CONNECTICUT
Health Strategy

Healthcare Benchmark Initiative

Proposed 2026-2030 Benchmarks and Recommendations of the Technical Team

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Commissioner

Pursuant to Conn. Gen. Statute §19a-754g

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Executive Summary

Pursuant to Conn. General Statute §19a-754g, the Connecticut Office of Health Strategy (OHS) must develop new annual cost growth benchmark and primary care spending target values for the years 2026 – 2030 by July 1, 2025. To inform this process OHS convened the Healthcare Benchmark Initiative (HCBI) Technical Team, comprised of local, regional and national health policy experts. Over a series of seven public meetings, the HCBI Technical Team reviewed a number of proposed methodologies and strategies for developing the next set of benchmarks. After that review and discussion, they proposed benchmark values and recommended adoption of these benchmarks to the OHS commissioner.

According to statute, in developing the Cost Growth and Primary Care benchmarks, the OHS Commissioner shall:

> "… consider (i) any historical and forecasted changes in median income for individuals in the state and the growth rate of potential gross state product, (ii) the rate of inflation, and (iii) the most recent report prepared by the executive director pursuant to subsection (b) of section 19a-754h."

After consideration of the statutorily required elements and the recommendations of the Technical Team, OHS proposes the following recommended values for public comment:

Table 1 -Recommended healthcare cost growth benchmarks 2026 -2030

Year	Technical Team Recommended Benchmark	OHS Proposed Benchmark
2026	2.7%	**2.8%**
2027	2.7%	**2.8%**
2028	2.5%	**2.8%**
2029	2.5%	**2.8%**
2030	2.2%	**2.8%**

Table 2 - Recommended primary care spending targets 2026-2030

Year	Technical Team Recommended Benchmark	OHS Proposed Benchmark
2026	10%	**10%**
2027	10%	**10%**
2028	10%	**10%**
2029	10%	**10%**
2030	10%	**10%**

OHS will accept public comment, and conduct both a public hearing and virtual listening session on these proposed benchmarks before the final recommendations are issued on July 1, 2025.

Introduction

Governor Lamont signed Executive Order #5 in January 2020, charging the Office of Health Strategy (OHS) with establishing a statewide healthcare cost growth benchmark. During the 2022 legislative session, Public Act 22-118 §§ 217-223 codified Executive Order No. 5's provision into law, directing OHS to adopt annual healthcare cost growth benchmarks and primary care spending targets in five-year increments.

The Healthcare Benchmark Initiative plays a key role in promoting improved affordability by identifying key drivers of healthcare spending and developing policies to slow the rate at which healthcare spending is growing. The quality and primary care elements of the Initiative promote high-quality healthcare and provide support to bolster and sustain Connecticut's primary care infrastructure. OHS publishes reports and data dashboards that improve transparency regarding health care spending and quality performance in Connecticut to support these activities and to better inform policy makers and stakeholders. A key part of the Healthcare Benchmark Initiative is the engagement of OHS advisory bodies to inform policies and operations, including advising on:

- setting and implementing healthcare cost growth benchmarks, quality benchmarks and primary care targets;
- performing data analysis to understand factors that are contributing to high and rising healthcare costs;
- using data to identify policy opportunities to make healthcare more affordable for residents, businesses, and state purchasers.

In the fall of 2024 OHS convened the HCBI Technical Team, a group of local and national experts to advise the agency on the development of 2026-2030 annual healthcare cost growth benchmarks and primary care spending targets. The Technical Team, comprised of individuals with expertise in healthcare economics, health policy, health insurance, healthcare purchasing and the impact of healthcare costs on consumers, was asked to recommend the following to OHS:

- annual healthcare cost growth benchmark values for 2026-2030;
- annual primary care spending targets for 2026-2030;
- considerations for OHS's annual inflation review methodology;

- modifications to the *Unintended Adverse Consequences Measurement Plan*, and
- parameters for defining a "significant contribution" to healthcare cost growth;
- any changes to how spending is reported for payers and Advanced Networks.

OHS charged the Technical Team with centering health equity in its recommendations. OHS also requested that the Technical Team advise on other technical components of the Healthcare Benchmark Initiative, including cost growth benchmark performance reporting and analytic methods.

A list of Technical Team members is provided in Appendix A. The Technical Team held seven two-hour meetings between November 2024 and March 2025. All meetings were open to the public and included an opportunity for public comment. Meeting materials are available on the OHS website.

The process and recommendations of the Technical Team are summarized in this report.

Technical Team Recommendations

This section contains the Technical Team recommendations to OHS, OHS's proposed benchmark values, and discusses the rationales for both.

