Presentation Agenda

1. Review what we know about healthcare cost growth in Connecticut’s commercial market
   
   Michael Bailit, President
   Bailit Health

2. Consider findings from an analysis of hospital costs by the National Academy of State Health Policy

   Marilyn Bartlett, Senior Policy Fellow,
   National Academy for State Health Policy (NASHP)
Cost Growth in the Commercial Market

Where has spending been growing fastest?
Cost Growth in the Commercial Market

• The Office of Health Strategy (OHS) employs two data sources to understand healthcare spending patterns in the state.
  ▫ CT All-Payer Claims Database (APCD)
  ▫ Cost Growth Benchmark payer submissions

• Our analysis today will primarily rely upon APCD analysis. Let’s briefly review the differences between these data sources.
Cost Growth Benchmark Analysis vs. APCD Analysis

**Benchmark Analysis**

- **What is this?** A calculation of healthcare cost growth over a given time period using payer-collected aggregate data.

  - **Data Type:** Aggregate data that allow assessment at four levels: 1) provider level, 2) insurer level, 3) market level, and 4) statewide.

  - **Data Source:** Insurers and public payers

- **What’s missing?** Claim-level detail to drill down into cost drivers

**APCD Analysis**

- **What is this?** A study of cost drivers to help identify promising opportunities for reducing cost growth and inform policy decisions.

  - **Data Type:** Granular data (claims and/or encounters)

  - **Data Source:** All-Payer Claims Database (APCD)

- **What’s missing?** Most self-insured commercial claims, non-claims payments, drug rebates from drug manufacturers, insurer administration costs and profit

How will we determine the level of cost growth from one year to the next relative to the benchmark? How will we determine the drivers of overall cost and cost growth? Where are there opportunities to contain spending?
Cost Growth Benchmark Baseline Analysis: Per Capita Medical Expenditures Grew Fastest in CT’s Commercial Market

Per Capita Growth in Total Healthcare Expenditures (THCE) and Total Medical Expense (TME) in Connecticut Insurance Markets, 2018-2019

Source: Commercial insurers and public payers reporting to OHS for the Healthcare Cost Growth Benchmark Program
Cost Growth Benchmark Baseline Analysis: Hospital Inpatient and Outpatient, and Retail Pharmacy Spending Drove Overall per Capita Spending Growth in Most Markets

Top Three Drivers of State and Market Cost Growth, 2018-2019

Source: Commercial insurers and public payers reporting to OHS for the Healthcare Cost Growth Benchmark Program
Cost Growth in the Commercial Market

• The data we will review today comes from the CT APCD.

• These APCD analyses confirm that commercial market healthcare spending growth has been high Connecticut. This is where affordability is most problematic for state residents.
Healthcare remains unaffordable to many...

Since 2000, Connecticut employer-sponsored insurance premiums have grown almost two and half times faster than personal income.

Affordability for Connecticut Residents with Commercial Coverage

A 2022 survey of residents found the following:

• **51%** of people with commercial coverage *went without care due to cost* in the prior 12 months
  ▫ **26%** did not fill a prescription, cut pills in half, or skipped doses due to cost

• Affordability was even more problematic for commercially insured residents with a disability and residents of color. % of respondents who *went without care due to cost*:
  ▫ **67%** of residents in a households with a person with a disability
  ▫ **57%** of Black residents
  ▫ **55%** of Hispanic residents

Source: Altarum Healthcare Value Hub, October 2022
Cost Growth in the Commercial Market

• The data we will review today track spending through 2021 for the commercial market.

• The analysis will look at trends and patterns in:
  1. Per member per month (PMPM) spending
  2. The relative roles of changes in payment rates and utilization
What did prior APCD analysis of 2015-19 cost growth in the commercial market tell us?

1. Hospital (inpatient and outpatient) and retail pharmacy accounted for 80% of spending growth.

2. For both hospital and pharmacy spending, growth was due to increased payment per service. Utilization had declined.

3. Brand name drugs were responsible for pharmacy spending growth.

4. Some hospitals benefited from much higher rates of service unit payment growth than did others.
Study Population

- Connecticut residents, 2017-2021
- Commercial (fully insured, and State employees and retirees)
  - Self-insured not included
- Exclusions
  - Non-Connecticut residents
  - Secondary payers
  - Denied, reversed, and non-primary claim lines
  - Claim lines with negative payment or cost-sharing
  - Payments made six months or longer after the service year
- **Reminder**: non-claims-based payments and pharmacy rebates are not in the APCD
Per Member Per Month (PMPM) Spending
Medical spending declined slightly in 2020 before sharply rising by 24% in 2021.

