All Payer Claims Database Advisory Group Regular Meeting

August 10, 2023

Agenda Topics

	Agenda Item
1	Welcome and Call to Order & Introductions
2	Public Comment
3	Artificial Intelligence – State Government Update
4	Healthcare Cost Growth Benchmark Presentation
5	**Action:** Review and Approve Minutes: May 11, 2023, Regular Meeting
6	APCD Strategic Prioritization Update
7	APCD Data Submission Guide Update
8	APCD Updates
9	APCD Data Release Committee Report
10	Wrap up & Meeting Adjournment

Public Comment

(2 minutes per commenter)

Artificial Intelligence – State Government Update

Adel Ebeid
Office of Policy & Management

AI Governance

August 2023

Public Act No. 23-16

- An Act concerning Artificial Intelligence, automated decision-making, and personal data privacy
- Effective July 1, 2023
- Intended to provide guardrails for the ethical and equitable use of AI in government
- Applies to all state agencies listed in Section 4d-1 of the general statutes
- Collaborative effort between Executive and Legislative which resulted in a more realistic and achievable bill
- CT's AI framework allows us to "see around the bend" but be mindful of activities playing out at the federal level
- We want to embrace all the good AI has to offer but do it in a responsible and consistent manner
- We expect future iterations of PA 23-16 and state policies to fine-tune CT's AI posture

Critical Milestones

- July 1, 2023 – Law goes into effect.
- December 31, 2023 – Inventory of all systems that employ AI and are in use by any state agency
- February 1, 2024 – Develop AI policies and procedures
- February 1, 2024 – Begin performing assessments of systems that employ AI to ensure compliance with policies and procedures
- February 1, 2024 – No agency shall implement any system that employs AI prior to performing an impact assessment to ensure that such system will not result in any unlawful discrimination
- February 1, 2024 – AI Working Group shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly
- February 1, 2024 – AI Working Group shall terminate once report is submitted

Activities July to December '23

- Early guidance to all agencies regarding generative AI
- Formation of an internal workgroup
- Central repository of helpful documents, links to other state's policies, and research papers
- Engagement with other branches of government
- Process for collecting feedback from agencies regarding proposed/current use of AI
- Education and outreach with key stakeholders
- Draft policy framework mid to late Fall
- Integrate AI vetting with project intake and architecture discussions
- Focus on AI during Digital Summit in September

Policy Elements

- Guiding Principles
  - Acceptable use of AI
  - Procedures and standards
  - Process for handling exceptions
- Ethical Considerations
  - Prevention of harm
  - Fairness, equality and non-discrimination
  - Transparency and auditability
  - Privacy
- Requirements for AI systems
  - Explainable, transparent, auditable
- Assessments, Inventory and Oversight

Current AI team members

Tom Armstrong

Jeff Brown

Adel Ebeid

Scott Gaul

Mark Raymond

Looking to add others in the coming weeks…

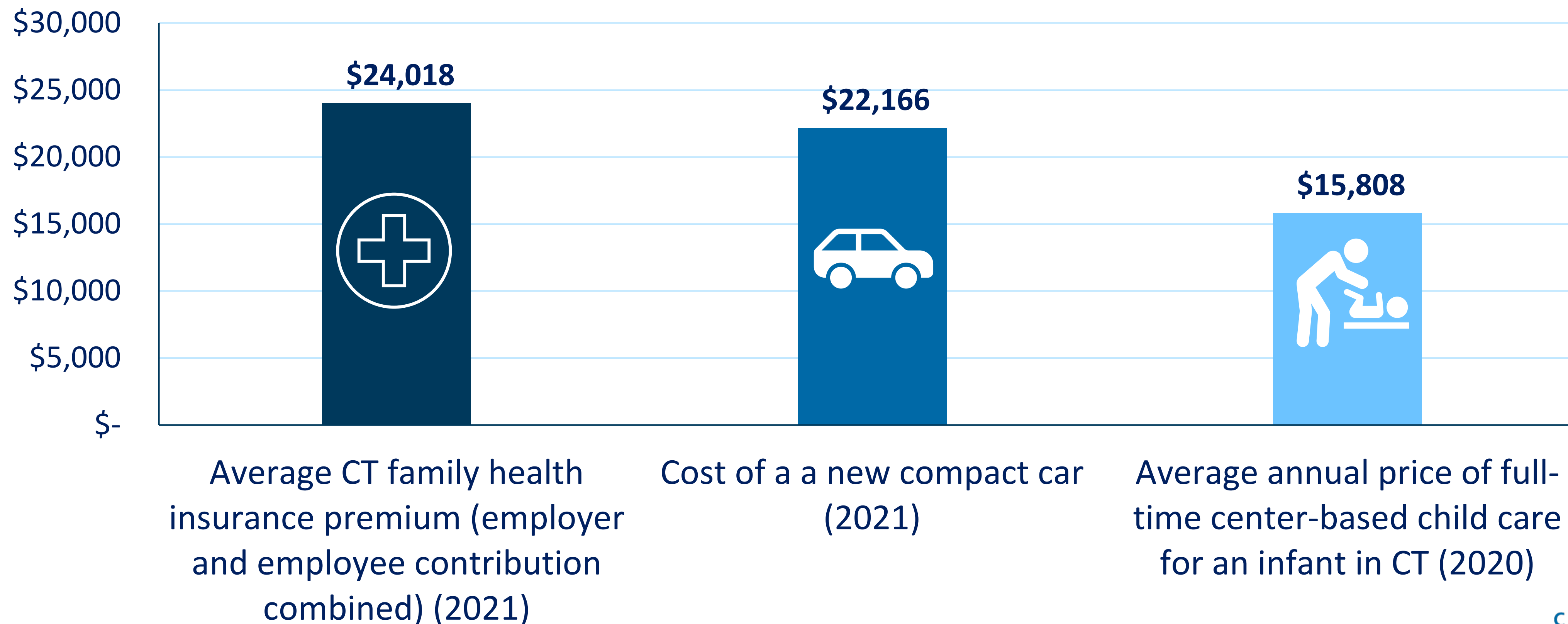
APCD Council Presentation: Cost Growth Benchmark Initiative and Use of APCD Data
August 10, 2023

"We collaborate, out of a shared concern and responsibility for all Connecticut residents, to develop consensus models that advance equity and consumer affordability of healthcare in our state."

Context: Healthcare Cost and Affordability in Connecticut

Healthcare is *Really* Expensive in Connecticut

The average CT family health insurance premium is higher than the average cost of a new compact car and the average annual price of infant childcare in CT.



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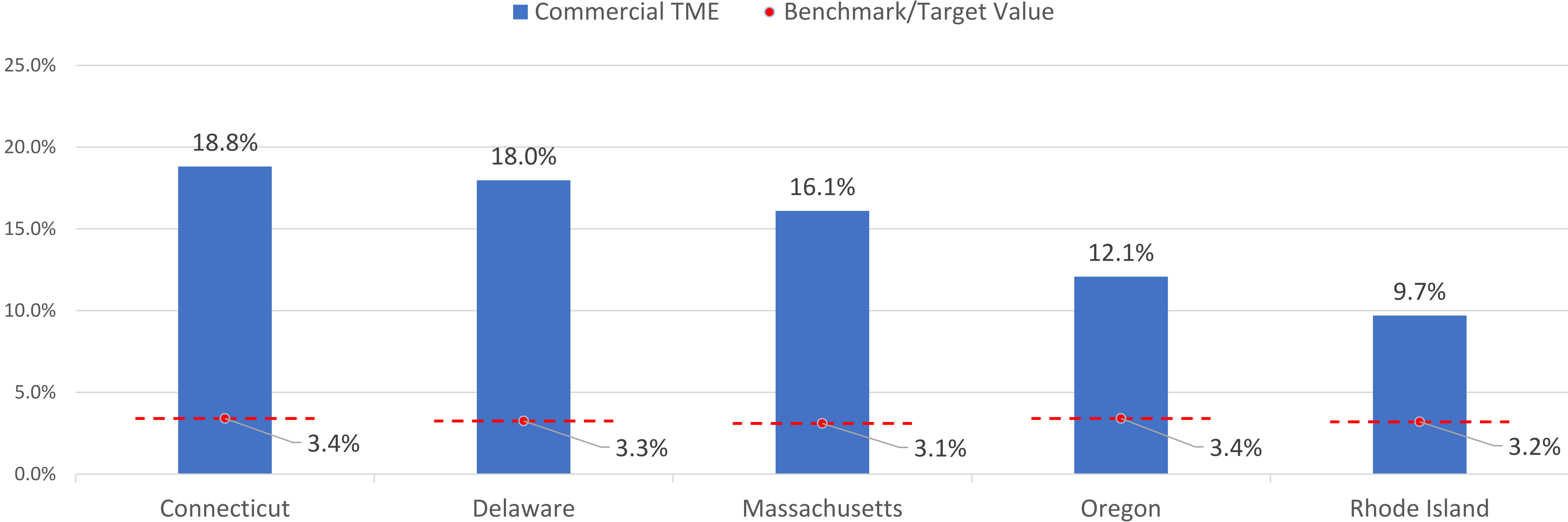
2021 was a *very bad* year for patients: commercial healthcare spending grew 18.8% in Connecticut while…

