Healthcare Cost Growth Benchmark Steering Committee Meeting
January 24, 2022

OHS
CONNECTICUT
Office *of* Health Strategy

Welcome and Roll Call

Meeting Agenda

Time	Topic
3:00 p.m.	I. Welcome and Roll Call
3:05 p.m.	II. Public Comment
3:10 p.m.	III. Approval of December 20, 2021 Meeting Minutes – Vote
3:15 p.m.	IV. Pre-Benchmark Analysis
4:15 p.m.	V. Input from the Stakeholder Advisory Board
4:25 p.m.	VI. Follow-Up Mathematica Analyses re: ED Utilization Disparities
4:55 p.m.	VII. Wrap-Up and Next Steps
5:00 p.m.	VIII. Adjournment

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Public Comment

Approval of the December 20, 2021 Meeting Minutes - Vote

Pre-Benchmark Analysis

Connecticut's Healthcare Cost Growth Benchmark

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

Connecticut's cost growth benchmark is an **annual rate-of-growth benchmark for statewide healthcare spending**.

The benchmark values are based on a methodology that was developed through a stakeholder process that considered various economic indicators.

The trends presented today are **pre-benchmark**, meaning they are establishing a baseline and not being measured against a specific benchmark value.

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Total Healthcare Expenditures

Total Medical Expense (TME) + **Net Cost of Private Health Insurance (NCPHI)** = **Total Healthcare Expenditures (THCE)**

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

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

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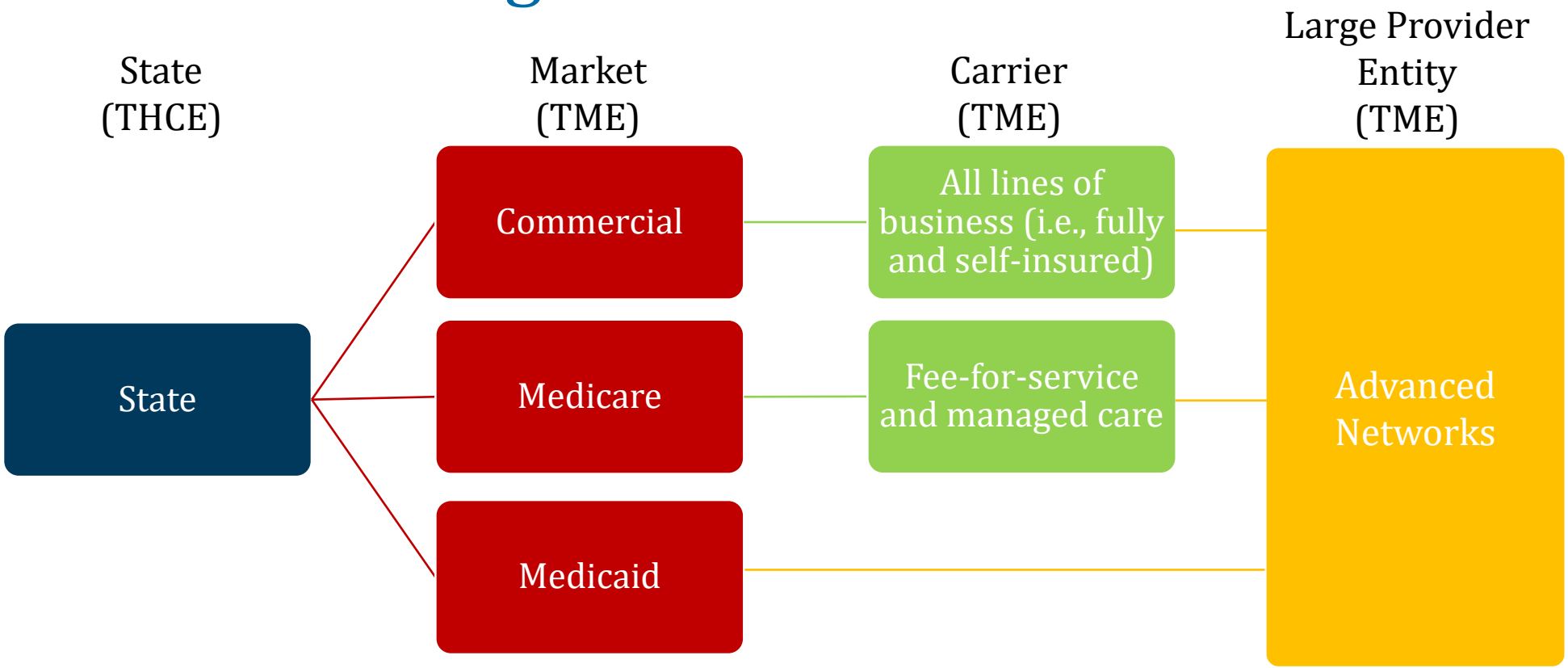
Four Levels of Performance Measurement Against the Benchmark and Target



Note: For 2018-2019 pre-benchmark measurement, cost growth is *only* being reporting at the state and market levels.

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Data Sources for THCE

THCE Component	Data Source
Commercial spending	TME reported by carriers
Medicare Managed Care spending	TME reported by carriers
Medicare FFS spending	Centers for Medicare & Medicaid Services
Medicaid spending	TME reported by Department of Social Services
NCPHI	Calculated from regulatory reports submitted by insurers or obtained through public sources
Veterans Health Administration spending	Veterans Health Administration
Department of Correction spending	Department of Correction

Insurance Carriers

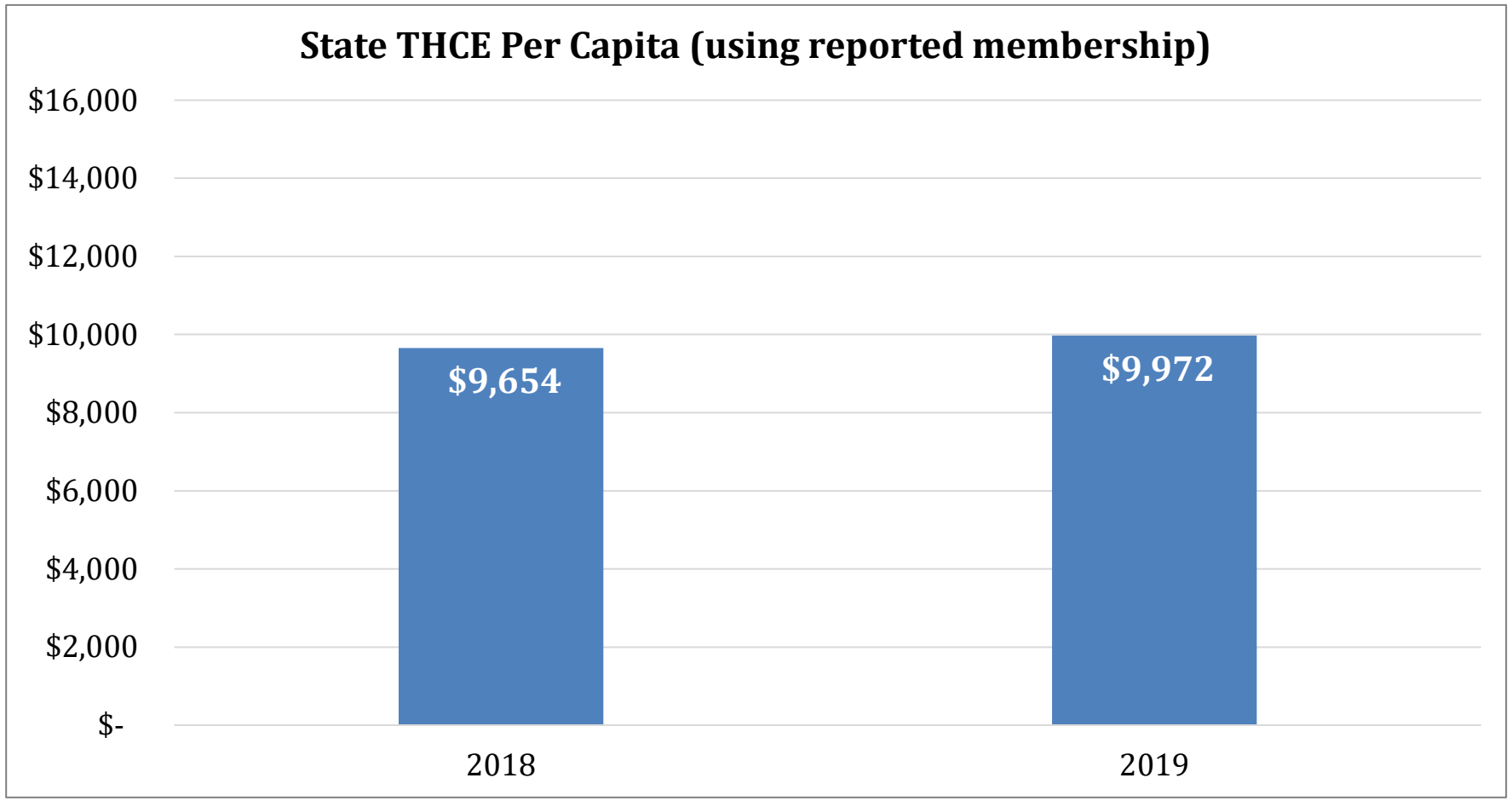
Insurance Carriers
1. Aetna Health & Life
2. Anthem
3. Cigna
4. ConnectiCare
5. Harvard Pilgrim Health Care
6. UnitedHealthcare

