CONNECTICUT

Healthcare Cost Growth Benchmark
Technical Team Meeting #1
November 1, 2024

Welcome

CONNECTICUT

Meeting Agenda

Time	Topic
2:00 p.m.	I. Call to Order and Introductions
2:05 p.m.	II. Charter
2:10 p.m.	III. Overview of Meeting Plan
2:15 p.m.	IV. Background and Orientation to Connecticut's Cost Growth Benchmark and Primary Care Target
3:50 p.m.	V. Public Comment
3:55 p.m.	VI. Wrap-up & Next Steps
4:00 p.m.	VII. Adjourn

I. Call to Order and Introductions

CT Healthcare Benchmark Technical Team

Loren Adler, MS, Fellow and Associate Director, Center on Health Policy, Brookings Institution

Donald M. Berwick, MD, MPP, Senior Fellow at the Institute for Healthcare Improvement

Sabrina Corlette, JD, Co-Director, Center of Health Insurance Reforms, Georgetown University's McCourt School of Public Policy

Francois de Brantes, MS, MBA, Senior Partner, High Value Care Incentives Advisory Group

Stefan Gildemeister, MA, State Health Economist and Director, Minnesota Department of Health

Paul Grady, Connecticut Business Group on Health

Jason Hockenberry, PhD, Associate Dean for Faculty Affairs, Department Chair and Professor of Public Health (Health Policy)

Chris Manzi, MBA, President, Pequot Health Care

Roslyn Murray, PhD, MPP, Assistant Professor of Health Services, Policy and Practice, Brown University Affiliated Faculty, Center for Advancing Health Policy through Research

Joshua Wojcik, Director, Health Policy and Benefits Services Division, Office of the State Comptroller

II. Charter

Objectives of the Cost Growth Benchmark Technical Team

- The Technical Team's charge is to recommend the following to OHS:
  - Annual healthcare cost growth benchmarks across all payers and populations for CYs 2026-2030
  - Primary care spending targets across all payers and populations as a share of total health care expenditures for CYs 2026-2030
  - A methodology and threshold for informing OHS' annual decision on whether to adjust the next year's benchmark value due to inflation
  - Whether to report Advanced Network spending growth by market only or overall, across markets
- The Technical Team is charged with centering health equity in its recommendations.

How We Will Achieve These Objectives (1 of 2)

- The Technical Team will convene for five two-hour meetings between November and January to develop its recommendations.
- Over the course of these meetings, we will present you a series of methodological design questions to inform your recommendations.
- We will provide context for the design questions, including statutory references, strengths and limitations, and insights from prior experience and approaches in other states.

How We Will Achieve These Objectives (2 of 2)

- This process is like the one implemented with OHS' 2020 Technical Team; however, given the compressed timeline and the State's implementation experience, we will not revisit every methodological decision OHS adopted in 2020.
- In addition, the Technical Team will not provide recommendations on design components that are defined in statute.
  - The initial benchmark and spending target were developed prior to the program being placed in statute.
- We will provide the necessary context and brief review of those details to Technical Team members during discussions.

III. Overview of Meeting Plan

Plan of Meetings: Meeting #1

Date	Meeting Goals

Meeting 1
November 1, 2024
	• Charter
	• Charge and purpose of the group
	• Overview of meeting plan
	• Background and orientation to Connecticut's Cost Growth Benchmark and Primary Care Target
	  ○ Statutory provisions
	  ○ General introduction to healthcare cost growth benchmark and primary care targets
	  ○ Connecticut's healthcare cost growth benchmark and primary care spending results to date
	  ○ Health equity in the context of healthcare cost growth benchmarks and primary care targets, including approaches taken in other states

Plan of Meetings: Meeting #2

Date	Meeting Goals

Meeting 2
November 26, 2024
	Healthcare Cost Growth Benchmark
	• Review of current total healthcare expenditure measurement and reporting methodology
	• Methodology for setting the 2026-2030 healthcare cost growth benchmarks
	  ○ Decision-making criteria for the economic indicator on which the benchmark will be based
	  ○ Review of other states' methodologies and values
	  ○ Review list of indicator options in Connecticut, e.g., gross state product, potential gross state product, median income, average wage *(without discussion of a value for the benchmark)*
	  ○ Historical and/or forecasted trends for indicators

Plan of Meetings: Meeting #3

Date	Meeting Goals

Meeting 3
December 13, 2024
	Healthcare Cost Growth Benchmark: Continuing discussion of methodology for 2026-2030 healthcare cost growth benchmarks
	• Cost growth benchmark modeling (e.g., blending two indicators)
	• Establishing the 2026-2030 cost growth benchmarks: consideration of any adjustments to the base value
	• Reporting performance against the healthcare cost growth benchmark, including
	  ○ Risk adjustment
	  ○ Improving statistical confidence (truncation, confidence intervals)
	
	Primary Care Spending Target
	• Review of Connecticut's primary care spending target initiative
	• Experience of other states with primary care spending targets
	• Defining and measuring primary care, including approaches other states have taken for each of these components

Plan of Meetings: Meetings #4 and #5

Date	Meeting Goals
Meeting 4 January 10, 2025	**Primary Care Spending Target: Continue discussion of defining primary care** • Defining and measuring primary care, including approaches other states have taken for each of these components *(continued)* • Measuring primary care as a percentage of total payments • Data source(s) for measurement • Payers from which OHS will collect data • Setting the primary care spending target, 2026-2030
Meeting 5 TBD	**Finalize recommendations for healthcare cost growth benchmark and primary care spending targets** **Additional discussion topics** • Inflation adjustment methodology and threshold • Assessing unintended consequences of the cost growth benchmark (*possibly*).

IV. Background and Orientation to Connecticut's Cost Growth Benchmark and Primary Care Target

Connecticut's Healthcare Benchmark Legislation and Governance Structure

About the Office of Health Strategy (OHS)

- The Office of Health Strategy (OHS) was established effective January 1, 2018 via June Special Session PA 17-2.
- OHS' mission is to implement comprehensive, data-driven strategies that promote equal access to high quality health care, control costs, and ensure better health outcomes for the people of Connecticut.
- OHS's work is divided into four workstreams:
    1. Health Data & Analysis (e.g., All-Payer Claims Database, oversight of Health Information Exchange)
    2. Health Innovation & Strategy (e.g., affordability, payment and service delivery reform)
    3. Health Systems Planning (e.g., certificate of need program)
    4. Health Equity and SDOH (e.g., hospital community benefit)

Healthcare Benchmark Legislation

- Governor Lamont signed Executive Order #5 in January 2020, charging OHS to:
  - set a benchmark for total healthcare expenditures growth in the state;
  - set benchmarks for healthcare quality in the state, and
  - set targets for increased primary care spending as a percentage of total health care expenditures.
- During the 2022 legislative session, C.G.S. §§ 19a-754f et seq codified Executive Order No. 5 into law.
- OHS carried out the initial development and the implementation of the *Healthcare Benchmark Initiative* in 2020 with the support of a predecessor Technical Team as the key deliberating body and a Stakeholder Advisory Board.

Connecticut's Healthcare Benchmark Initiative

- The Healthcare Benchmark Initiative plays a key role in improving the health of Connecticut residents. It helps:
  - ensure access to affordable, high-quality healthcare;
  - support and sustain Connecticut's primary care infrastructure, and
  - lower healthcare spending growth.
- In addition, the Healthcare Benchmark Initiative:
  - involves people interested in the performance of Connecticut's healthcare system, and
  - provides data to legislators and policymakers to improve healthcare quality and spending in Connecticut.

