Healthcare cost growth benchmark and primary care spending target initiatives - 2020 and 2021 performance

The Office of Health Strategy (OHS) was charged under §217-223 of Public Act 22-118 to prepare and post a report concerning total healthcare expenditures including, but not limited to, a breakdown of such population-adjusted total medical expenses by payer and provider entities. The report may include, but shall not be limited to, information regarding trends in major service category spending; primary care spending as a percentage of total medical expenses; net cost of private health insurance by market segment, including individual, small group, large group, self-insured, student and Medicare Advantage markets; and any other factors the executive director deems relevant to providing context on such data.

A Report Pursuant to §217-223 of Public Act 22-118

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Acronym Glossary

APCD	All-Payer Claims Database
CMS	Centers for Medicare and Medicaid Services
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

Acknowledgements

The Office of Health Strategy (OHS) expresses its gratitude to the Centers for Medicare and Medicaid Services, the Connecticut Department of Social Services, the Department of Correction and the Office of the State Comptroller for submitting data for this initiative. OHS also thanks the insurance carriers and Advanced Networks for their cooperation and collaboration on this initiative. OHS thanks Bailit Health and the Peterson-Milbank Program for Sustainable Health Care Costs for providing technical assistance. OHS thanks the Cost Growth Benchmark Stakeholder Advisory Board, Cost Growth Benchmark Technical Team, and the Healthcare Benchmark Initiative Steering Committee, for their guidance and expertise (see Appendix E, Appendix F and Appendix G for committee members). OHS thanks Vicki Veltri, former OHS Executive Director, for her leadership on this initiative.

Executive Summary

This report presents the results of the Office of Health Strategy's (OHS') healthcare cost growth benchmark and primary care spending target analyses using data from calendar years 2019-2021, per the requirements in Executive Order No. 5 and Public Act 22-118.

Background

Connecticut's healthcare cost growth benchmark was set with the goal of slowing the growth of healthcare spending and making healthcare more affordable for the citizens of Connecticut. The healthcare cost growth benchmark is the targeted annual per person healthcare spending growth rate, expressed as percentage growth from the prior year's per person spending. Connecticut is one of nine states that are pursuing cost growth benchmark strategies to slow unsustainable healthcare cost growth.[1] OHS sets Connecticut's benchmark on a calendar year basis and established it as 3.4 percent for calendar year 2021, which is the first year OHS is publicly reporting performance against the benchmark.

Connecticut's primary care spending target is a supplemental strategy to motivate increased primary care investment, which research has demonstrated leads to better patient outcomes, lower costs, and improved patient experience of care. Connecticut joins a growing number of states that are pursuing primary care spending target strategies.[2] OHS was required to set targets for primary care spending as a percentage of total healthcare spending to reach a target of 10.0 percent by 2025. OHS established the primary care spending target at 5.0 percent for calendar year 2021, which is the first year OHS is publicly reporting performance against the target.

Methodology

OHS collected data from insurance carriers (Aetna, Anthem, Cigna, ConnectiCare, UnitedHealthcare), the Centers for Medicare and Medicaid Services, the Connecticut Department of Social Services, the Connecticut Department of Correction, the Veterans Health Administration, the Office of the State Comptroller and from other publicly available sources. OHS collected spending and membership data in aggregate from payers by insurance market and by Advanced Network[3] and also for major service categories (e.g., hospital inpatient, hospital outpatient, professional physician). OHS assessed 2021 performance against the 3.4 percent cost growth benchmark at the state, market, insurance carrier and Advanced Network levels. OHS

[1] Connecticut was the fifth state to adopt a healthcare cost growth benchmark joining Massachusetts, Rhode Island, Delaware, and Oregon. New Jersey, Nevada, Washington, and California later adopted cost growth benchmark strategies.

[2] State Primary Care Investment Initiatives. Primary Care Collaborative. https://www.pcpcc.org/primary-care-investment/legislation. Accessed March 21, 2023.

[3] "Advanced Network" is OHS's term for a large provider entity. OHS only assessed performance against the cost growth benchmark for Advanced Networks that had at least 60,000 member months for the given market.

assessed 2021 performance against the 5.0 percent primary care spending target at the state, market and insurance carrier levels.

2021 Cost Growth Benchmark Performance

Connecticut spent $34 billion on healthcare and insurance costs in 2021, up from $31.9 billion in 2019 and $30.9 billion in 2020. Statewide healthcare costs grew 6.0 percent from 2020 to2021, exceeding the 3.4 percent benchmark. Cost growth in 2021 was driven by an 18.8 percent increase in commercial health insurance spending while increases in Medicare and Medicaid were more modest (1.4 percent and 0.8 percent growth, respectively). Hospital outpatient costs were the most significant contributor to the commercial trend, increasing by 33.1 percent per person from 2020-2021.

The following exceeded the 3.4 percent benchmark for 2020-2021 cost growth at the payer and Advanced Network levels:

- All five commercial payers
- Three out of four Medicare Advantage payers
- All Advanced Networks for the commercial market
- All Advanced Networks except two, for the Medicare Advantage Market
- While Medicaid overall came in significantly under the benchmark all Advanced Networks except four, for the Medicaid Market

2021 Primary Care Spending Target Performance

Connecticut spent $1 billion on primary care in 2021, up from $880 million in 2020. The target for primary care spending as a percentage of total spending in 2021 is 5.0 percent. Statewide primary care spending was 5.1 percent of total spending in 2021, which achieved the target. Medicaid exceeded the target with 8.3 percent but the commercial and Medicare Advantage markets did not (with 3.9 percent and 3.5 percent, respectively).

The following achieved the 5.0 percent primary care spend target for 2021 at the payer level:

- Two out of five commercial payers
- None of the four Medicare Advantage payers

Next Steps

As required by Public Act 22-118, by May 1, 2023, OHS will identify any entities that significantly contributed to exceeding the 2021 cost growth benchmark. By June 30, 2023, OHS will hold a public hearing on the results of this analysis. By October 15, 2023, OHS will report trends and recommendations to the General Assembly. Healthcare cost growth benchmark and primary care spending target will be complemented by reporting on quality benchmarks beginning in 2024.

Introduction

Background and Purpose

On January 22, 2020, Governor Lamont signed Executive Order No. 5 directing the Office of Health Strategy (OHS) to establish statewide healthcare cost growth benchmarks for calendar years 2021-2025, with the goal of slowing the growth of healthcare spending and making healthcare more affordable for the citizens of Connecticut. Annual healthcare cost growth has consistently outpaced growth in the Connecticut economy and, even more importantly, resident household median income, compromising residents' ability to afford critical healthcare services and other basic needs. Limiting healthcare cost growth is an economic imperative that will also help businesses compete and families better afford a high quality of life in Connecticut. While setting a public benchmark for healthcare spending growth in and of itself will not slow the rate of growth, Connecticut's benchmark establishes the expectation that healthcare spending should grow at a reasonable rate tied to the rate of state economic and income growth. Connecticut was the fifth state to adopt a healthcare cost growth benchmark joining Massachusetts, Rhode Island, Delaware, and Oregon. New Jersey, Nevada, Washington, and California later adopted cost growth benchmark strategies.

Executive Order No. 5 also required OHS to set targets to increase primary care spending as a percentage of total healthcare spending to 10.0 percent by 2025. Research has demonstrated that greater investment in primary care as a percentage of overall healthcare spending leads to better patient outcomes, lower costs, and improved patient experience of care. Other states have strengthened their healthcare system by supporting improved primary care delivery and shifting an increasing percentage of total spending allocated towards primary care. Connecticut follows pioneering states, Rhode Island and Oregon, that previously created primary care spending targets, and additional states are now pursuing this strategy.[4]

These actions implemented by Governor Lamont are key to addressing Connecticut's unsustainable healthcare cost growth, strengthening the state's primary care infrastructure and improving healthcare quality. They are also essential for improving health equity in the state. The COVID-19 pandemic exposed and deepened pre-existing health inequities that disproportionately affect underserved populations both nationally, and here in Connecticut. Each year, health disparities lead to significant financial burden as marginalized populations experience poor living conditions, struggle to manage chronic illnesses, and have more difficulty accessing quality, affordable healthcare services than other population groups.

[4] State Primary Care Investment Initiatives. Primary Care Collaborative. https://www.pcpcc.org/primary-care-investment/legislation. Accessed March 21, 2023.

Combined, the cost growth benchmark and the primary care spending target will rebalance and strengthen the state's healthcare system to support improved primary care delivery while also encouraging slower rates of healthcare cost growth.

Legislative Background

During the 2022 legislative session, Sections (§§)217-223 of Public Act 22-118 codified Executive Order No. 5's provisions into law. Public Act 22-118 also established requirements for OHS to collect and report on healthcare cost growth benchmark and primary care spending data. The public act requires OHS to prepare and post a report on total healthcare expenditures no later than March 31, 2023, and annually thereafter. The report must include a breakdown of population-adjusted total medical expenses by insurance carrier and Advanced Network.[5] Public Act 22-118 stipulates that the report may also include trends in major service category spending; primary care spending as a percentage of total medical expenses; net cost of private health insurance by market segment; and any other factors the executive director deems relevant to providing context on the data, including the impact of inflation and medical inflation, impacts, if any, on access to care, and responses to public health crises or similar emergencies.

This report presents the results of OHS' healthcare cost growth benchmark and primary care spending target analyses using data from calendar years 2019-2021, per the requirements in Public Act 22-118.

Healthcare Cost Growth Benchmark

Connecticut's healthcare cost growth benchmark ("benchmark") is the targeted annual rate-of-growth for per person healthcare spending. The benchmark is set on a calendar year basis. For example, the 2021 benchmark is 3.4 percent, meaning that between 2020 and 2021, per person healthcare cost growth was expected to increase no more than 3.4 percent.

The healthcare cost growth benchmark values are based on a calculated and pre-determined blend of the growth in the forecasted per capita potential gross state product (PGSP), and the forecasted growth in median income, determined in advance of the performance period. Formulas were developed and established with the advice of OHS advisory bodies. The detailed cost growth benchmark methodology can be found in the Connecticut Healthcare Benchmark Initiative Implementation Manual.

[5] Advanced Networks are OHS' term for an organized group of clinicians that come together for the purposes of contracting, or are an established billing unit that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if they are not engaged in a total cost of care contract. The term "Advanced Network" as used in this report is equivalent to the term "provider entity" as used in Public Act 22-118.

Table 1 below presents the healthcare cost growth benchmark values for calendar years 2021 through 2025.

Table 1. Healthcare Cost Growth Benchmark Values 2021-2025

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

Primary Care Spending Target

A primary care spending target is an expectation for what percentage of healthcare spending should be devoted to primary care. A primary care spending target evaluates primary care spending as a percentage of total medical expenditures. Connecticut's primary care spending target ("target") is the state's annual primary care spending as a percentage of total medical expenditures. OHS developed the definition of primary care providers and spending with the assistance of its advisory bodies. The definition built upon a methodology established in collaboration with the six New England states (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont). OHS uses this definition to calculate statewide, market and insurance carrier spending against the target established in Executive Order No. 5 and codified in Public Act 22-118.[6]

Table 2 below lists the primary care spending target values for calendar years 2021 through 2025. The target for calendar year 2021 was set based on OHS' best estimate of baseline statewide spending on primary care. The target for calendar year 2022 was set at 5.3 percent. The targets for calendar years 2023-2025 include near-equal annual increases of approximately 1.6 percentage points. The targets were established by OHS with guidance from its advisory bodies.

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

Table 2. Primary Care Spending Target Values 2021-2025

Calendar Year	Primary Care Spending Target Values
2021	5.0%
2022	5.3%
2023	6.9%
2024	8.5%
2025	10.0%

Overview of the Data Collection and Analysis Methodology

This section provides a summary of the cost growth benchmark and primary care spending target analysis methodology. For detailed methodological information about the cost growth benchmark and primary care spending target analysis, please see the Connecticut Healthcare Benchmark Initiative Implementation Manual.

Data Sources

Data for assessing performance against the cost growth benchmark come from several sources.

- **Commercial** spending data were reported by insurance carriers (Aetna, Anthem, Cigna, ConnectiCare, UnitedHealthcare).
- **Medicare Advantage** spending data were reported by insurance carriers (Aetna, Anthem, ConnectiCare, UnitedHealthcare).
- **Medicare Fee for Service (FFS)** spending data were reported by the Centers for Medicare and Medicaid Services (CMS).
- **Medicaid** spending data were reported by the Connecticut Department of Social Services (DSS).
- **Net cost of private health insurance (NCPHI)** data were calculated from regulatory reports submitted by insurers or obtained through other public sources.
- **Veterans Health Administration (VHA)** spending data are publicly available from the VHA.
- **Department of Correction (DOC)** spending data were reported by DOC.
- **State employee health plan** spending data were reported by the Office of the State Comptroller (OSC).[7]

From each source, OHS collects spending and membership data in aggregate from payers by insurance market and by Advanced Network.[8] Insurance carriers, CMS, DSS and OSC report

[7] OHS collects state employee health plan spending from OSC but does not report OSC's performance publicly. OSC's data are not included in state or market level performance because state employee spending is included in insurance carrier submissions.

[8] With the exception of CMS Medicare FFS, VHA, DOC and OSC data, which are only submitted in aggregate (not by Advanced Network).

spending in individual service categories (e.g., hospital inpatient, hospital outpatient, professional physician). For more details about service category spending and trend see the Trends in Major Service Category Spending section of this report.

Note that cost growth benchmark data analyses are not comparable to analyses using data from Connecticut's All-Payer Claims Database (APCD) because the APCD does not include non-claims payments, spending on the commercial self-insured population, or pharmacy rebates.

Advanced Networks

OHS annually requests that insurance carriers and DSS report commercial, Medicare Advantage and Medicaid FFS spending for a list of Advanced Networks.[9] "Advanced Network" is OHS' term for an organized group of clinicians that comes together for the purposes of contracting, or is an established billing unit that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if it is not engaged in a total cost of care contract. The list of Advanced Networks may be updated over time.

OHS' adopted methodology, as recommended by its technical advisory group, requests that insurance carriers use their own primary care attribution methodology to attribute patients to a primary care provider, and then organize the primary care providers into the larger Advanced Network entities. Also, insurance carriers report on a separate "members not attributed" category for spending not attributed to an Advanced Network either because the insurance carrier does not contract with the Advanced Network or because the spending was for members not attributed to the Advanced Networks. Additionally, insurers are to use the provider roster applicable to the relevant performance period.

Assessment of Performance Against the Cost Growth Benchmark

OHS assesses performance relative to the cost growth benchmark at four levels (1) the state, (2) health insurance market (i.e., commercial, Medicare and Medicaid), (3) individual insurance carrier by market, and (4) Advanced Network by market (for provider entities of a pre-defined size).[10] As detailed in the Data Sources section above, OHS utilizes data collected from insurance carriers, CMS, DSS, the DOC, and the VHA to assess performance.

At the state level, OHS assesses performance against the benchmark using total healthcare expenditures (THCE), which includes the total medical expenses (TME) incurred for Connecticut residents plus the costs associated with the administration of private health insurance, or net cost of private health insurance (NCPHI) (see **Figure 1**). THCE also includes spending on behalf of Connecticut residents who are insured through the VHA or are incarcerated in a state correctional facility.

[9] CMS is unable to report Medicare FFS or Medicare Shared Savings spending at the Advanced Network level.
[10] OHS publicly reports cost growth for Advanced Networks with a minimum of 60,000 member months for a given market.

OHS measures THCE in aggregate dollars and on a per capita basis (using membership data from data submitters). The aggregate dollar figure is reported for informational purposes only. The change in THCE on a per person basis is used to assess performance against the benchmark.

THCE (in aggregate) =

Commercial TME + Medicare Managed Care TME + Medicare FFS TME + DSS Medicaid TME + DOC TME + VHA TME + Insurer NCPHI

THCE (per capita) =

$$\frac{\left(\textit{Commercial TME + Medicare Managed Care TME + Medicare FFS TME + DSS Medicaid TME + DOC TME + VHA TME + Insurer NCPHI}\right)}{\textit{Connecticut members as reported in TME Data}}$$

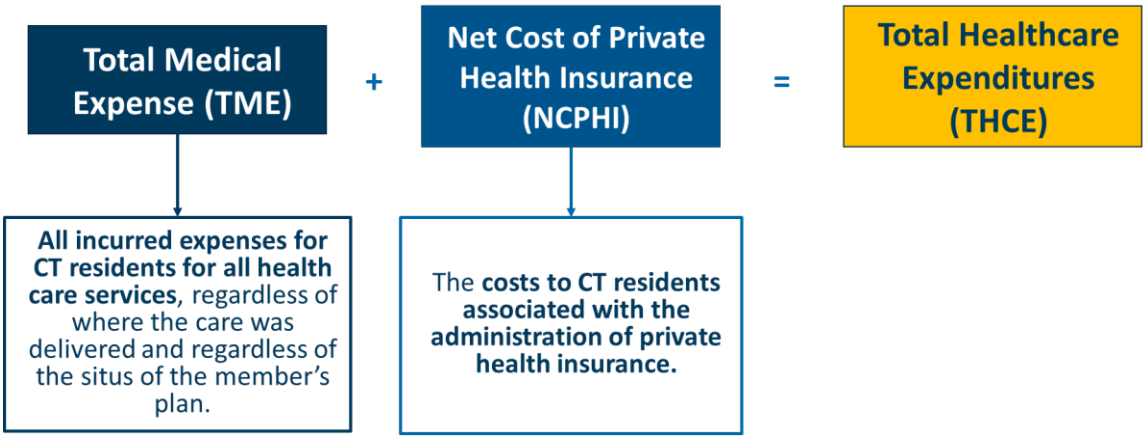
The percentage change in THCE per capita between the performance year and the prior calendar year will be used to assess performance against the benchmark applicable to the specific performance year. Additional information about the methodology can be found in the Connecticut Healthcare Benchmarks Initiative Implementation Manual.

At the market, insurance carrier and Advanced Network levels, OHS assesses performance against the benchmark using TME.[11] TME includes spending on behalf of Connecticut residents who: are insured by Medicare, Medicaid or commercial carriers; or who receive coverage from self-insured employers. TME includes spending on behalf of Connecticut residents who receive care from any provider in or outside of Connecticut. Spending data are collected from payers for Connecticut residents when the payer is the primary payer on the claim. Payers report "allowed amounts" (i.e., the payer's payment plus the member's financial obligation for deductible, coinsurance and copayments), except for DSS which reports just the payer payments.

TME is adjusted to account for any pharmacy rebates received by the payer, by subtracting the rebates (revenue) from the payer's TME.[12] At the insurance carrier and Advanced Network levels, OHS truncates high-cost outliers and risk-adjusts claims spending using member demographic information. OHS conducts statistical significance testing to assess insurance carriers' and Advanced Networks' performance against the cost growth benchmark.

[11] THCE is only reported at the state level because of NCPHI's volatility and because of OHS's desire to focus on medical spend rather than administrative trend at the market, insurance carrier and Advanced Network levels.
[12] The exception to this practice is Medicare FFS spending as CMS does not share pharmacy rebate information at the state level.

Figure 1. Total Medical Expense, NCPHI and Total Healthcare Expenditures



Assessment of Performance Against the Primary Care Spending Target

OHS assesses primary care spending relative to the primary care spending target at three levels: (1) the state, (2) health insurance market (i.e., commercial, Medicare and Medicaid), and (3) individual insurance carrier by market. To assess primary care spending, OHS uses data collected from insurance carriers and DSS through the cost growth benchmark data request, and separately calculates Medicare FFS primary care spending using data from the state's APCD. Due to the lag in the availability of Medicare FFS data in the APCD, however, OHS is releasing two calculations – primary care spending without Medicare FFS spending, published with the benchmark in this report, and primary care spending with Medicare FFS spending, once data are available.

