

The Manatt State Cost Containment Update May 16, 2022

Introduction

Welcome to the [Manatt State Cost Containment Update](#), a digital publication produced with generous support from the Robert Wood Johnson Foundation and developed in coordination with the [Peterson-Milbank Program for Sustainable Health Care Costs](#). This Manatt series, released quarterly through 2022, shares the latest updates on state cost growth benchmarking programs and other data-driven initiatives states are undertaking to contain health care cost growth. In each edition, we also feature a spotlight issue that speaks to how state benchmarking programs are evolving to meet new policy and program priorities.

May Spotlight

In this issue, Manatt examines how benchmarking programs can elevate the importance of primary care and behavioral health care investments and allow for the measurement of spending on these critical preventive services.

Leveraging State Benchmarking Programs to Drive Investments in Primary Care

The takeaway. State cost growth benchmarking programs support market transparency and accountability, and may be used to assess and redirect health care spending to higher-value, preventive services, such as primary and behavioral health care, through priority service targets.

What it is. States are increasingly seeking to both constrain health care cost growth as well as influence where health care dollars are being invested, with the goal of redirecting spending to high-value services and activities that support long-term population health, such as primary care.

While the U.S. far exceeds peer countries in health care spending—at \$4.1 trillion or \$12,530 per person in 2020¹—it continues to lag in terms of care access, administrative efficiency, equity and health care outcomes: There is a disconnect between how much the U.S. is investing in health and how much it is getting in return.² Studies indicate that the disconnect may be attributable, in part, to where health care dollars are being invested. Studies of other Organization for Economic Cooperation and Development (OECD) countries indicate that stronger primary care systems, for example, are correlated with better population health outcomes, such as lower overall mortality rates, lower rates of premature death and lower hospitalizations for ambulatory care sensitive conditions,³ and higher infant birth weight, life expectancy and overall satisfaction with the health care system.⁴ Even within the U.S., communities with

¹ “NHE Fact Sheet,” Centers for Medicare & Medicaid Services. Available here: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>

² “Mirror, Mirror 2021: Reflecting Poorly—Health Care in the U.S. Compared to Other High-Income Countries,” The Commonwealth Fund. August 4, 2021. Available here: <https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly>

³ M. Niti, T. Ng. “Avoidable hospitalisation rates in Singapore, 1991–1998: assessing trends and inequities of quality in primary care,” *Journal of Epidemiology and Community Health*. January 2003. Available here: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1732279/>

⁴ J. Macinko, B. Starfield, L. Shi. “The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970–1998,” *Health Services Research*. June 2003. Available here: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360919/>

greater primary care availability have reported better patient outcomes as well as decreased utilization of more costly health service categories, such as inpatient hospitalizations and emergency department visits.⁵

States like Rhode Island and Delaware have long recognized the value of investments in primary care and successfully directed attention and spending through existing insurance regulatory authorities. Other states, such as Connecticut and Massachusetts, are testing how they may leverage their benchmarking programs as a mechanism for advancing broader primary care investment agendas.

In 2010, **Rhode Island** implemented Affordability Standards,⁶ which established annual price inflation caps and required regulated commercial insurers to spend at least 10.7% of their total health care spending on primary care services under the health insurance commissioner's rate review authority.⁷ Insurer primary care spending subsequently increased from 5.7% in 2008 to 9.1% in 2012 and achieved the state-set target of 10.7% in 2014⁸ before reaching 12.3% of total medical spending in 2018 (see Figure 1).⁹ A 2019 study found that the Affordability Standards increased aggregate primary care spending and saw reductions in total spending growth, with no impacts on health care quality.¹⁰

⁵ C. Chang., T. A. Stukel, A. B. Flood, D. C. Goodman. "Primary Care Physician Workforce and Medicare Beneficiaries' Health Outcomes," JAMA. May 25, 2012. Available here: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3108147/>

⁶ 230-RICR-20-30-4.10 – Affordable Health Insurance – Affordability Standards. Current, effective June 2020. Available here: <https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-03/230-ricr-20-30-4-final-sos.pdf>

⁷ Equal to the Medicare price index plus one percentage point for both inpatient and outpatient services.

