CONNECTICUT
Health Strategy

Cost Growth Benchmark Initiative

2022-2023 Advanced Network Performance - Supplement

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Acting Commissioner

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

November 24, 2025

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Acknowledgements

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Acronym Glossary

Acronym	Term
CMS	Centers for Medicare and Medicaid Services
DSS	Department of Social Services
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
HCBI	Healthcare Benchmark Initiative
HMO	Health Maintenance Organization
NCPHI	Net Cost of Private Health Insurance
OHS	Office of Health Strategy
OSC	Office of the State Comptroller
PCMH	Person-Centered Medical Home
PGSP	Potential Gross State Product
PMPM	Per Member Per Month
THCE	Total healthcare expenditures (TME + NCPHI)
TIN	Tax Identification Number
TME	Total medical expense

Executive Summary

The cost growth benchmark program aims to slow healthcare spending growth as one tool to increase affordability for residents. Connecticut codified the benchmark initiative in 2022 under Conn. Statute § 19a-754g et. seq..

This report supplements analyses in the previously published Connecticut Office of Health Strategy (OHS) Healthcare Benchmark Initiative Cost Growth Benchmark 2023 Performance report. From 2022 to 2023, Connecticut's total healthcare expenditures (THCE) per capita grew by 7.9%, significantly faster than the 2.9% cost growth benchmark value. This supplement specifically addresses Advanced Network performance against the 2.9% cost growth benchmark using 2022-2023 data in the three largest markets: commercial, Medicaid, and Medicare Advantage.

Advanced Networks are large, organized groups of clinicians that come together for the purpose of contracting with payers. The 29 Advanced Networks in Connecticut can have some influence on one or both of the two major factors that contribute to healthcare spending growth: payment and utilization.

OHS included only limited analysis of Advanced Network data in the initial report as data validation was in progress at the time of report publication. Additionally, since publication, two payers - Cigna and the Connecticut Department of Social Services (DSS) - resubmitted data for Advanced Networks that had not previously been attributed based on taxpayer Identification number (TIN).

OHS assessed individual Advanced Network spending against the cost growth benchmark and finds that most Advanced Networks saw spending growth that far exceeded the 2.9% 2023 cost growth benchmark. Advanced Networks affiliated with hospitals exhibited particularly high growth, reflecting increasing payments, utilization, or a combination of the two.

OHS attributes spending growth to Advanced Networks through a Tier system, in which Tiers 1 and 2 are members who select a primary care practitioner in the Advanced Network or members covered by a value-based contract with the Advanced Network, respectively. Tier 3 represents spending attributed solely as a result of the member having received care from an Advanced Network clinician (see Appendix A: Methodology).

Advanced Networks generally have more contractual incentives in Tiers 1 and 2. OHS finds that slightly more than half (seven of 13) Advanced Networks in the commercial market had lower spending growth in Tiers 1 and 2 combined than in Tier 3. While spending growth may be higher in Tier 3, per member per month spending was often lower than in other tiers. The data is more mixed in the Medicare Advantage market and is not collected by tier level in the Medicaid market.

This data suggests further research and monitoring to determine if clinicians in an Advanced Network are more effective at managing spending growth for members to whom they are

assigned via member selection or through an insurer value-based contract. OHS will continue to collaborate with Advanced Networks to improve the accuracy of the attribution process and identify opportunities to address cost growth.

Introduction

The Healthcare Benchmark Initiative Cost Growth Benchmark 2023 Performance report published statewide and market-level performance for the 2022-2023 calendar years. OHS included only limited analysis of Advanced Network data in the initial report as data validation was in progress at the time of report publication. OHS reported only aggregated, de-identified data on Advanced Networks in that report. OHS has since completed data validation, and this updated supplement reports disaggregated, identified Advanced Network performance relative to the healthcare cost growth benchmark for 2022-2023.

Process

Pursuant to Conn. Gen. Statute § 19a-754g OHS monitors Advanced Network performance against the benchmarks.

Connecticut's healthcare marketplace is constantly shifting. Providers, patients, and ownership affiliations change frequently. OHS assesses three categories of Advanced Networks to provide context for performance:

- Hospital-affiliated
- Non-hospital affiliated, including independent physician groups
- Federally Qualified Health Center (FQHC-based network)

OHS collects cost growth data for Advanced Networks from the state's five largest commercial payers (Aetna, Anthem, Cigna, ConnectiCare, and UnitedHealthcare), five largest Medicare Advantage payers (Aetna, Anthem, ConnectiCare, UnitedHealthcare, and Wellcare), and from DSS for Medicaid. CMS does not report Medicare Fee-for-Service data to OHS with disaggregation at the Advanced Network level so it is not included.