The following are considered primary care providers for purposes of measuring against the primary care spending target:

- Doctors of medicine and doctors of osteopathic medicine practicing geriatric medicine (when practicing primary care), family medicine, internal medicine (when practicing primary care) and pediatric and adolescent medicine.
- Nurse practitioners and physician assistants when practicing primary care.

The following are included in primary care spending:

- Claims-based spending for care management; care planning; consultation services; health risk assessments, screenings and counseling; home visits; hospice/home health services; immunization administrations; office visits and preventive medicine and dental care visits. There is a specific code list to calculate claims-based primary care spending.
- Non-claims-based spending on capitation or salaried expenditures, Person-Centered Medical Home (PCMH) infrastructure, performance-based payments, risk-based

reconciliation, health information technology infrastructure, workforce expenditures, and COVID-19 support payments.

A primary care site of care for the purposes of measuring spending against the target is defined as a primary care outpatient setting (e.g., office, clinic, or center), FQHC, or via telehealth delivered by a primary care provider that is part of a primary care outpatient setting or FQHC.[13]

OHS determines statewide primary care spending as a percentage of TME by multiplying each market's percentage of spending on primary care by its total market share based on TME, a weighted average of each market's percentage spending. OHS assesses primary care spending against the primary care spending target at the market and insurance carrier levels by calculating primary care spending per member per month (PMPM) as a percentage of TME PMPM. TME for the primary care spending target is slightly different than TME for healthcare cost growth benchmark reporting. TME for the primary care spending target includes all spending categories captured for the benchmark, less long-term care.[14]

Healthcare Cost Trends

This section presents the results of OHS' analysis of 2019, 2020 and 2021 cost growth benchmark data.

COVID-19 Pandemic and Impact on Cost Trends

The COVID-19 pandemic significantly altered healthcare utilization nationally, which led to atypical trends for 2020 and 2021. Specifically, COVID-19 restrictions caused an abrupt reduction in the use of in-person care and a subsequent sharp drop in per person spending in 2020. Utilization rebounded in 2021, although not as high as pre-pandemic, which contributed to spending rising significantly, especially for the commercial market.[15] OHS acknowledges that 2021 cost growth benchmark performance was impacted by these unprecedented circumstances, with per person cost growth much higher than would be expected under normal conditions.

[13] OHS excludes primary care delivered at urgent care centers, retail pharmacy clinics and via stand-alone, third-party telehealth vendors because although such care settings may provide a quick alternative for patients to access primary care-focused services, they are not aligned with Connecticut's definition of high-quality, comprehensive primary care because they don't provide comprehensive, continuous care, including for chronic conditions; coordinate care across multiple provides and may not share data across care settings.

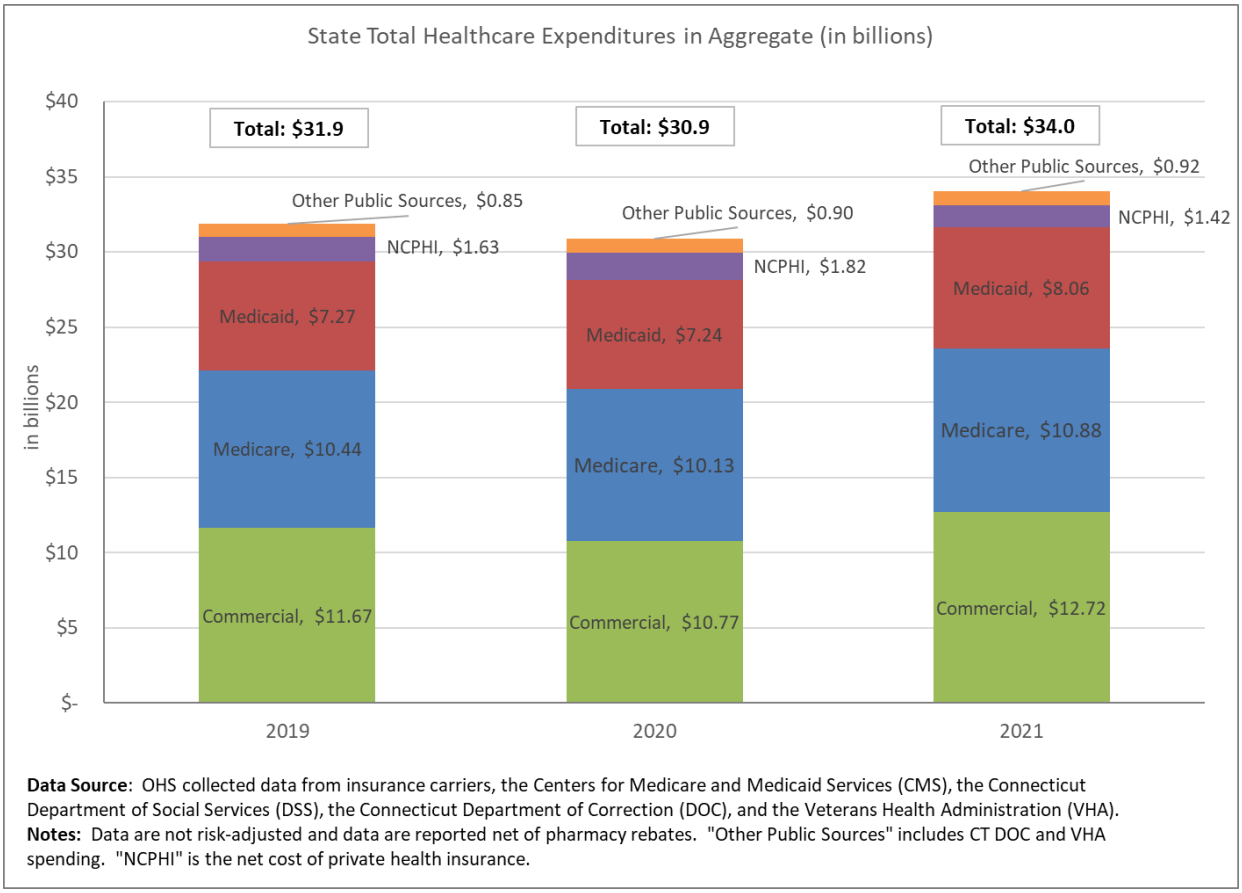
[14] OHS excluded long-term care services from TME for the primary care spending calculation to make calculations across commercial, Medicaid and Medicare markets comparable, since only Medicaid covers long-term care and long-term care is a source of significant Medicaid expenditures. This approach is consistent with the methodology used by six New England states (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont) measuring primary care spending.

[15] McGough M, Amin K and Cox C. "How has healthcare utilization changed since the pandemic?" Peterson-KFF Health System Tracker. January 24, 2023; Dingel H et al. "The state of the U.S. health system in 2022 and the outlook for 2023. December 22, 2022.

State Total Healthcare Expenditure Trends

Connecticut's state THCE was $31.9 billion in 2019 or $9,865 per person, $30.9 billion in 2020 or $9,556 per person, and $34.0 billion in 2021 or $10,130 per person (see **Figure 2**). The largest component of Connecticut's THCE in aggregate for all three years was commercial spending, followed by Medicare and Medicaid[16] spending, respectively. Net cost of private health insurance (NCPHI), Department of Correction (DOC) and federal Veterans Health Administration (VHA) spending comprised a small portion of aggregate TME and thus were not significant cost drivers.

Figure 2. State Total Healthcare Expenditures in Aggregate (in billions)

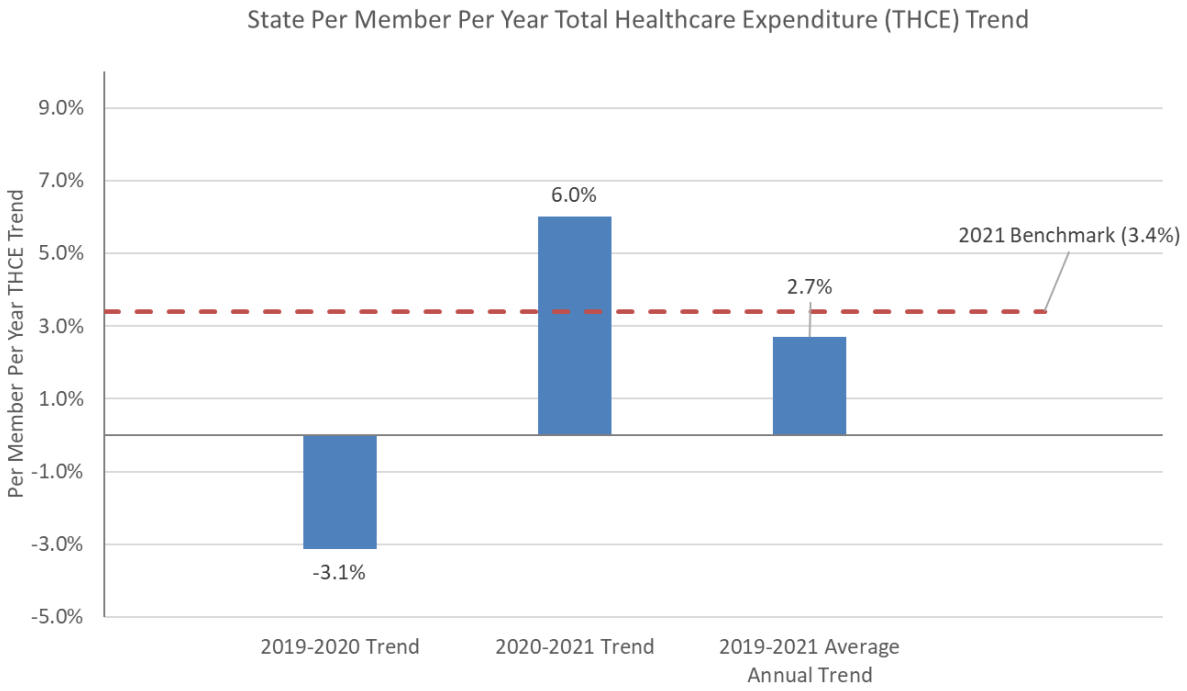


Data Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut Department of Correction (DOC), and the Veterans Health Administration (VHA).
Notes: Data are not risk-adjusted and data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

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

Connecticut's per person THCE trend was -3.1 percent in 2020 (see **Figure 3**). This decrease in spending was driven by the decrease in healthcare utilization during the COVID-19 pandemic as discussed above. Connecticut's per person growth in THCE in 2021 was 6.0 percent, which is above the 3.4 percent cost growth benchmark for 2021. This increase in spending was driven by the rebound in in-person healthcare utilization discussed above. Average annual growth in THCE between 2019-2021 was 2.7 percent.

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

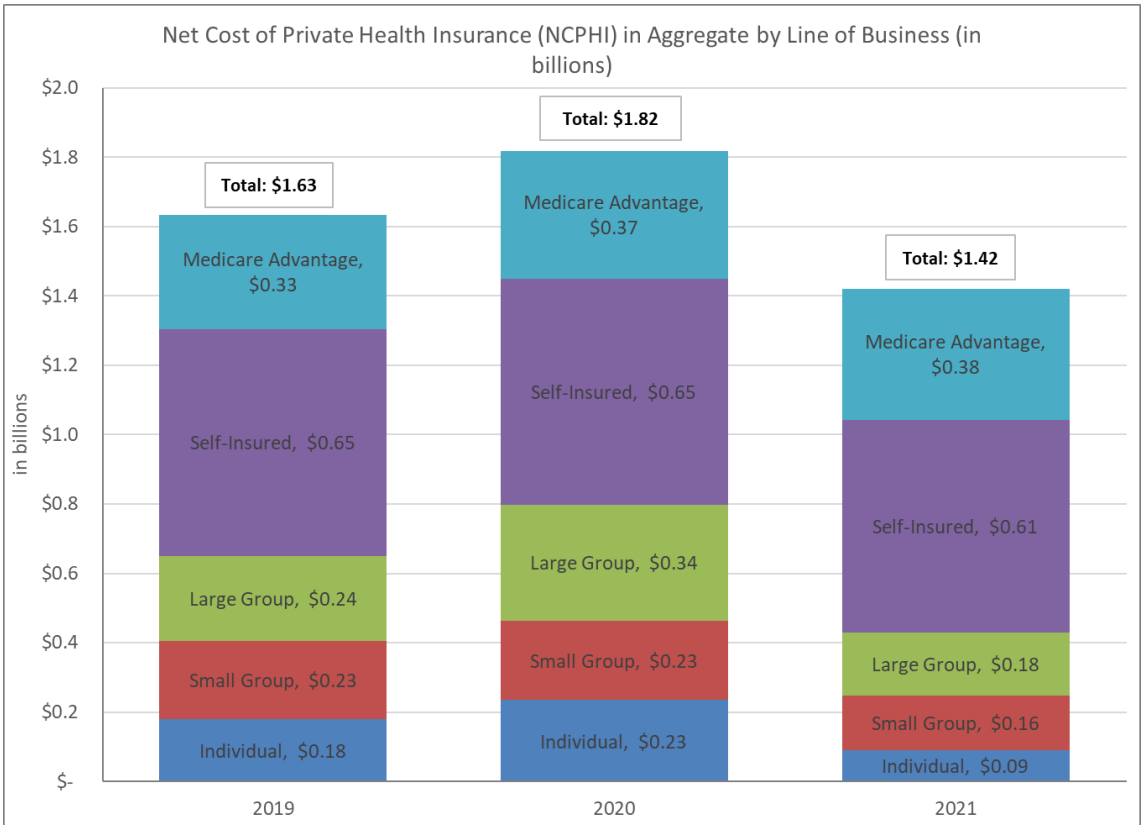


Data Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut Department of Correction (DOC), and the Veterans Health Administration (VHA).
Notes: Data are not risk-adjusted and data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

Net Cost of Private Health Insurance (NCPI) by Line of Business

NCPHI contributed $1.63 billion to state THCE in 2019, $1.82 billion in 2020 and $1.42 billion in 2021 (see **Figure 4**). The commercial self-insured market comprised the largest portion of NCPHI per person in all three years, followed by Medicare Advantage. NCPHI increased by 11.3 percent in 2020 and decreased by 21.9 percent in 2021. The increase in NCPHI in 2020 was driven by 2020 premiums being set in advance of the COVID-19 pandemic and the unanticipated decrease in healthcare utilization, elevating insurer profits. In 2021, utilization patterns returned to more anticipated levels, which drove NCPHI down from its previously elevated levels as insurer margins dropped from 2020.

Figure 4. Net Cost of Private Health Insurance (NCPHI) in Aggregate by Line of Business (in billions)



Data Source: OHS calculated NCPHI using data submitted from insurance carriers, regulatory reports and from public sources (i.e., Medical Loss Ratio data).

Total Medical Expense Trends by Market

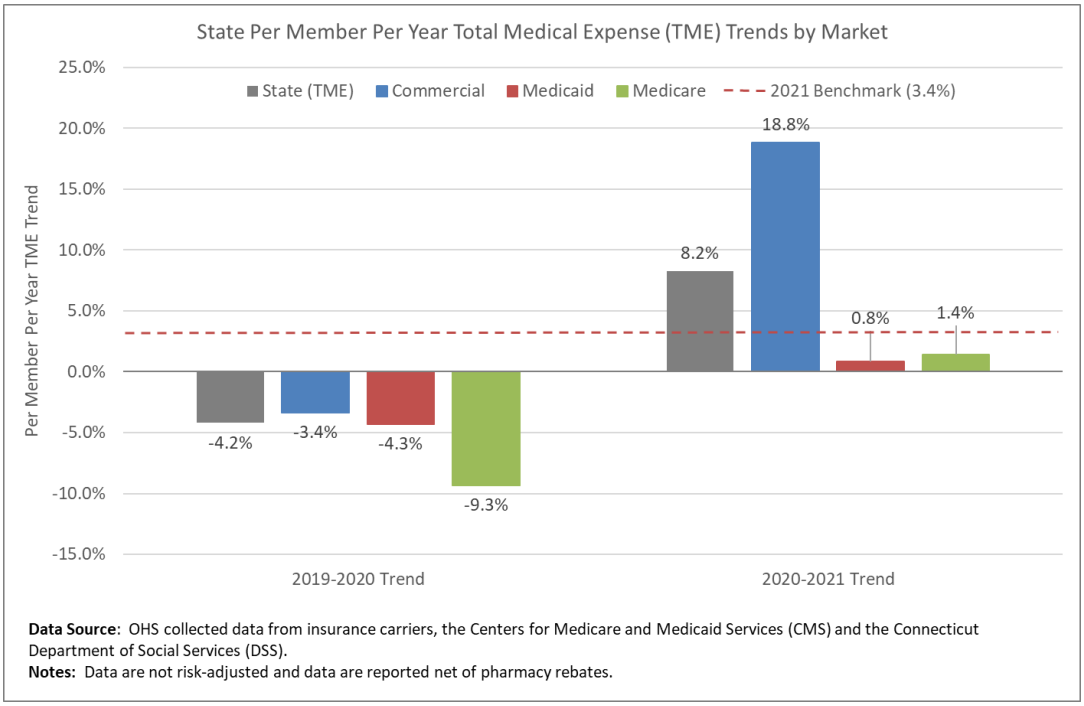
OHS assesses per member per year TME trends by market against the benchmark. Per member per year TME trends are a product of changes in both healthcare utilization and payment per service. Connecticut's 2019-2021 TME trends by market reflect the statewide experience of a small decline in 2020, followed by growth far exceeding the benchmark in 2021. There were significant differences in spending trends across markets, however.

Commercial spending decreased 3.4 percent to $6,505 per member per year in 2020, and then increased 18.8 percent (well above the 3.4 percent benchmark) to $7,729 per person in 2021 (see **Figure 5**). The 18.8 percent growth far exceeds the increases other cost growth benchmark states, including Massachusetts, Oregon and Rhode Island.[17] Connecticut's average annual commercial growth from 2019-2021 was still above the benchmark at 7.4 percent.

The commercial market experience contrasts with experience in the Medicare and Medicaid markets, where per member per year spending declined in 2020 and then increased much more modestly in 2021 (see **Figure 5**). **Medicare** per member per year spending decreased 9.3 percent to $14,945 in 2020, and then increased only 1.4 percent (below the 3.4 percent benchmark) to $15,157 per person in 2021. Medicare's average annual growth from 2019-2021 was -4.0 percent. **Medicaid** per member per year spending decreased 4.3 percent to $7,050 in 2020, and then barely increased 0.8 percent (below the 3.4 percent benchmark) to $7,110 per person in 2021. Medicaid's average annual growth in per member per year spending from 2019-2021 was -1.8 percent.

[17] Massachusetts has reported 11.6 percent per capita commercial cost growth from 2020-2021. Oregon and Rhode Island have not publicly reported 2020-2021 cost trends but OHS is aware of their trends through state-to-state conversations.

Figure 5. State Per Member Per Year Total Medical Expense (TME) 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.

Total Medical Expense Trends by Insurance Carrier

This section discusses TME trends by insurance carrier for their commercial and Medicare Advantage products. This section includes summary tables with insurance carriers' performance. Detailed performance, including OHS' statistical testing of insurance carrier performance, is included in Appendix B.

2019-2020 Total Medical Expense Trends

Insurance carriers' per person TME trends in the **commercial** market in 2020 were negative (four carriers) or modest (one carrier) (see **Table 3**). All four **Medicare Advantage** carriers had negative trends in 2020 (see **Table 3**).

Table 3. Summary of Insurance Carriers' 2019-2020 Total Medical Expense (TME) Trends

Insurance Carrier	2019-2020 Commercial TME Trend	2019-2020 Medicare Advantage TME Trend
Aetna	2.6%	-9.1%
Anthem	-4.1%	-8.6%
Cigna	-5.3%	NA
ConnectiCare	-14.9%	-7.9%
UnitedHealthcare	-4.7%	-2.2%

Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated, risk-adjusted, and net of pharmacy rebates.

