HEALTHCARE COST GROWTH BENCHMARK AND PRIMARY CARE SPENDING TARGET RECOMMENDATIONS TO THE GENERAL ASSEMBLY

The Office of Health Strategy (OHS) was charged under C.G.S. §19a-754j to prepare and submit this report to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health.

A Report Pursuant to C.G.S. §19a-754j

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Acronym Glossary

APCD	All-Payer Claims Database
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMIR	Cost and Market Impact Review
CID	Connecticut Insurance Department
CMS	Centers for Medicare and Medicaid Services
CON	Certificate of Need
CPS	Current Population Survey
DOC	Department of Correction
DSS	Department of Social Services
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
HEDIS	Health Care Effectiveness Data and Information Set
NCPHI	Net Cost of Private Health Insurance
NCQA	National Committee on Quality Assurance
OHS	Office of Health Strategy
OSC	Office of the State Comptroller
PBM	Pharmacy Benefit Manager
PCMH+	Person-Centered Medical Home Plus
PCPCM	Person-Centered Primary Care Measure
PIP	Performance Improvement Plan
PGSP	Potential Gross State Product
THCE	Total Health Care Expenditures
TME	Total Medical Expense
VHA	Veterans Health Administration

Glossary

Allowed Amount/Allowed Cost: The maximum amount a payer will pay a provider for a service.

Claim: A bill that healthcare providers submit to a patient's insurance provider, which contains unique medical codes detailing the care administered during a patient visit.

Copayment: The fixed amount the member pays for a covered service after the member has paid their deductible. For example, if an insurance plan's allowable cost for a service is $100 and the member's copayment for the service is $20, if the member has met their deductible, they pay $20 for the service. If the member has not met their deductible, they pay $100, the full allowed amount for the service.

Fee-for-Service: Private (commercial) health insurance that reimburses health care providers on the basis of a fee for each health service provided to the insured person.

Healthcare Cost Growth Benchmark ("benchmark"): The targeted annual per person growth rate for Connecticut's total healthcare spending, expressed as the percentage growth from the prior year's per spending. OHS has set values for each calendar year through 2025.

Hospital inpatient: The TME paid to hospitals for inpatient services generated from claims. This category includes all room and board and ancillary payments, all hospital types, and payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. This category does not include payments made for observation services, payments made for physician services provided during an inpatient stay that have been billed directly by the physician group practice or an individual clinician, or inpatient services at non-hospital facilities.

Hospital outpatient: The TME paid to hospitals for outpatient services generated from claims. This category includes all hospital types and all traditional hospital outpatient services (i.e., outpatient surgery, imaging, labs). It also includes payments made for hospital-licensed satellite clinics, emergency room services not resulting in admittance, and observation services. This category 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.

Insurance Carriers (Carriers): A private health insurance company that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, and Medicare Advantage.

Market: The highest levels of categorization of health insurance. Medicare and Medicare Advantage are collectively referred to as the "Medicare market." Medicaid Fee-for-Service is referred to as the "Medicaid market." Individual, self-insured, small and large group, and student health insurance markets are collectively referred to as the "Commercial market."

Net Cost of Private Health Insurance (NCPHI): Measures the costs to Connecticut residents associated with the administration of private health insurance including commercial and Medicare Advantage. It is defined as the difference between premiums earned and benefits incurred, and includes insurers' costs of paying bills, advertising, sales commissions, and other administrative costs, net additions or subtractions from reserves, rate credits and dividends, premium taxes and profits or losses.

Non-Claims: Payments that are made for something other than a fee-for-service claim. Non-claims-based payments can be based on historical claims data, but they are not paid on a fee-for-service claims basis. Non-claims payments are payments that include capitation payments, pay-for-performance bonuses, risk settlements, care management payments, etc.

Out-of-Pocket Spending: A member's expenses for medical care that are not reimbursed by insurance. Out-of-pocket costs including deductibles, coinsurance, and copayments for covered services plus all costs for services that are not covered.

Payer: A private or public entity that pays healthcare providers for healthcare services, prescription drugs, medical equipment and supplies on behalf of a covered population.

Premium: The amount a member pays for health insurance every month.

Primary Care Spending Target: This target is Connecticut's annual primary care spending as a percentage of total medical expenditures. The target should reach 10% by calendar year 2025, as directed in Public Act 22-118. OHS has set interim targets for each calendar year to reach 10% by 2025.

Professional physician: TME paid to primary care providers delivering care at a primary care site of care generated from claims using a code-level definition and the TME paid to physicians or physician group practices generated from claims, including services provided by a doctor 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. Professional physician also includes TME paid from claims to healthcare providers for services provided by a licensed practitioner other than a physician and not identified as primary care in the primary care definition.

Total Health Care Expenditures (THCE): The sum of all healthcare expenditures in Connecticut from public and private sources for a given calendar year, including: all claims-based spending paid to providers, net of pharmacy rebates, all patient cost-sharing amounts, and the Net Cost of Private Health Insurance. Defining specifications of THCE are included in the Connecticut Healthcare Benchmark Initiative Implementation Manual.

Total Medical Expense (TME): The total cost of care for the patient population of a payer or provider entity for a given calendar year, where cost is calculated for such year as the sum of: all claims-based spending paid to providers by public and private payers, and net of pharmacy rebates; all nonclaims payments for such year, including, but not limited to, incentive payments and care coordination payments; and all patient cost-sharing amounts expressed on a per capita basis for the patient population of a payer or provider entity in this state. TME is reported at multiple levels: market, payer and provider level. TME is reported net of pharmacy rebates at the state, market and payer levels only. Payers report TME by line of business (e.g., individual, self-insured, large group, small group, Medicare, Medicaid, Medicare/Medicaid dually eligible) and at the Advanced Network level whenever possible. More detailed TME reporting specifications are contained in the Appendices of the Connecticut Healthcare Benchmark Initiative Implementation Manual.

Executive Summary

As Connecticut General Statute (C.G.S.) Sec. 19a-754j requires, this report summarizes the results of the Office of Health Strategy's (OHS') healthcare cost growth benchmark and primary care spending target analyses using data from calendar years 2019-2021.

The report also presents the findings from OHS' plan for monitoring any unintended consequences resulting from benchmark and target implementation, and the executive director's recommendations on strategies to increase the efficiency of the state's health care system.

Background

OHS established Connecticut's healthcare cost growth benchmark ("the benchmark") with the goals of slowing healthcare spending growth and making healthcare more affordable for residents. The benchmark represents the targeted year-to-year increase in healthcare spending per person and is set to contain healthcare costs and make care more affordable. Connecticut is one of nine states pursuing[1] cost growth benchmark strategies to slow unsustainable rising healthcare costs.

OHS set Connecticut's benchmark in November 2020, for calendar years 2021-2025 based on a blend of forecasted per capita potential gross state product (PGSP)[2] and forecasted growth in median income. The per person spending growth target benchmark was set at 3.4% for 2021, 3.2% for 2022, and 2.9% for 2023, 2024 and 2025. In May 2023, OHS publicly reported performance against the 2021 benchmark.

Connecticut spent $34 billion on healthcare services and insurance coverage in 2021, up from $31.9 billion in 2019 and $30.9 billion in 2020. Healthcare spending in 2020 and 2021 was significantly altered by the COVID-19 pandemic. The 6% increase in statewide healthcare spending per person exceeded the benchmark for 2021. The spending growth in 2021 was driven by an 18.8% increase in per person spending for the **commercially insured**; whereas increases for **Medicare/Medicare Advantage** and **Medicaid populations** were significantly less at 1.4% and 0.8%, respectively. Per person spending on hospital outpatient services in the commercial market increased by 33.1% and was the most significant contributor to the commercial trend. Of insurance payers, 100% of commercial payers, and 75% of Medicare Advantage payers exceeded the 2021 benchmark. Per person spending for all five commercial payers (Aetna, Anthem [now Elevance], Cigna, ConnectiCare and UnitedHealthcare) and three of the four Medicare Advantage payers (Aetna, Elevance, ConnectiCare, and UnitedHealthcare) exceeded the 2021 benchmark.

The primary care spending target is a supplemental strategy in Connecticut to encourage increased primary care investment, which research has demonstrated leads to better patient outcomes, lower costs, and improved patient experience (Phillips & Bazemore, 2010; Primary Care Collaborative, 2022; Shi, 2012). OHS is required to set primary care spending targets, as a share of total healthcare spending, for each year through 2025. The primary care spending targets are 5% for 2021, 5.3% for 2022, 6.9% for

[1] Connecticut was the fifth state to adopt a healthcare cost growth benchmark joining Massachusetts, Rhode Island, Delaware, and Oregon. New Jersey, Nevada, Washington, and California later adopted cost growth benchmark strategies.

[2] *PGSP = (expected growth in national labor force productivity + expected growth in the state's labor force + expected national inflation) – expected state population growth*

2023, 8.5% for 2024 and 10% for 2025. In May 2023, OHS publicly reported performance against the 2021 target.

Connecticut spent $1 billion on primary care in 2021, a 13.6% increase from $880 million in 2020. The statewide primary care share of total healthcare spending was 5.1% in 2021, which met the state's 5% spending target. The **Medicaid** primary care share of total spending was at 8.3% and achieved the target for 2021 while the **commercial** and **Medicare Advantage** markets were below the target at 3.9% and 3.5%, respectively. Forty percent of commercial payers and none of the four Medicare Advantage payers achieved the 2021 spending target.

Monitoring Unintended Adverse Consequences

On the advice of the Cost Growth Benchmark Technical Team, which sunset after accomplishing its goals, OHS established its Cost Growth Benchmark Unintended Adverse Consequences Measurement Plan ("the plan") to monitor potential negative effects of the benchmark across three domains: underutilization, impact on underserved populations and consumer out-of-pocket spending. The plan utilizes multiple measures including preventive and chronic care quality measures, patient experience surveys, and Medicaid member grievances to assess the three domains. Tables 9-15 in the Appendix include performance on all the unintended adverse consequences measures discussed in this report.

