Joint Task Force on Affordable, Accessible Health Care
December 15, 2021

Policy Option: Cost Growth Benchmark v.2

Description

This policy option includes expanding Vermont's current cost growth benchmark to extend beyond the population covered through the state's All Payer Waiver while also providing clear authority to the Green Mountain Care Board (GMCB) to use additional tools to drive payers and providers to meet the cost growth benchmark.

What is a Cost Growth Benchmark and what has Vermont done to date?

A cost-growth benchmark program is a cost-containment strategy that sets a limit on how much a state's health care spending can grow each year. The strategy sets accountability for spending growth at the state, provider and insurer level. The intended outcome is for healthcare cost growth to be slowed to more closely align with wage and income growth so that healthcare can remain affordable for individuals, businesses and states. It is important to do this while not negatively impacting access or health inequities.

A component of Vermont's All-Payer ACO Model Agreement with the federal government (signed October 2016) set a goal for the All-Payer Total Cost of Care per Beneficiary growth rate at 3.5% (and not more than 4.3%) for the 5-year period between 2018-2022.[1] However, this does not constitute a state-wide effort that affects all covered residents because it is limited to insurers that report data through VHCURES (including Medicare, Medicaid, all commercially insured, Medicare Advantage and self-insured reporting to VHCURES). The target includes spending for Medicare, Medicaid and individual products offered by Blue Cross Blue Shield of Vermont (BCBSVT). In addition, setting a public target for spending growth alone is not sufficient in slowing the rate of growth; a benchmark needs to be complemented by strategies designed to move the needle.

To support the state's goals of meeting a cost growth target, a state can also work with its stakeholders to put in place initiatives and incentives to limit cost growth. Among others, one option that may be included to support reaching the cost growth benchmark is to look at emerging technologies and best practices with potential for a return on investment (ROI) and consider the implementation of those initiatives over a rolling three-year period, with identification of opportunities in year one, implementation in year two, and incorporation of savings into rates in year three.

Who will it affect and how?

Cost growth benchmarks are aimed at reducing the overall cost of healthcare by limiting growth. Because the cost growth benchmark is aimed at limiting overall growth in the health care system, it impacts different stakeholders in different ways. In addition, impacts will vary based on the actions Vermont takes in pursuit of the benchmark, as well as the accountability measures a state utilizes to enforce the benchmark.

[1] https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM_Summary_20211001.pdf

For example, reducing cost growth will limit the amount of cost increases an employer, Medicaid or Medicare pay for insurance coverage. Depending on how an employer sets cost-sharing with its employees as part of its overall insurance benefit design, limiting the amount of cost increases could also reduce the growth in employees' portion of the health insurance cost by limiting growth in cost-sharing, through constraining premium or co-payment growth, or both. Today, the cost growth has limited impact on consumers, because it does not apply to all Vermonters. Expanding the cost growth benchmark's reach could allow for consumers to have reduced growth in their cost sharing.

Setting a cost growth benchmark provides a mechanism to allow providers and payers to align in their negotiations towards the benchmark, tempering cost growth. Today, that impact is lessened because not all coverage is included. For providers, cost growth benchmarks may impact the services provided or patients seen based on what initiatives are put into place to reduce cost growth. This could, for example, increase spend in primary and preventive care while reducing hospital care and spending. For insurers, a cost growth benchmark could impact administrative funding and profits. Given that most health insurers that operate in Vermont are non-profit, the reduction in cost growth could impact the ability for these non-profits to re-invest in the health care system or the communities they serve.

There is a theoretical possibility that implementing a cost-growth benchmark could have unintended consequences (ex. restrictions on patients receiving medically necessary services), though there is not yet evidence to validate this concern.

While GMCB has broad authority relative to containing costs in Vermont, the statutory authority supporting it is permissive rather than requiring GMCB to take certain actions. To date, GMCB has not had the resources or capacity to put into place requirements without being directed to do so. Revising the cost growth benchmark to extend beyond the population covered through the state's All Payer Waiver while also requiring GMCB to publish cost growth at the insurer and provider level and to implement performance improvement plans will help solidify Vermont's efforts to contain costs. At the same time, requiring GMCB to work with providers and insurers to develop initiatives in areas that are shown to be cost drivers in the state and consider those initiatives when setting the cost growth benchmark will further help the state to successfully reduce cost growth. Modifications to GMCB statute could also include strengthening its authority relative to health provider rate reviews.

