MANAGED CARE DIGEST SERIES®

SINCE 1987

Health Care Digest™

Trends in Chronic Disease Management

2023

In This Volume

- Providers and Payers Focus on Measures of Health Care Quality, Equity, and Outcomes
- Health Care Landscape Evolves as Expenses Are Projected to Near 20% of GDP

37th Year
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Leading the Health Care Discussion

The nationally renowned Sanofi **Managed Care Digest Series®**—now in its 37th year—is a demonstration of our ongoing commitment to provide you with actionable data on, and analysis of, the continuing evolution of U.S. health care and its effects on utilization, costs, and outcomes. As always, our goal remains to keep you at the forefront of the transformations reshaping health care delivery across America: the nation's ongoing shift to value-based care, its recovery from the COVID-19 public health crisis, and the forecasted effects of major health care–related legislation. Data-driven insights, such as those found in this digest, will assist your organization in understanding health care trends and developments, and in making informed decisions.

Sanofi is pleased to provide you with your complimentary copy of the second volume of the *Health Care Digest™: Trends in Chronic Disease Management*, one of the many offerings in the multifaceted **Managed Care Digest Series®** for 2023. In addition to examinations of how providers deliver quality care to patient populations with chronic disease, the digest also studies Medicare and Medicaid health plan models, commercial insurers, health insurance exchanges, and pharmacy benefit managers.

The diagnosis-related, chronic disease–specific data that make this digest an essential resource are joined by data and analyses of health care stakeholders' ongoing efforts to address inequities highlighted by the pandemic. Enrollment trends in commercial and public health care programs further illustrate the shifting membership within managed care in the wake of the public health emergency.

Your Sanofi account director would be happy to provide you with additional information on our products and services. Beyond this annual digest, the **Managed Care Digest Series®** includes a comprehensive array of market-level trend reports focused on chronic disease and patterns of care. Thank you for your commitment to the quality of health care in America.

We look forward to continuing our partnership with you in this crucial endeavor.

Sincerely,

Martin Bick
Head of U.S. General Medicines Market Access
sanofi-aventis U.S. LLC
A SANOFI COMPANY

Managed Care Digest Series® 2023

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Contents, Vol. 2

Introduction

At the height of the COVID-19 pandemic in 2020, nearly 20% of the nation's gross domestic product (GDP) went toward national health expenditures (NHE). By 2023, the NHE as a percentage of GDP is projected to fall to 17.6% despite a rise in the total NHE of more than 10% from 2020, reaching $4.67 trillion.[1] Should past measurements prove consistent, spending on patients with chronic disease will account for around 90% of NHE, or $4.20 trillion, in 2023.[2] Yet this significant investment has not yielded expected results: compared with other high-income nations, the U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, and the highest rate of people with multiple chronic conditions, just a few signs of the urgency to transition from volume-based care reimbursement to one that rewards value.[3] Navigating this transition are stakeholders of U.S. health care management: providers, who direct patient care; Medicare and Medicaid, which fund large portions of such care; and commercial insurers, which help manage the care for both publicly and privately funded patients. As a resource to decision-makers within these organizations, Sanofi is pleased to present the *Health Care Digest*™, the culmination of the **Managed Care Digest Series®** research into the U.S. health care system for 2023 and the trends that affect these key parties.

Since 1987, the **Managed Care Digest Series®** has been helping health care organizations develop strategies, control costs, and assess value. Now in its 37th year, the **Managed Care Digest Series®** remains a proven source for the most trusted health care data and progressive analysis, including detailed diagnosis-related and chronic disease–specific patient claims and hospital discharges. Amidst the ongoing evolution of chronic care delivery in the U.S., the **Managed Care Digest Series®** remains committed to leading the health care discussion.

The *Health Care Digest* delivers an in-depth examination of **Emerging Topics** in the management of chronic disease and highlights issues faced by managed care stakeholders: **Providers, Medicare, Medicaid, and Commercial Payers**. The digest features more than a dozen of the most prevalent chronic diseases affecting the U.S. population: cardiometabolic conditions, such as diabetes and hypertension; respiratory and inflammatory disorders, such as asthma and rheumatoid arthritis; and conditions requiring specialty medicines and care, such as multiple sclerosis and cancers.

The **Emerging Topics** section of the *Health Care Digest* addresses the advances taking place in the delivery of health care—such as efforts to lower costs, and address health equity and social factors that influence outcomes—all while improving quality of care.

Provider pages examine chronic disease–specific inpatient and outpatient demographics, health care utilization, and quality. Patient claims data provide targeted looks at utilization and lab data for patients with Type 2 diabetes. Data on access to care and information on health care employment illuminate the challenges faced by individuals caring for patients.

The **Medicare** section explores the ever-changing role of this public program in U.S. health care delivery in the wake of significant policy changes via the Inflation Reduction Act. The increasing influence of Medicare Advantage (MA), an important care management partnership between public and private organizations, is explored via updated enrollment figures. Volume-based payments in the form of fee-for-service are also trended for historical context. Within these pages are Medicare quality results, such as MA Star Ratings and Hospital Readmission Reduction Program penalties.

Medicaid pages analyze enrollment trends in the midst of redetermination resumption as the COVID-19 public health crisis fades. The continued revolution in care delivery for Medicaid patients via digital health tools is also explored.

Commercial Payers and pharmacy benefit managers will find data relevant to their roles in U.S. health care. Enrollment, demographic, and lab trends are presented, as well as spotlights on health insurance exchanges. Claims data gathered on Type 2 diabetes patients with commercial coverage enable further understanding of the many conditions that can co-occur in these individuals.

For 37 years, the **Managed Care Digest Series®** has been distinguished by its authoritative data, and the *Health Care Digest* for 2023 is no exception. Long-term trends appear throughout, leveraging historical and projected data to provide perspective over time. The analysis explores the effects of chronic disease, not only on the patients themselves, but also on the institutions charged with delivery and management of care.

Account-level data capabilities are indicated throughout, where available.
Greater geographic detail may also be available. Contact your Sanofi account director for more information.

[1] Centers for Medicare & Medicaid Services. (2023). NHE Projections–Tables (ZIP). Retrieved from https://www.cms.gov/files/zip/nhe-projections-tables.zip. Accessed July 2023.

[2] Centers for Disease Control and Prevention. (2023). Health and Economic Costs of Chronic Diseases. Retrieved from https://www.cdc.gov/chronicdisease/about/costs/index.htm. Accessed August 2023.

[3] Gunja, M.Z., Gumas, E.D., and Williams II, R.D. The Commonwealth Fund. (2023). U.S. Health Care From a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes. Retrieved from https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022. Accessed August 2023.

Executive Summary

Emerging Topics

- After stabilizing near 17.5% from 2015 to 2019, U.S. national health expenditures—as a share of gross domestic product—spiked by more than two percentage points in 2020.
- Among all U.S. adults, the vaccination rate for influenza rose in the 2022–2023 season (47.4%), as compared with the previous season (45.4%). In both seasons, Hispanics had the lowest rates.
- Although shrinking, the share of enrollees in fee-for-service (FFS), or Original, Medicare remains around half. By 2030, the Centers for Medicare & Medicaid Services (CMS) aims to move all FFS Medicare enrollees into value-based care.
- CMS developed its "Universal Foundation" of quality metrics for adult and pediatric patients, with the aim of streamlining quality initiatives across its various programs. The adult set includes health equity.

Providers

- Through the first quarter of 2023, overall health care employment exceeded normalized pre-pandemic levels, but the care settings where those jobs exist have shifted.
- In 2021 to 2031 projections, nurse practitioners were forecasted as the fastest growing health care occupation. Estimates pointed to a 45.7% increase and an additional 112,700 such positions in that time.
- Falling from its highest ever value in performance year (PY) 2020, the average earned shared savings payment to Medicare Shared Savings Program accountable care organizations saw a 7.3% year-over-year reduction in PY 2021.
- From 2020 to 2022, patients with Type 2 diabetes on any insulin product had lower three- and 30-day readmission rates than those who were taking three non-insulin antidiabetic products.

Medicare

- Medicare Advantage (MA) enrollment is poised to overtake FFS; MA penetration reached 49.9% nationally in 2022. Half of large employers providing Medicare benefits offered at least one MA plan.
- In 2023, the 10 largest MA organizations by enrollment earned 3.9 stars, on average, for their overall Star Rating, down from 4.3 for 2022's top 10 organizations.
- All five of the profiled Senior Savings Model plan sponsors saw increased participation from 2022 to 2023; CVS Health gained 1.8 million enrollees in that time—a surge of 476% from 2022.
- From 2020 to 2021, Medicare FFS actual costs decreased for four of the six settings profiled. Such costs in ambulatory surgery and outpatient settings rose by 18.1% and 11.4%, respectively.

Medicaid

- Medicaid enrollment surpassed a record 90 million recipients in 2022, swelling by more than 21 million enrollees since 2019.
- From August 2021 to January 2022, telehealth utilization jumped yet again among Medicaid recipients.

Commercial Payers

- Enrollment in private health insurance approached pre-pandemic levels in 2021, with total enrollment down by less than half a percent—a decline of just under 650,000 lives—from 2019.
- Roughly 42% of commercial Type 2 diabetes patients nationally had an A1c >7.0% in 2022, a share that was even higher in 33 states and highest in Vermont (48.9%).
- A staggering 16.4 million plan selections were made through health insurance exchanges (HIXs) in 2023, with Florida reporting the largest number of selections (3.2 million), accounting for nearly one-fifth (19.7%) of the total.
- Nationwide for 2023, HIX plans performed best on asthma medication management (80.3%) and worst on eye exams for diabetes patients (43.8%), of the metrics profiled.

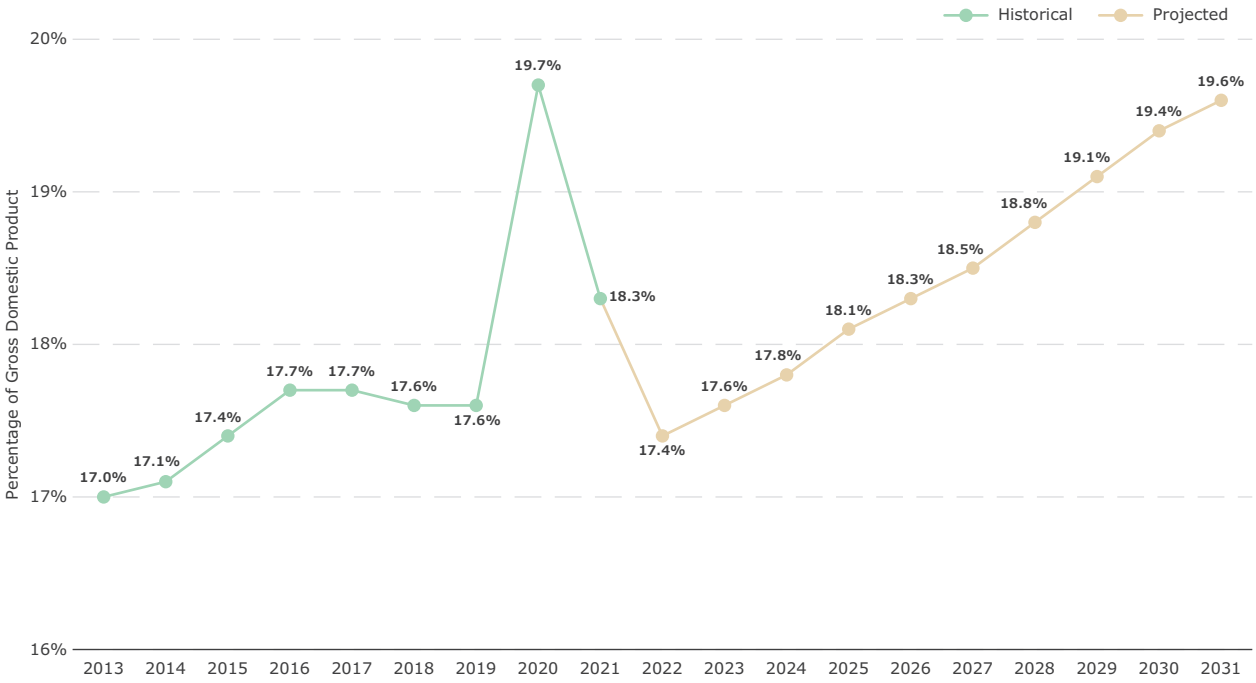
Emerging Topics

Trends in Chronic Disease Management

Backgrounder

After stabilizing near 17.5% from 2015 to 2019, U.S. national health expenditures—as a share of gross domestic product—spiked by more than two percentage points in 2020, reflecting the COVID-19 pandemic's opposing and unprecedented impacts on health care expenditures and overall economic activity. The former ticked higher as the latter plunged. Although this ratio fell in 2021 and is projected to have fallen again in 2022, it is expected to rise in each of the remaining nine years of the most recent forecast from the Centers for Medicare & Medicaid Services (CMS), culminating at 19.6% in 2031, just below the recent pandemic-era high (19.7%). By source of funds, Medicare outlays are projected to grow fastest, more than doubling from $0.90 trillion in 2021 to $1.85 trillion in 2031. On a per capita basis, average Medicare expenditure growth (5.5%) over this same period is expected to outpace that for Medicaid (4.4%) and private health insurance (5.1%).[1] Given its outsized role as a payer, CMS likely considered such trends in reshaping a strategic plan, which rests upon six pillars. Through 23 centers and offices, CMS aims to: 1) advance health equity, 2) expand access, 3) engage partners, 4) drive innovation, 5) protect programs, and 6) foster excellence.[2] CMS's Innovation Center leads especially important initiatives as it seeks to develop and expand alternative payment models (APM) that lower costs while also improving quality and outcomes. Statute dictates evidence-based evaluations of each model. In its first decade, just six of the center's more than 50 models showed statistically significant results, with only four of those meeting criteria for expansion. Moreover, a recent review of select APM programs revealed gaps in previous models' abilities to address health equity, often because essential data, such as race or social determinants of health, are lacking or sample sizes are too small. But the analysis also led to a framework for designing and promoting equitable quality improvement and evaluation for future models—an important step forward, as value-based care remains paramount to reining in the costs, not only for CMS, but for payers in general.[3,4]

National Health Expenditures as a Percentage of Gross Domestic Product, 2013–2031



Data source: Centers for Medicare & Medicaid Services © 2023

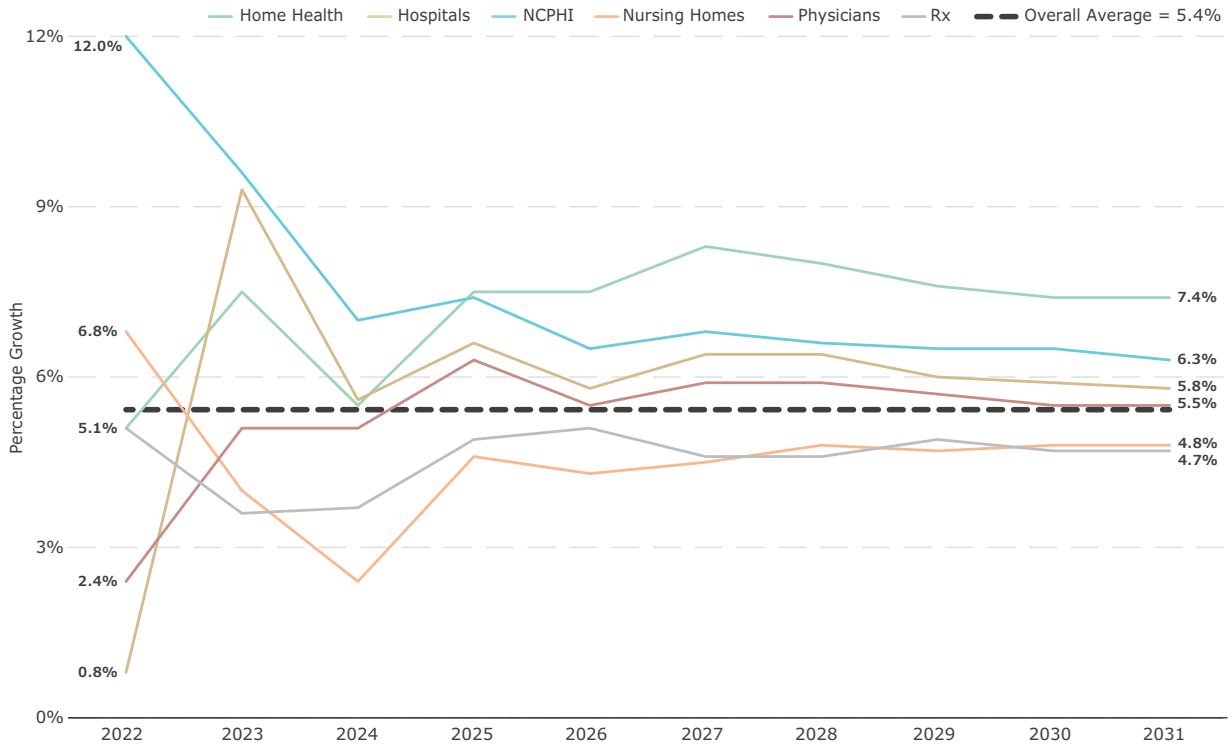
[1] CMS. (2023). NHE Projections–Tables (ZIP). Retrieved from https://www.cms.gov/files/zip/nhe-projections-tables.zip. Accessed July 2023.

[2] CMS. (2023). CMS Strategic Framework. Retrieved from https://www.cms.gov/files/document/cms-strategic-framework-fact-sheet.pdf. Accessed July 2023.

[3] CMS. (2023). Innovation Center Strategy Refresh. Retrieved from https://innovation.cms.gov/strategic-direction-whitepaper. Accessed July 2023.

[4] CMS. (2023). Assessing Equity to Drive Health Care Improvements: Learnings from the CMS Innovation Center. Retrieved from https://innovation.cms.gov/data-and-reports/2023/assessing-equity-hc-improv-wp. Accessed July 2023.

Projected Annual Percentage Growth of National Health Expenditures, Overall Average and by Select Components, 2022–2031



Data source: Centers for Medicare & Medicaid Services © 2023

The U.S. has a multi-decade history of trying to bend the trajectory of its health care cost curve. In the days leading up to final votes on the Patient Protection and Affordable Care Act (ACA)—the most prominent such attempt before the Inflation Reduction Act of 2022—six prominent health care organizations representing payers, providers, and manufacturers sent a letter in support of health care reform, which included promises to help save $2 trillion or more over the following decade.[1,2] By 2017, actual results suggested the cumulative savings met that goal just seven years after the ACA's passage.[3] Due to the ACA's expansion of insurance options and separate pandemic-related measures that paused Medicaid redeterminations and expanded financial support for health insurance exchange plans, the U.S.'s uninsured population hit an all-time low (7.7%) in 2023.[4] Yet polling data suggest that many Americans continue to give the U.S. health care system low marks on affordability and quality. Moreover, unfavorable trends in health care spending factored into a recent downgrade to the nation's credit rating.[5,6]

The inability of federal measures to control health care costs enough to influence public opinion helps explain why a small but increasing number of states are embarking on their own initiatives to restrain health expenditures. Using a mix of legislative and executive pathways, these actions aim to quantify statewide health care spending and set a state-specific target for health care cost growth.[7] While states are piloting efforts to identify drivers of health care spending, the Centers for Medicare & Medicaid Services (CMS) has released such national analyses for years. From 2022–2031, CMS projects that gross domestic product will grow by 4.6% annually; the overall yearly rise in national health expenditures will average 5.4%. Among the components shown above, net cost of private health insurance (NCPHI) is the only one to surpass the overall average in each year, whereas prescription drugs is the only category to remain below that mark. As policymakers strive to rein in health care spending, they will seek to balance incentives for innovation and profit with the need for high-quality, transparent, equitable, and affordable health care.

[1] Davis, K. (2009). Bending the Health Care Cost Curve: Lessons From the Past. Retrieved from https://www.commonwealthfund.org/publications/other-publication/2009/may/bending-health-care-cost-curve-lessons-past. Accessed August 2023.

[2] Pear, R. (2009). Industry Pledges to Control Health Care Costs. *New York Times*. Retrieved from https://www.nytimes.com/2009/05/11/health/policy/11drug.html. Accessed August 2023.

[3] Emanuel, E. (2019). Name the Much-Criticized Federal Program That Has Saved the U.S. $2.3 Trillion. Hint: It Starts with Affordable. Retrieved from https://www.statnews.com/2019/03/22/affordable-care-act-controls-costs/. Accessed August 2023.

[4] Office of the Assistant Secretary for Planning and Evaluation. (2023). National Uninsured Rate Reaches an All-Time Low in Early 2023 After the Close of the ACA Open Enrollment Period. Retrieved from https://aspe.hhs.gov/sites/default/files/documents/e06a66dfc6f62afc8bb809038dfaebe4/Uninsured-Record-Low-Q12023.pdf. Accessed August 2023.

[5] Saad, L. (2023). Americans Sour on U.S. Healthcare Quality. *Gallup*. Retrieved from https://news.gallup.com/poll/468176/americans-sour-healthcare-quality.aspx. Accessed August 2023.

[6] Fitch Group. (2023). Fitch Downgrades the United States' Long-Term Ratings to 'AA+' from 'AAA'; Outlook Stable. Retrieved from https://www.fitchratings.com/research/sovereigns/fitch-downgrades-united-states-long-term-ratings-to-aa-from-aaa-outlook-stable-01-08-2023. Accessed August 2023.

[7] Milbank Memorial Fund. (2023). Program for Sustainable Health Care Costs. Retrieved from https://www.milbank.org/focus-areas/total-cost-of-care/peterson-milbank/. Accessed August 2023.

NOTE: Hospitals is hospital care, Physicians is physicians and clinical services, Home Health is home health care, Nursing Homes is nursing care facilities and continuing care retirement centers.

Health Equity

> ***Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.***
>
> – Centers for Disease Control and Prevention (CDC)[1]

Upstream Risk Factors[2]

Social Inequities:

Income, education, occupation, race/ethnicity, immigration status, sexual orientation, and disability

Institutions:

Corporations and businesses, government agencies, schools, laws and regulations, and nonprofit organizations

Physical Environment:

Neighborhood design, transportation, housing, segregation, exposure to toxins, gentrification, and displacement

Social Environment:

Experience of class, racism, gender, immigration, culture, violence, and religion

Individual Behaviors:

Smoking, nutrition, physical activity, alcohol and drugs, sexual behavior, chronic stress, psychosocial, and mental factors

Disease and Injury:

Communicable disease, chronic disease, injury, and behavioral health

Downstream Consequences[2]

- Premature/disproportionate mortality and morbidity
- Years of potential life lost
- Disability-adjusted life years
- Low community resilience and recovery

$451 Billion was the U.S. annual cost of race-based health inequities (2% of GDP and $1,337 per person) as of 2018—an amount the U.S. could save if all racial and ethnic groups achieved equitable health outcomes.[3]

[1] CDC. (2022). What Is Health Equity? Retrieved from https://www.cdc.gov/nchhstp/healthequity/index.html. Accessed July 2023.