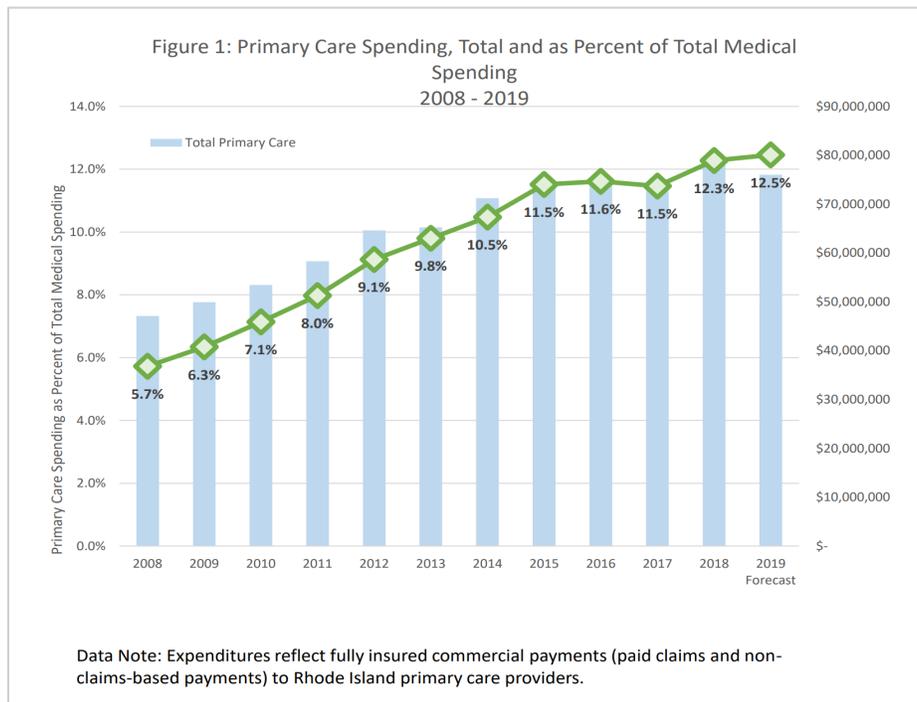
⁸ "Investing in Primary Care: A STATE-LEVEL ANALYSIS," Patient-Centered Primary Care Collaborative, Robert Graham Center and Milbank Memorial Fund. July 2019. Available here: [https://www.graham-](https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf)

<center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf>

⁹ <http://www.ohic.ri.gov/documents/2020/June/Primary%20Care%20Expenditure%20Data%20Update%20June%202020.pdf>

¹⁰ A. Baum et al. "Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers," Health Affairs. February 2019. Available here: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05164>

Figure 1. Primary Care Spending in Rhode Island, Total and as a Percentage of Total Medical Spending, 2008–2019



In 2020, **Delaware’s** Department of Insurance Office of Value Based Health Care Delivery (OVBHCD)¹¹ proposed similar affordability standards, which the state is seeking to codify through its proposed Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance.^{12,13} The standards would, among other actions, set a target for commercial health insurers to increase investments in primary care¹⁴ by 1.5% annually, targeting an increase in primary care spending from 7% of total cost of care in rate filing year 2022 (plan year 2023) to 11.5% by rate filing year 2025 (plan year 2026).^{15,16,17}

States may also advance primary care investment agendas through their existing benchmarking programs and processes.

¹¹ Established via Senate Bill 116, 150th General Assembly (2019–2020). Available here:

<https://legis.delaware.gov/BillDetail/47520>

¹² Office of Value Based Health Care Delivery (OVBHCD), Delaware Department of Insurance. Available here:

<https://insurance.delaware.gov/divisions/consumerhp/ovbhcd/>

¹³ “1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance, Proposed Rule, Public Notice.” Department of Insurance, Office of the Commissioner. Available here:

<https://regulations.delaware.gov/register/january2022/proposed/25%20DE%20Reg%20684%2001-01-22.htm>

¹⁴ Beginning in rate filing year 2022 (for plan year 2023).

¹⁵ “An Integrated Approach to Improve Access, Quality and Value,” OVBHCD, Delaware Department of Insurance. December 18, 2020. Available here: <https://insurance.delaware.gov/wp-content/uploads/sites/15/2020/12/Delaware-Health-Care-Affordability-Standards-Report-12182020.pdf>

¹⁶ “Delaware Sets Primary Care Investment Target,” Primary Care Collaborative. January 28, 2021. Available here:

<https://www.pcpcc.org/fr/node/209659>

¹⁷ Delaware’s Affordability Standards also incorporated price caps for aggregate unit price growth for inpatient and outpatient hospital services through 2025 to contain health care cost growth.

