CONNECTICUT
Health Strategy

Healthcare Benchmark Initiative

Recommendations to the General Assembly

Amy Porter

Acting Commissioner

Pursuant to Conn. Gen. Statute §§ 19a-754f et seq.

November 21, 2025

Table of Contents

Table of Tables/Figures

Acknowledgements

The Connecticut Office of Health Strategy expresses appreciation to the individuals and organizations who provided invaluable contributions to advance this work. We extend sincere thanks to the Centers for Medicare & Medicaid Services, the Connecticut Department of Social Services, the Department of Correction, the Office of the State Comptroller, the insurance carriers and advanced networks for submitting data to the Healthcare Benchmark program and for their continued collaboration and cooperation.

Authors

Alexander Reger, PhD

Patricia Blodgett, MBA

Lisa P. Sementilli, MA

Office of Health Strategy

Contributors

Michael Bailit

Matt Reynolds

Alyssa Vangeli

Bailit Health

Acronyms

APCD	All-Payer Claims Database
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMIR	Cost and Market Impact Review
CID	Connecticut Insurance Department
CMS	Centers for Medicare and Medicaid Services
CON	Certificate of Need
DOC	Department of Correction
DSS	Department of Social Services
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
HEDIS	Health Care Effectiveness Data and Information Set
NCPHI	Net Cost of Private Health Insurance
NCQA	National Committee on Quality Assurance
OHS	Office of Health Strategy
OSC	Office of the State Comptroller
PBM	Pharmacy Benefit Manager
PCMH+	Person-Centered Medical Home Plus
PCPCM	Person-Centered Primary Care Measure
PGSP	Potential Gross State Product
THCE	Total Health Care Expenditures
TME	Total Medical Expense
VHA	Veterans Health Administration

Executive Summary

Pursuant to Conn. Gen. Statutes §§ 19a – 754j (b)(3), this report is based on the OHS Commissioner's analysis of the most recent public hearing that compared the performance of payers and providers in the performance year to the quality benchmarks. The report also, 1) describes health care quality trends in this state and the factors underlying such trend, 2) includes the findings of the report prepared pursuant to Conn. Gen. Statutes §§ 19a – 754h(e) and, 3) includes recommendations concerning strategies to improve the quality of the state's health care system.

Cost Growth Benchmark

The cost growth benchmark measures healthcare spending in two ways: Total Healthcare Expenditures (THCE) and Total Medical Expenses (TME). THCE includes insurer profits and administrative expenses, and TME excludes these non-medical expenses. It compares spending growth to a benchmark value, which broadly represents a level of spending growth affordable for Connecticut residents. The cost growth benchmark for 2023 was set at 2.9%.

Connecticut THCE grew to $38 billion, an increase of 7.9% in 2023. Statewide TME grew 8.0%, to $11,194 per capita. Commercial market TME grew 6.2% to $8,625 per capita; Medicaid market TME grew 2.2% to $7,805 per capita; and Medicare market TME grew 13.7% to $18,889 per capita. Every market except Medicaid exceeded the 2023 cost growth benchmark value of 2.9%.

The cost growth benchmark analysis shows that spending growth was driven by a 6.9% increase in hospital outpatient services spending and a 9.3% growth in retail pharmacy spending. Retail pharmacy refers to spending on prescription drugs at a local or mail order pharmacy, rather than spending on prescription drugs that are administered by a healthcare professional, often in a hospital or outpatient setting, which is called medical pharmacy. These service categories have a relatively high level of spending and growth.

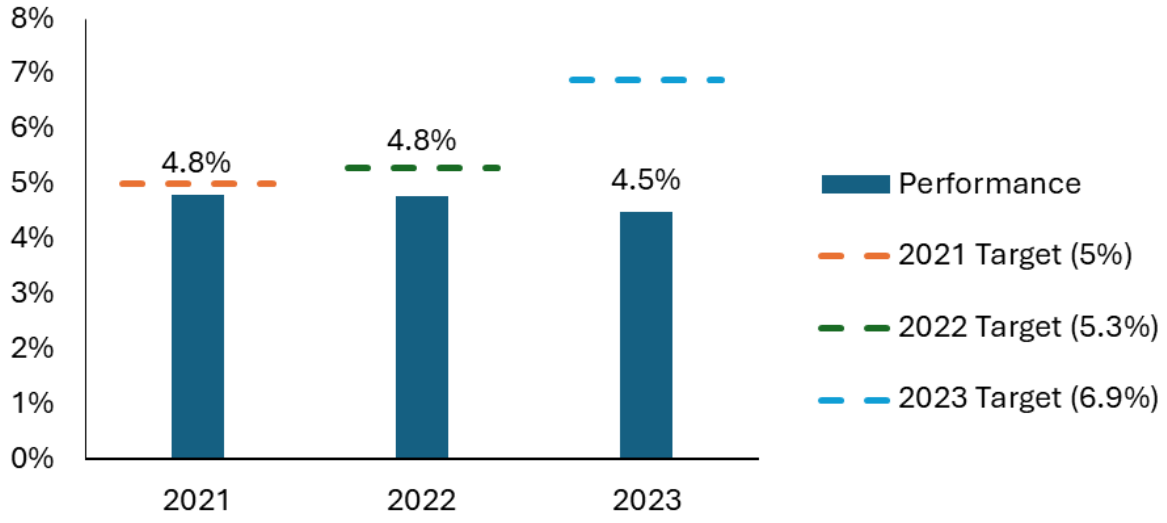
Spending growth is influenced by changes in payments and utilization. Analysis of the Connecticut All-Payer Claims Database shows that spending on retail pharmacy in the commercial market was driven mostly by an increase in payments, not by an increase in utilization.

Primary Care Spending Target

The primary care spending target measures primary care spending as a percentage of TME for Connecticut residents and assesses it against a target value. The 2023 target value was 6.9%. Only 4.5% of statewide TME was spent on primary care during the 2023 performance year. Statewide spending on primary care was approximately

$33 per person, per month. Although this was a marginal increase from $32 in 2022 the rest of healthcare spending grew fast enough that the percentage spent on primary care actually decreased from 2022 to 2023.

