial study on reinsurance, and it is looking at options.

Commissioner Godfread said North Dakota's waiver bill is waiting for the governor's signature, and the state has begun accepting public comments.

The Working Group discussed whether the states prefer state reinsurance programs or the federal reinsurance program that existed from 2014 to -2016. Due to the workload and state funding requirements, several members agreed that the federal program was preferable.

6. Reviewed the Process for Updating EHBs

Ms. Reif explained the steps Illinois took to meet the short timeline for submitting a request to the CMS to update essential health benefits (EHBs) by the deadline. She described engaging contractors and the need for many staff hours to complete the required actuarial certifications and other documents. The updated EHBs will go into effect for plan year 2020.

Ms. Bohn asked whether the issue of defraying the cost of newly mandated benefits came up. Ms. Reif said Illinois demonstrated that the changes were cost-neutral because they were merely clarifying the scope of the benefit. Ms. Bohn asked whether a state law gave the Illinois Department of Insurance the authority for the update. Ms. Reif said authority was not an issue, because preexisting state law gave the department broad authority.

Ms. Kruger said South Dakota is looking at this now, but state insurance regulators are concerned with the deadlines. She asked whether all documents need to be in a final state at the deadline. Ms. Reif said Illinois made changes after the deadline, and CMS was open to considering the updated information. She stressed the importance of using evidence-based resources, which make the process smoother.

Health Insurance Commissioner Ganim and Ms. Duhamel said Rhode Island and New Mexico are also considering updates to their EHBs.

The Working Group discussed how to achieve cost-neutrality. Ms. Bohn warned that it is hard to measure cost savings from enhancing a particular benefit. She suggested that it is easier to reduce another benefit, and she said most benefits only make a small contribution to costs, so the needed reductions are also small.

7. Discussed Innovative Initiatives from Working Group Member States and Future Directions for the Working Group

Health Insurance Commissioner Ganim asked the Working Group to report on health innovation efforts in their states and mention which ideas they would like the Working Group to devote time to in future meetings.

Working Group members mentioned state individual mandates, including Maryland's down payment proposal; Medicaid buy-ins; other public options; regulation of pharmacy benefits managers (PBMs); health care cost growth targets; and fees for employers who do not provide a threshold level of funds for health coverage.

Having no further business, the Health Innovations (B) Working Group adjourned.

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Draft: 7/29/19

Health Innovations (B) Working Group
Conference Call
July 11, 2019

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met via conference call July 11, 2019. The following Subgroup members participated: Marie Ganim, Chair (RI), Martin Swanson, Vice Chair, and Laura Arp (NE); Andrew Stolfi, Vice Chair (OR); Jacob Lauten and Sarah Bailey (AK); William Rodgers (AL); Andria Seip (IA); Alex Peck and Claire Szpara (IN); Julie Holmes (KS); Robert Wake (ME); Amy Hoyt, Danielle McAfee-Thoenen and Jessica Schrimpf (MO); Jeff Ubben (ND); Jennifer Patterson (NH); Chanell McDevitt (NJ); Paige Duhamel (NM); Annette James, Mark Garratt and Zhuang Zhang (NV); Alison Beam, Jessica Altman, Katie Dzurec and Sandra L. Ykema (PA); Rachel Bowden (TX); Heidi Clausen, Jaakob Sundberg and Tanji Northrup (UT); Molly Nollette (WA); Diane Dambach and Jennifer Stegall (WI); and Joylynn Fix (WV). Also participating were: Vincent Gosz (AZ); Chris Struk FL); Arlene Ige (HI); Donna Daniel and Kathy McGill (ID); Tyler Hoblitzell (MD); Kristi Bohn, Melinda Domzalski-Hansen and Sherri Mortensen-Brown (MN); Bob Williams (MS); Janell Williams and Pam Koenig (MT); Robert Croom (NC); Kendall Buchanan (SC); Candy Holbrook and Gretchen Brodkorb (SD); and Rachel Jrade-Rice (TN).

1. Discussed State Activity on Section 1332 Waivers

Health Insurance Commissioner Ganim said that the Working Group is looking to hear updates and challenges from states with regard to waivers under Section 1332 of the federal Affordable Care Act (ACA).

She described Rhode Island's experience of having large rate increases combined with the loss of the individual mandate and other destabilizing forces. She said that a workgroup including businesses and advocates met and developed a plan based on New Jersey's 1332 waiver. It includes an individual mandate. Rhode Island expects a 5% to 7% reduction in rates under its waiver.

Ms. Duhamel asked whether any states were considering waivers not for reinsurance, but to wrap federal premium tax credits with additional subsidies. Ms. Dzurec said she would also like to hear from states that have considered subsidy wraps, even if they have ultimately been rejected.

Ms. Williams described Montana's waiver application. She said that like Rhode Island, the state saw significant premium increases and convened a working group. Montana's state funds for reinsurance would come from a fee on all insured members. The reinsurance program would total $34 million and was estimated to reduce premiums 6% to 8%. Actual premium submissions are coming in around 9% lower. She encouraged other states to reach out early to the staff at the federal Centers for Medicare and Medicaid Services (CMS) and said that the main contacts are Lina Rashid, Michelle Koltov and Adam Shaw.

Mr. Ubben described North Dakota's waiver application. He said the state portion will be $43 million over 10 years. While the funds would immediately come from an assessment on large and small group plans, they would ultimately come out of state revenues because plans would be able to reduce their state tax payments by the amount of the assessment. The plans also agreed not to pass the assessment on to consumers. He said North Dakota expects $50 million over two years from the federal government and a rate reduction of 15% to 20%.

Health Insurance Commissioner Ganim said that states with approved waivers have already shared valuable information with other states and asked for any additional updates. Ms. Bailey said that Alaska recently held its annual public forum, but there was little participation because it is an invisible program. She said the state realigned time frames for reporting to ease the burden on issuers. Mr. Wake said that Maine's program is functioning smoothly. Ms. Bohn reported that Minnesota's legislature chose to reinstate the reinsurance program after its initial two-year authorization and that a board of directors was added to provide more governance for the outside agency that implements the program. Commissioner Stolfi said that Oregon approved a six-year extension of its program and raised the assessment that funds it, though some funds also go to Medicaid. He said that challenges include a lack of transparency on federal funding amounts, the difficulty in setting up a new state program, and the time lag of 2.5 years between issuers' rate setting and when they are actually paid the reinsurance amounts. He said the state is already questioning what to do when the program ends because without it, rates will go back up.

Commissioner Altman said that Pennsylvania is just getting started because in the previous week, Pennsylvania's governor signed a bill to create a state-based exchange (SBE) and a reinsurance waiver. She said the state will retain the existing user fee and use part to fund the SBE and the remainder to fund the waiver.

Ms. Arp asked about the CMS guidance from October 2018 and whether states believe there is truly flexibility in the requirement to have state legislation authorizing a waiver, particularly if the waiver does not require state funding. Ms. Seip said that Iowa proposed a waiver that used existing state authority, not a new law. She said that Iowa's proposal failed for other reasons; the existing authority was sufficient for CMS.

The Working Group discussed whether reinsurance waivers led to increased enrollment, and several members commented that they are more likely to have slowed declines in enrollment than to generate true increases.

2. Discussed its Meeting at the Summer National Meeting

Health Insurance Commissioner Ganim reviewed the planned agenda for the Working Group's meeting at the Summer National Meeting. She said there would be a presentation from Chapin White (RAND) on payments to hospitals and one from Joel Ario (Manatt Health) on a toolkit of cost control ideas. She said that she wants to hear from Working Group members on what they are working on or questions they have. Ms. Nolette said that she is working on Cascade Care, as known as Washington's public option, to drive down rates. Ms. Seip asked if other states are seeing growth in direct primary care and whether insurance companies work with these services to provide coverage for non-primary care services. Health Insurance Commissioner Ganim said that it would be good to discuss how to regulate insurance plans in such an environment.

Having no further business, the Health Innovations (B) Working Group adjourned.

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Findings from an Employer-led Hospital Price Transparency Study: Implications for State Regulators

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
HEALTH INNOVATIONS WORKING GROUP

AUGUST 3, 2019

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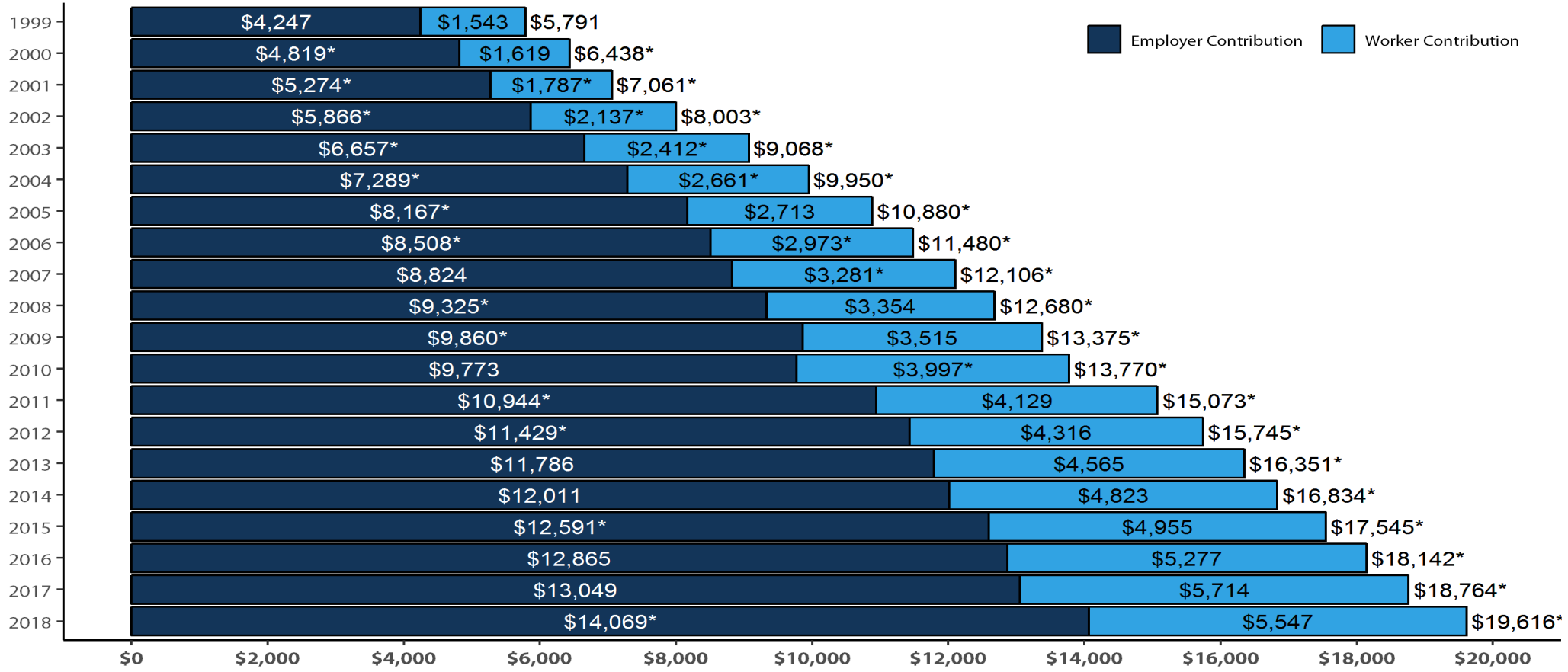
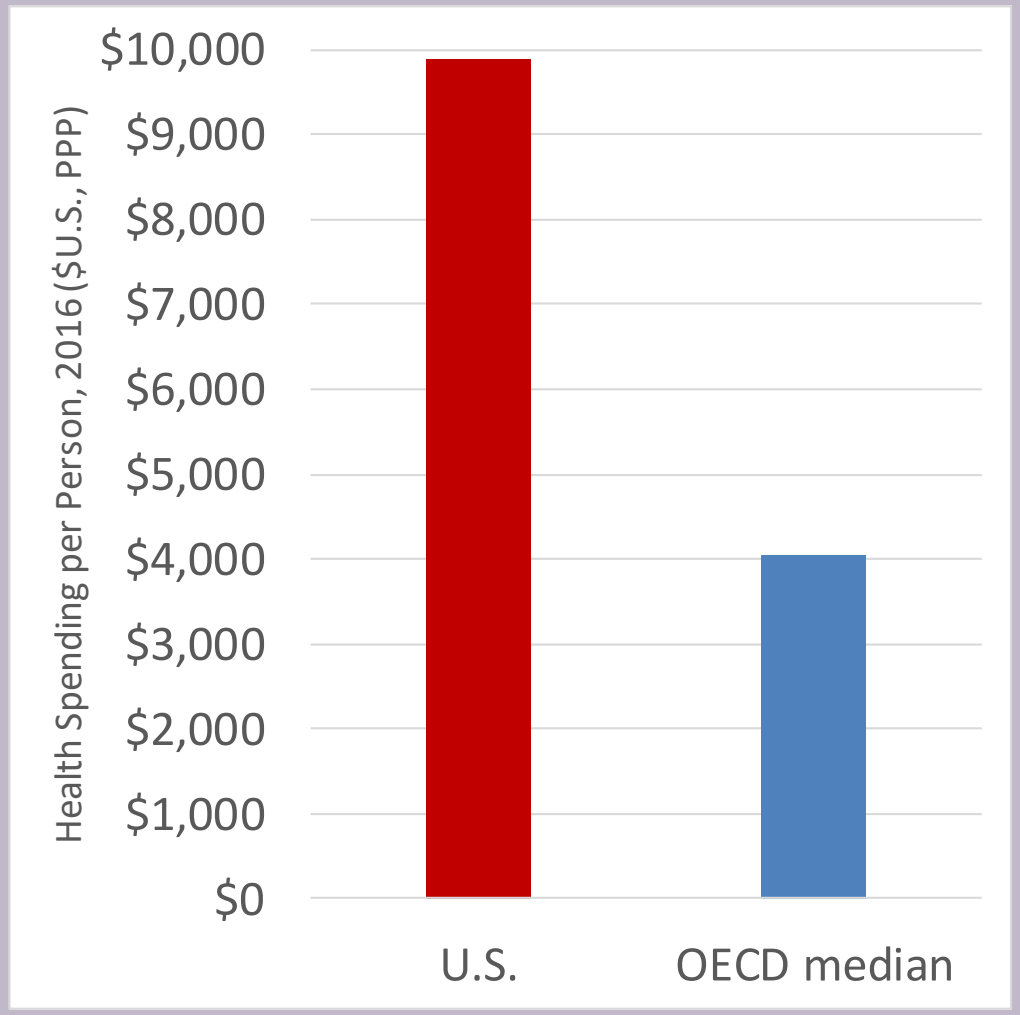
The Context: Rising Employer and Employee Premiums



*Estimate is statistically different from estimates for the previous year shown (p<.05).