OHS contacts each Advanced Network early in each calendar year to request its associated primary care provider TINs for the prior two calendar years. OHS provides the Advanced Network TINs to the payers. Payers then use the TINs to attribute patients to a specific Advanced Network using the following hierarchy:

1. a member's self-selection of a primary care provider as required by their plan design (e.g., HMO);
2. a member's inclusion in a contractual total cost of care arrangement between an Advanced Network and a payer; or
3. by where the member utilizes primary care services.

Each member may only be attributed through one methodology each month, using the order listed above. As patients may see multiple different primary care providers in a year, and providers themselves may change their network affiliation, the assignments can change

throughout a calendar year. More information about the attribution methodology is available in Appendix A: Methodology.

OHS considered an Advanced Network to have exceeded the benchmark if its growth in Total Medical Expenses (TME) and associated confidence interval were above the 2023 benchmark of 2.9%. Performance for an Advanced Network with a confidence interval crossing the benchmark is considered undetermined. If the benchmark value falls within the confidence interval, then the Advanced Network's spending growth is not statistically significant.

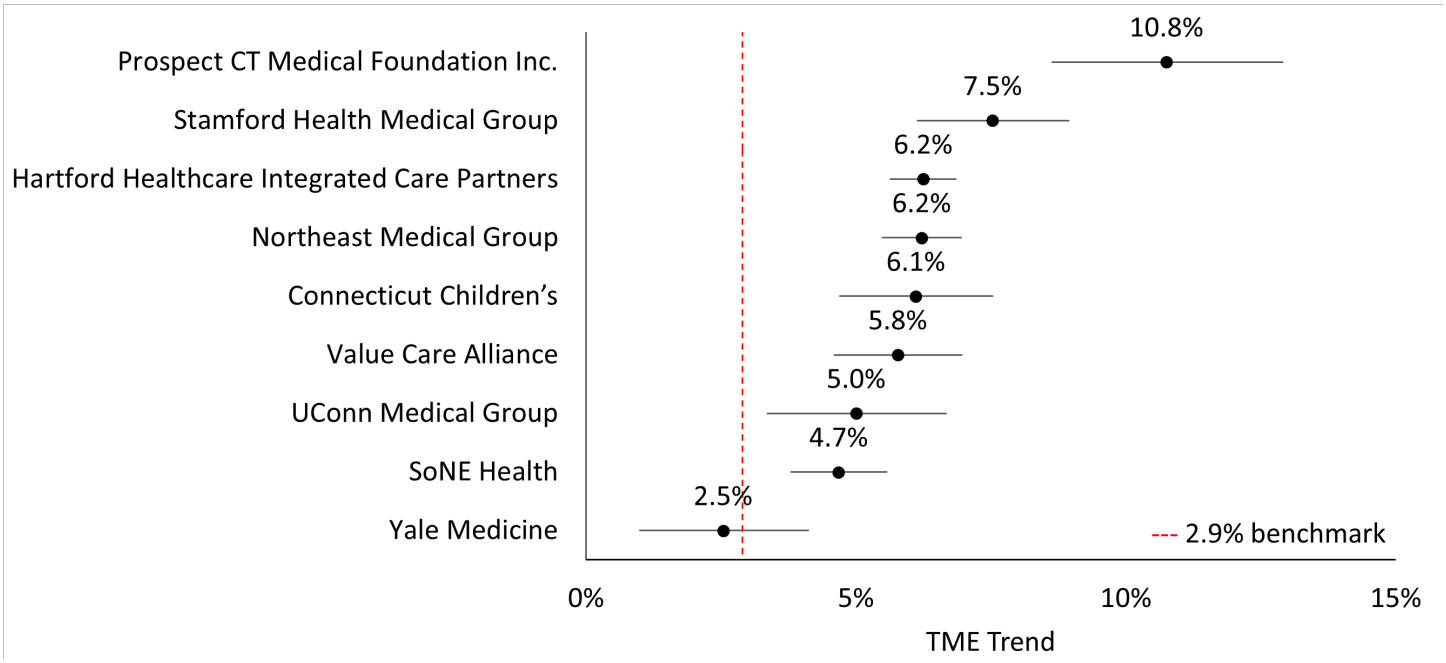
Advanced Network Spending Performance, 2022-2023

Across markets, Advanced Networks affiliated with hospitals exhibited high spending growth, reflecting increasing prices, utilization, or both.

Commercial Performance

Nearly all **hospital-affiliated Advanced Networks** exceeded the benchmark in the commercial market, with spending growth ranging from 2.5% to 10.8%, as shown in Figure 1 below. While spending growth for Yale Medicine was below the benchmark at 2.5%, the confidence interval is insufficient to demonstrate that the Advanced Network performed below the benchmark.