2021-2023 Connecticut Primary Care Spending as a Percentage of Total Medical Expense Assessed Against the Primary Care Target



Source: OHS collected data from insurance carriers and the Connecticut Department of Social Services (DSS). Cost Growth Benchmark Program 2021-2022 & 2022-2023.

Notes: Data are not risk adjusted and data are reported net of pharmacy rebates.

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 total medical spending can provide stakeholders – including policymakers, healthcare providers, purchasers, and healthcare payers – with actionable data to improve Connecticut's population health and health care access.

Unintended Adverse Consequences

This report assessed potential unintended adverse consequences of the cost growth benchmark program. Findings of the Measurement Plan, show that underutilization measures, member experience surveys, and member grievances did not illustrate negative implications based on stinting or rationing of care. Analysis of these measures shows no unintended adverse consequences are linked to the benchmark program. While some measures, such as out-of-pocket expenses, have increased, these increases are in line with national trends, attributable to changes in plan design or related to the continued rise of healthcare costs for consumers, business, and private and public payers.

Executive Summary

Recommendations

The Healthcare Benchmark Initiative brings transparency to healthcare spending and offers data-driven policy recommendations. The in-depth analyses described in the Cost Growth Benchmark and Primary Care Spending Target reports inform the policy recommendations in this report.

OHS recommends several policies to address rising spending on prescription drugs, as well as to expand the program's impact through enforcement, and support adoption of alternative payment models.

Introduction

Governor Lamont and the Connecticut General Assembly established Connecticut's healthcare cost growth benchmark to measure healthcare spending and produce data-driven policy suggestions to slow spending growth. The cost growth benchmark represents a rate of healthcare spending growth that is affordable for Connecticut residents. Connecticut is one of at least nine states that have adopted a benchmark strategy to better understand and address trends in healthcare growth.[1]

The findings of the benchmark report show that per-person medical spending continues to grow faster than the benchmark value. A recent Consumer Healthcare Experience State Survey report of Connecticut respondents shows 74% worry about affording healthcare in the future. Sixty-one percent of all respondents also reported delaying or going without healthcare due to cost in the last 12 months. Seventy-two percent of respondents believe the healthcare system is unaffordable.

Low-income respondents and respondents living with a disability or living in a household with a person with a disability report higher rates of going without care due to cost. They also reported incurring medical debt, depleting savings, and/or sacrificing basic needs due to medical bills.[2]

Businesses are also struggling with rising healthcare spending. In response to rising costs, many small business owners increase employee contributions to health insurance or shift to a lower benefit health insurance plan. One-fifth of businesses surveyed pass the rising cost of healthcare directly onto the consumer by raising prices.[3] Limiting healthcare cost growth helps businesses compete and retain talent, free up the resources for them to hire, grow, make capital investments, or increase employee wages.

The Primary Care Spending Target report shows that spending on primary care services is growing slower than other healthcare spending. It also shows overall spending on primary care remains low. Research demonstrates that increased investment in primary care can lead to better patient outcomes, lower costs, and

[1]How States Use Cost-Growth Benchmark Programs to Contain Health Care Costs, National Academy for State Health Policy, Accessed September 23, 2025: Policy,https://nashp.org/state-tracker/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/
[2]Healthcare Value Hub. (2025). Consumer Healthcare Experience State Survey, Accessed September 26, 2025: https://healthcarevaluehub.org/consumer-healthcare-experience-state-survey/connecticut
[3] Opinion poll: Small businesses struggling with rising healthcare costs, support bipartisan policy solutions, Small Business Majority, Accessed September 23, 2025: https://smallbusinessmajority.org/sites/default/files/research-reports/poll-small-businesses-struggling-with-healthcare-costs.pdf

numerous additional benefits.[4,5,6] Primary care can reduce more expensive care later. For example, the Commonwealth Fund's 2025 Scorecard on State H System Performance ranks Connecticut 48th nationally for avoidable hospital use and cost.[7]

The report also highlights significant burdens facing primary care practitioners, leading to less time with patients and more frustrating professional experience. Connecticut has a lower rate of primary care physicians practicing primary care compared to the national average. Also, physicians who finish their medical education in the state are less likely to stay here to practice than the national average.[8,9] Connecticut's retention rates for specialty health care providers (e.g., family medicine) are worse.[10] These factors mean that access to primary care is going to get harder in the coming years.

In general, 1) healthcare spending is growing faster than consumers can afford, 2) health insurance is too costly for businesses to provide without passing the cost onto employees and consumers, and 3) delivering care has become increasingly burdensome for many practitioners.

The analyses in this report provided OHS with data to determine growth trends based on a service category's aggregate spending and its growth rate. This helped inform OHS's strategy recommendations to policymakers and stakeholders to monitor and address healthcare cost growth. These recommendations consider growth rates and overall spending. Opportunities to mitigate the impact of high-spend high-growth categories may be of primary interest to the state.

---

[4]Investing in Primary Care, Y. Jabbarpour et al. July 2019 for the Patient-Centered Primary Care Collaborative and Robert Graham Center, https://archive.thepcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf

[5]PBGH Health Value Index for Successful and Collaborative Health Plan Management, Purchaser Group on Health, September 2021. https://www.pbgh.org/wp-content/uploads/2021/09/PBGH-Health-Value-Index-Results-2021.pdf

[6] The Effect of Primary Care Visits on Total Patient Care Cost: Evidence From the Veterans Health Administration, J. Gao et al. December 23, 2022, https://journals.sagepub.com/doi/10.1177/21501319221141792

[7]David C. Radley, Kristen Kolb, and Sara R. Collins, *2025 Scorecard on State Health System Performance: Fragile Progress, Continuing Disparities* (Commonwealth Fund, June 2025). https://doi.org/10.26099/w0ns-ae34

[8] Milbank Memorial Fund's Primary Care Scorecard https://www.milbank.org/primary-care-scorecard/

[9] Association of American Medical Colleges, Report on Residents, Table C6, Physician Retention in State of Residency Training, by State. https://www.aamc.org/data-reports/students-residents/report/report-residents

[10] Association of American Medical Colleges. Physician Retention in State of Residency Training, by Last Completed GME Specialty. Residents Who Completed Training, 2014-23, Table C4. https://www.aamc.org/data-reports/students-residents/data/report-residents

Finally, the healthcare marketplace is undergoing significant change due to recent federal legislation and budget issues.[11] Health insurance premiums are expected to rise at even higher rates than in recent years. As a result, Connecticut agencies are preparing for a significant number of people to lose access to Medicaid and qualified health plans through Access Health CT.[12]

OHS offers policy recommendations in this report to help position Connecticut's health system to better adapt to new access and affordability challenges.