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits. 1999-2017

Private Hospital
"It's Still the Prices, Stupid"

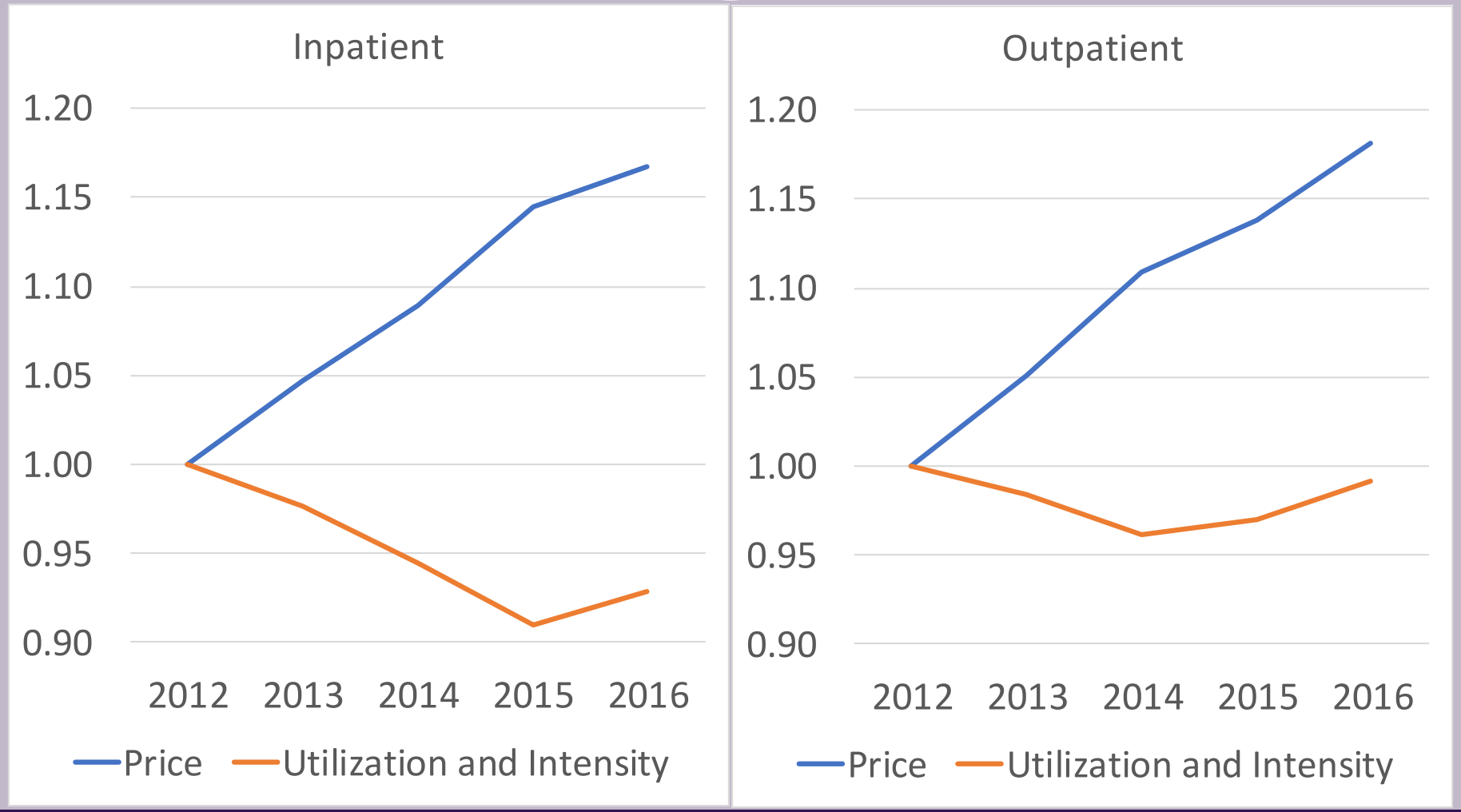


- Why private health plans?
  - persistently high growth in spending per capita
- Why hospitals?
  - $1.1T industry
  - private prices high, rising, and widely varying

Source: Anderson, G. F., Hussey, P., & Petrosyan, V. (2019). It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt. *Health Affairs, 38(1), 87-95. doi:10.1377/hlthaff.2018.05144.*

Inpatient Use Continued to Decline but Prices Rose Substantially

Outpatient Prices Drove Spending Growth



Health Care Cost Institute. (2018). *2016 Health Care Cost and Utilization Report. Retrieved from* http://www.healthcostinstitute.org/report/2016-health-care-cost-utilization-report/. Prices are from Appendix Table A3,, utilization and intensity is estimated by dividing spending (from Appendix Table A1) by prices.

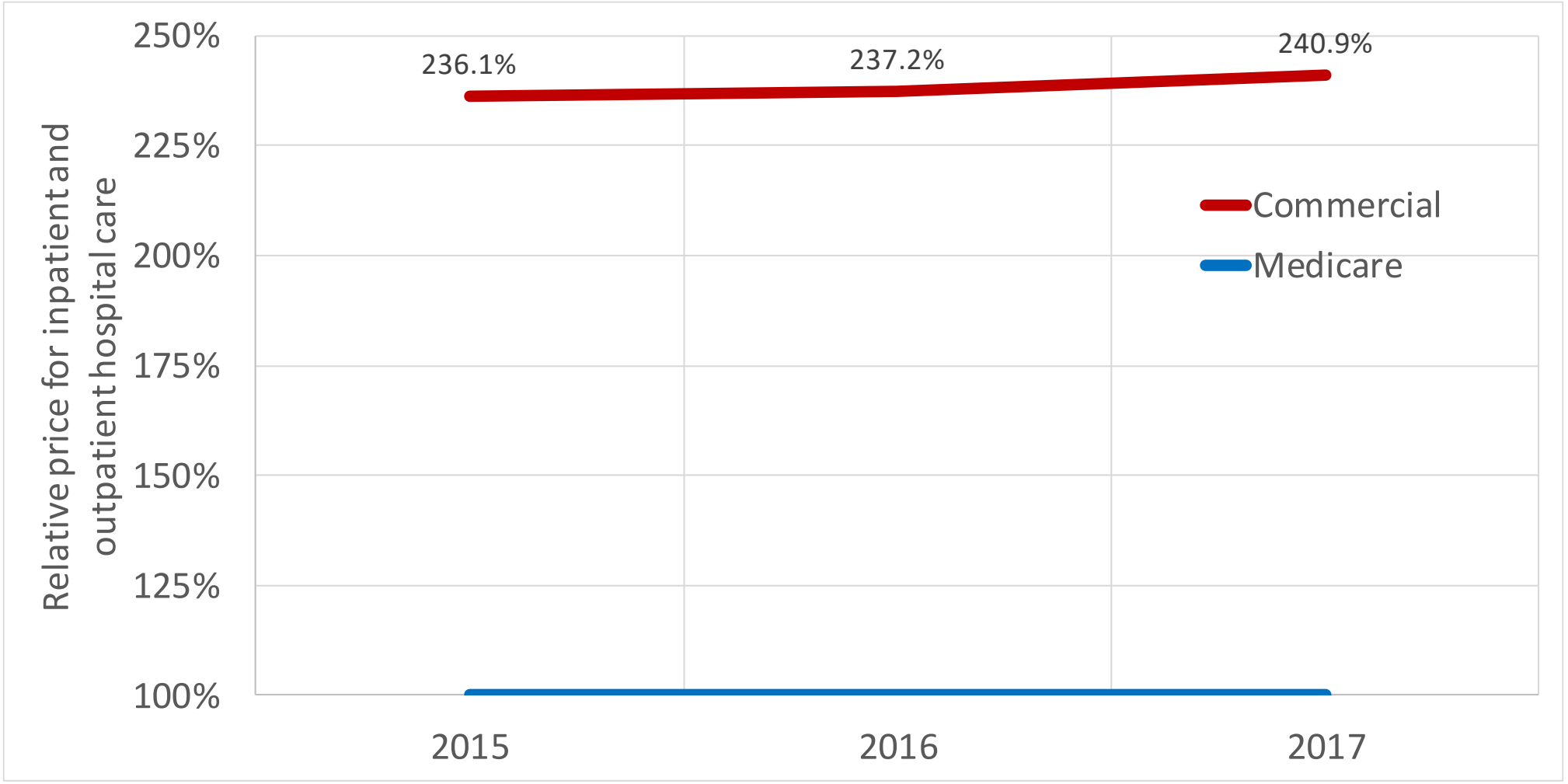
National Study ("RAND 2.0"): Methods and Data

- Obtain claims data from
  - self-funded employers, APCDs, health plans
- Measure prices in two ways
  - relative to a Medicare benchmark
  - price per casemix weight
- Create a *public* hospital price report
  - freely downloadable (https://www.rand.org/pubs/research_reports/RR3033.html)
  - hospitals and hospital systems *identified by name*
  - inpatient prices and outpatient prices

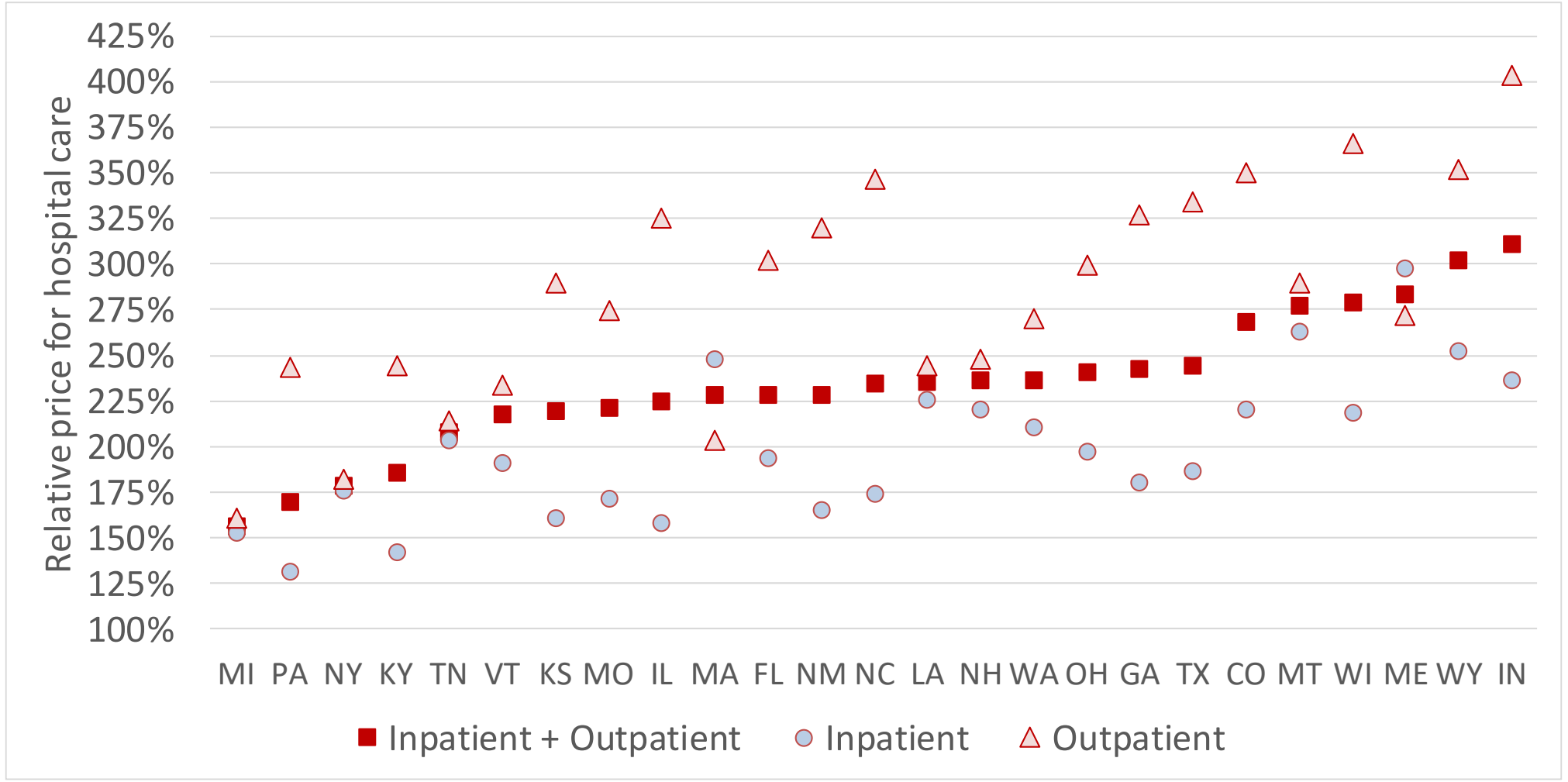
Why Compare to Medicare?