Data Collection, Validation and Analysis Timeline

Data Validation Process

- **Completeness checks** to ensure there were no obvious errors or omissions in the submitted data
- **Reasonableness checks** to ensure that data seemed appropriate when compared to external sources and at face value
- **Meetings with payers** to discuss potential data omissions and aberrant trends
- **Resubmissions** from payers to align data specifications in the Implementation Manual

Connecticut's Total Health Care Expenditures Grew 3.3% in 2019



THCE Trend Per Capita
3.3%

Data are not risk-adjusted. They are reported net of pharmacy rebates.
Data include the Net Cost of Private Health Insurance (NCPHI).
Total reported membership was 3,252,773 in 2019. The CT Census reported 3,565,287 individuals in 2019.

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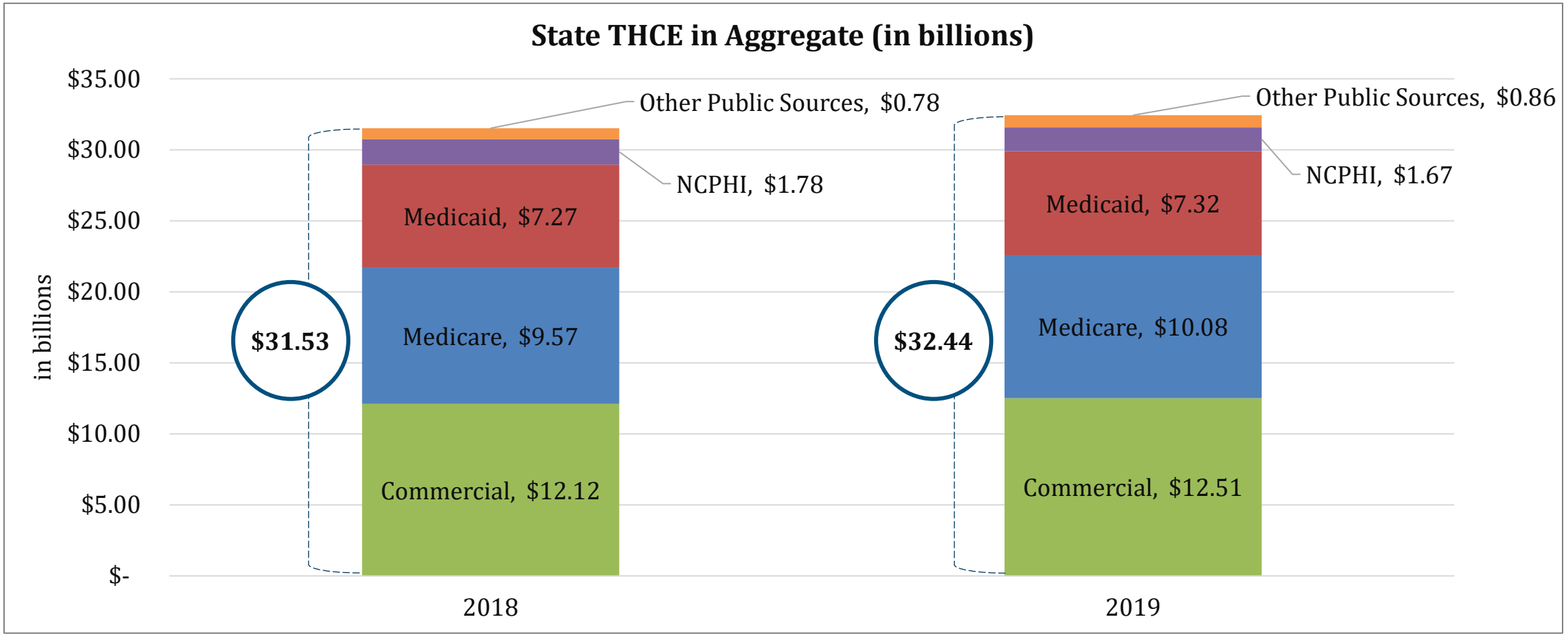
Connecticut's THCE was $32 billion in 2019



"Other Public Sources" includes CT Department of Correction and Veterans Health Administration spending.

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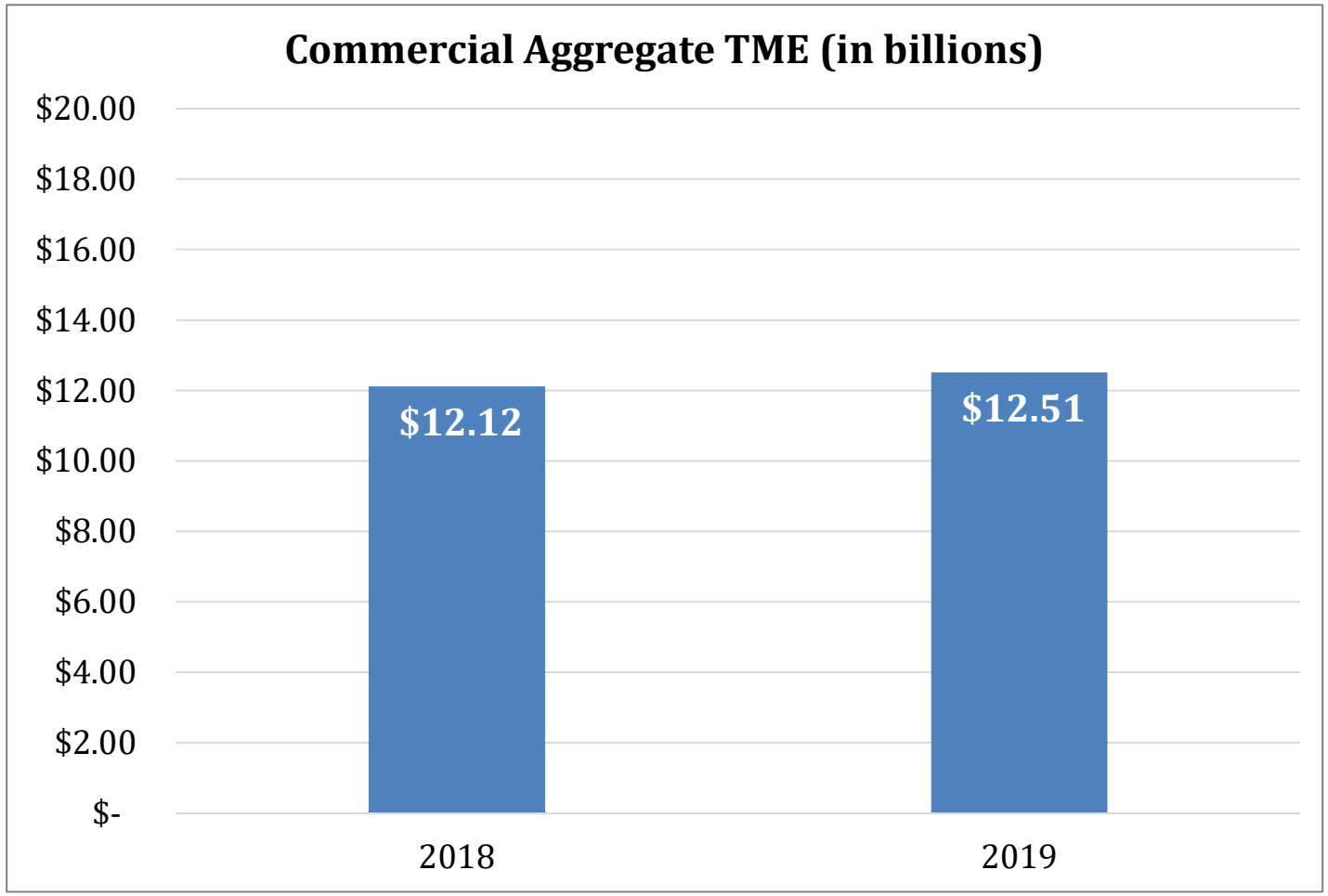
Commercial Per Capita Spending Growth in 2019 was 6.1%