Since the Executive Order and legislation implementing the Cost Growth Benchmark program did not occur until 2020 and 2022, respectively, OHS did not anticipate any adverse impact in the 2020-2021 measurement period. However, as outlined in the plan, OHS has begun monitoring for any unintended consequences and presents the initial data below.

Underutilization

For the **commercial market**, when examining the service utilization measure results, 60% (6 of 10) of the preventative and chronic care measures showed an increase in commercial providers screening or delivering preventative care to patients. This is an improvement since the implementation of the benchmark. Areas needing improvement include chlamydia screening in women, colorectal cancer screening, eye exams for patients with diabetes and timeliness of prenatal care (see Table 9).

For the **Medicaid market,** 50% (6 of 12) of utilization measures showed improvement since implementation of the benchmark. Areas needing improvement include annual dental visit, breast and cervical cancer screening, chlamydia screening in women, eye exams for patients with diabetes and timeliness of prenatal care (see Table 10).

Impact on underserved populations - patient experience of care

OHS examined patient experience in the **commercial market** by assessing changes in patient responses to survey questions related to getting care quickly and getting needed care. Of those surveyed in 2022, 83.8% indicated that they "usually" or "always" received care quickly while 83% indicated that they were "usually" or "always" getting care they needed. These results were a slight decline from 2020 performance results (see Table 11).

For adults and children served by **Medicaid**, the Department of Social Services (DSS) utilizes the Person-Centered Primary Care Measure (PCPCM) in its Person-Centered Medical Home Plus (PCMH+) program to monitor patient care. On average, 81.8% of adults responded positively (either "definitely" or

"mostly") to questions pertaining to their primary care experience while 85.3% of children responded positively to these questions in 2021 (see Table 12).

OHS tracked Medicaid member grievances pre- and post-benchmark implementation to monitor for impact on patient care and potential underutilization in the Medicaid population. OHS monitored the change in the number of Medicaid members filing complaints about no or limited access to providers, and the change in the number of Medicaid members filing complaints about delayed access and/or wait time for an appointment. Complaints about no or limited access to providers decreased by 58 percent post-benchmark implementation and complaints about delayed access and/or wait time for an appointment decreased by 36 percent (see Table 13). It is notable that complaint frequency about delayed access was very low, both pre- and post-benchmark.

Consumer out-of-pocket spending

OHS monitored changes in consumers healthcare costs using two different data sources: the All-Payer Claims Database (APCD) and the Current Population Survey (CPS). When OHS assessed out-of-pocket spending using the APCD, it found that Connecticut residents did not see increased out-of-pocket spending for medical or retail pharmacy services in the commercial market following benchmark implementation. However, CPS data, which includes data for all ages and insurance status, show that Connecticut residents did see growth in average medical out-of-pocket spending (see Table 14). When assessing insurance premiums pre- and post-benchmark implementation using CPS data, OHS found that Connecticut residents did not experience greater growth in premiums post-benchmark implementation compared to the Northeast and the United States (see Table 15).

Conclusion:

In the first year of monitoring for unintended consequences of the health care cost growth benchmark, CT did not see indications of underutilization or adverse impacts on underserved populations. The 2021 Current Population Survey showed increased out of pocket costs in 2021. While this increase is unlikely to be related to the benchmark initiative, the trend in out-of-pocket costs should be monitored and will be reported in subsequent years.

Recommendations

OHS makes recommendations in four general areas, including the following seven specific recommendations to slow the growth in healthcare spending in Connecticut:

1. **Institute Enforcement Mechanisms for the healthcare Cost Growth Benchmark**
    a. Adopt a requirement for performance improvement plans (PIPs) for entities exceeding the cost growth benchmark.
    b. Consider insurer use of the cost growth benchmark as a factor in rate filings review.
2. **Address Provider Price Growth**
    a. Institute out-of-network price caps to reduce market pressure by providers who refuse to participate in insurer networks.
    b. Expand the cost and market impact review (CMIR) trigger criteria to include hospitals and health systems that are identified as a significant contributor to healthcare cost growth or that exceed the benchmark.

c. Increase transparency of group practice consolidation by requiring a certificate of need application for any large group practice including private equity entities.

3. **Address Insurers' Role in Healthcare Cost Growth**
    a. Create affordability standards for Connecticut commercial insurers and incorporate the standards into the annual review of commercial insurers' rate filings.
4. **Pursue Strategies to Slow Pharmacy Price Growth**
    a. Increase pharmacy benefit manager price transparency.

Introduction

On January 22, 2020, Governor Lamont signed Executive Order No. 5 ("the Order") directing the Office of Health Strategy (OHS) to establish statewide healthcare cost growth benchmarks for calendar years 2021-2025, with the goal of slowing the growth of healthcare spending and making healthcare more affordable for the residents of Connecticut. Executive Order No. 5 also required OHS to set targets to increase the primary care share of total healthcare spending to 10% by 2025, with the goal of strengthening the state's primary care infrastructure.

These actions taken by Governor Lamont are key to addressing unsustainable healthcare cost growth, strengthening primary care, and improving healthcare quality and health equity in the state. Annual healthcare cost growth has outpaced growth in Connecticut's economy and, even more importantly, resident household median income. The discrepancy between growth in healthcare costs and that of household incomes compromises residents' ability to afford healthcare services (Agency for Healthcare Research and Quality, 2020). Limiting healthcare cost growth is an economic priority that will help families better afford a high quality of life in Connecticut and improve the business climate. Additionally, research has demonstrated that greater investment in primary care as a percentage of overall healthcare spending leads to better patient outcomes, lower costs, and improved patient experience of care (Phillips & Bazemore, 2010; Shi, 2012).

During 2022, the legislature codified the Order in C.G.S. Sec. 19a-754g et seq. requiring OHS to prepare and submit a report to the General Assembly's Insurance and Public Health committees no later than October 15, 2023, and annually thereafter. The report must describe health care spending trends and the factors underlying such trends, a plan for monitoring any unintended consequences resulting from the adoption of cost growth benchmarks and primary care spending targets and any findings from the implementation of such plan, and the executive director's recommendations concerning strategies to increase the efficiency of the state's health care system.

This report presents OHS' findings and recommendations pursuant to C.G.S. Sec. 19a-754j.

Not later than October 15, 2023, and annually thereafter, the executive director shall prepare and submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health. Such report shall be based on the executive director's analysis of the information submitted during the most recent informational public hearing conducted pursuant to this subsection and any other information that the executive director, in the executive director's discretion, deems relevant for the purposes of this section, and shall:

(A) Describe health care spending trends in this state, including, but not limited to, trends in primary care spending as a percentage of total medical expense, and the factors underlying such trends;

(B) Include the findings from the report prepared pursuant to subsection (b) of section 19a-754h;

(C) Describe a plan for monitoring any unintended adverse consequences resulting from the adoption of cost growth benchmarks and primary care spending targets and the results of any findings from the implementation of such plan; and

(D) Disclose the executive director's recommendations, if any, concerning strategies to increase the efficiency of the state's health care system, including, but not limited to, any recommended legislation concerning the state's health care system.

Health Care Spending Trends

This section of the report provides a summary of OHS' findings from the 2019-2021 cost growth benchmark and primary care spending target analyses. For detailed methodological information about the cost growth benchmark and primary care spending target analyses, please see the Connecticut Healthcare Benchmark Initiative Implementation Manual.

Healthcare Cost Growth Benchmark

OHS set Connecticut's benchmark on November 2020 for calendar years 2021-2025 with a growth target of 3.4% for 2021, 3.2% for 2022, and 2.9% for 2023, 2024 and 2025.

Connecticut spent $34 billion on healthcare statewide in 2021, up from $31.9 billion in 2019 and $30.9 billion in 2020. Statewide per person spending exceeded the 3.4% benchmark with a 6% increase. The spending growth in 2021 was driven by an 18.8% increase in **commercial** spending per person; whereas increases in **Medicare** and **Medicaid** were significantly less at 1.4% and 0.8%, respectively. Commercial hospital outpatient spending per person increased by 33.1% and was the most significant contributor to the commercial trend. Of insurance payers, 100% of commercial payers (Aetna, Anthem [now Elevance], Cigna, ConnectiCare and UnitedHealthcare), and 75% of Medicare Advantage payers (Aetna, Elevance, ConnectiCare, and UnitedHealthcare) exceeded the benchmark.

Primary Care Spending Target

Connecticut's primary care spending target is a supplemental strategy intended to encourage increased primary care investment, which research has demonstrated leads to better patient outcomes, lower overall costs, and improved patient experience (Phillips & Bazemore, 2010; Primary Care Collaborative, 2022; Shi, 2012). OHS is required to set primary care spending targets, as a share of total healthcare spending, to reach 10% by 2025. OHS established the primary care spending targets at 5% for 2021, 5.3% for 2022, 6.9% for 2023, 8.5% for 2024 and 10% for 2025.

Connecticut spent $1 billion on primary care in 2021, a 13.6% increase from $880 million in 2020. The statewide primary care share of total healthcare spending was 5.1%, which met the state's 5% spending target. The **Medicaid** primary care share of total spending achieved the benchmark target at 8.3% while the **commercial** and **Medicare Advantage** markets were below the target at 3.9% and 3.5%, respectively. Forty percent of commercial payers and none of the four Medicare Advantage payers achieved the 2021 spending target.

