# Healthcare Accountability and the Impact of Healthcare Costs

A Virtual forum hosted by the Office of Health Strategy

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# Lisa Trumble, MBA
# SoNE HEALTH, President and Chief Executive Officer

Ms. Trumble's career is showcased by successes in generating strong clinical and financial operating results for health care organizations as evidenced with *30+ years of experience*

**Key Skills**

- Value Based Care & Managed Care Operations
- Population Health Management and Strategies
- Strategic Planning, Mergers and Acquisitions
- Payor Contracting & Risk Stratification Methodologies
- Operational and Financial Management
- Physician Compensation Planning and Methodologies
- Change Management, Organization Restructuring and Turnaround

**Employers**

- **Cambridge Health Alliance**, Senior VP Accountable Care, VP of Finance and Operation, Chief Financial Officer of Physician Organization
- **Berkshire Health Systems,** VP Physician Services and Executive Director, Berkshire Health Systems Physicians Organization
- **Partners Healthcare, North Shore Medical Center**, Chief Financial Officer, North Shore Physician Organization and Administrative Director and Anesthesia & Surgery



SoNE HEALTH

# SoNE HEALTH Vital Statistics

- **Regional in scope**
  - Connecticut &
  - Massachusetts
- **Trinity Health Of New England Hospitals**
  - Saint Francis Hospital
  - Mercy Medical Center
  - Saint Mary's Hospital
  - Johnson Memorial Rehabilitation Hospital
  - Mount Sinai Rehabilitation Hospital
  - Mercy Rehabilitation Services
- **1,614 Providers**
  - 340 Primary Care,
  - 1,274 Specialty Care

- Covered Lives **+200K**
- Annually, manages **$1.5** billion in the total cost of care
- Last four years saved, Medicare, Medicaid, and Commercial Carriers **$123M**
- Medicare Shared Savings Program - **#1 in CT and #3 in MA**



SoNE HEALTH

# Access, Affordability, Equity and Quality

- SoNE HEALTH is a clinically integrated network focused on population health and improvement in health outcomes. **Affordability in healthcare is at the core of SoNE HEALTH's work.**
- As a leader in value-based care, we recognize the importance of driving value in our health system **by pursuing improved health outcomes (patient experience, quality, health equity, and cost of care).**
- We must commit to pursuing improved health outcomes to benefit **all stakeholders in our healthcare system – patients, employers, providers, hospitals, and most importantly, our community!**

## Connecticut's Health Care System




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# Improvement Doesn't Occur Without Measurement!

- Governor Lamont's Executive Order No. 5:
  - The Cost Growth Benchmark
  - Primary Care Spending Targets
  - Quality Performance
  - Data Integration



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# Healthcare Benchmark Initiatives

Kelly Sinko Steuber, Office of Health Strategy

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# Why is the State focusing on healthcare affordability?

1. Healthcare costs are among the **highest** in the country.
2. Healthcare costs are growing **much faster** than personal income.

It's a serious problem - and it gets worse *year after year after year*.

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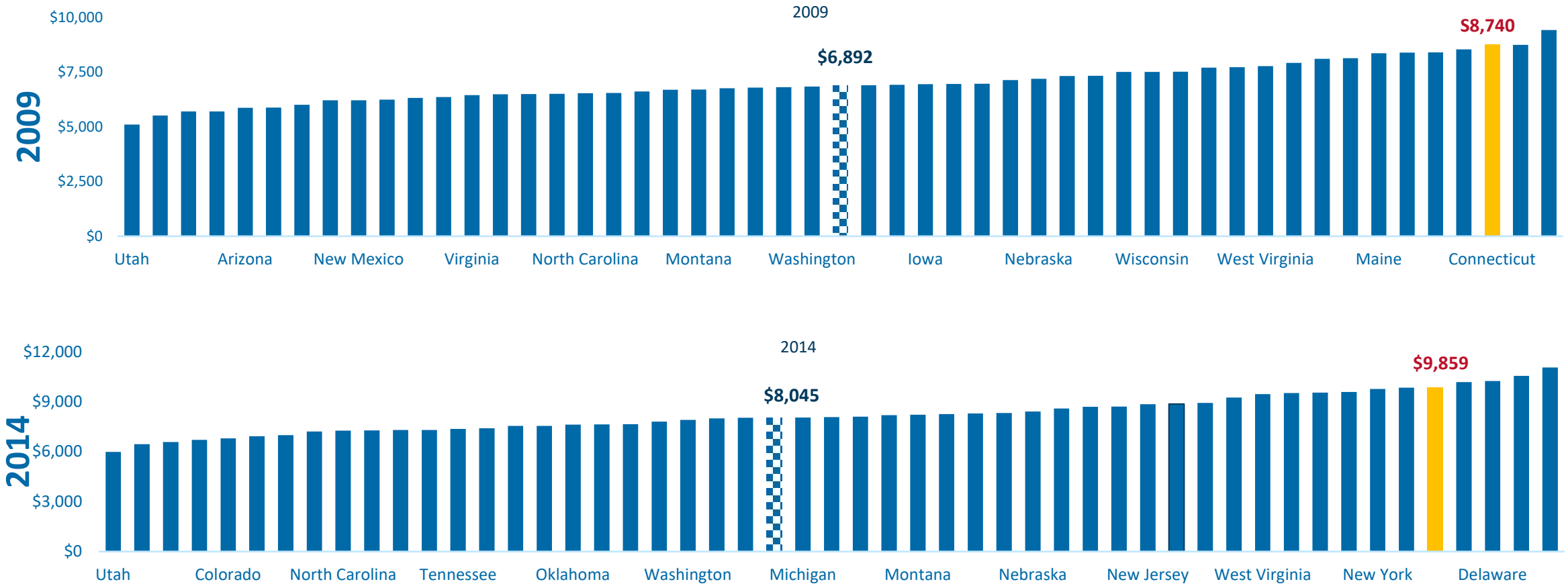
# Connecticut spends more on healthcare than almost any state

Personal healthcare spending, per capita, by state, 2009 and 2014




Source: Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2009 and 2014

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# Connecticut lags most states in personal income growth


Note: Earnings do not include unemployment benefits and other public assistance
Source: Pew Charitable Trust, 2021

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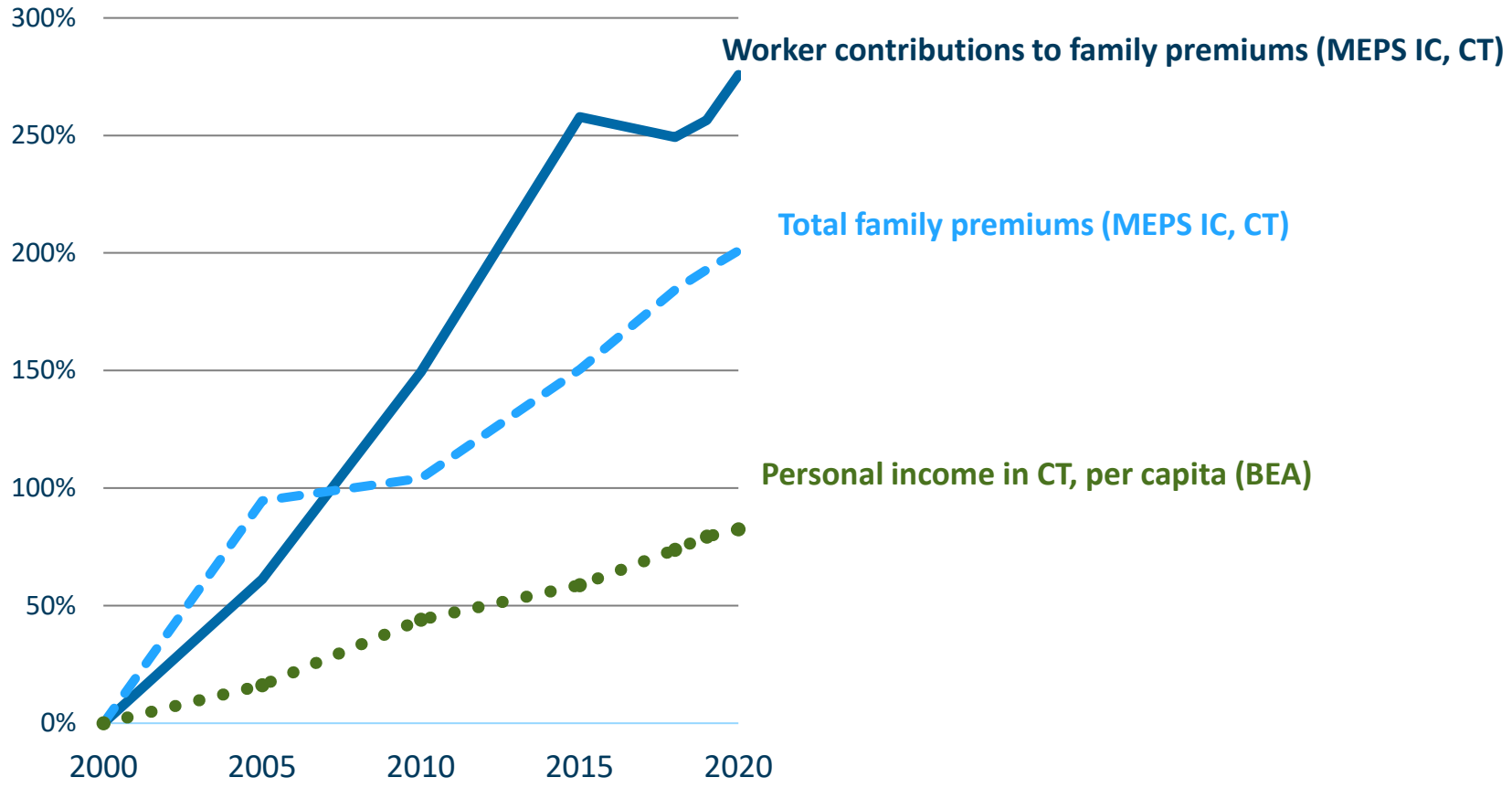
# Healthcare remains unaffordable to many…

Since 2000, Connecticut employer-sponsored insurance premiums have grown **two and half times** faster than personal income




Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey Insurance Component.

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# Healthcare Benchmark Initiatives

| | | |
|---|---|---|
| 1 | **Cost Growth Benchmark** | Develop recommendations for a cost growth benchmark that covers all payers and all populations for 2021-2025. |
| 2 | **Primary Care Target** | Develop recommendations for getting to a 10% primary care target that applies to all payers and populations as a share of total health care expenditures for CY 2021-2025. |
| 3 | **Quality Benchmarks** | Beginning in CY 2022, quality benchmarks are to be applied to all public and private payers. This work will be coordinated through OHS, DSS and the OHS Quality Council. |
| 4 | **Data Use Strategy** | This is a complementary strategy to the cost growth benchmark that leverages the state's APCD to analyze cost and cost growth drivers. |

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# 1. Cost Growth Benchmark

# What is a cost growth benchmark and why pursue one?

- A healthcare cost growth benchmark is a per annum rate-of-growth target for healthcare costs for a state.
- States pursue them as a mechanism to slow spending growth.

| Average Per Capita Health Care Cost Growth, 2015-2019:[1] | Average Per Capita GDP Growth, 2015-2019:[2] | Average Hourly Wage Growth, 2015-2019:[3] |
|---|---|---|
| 4.1% | 3.5% | 2.6% |


SOURCES:

1) Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, accessed February 17, 2021.
2) U.S. Bureau of Economic Analysis, Gross Domestic Product [GDP], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/GDP, February 16, 2021.
3) U.S. Bureau of Labor Statistics, Average Hourly Earnings of All Employees, Total Private [CES0500000003], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/CES0500000003, February 16, 2021.


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# A cost growth benchmark can spur action to slow spending

- Setting a public target for healthcare spending growth alone will not slow rate of growth.
- A benchmark can serve as the basis for transparency at the state, payer and provider levels and a catalyst for implementing cost growth mitigation strategies

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# Cost Growth Benchmark: Values

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

- Connecticut's cost growth benchmark values are based on a methodology that was developed through a stakeholder process that considered various economic indicators.
- To be effective, a benchmark must be complemented by supporting strategies.

# Cost Growth Benchmark: Recent & Upcoming Activities

| Recent Activities |
| --- |
| OHS notified payers and provider entities of the 2022 cost growth benchmark |
| Cost Growth Benchmark analysis for pre-benchmark period of 2018-19 was conducted |
| Established criteria for identifying and recommending cost growth mitigation strategies |

| Upcoming Activities |
| --- |
| OHS will request 2020 benchmark data from payers |
| Discussion of cost drivers and cost growth mitigation strategies with the Steering Committee and Stakeholder Advisory Board |

# 2. Primary Care

# Why establish a Primary Care Spending Target?

- The U.S. healthcare system is largely specialist-oriented. Research demonstrates that greater relative investment in primary care leads to better patient outcomes, lower costs, and improved patient experience of care.[1]

- Some states are strengthening their healthcare systems by:
  - ***supporting improved primary care delivery*** (e.g., expanding the primary care team, supporting advanced primary care model adoption)
  - ***increasing the percentage of total spending that is allocated towards primary care***.

[1]"Investing in Primary Care: A State-Level Analysis." July 2019. Patient-Centered Primary Care Collaborative. https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf

# What is a Primary Care Spending Target?

- A primary care spending target is an **expectation for what percentage of healthcare spending should be devoted to primary care**.
- Executive Order No. 5 establishes the expectation that Connecticut will **increase primary care spending as a percentage of total healthcare spending to 10%** by **2025**. Five states have implemented primary care spending targets with similar or even higher targets than our state—Colorado, Delaware, Rhode Island, Oregon, and Washington.