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

Data are not risk-adjusted. They are reported net of pharmacy rebates.
Data do not include the Net Cost of Private Health Insurance (NCPHI).

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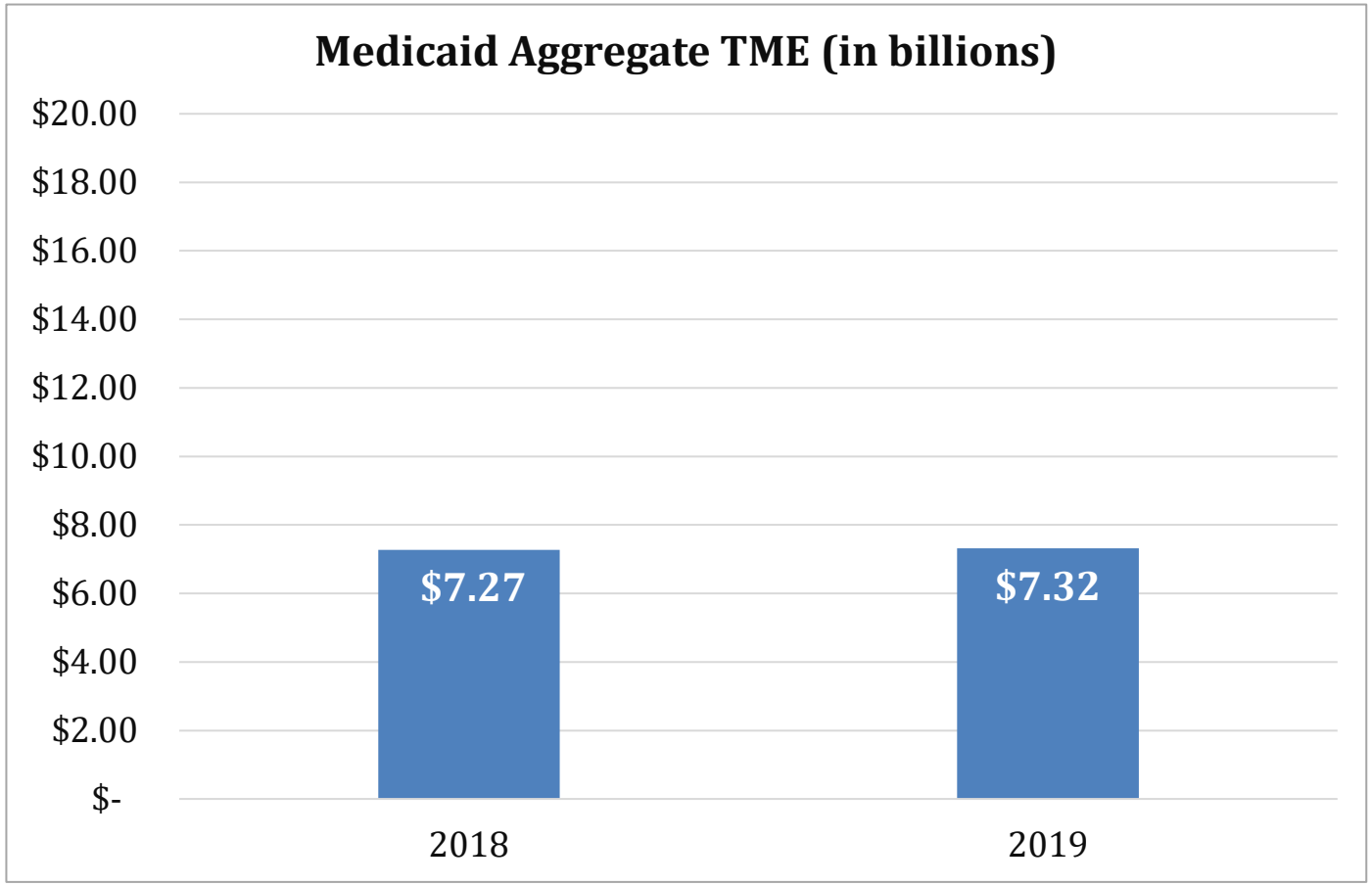
Medicaid Per Capita Spending Growth in 2019 was -0.9%



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

Data are not risk-adjusted. They are reported net of pharmacy rebates.
Data include Medicaid spending on the dually eligible population.
Data do not include payments to CT Administrative Services Organizations.

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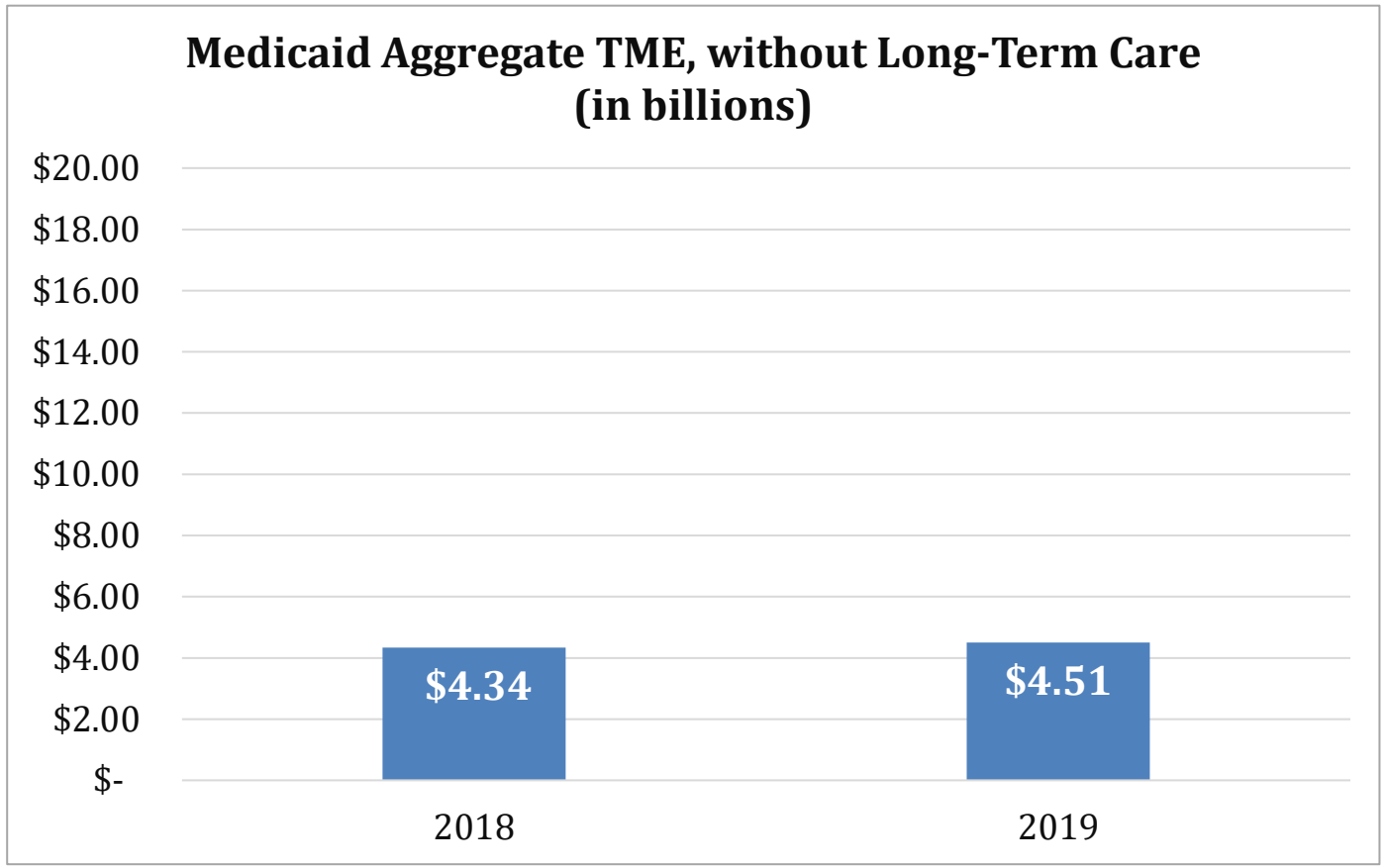
Medicaid Per Capita Spending Growth without Long-Term Care in 2019 was 2.1%



