

Healthcare Benchmark Initiative Stakeholder Advisory Board

June 9, 2022 Meeting



Call to Order

Agenda

<u>Time</u>	<u>Topic</u>
2:00 p.m.	I. Call to Order
2:05 p.m.	II. Public Comment
2:10 p.m.	III. Approval of March 10th Meeting Minutes - Vote
2:15 p.m.	IV. Public Act 22-118 and Other New Legislation
2:30 p.m.	V. Benchmark Methodology Changes
2:40 p.m.	VI. APCD Commercial Trend Analysis with Retail Pharmacy Added
2:45 p.m.	VII. Reasons for Commercial Hospital Price Growth
3:25 p.m.	VIII. Commercial Pharmacy Spending Analyses
3:55 p.m.	IX. Wrap-Up and Next Steps
4:00 p.m.	X. Adjourn

Public Comment

Approval of March 10th Meeting Minutes - Vote

Public Act 22-118 and Other New Legislation

Public Act 22-118

- Executive Order No. 5 created the Connecticut Healthcare Cost Growth Benchmark Initiative in January of 2020. Accordingly, OHS set benchmarks for 2021-2025, which are posted on the [OHS website](#).
- With the passage of Public Act 22-118, the Healthcare Cost Growth Benchmark Initiative has been put into statute.
- The following slides describe the new processes related to the Cost Growth Benchmark defined within Public Act 22-118.

Public Act 22-118: Setting Future Benchmarks

- **By July 1, 2025 and every five years thereafter, OHS must set benchmark values** for each of the coming five years.
 - OHS must hold **at least one informational public hearing** prior to adopting another five years of benchmark values, and may modify its benchmarks based on public feedback.

Public Act 22-118: Setting Future Benchmarks (cont.)

- If the average annual benchmark for a five-year period proposed by OHS exceeds the average benchmark of the prior five-year period by **more than 0.5%**, the benchmark recommendations will be submitted to the joint standing committee of the General Assembly for approval.
 - OHS' recommendations will be **considered approved unless rejected** by the joint committee **within 30 days**, in which case OHS can submit modified benchmarks.
 - In this scenario, the benchmark will be equal to the average annual benchmark of the prior five-year period until new benchmarks are approved by the joint standing committee.

Public Act 22-118: The Benchmarks and Inflation

- OHS must **review current and projected inflation annually** to determine whether to modify the benchmark for the coming year and must report its decision and reasoning.

Public Act 22-118: Benchmark Data Submissions

- Payers must submit data to OHS by **August 15th** of each year.
- OHS must meet with any payer or provider upon request to validate benchmark performance data and amend its findings, if necessary, prior to reporting.

Public Act 22-118: Benchmark Findings

- Starting in 2023, OHS must report the findings from its benchmark analyses, including any necessary contextualization, by **March 31st** of each year.
- OHS must identify payer and provider entities that exceeded the benchmark by **May 1st** each year and send official notice to each entity within 30 days.
- OHS must identify any other entities (such as drug manufacturers or pharmacy benefits managers) that significantly contributed to exceeding the benchmark by **May 1st** each year as well.

Public Act 22-118: Benchmark Hearings

- Starting in 2023, OHS must hold **an informational public hearing** on its Cost Growth Benchmark findings by **June 30th** of each year.
 - OHS may require any payer, provider, or other entity that is found to have been a significant contributor to healthcare cost growth in the state to provide testimony at this hearing.

Public Act 22-118: Report to the General Assembly

- By **October 15th** of each year (beginning in 2023), OHS must submit a report to the joint standing committee of the General Assembly that outlines:
 - healthcare spending trends;
 - plans for monitoring any unintended adverse consequences of the benchmark program, and
 - recommendations to increase the efficiency of the state's healthcare system (including, but not limited to, legislative proposals).

Other New Legislation

An Act Encouraging Primary and Preventive Care

- This piece of legislation requires health carriers to develop at least two health enhancement programs (HEP) by January 1, 2024.
- Each HEP must be available to each insured and provide coverage for certain preventive examinations and screenings.
- An HEP cannot impose a penalty or negative incentive on the insured, and the insured cannot be required to participate in an HEP.
- The insurance commissioner is authorized to adopt related implementing regulations.

Other New Legislation (cont.)

- The approved budget also contains key workforce investments, including funding for:
 - Private provider support
 - Salary increases, enhanced benefits, and infrastructure improvements
 - Connecticut State Colleges and Universities to support Healthcare Workforce Development
 - Child Psychiatrist Workforce Development
 - A DPH grant-in-aid program for a children's hospital in the state to coordinate a behavioral health training and consultation program

Benchmark Methodology Changes

Mitigating the Impact of High-Cost Outliers

- High-cost outliers are members/patients with extremely high levels of annual healthcare spending
 - The members/patients represent real spending that we need to represent in trend calculations. They mostly present randomly in a population, and there are limits to how much of their spending can be influenced due to their complex medical condition and high-intensity care needs.
 - Payer and provider performance against the benchmark can be significantly influenced by spending on high-cost outliers.

How to Address High-Cost Outliers

- It is common practice in total cost of care contracts to *truncate* expenditures when assessing financial performance, i.e., cap individual patient annual spending. This prevents a small number of patients from significantly affecting providers' per capita expenditures.
- Truncation is often applied by states to cost growth benchmark performance assessment.
 - Spending above the cap is *excluded* from benchmark performance assessment at the **payer** and **provider** entity levels.
 - Spending above the cap is *included* in benchmark performance assessment at the **state** and **market** levels.

Truncation Points by Market

- After consulting with payers and reviewing truncation points adopted in other states, OHS has decided on the following truncation thresholds to mitigate the impact of high-cost outliers at the payer and Advanced Network levels:
 - Commercial: \$150,000
 - Medicaid: \$250,000
 - Medicare Advantage: \$150,000

Applying Risk Adjustment

- Cost growth benchmark states typically risk adjust data to account for population changes over time.
 - The composition of a payer's or provider's population may change over the course of a year.
 - Such changes will impact spending growth, e.g., a population that is sicker than a year prior is expected to have higher spending than it would have otherwise.
- Risk adjustment is applied only at the payer and provider entity levels, since population changes are not significant at the market and state levels over the course of one year.

Coding Completeness and Rising Risk Scores

- The health status of a full population is typically fairly stable between consecutive years because changes in the demographic and health characteristics that might affect an entire population's risk score occur slowly.
- However, clinical risk scores can change annually without changes in the population's underlying risk due to improved documentation of patient condition on claims.

Risk-Adjustment Methodology Change

- After receiving input from the Steering Committee, OHS decided to adopt **age-sex risk adjustment** of payer and provider-level cost growth benchmark performance data.
 - Age/sex adjustment will capture the impact of an incrementally aging population, which may be the most significant change affecting population health status over the course of a year.
- OHS will model normalization of clinical risk scores using the APCD to evaluate the feasibility of implementing this methodology in the future.
 - Normalization supports recognition of population clinical profile changes while mitigating overall risk score increases due to coding.
 - This approach does not limit provider incentives to improve coding completeness.

