# Healthcare Benchmark Initiative Technical Team
# Meeting Minutes

| Meeting Date | Meeting Time | Location |
|---|---|---|
| January 10, 2025 | 2:00 pm – 4:00 pm | Microsoft Teams Meeting: Meeting ID: 252 359 878 700<br>Passcode: xwXjLc |

| Technical Team Member Name | Attendance | Technical Team Member Name | Attendance |
|---|---|---|---|
| Loren Adler | A | Paul Grady | A |
| Don Berwick | A | Jason Hockenberry | A |
| Sabrina Corlette | A | Chris Manzi | NA |
| 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 fourth meeting of the Healthcare Benchmark Initiative (HCBI) Technical Team. Deidre stated that a primary objective of the meeting was to bring the discussion of the 2026-2030 benchmark decision to closure. | | |
| **2.** | **Meeting 3 Recap and Revisiting Specific Questions** | **Michael Bailit** | **2:05 pm** |

Michael Bailit reviewed the meeting agenda.

<u>Separate benchmarks for utilization and price</u>

Michael Bailit summarized the rationale for favoring and not favoring separate benchmarks for utilization and price.

- Francois de Brantes asked clarifying questions regarding the application of the different data sources to the OHS benchmark affordability program. Michael explained that OHS's current benchmark methodology uses aggregate data submitted by insurers. Insurer-submitted data are reported in aggregate by market and by broad service categories. Michael reported that insurers do not submit price and utilization data as part of the healthcare cost growth benchmark reporting methodology. Michael said that APCD data are not used to analyze performance relative to the State's healthcare cost growth benchmark performance.
- Don Berwick commented that using APCD data to understand the role or price growth was appropriate. Don asked about OHS analysis of the variation in prices among providers, in addition to the rate at which prices were growing. Michael said that analyses to date have focused on factors that are contributing to spending growth and there has been less attention given to the variation in underlying prices among providers.
    - Don stated that providers with high base prices have a lot of leverage on the growth in prices and suggested that OHS consider calling attention to the variation in prices, in addition to the growth in prices. Deidre Gifford stated that OHS would consider Don's recommendation for the March 2025 report and June 2025 hearings.
- Francois said that he did not see a downside to requesting that payers report on price and utilization as part of the healthcare cost growth benchmark workstream as it is common practice for payers to isolate price and utilization. Francois said it is important for people to know the respective impact of

price and utilization growth directly from carriers to hold carriers and providers accountable and that the APCD data may not provide a complete view.
    - Deidre explained to Technical Team members that stakeholders have raised concerns about the underlying data used for the program. She said that reporting different results from the cost growth benchmark and APCD analysis would create further confusion and questions regarding the data, noting that there are legitimate methodological differences in the analyses the different data sources produce. Michael added that APCD data provide a level of detail and insight from APCD data that are not available from carrier-reported aggregate data.
    - Francois said requesting price and utilization data from carriers could spur discussion.
    - Stefan Gildemeister offered support for reporting performance relative to the healthcare cost growth benchmark using aggregate carrier-reported data and digging deeper into drivers using APCD data. Stefan said requesting too much from carriers at the front end may create such complexity that the basic objective of showing how entities are performing relative to the benchmark will get lost.
    - Paul Grady said that the program had been hearing about data concerns from the beginning and said asking carriers for price and utilization data could provide an additional data point for validation.
- Sabrina Corlette asked for clarification about the data concerns, and, specifically, if provider entities like hospitals are questioning the data reported by payers or the APCD data.
    - Deidre responded by saying there is a lot of generalized criticism about the data, and OHS is working to better understand the specific concerns.
    - Sabrina said it might be helpful for transparency purposes to request carriers to report their price and utilization information.
    - Stefan acknowledged that even though data may come from the same source, there are legitimate reasons and ways to represent the data differently, for example, situs, provider attribution, representing Medicare cost report systems, etc.

<u>Market-specific benchmarks</u>

Michael reviewed positions favoring and opposing separate healthcare cost growth benchmarks by market.

