Date: July 17, 2024

From: Zachary Goldman, Health Care Cost Economist

Subject: Report on Rulemaking Hearing and Public Comments

Hearing Date: June 18, 2024, 3 p.m.
Hearing Location: Remote, Zoom
Hearing Officer: Pete Edlund, HPA Rules Coordinator
Public Comment Period: June 1, 2024 through June 21, 2024
Title of Proposed Rules: Changes to the Sustainable Health Care Cost Growth Target Program
Repeal: none
Amend: OAR 409-065-0000, 409-065-0005, 409-065-0010, 409-065-0015, 409-065-0020, 409-065-0025, and 409-065-0030.
Adopt: OAR 409-065-0028, 409-065-0029, 409-065-0035, 409-065-0040, 409-065-0042, 409-065-0045, 409-065-0050, and 409-065-0055.

Meeting recording at: https://youtu.be/8oGTzrTqowo

Rules Hearing Attendance Record:
Pete Edlund, OHA
Zachary Goldman, OHA
Margaret Smith-Isa, OHA
Nick Kashey, Legacy Health
Andrea Seykora, Hospital Association of Oregon

Public Participants:
Jim Houser
AKing
Andrew Feher
Beau Reitz
Ben Johnson
Bryan Boehringer
CJ Howard
Daniel Porter
Eric Norton
Greg Daniel (Kaiser)
Heather
Jacob Olson
Jennifer Olson
Jill Hosseini (CA OHCA)
Jodi Hack
Joe Gardner
Kathy Therrien – Aetna
Kellie Hogue, HCAI
Kelly Cope
Leah Navarro
Leif Bruce
Lilly Sobolik, DCBS
Marris Alden – Regence
Megan Brubaker (OHCA)
Megan Lane (KP)
Ruth Miles, Salem Health
Scott
Sen. Deb Patterson
Vishaal Pegany

Summary of Oral Comments presented during the June 18, 2024 Rules Hearing.

Testimony by Andrea Seykora, Hospital Association of Oregon

General Comments: HAO appreciates the work OHA has done to incorporate feedback from the RAC process and we've seen a number of improvements to the rules. Will flag some things that needs further work: how the rules handle worker compensation. The rules do not reflect the full implementation of the bill. However, there was a proposal in the fifth RAC meeting regarding if the frontline worker cost growth exceeds the entity's cost growth. It appears to us that the proposal is good and would like to see language in rule about this. Also important to include in rules that a penalty will not be applied unless an entity has not made a good faith effort to comply with a performance improvement plan, which is consistent with the advisory committee and original implementation report. Will follow up with written comments.

Response: OHA thanks you for this comment.

Testimony by Nick Kashey, Legacy Health

General Comments: Echo the appreciation for the RAC process and we will follow up with written comments. Appreciate the back and forth with OHA. I have significant concerns with the structure of the program, the penalties, which are proportionate to the total cost of care, being applied to a wide range of entities. Would like to see further protection for the smaller groups of providers where penalties proportionate to the total cost of care could be catastrophic. I have significant concerns about access to primary care; we are already struggling with 6 to 9 months wait for patients to get into primary care. Impact of penalties could be detrimental to promote the health of Oregonians. Will follow with written commentary.

Response: OHA thanks you for this comment.

Summary of Written Comments received during the public comment period through June 21, 2024.
Chronological order of received. Note that commenters' footnotes and endnotes are not included in the comments below but are present in the exhibits.

Comments from Mary Anne Cooper, Regence (Exhibit 1)

Comment 1: **The reasonableness process should reflect all costs outside an entity's control:**
As we've discussed extensively in prior comments, we believe the reasonableness factors must be drafted to account for all factors outside an entity's control. We

continue to have concerns that many factors are written from a "provider" perspective and fail to account for how costs roll up to payers. We also believe that the list of factors fails to account for the full range of factors that impact payer costs, and which should be part of a reasonableness determination. We provided specific examples in our Feb. 14, 2024, comment letter but will broadly reiterate them here:

- OAR 409-065-0035(2)(d) includes "changes in taxes related to health care or other administrative requirements, including but not limited to changes in medical loss ratio rebate requirements pursuant to state or federal regulations." While changes in taxes can impact a payers' overall business model, that is not captured in the data payers submit to the state, which is solely focused on medical claims. However, we would anticipate that changes to provider taxes would show up in the reimbursement rates they ask for from payers and not be something payers would specifically claim or be able to submit data to OHA on.

- Similarly, OAR 409-065-0035(2)(g), includes "macro-economic factors such as periods of significant inflation, supply chain shortages or labor shortages" as a reasonable cause for cost growth. Given that payers' labor costs, inflation and supply chain challenges are not included in their claims data, and therefore not part of the cost growth target, this factor is only relevant to providers as drafted. For payers, these costs as incurred by providers would be reflected in payers' negotiated rate increases with providers due to rising input costs.

- OAR 409-065-0035(2)(i) includes high cost outliers but does not include how those outliers will roll up to payers.

OHA should include a new "acceptable reason" specific to payers that includes "changes in costs based on increased contract rates paid to providers or increased costs of pharmaceuticals." We would then recommend expanding on the specific factors in the guidance, including recognizing the need to balance network adequacy requirements and member abrasion risks against cost increase requests from providers that would cause payers to exceed the cost growth target.

We also recommend adding a factor for the macroeconomic "acceptable reason" that addresses calculated cost growth due to changes in a payer or provider's mix of business. An entity could demonstrate cost growth below the target for each line of business and yet exceed the target overall due to a shift from a line of business with less claims cost to a line of business with more claims cost on average.

Further, we believe that alongside detailed documentation of cost growth drivers, an entity should be able to provide information about how it tried to address that cost growth and what impacted their success. For example, if provider contracts are a significant factor in payer cost growth, the payer should both quantify the impact of that

cost growth and be able to explain why it was unable to address that cost impact to a sufficient degree to avoid an impact.

While we understand that the program was designed to measure changes in cost growth over time, we also believe that the reasonableness process should credit entities with lower overall costs, even if their cost growth is high in any given year. For example, an entity who is cost effective may have a few years of high cost growth because they endeavor to keep overall costs as low as possible. If an entity experiences high-cost growth over a period of time, but has low total costs, that should factor into that reasonableness process. This would encourage entities to focus not only on year-over-year cost growth, but on their overall affordability through total costs.

Response 1: OHA thanks you for this comment. The list of acceptable reasons was developed over the course of a year and after numerous discussions including the Advisory Committee, Rules Advisory Committee, and other interested parties. The current list of acceptable reasons strikes the balance between ensuring accountability while acknowledging acceptable reasons for exceeding the cost growth target. Additionally, OHA welcomes entities providing information about how it tried to address cost growth drivers as part of the determining reasonableness process outlined in rule and sub-regulatory guidance.

Comment 2: OHA should allow partial reasonableness determinations:

We strongly disagree with OHA's most recent changes that specify that reasonableness determinations are an "all or nothing" determination about cost growth. If OHA finds any portion of an entity's cost growth to be "reasonable," that cost growth should not be subject to a PIP or a penalty. For example, if a carrier exceeded the target by 2% (hitting 5.4%), but 1.5% (or 3.6%) of that was determined to be reasonable, it should only accrue a penalty on the 0.5% of cost growth that was "unreasonable," not the full 5.4% of cost growth. If OHA penalizes an entity for its total cost growth, even the portion that was "reasonable," it flies in the face of the assurances that cost growth will not count against an entity if it is reasonable, and it holds an entity financially accountable for cost growth that OHA has determined was outside its control or due to a reasonable cause. It also would serve as a disincentive for an entity to meet the target at all, or to invest in activities to improve quality and access to health care as any such investment could become subject to penalty if there was also a single dollar of non-reasonable growth above the target.

Response 2: OHA thanks you for this comment.

Comment 3: Financial penalties should be tied to non-compliance with the Performance Improvement Plan

In its Principles for Financial Penalties document, the CGT Advisory Committee recommended that "financial penalties should be a measure of last resort, to be employed only after an insurer has not met the obligations laid out in their Performance Improvement Plan (PIP)." The Principles document goes on to explain how the PIP

process relates to penalties and how this structure meets the goal of the program of improving health care cost management and efficiency rather than immediately resorting to punitive measures.

However, the draft rules do not contain this restriction on penalties, instead stating that penalties are to be levied if the payer or provider's cost growth exceeds the target without reasonable cause for at least three out of five calendar years. OAR 409-065-0045(1). Penalties should be imposed only if an insurer or provider organization has not made good faith efforts to meet the obligations in its PIP, and any failures to meet the PIP had a meaningful impact on consumer costs. This is consistent with the statute, which provides that the penalty criteria account for the good faith efforts of the payer or provider to address health care costs and the provider or payer's cooperation with the OHA. See ORS 442.386 (9).

Response 3: OHA thanks you for this comment. The goal of a Performance Improvement Plan is to reduce cost growth. If an entity's cost growth repeatedly exceeds the target over multiple years despite the entity's implementation of a Performance Improvement Plan, that Performance Improvement Plan is not achieving its goals. The rules state that OHA will reassess the PIP rules in 2030.

Comment 4: OHA must have an upper limit or cap on penalties

We encourage the adoption of a penalty cap as outlined in our prior comments. As we explained in our prior letter, we believe an appropriate penalty for an entity's first failure to meet the obligations of its PIP should be $50,000, increasing by $50,000 with each subsequent failure to meet the PIP. The maximum penalty for any annual failure to meet the obligations in a PIP should be $250,000. The $50,000 to $250,000 penalties should be a maximum, and OHA should set lower thresholds for smaller organizations and to account for mitigating factors such as cooperation with OHA during the cost growth and PIP process.

Under the proposal set by OHA, with initial penalties at 5% and growing by 5% with each additional evaluation, the penalties will quickly measure beyond $1 million for many entities regulated under the program. Penalties set at this level nearly guarantee an outcome that is opposite that intended by OHA, with entities passing the fine along to consumers in the form of higher prices (providers) and higher rates (payers). The boundless, accelerating penalty creates a feedback loop that is in direct conflict with the overall goals and objectives of the CGT Program. While nearly any penalty is likely to have a consumer impact as it's absorbed into the system, OHA should set penalties at a level that avoids material consumer impacts.

If OHA continues with a percentage-based penalty, OHA should cap the escalator clause. As drafted, the proposed penalties do not have any cap on the 5% escalator clause, which could result in penalties accruing indefinitely. If OHA moves forward with an escalating penalty, that penalty should reset after three years of compliance (where an

entity is either under the target or its cost growth was deemed reasonable). An entity's past overages should not be held against it indefinitely, but rather reset once it has demonstrated compliance with the target for three years. A reset also provides an additional incentive for an entity to beat the target every single year (not just three out of five years).

Response 4: OHA thanks you for this comment. The rules state that OHA will reassess the penalty rules in 2030.

Comment 5: Penalties should be assessed for single years only

We are also concerned that in OHA's example penalty calculation, it appears that the first penalty assessment will cover the total overage and underage in the first five-year period, as opposed for being assessed just for the cost growth in the final year that drove an entity to exceed the target in three out of five years. After that, cost growth penalties would be assessed for single years of cost growth. The cost growth program should only ever assess penalties for the single year that is the subject of the penalties, and penalties should never look retroactively beyond the year in question. To assess an initial penalty based on a five year look back will result in a penalty that is excessively high and penalizes years where cost growth was not intended to be subject to the penalty. OHA needs to ensure that all penalties are for a single cost growth year only. To accomplish this within the current framework, OHA could calculate the overage and underage on a PMPM basis over 5 years, but then multiply that PMPM by current enrollment to avoid amplifying the penalties in the first year.

Response 5: OHA thanks you for this comment.

Comment 6: Penalties should not flow to OHA programs

The draft rules provide no level of detail about the use of financial penalties submitted by an entity, outside of the fact that penalties must provide a community benefit and not directly benefit the entity subject to the penalty. We believe that the lack of restrictions surrounding use of penalty funds could easily become a mandate to fund unrelated OHA programs and priorities. This would create an incentive to impose penalties even when they do not further the objectives of the CGT Program. Further, we see no reason why penalties should not be directed toward executing an entity's PIP, as those funds would directly advance the CGT Program. We would like to see additional specificity on expectations around penalties to ensure that the resources do not become earmarked for unrelated OHA programs.

