NJHealth New Jersey Department of Health
Office of Health Care Affordability and Transparency

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Health Care Cost Growth Benchmark Report: Performance Year 1 (2022–2023)

Report to the New Jersey Health Care Affordability, Responsibility, and Transparency Program

January 2026

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Executive Summary

A. HART Program background

To improve health care affordability for New Jerseyans, Governor Phil Murphy signed Executive Order 277 in December 2021, launching the state's health care cost growth benchmarking effort, the Health Care Affordability, Responsibility, and Transparency (HART) Program, and establishing targets for health care spending growth. Executive Order 277 was accompanied by a compact agreed to by stakeholders throughout the state, including hospitals and health care providers, carriers, employers, consumer groups, union groups, and policy organizations, all of which committed to working collaboratively to meet the established targets for curbing health care spending growth and to analyzing data to monitor their progress in meeting those targets.

In January 2025, the governor signed Executive Order 377 to transition the HART Program within the Office of Health Care Affordability and Transparency from the Governor's Office to the New Jersey Department of Health to support sustainable and continued implementation of the administration's consumer-focused work on health care affordability.

To work toward the goals of making health care more affordable, facilitating the transparent reporting of health care costs in the state, and using data to understand the causes of rising health care costs and to inform strategies to reduce health care cost growth, the HART Program does the following:

1. Establishes a target rate of growth for health care spending
2. Collects data to track and report on progress in meeting those targets
3. Sheds light on factors driving spending growth
4. Identifies strategies to curb growth

In addition, the program will regularly produce two sets of reports: (1) reports on the cost growth benchmark that track the state's progress in meeting its annual target for health care spending and (2) cost driver reports that shed light on factors driving spending growth and that identify opportunities to curb that growth. This Cost Growth Benchmark Report for Performance Year 1 presents the findings from an analysis of 2022 and 2023 data on health care spending. Together, the annual reports will serve as resources for stakeholders to understand what is contributing to high health care spending in New Jersey and to take action to slow the rate of spending growth to make it more affordable for New Jerseyans.

B. Key findings for 2022 to 2023 health care cost growth

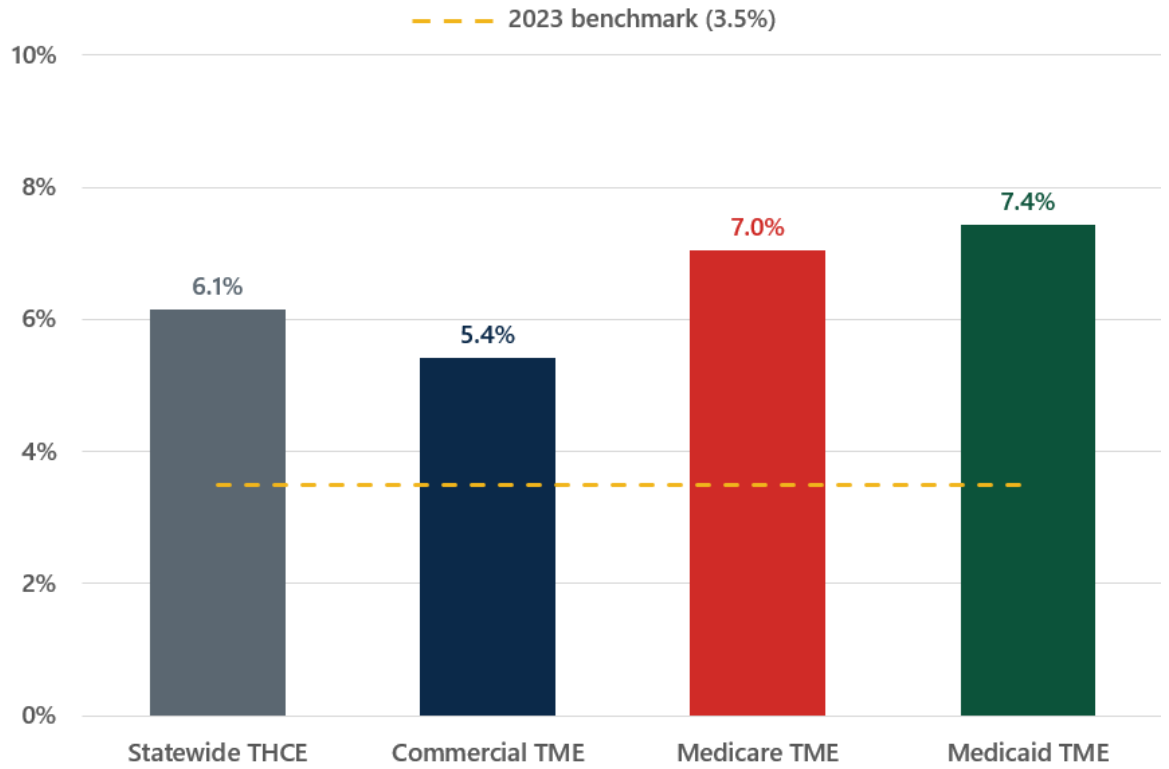
The HART Program's annual Cost Growth Benchmark Reports offer insight into the year-over-year change in total health care spending in New Jersey. This report presents health care spending for the program's Performance Year 1 (covering calendar years 2022 and 2023) and spending growth between those years both statewide and for each of the three major insurance markets—commercial, Medicare, and Medicaid—along with detailed analyses by categories of service. This report also includes carrier and provider level spending growth for the commercial, Medicare Advantage, and Medicaid Managed Care markets. This report compares spending growth at the statewide, market, carrier, and provider levels to the pre-established benchmark of 3.5 percent.

The HART Program measures health care spending as total health care expenditures, which is the sum of total medical expenses and the net cost of private health insurance. Total medical expenses measures the spending on the direct provision of health care services and consists of claims and non-claims payments that carriers made to providers as well as the cost sharing paid by members such as copayments, deductibles, and coinsurance. Net cost of private health insurance captures the administrative costs of private insurance, including Medicare Advantage and Medicaid Managed Care.

Exhibit ES.1 shows the key findings for 2022 and 2023 statewide and market level spending growth:

- **Statewide per person per year total health care expenditures increased by 6.1 percent between 2022 and 2023, exceeding the cost growth benchmark target of 3.5 percent by 2.6 percent.**
  - Between 2022 and 2023, total health care expenditures per person per year grew from $10,663 to $11,319.
- **All markets experienced growth in per person per year total medical expenses between 2022 and 2023 that exceeded the benchmark, but the degree to which they grew varied by market:**
  - The commercial market saw the lowest growth, increasing by 5.4 percent from $7,661 to $8,077.
  - The Medicare market saw the second highest growth, increasing by 7.0 percent from $16,729 to $17,908.
  - The Medicaid market saw the highest growth, increasing by 7.4 percent from $8,486 to $9,117.

Exhibit ES.1. 2022 to 2023 percentage change in statewide PPPY THCE and market level PPPY TME



PPPY = per person per year; THCE = total health care expenditures; TME = total medical expenses.

I. Introduction

A. The Health Care Affordability, Responsibility, and Transparency Program and the cost growth benchmark

New Jersey's rate of health care spending growth is unsustainable and places a heavy burden on the state, its employers, and its residents. A 2022 Altarum survey found that nearly three in five New Jerseyans reported experiencing some health care affordability burden within the past year and more than four in five (85 percent) worry about affording health care in the future.[1] The recent increases in spending have not resulted in substantial improvements in health care outcomes or the value of care received.[2, 3, 4]

As detailed in the *Health Care Spending Trends for New Jersey Residents with Commercial Insurance, 2016–2021* report, per person health care spending for New Jersey residents with employer-sponsored insurance increased from 2016 to 2021.[5] For New Jerseyans with employer-sponsored commercial health insurance, much of this increase in spending was from rising prices across all major service categories, including inpatient facility, outpatient facility, professional, and retail pharmacy services. Price increases drove spending growth during the study period, not utilization.

In response to rising health care costs and the burden placed on New Jersey residents, Governor Phil Murphy established the Health Care Affordability, Responsibility, and Transparency (HART) Program. In collaboration with the Health Care Affordability Advisory Group and the Health Care Affordability Interagency Working Group, the HART Program established a health care cost growth benchmark, a yearly target for per capita health care spending growth, founded on the notion that health care spending should not grow more than incomes of New Jerseyans or the state economy. The Interagency Working Group set forth four criteria that the benchmark should follow:

1. Provide a stable and predictable target
2. Rely on independent, objective data sources
3. Reflect the real world incomes of New Jerseyans, not outliers
4. Result in lower spending growth for the state

Based on these criteria, the Interagency Working group opted for a benchmark that was calculated from a blend of 25 percent Potential Gross State Product (or the expected growth rate of New Jersey's economy) and 75 percent forecasted Median Household Income. Additional methodological details on the establishment of the benchmark targets can be found in the HART Program Blueprint.

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[1] Healthcare Value Hub. "New Jersey Consumer Healthcare Experience State Survey". January 2023. https://www.healthcarevaluehub.org/advocate-resources/publications/new-jersey-residents-struggle-afford-high-healthcare-costs-worry-about-affording-healthcare-future-support-government-action-acr.

[2] New Jersey Health Care Quality Institute. "NJ: Increasing Prices Drive Health Care Spending Growth." n.d. https://www.njhcqi.org/wp-content/uploads/2018/10/NJ-HCCI-Charts_10.8.2018-1.pdf. Accessed August 6, 2025.

[3] Shrank, W.H. "Waste in the U.S. Health Care System: Estimated Costs and Potential for Savings." *JAMA*, vol. 322, no. 15, 2022, pp. 1501–1509.

[4] In addition to the analysis of cost growth benchmarks shared in this report, the HART Program will conduct other studies to assess drivers of health care spending growth.

[5] New Jersey HART Program Report. "Health Care Spending Trends for New Jersey Residents with Commercial Insurance, 2016–2021".

Exhibit I.1 shows the timeline for the program's benchmark reports, including the benchmark values for calendar years 2022 to 2027, the years for which the program measures spending growth, and the level of public reporting.

Exhibit I.1. HART Program cost growth benchmarks and spending measurement

Reporting cycle	Measuring cost growth between	Benchmark target	Level of public reporting
Pre-Benchmark	CY 2018-2019	No benchmark	State and market
Transition Year	CY 2021–2022	No benchmark	State, market, carrier, and provider
Performance Year 1 **(current report)**	CY 2022–2023	3.5%	State, market, carrier, and provider
Performance Year 2	CY 2023–2024	3.2%	State, market, carrier, and provider
Performance Year 3	CY 2024–2025	3.0%	State, market, carrier, and provider
Performance Year 4	CY 2025–2026	2.8%	State, market, carrier, and provider
Performance Year 5	CY 2026–2027	2.8%	State, market, carrier, and provider

Note: The program did not collect data for 2020 because of the COVID-19 pandemic. The benchmark target is based on a blend of potential gross state product (25 percent) and forecasted median household income (75 percent).

CY = calendar year; HART = Health Care Affordability, Responsibility, and Transparency.

Each year, the HART Program collects data from the largest health insurance carriers in New Jersey. These data are used to develop reports comparing year-over-year per person per year (PPPY) spending increases against the benchmark, with data and analyses by major insurance market (commercial, Medicare, and Medicaid). These reports bring transparency to what we collectively spend on health care, allowing the public to compare spending growth across markets and between different carriers and providers. In September 2024, the program released its first Annual Cost Growth Benchmark Report for the Pre-Benchmark Year, which presented the findings from an analysis of 2018 and 2019 data health care spending.

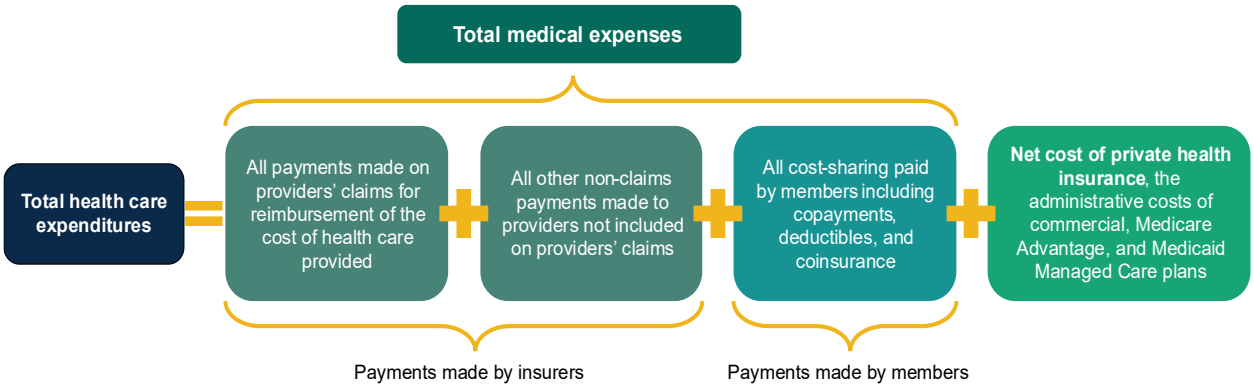
For this Performance Year 1 report, the program collected health care spending data for calendar years 2022 and 2023 and the report includes findings at the state, market, carrier, and provider levels. The report also compares performance relative to the target for each reporting level (that is, statewide, market, carrier, and provider).

B. Measuring costs and cost growth

The HART Program measures health care costs as total health care expenditures (THCE), which is the sum of total medical expenses (TME) and the net cost of private health insurance (NCPHI). As **Exhibit I.2** shows, TME, the spending on the direct provision of health care services, consists of claims and non-claims payments made to providers. Claims payments in this report reflect the allowed amounts, which include what carriers paid to providers for services rendered as well as any cost sharing paid by members such as copayments, deductibles, and coinsurance.