Expected Outcomes/ Policy Considerations

While the State already has a partial cost growth benchmark in place, this section describes steps the state could take to re-consider its current approach. Steps could include:

1. Consider options and determine a cost growth target methodology. Key questions about what health care spending is being measured include:
    a. How to define Total Health Care Expenditures
        i. what spending is being measured?
            1. Medical expenses paid to providers by private and public payers, including Medicare and Medicaid (both claims and non-claims-based payments)
            2. Patient cost-sharing amounts
            3. Administrative expenses and operating margins/profit
        ii. What population's spending is being measured?

1. Does Vermont want to include its entire population within the cost growth target or keep it as is (Medicare, Medicaid and individual market BCBSVT products)?
2. Should residents be included when seeing out of state providers?
3. Should out of state residents be included when seeing VT providers?

b. What data will be used to measure total health care expenditures?
c. What criteria will be used for selecting an indicator for the cost growth target?
    i. Will the target be tied to an economic indicator? Options include:
        1. personal income growth,
        2. potential gross state product,
        3. wage growth.

2. Setting the value of the target occurs after finalizing a methodology. As noted above, Vermont has previously set a cost growth benchmark as part of its all-payer waiver. As the state works to renew this waiver, it will negotiate a new cost growth benchmark with CMS. In considering the value, key items for consideration include:
    a. Use of historical vs forecasted values
    b. Adjustments to the target, including consideration of mitigation strategies to reduce growth
    c. Possible target values
    d. How often will the target be adjusted? Is it annually or a specific period of time? Will discussions about methodology be re-opened when considering the target?

3. Performance Assessment. Key questions include:
    a. how performance against the cost growth target will be measured at the state, insurance market, insurer and provider levels;
    b. patient attribution to provider entities and minimum payer and provider size for reporting performance against the target;
    c. mechanisms for risk adjusting performance against the target; and
    d. methodology for calculating annual percentage change in Total Health Care Expenditures.

4. Authority and Governance. In Vermont, the Green Mountain Care Board already has authority to monitor the existing Cost Growth Benchmark. Questions here will focus on:
    a. collecting data to assess performance;
    b. calculating and analyzing data on performance;
    c. publishing performance and other data analysis consistent with the data use strategy which considers available data through the state's All Payer Claims Database and other sources to provide insight into the cost drivers and cost growth drivers influencing target performance;
    d. procedures and timing for modifying the cost growth target; and
    e. which health care entities should be required to report, and measures to ensure compliance with reporting requirements.

5. Initiatives to Support Efforts to Reduce Cost Growth. This will be a key focus of work in Vermont – considering which strategies or actions should be taken by the state, payers, purchasers, and providers to reduce health care cost growth and help all entities meet the cost growth target.
    a. Publishing Reports on Performance: Considerations include:
        i. Frequency of public reporting
        ii. Format of reporting
        iii. Elements to be included in reporting
        iv. What levels to report at (statewide, market level, insurer level, provider level)
        v. Should state hold public hearings specifically on performance against benchmark?
    b. Setting Quality Targets: Vermont may want to consider setting quality targets to ensure that implementing a cost growth benchmark does not reduce utilization of necessary and high-value services, and promote continued quality improvement on population health measures.
    c. Provider and/or Insurer Collaborative: Vermont could bring together providers and/or insurers to collaborate on strategies to reduce cost growth in areas that have been identified as cost drivers in the state. Topics for collaboration could include, for example:
        i. Emerging technologies
        ii. Clinical Best Practices
        iii. Reducing waste, including low value services
    d. Performance Improvement Plans: These plans can be put in place to ensure that providers and/or insurers take the cost growth benchmark seriously by requiring those who continue to drive cost growth to put activities in place to reduce their own trends.
    e. Concurrent efforts: GMCB has begun an effort to pursue affordability standards. This effort may be aimed at targeting cost growth in particular areas of the health system (e.g., focus on increasing spending on preventive care) and initiatives to improve the delivery system and advance payment reform. At the same time, the state could consider putting in place household affordability standards which take into consideration all out of pocket spending, including health care premiums and cost-sharing (co-payments and deductibles). These efforts can both align with the state's efforts to set a cost growth benchmark.

