Healthcare Cabinet Meeting Minutes
January 11, 2022

Meeting Date	Meeting Time	Location
January 11, 2022	9:00 a.m. - 11:00 a.m.	Webinar and Conference Call

Participant Name and Attendance

Healthcare Cabinet Members					
Victoria Veltri	X	Hussam Saada	X	Heather Aaron	X
Claudio Capone	X	Alan Kaye	X	James Michel	X
Rev. Robyn Anderson	X	Paul Lombardo	X	David Whitehead	X
Patricia Baker	X	Manisha Juthani	X	Claudio Gualtieri	X
Nicole Taylor	X	Nichelle Mullins	X	Kurt Barwis	X
Shelly Sweatt	X	Danielle Morgan	X	Ellen Andrews	X
Colleen Harrington	X	Cassandra Murphy	X		
Ted Doolittle	X	Jill Zorn	X		
Others Present					
Members Absent					
Joshua Wojcik		Deidre Gifford			
Valencia Bagby Young		Margherita Giuliano			
William Handelman					

	Agenda	Responsible Person(s)
1	**Call to order and Introductions**	**Victoria Veltri**
	The regularly scheduled meeting of the Healthcare Cabinet was held on Tuesday, January 11, 2022 via Zoom. The meeting convened at 9:00 a.m. Victoria Veltri presiding. Attendance taken by roll call.	
2	**Public Comment**	**Victoria Veltri**
	There was no public comment.	
3	**Approval of the December 14, 2021 Meeting Minutes & HCC 2022 Meeting Schedule**	**Victoria Veltri**
	The motion was made to approve the December 14th meeting minutes by James Michel and seconded by Pat Baker.	
4	**Access Health - Update**	**James Michel, Access Health**
	Ms. Veltri introduced James Michel who gave a brief update on Access Health. 2022 Open Enrollment update below are the highlights from the update.	

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- Open Enrollment ends on January 15, 2022
- 95% of enrollees renewed into 2022 coverage
- 5k enrollees yet to be enrolled in 2022 coverage
- 12% point increase in enrollees eligible for financial help (related to removal of 400% FPL income threshold)
- Average Enrolled Household Net Premium 16% Lower Than Last OE
- Covered CT enrollees: 777

Covered Connecticut Marketing Update

Direct Mail Campaigns (3 years back, 10% above and below income requirement – audience size approx. 7,200).

- Pre-OE Virtual Summit
- Radio (Terrestrial AM/FM)
- Print Advertorials (*Courant* and 8 minority papers in English, Spanish and Polish)
- Social Media Paid & Organic
- Digital (Paid Search and Display)
- Blog Post
- Website Q&A Article
- Public Relations (Press Releases & Press Conferences)
- Email Campaigns (Acquisition & Renewals
- Out-of-Home (Billboards)
- Navigator Partners (Available Year-Round)
- Outreach Events
- Webinars

Print Advertorials (8 minority in English, Spanish and Polish)

- Social Media Paid & Organic
- Blog Post
- Website Q&A Article
- Digital (Paid Search and Display)
- Public Relations (Press Releases & Press Conferences)
- Toolkit
- Direct Mail Campaigns (Acquisition & Renewals)
- Email Campaigns (Acquisition & Renewals)
- Enrollment Locations (Regular Hours During OE)
- Enrollment Fairs (One-Day Events)
- Navigator Partners (Available Year-Round)
- Outreach Events
- Continued mentions in webinars