- The average annual increase of 6.9% compares to median annual household income growth of 2.7% for the same time period. That’s 2.5 times faster.
- The 2021 increase exceeds preliminary rates of increase observed in some other New England states.
Retail pharmacy spending growth was lower than medical’s but higher than income growth

<table>
<thead>
<tr>
<th>Payer</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>Average annual change (%)</th>
<th>2020 – 2021 change (%)</th>
<th>Total change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-payer</td>
<td>$110.28</td>
<td>$112.52</td>
<td>$112.92</td>
<td>$115.61</td>
<td>$129.83</td>
<td>4.3%</td>
<td>12.3%</td>
<td>17.7%</td>
</tr>
<tr>
<td>Aetna</td>
<td>$121.47</td>
<td>$128.16</td>
<td>$117.74</td>
<td>$110.18</td>
<td>$110.79</td>
<td>-2.1%</td>
<td>0.6%</td>
<td>-8.8%</td>
</tr>
<tr>
<td>Anthem</td>
<td>$144.23</td>
<td>$151.07</td>
<td>$167.31</td>
<td>$167.43</td>
<td>$188.33</td>
<td>7.0%</td>
<td>12.5%</td>
<td>30.6%</td>
</tr>
<tr>
<td>Cigna</td>
<td>$100.48</td>
<td>$108.75</td>
<td>$115.80</td>
<td>$133.11</td>
<td>$160.98</td>
<td>12.6%</td>
<td>20.9%</td>
<td>60.2%</td>
</tr>
<tr>
<td>ConnectiCare</td>
<td>$108.24</td>
<td>$124.39</td>
<td>$131.65</td>
<td>$134.81</td>
<td>$162.48</td>
<td>10.9%</td>
<td>20.5%</td>
<td>50.1%</td>
</tr>
<tr>
<td>Express Scripts</td>
<td>$81.32</td>
<td>$75.85</td>
<td>$75.70</td>
<td>$79.15</td>
<td>$90.13</td>
<td>2.9%</td>
<td>13.9%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Harvard Pilgrim</td>
<td>$92.24</td>
<td>$101.96</td>
<td>$120.62</td>
<td>$135.52</td>
<td>$153.33</td>
<td>13.6%</td>
<td>13.1%</td>
<td>66.2%</td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>$95.21</td>
<td>$99.51</td>
<td>$107.62</td>
<td>$128.27</td>
<td>$138.49</td>
<td>10.0%</td>
<td>8.0%</td>
<td>45.5%</td>
</tr>
</tbody>
</table>

- The average annual increase of **4.3%** compares to median annual household income growth of **2.7%** for the same time period. That’s 1.6 times faster.
- The 2021 increase exceeds preliminary rates of increase observed in some other New England states.
- Note: People with Express Scripts Rx coverage have medical coverage with another payer.
Hospital spending continues to consume a growing share of spending

<table>
<thead>
<tr>
<th>Payer</th>
<th>Percentage of Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017</td>
</tr>
<tr>
<td>Total PMPM</td>
<td>$520.85</td>
</tr>
<tr>
<td>Inpatient</td>
<td>16.6%</td>
</tr>
<tr>
<td>Outpatient*</td>
<td>26.8%</td>
</tr>
<tr>
<td><strong>Outpatient hospital</strong></td>
<td>25.1%</td>
</tr>
<tr>
<td>Outpatient ASC</td>
<td>1.6%</td>
</tr>
<tr>
<td>Professional</td>
<td>32.5%</td>
</tr>
<tr>
<td>Retail Pharmacy**</td>
<td>21.2%</td>
</tr>
<tr>
<td>Other***</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

* Outpatient includes outpatient hospital and ambulatory surgical center (ASC) spending.
** Retail pharmacy includes all members with pharmacy coverage, with or without medical coverage.
*** “Other” services include DME, home health, hospice, ICF and SNF claims.
PMPM spending fell in 2020 due to the pandemic, then increased dramatically in 2021.

* "Other" services include DME, home health, hospice, ICF and SNF claims.
** Retail pharmacy includes all members with pharmacy coverage, with or without medical coverage.
*** Medical pharmacy PMPM amounts are subtracted from respective medical service categories.
Utilization vs. Payment Rates
Payment per medical service rose while utilization dropped, 2017-19. In 2021, utilization rebounded while payment per service declined.

