CONNECTICUT Health Strategy

Healthcare Benchmark Initiative Technical Team Meeting Minutes

Meeting Date	Meeting Time	Location
November 26, 2024	2:00 pm – 4:00 pm	Microsoft Teams Meeting: TEAMS +1 860-840-2075, 224 170 659 768 Passcode: BiTmjN

Technical Team Member Name	Attendance	Technical Team Member Name	Attendance
Loren Adler	A	Paul Grady	A
Don Berwick	A	Jason Hockenberry	NA
Sabrina Corlette	A	Chris Manzi	A
Francois de Brantes	A	Roslyn Murray	A
Stefan Gildemeister	A	Joshua Wojcik	A
OHS and Contractors	**Attendance**	**OHS and Contractors**	**Attendance**
Deidre Gifford, OHS	A	Patty Blodgett, OHS	A
Alex Reger, OHS	A	Michael Bailit, Bailit Health	A
Lisa Sementilli, OHS	A	Erin Taylor, Bailit Health	A
A = Attended; NA = Did not attend			

Agenda

	Topic	Responsible Party	Time
1.	**Welcome**	**Deidre Gifford**	**2:00 pm**
	Deidre Gifford welcomed everyone to the second meeting of the Healthcare Benchmark Initiative (HCBI) Technical Team. Deidre reminded meeting attendees that the meeting would be recorded. Deidre also requested that Technical Team members submit their conflict-of-interest statements if they had not already done so. Alex Reger performed a roll call. Michael Bailit reviewed the meeting agenda and meeting plan.		
2.	**Meeting 1 Recap**	**Michael Bailit**	**2:05 pm**
	Michael Bailit provided a recap of the Technical Team's first meeting, including the identified action items and suggested additional comparative data one Technical Team member requested. Michael presented the average cost growth rate from 2019-2022 by state (Connecticut, Delaware, Massachusetts, Oregon, and Rhode Island) alongside the 2022 PMPY spending statewide and by market. The data were from states' cost growth benchmark programs. • Michael made the following points about the data: 1. Massachusetts reports statewide spending through the Health Policy Commission (HPC) and market-level spending through the Center for Health Information and Analysis (CHIA); 2. Medicaid spending includes long-term care spending, which is a large component across all states, and 3. data are self-reported through states' benchmark programs and in select cases, there are some commercial insurers that do not report all self-insured data and in rare cases, do not report Medicare Advantage. All five states use comparable specifications for their data requests. • For comparative statewide THCE, Michael noted that there is a lot of subtlety that gets lost when looking at statewide growth because of variation in commercial, Medicare, and Medicaid growth rates. • Francois de Brantes observed the variation in spending across states within each market and said it represents meaningful and significant differences.		
3.	**Healthcare Cost Growth Benchmark**	**Michael Bailit**	**2:15 pm**
	Michael Bailit reviewed the current total healthcare expenditure (THCE) measurement methodology in Connecticut and summarized the process states, including Connecticut, have implemented to request and validate data that insurers submit. In addition, Michael indicated that Connecticut and other states share a summary of what was reported by payers with payers and with provider entities whose spending is measured.		

Michael reviewed spending that is and is not included in the measurement of THCE, noting that patient out-of-pocket spending on non-covered services, spending by people who are not insured, and uncompensated care are not included. Michael also reviewed the population whose expenditures are measured and how OHS measures total medical expenses (TME).

- Deidre Gifford said a common question about the state's benchmark program is whether OHS is measuring at the hospital or hospital system level. She explained that OHS is measuring TME at the provider entity level using primary care attribution; there is no measurement or attribution specific to hospitals. Deidre said if a hospital operates a large physician group, it will have spending attributed to the group.

<u>Decision-making criteria for the indicator(s) on which the benchmark will be based</u>

Next, Michael began discussion of the methodology for setting the 2026-2030 healthcare cost growth benchmarks. He reviewed the decision-making criteria used to inform decisions about the indicator(s) on which the 2021-2025 benchmark was based. Michael asked Technical Team members if the criteria used previously resonated for them.

