Healthcare Cost Growth Benchmark Steering Committee Meeting
May 23, 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. Approval of March 28th Meeting Minutes – Vote
3:15 p.m.	IV. House Bill 5506 and Other New Legislation
3:35 p.m.	V. Update on OHS Data Sharing Activities
3:45 p.m.	VI. Update on the Data Analytics Workgroup
3:55 p.m.	VII. Risk-Adjustment and Truncation Point Decisions
4:05 p.m.	VIII. Commercial Pharmacy Spending Analyses
4:55 p.m.	IX. Wrap-Up and Next Steps
5:00 p.m.	X. Adjournment

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Public Comment

Approval of the March 28, 2022 Meeting Minutes - Vote

House Bill 5506 and Other New Legislation

House Bill 5506

- Executive Order No. 5 created the Connecticut Healthcare Cost Growth Benchmark Initiative in January of 2020. Accordingly, OHS set benchmarks for 2021-2025, which are posted on the OHS website.
- Governor Lamont recently signed House Bill 5506 into law, putting the Healthcare Cost Growth Benchmark Initiative in statute.
- The following slides describe the new processes related to the Cost Growth Benchmark defined within House Bill 5506.

House Bill 5506: Setting Future Benchmarks

- **By July 1, 2025 and every five years thereafter**, OHS must **set benchmark values** for each of the coming five years.
  - OHS must hold **at least one informational public hearing** prior to adopting another five years of benchmark values, and may modify its benchmarks based on public feedback.

House Bill 5506: Setting Future Benchmarks (cont.)

- If the average annual benchmark for a five-year period proposed by OHS exceeds the average benchmark of the prior five-year period by **more than 0.5%**, the benchmark recommendations will be submitted to the joint standing committee of the General Assembly for approval.
  - OHS' recommendations will be **considered approved unless rejected** by the joint committee **within 30 days**, in which case OHS can submit modified benchmarks.
  - In this scenario, the benchmark will be equal to the average annual benchmark of the prior five-year period until new benchmarks are approved by the joint standing committee.

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House Bill 5506: The Benchmarks and Inflation

- OHS must **review current and projected inflation annually** to determine whether to modify the benchmark for the coming year and must report its decision and reasoning.

House Bill 5506: Benchmark Data Submissions

- Payers must submit data to OHS by **August 15th** of each year.
- OHS must meet with any payer or provider upon request to validate benchmark performance data and amend its findings, if necessary, prior to reporting.

House Bill 5506: Benchmark Findings

- Starting in 2023, OHS must report the findings from its benchmark analyses, including any necessary contextualization, by **March 31st** of each year.
- OHS must identify payer and provider entities that exceeded the benchmark by **May 1st** each year and send official notice to each entity within 30 days.
- OHS must identify any other entities (such as drug manufacturers or pharmacy benefits managers) that significantly contributed to exceeding the benchmark by **May 1st** each year as well.

House Bill 5506: Benchmark Hearings

- Starting in 2023, OHS must hold **an informational public hearing** on its Cost Growth Benchmark findings by **June 30th** of each year.
  - OHS may require any payer, provider, or other entity that is found to have been a significant contributor to healthcare cost growth in the state to provide testimony at this hearing.

House Bill 5506: Report to the General Assembly

- By **October 15th** of each year (beginning in 2023), OHS must submit a report to the joint standing committee of the General Assembly that outlines:
  - healthcare spending trends;
  - plans for monitoring any unintended adverse consequences of the benchmark program, and
  - recommendations to increase the efficiency of the state's healthcare system (including, but not limited to, legislative proposals).

Other New Legislation

An Act Encouraging Primary and Preventive Care

- This piece of legislation requires health carriers to develop at least two health enhancement programs (HEP) by January 1, 2024.
- Each HEP must be available to each insured and provide coverage for certain preventive examinations and screenings.
- An HEP cannot impose a penalty or negative incentive on the insured, and the insured cannot be required to participate in an HEP.
- The insurance commissioner is authorized to adopt related implementing regulations.

Other New Legislation (cont.)

- The approved budget also contains key workforce investments, including funding for:
  - Private provider support
  - Salary increases, enhanced benefits, and infrastructure improvements
  - Connecticut State Colleges and Universities to support Healthcare Workforce Development
  - Child Psychiatrist Workforce Development
  - A DPH grant-in-aid program for a children's hospital in the state to coordinate a behavioral health training and consultation program

Update on OHS Data Sharing Activities

Recent OHS Data Sharing Activities

- **March**: The National Academy for State Health Policy (NASHP) presented a CT hospital financial breakeven analysis to the Healthcare Cabinet.
- **April**: OHS sent selected Advanced Networks their 2018-2019 pre-benchmark trend rates and offered an opportunity to ask questions.
- **April**: OHS met with Hartford HealthCare, Stamford Hospital and Yale New Haven Health System to review:
  - multi-year trends in their system and hospital-level commercial payments
  - multi-year pre-benchmark Advanced Network trend rates (Hartford and Yale only)

Update on the Data Analytics Workgroup

Data Analytics Workgroup

- The Data Analytics Workgroup met for the first time on May 12th and will continue to meet monthly going forward.
- The mission of the Workgroup is to aid the benchmark initiative by **designing and reviewing** standard cost driver reports, cost *growth* driver reports driver reports, and ad hoc analyses using available APCD data, **identifying opportunities to reduce spending growth**, and **offering recommendation for areas of focus** to this Steering Committee.

