Cost Growth Benchmark Technical Team Meeting

Meeting Date	Meeting Time	Location
May 19, 2020	3:00 pm – 5:00 pm	Webinar/Zoom

Participant Name and Attendance

Cost Growth Benchmark Technical Team					
Rebecca Andrews		Paul Grady		Kate McEvoy for Deidre Gifford	
Patricia Baker		Angela Harris		Rae-Ellen Roy for Melissa McCaw	
Judy Dowd		Paul Lombardo			
Others Present					
Michael Bailit		January Angeles		Olga Armah	
Megan Burns		Margaret Trinity		Jason Prignoli	
Members Absent:					
Luis Perez					
Zack Cooper					

Meeting Information is located at: https://portal.ct.gov/OHS/Services/Cost-Growth-Benchmark/Technical-Team

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Victoria Veltri, OHS**
	Victoria (Vicki) Veltri called the meeting to order.	
2.	**Public Comment**	**Victoria Veltri, OHS**
	There were no public comments.	
3.	**Approval of the CGB Technical Team Meeting Minutes**	**Victoria Veltri, OHS**
	Rae-Ellen Roy made a motion to approve the Technical Team's March 17th meeting minutes and was seconded by Pat Baker. The minutes were approved by roll call vote, with supporting votes from Judy Dowd, Kate McEvoy, Paul Lombardo, Rae-Ellen Roy, Angela Harris, Pat Baker, and Vicki Veltri. Paul Lombardo made a motion to approve the Technical Team's May 5th meeting minutes and was seconded by Pat Baker. The May 5th meeting notes were approved by a roll call vote, with supporting votes from Judy Dowd, Kate McEvoy, Paul Lombardo, Rae-Ellen Roy, Angela Harris, Pat Baker, and Vicki Veltri.	
4.	**Vote on Vice Chair and Amended Charter**	**Victoria Veltri, OHS**
	Paul Grady made a motion to add to the May 19th meeting agenda a vote to appoint a Vice Chair and was seconded by Paul Lombardo. The motion was approved by roll call vote, with supporting votes from Judy Dowd, Kate McEvoy, Paul Lombardo, Rae-Ellen Roy, Angela Harris, Pat Baker, and Vicki Veltri. Vicki Veltri stated that the Technical Team charter had been amended to include an additional focus on quality of care. Pat Baker submitted a motion to approve the charter as amended and it was seconded by Paul Lombardo. The amended charter was approved by a roll call vote with supporting votes from Judy Dowd, Kate McEvoy, Paul Lombardo, Rae-Ellen Roy, Angela Harris, Pat Baker, and Vicki Veltri.	
5.	**Defining Total Health Care Expenditures**	**Michael Bailit, Bailit Health**
	Michael Bailit reviewed the Governor's Executive Order #5 definition of total health care expenditures (THCE), which is "the per capita sum of all health care expenditures in this state from public and private sources for a given calendar year." He noted that HB 5018 provides more specificity to this definition, but the definition was still broad. He then reviewed other states' definitions of THCE as points of reference, and described the components of THCE: a) all categories of medical expense claim payments and all non-claims payments; b) all patient cost-sharing amounts, including but not limited to deductibles and copayments, and c) the net cost of private health insurance.	

Michael stated that Delaware, Massachusetts and Rhode Island define non-claims-based spending to include non-claims incentive program payments, prospective service payments, risk settlements, care management payments, recovery payments, and all other miscellaneous payments such as grants or other payments that do not fall under the other five categories of payments. He noted that Delaware and Rhode Island include recoveries, but Massachusetts does not. Kate McEvoy stated that it would be useful for the State's Medicaid program if the definition of THCE that is adopted include within non-claims-based payments Disproportionate Share Hospital (DSH) payments as well as certified public expenditure arrangements for mental health services. Michael replied that there are examples from other states of how they have handled such non-claims-based payments in Medicaid.

Michael Bailit asked the Technical Team members how they would like to address recoveries, as they are not treated consistently across the three comparator states. Paul Lombardo stated that recoveries are related to audits of claims processing where the carrier has overpaid. Michael Bailit said that recovery payments also include improper payments, adding that he did not know why Massachusetts did not include recovery payments in its definition of non-claims-based payments. Pat Baker stated that she agreed with Paul Lombardo that recovery payments should be included in Connecticut's definition of THCE, and suggested that the Technical Team consider stipulating a timeframe for inclusion of recoveries. Rae-Ellen Roy agreed that recoveries should be included in the definition of TCHE. Rebecca Andrews voiced her support for inclusion of recovery payments in the TCHE definition.

