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Healthcare Cost Growth Benchmark
Technical Team Meeting #3
December 13, 2024

I. Welcome

Meeting Agenda

Time	Topic
3:00 p.m.	I. Welcome
3:05 p.m.	II. Meeting #2 Recap
3:10-4:50 p.m.	III. Healthcare Cost Growth Benchmark *(continued discussion)* A. Benchmark indicator values and modeling B. Setting the 2026-2030 cost growth benchmark C. Reporting performance i. Risk adjustment ii. Truncation iii. Confidence Intervals
4:50 pm	IV. Public Comment
4:55 p.m.	V. Wrap-Up and Next Steps
5:00 p.m.	VI. Adjournment

Scheduling Request

- In order not rush our process and to provide ample time for exploration of policy options, OHS would like to add two additional meetings of this Technical Team.
- Are members willing to make this time commitment?

II. Meeting #2 Recap

Technical Team Meeting #2 Recap

- During the second meeting of the Technical Team, we reviewed the current healthcare cost growth benchmark measurement methodology.
- We also began discussion of methodology to set the 2026-2030 benchmarks, including:
  - **criteria** to guide selection of an indicator(s) to which the cost growth benchmark would be tied
  - cost growth benchmark **methodologies and values in other states**
  - **economic indicator options** to inform the 2026-2030 healthcare cost growth benchmark values

Meeting #2 Recap: Discussion Topics

Technical Team members provided feedback on the following during the second meeting:

- Criteria for selecting an economic indicator
- Benchmark construction
- Preferred indicators
- Additional discussion topics

Meeting #2 Recap: Criteria for Selecting an Economic Indicator (1 of 2)

- There were several comments suggesting modification of criterion #3, specifically that it should:
  - promote a *sustainable* growth of healthcare spending
  - specify *to what* the value of the benchmark is compared
  - capture *"ability to pay"*

Criterion #3 as Presented During Meeting #2	Criterion #3 Suggested Revision
"result in a benchmark value that lowers growth in healthcare spending for consumers, employers, and taxpayers"	"produce a benchmark value such that spending growth will not exceed change in resident ability to pay"

Meeting #2 Recap: Criteria for Selecting an Economic Indicator (2 of 2)

- Decision-making criteria for the indicator(s) on which the benchmark will be based
  1. provide a stable and therefore predictable target;
  2. rely on independent, objective sources with transparent calculations; and
  3. produce a benchmark value such that spending growth will not exceed change in resident ability to pay.

Meeting #2 Recap: Benchmark Construction (1 of 2)

Members proposed alternative and/or complementary approaches to the benchmark construction. These would represent a departure from the current methodology

1. **Create separate benchmarks for utilization and price**
   - Pros: Would bring more focus to price, historically the primary cost driver
   - Cons: Not specified in statute, would significantly expand payer reporting requirements, technically complex if holding changes in service mix constant

Meeting #2 Recap: Benchmark Construction (2 of 2)

2. Create market-specific benchmarks

- Pros: Would allow benchmark values to be more aggressive for some markets than others, e.g., allow a higher benchmark for Medicaid
- Cons: Medicaid and Medicare consistently trend below the benchmark, so raising it for that market would have little meaning, especially because the General Assembly is unlikely to respond with higher spending, also adds complexity for public messaging & no clear basis for setting a separate Medicare value

Meeting #2 Recap: Five Indicators of Interest

1. Inflation (two options)
    a) CPI-U *(all items)*
    b) Personal Consumption Expenditures (PCE)
2. Average Wage
3. Median Household Income
4. Growth Rate Necessary for THCE to Equal a Target Percentage of Median Household Income
5. Growth in Medicare Spending

Before we review data associated with these measures, let's discuss their relative merits further.

Meeting #2 Recap: Additional Discussion Topics

- Technical Team members reiterated the importance of **enforcement mechanisms** as a critical tool to meet the benchmark objectives.
- Technical Team members also discussed the value of OHS **reporting change in out-of-pocket spending**, consistent with the goal of promoting affordability for Connecticut residents.

III. Setting the 2026-2030 Healthcare Cost Growth Benchmark

Setting the 2026-2030 Healthcare Cost Growth Benchmark

1. Value of preferred indicator and / or combination of indicators
2. Setting a multi-year benchmark
   - Possible adjustments to the benchmark base value
3. Reporting performance against the healthcare cost growth benchmark, including…
   - Risk adjustment
   - Improving statistical confidence (truncation, confidence intervals)

Before we see the indicator values, let’s ground ourselves in Connecticut’s spending trends

Connecticut's Healthcare Cost Growth Benchmark, 2021-2025 and Performance to Date

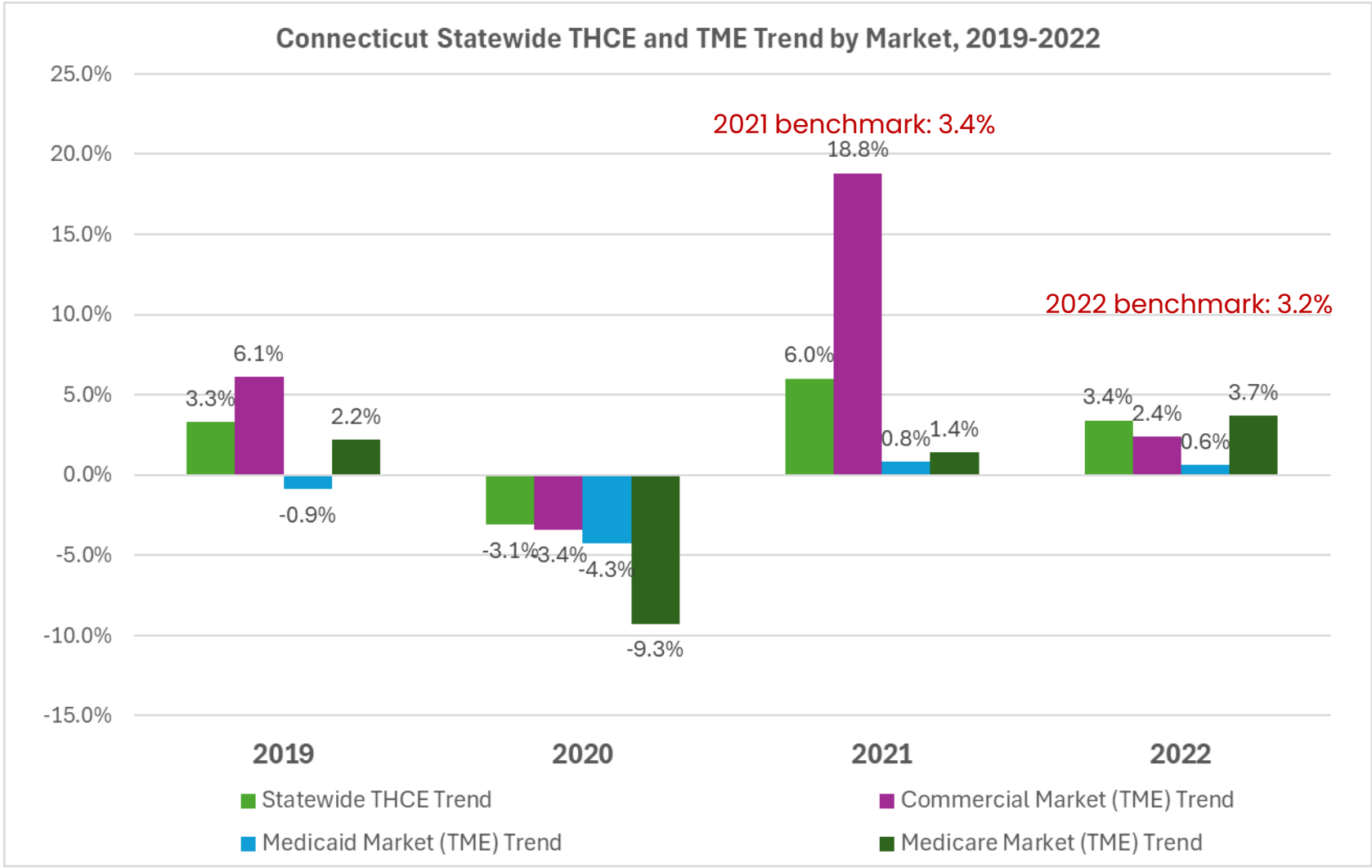
Calendar Year	Benchmark Value	Actual Healthcare Cost Growth
2021	3.4%	6.0%
2022	3.2%	3.4%
2023	2.9%	*n/a*
2024	*4.0%	*n/a*
2025	2.9%	*n/a*

