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October 21, 2020

Victoria Veltri
Executive Director
State of Connecticut Office of Health Strategy
P.O. Box 340308
450 Capitol Avenue MS#51OHS
Hartford CT 06134-0308

**Re: Connecticut Association of Health Plans (CTAHP) Comments: Preliminary Recommendations of the Healthcare Cost Growth Benchmark Technical Team.**

Dear Ms. Veltri:

The Connecticut Association of Health Plans (CTAHP) is pleased to offer the following comments to OHS on the Technical Team's Preliminary recommendations regarding the Healthcare Cost Growth Benchmark. By way of background, CTAHP is comprised of Aetna, Anthem, Cigna, ConnectiCare, Harvard Pilgrim, and UnitedHealth. Together we welcome the opportunity to work with OHS in fulfilling the obligations set forth in Governor Lamont's Executive Order #5.

CTAHP supports the State's commitment to improving health care outcomes for all Connecticut residents and reducing the overall growth rate of health care costs. The Association also supports increased transparency within the system and looks forward to working with OHS and other key stakeholders in developing effective strategies to achieve these goals. Toward that end, please see the following comments and suggested revisions for your consideration.

- It is imperative that any plan implemented pursuant to the executive order also recognize the monumental impact that COVID-19 and the Public Health Emergency have had, and will continue to have, on health care spending in 2020 and 2021. As such, CTAHP supports the recommendation to collect baseline data from 2018 and 2019 and to identify healthcare spending trends prior to the pandemic. Likewise, until the end of the pandemic, data collected should be used for informational purposes-only to reflect the unpredictable and changing landscape.

- CTAHP supports the recommendation to revisit the methodology and calculation of the health care cost benchmark if there is a sharp rise in inflation in the years 2021-2025. We further recommend that OHS include an automatic periodic review of the methodology to ensure that the benchmark continues to be appropriate -- especially in light of the anticipated continued economic impact of COVID.

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- CTAHP recommends that an extensive assessment of existing data sources be undertaken before any new collection measures are mandated or recommended. Utilizing existing sources will minimize the administrative burden placed on various stakeholders in complying with the initiative. Avoiding duplication of regulatory requirements is crucial in conserving ever valuable resources.

- With respect to the recommendation that the health care cost growth benchmark be calculated as a blend of 20% of the per capita Potential State Gross Product (PSGP) and 80% of the projected growth in median income, CTAHP appreciates the challenge facing Connecticut residents when healthcare costs as a percentage of income continue to increase. However, we recommend that OHS first conduct further analysis using prior years' experience to determine if the recommended weighting is likely to be appropriate for the initial years of the program. Five states with existing or proposed health care cost benchmarks all use PSGP alone to calculate their cost benchmarks. There is value to consistency across markets.

- Consideration of general utilization and various trend drivers -- the cost of pharmaceuticals in particular -- must be included in any analysis.

- Connecticut's emergency services surprise billing law must be revisited within the context of a cost growth target. The current "greatest of three" law is based off of charges submitted (not paid) artificially elevating the cost of certain services to the disservice of consumers.

- OHS should also consider the impact of various plan designs on cost growth and whether certain designs encourage or discourage value-based care.

- Out-of-state services provided must be contemplated in any analysis. Connecticut is a small state and many individuals seek care across the state's borders. OHS should adjust for this factor.

- Provider consolidation should be part of any ongoing analysis. As provider markets become more concentrated, the impact on cost growth must be determined. OHS should model the Massachusetts' health care cost benchmark program.

- OHS must be cognizant of the time needed by carriers to implement compliance procedures. Payers will need time to revise and/or establish internal processes and capabilities in order to comply with the Executive Order. Sufficient time must be granted for implementation. CTAHP also suggests that OHS recognize "good faith" compliance efforts by various stakeholders within the context of this effort as priorities shift with the ebb and flow of the pandemic.

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Some additional comments for your consideration.

**Health Care Cost Growth Target**

- The Team defines the Total Health Care Expenditures (THCE) as:
  - Allowed amount of claims-based spending from an insurer to a provider, net of pharmacy rebates;
  - All patient cost-sharing amounts, including, but not limited to deductibles and copayments; and
  - Net Cost of Private Health Insurance (NCPHI)

CTAHP recommends that the first component be changed from "allowed claims" to "paid claims" because allowed claims will include the cost-sharing amounts payable by individuals that are included in the second bullet.