Vicki Veltri reported that inclusion of dental services had been raised by a member of the Stakeholder Advisory Board at its May 14th meeting. Michael Bailit shared that dental services have not been included in other states' THCE definitions. He said that dental services were often covered by dental insurers and states have chosen to focus on a traditional definition of medical services. Paul Lombardo asked if dental service providers would be held accountable to the benchmark if the benchmark included dental expenditures. Vicki Veltri stated that OHS had not originally envisioned including dental services in the THCE definition. Michael stated that accountability for a benchmark is typically at the state level, the insurer level, or large provider level (excluding dental providers). He explained that the larger question was whether we should be holding the State and large providers accountable for dental services.

Paul Lombardo noted that large provider groups and insurers have little control over dental services. Vicki Veltri said that the State conducts little monitoring of dental spending, and that the APCD does not include dental claims. Pat Baker stated that dental care should be viewed as part of comprehensive care, but said she was conflicted because the data are not available in the APCD. Kate McEvoy commented that Medicaid offers a basis for examining the State's dental expenditures from the Medicaid perspective, and added that there is interest in transparency on dental care services and spending. Judy Dowd stated that if the State collected dental service expenditures data, that might provide pressure for improved dental services. Vicki Veltri remarked that it would be challenging to modify the APCD to collect dental expenditure data during Year 1 of the benchmark initiative (although the APCD does collects information on dental copays). Rae-Ellen Roy concurred. Michael Bailit noted that it would be a challenge to collect expenditure data from dental insurers.

Michael Bailit offered several options for the Technical Team's consideration: 1) exclude dental services from the THCE definition and seek a better understanding of the State's dental service expenditures as part of the overall data use strategy; 2) defer a decision on inclusion of dental services in the THCE and conduct research on the dental market in Connecticut, and on potential approaches to collecting dental expenditure data if the Technical Team is interested in holding parties accountable for dental spending as part of the THCE. Paul Lombardo expressed his preference for the first option. Pat Baker expressed her preference for the second option as it would allow the Technical Team to be more thoughtful as to inclusion of dental services. Angela Harris voiced her support for the second option as well. Megan Burns committed to contact Paul Lombardo to learn more about Connecticut's dental insurers.

The Technical Team expressed its support of the claims and non-claims-based spending definitions adopted by Delaware, Massachusetts and Rhode Island. The one exception was dental services, the treatment of which is pending further research by Bailit Health.

Pharmacy rebates. Michael Bailit asked the Technical Team to consider whether it wished to make THCE net of pharmacy rebates, noting that the effect of these rebates is substantial. He clarified that states are unable to get data from CMS on Medicare fee-for-service rebates, so when there is a pharmacy rebate adjustment for Medicare, it is only for Medicare Advantage. Michael stated that inclusion of pharmacy rebates is a negative adjustment, meaning that THCE would be net of pharmacy rebates. Kate McEvoy said that making the THCE net of pharmacy rebates was important because the Medicaid program has spent less year-over-year on pharmacy net of rebates.

Cost sharing. Michael Bailit defined cost-sharing spending as the out-of-pocket costs incurred by individuals based on the benefit design of their insurance products for individuals. He stated that out-of-pocket spending excludes non-covered services, discounts such as gym memberships, and health care costs paid by individuals who are uninsured. He explained that when reporting performance against the target, Delaware, Massachusetts and Rhode Island require payers to submit claims-based costs using "allowed amounts," which includes the amount the payer paid to a provider for health care services, plus member cost-sharing for a claim. Michael said that Delaware, Massachusetts and Rhode Island were not measuring cost sharing separately. Instead, they have payers report the allowed amount. He said that HB 5018 also uses this approach.

Michael said that the State is not able to capture spending for the uninsured, because it lacks a data source for this information. Pat Baker noted that the exclusion of spending associated with the uninsured constitutes a big gap in the THCE, particularly since the number of uninsured will likely increase in coming months. Kate McEvoy stated that examining uncompensated care hospital costs and sliding scale payments in clinics could offer a means of examining spending on the uninsured. Vicki Veltri stated that OHS would like to work with the Medicaid program to pursue a means of tracking spending for the uninsured.