A. 2026-2030 Healthcare Cost Growth Benchmark

At the outset of its work, the Technical Team affirmed the following criteria to inform its recommendation of a healthcare cost growth benchmark. The benchmark strategy should:

1. provide a stable and predictable target;
2. rely on independent, objective sources with transparent calculations; and
3. produce a benchmark value such that spending growth will not exceed change in resident ability to pay.

In formulating their recommendations, the Technical Team reviewed historical state healthcare spending growth, Connecticut benchmark performance, and a variety of economic indicators including historical and forecasted changes in median income for individuals in the state, the growth rate of potential gross state product, and the rate of inflation. The team was also provided with a summary of the most recent HCBI report and the approaches taken by the seven other cost growth benchmark states.[1] The Technical Team recommended OHS use **median household income** as the indicator on which to base the healthcare cost growth benchmark value based on that review. The Technical Team asserted that a reasonable rate of growth in healthcare spending is one that is in line with the income growth of residents – that is to say, the share of residents' income going to healthcare should not grow faster than their overall income.

> *"If OHS is looking at this from the perspective of a family and individual consumer, the question might be: 'Would they feel as though the benchmark is responsive to their own economic pressures?'"*
>
> *- Technical Team member*

The Technical Team observed that historically healthcare spending has grown significantly in excess of income growth for individuals with private (i.e., commercial) insurance. Pegging the benchmark to the median, rather than the mean, household income minimizes the impact of outlier earners, particularly high earners in the state, and includes income beyond wages, representing a fuller picture of overall resident finances. The Technical Team also recommended that OHS **use a long-term *forecasted* value** of median household income for the healthcare cost growth benchmark, as projections smooth out volatility in historical trends and provide a more predictable and stable target towards which to focus policy initiatives.

The recommendation to use 2024-2034 forecasted median household income as the basis for the benchmark yields a value of 2.7%.[2]

[1] California, Delaware, Massachusetts, New Jersey, Oregon, Rhode Island, Washington

[2] This represents the average annual change in forecasted median household income in Connecticut for the period 2023-2034. The data source is Connecticut Office of Policy and Management using S&P Global Forecast.

> *"Healthcare costs are already too high a proportion of family income and just slowing the rate of growth to bring it in line with income will not be enough."*
>
> *- Technical Team member*

The Technical Team discussed that healthcare costs are currently unaffordable for many residents with commercial coverage and will continue to be so even if payers and providers constrain future spending to an affordable benchmark rate.[3] **For this reason, the Technical Team recommended a two-step approach to setting benchmark values that gradually reduces the rate of growth below median household income growth:**

Step 1: For calendar years 2026 and 2027, set the benchmark at the value equal to forecasted average annual growth in median household income. This establishes that a reasonable rate of growth is one that does not exceed the income growth of residents.

Step 2: Apply a downward adjustment to the benchmark in calendar years 2028, 2029, and 2030 to account for the excess costs that are already built into the system. The resulting recommended values are shown in **Table 3**.

Table 3: Technical Team Recommended healthcare cost growth benchmarks, 2026-2030

Year	Benchmark
2026	2.7%
2027	2.7%
2028	2.5%
2029	2.5%
2030	2.2%

[3] Some members of the Technical Team suggested that OHS analyze variation in baseline costs among entities in addition to cost growth.

The Technical Team recognized that the recommendation was ambitious but believed it attainable and necessary for providing much-needed relief from persistent high healthcare costs for residents with commercial market coverage.

> *"Health systems are taking an unfair share of consumer and employer dollars. They need to re-engineer to find efficiencies in the system and reduce costs."*
>
> *- Technical Team member*

In addition to the healthcare cost growth benchmark, Technical Team members discussed aspects of the current methodology OHS employs to calculate and report spending performance of payers and provider entities. The Technical Team recommendations on those topics are summarized below.

1. **Advanced Network reporting**: The Technical Team did not recommend any changes to the current reporting practice for large provider organizations (Advanced Networks).[4] OHS currently reports annual change in per capita spending for Advanced Networks by market.
2. **Risk adjustment**: The Technical Team did not recommend any changes to the current practice of adjusting performance for changes in age and sex distribution year over year.
3. **Truncation**: The Technical Team recommended that OHS continue to truncate spending at defined levels, with some members expressing strong support for OHS's current effort to revisit the current levels to determine if they should be increased.
4. **Confidence intervals**: The Technical Team did not recommend any changes to the current practice of applying confidence intervals to assess insurer and provider entity performance relative to the benchmark.

Technical Team members also asserted that that the state should develop enforcement strategies to ensure compliance with the cost growth benchmarks as a critical lever to spur systems to become more efficient and ultimately slow the trajectory of spending growth.

[4] OHS defines Advanced Networks as organized groups of clinicians that come together for the purpose of contracting with payers.