Retail pharmacy payments per script rose despite decreasing utilization through 2020, and outpaced an increase in utilization in 2021.

Spending = PMPM; Average price = Spending per prescription; Utilization = prescriptions per member month
Inpatient hospital and emergency department payment per service increased each year, while utilization dropped significantly.

Emergency department visits include both outpatient and professional spending.

Spending = PMPM; Average price = Spending per prescription; Utilization = prescriptions per member month.
Outpatient hospital payment per service fell in 2020 and 2021 after increases from 2015-2019, while utilization grew after years of declines.

Outpatient ambulatory surgical center payment increases outpaced changes in utilization.

Spending = PMPM; Average price = Spending per prescription; Utilization = prescriptions per member month.
From 2017-20, payment per professional service grew at a modest pace; utilization was steady, dropped in 2020 and then rebounded in 2021.
Brand-name prescription drugs payment per script rose as use fell through 2019, reversed trends in 2020 and shows signs of reverting to pre-COVID trends in 2021.

For generic prescription drugs, utilization, spending, and payment/prescription all declined slightly.

Spending = PMPM; Average price = Spending per prescription; Utilization = prescriptions per member month.
### Retail Pharmacy is the Majority of Pharmacy Spending

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Percentage of Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>28.4%</td>
</tr>
<tr>
<td>Retail*</td>
<td>21.2%</td>
</tr>
<tr>
<td>Medical**</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

*“Retail pharmacy” refers to prescription drugs purchased in retail pharmacies.

**“Medical pharmacy” refers to drugs administered by clinicians, typically in physician offices or hospital outpatient departments.
The top 10 medical pharmacy drugs were only 3% of all prescriptions but 44% of all spending in 2019.
The top 10 drugs for medical pharmacy spending in 2019 were drugs primarily used to treat cancer, Crohn’s disease, and multiple sclerosis.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indication</th>
<th>Allowed Amount</th>
<th>Distinct Users</th>
<th># of Claims</th>
<th>Price (Allowed / # Claims)</th>
</tr>
</thead>
<tbody>
<tr>
<td>INJECTION OCRELIZUMAB 1 MG</td>
<td>Multiple Sclerosis</td>
<td>$37,866,205</td>
<td>690</td>
<td>774</td>
<td>$48,922.75</td>
</tr>
<tr>
<td>INJ INFLIXIMAB EXCL BIOSIMILR 10 MG</td>
<td>Rheumatoid Arthritis, Psoriasis, Crohn's disease, Ulcerative colitis</td>
<td>$35,080,751</td>
<td>5,944</td>
<td>7,607</td>
<td>$4,611.64</td>
</tr>
<tr>
<td>INJ TRASTUZUMAB EXCLD BIOSIM 10 MG</td>
<td>Cancer (breast, stomach)</td>
<td>$21,272,959</td>
<td>1,563</td>
<td>3,613</td>
<td>$5,887.89</td>
</tr>
<tr>
<td>INJECTION PEMBROLIZUMAB 1 MG</td>
<td>Cancer (melanoma, lung, bladder)</td>
<td>$18,750,009</td>
<td>808</td>
<td>1,095</td>
<td>$17,123.30</td>
</tr>
<tr>
<td>INJECTION RITUXIMAB 10 MG</td>
<td>Cancer, autoimmune disease</td>
<td>$18,642,495</td>
<td>929</td>
<td>1,573</td>
<td>$11,851.55</td>
</tr>
<tr>
<td>INJECTION PEGFILGRASTIM 6 MG</td>
<td>Cancer treatment side effect</td>
<td>$17,266,445</td>
<td>1,449</td>
<td>2,017</td>
<td>$8,560.46</td>
</tr>
<tr>
<td>INJECTION VEDOLIZUMAB 1 MG</td>
<td>Crohn's disease, Ulcerative colitis</td>
<td>$16,938,383</td>
<td>2,199</td>
<td>2,375</td>
<td>$7,131.95</td>
</tr>
<tr>
<td>INJECTION BEVACIZUMAB 10 MG</td>
<td>Cancer (colon, lung, brain, cervical, renal, ovarian)</td>
<td>$13,335,447</td>
<td>1,937</td>
<td>3,200</td>
<td>$4,167.33</td>
</tr>
<tr>
<td>INJECTION PERTUZUMAB 1 MG</td>
<td>Cancer (breast)</td>
<td>$12,441,323</td>
<td>849</td>
<td>1,184</td>
<td>$10,507.87</td>
</tr>
<tr>
<td>INJECTION NATALIZUMAB 1 MG</td>
<td>Multiple Sclerosis, Crohn’s disease</td>
<td>$10,820,739</td>
<td>1,313</td>
<td>1,477</td>
<td>$7,326.16</td>
</tr>
</tbody>
</table>
Key Takeaways

