

# Healthcare Cost Growth Benchmark Steering Committee Meeting March 27, 2023

**"We collaborate, out of a shared concern and responsibility for all Connecticut residents, to develop consensus models that advance equity and consumer affordability of healthcare in our state."**



# Welcome and Introductions

# Welcome, New Members!

- Timothy Archer, UnitedHealthcare
- Joanne Borduas, Community Health and Wellness Center
- Gui Woolston, CT Department of Social Services

# Meeting Agenda

<u>Time</u>	<u>Topic</u>
3:00 p.m.	I. Welcome and Introductions
3:05 p.m.	II. Announcement of 2021 Benchmark Results
3:10 p.m.	III. Remarks from Governor Lamont
3:15 p.m.	IV. Public Comment
3:20 p.m.	V. Approval of Minutes
3:25 p.m.	VI. Annual Cost Growth Benchmark and Primary Care Spend Target
4:55 p.m.	VII. Wrap-Up and Next Steps
5:00 p.m.	VIII. Adjournment

# Announcement of 2021 Healthcare Benchmark Results

# Connecticut's Healthcare Cost Growth Benchmark

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

- Connecticut's cost growth benchmark is a target **annual rate-of-growth** for per person healthcare spending.
- The benchmark values are based on a blend of forecasted per capita potential gross state product (PGSP) and forecasted growth in median income.

# Connecticut's Primary Care Spend Target

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

- Executive Order No. 5 and Public Act 22-118 established a target to increase primary care spending to 10 percent of total healthcare expenditures by calendar year 2025.
- The target is intended to rebalance and strengthen Connecticut's healthcare system by supporting improved primary care delivery.

# 2021 Healthcare Cost Growth Benchmark Results

- **Statewide** healthcare costs grew 6.0% from 2020-2021, exceeding the 3.4% benchmark.
- **Commercial** healthcare costs grew 18.8%, **Medicare** costs grew 1.4% and **Medicaid** costs grew 0.8%.
- All five **commercial payers** exceeded the 3.4% benchmark for 2020-2021 cost growth.
- Three out of four **Medicare Advantage payers** exceeded the 3.4% benchmark for 2020-2021 cost growth.
- **Advanced Network** performance will be included in OHS' written report on March 31<sup>st</sup>.



# 2021 Primary Care Spend Target Results

- **Statewide** primary care spending was 5.1% of total spending in 2021, which achieved the 5% primary care spend target.
- **Medicaid** achieved the 5% target with 8.3% of total spending on primary care, but the **commercial** (3.9%) and **Medicare Advantage** (3.5%) markets did not.
- Two out of five **commercial payers** achieved the 5% primary care spend target in 2021.
- None of the four **Medicare Advantage payers** achieved the 5% primary care spend target in 2021.

# Remarks from Governor Lamont

# Public Comment

# Approval of February 27<sup>th</sup> Meeting Minutes - Vote

# Results of the Annual Healthcare Cost Growth Benchmark Analysis

# Total Healthcare Expenditures

**Total Medical  
Expense (TME)**

+

**Net Cost of  
Private Health  
Insurance  
(NCPHI)**

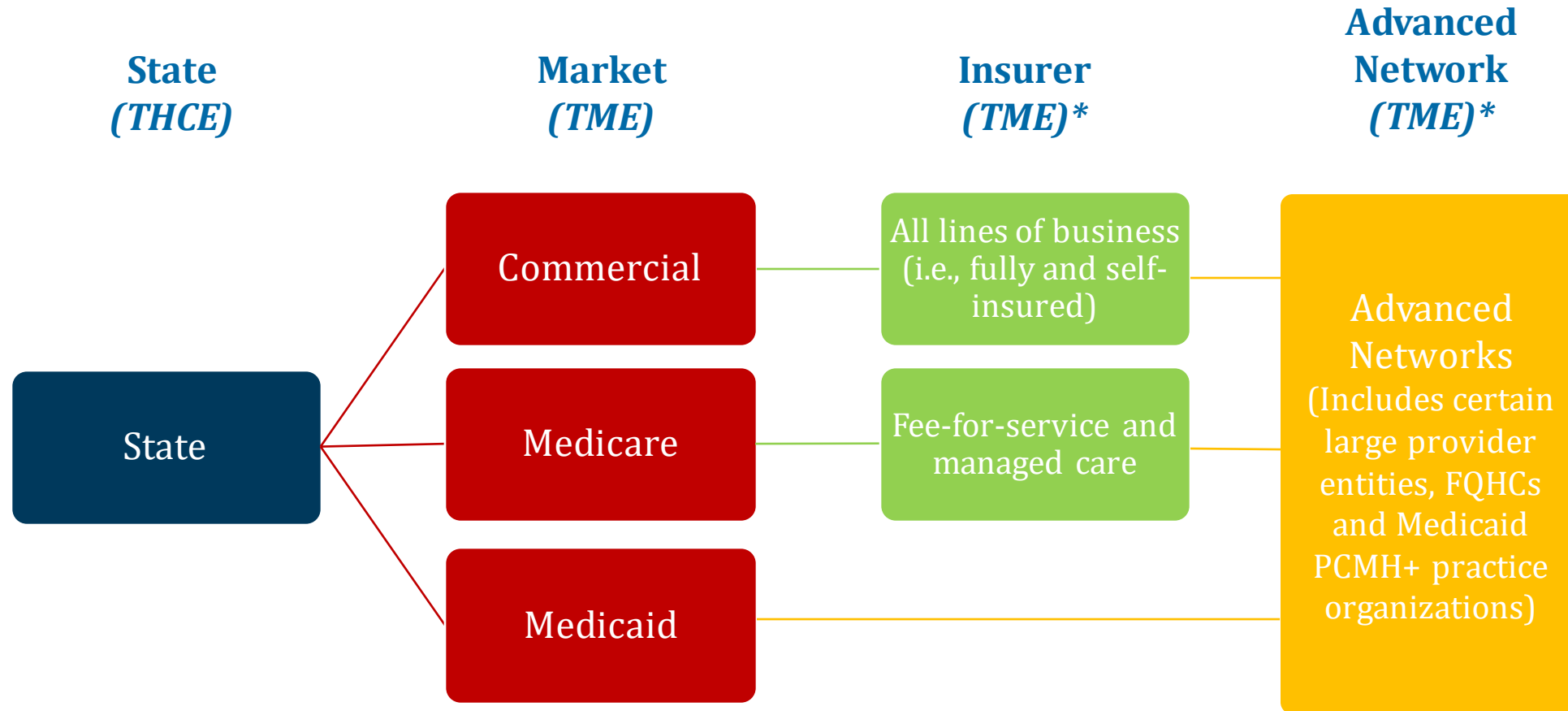
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**Total Healthcare  
Expenditures  
(THCE)**

**All incurred expenses  
for CT residents for all  
health care services,  
regardless of where the  
care was delivered and  
regardless of the situs of  
the member's health plan.**

**The costs to CT  
residents associated  
with the administration  
of private health  
insurance.**

# Four Levels of Public Reporting of Performance Against the Benchmark



\* OHS will only publicly report on Insurers and Advanced Networks with a minimum of 60,000 member months per market.

# Data Sources for THCE

<b>THCE Component</b>	<b>Data Source</b>
Commercial spending	TME reported by carriers (Aetna, Anthem, Cigna, ConnectiCare, UnitedHealthcare)
Medicare Managed Care spending	TME reported by carriers (Aetna, Anthem, ConnectiCare, UnitedHealthcare)
Medicare FFS spending	TME reported by the Centers for Medicare & Medicaid Services
Medicaid spending	TME reported by Department of Social Services
Net Cost of Private Health Insurance (NCPHI)	Calculated from regulatory reports submitted by insurers or obtained through public sources (e.g., Medical Loss Ratio data)
Veterans Health Administration spending	Veterans Health Administration
Department of Correction spending	Department of Correction



# Methodology Changes this Year

- Based on the Steering Committee's recommendations last year, OHS implemented two new methodologies to strengthen benchmark performance assessment:
  - **truncation of high-cost outlier spending** was added to prevent annual changes in small numbers of high-cost members from significantly affecting trends in insurers' and providers' per capita expenditures; and
  - **adjustment of spending using standard age-sex risk factors** replaced clinical risk adjustment because clinical risk scores can change annually without changes in the population's underlying risk due to improved documentation of patient condition on claims.
- These changes align with the methodological direction that several other states with cost growth benchmark programs have taken.

# Important Notes about the Findings (1 of 2)

- Benchmark Performance results are not comparable to results of All-Payer Claims Database (APCD) analyses because only the Benchmark Performance results include:
  - non-claims payments
  - spending on the commercial self-insured population, and
  - pharmacy rebates.
- Including these additional data provides a more comprehensive look at healthcare costs in Connecticut than what the APCD would support.
- These performance results are also not comparable to other publicly available measurements of health spending for similar reasons.

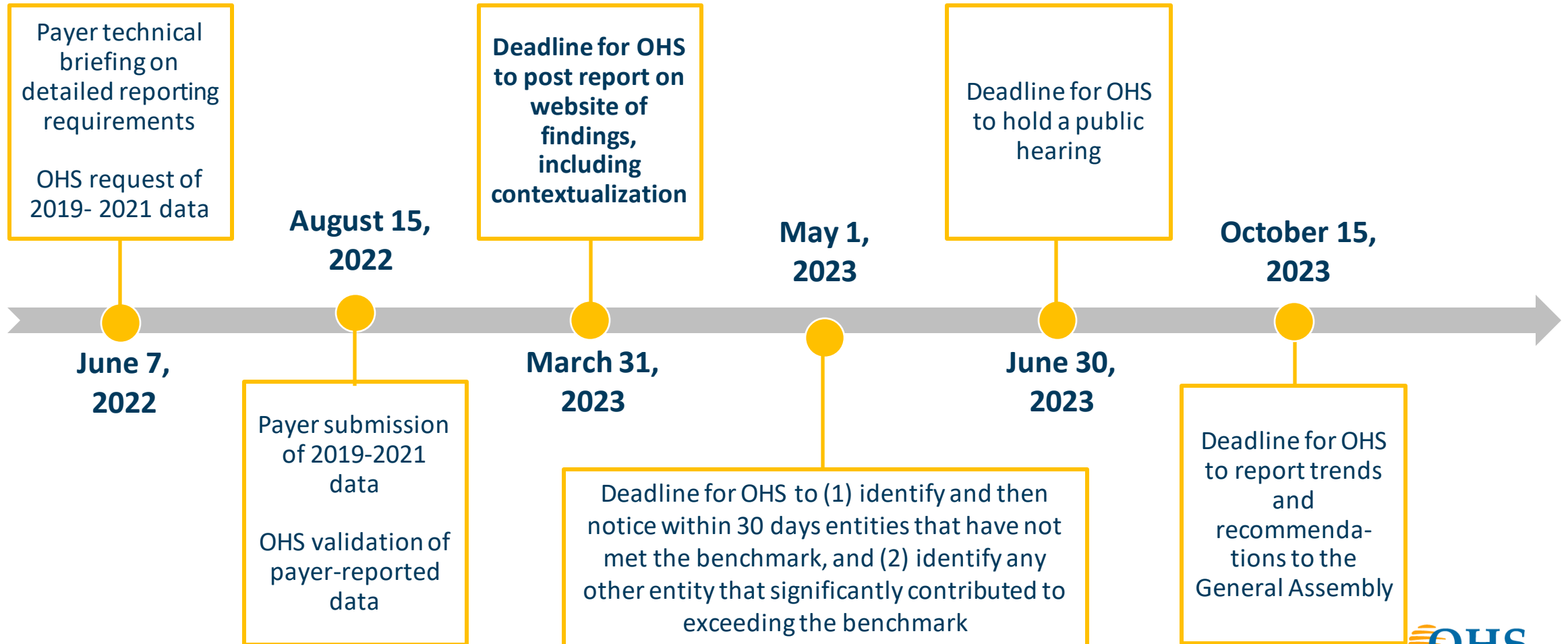
# Important Notes about the Findings (2 of 2)

- In 2023, OHS is reporting on two trend years:
  - 2020 – cost growth from 2019-2020 (pre-benchmark period)
  - 2021 – cost growth performance against the 3.4% benchmark for 2020-2021, and the 5.0% primary care spend target for 2021
- While 2020 preceded the effective date of the benchmark, we share 2019-2020 trend data to provide context for 2021 benchmark performance. Utilization and spending data from the APCD have shown COVID-19's impact.
- In the future, OHS will only report on one trend year annually.