**Modified from 2.9% to account for inflation*

- **Four-year (2019-2022) average growth rate: 2.4%**
  - 2020 was greatly influenced by COVID-19
- OHS is currently analyzing 2023 spending data.

Cost Growth Benchmark Results Statewide and by Market, 2019–2022

- Connecticut collected 2019 and 2020 spending from insurers as a baseline.
- The benchmark became effective in 2021.



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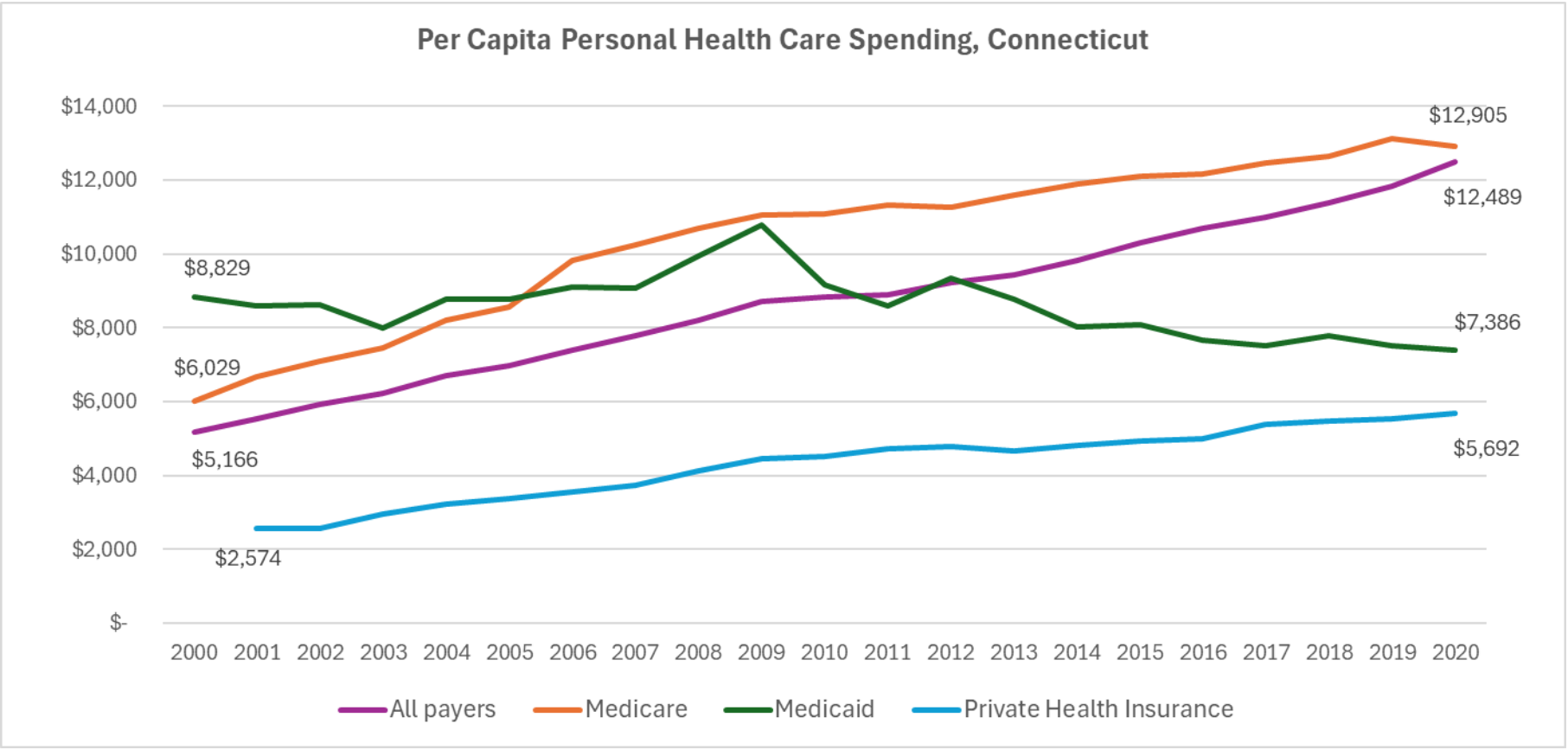
Historical Per Capita Personal Health Care Spending in Connecticut, 2000-2020



Average annual change per capita, 2000-2020:

- All payers: 4.5%
- Medicare: 4.0%
- Medicaid: -0.7%
- Private*: 4.3%

**Data for private insurance spending is available starting in 2001.*

Note: Health care spending refers to personal health care spending, which excludes public health activities, health insurer administrative expenses and profit, government administration, and investment.
Source: *State Health Expenditure Accounts by State of Residence, 1991-2020, Centers for Medicare & Medicaid Services.*

1. Values and Modeling of Preferred Indicator(s)

Economic Indicators: Historical and Forecasted Experience

There are differences in economic indicators calculated using historical actual data vs. forecasts.