Response 6: The cost growth target financial penalties, as specified in draft OAR 409-070-0045(8), must directly benefit community members in the geographic area that the entity serves. OHA will not receive the entity's financial penalty funds. Therefore, the financial penalties will not fund OHA programs.

Comment 7: OHA's rules and implementation of the CGT Program must avoid federal preemption

Regence has previously asserted that the reporting requirements under the CGT Program conflict with and are preempted by federal laws to the extent the state program seeks to impose requirements with respect to ERISA Plans, Medicare Advantage Plans, and Plans for federal employees that are governed by the Federal Employees Health Benefits Act (FEHBA) through and onto Regence. Moreover, the CGT Program continues to require Regence to report information on such plans, even though the program's requirements exceed the scope of a "health benefit plan" under Oregon law.

We raise the same objection to the program's currently proposed enforcement mechanisms and ask that, with respect to both reporting and enforcement requirements, the state reconsider its position by narrowing the program's scope to carve out these Plans from the Program.

As of this time, Regence will continue to comply with the reporting requirements, albeit with objection. Regence further continues to encourage OHA to adopt a reasonable enforcement scheme under the program, including exempting ERISA-based, Medicare-based, and FEHBA-based Plans from any enforcement mechanisms., With respect to both reporting requirements and enforcement mechanisms, we reserve all rights, including the right to assert and challenge that such reporting requirements and enforcement mechanisms as related to ERISA-based, Medicare-based, and FEHBA-based Plans are unlawful and preempted by federal law.

Response 7: OHA thanks you for this comment.

Comments from Nikolaus Kashey, MD, MPH, Legacy Health (Exhibit 2)

Comment 8: Primary Care Providers are penalized for costs beyond their control:

Per OHA's reporting, primary care accounts for 12%-13% of medical spend in Oregon, but primary care is accountable for 100% of the cost growth under the rules as generated. Primary care is not the source of high medical costs in Oregon nor is it able to control spend outside its offices by other entities or pharmaceutical companies. Accordingly, we request that primary care practices are only held financially responsible for cost growth in primary care services, not all services.

Response 8: The Sustainable Health Care Cost Growth Target Implementation Committee, which consisted of representatives from payers, providers, consumer advocates, and health systems including Legacy Health recommended that the program use a total medical expenditures approach and hold entities accountable based on primary care attribution.

Comment 9: Different market forces generate the same financial penalties:

Reimbursement methodologies are set differently for different markets. Government agencies set reimbursement for Medicaid and Medicare services. Managed Medicaid and Managed Medicare plans have some wiggle room to increase rates beyond the government-set rates, but very little. Consequently, unit cost growth is nearly always going to be below 3.4% for these markets, and if growth is higher, it is likely driven by government agencies such as OHA. Commercial market reimbursement is negotiated directly between payors and providers and so can be subject to unit cost increases on a different scale. Treating these markets the same for cost growth penalties assumes that unit cost could be the driver for all markets. If costs grow more than 3.4% for Medicare or Medicaid members, that growth is almost certainly driven by utilization. Because primary care practices lose money providing services to Medicaid and Medicare beneficiaries, this penalty program incentivizes providers either to reduce utilization/access or to stop service to these beneficiaries.

To preserve access for government payors to primary care services, penalties should be reduced to 1%, 2%, 3% with 1% increments rather than the 5%, 10%, 15% and 5% increments proposed now for all markets.

Response 9: OHA thanks you for this comment. The rules state that OHA will reassess the penalty rules in 2030.

Comment 10: Providers are penalized for reasonable growth:

If a provider's cost growth is 7%, and 2% are found to be reasonable for reasons outlined in the rule, such as changes in state-mandated benefits, the provider will still have cost growth in excess of the target, and the penalty will be assessed against the 7% growth, which is known to contain reasonable/excusable growth. It would be more appropriate to subtract the cost growth target from the unreasonable growth (5%) rather than total growth (7%).

The rule should be amended to state the formula for measuring cost growth above the target as (PMPM year 2 (exclusive of reasonable growth) – (PMPM year 1 * (1+Cost growth target percent))) = x.

Response 10: OHA thanks you for this comment.

Comment 11: Providers are penalized for known uncertainty:

Given that a provider may be found to have indeterminate performance if the lower bound of the 95% confidence interval spans the target threshold, OHA is appropriately acknowledging the uncertainty in their own calculations. The same acknowledgement should be granted when calculating a provider's financial penalties. Thus, a provider's cost growth penalty should be calculated not from the calculated PMPM but from the lower bound of the 95% confidence interval.

As an example, if a provider's baseline PMPM is $1000 and they are calculated to have a new PMPM of $1050, or 5% growth, but the lower bound is 3.8%, the penalty should be calculated as $1038 (3.8%) - $1034 (3.4%) not $1050 (5.0%) - $1034 (3.4%).

Response 11: OHA thanks you for this comment.

Comments from Daniel Smith, Samaritan Health Services (Exhibit 3)

Comment 12: We remain concerned that the proposed rules do not fully align with HB 2045 (from 2023), SECTION 2(10) "A provider shall not be accountable for cost growth resulting from the provider's total compensation."

Instead of having the cost associated with our frontline worker removed at the front end of the calculation process, OHA is proposing that "if the cost growth is greater than or equal to the total value of the entity's cost growth above the target across all accountable markets, then OHA will deem the cost growth reasonable." This is only partially aligned with the HB 2045 and providers may still be accountable for the same workforce investments that, we believe, the legislature clearly intended to exempt.

We support the Hospital Association's proposal to add additional provisions to OAR 409-065-0035, to further guide how this calculation and its role in determining reasonableness are described. HAO proposed the following new provisions to OAR 409-065-0035:

For provider organizations that have submitted a CGT-4 as described in OAR 409-065-0028, the Authority must calculate the provider organization's frontline worker cost growth as the difference in the grand total frontline worker compensation between the current calendar year and the previous calendar year.

- If the provider organization's frontline worker cost growth is greater than or equal to the total value of the provider organization's cost growth above the target across all accountable markets, the Authority must deem the cost growth reasonable, and the provider organization will not be required to participate in the Authority's determination of reasonableness process.
- If a provider organization's frontline worker cost growth is less than the total value of the provider organization's cost growth above the target across all accountable markets, the provider organization may still claim total compensation paid to frontline workers as a potentially acceptable reason for cost growth as part of the determination of reasonableness process.

Response 12: OHA thanks you for this comment. OHA will modify the rules to state "The Authority will deem there is reasonable cause for a provider organization exceeding the cost growth target if its frontline worker cost growth is greater than or equal to the total value of the provider organization's cost growth above the target across all accountable markets."

Comment 13: The rules should clearly indicate that a financial penalty will be imposed only if a payer or provider organization has failed to make a good faith effort to comply with a Performance Improvement Plan (PIP).

We agree with HAO's recommendation that this be clarified in the rules revision to OAR 409-065-0045 to read:

(1) Pursuant to ORS 442.386, the Authority may impose a financial penalty on a payer or provider organization when:

(a) The **payer or provider organization's** cost growth exceeded the target with statistical confidence, as defined by the Authority; *[and]*

(b) The payer or provider organization's cost growth is without reasonable cause, *[or]* **and** is not indeterminate, as defined in 409-065-0035, in the Medicaid, Medicare Advantage, or commercial insurance market for at least three out of five **consecutive** calendar years[.]; **and**

(c) The payer or provider organization has failed to make a good faith effort to comply with an approved PIP.

Response 13: OHA thanks you for this comment. The goal of a Performance Improvement Plan is to reduce cost growth. If an entity's cost growth repeatedly exceeds the target over multiple years despite the entity's implementation of a Performance Improvement Plan, that Performance Improvement Plan is not achieving its goals. The rules state that OHA will reassess the PIP rules in 2030.

Comments from Sean Kolmer, Hospital Association of Oregon (Exhibit 4)

Comment 14: We remain concerned that the proposed rules do not fully implement HB 2045.

At the fifth RAC meeting on May 15, 2024, OHA proposed, "If the entity's frontline worker cost growth is greater than or equal to the total value of the entity's cost growth above the target across all accountable markets, then the OHA will deem the cost growth reasonable," and offered an example calculation. Despite some limitations that were identified during the RAC meeting, and despite the fact that we do not consider it a full implementation of HB 2045, we support this proposal as a predictable measurement of the extent to which frontline worker compensation will be considered a reasonable cause of cost growth. However, this calculation and its role in determining reasonableness are not described in the proposed rules. We recommend adding the following new provisions to OAR 409-065-0035:

• For provider organizations that have submitted a CGT-4 as described in OAR 409-065-0028, the Authority must calculate the provider organization's frontline worker cost growth as the difference in the grand total frontline worker compensation between the current calendar year and the previous calendar year.

• If the provider organization's frontline worker cost growth is greater than or equal to the total value of the provider organization's cost growth above the target across all accountable markets, the Authority must deem the cost growth reasonable, and the provider organization will not be required to participate in the Authority's determination of reasonableness process.

• If a provider organization's frontline worker cost growth is less than the total value of the provider organization's cost growth above the target across all accountable markets, the provider organization may still claim total compensation paid to frontline workers as a potentially acceptable reason for cost growth as part of the determination of reasonableness process.

Response 14: See response to Comment #12.

Comment 15: We reiterate that, consistent with discussions by the Cost Growth Target Advisory Committee and comments by OHA in the Implementation Committee Report, the rules should indicate that a financial penalty will be imposed only if a payer or provider organization has failed to make a good faith effort to comply with a PIP.

We recommend the following revisions to OAR 409-065-0045 (1) to incorporate this limitation and further clarify the rule language:

(1) Pursuant to ORS 442.386, the Authority may impose a financial penalty on a payer or provider organization when:

(a) The **payer or provider organization's** cost growth exceeded the target with statistical confidence, as defined by the Authority; *[and]*

(b) The payer or provider organization's cost growth is without reasonable cause, *[or]* **and** is not indeterminate, as defined in 409-065-0035, in the Medicaid, Medicare Advantage, or commercial insurance market for at least three out of five **consecutive** calendar years[.]; **and**

(c) The payer or provider organization has failed to make a good faith effort to comply with an approved PIP.

Response 15: See response to Comment #3 and 13.

Comment 16: A financial penalty more than five years old should not be counted for the purpose of calculating escalating penalties, and the escalation percentage should be limited to 15 percent of the net total cost above and below the cost growth target in the five-year period.

To incorporate these changes, we recommend the following revisions to OAR 409-065-0045 (4)(a)-(d):

(4) The size of a payer or provider organization's financial penalty must be based on how much the payer or provider organization exceeded the cost growth target and must be determined as follows:

(a) A payer or provider organization's first instance of a financial penalty **imposed within a five-year period** within a given market must equal 5 percent of the net total cost above and below the cost growth target in the five-year period.
(b) A payer or provider organization's second instance of a financial penalty **imposed within a five-year period** within a given market must equal 10 percent of the net total cost above and below the cost growth target in the five-year period.
(c) A payer or provider organization's third **or subsequent** instance of a financial penalty **imposed within a five-year period** within a given market must equal 15 percent of the net total cost above and below the cost growth target in the five-year period.
[*(d) Each instance of a financial penalty within a given market must increase by 5 percentage points of the net total cost above the cost growth target in the five-year period.*]

Response 16: OHA thanks you for this comment.

Comments from Gregory Daniel, FSA, MAAA, Kaiser Foundation Health Plan of the Northwest (Exhibit 5)

Comment 17: Threshold for outliers

We recommend that the threshold for high-cost patient or member outliers in OAR 409-065-0035 (2)(i) be lowered to $500,000. Volatility related to high-cost patients can have a measurable impact on trend and many times is outside the control of providers and payers. We are concerned that a threshold of $1M is too high and does not allow providers and payers to effectively account for these costs. We estimate that the number of members to reach the $1M threshold is less than 1/10 of 1%. Lowering the threshold to $500,000 would result in about 1% of members at or above the threshold, which more accurately reflects the intent of this provision. We note that the Washington Cost Transparency Program currently uses a level of $200,000 at which about 3% of members and patients reach the threshold.

Response 17: OHA thanks you for this comment.

