Rhode Island Health Care Cost Trends Steering Committee

September 23, 2022

Welcome

Agenda

1. Welcome
2. Approval of July Meeting Minutes
3. New Cost Trends Compact for 2023-27
4. Target Methodology and Values
5. Public Health and Equity Target Proposal
6. Public Comment
7. Next Steps and Wrap-up

Approval of Meeting Minutes

Approval of Meeting Minutes

- Project staff shared minutes from the July 27th Steering Committee meeting in advance.
- **Does the Steering Committee wish to approve the July meeting minutes?**

New Cost Trends Compact for 2023-27

Recap of Summer Discussions

- The current Cost Trends compact, which is set to expire at the end of the year, commits its signatories to revisit the methodology of the cost growth target during 2022. To that end, the Steering Committee met in June and July to discuss this topic.

- During the June meeting some members raised concerns about the extraordinary economic circumstances due to high inflation. Other members voiced concern about the impact of general high price growth on consumer financial wellbeing.
  - Members heard from David Cutler about general inflation's impact on health care spending, its implications for setting cost growth targets, and the Massachusetts Health Policy Commission's decision to raise its target value from 3.1% to 3.6% for 2023.

Recap of Summer Discussions (cont'd)

- During the July meeting, project staff presented six target options that responded to members' requests for values that account for the dramatic upturn of inflation and better reflect consumer financial experience.
- Members did not reach agreement in July.
  - Many members felt that there ought to be an allowance for inflation in the target values; there lacked a consensus on how to do so.
  - Other members argued against such an adjustment, noting the economic pressures Rhode Islanders are experiencing during a time of high inflation.
- Prior to the July meeting, Sam Salganik wrote the co-chairs requesting that the new compact also include targets focused on public health and equity.

Continuing the Conversation

Picking up where we left off in July, the co-chairs and project staff will today present the following for Steering Committee consideration:

- Three cost growth target options for 2023-27
- Potential public health and equity measures for compact inclusion

First, we will summarize the three options and the policy implications for each and then we'll review the public health and equity measures.

Target Methodology and Values

Option 1: Methodology and Pros & Cons

- Methodology: Updates the inputs of the formula for **Potential Gross State Product (PGSP)** using the most current 2022 data sources.

- Pros
  - Supports affordability in a time of elevated inflation and consumer costs
  - Keeps the rate of growth below the projected rate of household income growth (projected HHI growth from 2023-24: 4.6%; from 2024-25: 4.0%)

- Cons
  - Not a fair expectation of providers given the high increase in provider input costs (e.g., high wage growth for certain categories of workers, increased supply costs)

Option 2: Methodology and Pros & Cons

- Methodology: Updates PGSP inputs with 2022 sources but modifies the inflation input by adjusting for 2-year lagged impact for inflation for 2023-25 and uses long-term (5-10 year) forecast for 2026-27.
- Pros
  - Fairer expectation of payers and providers subject to higher input costs
  - Recognizes deviation from long-term economic forecasts – current inflation is much higher than long-term forecasts
- Cons
  - Does not advance affordability as aggressively and therefore harms consumers and employer purchasers
  - Assumes that inflation will return to ‘normal’ levels in 2024 when this remains an open question

Option 3: Methodology and Pros & Cons

- Methodology: Uses a 50/50 blend of PGSP (values from Option 2) and forecasted median household income growth. It uses the current forecast for median household income growth for three years (2023-25) and long-term (5-10 year) forecast for 2026-27.

- Pros
  - Fairer expectation of payers and providers subject to high input costs
  - More reflective of consumer affordability concerns than a PGSP-only approach
  - Blend dampens the effect of elevated inflation in the PGSP input; helps to advance affordability

- Cons
  - Assumes that inflation will return to ‘normal’ levels in 2024 when this remains an open question

Options for 2023-27 Target Values

Option	2023	2024	2025	2026	2027
Option 1	3.2%	3.2%	3.2%	3.2%	3.2%
Option 2	6.7%	5.2%	3.5%	3.2%	3.2%
Option 3	5.3%	4.9%	3.8%	3.5%	3.5%

Note: These values have been updated since the July 27th Steering Committee meeting to account for the use of a modified data source for the population input of PGSP.

Impact of Cost Growth Target Options on Total Rhode Island Health Care Spending, 2023-27

	CY2019 Spending (Baseline)
Rhode Island Overall	$8.27 B

Option #	Potential Aggregate RI Health Care Spending, 2023-27	Δ with Option 1 (lowest spending)
Option 1	$45.49 B	-
Option 2	$47.85 B	$2.37 B
Option 3	$47.30 B	$1.81 B

Impact of Cost Growth Target Options on Rhode Island Commercial Health Care Spending, 2023-27

	CY2019 Spending (Baseline)
Rhode Island Commercial	$2.24 B

Option #	Potential Commercial RI Health Care Spending, 2023-27	Δ with Option 1 (lowest spending)
Option 1	$12.34 B	-
Option 2	$12.99 B	$0.64 B
Option 3	$12.84 B	$0.49 B

Discussion

- Which methodology and values should be adopted for the next Cost Trends compact?
- We may not all agree, but we should aim to arrive at a decision that is well-reasoned and will serve both Rhode Island consumers and our health care system.