Connecticut's Healthcare Benchmark Initiative Annual Timeline

- In **August** each year, payers are required to submit aggregate data to OHS for the Healthcare Benchmark Initiative.
  - OHS then validates and analyzes the data, meeting with payers during the process, as necessary, and sharing initial results with payers and Advanced Networks for review.
- OHS must then report its findings by the following **March** and hold a public hearing on the findings by the end of **June**.
- Finally, by mid-**October**, OHS must submit a report to the General Assembly with recommendations (legislative or otherwise).
  - Though not required, OHS typically consults with its stakeholder Steering Committee when developing such recommendations.

Connecticut Benchmark Program: Key Deliberating Bodies

In addition to the **Technical Team**, OHS also works with the following bodies to advance the Healthcare Benchmark Initiative:

- The **Steering Committee** is charged with providing policy input OHS. It will also provide feedback to Technical Team recommendations regarding the cost growth benchmark and primary care target.
- The **Quality Council** is charged with developing Quality Benchmarks recommendations to OHS.
- OHS periodically consults with **other bodies**, such as the Health Care Cabinet, the Medical Assistance Program Oversight Council (MAPOC), and other stakeholders.

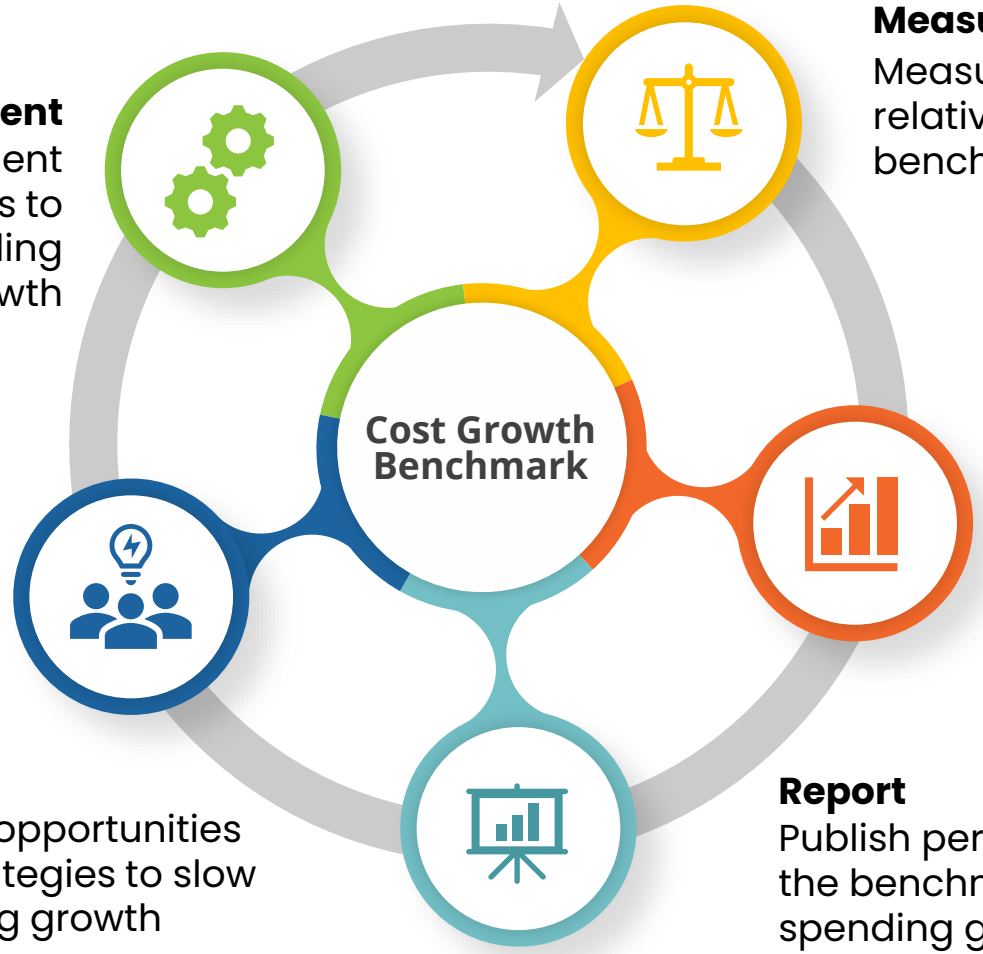
Connecticut's Healthcare Cost Growth Benchmark

What is a Healthcare Cost Growth Benchmark?

- It is a goal for how much health care spending per capita should grow each year.
- Benchmarks are set to promote more affordable and sustainable healthcare.
- *Ideally*, state leaders, health insurers, healthcare providers, businesses, and consumer advocates agree to these benchmarks and commit to taking action to achieve them.
  - Connecticut is still working to obtain these commitments from all health insurers and provider organizations.

States may use target or benchmark terminology. It's a matter of preference. States also use "**cost**" and "**spending**" interchangeably.

Logic Model for a Cost Growth Benchmark



Implement
Implement strategies to slow spending growth

Measure
Measure performance relative to the benchmark

Analyze
Analyze spending to understand spending trends and drivers

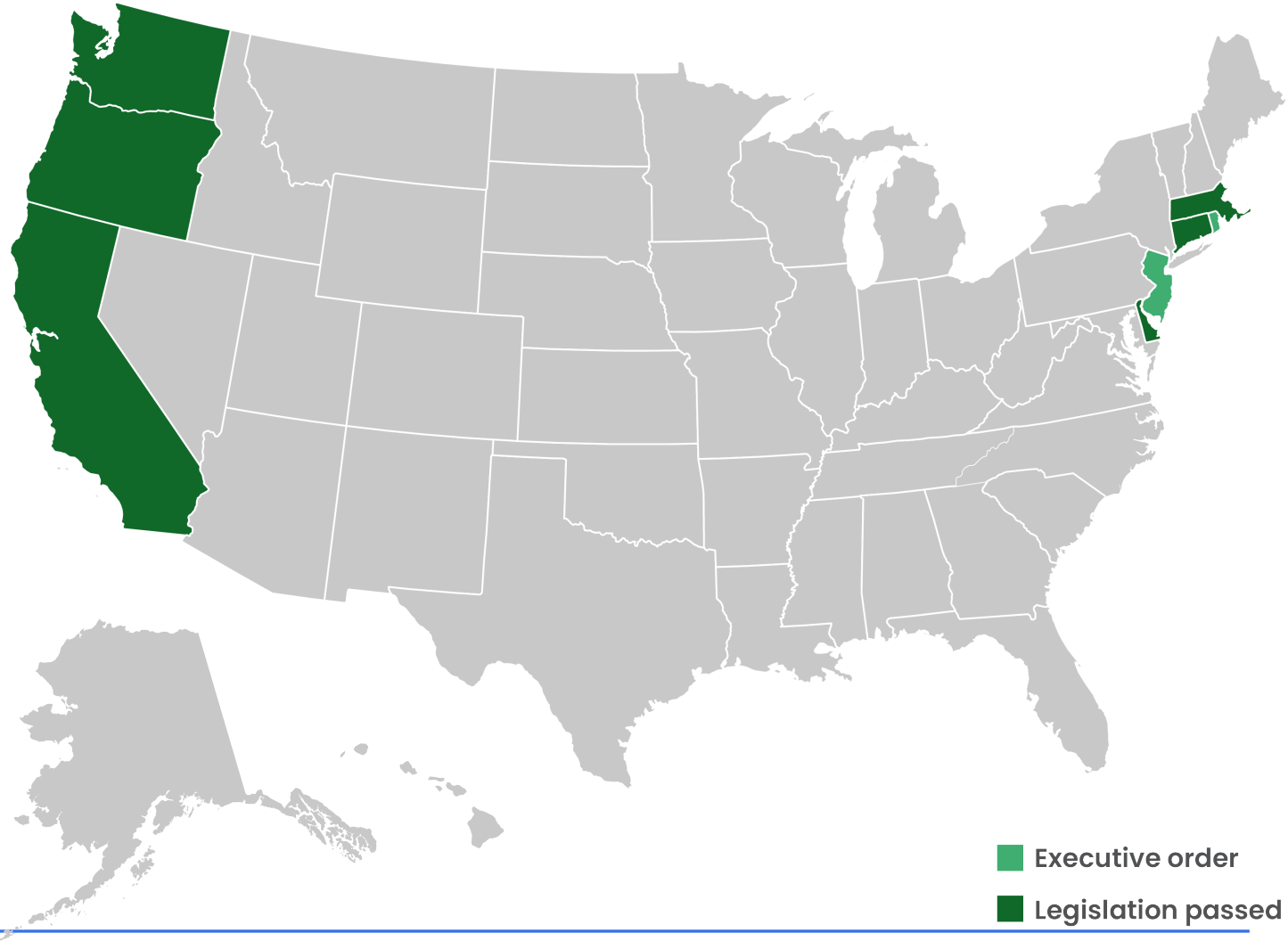
Report
Publish performance against the benchmark and analysis of spending growth drivers