NCPHI represents the administrative costs of private health insurance, reflecting the difference between the premiums private insurance companies earn and their claims and other payments to providers. It consists of carriers' costs related to paying bills, advertising, sales commissions and other administrative costs, premium taxes, and other fees. It also includes carriers' profits or losses. It applies to commercial insurance carriers, Medicare Advantage plans, and Medicaid Managed Care plans.

Exhibit I.2. Components of total health care expenditures



This report presents THCE, TME, and NCPHI for the state as a whole and for each of the three markets:

- **Commercial,** which includes insurance plans that employers sponsor and plans that people purchase on the open market.
- **Medicare,** which provides health insurance for adults age 65 and older and some younger people with certain disabilities. The Medicare market includes two submarkets: the privately administered Medicare Advantage (managed care) and Medicare fee-for-service (FFS), a federal program.
- **Medicaid,** which provides health insurance for families and people with limited income. The Medicaid market also includes two submarkets: privately administered Medicaid Managed Care and Medicaid FFS, which the state administers with federal oversight. Medicaid FFS is the primary insurer for a small share of the Medicaid population and pays for some services for eligible people that other managed care organizations or Medicare do not cover.

This report presents spending and spending growth in aggregate, PPPY, and by category of service, including pharmacy spending gross and net of rebates and spending on primary care.

C. Data sources for the report

The Cost Growth Benchmark report relies on health care spending data submitted to the New Jersey Department of Banking and Insurance by public payers and private health insurance carriers to facilitate a comprehensive picture of trends in New Jerseyans' health care spending. Detailed information on the data collection requirements and process that the state uses to validate private health insurance carriers' data submissions is available on the HART Program page of the Department of Health website.

In addition to the data collected directly from public payers and private health insurance carriers, the calculations of spending and spending growth in this report rely on the following data:

- Medical loss ratio data published by the Centers for Medicare & Medicaid Services at https://www.cms.gov/marketplace/resources/data/medical-loss-ratio-data-systems-resources
- Supplementary health care exhibits submitted to the Department of Banking and Insurance as supporting documentation for annual filings at https://www.state.nj.us/dobi/division_insurance/solvency/annualstatements/index.html

D. Report overview

The purpose of this report is to monitor health care spending growth in New Jersey and compare growth against the established benchmark targets, and to also serve as a resource for stakeholders to understand what is contributing to high health care spending in New Jersey and to take action to slow the rate of spending growth to make it more affordable for New Jerseyans. **Chapter II** of this report presents spending and spending growth at the state and market levels based on an analysis of 2022 and 2023 data on health care spending. **Chapter III** reports on spending and spending growth between 2022 and 2023 for seven categories of service. **Chapters IV and V** report on spending growth and performance against the cost growth benchmark at the carrier and provider levels by submarket. **Chapter VI** builds on Chapter III by examining primary care spending and pharmacy rebates, which offset some of a carriers' spending on prescription drugs.

In addition, a set of appendices provides a glossary, market-level population tables, and methodological notes.

What's New in the Performance Year 1 Report

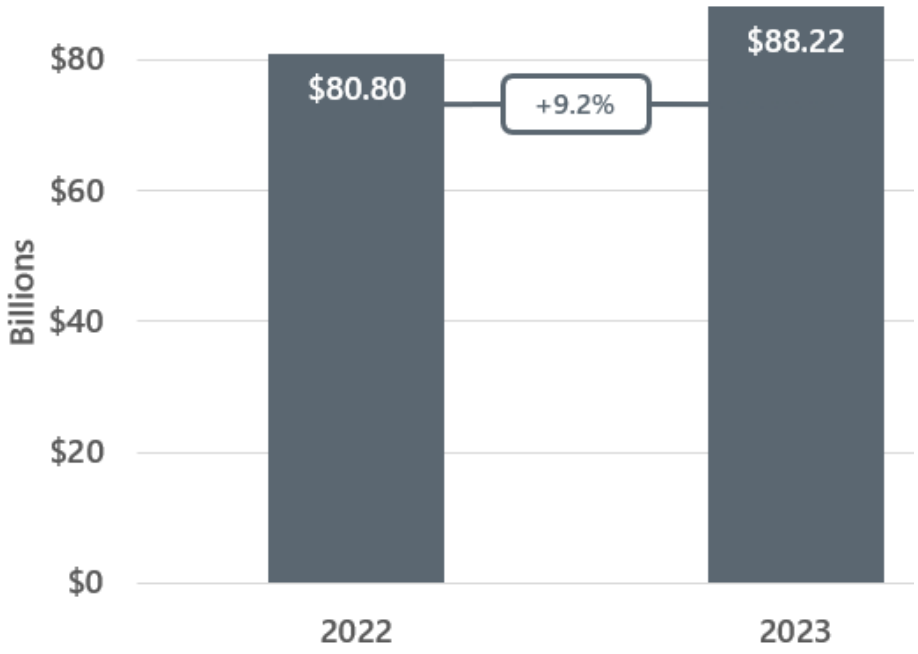
- Measures changes in spending between 2022 and 2023
- Compares spending growth at all levels (statewide, market, carrier, and provider) with the cost growth benchmark ◢

II. Health Care Spending Trends, 2022 to 2023

A. Total health care expenditures statewide

Statewide aggregate THCE in New Jersey increased $7.42 billion or 9.2 percent from 2022 to 2023 (**Exhibit II.1**). By comparison, New Jersey's gross domestic product grew from $758 billion in 2022 to $807 billion in 2023, an increase of about $49 billion or 6.4 percent.[6] The THCE captured in this report made up 10.9 percent of New Jersey's gross domestic product in 2023, up from 10.7 percent in 2022 as reported in the Transition Year benchmark report.

Exhibit II.1. Total health care expenditures, statewide (in billions)

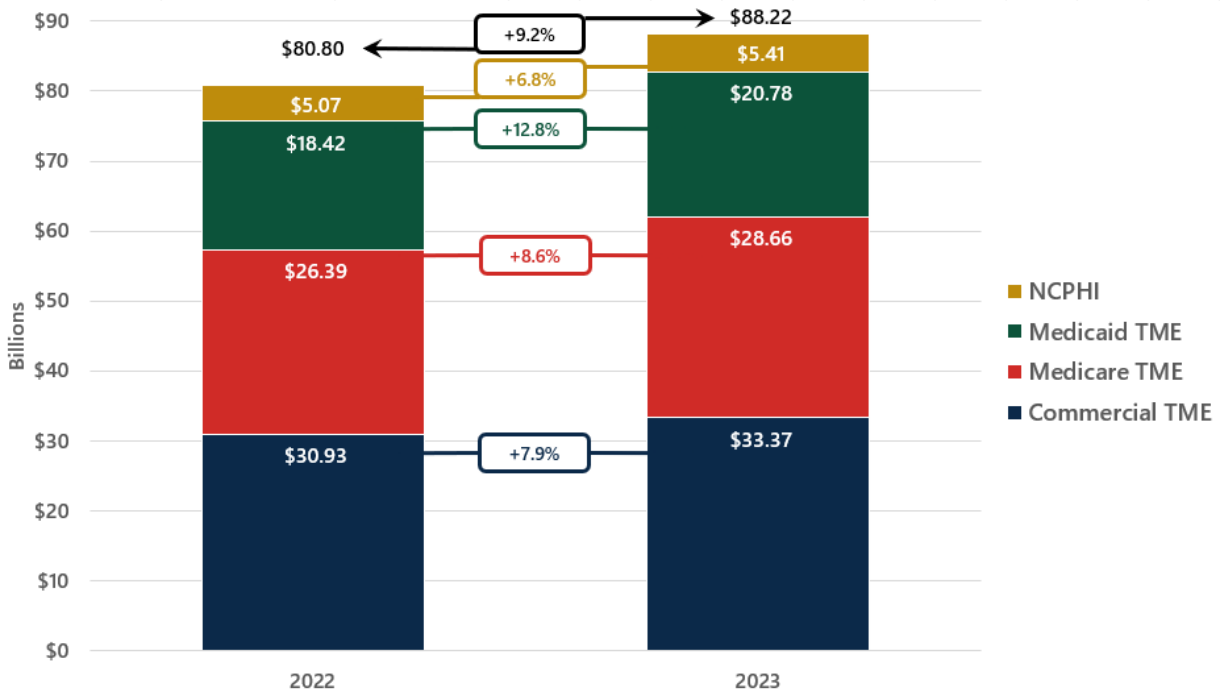


The vast majority of THCE was TME, which includes carrier payments made to providers for health care services and any cost sharing paid by members such as copayments, deductibles, and coinsurance. **Exhibit II.2** shows THCE broken out by major components, including TME by market, and total NCPHI across all markets:

- **Commercial** TME was the largest component of THCE, accounting for more than one-third (37.8 percent) of THCE in 2023. Commercial TME increased $2.44 billion or 7.9 percent from 2022 to 2023.
- **Medicare** TME followed, accounting for 32.5 percent of THCE in 2023. Medicare TME increased $2.27 billion or 8.6 percent from 2022 to 2023.
- **Medicaid** TME accounted for 23.6 percent of THCE in 2023. Medicaid TME increased $2.36 billion or 12.8 percent from 2022 to 2023.
- **NCPHI** accounted for 6.1 percent of THCE in 2023. Total NCPHI in 2023 increased $342 million or 6.8 percent from 2022 to 2023.

[6] U.S. Bureau of Economic Analysis. "SAGDP1 State Annual Gross Domestic Product (GDP) Summary." 2025. https://apps.bea.gov/regional/histdata/releases/0420gdpstate/index.cfm. Accessed July 30, 2025.

Exhibit II.2. Total health care expenditures by major component, statewide (in billions)



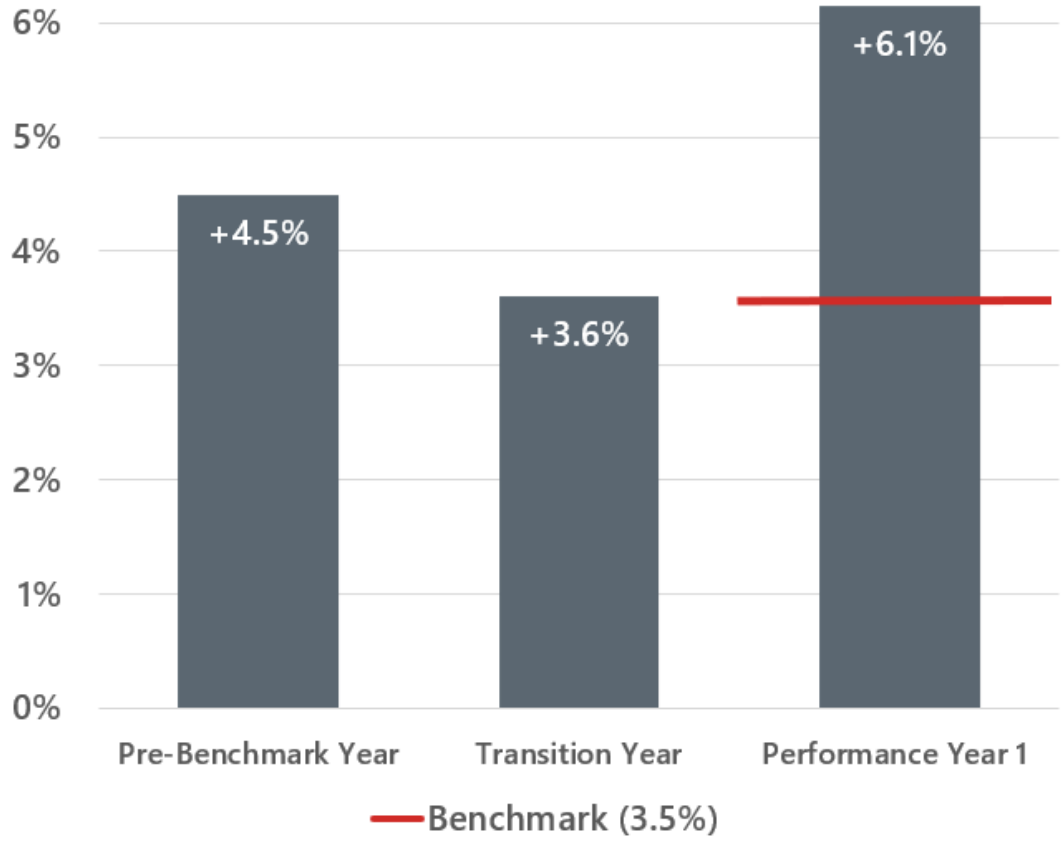
NCPHI = net cost of private health insurance; TME = total medical expenses.

The health care spending values in Exhibits II.1 and II.2 are total amounts, not per person, so they do not account for the number of insured New Jerseyans and the annual health care spending for those people.[7]

[7] KFF estimates that 8.1 and 8.4 percent of New Jerseyans were uninsured in 2022 and 2023, respectively. KFF. "Uninsured Rates for People Ages 0-64 by Federal Poverty Level (FPL)." 2023. https://www.kff.org/uninsured/state-indicator/people-0-64-uninsured-rate-federal-poverty-level-fpl

Statewide aggregate PPPY THCE in New Jersey increased from $10,663 in 2022 to $11,319 in 2023, a 6.1 percent increase. Compared with the prior report years, Performance Year 1 (2022–2023) represents a substantial increase from prior reporting years' cost growth and is well above the cost growth benchmark of 3.5 percent (**Exhibit II.3**).

