Healthcare Cost Growth Benchmark Steering Committee Meeting
August 22, 2022

OHS
CONNECTICUT
Office *of* Health Strategy

Welcome and Roll Call

Meeting Agenda

Time	Topic
3:00 p.m.	I. Welcome and Roll Call
3:05 p.m.	II. Public Comment
3:10 p.m.	III. July Meeting Recap and Approval of Minutes – Vote
3:20 p.m.	IV. Returning to In-Person Meetings
3:25 p.m.	V. Recap of Benchmark and Cost Driver Analyses
3:40 p.m.	VI. Cost Growth Mitigation Strategies
4:55 p.m.	VII. Wrap-Up and Next Steps
5:00 p.m.	VIII. Adjournment

OHS CONNECTICUT Office of Health Strategy

Public Comment

July Meeting Recap

Virtual Meeting Etiquette

- As a reminder, whenever possible please keep your cameras on and give your full attention to all meeting proceedings.
- It is fine to turn your camera off if you need to temporarily step away to attend to a pressing matter, but please turn your camera back on when you return.
- For this group to be successful, we need active participation by all members during meeting discussions, with respect, courtesy, and honesty our guiding principles.

- *Does anyone have any questions or concerns with this approach?*

OHS CONNECTICUT Office *of* Health Strategy

July Meeting Message Highlights

How can we successfully achieve our goal?

"We must give a little, to get a lot."

Overall, members share a common understanding that healthcare is an essential service, but the current rates of healthcare growth are unsustainable and there is a shared goal of driving real change.

By bringing all voices to the table-patients, providers, and insurers, we can work collaboratively across this shared space to come up with the right solutions.

Collectively, all agree we need to look at the broader picture, remember what our goals are and to act cohesively so that we can collaborate on models that work for ALL parties.

Approval of July 25th Meeting Minutes - Vote

Returning to In-Person Meetings

Returning to In-Person Meetings

- OHS would like the Steering Committee to consider returning to in-person meetings, either on a regular or alternating cadence, starting in September.

- *Please email Krista Moore* (krista.moore@ct.gov) *within the next week with your thoughts about returning in some fashion to in-person meetings.*

Recap of Benchmark and Cost Driver Analyses

Recap of Benchmark and Cost Driver Analyses

- Over the past year, OHS has provided the Steering Committee with multiple presentations of data analysis intended to make transparent where health care cost growth has been greatest in Connecticut in recent years.
- Because we will shortly begin to discuss potential cost growth mitigation strategies, and because it has been several months since we have reviewed some of the data, we will briefly recap the key findings.

Reminder: Cost Growth Benchmark Analysis vs. Data Use Strategy

How will we determine the level of cost growth from one year to the next?

Benchmark Analysis

- **What is this?** A calculation of health care cost growth over a given time period using payer-collected aggregate data.
- **Data Type:** Aggregate data that allow assessment at four levels: 1) provider level, 2) insurer level, 3) market level, and 4) statewide.
- **Data Source:** Insurers and public payers
- **Resources to be Used:** Bailit Health performs analyses at OHS direction

How will we determine the drivers of overall cost and cost growth? Where are there opportunities to contain spending?