Data Analytics Workgroup Members and Affiliations

- Alynne Mallory, Anthem
- Dashni Sathasivam, Health Equity Solutions
- Frank Mata, ConnectiCare
- Joe Quaranta, Community Medical Group
- Josh Wojcik (Chair), Office of the State Comptroller
- Mary Lyon, Connecticut Hospital Association
- Michaela Dinan, Yale School of Public Health
- Olga Armah, Office of Health Strategy
- Susan Smith, Department of Social Services

Risk-Adjustment and Truncation Point Decisions

Risk-Adjustment of Cost Growth Benchmark Performance Data

- After receiving input from this Steering Committee, OHS has decided to adopt **age-sex risk adjustment** of payer and provider-level cost growth benchmark performance data.
- OHS will model normalization of clinical risk scores using the APCD to evaluate the feasibility of implementing this methodology in the future.

Truncation of High-Cost Outliers

- After consulting with payers and reviewing truncation points adopted in other states, OHS has decided on the following truncation thresholds to mitigate the impact of high-cost outliers at the payer and Advanced Network levels:
  - Commercial: $150,000
  - Medicaid: $250,000
  - Medicare Advantage: $150,000

Commercial Pharmacy Spending Analyses

Analysis Purpose

- To assess pharmacy spending in CT
  1. Per member per month (PMPM)
  2. As it relates to other service categories
  3. Retail and Medical Pharmacy

The study population

- CT residents, 2017-2019
- Commercial (fully insured, and State employees and retirees)
  - Self-insured not otherwise included
- Exclusions
  - Non-CT residents
  - Secondary payers
  - Denied, reversed, and non-primary claim lines
  - Claim lines with negative payment or cost-sharing
  - Payments after six months of the service year

Pharmacy Costs

"Retail Pharmacy" costs or spend

- Prescription medicines purchased in retail pharmacies or via mail order

"Medical Pharmacy" costs or spend

- Prescriptions administered in providers' offices and hospitals

PMPM Spending

In 2019, 28% of commercial spending was on Pharmacy Services (Retail and Medical)

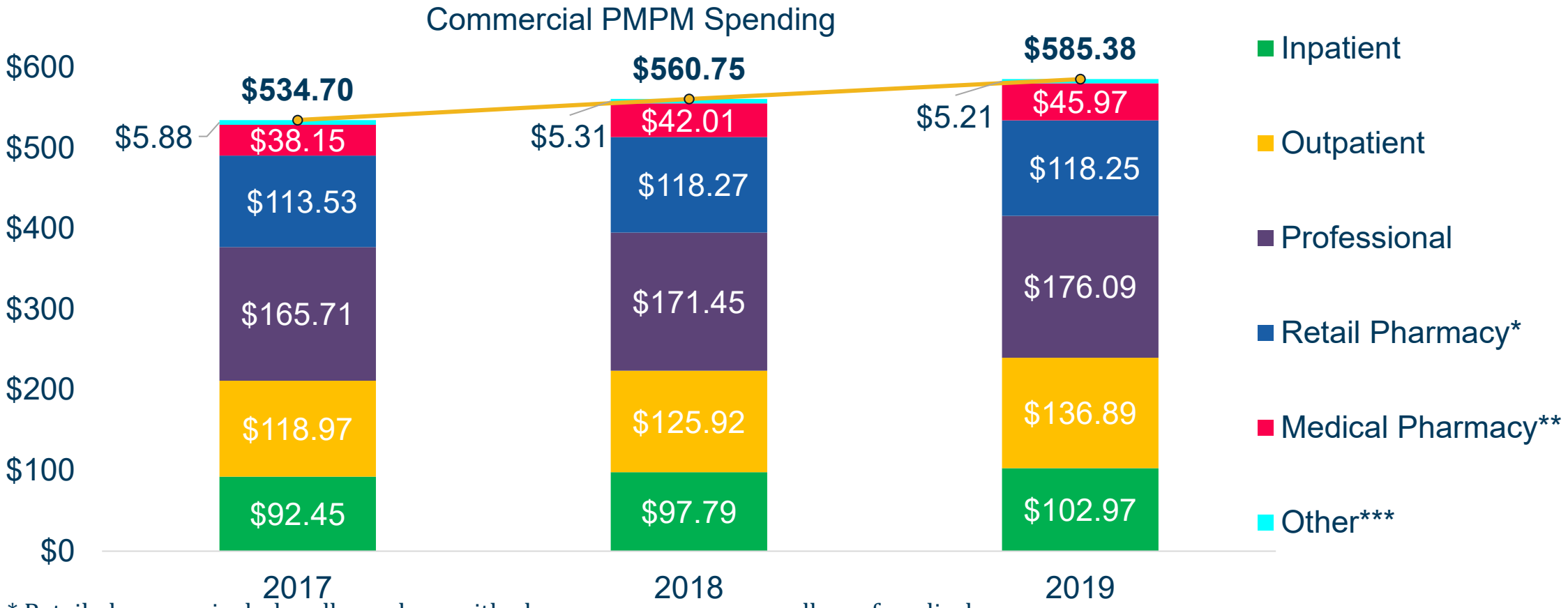
- **Pharmacy spending was greater than inpatient or outpatient spending, second only to professional.**

