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Health Care Cost Growth Benchmark Report: Pre-Benchmark Year (2018–2019)

Report to the New Jersey Health Care Affordability, Responsibility, and Transparency (HART) Program

September 2024

Contents

Exhibits

Executive Summary

A. HART Program background

To improve health care affordability for New Jerseyans, Governor Phil Murphy signed Executive Order 277 in December 2021, launching the state's health care cost growth benchmarking effort, the Health Care Affordability, Responsibility, and Transparency (HART) Program, and the establishment of health care spending growth targets. Executive Order 277 was accompanied by a compact agreed to by stakeholders throughout the state, including hospitals and health care providers, carriers, employers, consumer groups, union groups, and policy organizations, who all committed to working collaboratively to meet the established targets for curbing health care spending growth and to analyzing data to monitor progress in meeting those targets.

To work toward the goals of making health care more affordable, facilitating the transparent reporting of health care costs in the state, and using data to understand the causes of rising health care costs and to inform strategies to reduce health care cost growth, the HART Program:

1. Establishes a target rate of growth for health care spending,
2. Collects data to track and report on progress in meeting those targets,
3. Sheds light on factors driving spending growth, and
4. Identifies strategies to curb growth.

This First Annual Cost Growth Benchmark Report presents the findings from an analysis of 2018 and 2019 health care spending data.

B. HART Program cost growth reporting

The HART Program's annual Cost Growth Benchmark Reports offer insight into the year-over-year change in total health care spending in New Jersey. This first report measures health care spending as Total Health Care Expenditures (THCE), the sum of Total Medical Expenses (TME) and the Net Cost of Private Health Insurance (NCPHI). TME measures the spending on direct provision of health care services and consists of claims and non-claims payments made by carriers to providers, as well as the cost sharing paid by members such as copayments, deductibles, and coinsurance. NCPHI captures the administrative costs of private insurance, including Medicare Advantage and Medicaid Managed Care.

This report presents health care spending for calendar years 2018 and 2019 and spending growth between those years both statewide and for each of three major insurance markets—commercial, Medicare, and Medicaid—along with detailed analyses by categories of service. In an effort to acclimate payers and providers with the data submission process, this first annual report offers a look at spending growth in years for which there is no initial set target.[1]

[1] In future reporting cycles, carrier- and provider entity-level performance will be measured using risk-adjusted, truncated TME, not THCE. Additional information on the risk adjustment and truncation process can be found in the State Benchmark Program Implementation Manual, available on the New Jersey Department of Banking and Insurance website at https://nj.gov/dobi/division_insurance/HART/submitters.html.

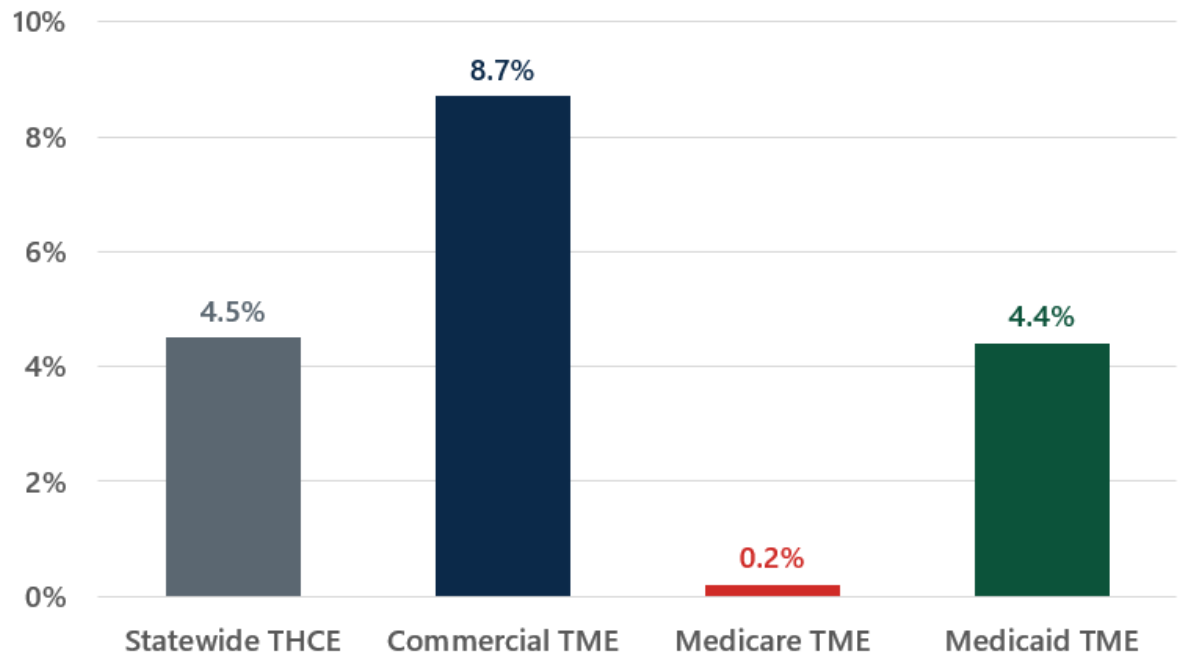
In future years, this annual report will include carrier- and provider entity-level spending growth. Starting with Performance Year 1, the report will compare spending growth for each reporting level (that is, statewide, market, carrier, and provider entity) against the established cost growth targets.

C. Key findings

Exhibit ES.1 shows the key findings for 2018 and 2019.

- **Statewide per person per year (PPPY) THCE increased by 4.5 percent between 2018 and 2019.[2]**
  - Between 2018 and 2019, THCE PPPY grew from $10,061 to $10,509.
- **All markets experienced growth in PPPY TME between 2018 and 2019; however, the degree to which they grew varied by market:**
  - The commercial market saw the highest growth, increasing by 8.7 percent from $7,449 to $8,095.
  - The Medicare market saw the lowest growth, increasing by 0.2 percent from $15,231 to $15,263.
  - The Medicaid market saw the second highest growth, increasing by 4.4 percent from $8,129 to $8,485.

Exhibit ES.1. 2018 to 2019 percent change in statewide PPPY THCE and market-level PPPY TME



PPPY = per person per year; THCE = Total Health Care Expenditures; TME = Total Medical Expenses

[2] The percent change in statewide PPPY THCE and market-level PPPY TME are the measures that will be compared to the benchmark target in future years.

I. Introduction

A. The HART Program and the cost growth benchmark

New Jersey's rate of health care spending growth is unsustainable, placing a heavy burden on the state, its employers, and its residents. A 2022 Altarum survey found that nearly three in five New Jerseyans reported experiencing some health care affordability burden within the past year and more than four in five (85 percent) worry about affording health care in the future.[3] Premiums and deductibles have also increased substantially over the years, outpacing income growth and constituting a greater share of household income.[4] Much of the increase in health care affordability burden is due to rising prices, but recent increases in spending, have not resulted in substantial improvements in health care outcomes and the value of care received.[5, 6, 7]

In response to rising health care costs and to the burdens placed on New Jersey residents, Governor Murphy established the Health Care Affordability, Responsibility, and Transparency (HART) Program. In collaboration with the Health Care Affordability Advisory Group and New Jersey's Interagency Working Group, the HART Program established a health care cost growth benchmark using a blend of 25 percent Potential Gross State Product and 75 percent forecasted median household income. The result is a target growth rate for per person per year (PPPY) spending of 3.2 percent that is underpinned by both the strength of New Jersey's economy and the wages that New Jersey workers earn within in it.

The HART Program will take a phased approach to collecting data, reporting it publicly, and comparing the growth rate in PPPY spending to the target. For this first report, the program collected data on calendar years 2018 and 2019 and reports on spending and spending growth at the state and market levels. In future years, the program will also report on the growth in PPPY spending for major carriers and large provider entities and will compare the growth in PPPY spending at all levels to the established target for that performance year (**Exhibit I.1**).

[3] https://www.healthcarevaluehub.org/advocate-resources/publications/new-jersey-residents-struggle-afford-high-healthcare-costs-worry-about-affording-healthcare-future-support-government-action-acr.

[4] Penn LDI. "The Burden of Health Care Costs for Working Families." April 2019.

[5] http://www.njhcqi.org/wp-content/uploads/2018/10/NJ-HCCI-Charts_10.8.2018-1.pdf.

[6] Shrank, W.H. "Waste in the U.S. Health Care System: Estimated Costs and Potential for Savings." *JAMA*, vol. 322, no. 15, 2019, pp. 1501–1509.

[7] In addition to the cost growth benchmark analysis shared in this report, the HART Program will conduct other studies to assess drivers of health care spending growth.