[2] American Academy of Family Physicians. (2019). Advancing Health Equity by Addressing the Social Determinants of Health in Family Medicine. Retrieved from https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine-position-paper.html. Accessed July 2023.

[3] National Institutes of Health. (2018). The Economic Burden of Racial, Ethnic, and Educational Health Disparities in the U.S. Retrieved from https://nimhd.nih.gov/about/publications/economic-burden-health-disparities-US-2018.html. Accessed July 2023.

Health Equity

To achieve **health equity** and reach the highest level of care, health disparities—modifiable factors within burden of disease, injury, violence, or other opportunities to achieve optimal health in socially disadvantaged populations—should be eliminated.[1]

Example: Risk Factors for Multiple Sclerosis[2,3]

Social Inequities · Physical Environment · Individual Behaviors · Institutions · Disease and Injury

Non-Modifiable

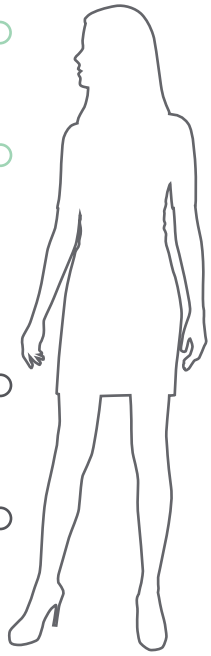
Age
(20–49 years)

Race
(White)

Co-Occurring Conditions

Autoimmune Diseases
(Type 1 diabetes, thyroid disease, intestinal inflammation)

Obesity



Modifiable

Environmental Factors

Smoking

Nutrition
(Vitamin D, gut health)

Hormone Levels

Access to Care

Optimizing Care: The Quadruple Aim[4]

Improve Patient Care	Achieve better care for individuals, including safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity
Reduce Health Care Costs	Decrease the per-capita costs for care
Improve Population Health	Address upstream causes, such as poor nutrition, physical inactivity, and substance abuse
Address Physician Burnout	Improve work life of clinicians and staff

[1] U.S. Department of Health and Human Services. (2022). Health Equity in Healthy People 2030. Retrieved from https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030. Accessed July 2023.

[2] Verywell Health. (2022). Can You Prevent Multiple Sclerosis? Retrieved from https://www.verywellhealth.com/can-you-prevent-multiple-sclerosis-5207758. Accessed July 2023.

[3] Mayo Clinic. (2023). Multiple Sclerosis. Retrieved from https://www.mayoclinic.org/diseases-conditions/multiple-sclerosis/symptoms-causes/syc-20350269. Accessed July 2023.

[4] Bodenheimer, T., et al. (2014). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Ann Fam Med*. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4226781/. Accessed July 2023.

Health Equity

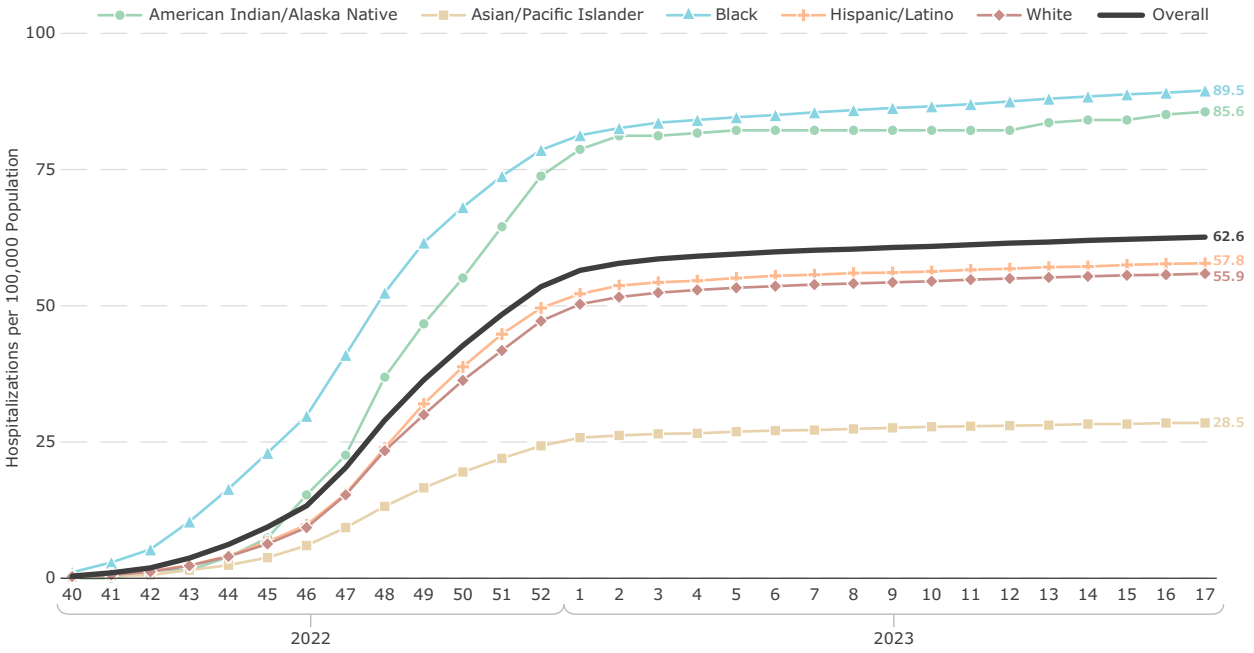
Overall Flu Vaccination Rate Ticks Higher, Yet Racial/Ethnic Differences Remain

- Among all U.S. adults, the vaccination rate for influenza rose in the 2022–2023 season (47.4%), as compared with the previous season (45.4%). In both seasons, Hispanics had the lowest rates.
- Hospitalization rates for flu during the 2022–2023 season also varied by race/ethnicity. For the latest tracking week, the group with the highest rate was more than triple that of the lowest.

Percentage of Adults Vaccinated for Influenza, Overall and by Race/Ethnicity, 2021–2022 vs. 2022–2023 Seasons

Race/Ethnicity	2021–2022 Season	2022–2023 Season
American Indian/Alaska Native, Non-Hispanic	37.5%	39.1%
Asian, Non-Hispanic	50.1	49.3
Black, Non-Hispanic	35.0	39.3
Hispanic	33.9	35.2
Other/Multiple Races, Non-Hispanic	34.2	44.5
Pacific Islander/Native Hawaiian, Non-Hispanic	n/a	44.3
White, Non-Hispanic	51.3	52.8
Overall	**45.4%**	**47.4%**

Cumulative Influenza Hospitalizations per 100,000 Population, by Race/Ethnicity and Tracking Week, 2022–2023 Season



Data source: Centers for Disease Control and Prevention © 2023

Key Takeaway

According to the most recently reported estimates (2021–2022 season), influenza vaccinations averted significant disease burden: 1.8 million symptomatic illnesses; 22,000 hospitalizations; and 1,000 deaths.[1] The reduction in hospitalizations alone saved the U.S. more than $200 million. From 2016 to 2020, average aggregate hospitalization costs for a primary diagnosis of influenza topped $1 billion per year, suggesting the potential for additional savings through greater vaccination.[2,3]

[1] Centers for Disease Control and Prevention. (2023). Past Seasons Estimated Influenza Disease Burden Averted by Vaccination. Retrieved from https://www.cdc.gov/flu/vaccines-work/past-burden-averted-est.html. Accessed July 2023.

[2] Agency for Health Care Quality and Research. (2023). HCUPNet, Health Care Cost and Utilization Project: Inpatient Stays, National. Retrieved from https://datatools.ahrq.gov/hcupnet/. Accessed July 2023.

[3] Savings were estimated using Healthcare Cost and Utilization Project's (HCUP) average inpatient hospital charges for principal diagnosis/procedure associated with RSP003 Influenza for the period from 2016 to 2020.

NOTE: An n/a indicates that data were not available.

Universal Foundation Underpins CMS's Quality Strategy, Includes Health Equity

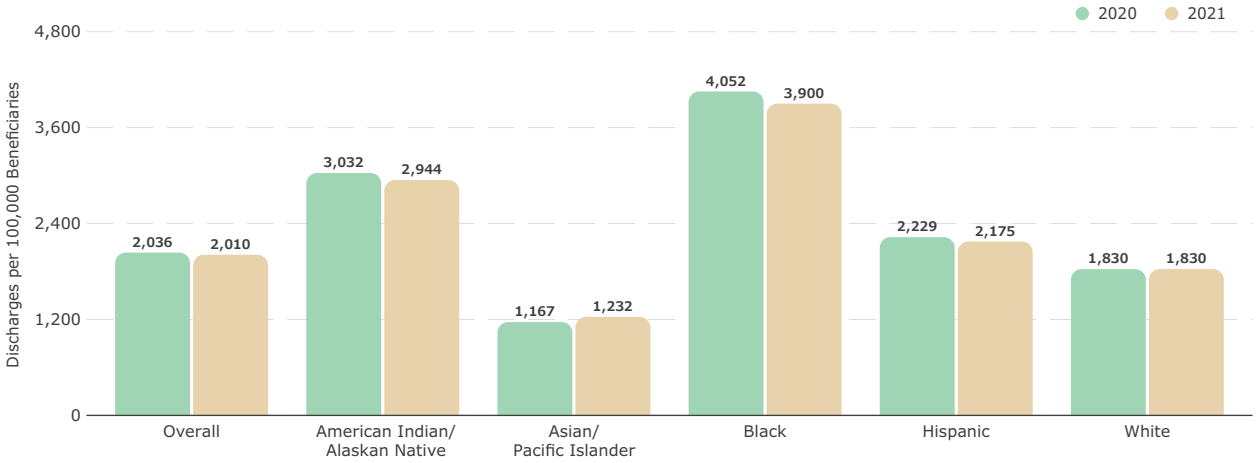
- The Centers for Medicare & Medicaid Services (CMS) developed its "Universal Foundation" of quality metrics, with the aim of streamlining quality initiatives across its various programs. The adult set includes health equity.[1,2]
- A separate measure, PQI 92, tracks select admissions for chronic conditions.[3,4] From 2020 to 2021, the gap between the highest and lowest rates by reported racial groups eased, but those rates still differed more than threefold both years.

Universal Foundation of Quality Metrics for Adult Patients, 2023[1]

Domain	Measure Identification Number and Name
Wellness and prevention	139: Colorectal cancer screening
	93: Breast cancer screening
	26: Adult immunization status
Chronic conditions	167: Controlling high blood pressure
	204: Hemoglobin A1c poor control (>9%)
Behavioral health	672: Screening for depression and follow-up plan
	394: Initiation and engagement of substance use disorder treatment
Seamless care coordination	561 or 44: Plan all-cause readmissions or all-cause hospital readmissions
Person-centered care	158 (varies by program): Consumer Assessment of Healthcare Providers and Systems (CAHPS) overall rating measures
Equity	Identification number undetermined: Screening for social drivers of health

Data source: Centers for Medicare & Medicaid Services © 2023

PQI 92: Composite of Select Chronic-Condition Hospitalizations Among Fee-for-Service Medicare Beneficiaries, by Race/Ethnicity, 2020–2021[4]



Data source: Agency for Healthcare Research and Quality © 2023

Key Takeaway

As part of its National Quality Strategy, CMS agencies developed a consensus framework, or Universal Foundation, of quality measures to buttress its numerous quality-rating and value-based care programs, supplemented by additional measures as needed, to serve particular populations or settings of care. Such national quality systems are also important for private insurers, which often deploy the same or similar quality metrics to adjust clinician reimbursement within their own value-based arrangements.[2]

[1] CMS. (2023). Aligning Quality Measures Across CMS–the Universal Foundation. Retrieved from https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation. Accessed July 2023.

[2] Jacobs, D.B., et al. (2023). Perspective: Aligning Quality Measures Across CMS–the Universal Foundation. *New England Journal of Medicine*. Retrieved from https://www.nejm.org/doi/full/10.1056/NEJMp2215539. Accessed July 2023.

[3] Agency for Healthcare Research and Quality. (2013). Prevention Quality Chronic Composite. Retrieved from https://qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%2092%20Prevention%20Quality%20Chronic%20Composite.pdf. Accessed July 2023.

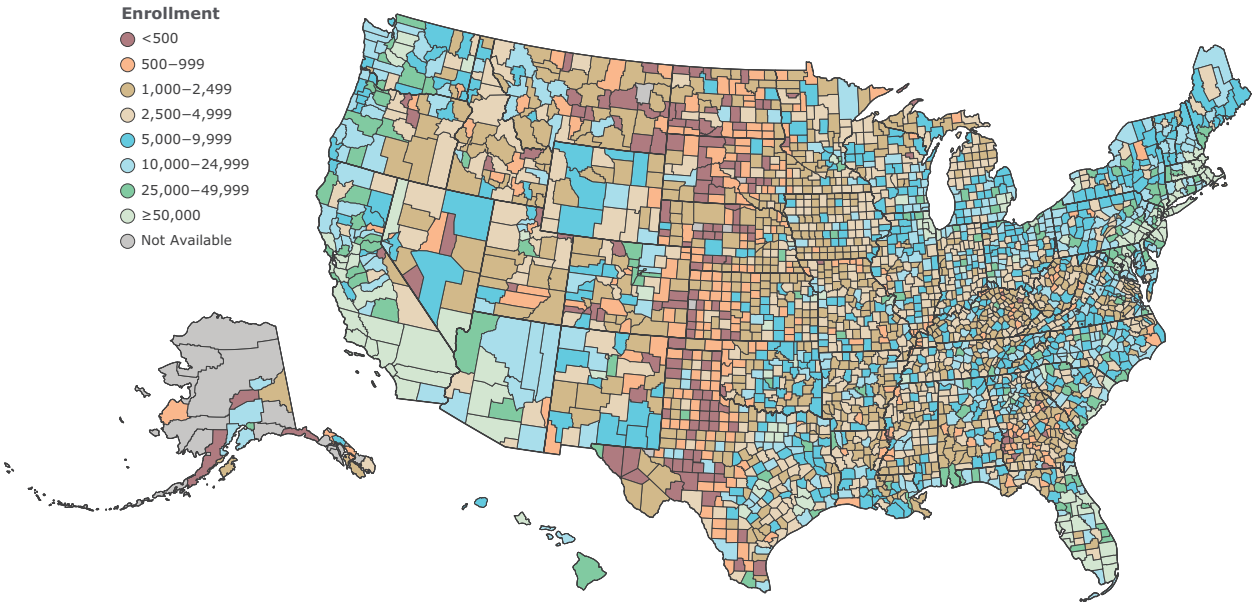
[4] Preventive Quality Indicator (PQI) 92 includes the following chronic conditions: angina, asthma, chronic obstructive pulmonary disease, diabetes, heart failure, and hypertension.

Social Determinants of Health

ACO REACH Requires SDoH Reporting as Push for Value-Based Care Continues

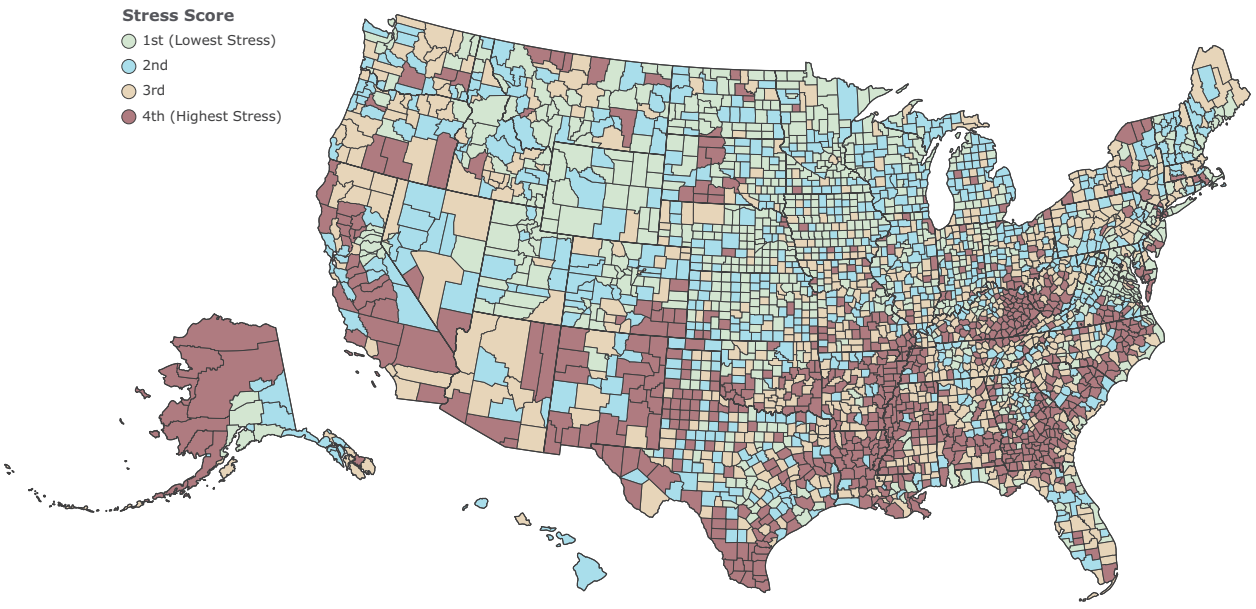
- Although shrinking, the share of enrollees in fee-for-service (FFS), or Original, Medicare remains around half.[1] By 2030, the Centers for Medicare & Medicaid Services (CMS) aims to move all FFS Medicare enrollees into value-based care (VBC).[2]
- CMS's Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model—one such VBC program—requires participants to collect and submit data on beneficiaries' social determinants of health (SDoH).[3]

Number of Original Medicare Beneficiaries, by County, 2023



Data source: Centers for Medicare & Medicaid Services © 2023

Combined Stress Score for Select Social Determinants of Health, by County, 2021



Data source: U.S. Census Bureau © 2023

[1] CMS. (2023). Medicare Monthly Enrollment. Retrieved from https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment. Accessed July 2023.

[2] CMS. (2023). The CMS Innovation Center's Strategy to Support High-Quality Primary Care. https://www.cms.gov/blog/cms-innovation-centers-strategy-support-high-quality-primary-care. Accessed July 2023.

[3] CMS. (2022). ACO Realizing Equity, Access, and Community Health (REACH) Model. Retrieved from https://innovation.cms.gov/media/document/aco-reach-indepth-ovw-webinar-slides. Accessed July 2023.

NOTE: Combined score represents a linear, equally weighted combination of county rankings for four SDoH elements: 1) percentage of population with income less than 150% of the federal poverty level; 2) percentage of households without a vehicle; 3) percentage of owner-occupied housing units (reversed); and 4) percentage of population aged 25+ who have completed high school (reversed). A higher combined score represents higher levels of stress with respect to these SDoH elements.

Providers

Trends in Chronic Disease Management

Backgrounder

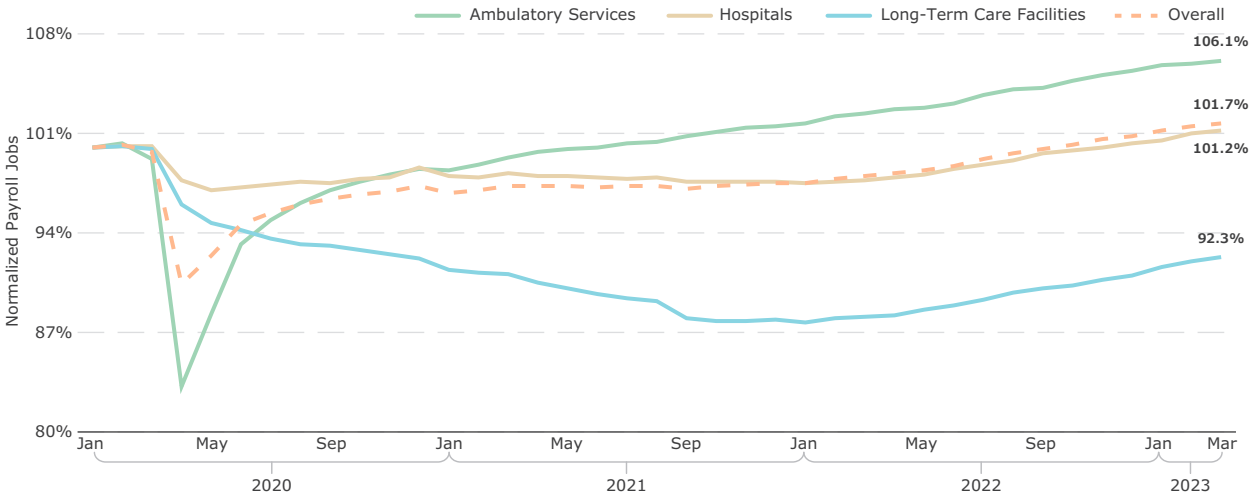
Seismic shifts caused by the COVID-19 pandemic have led to fundamental changes in the way care is delivered to patients across the nation. Through the first quarter of 2023, overall health care employment exceeded normalized pre-pandemic levels, but the care settings where those jobs exist have shifted. Long-term care facilities remain below their prior employment levels, whereas ambulatory services have surged to 106.1% of their benchmark (see below). New partnerships with payers—accelerated by the pandemic—may further shape this evolving landscape.

Through its health care services arm (Optum), UnitedHealth Group is spending billions to purchase provider groups—becoming the largest employer of providers in the nation.[1] Notable acquisitions by CVS Health (Oak Street Health) and Kaiser Permanente (Geisinger Health) demonstrate payers' strong investment in consolidating patient services.[2,3] These and other moves align with a major goal of such organizations: transitioning from a fee-for-service model to that of value-based care.[4]

Meanwhile, many patients—particularly those in rural parts of the nation—continue to face challenges when accessing care. In an effort to alleviate provider shortages, some in Congress seek to expand the range of services legally available from nurse practitioners and physician assistants. These providers tend to practice in rural parts of America where physicians are scarce.[5] Another method to improve access to care may lie in increased use of telehealth and digital health resources. Advanced tools like predictive analytics and remote monitoring can bridge gaps in care and assist in identifying high-risk patients, helping providers catch potential issues earlier, which could improve outcomes and reduce costs.

New methods to deliver care and stronger partnerships between payers and provider groups may present an opportunity to improve both care access and quality, but challenges remain. Administrative, financial, and cultural integration between the two parties may prove difficult and does not necessarily lead to lower costs or improved outcomes.

Health Care Jobs, Overall and by Facility Type, Nation, January 2020–March 2023[6]



Data source: Bureau of Labor Statistics © 2023

[1] Emerson, J. (2023). Meet America's Largest Employer of Physicians: UnitedHealth Group. Retrieved from https://www.beckerspayer.com/payer/meet-americas-largest-employer-of-physicians-unitedhealth-group.html. Accessed May 2023.

[2] Muoio, D. (2023). Kaiser Permanente to Acquire Geisinger Health in Bid to Launch Multisystem VBC Platform. Retrieved from https://www.fiercehealthcare.com/providers/kaiser-permanente-acquire-geisinger-health-bid-launch-multi-system-vbc-platform. Accessed May 2023.