6. Implementation Strategy. Once a new cost growth approach and benchmark is finalized, there will be several potential implementation steps, including:
    a. Legislation to modify or enhance authority provided to GMCB to implement a cost growth benchmark
    b. Modifications to existing technical specifications
    c. Requesting data submissions from insurers and analyzing performance against benchmarks
    d. Publishing performance
    e. Annual review and implementation of initiatives to reduce spending growth in the state

Legislative Options

The GMCB, through 18 V.S.A. § 9375(b)(1) is charged to oversee the development and implementation of health care payment and delivery system reforms, including the authority to implement by rule methodologies for achieving payment reform and containing costs which may include the creation of health care professional cost-containment targets. It may be helpful to utilize a different section of the statute to provide this authority so that it is separate from other activities that the GMCB could implement relative to alternative payment methodologies (APMs). In separating it out, the language could also be strengthened to require the GMCB to set a comprehensive statewide benchmark as part of its regular review process, which would allow for a public vote after a public comment period. This allows for transparency and public input without having a full rulemaking process that can slow progress. If the Legislature so choses, the cost growth benchmark itself could be set in statute, as is the case in Massachusetts, and then adjusted by the GMCB within certain parameters. If the Legislature does not set the cost growth benchmark, the GMCB would benefit from legislative direction on how to set the benchmark. In addition, the GMCB would need clear authority through legislation to utilize corrective action plans payers.

Key to the success of the cost growth benchmark – and a big differentiator from how the cost growth target has been implemented in Vermont to date – is requiring through legislation that GMCB will work annually with health plans, providers and other stakeholders to develop initiatives that can help reduce spending growth in the state. These initiatives may include piloting emerging technologies and analyzing their benefits, and then over time making assumptions about their adoption as part of setting of the cost growth.

Finally, the GMCB uses its existing legislative authority to evaluate hospital budgets annually and conduct rate reviews. The amount of these budgets is directly linked with overall cost growth in the state and holding hospitals and other providers to targets and specified rates will be an important piece of monitoring and meeting the cost growth benchmark. GMCB could benefit from having clear statutory language which allows it to condition budgets and explicitly put corrective action plans into place to require hospitals to meet these targets. Likewise, the GMCB's authority in 18 V.S.A. § 9375(b)(6) and 8 V.S.A. § 4062 is limited to "approving, modifying, or disapproving" proposed rates. The Board also has such incidental, implied powers as may be needed to achieve this task. *See In re ACTD LLC,* 2020 VT 89, ¶ 19 (2020). The Board also has authority under 8 V.S.A. §§ 4513, 4584 and 5104 1) to issue supplemental orders to non-profit hospital and medical service corporations (BCBSVT) and health maintenance organizations (MVP) in connection with health insurance rate decisions and 2) to attach reasonable conditions and limitations to such orders if 3) the Board finds, on the "basis of competent and substantial evidence," that they are necessary to ensure benefits and services are provided at "minimum cost under efficient and economical management." In order to ensure that the rate review process can be used to ensure that insurers are complying with the cost growth benchmark, GMCB would benefit from plain language within the statute that makes clear that the rate review process can be used to enforce the benchmark against insurers.

To ensure that the statutory language applies to a broader set of providers and payers than is typically true, the GMCB will require broader authority relative to the cost growth target. These changes will provide the state with some greater authority These sections are the sections which could be changed to establish the state and GMCB with the authority to require policy actions from an insurer to support cost containment and health reform goals.

In addition, defining "affordability" in the rate review statute to mean that medical trend meets the benchmark established would clarify that the state must consider and provide for the potential to vary from the benchmark in rate review if there are access or contracting issues.

What have other states done?

While Vermont has implemented a partial cost growth benchmark, other states have gone further – implementing statewide benchmarks with public reporting across state, market, insurer and large provider levels, as well as potential for penalties or corrective action plans if the benchmark is not met.