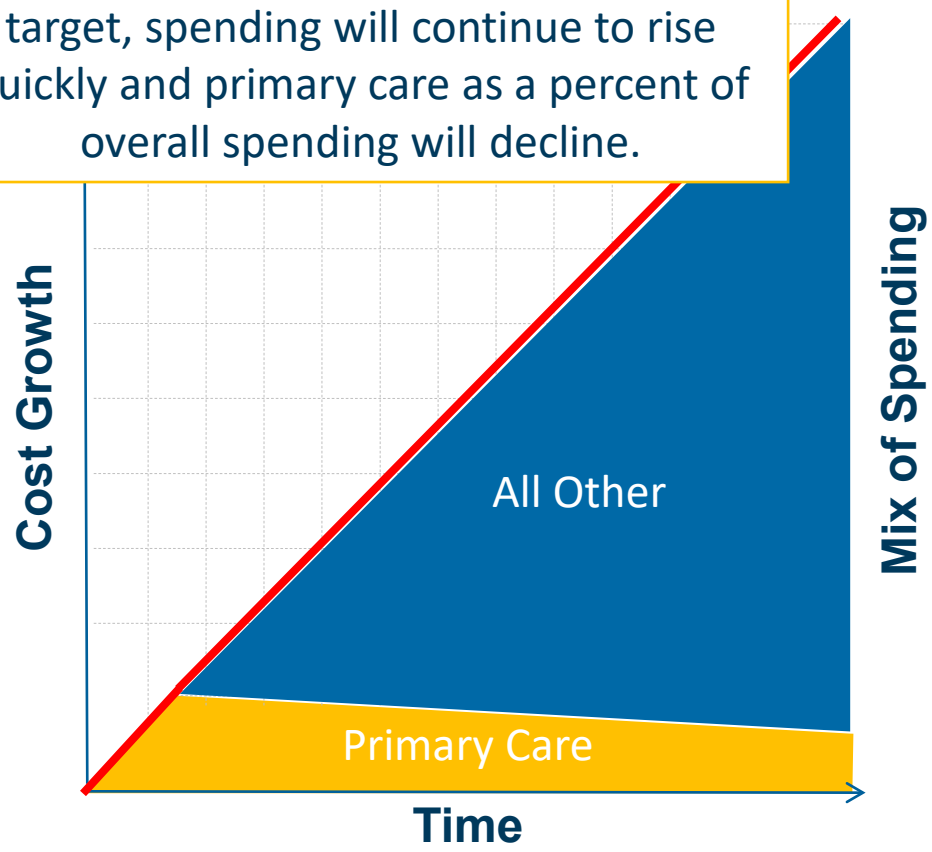
# Primary Care: Spend Targets

- The 2022 primary care spending target is set at 5.3%, the baseline level calculated for 2019.
- Make (near) equal increases in the target for years 2023, 2024 and 2025.

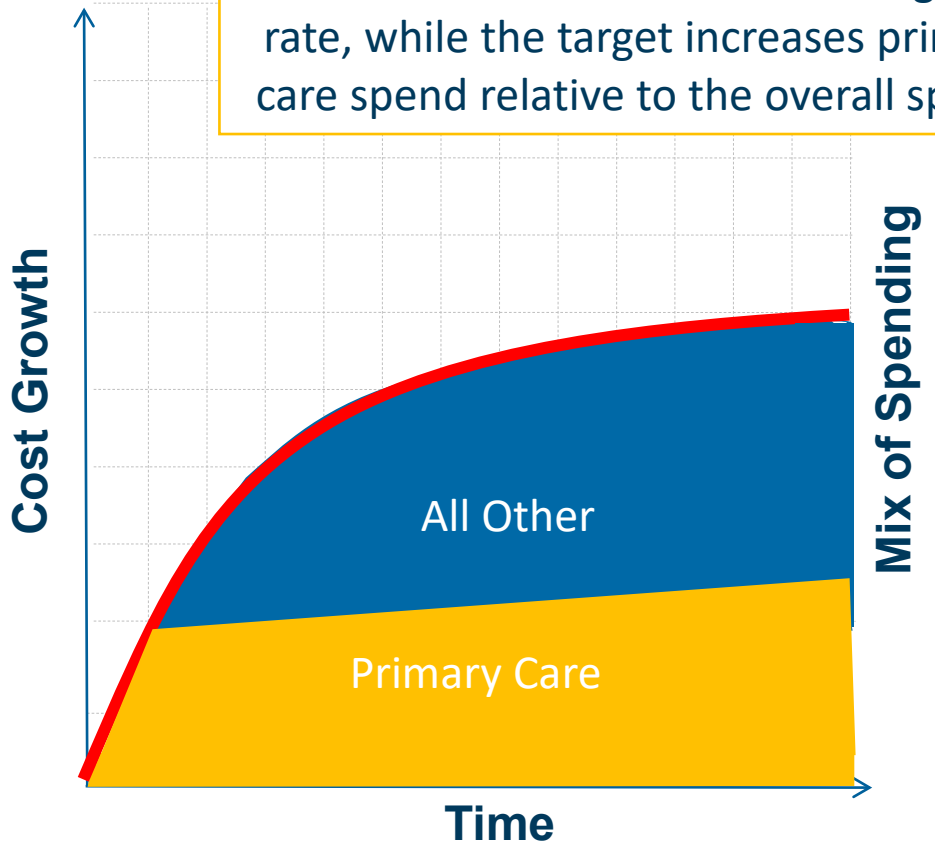
| Year | Target |
|---|---|
| 2022 | 5.3% |
| 2023 | 6.9% |
| 2024 | 8.5% |
| 2025 | 10% |

# The Cost Growth Benchmark & Primary Care Target Rebalance Spending

Without the impact of the benchmark or target, spending will continue to rise quickly and primary care as a percent of overall spending will decline.




The benchmark lowers the overall growth rate, while the target increases primary care spend relative to the overall spend.




Graphs not to scale.

The increased investment in primary care will be used to create high functioning primary care teams that are accountable for core functions and for addressing quality and equity performance expectations.

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# Stakeholder Engagement

- OHS is working with community and civic organizations to conduct educational briefings about the Healthcare Benchmark Initiative and the primary care spend target.
- OHS is seeking the input of patients themselves and has scheduled multiple listening sessions to receive feedback.
- OHS continues to provide briefings for stakeholders such as hospitals, payers, providers, employers, and more.

# Primary Care Spend Target: Recent & Upcoming Activities

| Recent Activities |
| --- |
| OHS has been working on a plan to enhance primary care in Connecticut, and has received feedback from various stakeholder groups |
| Primary care spend targets have been established for years 2022-2025 |
| OHS has notified payer and provider entities of the established spend target for 2022 |

| Upcoming Activities |
| --- |
| OHS is continuing its stakeholder engagement, with an emphasis on patient listening sessions |
| OHS is continuing to work toward CT residents having access to advanced primary care |

# 3. Quality Benchmarks

# What are Quality Benchmarks?

- Quality benchmarks are targets which all public and private payers, providers and the State work to achieve to maintain *and improve* healthcare quality in the state.
- Quality benchmarks may include clinical quality measures, under-and over-utilization measures, and patient safety measures, among others.
- Connecticut will be the second state to have statewide quality benchmarks.  Delaware was the first.

# Overview of the Quality Benchmarks

- The Quality Council recommended two types of measures for the Quality Benchmarks:
  - **health status measures**, which quantify certain population-level characteristics of CT residents and are assessed at the state level
  - **healthcare measures**, which quantify performance on healthcare processes or outcomes and are assessed at the state, market, insurer and provider levels

# Quality Benchmarks: Measures

## Phase 1: Beginning for 2022

- Asthma Medication Ratio
- Controlling High Blood Pressure
- Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control

## Phase 2: Beginning for 2024

- Child and Adolescent Well-Care Visits
- Follow-up After Hospitalization for Mental Illness (7-day)
- Follow-up After ED Visit for Mental Illness (7-day)
- Obesity Equity Measure*

*Performance for this measure will only be assessed at the state level (and not by market).

# Quality Benchmarks Values

- The Quality Council recommended **separate Quality Benchmark values** for each measure for the **commercial** market, **Medicaid** market, and **Medicare Advantage** market for 2025.
  - *Obesity Equity Measure* will only have one statewide value.
- Phase 1 measures also have **interim annual targets** (for 2022, 2023, and 2024).
  - OHS and the Quality Council recommended keeping the 2022 Benchmark value for Phase 1 measures the same value as the baseline rate.

# Quality Council: Recent & Upcoming Activities

## Recent Activities

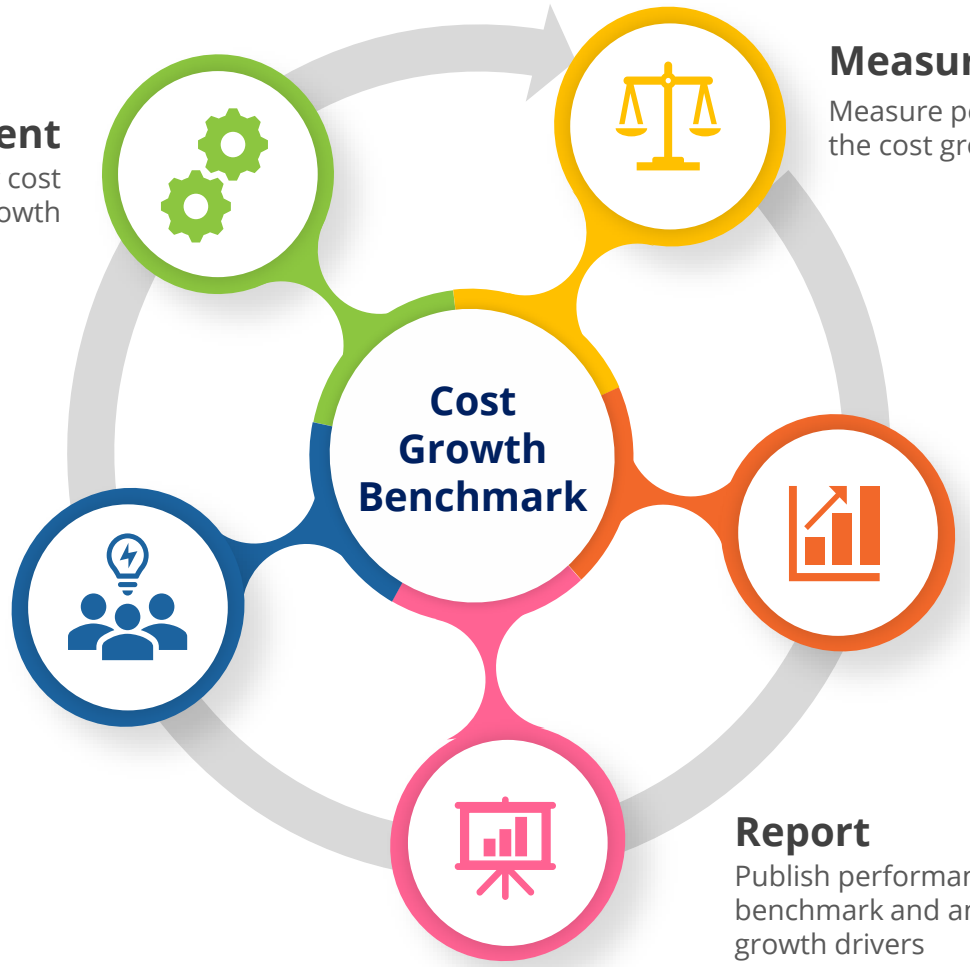
| |
|---|
| OHS' Quality Council recommended quality benchmark measures and values for the Commercial, Medicaid, and Medicare Markets |
| OHS has notified payer and provider entities of the established quality benchmarks for 2022 |
| OHS released a survey to insurers to capture measures in use by Connecticut payers in value-based contracts |

## Upcoming Activities

| |
|---|
| OHS's Quality Council will continue to identify and discuss how to advance strategies to improve quality benchmark performance |
| OHS's Quality Council will begin its annual review of the Core Measure Set |

# 4. Data Use Strategy

# The Logic Model for a Cost Growth Benchmark




**Measure**
Measure performance relative to the cost growth benchmark

**Analyze**
Analyze spending to understand cost trends and cost growth drivers

**Report**
Publish performance against the benchmark and analysis of cost growth drivers

**Identify**
Identify opportunities and strategies to slow cost growth

**Implement**
Implement strategies to slow cost growth

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# Data Use Strategy

- An initial analysis was conducted in order to **understand patterns in Connecticut health care spending**, and thereby perhaps **identify potential opportunities to slow spending growth** and meet the benchmark.
- Since then, additional analyses have been conducted. The additional analyses focused on two areas of inquiry:
  1. how increases in hospital payments have been driving spending growth in the employer-sponsored coverage ("commercial") market, and
  2. why ED utilization is so much higher among communities with higher proportions of people of color and lower income persons with commercial coverage.

# Long-Term Support for the Data Use Strategy

- OHS has contracted with Mathematica to provide ongoing support for OHS' data use strategy, including analysis of cost drivers and costs growth drivers.
- Mathematica will provide analytic services for health data including:
  - All-Payer Claims Database
  - Hospital Discharge Database
  - Outpatient Surgical Center Database
  - Hospital Reporting System
- These analyses will be used – in part – to inform strategy identification to support benchmark achievement.

# Data Use Strategy: Recent & Upcoming Activities

## Recent Activities

OHS utilized a subcontractor to conduct analyses on disparities in emergency department utilization and commercial market cost growth drivers

OHS finalized a contract with Mathematica (a data analytics vendor) to help support health care benchmark initiative work

## Upcoming Activities

OHS will utilize further data analytics to support cost growth mitigation strategy identification

# Healthcare Benchmark Initiative & House Bill 5042

1 **Cost Growth Benchmark**

2 **Primary Care Spend Target**

3 **Quality Benchmarks**

4 **Data Use Strategy**

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# Healthcare Cost Growth Benchmark Results of 2018-19 Pre-Benchmark Analysis

Michael Bailit, Bailit Health

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# Healthcare Cost Growth Benchmark Program

- **Executive Order No. 5** directs the Office of Health Strategy (OHS) to benchmark total healthcare expenditure growth in the state, with the goal of slowing spending growth and making healthcare more affordable for Connecticut citizens.

| 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 an **annual rate-of-growth benchmark for statewide healthcare spending**.
  - The benchmark values are based on Connecticut's **potential Gross State Product** and growth in Connecticut **median income**.
  - The 2018-19 trends presented are **pre-benchmark**, meaning they represent healthcare spending growth for a time period prior to the effective date of the benchmark (and COVID-19).

