CONNECTICUT
Health Strategy

Cost Growth Benchmark Initiative
2021-2022 Performance
A report Pursuant to C.G.S. 19a-754h

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Acronym Glossary

APCD	All-Payer Claims Database
CMS	Centers for Medicare and Medicaid Services
CT	Connecticut
DOC	Department of Correction
DSS	Department of Social Services
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
MCO	Managed care organization
NCPHI	Net Cost of Private Health Insurance
OHS	Office of Health Strategy
OSC	Office of the State Comptroller
PCMH	Person-Centered Medical Home
PGSP	Potential Gross State Product
THCE	Total healthcare expenditures
TME	Total medical expense
VHA	Veterans Health Administration
WAC	Wholesale Acquisition Cost

Glossary

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

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

Copayment: The fixed amount the member pays for a covered service after the member has paid their deductible. For example, if an insurance plan's allowable cost for a service is $100 and the member's copayment for the service is $20, if the member has met their deductible, they pay $20 for the service. If the member has not met their deductible, they pay $100, the full allowed amount for the service.

Fee-for-Service: Private (commercial) health insurance that reimburses 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 dir

ectly 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 Public Act 22-118, §§ 217-223. OHS has set interim targets for each calendar year to reach 10% by 2025.

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

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

Total Medical Expense (TME): The total cost of care for the patient population of a payer or provider entity for a given calendar year, where cost is calculated for such year as the sum of: all claims-based spending paid to providers by public and private payers, and net of pharmacy rebates; all nonclaims payments for such year, including, but not limited to, incentive payments and care coordination payments; and all patient cost-sharing

amounts expressed on a per capita basis for the patient population of a payer or provider entity in this state. TME is reported at multiple levels: market, payer and provider level. TME is reported net of pharmacy rebates at the state, market and payer levels only. Payers report TME by line of business (e.g., individual, self-insured, large group, small group, Medicare, Medicaid, Medicare/Medicaid dually eligible) and at the Advanced Network level whenever possible. More detailed TME reporting specifications are contained in the Appendices of the Connecticut Healthcare Benchmark Initiative Implementation Manual.

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

Acknowledgements

The Office of Health Strategy (OHS) expresses its gratitude to the Centers for Medicare & Medicaid Services, the Connecticut Department of Social Services, the Department of Correction and the Office of the State Comptroller for submitting data for this report. OHS also thanks the insurance carriers and the Advanced Networks for their cooperation and collaboration, and the Healthcare Benchmark Initiative Steering Committee for their guidance and input (see Appendix A for membership).

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Introduction

The rapid growth in healthcare costs over the last few decades has placed a profound burden on families and businesses. From 2000 to 2020, per person spending on healthcare in Connecticut grew at an average rate of 4.8% per year, compromising residents' ability to afford critical healthcare services and other basic needs.[1]

The average family premium for employer-sponsored coverage, through which more than half of Connecticut residents receive their healthcare coverage, nearly tripled over the last two decades, rising from $8,781 in 2001 to $24,746 in 2022 (see **Figure 1**).[2,3] By contrast, consumer price index (i.e. inflation) grew 61% and median household income grew 70% during that timeframe.[4,5]

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[1] Health Care Expenditures per Capita by State of Residence. (n.d.). KFF. Retrieved February 24, 2024, from https://www.kff.org/other/state-indicator/health-spending-per-capita/

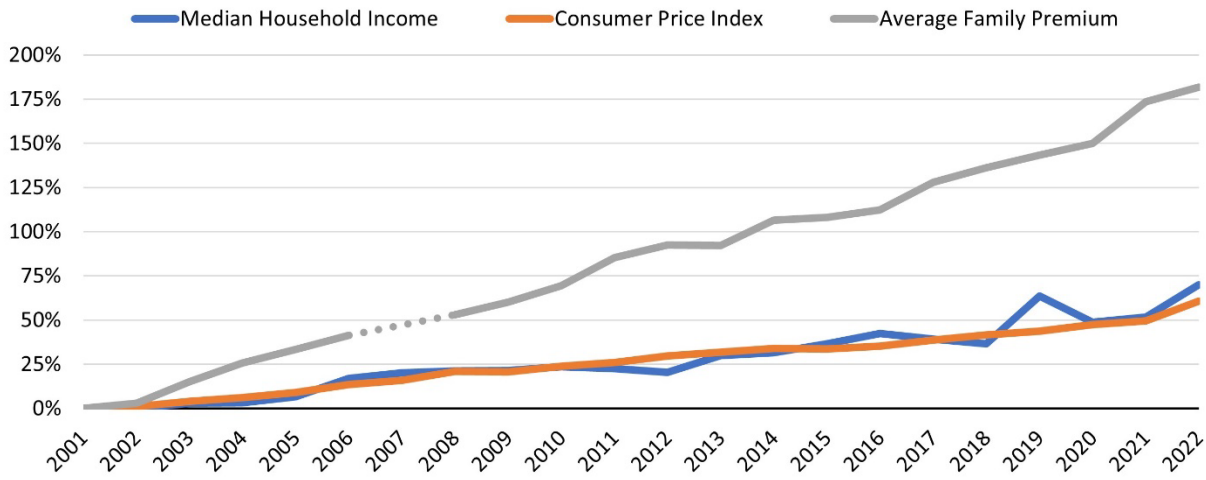
[2] KFF State Health Facts, Health Insurance Coverage of the Total Population. (n.d.). KFF. Retrieved February 24, 2024, from https://www.kff.org/other/state-indicator/total-population/

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

[4] U.S. Census Bureau. (1984, January 1). Median Household Income in Connecticut. FRED, Federal Reserve Bank of St. Louis; FRED, Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/series/MEHOINUSCTA646N

[5] U.S. Bureau of Labor Statistics. (1947, January 1). Consumer Price Index for All Urban Consumers: All Items in U.S. City Average. FRED, Federal Reserve Bank of St. Louis; FRED, Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/series/CPIAUCSL

Figure 1. Percentage Rate of Median Household Income, Consumer Price Index and Average Healthcare Premium Cost to Families (2001-2022)



Notes: Average Family Premium data is unavailable for 2007.
Sources: Agency for Healthcare Research and Quality (AHRQ)[3], US Census Bureau[4], US Bureau of Labor Statistics[5]

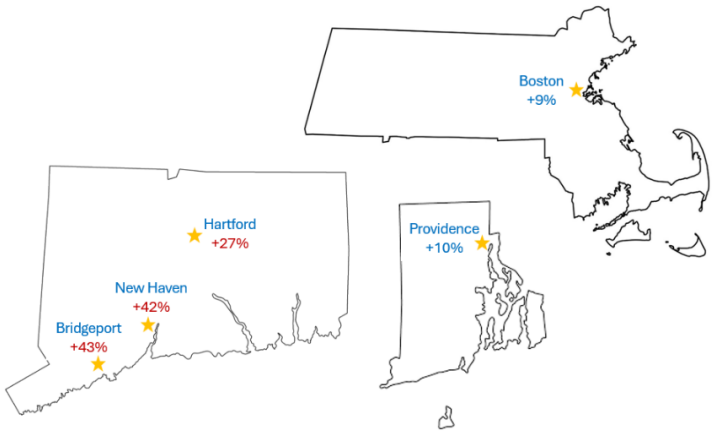
With premiums rising faster than incomes, families have to spend a larger portion of their income on healthcare coverage. Just as the total premium for employer-sponsored family coverage has nearly tripled from 2001 to 2022, the employee contribution for such coverage has also risen significantly, from $2,112, or 4% of median household income, to $6,299, or 6.9% of median household income. Moreover, not only are employees shouldering the cost of higher premiums, but they are also facing higher cost-sharing obligations. The average family deductible increased over 350% from $898 in 2002 to $4,053 by 2022, more than quadrupling over two decades.[6]

Connecticut residents face inpatient prices that are not only higher than many other comparable areas in New England but also far beyond 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 (see **Figure 2**).[7] Prices in these Connecticut cities are significantly higher than prices in

[6] See Footnote 3.
[7] HMI Interactive Report. (2017). Health Care Cost Institute. https://healthcostinstitute.org/hcci-originals/hmi-interactive

Boston, Massachusetts, and Providence, Rhode Island, which are 9% and 10% respectively above the national median.

Figure 2. 2021 Inpatient Prices in Local Metro Areas Relative to National Median



Connecticut residents are suffering under the weight of high healthcare costs. In a recent Healthcare Value Hub survey of CT respondents, it was reported:

- Nearly half (46%) delaying or foregoing care;
- More than three-quarters worried about future healthcare expenses (78%);
- One-third (33%) struggle to pay medical bills.[8]

Additionally, 11% of Connecticut residents report using up all or most of their savings on healthcare, and another 11% report being unable to pay for basic necessities such as food, heat and housing due to medical bills.

Many residents also experience a sense of foreboding when thinking about future healthcare expenses. Three out of five (60%) Connecticut residents worry about health insurance becoming unaffordable, and 57% are

[8] 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

concerned about the medical costs they would incur if they developed a serious illness or were involved in an accident.

More than two out of five adults with incomes under $75,000 incurred medical debt, depleted savings, and/or sacrificed basic needs to pay medical bills and were much more likely to forgo care or ration medicine. The issue also persists among those earning more than $75,000 per year, with more than 20% reporting medical debt, depleted savings, and/or sacrificing basic needs due to medical bills, and over a third reporting that they delayed care. Although high healthcare costs disproportionately impact lower-income individuals and families, the issue undoubtedly affects the middle class as well.[9]

In addition, high healthcare costs disproportionately affect marginalized racial and social groups, making them more susceptible to financial distress and compelling them to adopt cost-cutting measures, such as delaying care, more often.[10] Connecticut residents who identify as Black/African American, American Indian or Alaska Native, Asian, Native Hawaiian, or other Pacific Islander reported financial hardships resulting from medical bills at twice the rate of White individuals. Hispanic individuals were more likely to report delaying care or enduring financial hardship from medical bills compared to non-Hispanic/Latine individuals. Additionally, households with at least one person with a disability were more likely to delay care, more likely to worry about healthcare costs, and twice as likely to have recently experienced financial hardship due to medical bills.