COVID-19 Pandemic and Impact on Cost Trends

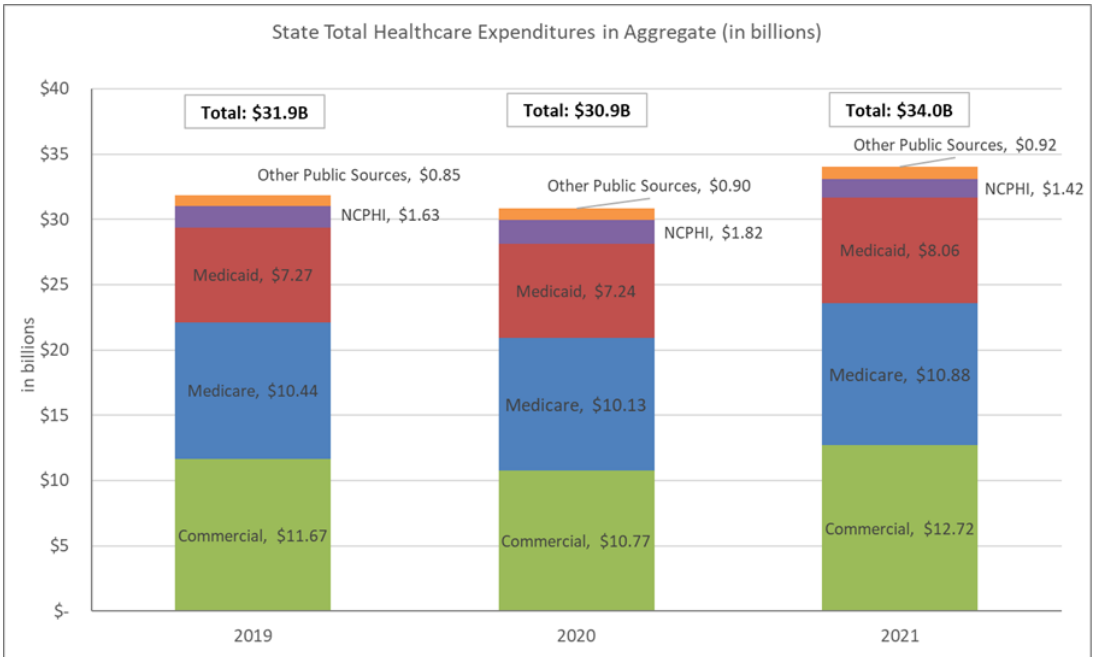
The COVID-19 pandemic significantly altered healthcare utilization nationally, which led to atypical trends for 2020 and 2021. Specifically, COVID-19 restrictions caused an abrupt reduction in the use of in-person care and a subsequent sharp drop in per person spending in 2020. While in-person care rebounded in 2021, although not to pre-pandemic levels as of October 2022, spending on health services contributed to increased spending, especially in the **commercial** market (McGough et al, 2023).

OHS acknowledges that 2021 cost growth benchmark performance was impacted by these unprecedented circumstances, with per person cost growth much higher than would be expected under typical conditions. Since the decline and subsequent rebound in health care utilization in 2020 and 2021 was a national phenomenon, comparing Connecticut's experience to that of other benchmark states around the country is one way of evaluating the 2021 trend in light of these highly unusual circumstances.

State Total Health Care Expenditure (THCE) Trends

Connecticut's state Total Health Care Expenditures (THCE) in the aggregate are presented in Figure 1. THCE were $31.9 billion ($9,865 per person) in 2019, $30.9 billion ($9,556 per person) in 2020, and $34.0 billion ($10,130 per person) in 2021. The largest component of Connecticut's THCE in aggregate for all three years was **commercial spending**, followed by **Medicare** and **Medicaid**[3] spending. The net cost of private health insurance (NCPHI), Department of Correction (DOC) spending and federal Veterans Health Administration (VHA) spending comprised a small portion of aggregate THCE and were not significant cost drivers.

FIGURE 1. STATE TOTAL HEALTH CARE EXPENDITURES IN AGGREGATE (IN BILLIONS)

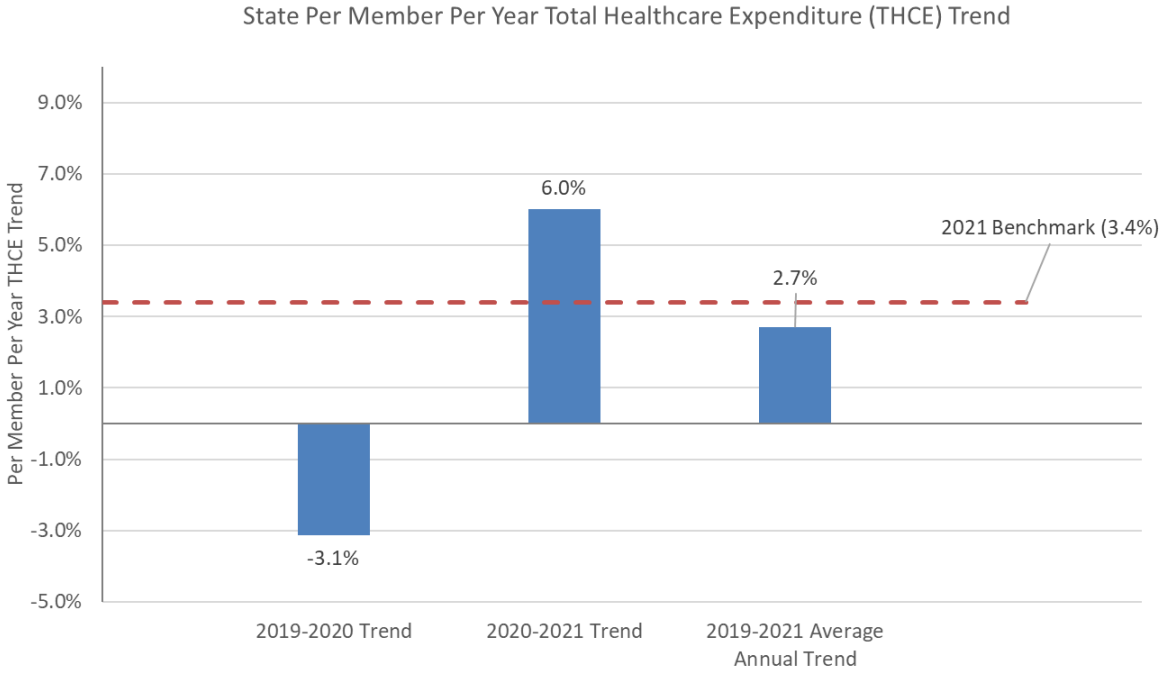


Data Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut Department of Correction (DOC), and the Veterans Health Administration (VHA).
Notes: Data are not risk-adjusted and data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

The average annual growth in per person THCE between 2019-2021, presented in Figure 2, was 2.7%. Connecticut's per person THCE trend decreased by -3.1% from 2019-2020, which is accounted for by the reduction in healthcare utilization during the onset of the COVID-19 pandemic. Connecticut's per person THCE grew 6% from 2020-2021, driven by the rebound in-person healthcare utilization post-pandemic.

[3] Medicaid-specific Department of Mental Health and Addiction Services (DMHAS) spending is captured in Medicaid Spending.

FIGURE 2. STATE PER MEMBER PER YEAR TOTAL HEALTH CARE EXPENDITURES (THCE) TREND

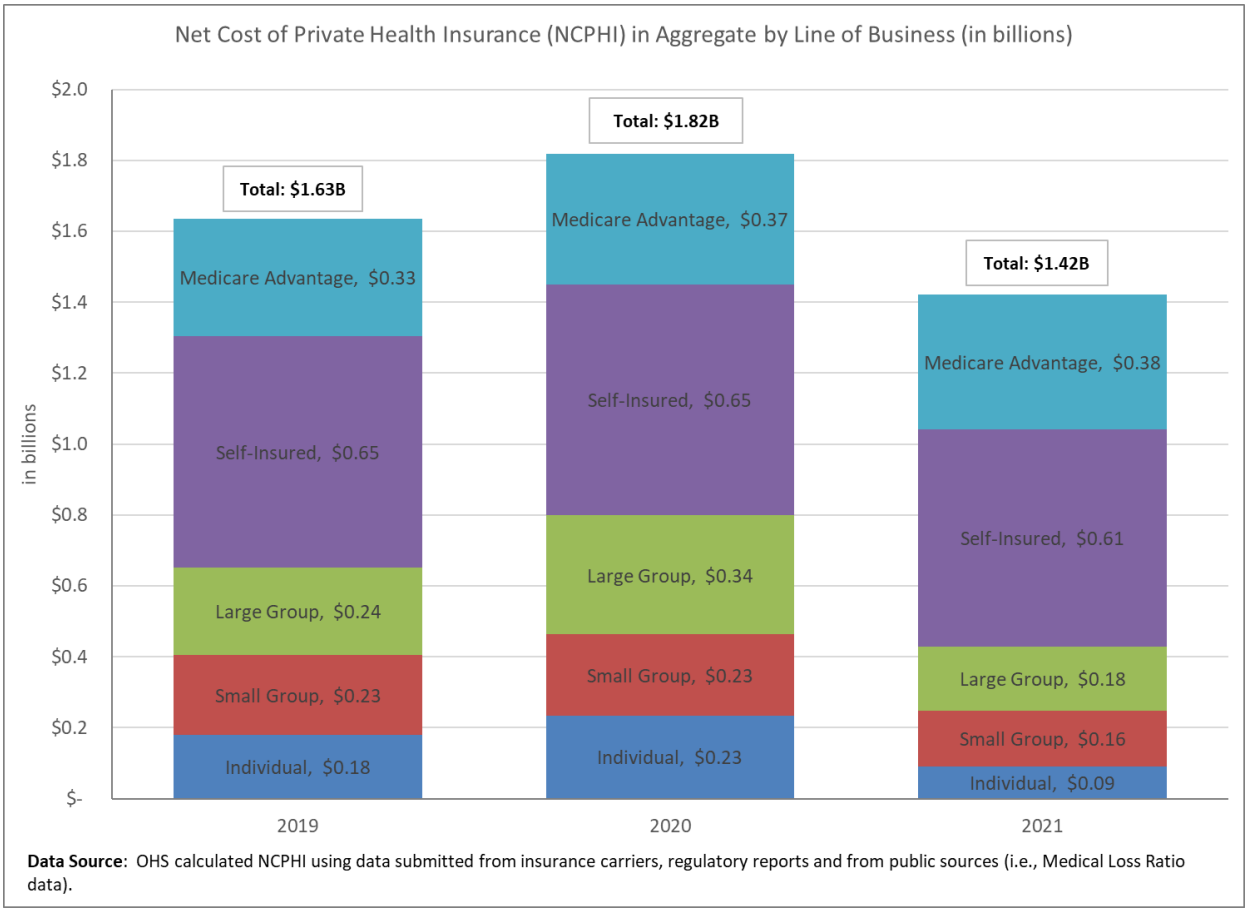


Data Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut Department of Correction (DOC), and the Veterans Health Administration (VHA).
Notes: Data are not risk-adjusted and data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

