



CONNECTICUT

Health Strategy

Healthcare Benchmark Initiative
Cost Growth Benchmark and
Primary Care Spending Target
2023–2024 Performance
Office of Health Strategy

Pursuant to [Conn. Gen. Statute §19a-754h](#)

April 21, 2026

Table of Contents

Acknowledgements.....	v
Authors	v
Contributors.....	v
Acronyms	vi
Executive Summary	1
Section 1: Cost Growth Benchmark.....	5
Data Analysis	6
Connecticut Challenges.....	8
The Role of Health Insurance.....	8
State Performance.....	9
Market and Payer Performance	13
Commercial Market	16
Medicare Market.....	19
Medicaid Market.....	25
Advanced Network Performance.....	29
Commercial Advanced Network Performance.....	30
Medicare Advantage Advanced Network Performance	32
Medicaid Advanced Network Performance	34
Performance by Market, Advanced Network, and Attribution Tier.....	37
Section 2: Primary Care Spending Target.....	41
Measuring Primary Care.....	41
Primary Care Results – State, Market and Payer Performance.....	42
Primary Care in Context.....	47
Appendix A: Cost Growth Benchmark Data Collection Process and Methodology	50
Background.....	50
Data Collection.....	51
Performance Reporting.....	53
Attribution Methodology.....	54
Payers Attributing Members by Utilization.....	55
Provider Tax Identification Number (TIN) Process.....	55

Appendix B: Primary Care Spending Target Methodology and Definitions	56
Appendix C: Key Terms	57

Table of Figures/Tables

Table 1 Per Capita Spending Growth and Total Spending, Statewide and by Market.....	2
Table 2 Spending Categories with Highest Per Capita TME Growth by Market.....	3
Table 3 Primary Care Spending (2024)	3
Figure 1 Elements of Total Primary Care Spending.....	7
Table 4 Connecticut Lives Included in Cost Growth Benchmark Data by Market, 2024	7
Figure 2 Average Connecticut and U.S. National Health Insurance Cost for Family Coverage, by Employee and Employer Contribution, 2020-2024	9
Table 5 Statewide and Market Spending Growth	9
Figure 3 State Per Capita Total Healthcare Expenditure (THCE) Growth (2019-2024)	10
Figure 4 Statewide Per Capita TME by Service Category (2023-2024)	11
Figure 5 Statewide Per Capita Contribution to TME Spending Growth by Service Category (2023-2024)	12
Figure 6 Lives by Market in Benchmark Data (2024)	13
Figure 7 State and Market Per Capita Total Medical Expense Growth and Spending (2023-2024) ...	14
Figure 8 Year over Year Annual Per Capita TME Trend by Market (2019-2024)	15
Figure 9 Cumulative Per Capita TME Growth by Market (2019-2024)	16
Figure 10 Commercial Market Lives by Payer (2024)	16
Figure 11 Commercial Per Capita Contribution to TME Spending Growth by Service Category (2023-2024)	17
Figure 12 Commercial Market Per Capita TME by Service Category (2023-2024)	18
Figure 13 Commercial Market Per Capita TME Growth by Insurer (2023-2024)	19
Figure 14 Covered Lives by Medicare Plan Type (2023-2024)	20
Figure 15 Cumulative Medicare Per Capita TME Growth (2019-2024)	21
Figure 16 Medicare Per Capita Contribution to TME Spending Growth by Service Category (2023-2024)	22
Figure 17 Medicare Per Capita TME by Service Category (2023-2024)	23
Figure 18 Medicare Advantage Market Lives by Payer (2024)	24
Figure 20 Medicaid Year over Year Annual Trends in Enrollment and Spending (2019-2024)	26
Figure 21 Medicaid Per Capita Contribution to TME Spending Growth by Service Category (2023-2024)	27
Figure 22 Medicaid Per Capita TME by Service Category (2023-2024)	28
Table 6 Advanced Network Per Capita TME Performance Trends by Market and Type (2023-2024)	29

Figure 23 Hospital-Affiliated Advanced Network Commercial TME Trends (2023-2024)	30
Figure 24 Non-Hospital-Affiliated Advanced Network Commercial TME Trends (2023-2024)	31
Figure 25 Hospital-Affiliated Advanced Network Medicare Advantage TME Trends (2023-2024)	32
Figure 26 Non-Hospital-Affiliated Advanced Network Medicare Advantage TME Trends (2023-2024)	33
Figure 27 Hospital-Affiliated Advanced Network Medicaid TME Trends (2023-2024)	34
Figure 28 Non-Hospital-Affiliated Advanced Network Medicaid TME Trends (2023-2024)	35
Figure 29 Federally Qualified Health Center-Affiliated Advanced Network Medicaid TME Trends (2023-2024)	36
Table 7 Per Capita TME Spending Trend by Market and Attribution Tier (2023-2024)	37
Figure 30 Advanced Network Member Months by Market and Attribution Tier (2024)	38
Table 8 Commercial Market Advanced Network TME Spending Trend by Attribution Tier (2023-2024)	39
Table 9 Medicare Advantage Advanced Network TME Spending Trend by Attribution Tier (2023 – 2024)	40
Figure 31 Primary Care Spending as Percentage of TME v. the Primary Care Spending Target, for the State and by Market (2023-2024)	43
Table 10 Aggregate Primary Care Spending Trends, by Market (2023-2024)	43
Table 11 Per Member Per Month Primary Care Spending Trends, by Market (2023-2024)	44
Figure 32 Per Capita Professional Spending, by Market (2024)	44
Figure 33 Primary Care as Percentage of Professional Spending, by Market (2024)	45
Figure 34 Commercial Primary Care Spending as a Percentage of Total Medical Expense Per Person Per Month (2023-2024)	46
Figure 35 Medicare Advantage Primary Care Spending as a Percentage of Total Medical Expense Per Person Per Month (2023-2024)	47
Table 12 Annual Cost Growth Benchmark Values	50
Figure 36 Elements of Total Health Care Expenditures	51
Table 13 Data Sources	52
Table 14 Types of Payment for Connecticut’s Healthcare Benchmark Program, by Service Category	53
Table 15 Member Attribution Hierarchies	54
Figure 37 Elements of Total Primary Care Spending	56

Acknowledgements

The Office of Health Strategy (OHS) expresses its gratitude to the Centers for Medicare & Medicaid Services, the Connecticut Department of Social Services, the Department of Correction, and the Office of the State Comptroller for submitting data for this report. OHS also thanks Aetna, Cigna, ConnectiCare (Molina Healthcare), Anthem Blue Cross and Blue Shield, United Healthcare, and WellCare for submitting data and both the insurance carriers and the Advanced Networks for their cooperation and collaboration. OHS also extends sincere appreciation for the feedback, questions, and advice provided by our stakeholder committees including the Healthcare Benchmark Initiative (HCBI) Steering Committee and the HCBI Data Analytics Workgroup.

This work was made possible through technical assistance provided by Bailit Health.

Authors

Alexander Reger, Ph.D., Office of Health Strategy

Lisa P. Sementilli, M.A., Office of Health Strategy

Patricia Blodgett, M.B.A., Office of Health Strategy

James D. Lee, M.D., M.P.H., National Clinician Scholars Program, Office of Health Strategy

Contributors

Christopher Romero–Gutierrez, Bailit Health

Caitlin Otter, Bailit Health

Michael Bailit, Bailit Health

Acronyms

AN	Advanced Network
CHAI	Connecticut Healthcare Affordability Index
CHC	Community Health Center
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
DOC	Department of Correction
DSS	Department of Social Services
ED	Emergency Department
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
HCBI	Healthcare Benchmark Initiative
MEPS	Medicare Expenditure Panel Survey
MLR	Medical Loss Ratio
NCPHI	Net Cost of Private Health Insurance
OHS	Office of Health Strategy
OSC	Office of the State Comptroller
PGSP	Potential Gross State Product
PMPM	Per Member Per Month
THCE	Total healthcare expenditures (TME + NCPHI)
TIN	Tax Identification Number
TME	Total medical expense
VHA	Veterans Health Administration

Executive Summary

This report describes the Office of Health Strategy (OHS) Cost Growth Benchmark, which measures healthcare spending in Connecticut and compares its growth to an annual benchmark value (4.0% in 2024), and the Primary Care Spending Target, which measures the percentage of total medical expenses spent on primary care. The goal is to make healthcare spending more transparent and provide policy makers with the data to make informed decisions about how to improve healthcare affordability and accessibility for Connecticut residents¹ and businesses² while balancing economic stability for healthcare payers and providers.

The Cost Growth Benchmark value represents a rate of healthcare spending growth that aligns with the growth in median household income, an approximate measure of how much healthcare spending can increase and remain affordable and accessible for Connecticut residents. Connecticut total healthcare expenditures (THCE), which includes both total medical expense (TME) and the administrative costs and profits related to private commercial health insurance, grew 7.9% to \$12,332 per person per year, totaling \$38 billion in healthcare spending and exceeding the benchmark value. Healthcare spending is growing faster than Connecticut residents' ability to afford services. Small businesses continue to face challenges to provide adequate health insurance to their employees, while continuing to invest in economic growth.

The primary care spending target is part of an incremental approach to increase primary care spending to 10% of total healthcare expenditures by 2025. Primary care services promote health maintenance and have the potential to reduce the occurrence of certain high cost or emergency medical services. Connecticut fell short of the 8.5% target in 2024, with primary care representing 4.6% of total medical expenses, this is only a slight increase over the 2023 percentage. Primary

2024 Cost Growth Benchmark and Primary Care Performance

Total healthcare expenditures for Connecticut residents in 2024:
\$38 Billion

Total healthcare expenditure growth from 2023: **7.9%**

Primary Care Spending as a percentage of total medical expenses: **4.6%**

Percent of Connecticut Population Covered by Cost Growth Benchmark Data: **84%**

¹ Healthcare Value Hub. 2025 Healthcare Snapshot for Connecticut. <https://healthcarevaluehub.org/healthcare-affordability-snapshot/>

² Klein, Liese, "CT Businesses Urged to Push for Change Amid Rising Health Care Costs That's Impacting Growth," CT Insider, November 22, 2024. <https://www.ctinsider.com/business/article/connecticut-healthcare-costs-business-impact-19936464.php>

Executive Summary

care spending growth is not keeping up with overall medical spending, underscoring the importance of policies that prioritize high value primary care services and slow spending in other, high spend services. This is the third consecutive year in which Connecticut did not meet its statewide primary care spending target.

The state did not meet the cost growth benchmark. OHS additionally assesses market, payer (e.g., insurer or government program), and Advanced Network performance against the benchmark. Only one market, Medicare (which includes both Medicare fee-for-service and Medicare Advantage), met the benchmark for cost growth. No payer met the benchmark in the Commercial market, while all met it in the Medicare Advantage market. Finally, the majority of Advanced Networks (ANs) did not meet the benchmark in any of the three markets.

Total Medical Expenditures (TME), which includes only healthcare related expenses, grew 8.6% statewide, driven primarily by increases in the Commercial and Medicaid markets. Per capita TME increased to \$11,820.

Table 1 Per Capita Spending Growth and Total Spending, Statewide and by Market

State or Market	Per Capita 2023-2024 Spending Growth	Per Capita 2024 Total Spending
Statewide THCE	7.9%	\$12,332
Statewide TME	8.6%	\$11,820
Commercial TME	7.4%	\$9,556
Medicaid TME	14.0%	\$8,371
Medicare TME	3.7%	\$18,157
Benchmark Value	4.0%	

Executive Summary

The top three spending drivers in each market, by per capita and percent growth, are shown below. Retail pharmacy continues to be a top spending driver in the Commercial and Medicaid market, while Medicare market growth was driven in part by spending on hospital services (inpatient and outpatient).

Table 2 Spending Categories with Highest Per Capita TME Growth by Market

Rank	Per Capita TME Spending Growth (\$)	Per Capita TME Spending Growth (%)
Commercial Market		
1	Retail Pharmacy (\$209)	Retail Pharmacy (12.8%)
2	Hospital Outpatient (\$194)	Professional Physician (8.4%)
3	Professional Physician (\$138)	Hospital Outpatient (7.3%)
Medicare Market		
1	Hospital Outpatient (\$267)	Other Professional (9.8%)
2	Hospital Inpatient (\$180)	Hospital Outpatient (9.1%)
3	Professional Physician (\$125)	Hospital Inpatient (5.0%)
Medicaid Market		
1	Long-Term Care (\$646)	Retail Pharmacy (22.4%)
2	Retail Pharmacy (\$144)	Long-Term Care (20.3%)
3	Hospital Outpatient (\$73)	Other Claims (8.9%)

The state did not meet the Primary Care Spending Target. Although aggregate spending on primary care increased substantially, primary care spending as a percentage of TME was nearly flat due to the increased spending on other healthcare services.

Table 3 Primary Care Spending (2024)

Measure	Value
Aggregate Primary Care Spending Growth	9.8%
Primary Care Spending (% of TME)	4.6% (Target 8.5%)

Increased spending on healthcare, which results from changes in utilization and payments per service, impacts all residents and businesses. According to the OHS Connecticut Healthcare Affordability Index ([CHAI](#)), Connecticut households spend between 6% and 10% of their budget on

Executive Summary

healthcare costs, including premiums and out-of-pocket expenses, substantially reducing the amount available to spend on other necessities.

The [Healthcare Benchmark Initiative](#), which includes the Cost Growth Benchmark, the Primary Care Spending Target, and the Quality Benchmarks, brings transparency to a complex healthcare ecosystem, providing policy makers and stakeholders the data necessary to inform policies that will decrease healthcare spending, increase healthcare access, and improve healthcare quality.

Section 1: Cost Growth Benchmark

Section 1: Cost Growth Benchmark

Each year, Connecticut measures healthcare spending cost growth against benchmarks established through the Cost Growth Benchmark program. Connecticut’s 2023–2024 healthcare spending exceeded the benchmark. This outcome highlights continuing challenges in ensuring affordable, accessible healthcare for state residents.

Pursuant to Conn. Gen. Stat. [§ 19a-754g et. seq.](#), this report describes total healthcare expenditures (THCE) in Connecticut, including total medical expenses (TME) by market, payer, provider, and major service category. The Office of Health Strategy (OHS) measures and compares this per member spending growth to the 2024 Cost Growth Benchmark value of 4.0%.

The cost growth benchmark is set by blending projections of state economic growth and household income. Broadly, the Cost Growth Benchmark value represents affordable and sustainable growth in the healthcare sector. A complete list of annual benchmark values is described in [Appendix A](#). The Cost Growth Benchmark and Primary Care Spending Target programs receive guidance from advisory committees, share best practices with similar programs across the country, and invite input from multiple constituencies, including the [Healthcare Benchmark Initiative Steering Committee](#).

Healthcare spending growth results from increases in healthcare utilization (i.e., more people are using services, more services are being used, or both) and/or from the amount paid for healthcare services. Some spending growth may indicate that the healthcare system is appropriately responding to the community’s medical needs: for example, by hiring more primary care providers and increasing accessibility, or reacting to a health emergency like COVID-19. Other spending growth, particularly growth in payments per service, may lead to fewer individuals being able to afford care. The Cost Growth Benchmark program helps make this spending transparent, so stakeholders and policymakers can work together towards mutual healthcare accessibility and affordability goals. Cost Growth Benchmark data reveal opportunities for efficiencies in healthcare spending that can be used to drive strategies to constrain cost growth.

The impact of rising healthcare spending impacts all state residents. A 2025 survey of 1,400 Connecticut adults reveals continuing healthcare affordability and accessibility challenges. Over 70% of survey respondents believe the healthcare system is unaffordable, and 61% delayed or went without care due to cost over the last twelve months.³ Delayed or forgone care can result in increased emergency department (ED) use and worse health outcomes. In Connecticut,

³ Healthcare Value Hub. 2025 Healthcare Snapshot for Connecticut.
<https://healthcarevaluehub.org/healthcare-affordability-snapshot/>

Section 1: Cost Growth Benchmark

payments of about \$818 million⁴ were made in 2024 for potentially avoidable ED visits, for health conditions that could have been properly and more effectively managed in a primary care setting, and at less cost to the system. According to the Commonwealth Fund, Connecticut ranks in the bottom half of states for potentially avoidable emergency department visits for ages 18-64, and almost last for ages 65 and older.⁵

Healthcare is one of the largest and fastest growing employment sectors in the state;⁶ it generates jobs and provides the critical infrastructure necessary to keep state residents healthy and treat them when they are ill. Healthcare spending can help increase accessibility and incentivize high quality care, like primary care services. However, consistent and continued spending growth, at almost double the benchmark rate, presents substantial affordability and accessibility challenges for state residents and businesses. The 7.9% THCE growth rate in 2024 exceeds the growth in Connecticut household income and inflation.⁷ Measuring this spending is complex and the Cost Growth Benchmark brings transparency to the service categories and markets driving spending while illuminating the role of payers and Advanced Networks (i.e., large provider groups). The Benchmark program is one of many tools OHS provides to help policy makers and stakeholders better understand and address the rising cost of healthcare. The program ensures [data transparency](#) by publishing detailed information on methodology, data use and data validation, as well as providing [healthcare data dashboards](#) to support independent analyses

Data Analysis

Data for the Cost Growth Benchmark and Primary Care Spending Target come directly from payers. A payer is an entity that pays for health care services, including the six health insurers that operate in the state (Anthem, Aetna, Cigna, ConnectiCare (Molina Healthcare), UnitedHealthcare, and WellCare), the Connecticut departments of Correction and Social Services, and some federal payers covering Connecticut residents (such as Medicare, but excluding the Veterans Health Administration, TRICARE, and others). OHS uses aggregate data submitted by these payers to calculate total medical expenses (TME, the total spending on healthcare services) and the Net

⁴ Office of Health Strategy analysis of *CT Hospital Association ChimeData Emergency Room Department and Annual Report on the Annual Status of Connecticut's Short-Term Acute Care Hospitals for Fiscal Year 2024*.

⁵ Radley, Kolb, Collins, "2025 Scorecard on State Health System Performance," June 18, 2025, Commonwealth Fund. <https://www.commonwealthfund.org/publications/scorecard/2025/jun/2025-scorecard-state-health-system-performance>

⁶ CT Department. of Labor. (2025, March 13) Year-End Jobs Report Shows Solid Job Growth In 2024 As Employers Hit New Employment Highs. (Press Release) <https://portal.ct.gov/dol/communications/press-room/2025/ct-dept-of-labor-releases-2024-year-end-jobs-report>

⁷ Kanimian S, Ho V. US Medical Prices and Health Insurance Premiums, 1999-2024. *JAMA Netw Open*. 2025 Dec 1;8(12):e2547462. doi: 10.1001/jamanetworkopen.2025.47462. PMID: 41359339; PMCID: PMC12687089.

Section 1: Cost Growth Benchmark

Cost of Private Health Insurance (NCPHI, the cost to insurers of administering private health insurance including overhead and profit). Total Healthcare Expenditures (THCE) is the combination of TME and NCPHI:

Figure 1 Elements of Total Primary Care Spending



In total, the benchmark data covers approximately 84% of Connecticut residents’ healthcare services, as shown in Table 4. This allows for a comprehensive exploration of spending trends by market, payer, and service category. Some members are enrolled in both Medicare and Medicaid and are identified as dual eligibles.

Table 4 Connecticut Lives Included in Cost Growth Benchmark Data by Market, 2024

Data Source	Covered Lives
Connecticut Department of Correction	10,435
Commercial Market Insurers	1,395,766
Medicaid (excluding dual eligibles)	946,926
Medicare and Medicare Advantage (excluding dual eligibles)	516,973
Medicaid/Medicare Dual Eligibles	214,109
Total	3,084,208
Connecticut Population (2024) ⁸	3,675,069
Percent of Population Included in the Cost Growth Benchmark	84%

Note: Numbers may not sum due to rounding.

⁸ Backus, K (2025) Town-level Population Estimates for Connecticut, July 1, 2024. Connecticut Department of Public Health, Health Statistics and Surveillance, Surveillance Analysis & Reporting, Hartford, CT. https://portal.ct.gov/dph/-/media/departments-and-agencies/dph/population/town-pop/pop_towns2024pdf.pdf?rev=4b45057d69654233a886771dd48bcfa4&hash=5104946F83014CE996BB3930DE956160#:~:text=The%20Population,1.51

Section 1: Cost Growth Benchmark

Connecticut Challenges

Unlike our neighboring New England states, Connecticut’s commercial and Medicare Advantage markets are dominated by several national insurers, including Aetna Health and Life, Anthem Blue Cross Blue Shield, Cigna, Molina Healthcare (owner of ConnectiCare), and UnitedHealthcare. National insurers provide efficiencies of scale as well as other advantages. However, Connecticut’s opportunities to implement state-specific policy solutions, cost reforms, and data sharing practices can be challenging as carriers with national market share have few incentives to adopt changes for a comparatively small population.

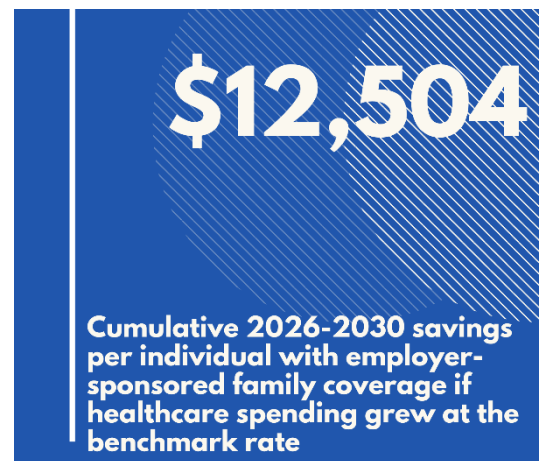
The Role of Health Insurance

In the commercial market, most residents pay for healthcare services through health insurance, which is often employer-sponsored.

