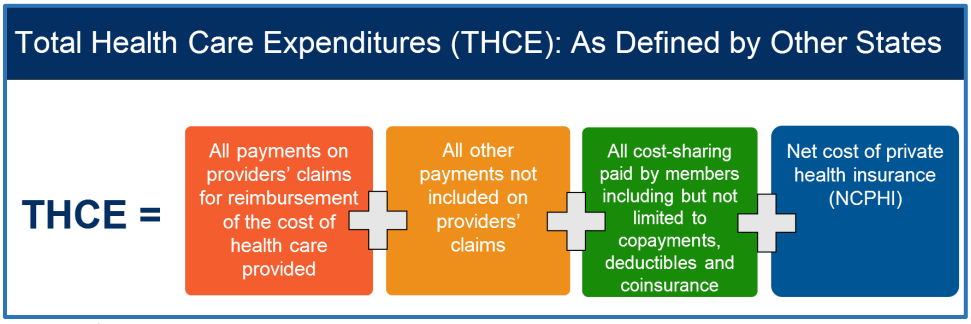
# New Jersey Health Care Affordability Advisory Group

May 26, 2021 Meeting Summary

*This summary presents highlights from the May 26, 2021 virtual meeting of New Jersey's Health Care Affordability Advisory Group, which was created pursuant to Executive Order #217 and is responsible for providing expertise, input and guidance around development and implementation of a health care cost benchmark. At the third meeting, members briefly discussed points related to finalizing the group's charter. The majority of the meeting, however, was spent reviewing options for calculating total health care spending in New Jersey, as well as criteria and options for an economic indicator to which the state's spending growth target would be tied. In reviewing the options, the group stressed needing an indicator that: links with the pocketbooks of New Jersey consumers; is predictable and sustainable over time; promotes quality and other desired investments; and would allow for mitigation of any unintended consequences. Below are highlights from the discussions around calculating health expenditures and options for economic indicators to which the growth of those expenditures might be tied.*

## Taking the Lead from Other States in Capturing Total Health Spending for New Jersey

Megan Burns from Bailit Health, which is helping guide a number of states through health cost benchmarking, walked the Advisory Group through the equation that those other states--including Connecticut, Delaware, Massachusetts, Oregon and Rhode Island—are using to calculate total health care expenditures. Total Health Care Expenditures (THCE) is the sum of claims and non-claims payments, along with cost sharing and the net cost of private health insurance, including administrative costs. Joel Cantor (Director, Rutgers Center for State Health Policy) led the group through the New Jersey THCE discussion, noting that there would be benefits in adopting a definition similar to other states, since the methodology has been tested in other states and could potentially allow some cross state comparison. Having said that, he noted, "This is New Jersey," and if there are "reasons to depart," there are reasons to depart. While the group mentioned New Jersey often having more regulatory burden than other states, along with what were called sometimes "upside down" Medicaid payments, ultimately, the group agreed on adopting a consistent definition of THCE. This was likewise the preliminary sense of the Interagency Working Group as conveyed by Shabnam Salih (Director, New Jersey Office of Health Care Affordability and Transparency), however, she wanted to ensure that that same sense was shared by the Advisory Group before moving forward to adopt the definition.




Similarly, the Group agreed with calculating costs for New Jersey residents covered by Medicaid, Medicare and Private Health Insurance, thereby capturing some 93% of the state's population.

## Sample Economic Indicators Used by Other States to Calculate Spending Growth Targets

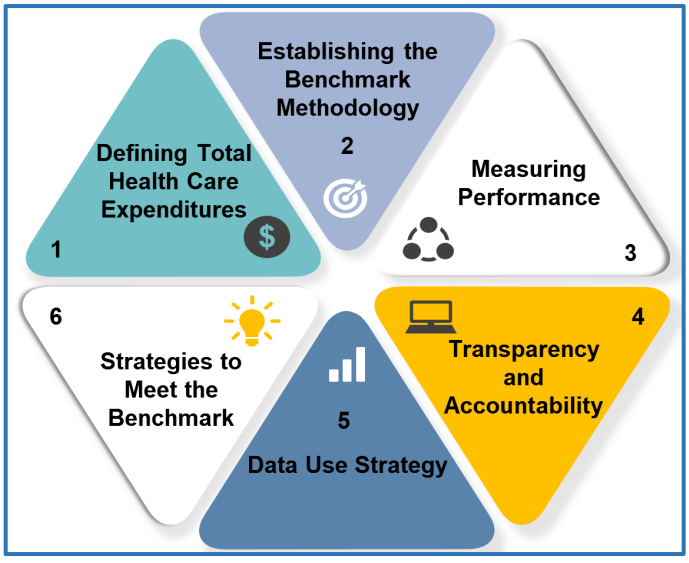
Ann Hwang from Bailit Health reviewed economic indicators chosen by other states to link their targets for spending growth. Massachusetts, Delaware and Rhode Island tied their targets to the projected growth in their state economies (potential gross state product--PGSP). Oregon linked its growth to historical gross state product (GSP) and wage growth, which closely tracked a target the state had set for public program growth. Connecticut used a combination of PGSP (20%) and projected growth in median wages (80%) to set its target.

## Preview of Available Indicators for New Jersey and Criteria for Assessing those Indicators

Ann then reviewed preliminary criteria that the Interagency Working Group had discussed for New Jersey's indicator, including that the target be: 1) stable and predictable; 2) derived from objective sources; 3) reflective of the real world pocketbook experiences of New Jerseyans; and 4) able to help curb the rate of spending growth for the state. She previewed trends for four economic indicators to set the stage for breakout discussions on possible metrics and their ability to meet the aforementioned criteria, along with any other criteria the Advisory Group might recommend. Ann noted, that while giving a "taste" of the options, this would not be the Group's only "bite at the apple" in setting a target. The four metrics previewed were New Jersey PGSP, Median Income, Average Wage, and Consumer Price Index (CPI), with each falling below projected health care spending.

## Break-Out Discussions on Indicators and Criteria

The group then split into three virtual break-out rooms to discuss possible indicators, the preliminary criteria for assessing those indicators, as well as other ideas for metrics and their measurement. Many echoed the importance of the benchmark reflecting consumer affordability, along with ensuring that it resulted in spending that was predictable and sustainable over time, as well as allowed for continued progress on improved quality or other desirable spending increases. In discussing the four sample indicators above, some questioned the methods underlying growth projections. Other members wondered whether some of the target indicators were possibly circular or self-referential (with GSP and CPI including health care as an economic input, and some Advisory Group members indicating a sizeable share of health care spending being driven by wages). Some underlined the importance of watching for unintended consequences in setting the target, with tying growth to wages possibly having negative effects on consumers, or exacerbating what was called a NJ "brain drain."




## More Discussion and Work to Come

While the group made progress on two of the six steps related to establishing New Jersey's benchmark program, more work lies ahead, including continued discussion on possible targets, as well as their related values, both on the group agenda for June.