- Largest purchaser of health care in the world
- Sets industry standards
- Prices and methods are empirically based and transparent
- Medicare prices intended to be fair
- Uses quality measures/value-based payment

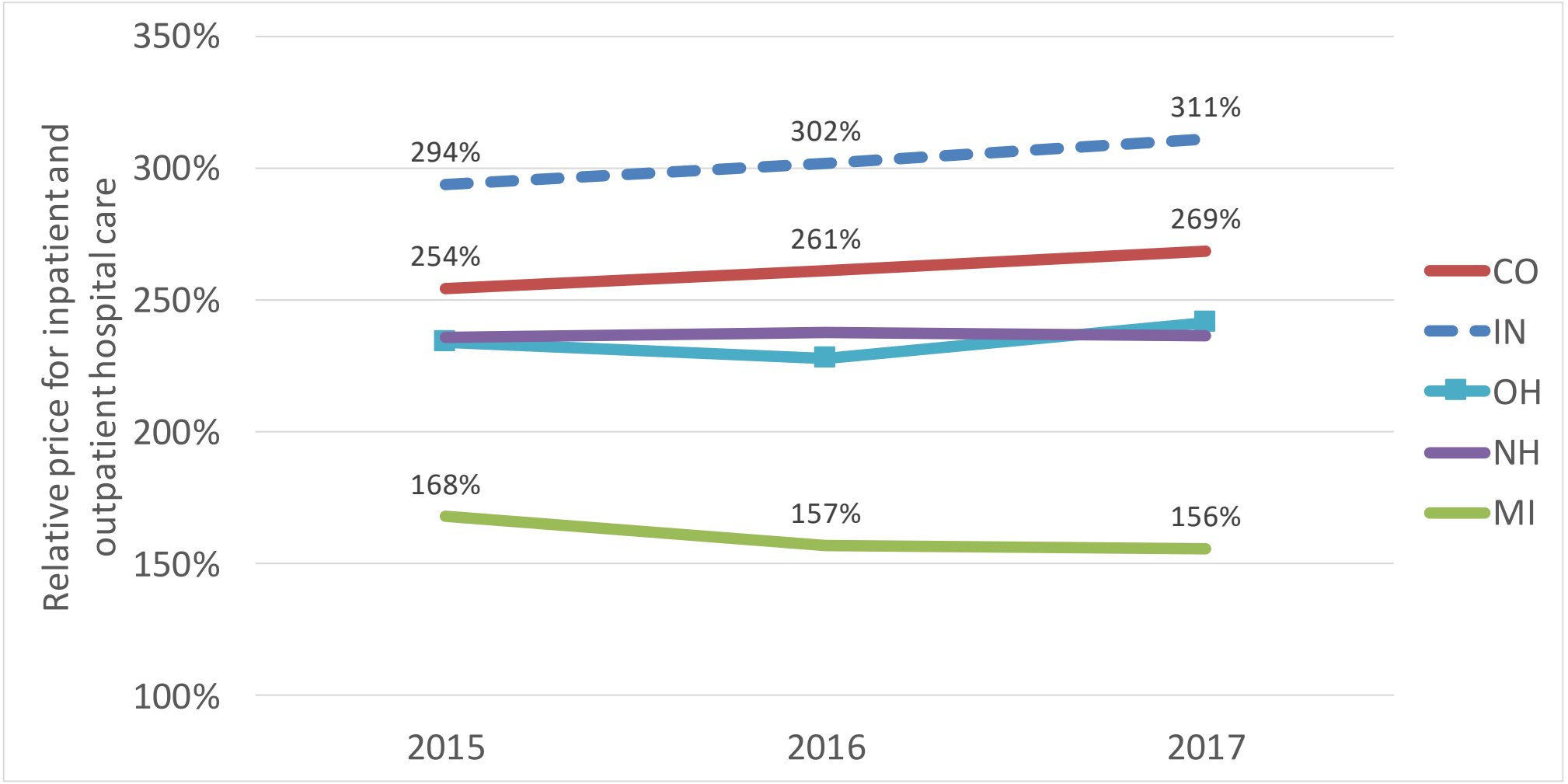
All-State Trends in Hospital Prices Relative to Medicare



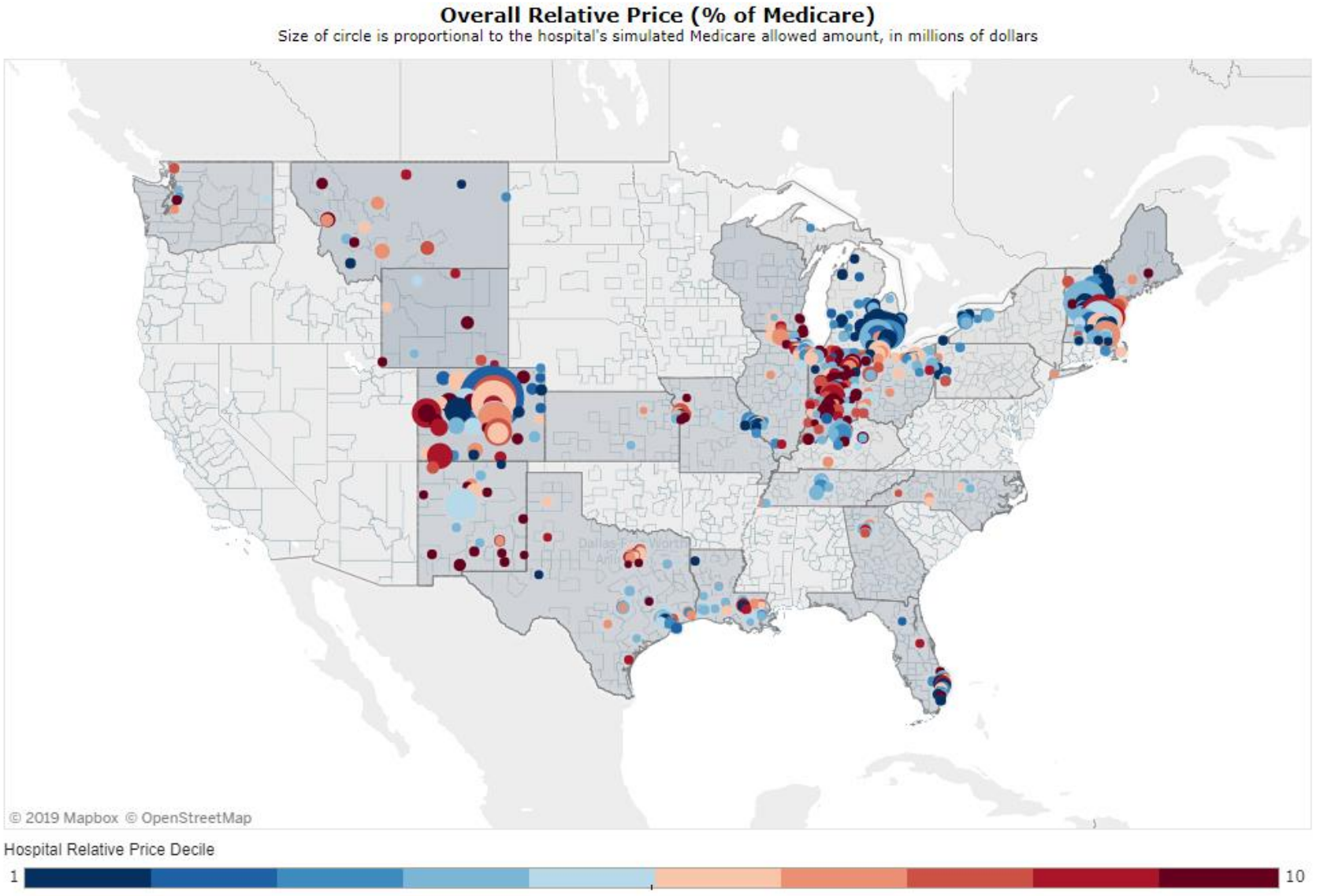
State Average Relative Prices, 2017



State Trends in Relative Prices, 2015-7



The National Hospital Price Landscape



Source: https://employerptp.org/#visualize

Hospital Prices: What Does it Mean?

Prices paid to hospitals by private health plans

do not reflect a functioning competitive market

The Three-legged Glitch

Leg 1. bilateral negotiations over prices & networks

\+

Leg 2. uncapped obligation for out-of-network care

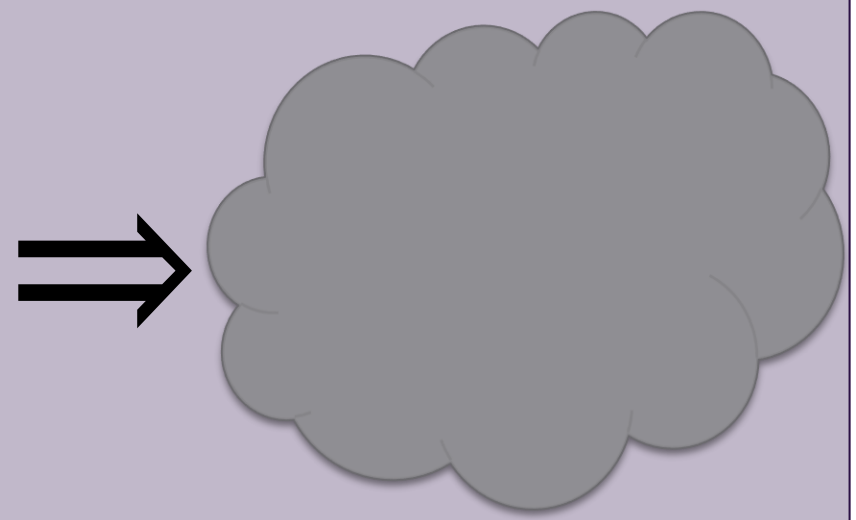
\+

Leg 3. widespread unshoppability

a. natural monopolies

b. humanmade monopolies

c. emergencies



The Three-legged Glitch

Leg 1. bilateral negotiations over prices & networks

+

Leg 2. uncapped obligation for out-of-network care

+

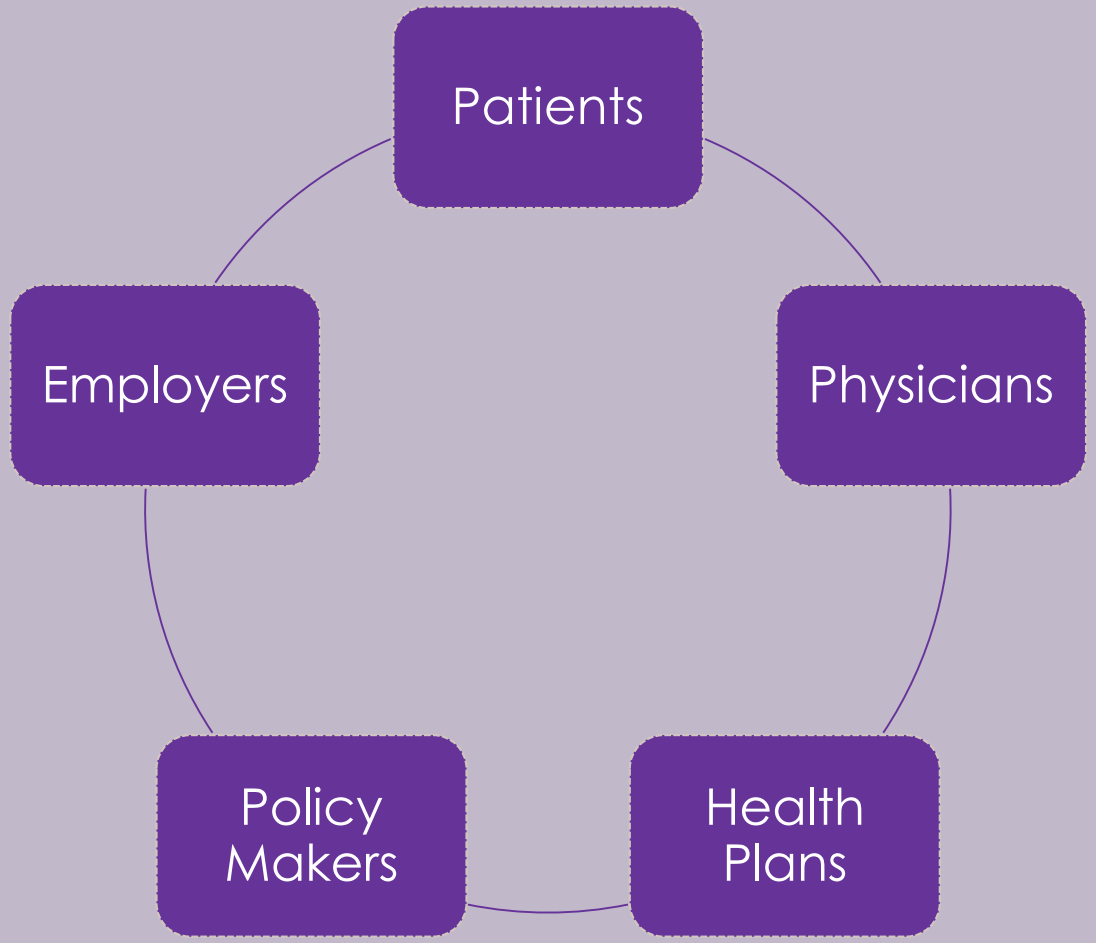
Leg 3. widespread unshoppability

a. natural monopolies

b. humanmade monopolies

c. emergencies

Takeaway #1: Hospital Shopping *Should be* a Team Sport



Takeaway #1: Hospital Shopping *Is …*

- "Chaos behind a veil of secrecy" (Uwe Reinhardt)
- "Where there's mystery there's margin"

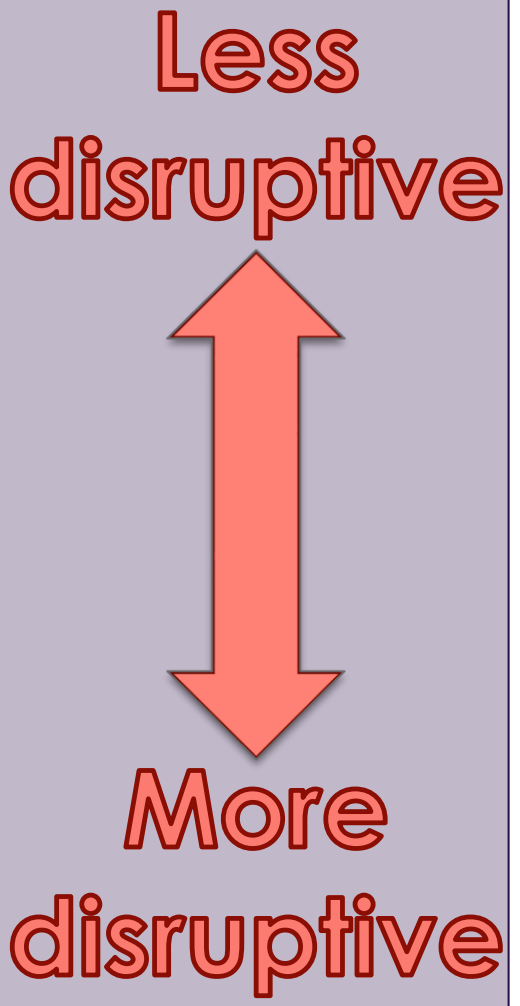
- Consolidated markets + secrecy
  ⇨ highest health care prices in the world