Massachusetts: Massachusetts was the first state to establish a cost growth benchmark in 2012 via Chapter 224. The benchmark was set equal to the Potential Gross State Product (PGSP) of 3.6% for 2013-2017 and then PGSP minus 0.5% (3.1%) for 2018-2022.[2] The Center for Health Information and Analysis was charged with analyzing and **reporting on payer and provider costs and cost trends** and to specifically compare growth rates relative to the benchmark.[3] The MA Health Policy Commission was also created and charged with monitoring performance of payers and providers relative to the benchmark to identify and implement strategies that would improve the ability of the state to meet its benchmark goals.[4] With regards to enforcement of the benchmark, the Health Policy Commission can **request performance improvement plans** from those that exceed the benchmark, as well as **convene public hearings** where those that exceed the benchmark are asked to testify.[5]

Delaware: Executive Order 25 in 2018 created a cost growth benchmark in Delaware. The growth rate was set at 3.8% for 2019, 3.5% for 2020, 3.25% for 2021, and 3.0% for 2022 and 2023 based on Delaware's per capita Potential Gross State Product (PGSP). Performance against the benchmark and related analyses are **publicly reported** by the Delaware Health Care Commission. There are not currently accountability measures outlined for those that exceed the benchmark.[6]

Rhode Island: Executive Order 19-03 in 2019 created a benchmark program in Rhode Island. The benchmark was set at Rhode Island's per capita Gross State Product (GSP) of 3.2% for 2019-2022, with a plan to reassess the target for 2023 and beyond. Performance against the benchmark and related analyses are **publicly reported** by the Office of the Health Insurance Commissioner (OHIC) and the Executive Office for Health and Human Services. There are not currently accountability measures outlined for those that exceed the benchmark.[7]

In addition to setting a cost growth benchmark, Rhode Island has also set affordability standards that insurers must demonstrate compliance with during their annual rate reviews. The Affordability Standards are intended to advance affordability of commercial coverage. The standards include:

[2] https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/
[3] https://www.chiamass.gov/mission-and-history/
[4] https://www.mass.gov/about-the-health-policy-commission-hpc
[5] https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/
[6] https://dhss.delaware.gov/dhss/files/benchmarksummary013119.pdf
[7] http://www.ohic.ri.gov/documents/cost%20trends%20project/Compact-to-Reduce-the-Growth-in-Health-Care-Costs-and-State-Health-Care-Spending-in-RI.pdf

- **Expansion and improvement of primary care infrastructure**
    - Insurers were required to increase the proportion of total medical payments that went towards primary care by one percentage point each year between 2010 and 2014- that figure must now be at least 10.7%[8]
- **Increased adoption of the patient-centered medical home (PCMH) model**
    - Insurers were required to provide financial support for an all-payer PCMH pilot project and now must ensure that 80% of their contracts with primary care practices are with OHIC designated PCMHs.[9]
- **Support for the use of electronic health records (EHRs) and the state health information exchange (HIE)**
    - Insurers were required to provide financial support to enable increased adoption of EHRs by providers and to support Rhode Island's HIE.[10]
- **Implementation of comprehensive payment reform**
    - This affordability standard includes several topics -- alternative payment models, quality incentives, care coordination, transparency, and administrative simplification among them -- but the limits that it set on annual rates of increase is perhaps the most impactful component of these affordability standards. Insurers' prices for both inpatient and outpatient services were not to increase annually at a rate greater than the percentage increase in the U.S. Consumer Price Index (CPI) plus one percent. More recently, insurers have also been required to limit their annual increases in budgets for Population-Based Contracts to the CPI plus one and a half percent.[11]

Rhode Island's Cost Growth Benchmark and Affordability Standards are not explicitly tied together. However, both efforts are led by the same state agency (OHIC) and are designed to work in step with each other towards the same ultimate purpose of controlling health care spending.

Oregon: Oregon created a benchmark program in 2019 via SB 889 that was implemented beginning January 1, 2021. The benchmark was set at 3.4% for 2021-2025 and 3.0% from 2026-2030 based on a review of various economic indicators as well as growth targets selected by other states.[12] The Oregon Health Authority reports publicly on performance and conducts analyses to understand drivers of cost growth and subsequently develop strategies to improve performance.[13] With regards to enforcement of the benchmark, **performance improvement plans are required** from any payer or provider that exceeds