Historical Experience	Forecasts
• Historical figures are relatively **easy mathematical calculations** (straight average growth over prior time periods). • Historical data reflects, to varying degrees, the **volatility** of year-over-year changes, including booms and busts, e.g., the effects of the pandemic and its aftermath. • Anomalous events can be addressed through smoothing or by extending the period, but **determining the appropriate time period** is not always obvious; the decision can have substantive impact.	• Forecasted data are designed to be predictable, **stable figures** and are often calculated by government agencies and private firms. • The figures and **methods of calculation va**ry. • Private forecast methodologies are **not available for scrutiny** and can vary by the philosophy and outlook of the chief economists at each organization. • They often prove to be **inaccurate** because economies are volatile over time.

Discussion

Should OHS use historical trends or forecasts?

	Historical	Forecasted
Advantages	• Easy to calculate. • Reflects actual experience.	• Smooths out historical variability and provides more stability and predictability.
Disadvantages	• Highly variable, reflecting economic booms and busts. • Unclear rationale for which time period to choose.	• Forecasts are predictions and may be incorrect. • Forecast methodologies may be opaque.

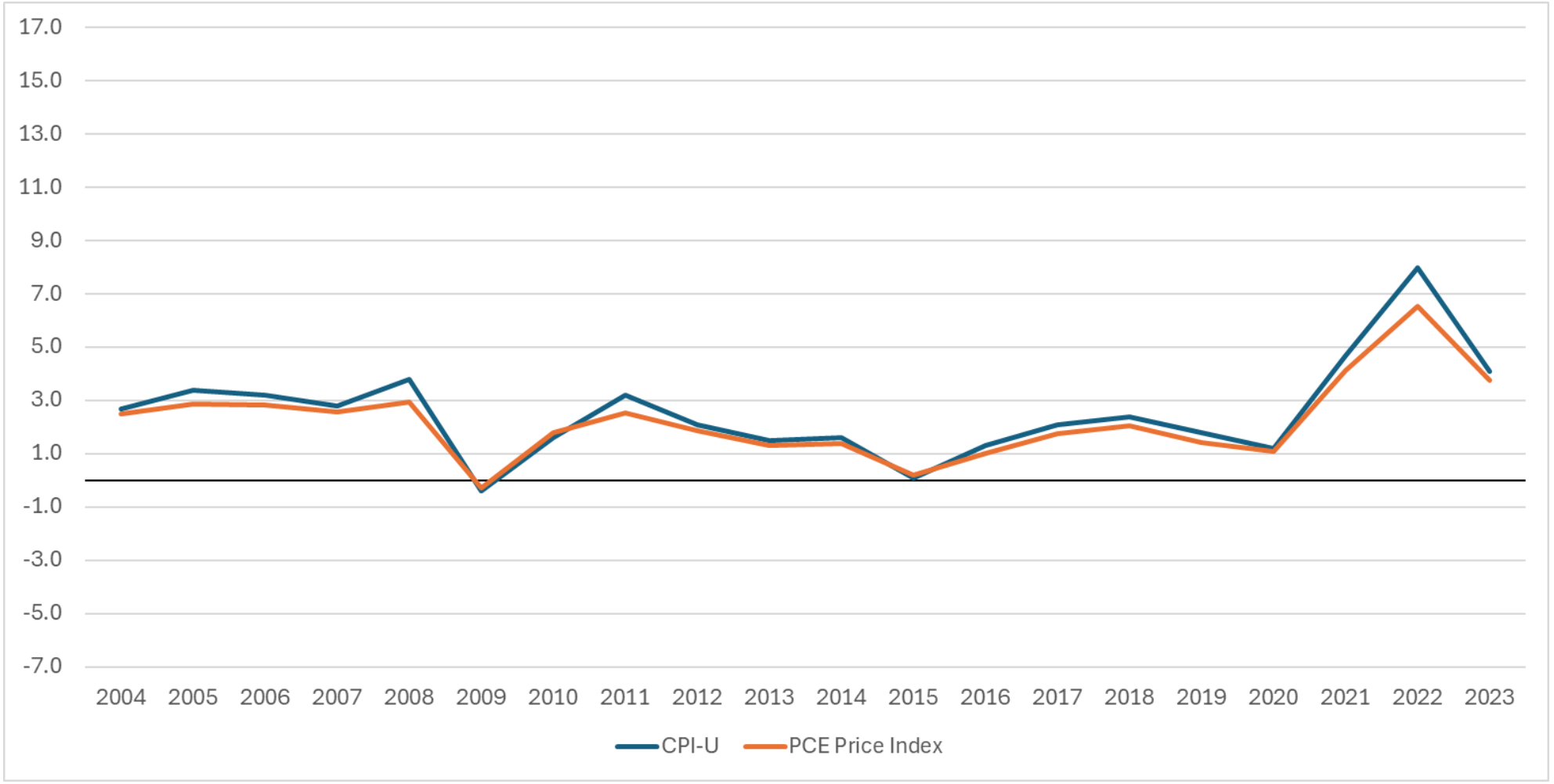
Note: During a previous meeting, one Technical Team member observed that a portion of historical healthcare spending has been wasteful. We can discuss whether an adjustment should be made to the benchmark value to account for waste. No other state has made such an adjustment to date.

Economic Indicators: Average Annual Change

	Average Annual Change (%)		
Indicator	**10-year**	**20-year**	**Forecast**
(1a) CPI-U	2.7% (2013-2023)	2.6% (2003-2023)	2.3% (2024-2034)
(1b) PCE Price Index	2.3% (2013-2023)	2.2% (2003-2023)	2.0% (2024-2034)
(2) Average Annual Wage	3.0% (2013-2023)	2.8% (2003-2023)	3.7% (2023-2034)
(3) Median Household Income	2.8% (2012-2022)	2.3% (2002-2022)	2.7% (2023-2034)
(4) Medicare Spending *(per capita)*	1.6% (2010-2020)	4.0% (2000-2020)	5.3%* (2023-2032)