Takeaway #2: How You Pay Matters

- How does Medicare pay?
  - base $ * facility-specific adjustments * casemix + outliers + bonuses
- How do private health plans pay?
  - mix of DRGs, discounted charges, per diems, fixed rates, P4P, shared savings …
- Multiple-of-Medicare contracting
  - simplifies shopping
  - bakes in value-based payment (bundling, P4P)
  - stabilizes price trend

Takeaway #3: The Inevitability of Hospital Price Controls

- State legislation limiting payments for out-of-network care
- State regulation of health plan contracts with hospitals (Rhode Island, Baum et al., 2019)
- State-based public option (Washington State)
- Medicare buy-in
- Direct state rate regulation (Maryland)
- State-based single payer (New York)
- Medicare for All



Baum, Aaron, Zirui Song, Bruce E. Landon, Russell S. Phillips, Asaf Bitton, and Sanjay Basu, "Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers," *Health Affairs, Vol. 38, No. 2, 2019, pp. 237-245.*

Links

- Public report
  - https://www.rand.org/content/dam/rand/pubs/research_reports/RR3000/RR3033/RAND_RR3033.pdf
- Detailed data
  - https://www.rand.org/content/dam/rand/pubs/research_reports/RR3000/RR3033/RAND_RR3033.data.zip
- Interactive map
  - https://employerptp.org/#visualize
- FAQ on enrolling in next round
  - https://employerptp.org/wp-content/uploads/2019/05/RAND-EFI-hospital-price-transparency-study-Round-3.0-FAQ.pdf

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Landscape of State Cost-Containment Initiatives

August 2019

Presented to:

National Association of Insurance Commissioners (NAIC) Summer National Meeting

Presented by:

Joel Ario, Managing Director, Manatt Health Strategies

Kathy Hempstead, Senior Policy Adviser, Robert Wood Johnson Foundation

Funded by the Robert Wood Johnson Foundation

Content

States Shifting Back Toward Affordability

States face different market dynamics, but a common theme is that lack of affordability is impeding further progress on expanded access

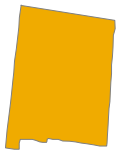
- Manatt Health found some similarities and some differences across the four states profiled on their cost-containment initiatives.
  - In all four states, the individual market was 6% of the total market, but the share on-Exchange vs. off-Exchange varied.
  - The Medicaid share of market varied widely, from 18% in Maryland to 34% in New Mexico.
- In all four states, cost-containment cut across agency lines, with insurance departments playing varying roles based on state history and the nature of cost-containment initiatives.
- All four states had made progress on expanding access under the Affordable Care Act (ACA) but are putting more emphasis on affordability for two reasons:
  - The likelihood of federal action to address affordability is small in the short term.
  - Improved affordability is seen as critical to continued expansion of access.

The Role of Insurance Departments Varies

Public Option

- States may expand affordable coverage options by offering state-sponsored plans on their Exchanges.
- Insurance Departments are likely to be major players in the design and implementation of such programs.

Medicaid Buy–ins



- States may allow Medicaid buy-in options outside of the commercial market to expand access to affordable coverage for those who would not otherwise qualify for subsidies (e.g., non-residents).
- Insurance Departments likely to play less of a role, though there will be concerns about impact on Exchanges and wider commercial market as scope of Medicaid-buy-in increases.

Cost Benchmarking

- States may implement health system performance reporting to better understand their cost-drivers against a pre-set benchmark; reporting allows policy-makers to take targeted actions.
- Insurance Departments may have an important regulatory and convening role (e.g., Rhode Island Commissioner involvement) depending on the initiative's design.

Drug Pricing

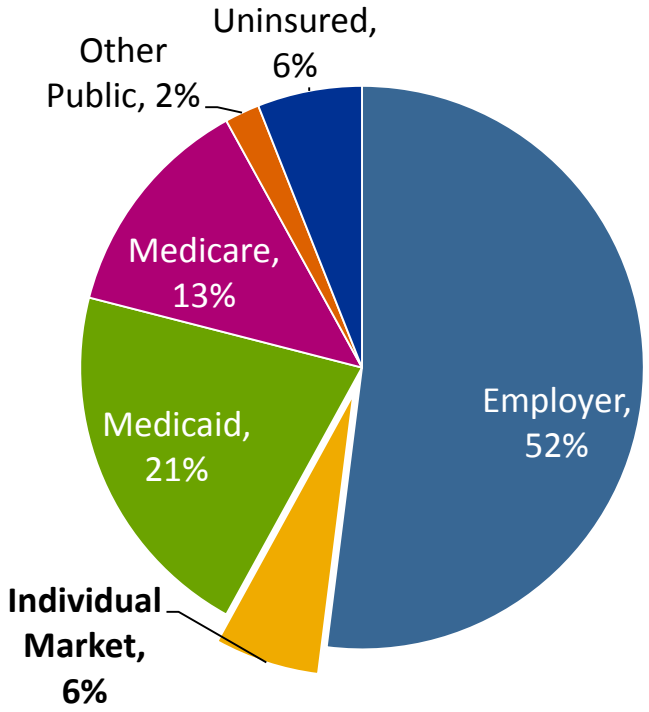
- States may pursue drug pricing as the leading cost-driver with both transparency and price regulation strategies.
- Insurance Department involvement may vary depending on governing statutes and whether there are other state regulators more knowledgeable about the issues of interest.

Public Option

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

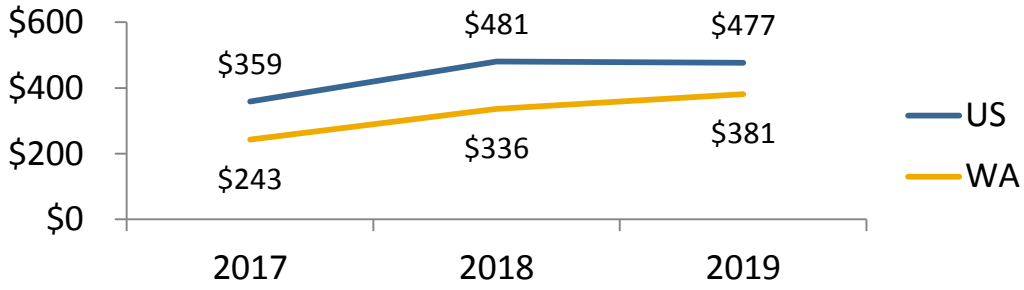
Washington is the first state to enact a public option to address affordability and limited insurer participation in the Exchange

Health Insurance Coverage (2017)

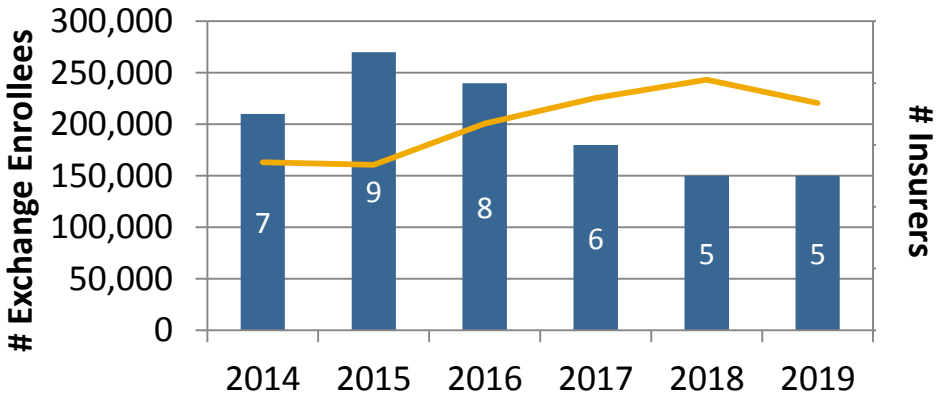


On-Exchange (2018): 243,227
(61%* received subsidies)
Off-Exchange (2018): 60,565

Average Exchange Benchmark Premiums (2017-2019)



Number of Exchange Enrollees and Insurers (2014-2019)



*Calculated based on effectuated Exchange enrollees, while the on-Exchange total is the number who selected a Exchange plan.

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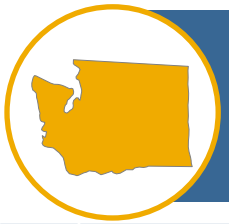
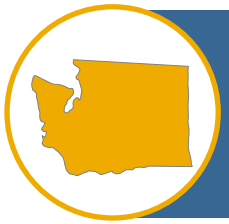
Washington State: First-in-the-Nation State Public Option



Despite a largely stable market, Washington continues to strive for increased affordability and cost-containment for customers and the government

	Initiative	Description	Lead Agency (or Agencies) and Role
Featured & Related Initiatives	**Standardized Plans & Washington Public Option (2019)**	Requires qualified health plan (QHP) carriers to offer Exchange plans with standardized deductibles and cost-sharing starting in 2021 The State contracts with one or more existing health carriers to offer state-sponsored QHPs, known as "Cascade Care," on the Marketplace *Note: Standardized plans will address cost-sharing while public option plans will address premiums.*	▪ **Washington Health Benefit Exchange (HBE)** designs standardized plan parameters for *all* Exchange bronze, silver, and gold-levels plans. Public option plans must conform to QHP standards. ▪ **Health Care Authority (HCA)** negotiates and contracts with health carriers to offer the Cascade Care QHP, which will incorporate delivery system reforms designed to reduce costs. ▪ **Office of the Insurance Commissioner (OIC)** approves rates, networks, and other QHP compliance.
Other Initiatives	**Prescription Drug Cost Transparency (2019)**	Mandatory cost data reporting	▪ **HCA** enforces fines and must publish report on website beginning January 1, 2021.
	"Subscription" Model for Hepatitis C (HCV) Drug Payment in Medicaid (2019)	Paying a negotiated, fixed annual fee to manufacturer for an unlimited supply of drugs for government healthcare programs	▪ **Department of Health (DOH)** develops HCV elimination plan. ▪ **HCA** coordinates with DOH, Centers for Medicare & Medicaid Services (CMS), and other agencies and purchasers to implement comprehensive procurement strategy.
	Tying Insurer Participation in State and School Employee Plans to the Exchange (2018)	Starting in 2020, requires carriers to offer at least one silver and one gold QHP in the Exchange in any county in which they also offer a fully insured health plan to state or school employees	▪ **HCA** performs an actuarial review during the annual rate setting process to ensure carriers' compliance.

Deep Dive: First-in-the-Nation State Public Option



The goal of Cascade Care is to reduce premiums through HCA purchasing leverage and reduce cost-sharing for key services through standardized benefit designs

- The three state agencies (HBE, HCA, OIC) are working closely on all aspects of implementation.
  - HBE is currently developing standardized plans, that must reduce deductibles, make more services available before the deductible, provide predictable cost-sharing, maximize subsidies, limit premium impact, etc. The public option plans will mirror the standardized plan cost-sharing design.
  - HCA will contract with insurers and ensure that plans are aligned with delivery reform and value-based purchasing strategy. These requirements may include standards for population health management; high-value, proven care; health equity; primary care; care coordination and chronic disease management; wellness and prevention; and patient engagement.
  - OIC will approve and the HBE Board will certify HCA-administered contracts for the public option plans.

Process Timeline

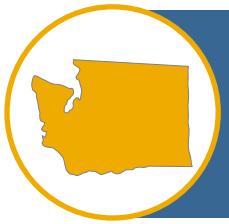
Stakeholder Engagement
June 2019 - December 2019

Plan Procurement Process
January 2020 - June 2020

Plan Approval and Certification
June 2020 - September 2020

Cascade Care Introduced
November 2020

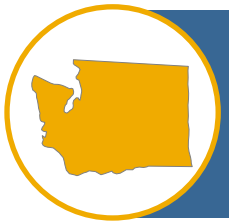
Deep Dive: First-in-the-Nation State Public Option



In Cascade Care plans, provider reimbursement rates will be benchmarked to Medicare rates, and are expected to lower premiums and increase quality and value

- The public option plans will be subject to the following provider reimbursement rate requirements:
  - **Aggregate cap:** The total amount a carrier reimburses providers and facilities cannot exceed 160% of Medicare rates
    - *Exceptions:* If the cap will raise premiums; if plans can achieve 10% premium reductions through other means; and/or plans are unable to form adequate networks given the reimbursement restrictions
  - **Primary Care Physician (PCP) Floor:** Reimbursement for primary care may not be <135% of Medicare rates
  - **Rural Floor:** Reimbursement for services provided by rural hospitals may not be <101% of Medicare rates (allowable costs)

Deep Dive: First-in-the-Nation State Public Option



Potential challenges include network adequacy, balancing the needs of the subsidized and unsubsidized populations, and limited impact on affordability

Key Challenges

1. **Providers are not required to participate in the public option, which may result in network adequacy issues.**
   - The plan also prohibits carriers from tying provider reimbursement rates in the public option plan with participation in other plans that the carrier offers.
2. **The legislation does not fund additional subsidies for enrollees >400% Federal Poverty Level (FPL).**
   - The plan should reduce premiums for the unsubsidized, but also will impact subsidies by reducing benchmark premiums.
3. **The 160% reimbursement cap may not result in significant changes in affordability for customers.**
   - Current Exchange plan reimbursement rates are estimated to be 175% of Medicare. According to an actuarial analysis, the cap and other design provisions will result in only 5-10% premium savings.

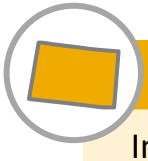
Additional Commissioned Reports

- **Due Dec. 2022:** HCA, OIC, and HBE are required to study the potential impacts of tying carrier and provider participation in public option plans to the state employee health plan or Medicaid program.
- **Due Nov. 2020:** HBE, in consultation with HCA and OIC, must develop a plan for using state funds to limit premiums to 10% of income for enrollees with incomes <500% FPL, including an analysis of providing cost-sharing reductions.

Public Option/Reference Pricing in Other States

Multiple states considered public option programs this legislative session; other states are considering reference pricing programs, a key component of reducing costs in public option programs

Public Option



Colorado

In April 2019, Colorado passed legislation directing the Department of Health Care Policy & Financing and the Division of Insurance to recommend a "state option for health care coverage" by November 2019 for implementation in 2021.

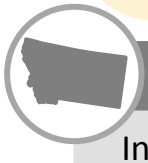
- The plan must assess costs, funding sources, necessary federal permissions and funding, consumer eligibility and state agency roles.
- Colorado has held 5 of 11 stakeholder meetings.

