Cost Growth Benchmark Technical Team Meeting #3
May 19, 2020

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Agenda

Time	Topic
3:00 p.m.	Call to Order
3:02 p.m.	Review and Approval of Prior Meeting Minutes
3:05 p.m.	Public Comment
3:15 p.m.	Vote on Charter
3:17 p.m.	Defining Total Health Care Expenditures
4:15 p.m.	Health Care Cost Growth Benchmark Methodology
4:55 p.m.	Wrap-up & Next Steps
5:00 p.m.	Adjourn

Approval of March 17, 2020 Meeting Minutes

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Approval of May 5, 2020 Meeting Minutes

Public Comment

Vote on Charter

Defining Total Health Care Expenditures

Defining Total Health Care Expenditures (THCE)

- Executive Order #5 defines Total Health Care Expenditures as:
  - *The per capita sum of all health care expenditures in this state from public and private sources for a given calendar year.*
- HB-5018 has more specific, yet still broad definitions (see next slide)
- Health care payment is complex, and without a specific definition of *"all health care expenditures"* the term would be open to varying interpretations.
- We will walk the Technical Team through more specific definitions that are consistent with HB-5018, by looking at how other states are defining THCE.

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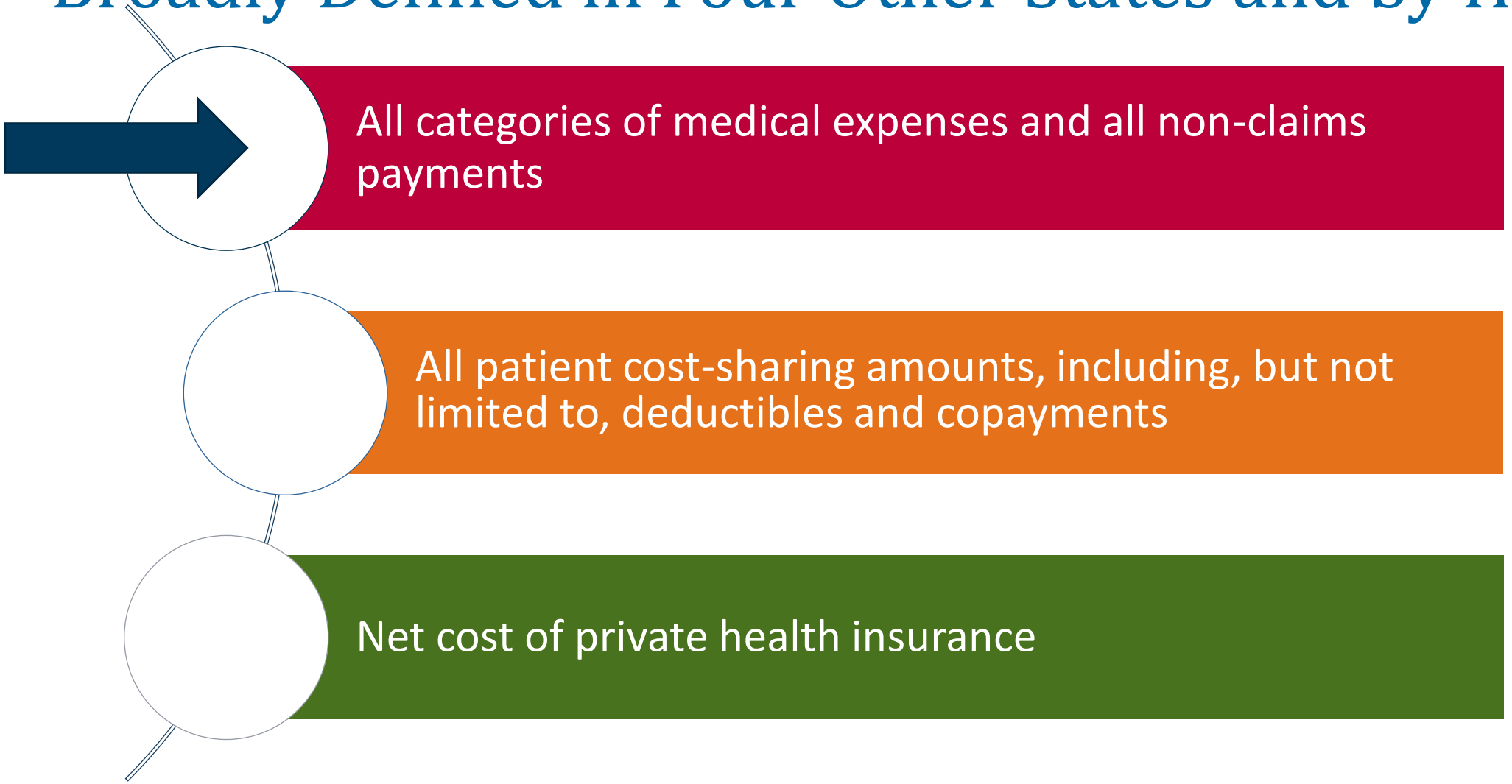
Total Health Care Expenditures: Broadly Defined in Four Other States and by HB 5018



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What Are Typical Claims-Based Payments? More Specifically Defined by DE, MA and RI

- Hospital inpatient
- Hospital outpatient
- Physicians
- Other professionals
- Home health
- Other: E.g., Hearing aids, optical services and transportation
- Long-term care
- Dental (when covered as a medical benefit)
- Vision (when covered as a medical benefit)
- Pharmacy
- Durable medical equipment
- Hospice

What is Non-Claims-Based Spending? More Specifically Defined by DE, MA and RI

1. **Non-claims incentive programs:** All payments made to providers for achievement relative to specific pre-defined goals for quality, cost reduction, or infrastructure development (e.g., P4P payments, EMR/HIT adoption incentive payments).
2. **Prospective service payments:** Prospective payments to cover health care services (e.g., capitation, episode-based payments, case rates).
3. **Risk settlements:** All payments made to providers as part of a reconciliation of payments made under risk-based contracts.

What is Non-Claims-Based Spending? More Specifically Defined by DE, MA and RI (cont'd)

4. **Care management:** All payments made to providers for high-risk care management, utilization review, discharge planning and other care management programs.
5. **Recovery:** All payments recouped during the performance year as the result of a prior review, audit or investigation, regardless of the time period of the initial payment. (Value is reported as a negative) (DE and RI only).
6. **Others:** All other payments pursuant to a payer's contract with a provider that were not made on the basis of a claim for a medical service and not classified in any of the other categories above (e.g., governmental payer shortfall payments, grants, or surplus payments).

Claims-Based and Non-Claims-Based Spending

- Based on what you just learned, does the Technical Team wish to use the definition of claims and non-claims-based spending adopted by DE, MA and RI?
  - Are there any modifications you wish to recommend?
  - How do you wish to address “recovery”?

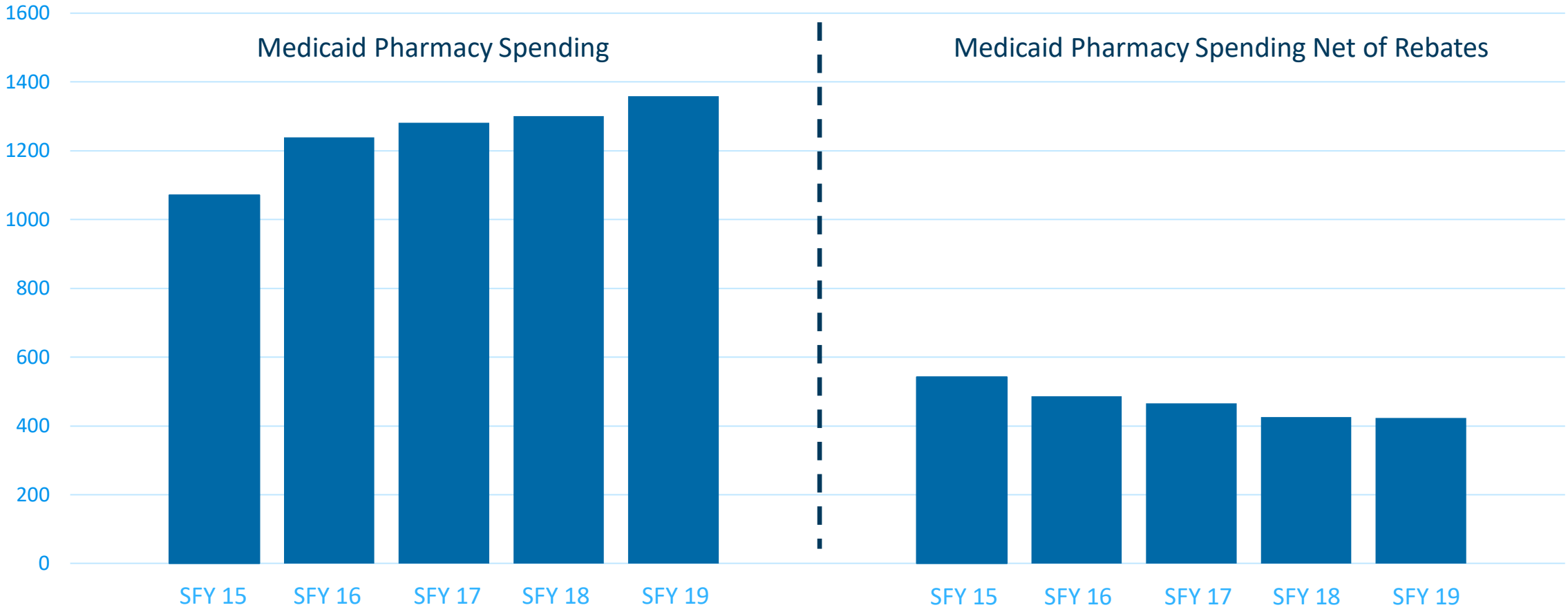
Raise Hand

Prescription Drug Rebates

- Prescription drug rebates and other price concessions are commonly granted to pharmacy benefit managers and health insurers from drug manufacturers.
- The effect of these rebates is quite substantial.
  - Connecticut's Medicaid rebate percentage grew from 49.4% in SFY 2015 to 68.9% in SFY 2019.
- HB-5018 defines THCE as net of pharmacy rebates.
- In DE, MA and RI insurers are required to report prescription drug rebates received. OR intends to do the same. **Total Health Care Expenditures is reported net of rebates.***

*States are unable to receive data on Medicare FFS rebates

Estimated Impact of Rebates on Medicaid Pharmacy Spending and Growth in Connecticut



NOTE: Total spending on pharmacy services including both the federal and state share of expenses before Medicaid pharmacy rebates.

SOURCE: "Financial Trends in the Connecticut HUSKY Health Program – Transparency and Sustainability," Presentation to the Medical Assistance Program Oversight Committee, February 14, 2020.

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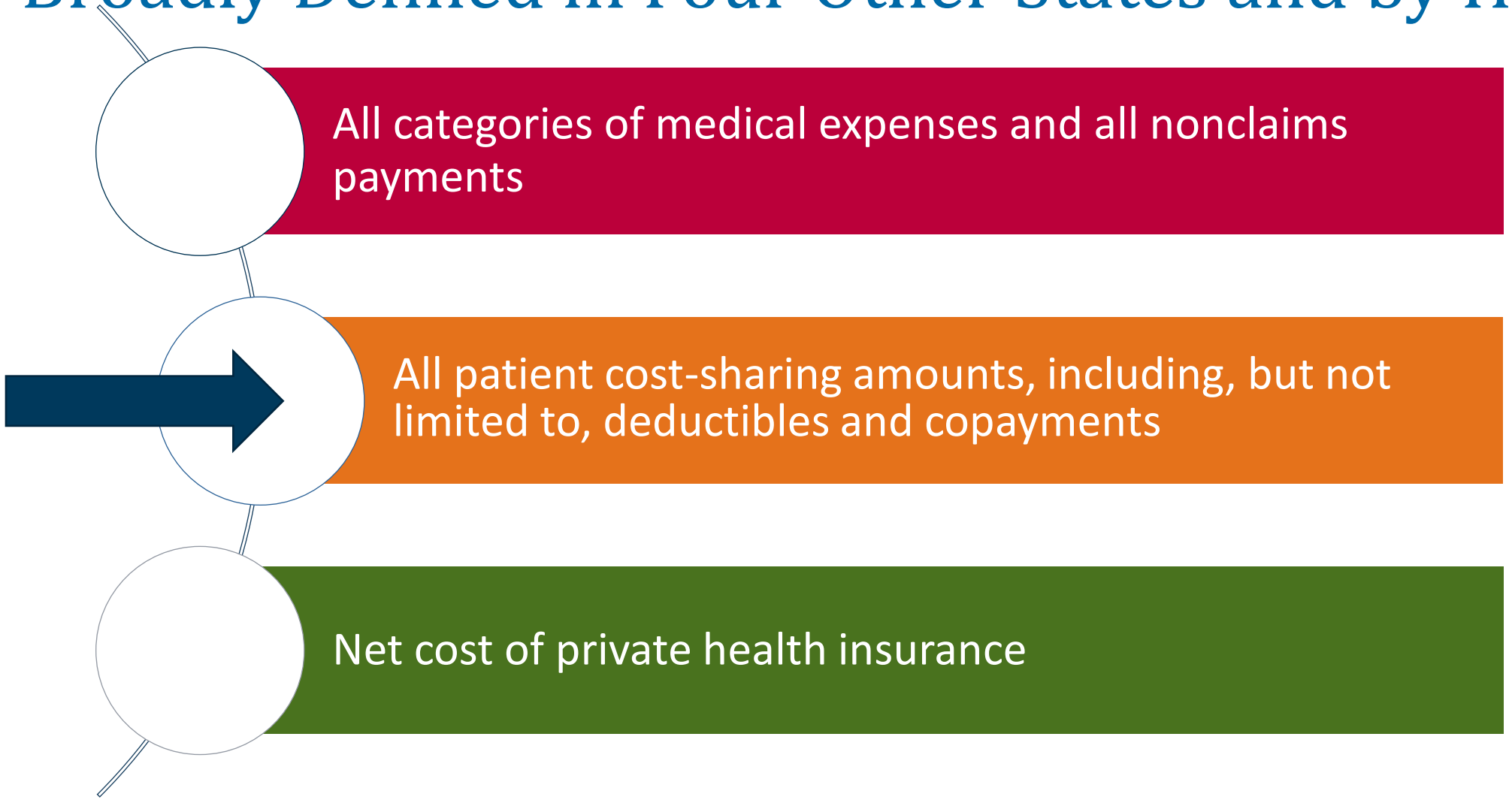
Pharmacy Rebates?