Figure 1. Hospital-Affiliated Advanced Network Commercial TME Trends (2022-2023)



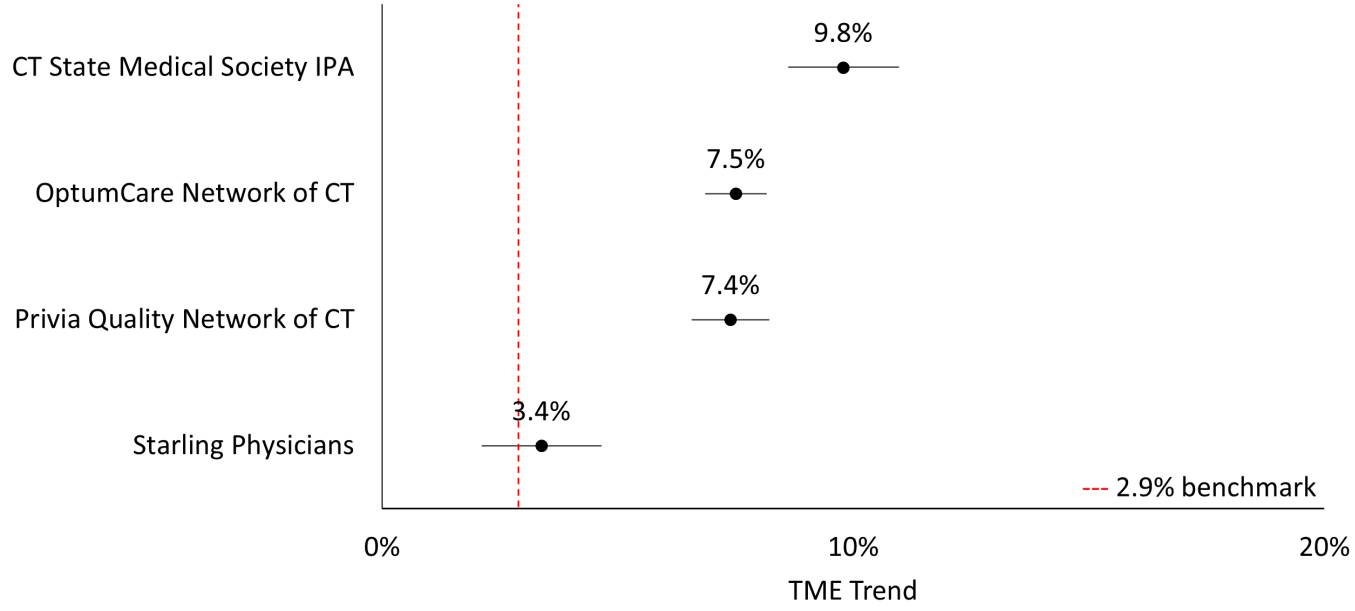
Source: OHS collected data from insurance carriers.

Notes: Data are truncated for outliers and age/sex adjusted. The points denote the year-over-year growth of an insurance carrier 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.

Among **non-hospital-affiliated Advanced Networks** spending growth ranged from 3.4% to 9.8%, with three out of four exceeding the benchmark in the commercial market, as shown in Figure 2 below.

Advanced Network Spending Performance, 2022-2023

Figure 2. Non-Hospital-Affiliated Advanced Network Commercial TME Trends (2022-2023)



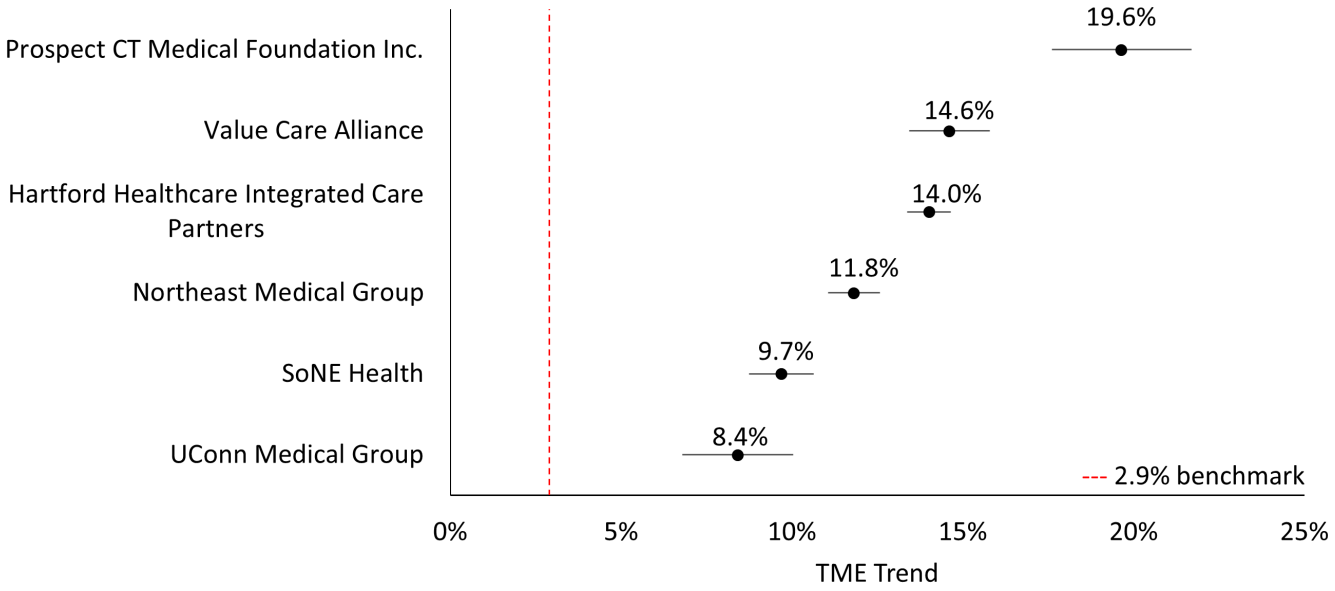
Source: OHS collected data from insurance carriers.