It is against this backdrop that Governor Lamont signed Executive Order #5 in January 2020, charging the OHS to establish a healthcare cost growth benchmark, with the goal of slowing the growth of healthcare spending and

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[9] Kylie Murdock, Joshua Kendall, & David Kendall. (2023, August 21). Medical Debt Hits the Heart of the Middle Class. Third Way. https://www.thirdway.org/report/medical-debt-hits-the-heart-of-the-middle-class

[10] David C. Radley, Jesse C. Baumgartner, Sara R. Collins, Laurie C. Zephyrin, & Eric C. Schneider. (2021, November 18). Achieving Racial and Ethnic Equity in U.S. Health Care. The Commonwealth Fund. https://doi.org/10.26099/ggmq-mm33

making healthcare more affordable for Connecticut residents. Containing the growth of healthcare costs is crucial for enhancing quality of life and economic well-being for all. The Cost Growth Benchmark Program aims to enhance transparency and establish a clear expectation that healthcare spending should only grow at a rate consistent with the state's income and economic growth.

This report presents the results of the analysis of the 2021 and 2022 spending data collected under the Cost Growth Benchmark Program. Section 1 presents 2022 state and market level performance against Connecticut's cost growth benchmark of 3.2%, and state and market trends in spending. Section 2 details payers' benchmark performance by insurance market. Section 3 describes Advanced Network benchmark performance by market. Section 4 explores trends in utilization and pricing of prescription drugs and examines the costliest drugs used by Connecticut residents, using data from the state's All-Payer Claims Database (APCD).

Section 1: 2021-2022 Growth in Healthcare Spending Statewide and by Market

In 2020, an OHS advisory body recommended a 2.9% cost growth benchmark to OHS. This benchmark was based on a 20/80 weighting of the projected growth in Connecticut's Potential Gross State Product (PGSP) and in Connecticut's median household income. For the first two years of implementing the benchmark, the advisory body recommended an upward adjustment to the benchmark value, setting the benchmark at 3.4% for 2021 and 3.2% for 2022.

To assess performance against the benchmark, the OHS collects and analyzes data from payers on healthcare spending in the state. This section reviews 2022 state, insurance market, insurance carriers, and Advanced Networks performance relative to the spending growth benchmark. It also explores the 2022 healthcare spending trends, drawing on OHS's annual cost growth data collection.

It is important to note that the 2021 data has been re-collected to ensure consistency across reporting periods. Consequently, 2021 spending figures now include adjustments and spending not reflected in the previous report. Comparisons with previously reported 2021 data may show slight variations, attributable to claims runout and other factors that impact spending data over time.

COVID-19 Pandemic and Impact on Healthcare Spending

The COVID-19 pandemic dramatically altered healthcare spending in 2020 and 2021. Utilization and spending dropped precipitously in 2020 but rebounded in 2021, in most cases returning to pre-pandemic levels, with outpatient hospital services even surpassing them.[11,12] In OHS's analysis of 2022 spending, both price and utilization in the commercial market surpassed pre-pandemic levels in 2022.

State Total Healthcare Expenditure Trends

OHS assesses statewide performance against the cost growth benchmark by calculating the year-over-year change in total healthcare expenditures (THCE) for Connecticut residents who receive healthcare coverage through commercial insurance (including self-insured products), Medicare, Medicaid, the Connecticut Department of Correction, and the Department of Veterans Affairs. THCE comprises claims and non-claims (e.g. performance incentive payments and provider salaries) payments to providers for covered services delivered (also referred to as total medical expense, or TME), and the cost of administering private health insurance (referenced as the Net Cost of Private Health Insurance, or NCPHI). Data to measure THCE are obtained from

[11] Matthew McGough, Krutika Amin, & Cynthia Cox. (2023, January 24). How has healthcare utilization changed since the pandemic? Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/chart-collection/how-has-healthcare-utilization-changed-since-the-pandemic/

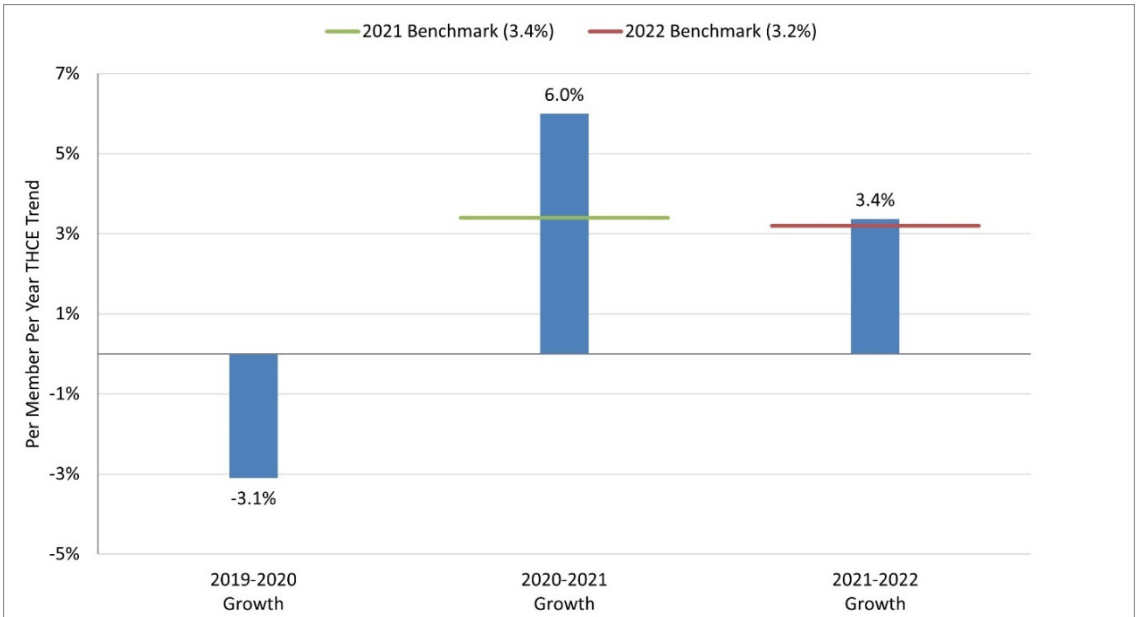
[12] Hanna Dingel, Emma Wager, Matthew McGough, Shameek Rakshit, Imani Telesford, Hope Schwartz, Cynthia Cox, & Krutika Amin. (2022, December 22). The state of the U.S. health system in 2022 and the outlook for 2023. Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/brief/the-state-of-the-u-s-health-system-in-2022-and-the-outlook-for-2023/

insurance carriers, the state, the federal government, and from publicly available regulatory reports.

Trends in Statewide Spending by THCE Component

In 2022, per person spending on healthcare in Connecticut was $10,851. This represents a growth of 3.4% over 2021, which is above the 3.2% cost growth benchmark established for the state (see **Figure 3**). This 3.4% increase showed a notable decrease from the 6% increase in spending from 2021 but was still greater than the 3.1% decrease in per person spending in 2020.[13,14]

Figure 3. State Per Member Per Year Total Healthcare Expenditure (THCE) 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).

[13] The 2021 cost growth benchmark was set at 3.4 percent.

[14] Healthcare cost growth benchmark and primary care spending target initiatives—2020 and 2021 performance. (2023). Connecticut Office of Health Strategy. https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/2020-2021-Benchmark-Report/Benchmark-Initiative---Final-Report.pdf

State's Total Healthcare Expenditure

The state's total healthcare spending increased by 4.5% to $36.4 billion in 2022, from $34.8 billion in 2021 (see **Figure 4**). Healthcare spending in the commercial market accounted for 35.2% ($12.8 billion) of the state's total healthcare spending, whereas spending on **Medicare** accounted for 31.6% ($11.5 billion) and **Medicaid**[15] accounted for 25.7% ($9.4 billion).

Figure 4. 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.

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

As reflected in Figure 4, net administrative expenses including profit, or NCPHI, totaled $1.65 billion in 2022, accounting for 4.5% of total healthcare spending.[16] This represents a 16.6% increase in 2022, following significant fluctuations in 2020 and 2021. Due to low utilization in 2020 the net administrative expenses (profit) increased by 11.3%. In 2021, the rebound in service utilization led to a 21.9% decrease in net administrative expense (profit). The growth in net administrative costs was primarily driven by the commercial individual and small group markets, which together accounted for more than 65% of the dollar increase.

Total spending on other public sources of healthcare, namely the Department of Correction (DOC) and Veterans Health Administration (VHA), grew by 14.9% to $1.06 billion.

Spending Growth by Market

Between 2021-2022, the state and all markets (excluding Medicare) were below the 3.2% benchmark.

Commercial spending increased by 2.4% (below the benchmark) to $8,062 per member per year in 2022 (see **Figure 5**). However, when accounting for administrative expenses, the commercial market was above the benchmark with spending growing by 4.1%. Commercial market enrollment dropped by 3.0% in 2022, continuing its decline in membership seen in both 2020 and 2021.