Rising costs make it harder for employers to offer and pay for health insurance and harder for employees to afford their share. A 2025 study shows that, over the last 25 years, the mean worker contribution toward family health insurance premiums increased by over 300%, while the premiums themselves increased by 342%.⁹

Meanwhile, between 1999 and 2024, worker earnings rose only 119%¹⁰. The average annual cost of commercial health insurance premiums for family coverage between 2020 and 2024 in Connecticut was more than \$27,000, about 10% higher than the national average as shown in Figure 2.¹¹

OHS analyses calculate that if healthcare spending grew at only the benchmark rate, the average individual with employer-sponsored family health insurance coverage would save \$12,504 from 2026–2030 through reduced premiums and average family out-of-pocket costs, compared to if health spending grew at the average 2021–2024 commercial market rate.



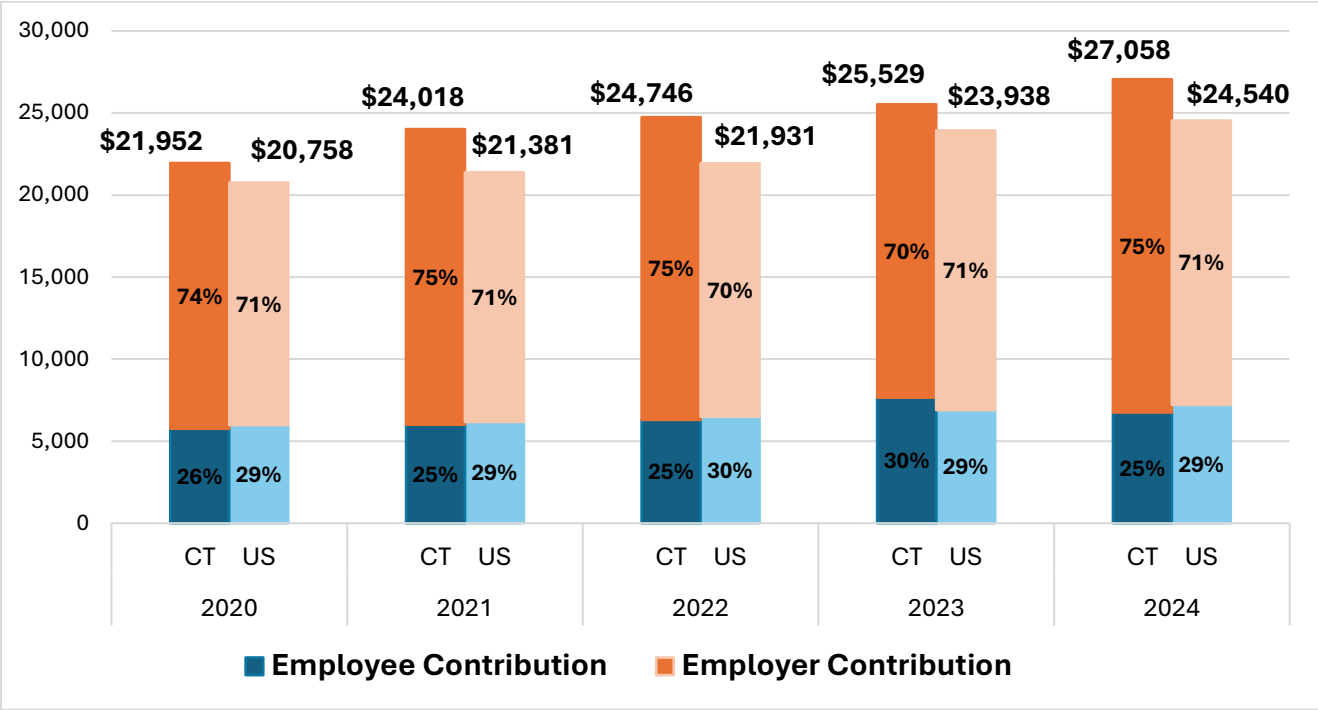
⁹ Kanimian S, Ho V. US Medical Prices and Health Insurance Premiums, 1999–2024. JAMA Netw Open. 2025;8(12):e2547462. doi:10.1001/jamanetworkopen.2025.47462

¹⁰ Kanimian S, Ho V. US Medical Prices and Health Insurance Premiums, 1999–2024. JAMA Netw Open. 2025 Dec 1;8(12):e2547462. doi: 10.1001/jamanetworkopen.2025.47462. PMID: 41359339; PMCID: PMC12687089.

¹¹ Agency for Health Care Research and Quality, Medical Expenditure Panel Survey, Insurance/Employer Component. (https://meps.ahrq.gov/survey_comp/Insurance.jsp)

Section 1: Cost Growth Benchmark

Figure 2 Average Connecticut and U.S. National Health Insurance Cost for Family Coverage, by Employee and Employer Contribution, 2020-2024



Source: Agency for Health Care Research and Quality, Medical Expenditure Panel Survey, Insurance/Employer Component. (https://meps.ahrq.gov/survey_comp/Insurance.jsp)

State Performance

Total Healthcare Expenditures (THCE) grew 7.9% in 2024, exceeding the cost growth benchmark of 4.0%. The 2024 Cost Growth Benchmark, which measures spending growth from 2023 to 2024, represents Connecticut families’ and businesses’ capacity to afford healthcare services. The OHS Commissioner increased the original 2024 value from 2.9% to account for the delayed impact of inflation on the healthcare sector.

Table 5 Statewide and Market Spending Growth

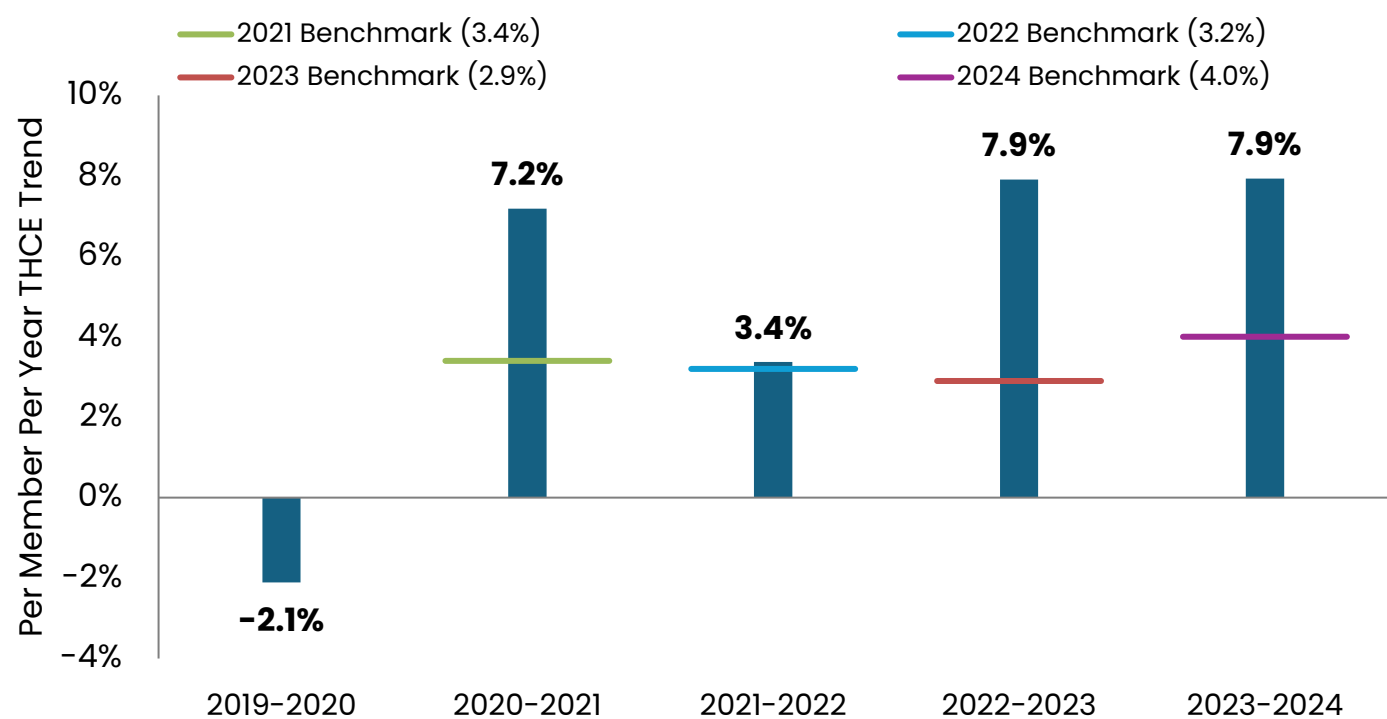
State or Market	Per Capita 2023-2024 Spending Growth
Statewide THCE	7.9%
Statewide TME	8.6%
Commercial TME	7.4%
Medicaid TME	14.0%
Medicare TME	3.7%
Benchmark Value	4.0%

Section 1: Cost Growth Benchmark

THCE includes the net cost of private health insurance (NCPHI), which decreased 7.3% in 2024. This means that 2024 was either a less profitable year, or that insurers spent more of their revenue on benefits and retained a lower percentage of their revenue for administrative costs and profits.

Since measurement against the Benchmark began, state healthcare spending growth has exceeded the benchmark value each year. Over the last five years, as shown in Figure 3, healthcare spending continues to rise and healthcare is becoming less, not more, affordable for most Connecticut families and businesses.

Figure 3 State Per Capita Total Healthcare Expenditure (THCE) Growth (2019-2024)

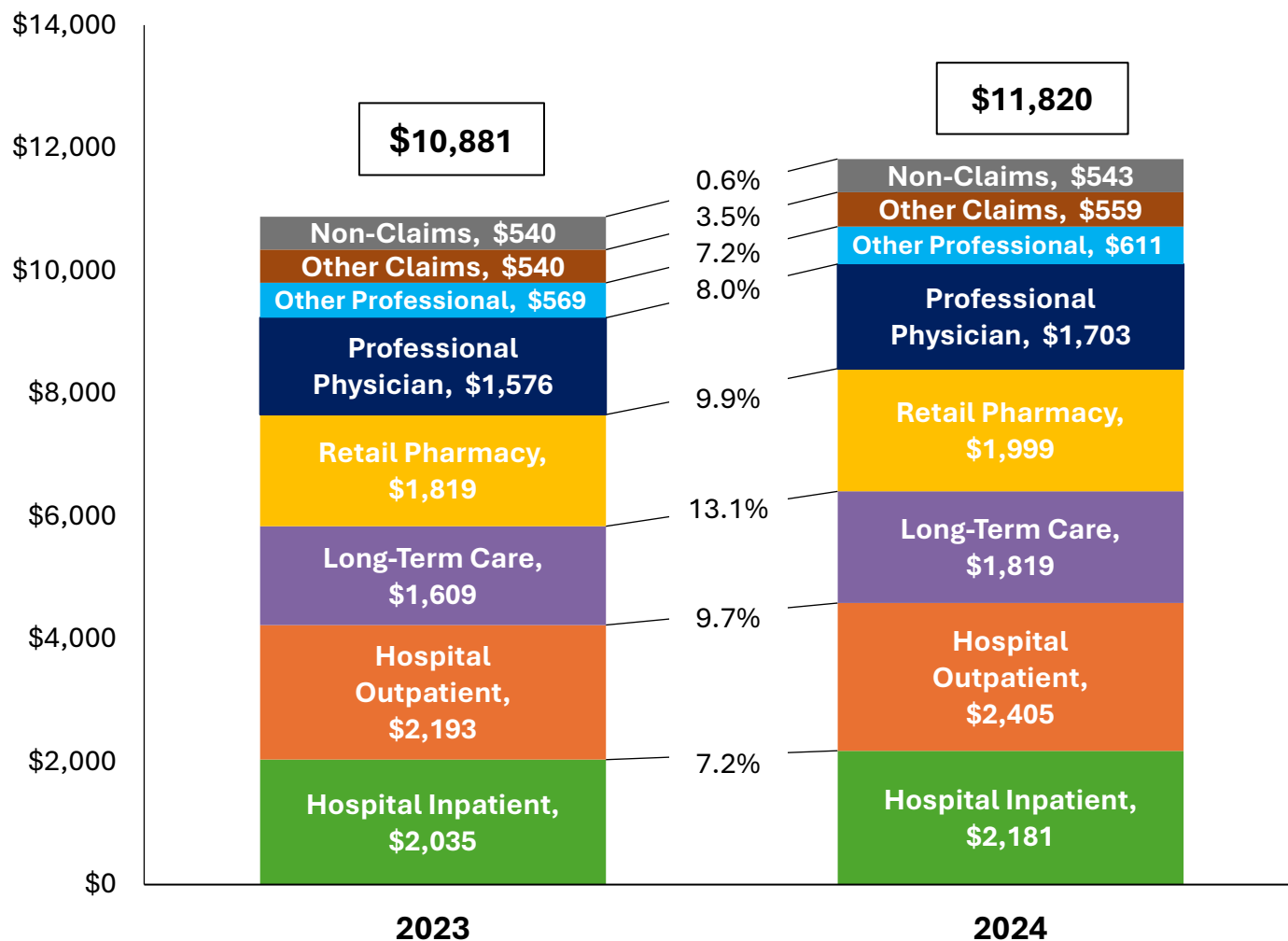


Notes: Data are not age/sex adjusted and data are reported net of pharmacy rebates. Data include the net cost of private health insurance (NCPHI). Reporting period reflects the most accurate data available, including resubmissions.

Section 1: Cost Growth Benchmark

Statewide, total medical expense (TME) growth was driven by increased spending on long-term care (13.1% growth), retail pharmacy (9.9%), and hospital outpatient services (9.7%). Hospital inpatient services (\$2,181), hospital outpatient services (\$2,405), and retail pharmacy (\$1,999) remain the three largest per capita spending categories in 2024.

Figure 4 Statewide Per Capita TME by Service Category (2023-2024)

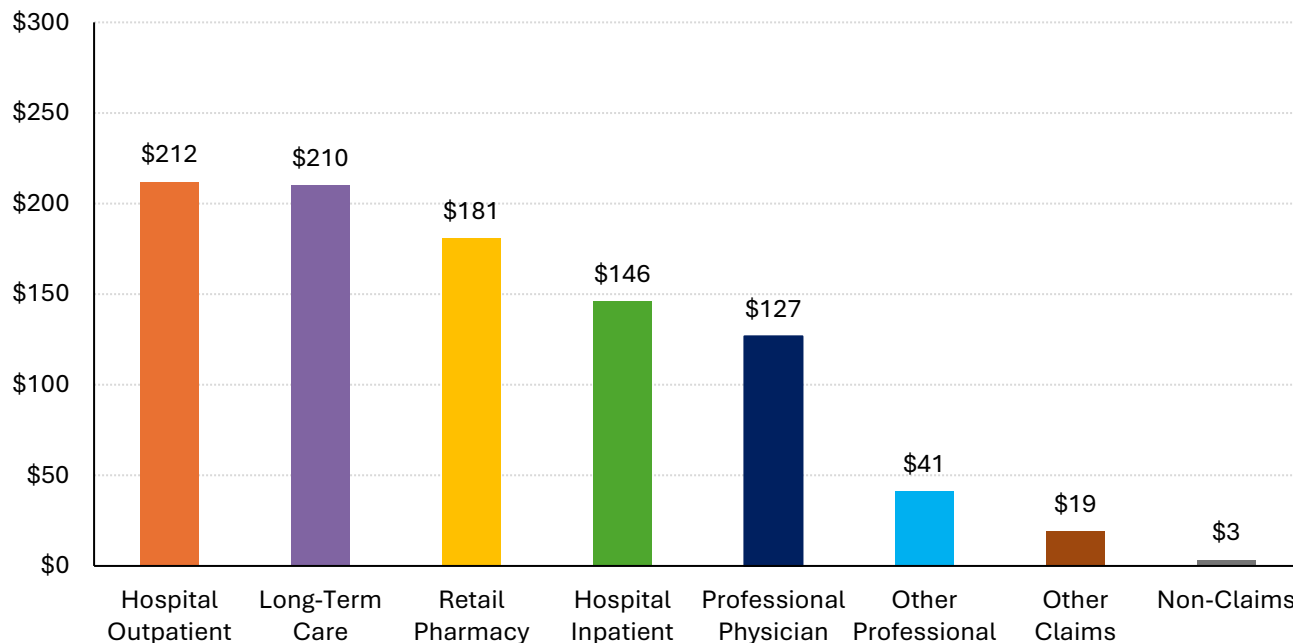


Notes: Data are not age/sex adjusted and data are reported net of pharmacy rebates.

Section 1: Cost Growth Benchmark

Hospital outpatient service per capita spending grew by \$212. The top three categories grew by a total of \$603, representing over 60% of per capita growth.

Figure 5 Statewide Per Capita Contribution to TME Spending Growth by Service Category (2023-2024)



Notes: Data are not age/sex adjusted and data are reported net of pharmacy rebates.

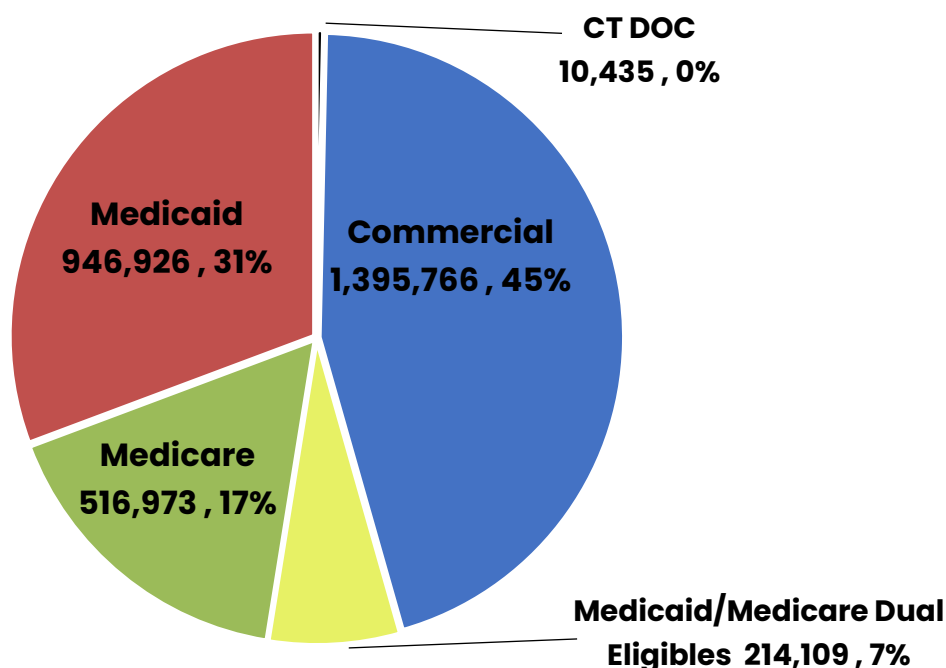
Section 1: Cost Growth Benchmark

Market and Payer Performance

The Cost Growth Benchmark measures healthcare spending growth across three markets: Commercial (i.e., small group, large group, or individually purchased), Medicaid, and Medicare. This provides an opportunity to focus on each market's unique reporting entities, spending patterns, growth drivers, and policy solutions.

More than 40% of Connecticut's population receives health benefits that are paid through commercial health insurance coverage. Commercial health insurance includes employer-sponsored coverage and individual coverage purchased through Access Health CT, the state's health insurance exchange. Another 17% of residents are covered through Medicare, while about 31% are covered through Medicaid. Another approximately 200,000 members are dually eligible for Medicare and Medicaid (although health spending for these individuals is assigned to only one market, based on whether Medicare or Medicaid paid for the specific service).

Figure 6 Lives by Market in Benchmark Data (2024)

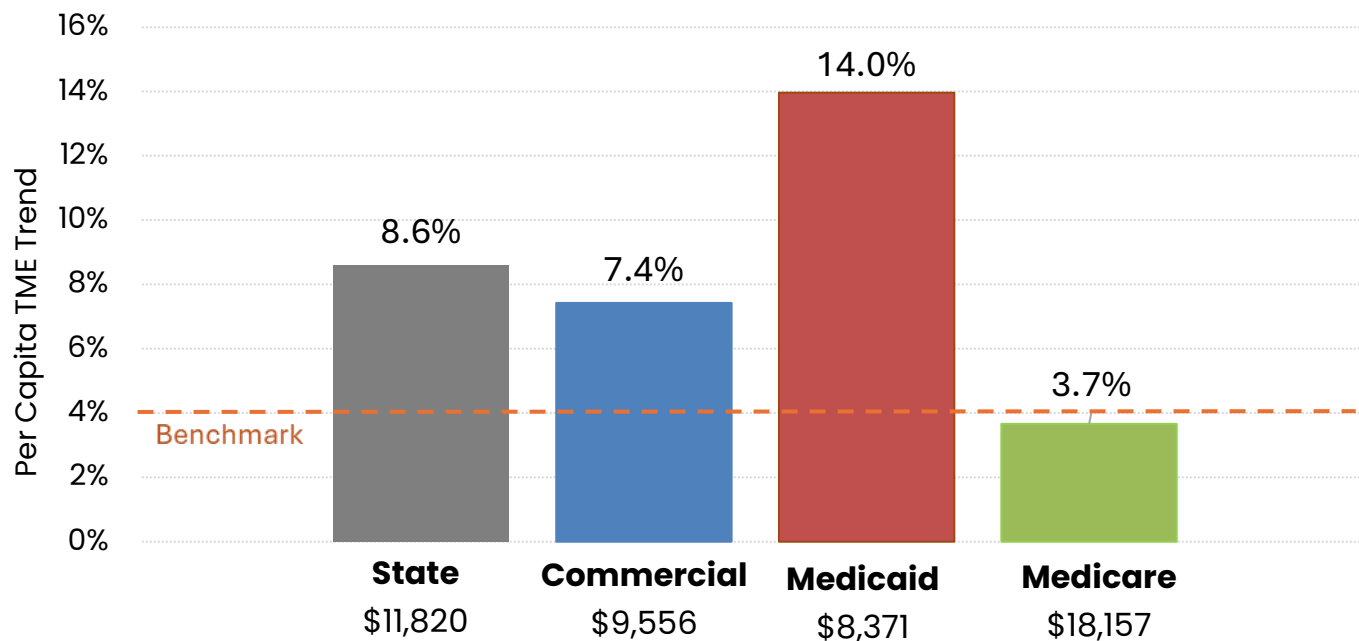


Notes: Medicare/Medicaid dual eligible members are reported separately from each market. Medicare includes Medicare Advantage and Medicare Fee for Service.