• Commercial spending growth continues to far exceed CT residents’ income growth; higher and higher percentages of residents’ income go to paying for healthcare.

• As expected, spending patterns in 2020 and 2021 were heavily impacted by the pandemic.
  ▫ Utilization dropped significantly in 2020, and then grew dramatically in 2021.
  ▫ Payment per service continued to grow, except for hospital outpatient in 2020 and 2021, and prescription drugs in 2021.
    • The 2021 hospital outpatient trend in payment per service and utilization warrant further analysis.
At what point are Connecticut hospitals at a financial breakeven point? How do they compare to hospitals in other states?

Marilyn Bartlett, Senior Policy Fellow, National Academy for State Health Policy (NASHP)
NASHP Cost Tool Analysis

• In 2021 OHS asked the National Academy of State Health Policy (NASHP) to conduct an analysis of Connecticut hospital finances using NASHP’s new Hospital Cost Tool.

• NASHP presented its findings to the Health Care Cabinet during the Cabinet’s March 2022 meeting.
What is NASHP’s Hospital Cost Tool?

- A downloadable tool health purchasers, including state officials, can use to better understand and address hospital costs
  - For example, the tool can help inform hospital rate negotiations or demonstrate hospital finances pre- and post-merger/acquisition
- The tool identifies costs using data that hospitals report annually to the federal government
  - Each hospital that serves Medicare patients must annually submit, and verify the accuracy of, a Medicare Cost Report (MCR) to the Centers for Medicare & Medicaid Services (CMS)
  - MCRs provide hospital level data and are the only national, public source of hospital costs
- The Hospital Cost Tool was developed by the National Academy for State Health Policy (NASHP) alongside Rice University, with support from Arnold Ventures
Breakeven Analysis

- **NASHP’s Hospital Cost Tool** calculates a hospital’s breakeven point: Revenue = Expenses
  - Revenue includes payments from all sources. Expenses include hospital operations, administration, ancillary services, & non-operating expenses.

- **NASHP Commercial Breakeven** – how much a hospital needs to be reimbursed by commercial payers in order to cover its expenses

- **RAND 3.0 Commercial Price** – how much a hospital was reimbursed by commercial payers in aggregate from 2016 to 2018
  - Calculated using data from the RAND Corporation’s Nationwide Evaluation of Health Care Prices Paid by Private Health Plans

- Breakeven and Price expressed as multiples of the individual hospital’s Medicare rates for comparability purchases

Example: Hospital A could afford a commercial price of 155 percent of Medicare. However, in 2018, its commercial price was 334 percent of Medicare.
1. View a hospital’s Medicare Cost Report

2. Input data from MCR into the Hospital Cost Tool

3. Receive calculated results tailored for states/ health plans

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**How to Use NASHP’s Hospital Cost Tool**

- For more information, and to access the tool, visit [https://www.nashp.org/hospital-cost-tool/](https://www.nashp.org/hospital-cost-tool/)
- **Now Available**: an interactive dashboard and national database of hospital costs
Factors That May Impact Breakeven Include:

- **Medicare Payment rate** – A hospital’s Breakeven is based on its own Medicare reimbursement rates. If a hospital is paid by Medicare in excess of its Medicare-related expenses, Breakeven would be lower.

- **Hospital Other Income** – If a hospital receives significant other income (e.g., return on investments, federal relief payments), the payment required from a commercial payer would be lower.

- **Reimbursement from Other Payers** – If the hospital generates payer mix adjusted profits from other payers (Medicaid, Medicare, CHIP and other local/state programs, Medicare Advantage), the payment required from a commercial payer would be lower.