…median household income ***increased only 1.9%.***

Source: Federal Reserve Economic Data

This was faster commercial healthcare spending growth than that of all other cost growth benchmark states



Notes: Commercial market total medical expenses do not include insurer administrative spending.

Data Sources: Data were obtained from states' public const growth benchmark reports, with the exception of Delaware's figure which was calculated using data files reported by the state.

Expensive Healthcare is an Access Problem

- A survey of more than 1,300 Connecticut adults conducted in July and August of 2022 found that:
  - More than half **(55%)** of Connecticut respondents experienced one or more **healthcare affordability burdens** in the previous 12 months.
  - Nearly half of respondents **(46%)** reported **delaying or going without care** in the previous 12 months.
  - **33%** of Black/African-American respondents and **30%** of Hispanic/Latinx respondents reported **rationing their medication** due to cost in the previous 12 months.
  - Nearly four in five **(78%) worry about affording** some aspect of healthcare now or in the future.

Source: Altarum 2022 Connecticut Healthcare Affordability Report

Connecticut's
Cost Growth Benchmark Initiative

Connecticut Healthcare Cost Growth Benchmark Initiative: Origins

- Executive Order No. 5 created the Connecticut Healthcare Cost Growth Benchmark Initiative in January of 2020. Accordingly, OHS set benchmarks for 2021-2025, which are posted on the OHS website.
- During the 2022 session the General Assembly passed House Bill 5506 (PA 22-118), putting the Healthcare Cost Growth Benchmark Initiative in statute.
- The following slides highlight a few key elements of the statute, focusing on elements specific to the cost growth benchmark.

Public Act 22-118 (1 of 2)

OHS must **set annual cost growth benchmark values.**

- Also, quality benchmark values and a primary care spending target.

- **August 15th:** Payers must submit data to OHS by of each year to allow OHS to assess insurer and larger provider organization performance relative to the benchmarks and target.
- **March 31st:** Starting in 2023, OHS must report the findings from its analyses, including any necessary contextualization, by of each year.
- **May 1st:** OHS must identify payer and provider entities that exceeded the benchmark and send official notice to each entity within 30 days.

Public Act 22-118 (2 of 2)

- **June 30th:** OHS must hold an informational public hearing on its Cost Growth Benchmark findings by of each year.
  - OHS may require any payer, provider, or other entity that is found to have been a significant contributor to healthcare cost growth in the state to provide testimony at this hearing.
- **October 15th**: OHS must submit a report to the joint standing committee of the General Assembly that outlines:
  - healthcare spending trends;
  - plans for monitoring any unintended adverse consequences of the benchmark program, and
  - recommendations to increase the efficiency of the state's healthcare system (including, but not limited to, legislative proposals).

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The Logic Model for the Cost Growth Benchmark

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 a target **annual rate-of-growth** for per person healthcare spending.
- The benchmark values are based on a blend of forecasted per capita potential gross state product (PGSP) and forecasted growth in median income.

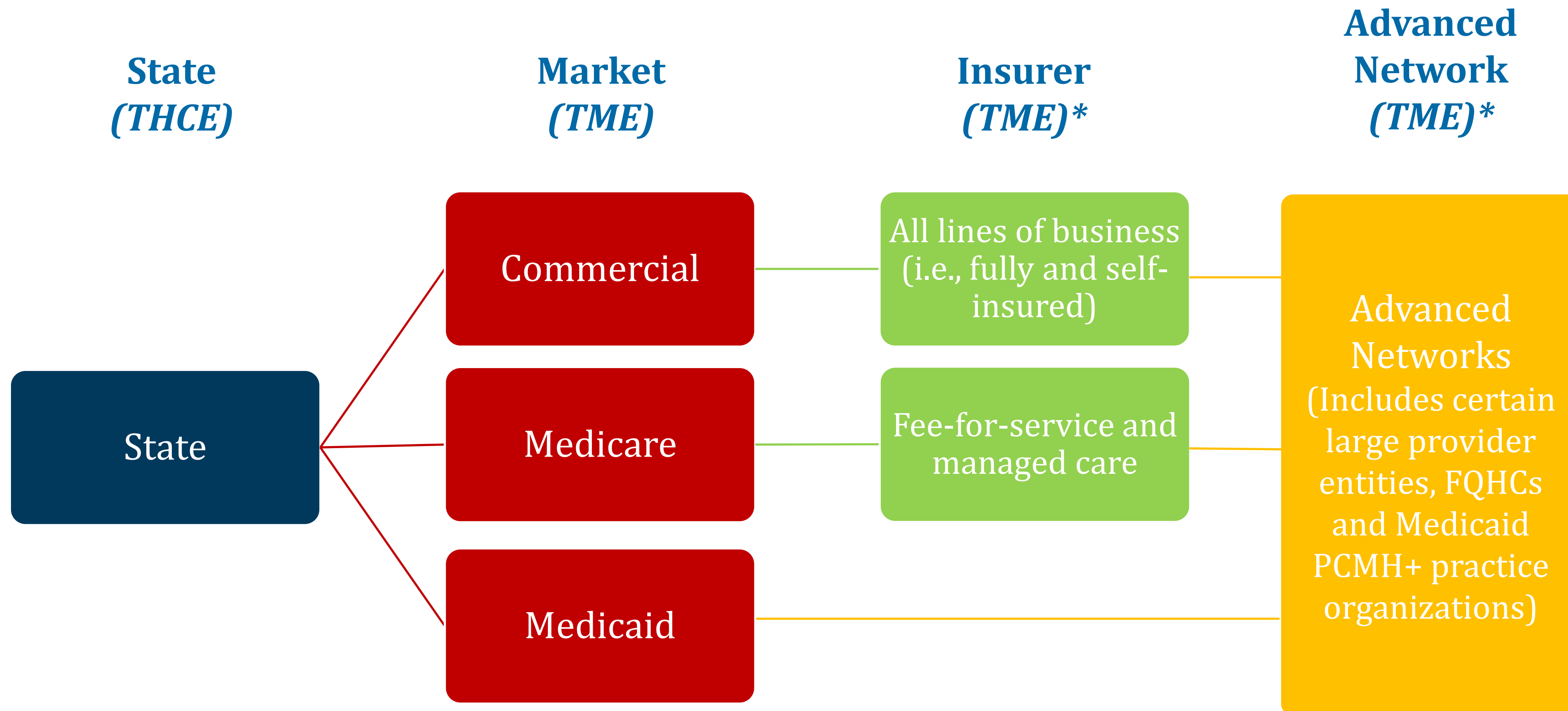
Total Healthcare Expenditures

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

Total Medical Expense (TME): **All incurred expenses for CT residents for all health care services,** regardless of where the care was delivered and regardless of the situs of the member's health plan.