Section 1: Cost Growth Benchmark

The Medicaid market, which was the only market in 2023 to meet the benchmark, saw the most substantial growth in 2024. Medicaid growth has historically been very low, so the 2024 change is unusual. The Medicare market was the market with the fastest spending growth from 2022 to 2023 but was the only market to meet the 2024 cost growth benchmark.

Figure 7 State and Market Per Capita Total Medical Expense Growth and Spending (2023-2024)

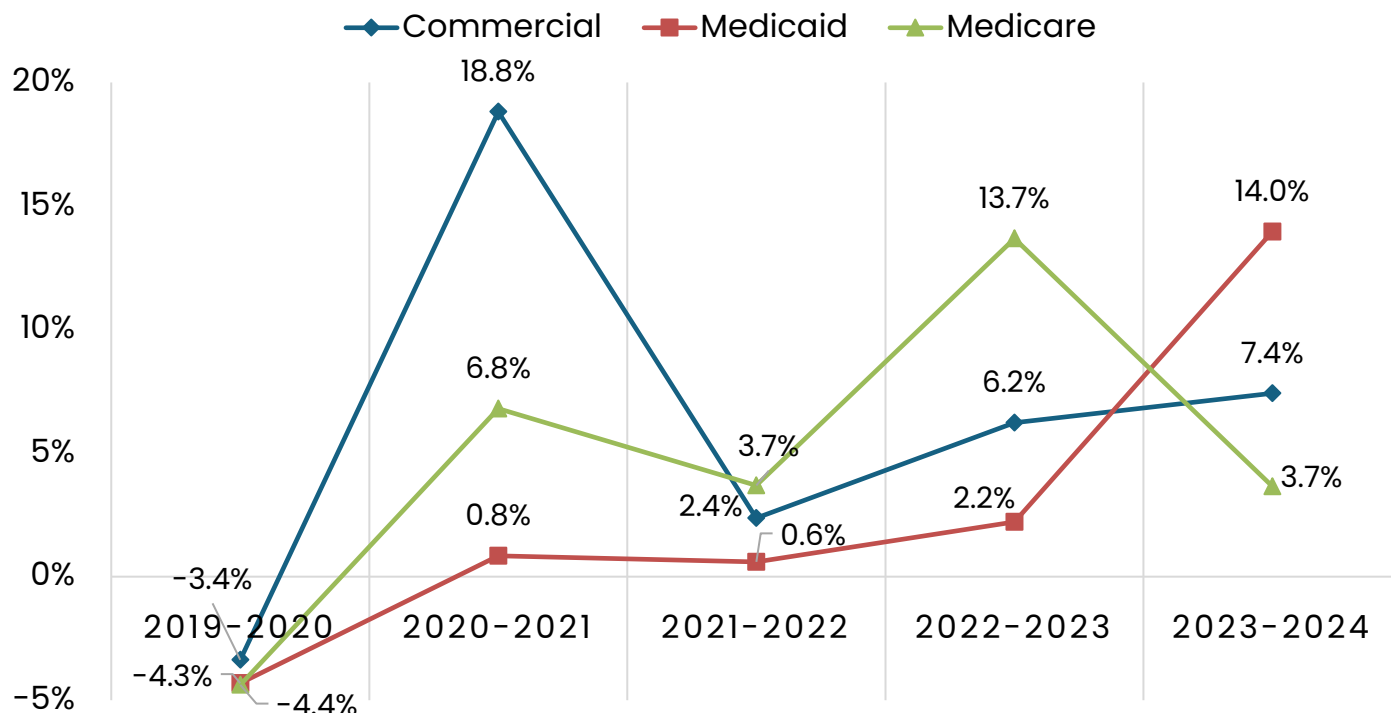


Notes: Data are not age/sex adjusted and data are reported net of pharmacy rebates.

Section 1: Cost Growth Benchmark

Total Medical Expense growth has varied by market over the last five years. Figure 8 illustrates volatility in per capita spending growth by market, reflecting changes resulting from the Covid-19 public health emergency, changes to Affordable Care Act eligibility and continuous enrollment, demographic shifts (such as Connecticut's aging population), and other market forces.

Figure 8 Year over Year Annual Per Capita TME Trend by Market (2019-2024)

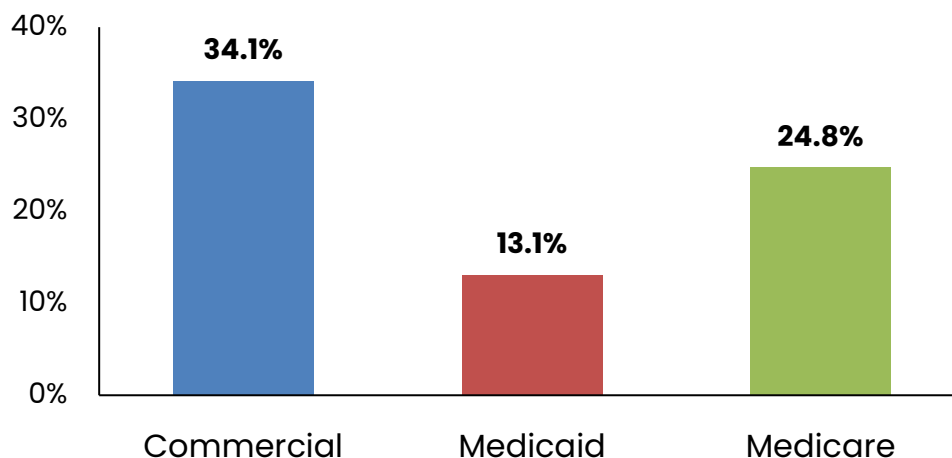


Notes: Data are not age/sex adjusted and data are reported net of pharmacy rebates. Medicaid and Medicare include dual eligibles. Medicare market includes both Medicare Fee for Service and Medicare Advantage. Reporting period reflects the most accurate data available, including resubmissions.

Section 1: Cost Growth Benchmark

Over the past five years, cumulative spending growth has been substantial, particularly in the commercial market, as shown in Figure 9.

Figure 9 Cumulative Per Capita TME Growth by Market (2019-2024)

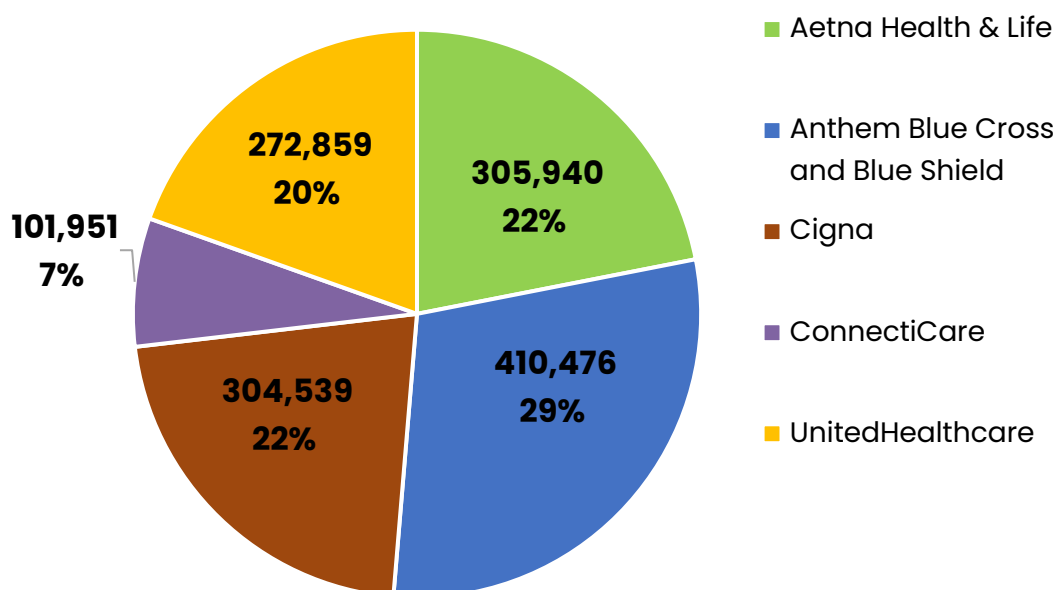


Notes: Data are not age/sex adjusted and data are reported net of pharmacy rebates. Medicaid and Medicare include dual eligibles. Medicare market includes both Medicare Fee for Service and Medicare Advantage. Reporting period reflects the most accurate data available, including resubmissions.

Commercial Market

Commercial market spending, representing spending on approximately 1.4 million Connecticut lives, grew to \$9,556 per person. Growth in commercial covered lives from 2023 to 2024 was essentially flat at 0.6%.

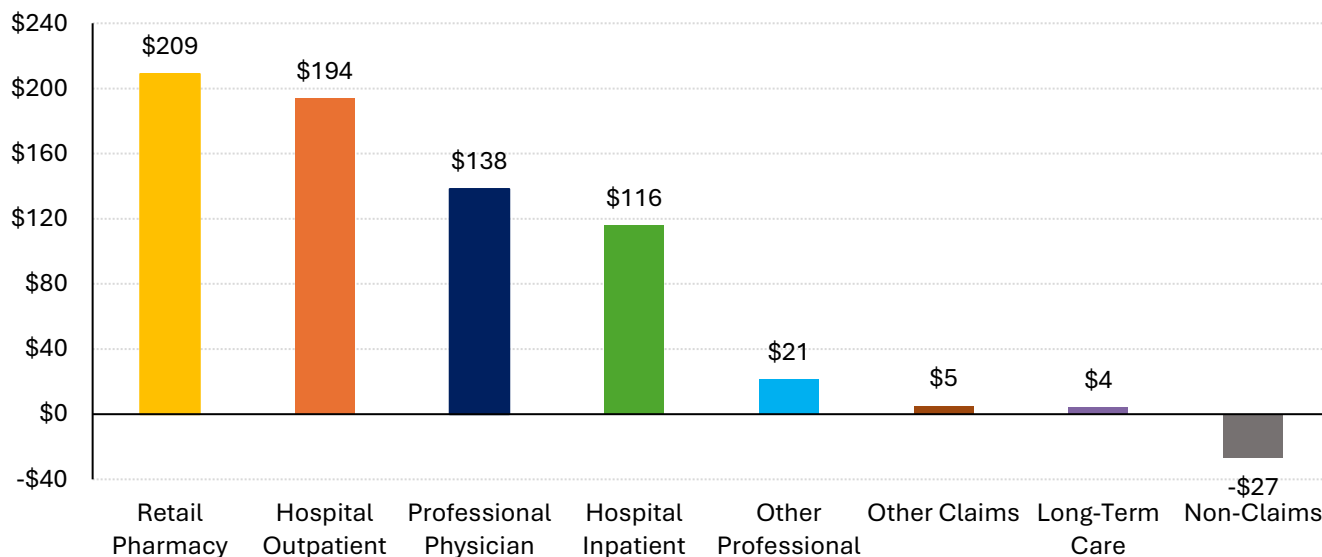
Figure 10 Commercial Market Lives by Payer (2024)



Section 1: Cost Growth Benchmark

Hospital outpatient services and retail pharmacy were the largest per capita spending categories, with hospital inpatient services and professional physician services close behind. These four service categories experienced the largest increases in per capita spending.

Figure 11 Commercial Per Capita Contribution to TME Spending Growth by Service Category (2023-2024)

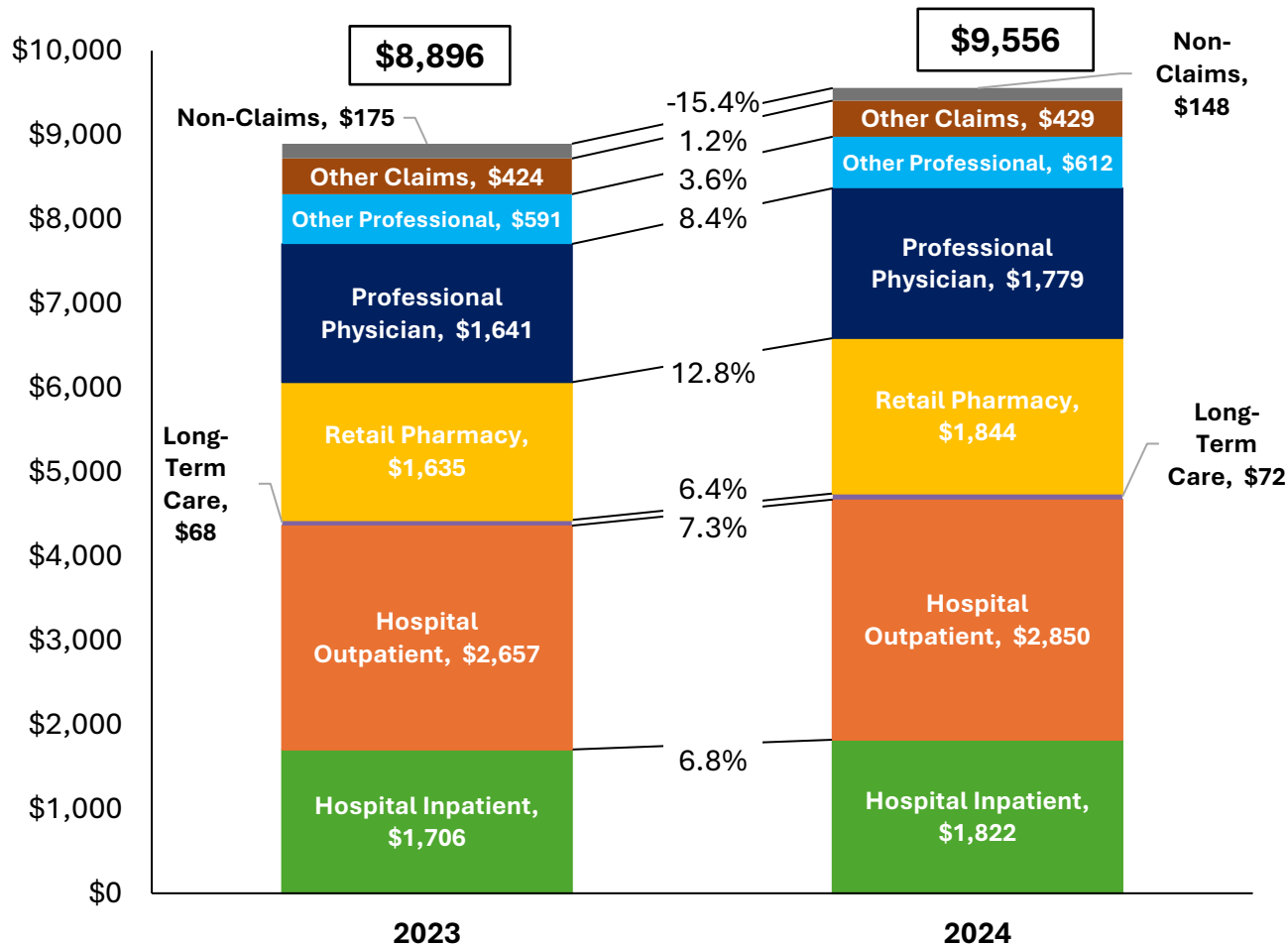


Notes: Data are not age/sex-adjusted and are reported net of pharmacy rebates.

Retail pharmacy, hospital outpatient services, and professional physician services grew the largest amount, while spending on non-claims, retail pharmacy, and professional physician services had the greatest percentage growth.

Section 1: Cost Growth Benchmark

Figure 12 Commercial Market Per Capita TME by Service Category (2023-2024)

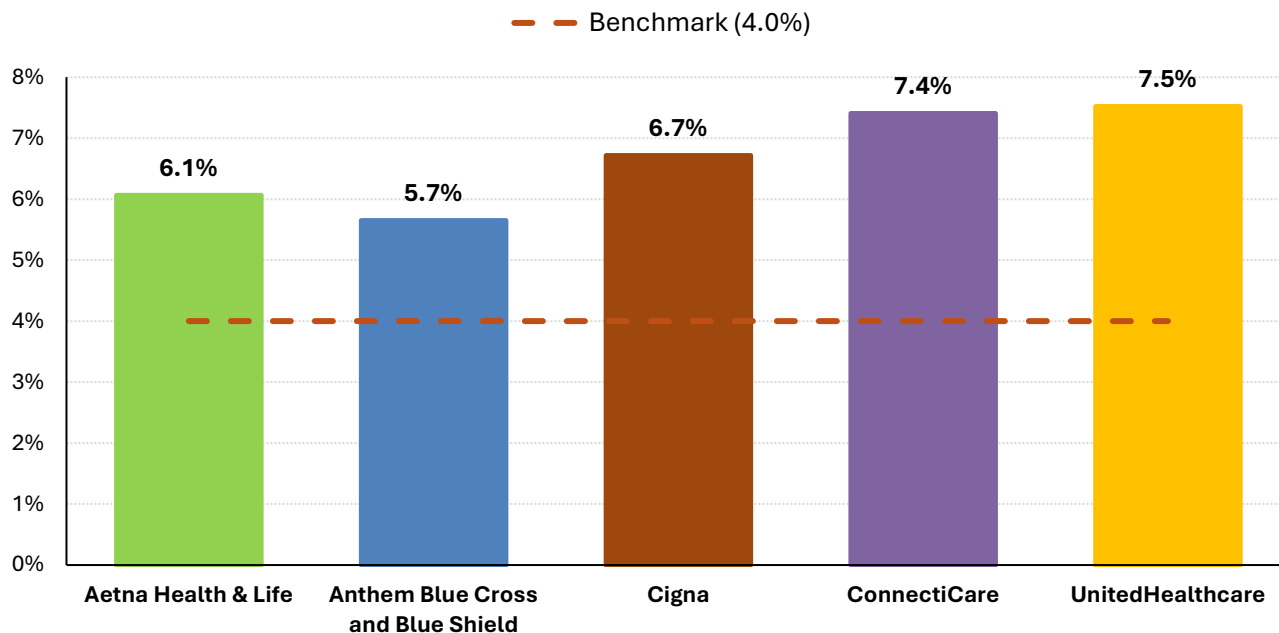


Notes: Data are not age/sex adjusted and data are reported net of pharmacy rebates.

Section 1: Cost Growth Benchmark

When assessing insurer performance against the cost growth benchmark by market, no commercial market insurer met the 4.0% cost growth benchmark, with growth ranging from 5.7% (Anthem Blue Cross and Blue Shield) to 7.5% (UnitedHealthcare) as seen in Figure 13.

Figure 13 Commercial Market Per Capita TME Growth by Insurer (2023-2024)



Notes: Performance data are truncated for outliers and age/sex adjusted.

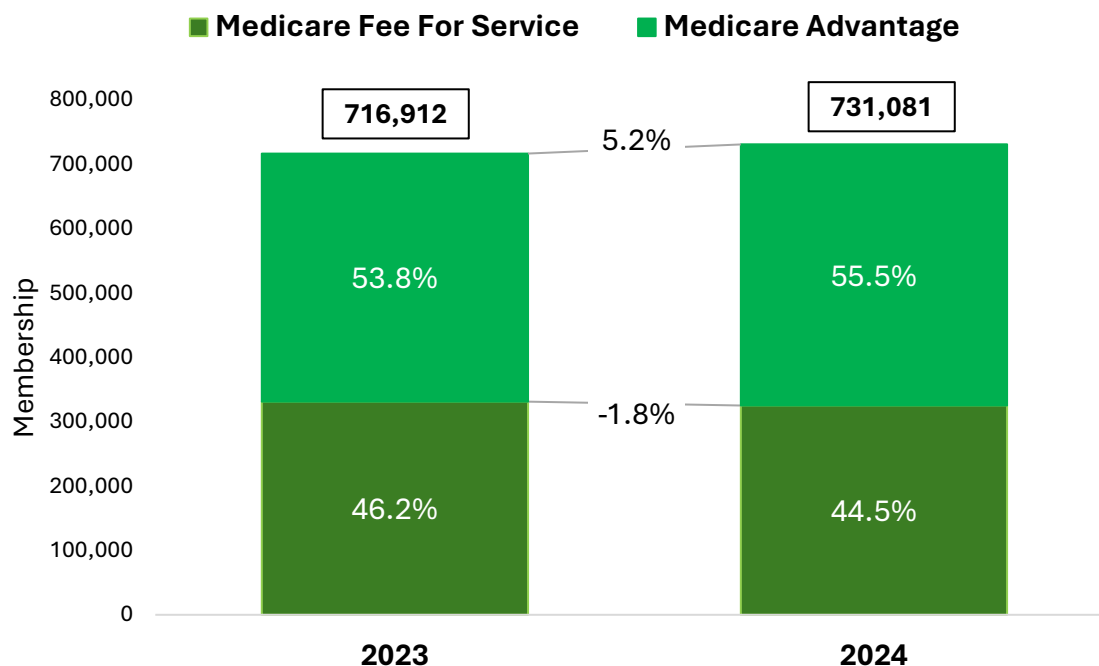
Medicare Market

Per capita healthcare spending in the Medicare market, representing approximately 730,000 covered lives (including dual eligible lives), slowed to 3.7%, meeting the benchmark. This is far below the 13.7% growth rate seen last year. The current growth was split between Medicare Advantage plans (administered by private insurers, 4.2%) and Medicare Fee for Service (FFS) (administered by the federal government, 3.3%). Per capita spending in 2024 was \$18,157.

Section 1: Cost Growth Benchmark

During this period, overall Medicare membership grew by 2.0%, led by a 5.2% growth in Medicare Advantage. Medicare FFS, Parts A and B, experienced a 1.8% membership decrease as seen in Figure 14.