[11] H.R. 1 (EH) - One Big Beautiful Bill Act, 119th Cong. (2025). https://www.govinfo.gov/app/details/BILLS-119hr1eh

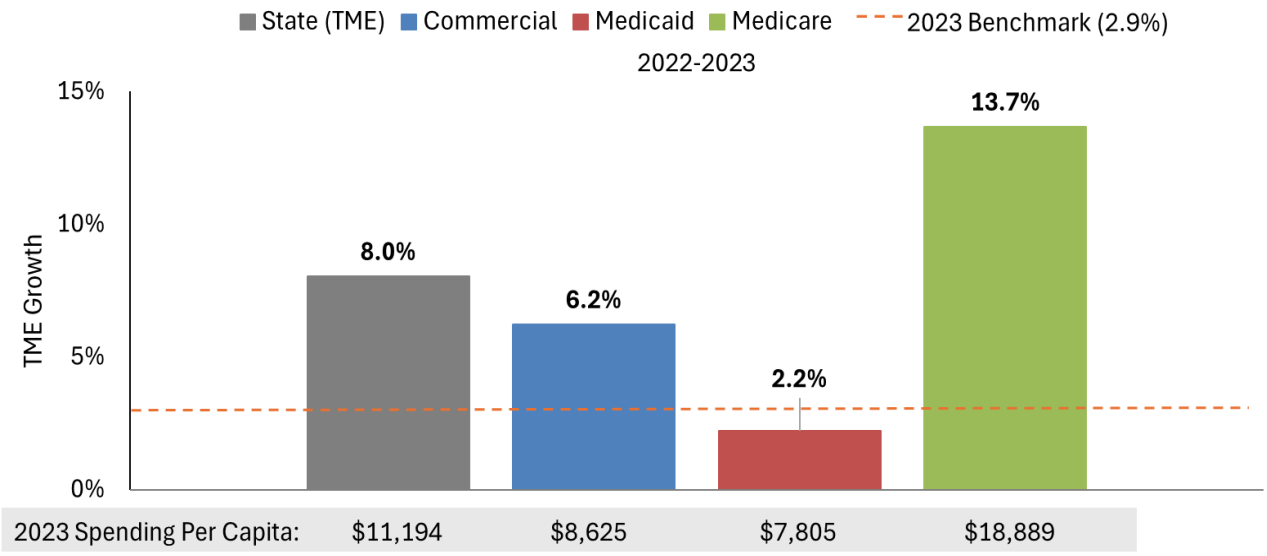
[12] Access Health CT (the state's health insurance exchange) estimates that the loss of subsidies, combined with additional requirements in the bill, could lead 30 to 35 percent of its more than 150,000 customers potentially losing coverage by 2034. See Access Health CT Estimates Impact of Reconciliation Bill, Up to 35 Percent of Customers May Lose Coverage by 2034, https://agency.accesshealthct.com/access-health-ct-estimates-impact-of-reconciliation-bill-up-to-35-percent-of-customers-may-lose-coverage-by-2034, Accessed September 23, 2025.

Summary of Cost Growth Benchmark Trends

The Cost Growth Benchmark Initiative measures healthcare spending in two ways: Total Healthcare Expenditures (THCE), which includes insurer profits and administrative expenses; and Total Medical Expenses (TME), which excludes these non-medical expenses. It compares this spending growth to a benchmark value, which broadly represents a level of growth that is affordable for Connecticut residents. The 2023 benchmark value was set at 2.9%.

From 2022 to 2023, Connecticut's THCE per capita grew 7.9%, significantly faster than the cost growth benchmark value. TME grew by 8.0% statewide, 6.2% per capita in the commercial market, 2.2% per capita for the Medicaid market and 13.7% per capita in the Medicare market. Per capita TME by market is shown in Figure 1 below.

Figure 1: State Per Capita Total Medical Expense (TME) Growth and Spending



Source: OHS collected data from insurance carriers, The Centers for Medicare and Medicaid Services (CMS), and the Connecticut Department of Social Services (DSS).

Note: Data are not risk-adjusted and data are reported net of pharmacy rebates. This data does not include the Net Cost of Private Health Insurance (NCPHI).

Summary of Cost Growth Benchmark Trends

The total spending growth can be further analyzed by looking at trends by service category, as shown in Table 1 below.

Table 1: State Per Capita Total Medical Expense by Service Category, 2022-2023

Service Category	Growth Rate (%)	Per Capita Spending Growth ($)	2023 Per Capita Spending ($)	% of Total Per Capita Spending
Non-Claims	114.0	332	622	5.6
Retail Pharmacy	9.3	158	1,851	16.5
Other Claims	8.4	46	596	5.3
Hospital Outpatient	6.9	147	2,292	20.5
Professional (Physician)	4.8	76	1,633	14.6
Professional (Other)	3.6	20	577	5.2
Hospital Inpatient	3.1	61	2007	17.9
Long-Term Care	-0.4	-6	1,615	14.4
Total	**8.0**	**833**	**11,194**	**100.0**

Non-claims spending had an outsized impact on healthcare spending growth in Connecticut in 2023, contributing almost 40% of the state's overall per capita spending growth. This was primarily due to significant increases in Medicare Advantage payments by UnitedHealthcare resulting from a switch from a fee-for-service payment model to a capitated payment model with a related organization.[13] Due to the outsized impact of these non-claims payments, OHS will continue to closely monitor non-claims spending to determine if this increase was isolated or the beginning of a trend.