Comment 18: Financial Penalties

Reasonable, predictable, and not overly punitive penalties are critical to the success of the program. We appreciate the changes and clarifications OHA made to the penalty calculation methodology during the RAC and reiterate the following recommendations:

- Penalties Should Only Apply If an Entity Fails to Make Good Faith Efforts to Comply with a PIP:
  We recommend that OAR 409-065-0045 (1) be amended to reflect discussions by the Cost Growth Target Advisory Committee and comments by OHA in the Implementation Committee Report2 that penalties should only be imposed if a

payer or provider organization fails to make good faith efforts to comply with a PIP. Suggested amendments are provided below:
(1) Pursuant to ORS 442.386, the Authority may impose a financial penalty on a payer or provider organization when:
a. The payer or provider organization's cost growth exceeded the target with statistical confidence, as defined by the Authority; ~~and~~
b. the payer or provider organization's cost growth is without reasonable cause, ~~or~~ and is not indeterminate, as defined in 409-065-0035, in the Medicaid, Medicare Advantage, or commercial insurance market for at least three out of five consecutive calendar years.; and
c. the payer or provider organization has failed to make a good faith effort to comply with an approved PIP.

Response 18: OHA thanks you for this comment.

Comment 19: Cap Escalation Mechanism

We recommend that the escalation mechanism in OAR 409-065-0045 (4) be capped at 15% and "reset" in years when an entity achieves the target.
The mechanism as currently drafted increases the financial penalty by 5% every time an entity fails to meet the target. There is no cap or end point in the proposed escalation mechanism. Providers and payers working in good faith to meet the target but still experience overages, even small overages, will be subject to never-ending penalty increases since there is no cap or mechanism to reset if an organization meets the target some reporting periods but not others. We are concerned that this is likely to further exacerbate unaffordability in direct conflict with the goals of the program. Suggested amendments are provided below:
(4) The size of a payer or provider organization's financial penalty shall be based on how much the payer or provider organization exceeded the cost growth target and shall be determined as follows:
(a) A payer or provider organization's first instance of a financial penalty within a given market shall equal 5 percent of the net total cost above and below the cost growth target collectively in the three or more years within a five-year period.
(b) A payer or provider organization's second consecutive instance of a financial penalty within a given market shall equal 10 percent of the net total cost above and below the cost growth target in the three or more years within a five-year period.
(c)A payer or provider organization's third and any subsequent consecutive instances of a financial penalty within a given market shall equal 15 percent of the net total cost above and below the cost growth target in the three or more years within a five-year period.
~~(d) Each instance of a financial penalty within a given market shall increase by 5 percentage points of the net total cost above the cost growth target in the three or more years within a five- year period.~~

Response 19: OHA thanks you for this comment. The rules state that OHA will reassess the penalty rules in 2030.

Comment 20 Upper Limit for Financial Penalties

We recommend that the financial penalties in OAR 409-065-0045 (4) be capped at an amount not to exceed $1.5M. Providing a known upper limit provides stability and predictability that allows organizations mitigate negative impacts that financial penalties may have on affordability. Uncapped penalties could create scenarios in which a provider or payor is subject to large penalties that negatively impact their ability to perform normal operations or threatens insolvency. This becomes increasingly likely if the entity has failed to meet targets, even if only by very small amounts, for one or more years.

Response 20: OHA thanks you for this comment. The rules state that OHA will reassess the penalty rules in 2030.

Comments from Dharia McGrew, PhD and Merlin Brittenham, PhRMA (Exhibit 6)

Comment 21: The Authority Lacks Power to "Require" Manufacturers to Participate at the Annual Public Hearing

The Proposed Rule states that the Authority may "request" that certain entities, including drug manufacturers, "participate" in the annual public hearing; but "[i]f [an] entity does not commit to participating in the annual public hearing, the director of the Authority may require participation." However, no statute gives the Authority the power to require such participation.

To the contrary, the Authority has limited subpoena powers under ORS § 413.037, which it cites as authority for this section of the Proposed Rule. The two subsections of that statute provide the Authority with power to compel testimony only under certain circumstances. Under subsection (1), the Authority "may administer oaths, take depositions and issue subpoenas to compel the attendance of witnesses and the production of to "compel the attendance of witnesses" thus may be exercised only in furtherance of the listed provisions. The CGT Statute, ORS § 442.386, is not included in that list.

Similarly, subsection (2) permits the Authority to "compel obedience" only in two situations: [a] where a person "fails to comply with a subpoena issued under this section"; or [b] where a person "refuses to testify on matters on which the person lawfully may be interrogated." The former situation would not apply to the Proposed Rule because, as above, the Authority has no power "under this section" to compel a manufacturer's attendance. The latter situation does not apply because it only allows

enforcement of a subpoena that is otherwise authorized by some other source of authority—which does not exist here.

Nor does the CGT statute itself empower the Authority to compel manufacturers to attend annual public hearings. The statute's only reference to such hearings provides: "Annually, the program shall … [h]old public hearings on the growth in total health expenditures in relation to the health care cost growth in the previous calendar year." This language provides the Authority with no power to compel prescription drug manufacturers to attend the public hearing or to provide testimony. Moreover, other provisions in the CGT statute permit the Authority to require the submission of information from certain entities (providers and payers), while leaving prescription drug manufacturers squarely outside of the scope of the Authority's regulatory remit.

In order to make the Proposed Rule consistent with its statutory authority, the Authority should revise Proposed Rule section 409-065-0055(2) by deleting the following proposed sentence: "If the entity does not commit to participating in the annual public hearing, the director of the Authority may require participation."

Response 21: OHA thanks you for this comment.

Comment 22: The Proposed Rule Provides Insufficient Protection for Confidential, Proprietary, and Trade Secret Information

As the Authority is aware, the U.S. District Court for the District of Oregon recently ruled that the "public disclosure" of manufacturers' trade secrets violates the Fifth Amendment "[u]nless just compensation is provided" at the time of disclosure. PhRMA appreciates that the Authority has taken some steps to protect confidential information in the Proposed Rule. Specifically, the Proposed Rule provides that the "Authority may disclose data to payers or provider organizations in the administration of the program, excluding information determined to be confidential pursuant to Or. Admin. R. 409-065-0042, regarding the determination of a reasonable cause of cost growth." These regulations are insufficient, however, because they do not require an independent confidentiality assessment of all information submitted to the Authority, and do not provide a process for challenging an adverse confidentiality determination by the Authority.

The Proposed Rule should be revised to require the Authority to independently assess the confidentiality of submitted information. The Authority cannot solely rely on submitting entities because those entities may be in possession of a third party's confidential, proprietary, or trade secret information and may fail to designate it as such. The only way to ensure that the Authority carries out its statutory mandate to protect confidential, proprietary, or trade secret information is to independently review all submitted information.

In addition, the regulations must establish a process for the owners of confidential, proprietary, or trade secret information to challenge any adverse decision by the Authority. If the Authority determines that certain information is not protected and intends to disclose it, entities impacted by that decision should be provided with notice and an opportunity to challenge it. Moreover, owners of confidential, proprietary, or trade secret information must be given access to judicial review of any adverse determination before the information is disclosed.

Response 22: OHA thanks you for this comment.

Comment 23: PhRMA is Uniquely Situated to Provide Insight into Trends in Prescription Drug Spending

While PhRMA has significant concerns with certain elements of the Proposed Rules, nonetheless we would welcome the opportunity to speak to the Board on a voluntary basis. PhRMA represents the country's leading innovative biopharmaceutical research companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier, and more productive lives. Given our role as a trade association, PhRMA is uniquely situated to provide insight into the policy landscape that impacts trends in prescription drug spending.

PhRMA appreciates that the Authority has considered discounts and rebates when measuring retail prescription drug spending growth over the last several years. The Authority's 2023 report noted that total medical expenses increased 5.6% from 2020-2021, with claims spending increasing 6.7%. That same report also found that, when accounting for rebates, retail prescription drug spending grew slower than total medical spending at 3.6%. These findings are consistent with national trends that have shown that prescription drugs have remained a stable portion of the overall health care spending. We are concerned, however, that the Patient Cost Sharing Report that was released in April 2024 demonstrates a concerning trend regarding patient out-of-pocket costs for retail prescription drugs. While overall prescription drug spending has remained stable, Oregonians' out-of-pocket costs have skyrocketed in recent years. In Medicare Advantage plans, retail prescription drugs made up 40% of patient's out-of-pocket costs in 2022. Most concerning is the rapid growth in co-insurance on specialty prescription drugs. The amount paid perperson on co-insurance for specialty drugs "skyrocketed" by 172% from 2015-2022. This hits patients in multiple ways because when a patient pays co-insurance, their percentage of cost sharing is usually calculated based on the list price, not the net price of the drug. PhRMA would appreciate the opportunity to speak with the Authority about these trends and others and recommend policy solutions that will help Oregonians better access and afford their medications.

Response 23: OHA thanks you for this comment.

Comments from Bryan Boehringer, Oregon Medical Association (Exhibit 7)

Comment 24: We appreciate the updates to the reasonable causes for exceeding the cost growth target to include high-cost patients or member outliers.

As we commented earlier, high-cost outlier cases often create misleading data and should be identified and factored in. Additionally, most outlier costs are generated by external factors beyond the providers' control. We would also suggest that the current outlier defining threshold of $1 million is too high for smaller medical practices and that the threshold should be closely monitored for modification in the future.

Response 24: OHA thanks you for this comment.

Comment 25: Additionally, we agree that federally qualified health centers (FQHCs) and pediatric providers be included as voluntary reporters and be exempted from financial penalties.

We also believe that some primary care clinics may be above the attributed patient threshold and operate in a fixed cost environment and so should also be exempt.

We remain concerned that the financial penalties have the potential to destroy medical practices. We appreciate that the rules allow the OHA to reduce penalties if the penalties threaten the solvency of the provider organization. However, other elements suggested by rules advisory committee members, like a penalty cap and consideration of a provider organization's good faith effort to participate in the program and lower costs should be examined as future options.

Response 25: OHA thanks you for this comment.

Comment 26: With regard to frontline worker compensation being allowed as a reasonable cause of cost growth, we continue to believe that this reasonable cause should be carried through to any participants that have Total Medical Expenditures that are impacted/increased by those investments.

Response 26: OHA thanks you for this comment.

Comment 27: Finally, we remain concerned that a performance improvement plan or financial penalty should not be enforced if the accuracy of the cost data available is disputed. The current burden remains on the provider clinics to spend considerable time, effort and resources to investigate the cost data in an attempt to bring appropriate transparency to reported figures that may not be accurate. Additionally, some clinics still struggle to access the data needed to assess the accuracy of the cost reports.

Response 27: OHA thanks you for this comment.

Comments from William Kramer, Purchaser Business Group on Health (Exhibit 8)

Comment 28: We want to reiterate our serious concern that the proposed financial penalty formula for entities that exceed the cost growth target would not be adequate.

Based on comments from you at the April 17 Rules Advisory Committee (RAC) meeting, we understand that the objectives of the financial penalties are:

• To compensate the community – employers, consumers, and patients – that have had to pay more for the entity's cost growth exceeding the target, and

• To provide an incentive for entities to meet the target.

According to the proposed rules, the size of a payer or provider organization's financial penalty for the first instance would be equal to only 5 percent of the total cost above the cost growth target, with gradual increases for multiple instances of exceeding the cost growth target. To even be subject to a financial penalty, however, entities would:

• Have to have failed to meet the target, after consideration of age/sex adjustments for their population and with statistical confidence;

• Have to have failed to meet the targets in three out of five years;

• Have to have failed to make progress on a performance improvement plan, as demonstrated over time; and

• Not have an "acceptable reason" for missing the target, which presently comprises an extensive and ill-defined list of exemptions.

It is clear that the proposed financial penalties do not meet these objectives or match the intent of the law that created it, favoring excessive leniency in lieu of pressing for real accountability, system change, and reform. The minimum fine proposed by the agency is much too low to effectively deter entities from exceeding the target, and it does not provide sufficient compensation to the community.

Given the number of chances an entity has to avoid potentially paying any fine whatsoever, the size of the penalties must be meaningful for any entity that has reached this point. Otherwise, paying fines would simply become part of the cost of doing business for healthcare payers and providers, particularly for larger entities. If the fine isn't significant, it is extremely likely that many entities will simply exceed the target and pay the fine. Using the CGT Penalty Calculator example distributed with the RAC meeting materials, an entity with $578 million in total revenue over 5 years that overspends by $9.3 million (net over 5 years) would be assessed a penalty of only $465,000. That amount is equal to 0.0804% of total revenue. The net benefit to the entity for overspending is $8,835,000; the ROI for the decision to overspend is 19:1. This penalty is clearly an insufficient incentive to keep spending below the cost growth target.