Net Cost of Private Health Insurance (NCPHI): The **costs to CT residents associated with the administration of private health insurance.**

Four Levels of Public Reporting of Performance Against the Benchmark

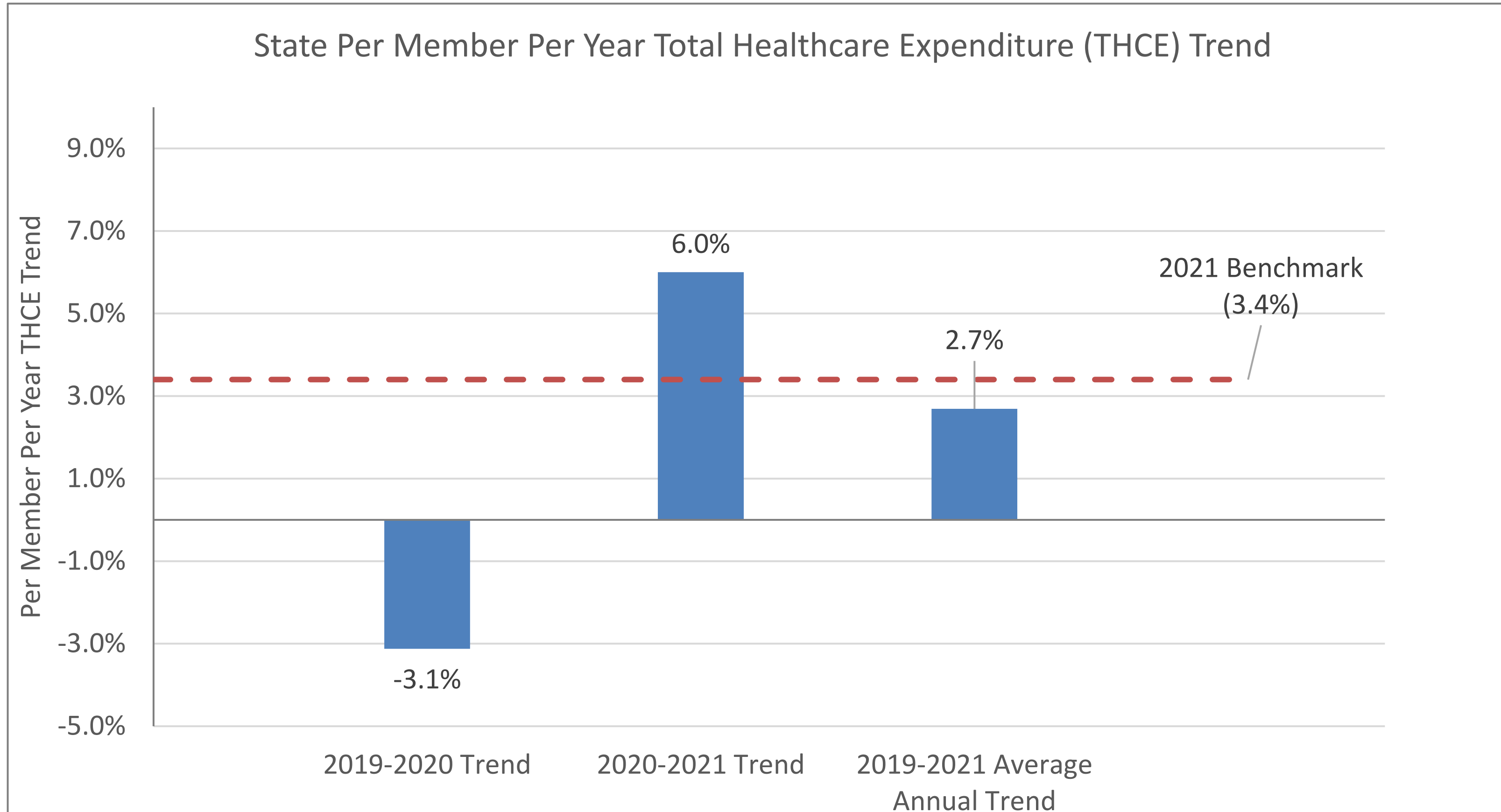


* *OHS will only publicly report on Insurers and Advanced Networks with a minimum of 60,000 member months per market.*

Data Sources for THCE

THCE Component	Data Source
Commercial spending	TME reported by carriers (Aetna, Anthem, Cigna, ConnectiCare, UnitedHealthcare)
Medicare Managed Care spending	TME reported by carriers (Aetna, Anthem, ConnectiCare, UnitedHealthcare)
Medicare FFS spending	TME reported by the Centers for Medicare & Medicaid Services
Medicaid spending	TME reported by Department of Social Services
Net Cost of Private Health Insurance (NCPHI)	Calculated from regulatory reports submitted by insurers or obtained through public sources (e.g., Medical Loss Ratio data)
Veterans Health Administration spending	Veterans Health Administration
Department of Correction spending	Department of Correction

Connecticut's Total Healthcare Expenditures decreased 3.1% in 2020 and grew 6.0% in 2021



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).

Year	THCE Per Member Per Year
2019	$9,865
2020	$9,556
2021	$10,130

- Average annual growth from 2019-2021 was 2.7%.

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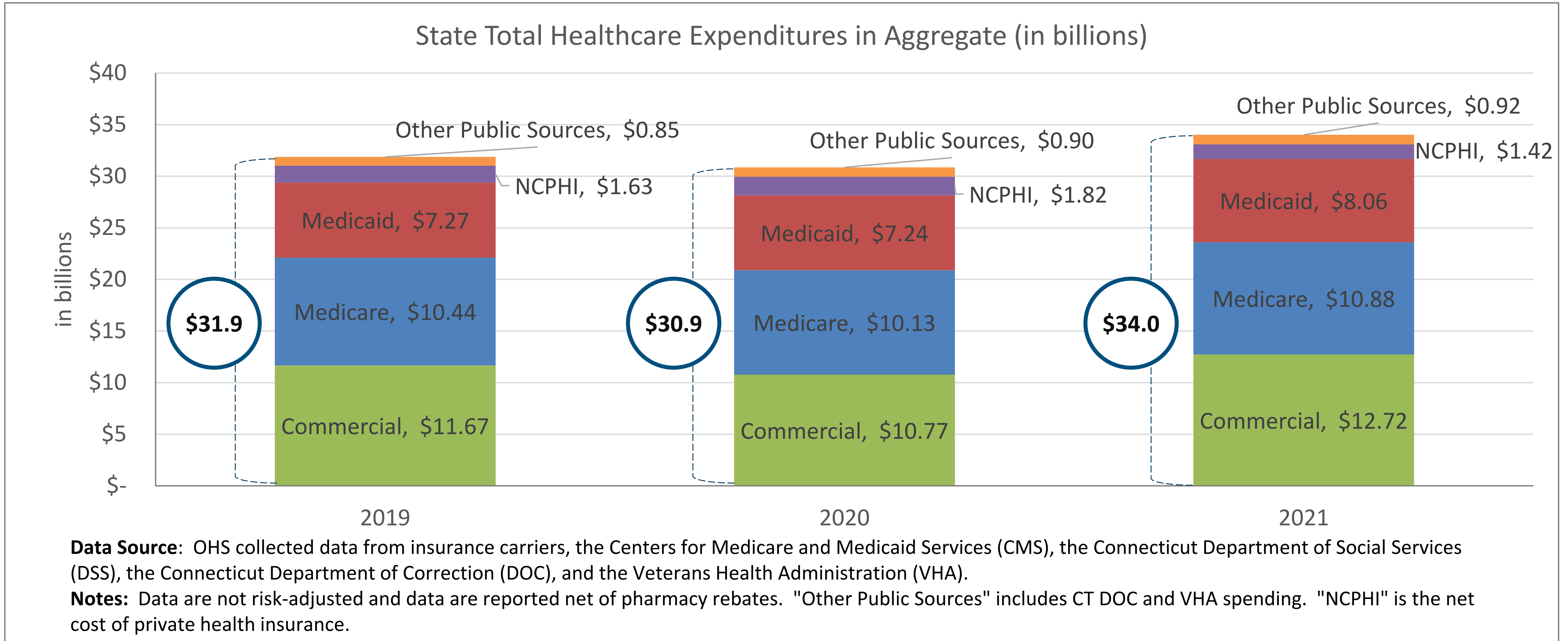
Connecticut's Total Healthcare Expenditures were $31.9 billion in 2019, $30.9 billion in 2020 and $34.0 billion in 2021