Service Category	Percentage of Spending		
	2017	2018	2019
Inpatient	17.3%	17.4%	17.6%
Outpatient	22.3%	22.5%	23.4%
Professional	31.0%	30.6%	30.1%
Pharmacy	28.4%	28.6%	28.0%
*Retail**	*21.2%*	*21.1%*	*20.2%*
*Medical***	*7.1%*	*7.5%*	*7.9%*
Other***	1.1%	0.9%	0.9%

* Retail pharmacy includes all members with pharmacy coverage, regardless of medical coverage.
**Medical pharmacy amounts are subtracted from respective medical service categories
***"Other" services include DME, home health, hospice, ICF and SNF claims.

Professional, outpatient and pharmacy services were the top three contributors to commercial PMPM spending growth

- **Spending for medical pharmacy increased the most (+20.5%), followed by outpatient spending (15.0%) and inpatient spending (+11.4%)**



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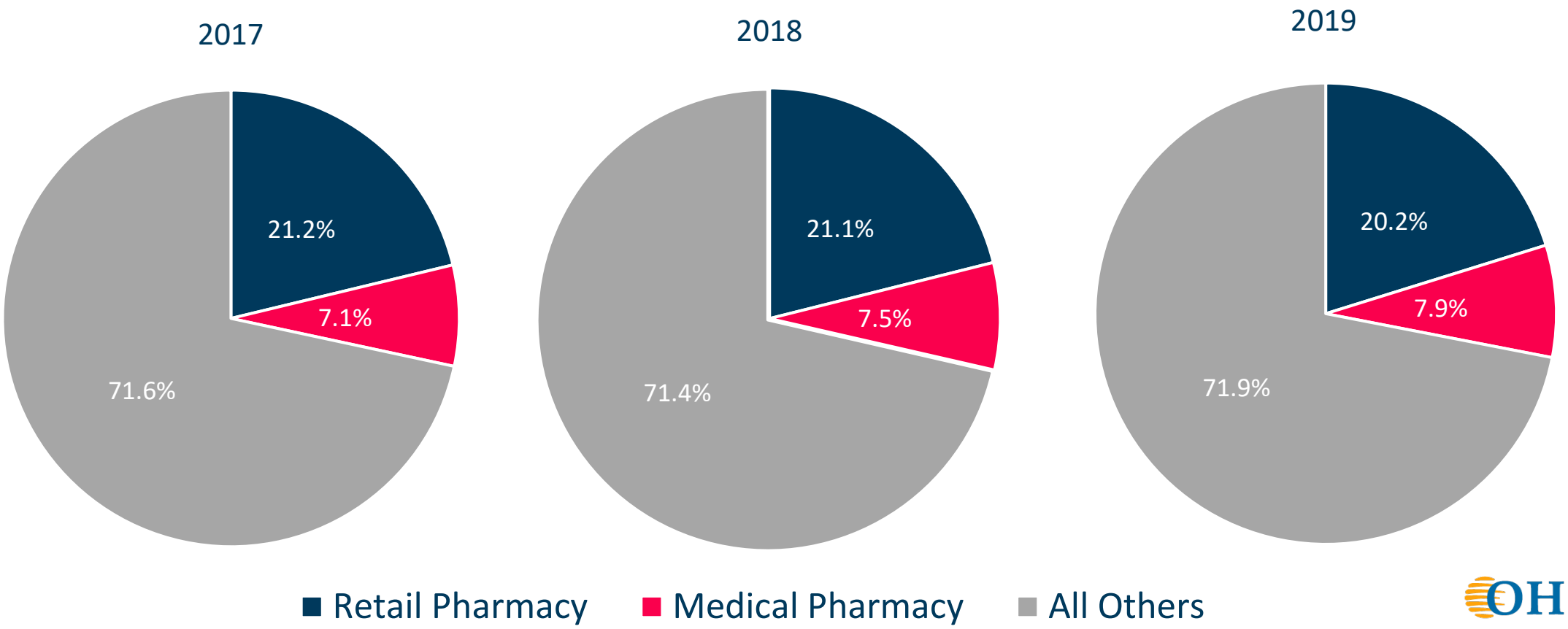
Retail and Medical Pharmacy share of commercial PMPM spending was consistent over time, because hospital spending growth was so high



