CONNECTICUT
Health Strategy

Cost Growth Benchmark Initiative
2022-2023 Performance
A report Pursuant to C.G.S. 19a-754h

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Commissioner

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Acknowledgements

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Acronym Glossary

APCD	All-Payer Claims Database
CMS	Centers for Medicare and Medicaid Services
CT	Connecticut
DOC	Department of Correction
DSS	Department of Social Services
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
IC	Insurance Component
MA	Medicare Advantage
MCO	Managed care organization
MEPS	Medicare Expenditure Panel Survey
NCPHI	Net Cost of Private Health Insurance
OHS	Office of Health Strategy
OSC	Office of the State Comptroller
PCMH	Person-Centered Medical Home
PGSP	Potential Gross State Product
PHE	Public Health Emergency
PMPM	Per Member Per Month
PMPY	Per Member Per Year
PPU	Payment Per Unit
THCE	Total healthcare expenditures (TME + NCPHI)
TME	Total medical expense
UPK	Units per 1,000 members
VHA	Veterans Health Administration
WAC	Wholesale Acquisition Cost

Update History

This report updates the previous version published on March 31, 2025by more accurately accounting for dual-eligible members and incorporating additional payer data. These changes impacted the total health care expenditure (THCE) and total medical expense (TME) trends, including service category trends. Additional revisions include adjustments to retail pharmacy data to align with updates made to the retail pharmacy dashboard available on the Office of Health Strategy website.

Executive Summary

The Cost Growth Benchmark program aims to slow healthcare spending growth as one tool to increase affordability for residents. The program was originally established by Governor Lamont by Executive Order (EO #5) and later codified by the Connecticut General Assembly in Public Act 22-118. The annual "Cost Growth Benchmark" is a targeted annual rate of growth in per person spending and is based on a blend of state economic growth and projected household income. The 2021-2025 benchmarks are shown below.

Annual Cost Growth Benchmark Values

Year	Benchmark Value
2021	3.4%
2022	3.2%
2023	**2.9%**
2024	4.0% (adjusted up from 2.9% to account for extraordinary inflation)
2025	2.9%

From 2022 to 2023, Connecticut's total healthcare expenditures (THCE) per capita grew by 7.9%, significantly faster than the 2.9% cost growth benchmark value. Total Medical Expense (TME) grew by 6.2% per capita in the commercial market, 13.7% per capita in the Medicare market, and 2.2% per capita for the Medicaid market.

Connecticut's 2023 healthcare spending exceeded the benchmark for the third consecutive year, signaling continuing challenges in containing spending growth at a rate that is affordable to residents and businesses. The cost growth benchmark is set by blending projections of state economic growth and Connecticut household income. Broadly, the benchmark value represents affordable and sustainable growth in the healthcare sector. Despite having a benchmark established by statute, Connecticut healthcare cost growth has continued to outpace this measure of affordability. Current strategies to contain cost growth do not appear to be working, or working sufficiently, to bring down the growth in spending. As part of the

benchmarking annual cycle, OHS will conduct a hearing by June 30, 2025, to hear the testimony of healthcare stakeholders impacted by high healthcare costs, as well as those who contribute to this cost growth. By October of 2025, OHS will develop and submit to the Connecticut General Assembly additional policy recommendations to address the on-going healthcare cost growth state residents, governments and businesses face. This 2023 Cost Growth Benchmark Report by the Office of Health Strategy (OHS) evaluates healthcare trends in Connecticut and identifies drivers of spending.

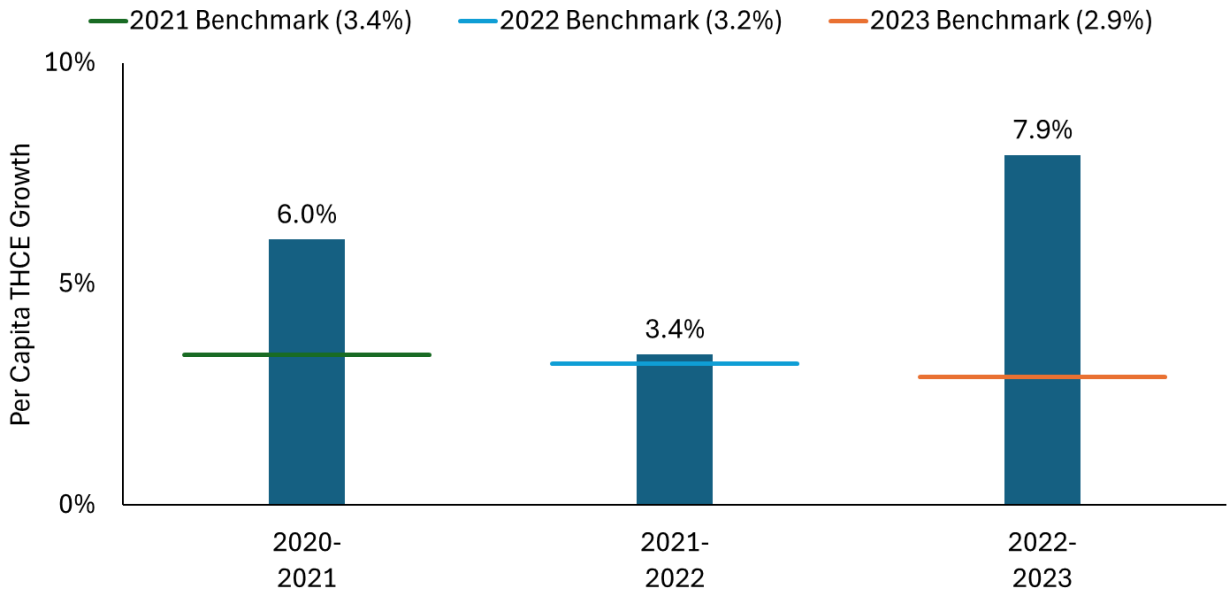
State Performance

Commercial and Medicare market spending placed upward pressure on Connecticut's total healthcare expenditures (THCE), leading to the state exceeding its cost growth benchmark for the third consecutive year. Connecticut's THCE per capita grew to $11,900, equivalent to 7.9% in 2023. This marks the highest annual increase since the program's inception, and nearly double the rate observed in 2022. Aggregate statewide spending rose significantly to $38.0 billion. Medicare was the largest component of aggregate spending, accounting for 35.0% of the state's expenditures, followed by the commercial market at 32.4% and Medicaid at 25.2%.

Key drivers of statewide spending growth in 2023 included non-claims spending (114.0%), retail pharmacy (9.3%), and hospital outpatient services (6.9%).

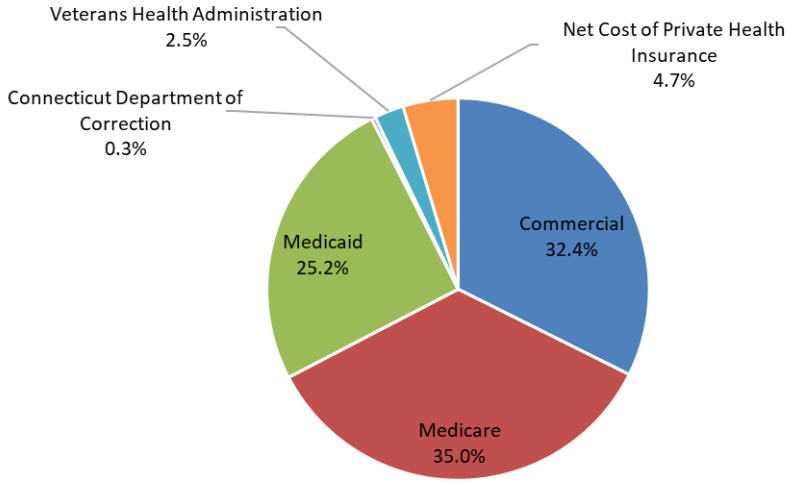
Key drivers of statewide spending growth in 2023 included non-claims spending (114.0% annual spending growth), retail pharmacy (9.3%), and hospital outpatient services (6.9%). Long-term care was the only service category to see a decline, falling by 0.4%.

State Per Capita Total Healthcare Expenditure (THCE) Growth (2020-2023)



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).

Components of Aggregate State Total Healthcare Expenditures (THCE) (2023)

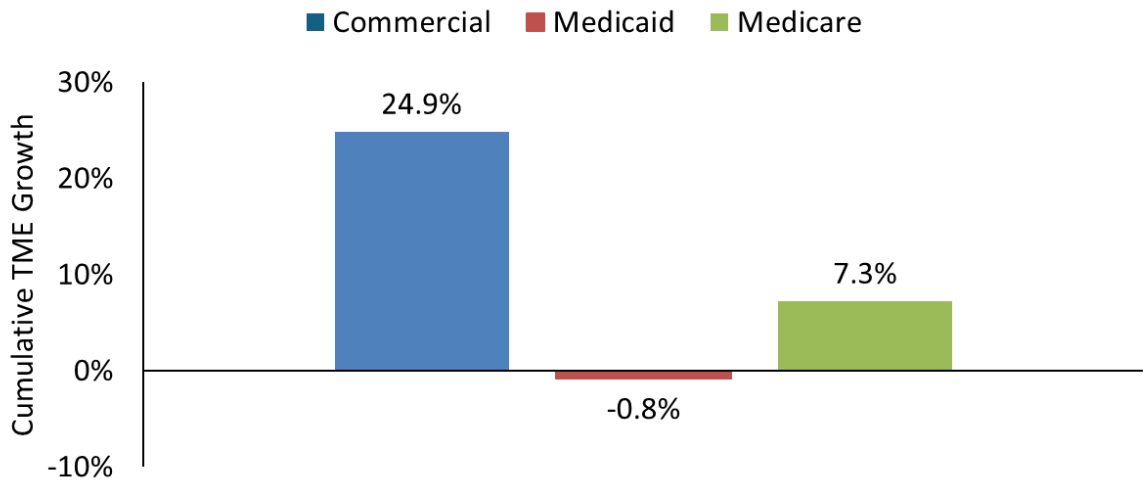


Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS) and the Connecticut Department of Social Services (DSS).
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

Market Performance

Since the creation of the cost growth benchmark, OHS has collected and analyzed five years of cost growth benchmark data (2019-2023). Over the course of these five years, cumulative commercial market spending growth has been substantially higher than in the Medicaid and Medicare markets.

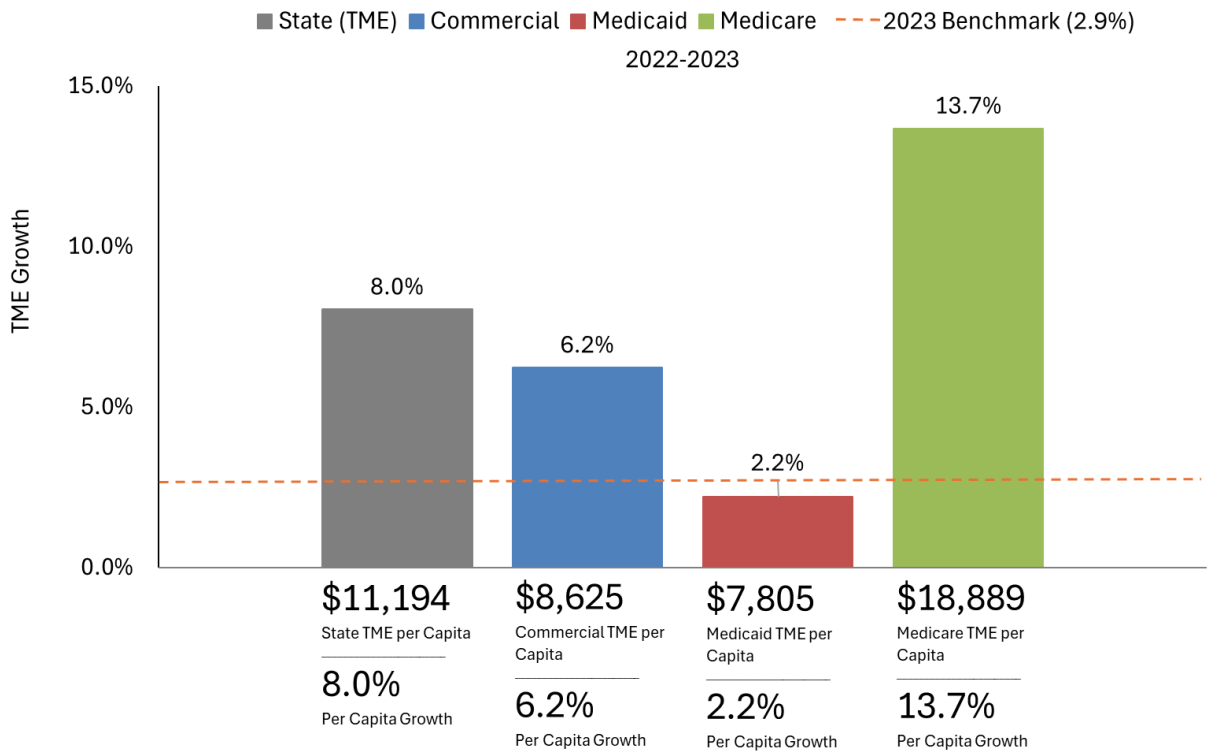
2019-2023 Cumulative Per Capita TME Growth by Market



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.

Spending in the commercial market grew substantially from 2022 to 2023, with per capita (per member per year) total medical expenses (TME) increasing by 6.2% to $8,625. Medicaid per capita spending grew modestly at 2.2%, once again below the benchmark. By contrast, Medicare saw the most dramatic increase in per capita spending since 2020, surging by 13.7% to $18,899—far above the benchmark. This spike was largely driven by an unusually large increase in non-claims spending, specifically within Medicare Advantage plans.

State Per Capita Total Medical Expense Growth and Spending (2022-2023)



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.

Non-claims spending

Traditionally, healthcare spending occurs on a fee-for-service (FFS) basis, which generally means there is a specific claim or bill for each service provided. However, payments are also made to providers that are not directly tied to a specific service. For example, this can include payments tied to support or reward improvements in quality, care coordination, and efficiency (such as payments for care management, quality performance, and shared savings payments).

Non-claims spending had an outsized impact on healthcare spending growth in Connecticut in 2023, contributing 40% of the state's overall per capita spending growth. This was primarily due to significant increases in Medicare Advantage payments by UnitedHealthcare.

UnitedHealth Group, a parent company of UnitedHealthcare, initiated a program to pay a related business provider group, OptumCare Network, a fixed percentage of its Medicare Advantage premiums for care and care coordination. A payment structure like this in which a provider receives a set amount to care for each patient is often called a "capitated" payment model. This resulted in a significant increase in non-claims spending because capitated payments are included in the non-claims category for cost growth benchmark reporting. Additionally, because of UnitedHealthcare's 46% market share in Connecticut's Medicare Advantage market, its sharp cost growth significantly influenced overall market trends.

Payer and Advanced Network Performance

In addition to measuring spending at the statewide and market level, the Cost Growth Benchmark program also measures how payers (such as health insurers) and large provider organizations (referred to as Advanced Networks) perform against the benchmark. Each of these entities plays a role in the healthcare system, including by negotiating reimbursement rates.

Payer Performance

All commercial and Medicare Advantage payers exceeded the 2.9% cost growth benchmark.

- **Commercial Market**: All five commercial payers evaluated (Aetna, Anthem, Cigna, ConnectiCare, and UnitedHealthcare) exceeded the 2.9% benchmark in 2023, with spending growth ranging from 4.8% to 7.2%.
- **Medicare Advantage Market**: All four participating Medicare Advantage payers (Aetna, Anthem, ConnectiCare, and UnitedHealthcare) exceeded the benchmark, with spending growth ranging from 7.6% to 35.9%. As described above, UnitedHealthcare and Aetna saw particularly high spending increases of 35.9% and 30.5%, respectively.

Advanced Network Performance

Because data validation with some specific Advanced Networks is on-going, OHS is reporting aggregate data on Advanced Networks in this report. In initial analyses nearly all Advanced Networks in Connecticut exceeded the benchmark across commercial, Medicare Advantage, and Medicaid markets. A full supplemental report on Advanced Network Performance will be published later in 2025.