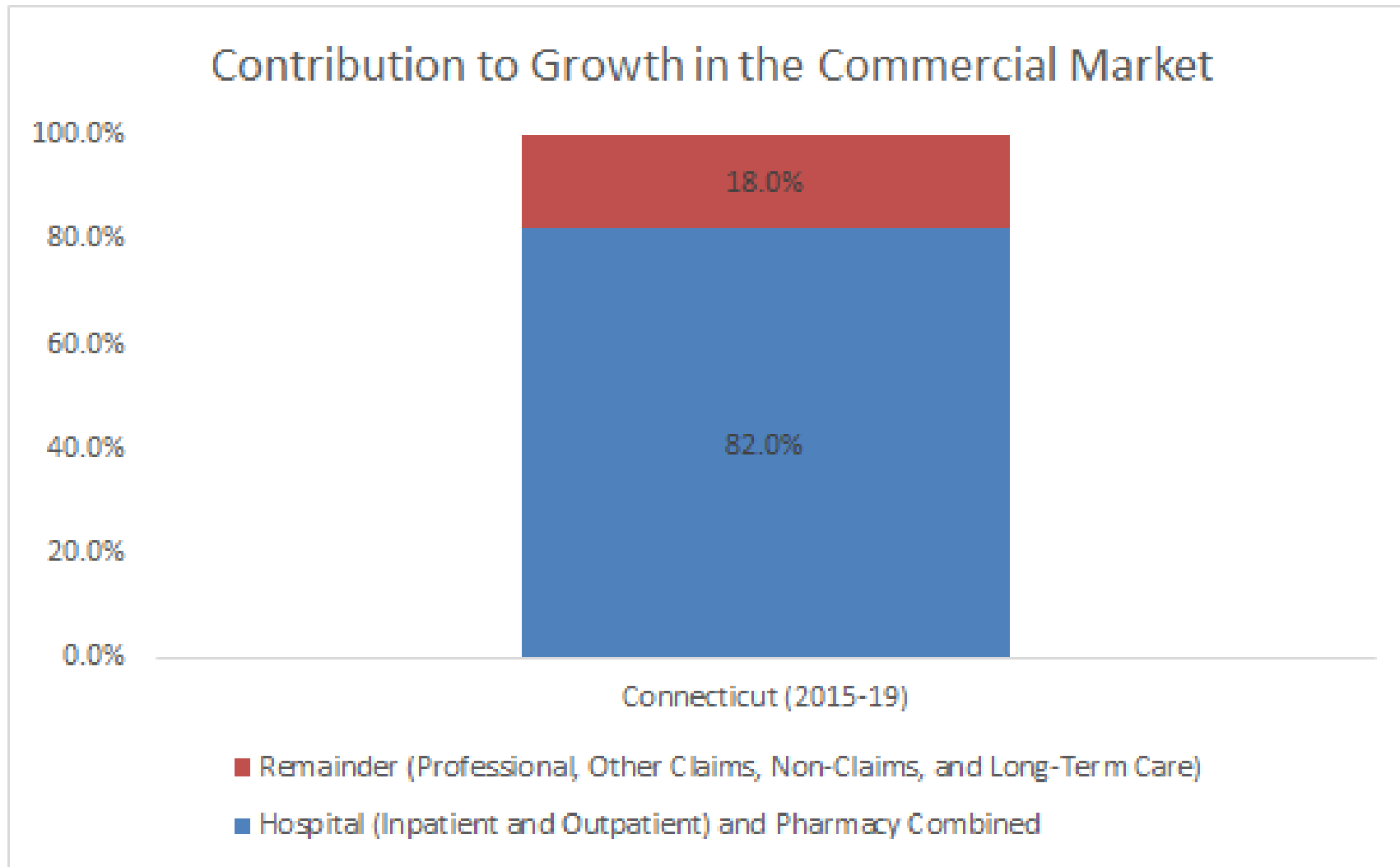
APCD Commercial Trend Analysis with Retail Pharmacy Added

Pharmacy was a Significant Contributor to Commercial Spending Growth Between 2015 and 2019, Pushing Up the All-Services Trend to 5.3% from 4.9%

Service Category	2015		2018		2019		2018-2019 change (%)	Average annual change (%)	Total change (%)	Change in category as percent of total PMPM change
	PMPM	%	PMPM	%	PMPM	%				
All services	\$480.24	100.0	\$565.02	100.0	\$589.13	100.0	4.3	5.3	22.7	100.0
Professional	\$169.69	35.3	\$183.77	32.5	\$188.73	32.0	2.7	2.7	11.2	17.5
Inpatient acute	\$78.57	16.4	\$94.02	16.6	\$98.71	16.8	5.0	5.9	25.6	18.5
Outpatient	\$126.03	26.2	\$151.53	26.8	\$163.82	27.8	8.1	6.8	30.0	34.7
Other	\$5.61	1.2	\$4.87	0.9	\$4.72	0.8	-2.9	-4.1	-15.8	-0.8
ED*	\$27.10	5.6	\$32.76	5.8	\$35.74	6.1	9.1	7.2	31.9	7.9
Pharmacy	\$100.34	20.9	\$130.84	23.2	\$133.14	22.6	1.8	7.6	32.7	30.1

* ED includes both professional and outpatient ED claims if delivered in an ED, and thus overlaps with Professional and Outpatient.

Hospital Services and Pharmacy Are Driving Cost Growth



Reasons for Commercial Hospital Price Growth

Reasons for Commercial Hospital Price Growth

- During a November Steering Committee meeting, a member asked for a presentation addressing two questions:
 1. **What has been behind hospital price growth?**
 2. **Is cost shifting occurring?**
- These questions are not being asked just in CT. Hospital price growth is an issue across the U.S. For this reason, we summarize national research on the following slides.

FEB 06, 2019

HEALTHCARE FINANCE

Growth in hospital prices outpaces that of physicians by nearly 20 percent, Health Affairs shows

Physician prices have seen a growth trend over the past several years, but between 2007 and 2014, hospital prices outpaced them, according to new research published in Health Affairs.

Healthcare Spending Increases

- We know that increases in healthcare spending can result from changes in a mix of factors, including:
 - Price
 - Service intensity
 - Utilization
 - Age
- The Mathematica analysis indicated that **hospital prices** were the main source of inflation in spending in the commercial market between 2015 and 2019. These findings are consistent with national research (Health Care Cost Institute 2020).