- Does the Technical Team wish to make THCE net of pharmacy rebates?

Raise Hand

Total Health Care Expenditures: Broadly Defined in Four Other States and by HB 5018



What Is Cost-Sharing Spending?

- Individuals who are insured pay out-of-pocket costs related to the benefit design of their insurance product.
  - Copayments
  - Deductibles
  - Coinsurance
- This category typically excludes out-of-pocket spending on:
  - Non-covered services (e.g., non-medical cosmetic surgery);
  - Use of non-health care services-related discounts offered by an insurer (e.g., gym membership), and
  - Health care costs paid by individuals who are uninsured.

Cost-Sharing Spending: DE, MA and RI Approaches

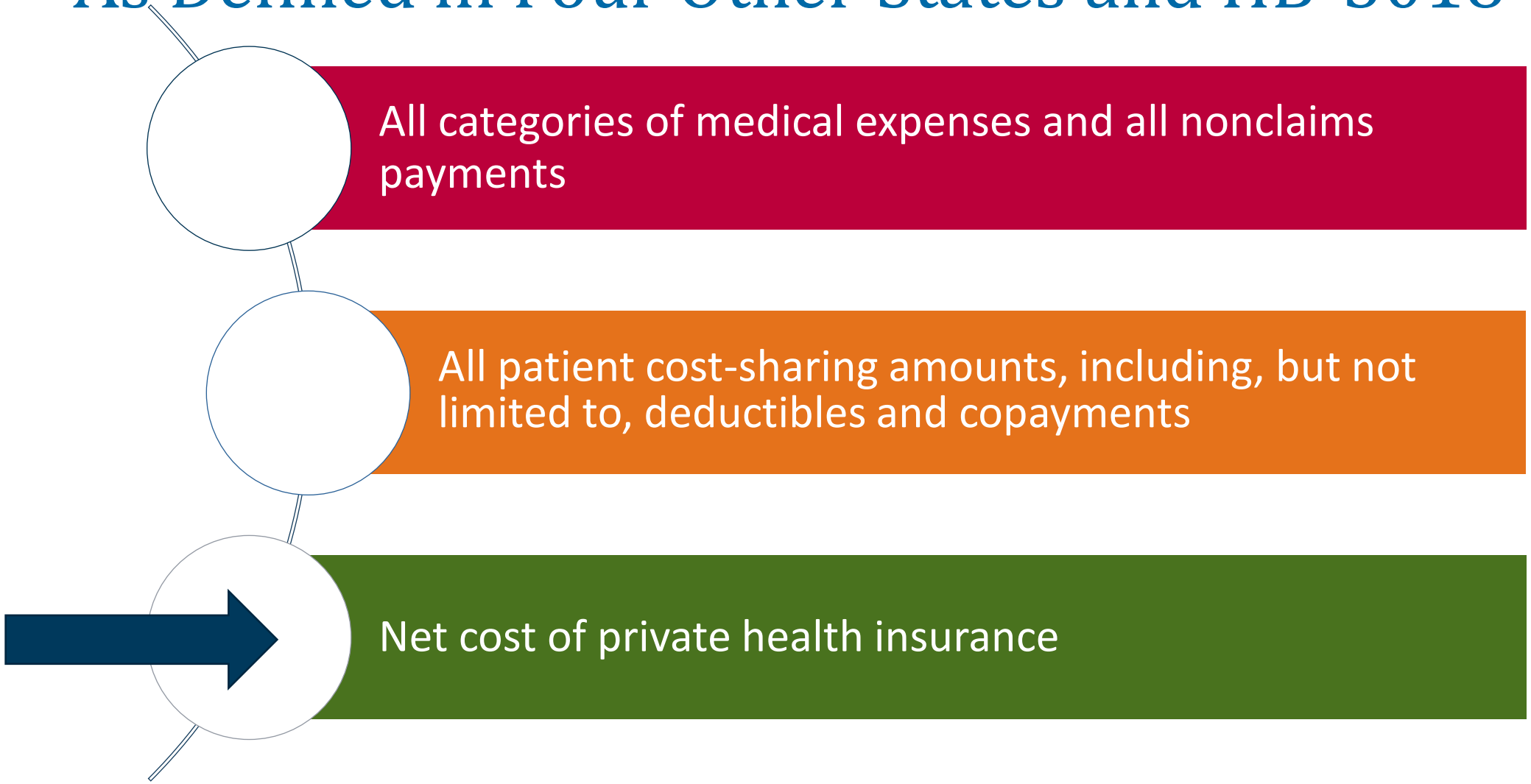
- When reporting performance against the target, MA, DE and RI require payers to submit claims-based costs using "allowed amounts."
  - This includes the amount the payer paid to a provider for a health care service, plus any member cost-sharing for a claim.
  - In these states, cost-sharing is not separately reported and cannot be separately analyzed.
  - It excludes out-of-pocket spending on non-covered services, non-medical related services and costs incurred by those without insurance.
- This definition is consistent with HB-5018.

Cost-Sharing Spending

- Based on what you just learned, does the Technical Team wish to adopt the definition of cost-sharing spending adopted by DE, MA and RI?
  - Are there any modifications you wish to recommend?

Raise Hand

Total Health Care Expenditures: As Defined in Four Other States and HB-5018



What Is the Net Cost of Private Health Insurance?

- Net cost of private health insurance (NCPHI) captures the cost associated with the administration of private health insurance. It is the difference between health premiums earned and benefits incurred.
- It consists of insurers' costs related to:
  - Paying bills
  - Advertising
  - Sales commissions
  - Other administrative costs
  - Premium taxes and other fees
- It also includes insurer profits[1] and/or losses.

[1] For non-for-profit insurers, profits are referred to as "contribution to reserves."

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NCPHI: DE, MA and RI Approaches

- DE, MA and RI all define and measure NCPHI in the same way, using the definition cited in the prior slide.
- HB 5018 does not provide any specificity, but is assumed to be the same definition.
- Each state collects information related to NCPHI through federally mandated financial reporting forms, and calculates NCPHI on a PMPM basis for each market segment:
  - Individual
  - Small group, fully insured
  - Large group, fully insured
  - Student markets
  - Medicare Advantage
  - Medicaid MCO (not applicable in CT)
  - Self-insured market

Net Cost of Private Health Insurance

- Based on what you just learned, does the Technical Team wish to adopt the definition of net cost of private health insurance adopted by DE, MA and RI?
  - Are there any modifications you wish to recommend?

Raise Hand

Determining Whose "Total Health Care Expenditures" Are Being Measured

Total Health Care Expenditures for Whom?

- Executive Order #5 does not provide guidance on exactly whose costs are being measured. It states only that THCE measure "the per capita sum of all health care expenditures in this state from public and private sources for a given calendar year."
- Therefore we needed to determine:
  - the population whose health care expenditures should be measured
  - the sources of insurance coverage for that population

Total Health Care Expenditures for Whom?

- We need to be specific with the definition of "who." We will walk through a series of questions to help define the coverage status of individuals whose health care spending is being measured.
- Data access may play a role in which coverage groups can be included. We will discuss this at a future meeting. **Today, we're going to discuss the question without consideration of how to obtain the needed data.**

Predominant Sources of Health Care Expenditures

- Medicare
  - Medicare FFS (Parts A, B, D)
  - Medicare Advantage
- Medicaid
- Medicare & Medicaid "Duals"
- Commercial
  - Fully-insured
  - Self-insured

All states with cost growth targets include these sources of coverage.

EO #5 requires all public and private sources of coverage to be included, which we assume to be those listed.

Other Sources of Health Care Expenditures

- Veterans Health Administration (VA)
- Federal Employee Health Benefits Program (FEHBP)
- Correctional Health System
- Indian Health Services (IHS)

There is variation among the four states with existing (or developing) programs with respect to including these populations.

We will review the pros and cons of including each of these sources.

Total Health Care Expenditures for Which Sources of Coverage?

	Advantages of Including	Disadvantages of Including
Veterans Health Administration (*MA and DE*)	• Including VHA would make CT's definition comprehensive.	• Data are limited and not "apples-to-apples." • Only 1% of Connecticut residents receive their coverage through the VHA or other military coverage.
FEHBP *(MA and DE)*	• Including FEHBP would make CT's definition comprehensive.	• Data on FEHBP spending was requested by DE, but could not be obtained. • The population of Connecticut residents covered through FEHBP likely small.

Total Health Care Expenditures for Which Sources of Coverage?

	Advantages of Including	Disadvantages of Including
Correctional Health System *(OR)*	• Including state correctional health system health care spending would make CT's definition comprehensive.	• Some inpatient costs are already included under Medicaid (in certain circumstances). • Only 0.4% of Connecticut residents are incarcerated. • State spending for corrections is disaggregated and may be complex to obtain in an apples-to-apples manner.
Indian Health Service *(OR)*	• Not applicable as CT has no IHS providers.	• Not applicable as CT has no IHS providers.

Total Health Care Expenditures for Which Sources of Coverage?

- Per EO #5, THCE will include the following sources of coverage
  - Medicare (FFS and Medicare Advantage)
  - Medicaid
  - Commercial (Fully- and Self-Insured)
- **Should we include any of the following?**
  - Veterans Health Administration
  - FEHBP
  - Correctional Health System
  - Indian Health Service
- **Are there any other sources of coverage we should consider for inclusion?**

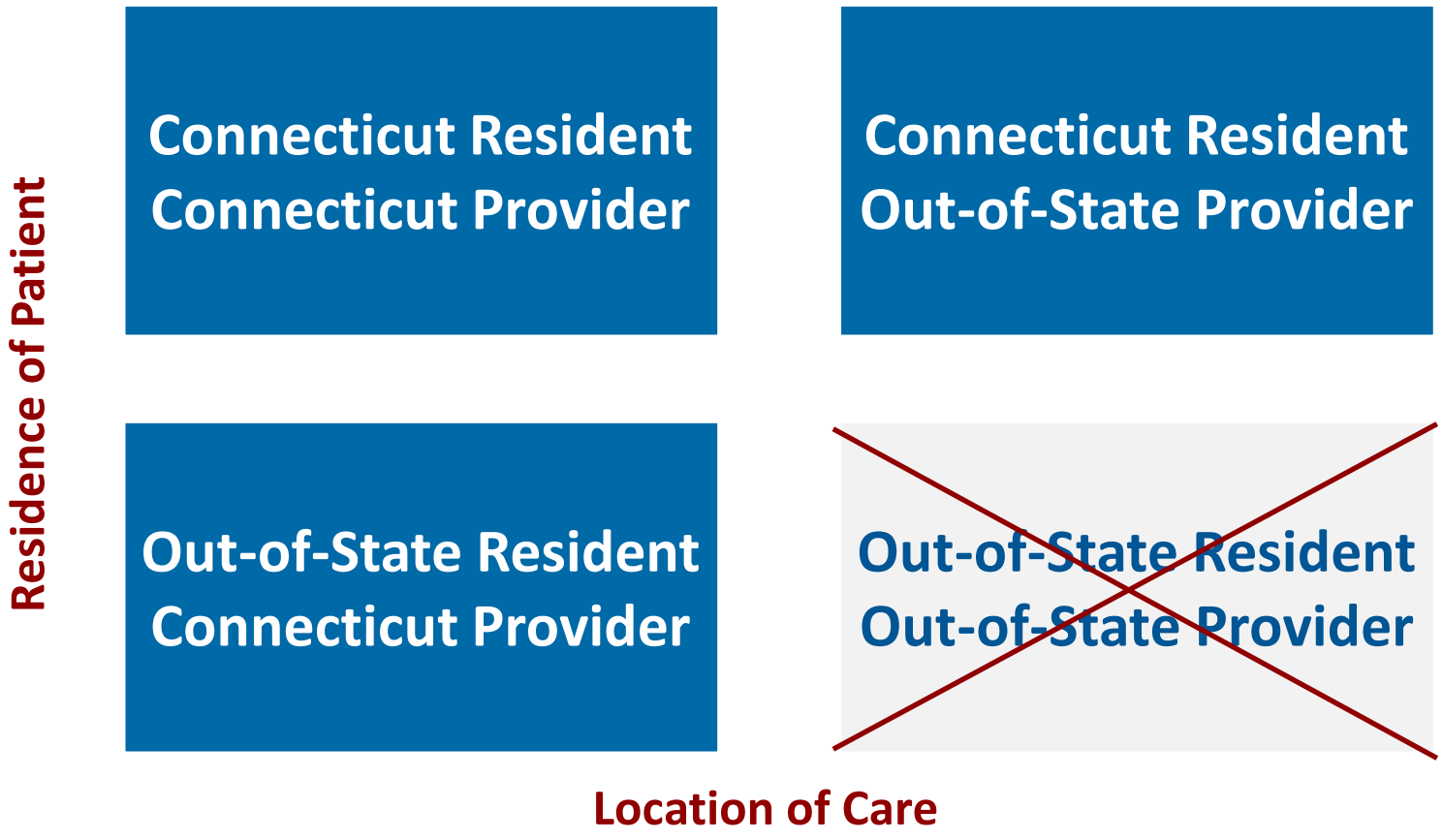
Raise Hand

Whose THCE is being measured?