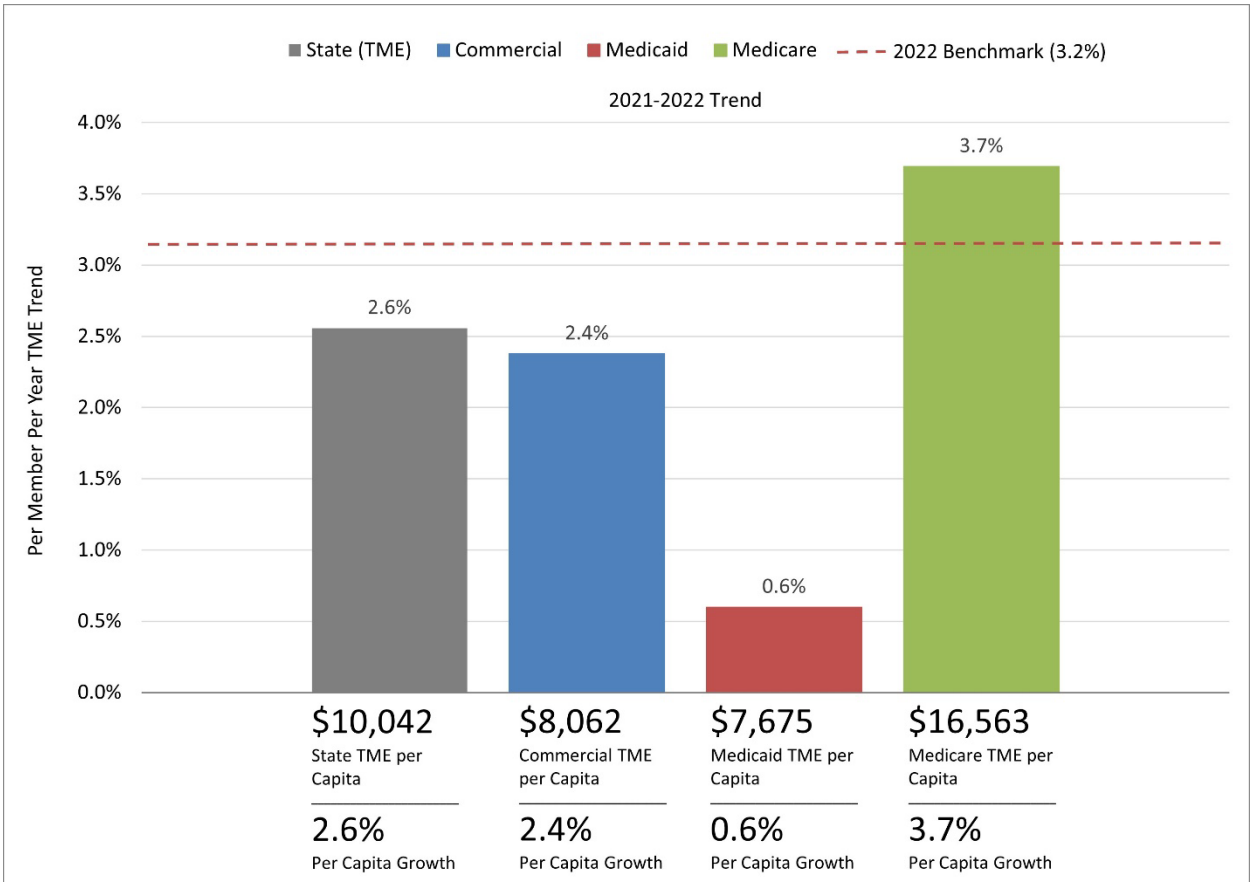
Medicare per member per year spending increased by 3.7% to $16,563 in 2022, above the benchmark. When accounting for administrative expenses,

[16] NCHPI captures the cost of administering private health insurance for Connecticut residents. It is broadly defined as the difference between the premium revenue health plans received on behalf of Connecticut residents and the spending incurred for covered benefits for those same members. NCPHI includes insurers' costs of paying bills, advertising, sales commissions, and other administrative costs. Because plan premiums are set prospectively based on historical claims data and actuarial assumptions, NCPHI can vary significantly from year to year depending on how closely actuarial projections match actual spending on healthcare services.

the rate of Medicare spending growth in 2022 remained nearly unchanged, at 3.6%. 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 5. 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.

Trends in Statewide Spending by Service

OHS collects aggregate claims and non-claims payment data from payers to analyze service category spending and to determine contributors to healthcare cost growth, as outlined in **Table 1**.

Table 1. Types of Payment Analyzed by Service Category*	
Aggregate Claims Service Categories	**Non-Claims Service Categories**
• **Hospital inpatient** • **Hospital outpatient** • **Professional, physician** • **Professional, specialty** • **Professional, other** • **Retail pharmacy** • **Long-term care** • **Other**	• Prospective capitation, global budget, case rate or episode-based payments • Performance incentive payments • Payments to support population health and practice infrastructure • Provider salaries • Recoveries • Other
*** Definitions of all claims and non-claims service categories are included in the Connecticut Healthcare Benchmark Initiative Implementation Manual and footnoted when discussed below.**	

On a per capita basis, non-claims and retail pharmacy spending experienced the largest increases (see **Figure 6**). Per member per year spending on non-claims services surged by 13.4%, notably outpacing growth in all other service categories. However, the change in non-claims spending has been volatile throughout the pandemic. In addition, non-claims spending represents only a small fraction of all medical spending, making it particularly prone to substantial fluctuations. Spending on retail pharmacy (net of rebates[17]) increased by 7.7% to $1,642, from $1,525 in 2021. Spending on professional physician services makes up nearly 20% of total spending and grew 1.9% in 2022. Spending declined for other professional (-2.1%), hospital inpatient (-0.9%) and other claims (-0.1%) services.

[17] Health plans often negotiate with drug manufacturers – either directly or through pharmacy benefit managers – to receive discounts on prescription drugs. These discounts or rebates are paid to the plan after a drug has been dispensed, effectively reducing the cost of the drug. Manufacturers use these rebates as a negotiation tool to earn favorable placement on the insurer's preferred drug list or formulary, which increases the drug's market share.

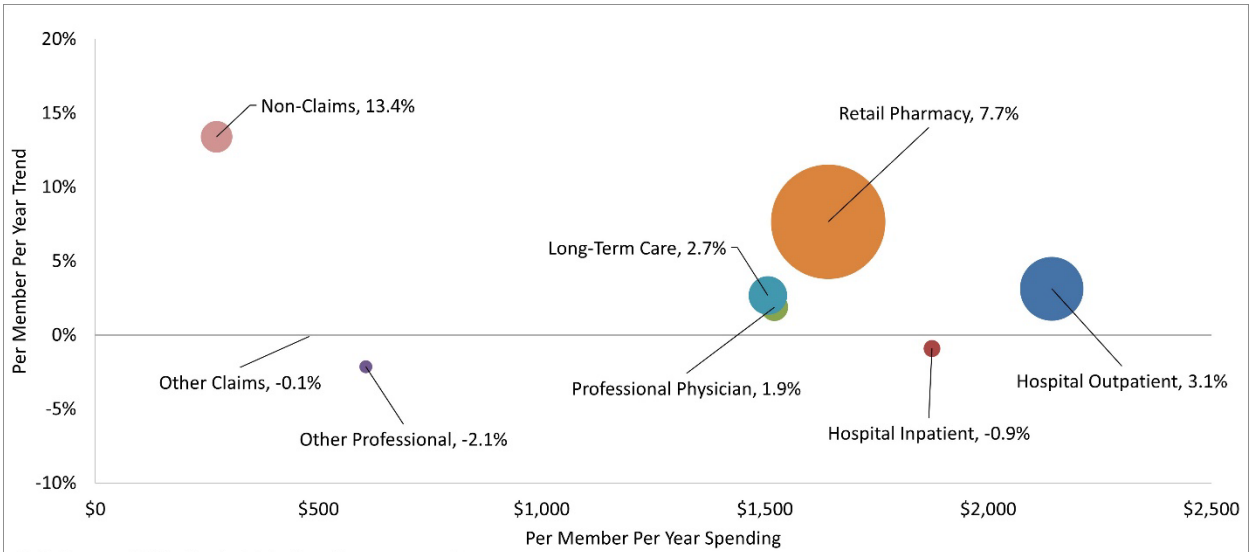
Figure 6. Per Capita State TME by Service Category (2021-2022)

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. "Other Public Sources" includes CT DOC and VHA spending. "NCPHI" is the net cost of private health insurance.

Drivers of Statewide Spending Growth

Statewide spending and its annual growth are determined by the annual growth of service categories that contribute the most to spending and their respective annual growth. State level service category contribution to per person spending trend is presented in **Figure 7**. The larger the bubble, the greater the service category's contribution to per person spending growth. At the state level, the greatest contributors to per person spending growth in 2022 were retail pharmacy (7.7%) and hospital outpatient (3.1%) service categories. Retail pharmacy's outsized contribution to spending growth was driven by a high rate of growth in 2022.

Figure 7. State Service Category Contribution to Trend (2022)



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. Service category contributions to spending growth varies from year to year.

In prior years, from 2019 to 2020, the decrease in overall spending was largely driven by hospital outpatient and professional physician services. Notably, during the same period, retail pharmacy spending remained mostly unchanged, in contrast to the decreases seen in most other service categories. Spending growth from 2020 to 2021 was driven by the rebound in hospital outpatient and professional physician services use, with spending surpassing pre-pandemic levels.

Section 2: 2021-2022 Growth in Healthcare Spending by Insurance Carrier and Market-Specific Cost Drivers

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

An insurance carrier whose spending growth and associated confidence interval that falls below the benchmark is considered to have met the

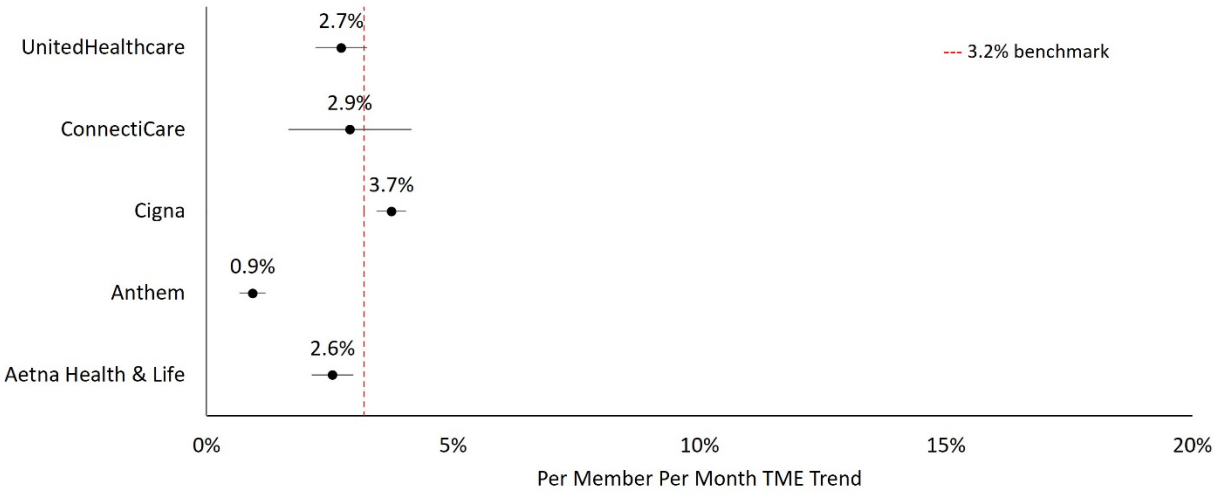
benchmark. Conversely, a carrier whose growth and associated confidence interval is above the benchmark is considered to have exceeded the benchmark. Performance relative to the benchmark is considered undetermined for those carriers whose confidence interval crosses the benchmark. If the confidence interval includes the benchmark value, then it is not statistically significantly different than the benchmark and therefore cannot be assessed.