Figure 14 Covered Lives by Medicare Plan Type (2023-2024)

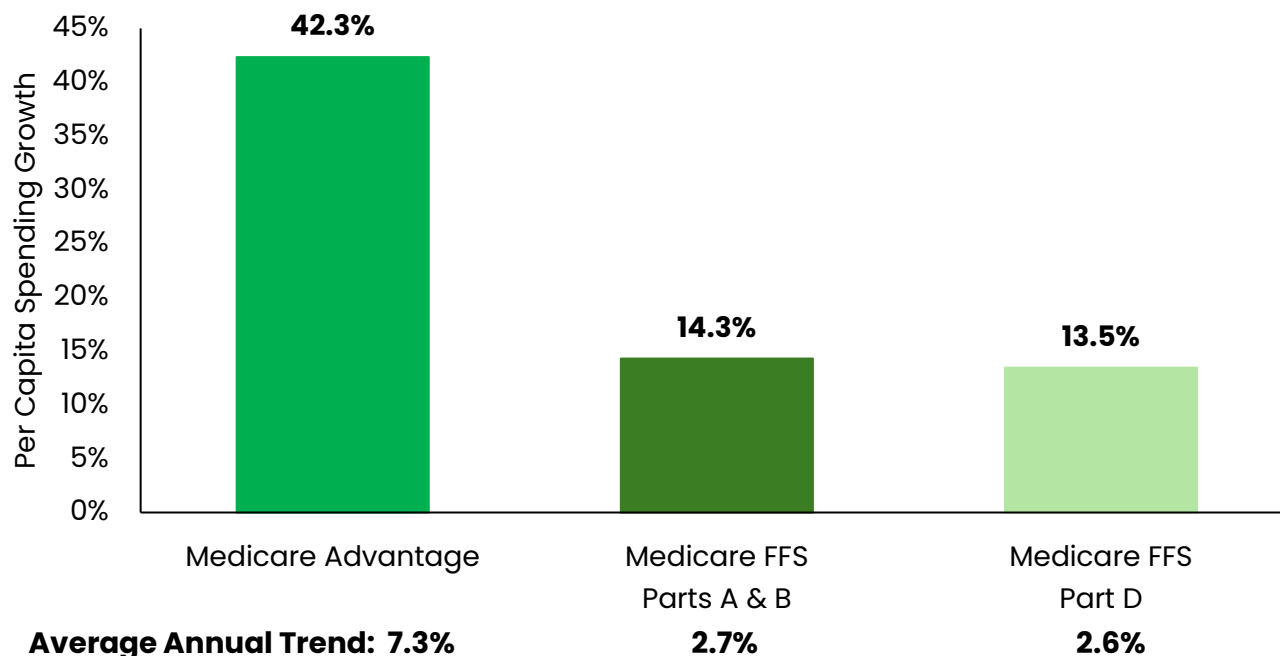


Note: Dual eligible members are included. Medicare FFS includes Part A and B.

Over the last five years, from 2019-2024, Medicare Advantage plans experienced a cumulative per capita spending increase of approximately 42%, or about 7.3% per year (see Figure 15). Meanwhile, Medicare FFS (which includes Medicare Parts A-hospital coverage, B-medical coverage, and D-pharmacy services coverage) has seen smaller increases in per capita spending over the same period, averaging less than 3% per year. Medicare Advantage plans must cover all medically necessary services that traditional Medicare FFS covers and they often offer additional benefits like vision or dental coverage or certain wellness services.

Section 1: Cost Growth Benchmark

Figure 15 Cumulative Medicare Per Capita TME Growth (2019-2024)



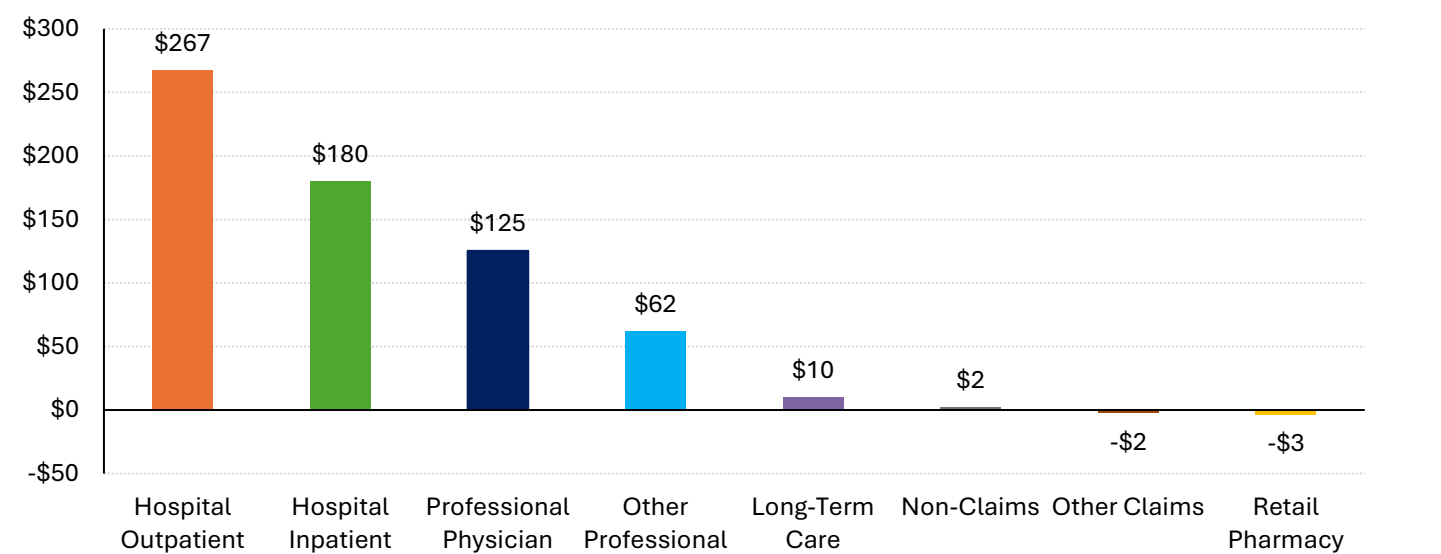
Notes: Data are not age/sex adjusted. Medicare Advantage is reported net of rebates. Dual Eligibles are included. Reporting period reflects the most accurate data available, including resubmissions.

In last year's report, OHS identified that the Medicare spending growth of 13.7% for 2022-2023 was largely driven by a more-than 350% increase in non-claims spending. That increase was attributed to a single Medicare Advantage payer (UnitedHealthcare) moving certain contracts from a fee-for-service model (in which payments would be associated with a claim and service category) to a percent-of-premium payment (in which there is a single, non-claims payment for certain bundled services). This year, non-claims spending growth was flat, indicating that last year's growth trend may have been an exception.

Section 1: Cost Growth Benchmark

The greatest per capita spending contributions to the 2024 Medicare trend were seen in the outpatient and inpatient hospital service categories, see Figure 16.

Figure 16 Medicare Per Capita Contribution to TME Spending Growth by Service Category (2023-2024)



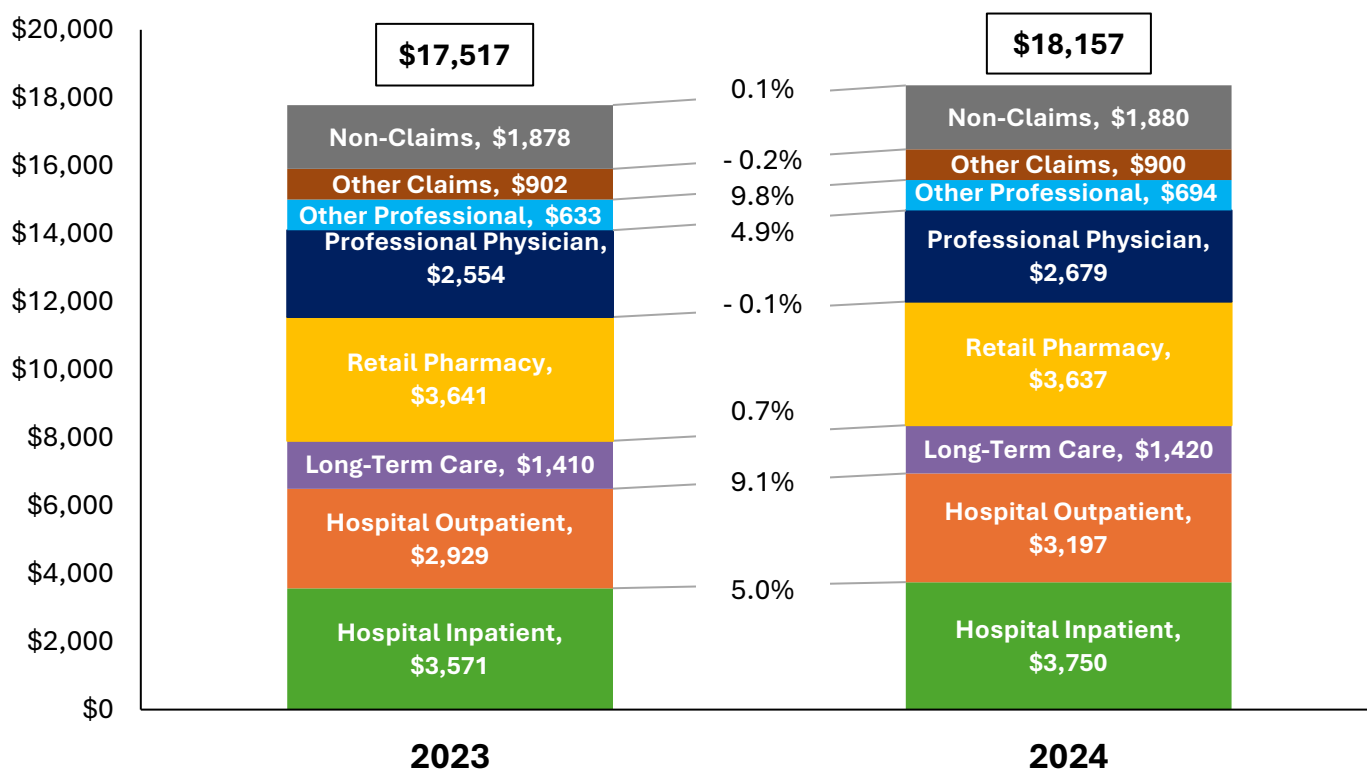
Notes: Data are not age/sex adjusted and data are reported net of pharmacy rebates.

Hospital inpatient was the largest category of spending in Medicare, with over \$3,700 spent on a per capita basis. Retail pharmacy had essentially 0% trend, in sharp contrast to all other markets and a substantial change from the historical growth patterns seen in retail pharmacy in the Medicare market. Despite not growing, retail pharmacy remains the second largest service category in 2024.

Section I: Cost Growth Benchmark

As seen in Figure 17, hospital outpatient services (9.1%) and other professional (9.8%) services had the greatest one-year percent increases. Despite a large increase in spending within the Other Professional service category, which includes certain payments to other healthcare professionals such as behavioral health services and allied health services, among others, it remains a smaller spending category.

Figure 17 Medicare Per Capita TME by Service Category (2023-2024)

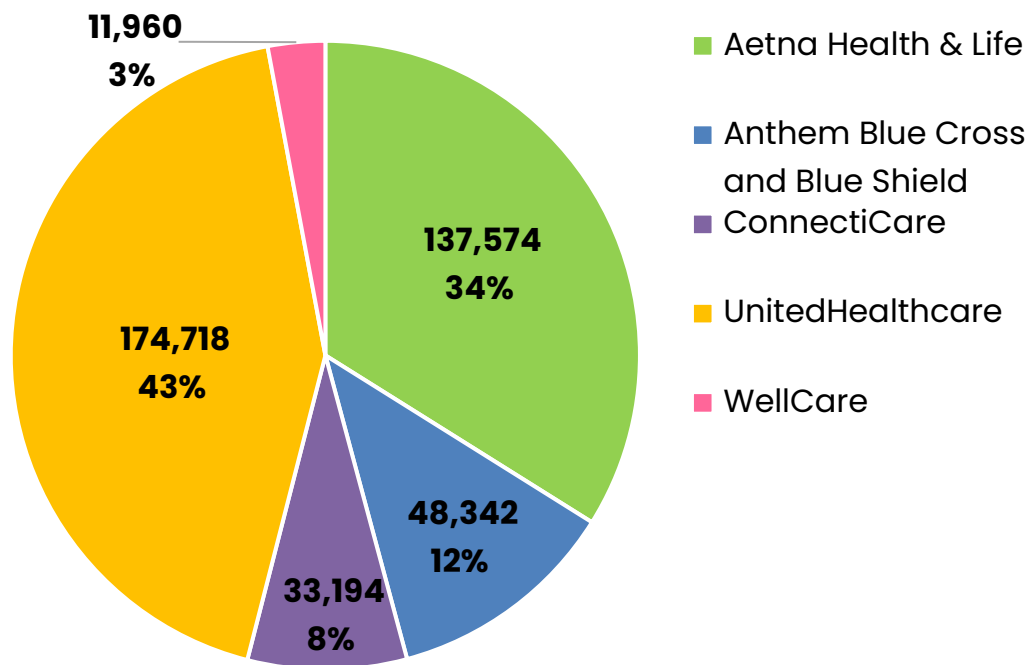


Notes: Data are not age/sex-adjusted, and data are reported net of pharmacy rebates.

Section 1: Cost Growth Benchmark

When looking at market membership in Figure 18, UnitedHealthcare and Aetna Health and Life have the most members in the Medicare Advantage market. WellCare provided data for the first time this year and the payer's lives and performance are shown below.

Figure 18 Medicare Advantage Market Lives by Payer (2024)

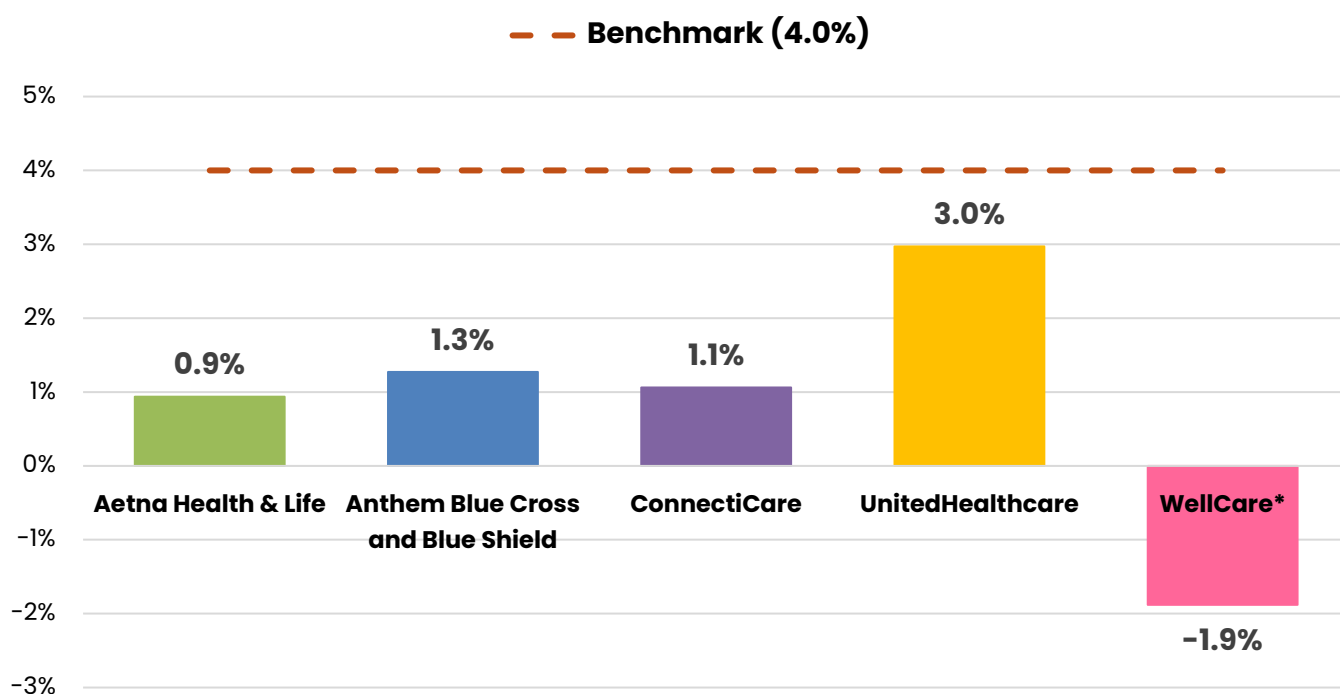


Note: Medicare Advantage reporting includes dual eligibles.

Section 1: Cost Growth Benchmark

All insurers met the cost growth benchmark in the Medicare Advantage market, with growth ranging from –1.9% to 3.0%, see Figure 19. OHS did not include WellCare’s data in the assessment of Advanced Networks in the Medicare Advantage market because they were not able to provide sufficiently detailed data to allow OHS to perform statistical testing or truncate for high-cost outliers. Additionally, WellCare did not include member cost sharing in their reported spending.

Figure 19 Medicare Advantage Per Capita TME Growth by Insurer (2023–2024)



Notes: Performance data are age/sex adjusted and truncated for outliers with the exception of *WellCare which was unable to truncate spending or provide standard deviations. Additionally, WellCare did not include member cost sharing in their reported spending.

Medicaid Market

Medicaid per capita spending, representing 1.2 million lives (including dual eligibles), increased by 14.0% to \$8,371 in 2024 – the fastest growing of the three markets.

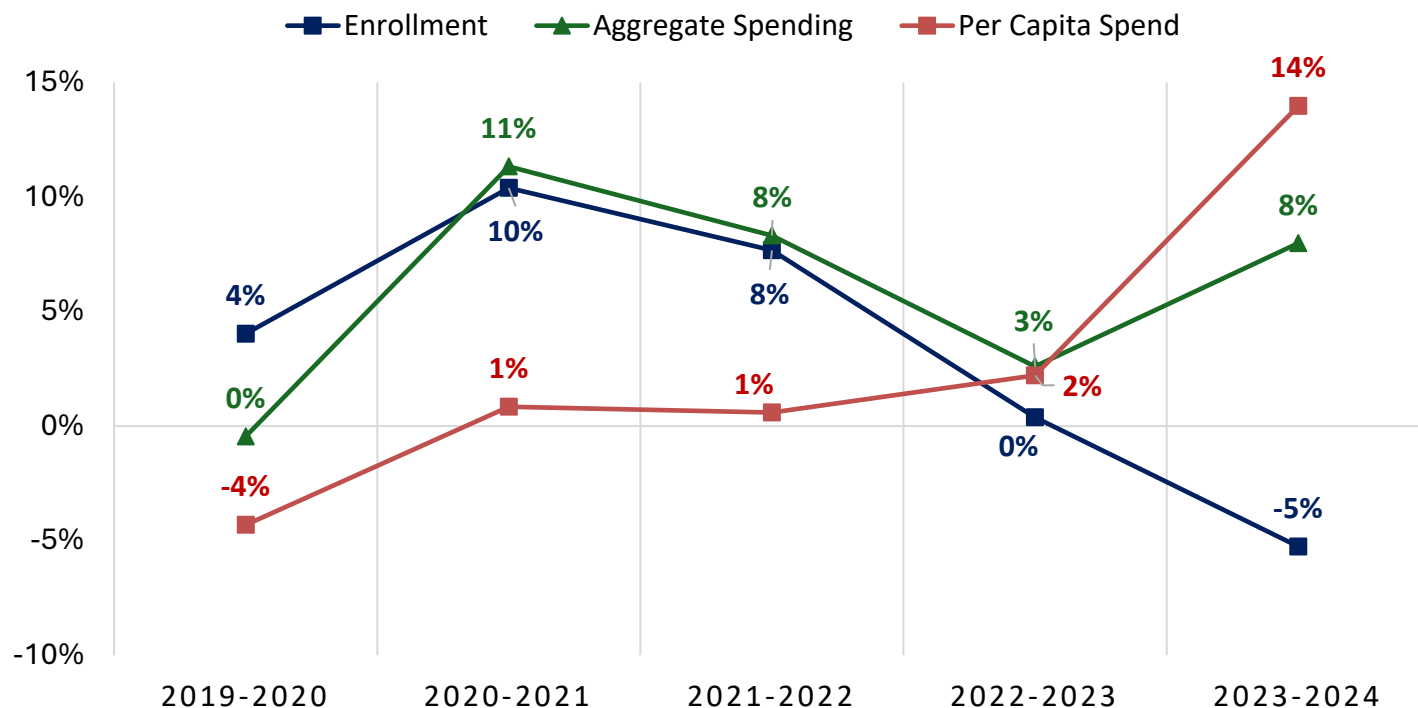
Medicaid enrollment during this period decreased 5.3%, and this was the first year in the last five years to show a decrease in covered lives. High Medicaid per capita spending growth this year represented a substantial shift from prior years, where growth had been modest or negative. This suggests that the program may have lost lower cost lives as a result of the Medicaid “unwinding” associated with the end of the temporarily expanded pandemic era coverage (the expanded coverage stabilized Medicaid enrollment by retaining lives who might have otherwise lost eligibility). Other states found that despite lower enrollment, spending grew due to provider rate

Section 1: Cost Growth Benchmark

increases, higher acuity among remaining enrollees, and rising long-term care and pharmacy costs.^{12, 13}

Figure 20 illustrates volatility in enrollment and spending during and since the pandemic.

Figure 20 Medicaid Year over Year Annual Trends in Enrollment and Spending (2019-2024)



Notes: Data are not age/sex adjusted, and data are reported net of pharmacy rebates.

