Castlight

2022 Castlight Workforce Health Index

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Workforce Health Index Advisory Board & Authors

Dena M. Bravata, M.D., M.S., Chief Medical Officer, Castlight Health. Senior Affiliate, Stanford Center for Primary Care and Outcomes Research

Michelle Chen, M.S., Data Scientist, Castlight Health

Nicole Arlette Hirsch, Ph.D., DEI Expert and Independent Scholar, University of California, Berkeley

Pen-Che Ho, M.S., Senior Manager Data Science, Castlight Health

Justin Mohatt, M.D., Medical Director for Innovation, Ohana, Montage Health and Chair, Division of Child, Adolescent and Family Psychiatry, Community Hospital of the Monterey Peninsula

Katie Roda, M.B.A., Director Product Marketing, Castlight Health

Emilie Song, M.S., Director Marketing, Castlight Health

Bruce Sherman, M.D., Advisor to the National Alliance of Healthcare Purchaser Coalitions, Adjunct Professor, Department of Public Health Education, University of North Carolina-Greensboro, Greensboro, NC

Christopher M. Whaley, Ph.D., Policy Researcher; Professor, Pardee RAND Graduate School

Foreword

As we enter the third year of the COVID-19 pandemic, employers continue to battle escalating clinical issues, including delayed care for chronic conditions, postponed preventive screenings, and the exponential increase in demand for behavioral health services.

In response, these organizations have renewed their dedication to employee health and wellbeing as a critical component of their overall workforce strategy. They are broadening the benefits they offer with the goal of improving health outcomes and better managing healthcare spend. Meanwhile, with a focus on diversity and equity, many benefits leaders are seeking to ensure healthcare benefits and programs are inclusive and address the needs of at-risk populations. Employers, big and small, are in need of data-driven insights to inform their benefit strategies, especially in light of the quickly shifting dynamics in healthcare utilization and spend during the pandemic.

In partnership to build a productive, engaged, and healthy workforce, we provide historical trends, current state, and forecasts for key aspects of medical spending for commercially-insured populations. We hope the 2022 Castlight Workforce Health Index and the accompanying **2022 Commercial Healthcare Spend Data** will be used by benefit leaders, health plans, consultants, policymakers, and providers working to improve access to, and affordability of the care required by commercially-insured populations.

Dena M. Bravata, M.D., M.S., Chief Medical Officer, Castlight Health
Senior Affiliate, Stanford Center for Primary Care and Outcomes Research

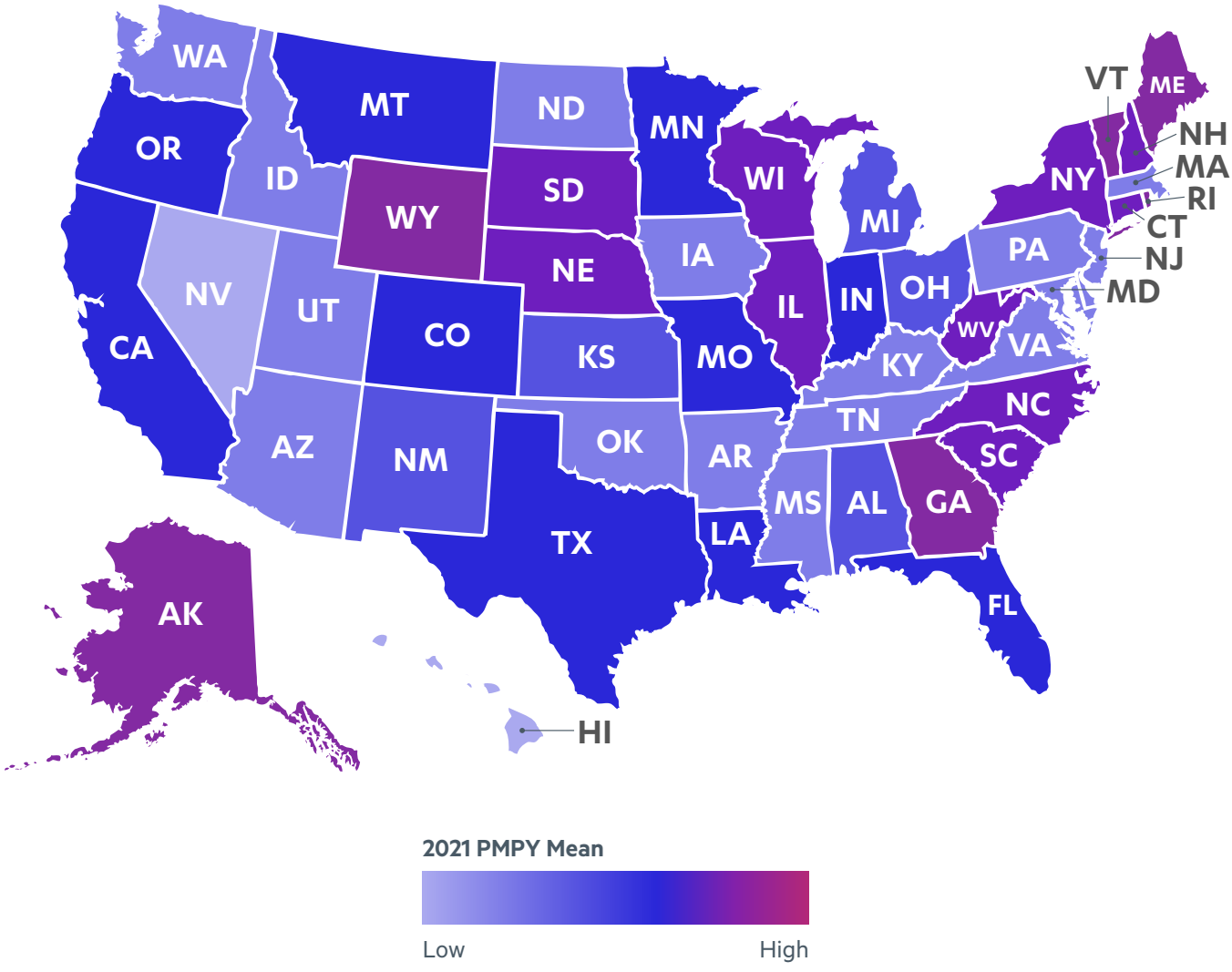
Executive Summary

The 2022 Castlight Workforce Health Index provides robust data on medical spending and health benefits utilization of commercially-insured populations in the US. Castlight analyzed more than 160 million medical claims, employer investments in digital programs, data from ecosystem partners, and responses to Castlight's Health Risk Assessment to provide insights into past healthcare utilization trends and predictions for anticipated future spend. We hope that these data and insights can inform efforts to improve the health and wellbeing of commercially-insured populations. In this report, given the effects of the COVID-19 pandemic on commercial spend, we provide detailed analyses on telehealth, preventive care and behavioral health, with a focus on how healthcare utilization and spending vary by income and racial makeup.

All analyses were conducted with medical claims, including employer and member spend. We focus on medical spend, rather than pharmaceutical spend, given the disproportionate impact of the pandemic on health services utilization. The medical spend trends in this report are consistent with those found elsewhere (e.g., MEPS[1]) but are reported in greater detail and with an eye toward informing benefit design strategies for commercially-insured populations.

In addition to the analyses which are presented in the report at the national level, we provide a dataset with an aggregate view of per member per year medical spend ($PMPY) at the state level for the prior 4 years, including a summary of the top 5 areas of spend by state.

To access the in-depth state by state analysis, click the map or visit castlighthealth.com/2022-whi-dataset.



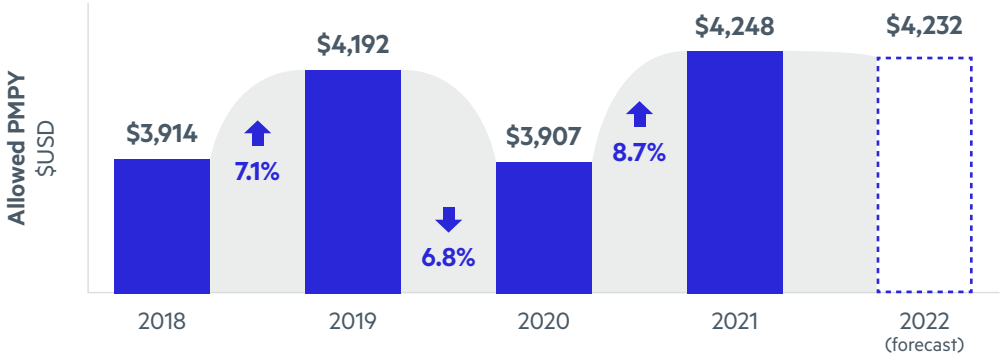
Medical Spend & Employee Health

Commercial healthcare spending fell in 2020 amidst the pandemic but rebounded in 2021. Flat growth is anticipated for 2022.

Commercial medical spending[i] grew steadily over the past decade[2, 3] until 2020, when the SARS CoV-2 pandemic upended this historical trend. Per member per year ($PMPY) spending grew 7.1% from 2018 to 2019. However, as access to care diminished during the pandemic, average $PMPY medical spend from 2019 to 2020 declined by 6.8% primarily driven by reduced utilization of care in the early months of the pandemic (March through May). The proportions of spend for inpatient, outpatient, and professional services were consistent over the past five years. In other words, lower medical spend observed during the pandemic impacted healthcare utilization across the board.

As access to care was restored in 2021, $PMPY medical spend returned to pre-pandemic levels. We project flat growth in medical spend for 2022. As such, employers should forecast and budget for $PMPY medical expenditures comparable to pre-pandemic levels. The accompanying **2022 Commercial Healthcare Spend Data** set provides the national data summarized here and state-by-state medical spend data for the past 4 years.

Total Medical Spend
2018-2022



- Allowed medical spend ($PMPY) grew 7.1% from 2018 to 2019
- From 2019 to 2020, allowed medical spend dropped 6.8%
- Following a bounce-back in 2021, Castlight projects flat growth in allowed medical spend in 2022

Total Medical Spend by Members in Low-Income vs Wealthier Communities
2018-2022

It is interesting to note that medical spending was consistently higher and declined less during the pandemic for people living in low-income communities[ii] compared to those living in wealthier communities[iii]. For those living in low-income communities, medical spend contracted by 5.4% in 2020. In contrast, medical spend contracted more than 9.0% in wealthier communities in the same year. These trends suggest that people living in wealthier communities may have deferred or decided to forgo care more often during the first year of the pandemic. A few reasons are plausible for this observation: individuals living in low-income communities tend to have more significant disease burden[4, 5] and therefore could not forgo needed care, or perhaps before the pandemic, there had been induced demand for care in wealthier communities[6] that rebalanced somewhat during the early months of the pandemic. As individuals living in wealthier communities are typically healthier than those living in lower income communities, the relative change observed may be less clinically impactful to populations in higher income areas.