Commercial Carriers' 2021-2022 Performance Against the Benchmark

For the commercial market, OHS collected data from five carriers: Aetna Health and Life ("Aetna"), Cigna, ConnectiCare, Anthem Blue Cross and Blue Shield ("Anthem"), and UnitedHealthcare.

Commercial carriers' spending growth from 2021 to 2022 ranged between 0.9 and 3.7%. Aetna and Anthem met the benchmark, with growth below 3.2% in 2022 (see **Figure 8**). ConnectiCare's and UnitedHealthcare's performance relative to the benchmark is undetermined, as it's confidence interval included the benchmark. Cigna exceeded the benchmark with year-over-year spending growth at 3.7%.

Figure 8. Commercial Carrier Per Member Per Month (PMPM) TME Trends (2021-2022)



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

Medicare Advantage Carriers' 2021-2022 Performance Against the Benchmark

For the Medicare Advantage market, OHS collected data from four carriers: Aetna, ConnectiCare, Anthem, and UnitedHealthcare.

Two Medicare Advantage Plans, Anthem and Aetna did not meet the benchmark; whereas ConnectiCare and UnitedHealthcare were not statistically significantly different than the benchmark and therefore could not be assessed (see **Figure 9**). Anthem's high spending growth is partly due to changes in the membership mix of medical-only and comprehensive plans, which include both medical and pharmacy spending.

Figure 9. Medicare Advantage Carrier TME Trends (2021-2022)

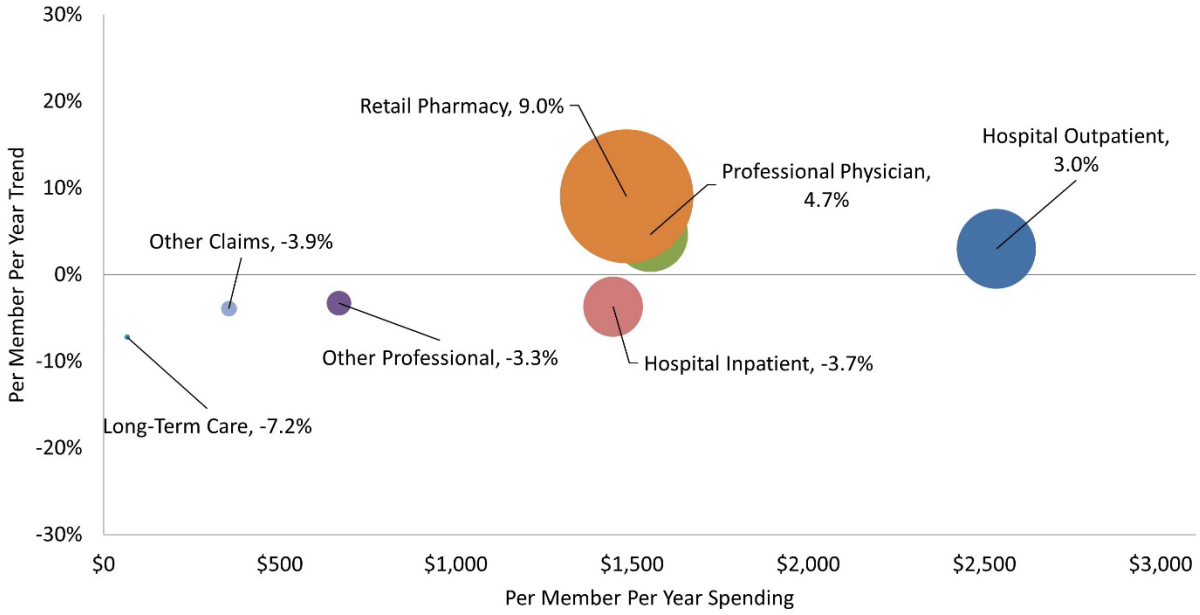
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated for outliers, risk-adjusted, and net of pharmacy rebates. The dots denote the year-over-year growth of an insurance carrier in a specific market, while the horizontal line through each dot indicates the range of values,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

2021-2022 Commercial Cost Drivers

Commercial service category contribution to trend is presented in **Figure 10**. The larger the bubble, the greater the service category's contribution to cost growth. The greatest contributors to commercial spending growth in 2022 were the retail pharmacy spending, professional physicians' services, and hospital outpatient service categories. In 2022, commercial retail spending increased by 9% to $1,484 per person, professional physician spending increased by 4.7% to $1,552 per person, and hospital outpatient spending increased by 3% to $2,534 per person.

Meanwhile, per person per year spending on hospital inpatient services, other professional services, long-term care, and other claims expenses all saw decreases in 2022.

Figure 10. Commercial Service Category Contribution to Trend (2022)



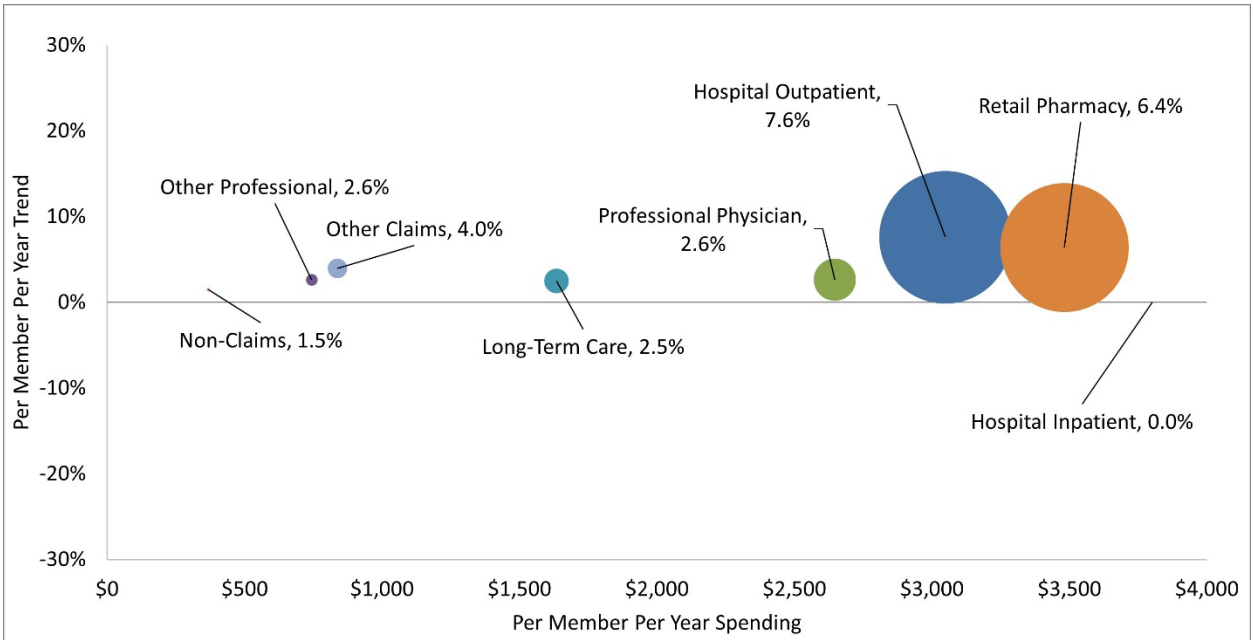
Data Source: OHS collected data from insurance carriers.
Notes: The width of the bubbles represents contribution to trend. Data are not risk-adjusted. Data are reported net of pharmacy rebates. Non-claims are not shown in this figure because the 2022 per capita amount was negative (-$44).

2021-2022 Medicare Cost Drivers

Medicare service category contribution to trend is presented in **Figure 11**. The hospital outpatient and retail pharmacy spending service categories were the greatest contributors to Medicare spending growth with the largest spending increases in 2022.

Medicare hospital outpatient spending increased by 7.6% to $3,048 per person while retail pharmacy spending increased by 6.4% to $3,482 per person in 2022. Meanwhile, hospital inpatient spending remained virtually unchanged, moving up slightly from $3,801 in 2021 to $3,802 in 2022.