Connecticut

In May 2019, lawmakers proposed but did not pass legislation authorizing a work group to establish a public plan, "ConnectHealth," by 2021. The proposed plan would be offered in partnership with an existing insurer and be designed with premiums at least 20% lower than existing options.

- The legislation also included an individual mandate, reinsurance program, a healthcare growth benchmark, and drug reforms.

Reference Pricing



Montana

In 2016, Montana implemented reference pricing for hospitals in the State of Montana Benefit Plan, its state employee health plan (SEHP).

- The reference price is set at 234% of Medicare rates on average.
- The new reimbursement model is estimated to have saved $13.6 million in the past 3 years.
- Montana is considering expanding the program to cover city, county, and university employees.

North Carolina

In October 2018, North Carolina rolled out a planned redesign for its SEHP for 2020 implementation.

- The plan proposed benchmarks ranging from 182-235% of Medicare rates applied to inpatient and outpatient hospital and professional charges.
- The State faces strong opposition from hospitals.
- A proposed bill would prohibit the SEHP from implementing reference pricing until 2021.

Source List for Public Option

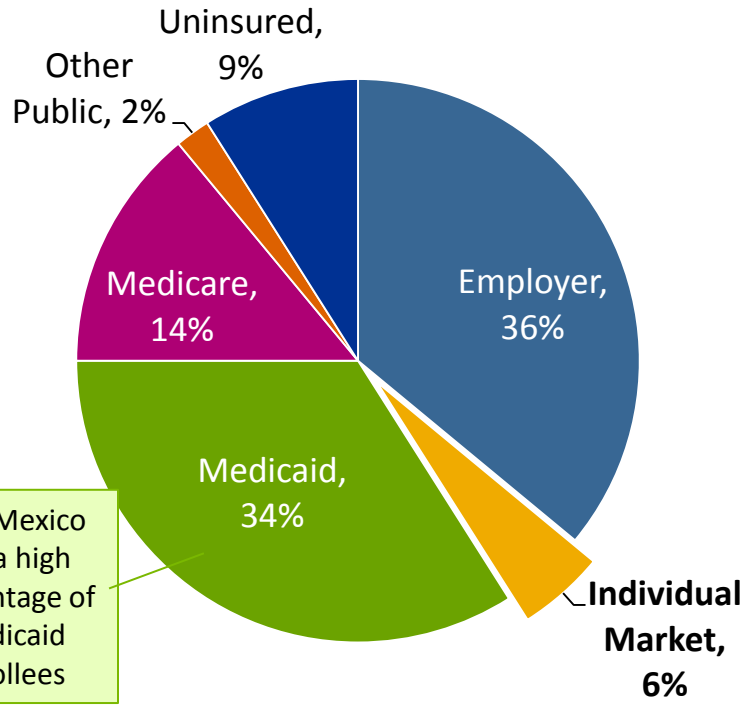
- Health Insurance Coverage of the Total Population, Kaiser Family Foundation
- A Brief Analysis of the Individual Health Insurance Market, Mark Farrah Associates (off-Exchange estimate)
- Marketplace Average Benchmark Premiums, Kaiser Family Foundation
- Database of State Laws Impacting Healthcare Cost and Quality (Washington), Source on Healthcare
- SB 5526: Individual Health Insurance Market – Standardized and State-Procured Plans
- HB 1224: Prescription Drug Pricing
- Directive of the Governor 18-13 (Eliminating Hepatitis C)
- HB 2408: Preserving Access to Individual Market Health Care Coverage Throughout Washington State
- Washington Health Benefit Exchange – Exchange Board Retreat Presentation
- Washington Health Benefit Exchange – Exchange Board Meeting Presentation
- US House Ways & Means Committee Testimony of Pam MacEwan, CEO of Washington Health Benefit Exchange
- Billy Wynne, “Washington State Takes an Important Step Forward,” Health Affairs
- HB 19-1004: Proposal for Affordable Health Coverage Option (Colorado)
- Montana's Experiment in Reference Pricing, Modern Healthcare
- N.C. Reference-Based Pricing Plan Hits Roadblock, Modern Healthcare
- HB 184: Study State Health Plan Design (North Carolina)

Medicaid Buy-In and Public Plan Expansion

New Mexico: Targeted Medicaid Buy-In

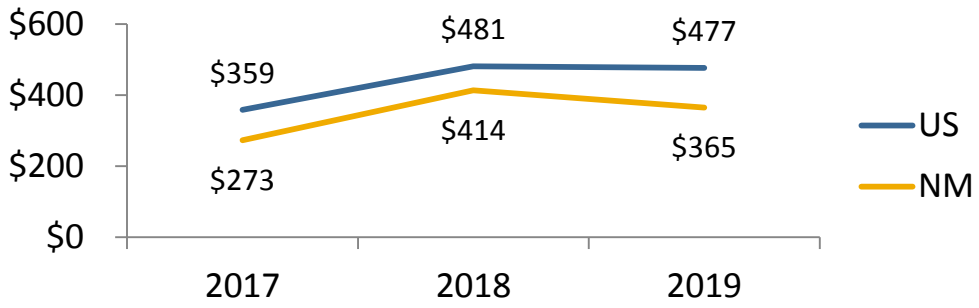
New Mexico's Medicaid population is more than five times as large as the state's Medicaid population

Health Insurance Coverage (2017)

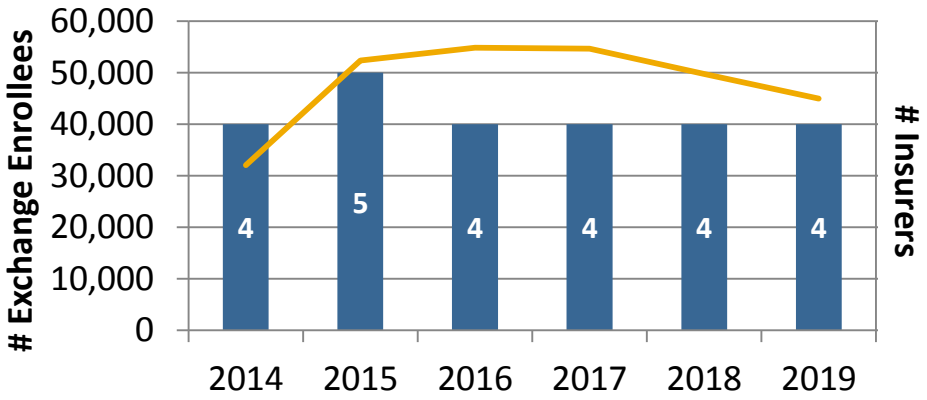


On-Exchange (2018): 49,792
(82%* received subsidies)
Off-Exchange (2018): 13,884

Average Exchange Benchmark Premiums (2017-2019)



Number of Exchange Enrollees and Insurers (2014-2019)



*Calculated based on effectuated Exchange enrollees, while the on-Exchange total is the number who selected a Exchange plan.

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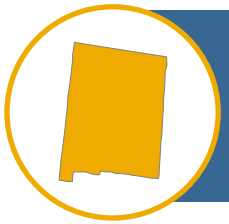
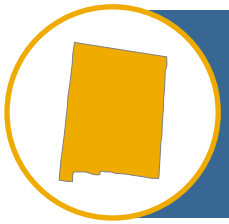
New Mexico: Targeted Medicaid Buy-In



New Mexico has been a national leader in looking at ways to leverage its large Medicaid program, but is also looking at other ways to address coverage and affordability challenges

	Initiative	Description	Lead Agency (or Agencies) and Role
Featured Initiative	**Study on Buy-In Options (2018-19)**	State-commissioned study on buy-in options, including a Targeted Medicaid Buy-In Option *Note: Despite the legislature's failure to implement this option in 2019, the legislation allocated funds for further study, maintaining the state's leadership on Medicaid buy-in.*	▪ **Human Services Department (HSD)**, which administers New Mexico's Medicaid program, would administer the Medicaid buy-in plan, leveraging New Mexico's purchasing power and high managed care penetration. ▪ **Health Insurance Exchange** would coordinate with HSD to establish a system for enrollment and a consumer outreach program. ▪ **Office of Superintendent of Insurance (OSI)** oversees insurers including rate review. OSI is an independent state agency, with the Superintendent appointed by a nominating committee instead of the Governor.
Other Initiatives	**Surprise Billing Protection Act (2019)**	Requires a provider to refund amount paid in excess of in-network cost-sharing amount	▪ **OSI** reviews reimbursement rates for surprise bills and promulgates rules to implement the Act, including mandating reporting by carriers.
	Interagency Pharmaceuticals Purchasing Council (failed in 2018)	Council would review and coordinate cost-containment strategies for procurement of pharmaceuticals and pharmacy benefits and pooling of risk for services by constituent agencies	▪ Constituent agencies include HSD; Department of Health; Children, Youth and Families Department; Corrections Department; public schools; state hospitals or any local, county or municipal government opting to participate in group purchasing of pharmaceuticals.

Deep Dive: Targeted Medicaid Buy-In



After the legislatively-authorized study and stakeholder engagement outlined four options, New Mexico opted to focus on the Targeted Medicaid Buy-In option for additional analysis

- In February 2018, New Mexico passed a bill (SM 3/HM 9) to study options for improving affordability and access for New Mexicans "to ensure health care coverage is expanded to low-income, uninsured residents."
- The study included four options:
  1. Targeted Medicaid Buy-In
  2. QHP Public Option
  3. Basic Health Program (BHP)
  4. Medicaid Buy-In for All

While similar to the public option, a **buy-in program** is state-sponsored Medicaid-like coverage offered *off* the Marketplace, typically for those not eligible for Medicaid, Medicare, or subsidized Exchange coverage.

The decision between public option or buy-in design will depend on state goals and target populations.

Process Timeline

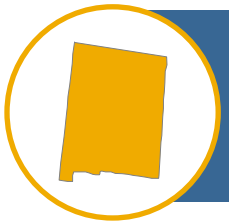
- Study Commissioned — February 12, 2018
- Stakeholder Engagement & Fact-finding — July - October 2018
- Report on Four Options Published — December 2018
- Actuarial Analysis on Targeted Medicaid Buy-In Published — January 2019
- Bills Failed to Reach Final Vote (but funds appropriated for additional study) — March 2019
- Ongoing Study of Buy-In Options — 2019

Deep Dive: Targeted Medicaid Buy-In

These four buy-in models were considered for implementation in New Mexico

Option One	Option Two	Option Three	Option Four
Targeted Medicaid Buy-In	**Qualified Health Plan (QHP) Public Option**	**Basic Health Program (BHP)**	**Medicaid Buy-In for All**
State offers Medicaid-like coverage *off* the Exchange to those not eligible for Medicaid, Medicare, or subsidized Exchange coverage. New Mexico could subsidize coverage for those who need financial assistance.	State offers lower cost product *on* the Exchange to individuals and small employers; would be offered as a QHP, likely in partnership with an existing insurer. New Mexico could capture potential savings under a waiver to further increase affordability.	State offers BHP for individuals with incomes below 200% FPL who are not Medicaid-eligible (including people who would be Medicaid eligible, but for their immigration status). Over time, New Mexico could expand BHP through buy-in.	State offers Medicaid-like coverage to *everyone* (except individuals covered by Medicare); would be offered as a lower cost option *off* the Exchange. Subsidy-eligible individuals could apply their subsidies to the cost of coverage.
Off-Exchange	**On-Exchange**	**Off-Exchange, Outside of Individual Market**	

Deep Dive: Targeted Medicaid Buy-In



The proposed Targeted Medicaid Buy-In Option model focuses on consumers who are not currently eligible for subsidized coverage

1 *Eligibility*

Targets individuals who lack access to other subsidized coverage, including:

- Individuals ineligible for Medicaid, Medicare or Exchange subsidies due to immigration status
- Individuals affected by the family glitch
- Individuals with incomes above 400% of FPL

2 *Benefit Package*

- Essential health benefit (EHB) package
- Potential Medicaid benefit add-ons:
  - Dental
  - Vision

3 *Premiums*

- Individuals pay premiums
- New Mexico subsidizes premiums for target population
- Mirrors the premium tax credit (PTC) structure offered for Exchange coverage (premiums equal to 2.1%-6.5% of income)

4 *Cost-Sharing/Deductibles*

- Metal tiers and actuarial value (AV) levels mirror the Marketplace: Silver, Gold, Platinum (70 AV, 80 AV, 90 AV)
- Individuals below 200% FPL can also enroll in cost-sharing reduction plan variants that mirror those in the Exchange (i.e., 87 AV and 94 AV)

The study estimates that New Mexico's proposed Targeted Medicaid Buy-In would have the following results:

- Monthly premiums of $377 to $403 (vs. 2020 average premium of $521 and lowest-cost Exchange premium of $475).
- Premiums reduction of 15-28% relative to the average and lowest-cost premiums in the Exchange.
- Projected total enrollment ranges from 7,000 to 16,000.
- State costs ranging from $12 million to $48 million.

Deep Dive: Targeted Medicaid Buy-In

Without legislative authority to implement Targeted Medicaid Buy-In for 2021, New Mexico will need to re-strategize on this effort and will study options before the next session

Key Challenges

1. **Policymakers expressed concerns about the level of state risk involved in an off-Exchange buy-in, particularly without federal waiver funding.**

2. **While the buy-in was shown to reduce premiums, the product may still be unaffordable for subsidized populations.**

3. **An off-Exchange product may disrupt the existing individual market.**

Other Recent Proposals for Public Plan Expansion

Similar to buy-in programs, there are several federal and state-level proposals that seek to increase coverage and access by expanding on existing government programs

Federal Proposals

Medicare-for-All

Under this proposal, the federal government would provide health coverage to all U.S. residents, displacing all existing coverage, and building upon the current Medicare program.

Medicare at 50 Act

Under this proposal, the federal government allows legal U.S. residents between 50 - 64 years old, who are currently ineligible for Medicare, to purchase Medicare coverage via premium contribution.

State Proposals

Basic Health Program Buy-In

Under the Affordable Care Act, states can offer a BHP.* To date, only two states – Minnesota and New York – have adopted a BHP.

Once a BHP is in place, a state can apply for a 1332 waiver to expand its BHP that would allow individuals with incomes >200% FPL to purchase BHP coverage.

In 2019, Minnesota legislators introduced, but did not pass, legislation to allow individuals with incomes >201% FPL to purchase a BHP-like product on the Exchange.