- From 2019 to 2020, allowed medical spend ($PMPY) contracted by 5.4% in low-income communities
- From 2019 to 2020, allowed medical spend ($PMPY) contracted by just over 9.0% in wealthy communities
- In 2021, two years into the pandemic, medical spend returned to levels slightly higher than observed in 2019
- Following a bounce-back in 2021, Castlight projects flat growth in paid medical spend in 2022 across low-income and wealthier communities

i. **Healthcare spending:** Per member per year ($PMPY) allowed medical spend which reflects the paid amount by employer and employee. Prescription spend not included.
ii. **Low-income communities:** Includes zip-codes where the median household income is less than or equal to 200% of the Federal Poverty Level. The Federal Poverty Level (FPL) is a measure of income issued every year by the Department of Health & Human Services.
iii. **Wealthy communities:** Includes zip-codes where the median household income is greater than 400% of the Federal Poverty Level. The Federal Poverty Level (FPL) is a measure of income issued every year by the Department of Health & Human Services.

Musculoskeletal and cancer care drive nearly 30% of commercial spend.

As they have for the past several years,[7] musculoskeletal and cancer care account for nearly 30% of commercial medical spend (with 14.7% for musculoskeletal care and 13.6% for cancer care in 2021).

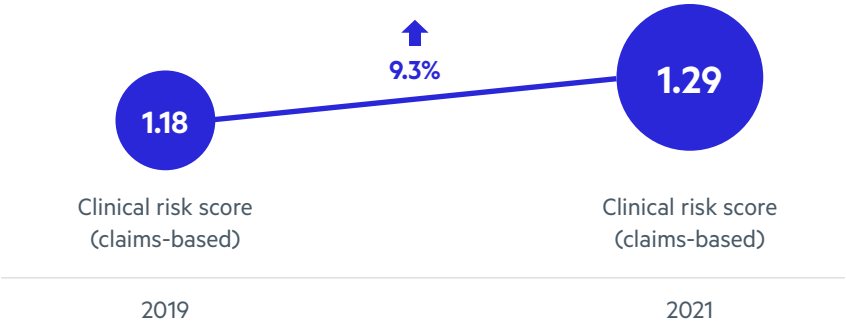
Cardiology and gastroenterology care continue to be the third and fourth most costly care categories (accounting for 9.3% and 8.7% of total medical spend, respectively. Notably, care for COVID-19-related illness resulted in a more than doubling of infectious disease-related spending.

% of Total Medical Spend by Category
2018-2021

- Top diagnostic reasons shown represent >75% of all medical spend
- Spend on musculoskeletal issues and cancer consistently top share of wallet, capturing 14.7% and 13.6%, respectively in 2021

Employees and their families are sicker than they were pre-pandemic.

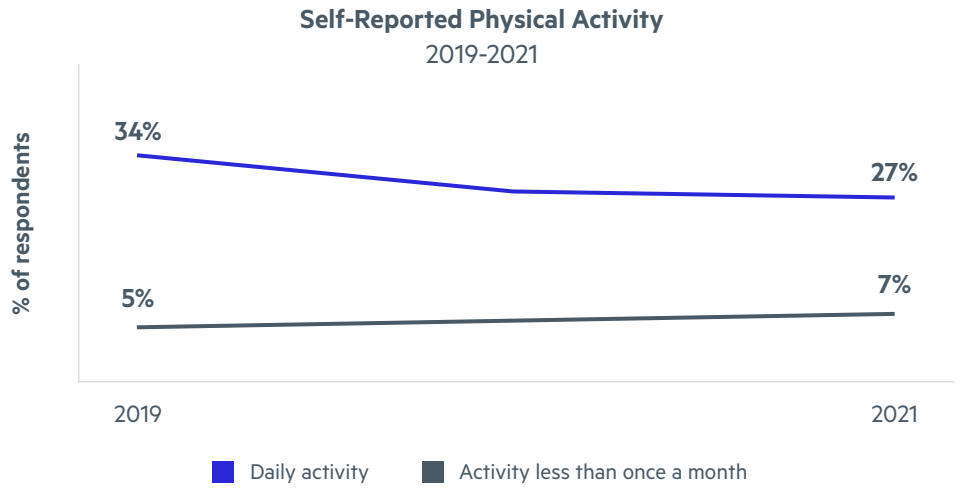
To evaluate the overall health of commercially-insured populations, Castlight tracked the healthcare claims of a cohort of employees and their families from 2019 to 2021. We calculated a population-level clinical risk score based on claims data and found that the clinical risk of this population dramatically increased by 9.3% from 2019 to 2021 (clinical risk score increased from 1.18 to 1.29). The risk of this population was only expected to increase by 3% on the basis of the cohort getting older over the time period—so the increased burden of disease was 3X what was expected. We speculate that this may have resulted from exacerbations of underlying conditions, perhaps resulting from delayed care and increased costs for COVID care.



Claims-based population clinical risk increased 3X what was expected from 2019 to 2021

To consider the role of self-care in contributing to the health of commercially-insured populations, we evaluated changes in behaviors based on self-reported status in the Castlight Health Risk Assessment. During the pandemic, self-reported physical activity decreased significantly (a key risk factor for numerous conditions including heart disease, type 2 diabetes, and cancer).[8] The percentage of individuals who reported daily physical activity dropped from 34% in 2019 to 27% in 2021, while those who engaged in physical activity less than once a month increased from 5% to 7%. Employers may be able to mitigate these findings by offering social challenges encouraging physical activity,[9] paired with incentives to drive engagement.

Unfortunately, a large proportion of smokers transitioned from smoking occasionally before the pandemic to smoking daily, with 89% of the smoking population engaging in the habit daily in 2021, up from 77% of the population in 2019.



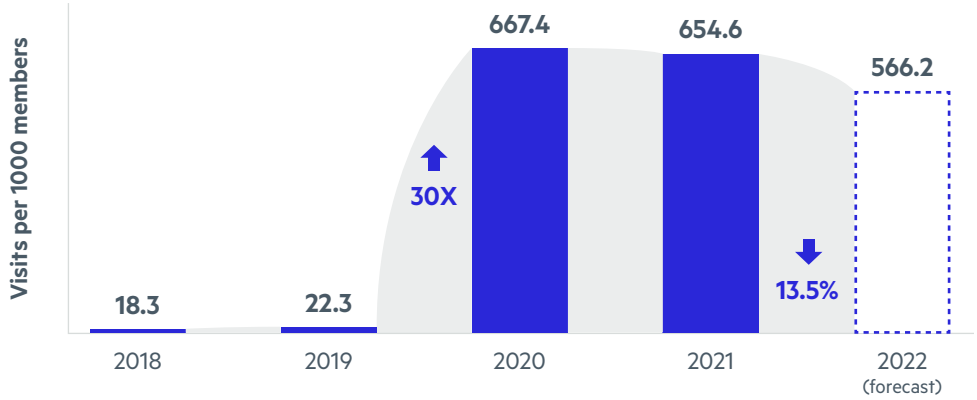

3X
greater burden
of disease than
expected in 2021

Telemedicine Utilization

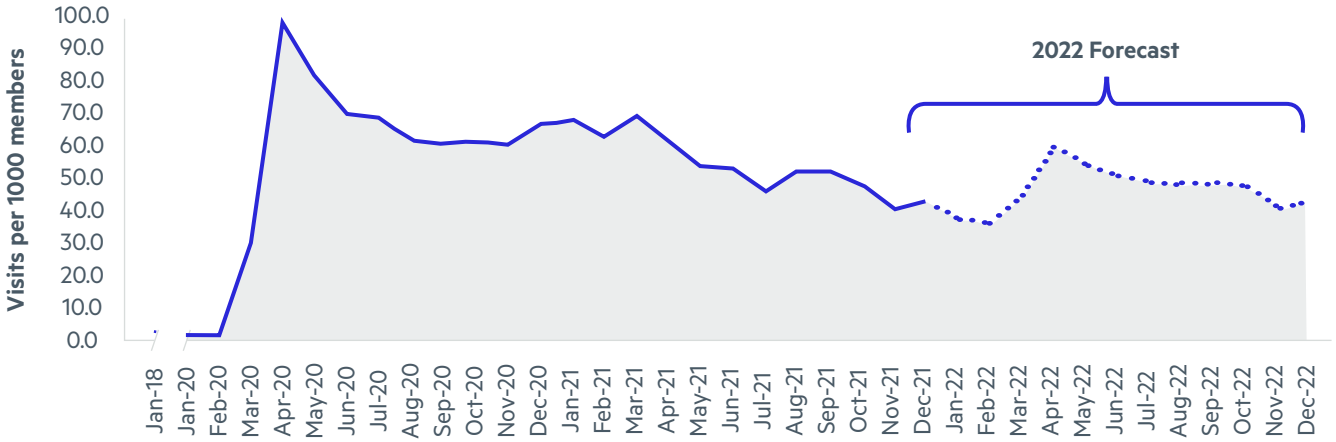
Telehealth utilization accelerates and shifts from tele-urgent care to virtual primary care and condition management.

Few aspects of healthcare delivery changed as much as a result of the pandemic than the use of telehealth services.[10, 11] Telehealth utilization increased more than 30X from 2019 to 2020. Importantly, the providers of telehealth services changed dramatically from tele-urgent care by specialized telehealth vendors to virtual care provided by healthcare professionals who had classically seen patients in the community.[12] The largest spikes in telemedicine utilization were observed in April, May, and June of 2020 and then settled into stable utilization patterns following the initial peak. Telehealth utilization in 2022 is forecast to drop 13.5% from 2021, though still achieving a 25X increase from 2019 levels.

