Key Healthcare Benchmark Terms

Allowed Amount: The amount the payer paid a provider, plus any member cost sharing (coinsurance, copay, deductible) for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims spending.

All-Payer Claims Database (APCD): The All-Payer Claims Database, created by law in 2012, is Connecticut's hub for insurance claims. Analysis of claims data helps to improve health and healthcare delivery in Connecticut by supporting policy and research that address healthcare delivery concerns. It includes commercial fully insured and some self-insured, Medicare Advantage, and Medicaid medical, pharmacy claims and enrollment data.

Calendar Year (also called Performance Year): The most recent calendar year (1/1-12/31) for which data were submitted for the applicable healthcare cost growth benchmark, primary care spending target or healthcare quality benchmark.

Coinsurance: The percentage of costs of a covered healthcare service the member pays after they have paid their deductible. For example, a member pays 20% and the plan pays 80% after the deductible is met.

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.

Commercial Market: Health insurance plans that cover fully insured, self-insured, individuals, small and large employer groups, CT state and municipal employees, and students are collectively referred to as the "commercial market."

Deductible: The amount the member pays for covered health services before their insurance plan starts to pay. For example, with a $2,000 deductible, the mem r pays for the first $2,000 of covered services themselves.

Fee-for-service: A negotiated or payer-specified payment rate for every unit of service providers deliver.

Fully Insured: A plan where employers pay a monthly premium to the insurer, and the health insurer assumes the risk and pays for the health care costs.

Healthcare Cost Growth Benchmark ("Benchmark"): The healthcare cost growth benchmark ("benchmark") is the targeted annual growth rate for Connecticut's healthcare spending, expressed as the percentage growth from the prior year's per person spending. The benchmark is set on a calendar year basis (i.e., benchmarks for each calendar year).

Market: The highest level of categorization of the health insurance coverage groups. This includes Medicaid, Medicare, and commercial.

Medicaid Market: Medicaid Fee-for-Service is referred to as the "Medicaid market."

Medical Pharmacy: Prescriptions administered to patients in providers' offices, hospitals and nursing facilities.

Medicare Market: Medicare Fee-For-Service (FFS) and Medicare Advantage are collectively referred to as the "Medicare market."

Member Months: The number of individuals receiving coverage from the payer each month for some period of months. A member with coverage for the year counts as 12 member months.

Payer: A payer includes any governmental or non-governmental organization paying for health insurance claims including Medicare and Medicare. Private payers include subsidiaries, affiliates or businesses owned or controlled by a payer that pay healthcare providers for healthcare services, or pharmacies or provider entities for prescription drugs.

Per Member Per Month (PMPM) Spending: The total dollars spent (spending) for the period divided by the number of member months.

Pharmacy Benefit Manager (PBM): Pharmacy Benefit Managers administer the prescription drug, prescription device, or pharmacist services portion of a health benefit plan on behalf of plan sponsors (e.g., self-insured employers, insurance companies, or HMOs).

Pharmacy Rebates: Pharmacy rebates are discounts on prescription drugs that are negotiated by pharmacy benefit companies (PBMs) with drug manufacturers. The All-Payer Claims Data are typically net of pharmacy rebates.

Payment or Payment per Unit (PPU): Average price or amount paid per unit. This amount includes both the payer payment and the member out-of-pocket or cost sharing payment. For inpatient hospital and long term care, a unit is a single hospital stay from admission to discharge. For pharmacy services, a unit represents a 30-day equivalent prescription. For all other service categories, a unit is a service provided during a medical visit.

Retail Pharmacy: Prescription medicines obtained by patients directly from retail pharmacies including both stores (e.g., CVS or Walgreens) and mail order pharmacies.

Self-insured: A plan where the employer assumes the risk and pays for the health care costs directly. The employer frequently pays a fee for a third-party administrator (TPA) or Administrative Services Organization (ASO) to administer the plan.

Spending: The total amount paid for a medical or prescription drug claim, including insurance payments and consumer out-of-pocket payments. Manufacturer rebates are typically not included

in drug claims. This is often referred to as the **Cost** of Medical Care. Generally, it is payment times utilization.

Utilization or Units per 1000 Members (UPK): The rate of use of services per thousand members, calculated as the number of units divided by the number of members times 1000. For inpatient hospital and long term care, a unit is a single hospital stay from admission to discharge. For pharmacy services, a unit represents a 30-day equivalent prescription. For all other service categories, a unit is a service provided during a medical visit.

Other Benchmark Terms

Advanced Network:[1] An organized group of clinicians that come together for the purposes of contracting, or are 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.

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 plans.

Net Cost of Private Health Insurance (NCPHI): Measures the costs to Connecticut residents associated with the administration of private health insurance (including 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.

Total Healthcare Expenditures (THCE): The sum of all healthcare expenditures in this state 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.

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 person 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,

[1] The term "Advanced Network" is equivalent to the term "provider entity" as used in Connecticut General Statute 19a-754g et. Seq.

small group, Medicare, Medicaid, Medicare/Medicaid dually eligible) and at the Advanced Network level whenever possible.

Primary Care Spending Target ("Target"): This target is Connecticut's annual primary care spending goal as a percentage of total medical expenditures. The target should reach 10 percent by calendar year 2025, as directed in Connecticut General Statute 19a-754g et. Seq. Interim targets are set on an annual calendar year basis (i.e., a target for each calendar year).