Furthermore, the penalty must be of sufficient size to fully compensate the community, which has been forced to pay more for necessary health care services from an entity that has consistently exceeded the cost growth target. The proposed penalty would provide compensation for only 1/20th of the revenue extracted from the community due to overspending.

Response 28: OHA thanks you for this comment.

Comment 29: We propose the following adjustments to the proposed rule:

- The Authority shall assess initial financial penalties in amounts fully commensurate with the entity's total cost above the cost growth target, and in escalating amounts for repeated or continuing failure to meet the targets.
- In addition to the factors listed in proposed ORS 442.386(9), the Authority should consider the following factors when assessing a penalty under this rule:
    - The provider or payer's degree of deviation from the average rate of reimbursement or cost growth as compared to other market participants;
    - Whether the provider or payer operates in bad faith in addressing health care costs, as shown by a preponderance of the evidence;
    - The market concentration of the provider or payer in one or more well defined geographic regions in the state;
    - Whether the payer or provider has a history of penalization under the program.
- The financial penalty structure should be revisited in two years and every two years thereafter to allow for strengthening as the model and market adapt to this new method of accountability.
- The application of financial penalties should not be delayed, as proposed during the April 17 RAC meeting. The proposed revision would delay the first potential instance of a penalty to after the 2025-26 period. The justification offered for this revision is inadequate, and it does not take into account the serious impact of this delay on the affordability crisis faced by patients, consumers, and employers.

Response 29: OHA thanks you for this comment. The rules state that OHA will reassess the penalty rules in 2030.

Comment 30: In summary, the proposed financial penalty formula – if adopted – would seriously undermine the effectiveness of the cost growth target program, resulting in a worsening of the already serious health care affordability crisis facing Oregonians. Ultimately, there is a better way to avoid the fines, which is to make the necessary efforts to control costs. Instead of worrying about the fines that may be levied against a few entities that refuse to make a solid effort to meet the target, we should be having a dialogue about how best to control spending.

Response 30: OHA thanks you for this comment.

Comments from Tara Harrison and Kristen Downey, Providence Health Plan (Exhibit 9)

Comment 31: Total Compensation to Frontline Workers (OAR 409-065-0028)

Providence requests clarification of the rule language to align with the intent OHA described in the most recent RAC meeting. This would include aligning the CGT-4 form with the law which clearly states entities will report total compensation in aggregate and defines "total compensation" to include wages, benefits, salaries, bonuses and incentive payments provided to a frontline worker by a provider. All other fields should be removed, or more clearly marked as optional for those providers that feel additional context is necessary.

Response 31: OHA thanks you for this comment.

Comment 32: Determining Reasonableness (OAR 409-065-0035)

Extend the frontline workers exemption for providers to payers as a reasonableness factor for payers. Providence supports the revised proposed rules, wherein providers are given an exemption from their cost growth calculation for frontline worker wages, as required by statute. Providence further recommends that the OHA recognize the downstream impact of this exemption on payers, whose contracted reimbursement rates are directly impacted by provider wages for frontline workers. Where the legislature has already determined that public policy is best served by enabling payers to improve frontline worker compensation, we ask that the OHA codify this policy for all who are impacted by it through a reasonableness factor available for payers to account for their cost growth.

Response 32: OHA thanks you for this comment.

Comment 33: Financial penalties (OAR 409-065-0045)

Good faith safe harbor for financial penalties. As discussed by Oregon's policy makers throughout this program's development, the expectation is that financial penalties will be rare and the result of flagrant disregard to participate in the program or performance improvement plans. We request this intention be reflected in the rule by including language that an entity would only be subject to financial penalties if it has not made a good faith effort to comply with a performance improvement plan (PIP) or has refused to participate in the PIP process. We have reiterated this request in multiple comment letters and do so again now. The original intent of cost growth programs, as developed by the Milbank Memorial Fund, is to obtain information regarding the causes of cost growth, such that all actors in a system, including policy makers, can see and respond to those causes. Where payers and providers are engaging in good faith efforts to address aspects of the cause that are within their control, we ask that they not be punished, particularly through onerous financial penalties. The actual causes of cost growth are complex, and the burden for addressing the issue should be borne by more than just payers and providers.

Response 33: OHA thanks you for this comment. See response to Comment #3.

Comment 34: Excluding reasonable cost growth from financial penalties.

Providence is very concerned by any penalty calculation formula that includes any portion of reasonable cost growth into the determination of an entity's PIP or financial penalties. Reasonable cost growth is growth that by its nature has been determined to be outside of payer or provider control and/or good policy for Oregonians. It is not only bad policy to punish and entity for such growth, but calculations that punish an entity for reasonable growth also exceed the authority given to OHA in statute, which provides that financial penalties are imposed for cost growth above the target "without reasonable cause." As such, we strongly encourage OHA to amend the proposed rules to exempt any growth determined to be reasonable from any PIPs or financial penalties. Growth that is determined to be reasonable, but that OHA would seek to otherwise address, is by its nature the responsibility of state leaders and policy makers to wrestle with.

Response 34: OHA thanks you for this comment.

Comment 35: Reasonable cap on financial penalty amounts.

While financial penalties should serve as an accountability tool, the intention was never to perpetuate cost growth, limit investments in workforce, reduce access to primary care, nor drive up health insurance costs. As we learn more about the impact of this program and develop more sophisticated strategies to track and discuss cost drivers, we recommend that OHA begin with a low penalty cap, such that OHA can learn through experience how penalties will impact the health care market before causing significant unintended consequences.

Response 35: OHA thanks you for this comment. The rules state that OHA will reassess the penalty rules in 2030.

Comment 36: Need for robust patient-centered risk adjustment.

Risk adjustment measures that only look to age and gender of patients and members create disincentives for providers and carriers to serve those in our community with a significant illness burden. Likewise, looking only at member months without looking at the members individually, OHA is inadvertently disincentivizing care and support for those with more significant medical needs. To resolve this unintended consequence, OHA should adopt a robust patient-centered risk adjustment methodology that accounts for an individual's severity of illness, factoring in chronic conditions and comorbidities. Doing so will allow a more real analysis of the cost growth as severity of illness burdens shift. Trying to identify cost outliers without this kind of risk adjustment is labor intensive and imprecise. Further, the failure to risk adjust in this way cuts against OHA's objectives around health equity and access to care. Frequently, members and patients of diversity tend to have greater health needs. We want to ensure that the program OHA develops continues to motivate improvements to care and access, rather than the opposite. Financial penalties should never be tied to providing care to patients and members with greater burdens of illness, regardless of race or ethnicity. Further, state programs should not incentivize payers and providers to seek out the healthy,

knowing that serving them affords the lowest risk of incurring a financial penalty. An OHA-adopted patient-centered risk adjustment model as described above would not only remove those incentives but would also create a level, more accurate floor from which to determine cost growth among carriers and providers.

Response 36: OHA thanks you for this comment.

Exhibits 1 through 9 are attached

June 21, 2024

Oregon Health Authority
Zachary Goldman
Sustainable Health Care Cost Growth Target Program
421 SW Oak Street, Ste 850
Portland, Oregon 97204

Submitted Via Email: zachary.k.goldman@oha.oregon.gov

Subject: Regence Comments on Draft Rules for Sustainable Health Care Cost Growth Target Program

Dear Mr. Goldman,

Thank you for the continued opportunity to engage in the development of the draft rules for the Oregon Health Authority's (OHA) Sustainable Health Care Cost Growth Target (CGT) Program. We appreciated the opportunity to participate as a member of the Rules Advisory Committee (RAC) and the work of OHA to be responsive to feedback received through that process. Despite the changes made through that RAC process, we remain concerned about the reasonableness process, the failure to tie penalties to performance improvement plans (PIPs), the magnitude of the proposed penalties, and the unlawful scope of the program and these proposed rules. We encourage OHA to adopt key changes to the rules that are described below before moving to final adoption of the program rules.

Regence supports the overall aim of the CGT program to slow the growth of health care spending so that these costs no longer outpace Oregonians 'wages or the state's economy. We are committed to helping the state achieve this goal by promoting high-value care and introducing appropriate measures to control costs. However, we remain concerned that the draft rules do not sufficiently advance the state's objectives under the program, and could unintentionally introduce new costs into the system. We strongly encourage the OHA to scale the program to meet the state's jurisdictional scope and appropriately focus on root causes of cost growth.

If OHA does not address these remaining issues, we are concerned that the program risks creating member abrasion as entities prioritize the cost growth target above other sources of consumer value. We also fear that an uncertain or inequitable approach to cost growth management may drive further consolidation and erode competition in the state.

Summary Feedback on Draft Rules

- The reasonableness process should reflect all costs outside an entity's control
- OHA should allow for partial reasonableness determinations
- Penalties should be tied to PIPs
- Penalties should have an upper limit
- Penalties should not flow to OHA programs
- The program scope should be limited to be consistent with federal preemption.

We provide specific feedback on each of these concerns below.

Complete Feedback on Draft Rules

The reasonableness process should reflect all costs outside an entity's control

As we've discussed extensively in prior comments, we believe the reasonableness factors must be drafted to account for all factors outside an entity's control. We continue to have concerns that many factors are written from a "provider" perspective and fail to account for how costs roll up to payers. We also believe that the list of factors fails to account for the full range of factors that impact payer costs, and which should be part of a reasonableness determination. We provided specific examples in our Feb. 14, 2024, comment letter but will broadly reiterate them here:

- OAR 409-065-0035(2)(d) includes "changes in taxes related to health care or other administrative requirements, including but not limited to changes in medical loss ratio rebate requirements pursuant to state or federal regulations." While changes in taxes can impact a payers' overall business model, that is not captured in the data payers submit to the state, which is solely focused on medical claims. However, we would anticipate that changes to provider taxes would show up in the reimbursement rates they ask for from payers and not be something payers would specifically claim or be able to submit data to OHA on.
- Similarly, OAR 409-065-0035(2)(g), includes "macro-economic factors such as periods of significant inflation, supply chain shortages or labor shortages" as a reasonable cause for cost growth. Given that payers' labor costs, inflation and supply chain challenges are not included in their claims data, and therefore not part of the cost growth target, this factor is only relevant to providers as drafted. For payers, these

costs as incurred by providers would be reflected in payers' negotiated rate increases with providers due to rising input costs.
- OAR 409-065-0035(2)(i) includes high cost outliers but does not include how those outliers will roll up to payers.

OHA should include a new "acceptable reason" specific to payers that includes "changes in costs based on increased contract rates paid to providers or increased costs of pharmaceuticals." We would then recommend expanding on the specific factors in the guidance, including recognizing the need to balance network adequacy requirements and member abrasion risks against cost increase requests from providers that would cause payers to exceed the cost growth target.

We also recommend adding a factor for the macroeconomic "acceptable reason" that addresses calculated cost growth due to changes in a payer or provider's mix of business. An entity could demonstrate cost growth below the target for each line of business and yet exceed the target overall due to a shift from a line of business with less claims cost to a line of business with more claims cost on average.

Further, we believe that alongside detailed documentation of cost growth drivers, an entity should be able to provide information about how it tried to address that cost growth and what impacted their success. For example, if provider contracts are a significant factor in payer cost growth, the payer should both quantify the impact of that cost growth and be able to explain why it was unable to address that cost impact to a sufficient degree to avoid an impact.

While we understand that the program was designed to measure changes in cost growth over time, we also believe that the reasonableness process should credit entities with lower overall costs, even if their cost growth is high in any given year. For example, an entity who is cost effective may have a few years of high cost growth because they endeavor to keep overall costs as low as possible. If an entity experiences high-cost growth over a period of time, but has low total costs, that should factor into that reasonableness process. This would encourage entities to focus not only on year-over-year cost growth, but on their overall affordability through total costs.