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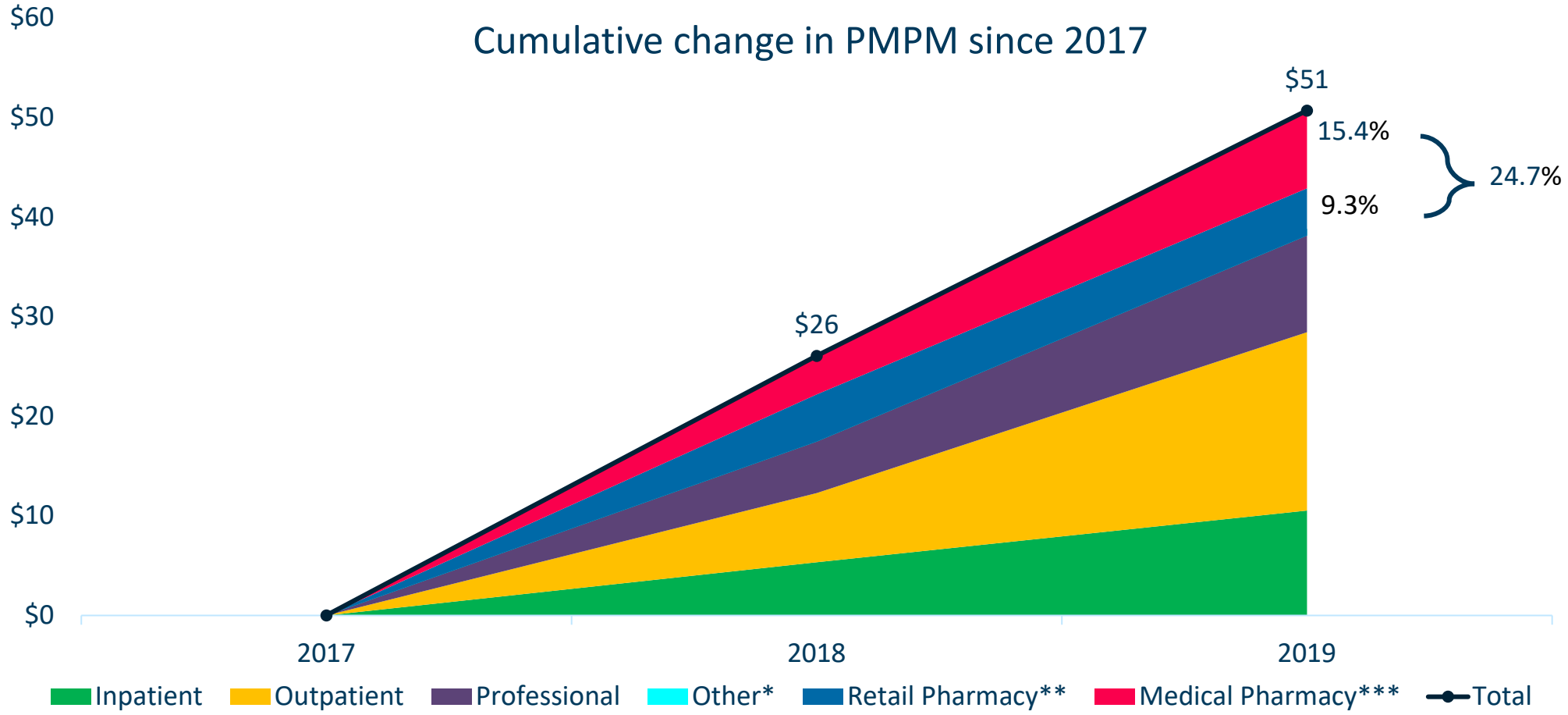
About one-quarter of cost increases between 2017 and 2019 were due to Retail and Medical Pharmacy