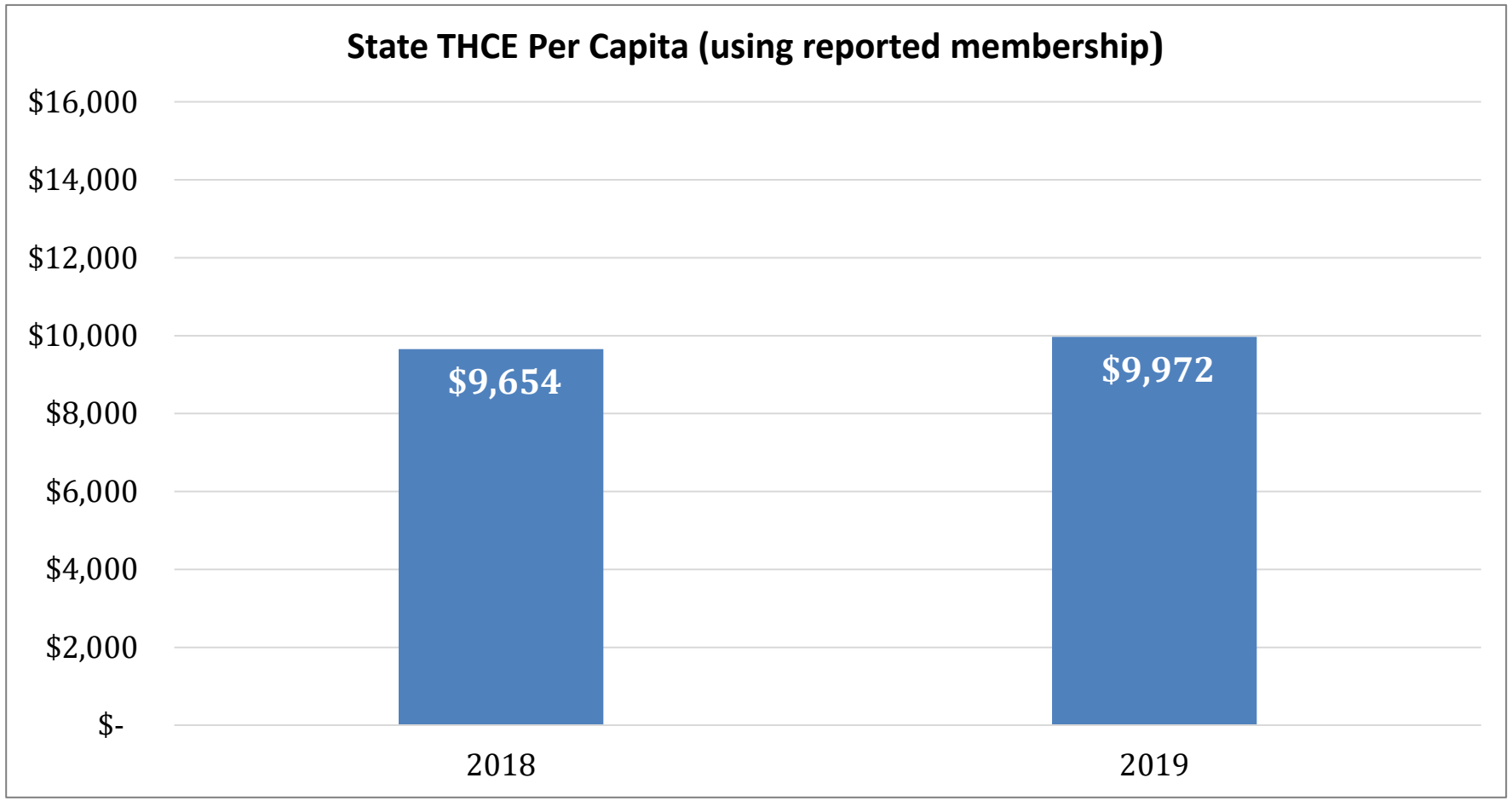
Data Use Strategy

- **What is this?** A plan to analyze cost drivers and identify promising opportunities for reducing cost growth and informing policy decisions.
- **Data Type:** Granular data (claims and/or encounters)
- **Data Source:** All-Payer Claims Database
- **Resources to be Used:** Mathematica performs the analyses at OHS direction

Pre-Benchmark Analysis

Calendar Year	Benchmark Values
2021	3.4%
2022	3.2%
2023	2.9%
2024	2.9%
2025	2.9%

Pre-Benchmark State Total Health Care Expenditure Growth

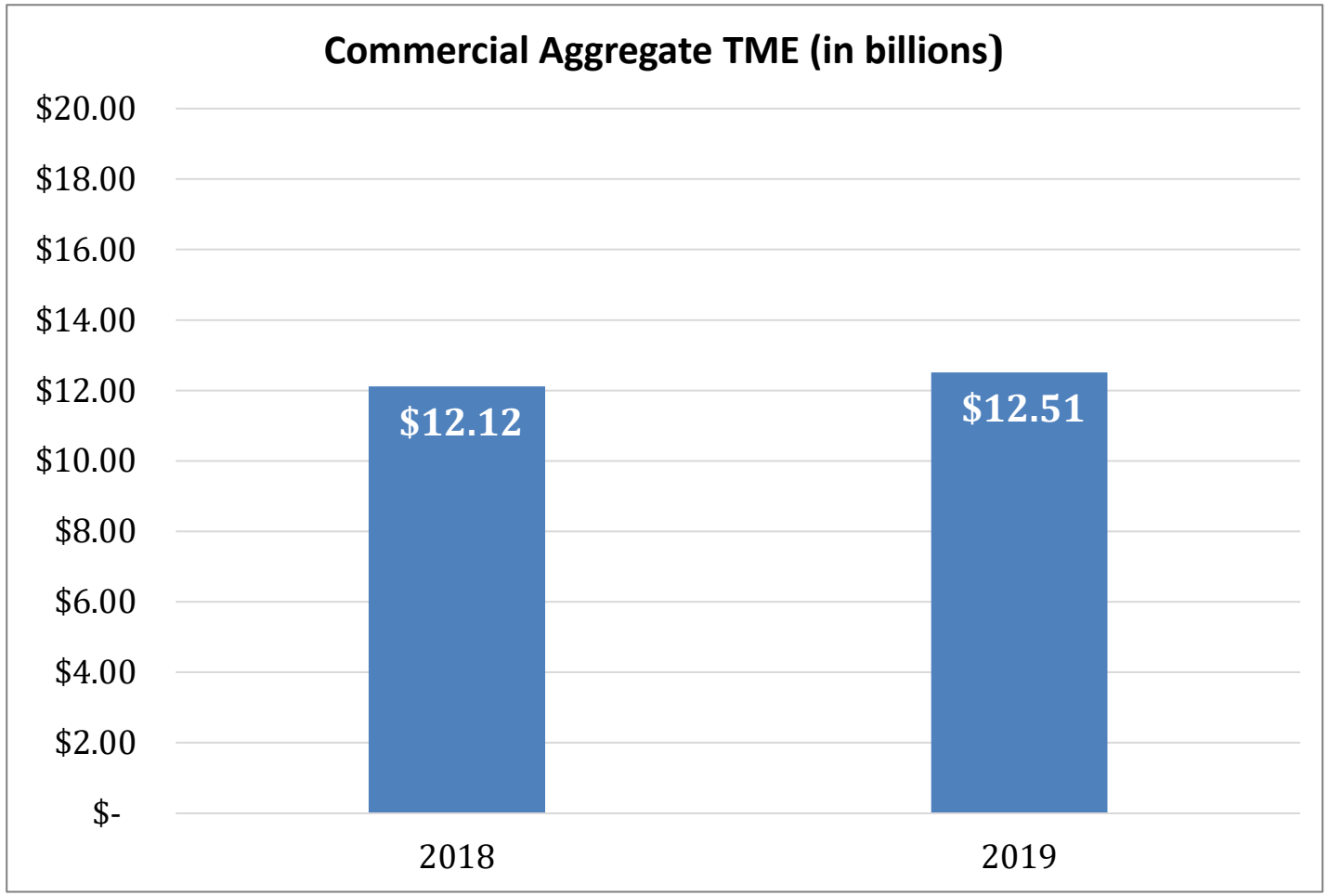


THCE Trend Per Capita
3.3%

Data are not risk-adjusted. They are reported net of pharmacy rebates.
Data include the Net Cost of Private Health Insurance (NCPHI).
Total reported membership was 3,252,773 in 2019. The CT Census reported 3,565,287 individuals in 2019.