1. What Causes Hospital Prices to Increase?

- **Market power has been identified as the leading factor in commercial hospital price growth.**
- Hospital market power can be achieved by one or more of the following:
 - Being the only provider in a geographic area
 - Being a specialty provider (e.g., children's hospitals)
 - Horizontal consolidation and/or vertical consolidation
 - Consumer brand recognition, compelling an insurer to include in network
 - Transactions that mimic consolidation without shifting ownership (e.g., management contracts, joint ventures, long-term leases)

Research Findings That Point to Market Power as the Driving Force of Price Increases

- “Hospital prices are positively associated with indicators of hospital market power.” (Cooper et al, 2015)
- Hospitals and doctors who face less competition charge higher prices to private payers, without accompanying gains in efficiency or quality. The same is true for insurance markets. (Gaynor, 2020)
- “The preponderance of evidence suggest that hospital consolidation leads to higher prices.” (MedPAC, 2020)
- Price variations are correlated to market leverage. (MA Attorney General Coakley, 2010)

Do Hospitals with Market Power Always Appear in Highly Concentrated Markets?

- No. Those with high concentration have significant market power, but it's not a requirement.
- As noted earlier, there are other factors that confer market power.
- In fact, a September 2021 *Health Affairs* paper demonstrated that high hospital prices often appear in low concentration markets.

Hospital Consolidation Increases Market Power

- When hospital consolidation is between close competitors, it raises prices by substantial amounts. Research has shown 20-65% price increases after hospital mergers in concentrated markets.
 - The new prices are not a result of a one-time event. They tend to last over time.
- Hospitals that consolidate in different markets can still garner increased prices on the order of 7-17%, taking advantage of multi-state employers who may favor insurance plans with provider networks covering all their employees.

What Has OHS Been Doing About Market Consolidation?

OHS has been taking the following actions within existing Certificate of Need (CON) laws to address consolidation:

- Administration of the CON requirements
- Application of future price caps put on mergers and acquisitions
- Requirements for negotiations with individual hospitals and not systems
- Banned IP and OP facility fees in CON transactions
- Added conditions on transactions to increase hospital systems' investments in community benefits
- Communicated concerns with gaps in CON laws to executive and legislative branches and the Attorney General's office
- Assembled physician practice work group to make recommendations re: vertical acquisitions and related acquisitions in outpatient space that affect market power
- Made recommendations re: acquisitions that affect market power based on continuous review of provider group acquisitions.

Internal OHS analyses have suggested that price conditions may be having the intended mitigating impact on high commercial price growth for affected hospitals.

2. Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

- **“Hospital cost shifting”** is defined as hospitals charging private payers more in response to shortfalls in public payments. That hospitals charge one payer more because it received less (relative to costs or trend) from another is widely believed. (Frakt, 2011)
- Are low public payer rates a problem for hospitals? *Certainly.* A higher share of hospital revenue from Medicaid has been associated with increased odds of hospital financial distress. (Enumah, 2021)
 - Does this mean that low public payer rates drive the rate of commercial hospital price growth?

No.

Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

- Reviews of empirical evidence and other studies have repeatedly failed to find substantial evidence that cost shifting exists. (Wu, 2010; Frakt, 2011; Dranove et al, 2017, RAND, 2020)
- **“...the preponderance of the evidence suggests that hospitals do not engage in cost shifting.** Moreover, the idea of cost shifting is inconsistent with economic theory: If hospitals could charge private payers more, it is unclear why they would do so only after payment cuts from public payers.” (Congressional Budget Office, 2022)

Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

- “If hospitals were able to cost shift, then hospitals with larger shares of Medicare and Medicaid patients (for whom prices are relatively low) would be paid relatively high prices by commercial insurers. However, **CBO’s analysis of data for more than 1,500 hospitals indicates a weak cross-sectional relationship between commercial insurers’ average prices for a hospital’s inpatient and outpatient services during the 2016–2018 period and the percentage of Medicare and Medicaid patients among the hospital’s discharges.**” (Congressional Budget Office, 2022)

Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

- What hospitals may do (as do many other businesses in various industries) is *price discriminate*. Meaning, they charge one payer (or customer) more than another for the same set of services up to what the market will bear.
- **Price discrimination is not the same as cost shifting.**
- “Cost shifts are driven by strategic hospital decisions, not by shortfalls from public insurance.” (CO Dept of Health Care Financing and Policy, 2020)
- “...hospitals that get paid more or have a better payer mix tend to spend more and cost more.” (CT hospital CEO, 2022)

Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

- The empirical literature finds that to the extent cost shifting has occurred at all, it is at a low rate. Instead, the vast majority of public payers' shortfalls are accommodated by cost *cutting*, not cost *shifting*. (Frakt, 2011)
- MedPAC has shown that the ability or willingness of hospitals to control their operating costs is directly related to the level of negotiating power they face from both public and private payers in a given market. When hospitals have more power, they are less likely to control costs. (Catalyst for Payment Reform, 2017)

Do Hospitals Negotiate Higher Prices to Make Up for Low Public Payer Rates (i.e., Cost Shift)?

Percentage of Payments from Private Payers in 2019	Average Annual Percent Change in Payments per CMAD 2016-2019
<50% private pay hospitals (median)	4.30%
≥50% private pay hospitals (median)	6.92%

- This table shows that CT hospitals receiving a greater proportion of payments from private payers had higher growth in payments per CMAD than those more dependent on public payers.
- If there was a “cost shift,” those with fewer private pay patients should have had *faster* growing payments per CMAD, not *slower* growing payments.

Key Takeaways

- 1. Market power is driving high growth in hospital prices.**
- 2. Market power can be achieved through multiple means, including consolidation.**
 - Hospital consolidations have received increased scrutiny, so more research has been conducted on its effects than on other means.
 - Many policymakers are now addressing vertical acquisitions and capital spending as issues that contribute to market power and higher prices.
- 3. The act of cost shifting isn't borne out in the literature as the reason for high hospital prices.** Cost cutting has been proven to be the tool used to respond to low government payer rates.

Commercial Pharmacy Spending Analyses

The study population

- CT residents, 2017-2019
- Commercial (fully insured, and State employees and retirees)
 - Self-insured not otherwise included
- Exclusions
 - Non-CT residents
 - Secondary payers
 - Denied, reversed, and non-primary claim lines
 - Claim lines with negative payment or cost-sharing
 - Payments after six months of the service year

Pharmacy Costs

“Retail Pharmacy” costs or spend

- Prescription medicines purchased in retail pharmacies or via mail order

“Medical Pharmacy” costs or spend

- Prescriptions administered in providers’ offices and hospitals

PMPM Spending

In 2019, 28% of commercial spending was on Pharmacy Services (Retail and Medical)

/ Pharmacy spending was greater than inpatient or outpatient spending, second only to professional.

