NJ Health Care Affordability, Responsibility, and Transparency (HART) Benchmark Program Implementation Advisory Group

June 20, 2022, Meeting Summary

This summary presents highlights from the June 20, 2022, virtual meeting of New Jersey's HART Program Implementation Advisory Group, which was created pursuant to Executive Order #277 to provide expertise, input, and guidance on implementation of the state's health care cost growth benchmark program. At its first meeting, after reviewing HART program basics, the group discussed both the advisory structure and plans for first-year data collection and reporting. Advisory Group members wanted to ensure that the program was responsive to and reflective of changes across New Jersey's health care landscape. Below are highlights from the discussions.

Welcome and Review of HART Program Foundations

Shabnam Salih (New Jersey Governor's Office of Health Care Affordability and Transparency) welcomed all, opening the meeting with some level-setting, foundational information about the HART Program and its development with input from the Program Development Advisory Group throughout 2021. She noted that 2022 is the first program year, but focused on "reporting only," with no accompanying target, in consideration of COVID and other market factors. The first performance year will focus on a target of 3.5%, before moving to, and eventually below, the 3.2% target, which was built from a combination of Potential Gross State Product and Forecasted Median Household Income. Shabnam also reviewed a series of additional Administration initiatives aimed at improving health care affordability within the state, recognizing, that, despite "significant" progress, there is "more to be done." She additionally acknowledged that a benchmark alone will not curb costs, but rather provide the necessary information to help prompt action to slow spending growth throughout the state.

Layout of HART Program Advisory Structure

Justin Zimmerman (New Jersey Department of Banking and Insurance) then reviewed the HART Program Implementation Advisory Structure, which, along with the Implementation Advisory Group, includes a Technical Subgroup to provide input on technical design issues, along with an Independent Expert Panel to offer advice related to the broader health care context and landscape. Each of these groups will feed into decision making of the Health Care Affordability Interagency Working Group which is comprised of departmental leaders throughout the state.

Questions on Programmatic Decisions Reflecting Broader Health Care Context

Along with questions on additional background information, Advisory Group members asked about how plans for the program fit with the current economic climate, including inflationary pressures, as well as how evolving health care practice transformation and integration would be incorporated into the program decisions. Shabnam noted that the program design was reflective of both, with New Jersey not only adopting a transition year in its benchmark glide path, but also

having the opportunity to incorporate input from an expert panel on any factors that might warrant reassessing its program plans and targets. Joel Cantor (Rutgers Center for State Health Policy) noted that the design phase included substantial conversations related to inflation. However, the Independent Experts will help weigh-in on any adjustments that might need to be made as implementation progresses. He also noted that the team is relying on experience from other benchmark states.

Review of Two HART Program Reporting Streams: Benchmark and Cost Driver Analyses

Ann Hwang (Bailit Health) then reminded the group of the two main types of analysis planned for the HART program: first, the benchmark analysis, which focuses on annual per capita health care cost growth; and second, the cost driver analysis, which focuses on the "whys" behind changes in this growth.

Some asked about the experience of other states related to capturing higher demand in the area of behavioral health. Ann noted that, while there has been interest in measuring these costs, states have not yet been able to capture a clear definition of behavioral health spending, so have consequently not yet been able to disaggregate it. However, she noted progress over time in defining and disaggregating spending in other areas, like primary care, so, this, likewise, could be an evolving area over time.

Some asked whether the first-year plans include both reporting on total spending growth and the relative contributions to spending growth, with both planned for release.

Focus on Current Plans and Potential Topics for Cost Driver Analyses

The remainder of the meeting focused on plans for New Jersey's Cost Driver Analysis, again, the more granular analyses related to the "whys" or what's driving health care costs. Cost Driver analyses include both standard reports (released annually) and supplemental reports, which are informed through input from the advisory groups.

Joel noted that the first phase of cost driver reports would focus on the commercial side, and outmigration (something that members of the Program Development Advisory Group had raised as an important concern). Phase two would focus on Medicaid and monitoring key domains, like access, affordability, equity, and quality.

A number of potential future topics ranging from condition specific analyses to specialty pharma were also discussed.

Some clarified that the cost driver analyses would also focus on broader trends over time (rather than solely on year-to-year changes like the benchmark analysis) and emphasized the importance of flexibility in examining a range of data sources over time. Others expressed interest in particular topics in the queue for these analyses, including high-deductible plans; the impact of insurance subsidies; trends and shifts in intensity of care provided; as well as the dynamics of interactions between markets. Shabnam closed the meeting by thanking the group.