*BHP provides coverage to individuals with incomes <200% FPL who are not Medicaid-eligible but who would otherwise qualify for subsidies in the Exchange. States receive federal funding equal to 95% of the amount of the federal subsidies that would have been provided to BHP-eligible individuals on the Exchange.

Source List for Medicaid Buy-In and Public Plan Expansion

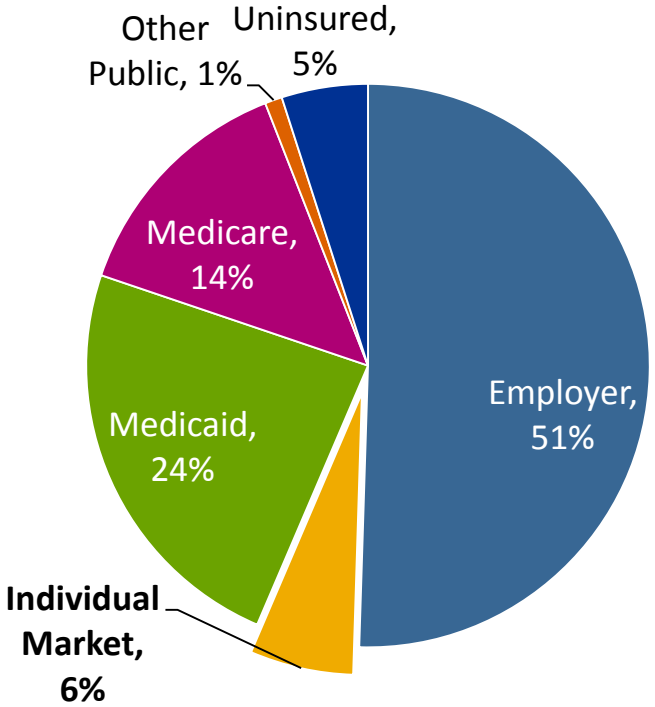
- Health Insurance Coverage of the Total Population, Kaiser Family Foundation
- A Brief Analysis of the Individual Health Insurance Market, Mark Farrah Associates (off-Exchange estimate)
- Marketplace Average Benchmark Premiums, Kaiser Family Foundation
- Database of State Laws Impacting Healthcare Cost and Quality (New Mexico), Source on Healthcare
- "Quantitative Evaluation of a Targeted Medicaid Buy-In," Manatt Health
- HB 207: Surprise Billing Protection Act
- SB 008: Interagency Pharmaceutical Purchasing Council
- SM 3: Study NM Medicaid Buy-In Plans
- HM 9: Explore Medicaid Buy-In Plan
- HB 416: Medicaid Buy-In Act
- "The Landscape of Federal and State Healthcare Buy-In Models: Considerations for Policymakers," Manatt Health

Cost Growth Benchmarking

Rhode Island: From Affordability to Cost Benchmarking

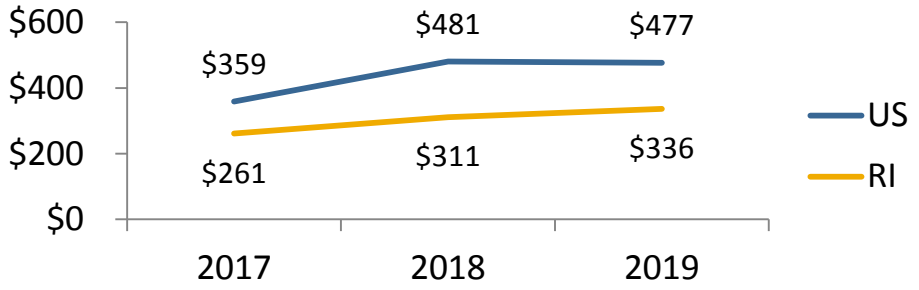
Rhode Island has been a national leader in taking early action on affordability and more recently moving to cost benchmarking

Health Insurance Coverage (2017)[1]

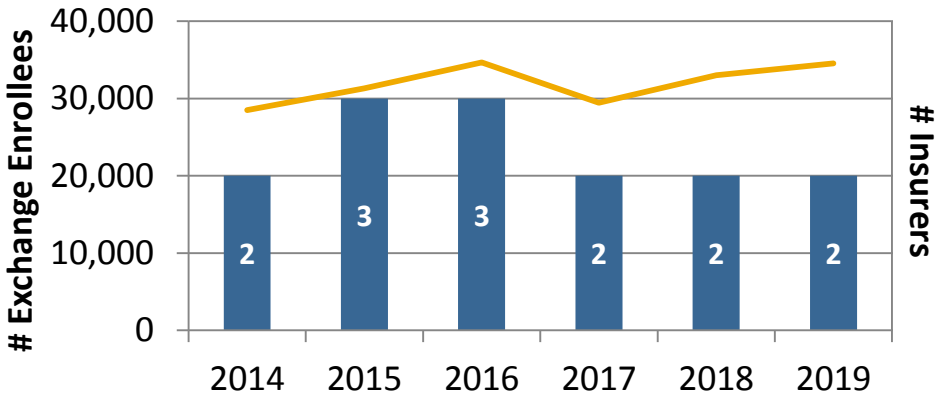


On-Exchange (2018): 33,021
(83%[2] received subsidies)
Off-Exchange (2018): 11,839

Average Exchange Benchmark Premiums (2017-2019)



Number of Exchange Enrollees and Insurers (2014-2019)



1. These percentages do not add up to 100% due to rounding.
2. Calculated based on effectuated Exchange enrollees, while the on-Exchange total is the number who selected a Exchange plan.

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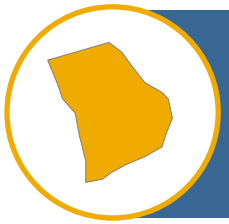
Rhode Island: From Affordability to Cost Benchmarking

Rhode Island is building on its 2010 affordability standards with enhanced coordination between the public and private sectors to reduce overall spending

	Initiative	Description	Lead Agency (or Agencies) and Role
Featured & Related Initiatives	**Rhode Island Health Care Cost Trends Project (2018)**	A project to reduce healthcare costs by developing a growth target and providing transparent healthcare performance data to inform purchasing decisions and care delivery reforms	▪ The Project's **Steering Committee**, including key healthcare organizations, developed a methodology for setting a healthcare cost growth target, signed a compact agreement to commit to this target, and will monitor spending against it. ▪ **Governor Gina M. Raimondo** issued an Executive Order establishing the target and directing agencies to implement it. ▪ **Office of the Health Insurance Commissioner (OHIC)** and **Executive Office of Health and Human Services (EOHHS)** engage providers, insurers, and community partners and issues annual reports to track the state's progress.
	"Affordability" Standards (2010, updated in 2015)	Set healthcare "affordability" standards for commercial health insurers	▪ **OHIC,** advised by its **Health Insurance Advisory Council**, established and enforces compliance with set of four criteria, including directing increased investment in the state's primary care health system and by capping hospital spending growth.
Other Initiatives	**Shared Responsibility Payment Penalty (2019)**	Creates individual health insurance mandate and imposes penalties for non-compliance	▪ **Division of Taxation** implements the penalties, in consultation with **OHIC, Office of Management and Budget, EOHHS,** and the **Rhode Island Health Benefits Exchange** (HealthSourceRI).
	Hospital Price Transparency (2017)	Requires hospitals to provide patients with a cost estimate of services	▪ **Department of Health** licenses hospitals and enforces this law.

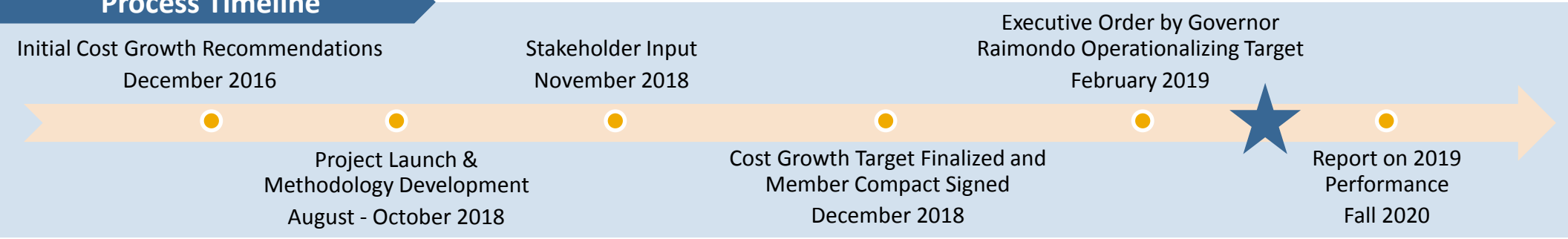
Deep Dive: From Affordability to Cost Benchmarking



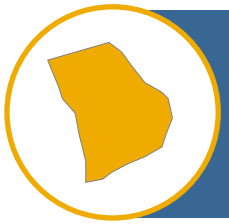
Rhode Island created the Health Care Cost Trends Project to promote quality and affordability with greater transparency and increased stakeholder accountability

- Rhode Island has taken a bilateral, collaborative approach to establishing its cost growth target. The 18-member Steering Committee is comprised of payers, providers, and other business and community representatives, jointly led by Rhode Island's Health Insurance Commissioner, the CEO of the state's largest insurer, and a provider CEO.
- The Health Care Cost Trends Project is organized into three concurrent work streams:
  1. Develop a methodology for a healthcare cost growth target for operationalization in 2019;
  2. Conduct a data analysis to measure healthcare system cost performance and identify cost-drivers;
  3. Create a data use strategy to leverage the state's all-payer claims database (APCD), HealthFacts RI, in identifying cost-drivers and sources of cost growth variation.

Process Timeline



Deep Dive: From Affordability to Cost Benchmarking



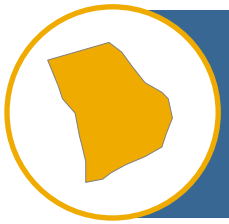
Rhode Island's cost growth target goes beyond the commercial health insurance market by including government programs to lower overall total healthcare costs

- The state per capita healthcare cost growth target is set at 3.2% annual growth, compared to 2018, for 2019-2022, and will be re-evaluated thereafter.
- 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 following populations and costs are included:

Methodological Consideration	Included	Excluded
Payer Populations[1]	▪ Commercial (both fully insured and self-insured populations) ▪ Medicaid ▪ Medicare	▪ Correctional Health ▪ TRICARE ▪ Veteran's Health Administration
State of Residence and Locations of Care	▪ Rhode Island residents with Rhode Island providers ▪ Rhode Island residents with out-of-state providers	▪ Out-of-state residents with Rhode Island providers ▪ Out-of-state residents with out-of-state providers
Types of Spending	▪ Claims-based spending ▪ Non-claims-based spending ▪ Pharmacy carveouts	▪ Behavioral health carveout contracts[2]

1. Provider resources applied in the delivery of care for uninsured Rhode Islanders are excluded from calculations of healthcare spending because they are not technically not "spending" as defined by the Steering Committee.
2. Most behavioral healthcare coverage in Rhode Island is provided through the insurer. Behavioral health carveout is small and the trend is stable.

Deep Dive: From Affordability to Cost Benchmarking



Rhode Island has not fully linked its cost benchmarking to other programs nor decided on the consequences if targets are missed

Key Challenges

1. **Rhode Island's target is not tied to any rewards or penalties, which may become necessary as the program matures.**

2. **It is not clear on how the growth target will interact with OHIC's hospital price and Accountable Care Organization (ACO) budget growth caps.**
   - The Steering Committee recommends providing information on the relationship between these caps in the future.

3. **Uncompensated care is excluded from the measurement of total healthcare spending.**
   - While this will likely remain excluded, the Steering Committee recommends that future reporting on spending relative to the target should indicate that this may be significant for certain providers.

Cost Growth Benchmarking in Other States

Massachusetts

Massachusetts' 2012 Cost Containment Law established the nation's first healthcare cost growth benchmark. The law created two new independent state agencies, the Center for Health Information and Analysis and the Health Policy Commission, to implement the benchmark.

- The benchmark is set at 3.1% for 2018-2022. Since 2013, healthcare spending growth has been, on average, below the benchmark, and lower than national growth trends.
- Entities that exceed the benchmark are publicly reported, may be required to file and implement performance improvement plans (PIP), and can be fined up to $500,000 for non-compliance with PIP implementation. To date, Massachusetts has not needed to enforce penalties or additional levers.

Delaware

Delaware set a 2019 benchmark of 3.8%, trending down, by 2024, to greater than or equal to 3.0%.

- The program includes quality benchmarks to monitor population health targets.
- The Delaware Economic and Financial Advisory Committee will review the benchmark annually, and the Delaware Health Care Commission will collect and report cost and quality data for the state, for each insurance market, and for large payers and providers.

Oregon

In June 2019, Oregon created the Oregon Health Care Cost Growth Benchmark Program.

- While Oregon already has established a 3.4% growth rate for public programs, this new benchmark will apply to insurers, hospitals, and healthcare providers.
- Establishes a citizen- and stakeholder-led Implementation Committee, selected by Governor Brown and under the Oregon Health Policy Board's supervision, that will develop recommendations for program implementation and enforcement by September 2020.