OHA should allow partial reasonableness determinations:

We strongly disagree with OHA's most recent changes that specify that reasonableness determinations are an "all or nothing" determination about cost growth. If OHA finds any portion of an entity's cost growth to be "reasonable," that cost growth should not be subject to a PIP or a penalty. For example, if a carrier exceeded the target by 2% (hitting 5.4%), but 1.5% (or 3.6%) of that was determined to be reasonable, it should only accrue a penalty on

the 0.5% of cost growth that was "unreasonable," not the full 5.4% of cost growth. If OHA penalizes an entity for its total cost growth, even the portion that was "reasonable," it flies in the face of the assurances that cost growth will not count against an entity if it is reasonable, and it holds an entity financially accountable for cost growth that OHA has determined was outside its control or due to a reasonable cause. It also would serve as a disincentive for an entity to meet the target at all, or to invest in activities to improve quality and access to health care as any such investment could become subject to penalty if there was also a single dollar of non-reasonable growth above the target.

Financial penalties should be tied to non-compliance with the Performance Improvement Plan

In its Principles for Financial Penalties document, the CGT Advisory Committee recommended that "financial penalties should be a measure of last resort, to be employed only after an insurer has not met the obligations laid out in their Performance Improvement Plan (PIP)." The Principles document goes on to explain how the PIP process relates to penalties and how this structure meets the goal of the program of improving health care cost management and efficiency rather than immediately resorting to punitive measures.

However, the draft rules do not contain this restriction on penalties, instead stating that penalties are to be levied if the payer or provider's cost growth exceeds the target without reasonable cause for at least three out of five calendar years. OAR 409-065-0045(1). Penalties should be imposed only if an insurer or provider organization has not made good faith efforts to meet the obligations in its PIP, and any failures to meet the PIP had a meaningful impact on consumer costs. This is consistent with the statute, which provides that the penalty criteria account for the good faith efforts of the payer or provider to address health care costs and the provider or payer's cooperation with the OHA. *See* ORS 442.386 (9).

OHA must have an upper limit or cap on penalties

We encourage the adoption of a penalty cap as outlined in our prior comments. As we explained in our prior letter, we believe an appropriate penalty for an entity's first failure to meet the obligations of its PIP should be $50,000, increasing by $50,000 with each subsequent failure to meet the PIP. The maximum penalty for any annual failure to meet the obligations in a PIP should be $250,000. The $50,000 to $250,000 penalties should be a maximum, and OHA should set lower thresholds for smaller organizations and to account for mitigating factors such as cooperation with OHA during the cost growth and PIP process.

Under the proposal set by OHA, with initial penalties at 5% and growing by 5% with each additional evaluation, the penalties will quickly measure beyond $1 million for many entities

regulated under the program. Penalties set at this level nearly guarantee an outcome that is opposite that intended by OHA, with entities passing the fine along to consumers in the form of higher prices (providers) and higher rates (payers). The boundless, accelerating penalty creates a feedback loop that is in direct conflict with the overall goals and objectives of the CGT Program. While nearly any penalty is likely to have a consumer impact as it's absorbed into the system, OHA should set penalties at a level that avoids material consumer impacts.

If OHA continues with a percentage-based penalty, OHA should cap the escalator clause. As drafted, the proposed penalties do not have any cap on the 5% escalator clause, which could result in penalties accruing indefinitely. If OHA moves forward with an escalating penalty, that penalty should reset after three years of compliance (where an entity is either under the target or its cost growth was deemed reasonable). An entity's past overages should not be held against it indefinitely, but rather reset once it has demonstrated compliance with the target for three years. A reset also provides an additional incentive for an entity to beat the target every single year (not just three out of five years).

Penalties should be assessed for single years only

We are also concerned that in OHA's example penalty calculation, it appears that the first penalty assessment will cover the total overage and underage in the first five-year period, as opposed for being assessed just for the cost growth in the final year that drove an entity to exceed the target in three out of five years. After that, cost growth penalties would be assessed for single years of cost growth. The cost growth program should only ever assess penalties for the single year that is the subject of the penalties, and penalties should never look retroactively beyond the year in question. To assess an initial penalty based on a five year look back will result in a penalty that is excessively high and penalizes years where cost growth was not intended to be subject to the penalty. OHA needs to ensure that all penalties are for a single cost growth year only. To accomplish this within the current framework, OHA could calculate the overage and underage on a PMPM basis over 5 years, but then multiply that PMPM by current enrollment to avoid amplifying the penalties in the first year.

Penalties should not flow to OHA programs

The draft rules provide no level of detail about the use of financial penalties submitted by an entity, outside of the fact that penalties must provide a community benefit and not directly benefit the entity subject to the penalty. We believe that the lack of restrictions surrounding use of penalty funds could easily become a mandate to fund unrelated OHA programs and priorities. This would create an incentive to impose penalties even when they do not further the objectives of the CGT Program. Further, we see no reason why penalties should not be directed toward executing an entity's PIP, as those funds would directly advance the CGT

Program. We would like to see additional specificity on expectations around penalties to ensure that the resources do not become earmarked for unrelated OHA programs.

OHA's rules and implementation of the CGT Program must avoid federal preemption

Regence has previously asserted that the reporting requirements under the CGT Program conflict with and are preempted by federal laws to the extent the state program seeks to impose requirements with respect to ERISA Plans, Medicare Advantage Plans, and Plans for federal employees that are governed by the Federal Employees Health Benefits Act (FEHBA) through and onto Regence. Moreover, the CGT Program continues to require Regence to report information on such plans, even though the program's requirements exceed the scope of a "health benefit plan" under Oregon law.

We raise the same objection to the program's currently proposed enforcement mechanisms and ask that, with respect to both reporting and enforcement requirements, the state reconsider its position by narrowing the program's scope to carve out these Plans from the Program.

As of this time, Regence will continue to comply with the reporting requirements, albeit with objection. Regence further continues to encourage OHA to adopt a reasonable enforcement scheme under the program, including exempting ERISA-based, Medicare-based, and FEHBA-based Plans from any enforcement mechanisms., With respect to both reporting requirements and enforcement mechanisms, we reserve all rights, including the right to assert and challenge that such reporting requirements and enforcement mechanisms as related to ERISA-based, Medicare-based, and FEHBA-based Plans are unlawful and preempted by federal law.

We also incorporate our concerns from our prior draft comments submitted during the RAC process, which were outlined in our May 24, 2024 letter.

Thank you for your consideration, and please let me know if you have any questions.

Sincerely,

Mary Anne Cooper
Director of Public Affairs and Government Relations
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June 20, 2024

Sarah Bartelmann, Cost Programs Manager
Zachary Goldman, Health Care Cost Economist
Sustainable Health Care Cost Growth Target Program
Oregon Health Authority

Delivered electronically to HealthCare.CostTarget@oha.oregon.gov.

Re: Comments for Proposed Rules on Cost Growth Target Accountability

Ms. Bartelmann and Mr. Goldman:

Legacy Health would like to extend appreciation to the Oregon Health Authority (OHA) for listening and incorporating many of our concerns to date. OHA has shown a willingness to listen to a spectrum of concerns and to make adjustments in the program.

There are, however, still areas of concern, and issues still to be addressed, and we wish to restate them here for further consideration.

Primary Care Providers are penalized for costs beyond their control: Per OHA's reporting, primary care accounts for 12%-13% of medical spend in Oregon, but primary care is accountable for 100% of the cost growth under the rules as generated. Primary care is not the source of high medical costs in Oregon nor is it able to control spend outside its offices by other entities or pharmaceutical companies.

Accordingly, we request that primary care practices are only held financially responsible for cost growth in primary care services, not all services.

Different market forces generate the same financial penalties: Reimbursement methodologies are set differently for different markets. Government agencies set reimbursement for Medicaid and Medicare services. Managed Medicaid and Managed Medicare plans have some wiggle room to increase rates beyond the government-set rates, but very little. Consequently, unit cost growth is nearly always going to be below 3.4% for these markets, and if growth is higher, it is likely driven by government agencies such as OHA. Commercial market reimbursement is negotiated directly between payors and providers and so can be subject to unit cost increases on a different scale. Treating these markets the same for cost growth penalties assumes that unit cost could be the driver for all markets. If costs grow more than 3.4% for Medicare or Medicaid members, that growth is almost certainly driven by utilization. Because primary care practices lose money providing services to Medicaid and Medicare beneficiaries, this penalty program incentivizes providers either to reduce utilization/access or to stop service to these beneficiaries.

To preserve access for government payors to primary care services, penalties should be reduced to 1%, 2%, 3% with 1% increments rather than the 5%, 10%, 15% and 5% increments proposed now for all markets.

Providers are penalized for reasonable growth: If a provider's cost growth is 7%, and 2% are found to be reasonable for reasons outlined in the rule, such as changes in state-mandated benefits, the provider will still have cost growth in excess of the target, and the penalty will be assessed against the 7% growth, which is known to contain reasonable/excusable growth. It would be more appropriate to subtract the cost growth target from the unreasonable growth (5%) rather than total growth (7%).

The rule should be amended to state the formula for measuring cost growth above the target as (PMPM year 2 (exclusive of reasonable growth) – (PMPM year 1 * (1+Cost growth target percent))) = x.

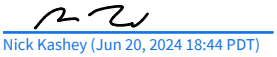
Providers are penalized for known uncertainty: Given that a provider may be found to have indeterminate performance if the lower bound of the 95% confidence interval spans the target threshold, OHA is appropriately acknowledging the uncertainty in their own calculations. The same acknowledgement should be granted when calculating a provider's financial penalties. Thus, a provider's cost growth penalty should be calculated not from the calculated PMPM but from the lower bound of the 95% confidence interval.

As an example, if a provider's baseline PMPM is $1000 and they are calculated to have a new PMPM of $1050, or 5% growth, but the lower bound is 3.8%, the penalty should be calculated as

$1038 (3.8%) - $1034 (3.4%)
not $1050 (5.0%) - $1034 (3.4%).

Thank you again for the opportunity to participate in this process.

Sincerely,


Nick Kashey (Jun 20, 2024 18:44 PDT)

Nikolaus Kashey, MD, MPH
Clinical Vice President Population Health

Samaritan Health Services

June 21, 2024

Sara Bartelmann, Cost Programs Manager
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Delivered electronically to healthcare.costtarget@odhsoha.oregon.gov and Zachary.k.goldman@oha.oregon.gov

Ms. Bartelmann and Mr. Goldman:

Samaritan Health Services (SHS), based in Corvallis, Oregon, is a mission-driven, nonprofit health system offering care to Oregonians in Benton, Lincoln, Linn and portions of Marion and Polk counties. More than 6,000 Samaritans work within our five hospitals, 100 clinics, medical group, health plans and foundations, to build healthier communities together. It's payer subsidiaries, Samaritan Health Plans and IHN CCO, cover over 100,000 lives and providers serve over 290,000 community members living in our region. SHS operates as both a payer and provider under the Sustainable Health Care Cost Growth Target Program, providing a unique perspective on the drivers of cost for health care and the program.

We appreciate the work the Oregon Health Authority (OHA) has done to lead a robust Rulemaking Advisory Committee (RAC) on the cost growth target accountability, OAR 409-065-0000 through 409-065-0055. SHS supports the written comments provided by the Hospital Association of Oregon (HAO) and other health care systems. We specifically want to underscore that accountability for cost growth is a piece of the health care affordability puzzle and the tools to hold accountable pose a considerable threat to access, quality and our health care workforce if not implemented thoughtfully in today's challenging environment. It is crucial that the proposed rules are crafted and applied in a manner that does not penalize or deter our investments into our workforce. That was the intent of HB 2045.

We remain concerned that the proposed rules do not fully align with HB 2045 (from 2023), SECTION 2(10) "A provider shall not be accountable for cost growth resulting from the provider's total compensation." Instead of having the cost associated with our frontline worker removed at the front end of the calculation process, OHA is proposing that "if the cost growth is greater than or equal to the total value of the entity's cost growth above the target across all accountable markets, then OHA will deem the cost growth reasonable." This is only partially aligned with the HB 2045 and providers may still be accountable for the same workforce investments that, we believe, the legislature clearly intended to exempt.

We support the Hospital Association's proposal to add additional provisions to OAR 409-065-0035, to further guide how this calculation and its role in determining reasonableness are described. HAO proposed the following new provisions to OAR 409-065-0035:

For provider organizations that have submitted a CGT-4 as described in OAR 409-065-0028, the Authority must calculate the provider organization's frontline worker cost growth as the difference in the grand total frontline worker compensation between the current calendar year and the previous calendar year.