Service Category	Percentage of Spending		
	2017	2018	2019
Inpatient	17.3%	17.4%	17.6%
Outpatient	22.3%	22.5%	23.4%
Professional	31.0%	30.6%	30.1%
Pharmacy	28.4%	28.6%	28.0%
<i>Retail*</i>	21.2%	21.1%	20.2%
<i>Medical**</i>	7.1%	7.5%	7.9%
Other***	1.1%	0.9%	0.9%

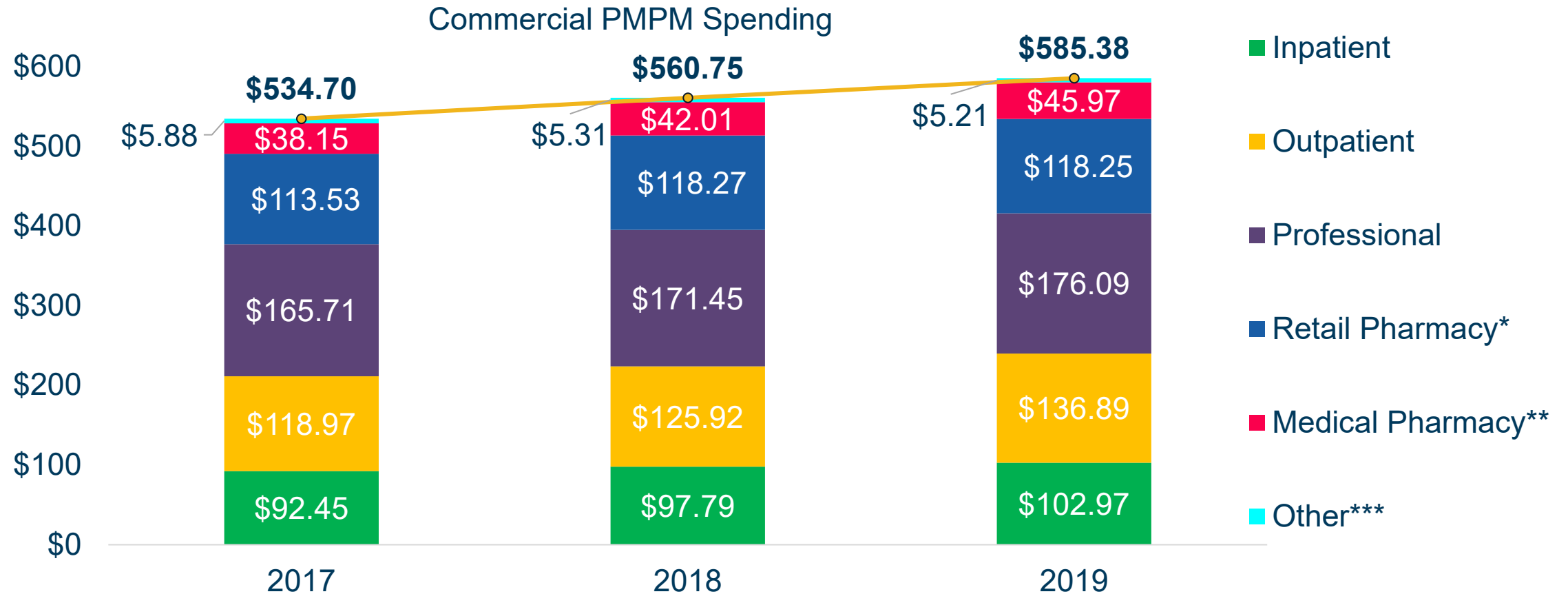
* Retail pharmacy includes all members with pharmacy coverage, regardless of medical coverage.

**Medical pharmacy amounts are subtracted from respective medical service categories

***"Other" services include DME, home health, hospice, ICF and SNF claims.

Professional, outpatient and pharmacy services were the top three contributors to commercial PMPM spending growth

Spending for medical pharmacy increased the most (+20.5%), followed by outpatient spending (15.0%) and inpatient spending (+11.4%)