Source List for Cost Growth Benchmarking

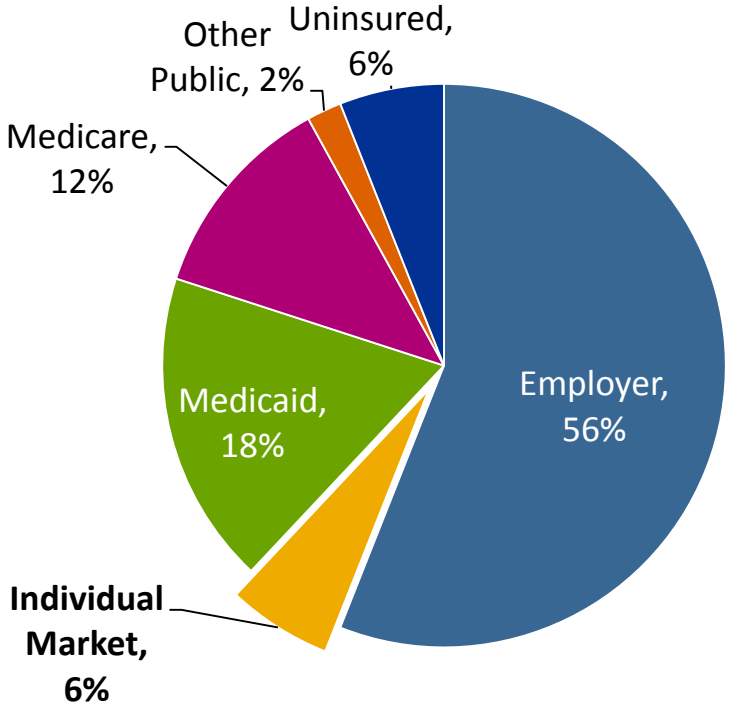
- Health Insurance Coverage of the Total Population, Kaiser Family Foundation
- A Brief Analysis of the Individual Health Insurance Market, Mark Farrah Associates (off-Exchange estimate)
- Marketplace Average Benchmark Premiums, Kaiser Family Foundation
- Database of State Laws Impacting Healthcare Cost and Quality (Rhode Island), Source on Healthcare
- "Compact to Slow Health Care Spending Growth Signed in Rhode Island," The Milbank Memorial Fund
- "Affordability Standards: A Summary," Rhode Island Office of the Health Insurance Commissioner
- "Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers," Health Affairs (February 2019)
- S 0683: Relating to Insurance Health Care Market Stability
- S 0146: Relating to Health and Safety – Licensing of Health Care Facilities
- "Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island"
- RI Press Release, "Raimondo Signs Executive Order"
- Governor Gina M. Raimondo's Executive Order Establishing Cost Growth Target
- "Leveraging Multi-Payer Claims Databases for Value" Webinar (March 27, 2019), RI Health Insurance Commissioner
- "Leveraging HealthFacts RI for Value: Analysis and Recommendations" Stakeholder Meeting (May 14, 2019)
- Health Care Cost Growth Benchmark, Massachusetts Health Policy Commission
- Kara Odom Walker, "Can A Small State Improve Both Health Care Costs And Health Outcomes? Lessons From Delaware," Health Affairs Blog (Delaware)
- Delaware Health Care Spending and Quality Benchmarks Implementation Manual Version 1.0
- "Oregon passes bipartisan legislation to slow rising cost of health care and increase transparency for consumers," State of Reform (Oregon)

Drug Cost-Containment Initiatives

Maryland: Prescription Drug Affordability Board

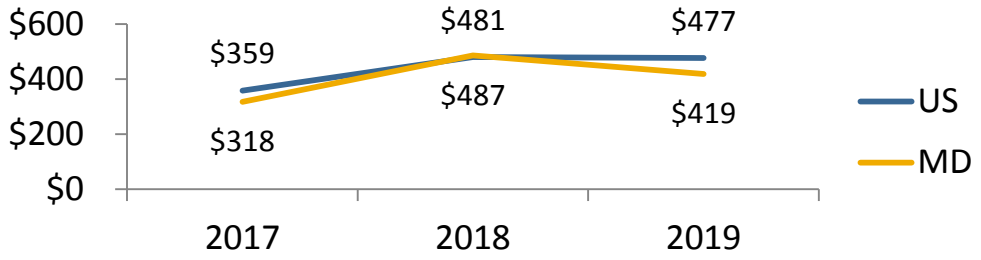
Maryland's average Exchange benchmark premiums increased dramatically in 2017, fueling further interest in cost control, including drug pricing

Health Insurance Coverage (2017)

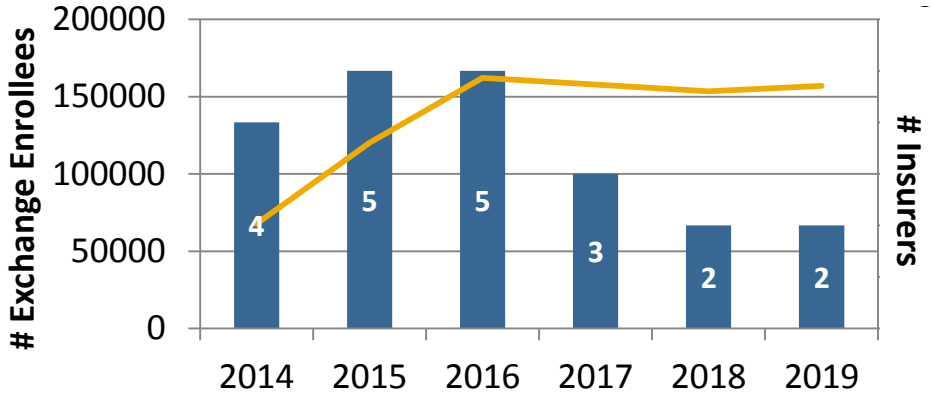


On-Exchange (2018): 153,584
(85%* received subsidies)
Off-Exchange (2018): 130,406

Average Exchange Benchmark Premiums (2017-2019)



Number of Exchange Enrollees and Insurers (2014-2019)



*Calculated based on effectuated Exchange enrollees, while the on-Exchange total is the number who selected a Exchange plan.

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Maryland: Prescription Drug Affordability Board

Maryland is seeking to reduce drug costs for public and private purchasers as a complement to its leadership with containing hospital rates

	Initiative	Description	Lead Agency (or Agencies) and Role
Featured & Related Initiatives	**Prescription Drug Affordability Board (2019)**	Independent unit of state government responsible for reviewing prescription drug prices and considering state policy options to increase affordability	▪ **Affected purchasers,** including state or local government units, state or county correctional facilities, state hospitals, health clinics at state higher education institutions, government employee health benefit plans, Medicaid. ▪ **Office of the Attorney General** enforces this law.
	Anti-Price-Gouging Bill (2017)	Combats price gouging *Note: Overturned by a Circuit Court, Supreme Court decided not to review.*	▪ **Office of the Attorney General** would have the authority to sue pharmaceutical companies for "unconscionable" price increases for generics.
	Bans on Pharmacy Benefit Manager (PBM) "Gag Clauses" (2018)	Blocks insurers or PBMs from prohibiting pharmacies from informing customers of actual cost	▪ **Office of the Attorney General and Commissioner of Insurance** enforce the law.
Other Initiatives	**Maryland Total Cost of Care Model (TCOC) (2018)**	The Centers for Medicare & Medicaid Services (CMS)/State of Maryland demonstration that sets a per capita limit on Medicare total cost of care in Maryland, building off of the Maryland All-Payer Model's global hospital budget	▪ **Maryland Department of Health (MDH)** assists CMS in the implementation of the Maryland Primary Care Program (MDPCP). ▪ **Health Services Cost Review Commission (HSCRC)** sets reimbursement rates for the state's hospitals.
	All-Payer Claims Database (APCD) (1994)	Collects claims data to promote healthcare price transparency	▪ **Maryland Health Care Commission** operates the Maryland Medical Care Data Base (MCDB).

Deep Dive: Prescription Drug Affordability Board

Maryland's Prescription Drug Affordability Board will study the pharmaceutical distribution and payment system, propose policy options for government-purchased drugs, and implement approved approaches

- The Board will be comprised of five appointed experts in healthcare economics or clinical medicine; and must consult with a 26-member Stakeholder Council.
- The Board will consider policy options including **setting upper payment limits, using a reverse auction marketplace, and bulk purchasing of drugs**.
- The Board's authority is limited to government-purchased drugs (i.e., state hospitals, Medicaid, and government employee plans), but may be expanded to the commercial sector in the future.
- Initially, the Board must report to a committee of key legislative leaders for approval to move forward with key phases of its work.

Process Timeline

Board Establishment
Pending

Study System and Review Policy Options
By Dec. 31, 2020

Submit Plan of Action to Legislature
By July 1, 2021

Implementation of Plan to State-Purchased Drugs
By Jan. 1, 2022

Recommendations for Statewide Expansion
By Dec 1, 2023

Deep Dive: Prescription Drug Affordability Board

The Board will identify drugs that meet certain price criteria and determine which of those should be subject to efforts to lower prices

Identify Drugs Meeting Price Criteria

The Board identifies drugs with a launch wholesale acquisition cost (WAC) or a WAC increase that exceeds certain thresholds based on drug type (i.e., brand name, biosimilar, generic).

- E.g., Brand name drugs or biologics that have a launch WAC of >$30,000/year or course of treatment

Select Drugs for Full Cost Review

The Board determines whether the drug presents affordability challenges based on:

- WAC and other relevant prescription drug cost indices
- Monetary price concession, discount, or rebates for the drug under review
- Price and rebates for therapeutic alternatives
- Patient access and cost-sharing

Regulate Drugs with Affordability Challenges

If upper payment limits are approved, the Board will determine criteria for setting upper payment limits, considering cost of:

- Administering the drug
- Delivering the drug to consumers
- Other relevant administrative costs

Note: In the case of shortages, the Board must reconsider or suspend upper payment limits.

Deep Dive: Prescription Drug Affordability Board

Maryland's efforts to regulate drug pricing have encountered resistance from the Governor and are likely to face legal challenges from the pharmaceutical industry

Key Challenges

1. **The phased-in board authority may limit the Board's initial impact, especially with the Governor not providing funding and the history of legal challenges.**
2. **The Board may face difficulties in calculating reasonable upper payment limits.**
3. **Without state mandatory prescription drug cost reporting, data integrity may be a challenge.**
   - The Board plans to use publicly-available data and data requested from supply chain participants. Simultaneously, the Board will seek to enter an agreement with other states that require cost reporting and adopt regulations for collecting additional data as necessary.
4. **Legal challenges from the pharmaceutical industry are likely.**
   - Given a successful legal challenge of the 2017 anti-price-gouging law – for violating the Dormant Commerce Clause (DCC) – the pharmaceutical industry has indicated its intent to sue the State. However, the Board is designed specifically to avoid a DCC challenge.

Recent Drug Cost-Containment Initiatives in Other States

Massachusetts

On July 31, 2019, Governor Baker signed into law a new budget that gives Medicaid additional powers to obtain increased rebates for high-cost drugs* from drug manufacturers.

- Grants Medicaid the authority to propose a price, hold public hearings, or refer the drug price in question to the Health Policy Commission.
- While some requirements were relaxed, the law permits monetary penalties of up to $500,000 if a manufacturer refuses to provide information or provides false or misleading information.

California

Earlier this year, Governor Newsom signed an executive order to create the nation's largest prescription drug purchaser:

- Combines the California Pharmaceutical Collaborative (including the corrections health services, California Veteran's Associations, and state university system) with Medicaid purchasing.
- Transitions pharmacy services for Medicaid managed care to a fee-for-service benefit to increase purchasing power for 13M enrollees.

Oregon

In 2018, Oregon established a "Task Force on the Fair Pricing of Prescription Drugs," which is co-chaired by the State Commissioner of Insurance.

- Over six months, the task force developed and analyzed a transaction and transparency survey, conducted national research on pharmaceutical transparency and strategies, and defined relevant supply chain and cost factors to produce fourteen recommendations.

Oklahoma

In 2018, Oklahoma's Medicaid program secured four value-based payment (VBP) contracts with pharmaceutical drug manufacturers using supplemental rebate agreements.

- e.g., A manufacturer will pay higher rebates to the State if the patients taking the medication are hospitalized for conditions the drug is intended to treat. In exchange, the State no longer subjects the drug to prior authorization.

*Annual aggregate cost of >$10M or annual per utilizer cost of >$25k after federal rebates)

Source List for Drug Cost-Containment Initiatives

- Health Insurance Coverage of the Total Population, Kaiser Family Foundation
- A Brief Analysis of the Individual Health Insurance Market, Mark Farrah Associates (off-Exchange estimate)
- Marketplace Average Benchmark Premiums, Kaiser Family Foundation
- Database of State Laws Impacting Healthcare Cost and Quality (Maryland), Source on Healthcare
- HB 631: Public Health – Essential Off–Patent or Generic Drugs – Price Gouging – Prohibition
- Amendment 2 to the Maryland All-Payer Model Agreement
- "Maryland Passes Nation's First Prescription Drug Affordability Board," NASHP
- "Prescription Drug Board a Casualty of Hogan Cuts," The Washington Informer
- "Massachusetts House Pushes Medicaid Supplemental Rebate Law in Budget," Drug Pricing Policy Watch
- "Massachusetts Moves To Negotiate Medicaid Drug Prices," WBUR
- "California Moves One Step Closer Toward Creating A Prescription Drug Single-Purchaser System," Office of Governor Gavin Newson
- Overview of Oregon's Joint Interim Task Force On Fair Pricing of Prescription Drugs
- "Extending VBP Models into Medicaid Drug Purchasing: Challenges and Opportunities," Health Affairs Blog (Oklahoma)

Thank You

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Rhode Island Health Cost Growth Target

July 2018

- Priority of Governor Raimondo
- Formed a broad stakeholder Steering Committee
- Funding provided by the Peterson Center on Health Care
- Partnership: Brown U School of Public Health and State

Vision:

To provide RI citizens with high-quality, affordable health care through greater transparency of health care performance and increased accountability of key stakeholders.

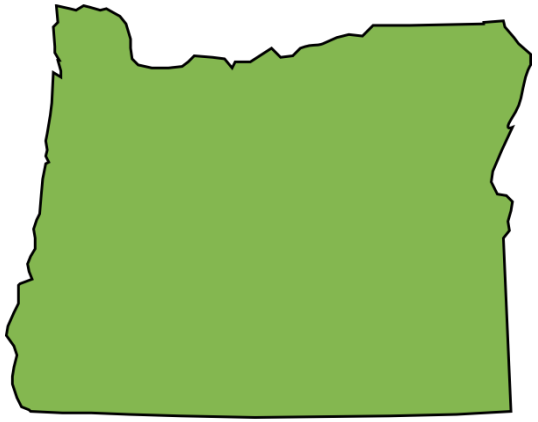
Rhode Island: 3 Workstreams

1) **Cost Growth Target:**
- Statewide per capita target of 3.2% for 2019-2022 (Compact and Order)
- Health care spending will be calculated and annually reported by Medicare, Medicaid and all major insurers to assess performance at the state, insurance market, insurer and large provider levels.

2) **Data Analysis Decisions:**
- State APCD (All-Payer Claims Database) for analysis on specific cost *drivers*
- Insurer data to set 2018 spending baseline and measure annual growth *trends*

3) **Data Use Strategy:** plan for reports to improve health system performance

Oregon Health Care Cost Growth Benchmark – Background



- SB 419 (2017) created the Task Force on Health Care Cost Review. The Task Force started with review of Maryland all-payer rate setting model, but ultimately decided to pursue a cost growth benchmark based on Massachusetts.
- SB 889 introduced as Task Force recommendation in 2019 Oregon Legislative Session, passed with widespread stakeholder support and a bipartisan vote in both chambers.
- Governor Kate Brown signed into law July 15.