For the recommended payers:

1. What should be the **residence** of the **individual**?
2. What should be the **location** of the **provider**?

State of Residence and Location of Care



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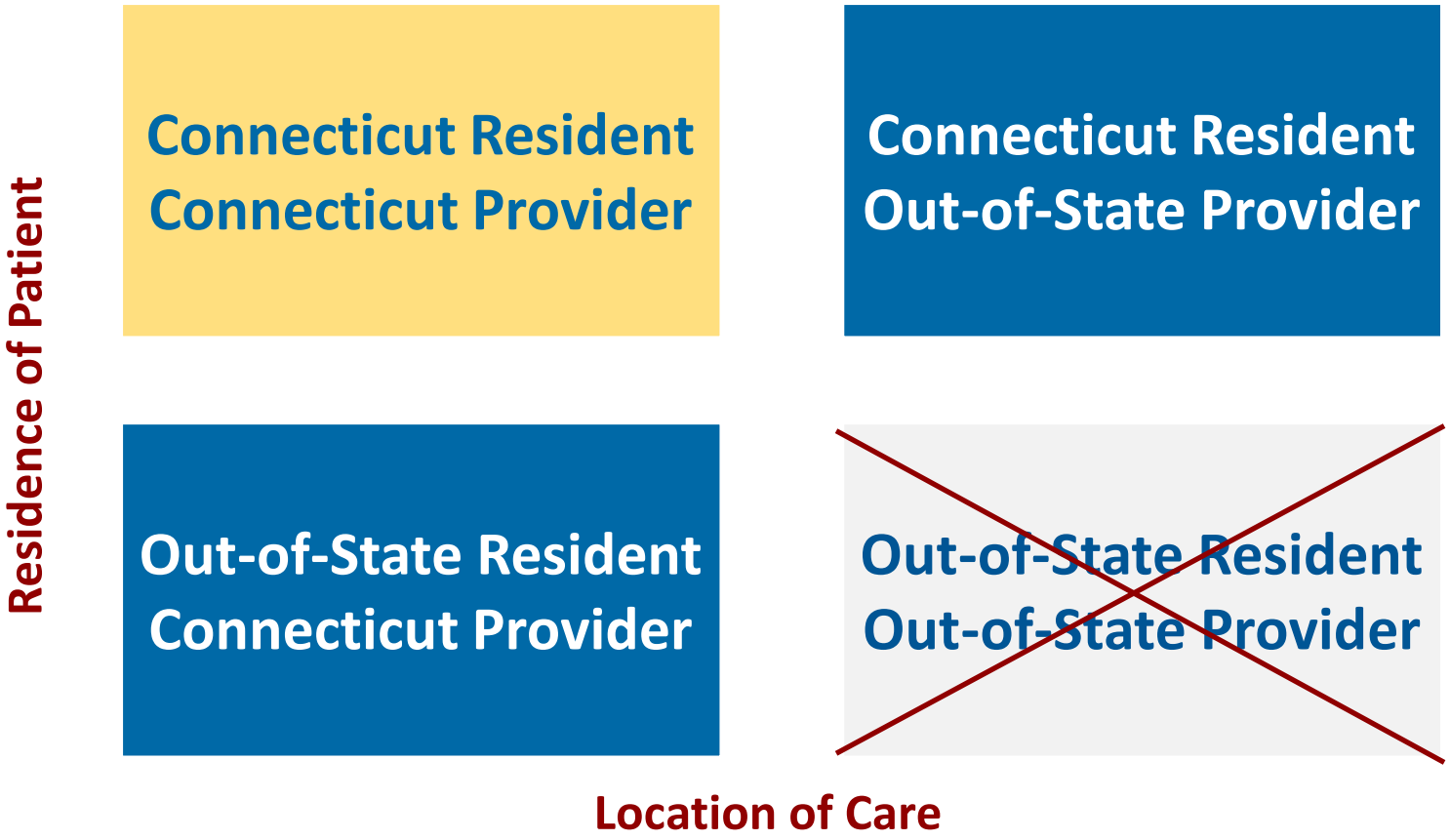
State of Residence and Location of Care



It's clear that we would want to include Connecticut residents who received care from Connecticut providers.

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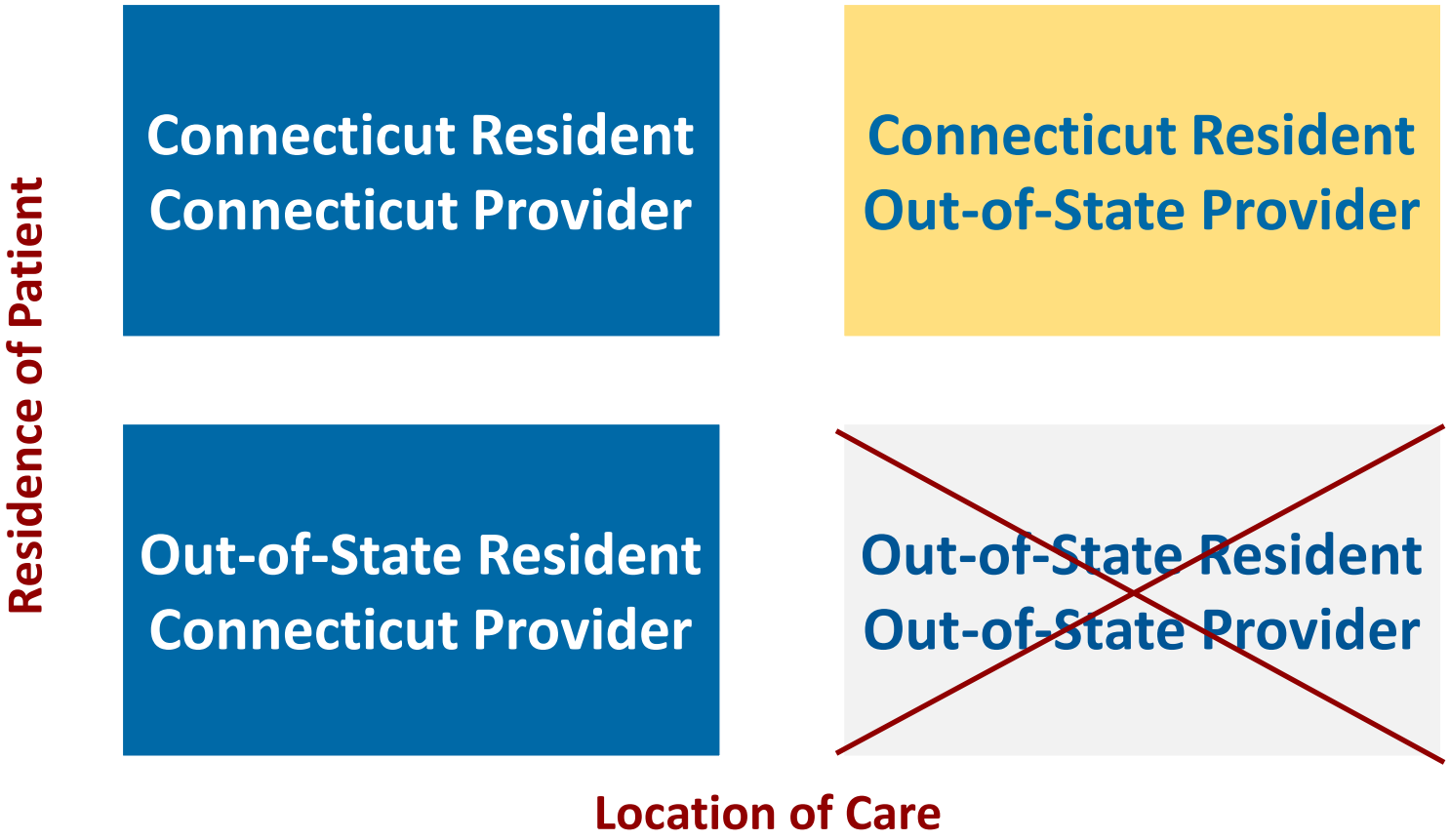
State of Residence and Location of Care



Should we include Connecticut residents who received care from out-of-state providers?

Some health systems and ACOs have affiliated or employed physicians who are practicing in bordering states.

Some CT residents may winter in warmer climates.

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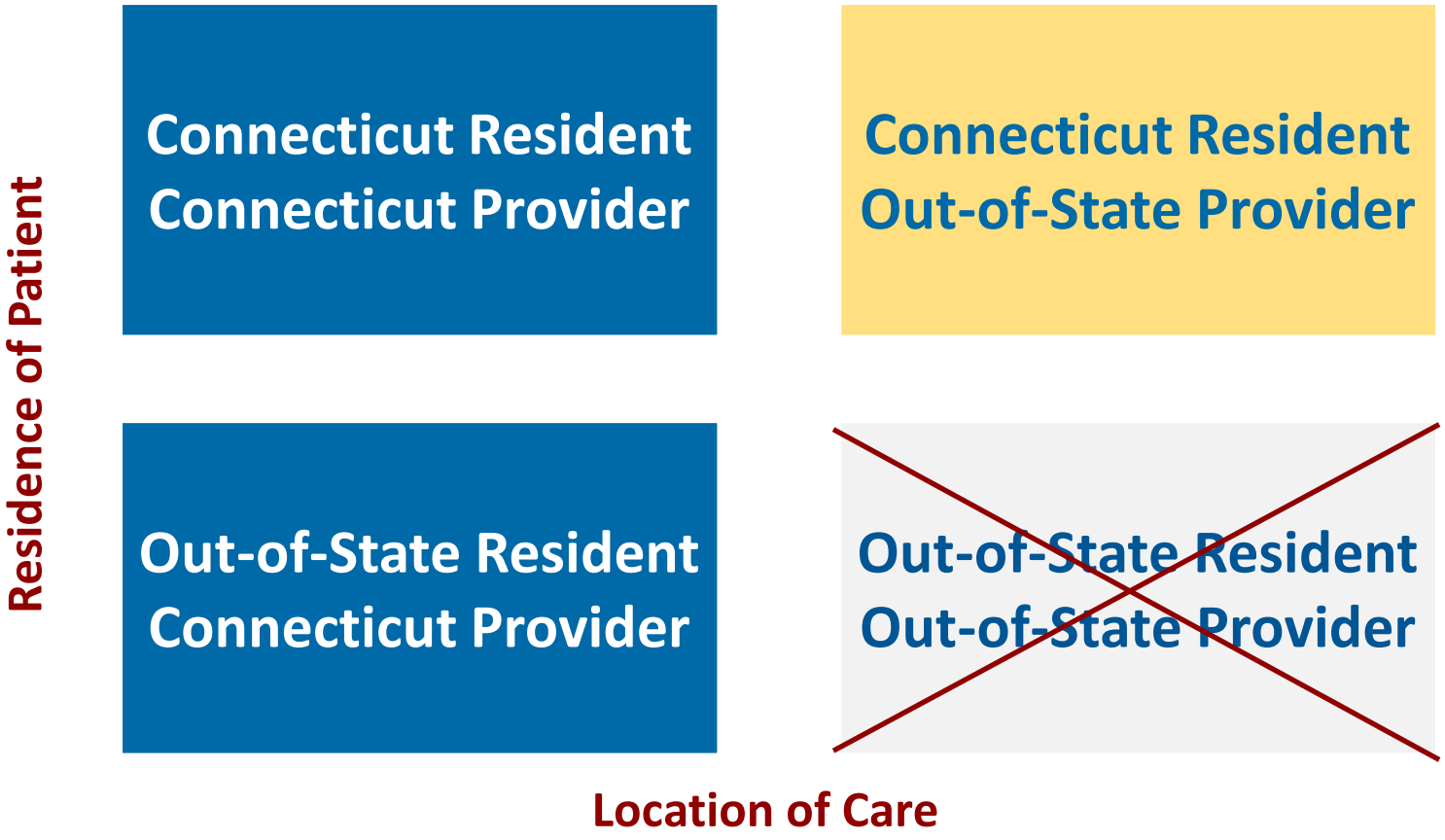
State of Residence and Location of Care



Medicare reports personal health care expenditures by state of provider and by state of residence.