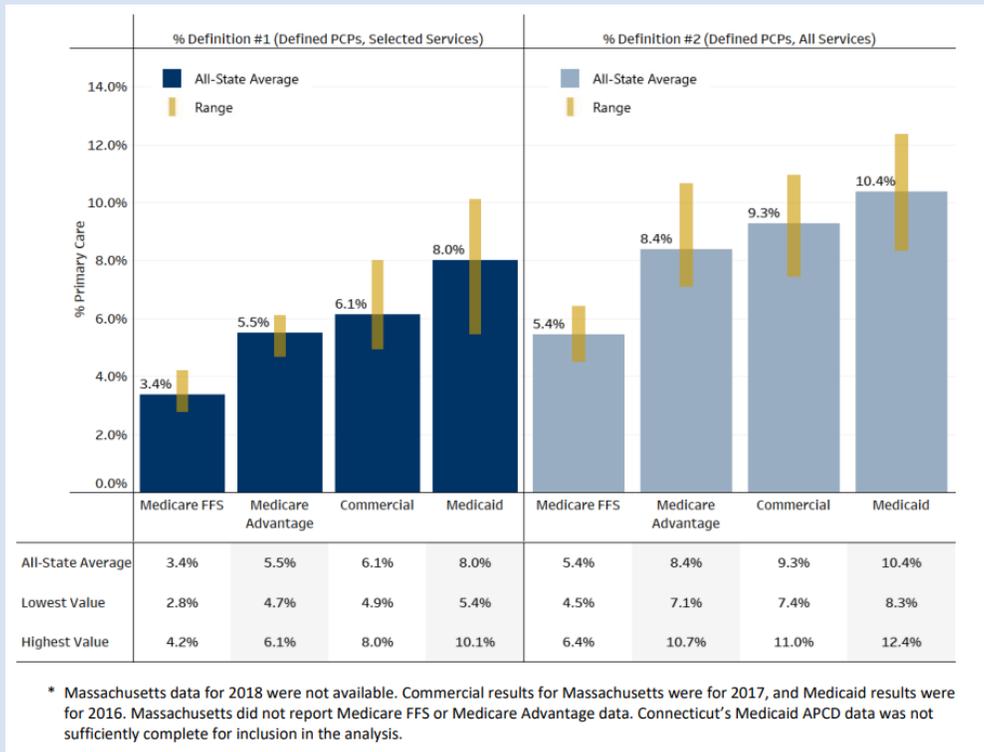
The Challenge of Defining “Primary Care Services” to Support Spending Measurement

In 2018, the New England States Consortium Systems Organization (NECSO) developed a standardized methodology for calculating all-payer primary care spending across six New England states—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont—using each state’s respective all-payer claims database (APCD) data.¹⁸ NECSO developed and tested the following definitions for primary care in its analysis:

- **“Defined PCPs, Selected Services,”** which includes selected claims payments for general practice, family medicine, pediatrics, internal medicine, nurse practitioner and physician assistant and excludes OB/GYN services.
- **“Defined PCPs, All Services,”** which includes all claims payments for the provider services listed in Definition 1 and continues to exclude OB/GYN services. This definition did not restrict service codes.

NECSO found that the all-state average of primary care spending as a proportion of total medical spending ranged from **5.5% to 8.2%, depending on the definition used to capture primary care providers, services and spending.** Primary care spending as a proportion of total spending was highest for the Medicaid population (8.0%–10.4% by state), followed by commercial (6.1%–9.3%), Medicare Advantage (5.5%–8.4%) and Medicare fee-for-service (3.4%–5.4%). See Figure 2 below for more detail. These findings align with other recent state studies that have examined total primary care spending.¹⁹

Figure 2. Primary Care Percentage of Total Medical Payments by Payer Type, 2018, NECSO Study