Net Cost of Private Health Insurance (NCPHI) by Line of Business

The Net Cost of Private Health Insurance (NCPHI), which measures the costs to Connecticut residents associated with the administration of private health insurance, is presented in Figure 3. NCPHI contributed $1.63 billion to state THCE in 2019, $1.82 billion in 2020 and $1.42 billion in 2021 but decreased by 21.9% in 2021. The increase in NCPHI during 2020 was driven by 2020 premiums being set in advance of the COVID-19 pandemic. With the unanticipated decrease in healthcare utilization, insurers spent less of the premium on claims, retained a greater percentage of the premium dollars and experienced elevated profits. In 2021, utilization patterns returned to more anticipated levels, and more of the premium dollar was spent on claims which drove NCPHI down from its previously elevated levels.

FIGURE 3. NET COST OF PRIVATE HEALTH INSURANCE (NCPHI) IN AGGREGATE BY LINE OF BUSINESS (IN BILLIONS)



Data Source: OHS calculated NCPHI using data submitted from insurance carriers, regulatory reports and from public sources (i.e., Medical Loss Ratio data).

Total Medical Expense (TME) Trends

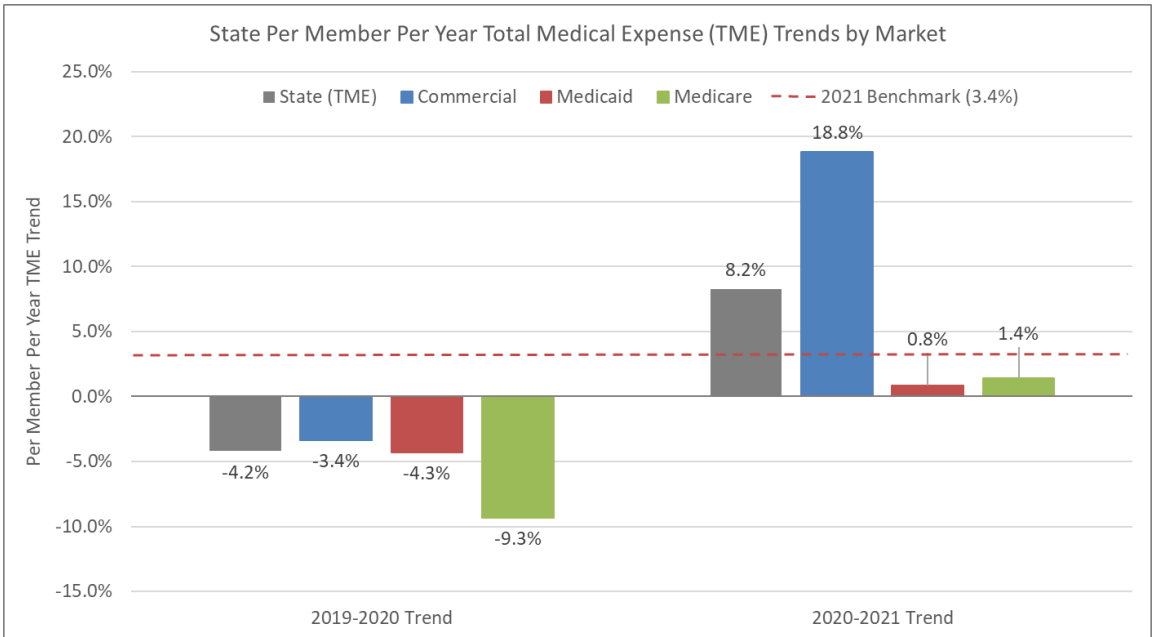
TME Trends by Insurance Market

OHS assesses per member per year Total Medical Expense (TME) trends by insurance market against the benchmark as presented in Figure 4. Per member per year TME trends are a product of changes in both healthcare utilization and payment per service. Connecticut's 2019-2021 per person per year TME trends by market reflect a small decline statewide in 2020, followed by growth far exceeding the benchmark in 2021.

There were substantial differences in TME growth across markets. **Commercial** spending decreased 3.4% to $6,505 per member per year in 2020, and then increased 18.8% to $7,729 per person in 2021. Connecticut's average annual growth in commercial spending per person from 2019-2021 was 7.4%. The 18.8% growth in commercial spending from 2020-2021 exceeded not only Connecticut's benchmark but outpaced increases in other cost growth benchmark states, including Massachusetts (16.1%), Oregon (12.1%), and Rhode Island (9.7%) (Massachusetts Center for Information and Analysis, 2023; Oregon Health Authority, 2023; Rhode Island Office of the Health Insurance Commissioner, 2023). Whereas Connecticut's commercial market spending exceeded the benchmark in 2021, Medicaid and Medicare spending growth remained well below the benchmark. **Medicare** per member per year spending

decreased 9.3% to $14,945 in 2020, and then increased by 1.4% to $15,157 per person in 2021. **Medicaid** per member per year spending decreased 4.3% to $7,050 in 2020, and then increased 0.8% to $7,110 per person in 2021. The average annual growth rates for Medicare and Medicaid were negative from 2019-2021, -4% and -1.8%, respectively.

FIGURE 4. STATE PER MEMBER PER YEAR TOTAL MEDICAL EXPENSE (TME) BY MARKET



Data Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS) and the Connecticut Department of Social Services (DSS).
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

Trends by Insurance Carrier

Insurance carriers' performance against the benchmark is presented in Table 1. During the 2020-2021 performance year, all **commercial** carriers exceeded the benchmark with increases ranging from 11.3% to 18.9%. Similarly, most (75%) of **Medicare Advantage** carriers exceeded the benchmark with increases ranging from 8.2% to 11.1% except for Aetna which posted a -4.1% trend.

TABLE 1. SUMMARY OF INSURANCE CARRIERS' 2020-2021 PERFORMANCE AGAINST THE 3.4% BENCHMARK

Insurance Carrier	2020-21 Commercial Performance (TME Trend)	2020-21 Medicare Advantage Performance (TME Trend)
Aetna	Did not meet the benchmark 17.2%	Met the benchmark -4.1%
Anthem	Did not meet the benchmark 18.9%	Did not meet the benchmark 8.2%
Cigna	Did not meet the benchmark 16.6%	Not Applicable
ConnectiCare	Did not meet the benchmark 17.1%	Did not meet the benchmark 11.1%
UnitedHealthcare	Did not meet the benchmark 11.3%	Did not meet the benchmark 8.4%

Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated, risk-adjusted, and net of pharmacy rebates.

2021 Trends in Major Service Category Spending

OHS collects aggregate claims and non-claims payment data as outlined in Table 2 from payers to analyze service category spending and to determine healthcare cost growth contributors for a list of claims and non-claims service categories.

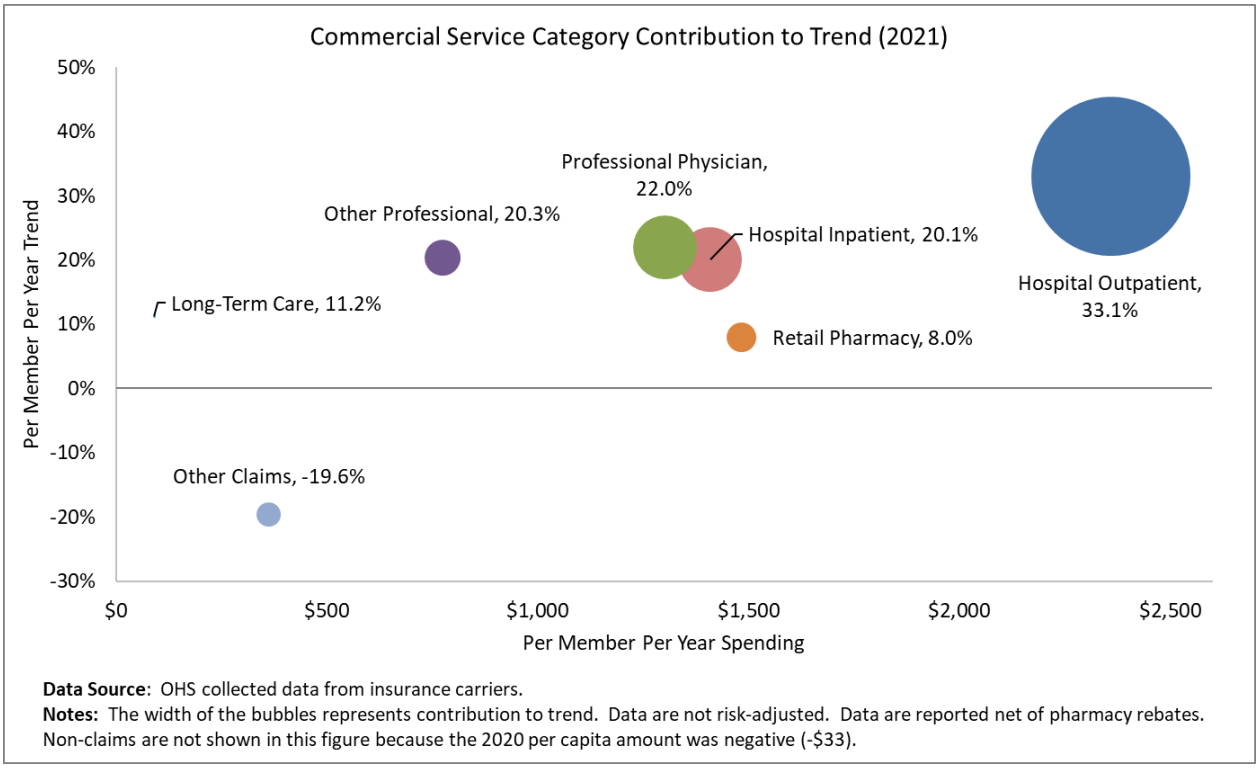
Table 2. Types of Payment Analyzed by Service Category*

Aggregate Claims Service Categories	Non-Claims Service Categories
• Hospital inpatient • Hospital outpatient • Professional, physician • Professional, specialty • Professional, other • Retail pharmacy • Long-term care • Other	• Prospective capitation, global budget, case rate or episode-based payments • Performance incentive payments • Payments to support population health and practice infrastructure • Provider salaries • Recoveries • Other

* Definitions of all claims and non-claims service categories are included in the Connecticut Healthcare Benchmark Initiative Implementation Manual and footnoted when discussed below.