Notes: Data are truncated for outliers and age/sex adjusted. The points denote the year-over-year growth of an insurance carrier 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.

Medicare Advantage Performance

All **hospital-affiliated Advanced Networks** exceeded the cost growth benchmark in the Medicare Advantage market, with spending growth ranging from 8.4% to 19.6%. Four Advanced Networks experienced double-digit growth rates, as shown in Figure 3 below.

Figure 3. Hospital-Affiliated Advanced Network Medicare Advantage TME Trends (2022-2023)



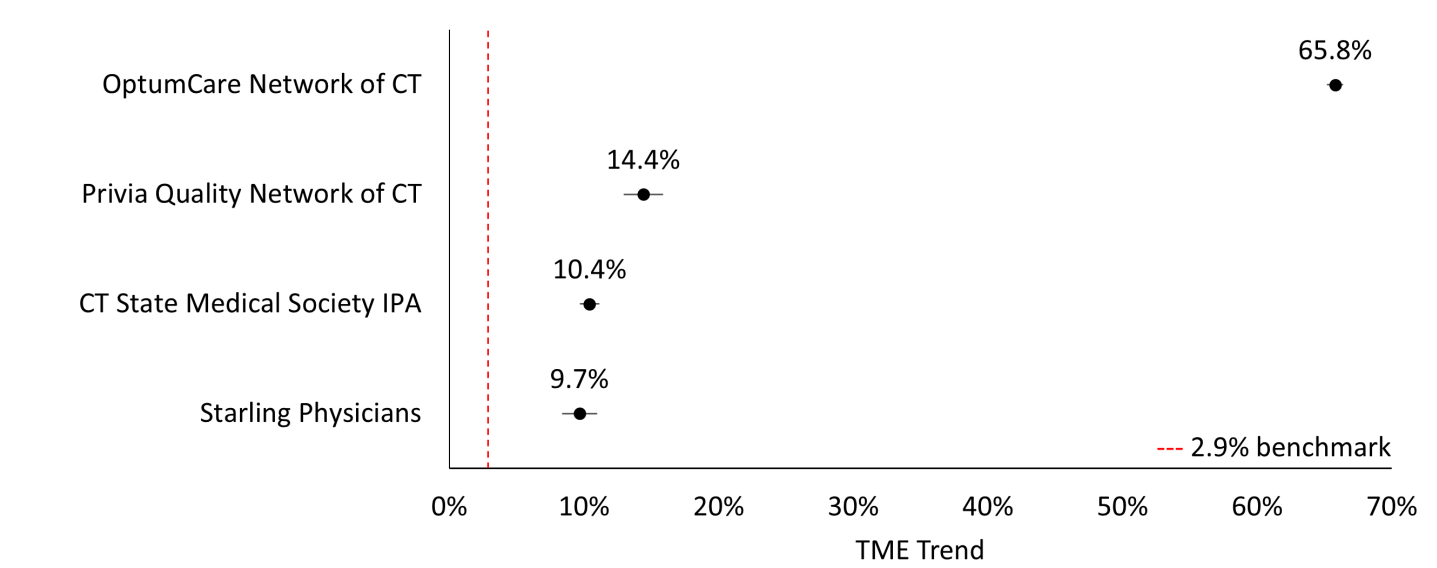
Source: OHS collected data from insurance carriers.