[8] http://www.ohic.ri.gov/documents/2020/July/31/230-RICR-20-30-4%20FINAL%20SOS.pdf
[9] http://www.ohic.ri.gov/documents/2019/December%202019/AS%20Revisions/Revisions%20to%20the%20Affordability%20Standards%20230-RICR-20-30-4.pdf
[10] https://www.healthaffairs.org/doi/suppl/10.1377/hlthaff.2018.05164/suppl_file/2018-05164_suppl_appendix.pdf
[11] http://www.ohic.ri.gov/documents/2019/December%202019/AS%20Revisions/Revisions%20to%20the%20Affordability%20Standards%20230-RICR-20-30-4.pdf
[12] https://www.oregon.gov/oha/HPA/HP/HCCGBMeetingDocs/2.12.20%20Presentation%20Slides_updated.pdf
[13] https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Governor-Appontment-Letter-10-18-2019.pdf

the benchmark, and those that that surpass the benchmark 3 out of 5 years **may be fined in proportion to their excessive spending**.[14]

Connecticut: Connecticut created a benchmark via Executive Order No. 5 in 2020. Connecticut's benchmark was set at 2.9% using a 20/80 weighting of CT Potential Gross State Product (PGSP) and median income, though the rate was adjusted to 3.4% and then 3.2% for the first two years of implementation.[15] The CT Office of Health Strategy is currently establishing a baseline by analyzing pre-benchmark cost growth, and will **publicly report** on performance relative to the benchmark in the future.[16] Connecticut currently does not have established consequences for entities exceeding the benchmark.

Washington: With the passing of HB 2457 in 2020, Washington created the Health Care Cost Transparency Board. On September 14, 2021, the Board voted to set their benchmark at 3.2% for 2022-2023, 3.0% for 2024-2025, and 2.8% for 2026, based on a 30/70 blend of Washington's Potential Gross State Product(PGSP) and historical median wage.[17] To help achieve the benchmark's goals, the Board will also work towards identifying cost drivers and providing recommendations for reducing health care spending to the Legislature on an annual basis.[18]

New Jersey: Executive Order 217 was signed on January 28, 2021, to create an Interagency Working Group to determine their benchmark value and strategy for implementation.[19] New Jersey intends to use 2022 as a transition year for their benchmark program before using a benchmark value of 3.5% for 2023, 3.2% for 2024, 3.0% for 2025, 2.8% for 2026, and 2.5% for 2027. New Jersey based its benchmark value on a 25/75 blend of Potential Gross State Product (PGSP) and projected median income.

Nevada: Nevada is in the process of drafting an executive order to establish their cost-growth benchmark, with a goal of it taking effect at the start of 2022.

What has the federal government done?

The only federal government involvement in cost-growth benchmarks has been CMS agreements with Vermont and Maryland that set targets for cost-growth for all payers (Maryland's rate was set at 3.58%). Similarly, to Vermont, however, Maryland's agreement with CMS sets a growth rate target as a goal for a separate program (namely an All-Payer Model) rather than the benchmark being its own central focus with strategies specifically designed for that purpose.[20]

Health Equity Impact

The United States Centers for Disease Control and Prevention (CDC) describes Health Equity as "…action to ensure all population groups living within an area have access to the resources that promote and protect health"[21]. By managing the growth in overall costs, this option will promote access and improve

[14] https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/
[15] https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/
[16] https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/Guidance-for-Payer-and-Provider-Groups/CT-OHS-Implementation-Manual_final-v-1_5.pdf
[17] https://www.hca.wa.gov/assets/program/board-meeting-summary-20210914.pdf
[18] https://www.hca.wa.gov/about-hca/health-care-cost-transparency-board
[19] http://www.cshp.rutgers.edu/content/nj-benchmark-program
[20] https://hscrc.maryland.gov/Documents/Modernization/Total%20Cost%20of%20Care%20Model%20-%20Background%20and%20Summary_7_26_17.pdf
[21] https://www.cdc.gov/minorityhealth/publications/health_equity/index.html

equity by making healthcare more affordable for Vermont households. To the extent that growth in out-of-pocket costs are targeted to a lower overall rate than the benchmark the impact on individuals may be impacted positively over time.

Alignment with other proposed Options

As part of Vermont's overarching Cost Growth Target and Affordability Index, the ROI on performance improvement plans tracked by a shared statewide vendor can also include Blueprint for Health expansion activities as well as savings experienced long term via the expansion of Vermont's Moderate Needs HCBS. Additionally, those identified savings can be used to set rates for a public option offered by the state on Vermont's health insurance exchange.