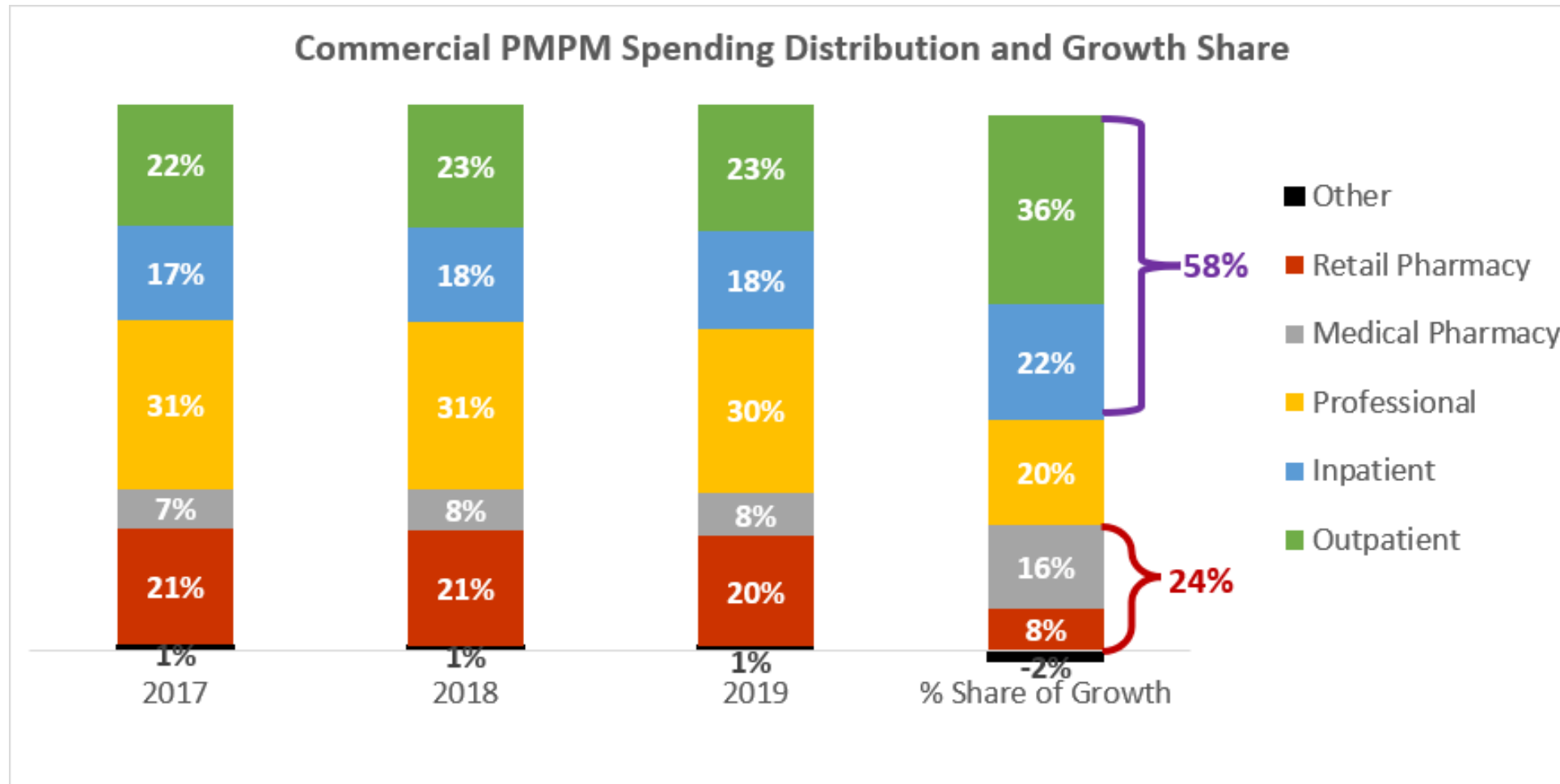


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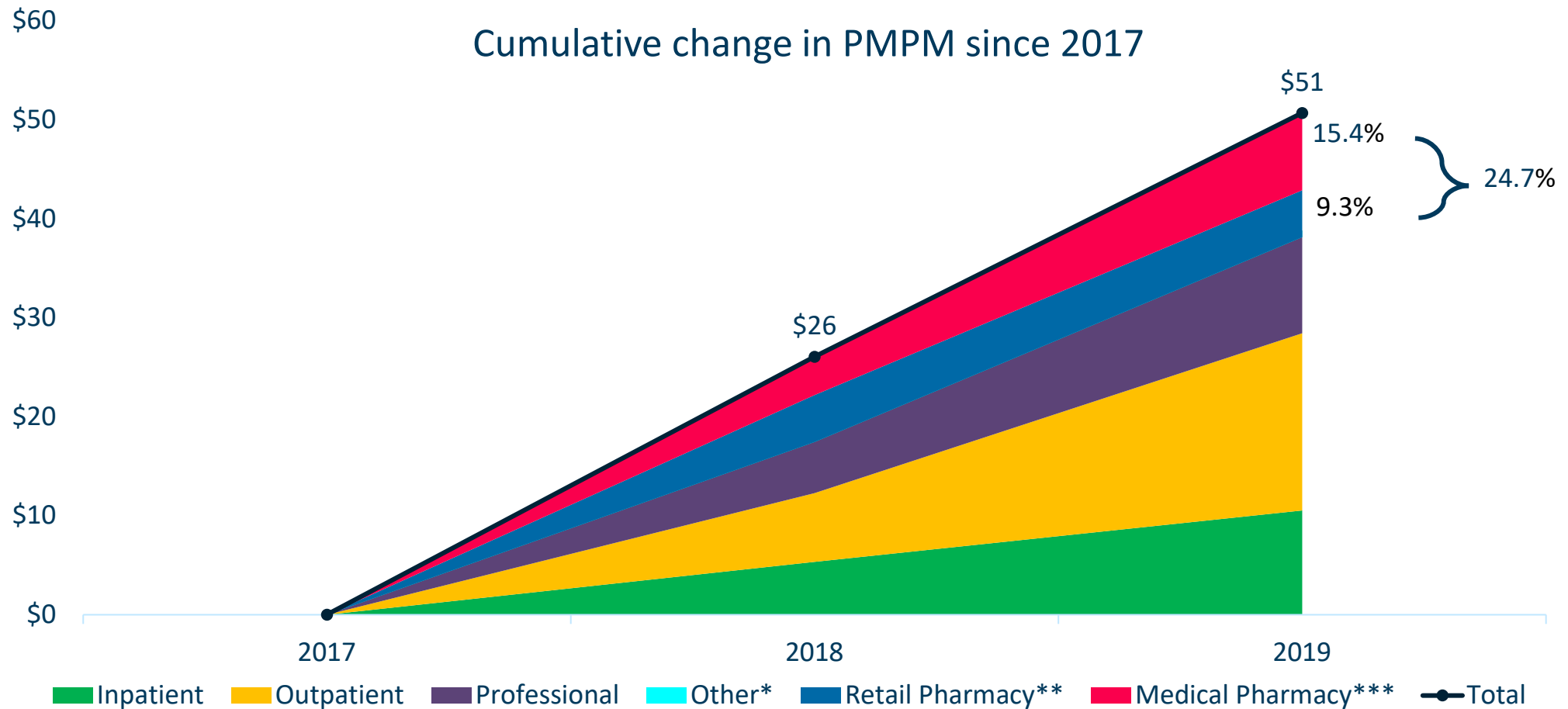
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Retail and Medical Pharmacy share of commercial PMPM spending was consistent over time, because hospital spending growth was so high



About one-quarter of cost increases between 2017 and 2019 were due to Retail and Medical Pharmacy



* 'Other' services include DME, home health, hospice, ICF and SNF claims.