These data underscore the growing challenge Connecticut faces in meeting its cost growth benchmark and keeping healthcare costs at an affordable level for CT residents. Though it came close in 2022, Connecticut has failed to meet its cost growth benchmark at the state level each year since it was established. While the Cost Growth Benchmark Program has improved transparency, the findings highlight structural issues in the state's healthcare system, including rising hospital outpatient spending without concomitant reductions in other areas, and prescription drug costs. In addition, the complexity of emerging payment models between insurers and related provider organizations has the potential to decrease transparency in healthcare. These trends may exacerbate affordability concerns for residents and further strain public and private budgets.

Introduction

In January 2020, Governor Lamont signed Executive Order #5, directing the Office of Health Strategy (OHS) to establish a healthcare cost growth benchmark —a directive later codified into law during the 2022 legislative session under Connecticut General Statute § 19a-754g et. seq. Healthcare benchmark initiatives in Connecticut and in other states were developed in response to rising healthcare costs impacting residents, businesses, state, and municipal budgets across the U.S. The goal of these benchmarks is to slow the growth of healthcare spending and make healthcare more affordable for state residents. OHS regularly solicits input from its Steering Committee, other state advisory bodies, and legislators.

In 2020, an Office of Health Strategy (OHS) advisory body recommended the adoption of a 2023 cost growth benchmark of 2.9%. This benchmark was based on a 20/80 weighting of the projected growth in Connecticut's Potential Gross State Product (PGSP) and in Connecticut's median household income. These indicators were used to set targets to limit healthcare spending growth to levels in line with economic and household income growth, with the aim of improving healthcare affordability for families. An upward adjustment to the benchmark was implemented for 2021 and 2022 to ease the transition for payers and provider organizations; for 2023, the benchmark was set at 2.9%.

The Benchmark Program measures growth in the three largest markets: the commercial market, which includes all fully- and self-insured health insurance plans sold in Connecticut; the Medicaid market; and the Medicare market, which includes traditional Medicare (Medicare Fee-for-Service) and Medicare Advantage plans. These three markets capture approximately 94% of Connecticut residents with health coverage.[1]

[1] KFF. (n.d.). Health Insurance Coverage of the Total Population. Health Insurance Coverage of the Total Population. Retrieved February 24, 2025, from https://www.kff.org/other/state-indicator/total-population/

This report emphasizes growth in the commercial market as state policymakers cannot significantly impact the Medicare Advantage market and Medicaid per capita cost growth is consistently modest.

Connecticut In Context

According to national health expenditure data, Connecticut had the 9th highest per capita healthcare spending in the nation in 2020.[2] Connecticut residents with private health insurance had the 5th highest spending nationally compared to their counterparts in other states. Those with Medicare coverage had the 9th highest rate of spending in the country. Connecticut Medicaid spending per enrollee fell below the national average.

An analysis of publicly available data from five states with cost growth targets (Connecticut, Delaware, Massachusetts, Oregon, and Rhode Island) shows that Connecticut had the second highest rate of commercial market spending growth from 2019 to 2022, a cumulative increase of 17.5% over the three-period.

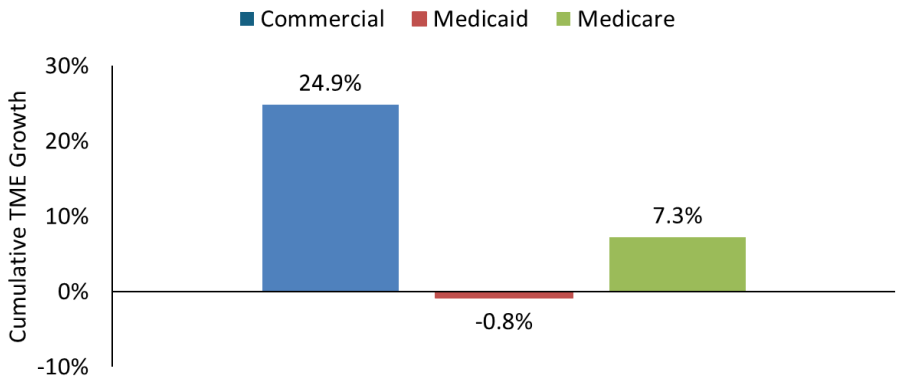
Unlike its neighboring New England states, Connecticut's commercial and Medicare Advantage markets are dominated by several national insurers, including Aetna Health and Life, Anthem, Cigna, Molina Healthcare (owner of ConnectiCare), and UnitedHealthcare. While there may be advantages for employers and others who work with these large carriers, it can also pose a challenge when working to implement state-specific policy solutions to rising costs. Efforts such as aligning measure sets and other business practices with market standards, or customizing plan designs, care coordination, and data sharing practices which may aid in payment and delivery system reforms to lower costs can be challenging to coordinate with large national payers.

[2] Centers for Medicare and Medicaid Services. (n.d.). NHE State (Residence) tables [Internet]. Retrieved March 7, 2025, from https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence

Since the establishment of the cost growth benchmark, commercial market spending has soared (see Figure 1) In contrast, spending growth in the Medicare and Medicaid markets has been relatively low.

Although state policy makers have some tools available to constrain growth in the commercial and Medicaid markets, the cooperation of payers and providers is instrumental to success. The ability of state policy makers to constrain growth in the Medicare market is limited.

Figure 1 - 2019-2023 Cumulative Per Capita TME Growth by Market



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.

Over 40% of Connecticut residents rely on commercial health insurance (see Figure 2), with more than half of these individuals covered under self-insured plans. Due to the federal Employee Retirement Income Security Act, the state generally cannot regulate self-insured plans. This Healthcare benchmark report may understate the commercial market membership because some smaller insurers do not meet OHS' threshold for reporting, and Anthem and United do not report some self-insured data to OHS. In total, Benchmark data covers spending for almost 90% of Connecticut lives, when compared against the total 2023 population as reported by the U.S. Census Bureau. Among commercial payers, Anthem has the largest market share of reported lives. About 32% of all lives are covered by Medicaid. Additionally, slightly more than half of Medicare beneficiaries are enrolled in Medicare Advantage, administered by private insurers, rather than Medicare Fee-for-Service (FFS), administered by CMS.

Data Sources and Methodology

OHS collects two types of data from payers: Cost Growth Benchmark submissions and claims data from the All-Payer Claims Database (APCD).

Cost Growth Benchmark Data

Payers submit aggregate total medical expense data for the Benchmark program which are used to calculate performance against the benchmark. OHS collects these data annually from payers by market, which includes commercial (fully insured and some self-insured), Medicaid, and Medicare (Medicare Advantage and Fee for Service) and by Advanced Network. The data include costs associated with administering private health insurance (called the net cost of private health insurance, or NCPHI).

The data are provided in broad service categories (Table 1) to determine areas of spending that are driving healthcare cost growth. For each category, OHS receives aggregate spending for each year of the two-year benchmark period (2022 and 2023 for this report) and calculates the year-over-year increase on a per person basis.

Table 1 - Types of Payment for Connecticut's Healthcare Benchmark Program, by Service Category

Claims	Non-Claims
• 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

A description of these claim service categories is available in the OHS Benchmark Implementation Manual.

These data are (1) adjusted for one-year differences in the population's age and sex and (2) truncated for high-cost outliers (i.e., OHS excludes very high spending on individual members) at the payer and Advanced Network level. This means that for a given year, data is adjusted for variations in the age and sex of a payer's population mix and that random variation in high-cost members will not adversely impact a payer's or Advanced Network's performance against the benchmark. The truncation point generally varies between approximately $150,000 and $250,000 per member based on the type of insurance and claim (called an "insurance category" in the implementation manual, this differentiates between Medicare and Medicaid dual or non-dual eligible members and between full and partial claims in commercial insurance coverage). Claim dollars above these levels are excluded.

All payer-submitted data undergo a validation process at the payer, market, and advanced network level to ensure consistency in spending and membership. More information on OHS's methodology, data use, and data validation is available on the Healthcare Benchmark Data Transparency webpage.

Payer spending data is supplemented by other data from the state, the federal government, and from publicly available regulatory reports. Thus, THCE also includes student health plans; state employees, retirees, and some municipalities; individuals covered by the Veterans Health Administration (VHA); and those residing in a state correctional facility.

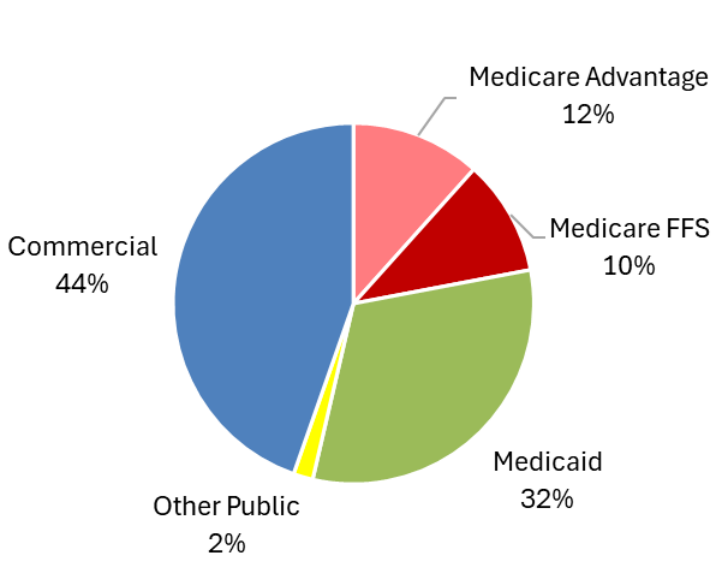
All Payers Claim Database Data

OHS reviews the benchmark data described above for spending drivers and then also analyzes claims level data to uncover actionable trends. This year, Sections 4 and 5 of this report provide a deeper dive into pharmacy and hospital spending, respectively.

To analyze spending drivers at the claims level, OHS uses the APCD, which is a database of over 1 billion health records collected from insurers, the state and the federal government and represents approximately 55% of the

commercially covered lives in Connecticut and almost 70% of the total state population. It includes medical claims, pharmacy claims, and enrollment data. However, the APCD does not include non-claims payments (e.g., capitated payments), some drug manufacturer rebates, or insurance costs. The APCD includes data from the commercial fully insured market; some self-insured employers; state employees and retirees; municipal employees in the State Partnership 2.0 plan; Medicaid; and Medicare (Medicare Advantage, excluding Medicare Fee-For-Service). More information about what data OHS collects and how they are used is available on the Healthcare Benchmark Data Transparency webpage.

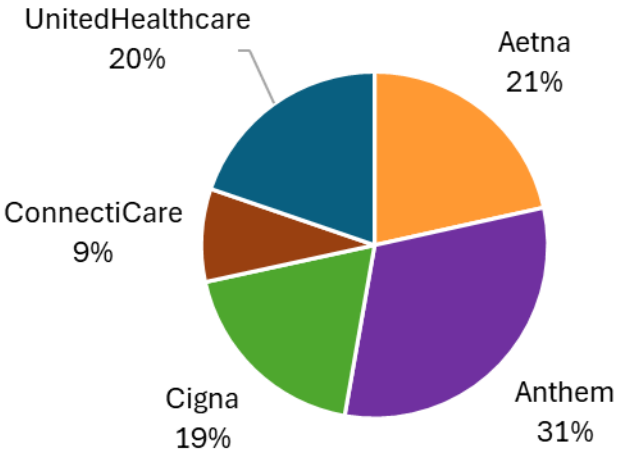
Figure 2 - 2023 Connecticut Health Insurance Membership by Market



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). Dual eligible members are included within the Medicare population.

The Cost Growth Benchmark Initiative collects data from the largest private insurers in the commercial and Medicare Advantage markets, Medicare FFS, the Department of Health and Human Services, the Department of Corrections, and Veterans Health Affairs. However, it does not collect data on uninsured individuals and does not contain complete data for self-insured plans administered by large private insurers.

Figure 3 - Connecticut Commercial Insurance Market Membership by Payer



Source: OHS collected data from insurance carriers.

Impact

About 90% of commercial market lives are covered under employer sponsored health insurance, with most of these in self-insured plans According to the Connecticut Insurance Department's 2023 Consumer Report Card on Health Insurance Carriers in Connecticut, about 5% of people in the commercial market are covered by fully or self- insured small group plans, and over 85% are covered by fully or self- insured large group plans. Employer-sponsored plans remain the most common form of commercial coverage in the United States and the largest by membership size in Connecticut. The sharp rise in spending in the commercial market can impact consumers in different ways, including potentially higher health insurance premiums for employers and employees or higher out-of-pocket costs for healthcare. As OHS' recent Connecticut Healthcare Affordability Index shows, as healthcare spending increases, families have less available income for other necessities.

Data published by the Agency for Healthcare Research and Quality (AHRQ), derived from their Medical Expenditure Panel Survey (MEPS), show that employers are increasingly passing on the cost of healthcare to their employees. In Connecticut, the average family deductible has risen sharply, increasing from $898 in 2002 to $4,094 in 2023—more than quadrupling over this period.[3] During the same time frame, employees have also taken on a larger share of premium costs. Since 2002, employee contributions to premiums have grown from 22% to 30% of the total premium by 2023. This burden is further compounded by the significant rise in average family premiums, which have increased from $9,047 in 2002 to $25,529 in 2023. On average, employees contributed $7,653 toward the total premium, accounting for approximately 8% of the median household income in 2023.[4]

Lower-income families bear the heaviest burden of high healthcare costs; more than 50% of Connecticut residents with an annual income below $75,000 reported delaying or forgoing care due to costs.[5] Additionally, over 40% of these residents have incurred medical debt, depleted their savings, or sacrificed basic needs to pay medical bills. Racial and ethnic minorities, as well as individuals with disabilities or those in households with a family member with a disability, face higher financial hardships due to healthcare costs and barriers accessing care.[6]

The pace of commercial market spending growth places not only a significant burden on consumers and employers, but also on the broader

[3] Agency for Healthcare Research and Quality. (2024). MEPS-IC Data Tools – Medical Expenditure Panel Survey (MEPS) Insurance Component (IC). https://datatools.ahrq.gov/meps-ic/

[4] U.S. Census Bureau. (2025, January 30). QuickFacts: Connecticut. https://www.census.gov/quickfacts/fact/table/CT/INC110223

[5] Healthcare Value Hub. (2022). Connecticut Residents Bear Healthcare Affordability Burdens Unequally; Distrust of/Disrespect by Healthcare Providers Leads Some to Delay/Go Without Needed Care (134). https://www.healthcarevaluehub.org/advocate-resources/publications/connecticut-residents-bear-healthcare-affordability-burdens-unequally-distrust-disrespect-healthcare-providers-leads-some-delayg

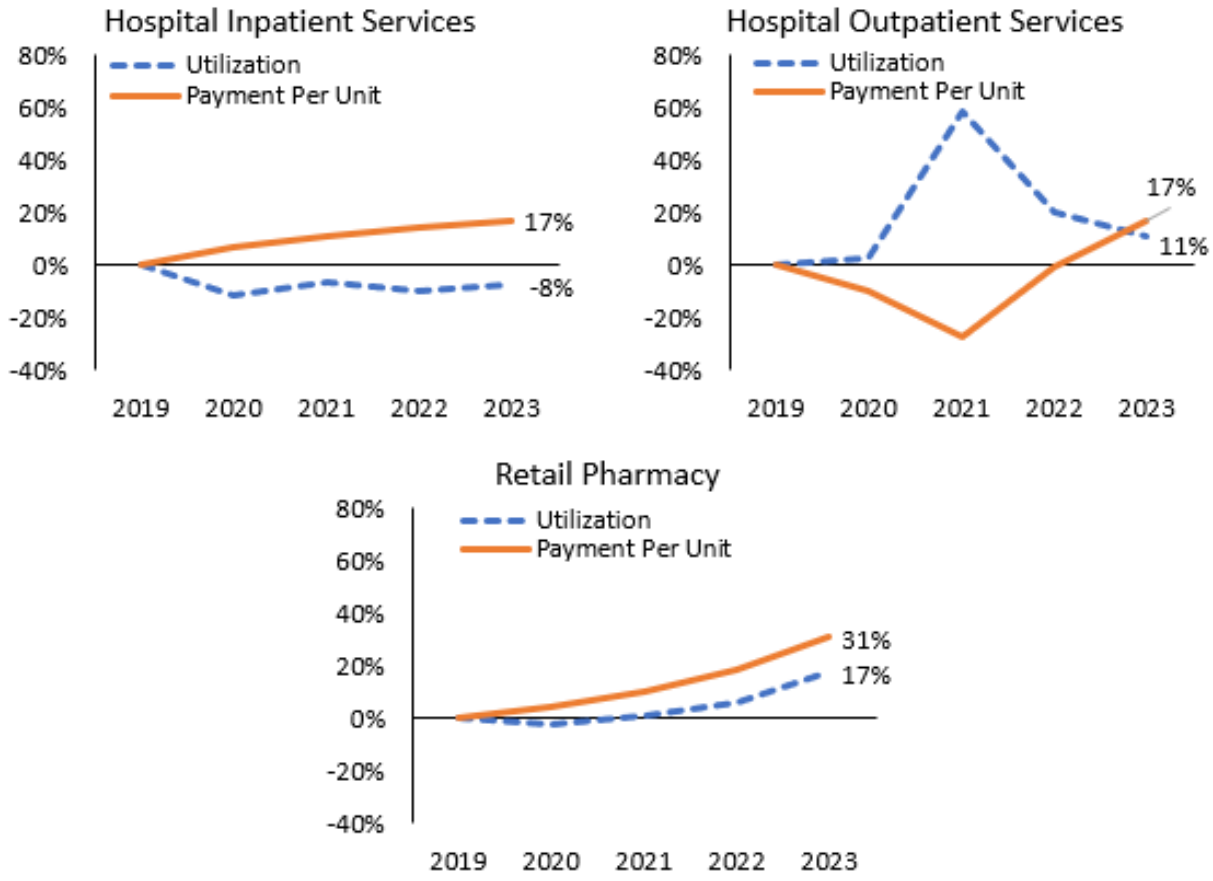
[6] See footnote 4.

state economy. For example, hospital price increases have been associated with declines in income, reductions in tax revenues, and job losses.[7]

Growth in healthcare spending can be driven by rising payments per service, increasing utilization, or a combination of the two. Since 2019, increases in payments per service have been the primary driver of spending growth for hospital inpatient and outpatient services, as well as for retail pharmacy, in the commercial market. An analysis of the All-Payer Claims Database (APCD) shows that payments made for hospital inpatient services, hospital outpatient services, and retail pharmacy increased by 17%, 17% and 31%, respectively, from 2019 to 2023 (see Figure 4). For hospital outpatient services and retail pharmacy, spending growth was further elevated by increases in utilization.