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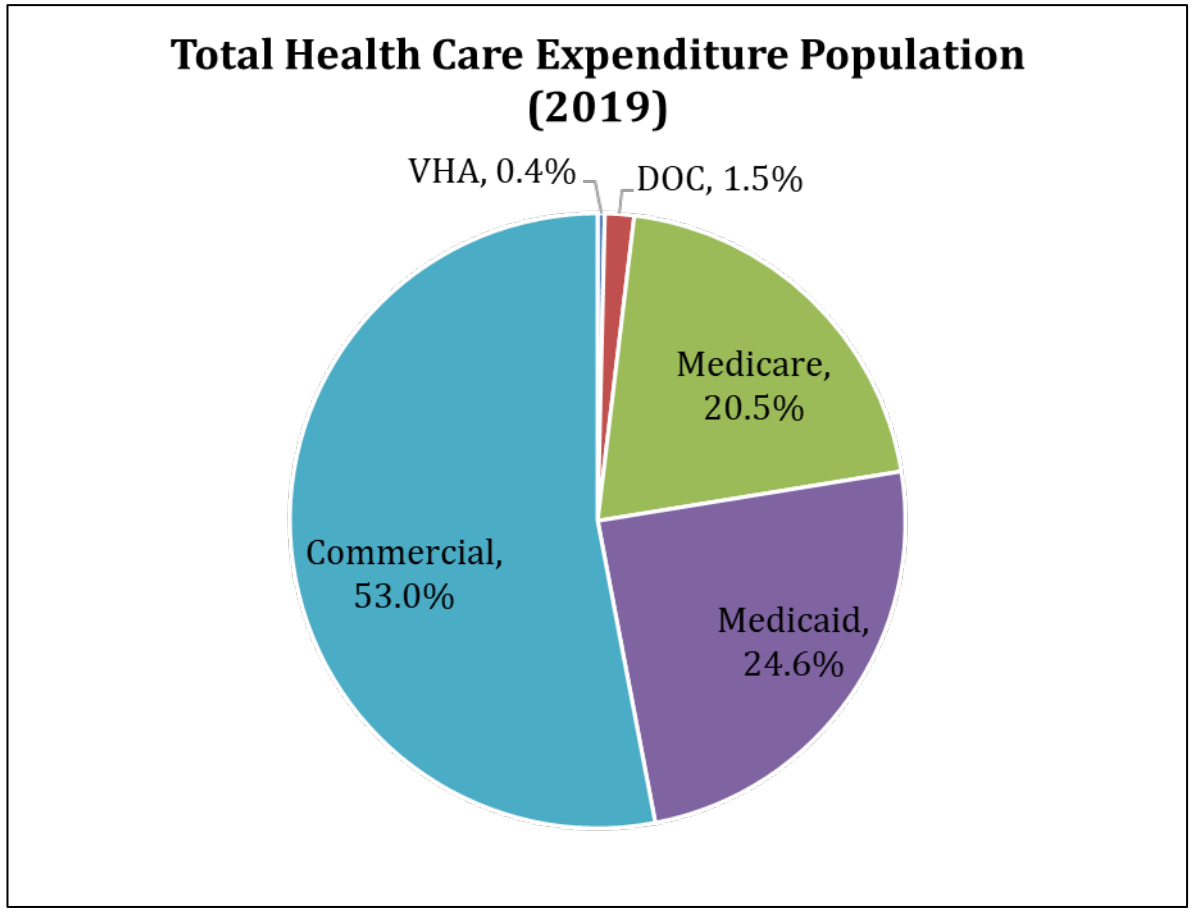
# Summary of Pre-Benchmark Analysis Findings

- Per capita total healthcare expenditure growth in Connecticut from 2018-19 was **3.3%**
  - Spending in the **Commercial** market grew by **6.1%**
  - Spending in the **Medicaid** market decreased by **0.9%**
  - Spending in the **Medicare** market grew by **2.2%**

- Three service categories drove spending growth from 2018-19:
  - **Outpatient hospital**
  - **Inpatient hospital**
  - **Retail pharmacy**

# Population for Total Health Care Expenditures




| Total Health Care Expenditure Category | Members |
|---|---|
| Veterans Health Administration (VHA) | 12,181 |
| Department of Correction (DOC) | 49,652 |
| Medicare | 667,830 |
| Medicaid | 799,034 |
| Commercial | 1,724,077 |
| **TOTAL** | **3,252,773** |

The THCE population includes members who are CT residents, regardless of the location of the member's plan.
Membership was reported to OHS by private payers, the CT Department of Social Services (DSS), the Centers for Medicare & Medicaid Services, the CT DOC, and the VHA.
To avoid double counting, member counts for Medicare and Medicaid dually eligible individuals are included in Medicare totals only.

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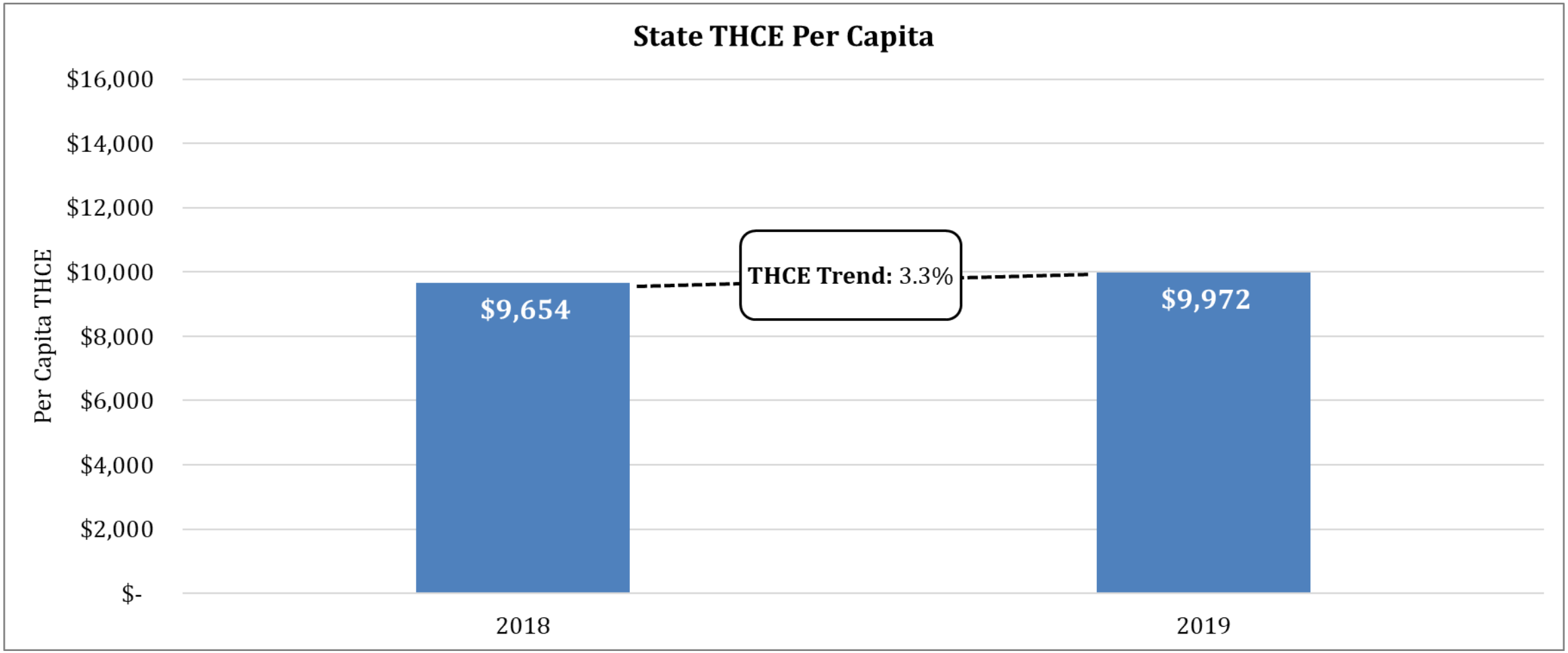
# Statewide Total Health Care Expenditures (THCE) Per Capita




Data are not risk-adjusted, and are reported net of pharmacy rebates.
THCE is defined as the total medical expense for all healthcare services for all payers reporting to OHS plus the net cost of private health insurance, i.e., private insurer administrative expense and margin.

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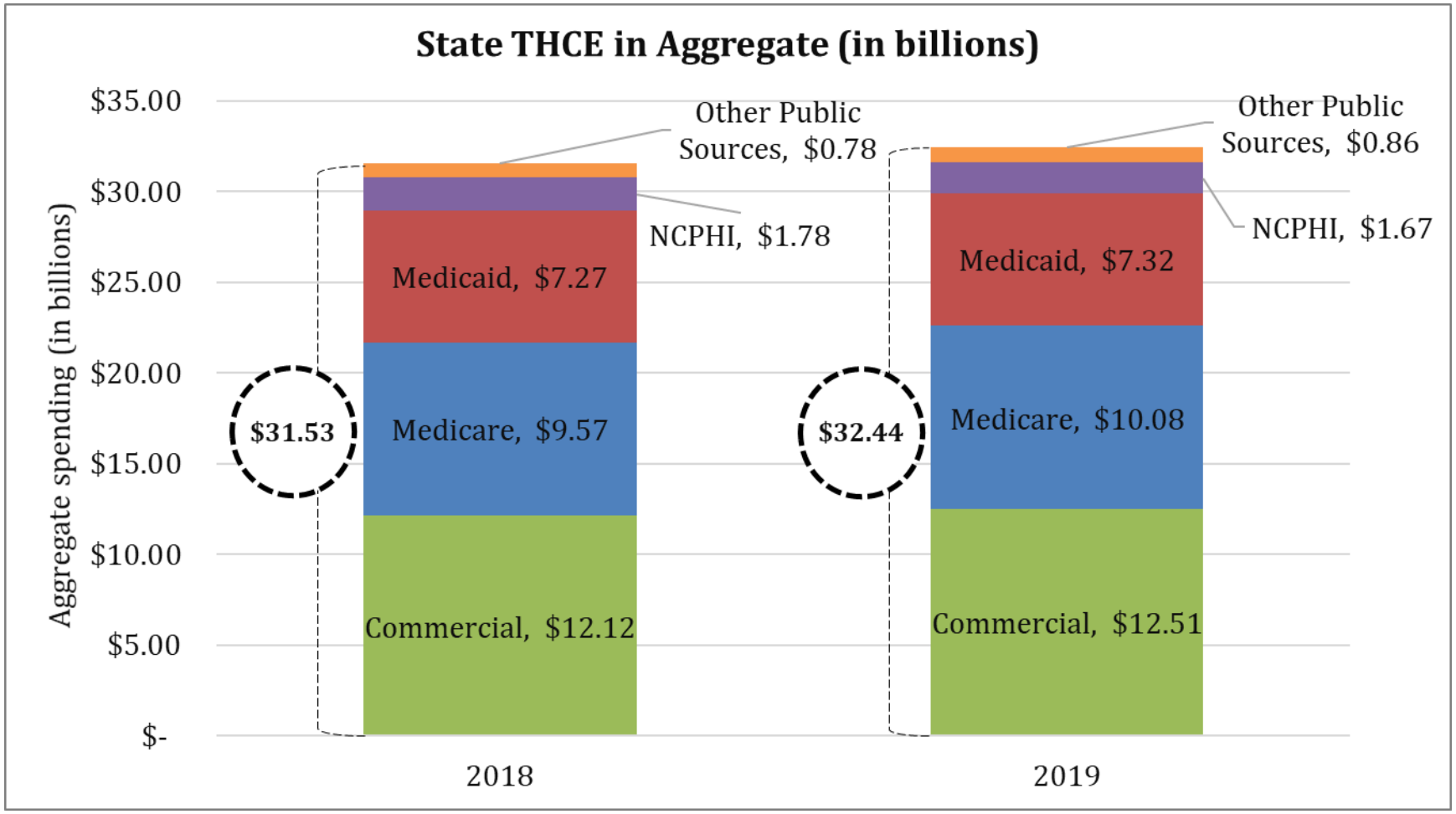
# Components of Statewide THCE




**Key Findings:**

- Aggregate THCE was $32.44 billion in 2019.
- In 2019, spending in the commercial market made up 38.5% of state THCE. Medicare spending was 31.1%, while Medicaid spending was 22.6% of THCE.

Data are not risk-adjusted, and are reported net of pharmacy rebates.
THCE is defined as the total medical expense for all healthcare services for all payers reporting to OHS plus the net cost of private health insurance (NCPHI), i.e., private insurer administrative expense and margin.
"Other Public Sources" includes Veterans Health Administration and CT Department of Correction spending.