2020-2021 Performance Against the Cost Growth Benchmark

Per person TME trend in the **commercial** market in 2021 was dramatically different than 2020 (see **Table 4**). In 2021, every carrier reported per person trend between 11.3 percent and 18.9 percent and far exceeded the 2021 benchmark of 3.4 percent. The 2020 and 2021 two-year average rate of growth for every carrier, except for ConnectiCare, was also well above the 2021 benchmark.

Medicare Advantage carrier trends were lower than the commercial market in 2021 (see **Table 4**). Despite the comparatively lower enrollment, trend was also less variable than in the commercial market. Medicare Advantage carriers reported per person trends between -4.1 percent and 11.1 percent. For 2021, Medicare Advantage trend was positive for each carrier but Aetna, whose trend was far below the unusually high levels observed in the commercial market. In addition, when balanced with the declines observed in 2020, the two-year Medicare Advantage trend was quite modest. All Medicare Advantage carriers but Aetna exceeded the benchmark in 2021.

The following key terms utilized in this section are explained in Appendix A:

- Confidence interval lower/upper bound
- Truncation
- Did not meet the benchmark
- Met the benchmark
- Minimum lives requirement not met
- Risk-adjusted TME
- Unable to determine

Table 4. Summary of Insurance Carriers' 2020-2021 Performance Against the 3.4% Benchmark

Insurance Carrier	2020-21 Commercial Performance (TME Trend)	2020-21 Medicare Advantage Performance (TME Trend)
Aetna	Did not meet the benchmark 17.2%	Met the benchmark -4.1%
Anthem	Did not meet the benchmark 18.9%	Did not meet the benchmark 8.2%
Cigna	Did not meet the benchmark 16.6%	NA
ConnectiCare	Did not meet the benchmark 17.1%	Did not meet the benchmark 11.1%
UnitedHealthcare	Did not meet the benchmark 11.3%	Did not meet the benchmark 8.4%

Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated, risk-adjusted, and net of pharmacy rebates.

Total Medical Expense Trends by Advanced Network

This section discusses TME trends by Advanced Network for their commercial, Medicare Advantage, and Medicaid FFS populations. This section includes summary tables with Advanced Networks' performance. Detailed performance, including OHS' statistical testing of Advanced Network performance, is included in Appendix C. See the Advanced Networks section above for an explanation of how these entities were defined and selected.

Analysis at the Advanced Network level (by market) involves smaller populations than at the insurer level. For this reason, we expect to see more variation in performance across Advanced Networks than for insurance carriers. In addition, we observe much larger confidence intervals at the Advanced Level because of the diminished statistical precision of measurements when assessing smaller populations, which results in more Advanced Networks with performance for which we cannot determine with statistical significance whether the benchmark was met. Utilizing confidence intervals is important to indicate the range of reasonable estimates of actual healthcare cost growth.

OHS presents performance for hospital-affiliated Advanced Networks and non-hospital-affiliated Advanced Networks separately in recognition that hospital-affiliated Advanced Networks have comparatively greater influence over hospital price growth through the affiliated hospital(s). This is relevant because prior analyses of APCD data have revealed hospital price growth to have been a significant driver of spending growth in Connecticut in the commercial market between 2015 and 2019.

It is important to note that Advanced Network trends will always exceed market level trends, because market level trends include individuals who do not seek care and are not attributed to an Advanced Network. When assessing Advanced Network performance, we are measuring trend only for individuals who sought care during the year or during a recent prior year with an Advanced Network (usually primary care) clinician. This is especially relevant for 2020 when so many individuals stopped seeking care.

2019-2020 Total Medical Expense Trends

2020 **commercial** spending declined less for hospital-affiliated Advanced Networks than for non-hospital-affiliated Advanced Networks (see **Table 5** and **Table 6**Error! Reference source not found.), but in both cases, trend was mostly negative. Average commercial growth was -2.3 percent for hospital-affiliated Advanced Networks and -4.8 percent for non-hospital-affiliated Advanced Networks.

Declines in 2020 **Medicare Advantage** spending were similar for non-hospital-affiliated Advanced Networks than for hospital-affiliated Advanced Networks (see **Table 5** and **Table 6**Error! Reference source not found.). Average Medicare Advantage spending declined by 4.2 percent for hospital-affiliated Advanced Networks and declined by 3.6 percent for non-hospital-affiliated Advanced Networks.

2020 spending declined less for Advanced Networks serving **Medicaid** members than for those serving commercial and Medicare Advantage members, but trend was still largely negative (**Table 5** and **Table 6)**. Medicaid spending declined less for hospital-affiliated Advanced Networks than for non-hospital-affiliated Advanced Networks. Average Medicaid spending declined by 0.9 percent for hospital-affiliated Advanced Networks and declined by 2.1 percent for non-hospital-affiliated Advanced Networks. Connecticut Children's Medical Center had the biggest drop in per person Medicaid spending, which was also true for the commercial population. This suggests that perhaps utilization for children may have dropped off more dramatically than for adults in 2020.

We note the high prevalence of FQHCs, for which patient populations were not large enough for reporting for the commercial and Medicare Advantage markets. DSS provided Advanced Network spending data only for its PCMH program providers. Therefore, some provider entities are not included in the Medicaid analysis despite serving enough Medicaid members to meet the minimum reporting threshold.

Table 5. Summary of Hospital-Affiliated Advanced Networks' 2019-2020 Total Medical Expense (TME) Trends

Advanced Network	2019-2020 Commercial TME Trend	2019-2020 Medicare Advantage TME Trend	2019-2020 Medicaid FFS TME Trend
Connecticut Children's Medical Center	-7.5%	NA	-10.0%
Integrated Care Partners	-4.6%	-2.5%	3.9%
Northeast Medical Group	-2.9%	-3.6%	-1.1%
Prospect Connecticut Medical Foundation Inc.	-3.0%	-6.9%	-3.5%
SoNE Health	-0.7%	-5.3%	NA
Stamford Medical Group	-1.8%	NA	NA
UConn Medical Group	3.0%	-2.1%	3.9%
Value Care Alliance	-4.7%	-6.8%	-3.0%
Yale Medicine	1.6%	NA	7.1%

Data Source: OHS collected data from insurance carriers and the Department of Social Services (DSS).
Notes: Data are truncated and risk-adjusted. Advanced Networks marked "NA" did not meet the minimum attributed lives threshold (60,000 member months) for the market. Advanced Networks not shown did not meet the minimum attributed lives threshold for any market.

Table 6. Summary of Non-Hospital-Affiliated Advanced Networks' 2019-2020 Total Medical Expense (TME) Trends

Advanced Network	2019-2020 Commercial TME Trend	2019-2020 Medicare Advantage TME Trend	2019-2020 Medicaid FFS TME Trend
Charter Oak Health Center	NA	NA	-3.4%
CIFC Greater Danbury Community Health Center	NA	NA	0.1%
Community Health Center	NA	NA	-3.0%
Community Health Services	NA	NA	-5.9%
Community Medical Group	-5.1%	3.0%	NA
Cornell Scott Hill Health Center	NA	NA	3.0%
CT State Medical Society IPA	-7.6%	-2.0%	NA
Fair Haven Community Health Center	NA	NA	-4.9%
First Choice Community Health Centers	NA	NA	1.2%
Generations Family Health Center	NA	NA	2.6%
Optimus Health Care, Inc.	NA	NA	-4.2%
OptumCare Network of CT	-1.3%	-9.5%	NA
ProHealth	-6.7%	-5.9%	-4.8%
Southwest Community Health Center, Inc.	NA	NA	3.5%
Starling Physicians	-3.1%	-3.2%	-3.0%
United Community and Family Services	NA	NA	-9.0%

Data Source: OHS collected data from insurance carriers and the Department of Social Services (DSS).
Notes: Advanced Networks marked "NA" did not meet the minimum attributed lives threshold (60,000 member months) for the market. Advanced Networks not shown did not meet the minimum attributed lives threshold for any market.

2020-2021 Performance Against the Cost Growth Benchmark

In 2021, every hospital-affiliated Advanced Network had double digit **commercial** market spending growth, with a range of 16.1 percent to 23.3 percent, and a flat (i.e., not weighted) average of 19.3 percent (see **Table 7**). All hospital-affiliated Advanced Networks exceeded the benchmark for the commercial market in 2021. Among non-hospital-affiliated Advanced Networks, trend was also consistently high, with three of five Advanced Networks exceeding 20 percent trend (see **Table 8**). Overall, this group of Advanced Networks averaged 19.8 percent per person spending growth in 2021 and all exceeded the benchmark. We do not observe consistent performance patterns by Advanced Networks across this aberrant two-year time period.

We next consider 2021 **Medicare Advantage** performance by Advanced Networks, first for the hospital-affiliated Advanced Networks. Except for the Southern New England Healthcare Organization (SoNE Health), trends ranged between 11.6 percent and 16.5 percent - lower than in the commercial market (**Table 7**). All exceeded the benchmark except for SoNE Health. These results should be assessed in the context of the negative trend for many Medicare Advantage Advanced Networks in 2020.

Non-hospital-affiliated Advanced Networks had significantly lower trend in 2021 in the Medicare Advantage market when compared to hospital-affiliated Advanced Networks, with OptumCare Network being the one exception (see **Table 8**). Except for OptumCare, trends ranged between 1.2 and 9.2 percent. Community Medical Group was the only Advanced Network that met the benchmark for the Medicare Advantage market, with a trend of 1.2 percent. Again, these results should be assessed in the context of the 2020 negative trend for many Medicare Advantage Advanced Networks.

Medicaid spending for hospital-affiliated Advanced Networks grew an average of 5.7 percent in 2021 (see **Table 7**). Only Prospect Connecticut Medical Foundation met the benchmark with a trend of 1.1 percent. For Integrated Care Partners and Stamford Medical Group, we cannot determine with statistical significance whether the benchmark was met. Connecticut Children's Medical Center had a large jump in trend (11.9 percent) following its negative trend the prior year. These results should be assessed in the context of the negative trend for many Medicaid Advanced Networks in 2020. Again, for the Medicaid market, it is especially important to note that Advanced Network trends will always exceed market level trends, because market level trends include individuals who do not seek care and are not attributed to an Advanced Network. When assessing Advanced Network performance, we are measuring trend only for individuals who sought care during the year or during a recent prior year with an Advanced Network (usually primary care) clinician. This is especially relevant for 2020 when so many individuals stopped seeking care.

Table 7. Summary of Hospital-Affiliated Advanced Networks' 2020-2021 Performance Against the 3.4% Benchmark

Advanced Network	2020-2021 Commercial Performance TME Trend	2020-2021 Medicare Advantage Performance TME Trend	2020-2021 Medicaid FFS Performance TME Trend
Connecticut Children's Medical Center	Did not meet the benchmark 23.3%	NA	Did not meet the benchmark 11.9%
Integrated Care Partners	Did not meet the benchmark 17.2%	Did not meet the benchmark 12.1%	Unable to determine 4.8%
Northeast Medical Group	Did not meet the benchmark 20.7%	Did not meet the benchmark 16.5%	Did not meet the benchmark 5.1%
Prospect Connecticut Medical Foundation Inc.	Did not meet the benchmark 16.9%	Did not meet the benchmark 14.0%	Met the benchmark 1.1%
SoNE Health	Did not meet the benchmark 16.1%	Unable to determine 4.4%	NA
Stamford Medical Group	Did not meet the benchmark 19.3%	NA	Unable to determine 3.4%
UConn Medical Group	Did not meet the benchmark 23.2%	Did not meet the benchmark 11.6%	Did not meet the benchmark 6.5%
Value Care Alliance	Did not meet the benchmark 19.4%	Did not meet the benchmark 14.3%	Did not meet the benchmark 7.1%
Yale Medicine	Did not meet the benchmark 17.1%	NA	NA

Data Source: OHS collected data from insurance carriers and the Department of Social Services (DSS).

Notes: Data are truncated and risk-adjusted. Advanced Networks marked "NA" did not meet the minimum attributed lives threshold (60,000 member months) for the market. Advanced Networks not shown did not meet the minimum attributed lives threshold for any market. If an entity's cost growth benchmark performance is marked "unable to determine" this means that the entity's confidence interval intersected with the cost growth benchmark, meaning OHS cannot determine with 95% certainty whether the entity's TME growth rate exceeded or met the cost growth benchmark.

2021 Medicaid trend for non-hospital-affiliated Advanced Networks grew 6.4 percent on average, with a few FQHCs with trends higher than most other Advanced Networks (see **Table 8**). Three Advanced Networks met the benchmark (Southwest Community Health Center, Starling Physicians and Fair Haven Community Health Center), with nearly all others exceeding the benchmark. **Again, these results should be assessed in the context of the negative trend for many Medicaid Advanced Networks in 2020**.

Table 8. Summary of Non-Hospital-Affiliated Advanced Networks' 2020-2021 Performance Against the 3.4% Benchmark

Advanced Network	2020-2021 Commercial Performance TME Trend	2020-2021 Medicare Advantage Performance TME Trend	2020-2021 Medicaid FFS Performance TME Trend
Charter Oak Health Center	NA	NA	Unable to determine 5.7%
CIFC Greater Danbury Community Health Center	NA	NA	Did not meet the benchmark 9.8%
Community Health Center	NA	NA	Did not meet the benchmark 6.1%
Community Health Services	NA	NA	Did not meet the benchmark 8.6%
Community Medical Group	Did not meet the benchmark 20.7%	Met the benchmark 1.2%	NA
Cornell Scott Hill Health Center	NA	NA	Did not meet the benchmark 11.9%
CT State Medical Society IPA	Did not meet the benchmark 18.9%	Did not meet the benchmark 9.2%	NA
Fair Haven Community Health Center	NA	NA	Met the benchmark -0.1%
First Choice Community Health Centers	NA	NA	Did not meet the benchmark 11.2%
Generations Health Center	NA	NA	Did not meet the benchmark 6.1%

Advanced Network	2020-2021 Commercial Performance TME Trend	2020-2021 Medicare Advantage Performance TME Trend	2020-2021 Medicaid FFS Performance TME Trend
Optimus Health Care, Inc.	NA	NA	Unable to determine 3.0%
OptumCare Network of CT	Did not meet the benchmark 24.0%	Did not meet the benchmark 22.0%	NA
ProHealth	Did not meet the benchmark 20.8%	Did not meet the benchmark 6.1%	Did not meet the benchmark 6.5%
Southwest Community Health Center, Inc.	NA	NA	Met the benchmark 1.3%
Starling Physicians	Did not meet the benchmark 14.5%	Did not meet the benchmark 7.7%	Met the benchmark 0.3%
United Community and Family Services	NA	NA	Did not meet the benchmark 12.9%

Data Source: OHS collected data from insurance carriers and the Department of Social Services (DSS).
Notes: Data are truncated and risk-adjusted. Advanced Networks marked "NA" did not meet the minimum attributed lives threshold (60,000 member months) for the market. Advanced Networks not shown did not meet the minimum attributed lives threshold for any market. If an entity's cost growth benchmark performance is marked "unable to determine" this means that the entity's confidence interval intersected with the cost growth benchmark, meaning OHS cannot determine with 95% certainty whether the entity's TME growth rate exceeded or met the cost growth benchmark.

2021 Trends in Major Service Category Spending

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

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

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

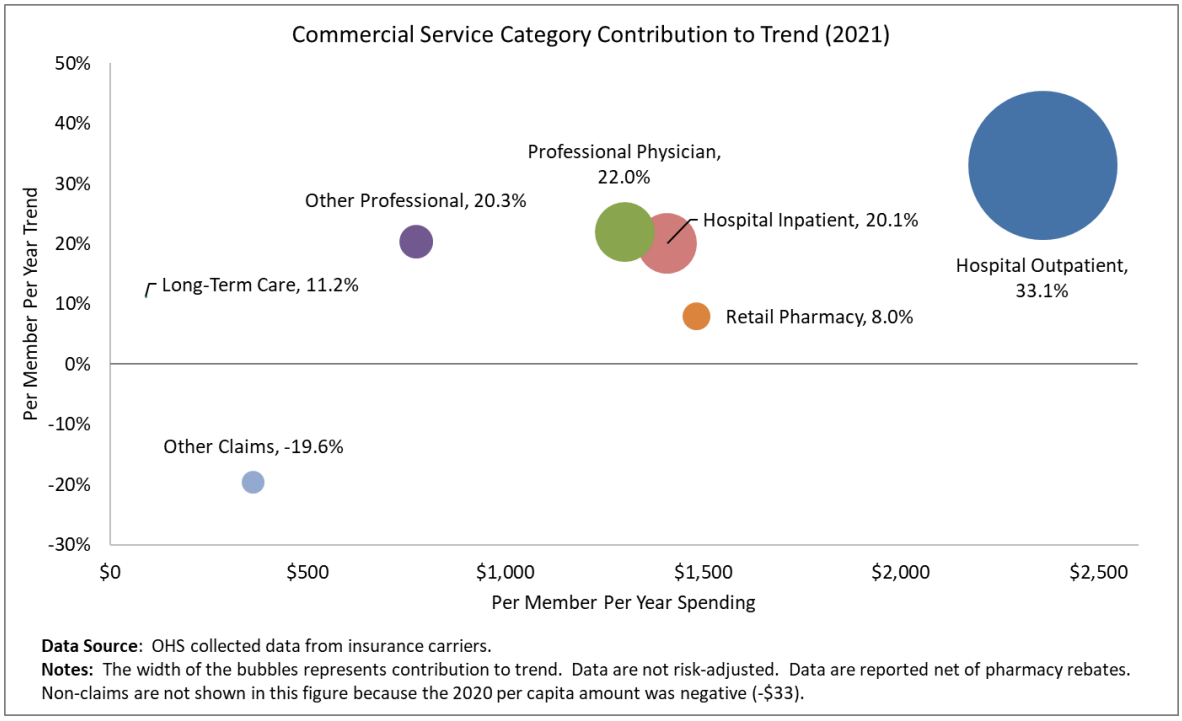
1. Prospective capitation, global budget, case rate or episode-based payments
2. Performance incentive payments
3. Payments to support population health and practice infrastructure
4. Provider salaries
5. Recoveries
6. Other

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

This section highlights the service categories that drove Connecticut's per person spending trends in the commercial, Medicare and Medicaid markets in 2021. We focus on 2021 because of the atypical utilization and spending patterns in 2020 (2020 trends in major service category spending are included in Appendix D). The figures in this section visualize contribution to trend by showing each service category as a bubble, with per person spending on the x axis and trend in per person spending on the y axis. The width of the bubble represents how much the service category contributed to the market's overall cost trend (i.e., the larger the bubble, the more the service category contributed to cost growth).

Hospital outpatient[18], professional physician[19], and hospital inpatient[20] drove **commercial spending** growth in 2021 (see **Figure 6**).

Figure 6. Commercial Service Category Contribution to Trend (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).

[18] **Hospital outpatient** is 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 physicians services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

[19] **Professional physician** is the 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.