[7] Zarek Brot-Goldberg, Zack Cooper, Stuart Craig, Lev Klarnet, Ithai Lurie, & Corbin Miller. (2024, December). Who Pays For Rising Health Care Prices? Evidence from Hospital Mergers. Tobin Center for Economic Policy. https://tobin.yale.edu/research/who-pays-rising-health-care-prices-evidence-hospital-mergers

Figure 4 - Cumulative Growth in Commercial Market Utilization, Unit Payments, and Per Member Per Month Spending, Select Categories (2019-2023)



Source: Connecticut All-Payer Claims Database.

Introduction

This report presents the results of OHS' analysis of the 2022 and 2023 spending data collected under the Cost Growth Benchmark Program.

- Section 1: 2022-2023 Growth in Connecticut Healthcare Spending by Market presents market-level performance against Connecticut's 2023 cost growth benchmark of 2.9%, along with the aggregate state spending trend.
- Section 2: 2022-2023 Growth in Healthcare Spending by Insurance Carrier and Market describes payers' benchmark performance by insurance market.
- Section 3: 2022-2023 Growth in Healthcare Spending by Advanced Network and Market describes Advanced Network benchmark performance by insurance market.
- Section 4: Special Focus Pharmacy Spending assesses retail and medical pharmacy spending, identifying key drivers behind pharmacy spending growth.
- Section 5: Special Focus Hospital Spending examines trends in hospital spending, utilization of services, and prices.

Section 1: 2022-2023 Growth in Connecticut Healthcare Spending by Market

OHS annually collects and analyzes data from payers on healthcare spending in the state to assess the Connecticut healthcare system's performance against the benchmark. This section reviews 2023 insurance market and state performance relative to the spending growth benchmark. It also explores 2023 healthcare spending trends and cost drivers, drawing on OHS's annual cost growth data.

OHS reports results against the benchmark for Total medical expenses (TME) and Total Healthcare Expenditures (THCE). Broadly, TME represents the total cost of care for a patient population in a calendar year, including claims-based spending, patient cost sharing, and nonclaims payments (such as quality incentive payments). THCE represents TME plus the "net cost of private health insurance" (NCPHI), which is the cost to Connecticut residents of administering private health insurance (such as administrative costs, commissions, and profit).

At the market level, OHS assesses performance against the benchmark using TME. TME includes spending on behalf of Connecticut residents who are covered by Medicare (Fee-for-Service Medicare or Medicare Advantage), Medicaid, or commercial carriers; or who receive coverage from self-insured employers. TME includes spending on behalf of Connecticut residents who receive care from any provider, in or outside of Connecticut. OHS uses TME for this assessment at the market level rather than THCE because THCE includes NCPHI, which varies from year to year. Further, OHS focuses on trends in medical spending, rather than administrative spending trend, at the market, insurance carrier, and Advanced Network levels, as medical spending constitutes the great majority of THCE.

State Total Medical Expenditure Trends

The statewide, Medicare market, and commercial market total medical expenses (TME) for 2023 were all above the 2.9% benchmark. Medicare Advantage was the largest contributor to state-level spending growth, followed by the commercial market. Only the Medicaid market was below the benchmark for 2023.

Commercial spending, representing 1.4 million lives, increased by 6.2% to $8,625 per member per year in 2023 (see Figure 4). Commercial market enrollment increased by 2.0% in 2023. This contrasts with the downward trend in membership seen from 2020 to 2022.

The COVID-19 Pandemic may have shifted healthcare market spending

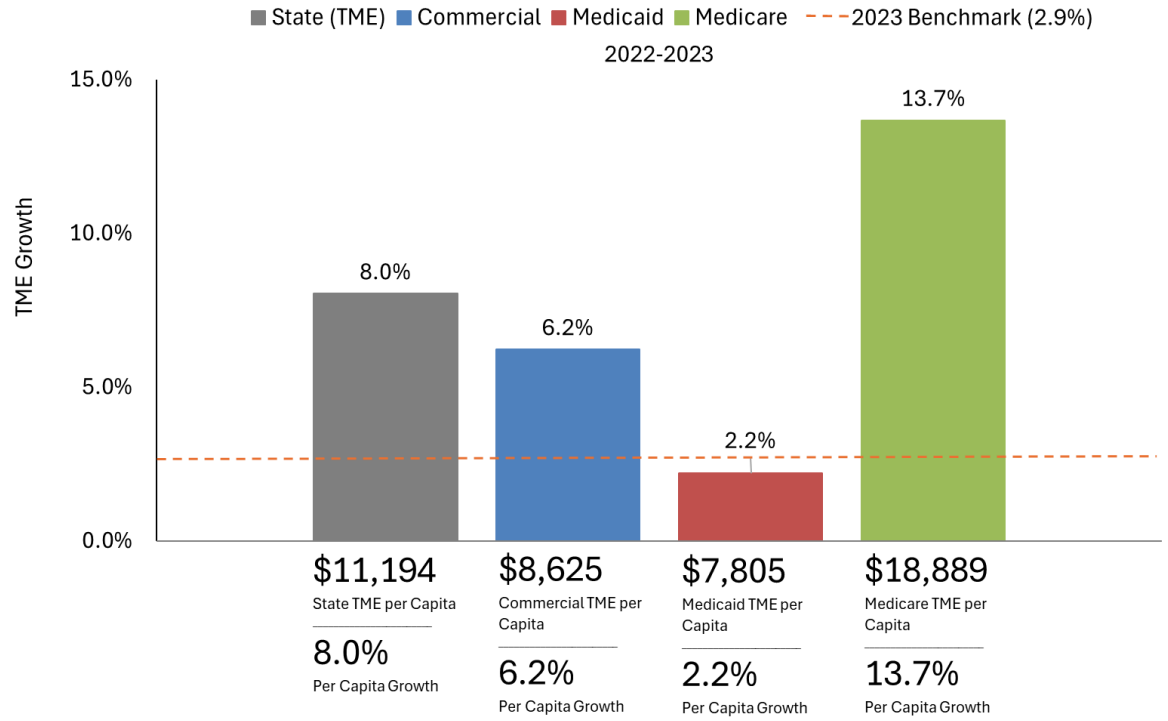
The COVID-19 Public Health Emergency (PHE) unwinding, or resumption of Medicaid redeterminations, began in 2023, which may have impacted the overall trend. We surmise that PHE unwinding had an upward impact on Medicaid spending trend in 2023 because those losing eligibility were more likely to have had commercial coverage along with Medicaid, which they were using to access services.

Medicaid per member per year spending, representing 1.2 million lives, increased by 2.2% to $7,805 in 2023 – the slowest growth of the three major markets. Medicaid enrollment during this period remained relatively steady at 0.4% growth.

Medicare per member per year spending, representing nearly 690,000 lives, **grew at the fastest pace of all markets in 2023, increasing 13.7% per capita (well above the 2.9% benchmark) to $18,899**. During this same period, Medicare enrollment increased by 2.4%. This increase in Medicare spending is far above Medicare trend in any prior year assessed by OHS. Anomalously, in 2023, Medicare was the largest contributor to state-level spending growth, followed by the commercial market.

Medicare was the largest contributor to state-level spending growth, followed by the commercial market.

Figure 5 - State Per Capita Total Medical Expense (TME) Growth and Spending (2022-2023)

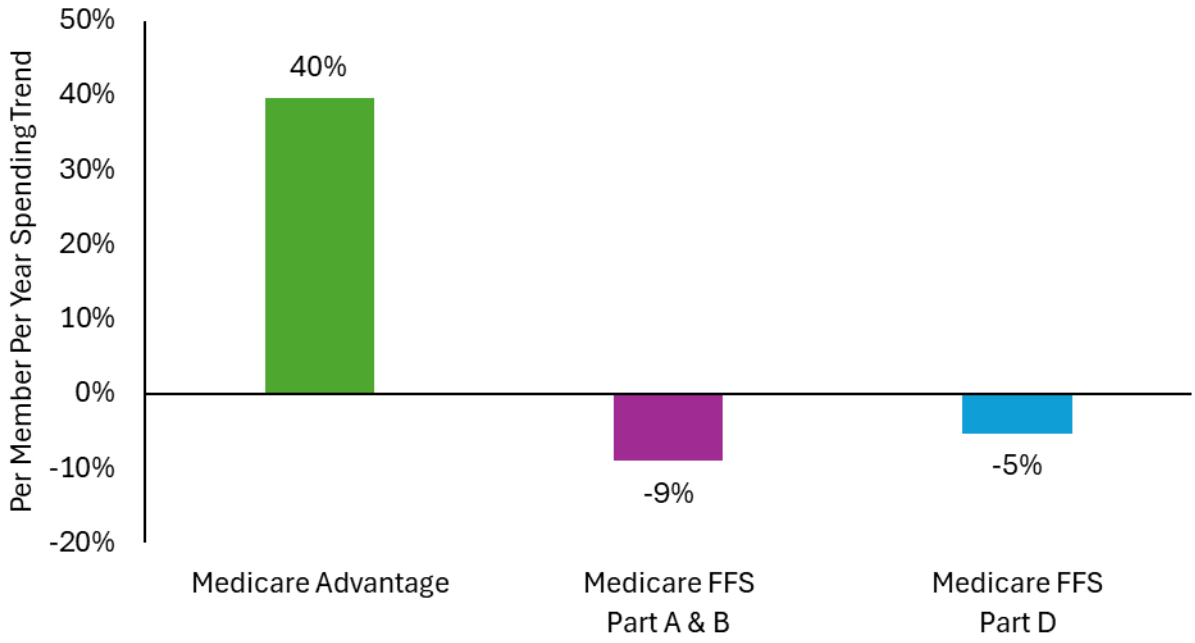


Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), and the Connecticut Department of Social Services (DSS).
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

Although Medicare per capita spending was the highest when looking at 2023 alone, cumulative per capita TME growth from 2019 to 2023 was higher in the commercial market than in either the Medicaid or Medicare markets (see Figure 1).

Additionally, from 2019-2023, Medicare Advantage plans—Medicare plans administered by insurers—experienced a per capita spending increase of almost 40% (see Figure 6). Meanwhile, Medicare FFS, administered by the Centers for Medicare and Medicaid Services, has seen a decrease in per capita spending since 2019. Medicare FFS includes Part A, Part B, and Part D, which correspond to hospital, medical, and pharmacy services, respectively.

Figure 6 - 2019-2023 Medicare Advantage and Medicare Fee-For-Service Cumulative Per Capita TME Growth (2019-2023)

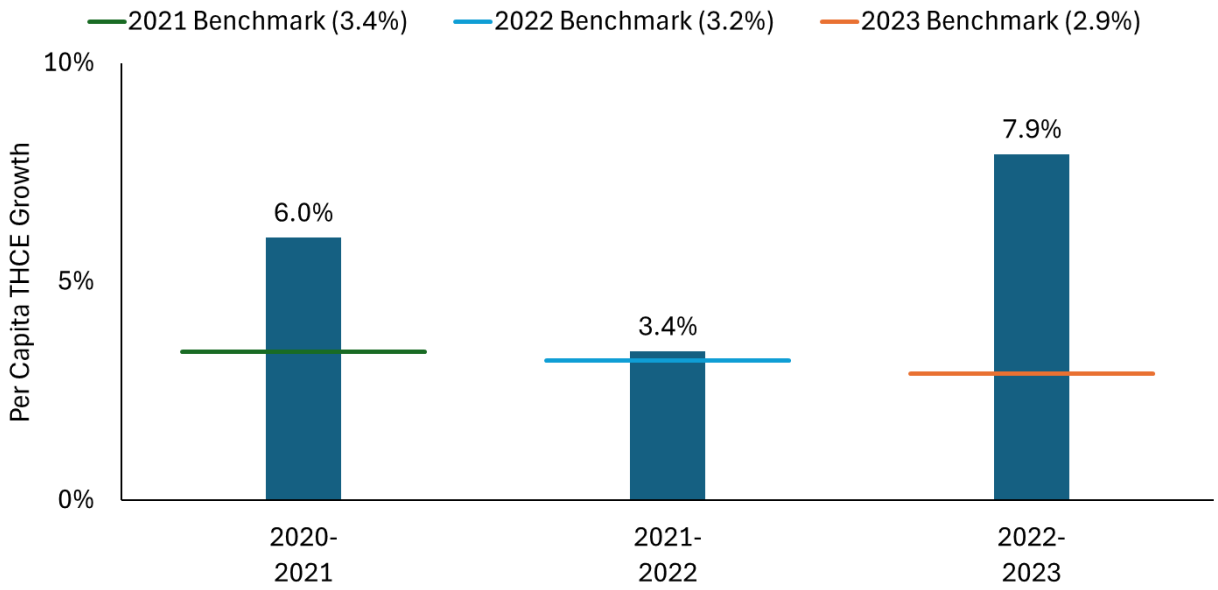


Source: OHS collected data from insurance carriers and the Connecticut Department of Social Services (DSS), and the Centers for Medicare and Medicaid Services (CMS). Cost Growth Benchmark Program 2019-2021, 2021-2022, & 2022-2023.
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

State's Total Healthcare Expenditure (THCE)

Per capita THCE exceeded the benchmark for the third year in a row in 2023, growing by 7.9% to $11,900 in per person spending, a rate more than twice as high as that in 2022 (see Figure 7). This year-over-year increase is the highest that Connecticut has seen since 2020 when reporting began, and higher than the increases seen after the initial impact of the COVID-19 pandemic. While it came close in 2022, Connecticut has failed to meet its cost growth benchmark at the state level in each year since it was established.