Exhibit I.1. HART Program cost growth benchmarks and spending measurement

Reporting cycle	Measuring cost growth between	Benchmark target	Level of public reporting
Pre-benchmark **(current report)**	CY 2018–2019	No benchmark	State and market
Transition year	CY 2021–2022	No benchmark	State, market, carrier, and provider entity
Performance Year 1	CY 2022–2023	3.5%	State, market, carrier, and provider entity
Performance Year 2	CY 2023–2024	3.2%	State, market, carrier, and provider entity
Performance Year 3	CY 2024–2025	3.0%	State, market, carrier, and provider entity
Performance Year 4	CY 2025–2026	2.8%	State, market, carrier, and provider entity
Performance Year 5	CY 2026–2027	2.8%	State, market, carrier, and provider entity

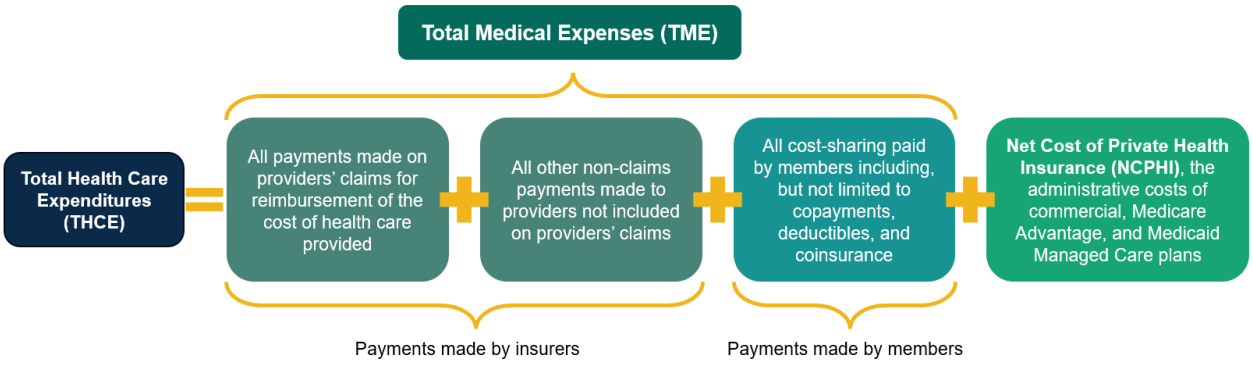
CY = Calendar Year.

B. Measuring costs and cost growth

This report measures health care costs as Total Health Care Expenditures (THCE), the sum of Total Medical Expenses (TME) and the Net Cost of Private Health Insurance (NCPHI). As depicted in Exhibit I.2. TME, the spending on direct provision of health care services, consists of claims and non-claims payments made to providers. Claims payments in this report reflect the allowed amounts, which include both what carriers pay to providers for services rendered, as well as any cost sharing paid by members such as copayments, deductibles, and coinsurance.

NCPHI represents the administrative costs of private health insurance, reflecting the difference between the premiums private insurance companies earn and their claims and other payments to providers. It consists of carriers' costs related to paying bills, advertising, sales commissions and other administrative costs, premium taxes, and other fees. It also includes carriers' profits or losses. It applies to health insurance carriers that provide commercial, Medicare Advantage, or Medicaid Managed Care plans.

Exhibit I.2. Components of Total Health Care Expenditures



This report presents THCE, TME, and NCPHI for the state as a whole and for each of three markets:

- **Commercial,** which includes both insurance plans that are sponsored by employers and plans that individuals purchase on the open market.
- **Medicare,** which serves adults ages 65 and older and some younger people with disabilities. The Medicare market includes two submarkets: the privately administered Medicare Advantage plans and Original Medicare, a federal program.
- **Medicaid,** which provides health insurance for families and individuals with low incomes. The Medicaid market also includes two submarkets: privately administered Medicaid Managed Care plans and fee-for-service (FFS) Medicaid, which is administered at the state level with federal oversight. FFS Medicaid not only serves as the primary insurer for a small share of the Medicaid population but also pays for some services for eligible individuals that are not covered by Medicaid Managed Care Organizations or Medicare.

This report presents spending and spending growth in aggregate, PPPY, and by category of service, including pharmacy spending gross and net of rebates and spending on primary care.

C. Data sources for the report

The Cost Growth Benchmark report relies on health care spending data submitted to the New Jersey Department of Banking and Insurance (DOBI) by both public payers and private health insurance carriers to facilitate a comprehensive picture of trends in New Jerseyans' health care spending. Detailed information on the data collection requirements and process that the state uses to validate private health insurance carriers' data submissions is available on the HART Program page of the DOBI website at https://nj.gov/dobi/division_insurance/HART/index.html.

In addition to the data collected directly from public payers and private health insurance carriers, the calculations of spending and spending growth in this report also rely on the following data:

- Medical Loss Ratio Data published by the Centers for Medicare & Medicaid Services at https://www.cms.gov/marketplace/resources/data/medical-loss-ratio-data-systems-resources
- Supplementary Health Care Exhibits, submitted to DOBI as supporting documentation for annual filings, at https://www.state.nj.us/dobi/division_insurance/solvency/annualstatements/index.html

D. Report overview

Chapter II of this report presents spending and spending growth at the state and market levels. The purpose of this chapter is to present the statewide and market-level spending and spending growth values based on an analysis of 2018 and 2019 health care spending data. **Chapter III** reports on spending and spending growth between 2018 and 2019 for seven categories of service. **Chapter IV** builds on Chapter III by examining primary care spending as well as pharmacy rebates for 2018 and 2019. Pharmacy rebates can be used to offset some of a carrier's spending on prescription drugs. The purpose of Chapters III and IV is to highlight areas of the health care delivery ecosystem that may provide opportunities for stakeholder action as they collaborate to meet the established cost growth targets, while also improving the quality and equity of the New Jersey health care system.

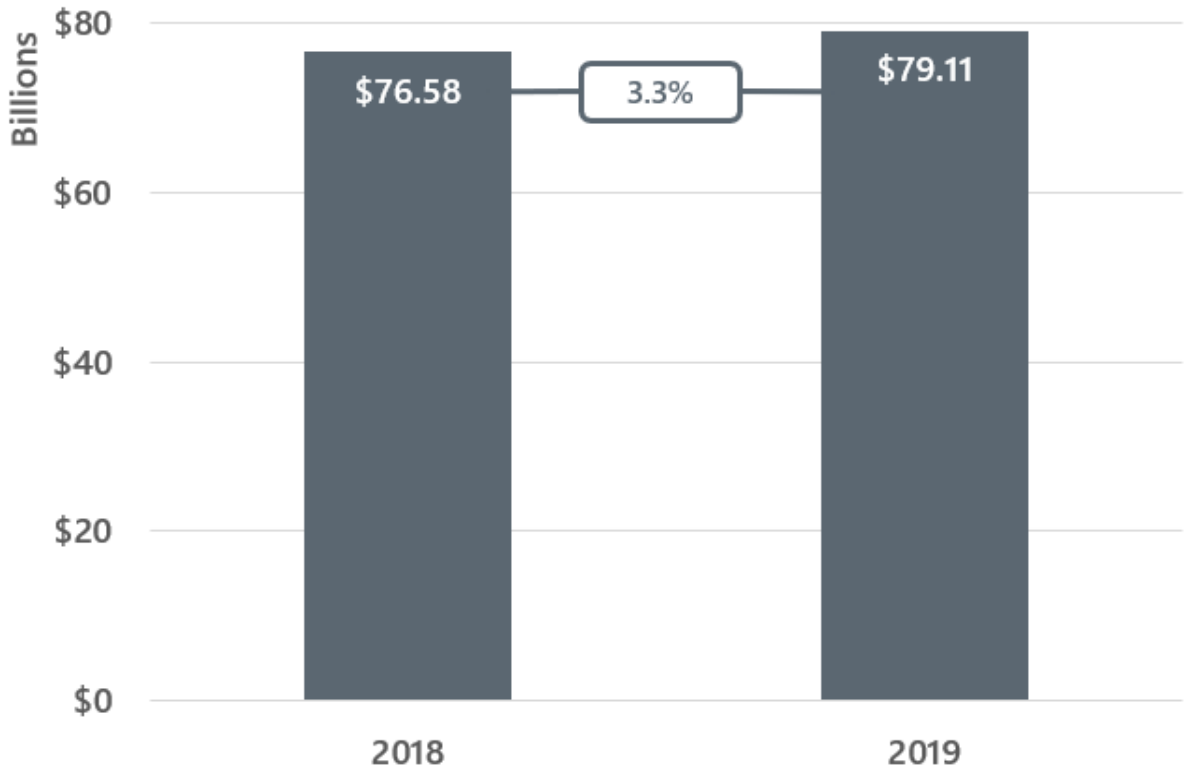
In addition, a set of appendices provide a glossary, market-level population tables, and a set of methodological notes.

II. Health Care Spending Trends, 2018 to 2019

A. Total health care expenditures statewide

Statewide, including all markets and both Total Medical Expenses (TME) and the Net Cost of Private Health Insurance (NCPHI), Total Health Care Expenditures (THCE) in New Jersey increased from $76.58 billion in 2018 to $79.11 billion in 2019, an increase of $2.53 billion or 3.3 percent (**Exhibit II.1**). By comparison, New Jersey's Gross Domestic Product grew from $622 billion in 2018 to $644 billion in 2019, an increase of about $22 billion or 3.7 percent.[8] The Total Health Care Expenditures (THCE) captured in this report made up 12.3 percent of New Jersey's Gross Domestic Product in 2019.