# COVID-19 and Cost Growth Benchmark Performance

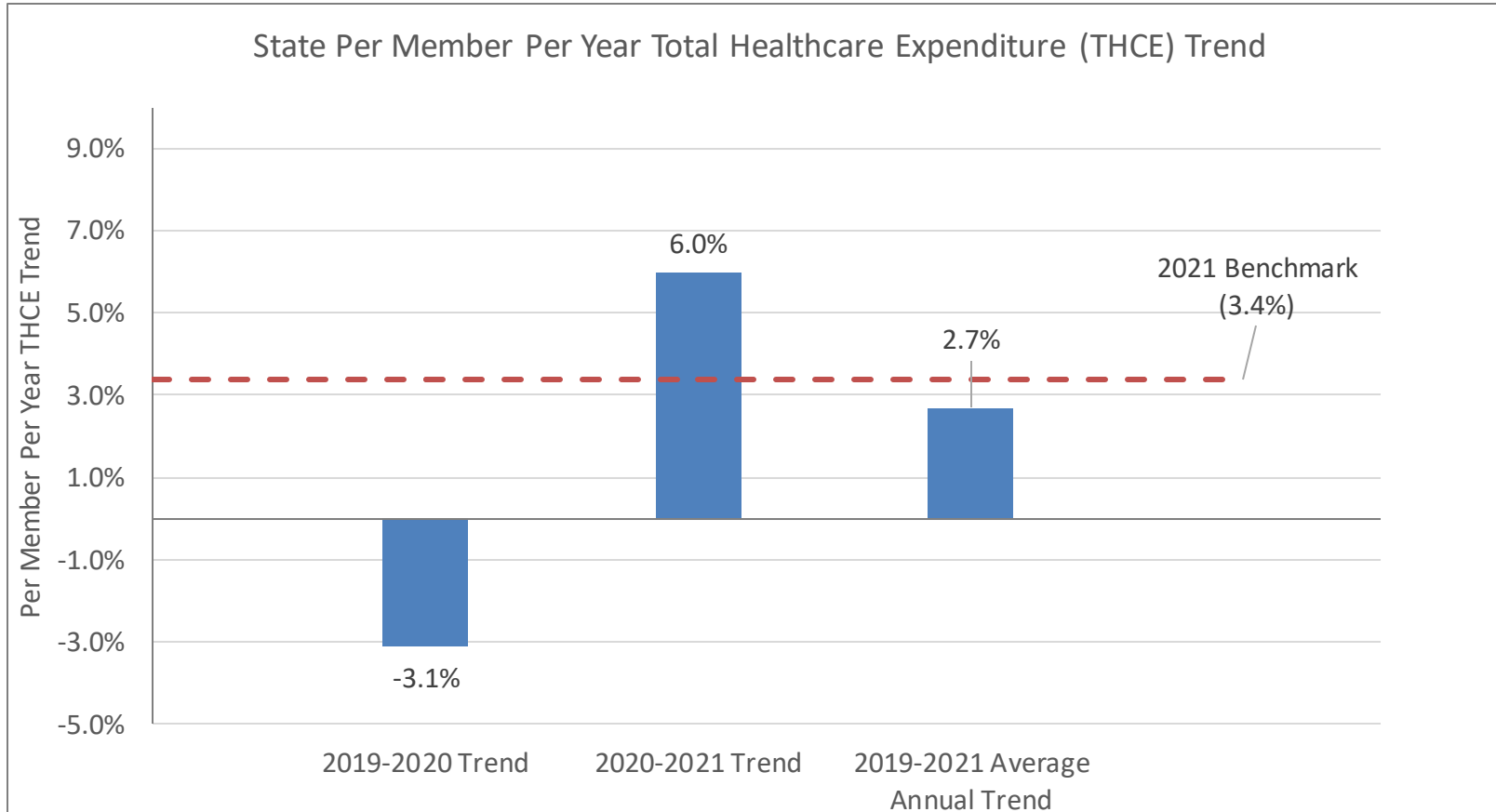
- When reviewing performance, please keep in mind the COVID-19 pandemic's impact on healthcare utilization and spending.
  - In 2020, utilization and overall spending decreased due to the temporary suspension of nonessential services and a decline in in-person care seeking by patients, while selected spending (e.g., telehealth, non-claim payments) increased.
  - In 2021, utilization and spending rebounded as in-person care approached or exceeded pre-pandemic levels.
  - Federal provider relief payments, primarily to hospitals, are not reflected in this analysis.
- OHS acknowledges that 2021 cost growth benchmark performance was impacted by these unprecedented circumstances. More entities exceeded the 2021 benchmark than would be expected under normal conditions.

# Data Collection and Reporting Timeline



# State Total Health Care Expenditure Trends

# Connecticut's Total Health Care Expenditures decreased 3.1% in 2020 and grew 6.0% in 2021



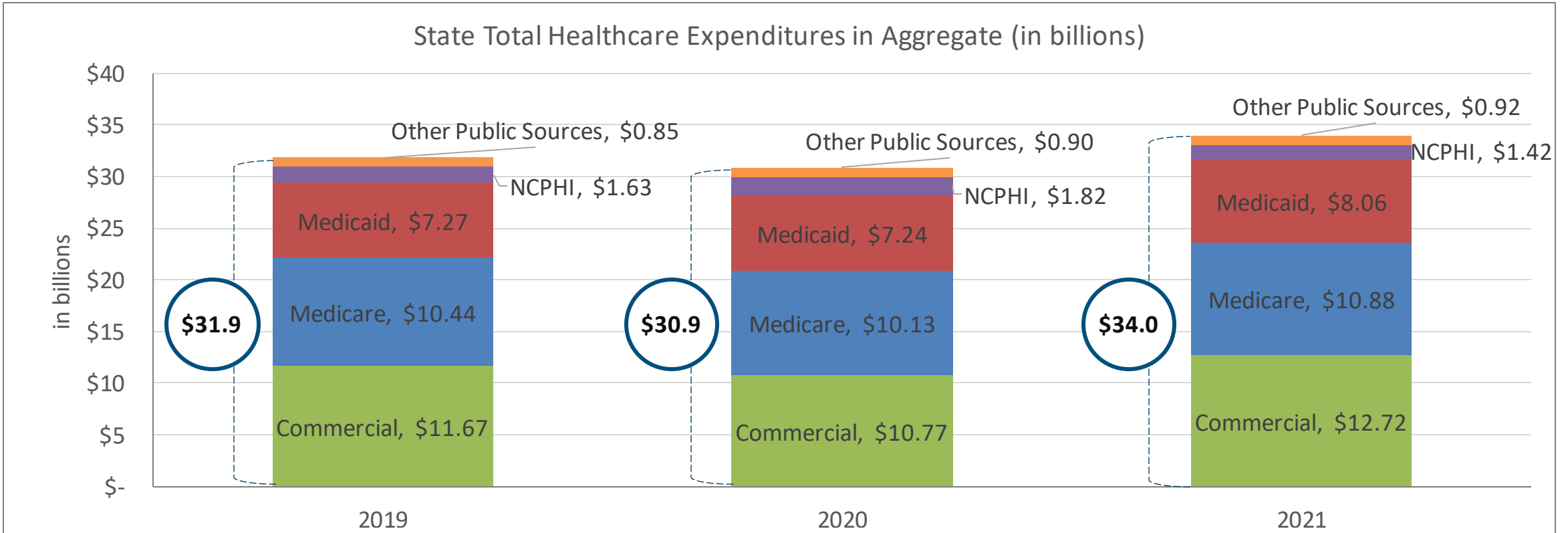
**Data Source:** OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut Department of Correction (DOC), and the Veterans Health Administration (VHA).

**Notes:** Data are not risk-adjusted and data are reported net of pharmacy rebates. Data include the net cost of private health insurance (NCPHI).

Year	THCE Per Member Per Year
2019	\$9,865
2020	\$9,556
2021	\$10,130

- Average annual growth from 2019-2021 was 2.7%.

# Connecticut's Total Health Care Expenditures were \$31.9 billion in 2019, \$30.9 billion in 2020 and \$34.0 billion in 2021

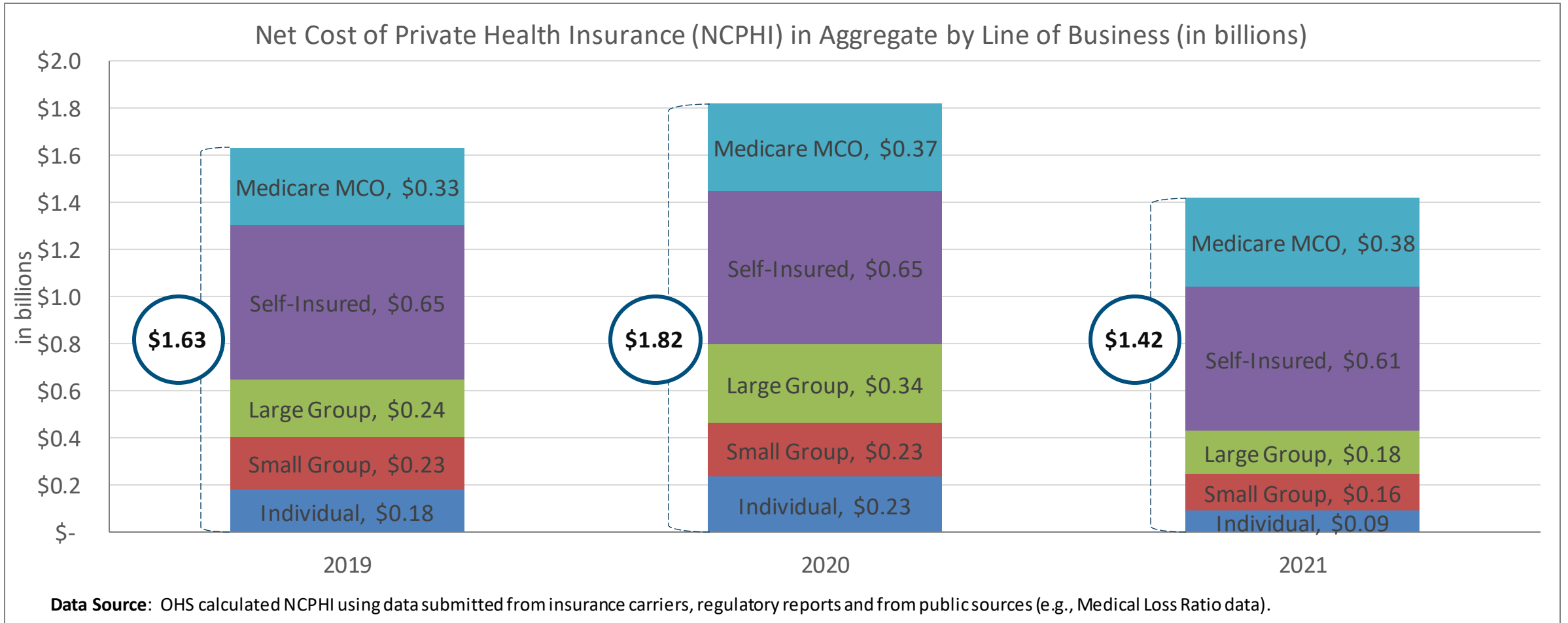


**Data Source:** OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut Department of Correction (DOC), and the Veterans Health Administration (VHA).