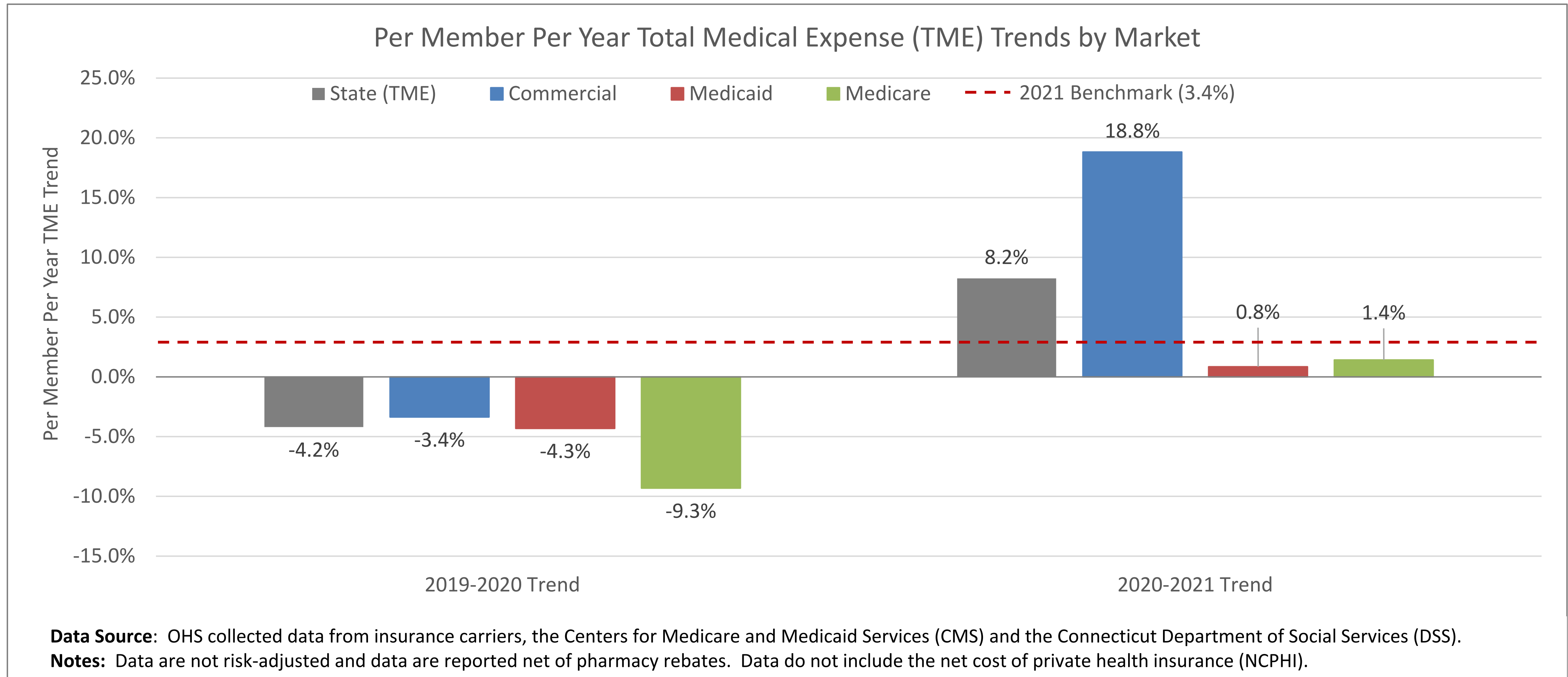


Data Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut Department of Correction (DOC), and the Veterans Health Administration (VHA).

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.

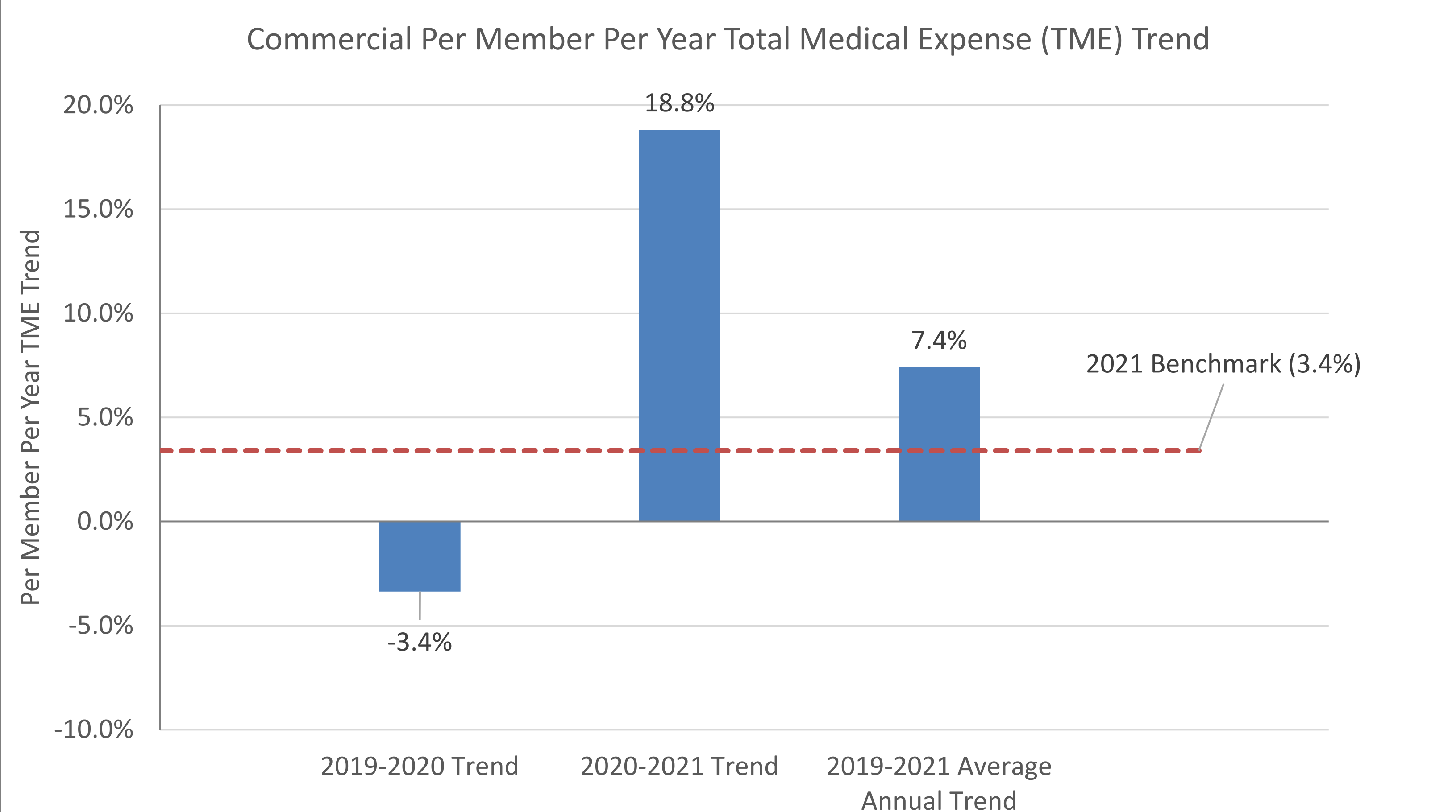
Total Medical Expense Trends by Market

Total Medical Expense Trends by Market



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

Commercial Total Medical Expenses decreased 3.4% in 2020 and increased 18.8% in 2021



Data Source: OHS collected data from insurance carriers.
Notes: Data are not risk-adjusted. Data are reported net of pharmacy rebates. Data do not include the net cost of private health insurance (NCPHI).

Year	TME Per Member Per Year
2019	$6,732
2020	$6,505
2021	$7,729

- Average annual commercial growth from 2019-2021 was 7.4%.