Exhibit II.1. Total Health Care Expenditures, statewide (in billions)

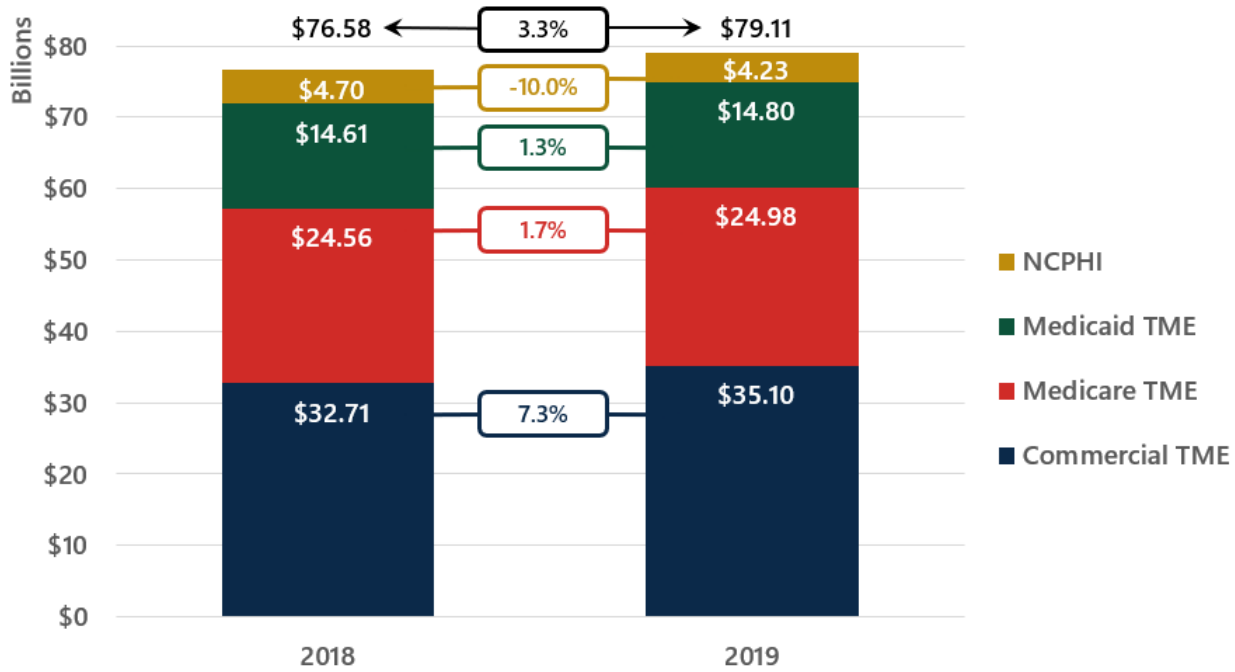


[8] https://apps.bea.gov/regional/histdata/releases/0420gdpstate/index.cfm.

The vast majority of THCE was TME, claims and non-claims payments to providers. **Exhibit II.2** shows TME by market, as well as total NCPHI—the cost of administering private insurance including commercial, Medicare Advantage, and Medicaid Managed Care plans—across all markets:

- **Commercial** TME was the largest component of THCE, accounting for nearly half (44.4 percent) of THCE in 2019. Commercial TME in 2019 was $32.71 billion, an increase of $2.39 billion or 7.3 percent from the 2018 total.
- **Medicare** TME followed, accounting for 31.6 percent of THCE in 2019. Medicare TME in 2019 was $24.98 billion, an increase of $423 million or 1.7 percent from the 2018 total.
- **Medicaid** TME accounted for 18.7 percent of THCE in 2019. Medicaid TME in 2019 was 14.8 billion, an increase of $189 million or 1.3 percent from the 2018 total.
- **NCPHI** accounted for 5.3 percent of THCE in 2019. Total NCPHI in 2019 was $4.23 billion, a decrease of $470 million or 10 percent from the 2018 total.

Exhibit II.2. Total Health Care Expenditures by major component, statewide (in billions)

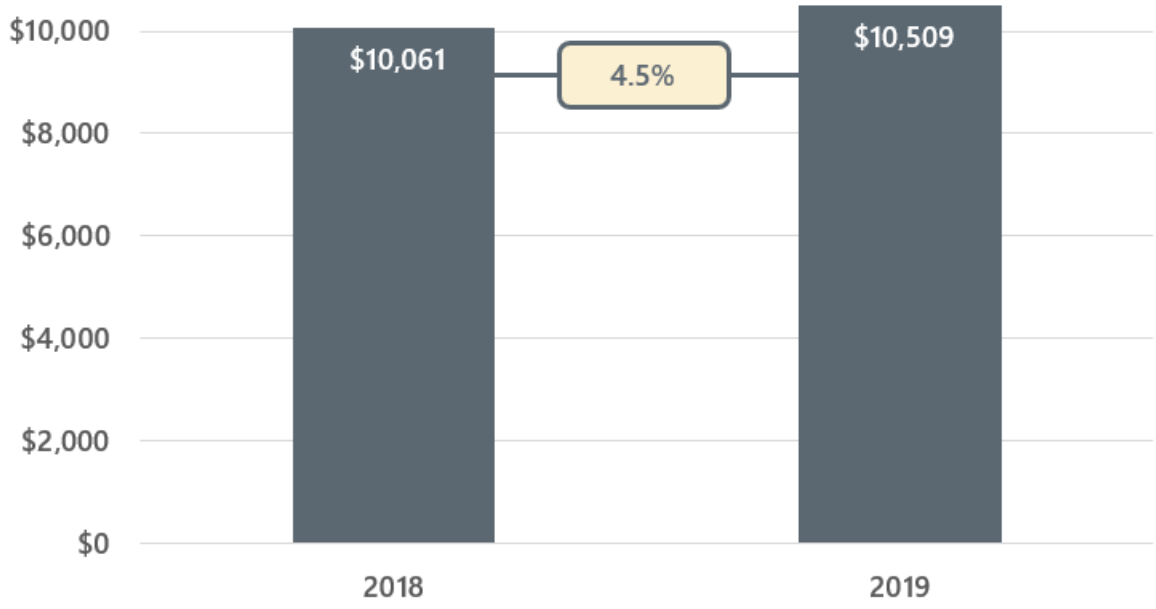


NCPHI = Net Cost of Private Health Insurance; TME = Total Medical Expenses.

The total health care spending values reported in Exhibits II.1 and II.2 are total amounts—not per person—so they are impacted by the number of insured New Jerseyans and the annual health care spending for those individuals.[9] The cost growth benchmark used in future reporting years will only apply to changes in per person per year (PPPY) spending.

Statewide PPPY THCE (that is, across all markets) in New Jersey increased from $10,061 in 2018 to $10,509 in 2019, a 4.5 percent increase (**Exhibit II.3**). **In future reporting years, this percent change value will be compared to the cost growth benchmark for that performance year.**

Exhibit II.3. Per person per year Total Health Care Expenditures, statewide



[9] The American Community Survey estimates that the percentage of New Jerseyans that were uninsured between 2016 and 2022 ranged from 6.8% to 8.0%. https://www.americashealthrankings.org/explore/measures/HealthInsurance/NJ.

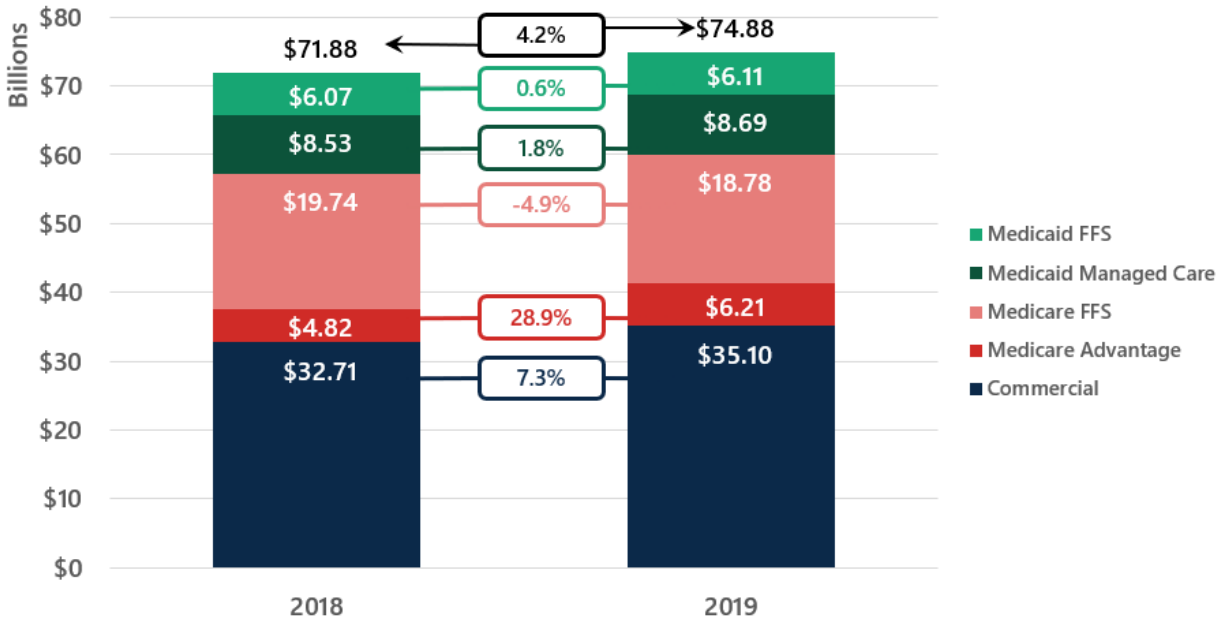
B. Total medical expenses by market and submarket

TME represents a subset of THCE and includes claims and non-claims payments made by carriers to providers, with claims data being reported gross of pharmacy rebates (that is, pharmacy rebate amounts are not subtracted from spending amounts).