Prescription drugs also continue to be a service category with significant spending. Statewide, the spending on retail pharmacy (which captures spending associated with prescription drugs filled and dispensed at local pharmacies or through mail order) increased by 9.3% from 2022 to 2023, reaching $1,851 per person annually. In most markets, this growth in spending

[13] "How Insurers That Own Providers Can Game The Medical Loss Ratio Rules", Health Affairs Forefront, September 29, 2025. DOI: 10.1377/forefront.20250926.660140 https://www.healthaffairs.org/content/forefront/insurers-own-providers-can-game-medical-loss-ratio-rules

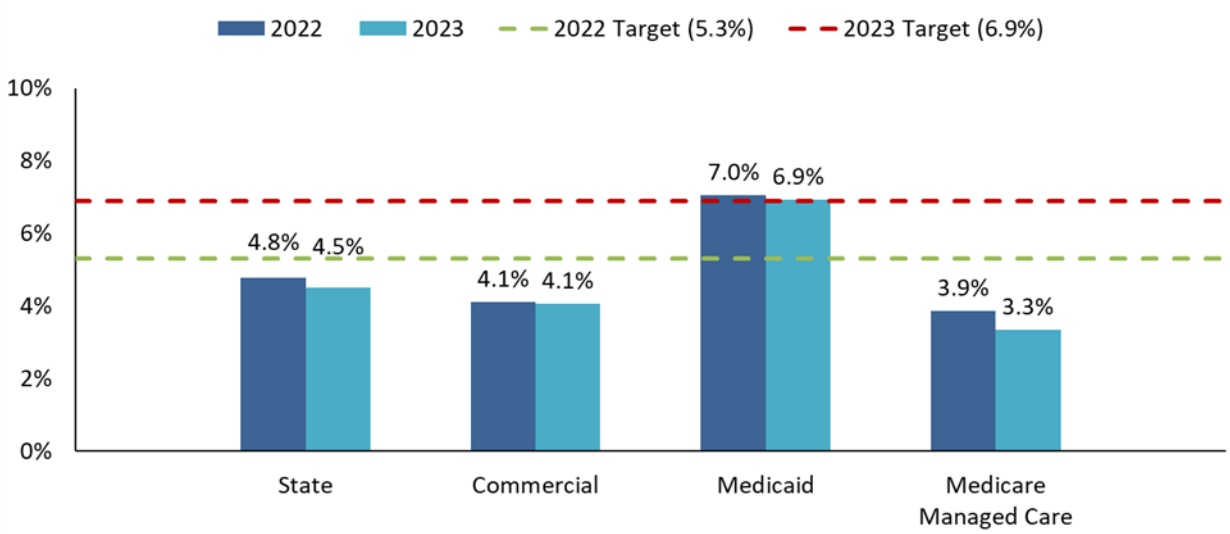
was driven by both increases in utilization and higher cost per unit. This means consumers were prescribed more medications, there was an increase in the price of medications, there was a shift to higher cost medicines, or some combination of the three.

Summary of Primary Care Spending

The Primary Care Spending Target Report measures the percentage of TME spent on primary care services and measures it against a target value, which was 6.9% in 2023. The primary care target increased to 8.5% in 2024 and will increase again when it reaches the goal value of 10% for 2025-2030.

Primary care spending in Connecticut grew by approximately $76 million to $1.13 billion in 2023. The spending on other healthcare services grew at a faster rate, however, so the percentage of dollars spent on primary care decreased from 4.8% to 4.5%, as shown in Figure 2 below.

Figure 2: Connecticut Primary Care Spending as a Percentage of Total Medical Expense, State and by Market



Source: OHS collected data from insurance carriers and from the Connecticut Department of Social Services (DSS).

Notes: Data are not risk-adjusted. Data are net of pharmacy rebates. Data include commercial, Medicare Advantage and Medicaid FFS spending. TME includes all of the spending categories captured for the cost growth benchmark, less long-term care.

Table 2: Total Primary Care Spending and Per Person Per Month at the State and Market Level

Calendar Year	Total Statewide Primary Care Spending	Statewide Primary Care Spending Per Person Per Month
Statewide		
2022	$1,051 M	$32
2023	$1,127 M	$33
Commercial		
2022	$461 M	$27
2023	$494 M	$29
Medicaid		
2022	$388 M	$26
2023	$392 M	$27
Medicare Advantage		
2022	$201 M	$49
2023	$240 M	$54

Source: OHS collected data from insurance carriers and the Connecticut Department of Social Services (DSS).

Access to high-quality primary care is essential for patient 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 total medical spending can provide stakeholders with actionable data to improve Connecticut's population health and access.

A panel of healthcare experts recommended that OHS pursue additional complementary strategies to strengthen primary care. This recommendation appears in OHS's recently published Proposed 2026-2030 Benchmarks and Recommendations of the Technical Team report.

Monitoring Unintended Adverse Consequences

OHS developed the Cost Growth Benchmark Unintended Adverse Consequences Measurement Plan in 2020 and updated it in 2021 to monitor for any unintended adverse consequences of implementing the benchmark program. OHS designed the plan to identify and address issues such as healthcare providers reducing access to services inappropriately or insurers shifting costs to consumers to curb utilization and spending.

OHS's measurement plan includes underutilization measures and consumer out-of-pocket spending. Analysis of these measures shows no unintended adverse consequences are causally linked to the benchmark program. While some measures have increased, they are in line with national trends, which are attributable to changes in plan design, the continued rise of healthcare costs for consumers, businesses, private and public payers.

The cost growth benchmark does not operate in isolation from other market factors impacting healthcare affordability, utilization, and member experience in the United States or in Connecticut. The number and composition of covered lives, provider panels, business ownership and affiliations are continuously reconfigured as are plan designs. These policies and market factors are likely to affect member experience as well.

Underutilization Measure: Clinical Quality

OHS evaluates preventive and chronic care performance through 2024 for the commercial market and for Medicaid through 2023. Final 2024 performance data for Medicaid will not be available until the end of calendar year 2025.