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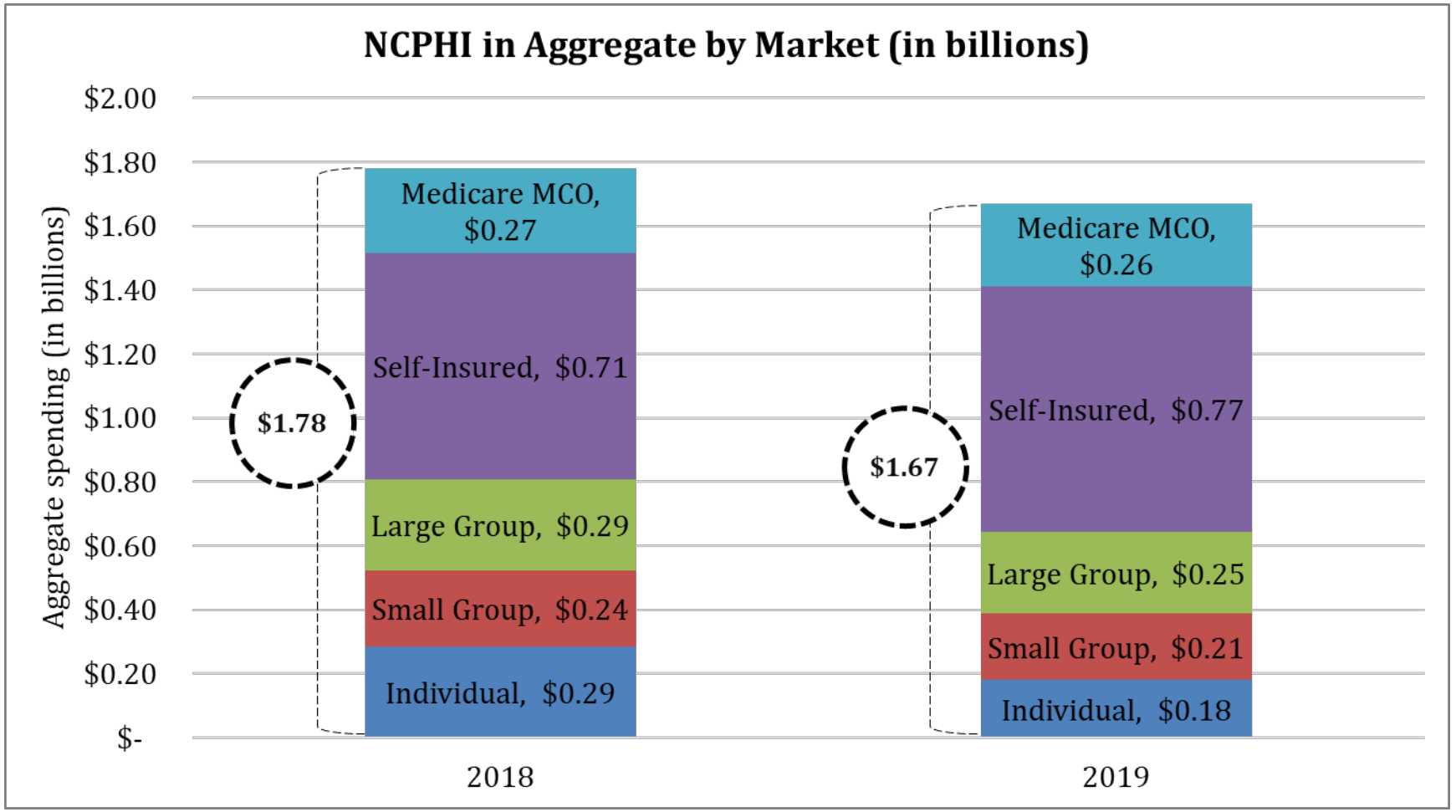
# Net Cost of Private Health Insurance (NCPHI)




**Key Findings:**

- NCPHI contributed $1.67 billion to statewide THCE in 2019.
- In 2019, nearly half (46.1%) of spending on NCPHI was for the commercial self-insured market.

NCPHI measures the costs to CT residents associated with the administration of private health insurance.
THCE is defined as the total medical expense for all healthcare services for all payers reporting to OHS plus the net cost of private health insurance.

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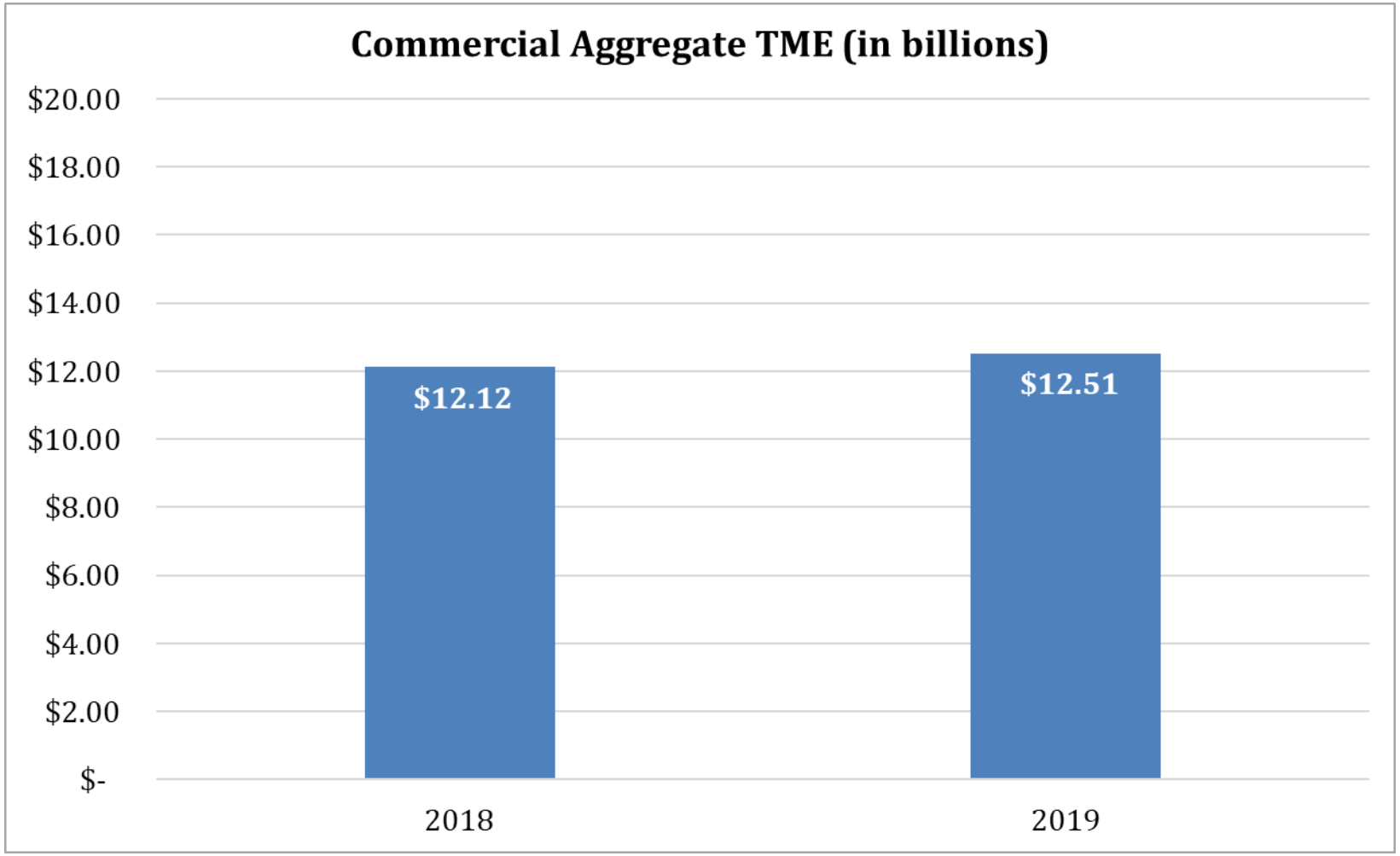
# Commercial Total Medical Expense (TME)




| Year | TME Per Capita | TME Trend Per Capita |
|---|---|---|
| 2018 | $6,843 | 6.1% |
| 2019 | $7,257 | |

Data are not risk-adjusted, and are reported net of pharmacy rebates.
TME is defined as all incurred expenses for all healthcare services, regardless of where the care was delivered.

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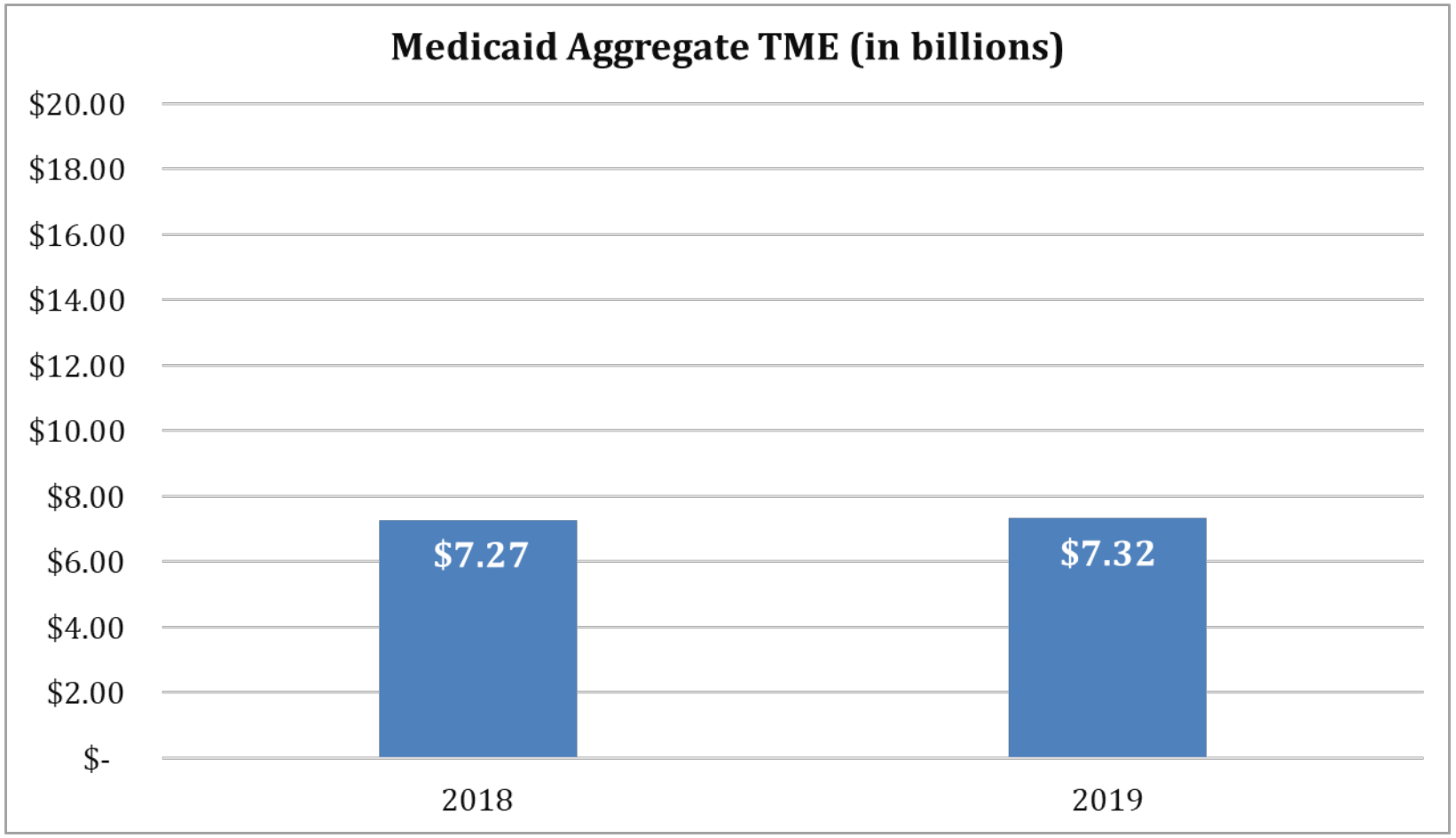
# Medicaid Total Medical Expense (TME)




| Year | TME Per Capita | TME Trend Per Capita |
|---|---|---|
| 2018 | $8,498 | -0.9% |
| 2019 | $8,419 | |

Data are not risk-adjusted, and are reported net of pharmacy rebates.
TME is defined as all incurred expenses for all healthcare services, regardless of where the care was delivered.
Medicaid includes spending on the dually eligible population. It does not include payments to CT Administrative Services Organizations.

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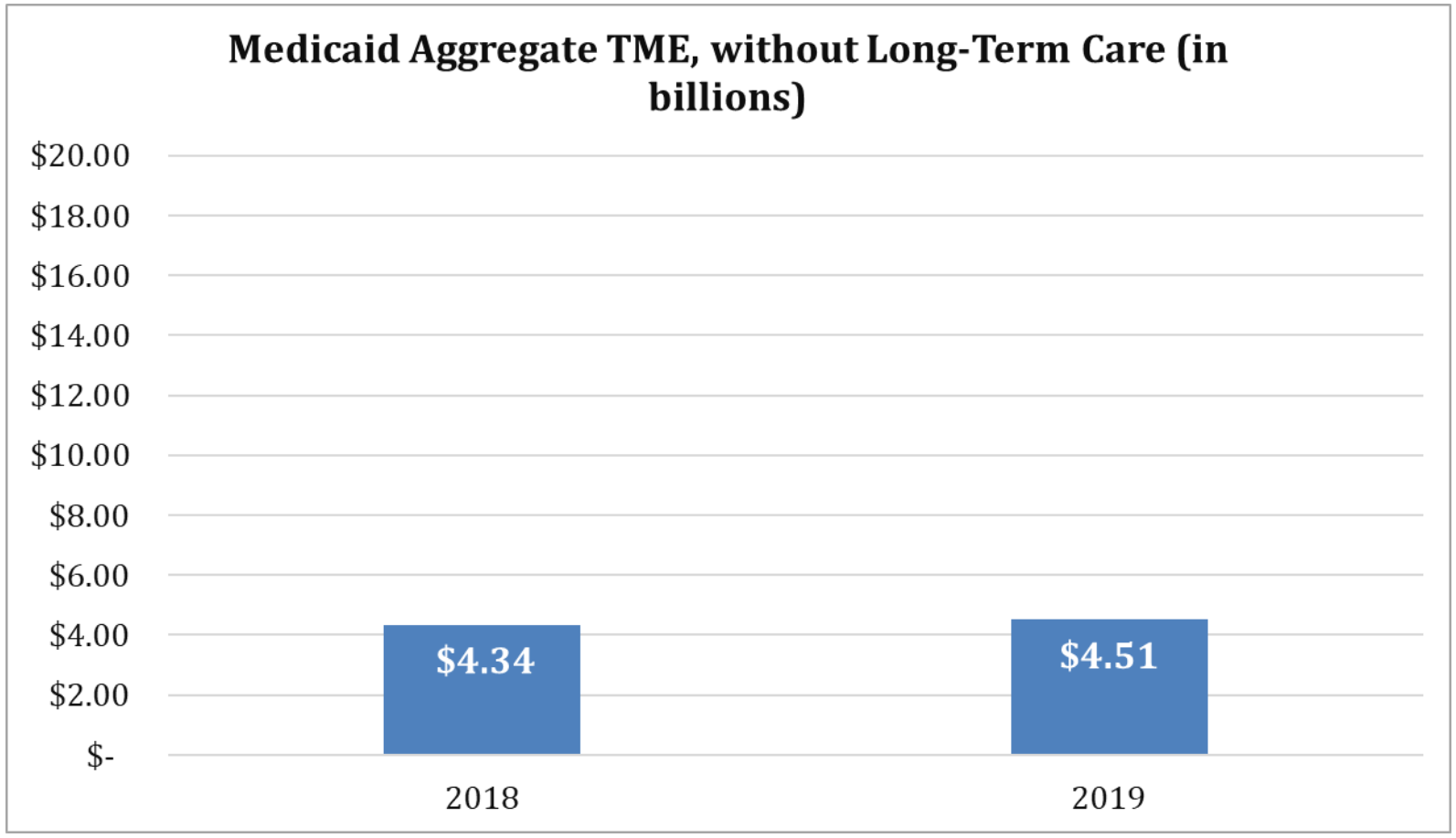
# Medicaid Total Medical Expense (TME) without Long-Term Care




| Year | TME Per Capita | TME Trend Per Capita |
|---|---|---|
| 2018 | $5,073 | 2.1% |
| 2019 | $5,181 | |

Data are not risk-adjusted and are reported net of pharmacy rebates.
TME is defined as all incurred expenses for all healthcare services, regardless of where the care was delivered.
Medicaid includes spending on the dually eligible population. It does not include payments to CT Administrative Services Organizations.