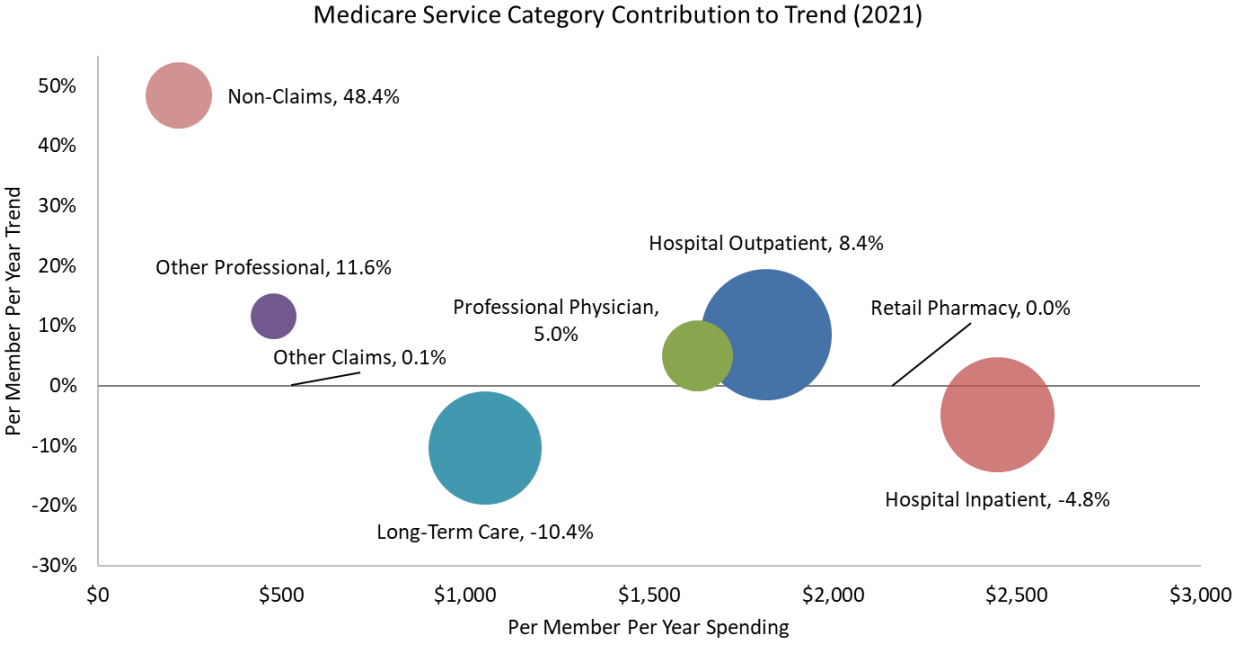
[20] **Hospital inpatient** is the TME paid to hospitals for inpatient services generated from claims. This category includes all room and board and ancillary payments, all hospital types, and payments for emergency room services when the member is admitted to the hospital, in accordance with the specific 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.

Commercial hospital outpatient spending increased by 33.1 percent to $2,358 per person in 2021. Commercial professional physician spending increased by 22.0 percent to $1,301 per person in 2021. Commercial hospital inpatient spending increased by 20.1 percent to $1,409 per person in 2021. While this analysis is the result of data that are collected in the aggregate from payers, these patterns are consistent with those observed by OHS through analysis of APCD data for 2015-19.

The main cost drivers differed between the commercial, Medicare and Medicaid markets. Hospital outpatient and professional physician services were a consistent source of spending growth across all three markets; however, hospital inpatient services were less impactful in Medicare and Medicaid than they were in the commercial market.

Hospital outpatient and professional physician spending drove the increase in **Medicare spending** in 2021 (see **Figure 7**). Medicare hospital outpatient spending increased by 8.4 percent to $1,819 in 2021. Medicare professional physician spending increased by 5.0 percent to $1,632 in 2021.

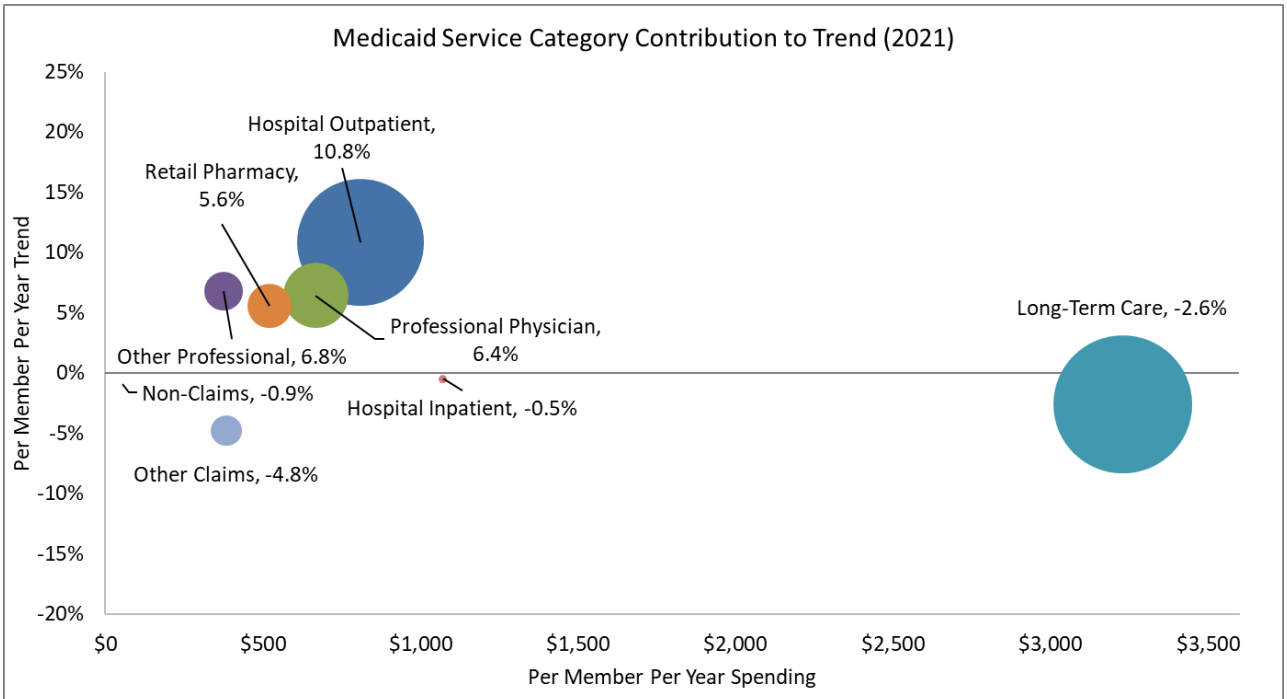
Figure 7. Medicare Service Category Contribution to Trend (2021)



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.

For Medicaid, hospital outpatient and professional physician services drove the increase in **Medicaid spending** in 2021 (see **Figure 8**). Medicaid hospital outpatient increased by 10.8 percent to $810 per person in 2021. Medicaid professional physician spending increased by 6.4 percent to $688 per person in 2021. Long-term care is a larger percentage of Medicaid spending than for the other markets because Medicaid covers certain long-term care services that commercial and Medicare Advantage do not, and because Medicaid covers individuals eligible and enrolled due to their disability status.

Figure 8. Medicaid Service Category Contribution to Trend, 2021



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.

Primary Care Spending as a Percentage of Total Medical Expenses

This section presents an analysis of Connecticut's primary care spending against the primary care spending target in 2020 and 2021 at the state, market and insurance carrier levels.[21]

State Primary Care Spending

Connecticut met the 5.0 percent primary care spending target at the state level in 2021. Aggregate primary spending increased from $880 million in 2020 to $1 billion in 2021 and per person per year primary care spending also grew from $26 to $29 in the same period (See **Table 9)**.

Table 9. Statewide Primary Care Spending in Aggregate and Per Person Per Year

Year	Statewide Primary Care Spending in Aggregate	Statewide Primary Care Spending Per Person Per Year
2020	$880,235,324	$26
2021	$1,007,490,910	$29

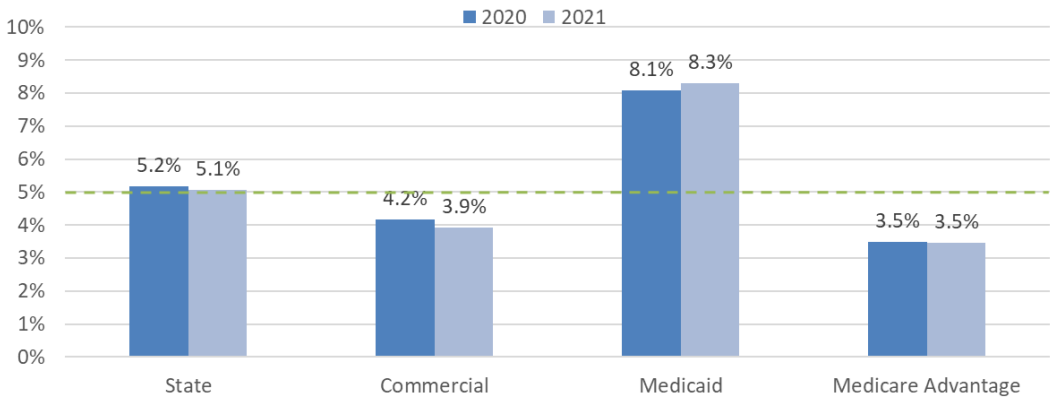
Data Source: OHS collected data from insurance carriers and the Connecticut Department of Social Services (DSS).

However, statewide primary care spending as a percentage of total spending decreased from 5.2 percent in 2020 to 5.1 percent in 2021 (see

Figure 9). This slight decrease was caused by a reduction in primary care spending as a percentage of total spending in the commercial market (discussed more below).

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

Figure 9. State and Market Primary Care Spending as a Percentage of Total Medical Expense



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

Primary Care Spending by Market

The Connecticut **commercial market** did not meet the 5.0 percent primary care spending target in 2021. Commercial primary care spending grew to $494 million and per person commercial primary care spending to $25 (see **Table 10**). But commercial primary care spending as a percentage of total spending decreased from 4.2 percent in 2020 to 3.9 percent in 2021 (see

Figure 9). This is because spending for some other service categories (i.e., hospital and professional physician) grew at a faster rate than primary care spending from 2020 to 2021.

Table 10. Commercial Primary Care Spending in Aggregate and Per Person Per Year

Year	Commercial Primary Care Spending in Aggregate	Commercial Primary Care Spending Per Person Per Year
2020	$443,579,426	$22
2021	$494,443,719	$25

Data Source: OHS collected data from insurance carriers.

The Connecticut **Medicaid market** met the 5.0 percent primary care spending target in 2021. Medicaid aggregate primary care spending totaled increased to $365 million, and per person spending to $27 to 2021 (see **Table 11**). As a percentage of total Medicaid expenditures, Medicaid spent 8.3 percent on primary care in 2021, an increase from 8.1 percent in 2020 (

Figure 9).

Table 11. Medicaid Primary Care Spending in Aggregate and Per Person Per Year

Year	Medicaid Primary Care Spending in Aggregate	Medicaid Primary Care Spending Per Person Per Year
2020	$310,382,730	$25
2021	$365,235,907	$27

Data Source: OHS collected data from the Department of Social Services (DSS).

The Connecticut **Medicare Advantage market** did not meet the 5.0 percent primary care spending target in 2021. Medicare Advantage spending on primary care grew to $148 million per person spending to $39 in 2021 (see **Table 12**). Medicare Advantage primary spending as a percentage of total Medicare Advantage spending remained level from 2020 to 2021, at 3.5 percent (see

Figure 9).

Table 12. Medicare Advantage Primary Care Spending in Aggregate and Per Person Per Year

Year	Medicare Advantage Primary Care Spending in Aggregate	Medicare Advantage Primary Care Spending Per Person Per Year
2020	$126,273,168	$36
2021	$147,811,284	$39

Data Source: OHS collected data from insurance carriers.

Primary Care Spending by Insurance Carrier

Two out of the five commercial carriers achieved the 5.0 percent primary care spending target in 2021 (see **Table 13**). Commercial payers' per member per month spending on primary care ranged from $19 to $28 in 2020 and $19 to $32 in 2021. Primary care spending as a percentage of total spending ranged from 3.5 percent to 6.8 percent in 2020 and 3.5 percent to 5.9 percent in 2021.

Table 13. Commercial Payers' Primary Care Spending as a Percentage of Total Medical Expenses

Insurer	2020 Primary Care as a Percentage of Total Medical Expenses	2021 Primary Care as a Percentage of Total Medical Expenses
Aetna	4.9%	4.6%
Anthem	3.5%	3.5%
Cigna	4.5%	4.3%
ConnectiCare	6.8%	5.9%
UnitedHealthcare	5.0%	5.3%

Data Source: OHS collected data from insurance carriers.

None of the four Medicare Advantage carriers achieved the 5.0 percent primary care spending target in 2021 (see **Table 14**). Primary care spending per member per month for Medicare Advantage carriers ranged from $29 to $42 in 2020 and $34 to $42 in 2021. Primary care spending as a percentage of total spending ranged from 3.0 percent to 5.3 percent in 2020 and 3.3 percent to 4.5 percent in 2021.

Table 14. Medicare Advantage Payers' Primary Care Spending as a Percentage of Total Medical Expenses

Insurer	2020 Primary Care as a Percentage of Total Medical Expenses	2021 Primary Care as a Percentage of Total Medical Expenses
Aetna	5.3%	4.5%
Anthem	3.0%	3.3%
ConnectiCare	3.7%	3.9%
UnitedHealthcare	3.3%	3.5%

Data Source: OHS collected data from insurance carriers.

Appendix

Appendix A. Definitions of Key Terms

Advanced Network: An organized group of clinicians that come together for the purposes of contracting, or are an established billing unit that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if it is not engaged in a total cost of care contract. This term is equivalent to ”provider entities” referenced in Public Act 22-118.

Allowed Amount: The amount the payer paid a provider, plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of Total Medical Expense.

Coinsurance: The percentage of costs of a covered health care services the member pays after they have paid their deductible. For example, if an insurance plan’s allowable cost for a service is $100 and the member’s coinsurance is 20 percent, if the member has met their deductible, they paid 20 percent of $100, or $20. If the member has not met their deductible, they pay $100, the full allowed amount for the service.

Confidence interval lower/upper bound: OHS conducts statistical significance testing to assess insurer and Advanced Network performance against the cost growth benchmark. This involves developing confidence intervals around each insurer and Advanced Network’s cost growth and determining whether the confidence interval intersects with the benchmark. A confidence interval, in statistics, refers to the range of values for which we are fairly certain our population parameter lies within. In the case of the cost growth benchmark, the confidence interval lower and upper bounds represent the range of values within which we can be 95 percent certain that an insurer or Advanced Network's cost growth lies in. If an entity's confidence interval lower bound is above the cost growth benchmark, that means we can be 95 percent certain the entity has exceeded the cost growth benchmark. If an entity's confidence interval upper bound is below the cost growth benchmark, that means we can be 95 percent certain the entity has met the cost growth benchmark. If an entity's confidence interval (the distance between their upper and lower confidence interval bounds) intersects with the cost growth benchmark, that means we cannot determine with 95 percent certainty whether the entity has exceeded or met the cost growth benchmark.

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.

Did not meet the benchmark: If an entity's cost growth benchmark performance is marked "Did not meet the benchmark" this means that the entity's confidence interval lower bound is above

the cost growth benchmark, meaning that we can be 95 percent certain that the entity's risk-adjusted TME growth rate has exceeded the cost growth benchmark.

Deductible: The amount the member pays for covered health services before their insurance plan starts to pay. For example, with a $2,000 deductible, the member pays for the first $2,000 of covered services themselves.

Healthcare Cost Growth Benchmark ("Benchmark"): The healthcare cost growth benchmark ("benchmark") is 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. The Benchmark is set on a calendar year basis (i.e., benchmarks for each calendar year).

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 the health insurance market. Medicare and Medicare MCO 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."

Medical Pharmacy Rebates: The estimated value of rebates attributed to Connecticut resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding with the reporting period, excluding manufacturer-provided fair maker value bona fide service fees for pharmaceuticals that are paid for under the member's medical benefit. These drugs may be included in the professional claims category with J codes or part of facility fees for drug infusions administered in the outpatient setting. This amount should include PBM rebate guarantee amounts, and any additional rebate amounts transferred by the PBM. The computation of THCE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).

Met the benchmark: If an entity's cost growth benchmark performance is marked "Met the benchmark" this means that the entity's confidence interval upper bound is below the cost growth benchmark, meaning that we can be 95 percent certain that the entity's risk-adjusted TME growth rate has exceeded the cost growth benchmark (see "confidence interval lower/upper bound" definition).

Minimum lives requirement not met: If an Advanced Network's cost growth benchmark performance is marked as "minimum lives requirement not met", this means the Advanced Network did not have at least 60,000 attributed member months for the given market. OHS only reports publicly on the risk-adjusted TME growth of Advanced Networks that have a minimum of 60,000 attributed members months for the commercial, Medicare Managed Care, or Medicaid FFS markets.

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

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.

Payer Recoveries: Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payment recoveries is a separate, reportable field in total medical expense (TME) reporting.

Performance Year: The most recent calendar year for which data were submitted for the applicable healthcare cost growth benchmark, primary care spending target or healthcare quality benchmark.

Primary Care Spending Target ("Target"): This Target is Connecticut's annual primary care spending as a percentage of total medical expenditures. The Target should reach 10 percent by calendar year 2025, as directed in in Public Act 22-118. Interim targets are set on an annual calendar year basis (i.e., a target for each calendar year).

Retail Pharmacy Rebates: The estimated value of rebates attributed to Connecticut resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding to the reporting period, excluding manufacturer-provided fair market value bona fide service fees for retail prescription drugs.[22] This amount should include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. The computation of THCE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).[23]

Risk-adjusted TME: Risk-adjusted TME refers to an entity's risk-adjusted, truncated claims spending plus its non-claims spending. OHS risk-adjusts claims spending using risk scores developed using payer-submitted age/sex spending data. Risk-adjusted TME is used to assess performance against the cost growth benchmark at the insurer and Advanced Network level.

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[22] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurer, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

[23] CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the state and Medicare market levels, spending will be gross of Medicare FFS pharmaceutical rebates.

Total Healthcare 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 Healthcare Expenditures Per Capita: Total Healthcare Expenditures (as defined above) divided by Connecticut's covered population as reported in the total medical expense (TME) data. The annual change in THCE per capita is compared to the Benchmark at the state level.

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.

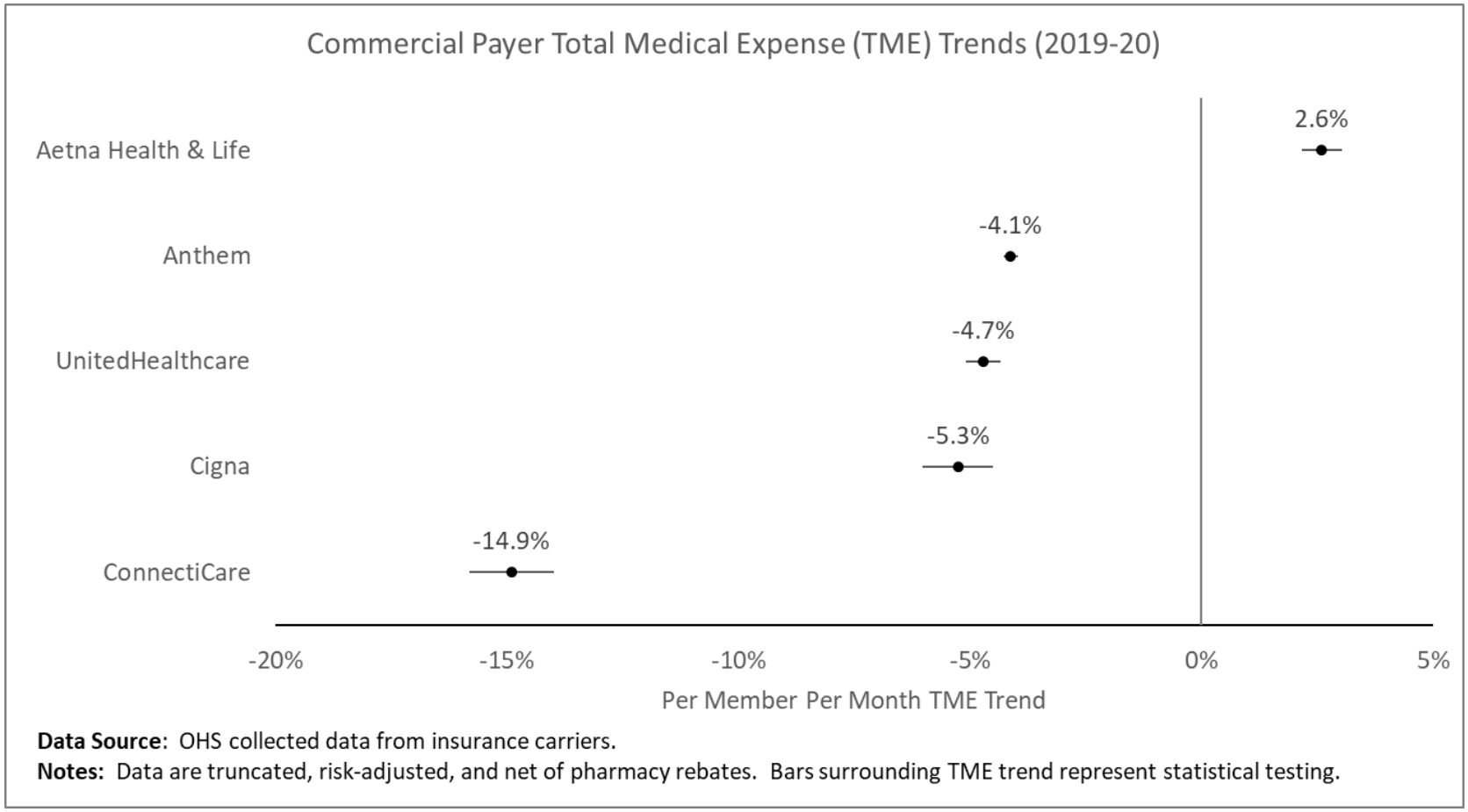
Truncation: Truncation is applied to individuals' total spending, inclusive of all medical and pharmacy spending. The truncation point for: Medicaid expenses for non-dual eligible members is $250,000; Medicaid expenses for Medicare/Medicaid dual eligible is $250,000; Medicare expenses for non-dual eligible members is $150,000; and commercial full or partial claims is $150,000.