OHS CONNECTICUT Office of Health Strategy

Pre-Benchmark Commercial Per Capita Spending Growth

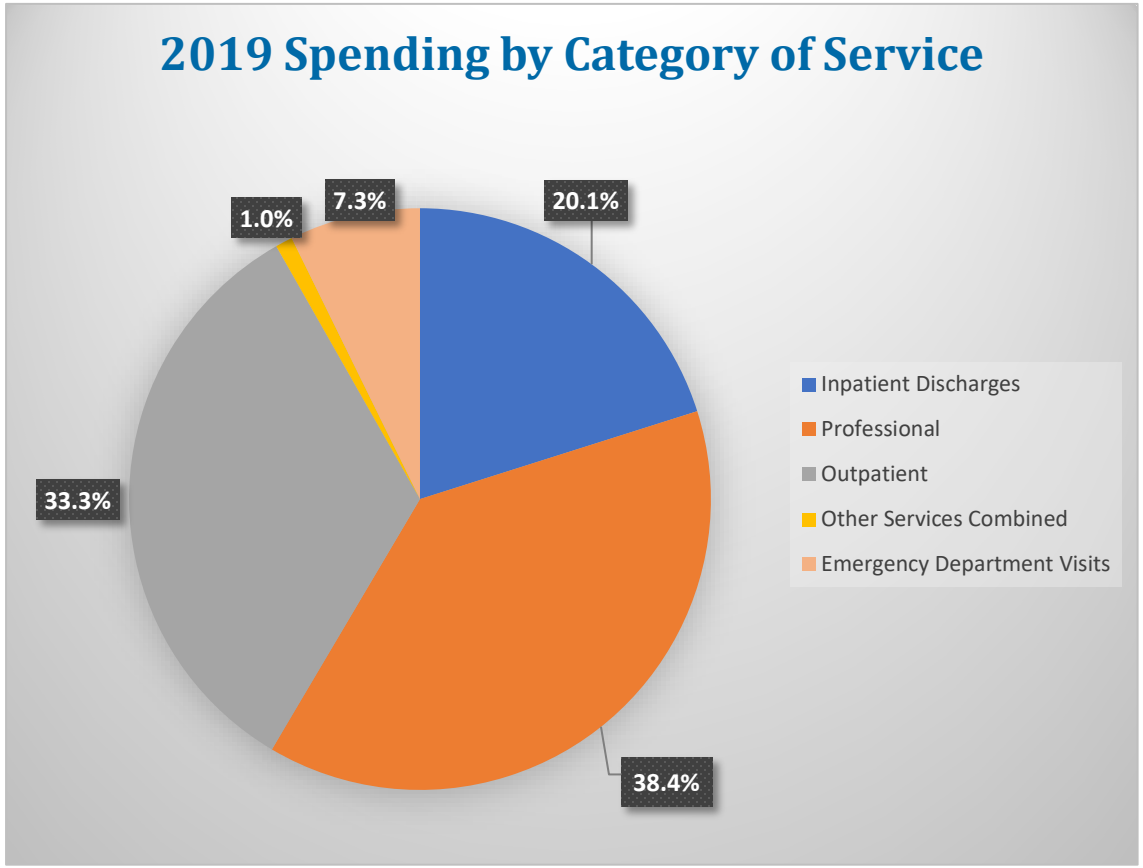


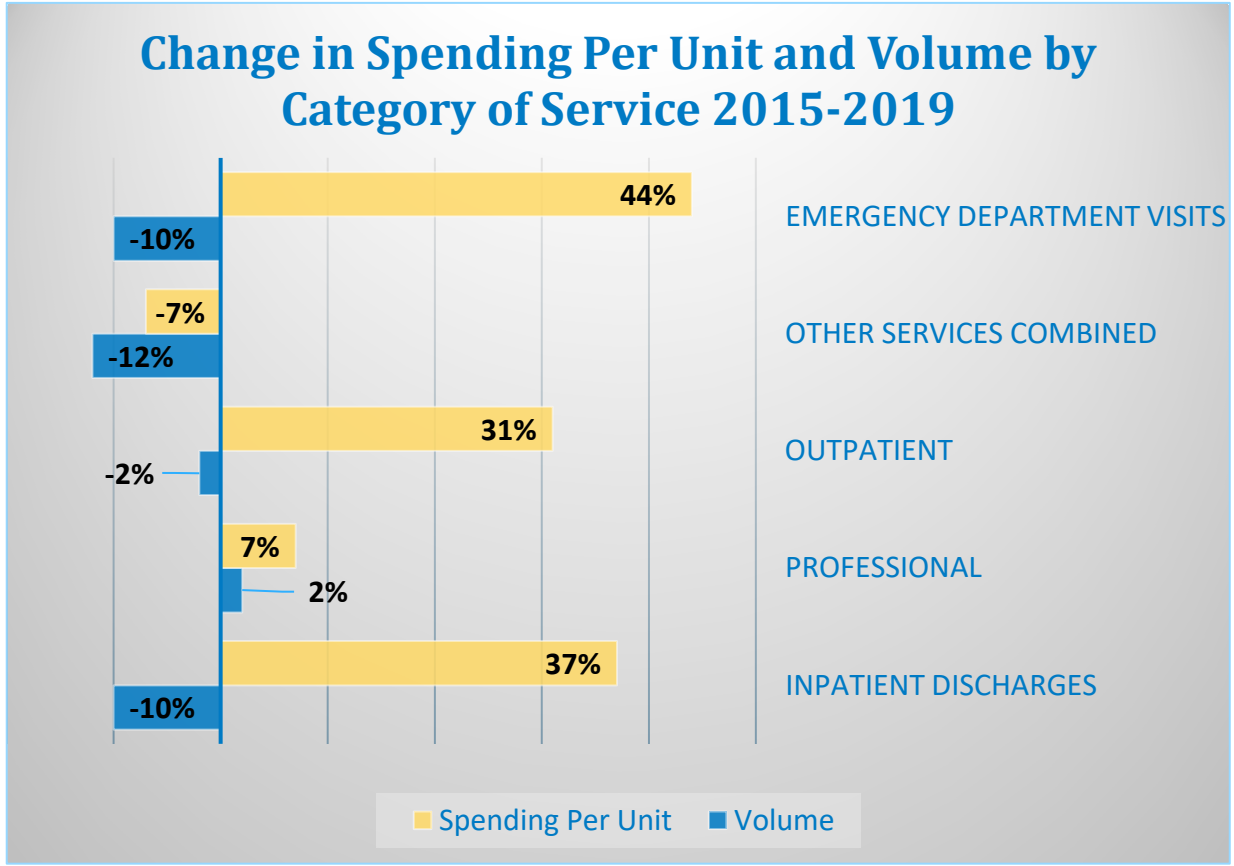
Year	TME Per Capita	TME Trend Per Capita
2018	$6,843	6.1%
2019	$7,257	

Data are not risk-adjusted. They are reported net of pharmacy rebates.
Data do not include the Net Cost of Private Health Insurance (NCPHI).

OHS CONNECTICUT Office of Health Strategy

Where are the healthcare dollars spent?