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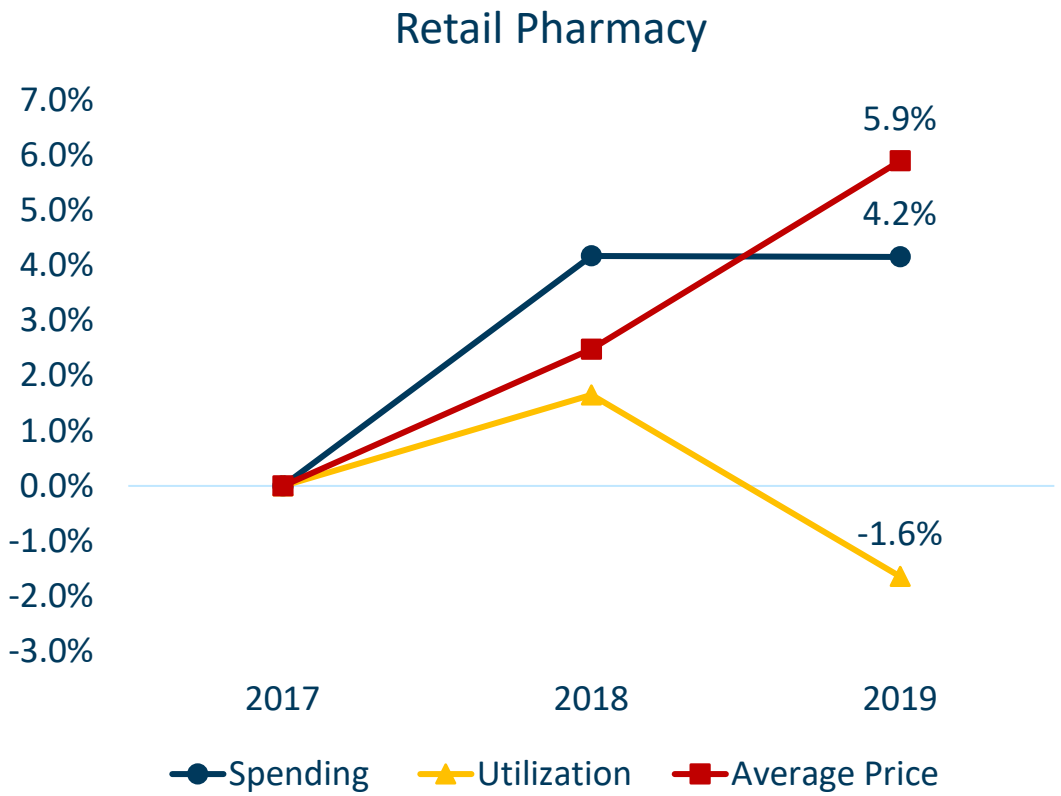
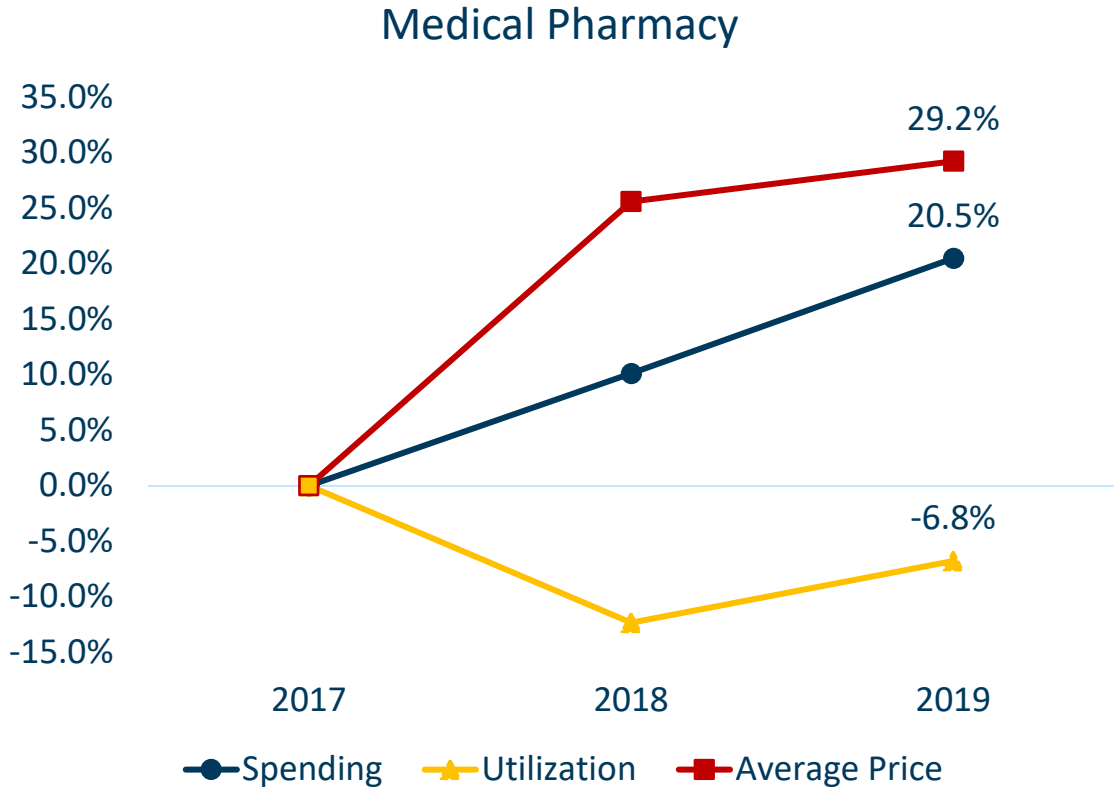
Utilization vs Price