Notes: Data are truncated for outliers and age/sex adjusted. The points denote the year-over-year growth of an insurance carrier 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 **non-hospital-affiliated Advanced Networks** in the Medicare Advantage market also surpassed the benchmark, with growth ranging from 9.7% to 14.4% with the outlier of OptumCare Network of Connecticut at 65.8%, as shown in Figure 4 below. UnitedHealthcare's transition to a non-claims based prospective payment structure with OptumCare Network of Connecticut, a shift that contributed to this surge is discussed in the 2023 Cost Growth Benchmark report.

Advanced Network Spending Performance, 2022-2023

Figure 4. Non-Hospital-Affiliated Advanced Network Medicare Advantage TME Trends (2022-2023)



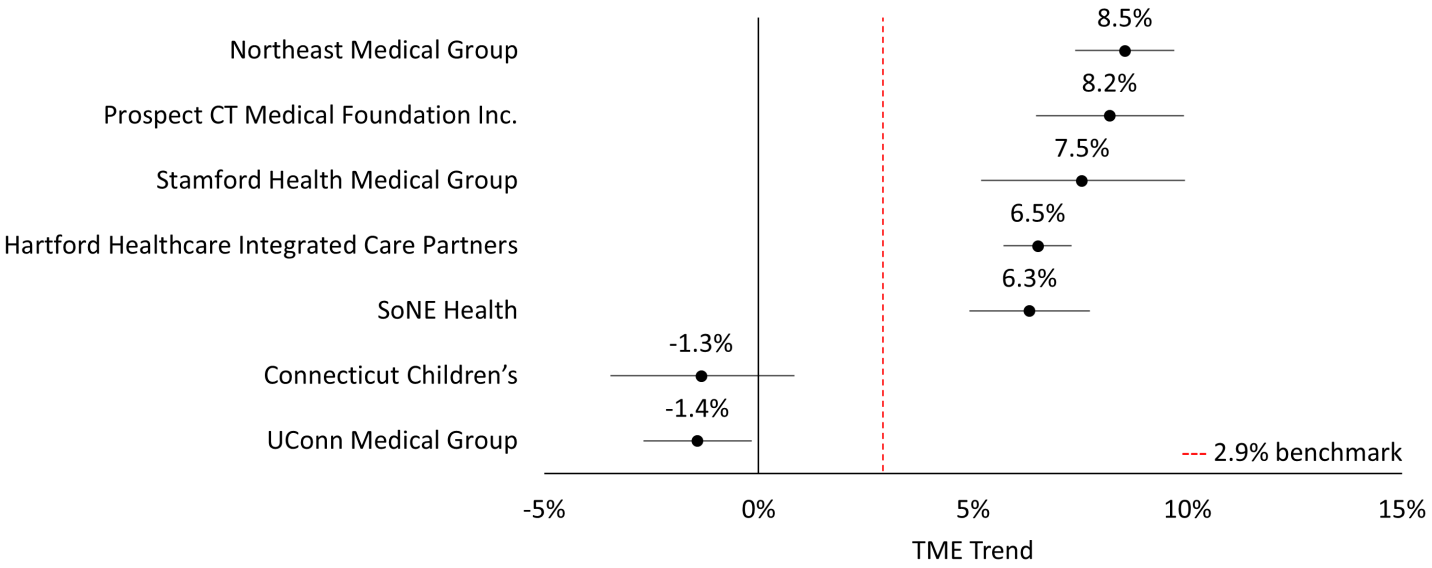
Source: OHS collected data from insurance carriers.

Notes: Data are truncated for outliers and age/sex adjusted. The points denote the year-over-year growth of an insurance carrier 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. OptumCare Network moved to a prospective percentage-of-payment arrangement with UnitedHealthcare, a related corporate entity and the largest Medicare Advantage insurer in Connecticut. This change caused a one-time spike in the trend due to a cash flow shift.

Medicaid Performance

Two **hospital-affiliated Advanced Networks**, Connecticut Children's Medical Group and UConn Medical Group, met the benchmark in the Medicaid market. Five exceeded the cost growth benchmark in this market, with spending growth ranging from 6.3% to 8.5%, as shown in Figure 5 below.

Figure 5. Hospital-Affiliated Advanced Network Medicaid TME Trends (2022-2023)



Source: OHS collected data from insurance carriers.

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 insurance carrier 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.

Non-hospital-affiliated Advanced Networks had mixed performance in the Medicaid market.