- Joshua (Josh) Wojcik suggested a change to the third criterion that focused on "sustainability" of healthcare cost growth in the state so that it spoke instead to an "ability to pay."
- Francois de Brantes asked if the methodology must be based on economic indicators.
    - Michael Bailit clarified that it is not a requirement to tie the methodology to an economic indicator.
- Francois de Brantes raised a point about two components to spending: utilization and price. Francois said the work OHS has done to date has shown that prices have been more of a factor contributing to cost growth than utilization. Francois asked if benchmark might be split between one that is for utilization of services and one for price growth. Francois said doing so would enable OHS to distinguish Medicare, Medicaid, and the commercial markets given the influence and impact of utilization and price.
    - Michael Bailit indicated that the statute requires the benchmark to be for total spending and separate utilization and price benchmarks would need to be *in addition* to the total spending benchmark.
- Roslyn (Roz) Murray Technical Team asked if there could be separate benchmarks by market segment.
    - Michael Bailit said this was possible.
- Don Berwick asked what the comparison point was for criterion 3 ("compared to what?") and asked whether the benchmark result should be predictive or prescriptive.
    - Michael Bailit said the benchmark was intended to be prescriptive.
- Don Berwick asked how tough the methodology should be to serve the interests of the public.
    - Michael Bailit said that five years earlier, the benchmark value was assessed relative to historical spending growth in the state; there was no explicit percentage discount off of historical spending that the prior Technical Team selected. Michael said the prior Technical Team picked a value that was below historical spending and matched the economic indicators that were selected. Michael also noted that states generally have picked benchmarks that run about 30% below historical spending. He notes that OHS had not adopted a decision rule for how much lower would be considered "sustainable."
    - Josh Wojcik said sustainability should be defined relative to ability to pay and payers of healthcare include residents, employers and the government. The ability of these entities to incur additional healthcare costs should be directly considered by leveraging measures that relate to their increased ability to pay (e.g., individual income growth, GSP growth, etc.).
- Loren Adler asked whether OHS could adopt an additional benchmark for commercial spend and / or prices and whether either would be entirely separate.
    - Michael Bailit said that because spending growth in Medicare and Medicaid has been low, the Connecticut cost growth benchmark, so far, only has had practical application for the commercial market where spending growth for most years has been higher.
    - Deidre Gifford indicated that OHS would consider the question in the context of the statute and reminded the Technical Team that at the moment, the state's healthcare benchmark initiative is about reporting and transparency. Deidre said OHS is empowered to call entities

that contribute significantly to spending growth to a public hearing but does not have authority to impose a performance improvement plan (PIP) or a penalty. Deidre added that the broad reporting authority permits OHS to report additional information as part of the program.

- Stefan Gildemeister asked if OHS discussed previously that not all spending is equal and how investments in outcomes and health – however difficult to measure – are built into the model. Stefan said this could be where the primary care target comes in and asked if there has been previous discussion on the question.
    - Michael Bailit said the statute implicitly directs slowed spending growth for non-primary care services because of the primary care spending target. Michael also stated that the statute has quality benchmarks, which call for improving quality performance on a limited number of measures. He concluded by saying that outside of primary care and improved performance on selected quality measures, there has not been additional conversation about increasing spending for certain populations or services.
    - Stefan responded that the balance between the primary care target and focus on quality measurement and public reporting could be sufficient.
- Paul Grady described a story of an employer working with an efficient medical plan and assuming a 7% increase in medical costs for next year, which the employer must absorb and / or pass along to employees. Paul suggested that the Technical Team consider applying pressure to be more efficient, noting that the healthcare system may not feel the kind of pressure to be so efficient.
    - Michael Bailit said the intent when the benchmark was first created was to put pressure on payers and provider organizations to become more efficient, but this has not yet been achieved.
    - Paul stated that the vision from the beginning was to see collaboration among stakeholders to act to slow spending and noted that this has not happened in Connecticut. Paul added that the state is not seeing adoption of value-based payment models or other strategies – just more spending and offered a proposal that the system could be 5-10% more efficient and that this get incorporated into the benchmark value.
    - Don Berwick said that organizations do not take cost management as part of their core mission and tension is needed to lower costs.
    - Deidre Gifford stated that the eventual utility of the benchmark in driving down healthcare spending relates to the validity of the process OHS undertakes to develop the benchmark value. Deidre said a solid foundation is necessary for policymakers to embark on some kind of potential enforcement mechanism. Deidre added that any enforceability must tie back to the criterion and the metrics to include in calculation of benchmark.
- Francois de Brantes said the growth rate in price in Medicaid and Medicare are fixed to a certain extent, and by the Veterans Administration (VA). Francois said if we can show that the majority of growth has been driven by price increases in the commercial market, then the benchmark should be focused on that for the next five years. Francois said to make the benchmark actionable, transparent, and defensible, a level of granularity about what is causing the growth is needed.
    - Loren Adler agreed and added that granularity would be useful for transparency purposes, particularly given how many factors are outside of a system's control, such as aging of the population, broader health risks of the population, etc.
    - Don Berwick added that stringent TME growth targets with traction would force providers to focus on prices if they are to be successful.
- Michael summarized the discussion so far, as follows:
    - Some Technical Team members expressed belief that the State needs to apply force with the benchmark in order for the system to become more efficient and for spending growth to slow.
    - Some Technical Team members urged the benchmark focus on price growth. Michael said the Technical Team should discuss whether the focus on price should be through the 2026-2030 benchmark or some other OHS action. He said that OHS would look at the statute for any additional guidance or limitations.