Price increased for both Retail and Medical Pharmacy while utilization declined

- **Average price and spending increased at a far higher rate for Medical Pharmacy than for Retail Pharmacy.**
- **Utilization fell more sharply for Medical Pharmacy than Retail Pharmacy.**





Spending = PMPM; Average price = Spending per prescription; Utilization = prescriptions per member month

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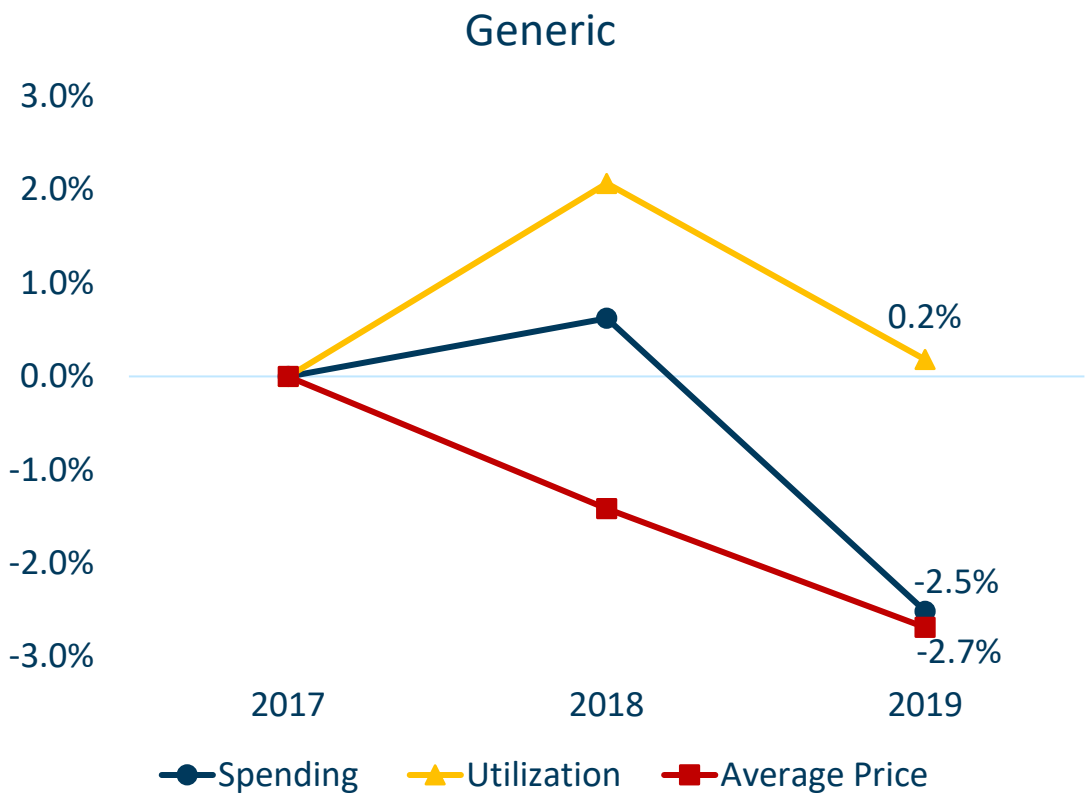
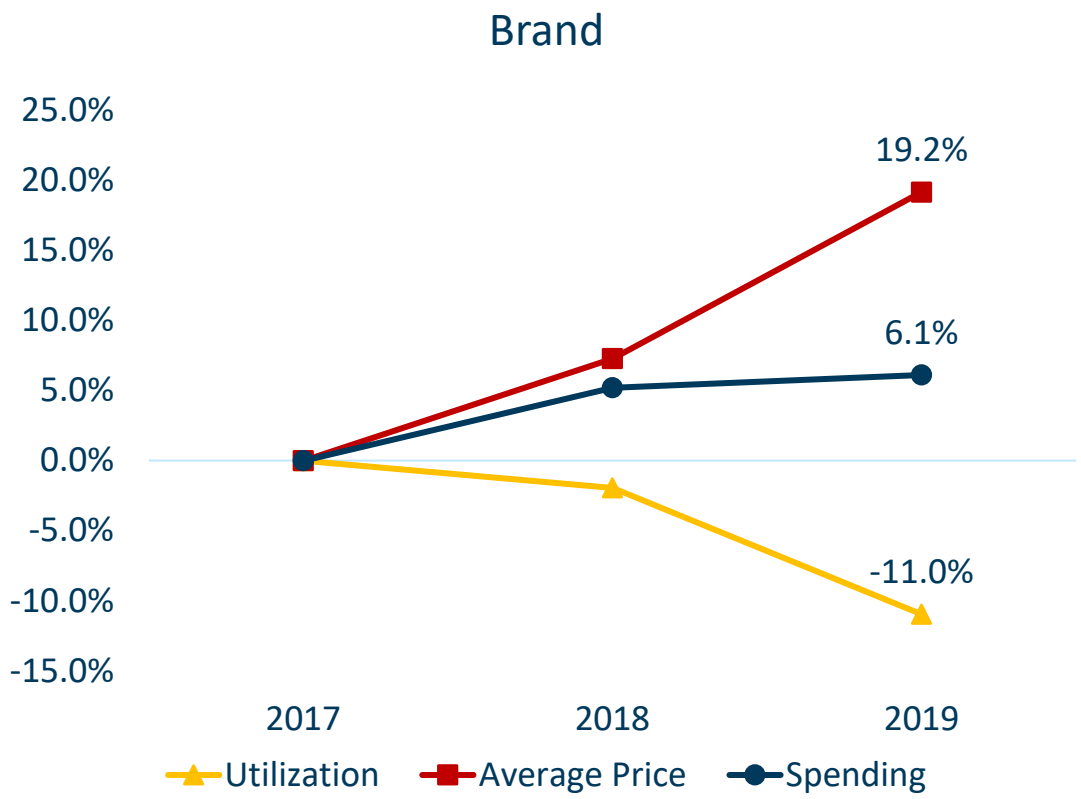
Utilization of generic retail drugs remained flat while price and spending fell, while the opposite trend occurred with brand-name retail drugs