**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.

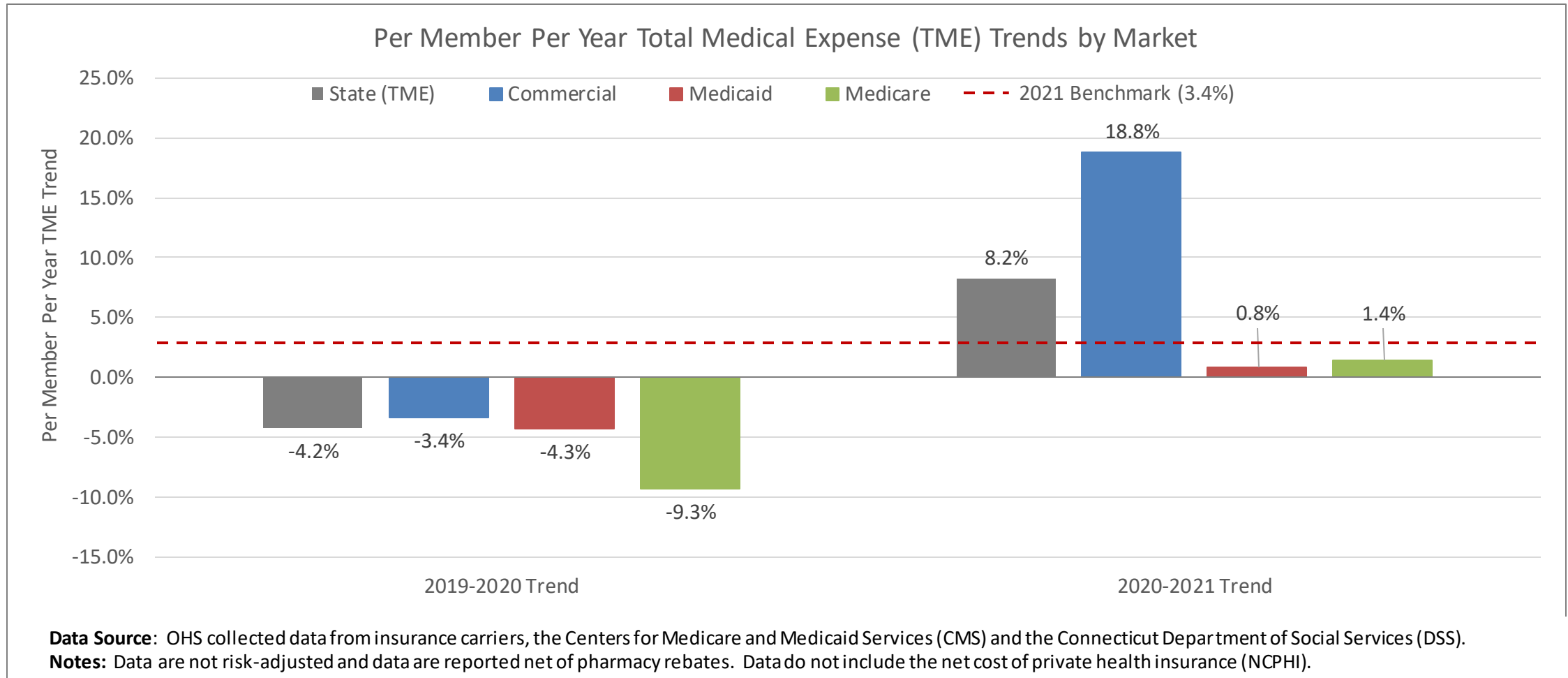


# Net Cost of Private Health Insurance contributed \$1.63 billion to State THCE in 2019, \$1.82 billion in 2020 and \$1.42 in 2021

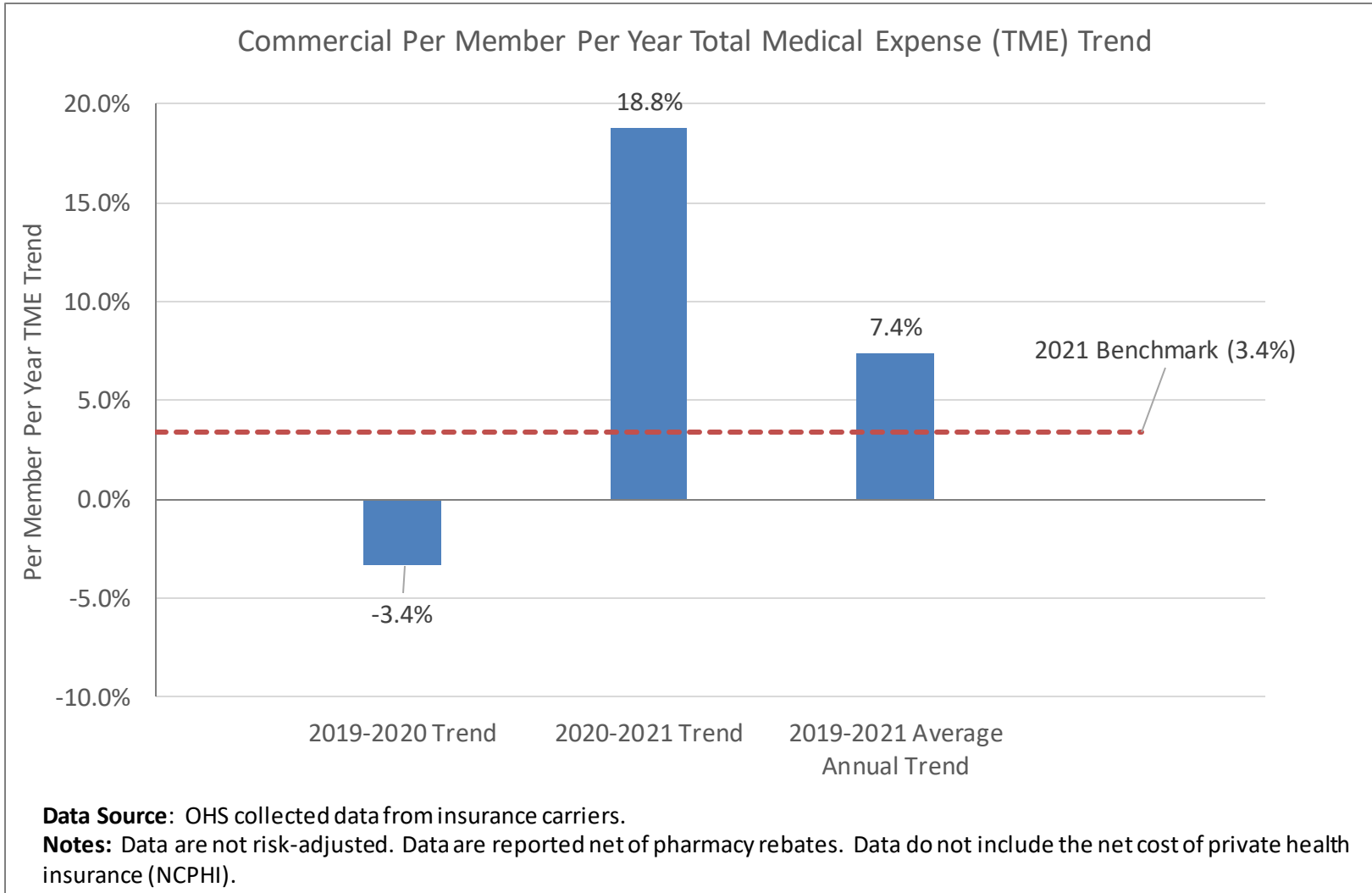


# Total Medical Expense Trends by Market

# Total Medical Expense Trends by Market



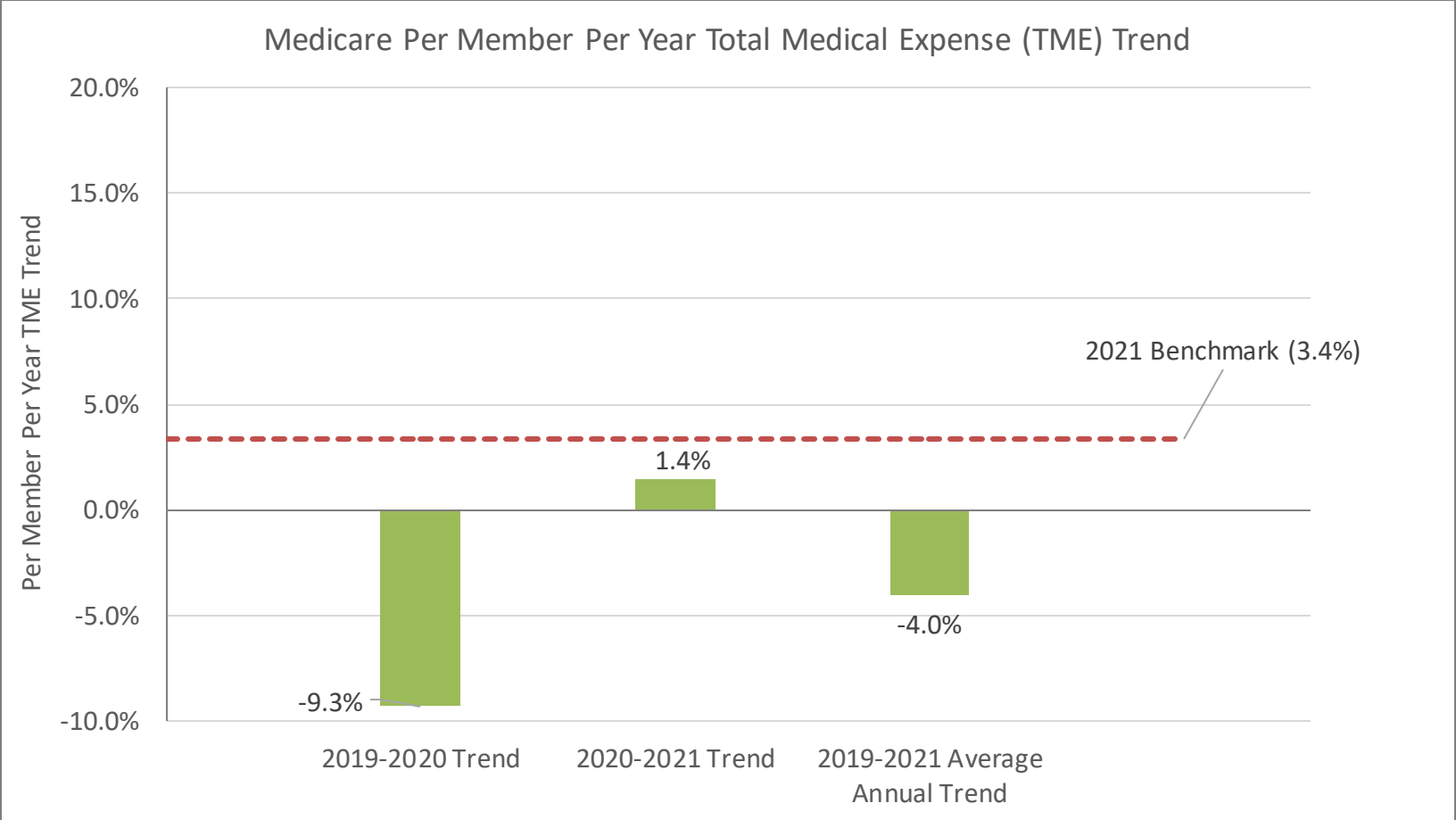
# Commercial Total Medical Expenses decreased 3.4% in 2020 and increased 18.8% in 2021



Year	TME Per Member Per Year
2019	\$6,732
2020	\$6,505
2021	\$7,729

- Average annual commercial growth from 2019-2021 was 7.4%.