- Paul referenced prior Technical Team discussion about a downward adjustment to the benchmark (i.e., "minus x") and said there would need to be different adjustments by market to account for where the growth is occurring, i.e., in the commercial market.
- Francois said it is necessary for the State to address growth in spending in the commercial market head on and worries that a combined benchmark and respective analytics provide too much room for provider entities to question the data without the State having a strong data-driven counterpoint (referring back to the point about asking carriers for price and utilization data.)
- Don said any effort that puts pressure on the provider entity community to reconsider its cost and cost structure will face opposition and questions about data. Don asked if the OHS wanted to consider 1) getting to an agreed-upon data structure with providers to measure costs or 2) standing by the data source and focusing on policy discussions. Don said he doubted there was a pathway whereby provider entities would accept any data as correct.

<u>Economic indicators</u>

Michael summarized prior Technical Team discussions that favored using a consumer-centric indicator to which to tie the healthcare cost growth benchmark and forecasted values of those indicators.

<u>Adjustments to the benchmark</u>

Michael reviewed prior discussion about adjusting the benchmark and asked if there should be an adjustment to the benchmark based on primary care investment.

- Loren Adler favored removing primary care spending from assessment of performance so entities are not penalized from among the options presented but said he did not have a strong preference. Michael added that removing primary care spending from benchmark performance assessment would not be technically difficult to do.

Analytic requests

Michael presented findings from analytic requests, including the impact on historical trend when high-wage ($500k+) earners were excluded. Michael reported that there was modest statistical impact. Technical Team members did not offer any comments.

| 3. | **Setting the 2026-2030 Healthcare Cost Growth Benchmark** | **Michael Bailit** | **2:50 pm** |
|---|---|---|---|

Michael transitioned to discussion of setting the 2026-2030 benchmarks.

- Alex Reger noted a correction to the language regarding legislature review and approval that was presented during the meeting. Alex said if the legislature takes no action on the recommended benchmarks, they are deemed approved. If the legislature rejects the benchmark values, the benchmark defaults to 3.3% until a new value is approved.

For additional context, Deidre reminded the Technical Team of the 2021-2025 benchmark methodology, which is a blend of forecasted median household income (80% weight) and potential gross state product (PGSP) (20% weight). This methodology yielded a value of 2.9% (the 2025 benchmark.)

Michael invited Technical Team members to discuss several questions, including:

- Which indicator(s) should OHS use?
- If using more than one indicators, which ones, and with what weighting?
- What should be the value of the downward adjustment?
- Should the downward adjustment be fixed (so the value is the same across the five-year period) or change across the years (i.e., gradually decline?)
- Should there be an adjustment for primary care spend?

    - Don placed the questions in the context of the experience of a resident of Connecticut. Don asked if, on principle, the Technical Team should accept that residents' healthcare expenses should not rise faster than their income. Michael stated that other states have linked their healthcare cost growth benchmarks to income based on the rationale that Don described.
    - Paul conveyed his thoughts on employer responses to health care costs/premium increases. Paul said in the last few years, in the competitive labor market, employers have been willing to absorb increases of 5% or less without passing on a share of the increase to their employees. Paul asserted that a ~2.5% statewide target is likely to result in a much higher annual growth in the commercial market (8% or more) and thus will result in increased cost shifting to employees.
    - Loren expressed a preference for median household income because it controls for outliers in a way that average does not and includes more income in the metric. He acknowledged that the base value is aggressive and so maybe the Technical Team should not recommend an initial downward adjustment, or one of a half a percentage point. He said the aggressive value acknowledges that spending is already too high and just keeping up with it is hard for residents.
    - Francois asked if the benchmark itself applies to each type of insurance. Michael said that OHS is applying the benchmark to insurer and provider entity spending growth performance, by insurance market.
    - Josh Wojcik said the base value of median household income may not warrant a downward adjustment, even though he liked the message a "minus x" sends. Josh made a point that if healthcare spending continued to grow at residents' ability to pay, they could adjust, but it is growing at a higher rate, forcing people to continuously re-adjust their budgets and finances. Josh said there is a concern about setting a value that is not feasible and therefore ignored, particularly without enforcement mechanisms.
    - Sabrina asked if the Technical Team's recommendation could and/or should consider the feasibility of securing enforcement mechanisms with the legislature. Deidre said OHS has heard from stakeholders about a general desire to enact enforcement mechanisms and indicated that OHS had proposed a study to lay out options for enforcement in this legislative session. Deidre encouraged the Technical Team to think about feasibility.
    - Don added that *technically feasible* means a system can find savings (i.e., cut out waste) to reduce growth making the benchmark achievable. Don said healthcare costs are far too high