[3] Landi, H. (2023). CVS Closes $10.6B Acquisition of Oak Street Health to Expand Primary Care Footprint. Retrieved from https://www.fiercehealthcare.com/providers/cvs-closes-106b-acquisition-oak-street-health-expand-primary-care-footprint. Accessed May 2023.

[4] Minemyer, P. (2023). CVS Chief Karen Lynch: PBMs Play "An Essential Role" in Drug Landscape. Retrieved from https://www.fiercehealthcare.com/payers/heels-oak-street-deals-closure-cvs-reports-21b-profit-q1. Accessed May 2023.

[5] Hollowell, A. (2023). Bill to Expand Scope of Practice for Advanced Practitioners Reintroduced to Congress. Retrieved from https://www.beckershospitalreview.com/?view=article&id=223837:bill-to-expand-scope-of-practice-for-advanced-practitioners-reintroduced-to-congress. Accessed May 2023.

[6] Job counts have been normalized to average values from December 2019 to February 2020. Legend labels refer to the following data series from the Bureau of Labor Statistics: Ambulatory Services (Ambulatory Health Care Services, CES6562100001); Hospitals (Hospitals, CES6562200001); Long-Term Care Facilities (Nursing and Residential Care Facilities, CES6562300001); and Overall (Health Care, CES6562000101).

Demographics

Percentage of Type 2 Diabetes Patients With Controlled A1c Improves in 2022

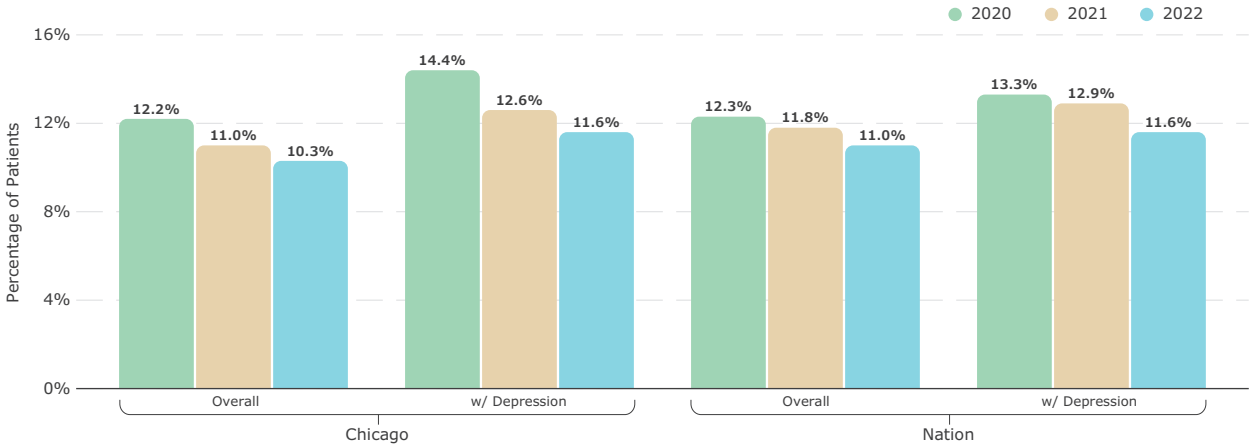
- The Midwest saw the largest improvement, by region, in A1c levels for Type 2 diabetes patients, as the share of patients at or below 7.0% increased 2.3 percentage points from 2021 to 2022.
- Likewise, in Chicago and across the nation, just 11.6% of Type 2 diabetes patients with depression had an A1c >9.0% in 2022—a favorable dip from 2020 values (14.4% and 13.3%, respectively).

Account-Level Data Available

Distribution of Type 2 Diabetes Patients, by A1c Level Range, 2021–2022[1]

	≤7.0%		7.1–7.9%		8.0–9.0%		>9.0%	
Region	2021	2022	2021	2022	2021	2022	2021	2022
Midwest	57.6%	59.9%	19.5%	18.9%	11.5%	10.6%	11.5%	10.5%
Northeast	62.8	64.5	17.4	16.9	9.9	9.3	10.0	9.4
South	59.5	61.1	18.1	17.8	10.9	10.2	11.5	11.0
West	56.1	58.0	18.8	18.5	11.6	10.8	13.6	12.6
Nation	**59.0%**	**60.8%**	**18.3%**	**17.9%**	**10.9%**	**10.2%**	**11.8%**	**11.0%**

Percentage of Type 2 Diabetes Patients With an A1c Level >9.0%, Overall vs. With a Comorbidity of Depression, 2020–2022[1,2]



Data source: IQVIA © 2023

Key Takeaway

For patients with poorly managed Type 2 diabetes, adding a comprehensive telehealth approach—including telemonitoring, nutrition support, and medication management—to existing treatment plans may help lower A1c levels by up to 1.6%.[3] Such promising results underscore the evolving role of digital health care in the treatment of chronic conditions.

[1] The A1c test measures the average blood glucose over the past 3 months. Figures reflect the percentage of diabetes patients who have had at least one A1c test in a given year.

[2] A comorbidity is a condition a patient with diabetes may also have, which may not be directly related to the diabetes. Comorbidities of diabetes include, but are not limited to, depression, hyperlipidemia, hypertension, knee osteoarthritis, obesity, pneumonia, and rheumatoid arthritis.

[3] Crowley, M. J., et al. (2022). Effect of a Comprehensive Telehealth Intervention vs. Telemonitoring and Care Coordination in Patients With Persistently Poor Type 2 Diabetes Control: A Randomized Clinical Trial. *JAMA Internal Medicine*. Retrieved from https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2794747. Accessed June 2023.

NOTE: The Chicago market includes Naperville and Elgin, and parts of Indiana and Wisconsin.

Settings of Care

Inpatient Percentage of Cases Climbs in 2022 for Atrial Fibrillation and Stroke

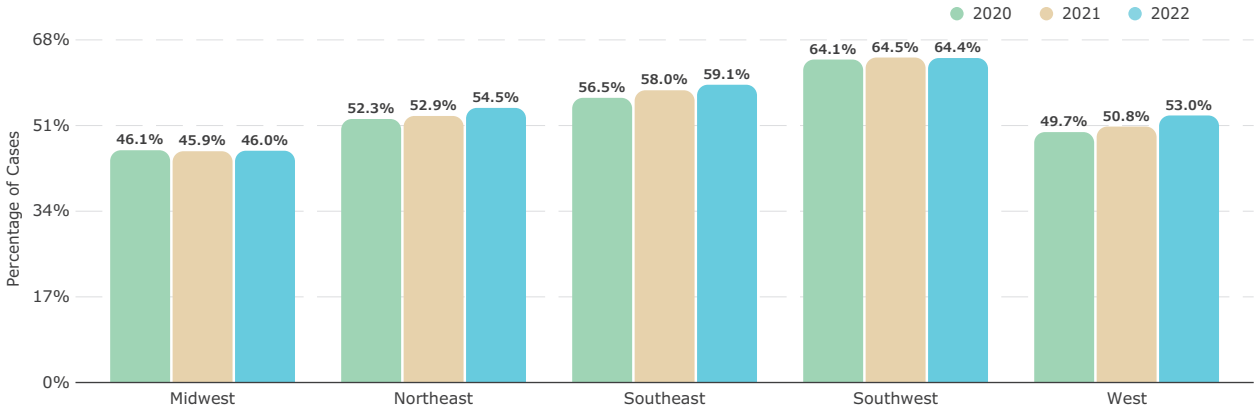
- From 2021 to 2022, the inpatient share of all-payer cases for atrial fibrillation (AFib) and stroke each increased by more than four percentage points (4.6 and 4.3, respectively).
- The percentage of commercial AFib cases seen in the inpatient setting rose for four of five regions from 2020 to 2022, growing most in the West (3.3 percentage points) during that time.

Account-Level Data Available

Inpatient and Outpatient Distribution of All-Payer Cases, 2021–2022[1]

	2021		2022	
Disease State	Inpatient	Outpatient	Inpatient	Outpatient
Acute Coronary Syndromes (ACS)	67.5%	32.5%	69.8%	30.2%
Asthma	27.0	73.0	27.7	72.3
Atrial Fibrillation	33.2	66.8	37.8	62.2
Breast Cancer	15.6	84.4	17.9	82.1
COVID-19	46.5	53.5	38.0	62.0
Depression	41.9	58.1	45.0	55.0
Diabetes Mellitus	29.9	70.1	32.5	67.5
Hypertension	28.7	71.3	31.4	68.6
Knee Osteoarthritis	23.1	76.9	24.6	75.4
Lipid Disorders	25.5	74.5	27.7	72.3
Multiple Sclerosis	24.4	75.6	27.1	72.9
Osteoarthritis	23.6	76.4	24.7	75.3
Prostate Cancer	13.5	86.5	16.6	83.4
Rheumatoid Arthritis	21.3	78.7	22.7	77.3
Stroke	57.1	42.9	61.4	38.6

Inpatient Percentage of Commercial Atrial Fibrillation Cases, by Region, 2020–2022



Data source: Definitive Healthcare © 2023

Key Takeaway

Many Americans avoided or delayed health care during the COVID-19 pandemic—including routine screenings for cancer. This drop in preventative services across many disease states may result in significant downstream complications for patients. Hospitals are requesting additional support from Congress in anticipation of rising inpatient acuity and average lengths of stay.[2]

[1] Data for 2022 include commercial and Medicaid claims for the full calendar year and Medicare claims for January 1 through September 30, 2022.

[2] American Hospital Association. (2022). Pandemic-Driven Deferred Care Has Led to Increased Patient Acuity in America's Hospitals. Retrieved from https://www.aha.org/system/files/media/file/2022/08/pandemic-driven-deferred-care-has-led-to-increased-patient-acuity-in-americas-hospitals.pdf. Accessed June 2023.

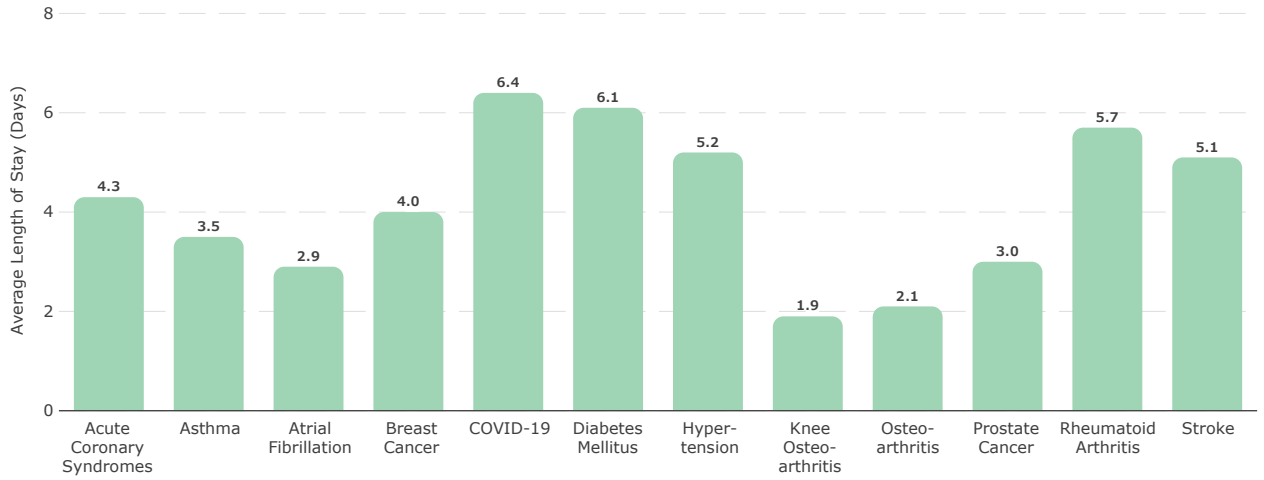
Settings of Care

Medicare ALOS Exceeds Six Days for Diabetes Mellitus

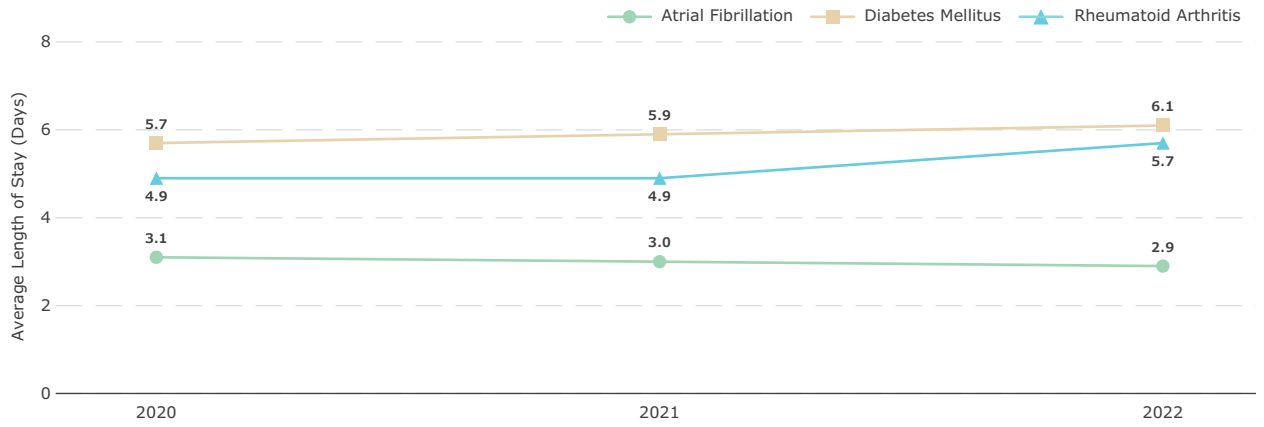
- In 2022, patients with COVID-19 or diabetes mellitus had the longest Medicare average length of stay (ALOS) of the profiled conditions, at 6.4 and 6.1 days, respectively.
- Meanwhile, from 2021 to 2022, the Medicare ALOS per primary inpatient claim sharply increased for rheumatoid arthritis, rising by nearly a full day of inpatient care in that time (0.8 days).

Account-Level Data Available

Average Medicare Length of Stay (Days) per Primary Inpatient Claim, 2022[1]



Average Medicare Length of Stay (Days) per Primary Inpatient Claim, by Select Condition, 2020–2022[1]



Data source: Definitive Healthcare © 2023

Key Takeaway

Delays in patient discharges—a result of staffing shortages in acute care, long-term care, and rehabilitation facilities alike—contributed to a staggering 19.2% rise in ALOS from 2019 to 2022. As a result, hospital lobbyists appealed to Congress for a temporary per diem Medicare payment to alleviate the cost burden associated with extended (and often unpaid) patient stays.[2]

[1] Data for 2022 include Medicare claims for January 1 through September 30, 2022.

[2] Muoio, D. (2022). Faced With Costly Discharge Bottlenecks, Hospitals Want Congress to Pay for Patients' Extended Stays. Retrieved from https://www.fiercehealthcare.com/providers/downstream-capacity-issues-keep-patients-waiting-discharges-hospitals-wants-congress-pay. Accessed June 2023.

Settings of Care

Inpatient Discharges to Skilled Nursing Facilities Rise Across All Disease States

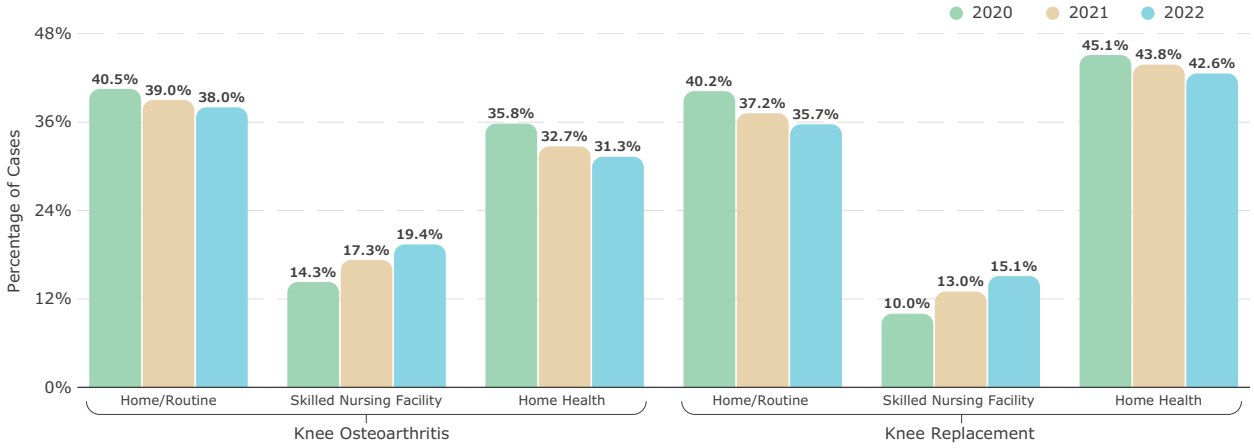
- From 2021 to 2022, increases in all-payer IP cases discharged to skilled nursing facilities (SNFs) were reported for all disease states shown; COVID-19 saw the largest rise (3.6 percentage points).
- Similarly, the share of knee osteoarthritis and knee replacement cases discharged to SNFs both rose by 5.1 percentage points from 2020 to 2022, while discharges to home destinations fell.

Account-Level Data Available

Percentage of All-Payer Inpatient (IP) Cases, by Discharge Destination, 2021–2022

	Home/Routine		Skilled Nursing Facility		Home Health		Died	
Disease State	2021	2022	2021	2022	2021	2022	2021	2022
Acute Coronary Syndromes (ACS)	47.7%	50.5%	11.1%	11.9%	15.4%	15.7%	9.1%	5.2%
Asthma	38.2	39.7	18.2	19.1	21.8	21.7	5.9	3.8
Atrial Fibrillation	65.7	67.9	7.4	7.5	14.7	13.9	1.8	0.8
Breast Cancer	46.8	48.3	11.8	12.3	21.9	21.7	4.7	2.9
COVID-19	51.8	51.9	10.5	14.1	14.0	16.8	10.0	3.6
Diabetes Mellitus	45.2	46.3	15.0	16.0	20.8	21.0	4.0	2.0
Hypertension	46.9	48.1	14.8	15.5	19.8	19.6	3.8	2.2
Knee Osteoarthritis	39.0	38.0	17.3	19.4	32.7	31.3	1.0	0.6
Osteoarthritis	43.5	43.5	16.5	17.6	25.0	24.7	2.0	1.2
Prostate Cancer	46.7	47.0	13.1	14.2	20.4	20.3	4.4	3.2
Stroke	31.3	33.3	16.3	17.1	14.7	14.9	6.9	3.6

Percentage of All-Payer Inpatient (IP) Cases, Knee Osteoarthritis vs. Knee Replacement, by Select Discharge Destination, 2020–2022



Data source: Definitive Healthcare © 2023

Key Takeaway

With hospital discharges stabilizing in 2023, home health staffing shortages (compounded by rising patient acuity) may be driving up the share of cases sent to SNFs. Nonetheless, rejection rates for referrals to home health (76%) and SNFs (80%) remain high. Although both settings are being affected by workforce challenges, leveraging technology—like telehealth—could relieve some of the burden across all settings as acute care providers work to balance the needs of its patients.[1]

[1] Stulick, A. (2023). Skilled Nursing vs. Home Health: Referral Trends Shift Due to Acuity, Staffing Shortages, Regulation. Retrieved from https://skillednursingnews.com/2023/03/skilled-nursing-vs-home-health-referral-trends-shift-due-to-acuity-staffing-shortages-regulation/. Accessed May 2023.

NOTE: Data for 2022 include commercial and Medicaid claims for the full calendar year and Medicare claims for January 1 through September 30, 2022.

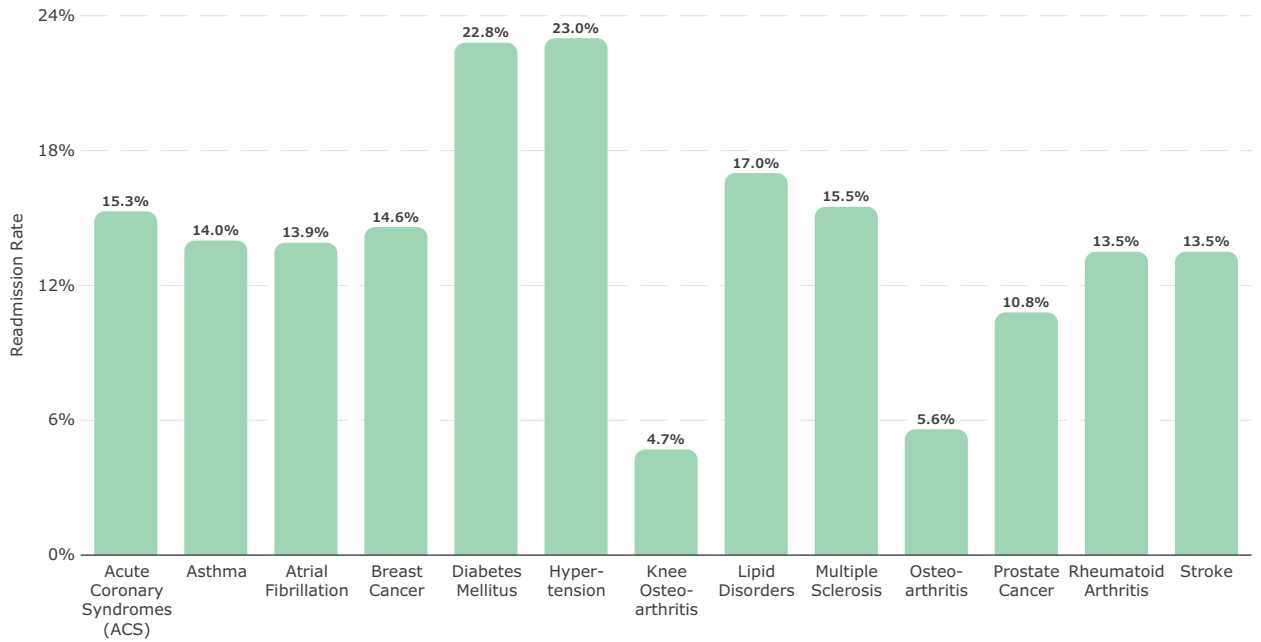
Quality

30-Day Medicare Readmission Rate for Hypertension Reaches 23%

- In 2022, Medicare cases with a primary diagnosis of hypertension recorded the highest 30-day readmission rate of the disease states shown, with 23.0% of such cases being readmitted in that time.
- From 2020 to 2022, patients with Type 2 diabetes on any insulin product had lower three- and 30-day readmission rates than those who were taking three non-insulin antidiabetic products.