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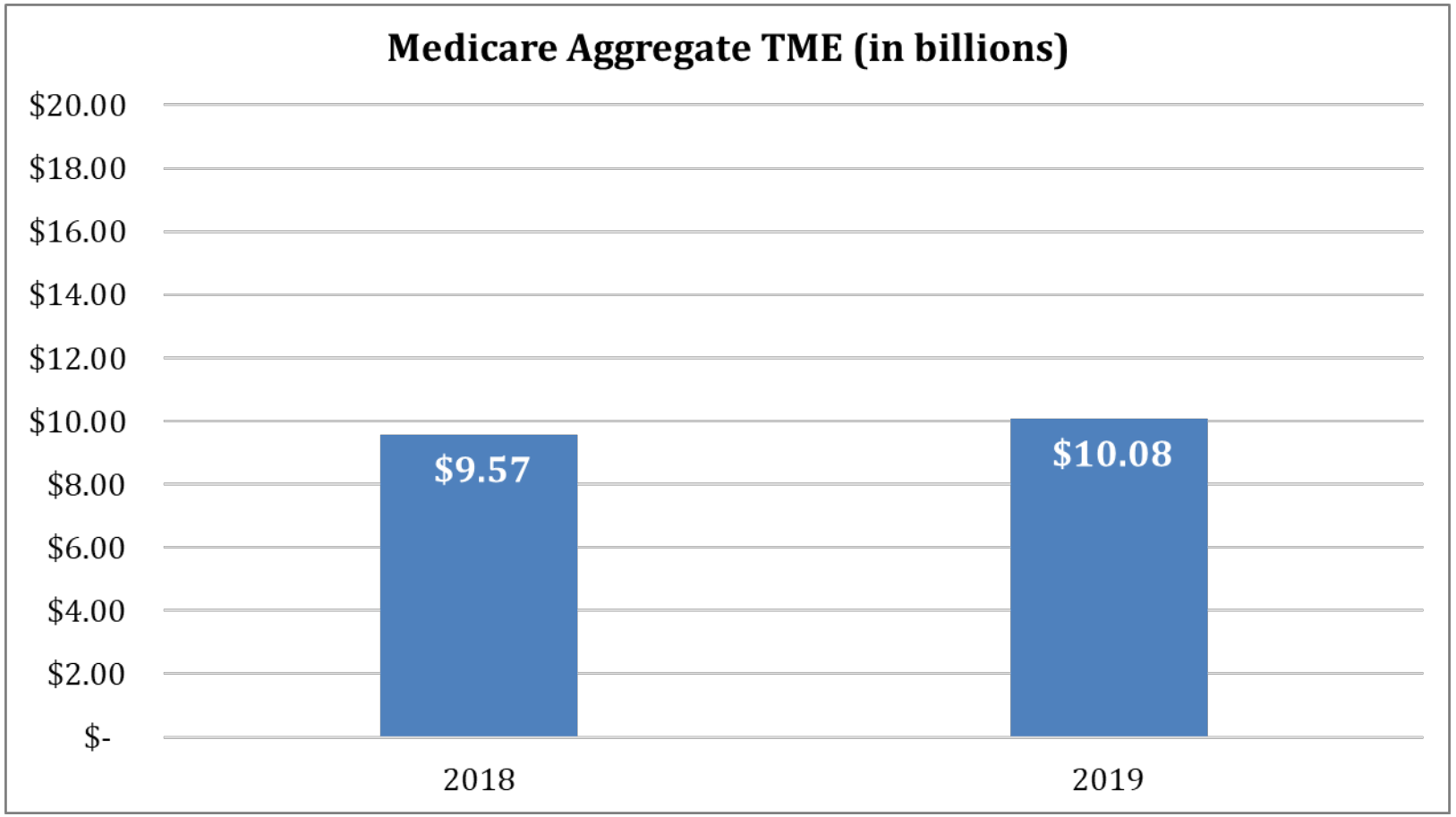
# Medicare Total Medical Expense (TME)




| Year | TME Per Capita | TME Trend Per Capita |
|---|---|---|
| 2018 | $14,763 | 2.2% |
| 2019 | $15,087 | |

Data are not risk-adjusted, and are reported net of pharmacy rebates (however, OHS did not receive pharmacy rebate information from CMS).
Data include Medicare spending on the dually eligible population.
Data do not include the net cost of private health insurance (NCPHI).
TME is defined as all incurred expenses for all healthcare services, regardless of where the care was delivered.

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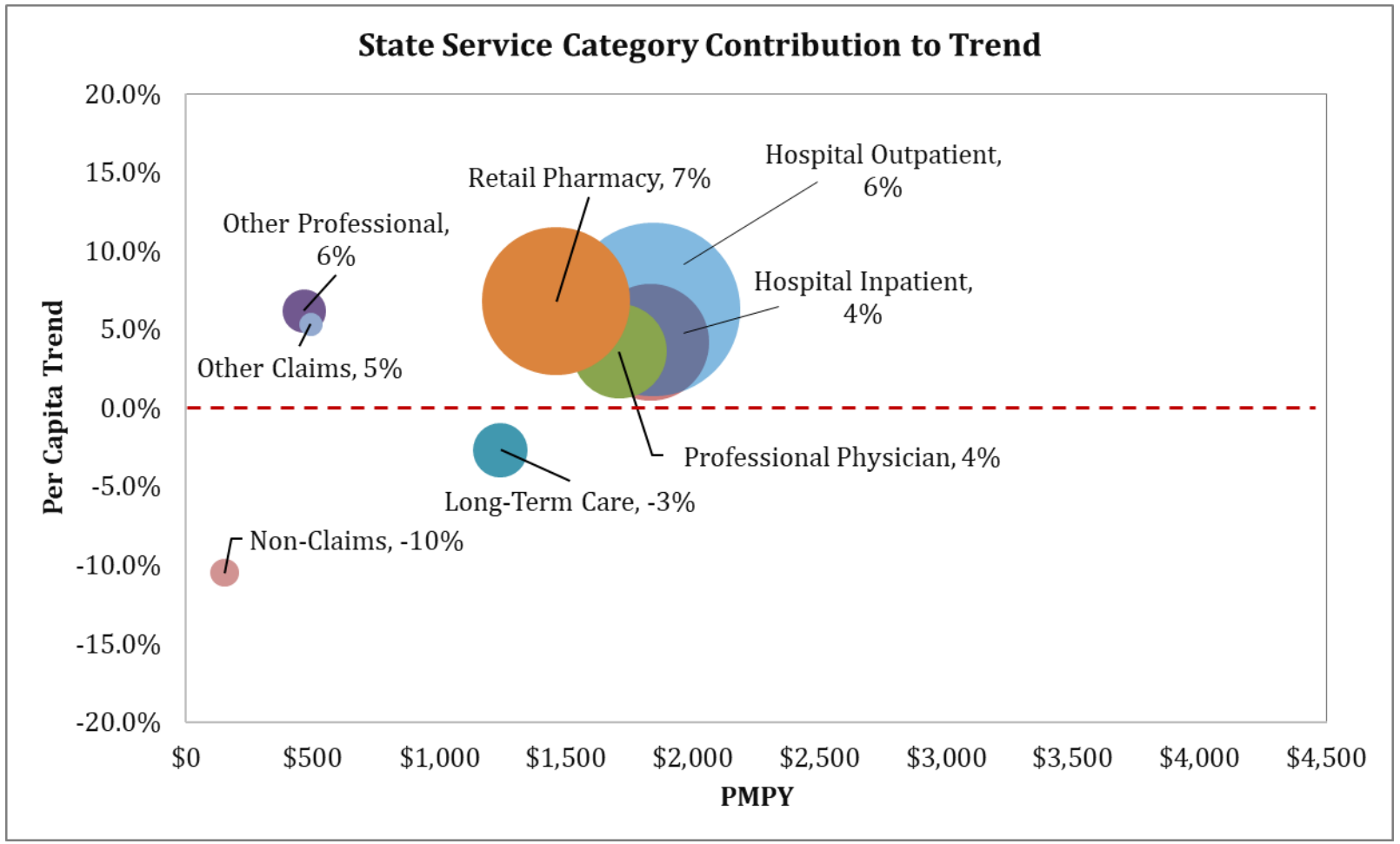
# State Service Category Cost Drivers




**Key Findings:**

- The primary drivers of per capita state total medical expense (TME) growth in 2019 were:
  1. **Hospital outpatient** (6.3% growth)
  2. **Retail pharmacy** (6.8% growth)

*The width of the bubbles in the figure represents contribution to trend.*

Data are not risk-adjusted, and are reported net of pharmacy rebates.
TME is defined as all incurred expenses for all healthcare services, regardless of where the care was delivered.

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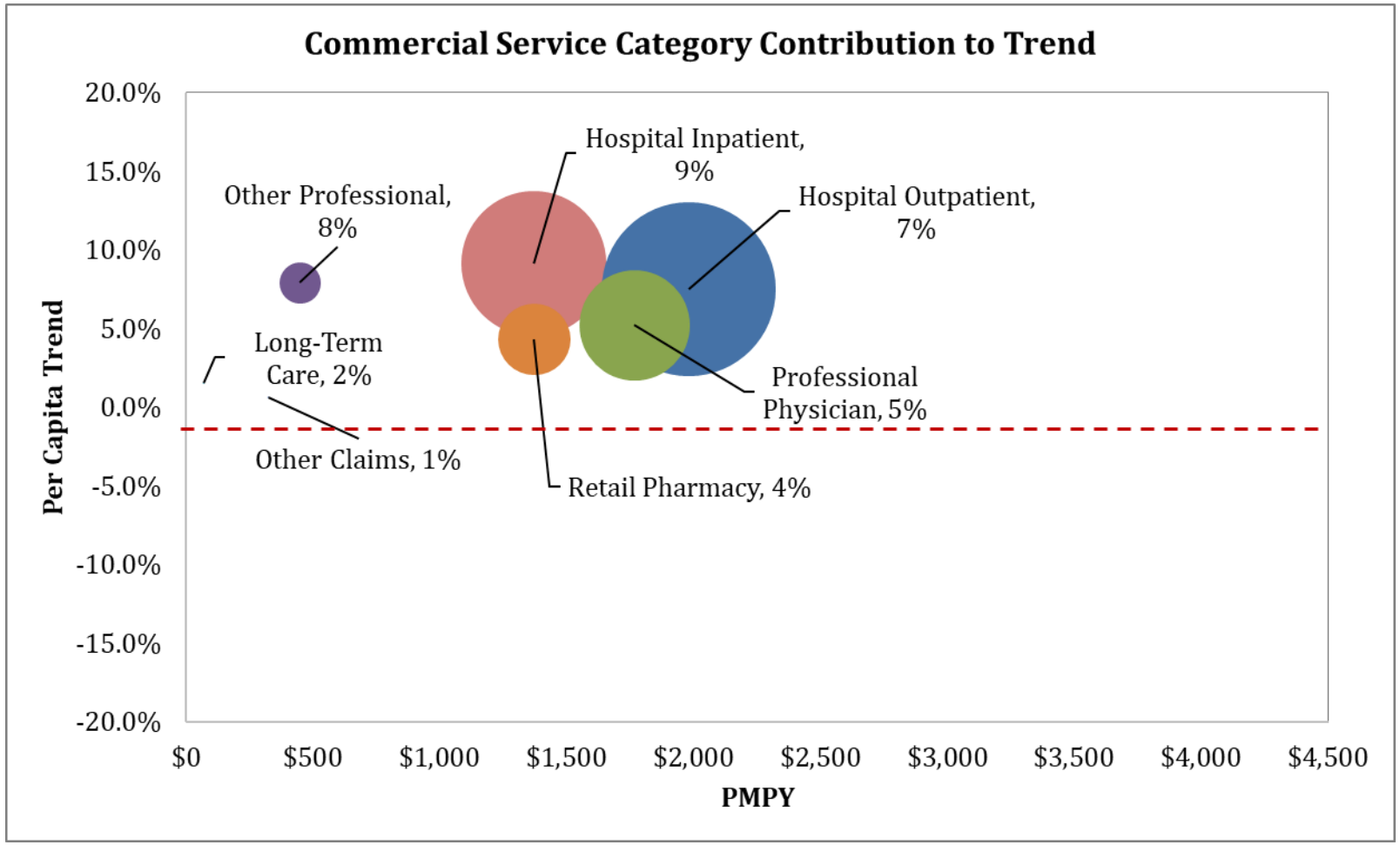
# Commercial Service Category Cost Drivers




**Key Findings:**

- The primary drivers of per capita commercial total medical expense (TME) growth in 2019 were:
  1. **Hospital outpatient** (7.5% growth)
  2. **Hospital inpatient** (9.2% growth)

*The width of the bubbles in the figure represents contribution to trend.*

Data are not risk-adjusted, and are reported net of pharmacy rebates.
TME is defined as all incurred expenses for all healthcare services, regardless of where the care was delivered.