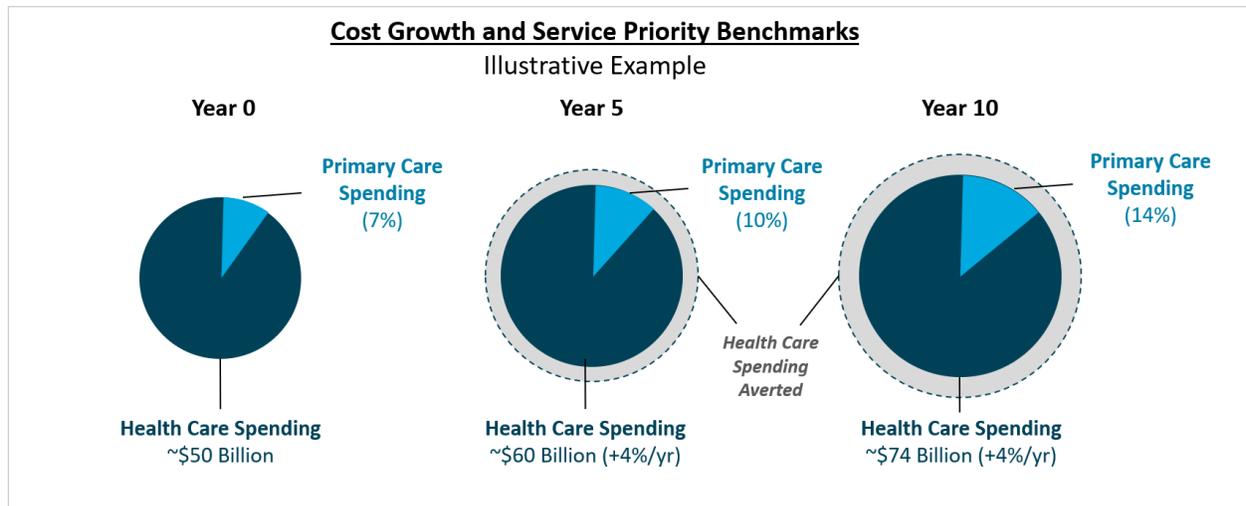
¹⁸ “The New England States’ All-Payer Report on Primary Care Payments,” New England States Consortium Systems Organization (NECSO). December 22, 2020. Available here: <https://nescso.org/wp-content/uploads/2021/02/NECSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf>

¹⁹ “Investing in Primary Care, A State-Level Analysis,” Patient-Centered Primary Care Collaborative (PCCC). July 2019. Available here: https://www.pccc.org/sites/default/files/resources/pcmh_evidence_report_2019.pdf

What it means. Health care cost growth benchmarking programs can provide states with a mechanism to similarly advance cost containment and “**priority service**” objectives, allowing stakeholders to measure and monitor primary care spending against total system spend and use this information to influence investments in preventive services.

State cost growth benchmarking programs are data-driven, transparency-focused cost-containment initiatives that measure resident health care spending growth in relation to established targets; payers and providers that exceed targets may be subject to public inquiry or penalty. States collect benchmarking data directly from public and private payers operating in their states, monitoring health care spending across all lines of business. Payers may be asked to segment spending data by service category (which may be expanded to include primary care services and other priority services), key populations or product types, attribute spending to providers who may influence patient service utilization, or supplement “core” reporting with contextual information.²⁰ States are then able to analyze payer data to understand broad market health care spending trends, and to better target policy and program actions to address cost drivers—or, for “priority service” areas like primary care, advance agendas that displace lower-value spending with spending on services that promote long-term population health outcomes (see Figure 3 below).

Figure 3. Illustrative Example of Increased Investments in Primary Care and Impacts on Overall Health Care Cost Growth Over Time