- **Reporting Error** – Medicare Cost Reports are completed by the hospital or their contractor and may contain reporting errors, impacting Breakeven calculations.
Connecticut and Neighboring States, 2019

Breakevens of Hospitals in Connecticut, Neighboring States, and the Nation; 2019

Source: NASHP Hospital Cost Tool, 2019 Data
Connecticut and Neighboring States, 2020

Breakevens and Prices of Hospitals in Connecticut, Neighboring States, and the Nation

Source: NASHP Hospital Cost Tool, 2020 Data; price from RAND Corporation, 2018 Data
Connecticut and Neighboring States, 2019 vs 2020

Breakevens and Prices of Hospitals in Connecticut, Neighboring States, and the Nation

Source: NASHP Hospital Cost Tool, 2019 and 2020 Data; price from RAND Corporation, 2018 Data
Connecticut Health Systems, 2019

Median Breakevens and Prices of Major Health Systems* in Connecticut
(*systems with two or more hospitals operating in the state)

Source: NASHP Hospital Cost Tool, 2019 Data; price from RAND Corporation, 2018 Data
Connecticut Health Systems, 2020

Median Breakevens and Prices of Major Health Systems* in Connecticut
(*systems with two or more hospitals operating in the state)

Source: NASHP Hospital Cost Tool, 2020 Data; price from RAND Corporation, 2018 Data
Connecticut Health Systems, 2019 vs 2020

Median Breakevens of Major Health Systems* in Connecticut, 2019 vs 2020
(*systems with two or more hospitals operating in the state)

Source: NASHP Hospital Cost Tool, 2019 and 2020 Data; price from RAND Corporation, 2018 Data
Hospitals’ Commercial Prices do not appear to be based on their Commercial Breakevens, with both varying inconsistently.

Many of the hospitals with the highest Prices and Breakevens are in Fairfield County.

Source: NASHP Hospital Cost Tool, 2019 Data; price from RAND Corporation, 2018 Data
Counties with Many Hartford System Beds

- Hartford Healthcare Corp. system has the largest Median Breakeven vs Median Price spread (91%).
- Its largest spread hospitals are in Hartford County, where it also owns the majority of hospital beds.

Source: NASHP Hospital Cost Tool, 2019 Data; price from RAND Corporation, 2018 Data
Factoring Payer Mix into Hospital Reported Profit/ Loss

- A more complete picture of a hospital’s profit/ loss on a payer can be seen by factoring payer mix into payer-specific profit/loss
  - Johnson Memorial reported a loss of 48% on its Medicaid line
  - Medicaid represents only 19% of its patient business
  - So, Medicaid had an overall net impact of negative 9% on Johnson Memorial's Operating Income

Source: NASHP Hospital Cost Tool, 2019 Data; price from RAND Corporation, 2016-2018 Data
No correlation nationally between a hospital’s public insurance reliance and its private insurance prices\(^1\)

If the cost-shifting argument were true, one would expect a positive correlation between these two variables.

Additionally, The National Bureau of Economic Research found that when hospitals received an unexpected 10 percent increase in Medicare payment rates, they did not reduce their private prices\(^2\).

Instead, they:
- Added new technology;
- Increased nursing staff;
- Increased payroll by one-third.

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Key Takeaways and Cost Considerations

1. Compared to hospitals in surrounding states, Connecticut hospitals have relatively high median Commercial Breakevens and relatively standard median Commercial Prices.
   - Connecticut’s median RAND 3.0 Commercial Price (2016 - 2018) was 208 percent of Medicare rates
     - Range: 151% to 295% of Medicare rates (data unavailable for 3 independent hospitals)
   - Connecticut’s median NASHP Commercial Breakeven (2019) was 131 percent of Medicare rates
     - Range: 58% to 253% of Medicare rates
   - This suggests the potential both for (a) commercial prices to be lowered to more closely align with commercial breakeven, and (b) inefficiencies to be addressed, securing lower hospital costs and decreasing breakevens.

2. Of the major health systems, Hartford Healthcare Corp. has the largest spread between its Commercial Breakeven and Commercial Price.
   - Its median Commercial Price (2016-2018) was 91 percentage points higher than its Commercial Breakeven (2019) and 99 percentage points higher than its Commercial Breakeven (2020).
NASHP’s Health System Costs Resources: https://www.nashp.org/policy/health-system-costs/

- Written research and analysis & state legislative tracking
- Model legislation & regulation to address consolidation and more
- Hospital Cost Tool & hospital financial transparency reporting template
- A Hospital Cost Searchable Database

For More Information