Annual Telehealth Utilization
2018-2022



Monthly Telehealth Utilization
2018-2022

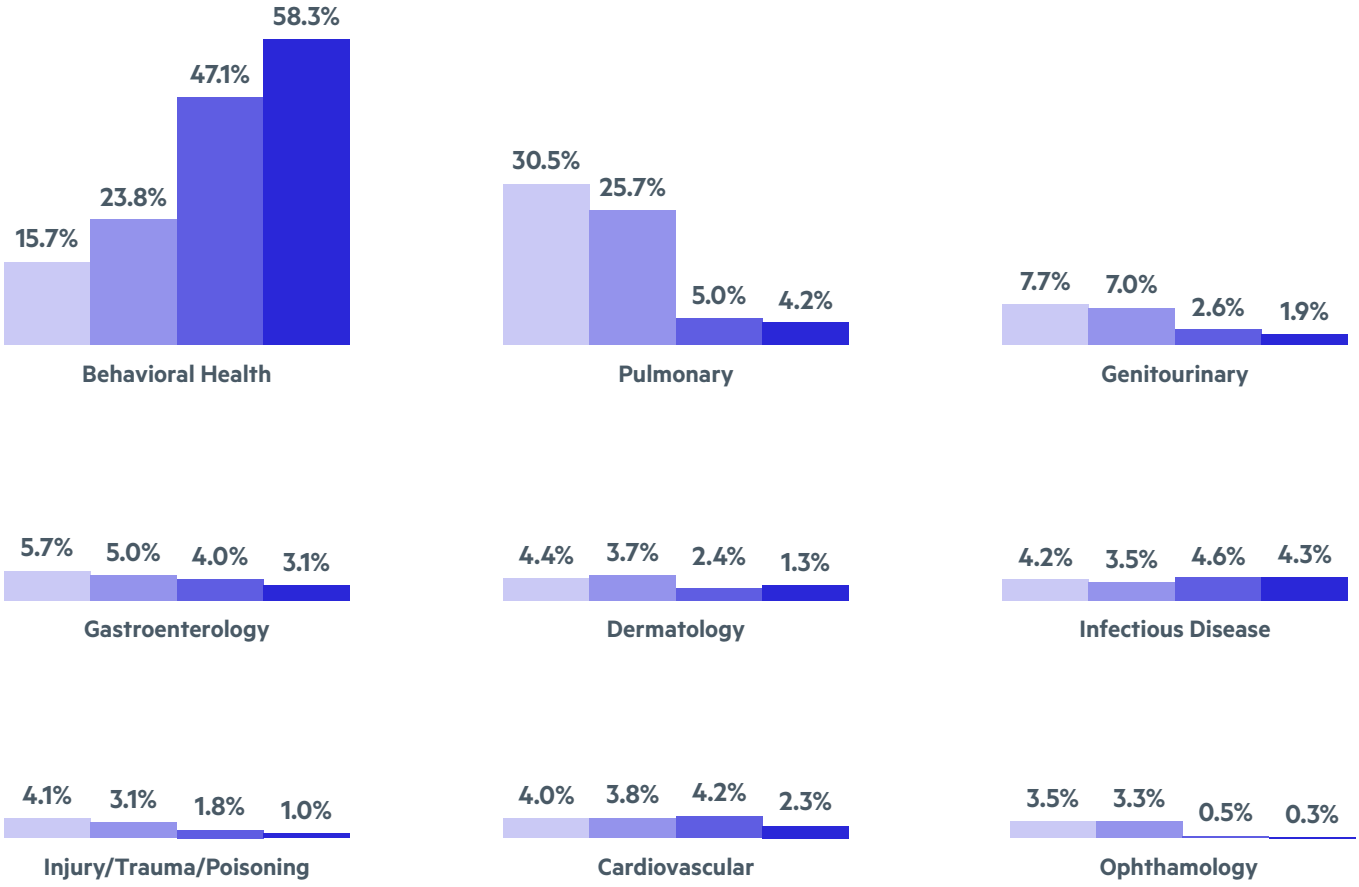


- Telemedicine utilization grew nearly 30X in 2020
- With utilization stabilizing to roughly 55 visits per 1000 members per month in 2021, telemedicine is expected to continue to be an important part of the care delivery landscape going forward

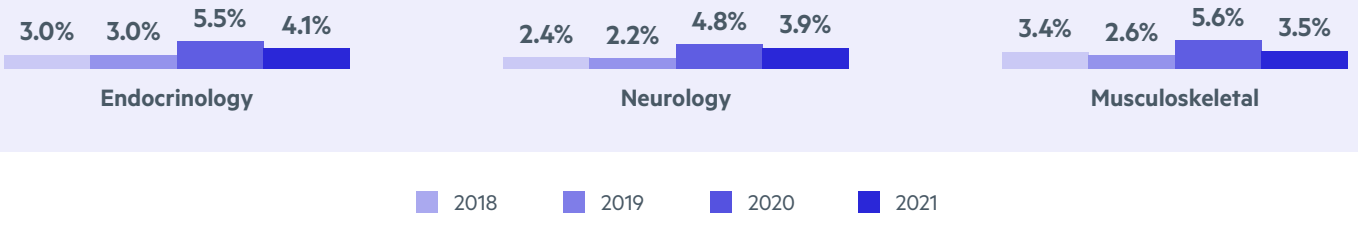
Further, the reasons why individuals sought virtual care shifted from urgent care needs to primary care and condition management.[13] Several new clinical categories addressing primary care and chronic conditions appeared for the first time as diagnostic reasons for seeking care through telemedicine.

Most importantly, we observed a dramatic increase in the use of telemedicine for mental and behavioral health needs during the pandemic, representing nearly 60% of all virtual visits in 2021. As telehealth lends itself more readily to talk therapy and visits that do not require physical interaction, it may indeed prove to be the dominant platform for behavioral health care delivery in the future.[14]

Top Telemedicine Care Categories by Year
2018-2021



New to Top Telemedicine Care Categories in 2020



2018 2019 2020 2021

- Categories of care for *endocrinology* (4.1% of visits in 2021), *neurology* (3.9% of visits in 2021), and *musculoskeletal* (3.5% of visits in 2021) moved into the top reasons for telemedicine visits in 2020
- Behavioral health represented 15.7% of the total telemedicine market in 2018 and grew to 58.3% of telemedicine market share in 2021

Telehealth uptake by low-income communities lags behind wealthier communities.

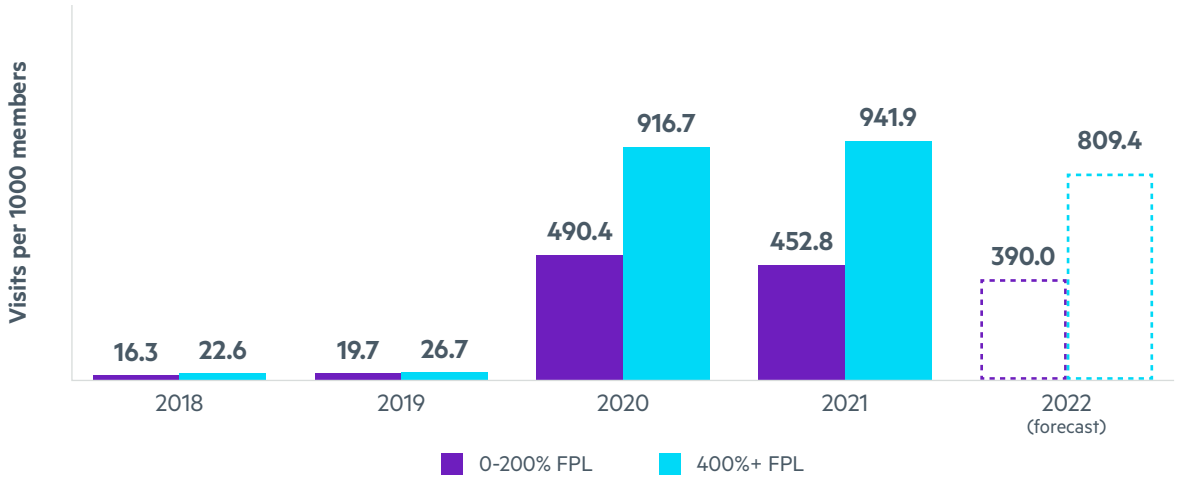
In early 2020, many employers reduced or eliminated co-pays for telemedicine services. What followed was a substantial growth in telehealth utilization among both low-income and wealthy communities; however, the increase in low-income areas was 25X, compared with 34X for wealthier areas.

Telemedicine utilization in low-income communities hovers at roughly half that of wealthy communities year-over-year. Several factors likely contribute to this finding including differences in infrastructure, internet stability, and technical know-how.[15] Members of low-income communities may also have concerns about unexpected costs that may come with a telehealth visit.

Nonetheless, based on the significant jump in utilization in 2020 and anticipated sustained utilization into 2022 for low-income communities, we remain optimistic that telemedicine can be a viable method to reduce inequities in access to healthcare.

In addition to addressing common barriers to in-person care that asymmetrically impact low-income communities (i.e., childcare, transportation, ability to take time off work),[16] employers should consider addressing the barriers to virtual care, as well. Specifically, employers focused on promoting greater equity in healthcare could continue to reduce or eliminate copays for both wellness visits and telehealth services.

Telehealth Utilization Comparing Low-Income vs Wealthier Communities
2018-2022

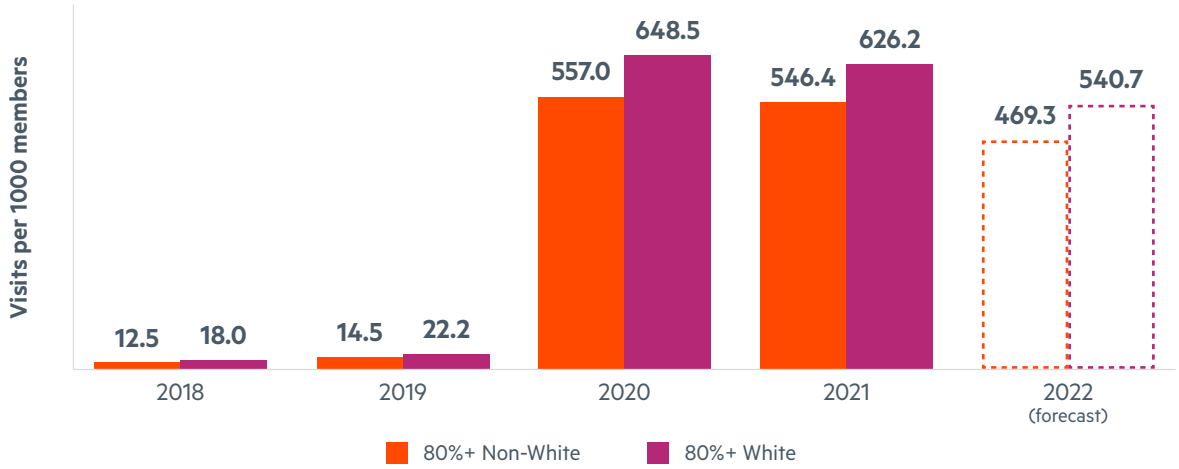


- Telemedicine utilization increased in low-income communities nearly 25X in 2020
- Differences in telemedicine utilization between low-income communities and wealthy communities are projected to continue in 2022

Telemedicine utilization in communities of color lagged historically compared to white communities but shows promise to catch up.

Disparities in access to care, both in-person and virtual, for communities of color[iv] have been observed in several publications.[17, 18, 19] Our analysis supports that telemedicine utilization in white communities[v] was 1.5X higher than communities of color in 2019. Although this disparity is projected to continue into 2022, the data provide some optimistic findings that communities of color are catching up in telemedicine utilization rates.