Exhibit II.3. Percentage change in per person per year total health care expenditures trend, statewide



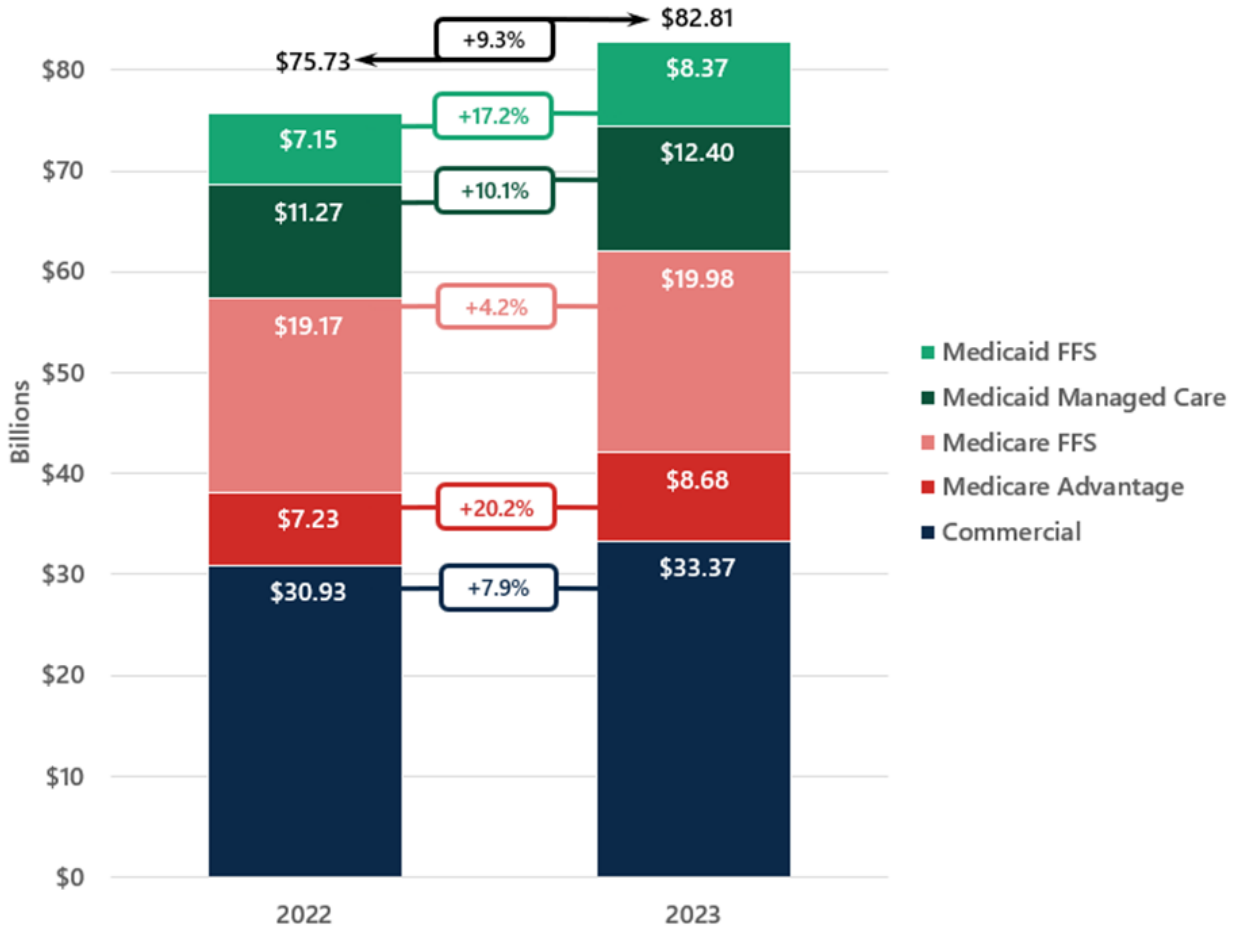
Note: Pre-Benchmark Year measures cost growth between 2018–2019. Transition Year measures cost growth between 2021–2022. The program did not collect data for 2020 because of the COVID-19 pandemic.

B. Total medical expenses by market and submarket

TME represents a subset of THCE and includes claims and non-claims payments that carriers made to providers as well as any cost sharing paid by members such as copayments, deductibles, and coinsurance. TME is reported gross of pharmacy rebates (that is, the program does not subtract pharmacy rebate amounts from the total spending amounts).

Exhibit II.4 breaks TME spending and spending growth out by submarket and does not account for year-to-year changes in the number of New Jerseyans enrolled in health care insurance plans or changes in PPPY spending. For example, the 20.2 percent increase in total Medicare Advantage spending shown in the exhibit is associated with a 5.6 percent increase in Medicare Advantage enrollment (Appendix B).

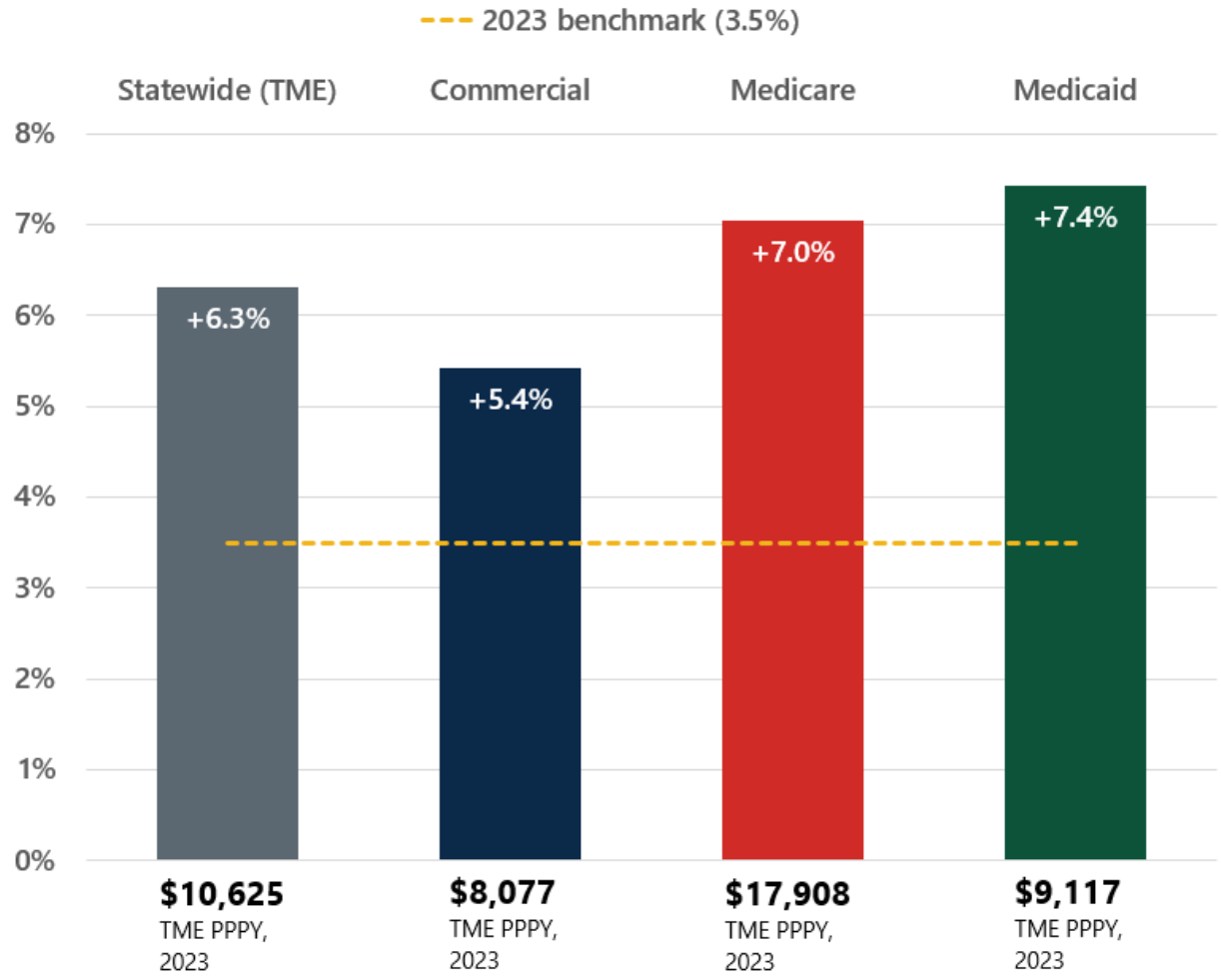
Exhibit II.4. Total medical expenses by submarket (in billions)



FFS = fee-for-service.

The TME values shown in Exhibit II.4 are total amounts, not per person, so they are subject to fluctuations in the number of insured New Jerseyans within a given market. The cost growth benchmark assesses cost growth on a PPPY basis. Between 2022 and 2023, PPPY TME grew more quickly in the Medicaid market than in any other market, but the growth in all markets, including statewide TME, exceeded the cost growth benchmark of 3.5 percent (**Exhibit II.5**).

Exhibit II.5. Percentage change in per person per year total medical expenses trend by market



PPPY = per person per year; TME = total medical expenses.

C. Net cost of private health insurance by market

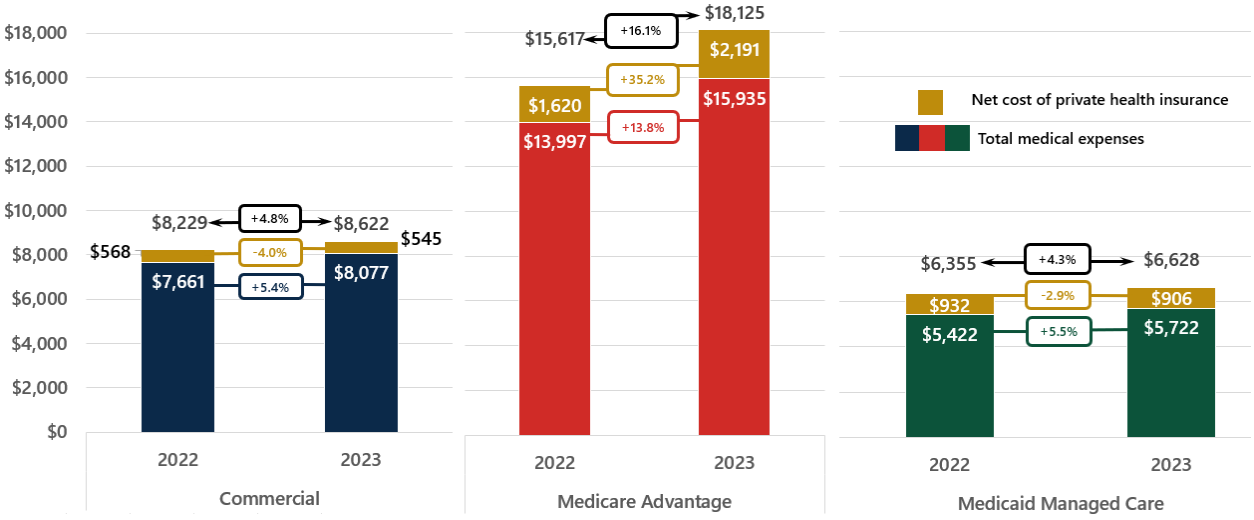
NCPHI represents the administrative costs of private health insurance, reflecting the difference between the premiums private insurance companies earn and their claims and other payments to providers. NCPHI is only pertinent to Medicare Advantage in the Medicare market and to Medicaid Managed Care in the Medicaid market.

As Exhibit II.2 shows, statewide NCPHI in New Jersey increased 6.8 percent, from $5.07 billion in 2022 to $5.41 billion in 2023.

The percentage change in PPPY NCPHI costs between 2022 and 2023 varied by market (**Exhibit II.6)**:

- **Commercial** PPPY NCPHI decreased from $568 in 2022 to $545 in 2023, a 4.0 percent decrease. In 2023, NCPHI comprised 6.3 percent of THCE PPPY for the commercial market.
- **Medicare Advantage** PPPY NCPHI increased from $1,620 in 2022 to $2,191 in 2023, a 35.2 percent increase. In 2023, NCPHI comprised 12.1 percent of THCE PPPY for Medicare Advantage plans.
- **Medicaid Managed Care** PPPY NCPHI decreased from $932 in 2022 to $906 in 2023, a 2.9 percent decrease. In 2023, NCPHI comprised 13.7 percent of THCE PPPY for Medicaid Managed Care plans.

Exhibit II.6. Per person per year net cost of private health insurance and total medical expenses by market



Note: The program excludes Medicare fee-for-service and Medicaid fee-for-service from this figure because there is no net cost of private health insurance for those submarkets.

III. Health Care Spending Trends by Service Category

Spending on direct provision of care, which this report measures by TME, accounts for the majority of THCE in New Jersey. This chapter divides this TME into seven mutually exclusive and collectively exhaustive service categories. This shows service category contribution to total health care spending and highlights where there may be opportunities for stakeholders to focus their efforts as they collaborate to meet the established cost growth targets.

Service categories

This report analyzes spending and spending growth in terms of seven mutually exclusive service categories: hospital inpatient facility, hospital outpatient facility, professional, retail pharmacy, long-term care, other claims, and non-claims payments. These categories, which are standard in health policy research, are based on the place of service and how the provider bills for the service.