Identify
Identify opportunities and strategies to slow spending growth

- The benchmark is not an end, but a means to slow spending growth.
- Complementary actions are required to attain that goal.

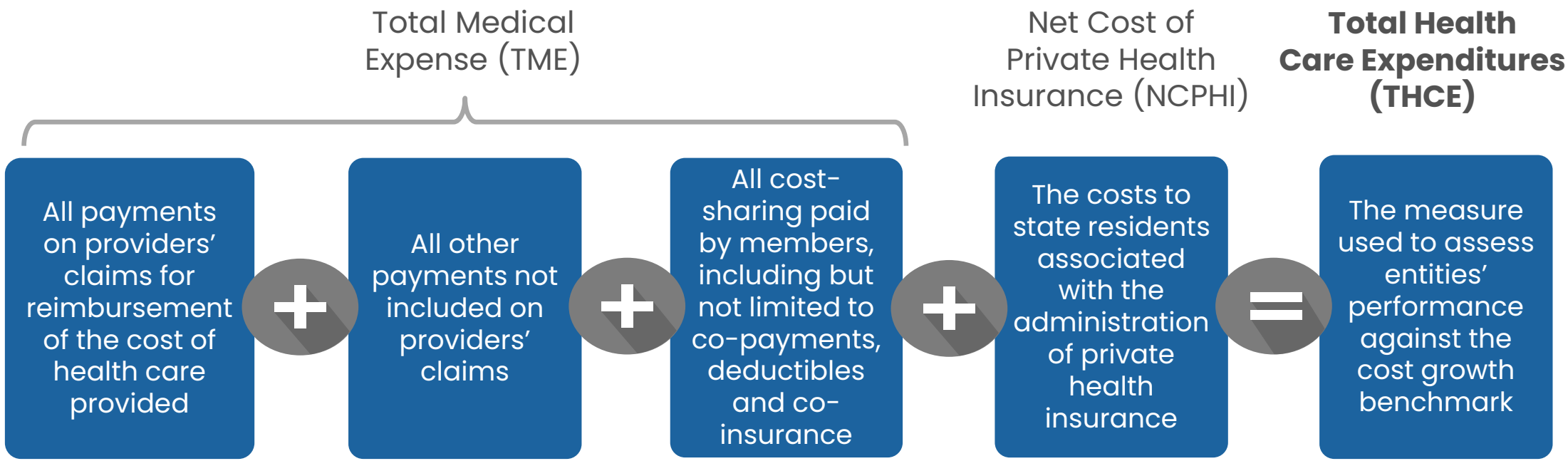
States with Healthcare Cost Growth Benchmarks

- 1 in 5 Americans Live in a State With a Cost Growth Benchmark
- Connecticut was the 5th state to establish a healthcare cost growth benchmark



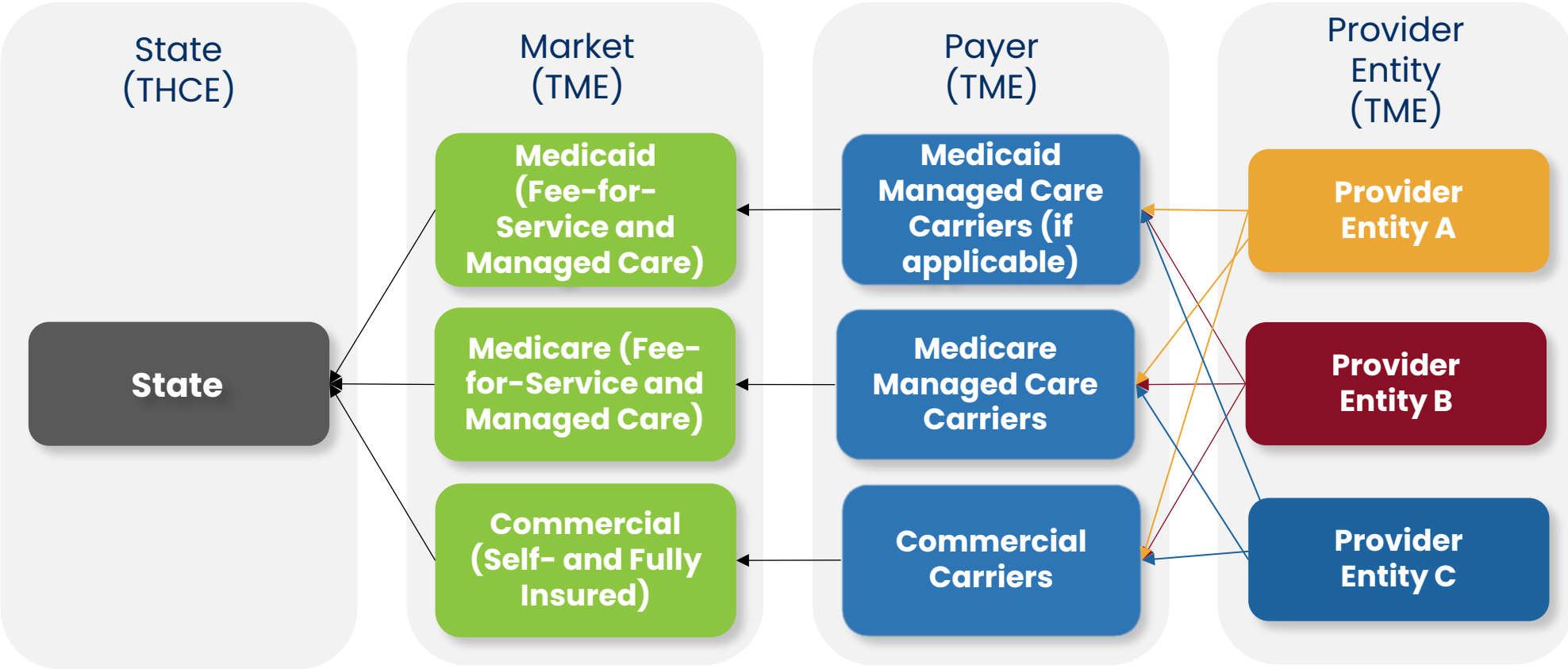
Measuring Healthcare Spending

Healthcare benchmark programs provide a comprehensive view of healthcare spending for their residents, across public and private payers.



Assessing Performance Against the Benchmark

States report healthcare spending at different levels to promote transparency and accountability for meeting benchmarks.



Importance of Equity in Cost Growth Benchmarks (1 of 2)

- Inequities within the health care system are well documented and are reflected in persistent health disparities and elevated disease burden.
- Inequities are present in higher health care spending, higher cost burdens, and an imbalanced distribution of resources.
- Inequities can occur across a broad range of dimensions including race and ethnicity, socioeconomic status, age, geography, language, gender, disability status, citizenship status, sexual orientation and gender identity.