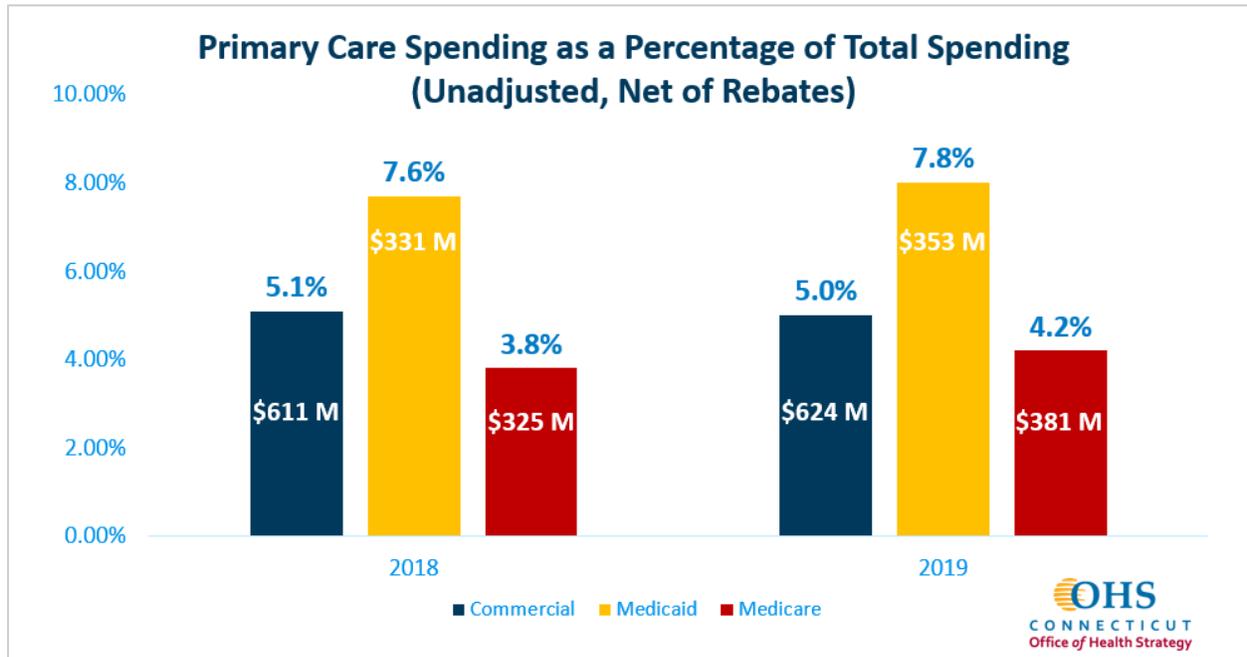


Connecticut. In 2020, Connecticut’s Governor Lamont issued Executive Order No. 5, which, in addition to establishing the statewide cost growth benchmark, also charged the Office of Health Strategy (OHS) with developing and recommending a primary care spending target for the state beginning in 2021 in order to reach a primary care spending target of 10% (as a percentage of total health care expenditures, or THCE) by 2025. OHS’ preliminary analysis of primary care spending in the state by market found that the state’s average primary care spending in 2019 was 5.3%, with the highest percentage of primary

²⁰ J. Ario, K. McAvey, A. Zhan. “State Benchmarking Models: Promising Practices to Understand and Address Health Care Cost Growth,” Manatt Health. June 2021. Available here: <https://www.manatt.com/insights/white-papers/2021/state-benchmarking-models-promising-practices-to-u>

care spend within Medicaid (7.8%), followed by the commercial market (5.0%) and Medicare (4.2%) (see Figure 4). In December 2021, OHS adopted primary care spending targets of 5.3% for 2022, 6.9% for 2023, 8.5% for 2024 and 10% by 2025. OHS will collect primary care spending data from payers within their cost growth benchmark data submissions in late 2022.

Figure 4. Primary Care Spending as a Percentage of Total Spending in Connecticut, 2018 and 2019²¹



Massachusetts. In March 2022, **Massachusetts’** Governor Baker similarly filed “An Act Investing in the Future of Our Health” for the creation of a statewide aggregate primary care and behavioral health care spending target and set a goal of increasing spending on these services by 30% over three years while maintaining the state’s health care cost growth benchmark.^{22,23} Payer and provider progress toward meeting spending targets will be assessed by the state’s Center for Health Information (CHIA) and Health Policy Commission (HPC) through its regular cost growth benchmark reporting process. Entities that fail to achieve the established primary care spending target may be required to complete a performance improvement plan (PIP) wherein they identify strategies to increase investments in primary care and behavioral health. The Baker-Polito Administration estimates this action will generate nearly \$1.4 billion in systemwide investments for primary care and behavioral health services over the next three years.²⁴

²¹ “Leveraging State Benchmarking Models to Address Health Care Cost Growth,” Manatt Health webinar, April 2022. Available here: <https://www.manatt.com/insights/webinars/leveraging-state-benchmarking-models-to-address-he>

²² S. 2774, “An Act Investing in the Future of Our Health.” Filed March 17, 2022. Available here: <https://malegislature.gov/Bills/192/S2774>

²³ Calendar year (CY) 2019 will serve as the baseline year CY 2024 spending will be measured against.