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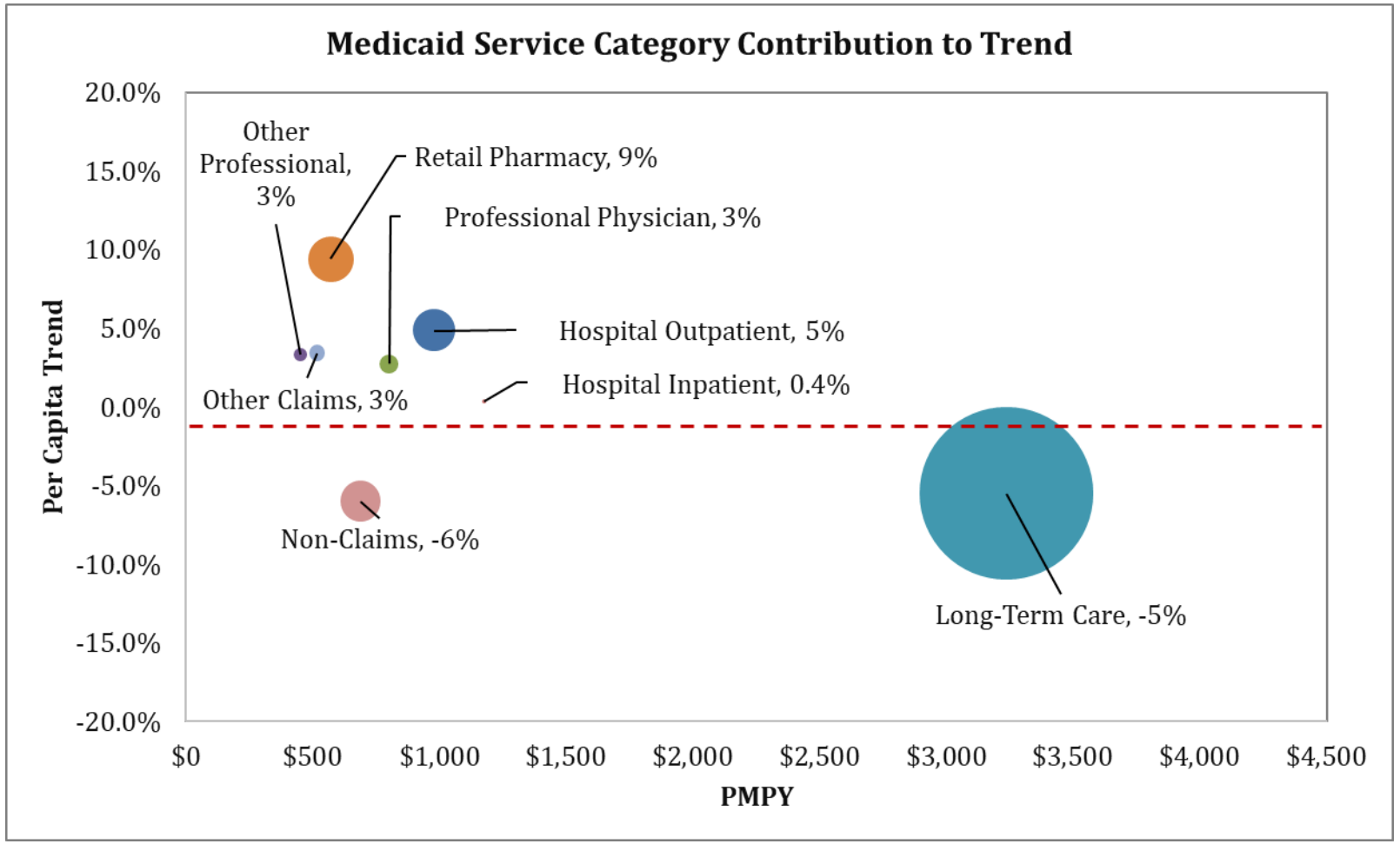
# Medicaid Service Category Cost Drivers




## Key Findings:

- The primary drivers of per capita Medicaid total medical expense (TME) growth in 2019 were:
  1. **Retail pharmacy** (9.4% growth)
  2. **Hospital outpatient** (4.9% growth)
- A decrease in per capita long-term care spending drove the overall negative per capita Medicaid trend.

*The width of the bubbles in the figure represents contribution to trend.*

Data are not risk-adjusted, and are reported net of pharmacy rebates.
TME is defined as all incurred expenses for all healthcare services, regardless of where the care was delivered.

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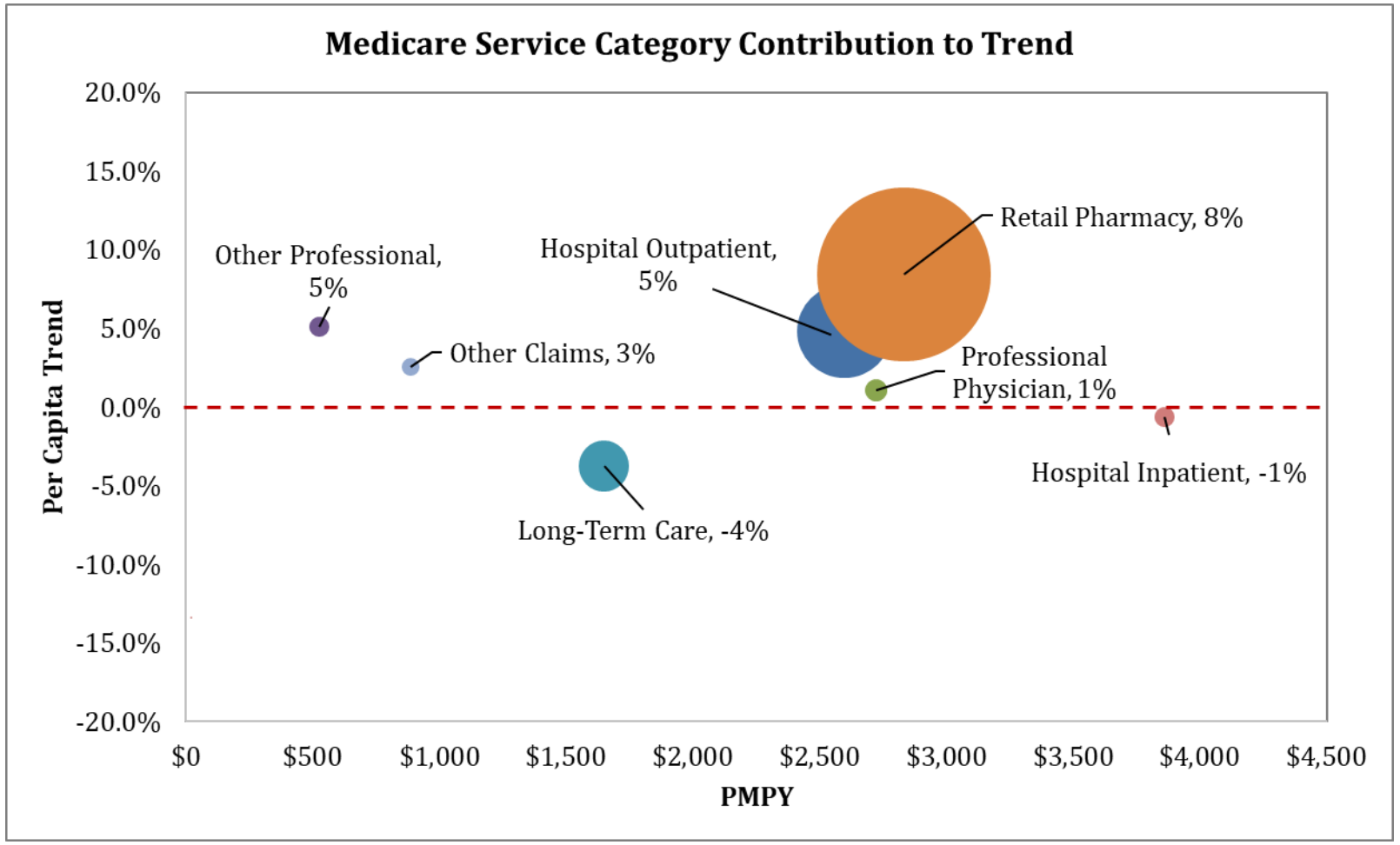
# Medicare Service Category Cost Drivers




**Key Findings:**

- The primary drivers of per capita Medicare total medical expense (TME) growth in 2019 were:
  1. **Retail pharmacy** (8.5% growth)
  2. **Hospital outpatient** (4.8% growth)

*The width of the bubbles in the figure represents contribution to trend.*

Data are not risk-adjusted, and are reported net of pharmacy rebates.
TME is defined as all incurred expenses for all healthcare services, regardless of where the care was delivered.

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# Key Takeaways: Three Service Categories Drove Per Capita TME Cost Growth Across All Markets in 2019

| | Hospital Inpatient | Hospital Outpatient | Retail Pharmacy (Net of Rebates) |
|---|---|---|---|
| **State** | | ✓ | ✓ |
| **Commercial** | ✓ | ✓ | |
| **Medicaid** | | ✓ | ✓ |
| **Medicare** | | ✓ | ✓ |

OHS CONNECTICUT Office of Health Strategy

# Healthcare Accountability and the Impact of Healthcare Costs

**The second half of the virtual forum will begin shortly.**

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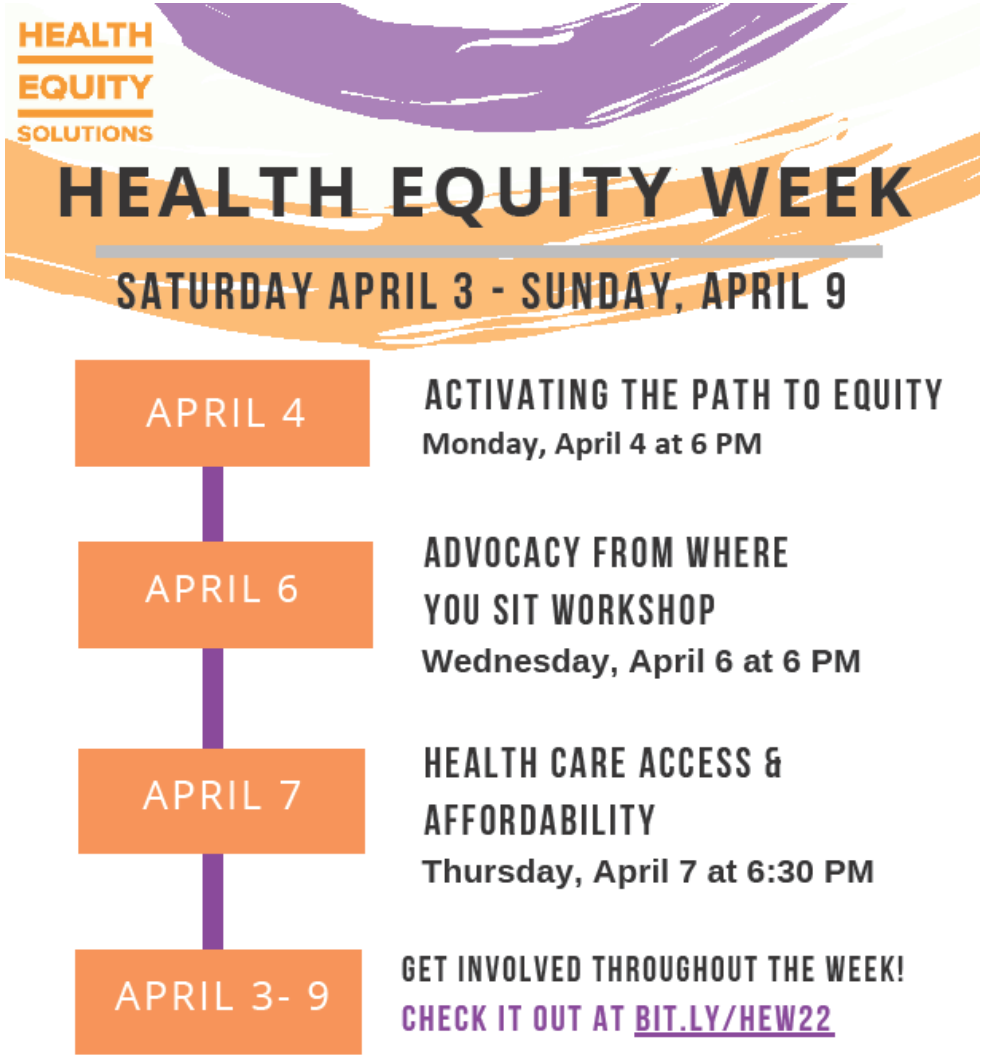
HEALTH EQUITY SOLUTIONS
HEALTH EQUITY WEEK
SATURDAY APRIL 3 - SUNDAY, APRIL 9
APRIL 4
ACTIVATING THE PATH TO EQUITY
Monday, April 4 at 6 PM
APRIL 6
ADVOCACY FROM WHERE YOU SIT WORKSHOP
Wednesday, April 6 at 6 PM
APRIL 7
HEALTH CARE ACCESS & AFFORDABILITY
Thursday, April 7 at 6:30 PM
APRIL 3- 9
GET INVOLVED THROUGHOUT THE WEEK!
CHECK IT OUT AT BIT.LY/HEW22
Follow us on social media! Comment and follow using #HEW22 and #Path2Equity
StanleyBlack&Decker