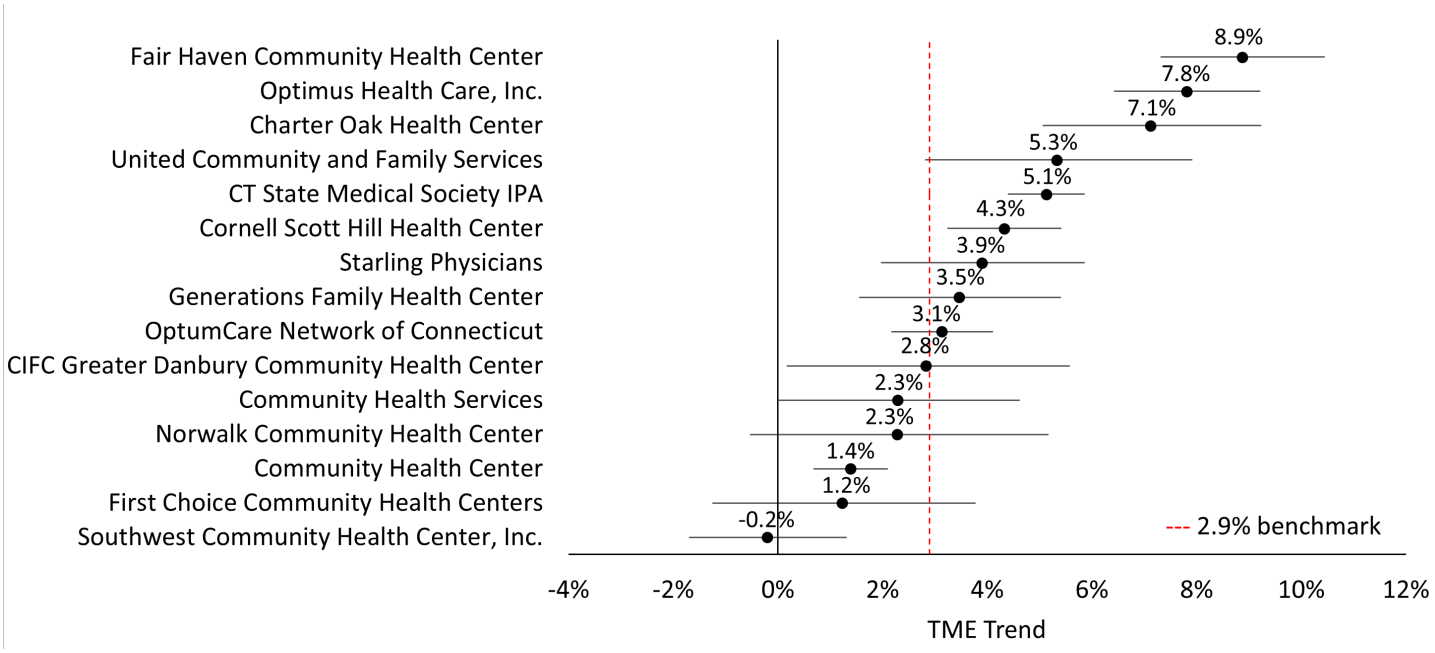
Five Advanced Networks exceeded the benchmark with growth ranging between 4.3% and 8.9%. While spending growth for United Community and Family Services was within the that range, at 5.3%, the confidence interval is insufficient to demonstrate that the Advanced Network exceeded the benchmark.

Two Advanced Networks met the benchmark: Community Health Center and Southwest Community Health Center. While spending growth for First Choice Community Health Center was below the benchmark at 1.2%, the confidence interval is insufficient to demonstrate that the Advanced Network performed below the benchmark.

In total, eight Advanced Networks had confidence intervals intersecting with the benchmark value and as a result performance against the benchmark could not be determined.

Advanced Network Spending Performance, 2022-2023

Figure 6. Non-Hospital-Affiliated Advanced Network Medicaid TME Trends (2022-2023)



Source: OHS collected data from insurance carriers.

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 insurance carrier 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.

Performance by Market, Advanced Network and Attribution Tier

Advanced Networks may have more control over costs associated with a member's health care for members in Tiers 1 and 2, as compared to Tier 3, in part because of financial incentives to manage patient health. Additionally, clinicians who have cultivated relationships with members can better coordinate care with other network clinicians, schedule follow-ups, work to most effectively and efficiently offer preventive services, and manage chronic care which reduces unnecessary utilization and spending. However, there is no clear trend: at least six networks had lower spending trends in Tier 3 than in Tier 1 and 2, as shown in Table 1 below.