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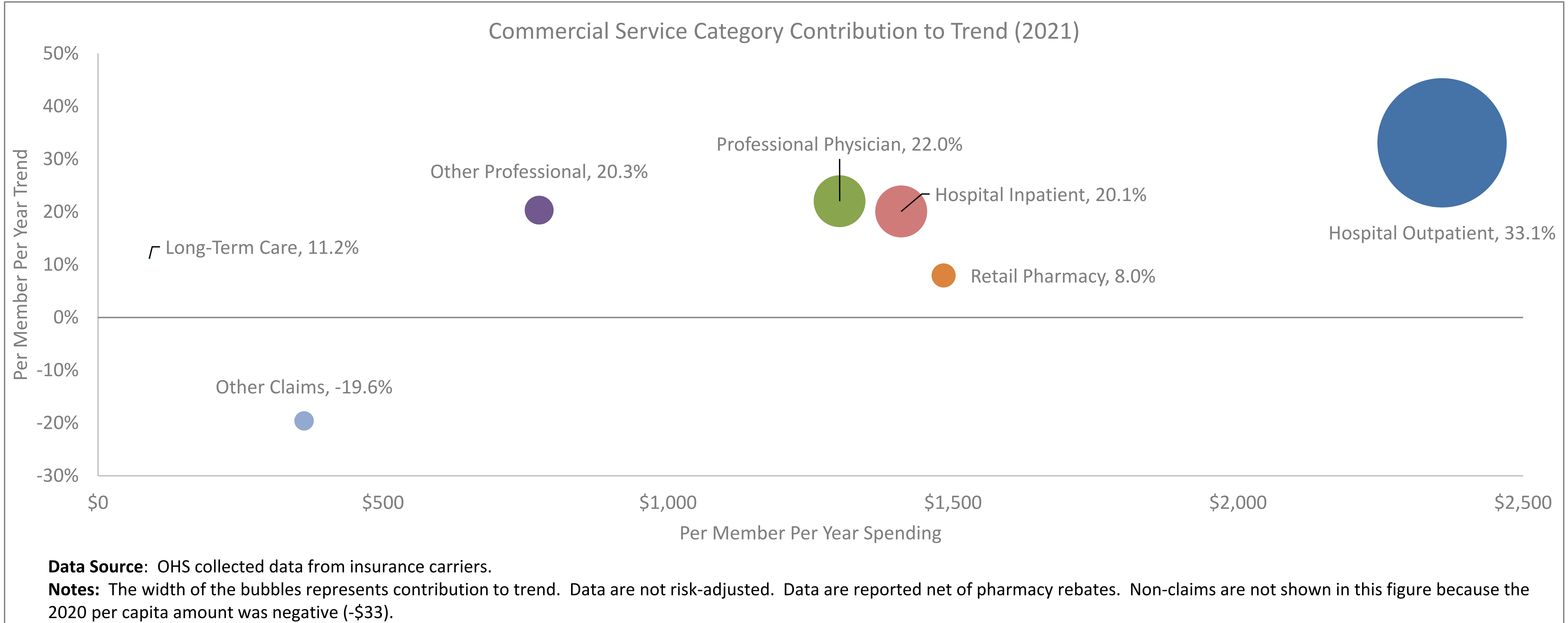
2021 Service Category Trends

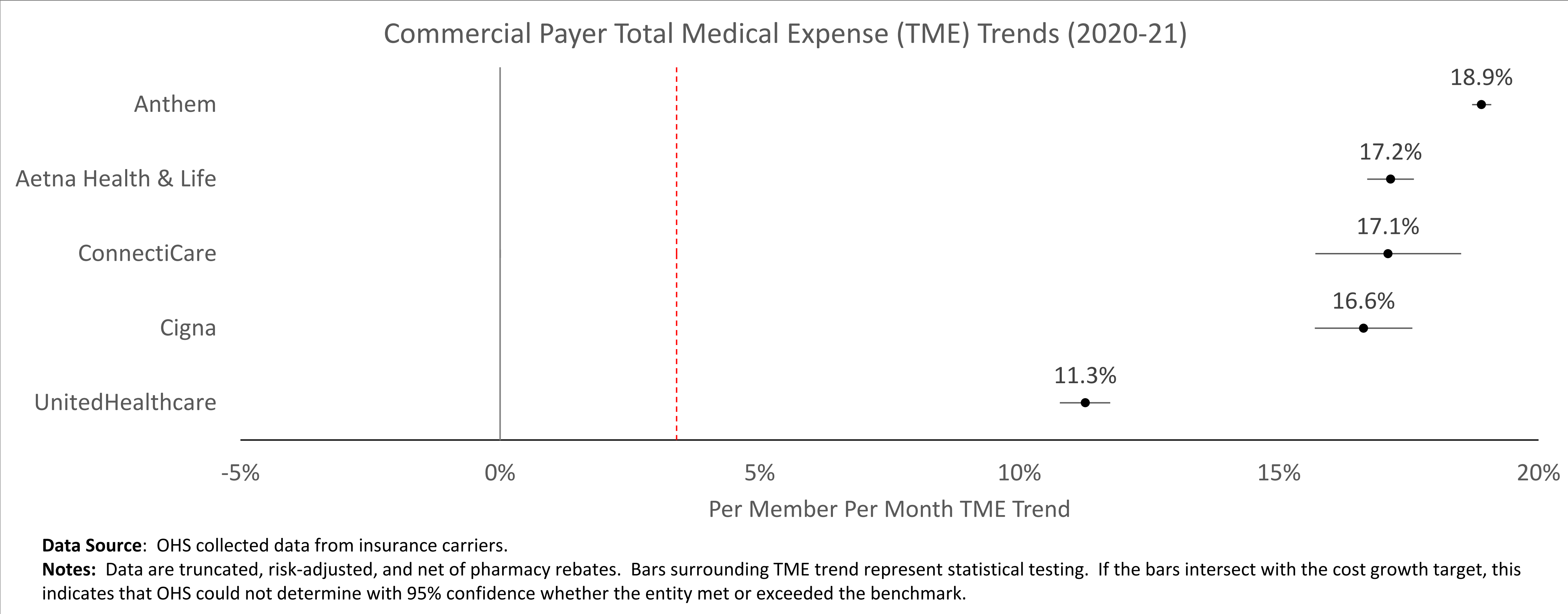
Hospital Outpatient drove Connecticut’s Commercial spending growth in 2021



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

2021 Total Medical Expense (TME) Trends by Payer

Commercial Payer 2021 Performance Against the 3.4% Benchmark



Data Source: OHS collected data from insurance carriers.

Notes: Data are truncated, risk-adjusted, and net of pharmacy rebates. Bars surrounding TME trend represent statistical testing. If the bars intersect with the cost growth target, this indicates that OHS could not determine with 95% confidence whether the entity met or exceeded the benchmark.

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OHS Use of the APCD to Support the Cost Growth Benchmark Initiative

Cost Growth Benchmark Analysis vs. APCD Cost Driver Analysis

How will we determine the level of cost growth from one year to the next?

Benchmark Analysis

- **What is this?** A calculation of health care cost growth over a given time period using payer-collected aggregate data.
- **Data Type:** Aggregate data for ALL covered lives that allow assessment at four levels: 1) provider level, 2) insurer level, 3) market level, and 4) statewide.
- **Data Source:** Insurers and public payers
- **Resources to be Used:** Contractor Bailit Health performs analyses at OHS direction

How will we determine the drivers of overall cost and cost growth? Where are there opportunities to contain spending?