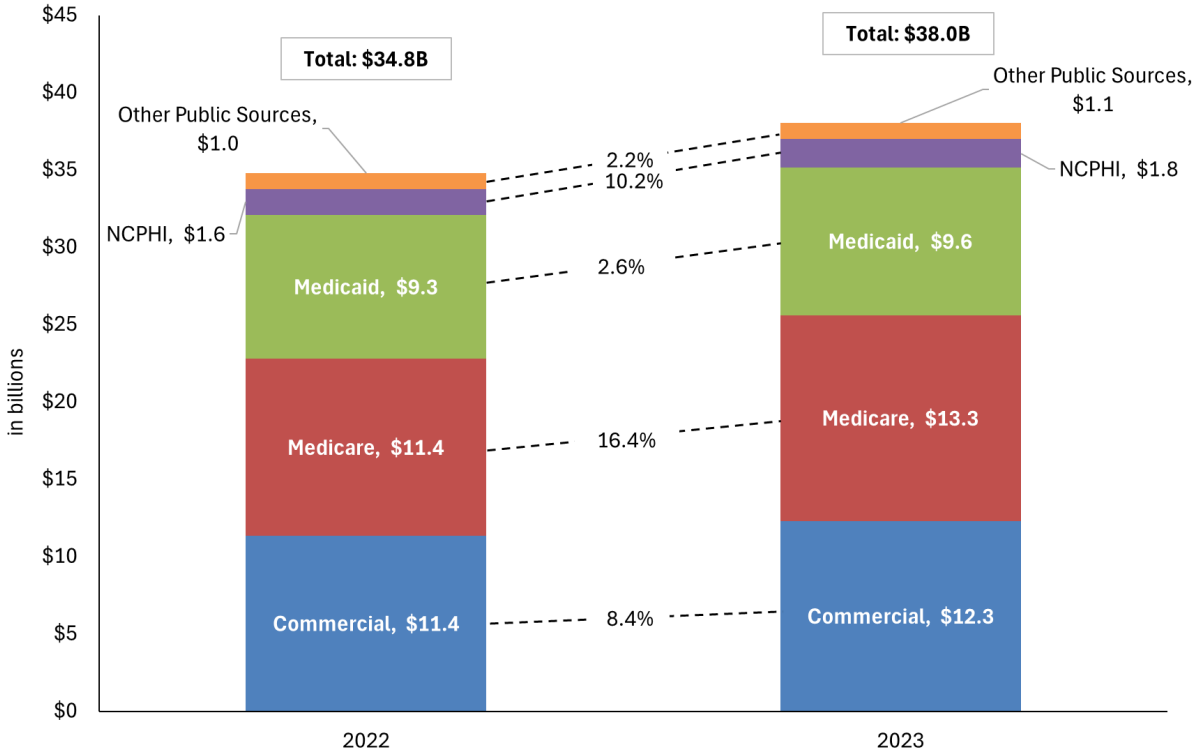
Figure 7 - State Per Capita Total Healthcare Expenditure (THCE) Growth (2020-2023)



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).

Aggregate statewide THCE totaled $38.0 billion in 2023, increasing 9.4% from 2022 when it was $34.8 billion (see Figure 8). Healthcare spending in the Medicare market accounted for 35.0% ($13.3 billion) of the state's total healthcare spending, whereas spending in the commercial market accounted for 32.4% ($12.3 billion) and on Medicaid accounted for 25.2% ($9.6 billion) of the state's total healthcare spending. Total spending on other public sources of healthcare, specifically the Department of Correction (DOC) and VHA, grew by an aggregate 2.2% to $1.1 billion.

Figure 8 - Aggregate State Total Healthcare Expenditures in billions (2022-2023)

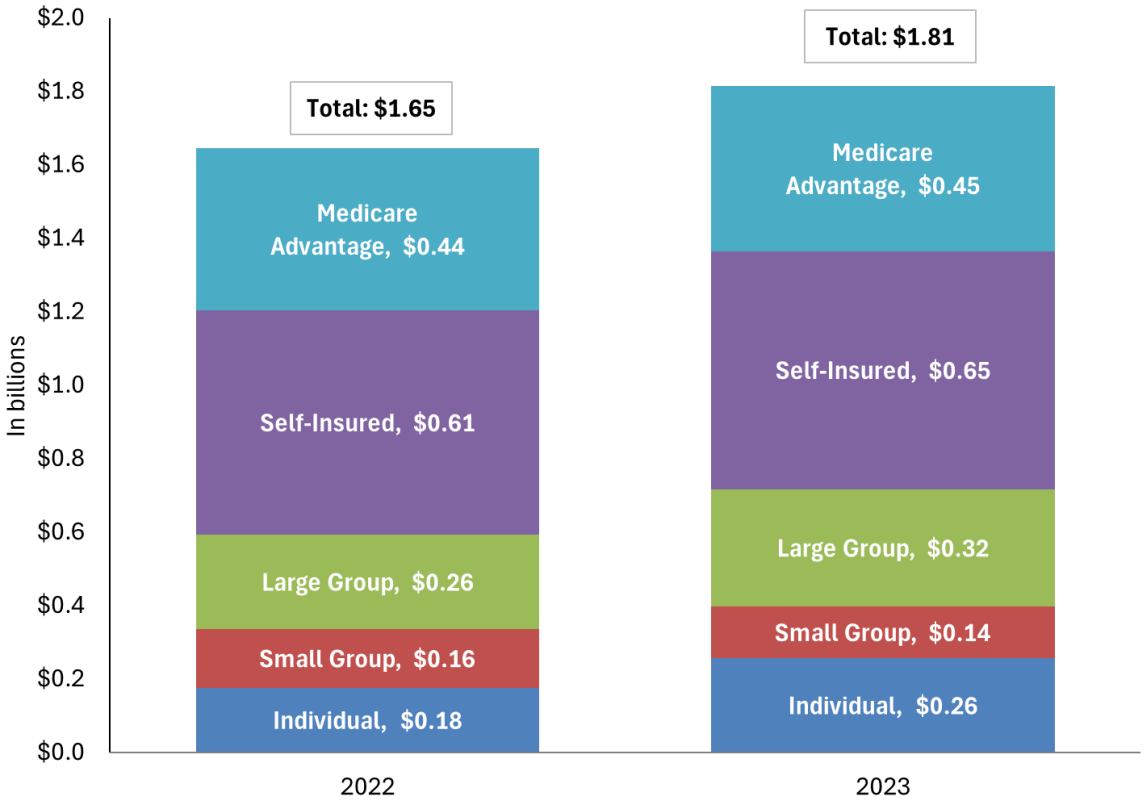


Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut Department of Correction (DOC), and the Veterans Health Administration (VHA).
Notes: Data are not risk-adjusted and data are reported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

Net Cost of Private Health Insurance (NCPHI)

NCPHI totaled $1.81 billion in 2023, accounting for 4.8% of total healthcare spending (see Figure 9). This is a 10.2% increase from 2022, when NCPHI totaled $1.65 billion. The growth in net administrative costs was primarily driven by the commercial individual and large group markets.

Figure 9 - Net Cost of Private Health Insurance (NCPHI) in Aggregate by Line of Business (in billions) (2022-2023)

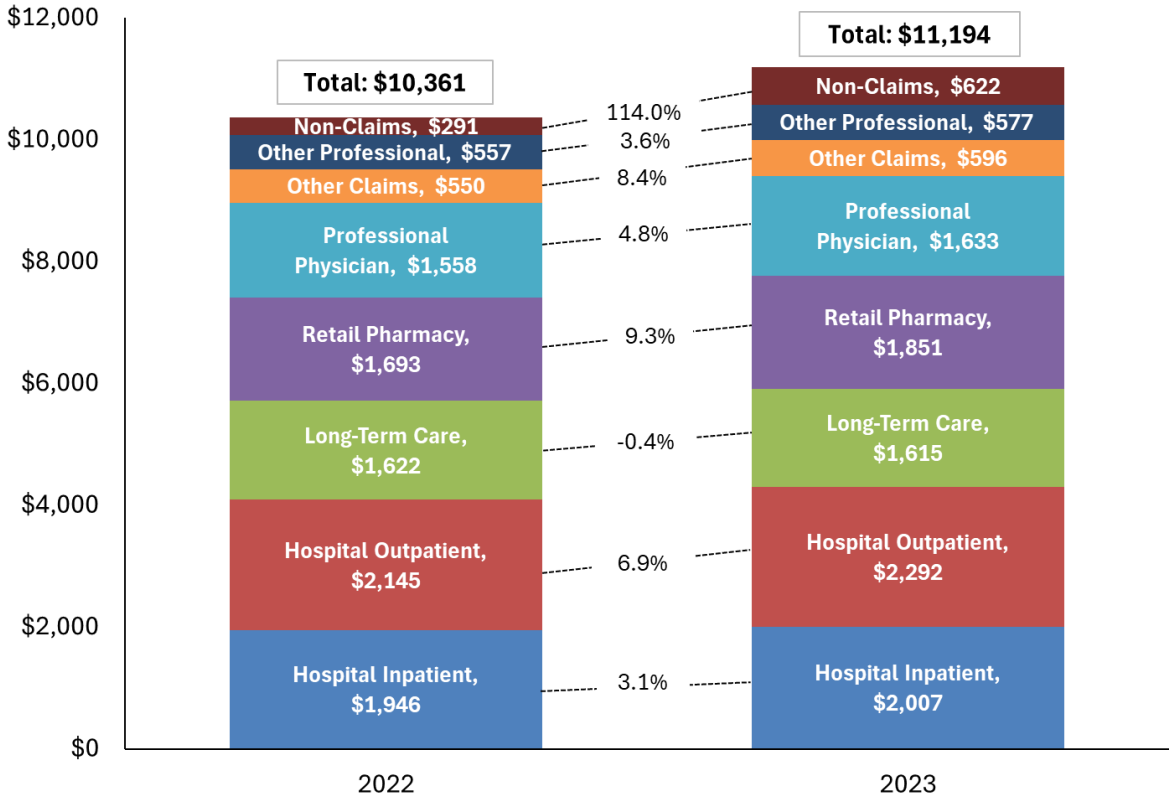


Source: OHS calculated NCPHI using data submitted from insurance carriers, regulatory reports and from public sources (i.e., Medical Loss Ratio data).

Statewide Spending Growth by Service Category

Non-claims spending had a substantial impact on 2023 statewide spending growth, mainly due to the increase in non-claims spending within Medicare Advantage, growing by 114% to $622 per member per year spending. As in 2022, retail pharmacy (net of rebates) and hospital outpatient spending had a significant impact on spending growth in 2023, growing 9.3% and 6.9% respectively. Pharmacy spending in 2023 was likely affected by the uptake of newly available Glucagon-Like Peptide-1 (GLP-1) drugs (GLP-1's, like Ozempic, have gained widespread attention for their effectiveness in treating obesity). The only service category to decline was long-term care, which decreased -0.4% to $1,615 (see Figure 10).

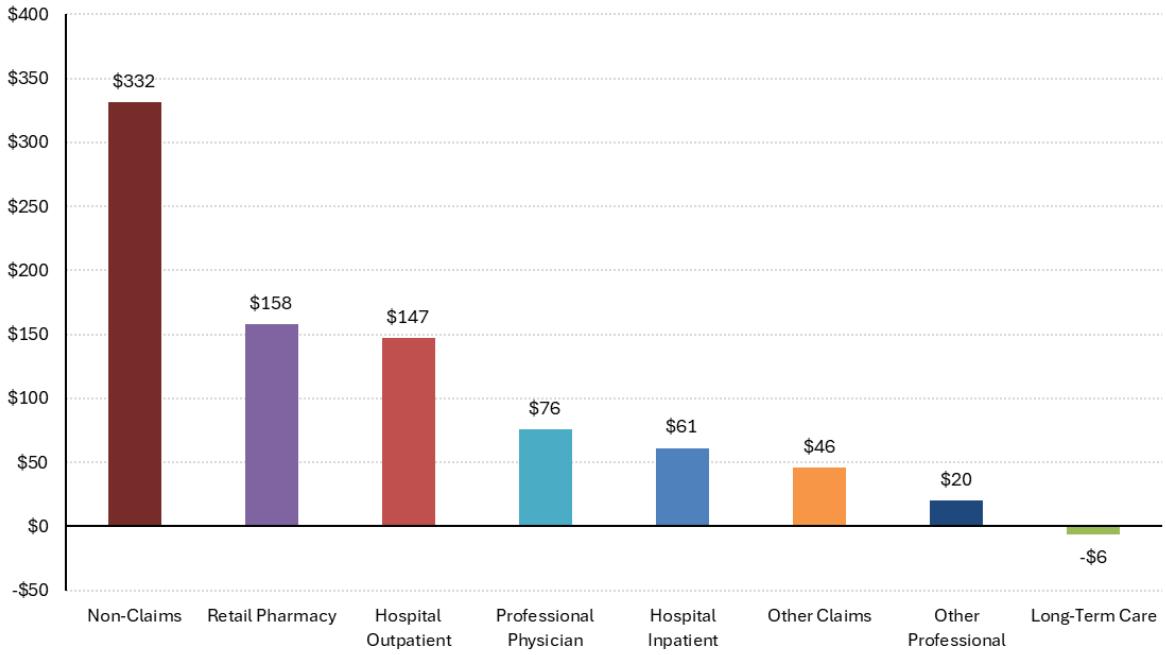
Figure 10 - Per Capita State TME by Service Category (2022-2023)



Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), and the Connecticut Department of Social Services (DSS).

The relative contribution of each healthcare service category to per person spending trend at the state level is presented in Figure 11. Non-claims spending saw the largest per capita increase, rising by $332 per person per year. Retail pharmacy and hospital outpatient spending also contributed significantly, increasing by $158 and $147, respectively.

Figure 11 – State Increase in Annual Per Capita Spend by Service Category (2022-2023)



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

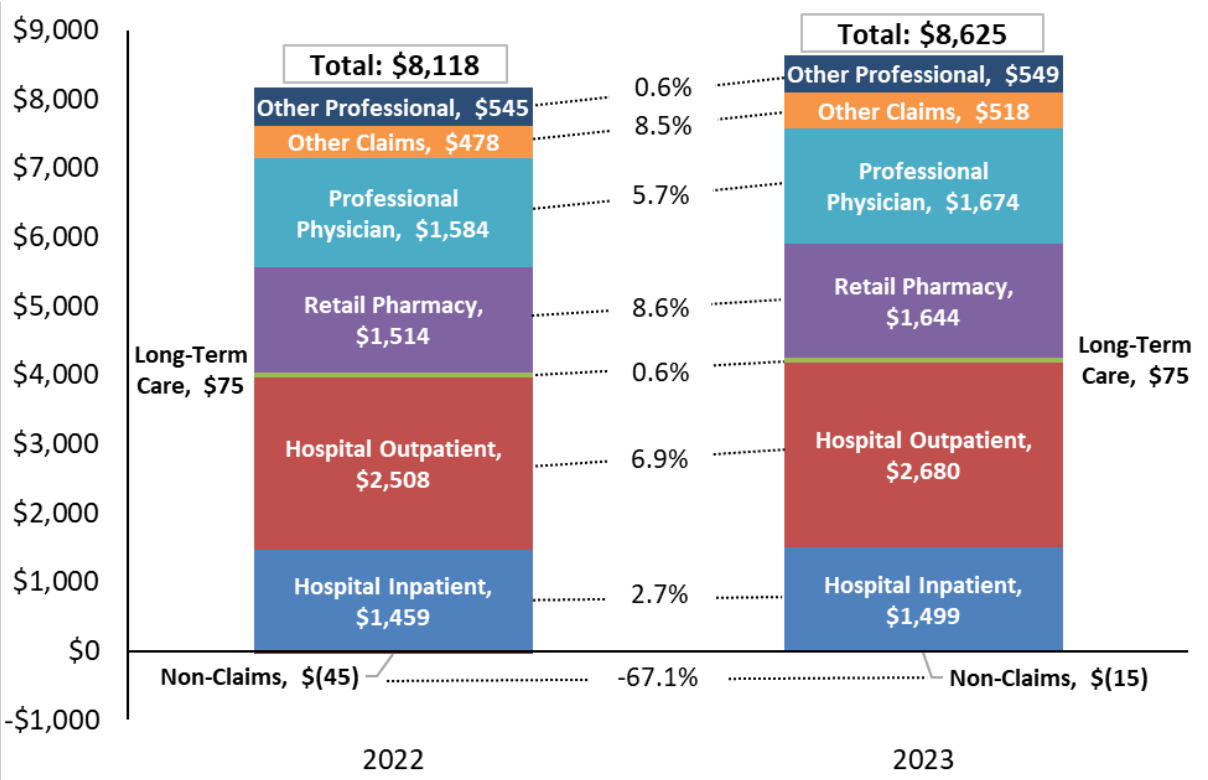
Spending Growth by Service Category by Market

Each market experienced a unique set of cost growth drivers in 2023, deviating from 2022 when hospital outpatient services and retail pharmacy largely drove spending growth across all markets.