Unable to determine: If an entity's cost growth benchmark performance is marked "unable to determine" this means that the entity's confidence interval intersected with the cost growth benchmark, meaning we cannot determine with 95 percent certainty whether the entity's risk-adjusted TME growth rate has exceeded or met the cost growth benchmark.

Appendix B. Insurance Carrier Total Medical Expense Trends

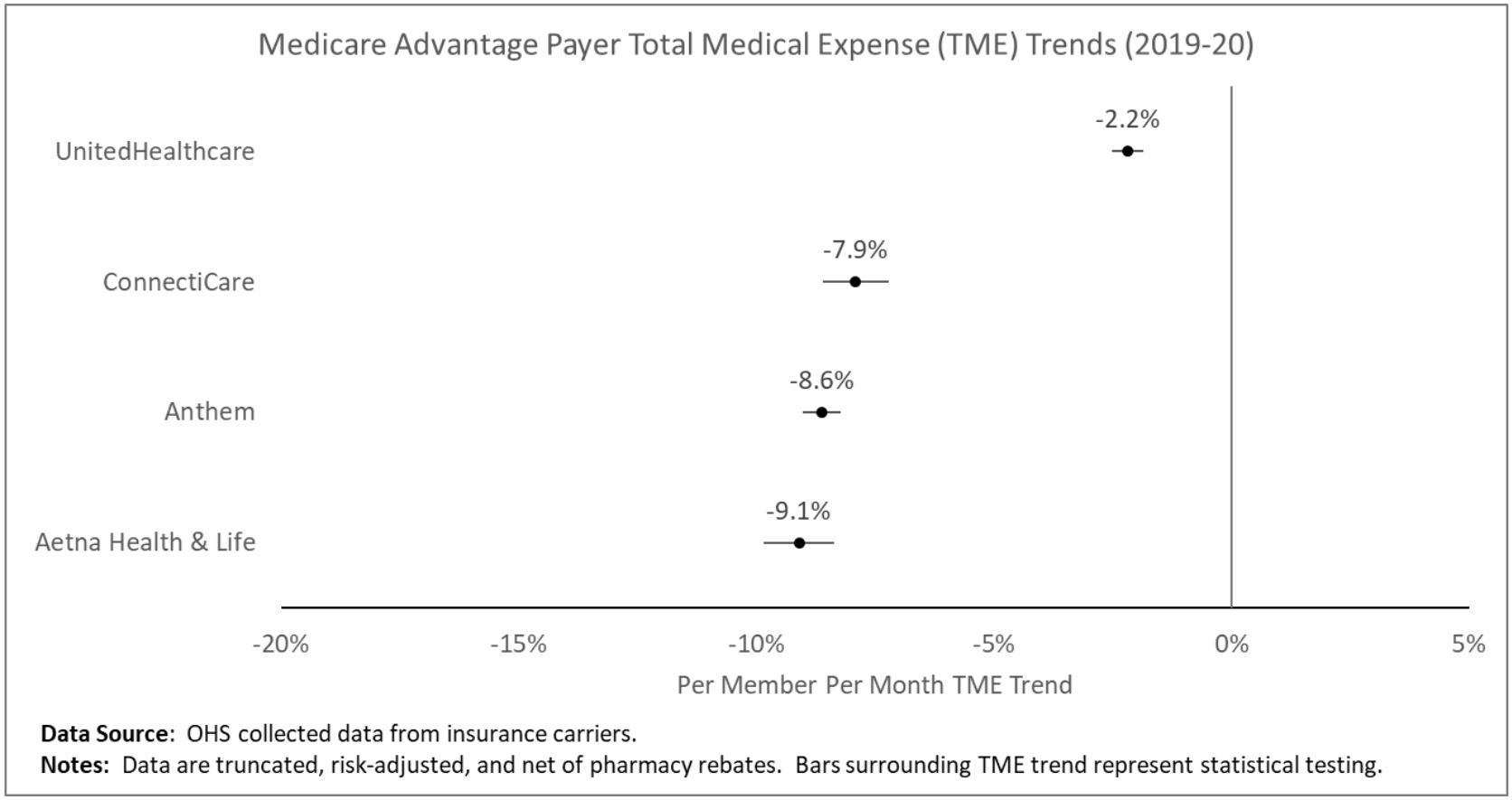
The figures in this section depict insurance carrier cost trends in 2020 and 2021. Each plotted point represents per member per month total medical expense (TME) trend, with the horizontal line through the point (if any) representing the range of values (the "confidence interval") for which we are 95 percent confident actual performance lies. If a confidence interval crosses the benchmark value (the dotted red line), it means we cannot be certain whether the benchmark was or was not met.

Figure 10. Commercial Payer Total Medical Expense (TME) Trends (2019-20)



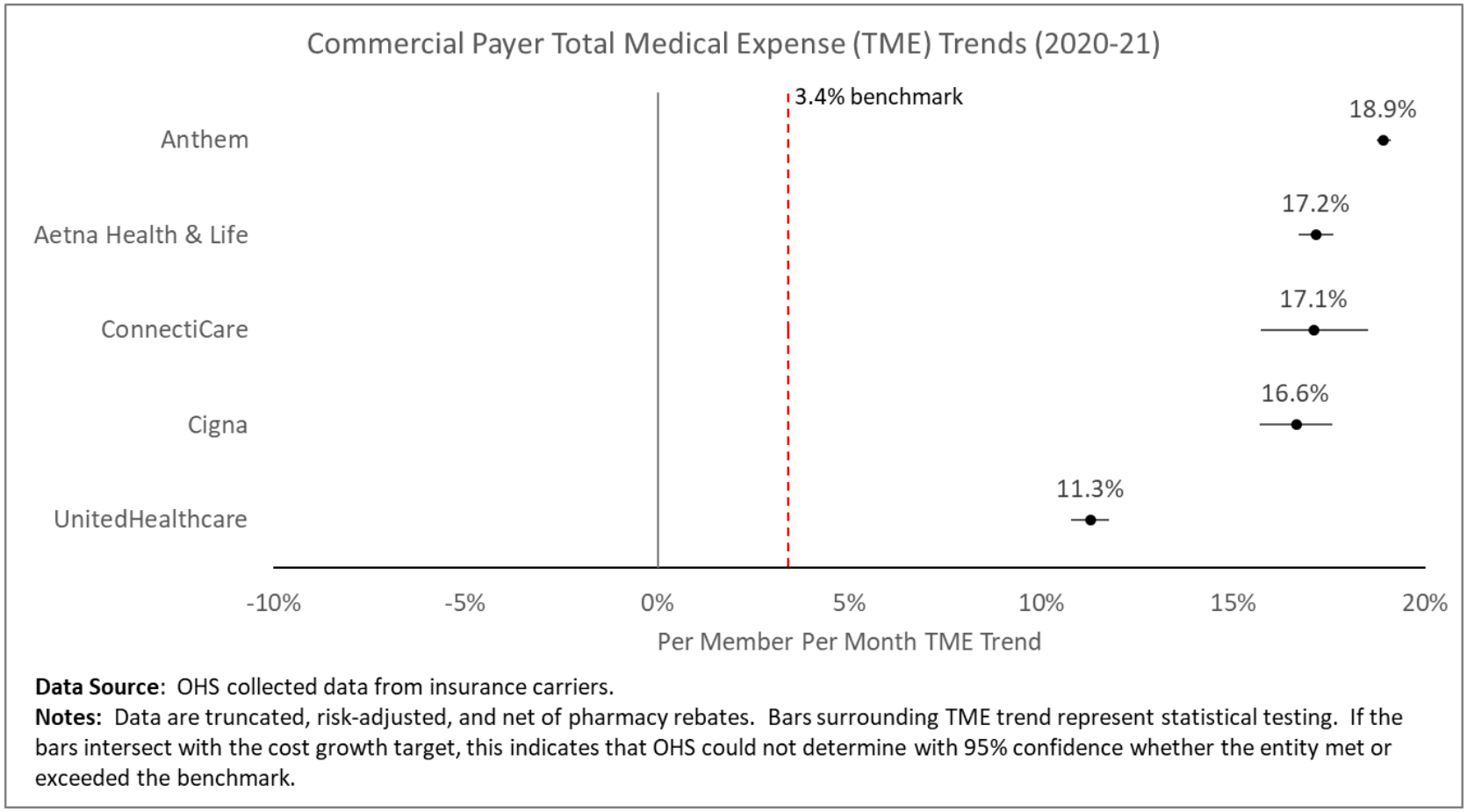
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated, risk-adjusted, and net of pharmacy rebates. Bars surrounding TME trend represent statistical testing.

Figure 11. Medicare Advantage Payer Total Medical Expense (TME) Trends (2019-20)



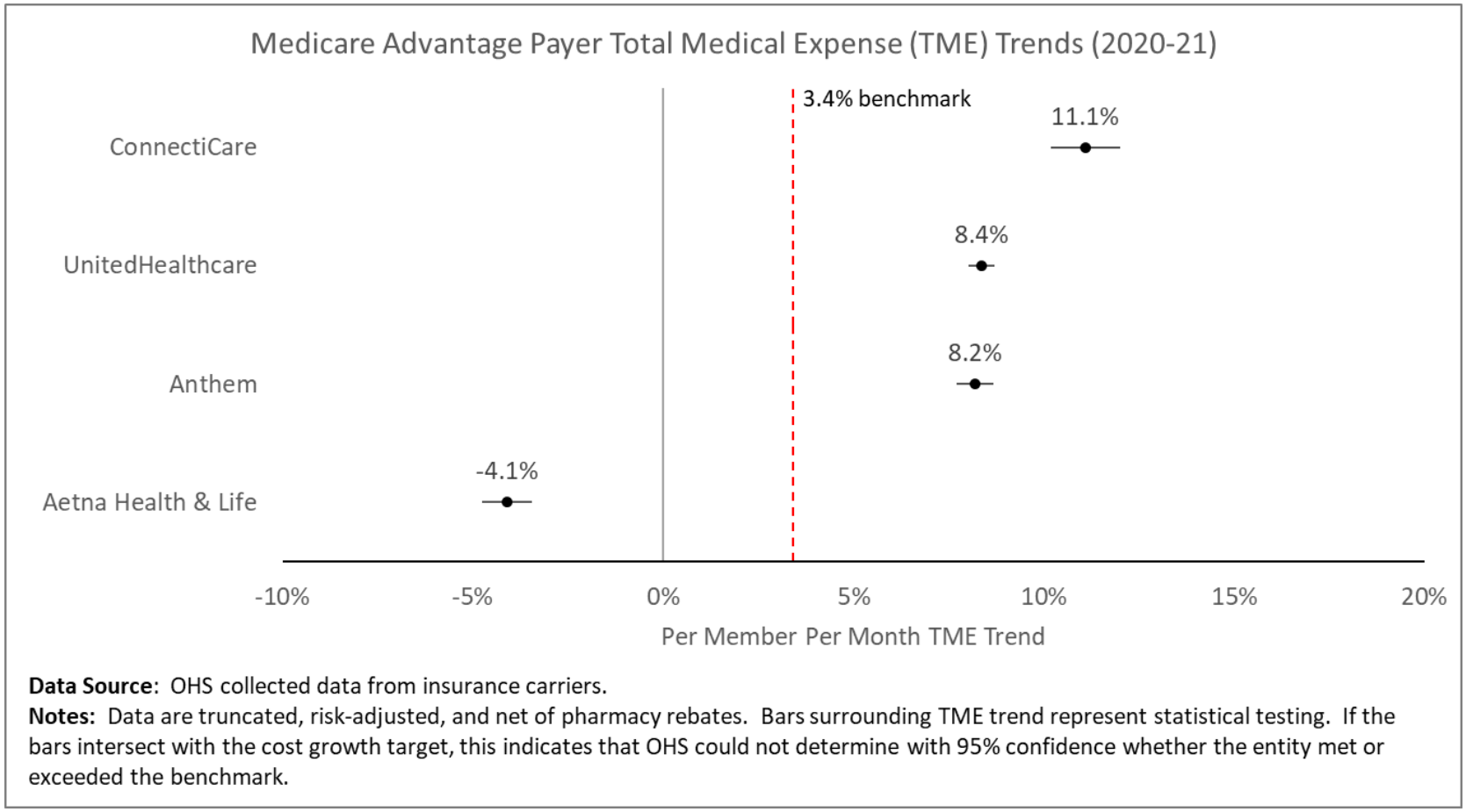
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated, risk-adjusted, and net of pharmacy rebates. Bars surrounding TME trend represent statistical testing.

Figure 12. Commercial Payer Total Medical Expense (TME) Trends (2020-21)



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.

Figure 13. Medicare Advantage Payer Total Medical Expense (TME) Trends (2020-21)

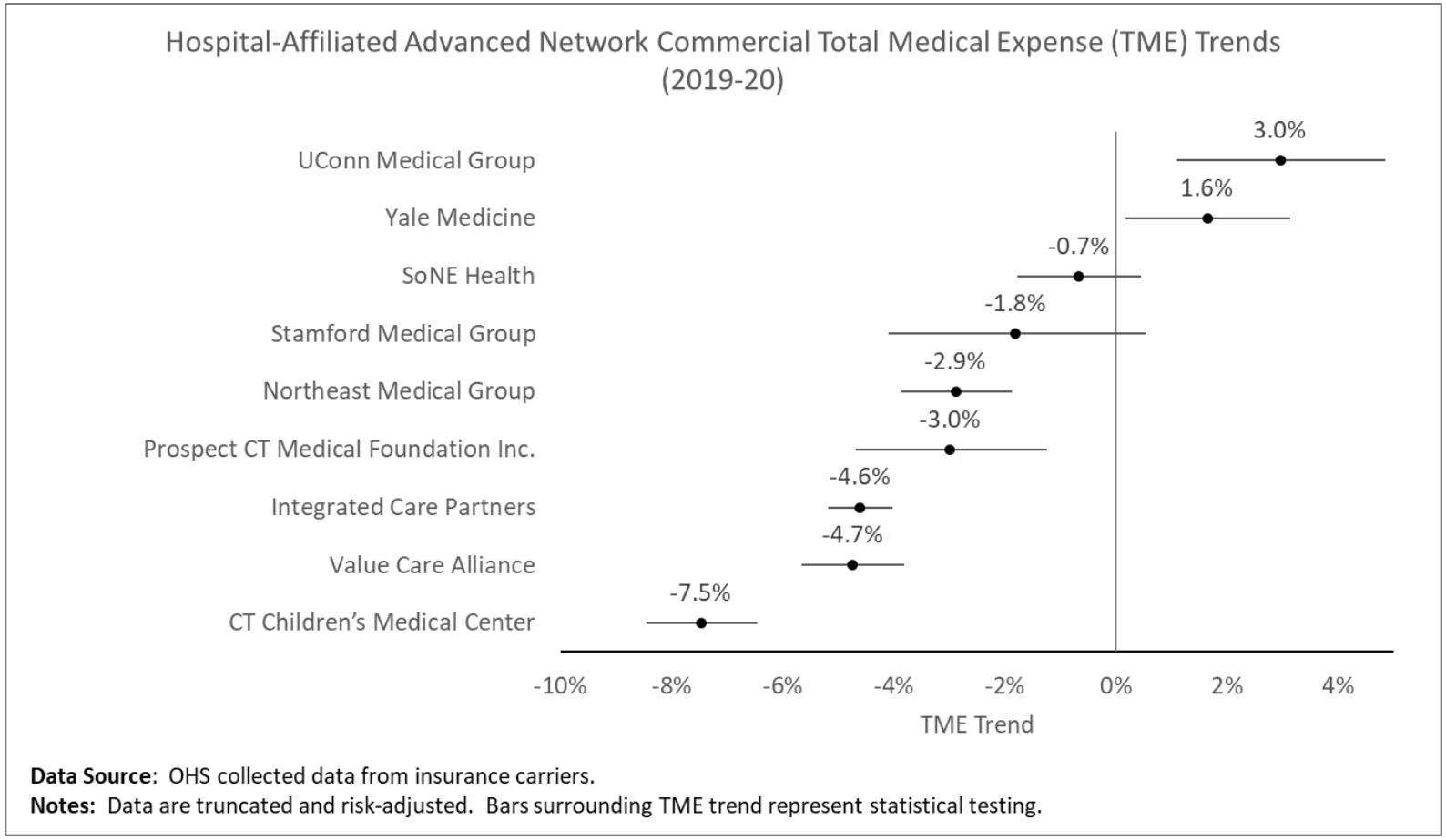


Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated, risk-adjusted, and net of pharmacy rebates. Bars surrounding TME trend represent statistical testing. If the bars intersect with the cost growth target, this indicates that OHS could not determine with 95% confidence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

Appendix C. Advanced Network Total Medical Expense Trends

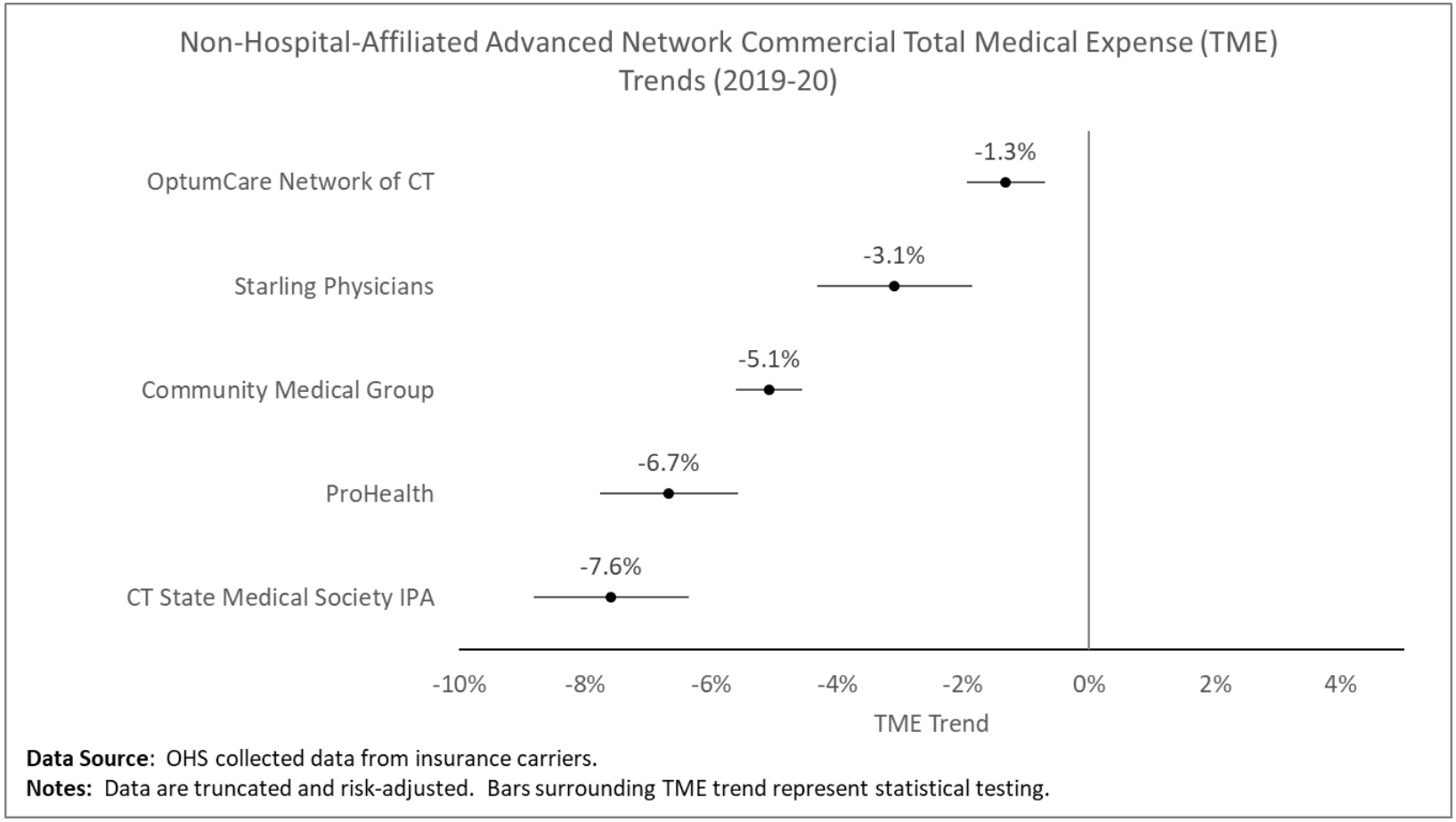
The figures in this section depict Advanced Network cost trends in 2020 and 2021. Each plotted point represents per member per month total medical expense (TME) trend, with the horizontal line through the point (if any) representing the range of values (the "confidence interval") for which we are 95 percent confident actual performance lies. If a confidence interval crosses the benchmark value (the dotted red line), it means we cannot be certain whether the benchmark was or was not met. Advanced Networks not shown in the figures did not meet the minimum attributed lives threshold (60,000 member months) for the market.