Importance of Equity in Cost Growth Benchmarks (2 of 2)

- States are incorporating health equity into their cost growth benchmark programs in various ways, including:
  - Tying their benchmarks to consumer-centric economic indicators (e.g., income and wages)
  - Ensuring diverse representation of individuals on governing and/or advisory bodies
  - Incorporating equity into analyses of drivers of spending and spending growth by examining variation in utilization and spending by subpopulation
  - Analyzing price disparities among providers by geography (e.g., rural) and population (e.g., safety-net provider)
  - Monitoring for unintended consequences of their cost growth benchmarks, including decreased access to care and services.

Connecticut's Healthcare Cost Growth Benchmark, 2021-2025

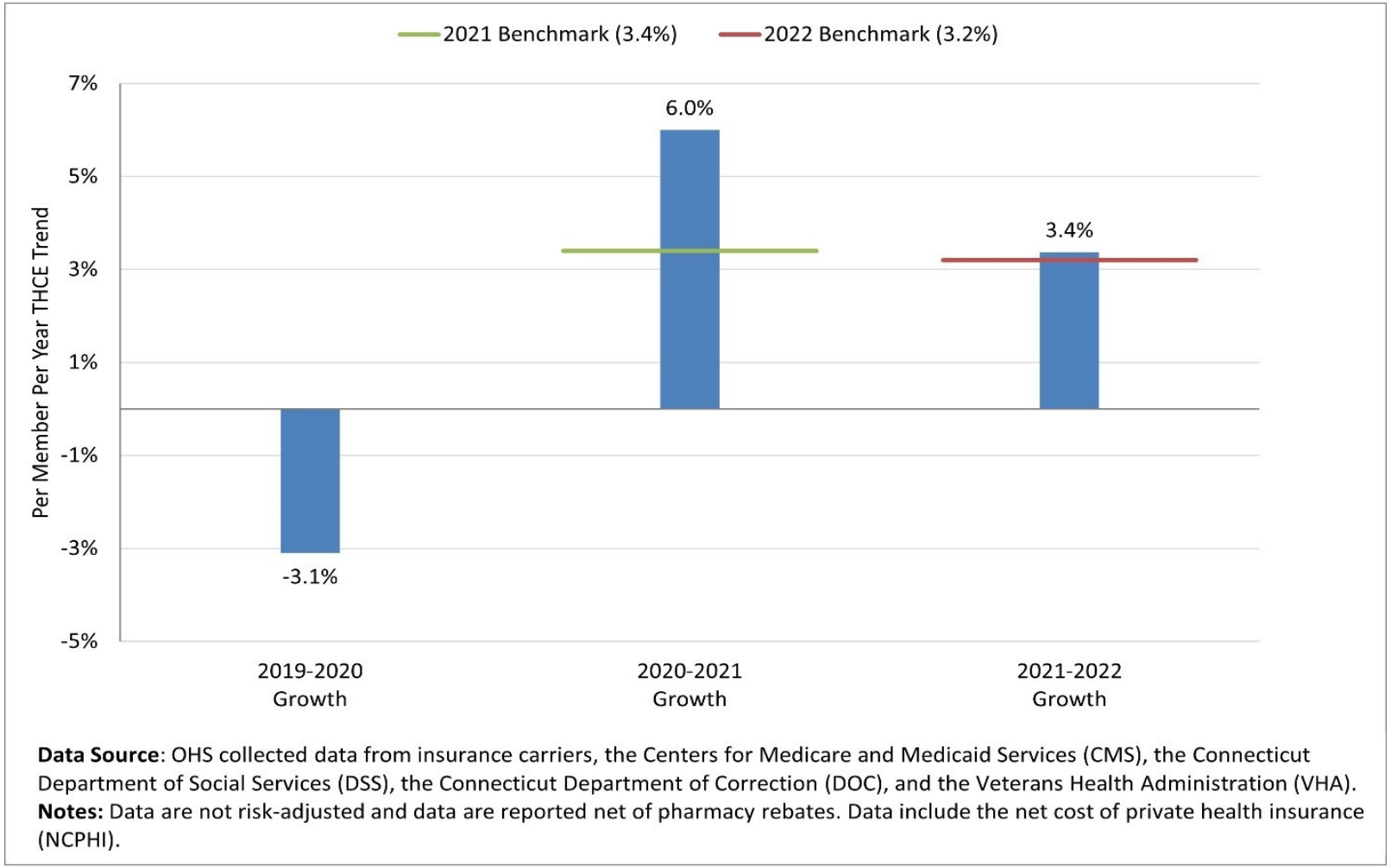
- The current benchmark value is based on a blend of forecasted per capita potential gross state product (PGSP) and forecasted growth in median income.
- Today we will provide general background information about cost growth benchmarks.

Calendar Year	Benchmark Values
2021	3.4%
2022	3.2%
2023	2.9%
2024	*4.0%
2025	2.9%

**Modified from 2.9% to account for inflation*

Statewide Cost Growth Benchmark Results, 2019–2022

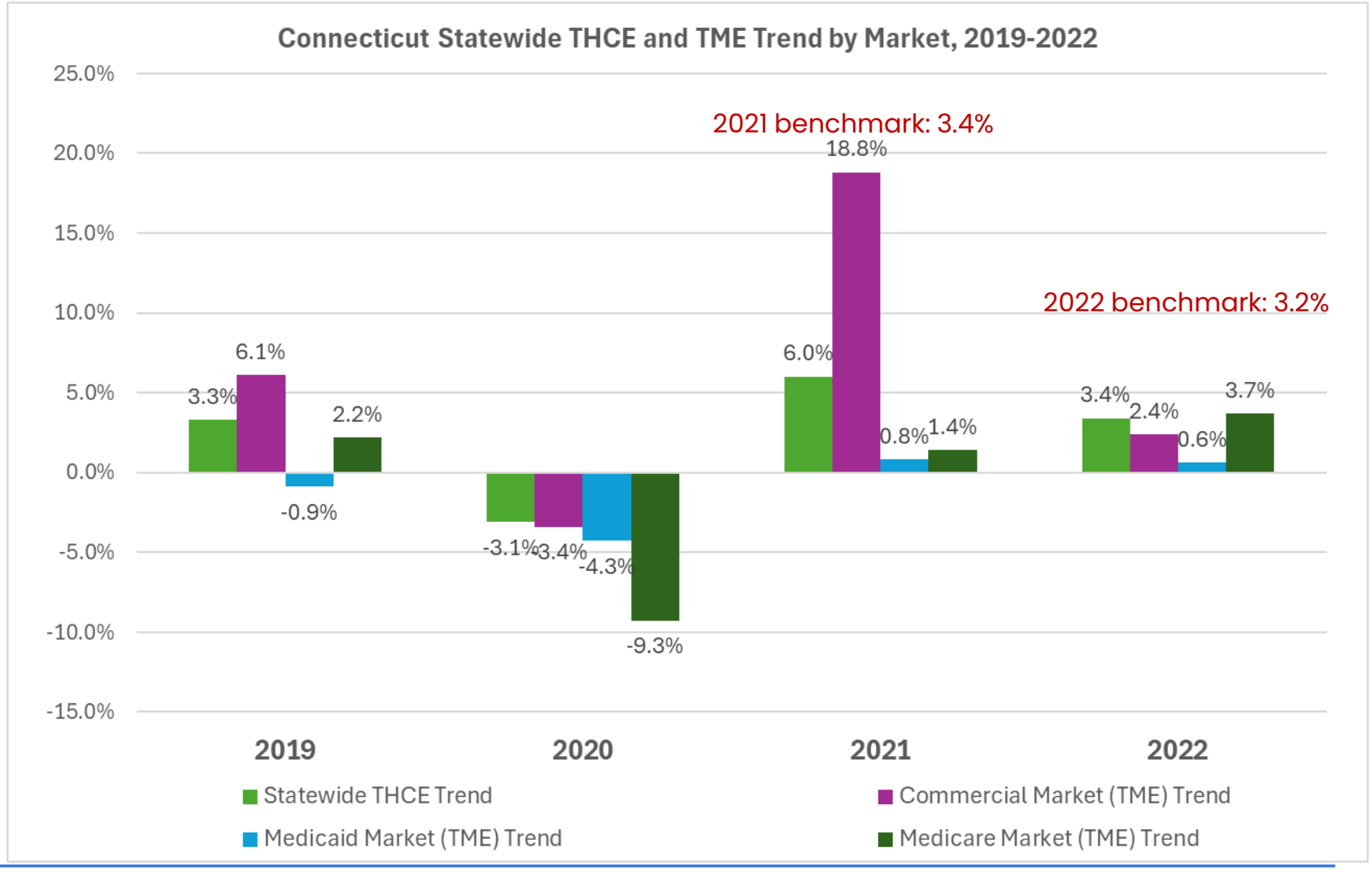
- Connecticut's Total Health Care Expenditures Grew 3.4% in 2022.
- Spending in 2022 grew more slowly than in 2021 but still exceeded the benchmark.
- OHS is currently analyzing 2023 spending data.