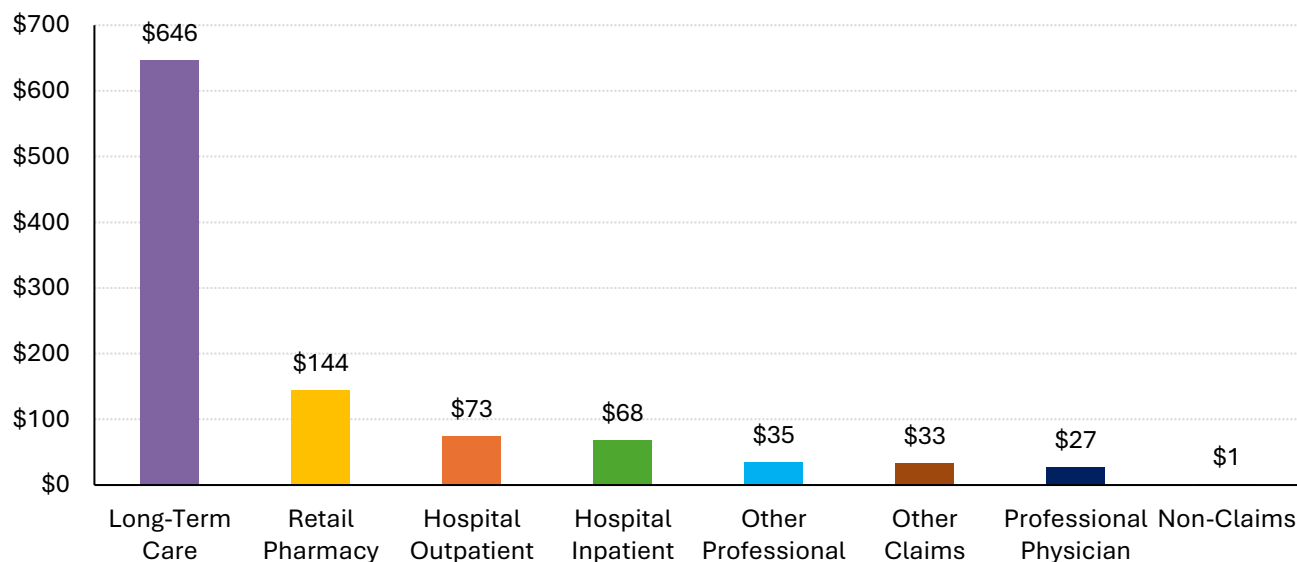
¹²Williams et al. "Medicaid Enrollment and Spending Growth Amid the Unwinding of the Continuous Enrollment Provision: FY 2023 & 2024" KFF, November 14, 2025 <https://www.kff.org/medicaid/medicaid-enrollment-and-spending-growth-amid-the-unwinding-of-the-continuous-enrollment-provision-fy-2023-2024/>

¹³ <https://www.kff.org/medicaid/state-medicare-officials-project-flat-enrollment-post-unwinding-but-increased-spending-and-budget-pressure-as-states-prepare-for-impact-of-federal-medicare-policy-changes/>

Section 1: Cost Growth Benchmark

Long-term care had the largest per capita spending impact, followed by retail pharmacy and hospital outpatient services. Long-term care comprised about 46% of all Medicaid spending in 2024. When excluding long-term care, Medicaid growth is 9.1%.

Figure 21 Medicaid Per Capita Contribution to TME Spending Growth by Service Category (2023-2024)

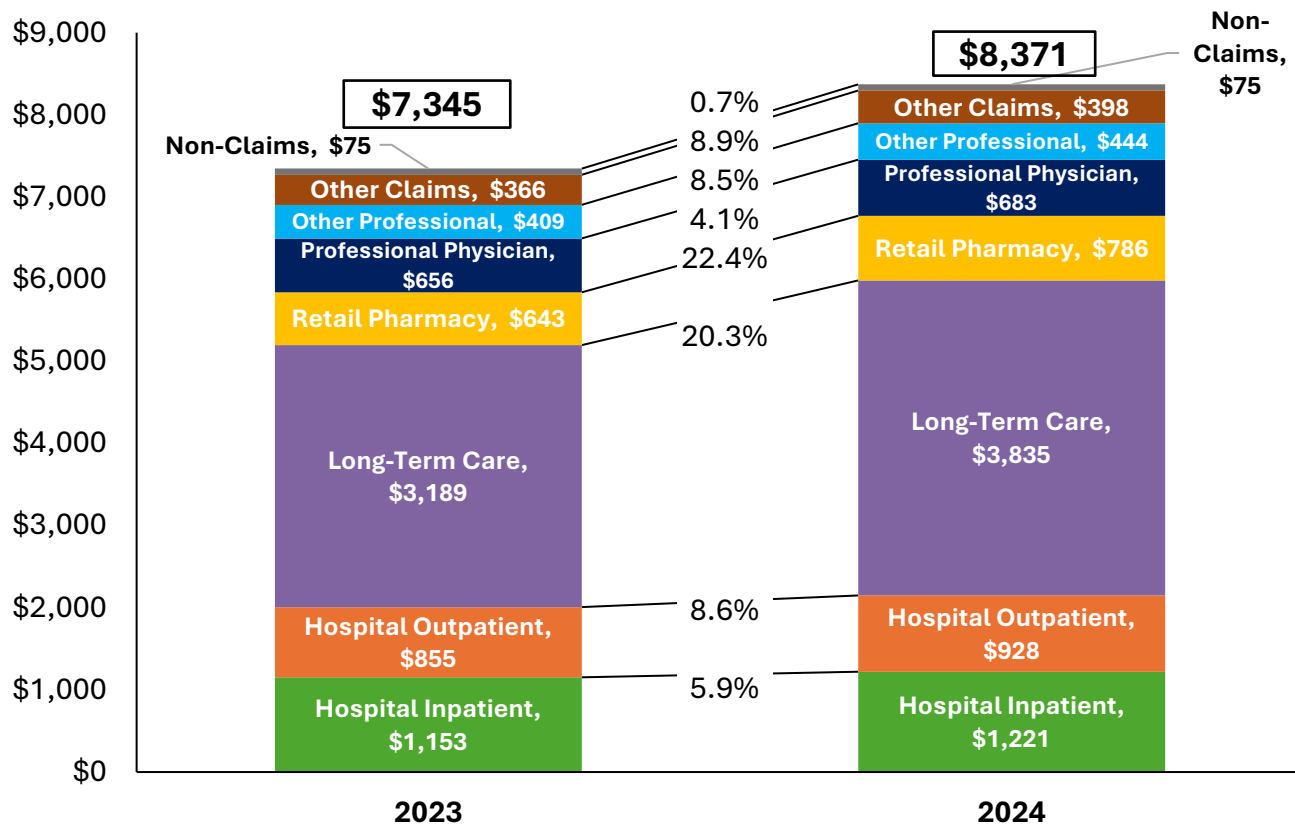


Notes: Data are not age/sex adjusted, and data are reported net of pharmacy rebates.

Section I: Cost Growth Benchmark

Retail pharmacy (22.4%) and long-term care (20.3%) increased substantially compared to all other service categories, as seen in Figure 22.

Figure 22 Medicaid Per Capita TME by Service Category (2023-2024)



Notes: Data are not age/sex adjusted, and data are reported net of pharmacy rebates

Section 1: Cost Growth Benchmark

Advanced Network Performance

OHS assessed Advanced Network (AN) performance against the cost growth benchmark, as required by Conn. Gen. Stat. [§ 19a-754g et. seq.](#)

In the [2023 Cost Growth Benchmark Advanced Network Supplement](#), OHS identified potential differences in spending growth between hospital-affiliated and non-hospital affiliated ANs. This year, OHS did not identify substantive differences in the spending growth between these types of ANs. The Medicaid market had the highest per capita spending trend for ANs, see Table 6.

Table 6 Advanced Network Per Capita TME Performance Trends by Market and Type (2023–2024)

Market	Advanced Network Type	# of ANs*	# of ANs Met Benchmark	2024 Mbr Mos	Per Capita TME Trend
Commercial	All	16	2	8,798,692	6.7%
	Hospital Affiliated	11	2	5,501,983	6.7%
	Non-Hospital Affiliated	5	0	3,296,709	6.7%
Medicare Advantage	All	12	4	3,182,280	3.5%
	Hospital Affiliated	8	3	1,859,069	3.3%
	Non-Hospital Affiliated	4	1	1,323,211	3.9%
Medicaid	All	26	2	6,280,275	9.0%
	Hospital Affiliated	10	1	2,255,620	8.8%
	Non-Hospital Affiliated	4	0	1,879,308	9.9%
	FQHC	12	1	2,145,347	8.3%

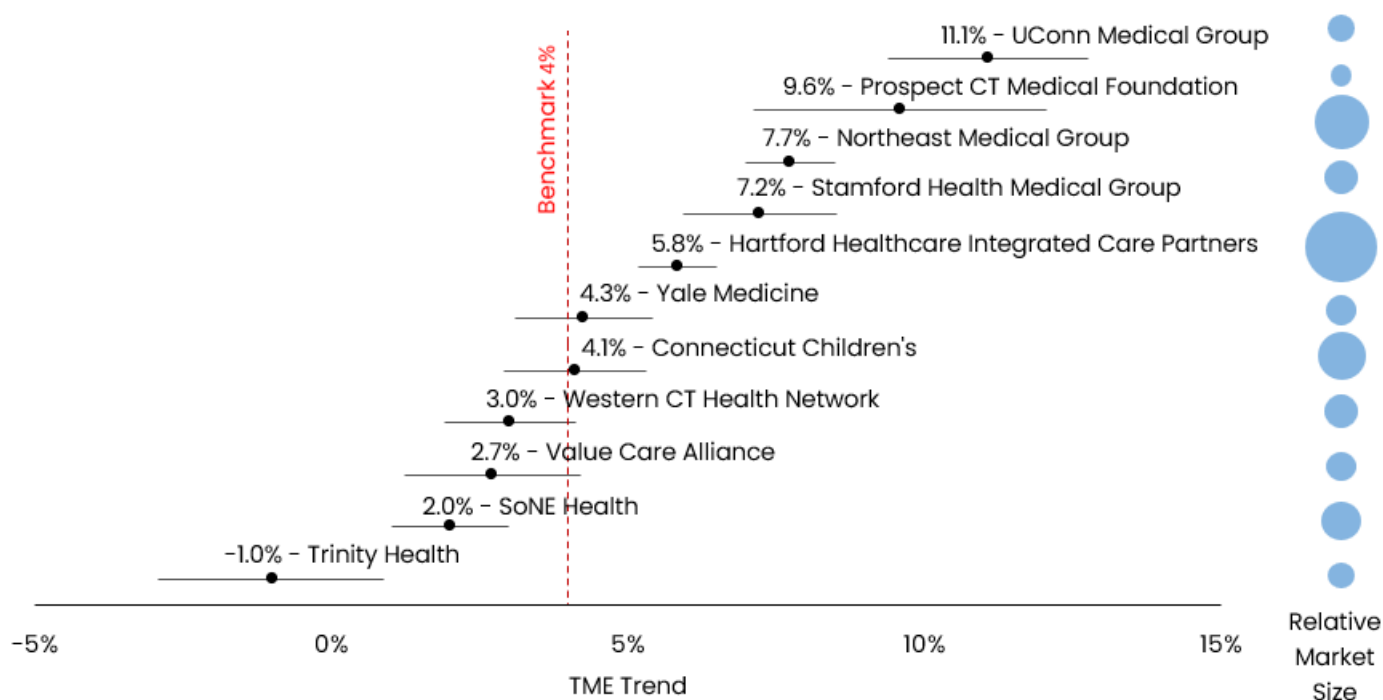
*Analysis limited to Advanced Networks meeting the minimum threshold of 60,000 member months in each reporting year. Unattributed lives and spending are excluded.

Section 1: Cost Growth Benchmark

Commercial Advanced Network Performance

Out of eleven **hospital-affiliated Advanced Networks**, five exceeded the benchmark in the commercial market, with spending change ranging from -1.0% to 11.1%, as shown in Figure 23. Spending growth for two Advanced Networks were below the benchmark. Four Advanced Networks could not be definitively classified as above or below the benchmark because their performance confidence interval intersected the benchmark value. The per capita TME trend for this group was 6.7%.

Figure 23 Hospital-Affiliated Advanced Network Commercial TME Trends (2023-2024)

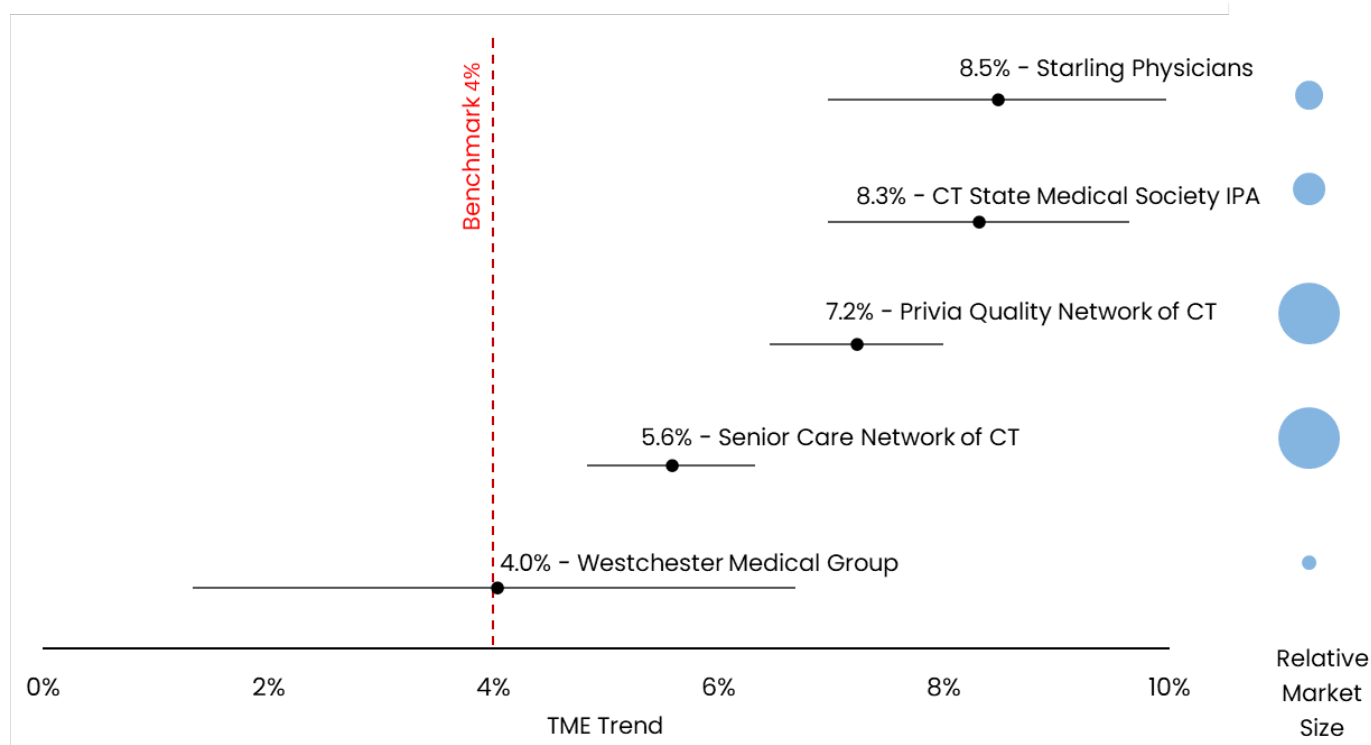


Notes: Data are truncated for outliers and age/sex adjusted. The points denote the year-over-year growth of an Advanced Network in a specific market, while the horizontal line through each point indicates the range of values, or confidence interval, within which OHS is 95 percent confident the actual performance lies. The larger the bubble on the right, the larger the relative membership is for that Advanced Network.

Section 1: Cost Growth Benchmark

Among **non-hospital-affiliated Advanced Networks**, commercial market spending growth ranged from 4.0% to 8.5%, with four out of five exceeding the benchmark, as shown in Figure 24. The per capita TME trend for this group was 6.7%. One advanced network could not be definitively classified as above or below the benchmark because its performance confidence interval intersected the benchmark value.

Figure 24 Non-Hospital-Affiliated Advanced Network Commercial TME Trends (2023-2024)



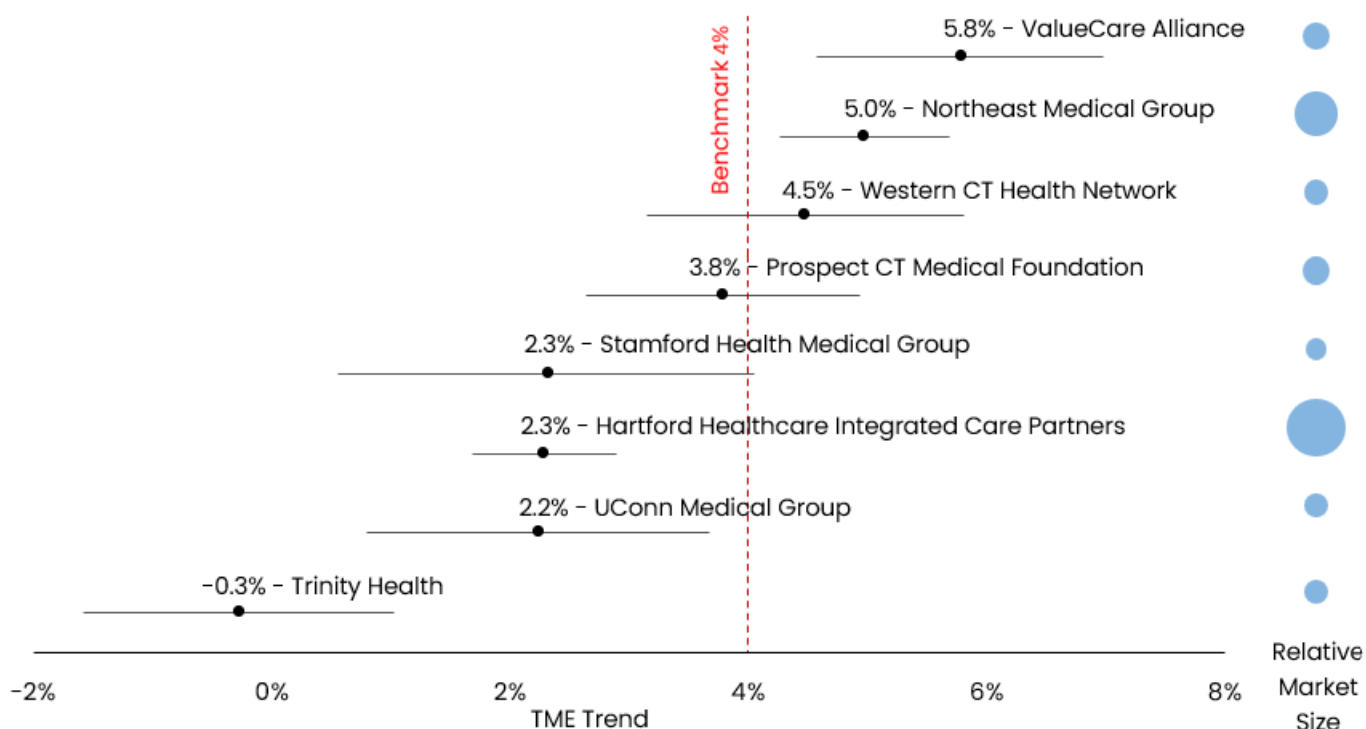
Notes: Data are truncated for outliers and age/sex adjusted. The points denote the year-over-year growth of an Advanced Network in a specific market, while the horizontal line through each point indicates the range of values, or confidence interval, within which OHS is 95 percent confident the actual performance lies. The larger the bubble on the right, the larger the relative membership is for that Advanced Network.

Section 1: Cost Growth Benchmark

Medicare Advantage Advanced Network Performance

Eight **hospital-affiliated Advanced Networks** had spending growth ranging from -0.3% to 5.8% in the Medicare Advantage market. Three met the benchmark, two were above the benchmark, and three Advanced Networks could not be definitively classified as above or below the benchmark because their performance confidence interval intersected the benchmark value. The per capita TME trend for this group was 3.3%.

Figure 25 Hospital-Affiliated Advanced Network Medicare Advantage TME Trends (2023-2024)

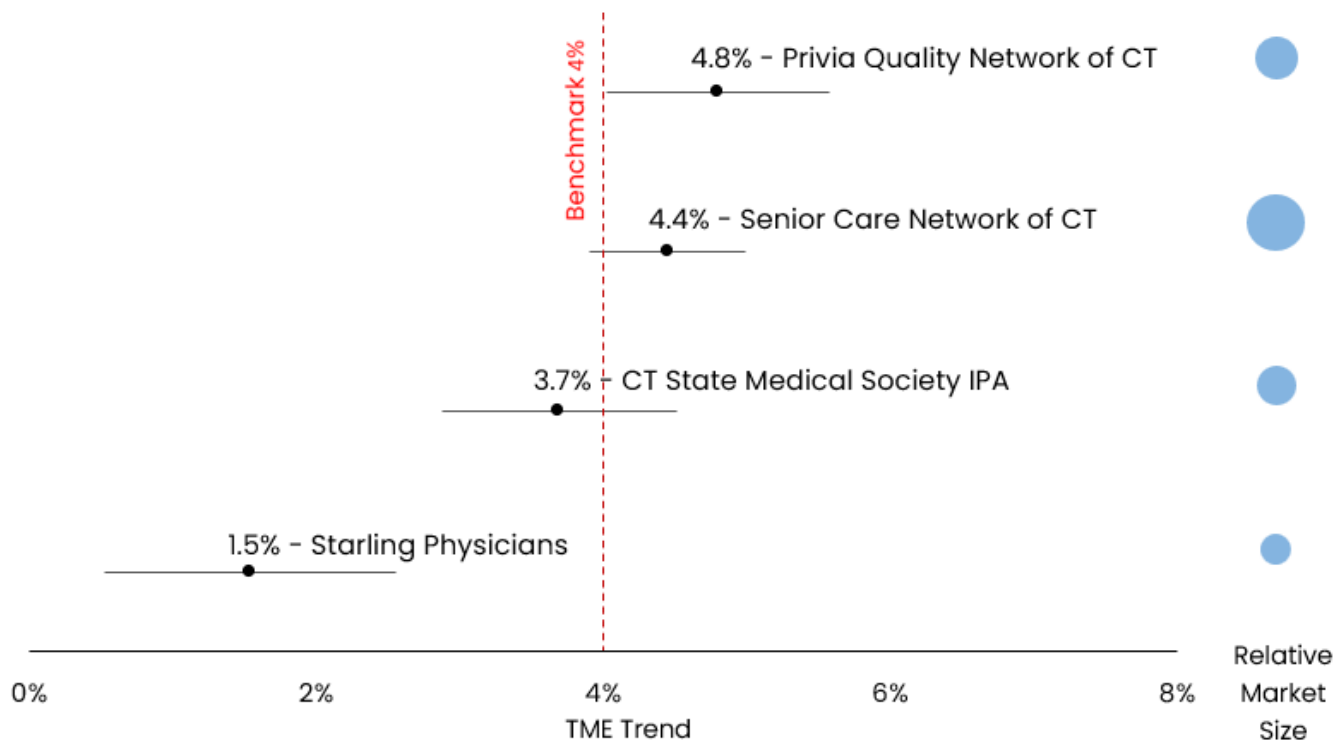


Notes: Data are truncated for outliers and age/sex adjusted. The points denote the year-over-year growth of an Advanced Network in a specific market, while the horizontal line through each point indicates the range of values, or confidence interval, within which OHS is 95 percent confident the actual performance lies. The larger the bubble on the right, the larger the relative membership is for that Advanced Network.