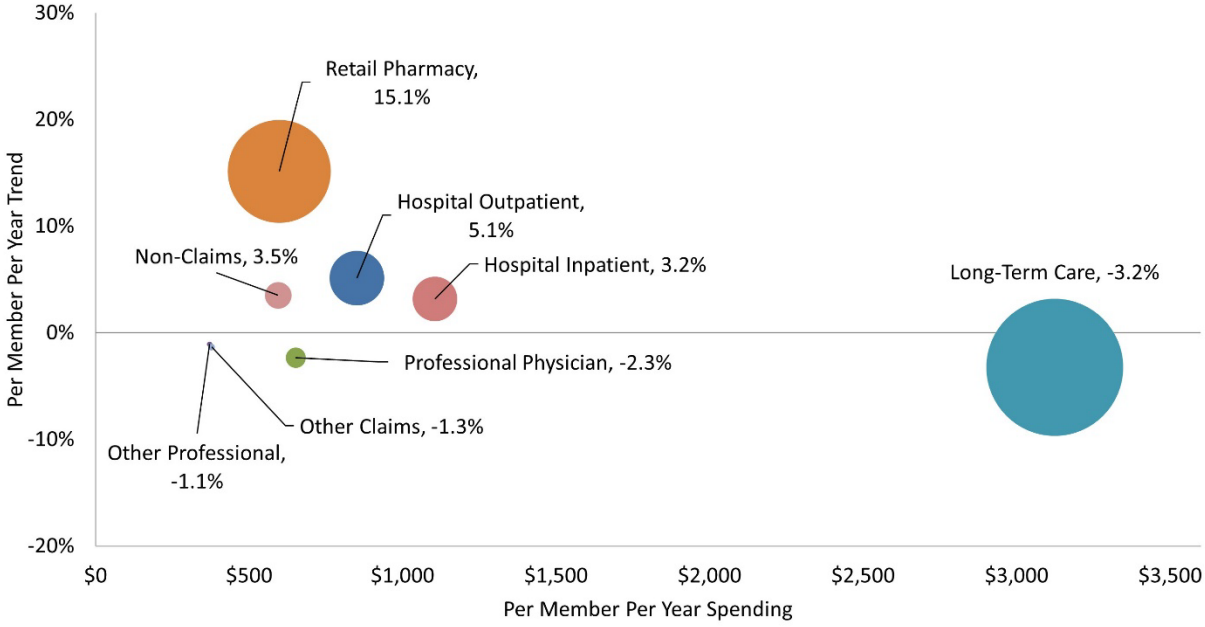
Figure 11. Medicare Service Category Contribution to Trend (2022)



Data Source: OHS collected data from insurance carriers and the Centers for Medicare and Medicaid Services (CMS).
Notes: The width of the bubbles represents contribution to trend. Data are not risk-adjusted. Data are reported net of pharmacy rebates (OHS did not receive pharmacy rebates from CMS). Medicare spending includes traditional Medicare, Medicare Advantage, and Part D pharmacy. Data include Medicare spending on the dually eligible population.

Medicaid service category contribution to trend is presented in **Figure 12**. Similarly, to Medicare and commercial, the retail pharmacy and hospital outpatient service categories were the greatest contributors to Medicaid per person spending growth in 2022. Medicaid retail pharmacy (net of rebates) per person spending grew by 15.1% to $598 in 2022 while hospital outpatient services increased by 5.1% to $852.

Figure 12. Medicaid Service Category Contribution to Trend (2022)



Data Source: OHS collected data from the Connecticut Department of Social Services (DSS).
Notes: The width of the bubbles represents contribution to trend. Data are not risk-adjusted. Data 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.

Medicaid hospital inpatient per person spending also increased by 3.2% from $1,071 to $1,1,05. Conversely, long-term care spending fell by 3.2% to $3,124 in 2022. Given that long-term care accounts for a substantial portion of Medicaid spending, this decline led to a more subdued change in per person per year Medicaid spending compared to the Medicare and commercial markets.

Section 3: 2021-2022 Growth in Healthcare Spending by Advanced Network and Market

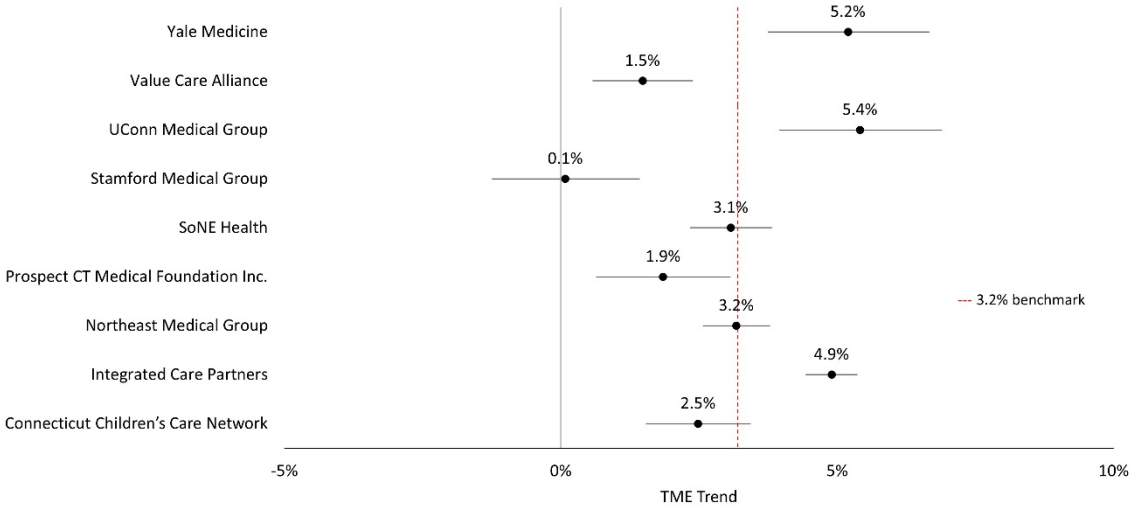
Advanced Networks, also referred to as large provider entities, are organized groups of clinicians that come together for the purposes of contracting. OHS assesses performance against the benchmark for Advanced Networks that have a minimum of 5,000 lives or 60,000 member months in a market and are considered large enough to be able to engage in a total cost of care contract.

Similar to the assessment of carrier performance, any Advanced Network with spending growth and an associated confidence interval below the benchmark is considered to have met the benchmark. An Advanced Network is considered to have exceeded the benchmark if its spending growth and associated confidence interval is above the benchmark. OHS considers performance as undetermined for an Advanced Network with a confidence interval crossing the benchmark. If the confidence interval includes the benchmark value, then it is not statistically significantly different than the benchmark and therefore cannot be assessed.

Advance Networks' Commercial 2021-2022 Performance Against the Benchmark

Among the nine **hospital-affiliated** Advanced Networks in the commercial market, three (Stamford Medical Group, Prospect CT Medical Foundation Inc, and Value Care Alliance) met the benchmark with year-over-year per person spending growth ranging from 0.1% to 1.9%; three (Integrated Care Partners, UConn Medical Group, and Yale Medicine) exceeded the benchmark, with spending growth between 4.9% and 5.4%; and three (CT Children's Care Network, SoNE Health and Northeast Medical Group) could not be determined (see **Figure 13**).

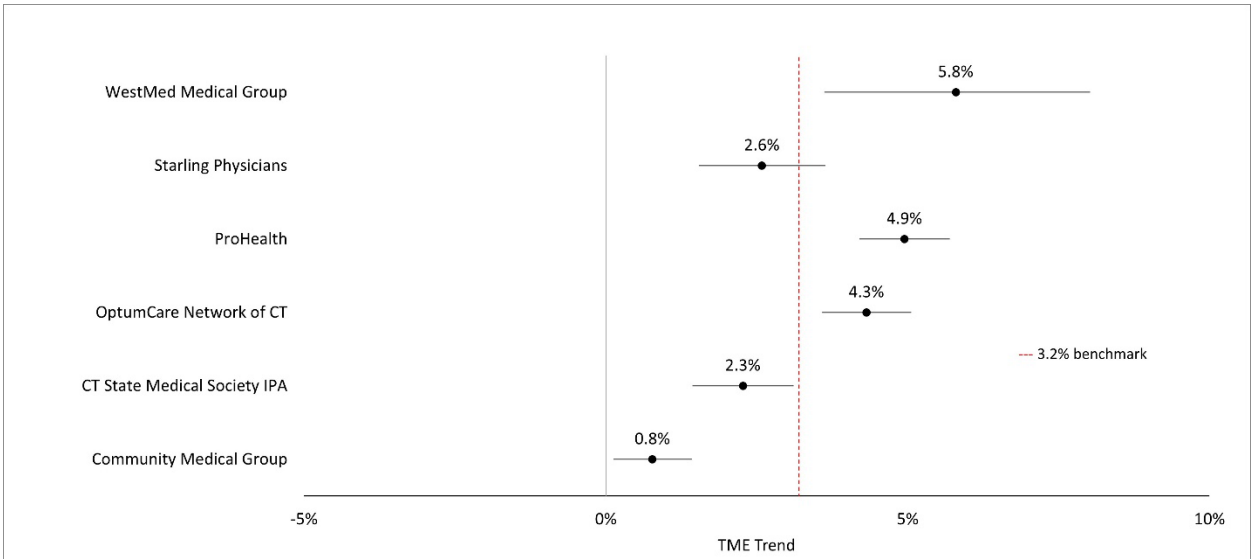
Figure 13. Hospital-Affiliated Advanced Network Commercial TME Trends (2021-22)



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

Among the six **non-hospital-affiliated** Advanced Networks in the commercial market, per person spending growth rates for Community Medical Group (0.8%) and CT State Medical Society (2.3%) met the benchmark, while OptumCare Network of CT (4.3%), ProHealth (4.9%), and WestMed Medical Group (5.8%) exceeded the benchmark. Starling Physicians performance against the benchmark could not be determined since it is not statistically significantly different from the benchmark (see **Figure 14**).