# The Impact of Healthcare Costs

Dan Pflug

# Pre-Benchmark Analysis with the Connecticut Healthcare Affordability Index

Joshua Wojcik, Office of the State Comptroller
Lisa Manzer, Center for Women's Welfare, University of Washington

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# Connecticut Healthcare Affordability Index CHAI

**The CHAI sets a maximum percentage of income a household can spend on healthcare* while leaving room to cover other expenses required to meet basic needs.**

**The measure is described as an index because it varies based upon a number of factors including:**

- **Household type;**
- **Geographic region;**
- **Health risk factors;**
- **Market through which a household can access health coverage;**

**Depending on the above factors Connecticut households can generally afford between 7% and 11%**

*healthcare costs include both premiums and out-of-pocket costs

# Analyzing the Connecticut Healthcare Cost Growth Benchmark using the CHAI affordability standards

**Impact on Commercial Hospital Spend by 2025**

**-$1.1 billion or -14.2%**

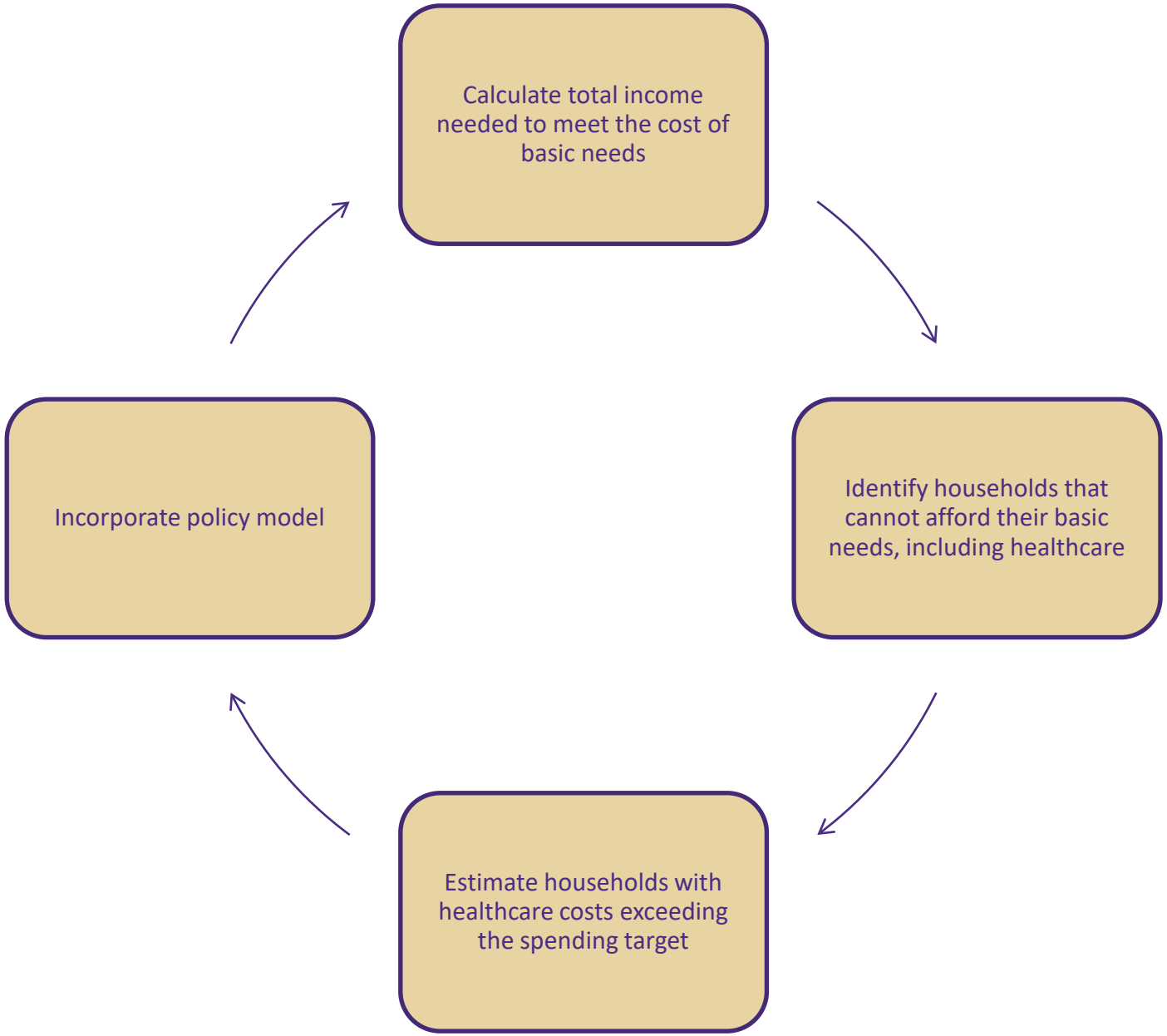
**Impact on Commercial Insurance Premiums**

**-5.2% individual market**

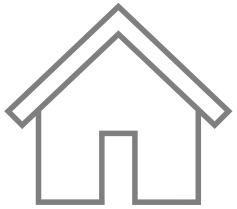
**-5.5% employer market**

| | Commercial Hospital Growth Rates | | | |
|---|---|---|---|---|
| | Actual 2018-2019 growth continues into the future | | Growth meets annual cost growth benchmark | |
| Year | Outpatient | In-Patient | Outpatient | In-Patient |
| 2021 | 6.3% | 4.7% | 3.4% | 3.4% |
| 2022 | 6.3% | 4.7% | 3.2% | 3.2% |
| 2023 | 6.3% | 4.7% | 2.9% | 2.9% |
| 2024 | 6.3% | 4.7% | 2.9% | 2.9% |
| 2025 | 6.3% | 4.7% | 2.9% | 2.9% |

# Research Process



# Define Total Income Needed to Meet the Cost of Basic Needs

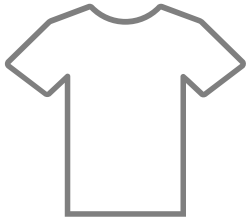


Housing

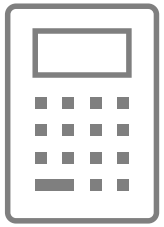
Child Care

Food

Health Care

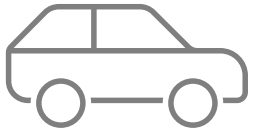


Miscellaneous

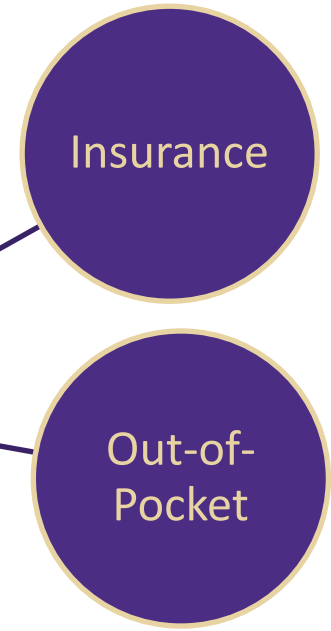


Taxes & Tax Credits

Emergency Savings



Transportation

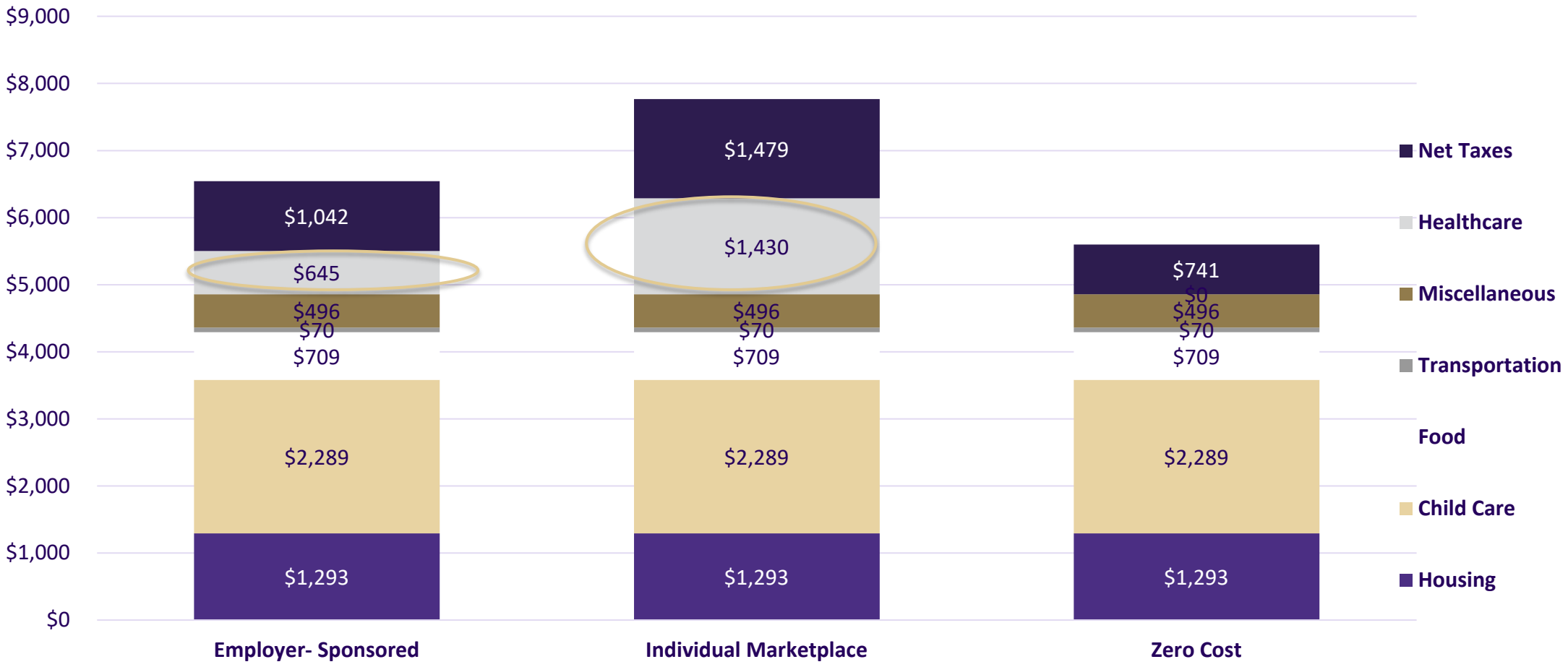



- Employer-Sponsored
- Individual Marketplace
- Zero Cost

- Age
  - 18-34, 35-49, 50-64
- Health Risk Score
  - Low, Medium, High

# Connecticut Healthcare Affordability Index Total Income Needed to Meet Basic Needs: Bridgeport, CT 2019

*One Adult (18-34, Low Health Risk Score), One Preschooler, and One School-age Child*

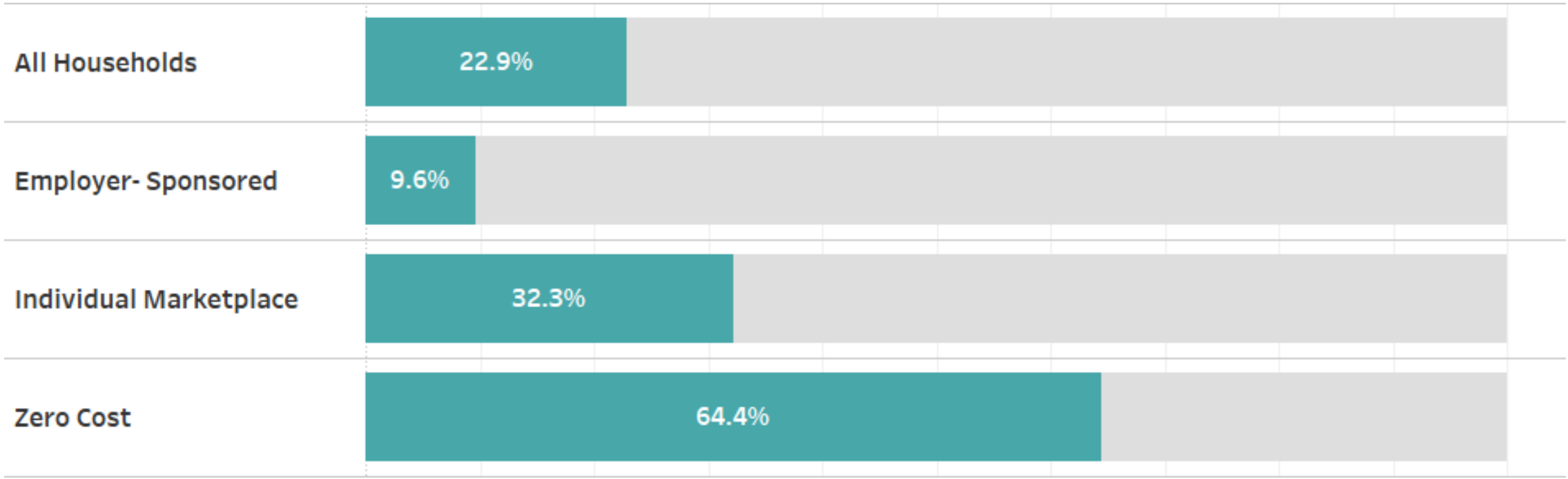


# Identify households that cannot afford their basic needs

- **Household Income < CHAI Income Threshold = *Inadequate* Income to Meet Basic Needs**

  - **Data: 2019 American Community Survey Microdata Sample**
  - **Sample Unit: Household/Householder**
  - **Excludes: Adults over 65 or adults with work-limiting disability.**

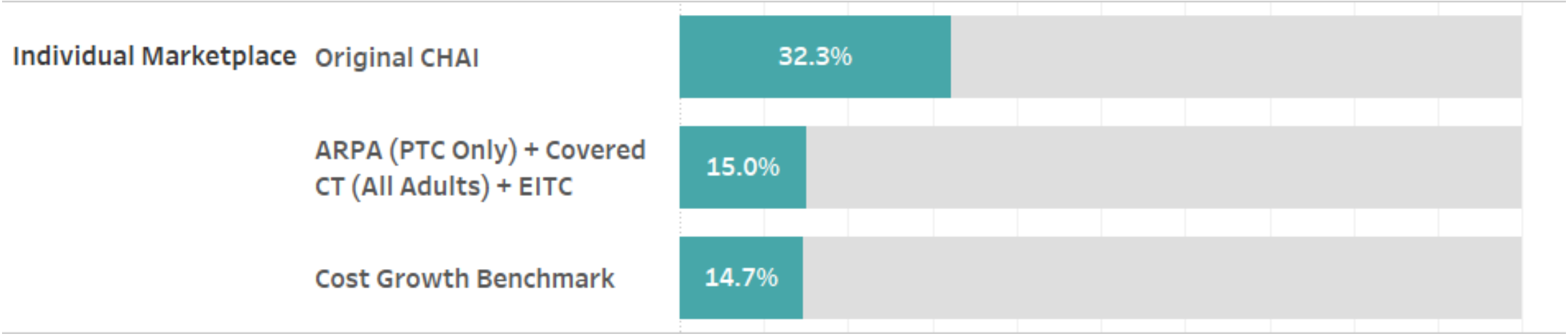
# Percentage of Households with Inadequate Income by Insurance Category




Source: U.S. Census Bureau, 2019 ACS 1-Year Public Use Microdata Sample.