Statewide, TME spending in New Jersey increased from $71.88 billion in 2018 to $74.88 billion in 2019, an increase of $3.00 billion or 4.2 percent (**Exhibit II.4**). This trend varied by submarket:

- **Commercial** TME increased from $32.71 billion in 2018 to $35.10 billion in 2019, an increase of $2.39 billion or 7.3 percent.
- **Medicare Advantage** TME increased from $4.82 billion in 2018 to $6.21 billion in 2019, an increase of $1.39 billion or 28.9 percent.
- **Medicare Fee for Service (FFS)** TME decreased from $19.74 billion in 2018 to $18.78 billion in 2019, a decrease of $968 million or 4.9 percent.
- **Medicaid Managed Care** TME increased from $8.53 billion in 2018 to $8.69 billion in 2019, a 1.8 percent increase.
- **Medicaid FFS** TME increased from $6.07 billion in 2018 to $6.11 billion in 2019, a 0.6 percent increase.

Exhibit II.4. Total Medical Expenses by submarket (in billions)



FFS = Fee for Service.

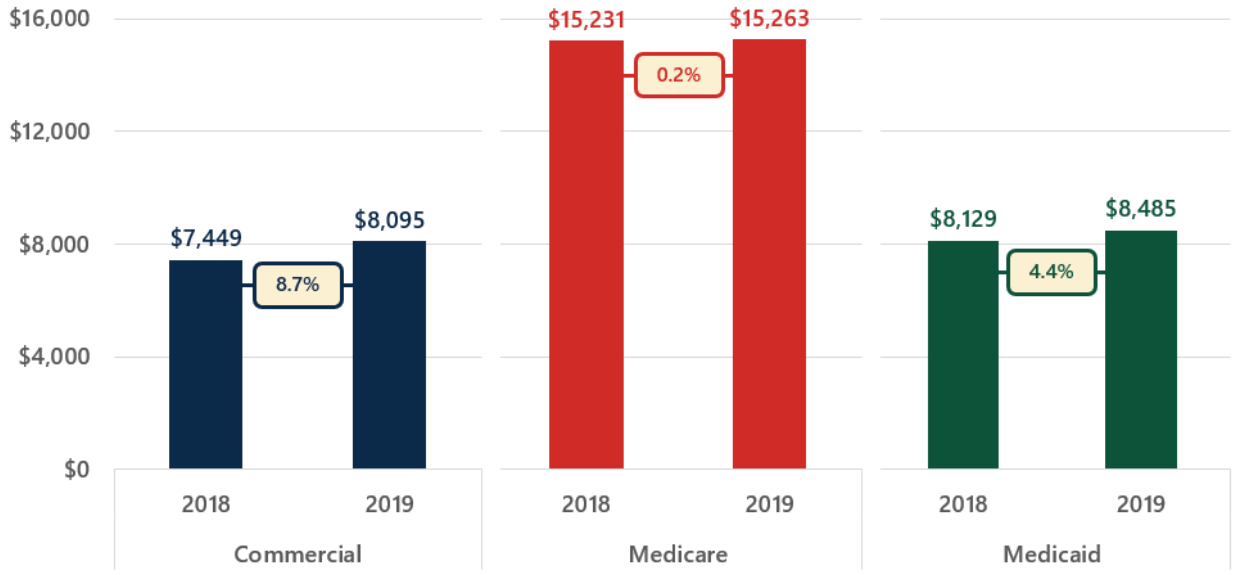
Because Exhibit II.4 depicts total spending, observed changes may be driven both by changes in enrollment and by changes in PPPY spending. For example, the 28.9 percent increase in total Medicare Advantage spending shown above is associated with a 26.4 percent increase in Medicare Advantage enrollment (Appendix B).

In future reporting years, the HART Program will compare spending growth in PPPY TME to the benchmark at the market level, not the submarket level. Between 2018 and 2019, PPPY TME grew more quickly in the commercial market than in either other market (**Exhibit II.5**):

- **Commercial** PPPY TME increased from $7,449 in 2018 to $8,095 in 2019, an 8.7 percent increase.
- **Medicare** PPPY TME increased from $15,231in 2018 to $15,263 in 2019, a 0.2 percent increase.
- **Medicaid** PPPY TME increased from $8,129 in 2018 to $8.485 in 2019, a 4.4 percent change.

In future reporting years, these percent change values will be compared to the cost growth benchmark for that performance year.

Exhibit II.5. Per person per year Total Medical Expenses by market



C. Net cost of private health insurance by market

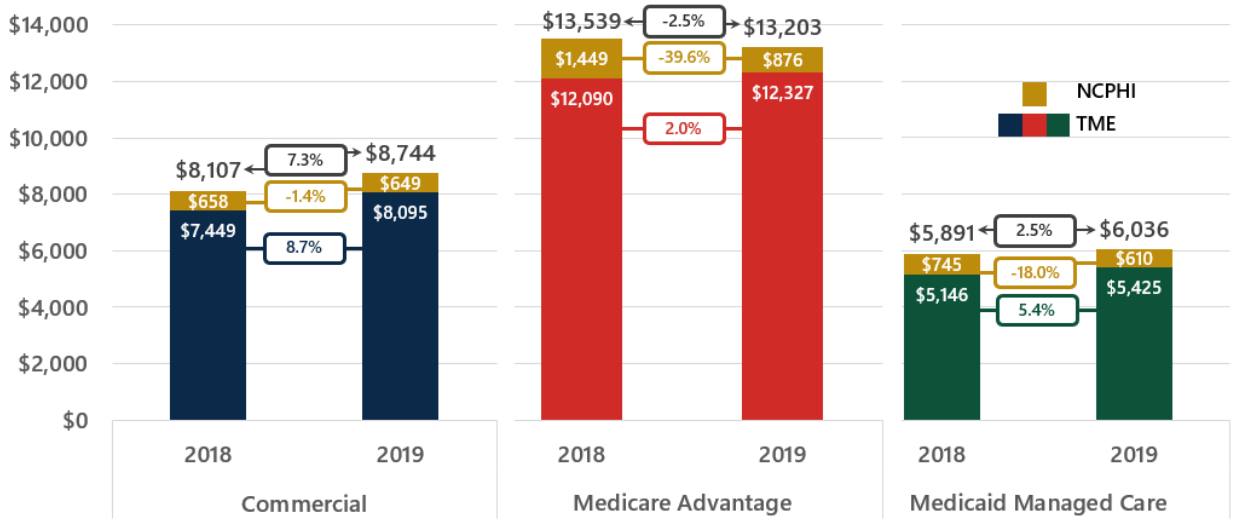
NCPHI represents the administrative costs of private health insurance, reflecting the difference between the premiums private insurance companies earn and their claims and other payments to providers. NCPHI is only pertinent to Medicare Advantage in the Medicare market and to Medicaid Managed Care in the Medicaid market.

As shown previously in Exhibit I.2, statewide NCPHI in New Jersey decreased from $4.7 billion in 2018 to $4.23 billion in 2019, a 10 percent decrease.

The percent change in PPPY NCPHI costs between 2018 and 2019 varied by market (**Exhibit II.6)**:

- **Commercial** PPPY NCPHI decreased from $658 in 2018 to $649 in 2019, a 1.4 percent decrease. In 2019, NCPHI comprised 7.4 percent of THCE for the commercial market.
- **Medicare Advantage** PPPY NCPHI decreased from $1,449 in 2018 to $876 in 2019, a 39.6 percent decrease. In 2019, NCPHI comprised 6.6 percent of THCE for Medicare Advantage plans.
- **Medicaid Managed Care** PPPY NCPHI decreased from $745 in 2018 to $610 in 2019, an 18.0 percent decrease. In 2019, NCPHI comprised 10.1 percent of THCE for Medicaid Managed Care plans.

Exhibit II.6. Per person per year Net Cost of Private Health Insurance and Total Medical Expenses by market



Note: Medicare FFS and Medicaid FFS are excluded from this figure because there is no NCPHI for those submarkets.
FFS = Fee for Service; NCPHI = Net Cost of Private Health Insurance; TME = Total Medical Expenses.

III. Health Care Spending Trends by Service Category

The majority of health care spending in New Jersey is accounted for by spending on the direct provision of care, in this report measured by Total Medical Expenses (TME). This chapter divides this spending into seven mutually exclusive and collectively exhaustive service categories. Looking at spending trends for specific service categories can highlight areas of the health care delivery ecosystem that may provide opportunities for stakeholders to focus their efforts as they collaborate to meet the established cost growth targets.

Service categories

This report analyzes spending and spending growth in terms of seven mutually exclusive service categories: hospital inpatient facility, hospital outpatient facility, professional, retail pharmacy, long-term care, other claims, and non-claims payments. These categories, which are standard in health policy research, are defined by the place of service and how the service is billed.