- For reference, Massachusetts calculates the THCE as:
  - All medical expenses paid to providers by private and public payers, including Medicare and Medicaid (MassHealth);
  - All patient cost-sharing amounts (for example, deductibles and co-payments); and
  - The net cost of private insurance (for example, administrative expenses and operating margins for commercial payers).

- The Team recommends THCE include self-insured data. CTAHP strongly urges OHS and the State to consider the ERISA preemption issues related to submissions by third-party administrators (TPAs) of self-insured ERISA health plan data. The conversation regarding self-insured data needs to be expanded to include the employer community.

- The Team recommends the THCE include Medicare data. Release of Medicare data is subject to CMS approval and to a series of confidentiality provisions making the process to obtain carrier data complex and complicated. OHS should further explore getting the any necessary data directly from CMS.

- The Team recommends OHS gather social risk data and analyze the relationship between social risk variables and health care spending using APCD data to inform future social risk adjustment of cost growth relative to the cost growth benchmark. CTAHP also recognizes the importance of accounting for social risk variables in risk adjustment and supports the Team's recommendation to explore the emerging focus on social determinants of health provided that collection efforts are conducted on a consensus basis.

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- The Team recommends the cost growth target be calculated at the state, payer, market, and large provider entity level. CTAHP encourages OHS to consider, if data is readily available, also calculating and reporting targets by service category including, but not limited to, hospital inpatient, hospital outpatient, physician primary care, physician specialty care, and pharmacy.

**Primary Care Spending Target**

- The Team recommends that by 2025 primary care spending in Connecticut, as a percentage of total health care expenditures, should reach a target of 10%. CTAHP recognizes the value of primary care services and supports OHS' commitment to increasing primary care spending as a percentage of total health care spending. Primary care physicians provide preventive care, encourage healthy lifestyle choices, identify and treat medical conditions, and make referrals to specialists. Achievement of a 10% target should be reflective of both value-based payment investments as well as the resulting reduction in spending from non-primary care services (i.e., specialists, hospitals, pharmaceuticals) that would be expected to occur under a more robust primary care system. Increased primary care can lead to a significant decrease in overall health care spending and CTAHP supports this goal. A 10% target, however, may be too aggressive given that the current percentage is less than 5%. With COVID and the current level of disruption to the delivery system, we would encourage OHS to be flexible on the target percentage and establish ranges instead.

- CTAHP understands the current challenges in setting a primary care spending target in 2020 and supports the Team's recommendation for a target of 5% for 2021, but again suggests that ranges may be more appropriate given the current climate. We look forward to collaborating with OHS to develop recommendations for annual primary care spending targets for 2022-2024.

- The Team offered two definitions of primary care spending to calculate primary care services as a percentage of total health care expenditures. CTAHP supports the broader definition that includes these OB/GYN services etc. This definition is a more accurate reflection of how individuals access care.

- The Team specifically references Oregon and Rhode Island but, it bears noting that neither state includes primary care data from self-insured ERISA plans. CTAHP recommends excluding self-insured ERISA plan data from the primary care spending targets.

- The Team recommends that efforts to increase primary care spending:
  - align with existing statewide initiatives and policies;
  - increase utilization of value-based incentives;
  - provide value; and
  - reward performance.

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CTAHP agrees with these principles and supports the promotion of value-based care and movement toward new, lower cost payment models. Incentivizing providers to take on more responsibility for patients' overall care will help to reduce healthcare costs.

**Data Use Strategy**

- The Team made preliminary recommendations on four priority audiences because of their ability to utilize analysis insights to safely lower health care spending growth: provider organizations, policymakers, employers, and the public. While we agree with the inclusion of these important stakeholders, we recommend that OHS include payers as a fifth priority audience. Payers are uniquely qualified to examine demographic, claims, and provider data to identify trends and opportunities for improvement. Given that NCPHI data is a key component of the cost growth target, OSH should include payers as a priority audience.

Thank you for the opportunity to comment.

Sincerely,

Susan J. Halpin
Executive Director

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