MA, DE, RI (and OR proposed) include spending by residents with out-of-state providers in the numerator for their cost-growth target.

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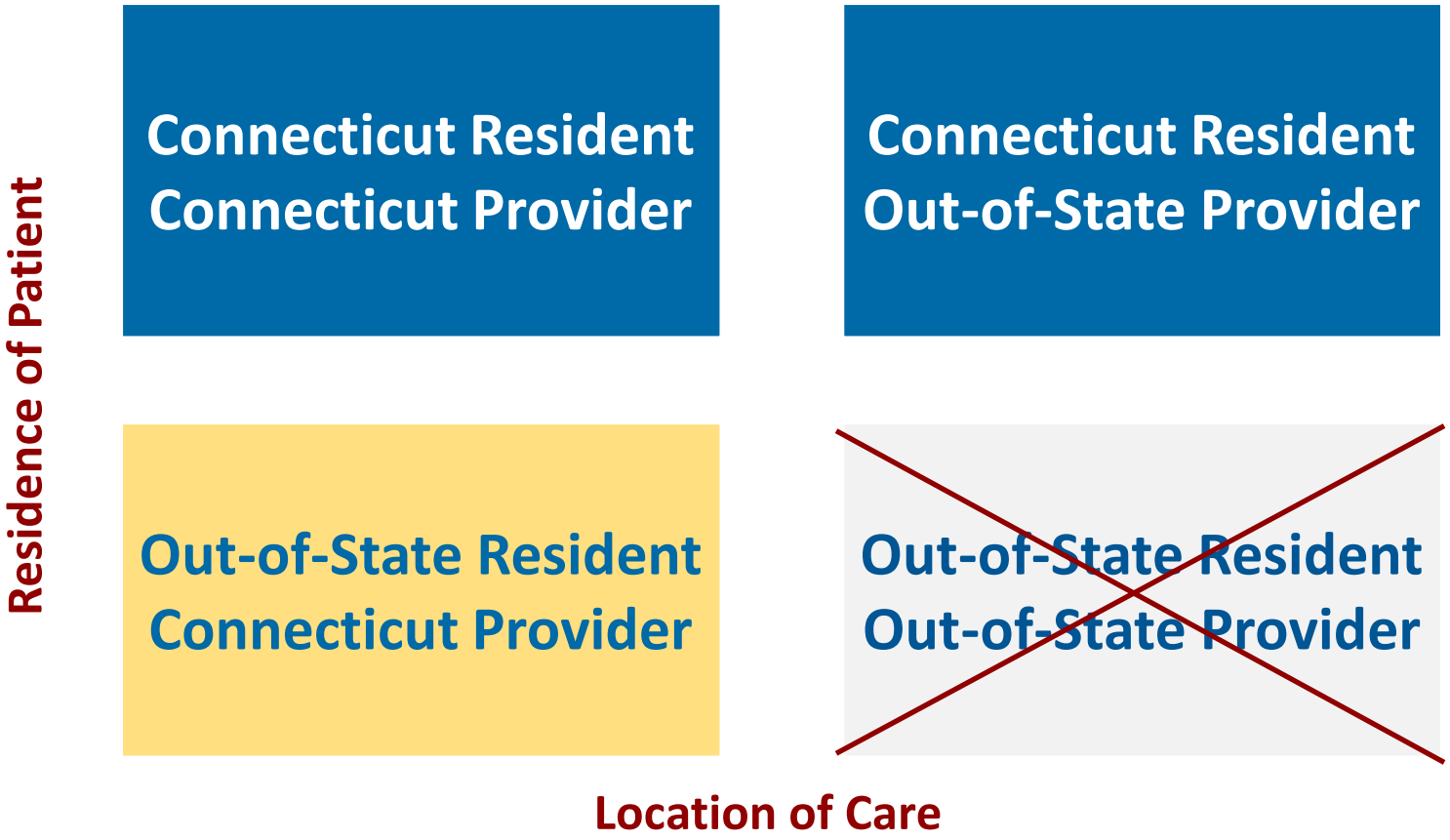
State of Residence and Location of Care



Should we include out-of-state residents who received care from Connecticut providers?

These dollars could only be captured by those insurers required to report and may not represent all out-of-state residents who receive care from Connecticut providers.

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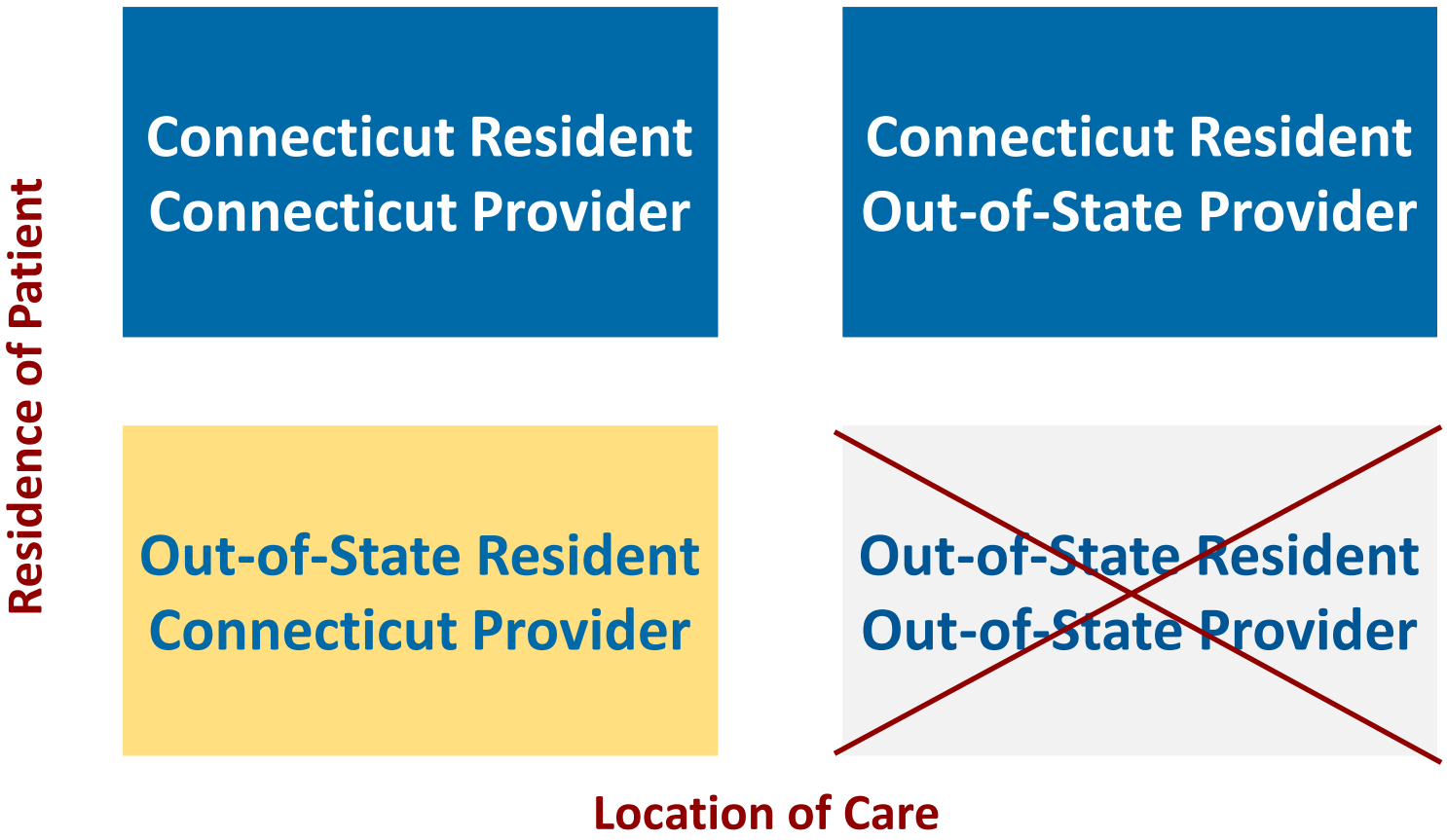
State of Residence and Location of Care



Do we care about this spending since it is not spending by Connecticut residents?

What about out-of-state visitors accessing Connecticut-based emergency rooms or other services?

MA, DE and RI do not measure expenditures for out-of-state residents who receive care from in-state providers

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State of Residence and Location of Care: Insurer and Employer Perspective

While intuitively it doesn't make sense to have non-state residents seeking care from out-of-state providers included, there are two special perspectives to consider.

1. **Insurer Perspective**
   - Connecticut-licensed insurers likely cover at least some individuals who do not reside in Connecticut
   - Should these individuals be included? Does it matter whether they seek care from Connecticut providers or not?
2. **Employer Perspective**
   - What about Connecticut employers who pay for health care for employees who don't live in Connecticut?
   - Should this be considered state spending if neither the patient nor the provider resides in Connecticut?

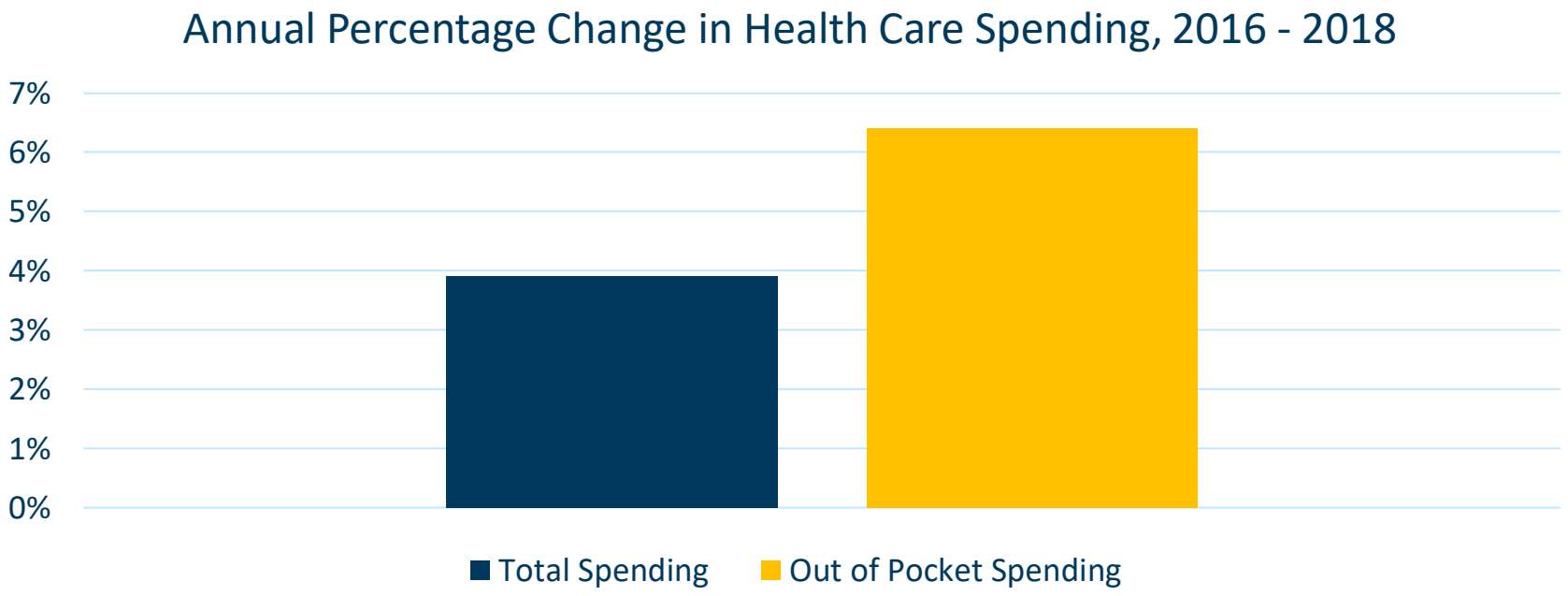
Cost Growth Benchmark Methodology

Determining the Cost Growth Benchmark Methodology

- We are going to pivot away from determining what the benchmark will measure, to how to identify the methodology for setting, and the value of, the benchmark.
- We will *slowly* walk through some deep weeds together, looking at:
  - A snapshot of health care costs in Connecticut;
  - Potential criteria for choosing a benchmark methodology;
  - Four methodological options - without discussing a possible value
    - At our next meeting, we will discuss actual value possibilities

At a Glance: CT's Growth in Health Care Spending

- Much of CT's growth in health care spending has fallen onto consumers. From 2016-2018, annual growth in total spending was 3.9% and growth in out-of-pocket spending nearly doubled at 6.4%.



