CONNECTICUT
Health Strategy

Healthcare Benchmark Initiative Recommendations to the General Assembly

A Report Pursuant to C.G.S. §§ 19a-754f et seq

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Commissioner

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

Contents

Executive Summary

Pursuant to Connecticut General Statutes §§ 19a – 754f et seq, this report summarizes the 2021-2022 calendar year results of the Office of Health Strategy's (OHS') Benchmark Initiatives, which include the:

- healthcare cost growth benchmark,
- primary care spending target, and
- quality benchmark analyses.

This report also (1) presents the findings from OHS' plan for monitoring any unintended consequences resulting from implementing these programs and (2) includes the commissioner's recommendations on strategies to increase the efficiency and quality of the state's healthcare system.

Context and Background

Healthcare represents a significant portion of Connecticut's economy and impacts every resident. The Benchmark Initiatives strive to measure and report on spending growth and ensure access to high quality, affordable care. The findings of the Benchmark initiative show that per-person medical spending continues to grow, with adverse impacts that affect Connecticut residents. For example,

In a 2022 Healthcare Value Hub survey of CT respondents, it was reported:

- Nearly half (46%) were delaying or foregoing care due to cost;
- More than three-quarters (78%) worried about future healthcare expenses;
- One-third (33%) struggle to pay medical bills.[1]

[1] Healthcare Value Hub. (2022, October). Connecticut Residents Struggle to Afford High Healthcare Costs; Worry about Affording Healthcare in the Future; Support Government Action across Party Lines. Altarum. https://www.healthcarevaluehub.org/advocate-resources/publications/connecticut-residents-struggle-afford-high-healthcare-costs-worry-about-affording-healthcare-future-support-government-action-ac

In addition, Connecticut residents face hospital inpatient prices that exceed the national median. In 2021, hospital inpatient prices in Hartford were 27% greater, New Haven 42% greater, and Bridgeport 43% greater than the national median for hospital inpatient prices of US metro areas.[2] Prices in these Connecticut cities are significantly higher than prices in Boston, Massachusetts and Providence, Rhode Island, which are 9% and 10% above the national median, respectively.

Limiting healthcare cost growth helps businesses compete and retain talent and Connecticut families better afford a high quality of life. A recent paper by Yale researchers and the National Bureau of Economic Research showed that a 1% increase in healthcare prices reduces both payroll and employment at employers outside the healthcare sector by 0.4%. A hospital merger that raises prices by 5% results in $32 million in lost wages, 203 job losses, and a $6.8 million reduction in federal tax revenue.[3]

In response to rising prices and affordability challenges, Governor Lamont and the CT General Assembly established Connecticut's healthcare cost growth benchmark ("the benchmark") with the goals of slowing the growth of healthcare spending and making healthcare more affordable for the residents of Connecticut. The cost growth benchmark represents the targeted year-over-year increase in healthcare spending per person that would be affordable for CT residents. Connecticut is one of eight states that have adopted a cost growth benchmark strategy.[4]

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[2] Healthy Marketplace Index. Health Care Cost Institute. https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Summary-Report-Current-Spending Accessed September 8, 2024.

[3] Brot-Goldberg, Z, Cooper, Z, Craig, SV, Klarnet, L, Lurie, I, and Miller, C. "Who Pays For Rising Health Care Prices? Evidence from Hospital Mergers." NBER Working Paper No. 32613.

[4] Connecticut was the fifth state to adopt a healthcare cost growth benchmark joining Massachusetts, Rhode Island, Delaware, and Oregon. New Jersey, Washington, and California have subsequently adopted cost growth benchmark programs.

In consultation with technical experts and stakeholders, OHS set Connecticut's benchmark in November 2020 for the calendar years 2021-2025. The per person spending growth benchmark for the 2021-2022 calendar years was set at 3.2% .

Connecticut's Primary Care Spending Target. Research demonstrates that greater investment in primary care as a percentage of overall healthcare spending is likely to lead to better patient outcomes, lower costs, and improved patient experience of care.[5,6,7,8] In establishing a primary care spending target, Connecticut joined a growing number of states that are pursuing this strategy.[9] OHS established the primary care spending target at 5.3 percent for calendar year 2022. The target increases annually until it reaches 10% by 2025.

Healthcare Quality Benchmarks. The Quality Benchmarks complement OHS' Cost Growth Benchmark program by offering a balanced perspective on health system performance, monitoring any potential care reduction and protecting patients' interests in the context of a spending growth benchmark. In 2021, OHS selected seven Quality Benchmark measures for a two-phase implementation on the recommendation of the Quality Council, which is an advisory body on quality measurement.[10] [11]

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[5] Shi L. "The Impact of Primary Care: A Focused Review." *Scientifica* (Cairo). Published online 2012. doi:10.6064/2012/432892

[6] Phillips RL, Bazemore AW. "Primary Care And Why It Matters For U.S. Health System Reform." *Health Affairs*. 2010;29(5):806-810. doi:10.1377/hlthaff.2010.0020

[7] Shi L. "The Impact of Primary Care: A Focused Review." *Scientifica* (Cairo). Published online 2012. doi:10.6064/2012/432892

[8] Phillips RL, Bazemore AW. "Primary Care And Why It Matters For U.S. Health System Reform." *Health Affairs*. 2010;29(5):806-810. doi:10.1377/hlthaff.2010.0020

[9] State Primary Care Investment Initiatives. Primary Care Collaborative. https://www.pcpcc.org/primary-care-investment/legislation. Accessed September 8, 2024.

[10] For a summary of OHS' process for selecting the Quality Benchmark measures for phased implementation, please see: Connecticut Office of Health Strategy. (2022). Connecticut quality benchmarks. Retrieved September 9, 2024, from https://portal.ct.gov/ohs/-/media/ohs/quality-council/quality-benchmarks/quality-benchmarks-report-may-2022.pdf.

[11] For a list of Phase 1 and Phase 2 Quality Benchmark measures and values, please see:

Summary of Healthcare Spending and Quality Trends

Connecticut spent $36.4 billion on healthcare and insurance costs in 2022, up from $34.8 billion in 2021. Statewide healthcare costs grew 3.4 percent per capita from 2021 to 2022, slightly exceeding the 3.2 percent benchmark. OHS analyses show that retail pharmacy and hospital outpatient costs were the most significant contributors to statewide spending growth.

The Primary Care Spending Target analyses found that Connecticut spent at least $1.06 billion in primary care in 2022, up from $996 million in 2021. Statewide primary care spending was 4.9 percent of total spending in 2022, falling short of the 5.3 percent target. By market, OHS found that Medicaid achieved the target with 7.0 percent of spending going to primary care, but the commercial and Medicare Advantage markets did not (4.0 percent and 3.2 percent, respectively).

For the commercial and Medicare Advantage markets, Connecticut met the 2022 Quality Benchmarks for all applicable measures (*Asthma Medication Ratio, Controlling High Blood Pressure,* and *HbA1c Control for Patients with Diabetes*: *HbA1c Poor Control.)* For the Medicaid market, Connecticut met the 2022 Quality Benchmarks for four of five measures (Medicaid did not meet the target for *Asthma Medication Ratio* in the 5-18 age range.)

Monitoring of Unintended Adverse Consequences

In 2020, OHS established its Cost Growth Benchmark Unintended Adverse Consequences Measurement Plan ("the plan") to monitor potential negative effects of the benchmark across three domains: underutilization, impact on underserved populations and consumer out-of-pocket spending.