# Medicare Total Medical Expenses decreased 9.3% in 2020 and grew 1.4% in 2021

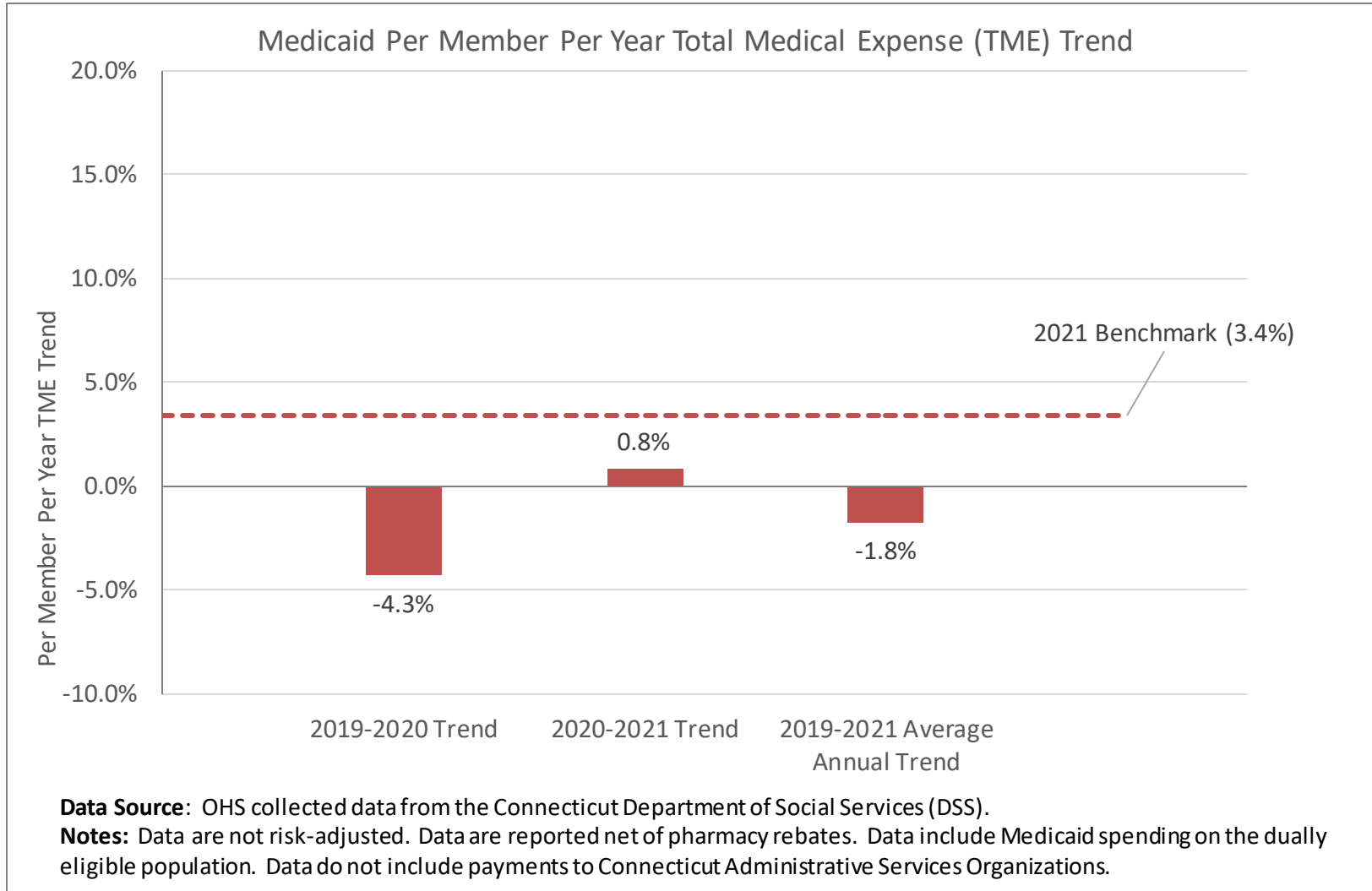


Year	TME Per Member Per Year
2019	\$16,481
2020	\$14,945
2021	\$15,157

- Average annual Medicare growth from 2019-2021 was -4.0%.

**Data Source:** OHS collected data from insurance carriers and the Centers for Medicare and Medicaid Services (CMS).  
**Notes:** Data are not risk-adjusted. Data are reported net of pharmacy rebates. Data do not include the net cost of private health insurance (NCPHI). Medicare spending includes traditional Medicare, Medicare Advantage, and Part D pharmacy. Data include Medicare spending on the dually eligible population.

# Medicaid Total Medical Expenses decreased 4.3% in 2020 and grew 0.8% in 2021



Year	TME Per Member Per Year
2019	\$7,368
2020	\$7,050
2021	\$7,110

- Average annual Medicaid growth from 2019-2021 was -1.8%.

# Service Category Trends

# Service Category Definitions (1 of 4)

- OHS's collects aggregate claims data from payers according to the following service categories:
  1. **Hospital Inpatient:** The TME paid to hospitals for inpatient services, including all room and board and ancillary payments, and payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services, for physician services during an inpatient stay that have been billed directly by a physician group practice or an individual physician, and inpatient services at non-hospital facilities.
  2. **Hospital Outpatient:** The TME paid to hospitals for outpatient services, including payments made for hospital-licensed satellite clinics, emergency room services not resulting in admittance, and observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.



# Service Category Definitions (2 of 4)

- OHS's collects aggregate claims data from payers according to the following service categories:
  - 3. Professional, Primary Care:**\* The TME paid to primary care providers delivering care at a primary care site of care generated from claims using a code-level definition.
  - 4. Professional, Specialty:**\* The TME paid to physicians or physician group practices generated from claims, including services provided by a doctors of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined as primary care in the primary care definition.
  - 5. Professional, Other:** The TME paid from claims to healthcare providers for services provided by a licensed practitioner other than a physician and is not identified as primary care in the primary care definition.

\*The professional primary care and specialty categories are combined into one “Professional Physician” category for the market-level analysis.

# Service Category Definitions (3 of 4)

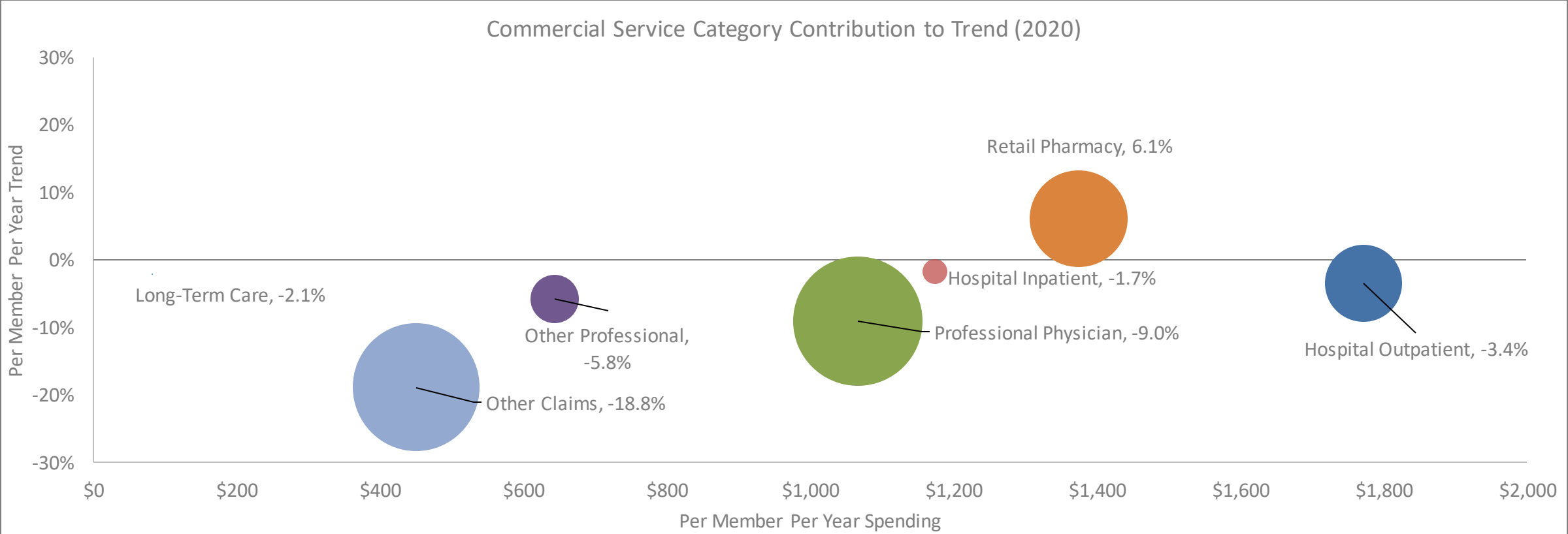
- OHS's collects aggregate claims data from payers according to the following service categories:
  6. **Pharmacy:**\* The TME paid from claims to healthcare providers for prescription drugs, biological products or vaccines as defined by the insurance carrier's prescription drug benefit, attributed to the location in which it was delivered. Does not include stand-alone prescription drug plans.
  7. **Long-Term Care:** All TME data from claims to providers for nursing homes and skilled nursing facilities, intermediate care and assisted living facilities, and providers of home- and community-based services, including personal care, homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services, and programs designed to assist individuals with long-term care needs who receive care in their home and community.
  8. **Other:** All TME paid from claims to healthcare providers for medical services not otherwise included in other categories, including durable medical equipment, facility fees of community health services, freestanding ambulatory surgical center services, freestanding diagnostic facility services, hospice, hearing aid services and optical services.

\*Pharmacy spending is reported net of applicable rebates in the market-level analysis.

# Service Category Definitions (4 of 4)

- OHS's collects aggregate non-claims data from payers according to the following categories:
  1. Prospective Capitation, Global Budget, Case Rate or Episode-based Payments
  2. Performance Incentive Payments
  3. Payments to Support Population Health and Practice Infrastructure
  4. Provider Salaries
  5. Recoveries
  6. Other

# Only Retail Pharmacy spending grew in the Commercial market in 2020; Physician and Other Claims declined the most

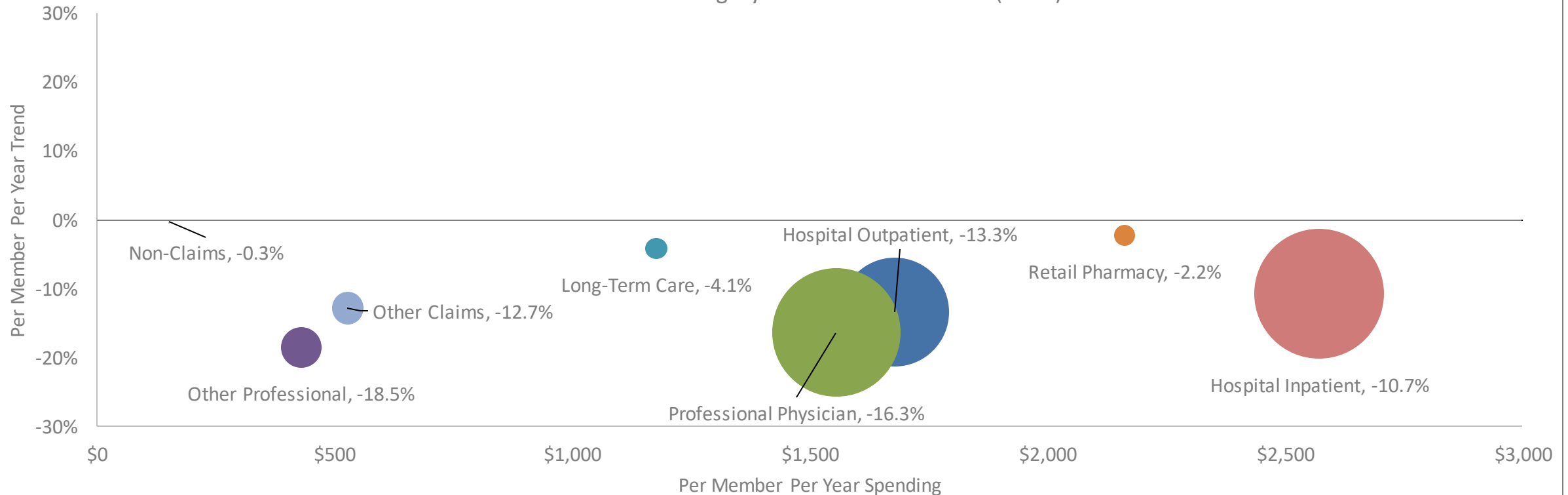


**Data Source:** OHS collected data from insurance carriers.

**Notes:** The width of the bubbles represents contribution to trend. Data are not risk-adjusted. Data are reported net of pharmacy rebates. Non-claims are not shown in this figure because the 2020 per capita amount was negative (-\$43).

