CONNECTICUT

Healthcare Cost Growth Benchmark
Technical Team Meeting #4
January 10, 2025

I. Welcome

Meeting Agenda

Time	Topic
2:00 p.m.	I. Welcome
2:05-2:35 p.m.	II. Meeting #3 Recap and Revisit of Specific Questions
2:35-3:20 p.m.	III. Setting the Healthcare Cost Growth Benchmark *(continued discussion)* A. Benchmark indicator values and modeling B. Setting the 2026-2030 cost growth benchmark C. Increasing statistical confidence in performance reporting i. Truncation ii. Confidence Intervals
3:20-3:50 pm	IV. Primary Care Spending Target A. Review of Connecticut's primary care spending target initiative B. Current data source used to measure primary care spending C. Defining and measuring primary care
3:50 PM	V. Public Comment
3:55 p.m.	VI. Wrap-Up and Next Steps
4:00 p.m.	VII. Adjournment

II. Meeting #3 Recap and Revisit of Specific Questions

Technical Team Meeting #3 Recap

- During the third meeting of the Technical Team, we discussed the following:
  - proposed alternative or complementary approaches to cost growth benchmark construction, including a) separate benchmarks for utilization and price and b) market-specific benchmarks;
  - economic indicator options, and use of historical or forecasted values; and
  - risk adjustment in calculation of total medical expense (TME) performance.

Create Separate Benchmarks for Utilization and Price (1 of 2)

- Technical Team members continued discussion of separate benchmarks for utilization and price.

Reasons for supporting	Reasons for opposing
• Focuses attention on the role of prices in spending growth, historically the primary cost driver in the commercial market • Feasible for insurers to report without significant added burden	• Aggregate benchmark allows providers and payers to determine how they will meet the benchmark • Duplicates (and could conflict with) current APCD-based cost driver analysis of the role of price and utilization • Could be challenged because the statute defines the benchmark as being for THCE

APCD = All-Payer Claims Database THCE = Total Health Care Expense

Create Separate Benchmarks for Utilization and Price (2 of 2)

- **OHS currently reports utilization and price trends alongside aggregate trend using APCD data.** This practice achieves the policy objective of focusing attention on the contribution of price to overall spending growth but *does not use the same data source* as for the benchmark.

Option	Pros	Cons
1. When reporting benchmark results, give greater attention to the role of price growth **using APCD data**.	• Easy to implement. Requires a change in emphasis when messaging results annually. • Hospitals will attack State's efforts no matter what.	• Hospitals complain that the data sources are different and that they need better line of sight to the State's reported results.
2. Ask payers to report price and utilization as **part of the benchmark reporting and report with overall benchmark findings.**	• Payers have the data. • The data source will be the same in the benchmark analysis.	• Using two different data sources (APCD and aggregate insurer data) to report on price could lead to confusion. • Added reporting effort for payers.

OHS Suggested Approach

- When reporting benchmark results, give greater attention to the role of price growth using APCD data. Focus ongoing messaging on the primary driver of commercial market spending growth in most years – prices.
  - Avoids creating confusion from using the APCD and aggregate insurer data to report on price.
  - Requires little added effort

Create Market-Specific Benchmarks (1 of 2)

- Technical Team members continued discussion of separate benchmarks by market.

Reasons for supporting	Reasons for opposing
• Allow benchmark values to be more aggressive for some markets, e.g., higher for Medicaid, lower for commercial. • Market-specific benchmarks would provide more focused attention and discussion around commercial market trend. • Could support future efforts to add enforcement authority for excess spending growth.	• Could result in a discussion of cost shifting, which would distract attention from the affordability policy objective. • Complicates benchmark messaging (in an already complex messaging environment) • The State lacks policy influence over Medicare spending growth. • Spotlight on separate Medicaid spending growth may result in unintended consequences (e.g., cuts to the program) • Insurers and provider entities are already held accountable to the benchmark at the commercial market level.

Create Market-Specific Benchmarks (2 of 2)

- OHS emphasizes the market-level trend and entity-level accountability for market trends.