Service category descriptions

Hospital inpatient facility services	Hospital-based inpatient care and emergency department costs immediately prior to an inpatient admission. Examples include childbirth and complex surgeries.
Hospital outpatient facility services	Hospital-based outpatient care including services provided at hospital-licensed satellite clinics, emergency department services that do not result in admission, and observation services. Excludes payments made for physician services provided on an outpatient basis that a physician or group practice billed directly.
Professional services	Services provided by independent and hospital-affiliated clinicians, such as physicians, nurse practitioners, and physician's assistants. Includes professional services provided in offices, clinics, and hospitals, both inpatient and outpatient.
Retail pharmacy services	Retail drugs obtained at pharmacies or other location. Does not include physician-administered medications that are billed under other service categories. (Chapter III of this report details pharmacy spending gross of rebates, that is, the amount that the carrier paid the pharmacy.)
Long-term care facility services	Care provided in a long-term care setting including nursing homes and skilled nursing facilities, assisted living facilities, and home-based care.
Other claims services	Claims payments made to providers for medical services that are not included in any of the previous service categories. Examples include durable medical equipment, freestanding ambulatory surgical center and urgent care center services, hospice facility or services, freestanding diagnostic facility services, hearing aid services, and optical services.
Non-claims payments	Payments made to providers outside of the claims system. Examples include prospective payment arrangements, performance incentives, population health and practice infrastructure payments, and recoveries.

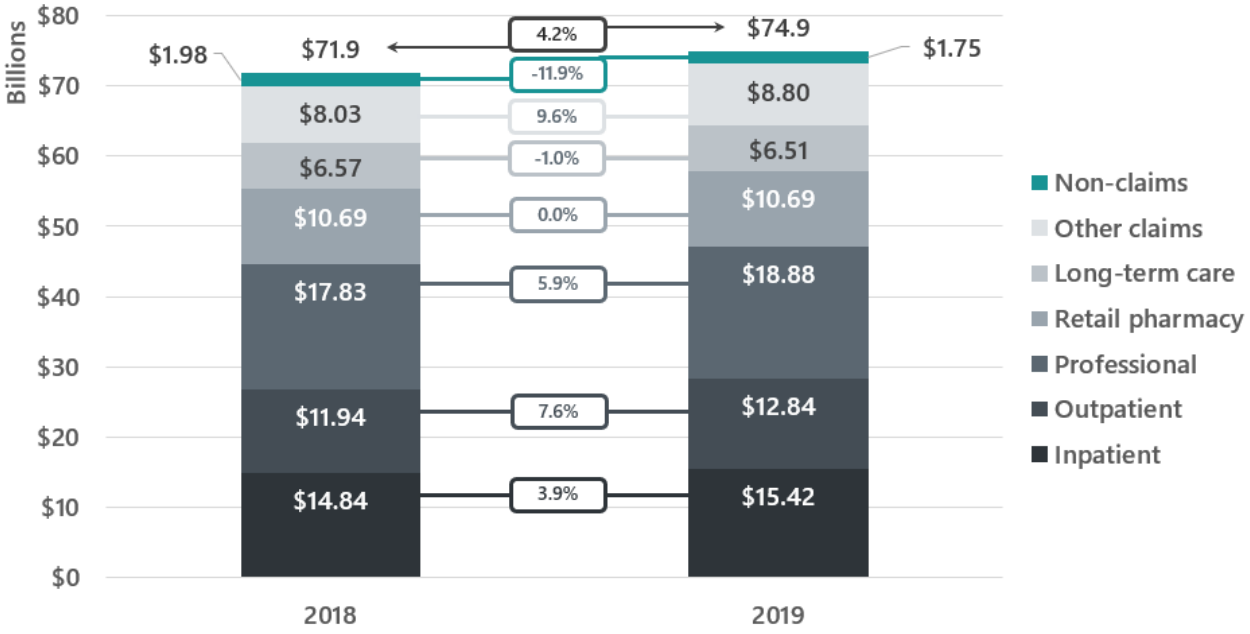
A. Total medical expenses by service category statewide

As shown in **Exhibit III.1**, TME was $74.9 billion in 2019; this amount was distributed among categories of service as follows, with categories listed in order of magnitude:

- **Professional services** spending represented the largest component of TME, accounting for 25.2 percent of TME and spending of $18.88 billion.
- **Inpatient facility services** spending represented the second largest component of TME, accounting for 20.6 percent of TME and spending of $15.42 billion.
- **Outpatient facility services** accounted for 17.1 percent of TME with spending of $12.84 billion.
- **Retail pharmacy services** accounted for 14.3 percent of TME with spending of $10.69 billion.
- **Other claims services** made up 11.7 percent of TME with spending of $8.8 billion.
- **Long-term care services** made up 8.7 percent of TME with spending of $6.51 billion.
- **Non-claims payments** were the smallest component of TME in 2019, making up 2.3 percent with spending of $1.75 billion.

The exhibit also shows the growth rate of each category between 2018 and 2019.

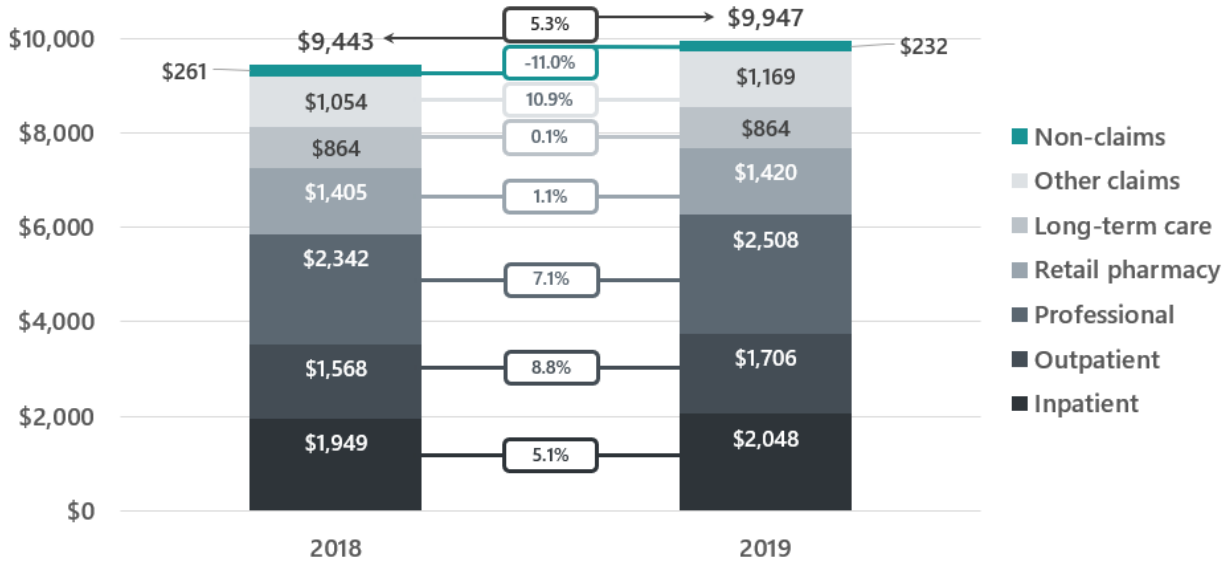
Exhibit III.1. Overall Total Medical Expenses by service category (in billions)



On a per person basis, between 2018 and 2019, TME increased in all service categories, apart from non-claims payments (**Exhibit III.2**).

- Three service categories displayed high spending growth, defined as spending growth of greater than 7 percent:
  - **Other claims services** rose from $1,054 per person per year (PPPY) in 2018 to $1,169 in 2019, a 10.9 percent increase.
  - **Outpatient facility services** climbed from $1,568 in 2018 to $1,706 in 2019, an 8.8 percent increase.
  - **Professional services** went from $2,342 in 2018 to $2,508 in 2019, a 7.1 percent increase.
- One service category demonstrated moderate spending growth, defined as growth between 3 and 7 percent:
  - Specifically, **inpatient facility services** PPPY were $1,949 in 2018 and $2,048 in 2019, a 5.1 percent increase.
- Growth in the remaining categories was low or negative:
  - **Retail pharmacy services** edged up from $1,405 PPPY in 2018 to $1,420 in 2019, a 1.1 percent increase.
  - **Long-term care services** were flat—$863.8 in 2018 and $864.3 in 2019, a 0.1 percent increase.
  - Finally, **non-claims payments** declined from $261 in 2018 to $232 in 2019, an 11 percent decrease.

Exhibit III.2. Per person per year Total Medical Expenses by service category



B. Total medical expenses by market and service category

1. Commercial market

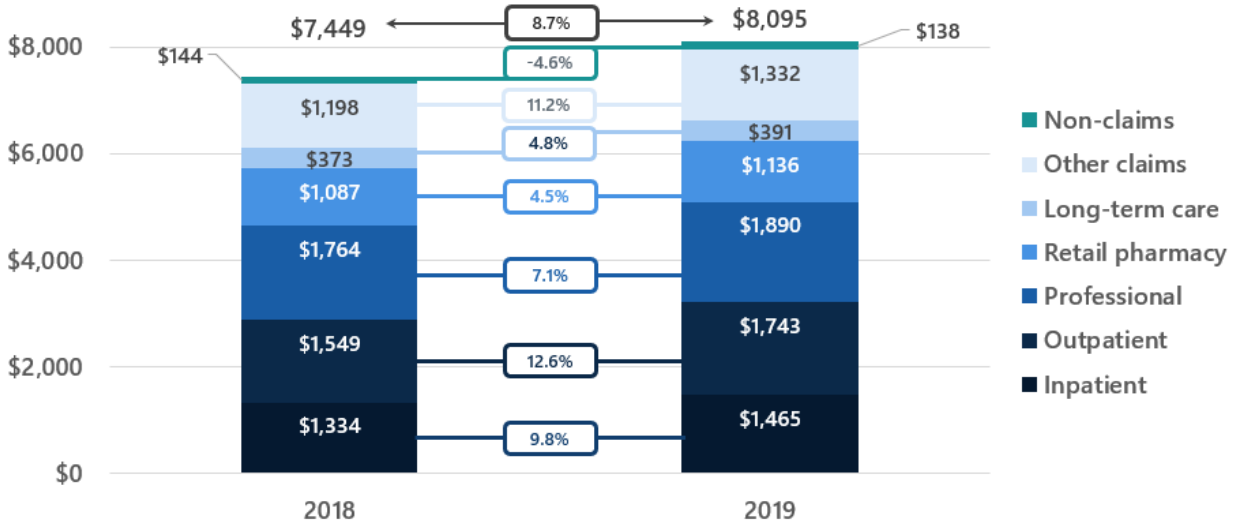
From 2018 to 2019, the commercial market experienced high PPPY spending growth of 8.7 percent, with increases in all service categories (**Exhibit III.3**).