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

Data are not risk-adjusted. They are reported net of pharmacy rebates.
Data include Medicaid spending on the dually eligible population.
Data do not include payments to CT Administrative Service Organizations.

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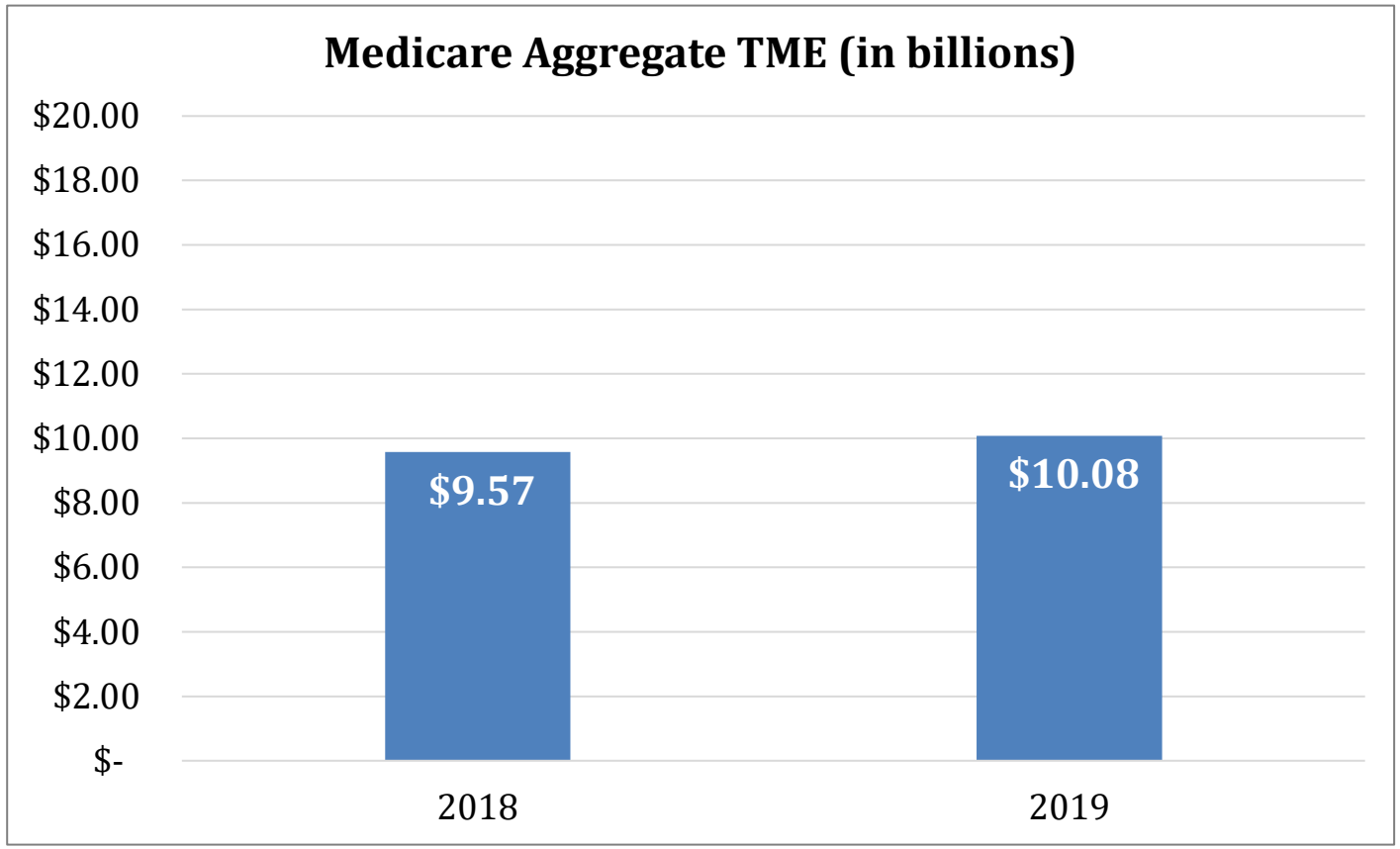
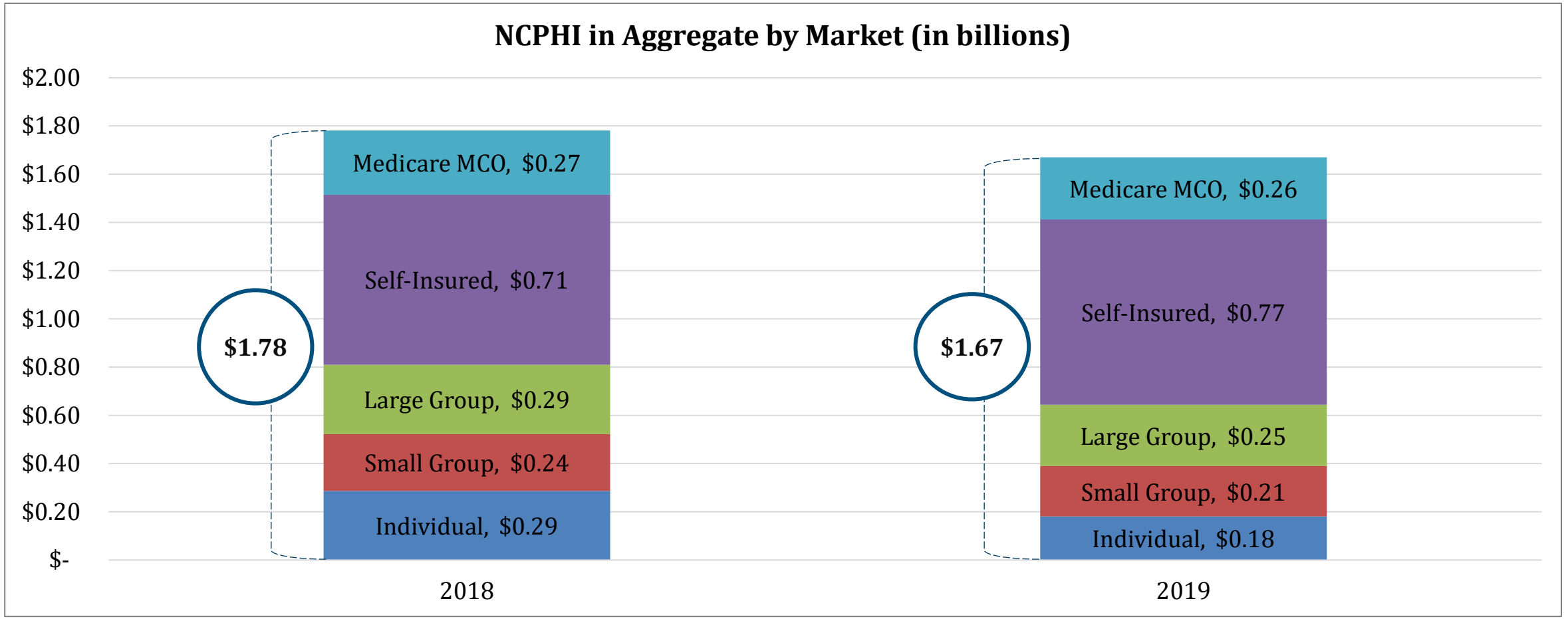
Medicare Per Capita Spending Growth in 2019 was 2.2%



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

Medicare spending includes traditional Medicare, Medicare Advantage, and Part D pharmacy.
Data are not risk-adjusted. They are reported net of pharmacy rebates (OHS did not receive pharmacy rebate information from CMS).
Data include Medicare spending on the dually eligible population.
Data do not include NCPHI.