Service category descriptions

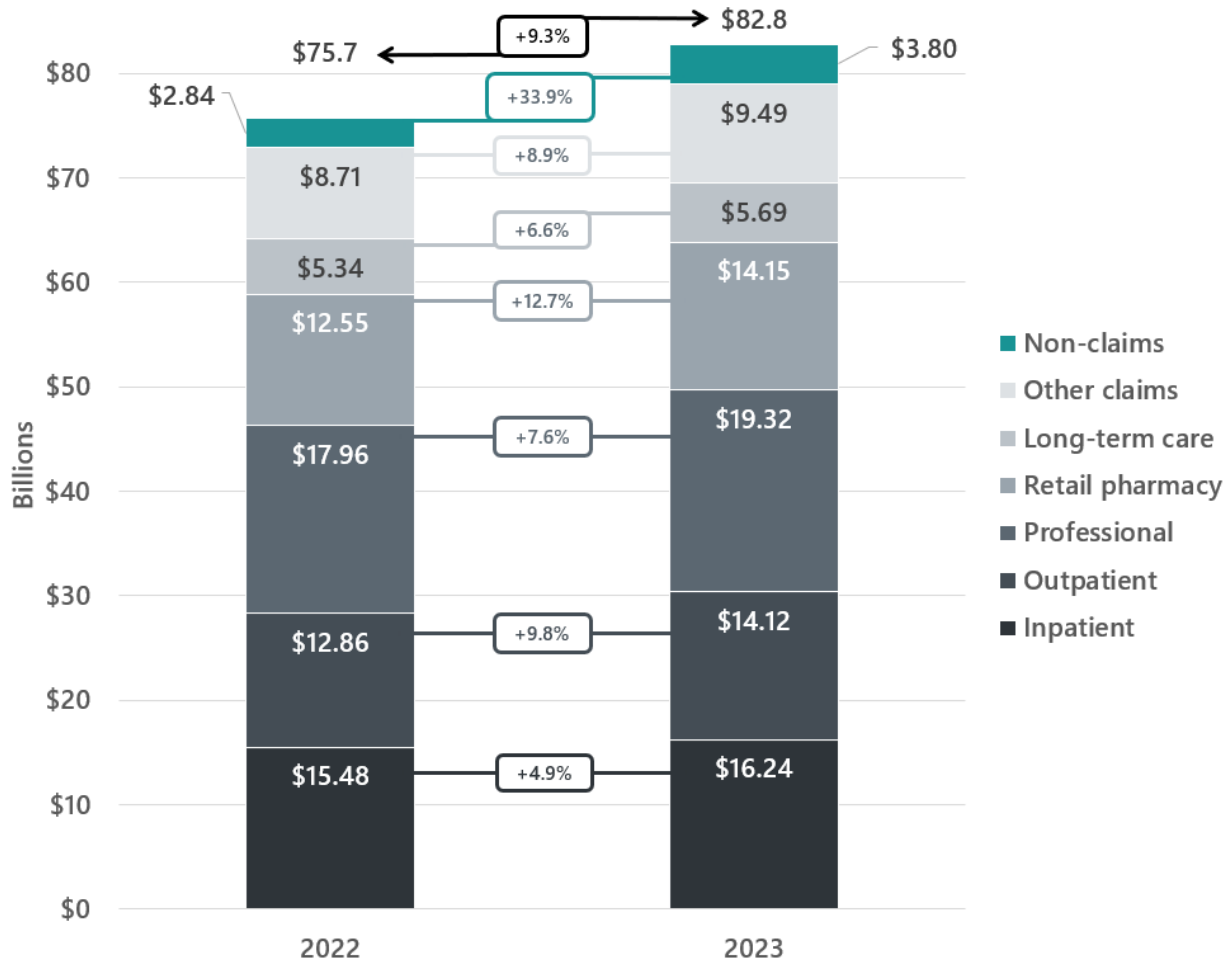
Hospital inpatient facility services	Hospital-based inpatient care and any associated emergency department costs immediately before an inpatient admission. Examples include childbirth and complex surgeries. This excludes the cost of any services provided by a physician or other practitioner (for example, a physician assistant or nurse practitioner) that can be billed directly to a carrier, which are captured under professional services.
Hospital outpatient facility services	Hospital-based outpatient care includes services provided at hospital-licensed satellite clinics, emergency department services that do not result in admission, and observation services. This excludes the cost of any services provided by a physician or other practitioner (for example, a physician assistant or nurse practitioner) that can be billed directly to a carrier, which are captured under professional services.
Professional services	Services provided by a physician or other practitioner (for example, a physician assistant or nurse practitioner) that can be billed directly to a carrier. This category includes professional services provided in both inpatient and outpatient settings (offices, clinics, and hospitals).
Retail pharmacy services	Retail drugs obtained at pharmacies or other locations. This category excludes physician-administered medications that providers bill under other service categories.
Long-term care facility services	Care provided in a long-term care setting, including nursing homes and skilled nursing facilities, assisted living facilities, and home-based care.
Other claims services	Claims payments made to providers for medical services that the previous service categories exclude. Examples include durable medical equipment, freestanding ambulatory surgical center and urgent care center services, hospice facility or services, freestanding diagnostic facility services, hearing aid services, and optical services.
Non-claims payments	Payments made to providers outside of the claims system. Examples include prospective payment arrangements, performance incentives, population health and practice infrastructure payments, and recoveries.

A. Total medical expenses by service category statewide

Exhibit III.1 shows the service category contribution to TME and the change in spending for each category of service between 2022 and 2023. The categories are listed in order of magnitude:

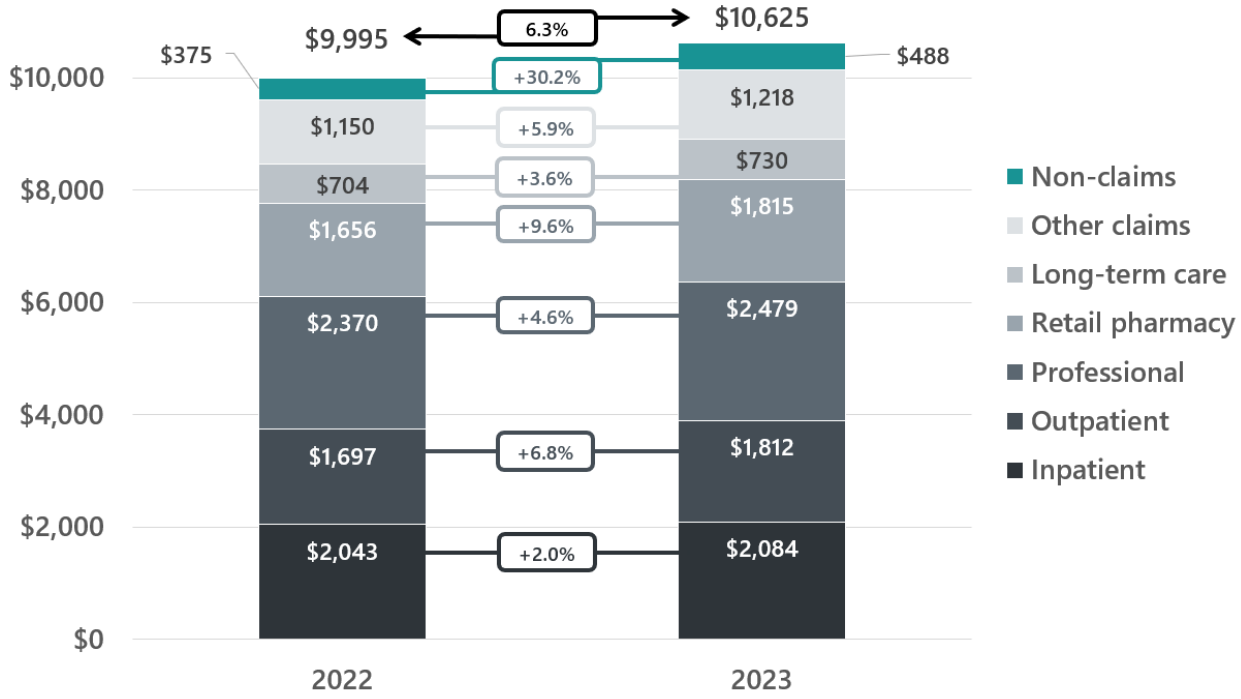
- **Professional services** spending represented the largest component of TME, accounting for 23.3 percent of TME in 2023.
- **Inpatient facility services** spending represented the second largest component of TME, accounting for 19.6 percent of TME in 2023.
- **Retail pharmacy services** accounted for 17.1 percent of TME in 2023.
- **Outpatient facility services** accounted for 17.1 percent of TME in 2023.
- **Other claims services** made up 11.5 percent of TME in 2023.
- **Long-term care services** made up 6.9 percent of TME in 2023.
- **Non-claims payments** were the smallest component of TME in 2022, making up 4.6 percent in 2023.

Exhibit III.1. Overall total medical expenses by service category (in billions)



On a PPPY basis, between 2022 and 2023, TME increased in all service categories (**Exhibit III.2**). Retail pharmacy services and non-claims payments had the highest growth rates at 9.6 percent and 30.2 percent, respectively. Inpatient facility services exhibited the lowest growth rate at 2.0 percent.

Exhibit III.2. Per person per year total medical expenses by service category



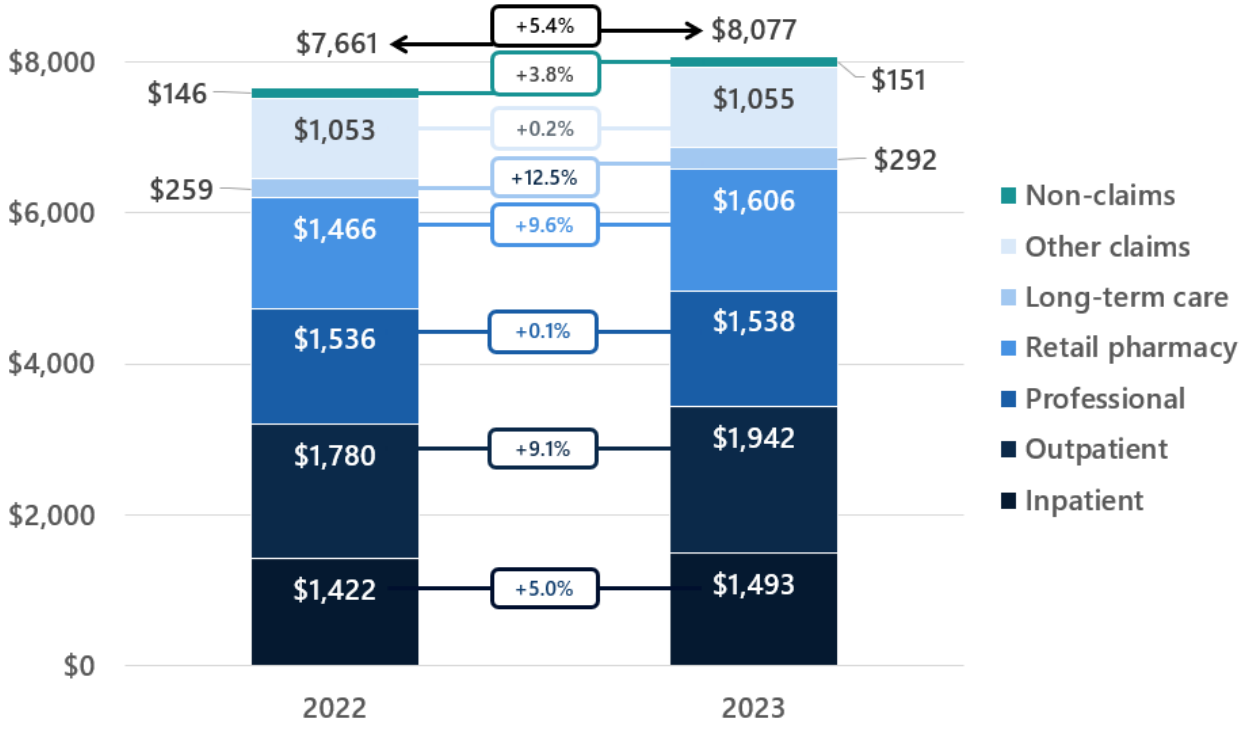
B. Total medical expenses by market and service category

1. Commercial market

From 2022 to 2023, the commercial market experienced a PPPY TME spending growth of 5.4 percent, with increases in all service categories (**Exhibit III.3**):

- **Inpatient facility services,** which grew 5.0 percent from 2022 to 2023 and accounted for 18.5 percent of PPPY TME in 2023.
- **Outpatient facility services,** which grew 9.1 percent from 2022 to 2023 and accounted for 24.0 percent of PPPY TME in 2023.
- **Professional services,** which grew 0.1 percent from 2022 to 2023 and accounted for 19.0 percent of PPPY TME in 2023.
- **Retail pharmacy services,** which grew 9.6 percent from 2022 to 2023 and accounted for 19.9 percent of PPPY TME in 2023.
- **Long-term care services,** which grew 12.5 percent from 2022 to 2023 and accounted for 3.6 percent of PPPY TME in 2023.
- **Other claims services,** which grew 0.2 percent from 2022 to 2023 and accounted for 13.1 percent of PPPY TME in 2023.
- **Non-claims payments,** which grew 3.8 percent from 2022 to 2023 and accounted for 1.9 percent of PPPY TME in 2023.