Commercial market performance has improved since benchmark implementation for five out of 10 preventive and chronic care measures, with performance for another two measures remaining relatively unchanged (within three percentage points). Three measures have seen a decline in performance post-benchmark implementation: *Chlamydia Screening* (-9.9 percentage points), *Eye Exam for Patients with Diabetes* (-5.9 percentage points), and *Colorectal Cancer Screening* (-3.8 percentage points) (see Appendix A Table 3). However, both regional (New England) and national performance also declined over this period for each of these measures, suggesting that these trends are neither specific to Connecticut nor influenced by the cost growth benchmark.

Medicaid performance has improved since benchmark implementation for five out of eleven preventive and chronic care measures, with performance for another six

measures remaining relatively unchanged (within three percentage points). Only one measure has seen a notable decline in performance post-benchmark implementation: *Eye Exam for Patients with Diabetes* (-4.9 percentage points) (see Appendix A Table 4). However, both regional (New England) and national performance for the measure have also declined over this period for this measure, and to a greater extent. Here again, this suggests that these trends are neither specific to Connecticut nor influenced by the cost growth benchmark.

Underutilization Measure: Member Experience

OHS monitors commercial and Medicaid pre- and post-benchmark performance on member experience surveys to assess member perception of access to care, as well as patient satisfaction with healthcare services and providers. While these are not direct measurements of underutilization, they may help identify patient perception of underutilization.

For the commercial market, OHS monitors changes in performance for two composite rates from the Health Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey: (1) the "Getting Care Quickly" composite[14] and (2) the "Getting Needed Care" composite.[15] Commercial performance on these two measures has decreased since benchmark implementation; performance on "Getting Care Quickly" and "Getting Needed Care" decreased by 6.2 and 6.1 percentage points respectively (see Appendix A Table 5). Both regional (New England) and national performance saw similar declines over this period for both measures, making cost growth benchmark causation unlikely.

For the Medicaid market, OHS monitors changes in performance for the PCMH+ Person-Centered Primary Care Measure (PCPCM) for adult and child survey respondents.[16] DSS started collecting PCPCM data post-benchmark implementation, in 2021. Performance rates across nearly all PCPCM composites declined over the period of 2021-2024 for both the adult and child surveys (see Appendix A Table 6 and Table 7). There are many factors outside of the cost growth benchmark that may

[14] The "Getting Care Quickly" composite is the percentage of members who responded "Always" or "Usually" to the questions "In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?" and "In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?"
[15] The "Getting Needed Care" composite is the percentage of members who responded "Always" or "Usually" to the questions "In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?" and "In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?"
[16] OHS initially planned to monitor changes in Medicaid member experience using the Clinician and Group (CG) CAHPS survey. DSS replaced CG-CAHPS with the PCPCM survey in the PCMH+ Wave 3 Quality Measure Set, effective January 1, 2021. For this reason, 2020 PCPCM performance data are not available.

have contributed to these declines in Medicaid member experience, including the various pressures facing safety net primary care physicians in Connecticut and elsewhere.

Unlike many of the other measures assessed through OHS's monitoring approach, OHS does not have access to regional or national PCPCM performance rates with which to compare these Connecticut trends. The observed declines in DSS's PCPCM performance cannot be causally attributed to the cost growth benchmark for these reasons. OHS will continue to monitor PCPCM performance trends and coordinate with DSS in evaluating and addressing any factors that may be impacting Medicaid member experience in Connecticut.

Underutilization Measure: Member Grievances

OHS also tracked Medicaid member grievances pre- and post-benchmark implementation to monitor for impact on patient care and potential underutilization in the Medicaid population. OHS monitored the change in the number of Medicaid members filing complaints about no or limited access to providers, and the change in the number of Medicaid members filing complaints about delayed access and/or wait time for an appointment. Complaints about no or limited access to providers have decreased by 72% post-benchmark implementation and complaints about delayed access and/or wait time for an appointment have decreased by 48% (see Appendix A Table 8).

Consumer Out-of-Pocket Spending

Finally, OHS monitors changes in consumers' healthcare costs using two different data sources: the state's All-Payer Claims Database (APCD) and the U.S. Census Bureau's Current Population Survey (CPS). While changes in out-of-pocket costs cannot be tied to the benchmark program specifically, these costs play a significant role in healthcare affordability for consumers and merit monitoring.

OHS assessed out-of-pocket expense using the APCD and found that overall, Connecticut residents in the commercial market pay about the same today as they did before benchmark implementation. Specifically, the percentage of total healthcare out-of-pocket expenses for medical and retail pharmacy services that these consumers experienced has negligibly changed (see Appendix A Table 9 and Table 10).

CPS data, which include data for all ages and insurance status, show that the *median* medical out-of-pocket spending decreased slightly for Connecticut residents, and trend similar to that of the northeast region and nationally since benchmark implementation.

Mean medical out-of-pocket spending has increased over this period. Mean medical out-of-pocket spending is greater in Connecticut than in the northeast region or across the country and continues to increase at a greater rate in our state. (see Appendix A Table 11).

Recommendations

This report recommends the following policies to address the high spending trends and access barriers identified in the cost growth benchmark and primary care spending target reports.

Recommendation 1: Increase Cost Growth Benchmark Enforcement.

OHS recommends strengthening the cost growth benchmark by adding enforcement mechanisms for entities that either exceed the benchmark or fail to participate in the Benchmark's public hearing as required by law. The Healthcare Benchmark program is designed to measure and report on healthcare spending and provide data-driven solutions to policymakers.

For the program to evolve, it must be able to hold stakeholders accountable through enforcement mechanisms. These can range from performance improvement plans for entities routinely exceeding the cost growth benchmark to a more integrated health insurance rate review (HB 6871) process (further supporting PA 25-94, §§ 6 & 7), or financial penalties for not appearing at the hearing as required by law.

Some benchmark states, like Massachusetts, California, and Oregon, are authorized to impose performance improvement plans (PIPs) on entities who exceed the benchmark. OHS generally supports authorizing PIPs rather than financial penalties, allowing the state and entities that exceed the benchmark to work together to formulate a plan to bring cost in line with the benchmark.