Section 1: Cost Growth Benchmark

Only one of the four **non-hospital-affiliated Advanced Networks** in the Medicare Advantage market met the benchmark. The growth for these Advanced Networks ranges from 1.5% to 4.8%, as shown in Figure 26. The per capita TME trend for this group was 3.9%.

Figure 26 Non-Hospital-Affiliated Advanced Network Medicare Advantage TME Trends (2023-2024)



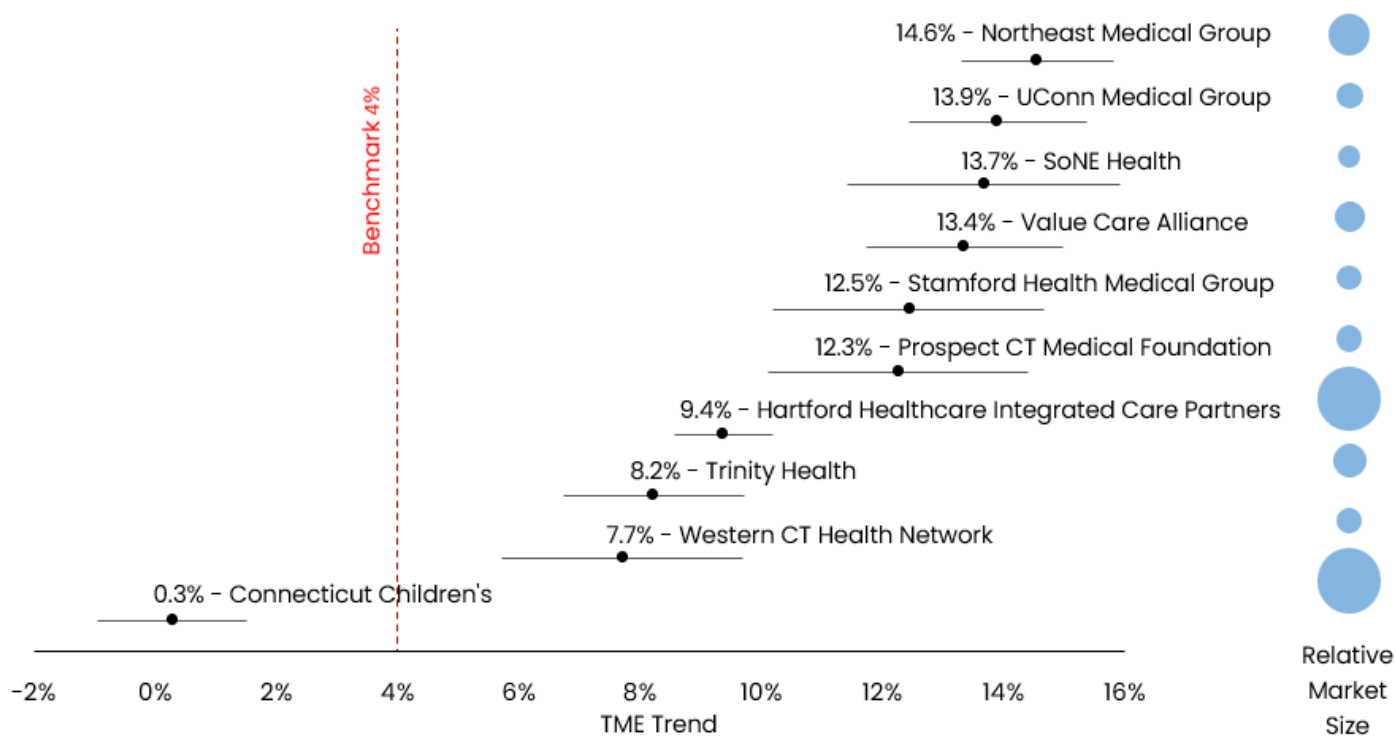
Notes: Data are truncated for outliers and age/sex adjusted. The points denote the year-over-year growth of an Advanced Network in a specific market, while the horizontal line through each point indicates the range of values, or confidence interval, within which OHS is 95 percent confident the actual performance lies. The larger the bubble on the right, the larger the relative membership is for that Advanced Network.

Section 1: Cost Growth Benchmark

Medicaid Advanced Network Performance

One **hospital-affiliated Advanced Network** met the benchmark in the Medicaid market with a performance trend of 0.3%. The remaining nine exceeded the cost growth benchmark in this market. The spending growth for all hospital-affiliated Advanced Networks ranged from 0.3% to 14.6%, as shown in Figure 27. The per capita TME trend for this group was 8.8%.

Figure 27 Hospital-Affiliated Advanced Network Medicaid TME Trends (2023-2024)

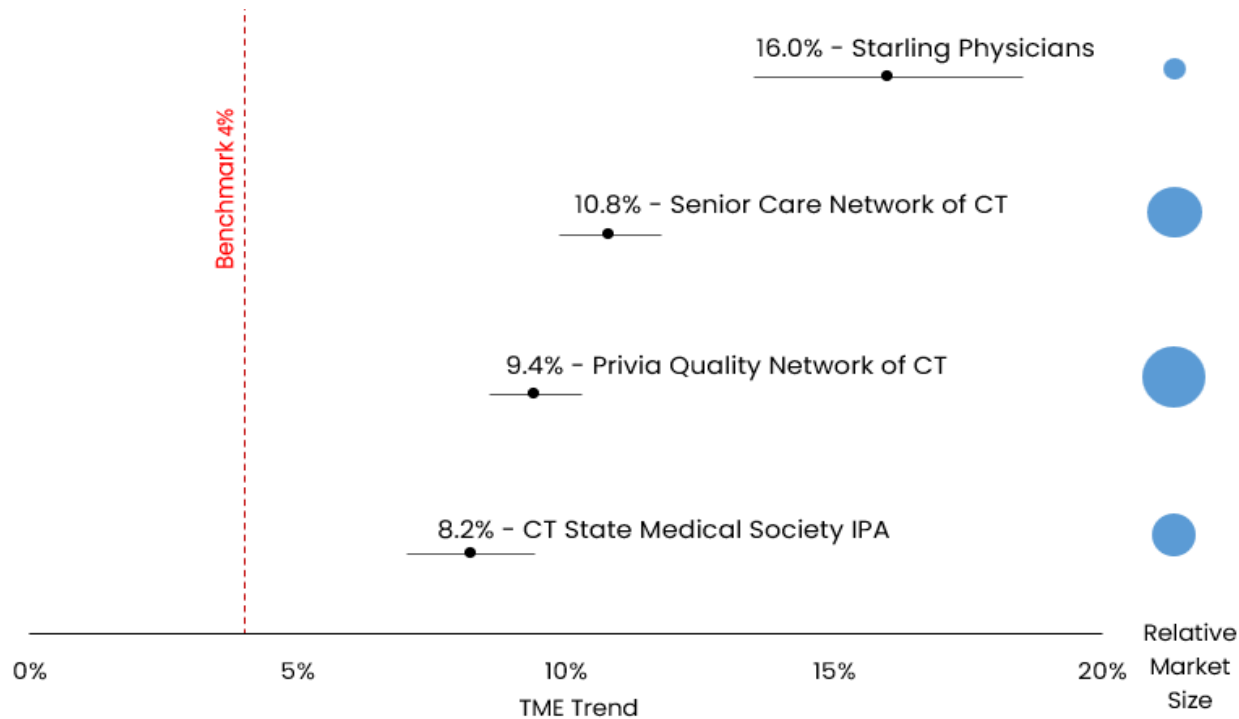


Notes: Data are truncated for outliers and age/sex adjusted. Data do not include Medicaid spending on the dually eligible population. The points denote the year-over-year growth of an Advanced Network in a specific market, while the horizontal line through each point indicates the range of values, or confidence interval, within which OHS is 95 percent confident the actual performance lies. The larger the bubble on the right, the larger the relative membership is for that Advanced Network.

Section 1: Cost Growth Benchmark

All four **non-hospital-affiliated Advanced Networks** substantially exceeded the benchmark with growth ranging from 8.2% to 16.0% as seen in Figure 28. The per capita TME trend for this group was 9.9%.

Figure 28 Non-Hospital-Affiliated Advanced Network Medicaid TME Trends (2023-2024)

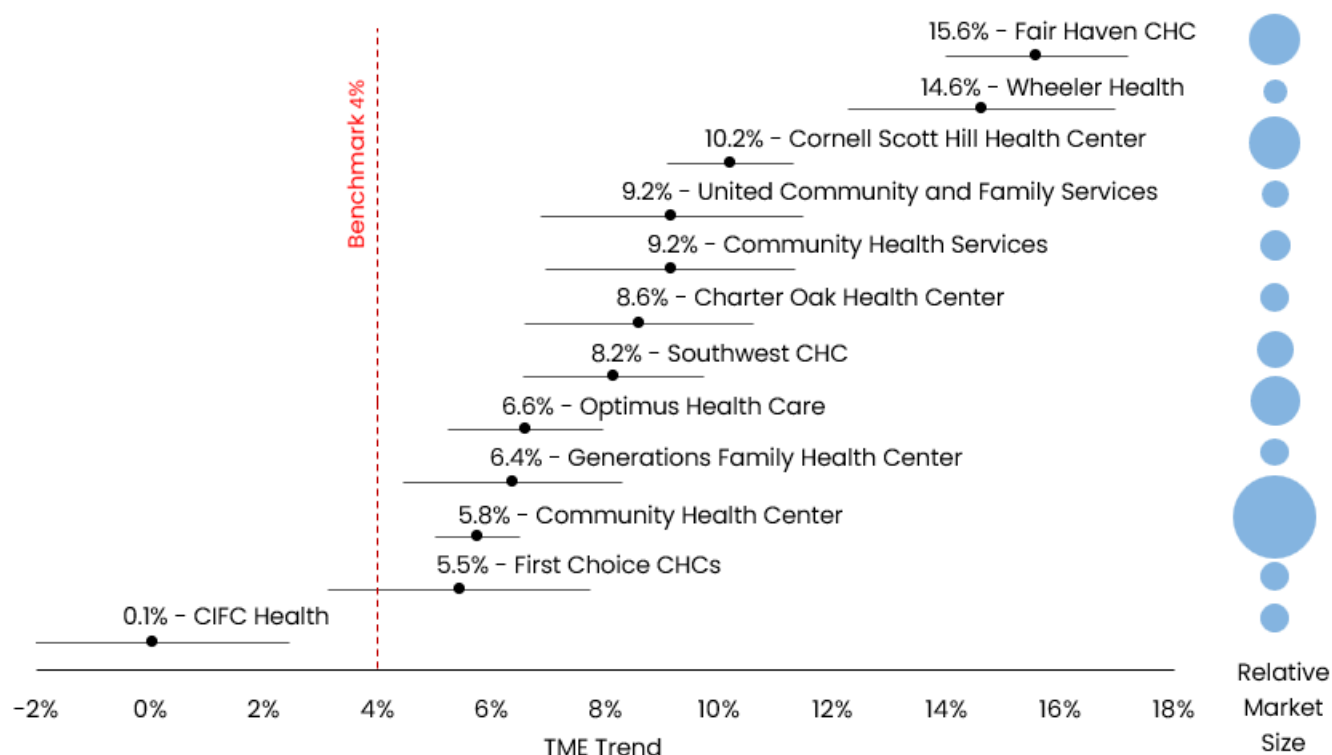


Notes: Data are truncated for outliers and age/sex adjusted. Data do not include Medicaid spending on the dually eligible population. The points denote the year-over-year growth of an Advanced Network in a specific market, while the horizontal line through each point indicates the range of values, or confidence interval, within which OHS is 95 percent confident the actual performance lies. The larger the bubble on the right, the larger the relative membership is for that Advanced Network.

Section 1: Cost Growth Benchmark

Federally Qualified Health Centers (FQHCs) serve a large proportion of the Medicaid market. One out of the twelve FQHCs met the benchmark with a 0.1% performance trend. Ten FQHCs exceeded the benchmark in this market, with spending growth ranging from 5.8% to 15.6% as shown in Figure 29. One FQHC could not be definitively classified as above or below the benchmark because their performance confidence interval intersected the benchmark value. The per capita TME trend for this group was 8.3%.

Figure 29 Federally Qualified Health Center-Affiliated Advanced Network Medicaid TME Trends (2023-2024)



Notes: Data are truncated for outliers and age/sex adjusted. Data do not include Medicaid spending on the dually eligible population. The points denote the year-over-year growth of an Advanced Network in a specific market, while the horizontal line through each point indicates the range of values, or confidence interval, within which OHS is 95 percent confident the actual performance lies. The larger the bubble on the right, the larger the relative membership is for that Advanced Network. CHC is an abbreviation for Community Health Center.

Section 1: Cost Growth Benchmark

Performance by Market, Advanced Network, and Attribution Tier

Membership, claims, and non-claims data are attributed to Advanced Networks by payers based on associated provider tax identification numbers (TINs), provided by Advanced Networks, and are analyzed by attribution tier. Members are assigned to attribution tiers in hierarchical order, with Tier 1 based on a member selecting a primary care provider in that Advanced Network, Tier 2 based on a member's inclusion in a contractual total cost of care arrangement (or other contractual arrangement) between an Advanced Network and a payer, and Tier 3 based on whether a member utilized services from a primary care provider in that Advanced Network. Advanced Networks may have more direct accountability and opportunity to manage care for members in Tiers 1 and 2 than for those in Tier 3, where attribution is based on claims history. This year, OHS did not identify consistent spending growth patterns by attribution tier. Further description of attribution can be found in Appendix A.

In addition, per member per month (PMPM) costs vary by market, with Medicare Advantage spending approximately double that of the commercial and Medicaid markets. While Medicaid had a significantly higher spending trend than any other market, it also had the lowest PMPM spending, in part due to lower payment rates. As shown in Table 7 and Figure 30, only 3.1% of Medicaid lives are attributed to Tier 1 or Tier 2. While Medicaid had the highest Tier 1 and Tier 2 growth rates, the small number of lives attributed by member selection and contractual arrangements are not sufficient to draw conclusions.

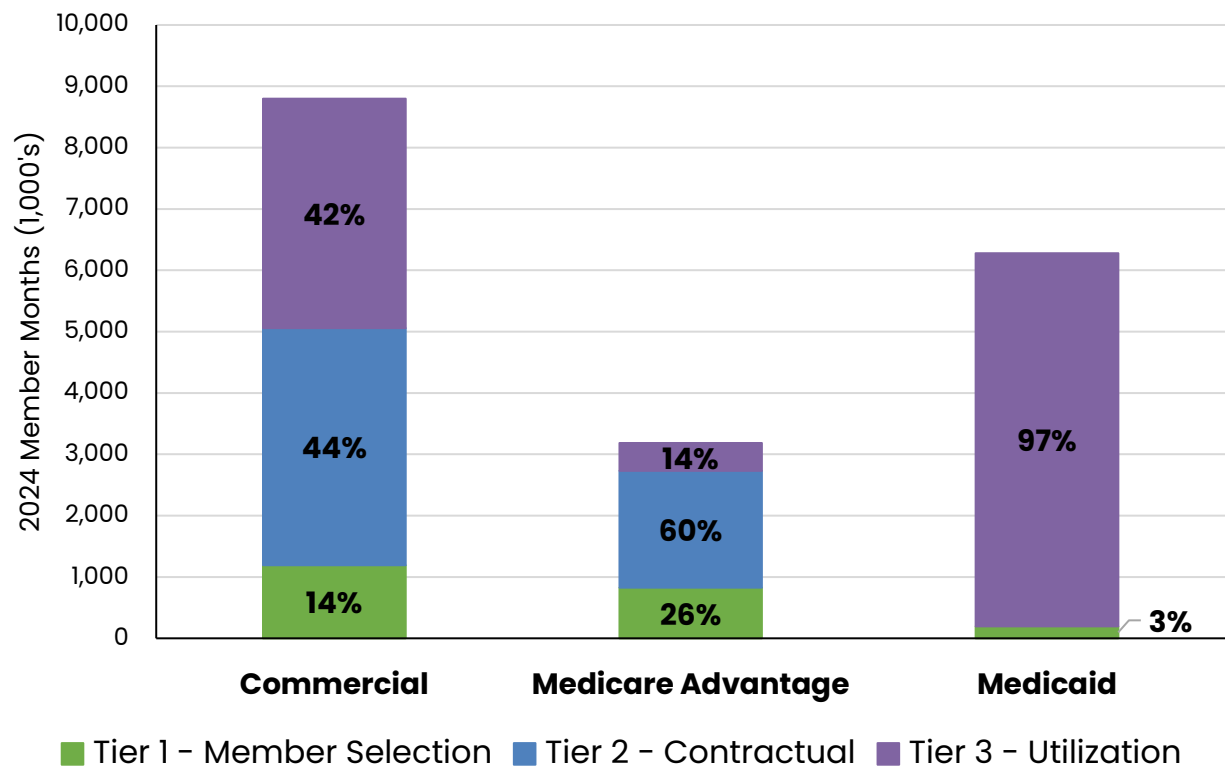
Table 7 Per Capita TME Spending Trend by Market and Attribution Tier (2023–2024)

Market	# of ANs*	2024 PMPM	% Mbr Mos in Tiers 1 & 2	PMPM Spending Trend		
				Tiers 1 & 2	Tier 3	All Tiers
Commercial	16	\$877	57.5%	7.7%	5.1%	6.7%
Medicare Advantage	12	\$1,636	85.8%	2.8%	8.2%	3.5%
Medicaid	26	\$833	3.1%	36.7%	8.2%	9.0%

*Analysis limited to Advanced Networks meeting the minimum threshold of 60,000 member months in each reporting year. Unattributed lives and spending are excluded.

Section 1: Cost Growth Benchmark

Figure 30 Advanced Network Member Months by Market and Attribution Tier (2024)



Notes: Analysis limited to Advanced Networks meeting the minimum threshold of 60,000 member months in each reporting year. Unattributed lives are excluded.

Section 1: Cost Growth Benchmark

Individual Advanced Network per capita TME trend by tier is provided in Tables 8 and 9 for the commercial and Medicare Advantage markets, respectively. These data are not provided for the Medicaid market by Advanced Network because of the small proportion of lives in Tiers 1 and 2.

Table 8 Commercial Market Advanced Network TME Spending Trend by Attribution Tier (2023-2024)

Advanced Network	PMPM Spending Trend		
	Tiers 1&2	Tier 3	All Tiers
Connecticut Children's	7.0%	0.6%	4.1%
Connecticut State Medical Society IPA	7.5%	9.5%	8.3%
Hartford Healthcare Integrated Care Partners	4.4%	8.3%	5.8%
Northeast Medical Group	9.0%	6.5%	7.7%
Privia Quality Network of CT	8.9%	3.2%	7.2%
Prospect Connecticut Medical Foundation Inc.	8.0%	13.3%	9.6%
Senior Care Network of CT	6.8%	3.2%	5.6%
SoNE Health (Southern New England Health Care Org.)	2.2%	4.9%	2.0%
Stamford Health Medical Group	5.9%	8.5%	7.2%
Starling Physicians	8.9%	6.4%	8.5%
Trinity Health, Inc.	1.6%	-7.3%	-1.0%
UConn Medical Group	12.0%	9.0%	11.1%
ValueCare Alliance	3.8%	-1.5%	2.7%
Westchester Medical Group PLLC	5.9%	2.9%	4.0%
Western CT Health Network	8.0%	-1.2%	3.0%
Yale Medicine	4.8%	4.3%	4.3%

Notes: Data are truncated for outliers and age/sex adjusted at all tier levels. OHS requires 60,000 member months across all tiers for public reporting; the number of member months in any individual tier may be lower. Unattributed lives are excluded.

Section 1: Cost Growth Benchmark

Table 9 Medicare Advantage Advanced Network TME Spending Trend by Attribution Tier (2023 – 2024)

Advanced Network	PMPM Spending Trend		
	Tier 1&2	Tier 3	All Tiers
Connecticut State Medical Society IPA	4.9%	0.3%	3.7%
Hartford Healthcare Integrated Care Partners	-1.3%	12.7%	2.3%
Northeast Medical Group	4.8%	4.4%	5.0%
Privia Quality Network of CT	6.0%	-5.3%	4.8%
Prospect Connecticut Medical Foundation Inc.	3.1%	5.9%	3.8%
Senior Care Network of CT	2.9%	13.3%	4.4%
Stamford Health Medical Group	2.5%	0.1%	2.3%
Starling Physicians	1.3%	-2.6%	1.5%
Trinity Health, Inc.	-0.9%	1.3%	-0.3%
UConn Medical Group	2.0%	2.6%	2.2%
ValueCare Alliance	3.7%	4.8%	5.8%
Western CT Health Network	4.7%	-4.3%	4.5%

Notes: Data are truncated for outliers and age/sex adjusted for all tier levels. OHS requires 60,000 member months across all tiers for public reporting; the number of member months in any individual tier may be lower. Unattributed lives are excluded.

