Quality is Our Bottom Line

Dear Commissioner and OHS Staff,

Thank you for the opportunity to comment on the proposed 2026–2030 Healthcare Cost Growth Benchmarks and the accompanying Technical Team recommendations. We value the continued engagement between OHS and industry stakeholders in working toward a more sustainable and affordable healthcare system.

With the passage of Public Act 25-94 (Secs. 6–7) and the accompanying enforcement authority, it is more important than ever that the benchmark framework be realistic, comprehensive, and balanced in its approach. We offer the following observations and recommendations with the goal of supporting a framework that is both fair and effective.

1. **Broader Context of the Benchmarking Initiative**

- Benchmarking has long held promise as a tool to bring transparency and focus to healthcare cost trends. One of the cornerstone principles of the initiative has been its voluntary and collaborative nature, which allowed stakeholders to engage constructively and refine the process over time.
- However, with the shift toward enforcement under passage of PA 25-94 instituting the possibility of rate reduction tied to the benchmark, that foundational principle is at risk. Carriers—who are already subject to extensive regulatory review—now face the only punitive consequences under the program, while other major cost drivers, such as hospitals and pharmaceuticals, are not held to similar accountability.
- This approach raises questions of equity and achievability and may erode trust in the benchmarking process itself.
- Since inception of the benchmark, questions have been raised about the accuracy of the data—concerns that apply not only to the benchmark figure itself, but also amplify the potential harm of introducing potential punitive rate reductions based on data that may lack sufficient precision or completeness.

2. Concerns Regarding the 2.8% Benchmark Target

- While we understand the aspiration behind the 2.8% target, it does not reflect the prevailing health cost trends in Connecticut. The most recent data show healthcare costs growing significantly faster than the benchmark, driven largely by factors outside of payer control, including hospital labor costs, persistent inflation, and pharmaceutical pricing.
- The current inflation-trigger adjustment is too narrow to address these systemic pressures. A more flexible and economically grounded benchmark would enhance both accuracy and credibility.
- We appreciate the goal of setting an ambitious target, but when coupled with rate enforcement provisions, an unrealistic benchmark risks creating practical and financial challenges for payers who are unable to reconcile actuarial soundness with compliance pressures. Health Plans around the country went insolvent several years ago because of inadequate premium rates. Insolvency hurts consumers and health care providers. Consumers are forced to choose new plans and lose their annual deductible and max out of pocket accumulations. Providers don't get paid by the insolvent plan for care they have already delivered.

- Connecticut's actual cost growth has been two to three times higher than the benchmark, highlighting a clear disconnect between policy goals and prevailing economic conditions. This reinforces the need for caution when applying enforcement provisions.

3. Enforcement Provisions Under Public Act 25-94 (Secs. 6–7)

Beginning in 2027, the Insurance Commissioner may reduce carrier rate filings by up to two percentage points if the benchmark is exceeded two years in a row. While we understand the intent of this provision, its implications are significant and potentially counterproductive.

Benchmarking and rate review serve different purposes and operate at different levels of analysis. Benchmarking data reflects total medical spend across the entire healthcare market, while rate filings are evaluated based on the specific experience of a single line of business—such as the individual or small group market. These data sets do not directly align and, as such, should not be used interchangeably to justify rate adjustments.

As you evaluate enforcement tied to benchmarks, it is crucial to factor in how:

- Market-wide spending—represented in Total Healthcare Expenditures (THCE)—captures system-level cost drivers, while rate review focuses on market-segment-specific data, such as the individual and small group markets. These data sets are not reconcilable.
- With statewide cost trends continuing to outpace benchmark targets—and projections indicating sustained upward pressure—there is real risk that carriers will be unfairly penalized for factors outside of their control.
- Actuarially sound rate development is required by the Department of Insurance and standards of actuarial process to ensure solvency and adequate coverage for consumers. Penalizing plans based on system-wide benchmarks that are largely outside their control risks undermining the financial stability of Connecticut's markets and puts the Department and health plan actuaries in a precarious situation.
- This concern is particularly urgent given the current market dynamics: only two carriers remain active in the individual and small group markets, and just one participates in both. The imposition of penalties tied to system-wide performance could create a chilling effect on continued market participation.

We strongly recommend that this risk be explicitly identified as an unintended adverse consequence in future OHS documentation and reviews.

4. Reassessing the Primary Care Benchmark

- A spending-based benchmark, with total medical expenditures as the denominator, does not accurately capture improvements in utilization or patient experience and may inadvertently penalize plans that are shifting care to lower-cost, high-value settings.
- The benchmark fails to recognize improvements in total primary care spending and utilization. The OHS report indicates that primary care spending increased across all markets from 2022 to 2023. However, because hospital and pharmaceutical costs are increasing at rates well above the cost benchmark and these trends are included in the primary care measure denominator, the current OHS primary care measure gives the false impression that the system is not increasing primary care utilization and investment.
- We urge a transition to a utilization-focused measure—such as preventive visit rates, continuity of care, and chronic disease management—that better reflects progress and outcomes.

5. Summary & Recommendations

As Connecticut enters this new phase of implementation, we respectfully offer the following for consideration:

- Reassess the 2.8% benchmark target considering current health spending trends and cost drivers.
- Reassess the policy tying the benchmark to carrier rate review and approval.
- If a tie to rate review is maintained, delay implementation of policy until all stakeholders, including hospitals and pharmaceutical manufacturers, are held accountable to the cost growth benchmarks.
- Recognize and document the potential for reduced carrier participation and market destabilization as an unintended consequence of tying benchmark enforcement to rate review.
- Refine the primary care benchmark to focus on access and utilization, rather than spend alone.
- Reaffirm the importance of voluntary participation in the benchmarking process and ensure that enforcement burdens are distributed more equitably across the healthcare landscape. Reconsider the use of any penalty provisions.

Many thanks for your consideration.