Net Cost of Private Health Insurance contributed $1.67 billion to State THCE in 2019



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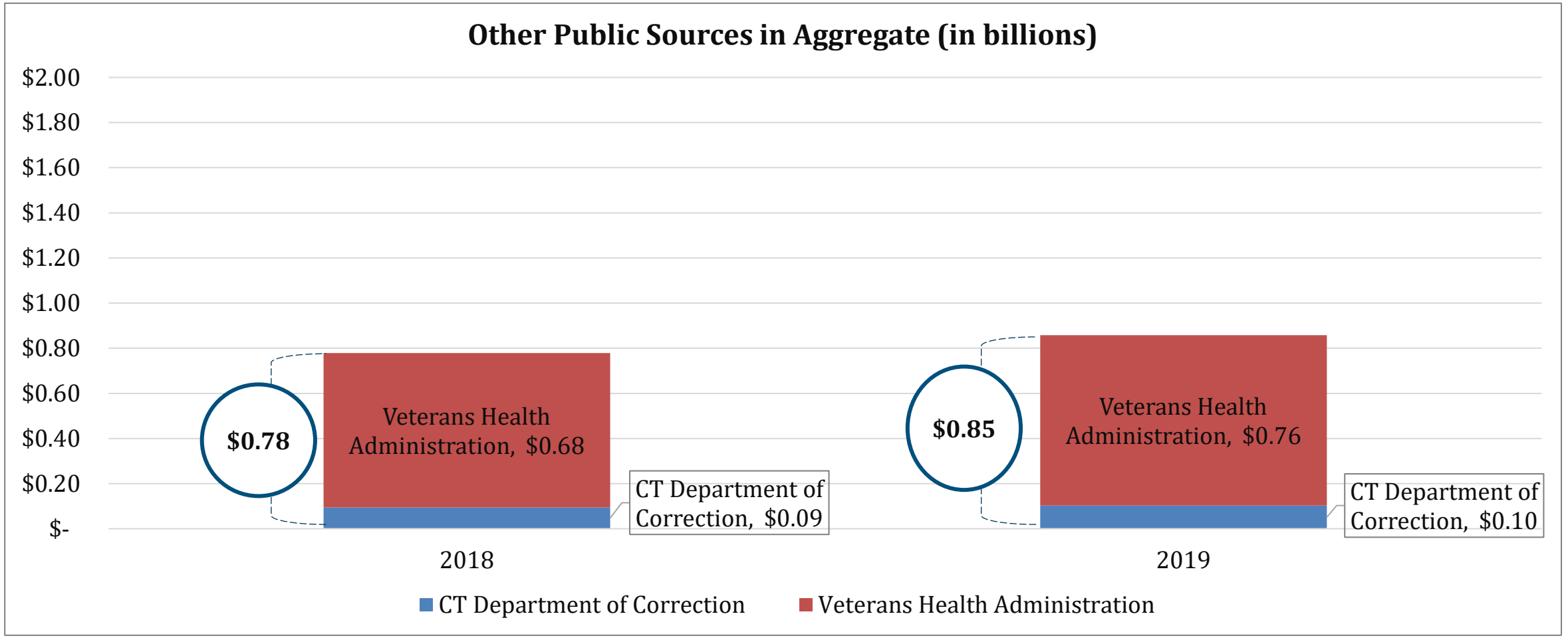
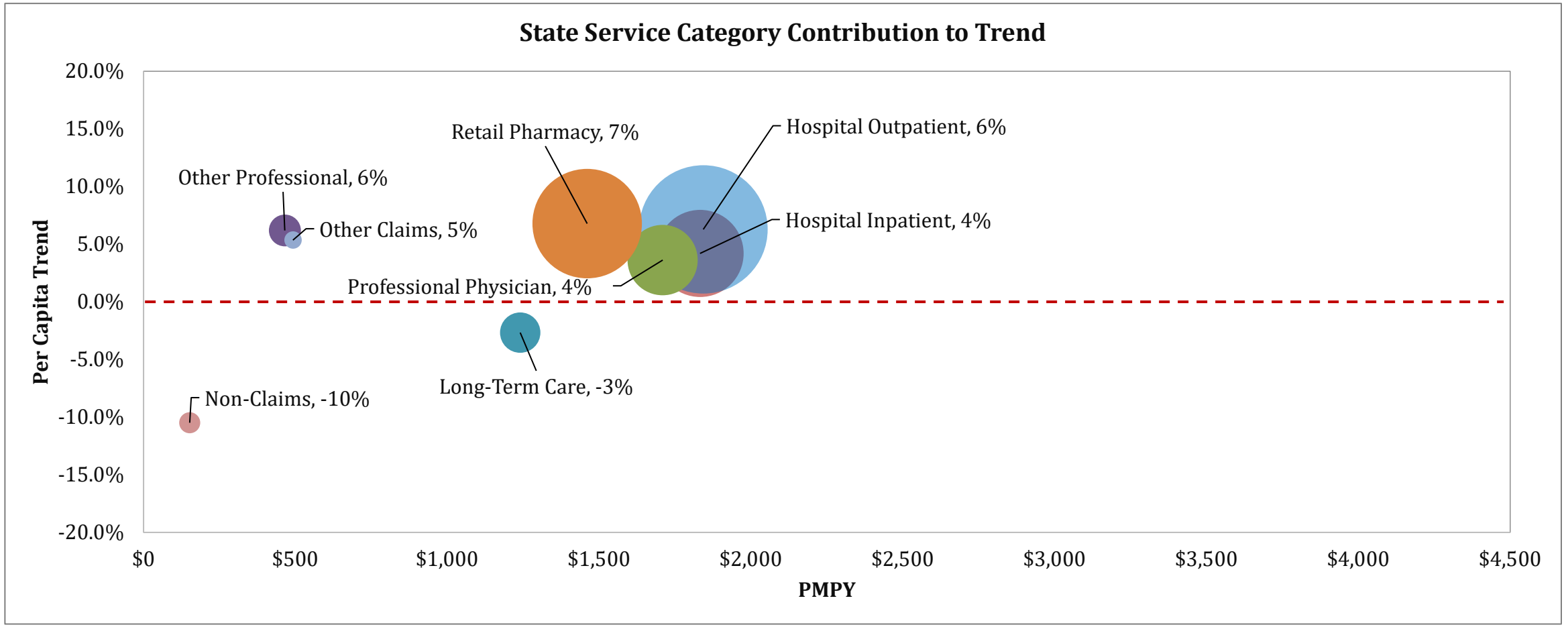
Other Public Sources contributed $0.86 billion to State THCE in 2019



Retail Pharmacy and Hospital Outpatient Drove Connecticut's State Level Spending Growth in 2019



Data are not risk-adjusted. They are reported net of pharmacy rebates.
The width of the bubbles represents contribution to trend.