All-Payer Claims Database Cost Driver Analysis

- **What is this?** A plan to analyze cost drivers and identify promising opportunities for reducing cost growth and informing policy decisions.
- **Data Type:** Granular data (claims and/or encounters); commercial self-insured missing except for OSC
- **Data Source:** All-Payer Claims Database
- **Resources to be Used:** Contractor Mathematica performs the analyses at OHS direction

Example:
Using the APCD to Understanding Growth in Commercial Hospital Spending

Annual Change in Commercial Hospital Payments per Service ("Price"), 2016-21

Service Cat.	2016	2017	2018	2019	2020	2021
Inpatient						
- Price	$22,026	$23,989	$25,606	$28,137	$29,882	$31,989
- Price Chg	-	8.9%	6.7%	9.9%	6.2%	7.1%
Outpatient						
- Price	$232.63	$243.83	$271.67	$296.63	$316.78	$292.59
- Price Chg	-	4.8%	11.4%	9.2%	6.8%	-7.6%

- Average annual increase in inpatient price: **7.8%**
- Average annual increase in outpatient price: **4.9%** with 2021, **8.0%** without 2021
- CT annual median household income growth in this period: **1.3%**

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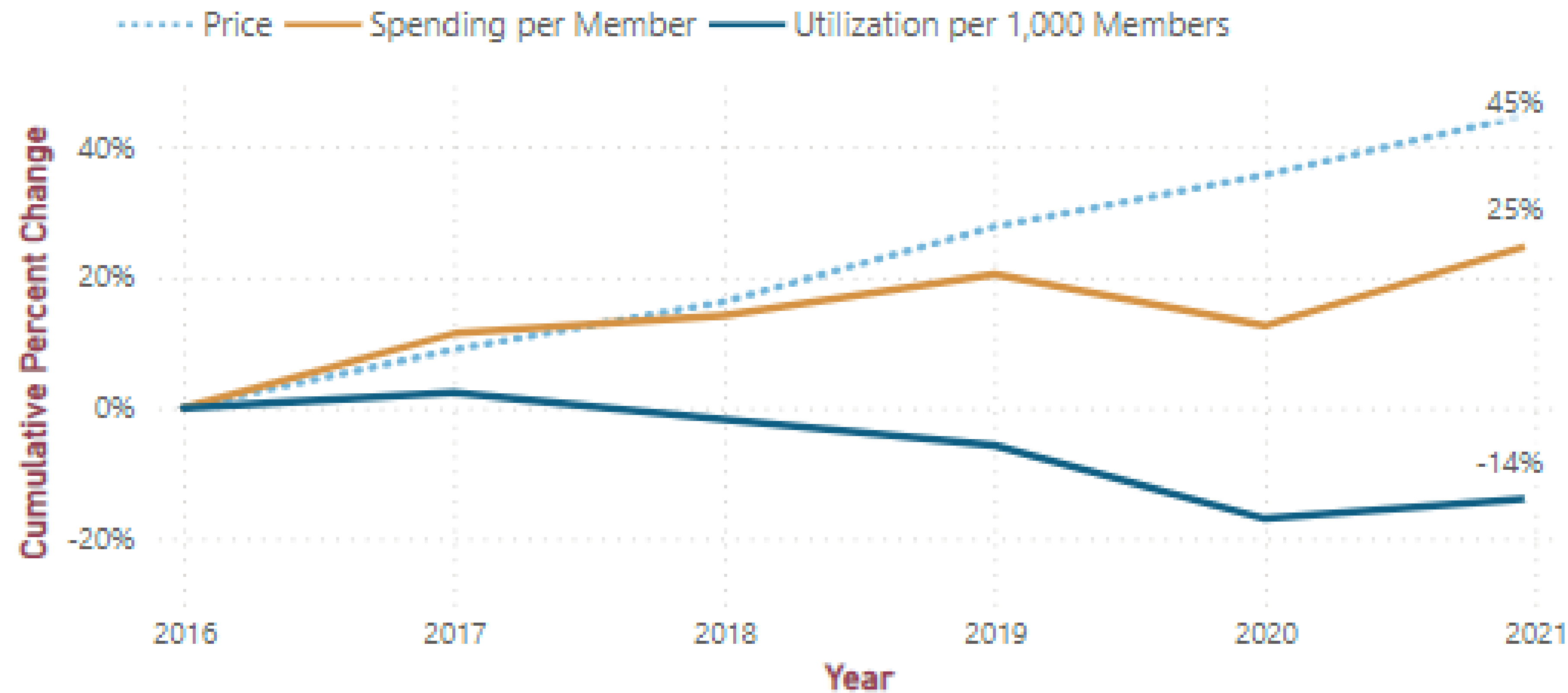
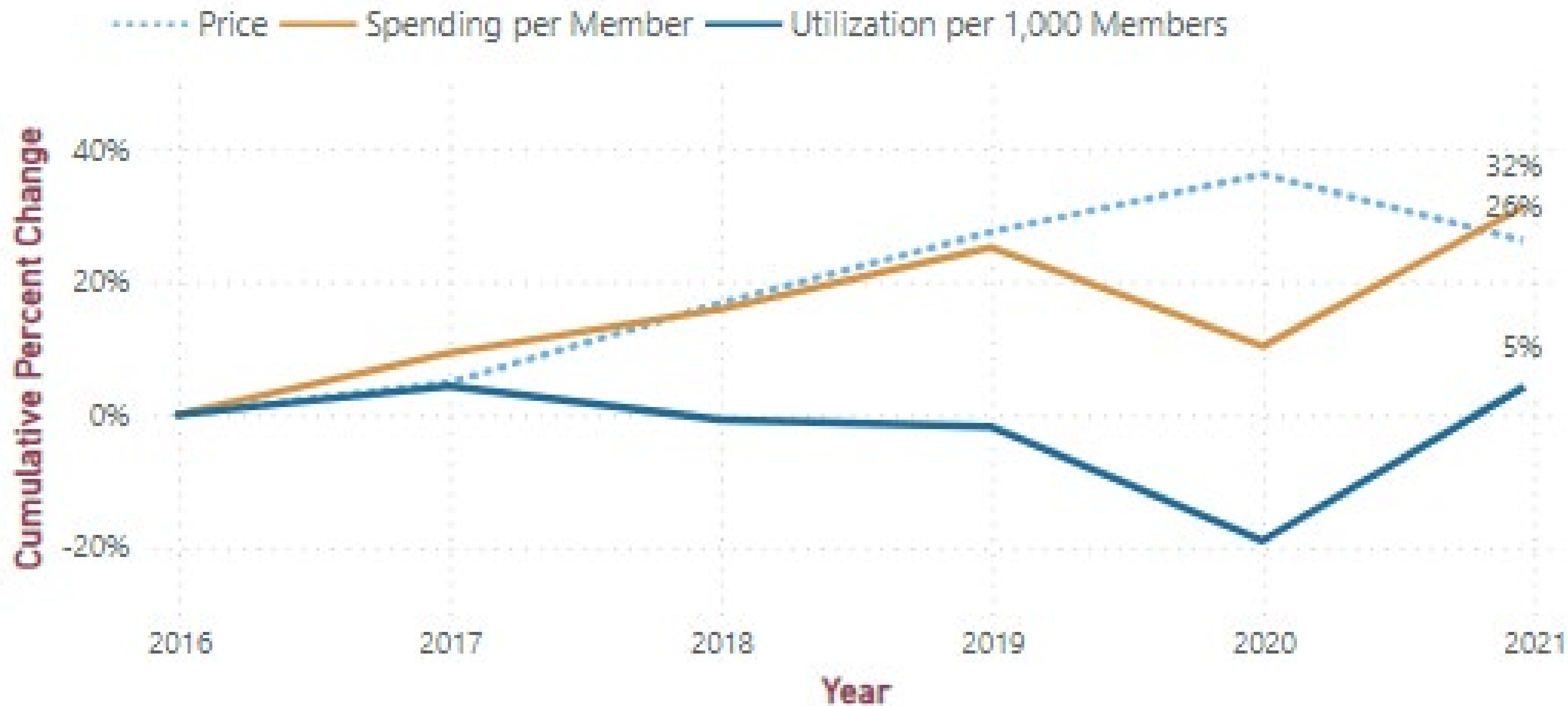
Trends in “Price” and Utilization Relative to Inpatient Commercial Hospital Spending, 2016-21



Trends in “Price” and Utilization Relative to Outpatient Commercial Hospital Spending, 2016-21