The Technical Team expressed comfort with including all patient cost-sharing amounts, including but not limited to deductibles and copayments. The Technical Team requested supplemental tracking and reporting of costs for individuals who are uninsured since their payments will not be included in cost growth benchmark.

Michael Bailit noted that Delaware, Massachusetts and Rhode Island all define and measure Net Cost of Private Health Insurance (NCPHI) in the same way, and added that HB 5018 uses the same definition although it lacks specificity. He noted that other states typically exclude administrative costs in their calculation of NCPHI. Michael explained that the NCPHI captures the costs only for commercial private insurance (not Medicaid or Medicare). Kate McEvoy stated that Medicaid extensively reports on administrative costs, and recommended that the Technical Team include spending for Medicaid administrative costs, noting there is an existing mechanism for doing so. Technical Team members expressed support for Kate McEvoy's proposal.

Michael Bailit noted that Executive Order #5 does not provide guidance on whose costs are being measured in the calculation of THCE, and asked the Technical Team to provide its guidance on this topic. Michael stated that the predominant sources of health care expenditures were Medicare, Medicaid, Medicare and Medicaid Duals, and commercial, which is split between fully insured and self-insured. He said that the comparator states include these categories and it appears the Executive Order includes these categories as well. Michael asked for the Technical Team's input on whether the following four additional sources of health care expenditures should be included.

- **Veterans Health Administration (VHA)**. Michael Bailit noted that VHA expenditures are included in Delaware's and Massachusetts' definition of THCE, and inclusion of these expenditures would make Connecticut's definition comprehensive. He noted that only one percent of Connecticut residents receive VHA or other military coverage. Pat Baker stated that she would like to be as inclusive as possible in the State's calculation of THCE. Kate McEvoy expressed her strong support for inclusion of VHA data.

- **Federal Employee Health Benefits Program (FEHBP)**. Michael Bailit noted that both Delaware and Massachusetts include FEHBP expenditures in calculation of THCE. Megan Burns stated that Technical Team staff needed to determine if FEHBP carriers can disaggregate these expenditures from commercial data. Angela Harris expressed her support for disaggregation of FEHBP data.
- **Correctional Health Systems**. Michael explained that inclusion of state correctional health system health care spending would make Connecticut's definition more comprehensive, however, these expenditures are relatively small. Kate McEvoy said DSS had only recently begun to capture inpatient correctional health system expenditures. Judi Dowd expressed support for inclusion of correctional health systems expenditures. Michael Bailit stated that he and Megan Burns would explore whether inclusion of correctional health expenditures was feasible, and the Technical Team expressed its support for them doing so.
- **Indian Health Service**. Michael noted that this category is not applicable as Connecticut has no Indian Health Service providers. Kate McEvoy stated that the state's tribes are self-insured.

Michael Bailit reviewed with the Technical Team the question of whose THCE should be measured, and whether it mattered where an individual resides and where a provider is located. The Technical Team agreed that expenditures for services received by **Connecticut residents from Connecticut providers** should be included in the THCS. Pat Baker expressed support for including expenditures associated with **Connecticut residents who receive services from out-of-state providers**, and Michael noted that such expenditures are included by Delaware, Massachusetts and Rhode Island in the numerator for their cost growth benchmark. Kate McEvoy also supported inclusion of such expenditures, as doing so would capture some of the service utilization patterns within Medicaid for special needs populations.

For expenditures associated with **out-of-state residents receiving care from Connecticut providers**, Michael said these dollars could only be captured from those insurers required to report and may not represent all out-of-state residents who receive care from Connecticut providers. Michael said that Delaware, Massachusetts and Rhode Island do not measure expenditures for out-of-state residents receiving care from in-state providers. He noted two additional considerations. First, Connecticut-licensed insurers likely cover at least some individuals who do not reside in state, and some Connecticut employers pay for health care for employees who do not live in Connecticut. Paul Grady stated that he was comfortable with excluding out-of-state residents receiving services from Connecticut providers. Paul Lombardo noted that for a Connecticut-based employer with out-of-state employees, their expenditures should be reflected in the premium structure. Michael Bailit noted that the one potential challenge of including expenditures for out-of-state residents receiving care from Connecticut providers was that it would be difficult to determine an accurate denominator for calculation of the per capita spending. Paul Lombardo asked how expenditures for Connecticut employees who are non-state residents and receive care from Connecticut providers would be excluded from those that are reported now. Megan Burns stated that an adjustment is made to the calculation whereby an estimate of non-state residents is applied to members reported by insurers.