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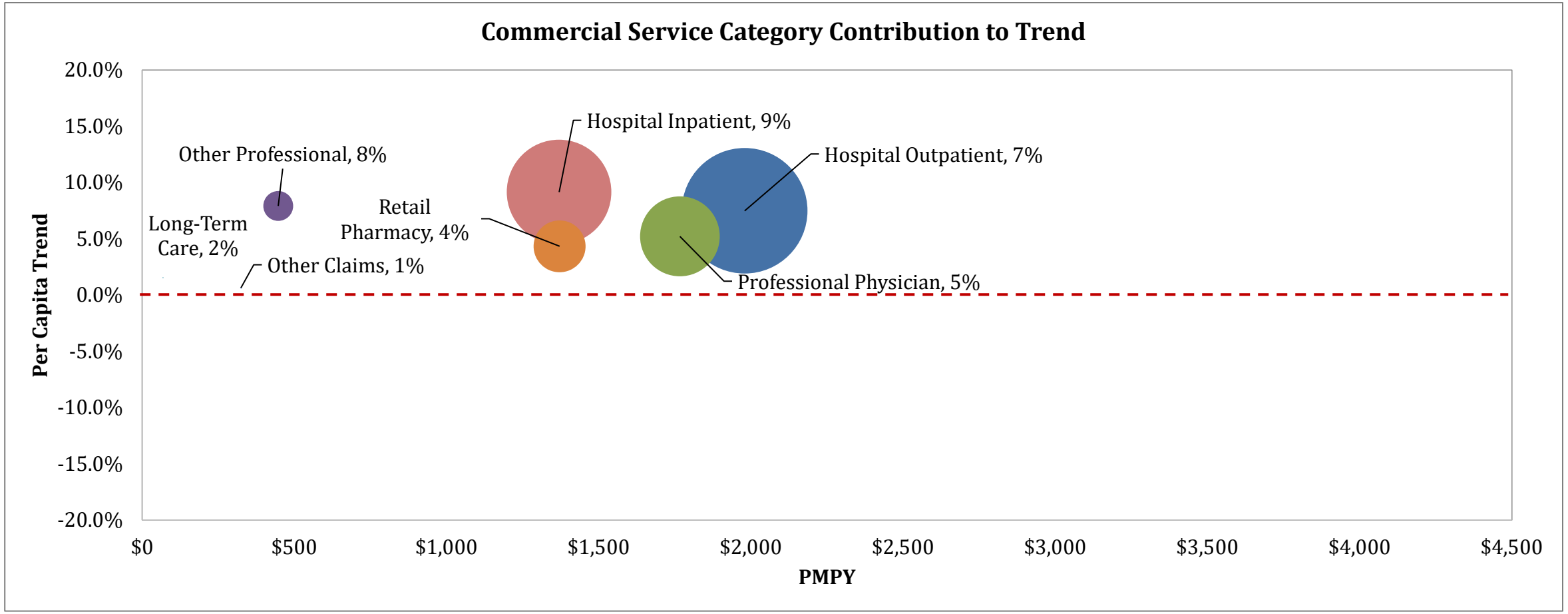
Hospital Outpatient and Hospital Inpatient Drove Connecticut's Commercial Market Spending Growth in 2019



Data are not risk-adjusted. They are reported net of pharmacy rebates.
The width of the bubbles represents contribution to trend.

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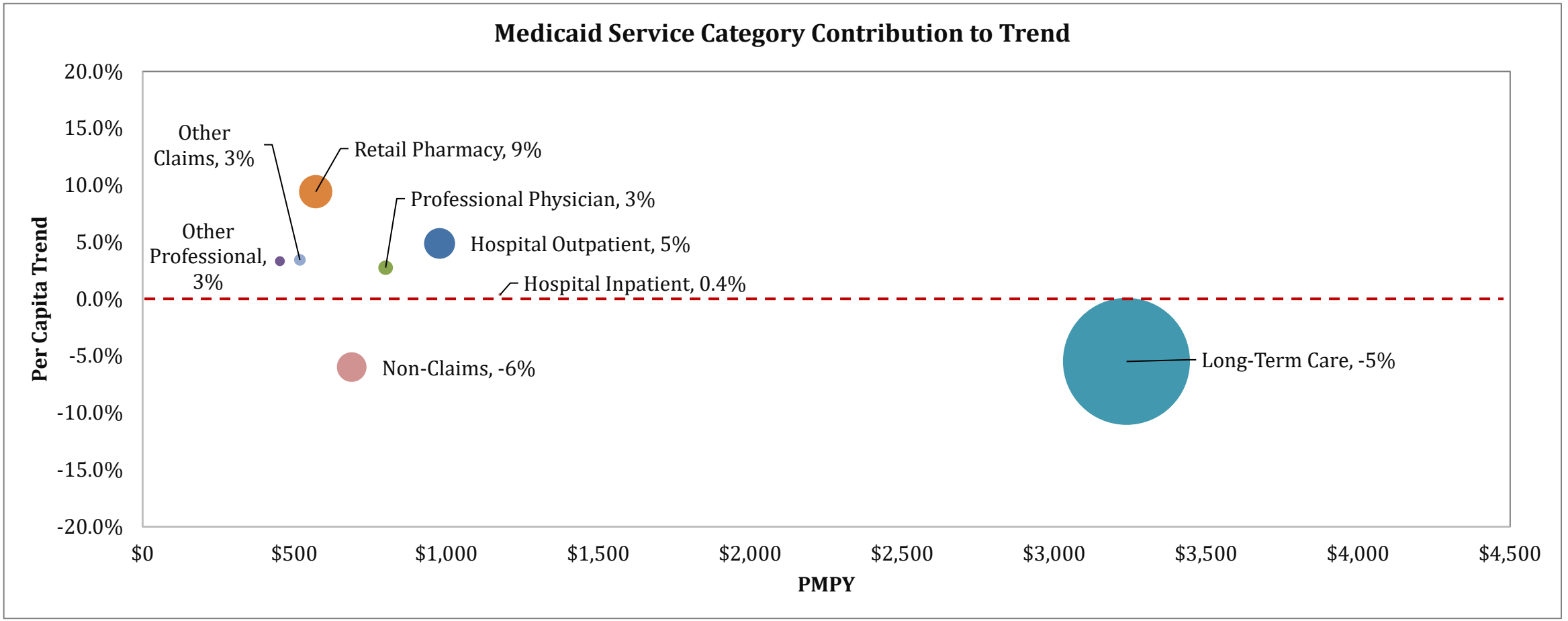
Retail Pharmacy and Hospital Outpatient Experienced the Largest Growth in the Medicaid Market in 2019



Data are not risk-adjusted. They are reported net of pharmacy rebates.
The width of the bubbles represents contribution to trend.

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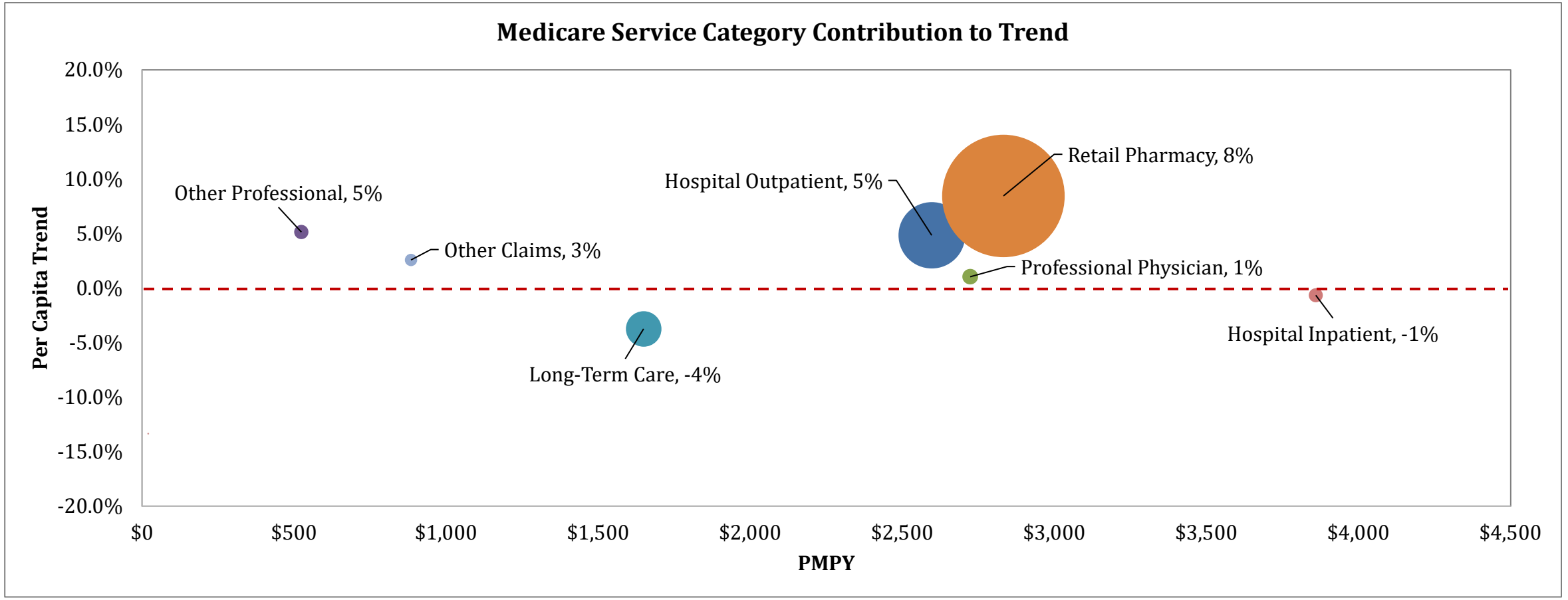
Retail Pharmacy and Hospital Outpatient Drove Connecticut's Medicare Market Spending Growth in 2019