Additionally, despite the state's efforts to engage with stakeholders, pharmaceutical companies have refused to participate in the benchmark hearings. Their participation is required by law when they are identified as a significant contributor to the state exceeding the benchmark. The state should consider developing financial penalties for entities legally required to attend the annual benchmark hearing but who fail to appear and participate.

Recommendation 2: Increase and incentivize the use of biosimilar and generic substitution.

Biosimilar and generic medications are available at lower per unit costs than the brand name drug. The increased adoption of these medications will lower prescription drug costs across the healthcare system and since the patient's cost share is often based on the gross cost of the drug, lower cost biosimilars offer the potential to lower patient out-of-pocket costs as well. Connecticut could seek to increase biosimilar adoption. The OHS Report of Pharmacy Benefit Manager Practices

recommends a number of strategies to help achieve this goal, including requiring 1) PBMs and payers provide lower patient cost share via formularies for preferred products when a less-expensive biosimilar is available in the market, and 2) PBMs to provide net price justification, including transparency into net cost after rebates, when preferring higher list price products over lower list price alternatives (generics or biosimilars).

Recommendation 3: Support Alternative Primary Care Payment Models.

Another way to support primary care investment is to bolster alternative payment models and other robust primary care initiatives that help rebalance existing healthcare dollars to alleviate access challenges that Connecticut residents currently face. OHS recommends supporting existing alternative payment models, such as the new U.S. Centers for Medicare and Medicaid Services (CMS) Achieving Healthcare Efficiency through Accountable Design (AHEAD) demonstration model. The AHEAD model proposes a voluntary global budget, which helps limit cost growth, while providing additional primary care payments to participating practices.

Appendices

Appendix A: Unintended Consequences Data Tables

Table 3: Connecticut Performance on Underutilization Measures in the Commercial Market

	Pre-Benchmark		Post-Benchmark				
Measure Name	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**Pre/post benchmark (2019 vs. 2024[17]) change in percentage points**
Asthma Medication Ratio	78.30%	78.50%	81.70%	83.30%	83.20%	78.20%	-0.1 ↓
Breast Cancer Screening	77.70%	78.40%	76.50%	81.30%	82.10%	82.90%	5.2 ↑
Cervical Cancer Screening	81.80%	82.50%	79.90%	83.20%	83.40%	84.90%	3.1 ↑
Child and Adolescent Well-Care Visits	NA[18]	72.30%	77.20%	78.80%	80.40%	80.90%	8.6 ↑
Chlamydia Screening in Women	66.20%	66.70%	58.80%	55.20%	54.80%	56.40%	-9.9 ↓

[17] All measures assess the change in performance from 2019 to 2024, except for Child and Adolescent Well-Care Visits which assesses the change in performance from 2020 to 2024 because it was new for measurement year 2021 (calendar year 2020).
[18] Child and Adolescent Well-Care Visits was new for calendar year 2020.

Appendix A

	Pre-Benchmark		Post-Benchmark				
Measure Name	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**Pre/post benchmark (2019 vs. 2024[17]) change in percentage points**
Colorectal Cancer Screening	72.80%	74.10%	71.50%	70.10%	73.70%	69.00%	-3.8 ↓
Controlling High Blood Pressure	61.10%	61.40%	58.50%	65.30%	70.10%	70.90%	9.8 ↑
Eye Exam for Patients with Diabetes	65.70%	67.10%	60.90%	62.20%	59.10%	59.80%	-5.9 ↓
Prenatal and Postpartum Care – Postpartum Care	85.70%	86.10%	82.10%	86.70%	87.80%	93.80%	8.2 ↑
Prenatal and Postpartum Care – Timeliness of Prenatal Care	89.00%	89.50%	85.10%	88.90%	83.80%	86.80%	-2.2 ↓

Data Source: NCQA Quality Compass® 2020-2025. Connecticut performance is a weighted average of commercial plan performance.

Appendix A

Table 4: Connecticut Performance on Medicaid Underutilization Measures

Measure Name	2019	2020	2021	2022	2023	Pre/post benchmark (2019 vs. 2023[19]) change in percentage points
Asthma Medication Ratio	64.3%	69.3%	65.2%	64.6%	66.3%	2.0 ↑
Behavioral Health Screening	37.9%	38.5%	42.5%	45.3%	46.5%	8.6 ↑
Breast Cancer Screening	59.7%	56.0%	55.5%	57.7%	57.5%	-2.2 ↓
Cervical Cancer Screening[20]	59.7%	56.1%	55.2%	54.3%	59.2%	-0.5 ↓
Child and Adolescent Well-Care Visits	NA[21]	60.4%	66.6%	64.1%	66.9%	6.5 ↑

[19] All measures assess the change in performance from 2019 to 2023, except for *Child and Adolescent Well-Care Visits* which assesses the change in performance from 2020 to 2023 because it was new for measurement year 2021 (calendar year 2020).
[20] This hybrid data (i.e., administrative and clinical data) measure is reported using administrative claims data only for all rates due to data availability limitations.
[21] *Child and Adolescent Well-Care Visits* was new for calendar year 2020.

Appendix A

Measure Name	2019	2020	2021	2022	2023	Pre/post benchmark (2019 vs. 2023[19]) change in percentage points
Chlamydia Screening in Women	67.7%	63.6%	66.1%	66.4%	66.4%	-1.3 ↓
Controlling High Blood Pressure	61.2%	60.0%	63.7%	62.2%	70.4%	9.2 ↑
Developmental Screening in the First Three Years of Life	63.0%	63.3%	65.0%	63.7%	64.6%	1.6 ↑
Eye Exam for Patients with Diabetes[22]	56.9%	50.6%	53.7%	53.8%	52.0%	-4.9 ↓
Prenatal and Postpartum Care – Postpartum Care[23]	52.7%	53.1%	55.0%	58.6%	59.9%	7.2 ↑
Prenatal and Postpartum Care –	67.4%	70.2%	65.8%	67.6%	66.7%	-0.7 ↓

[22] This hybrid measure is reported using administrative claims data only for all rates due to data availability limitations.
[23] This hybrid measure is reported using administrative claims data only for all rates due to data availability limitations.