- Changes in spending per unit may be affected by both changes in service mix and changes in service-level prices.
- Includes CT residents under age 65. Results are not age/gender-adjusted.
- Inpatient stay units defined as discharges, which can include multiple inpatient claims. ED units defined as visits which can include multiple outpatient and/or professional claims.
- "Other" category of service units defined as individual claims.

OHS CONNECTICUT Office of Health Strategy

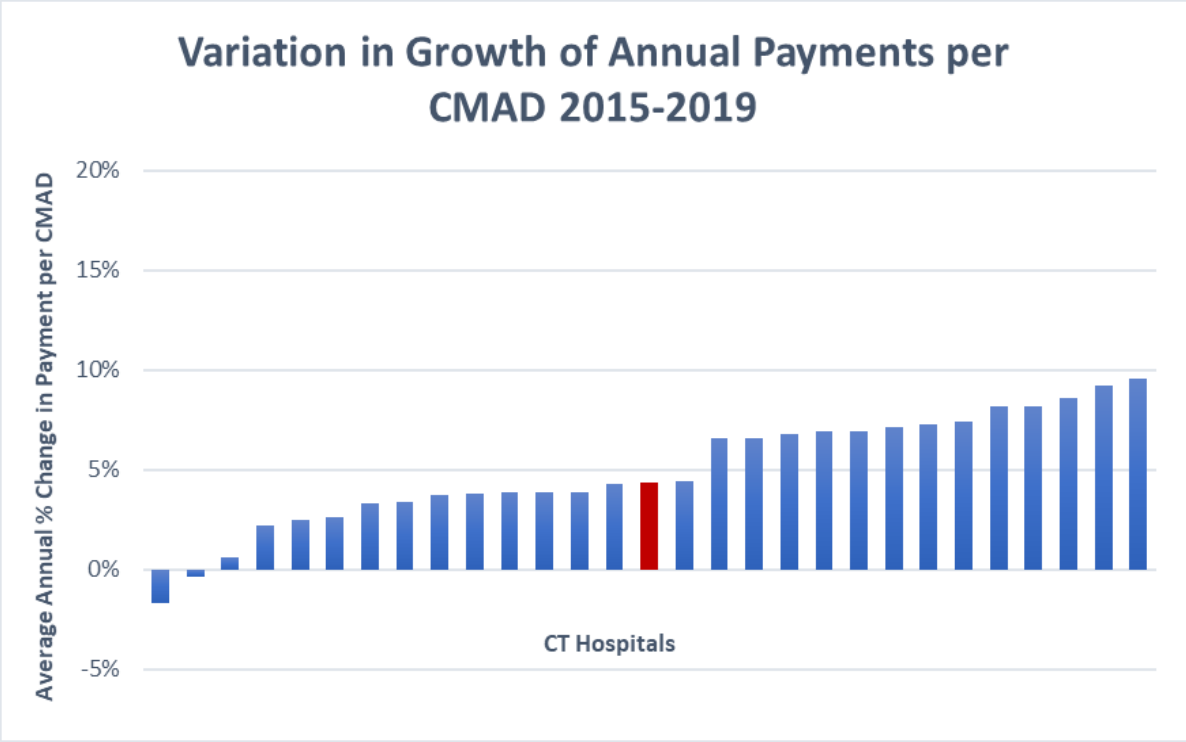
Between 2015 and 2019 per capita spending growth varied significantly by service type

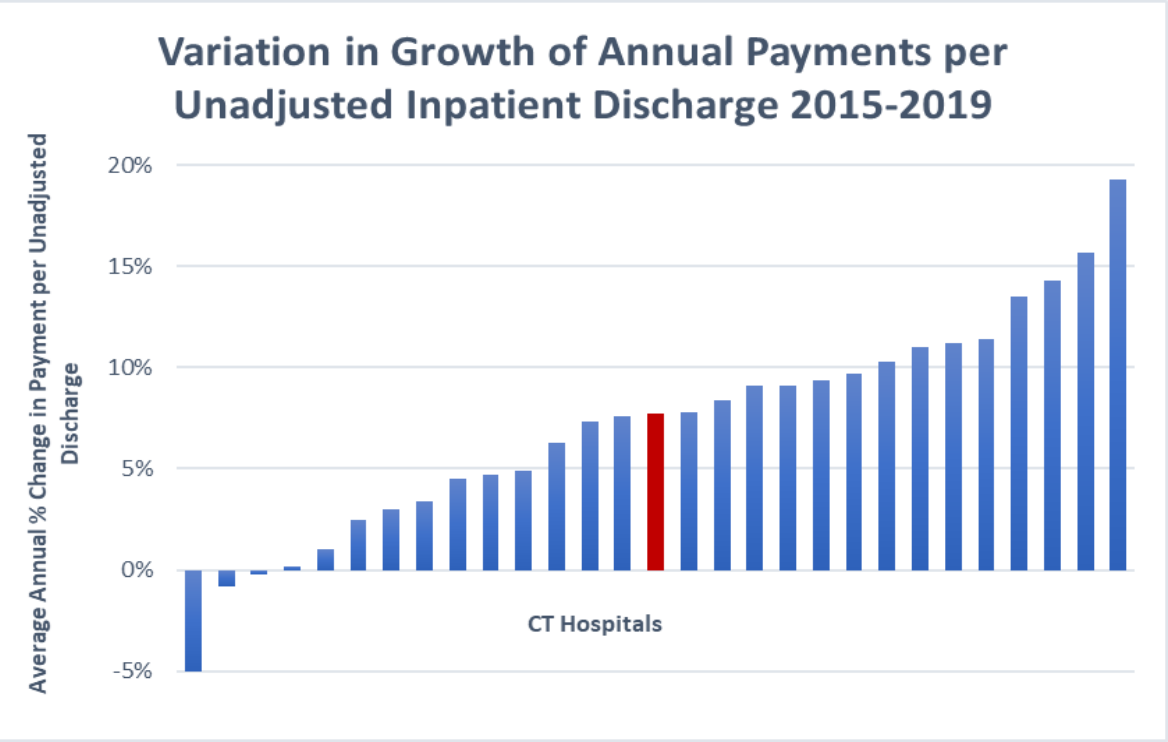
Service Category	2015		2018		2019		2018-2019 change (%)	Average annual change (%)	Total change (%)	Change in category as percent of total PMPM change
	PMPM	%	PMPM	%	PMPM	%				
All services	$480.24	100.0	$565.02	100.0	$589.13	100.0	4.3	5.3	22.7	100.0
Professional	$169.69	35.3	$183.77	32.5	$188.73	32.0	2.7	**2.7**	11.2	17.5
Inpatient acute	$78.57	16.4	$94.02	16.6	$98.71	16.8	5.0	**5.9**	25.6	18.5
Outpatient	$126.03	26.2	$151.53	26.8	$163.82	27.8	8.1	**6.8**	30.0	34.7
Other	$5.61	1.2	$4.87	0.9	$4.72	0.8	-2.9	-4.1	-15.8	-0.8
ED*	$27.10	5.6	$32.76	5.8	$35.74	6.1	9.1	**7.2**	31.9	7.9
Retail Pharmacy	$100.34	20.9	$130.84	23.2	$133.14	22.6	1.8	**7.6**	32.7	30.1