Option	Pros	Cons
1. De-emphasize statewide THCE trend in reporting and **make commercial trend the "headline"**	• Meets the policy objective to focus attention at the market level without adding complexity of three different benchmarks. • Does not represent a significant shift in the benchmark construction.	• Does not allow variation in benchmark values that would reflect different baseline spending and historical trend in each market.
2. Create new statutory language that introduces market-specific benchmarks	• Explicit about accountability at the different levels so OHS can focus on the markets and entities with excess growth. • Allows variation in benchmark values that would reflect different baseline spending and historical trend in each market.	• Would require statutory change. • Complicates benchmark messaging (in an already complex messaging environment).

OHS Suggested Approach

- Make commercial trend the “headline”, beginning with the March 2025 report. Focus ongoing messaging on where the problem of spending growth is most acute – the commercial market.
  - Three separate benchmarks would create confusion which could harm efforts to expand accountability.
  - The likelihood of legislative support for creating separate benchmarks in the foreseeable future is low.

Economic Indicators

- Most Technical Team members favored use of one of the following consumer-centric indicators:
  - Average wage*
  - Median household income
- Technical Team members expressed a preference for using ***forecasted*** values.

* Forecasted median wage growth data are not available.

Adjustments to the Benchmark Value

- Technical Team members proposed applying a downward adjustment (“minus x”).
- Members discussed how investment in primary care, might be incorporated into the benchmark. Three possibilities:
    1. When assessing payer performance relative to the benchmark for primary care investment, remove primary care spending so there is no penalty for increased investment.
    2. When assessing payer performance relative to the benchmark for primary care investment, excuse a payer that exceeded the benchmark if it boosted investment in primary care.
    3. Reduce the “minus” in the benchmark if the payer increased primary care investment.

Analytic Request: Excluding Primary Care Spending from Trend Calculation

- What happens if we exclude primary care spending when calculating trend?
  - Based on an analysis of 2022 and 2023 benchmark data, the impact on trend of removing primary care was as follows:
    - 0.1% at the market level
    - 0.2 to 0.4% at the payer/market level.

Analytic Request: Excluding High Wage Earners from Growth Trends

- Model each indicator with high wage earners/household earners excluded and determine whether doing so impacts forecasted growth.
  - Exclusion of the highest wage earners ($500k+) has a small impact on historical analysis of average wage growth.
  - We obtained historical median wage growth data during this time and found that it was slightly below average wage growth.
    - Exclusion of high wage earners from median wage growth also had a small impact on historical trends.
- OHS has requested additional *forecast* analyses from CT Department of Labor that would exclude high wage earners.

Reporting Performance Against the Healthcare Cost Growth Benchmark: Risk Adjustment

- Technical Team members recommended that OHS continue to report age and sex-adjusted spending performance for payer and provider entities

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. Adjustments to the benchmark base value
   - One-time to establish a “fixed” benchmark for 2026-2030
   - Multiple adjustments to set “variable” benchmarks for 2026-2030
3. Improving statistical confidence in reporting performance against the healthcare cost growth benchmark
   - Truncation
   - Confidence intervals

Reminder:
Criteria for Selecting an Economic Indicator(s)

- 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 consumer, employer, and taxpayer ability to pay.

Economic Indicators: Forecasted Average Annual Change Base Values

Indicator	Forecasted Average Annual Change (%)
Average Annual Wage	3.7% (2023-2034)
Median Household Income	2.7% (2022-2034)

- The 2025 benchmark value is 2.9%.
- A 2026-2030 benchmark value that is **lower than 2.8% or higher than 3.8%** will trigger a review by the legislature.
- If the legislature takes no action (i.e., does not approve / reject OHS' recommendation), the value defaults to 3.3%. This would represent an *increase* from the 2025 benchmark.

Adjusting Base Values ("minus x")

- Technical Team members have discussed applying an adjustment to the base value of the benchmark.
- Your previously stated rationale:
  - Health care is *already unaffordable* for consumers. It is not enough for it to grow at the rate of consumer wage or income (an affordable rate) – it must be lower so consumers can "catch up" and recapture some of the income they have lost to fast-growing health care costs.
- One member said the value of the adjustment mattered less than the message it would convey.