Four categories of service exhibited high spending growth as defined above. Spending for **outpatient facility services** rose the fastest at 12.6 percent. Spending growth was also high in **inpatient facility services** at 9.8 percent, **professional services** at 7.1 percent, and **other claims services** at 11.2 percent.

Spending growth was more moderate in **retail pharmacy services** at 4.5 percent and **long-term care services** at 4.8 percent.

Non-claims payments declined by 4.6 percent.

Exhibit III.3. Per person per year Total Medical Expenses by service category, commercial



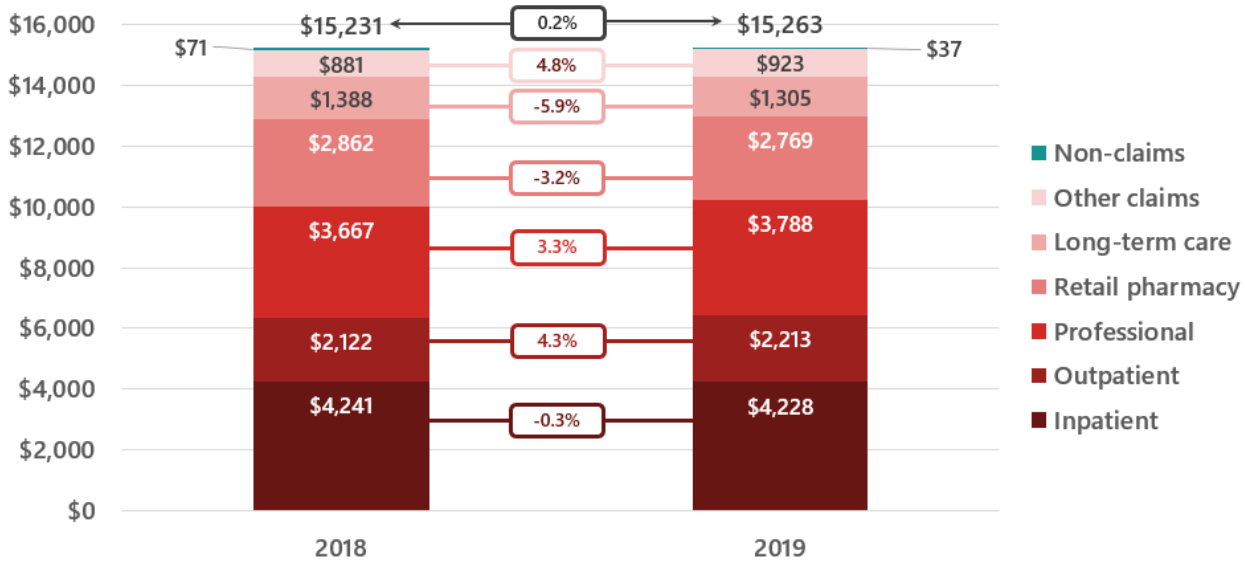
2. Medicare market

From 2018 to 2019, New Jersey's Medicare market experienced low PPPY spending growth of 0.2 percent (**Exhibit III.4**).

Spending growth was moderate for three service categories: **other claims services** grew by 4.8 percent, **outpatient facility services** grew by 4.3 percent, and spending for **professional services** increased 3.3 percent.

Spending declined in the **inpatient facility services**, **retail pharmacy services**, **long-term care services**, and **non-claims payments** categories with growth rates of -0.3 percent, -3.2 percent, -5.9 percent, and -48.2 percent, respectively.

Exhibit III.4. Per person per year Total Medical Expenses by service category, Medicare



Note: Per person per year non-claims Total Medical Expenses for the Medicare market decreased by 48.2 percent from 2018 to 2019. The value is not shown on the graphic due to space limitations.

3. Medicaid market

From 2018 to 2019, PPPY growth in the Medicaid market was 4.4 percent (**Exhibit III.5**).

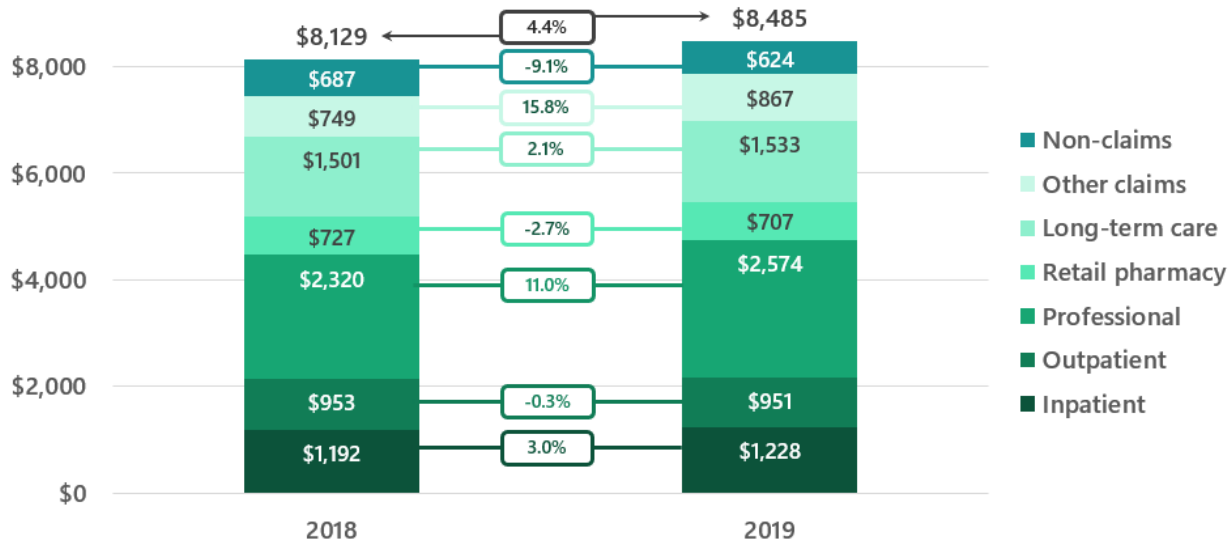
Two service categories experienced high spending growth: **other claims services** increased the most at 15.8 percent, and **professional services** grew by 11.0 percent.

The **inpatient facility services** category experienced moderate spending growth of 3.0 percent.

The **long-term care services** category saw low growth at 2.1 percent.

Spending declined for the remaining service categories: **outpatient facility services**, **retail pharmacy services**, and **non-claims payments** had changes of -0.3 percent, -2.7 percent, and -9.1 percent, respectively.

Exhibit III.5. Per person per year Total Medical Expenses by service category, Medicaid



IV. Additional Topics: Pharmacy Rebates and Primary Care Spending

This final chapter of the report examines two special topics: pharmacy rebates and primary care spending. Pharmacy rebates significantly affect the net cost of prescription drugs to carriers, and many observers believe that the U.S. is under-investing in primary care with negative consequences for patient health.

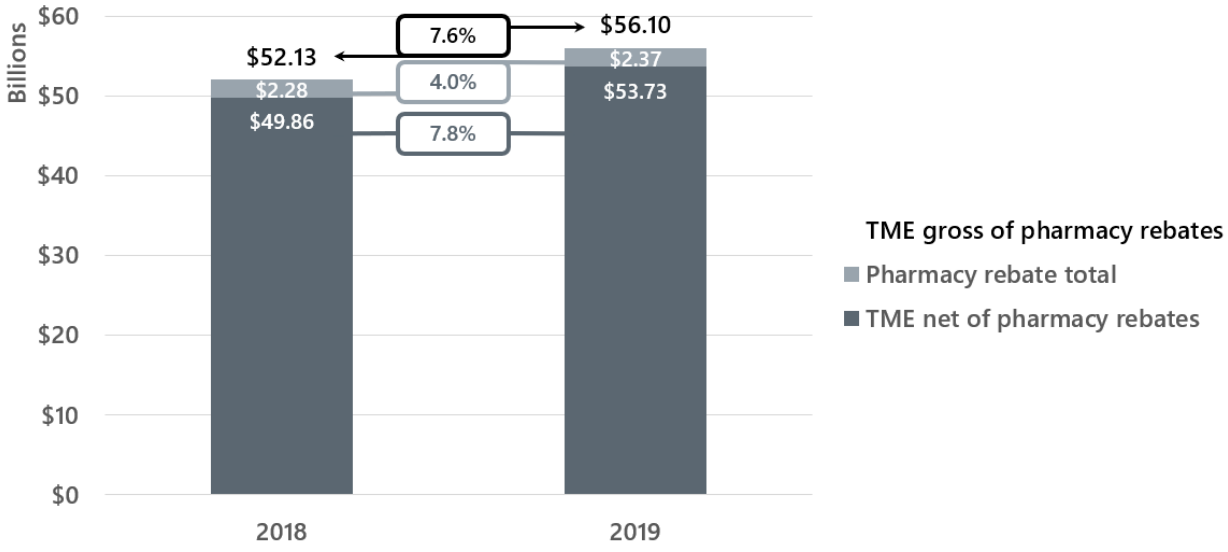
A. Pharmacy rebates

Both retail and medical pharmacy are consistently identified as primary drivers of health care spending and spending growth. Retail pharmacy refers to drugs that are acquired at a pharmacy and taken at home; medical pharmacy refers to drugs, such as infusion drugs and chemotherapy, that are administered by a health care provider in an inpatient or outpatient setting.