- **Despite this downward trend in utilization, spending and price trended upward for brand drugs.**





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Pharmacy Costs: Deeper Dive

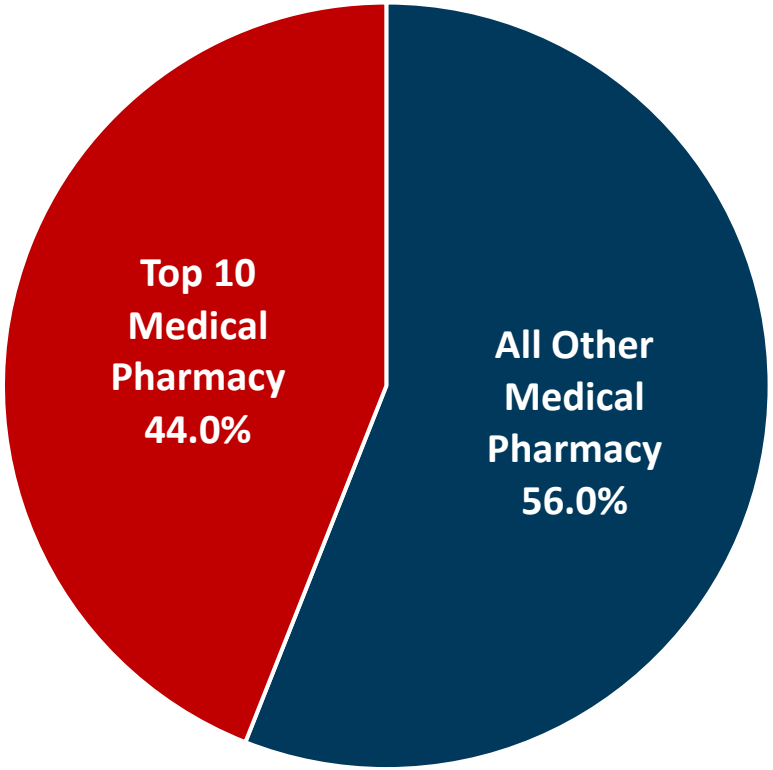
The top 10 medications for medical pharmacy spending in 2019 were drugs primarily used to treat cancer, Crohn's disease, and multiple sclerosis