Modeling Adjustments

- Staff did not identify an empirical basis for the value of an adjustment but agree that the power of the adjustment is in simply having one.
- The base value of forecasted median household income (2.7%) will already trigger legislative review. Any downward adjustment would do the same.
- The base value for forecasted average wages is 3.7%, well above the current benchmark.
  - Adjusting downward by 0.9 produces a value (2.8%) that does not trigger legislative review and is lower than the current benchmark.
  - A downward adjustment of 1%+ would result in legislative review.

Combining Indicators

- Technical Team members have talked about adopting a single indicator. There is precedence in Connecticut for using a weighted average of multiple indicators.
  - The 2021-2025 benchmark is a blend of PGSP (20%) and forecasted median household income (80%).
- The Technical Team could recommend more than one indicator when setting the benchmark value.

Recommendation for 2026-2030 Benchmark

- 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?

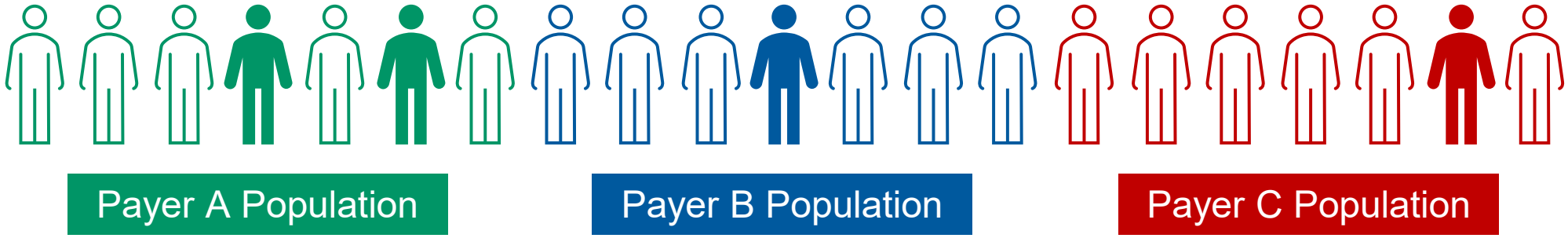
Improving statistical confidence in reporting performance against the healthcare cost growth benchmark

Reporting Performance Against the Healthcare Cost Growth Benchmark

- During the last meeting, we discussed risk adjusting payer and provider entity level TME trend by age and sex factors.
- There are two other components of reporting performance to improve statistical confidence
  - Truncation
  - Confidence intervals

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?