Pharmacy rebates are payments from drug manufacturers to health plans or pharmacy benefit managers that return some of the purchase price of a prescription drug. Rebates may be offered in exchange for a carrier placing specific drugs on its preferred drug list or on its formulary, as well as for the carrier achieving certain targets related to the volume of drug sales. Rebates apply to both retail and medical pharmacy. Rebate payments are an important lever of negotiation by manufacturers with carriers. In effect, rebates reduce the cost of drugs to the carrier or its pharmacy benefit manager. Public payers like Medicare and Medicaid use drug rebates to reduce the overall cost of providing coverage. How private payers use rebates to impact payments and savings is kept as a trade secret.

In New Jersey in 2018 and 2019, pharmacy rebates totaled $2.28 billion (4.4 percent of Total Medical Expenses [TME]) and $2.37 billion (4.2 percent of TME), respectively, excluding the Medicare Fee for Service submarket (**Exhibit IV.1**).

Exhibit IV.1. Total Medical Expenses, gross and net of pharmacy rebates, statewide (in billions)

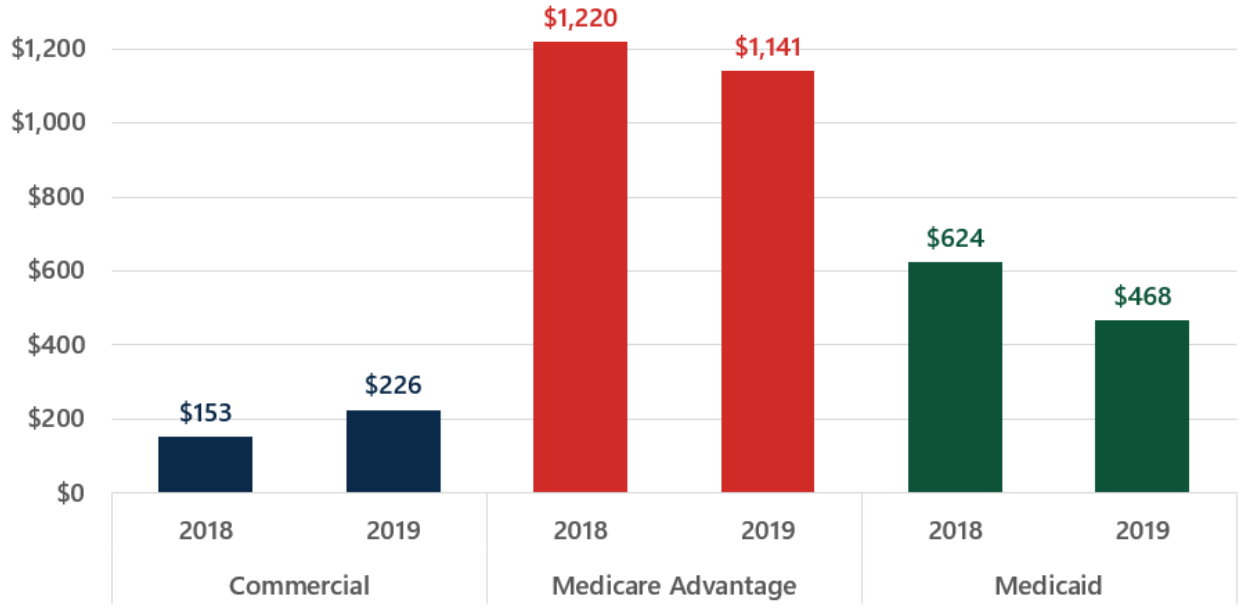


Note: Medicare Fee for Service is excluded from this figure because pharmacy rebate data for that submarket are not available.
TME = Total Medical Expenses.

The amount of pharmacy rebates, both on a per person per year (PPPY) basis and as a proportion of overall TME, varied by market (**Exhibit IV.2**):

- **Commercial** PPPY pharmacy rebates were $153 and $226 in 2018 and 2019, respectively. Pharmacy rebates were 2.1 percent of overall commercial TME in 2018 and 2.8 percent in 2019.
- **Medicare Advantage** PPPY pharmacy rebates were $1,220 and $1,141 in 2018 and 2019, respectively. Pharmacy rebates were 10.1 percent of overall Medicare Advantage TME in 2018 and 9.3 percent in 2019.
- **Medicaid** PPPY pharmacy rebates were $624 and $468 in 2018 and 2019, respectively. Pharmacy rebates were 7.7 percent of overall Medicaid TME in 2018 and 5.5 percent in 2019.

Exhibit IV.2. Per person per year pharmacy rebates by market



Note: Medicare Fee for Service is excluded from this figure because pharmacy rebate data for that submarket are not available.

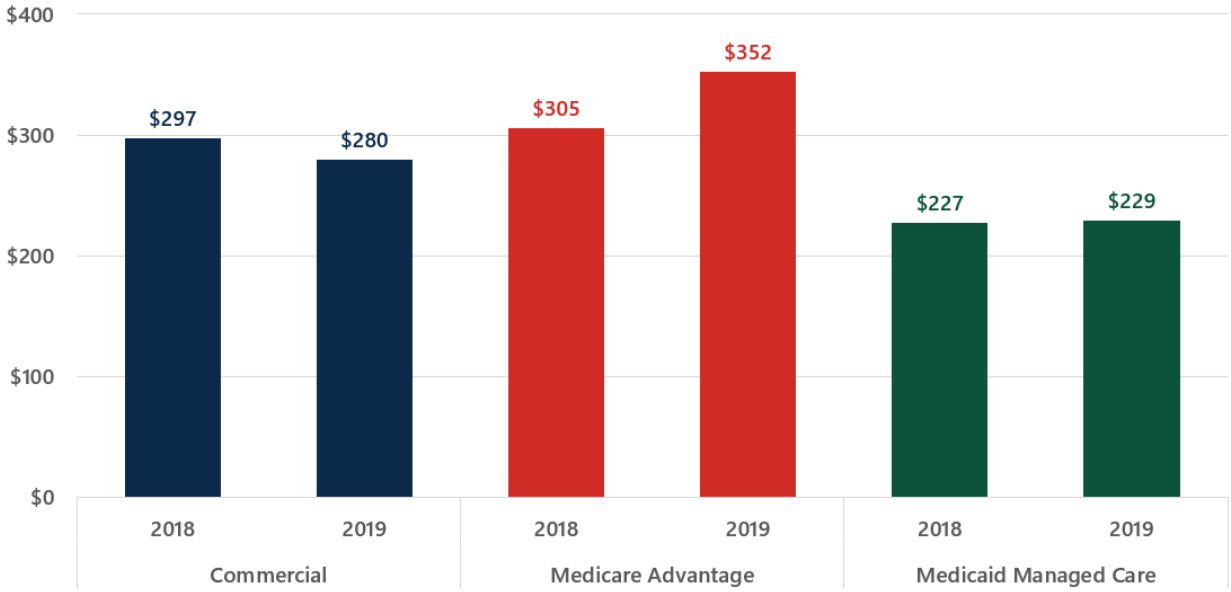
B. Primary care spending

Effective and appropriately administered primary care services for members have consistently proven to reduce hospitalizations, improve patient health outcomes overall, and promote equity in the health system.[10, 11] However, over time, spending on primary care in the aggregate has been in steady decline, with implications for patient outcomes as well as for avoidable spending.[12]

Statewide, total primary care spending in New Jersey decreased from $1.81 billion in 2018 to $1.76 billion in 2019, a 2.6 percent decrease. As illustrated in **Exhibit IV.3,** this trend varied by market:

- **Commercial** PPPY primary care spending was $297 in 2018 and $280 in 2019, a 6.0 percent decrease. Primary care spending was 3.7 percent of overall commercial TME in 2018 and 3.6 percent 2019.
- **Medicare Advantage** PPPY primary care spending was $305 in 2018 and $352 in 2019, a 15.3 percent increase. Primary care spending was 2.8 percent of overall Medicare Advantage TME in 2018 and 3.1 percent in 2019.
- **Medicaid Managed Care** PPPY primary care spending was $227 in 2018 and $229 in 2019, a 0.8 percent increase. Primary care spending was 4.5 percent of overall Medicaid Managed Care TME in 2018 and 4.3 percent in 2019.