State methodologies

Michael reviewed the methodologies other states have adopted to set their benchmarks.

- Loren Adler asked if the group should consider something based on inflation given how high baseline costs are and in response to suggestions of sustainability and setting a trend that reduces costs, and encourages cost efficiencies over time. Loren offered as examples median wage plus / minus inflation, inflation with an adjustment, or some variation of how the Affordable Care Act (ACA) targets work.
    - Michael Bailit indicated that one option was to pick an indicator and then "discount" the value, which may get to the same place as an inflation measure.
    - Loren added that inflation is part of household income.
    - Deidre Gifford asked Loren for clarification about the inflation comments, specifically: 1) whether the benchmark should be modified based on the impact of inflation on sustainability and affordability (that is, wage growth might be x but because of the impact of inflation, real wage increase is less.) or 2) whether the benchmark value should be higher because when there is high inflation, provider costs are higher. Deidre said the latter is how OHS has viewed inflation for the annual adjustment. Deidre explained she was asking if the recommendation was to look at inflation from a consumer perspective or provider perspective.
    - Loren suggested that OHS consider a little of both. Loren said he expects inflation to grow more slowly in the future compared to the last five years. Loren said it seemed fair to account for growth in input costs, but added there should also be accountability for the fact that prices may go up faster than what he views as justifiable.
    - Sabrina Corlette referenced Rhode Island's rate review affordability standard, noting that annual hospital rate increases are capped at CPI-U (less food & energy) +1%. https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-09/OHIC%20Bulletin%202024-3%20%20Final.pdf
    - Michael Bailit said that when OHS has modeled inflation in the past, it has grown slower over the long term than any of the other indicators that are part of today's discussion.
    - Don Berwick said if OHS is looking at this from the perspective of a family and individual consumer, the question might be: "Would they feel as though the benchmark is responsive to their own economic pressures?" Would families, patients, governments say that a 3% growth rate target, for example, is sustainable or not?
    - Francois de Brantes responded that the overall growth rate masks the impact to consumers because someone with commercial insurance is seeing a much higher growth rate that an individual would likely deem unsustainable.
    - Don Berwick added that consumers may not be feeling a 3% increase if their out-of-pocket costs are growing. Loren Adler said that cost-sharing has remained pretty consistent as a share of total premiums/costs over the last couple of decades.
    - Deidre Gifford stated that one of the most frequent questions OHS gets from legislators is how will the benchmark translate into out-of-pocket spending? Deidre said legislators are looking for assurances that the benchmark initiative, which is meant to lower cost growth, will translate into a pocketbook benefit for Connecticut residents. Deidre said the link is not always as strong as OHS would like it to be.

Indicator options for Connecticut's benchmarks

Michael Bailit indicated that there are four economic indicators he would be sharing next as possible options to inform the value of the 2026-2030 cost growth benchmarks. He invited Technical Team members to suggest other indicators, acknowledging the Technical Team's earlier discussion about inflation. For each indicator, Michael described what the indicator measures and represents and what the message would be if the benchmark value were tied to the indicator.

Indicator #1: Gross State Product (GSP)

- Francois de Brantes said that there is an inherent problem with GSP because it includes healthcare, which is an inflator.

Indicator #2: Potential GSP (PGSP)

- Michael Bailit said PGSP is a long-run projection (five years and beyond) and it removes the swings of historical trends. He noted that actual growth will never be smooth.
- Josh Wojcik asked if there was a sense for how accurate the projections have been relative to actual performance over time.
    - Michael Bailit said the measure uses publicly available forecasts and noted that the forecasts reflect long-term historical experience. Michael said the values produced in a forecast don't look all that different than a long-term historical perspective but they smooth out the volatility. Michael said states have used PGSP in part or in whole in their benchmark programs.
- Don Berwick said the "stable and therefore predictable" criterion needs a second look and offered an alternative, which is a benchmark that is more sensitive and responsive to shorter term economic downturns, etc. Don said long-term historical experience has less salience at the kitchen table.
    - Michael Bailit said that most states use stable and predictable so insurers and payers know what it is and can build it into their contracts and negotiated rates. Michael added that Connecticut and Rhode Island adjusted their benchmarks in recent years for inflation. Other states kept values constant, acknowledging that when the economy falls and inflation goes up, there is greater pressure on consumers. Michael said that Massachusetts and Delaware revisit benchmarks annually. Massachusetts has kept values fairly constant while Delaware has not made any changes.
- Francois de Brantes said the same issue of healthcare being included in the indicator applies to PGSP.
- Loren Adler suggested that the group reconsider inflation – CPI-type of inflation, not medical inflation – in the benchmark given the conversation and focus on predictability. Loren said states could be double counting inflation, adding that it's baked into median household income.