Appendix A

Measure Name	2019	2020	2021	2022	2023	Pre/post benchmark (2019 vs. 2023[19]) change in percentage points
Timeliness of Prenatal Care[24]						

Data Source: Data were obtained from DSS's HUSKY Health Program Health Equities Report, MY2019, MY2020, MY2021, MY2022, and MY2023, except for *Controlling High Blood Pressure* for MY2022 and MY2023, for which performance data were obtained from DSS's Quality Benchmark data.

[24] This hybrid measure is reported using administrative claims data only for all rates due to data availability limitations.

Table 5: Connecticut Commercial Member Experience Measures

Measure Name	2020	2021	2022	2023	2024	Pre/post benchmark (2020 vs. 2024[25]) change in percentage points
"Getting Care Quickly" Composite[26] (Health Plan CAHPS)	87.0%	83.5%	83.8%	80.8%	NA	-6.2 ↓
"Getting Needed Care" Composite[27] (Health Plan CAHPS)	90.1%	84.4%	83.0%	85.1%	84.0%	-6.1 ↓

Data Source: NCQA Quality Compass® 2021-2025. Connecticut performance is a weighted average of commercial plan performance.

[25] For the "Getting Care Quickly" Composite, the reported change is for 2020-2023, as none of the four largest commercial insurers had sufficient denominator sizes for reporting on this composite in 2024.
[26] The "Getting Care Quickly" composite is the percentage of members who responded "Always" or "Usually" to the questions "In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?" and "In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?"
[27] The "Getting Needed Care" composite is the percentage of members who responded "Always" or "Usually" to the questions "In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?" and "In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?"

Appendix A

Table 6: Medicaid Adult Composite Member Experience Measures

How would you assess your primary care experience (total "definitely" or "mostly")?	2021	2022	2023	2024	2021-2024 change in percentage points
In caring for me, my doctor considers all factors that affect my health	89.0%	87.5%	87.3%	88.3%	-0.7 ↓
My practice is able to provide most of my care	89.0%	86.1%	86.3%	88.2%	-0.8 ↓
My practice makes it easy to get care	88.3%	84.8%	85.4%	87.8%	-0.5 ↓
Over time, my practice helps me to stay healthy	87.4%	85.4%	85.5%	84.4%	-3.0 ↓
My practice coordinates the care I get from multiple practices	82.6%	82.0%	81.2%	82.6%	=
Over time, my practice helps me meet my goals	85.5%	81.6%	79.4%	77.0%	-8.5 ↓
My doctor or practice knows me as a person	79.8%	72.9%	78.9%	75.4%	-4.4 ↓
My doctor or practice stands up for me	79.8%	74.4%	76.5%	74.2%	-5.6 ↓
The care I get takes into account the knowledge of my family	79.7%	78.8%	74.5%	72.1%	-7.6 ↓
The care I get in this practice is informed by knowledge of my community	74.3%	72.1%	67.6%	67.1%	-7.2 ↓
My doctor and I have been through a lot together	64.6%	54.9%	55.8%	55.1%	-9.5 ↓
Average	**81.8%**	**78.2%**	**78.0%**	**77.5%**	**-4.3 ↓**

Data Source: 2021 PCMH+ PCPCM Survey Person-Centered Primary Care Measure Composite Findings, 2024 PCMH+ PCPCM Survey Person-Centered Primary Care Measure Composite Findings

Appendix A

Table 7: Medicaid Child Composite Member Experience Measures

How would you assess your primary care experience (total "definitely or "mostly")?	2021	2022	2023	2024	2021-2024 change in percentage points
In caring for me, my doctor considers all factors that affect my health	90.8%	89.8%	89.3%	90.7%	-0.1 ↓
My practice is able to provide most of my care	91.7%	89.7%	89.9%	91.3%	-0.4 ↓
My practice makes it easy to get care	90.9%	87.5%	88.5%	89.4%	-1.5 ↓
Over time, my practice helps me to stay healthy	90.1%	89.1%	89.9%	87.8%	-2.3 ↓
My practice coordinates the care I get from multiple practices	80.2%	82.6%	83.9%	84.1%	3.9 ↑
Over time, my practice helps me meet my goals	89.3%	84.5%	82.9%	81.0%	-8.3 ↓
My doctor or practice knows me as a person	83.8%	79.2%	83.2%	77.2%	-6.6 ↓
My doctor or practice stands up for me	83.7%	78.0%	78.1%	75.4%	-8.3 ↓
The care I get takes into account the knowledge of my family	87.4%	85.6%	84.4%	82.5%	-4.9 ↓
The care I get in this practice is informed by knowledge of my community	81.0%	75.7%	73.7%	74.3%	-6.7 ↓
My doctor and I have been through a lot together	69.0%	57.4%	54.9%	56.1%	-12.9 ↓
Average	**85.3%**	**81.7%**	**81.7%**	**80.9%**	**-4.4 ↓**

Data Source: 2021 PCMH+ PCPCM Survey Person-Centered Primary Care Measure Composite Findings, 2024 PCMH+ PCPCM Survey Person-Centered Primary Care Measure Composite Findings

Appendix A

Table 8: Medicaid Member Complaints per 1,000 Member Months (MM)

Measure	Pre-Benchmark (2019-2020)		Post-Benchmark (2021-2024)		Pre/Post Benchmark Change
	Total	Per 1,000 MM	Total	Per 1,000 MM	
Complaints about no or limited access to a specific provider type	690	0.033	457	0.009	-72% ↓
Complaints about delayed access and/or wait time for an appointment (e.g., delay in obtaining appointment, wait time while in office)	69	0.003	84	0.002	-48% ↓

Data Source: DSS

Appendix A

Table 9: Commercial Medical Out-of-Pocket (OOP) Spending Per Member Per Month (PMPM) and Percentage of Total Spending PMPM by Payer