# Hospital Inpatient and Professional Physician drove the *decrease* in Medicare spending in 2020

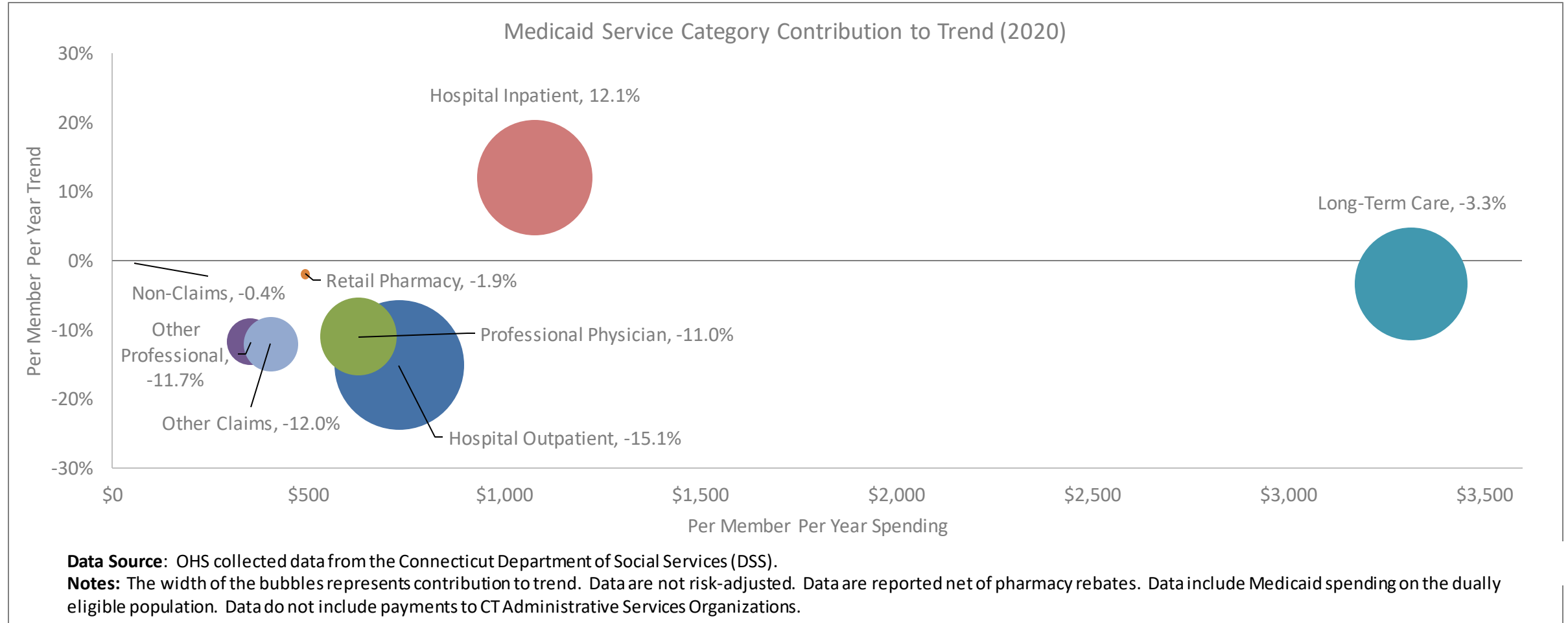
Medicare Service Category Contribution to Trend (2020)



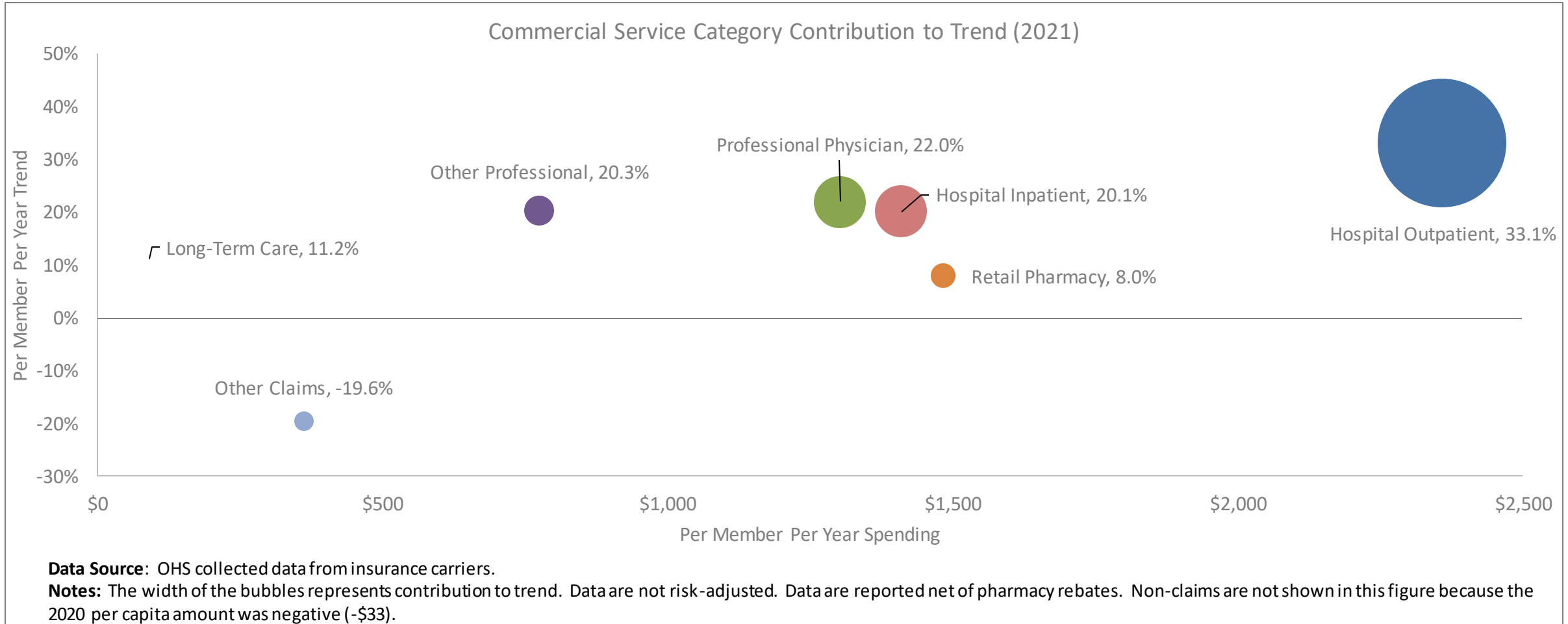
**Data Source:** OHS collected data from insurance carriers and the Centers for Medicare and Medicaid Services (CMS).

**Notes:** The width of the bubbles represents contribution to trend. Data are not risk-adjusted. Data are reported net of pharmacy rebates (OHS did not receive pharmacy rebates from CMS). Medicare spending includes traditional Medicare, Medicare Advantage, and Part D pharmacy. Data include Medicare spending on the dually eligible population.

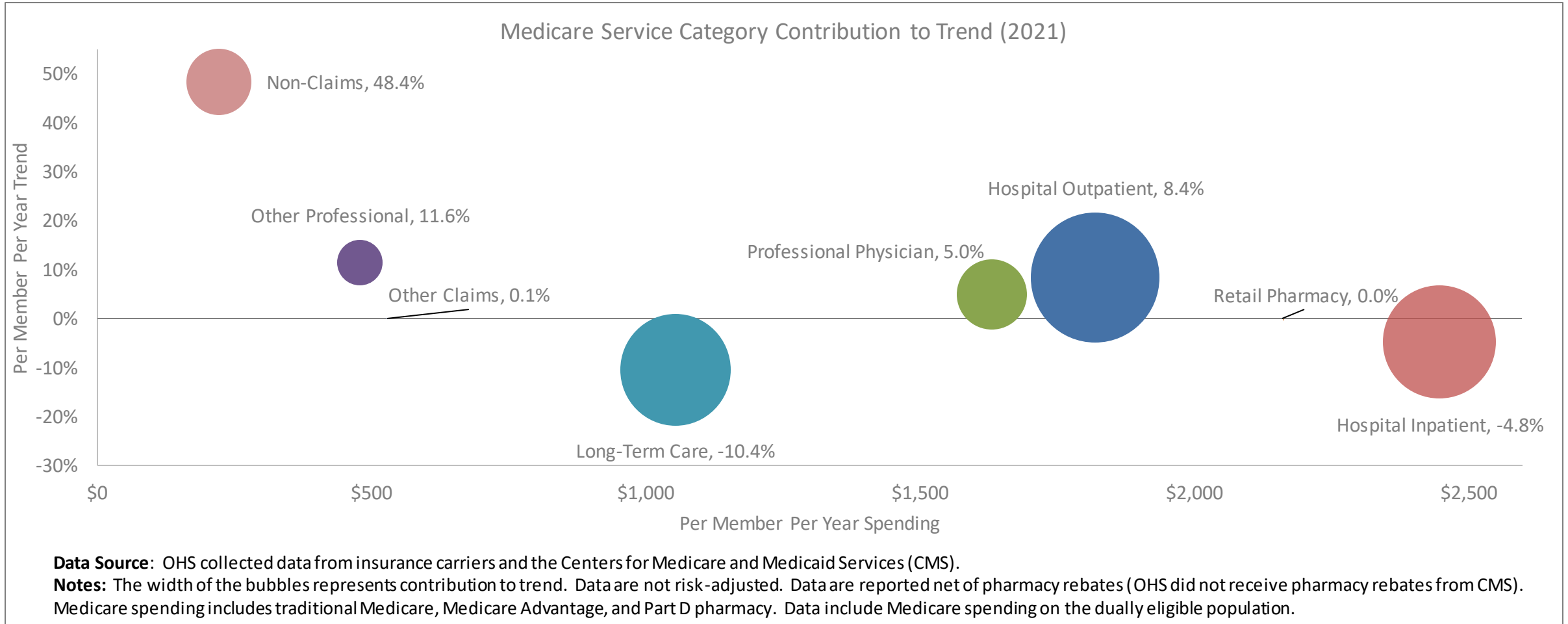
# Hospital Outpatient and Long-Term Care drove the *decrease* in Medicaid spending in 2020