Source: Health Care Cost Institute. "2018 Health Care Cost and Utilization Report."

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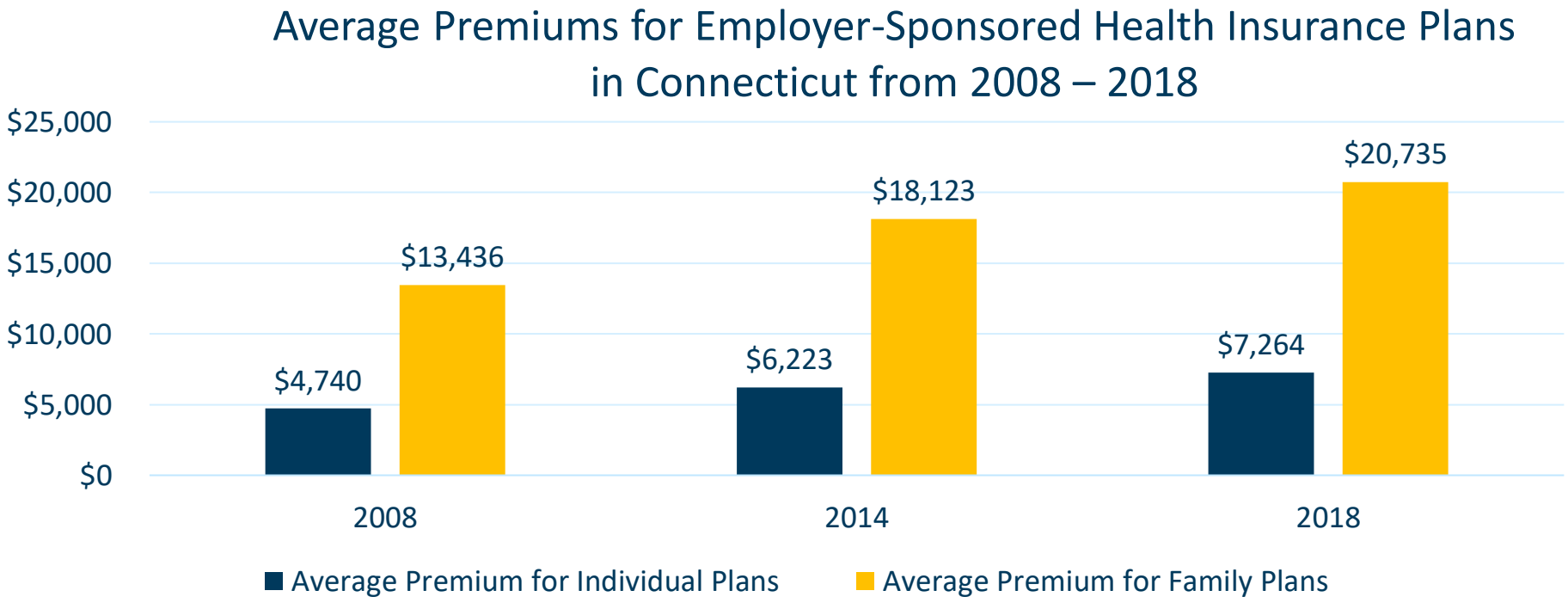
In the Details: Growth in Premiums are Consistent Among Plan Types, but Slowed in Recent Years

- In CT, average annual growth in premiums for employer-sponsored health insurance plans was ~5% from 2008 – 2018 for individual plans and family plans.



Average annual growth for individual plans: 5.3%

For family plans: 5.4%

Source: The Commonwealth Fund. "Trends in Employer Insurance Costs, 2008 – 2018."

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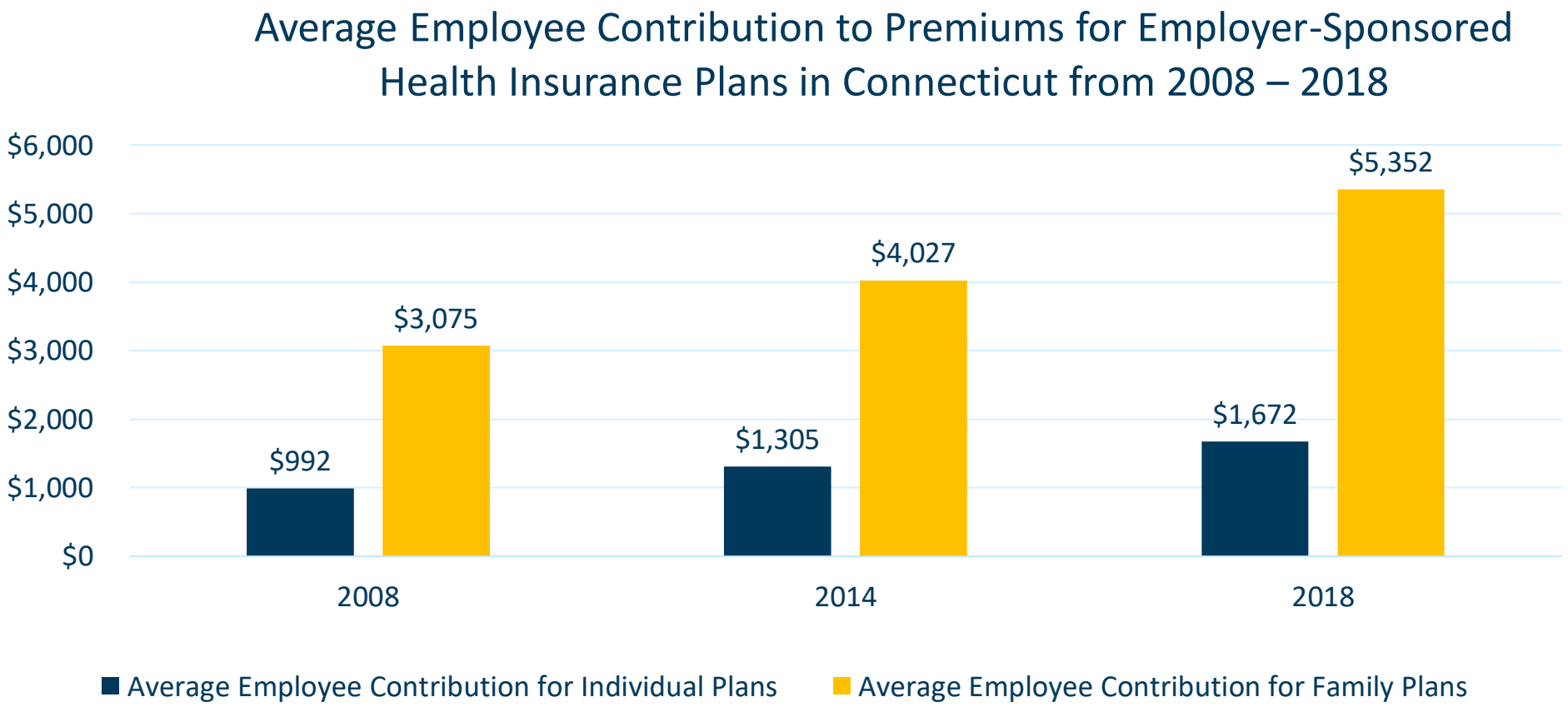
Growth in Employee Contribution to Premiums is Higher than Premium Growth



Average annual growth for individual plan: 6.9%

For family plans: 7.4%

Source: The Commonwealth Fund. "Trends in Employer Insurance Costs, 2008 – 2018."

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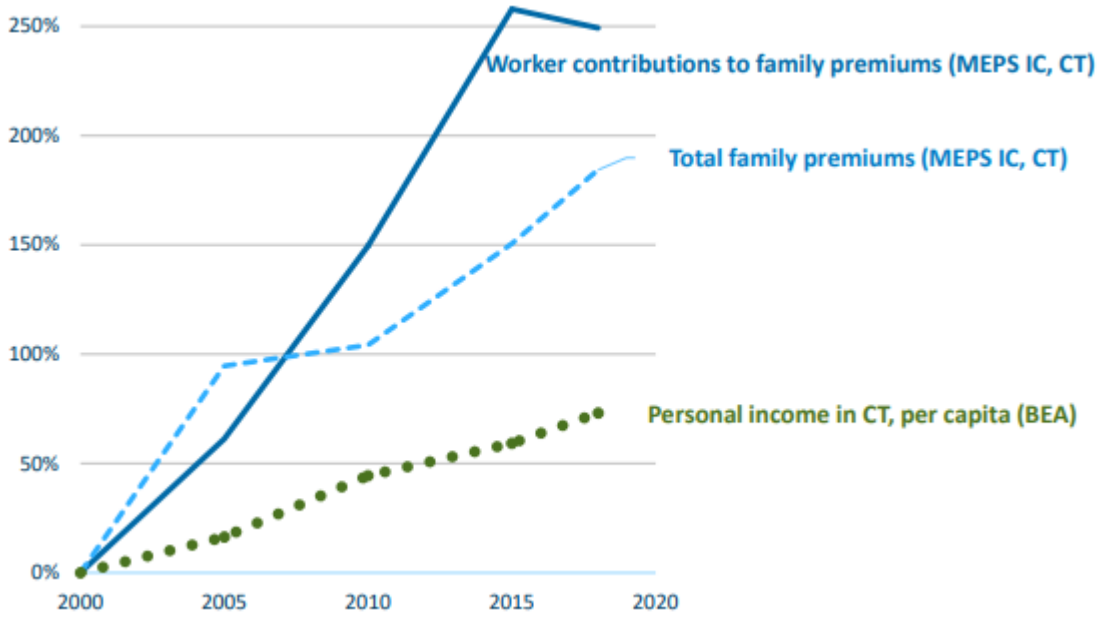
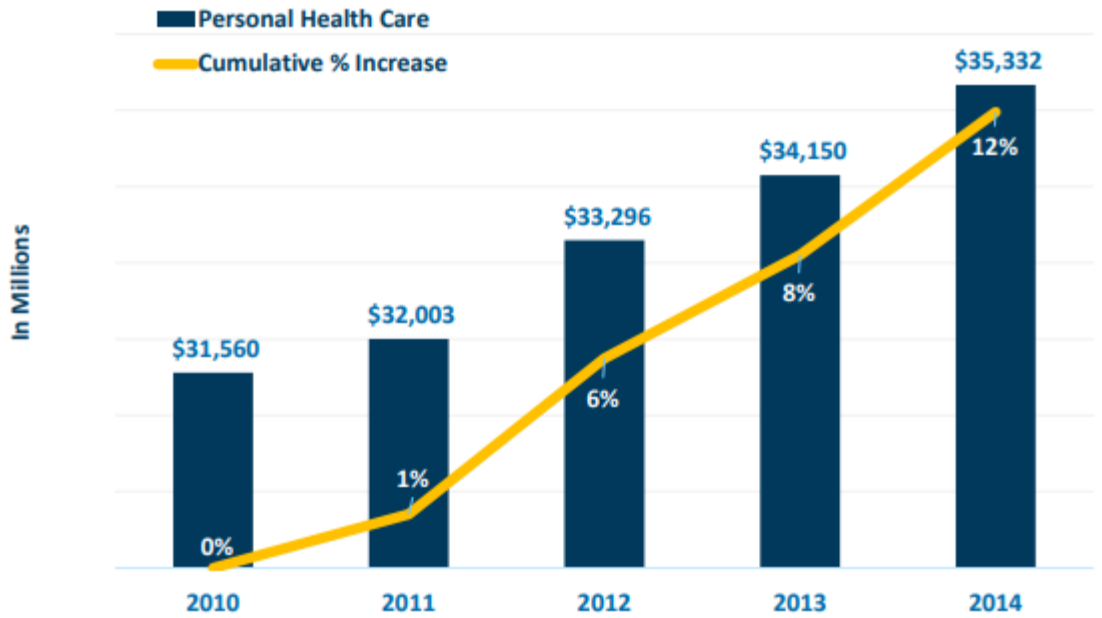
Health Care is Becoming Unaffordable in CT Relative to Other Economic Indicators

CT employer-sponsored insurance premiums have grown 2.5 times faster than personal income since 2000.



Personal health care expenditure in CT grew 12% from 2010 – 2014 and averaged 14% of state GDP.