Section 2: Primary Care Spending Target

Section 2: Primary Care Spending Target

The statewide primary care spending target aims to increase primary care spending to 10 percent and is intended to rebalance and strengthen Connecticut’s healthcare system by supporting primary care. While the 2024 target was 8.5% of total medical expenses, primary care spending represented only 4.6% of total medical expenses. This marks the third consecutive reporting period in which Connecticut did not meet the statewide primary care spending target.

Avoidable emergency department costs contribute to high medical spending growth. An avoidable emergency department (ED) visit is an ED service that could be more cost effectively delivered in a primary care setting, and a high level of avoidable services may indicate a lack of primary care access or affordability. In 2024 there were over **500,000** avoidable ED visits, and more than **\$818 million** in associated payments, indicating an opportunity for the state to lower healthcare spending by increasing access to primary care.¹⁴

Measuring Primary Care

Connecticut state law ([C.G.S. § 19a-754f et. Seq.](#)) requires the Office of Health Strategy to measure primary care spending as a percentage of TME. The rationale for a primary care spending target is that investment in primary care increases access to high-quality primary care which is essential for health maintenance, disease prevention, chronic disease management and care coordination. Primary care investment improves the health of Connecticut residents and has the potential to decrease future healthcare costs. Measuring primary care spending as a percentage of TME can provide stakeholders – including policy makers, healthcare providers, purchasers, and healthcare payers – with actionable data to improve population health and access.

Primary care, for the purpose of the spending target, includes a specific list of more than 140 healthcare services ranging from annual wellness and back-to-school visits to vaccine administration. These primary care services are included in the primary care spending target when they are delivered by a primary care provider, which includes physicians and nurse practitioners practicing family medicine, internal medicine, pediatrics, and other service areas. Primary care clinicians deliver care in private group practices, Federally Qualified Health Centers (FQHCs), school-based health centers, nursing homes and in private, hospital and corporate-owned practices. A full list of primary care procedure codes, place of service codes, and provider

¹⁴ CT Hospital Association ChimeData Emergency Room Department Database

*CT Office of Health Strategy Annual Report on the Annual Status of Connecticut's Short-Term Acute Care Hospitals for Fiscal Year 2024.

Section 2: Primary Care Spending Target

taxonomy codes is available [online](#). For this analysis, spending on long-term care services is excluded from primary care spending.

Connecticut is one of approximately 20 states that measure primary care spending. While code-level definitions vary across states, most focus on core primary care specialties; only five include obstetricians/gynecologists (OB/GYNs) and certified nurse-midwives (CNMs) within their definitions. OHS has elected to use a narrow definition that concentrates on core primary care providers in order to align with the state's primary care investment goals. Although Connecticut has also established a broader *monitoring* definition for primary care that includes OB/GYNs, CNMs, and behavioral health clinicians, incorporating OB/GYN/CNM spending would increase the statewide share of TME by only 1% and would not materially change performance relative to the target. Even under that broader approach, no market and only one payer in one market—UnitedHealthcare in the commercial market—would meet the 2024 target.

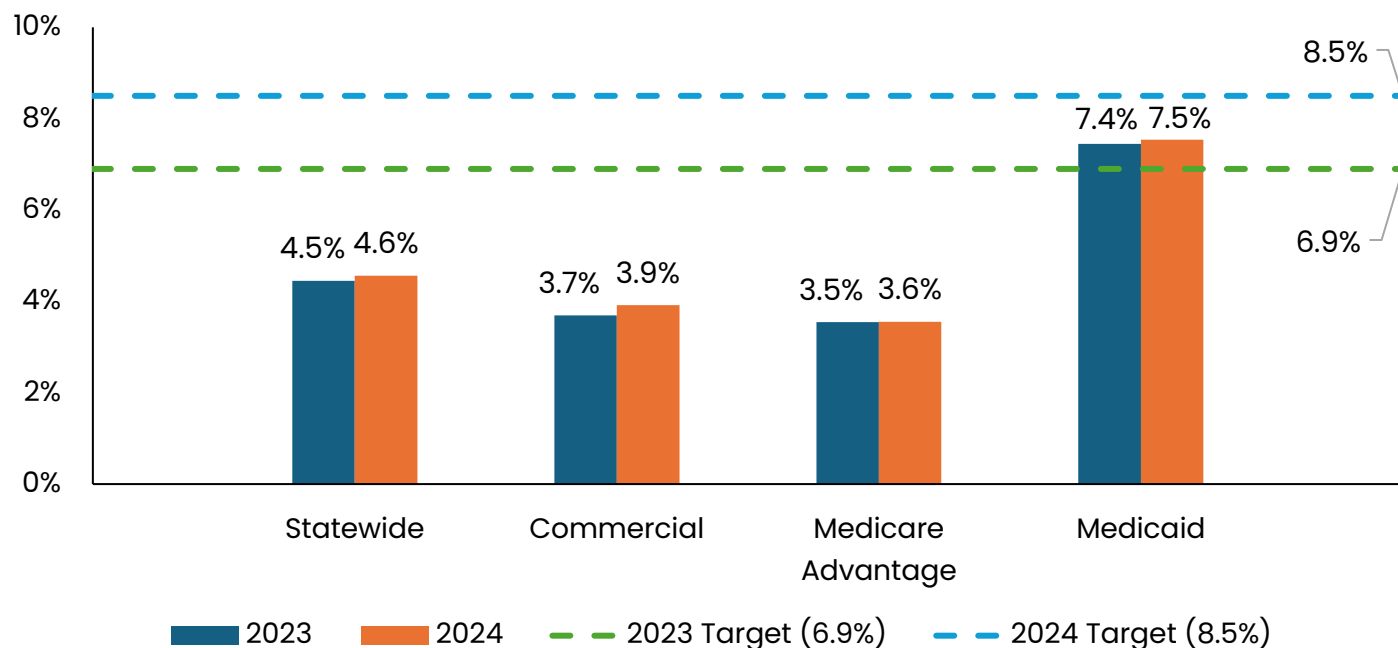
Primary Care Results – State, Market and Payer Performance

Statewide, total primary care spending grew by approximately \$105 million between 2023 and 2024, to \$1.2 billion. In aggregate, primary care spending increased almost 10% statewide, and almost 15% in the Commercial market. However, total medical expenses also grew substantially, resulting in only a small increase in primary care's share of overall spending.

Section 2: Primary Care Spending Target

Figure 31 illustrates each market's performance against the primary care spending target. The Medicaid market came closest to meeting the primary care spending target (and was the only market to have met the target in previous years) but all three markets missed the target in 2024.

Figure 31 Primary Care Spending as Percentage of TME v. the Primary Care Spending Target, for the State and by Market (2023-2024)



Note: Data excludes long-term care spending.

Aggregate spending on primary care grew both statewide and in each market.

Table 10 Aggregate Primary Care Spending Trends, by Market (2023-2024)

Market	Aggregate Primary Care Spending 2023	Aggregate Primary Care Spending 2024	Trend
Statewide	\$1,066,316,562	\$1,171,268,607	9.8%
Commercial	\$452,715,111	\$518,775,761	14.6%
Medicare Advantage	\$234,206,567	\$255,362,161	9.0%
Medicaid	\$379,394,884	\$397,130,685	4.7%

Section 2: Primary Care Spending Target

In addition, as shown in Table 11, PMPM primary care spending grew in every market. The PMPM trend differs from aggregate spending growth trend seen above due to market and demographic shifts in covered lives from year to year.

Table 11 Per Member Per Month Primary Care Spending Trends, by Market (2023-2024)

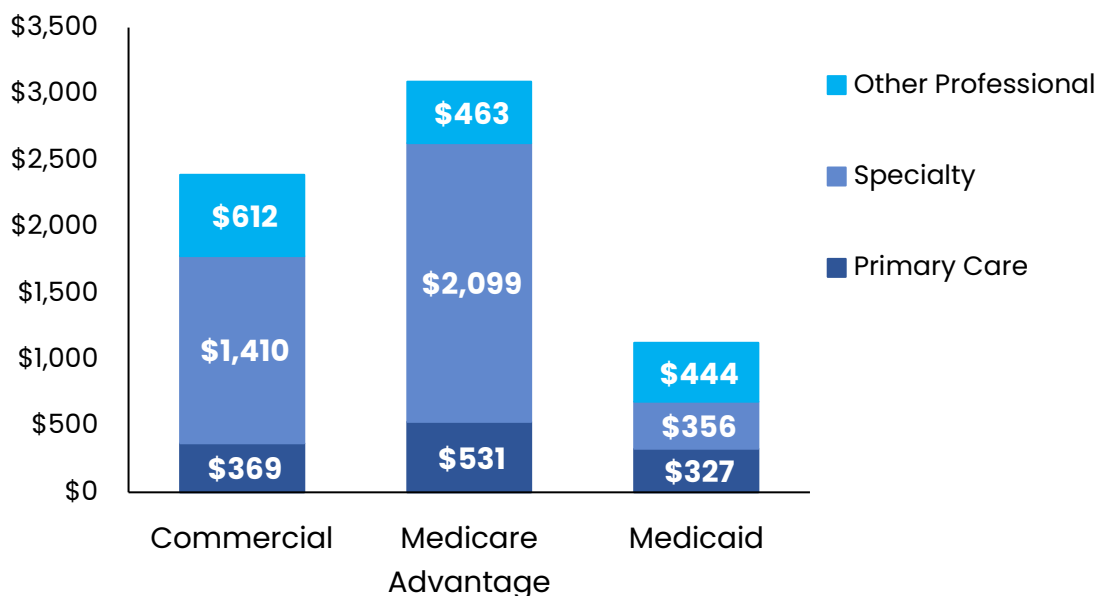
Market	PMPM Primary Care Spending (2023)	PMPM Primary Care Spending (2024)	Trend
Statewide	\$32	\$36	11.3%
Commercial	\$27	\$31	13.9%
Medicare Advantage	\$51	\$52	3.6%
Medicaid	\$26	\$29	10.5%

Note: Includes non-claims primary care payments.

Professional spending can be divided into three categories: primary care (spending associated with primary care practitioners); specialty (spending associated with clinicians providing specialty care); and other professional – spending which includes certain behavioral health services, dental care, chiropractic, dietician service, allied health services and other professional fees.

As seen in Figures 32 and 33, primary care spending makes up a relatively modest portion of overall professional spending within each market. The Medicaid market has the largest proportion – with 29% of professional spending on primary care services. Per capita spending on primary care was greatest within the Medicare Advantage market, at \$531 per capita in 2024.

Figure 32 Per Capita Professional Spending, by Market (2024)

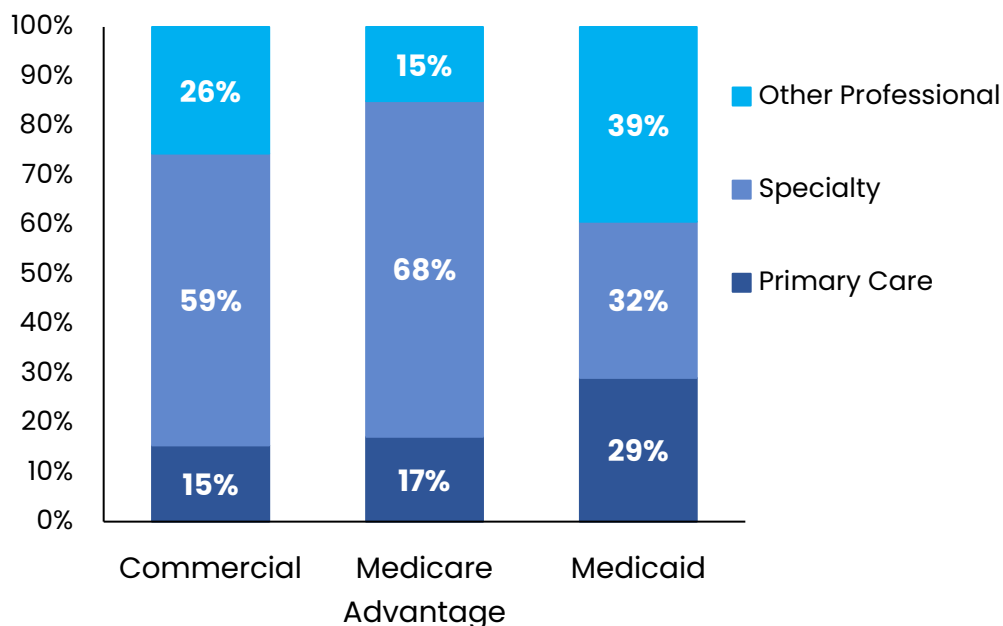


Note: Does not include non-claims primary care payments.

Section 2: Primary Care Spending Target

Data show the largest portion of spending on professional clinical services goes to specialty care in the Commercial and Medicare Advantage markets, while professional service spending in the Medicaid market was more evenly split among the three categories.

Figure 33 Primary Care as Percentage of Professional Spending, by Market (2024)

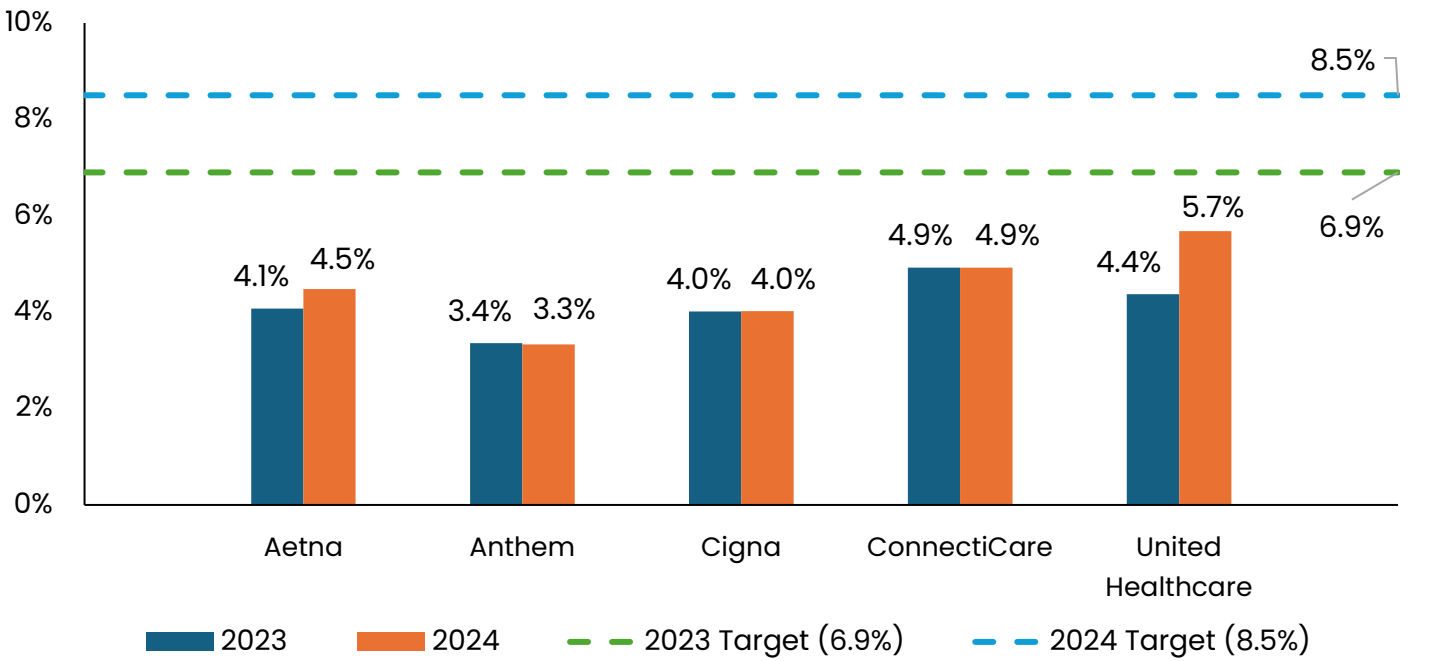


Note: Does not include non-claims primary care payments.

Section 2: Primary Care Spending Target

Taking a deeper look at the commercial market, no payer met the primary care spending target for 2024, with percentages ranging from a high of 5.7% by UnitedHealthcare and a low of 3.3% by Anthem, see Figure 34.

Figure 34 Commercial Primary Care Spending as a Percentage of Total Medical Expense Per Person Per Month (2023-2024)

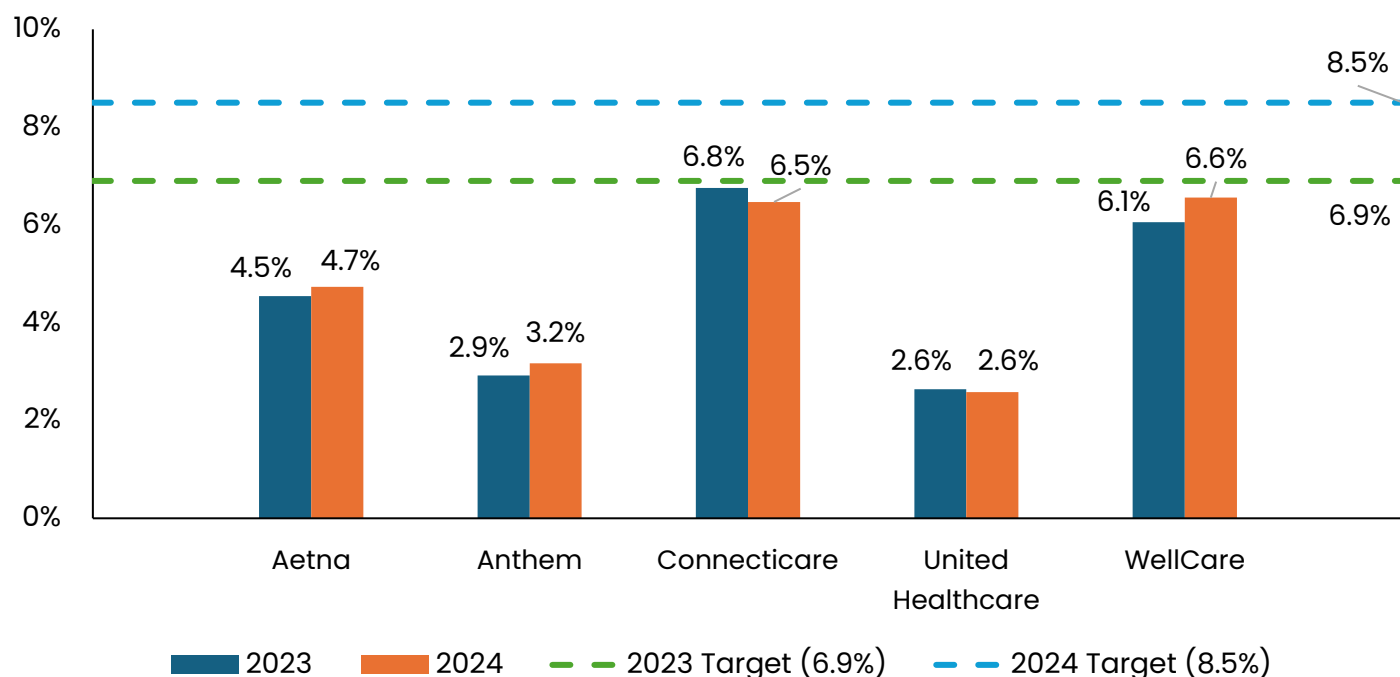


Note: WellCare did not include member cost sharing in their reported spending. Data excludes long-term care spending.

Section 2: Primary Care Spending Target

As seen in Figure 35, no payer met the primary care spending target for the Medicare Advantage market in 2024, with spending ranging from a high of 6.6% by WellCare to a low of 2.6% by UnitedHealthcare. Population variances and differences in reimbursement rates impact a payer's primary care spending.

Figure 35 Medicare Advantage Primary Care Spending as a Percentage of Total Medical Expense Per Person Per Month (2023-2024)



Note: WellCare did not include member cost sharing in their reported spending. Data excludes long-term care spending.

Primary Care in Context

A wide range of states, including Alabama, Arizona, California, Illinois, Massachusetts, Minnesota, Missouri, North Carolina, Virginia, and Wisconsin¹⁵ allocated greater percentages of their healthcare spending towards primary care than did Connecticut.

While Connecticut allocated 4.6% of overall statewide healthcare spending to primary care in 2024, access to primary care throughout the state may be further compromised by socio-demographic status, insurance type and other factors. According to the 2025 DataHaven Community Wellbeing Survey, 16% of Connecticut respondents say they do not have one person or place that they see as their personal healthcare provider, with the majority of those (68%)

¹⁵ Millbank Memorial Fund. 2026 Primary Care Scorecard Data Dashboard. <https://www.milbank.org/primary-care-scorecard/>, using the narrow definition of primary care.

Section 2: Primary Care Spending Target

indicating that this is because they have no provider at all.¹⁶ The survey found that respondents who identified as Black or Latino, those who had lower levels of educational attainment, and those with lower incomes were more likely to be without a medical home.

Primary care access limitations may be further exacerbated by primary care workforce challenges. Clinicians in Connecticut—including physicians, nurse practitioners, and physician assistants—are less likely to work in primary care as compared to the national average. According to the Milbank Memorial Fund's Primary Care Scorecard Data Dashboard¹⁷, about one-quarter (25%) of Connecticut's new physicians are entering the primary care workforce, compared to a national average of about 30%. Both New York and New Jersey have higher rates of physicians entering primary care.

State physician workgroups¹⁸, the National Academies of Science, Engineering and Medicine¹⁹ along with the team which assembled Connecticut's Rural Health Transformation Grant²⁰ have documented healthcare workforce shortages, especially in the context of the state's aging population.²¹ Nationally, primary care physicians have cited poor work-life balance, insufficient time with patients, dissatisfaction with compensation, and administrative burden²² as key challenges. These issues may constrain access to primary care, especially for individuals in asset-limited, income-constrained households.