and, with action, could be lower, with a lot of will behind the action. Don said the policy objective then is that healthcare costs in Connecticut should not rise higher than median family income. Don said costs are not just the rate of rise but what is baked in already. He said healthcare costs are already too high a proportion of family income and just slowing the rate of growth to bring it in line with income will not be enough. Don proposed a benchmark tied to median household income for the first two years, and then a gradual decline thereafter to recover from some of the high built-in costs that are contributing to unaffordability.
    - Francois and Sabrina agreed that Don's proposed approach would put entities on notice and give time for adjustment.
    - Paul suggested identifying opportunities for slowing growth when communicating the value.
- Michael asked the Technical Team what the downward adjustment should be for the later years.
    - Paul suggested half a percentage point, which would bring the value from 2.7% to 2.2% in the later years. Don said that would be politically challenging and asked about using the actual median household income growth. Michael said that is not known until the year is over and the benchmark needs to be set in advance to give affected payers and provider entities predictability.
    - Josh advised against a benchmark that is lower than 2.5%.
    - Stefan favored starting with something modest and putting the system on notice through a slight downward adjustment: 2.7% or 2.6% for the first two years, and then a continuous gradual decline.
    - Sabrina said that there will be opposition to any value and favored tying the benchmark to median household income with a gradual downward adjustment over five years that would end with a 2.2% benchmark.
    - Loren suggested that the benchmark communication consider what would resonate with a general public audience, for example, conveying that Connecticut spends x% of household income on healthcare now and the goal is to bring it down to x%. Deidre said OHS could incorporate this recommendation about messaging into the forthcoming report and June hearings.
    - Don agreed and said first the goal is to smooth out the trajectory of growth and then see a decline.

Technical Team members discussed whether the value should be adjusted for primary care spending.

- Paul favored an adjustment.
- Josh suggested removing primary care spending up until the point when a carrier meets the primary care spend target.
- Don suggested that the Technical Team think about this further during the next meeting to make sure it will translate to the general audience.
- Alex acknowledged that there is a risk of causing greater confusion when communicating policies that seek to rebalance the spending, that is, increasing spending in one area to slow spending in others.

<u>Improving statistical confidence in reporting performance against the healthcare cost growth benchmark</u>
Michael reviewed the current benchmark methodology for truncating spending above a certain level and using confidence intervals when reporting performance of payer and provider entities relative to the benchmark.

- Francois agreed that spending outliers should be excluded but commented that the current truncation levels OHS were employing seemed low.
- Loren said increasing the levels at which spending is truncated in a way that is consistent with the overall growth is a reasonable approach.
- Don asked about the impact of including the spending that is truncated. Michael said for individual entities, excluding the high spending can make the difference in meeting or exceeding the benchmark. Michael said some years it will push an entity's trend down and other years it will go up. Michael added that OHS has looked at the breakdown of the truncated spending to assess whether it was occurring randomly, and found that it had been. Michael said analysis also found that a growing percentage of the spending for people who exceed the truncated levels was for pharmacy.

| | | | |
|---|---|---|---|
| | ○ Francois said as the costs of therapies for certain conditions continue to rise, OHS should consider whether truncated spending is truly outlier spending.<br><br>Michael asked Technical Team members if OHS should continue to use confidence intervals when assessing and reporting entity performance relative to the benchmark?<br>• Don asked about the application of confidence intervals when the program is not sampling from a population. Michael said OHS sought input on this very question from an expert statistician who said it is appropriate to apply confidence intervals in this context (i.e., the whole population) because the population is not the same every year. Michael added that the other states with cost growth benchmarks also use confidence intervals.<br>• Technical Team members did not have any objections to continued use of confidence intervals.<br><br>Michael indicated that the Technical Team would begin discussion of the primary care spending target during the next meeting. | | |
| **4.** | **Public Comment** | **Members of the Public** | **3:50 pm** |
| | There was no public comment. | | |
| **5.** | **Wrap-up and Next Steps** | **Deidre Gifford** | **3:55 pm** |
| | Deidre thanked the members of the Technical Team for their insights and reviewed the details of the next meeting, to be held on January 27, 2025, from 10:30 am - 12:30 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