Oregon Health Care Cost Growth Benchmark – SB 889 Overview

- The bill establishes a cost growth benchmark program for the entire Oregon health care system.

- Many of the details are to be determined by state agencies and a new advisory committee, on the following schedule:
  - Initial program design and benchmark figure: 9/15/20
  - Benchmark goes into effect: 2021
  - Reporting & enforcement begin: 2022

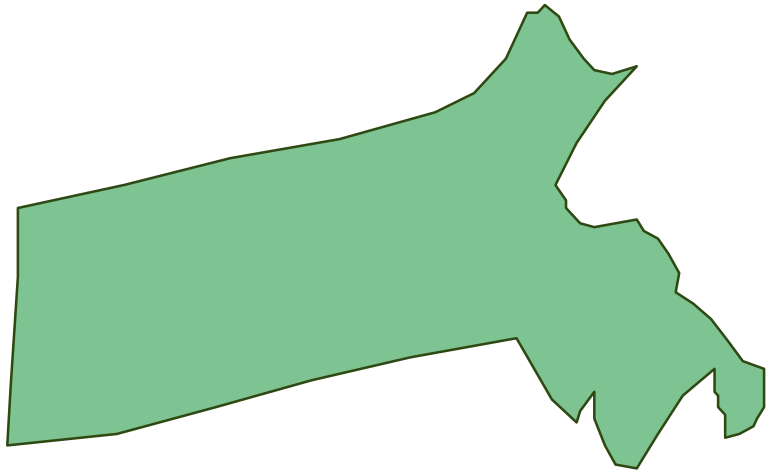
Elements of Oregon's Health Care Cost Growth Benchmark (1)

- The benchmark must:
  - Ensure the rate of increase in health care costs does not exceed the rate of increase of Oregon's economy, or increases in Oregonians' incomes;
  - Apply to all providers, payers and health care entities in Oregon's health care system;
  - Use established economic indicators; and
  - Be measurable on a per capita, statewide and health care entity basis.

Elements of Oregon's Health Care Cost Growth Benchmark (2)

- The program must establish:
  - Reporting requirements for health care entities; and
  - A methodology for calculating the annual percentage change in total health expenditures.
- Each year the program will be required to
  - Hold public hearings;
  - Publish a report on health care cost trends and recommendations for improving the efficiency of the health care system; and
  - If appropriate, require a performance improvement plan of health care entities exceeding the benchmark.

Massachusetts Health Care Cost Growth Target



Mass. Chapter 224 of the Acts of 2012 created the Health Policy Commission (HPC):

- a quasi-independent entity that resides within, but not under the control of, the Executive Office for Administration and Finance
- charged with establishing **an annual cost growth target** and monitoring progress through annual public cost trends hearings

What was the purpose? To inform the public and to drive behavior change within the delivery system.

- "To give certainty about how much medical care costs and to lower it from what it otherwise would have been." – Health Policy Commission member

Massachusetts Health Care Cost Growth Target

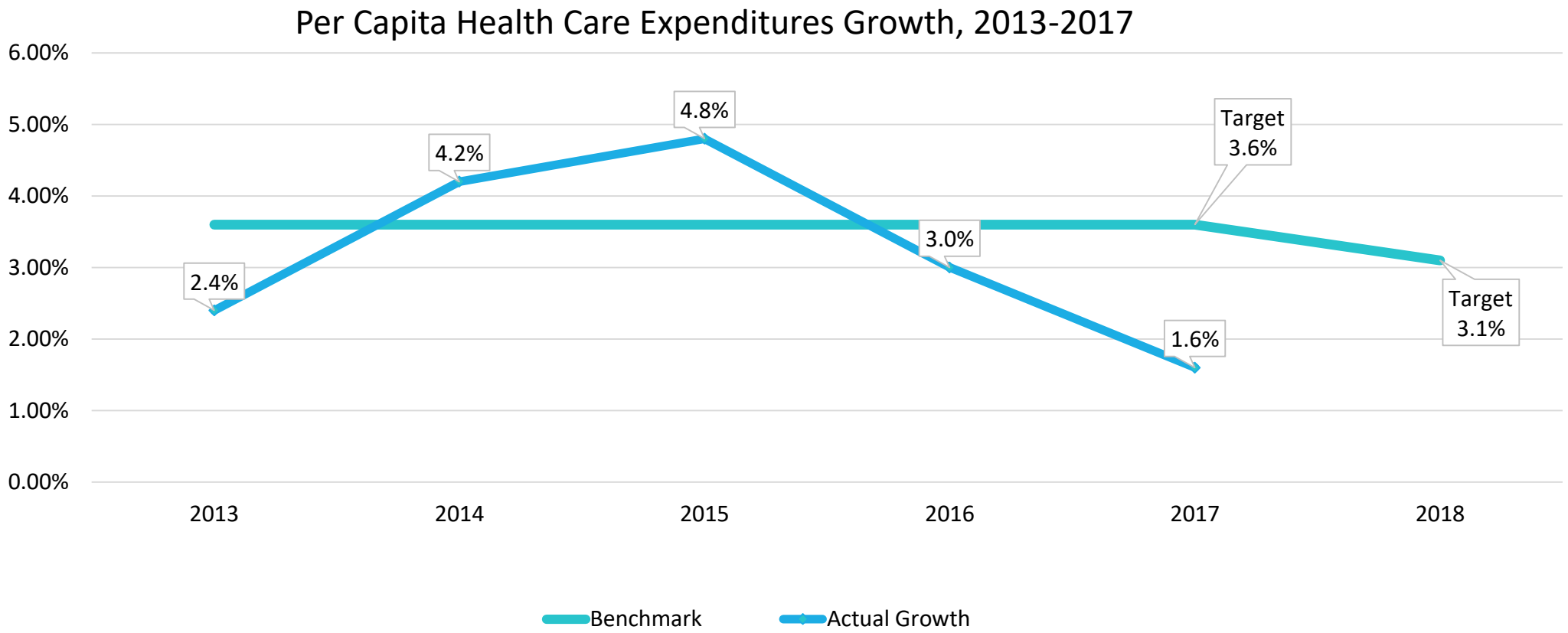
What happens if an organization exceeds the target?

- The HPC *may* require health care entities that exceed the benchmark to file and implement performance improvement plans.
- An entity can be fined up to $500,000 for failure to submit, implement, or report on its performance improvement plan.

What happens if the benchmark strategy doesn't work?

- "The commission may submit a recommendation for proposed legislation to the joint committee on health care financing if the commission determines that further legislative authority is needed to achieve the health care quality and spending sustainability objectives of this act, assist health care entities with the implementation of performance improvement plans or otherwise ensure compliance with the provisions of this section."

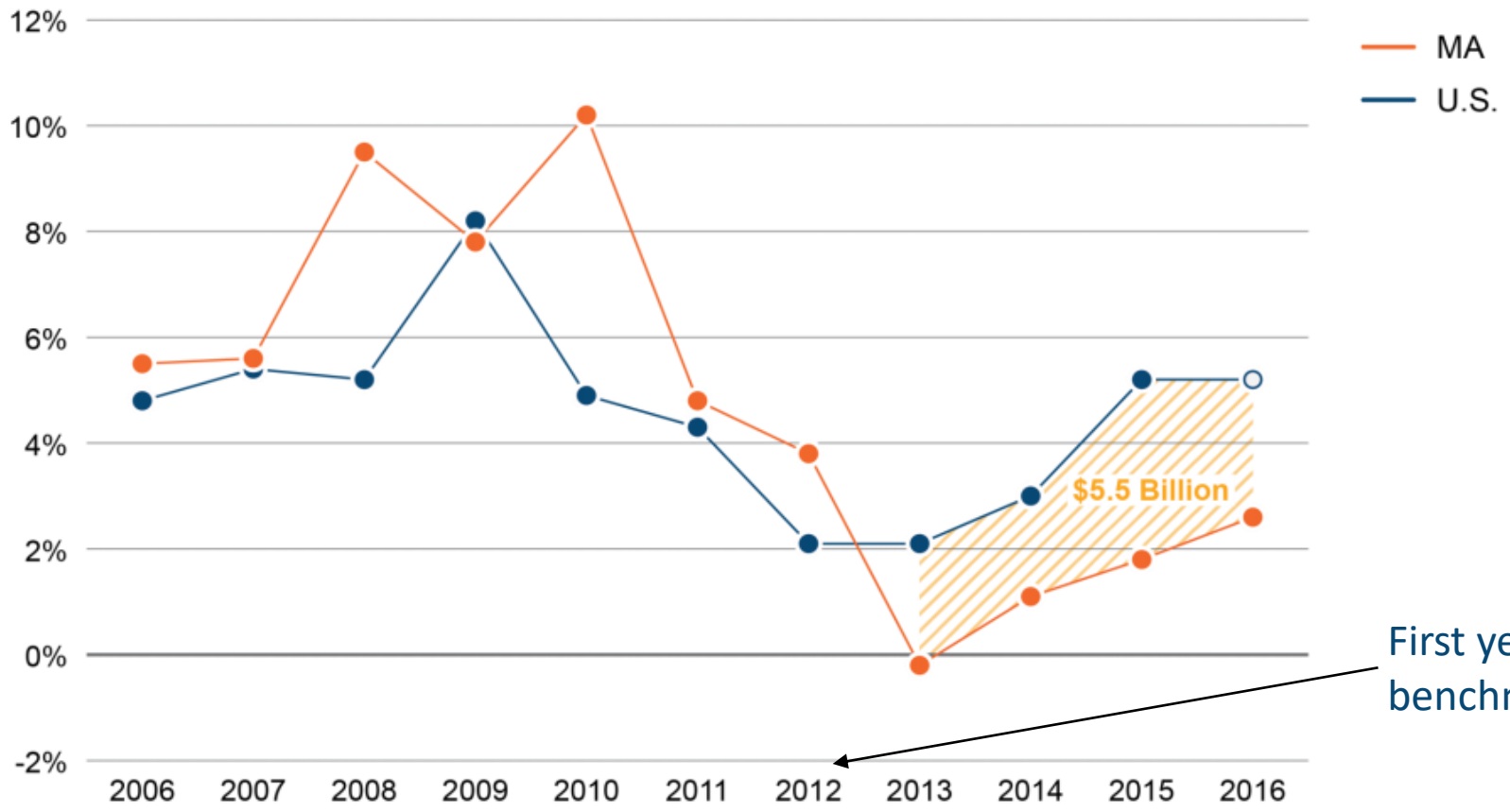
Massachusetts Experience



Sources: Center for Health Information and Analysis (CHIA) Performance of the Massachusetts Health Care System Annual Report, September 2018, September 2017, and September 2016; Total Health Care Expenditures from payer-reported data to CHIA and other public sources.

In recent years, growth in spending on private health insurance in Massachusetts has been consistently lower than national rates

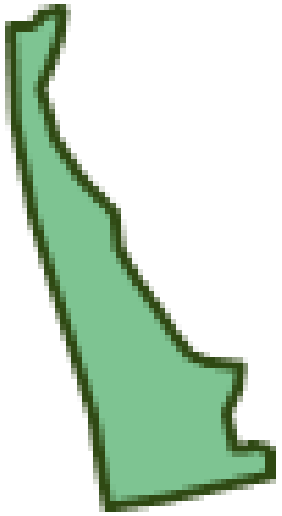
Annual growth in commercial health insurance premium spending from previous year, per enrollee, MA and the U.S.



Notes: U.S. data includes Massachusetts. Center for Health Information and Analysis data are for the fully-insured market only. U.S. data for 2016 is partially projected.

Source: Centers for Medicare and Medicaid Services, State and National Healthcare Expenditure Accounts and Private Health Insurance Expenditures and Enrollment (U.S. and MA 2005-2014); Center for Health Information and Analysis Annual Reports (MA 2015-2016)

Delaware Health Care Cost Growth Targets



Governor Carney established Health Care Spending and Quality Benchmarks in Executive Order (EO) 25 (November 2018).

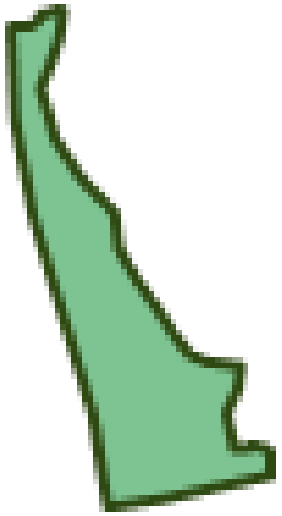
Delaware has set a target of keeping annual per capita health care spending growth at or below:

- 3.8% (2019)
- 3.5% (2020)
- 3.25% (2021)
- 3.0% (2022 and 2023)

To measure the change in health care spending year-over-year, the Delaware Health Care Commission has requested data of each Insurer.

The Delaware Financial Advisory Committee may change the Benchmark if any of the inputs to the methodology have changed in a material way.

Delaware Health Care Cost Growth Targets



EO 25 also established calendar year (CY) 2019–2021 quality benchmarks and aspirational longer-term goals. There are eight quality benchmarks starting in 2020.

HEALTH STATUS MEASURE	SPECIFICATION	CY 2019 BENCHMARK
Adult Obesity	% of adults with body mass index ≥30	30.0%
High School Students Physically Active	% of students with physical activity for ≥60 mins a day on five or more days	44.6%
Opioid-related Overdose Deaths	# of opioid-related deaths	16.2 deaths per 100,000
Tobacco Use	% of adults who currently smoke	17.1%

HEALTH CARE MEASURE	SPECIFICATION	CY 2019 BENCHMARK
Concurrent Use of Opioids and Benzodiazepines	% of individuals age 18 and older with concurrent use of opioids and benzos	TBD
Emergency Department (ED) Utilization (Commercial Market only)	# of ED visits for individuals age 18 and older	190 visits per 1,000
Persistence of Beta Blocker Treatment After a Heart Attack	% of individuals age 18 and older who received beta-blockers for 6 months after discharge	82.5% Commercial 78.8% Medicaid
Statin Therapy Adherence for Patients with Cardiovascular Disease	% of at-risk individuals who adhered to medication for ≥ 80% of treatment period	79.9% Commercial 59.2% Medicaid