# Hospital Outpatient drove Connecticut's Commercial spending growth in 2021

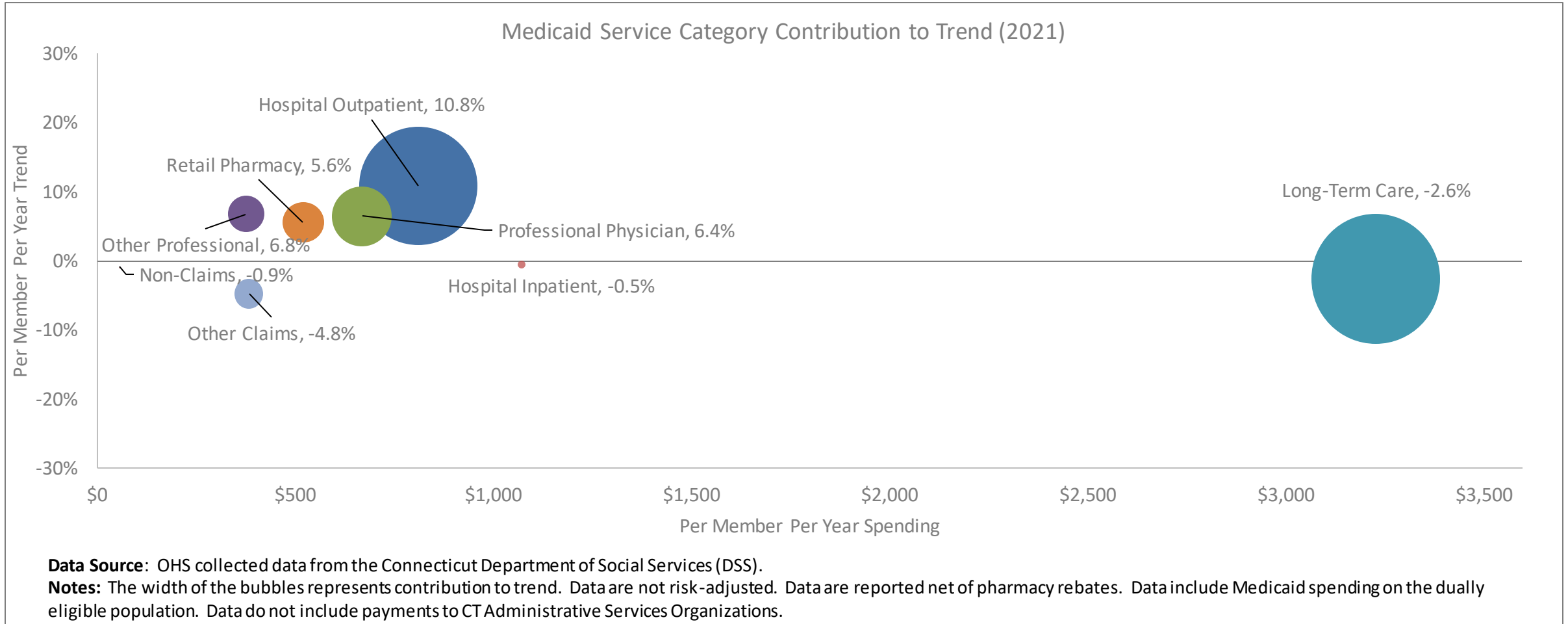


# Hospital Outpatient and Professional Physician drove the increase in Medicare spending in 2021





# Hospital Outpatient and Professional Physician drove the increase in Medicaid spending in 2021

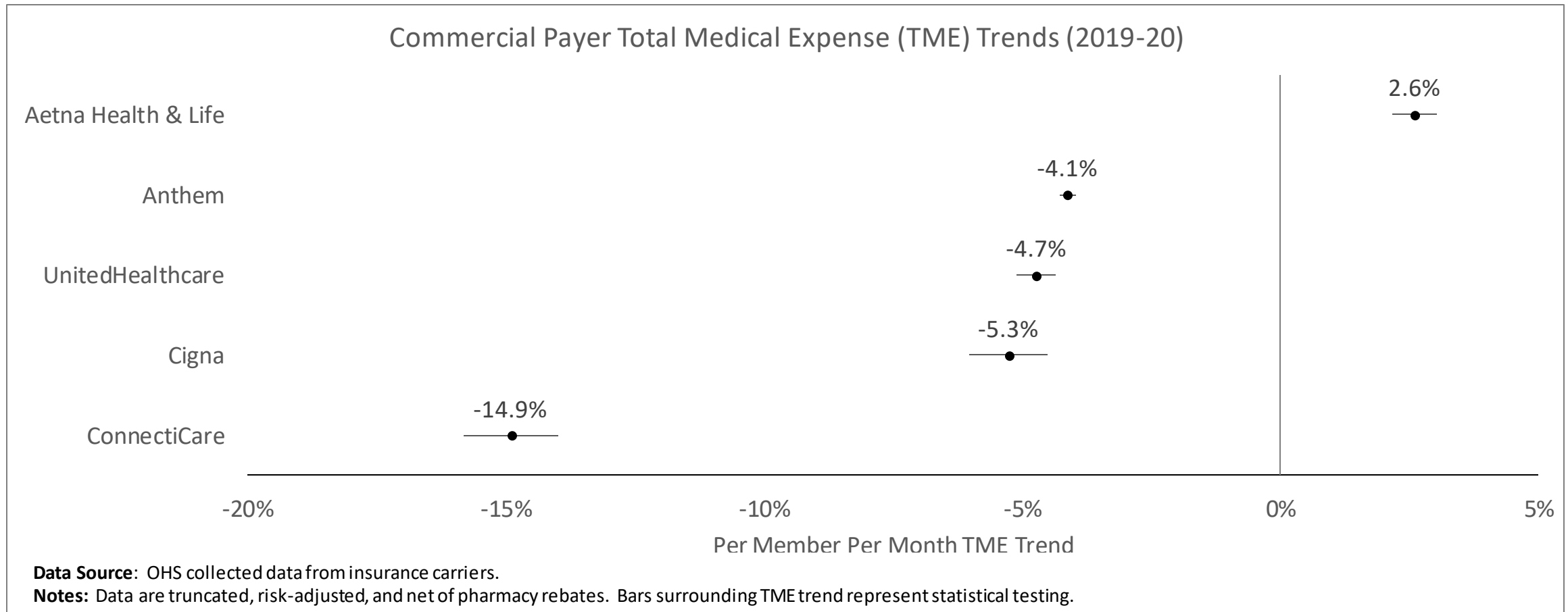


# Takeaway Observations

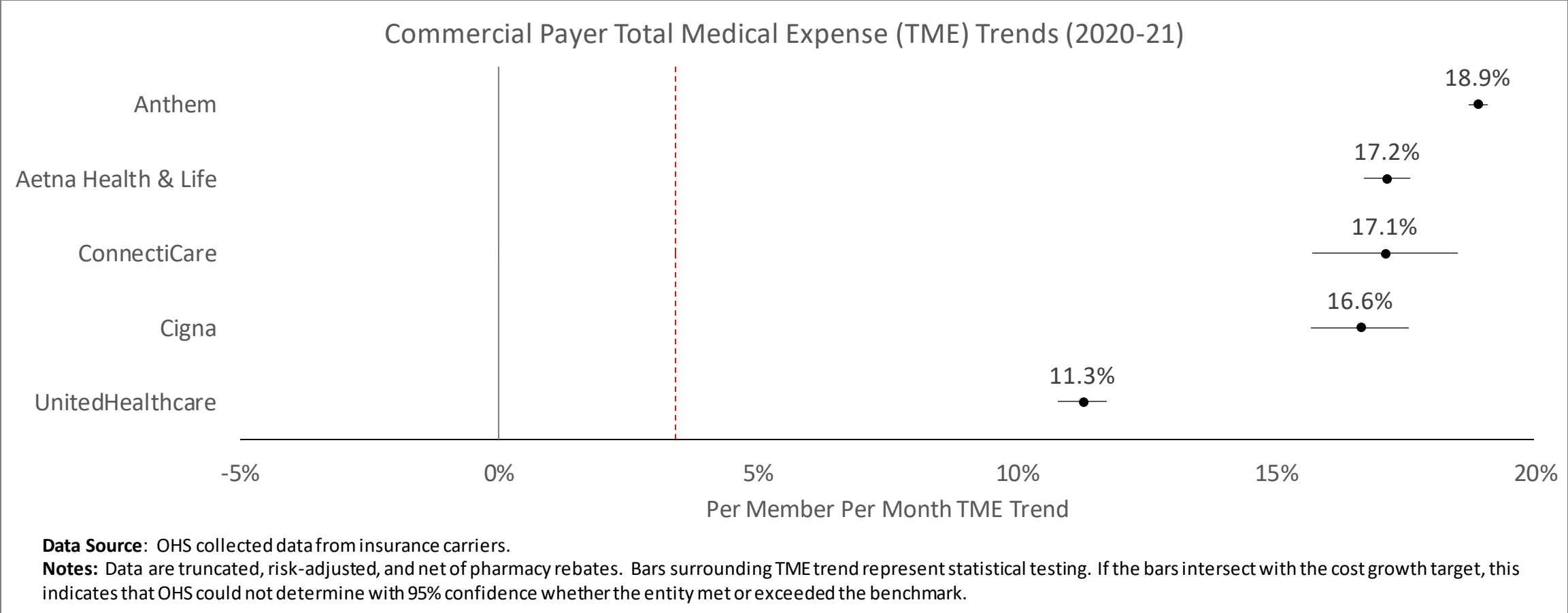
1. Spending declined in 2020, consistent with observations in other states. This was expected due to the absence of federal relief payments in the cost growth benchmark data.
2. In 2021 spending growth was modest in Medicaid and Medicare, but very high in the commercial market.
  - CT's 2021 commercial trend significantly exceeded that observed in three other cost growth benchmark states (MA reported 11.6% commercial cost growth from 2020-21; OR and RI have not publicly reported 2020-21 cost trends but OHS is aware of their trends through state-to-state conversations).
3. Across all three markets, outpatient hospital services drove spending growth in 2021, although with far more financial impact in the commercial market than the others.

# Total Medical Expense (TME) Trends by Payer

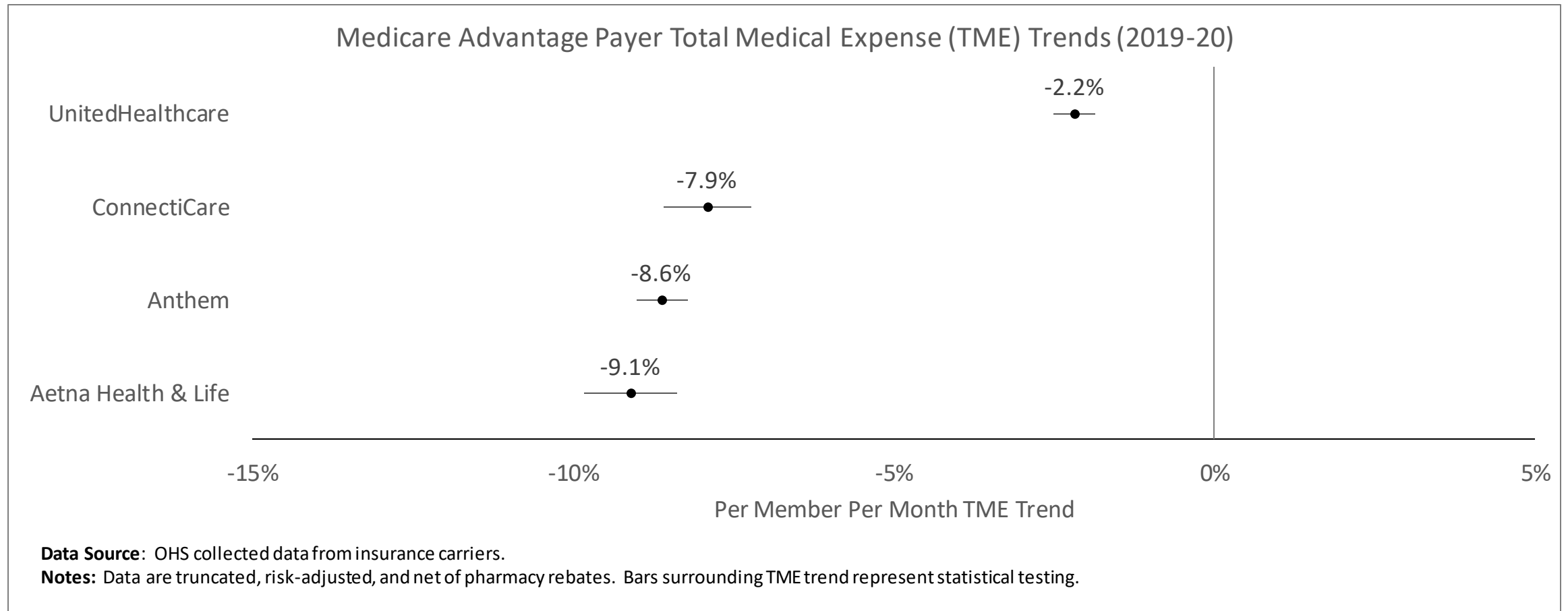
# Commercial Payer 2020 Cost Growth



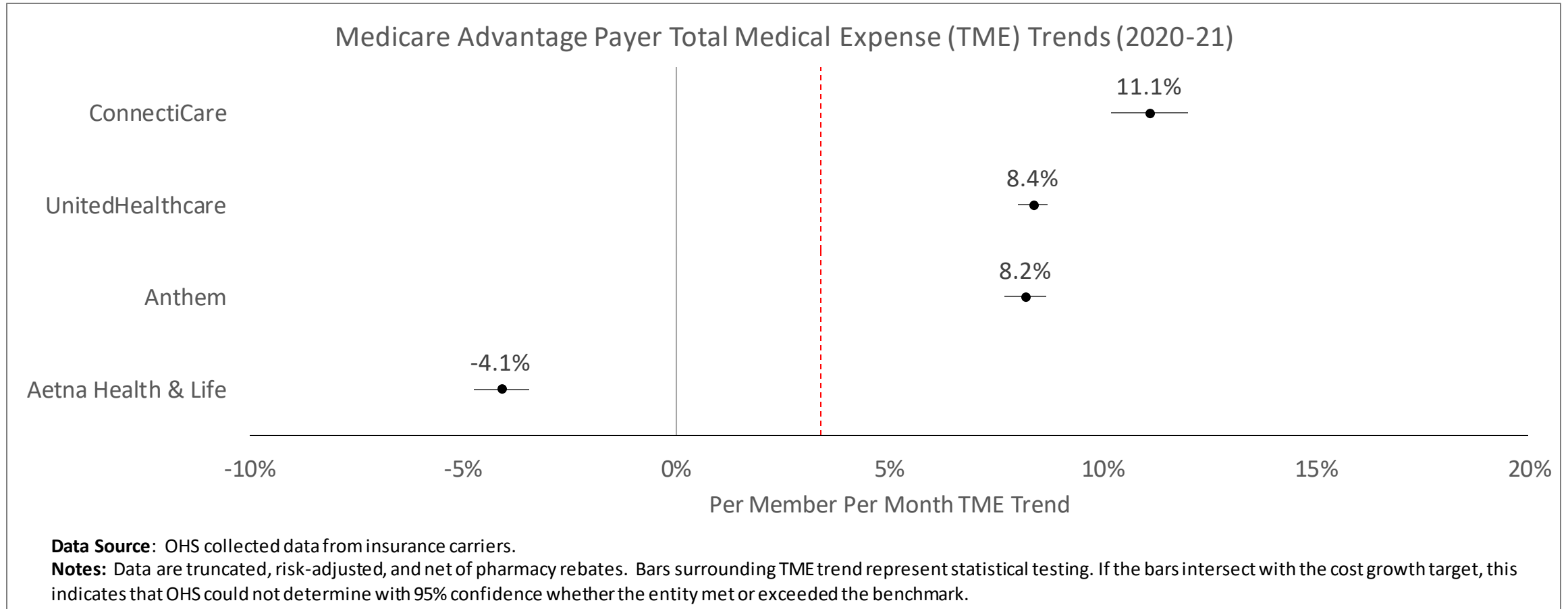
# Commercial Payer 2021 Performance Against the 3.4% Benchmark



# Medicare Advantage Payer 2020 Cost Growth



# Medicare Advantage Payer 2021 Performance Against the 3.4% Benchmark



# Summary of Payers' 2021 Performance Against the 3.4% Benchmark

Payer	2020-21 Commercial Performance (TME Trend)	2020-21 Medicare Advantage Performance (TME Trend)
<b>Aetna</b>	Did not meet the benchmark (17.2%)	Met the benchmark (-4.1%)
<b>Anthem</b>	Did not meet the benchmark (18.9%)	Did not meet the benchmark (8.2%)
<b>Cigna</b>	Did not meet the benchmark (16.6%)	NA
<b>ConnectiCare</b>	Did not meet the benchmark (17.1%)	Did not meet the benchmark (11.1%)
<b>UnitedHealthcare</b>	Did not meet the benchmark (11.3%)	Did not meet the benchmark (8.4%)

TME = Total Medical Expense



# Results of Primary Care Spend Target Analysis

# Definition of Primary Care Spending (1 of 2)

- OHS and the predecessor advisory body to this Steering Committee established a definition of primary care spending in 2020 that built upon a methodology established in collaboration with other New England states.
  - **Claims-based spending:** spending for care management; care planning; consultation services; health risk assessments, screenings and counseling; home visits; hospice/home health services; immunization administrations; office visits and preventive medicine and dental care visits.
    - There is a specific code list to calculate claims-based primary care spending.
  - **Non-claims-based spending:** capitation or salaried expenditures, PCMH and HIT infrastructure payments, performance-based payments, risk-based reconciliation, workforce expenditures, COVID-19 support payments.