- If the provider organization's frontline worker cost growth is greater than or equal to the total value of the provider organization's cost growth above the target across all accountable markets, the Authority must deem the cost growth reasonable, and the provider organization will not be required to participate in the Authority's determination of reasonableness process.
- If a provider organization's frontline worker cost growth is less than the total value of the provider organization's cost growth above the target across all accountable markets, the provider organization may still claim total compensation paid to frontline workers as a potentially acceptable reason for cost growth as part of the determination of reasonableness process.

The rules should clearly indicate that a financial penalty will be imposed only if a payer or provider organization has failed to make a good faith effort to comply with a Performance Improvement Plan (PIP). We agree with HAO's recommendation that this be clarified in the rules revision to OAR 409-065-0045 to read:

(1) Pursuant to ORS 442.386, the Authority may impose a financial penalty on a payer or provider organization when:

(a) The **payer or provider organization's** cost growth exceeded the target with statistical confidence, as defined by the Authority; [*and*]

(b) The payer or provider organization's cost growth is without reasonable cause, [*or*] **and** is not indeterminate, as defined in 409-065-0035, in the Medicaid, Medicare Advantage, or commercial insurance market for at least three out of five **consecutive** calendar years[.]**; and**

(c) The payer or provider organization has failed to make a good faith effort to comply with an approved PIP.

We thank OHA for its consideration of these recommendations to the proposed rules that we believe support the legislature's intent to ensure "the long-term affordability and financial sustainability of the health care system in this State" and that reduces waste and improves efficiency, resulting in better care at a lower cost while protecting our investments in our workforce.

Respectfully submitted,

Daniel B. Smith
Senior Vice President, Chief Financial Officer
Samaritan Health Services

Hospital Association of Oregon

June 21, 2024

Sarah Bartelmann, Cost Programs Manager
Zachary Goldman, Health Care Cost Economist
Sustainable Health Care Cost Growth Target Program
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Ms. Bartelmann and Mr. Goldman:

On behalf of our 61 member hospitals, the Hospital Association of Oregon greatly appreciates the work the Oregon Health Authority (OHA) has done to lead a robust Rules Advisory Committee (RAC) process and integrate stakeholder feedback into the proposed rules on cost growth target accountability, OAR 409-065-0000 through 409-065-0055. We support many of the changes OHA has made to these rules throughout the RAC process to improve predictability, consistency, and efficiency. The following comments build on our previous input.

Accountability for cost growth is one piece of the health care affordability puzzle, and the accountability tools in this program pose a considerable threat to access, quality, and the health care workforce if not implemented thoughtfully. This perspective is especially important now, given the financial challenges our community hospitals are facing. Over the past four years, workforce shortages, supply chain fractures, emergency department overcrowding, hospital discharge delays, and high inflation have pushed hospital operating costs to a breaking point.[1] In future years, we should expect that continued investment in our hospitals and their workforce will result in increased cost growth, as measured by the state's program. It is crucial that the proposed rules are crafted and applied in a manner that does not penalize or deter those investments.

We remain concerned that the proposed rules do not fully implement HB 2045.[2] At the fifth RAC meeting on May 15, 2024, OHA proposed, "If the entity's frontline worker cost growth is greater than or equal to the **total value** of the entity's cost growth above the target **across all accountable markets**, then the OHA will deem the cost growth reasonable," and offered an example calculation.[3] Despite some limitations that were identified during the RAC meeting, and despite the fact that we do not consider it a full implementation of HB 2045, we support this proposal as a predictable measurement of the extent to which frontline worker compensation will be

[1] *See, for example,* Oregon Health Authority, Oregon Acute Care Hospitals: Financial & Utilization Trends Q2 2023, p. 1, reporting that hospitals' total operating expense increased 6% from Q2 2022, and Oregon Acute Care Hospitals: Financial & Utilization Trends Q3 2023, p. 1, reporting that hospitals' total operating expense increased 4.8% from Q3 2022; *see also* Q2 2023 Oregon Hospital Utilization and Financial Analysis, p. 6, reporting 31% - 52% increases across various expense categories compared to Q2 2020.
[2] HB 2045 (2023).
[3] Oregon Health Authority, Sustainable Health Care Cost Growth Target Program: Rules Advisory Committee (RAC) Meeting #5 (slide deck), May 15, 2024, slides 15 (**emphasis in original**) and 16.

considered a reasonable cause of cost growth. However, this calculation and its role in determining reasonableness are not described in the proposed rules. We recommend adding the following new provisions to OAR 409-065-0035:

- For provider organizations that have submitted a CGT-4 as described in OAR 409-065-0028, the Authority must calculate the provider organization's frontline worker cost growth as the difference in the grand total frontline worker compensation between the current calendar year and the previous calendar year.
- If the provider organization's frontline worker cost growth is greater than or equal to the total value of the provider organization's cost growth above the target across all accountable markets, the Authority must deem the cost growth reasonable, and the provider organization will not be required to participate in the Authority's determination of reasonableness process.
- If a provider organization's frontline worker cost growth is less than the total value of the provider organization's cost growth above the target across all accountable markets, the provider organization may still claim total compensation paid to frontline workers as a potentially acceptable reason for cost growth as part of the determination of reasonableness process.

We reiterate that, consistent with discussions by the Cost Growth Target Advisory Committee[4] and comments by OHA in the Implementation Committee Report,[5] the rules should indicate that a financial penalty will be imposed only if a payer or provider organization has failed to make a good faith effort to comply with a PIP. We recommend the following revisions to OAR 409-065-0045 (1) to incorporate this limitation and further clarify the rule language:

> (1) Pursuant to ORS 442.386, the Authority may impose a financial penalty on a payer or provider organization when:
>
> > (a) The **payer or provider organization's** cost growth exceeded the target with statistical confidence, as defined by the Authority; [*and*]
> >
> > (b) The payer or provider organization's cost growth is without reasonable cause, [*or*] **and** is not indeterminate, as defined in 409-065-0035, in the Medicaid, Medicare Advantage, or commercial insurance market for at least three out of five **consecutive** calendar years[.]**; and**
> >
> > **(c) The payer or provider organization has failed to make a good faith effort to comply with an approved PIP.**

[4] Cost Growth Target Advisory Committee, Draft Principles for Financial Penalty Development, November 15, 2023, p. 3, stating, "Financial penalties should be rare, and only imposed after careful consideration of whether the entity had the opportunity to control costs and whether the entity has demonstrated good faith efforts in working to control costs and to implement a performance improvement plan." *See also* Cost Growth Target Advisory Committee Meeting, November 15, 2023, recording starting at 1:18:32, in which one of the Advisory Committee Co-Chairs further described the "level of flagrancy" that would warrant a financial penalty as a payer or provider organization having to "still be outside the cost growth target, be on a performance improvement plan, and then still be ignoring your performance improvement plan to get to a financial penalty."

[5] Sustainable Health Care Cost Growth Target: Implementation Committee Recommendations Final Report to the Oregon Legislature, January 2021, p. 46, stating, "OHA intends for any accountability mechanisms to apply as a last resort only after transparency and collaborative efforts to contain costs do not have an impact."

A financial penalty more than five years old should not be counted for the purpose of calculating escalating penalties, and the escalation percentage should be limited to 15 percent of the net total cost above and below the cost growth target in the five-year period. To incorporate these changes, we recommend the following revisions to OAR 409-065-0045 (4)(a)-(d):

> (4) The size of a payer or provider organization's financial penalty must be based on how much the payer or provider organization exceeded the cost growth target and must be determined as follows:
>
> > (a) A payer or provider organization's first instance of a financial penalty **imposed within a five-year period** within a given market must equal 5 percent of the net total cost above and below the cost growth target in the five-year period.
> >
> > (b) A payer or provider organization's second instance of a financial penalty **imposed within a five-year period** within a given market must equal 10 percent of the net total cost above and below the cost growth target in the five-year period.
> >
> > (c) A payer or provider organization's third **or subsequent** instance of a financial penalty **imposed within a five-year period** within a given market must equal 15 percent of the net total cost above and below the cost growth target in the five-year period.
> >
> > [*(d) Each instance of a financial penalty within a given market must increase by 5 percentage points of the net total cost above the cost growth target in the five-year period.*]

With the revisions proposed above, the rules will better reflect the goal of the cost growth target program to "ensure the long-term affordability and financial sustainability of the health care system in this state."[6] We maintain that the accountability mechanisms in this program should be applied thoughtfully to avoid unintended consequences for patients and health care workers.

Sincerely,

Sean Kolmer
Executive Vice President, External Affairs
Hospital Association of Oregon

About the Hospital Association of Oregon

Founded in 1934, the Hospital Association of Oregon (HAO) is a mission-driven, nonprofit trade association representing Oregon's 61 hospitals. Together, hospitals are the sixth largest private employer statewide, employing more than 70,000 employees. Committed to fostering a stronger, safer, more equitable Oregon where all people have access to the high-quality care they need, the hospital association supports Oregon's hospitals so they can support their communities; educates government officials and the public on the state's health landscape and works collaboratively with policymakers, community based organizations and the health care community to build consensus on and advance health care policy benefiting the state's 4 million residents.

[6] ORS 442.386 (1)(c).

June 21, 2024

Sustainable Health Care Cost Growth Target Program
Oregon Health Authority
500 Summer Street, NE E-20
Salem, OR 97301

Delivered electronically to zachary.k.goldman@oha.oregon.gov

Re: *Comments in response to Notice of Proposed Rulemaking to adopt and amend rules for the Sustainable Health Care Cost Growth Target Program*

Dear Mr. Goldman:

Thank you for the opportunity to submit comments in response to proposed rules to implement the Sustainable Health Care Cost Growth Target Program. Kaiser Permanente is an integrated health care system that covers and cares for over 663,000 members in Oregon and SW Washington. Operating as both a payer and provider, we have a unique perspective on the program and drivers of cost for health care. We are committed to delivering affordable, coordinated, and high-quality care and coverage that supports not only our members but also the communities we serve.

We appreciate the collaborative discussions that took place during the preceding Cost Growth Target Accountability Rulemaking Advisory Committee (RAC) meetings and reiterate the following recommendations to further improve the program.

Threshold for outliers

We recommend that the threshold for high-cost patient or member outliers in OAR 409-065-0035 (2)(i) be lowered to $500,000. Volatility related to high-cost patients can have a measurable impact on trend and many times is outside the control of providers and payers. We are concerned that a threshold of $1M is too high and does not allow providers and payers to effectively account for these costs. We estimate that the number of members to reach the $1M threshold is less than 1/10 of 1%. Lowering the threshold to $500,000 would result in about 1% of members at or above the threshold, which more accurately reflects the intent of this provision. We note that the Washington Cost Transparency Program currently uses a level of $200,000 at which about 3% of members and patients reach the threshold[1].

Financial Penalties

Reasonable, predictable, and not overly punitive penalties are critical to the success of the program. We appreciate the changes and clarifications OHA made to the penalty calculation methodology during the RAC and reiterate the following recommendations:

Penalties Should Only Apply If an Entity Fails to Make Good Faith Efforts to Comply with a PIP

[1] Implementation manual for the 2024 data call (wa.gov)

We recommend that OAR 409-065-0045 (1) be amended to reflect discussions by the Cost Growth Target Advisory Committee and comments by OHA in the Implementation Committee Report[2] that penalties should only be imposed if a payer or provider organization fails to make good faith efforts to comply with a PIP. Suggested amendments are provided below:

(1) Pursuant to ORS 442.386, the Authority may impose a financial penalty on a payer or provider organization when:
   a. The payer or provider organization's cost growth exceeded the target with statistical confidence, as defined by the Authority; ~~and~~
   b. the payer or provider organization's cost growth is without reasonable cause, ~~or~~ and is not indeterminate, as defined in 409-065-0035, in the Medicaid, Medicare Advantage, or commercial insurance market for at least three out of five consecutive calendar years~~.~~; and
   c. the payer or provider organization has failed to make a good faith effort to comply with an approved PIP.

Cap Escalation Mechanism

We recommend that the escalation mechanism in OAR 409-065-0045 (4) be capped at 15% and "reset" in years when an entity achieves the target.