B. 2026-2030 Primary Care Spending Target

The Technical Team reviewed historical primary care spending and growth, Connecticut primary care spending target performance, and the approaches taken by other states with primary care spending targets. Based on that review the Technical Team recommended that OHS maintain the primary care spending target at 10% of total spending for 2026-2030.

> *"Employers are being targeted because of what is perceived to be inadequate payments by public payers…commercial price increases by hospitals have been exorbitant and the burden has been borne by residents. There is no fundamental reason for the increases to continue."*
>
> *"Strategies to reduce excess costs should be specific to each health system, but all should be charged with avoiding waste and unproductive expenses."*
>
> *- Technical Team members*

Table 4 Recommended primary care spending targets, 2026-2030

Year	Benchmark
2026	10%
2027	10%
2028	10%
2029	10%
2030	10%

After reviewing additional information about healthcare cost spending drivers, the Technical Team members observed that Connecticut's primary care spending target has not resulted in a re-allocation of spending away from specialty, hospital and drug spending to primary care. In fact, the spending on primary care as a percentage of total spending decreased from 2022 to 2023, the most recent years for which data is available.

The Team observed that progress to meet the target is lacking, and the state is highly unlikely to meet the 2025 goal set by Governor Lamont in 2020 and subsequently codified in law. In addition, the Technical Team observed that a significant amount of spending on services that could be delivered in primary care settings is instead going to much more expensive care in urgent and emergency department settings.

> *"The measurement of primary care spending has deviated from the policy objective, which is to ensure people have an established relationship with a primary care provider who coordinates care."*
>
> *- Technical Team member*

The Technical Team recommended that OHS pursue additional, complementary strategies to strengthen traditional primary care, noting that a primary care target alone is unlikely to achieve that desired outcome. The Technical Team encouraged OHS to establish additional primary care outcome goals, for example around access to care, and identify measures to track performance and progress.

The Technical Team did not recommend any changes to the current methodology for measuring primary care spending in Connecticut.

C. Inflation Review Methodology

OHS is required to annually review the current and projected rate of inflation to inform consideration of whether to modify the healthcare cost growth benchmark. The Technical Team agreed that healthcare inflation generally lags general inflation by up to two years, because most contracts between payers and providers are set in advance. As a result, the **Technical Team recommended increasing a target year's benchmark value if general inflation two years before the target year was at least 3% or higher than the target year benchmark.**

> *"I have not seen evidence that hospitals' inflation experience is higher than economy-wide inflation."*
>
> *- Technical Team member*

For example, when considering whether to make an inflation adjustment to the 2026 healthcare cost growth benchmark, OHS would analyze inflation in 2024 and determine if it was at least three percentage points above the 2026 benchmark value.

The Technical Team did not recommend a specific adjustment value and specifically noted that the adjustment amount need not automatically equal the inflation increase.

D. Monitoring unintended adverse consequences

In 2020, OHS adopted the *Unintended Adverse Consequences Measurement Plan* to monitor potential negative effects of the healthcare cost growth benchmark across three domains: underutilization, impact on underserved populations and consumer

out-of-pocket spending. The most recent analysis, which looked at 2023 performance, did not suggest adverse patient impacts resulting from the cost growth benchmark.

The Technical Team reviewed the *Unintended Adverse Consequences Measurement Plan*, including the measures OHS adopted to monitor for underutilization of healthcare services and the data OHS analyzes to track changes in consumers' healthcare costs. Technical Team members observed that it is difficult to isolate the impact of the cost growth benchmark from other factors and dynamics. **The Technical Team supported the plan and recommended that OHS adopt additional measures to monitor restrictions to access to care, including administrative barriers to care, and the time it takes to access care.** The Technical Team recommended the following specific measures and monitoring activities:

- anti-stinting measures[5] that can help inform whether providers are limiting access to care to reduce cost growth;
- monitoring administrative barriers to care, including prior authorizations, rates of denials, and rates that denials that are overturned on appeal;
- assessment of the amount of time it takes for someone to see a primary care provider, obtain specialty care, and receive needed treatment (e.g., surgery), and
- analysis of changes in payer mix over time for certain entities (e.g., hospitals) to monitor trends by insurance type (i.e., to monitor for reduction in care to individuals with public insurance).

E. Significant contribution to cost growth and public hearing process

OHS holds an annual informational public hearing on performance relative to the healthcare cost growth benchmark. The commissioner is authorized to require testimony from a) any payer or provider entity that fails to meet the primary care spending target, and b) entities that are found to be significant contributors to healthcare cost growth. Further, the commissioner may require such entities to provide information on actions they will take to reduce future healthcare costs.