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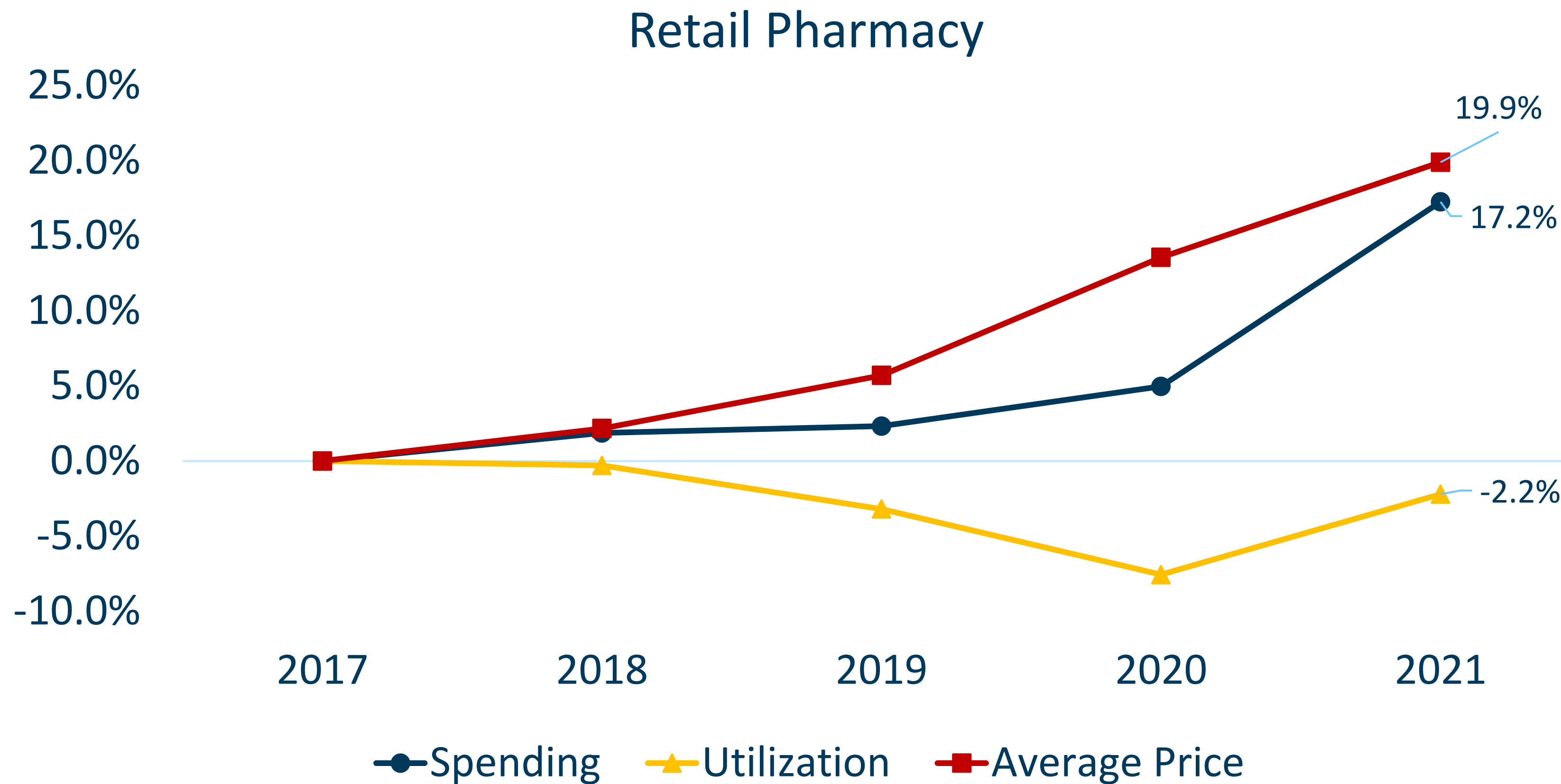
Example:
Using the APCD to Understanding Growth in Commercial Pharmacy Spending

Drug Prices

- There are two different categories of drug spending:
  - **Retail pharmacy**: drugs a patient obtains from a retail pharmacy or via mail order
  - **Medical pharmacy**: drugs that are administered by a clinician in a hospital outpatient department, freestanding infusion center or in a professional office

- In 2019, 28% of commercial spending was for pharmacy services, more than inpatient hospital or outpatient hospital.
  - 20.2% was retail pharmacy
  - 7.9% was medical pharmacy (and growing as a share of total pharmacy)

Retail Pharmacy: Growing Prices and Flat Utilization Since 2017



Spending = Spending per member per month (PMPM); Average price = Spending per prescription; Utilization = prescriptions per member month

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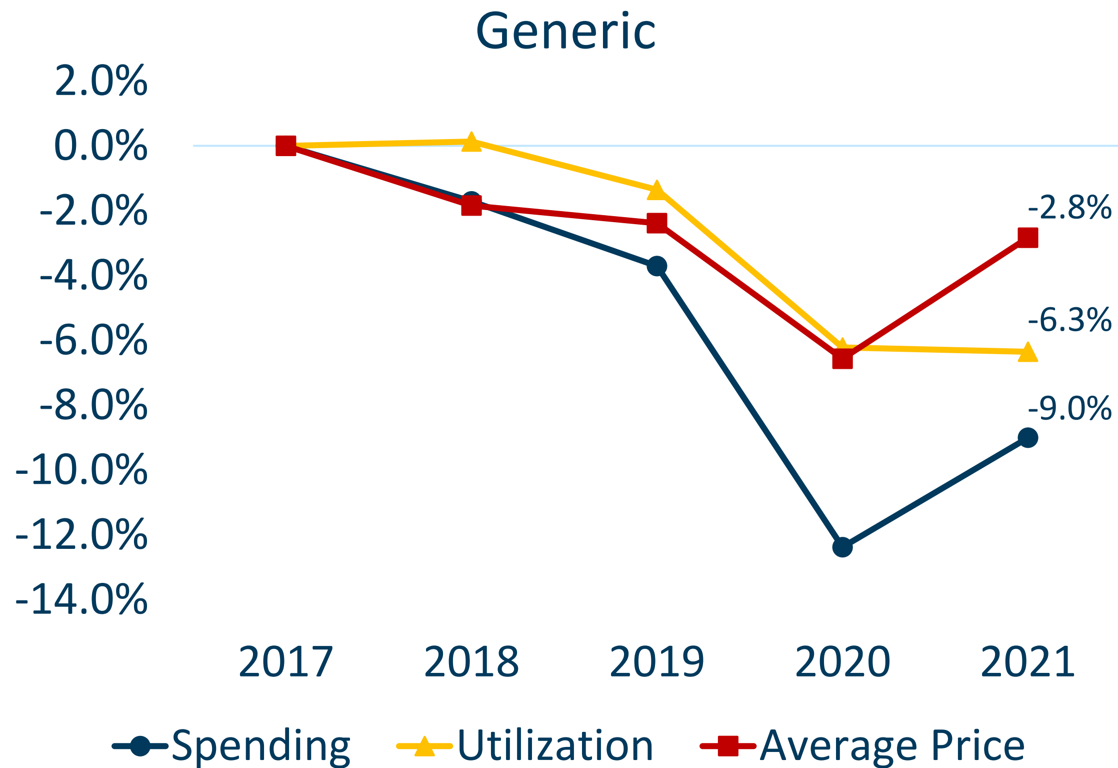
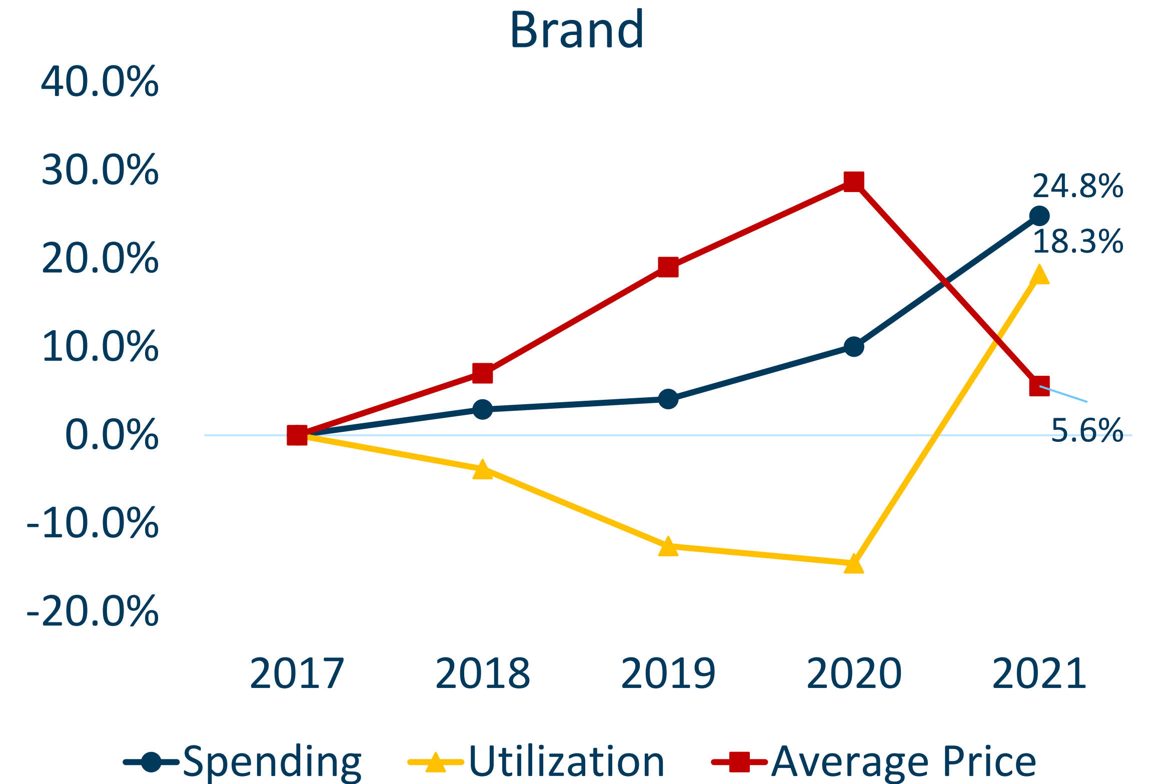
Spending Growth Has Occurred with Brand Drugs And Not Generics…Except for in 2021