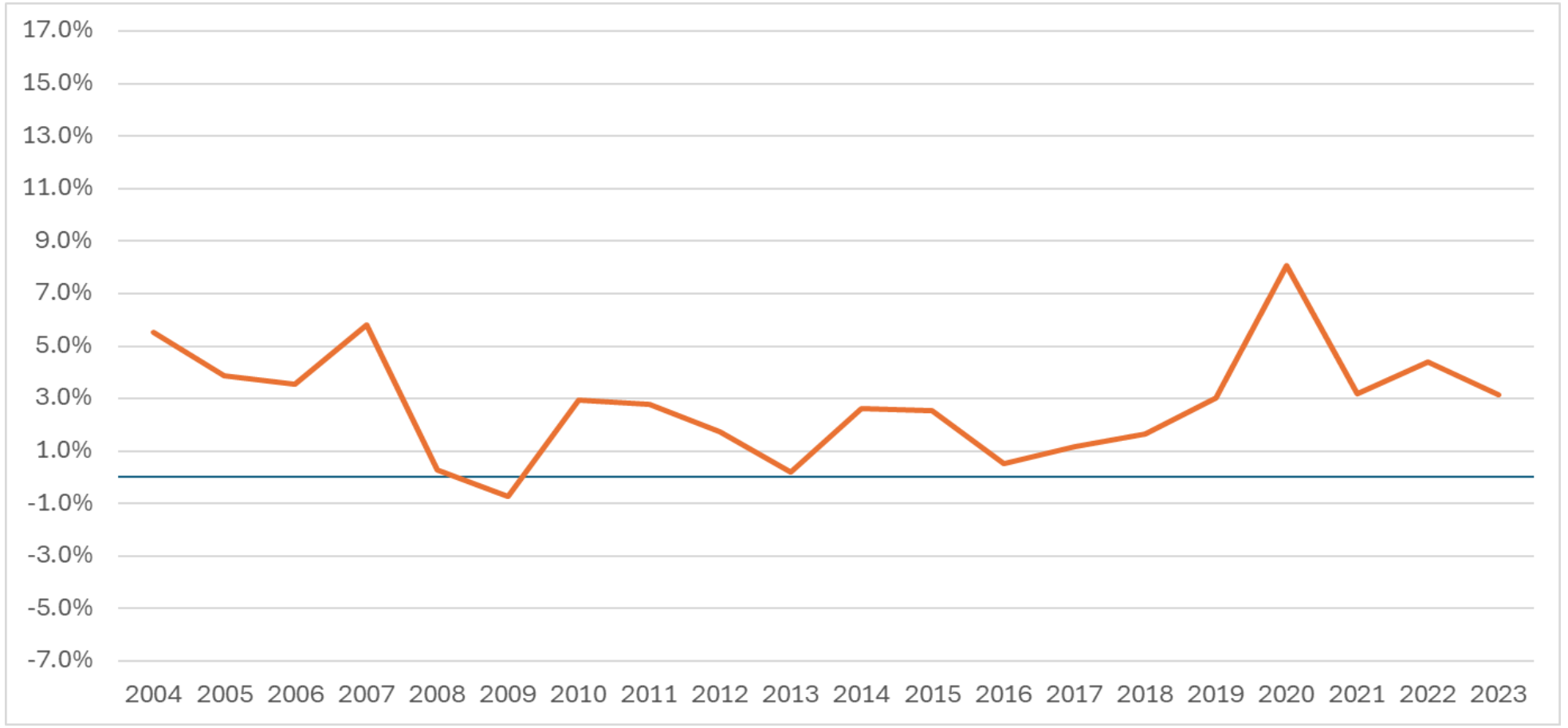
**Medicare projections are for the total U.S. population and represent average per person spending projections. Medicare historical trends are for Connecticut residents. State forecasts for per person Medicare spending are not available.*

Inflation Indicators CPI-U and PCE, Average Annual Change, 2003-2023



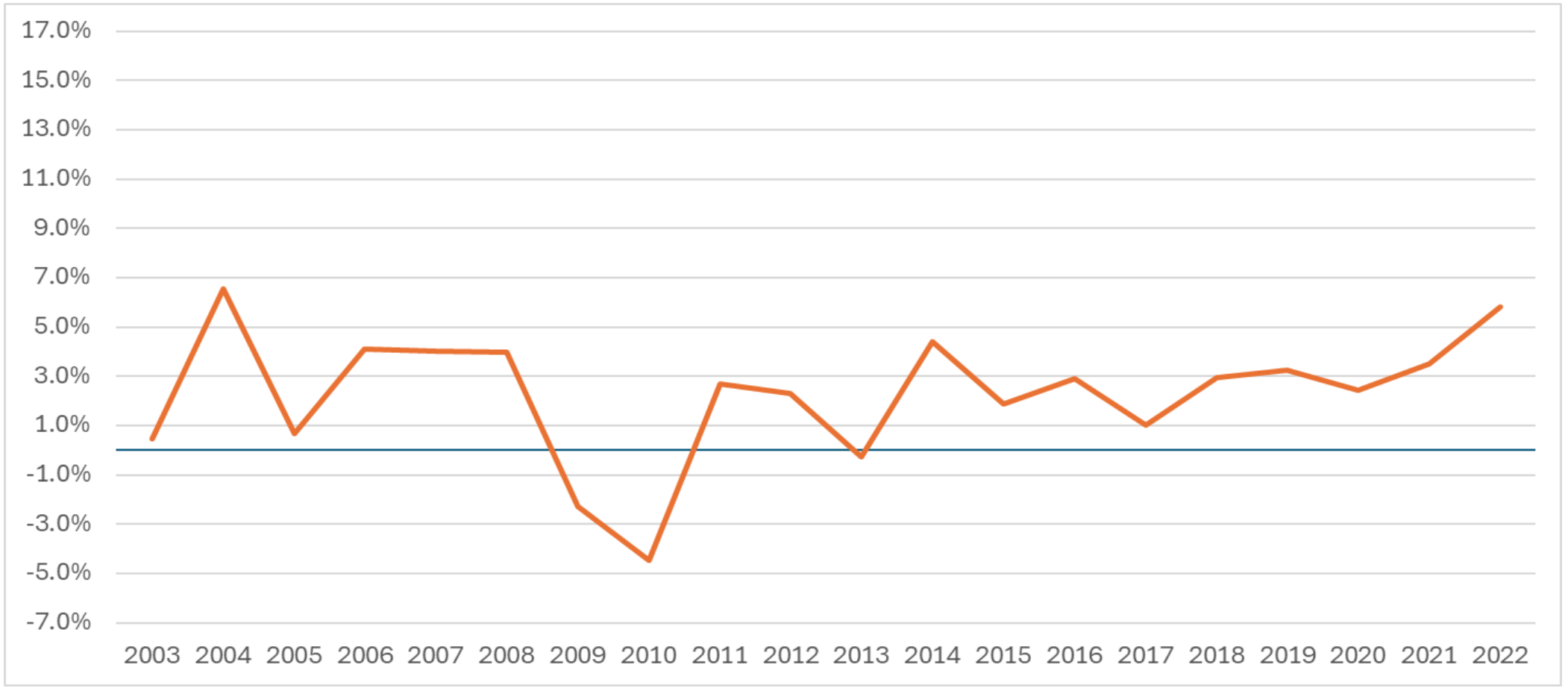
Sources: CPI-U, Bureau of Labor Statistics. All items in U.S. city average, all urban consumers, not seasonally adjusted, 2003-2023; PCE, U.S. Bureau of Economic Analysis, Table 2.3.4. Price Indexes for Personal Consumption Expenditures by Major Type of Product

