Healthcare Benchmark Initiative Stakeholder Advisory Board

Meeting Date	Meeting Time	Location
June 9, 2022	2:00 pm – 4:00 pm	Zoom Meeting Recording https://us02web.zoom.us/j/89533007205?pwd=L2hHcnRDRnVpU203UzlBTWVuUElMZz09

Participant Name and Attendance | Steering Committee Members					
Rebecca Andrews	R	Hector Glynn	R	Richard Searles	X
Pareesa Charmchi Goodwin	X	Angela Harris	R	Kelly Sinko Steuber	R
Reggy Eadie	X	Susan Millerick	R	Marie Smith	R
Tekisha Everette	X	Lori Pasqualini	X	Kristen Whitney-Daniels	R
Howie Forman	R	Luis Perez	X	Jill Zorn	X
Jonathan Gonzelez-Cruz	R	Theresa Riordan	R		
Jeannina Thompson, OHS	R	Hanna Nagy, OHS	R	Michael Bailit, Bailit Health	R
Krista Moore, OHS	R	Olga Armah, OHS	R	Matt Reynolds, Bailit Health	R
		R = Attended Remotely; **IP** = In Person; **X** = Did Not Attend			

Agenda

	Topic	Responsible Party	Time
1.	**Call to Order**	**Kelly Sinko Steuber**	**2:00 pm**
	Kelly Sinko Steuber welcomed everyone to the June Stakeholder Advisory Board meeting and reviewed the agenda for the meeting. Kelly then invited Matt Reynolds to conduct a roll call. While there was not a quorum present at the time of roll call, there was a quorum when the minutes were voted on and when the meeting was adjourned.		
2.	**Public Comment**	**Members of Public**	**2:05 pm**
	Kelly Sinko Steuber offered the opportunity for public comment. There were no public comments.		
3.	**Board Action: Approval of March 10, 2022 Minutes**	**Board Members**	**2:10 pm**
	Susan Millerick motioned to approve the minutes. Angela Harris seconded the motion. There was no opposition nor any abstentions. The minutes were approved.		
4.	**Public Act 22-118 and Other New Legislation**	**Kelly Sinko Steuber**	**2:15 pm**
	Kelly Sinko Steuber informed the Stakeholder Advisory Board that Public Act 22-118 put the Healthcare Cost Growth Benchmark Initiative into statute. Kelly also reviewed key information from the bill: • By July 1, 2025, and every five years thereafter, OHS must set benchmarks for the next five years and hold one informational public hearing prior to doing so. • OHS must review current and projected inflation annually to determine whether to modify the benchmark for the coming year. • Payers must submit data to OHS by August 15th of each year and OHS must meet with any payer or provider who so requests to validate their data. • OHS must report its findings by March 31st of each year and identify payers, providers, and other entities that exceeded the benchmark by May 1st of each year. • OHS must hold an informational public hearing on its findings by June 30th of each year and may require any entity that exceeded the benchmark to provide testimony. • By October 15th of each year, OHS must submit a report to the joint standing committee of the General Assembly outlining spending trends, plans for monitoring adverse consequences, and legislative proposals.		