Commercial Market Cost Drivers

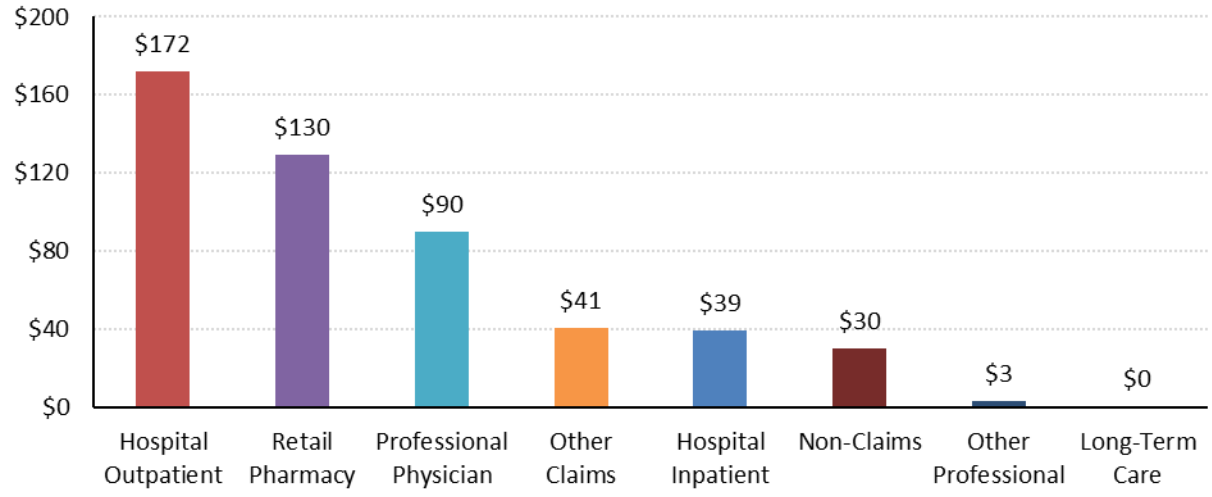
Similar to 2022, **commercial market** spending growth was driven by increases in retail pharmacy spending and hospital outpatient services which rose by 8.6% and 6.9% respectively (see Figure 11). Professional physician services also made a notable contribution to overall spending growth, increasing by 5.7%. On a per capita basis, hospital outpatient spending increased by $172 per year, the highest among all service categories (see Figure 12).

Figure 12 - Per Capita Commercial TME by Service Category (2022-2023)



Source: OHS collected data from insurance carriers.
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

Figure 13 - Commercial Market Increase in Annual Per Capita Spend by Service Category (2022-2023)



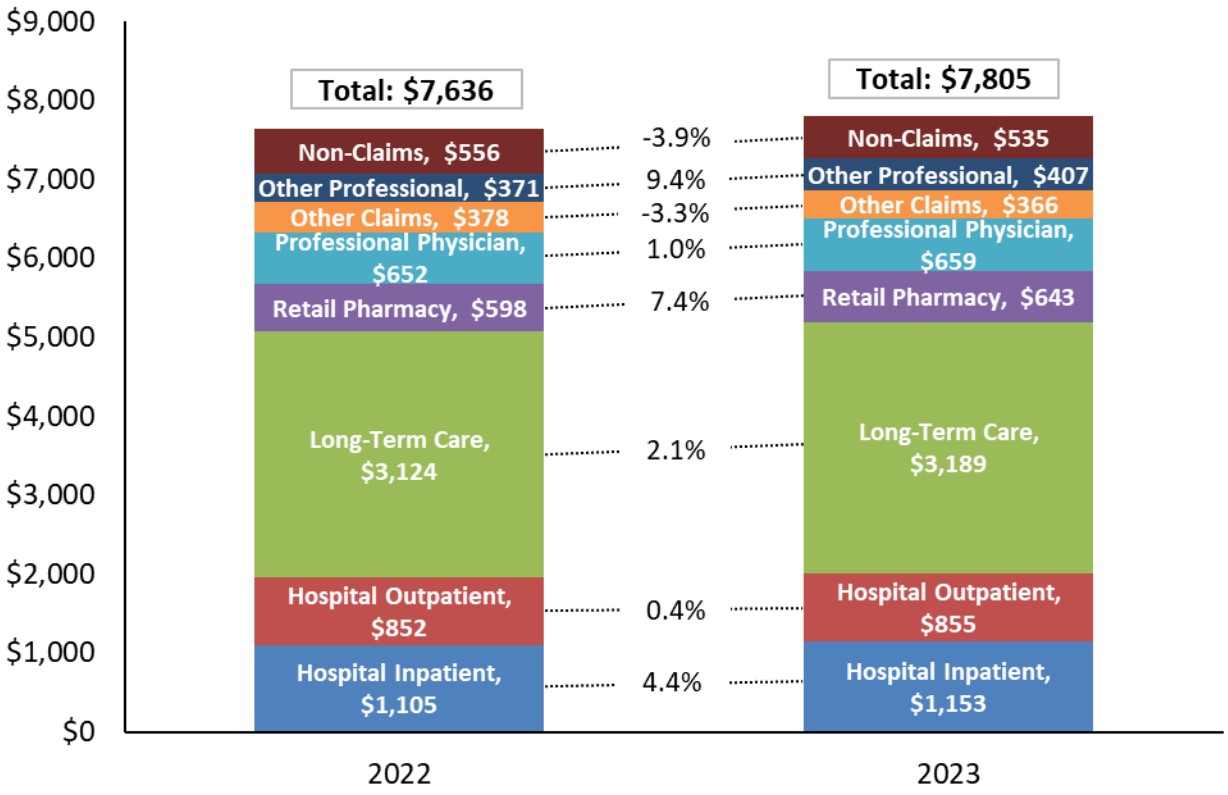
Source: OHS collected data from insurance carriers.
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

Medicaid Market Cost Drivers

While **Medicaid** spending growth was modest in 2023, it was higher than in prior years. Spending on other professional services (9.4%), retail pharmacy (7.4%), and hospital inpatient services (4.4%) all had notable increases in spending (see Figure 14).

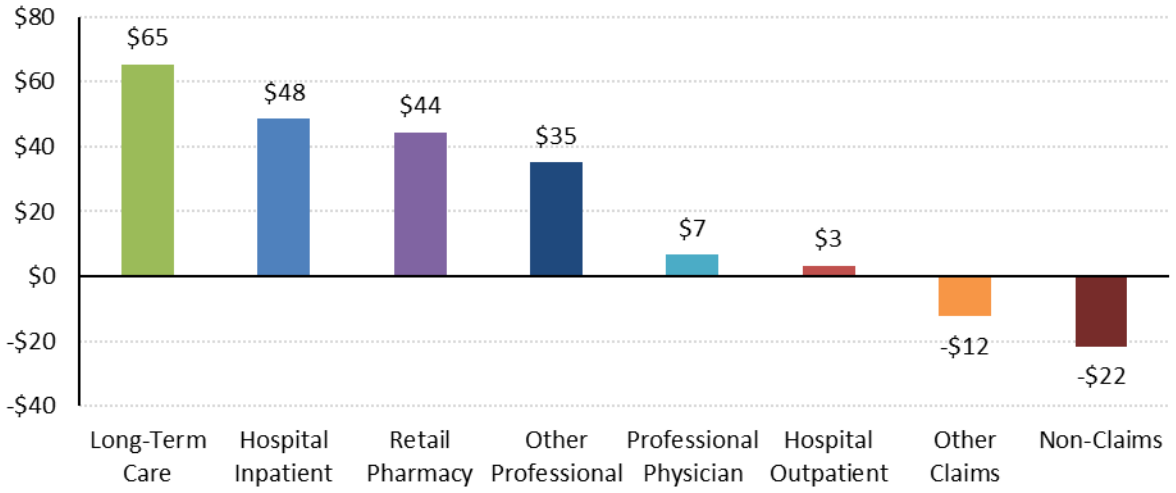
On a dollar basis, long-term care had the largest per capita spending impact, followed by hospital inpatient services and retail pharmacy (see Figure 15). Long-term care comprised about 41% of all Medicaid spending in 2023.

Figure 14 - Per Capita Medicaid TME by Service Category (2022-2023)



Source: OHS collected data from the Department of Social Services.
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

Figure 15 - Medicaid Market Increase in Annual Per Capita Spend by Service Category (2022-2023)



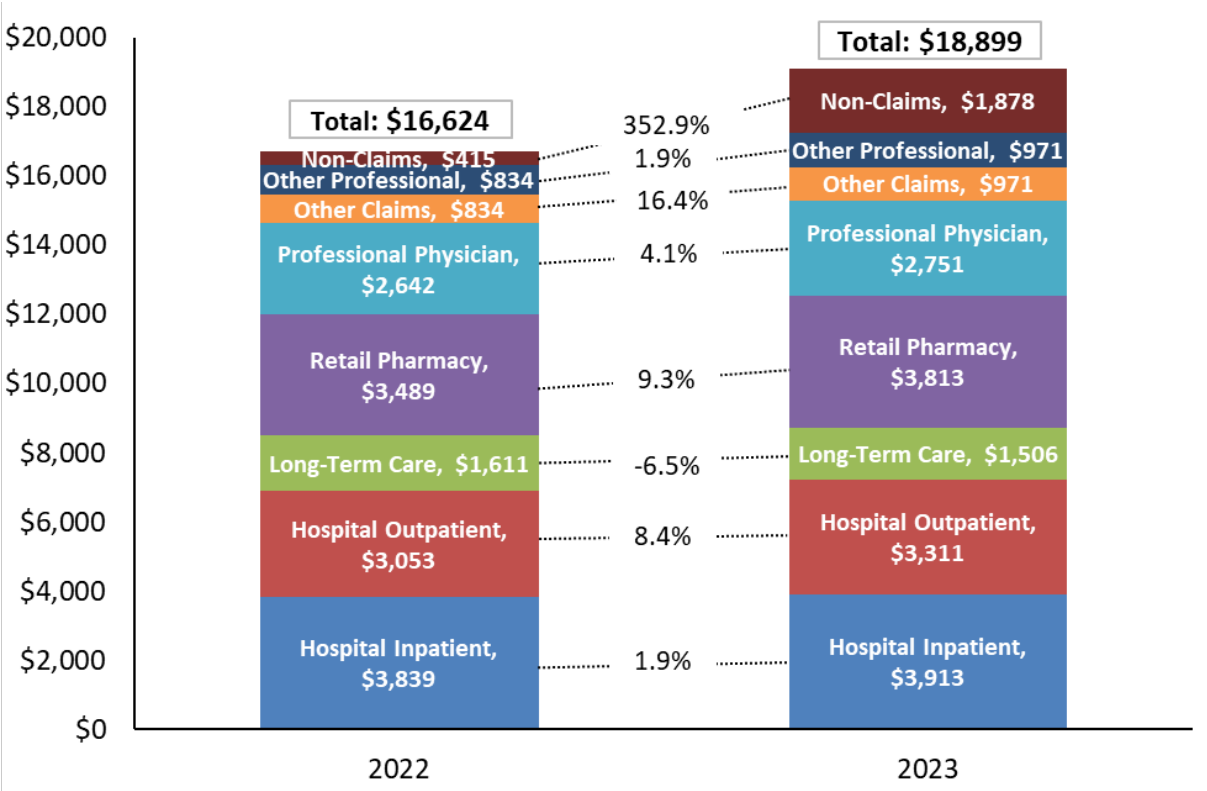
Source: OHS collected data from the Department of Social Services.
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

Medicare Market Cost Drivers

In the **Medicare market**, spending growth was largely driven by non-claims spending, which rose by 352.9% (see Figure 16). Most of this increase can be attributed to a single Medicare Advantage payer, UnitedHealthcare, and one provider contract that switched from fee-for-service to percentage-of-premium payment. Thus, spending that had previously fallen under claims service categories was directed towards non-claims spending. The data support this: UnitedHealthcare Medicare Advantage claims spending went down in almost every service category. However, the decrease in claims spending is relatively small compared to the growth in nonclaims spending, indicating that the switch to a new payment model is not the sole explanation for the high Medicare Advantage growth.

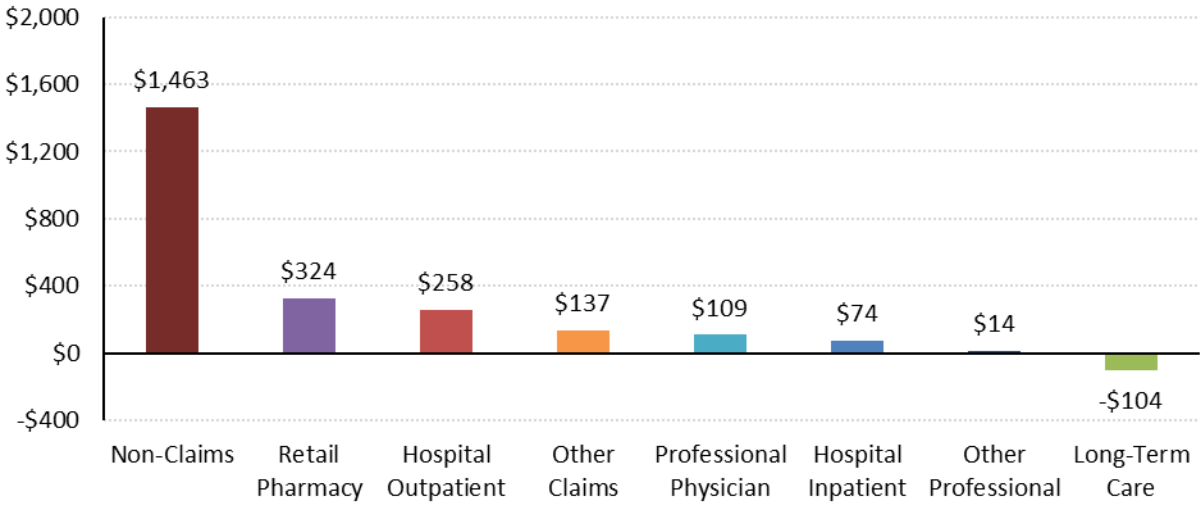
Retail pharmacy and hospital outpatient services also saw substantial increases, with per capita spending rising by $324 and $258 year-over-year, respectively (see Figure 17).

Figure 16 - Per Capita Medicare TME by Service Category (2022-2023)



Source: OHS collected data from insurance carriers and the Centers for Medicare and Medicaid Services.
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

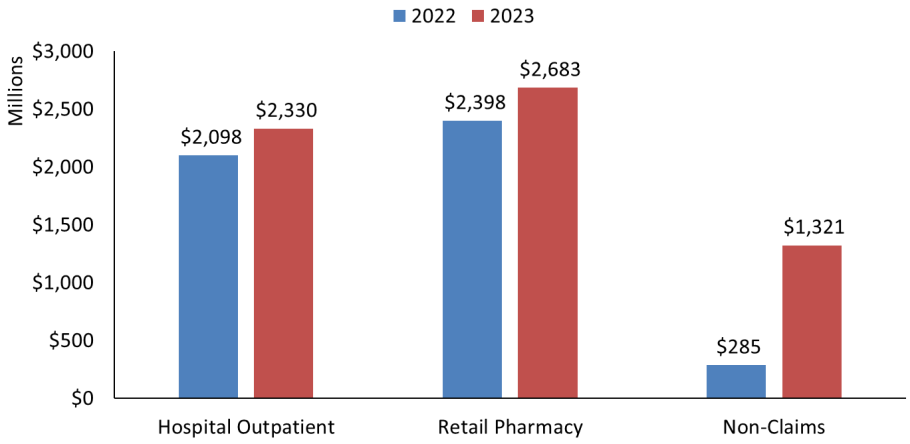
Figure 17 - Medicare Market Increase in Annual Per Capita Spend by Service Category (2022-2023)



Source: OHS collected data from insurance carriers and the Centers for Medicare and Medicaid Services.
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates.

As shown in Figure 18, while spending growth in hospital outpatient and retail pharmacy was large, the growth was significantly larger in non-claims spending.

Figure 18 - Medicare Spending in Aggregate by Select Service Categories (2022-2023)



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

Section 2: 2022-2023 Growth in Healthcare Spending by Insurance Carrier and Market

Commercial Carriers' 2022-2023 Performance Against the Benchmark

OHS collected data from five carriers for the commercial market: Aetna Health and Life (Aetna), Anthem Blue Cross and Blue Shield (Anthem), Cigna, ConnectiCare, and UnitedHealthcare. The percentage of covered lives each carrier represents for the commercial market is shown in Table 2.

