Cost Growth Benchmark Stakeholder Advisory Board Meeting #2 June 11, 2020

OHS
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Office *of* Health Strategy

Agenda

Time	Topic
1:00 p.m.	Call to Order and Introductions of New Members
1:05 p.m.	Review and Approval of Prior Meeting Minutes
1:10 p.m.	Review and Approval of Charter and Bylaws
1:20 p.m.	Public Comment
1:30 p.m.	Technical Team Preliminary Recommendations
2:20 p.m.	Other Stakeholder Input
2:25 p.m.	Wrap-up & Next Steps
2:30 p.m.	Adjourn

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Call to Order and Introductions

Stakeholder Advisory Board Members

- Vicki Veltri – Office of Health Strategy
- Reginald Eadie – Trinity Health of NE
- Kathleen Silard – Stamford Health
- Janice Henry – Anthem BCBS of CT
- Robert Kosior - ConnectiCare
- Richard Searles – Merritt Healthcare Sol.
- Ken Lalime - CHCAC
- Margaret Flinter – Community Health Ctr
- Karen Gee – OptumCare Network of CT
- Marie Smith – UConn School of Pharmacy
- Tekisha Everette – Health Equity Solutions
- Pareesa Charmchi Goodwin – CT Oral Health Initiative
- Howard Forman – Yale Universoty
- Nancy Yedlin – Donaghue Foundation
- Fiona Mohring – Stanley Black and Decker
- Lori Pasqualini – Ability Beyond
- Sal Luciano – CT AFL-CIO
- Kathy Flaherty – CT Legal Rights Project
- Hector Glynn – The Village for Fam & Children
- Rick Melita – SEIU CT State Council
- Ted Doolittle – Office of the Healthcare Adv
- Susan Millerick* - patient representative
- Kristen Whitney-Daniels* - patient representative

*New member as of June 11, 2020

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Review and Approval of Prior Meeting Minutes

Review of Proposed Charter and Bylaws

Summary of Edits

- We received feedback in two areas:
  - Representation of patients on the Advisory Board
  - Concerns on the process for terminating members
- As introduced earlier, two new patient representatives have joined the Advisory Board based on the recommendation of Representative Bill Petit and Protect our Care.
- We amended Section IX – "Termination of Members, other than state officials or their designees, for Cause" to specifically note that unethical behavior does NOT include the expression of Advisory Board member individual viewpoints.
- We also added some clarifying edits to Section VI-Member Preparedness that address Advisory Member expectations.

Public Comment

Technical Team Preliminary Recommendations

Technical Team

- As a reminder, the Technical Team is the primary stakeholder body advising OHS on how best to respond to the Executive Order to create a cost growth benchmark and a primary care target.
  - The Quality Council will be the primary body with responsibility for defining the quality benchmarks required by the Executive Order.
- This Stakeholder Advisory Board serves to advise the Technical Team.
- Since the Board's last meeting, the Technical Team has met twice, focusing its conversation upon the methodology for the cost growth benchmark.

What Does a Cost Growth Benchmark Measure?

- During its May 19 meeting, the Technical Team discussed how Total Health Care Expenditures (THCE) should be defined. The Technical Team suggested a definition consistent with the other states that have cost growth benchmarks.
- Specifically, they agreed THCE should consist of:
  - **Total Medical Expense** (TME) spending on all medical services for all state residents regardless of where care was provided, including non-claims-related payments to providers
  - **Patient cost sharing** (e.g., copay, deductible, co-insurance)
  - **Net Cost of Private Health Insurance** (NCHPI), a measure of the costs to state residents associated with the administration of private health insurance (including Medicare Advantage plans)

What Does a Cost Growth Benchmark Measure?

- During the May 14, 2020 SAB meeting a member discussed the importance of including **dental care spending** that may not be considered part of the medical benefit.
- The Technical Team weighed in on this topic during its May 19, 2020 meeting. Many agreed that including dental spending would be important but recognized the possible technical challenges with gathering data. The Team agreed to defer the conversation until project staff can conduct further research on the availability of data from dental insurance carriers.
- The Technical Team will hear an update on the research during an upcoming meeting.

Cost Growth Benchmark Methodology: Key Considerations

- The Technical Team agreed on the following recommended three criteria for determining the cost growth benchmark methodology:
  1. Provides a stable and therefore predictable target
  2. Relies on independent, objective data sources with transparent calculations
  3. Will lower growth in spending

Cost Growth Benchmark Methodology: Economic Indicators

- It is sensible to define an explicit basis for the value of a cost growth benchmark.
- Other states have considered economic indicators for this reason because we often talk about health care spending relative to other financial measures.
  - "My health insurance premium is eating into my take-home pay."
  - "Health care spending is consuming the state budget."
  - "Health care is taking over the economy."

Cost Growth Benchmark Methodology: Economic Indicators

- For this reason, the Technical Team considered four economic indicators to which to tie the benchmark.
- Each of the indicators has a different meaning and would convey a different message if it is used to set the benchmark value.