Source: (1) Medical Expenditure Survey, Tables D.1 and D.2 for various years
(2) CMS State Expenditure by Provider 2014.

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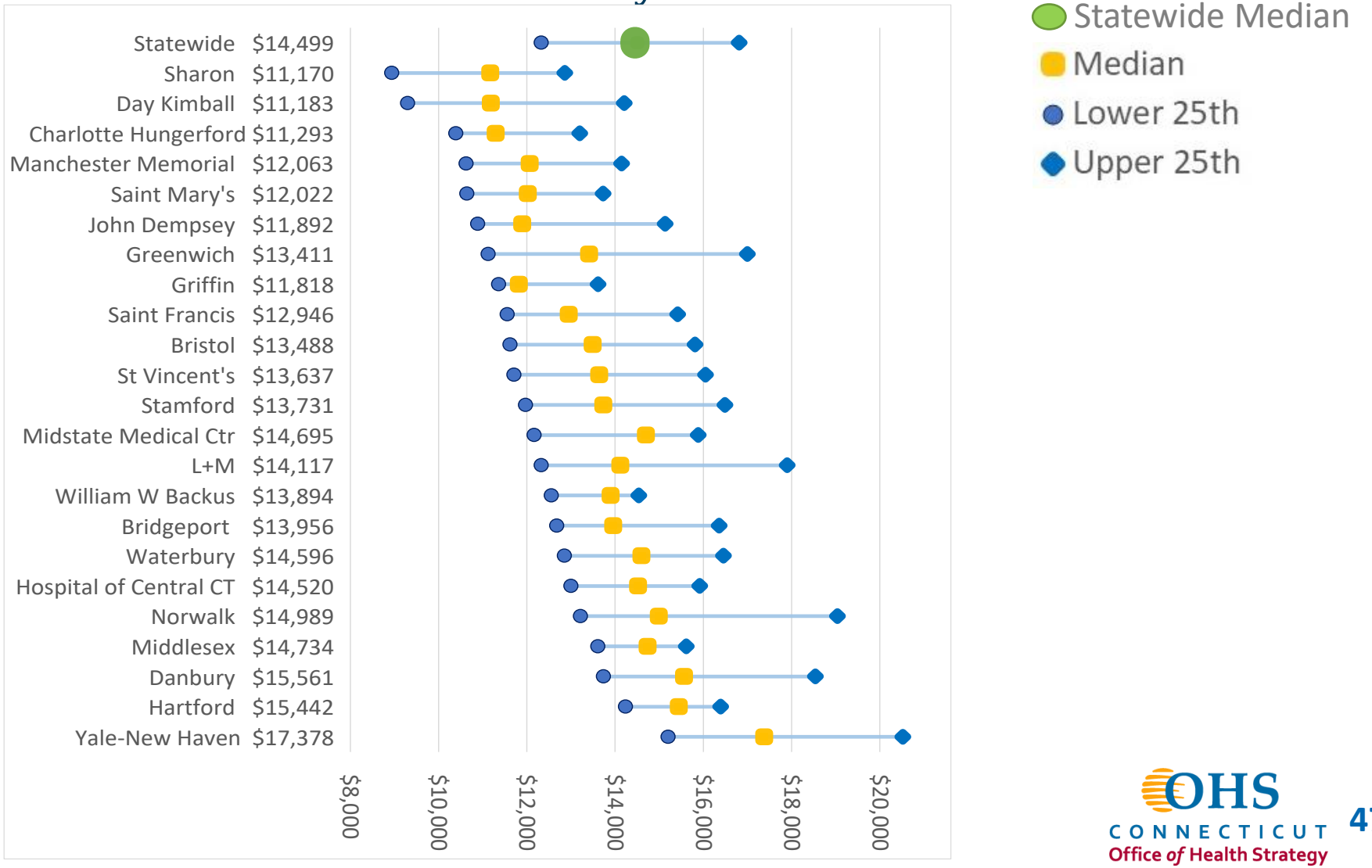
Prices for Care Vary Significantly in Connecticut

Variations in "allowed amounts" for a normal delivery



"Allowed amounts" includes provider reimbursement + patient cost sharing

Source: OHS CT All-Payer Claims Data 2017 Allowed Amounts

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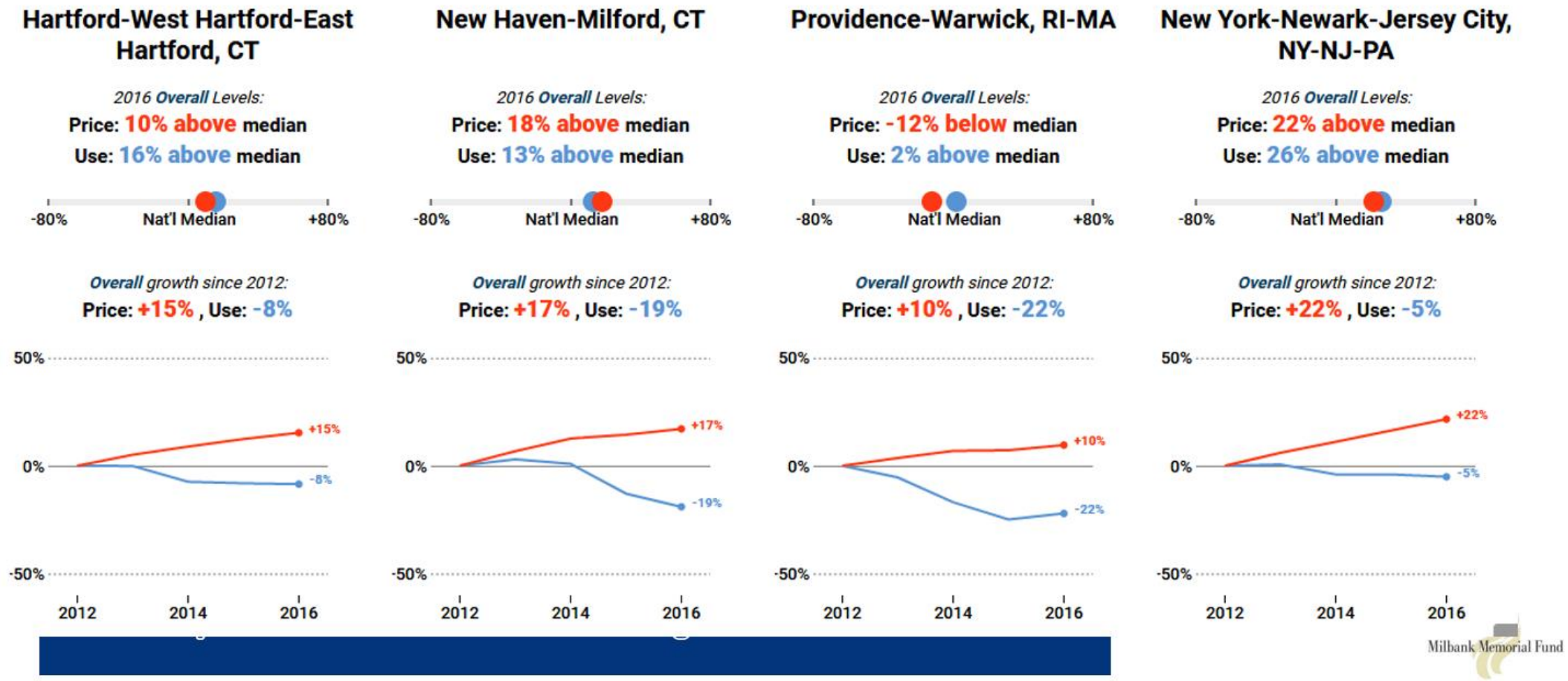
Commercial Price and Utilization Trends in CT and Other Metro Areas



Source: Health Care Cost Institute 2017 Annual Report Interactive Tables – available at https://healthcostinstitute.org/research/hccur/2017-health-care-cost-and-utilization-report

Cost Growth Benchmark Methodology

- The essential question is: what is the value of the cost growth benchmark?
- Since we know health care spending is outpacing many economic measures, bringing it in line with the economy would be a helpful start to reducing the financial burden high spending growth rates have caused to consumers, employers, and other health care purchasers.
- But which economic indicator should be chosen?

Establishing the Criteria for Choosing the Economic Indicator

- We have four economic indicators to share as possible options to which to inform the value of the cost growth benchmark.
- Determining which one is a matter of preference – there is no objective right or wrong answer.
- Identifying decision-making criteria may help facilitate the process, however. We therefore offer two criteria suggestions.

Suggested Criteria

1. Provide a stable and therefore predictable target.
2. Rely on independent, objective data sources with transparent calculations.

Do these two criteria resonate with you?

Are there other criteria you wish to consider?

What Are the Options for the Cost Growth Benchmark?

1. Annualized growth in Connecticut's Gross Domestic Product
2. Annualized growth in the personal income of Connecticut residents
3. Annualized growth in average Connecticut worker wage growth
4. Annualized inflation rate

What Will We Learn About Each of the Indicators?

What each of these indicators measure in the real world

What the "message" would be if the target was pegged to one of these indicators

Messaging is potentially important, as it provides the rationale for how and why the benchmark is chosen.

What the annual rate of change has been over the last 20 years (for informational purposes only)

Option 1: Rate of Growth in Connecticut's Gross Domestic Product

Rate of Growth in Connecticut's Economy

Gross State Domestic Product (GSP): the total value of goods produced and services provided in a state during a defined time period.

- This is the state counterpart to Gross Domestic Product (GDP), which is measured at the national level, with a few methodological differences in how the figures are calculated.

The growth in GSP tells us how fast the state's economy is growing. By tying the benchmark to GSP, we would be recommending an expectation that **health care spending should not grow faster than the economy.**

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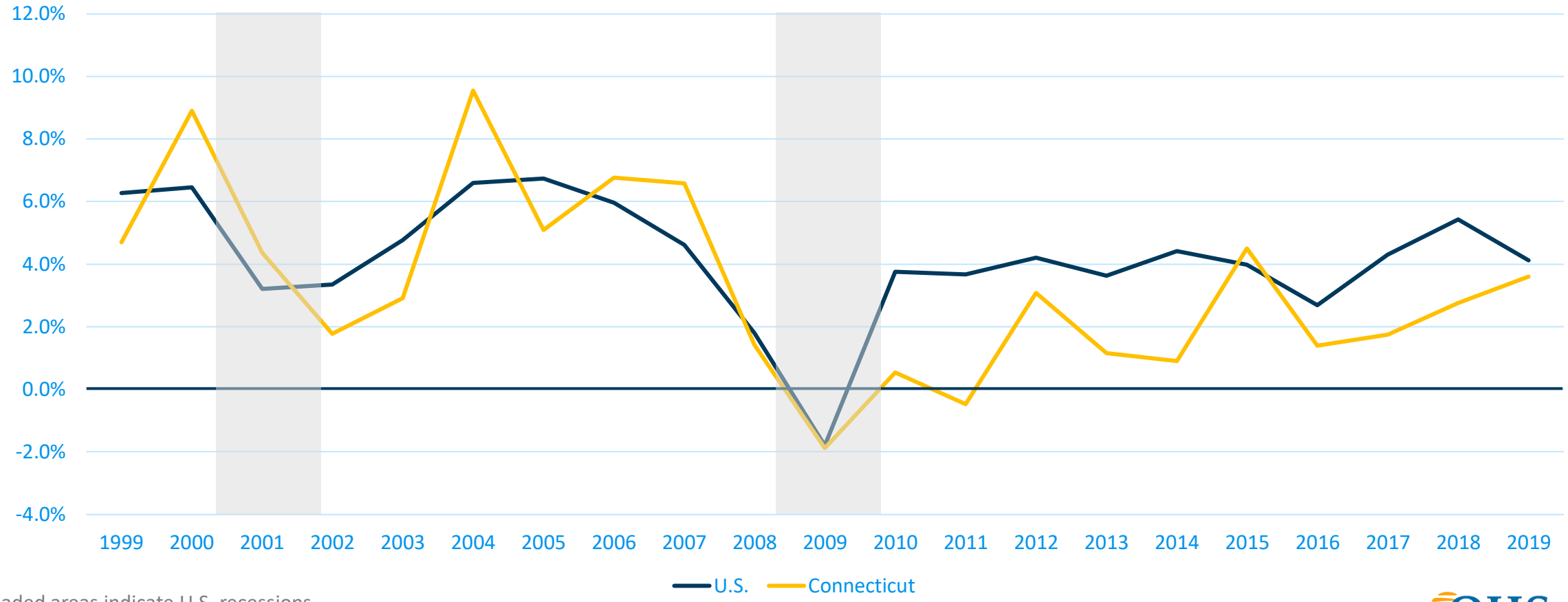
Annual Rate of Growth of the U.S. and Connecticut Total Gross Domestic Product, 1999-2019



Shaded areas indicate U.S. recessions.

SOURCE: U.S. Bureau of Economic Analysis, Total Gross Domestic Product for Connecticut [CTNGSP], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/CTNGSP, May 4, 2020.