# Definition of Primary Care Spending (2 of 2)

- **Primary care providers:**
  - **MDs and DOs:** family medicine, pediatric and adolescent medicine, internal medicine (when practicing primary care) and geriatric medicine (when practicing primary care)
  - **NPs and PAs:** when practicing primary care
  - Of note, OHS is also measuring primary care spending associated with OB/GYNs and midwifery for monitoring purposes.

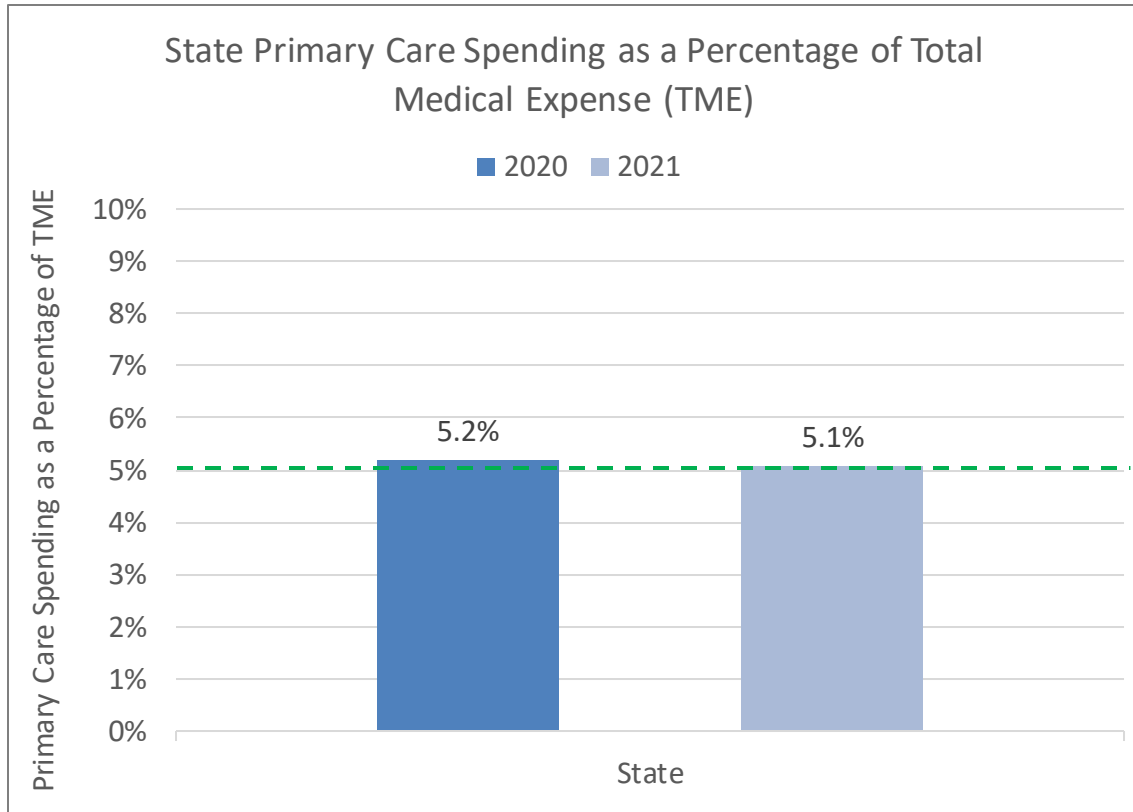
# Primary Care Spending Analysis Methodology

- 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 spend target is slightly different than TME for cost growth benchmark reporting.
  - TME for the primary care spend target includes all the spending categories for the cost growth benchmark, except for long-term care.

# 2020 and 2021 Primary Care Spend Analysis

- OHS collected 2019-21 primary care spending as a part of the cost growth benchmark data request from the following entities:
  - Five commercial and four Medicare Advantage insurers:
    - Aetna Health & Life
    - Anthem
    - Cigna
    - ConnectiCare
    - UnitedHealthcare
  - Connecticut Department of Social Services (for Medicaid)
- The analysis reported today does not include Medicare FFS data.

# Connecticut Achieved the 5% Primary Care Spend Target at the State Level in 2021

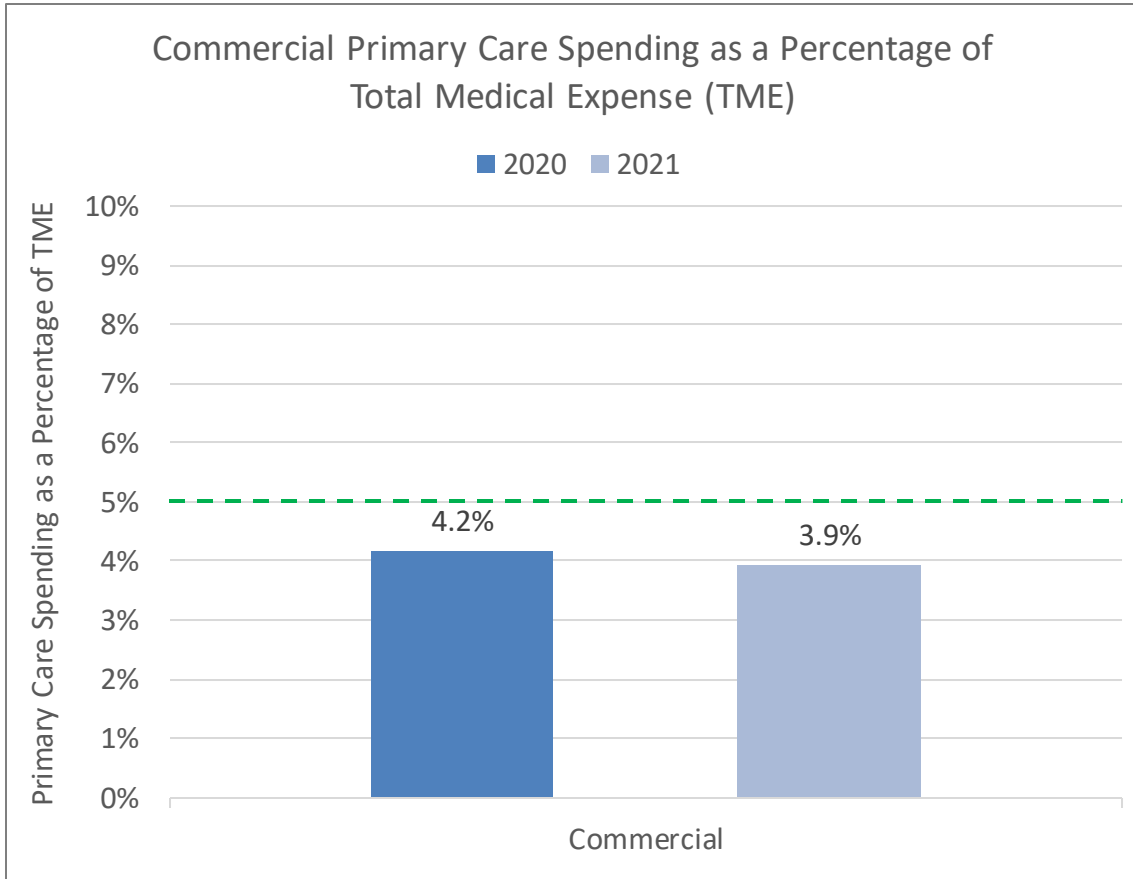


**Data Source:** OHS collected data from insurance carriers and from the Connecticut Department of Social Services (DSS).

**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 long-term care.

2021 Aggregate Primary Care Spending	2021 Per Member Per Month Primary Care Spending	2020-21 Per Member Per Month Trend
\$1,007,490,910	\$29	10.0%

# Connecticut Did Not Achieve the 5% Primary Care Spend Target for the Commercial Market in 2021

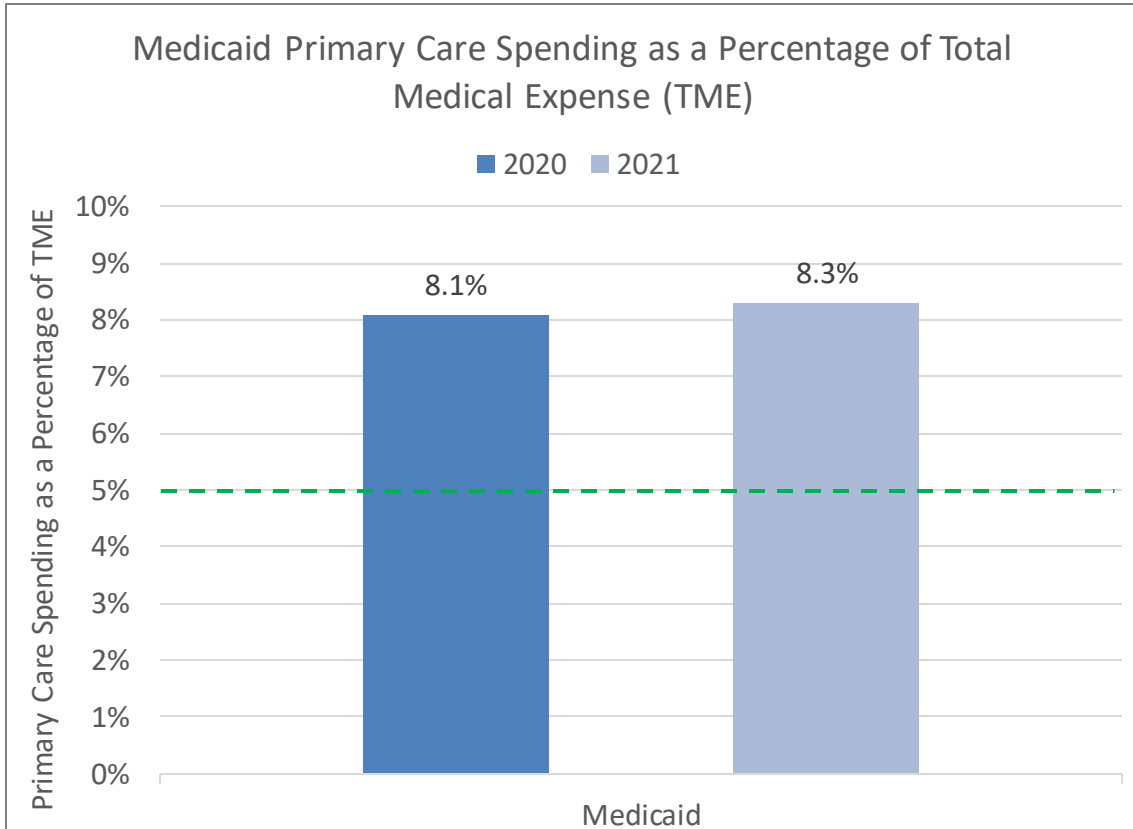


**Data Source:** OHS collected data from insurance carriers.

**Notes:** Data are not risk adjusted. Data are net of pharmacy rebates. TME includes all of the spending categories captured for the cost growth benchmark, less long-term care.