Table 2 - Percentage of covered lives by carrier, commercial market (2023)

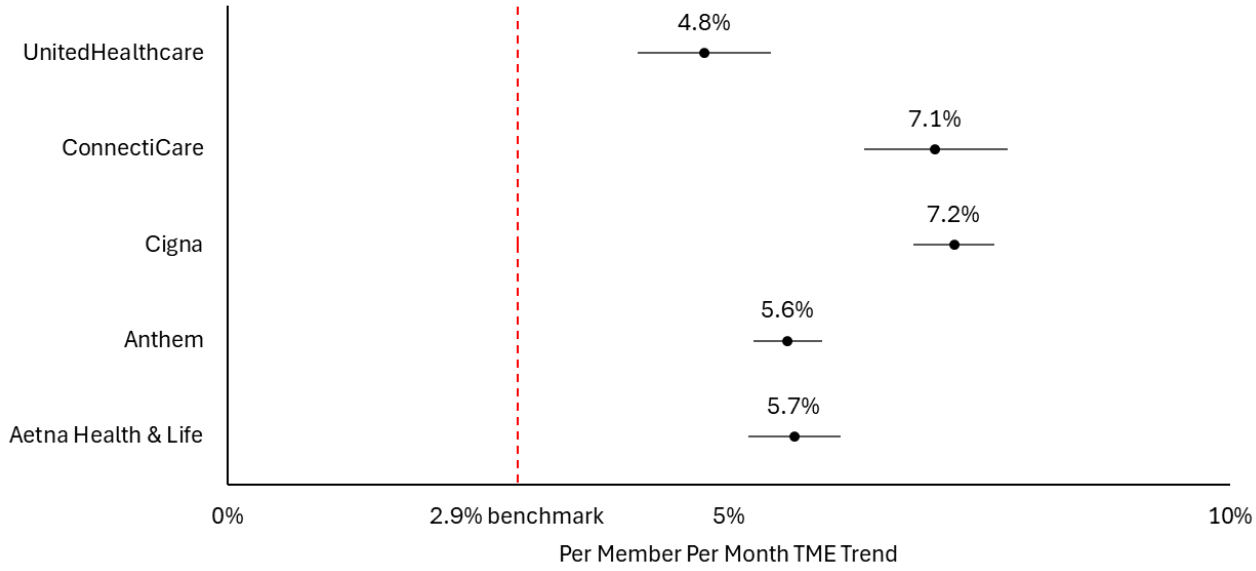
Carrier	Percentage of covered lives[8]
Aetna	22%
Anthem	31%
Cigna	19%
ConnectiCare	9%
UnitedHealthcare	20%

Source: Cost Growth Benchmark Payer Submissions

All payers exceeded the 2.9% benchmark in 2023, with reported spending growth ranging from 4.8% to 7.2% (see Figure 19).

[8] Due to rounding, the total percentage of covered lives will not be equal to 100%.

Figure 19 - Commercial Carrier Per Member Per Month TME Trends (2022-2023)



Source: OHS collected data from insurance carriers.
Notes: Data are truncated for outliers, risk-adjusted, and net of pharmacy rebates. The dots denote the year-over-year growth of an insurance carrier in a specific market, while the horizontal line through each dot indicates the range of values, or confidence interval, within which OHS is 95 percent confident the actual performance lies.

Medicare Advantage Carriers' 2022-2023 Performance Against the Benchmark

OHS collected data from four carriers for the Medicare Advantage market: Aetna, Anthem, ConnectiCare, and UnitedHealthcare.[9]

[9] OHS requested but did not receive Medicare Advantage spending data from Wellcare which represents less than 3% of the Medicare Advantage market in Connecticut as of December 2024. OHS does not collect Medicare Advantage data from Cigna as they have a very small presence—1% of the Medicare Advantage population—in Connecticut.

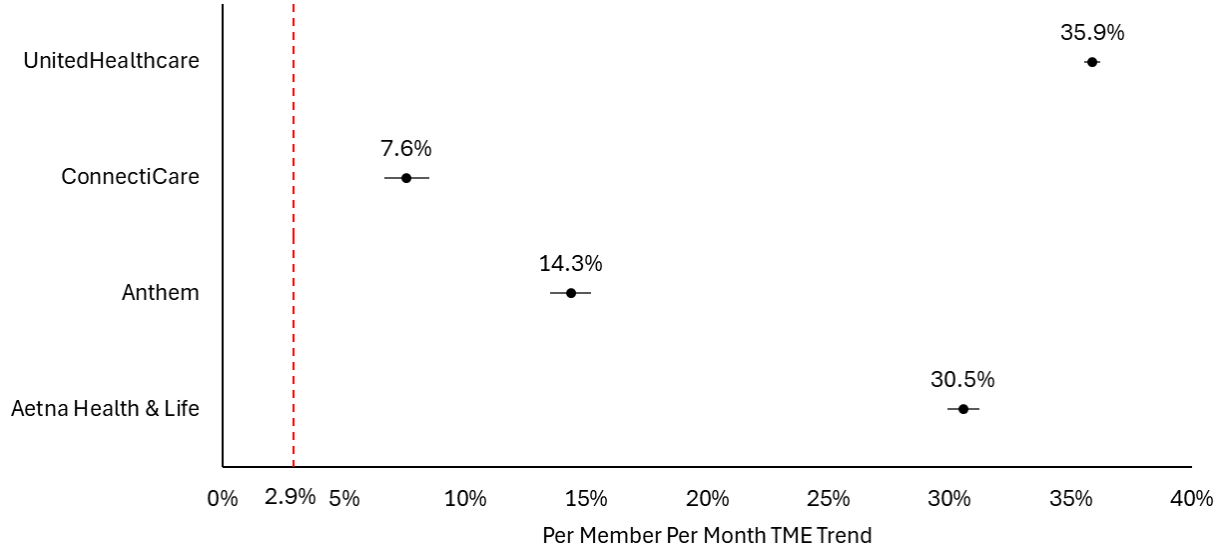
In 2023, two payers – UnitedHealthcare and Aetna – saw unusually high rates of Medicare Advantage spending growth.

In 2023, all Medicare Advantage payers exceeded the 2.9% benchmark and had a broad range of spending growth, with rates ranging from 7.6% to 35.9% (see Figure 20). Two payers – UnitedHealthcare and Aetna – saw unusually high rates of spending growth in 2023.

UnitedHealthcare's Medicare Advantage spending increased by 35.9% in 2023. UnitedHealthcare experienced a significant increase in its non-claims-based payment arrangements, due to a transition to percentage-of-premium payments to its related business provider group (OptumCare Network). The switch from fee-for-service to capitated payment would create a one-time bump in trend due to the cash flow change. UnitedHealthcare also reported an increase in dually eligible members, which would increase per capita spending. UnitedHealthcare alone accounted for approximately 46% of 2023 Medicare Advantage enrollment in Connecticut and OptumCare Network serves 30% of UnitedHealthcare's Medicare Advantage membership. Thus, UnitedHealthcare's significant spending growth had an outsized impact on market level trends.

Aetna's Medicare Advantage spending increased by 30.5% in 2023, primarily due to its new role managing the Medicare Advantage program for the state employee health plan. The program's comprehensive coverage, including pharmacy benefits, means that Aetna spent more per member on coverage. This was a key factor driving its significant spending growth.

Figure 20 - Medicare Advantage Carrier Per Member Per Month TME Trends (2022-2023)



Source: OHS collected data from insurance carriers.
Notes: Data are truncated for outliers, risk-adjusted, and net of pharmacy rebates. The dots denote the year-over-year growth of an insurance carrier in a specific market, while the horizontal line through each dot indicates the range of values, or confidence interval, within which OHS is 95 percent confident the actual performance lies.

Insurance Carrier and Market Specific Methodology

OHS reports performance against the benchmark for insurance carriers in the commercial and Medicare Advantage markets that have at least 5,000 attributed lives (60,000 member months) in the respective market. To measure carriers' performance, OHS tracks year-over-year growth in per member per month (PMPM) TME, and calculates a 95% confidence interval around the growth.

Insurance carriers were assessed against the cost growth benchmark of 2.9%. A carrier was considered to have exceeded the benchmark if its spending growth and associated confidence interval were above the benchmark. Performance for a carrier with a confidence interval crossing the benchmark is undetermined. If the confidence interval included the benchmark value, then it was evaluated as not statistically significantly different than the benchmark.

Section 3: 2022-2023 Growth in Healthcare Spending by Advanced Network and Market

This section evaluates the performance of provider entities against the cost growth benchmark. These entities—referred to as Advanced Networks—are large, organized groups of clinicians that come together for the purpose of contracting with payers. These provider organizations can have some influence on one or both of the two major factors that contribute to healthcare spending growth: payment (through their negotiations with payers) and utilization (through their care coordination and care management practices).

OHS assesses benchmark performance for Advanced Networks with a minimum of 5,000 attributed patients (or 60,000 member months) in a given market. Payers attribute patients to Advanced Networks through their relationships with primary care providers who are affiliated with an Advanced Network. Payers attribute patients in three different ways: a member's self-selection of a primary care provider; a member's inclusion in a contractual total cost of care arrangements between Advanced Networks and payers; or by virtue of where the member generally seeks primary care services.

Following validation and analysis of payer-reported data, OHS provides each Advanced Network with a "first look" report in February detailing their attributed spending and providing an opportunity to review and comment. This year, four Advanced Networks contacted OHS to discuss their reports and provide feedback. OHS has begun, but has not completed, the process of working with ANs and insurers to address the identified concerns where applicable. Because of this, OHS is only reporting de-identified results at this time. OHS expects to publish full results by Advanced Network at a later point, once additional data validation processes occur.

Enhancing Data Collection for Advanced Networks

This year, OHS implemented a new Tax Identification Number (TIN) methodology to improve the comprehensiveness of attributing spending to Advanced Networks. This process is the result of a 2024 working group of payer and Advanced Network representatives convened to discuss ways to improve the attribution process. "Attribution" refers to the method by which a payer associates spending for a member with a specific Advanced Network. As described in the "Data Sources and Methodology" section above, spending data attributed to Advanced Network is (1) truncated to reduce the impact of random high claims and (2) adjusted for the age and sex of a network's population.

The working group recommended that payers use Tax Identification Numbers (TINs) to attribute spending to an Advanced Network. OHS began implementing the TIN process in June 2024, requesting TINs from all Advanced Networks and communicating them to payers along with implementation instructions in order to improve the completeness and accuracy of the AN data.

OHS requested TINs and assessed performance against the benchmark for the following 29 Advanced Networks:

Advanced Network
Charter Oak Health Center (FQHC-based network)
CIFC Greater Danbury Community Health Center (FQHC-based network)
Community Health and Wellness Center of Greater Torrington (FQHC-based network)
Community Health Center (FQHC-based network)
Community Health Services (FQHC-based network)
Connecticut Children's Care Network (hospital-affiliated network)
Connecticut State Medical Society IPA (non-hospital affiliated network)
Cornell Scott Hill Health Center (FQHC-based network)
Fair Haven Community Health Center (FQHC-based network)
Family Centers (FQHC-based network)
First Choice Community Health Centers (FQHC-based network)

Generations Family Health Center (FQHC-based network)
Integrated Care Partners (hospital-affiliated network)
Northeast Medical Group (hospital-affiliated network)
Norwalk Community Health Center (FQHC-based network)
Optimus Health Care, Inc. (FQHC-based network)
OptumCare Network of Connecticut (non-hospital network)
Privia Quality Network of Connecticut (formerly Community Medical Group) (non-hospital network)
Prospect Connecticut Medical Foundation Inc. (dba Prospect Medical, Prospect Health Services, Prospect Holdings) (hospital-affiliated network)
SoNE Health (hospital-affiliated network)
Southwest Community Health Center, Inc. (FQHC-based network)
Stamford Medical Group (hospital-affiliated network)
Starling Physicians (non-hospital network)
Summit Health (non-hospital network)
UConn Medical Group (hospital-affiliated network)
United Community and Family Services (FQHC-based network)
Value Care Alliance (hospital-affiliated network)
Wheeler Clinic (FQHC-based network)
Yale Medicine (hospital-affiliated network)

OHS then distributed TINs to insurance carriers and the Department of Social Services for attributing spending and members to Advanced Networks. An individual may see providers in more than one Advanced Network in a calendar year, but members can only be attributed to a single Advanced Network at any given time. Because members may seek care from more than one primary care practice in a year, the final number of attributed members reported to OHS may differ from an Advanced Network's data on its patient panel.

Of the 29 total Advanced Networks OHS reports on, ten advanced networks that previously met the minimum threshold for public reporting in at least one market did not submit complete TIN information:

1. Privia Quality Network Connecticut (Community Medical Group)
2. Charter Oak Health Center
3. CIFC Greater Danbury Community Health Center
4. Community Health Services
5. Family Centers
6. First Choice Community Health Centers
7. Generations Family Health Center
8. Stamford Health Medical Group
9. Summit Health (formerly WestMed Medical Group)
10. United Community and Family Services

At least one payer, CIGNA, as well as DSS, did not attribute any spending to an Advanced Network that did not submit complete TIN information to OHS.

OHS continues to work with payers and ANs to assess the member attribution and TIN collection processes, as well as additional questions raised by ANs through the consultation process. Because this reconciliation process is still underway, OHS is only reporting aggregate Advanced Network benchmark results at this time. Once these data reconciliation processes have concluded OHS will publish full results by Advanced Network. OHS thanks all the Advanced Networks for their feedback in refining this process.

Advanced Networks' Aggregate 2022-2023 Performance Against the Benchmark

Advanced Networks were assessed against the cost growth benchmark of 2.9%. An Advanced Network was considered to have exceeded the benchmark if its spending growth and associated confidence interval were above the benchmark. Performance for an Advanced Network with a confidence interval crossing the benchmark is characterized as undetermined. If the confidence

interval included the benchmark value, then it was evaluated as not statistically significantly different than the benchmark.

Initial results show that most Advanced Networks in the Commercial and Medicare Advantage market exceeded the benchmark value. (In the Medicare Advantage market, OHS does not also assess Medicare Fee-For-Service, which is administered by CMS, and for which OHS does not receive data stratified by attributed network.) Table 3 below shows Advanced Networks' aggregate performance against the benchmark by market, excluding Advanced Networks that did not meet the minimum number of lives to publicly report.

Table 3 -Advanced Networks Performance Against the Benchmark, by Market and Hospital Affiliation

	Commercial (N= 11)			Medicare Advantage (N=10)			Medicaid (N=12)		
Advanced Network Affiliation	Met	Exceeded	Undetermined*	Met	Exceeded	Undetermined*	Met	Exceeded	Undetermined*
Hospital-Affiliated (9)	0	8	1	0	6	0	2	4	0
Non-Hospital-Affiliated (5)	0	3	1	0	4	0	2	4	3
FQHC (7)	N/A	N/A	N/A	N/A	N/A	N/A	2	4	1
Total	**0**	**11**	**2**	**0**	**10**	**0**	**6**	**12**	**4**

*The results of some Advanced Networks could not be determined if the confidence interval of their calculated spending trend included the benchmark.

Section 4: Special Focus - Pharmacy Spending

This year, the Cost Growth Benchmark data shows significant spending growth in pharmacy. This section uses claims-level data from the APCD to help explain and contextualize this trend.

Statewide retail pharmacy per capita spending grew 9.3%, from $1,693 to $1,851 per capita. Retail pharmacy accounted for 19% of total per capita spending growth and 16.5% of aggregate total medical expense.

Many Americans depend on prescription drugs to maintain or improve their health. According to the National Health and Nutrition Examination Survey, 67% of Americans aged 45-64 have used at least one prescription drug in the last 30 days.[10] However, high costs continue to impede patient access to pharmaceuticals. A 2022 survey of Connecticut residents found that 23% of respondents had cut pills in half, skipped doses of medicine, or did not fill a prescription due to costs.[11]

High and rising prescription drug costs were a significant contributor to Connecticut's healthcare spending growth in 2023. As discussed in Section 1: 2022-2023 Growth in Healthcare Spending by Market, Connecticut's 2022-2023 cost growth benchmark analysis found that statewide retail pharmacy per capita spending grew 9.3%, from $1,693 to $1,851 per capita. Retail pharmacy accounted for 19% of total per capita spending growth and 16.5% of aggregate total medical expense.