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	Ms. Veltri thanked Mr. Michel for the update. Several discussions ensued for more information please see the meeting recording link below. January 11 2022 (ct.gov)	
6	**Analysis of Hospitals' Other Operating Expenses**	**Ron Ciesones, OHS**
	Ms. Veltri introduced Ron Ciesones from OHS who gave a reported on the Analysis of Hospitals' Other Operating Expenses. Mr. Ciesones noted that the following is a summary of the Office of Health Strategy's Hospital Reporting System Report 175 which is reported by all hospitals. Below are the highlights from the Statewide Hospital Expense Data Fiscal Years 2017 - 2020 Connecticut's Acute Care Hospitals presentation: The categories above are the seven (7) categories presented, of the Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for 2020. • Summary of hospital expense FY 2020. • Salary and Wages 33% • Fringe Benefits 9% • Supplies 8% • Drugs 8% • Depreciation and Amortization 4% • Interest Expense 1% • Other Operating Expenses 37% A further breakdown of other operating expenses reported by hospitals are as follows. • FY 2020, total operating expenses increased $1.1 billion. • The top three categories, salaries and wages ($274m), fringe benefits ($211m), and other operating expenses ($551m) accounted for 95% ($1.04 billion) of the $1.1 billion total. • Total other operating expenses made up 50% of the $1.1 billion difference in expenses between FY 2019 and FY 2020. Since FY 2017, amounts for salaries and wages have decreased by 2.5 percentage points while other operating expenses have increased by almost four percentage points and drugs have increased by almost 8%. • FY 2020, the top 3 categories (contract labor, corporate parent/system fees, and purchased services account for 90% ($499 million) of the $551 million increase in other operating expenses and 63% ($3.2 billion) of the $5.0 billion total. In FY 2020, four hospitals accounted for 56% of miscellaneous other operating expenses. The hospitals include Yale-New Haven (18%), Saint Francis Hospital and Medical Center (14%), Bridgeport (14%), and Norwalk Hospital (14%). There were 14 hospitals having declines in this category.	

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- FY 2020, Yale-New Haven Hospital had the largest year over year increase in contract labor expense ($29.5 million) and purchased services ($55 million). Hartford Hospital had the largest year-over-year increase in corporate fees ($64 million). St. Vincent's Hospital and Medical Center had the largest decrease in misc. other operating expenses ($56 million). Ms. Veltri thanked Mr. Ciesones for the presentation. Several discussions ensued for more information please see meeting recording link below.

An analysis of the 4 largest expenses categories that are a part of the Other Operating expenses on the HRS report 175, Corporate Parent – Systems Fees; Contract Labor and Purchased Services was also presented. Please note that Contract Labor - the sum of amounts reported for contract labor categories Nursing Fees, Physician Fees, Other Medical Personnel and Non Medical Personnel. Purchased services - includes amounts reported for the categories purchased services medical and purchased services non-medical.

Ms. Veltri thanked Mr. Ciesones for presenting to the cabinet today. Several discussions ensued for more information, please see the meeting's recording link below.
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7	**Trends in Connecticut Commercial Health Care Spending, 2015-2019**	**Michael Bailit, Bailit Health**

Ms. Veltri introduced Mr. Bailit who presented to the cabinet members Trends in Connecticut Commercial Health Care Spending, 2015-2019.
Mr. Bailit began the presentation with an Overview of Analytic Population and Framework:

- CT residents under age 65, as indicated, in 2015 - 2019
- Commercial (fully insured, and State employees and retirees)
  - 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
  - Payments after runout period (after June 30th of following year) 5
- Also missing: non-claims-based payments, drug rebates, and retail pharmacy

Below are the highlights from the presentation:

Per Member Per Month (PMPM) Total Commercial Spending & Out-of-Pocket Commercial Spending

- Medical spending PMPM increased 21%, 2015-19 7 Notes: 1) The average annual increase was 4.

It was noted that the average annual increase was 4.9%. Average wage growth in CT for the same time period was 2.6%. Limited to CT residents under age 65. Excludes retail pharmacy spend, a major contributor to spending growth in other states.

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Mr. Bailit noted that the consumer out-of-pocket spending increased much faster than total spending. The average annual increase in out-of-pocket spending was 6.5%. This includes patient co-insurance, deductible, and co-payment obligations. It does not include premium contributions. This finding reflects changes in employer decisions on plan design, and employee plan selection.