2021 Aggregate Primary Care Spending	2021 Per Member Per Month Primary Care Spending	2020-21 Per Member Per Month Trend
\$494,443,719	\$25	12.1%

# Connecticut Achieved the 5% Primary Care Spend Target for the Medicaid Market in 2021



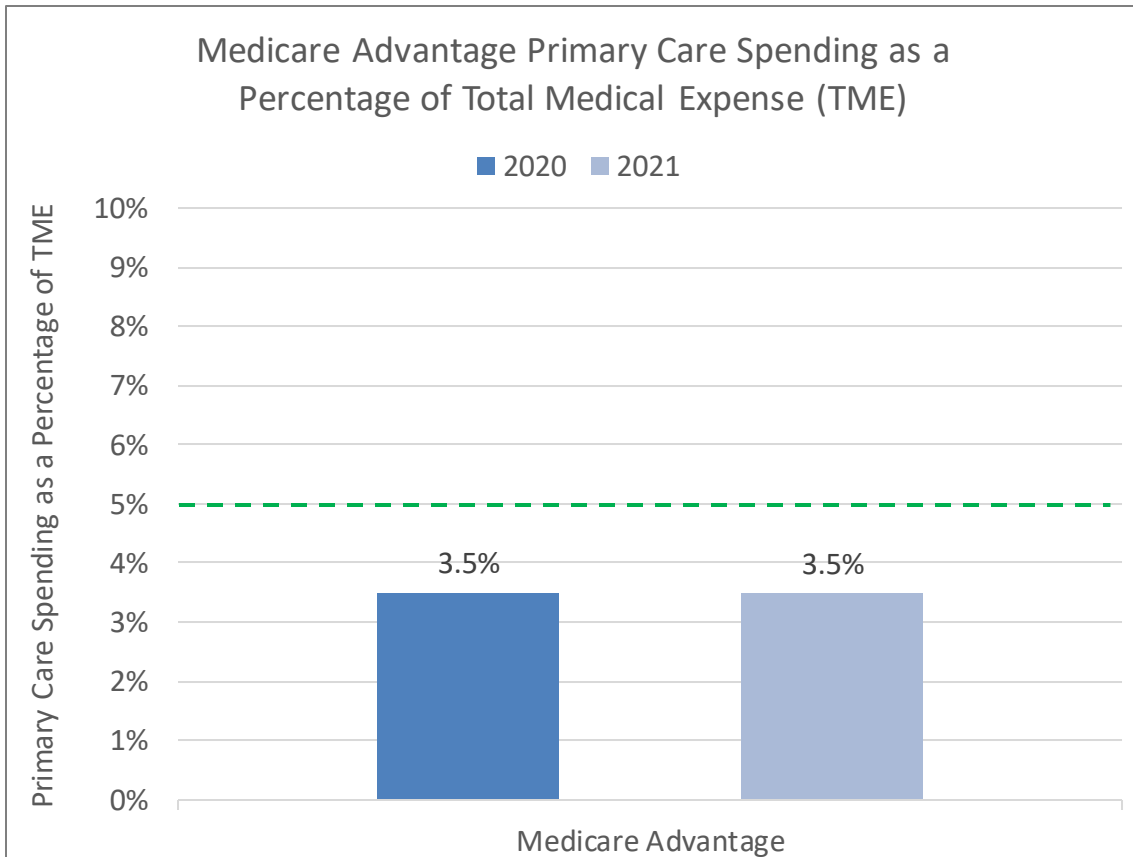
**Data Source:** OHS collected data from the Connecticut Department of Social Services (DSS).

**Notes:** Data are not risk adjusted. Data are net of pharmacy rebates. TME includes all of the spending categories captured for the cost growth benchmark, less long-term care.

2021 Aggregate Primary Care Spending	2021 Per Member Per Month Primary Care Spending	2020-21 Per Member Per Month Trend
\$365,235,907	\$27	6.6%



# Connecticut Did Not Achieve the 5% Primary Care Spend Target for the Medicare Advantage Market in 2021

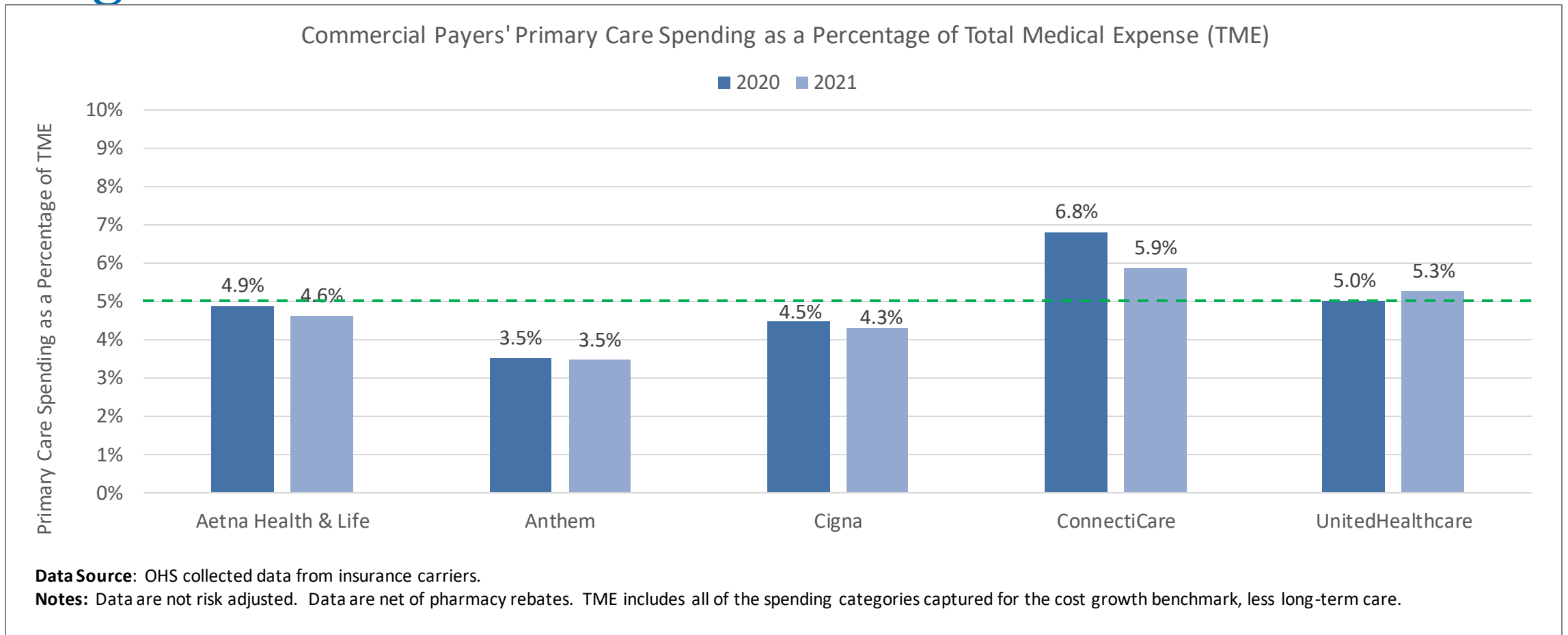


**Data Source:** OHS collected data from insurance carriers.

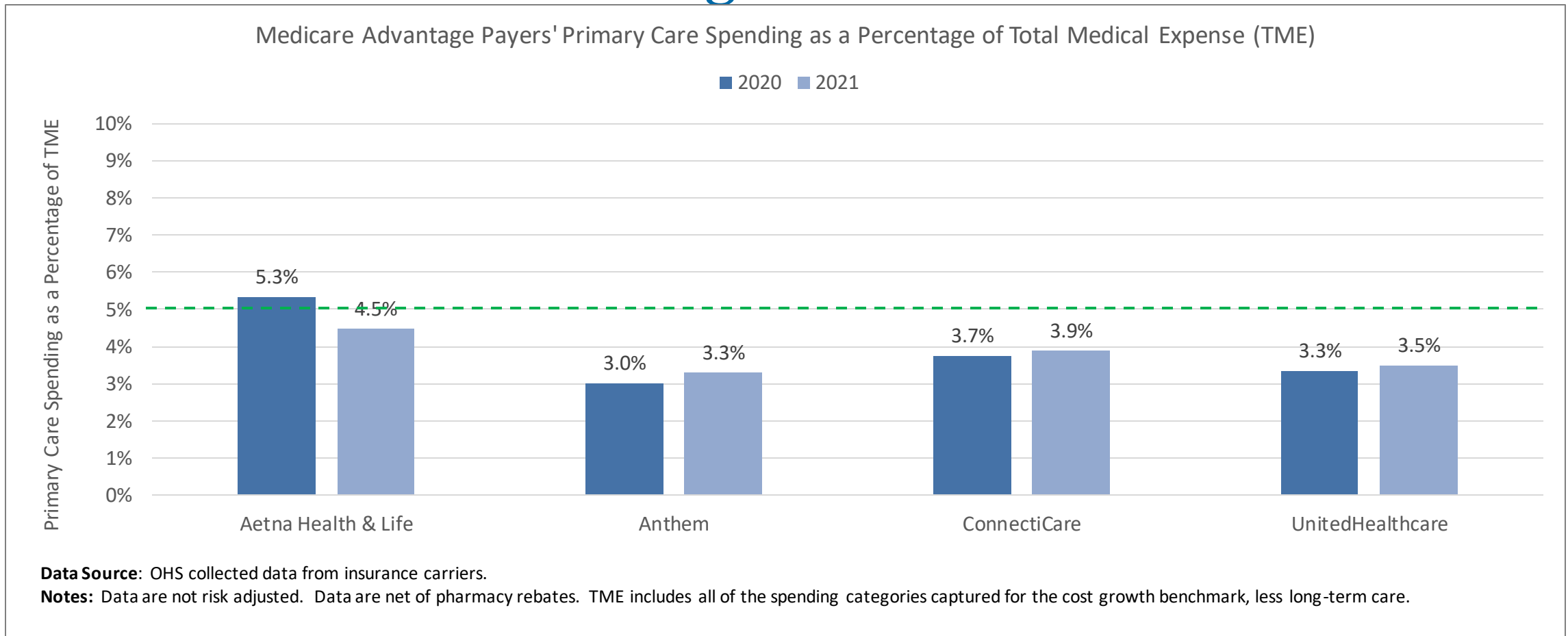
**Notes:** Data are not risk adjusted. Data are net of pharmacy rebates. TME includes all of the spending categories captured for the cost growth benchmark, less long-term care.

2021 Aggregate Primary Care Spending	2021 Per Member Per Month Primary Care Spending	2020-21 Per Member Per Month Trend
\$147,811,284	\$39	8.3%

# Two Payers Achieved the 5% Primary Care Spend Target for the Commercial Market in 2021



# No Payer Achieved the 5% Primary Care Spend Target for the Medicare Advantage Market in 2021



# Takeaway Observations

1. Connecticut met the 2021 primary care spend target because of the high level of primary care spend relative to TME in the Medicaid market.
2. Significant growth in primary care spending, relative to rates of growth for other healthcare spending, will need to occur in the commercial and Medicare Advantage markets if the higher targets are to be achieved in future years.

# Wrap-Up and Next Steps

# In Conclusion... (1 of 2)

- This report marks the first year of reporting against the cost growth benchmark and primary care spend target. OHS will be releasing a full report with findings, including at the Advance Network level, on March 31<sup>st</sup>.
- This new transparency of healthcare system performance will be complemented by reporting on the quality benchmarks beginning in April 2024.
- Increased benchmark and target performance transparency, coupled with growing numbers and types of analyses using All-Payer Claims Database data, are intended to increase understanding of system performance, inform dialogue, and lead to the design and implementation of actions to improve Connecticut residents' access to affordable, high-quality healthcare.

# In Conclusion... (2 of 2)

- This Steering Committee will continue to study cost drivers and work on cost growth mitigation strategies in the two areas prioritized for Steering Committee attention in 2023:
  - Pharmacy spending
  - Hospital spending

# Next Meeting

- The Steering Committee will hold its next meeting on April 24<sup>th</sup> from 3:00-5:00pm. This will be a *virtual* meeting.