Telehealth Utilization Across Communities of Varying Racial Makeup
2018-2022

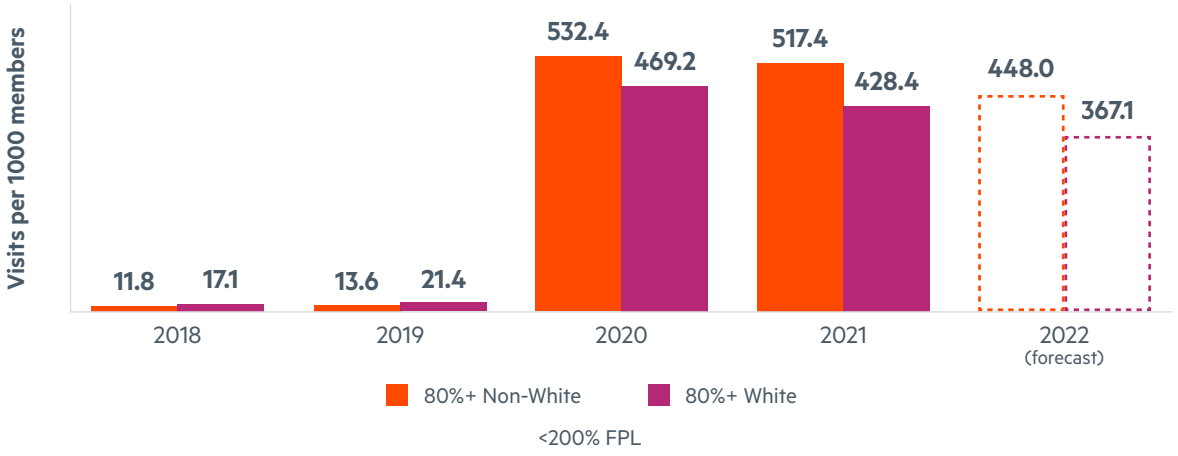


- In 2019, pre-pandemic telemedicine utilization in white communities was 1.5X that of communities of color
- In 2020, for communities of color, telemedicine utilization jumped 38X to 557 visits per 1000 members. During this same time, telemedicine utilization for white communities grew 29X to nearly 650 visits per 1000 members

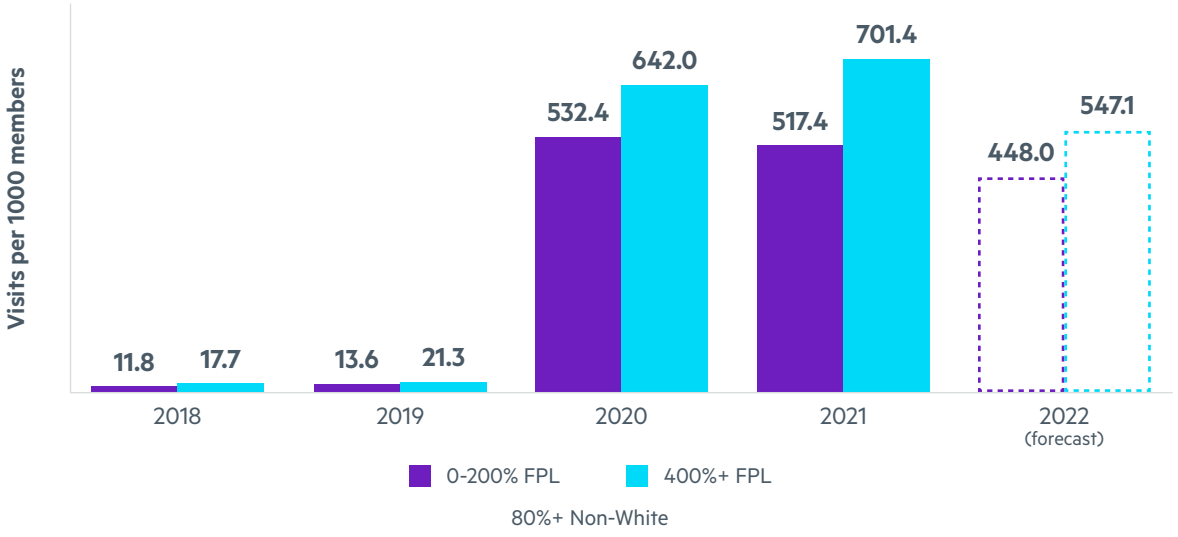
iv. **Communities of color:** Includes zip-codes where >80% of those living are identified as Non-White, as determined by US Census data
v. **White communities:** Includes zip-codes where >80% of those living are identified as White, as determined by US Census data

The increase in telemedicine adoption in low-income communities of color was bigger than in low-income white areas during the pandemic (39X vs 22X). It's possible that clinical co-morbidities and barriers to accessing in-person care are compounded for people in low-income communities of color, driving higher adoption of telemedicine.

Telemedicine Utilization Comparing Low-Income White Communities to Low-Income Communities of Color



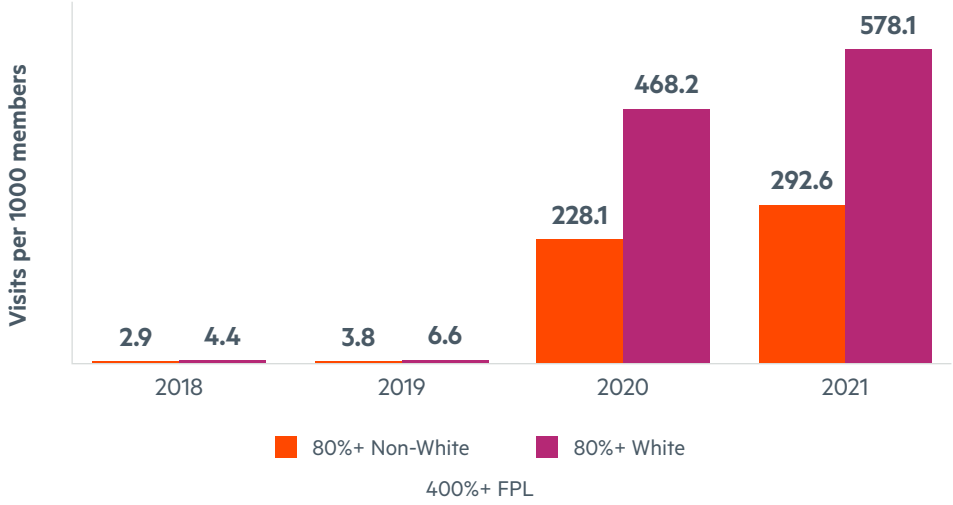
Telemedicine Utilization Comparing Low-Income Communities of Color to Wealthier Communities of Color



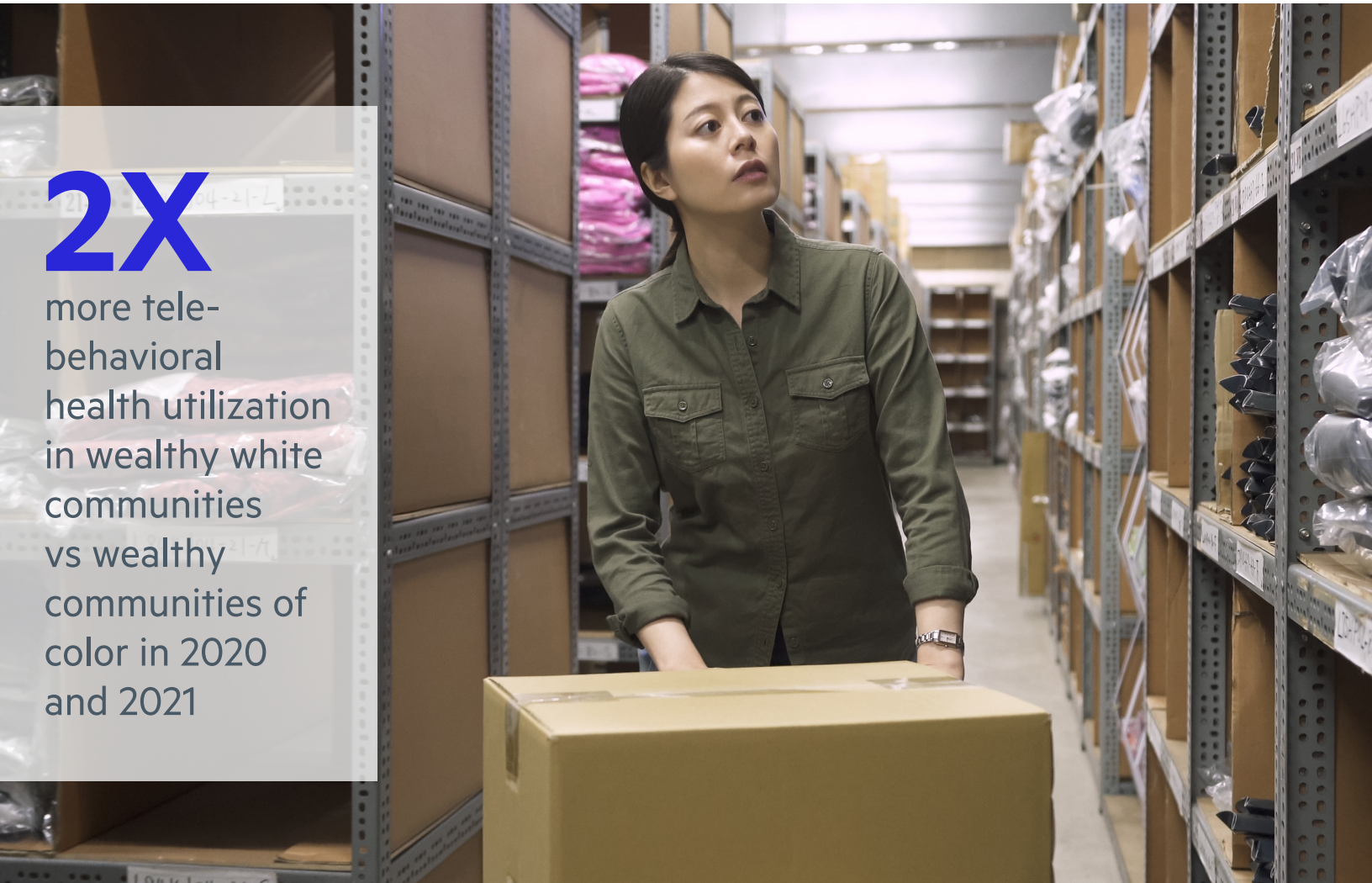
- Regardless of race or income, an uptick in telemedicine was observed in 2020, with some tapering in 2021
- Telemedicine utilization in wealthy communities of color is projected to out-pace utilization in lower income communities of color in 2022

Interestingly, a sub-analysis of tele-behavioral health utilization by income and race revealed that utilization was lower in wealthy communities of color compared to wealthy white communities, suggesting potential language or cultural barriers prevent greater use of virtual mental health services for communities of color regardless of income level.