The results of this year's analysis do not suggest adverse impacts of the cost growth benchmark. Performance on underutilization measures improved more than it declined. While measures of patient experience for the commercial population have seen declines, these dips are mirrored in the

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Connecticut Office of Health Strategy. (n.d.). Quality benchmarks. Retrieved September 9, 2024, from https://portal.ct.gov/OHS/Pages/Quality-Council/Quality-Benchmarks.

rest of New England and the country. Medicaid member grievances have declined since benchmark implementation, though the volume of grievances has been low both pre- and post-benchmark. Finally, OHS assessments of changes in consumer out-of-pocket spending yielded mixed results. The Adverse Impacts analysis does not suggest a systematic impact of the Benchmark Initiative on access, quality or patient out of pocket expenses…

Recommendations

During 2024, OHS has identified several trends that warrant the General Assembly's consideration. The following recommendations stem from these trends but are not necessarily related to a specific legislative policy; rather, they encourage stakeholders to consider the impact of these trends on Connecticut and provide examples of how other states are working to address them.

The healthcare benchmark program's intent is to create accountability by enhancing the transparency around healthcare spending and the drivers of health care costs. However, the General Assembly's intention to create accountability for healthcare spending growth has been stymied by the refusal of parties to appear at OHS' annual hearing when called to appear for significantly contributing to spending growth. Second, continued year-over-year high growth in drug prices is impacting the commercial, Medicaid and Medicare markets in Connecticut. Third, primary care investments are not growing consistent with the primary care spending target and the state's primary care supply is increasingly challenged to serve all Connecticut residents. Finally, the collapse of a private equity-owned multi-hospital system operating in Massachusetts and elsewhere along with increased consolidation across healthcare entities in the state are regional notices to more closely monitor transfers of ownership and consolidation activity in the state and to take action when warning signs appear or when proposals are likely to have adverse effects on residents.

In this context, OHS makes the following recommendations:

1. Institute a stronger system of accountability for entities called by OHS to participate in the annual public hearing who fail to appear.
2. Improve collection of data on drug rebates at the National Drug Code level, which will help OHS more accurately understand which prescription drugs are driving spending growth.
3. Institute a prescription drug affordability board (PDAB) to review the cost drivers for prescription drugs and make recommendations to reduce costs that acknowledge the important role of innovative and high value drugs.
4. Increase oversight of transfers of ownership and consolidation of healthcare provider entities to ensure the stability of Connecticut's health systems and safeguard access and affordability.
5. Study policy options and analyze efforts across states to implement additional affordability programs such as reference-based pricing, out-of-network caps, hospital global budgets, and regulatory review of payer-provider contracts for health care entities.
6. Examine the use of Performance Improvement Plans (PIPs) in other states as a means of managing cost growth and consider PIPs as a tool in Connecticut.
7. Work with industry stakeholders to better understand and reduce administrative burdens for primary care, in order to allow primary care practitioners to spend more time practicing and helps maintain the primary care workforce.

Acronym Glossary

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

Glossary

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

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

Copayment: 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.

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

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

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

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

that have been billed directly by a physician group practice or an individual physician.

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

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

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

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

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

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

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

Primary Care Spending Target: This target is Connecticut's annual primary care spending as a percentage of total medical expenditures. The target should reach 10% by calendar year 2025, as directed in C.G.S. §§ 19a-754f et seq. OHS has set interim targets for each calendar year to reach 10% by 2025.

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

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

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

Introduction

On January 22, 2020, Governor Lamont signed Executive Order No. 5 directing the Office of Health Strategy (OHS) to establish statewide healthcare cost growth benchmarks for calendar years 2021-2025, with the goal of slowing the growth of healthcare spending and making healthcare more affordable for the residents of Connecticut. Executive Order No. 5 also required OHS to set targets to increase primary care spending as a percentage of total healthcare spending to 10.0 percent by 2025, with the goal of strengthening the state's primary care infrastructure. The benchmark program was codified during the 2022 legislative session (C.G.S. §§19a-754f et seq).

These actions implemented by Governor Lamont are key to addressing Connecticut's unsustainable healthcare cost growth, strengthening the state's primary care infrastructure, and improving healthcare quality and health equity in the state. Annual healthcare cost growth has consistently outpaced growth in the Connecticut economy and, even more importantly, resident household median income, compromising residents' ability to afford critical healthcare services and other basic needs[12].

C.G.S. §§19a-754f et seq also requires OHS to prepare and annually submit a report to the General Assembly that must describe healthcare spending and quality trends and their underlying factors, any unintended consequences resulting from the Healthcare Benchmark Initiative, and the commissioner's recommendations concerning strategies to improve the efficiency and quality of the state's healthcare system.

This report presents OHS' findings and recommendations pursuant to these outlined requirements.

[12] Medical Expenditure Panel Survey, Tables D.1 and D.2 for various years

Healthcare Spending and Quality Trends

This section of the report provides a summary of OHS' findings from the 2021-2022 cost growth benchmark, primary care spending target, and quality benchmark analyses. For more detailed summaries of 2021-2022 cost growth benchmark, primary care spending target, and quality benchmark performance, please see OHS' cost growth, primary care spending, and quality benchmark reports published earlier this year. For detailed methodological information about these analyses, please see the Connecticut Healthcare Benchmark Initiative Implementation Manual.

State Total Healthcare Expenditure (THCE) Trends

OHS examines year-over-year spending trends in at least three ways: 1. Total aggregate spending on healthcare plus insurance (THCE); 2. Per person per year spending on THCE; and 3. Per person per year spending on healthcare only (TME).

Connecticut's aggregate THCE[13] was $34.8 billion in 2021 and $36.4 billion in 2022, an increase of 4.5% (see **Figure 1**). The largest component of Connecticut's THCE for both years was commercial spending, followed by Medicare and Medicaid[14] spending, respectively. The net cost of private health insurance (NCPHI)[15], (one component of THCE), Department of Correction (DOC) spending and federal Veterans Health Administration (VHA) spending comprised a small portion of aggregate THCE and thus were not significant cost drivers.

[13] THCE is 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 (NHCPI).

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

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

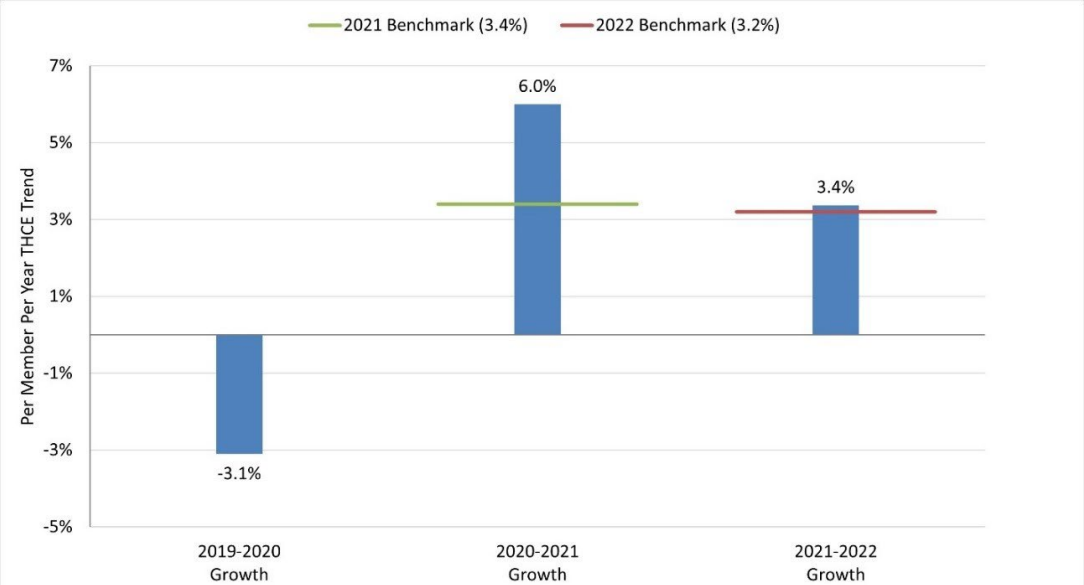
In 2022, per person spending on healthcare plus insurance in Connecticut was $10,851, representing growth of 3.4% over 2021, which is above the 3.2% cost growth benchmark for the state (see Figure 2).