Figure 14. Hospital-Affiliated Advanced Network Commercial Total Medical Expense (TME) Trends (2019-20)



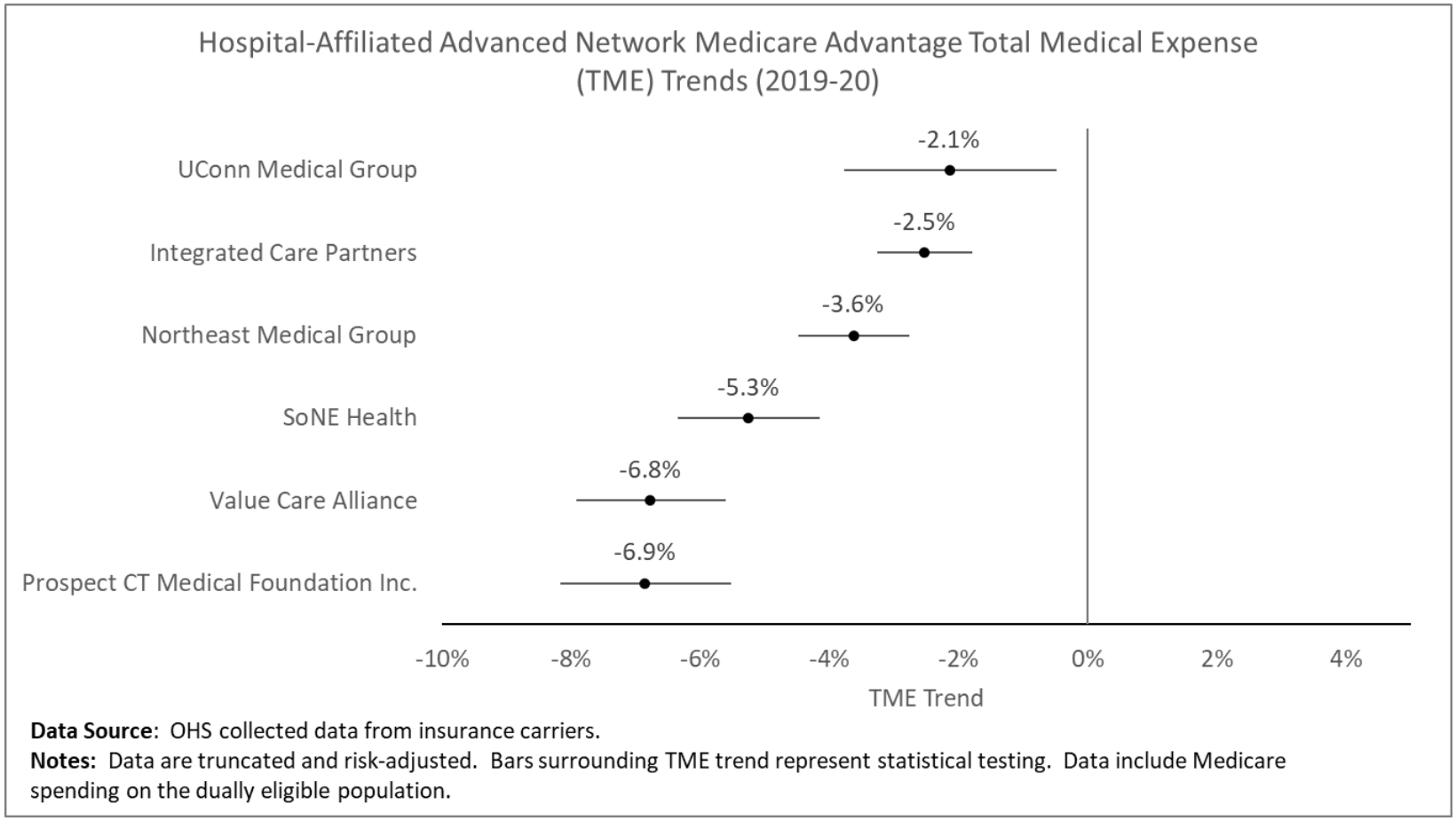
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated and risk-adjusted. Bars surrounding TME trend represent statistical testing.

Figure 15. Non-Hospital-Affiliated Advanced Network Commercial Total Medical Expense (TME) Trends (2019-20)



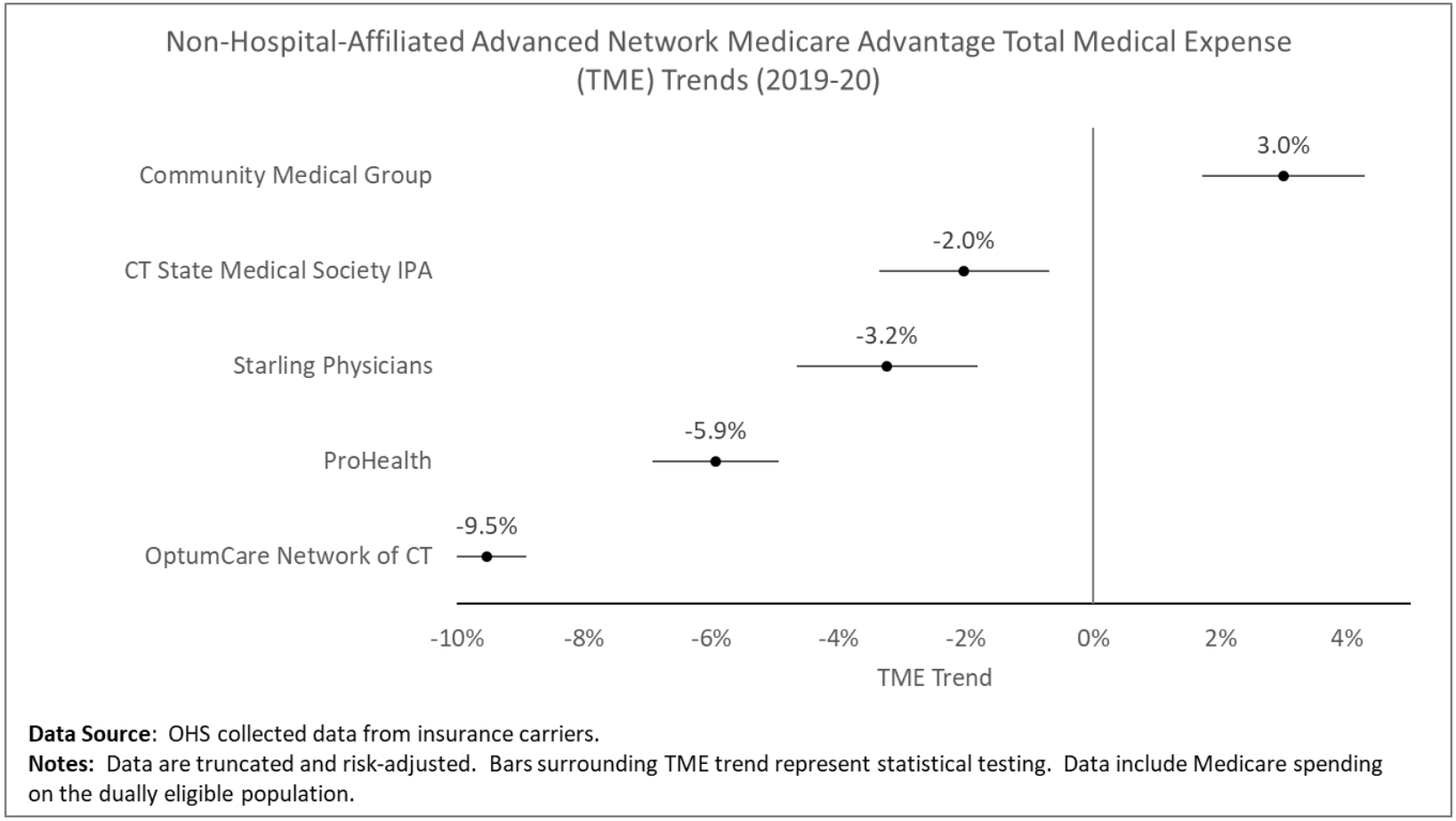
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated and risk-adjusted. Bars surrounding TME trend represent statistical testing.

Figure 16. Hospital-Affiliated Advanced Network Medicare Advantage Total Medical Expense (TME) Trends (2019-20)



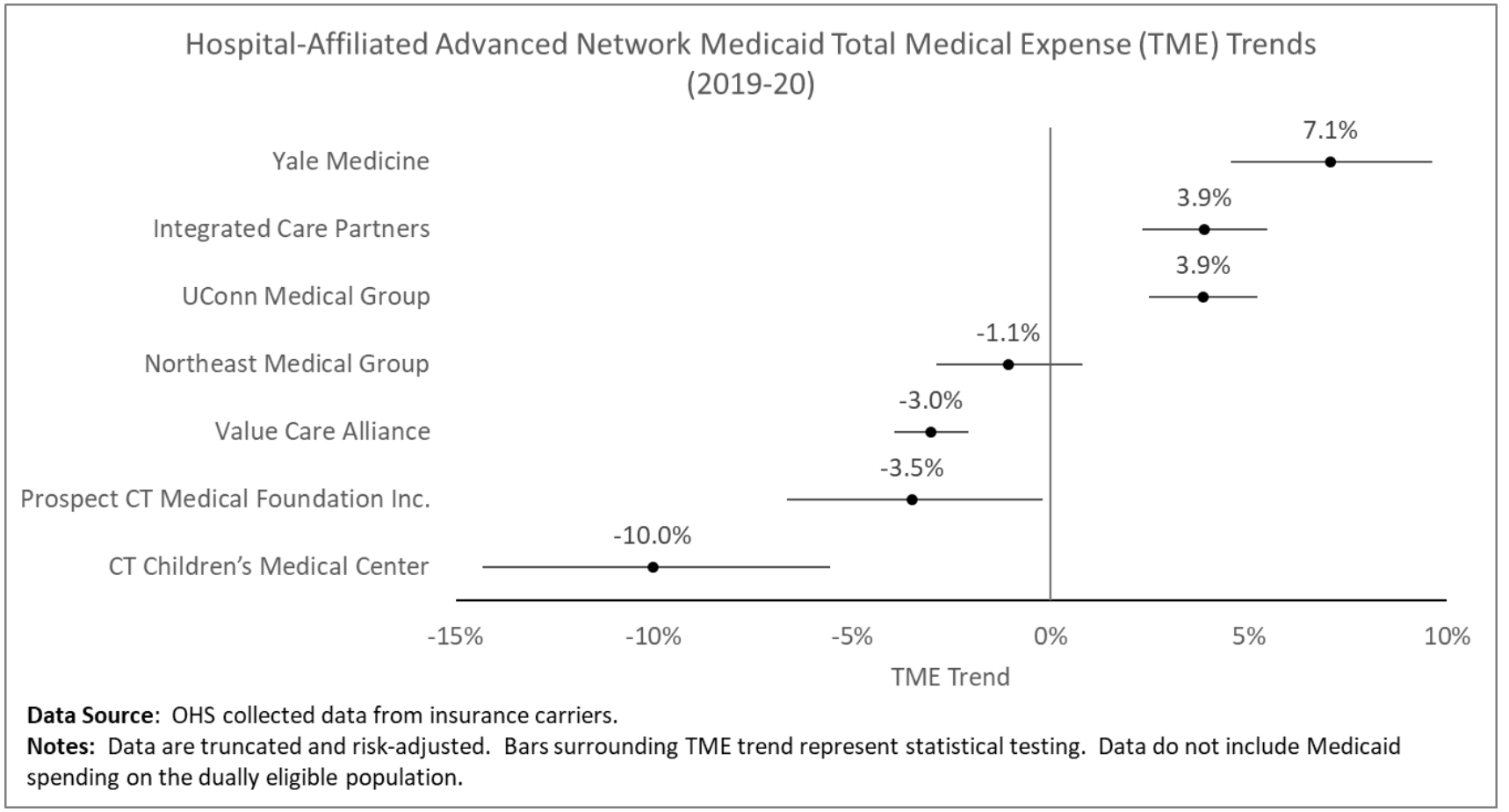
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated and risk-adjusted. Bars surrounding TME trend represent statistical testing. Data include Medicare spending on the dually eligible population.

Figure 17. Non-Hospital-Affiliated Advanced Network Medicare Advantage Total Medical Expense (TME) Trends (2019-20)



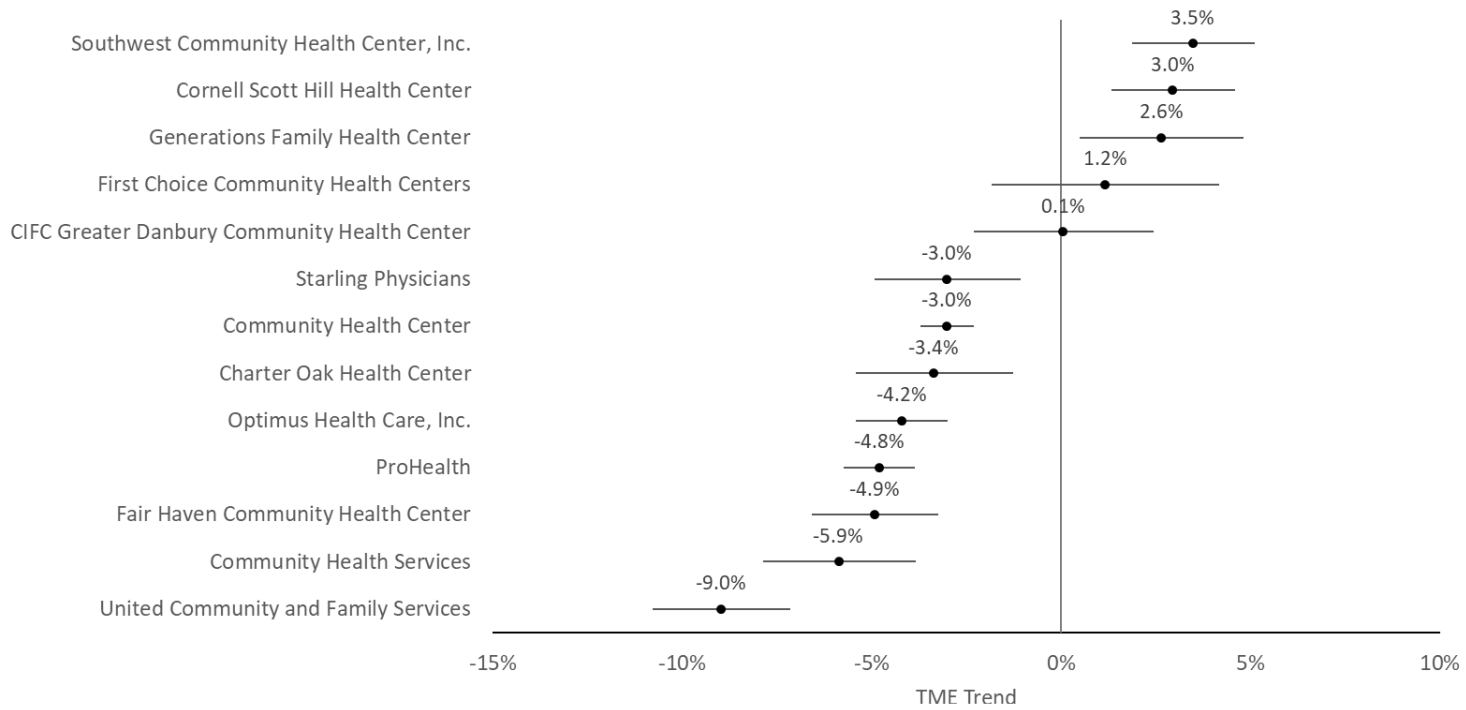
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated and risk-adjusted. Bars surrounding TME trend represent statistical testing. Data include Medicare spending on the dually eligible population.