Tele-Behavioral Health Utilization in Wealthy Communities by Racial Makeup
2018-2021



Wealthy white communities consumed ~2X more telemedicine for behavioral health in 2020 and 2021 than wealthy communities of color



2X

more tele-behavioral health utilization in wealthy white communities vs wealthy communities of color in 2020 and 2021

Preventive Care Spend

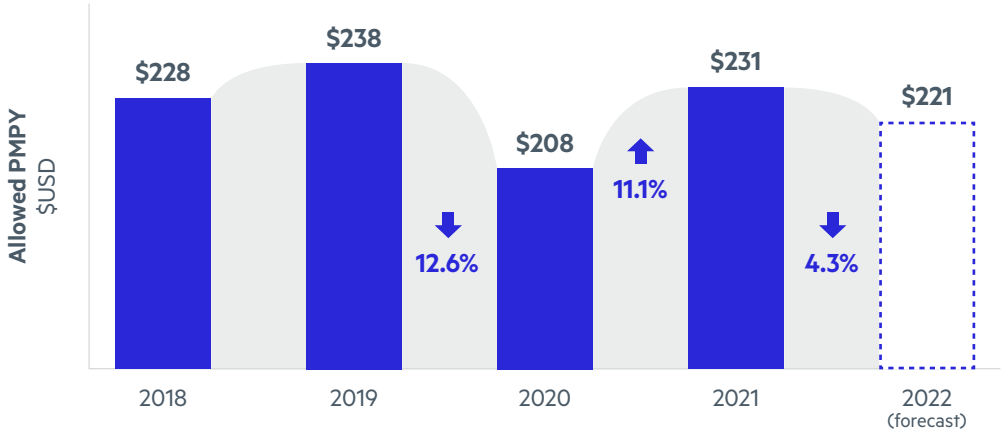
Reductions in preventive care spend during the pandemic are projected to rebound in 2022 but fail to reach pre-pandemic levels.

Healthcare providers and employers have been ringing the alarm regarding deferred preventive care driven by the COVID-19 pandemic.[20] Concerns of a *'secondary pandemic'* fueled by late diagnoses and exacerbated medical issues have risen to the forefront of discussions across the healthcare community, as study after study have shown that people postponed their routine healthcare screenings in the wake of COVID-19.[21, 22]

An analysis of representative services for primary care[vi] showed a 12.6% decline in preventive care spend from 2019 to 2020. All categories of preventive care (e.g., cancer and diabetes screenings, hypertension and other chronic disease management, immunizations) dropped, with the largest reductions observed in cervical and colorectal cancer screenings, shrinking 16.0% and 24.1%, respectively.

With 2022 projections indicating that most preventive care categories fail to resurge to pre-pandemic levels, proactive initiatives must be in place to close these gaps in care. Closing gaps in wellness visits is particularly critical, as the PCP visit is often the gateway to other preventive care services.

Preventive Care Medical Spend
2018-2022

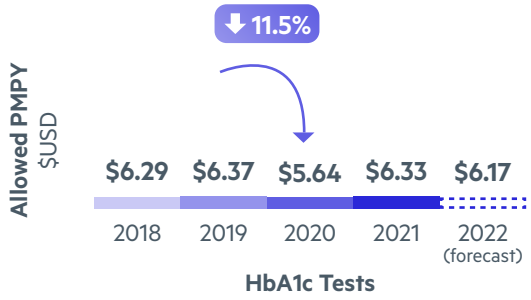


- From 2019 to 2020, spend on representative preventive care services dropped 12.6%
- Preventive care spend bounced back in 2021 by 11.1%, not yet fully recovering to pre-pandemic levels
- The forecast for 2022 suggests a 4.3% decline in preventive care spend, arriving at $PMPY preventive care spend below 2018 levels

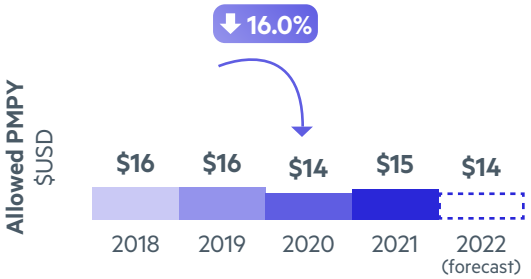
vi. **Representative services for primary care:** cervical cancer screenings, colorectal cancer screenings, HbA1c tests, immunizations, mammograms, dental screenings & wellness exams. See appendix for eligibility criteria across these populations.

Preventive Care Spend by Category*

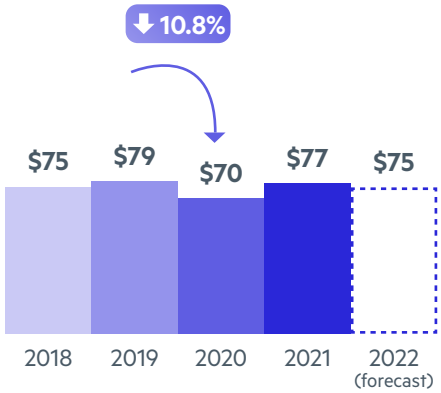
2018-2022



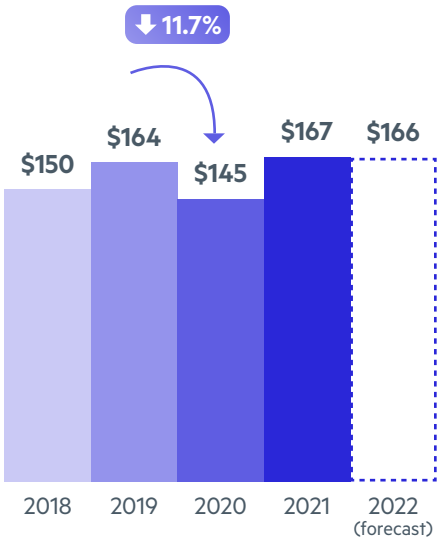
HbA1c Tests



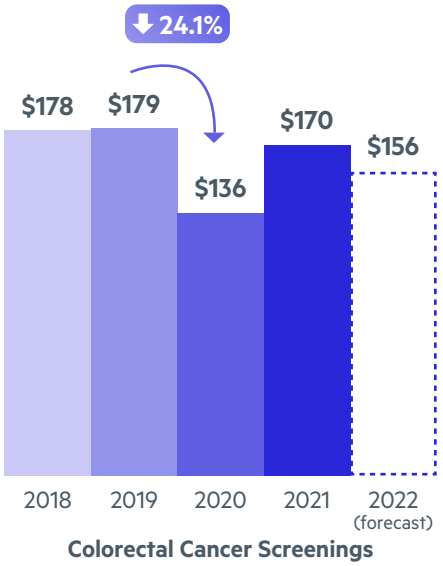
Cervical Cancer Screenings



Wellness Exams



Mammograms



Colorectal Cancer Screenings

- In 2020, a significant drop in preventive screenings was observed across all categories: cervical cancer screenings (16.0% reduction), colorectal cancer screenings (24.1% reduction), HbA1c tests (11.5% reduction), mammograms (11.7% reduction) and wellness exams (10.8% reduction)
- In 2021, some preventive screenings bounced back to meet or exceed pre-pandemic levels, namely mammograms & wellness exams
- Projections for 2022 indicate that colorectal and cervical cancer screenings continue to lag behind pre-pandemic levels

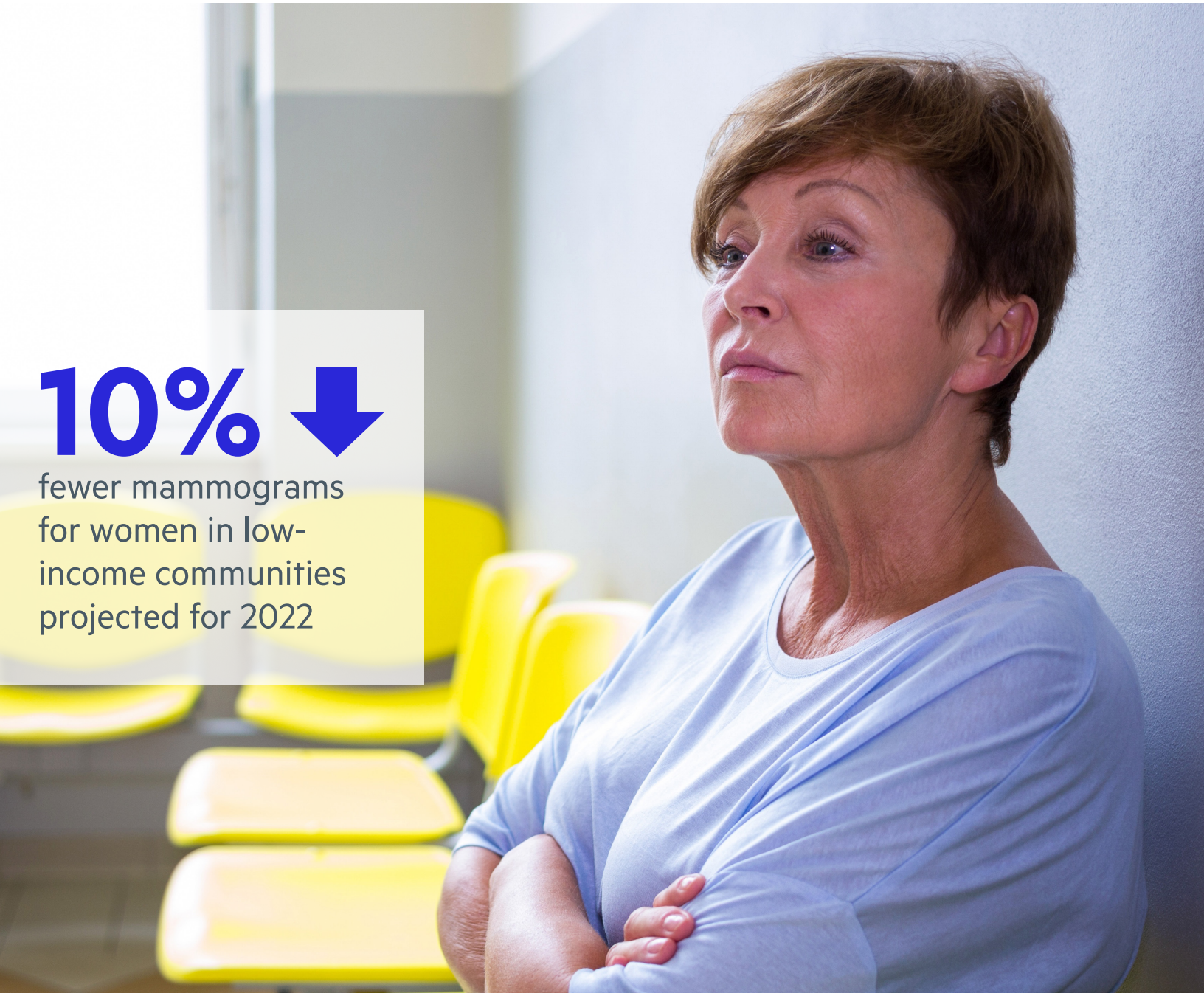
*Analysis based on eligibility criteria as found in the appendix.

Gaps in primary care utilization, specifically cancer screenings, are even more pronounced in low-income communities.

People in low-income communities forgo their care more frequently than those in wealthier areas.[6] This was true before the pandemic but was exacerbated in 2020, for cancer screenings in particular.