Figure 14. Non-Hospital-Affiliated Advanced Network Commercial TME Trends (2021-22)

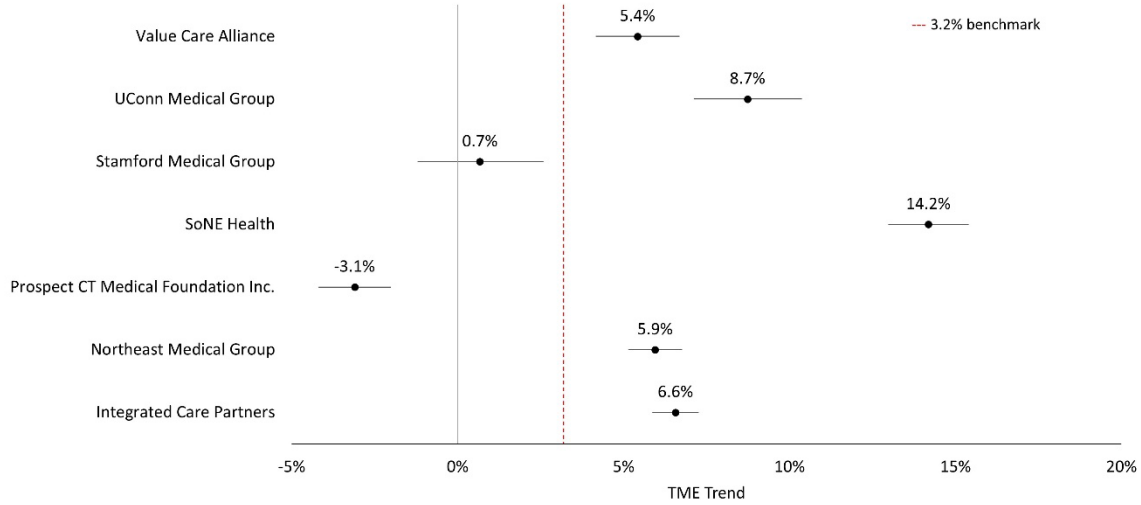


Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated for outliers and risk-adjusted. The dots denote the year-over-year growth of an insurance carrier in a specific market, while the horizontal line through each dot indicates the range of values, or confidence interval,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

Advance Networks' Medicare Advantage 2021-2022 Performance Against the Benchmark

Only two **hospital-affiliated** Advanced Networks in the Medicare Advantage market met the 2022 benchmark: Stamford Medical Group (-3.1%) and Prospect Medical Group (0.7%). All other hospital-affiliated Advanced Networks in the Medicare Advantage market exceeded the benchmark (see **Figure 15**). Southern New England Healthcare Organization (SoNE Health) surpassed the benchmark with a year-over-year growth of 14.2%, the largest increase among all in this category. Integrated Care Partners (6.6%), Northeast Medical Group (5.9%), UConn Medical Group (8.7%), and Value Care Alliance (5.4%) also exceeded the benchmark.

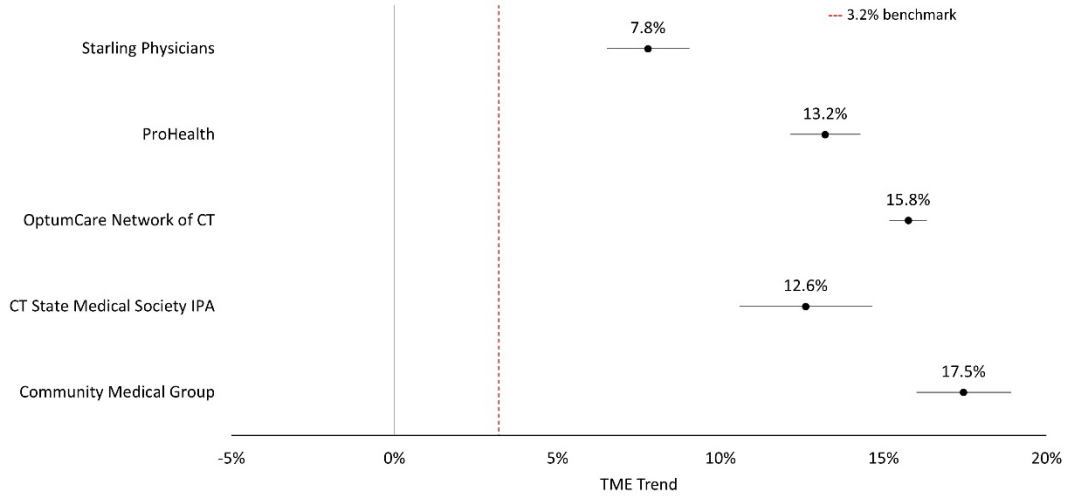
Figure 15. Hospital-Affiliated Advanced Network Medicare Advantage TME Trends (2021-2022)



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

All **non-hospital-affiliated** Advanced Networks in the Medicare Advantage market markedly exceeded the benchmark (see **Figure 16**). In 2022, Community Medical Group, CT State Medical Society IPA, OptumCare Network of CT, and ProHealth all experienced double-digit growth, with rates from 12.6 to 17.5%. Starling Physicians' spending increased by 7.8%.

Figure 16. Non-Hospital-Affiliated Advanced Network Medicare Advantage TME Trends (2021-2022)

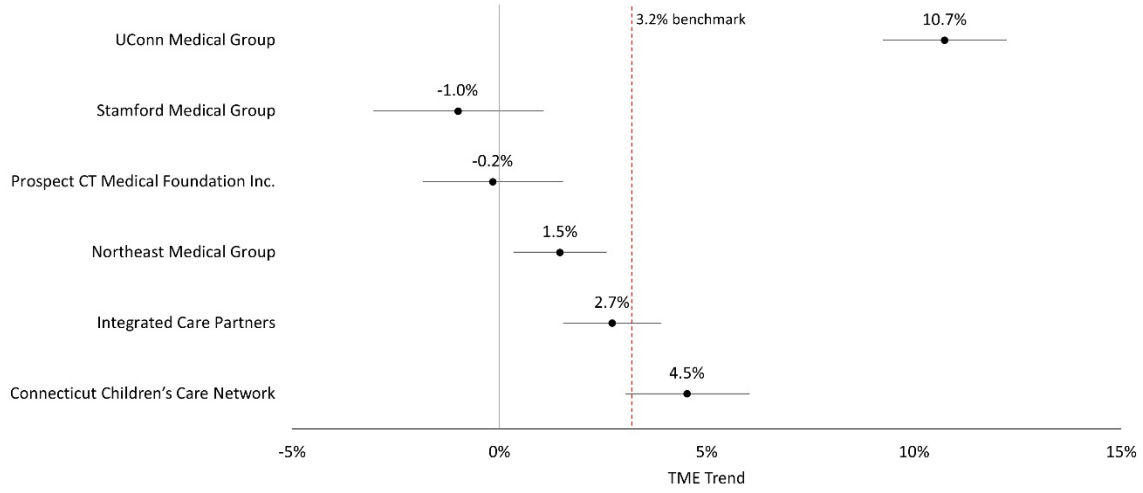


Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated for outliers and risk-adjusted. The dots denote the year-over-year growth of an insurance carrier in a specific market, while the horizontal line through each dot indicates the range of values, or confidence interval,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

Advance Networks' Medicaid 2021-2022 Performance Against the Benchmark

Half of the **hospital-affiliated** Advanced Networks achieved the benchmark in the Medicaid market (see **Figure 17**). Northeast Medical Group (1.5%), Prospect CT Medical Foundation Inc. (-0.2%), and Stamford Medical Group (-1%) spending growth met the benchmark. UConn Medical Group surpassed the benchmark, with a growth rate of 10.7%, the highest among all Advanced Networks in the Medicaid market.

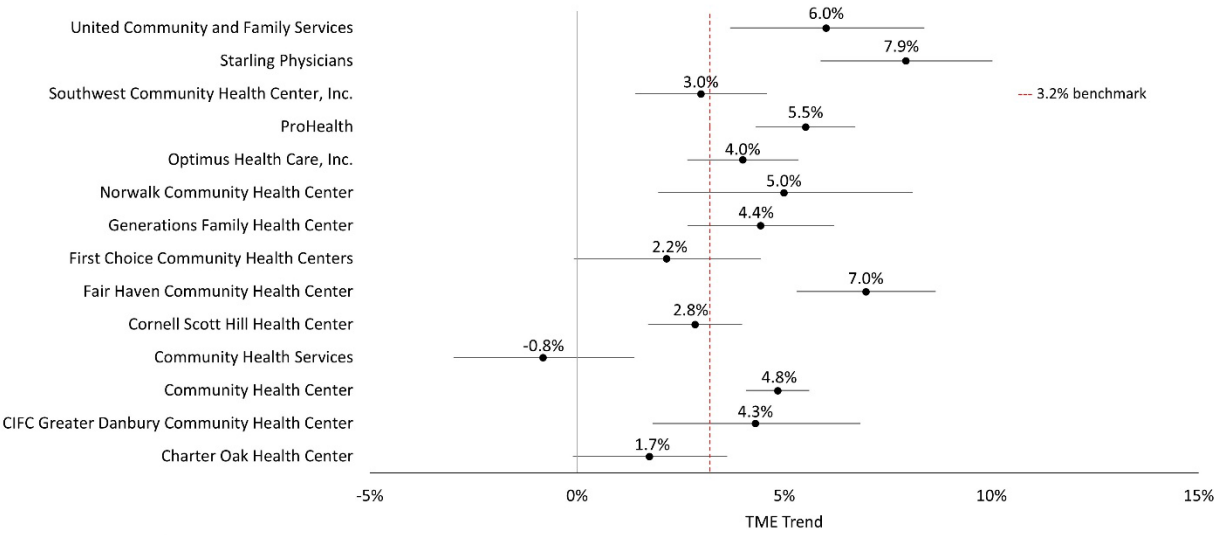
Figure 17. Hospital-Affiliated Advanced Network Medicaid TME Trends (2021-2022)



Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated for outliers and risk-adjusted. Data do not include Medicaid spending on the dually eligible population. The dots denote the year-over-year growth of an insurance carrier in a specific market, while the horizontal line through each dot indicates the range of values, or confidence interval, within which OHS is 95 percent confident the actual performance lies.

Five **non-hospital-affiliated** Advanced Networks exceeded the spending growth benchmark: Community Health Center (4.8%), Fair Haven Community Health Center (7%), ProHealth (5.5%), Starling Physicians (7.9%), and United Community and Family Services (6%) (see **Figure 18**). Only Community Health Services met the benchmark, with a decrease in spending of 0.8%. OHS was unable to determine performance against the benchmark for 57% (8 out of 14) of the non-hospital-affiliated Advanced Networks since they were not statistically significantly different from the benchmark.

Figure 18. Non-Hospital-Affiliated Advanced Network Medicaid TME Trends (2021-2022)



Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated for outliers and risk-adjusted. Data do not include Medicaid spending on the dually eligible population. The dots denote the year-over-year growth of an insurance carrier in a specific market, while the horizontal line through each dot indicates the range of values, or confidence interval, within which OHS is 95 percent confident the actual performance lies.