¹⁶DataHaven. (2025). 2025 DataHaven Community Wellbeing Survey Connecticut Crosstabs. New Haven, CT: DataHaven. Available at <https://ctdatahaven.org/wellbeingsurvey>. Survey data report published October 26, 2025.

¹⁷Milbank Memorial Fund 2026 Primary Care Scorecard Data Dashboard <https://www.milbank.org/primary-care-scorecard/>

¹⁸ Connecticut Department of Public Health. (2024). *Physician Recruitment and Retention Working Group*. https://portal.ct.gov/dph/working-groups/physician-working-group?language=en_US

¹⁹ National Academies of Sciences, Engineering, and Medicine. (2021). *Implementing high-quality primary care: Rebuilding the foundation of health care*. The National Academies Press. <https://doi.org/10.17226/25983>

²⁰ Connecticut Department of Social Services. (2025, November 5). *CMS project narrative: Rural Health Transformation Program*. https://portal.ct.gov/dss/-/media/departments-and-agencies/dss/health-and-home-care/rural-health-transformation-program/cms_project_narrative_20251105.pdf

²¹ Tufts Health Plan Foundation & UMass Boston Gerontology Institute. (2025, April). *Connecticut healthy aging highlights 2025*. https://healthyagingdatareports.org/wp-content/uploads/2025/04/CT_Healthy_Aging_Highlights_2025.pdf

²² Bailey, S. R., & Abrams, M. K. (2025, October). *Administrative burden in primary care: Causes and potential solutions*. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2025/oct/administrative-burden-primary-care-causes-potential-solutions>

Section 2: Primary Care Spending Target

Nearly two out of three (64%) Connecticut respondents in the Health Care Value Hub 2025 Health Care Affordability survey experienced at least one health care affordability burden in the past year and nearly three in four (74%) worry about affording health care in the future.²³

²³ Healthcare Value Hub. 2025 Healthcare Snapshot for Connecticut.
<https://healthcarevaluehub.org/healthcare-affordability-snapshot/>

Appendix A: Cost Growth Benchmark Data Collection Process and Methodology

Background

The annual Cost Growth Benchmark is a targeted annual rate of growth in per person spending and is based on a blend of state economic growth and projected household income determined in advance of the performance period. The 2021-2030 benchmarks are shown below.

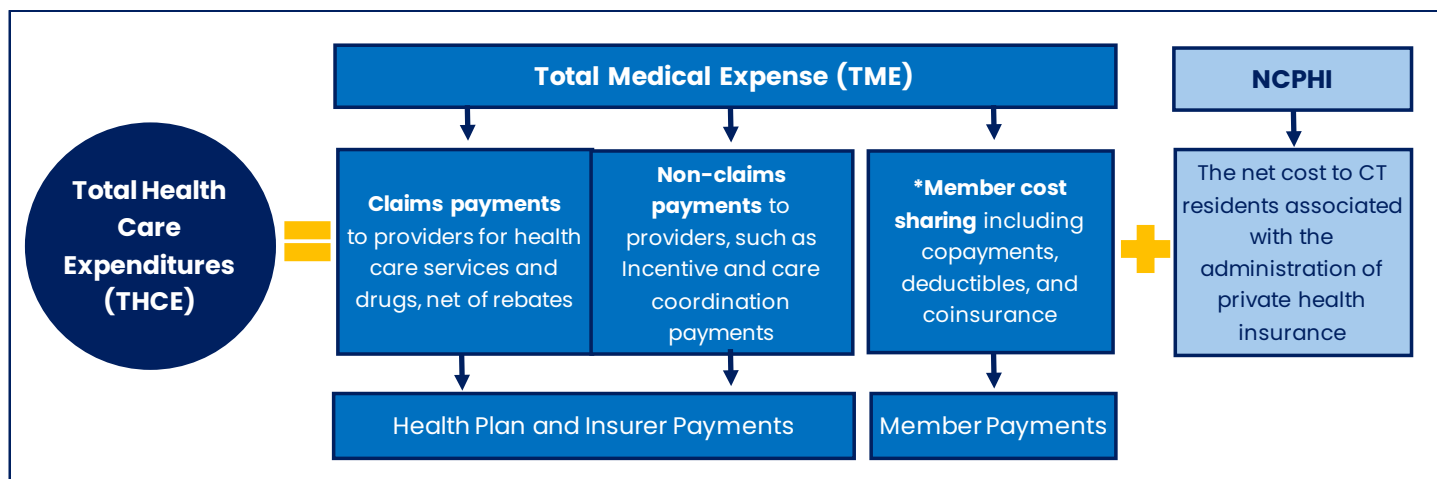
Table 12 Annual Cost Growth Benchmark Values

Year	Benchmark Value
2021	3.4%
2022	3.2%
2023	2.9%
2024	4.0% (adjusted up from 2.9% to account for elevated CT inflation in 2022)
2025	2.9%
2026-2030	2.8%

The Cost Growth Benchmark measures Total Healthcare Expenditures, which is the sum of all healthcare claims payments, non-claims payments (such as quality incentive bonuses), member cost sharing, and the Net Cost of Private Health Insurance (i.e., the cost to insurers associated with Connecticut residents of administering health insurance, including marketing, overhead, and profit).

Appendix A

Figure 36 Elements of Total Health Care Expenditures



*Member cost sharing payments are provided in all data submissions except Medicaid or WellCare.

Data Collection

The Cost Growth Benchmark program collects data from the largest private insurers in the commercial and Medicare Advantage markets, Medicare FFS data from the Centers for Medicare and Medicaid Services, Medicaid data from the CT Department of Social Services, and additional data from the CT Department of Corrections, and in past years, data from the Veterans Health Administration (VHA, which is excluded from this 2024 report due to VHA reporting changes). However, it does not collect data on spending by uninsured individuals and does not contain some self-insured plan data.

Payers submit aggregate total medical expense data for the Benchmark program which are used to calculate performance against the benchmark. OHS collects these data annually from payers by market, which includes commercial (fully insured and some self-insured), Medicaid, and Medicare (Medicare Advantage and Fee for Service) and by Advanced Network. The data include costs associated with administering private health insurance (called the net cost of private health insurance, or NCPHI).

Payer spending data is supplemented by other data from the state, the federal government, and from publicly available regulatory reports. Thus, THCE also includes student health plans; state employees, retirees, and some municipalities; individuals covered by the VHA (although not for 2024); and those residing in a state correctional facility (DOC).

Appendix A

Table 13 Data Sources

Data Source	Reporting Level	Description
Insurer (Aetna, Anthem, Cigna, ConnectiCare, UnitedHealthcare, WellCare)	State, Market, Payer, AN	Commercial and Medicare Advantage Total Medical Expenses split by comprehensive coverage vs. partial coverage. Non-claim payments. Pharmacy Rebates.
DOC	State	State Total THCE
CMS	State, Market	Medicare Fee for Service (Part A, B, and D) and Medicare Advantage (Part C and D)
DSS	State, Market, AN	Medicaid Total Medical Expenses. Pharmacy Rebates.
OSC	State, Market	Total Medical Expense – Not Reported Separately
Insurer Medical Loss Ratio (MLR) Reports	State	NCPHI for THCE
Supplemental Health Care Exhibits	State	NCPHI for THCE
VHA	State	State Total THCE – Not available for 2024 Reporting

All TME claims reporting for the commercial and Medicare market is based on the date of service from January 1 to December 31 for the given year with six months of actual paid claim runout. Carriers are expected to adjust expenditure data for a reasonable and appropriate estimate of unpaid claims liability. Medicaid data as reported by DSS are based on the paid date of the claim from January 1 to December 31 for the given year. Additionally, both Medicaid and WellCare report the paid claim amount and do not provide any member cost sharing.

Appendix A

The data are provided in broad service categories (Table 14) to determine areas of spending that are driving healthcare cost growth. For each category, OHS receives spending for each year of the two-year benchmark period (2023 and 2024 for this report) and calculates the year-over-year increase on a per person basis.

Table 14 Types of Payment for Connecticut’s Healthcare Benchmark Program, by Service Category

Claims	Non-Claims
• Hospital inpatient • Hospital outpatient • Professional, physician • Professional, specialty • Professional, other • Retail pharmacy • Long-term care • Other	• Prospective capitation, global budget, case rate or episode-based payments • Performance incentive payments • Payments to support population health and practice infrastructure • Provider salaries • Recoveries • Other

A description of these claim service categories is available in the [OHS Benchmark Data Submission Guide](#).

These data are (1) adjusted for one-year differences in the population’s age and sex and (2) truncated for high-cost outliers at the payer and Advanced Network level. This means that for a given year, data are adjusted for variations in the age and sex of a payer’s population mix and that random variation in high-cost covered lives will not adversely impact a payer’s or Advanced Network’s performance against the benchmark. The truncation point generally varies between approximately \$160,000 and \$250,000 per member based on the market being assessed. Claim dollars above these levels are excluded for an individual member.

All payer-submitted data undergo a validation process at the payer, market, and Advanced Network level to ensure consistency in spending and covered lives. More information on OHS’s methodology, data use, and data validation is available on the [Healthcare Benchmark Data Transparency webpage](#).

Performance Reporting

OHS reports performance against the benchmark for insurance carriers in the commercial and Medicare Advantage markets that have at least 5,000 attributed lives (60,000 member months) in that respective market. To assess a carrier’s performance, OHS tracks year-over-year growth in per member per month (PMPM) TME, and calculates a 95% confidence interval around the growth.

Appendix A

A carrier was considered to have exceeded the benchmark if its spending growth and associated confidence interval were above the benchmark. A carrier was considered to have met the benchmark if its spending growth and associated confidence interval were below the benchmark. If a carrier’s confidence interval intersected with the benchmark, then it was evaluated as not statistically significantly different than the benchmark, or its benchmark attainment as unable to be determined.

Attribution Methodology

OHS assesses benchmark performance for Advanced Networks with a minimum of 5,000 attributed patients (or 60,000 member months) in each market. Payers attribute claims and members to Advanced Networks through their relationships with primary care providers who are affiliated with an Advanced Network. Advanced Networks provide TINs to OHS, and OHS shares these TINs with payers to identify these provider affiliations. Payers then attribute patients to a specific Advanced Network according to the following hierarchy:

Table 15 Member Attribution Hierarchies

Tier	Description
Tier 1	Member selection: Members who were required to select a primary care provider by plan design should be assigned to that primary care provider’s organization.
Tier 2	Contractual arrangement: Members not included in Tier 1 who were attributed to primary care providers during the measurement period pursuant to a total cost of care contract (or another similar contractual arrangement) between the payer and Advanced Network are attributed to that organization.
Tier 3	Utilization: Members not included in Tier 1 or 2 may be attributed to a primary care provider based on the member’s utilization of services from that primary care provider, using the payer’s own attribution methodology.

Each member may only be attributed through one methodology each month. Attribution occurs in the order listed above, with Tier 1 taking precedence over Tier 2, and Tier 2 taking precedence over Tier 3.

For attributed members, total spending includes allowed amounts from claims (i.e., the provider payment plus any corresponding member cost sharing obligation except for Medicaid, which excludes cost sharing), as well as associated non-claims payments, such as performance

Appendix A

incentive payments and capitation. OHS does not net out pharmacy rebates for measurement at the Advanced Network level.

Payers Attributing Members by Utilization

As noted above, for Tier 3, OHS instructs payers to attribute members to Advanced Networks based on their utilization of primary care services. While specific methodologies vary slightly across payers, attribution is generally determined by assessing a member's use of primary care services within a defined period. Some payers also consider the primary care clinician who issued prescriptions for a patient but did not see him or her during the lookback period. An individual may see providers in more than one Advanced Network in a calendar year, but members are only attributed to a single Advanced Network for any given month. Because members may seek care from more than one primary care practice in a year, the final number of attributed members reported to OHS may differ from an Advanced Network's data on its patient panel. In some cases, payers attribute members to Advanced Networks based on specialist provider utilization or selection of an OB/GYN as a primary care provider.

Provider Tax Identification Number (TIN) Process

This is the second cycle where OHS has utilized a TIN methodology to improve the comprehensiveness of attributing spending to Advanced Networks. OHS contacts each Advanced Network early in each calendar year to request its TIN(s) for the two prior calendar years. Guidance provided to payers on the use of TINs can be found in the Cost Growth Benchmark Program's data submission guide on the HCBI Guidance for Payers and Providers webpage. OHS requested TINs for 32 Advanced Networks and assessed performance against the benchmark for 28 Advanced Networks that met the threshold for reporting.

Appendix B: Primary Care Spending Target

Methodology and Definitions

The Primary Care Spending Target is the percent of total medical expenses (TME) spent on primary care based on three factors: procedure code, site of care and type of provider (taxonomy).

Figure 37 Elements of Total Primary Care Spending



Primary care for OHS measurement purposes includes a specific list of more than 140 healthcare services ranging from annual wellness and back-to-school visits to influenza and other vaccine administration. These services are included in the spending measurement when they are delivered by a primary care provider, which includes physicians and nurse practitioners practicing family medicine, internal medicine, pediatrics, and other areas.

However, long-term care spending, spending on drugs prescribed or administered by primary care clinicians, certain preventive diagnostic services such as mammograms and colonoscopies are excluded. Since only Medicaid covers long-term care and long-term care is a source of significant Medicaid expenditures, these services are excluded from TME to make calculations across commercial, Medicaid and Medicare markets comparable.

Primary care delivered at urgent care centers, retail pharmacy clinics and via stand-alone, third-party telehealth vendors are excluded. Although these care settings may provide a quick alternative for patients to access primary care services, they do not provide comprehensive, continuous care, including for chronic conditions; coordinate care across multiple providers and may not share data across care settings.

A full list of primary care procedure codes, place of service codes, and provider taxonomy codes is available in the [Cost Growth Benchmark Primary Care Taxonomy and Procedure Codes](#) document on the [Healthcare Benchmark Initiative Guidance for Payers and Providers webpage](#). Primary care spending also includes non-claims spending, which is spending on payments for quality incentives and other non-claim related primary care spending.

Appendix C: Key Terms

Advanced Network: An organized group of clinicians that come together for the purposes of contracting, or an established billing unit that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if it is not engaged in a total cost of care contract. This term is equivalent to provider entities referenced in Connecticut General Statute [19a-754g et. Seq.](#)

Allowed Amount/Allowed Cost: The maximum amount a payer will pay a provider for a service.

Claim: A bill that healthcare providers submit to a patient's insurance provider, which contains unique medical codes detailing the care administered during a patient visit.

Commercial Insurance: private for-profit or non-profit small or large group health coverage obtained through employers or purchased directly by individuals, including through Access Health CT, Connecticut's health insurance marketplace.

Copayment: The fixed amount the member pays for a covered service after the member has paid their deductible. For example, if an insurance plan's allowable cost for a service is \$100 and the member's copayment for the service is \$20, if the member has met their deductible, they pay \$20 for the service. If the member has not met their deductible, they pay \$100, the full allowed amount for the service.

Confidence Interval: A confidence interval, in statistics, refers to the range of values for which one is fairly certain the population parameter lies within. In the case of the cost growth benchmark, the confidence interval lower and upper bounds represent the range of values within which we can be 95 percent certain that a payer's or Advanced Network's cost growth lies in. If an entity's confidence interval lower bound is above the cost growth benchmark, that means we can be 95 percent certain the entity has exceeded the cost growth benchmark. If an entity's confidence interval upper bound is below the cost growth benchmark, that means we can be 95 percent certain the entity has met the cost growth benchmark. If an entity's confidence interval (the distance between their upper and lower confidence interval bounds) intersects with the cost growth benchmark, that means we cannot determine with 95 percent certainty whether the entity has exceeded or met the cost growth benchmark.

Dual eligibles (Medicare/Medicaid Duals): Refers to individuals enrolled in both Medicare (for beneficiaries who are older or have disabilities) and Medicaid (for beneficiaries who have low-, limited- incomes and or assets). These individuals receive comprehensive coverage with either no cost or significantly reduced out-of-pocket costs. Medicaid wraps around Medicare to pay premiums, deductibles, and services not covered by Medicare, such as long-term nursing home care. Medicaid is considered the payer of last resort.

Appendix C

Fee-for-Service: Private (commercial) or public (Medicare or Medicaid) health insurance that reimburses healthcare providers on the basis of a fee for each health service provided to the insured person.

Fully insured plan: A fully insured health plan is one in which the insurer assumes the financial risk, including the responsibility for paying claims, in exchange for premiums.

Healthcare Cost Growth Benchmark (benchmark): The targeted annual per person growth rate for Connecticut's total healthcare spending, expressed as the percentage growth from the prior year's per spending.

Hospital inpatient: The TME paid to hospitals for inpatient services generated from claims. This category includes all room and board and ancillary payments, all hospital types, and payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. This category does not include payments made for observation services, payments made for physician services provided during an inpatient stay that have been billed directly by the physician group practice or an individual clinician, or inpatient services at non-hospital facilities.

Hospital outpatient: The TME paid to hospitals for outpatient services generated from claims. This category includes all hospital types and all traditional hospital outpatient services (i.e., outpatient surgery, imaging, labs). It also includes payments made for hospital-licensed satellite clinics, emergency room services not resulting in admittance, and observation services. This category does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

Insurance Carrier (Carrier): A private health insurance company that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, and Medicare Advantage.

Market: The highest levels of categorization of health insurance. Medicare Fee-for-Service and Medicare Advantage are collectively referred to as the Medicare market. Medicaid Fee-for-Service is referred to as the Medicaid market. Individual, self-insured, small and large group, and student health insurance markets are collectively referred to as the commercial market.

Medicaid: A joint federal and state program established by Title XIX of the Social Security Act which provides federal funds to states for medical costs for some people with limited income and resources. Each state runs its own program, and in Connecticut, it is also known as HUSKY health insurance. Medicaid covers nursing home care and other long-term care services. See also dual-eligibles.

Medicare Fee-for-Service (FFS): A federal, publicly funded health insurance for people 65 or older, and some people under 65 with certain disabilities or conditions. Traditional or Fee-for-

Appendix C

Service Medicare helps cover costs for hospital stays (Part A), doctor visits/services (Part B), and prescription drugs (Part D). It is administered by the Centers for Medicare and Medicaid. See also dual eligibles.

Medicare Advantage: (Part C) is a publicly funded health insurance program for people 65 or older, and some people under 65 with certain disabilities or conditions, which is administered by private insurance companies. Advantage plans bundle Parts A, B and typically D plus other benefits such as vision, dental, hearing and wellness programs.

Net Cost of Private Health Insurance (NCPHI): Measures the costs to Connecticut residents associated with the administration of private health insurance including commercial and Medicare Advantage plans; this does not include Medicare FFS or Medicaid. It is defined as the difference between premiums earned and benefits incurred, and includes insurers' costs of paying bills, advertising, sales commissions, and other administrative costs, net additions or subtractions from reserves, rate credits and dividends, premium taxes and profits or losses.

Non-Claims: Payments that are made for something other than a fee-for-service claim. Non-claims-based payments can be based on historical claims data, but they are not paid on a fee-for-service claims basis. Non-claims payments are payments that include capitation payments (single payments to providers to provide healthcare services over a defined period of time), pay-for-performance bonuses, risk settlements, care management payments, etc.

Other Professional: TME paid to certain behavioral health and dental providers, chiropractors and other allied health professionals.

Out-of-Pocket Spending/Cost Sharing: A member's expenses for medical care that are not reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that are not covered.

Payer: A private or public entity that pays healthcare providers for healthcare services, prescription drugs, medical equipment and supplies on behalf of a covered population.

Premium: The amount a member pays for health insurance every month.

Primary Care (spending category): A specific list of more than 140 healthcare services ranging from annual wellness and back-to-school visits to vaccine administration. These services are included in TME spending when they are delivered by a primary care provider, which includes physicians and nurse practitioners practicing family medicine, internal medicine, pediatrics, and other areas. A full list of primary care procedure codes and provider taxonomy is available in the [Cost Growth Benchmark Primary Care Taxonomy and Procedure Codes](#) document on the Cost Growth Benchmark Implementation website.

Primary Care Spending Target: This target is Connecticut's annual primary care spending as a percentage of total medical expenditures. The target sets spending at 10% by performance year

Appendix C

2025, as directed in [Public Act 22-118, §§ 217-223](#). OHS has set the primary care spending target at 10% of total medical expenditures for each calendar year through 2030.

Professional physician: TME paid to both specialists and primary care providers. Primary care includes services provided at primary care sites generated from claims using code-level definitions, and TME paid to physicians or physician group practices generated from claims. The professional physician category also includes services provided by a doctor of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine.

Self-insured plan: A self-insured benefit plan is one in which the plan sponsor (e.g., the employer) assumes the financial risk of providing health benefits.

Total Health Care Expenditures (THCE): The sum of all public and private healthcare expenditures in Connecticut for a given calendar year, including: all claims-based spending paid to providers, net of pharmacy rebates, all non-claims spending paid to providers, all patient cost-sharing amounts, and the Net Cost of Private Health Insurance. More detailed THCE reporting specifications are included in the Cost Growth Benchmark Program's data submission guide on the [HCBI Guidance for Payers and Providers](#) webpage.

Total Medical Expense (TME): The sum of all public and private healthcare expenditures in Connecticut for a given calendar year, including all claims-based spending paid to providers (net of pharmacy rebates), all non-claims spending paid to providers, and all patient cost-sharing amounts, but excluding the Net Cost of Private Health Insurance. TME is reported at multiple levels: market, payer and provider level. TME is reported net of pharmacy rebates at the state, market and payer levels only. Payers report TME by line of business (e.g., individual, self-insured, large group, small group, Medicare, Medicaid, Medicare/Medicaid dually eligible) and at the Advanced Network level whenever possible. More detailed TME reporting specifications are included in the Cost Growth Benchmark Program's data submission guide Appendices on the: [HCBI Guidance for Payers and Providers](#) webpage.