* ED includes both professional and outpatient ED claims if delivered in an ED, and thus overlaps with Professional and Outpatient.

OHS
CONNECTICUT
Office *of* Health Strategy

Why is there variation in annual payment growth across hospitals?



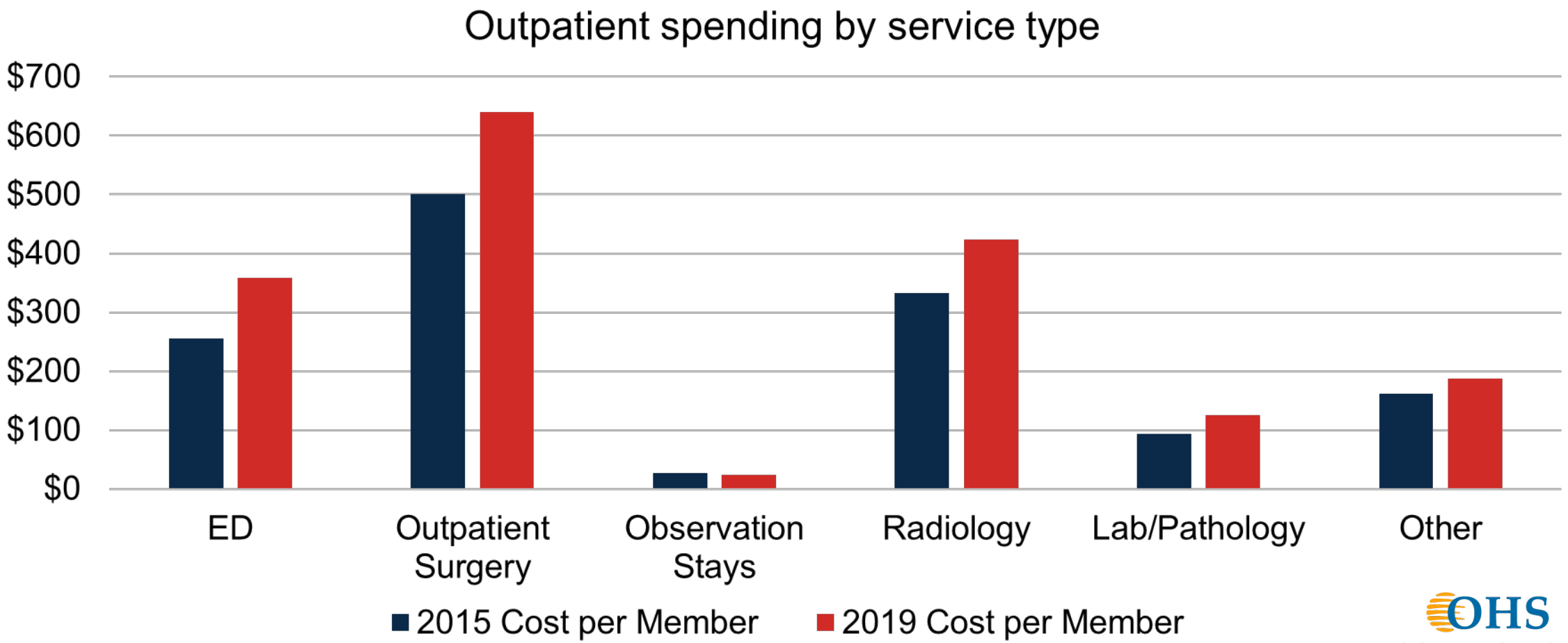


Notes:

- CMAD = Case Mix-Adjusted Discharge
- The red bar indicates the median.

OHS CONNECTICUT Office of Health Strategy

ED, outpatient surgery, and radiology make up the majority of outpatient facility spending