Account-Level Data Available

30-Day Medicare Hospital Readmission Rates, by Primary Diagnosis, 2022



Data source: Definitive Healthcare © 2023

Hospital Readmission Rates for Patients Diagnosed With Type 2 Diabetes, Overall Vs. With Hypoglycemia, by Type of Therapy, 2020–2022[1–3]

	Three-Day Readmissions		30-Day Readmissions	
	Any Insulin Products	Three Non-Insulin Antidiabetic Products	Any Insulin Products	Three Non-Insulin Antidiabetic Products
Overall	6.4%	15.8%	17.5%	32.3%
w/ Hypoglycemia	12.5%	26.9%	34.5%	54.7%

Data source: IQVIA © 2023

Key Takeaway

To lighten the burden of the pandemic, the Centers for Medicare & Medicaid Services eased requirements for hospital readmission measures: fiscal year 2023 saw the fewest hospitals penalized since 2014. As quality metrics return to pre-pandemic specifications, hospitals will need strategies to prioritize patients at risk of readmission when first admitting them.[4]

[1] Figures reflect the percentages of all-payer Type 2 diabetes patients who were readmitted to an inpatient facility in the three-year period between 2020 and 2022. These percentages include patients who filled multiple prescriptions. Readmissions are not necessarily due to Type 2 diabetes.

[2] Patients who filled prescriptions for any insulin products may have also filled prescriptions for products in the non-insulin category, and vice versa.

[3] A complication is defined as a patient condition caused by diabetes. Complications of diabetes include, but are not limited to, atherosclerotic cardiovascular disease (ASCVD), cardiovascular (CV) disease, chronic kidney disease (CKD), congestive heart failure, diabetic ketoacidosis (DKA), end-stage renal disease (ESRD), hyperglycemia, hypoglycemia, myocardial infarction (MI), nephropathy, neuropathy, peripheral artery disease (PAD), retinopathy, and stroke. ASCVD includes patients with acute coronary syndromes (ACS), MI, stroke, and other cardiovascular diseases.

[4] Rau, J. (2022). Medicare Fines for High Hospital Readmissions Drop, But Nearly 2,300 Facilities Are Still Penalized. Retrieved from https://kffhealthnews.org/news/article/medicare-fines-hospital-readmissions-drop-covid/. Accessed July 2023.

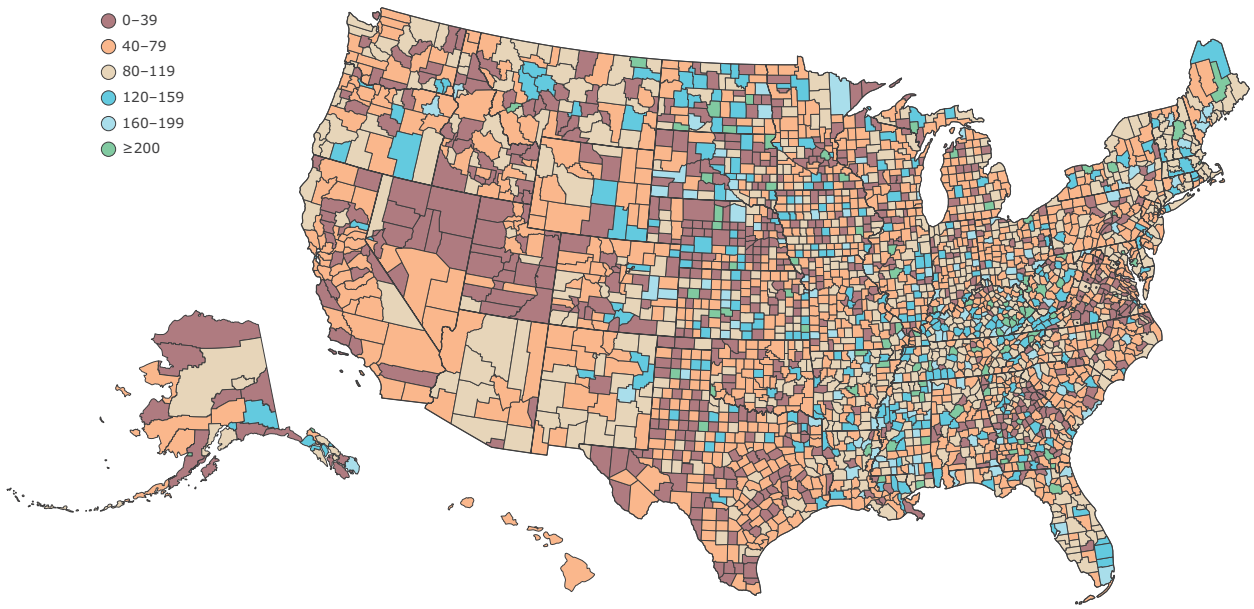
NOTE: Data from Definitive Healthcare for Medicare in 2022 are from January 1 to September 30, 2022.

Access to Care

Expected Employment Growth for NPs Remains High Amid Persistent Need

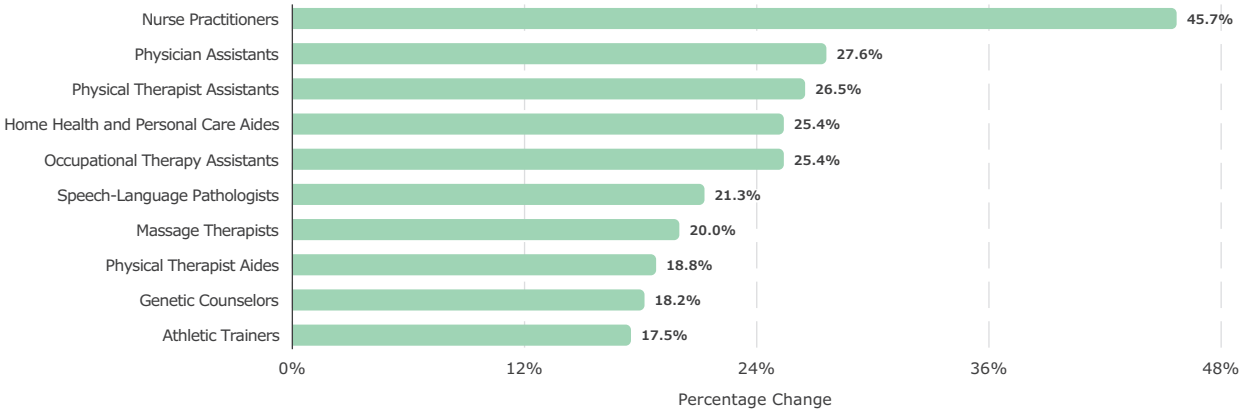
- U.S. counties, on average, reported 101.7 nurse practitioners (NPs) per 100,000 people in 2021, while 4.2% of counties still had fewer than 10 NPs per 100,000 population that same year.
- In 2021 to 2031 projections, NPs were forecasted as the fastest growing health care occupation. Estimates pointed to a 45.7% increase and an additional 112,700 such positions in that time.

Number of Nurse Practitioners per 100,000 Population, by County, 2021[1]



Data sources: Health Resources and Services Administration and U.S. Census Bureau © 2023

Projected Employment Percentage Change, by Health Care Occupation, 2021–2031



Data source: Bureau of Labor Statistics © 2023

Key Takeaway

In 2021, nearly two-thirds of primary care Health Professional Shortage Areas (HPSAs) were rural, with only 12% of physicians practicing in such areas. However, states with full practice authority laws report a higher likelihood of NPs practicing in HPSAs, thereby providing an opportunity to address gaps in health care, especially where management of chronic diseases proves challenging.[2,3]

[1] Data represent nurse practitioners with a National Provider Identifier (NPI).

[2] National Institute for Health Care Management. (2022). Rural Health During the Pandemic: Challenges and Solutions to Accessing Care. Retrieved from https://nihcm.org/publications/rural-health-during-the-pandemic. Accessed April 2023.

[3] Poghosyan, L., et al. (2022). State Responses to COVID-19: Potential Benefits of Continuing Full Practice Authority for Primary Care Nurse Practitioners. *Nursing Outlook*. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8346350/. Accessed April 2023.

NOTE: Raw employment data not shown.

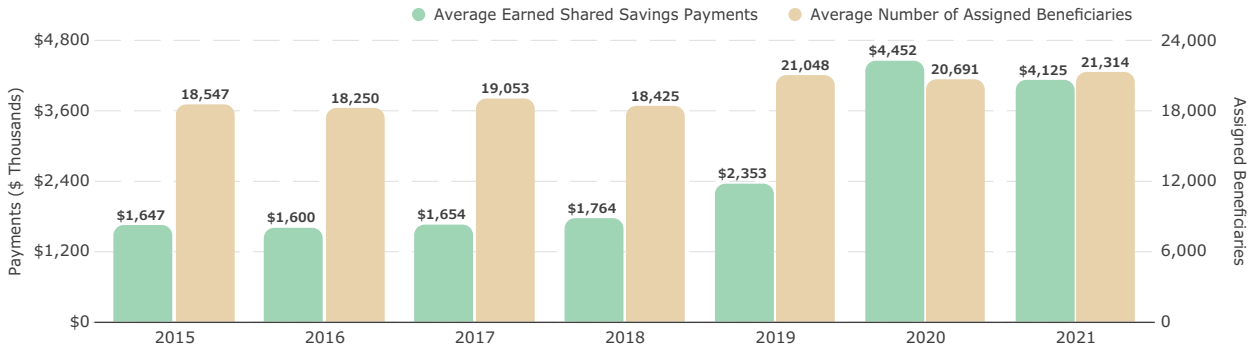
MSSP ACOs Earn Slightly Smaller Average Shared Savings Payments in PY 2021

- Falling from its highest ever value in performance year (PY) 2020, the average earned shared savings payment to MSSP ACOs saw a 7.3% year-over-year reduction in PY 2021.
- However, the earned shared savings payment for Palm Beach ACO increased by 14.0%, climbing to a nearly $62 million payment that same performance year.

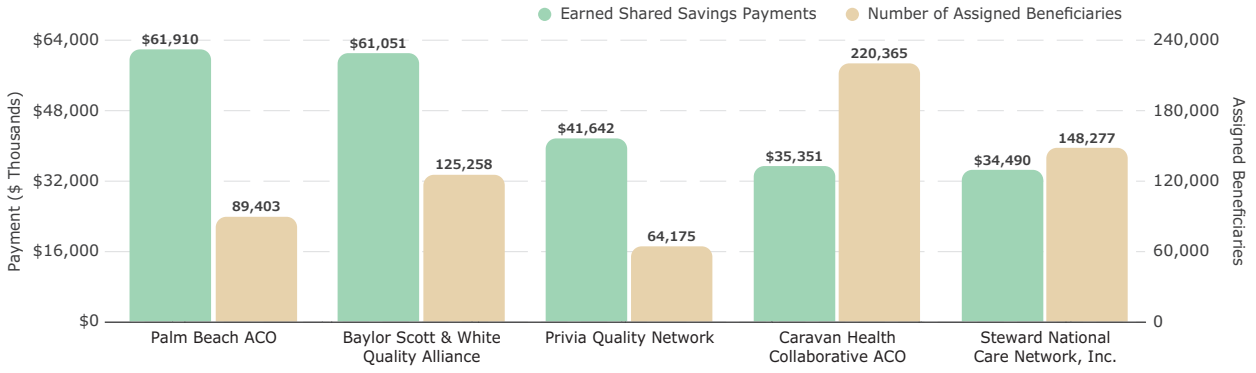
Account-Level Data Available

Earned Shared Savings Payments (in $ Thousands) and Assigned Beneficiaries per MSSP ACO, Performance Years 2015–2021[1,2]

LONG-TERM TREND



Earned Shared Savings Payments (in $ Thousands) and Assigned Beneficiaries for the Top 5 MSSP ACOs, Ranked by Payment Amount, Performance Year 2021[1,2]



Data source: Centers for Medicare & Medicaid Services © 2023

Key Takeaway

MSSP ACOs saved Medicare nearly $1.7 billion in 2021, the fifth consecutive year the program generated lower costs compared with spending targets.[3] With a transition from fee-for-service to value-based models in full swing, proposed rule changes in 2023 are projected to save Medicare more than $15 billion and generate $650 million in higher shared savings payments to ACOs.[4]

[1] A performance year is defined as the calendar year from January 1 to December 31.

[2] Earned shared savings payments: The ACO's share of savings for ACOs whose savings rate equaled or exceeded their minimum savings rate (MSR), and who were eligible for a performance payment because they met the program's quality performance standard.

[3] Centers for Medicare & Medicaid Services. (2022). Medicare Shared Savings Program Saves Medicare More Than $1.6 Billion in 2021 and Continues to Deliver High-Quality Care. Retrieved from https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-16-billion-2021-and-continues-deliver-high. Accessed May 2023.

[4] National Association of ACOs. (2023). Many Significant ACO Changes Included in Proposed Medicare Rule. Retrieved from https://www.naacos.com/press-release--many-significant-aco-changes-included-in-proposed-medicare-rule. Accessed May 2023.

NOTE: MSSP ACO is Medicare Shared Savings Program accountable care organization.

Medicare

Trends in Chronic Disease Management

Backgrounder

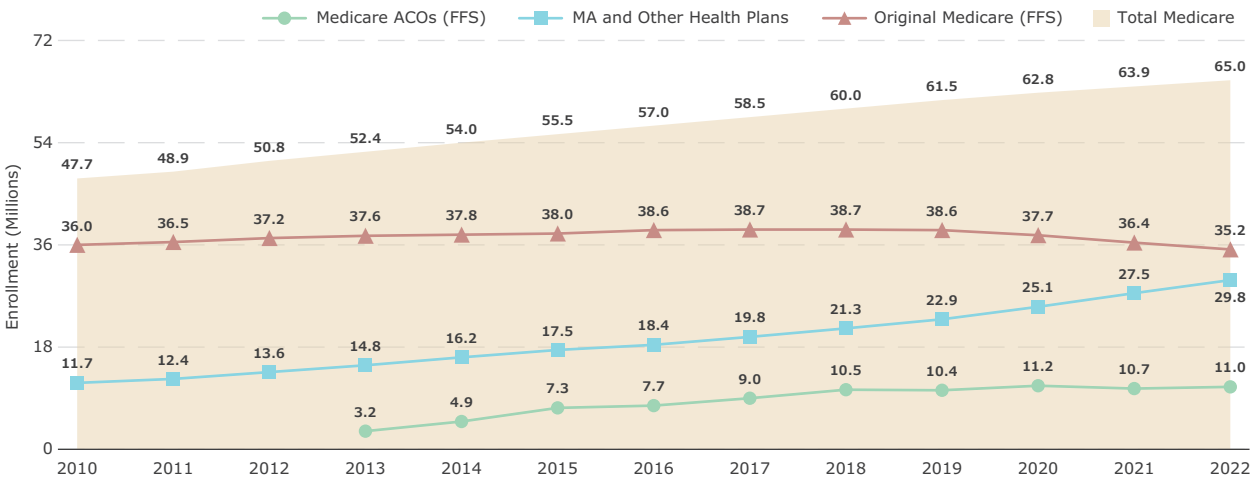
While total Medicare participation increased by more than 14 million beneficiaries in the past decade, enrollment in traditional fee-for-service (FFS) Medicare decreased, falling 5.4% between 2012 and 2022. Instead, beneficiaries are choosing Medicare Advantage (MA) plans—managed care arrangements between the Centers for Medicare & Medicaid Services (CMS) and private insurance companies. MA enrollment is poised to overtake FFS; MA penetration reached 49.9% (adjusted) nationally in 2022.[1,2] Half of large employers providing Medicare benefits offered at least one MA plan, with 44% offering exclusively MA plans.[2] Despite the cost savings promised by those plans, Medicare's financial durability remains in doubt amid increasing enrollment and investigations into inappropriate spending.[2]

The continued solvency of Medicare is a topic at the forefront of the Biden administration's agenda; the passage of the Inflation Reduction Act (IRA) in 2022 empowered CMS to negotiate drug prices with pharmaceutical manufacturers for the first time in Medicare history.[3] The Medicare Drug Price Negotiation Program will negotiate prices for 10 high-expenditure Medicare Part D drugs in its first year, with price changes taking effect in 2026.[3] A proposed budget from the Biden administration revealed further plans to bolster the Medicare trust by expanding the Negotiation Program and by increasing taxation on households earning more than $400,000. Although the proposal could extend Medicare solvency beyond 2050, it would require increased federal spending, a fiscal move opposed by many in Congress.[4,5]

Account-Level Data Available

Number of Medicare Beneficiaries (in Millions), Nation, 2010–2022

LONG-TERM TREND



Data source: Centers for Medicare & Medicaid Services © 2023

[1] Trish, E., et al. (2023). Substantial Growth in Medicare Advantage and Implications for Reform. *Health Affairs*. Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00668. Accessed March 2023.

[2] Miller, M. (2023). More Retiree Health Plans Move Away From Traditional Medicare. *The New York Times*. Retrieved from https://www.nytimes.com/2023/03/10/business/medicare-advantage-retirement-nyc.html. Accessed March 2023.

[3] CMS. (2023). Medicare Drug Price Negotiation Program: Next Steps in Implementation for Initial Price Applicability Year 2026. Retrieved from https://www.cms.gov/files/document/medicare-drug-price-negotiation-program-next-steps-implementation-2026.pdf. Accessed March 2023.

[4] Biden, J. (2023). Joe Biden: My Plan to Extend Medicare for Another Generation. *The New York Times*. Retrieved from https://www.nytimes.com/2023/03/07/opinion/joe-biden-medicare.html. Accessed March 2023.

[5] Emma, C. and Cancryn, A. Biden Sticks It to Republicans With His Budget Proposal. Retrieved from https://www.politico.com/news/2023/03/09/biden-budget-medicare-house-republicans-00086124. Accessed March 2023.

NOTE: Data for MA and Other Health Plans, Original Medicare (FFS), and Total Medicare include counts of Medicare beneficiaries with hospital/medical coverage broken out by health care delivery. Original Medicare (FFS) is Medicare's traditional health care system (also known as fee-for-service) and includes enrollees with any combination of Part(s) A and/or B. MA and Other Health Plans are health plans that are offered by private companies approved by Medicare to provide hospital/medical coverage. Other Health Plans include Medicare-Medicaid plans, Medicare cost plans, and Program of All-Inclusive Care for the Elderly (PACE) plans. For yearly data, Medicare enrollment counts are determined using a person-year methodology. For each calendar year, total person-year counts are determined by summing the total number of months that each beneficiary is enrolled during the year and dividing by 12. Using this methodology, a beneficiary's partial-year enrollment may be counted in more than one category (i.e., Original Medicare [FFS] and MA and Other Health Plans). Data for Medicare ACOs (FFS) include Medicare beneficiaries enrolled in Original Medicare (FFS) who have been assigned to any Medicare ACO in the given year.

MA Membership Continues to Climb, Approaching 30 Million Lives in 2022

- Total enrollment in Medicare Advantage (MA) plans neared 30 million in 2022, with increased membership reflected across all plan types, excepting PFFS, which declined 23% from 2021.
- All five of the profiled Senior Savings Model plan sponsors saw participation increase from 2022 to 2023; CVS Health gained 1.8 million enrollees in such plans—a surge of 476% from 2022.

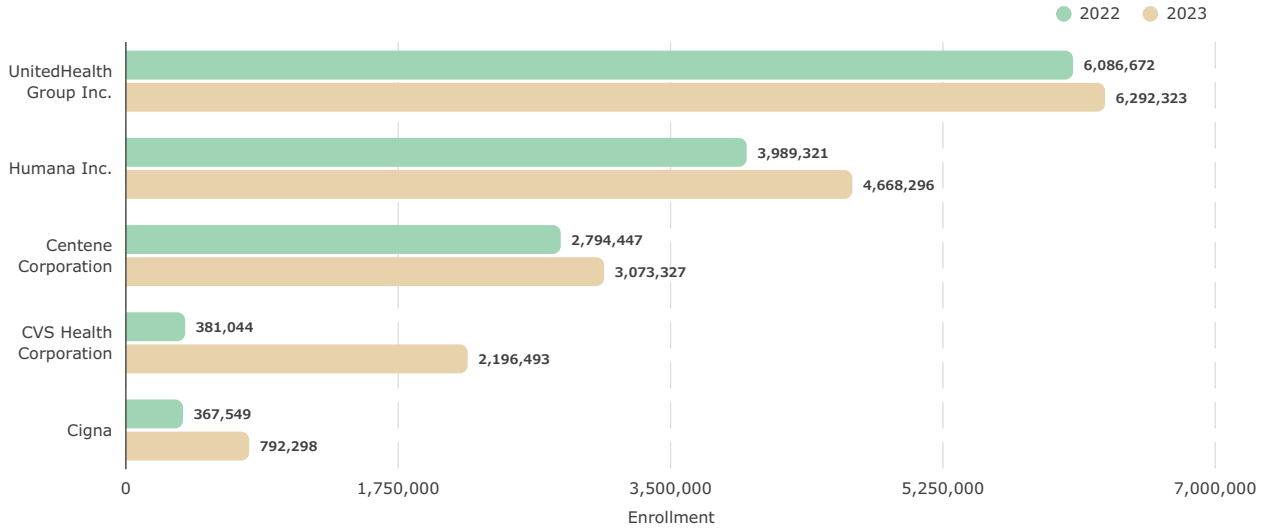
Account-Level Data Available

Medicare Advantage Enrollment, by Plan Type, 2016–2022[1]

LONG-TERM TREND

Plan Type	2016	2017	2018	2019	2020	2021	2022
HMO[2]	11,516,913	12,144,435	12,968,982	13,899,363	15,112,043	16,242,024	17,185,572
PPO[3]	5,609,535	6,442,307	7,220,121	8,395,353	9,386,756	10,789,647	12,120,318
PFFS	224,989	177,646	142,428	104,892	75,681	53,115	40,819
Other[4]	715,276	749,487	739,487	325,065	309,754	303,192	311,716
Total	**18,066,713**	**19,513,875**	**21,071,018**	**22,724,673**	**24,884,234**	**27,387,978**	**29,658,425**

Select Part D Senior Savings Model Participating Sponsor Enrollment, 2022–2023[5]



Data source: Centers for Medicare & Medicaid Services © 2023

Key Takeaway

In January 2021, the Centers for Medicare & Medicaid Services launched the Part D Senior Savings Model—a voluntary program that capped out-of-pocket costs for select insulin therapies at $35 per month. This model will end in December 2023, replaced by provisions in the Inflation Reduction Act, which extend this same cap to each insulin product covered by a Medicare prescription drug plan.[6]

[1] Enrollment figures are as of December of the year shown and do not include Medicare Advantage enrollees in Puerto Rico and U.S. territories. Figures differ from page 19, which uses a person-year methodology to determine enrollment counts during the given year.

[2] Includes HMO/HMO point-of-service and Medicare-Medicaid Plan HMO/HMO point-of-service.

[3] Includes local and regional PPOs.

[4] "Other" includes 1876 cost, HCPP-1833 cost, MSA, and National PACE plans.

[5] For each year shown, enrollment data reflect March enrollment for that year in plans identified as participating in that plan year's Part D Senior Savings Model (SSM) program. Data for all years include Medicare Advantage and prescription drug plan (PDP) programs. Sponsors are shown in descending order of SSM enrollment in 2023.