Medical Pharmacy Spend: Top 10 Medications (Total Allowed), 2019

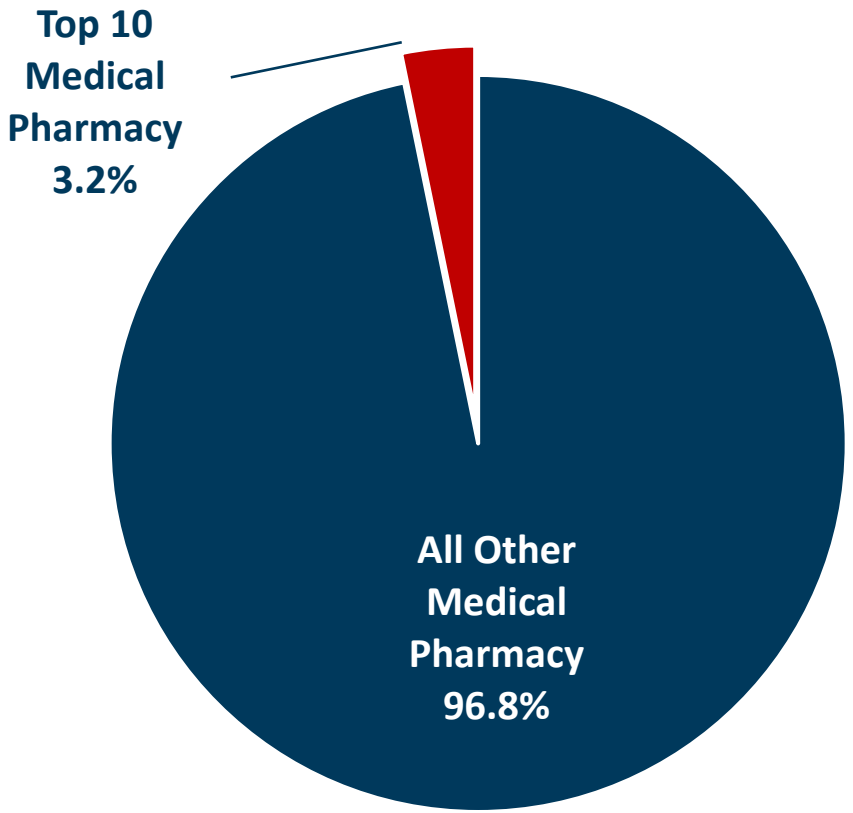
Medication	Indication	Allowed Amount	Distinct Users	# of Claims	Price (Allowed / # Claims)
INJECTION OCRELIZUMAB 1 MG	Multiple Sclerosis	$37,866,205	690	774	$48,922.75
INJ INFLIXIMAB EXCL BIOSIMILR 10 MG	Rheumatoid Arthritis, Psoriasis, Crohn's disease, Ulcerative colitis	$35,080,751	5,944	7,607	$4,611.64
INJ TRASTUZUMAB EXCLD BIOSIM 10 MG	Cancer (breast, stomach)	$21,272,959	1,563	3,613	$5,887.89
INJECTION PEMBROLIZUMAB 1 MG	Cancer (melanoma, lung, bladder)	$18,750,009	808	1,095	$17,123.30
INJECTION RITUXIMAB 10 MG	Cancer, autoimmune disease	$18,642,495	929	1,573	$11,851.55
INJECTION PEGFILGRASTIM 6 MG	Cancer treatment side effect	$17,266,445	1,449	2,017	$8,560.46
INJECTION VEDOLIZUMAB 1 MG	Crohn's disease, Ulcerative colitis	$16,938,383	2,199	2,375	$7,131.95
INJECTION BEVACIZUMAB 10 MG	Cancer (colon, lung, brain, cervical, renal, ovarian)	$13,335,447	1,937	3,200	$4,167.33
INJECTION PERTUZUMAB 1 MG	Cancer (breast)	$12,441,323	849	1,184	$10,507.87
INJECTION NATALIZUMAB 1 MG	Multiple Sclerosis, Crohn's disease	$10,820,739	1,313	1,477	$7,326.16

The top 10 Medical Pharmacy medications comprised 3% of all prescriptions and 44% of all spending

Spending on Medical Pharmacy



Volume of Medical Pharmacy



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The top 10 medications for Retail Pharmacy spending in 2019 were drugs primarily used to treat arthritis, multiple sclerosis, and psoriasis

Retail Pharmacy Spend: Top 10 Medications (Total Allowed), 2019

Medication	Indication	Allowed Amount	Distinct Users	# of Claims	Price (Allowed / # Claims)
HUMIRA PEN 0.4 ML	Rheumatoid arthritis, Crohn's disease, psoriasis	$56,924,279	7,803	8,970	$6,346.07
HUMIRA PEN 0.8 ML	Rheumatoid arthritis, Crohn's disease, psoriasis	$54,638,434	7,168	8,221	$6,646.20
STELARA 90 MG/ML SYRINGE	Psoriasis, Crohn's disease	$38,336,167	1,772	1,920	$19,966.75
ENBREL SURECLICK	Rheumatoid arthritis, psoriasis	$26,077,264	4,177	4,696	$5,553.08
TECFIDERA	Multiple sclerosis	$22,419,921	2,455	2,878	$7,790.10
OTEZLA	Psoriatic arthritis and plaque psoriasis	$17,735,746	4,475	5,062	$3,503.70
GILENYA	Multiple sclerosis	$17,370,060	1,773	1,968	$8,826.25
ELIQUIS 5 MG TABLET	Deep vein thrombosis, pulmonary embolism	$15,365,839	24,950	26,636	$576.88
VICTOZA	Diabetes	$15,144,633	10,792	11,606	$1,304.90
DUPIXENT 300 MG/2 ML SYRINGE	Asthma	$15,020,931	3,961	4,768	$3,150.36

The top 10 Retail Pharmacy prescriptions comprised <1% of all prescriptions and 15% of all spending

Spending on Retail Pharmacy

Volume of Retail Pharmacy

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Key Takeaways

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

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

Commercial Pharmacy Cost Trends

- What reflections do Steering Committee members wish to offer on the pharmacy spending analyses?
- Are there areas you recommend for further inquiry?

Wrap-Up and Next Steps

Wrap-Up and Next Steps

- The next meeting will be held on Monday, June 27th from 3–5:00 p.m.