Cost Growth Benchmark Methodology: What the Technical Team Considered

	Advantages	Disadvantages
1. Gross State Product/Potential Gross State Product	Used by most other states with cost growth targets; there may be value to applying a consistent approach.	This is an abstract economic concept that may not resonate with citizens.
2. Median Household Income	Recognizes that income is more than just wages.	There is no link to the price of goods.
3. Average Wage	A consumer-oriented reference to "take-home pay."	There is no link to the price of goods. Does not include other income and therefore may not reflect consumers' true purchasing power. Averages are skewed by high income earners.
4. CPI-U	Treats health care as another consumer household expense, much as consumers do.	Would assess health care on price and not service volume only.

Cost Growth Benchmark Methodology: Discussion of Options

- Technical Team members emphasized the importance of choosing an indicator that captures the consumer experience since that is one of the key issues driving the need to slow the growth in healthcare costs.

- There was significant interest in a composite measure that combines two types of measures, e.g., inflation and household income, considering different weightings of each value.

Impact of Indicator Linkage

- Tying the benchmark to an indicator does not mean that the costs each consumer experiences will grow at the rate of the benchmark, unfortunately.
- For example, in Massachusetts, healthcare cost growth has been at or below the benchmark, but consumer out-of-pocket costs have grown at a faster rate.
  - This is because cost growth benchmarks are not designed to limit consumer out-of-pocket spending, even though it is included in total spending. That spending is heavily influenced by employer benefit design decisions, e.g., increase the deductible.
  - Protecting against higher consumer out-of-pocket spending would require separate tools, and OHS will be separately reporting on trend in out-of-pocket spending.
- Based on Massachusetts' experience, provider prices are most affected by the target.

What Input Does the Stakeholder Advisory Board Want to Provide on the Benchmark Methodology?

1. What criteria should the Technical Team consider in selecting an economic indicator for the benchmark?
2. Which economic indicators resonate with you for the purposes of tying it to the benchmark?

Historical Cost Growth in Connecticut's Commercial, Medicare and Medicaid Markets

	Average Annual Growth (time period)
Commercial (SIM Evaluation)	6.6% (2013-2017)
Commercial (HCCI)	3.9% (2016-2018)
Medicare	3.5% (2015-2018)
Medicaid	0.3% (2013-2019)

Sources: University of Connecticut Center for Population Health, "Connecticut State Innovation Model Final Evaluation Report"; Health Care Cost Institute, "2018 Health Care Cost and Utilization Report"; Centers for Medicare & Medicaid Services Office of Enterprise Data and Analytics; and Connecticut Department of Social Services.

Comparison of Historical and Forecasted Values of Potential Indicators: What the Technical Team Considered

	Historical ~20-Year Lookback	Forecast (2026-2030)
Gross State Product and Potential Gross State Product	**3.3%** (1999-2019)	**3.7%***
Median Household Income	**2.0%** (2001-2018)	**2.7%****
Average Per Worker Wage	**2.1%** (2001-2018)	**3.5%****
Consumer Price Index	**2.1%** (2001-2019)	**2.4%****

*The CT specific inputs to PGSP are using forecasts calculated May 21, 2020 but the national inputs are generally updated each January and August.

**Forecasts were made May 2020 and therefore inclusive of the COVID-19 impact through such time.

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Cost Growth Benchmark Value: Discussion of Options

- Technical Team members were inclined to use forecasted values since they tend to be stable.
- The Technical Team did not settle on a recommended benchmark value. It requested information on other states' benchmarks relative to historical cost growth in those states to inform future discussion.
- There was also a request to calculate potential values for three new composite (combined) measures. Depending on the weighting the minimum and maximum forecasted values for these new measures would be as follows:
  - Potential Gross State Product and median income: 2.7% to 3.7%
  - Consumer Price Index and median income: 2.4% to 2.7%
  - Potential Gross State Product and average wage: 3.5% to 3.7%

Adjusting the Benchmark: Discussion of Options

- There was some interest in some sort of transitional adjustment to the benchmark value between 2021 and 2025, similar to what 3 out of 4 cost growth benchmark states have done.
- There was general agreement that there should be a minimum of three years before the benchmark methodology is re-evaluated.
- Technical Team members expressed significant interest in having a provision that allows for re-visiting the benchmark value and methodology for certain exceptional circumstances.
  - However, members also recognized that there are other means of addressing exceptional circumstances that do not require adjustments to the benchmark.

What Input Does the Stakeholder Advisory Board Want to Provide on the Benchmark Value and Adjustments?

1. What minimum and maximum values should the Technical Team consider for the benchmark?
2. Should there be a mechanism for revisiting the benchmark methodology for the 2021-2025 period? If so, under what circumstances should it be applied?

Other Stakeholder Input: Consumer Advisory Council

Wrap-Up & Next Steps

Plan of Meetings

Meeting #	Date	Meeting Goals
3	July 14 1p.m.-3p.m.	• Report back on Technical Team recommendations re: cost growth benchmark methodology and values • Discuss what steps should be taken to ensure the Cost Growth Benchmark is successful, and how to avoid any unintended consequences • Solicit Advisory Board input regarding the primary care spending target.
4	September 16, 1p.m.-3p.m.	• Report back on Technical Team recommendations re: Primary Care Target • Discuss the data use strategy • Discuss upcoming Quality Benchmark development