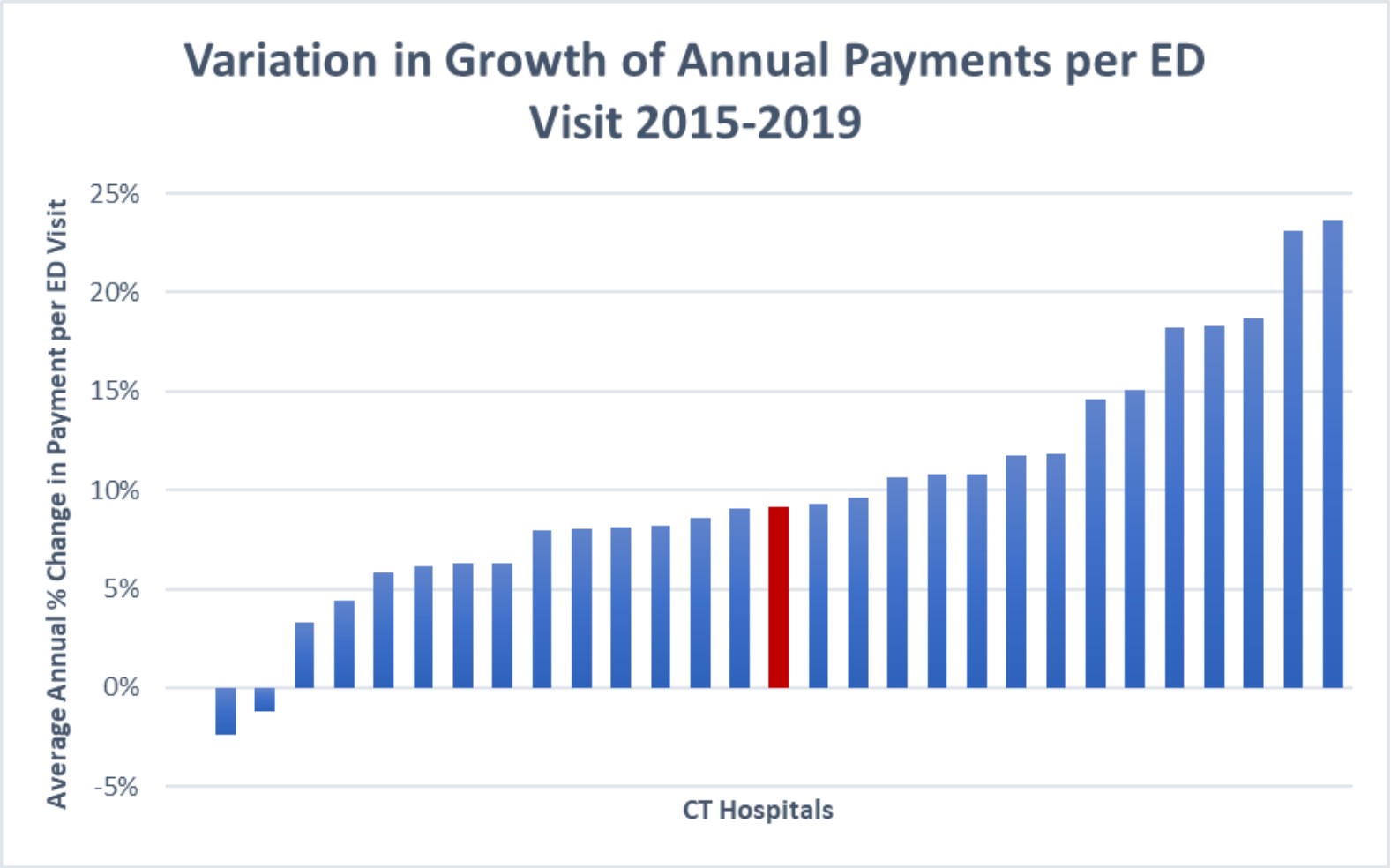
OHS CONNECTICUT Office of Health Strategy

Across all major outpatient service types, changes in outpatient spending were driven by spending per unit not units per person

Service type	2015 – 2019 Percent Change			
	Spending per person	Units per member	Spending per unit	Interaction of both factors
ED	40.1%	-6.3%	49.5%	-3.1%
Outpatient surgery	28.1%	2.3%	25.2%	0.6%
Radiology	27.5%	0.0%	27.6%	0.0%
Lab/pathology	35.5%	-5.2%	42.8%	-2.2%

- For ED, spending per unit rose by almost 50 percent between 2015 and 2019.

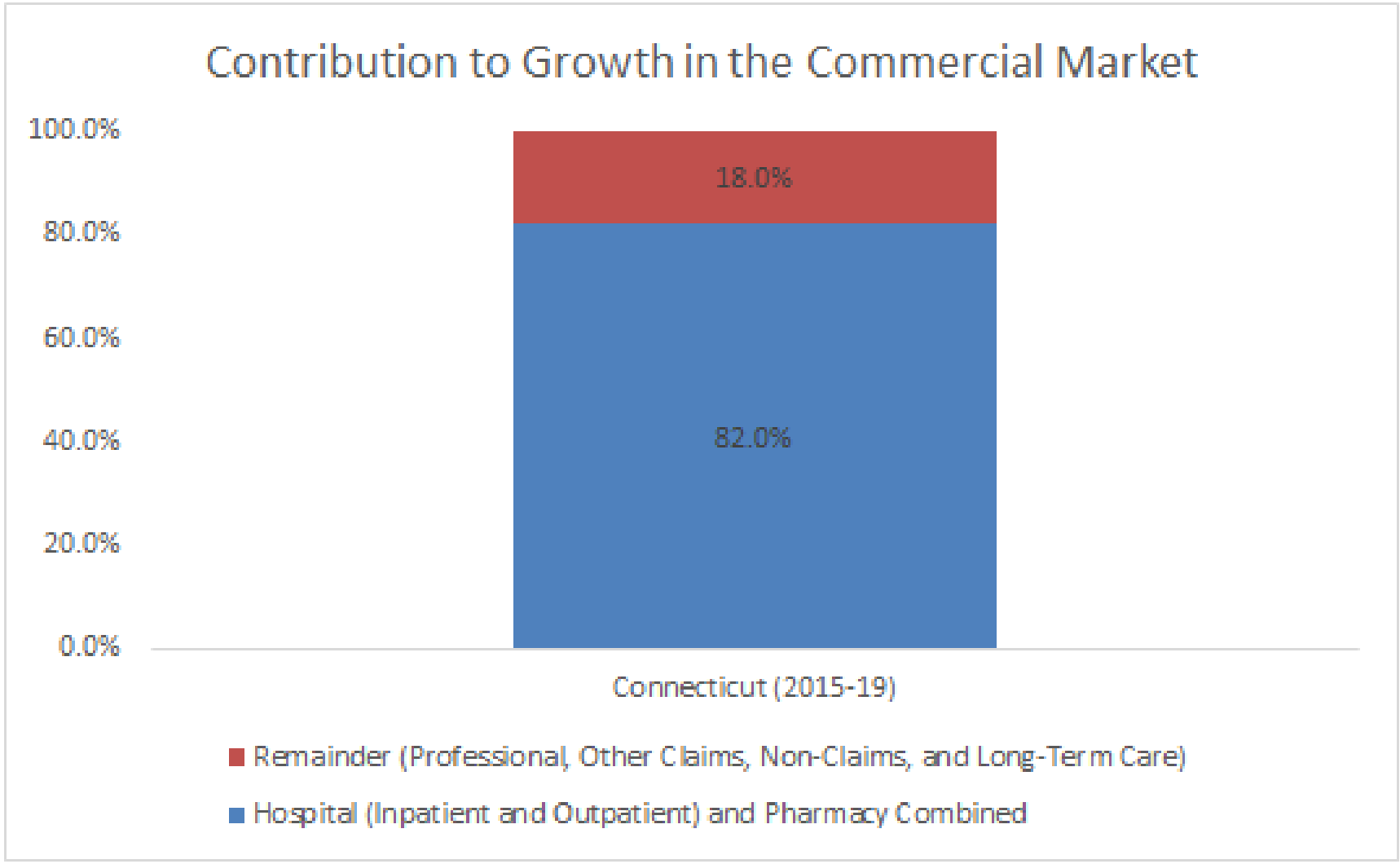
Why is there variation in payment per ED visit growth across hospitals?