Spending = Spending per member per month (PMPM); Average price = Spending per prescription; Utilization = prescriptions per member month

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2021 Top 10 Medications For Retail Pharmacy Spend

Retail Pharmacy Spend: Top 10 Medications (Total Allowed), 2021

Drug Name	Total Spending	Total number of prescriptions	Total prescribed days	Price per 30-day supply
HUMIRA PEN	$119,926,443	17,219	532,856	$6,751.91
STELARA	$74,370,201	3,718	169,172	$13,188.39
ENBREL SURECLICK	$33,995,264	6,079	192,057	$5,310.18
DUPILUMAB	$29,798,237	9,489	280,713	$3,184.56
TRIKAFTA	$25,543,449	1,178	36,898	$20,768.16
ELIQUIS	$22,804,127	35,491	1,684,275	$406.18
OTEZLA	$22,008,073	5,798	197,202	$3,348.05
SKYRIZI	$21,901,497	1,486	72,600	$9,050.21
BIKTARVY	$18,731,777	5,114	172,920	$3,249.79
HUMIRA PEN	$18,527,797	2,563	84,019	$6,615.57

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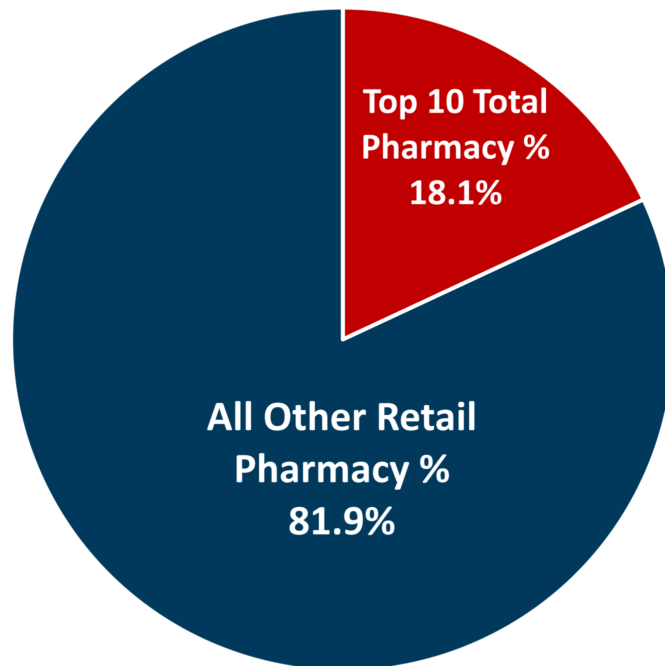
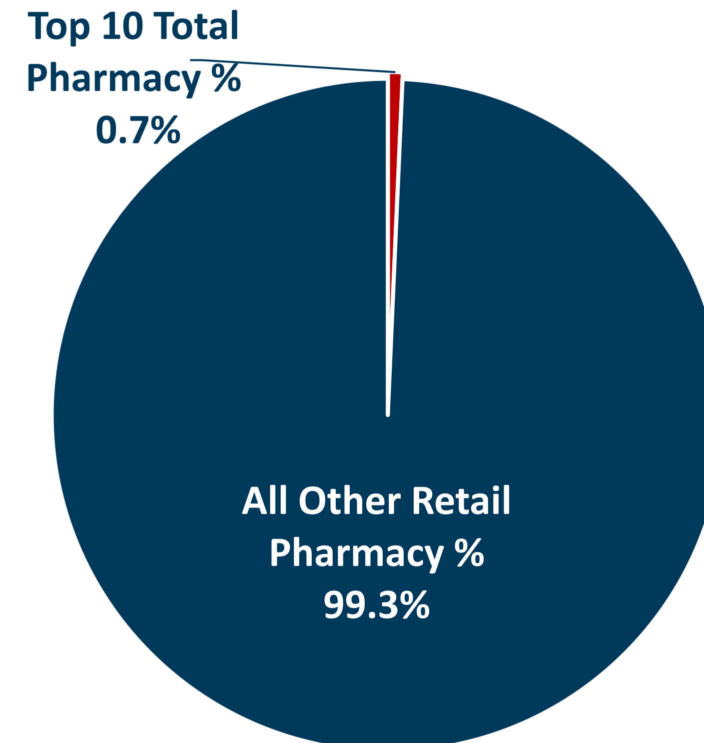
The Top 10 Retail Pharmacy Prescriptions Comprised <1% Of All Prescriptions And 18% Of All Spending In 2021

Spending on Retail Pharmacy



Volume of Retail Pharmacy



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In Summary

- The APCD has proven to be an essential tool for understanding health care spending patterns in Connecticut.
- Increasingly sophisticated analyses will allow OHS and the public to better understand what is driving spending and spending growth, and thus inform efforts to strategies to improve affordability.

Review and Approve Minutes

May 11, 2023 Regular Meeting

APCD Strategic Prioritization Update

Sumit Sajnani, HITO

APCD Data Submission Guide Update

Olga Armah, OHS

APCD Data Submission Guide Update

- DSG 30-Day Public Comment Period closed in June
- Approximately 15 questions received from six respondents
- Responses published on OHS website and shared with submitters in July
- Public comment period resulted in no changes to the DSG
- DSG is effective October 2023
- Deadline to commence reporting extended to January 2024 (February submission for January data…)

APCD Updates

Olga Armah, OHS

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APCD Data Types & Years Available

The APCD comprises **medical, pharmacy, and dental*** claims information from enrollment and eligibility files

Payer Source	Claim Type	Years Available
Commercial** ▪ Fully Insured Claims ▪ State Employees & Retirees ▪ Medicare Advantage (Medical only)	Eligibility/Enrollment Medical Claims Pharmacy Claims	1/1/2012 – 3/31/2023
Medicaid	Eligibility/Enrollment Medical Claims Pharmacy Claims	1/1/2015 – 3/31/2023
Medicare	Eligibility/Enrollment Medical Claims	1/1/2012- 12/31/2019
	Pharmacy Claims	1/1/2012 – 12/31/2018

*Collection slated to begin in 2023 including 3 historical years

**Anthem, Aetna, Cigna East, Cigna West, ConnectiCare, United Healthcare, HealthyCT, Harvard Pilgrim, Optum Health, Oxford, WellCare Health, eviCORE Healthcare, Express Scripts, Caremark

Reporting threshold – 3,000 members

APCD Data Release Committee Report

Dr. Patricia Checko, APCD-DRC Chair

Wrap up and Adjournment

Next Meeting: November 9, 2023