Public Health and Equity Target Proposal

Public Health and Equity Target Proposal

- Embedded in the revised draft Cost Trends compact is a section titled "Public Health and Equity Accountability" Measures. The co-chairs propose including a set of such measures to be monitored in conjunction with the cost growth target. This revised draft includes five measures as a straw model proposal. We will review a full menu of measures for consideration shortly.
- These measures should not be understood to be tied to any 'target'; rather, OHIC poses the question to the Steering Committee how payers and providers should be held accountable to performance on these measures on an annual basis.

Public Health and Equity Target Proposal (cont'd)

- OHIC assessed measures for consideration using the following criteria:
  - **Each measure can be stratified by race/ethnicity.** Given OHIC's increased attention and commitment to health equity, it was imperative to select measures for which we could examine where the racial disparities are largest.
  - **Performance is subject to some degree of provider organization and/or payer influence.** OHIC recognizes it would be difficult for payers and providers to be held accountable for measures over which they have no control.
  - **Performance data are published annually.** Each of these measures come from data sources that are published annually. This criterion excluded all screening measures, as questions about screenings are only required to be asked on national surveys every two years.
- Based on these criteria, OHIC and project staff compiled the following menu of measures. For each measure, we calculated the ratio of performance between the White, non-Hispanic population and the lowest performing group to show the greatest opportunity for improvement.

Public Health and Equity Target Proposal (cont’d)

- The first group of measures addresses children and adults accessing health care:

Measure	RI Performance	National Performance
Visited a dentist or dental clinic within the past year for any reason Ratio of ‘Yes’ responses for the White, non-Hispanic population and the Hispanic population	1.27 (2020)	N/A (national data do not have race/ethnicity breakdown)
Child had one or more preventive visits in the past year Ratio of ‘Yes’ responses for the White, non-Hispanic population and the Hispanic population	1.26 (2019)	1.11 (2019)
Preventive dental care for children in the past year Ratio of ‘Yes’ responses for the White, non-Hispanic population and the Hispanic population	1.18 (2019)	1.06 (2019)

Public Health and Equity Target Proposal (cont'd)

- The next group of measures addresses immunization status for children, adolescents, and adults:

Measure	RI Performance	National Performance
Combined 7 Series Immunization Ratio of statewide vaccination rates for children born in 2014-17 (3-6 years old at time of survey) for the White, non-Hispanic population and the Black, non-Hispanic, non-Hispanic population	1.25 (2020)	1.11 (2020)
At least one dose of Tdap vaccination amongst teens (13-17 years) Ratio of statewide vaccination rates for the White, non-Hispanic population and the Hispanic population	1.02 (2021)	1.03 (2021)
Pneumococcal vaccine for adults 18-65 years at increased risk Ratio of statewide vaccination rates (general population) for the White, non-Hispanic population and the Hispanic population	1.61 (2020)	1.45 (2020)
Pneumococcal vaccine for adults >= 65 years Rate of statewide vaccination rates (general population) for the White, non-Hispanic population and the Hispanic population	1.17 (2020)	1.31 (2020)

Included in the draft compact as a straw proposal

Public Health and Equity Target Proposal (cont'd)

- The last group of measures addresses prenatal care and infant mortality rates:

Measure	RI Performance	National Performance
Early prenatal care Ratio of percent of live births for the White, non-Hispanic population and the Black, non-Hispanic population	1.10 (2018-2020 average)	1.22 (2018-2020 average)
Late/no prenatal care Ratio of percent of live births for the Black, non-Hispanic population and the White, non-Hispanic population	1.22 (2018-2020 average)	2.11 (2018-2020 average)
Adequate/adequate plus prenatal care* Ratio of percent of live births for the White, non-Hispanic population and the Black, non-Hispanic population	1.11 (2018-2020 average)	1.19 (2018-2020 average)
Inadequate prenatal care Ratio of percent of live births for the Black, non-Hispanic population and the White, non-Hispanic population *(lower rate is better)*	2.26 (2018-2020 average)	2.01 (2018-2020 average)
Infant mortality rates Ratio of per 1,000 births for the Black, non-Hispanic population and the White, non-Hispanic population	3.73 (2017-2019 average)	3.50 (2017-2019 average)

***Definition: pregnancy-related care beginning in the first four months of pregnancy with the appropriate number of visits for the infant's gestational age.**

Included in the draft compact as a straw proposal

Discussion

- The proposed language of the compact states, *"reducing cost growth must explicitly be done in concert with improving* ***health care access, equity, patient experience, and quality*** *in Rhode Island to achieve necessary improvement in outcomes on a statewide scale."*
- Do members of the Steering Committee believe that these measures address these domains?
- Which measures does the Steering Committee recommend to be included in the compact?
- Should providers and payers in Rhode Island be held accountable for these measures, and if so, how?

Public Comment

Next Steps and Wrap-up