Note: The red bar indicates the median.

OHS CONNECTICUT Office of Health Strategy

Hospital services and retail pharmacy drove 82% of commercial spending growth between 2015 and 2019



OHS CONNECTICUT Office of Health Strategy

Commercial Pharmacy Spending Key Takeaways

1. **Payment per prescription and spending increased, while utilization decreased, 2017-19.**
   - Increases were at a higher rate for medical pharmacy than retail pharmacy.
2. **A disproportionately large share of pharmacy spending was on a small number of very expensive drugs.**
   - These drugs were primarily used to treat cancer, arthritis, Crohn's disease, multiple sclerosis, and psoriasis.
3. **The price problem was with brand-name retail drugs and Medical Pharmacy, and not generics, despite the occasionally publicized examples of generic price gouging.**

This analysis did not answer the question of whether the growth in prices was about new drugs at higher price points or increases in "old" drugs.

Commercial Hospital Growth Key Takeaways

1. **Price increases drove hospital spending but were not uniformly high across hospitals.**

2. **Price increases occurred alongside declining or flat utilization in inpatient and outpatient settings.**

3. **While low prices paid by public payers present significant challenges to hospitals, research literature demonstrates it does not explain rates of commercial price growth.** Cost cutting has been proven to be the tool used to respond to low government payer rates.

Cost Growth Mitigation Strategies

Cost Growth Mitigation Strategies (1 of 3)

- After many meetings reviewing and discussing data analysis into Connecticut commercial health care cost drivers, we will begin to turn our attention to actions that could effectively moderate cost growth to a sustained level that:
  1. is affordable for consumers, as well as employer and government purchasers
  2. ensures accessible, high-quality and equitable healthcare
  3. supports Connecticut's health care delivery system

- As a reminder, we agreed during our July meeting to select two cost growth mitigation strategies by year-end.

Cost Growth Mitigation Strategies (2 of 3)

- Our approach to this conversation will be to first consider the range of strategies that have been implemented, or are being considered, in other states.
  - For today, we'll just provide a high-level overview of these strategies.
- We will then ask you for any other ideas that you would like to put forth for consideration.
- Lastly, we will ask you to identify the ideas of greatest interest to you so that we can delve into them in more detail in upcoming meetings.

Cost Growth Mitigation Strategies (3 of 3)

- The five strategies briefly described on the following slides are presented solely for educational purposes.
- They represent strategies in development or use in other states.
  - They are also strategies being discussed in multiple national policy forums, e.g., "Reducing Health Care Spending: What Tools Can States Leverage?", The Commonwealth Fund, August 2021
- OHS is not presenting these strategies as recommendations.

Cost Growth Mitigation Strategies in Other States

Many other states have been having conversations like the one we are having today. Here are some of the ideas they are pursuing:

1. Pharmacy price growth limitations (multiple approaches)
2. Accelerated multi-payer adoption of advanced Value-Based Payment models
3. Expanded regulatory constraints on market consolidation
4. Caps on commercial price growth and/or prices
5. Expanded insurer rate review

1. Pharmacy price growth limitations

- Problem to be solved:
  - Commercial retail Rx costs grew 7.6% annually from 2015 to 2019
  - Medical Rx costs grew 9.9% annually from 2017 to 2019
  - Price, and not utilization, has been the cause
- States pursuing this strategy:
  - *many*, including Connecticut via Governor Lamont (see next slides)

Pharmacy price growth limitation strategies (1 of 2)

Strategy	Description	State Examples	Comments
1. Upper Payment Limits (UPLs)	• Identify drugs subject to the UPL • Determine the UPL • Prohibit payments in excess of the UPL	CO, WA, maybe MD	Applies to relatively few drugs; significant effort to implement/ administer
2. International Reference Pricing	• Identify drugs subject to the reference rate • Determine reference rate (e.g., Canadian pricing) • Prohibit payments in excess of the reference rate	Bills introduced in HI, ME, NC, ND, OK, and RI	Using international reference prices may be simpler & more impactful than establishing upper payment limits; has not yet been passed by any state

Pharmacy price growth limitation strategies (2 of 2)

Strategy	Description	State Examples	Comments
3. Prohibition of Unsupported Price Increases	• Imposes penalty on manufacturers of drugs with “unsupported” price increases, as identified by ICER	Bills introduced in HI, ME and WA	Applies to drugs identified in ICER's assessment; has not yet been passed by any state
4. Penalization of "Excess" Prices	• Impose a penalty on manufacturers for selling drugs at prices that grow faster than inflation	Proposed by Governors of CT and MA	Applies to drugs whose prices grow faster than the target rate; has not yet been passed by either state
5. Prohibition of Price Gouging	• Prohibits excessive price increases (or base price)	MD passed law in 2017, which was struck down by the courts	Successful legal challenge in Maryland may make other states less likely to pursue this approach; may need to limit to generic or off patent drugs

Recent attempted policy action in Connecticut

BUSINESS

Connecticut Gov. Lamont wants to put a cap on prescription drug prices, including those that can cost thousands a year

By Stephen Singer
Hartford Courant
Feb 14, 2022

Gov. Ned Lamont is proposing price caps on drugs and seeking imports from Canada as part of a health care package he's sent to the legislature. Connecticut's largest business group and the pharmaceutical industry are opposed, pointing to the success of drug companies to rapidly bring to market COVID-19 vaccines.

Learning more about pharmacy price growth limitation strategies

- The National Academy of Health Policy (NASHP) is the national expert on state pharmacy cost strategies.
- OHS has been in conversation with NASHP about a future meeting presentation if this is an area of high interest to the Steering Committee.