Average Annual Change, Average Annual Wages, Connecticut, 2003-2023



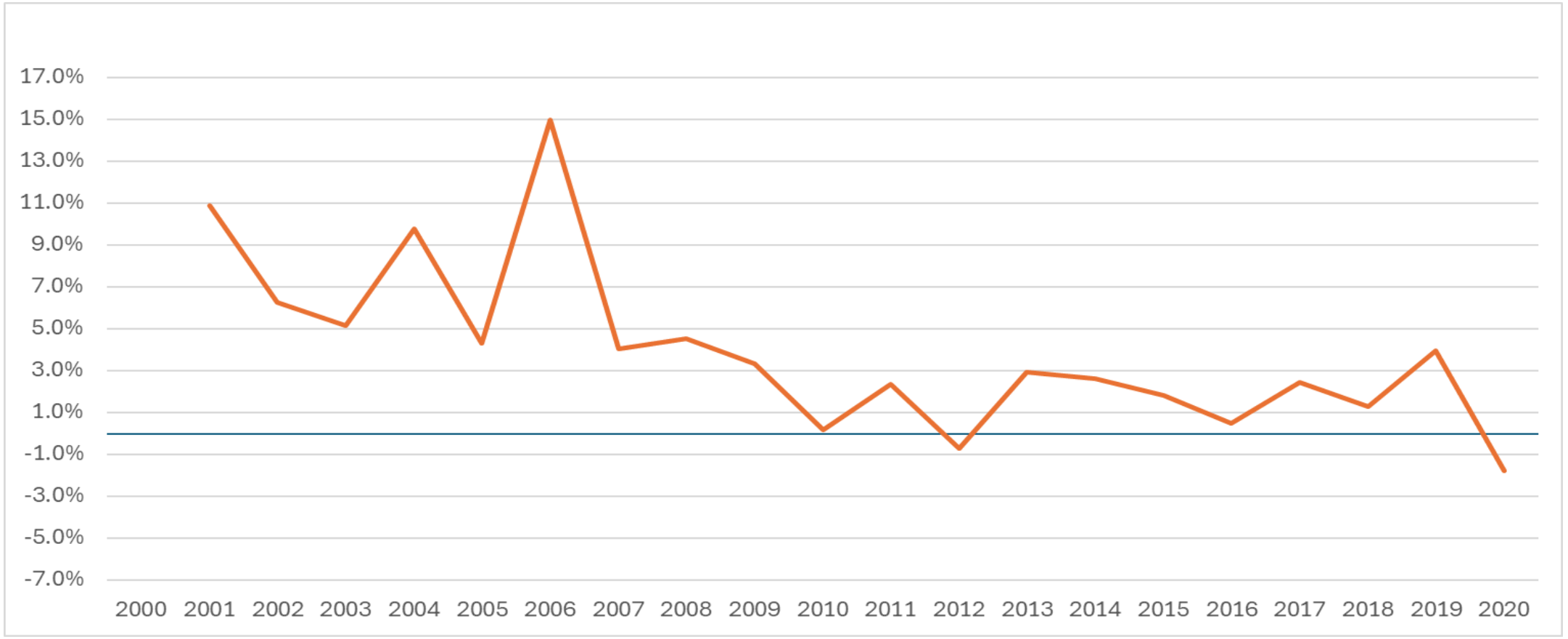
Source: Connecticut Department of Labor, Office of Research, Quarterly Census of Employment and Wages (QCEW) program.

Average Annual Change, Median Household Income, Connecticut, 2002–2022



Source: Connecticut Office of Policy and Management using S&P Global Forecast. Data are seasonally adjusted.

Average Annual Change, Per Capita Medicare Spending* in Connecticut, 2000–2020



**Spending refers to personal health care spending, which excludes public health activities, health insurer administrative expenses and profit, government administration, and investment.*

Sources: U.S. Census Bureau; and Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

Target % of Median Household Income

- Loren proposed the cost growth benchmark link to a rate of growth that would be required for healthcare spending to equal a targeted percentage of median household income.
- To support discussion, we calculated the amount of healthcare spending as a percentage of median household income and found that ***nearly one-third of median household income was consumed by healthcare spending***.
  - The calculation was performed using 2022 data for a) median household income, b) Connecticut THCE, as reported through the benchmark program, and c) number of Connecticut households in 2022 (American Community Survey, ACS, five-year average, 2018-2022).
- This approach would require that a targeted percentage be determined.

Discussion of Options (Excluding Target % of Median Household Income)

	Advantages	Disadvantages
Inflation	• Treats healthcare as another consumer household expense, much as consumers do.	• Would assess healthcare on price and not service volume only.
Average Annual Wage	• Consumer-centric reference to "take-home pay." • May better reflect costs for working families or families with lower incomes as compared to household income • Direct tie to healthcare spending as wages have stagnated due to rising premiums	• There is no link to the price of goods. • Does not include other income (e.g., capital gains, retiree income) and therefore may not reflect consumers' true purchasing power. • Averages are skewed by high income earners.
Median Household Income	• A comprehensive measure of total income as it includes all sources of income and not just wages	• There is no link to the price of goods. • Connecticut residents with *very* high incomes may skew even median values.
Medicare	• Ties the benchmark to a well-established standard with a rigorous methodology, which includes adjustments for demographic characteristics, health status, and county-of residence and "upcoding"	• Little state control over Medicare spending and policies that influence spending

Criteria for Selecting an Economic Indicator

- Decision-making criteria for the indicator(s) on which the benchmark will be based
  1. provide a stable and therefore predictable target;
  2. rely on independent, objective sources with transparent calculations; and
  3. produce a benchmark value such that spending growth will not exceed change in resident ability to pay.

Economic Indicator Discussion

- Which indicator(s) do you recommend for the benchmark value?

- If combining indicators, what weights would you attach to each?

- Do you recommend historical or forecasted values?

2. Setting a Multi-Year Benchmark

Setting a Multi-Year Benchmark

- States have established multi-year benchmarks to promote predictability.
  - States have set targets for periods ranging from four to 20 years.
  - The Technical Team is charged with recommending the benchmark methodology for Connecticut's next five-year period: 2026-2030.
- States have established a **fixed** benchmark value over the multiple years & adopted **variable** benchmarks for the period.
- States with variable benchmarks **adjust** their base benchmark values upward and / or downward to set their final value(s).