Figure 18. Hospital-Affiliated Advanced Network Medicaid Total Medical Expense (TME) Trends (2019-20)



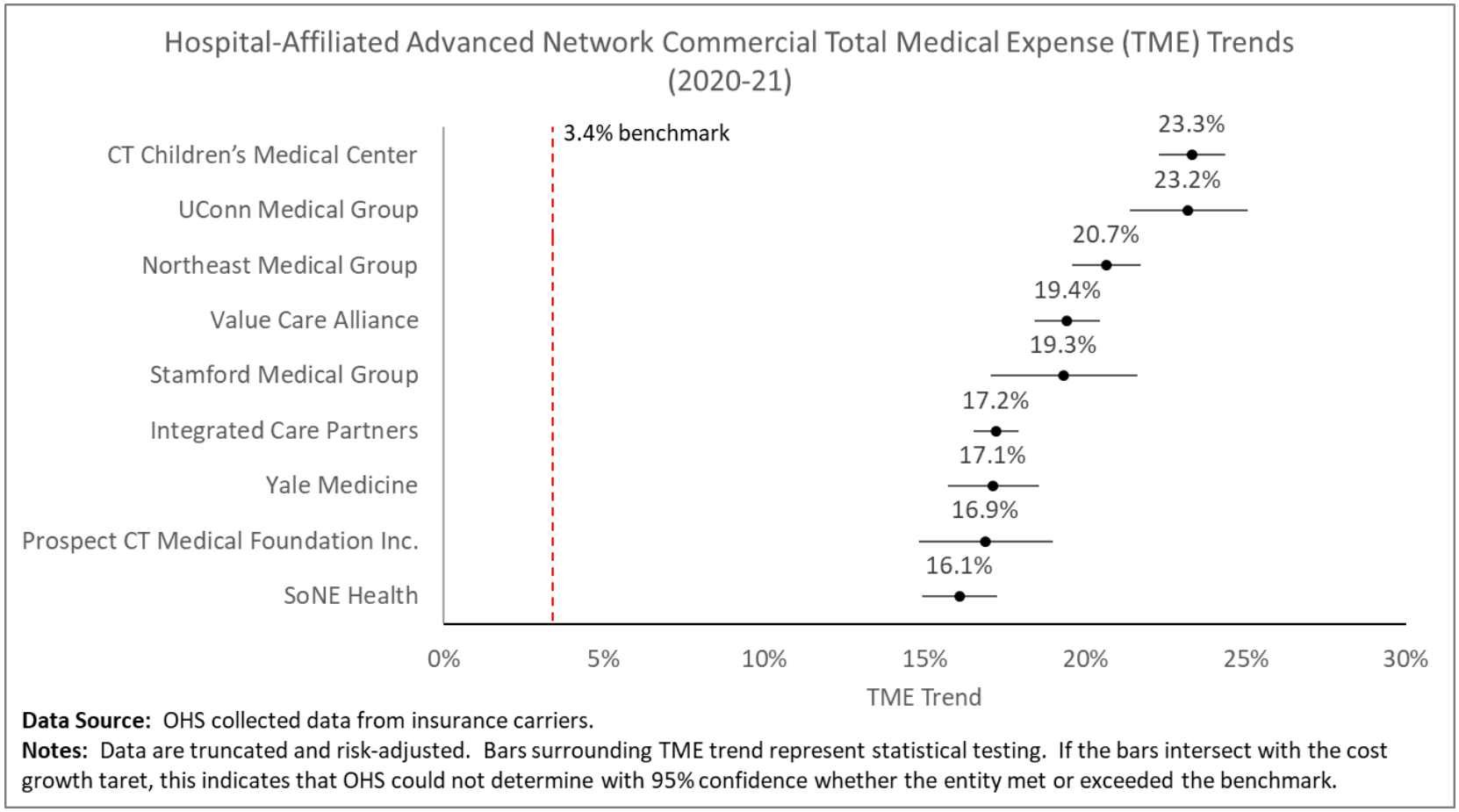
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated and risk-adjusted. Bars surrounding TME trend represent statistical testing. Data do not include Medicaid spending on the dually eligible population.

Figure 19. Non-Hospital-Affiliated Advanced Network Medicaid Total Medical Expense (TME) Trends (2019-20)



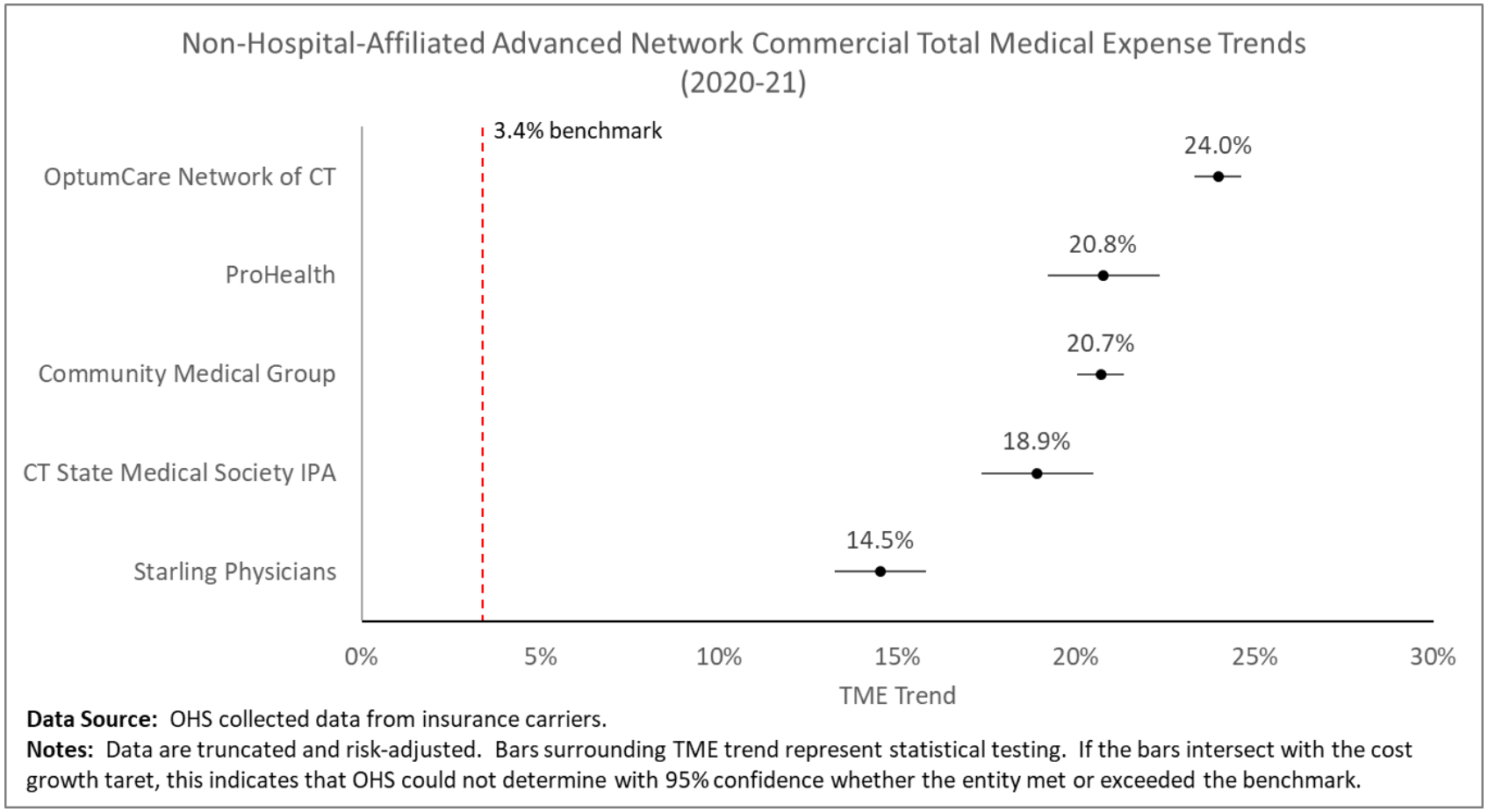
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated and risk-adjusted. Bars surrounding TME trend represent statistical testing. Data do not include Medicaid spending on the dually eligible population.

Figure 20. Hospital-Affiliated Advanced Network Commercial Total Medical Expense (TME) Trends (2020-21)



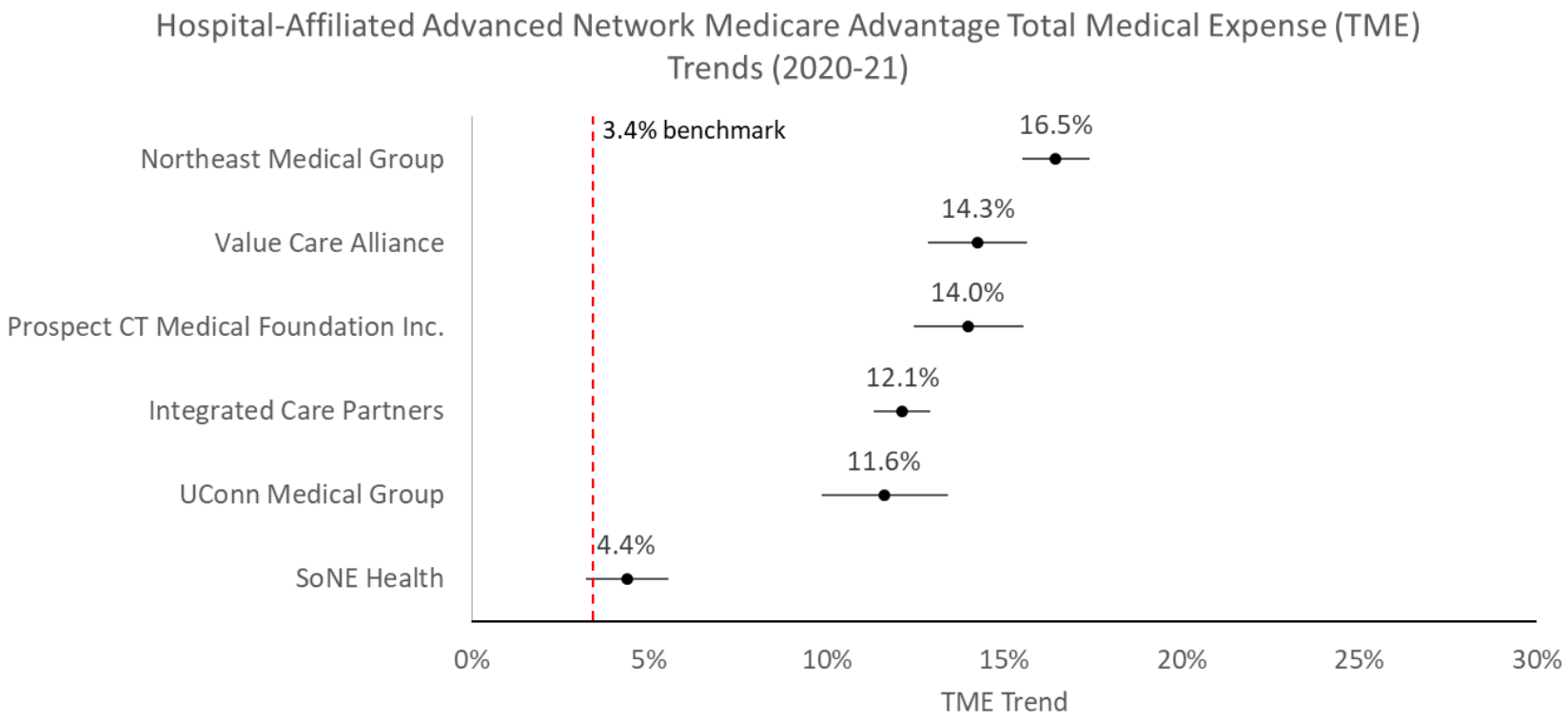
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated and risk-adjusted. Bars surrounding TME trend represent statistical testing. If the bars intersect with the cost growth taret, this indicates that OHS could not determine with 95% confidence whether the entity met or exceeded the benchmark.

Figure 21. Non-Hospital-Affiliated Advanced Network Commercial Total Medical Expense (TME) Trends (2020-21)



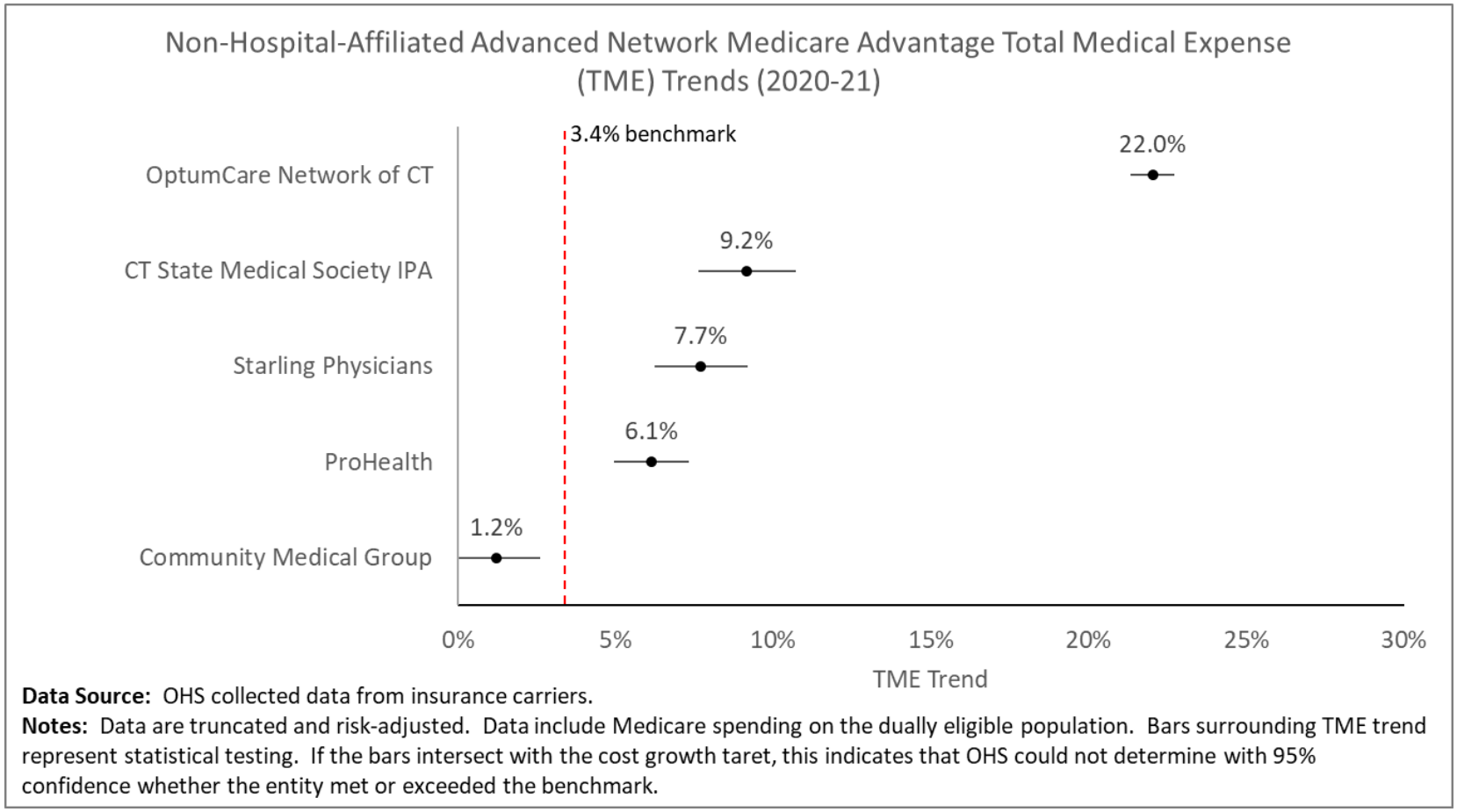
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated and risk-adjusted. Bars surrounding TME trend represent statistical testing. If the bars intersect with the cost growth taret, this indicates that OHS could not determine with 95% confidence whether the entity met or exceeded the benchmark.

Figure 22. Hospital-Affiliated Advanced Network Medicare Advantage Total Medical Expense (TME) Trends (2020-21)



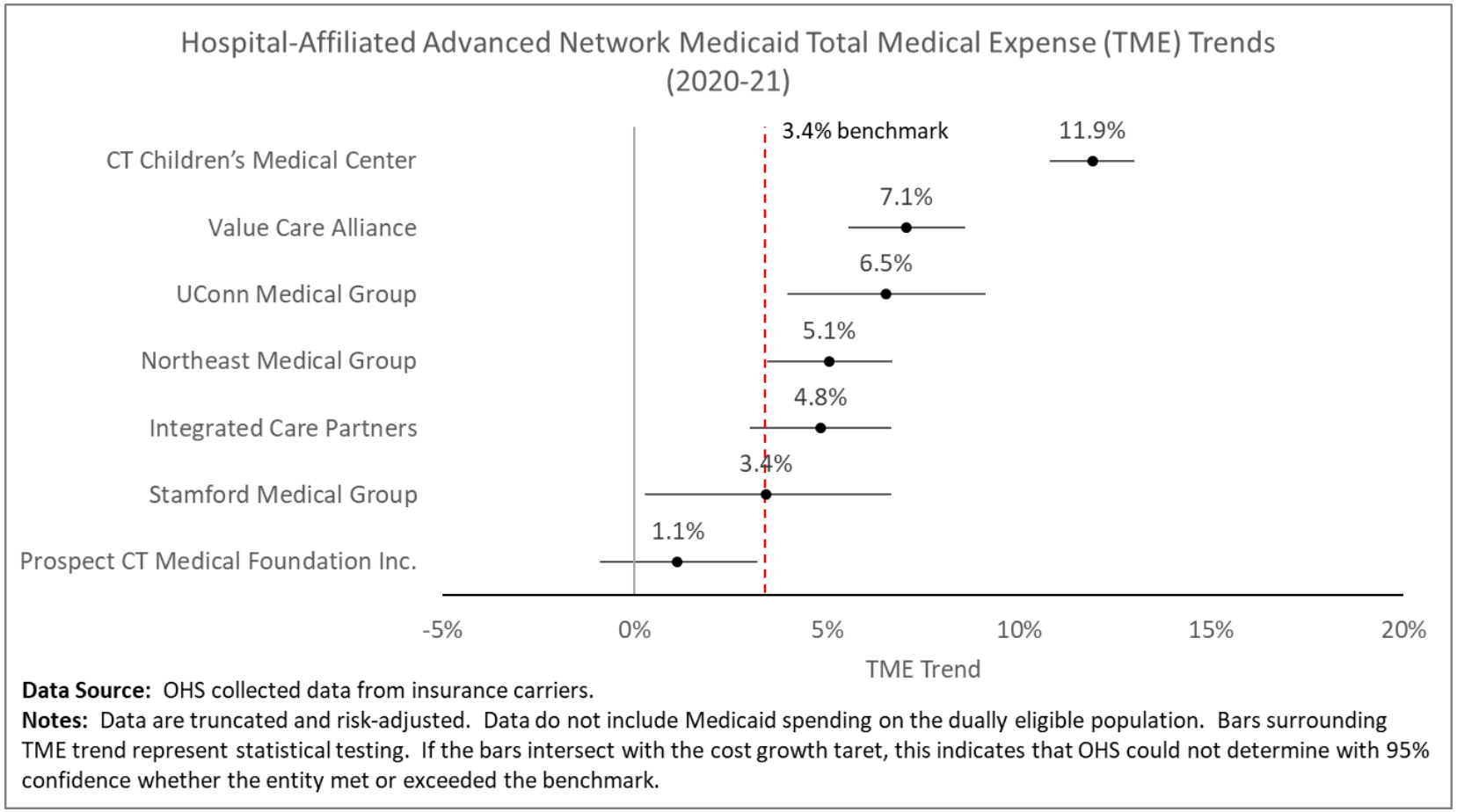
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated and risk-adjusted. Data include Medicare spending on the dually eligible population. Bars surrounding TME trend represent statistical testing. If the bars intersect with the cost growth taret, this indicates that OHS could not determine with 95% confidence whether the entity met or exceeded the benchmark.