Commercial service category contribution to trend is presented in Figure 5. The greatest contributors to commercial spending growth in 2021 were the hospital outpatient, professional physician, and hospital inpatient service categories. The larger the bubble, the greater the service category's contribution to cost growth. Commercial hospital outpatient spending increased by 33.1% to $2,358 per person in 2021, professional physician spending increased by 22.0% to $1,301 per person, and hospital inpatient spending increased by 20.1% to $1,409 per person.

FIGURE 5. COMMERCIAL SERVICE CATEGORY CONTRIBUTION TO TREND (2021)

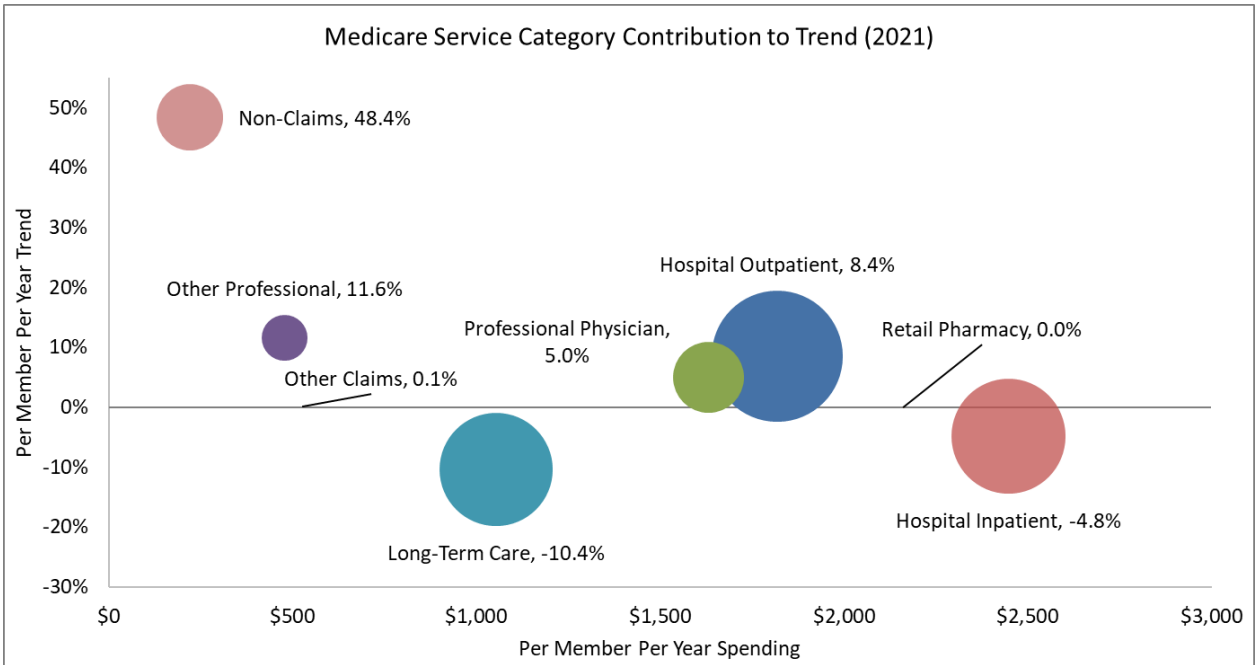


Data Source: OHS collected data from insurance carriers.
Notes: The width of the bubbles represents contribution to trend. Data are not risk-adjusted. Data are reported net of pharmacy rebates. Non-claims are not shown in this figure because the 2020 per capita amount was negative (-$33).

While this analysis is the result of data that were collected in the aggregate from payers, the patterns are consistent with those observed by OHS through analysis of APCD data. As shown in Figures 5-7, hospital outpatient and professional physician services were a consistent source of spending growth across all three markets; however, hospital inpatient services were less impactful in Medicare and Medicaid than they were in the commercial market.

Medicare service category contribution to trend is presented in Figure 6. The hospital outpatient and professional physician service categories were the greatest contributors to Medicare spending growth with the largest spending increases in 2021. Medicare hospital outpatient spending increased by 8.4% to $1,819 per person while professional physician spending increased by 5% to $1,632 per person in 2021.

FIGURE 6. MEDICARE SERVICE CATEGORY CONTRIBUTION TO TREND (2021)

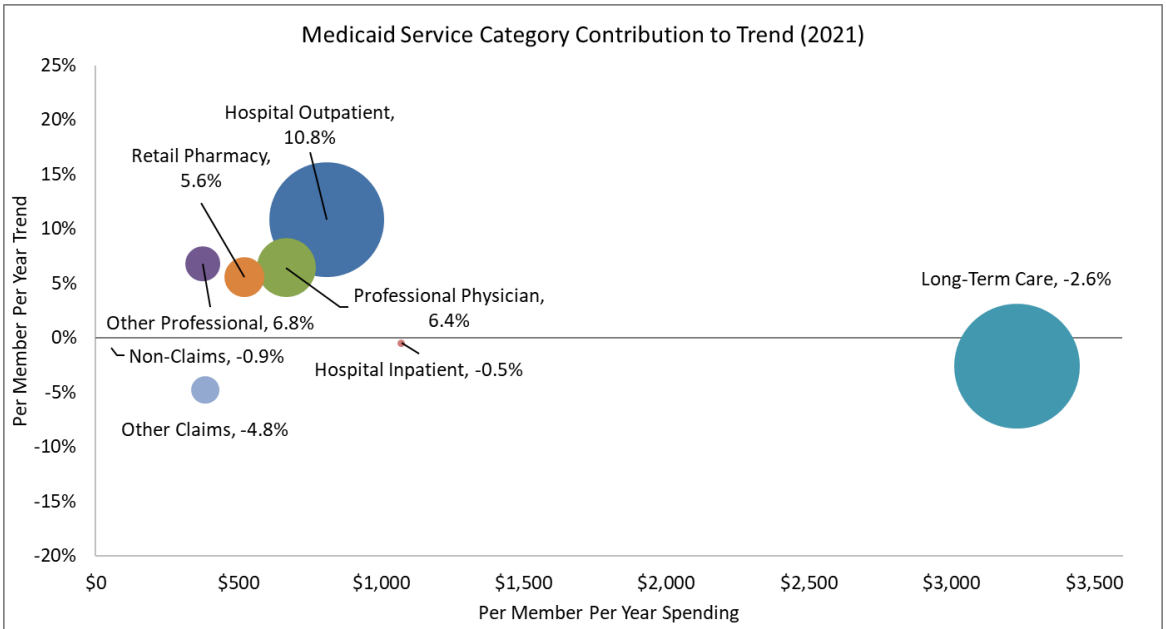


Data Source: OHS collected data from insurance carriers and the Centers for Medicare and Medicaid Services (CMS).
Notes: The width of the bubbles represents contribution to trend. Data are not risk-adjusted. Data are reported net of pharmacy rebates (OHS did not receive pharmacy rebates from CMS). Medicare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

Medicaid service category contribution to trend is presented in Figure 7. Similarly, to Medicare, the hospital outpatient and professional physician service categories were the greatest contributors to Medicaid spending growth in 2021. Medicaid hospital outpatient increased by 10.8% to $810 per person in 2021 while professional physician spending increased by 6.4% to $688 per person in 2021.

The long-term care service category is a larger contributor to the Medicaid spending trend than for the other markets because Medicaid covers some long-term care services that commercial and Medicare Advantage do not, and because Medicaid covers individuals living with disabilities.

FIGURE 7. MEDICAID SERVICE CATEGORY CONTRIBUTION TO TREND, 2021



Data Source: OHS collected data from the Connecticut Department of Social Services (DSS).
Notes: The width of the bubbles represents contribution to trend. Data are not risk-adjusted. Data are reported net of pharmacy rebates. Data include Medicaid spending on the dually eligible population. Data do not include payments to CT Administrative Services Organizations.

Primary Care Spending as a Percentage of Total Medical Expenses

This section presents the analysis of Connecticut's primary care spending against the primary care spending target in 2020 and 2021 at the state, market (commercial, Medicare Advantage, Medicaid), and insurance carrier (i.e., Aetna, Anthem, Cigna, ConnectiCare, United Healthcare) levels.[4] The primary care spending target evaluates primary care spending as a percentage of total medical expenditures. For OHS' definition of primary care spending, please see the Connecticut Healthcare Benchmark Initiative Implementation Manual.

