Healthcare Benchmark Initiative
Cost Growth Benchmark Program
Advanced Network Frequently Asked Questions
October 2025

The Office of Health Strategy (OHS) has provided responses to these Frequently Asked Questions (FAQs) for Advanced Networks for which spending is measured under the Cost Growth Benchmark Initiative

1. What is the Cost Growth Benchmark?

Governor Lamont signed Executive Order #5 in January 2020, charging the OHS to benchmark total healthcare expenditure growth in the state. During the 2022 legislative session, Public Act 22-118 §217-223 codified most of Executive Order No. 5's provisions into law (Conn. Gen. Statute §19a-754f et seq).

In 2020, an OHS advisory body recommended a benchmark target for constraining healthcare spending growth to a level in line with projected state economic and household income growth, with the aim of improving healthcare affordability for Connecticut residents and employers. That cost growth benchmark value was 2.9% and was based on a 20/80 weighting of the projected growth in Connecticut's Potential Gross State Product (PGSP) and in Connecticut's median household income.

The advisory body recommended an upward adjustment to the benchmark value for the first two years and OHS concurred, setting the benchmark at 3.4% for 2021 and 3.2% for 2022 (see Table 1). OHS subsequently adjusted the 2024 benchmark value upwards to account for the lagged impact of extraordinary inflation in 2022 to 4.0%.

In 2025, OHS convened another advisory body to recommend cost growth benchmark values for 2026-2030. Following the work of that body, OHS adopted a 2.8% cost growth benchmark for those five years, linked to projected median household income growth.

Additional background data and information can be found on the OHS Healthcare Benchmark Initiative webpage.

Table 1. *Annual Cost Growth Benchmark Values, 2021-30*

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

2. How does OHS assess spending against the benchmark?

OHS assesses Advanced Network spending on a per capita basis, using a per-member-per-month (PMPM) measure. Spending growth is risk-adjusted for changes in each Advanced Network's attributed patient population's age and sex composition using data provided by payers.

A confidence interval is constructed around each Advanced Network's spending using statistical data submitted by payers. If the lower bound of the confidence interval exceeds the benchmark, the entity is determined to have exceeded the benchmark. If the upper bound is below the benchmark, the entity is considered to have met the benchmark. If the benchmark value falls within the confidence interval, the entity's performance relative to the benchmark cannot be determined.

OHS publicly reports Advanced Network performance against the benchmark for a given market (e.g., commercial, Medicaid, Medicare) only if an Advanced Network had more than 60,000 member months attributed in both the baseline year and the performance year for that market.

3. How does OHS collect Advanced Network-level cost growth data?

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 the Department of Social Services for Medicaid. Medicare Fee-for-Service provided by CMS data is not disaggregated to the Advanced Network level; therefore, Advanced Network Medicare trends are limited to Medicare Advantage, which is indicated in all public reporting.

Payers attribute each member to an Advanced Network based on primary care provider affiliation using one of three methods and a list of Advanced Network provided Tax Identification Numbers (see page 4 *and 4*).

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. Payers use a runout period of at least six months and apply completion factors for claims incurred but not yet reported or paid.

Spending is limited to Connecticut residents within plans that include, at a minimum, medical benefits. OHS does not net out pharmacy rebates for measurement at the Advanced Network level. Non-medical spending made on behalf of members is not included in reported spending (i.e., gym memberships).

4. How does OHS enforce the benchmark?

The primary accountability mechanism of the cost growth benchmark program is transparent public reporting and discussed in at least one public hearing.

5. What is the timeline for Cost Growth Benchmark reporting?

A brief outline of cost growth benchmark reporting can be found in Table 2.

Table 2. *Timeline for Cost Growth Benchmark Reporting*

Date	Description
August 15, 2025	Payers are required to submit their cost growth benchmark data by this date.
August-November 2025	OHS validation of payer submissions.
December 2025	OHS preparation and sharing of preliminary results with each Advanced Network in the form of a "First Look Report."
January 2026	OHS request to each Advanced Network for their 2024 and 2025 TINs.
March 31, 2026	The statutory deadline for OHS to publish cost growth benchmark results.

6. How do payers attribute members to Advanced Networks?

OHS instructs payers to attribute members to Advanced Networks based on the member's relationship with a primary care provider, using one of three methodologies: (1) member selection, (2) contractual arrangements, or (3) utilization (see Table 3 for definitions). Members are first attributed to primary care providers, who are then attributed to Advanced Networks using the TINs list provided by each Advanced Network. Each member may only be attributed through a single methodology to one Advanced Network for a given calendar month.

***Table 3**. Member Attribution Hierarchy Tiers*

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 (see *FAQ #8*).

7. How do payers attribute Advanced Network patients via utilization?

As noted above, for Tier 3, OHS instructs payers to attribute members to Advanced Networks based on their utilization of primary care services with primary care providers. As discussed in *FAQ #6 on page 4*, primary care providers are then linked to Advanced Networks using the TINs provided to OHS by each Advanced Network.

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, either the calendar year being assessed or a pre-determined look-back period. Some payers also consider the primary care clinician who issued prescriptions for a patient but did not see the clinician during the lookback period.

In some cases, payers may attribute members to Advanced Networks via specialists based on contractual arrangements or because the members received primary care services from specialist providers associated with the Advanced Network (e.g., OB/GYNs).

8. How and why does OHS collect Taxpayer Identification Numbers (TINs) from Advanced Networks?

OHS contacts each Advanced Network early in each calendar year to request the Taxpayer Identification Number(s) (TIN(s)) of their primary care providers for the two prior calendar years. For example, in January 2026, OHS will request TINs for calendar years 2024 and 2025. TINs are provided by market and applicable timeframe.

OHS follows up with an Advanced Network if any reported TIN overlaps with those of another Advanced Network to remove duplications. Guidance provided to payers on the use of TINs can be found in the Cost Growth Benchmark Program's data submission guide: HCBI Guidance for Payers and Providers.

9. What do Advanced Networks do if they have data questions when they receive their First Look report?

Please note that data contained in "First Look" reports may differ from data received from payers in medical cost reports. Several factors contribute to these differences in membership and spending including: the exclusion of members in self-funded plans by some payers, the exclusion of non-Connecticut residents, and the inclusion of members attributed through utilization (see *FAQ #7, page 4*).

If Advanced Networks have questions about payer-reported data, OHS encourages them to reach out directly to their payer representatives. OHS can also provide contacts for payer personnel involved in the cost growth benchmark reporting. Additionally, if Advanced Networks would like support in their communications with payers, OHS can serve as a point of contact and facilitate conversations between Advanced Networks and payers.