[6] Centers for Medicare & Medicaid Services. (2023). Part D Senior Savings Model. Retrieved from https://innovation.cms.gov/innovation-models/part-d-savings-model. Accessed April 2023.

NOTE: PFFS is private fee-for-service.

Average Overall Star Ratings Decline for Top 10 MA Plans in 2023

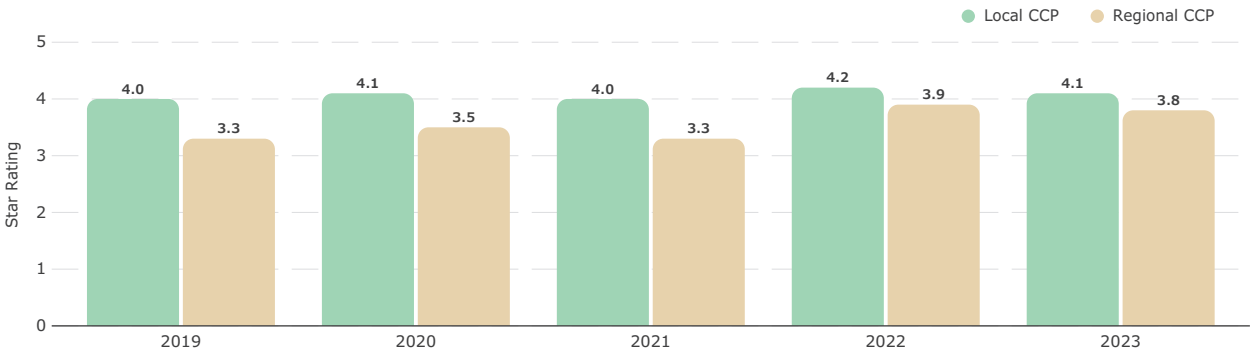
- The 10 largest Medicare Advantage (MA) organizations by enrollment earned 3.9 stars, on average, for their overall Star Rating, down from 4.3 for 2022's top 10 organizations.
- While Humana's local CCPs continued to earn a higher average overall Star Rating than its regional CCPs in 2023, both organization types recorded a decrease of 0.1 stars from 2022.

10 Largest Medicare Advantage Organizations, Average Star Ratings for Select Measures, 2023

Organization	Annual Flu Vaccine	Diabetes Care–Blood Sugar Controlled[1]	Statin Therapy for Patients With CV Disease[2]	Reducing the Risk of Falling[3]	2023 Overall Star Rating[4]
UnitedHealth Group Inc.	3.2	4.5	3.4	3.0	3.9
CVS Health Corporation	3.0	4.1	3.4	3.0	3.6
Humana Inc.	2.6	4.5	3.8	2.8	4.0
Centene Corporation	2.2	3.0	3.5	3.1	2.9
Cigna	3.1	4.5	3.6	3.1	3.6
Elevance Health Inc.	2.7	4.1	3.3	3.5	3.5
Kaiser Foundation Health Plan Inc.	4.9	4.9	4.4	2.7	4.8
Blue Cross Blue Shield of Michigan	4.5	4.8	3.5	2.0	4.3
Highmark Health	4.3	4.8	4.2	2.8	4.7
Health Care Service Corporation	4.1	3.8	3.4	2.3	3.4

Humana Inc. Average Overall Star Rating, by Organization Type, 2019–2023

LONG-TERM TREND



Data source: Centers for Medicare & Medicaid Services © 2023

Key Takeaway

The Centers for Medicare & Medicaid Services enacted several changes to Star Rating methodology in 2023, giving more weight to patient experience measures like care coordination, getting needed prescription drugs, and members' ratings of health care quality.[5] Although the impact may vary across plans, these changes emphasize efforts to prioritize consumer feedback in the MA space.[6]

[1] Percentage of plan members 18–75 years of age with diabetes who either had an A1c (average blood glucose over the past 3 months) >9.0% or were not tested during the measurement period. The value is subtracted from 100%, which provides the performance rate. A higher performance rate indicates better quality.

[2] Percentage of members with clinical atherosclerotic cardiovascular disease (ASCVD) who received at least one high or moderate-intensity statin medication during the measurement year.

[3] Percentage of plan members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months.

[4] Simple average of all Parts C and D quality measures (not all 2023 measures are shown). Other than the overall Star Rating, only Part C measures are presented herein.

[5] Centers for Medicare & Medicaid Services. (2023). Medicare 2023 Part C & D Star Ratings Technical Notes. Retrieved from https://www.cms.gov/files/document/2022-star-ratings-technical-notes-oct-4-2022.pdf. Accessed April 2023.

[6] King, R. (2022). 87% of Medicare Advantage Plans Could Lose One or More Stars in 2023 Ratings. Retrieved from https://www.fiercehealthcare.com/payers/study-87-medicare-advantage-plans-could-lose-one-or-more-stars-2023-ratings. Accessed April 2023.

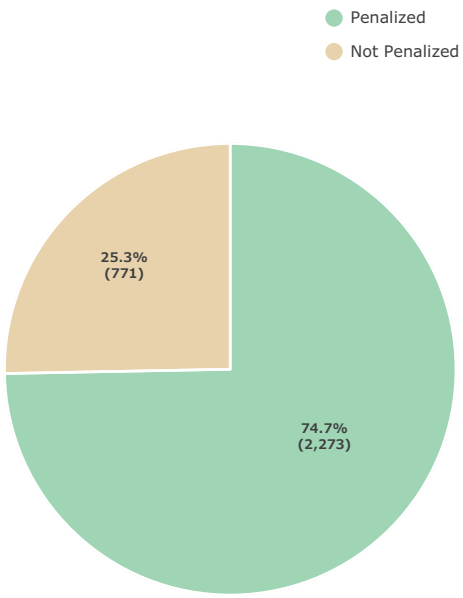
NOTE: CCP is coordinated care plan.

Quality

Percentage of Participating Hospitals Penalized Under HRRP Falls in FY 2023

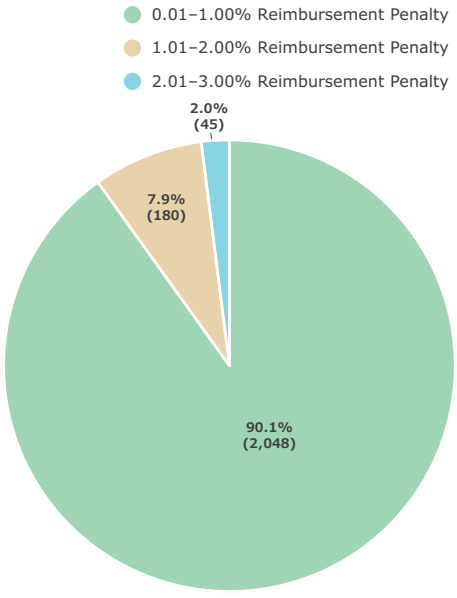
- In fiscal year (FY) 2023, roughly three of every four facilities participating in the Hospital Readmissions Reduction Program (HRRP) received a payment penalty, a decline from 82.0% in FY 2022.
- HF was the leading diagnosis in FY 2023 for which hospitals were penalized under the HRRP (43.9%). Pneumonia, the prior year leader in penalties, was suppressed from the HRRP in FY 2023.

Distribution (Number) of Hospitals Under HRRP, by Penalty Status, FY 2023[1]



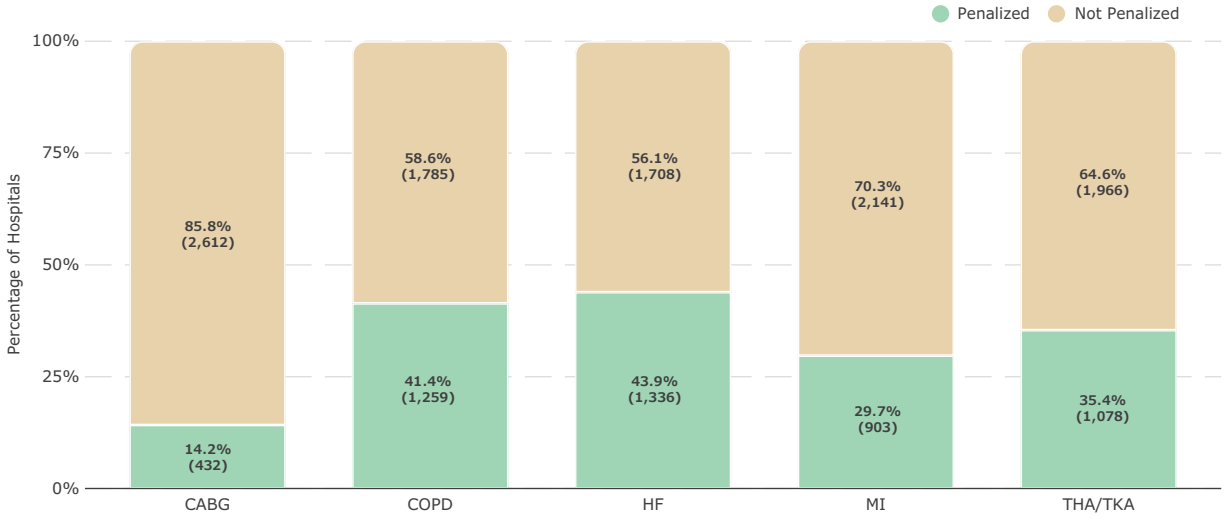
FY 2022: **Penalized: 82.0% (2,500)**
Not Penalized: 18.0% (547)

Distribution (Number) of Penalized Hospitals, by Reimbursement Penalty, FY 2023[1]



FY 2022: **0.01–1.00%: 78.6% (1,966)**
1.01–2.00%: 16.1% (402)
2.01–3.00%: 5.3% (132)

Distribution (Number) of Hospitals Under HRRP, by Penalty Status and Diagnosis, FY 2023[1]



Data source: Centers for Medicare & Medicaid Services © 2023

[1] The total number of hospitals evaluated and penalized may include institutions that have closed or merged with other facilities, and excludes Maryland.

NOTE: CABG is coronary artery bypass graft, COPD is chronic obstructive pulmonary disease, HF is heart failure, MI is myocardial infarction, and THA/TKA is total hip arthroplasty/total knee arthroplasty. FY 2022 HRRP data by diagnosis are not shown.

Financials

Medicare FFS Actual Costs Rise for Outpatient, Ambulatory Surgery Centers

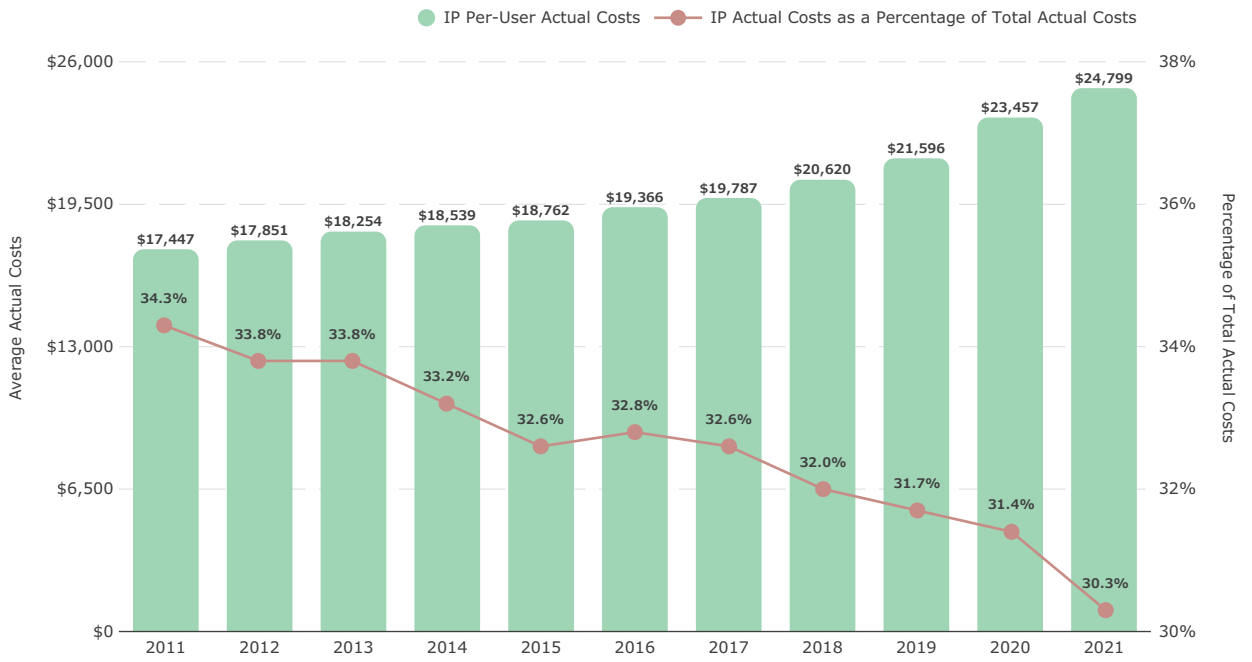
- From 2020 to 2021, Medicare fee-for-service (FFS) actual costs decreased for four of the six settings shown. Such costs in ambulatory surgery and OP settings rose by 18.1% and 11.4%, respectively.
- IP per-user costs within FFS Medicare amounted to nearly $25,000 in 2021—up from $23,457 in 2020. Meanwhile, the IP share of total FFS actual costs declined by 1.1 percentage points.

FFS Medicare Actual Costs (in $ Billions), by Setting, 2019–2021

Setting	2019	2020	2021
Inpatient (IP)	$117.1	$109.4	$108.9
Outpatient (OP)	60.5	55.4	61.8
Post-Acute Care: Skilled Nursing Facility	24.9	26.0	24.3
Post-Acute Care: Home Health	16.7	16.0	15.6
Hospice	12.2	12.6	12.2
Ambulatory Surgery Center	4.1	3.8	4.4

FFS Medicare IP Per-User Actual Costs and Percentage of Total Actual Costs, 2011–2021

LONG-TERM TREND



Data source: Centers for Medicare & Medicaid Services © 2023

Key Takeaway

In 2021, the Centers for Medicare & Medicaid Services moved to eliminate the Inpatient Only list from its OP Prospective Payment System rule, likely in an attempt to shift more IP care to OP settings.[1] Although ultimately reversed, this move was perhaps motivated by the sizable cost difference between IP and OP costs per user: $24,799 vs. $2,938 (OP data not shown).

[1] Centers for Medicare & Medicaid Services. (2021). CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1753FC). Retrieved from https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0. Accessed March 2023.

Medicaid

Trends in Chronic Disease Management

Backgrounder

Medicaid enrollment surpassed a record 90 million recipients in 2022, swelling by more than 21 million enrollees since 2019. Participation in Medicaid grew year over year throughout the COVID-19 Public Health Emergency (PHE), a trend that was driven in part due to the pause in the annual Medicaid redeterminations cycle—the process through which continuing eligibility for Medicaid is determined. In early 2023, the COVID-19 PHE officially came to an end, an event that is expected to have a profound impact on Medicaid enrollment, not to mention the enrollees themselves.[1]

State Medicaid agencies have been tasked with resuming normal Medicaid redetermination processes over the course of a 14-month unwinding period. The Centers for Medicare & Medicaid Services (CMS) issued guidance to the states in an attempt to smooth the transition to pre-PHE Medicaid eligibility and enrollment operations, but ultimately state Medicaid agencies will decide how to handle the coming redeterminations.[2,3]

Medicaid expansion—a provision of the Affordable Care Act that allows states to extend Medicaid coverage to people with household incomes up to 138% of the federal poverty level—may soften the impact of resuming redeterminations for recipients in states that have adopted it. To date, 40 states and Washington, D.C., have adopted Medicaid expansion, with only 10 states maintaining non-expansion status.[4]

Two states that recently expanded Medicaid—North Carolina and South Dakota—have been put into a challenging position by the restart of redetermination. Both states have adopted but not implemented Medicaid expansion, meaning that the additional coverage is not yet available to residents. South Dakota began processing redeterminations on April 1, 2023—the earliest possible date—removing 16,000 residents from Medicaid in that month alone; 1,700 of those removed would qualify for coverage under Medicaid expansion.[4,5] The challenges of this transition period will play out in the coming months.

Total Number of Medicaid Recipients (in Millions), Nation, 2014–2022[6]

LONG-TERM TREND

Data source: Centers for Medicare & Medicaid Services © 2023

[1] Department of Health and Human Services (HHS). (2023). Guidance for the Expiration of the COVID-19 Public Health Emergency (PHE). Retrieved from https://www.cms.gov/files/document/qso-23-13-all.pdf. Accessed May 2023.

[2] CMS. (2022). Medicaid and Children's Health Insurance Program (CHIP) Unwinding Planning Efforts. Retrieved from https://www.medicaid.gov/resources-for-states/downloads/state-unwinding-best-practices.pdf. Accessed May 2023.

[3] HHS. (2023). Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf. Accessed May 2023.

[4] Kaiser Family Foundation. (2023). Status of State Medicaid Expansion Decisions. Retrieved from https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/. Accessed May 2023.

[5] Zionts, A. (2023). Thousands Face Medicaid Whiplash in South Dakota and North Carolina. Retrieved from https://www.cbsnews.com/news/medicaid-eligibility-whiplash-south-dakota-north-carolina/. Accessed May 2023.

[6] Data for 2014 through 2022 are as of December. All data include Medicaid and CHIP recipients. Data for 2014 through 2021 do not account for any restatements of enrollment figures from CMS.

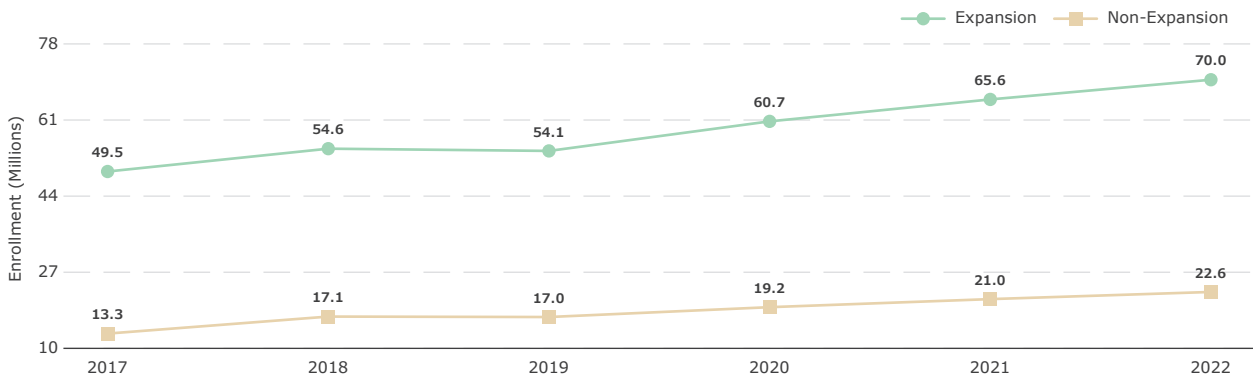
Demographics

Medicaid Enrollment Climbs in Expansion and Non-Expansion States in 2022

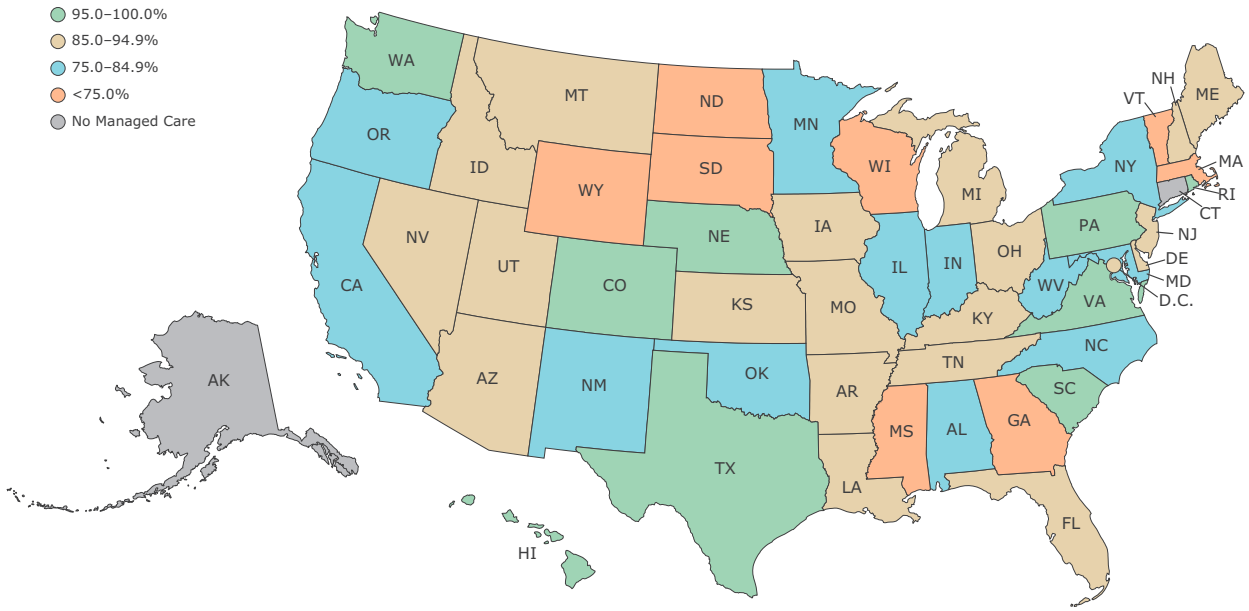
- States with expanded Medicaid eligibility saw an enrollment increase of 4.4 million recipients from 2021 to 2022. Enrollment for non-expansion states during that time grew by 1.6 million.
- Over 75% of Medicaid recipients in 40 states and Washington, D.C., were covered in 2020 under a managed care plan; in fact, nine of these states reported 95% or more managed care penetration.

Total Medicaid Enrollment (in Millions), Expansion vs. Non-Expansion States, 2017–2022[1]

LONG-TERM TREND



Managed Care Penetration Into Medicaid, by State, 2020



Data source: Centers for Medicare & Medicaid Services © 2023

Key Takeaway

In 2023, the Centers for Medicare & Medicaid Services proposed new quality and reporting standards for managed Medicaid plans, which cover nearly three-quarters of recipients. Pending approval, states would be required to conduct annual surveys and payment comparisons, as well as to implement quality rating systems—an effort to ensure enrollees can select quality care.[2]

[1] Data for 2017 through 2022 are as of December. All data include Medicaid and Children's Health Insurance Program (CHIP) recipients. Data for 2017 through 2021 do not account for any restatements of enrollment figures from the Centers for Medicare & Medicaid Services (CMS).