Payer	Average pre-benchmark (2017-2020)		Average post-benchmark (2021-2023)		Pre/Post benchmark change
	OOP PMPM	% of Total PMPM	OOP PMPM	% of Total PMPM	Percentage points (pp)
All Payers	**$53.05**	**12.50%**	**$59.77**	**11.60%**	**-0.9 pp ↓**
Aetna	$57.36	14.40%	$64.63	12.90%	*-1.5 pp ↓*
Anthem	$43.23	9.50%	*$39.69*	*7.10%*	*-2.4 pp ↓*
State Employees	*$9.59*	*1.90%*	*$9.97*	*1.60%*	*-0.2 pp ↓*
Non-State Employees	*$61.56*	*14.50%*	$56.65	10.60%	*-3.8 pp ↓*
Cigna	$55.51	13.40%	$65.45	13.90%	*0.4 pp ↑*
ConnectiCare	$93.10	19.40%	$94.41	17.60%	*-1.8 pp ↓*
Harvard Pilgrim Health Care	$75.72	19.10%	$83.24	17.30%	*-1.7 pp ↓*
Tufts Health Plan	$36.91	15.50%	$61.23	13.60%	*-1.9 pp ↓*
UnitedHealthcare	$44.57	12.00%	$71.27	16.60%	*4.6 pp ↑*
State Employees	*$10.21*	*2.30%*	-	-	-
Non-State Employees	*$58.25*	*16.80%*	*$71.27*	*16.60%*	*-0.2 pp ↓*

Data Source: Connecticut All-Payer Claims Database
Note: The ↑ symbol indicates that out-of-pocket spending increased post-benchmark implementation, the ↓ symbol indicates that out-of-pocket spending decreased post-benchmark implementation, and the → symbol indicates that out-of-pocket spending did not change post-benchmark implementation. United Healthcare only included State Employees from 2017-2020.

Appendix A

Table 10: Commercial Retail Pharmacy Out-of-Pocket (OOP) Spending Per Member Per Month (PMPM) and Percentage of Total Spending PMPM by Payer

Payer	Average pre-benchmark (2017-2020)		Average post-benchmark (2021-2023)		Pre/Post benchmark change
	OOP PMPM	% of Total PMPM	OOP PMPM	% of Total PMPM	Percentage points (pp)
All Payers	**$11.56**	**11.10%**	**$14.88**	**10.80%**	**-0.3 pp ↓**
Aetna	$7.57	6.60%	$12.58	9.50%	2.9 pp ↑
State Employees	*$3.81*	*2.40%*	*$15.65*	*9.20%*	*6.8 pp ↑*
Non-State Employees	*$9.23*	*9.50%*	*$10.98*	*9.70%*	*0.2 pp ↑*
Anthem	$22.26	15.00%	$23.70	12.90%	-2.2 pp ↓
Cigna	$13.22	13.00%	$15.47	9.60%	-3.4 pp ↓
ConnectiCare	$17.94	14.60%	$20.81	11.10%	-3.5 pp ↓
Express Scripts	$7.50	11.60%	$9.81	11.40%	-0.2 pp ↓
Harvard Pilgrim Health Care	$13.99	13.20%	$15.59	10.00%	-3.3 pp ↓
Tufts Health Plan	$11.27	10.70%	$13.33	8.70%	-2.0 pp ↓
UnitedHealthcare	$14.61	14.40%	$16.17	10.90%	-3.5 pp ↓

Data Source: Connecticut All-Payer Claims Database

Note: The ↑ symbol indicates that out-of-pocket spending increased post-benchmark implementation, the ↓ symbol indicates that out-of-pocket spending decreased post-benchmark implementation, and the → symbol indicates that out-of-pocket spending did not change post-benchmark implementation. Tufts did not include pharmacy coverage until 2020.

Appendix A

Table 11: Medical Out-of-Pocket Spending Per Member Per Month

Region	Average pre-benchmark (2019-2020)				Average post-benchmark (2021-2023)				Pre/Post benchmark percent change			
	Q25	Med	Q75	Mean	Q25	Med	Q75	Mean	Q25	Med	Q75	Mean
Connecticut	$8.33	$50.00	$241.67	$182.51	$7.19	$48.96	$250.42	$201.30	-14%	-2% ↓	4%	10% ↑
Northeast	$5.83	$39.17	$184.17	$156.17	$4.38	$37.79	$189.00	$161.94	-25%	-4% ↓	3%	4% ↑
National	$5.00	$37.58	$183.33	$151.85	$4.17	$36.98	$183.92	$155.78	-17%	-2% ↓	0%	3% ↑

Data Source: Current Population Survey (CPS) – Annual Social and Economic (ASEC) Supplement, Years 2019-2024, https://www.census.gov/data/datasets/time-series/demo/cps/cps-asec.html.

Note: The ↑ symbol indicates that out-of-pocket spending increased post-benchmark implementation, the ↓ symbol indicates that out-of-pocket spending decreased post-benchmark implementation, and the → symbol indicates that out-of-pocket spending did not change post-benchmark implementation.

Appendix B: Glossary

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.

Copayment: 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.

Fee-for-Service: Private (commercial) health insurance that reimburses healthcare providers based on 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 spending. OHS has set values for each calendar year through 2025.

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 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. 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, pay-for-performance bonuses, risk settlements, care management payments, etc.

Out-of-Pocket Spending: 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 Target: This target is Connecticut's annual primary care spending as a percentage of total medical expenditures. The target should reach 10% by calendar year 2025, as directed in C.G.S. §§ 19a-754f et seq. OHS has set interim targets for each calendar year to reach 10% by 2025.

Professional physician: TME paid to primary care providers delivering care at a primary care site of care generated from claims using a code-level definition and the TME paid to physicians or physician group practices generated from claims, including services provided by a doctor of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined as primary care in the primary care definition.

Professional physician also includes TME paid from claims to healthcare providers for services provided by a licensed practitioner other than a physician and not identified as primary care in the primary care definition.

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 Connecticut Healthcare Benchmark Initiative Implementation Manual.

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 are contained in the Appendices of the Connecticut Healthcare Benchmark Initiative Implementation Manual.