Section 4: Trends in Prescription Drug Spending

Many Americans depend on prescription drugs to maintain or improve their health. According to a U.S. Department of Health and Human Services brief, over two-thirds (69%) of adults aged 40-79 in the United States have used at least one prescription drug in the last 30 days.[18]

Despite widespread use, high costs impede patient access to pharmaceuticals. A 2022 survey of Connecticut residents found that 23% of respondents had cut pills in half, skipped doses of medicine, or did not fill a prescription due to costs.[19] The implications for health disparities are severe: people of color, those with at least one member with a disability in their

[18] Hales, C. M., Servais, J., Martin, C. B., & Kohen, D. (2019). Prescription Drug Use Among Adults Aged 40-79 in the United States and Canada. NCHS Data Brief, 347, 1–8. https://pubmed.ncbi.nlm.nih.gov/31442200/

[19] See footnote 8.

household, and those with low incomes were more likely to modify or skip their prescription.[20]

Not only are prescription drug costs high, but paid prices grow year over year at a rapid pace; they were a considerable contributor to spending growth in 2022. In Connecticut, slowing pharmacy spending represents a crucial opportunity to reduce financial strains for consumers, employers, and government.

As shown earlier, cost growth benchmark data indicate that 2022 was a substantial year for retail pharmacy spending in Connecticut. Retail pharmacy per capita spending grew 7.7% between 2021 and 2022, from $1,525 to $1,642 per capita, and had an outsized contribution to spending growth.

Per Member Per Month (PMPM) spending for retail pharmacy saw higher percent growth in 2022 than in any year since 2017. Commercial retail PMPM

Pharmacy Rebate Data

One limitation of APCD data is the exclusion of pharmacy rebate data. Drug manufacturers give rebates to pharmacy benefit managers (PBMs) to have their drugs included in the PBM's formularies (i.e., lists of covered drugs). Drug manufacturers correctly state that the lack of rebate data in the APCD results in overstatement of pharmacy spending.[21] However, recent analysis shows that even when pharmacy rebates are considered, spending on prescription drugs in Connecticut's commercial market have grown in the past at an unaffordable rate.[22]

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

[21] Connecticut Office of Health Strategy. (2023, June 28). Cost Growth Benchmark Public Hearing. https://portal.ct.gov/OHS/Services/Cost-Growth-Quality-Benchmarks-Primary-Care-Target

[22] Mar, J., & Angeles, J. (2023). In Three States, Growth In Prescription Drug Spending Is Unaffordable Even When Accounting For Rebates. Health Affairs Forefront. https://doi.org/10.1377/forefront.20231214.400642

spending (14.1%) grew more than Medicaid retail PMPM spending (5.0%) between 2021 and 2022.

To better understand commercial and Medicaid pharmacy spending trends in Connecticut, OHS examined claims data using the Connecticut All-Payer Claims Database (APCD).[23] OHS looked not only at spending growth in 2022 but for the broader time period of 2017-2022. Despite the APCD containing a small percentage of the commercial self-insured market, and drug rebate information, the database is a useful tool for gaining insights not available through cost growth benchmark data submissions.

The following data include both retail pharmacy and hospital outpatient medical pharmacy. "Retail pharmacy" refers to drug prescriptions that are filled at local pharmacies and by mail order drug companies. In contrast, "medical pharmacy" refers to drugs that are administered in clinical settings such as hospital outpatient clinics, hospital inpatient services, and private provider offices. The following analyses include *only* medical pharmacy administered in hospital outpatient clinics. They also exclude COVID-19 vaccines.

Retail Pharmacy Spending in 2022

The increased 2022 PMPM spending in the retail sector can be explained primarily by increased payment per unit as well as increased utilization. While the utilization per 1,000 members (UPK) of commercial retail drugs grew by 5.9% in 2022, payment per unit (PPU) increased by 7.0%.[24] This phenomenon is even more pronounced in the Medicaid market, where utilization *decreased* by 3.3%, while PPU increased by 8.6%.

The following analyses use data from 2017 to 2022 to observe historical trends in PMPM spending, PPU and utilization.

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[23] Medicare was excluded from the analysis because spending data from CMS for Traditional Medicare was only available through 2019 at the time of report publication.

[24] A unit refers to a 30-day equivalent prescription.

Retail and Hospital Outpatient Pharmacy Per Member Per Month Spending

OHS analyses show that PMPM spending increased between 2017 and 2022 across markets (commercial and Medicaid) and drug type (retail and hospital outpatient medical).

For commercial drugs (retail and hospital outpatient medical combined), PMPM spending grew 31.9% between 2017 and 2022, or 5.8% on average annually, with substantial variability from year to year. Notably, the highest growth occurred in the two most recent years (see **Table 2**).

Between 2017 and 2022, PMPM spending grew faster for hospital outpatient medical drugs (57.6%) than retail drugs (29.6%).

Table 2: PMPM Pharmacy Spending (Commercial Market)

Year	PMPM Spending (Retail)	Year to Year Percent Growth (Retail)	PMPM Spending (Outpatient Hospital Medical)	Year to Year Percent Growth (Outpatient Hospital Medical)	PMPM Spending (Retail and Outpatient Hospital Medical Combined)	Year to Year Percent Growth (Retail and Outpatient Hospital Medical Combined)
2017	$108.00	--	$9.46	--	$117.46	--
2018	$110.00	1.3%	$11.37	20.2%	$121.37	3.33%
2019	$110.00	-0.2%	$12.88	13.3%	$122.88	1.25%
2020	$111.00	1.5%	$13.13	1.9%	$124.13	1.02%
2021	$122.00	10.1%	$14.72	12.1%	$136.72	**10.15%**
2022	$140.00	14.1%	$14.90	1.2%	$154.90	**13.30%**
Average Annual Growth	--	5.4%	--	9.8%	--	5.8%

Growth in PMPM spending in the Medicaid market (retail and hospital outpatient medical combined) between 2017 and 2022 was less dramatic, growing 4.8% between 2017 and 2022, or only 1% annually on average, with the highest growth in 2022 (see **Table 3**).

Hospital outpatient medical pharmacy PMPM spending also outpaced retail in the Medicaid market. Hospital outpatient medical pharmacy PMPM grew 39.9% whereas retail pharmacy PMPM spending grew only 4.3% between 2017 and 2022.

Table 3: PMPM Pharmacy Spending (Medicaid Market)

Year	PMPM Spending (Retail)	Year to Year Percent Growth (Retail)	PMPM Spending (Outpatient Hospital Medical)	Year to Year Percent Growth (Outpatient Hospital Medical)	PMPM Spending (Retail and Outpatient Hospital Medical Combined)	Year to Year Percent Growth (Retail and Outpatient Hospital Medical Combined)
2017	$140.00	--	$2.15	--	$142.15	
2018	$138.00	-1.0%	$2.54	18.00%	$140.54	-1.1%
2019	$143.00	3.2%	$2.84	11.80%	$145.84	3.8%
2020	$136.00	-4.9%	$2.74	-3.70%	$138.74	-4.9%
2021	$139.00	2.8%	$3.14	14.70%	$142.14	2.5%
2022	$146.00	5.0%	$3.02	-4.00%	$149.02	**4.8%**
Average Annual Growth	--	1.0%	--	7.4%	--	1.0%

Overall, PMPM spending grew between 2017 and 2022 across markets and drug types, particularly in the commercial market and for outpatient hospital medical pharmacy.

The Roles of Payment per Unit (PPU) and Utilization

Analyses of the roles of PPU and utilization point to increases in PPU, more so than utilization, as a driver of growth in PMPM pharmacy spending.

Average annual percent growth in PPU outpaced growth in utilization for commercial retail, Medicaid retail, and Medicaid outpatient hospital medical pharmacy between 2017 and 2022 (see **Table 4**).

However, outpatient hospital medical pharmacy in the commercial market is an exception where the average annual percent growth in PPU *did not* outpace growth in utilization between 2017 and 2022.

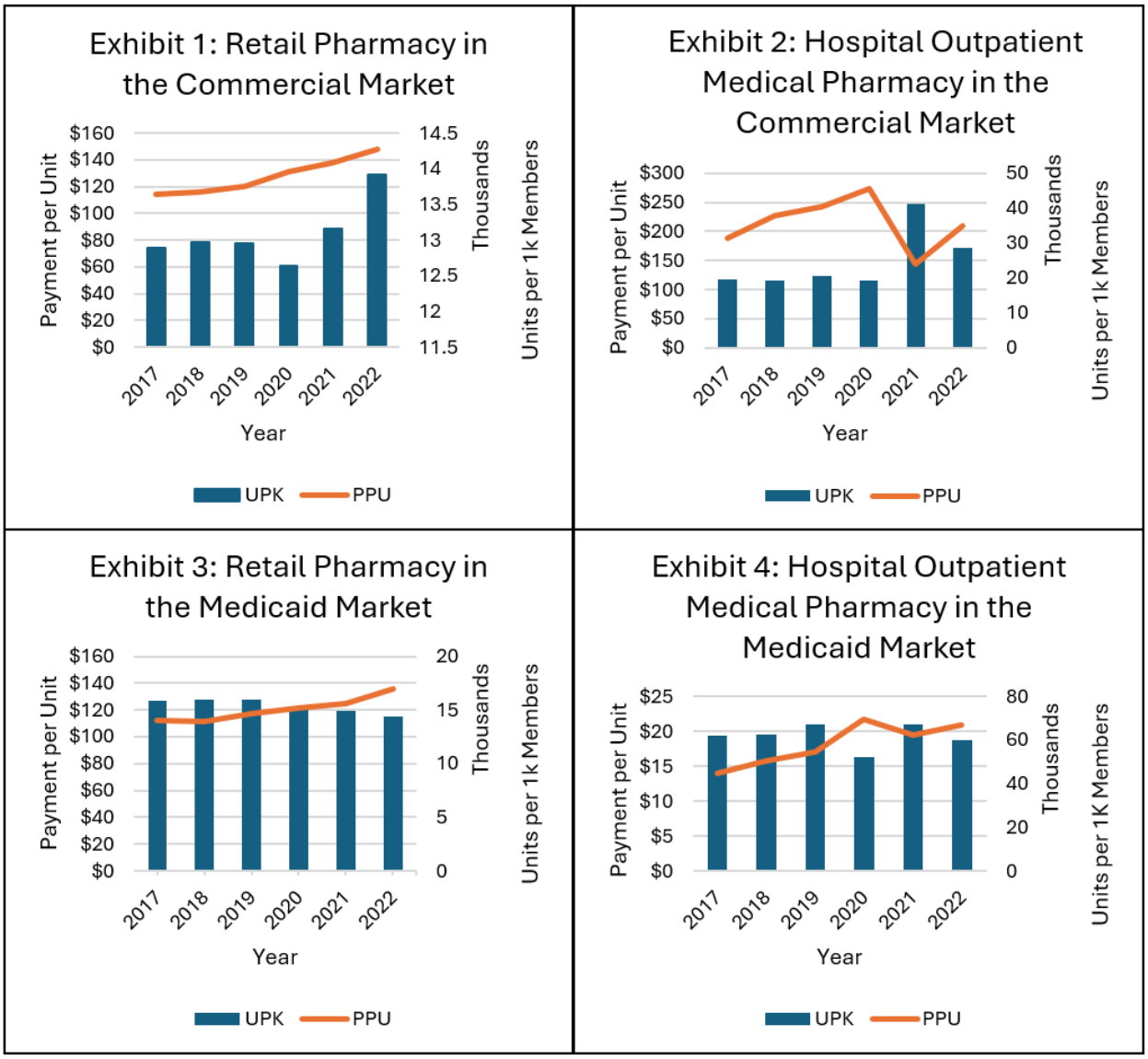
Table 4: Average Percent Growth in Payment per Unit versus Utilization between 2017 and 2022