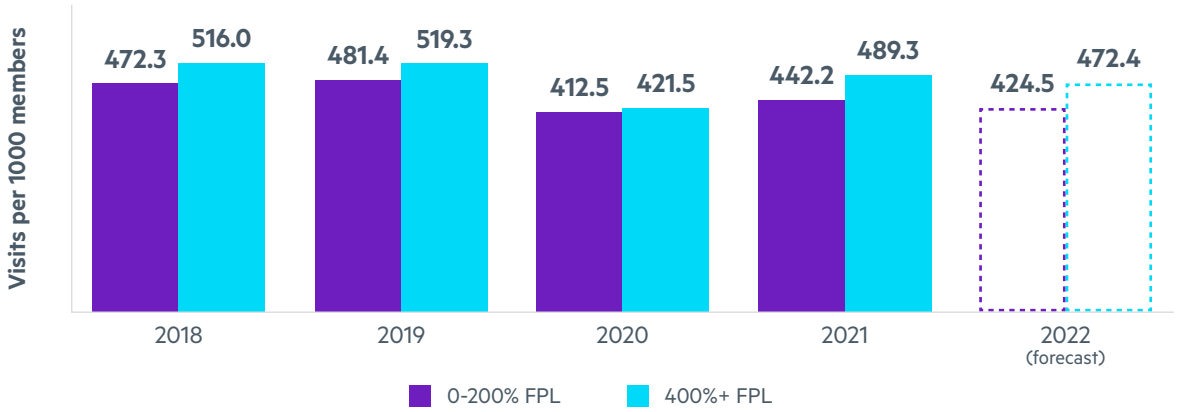
Frontline workers, who found themselves with limited ability to get time off work to receive preventive care, are more likely to live in low-income areas, perhaps creating some of the disparity.

In 2022, forecasts indicate that individuals in low-income communities will complete 10% fewer mammograms, 20% fewer cervical cancer screenings, and 24% fewer colorectal cancer screenings per 1000 members than individuals in wealthier communities. Given a generally higher disease burden and higher annual medical spend in low-income communities,[23] delayed preventive screenings for these populations is a concerning trend. Offering dedicated time off and incentives for employees who complete preventive care screenings could drive preventive care in low-income communities.



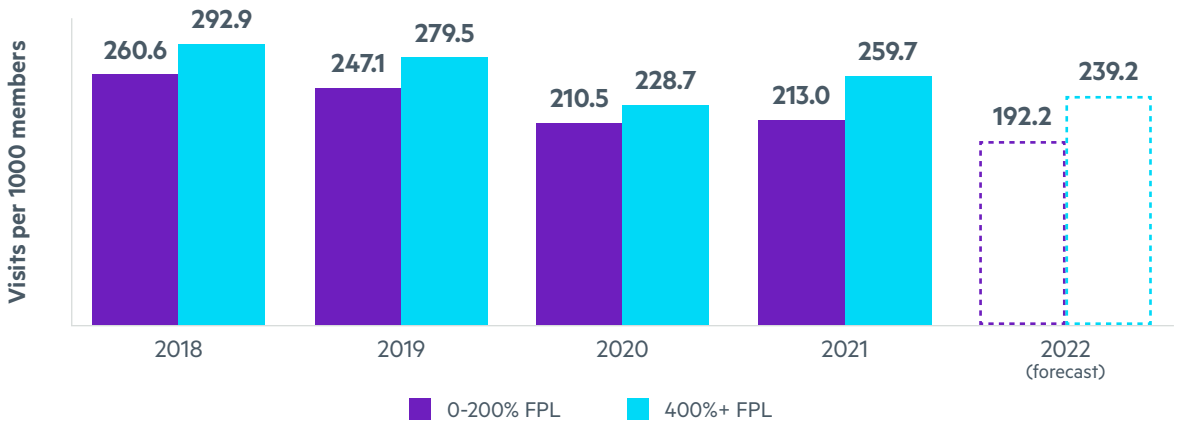
Mammograms by Low-Income vs Wealthier Communities

2018-2022



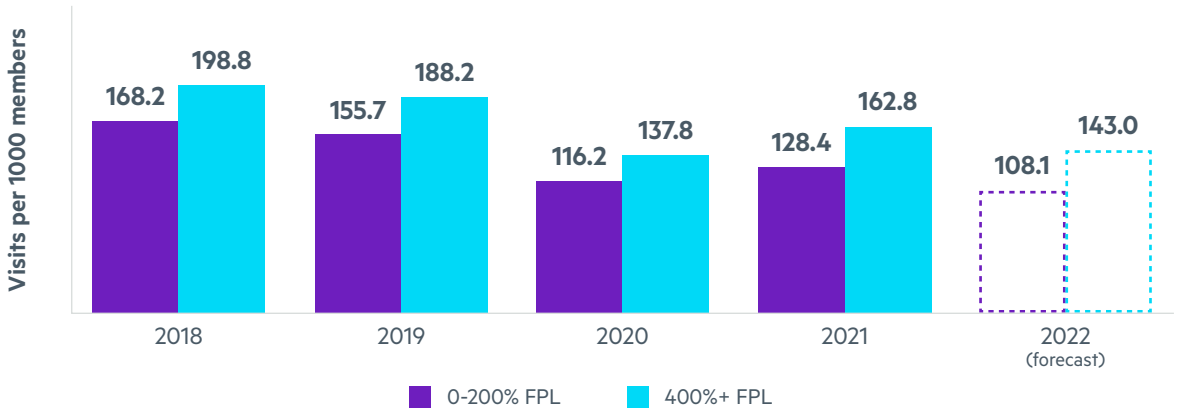
Cervical Cancer Screenings by Low-Income vs Wealthier Communities

2018-2022



Colorectal Cancer Screenings by Low-Income vs Wealthier Communities

2018-2022



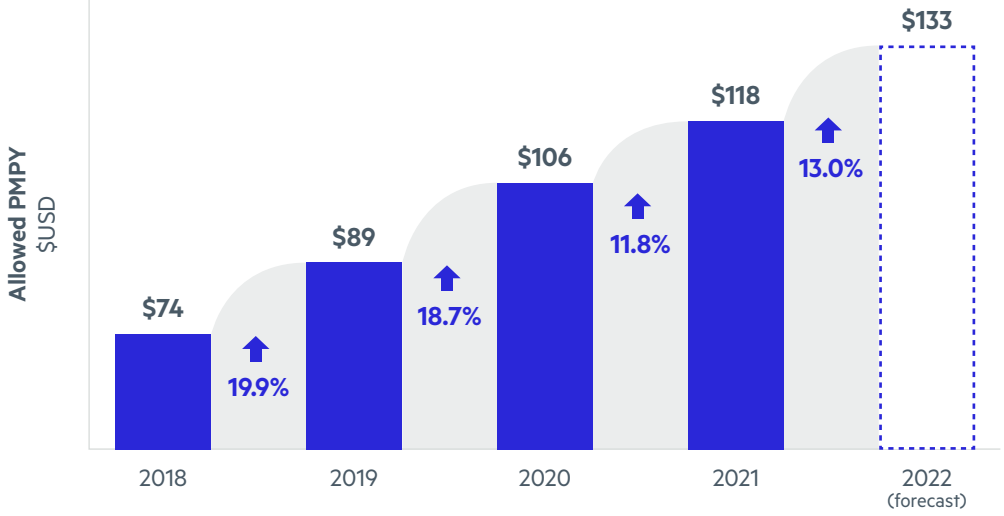
Behavioral Health

Significant growth in employee demand for behavioral health services is projected to continue.

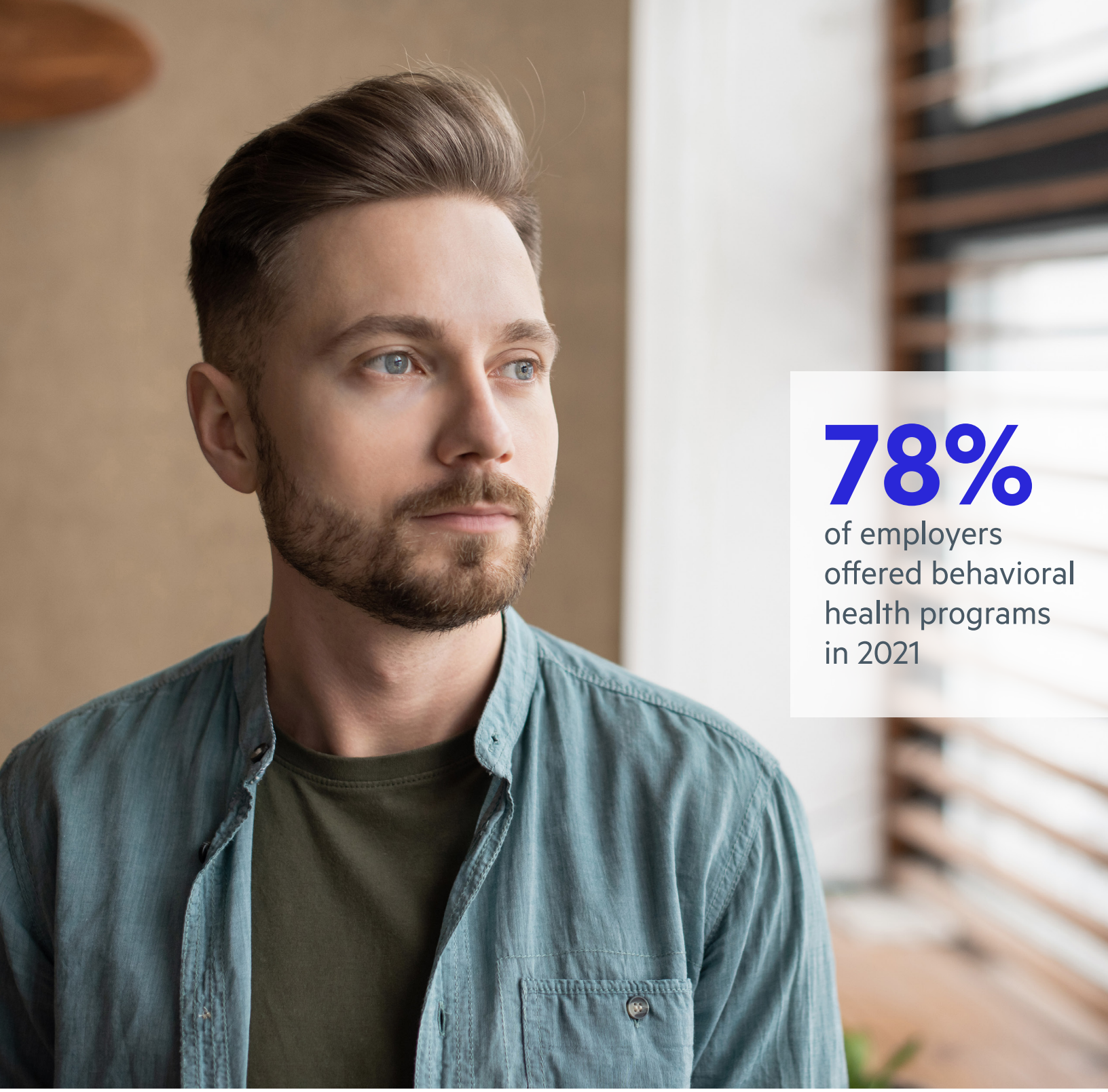
Before the COVID-19 pandemic began, supporting behavioral health was a growing priority for employers and health plans.[24] But the profound and lasting impacts of chronic stress, isolation, and economic uncertainty brought on by COVID-19 created even more urgency to identify and address mental health concerns.[25]

We observed a consistent year-over-year, double-digit increase in behavioral health-related medical spend in the commercially-insured population. Individuals also self-reported declining mental wellbeing, with 23% of the population reporting feeling down, depressed, or hopeless several days over a two-week span in 2021, a 21% growth from 2019. We project medical spend on behavioral health services will continue into 2022 at a growth rate of nearly 13%.