Indicator 3: Median household income

- Francois de Brantes suggested removing the top 5% and then looking at median household income.
- Josh Wojcik returned to the conversation about market-specific benchmarks. Josh said that commercial market spending exceeds the benchmark and a statewide benchmark may not be enough for payers to use as a negotiating tactic if total spending meets or is close to the benchmark.
- Don Berwick emphasized the importance of capturing the out-of-pocket experience of Connecticut residents, perhaps as a separate section of an annual report.

Indicator 4: Average Wage

- Sabrina Corlette asked others if wage growth would be a better measure of people's ability to afford growth in healthcare costs for working families and families with lower incomes. Sabrina mentioned the equity component of the benchmark -setting exercise, adding that wage growth may better reflect the costs for working families as compared to household income growth.
- Francois de Brantes said there is a lot of distortion in Connecticut in median household income and agreed that average wage may better represent what it means for the average worker.
- Josh Wojcik said average wage may not account for retiree income, Social Security or pensions.
- Don Berwick said wage growth should correlate well with costs of production.
- Loren Adler said wage growth is influenced by healthcare spending, noting the tradeoff employers make between premium increases and wage growth with employer-sponsored insurance.

<u>Additional Considerations</u>

Michael Bailit said that some Connecticut hospitals have asserted that the future cost growth benchmark value(s) should factor in the costs of delivering care. Michael asked if provider costs should be a determination when setting the benchmark.

- Many members of the Technical Team replied "no." Don Berwick said a goal of the benchmark is to charge providers with reducing their costs.

<u>Other indicators</u>

Michael Bailit asked if Technical Team members had suggestions for other indicators to which to tie the benchmark, in addition to inflation, which members had discussed earlier in the meeting.

	• Francois de Brantes said there are many benchmarks in healthcare from which to choose, including average medical spend in the United States. Francois said that could be a benchmark, with some adjustments, much like the Centers for Medicare and Medicaid Services (CMS) does for regional price and other factors. Francois expressed concern that Connecticut commercial market spending is already high, and the benchmark for the next five years needs to respond accordingly. Francois also suggested using Medicare spending as a benchmark. ○ Deidre Gifford said this might lead to a negative benchmark value, or zero growth, for a couple of years. ○ Francois said the discussion goes back to the differences between commercial, Medicare, and Medicaid. ○ Roz Murray asked if the group could set separate benchmarks for different market segments, potentially using different indicators, such as average wage for the commercial market given wage stagnation resulting from high healthcare costs. ○ Michael Bailit observed that separate values and indicators would increase complexity for messaging about the program. • Loren Adler suggested picking a target percentage for per member per month spending as a share of median household income, and then create a growth rate to get there within a defined period. • Sabrina Corlette asked if the Technical Team should treat as a constraint keeping the benchmark value for the next five-year period within .5% of the 3.3% benchmark average across 2021-2025. ○ Alex Reger said if the new benchmark value goes to the legislature and is not approved, the benchmark reverts to the average. ○ Deidre Gifford asked the group to continue to explore different avenues and not feel constrained. • Loren Adler presented an option of median household income minus half a percent (or inflation plus a percent) to get to the efficiency gains discussed earlier in the meeting. Loren said that may bring the benchmark close to where it currently is. ○ Deidre Gifford said the approach might resonate with colleagues in the legislature because it is understandable. Deidre said one of the challenges has been that some of the indictors are not familiar to many people, for example, PGSP. Deidre said CPI is a bit more familiar. Deidre added that weighting different indicators introduces another level of complexity that makes it hard for people to understand. Deidre said a percentage of income as a target merits further discussion. ○ Don Berwick suggested comparing an "aggressive" (i.e., negative or zero growth value) approach with the percentage of income, and discussing the pros and cons, with a focus on "the kitchen table."		
4.	**Public Comment**	**Members of the Public**	**3:50 pm**
	Deidre Gifford offered the opportunity for public comment. There were no comments.		
5.	**Wrap-up and Next Steps**	**Deidre Gifford**	**3:55 pm**
	Deidre Gifford thanked the members of the Technical Team and said the next meeting is scheduled for Friday, December 13, 2024, from 3:00-5:00 pm EST		
6.	**Adjourn**	**All**	**4:00 pm**

All meeting information and materials are published on the OHS website located at:
https://portal.ct.gov/ohs/programs-and-initiatives/healthcare-benchmark-initiative/hcbi-technical-team?language=en_US