Data Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut Department of Correction (DOC), and the Veterans Health Administration (VHA).
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates. Data include the net cost of private health insurance (NCPHI).

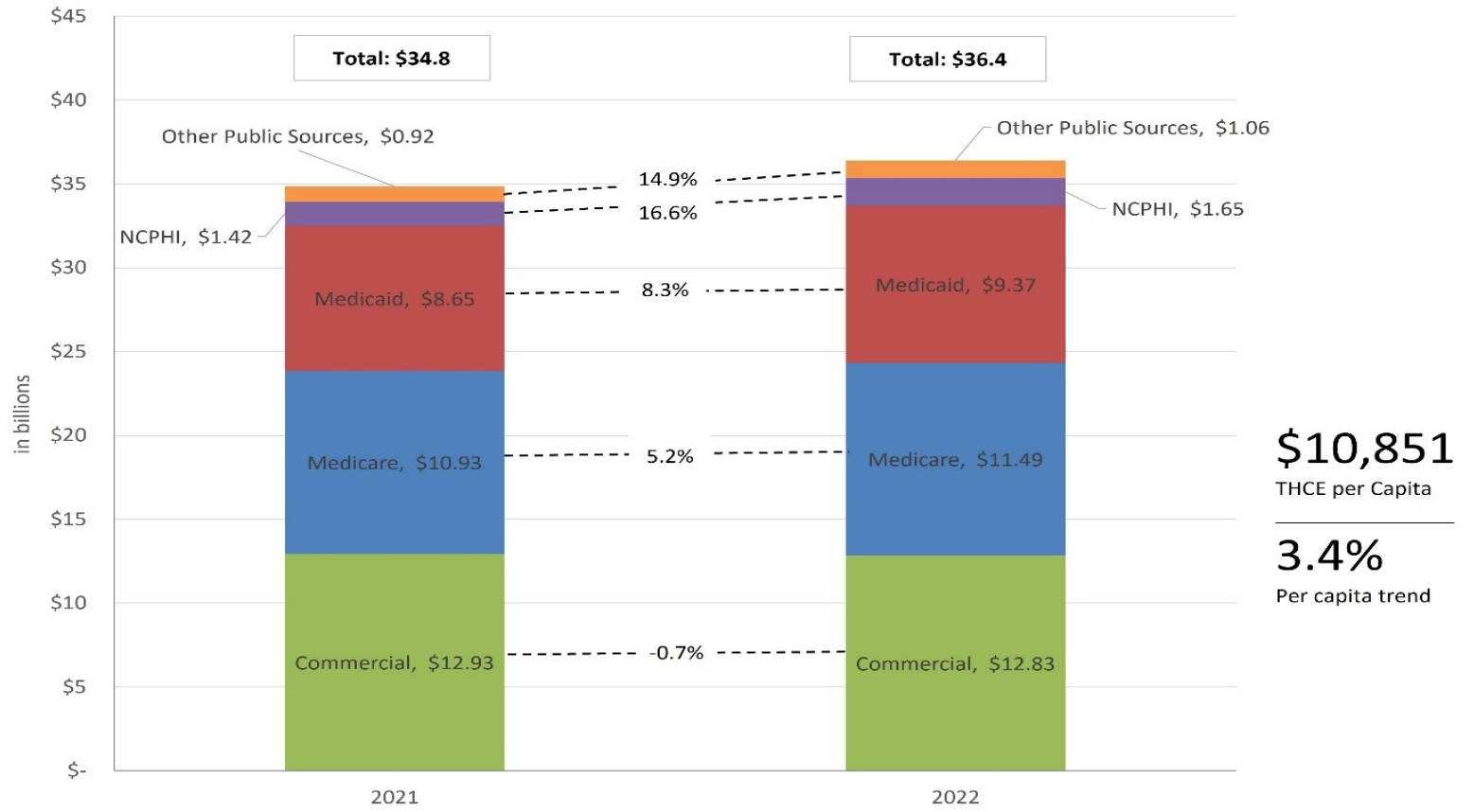
Cost Growth Benchmark Results Statewide and by Market, 2019–2022

- Connecticut collected 2019 and 2020 spending from insurers as a baseline.
- The benchmark became effective in 2021.