2. Accelerated multi-payer adoption of advanced Value-Based Payment models

- Problem to be solved:
  - Fee-for-service payment remains the standard in Connecticut across all markets
  - The model is inherently inflationary because it pays more for delivering more (and higher margin) services
- States pursuing this strategy:
  - Oregon and Rhode Island
    - Connecticut is pursuing episode-based payment through OSC and Medicaid (for maternity only). This is not part of a broader multi-payer strategy

Examples of multi-payer VBP models

VBP Model	Summary
Hospital global budgets	Fixed payment, determined prospectively, based on historical utilization and adjusted annually based on changing demographics, market share and service mix
Episode-based payment	Bundle payment for all services related to a specific episode of care, usually connected to a specific service or condition
Specialty capitation (specialty prospective payment)	Prospective per capita monthly payment for all the patients for whom a specialty group is accountable (only includes payment for services to be delivered by the specialty group)
Global capitation	Involves a prospective budget and prospective payment
Total cost of care with shared savings	Involves a prospective budget, with fee-for-service payment and retrospective reconciliation

Examples of states pursuing accelerated *multi-payer* adoption of advanced Value-Based Payment models

- Oregon and Rhode Island are both seeking to attain their cost growth benchmarks through implementation of multi-payer Value-Based Payment.
- In both states, insurers, providers, the state and other partners signed a compact committing themselves to specific payment models, actions, targets and timelines.
  - **Oregon** (Oct 2021): hospital payment and primary care payment at over above HCP-LAN "3B"
  - **Rhode Island** (Apr 2022): hospital global budget, specialty care model (TBD), and primary care prospective payment

3. Expanded regulatory constraints on market consolidation

- Problem to be solved:
  - Market consolidation is widely understood to be a leading cause for fast-growing provider prices in the commercial market
- States pursuing this strategy:
  - A number of states, including Connecticut, have certificate of need programs, but some states, including Massachusetts and Oregon, have created more rigorous and far-reaching review processes

Oregon's Health Care Market Oversight Program

- Launched in 2022 in response to 2021 state legislation (HB 2362).
- Requires review of business deals between health care entities such as hospitals, health insurance companies, and provider groups.
  - One entity has to have at least $25M in revenue and the other $10M to be subject to review
- State reviews proposed health care transactions to make sure they support statewide goals related to cost, equity, access, and quality.
- The designated state agency has full authority to approve or deny proposed transactions.

4. Caps on commercial price growth and/or prices

- Problem to be solved:
  - Hospital price growth was the primary contributor to commercial spending growth in Connecticut between 2015 and 2019
- States pursuing this strategy:
  - Delaware and Rhode Island

What are provider price growth caps/price caps?

Set a cap for the growth rate of provider prices, or absolute levels of provider prices.

Price Growth Caps

- Limit the amount provider prices can grow each year.
- Enforced through insurance regulation.

Price Caps

- Cap provider prices, e.g.,:
  - Within public employee programs
  - Within a public option
  - For out-of-network payments
  - Broadly across the commercial market
- Implemented through purchasing authority and/or through insurance regulation.

OHS CONNECTICUT Office of Health Strategy

State experience with caps on commercial *price growth*

- **Delaware** is implementing a cap in 2022. The cap applies to commercial hospital prices. The cap equals the greater of 3% or **core CPI** plus 1% for 2022. For 2024 through 2026, it is the greater of 2% or **core CPI** plus 1%.
- **Rhode Island** implemented in 2010. The cap initially applied to commercial hospital prices and was set to the Medicare Price Index plus 1%. It is now equal to **CPI** plus 1%. The State is considering expansion to specialist fees.
  - An evaluation published in *Health Affairs* in 2019 found the program resulted in an 8.1% decline in spending relative to a control group (the other New England states).

State experience with caps on commercial *prices*

- Since 2018, **Oregon** legislation has capped hospital prices in its public employee benefit program, limiting payments for in-network hospital services to 200% of Medicare rates for the services and limiting payments for out-of-network hospitals to 185% of the amount Medicare would pay.
  - Estimated one-year savings were $81 million, representing roughly 5% of total costs.
- **Montana** implemented a similar program in 2016, setting the cap at 234% of Medicare rates on average, but the caps were set through negotiation rather than through legislation.
  - The state self-reported $13.6M in savings over the first three years of the program.

5. Expanded insurer rate review

- Problem to be solved:
  - Consumers and employers have experienced high rates of premium growth for insured products
- States pursuing this strategy:
  - All states perform rate review, but only about half have authority to review, disapprove, or modify rates, and even fewer use rate review as an active strategy to tamp down on premium growth
    - Some of these states are California, Colorado, Oregon, Rhode Island, Vermont and Washington

Key elements of effective insurance rate review

1. Statutory authority to approve, disapprove, and modify proposed rates, with sufficient timeline for review and review criteria that support affordability assessment
2. Statutory authority over the full insured market, i.e., individual, small group and large group
3. Sustainable funding for operations, e.g., state budget allocation, user fees, costs of examinations, reimbursing for actuarial expenses
4. Adequate staffing, including actuarial expertise
5. Efforts must be sustained over time; threats include regulatory capture and erosion of political will

State experience with insurance rate review (1 of 2)

- **Vermont** must determine whether a rate is "affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State."
- Several states, including **Oregon** and **Washington**, have the ability to deny increases that are not "reasonable."
- **Rhode Island** uses the rate review process to advance broader goals around insurance affordability. The statute for rate review requires plans to establish "that the rates proposed to be charged are consistent with the proper conduct of its business and with the interest of the public."

State experience with insurance rate review (2 of 2)

- One 2015 peer-reviewed study in *Health Affairs* found that states with stronger rate review policies had lower individual market premiums.
- **Vermont** commissioned a study that found that for rates effective from 2012 to 2016, the total premium adjustments made in the rate review process saved Vermonters approximately $66 million, or about 3%.
- Additional assessments by advocacy organizations also have documented savings related to rate review in **California** and **Oregon**, but these results do not report savings as a percentage of total spending across the market.

Other potential cost growth mitigation strategies

- *What other strategies do members propose for Steering Committee consideration?*

Potential cost growth mitigation strategies for further review

- *Which potential cost growth mitigation strategies would you like to explore in further detail during our upcoming meetings?*

Wrap-Up and Next Steps

Wrap-Up and Next Steps

- The next meeting will be held on Monday, **September 26th** from 3–5:00 p.m.