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Option 2: Rate of Growth in Personal Income

What Is Personal Income?

- **Personal income** is the sum of all payments received by individuals within the state.
- It includes:
  - Wages and salaries
  - Other income (employee benefits)
  - Proprietor's income (farm and non-farm)
  - Property income (dividends, rent and interest)
  - Transfer payments (pensions, Social Security)
- The calculation excludes payroll taxes for income earned in Connecticut by out-of-state residents.
- It does not include all sources of income (e.g., capital gains).

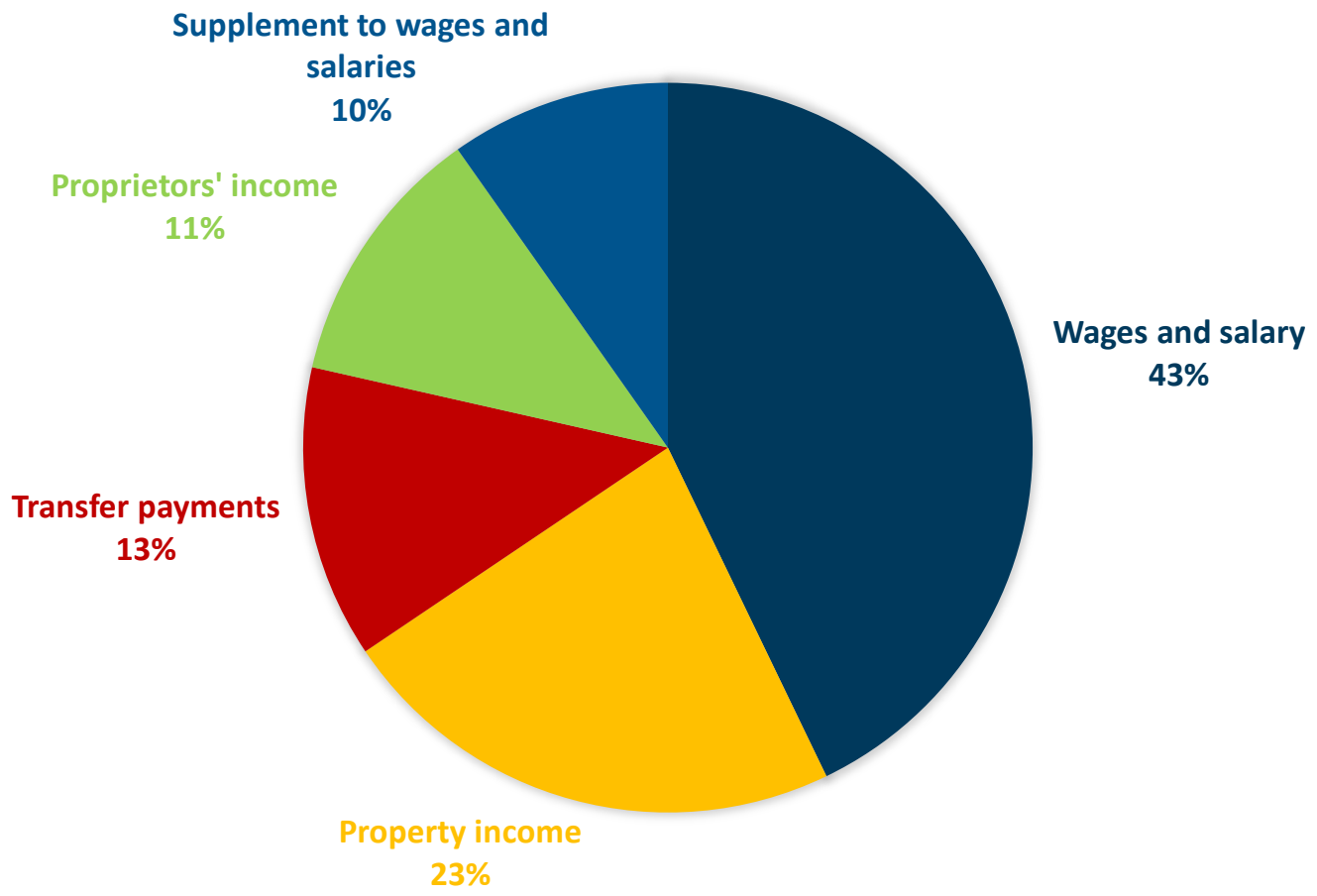
What It Means to Use Rate of Growth in Connecticut Residents' Personal Income

States track personal income growth as one **measure of a state's economic trends**, as state revenue and spending on government assistance programs depends on personal income.

- Personal income growth can offer clues to the financial health of Connecticut residents and future consumer spending.

By tying the benchmark to personal income growth, we would be recommending **health care not grow faster than personal income growth**.

Personal Income in Connecticut by Type



SOURCE: U.S. Bureau of Economic Analysis, Personal Income and Employment by Major Component, retrieved from https://apps.bea.gov/itable/iTable.cfm?ReqID=70&step=1 on May 12, 2020.

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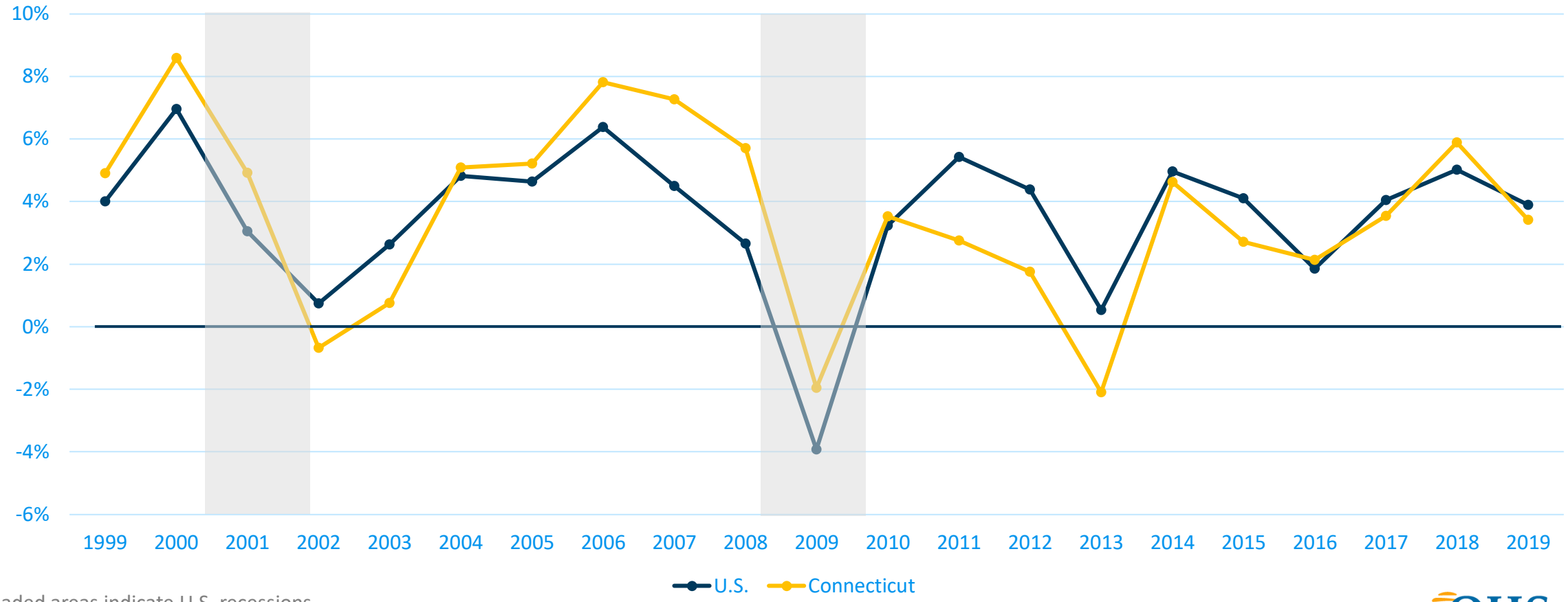
Annual Rate of Growth of Per Capita Personal Income in the U.S. and Connecticut, 1999-2019



Shaded areas indicate U.S. recessions.

SOURCE: U.S. Bureau of Economic Analysis, Per Capita Personal Income in Connecticut [CTPCPI], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/CTPCPI, May 4, 2020.

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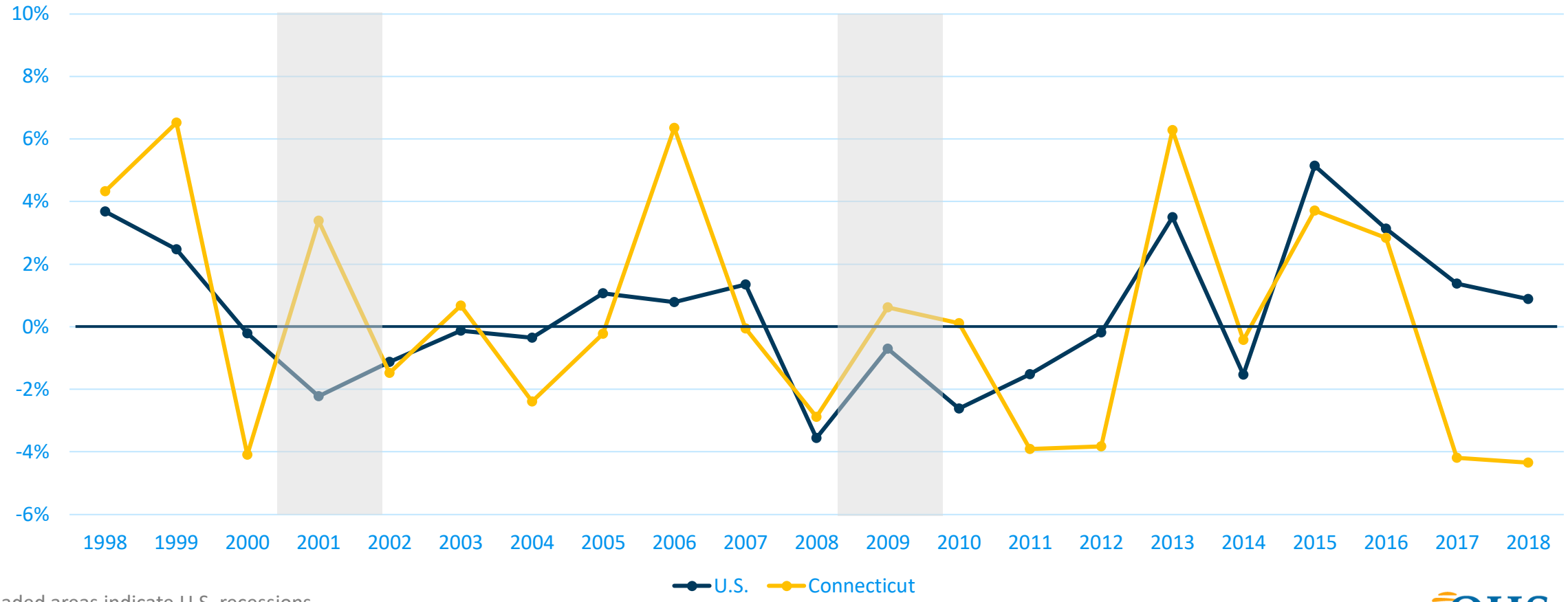
Annual Rate of Growth of Median Household Income in the U.S. and Connecticut, 1999-2019



Shaded areas indicate U.S. recessions.

SOURCE: U.S. Census Bureau, Real Median Household Income in Connecticut [MEHOINUSCTA672N], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/CTPCPI, May 6, 2020.

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Option 3: Rate of Growth in Wages

What It Means to Use Rate of Growth in Connecticut Residents' Wages

Wages + salaries (wages) is compensation received by individuals for work as an employee or as a contractor with an employer.