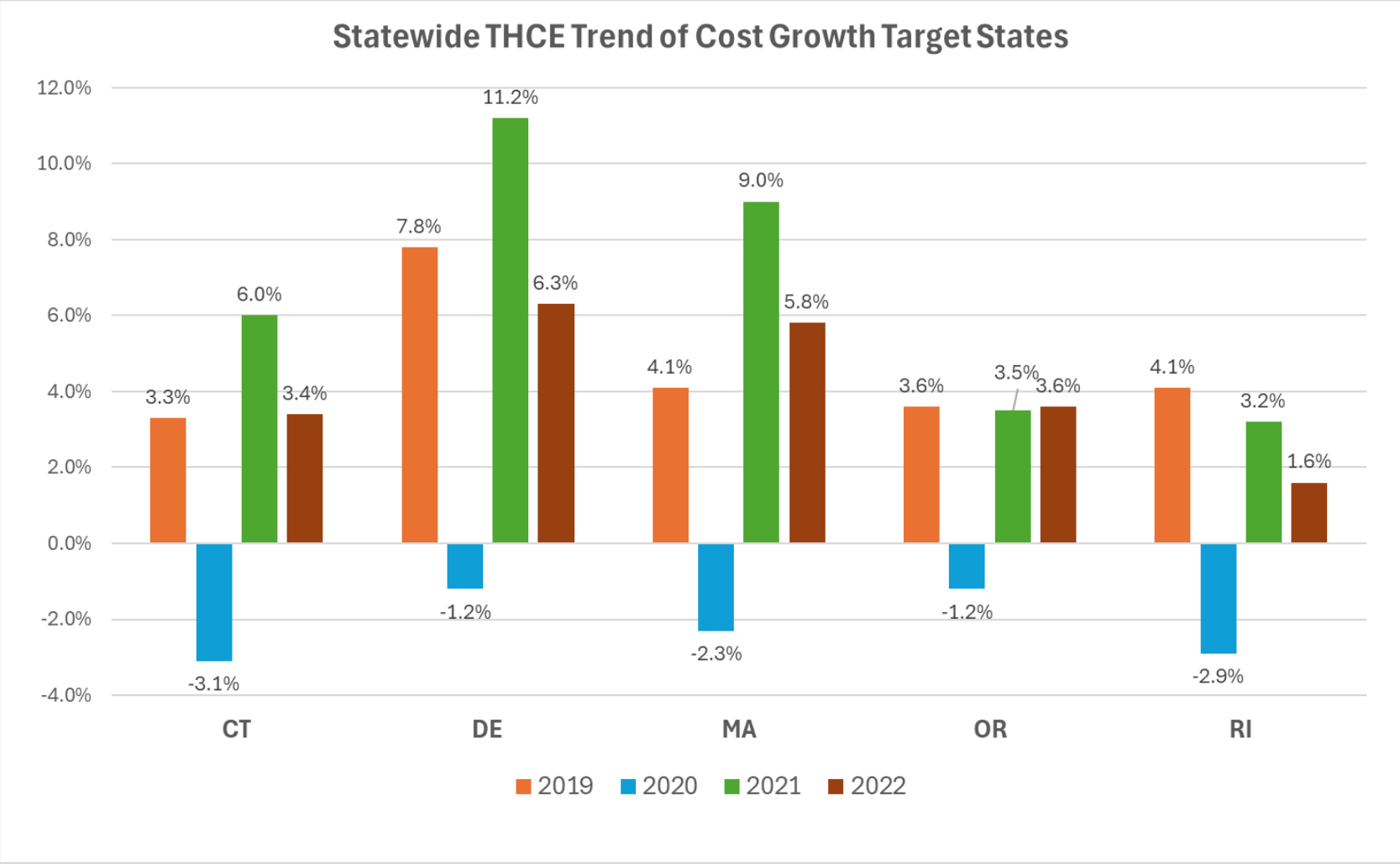
CONNECTICUT

Connecticut's Total Healthcare Expenditures were $36.4 billion in 2022

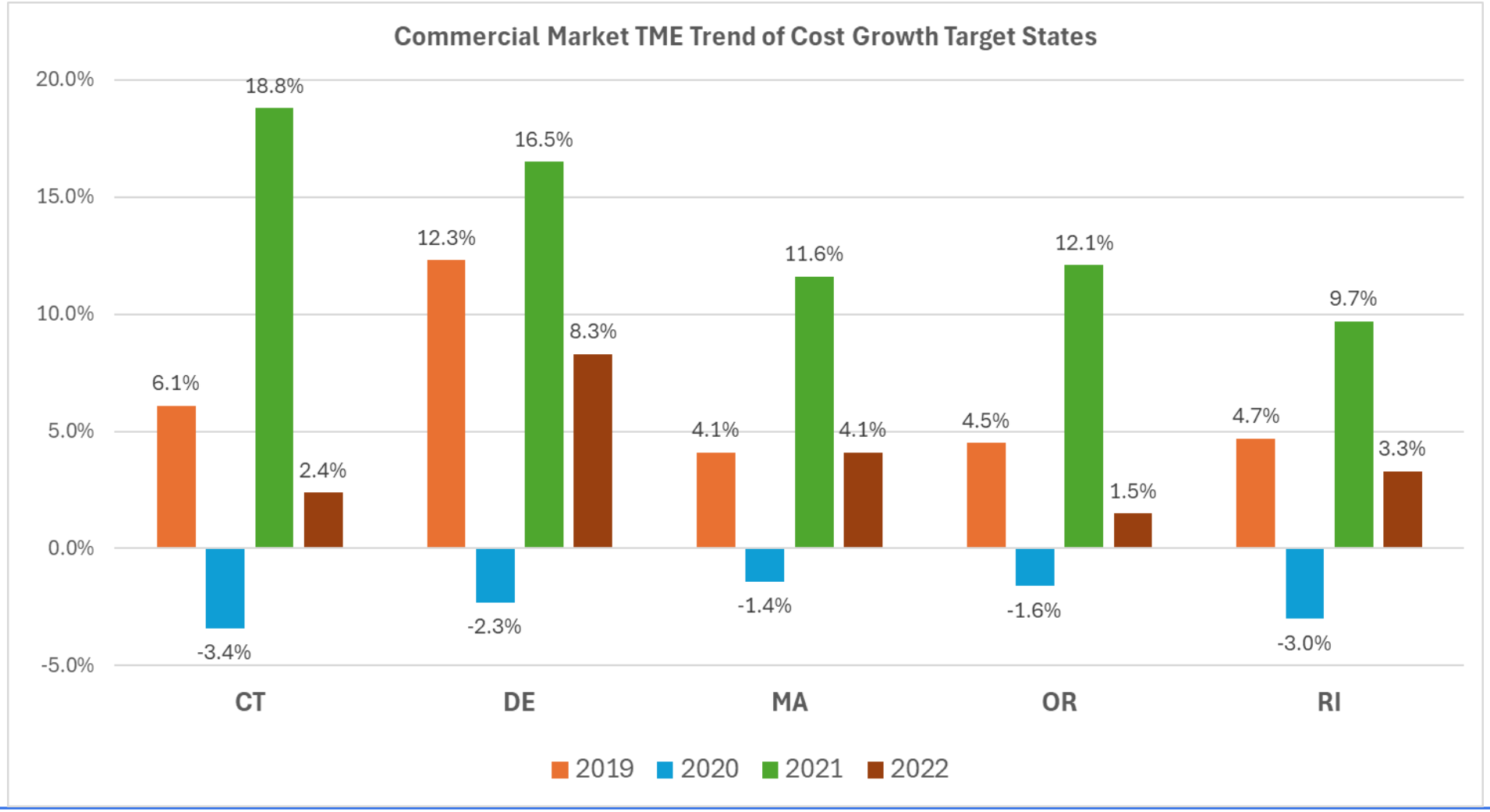


Data Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut Department of Correction (DOC), and the Veterans Health Administration (VHA).
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates. "Other Public Sources" includes CT DOC and VHA spending. "NCPHI" is the net cost of private health insurance.