"Retail pharmacy" refers to drug prescriptions that are filled at local pharmacies and by mail order drug companies. In contrast, "medical

[10] National Center for Health Statistics. Prescription medication use, by number of medications: One or more [Internet]. U.S. Department of Health and Human Services. https://covid.cdc.gov/covid-data-tracker

[11] Healthcare Value Hub. (2022). Connecticut Residents Bear Healthcare Affordability Burdens Unequally; Distrust of/Disrespect by Healthcare Providers Leads Some to Delay/Go Without Needed Care (134). https://www.healthcarevaluehub.org/advocate-resources/publications/connecticut-residents-bear-healthcare-affordability-burdens-unequally-distrust-disrespect-healthcare-providers-leads-some-delayg

pharmacy" refers to drugs that are administered in clinical settings such as hospital outpatient clinics, hospital inpatient services, and private provider offices. The analyses in this section include only medical pharmacy administered in hospital outpatient clinics (the primary site where they are delivered). They also exclude COVID-19 vaccines.

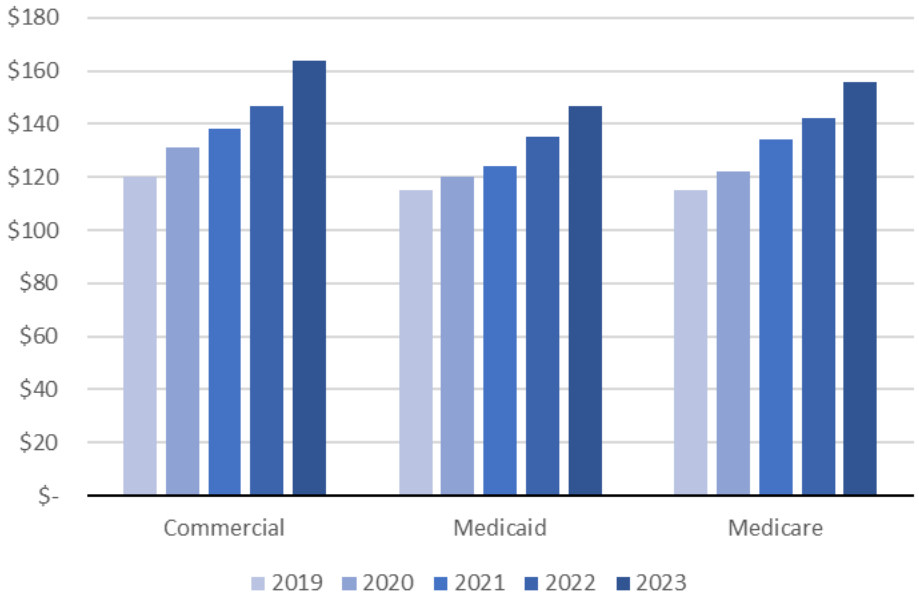
Trends in Retail Pharmacy Spending

From 2019-2023, PPU for retail pharmacy grew across all markets, while utilization grew in the commercial and Medicare markets but decreased for Medicaid.

As noted above, retail pharmacy spending is a significant contributor to healthcare cost growth in Connecticut. It is important to note that the increase in total retail pharmacy spending reflects both actual unit payment changes for existing medications and a shift toward newer, higher-cost drugs, which raises the average payment per unit (PPU).[12] The increase in retail pharmacy spending in Connecticut has been driven by both increases in PPU and increased utilization. PPU for retail pharmacy grew across all markets, while utilization grew in the commercial and Medicare markets but decreased for Medicaid from 2019-2023, (see Figure 21 and Figure 22). In 2023, PPU was highest in the commercial market.

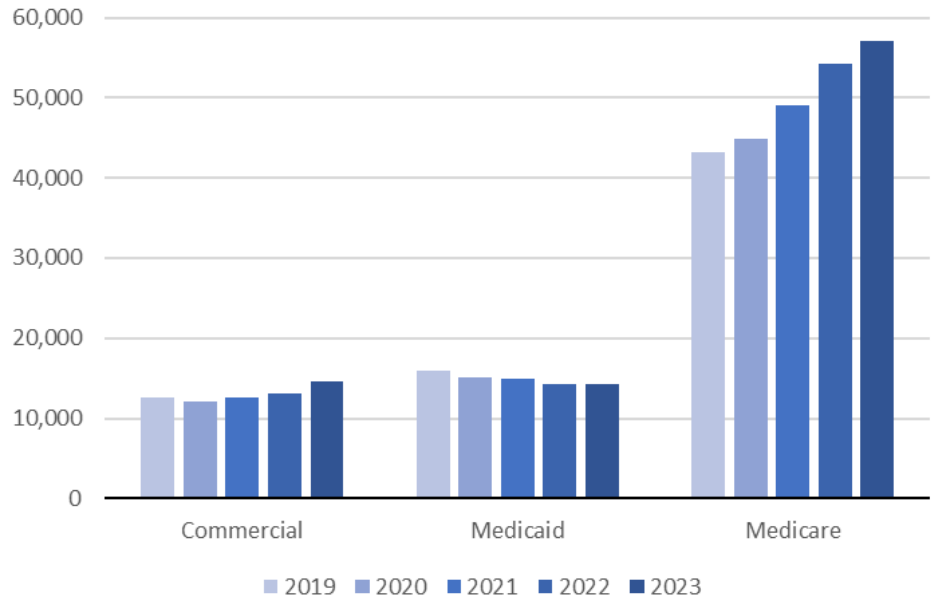
[12] For the purpose of this analysis, a unit of drugs is defined as a 30-day supply.

Figure 21 - Payment Per Unit (PPU) (30-Day Equivalent) of Retail Prescription Drugs by Market



Source: APCD

Figure 22 – Utilization of Retail Prescription Drugs by Market (Units per 1,000 Members)



Source: APCD

The two drug categories accounting for the majority of 2023 commercial prescription drug spending, as captured in the APCD, were immunosuppressants ($721 million), followed by hormones and synthetic substances ($548 million).[13]

Recent growth in spending on GLP-1 drugs within the hormones and synthetic substances category is notable.[14] PMPM spending on hormones and synthetic substances has grown by almost 50% since 2018. PPU was generally stable but utilization increased dramatically between 2022 and 2023 for the seven common GLP-1 drugs within the hormones and synthetic substances category. For example, utilization for Mounjaro increased by 795% between 2022-2023 (see Table 4).

Table 4 - Change in Commercial Payment and Utilization for Seven GLP-1 Drugs

Drug	2022		2023		Change from 2022-2023	
	Payment Per 30-Day Equivalent	30-Day Equivalents per 1000 members	Payment Per 30-Day Equivalent	30-Day Equivalents per 1000 members	Change in Payment Per 30-Day Equivalent	Change in 30-Day Equivalent per 1000 members
MOUNJARO	$746	4.63	$737	41.43	-1%	795%
WEGOVY	$823	3.09	$823	18.3	0%	492%
RYBELSUS	$597	10.74	$578	17.09	-3%	59%
OZEMPIC	$608	42.42	$616	60.74	1%	43%
TRULICITY	$645	39.01	$659	43.28	2%	11%
SAXENDA	$892	1.71	$676	2.32	-24%	36%
VICTOZA	$593	9.08	$515	5.57	-13%	-39%

Source: Connecticut APCD.

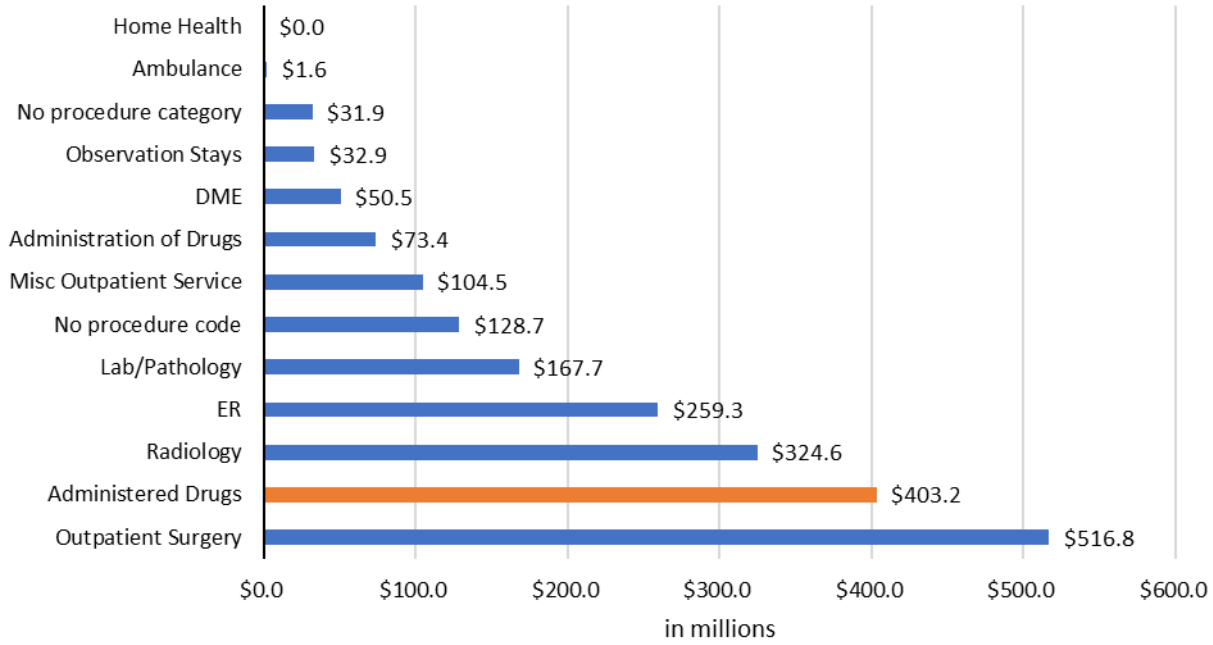
[13] Immunosuppressant drugs prevent the immune system from mistakenly attacking the body's immune system. They are most commonly used to treat rheumatoid arthritis and psoriasis, but are also used to treat inflammatory bowel disease, multiple sclerosis and lupus.
[14] GLP-1 drugs have been used as a treatment for type 2 diabetes for over a decade, but newer forms of these drugs (e.g., Ozempic) have gained widespread attention for their effectiveness as a treatment for obesity.

Trends in Medical Pharmacy Spending

Commercial spending on medical pharmacy (i.e., drugs administered in a clinical setting), as assessed using APCD data, was $403 million or 19% of total commercial outpatient hospital spending in 2023. , This was the second costliest procedure category in the outpatient hospital setting, second only to outpatient surgery (see Figure 23).

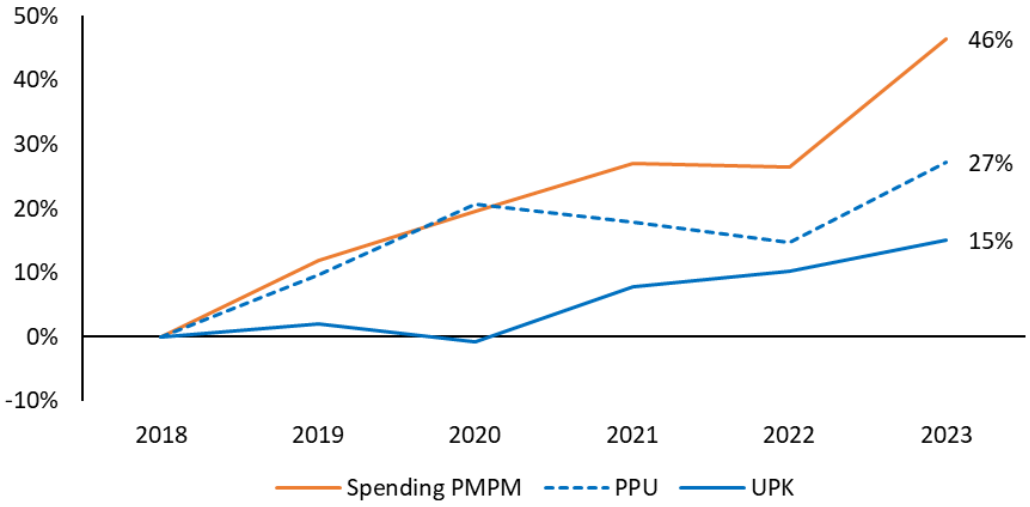
The two types of drugs that comprise administered drugs are chemotherapy and non-chemotherapy injections/infusions. Both categories grew in total spending between 2018-2023; the growth in chemotherapy drug spending was driven primarily by increases in payment per unit (PPU), while the growth in other injection/infusion spending was driven primarily by increased utilization. Payment per unit for chemotherapy drugs grew by 27%, compared to 4% for injections and infusions between 2018 and 2023 (see Figure 24 and Figure 25). Utilization for injections and infusions grew by 39% during this period, compared to 15% for chemotherapy.

Figure 23 - 2023 Commercial Outpatient Hospital Spending by Procedure Category



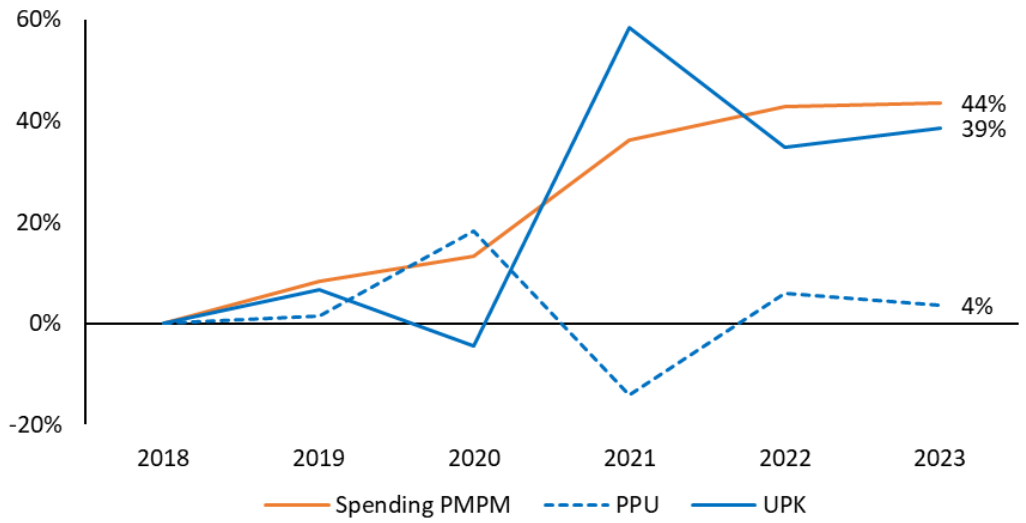
Source: Connecticut APCD.

Figure 24 - Cumulative Change in Outpatient Chemotherapy Spending PMPM, UPK, and PPU since 2018*



Source: Connecticut APCD.
*PMPM = per member per month; UPK = utilization per 1,000 members; PPU = payment per unit

Figure 25 - Cumulative Change in Outpatient Non-Chemotherapy Injection and Infusion Spending PMPM, UPK, and PPU since 2018*



Source: Connecticut APCD.
*PMPM = per member per month; UPK = utilization per 1,000 members; PPU = payment per unit

Prescription drugs are vital to maintaining and improving health. However, the high and rising costs of both retail and medical prescription drugs are putting a financial strain on families, employers, and governments. Connecticut will not be able to meet its goal of constraining unsustainable healthcare spending growth and improving healthcare affordability without addressing the role of high and rising prescription drug prices.

Section 5: Special Focus - Hospital Spending

Hospitals play a unique and essential role in providing care for a wide range of acute and chronic conditions. This role typically includes, but is not limited to, 24/7 availability for emergency care and operating as a safety net for those with limited means to pay for healthcare services. While hospitals play a critical role, they have also been a major factor in healthcare spending growth in Connecticut during the past several years, contributing to the increasing unaffordability of healthcare.[15]

Hospital Spending

As discussed in Section 1, Connecticut's 2022-2023 cost growth benchmark analysis found that hospital spending accounted for 40 percent of Connecticut healthcare spending in 2023, and nearly 50 percent of spending in the commercial market. It is therefore critical for the State to understand the drivers of hospital spending and how spending varies across the state's hospitals.