The mechanism as currently drafted increases the financial penalty by 5% every time an entity fails to meet the target. There is no cap or end point in the proposed escalation mechanism. Providers and payers working in good faith to meet the target but still experience overages, even small overages, will be subject to never-ending penalty increases since there is no cap or mechanism to reset if an organization meets the target some reporting periods but not others. We are concerned that this is likely to further exacerbate unaffordability in direct conflict with the goals of the program. Suggested amendments are provided below:

(4) The size of a payer or provider organization's financial penalty shall be based on how much the payer or provider organization exceeded the cost growth target and shall be determined as follows:

(a) A payer or provider organization's first instance of a financial penalty within a given market shall equal 5 percent of the net total cost above and below the cost growth target collectively in the three or more years within a five-year period.

(b) A payer or provider organization's second consecutive instance of a financial penalty within a given market shall equal 10 percent of the net total cost above and below the cost growth target in the three or more years within a five-year period.

[2] Sustainable Health Care Cost Growth Target: Implementation Committee Recommendations Final Report to the Oregon Legislature, January 2021, p. 46, stating, "OHA intends for any accountability mechanisms to apply as a last resort only after transparency and collaborative efforts to contain costs do not have an impact."

(c)A payer or provider organization's third and any subsequent consecutive instances of a financial penalty within a given market shall equal 15 percent of the net total cost above and below the cost growth target in the three or more years within a five-year period.

~~(d) Each instance of a financial penalty within a given market shall increase by 5 percentage points of the net total cost above the cost growth target in the three or more years within a five- year period~~.

Upper Limit for Financial Penalties

We recommend that the financial penalties in OAR 409-065-0045 (4) be capped at an amount not to exceed $1.5M. Providing a known upper limit provides stability and predictability that allows organizations mitigate negative impacts that financial penalties may have on affordability. Uncapped penalties could create scenarios in which a provider or payor is subject to large penalties that negatively impact their ability to perform normal operations or threatens insolvency. This becomes increasingly likely if the entity has failed to meet targets, even if only by very small amounts, for one or more years.

We thank you for the opportunity to provide comments and look forward to our continued collaboration. Please do not hesitate to contact us with questions.

Sincerely,

/s/ electronically

Gregory Daniel, FSA, MAAA
Senior Actuarial Director

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June 21, 2024

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Pete Edlund, Rules Coordinator
Office of the Secretary of State
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Re: Notice of Proposed Rulemaking: Sustainable Health Care Cost Growth Target Program

Dear Mr Goldman,

The Pharmaceutical Research and Manufacturers of America ("PhRMA") is writing to comment on the proposed amendments to the rules governing the Sustainable Health Care Cost Growth Target Program (the "Proposed Rule") published May 30, 2024 by the Oregon Health Authority (the "Authority").[1]

PhRMA appreciates the role that annual public hearings play in promoting public participation and transparency under the Cost Growth Target ("CGT") Program. As a trade association, PhRMA is uniquely situated to provide insight into trends in prescription drug spending and has voluntarily presented to the Authority on this topic previously, for example through participation in the Department of Consumer and Business Services annual public hearing on prescription drug prices. However, we are concerned that the Authority does not have the power to *require* drug manufacturers to participate at the public hearing as contemplated in the Proposed Rule. Further, we are concerned that the Proposed Rule does not provide sufficient protection for confidential, proprietary, or trade secret information that may be submitted to the Authority. Our concerns are described further below.

The Authority Lacks Power to "Require" Manufacturers to Participate at the Annual Public Hearing

The Proposed Rule states that the Authority may "request" that certain entities, including drug manufacturers, "participate" in the annual public hearing; but "[i]f [an] entity does not commit to participating in the annual public hearing, the director of the Authority may require participation."[2] However, no statute gives the Authority the power to require such participation.

To the contrary, the Authority has limited subpoena powers under ORS § 413.037, which it cites as authority for this section of the Proposed Rule.[3] The two subsections of that statute provide the Authority with power to compel testimony only under certain circumstances. Under subsection (1), the Authority "may administer oaths, take depositions and issue subpoenas to compel the attendance of witnesses and the production of

[1] Or. Admin. R. ch. 409, div. 65. PhRMA had previously provided comments to the Sustainable Health Care Cost Growth Target Program on a draft version of these regulations on May 24, 2024 and we reiterate our concerns expressed in those prior comments with respect to the Proposed Rule.
[2] Proposed Rule 409-065-0055(2).
[3] *See* ORS § 413.037; Proposed Rule 409-065-0055.

documents or other written information *as necessary to carry out*" certain identified provisions.[4] The power to "compel the attendance of witnesses" thus may be exercised only in furtherance of the listed provisions.[5] The CGT Statute, ORS § 442.386, is not included in that list.

Similarly, subsection (2) permits the Authority to "compel obedience" only in two situations: [a] where a person "fails to comply with a subpoena issued under this section"; or [b] where a person "refuses to testify on matters on which the person lawfully may be interrogated."[6] The former situation would not apply to the Proposed Rule because, as above, the Authority has no power "under this section" to compel a manufacturer's attendance. The latter situation does not apply because it only allows enforcement of a subpoena that is otherwise authorized by some other source of authority—which does not exist here.

Nor does the CGT statute itself empower the Authority to compel manufacturers to attend annual public hearings.[7] The statute's only reference to such hearings provides: "Annually, the program shall … [h]old public hearings on the growth in total health expenditures in relation to the health care cost growth in the previous calendar year."[8] This language provides the Authority with no power to compel prescription drug manufacturers to attend the public hearing or to provide testimony. Moreover, other provisions in the CGT statute permit the Authority to require the submission of information from certain entities (providers and payers), while leaving prescription drug manufacturers squarely outside of the scope of the Authority's regulatory remit.[9]

In order to make the Proposed Rule consistent with its statutory authority, the Authority should revise Proposed Rule section 409-065-0055(2) by deleting the following proposed sentence: "If the entity does not commit to participating in the annual public hearing, the director of the Authority may require participation."

The Proposed Rule Provides Insufficient Protection for Confidential, Proprietary, and Trade Secret Information

As the Authority is aware, the U.S. District Court for the District of Oregon recently ruled that the "public disclosure" of manufacturers' trade secrets violates the Fifth Amendment "[u]nless just compensation is provided" at the time of disclosure.[10] PhRMA appreciates that the Authority has taken some steps to protect confidential information in the Proposed Rule. Specifically, the Proposed Rule provides that the "Authority may disclose data to payers or provider organizations in the administration of the program, *excluding information determined to be confidential* pursuant to Or. Admin. R. 409-065-0042, regarding the determination of a reasonable cause of cost growth." These regulations are insufficient, however, because they do not require an independent confidentiality assessment of all information submitted to the Authority, and do not provide a process for challenging an adverse confidentiality determination by the Authority.

The Proposed Rule should be revised to require the Authority to *independently* assess the confidentiality of submitted information. The Authority cannot solely rely on submitting entities because those entities may

[4] ORS § 413.037(1) (emphasis added).
[5] *See id.* (listing ORS §§ 413.006-.042, ORS §§ 415.012-.430; ORS § 415.501; ORS § 741.340).
[6] ORS § 413.07(2).
[7] ORS § 442.386.
[8] ORS § 442.386(6)(a).
[9] *See* ORS § 442.386(5)(a) (Authority shall "establish requirements for providers and payers to report data and information necessary to calculate health care cost growth under subsection (4) of this section").
[10] *PhRMA v. Stolfi*, --- F. Supp. 3d ----, 2024 WL 1177999 (D. Ore. Mar. 19, 2024), *appeal pending*, No. 24-1570 (9th Cir. filed Mar. 15, 2024).

be in possession of a third party's confidential, proprietary, or trade secret information and may fail to designate it as such. The only way to ensure that the Authority carries out its statutory mandate to protect confidential, proprietary, or trade secret information is to independently review *all* submitted information.

In addition, the regulations must establish a process for the owners of confidential, proprietary, or trade secret information to challenge any adverse decision by the Authority. If the Authority determines that certain information is not protected and intends to disclose it, entities impacted by that decision should be provided with notice and an opportunity to challenge it. Moreover, owners of confidential, proprietary, or trade secret information must be given access to judicial review of any adverse determination *before* the information is disclosed.

PhRMA is Uniquely Situated to Provide Insight into Trends in Prescription Drug Spending

While PhRMA has significant concerns with certain elements of the Proposed Rules, nonetheless we would welcome the opportunity to speak to the Board on a voluntary basis. PhRMA represents the country's leading innovative biopharmaceutical research companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier, and more productive lives. Given our role as a trade association, PhRMA is uniquely situated to provide insight into the policy landscape that impacts trends in prescription drug spending.

PhRMA appreciates that the Authority has considered discounts and rebates when measuring retail prescription drug spending growth over the last several years. The Authority's 2023 report noted that total medical expenses increased 5.6% from 2020-2021, with claims spending increasing 6.7%. That same report also found that, when accounting for rebates, retail prescription drug spending grew slower than total medical spending at 3.6%.[11] These findings are consistent with national trends that have shown that prescription drugs have remained a stable portion of the overall health care spending.[12] We are concerned, however, that the Patient Cost Sharing Report that was released in April 2024 demonstrates a concerning trend regarding patient out-of-pocket costs for retail prescription drugs. While overall prescription drug spending has remained stable, Oregonians' out-of-pocket costs have skyrocketed in recent years. In Medicare Advantage plans, retail prescription drugs made up 40% of patient's out-of-pocket costs in 2022.[13] Most concerning is the rapid growth in co-insurance on specialty prescription drugs. The amount paid per-person on co-insurance for specialty drugs "skyrocketed" by 172% from 2015-2022.[14] This hits patients in multiple ways because when a patient pays co-insurance, their percentage of cost sharing is usually calculated based on the list price, not the net price of the drug. PhRMA would appreciate the opportunity to speak with the Authority about these trends and others and recommend policy solutions that will help Oregonians better access and afford their medications.

* * *

[11] Health Care Cost Growth Trends in Oregon, 2023 Sustainable Health Care Cost Growth Target Annual Report https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2023-Oregon-Cost-Growth-Target-Annual-Report.pdf.
[12] IQVIA, "The Use of Medicines in the U.S. 2023: Usage and Spending Trends and Outlook to 2027", May 2, 2023.
[13] Patient Cost Sharing in Oregon: State and Market-Level Trends, 2015-2022, April 2024, https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Patient-Cost-Sharing-Report-2015-2022.pdf.
[14] *Id.*

We thank you again for this opportunity to provide comments and feedback, and for your consideration of our concerns. Although PhRMA has concerns with the Proposed Rule, we stand ready to be a constructive partner in this dialogue. Please contact dmcgrew@phrma.org with any questions.

Sincerely,

Dharia McGrew, PhD
Director, State Policy

Merlin Brittenham
Assistant General Counsel, Law

Cc: Pet Edlund, Rules Coordinator, Office of the Secretary of State

OREGON MEDICAL ASSOCIATION

June 21, 2024

Via Email peter.m.edlund@dhsoha.state.or.us
Peter Edlund, Rules Coordinator
Oregon Health Authority
Health Policy and Analytics
500 Summer Street, NE, E-65
Salem, OR 97301

Re: Sustainable Health Care Cost Growth Target Program

Mr. Edlund:

The Oregon Medical Association (OMA) is a nonprofit organization that represents over 7,700 physicians and PAs in the state of Oregon. As a mission-driven organization, the OMA dedicates itself to promoting evidence-based solutions to support a healthcare environment that is sustainable, equitable, and accessible to all Oregonians.

We are offering public comment on amended rules for the Sustainable Health Care Cost Growth Target Program. The OMA believes that understanding the metric of the total cost of healthcare is a helpful public policy tool. After reviewing the latest version of the rules, we offer the following comments:

We appreciate the updates to the reasonable causes for exceeding the cost growth target to include high-cost patients or member outliers. As we commented earlier, high-cost outlier cases often create misleading data and should be identified and factored in. Additionally, most outlier costs are generated by external factors beyond the providers' control. We would also suggest that the current outlier defining threshold of $1 million is too high for smaller medical practices and that the threshold should be closely monitored for modification in the future.

Additionally, we agree that federally qualified health centers (FQHCs) and pediatric providers be included as voluntary reporters and be exempted from financial penalties. We also believe that some primary care clinics may be above the attributed patient threshold and operate in a fixed cost environment and so should also be exempt.