Exhibit III.3. Per person per year total medical expenses by service category, commercial



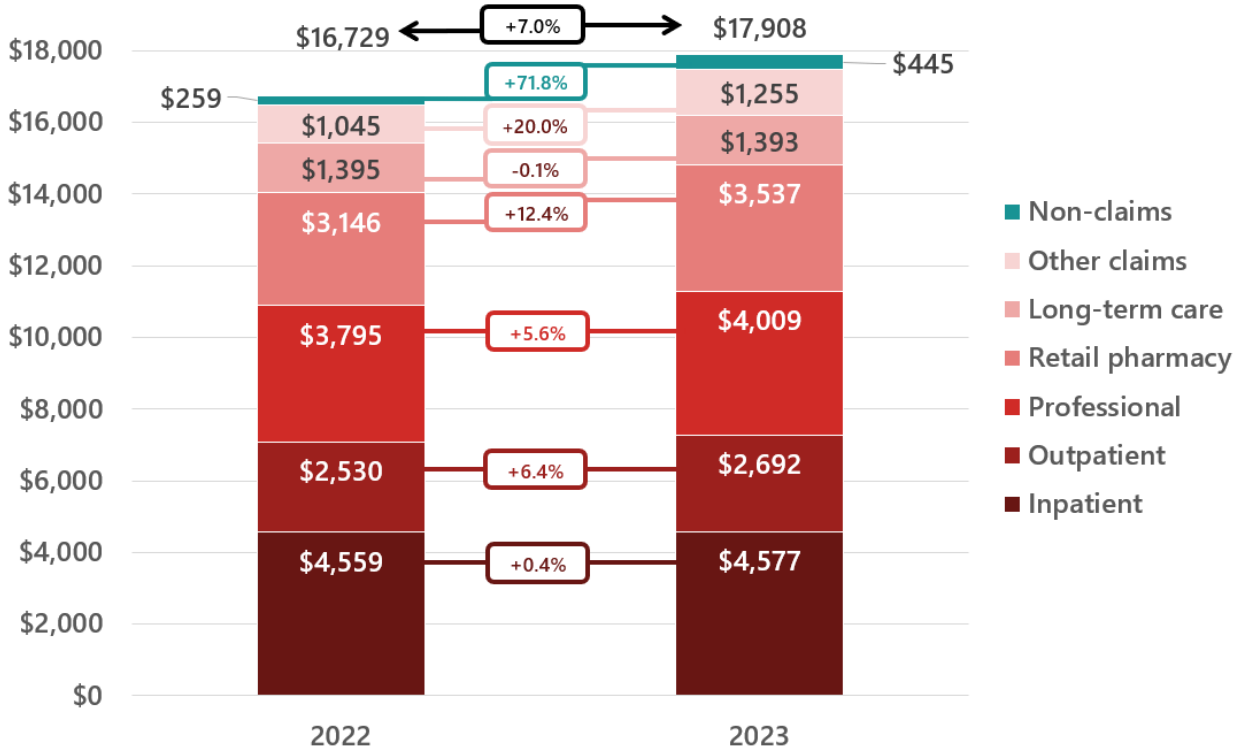
2. Medicare market

From 2022 to 2023, New Jersey's Medicare market experienced a PPPY TME spending growth of 7.0 percent, with an increase in six of the seven service categories (**Exhibit III.4**):

- **Inpatient facility services,** which grew 0.4 percent from 2022 to 2023 and accounted for 25.6 percent of PPPY TME in 2023.
- **Outpatient facility services** which grew 6.4 percent from 2022 to 2023 and accounted for 15.0 percent of PPPY TME in 2023.
- **Professional services** which grew 5.6 percent from 2022 to 2023 and accounted for 22.4 percent of PPPY TME in 2023.
- **Retail pharmacy services** which grew 12.4 percent from 2022 to 2023 and accounted for 19.8 percent of PPPY TME in 2023.
- **Other claims services** which grew 20.0 percent from 2022 to 2023 and accounted for 7.8 percent of PPPY TME in 2023.
- **Non-claims payments** which grew 71.8 percent from 2022 to 2023 and accounted for 2.5 percent of PPPY TME in 2023.

Long-term care services saw a slight decrease of -0.1 percent from 2022 to 2023 and accounted for 7.8 percent of PPPY TME in 2023.

Exhibit III.4. Per person per year total medical expenses by service category, Medicare

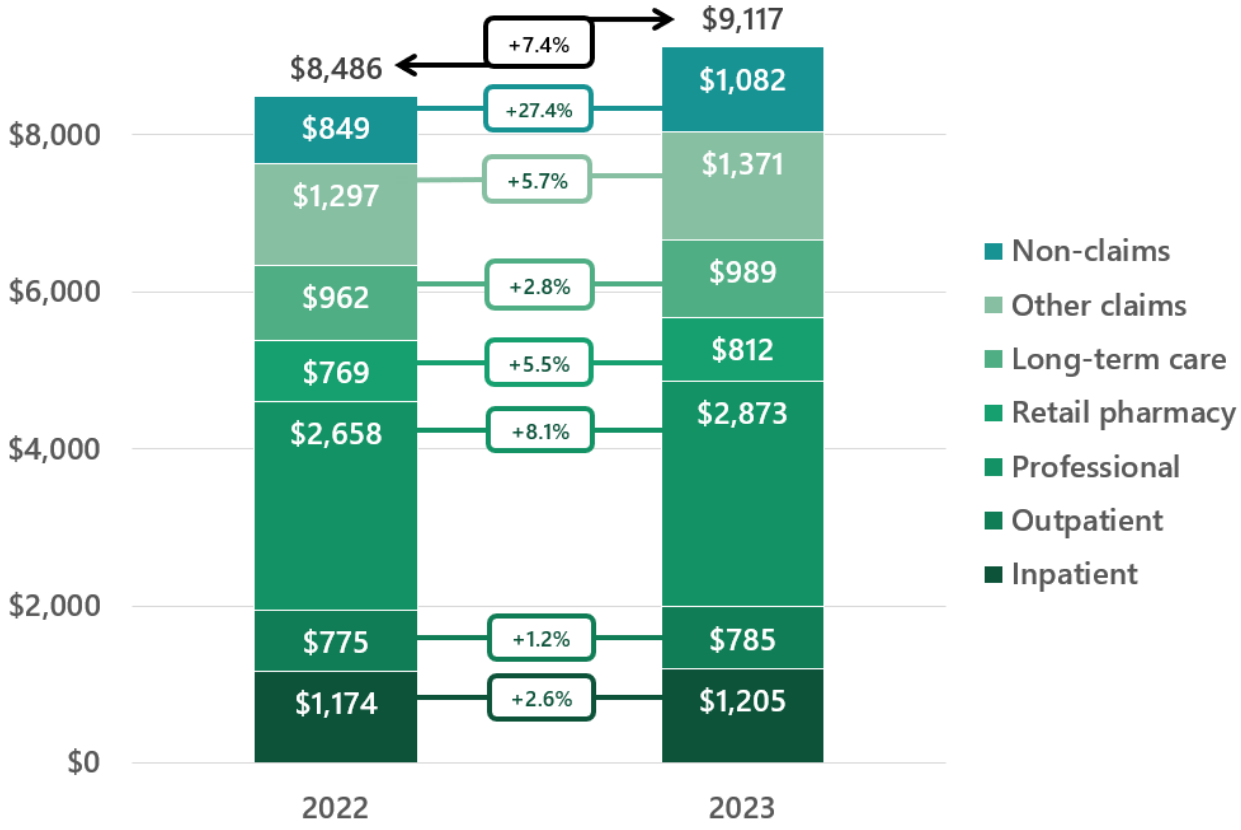


3. Medicaid market

From 2022 to 2023, New Jersey's Medicaid market experienced a PPPY TME spending growth of 7.4 percent, with an increase in all seven service categories (**Exhibit III.5**):

- **Inpatient facility services,** which grew 2.6 percent from 2022 to 2023 and accounted for 13.2 percent of PPPY TME in 2023.
- **Outpatient facility services,** which grew 1.2 percent from 2022 to 2023 and accounted for 8.6 percent of PPPY TME in 2023.
- **Professional services,** which grew 8.1 percent from 2022 to 2023 and accounted for 31.5 percent of PPPY TME in 2023.
- **Retail pharmacy services,** which grew 5.5 percent from 2022 to 2023 and accounted for 8.9 percent of PPPY TME in 2023.
- **Long-term care services,** which grew 2.8 percent from 2022 to 2023 and accounted for 10.8 percent of PPPY TME in 2023.
- **Other claims services,** which grew 5.7 percent from 2022 to 2023 and accounted for 15.0 percent of PPPY TME in 2023.
- **Non-claims payments,** which grew 27.4 percent from 2022 to 2023 and accounted for 11.9 percent of PPPY TME.

Exhibit III.5. Per person per year total medical expenses by service category, Medicaid



IV. Health Care Spending Trends by Carrier

This section outlines truncated risk-adjusted PPPY TME trends in spending growth with confidence intervals for New Jersey carriers in three submarkets: commercial, Medicare Advantage, and Medicaid Managed Care. In the exhibits that follow in this chapter, the dots represent 2022 to 2023 cost growth for the carriers listed, and horizontal lines represent confidence intervals. Positive percentages indicate that PPPY health care spending increased, and negative cost growth percentages mean that PPPY health care spending decreased. Percentages are compared to the pre-established benchmark target of **3.5 percent**.

A. Truncation

The truncation of TME spending data accounts for the impact of a very small number of high-cost outliers on carrier cost growth. In carriers' data submissions, if an individual member has more than $250,000 in claims spending during a calendar year, carriers truncate claims spending at $250,000. Carriers do not truncate non-claims spending. A complete description of the truncation methodology is available in the Carrier Benchmark Data Submission Guide.

B. Risk adjustment

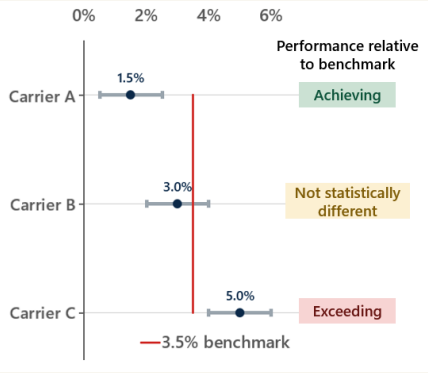
The HART Program's risk adjustment aims to account for differences among carriers in the distribution of patients across demographic groups and insurance categories. The program derives each carrier's risk score for a market from population counts and spending by insurance category, age, and sex bands. A complete description of the risk adjustment methodology is available in the State Benchmark Implementation Manual.

Interpreting confidence intervals

Confidence intervals provide a range of likely values, helping to ensure the data's precision and trustworthiness. When estimating cost growth, the HART Program applies a 95 percent confidence interval, indicating a 95 percent certainty for comparing a provider's PPPY cost growth to the benchmark. On the following charts, horizontal lines represent these intervals. Longer lines suggest a wider range of uncertainty, and shorter lines indicate more precise amounts. Typically, carriers with larger populations of members will have narrower intervals, whereas those with smaller populations will show wider intervals.

In this report, carriers are assigned one of three designations based on how their confidence interval compares to the benchmark, which is shown in the figures using a red line:

1. **Achieving the benchmark**, indicating that upper bound of the confidence interval is *below* the benchmark target value.
2. **Exceeding the benchmark**, indicating that the lower bound of the confidence interval is *above* the benchmark target value.
3. **Not statistically different from the benchmark**, indicating that the benchmark target is *within* the confidence interval. In this instance, actual performance may fall above or below the benchmark.



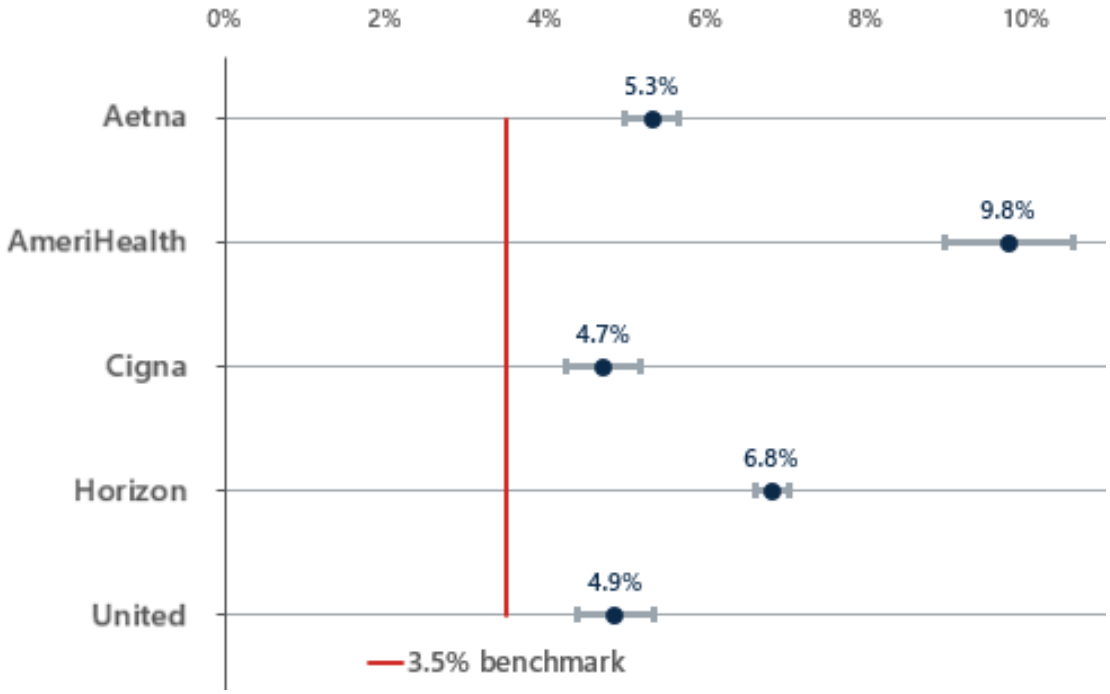
The example figure demonstrates how the graph should be read to identify whether carriers achieve the benchmark, exceed the benchmark, or are not statistically different from the benchmark. In the example Carrier A achieves the benchmark, Carrier B is not statistically different from the benchmark, and Carrier C exceeds the benchmark.

C. Spending trends by carrier

1. Commercial market

The HART program assesses spending growth for the six carriers that participate in the commercial market. From 2022 to 2023 spending growth varied by carrier, with Cigna representing the smallest growth at 4.7 percent, AmeriHealth representing the largest growth at 9.8 percent, and no carriers achieving the cost growth target (**Exhibit IV.1**).