Figure 1. Aggregate State Total Healthcare Expenditures in billions (2021-2022)

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

Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates. "Other Public Sources" includes CT DOC and VHA spending. "NCPHI" is the net cost of private health insurance.

Figure 2. State Per Person Per Year Total Healthcare Expenditure Trend (2019-2022)



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

Total Medical Expense (TME) Trends

TME Trends by Market

TME examines spending on healthcare costs alone, minus the cost of health insurance. OHS assesses per member per year TME[16] trends in three markets: Medicare, Medicaid and Commercial. Per member per year TME trends are a product of changes in both healthcare utilization and payment per service.

Commercial spending increased by 2.4% (below the benchmark) to $8,062 per member per year between 2021 and 2022 (see **Figure 3**). Commercial market

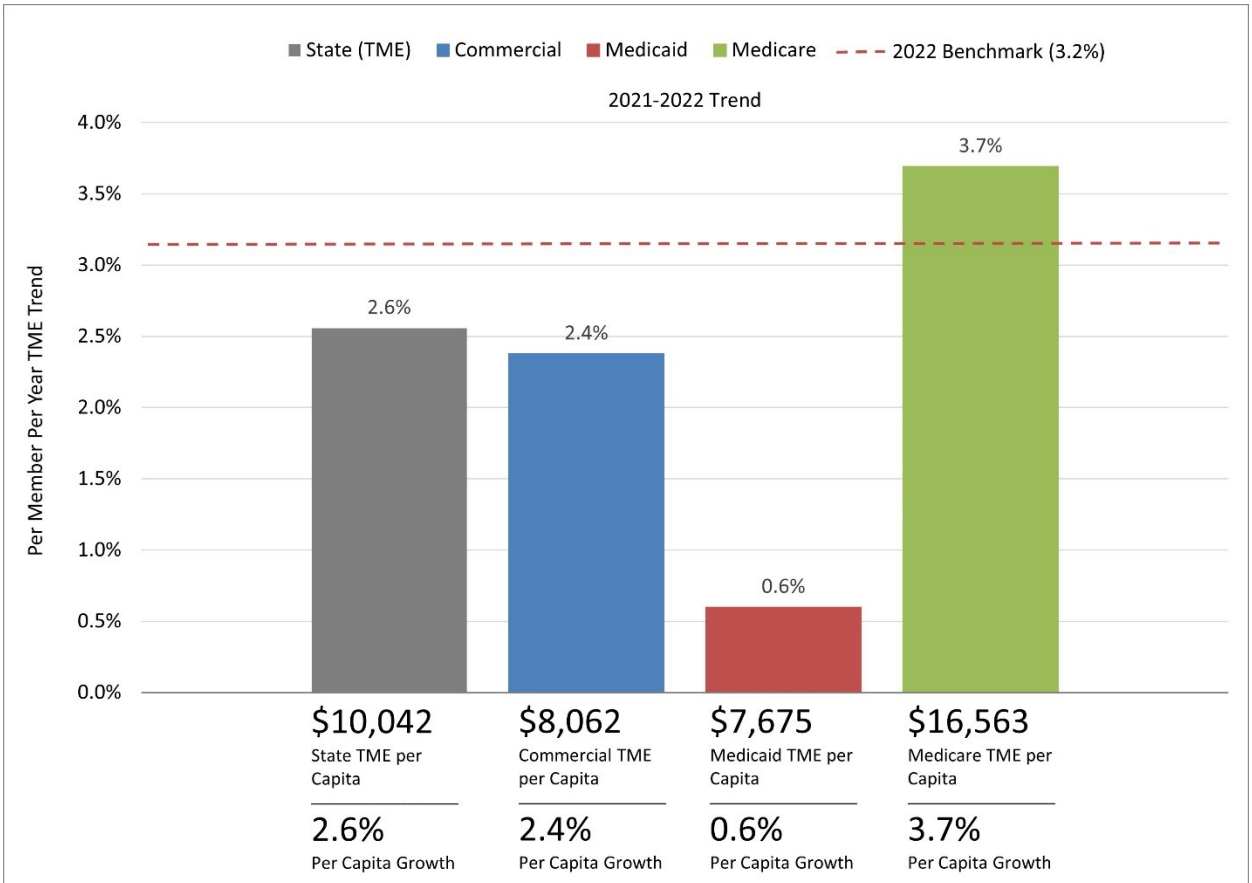
[16] TME is the total cost of care for the patient population of a payer or provider entity for a given calendar year, where cost is calculated for such year as the sum of: all claims-based spending paid to providers by public and private payers, and net of pharmacy rebates; all nonclaims payments for 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.

enrollment dropped by 3.0% in 2022, continuing its decline in membership seen in both 2020 and 2021.

Medicare per member per year spending increased by 3.7% to $16,563 in 2022, above the benchmark. During the same period, Medicare enrollment increased by 7.7%.

Medicaid per member per year spending increased by 0.6% to $7,675 in 2022, experiencing the slowest growth of the three major markets. Medicaid enrollment during this period increased by 3.5%.

Figure 3. State Per Member Per Year Total Medical Expense (TME) Trends by Market (2021-2022)



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

2022 Trends in Major Service Category Spending

OHS collects and analyzes service category spending to determine the main contributors to healthcare cost growth. OHS collects aggregated claims-based data from payers according to the following service categories:

1. Hospital inpatient
2. Hospital outpatient
3. Professional, physician
4. Professional, specialty
5. Professional, other
6. Retail pharmacy
7. Long-term care
8. Other

OHS also collects aggregate non-claims payments from payers according to the following categories:

1. Prospective capitation, global budget, case rate or episode-based payments
2. Provider salaries
3. Performance incentive payments
4. Payments to support population health and practice infrastructure
5. Recoveries
6. Other

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

At the state level, the greatest contributor to per person spending growth in 2022 was the retail pharmacy service category, which increased by 7.7% between 2021 and 2022. Retail pharmacy drove spending growth across all three markets. Other cost drivers include hospital outpatient services (7.6% growth in the Medicare market and 5.1% growth in the Medicaid market), and professional physician services (4.7% increase in the commercial market).

Table 1. Trends in Major Service Category Spending

Market	2021-2022 Spending Trend			
	Retail Pharmacy	Hospital Outpatient	Hospital Inpatient	Physician Services
Commercial	9.0%	3.0%	-3.7%	4.7%
Medicare	6.4%	7.6%	0.0%	2.6%
Medicaid	15.1%	5.1%	3.2%	-2.3%

Primary Care Spending as a Percentage of Total Medical Expenses

This report section presents an analysis of Connecticut's primary care spending against the primary care spending target in 2021 and 2022 at the state and market levels.[17] A primary care spending target is an expectation of the percentage of healthcare spending that should be devoted to primary care. The primary care spending target evaluates primary care spending as a percentage of total medical expenditures. For OHS' definition of primary care spending, please see the Connecticut Healthcare Benchmark Initiative Implementation Manual.

State Primary Care Spending

Statewide primary care spending in 2022 reached $1.05 billion, an increase from approximately $1 billion in 2021 (see **Table 2**). On a per person per month basis, primary care rose modestly to $30 in 2022 from $29 in 2021. Commercial primary care spending increased to $503 million, up slightly from $495 million in 2021. On a per person per month basis, primary care spending in the commercial market rose to $26, an increase from $25 in 2021.

Medicaid aggregate primary care spending totaled $388 million, up from $365 million in 2021. However, per person per month spending on primary care decreased from $27 per person in 2021 to $26 per person in 2022. Spending on primary care within the Medicare Advantage market increased to $165 million, marking a substantial rise from $135 million in 2021.