State Primary Care Spending

Primary care spending as a percentage of total spending and per person per month is presented in Table 3. For 2021, Connecticut as a state, set and met its target of spending 5% of TME on primary care. Aggregate primary spending increased from $880 million in 2020 to $1 billion in 2021 and per person per month primary care spending grew from $26 to $29 within the same period. Despite increases in aggregate primary care spending overall, the percentage of total spending decreased slightly from 5.2% in 2020 to 5.1% in 2021.

[4] In addition to the primary care definition discussed in this report, OHS collects and monitors spending for a broader primary care spending definition. The broader definition includes spending associated with primary care services provided by obstetrics/gynecology (OB/GYN) providers and midwifery.

TABLE 3. STATEWIDE PRIMARY CARE SPENDING IN AGGREGATE AND PER PERSON PER MONTH

Year	Statewide Primary Care Spending in Aggregate	Statewide Primary Care as a Percent of Total Spending	Statewide Primary Care Spending Per Person Per Month
2020	$880,235,324	5.2%	$26
2021	$1,007,490,910	5.1%	$29

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

Primary Care Spending by Market

Commercial primary care spending as a percent of total spending and per person per month is presented in Table 4. The commercial market fell short of meeting the primary care spending target for 2021. Commercial primary care spending grew to $494 million and increased to $25 per person between 2020 and 2021. However, commercial primary care spending as a percentage of total spending decreased from 4.2% in 2020 to 3.9% in 2021. The decrease is due to spending in other service categories (e.g., hospital and professional physician) growing at a faster rate than primary care spending from 2020 to 2021.

TABLE 4. COMMERCIAL PRIMARY CARE SPENDING IN AGGREGATE AND PER PERSON PER MONTH

Year	Commercial Primary Care Spending in Aggregate	Commercial Primary Care Spending as a Percent of Total Spending	Commercial Primary Care Spending Per Person Per Month
2020	$443,579,426	4.2%	$22
2021	$494,443,719	3.9%	$25

Data Source: OHS collected data from insurance carriers.

Medicaid primary care spending as a percentage of total spending and per person per month is presented in Table 5. The Medicaid market exceeded the primary care spending target, up from 8.1% total spending in 2020 to 8.3% in 2021. Medicaid aggregate primary care spending increased to $365 million and per person month spending increased to $27 to 2021.

TABLE 5. MEDICAID PRIMARY CARE SPENDING IN AGGREGATE AND PER PERSON PER MONTH

Year	Medicaid Primary Care Spending in Aggregate	Medicaid Primary Care Spending as a Percent of Total Spending	Medicaid Primary Care Spending Per Person Per Month
2020	$310,382,730	8.1%	$25
2021	$365,235,907	8.3%	$27

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

Medicare Advantage primary care spending as a percentage of total spending and per person per month is presented in Table 6. The Medicare Advantage market was below the primary care spending target with primary care spending a percent of total spending remaining flat at 3.5% in both 2020 and 2021.[5] Medicare Advantage spending on primary care grew to $148 million, with per person per month spending reaching $39, in 2021.

TABLE 6. MEDICARE ADVANTAGE PRIMARY CARE SPENDING IN AGGREGATE AND PER PERSON PER MONTH

Year	Medicare Advantage Primary Care Spending in Aggregate	Medicare Advantage Spending as a Percent of Total Spending	Medicare Advantage Primary Care Spending Per Person Per Month
2020	$126,273,168	3.5%	$36
2021	$147,811,284	3.5%	$39

Data Source: OHS collected data from insurance carriers.

Primary Care Spending by Insurance Carrier

Commercial payers primary care spending as a percentage of total medical expenses from 2020-2021 is presented in Table 7. Forty percent (two out of five) of commercial carriers achieved the primary care spending target in 2021. Commercial payers per member per month spending on primary care ranged from $19 to $28 in 2020 and $19 to $32 in 2021. Primary care spending as a percentage of total spending ranged from 3.5% to 6.8% in 2020 and 3.5% to 5.9% in 2021.

TABLE 7. COMMERCIAL PAYERS' PRIMARY CARE SPENDING AS A PERCENTAGE OF TOTAL MEDICAL EXPENSES

Insurer	2020 Primary Care as a Percentage of Total Medical Expenses	2021 Primary Care as a Percentage of Total Medical Expenses
Aetna	4.9%	4.6%
Anthem	3.5%	3.5%
Cigna	4.5%	4.3%
ConnectiCare	6.8%	5.9%
UnitedHealthcare	5.0%	5.3%

Data Source: OHS collected data from insurance carriers.

Medicare Advantage payers primary care spending as a percentage of total medical expenses from 2020-2021 is presented in Table 8. None of the Medicare Advantage carriers achieved the primary care spending target in 2021. Primary care spending per member per month for Medicare Advantage carriers ranged from $29 to $42 in 2020 and $34 to $42 in 2021. Primary care spending as a percentage of total spending ranged from 3% to 5.3% in 2020 and 3.3% to 4.5% in 2021.

[5] OHS evaluates the Medicare Advantage market against the primary care spending target but not the Medicare FFS market because CMS is unable to provide OHS with Medicare FFS primary care spending in alignment with OHS' code-level primary care definition.

TABLE 8. MEDICARE ADVANTAGE PAYERS' PRIMARY CARE SPENDING AS A PERCENTAGE OF TOTAL MEDICAL EXPENSES

Insurer	2020 Primary Care as a Percentage of Total Medical Expenses	2021 Primary Care as a Percentage of Total Medical Expenses
Aetna	5.3%	4.5%
Anthem	3.0%	3.3%
ConnectiCare	3.7%	3.9%
UnitedHealthcare	3.3%	3.5%

Data Source: OHS collected data from insurance carriers.

Monitoring Unintended Adverse Consequences

On the advice of the Cost Growth Benchmark Technical Team, which sunset after accomplishing its goals, OHS established its Cost Growth Benchmark Unintended Adverse Consequences Measurement Plan ("the plan") to monitor potential negative effects of the benchmark across three domains: underutilization, impact on underserved populations and consumer out-of-pocket spending. The plan utilizes multiple measures including preventive and chronic care quality measures, patient experience surveys, and Medicaid member grievances to assess the three domains. Tables 9-15 in the Appendix include performance on all the unintended adverse consequences measures discussed in this report.

Since the Executive Order and legislation implementing the healthcare Cost Growth Benchmark program did not occur until 2020 and 2022, respectively, OHS did not anticipate any adverse impact in the 2020-2021 measurement period. However, as outlined in the Measurement Plan, OHS has begun monitoring for any unintended consequences and presents the initial data below:

Underutilization

For the **commercial market**, when examining the service utilization measure results, 60% (6 of 10) of the preventative and chronic care measures showed an increase in commercial providers screening or delivering preventative care to patients. This is an improvement since the implementation of the benchmark. Areas needing improvement include chlamydia screening in women, colorectal cancer screening, eye exams for patients with diabetes and timeliness of prenatal care (see Table 9).

For the **Medicaid market,** 50% (6 of 12) of utilization measures showed improvement since implementation of the benchmark. Areas needing improvement include annual dental visit, breast and cervical cancer screening, chlamydia screening in women, eye exams for patients with diabetes and timeliness of prenatal care (see Table 10Table).

Impact on underserved populations - Patient Experience of Care

OHS examined patient experience in the **commercial market** by assessing changes in patient responses to survey questions related to getting care quickly and getting needed care. Of those surveyed in 2022, 83.8% indicated that they "usually" or "always" received care quickly while 83% indicated that they were "usually" or "always" getting care they needed. These results were a slight decline from 2020 performance results (see Table 11).

For adults and children served by **Medicaid**, the Department of Social Services (DSS) utilizes the Person-Centered Primary Care Measure (PCPCM) in its Person-Centered Medical Home Plus (PCMH+) program to monitor patient care. On average, 81.8% of adults responded positively (either "definitely" or "mostly") to questions pertaining to their primary care experience while 85.3% of children responded positively to these questions in 2021 (see Table 12).

Tracking member grievances

Medicaid member complaints are presented in Table 13. OHS tracked Medicaid member grievances pre- and post-benchmark implementation to monitor for impact on patient care and potential underutilization in the Medicaid population. OHS monitored the change in the number of Medicaid members filing complaints about no or limited access to providers, and the change in the number of Medicaid members filing complaints about delayed access and/or wait time for an appointment. Complaints about no or limited access to providers decreased by 58 percent post-benchmark implementation (from 0.03 complaints per 1,000 member months in 2019 and 2020 to 0.01 complaints per 1,000 member months in 2021 and 2022). Complaints about delayed access and/or wait time for an appointment decreased by 36 percent (from 0.003 complaints per 1,000 member months in 2019 and 2020 to 0.002 complaints per 1,000 member months in 2021 and 2022). It is notable that complaints about provider access were very low, both pre- and post-benchmark (69 complaints in 2019 and 2020, and 52 complaints in 2020 and 2021).

Consumer out-of-pocket spending

OHS monitored changes in consumers healthcare costs using two different data sources: the All-Payer Claims Database (APCD) and the Current Population Survey (CPS). When OHS assessed out-of-pocket spending using the APCD, it found that Connecticut residents did not see increased out-of-pocket spending for medical spending or retail pharmacy spending in the commercial market following benchmark implementation. However, CPS data, which includes data for all ages and insurance statuses, show that Connecticut residents did see growth in average medical out-of-pocket spending (see Table 14). When assessing insurance premiums pre- and post-benchmark implementation using CPS data, OHS found that Connecticut residents did not experience greater growth in premiums post-benchmark implementation compared to the Northeast and the United States (see Table 15).

When assessing average annual **out of-pocket spending** pre-and post-benchmark using, CPS data (which includes all ages and insurance markets) the analysis showed that Connecticut residents saw more growth in medical out-of-pocket spending (11%) following benchmark implementation compared to the Northeast (1%) and nationally (-1%) (see Table 14).