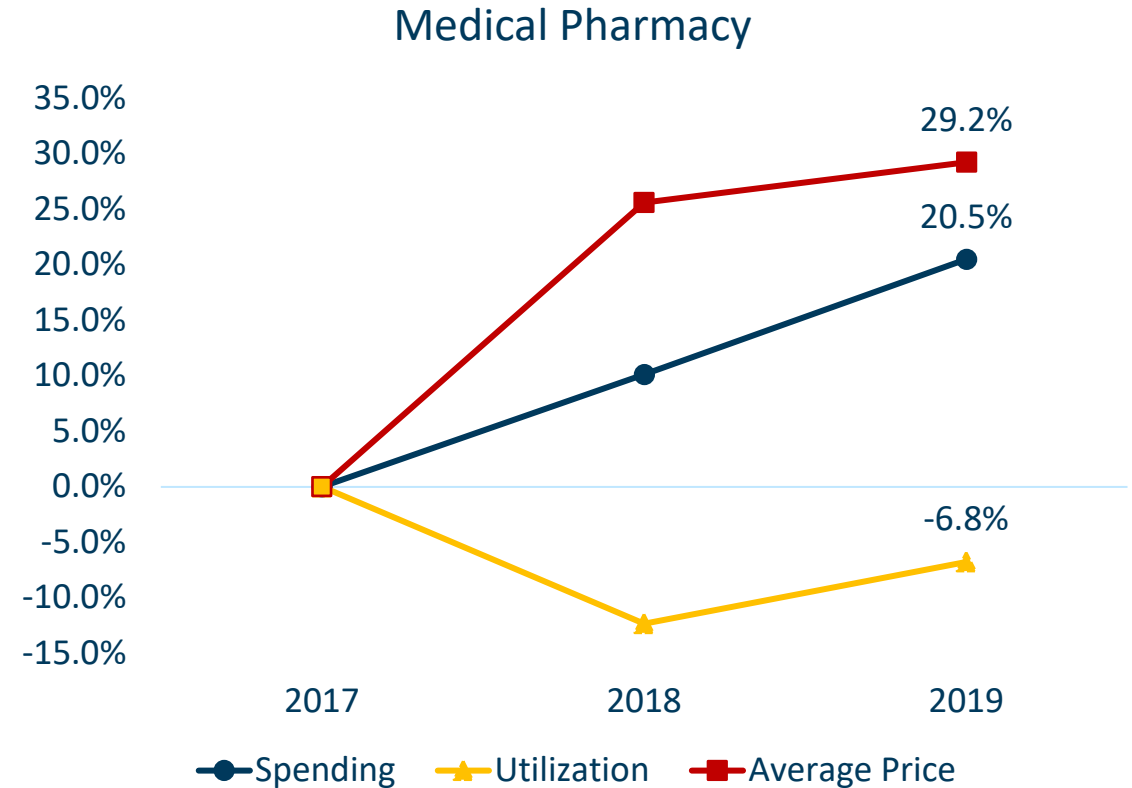
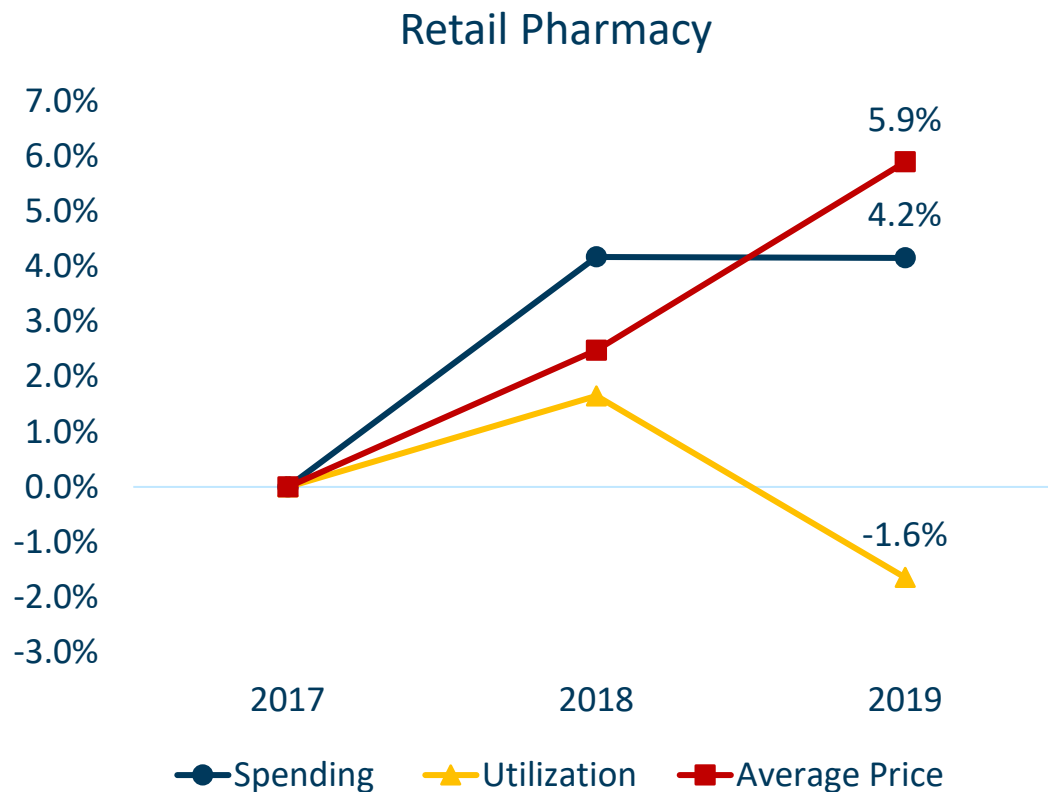
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Utilization vs Price

Price increased for both Retail and Medical Pharmacy while utilization declined

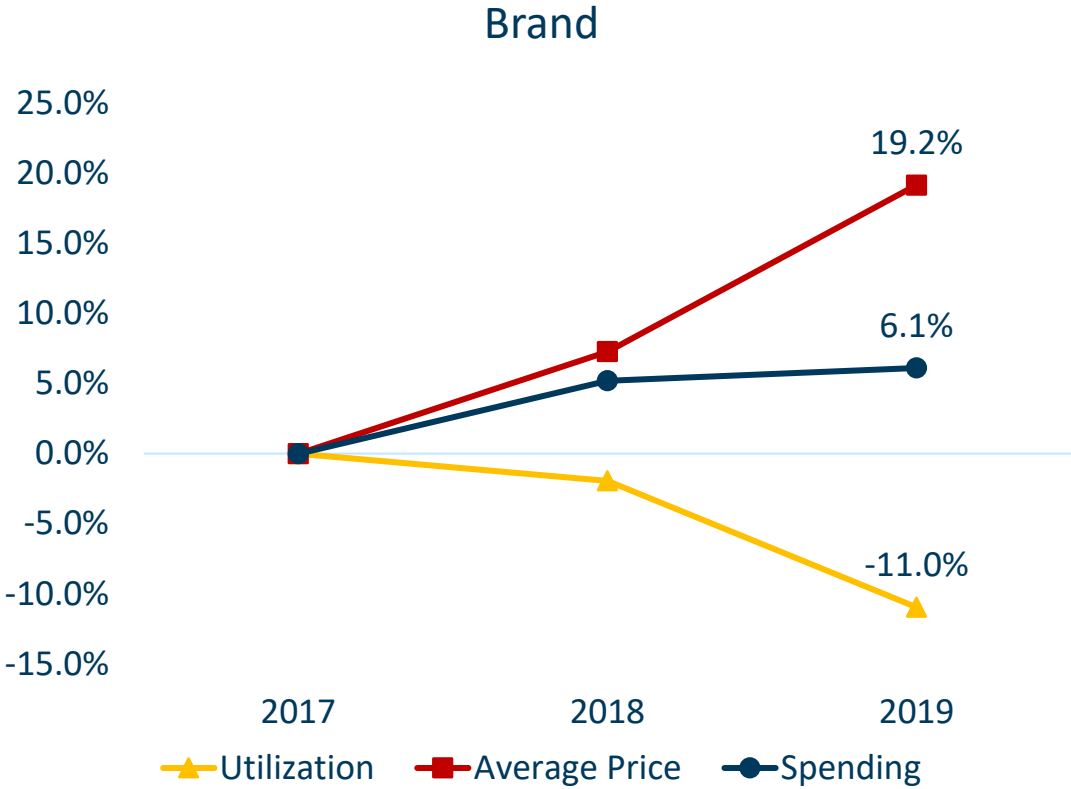
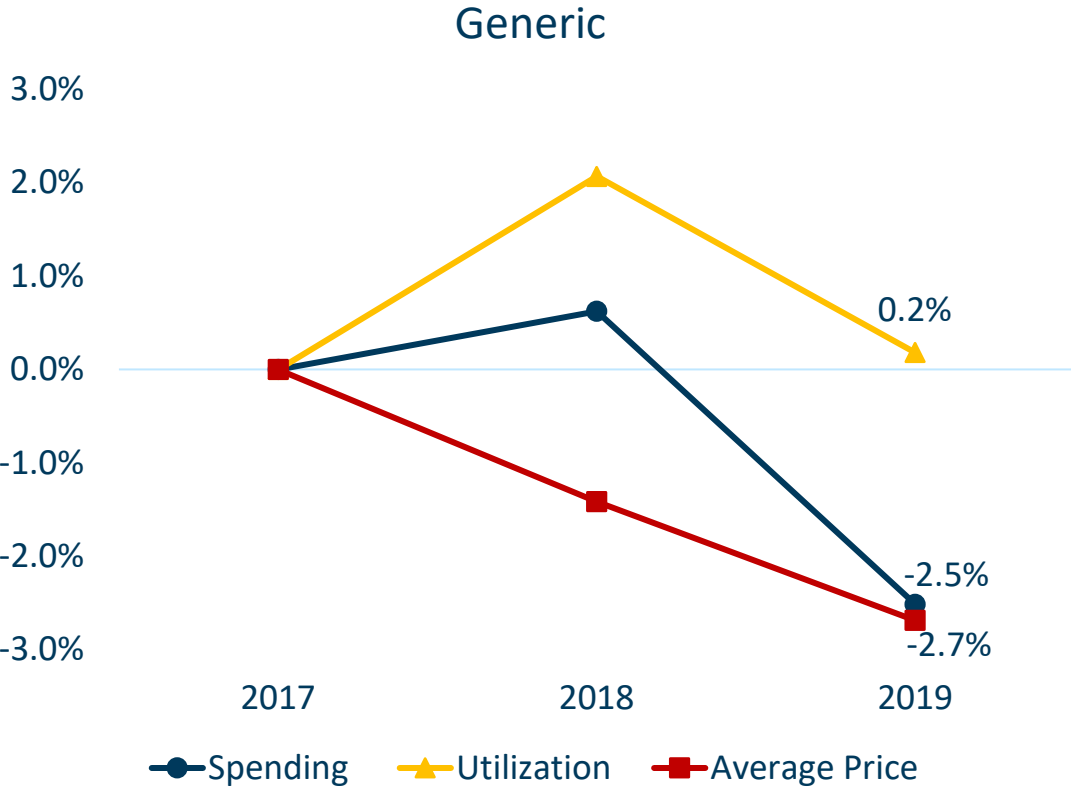
- / Average price and spending increased at a far higher rate for Medical Pharmacy than for Retail Pharmacy.
- / Utilization fell more sharply for Medical Pharmacy than Retail Pharmacy.