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

Table 2. Primary Care Spending Totals and Per Person Per Month

Year	Category	Total Primary Care Spending	Spending Per Person Per Month
2021	Statewide Aggregate	$995,572,927	$29
2022	Statewide Aggregate	$1,056,133,091	$30
2021	Commercial	$494,619,698	$25
2022	Commercial	$502,839,349	$26
2021	Medicaid	$365,235,907	$27
2022	Medicaid	$387,945,411	$26
2021	Medicare Advantage	$135,717,322	$35
2022	Medicare Advantage	$165,348,332	$40

State Primary Care Spending by Market

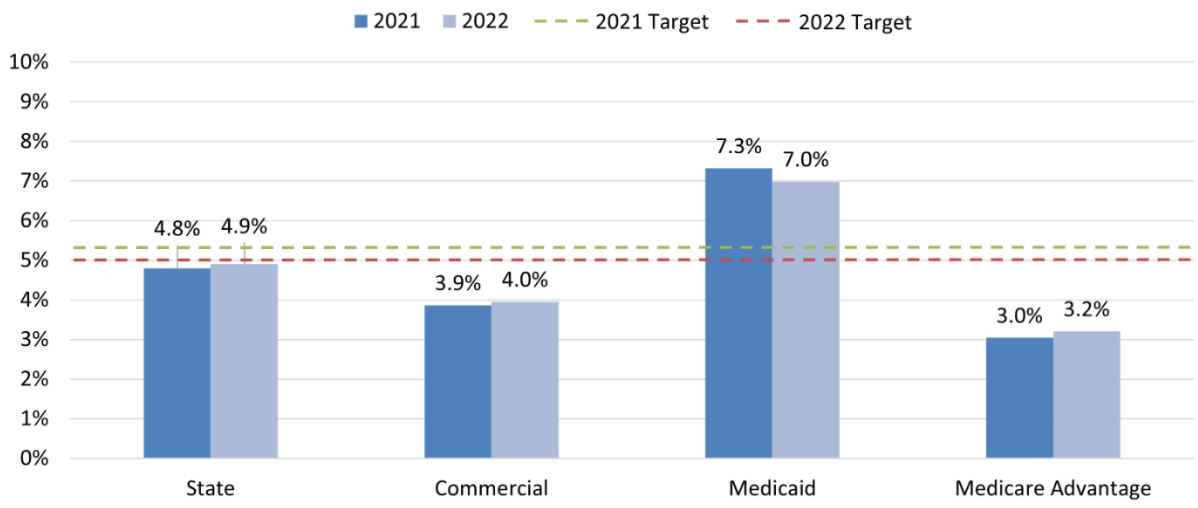
In 2022, statewide, primary care spending accounted for 4.9 percent of all medical spending, falling short of the 5.3 percent target and showing only a small increase from 4.8 percent in 2021 (see **Figure 4**). Connecticut's **commercial market** primary care spending in 2022 accounted for 4.0 percent of overall spending, falling below the target.

The Connecticut **Medicaid market** allocated 7.0 percent of total healthcare spending to primary care, meeting the 5.3 percent target. While the share of Medicaid's per person spending on primary care decreased to 7.0 percent in 2022, it was above the 2022 benchmark. Primary care spending in Connecticut's **Medicare Advantage market** accounted for 3.2 percent of total healthcare spending in 2022, falling short of the 5.3 percent target for primary care spending.[18] On a per person basis, primary care spending in the Medicare

[18] OHS is unable to include Medicare FFS primary care spending in this report due to the lack of availability of 2022 data from the federal Centers for Medicare & Medicaid Services (CMS).

Advantage market increased to 3.2 percent in 2022, up from 3.0 percent in 2021.

Figure 4. State and Market Primary Care Spending as a Percentage of Total Medical Expense



Data Source: OHS collected data from insurance carriers and from the Connecticut Department of Social Services (DSS).
Notes: Data are not risk adjusted. Data are net of pharmacy rebates. Data include commercial, Medicare Advantage and Medicaid FFS spending. TME includes all of the spending categories captured for the cost growth benchmark, less long-term care.

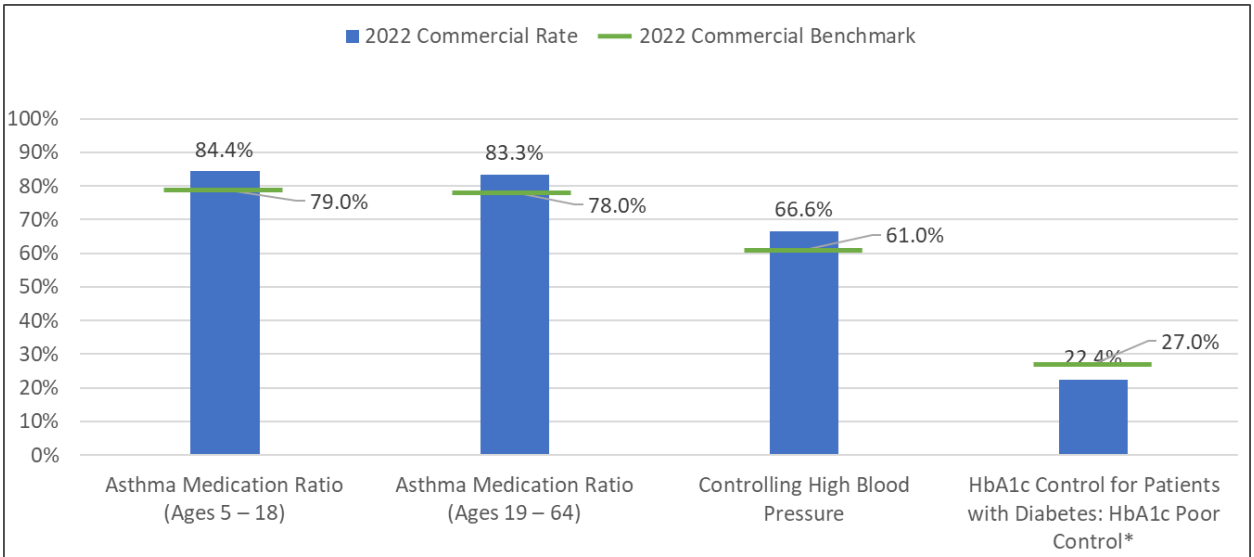
Quality Benchmark Performance by Market

This section presents 2022 market level performance on the Quality Benchmark measures for the commercial, Medicare Advantage and Medicaid markets.

Commercial Performance

Connecticut met the 2022 commercial Quality Benchmarks for all three measures (*Asthma Medication Ratio, Controlling High Blood Pressure, and HbA1c Control for Patients with Diabetes: HbA1c Poor Control)* (see **Figure 5**).