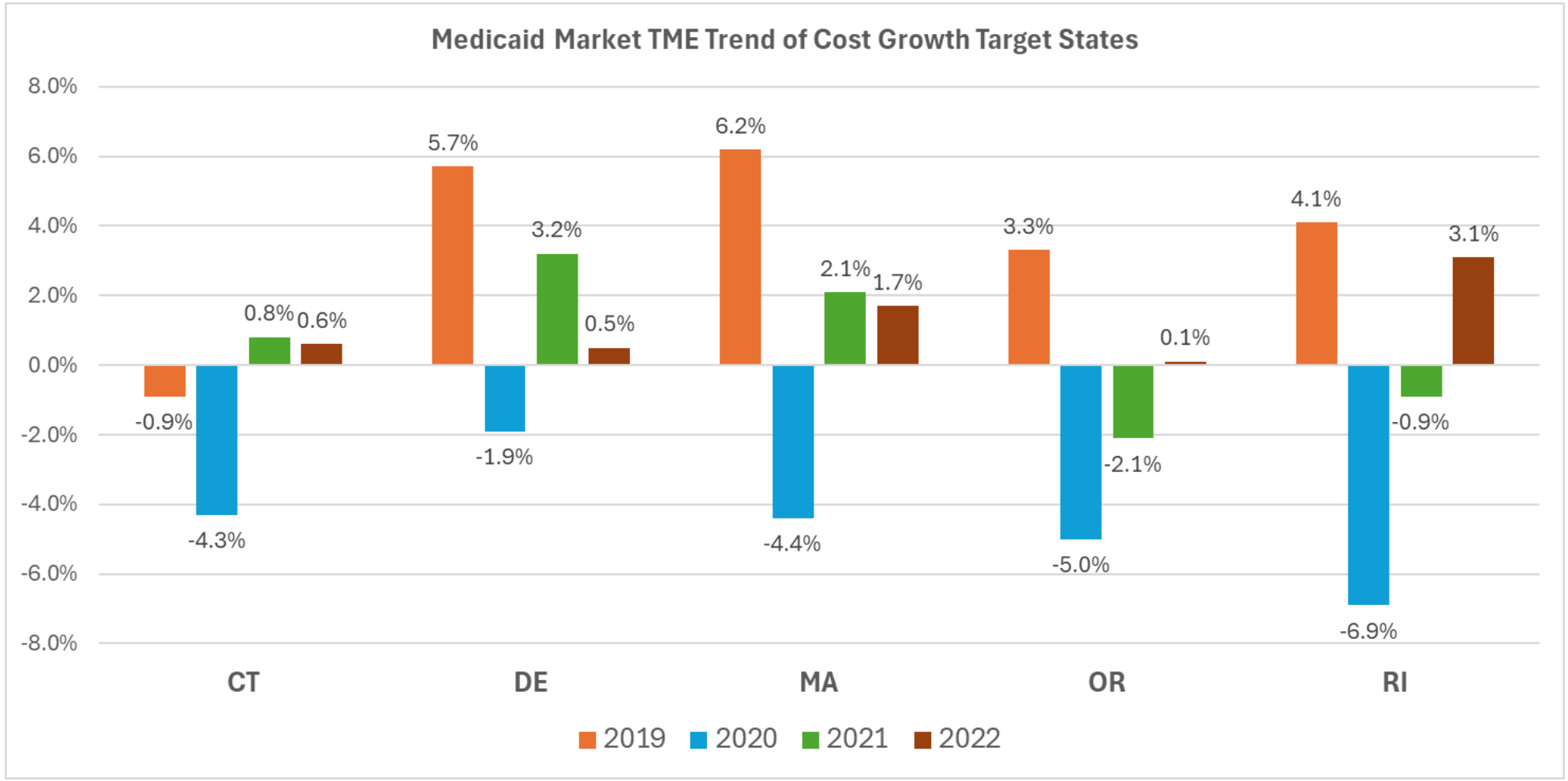
Comparison of CT's Spending Trends with Other Cost Growth Target States: THCE



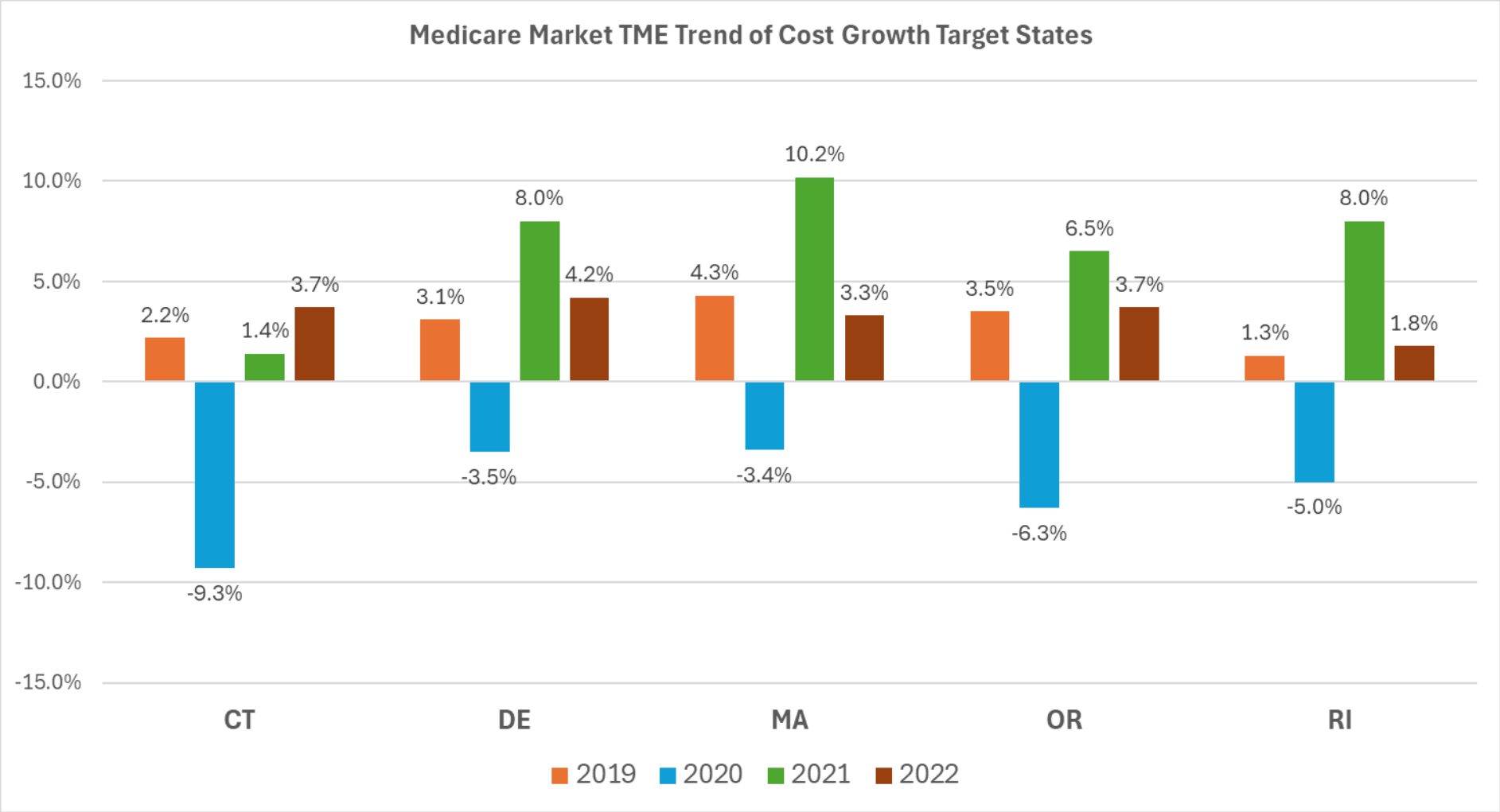
Comparison of CT's Spending Trends with Other Cost Growth Target States: Commercial Market TME



Comparison of CT's Spending Trends with Other Cost Growth Target States: Medicaid Market TME



Comparison of CT's Spending Trends with Other Cost Growth Target States: Medicare Market TME



Healthcare Cost Growth Benchmark Activities in Other States

How States Have Set Their Cost Growth Benchmarks

- Each state has engaged in a public process, with a stakeholder body deciding, or advising the state, on the policy and implementation of the program.
- States have tied the benchmark value to a single economic indicator or combination of indicators (e.g., growth in wages, household income, or state economic growth) to assert that healthcare spending should not grow faster than the economy or faster than what families and individuals can afford.

Review of Healthcare Cost Growth Benchmark Programs in Other States

- The following slides review details of these states' benchmark programs, including their benchmark methodologies and values.
- As the Technical Team considers methodological questions for the 2026-2030 healthcare cost growth benchmark, we will continue to provide information about other states' approaches and experiences.