Spending = PMPM; Average price = Spending per prescription; Utilization = prescriptions per member month

Utilization of generic retail drugs remained flat while price and spending fell, while the opposite trend occurred with brand-name retail drugs

Despite this downward trend in utilization, spending and price trended upward for brand drugs.



Spending = PMPM; Average price = Spending per prescription; Utilization = prescriptions per member month

Pharmacy Costs: Deeper Dive

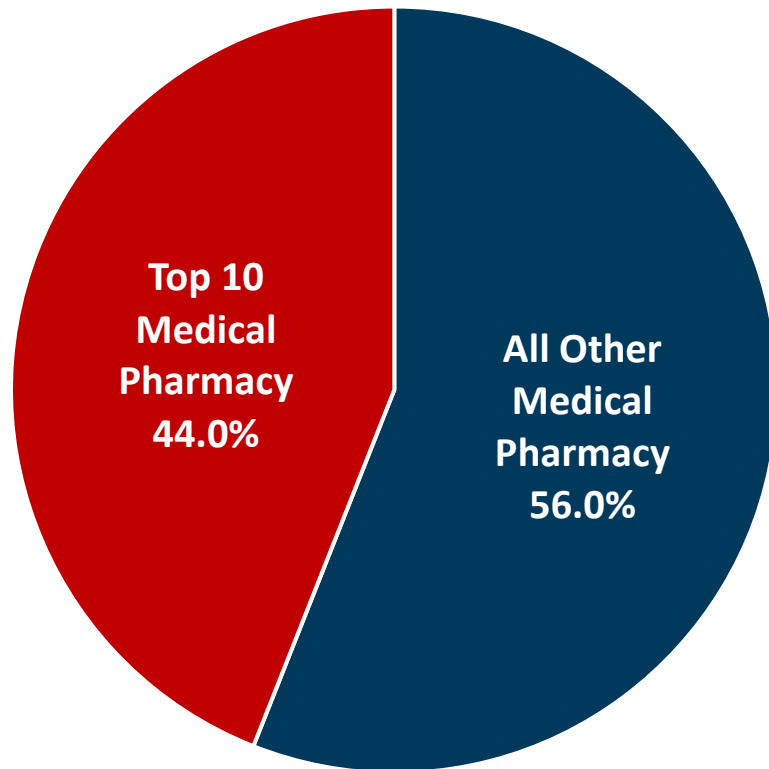
The top 10 medications for medical pharmacy spending in 2019 were drugs primarily used to treat cancer, Crohn's disease, and multiple sclerosis

Medical Pharmacy Spend: Top 10 Medications (Total Allowed), 2019

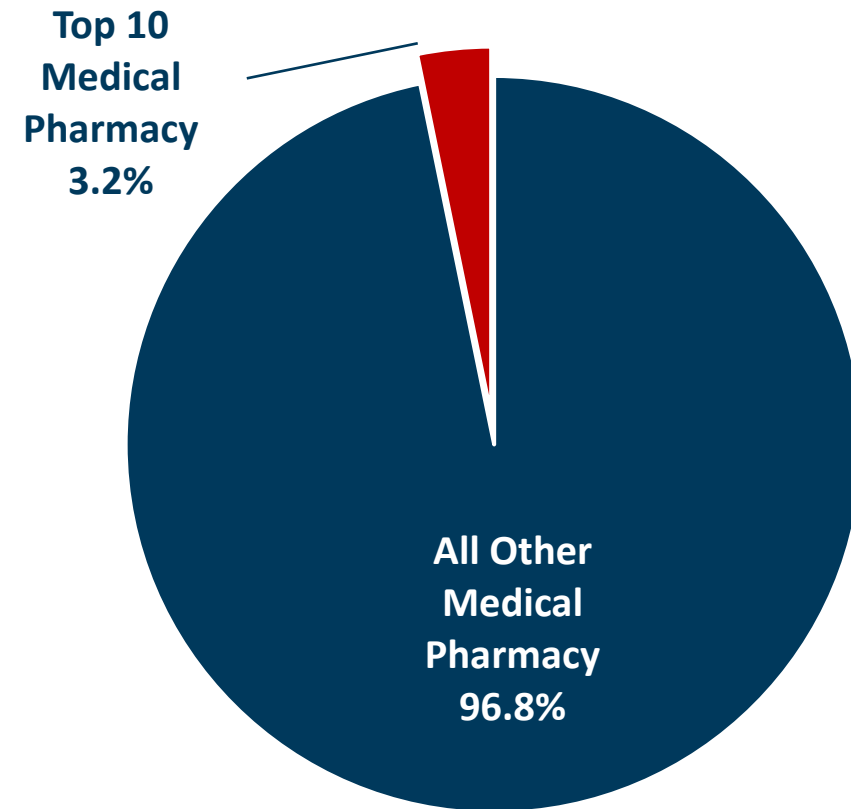
Medication	Indication	Allowed Amount	Distinct Users	# of Claims	Price (Allowed / # Claims)
INJECTION OCRELIZUMAB 1 MG	Multiple Sclerosis	\$37,866,205	690	774	\$48,922.75
INJ INFLIXIMAB EXCL BIOSIMILR 10 MG	Rheumatoid Arthritis, Psoriasis, Crohn's disease, Ulcerative colitis	\$35,080,751	5,944	7,607	\$4,611.64
INJ TRASTUZUMAB EXCLD BIOSIM 10 MG	Cancer (breast, stomach)	\$21,272,959	1,563	3,613	\$5,887.89
INJECTION PEMBROLIZUMAB 1 MG	Cancer (melanoma, lung, bladder)	\$18,750,009	808	1,095	\$17,123.30
INJECTION RITUXIMAB 10 MG	Cancer, autoimmune disease	\$18,642,495	929	1,573	\$11,851.55
INJECTION PEGFILGRASTIM 6 MG	Cancer treatment side effect	\$17,266,445	1,449	2,017	\$8,560.46
INJECTION VEDOLIZUMAB 1 MG	Crohn's disease, Ulcerative colitis	\$16,938,383	2,199	2,375	\$7,131.95
INJECTION BEVACIZUMAB 10 MG	Cancer (colon, lung, brain, cervical, renal, ovarian)	\$13,335,447	1,937	3,200	\$4,167.33
INJECTION PERTUZUMAB 1 MG	Cancer (breast)	\$12,441,323	849	1,184	\$10,507.87
INJECTION NATALIZUMAB 1 MG	Multiple Sclerosis, Crohn's disease	\$10,820,739	1,313	1,477	\$7,326.16