Figure 5: 2022 Statewide Commercial Performance on Quality Benchmark Measures

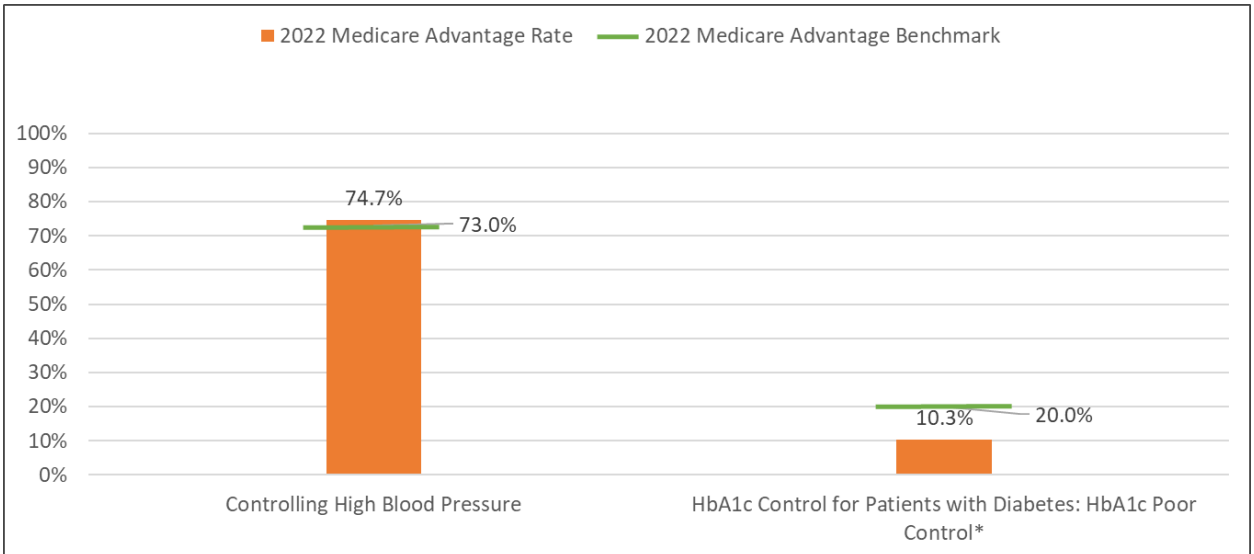


*A lower performance rate indicates better performance for HbA1c Poor Control.
Data Source: OHS collected performance data from insurance carriers.
Notes: Commercial performance is a weighted average of insurer performance, using commercial member months from OHS' cost growth benchmark data request.

Medicare Advantage Performance

Connecticut met the Quality Benchmarks for both Medicare Advantage measures – *Controlling High Blood Pressure* and *HbA1c Control for Patients with Diabetes*: *HbA1c Poor Control* (see **Figure 6**).

Figure 6: 2022 Statewide Medicare Advantage Performance on Quality Benchmark Measures

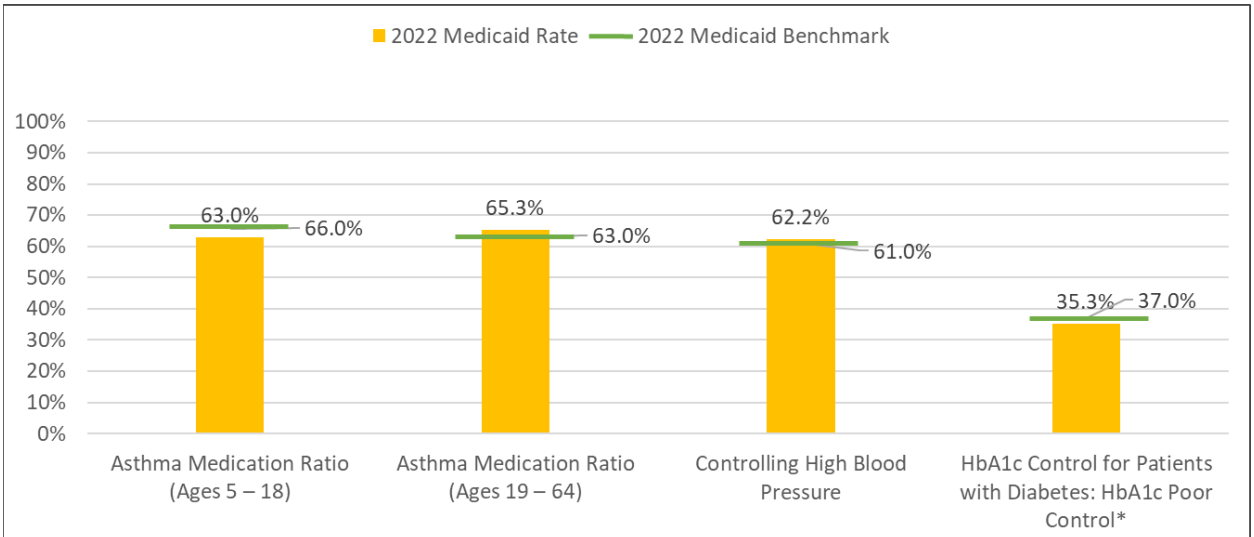


*A lower performance rate indicates better performance for HbA1c Poor Control.
Data Source: OHS collected performance data from insurance carriers.
Notes: Medicare Advantage performance is a weighted average of insurer performance, using Medicare Advantage member months from OHS' cost growth benchmark data request.

Medicaid Performance

Connecticut met the 2022 Medicaid Quality Benchmarks for *Asthma Medication Ratio (Ages 19-64), Controlling High Blood Pressure* and *HbA1c Control for Patients with Diabetes: HbA1c Poor Control* but not for *Asthma Medication Ratio (Ages 5-18)* (see **Figure 7**).

Figure 7: 2022 Statewide Medicaid Performance on Quality Benchmark Measures



*A lower performance rate indicates better performance for HbA1c Poor Control.
Data Source: OHS collected performance data from the Department of Social Services (DSS).
Notes: Medicaid performance includes HUSKY A/B, HUSKY C, and HUSKY D but excludes Medicare/Medicaid dual eligible members. Medicaid performance for the hybrid measures (Controlling High Blood Pressure and HbA1c Poor Control) are a weighted average of HUSKY A/B, HUSKY C and HUSKY D.

Monitoring of Unintended Adverse Consequences

OHS' Cost Growth Benchmark Unintended Adverse Consequences Measurement Plan ("measurement plan") was developed at the recommendation of a Technical Team and Stakeholder Advisory Board, two former advisory bodies to OHS. These advisory bodies observed that the cost growth benchmark could possibly result in unintended adverse consequences, such as providers inappropriately reducing access to healthcare services to meet the benchmark, especially for marginalized populations, and insurers transferring costs to consumers to suppress utilization and spending.

OHS' measurement plan includes: (1) underutilization measures (including preventive and chronic care measures, member experience surveys, and member grievances) and (2) consumer out-of-pocket spending. An analysis of these measures pre- and post-benchmark follows below.

Additional measures that OHS is interested in monitoring, but which require further development, include: anti-stinting measures; timely access to specialty care; consumer out-of-pocket spending trends for preventive services; and measures specific to marginalized populations. Details on these measures and the additional work required to implement them can be found in the measurement plan.

Underutilization Measures

Commercial performance has improved since benchmark implementation for five out of ten preventive and chronic care measures, with performance for another two measures remaining relatively unchanged (within three percentage points). Three measures have seen a decline in performance post-benchmark implementation: *Chlamydia Screening* (-11.5 percentage points), *Eye Exam for Patients with Diabetes* (-6.6 percentage points), and *Timeliness of Prenatal Care* (-5.1 percentage points) (see Error! Reference source not found.**3** in the Appendix). However, both regional (New England) and national performance also declined over this period for each of these measures, suggesting that these trends are neither specific to Connecticut

nor influenced by the cost growth benchmark. (See Appendix for detailed data).

Medicaid performance has improved since benchmark implementation for three out of twelve preventive and chronic care measures, with performance for another six measures remaining relatively unchanged (within three percentage points). Three measures have seen a decline in performance post-benchmark implementation: *Annual Dental Visit* (-9.1 percentage points), *Cervical Cancer Screening* (-5.4 percentage points), and *Eye Exam for Patients with Diabetes* (-3.1 percentage points) (see **Table 6** in the Appendix). However, both regional (New England) and national performance have also declined over this period (and to a greater extent) for each of these measures. Here again, this suggests that these trends are neither specific to Connecticut nor influenced by the cost growth benchmark.

Member experience surveys

OHS monitors commercial and Medicaid pre- and post-benchmark performance on member experience surveys to assess member perception of access to care, as well as patient satisfaction with healthcare services and providers. While these are not direct measurements of underutilization, they may help identify patient perception of underutilization that is only captured through a survey.