Market and Type of Drug	Average Annual Percent Growth in Payment per Unit between 2017-2022	Average Annual Percent Growth in Utilization per 1,000 Members between 2017-2022
Commercial Retail	5.4%	1.6%
Commercial Outpatient Hospital Medical	7.7%	16.5%
Medicaid Retail	3.9%	-1.8%
Medicaid Outpatient Hospital Medical	9.2%	0.8%

*Blue boxes indicate greater average annual percent growth.

Figure 19 compares the retail and outpatient pharmacy prices and utilization by market. The utilization per 1,000 members (UPK) is charted in the thousands (right hand legend), against the price per unit (PPU) from 2017-2022. Trends in price and utilization for retail and outpatient hospital medical pharmacy contrast in other ways too. Retail pharmacy (see **Figure 19, Exhibits 1 and 3**) saw steady growth in PPU with more dramatic growth in recent years. However, for hospital outpatient medical pharmacy (see **Figure 19, Exhibits 2 and 4**), utilization increased while PPU decreased between 2020 and 2021, with these trends reversing in 2022. While increased utilization in 2021 may be partially explained by deferred care after COVID-19, our analyses cannot explain the decrease in PPU during 2021, although it is likely that high-volume, low-cost COVID-19 vaccines was an influence.

Figure 19. Retail and Outpatient Pharmacy Prices and Utilization by Market



Outpatient Drugs with Highest Commercial Costs in 2024

The preliminary 2024 list of Connecticut's "highest cost commercial outpatient drugs" (i.e., drugs with the most commercial spending) is reported in **Table 5**. All drugs on the list had to meet the criteria set forth in C.G.S. §19a-754b of having increased more than 16% in wholesale acquisition cost (WAC) from CY 2020-2022 and WAC that was higher than $40 for a unit. Six of the eight costliest drugs are brand name drugs, whereas only two are generic. The percentage WAC per unit increase between 2020 and 2022 was similar across all drugs, hovering between 16-21%.

Despite the large price hikes for some major drugs, research shows that there is often not enough clinical evidence to justify these price increases. The Institute for Clinical and Economic Review (ICER) found that for seven out of 10 high-expenditure drugs that had substantial 2022 net price increases, the increases were not supported by new clinical evidence.[25] The seven drugs with substantial and unsupported price increases identified by ICER included Xifaxan, one of the costliest drugs in Connecticut.

Table 5: Drugs with the Highest Commercial Costs in Connecticut, 2024

Drug Name	Brand vs Generic	Therapeutic Description	2020 WAC Per Unit	2022 WAC Per Unit	WAC percent increase 2020-2022
Enbrel	Brand	Treats auto-immune diseases such as rheumatoid arthritis, juvenile idiopathic arthritis, etc.	$1,389.24	$1,640.91	18.1%
Otezla	Brand	Medication for treatment of certain types of psoriasis and psoriatic arthritis	$59.86	$71.40	21.0%
Xifaxan	Brand	Used to treat travelers' diarrhea caused by E. coli bacteria	$42.59	$49.59	16.4%

[25] David M. Rind, Foluso Agboola, Dmitriy Nikitin, Avery McKenna, Emily Nhan, Matt Seidner, & Steven D. Pearson. (2023). Unsupported Price Increase Report: Unsupported Price Increases Occurring in 2022. Institute for Clinical and Economic Review. https://icer.org/wp-content/uploads/2023/04/UPI_2023_Report_121123.pdf

Drug Name	Brand vs Generic	Therapeutic Description	2020 WAC Per Unit	2022 WAC Per Unit	WAC percent increase 2020-2022
Xyrem	Brand	Used to treat symptoms of narcolepsy	$28.39	$33.39	17.6%
Xiaflex	Brand	Used for the treatment of a Dupuytren's contracture	$4,942.89	$5,870.44	18.8%
Epidiolex	Brand	Treats seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis	$13.10	$15.40	17.6%
Modafinil	Generic	Used to treat narcolepsy	$59.68	$71.43	19.7%
Diclofenac Potassium	Generic	Nonsteroidal anti-inflammatory drug	$13.09	$15.52	18.6%

Reflections on Trends in Prescription Drug Spending

PMPM pharmacy spending has increased between 2017 and 2022 for both retail and outpatient hospital medical pharmacy in the commercial and Medicaid markets. Price per unit increases, rather than utilization increases, likely explain the PMPM spending growth during these years.

If these trends continue, more and more Connecticut residents may alter or forgo their prescriptions, posing a danger to their health. Moreover, prescription drugs could continue to contribute to overall healthcare

spending growth in Connecticut and the U.S. In the pursuit of more affordable healthcare, prescription drugs present a crucial opportunity to curb healthcare spending growth.

Conclusion

Connecticut's healthcare spending growth in 2022 was 3.4% exceeding the 3.2% cost growth benchmark. However, the statewide rate of growth was, substantially slower than seen in 2021 (6%), especially in the commercial markets which was 2.4% in 2022 versus 18.8% in 2021.

Spending grew the fastest in the following three areas:

- Retail pharmacy spending was a substantial cost driver, as seen in prior years. Separately, medical pharmacy, which is administered in clinical settings, trended even higher than retail pharmacy in recent years.
- Professional services spending growth was more substantial in 2022 than prior years.
- Hospital outpatient spending growth was a less prominent cost driver in 2022 than witnessed in prior years, but still meaningful given the amount of total spending incurred in that service setting.

While Connecticut nearly met the 2022 benchmark, the prospects for meeting the benchmark in 2023 and 2024 are worrisome. Large increases in hospital negotiated rates (particularly in the commercial market), the recent introduction of new costly drugs, and the anticipated ripple effect of high inflation during late 2022 and early 2023, are all factors that may impact our ability to contain costs moving forward.

Despite these challenges, the Cost Growth Benchmark program has enhanced transparency in healthcare spending for Connecticut residents. Policymakers now know where healthcare spending goes, how much it increases, and whether payments or service volume is the primary driver. Transparency alone, however, will not solve the problem of affordability for Connecticut residents. It is policy action that ultimately will lead to more affordable healthcare in the state.

Appendix

Appendix A Healthcare Benchmark Initiative Steering Committee Members

Members as of February 29, 2024:

- Timothy Archer, CEO, United Healthcare of New England
- Joanne Borduas, CEO Community Health and Wellness Center Torrington
- James Cardon, Chief Clinical Integration Officer and Chief Executive Officer, Hartford Healthcare
- Ayesha Clarke, Interim Executive Director, Health Equity Solutions
- Francois de Brantes, Executive Vice President, XO Health
- Tiffany Donelson, President and Chief Executive Officer, CT Health Foundation
- Judy Dowd, Health and Human Services Section Director, CT Office of Policy and Management
- Lou Gianquinto, President, Anthem Blue Cross Blue Shield of CT, under Elevance Health
- Deidre Gifford, Executive Director, CT Office of Healthcare Strategy
- Paul Grady, Principal of Alera Group, CT Moving to Value Alliance
- Angela Harris, Chair, Phillips Health Ministry
- Gail Kosyla, Chief Financial Officer, Yale New Haven Health
- Sean King, Office of the Healthcare Advocate
- Paul Lombardo, Director, Life & Health Division, CT Insurance Department
- Chris Manzi, President, Pequot Health Care
- Andy Markowski, Connecticut State Director, National Federation of Independent Business
- Christine Marsh, Vice President, Market Access, Boehringer Ingelheim Pharmaceuticals
- Mark Meador, President, ConnectiCare
- Susan Millerick, Patient Representative
- Cassandra Murphy, Executive Director, CT Coalition of Taft-Hartley Health Funds

- Lori Pasqualini, Vice President, Chief Financial & Administrative Officer, Ability Beyond
- Kathy Silard, President & Chief Executive Officer, Stamford Health
- Marie Smith, Assistant Dean, Practice and Public Policy Partnerships, UConn School of Pharmacy
- Stephen Traub, President and Chief Executive Officer, ProHealth Physicians
- Chris Ulbrich, Chief Executive Officer, Chairman, Ulbrich Stainless Steels & Special Metals, Inc.
- Kristen Whitney-Daniels, Chapter Leader, Patient Representative, CT Insulin 4 All
- Josh Wojcik, Policy Director, CT Office of the State Comptroller
- Gui Woolston, Medicaid Director, CT Department of Social Services

More information can be found at: https://portal.ct.gov/OHS/Pages/Healthcare-Benchmark-Initiative-Steering-Committee.