Exhibit IV.1. Percentage change in truncated risk-adjusted per person per year total medical expenses with confidence intervals by carrier, commercial market, 2022–2023

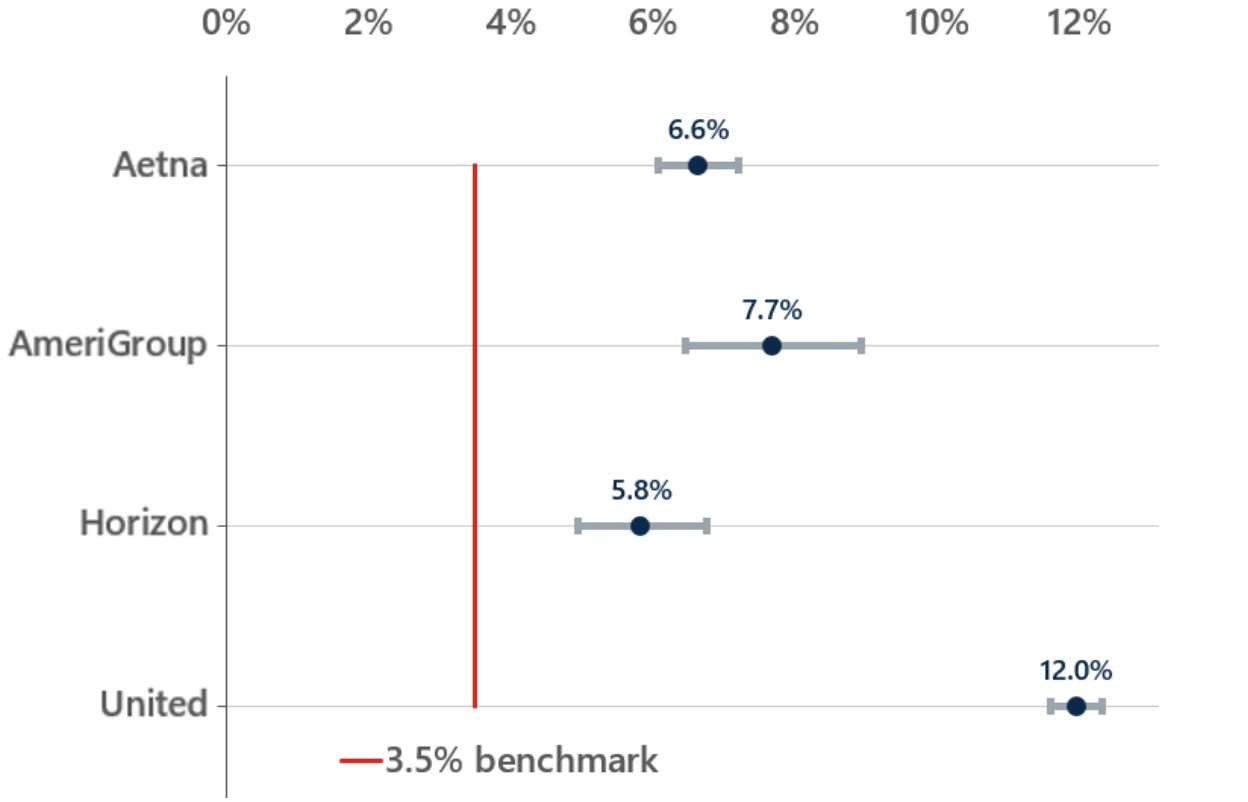


Note: Although WellCare (Fidelis) submitted data for the commercial market and there are no specific public reporting threshold criteria for carriers, the HART Program has chosen not to report on their performance for the commercial market because of the small sample size.

2. Medicare Advantage submarket

The HART program assesses spending growth for the five carriers that participate in the Medicare advantage submarket. From 2022 to 2023 spending growth varied by payer, with Horizon representing the smallest growth at 5.8 percent and United representing the largest growth at 12.0 percent, apart from an outlier increase for WellCare (Fidelis) as described below the figure. No carriers achieved the benchmark in the Medicare Advantage submarket (**Exhibit IV.2**).

Exhibit IV.2. Percentage change in truncated risk-adjusted per person per year total medical expenses with confidence intervals by carrier, Medicare Advantage, 2022–2023

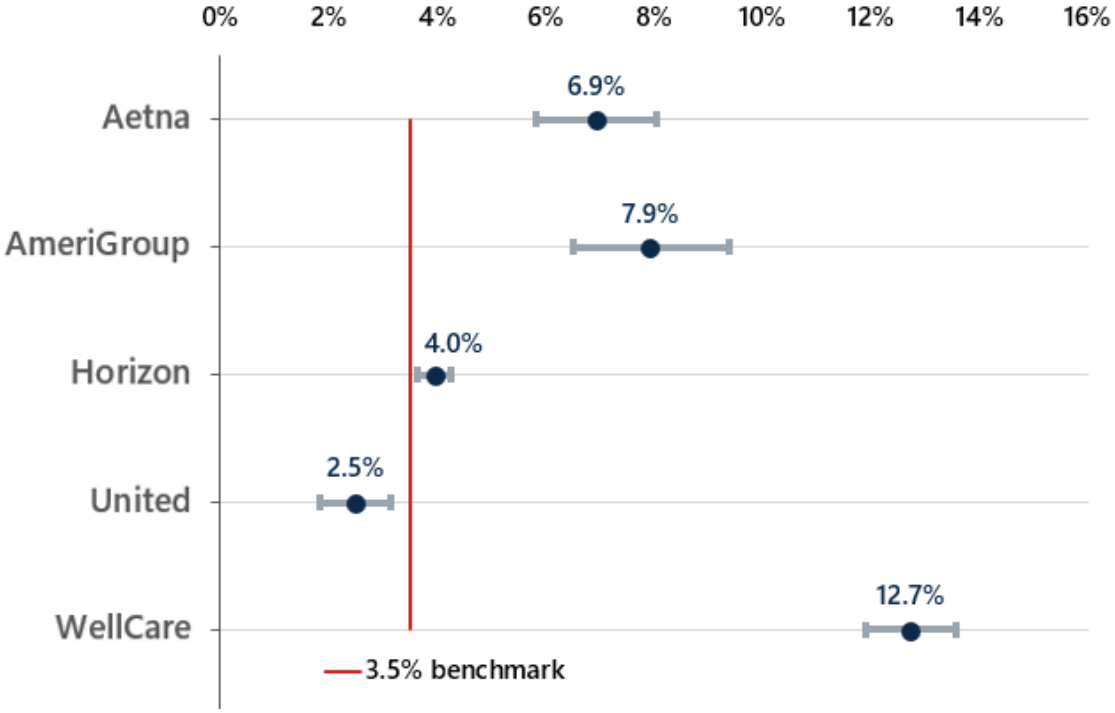


Note: WellCare (Fidelis) does not have a bar on the figure above because of an outlier increase in percentage change in truncated risk-adjusted per person per year total medical expenses of 86.6 percent (confidence interval: 83.4 percent, 89.9 percent). This is caused in part by a significant shift in the make-up of its Medicare Advantage plans, in the number of members covered and the expected health care spending of those members, because they stopped offering certain products.

3. Medicaid Managed Care submarket

The HART program assesses spending growth for the five carriers that participate in the Medicaid Managed Care submarket. From 2022 to 2023 spending growth varied by payer, with United representing the smallest growth at 2.5 percent, WellCare representing the largest growth at 12.7 percent, and one carrier (United) achieving the cost growth target (**Exhibit IV.3**).

Exhibit IV.3. Percentage change in truncated risk-adjusted per person per year total medical expenses with confidence intervals by carrier, Medicaid Managed Care, 2022–2023



4. Across all markets compared with the cost growth benchmark

The figures for each market in the previous subsections are limited to those carriers that have plans within the given market. **Exhibit V.4** below shows, for each market, how each carrier performed relative to the benchmark as described in the introduction to this section. A designation of "Not in market" indicates that the carrier does not have any offerings in that market.

Exhibit V.4. Assessment of carrier performance against the cost growth benchmark across all markets, 2022–2023

Carrier	Commercial	Medicare Advantage	Medicaid Managed Care
Aetna	Exceeding	Exceeding	Exceeding
Amerigroup (Wellpoint)	Not in market	Exceeding	Exceeding
AmeriHealth	Exceeding	Not in market	Not in market
Cigna	Exceeding	Not in market	Not in market
Horizon	Exceeding	Exceeding	Exceeding
United	Exceeding	Exceeding	Achieving
WellCare (Fidelis)	Suppressed[a]	Exceeding	Exceeding

[a] Although WellCare (Fidelis) submitted data for the commercial market, and there are no specific public reporting threshold criteria for carriers, the HART Program has chosen to not report its performance for the commercial market because of the small sample size.

V. Health Care Spending Trends by Provider

This section outlines truncated risk-adjusted PPPY TME trends in spending growth with confidence intervals for New Jersey providers in three submarkets: commercial, Medicare Advantage, and Medicaid Managed Care. In the following exhibits, circles represent 2022 to 2023 cost growth for the providers listed, and horizontal lines represent confidence intervals. Positive percentages show how much PPPY health care spending increased, and negative percentages indicate that PPPY health care spending went down. Percentages are compared to the pre-established benchmark target of **3.5 percent**.

A. Provider attribution

The HART Program requires carriers to attribute members to a provider if they can both assign the member to a primary care provider and assign the primary care provider to a large provider entity. Carriers use their own methodology for attribution, regardless of whether a provider had a total cost of care or other type of value-based care contract in place with the provider for the corresponding reporting year.[8]

B. Truncation

The truncation of TME spending data accounts for the impact of a very small number of high-cost outliers on providers' cost growth. In carriers' data submissions, if an individual member has more than $250,000 in claims spending during a calendar year while attributed to a provider, carriers truncate claims spending at $250,000. Carriers do not truncate non-claims spending. A complete description of the truncation methodology is available in the Carrier Benchmark Data Submission Guide.

C. Risk adjustment

The HART Program's risk adjustment aims to account for differences among providers in the distribution of patients across demographic groups and insurance categories. The program derives each provider's risk score for a market from population counts and spending by insurance category, age, and sex bands. A complete description of the risk adjustment methodology is available in the State Benchmark Implementation Manual.

D. Public reporting thresholds

The HART Program publicly reports market level percentage change in truncated risk-adjusted PPPY TME for providers that meet both criteria shown in **Table V.1**.

Table V.1. HART Program public reporting threshold criteria for providers and rationale

Criterion	Rationale
Have at least 60,000 attributed member months across all private carriers in the market for each of the two years covered in this report.	Establish a floor amount of member months as a basic assessment of minimum statistical reliability.
At least 30 percent of attributed member months are associated with total cost of care contracts across all markets for each of the two years covered in this report.	Ensure public reporting aligns with language in the compact that providers should have a significant portion of their members in total cost of care contracts.

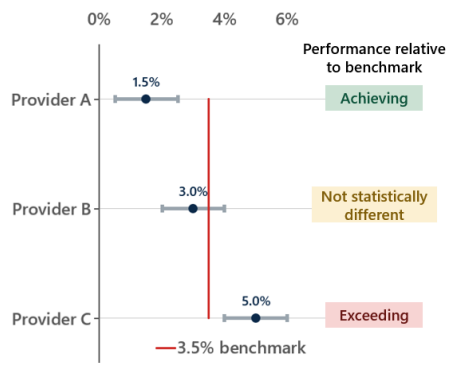
[8] The program does not have member attribution data from Medicare FFS or NJ FamilyCare, so this report does not include TME at the carrier or provider level for Medicare and Medicaid FFS beneficiaries.

Interpreting confidence intervals

Confidence intervals provide a range of likely values, helping to ensure the data's precision and trustworthiness. When estimating cost growth, the HART Program applies a 95 percent confidence interval, indicating a 95 percent certainty for comparing a provider's PPPY cost growth to the benchmark. On the following charts, horizontal lines represent these intervals. Longer lines suggest a wider range of uncertainty, and shorter lines indicate more precise amounts. Typically, providers with larger populations of members will have narrower intervals, whereas those with smaller populations will show wider intervals.

In this report, providers that meet the public reporting threshold criteria are assigned one of three designations based on how their confidence interval compares to the benchmark, which is shown in the figures using a red line:

1. **Achieving the benchmark**, indicating that upper bound of the confidence interval is *below* the benchmark target value.
2. **Exceeding the benchmark**, indicating that the lower bound of the confidence interval is *above* the benchmark target value.
3. **Not statistically different from the benchmark**, indicating that the benchmark target is *within* the confidence interval. In this instance, actual performance may fall above or below the benchmark.