	Kelly then provided a summary of An Act Encouraging Primary and Preventive Care, which requires health carriers to develop at least two health enhancement programs (HEPs) by January 1, 2024. Each HEP must be available to each insured and provide coverage for certain preventive examinations and screenings. Kelly shared that the budget bill also contained funding for key workforce investments such as private provider support, salary increases, enhanced benefits, infrastructure improvements, Connecticut State Colleges and Universities to support Healthcare Workforce Development, Child Psychiatry Workforce Development, and a DPH grant-in-aid program for a children's behavioral health training and consultation program.		
5.	**Benchmark Methodology Changes**	**Michael Bailit**	**2:30 pm**
	Michael Bailit shared two changes that OHS made to the benchmark methodology after consulting with its Steering Committee. Michael noted the changes would go into effect for data collection in 2022. He described the changes as follows: 1. Truncating high-cost member/patient outliers at the payer and provider entity levels. Michael shared that the truncation points by market were set at: a. Commercial: $150,000 b. Medicaid: $250,000 c. Medicare Advantage: $150,000 2. Switching from clinical risk adjustment to age-sex risk adjustment of payer and provider entity-level cost growth benchmark performance data. a. Michael Bailit noted that OHS would model normalization of clinical risk scores using the APCD to evaluate the feasibility of implementing this methodology in the future.		
6.	**APCD Commercial Trend Analysis with Retail Pharmacy Added**	**Michael Bailit**	**2:40 pm**
	Michael Bailit shared that between 2015 and 2019, retail pharmacy spending grew an average of 7.6% per year. In response to a question from Marie Smith, Michael noted that while benchmark data does include rebates, the APCD data that Mathematica used for the analysis he was presenting did not include drug rebates. Michael noted that hospital (inpatient and outpatient) and pharmacy spending combined accounted for 82% of total spending growth in the commercial market between 2015 and 2019. Susan Millerick asked if this was different from earlier years. Michael noted that what was new was the introduction of very expensive medical pharmacy medications. Michael shared that the commercial market spending analysis would be updated in the next few months with 2020 and 2021 data. In addition, the analysis will be replicated with Medicaid data.		
7.	**Reasons for Commercial Hospital Price Growth**	**Michael Bailit**	**2:45 pm**
	Michael Bailit presented information that had been provided to the Steering Committee in March in response to questions posed by a Steering Committee member. <u>What has been behind hospital price growth?</u> Michael Bailit shared research that showed market power has been the leading factor in commercial hospital price growth in the U.S. Kelly Sinko Steuber informed the Steering Committee of the actions OHS had been taking to address market consolidation, a significant contributor to market power. <u>Is cost shifting occurring?</u> Michael Bailit shared that repeated national research has indicated that hospitals do not shift health care costs from public payers to private payers, but rather price discriminate, meaning they charge one payer more than another for the same set of services up to what the market will bear. Instead, research shows, hospital financial shortfalls on public payer business are generally accommodated by cost cutting, not cost shifting. Susan Millerick asked if cost shifting had stopped happening or if it was always fictitious. Michael Bailit stated that he could not say; he could only say that studies show that it has not been occurring.		

8.	**Commercial Pharmacy Spending Analyses**	**Michael Bailit**	**3:25 pm**
	Michael Bailit shared information on commercial pharmacy spending that had been presented to the Steering Committee in May. Michael shared that pharmacy spending had accounted for a quarter of spending growth between 2017 and 2019. He noted that pharmacy spending growth was due to increases in price, and not utilization. For retail pharmacy, Michael added that the issue is specifically for brand name drugs, and not generics. Rebecca Andrews asked what other states have done about expensive medical pharmacy medications for conditions like cancer and multiple sclerosis. Michael Bailit stated no states have grappled with this. He noted that the challenge is that manufacturers can introduce the drugs at whatever price point they want. Rebecca asked if this should be addressed at a federal level because she did not see how one state could make an impact. Michael noted that neither political party has been able to take action on pharmacy prices at the federal level and thus he thought that unfortunately, states would have to act in concert with one another, if not individually. Michael displayed analysis showing that a disproportionately large share of medical pharmacy, i.e., physician-administered drugs, spending has been on a small number of very expensive drugs. Michael shared that this analysis did not answer the question of whether the growth in prices was about new drugs at higher price points, or price increases for drugs already in the market. Marie Smith wondered how 340B contracting by health systems came into play, noting that provider organizations generate significant margins on these drugs. Michael Bailit noted that 340B pricing would likely be discussed when the Steering Committee and Stakeholder Advisory Board discuss pharmacy price strategies at their next meetings.		
9.	**Wrap-Up and Next Steps**	**Kelly Sinko Steuber**	**3:55 pm**
	Kelly Sinko Steuber stated that the next meeting would be held on Thursday, September 8th from 2-4 pm.		
10.	**Board Action: Adjournment**	**Board Members**	**4:00 pm**
	Susan Millerick motioned to adjourn the meeting. Angela Harris seconded the motion. The meeting adjourned at 3:17 pm.		

Upcoming Meeting Dates:
Thursday, September 8
Thursday, December 8

All meeting information and materials are published on the OHS website located at:
https://portal.ct.gov/OHS/Pages/Cost-Growth-Benchmark-Stakeholder-Advisory-Board/Meeting-Agendas