Data are not risk-adjusted. They are reported net of pharmacy rebates.
The width of the bubbles represents contribution to trend.

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Three Service Categories Drove TME Cost Growth Across All Markets in 2019

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

Input from the Stakeholder Advisory Board

Input from the Stakeholder Advisory Board

- On December 8th, the Stakeholder Advisory Board met and reviewed the commercial cost growth driver and ED utilization disparity findings from Mathematica's latest analysis that were presented to the Steering Committee in October.
- The Stakeholder Advisory Board were asked for their thoughts on how to respond to the presented findings. We share their input with you today.

Input from the Stakeholder Advisory Board

ED Utilization Disparity

- One member thought there was a need for greater connection of patients to primary care providers, community health workers, and social workers (particularly for those with multiple chronic conditions) to improve ED utilization disparity.
- Another was interested in determining the number of patients who were "frequent flyers" in EDs.

Hospital Price Growth

- One member thought that system-level and hospital price growth data should be made public.
- Another proposed hosting events that bring patients and legislators together to understand and respond to the findings.

Follow-Up Mathematica Analyses to Understand ED Utilization Disparities

Follow-Up Mathematica Analyses

- During the Steering Committee's November review of ED utilization disparities by race and income, members asked if the disparities persisted if an analysis controlled for:
  - chronic illness prevalence
  - age and sex
  - utilization of urgent care facilities
- Mathematica has completed an analysis of the impact of chronic illness prevalence, age and sex. Its analysis of utilization of urgent care facilities is nearly done but is not ready for this meeting.

Purpose of the Analysis

- To assess disparities in Emergency Department (ED) use after controlling for chronic condition prevalence and population demographics (age and gender)
- Research question: *Once we control for differences among deciles in population demographics and chronic conditions (i.e., set them to the state average), what are the disparities in ED use?*

Study Population

- CT residents under age 65, as indicated in 2019
- Commercial (fully insured, and State employees and retirees)
- Enrolled for entirety of 2018 – 2019
- Exclusions (about 7% of members and claim lines per year):
  - Non-CT residents
  - Secondary payers, vision-only, and some student plans
  - Denied, reversed, and non-primary claim lines
  - Claim lines with negative payment or cost-sharing
  - Paid date within 6 months of service year

Methods

- **Chronic conditions**
  - Chronic conditions defined by Chronic Condition Warehouse (CCW) algorithm
  - Logic reviews of two years of historical claims to identify members with certain chronic conditions
  - Study population restricted to those with two full years of enrollment (2018-2019) to reduce portion of false negatives, i.e., those with chronic conditions but insufficient claims history to observe diagnoses
- **Race and Income Deciles**
  - Using U.S. Census data, assign CT zip codes to race and income deciles based on the percentage of white residents and the median income, respectively.
  - Decile 1: Highest proportion of people of color; lowest incomes
  - Decile 10: Lowest proportion of people of color; highest incomes

Methods – Adjusted ED rates

- Adjustment controls for differences among communities in population demographics (age and gender) and in rates of chronic conditions
- First model just includes demographic adjustment; second model adds chronic conditions
- Based on a linear regression
  - Unit of observation is the zip code
  - All variables are calculated from the study data
  - Adjusted ED rate removes differences among zip codes that can be explained by age, gender, and chronic conditions but retains other, unexplained differences

Lower income deciles tend to have a higher proportion of older persons and females

Group/	CT	Income Decile									
		1	2	3	4	5	6	7	8	9	10
	52.1%	53.1%	53.0%	52.8%	52.1%	52.6%	52.7%	52.4%	51.8%	51.5%	51.3%
M All	**47.9%**	46.9%	47.0%	47.2%	47.9%	47.4%	47.3%	47.6%	48.2%	48.5%	48.7%
	3.4%	2.3%	2.0%	2.6%	2.8%	3.0%	3.2%	3.4%	3.8%	3.9%	4.1%
5-11	**8.1%**	6.3%	5.7%	6.0%	6.5%	6.9%	7.2%	7.7%	8.6%	9.1%	10.7%
	9.0%	6.7%	6.8%	6.9%	7.1%	7.7%	8.3%	8.7%	9.2%	10.2%	11.8%
18-25	**11.9%**	11.7%	12.0%	11.0%	10.7%	11.2%	11.4%	11.3%	11.3%	13.1%	13.4%
	9.5%	12.9%	11.9%	11.6%	11.7%	11.4%	10.1%	10.1%	9.3%	7.8%	5.8%
35-44	**14.4%**	16.5%	15.4%	15.9%	15.6%	15.0%	14.3%	14.5%	14.7%	13.9%	12.5%
	20.2%	20.5%	21.9%	20.8%	20.7%	20.1%	20.1%	20.4%	20.1%	19.8%	20.0%
55-64	**23.4%**	22.9%	24.4%	25.3%	24.8%	24.6%	25.4%	23.8%	23.0%	22.3%	21.6%

Limited to CT residents up to age 64 who were fully enrolled in commercial plans in 2018 and 2019. Non-excluded members only.

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Communities with more people of color tend to have a higher proportion of older persons and females

Group	CT	Race Decile									
		1	2	3	4	5	6	7	8	9	10
	52.1%	52.8%	53.4%	52.5%	52.6%	52.5%	51.9%	51.5%	51.7%	51.4%	51.8%
M All	**47.9%**	47.2%	46.6%	47.5%	47.4%	47.5%	48.1%	48.5%	48.3%	48.6%	48.2%
	3.4%	2.4%	2.7%	3.2%	3.3%	3.6%	3.9%	3.6%	3.8%	3.4%	3.4%
5-11	**8.1%**	6.2%	6.5%	6.6%	7.1%	8.2%	9.1%	8.8%	9.1%	7.9%	8.1%
	9.0%	7.0%	7.1%	6.8%	7.8%	9.0%	9.5%	10.0%	10.1%	9.6%	9.4%
18-25	**11.9%**	11.8%	11.5%	10.6%	10.9%	11.6%	11.6%	12.5%	12.1%	12.5%	12.2%
	9.5%	11.7%	12.4%	13.1%	11.1%	10.0%	8.8%	8.4%	7.8%	8.0%	8.1%
35-44	**14.4%**	16.2%	15.7%	16.4%	15.5%	14.8%	14.8%	13.6%	13.6%	12.8%	12.9%
	20.2%	21.2%	20.3%	19.9%	20.2%	20.0%	19.8%	20.0%	20.4%	20.4%	20.6%
55-64	**23.4%**	23.5%	23.8%	23.4%	24.1%	22.7%	22.6%	23.0%	23.2%	25.4%	25.2%

Limited to CT residents up to age 64 who were fully enrolled in commercial plans in 2018 and 2019.
Non-excluded members only.