²⁴ “Baker-Polito Administration Files Health Care Legislation Aimed at Expanding Access to Care,” Press Release, Office of Governor Baker and Lt. Governor Polito. March 15, 2022. Available here: <https://www.mass.gov/news/baker-polito-administration-files-health-care-legislation-aimed-at-expanding-access-to-care>

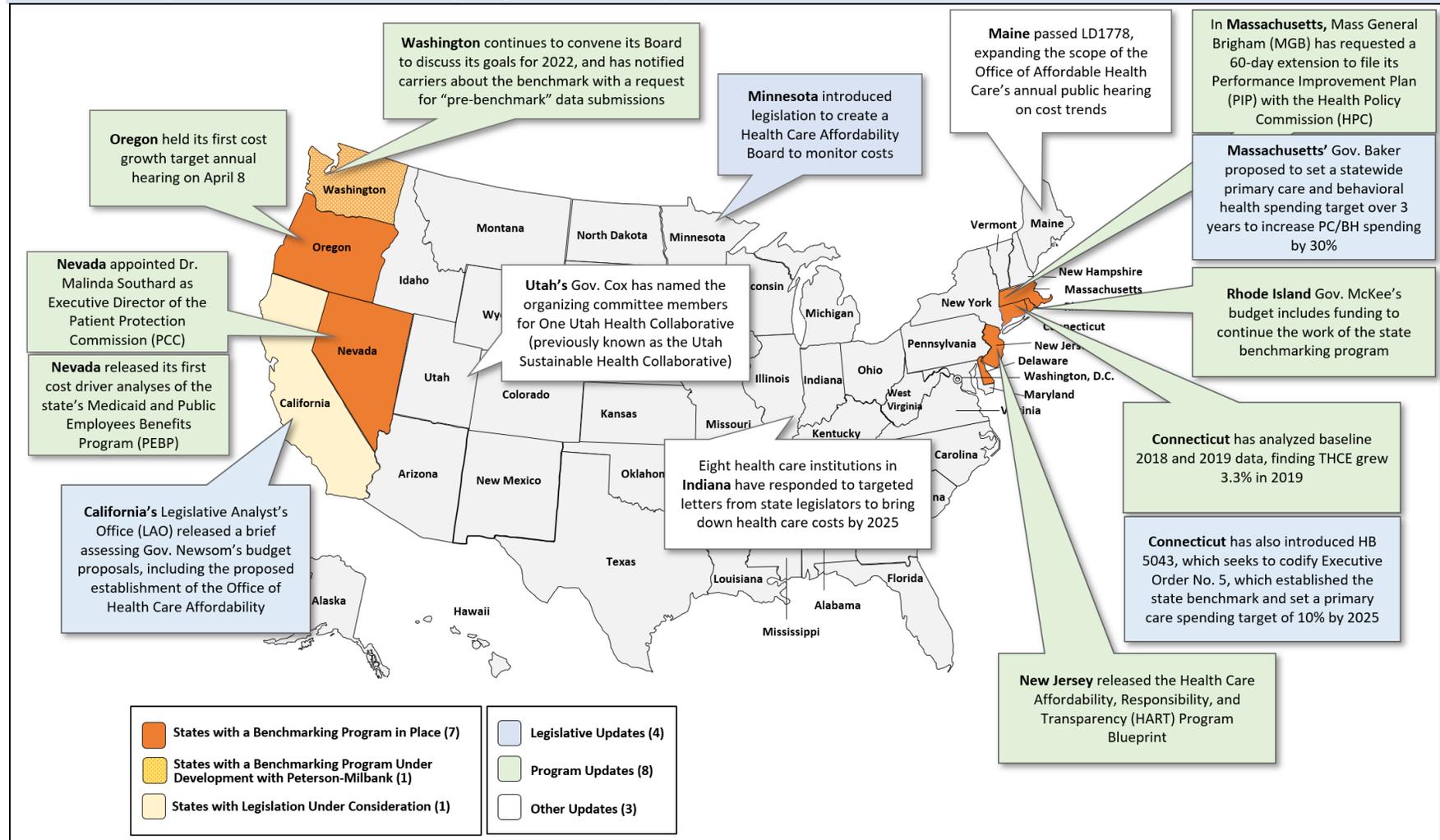
Other states pursuing benchmarking programs are also considering setting primary care and behavioral health priority service targets as part of their programs.²⁵ California’s AB-1130, proposes establishing an Office of Health Care Affordability, a statewide cost growth benchmark, and priority service benchmarks for primary care and behavioral health investments.²⁶

What happens next. As state cost growth benchmarking programs continue to proliferate and mature, more states will explore ways to leverage their data collection and reporting to advance local priorities, including increasing investments in preventive services like primary care and behavioral health.