Methodology

Hospital spending is comprised of two service categories - outpatient services and inpatient services. Outpatient services are those delivered on the same day in a hospital setting while inpatient services are those that require an acute or short-term hospital stay. [16]

This section focuses on hospital spending in the commercial market because historical spending growth has been especially high in the commercial market. Hospital spending accounted for nearly half of total commercial

[15] Bailit, M. (n.d.). What Is Driving Health Care Spending Upward In States With Cost Growth Targets? https://doi.org/10.1377/forefront.20220805.244579

[16] "Hospital setting" refers to any location where services are billed under a hospital's outpatient department. This can include not only traditional hospital facilities but also off-site locations such as private physician offices or clinics owned and operated by the hospital, which are classified as outpatient departments for billing purposes.

spending in 2023 and the commercial market exhibits greater variability in hospital prices compared to Medicare and Medicaid.

Two data sources inform this section of the report: the RAND Corporation's Round 5.1 Price Transparency Study (RAND 5.1) and data available through 2023 in Connecticut's APCD.

RAND 5.1 includes payment information for services provided to the commercially insured population in hospital settings. RAND 5.1 sourced its data from state APCDs, directly from health plans, and directly from self-insured employers who opted to participate.[17] In addition to many other measures, RAND calculates what it terms relative price – the ratio of actual private insurer allowed amounts (payments) compared with what Medicare would have paid for the same service.[18]

[17] The Connecticut APCD contributed approximately 95% of the data for Connecticut hospitals in RAND 5.1. The other approximately 5% came from large, self-insured employers.
[18] RAND 5.1 addresses differences in service mix by standardizing commercial prices to Medicare rates. By calculating the ratio of hospital-specific allowed amounts (including both insurer and patient payments) to Medicare reimbursement amounts for the same services, the study ensures comparability across hospitals regardless of variations in service mix and complexity.

Trends in Hospital Outpatient and Inpatient Spending

Outpatient hospital spending has been growing faster than inpatient hospital spending in Connecticut. From 2018-2023, outpatient spending per member per year (PMPY) grew by 41%, while inpatient spending PMPY grew by only 12%.

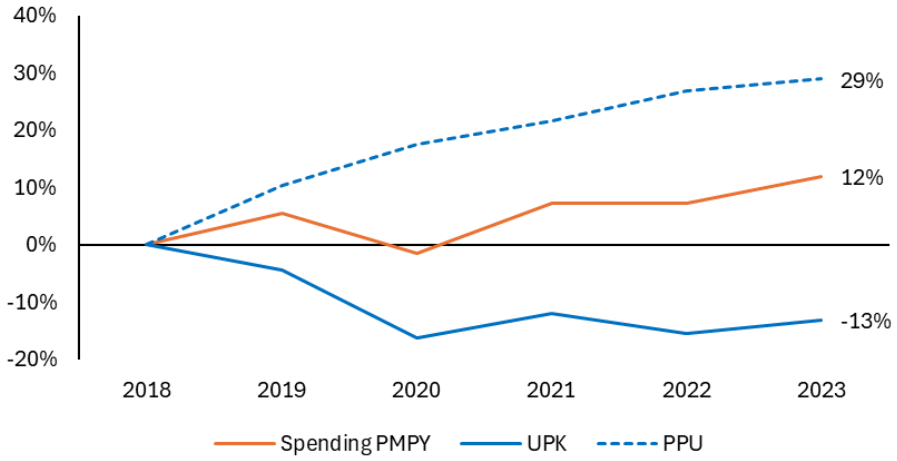
Outpatient hospital spending has been growing faster than inpatient hospital spending in Connecticut. Outpatient spending per member per year (PMPY) grew by 41%, while inpatient spending PMPY grew by only 12% from 2018-2023 (see Figure 27 and Figure 26, based on the Connecticut APCD). The average payment per discharge for inpatient services grew by 29% and the payment-per-unit (PPU, which is generally a claim service with an associated CPT or HCPCS code) for outpatient services grew by 17%. Per capita utilization of inpatient services decreased by 13% and per capita utilization of outpatient services increased by 20% from 2018-2023. These trends indicate that service unit payments drove inpatient spending growth, whereas a combination of service unit payments and utilization drove outpatient spending growth. A change in service mix, which OHS does not measure, may contribute to rising spending. (Broadly, service mix reflects the types of healthcare services a hospital is offering. If a hospital replaced lower spending services with higher spending services, this would result in increased PPU and spending without impacting utilization).

The two hospital outpatient service categories with the highest spending were ambulatory surgery and administered drugs (i.e., chemotherapy and other infusion drugs). Outpatient surgery comprised only three percent of the overall volume of hospital outpatient services in 2023 but accounted for 25 percent of total hospital outpatient spending.[19] Meanwhile, administered

[19] Bailit Health analysis of CT APCD.

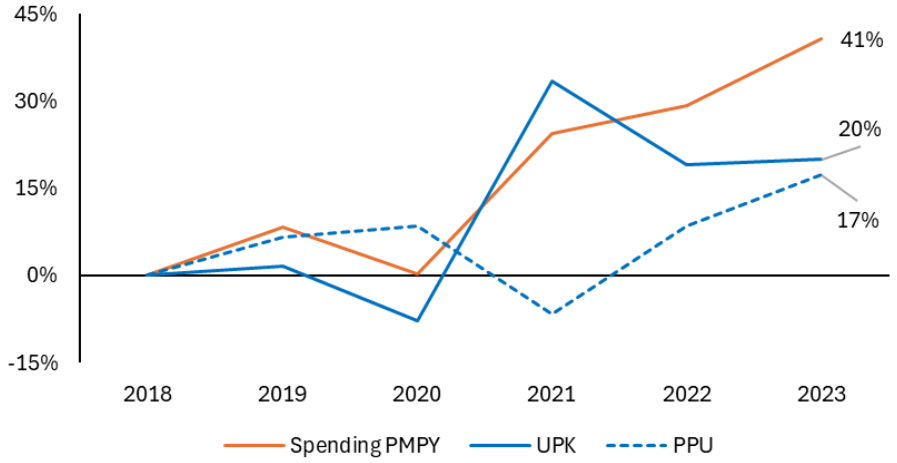
drugs made up 11 percent of the overall volume of hospital outpatient services, but accounted for 19 percent of spending.[20]

Figure 26 - Cumulative Change in Connecticut Inpatient Spending PMPY, UPK, and PPU since 2018*



Source: Connecticut APCD.
*PMPM = per member per month; UPK = utilization per 1,000 members; PPU = payment per unit

Figure 27 - Cumulative Change in Connecticut Outpatient Spending PMPY, UPK, and PPU since 2018*



Source: Connecticut APCD.
*PMPM = per member per month; UPK = utilization per 1,000 members; PPU = payment per unit

[20] Bailit Health analysis of CT APCD.

Payment Variation Across Hospitals

Within Connecticut, there is significant variation in commercial payment for hospital services. Some hospital systems, such as Hartford HealthCare and Yale New Haven typically have higher payments, while independent hospitals typically have lower payments.

Connecticut hospitals' commercial payments for total services were between 184% and 312% of what Medicare would have paid for the same services.

Table 5 compares hospital commercial prices relative to Medicare across Connecticut acute care hospitals, including relative prices for outpatient facility, inpatient facility, and total facility services**.** Connecticut hospitals' commercial payments for total services were between 184% and 312% of what Medicare would have paid for the same services. Generally, relative prices for outpatient services were higher than relative inpatient services. Research has demonstrated that hospitals can maintain financial stability, with nominal impacts on operating margins, when commercial in-network payments are set at 200% of Medicare rates.[21]

There was substantial price variation by hospital and by inpatient and outpatient categories. Stamford Hospital had the highest commercial payments relative to Medicare for services overall (312% of Medicare), inpatient services (286% of Medicare), and outpatient services (379% of Medicare). Multiple Hartford HealthCare-owned hospitals' prices were also particularly high compared to other Connecticut hospitals; both Hospital of Central Connecticut and Backus Hospital had among the highest total relative prices for services overall, inpatient services, and outpatient services. Overall, Yale New Haven Health-owned hospitals had mid-range relative prices for total facility services as compared to hospitals statewide. Yale New Haven Health hospitals tended to have higher commercial payments relative

[21] Murray, R. C., Whaley, C. M., Fuse Brown, E. C., & Ryan, A. M. (2024). Hospital Payment Caps Could Save State Employee Health Plans Millions While Keeping Hospital Operating Margins Healthy. Health Affairs, 43(12), 1680–1688. https://doi.org/10.1377/hlthaff.2024.00691

to Medicare for inpatient services and lower commercial payments relative to Medicare for outpatient services.

Table 6 compares commercial PPUs (i.e., service unit payments) for common outpatient and inpatient services at Stamford Hospital and UConn John Dempsey Hospital.[22] Table 6 highlights significant disparities in service unit payments between these two hospitals in 2023, with Stamford consistently receiving more for the same services. For outpatient services, Stamford's PPUs were 96% to 220% higher, while inpatient services show comparatively smaller but still notable differences, ranging from 20% to 35% higher. These findings underscore substantial cost variation between the two hospitals, particularly for outpatient services. Hospital payment variation in Connecticut is not limited to these two hospitals.

Table 5 - Relative Commercial Payments to Connecticut Hospitals as % of Medicare, by Hospital Inpatient Capacity, 2020-2022

Key
‡ = Lowest relative price
^ = Highest relative price

Hospital	Hospital System	Staffed Beds	Relative Price *Total Facility*	Relative Price ***Inpatient*** *Facility Services*	Relative Price ***Outpatient*** *Facility Services*
Yale New Haven Hospital	Yale New Haven Health	1,601	272%	266%	280%
Hartford Hospital	Hartford HealthCare	946	249%	249%	279%
Saint Francis Hospital	Trinity Health	485	227%	222%	250%
Bridgeport Hospital	Yale New Haven Health	429	223%	251%	206%
Danbury Hospital	Nuvance Health	374	259%	249%	284%

[22] OHS chose these two hospitals to compare because they had the highest and lowest commercial payments relative to Medicare in the RAND 5.1 study.

Hospital	Hospital System	Staffed Beds	Relative Price *Total Facility*	Relative Price ***Inpatient*** *Facility Services*	Relative Price ***Outpatient*** *Facility Services*
St Vincent's Medical Center	Hartford HealthCare	315	226%	222%	258%
Stamford Hospital	N/A	305	**312%^**	**286%^**	**379%^**
Hospital of Central Connecticut	Hartford HealthCare	280	**290%^**	261%	**353%^**
Waterbury Hospital	Prospect Medical Holdings	265	199%	208%	**199%‡**
Lawrence and Memorial Hospital	Yale New Haven Health	252	238%	256%	246%
Middlesex Hospital	N/A	207	269%	281%	300%
Norwalk Hospital	Nuvance Health	206	259%	240%	296%
Backus Hospital	Hartford HealthCare	187	278%	**284%^**	305%
Greenwich Hospital Association	Yale New Haven Health	185	242%	278%	231%
Manchester Memorial Hospital	Prospect Medical Holdings	181	224%	197%	258%
UConn John Dempsey Hospital	N/A	159	**184%‡**	**128%‡**	236%
Saint Mary's Hospital	Trinity Health	158	195%	184%	209%
Midstate Medical Center	Hartford HealthCare	143	250%	250%	271%
Bristol Hospital	N/A	138	233%	230%	256%
Griffin Hospital	N/A	117	210%	184%	238%
Charlotte Hungerford Hospital	Hartford HealthCare	108	**186%‡**	190%	**194%‡**

Hospital	Hospital System	Staffed Beds	Relative Price *Total Facility*	Relative Price ***Inpatient*** *Facility Services*	Relative Price ***Outpatient*** *Facility Services*
Day Kimball Hospital	N/A	104	202%	**175%**‡	221%
Rockville General Hospital	Prospect Medical Holdings	102	288%	N/A*	318%
Sharon Hospital	Nuvance Health	67	201%	182%	217%
Johnson Memorial Hospital	Trinity Health	64	239%	183%	267%
Windham Hospital	Hartford HealthCare	46	255%	192%	282%

Source: RAND 5.1 and American Hospital Directory. Hospitals are presented in descending order by number of staffed beds (2022). Shading indicates the two hospitals with the highest (orange, in bold text) and lowest (green) relative prices for each category (overall, inpatient, and outpatient). The American Hospital Directory only provides information on the number of staffed beds.
*Rockville General Hospital did not have a relative price for inpatient facility services because it had less than 50 inpatient claims for at least one year (2020-2022).

Table 6 - 2023 Commercial Price Per Unit (PPU) for Common Outpatient and Inpatient Services at Stamford Hospital and John Dempsey Hospital

Service	2023 PPU - Stamford Hospital	2023 PPU - John Dempsey Hospital	% Difference in PPU
Outpatient Services			
Moderate Complexity ER Visit	$2,673	$835	220%
High Complexity ER Visit	$2,390	$1,107	116%
Low Complexity ER Visit	$1,859	$947	96%
Inpatient Services			
Routine Vaginal Delivery	$12,006	$9,981	20%
Severe Blood Infection Without Major Complications	$21,073	$16,435	28%
Hip or Knee Replacement Surgery	$43,635	$32,237	35%

Source: Connecticut APCD.

Conclusion

Connecticut's statewide per capita healthcare spending growth in 2023 was 7.9%, far exceeding the 2.9% cost growth benchmark and the highest annual increase since the inception of the Cost Growth Benchmark program. Connecticut's increase in per capita healthcare spending growth was primarily driven by commercial market growth, unusual Medicare cost growth, and large increases in retail pharmacy and hospital outpatient spending.

Spending grew the fastest in the following four areas:

- **Commercial Market Spending**: Commercial per capita spending increased by 6.2%, with all major payers exceeding the benchmark. Advanced Networks affiliated with hospitals exhibited particularly high growth, reflecting increasing prices and utilization.

Connecticut's increase in per capita healthcare spending growth was primarily driven by commercial market growth, unusual Medicare cost growth, and large increases in retail pharmacy and hospital outpatient spending.

- **New Medicare Cost Growth**: Medicare per capita spending surged by 13.7%, more than four times the benchmark, primarily due to an exceptional increase in non-claims spending. Much of this was tied to UnitedHealthcare's transition to percentage-of-premium payments to its related company, OptumCare Network, resulting in a one-time increase that significantly impacted overall spending trends. Given UnitedHealthcare's dominant Medicare Advantage market share, and the fact that OptumCare services 30% of UnitedHealthcare's Medicare Advantage membership, this spike had an outsized effect on statewide cost growth.
- **Retail Pharmacy Spending**: Pharmacy expenditures grew by 9.3% from 2022 to 2023, contributing 19% of total per capita spending growth (see Figure 10). Increased utilization of GLP-1 drugs such as Mounjaro

(+795%) and Wegovy (+492%) played a role in retail pharmacy spending growth.

- **Hospital Outpatient Spending**: Outpatient spending per capita rose by 41% between 2018-2023, driven by increased utilization of 20% and rising service unit payments of 17% (see Figure 27). Ambulatory surgery and administered drugs were the largest contributors to this trend.

The commercial market, which accounts for over one-third of total healthcare expenditures, has driven overall cost growth during this period. Since 2021, per capita commercial spending has increased by a cumulative 24.9%.

For the third consecutive year, Connecticut has not met its cost growth benchmark**.** The commercial market, which accounts for over one-third of total healthcare expenditures, has driven overall cost growth during this period. Since 2021, per capita commercial spending has increased by a cumulative 24.9%. Given these trends, it is time to take additional policy steps to slow healthcare spending growth, particularly in the commercial market, to stem continuing losses in healthcare affordability for Connecticut residents.

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 healthcare providers on the basis of a fee for each health service provided to the insured person.

Fully insured plan: A fully insured health plan is one in which the insurer assumes the financial risk, including the responsibility for paying claims, in exchange for premiums.

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 plans; this does not include Medicare FFS or Medicaid. 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 (single payments to providers to provide healthcare services over a defined period of

time), 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. §§ 217-223. 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.

Self-insured plan: A self-insured benefit plan is one in which the plan sponsor (e.g., the employer) assumes the financial risk of providing health benefits. Because of the federal Employee Retirement Income Security Act (ERISA), state regulation, including coverage requirements, does not apply to self-insured benefit plans.

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.

Wholesale Acquisition Cost: defined by the federal 42 USC 1395w-3a as the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.