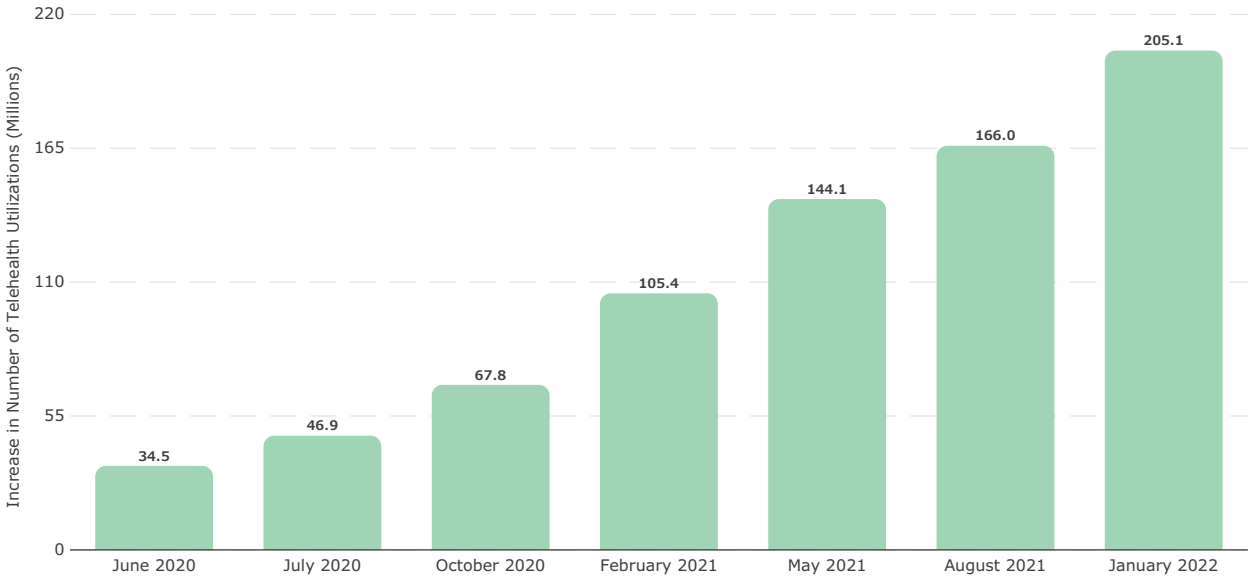
[2] CMS. (2023). Summary of CMS's Access-Related Notices of Proposed Rulemaking: Ensuring Access to Medicaid Services (CMS 2442-P) and Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P). Retrieved from https://www.cms.gov/newsroom/fact-sheets/summary-cmss-access-related-notices-proposed-rulemaking-ensuring-access-medicaid-services-cms-2442-p. Accessed June 2023.

Digital Health Care

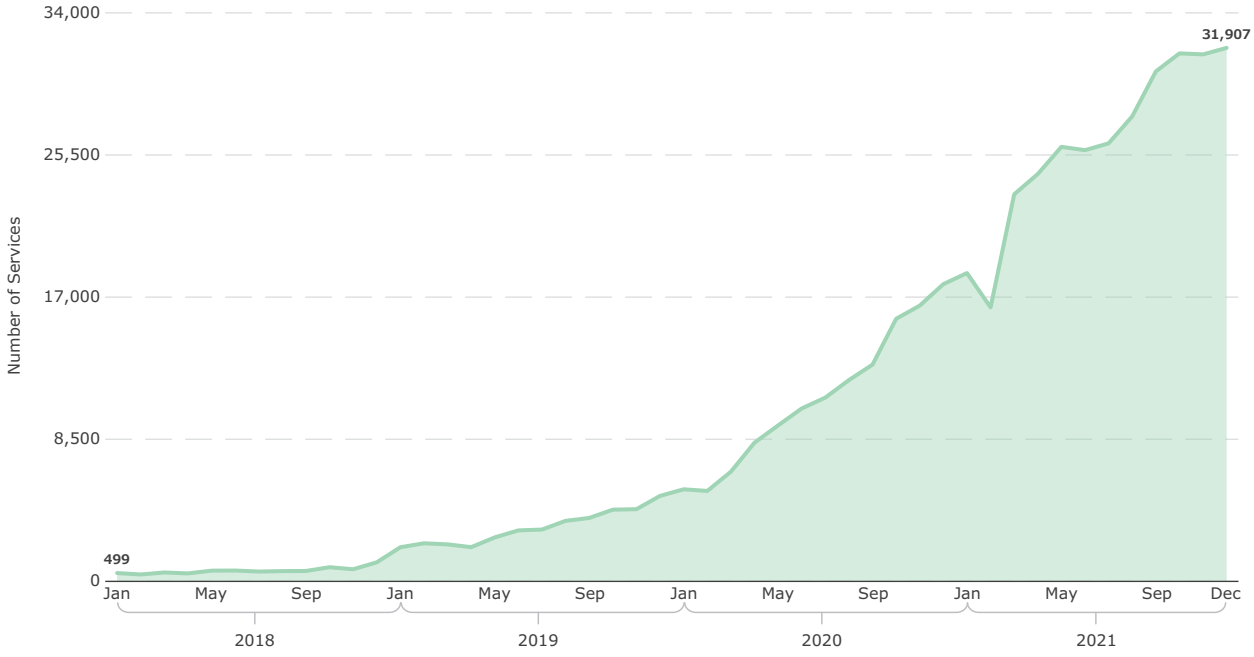
Medicaid Telehealth Use Continues to Climb as COVID-19 Pandemic Subsides

- From August 2021 to January 2022, telehealth utilization jumped yet again among Medicaid recipients, with 39.1 million more such services used during that time.
- Similarly, use of remote patient monitoring services by Medicaid and CHIP populations skyrocketed since 2018, increasing more than 300% from March 2020 to December 2021 alone.

Increase in Utilization of Telehealth Services (in Millions) by Medicaid Recipients, 2020–2022[1]



Utilization of Remote Patient Monitoring Services by Medicaid and CHIP Recipients, 2018–2021



Data source: Centers for Medicare & Medicaid Services © 2023

[1] Each data point reflects telehealth utilization beginning in March 2020 and ending in the month and year displayed versus a pre-pandemic comparator (the same period, two years prior). The dates indicate reporting points and, therefore, do not represent a timeline with evenly spaced events.

NOTE: CHIP is Children's Health Insurance Program.

Commercial Payers

Trends in Chronic Disease Management

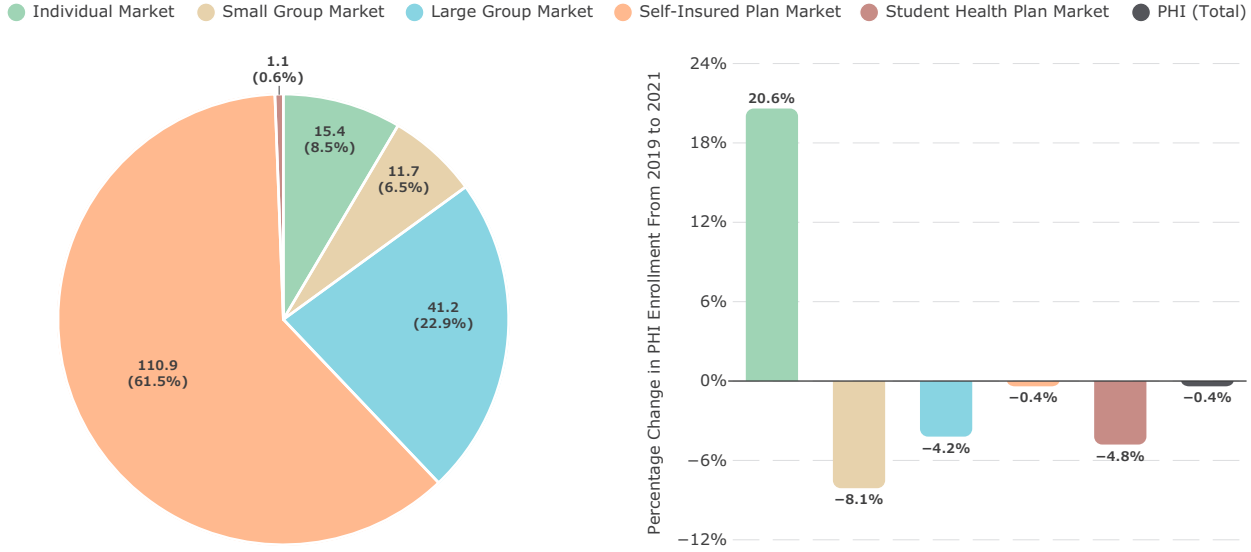
Backgrounder

Enrollment in private health insurance (PHI) neared pre-pandemic levels in 2021, with total enrollment down by less than half a percent—a decline of just under 650,000 lives—from 2019. By component, the individual market was the only segment to see an increase in enrollment during that time, spiking by 20.6% (2.6 million lives) from 2019 to 2021. The health insurance exchange marketplaces were a major driver of individual market enrollment in 2021, with 11.3 million enrollees choosing coverage through a marketplace plan in the first quarter of 2021 alone.[1] As part of a broader Biden administration initiative to lower health care costs for Americans, the American Rescue Plan Act expanded eligibility for marketplace premium tax credits in 2021 and 2022; the Inflation Reduction Act extended this through 2025.[1,2]

As health care normalizes in the wake of COVID-19, payers are feeling the impact of a return to pre-pandemic operations. Insurers had been benefiting from a delay in non-urgent procedures—due to the pandemic itself and resulting health care staffing shortages—but those gains appear to be dwindling. Market valuation for UnitedHealth Group, the largest U.S. health care provider, dropped in mid-2023, with UnitedHealth citing a rise in costs driven by outpatient care for seniors.[3] In parallel, commercial payers are set to issue $1.1 billion in medical loss ratio (MLR) rebates in 2023. The 2023 MLR calculation still includes data for pandemic years 2020 and 2021, meaning the rising service costs that are currently impacting payer valuations may not lower MLR rebates until 2024.[4]

Account-Level Data Available

Number (Distribution) of PHI Enrollment (in Millions) and Two-Year Percentage Change, by Component, 2021



Data source: Centers for Medicare & Medicaid Services © 2023

[1] Ortaliza, J., Amin, K., and Cox, C. (2022). As ACA Marketplace Enrollment Reaches Record High, Fewer Are Buying Individual Market Coverage Elsewhere. Retrieved from https://www.kff.org/policy-watch/as-aca-marketplace-enrollment-reaches-record-high-fewer-are-buying-individual-market-coverage-elsewhere/. Accessed July 2023.

[2] Internal Revenue Service. (2022). The Premium Tax Credit–The Basics. Retrieved from https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics. Accessed July 2023.

[3] Satija, B. and Leo, L. (2023). Health Insurers Slammed After UnitedHealth Says More Surgeries Driving Up Costs. Retrieved from https://www.reuters.com/business/healthcare-pharmaceuticals/unitedhealth-falls-warning-higher-medical-costs-2023-06-14/. Accessed July 2023.

[4] Bailey, V. (2023). KFF: Payers Will Issue $1.1B in Medical Loss Ratio Rebates in 2023. Retrieved from https://healthpayerintelligence.com/news/kff-payers-will-issue-1.1b-in-medical-loss-ratio-rebates-in-2023. Accessed July 2023.

NOTE: The individual market represents all PHI plans provided to individuals and their dependents. The small group market serves employers with 1–50 employees, unless the state in which the policy is written elects an upper limit of 100 employees. The large group market serves employers with more employees than the state's upper limit, generally 51 or more employees. The self-insured plan market includes those plans for which a reporting entity, as an administrator, performs administrative services such as claims processing for an employer that is at risk, and accordingly, the administrator has not issued an insurance policy. The student health plan market includes all insurance policies issued to students and their dependents pursuant to a written agreement between the issuer and the institution of higher education.

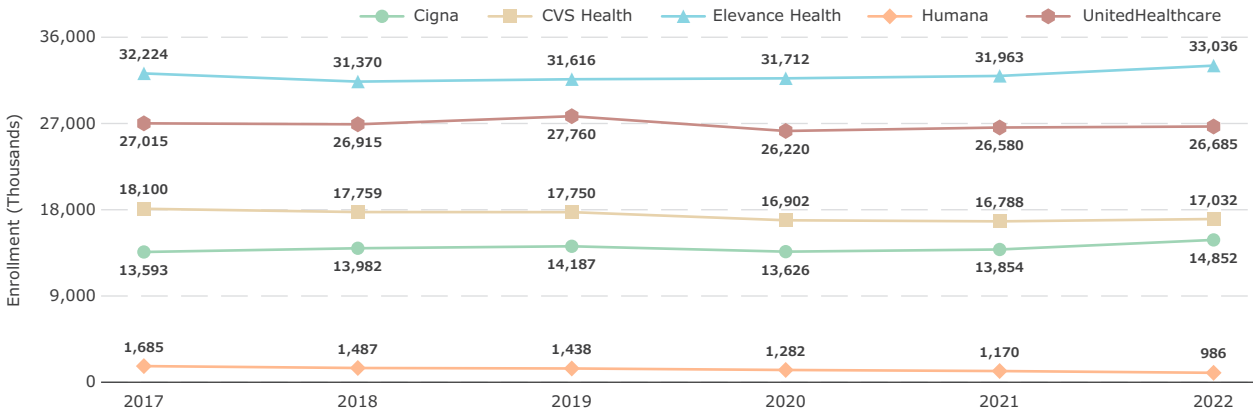
Demographics

2022 PHI Enrollment Increases for Majority of Top National Plans

LONG-TERM TREND

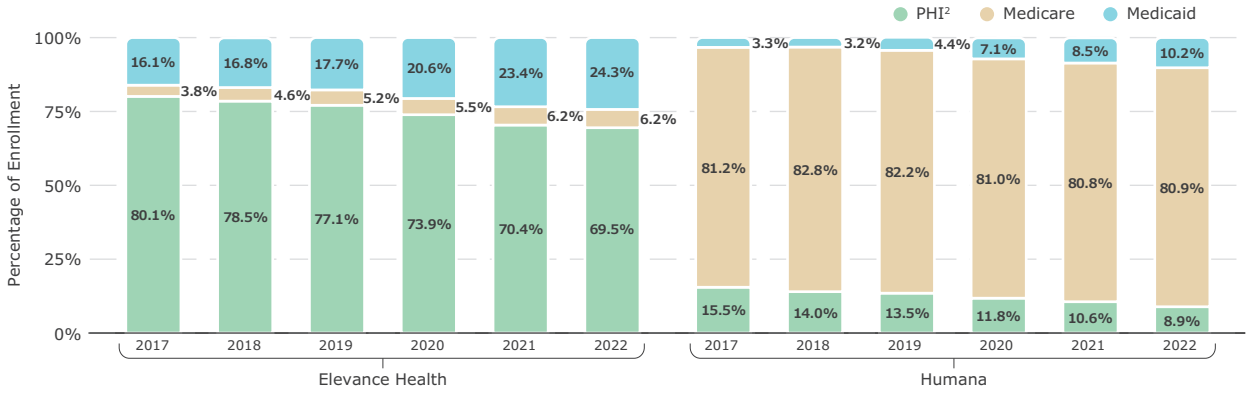
- In 2022, PHI membership increased again for Cigna, Elevance Health, and UnitedHealthcare. Meanwhile, following a four-year fall, CVS Health's PHI membership grew, surpassing 2020 levels.
- Medicaid enrollment shares for Elevance Health and Humana have expanded since 2018, notably spiking in 2020. Medicare portions remained relatively stagnant from 2021 to 2022, while PHI shrank.

PHI Enrollment, Top National Plans (in Thousands), 2017–2022[1,2]



Data sources: Cigna, CVS Health, Elevance Health, Humana, and UnitedHealthcare 10-K Filings © 2023

Distribution of Total Enrollment, by Book of Business, 2017–2022[3]



Data sources: Elevance Health and Humana 10-K Filings © 2023

Key Takeaway

In 2022—for the first time in at least six years—Humana's PHI enrollment fell below one million. Indeed, Humana announced a gradual exit from the commercial business in February 2023. Such a move will ripple through this segment, carrying significant implications for its enrollees. Analysts expect regulatory and strategic shifts may trigger similar exits by other plans, moves that can disrupt coverage and care of members with chronic disease.[4,5]

[1] Enrollment plan counts include fully insured and administrative services contracts. Elevance Health enrollment also includes federal employees.

[2] PHI is private health insurance.

[3] Plan distributions are based on total enrollment, excluding military services.

[4] Joszt, L. (2023). Humana Leaving Commercial Business, Will Focus on Government-Funded Programs. *American Journal of Managed Care*. Retrieved from https://www.ajmc.com/view/humana-leaving-commercial-business-will-focus-on-government-funded-programs. Accessed March 2023.

[5] Plescia, M. (2023). Is Exiting the Employer Insurance Market a Smart Move for Humana? Retrieved from https://medcitynews.com/2023/02/is-exiting-the-employer-insurance-market-a-smart-move-for-humana/. Accessed March 2023.

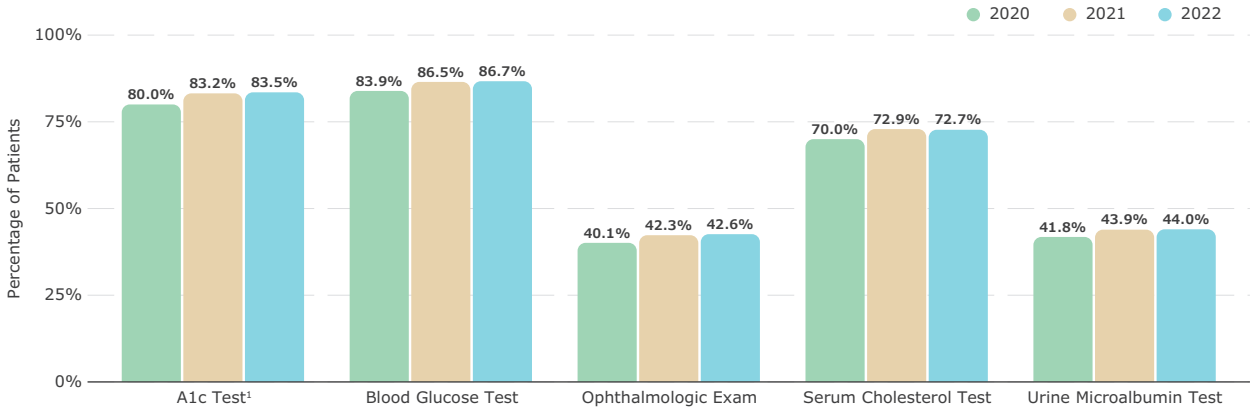
Demographics

Screening Rates for Type 2 Diabetes Patients Continue to Recover in 2022

- From 2021 to 2022, national screening rates for commercial Type 2 diabetes patients rose in four of five categories shown, following a pandemic-induced dip in screening rates in 2020.
- The share of commercial Type 2 diabetes patients with select complications declined across half of the categories profiled from 2021 to 2022—CKD, DKA, and retinopathy excepted.

Account-Level Data Available

Percentage of Commercial Type 2 Diabetes Patients Receiving Various Screenings, 2020-2022



Percentage of Commercial Type 2 Diabetes Patients, by Reported Complication, 2020-2022[2]

	2020	2021	2022
ASCVD	34.6%	34.8%	34.4%
CKD	18.6	18.6	19.2
DKA	1.1	1.1	1.1
Hyperglycemia	39.5	40.1	39.7
Hypoglycemia	2.9	2.9	2.8
Retinopathy	15.4	16.2	16.7

Data source: IQVIA © 2023

Key Takeaway

Despite the rising prevalence of diabetic retinopathy, screening rates among diabetes patients in the U.S. remain less than optimal. Healthy People 2030 set a goal to increase the national diabetic retinopathy screening rate to 67.7%, underscoring that social determinants of health such as insurance status, race, and income level can impact a patient's ability to receive needed screenings.[3]

[1] The A1c test measures the average blood glucose over the past 3 months. Figures reflect the percentage of diabetes patients who have had at least one A1c test in a given year.

[2] A complication is defined as a patient condition caused by diabetes. Complications of diabetes include, but are not limited to, atherosclerotic cardiovascular disease (ASCVD), chronic kidney disease (CKD), diabetic ketoacidosis (DKA), hyperglycemia, and retinopathy. ASCVD includes patients with acute coronary syndromes, myocardial infarction, stroke, and other cardiovascular diseases.

[3] Lin, G., et al. (2022). Diabetic Retinopathy Screening. *American Academy of Opthalmology*. Retrieved from https://eyewiki.aao.org/Diabetic_Retinopathy_Screening#Screening_Rates_in_the_United_States_and_Impact_of_Social_Determinates_of_Health. Accessed May 2023.

NOTE: Pre-2020 data are not shown.