²⁵ “Groundbreaking Study Links Higher Primary Care Spending to Better Care Quality in California,” California Health Care Foundation. April 19, 2022. Available here: <https://www.chcf.org/press-release/groundbreaking-study-links-higher-primary-care-spending-to-better-care-quality-in-california/>

²⁶ AB-1130, California Health Care Quality and Affordability Act (2021–2022 Regular Session). Introduced February 18, 2021. Available here: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1130

The State of Play: Cost Growth Benchmarking Programs (as of May 16, 2022)



Detailed State Updates as of May 16, 2022

State	Update	Detail
CA	Legislative Update	California’s Legislative Analyst’s Office (LAO) released a brief assessing Governor Gavin Newsom’s budget proposals to improve access and affordability in California, including the Governor’s renewed proposal to establish the Office of Health Care Affordability. California continues to advance its proposal to establish an Office of Health Care Affordability.
CT	Legislative Update	On March 10, Connecticut filed HB 5042 , which codifies Executive Order No. 5, which established the state’s cost growth benchmark and established requirements that the statewide benchmarks account for primary care spending, and set a target of 10% of primary care spending as a percentage of total health care expenditures by 2025.
CT	Benchmarking Program	<p>Findings from Connecticut’s pre-benchmark analysis of 2018 and 2019 cost growth data determined that the state’s Total Health Care Expenditures grew 3.3% in 2019, with per capita spending growth in 2019 varying significantly by market:</p> <ul style="list-style-type: none"> • Commercial, 6.1% • Medicaid, -0.9% (2.1% when long-term care is removed) • Medicare, 2.2% <p>Retail pharmacy and hospital outpatient were primary drivers of state, Medicaid and Medicare spending growth in 2019. In the commercial market, hospital outpatient and hospital inpatient services were the largest drivers of cost growth.</p>
IN	Other Update	In response to targeted letters from Indiana state leaders calling on health care industry leaders to propose and implement specific measures to bring Indiana hospital prices down to “at least the national average” by 2025, Indiana University Health tells legislative leaders that health care costs cannot be reduced. Eight other health care institutions in the state have responded to the legislative letters as well.
MA	Benchmarking Program	Mass General Brigham requested a 60-day extension to respond to the Health Policy Commission’s Performance Improvement Plan requirement.
MA	Legislative Update	On March 15 , the Baker-Politico Administration filed S. 2774, titled “An Act Investing in the Future of Our Health,” which proposes to set a statewide primary care and behavioral health spending target, requiring health care providers and payers to increase expenditures on primary care and behavioral health by 30% over three years. This is estimated to result in a systemwide investment of approximately \$1.4 billion into primary care and behavioral health.



ME	Other Updates	On March 29, Maine’s Governor Janet Mills signed LD1778 , requiring the Office of Affordable Health Care to expand the scope of its annual public hearing on cost trends to include barriers to health care affordability beginning in 2023, and extends the date for the office to report to the Legislature on its study of the effects of policies aimed at improving health care affordability and coverage from January 1, 2023, to January 1, 2024.
MN	Legislative Update	On April 1 , Minnesota introduced HF4430/SF4354 , which proposes to establish a Health Care Affordability Board to monitor health care costs, set targets to limit those costs and issue fines if those targets are exceeded.
NJ	Benchmarking Program	<p>On March 30, the Murphy Administration released the Health Care Affordability, Responsibility, and Transparency (HART) Program, which outlines the state’s plan to improve health care affordability in New Jersey through its new cost growth benchmarking program.</p> <p>In 2022, the New Jersey Office of Health Care Affordability and Transparency plans to identify an Implementation Advisory Group and a Technical Subgroup to work through the details of data collection and reporting, and to convene an Expert Panel to advise the state on economic and other factors influencing benchmark attainment, begin the data collection for benchmark and cost driver analysis, and more.</p>
NV	Benchmarking Program	On April 20 , the Nevada Patient Protection Commission (PCC) reviewed and discussed the benchmarking program’s first cost driver analyses: Medicaid Phase 1 Cost Driver Analysis and Public Employees Benefits Program (PEBP) Phase 1 Cost Driver Analysis . Bailit consulting also provided an introduction to the data use strategy for program leaders to begin strategizing in advance of the state’s 2023 baseline cost growth benchmark report.
NV	Benchmarking Program	On March 28, Dr. Malinda Southard was appointed by Governor Sisolak to serve as the new executive director of Nevada’s Patient Protection Commission, which leads the state’s cost growth benchmarking program.
OR	Benchmarking Program	On April 8, Oregon held its first cost growth target annual hearing , which included panels on the impact of COVID-19 on Health Care Costs in Oregon, the Health Care Cost Impacts on Consumers, and Efforts to Address Health Care Costs. Speakers for the consumer panel included representatives from OSPIRG, SEIU Local 49, Saldivar Insurance, Main Street Alliance and several consumers.
RI	Benchmarking Program	Governor McKee’s 2022–2023 budget proposal included funding from the State Fiscal Recovery Fund to continue the work of the state’s cost growth benchmarking program.
UT	Other Updates	Governor Cox has named the organization committee members for One Utah Health Collaborative (previously known as the Utah Sustainable Health Collaborative).