We remain concerned that the financial penalties have the potential to destroy medical practices. We appreciate that the rules allow the OHA to reduce penalties if the penalties threaten the solvency of the provider organization. However, other elements suggested by rules advisory committee members, like a penalty cap and consideration of a provider organization's good faith effort to participate in the program and lower costs should be examined as future options.

With regard to frontline worker compensation being allowed as a reasonable cause of cost growth, we continue to believe that this reasonable cause should be carried through to any participants that have Total Medical Expenditures that are impacted/increased by those

investments.

Finally, we remain concerned that a performance improvement plan or financial penalty should not be enforced if the accuracy of the cost data available is disputed. The current burden remains on the provider clinics to spend considerable time, effort and resources to investigate the cost data in an attempt to bring appropriate transparency to reported figures that may not be accurate. Additionally, some clinics still struggle to access the data needed to assess the accuracy of the cost reports.

Thank you for your consideration. We would be glad to supplement our comments with further information as needed.

Sincerely,

Bryan Boehringer
CEO and Executive Vice President
Oregon Medical Association

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June 21, 2024

Sarah Bartelmann, Cost Programs Manager
Zachary Goldman, Health Care Cost Economist
Oregon Health Authority
421 SW Oak St., Suite 850
Portland, OR 97204

Submitted via email to Zachary Goldman

Subject: Notice of Proposed Rulemaking for the Sustainable Health Care Cost Growth Target Program

Dear Ms. Bartelmann and Mr. Goldman:

The Purchaser Business Group on Health is pleased to offer comments on the proposed rules for the Sustainable Health Care Cost Growth Target Program. PBGH's membership consists of 40 public and private purchasers -- including major Oregon employers -- that collectively spend $350 billion on health care annually and provide care for more than 21 million Americans.

PBGH members are extremely concerned about the health care affordability crisis. As the data presented by the Oregon Health Authority have shown, costs are too high and are increasing too rapidly. This is unsustainable from an employer perspective, threatening the ability to continue to offer health benefits. According to a joint KFF-PBGH survey , 87% of C-Suite respondents believe that the cost of providing health benefits to employees will become unsustainable in the next five to 10 years. Furthermore, recent research has shown that high health care costs are squeezing out wage increases, and they crowd out job growth and business investment. In addition, research shows that high costs create barriers to needed care and cause health inequities.

The Sustainable Health Care Cost Growth Target Program is a critical tool in addressing the affordability crisis. The program has been successful in its early years by reporting on cost growth by health plans, hospitals, and physician groups. The proposed rules will be used in the next phase of the Program's work, which is to ensure accountability for meeting the cost growth targets, consistent with legislative intent.

We want to reiterate our serious concern that the proposed financial penalty formula for entities that exceed the cost growth target would not be adequate. Based on comments from you at the April 17 Rules Advisory Committee (RAC) meeting, we understand that the objectives of the financial penalties are:

- To compensate the community – employers, consumers, and patients – that have had to pay more for the entity's cost growth exceeding the target, and
- To provide an incentive for entities to meet the target.

According to the proposed rules, the size of a payer or provider organization's financial penalty for the first instance would be equal to only **5 percent of the total cost above the cost growth target**, with gradual increases for multiple instances of exceeding the cost growth target. To even be subject to a financial penalty, however, entities would:

- Have to have failed to meet the target, after consideration of age/sex adjustments for their population and with statistical confidence;
- Have to have failed to meet the targets in three out of five years;
- Have to have failed to make progress on a performance improvement plan, as demonstrated over time; and
- Not have an "acceptable reason" for missing the target, which presently comprises an extensive and ill-defined list of exemptions.

It is clear that the proposed financial penalties do not meet these objectives or match the intent of the law that created it, favoring excessive leniency in lieu of pressing for real accountability, system change, and reform. **The minimum fine proposed by the agency is much too low to effectively deter entities from exceeding the target, and it does not provide sufficient compensation to the community.**

Given the number of chances an entity has to avoid potentially paying any fine whatsoever, the size of the penalties must be meaningful for any entity that has reached this point. Otherwise, paying fines would simply become part of the cost of doing business for healthcare payers and providers, particularly for larger entities. If the fine isn't significant, it is extremely likely that many entities will simply exceed the target and pay the fine. Using the CGT Penalty Calculator example distributed with the RAC meeting materials, an entity with $578 million in total revenue over 5 years that overspends by $9.3 million (net over 5 years) would be assessed a penalty of only $465,000. That amount is equal to 0.0804% of total revenue. The net benefit to the entity for overspending is $8,835,000; the ROI for the decision to overspend is 19:1. This penalty is clearly an insufficient incentive to keep spending below the cost growth target.

Furthermore, the penalty must be of sufficient size to fully compensate the community, which has been forced to pay more for necessary health care services from an entity that has consistently exceeded the cost growth target. The proposed penalty would provide compensation for only 1/20th of the revenue extracted from the community due to overspending.

We propose the following adjustments to the proposed rule:

- **The Authority shall assess initial financial penalties in amounts <u>fully commensurate</u> with the entity's total cost above the cost growth target, and in escalating amounts for repeated or continuing failure to meet the targets.**
- In addition to the factors listed in proposed ORS 442.386(9), the Authority should consider the following factors when assessing a penalty under this rule:
    - The provider or payer's degree of deviation from the average rate of reimbursement or cost growth as compared to other market participants;
    - Whether the provider or payer operates in bad faith in addressing health care costs, as shown by a preponderance of the evidence;
    - The market concentration of the provider or payer in one or more well-defined geographic regions in the state;
    - Whether the payer or provider has a history of penalization under the program.
- The financial penalty structure should be revisited in two years and every two years thereafter to allow for strengthening as the model and market adapt to this new method of accountability.
- The application of financial penalties should not be delayed, as proposed during the April 17 RAC meeting. The proposed revision would delay the first potential instance of a penalty to after the 2025-26 period. The justification offered for this revision is inadequate, and it does not take into account the serious impact of this delay on the affordability crisis faced by patients, consumers, and employers.

In summary, the proposed financial penalty formula – if adopted – would seriously undermine the effectiveness of the cost growth target program, resulting in a worsening of the already serious health care affordability crisis facing Oregonians. Ultimately, there is a better way to avoid the fines, which is to make the necessary efforts to control costs. Instead of worrying about the fines that may be levied against a few entities that refuse to make a solid effort to meet the target, we should be having a dialogue about how best to control spending.

Thank you for this opportunity to offer our recommendations, and we would be pleased to provide additional information and perspectives if it would be helpful.

Sincerely,

William E. Kramer

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June 21, 2024

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Subject: Final Comment on Cost Growth Target Rulemaking

Dear Health Policy & Analytics Division leadership,

Providence Health & Services and Providence Health Plan, collectively "Providence," offers this comment to support Oregon Health Authority's (OHA's) efforts to adopt rules to finalize implementation of Oregon's Cost Growth Target Program. This comment letter details Providence's feedback regarding both the most recent Rules Advisory Committee (RAC) meeting and reiterates some of our most significant remaining concerns.

Total Compensation to Frontline Workers (OAR 409-065-0028)

Providence requests clarification of the rule language to align with the intent OHA described in the most recent RAC meeting. This would include aligning the CGT-4 form with the law which clearly states entities will report total compensation in aggregate and defines "total compensation" to include wages, benefits, salaries, bonuses and incentive payments provided to a frontline worker by a provider. All other fields should be removed, or more clearly marked as optional for those providers that feel additional context is necessary.

Determining Reasonableness (OAR 409-065-0035)

Extend the frontline workers exemption for providers to payers as a reasonableness factor for payers. Providence supports the revised proposed rules, wherein providers are given an exemption from their cost growth calculation for frontline worker wages, as required by statute. Providence further recommends that the OHA recognize the downstream impact of this exemption on payers, whose contracted reimbursement rates are directly impacted by provider wages for frontline workers. Where the legislature has already determined that public policy is best served by enabling payers to improve frontline worker compensation,[1] we ask that the OHA codify this policy for all who are impacted by it through a reasonableness factor available for payers to account for their cost growth.

Financial penalties (OAR 409-065-0045)

Good faith safe harbor for financial penalties. As discussed by Oregon's policy makers throughout this program's development, the expectation is that financial penalties will be rare and the result of flagrant disregard to participate in the program or performance improvement plans. We request

[1] ORS 442.385 (1) and (9).

this intention be reflected in the rule by including language that an entity would only be subject to financial penalties if it has not made a good faith effort to comply with a performance improvement plan (PIP) or has refused to participate in the PIP process. We have reiterated this request in multiple comment letters and do so again now. The original intent of cost growth programs, as developed by the Milbank Memorial Fund, is to obtain information regarding the causes of cost growth, such that *all actors* in a system, including policy makers, can see and respond to those causes.[2] Where payers and providers are engaging in good faith efforts to address aspects of the cause that are within their control, we ask that they not be punished, particularly through onerous financial penalties. The actual causes of cost growth are complex, and the burden for addressing the issue should be borne by more than just payers and providers.

Excluding reasonable cost growth from financial penalties. Providence is very concerned by any penalty calculation formula that includes any portion of reasonable cost growth into the determination of an entity's PIP or financial penalties. Reasonable cost growth is growth that by its nature has been determined to be outside of payer or provider control and/or good policy for Oregonians. It is not only bad policy to punish and entity for such growth, but calculations that punish an entity for reasonable growth also exceed the authority given to OHA in statute, which provides that financial penalties are imposed for cost growth above the target "without reasonable cause."[3] As such, we strongly encourage OHA to amend the proposed rules to exempt any growth determined to be reasonable from any PIPs or financial penalties. Growth that is determined to be reasonable, but that OHA would seek to otherwise address, is by its nature the responsibility of state leaders and policy makers to wrestle with.

Reasonable cap on financial penalty amounts. While financial penalties should serve as an accountability tool, the intention was never to perpetuate cost growth, limit investments in workforce, reduce access to primary care, nor drive up health insurance costs. As we learn more about the impact of this program and develop more sophisticated strategies to track and discuss cost drivers, we recommend that OHA begin with a low penalty cap, such that OHA can learn through experience how penalties will impact the health care market before causing significant unintended consequences.

Need for robust patient-centered risk adjustment. Risk adjustment measures that only look to age and gender of patients and members create disincentives for providers and carriers to serve those in our community with a significant illness burden. Likewise, looking only at member months without looking at the members individually, OHA is inadvertently disincentivizing care and support for those with more significant medical needs. To resolve this unintended consequence, OHA should adopt a robust patient-centered risk adjustment methodology that accounts for an individual's severity of illness, factoring in chronic conditions and comorbidities. Doing so will allow a more real analysis of the cost growth as severity of illness burdens shift. Trying to identify cost outliers without this kind of risk adjustment is labor intensive and imprecise. Further, the failure to risk adjust in this way cuts against OHA's objectives around health equity and access to care. Frequently, members and patients of diversity tend to have greater health needs. We want to ensure that the program OHA develops continues to motivate improvements to care and access, rather than the opposite. Financial penalties should never be tied to providing care to patients and members with greater burdens of illness, regardless of race or ethnicity. Further, state programs should not incentivize payers and providers to seek out the healthy, knowing that

[2] Cost growth targets "serve as an annual statewide goal for health care spending growth that state leaders, health insurers, health care providers, businesses, and consumer advocates have all agreed to and are committed to achieving. With this common goal in mind, *everyone* can work together to find shared solutions for making health care more affordable in their state." Milbank Memorial Fund, Peterson-Milbank Program for Sustainable Health Care Costs, available at https://www.milbank.org/focus-areas/total-cost-of-care/peterson-milbank/?fwp_resource_types=publication&fwp_publication_types=fact-sheet#resource-library (last visited, May 23, 2024) (emphasis added).

[3] "The authority shall adopt by rule criteria for imposing a financial penalty on any provider or payer that exceeds the cost growth target without reasonable cause . . . ." ORS 442.386 (9).

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serving them affords the lowest risk of incurring a financial penalty. An OHA-adopted patient-centered risk adjustment model as described above would not only remove those incentives but would also create a level, more accurate floor from which to determine cost growth among carriers and providers.

Thank you for the opportunity to provide additional comment, please reach out if you would like to discuss our comments in further detail.

Kind regards,

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