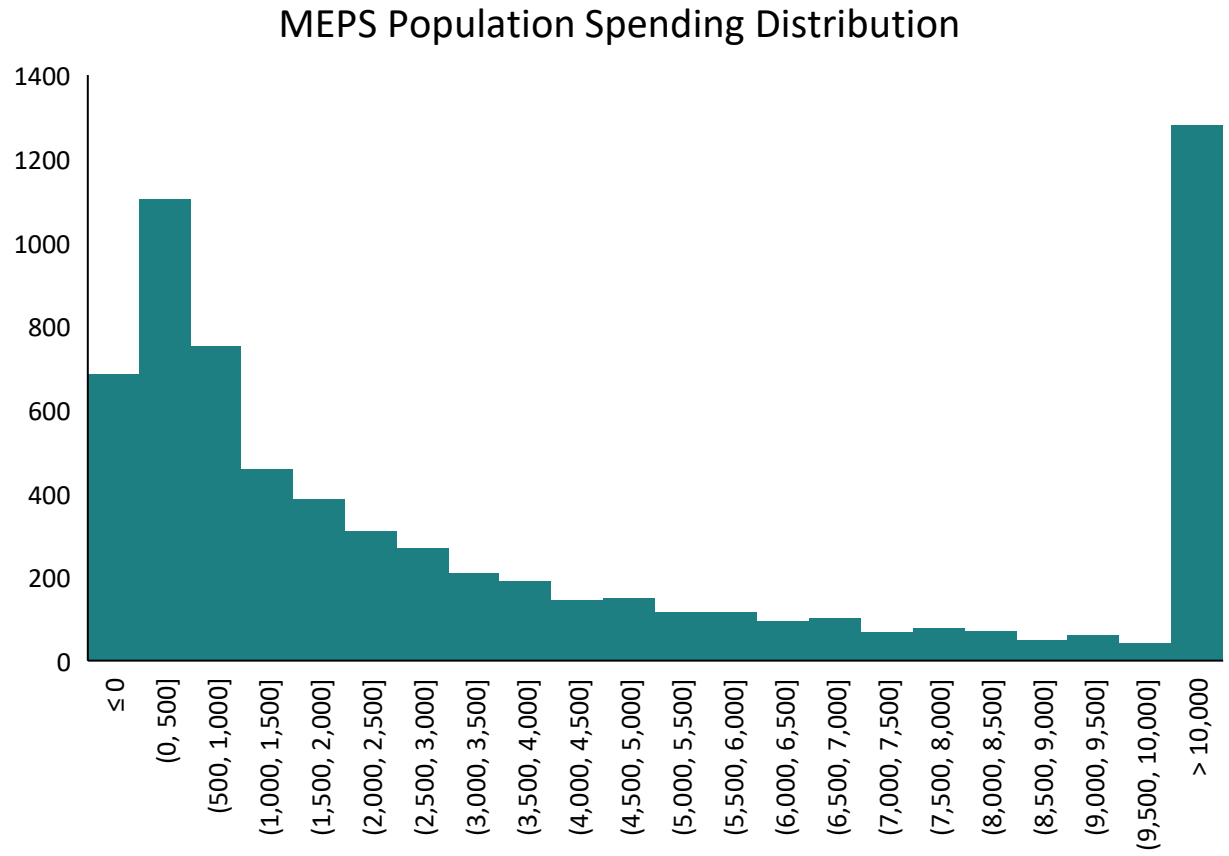
Note: OHS is currently pursuing development of a new regression-based model to potentially determine future truncation values.

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?

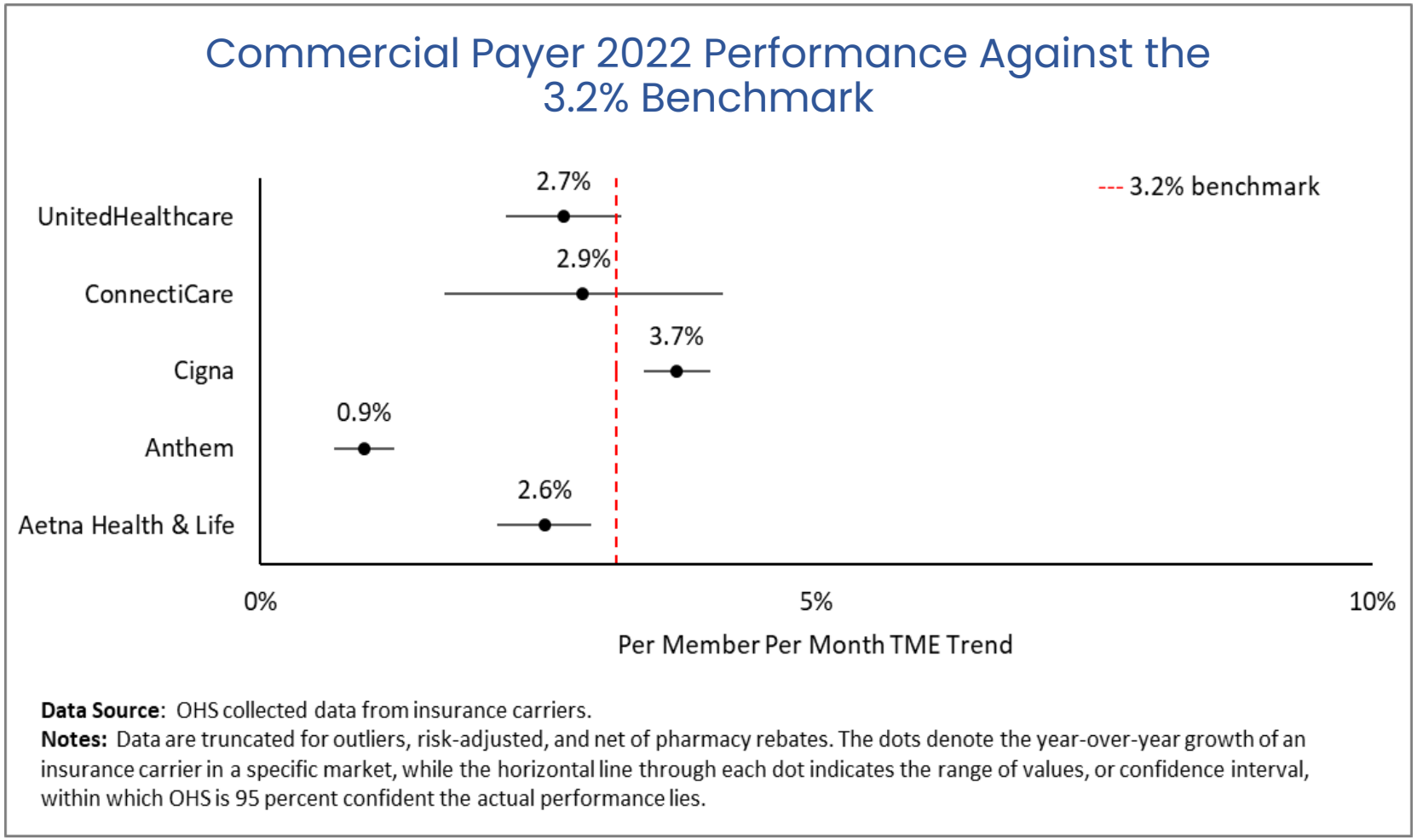
- Confidence intervals (CIs) account for inherent variability in healthcare spending.
- CIs lend credibility when holding payer and provider entities accountable against the benchmark.
- CIs are designed for normal distributions*, whereas spending distributions are typically non-normal.