Figure 23. Non-Hospital-Affiliated Advanced Network Medicare Advantage Total Medical Expense (TME) Trends (2020-21)



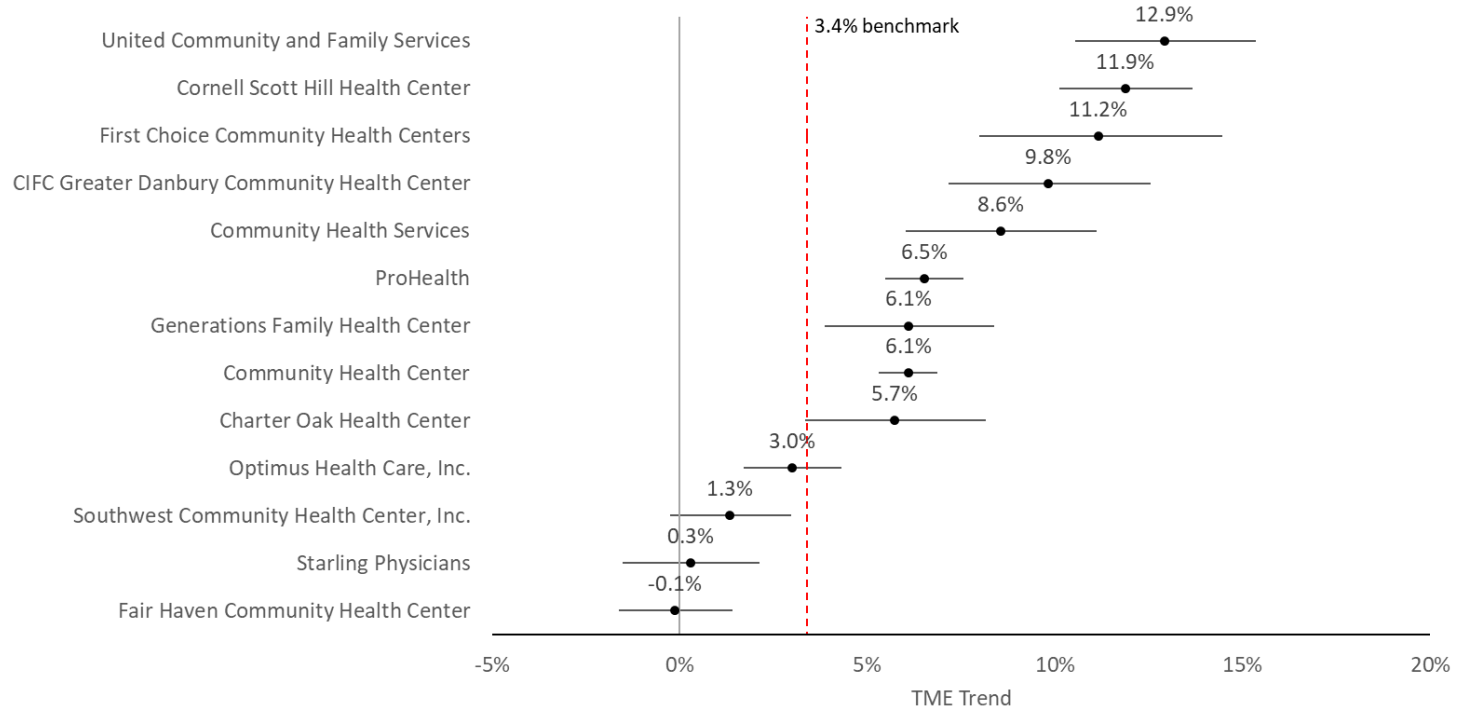
Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated and risk-adjusted. Data include Medicare spending on the dually eligible population. Bars surrounding TME trend represent statistical testing. If the bars intersect with the cost growth taret, this indicates that OHS could not determine with 95% confidence whether the entity met or exceeded the benchmark.

Figure 24. Hospital-Affiliated Advanced Network Medicaid Total Medical Expense (TME) Trends (2020-21)



Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated and risk-adjusted. Data do not include Medicaid spending on the dually eligible population. Bars surrounding TME trend represent statistical testing. If the bars intersect with the cost growth taret, this indicates that OHS could not determine with 95% confidence whether the entity met or exceeded the benchmark.

Figure 25. Non-Hospital-Affiliated Advanced Network Medicaid Total Medical Expense (TME) Trends (2020-21)

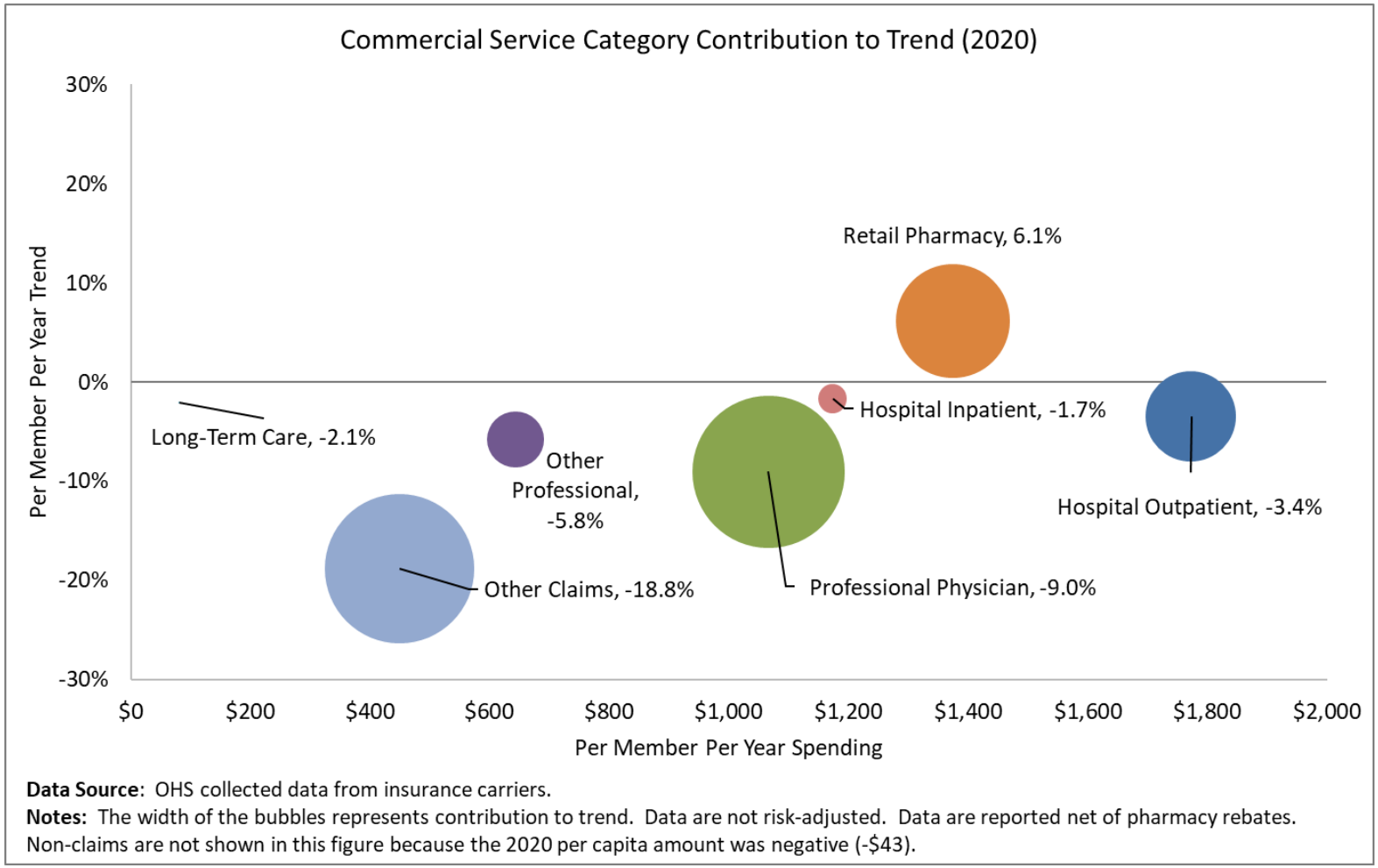


Data Source: OHS collected data from insurance carriers.
Notes: Data are truncated and risk-adjusted. Data do not include Medicaid spending on the dually eligible population. Bars surrounding TME trend represent statistical testing. If the bars intersect with the cost growth taret, this indicates that OHS could not determine with 95% confidence whether the entity met or exceeded the benchmark.

Appendix D. 2020 Trends in Major Service Category Spending

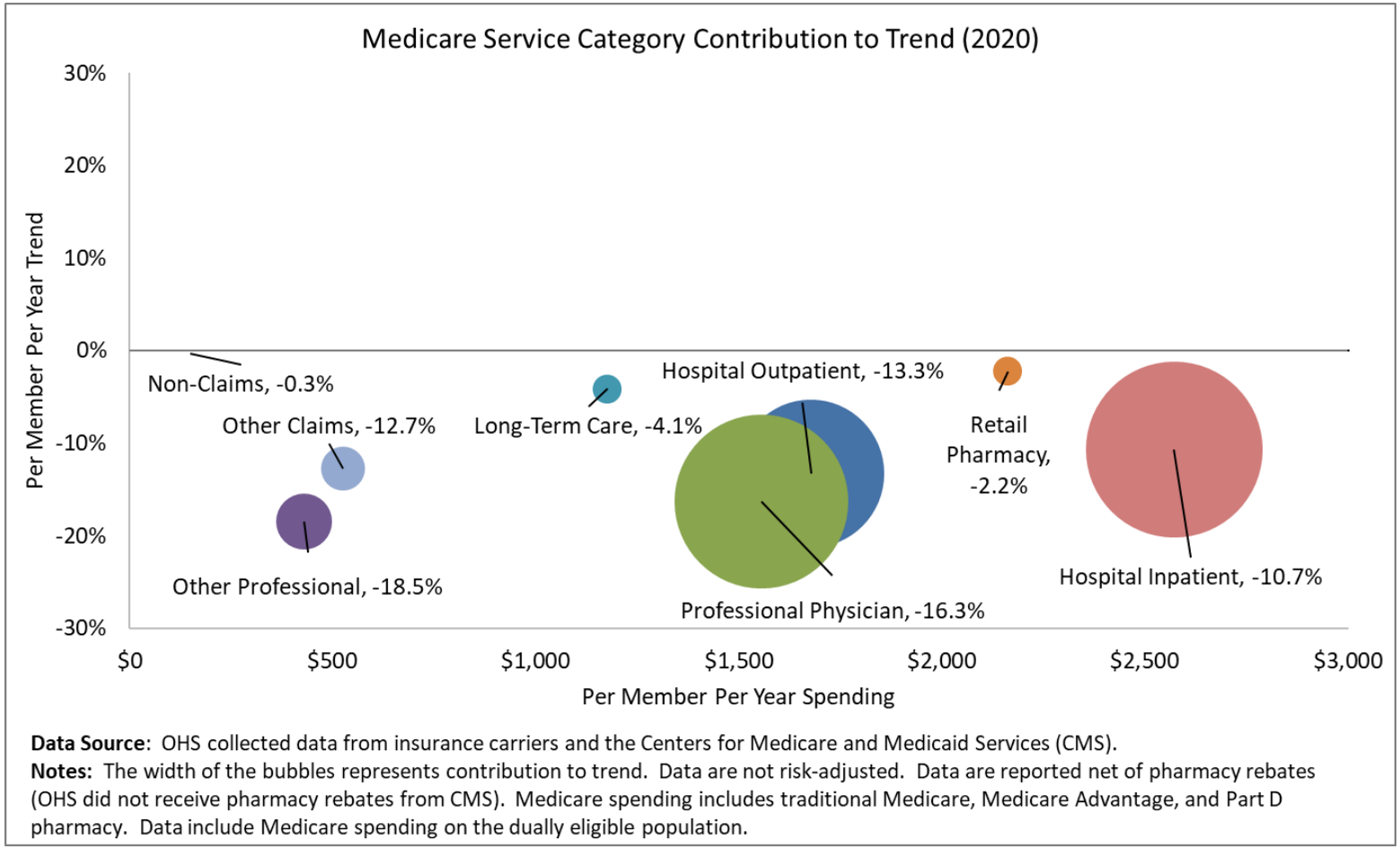
The figures in this section visualize contribution to trend by showing each service category as a bubble, with per person spending on the x axis and trend in per person spending on the y axis. The width of the bubble represents how much the service category contributed to the market's overall cost trend (i.e., the larger the bubble, the more the service category contributed to cost growth).

Figure 26. Commercial Service Category Contribution to Trend (2020)



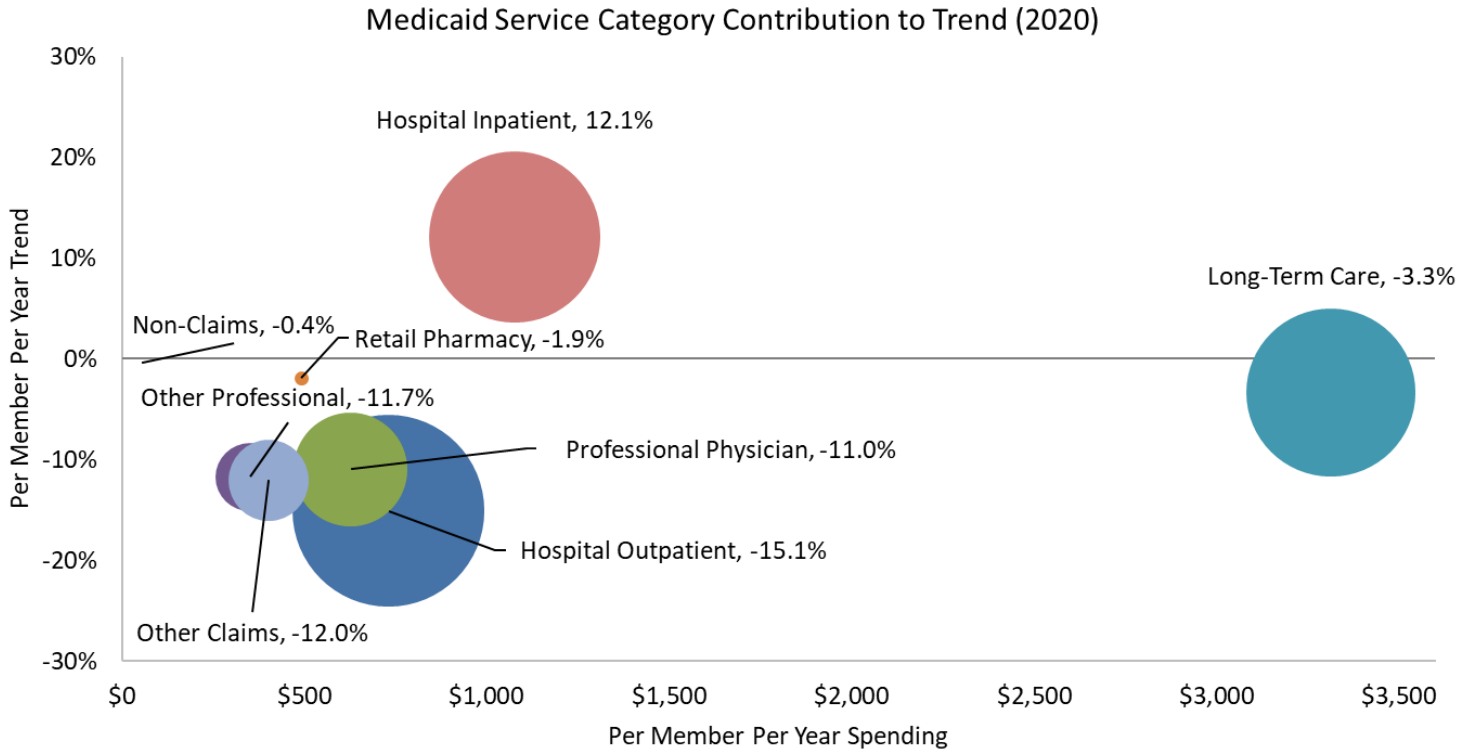
Data Source: OHS collected data from insurance carriers.
Notes: The width of the bubbles represents contribution to trend. Data are not risk-adjusted. Data are reported net of pharmacy rebates. Non-claims are not shown in this figure because the 2020 per capita amount was negative (-$43).

Figure 27. Medicare Service Category Contribution to Trend (2020)



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.

Figure 28. Medicaid Service Category Contributon to Trend (2020)



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.

Appendix E. Cost Growth Benchmark Stakeholder Advisory Board Members

More information can be found at: https://portal.ct.gov/OHS/Pages/Cost-Growth-Benchmark-Stakeholder-Advisory-Board.

Members as of June 9, 2022: (last meeting of the Stakeholder Advisory Board):

- Kelly Sinko Steuber, Director of Healthcare Innovation, Office of Health Strategy
- Reginald Eadie, President, Chief Executive Officer, Trinity Health of New England
- Theresa Riordan, Vice President, Provider Engagement, Anthem Blue Cross & Blue Shield of CT
- Richard Searles, Managing Director, Merritt Healthcare Solutions
- Marie Smith, PharmD, UConn School of Pharmacy
- Tekisha Everette, Executive Director, Health Equity Solutions
- Pareesa Charmchi Goodwin, Executive Director, Connecticut Oral Health Initiative
- Howard Forman, Professor of Diagnostic Radiology, Public Health Management, and Economics, Yale University
- Fiona Mohring, Director, Health & Group Benefits, Stanley Black & Decker
- Lori Pasqualini, Chief Financial & Administrative Officer, Ability Beyond
- Sal Luciano, President, Connecticut AFL-CIO
- Jill Zorn, Senior Policy Officer, Universal Health Care Foundation of Connecticut
- Hector Glynn, The Village for Families and Children
- Rick Melita, Director, Service Employees International Union Connecticut State Council
- Jonathan Gonzalez-Cruz, Patient Rep
- Susan Millerick, Patient Rep
- Kristen Whitney-Daniels, Patient Rep
- Rebecca Andrews, Professor of Medicine, UCONN Health
- Luis Perez, President & CEO, Mental Health Connecticut
- Angela Harris, Chair, Phillips Health Ministry

Appendix F. Cost Growth Benchmark Technical Team Members

More information can be found at: https://portal.ct.gov/OHS/Pages/Cost-Growth-Benchmark-Technical-Team.

Members as of June 29, 2021 (last meeting of the Technical Team):

Appointments

- Victoria Veltri, JD, LLM, Executive Director, Office of Health Strategy
- Angela Harris, Chair, Phillips Health Ministry, Phillips Metropolitan CME Church
- Luis B. Pérez, LCSW, President and CEO, Mental Health Connecticut, Inc.
- Paul Grady, Connecticut Business Group on Health, c/o Alera Group
- Patricia Baker, President and CEO, Connecticut Health Foundation
- Zack Cooper, Ph.D., MSc, Associate Professor of Public Health and Economics, Yale University

Designated

- Melissa McCaw, MPA, Secretary, State of Connecticut (Designee: Judy Dowd)
- Deidre Gifford, MD, MPH, Commissioner, Department of Social Services (Designee: Kate McEvoy, Esq.)
- Paul Lombardo, A.S.A., M.A.A.A., Director, Life & Health Division, Connecticut Insurance Department
- Rae-Ellen Roy, Assistant Director of the Health Policy and Benefits Division, Office of the State Comptroller
- Rebecca Andrews, MD FACP, American College of Physicians Connecticut Chapter Governor

Appendix G. Healthcare Benchmark Initiative Steering Committee Members

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

Members as of March 31, 2023:

- Timothy Archer, CEO, United Healthcare of New England
- Joanne Borduas, CEO Community Health and Wellness Center Torrington
- Ayesha Clarke, Interim Executive Director, Health Equity Solutions (HES)
- Stephanye Clarke, Program Officer, Community Foundation of Eastern CT
- Tiffany Donelson, President and Chief Executive Officer, CT Health Foundation
- Ted Doolittle, Healthcare Advocate, Office of the Healthcare Advocate
- Judy Dowd, Health and Human Services Section Director, Office of Policy and Management
- Jeff Flaks, President & Chief Executive Officer, Hartford Healthcare
- Lou Gianquinto, President, Anthem BCBCS of CT
- Deidre Gifford, Executive Director, CT Office of Healthcare Strategy
- Jonathan Gonzalez-Cruz, Consumer Representative
- Paul Grady, Principal of Alera Group, Connecticut Moving to Value Alliance (MTVA)
- Angela Harris. Chair, Phillips Health Ministry
- Paul Lombardo, Director, Life & Health Division, Connecticut Insurance Department
- Andy Markowski, Connecticut State Director, National Federation of Independent Business
- Christine Marsh, Vice President, Market Access, Boehringer Ingelheim Pharmaceuticals
- Susan Millerick, Patient Representative
- Fiona Scott Morton, Theodore Nierenberg Professor of Economics, Yale University School of Management
- Cassandra Murphy, Executive Director, CT Coalition of Taft-Hartley Health Funds
- Chris O'Connor, President, Yale New Haven Health
- 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
- 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, Connecticut Office of the State Comptroller
- Gui Woolston, Medicaid Director, CT Department of Social Services