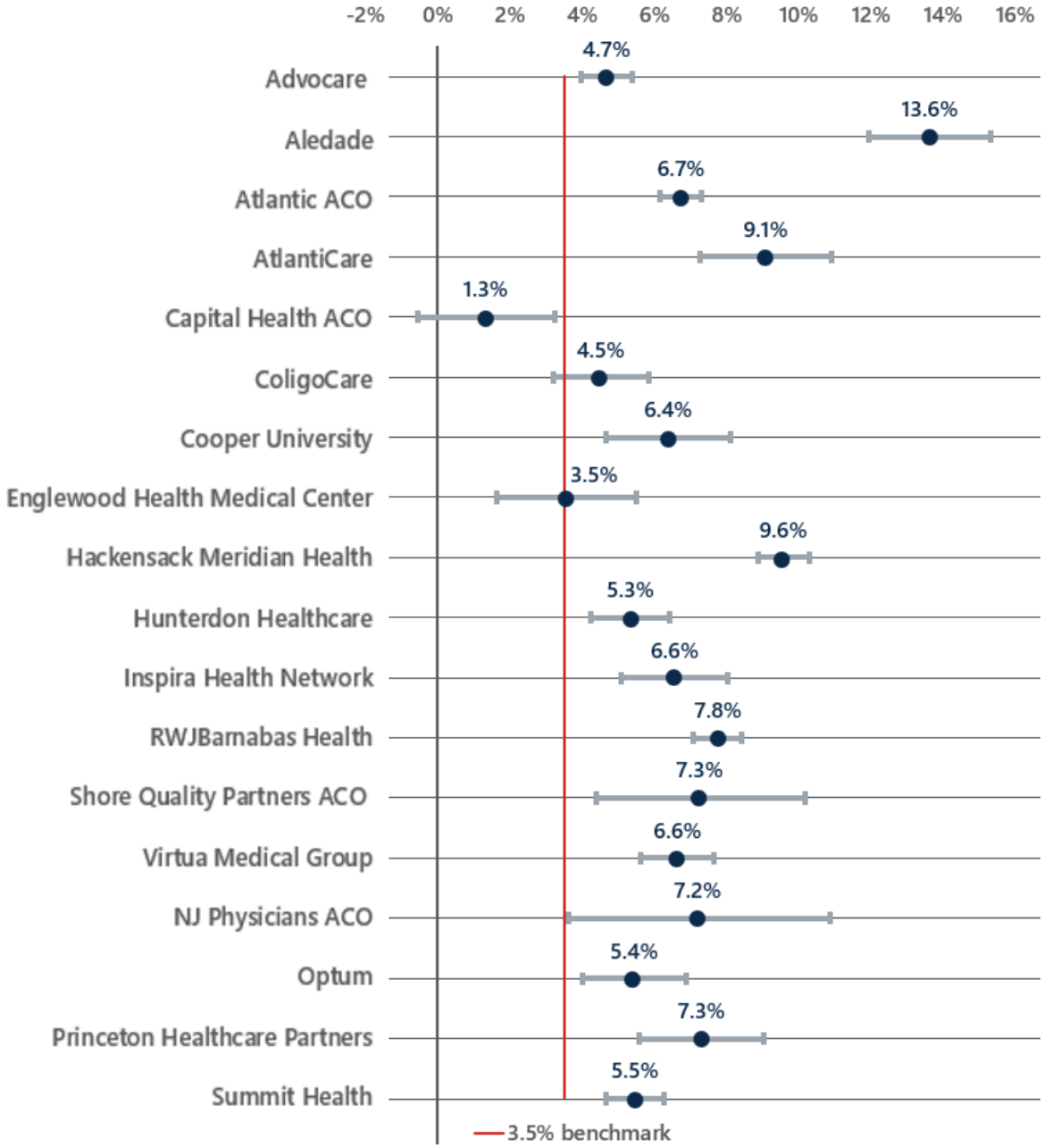
The example figure demonstrates how the graph should be read to identify whether providers achieve the benchmark, exceed the benchmark, or are not statistically different from the benchmark. In the example Provider A achieves the benchmark, Provider B is not statistically different from the benchmark, and Provider C exceeds the benchmark.

E. Spending trends by provider

1. Commercial market

From 2022 to 2023, 18 of the 19 providers that participate in the commercial market met the public reporting thresholds. Commercial PPPY TME spending growth varied by provider, with Capital Health ACO representing the smallest growth at 1.3 percent and Aledade representing the largest growth at 13.6 percent. One provider achieved the benchmark, **Capital Health ACO**. Two providers' performance was not statistically different from the benchmark, **ColigoCare** and **Englewood Health Medical Center** (**Exhibit V.1**).

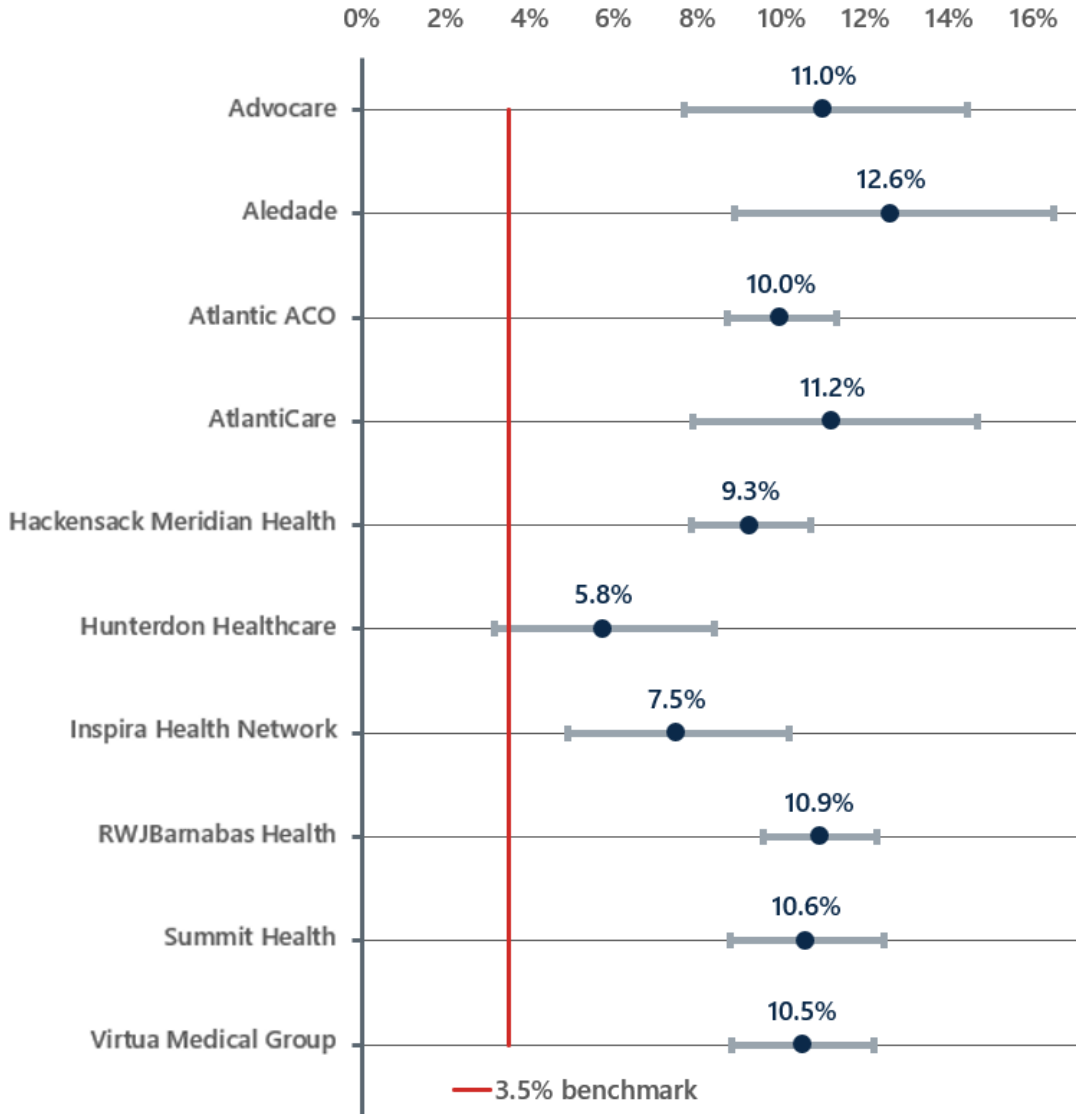
Exhibit V.1. Percentage change in truncated risk-adjusted per person per year total medical expenses with confidence intervals by provider, commercial, 2022–2023



2. Medicare Advantage submarket

From 2022 to 2023, 11 of the 19 providers that participate in the Medicare Advantage submarket met the public reporting thresholds. Spending growth for Medicare Advantage PPPY varied by provider, with Hunterdon Healthcare representing the smallest growth at 5.8 percent and Aledade representing the largest growth at 12.6 percent, apart from an outlier increase for Optum as described below the figure. No provider achieved the benchmark. One provider's performance was not statistically different from the benchmark, **Hunterdon Healthcare** (**Exhibit V.2**).

Exhibit V.2. Percentage change in truncated risk-adjusted per person per year total medical expenses with confidence intervals by large provider entity, Medicare Advantage, 2022–2023

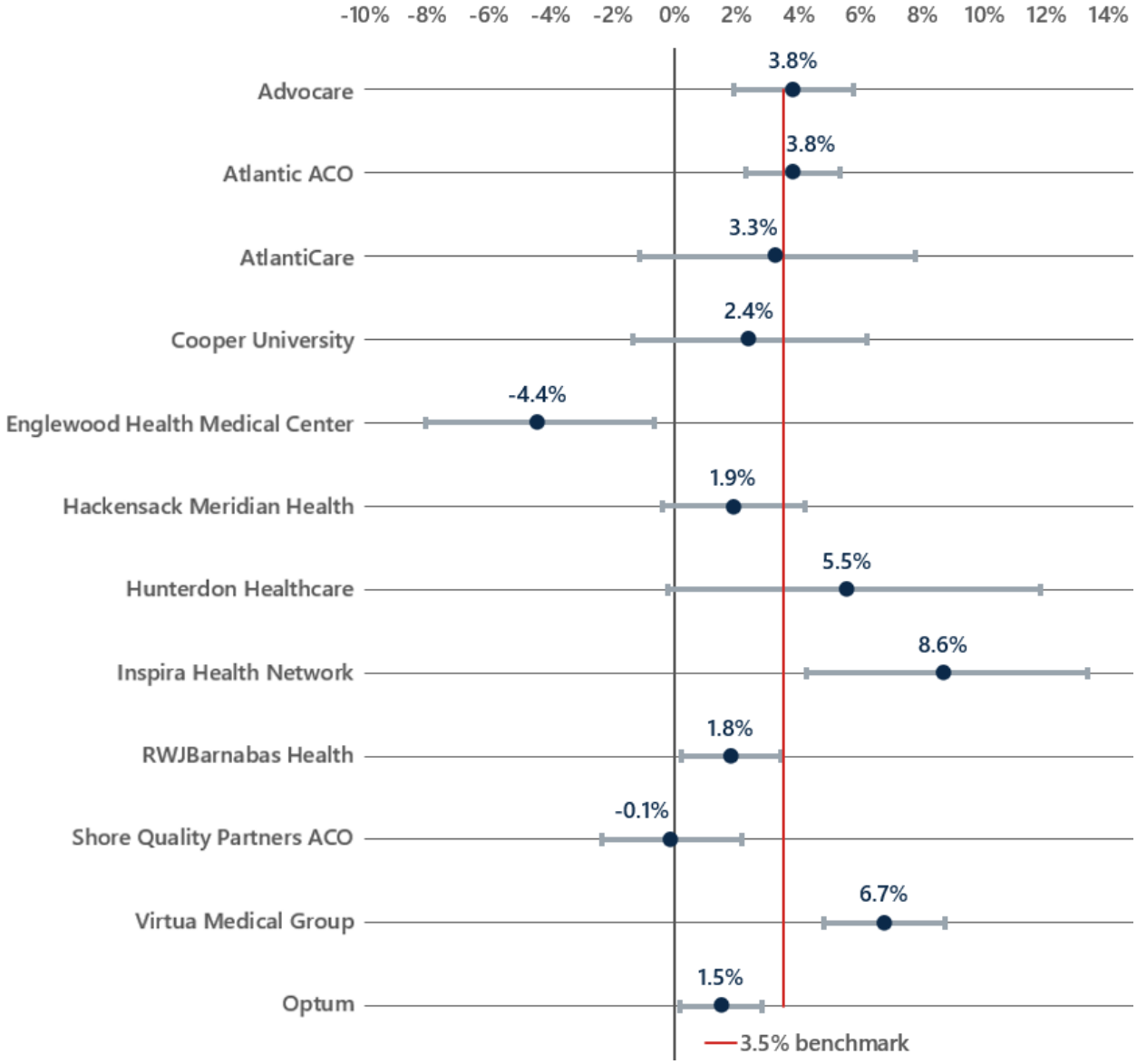


Note: Optum does not have a bar on the figure above because of an outlier increase in the percentage change in truncated risk-adjusted per person per year total medical expenses of 230.9 percent (confidence interval: 227.1 percent, 234.8 percent). This is caused in part by a substantial increase in attributed members from 2022 to 2023 and an accompanying increase in non-claims payments.

3. Medicaid Managed Care submarket

From 2022 to 2023, 12 of the 19 providers that participate in the Medicaid Managed Care submarket met the public reporting thresholds. Spending trends in Medicaid Managed Care PPPY TME varied by provider, with Englewood Health Medical Center experiencing negative growth at -4.4 percent and Inspira Health Network representing the largest growth at 8.6 percent. Four providers achieved the benchmark, **Englewood Health Medical Center**, **RWJ Barnabas Health**, **Shore Quality Partners ACO**, and **Optum**. Performance was not statistically different from the benchmark for six providers, **Advocare, Atlantic ACO, AtlantiCare, Cooper University, Hackensack Meridian Health,** and **Hunterdon Healthcare** (**Exhibit V.3**).

Exhibit V.3. Percentage change in truncated risk-adjusted per person per year total medical expenses with confidence intervals by large provider entity, Medicaid Managed Care, 2022–2023



4. Across all markets compared with the cost growth benchmark

The figures for each market in the previous subsections are limited to those providers that met the public reporting threshold criteria for the given market. **Exhibit V.4** shows, for each market, how each provider performed relative to the benchmark as described in the introduction to this section or whether they did not meet the public reporting threshold criteria.