** 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.



Confidence Intervals Discussion

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

IV. Connecticut's Primary Care Spending Target

Primary Care Spending Target

- **Technical Team charge**: Establish primary care spending targets across all payers and populations as a share of total health care expenditures for CYs 2026-2030

Let's now review…

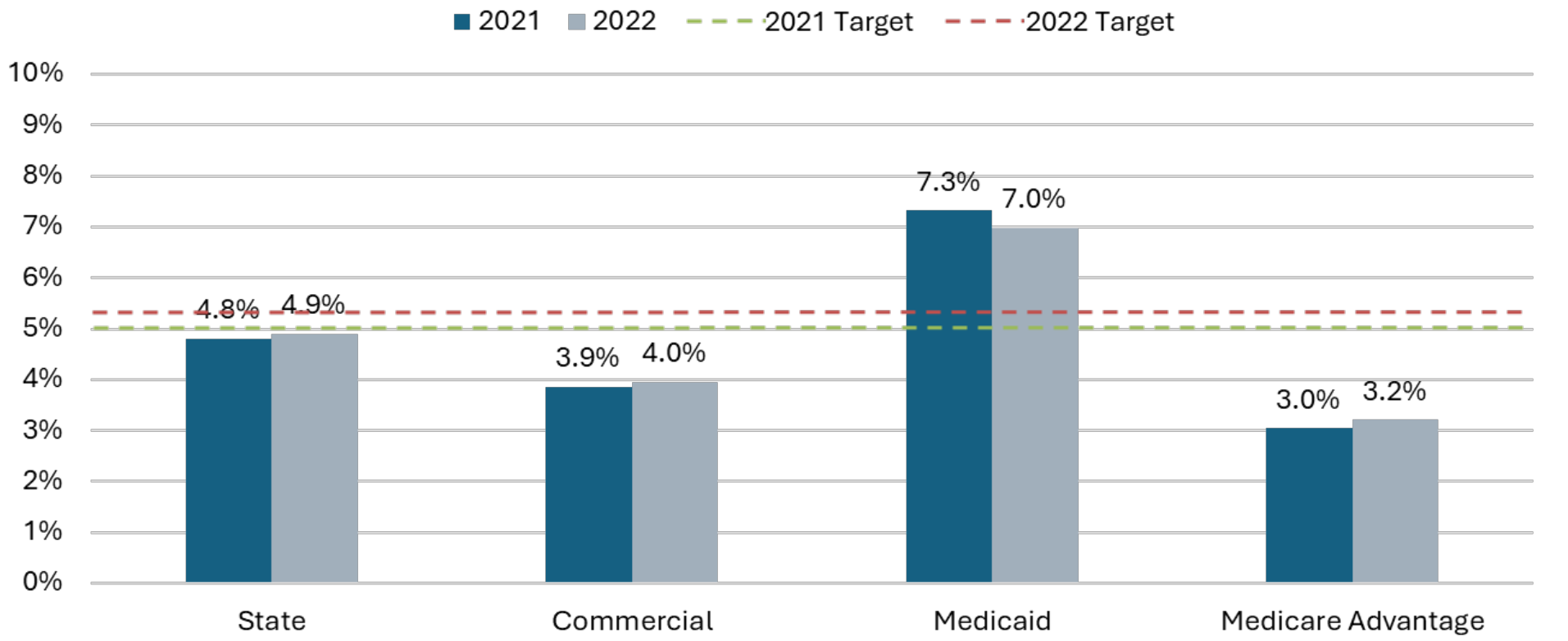
- Connecticut's primary care spending target initiative
  - Current data source used to measure primary care spending
  - Experience of other states with primary care spending targets
  - Defining and measuring primary care, including services and providers
- Approaches other states have taken for each of these components