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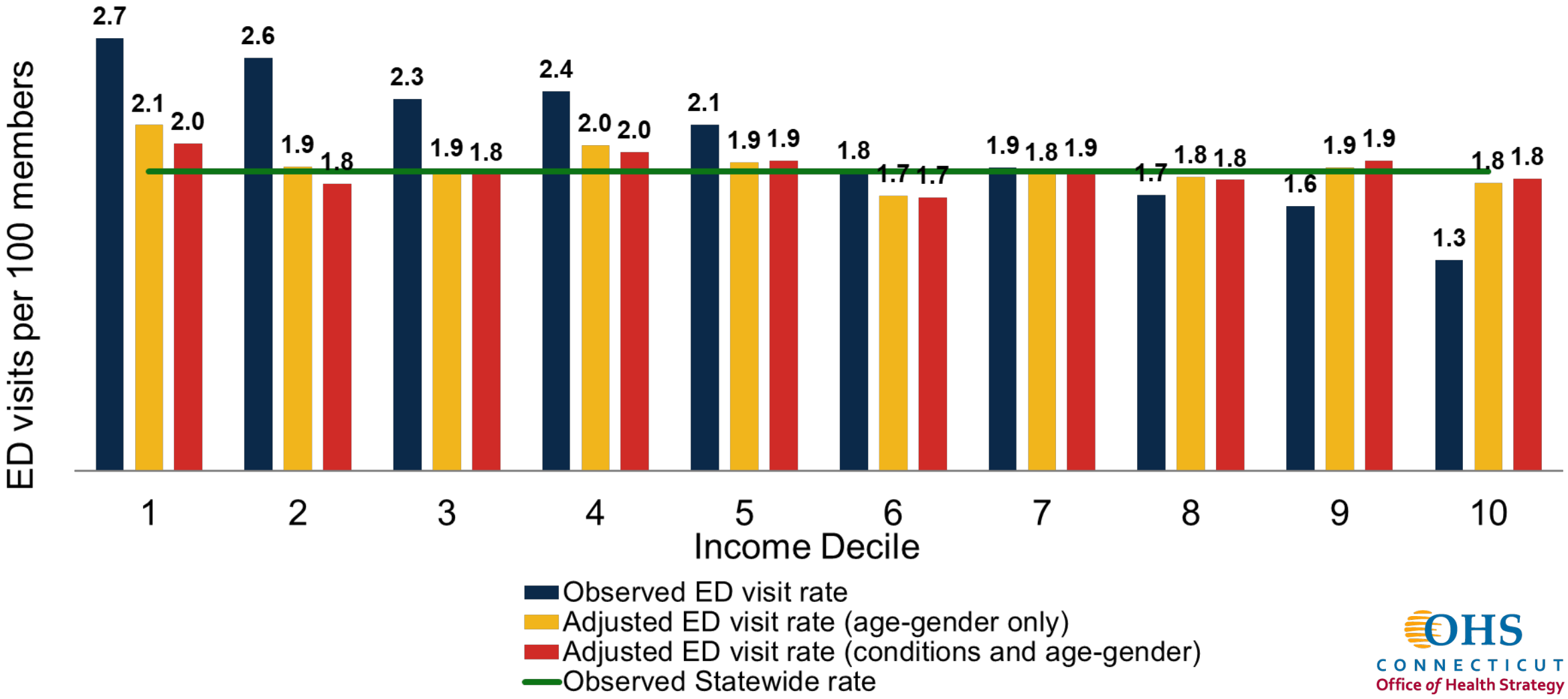
Controlling for age-gender rates greatly reduces disparities in observed ED use across income deciles



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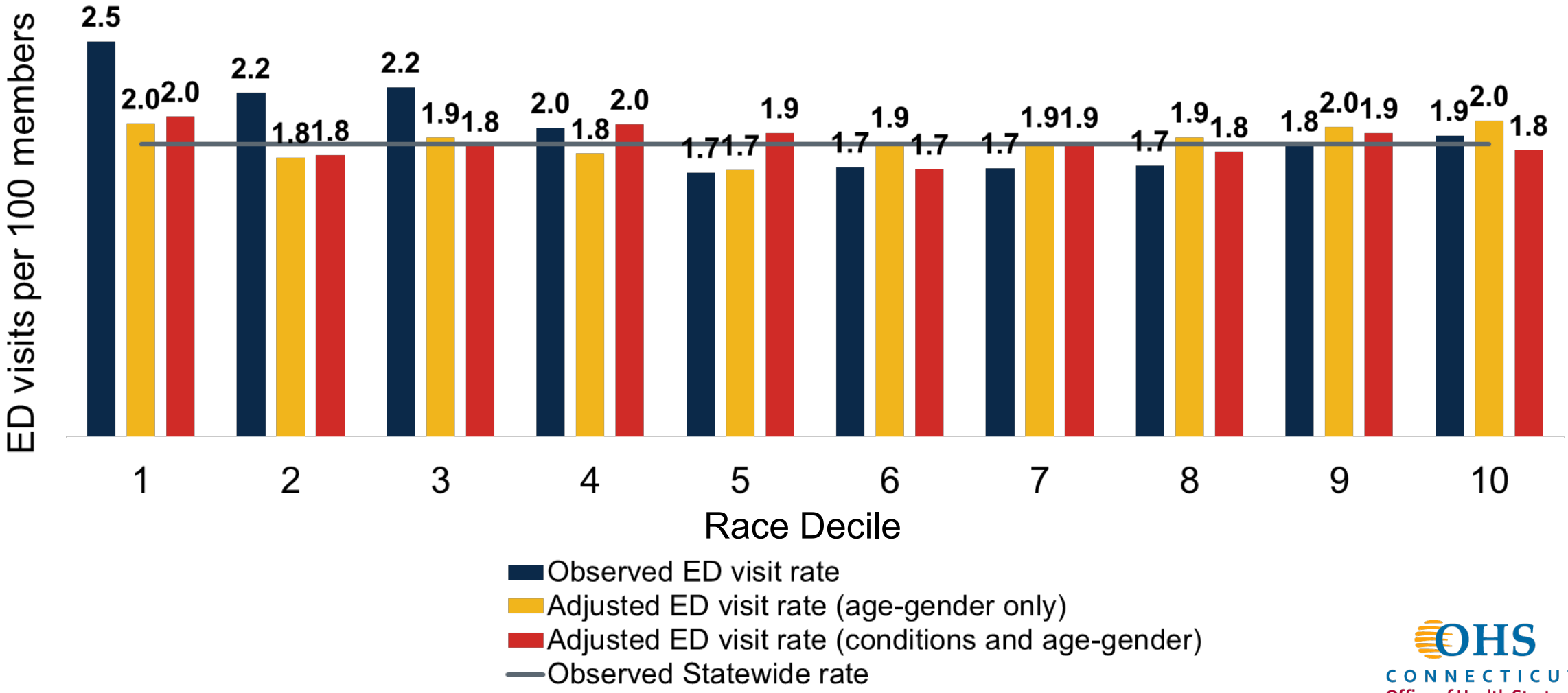
Controlling for age-gender rates also eliminated disparities in observed ED use across race deciles



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Key Takeaways

- **ED use is higher in lower income communities**
  - Much of this difference can be explained by differences in population demographics (age/gender) and chronic condition prevalence
  - Once we control for age/gender, chronic conditions have little additional explanatory power.
- **ED use is also higher in communities with more people of color, especially in the first three deciles.**
  - Again, controlling for age and gender greatly reduces observed disparities

What's going on here?

- A national study published in January 2021 found age-standardized per-person spending was significantly greater for Black individuals for emergency department care than the all-population mean, but lower for Hispanic individuals.
  - This study was at a person level, as compared to our analysis which looks at the community-level where it's a bit harder to detect differences.
- Still, we may be missing important differences between Black and Hispanic populations by combining them.
- OHS will consider a follow-up analysis that separates Black and Hispanic populations.
  - Not having granular race, ethnicity, and language data in the APCD makes this a challenge and this remains an area of focus for OHS.

Wrap-Up and Next Steps

Wrap-Up and Next Steps

- The next meeting will be held on **February 28th** from 3–5:00 p.m. We will discuss the following topics:
  1. Answers to the following questions posed during the December meeting:
     - What is driving hospital price growth?
     - What is the impact of the cost shift?
  2. Potential strategies to address hospital price growth
- In future meetings we will discuss how to address retail pharmacy spending growth and other cost growth mitigation strategies.

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