When assessing **insurance premiums** pre-and post-benchmark implementation using CPS data, OHS found that Connecticut residents did not experience greater growth in premiums post-benchmark implementation (-3%) relative to the Northeast (-3%) or nationally (-3%) (see Table 15).

Interpreting Unintended Adverse Consequences Measures

Though there were several areas that demonstrated improved outcomes, half of **Medicaid** measures and 40% of **commercial** preventative and chronic care measures demonstrated a decline. Select commercial patient experience survey questions saw a slight decline, and CPS data showed growth in

medical out-of-pocket spending, signaling that there are areas of utilization, patient experience and consumer cost that need improvement. However, these changes cannot solely be associated with the benchmark, and there may be multiple factors influencing performance in these areas, independent of the benchmark itself. Furthermore, healthcare-seeking and delivery patterns were significantly altered during the COVID-19 pandemic. Finally, healthcare utilization increased dramatically in 2021, showing no evidence of care withholding.

This is the first year of monitoring for unintended consequences of the benchmark. OHS will continue to refine and analyze these measures, including efforts to relate findings to the benchmark process itself.

Recommendations

As required by statute, this section of the report presents the Executive Director's recommendations concerning strategies to slow the growth in healthcare spending in Connecticut, as well as the rationale behind each recommendation. The Office of Health Strategy developed these recommendations based on several sources:

- The Cost Growth Benchmark Hearing held in June, 2023
- An Information Hearing held in August, 2023 by the Connecticut Insurance Department
- Follow-up discussions held with hearing participants
- Discussions with members of the Cost Growth Benchmark Steering Committee
- Experiences and recommendations of other Cost Growth Benchmark states
- Discussions with stakeholders, including community organizations, advocates and members of the Connecticut General Assembly

1. Institute Enforcement Mechanisms for the Cost Growth Benchmark

A. Adopt a Requirement for Performance Improvement Plans for Entities Exceeding the Cost Growth benchmark

As noted in this report and the March Cost Growth Benchmark Initiative Report, very few entities met the benchmark or primary care spending goals in 2021. As such, to increase accountability, OHS recommends "Phasing in performance improvement plans ("PIP") with entities that exceed the benchmark and allowing for application of a civil penalty if an entity willfully neglects to file a PIP." While OHS acknowledges that the 2020-2021 time period was not typical in terms of utilization and total cost, we also have heard from stakeholders that public transparency alone is unlikely to persuade payers and providers to achieve the cost growth benchmark over the long term (as observed in Massachusetts.) Connecticut insurers report that provider organizations have been reluctant to recognize the benchmark value when negotiating prices for contract renewals. Massachusetts was the first state to adopt a cost growth benchmark in 2012. Relying only on public transparency and the possibility of a required performance improvement plan for exceeding the benchmark, commercial market cost growth trend in Massachusetts initially dropped below the national average for several years before returning to a growth rate above the national average. Other states such as Oregon and California are also instituting enforcement mechanisms tied to performance on the benchmark.

Because the benchmark process is new to both providers and payers, OHS recommends that any enforcement mechanisms be implemented over time, to allow impacted entities to continue to refine

and understand the benchmark data and to ensure stakeholder buy-in and engagement with the process. OHS believes that agreement on the validity and accuracy of the benchmark data is critical and will continue to work with stakeholders to achieve consensus on the measures used to establish performance against the benchmark. However, we have heard from stakeholders that indicating a willingness to add enforcement mechanisms to the benchmark process will be critical to ensuring it has a measurable impact on cost growth going forward.

B. Consider the formal incorporation of the Cost Growth Benchmark into the review of annual insurer Rate Filings with CID

Connecticut could consider the use of the benchmark when calculating the trend factor in annual commercial insurer rate filings submitted to Connecticut Insurance Department (CID). The trend factor anticipates how much insurers think the prices they pay are going to grow, coupled with the expected growth in service utilization. Incorporating the benchmark as a factor when asking for rate increases with CID would allow for the CID rate review process to add to the significance of the benchmark in provider/payer negotiations.

2. Address Provider Price Growth

Analyses using data from Connecticut's APCD show that, between 2016 and 2021, the amount that commercial insurers paid to hospitals for outpatient services increased by an average of 4.9% each year, and for inpatient services by an average of 7.8% each year. It will not be possible for Connecticut to meet the cost growth benchmark and achieve healthcare affordability without taking action to address provider price growth. While engaging insurers further in benchmark enforcement, as well as applying additional performance improvement plans to entities that exceed the benchmark target could assist with benchmark effectiveness, other options include:

A. Out-of-Network Price Caps

Institute out-of-network price caps. OHS has heard repeatedly from stakeholders that large provider entities wield their market power to increase prices by threatening to remain "out of network" during contract negotiations. This is consistent with national data suggesting that healthcare market consolidation tends to lead to higher overall healthcare spending.

CT should consider a cap on out-of-network rates that could be charged by non-participating providers. An out-of-network rate cap would lessen providers' incentive to reject an insurer contract and "go out of network" and could lessen both out of pocket costs for consumers and overall healthcare spending. To date, no state has instituted broad out-of-network caps, although Oregon has capped out-of-network charges for their public employee plans at 185% of Medicare compared to their in-network provider rates of 200% of Medicare. Both the Federal No Surprises Act and CT's own limits on out-of-network charges could be extended to a broader array of services and providers in order to continue to encourage providers to remain within insurer-negotiated payment limits.

B. Improve the Utility of Cost and Market Impact Review

Expand the cost and market impact review (CMIR) trigger criteria to include hospital and health systems that are identified as a significant contributor to healthcare cost growth or that exceed the benchmark. Currently, cost and market impact reviews (CMIR) in Connecticut are triggered when a hospital or health system with a 2013 net revenue of $1.5B, seeks a Certificate of Need (CON) for a transfer of ownership

of another hospital or health system per CT General Statute Sec. 19a-639f. The CMIR process is intended to assess whether such a transaction would lead to dominant market share, materially higher prices, or materially higher health status-adjusted medical expenses.

As Massachusetts has done, CT could also allow the Office of Health Strategy to conduct a Cost and Market Impact Review triggered by performance against the benchmark. This would provide further data to stakeholders about the causes and impacts of benchmark performance and add to the transparency and accountability associated with the benchmark program.

C. Increase transparency of group practice consolidation by requiring a certificate of need application for any large group practice including private equity entities.

3. Address Insurers' Role in Healthcare Cost Growth

In 2021, every commercial insurer in Connecticut reported per person cost growth between 11.3% and 18.9% far exceeding the 2021 benchmark. This was the highest rate of growth reported of all of the cost growth benchmark states reporting results for 2021 and double the rate of growth in neighboring Rhode Island.

A. Affordability Standards

Affordability standards are state requirements of commercial health insurers. The requirements specify actions insurers must take to ensure that consumer costs do not grow at a rate that is unaffordable and deters access to necessary care.

Current statute defining the authority of the Connecticut Insurance Department's review of insurer rate requests does not explicitly require consideration of consumer affordability as a review criterion, nor does it permit the Department to require insurers to take actions that will ensure future affordability of coverage and of covered services.

Rhode Island's authorizing statute and its associated regulations together give its Office of the Health Insurance Commissioner the authority to apply affordability standards. Independent evaluation has demonstrated that Rhode Island's commercial health insurance costs grew at a slower rate than in the rest of New England as a result of this policy.

In creating affordability standards for Connecticut commercial insurers, Connecticut could allow CID to consider the "affordability" of rate requests in conjunction with the "excessive" standard when reviewing requests for rate increases.

4. Pursue Strategies to Slow Pharmacy Price Growth

Commercial market per person retail pharmacy expenditures increased 8% in 2021, again outpacing the rate of growth of median household income in Connecticut. Additionally, analyses of data from Connecticut's APCD have consistently found pharmacy price growth (along with hospital price growth) to be a primary contributor to rising health care costs. This trend has been observed in other cost growth benchmark states as well and will require thoughtful action to address the problem in a manner that does not compromise access.

A. Increase Pharmacy Benefit Manager Price Transparency

Since Pharmacy Benefit Managers (PBMs) negotiate with drug manufacturers and pharmacies to control drug spending, PBMs have a notable impact on drug costs. Part of the problem stems from a lack of transparency around rebates and pricing. Connecticut could expand PBM transparency through the following actions:

- **Expand the definition of rebates** to capture the complexity of rebate relationships and how they are funneled through various entities. This would help to capture the full scope of rebates that PBMs receive.
- **Require PBMs to disclose drug-specific rebate** data for drugs that have the highest total expenditures in the commercial market. Currently, Connecticut law only requires rebates reported in aggregate.
- **Provide data regarding PBM spread pricing.** Currently, PBMs can charge health plans or employers more for a drug than the pharmacy charges the PBM and keep the difference as profit.

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Appendix

TABLE 9. COMMERCIAL UNDERUTILIZATION MEASURES

Measure Name[6]	2019 Connecticut Performance	2020 Connecticut Performance	2021 Connecticut Performance	2022 Connecticut Performance	Pre/post benchmark change (2019-2022[7]) Percentage points (pp)
Asthma Medication Ratio	78.3%	78.5%	81.7%	83.3%	5.0 pp ↑
Breast Cancer Screening	77.7%	78.4%	76.5%	81.3%	3.6 pp ↑
Cervical Cancer Screening	81.8%	82.5%	79.9%	83.2%	1.5 pp ↑
Child and Adolescent Well-Care Visits	NA[8]	72.3%	77.2%	78.8%	6.5 pp ↑
Chlamydia Screening in Women	66.2%	66.7%	58.8%	55.2%	-11.0 pp ↓
Colorectal Cancer Screening	72.8%	74.1%	71.5%	70.1%	-2.7 pp ↓
Controlling High Blood Pressure	61.1%	61.4%	58.5%	65.3%	4.2 pp ↑
Eye Exam for Patients with Diabetes	65.7%	67.1%	60.9%	62.2%	-3.6 pp ↓
Prenatal and Postpartum Care – Postpartum Care	85.7%	86.1%	82.1%	86.7%	1.0 pp ↑
Prenatal and Postpartum Care – Timeliness of Prenatal Care	89.0%	89.5%	85.1%	88.9%	-0.05 pp ↓

Data Source: NCQA Quality Compass® 2020-2023. Connecticut performance is a weighted average of commercial plan performance.