For the **commercial** market, OHS monitors changes in performance for two composite rates from the Health Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey: (1) the "Getting Care Quickly" composite[19] and (2) the "Getting Needed Care" composite[20]. Commercial

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

[20] The "Getting Needed Care" composite is the percentage of members who responded "Always" or "Usually" to the questions "In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?" and "In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?"

performance on these two measures has decreased since benchmark implementation; performance on "Getting Care Quickly" and "Getting Needed Care" decreased by 6.2 and 5.1 percentage points respectively (see **Table5** in the Appendix). However, again both regional (New England) and national performance also saw similar declines over this period for both measures, making cost growth benchmark causation unlikely, and highlighting the need to strengthen Connecticut's primary care infrastructure.

For the **Medicaid** market, OHS monitors changes in performance for the PCMH+ Person-Centered Primary Care Measure (PCPCM) for adult and child survey respondents.[21] The most recent PCPCM data available are post-benchmark implementation (2021). In 2021, 81.8% of adult survey respondents answered favorably to survey questions about the care they received, and 85.3% of child survey respondents answered favorably (see **Table4** in the Appendix). OHS will continue to monitor changes in PCPCM performance post-benchmark as results become available from DSS.

Tracking member grievances

OHS also tracked Medicaid member grievances pre- and post-benchmark implementation to monitor for impact on patient care and potential underutilization in the Medicaid population. OHS monitored the change in the number of Medicaid members filing complaints about no or limited access to providers, and the change in the number of Medicaid members filing complaints about delayed access and/or wait time for an appointment. Complaints about no or limited access to providers have decreased by 69 percent post-benchmark implementation and complaints about delayed access and/or wait time for an appointment have decreased by 42 percent (see **Table 10** in the Appendix). It is notable that complaint frequency about delayed access was very low, both pre- and post-benchmark.

[21] As described in its Unintended Consequences Measure Plan, OHS intended to monitor changes in Medicaid member experience using the Clinician and Group (CG) CAHPS survey; however, DSS replaced CG-CAHPS with the PCPCM survey in the PCMH+ Wave 3 Quality Measure Set as of January 1, 2021. For this reason, 2020 PCPCM performance data are not available.

Consumer Out-of-Pocket Spending

Finally, OHS monitored changes in consumers' healthcare costs using two different data sources: the State's All-Payer Claims Database (APCD) and the U.S. Census Bureau's Current Population Survey (CPS). When OHS assessed out-of-pocket spending using the APCD, it found that Connecticut residents pay approximately the same percentage of healthcare costs out-of-pocket for medical or retail pharmacy services in the commercial market following benchmark implementation as before it (see **Tables 8 and 9** in the Appendix). CPS data, which include data for all ages and insurance status, show that *median* medical out-of-pocket spending actually *decreased* for Connecticut residents since benchmark implementation while the *mean* medical out-of-pocket spending has *increased* over this period (see **Table 7** in the Appendix). While changes in out-of-pocket costs cannot be tied to benchmark program specifically, these costs play a significant role in healthcare affordability for consumers and merit monitoring.

Recommendations

During 2024, OHS has identified several trends that it believes warrant further attention:

- The General Assembly's intention to statutorily create accountability for healthcare spending growth has been impeded by the refusal of some parties to appear at OHS' annual hearing when called.
- Continued year-over-year high growth in drug prices is impacting the commercial, Medicaid and Medicare markets in Connecticut. Understanding the roll of rebates in this process and implementing a prescription drug affordability review board will help contain cost growth.
- Transfers of ownership and consolidation of healthcare providers presents unique challenges for Connecticut's health system and OHS recommends increased scrutiny of these transactions to ensure they do not raise healthcare costs and contribute to the state missing its benchmark.
- OHS recommends studying a range of cost-growth mitigation strategies adopted in other states, including reference-based pricing, out-of-network caps, hospital global budgets, and regulatory review of payer-provider contracts.
- OHS recommends examining whether performance improvement plans have contributed to successful benchmark programs in other states.
- Administrative burdens consistent add to the cost of healthcare and reduce the time that providers can spend with patients. OHS recommends exploring ways to reduce these administrative hurdles.

In this context, the Commissioner offers the following recommendations to increase the efficiency and quality of the state's healthcare system. Many of these recommendations were presented to the Healthcare Benchmark Steering Committee in September 2024; however, the Committee does not necessarily endorse or oppose any specific recommendation or set of recommendations.

1. Institute a stronger system of accountability for entities called by OHS to participate in the annual public hearing who fail to appear.

   Rationale: It is essential that organizations influencing the growth of healthcare costs in Connecticut participate in the public conversation on solutions. If Connecticut is to improve access to affordable, high-quality healthcare for its residents, it will need all stakeholders actively engaged and working collaboratively toward a common goal. Although many stakeholders do so, OHS has identified a few who do not, which leaves their important voices and expertise out of the conversation.

   Policy Options: Although some states penalize entities for exceeding the benchmark, it is unclear if any states authorize the benchmarking agency to penalize entities for not participating in the hearing process despite a legal obligation to do so. Connecticut could enact legislation granting OHS greater enforcement authority power to require entities to appear at the annual public hearings.

2. Improve collection of data on drug rebates at the National Drug Code level, which will help OHS more accurately understand which prescription drugs are driving spending growth.

   Rationale: OHS analyses of both payer-submitted cost growth benchmark data and data from the All-Payer Claims Database (APCD) have repeatedly identified retail pharmacy as one of the primary drivers of healthcare cost growth in Connecticut. However, OHS' analyses are limited by the lack of drug-specific rebate data. For example, during the 2023 Cost Growth Benchmark Initiative public hearing, a drug manufacturer remarked that OHS' drug-specific analyses are incomplete without accounting for rebates, yet that same manufacturer was unwilling to share drug-specific rebate data unless required.

   Policy Options: Connecticut could look to New Jersey, Minnesota and Maine for examples of how to require submission of drug-specific rebate

data. New Jersey requires pharmacy benefit managers (PBMs) and drug wholesalers to report the total rebates negotiated with the manufacturer for each drug. Minnesota requires manufacturers, pharmacies, PBMs, and wholesalers to annually report the total rebates received and paid for each drug. Finally, Maine requires manufacturers, wholesale distributors, and PBMs to submit pricing component data including the number of units sold and total rebates received or paid, which enables calculation of drug-specific rebates. Drug-specific rebate data would provide a more complete picture on retail prescription drug costs. Additionally, Connecticut could follow West Virginia's precedent, which requires requiring drug rebates to be calculated at the point of sale and passed through to consumers.

3. Institute a prescription drug affordability board (PDAB) to review the cost drivers for prescription drugs, focusing on drugs that do not provide high patient value or innovation, and make recommendations on policies to reduce drug costs.

   Rationale: As discussed in Recommendation 2, analyses have repeatedly identified retail pharmacy as one of the primary drivers of healthcare cost growth in Connecticut. Currently, the state is limited in its ability to address the costs head-on. A PDAB would allow Connecticut to leverage the work of experts in the state as well as PDABs of other states to better analyze prescription drug cost information to identify the root causes of high drug prices. The PDAB would then be able to make recommendations to the legislature and other policymakers for methods to address high and continually rising drug costs.

   Policy Option: Connecticut previously considered creating a PDAB to bring together experts with experience in the field of prescription drug economics to study the issue of drug prices and make policy recommendations. Currently, 11 states have enacted PDABs and 13 states have considered or are currently considering legislation to implement a PDAB. Each has slightly different responsibilities and authorities, and

Connecticut may want to tailor any PDAB to reflect drug value and innovation. All PDABs, though, are tasked with assessing ways to make prescription drugs more affordable.

4. Increase oversight of transfers of ownership and consolidation of healthcare provider entities to ensure the stability of Connecticut's health systems and safeguard access and affordability.

   Rationale: National Research shows that health care market consolidation both horizontally (one hospital system acquiring another), or vertically (a hospital acquiring a physician practice) can lead to higher health care prices. In addition, the Office of Health Strategy (2024) "Impacts of Connecticut Hospital and Health Care System Consolidation (2016-2021)" report found that overall, hospital consolidation contributed to faster increases in health care prices. Recently, a prominent hospital system faced bankruptcy as a result of harmful financial practices, such as selling off real estate assets to generate quick returns at the expense of long-term stability.