ARPA PTC = American Relief Plan Act Premium Tax Credit

# Percentage of Individual Marketplace Households with Inadequate Income by Policy Model



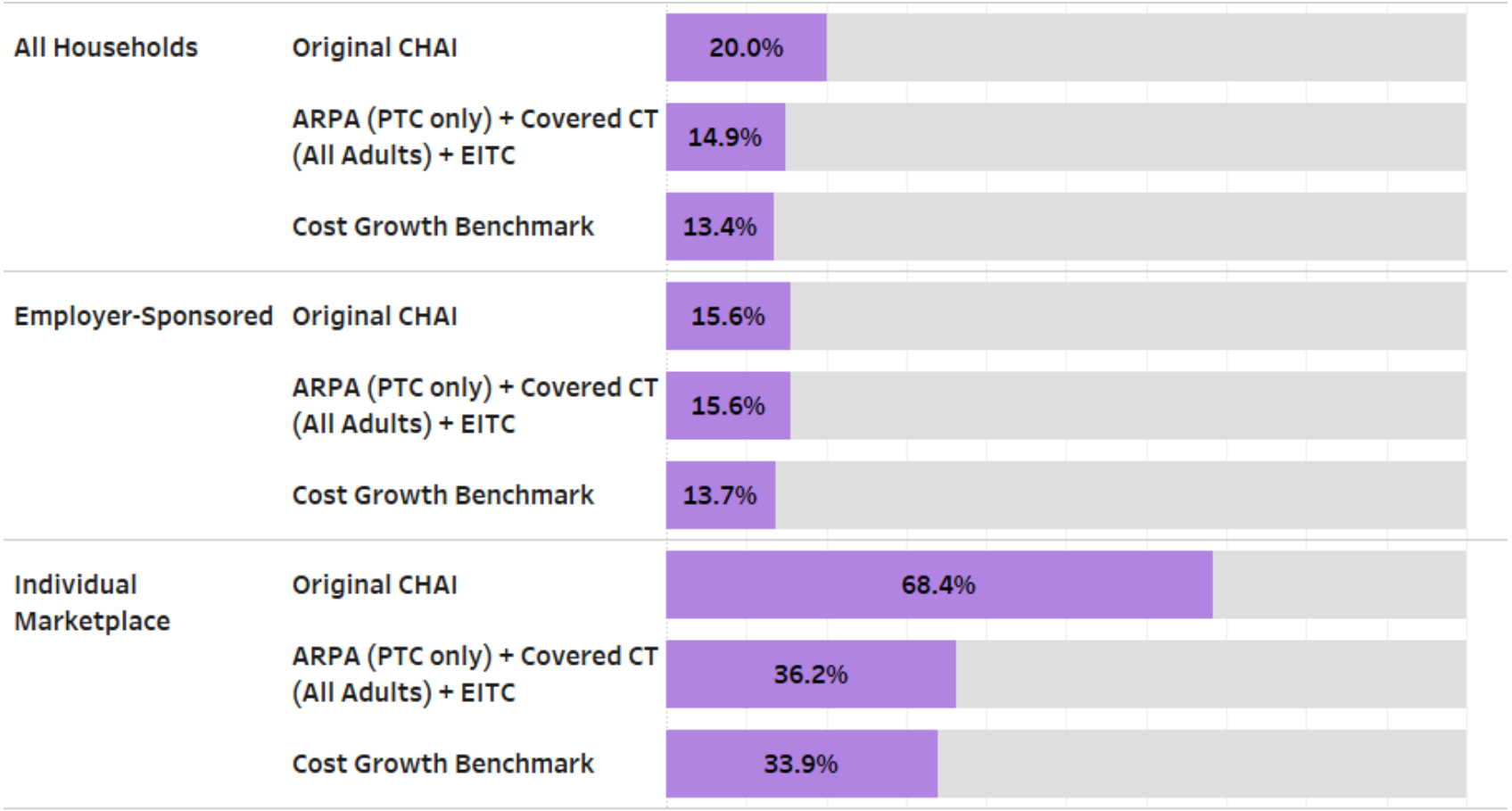

Source: U.S. Census Bureau, 2019 ACS 1-Year Public Use Microdata Sample.

Notes: ARPA PTC = American Rescue Plan Act removal of the Premium Tax Credit income cap. Covered CT program provides zero cost healthcare for adults and caregivers not eligible for Medicaid with income up to 175% of the federal poverty guidelines.

# Estimate Number of Households with Unaffordable Healthcare Expenditures

(Premium + Out-of-Pocket Cost – Premium Tax Credit)
/ Household Income
**>** than the maximum CHAI Spending Target
= Healthcare Costs are Unaffordable

# Percentage of Households with Healthcare Expenses Exceeding the *Connecticut Household Healthcare Spending Target*




Source: U.S. Census Bureau, 2019 ACS 1-Year Public Use Microdata Sample.

# Conclusion

> ***Reducing healthcare costs to the cost growth benchmark results in over 14,000* additional households with affordable healthcare according to the Connecticut Household Healthcare Spending Target.***

*Householders that are over 65 or with a work-limiting disability are not included in the analysis. Results would be even **higher** with these groups included.

# CT Healthcare Affordability Index

**Healthcare Costs** | Income Inadequacy Rates | Affordable Healthcare Rates

Healthcare is affordable in Connecticut if a family can reliably secure it to maintain good health and treat illnesses and injuries when they occur, *without* sacrificing the ability to meet all other basic needs. Use this tool to explore how different policy assumptions change the income needed to afford basic needs depending upon the town, family composition, and healthcare cost factors. The original CHAI model provides the baseline and more models will be added overtime for comparison. Hover over a datapoint in the table for more details and definitions.

**Select CHAI Model for Comparison** (Multiple values)

**Select Connecticut Town** Andover

**Select Healthcare Cost Factors**

| Health Insurance Type | Health Risk Score | Adult Age Range |
|---|---|---|
| Employer-Sponsored | Low | 35-49 |

**Select Family Composition**

| Adults | Infants | Preschoolers | Schoolagers | Teenagers |
|---|---|---|---|---|
| 2 | 0 | 1 | 1 | 1 |

**Monthly Cost of Basic Needs in Andover**

Assumes Employer- Sponsored Health Insurance for an 35-49 householder with a Low Health Risk Score

| | Original CHAI | ARPA (PTC Only) + 30.5% EITC | Cost Growth Benchmark |
|---|---|---|---|
| Housing | $1,482 | $1,482 | $1,482 |
| Child Care | $1,680 | $1,680 | $1,680 |
| Food | $1,077 | $1,077 | $1,077 |
| Health Care | $595 | $595 | $563 |
| Transportation | $544 | $544 | $544 |
| Miscellaneous | $541 | $541 | $541 |
| Taxes | $1,368 | $1,368 | $1,357 |
| Premium Tax Credit (-) | $0 | $0 | $0 |
| Earned Income Tax Credit (-) | $0 | $0 | $0 |
| Child Tax Credit (-) | ($500) | ($500) | ($500) |
| Child Care Tax Credit (-) | ($100) | ($100) | ($100) |
| **Income Needed to Meet Basic Needs** | | | |
| Hourly Wage | $19.00 | $19.00 | $18.87 |
| Monthly Income | $6,687 | $6,687 | $6,643 |
| Annual Income | $80,241 | $80,241 | $79,720 |

Source: The cost of basic needs are based on the Self-Sufficiency Standard for Connecticut calculated by the University of Washington Center for Women's Welfare. The Connecticut Healthcare Affordability Index (CHAI) substitutes the original Self-Sufficiency Standard healthcare costs with detailed costs to account for factors that impact affordability including differences in (1) type of insurance coverage, (2) age-related premiums, and (3) out-of-pocket costs by health risk score of householder (low indicates

Healthcare Costs | **Income Inadequacy Rates** | Affordable Healthcare Rates

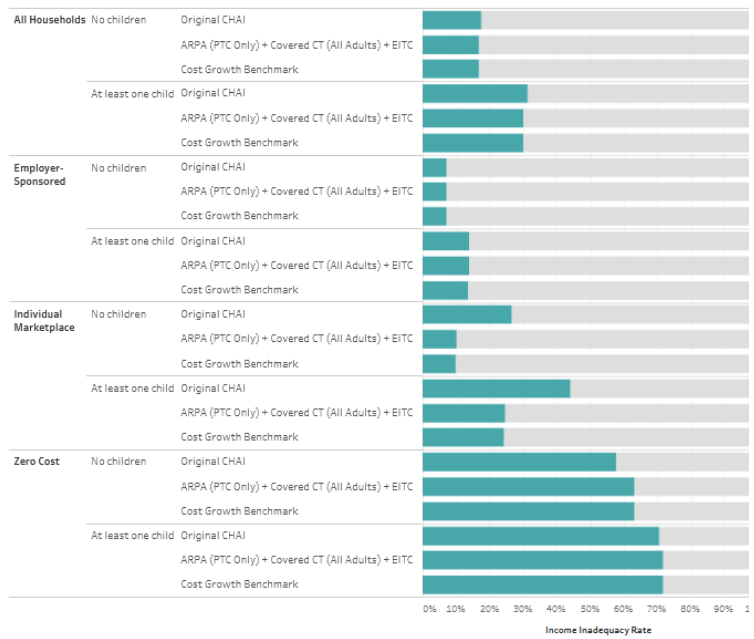
Connecticut households are identified as being at risk of affording their basic needs -- including healthcare -- if their household earnings less than the income defined as necessary by the Connecticut Healthcare Affordability Index (CHAI). When policy levers impact this incon definition or when a program like Covered CT changes eligibility for zero cost health insurance, our estimate of households at risk of affording their basic needs can also change. Use this tool to explore how the rate of households with inadequate income shifts dependin upon the inclusion of different policy assumptions. The original CHAI model provides the baseline and models will be added overtime for comparison. Use your mouse to hover over a datapoint in the chart for more details and definitions.

**Select CHAI Model** (Multiple values)

**Select Health Insurance Type** (All)

**Select Demographic Group** Children present

**Income Inadequacy Rate by Children present**




Source: U.S. Census Bureau, 2019 ACS 1-Year Public Use Microdata Sample.

Healthcare Costs | Income Inadequacy Rates | **Affordable Healthcare Rates**

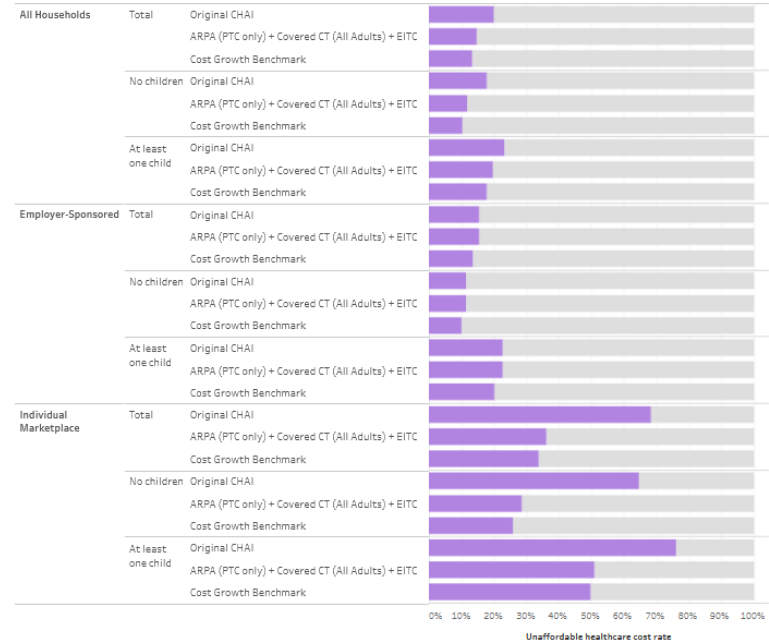
Families should pay no more than between approximately 7% and 11% of their household expenses to healthcare, depending on family size, according to the *Connecticut Household Healthcare Spending Target*. Policy levers can change how much a household is paying for healthcare and as a result, the rate of households with affordable healthcare costs according to the Connecticut Households Healthcare Spending Target. The original CHAI model provides the baseline and models will be added overtime for comparison. Use your mouse to hover over a datapoint in the chart for more details and definitions.

**Select CHAI Model** (Multiple values)

**Select Health Insurance Type** (Multiple values)

**Select Demographic Group** Children present in household

**Households with Unaffordable Healthcare Costs by Children present in household**




Source: U.S. Census Bureau, 2019 ACS 1-Year Public Use Microdata Sample.
Definitions: CHAI = Connecticut Healthcare Affordability Index. ARPA = American Rescue Plan Act of 2021. Covered CT is a zero cost health care program for adults with incomes

# Call to Action

Wyatt Bosworth, Connecticut Business and Industry Association

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# Closing Remarks

Victoria Veltri, Office of Health Strategy

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