Table 1. Commercial Market Spending Trend by Attribution Tier (2022-2023)

Advanced Network	PMPM Spending Trend – Tiers 1 & 2	PMPM Spending Trend – Tier 3	PMPM Spending Trend – All Tiers
Privia Quality Network of Connecticut	3.7%	9.6%	7.4%
Connecticut Children's	1.8%	15.8%	6.1%
Connecticut State Medical Society IPA	10.0%	9.4%	9.8%
Hartford Healthcare Integrated Care Partners	6.2%	6.7%	6.2%
Northeast Medical Group	9.4%	4.1%	6.2%
OptumCare Network of Connecticut	6.6%	9.6%	7.5%
Prospect Connecticut Medical Foundation Inc.	12.5%	7.0%	10.8%
Southern New England Healthcare Organization (SoNE Health)	4.8%	3.4%	4.7%
Value Care Alliance	4.5%	8.7%	5.8%
Stamford Health Medical Group	10.3%	4.0%	7.5%
Starling Physicians	2.5%	4.5%	3.4%
UConn Medical Group	3.4%	9.7%	5.0%

Advanced Network Spending Performance, 2022-2023

Advanced Network	PMPM Spending Trend – Tiers 1 & 2	PMPM Spending Trend – Tier 3	PMPM Spending Trend – All Tiers
Yale Medicine	6.7%	-7.7%	2.5%

Source: OHS collected data from insurance companies.

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

It is more difficult to draw conclusions about the Medicare Advantage market spending growth trend as some network results reflect significant variations in membership between years within a tier. The results are shown in Table 2 below.

Table 2. Medicare Advantage Spending Trend by Attribution Tier (2022 – 2023)

Advanced Network	PMPM Spending Trend – Tiers 1 & 2	PMPM Spending Trend – Tier 3	PMPM Spending Trend – All Tiers
Privia Quality Network of Connecticut	16.2%	9.7%	14.4%
Connecticut State Medical Society IPA	15.3%	-3.5%	10.4%
Hartford Healthcare Integrated Care Partners	14.9%	12.2%	14.0%
Northeast Medical Group	10.2%	20.2%	11.8%
OptumCare Network of Connecticut	73.1%	3.6%	65.8%
Prospect Connecticut Medical Foundation Inc.	22.9%	11.7%	19.6%
Southern New England Healthcare Organization (SoNE Health)	23.5%	-7.3%	9.7%
Value Care Alliance	13.1%	17.1%	14.6%
Starling Physicians	10.6%	7.7%	9.7%
UConn Medical Group	6.4%	24.3%	8.4%

Source: OHS collected data from insurance companies.

Advanced Network Spending Performance, 2022-2023

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

A table was not completed for the Medicaid Market Spending Trend by Attribution Tier as DSS, which manages the Medicaid program, generally attributes all member spending through Tier 3 using a utilization method, including for members in PCMH who select a primary care provider as part of that program.

Conclusion and Next Steps

Advanced Networks play a role in managing the health, and healthcare spending of Connecticut residents, and providing the attributed spending data allows for a more robust conversation. OHS reports that most Advanced Networks saw spending growth that far exceeded the cost growth benchmark of 2.9% in 2022-2023. Importantly:

- Advanced Networks affiliated with hospitals exhibited particularly high growth, reflecting increasing prices and/or utilization.
- In the commercial market, most Advanced Networks exceeded the cost growth benchmark.
- In the Medicare Advantage market, every Advanced Network exceeded the benchmark.
- The Medicaid market saw more variable patterns in performance with some Advanced Networks meeting the benchmark. Connecticut Children's and UConn Medical Group were the two hospital-affiliated Advanced Networks to meet the benchmark, while Community Health Center and Southwest Community Health Center were the two non-hospital affiliated networks to do so.

OHS continues to work closely with both payers and individual Advanced Networks to ensure that the payer submissions provide the best reflection of provider affiliations as possible. OHS will also continue to:

- Report Advanced Network performance against the cost growth benchmark at the market and payer levels using hospital affiliation and attribution tier reporting, as appropriate.
- Collaborate with Advanced Networks both collectively and one-on-one to work through member attribution and provider changes.
- Collaborate with Advanced Networks to better understand performance and available levers to address cost growth based on payment and utilization.
- Develop policy solutions to advance healthcare affordability, accessibility, equity and quality for Connecticut residents.

Appendix A: Methodology

Member Attribution

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 member data for patients to Advanced Networks through their relationships with primary care providers who are affiliated with an Advanced Network. Advanced Networks provide TINs to OHS and ultimately to payers to identify these provider affiliations. Payers then attribute patients to a specific Advanced Network according to the follow hierarchy:

1. a member's self-selection of a primary care provider as required by their plan design (e.g., HMO);
2. a member's inclusion in a contractual total cost of care arrangement between an Advanced Network and a payer; or
3. by where the member utilizes primary care services.

Each member may only be attributed through one methodology each month, using the order listed above.

Table 3. Member Attribution Hierarchies

Tier	Description
Tier 1	**Member selection:** Members who were required to select a primary care provider by plan design should be attributed to the Advanced Network with which the primary care provider is affiliated.
Tier 2	**Contractual arrangement:** Members not included in Tier 1 who were attributed to a primary care provider during the measurement period pursuant to a contract between the payer and provider, should be attributed to that Advanced Network with which the primary care provider is affiliated. For example, if a provider is engaged in a total cost of care arrangement, then the payer may use its attribution model for that contract to attribute members to an Advanced Network.
Tier 3	**Utilization:** Members not included in Tier 1 or 2 should be attributed to an Advanced Network based on the member's past utilization of primary care services with a primary care provider with whom the Advanced Network is affiliated, using the payer's own attribution methodology.