   Policy Options: Connecticut previously considered requiring hospitals to obtain state permission when selling 10% or more of its assets, including real estate, and the State could pursue this strategy once more. California is currently considering legislation that would require Attorney General approval for significant healthcare transactions involving private equity firms. Alternatively, Connecticut could borrow from New York's new law, which requires public notification and review of significant healthcare transactions.

   Other potential policies Connecticut could pursue include:

   - Enhance reviews of all transfers of ownership and other significant transactions that have the potential to significantly increase costs of care, reduce residents' access to care, or contribute to the state failing to meet its healthcare benchmarks;

- Requiring detailed reporting on the financial health and operations of healthcare provider entities to be able to identify early warning signs of financial distress or potentially harmful financial practices;
- Implementing regulations to protect staff levels and prevent drastic cost-cutting following material changes of provider organizations;
- Restricting the sale of critical assets like real estate shortly after an acquisition;
- Capping the amount of debt that can be used in leveraged buyouts to reduce financial risk, and
- Developing and enforcing quality-of-care metrics for healthcare provider entities.

Of note, several of these strategies are incorporated in model legislation recently developed by the National Academy for State Health Policy.

5. Study policy options and analyze efforts across states to implement reference-based pricing, out-of-network caps, hospital global budgets, and regulatory review of payer-provider contracts for health care entities.

Rationale: Benchmark analyses have consistently identified hospital prices as a key driver of unsustainable growth in healthcare costs. Payers have argued that hospital prices are one of the key reasons that the commercial insurers continue to request double-digit percentage increases in premiums. States have taken a variety of steps to address certain aspects of high hospital prices, and Connecticut would benefit from a more thorough understanding of the potential benefits and pitfalls of such policy initiatives.

Policy Options: Just as Connecticut has taken a close look at other key issues such as pharmacy benefits managers (PBMs), behavioral health parity, hospital consolidation, and hospital community benefit expenditures, the legislature could request and fund an analysis of policy options specifically directed at drivers of hospital costs. The legislature

might convene a working group or fund a study and report that looks at ways states have implemented policies that have been considered in the state, like reference-based pricing for hospitals, caps on the amount that can be charged for out-of-network care, hospital global budgets, and having state agencies review the contracts between payers and healthcare providers to ensure the rates paid are reasonable. For example, Delaware passed a law that will ultimately allow have a Hospital Cost Review Board review all payer-provider contracts to align hospital payment rates with the underlying cost of care at that hospital. In the interim, Delaware will have a reference-based pricing cap prohibiting hospitals from having reimbursement rates in excess of 250% of the Medicare rate for the service at that hospital.

6. Examine the use of Performance Improvement Plans (PIPs) in other states as a means of managing cost growth amongst cost driving entities and consider PIPs as a tool in Connecticut.

   Rationale: Performance improvement plans provide a mechanism for states to work with entities that are identified as significant cost contributors or who are exceeding the benchmark to find ways to reduce costs without sacrificing quality and accessibility of care.

   Policy Options: Instituting Performance Improvement Plans serves as a deterrent for entities to keep healthcare cost growth within the benchmark target. Massachusetts has implemented the PIP and is currently working with Mass General Brigham, who had $293 million of commercial spending growth in excess of the benchmark between 2014-2019 – more than any other provider.[22] Since implementing a PIP, Mass General Brigham has reported $45.3 million in cumulative savings at the close of the 2nd

[22] 1 Massachusetts Health Policy Commission, (2022, Sept. 27). HPC Board Meeting. Retrieved from https://www.mass.gov/doc/extract-of-board-presentation-september-27-2022/download

quarterly reporting period of the total 18-month PIP.[23] The total savings target under the 18-month PIP period is $176.3M.

Studying Performance Improvement Plans in other states will assist Connecticut with understanding the use of such plans, their effectiveness, and potential outcomes to achieving cost containment goals.

7. Work with industry stakeholders to reduce administrative burdens for primary care (e.g., prior authorization), which allows primary care practitioners to spend more time practicing and helps maintain the primary care workforce.

   Rationale: The administrative burden associated with delivering primary care poses a challenge for current practitioners, as well as for attracting future providers. This is a national problem, and Connecticut is no exception. Potential areas of focus could be prior authorization, and disparate reporting requirements across insurers. Broadly, OHS recommends better understanding administrative burdens faced by primary care practitioners and crafting solutions that strengthen the primary care workforce**.**

   Policy Options: Connecticut can look to several states which have passed laws based on model legislation from the American Medical Association, which includes reforms such as reducing the amount of time insurers have to respond to a prior authorization request. Reducing certain prior authorization burdens can potentially increase health care costs: so, Connecticut may consider pairing prior authorization legislation with additional monitoring of adverse consequences.

   To reduce administrative burden related to quality measure reporting, Connecticut has an Aligned Measure Set to guide payer decisions around which quality measures to use in contracts. Connecticut could require adoption of its Aligned Measure Set, as is done in Rhode Island.

[23] Mass General Brigham, Performance Improvement Plan March 2023 Update, Retrieved from https://www.mass.gov/doc/mass-general-brigham-pip-public-6-month-report/download

Appendix

Table 3. Commercial Underutilization Measures

Measure Name[24]	2019 Connecticut Performance	2020 Connecticut Performance	2021 Connecticut Performance	2022 Connecticut Performance	2023 Connecticut Performance	Pre/post benchmark change (2019-2023[25]) Percentage points (pp)
Asthma Medication Ratio	78.3%	78.5%	81.7%	83.3%	83.2%	4.9 ↑
Breast Cancer Screening	77.7%	78.4%	76.5%	81.3%	82.1%	4.4 ↑
Cervical Cancer Screening	81.8%	82.5%	79.9%	83.2%	83.4%	1.6 ↑
Child and Adolescent Well-Care Visits	NA[26]	72.3%	77.2%	78.8%	80.4%	8.1 ↑

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

[25] All measures assess the change in performance from 2019 to 2023, except for *Child and Adolescent Well-Care Visits* which assesses the change in performance from 2020 to 2023 because it was new for measurement year 2021 (calendar year 2020).

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

Chlamydia Screening in Women	66.2%	66.7%	58.8%	55.2%	54.8%	-11.5 ↓
Colorectal Cancer Screening	72.8%	74.1%	71.5%	70.1%	73.7%	0.9 ↑
Controlling High Blood Pressure	61.1%	61.4%	58.5%	65.3%	70.1%	9.0 ↑
Eye Exam for Patients with Diabetes	65.7%	67.1%	60.9%	62.2%	59.1%	-6.6 ↓
Prenatal and Postpartum Care – Postpartum Care	85.7%	86.1%	82.1%	86.7%	87.8%	2.2 ↑
Prenatal and Postpartum Care – Timeliness of Prenatal Care	89.0%	89.5%	85.1%	88.9%	83.8%	-5.1 ↓

Data Source: NCQA Quality Compass® 2020-2024. Connecticut performance is a weighted average of commercial plan performance.