Behavioral Health Medical Spend
2018-2022



- From 2019 to 2020, spend on behavioral health services grew 18.7%, while total medical spend dropped 6.8%
- 2021 behavioral health spend also realized significant growth, achieving an additional 11.8% growth from 2020
- Castlight projects continued growth in behavioral health spend for 2022 at nearly 13%



78%
of employers offered behavioral health programs in 2021

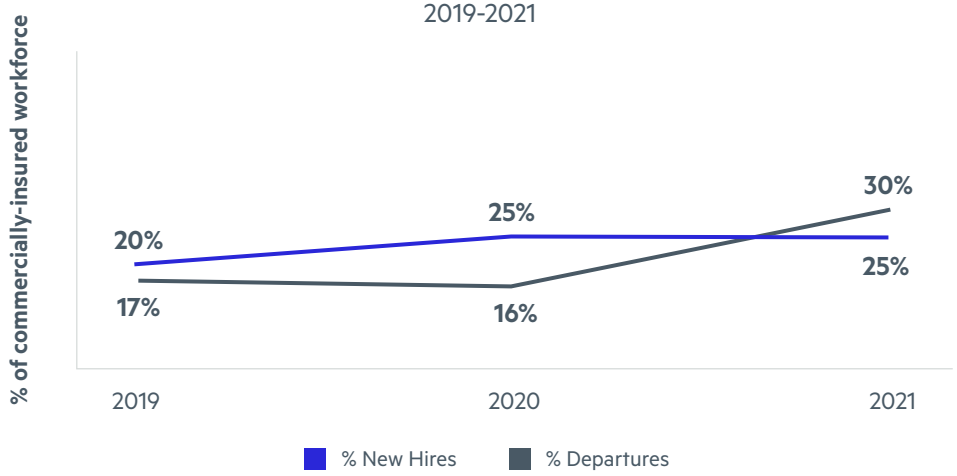
In response, employers have enhanced support for their workforce with a variety of behavioral health programs, including tools for resilience, substance use, behavioral health condition management and more. The percentage of employers offering behavioral health programs increased from roughly 54% in 2019 to nearly 76% in 2020, and 78% in 2021.

Engagement with behavioral health and resilience programs is positively influenced by incentives, with 4.5X more total population engagement when incentives are offered. To encourage engagement and improve mental health and wellbeing at scale, employers can apply incentives to behavioral health and resilience tools with confidence that they make an impact.

The sharp increase in demand and utilization of behavioral health services is observed in the context of an increasingly unstable workforce.[26] Castlight examined the patterns of workforce turnover and retention. Taking into account new hires and those who have left their place of employment, there is growing instability year-over-year. In 2019, 20% of the workforce had started a new job, compared to 25% in 2021. Of note in 2019, only 17% of the workforce had left their place of employment, compared to 30% in 2021, suggesting a contraction in the size of the workforce as a whole, putting more pressure on the employers to find and retain talent.

The increased stress created by the uncertainties and challenges of the pandemic appears to have spilled over into employee disengagement and job turnover. In 2019 and 2020 our analysis shows that the new hire rate comfortably matches the departure rate. However, 2021 saw an inverted relationship emerge between the new hire rate and departure rate indicating that employees are feeling the burden of a continuous labor shortage. And though the COVID-19 pandemic is seemingly receding, the rise of inflation in 2021 and 2022 places further financial stressors on households, potentially driving ever higher demand for behavioral health services. Benefits leaders may be well-served to continue to advocate for comprehensive behavioral health support and organizational strategies to address the added stressors that the prolonged pandemic have on the workforce.

Workforce Stability % of Commercially-Insured Workforce Represented by New Hires and Departures
2019-2021



30%
of the commercially-insured workforce departed in 2021

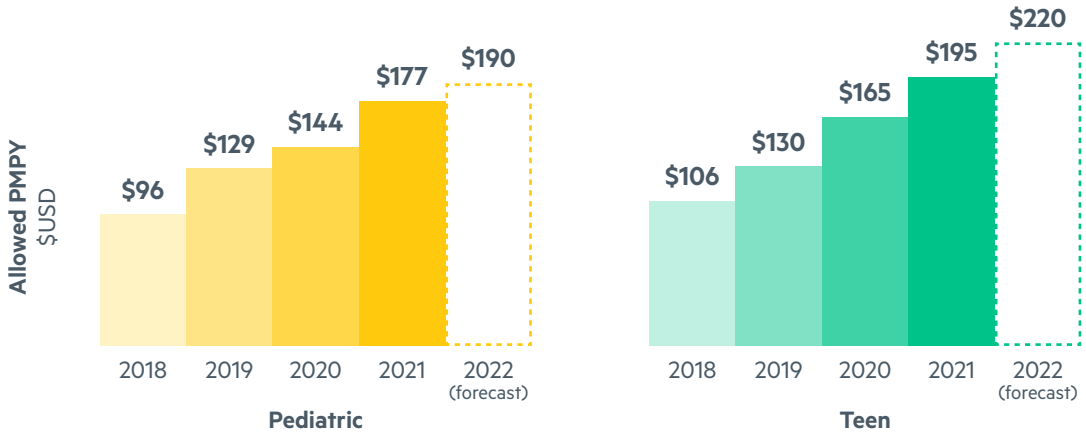
Striking growth in behavioral health medical spend is projected to continue for both pediatrics and teens.

Children and teens have experienced major disruptions during the COVID-19 pandemic including school closures, social isolation, virtual learning, loss of loved ones, and a series of new social norms resulting in poor mental health outcomes for some.[27]

Annual growth rates in medical spend on behavioral health services for pediatric and teen populations is alarming. Growth in medical spend for teens was 26.9% in 2020 and 17.9% in 2021. Just as concerning is pediatric behavioral health medical spend, doubling from a growth rate of 11.5% in 2020 to 22.7% in 2021.

With changing public health guidelines and school policies, and the ongoing stressors of an ever-evolving pandemic, growth in behavioral health medical spend for pediatrics and teens is projected to continue in 2022, at 7.3% and 12.6%, respectively.

Behavioral Health Spend Across Pediatric and Teen Populations
2018-2022



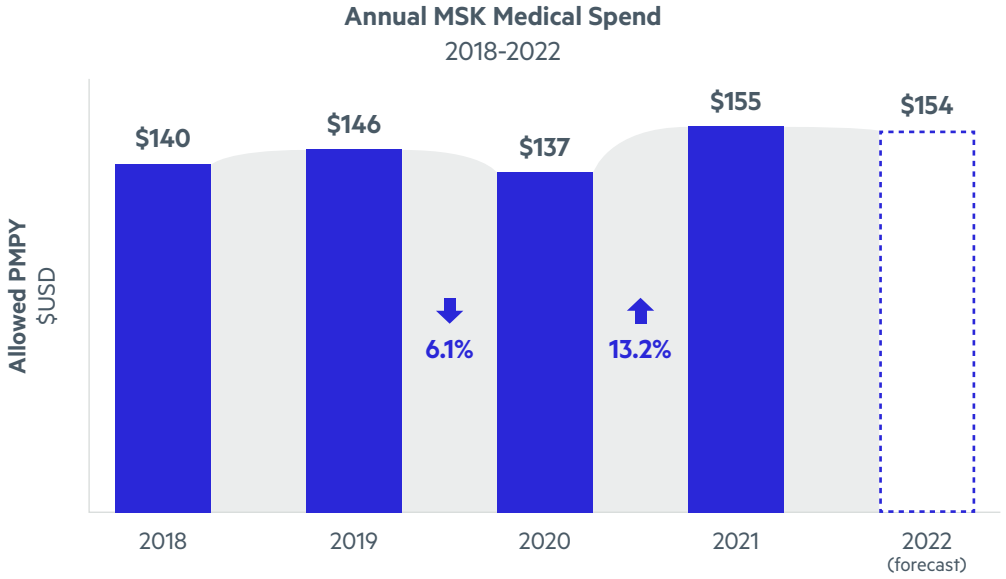
- Growth in pediatric and teen behavioral health spend has grown year-over-year since 2018 and is projected to continue in 2022
- Growth in teen behavioral health spend hit 26.9% in 2020 and is projected to grow an additional 12.6% in 2022

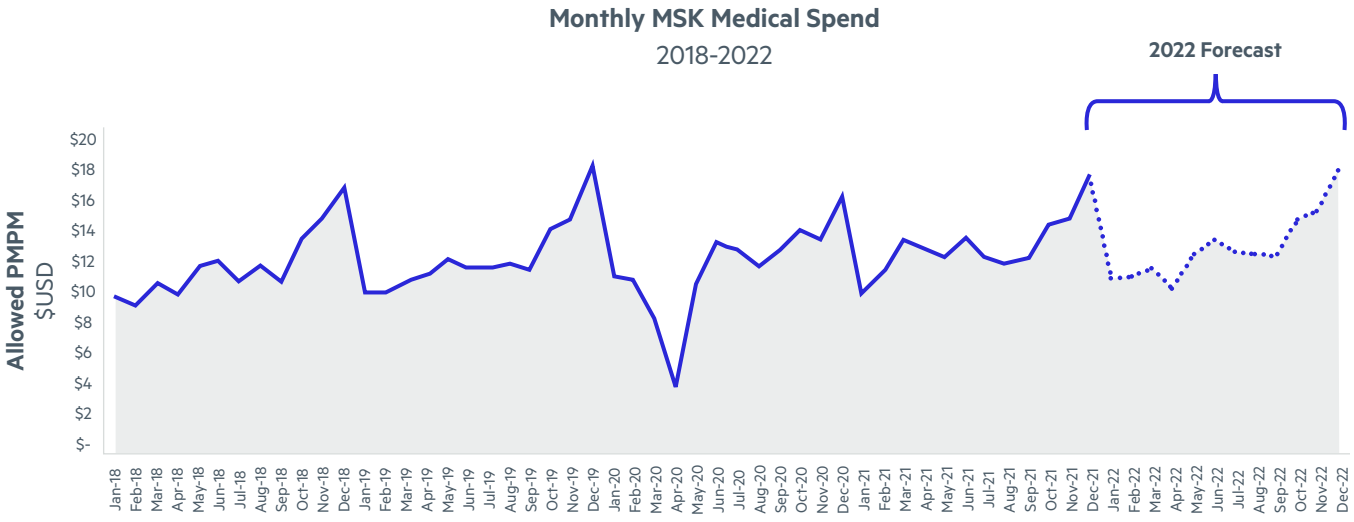
Elective Care - Musculoskeletal Procedures

Demand for MSK services was exacerbated by the pandemic and is expected to grow in 2022.