State Benchmarks and Methodologies (1 of 2)

State	Benchmark Methodology	Benchmark Value
California	Average annual rate of change in historical median household income from 2002-2022. Add-on factors: +0.5% for CY 2025-2026, +0.2% for CY 2027-2028, +0.0% for CY2029	3.5% for 2025-2026 3.2% for 2027-2028 3.0% for 2029
Connecticut	80/20 blend of forecasted median wage and PGSP Add-on factors: +0.5% for CY 2021, +0.3% for CY2022, +0.0% for CY 2023-2025	3.4% for 2021 3.2% for 2022 2.9% for 2023 4.0% for 2024* 2.9% for 2025
Delaware	PGSP Add-on factors: +0.25% for 2021, +0.0% for CY2022-2023	3.8% for 2019 3.5% for 2020 3.25% for 2021 3.0% for 2022-2024
Massachusetts	2013-2017: PGSP 2018-2022: PGSP (3.6% in 2018) minus 0.5% 2023 and beyond: default rate of PGSP, per statute	3.6% for 2013-2017 3.1% for 2018-2022 3.6% for 2023-2025

*Modified from 2.9% to account for inflation

State Benchmarks and Methodologies (2 of 2)

State	Benchmark Methodology	Benchmark Value
New Jersey	75/25 blend of median projected household income and PGSP Add-on factors: +0.3% for 2023, +0.0% for 2024, -0.2% for 2025, -0.4% for CY2026-2027	3.5% for 2023 3.2% for 2024 3.0% for 2025 2.8% for 2026-2027
Rhode Island	PGSP for 2019-2022. 75/25 blend of PGSP and forecasted median household income growth for 2023-2027. *Accounted for the lagged impact of inflation on health care costs by adjusting the PGSP inflation input with inflation experience on a two-year lagged basis for 2023-2025.*	3.2% for 2019-2022 6.0% for 2023 5.1% for 2024 3.6% for 2025
Oregon	Non-formulaic consideration of: historical GSP; historical median wage; CMS waiver & legislative growth caps applied to the state's Medicaid and publicly purchased programs	3.4% for 2021-2025 3.0% for 2026
Washington	70/30 blend of historical median wage and PGSP, with a downward adjustment starting in 2024	3.2% for 2022-2023 3.0% for 2024-2025 2.8% for 2026

Connecticut's Primary Care Spending Target

Why set a primary care spending target?

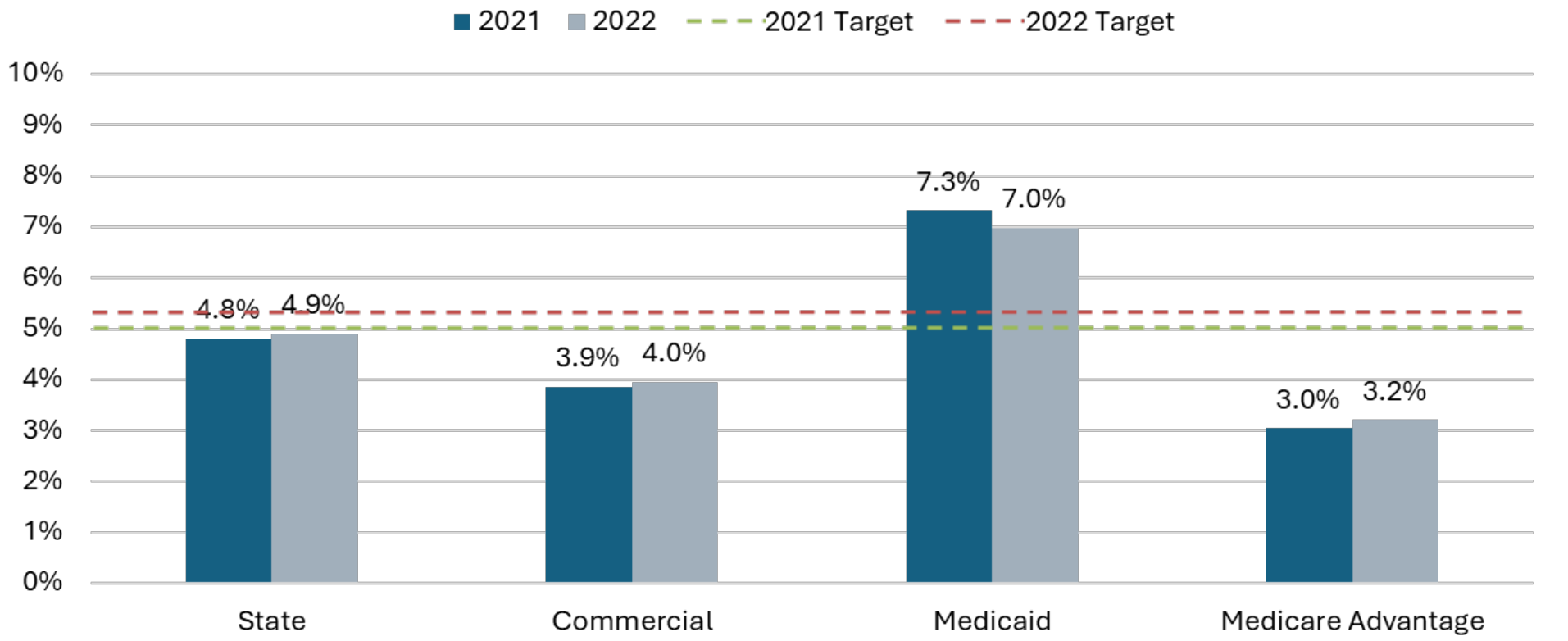
- The U.S. healthcare system is largely specialist-oriented. Research has demonstrated that greater relative investment in primary care leads to better patient outcomes, lower costs, and improved patient experience of care.
- States have elected to utilize primary care to strengthen their healthcare systems by:
  - supporting improved primary care delivery (e.g., expanding the primary care team, supporting advanced primary care model adoption)
  - increasing the percentage of total spending that is allocated towards primary care.

Connecticut's Primary Care Spending Target

Calendar Year	Target Values
2021	5.0%
2022	5.3%
2023	6.9%
2024	8.5%
2025	10.0%

- Connecticut's primary care spending target aims to **increase primary care spending** to 10 percent of total healthcare expenditures by 2025.
- The target is intended to rebalance and strengthen Connecticut's healthcare system by supporting improved primary care delivery.

State and Market Performance Against the Primary Care Spending Target



Data Source: OHS collected data from insurance carriers and from the Connecticut Department of Social Services (DSS).

Notes: Data are not risk adjusted. Data are net of pharmacy rebates. Data include commercial, Medicare Advantage and Medicaid FFS spending. TME includes all of the spending categories captured for the cost growth benchmark, less

Primary Care Spending Targets in Other States

State	Primary Care Spending Targets
Colorado	2022 and 2023: Carriers were required to increase the proportion of total medical expenditures allocated to primary care by 1 percentage point in each of 2022 and 2023.
Delaware	2022: Carriers are required to increase primary care spend to 7% and then 1.5% per year until 11.5% (2025).
Oregon	2017-2023: Private health plans, state employee benefit plans, and Medicaid coordinated care organizations (CCOs) were required to allocate at least 12 percent of the health care expenditures to primary care by 2023.
Rhode Island	2010-2014: Commercial insurers were required to increase primary care spending by one percentage point every year. 2015 and beyond: Commercial insurers' primary care expenses must comprise at least 10.7% of annual medical expenses for all insured lines of business.

Primary Care Spending Analysis: 2021-2025 Methodology

- OHS and the predecessor Technical Team established a definition of primary care spending in 2020 that built upon a methodology established in collaboration with other New England states.
- To assess primary care spending at the state, market and payer levels, OHS calculates primary care spending per member per month (PMPM) as a percentage of total medical expenses (TME) PMPM.
- TME for the primary care spending target includes all the spending categories for the cost growth benchmark **except for long-term care** so that calculations across commercial, Medicaid, and Medicare markets are comparable.

V. Public Comment

VI. Wrap-Up and Next Steps

Wrap-Up and Next Steps

- The next meeting is scheduled for **November 26, 2024 from 2-4 pm**.
- During the next meeting we will review Connecticut's 2021-2025 healthcare cost growth benchmark methodology and begin discussion of the methodology for 2026-2030.