Setting a Multi-Year Benchmark: Fixed or Variable Benchmarks

- Connecticut adjusted the base value of its benchmark upward for the initial two years (+0.5% and +0.3% respectively) before fixing the value at 2.9%.*
  - Many states have done this for their initial benchmarks to support a transition period for insurer and provider entities
- Massachusetts, Oregon, and Rhode Island *(initially)*, fixed their benchmark values over multiple years.

**The 2024 benchmark was subsequently adjusted to account for inflation.*

Setting a Multi-Year Benchmark: Adjustments

- States may apply adjustments from the base values to set their benchmarks.
  - States that have adjusted their benchmarks *upward* have generally added 0.2-0.5% to the base value.
  - Massachusetts and New Jersey have implemented *downward* adjustments of 0.5% and 0.4%, respectively, in the later years of their programs.
- States may opt to adjust the base value and then fix their benchmarks or apply different adjustments to set variable benchmarks.

Setting a Multi-Year Benchmark Discussion

- Should the benchmark be fixed for the period 2026-2030 or change over the years?

- Should the base value be adjusted? If so, how and on what basis?

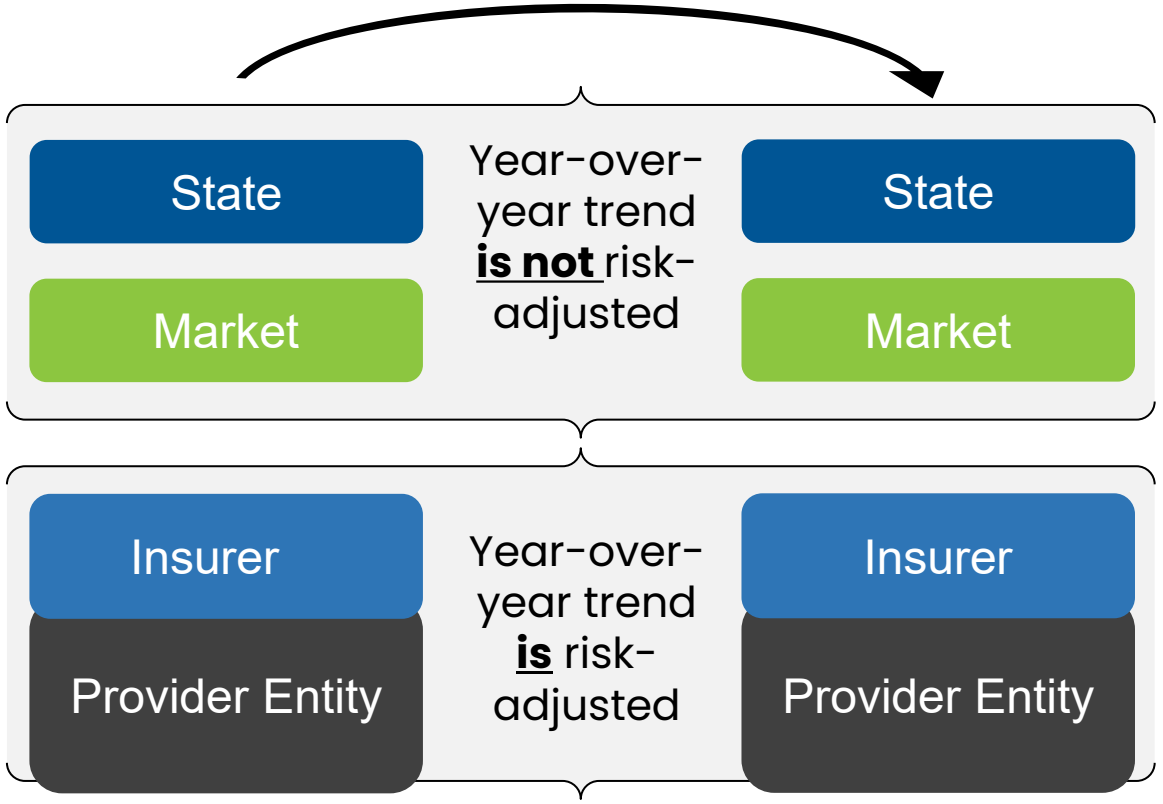
3. Reporting Performance Against the Healthcare Cost Growth Benchmark

Reporting Performance Against the Healthcare Cost Growth Benchmark

- Risk adjustment
- Improving statistical confidence
  - Truncation
  - Confidence intervals

Risk Adjustment in Benchmark Programs (1 of 2)

- Healthcare spending growth is measured and reported as year-over-year change.
- A payer or a provider entity's population risk is relatively stable over two years
- However, some benchmark states risk adjust the data submitted by payers when assessing **payer and provider** performance relative to a benchmark to account for any annual changes in the population's health status.



Risk Adjustment in Spending Target Programs (2 of 2)

- OHS is required to publish a report on total health care expenditures, including a breakdown of “population-adjusted” total medical expenses by payer and provider entities.
- OHS reports spending, *adjusted* by age and sex factors, using data collected from payers.
- Most states that risk adjust spending use age and sex adjustment (CA, CT, OR, RI, NJ, WA)
- Massachusetts (per statute) and Delaware report clinically risk-adjusted spending.
  - Massachusetts also reports unadjusted spending

Risk Adjustment Options

Unadjusted	• Reports all money spent by payers. • Given that year-over-year changes in population health tend to be small, risk adjustment may not be warranted.
Age/Sex Adjustment	• Accounts for aging, which is expected to be the largest driver of spending growth in the coming decades. • A compromise between no adjustment and clinical risk adjustment.
Clinical Risk Adjustment	• Captures differences in risk at the most granular level – but susceptible to changes in billing and coding practices. • Responsive to provider and payer desire for clinical risk adjustment.

Clinical Risk Adjustment

- Clinical risk adjustment is used to assess conditions diagnosed and treated during the performance year to predict spending in the same year.
- However, clinical risk scores can change annually without changes in the population's underlying risk due to more extensive documentation of patient condition on claims.