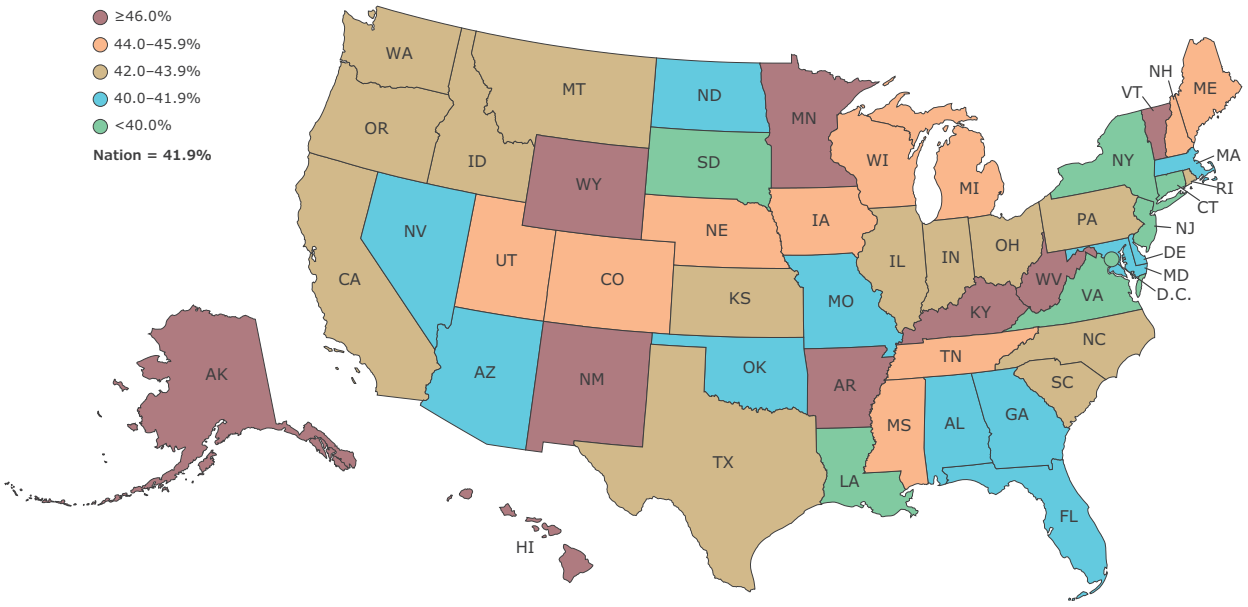
Demographics

More Than Four in 10 Commercial Type 2 Diabetes Patients Have A1c >7.0%

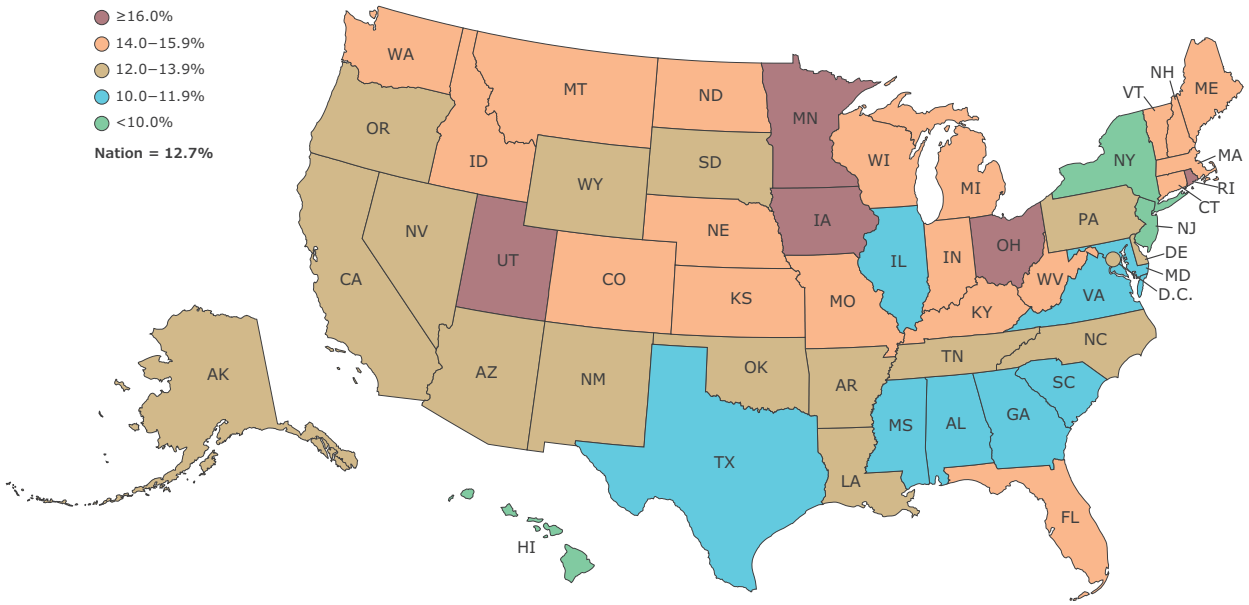
- Roughly 42% of commercial Type 2 diabetes (T2D) patients nationally had an A1c >7.0% in 2022, a share that was even higher in 33 states and highest in Vermont (48.9%).
- In 2022, Minnesota had the highest share (19.2%), by state, of commercial T2D patients with depression; Minnesota also had the second-highest share of T2D patients with an A1c >7.0%.

Account-Level Data Available

Percentage of Commercial Type 2 Diabetes Patients With an A1c Level >7.0%, by State, 2022[1]



Percentage of Commercial Type 2 Diabetes Patients With Depression, by State, 2022[2]



Data source: IQVIA © 2023

[1] The A1c test measures the average blood glucose over the past 3 months. Figures reflect the percentage of diabetes patients who have had at least one A1c test in a given year.

[2] A comorbidity is a condition a patient with diabetes may also have, which may not be directly related to the diabetes. Comorbidities were narrowed down to a subset of conditions which are typically present in patients with diabetes. Comorbidities of diabetes include, but are not limited to, depression, hyperlipidemia, hypertension, knee osteoarthritis, obesity, pneumonia, and rheumatoid arthritis.

Health Insurance Exchange Plan Enrollment Hits Another All-Time High

- A staggering 16.4 million plan selections were made through HIXs in 2023, with Florida reporting the largest number of selections (3.2 million), accounting for nearly one-fifth (19.7%) of the total.
- Meanwhile, HIX plans in 14 of the states shown had an average overall quality rating greater than the national average (3.4 stars); Massachusetts plans scored highest—one full star above the average.

Number and Distribution of Individuals Who Selected a Plan Via HIX and Average HIX Overall Quality Rating, by State, 2023[1]

State	Plan Selection	Selection Distribution			Overall Quality Rating
		New Enrollment	Active Reenrollment	Automatic Reenrollment	
Florida	3,225,435	22.5%	58.9%	18.6%	2.7
Texas	2,410,810	29.5	54.7	15.8	2.4
California	1,739,368	15.1	25.0	59.9	2.9
Georgia	879,084	28.4	51.3	20.3	3.2
North Carolina	800,850	23.2	55.4	21.4	3.4
South Carolina	382,968	26.4	51.3	22.3	2.8
Pennsylvania	371,516	17.5	16.5	66.1	3.6
Tennessee	348,097	27.4	50.3	22.2	3.0
Virginia	346,140	22.2	53.2	24.7	4.0
Illinois	342,995	23.2	50.3	26.5	3.3
New Jersey	341,901	22.5	18.3	59.2	2.8
Michigan	322,273	20.7	52.3	26.9	3.9
Utah	295,196	18.0	63.9	18.1	3.3
Ohio	294,644	25.4	48.4	26.2	3.7
Alabama	258,327	24.6	49.6	25.8	3.0
Missouri	257,629	23.9	48.5	27.6	2.6
Arizona	235,229	26.5	49.4	24.1	2.6
Massachusetts	232,621	12.6	17.4	70.0	4.4
Washington	230,371	17.1	20.9	62.0	4.1
Wisconsin	221,128	17.9	60.4	21.6	3.9
New York	214,052	13.9	27.5	58.6	4.1
Oklahoma	203,157	19.8	47.9	32.3	2.0
Colorado	201,758	19.8	50.7	29.5	3.2
Indiana	185,354	26.2	48.5	25.3	3.5
Mississippi	183,478	26.7	46.9	26.5	2.5
Maryland	182,166	18.8	16.1	65.2	4.3
Oregon	141,963	18.8	58.1	23.2	4.0
Kansas	124,473	23.6	52.8	23.5	3.0
Louisiana	120,804	24.7	45.5	29.8	3.7
Minnesota	118,431	21.8	11.1	67.1	4.0
Connecticut	108,132	18.2	23.1	58.7	4.0
Nebraska	101,490	18.6	66.4	15.0	2.5
Arkansas	100,407	26.3	39.3	34.4	1.5
Nation	**16,357,030**	**22.6%**	**46.6%**	**30.7%**	**3.4**

Data source: Centers for Medicare & Medicaid Services © 2023

[1] States with fewer than 100,000 enrollees were excluded. Plan selection data are as of March 2023; data for any state-based marketplaces (SBMs) using their own platforms shown here represent the reporting period for plan selection and marketplace activity from the beginning of the open enrollment period (OEP) on November 1, 2022, to the end of each SBM's respective OEP and any run-out period that captures remaining in-line applications and post-OEP cleanup activities. Any renewals processed before November 1, 2022, are also included. Overall quality rating data are as of October 2022. New enrollment, active reenrollment, and automatic reenrollment definitions may differ slightly between state-based exchanges and those offered on the federally facilitated exchange, Healthcare.gov.

NOTE: HIXs are health insurance exchanges. Data include states operating through the federally facilitated exchange and state-based exchanges. Pre-2023 plan year data are not shown. Numbers may not sum to 100% due to rounding.

Access to Care Challenges Health Insurance Exchange Plans in Many States

- In 2023, HIX plans in Arkansas averaged a 101.5 score for access to care, the only state of the 39 profiled to exceed 100.0; 12 of the profiled states were below 90.0 for this measure.
- Nationwide that same year, HIX plans performed best on asthma medication management (80.3%) and worst on eye exams for diabetes patients (43.8%), of the metrics profiled.

Account-Level Data Available

Average Ratings on Select HIX Plan Quality Measures, by State, 2023[1]

State	Access to Care (Score)	Asthma Medications Managed	Antidepressant Medications Managed	Controlling High Blood Pressure	Comprehensive Diabetes Care		Flu Vaccinations for Adults
					Controlled HbA1c (<8.0%)	Received Eye Exam	
Arkansas	101.5	53.2%	51.7%	51.2%	42.1%	34.8%	31.0%
Arizona	85.7	79.6	73.5	49.7	47.1	35.0	53.3
California	83.2	76.6	62.8	58.2	60.8	46.0	48.7
Colorado	87.5	81.2	70.7	58.1	50.2	39.3	57.1
Connecticut	89.6	76.7	71.5	60.6	61.0	50.3	52.6
Washington, D.C.	90.3	81.6	81.1	46.7	57.1	42.0	70.3
Florida	89.9	80.8	65.2	67.6	62.6	34.5	38.6
Georgia	93.2	87.9	63.9	53.2	52.5	35.9	46.9
Idaho	92.8	76.5	74.1	57.1	45.3	47.8	44.3
Illinois	91.5	81.9	70.5	60.9	56.2	39.0	49.1
Kansas	93.2	77.7	67.5	59.6	50.4	32.9	54.2
Louisiana	94.4	79.1	71.0	67.2	52.4	45.1	42.7
Massachusetts	90.5	77.1	72.1	56.2	53.2	59.6	64.1
Maryland	92.3	87.1	73.2	61.9	60.7	50.2	59.8
Maine	91.3	76.7	74.3	58.3	51.9	58.9	56.5
Michigan	92.7	85.2	72.2	63.9	61.5	46.2	50.9
Minnesota	93.8	81.6	80.6	70.5	65.2	49.5	56.1
Missouri	91.3	74.0	66.0	55.4	49.2	29.9	50.5
Montana	94.4	84.9	73.3	55.9	53.8	44.1	44.3
North Carolina	92.8	82.9	69.7	63.8	56.0	33.9	46.1
North Dakota	97.0	89.3	71.8	68.3	57.8	48.7	46.9
New Hampshire	91.8	75.6	75.2	59.4	57.3	51.9	58.4
New Jersey	90.3	79.5	69.8	57.9	60.3	35.4	45.3
New Mexico	84.2	87.1	70.0	52.3	55.2	30.2	52.5
Nevada	83.6	75.6	65.2	59.7	62.8	37.1	47.3
New York	89.3	84.3	69.9	61.7	61.5	53.2	61.3
Ohio	95.6	85.6	69.7	66.3	58.0	44.1	53.3
Oklahoma	92.2	80.3	69.0	48.0	41.2	31.1	41.3
Oregon	87.6	80.4	73.9	62.1	59.5	62.2	51.0
Pennsylvania	93.1	75.4	71.1	67.0	63.3	48.4	50.5
Rhode Island	89.7	75.7	63.3	72.4	66.0	61.9	57.4
South Carolina	91.6	81.7	70.6	62.5	56.7	29.0	40.5
South Dakota	98.7	77.1	67.1	71.2	66.1	47.6	51.0
Tennessee	94.5	80.8	70.9	58.4	50.1	30.6	46.1
Texas	96.0	82.0	61.3	50.0	55.1	36.8	49.3
Utah	93.2	73.3	59.8	63.5	55.9	41.0	51.3
Virginia	89.9	87.0	72.0	54.6	56.2	45.3	54.8
Washington	87.0	82.0	69.5	63.5	59.9	53.6	58.1
Wisconsin	95.5	81.1	73.3	71.8	63.0	49.0	52.4
Nation	**91.7**	**80.3%**	**69.5%**	**60.4%**	**56.7%**	**43.8%**	**51.4%**

Data source: Centers for Medicare & Medicaid Services © 2023

[1] States with quality scores representing fewer than three plans were not included.

NOTE: HIXs are health insurance exchanges. Data include states operating through the federally facilitated exchange and state-based exchanges.

Demographics

Proportion of T2D Patients with A1c ≤7.0% Increases Across All Payer Types

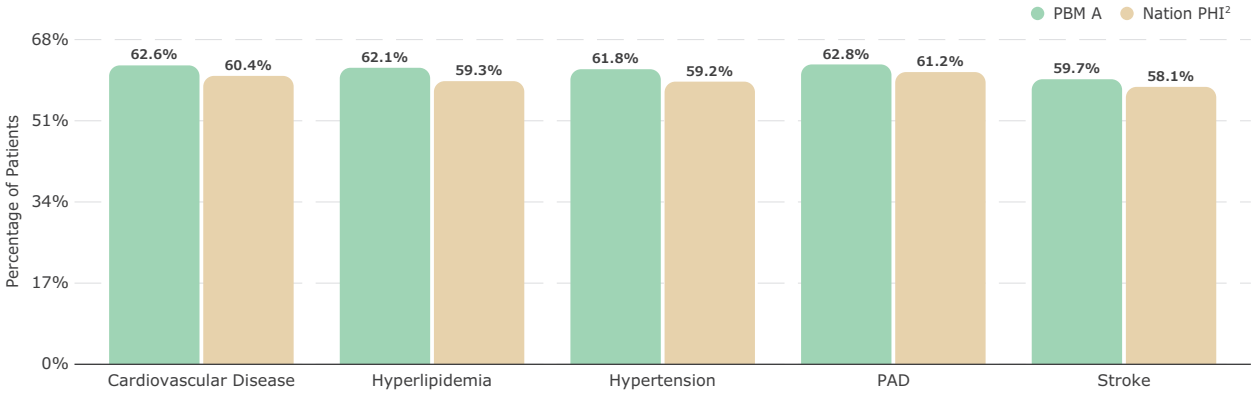
- Regardless of payer type, the share of Type 2 diabetes (T2D) patients with an A1c level ≤7.0% grew between 2020 and 2022 nationally and for all six profiled PBMs.
- Compared with such patients nationally in 2022, PBM A had a higher share of Type 2 diabetes patients with an A1c level ≤7.0% across the cardiometabolic conditions shown.

Account-Level Data Available

Percentage of Type 2 Diabetes Patients With an A1c Level ≤7.0%, by Payer, 2020 and 2022[1]

	All-Payer		PHI[2]		Medicare Advantage		Managed Medicaid	
PBM	2020	2022	2020	2022	2020	2022	2020	2022
PBM A	57.8%	60.8%	56.6%	60.0%	62.2%	65.6%	50.7%	54.9%
PBM B	53.5	57.3	53.9	58.1	56.6	62.1	50.9	55.5
PBM C	56.8	60.7	56.3	60.5	58.4	63.7	51.2	55.2
PBM D	51.9	55.7	52.6	55.0	58.1	63.9	47.4	52.0
PBM E	54.2	56.7	53.7	56.7	57.2	60.9	48.0	52.0
PBM F	57.1	59.6	57.2	60.1	56.9	61.5	43.5	48.0
Nation	**57.7%**	**60.8%**	**54.8%**	**58.2%**	**57.3%**	**61.2%**	**49.4%**	**52.6%**

Percentage of Type 2 Diabetes Patients, by Select Cardiometabolic Condition, With an A1c Level ≤7.0%, 2022[1,3]



Data source: IQVIA © 2023

Key Takeaway

As of July 2023, the Inflation Reduction Act (IRA) caps out-of-pocket costs for covered insulins at $35 monthly for Medicare Parts B and D, underscoring a national focus on lowering costs for patients.[4] Many anticipate effects on private health insurance costs from the changes to Medicare dictated by the IRA, but the magnitude and direction remain to be seen.[5]

[1] The A1c test measures the average blood glucose over the past 3 months. Figures reflect the percentage of diabetes patients who have had at least one A1c test in a given year.

[2] Private health insurance (PHI) includes employer-based and direct-purchase HMOs, PPOs, point-of-service, and exclusive provider organization plans.

[3] A co-occurring condition is a condition a patient with diabetes may also have, which may or may not be directly related to the diabetes. Co-occurring conditions were narrowed down to a subset of cardiometabolic conditions, including, but not limited to, cardiovascular disease, hyperlipidemia, hypertension, peripheral artery disease (PAD), and stroke.

[4] Sayed, B.A., Finegold, K., Olsen, T. A., De Lew, N., Sheingold, S., Ashok, K., and Sommers, B. D. (2023). Insulin Affordability and the Inflation Reduction Act: Medicare Beneficiary Savings by State and Demographics. Assistant Secretary for Planning and Evaluation: Office of Health Policy. Retrieved from https://aspe.hhs.gov/sites/default/files/documents/bd5568fa0e8a59c2225b2e0b93d5ae5b/aspe-insulin-affordibility-datapoint.pdf. Accessed July 2023.

[5] Bailey, V. (2022). How the Inflation Reduction Act Will Impact Employers, Health Plans. Retrieved from https://healthpayerintelligence.com/features/how-the-inflation-reduction-act-will-impact-employers-health-plans. Accessed July 2023.

NOTE: On pages 33 and 34, six national pharmacy benefit managers (PBMs) have been blinded (A through F). Unless otherwise specified, the figures shown for the profiled PBMs on these pages are all-payer. PHI, Medicare, and Medicaid benchmarks were selected based on available data and the payer mix of the PBM's data sample.

Annual T2D Rx Payments for All Profiled PBMs Are Lower Than U.S. PHI Mean

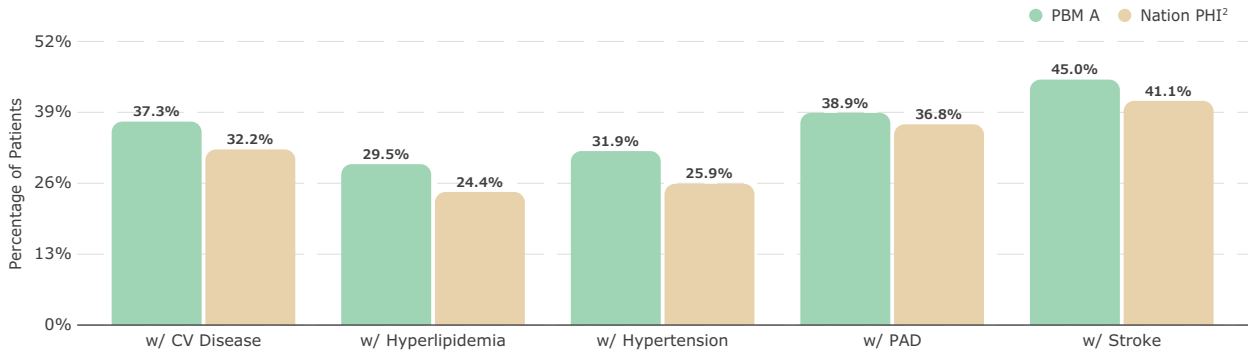
- Among Type 2 diabetes (T2D) patients covered by PHI, annual payments for GLP-1 receptor agonists were lower for all profiled PBMs versus such payments across the nation in 2022.
- That same year, T2D patients with select cardiometabolic conditions at PBM A were more likely than their national counterparts to receive any insulin product.

Account-Level Data Available

Annual Payments per Type 2 Diabetes Patient for Select Therapies, by Payer, 2022[1]

	GLP-1 Receptor Agonists				Long-Acting Insulin			
PBM	All-Payer	PHI[2]	Medicare Advantage	Managed Medicaid	All-Payer	PHI[2]	Medicare Advantage	Managed Medicaid
PBM A	$6,460	$5,970	$6,815	$6,173	$3,188	$2,769	$3,389	$2,430
PBM B	6,693	6,467	7,112	5,767	3,003	2,901	3,174	2,458
PBM C	5,981	5,859	6,606	5,744	2,891	2,689	3,208	2,538
PBM D	6,122	5,979	5,753	6,381	2,565	1,944	2,616	3,101
PBM E	6,566	6,488	6,394	6,507	3,083	3,056	3,096	2,298
PBM F	6,780	4,900	7,016	5,919	3,474	2,051	3,633	2,603
Nation	**$7,121**	**$6,841**	**$7,346**	**$6,122**	**$3,361**	**$3,116**	**$3,547**	**$2,599**

Percentage of Type 2 Diabetes Patients, by Select Cardiometabolic Conditions Receiving Any Insulin Products, 2022[3,4]



Data source: IQVIA © 2023

Key Takeaway

Consolidation of PBMs and the opacity in drug price negotiations have led to calls for mandated transparency for PBMs. Bipartisan support exists for more detailed reporting to the Federal Trade Commission and to enhance employer contract negotiations with PBMs. The extent of the final changes, and therefore possible outcomes, are still under congressional consideration.[5]

[1] Figures reflect the per-patient yearly payments for diabetes patients receiving a particular type of therapy. These are the actual amounts paid by the insurer and patient for such prescriptions. Costs mainly include copayments, but can also include tax, deductibles, and cost differentials where applicable.

[2] PHI is private health insurance.

[3] Patients who filled prescriptions for any insulin products may have also filled prescriptions for products in the non-insulin category, and vice versa.

[4] A co-occurring condition is a condition a patient with diabetes may also have, which may or may not be directly related to the diabetes. Co-occurring conditions were narrowed down to a subset of cardiometabolic conditions, including, but not limited to, cardiovascular (CV) disease, hyperlipidemia, hypertension, peripheral artery disease (PAD), and stroke.

[5] Bipartisan Policy Center. (2023). High Drug Prices: Are PBMs the Right Target? Retrieved from https://bipartisanpolicy.org/blog/are-pbms-the-right-target/#. Accessed July 2023.

Looking Forward

Stakeholders Turn to Courts as Federal and State Govts Push Reform

In 2022, the 12-month change in the consumer price index hit its highest level in decades (9.1%).[1] That same year saw not only the largest ever year-over-year change in that metric, but also the highest ever percentage of Americans self-reporting a delay in medical care due to cost.[2] Lawmakers responded through the Inflation Reduction Act of 2022 (IRA), which extended affordability measures for health insurance exchange plans and empowered the Department of Health and Human Services to negotiate prices for select drugs covered by Medicare. The legislation also fit with the White House's broader effort to tackle racial inequities and added to health care reforms in the No Surprises Act, a federal law passed in 2020 with the aim of taming health care inflation through increased consumer protections. Specifically, the act shielded individuals with private health insurance from surprise bills related to certain medical services. However, much like the earlier Patient Protection and Affordable Care Act—the subject of more than 2,000 legal challenges to date—both the IRA and the No Surprises Act are sparking lawsuits from impacted stakeholders. In the case of the No Surprises Act, the independent dispute resolution (IDR) process that was created to set compensation for impacted out-of-network providers, is proving contentious, with certain provider groups contesting the newly established rules while payers and employers generally offer support. The Centers for Medicare & Medicaid Services (CMS), which is charged with establishing the new IDR rules, has paused arbitrations multiple times in response to court actions, further exacerbating delays within a system already swamped with claims. The IRA is also spawning multiple legal cases related to the newly created drug pricing authority, even as CMS works to finalize rules for the first round of negotiations.[3–6] Elsewhere, federal and state lawmakers are examining PBMs through: 1) a Federal Trade Commission investigation, 2) multiple bills under consideration in Congress, and 3) a flurry of new state laws following an impactful ruling by the U.S. Supreme Court. Notably, the high court sided with states in a case challenging their ability to regulate PBMs locally.[7] Separately, hospital systems face questions about their nonprofit status, the appropriate use of the 340B program, and an increase in facility fees following consolidation. Lawsuits are following.[8–10] Stakeholders will need either to negotiate revenue models aligned to their demonstrable value creation, or else risk the costs and uncertainty associated with mandated reform and the nearly inevitable ensuing legal challenges. To this end, payers, PBMs, providers, and manufacturers are turning increasingly to value-based arrangements.