For attributed members, total spending includes allowed amounts from claims (i.e., the provider payment plus any corresponding member cost sharing obligation), as well as associated non-claims payments, such as performance 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 Tiers 2 and 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 the 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 at any given time. 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 may also attribute members to Advanced Networks based on contractual arrangements or because the members received primary care services from specialist providers associated with the Advanced Network.

Provider Tax Identification Number (TIN) Process

For this reporting cycle, OHS implemented a new 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 TINs for the two prior calendar years. For example, in January 2026, OHS will request TINs for calendar years 2024 and 2025. 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 and assessed performance against the benchmark for the following 29 Advanced Networks:

Table 4. Connecticut's Advanced Networks

Connecticut's Advanced Networks
Charter Oak Health Center (FQHC-based network)
CIFC Greater Danbury Community Health Center (FQHC-based network)
Community Health and Wellness Center of Greater Torrington (FQHC-based network)
Community Health Center (FQHC-based network)
Community Health Services (FQHC-based network)

Connecticut's Advanced Networks
Connecticut Children's (hospital-affiliated network)
Connecticut State Medical Society IPA (non-hospital affiliated network)
Cornell Scott Hill Health Center (FQHC-based network)
Fair Haven Community Health Center (FQHC-based network)
Family Centers (FQHC-based network)
First Choice Community Health Centers (FQHC-based network)
Generations Family Health Center (FQHC-based network)
[Hartford Healthcare] Integrated Care Partners (hospital-affiliated network)
Northeast Medical Group (hospital-affiliated network)
Norwalk Community Health Center (FQHC-based network)
Optimus Health Care, Inc. (FQHC-based network)
OptumCare Network of Connecticut (non-hospital network)
Privia Quality Network of Connecticut (formerly Community Medical Group) (non-hospital network)
Prospect Connecticut Medical Foundation Inc. (dba Prospect Medical, Prospect Health Services, Prospect Holdings) (hospital-affiliated network)
SoNE Health (hospital-affiliated network)
Southwest Community Health Center, Inc. (FQHC-based network)
Stamford Medical Group (hospital-affiliated network)
Starling Physicians (non-hospital network)
Summit Health (non-hospital network)
UConn Medical Group (hospital-affiliated network)
United Community and Family Services (FQHC-based network)
Value Care Alliance (hospital-affiliated network)
Wheeler Clinic (FQHC-based network)
Yale Medicine (hospital-affiliated network)

OHS then distributed the TINs to insurance carriers and DSS for attributing both spending and members to Advanced Networks.

Following validation and analysis of payer-reported data, OHS provided each Advanced Network with a preview report in February detailing their attributed spending and providing an opportunity to review. This year, four Advanced Networks provided feedback to OHS.

Of the 29 total Advanced Networks OHS reports on, 10 Advanced Networks that previously met the minimum threshold for public reporting in at least one market did not submit Taxpayer Identification information. These Advanced Networks were included in the figures for all markets where complete data was available:

1. Privia Quality Network Connecticut (Community Medical Group)

2. Charter Oak Health Center
3. CIFC Greater Danbury Community Health Center
4. Community Health Services
5. Family Centers
6. First Choice Community Health Centers
7. Generations Family Health Center
8. Stamford Health Medical Group
9. Summit Health (formerly WestMed Medical Group)
10. United Community and Family Services

Appendix B: Glossary

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.

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.

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

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 person spending.

Insurance Carriers (Carriers): 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 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."

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 fee-for-service 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.

Out-of-Pocket Spending/Cost Sharing: A member's expenses for medical care that are not reimbursed by insurance. Out-of-pocket costs including 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.

Total Health Care Expenditures (THCE): The sum of all healthcare expenditures in Connecticut from public and private sources for a given calendar year, including: all claims-based spending paid to providers, net of pharmacy rebates, all patient cost-sharing amounts, and the Net Cost of Private Health Insurance. Defining specifications of THCE 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 total cost of care for the patient population of a payer or provider entity for a given calendar year, where cost is calculated for such year as the sum of: all claims-based spending paid to providers by public and private payers, and net of pharmacy rebates; all nonclaims payments for such year, including, but not limited to, incentive payments and care coordination payments; and all patient cost-sharing amounts expressed on a per capita basis for the patient population of a payer or provider entity in this state. 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 can be found in the Cost Growth Benchmark Program's data submission guide Appendices on the: HCBI Guidance for Payers and Providers webpage.