PMPM Commercial Spending, by Service & Relative Impact of Price and Utilization
Between 2015 and 2019 per capita spending growth varied significantly by service type.

- Recall that Rx spending is not included in the analysis. It often represents around 25% of commercial spend.
- Annual hospital spending growth is particularly high. By comparison, in RI insurer-reported data showed 2018-19 trends in per capita commercial hospital spending of 1% for IP services and 7% for OP (including ED) services.

Hospital discharges were concentrated in a few systems; discharge volume changes were variable. Two health systems represented 57% of 2019 inpatient discharges. The two next largest systems represented 10% and 9% of 2019 inpatient discharges respectively. Together, these four systems represented 76% of 2019 inpatient discharges. While discharge volume per 1000 members dropped 9% between 2015 and 2019, there was considerable variation across systems. Two systems had declines of only -0.4%, while two had a drop of -21.5% and -16.9% respectively. Hospitals with the highest inpatient costs grew fastest, while those with the lowest grew slowest. Of the ten hospitals with the highest rates of growth in payment per CMAD, five hospitals also had the highest cost per CMAD in 2019. Four of five were affiliated with the largest systems. Of the ten hospitals with the lowest rates of growth in payment per CMAD, five hospitals also had lowest cost per CMAD in 2019. Four of five were unaffiliated with the largest systems.

It was noted that ED, outpatient surgery, and radiology made up the majority of outpatient facility spending. Across all major outpatient service types, changes in outpatient spending were driven by spending per unit not units per person.

Emergency Department Utilization
Methods: ED Utilization Analysis 2016 – 2019*

- Focus on disparities by age, gender, income, and race;
- Deciles are based on resident zip code** and derived from Census data;
- Income Decile 1 is lowest income; Decile 10 is highest income;
- Race decile is defined by the percentage of people of color in the community;
- Race decile 1 is the highest portion of people of color; race decile 10 is lowest portion of people of color;
- Professional and outpatient ED claims for the same member on the same date were grouped into ED visits.

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ED utilization and PCP visits - Members with ED visits were more likely to have had a PCP visit than those members without an ED visit (76% vs. 55%). Nothing changed in this respect between 2015 and 2019. Members in communities with higher proportions of people of color were less likely to have had a PCP visit. Nothing changed in this respect between 2015 and 2019.

Certain diagnoses have notably higher ED rates in low-income communities 24

- All ages
  - Asthma (2.4x)*
  - Complications in pregnancy (2.3x)
  - Low back pain (2.1x) Musculoskeletal pain, not low back pain (1.9x)
  - Viral infection (1.8x)
- Children (0-17)
  - Asthma (2.7x)
  - Other specified upper respiratory infections (1.8x)
  - Otitis media (1.8x)
  - Respiratory signs and symptoms (1.8x)
  - Nausea and vomiting (1.7x)
- Special interest (all ages)
  - Influenza (All) (1.5x)
  - Non-traumatic dental (1.7x

It was noted that ED visits are declining but remain higher among residents in lower income communities. Around 45% of ED visits were non-emergent or avoidable.

Other ED visit disparity observations:

- Bottom income decile members were 2x more likely to have a chronic condition and were 2x as likely to have two chronic conditions, compared to top income decile members. Disparities were greatest for glaucoma and ischemic heart disease. There was not a great deal of variation by chronic condition.
- Members in the decile with the highest % of people of color were 1.5x more likely to have one chronic condition and two or more chronic conditions, compared to decile with the lowest %. There was not a great deal of variation by chronic condition.
- There is certain correlation between income and race. These data suggest that income is more explanatory than race.

Ms. Veltri thanked Mr. Bailit for presenting to the cabinet today. Several discussions ensued for more information, please see the meeting's recording link below.

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Adjourn	**Victoria Veltri**

The motion to adjourn the meeting was made by Pat Baker and seconded by Allan Kaye. The motion passed.

The meeting adjourned at 11:00 a.m.