Note: The ↓ symbol indicates that quality measure performance declined post-benchmark implementation and the ↑ symbol indicates that quality measure performance improved post-benchmark implementation.

[6] In the Unintended Adverse Consequences Measurement Plan, OHS indicated that it planned to track NCQA's *HbA1c Testing* measure, however this measure was retired for HEDIS measurement year 2023 (calendar year 2022) and thus OHS will not be able to monitor performance going forward.

[7] All measures assess the change in performance from 2019 to 2022, with the exception of *Child and Adolescent Well-Care Visits* which assesses the change in performance from 2020 to 2022 because it was new for HEDIS measurement year 2021 (calendar year 2020).

[8] *Child and Adolescent Well-Care Visits* was new for HEDIS measurement year 2021 (calendar year 2020). It combined *Well-Child Visits in the Third, Fourth Fifth and Sixth Years of Life* with *Adolescent Well-Care Visits* and added age 7-11 to the measure.

TABLE 10. MEDICAID UNDERUTILIZATION MEASURES

Measure Name	2019 Connecticut Performance	2020 Connecticut Performance	2021 Connecticut Performance	Pre/post benchmark change (2019-2021[9]) Percentage points (pp)
Annual Dental Visit	74.0%	57.9%	65.1%	-8.9 pp ↓
Asthma Medication Ratio	64.3%	69.3%	65.2%	0.9 pp ↑
Behavioral Health Screening	37.9%	38.5%	42.5%	4.6 pp ↑
Breast Cancer Screening	59.7%	56.0%	55.5%	-4.2 pp ↓
Cervical Cancer Screening[10]	59.7%	56.1%	55.2%	-4.5 pp ↓
Child and Adolescent Well-Care Visits	NA[11]	60.4%	66.6%	6.2 pp ↑
Chlamydia Screening in Women	67.7%	63.6%	66.1%	-1.6 pp ↓
Controlling High Blood Pressure	61.2%	60.0%	63.7%	2.5 pp ↑
Developmental Screening in the First Three Years of Life	63.0%	63.3%	65.0%	2.0 pp ↑
Eye Exam for Patients with Diabetes[12]	56.9%	50.6%	53.7%	-3.2 pp ↓
Prenatal and Postpartum Care – Postpartum Care[13]	52.7%	53.1%	55.0%	2.3 pp ↑
Prenatal and Postpartum Care – Timeliness of Prenatal Care[14]	67.4%	70.2%	65.8%	-1.6 pp ↓

Data Source: Data were obtained from DSS' HUSKY Health Program Health Equities Report, MY2019, MY2020 and MY2021, with the exception of *Controlling High Blood Pressure* for which performance data was obtained from OHS' Quality Benchmark data.

Note: The ↓ symbol indicates that quality measure performance declined post-benchmark implementation and the ↑ symbol indicates that quality measure performance improved post-benchmark implementation.

[9] All measures assess the change in performance from 2019 to 2021, with the exception of *Child and Adolescent Well-Care Visits* which assesses the change in performance from 2020 to 2021 because it was new for HEDIS measurement year 2021 (calendar year 2020).

[10] This hybrid measure is reported using administrative claims data only for all rates.

[11] *Child and Adolescent Well-Care Visits* was new for HEDIS measurement year 2021 (calendar year 2020). It combined *Well-Child Visits in the Third, Fourth Fifth and Sixth Years of Life* with *Adolescent Well-Care Visits* and added age 7-11 to the measure.

[12] This hybrid measure is reported using administrative claims data only for all rates.

[13] This hybrid measure is reported using administrative claims data only for all rates.

[14] This hybrid measure is reported using administrative claims data only for all rates.

TABLE 11. PERCENTAGE OF COMMERCIAL MEMBERS WHO INDICATED "USUALLY" OR "ALWAYS" RECEIVED EXPERIENCE MEASURES

Measure Name	2020 Connecticut Performance	2021 Connecticut Performance	2022 Connecticut Performance	Pre/post benchmark change (2020-2022) Percentage points (pp)
"Getting Care Quickly" Composite[15] (Health Plan CAHPS)	87.0%	83.5%	83.8%	-3.2 pp ↓
"Getting Needed Care" Composite[16] (Health Plan CAHPS)	90.1%	84.4%	83.0%	-7.2 pp ↓

Data Source: NCQA Quality Compass® 2020-2023. Connecticut performance is a weighted average of commercial plan performance.
Note: The ↓ symbol indicates that quality measure performance declined post-benchmark implementation and the ↑ symbol indicates that quality measure performance improved post-benchmark implementation.

[15] The "Getting Care Quickly" composite is the percentage of members who responded "Always" or "Usually" to the questions "In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?" and "In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?"
[16] The "Getting Needed Care" composite is the percentage of members who responded "Always" or "Usually" to the questions "In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?" and "In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?"

TABLE 12. MEDICAID MEMBER EXPERIENCE MEASURES

How would you assess your primary care experience (total "definitely or "mostly")?	2021 Adult Composite	2021 Child Composite
My practice makes it easy to get care	88.3%	90.9%
My practice is able to provide most of my care	89.0%	91.7%
In caring for me, my doctor considers all facets that affect my health	89.0%	90.8%
My practice coordinates the care I get from multiple practices	82.6%	80.2%
My doctor or practice knows me as a person	79.8%	83.8%
My doctor and I have been through a lot together	64.6%	69.0%
My doctor or practice stands up for me	79.8%	83.7%
The care I get takes into account the knowledge of my family	79.7%	87.4%
The care I get in this practice is informed by knowledge of my community	74.3%	81.0%
Over time, my practice helps me to stay healthy	87.4%	90.1%
Over time, my practice helps me meet my goals	85.5%	89.3%
Average	**81.8%**	**85.3%**

Data Source: 2021 PCMH+ PCPCM Survey, Person-Centered Primary Care Measure Composite Findings, https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/PCMH-Plus/2021-PCMH-PCPCM-Survey-ResultsCorrected.pdf.

TABLE 13. MEDICAID MEMBER COMPLAINTS PER 1,000 MEMBER MONTHS (MM)

Measure	Pre-benchmark				Post-benchmark				Total pre-benchmark (2019 & 2020)		Total post-benchmark (2020 & 2021)		Pre/post-benchmark change
	2019		2020		2021		2022						
	#	per 1,000 MM	#	per 1,000 MM	#	per 1,000 MM	#	per 1,000 MM	#	per 1,000 MM	#	per 1,000 MM	
Complaints about no or limited access to a specific provider type	374	0.036	316	0.029	267	0.022	72	0.006	690	0.033	339	0.014	-58% ↓
Complaints about delayed access and/or wait time for an appointment (e.g., delay in obtaining appointment, wait time while in office)	40	0.004	29	0.003	27	0.002	25	0.002	69	0.003	52	0.002	-36% ↓

Data Source: Connecticut Department of Social Services

Note: The ↑ symbol indicates that Medicaid member complaints increased post-benchmark implementation, the ↓ symbol indicates that Medicaid member complaints decreased post-benchmark implementation.

TABLE 14. MEDICAL OUT-OF-POCKET SPENDING PER MEMBER PER MONTH BY REGION

Region	Average pre-benchmark (2019-2020)				Average post-benchmark (2021-2022)				Pre/post benchmark percent change			
	Q25	Med	Q75	Mean	Q25	Med	Q75	Mean	Q25	Med	Q75	Mean
Connecticut	$8.33	$50.00	$241.67	$182.51	$6.88	$50.00	$236.25	$202.56	-18%	0%	-2%	11% ↑
Northeast	$5.83	$39.17	$184.17	$156.17	$4.17	$36.25	$185.50	$158.46	-29%	-7%	1%	1% ↑
National	$5.00	$37.58	$183.33	$151.85	$4.17	$34.38	$177.92	$150.10	-17%	-9%	-3%	-1% ↓

Data Source: Current Population Survey (CPS) – Annual Social and Economic (ASEC) Supplement, Years 2019-2022, https://www.census.gov/data/datasets/time-series/demo/cps/cps-asec.html.

Note: The ↑ symbol indicates that out-of-pocket spending increased post-benchmark implementation and the ↓ symbol indicates that out-of-pocket spending decreased post-benchmark implementation.

TABLE 15. HEALTH INSURANCE PREMIUMS PER MEMBER PER MONTH BY REGION

Region	Average pre-benchmark (2019-2020)				Average post-benchmark (2021-2022)				Pre/post benchmark percent change			
	Q25	Med	Q75	Mean	Q25	Med	Q75	Mean	Q25	Med	Q75	Mean
Connecticut	$0.00	$0.00	$112.50	$97.65	$0.00	$0.00	$86.67	$94.90	NC*	NC*	-23%	-3% ↓
Northeast	$0.00	$0.00	$81.67	$90.07	$0.00	$0.00	$70.83	$87.07	NC*	NC*	-13%	-3% ↓
National	$0.00	$0.00	$73.50	$82.01	$0.00	$0.00	$62.50	$79.85	NC*	NC*	-15%	-3%↓

Data Source: Current Population Survey (CPS) – Annual Social and Economic (ASEC) Supplement, Years 2019-2022, https://www.census.gov/data/datasets/time-series/demo/cps/cps-asec.html.

Note: The ↑ symbol indicates that out-of-pocket spending increased post-benchmark implementation and the ↓ symbol indicates that out-of-pocket spending decreased post-benchmark implementation.

*NC: No Change