Exhibit IV.3. Per person per year primary care spending by submarket



Note: Primary care spending was not collected for the Medicare Fee for Service or Medicaid Fee for Service submarkets; therefore, they are excluded from this figure.

[10] Starfield, Barbara, Leiyu Shi, and James Macinko. "Contribution of Primary Care to Health Systems and Health." *Milbank Quarterly*, vol. 83, no. 3, 2005, pp. 457-502. https://doi.org/10.1111/j.1468-0009.2005.00409.x

[11] Stange, Kurt C, William L. Miller, and Rebecca S. Etz. "The Role of Primary Care in Improving Population Health." *Milbank Quarterly*, vol. 101, no. S1, 2023, pp. 795-840. https://doi.org/10.1111/1468-0009.12638

[12] Horstman, Celli, Corinne Lewis, and Melinda K. Abrams. "Strengthening Primary Health Care: The Importance of Payment Reform," To the Point (blog), Commonwealth Fund, Dec. 10, 2021. https://doi.org/10.26099/w4gh-f259.

Appendix A. Glossary

Carrier: A public or private organization or entity that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, Medicaid Managed Care plans, or Medicare Advantage plans. Also referred to as insurance carriers and payers.

Claims payments: Payments made by carriers and members to providers for health care services delivered. For the purposes of this report, claims payments reflect the allowed amount on provider claims to carriers, which includes the amount carriers paid to providers and any member cost sharing, such as copayments, deductibles, and coinsurance.

Coinsurance: The percentage of costs of a covered health care service that members pay after their deductible has been met.

Copayment: A fixed amount that members pay for a covered health care service after their deductible has been met.

Cost growth: The change in cost of health care. In this report, cost growth is measured on a per person per year basis.

Cost sharing: The portion of the cost of covered services (that is, claims spending) that is paid by members as opposed to carriers. It encompasses various out-of-pocket costs that individuals may incur when accessing health care services, such as deductibles, copayments, and coinsurance.

Deductible: The amount that members pay for covered health care services before their insurance plan starts to pay. Once the deductible has been met, members will pay either a copayment or coinsurance and the carrier will pay the rest.

Fee for service (FFS): A system of health insurance payment in which a doctor or other health care provider is paid for each service performed. Although private carriers can reimburse providers on an FFS basis, in this report, FFS refers to insurance coverage that is administered by the government—the federal government for Medicare coverage and the New Jersey State government for Medicaid coverage.

Market: A grouping of types of health insurance that is based on the source of the plan's funding. This report divides health insurance into three markets: commercial, Medicare, and Medicaid.

Managed care: A system of health insurance payment in which a carrier uses a non-FFS structure to reimburse providers for care delivered to covered members. In this report, managed care broadly refers to insurance coverage within the Medicare and Medicaid markets that is administered by a private (that is, non-governmental) entity. Managed care plans within the Medicare market are referred to as Medicare Advantage, whereas managed care plans within the Medicaid market are referred to as Medicaid Managed Care.

Non-claims payments: All payments other than providers' claims that carriers make to providers. This includes incentive payments, capitation or bundled payments, payments that support care transformation and infrastructure (for example, care manager payments, lump sum investments, patient-centered primary care home payments), and other payments that support provider services.

Net Cost of Private Health Insurance (NCPHI): The cost to New Jersey residents associated with the administration of private health insurance. It is the difference between health premiums earned and claims and other payments to providers. It consists of carriers' costs related to paying bills, advertising, sales commissions, other administrative costs, premium taxes, and other fees. It also includes carriers' profits (contribution to margin) or losses. NCPHI is calculated for the commercial, Medicare Advantage, and Medicaid Managed Care submarkets but not for the Medicare FFS and Medicaid FFS submarkets.

Pharmacy benefit managers: Third-party administrators that manage prescription drug benefits on behalf of health insurance plans, self-insured employers, and government programs. They play an important role in negotiating drug prices with pharmaceutical manufacturers, develop formularies, process prescription claims, and administer pharmacy networks.

Provider entity: An organization with primary care providers who engage in total cost of care contracts for a significant proportion of the population they serve, and for whom carriers attribute and report total medical expense data.

Service category: A standard practice in health policy research of grouping payments for health care services, whereby spending is categorized based on where the service is delivered and how it is billed. In this report, we use seven service categories: hospital inpatient facility, hospital outpatient facility, professional, retail pharmacy, long-term care facility, other claims, and non-claims payments.

Submarket: Subcategories of the Medicare and Medicaid market including Medicare Advantage, Medicare FFS, Medicaid Managed Care, and Medicaid FFS.

Total Health Care Expenditures (THCE): The sum of the Total Medical Expenses incurred by New Jersey residents for all health care services that carriers report to the state plus the Net Cost of Private Health Insurance for administering carriers' plans.

Total Medical Expenses (TME): The sum of total claims payments and total non-claims payments to providers for health care services delivered to New Jersey residents. Includes both payments by carriers and cost sharing payments by members.

Appendix B. Population Included in the Report

A. Population inclusion

The Cost Growth Benchmark report relies on health care spending and enrollment data submitted to the New Jersey Department of Banking and Insurance by both public payers and private carriers. In their data submissions, carriers are directed to include all New Jersey residents who have comprehensive health care coverage, regardless of the plan's situs (that is, where the insurer for the given plan is located).

The list of private carriers from whom data was collected includes Aetna Better Health, Amerigroup, AmeriHealth Insurance Company, Cigna Health & Life Insurance Company, Horizon Healthcare of New Jersey, United HealthCare Insurance Company, and WellCare/Fidelis Health Plans of New Jersey.

B. Population table and notes

Appendix Table B.1 below presents the population included in this report as member years by submarket and year, along with year-over-year assessment of change.

Appendix Table B.1 Report population in member years by submarket and year

Submarket	2018	2019	Absolute change	Percent change
Commercial	4,391,235	4,336,164	-55,071	-1.3%
Medicare Advantage	398,298	503,402	105,104	26.4%
Medicare FFS	1,214,158	1,133,404	-80,754	-6.7%
Medicaid Managed Care	1,658,364	1,601,208	-57,156	-3.4%
Medicaid FFS	138,491	142,619	4,128	3.0%
Subtotal	**7,800,546**	**7,716,796**	**-83,749**	**-1.1%**
Medicaid portion of coverage for dually eligible beneficiaries	188,739	189,175	436	0.0%
Total	**7,611,807**	**7,527,621**	**-84,186**	**-1.1%**

FFS = Fee for Service.

1. Medicare Fee-for-Service (FFS) population

For the Medicare FFS population, the member years reflected in the table above represent those beneficiaries with either Part A or Part B coverage during the year. This total is used as the denominator in all per person per year (PPPY) calculations that involve Medicare FFS spending totals, such as service category-level spending for the Medicare market (this includes PPPY calculations for the retail pharmacy service category).

2. Treatment of dually eligible beneficiaries

Spending and enrollment information for beneficiaries that are dually eligible for both Medicare and Medicaid coverage is collected separately from those beneficiaries that are not dually eligible for the two programs. How spending and enrollment are handled for this population depends on the level of reporting:

- At the **statewide level**, spending for both the Medicare and Medicaid portions of their coverage are included in spending totals, but only the *Medicare* portion of their enrollment is included in the population total for PPPY calculations.
- At the **market and submarket levels**, spending for the given market is included in spending totals, and dually eligible beneficiaries' enrollment for the given market is included in the population total for PPPY calculations—that is, the dually eligible population appears in the population total for both Medicare and Medicaid.

3. Member years

Public payers and private carriers report enrollment data using member months. For PPPY calculations in this report, member years is calculated by dividing the member months by 12.

Appendix C. Methodology Notes

A. Pharmacy rebate estimation

In some instances, private carriers did not submit pharmacy rebate data for the commercial partial claims insurance category. When this occurred, the state estimated pharmacy rebates on their behalf using the following formula:

$$Estimated\ pharmacy\ rebates\ PPPY\ for\ commercial\ partial\ claims = Retail\ pharmacy\ claims\ PPPY\ for\ commercial\ partial\ claims\ x\ \frac{Pharmacy\ rebate\ PPPY\ for\ commercial\ full\ claims}{Retail\ pharmacy\ claims\ PPPY\ for\ commercial\ full\ claims}$$

PPPY = per person per year.

B. Primary care definitions

Primary care spending data is collected from the private carriers (that is, primary care data is not collected for the Medicare or Medicaid Fee for Service submarkets). For the data submission process and subsequently this report, primary care services are defined as those which meet all the following criteria:

1. The rendering or billing provider practices included any of the following specialties: family medicine, geriatric medicine, internal medicine, or pediatric medicine.
2. The care delivered included any of the following services: care management, care planning, consultation services, health risk assessments, screenings, counseling, home visits, hospice, immunization administrations, office visits, and preventive medicine visits.
3. The setting where they delivered services was at any of the following sites of care: primary care outpatient setting (for example, office, clinic, or center), federally qualified health center, school-based health center, or via telehealth.

A complete table of codes (provider taxonomies, procedure codes, and place of service codes) used to define primary care services can be found in Appendix B of the Carrier Benchmark Data Submission Guide, available on the HART Program page of the Department of Banking and Insurance website at https://nj.gov/dobi/division_insurance/HART/index.html.