When asked what constitutes a significant contribution to healthcare costs, **the Technical Team recommended that OHS establish a cutoff, such as the top decile**

[5] OHS previously identified anti-stinting measures in the underutilization domain of the *Unintended Adverse Consequences Measurement Plan*. These measures required additional development at the time the plan was implemented and would still need to be developed.

or quintile, to identify the highest (outlier) spending growth contributors. The Technical Team recommended that OHS continue to assess where spending growth is high, identify which entity(ies) had the highest growth in the category, and then perform additional analyses for a deeper understanding of what is contributing to the growth. For example, analyzing retail pharmacy spending to identify which brand drugs are contributing most to spending growth.

Table 5 - Summary of Technical Team Recommendations

Technical Team Recommendations
1. The Technical Team recommended OHS use **median household income** as the indicator on which to base the healthcare cost growth benchmark value based on that review.
2. The Technical Team recommended a two-step approach to setting benchmark values that gradually reduces the rate of growth below median household income growth.
3. Connecticut should develop enforcement strategies to ensure compliance with the cost growth benchmarks as a critical lever to spur systems to become more efficient and ultimately slow the trajectory of spending growth.
4. OHS should pursue additional, complementary strategies to strengthen traditional primary care, noting that a primary care target alone is unlikely to achieve that desired outcome.
5. OHS should increase a target year's benchmark value if general inflation two years before the target year was at least 3% or higher than the target year benchmark.
6. OHS should adopt additional measures to monitor restrictions to access to care, including administrative barriers to care, and the time it takes to access care.
7. OHS should establish a cutoff, such as the top decile or quintile, to identify the highest (outlier) spending growth contributors.

OHS Response to Technical Team Recommendations

OHS accepts the recommendations of the Technical Team as outlined above, except for the recommended cost growth benchmark values. The OHS proposed cost growth benchmark values are as follows:

Table 6 - OHS Proposed healthcare cost growth benchmarks 2026-2030

Year	Benchmark
2026	2.8%
2027	2.8%
2028	2.8%
2029	2.8%
2030	2.8%

While the Technical Team noted that a reduction in the benchmark value below projected growth in Median Household Income for the years 2028-2030 would provide additional relief to consumers covered by commercial insurance, OHS is choosing not to recommend the out-year reductions. Further, OHS proposes using the projected 2026-2030 median household income values for Connecticut to avoid including any unusual COVID-related changes in income from the period prior to 2025. This results in a proposed 2.8% benchmark for 2026-2030.

As confirmed by the Technical Team and by stakeholders from the Connecticut healthcare community, in order to optimally inform policy, the benchmark values must be pragmatic and achievable. A reduction below 2.8% was appealing as a recognition of the already-high burden of healthcare costs in Connecticut, however given the degree to which commercial trend has exceeded the benchmark to date, OHS believes that restraining spending growth across all three markets to the rate of median household income growth would be a substantive step towards affordability.

OHS believes that by basing the value on median household income and continuing to vigorously advocate for the benchmark as an integral part of health pricing discussions in the state, we optimize the chances of achieving real savings for consumers and employers.

Next Steps

The OHS commissioner proposes the cost growth benchmark and primary care spending target recommendations as outlined in this report. In accordance with C.G.S. § 19a-754g, an informational public hearing on these benchmarks will occur before July 1, 2025. OHS will consider the other recommendations of the Technical Team in determining how best to advance the aims of the Healthcare Benchmark Initiative.

Acknowledgments

OHS appreciates the Technical Team's time, engagement, and thoughtful discussion to inform these recommendations. Consistent with its commitment to stakeholder engagement, OHS reviewed the Technical Team's input with the Healthcare Benchmark Initiative Steering Committee to keep committee members informed of discussions. OHS thanks all stakeholders for their continued collaboration in this important work to make healthcare more affordable and improve primary care access and outcomes for Connecticut residents.

Appendix: OHS Technical Team Members

1. **Loren Adler**, MS, Fellow and Associate Director, Center on Health Policy, Brookings Institution
2. **Don Berwick**, MD, MPP, Senior Fellow, Institute for Healthcare Improvement
3. **Sabrina Corlette**, JD, Co-Director, Center of Health Insurance Reforms, Georgetown University's McCourt School of Public Policy
4. **Francois de Brantes**, MS, MBA, Senior Partner, High Value Care Incentives Advisory Group
5. **Stefan Gildemeister**, MA, State Health Economist and Director, Health Economics Program, Minnesota Department of Health
6. **Paul Grady**, Connecticut Business Group on Health
7. **Jason Hockenberry**, PhD, Associate Dean for Faculty Affairs, Department Chair and Professor of Public Health (Health Policy), Yale School of Public Health
8. **Chris Manzi**, MBA, President, Pequot Health Care
9. **Roslyn Murray**, PhD, MPP, Assistant Professor of Health Services, Policy and Practice, Brown University Affiliated Faculty, Center for Advancing Health Policy through Research
10. **Josh Wojcik**, Director, Health Policy and Benefits Services Division, Office of the State Comptroller