<p>WA</p>	<p>Benchmarking Program</p>	<p>Plan for Year Two. During the January Health Care Cost Transparency Board meeting, the Board outlined its plans for year two of the benchmarking program. In March, the Board will review existing data on Washington cost growth drivers. Over the following months, the Board will then identify areas of interest in cost growth mitigation, review the pre-benchmark data call process and reporting, and review the initial cost driver analysis.</p> <p>Pre-Benchmark Insurer Data Request. In late March, the Board notified health insurers about the benchmark and asked them to share “pre-benchmark” performance data for calendar years 2017, 2018 and 2019.</p> <p>Preparing for Preliminary Data Call. The Washington Advisory Committee on Data Issues plans to hold payer seminars and office hours in May and June of 2022, with a request for preliminary data submission to be opened on June 30, 2022. Full meeting materials for the Board and Advisory Committees are available here.</p>
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Health Data Corner

The Health Data Corner compiles the latest state health care data capacity innovations and policy developments, and showcases select, novel data use cases emerging from states.

- The **Delaware** Department of Insurance is seeking to codify its proposed Affordability Standards, which would establish primary care investment targets through 2025 through [new proposed regulation](#).
- **Delaware’s** Department of Health and Social Services released a new [CostAware website](#), which uses data from the Delaware Health Care Claims Database and publicly shares health care pricing and quality data for providers in the state. The state plans to continue to incorporate additional pricing data and consumer features in the website throughout the year.
- The **National Academy for State Health Policy (NASHP)** released a new [Interactive Hospital Cost Tool](#), which analyzes a hospital’s annual Medicare Cost Report (MCR) to provide insights into how much hospitals spend on patient care services, and how those costs relate to both the hospital charges (list prices) and the actual prices paid by health plans. Additional resources on unique features of the Interactive Hospital Cost Tool, such as the [commercial breakeven feature](#), are also available.
- E. Lowry, A. Johnson, A. Hunt and T. Lee’s recent **Health Affairs** [piece](#) examines state performance within the **Altarum Healthcare Value Hub’s** [2021 Healthcare Affordability State Policy Scorecard](#), which examines four key domains: curbing excess prices in the system, reducing low-value care, extending coverage to all residents and making out-of-pocket costs affordable.

Other Cost Containment Resources

- The **California Health Care Foundation**'s new [issue brief](#) outlines developing state-level benchmarking programs and their progress in establishing cost growth targets and other program components.
- The **Commonwealth Fund**'s recent [issue brief series](#) outlines ten strategies for states to address cost growth in the commercial market, with the most resource-intensive strategies listed first.
- M. J. Pany, M. Chernew and L. S. Dafny's recent **Health Affairs** [piece](#) discusses two key strategies for limiting health care prices at the state level, including comprehensive price caps supported by rate review and out-of-network price caps.
- A **Kaiser Family Foundation (KFF)** [study](#) finds that large shares of non-elderly households do not have enough liquid assets to meet typical health plan cost-sharing amounts—an effect that is exacerbated for lower-income households, which were much less likely to have liquid assets available.
- **32BJ**'s [new report](#) examines hospital prices and outlines four policy interventions for addressing rising health care costs, including aggregated purchasing coalitions, restricting anti-competitive contracting by large hospital systems, ensuring nonprofit hospitals act in accordance with nonprofit hospitals, and leveraging rate regulation and global budgets.
- The [1% Steps for Health Care Reform Project](#) compiles literature from leading scholars on specific challenges contributing to rising health care costs and offers specific policy actions for reform.

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