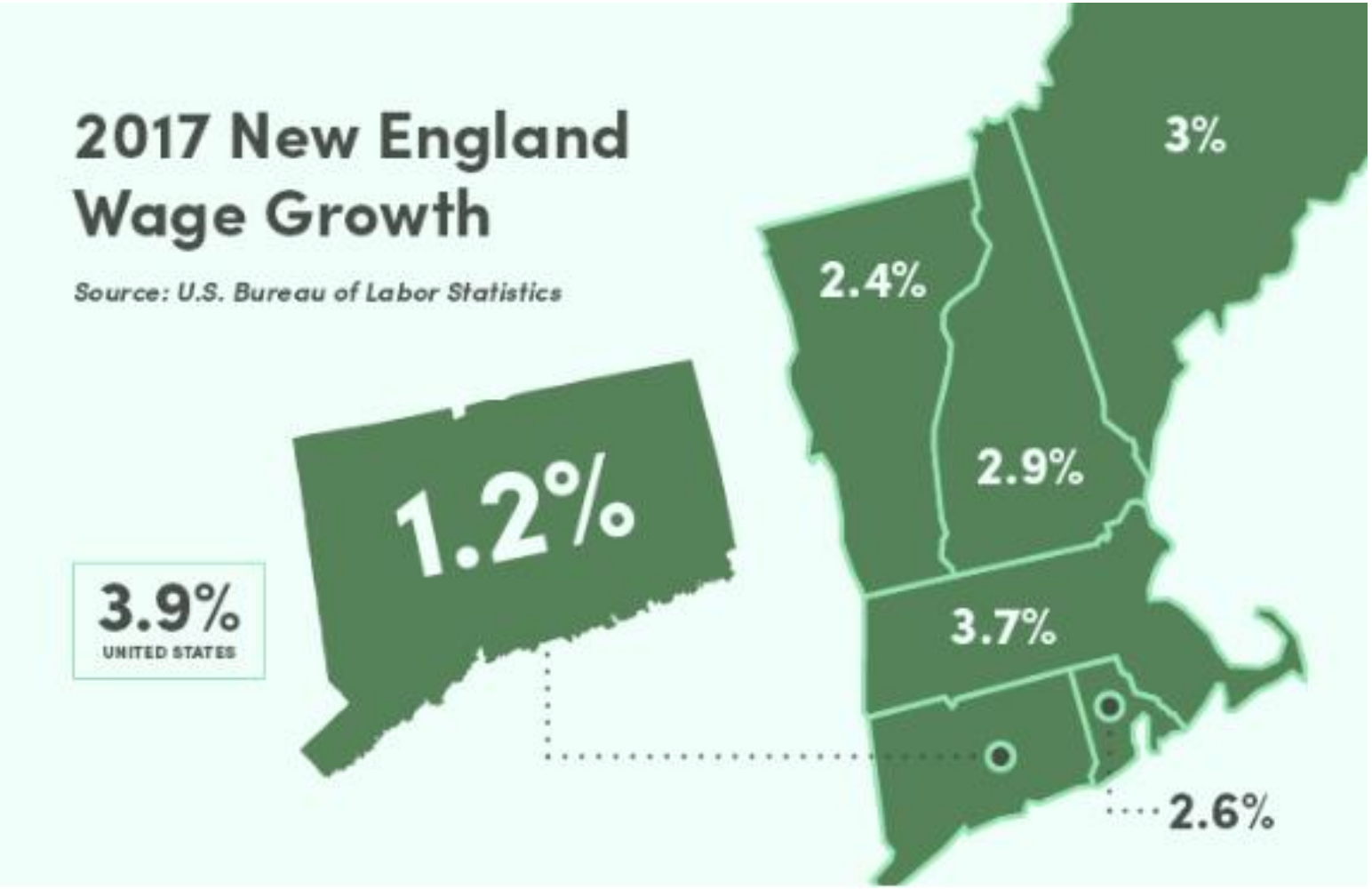
- Wage is a more tangible indicator for most individuals than "personal income" as it more closely represents "take-home pay."

Setting the cost growth target to the growth of Connecticut residents' wage growth implies that **health care should not grow faster than "take-home pay" of Connecticut residents**.

What It Means to Use Rate of Growth in Connecticut Residents' Wages

- Wages and salaries represent 43% personal income and have grown slower than personal income due to:
  - Retirement of baby boomers
  - Boost in non-wages over recent past, in particular among the highest income earners
- Public Act 19-4 sets the minimum wage to increase gradually according to the following schedule, after which it is indexed to federal economic indicators:
  - $11 on October 1, 2019
  - $12 on September 1, 2020
  - $13 on August 1, 2021
  - $14 on July 1, 2022
  - $15 on June 1, 2023

In 2017, Connecticut Wage Growth was the Fifth Slowest in the U.S., and Slowest in New England



Wages were the fifth highest in the country – 20% above the national level – but growth was slow.

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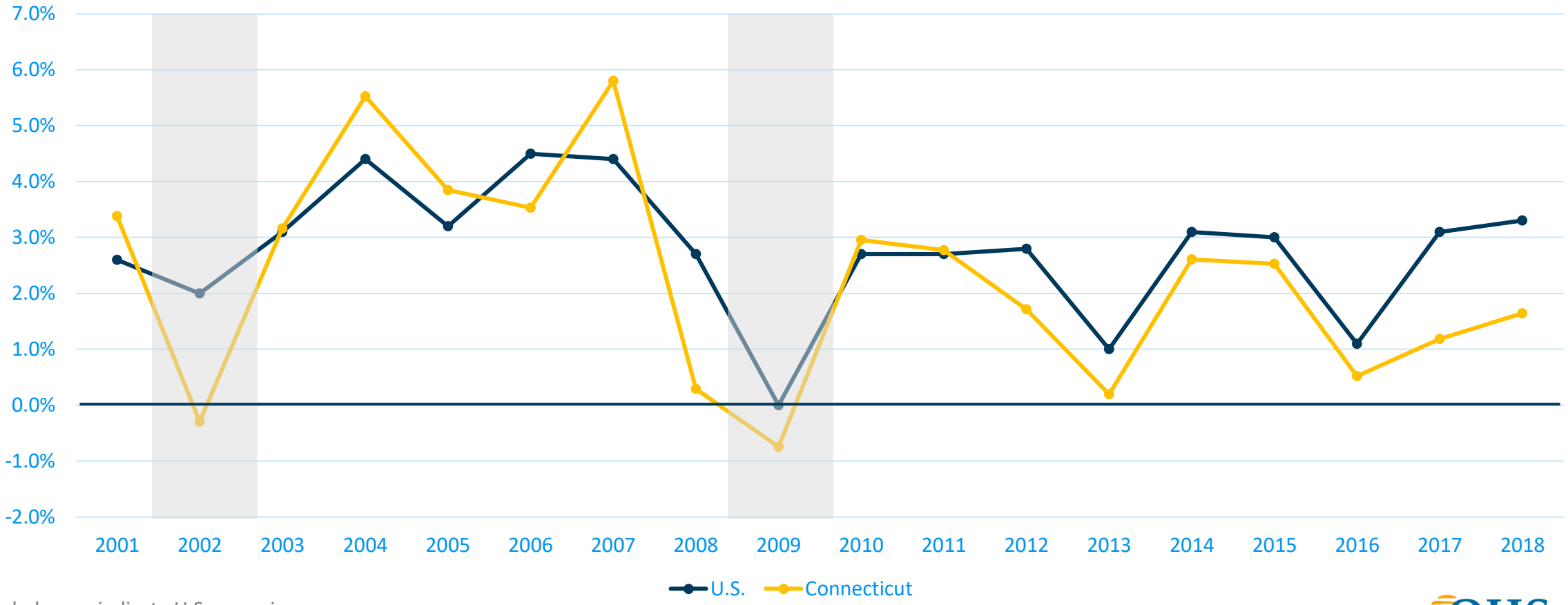
Annual Rate of Average Per Worker Wage Growth in the U.S. and Connecticut, 2001-2018



Shaded areas indicate U.S. recessions.

SOURCE: Connecticut Department of Labor, Office of Research, Annual Averages – Employment & Wages by Industry (QCEW), retrieved from https://www1.ctdol.state.ct.us/lmi/202/202_annualaverage.asp, May 6, 2020.

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Option 4: Inflation, as Measured by Consumer Price Index – All Urban (CPI-U)

What It Means to Use the Consumer Price Index

The Consumer Price Index looks at prices paid by typical consumers for a "market basket" of retail goods and other items.

- It is most often measured using "CPI All Urban or CPI-U," which captures the experience of 94% of Americans.

It includes prices related to:

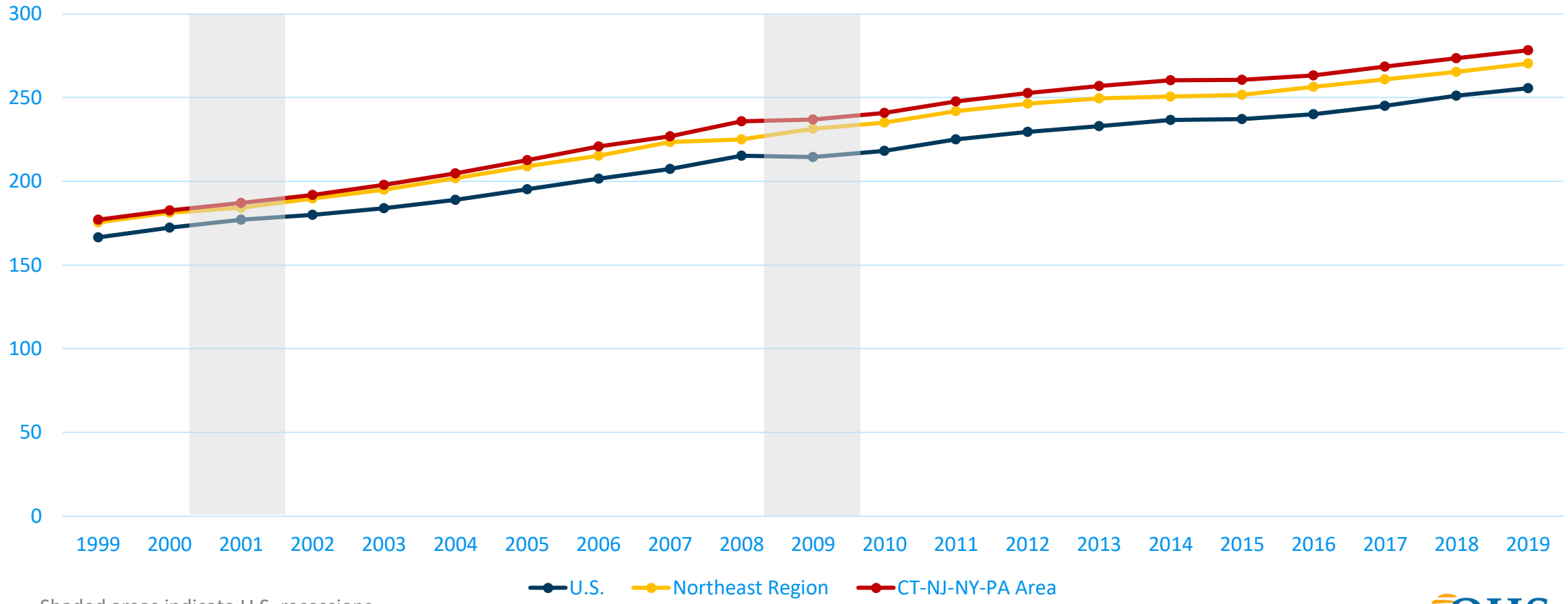
- Food
- Clothing
- Shelter
- Fuel
- Transportation
- Medical care
- Prescription drugs
- Other goods and services that people buy for day-to-day living

What It Means to Use the Consumer Price Index

Generally, if the cost growth target is tied to inflation, then the target would imply that **health care should not grow faster than the average rise in consumer prices**.

- This would tie the health care cost growth target to the experience of consumers at the grocery store or shopping mall.
- The U.S. Bureau of Economic Analysis no longer measures CPI specifically for Connecticut, but does so for the "Northeast Region" and the "CT-NJ-NY-PA Area."

Average Annual CPI-U in the U.S., Northeast Region and CT-NJ-NY-PA Area, 1999-2019



Shaded areas indicate U.S. recessions.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Retrieved from: https://www.bls.gov/regions/new-england/data/consumerpriceindex_northeast_table.htm, May 6, 2020.

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Comparison of Options for Establishing a Cost Growth Benchmark

Comparison of Options for Establishing the Benchmark

	Advantages	Disadvantages
1. Gross State Product	Used by most other states with cost growth targets; there is value to having consistent policies.	Abstract economic concept that may not resonate with citizens.
2. Personal Income	Recognizes that income is more than just wages.	Measure grows faster than wages because it accounts for higher earner non-wage income.
3. Average Wage	More consumer-oriented reference to "take-home pay."	Does not reflect relationship of health care spending growth vis-a-vis the larger economy.
4. Inflation – CPI-U	Treats health care as another consumer household expense, much as consumers do.	There is no longer a Connecticut-specific measure of CPI-U so may not be reflective of Connecticut's experience. Also, captures only price & not volume.

What We'll Discuss During the Next Meeting

- Before we make any decisions about a cost growth benchmark methodology, we need to discuss a few more pieces of the puzzle.
- **Historical vs. Forecasted:** The trend of each of these measures can measured by looking at historical time periods (what was the growth over the past 5, 10, 20 years) or looking at forecasts (what's the expected growth in the future).
- We will then review possible values for the economic indicators of interest to you, calculated in multiple ways.

Wrap-Up & Next Steps

Meeting Schedule

Meeting #	Date	Time
4	Thursday, June 4	1-3pm
5	Tuesday, June 16	2-4pm
6	Thursday, July 2	1-3pm
7	Wednesday, July 29	1-3pm
8	Thursday, August 13	1-3pm
9	Thursday, August 27	1-3pm
10	Thursday, September 24	1-3pm