The top 10 Medical Pharmacy medications comprised 3% of all prescriptions and 44% of all spending

Spending on Medical Pharmacy



Volume of Medical Pharmacy



The top 10 medications for Retail Pharmacy spending in 2019 were drugs primarily used to treat arthritis, multiple sclerosis, and psoriasis

Retail Pharmacy Spend: Top 10 Medications (Total Allowed), 2019

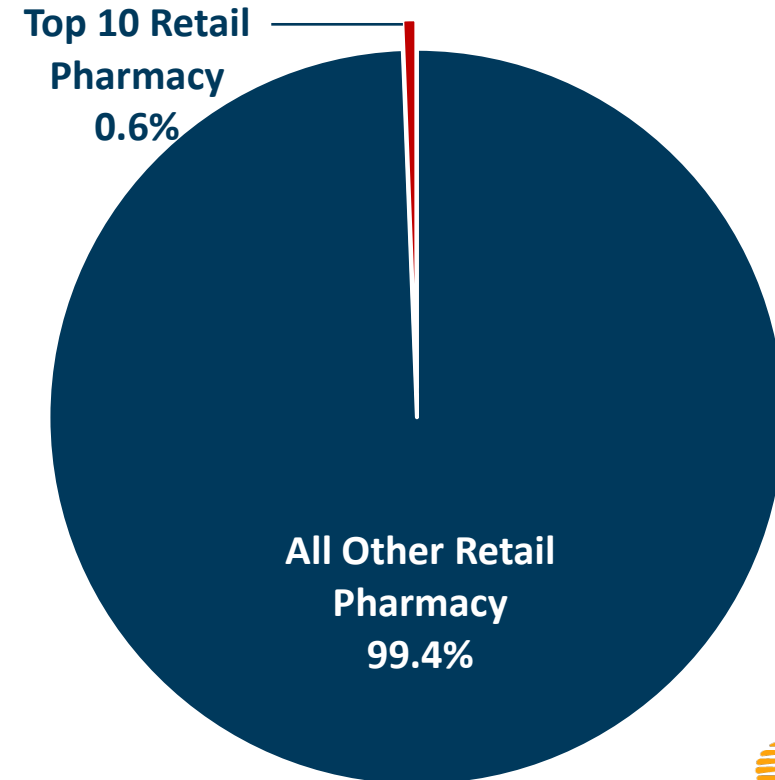
Medication	Indication	Allowed Amount	Distinct Users	# of Claims	Price (Allowed / # Claims)
HUMIRA PEN 0.4 ML	Rheumatoid arthritis, Crohn's disease, psoriasis	\$56,924,279	7,803	8,970	\$6,346.07
HUMIRA PEN 0.8 ML	Rheumatoid arthritis, Crohn's disease, psoriasis	\$54,638,434	7,168	8,221	\$6,646.20
STELARA 90 MG/ML SYRINGE	Psoriasis, Crohn's disease	\$38,336,167	1,772	1,920	\$19,966.75
ENBREL SURECLICK	Rheumatoid arthritis, psoriasis	\$26,077,264	4,177	4,696	\$5,553.08
TECFIDERA	Multiple sclerosis	\$22,419,921	2,455	2,878	\$7,790.10
OTEZLA	Psoriatic arthritis and plaque psoriasis	\$17,735,746	4,475	5,062	\$3,503.70
GILENYA	Multiple sclerosis	\$17,370,060	1,773	1,968	\$8,826.25
ELIQUIS 5 MG TABLET	Deep vein thrombosis, pulmonary embolism	\$15,365,839	24,950	26,636	\$576.88
VICTOZA	Diabetes	\$15,144,633	10,792	11,606	\$1,304.90
DUPIXENT 300 MG/2 ML SYRINGE	Asthma	\$15,020,931	3,961	4,768	\$3,150.36

The top 10 Retail Pharmacy prescriptions comprised <1% of all prescriptions and 15% of all spending

Spending on Retail Pharmacy



Volume of Retail Pharmacy



Key Takeaways

- 1. Drug prices and spending increased, while utilization decreased.**
 - Average price and spending increased at a higher rate for medical pharmacy than retail pharmacy.
- 2. A disproportionately large share of pharmacy spending is on a small number of very expensive drugs.**
 - These drugs are primarily used to treat cancer, arthritis, Crohn's disease, multiple sclerosis, and psoriasis.
- 3. The price problem is with brand-name retail drugs and Medical Pharmacy, and not generics despite the occasionally publicized examples of generic price gouging.**

This analysis does not answer the question of whether the growth in prices is about new drugs at higher price points or increases in "old" drugs.

What's Next?

1. Now that we know that hospital and pharmacy prices and have been driving high spending growth in the commercial market, it is time to begin to contemplate strategies that will address these cost drivers.
2. OHS will also update its commercial market analyses with 2020 and 2021 data over the next few months.
3. OHS will replicate the analyses with Medicaid data when those data become available to OHS shortly.

Wrap-up & Next Steps

Next Steps

- The next Stakeholder Advisory Board meeting will be held on Thursday September 8th from 2:00-4:00 p.m.

Adjourn