ACCOUNTABLE CARE

By Michael E. Chernew, Jessica Carichner, Jeron Impreso, J. Michael McWilliams, Thomas G. McGuire, Sartaj Alam, Bruce E. Landon, and Mary Beth Landrum

Coding-Driven Changes In Measured Risk In Accountable Care Organizations

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Insurers Pocketed $50 Billion From Medicare for Diseases No Doctor Treated

Questionable diagnoses of HIV and other maladies triggered extra Medicare Advantage payments; 'It's anatomically impossible'


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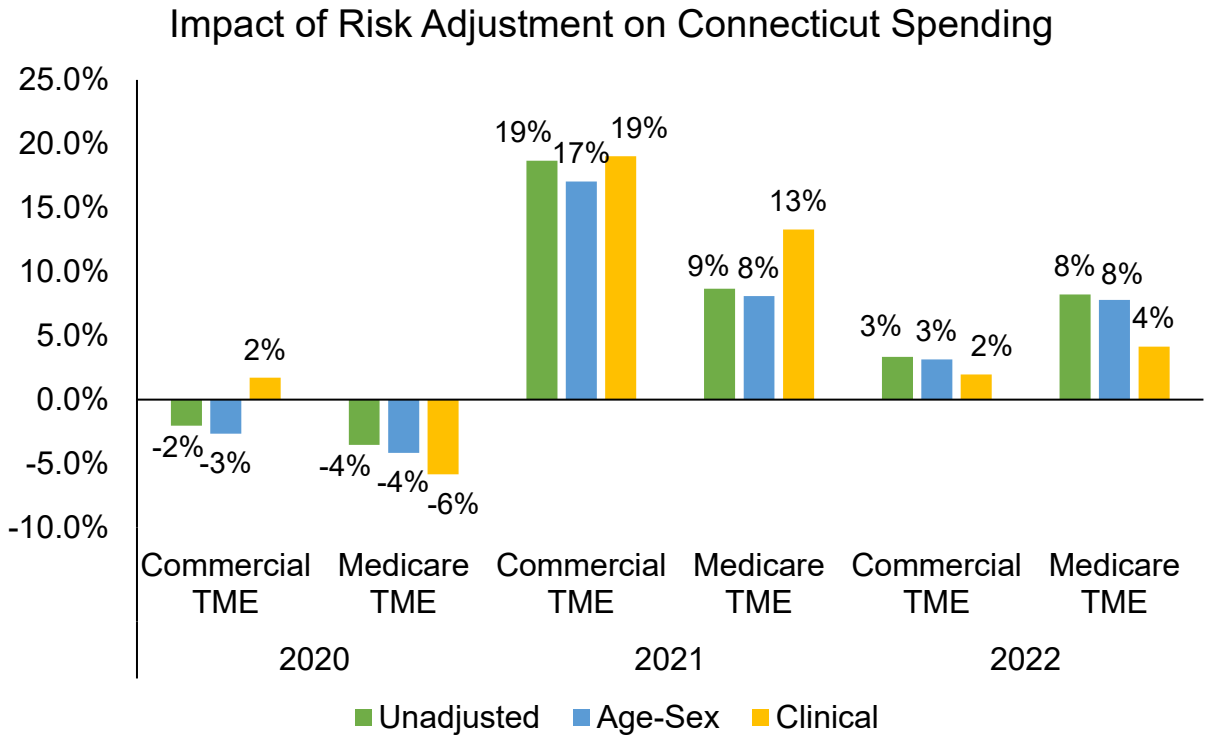
Assessing the Impact of Risk Adjustment

- In Connecticut, clinical risk scores tend to result in substantial shifts compared to age/sex risk adjustment (inconsistent directional impact).
- In Massachusetts, clinical risk adjustment has consistently driven trend downward.



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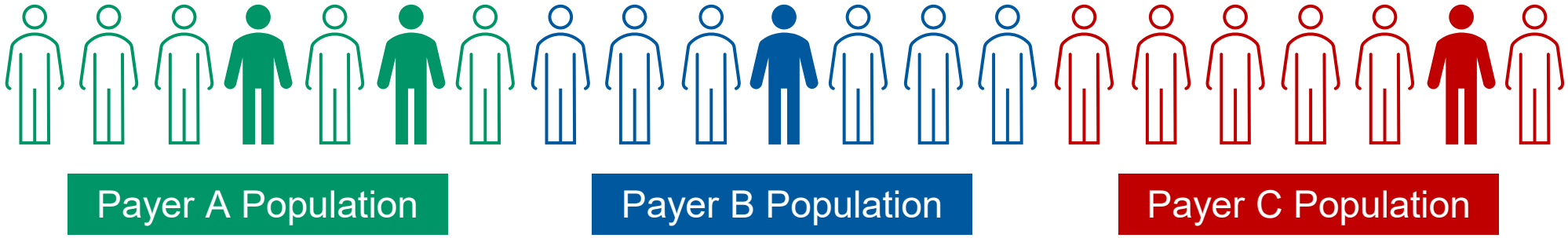
Risk Adjustment Discussion

» Should OHS continue to report age and sex-adjusted spending performance for payer and provider entities?

Truncation (1 of 2)

- Truncation is used to **mitigate the effect of high-cost outliers**.
- The number of outlier patients is expected to be randomly distributed across both payers and provider entities every year, so each payer or provider could have either many or few high-cost outlier members each year; this means that high-cost outliers can cause significant shifts in measured spending growth from year to year.



Truncation (2 of 2)

- Currently, truncation is being applied at the payer/provider level(s) in about half of all states* with cost growth benchmarks.
- Most of those states vary the truncation value by market.

State	Commercial	Medicare Duals and Non-Duals	Medicaid Duals and Non-Duals
CT	$150,000	$150,000	$250,000
NJ	$250,000	$250,000	$250,000
RI	$150,000	$100,000	$250,000
WA	$200,000	$125,000	$125,000

*California, Delaware, Massachusetts, and Oregon do not utilize truncation. Oregon considers the impact of high-cost outliers when assessing for possible enforcement action.

Truncation Discussion

Should OHS continue to apply truncation at the payer and provider entity levels for public reporting?