Connecticut's Primary Care Spending Target

Calendar Year	Target Values
2021	5.0%
2022	5.3%
2023	6.9%
2024	8.5%
2025	10.0%

- Connecticut's primary care spending target aims to **increase primary care spending** to 10 percent of total healthcare expenditures by 2025.
- The target is intended to rebalance and strengthen Connecticut's healthcare system by supporting improved primary care delivery.

State and Market Performance Against the Primary Care Spending Target



Data Source: OHS collected data from insurance carriers and from the Connecticut Department of Social Services (DSS).

Notes: Data are not risk adjusted. Data are net of pharmacy rebates. Data include commercial, Medicare Advantage and Medicaid FFS spending. TME includes all of the spending categories captured for the cost growth benchmark, less

Data Source Used to Measure Primary Care Spending in Connecticut

- OHS collects primary care spending data directly from payers
- Payers report primary care spending data for in-state residents and all providers when they submit their cost growth benchmark data.
  - OHS does not currently collect primary care spending for Medicare FFS but anticipates doing so under the new AHEAD model.
- OHS does not utilize the APCD for this effort.
  - Why? Because payers are the only source of non-claims payment, self-insured data, and pharmacy rebates.

Primary Care Spending Investments and Targets in Other States

State	Description
California	• Annual improvement benchmark: 0.5 percentage points to 1 percentage point per year increase in primary care spending as a percent of total medical expense for each payer for performance years 2025 through 2033; and • Statewide investment benchmark: **15%** of total medical expense allocated to primary care for all payers by performance year 2034.
Colorado	• 2022 and 2023: Carriers were required to increase the proportion of total medical expenditures allocated to primary care by 1 percentage point in each of 2022 and 2023. • Carriers are required to submit primary care expenditures and describe strategies for increasing the percentage of TME allocated to primary care as part of the annual rate filing.
Delaware	• 2022: Carriers are required to increase primary care spend to 7% and then 1.5% per year until **11.5%** (2025). • *(Delaware additionally requires its private insurers to, at a minimum, match Medicare reimbursement rates for primary care.)*
Oregon	• Private health plans, public employee benefit plans, and Medicaid coordinated care organizations (CCOs) must spend at least 12 percent of total physical and mental health care services on primary care. Failure to do so requires submission of a plan demonstrating how carriers will increase primary care spend to reach the **12%** threshold.
Rhode Island *(proposed rules for 2025 and beyond)*	• 2025: Commercial insurers must increase annual primary care expenditures as a percentage of TME for all insured lines of business by at least one-half of one percentage point above 2022 baseline ratio. • 2026-2028: Continued increase by an additional one percentage point / year. • By the end of 2028: Primary care expenditures represent **10%** of annual TME, and at least 8% of TME must be paid as claims-based payments for primary care services and/or service-based primary care payments under a primary care alternative payment model (e.g., primary care capitation).