Provider Consolidation Creates Opportunities and Pitfalls

Faced with a post-pandemic health care landscape filled with swiftly changing political, financial, and regulatory incentives, the near future will likely define how a provider works within broader systems. Provider consolidation by payer and hospital groups will likely continue, driven by conversations around value-based care (VBC) and increased patient access. Furthermore, providers will be asked to drive these proposed efficiencies with new tools, both physical and digital, deployed in arenas where previous patient access has been limited. Recently, consolidation has become the norm across the health care space. Private equity wields enormous influence on the trajectory of this consolidation, which creates challenges and opportunities for the market as a whole.[11] To address cost-of-care concerns created by such consolidation, America's Health Insurance Plans (AHIP) is asking lawmakers to enact legislation that supports healthy competition and increases transparency.[12] As pressure mounts to reduce costs and improve quality, providers may seek out value-based reimbursement arrangements. With potential positive impacts on patient health and access to care, the promise of such arrangements has led CMS to propose that all Original Medicare and most Medicaid members be enrolled in one by 2030. According to proponents, if realized, the potential of VBC could help lower the overall cost of care by reducing the need for downstream hospitalizations and emergency department visits.[13] For those who enter VBC arrangements, the pressure to maintain access to care—especially for high-risk patients who require more frequent interventions—remains a significant challenge, one which may be partially met using digital tools. Adoption of digital health tools is accelerating, with one survey showing the average number of tools in use by a physician nearly doubling between 2016 and 2022.[14] The use of these tools will be critical to address access disparities faced by rural patients, who tend to be older and less healthy on average than their urban counterparts.[15] Forces beyond consolidation (e.g., inflation) continue to push health care costs higher, and VBC and digital tools may help mitigate this trend for large and small practices alike. Indeed, consolidation itself may serve as a lifeline to these tools for smaller medical groups being acquired, presuming new ownership grants access to needed administrative and financial resources. Providers of all sizes will need to remain flexible in their adoption and application of new tools, as well as use available outcomes data to drive their decision-making.

1 U.S. Bureau of Labor Statistics (2023). 12–Month Percentage Change, Consumer Price Index, Selected Categories. Retrieved from https://www.bls.gov/charts/consumer-price-index/consumer-price-index-by-category-line-chart.htm#startcontent. Accessed August 2023.

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3 Ford, C. (2023). What's Next for Biopharma Under the Inflation Reduction Act. Retrieved from https://www.pharmexec.com/view/whats-next-for-biopharma-under-the-ira. Accessed August 2023.

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Looking Forward

Managed Care Covers Half of Medicare Patients as Medicaid Shifts

Medicare Advantage (MA) continued to grow in the Medicare space in 2022, with MA enrollment spiking by 8.3% (or 2.3 million members) from 2021 to 2022. MA accounted for just under half (49.9%) of all Medicare participation in 2022; as of 2023, MA now exceeds 50% of Medicare enrollment for 22 states, up from just 11 states meeting that threshold in 2022.[1,2] Two major payers in the MA space, UnitedHealthcare and Humana, accounted for 44% and 21% of new MA enrollment in 2023, respectively.[2] Humana's successes in MA caused the payer to shift focus almost entirely toward its Medicare plan offerings, announcing plans to phase out of the private health insurance space—fully insured, self-insured, and Federal Employee Health Benefit medical plans—over the course of the next two years.[3] Despite the striking growth in MA, the program itself has been under public scrutiny due to concerns over persistent issues with annual overpayment of MA plans. The Medicare Payment Advisory Commission estimated that MA plans were overpaid by 6% ($27 billion) in 2023, as a result of coding intensity and Star Rating quality bonuses; MA plans may be overpaid by up to 20% when favorable selection of low-risk patients is considered.[4]

Throughout the COVID-19 public health emergency (PHE), Medicaid enrollment ballooned as states paused annual Medicaid redeterminations in exchange for increased federal financial assistance. However, 2023 marked a pivotal shift for Medicaid as both the PHE and the pause in redeterminations ended. In the first month of the unwinding period, nearly 4 million Americans lost Medicaid coverage—with some estimates predicting a much higher number of individuals losing coverage over the next year. Nearly three-quarters of such recipients lost Medicaid coverage due to "paperwork reasons" including not receiving a renewal notice, not understanding the renewal process, or inability of the state to process the renewal in time.[5] The Centers for Medicare & Medicaid Services (CMS) established a temporary special enrollment period for people who are losing Medicaid eligibility due to ongoing Medicaid unwinding, allowing those impacted to select coverage through a federal or state marketplace plan.[6] It is expected that these large-scale Medicaid redeterminations will shift lives toward both the uninsured population and the health insurance exchanges.

Long-Lasting Impacts of COVID-19 Play Out in Commercial Insurance

Private insurers expect to issue $1.1 billion in medical loss ratio (MLR) rebates across all commercial markets in 2023. A provision of the Affordable Care Act, the MLR rebate system holds private health insurers accountable for investing in care delivery and quality of care improvements, by dictating that 80% of premium income for individual and small group markets, and 85% of such income for large group markets, is spent on health care claims and quality improvement efforts. As evidence of the lingering impacts of the COVID-19 pandemic, the estimated 2023 MLR rebate calculation remains inflated compared to prior years—up slightly from $1.0 billion in total rebates in 2022.[7]

Despite the hefty MLR rebate estimated for 2023, utilization of medical services for the commercial market appears to have normalized to nearly pre-pandemic levels this year. Combined with this rebound in utilization, higher medical and prescription costs, along with rising inflation, may drive up health insurance premiums for employer-sponsored plans and health insurance marketplace plans alike.[8,9] Marketplace insurers are estimating a 6% increase in premiums for 2024, however many marketplace consumers may be newly eligible for expanded premium assistance under the Inflation Reduction Act. According to CMS, under the expanded tax credits, four of five marketplace consumers could find a plan for $10 or less per month.[9]

In recent years, much of the private health insurance space has transitioned to value-based payment models—those that aim to drive better health outcomes at a lower cost by prioritizing preventive care and proactive communication between health plans and members. Yet despite this focus on value-based care, many commercial plans are still missing the mark on consumer satisfaction, particularly among Millennial and Gen Z members. According to a recent study, commercial health plans are struggling to coordinate the support needed for patients; in particular, only 17% of patients who self-assessed as being in "poor and fair" health condition were assigned a case manager. For highly complex patients—those seeing multiple providers and taking multiple prescription medications to manage chronic health conditions—uncoordinated, or "fragmented" care can lead to poorer health outcomes and higher spending for the health plan.[10] Despite the intuitive merit of value-based care arrangements, declining consumer satisfaction highlights that there are still improvements to be made in care coordination in the commercial space.

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Research Methodology

Data for the *Health Care Digest™* were gathered from the following sources:

Inpatient and Outpatient Data

Definitive Healthcare Medicare Standard Analytics Files (SAFs) are part of the Limited Data Set (LDS) files released on a yearly and quarterly basis by the Centers for Medicare & Medicaid Services. The SAFs capture adjudicated claims and are 100% Medicare fee-for-service claims (does not include Medicare Advantage). Claims adjudication refers to the determination of the insurer's payment or financial responsibility after the member's insurance benefits are applied to a medical claim to yield "final action" claims. The SAFs are available for all claim settings (e.g., Inpatient, Outpatient, Home Health Association, Skilled Nursing Facility, and Hospice).

The Definitive Healthcare commercial data set, which includes Medicaid, is sourced from some of the largest medical claim clearinghouses in the United States and includes a mixture of professional and institutional claims processed through those clearinghouses. Professional claims are generated for work performed by physicians, suppliers, and other non-institutional providers for both inpatient and outpatient services. Institutional claims are generated for work performed by hospitals, skilled nursing facilities, and other institutions for inpatient and outpatient services (e.g., use of equipment/supplies, laboratory, radiology). Definitive Healthcare aggregates claims data and reports as cases.

Patient Claims Data

Patient-level, chronic disease–specific claims data derive from the **Managed Care Digest Series®** *Local Trends Summary™* database. These data come from health care professional and institutional insurance claims, including all physician specialties and all hospital types. IQVIA gathers prescription activity from the National Council for Prescription Drug Programs (NCPDP). These data account for some 4 billion prescription claims annually, or more than 92% of the retail prescription universe and 72% of the traditional and specialty mail order universe.

Proprietary lab data derive from one of the largest independent commercial lab companies in the U.S. Patient information is de-identified, matched, and linked with other patient data assets (e.g., medical claims data). The most common attributes used are the de-identified patient ID, observation date, diagnosis, test name, test code, and test result.

Claims undergo a careful de-duplication process to ensure that when multiple, voided, or adjusted claims are assigned to a patient encounter, they are applied to the database, but only for a single, unique patient. Through its patient encryption methods, IQVIA creates a unique, random numerical identifier for every patient, and then strips away all patient-specific health information that is protected under the Health Insurance Portability and Accountability Act (HIPAA). The identifier allows IQVIA to track disease-specific diagnosis and procedure activity across the various settings where patient care is provided (hospital inpatient, hospital outpatient, emergency rooms, clinics, doctors' offices, and pharmacies), while protecting the privacy of each patient.

Hospital Claims Regions (Page 13)

Region	States
Midwest	Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
Northeast	Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
Southeast	Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, Washington, D.C., West Virginia
Southwest	Arizona, New Mexico, Oklahoma, Texas
West	Alaska, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, Utah, Washington, Wyoming

U.S. Census Bureau Regions and Divisions (All Other Pages)

Region	Division	States
Midwest	East North Central	Illinois, Indiana, Michigan, Ohio, Wisconsin
	West North Central	Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
Northeast	Middle Atlantic	New Jersey, New York, Pennsylvania
	New England	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
South	East South Central	Alabama, Kentucky, Mississippi, Tennessee
	South Atlantic	Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, Washington, D.C., West Virginia
	West South Central	Arkansas, Louisiana, Oklahoma, Texas
West	Mountain	Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
	Pacific	Alaska, California, Hawaii, Oregon, Washington

Research Methodology

Medicare, Medicaid, and Health Insurance Exchanges (HIXs)

The Centers for Medicare & Medicaid Services (CMS) provided data on the following: Medicare Advantage enrollment and Star Ratings; Medicare costs; accountable care organizations (ACOs) payments; readmission rate penalties; and Medicaid enrollment.

Medicare readmission rate penalty data for fiscal year (FY) 2023 are from the CMS Hospital Readmissions Reduction Program (HRRP). For FY 2023, CMS calculates excess readmission ratios (the ratio of predicted readmissions to expected readmissions), dual proportions, and hospitals' payments for each condition/procedure and overall using discharges that occurred during a non-contiguous 29-month period, including portions of 2018–2021. For FY 2023, CMS suppressed the pneumonia readmission measure due to the substantial impact of COVID-19 on this measure. Medicare Shared Savings Program (MSSP) ACO performance data are for 2021 and are current as of March 2023.

Data on Medicare fee-for-service (FFS) actual costs by setting are derived from CMS's Geographic Variation Public Use Files (PUFs), which are current as of March 2023. Overall Medicaid enrollment data are from state Medicaid and Children's Health Insurance Program (CHIP) applications, eligibility, determinations, and enrollment data, and are current as of December 2022. Information on these and other public sources listed can be found on their respective Web sites.

Data on HIXs are provided by PUFs from CMS. State-level HIX enrollment data come from the state-level PUF that includes total health plan selections in all 50 states plus the District of Columbia. The PUF provides state-level data on metrics such as average monthly premium, financial assistance, age, gender, metal level, self-reported race and ethnicity, rural location, household income as a percentage of the federal poverty level (FPL), and plan switching behavior among consumers with a plan selection. In addition, the state-level PUF includes data on dental plan selections and Basic Health Plan (BHP) enrollments. Certain data elements are only available for the 33 states using the federal marketplace (HC.gov) in 2023.

Emerging Topics

CMS provided historical and projected data for the National Health Expenditure Accounts, as well as estimates of the FFS Medicare population. The U.S. Census Bureau served as the source of data for the following social determinants of health (SDoH): 1) percentage of population with income less than 150% of the federal poverty level; 2) percentage of households without a vehicle; 3) percentage of owner-occupied housing units; and 4) percentage of population aged 25+ who have completed high school. Combined scores were calculated for each county as linear, equally weighted combinations of county rankings for the four SDoH elements—higher combined score represented higher levels of SDoH stress. Data on Prevention Quality Indicator #92 were downloaded from the Agency for Healthcare Research and Quality. Influenza data were supplied by the Centers for Disease Control and Prevention.

Select maps in this digest were generated using R (R Core Team (2021). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. https://www.R-project.org/). The bivariate maps were inspired by the work of Timo Grossenbacher and Angelo Zehr (https://timogrossenbacher.ch/2019/04/bivariate-maps-with-ggplot2-and-sf/).

Disease State	ICD-10 Codes
Acute Coronary Syndromes	I20.0, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9, I22.0, I22.1, I22.2, I22.8, I22.9, I23.0, I23.1, I23.2, I23.3, I23.4, I23.5, I23.6, I23.7, I23.8, I24.0, I25.110, I25.700, I25.710, I25.720, I25.730, I25.750, I25.760, I25.790
Asthma	J45, J45.2, J45.20, J45.21, J45.22, J45.3, J45.30, J45.31, J45.32, J45.4, J45.40, J45.41, J45.42, J45.5, J45.50, J45.51, J45.52, J45.9, J45.90, J45.901, J45.902, J45.909, J45.99, J45.990, J45.991, J45.998, J82.83
Atrial Fibrillation	I48.0, I48.1, I48.11, I48.19, I48.2, I48.20, I48.21, I48.91
Breast Cancer	C50.011, C50.012, C50.019, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, D48.60, D48.61, D48.62, D49.3
COVID-19	J12.82, M35.81, U07.1, U09.9, Z86.16
Depression	F32, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.81, F32.89, F32.9, F32.A, F33, F33.0, F33.1, F33.2, F33.3, F33.4, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F43.21, F43.23, F43.81
Diabetes Mellitus	Includes select codes from the following groups: E08, E09, E10, E11, E13
Hypertension	I10, I11, I11.0, I11.9, I12, I12.0, I12.9, I13, I13.0, I13.1, I13.10, I13.11, I13.2, I15, I15.0, I15.1, I15.2, I15.8, I15.9, I16, I16.0, I16.1, I16.9
Knee Osteoarthritis	M17, M17.0, M17.10, M17.11, M17.12, M17.2, M17.3, M17.30, M17.31, M17.32, M17.4, M17.5, M17.9
Lipid Disorders	E78.0, E78.00, E78.01, E78.2, E78.4, E78.41, E78.49, E78.5
Multiple Sclerosis	G35
Osteoarthritis	Includes select codes from the following groups: M15, M16, M17, M18, M19, M47
Prostate Cancer	C61
Rheumatoid Arthritis	Includes select codes from the following groups: M05, M06, M08
Stroke	Includes select codes from the following groups: I63, R29

Key Terms

Unless otherwise noted, all definitions are provided by the Centers for Medicare & Medicaid Services (CMS).

Accountable Care Organization (ACO): An ACO is an associated network of primary care physicians, specialists, and hospitals that actively coordinates the delivery of care to effect higher quality outcomes. ACOs report on quality measures, and the providers, who likewise are accountable for maintaining a high standard of individual performance, are rewarded for their participation.

Alternative Payment Model (APM): An APM is a provider payment method that incentivizes the delivery of high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a period of care, or a population.

Average Length of Stay (ALOS): Sometimes referred to as length of stay (LOS), ALOS measures the length of time, in days, between a patient's admittance to and discharge from a hospital, averaged among all patients in a given population.

Digital Health: Digital health includes mobile health (mHealth), health information technology (IT), wearable devices, telehealth and telemedicine, and personalized medicine for applications associated with general wellness, medical devices, and more.

Health Equity: Health equity represents an equal and fair opportunity for individuals to achieve their optimal level of health regardless of race, ethnicity, socioeconomic status, disability, gender identity, sexual orientation, geography, preferred language, or other measures that affect access to health care and health outcomes.

Health Insurance Exchange (HIX): A key provision of the Affordable Care Act (ACA) was the creation of HIXs (or Marketplaces) for each state, through which individuals and small businesses can choose among a variety of qualified health insurance plans.

Home Health: Home health care is a range of health care services that can be delivered in a patient's home. These services, including skilled nursing care, physical and occupational therapy, and speech-language therapy, tend to be less expensive than those rendered in a hospital or skilled nursing facility, and allow for patients to receive their care from the comfort of their home.

Hospital Readmissions Reduction Program (HRRP): The HRRP is a national value-based Medicare program that incentivizes improvements in care delivery by penalizing hospitals for excess readmissions. The overarching goal of the program is to encourage hospitals to improve discharge planning and subsequent care coordination for patients being treated.

Inflation Reduction Act (IRA): The IRA—a legislative package signed into law on August 16, 2022—enacts deficit reduction to combat rising inflation, including investments in clean energy that target a 40% reduction in carbon emissions by 2030. In addition to lowering health care premiums through the Affordable Care Act, the IRA also enables the Department of Health and Human Services to negotiate prices for select drugs with manufacturers and caps Part D out-of-pocket costs at $2,000.

Managed Care Organization (MCO): MCOs control the finance, insurance, delivery, and payment of health care services by negotiating contracts with providers and maintaining efficient practices. MCOs include health management organizations (HMOs), preferred provider organizations (PPOs), point-of-service (POS), and fee-for-service (FFS) plans.

Medical Loss Ratio (MLR): The MLR is a basic financial measurement used under the ACA to encourage health plans to provide value to enrollees. An MLR of 80% indicates that the insurer is using that amount of premium dollars for enrollees' medical claims and activities that improve the quality of care, and the remaining 20% for overhead expenses, such as marketing, salaries, administrative costs, agent commissions, and profit. The ACA sets minimum MLRs for different markets, as do some state laws.

Medicare Advantage (MA): Unlike the traditional Medicare FFS arrangement, MA (also known as Medicare Part C) gives Medicare beneficiaries the option of receiving Part A, Part B, and Part D benefits through a single health plan. Of the various plan types offering MA benefits, HMOs remain the most popular among Medicare beneficiaries. HMOs provide basic Medicare coverage (they must cover all of Medicare Part A and Part B health care), plus additional coverage to fill the gaps in what is provided by Medicare. Participating health plans are prohibited from charging higher out-of-pocket costs than traditional Medicare for the same services.

Medicare Shared Savings Program (MSSP): CMS established the MSSP to facilitate coordination among providers to improve the quality of care and reduce unnecessary costs for Medicare FFS beneficiaries. Eligible providers, hospitals, and suppliers may participate in the program by creating or participating in an ACO. The program will reward ACOs that lower their health care costs while meeting performance standards on quality of care.

National Health Expenditure Accounts (NHEA): The NHEA are official, annual estimates of total national health spending. The NHEA measure expenditures on health care goods and services, government administration, cost of health insurance, health care investments, and public health affairs.

Key Terms

Nurse Practitioner (NP): NPs are advanced practice registered nurses—practicing in nearly every health care setting—that have obtained a graduate-level education and national board certification. While the scope of practice for NPs varies from state to state, their responsibilities can involve the initiation, diagnosis, and management of acute and chronic health conditions, prescribing medication, and coordination of patient care.

Pharmacy Benefit Manager (PBM): PBMs act as intermediaries between health insurers and other stakeholders in the health care industry. PBMs administer prescription drug plans for the many Americans with health insurance from a variety of private and government payers. PBM services include drug formulary creation and negotiation; management and negotiation of rebates from drug manufacturers; creation of pharmacy networks and home delivery of medications; and drug utilization review.

Post-Acute Care: Post-acute care is provided after, or sometimes instead of, a stay in an acute-care hospital, and involves rehabilitation or palliative services. Treatment locations will vary, depending on the level of care needed, but can include a facility stay, outpatient therapy, or at-home care.

Private Fee-for-Service (PFFS): PFFS plans are MA plans in which private insurers, under contract with Medicare, receive monthly payments from Medicare, then reimburse providers for the care they give to beneficiaries on a service-by-service basis.

Public Health Emergency (PHE): Under Section 319 of the Public Health Service Act, the Health and Human Services (HHS) Secretary may determine that a disease or disorder presents a PHE, or that a PHE otherwise exists. Such declaration lasts for the duration of the emergency or 90 days.

Redetermination: A reevaluation of eligibility where information is collected periodically by a public agency and used to determine a recipient's continued eligibility for insurance assistance.

Risk Adjustment: Risk adjustment is a calculation employed by CMS to estimate the member's "risk score," which represents the predicted annual cost associated with health care needs, use of health care services, and the costs associated with such services.

Skilled Nursing Facility (SNF): SNFs are Medicare-certified facilities with skilled nursing and rehabilitation staff that manage, observe, and evaluate care. SNFs must have a transfer agreement in place with hospitals in case a resident/patient requires rehospitalization.

Social Determinants of Health (SDoH): SDoH are the conditions in which people are born, grow, live, work, and age (e.g., socioeconomic status, education, internet access, air quality, and proximity to health care).

Star Rating: A rating based on the Five-Star Quality Rating System, which was created by CMS to assist consumers in evaluating several care settings, including hospitals, nursing homes, home health, and physician practices. These ratings provide a standardized result of 1 to 5, where more stars represent better performance.

Value-Based Care (VBC): VBC is a health care reimbursement model in which providers, including hospitals and physicians, are compensated for patient services relative to measurable health outcomes. The arrangement motivates providers to reduce the incidence and effects of chronic disease, helps patients live healthier lives, and ultimately measures health outcomes with respect to the cost of delivering care.

Definition sources:

ALOS: *https://www.definitivehc.com/resources/glossary/length-of-stay*

Digital Health: *https://www.fda.gov/medical-devices/digital-health-center-excellence/what-digital-health*

HIX: *https://www.healthinsurance.org/glossary/health-insurance-exchange/*

IRA: *https://www.democrats.senate.gov/imo/media/doc/inflation_reduction_act_one_page_summary.pdf*

MA: *https://www.hhs.gov/answers/medicare-and-medicaid/what-is-medicare-part-c/index.html*

MLR: *https://www.healthcare.gov/glossary/medical-loss-ratio-mlr/*

NP: *https://www.aanp.org/advocacy/advocacy-resource/position-statements/scope-of-practice-for-nurse-practitioners*

PBM: *https://www.pcmanet.org/value-of-pbms/*

PHE: *https://aspr.hhs.gov/legal/PHE/Pages/Public-Health-Emergency-Declaration.aspx*

Post-Acute Care: *https://www.medpac.gov/research_area/post-acute-care/*

Redetermination: *https://www.medicaidplanningassistance.org/medicaid-renewals/*

SDoH: *https://health.gov/healthypeople/priority-areas/social-determinants-health*

SNF: *https://www.agingcare.com/articles/difference-skilled-nursing-and-nursing-home-153035.htm*

VBC: *https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558*

Uses for this Digest

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