Surgical procedures for MSK conditions remain an ongoing area of concern for employers.[28] Organizations with manual laborers continue to contend with complications caused by heavy lifting and strenuous physical work. Meanwhile, companies that traditionally had high volumes of office workers need to address poor ergonomics among work-from-home workers.

The pandemic drove a big dip in elective MSK procedure spend with a noticeable drop-off in March through May of 2020. Overall, we observed a 6.1% drop in spend on representative elective MSK procedures from 2019 to 2020. We forecast MSK spend in 2022 will be comparable to that of 2021.



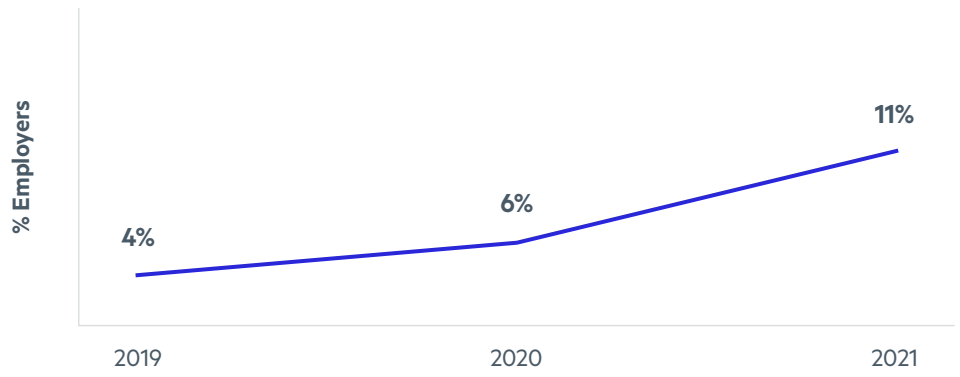


- From 2019 to 2020, spend on MSK procedures dropped 6.1%
- The forecast for 2022 elective MSK procedures indicates spend comparable to 2021
- Seasonal winter spikes in year-end elective procedure spend are common and observed

Despite MSK conditions consistently accounting for over 15% of employer medical spend, employer adoption of MSK programs has not been as robust as it has been for other clinical areas such as behavioral health. Only 11% of employers in our analysis offered MSK programs for their employees compared to >75% of employers offering behavioral health programs, in 2021. Employers in some industries were more likely to invest in digital MSK programs, with 20% of employers from manufacturing; food and beverage; and oil, energy and utilities offering these programs to their workforce. For those employers who offered financial incentives and rewards alongside the MSK program, engagement increased more than 13X compared to employers who offered similar MSK programs without incentives.

Given the significant costs associated with care for MSK and chronic pain issues and the proliferation of available digital MSK services, Castlight anticipates that more employers will augment in-person care with digital programs.

% of Employers Offering MSK Programs
2019-2021



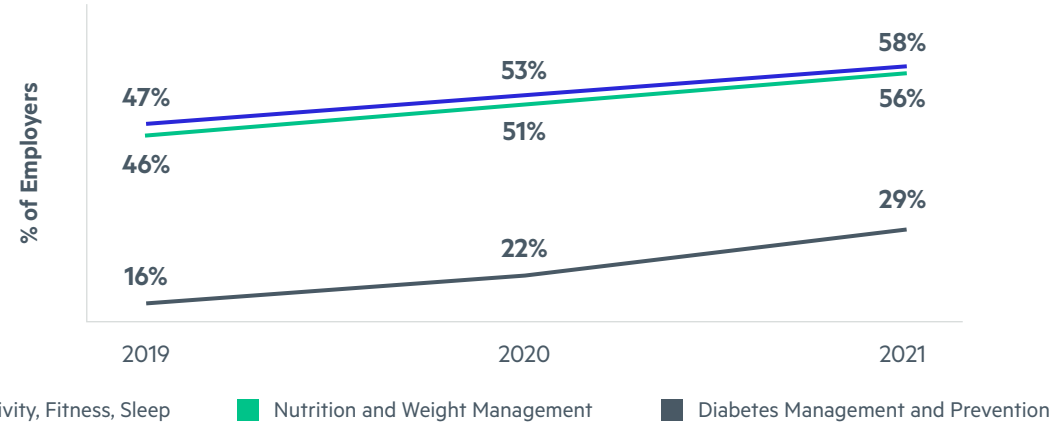
Program Engagement

Investments in health and wellbeing programs have grown.

Employers have steadily increased their investment in digital health programs.[29] In 2021, the average employer offered more than 12 digital programs to their workforce.

To bridge the gap in access to brick-and-mortar healthcare services, employers have leaned into digital offerings more significantly than ever before, investing heavily in activity, fitness and sleep programs, nutrition and weight management tools, and digital diabetes management and prevention programs.

% of Employers Offering Digital Health Programs
2019-2021

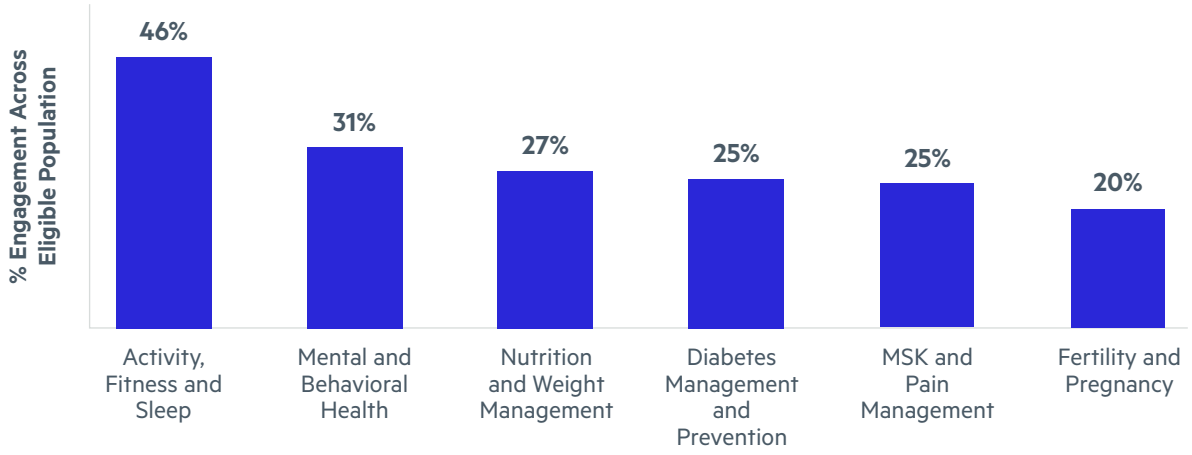


- Total number of programs offered by employers grew in both 2020 and 2021, by 20.6% and 4.3%, respectively
- In 2021, on average employers offered more than 12 programs, with some employers offering more than 25 programs

8X
increase in program utilization when incentives are offered

Offering incentives drives an increase in engagement across virtually every type of health and wellness program. With incentives applied for eligible populations, engagement levels with programs were on average 8 times higher when compared to engagement levels without incentives. Employers can use targeted incentives to drive utilization of key programs that meet the unique health risks and needs of their populations.

Program Engagement Across Top Categories for Digital Health When Incentives Are Offered
2021



Conclusion

Workforce health and wellbeing are core to the overall strategy of forward-thinking organizations. We hope the 2022 Castlight Workforce Health Index and accompanying 2022 Commercial Healthcare Spend Data deliver insights about the healthcare utilization and associated medical spend anticipated for the commercial workforce coming out of the pandemic.

Appendix

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Methodology

Analysis Timeframe: All analyses include years 2018-2021. In cases where data was not available for prior years, analyses was conducted for years 2019-2021. Member medical claims are analyzed from January 2018 through September 2021. The forecasting period begins from October 2021 and runs through December 2022.

Forecasting Approach: Exponential smoothing models are used for all the forecasts. Models are built with medical claims data. Prescription claims are not included in this analysis.

Medical Inflation: Forecasts capture medical inflation, if any, as this will be included as a part of medical cost trend. Castlight did not assume a fixed medical inflation (i.e. 6-7%) in our calculations as the ongoing pandemic has altered medical spend trends in 2020 and 2021.

Clinical Risk Calculations: Clinical risk is calculated from member claims data and is based on the DxCG concurrent model, which evaluates the member risk of incurring costs related to their diagnosis. A risk score = 1 indicates that the user is expected to have exactly an average health spend.

Castlight Health Assessment Results: The Castlight Health Risk Assessment is set of standardized questions to personalize the Castlight member experience and is available to all individuals with Castlight as a benefit. Results are synthesized from over 400,000 self-reported answers.

Eligibility Criteria for Preventive Care Analyses: Eligibility criteria were based upon guidance from the Centers of Disease Control.

1. **Wellness exam:** All members
2. **Mammogram:** Women ages 40-74
3. **Cervical cancer test:** Women ages 21-65
4. **Colorectal cancer test:** All members ages 50-75
5. **HbA1c:** All members ages 45+

Workforce Stability Index: New hires and individuals who left their place of employment were identified through an analysis of employer-sponsored medical benefits. New hires are those who had at least a one-month gap in medical coverage prior to the start date in that medical coverage year. Departures are those who had at least a one-month gap in medical coverage after the end date in that medical coverage year. Individuals identified as both a new hire and one who departed their place of employment during the timeframe of the analysis are counted as such to determine the full impact of their movement to an organization's workforce stability.

Elective Care – Musculoskeletal Procedures Analysis: Includes MSK surgeries. Analysis examines case rate per 1000 per year.

Program Engagement Analysis: Eligibility for this analysis was determined by eligibility criteria provided by the employer.

Due to rounding, numbers presented throughout this report may not add up precisely to the totals.

Definitions

Healthcare spending: Per member per year ($PMPY) allowed medical spend which reflects the paid amount by employer and employee. Prescription spend not included.

Member: An individual covered by employer medical benefits.

Low-income communities: Includes zip-codes where the median household income is less than or equal to 200% of the Federal Poverty Level. The Federal Poverty Level (FPL) is a measure of income issued every year by the Department of Health & Human Services.

Wealthy communities: Includes zip-codes where the median household income is greater than 400% of the Federal Poverty Level. The Federal Poverty Level (FPL) is a measure of income issued every year by the Department of Health & Human Services.

Communities of color: Includes zip-codes where >80% of those living are identified as Non-White, as determined by US Census data.

White communities: Includes zip-codes where >80% of those living are identified as White, as determined by US Census data.

Pediatric: All members ages 0-12.

Teens: All members ages 13-19.

Castlight

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