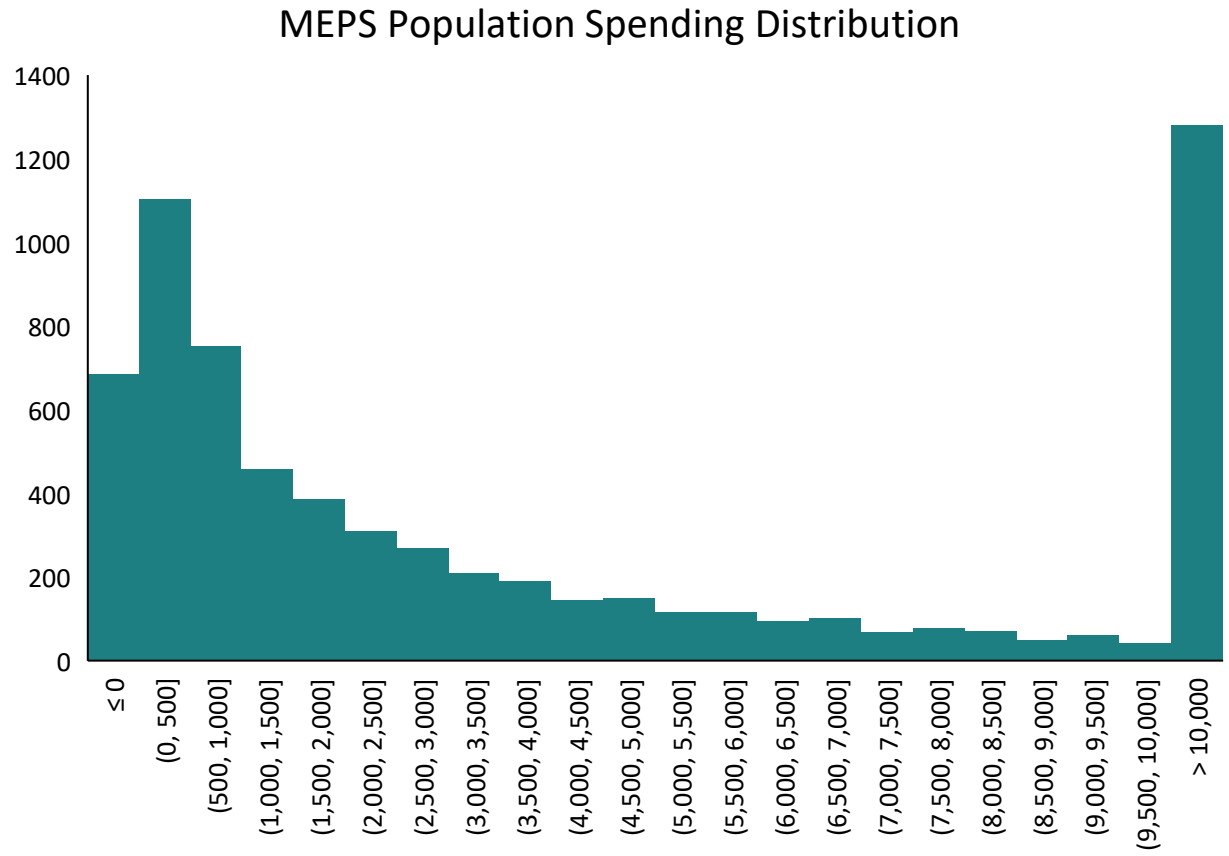
Note: OHS is pursuing development of a new regression-based model to potentially determine future truncation values.

State	Commercial	Medicare Duals and Non-Duals	Medicaid Duals and Non-Duals
CT	$150,000	$150,000	$250,000

Confidence Intervals (1 of 2)

Should confidence intervals (CIs) be used to assess performance against the target?

- Confidence intervals (CIs) account for inherent variability in healthcare spending.
- CIs lend credibility when holding payer and provider entities accountable against the benchmark.
- However, CIs are designed for normal distributions*, whereas spending distributions are often non-normal.

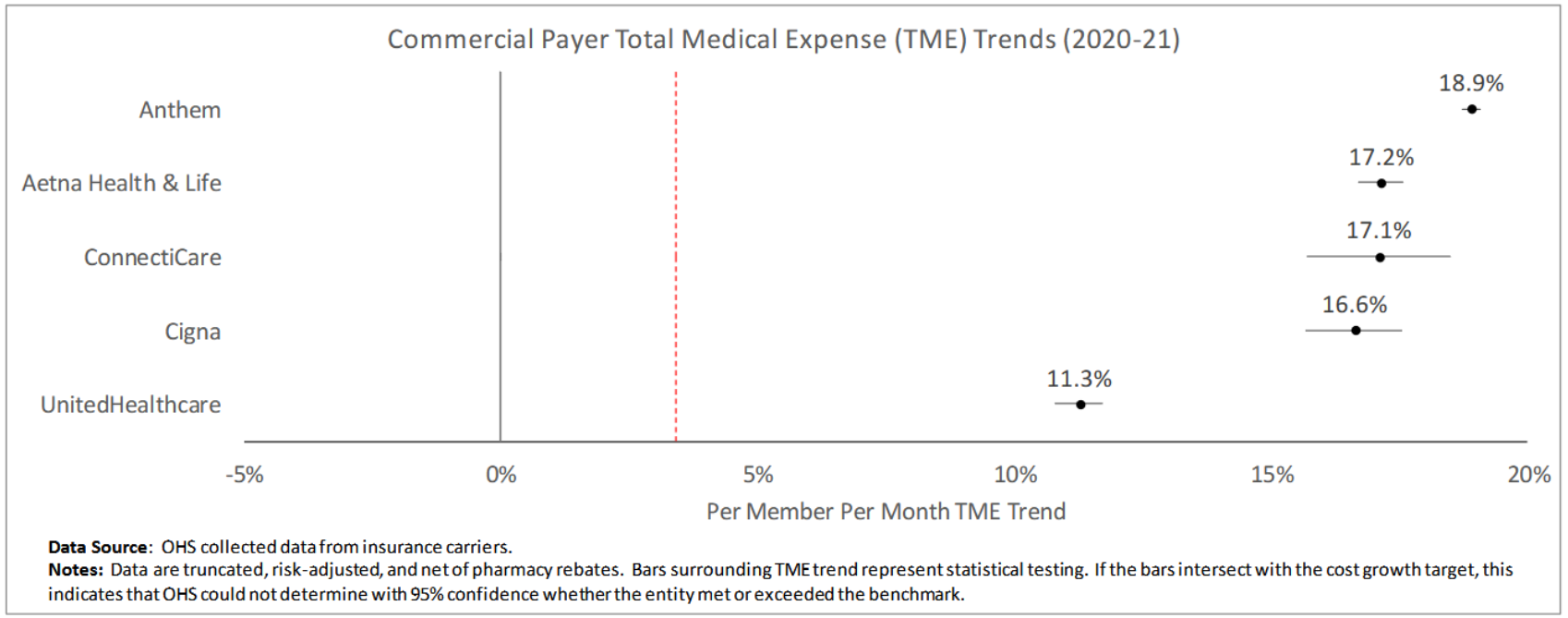


** CIs are, however, frequently applied to non-normal distributions, such as electoral polls and surveys with categorical data.*

Confidence Intervals (2 of 2)

- All cost growth benchmark states have used CIs to assess payer performance to date and have received support on the use of CIs.
- CIs are a commonly understood tool and are a statistically recognized method in legal contexts.

Commercial Payer 2021 Performance Against the 3.4% Benchmark



Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated, risk-adjusted, and net of pharmacy rebates. Bars surrounding TME trend represent statistical testing. If the bars intersect with the cost growth target, this indicates that OHS could not determine with 95% confidence whether the entity met or exceeded the benchmark.

Confidence Intervals Discussion

» Should OHS continue to use confidence intervals when assessing and reporting entity performance relative to the benchmark?

IV. Public Comment

V. Wrap-Up and Next Steps

Wrap-Up and Next Steps

- The next meeting is scheduled for January 10, 2025, from 2:00–4:00 pm EST.
- Time permitting, during the next meeting we will begin discussion of setting Connecticut's primary care spending target.

VI. Adjourn