What is Primary Care?

- The definition of primary care can be sub-divided into the following two questions:

    1. Who are “primary care providers”?
    2. What services are considered “primary care services”?

OHS Current Focus of Primary Care

- OHS adopted two definitions for understanding primary care investment in the state. It uses the "narrow" definition to assess performance relative to the target.

	Narrow Definition	Broad Definition
Purpose	• **OHS uses this definition to measure performance against the Primary Care Target.** • Focuses on investment in primary care services delivered by traditional primary care specialties. • This definition does *not include OB/GYN or midwifery in its definition of a primary care provider or include services typically performed by them* in the definition of services.	• To more broadly measure primary care spending beyond the Primary Care Target definition recognizing that many women utilize OB/GYN or midwifery services for primary care and *includes those providers and routine primary care and non-specialty gynecological services* delivered by OB/GYNs and midwifery in the definition.

Who are “primary care providers”?

	Narrow Definition	Broad Definition
Included Providers (in outpatient settings)*	• MDs and DOs: Internal Medicine when practicing primary care, Family Medicine, Pediatric and Adolescent Medicine, Geriatric Medicine when practicing primary care • NPs and PAs: when practicing primary care	• MDs and DOs: Internal Medicine when practicing primary care, Family Medicine, Pediatric and Adolescent Medicine, Geriatric Medicine when practicing primary care, **OB/GYN and midwifery** • NPs and PAs: when practicing primary care
Excluded Providers (among others)	• **OB/GYN and midwifery** • Behavioral health provider • Emergency room physician • Naturopathic health care provider	• Behavioral health provider • Emergency room physician • Naturopathic health care provider

*Including but not limited to private practices, primary care clinics, FQHCs and school-based health centers

What services are considered “primary care services”?: Included services

	Narrow Definition	Broad Definition
Included Services	• Office or home visits • General medical exams • Routine adult medical and child health exams • Preventive medicine evaluation or counseling • Telehealth visits • Administration and interpretation of health risk assessments • Behavioral health risk assessments, screening, and counseling, if performed by a PCP • Immunizations • Hospice care • Preventive dental care and fluoride varnish • Pediatric dental risk assessments • Home visits for newborns • Routine, non-specialty gyn. services, if performed by a PCP	• Office or home visits • General medical exams • Routine adult medical and child health exams • Preventive medicine evaluation or counseling • Telehealth visits • Administration and interpretation of health risk assessments • Behavioral health risk assessments, screening, and counseling, if performed by a PCP • Immunizations • Hospice care • Preventive dental care and fluoride varnish • Pediatric dental risk assessments • Home visits for newborns • Routine, non-specialty gyn. services, if performed by a PCP • **Routine primary care and non-specialty gynecological. services delivered by OB/GYNs and midwifery**

What services are considered “primary care services”?: Excluded services

	Narrow Definition	Broad Definition
Excluded Services	• **Routine primary care and non-specialty gynecological services delivered by OB/GYNs and midwifery** • Minor outpatient procedures • Inpatient care • ED care • Urgent care • Nursing facility care • Practice-administered pharmacy	• Minor outpatient procedures • Inpatient care • ED care • Urgent care • Nursing facility care • Practice-administered pharmacy

Defining Primary Care Spending: Discussion

- Should OHS amend its definition of primary care for assessing performance relative to the target?
  - *Primary care providers*
  - *Primary care services*

V. Public Comment

VI. Wrap-Up and Next Steps

Wrap-Up and Next Steps

- The next meeting is scheduled for January 27, 2025, from 10:30 am -12:30 pm EST.
- During the next meeting we will continue our discussion of setting Connecticut's primary care spending target.

VII. Adjourn