Paul Grady expressed his support for excluding out-of-state residents who receive care from in-state providers. Rebecca Andrews acknowledged the complexity of the issue and said she leaned toward not including expenditures for out-of-state residents. She said that if telehealth becomes widely accepted then it will be easier for out-of-state residents to access primary care providers in their home state.

Pat Baker said that given the complexity, she supported exclusion of expenditures for out-of-state residents receiving care from Connecticut providers. Overall, the Technical Team leaned toward accepting this exclusion. Paul Grady noted that consistency with the approach taken by other states on this topic had value.

6.	**Determining the Cost Growth Benchmark Methodology**	**Megan Burns, Bailit Health**

Megan Burns said that at its June 4th meeting, the Technical Team would discuss actual value possibilities for the cost growth benchmark. She reviewed trends in Connecticut's growth in health care spending, and noted overall

	growth of almost 4 percent between 2016 and 2018, and that much of this growth has fallen on consumers. Megan stated since health care spending is outpacing many economic measures, bringing the cost growth benchmark in line with the economy might lessen the burden on consumers and employees. Megan shared two suggested criteria for selection of an economic indicator: 1) provide a stable and therefore predictable target, and 2) rely on independent, objective data sources with transparent calculations. Pat Baker stated that she supported the two criteria, but wondered if there were additional criteria that the Technical Team could consider, noting that the target should bend the spending curve and be lower than current health spending. Judy Dowd commented on the trend showing utilization was decreasing and expressed her wish to avoid setting a benchmark that was too low. Rebecca Andrews stated that as a primary care physician her primary concern was controlling chronic diseases. If health care costs are high, then patients will forgo care and that makes it more difficult for primary care physicians to help patients control chronic diseases. She noted that these trends contribute to high burnout amongst primary care physicians. Vicki Veltri said that establishment of the primary care target is an effort to boost primary care spending in the State. Megan Burns noted that calculation of the primary care target and the data use strategy together will highlight where further action is needed to resolve some of the issues that Rebecca Andrews raised. Angela Harris asked if there were limitations on independent, objective data sources to inform the benchmark value. Megan replied that forecasting firms provide a variety of forecasted measures that allow for transparency in communicating with the public and legislators the underlying forecast data that could be used when calculating the benchmark. Judy Dowd said that there were many unknowns as a result of the pandemic, and the Technical Team would need to bear this in mind as it moves forward. Judy noted that the question of which year to start measuring claims. Michael Bailit stated that crafting the cost growth benchmark is a long-term strategy, and health care affordability will continue to be an issue after the short-term effects that we are experiencing currently as a result of COVID-19 have passed. Paul Grady stated that maybe now is the time to establish an aggressive cost growth benchmark. Paul Grady said transparency and accountability surrounding the benchmark may have a greater impact than the value of the benchmark itself. Pat Baker suggested, and the Technical Team supported, adding a third criteria in selecting cost growth benchmark: the method should result in a benchmark that lowers health care spending. The Technical Team members expressed support for inclusion of this third criteria. Megan Burns introduced four options for determining the cost growth benchmark: annualized growth in Connecticut's Gross Domestic Product, annualized growth in personal income of Connecticut residents, annualized growth in average Connecticut worker wage growth, and annualized inflation rate. Pat Baker said that it will be important to weigh intended and unintended consequences of each of these options. Angela Harris requested consideration of a fifth option: growth in employment/unemployment. Paul Grady requested inclusion of historical data on all options in a single table for ease of comparison. Pat Baker submitted a motion to designate Paul Grady as Vice Chair, which was seconded by Paul Lombardo. Paul Grady's designation as Vice Chair was approved by a roll call vote with supporting votes from Judy Dowd, Paul Lombardo, Rae-Ellen Roy, Angela Harris, Rebecca Andrews, Paul Grady, Pat Baker, and Vicki Veltri.	
7.	**Adjourn**	**Victoria Veltri, OHS**
	Paul Grady made a motion to adjourn, which Pat Baker seconded. The meeting adjourned at 4:58.	