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

Table 4. Medicaid Underutilization Measures

Measure Name	2019 Connecticut Performance	2020 Connecticut Performance	2021 Connecticut Performance	2022 Connecticut Performance	Pre/post benchmark change (2019-2022[27]) Percentage points (pp)
Annual Dental Visit	74.0%	57.9%	65.1%	64.9%	-9.1 ↓
Asthma Medication Ratio	64.3%	69.3%	65.2%	64.6%	0.3 ↑
Behavioral Health Screening	37.9%	38.5%	42.5%	45.3%	7.4 ↑
Breast Cancer Screening	59.7%	56.0%	55.5%	57.7%	-2.0 ↓
Cervical Cancer Screening[28]	59.7%	56.1%	55.2%	54.3%	-5.4 ↓
Child and Adolescent Well-Care Visits	NA[29]	60.4%	66.6%	64.1%	3.7 ↑
Chlamydia Screening in Women	67.7%	63.6%	66.1%	66.4%	-1.3 ↓
Controlling High Blood Pressure	61.2%	60.0%	63.7%	62.2%	1.0 ↑

[27] All measures assess the change in performance from 2019 to 2022, except for *Child and Adolescent Well-Care Visits* which assesses the change in performance from 2020 to 2022 because it was new for measurement year 2021 (calendar year 2020).
[28] This hybrid measure is reported using administrative claims data only for all rates.
[29] *Child and Adolescent Well-Care Visits* was new for measurement year 2021 (calendar year 2020). It combined *Well-Child Visits in the Third, Fourth Fifth and Sixth Years of Life* with *Adolescent Well-Care Visits* and added age 7-11 to the measure.

Developmental Screening in the First Three Years of Life	63.0%	63.3%	65.0%	63.7%	0.7 ↑
Eye Exam for Patients with Diabetes[30]	56.9%	50.6%	53.7%	53.8%	-3.1 ↓
Prenatal and Postpartum Care – Postpartum Care[31]	52.7%	53.1%	55.0%	58.6%	5.9 ↑
Prenatal and Postpartum Care – Timeliness of Prenatal Care[32]	67.4%	70.2%	65.8%	67.6%	0.2 ↑

Data Source: Data were obtained from DSS' HUSKY Health Program Health Equities Report, MY2019, MY2020, MY2021, and MY2022, with the exception of *Controlling High Blood Pressure* for MY 2022 for which performance data were obtained from DSS' Quality Benchmark data.

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

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

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

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

Table 5. Commercial Member Experience Measures

Measure Name	2020 Connecticut Performance	2021 Connecticut Performance	2022 Connecticut Performance	2023 Connecticut Performance	Pre/post benchmark change (2020-2023) Percentage points (pp)
"Getting Care Quickly" Composite[33] (Health Plan CAHPS)	87.0%	83.5%	83.8%	80.8%	-6.2 ↓
"Getting Needed Care" Composite[34] (Health Plan CAHPS)	90.1%	84.4%	83.0%	85.1%	-5.1 ↓

Data Source: NCQA Quality Compass® 2020-2024. Connecticut performance is a weighted average of commercial plan performance.

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

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

[34] The "Getting Needed Care" composite is the percentage of members who responded "Always" or "Usually" to the questions "In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?" and "In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?"

Table 6. Medicaid Member Experience Measures

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

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

Table 7. Medical Out-of-Pocket Spending Per Member Per Month by Region

Region	Average pre-benchmark (2019-2020)				Average post-benchmark (2021-2023)				Pre/post benchmark percent change			
	Q25	Med	Q75	Mean	Q25	Med	Q75	Mean	Q25	Med	Q75	Mean
Connecticut	$8.33	$50.00	$241.67	$182.51	$6.81	$47.22	$243.61	$201.97	-18%	-6%	1%	11% ↑
Northeast	$5.83	$39.17	$184.17	$156.17	$4.44	$36.50	$188.11	$160.59	-24%	-7%	2%	3% ↑
National	$5.00	$37.58	$183.33	$151.85	$4.17	$35.42	$179.94	$151.77	-17%	-6%	-2%	0% →

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

Note: The ↑ symbol indicates that out-of-pocket spending increased post-benchmark implementation, the ↓ symbol indicates that out-of-pocket spending decreased post-benchmark implementation, and the → symbol indicates that out-of-pocket spending did not change post-benchmark implementation.

Table 8. Commercial Medical Out-of-Pocket (OOP) Spending Per Member Per Month (PMPM) and Percentage of Total Spending PMPM by Payer

Payer	Average pre-benchmark (2017-2020)		Average post-benchmark (2021-2022)		Pre/post benchmark change
	OOP PMPM	% of Total PMPM	OOP PMPM	% of Total PMPM	Percentage points (pp)
All Payer	**$53.09**	**12.5%**	**$59.17**	**11.6%**	**-0.9 pp ↓**
Aetna	$57.46	14.4%	$63.51	12.6%	-1.8 pp ↓
Anthem	$43.22	9.5%	$38.68	7.0%	-2.5 pp ↓
State Employees	*$9.59*	*1.9%*	*$9.54*	*1.6%*	*-0.3 pp ↓*
Non-State Employees	*$61.56*	*14.5%*	*$54.80*	*10.5%*	*-4.0 pp ↓*
Cigna	$55.77	13.4%	$64.16	13.5%	0.0 pp →
ConnectiCare	$93.10	19.4%	$93.42	17.9%	-1.5 pp ↓
Harvard Pilgrim Health Care	$75.70	19.1%	$85.63	18.2%	-0.9 pp ↓
Tufts Health Plan	$37.05	15.6%	$61.25	14.7%	-0.9 pp ↓
UnitedHealthcare	$44.56	12.0%	$70.99	16.6%	4.6 pp ↑
State Employees	*$10.21*	*2.3%*	-	-	-
Non-State Employees	*$58.24*	*16.8%*	*$70.99*	*16.6%*	*-0.2 pp ↓*

Data Source: Connecticut All-Payer Claims Database

Note: The ↑ symbol indicates that out-of-pocket spending increased post-benchmark implementation, the ↓ symbol indicates that out-of-pocket spending decreased post-benchmark implementation, and the → symbol indicates that out-of-pocket spending did not change post-benchmark implementation.

Table 9. Commercial Retail Pharmacy Out-of-Pocket (OOP) Spending Per Member Per Month (PMPM) and Percentage of Total Spending PMPM by Payer

Payer	Average pre-benchmark (2017-2020)		Average post-benchmark (2021-2022)		Pre/post benchmark change
	OOP PMPM	% of Total PMPM	OOP PMPM	% of Total PMPM	Percentage points (pp)
All Payer	**$11.89**	**11.1%**	**$14.23**	**10.8%**	**-0.3 pp ↓**
Aetna	$7.68	6.6%	$8.98	7.4%	0.8 pp ↑
State Employees	*$3.81*	*2.4%*	*$8.93*	*5.7%*	3.3 pp ↑
Non-State Employees	*$9.39*	*9.5%*	*$8.92*	*8.6%*	*-0.9 pp ↓*
Anthem	$22.46	15.0%	$25.67	14.0%	-1.1 pp ↓
Cigna	$13.44	13.0%	$15.79	10.2%	-2.8 pp ↓
ConnectiCare	$18.04	14.6%	$21.87	12.4%	-2.3 pp ↓
Express Scripts	$8.08	11.6%	$9.68	12.0%	0.3 pp ↑
Harvard Pilgrim Health Care	$14.14	13.3%	$16.45	10.8%	-2.4 pp ↓
Tufts Health Plan	$11.51	11.0%	$13.45	9.3%	-1.7 pp↓
UnitedHealthcare	$14.73	14.4%	$16.40	11.6%	-2.7 pp ↓

Data Source: Connecticut All-Payer Claims Database

Note: The ↑ symbol indicates that out-of-pocket spending increased post-benchmark implementation, the ↓ symbol indicates that out-of-pocket spending decreased post-benchmark implementation, and the → symbol indicates that out-of-pocket spending did not change post-benchmark implementation.

Table 10. Medicaid Member Complaints per 1,000 Member Months (MM)

Measure	Pre-Benchmark (2019-2020)		Post-Benchmark (2021-2023)		Pre/Post-Benchmark Change
	Total	Per 1,000 MM	Total	Per 1,000 MM	
Complaints about no or limited access to a specific provider type	690	0.033	386	0.010	-69% ↓
Complaints about delayed access and/or wait time for an appointment (e.g., delay in obtaining appointment, wait time while in office)	69	0.003	71	0.002	-42% ↓