Exhibit V.4. Assessment of provider performance against the cost growth benchmark across all markets, 2022–2023

Large provider entity	Commercial	Medicare Advantage	Medicaid Managed Care
Advocare	Exceeding	Exceeding	Not statistically different
Aledade	Exceeding	Exceeding	Reporting criteria not met
Atlantic Health System / Optimus	Exceeding	Exceeding	Not statistically different
AtlantiCare	Exceeding	Exceeding	Not statistically different
Capital Health	Achieving	Reporting criteria not met	Reporting criteria not met
ColigoCare	Not statistically different	Reporting criteria not met	Reporting criteria not met
Cooper University	Exceeding	Reporting criteria not met	Not statistically different
Englewood Health Medical Center	Not statistically different	Reporting criteria not met	Achieving
Hackensack Meridian Health	Exceeding	Exceeding	Not statistically different
Hunterdon Healthcare	Exceeding	Not statistically different	Not statistically different
Inspira Health Network	Exceeding	Exceeding	Exceeding
Partners in Care ACO	Reporting criteria not met	Reporting criteria not met	Reporting criteria not met
RWJBarnabas Health	Exceeding	Exceeding	Achieving
Shore Quality Partners ACO	Exceeding	Reporting criteria not met	Achieving
Virtua Medical Group	Exceeding	Exceeding	Exceeding
NJ Physicians ACO	Exceeding	Reporting criteria not met	Reporting criteria not met
Optum	Exceeding	Exceeding	Achieving
Princeton Healthcare Partners	Exceeding	Reporting criteria not met	Reporting criteria not met
Summit Health (VillageMD)	Exceeding	Exceeding	Reporting criteria not met

VI. Additional Topics: Pharmacy Rebates and Primary Care Spending

This final chapter of the report examines two special topics: pharmacy rebates and primary care spending. Pharmacy rebates significantly affect the net cost of prescription drugs to carriers and under-spending on primary care in the short term can lead to higher health care spending costs and worse patient outcomes in the long term.

A. Pharmacy rebates

Retail and medical pharmacy are consistently identified as primary drivers of health care spending and spending growth.[9] Retail pharmacy refers to drugs acquired at a pharmacy and taken at home; medical pharmacy refers to drugs, such as infusion drugs and chemotherapy, administered by a health care provider in an inpatient or outpatient setting.

Pharmacy rebates are payments from drug manufacturers to health plans or pharmacy benefit managers that return some of the purchase price of a prescription drug to the health plan or benefit manager. Rebates may be offered in exchange for a carrier placing specific drugs on its preferred drug list or on its formulary as well as for the carrier achieving certain targets related to the volume of drug sales. Rebates apply to retail and medical pharmacy. Rebate payments are an important lever of negotiation by manufacturers with carriers because, in effect, rebates reduce the cost of drugs to the carrier or its pharmacy benefit manager. Public payers such as Medicare and Medicaid use drug rebates to reduce the overall cost of providing coverage. New Jersey law requires rebates to either reduce out-of-pocket costs at the point of sale or to offset premium costs in future plan years, but how each carrier chooses to implement this is proprietary information.[10]

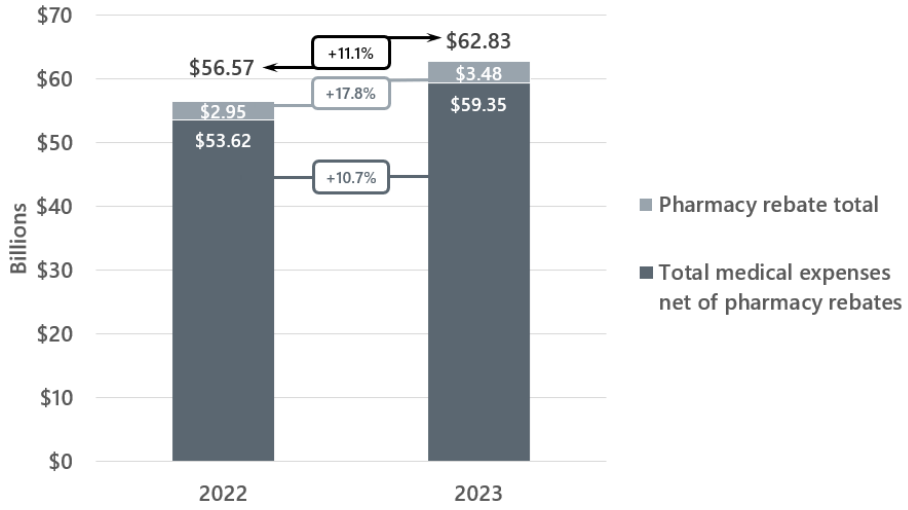
Sections II to V report TME spending gross of rebates, meaning that pharmacy rebates are not applied to the spending totals. Inconsistencies in carriers' submission of pharmacy rebates could lead to under- or over-reporting of spending if they were applied, and, as noted above, pharmacy rebates do not necessarily lead directly to lower costs for New Jerseyans. To ensure consistency with reporting, the following exhibits report pharmacy rebates separately at the market level.

In New Jersey in 2022 and 2023, pharmacy rebates totaled $2.95 billion (5.2 percent of TME) and $3.48 billion (5.5 percent of TME), respectively, excluding the Medicare FFS submarket (**Exhibit VI.1**).

[9] Martin, Anne B., Micah Hartman, Benjamin Washington, Aaron Catlin, and The National Health Expenditure Accounts Team. "National Health Expenditures in 2023: Faster Growth as Insurance Coverage and Utilization Increased." Health Affairs, vol. 44, no. 1, 2025, pp. 12-22. Health Affairs, https://doi.org/10.1377/hlthaff.2024.01375

[10] New Jersey Statutes Annotated. Title 17B – Insurance, § 17B:27F-3.2, Public Law 2023, Chapter 107, State of New Jersey Legislature, Jul. 10, 2023, New Jersey Legislature, https://pub.njleg.state.nj.us/Bills/2022/AL23/107_.pdf

Exhibit VI.1. Total medical expenses, gross and net of pharmacy rebates, statewide (in billions)

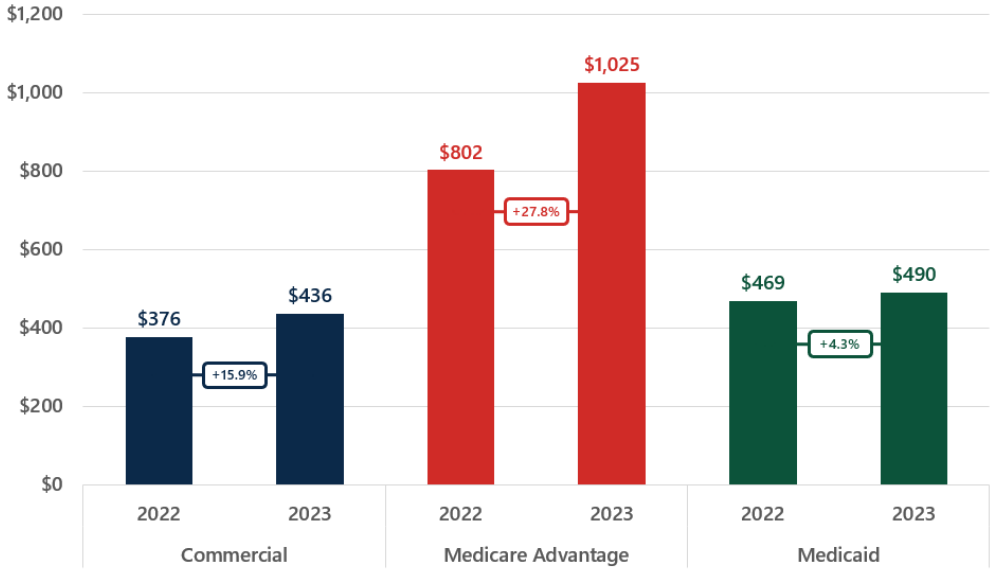


Note: The program excludes Medicare fee-for-service from this figure because pharmacy rebate data for that submarket are not available.

The amount of pharmacy rebates, both PPPY and as a proportion of overall TME, varied by market (**Exhibit VI.2**):

- **Commercial** pharmacy rebates as a proportion of overall commercial TME increased from 4.9 percent in 2022 to 5.4 percent in 2023. PPPY pharmacy rebates increased 15.9 percent.
- **Medicare Advantage** pharmacy rebates as a proportion of overall Medicare Advantage TME increased from 5.7 percent in 2022 to 6.4 percent in 2023. PPPY pharmacy rebates increased 27.8 percent.
- **Medicaid** pharmacy rebates as a proportion of overall Medicaid TME decreased slightly from 5.5 percent in 2022 to 5.4 percent in 2023. PPPY pharmacy rebates increased 4.3 percent.

Exhibit IV.2. Per person per year pharmacy rebates by market



Note: The program excludes Medicare fee-for-service from this figure because pharmacy rebate data for that submarket are not available.

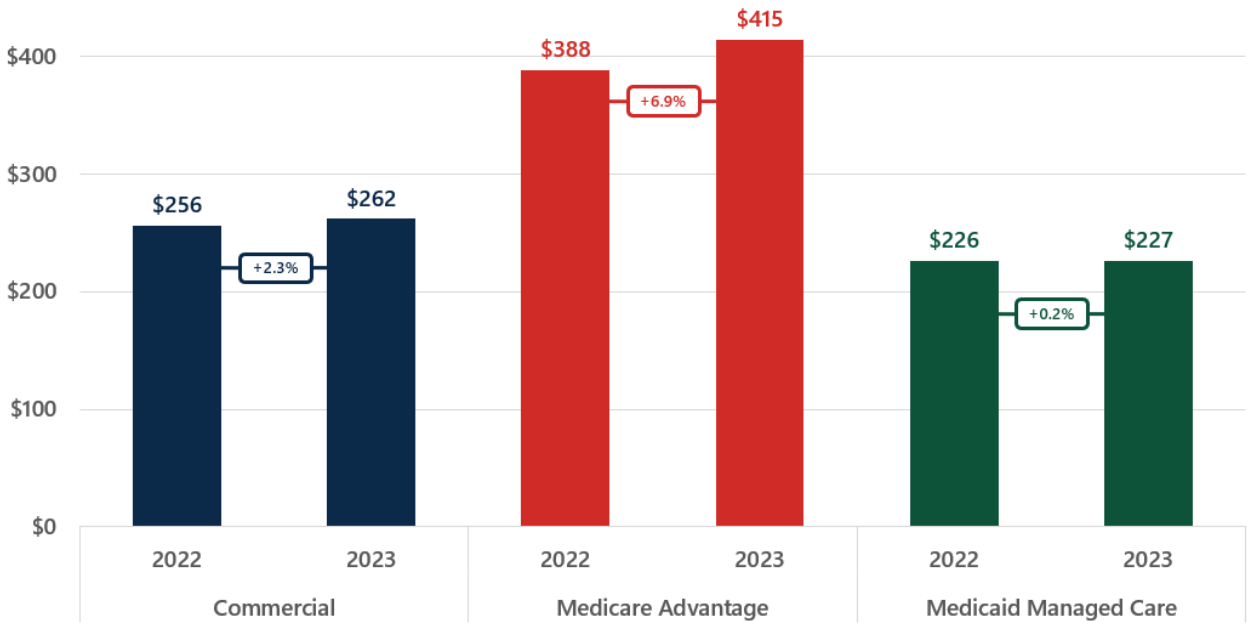
B. Primary care spending

Effective and appropriately administered primary care services have consistently proven to reduce hospitalizations, improve overall patient health outcomes, and promote equity.[11, 12] Over time, however, spending on primary care in the aggregate has been in steady decline, with implications for patients' outcomes and avoidable spending.[13]

Statewide, total primary care spending in New Jersey increased from $1.73 billion in 2022 to $1.82 billion in 2023, a 5.8 percent increase. As **Exhibit VI.3** shows, this trend varied by market:

- **Commercial** PPPY primary care spending was $256 in 2022 and $262 in 2023, a 2.3 percent increase. Primary care spending as a proportion of overall commercial TME decreased slightly from 3.3 percent in 2022 to 3.2 percent in 2023.
- **Medicare Advantage** PPPY primary care spending was $388 in 2022 and $415 in 2023, a 6.9 percent increase. Primary care spending as a proportion of overall Medicare Advantage TME decreased from 2.8 percent in 2022 to 2.6 percent in 2023.
- **Medicaid Managed Care** PPPY primary care spending was $226 in 2022 and $227 in 2023, a 0.2 percent increase. Primary care spending as a proportion of overall Medicaid Managed Care TME in decreased from 4.4 percent in 2022 to 4.2 percent in 2023.

Exhibit VI.3. Per person per year primary care spending by submarket



Note: The program excludes Medicare fee-for-service and Medicaid fee-for-service from this figure because primary care spending data was not collected for those submarkets.

[11] Starfield, Barbara, Leiyu Shi, and James Macinko. "Contribution of Primary Care to Health Systems and Health." *Milbank Quarterly*, vol. 83, no. 3, 2005, pp. 457–502. https://doi.org/10.1111/j.1468-0009.2005.00409.x

[12] Stange, Kurt C, William L. Miller, and Rebecca S. Etz. "The Role of Primary Care in Improving Population Health." *Milbank Quarterly*, vol. 101, no. S1, 2023, pp. 795–840. https://doi.org/10.1111/1468-0009.12638

[13] Horstman, Celli, Corinne Lewis, and Melinda K. Abrams. "Strengthening Primary Health Care: The Importance of Payment Reform." 2021. https://doi.org/10.26099/w4gh-f259.

Appendix A. Glossary

Attribution: The method or process of assigning patients to a provider accountable for a patient's care. This report relies on carriers to provide data on the spending attributed to a specific provider.

Carrier: A public or private organization or entity offering one or more of the following: commercial insurance, benefit administration for self-insured employers, Medicaid Managed Care plans, or Medicare Advantage plans. They are also referred to as "insurance carriers" and "payers".

Claims payments: Payments that carriers and members make to providers for health care services delivered. For the purposes of this report, claims payments reflect the allowed amount on provider claims to carriers, which includes the amount carriers paid to providers and any member cost sharing, such as copayments, deductibles, and coinsurance.

Coinsurance: The percentage of costs of a covered health care service that members pay after their deductible has been met.

Copayment: A fixed amount that members pay for a covered health care service after meeting their deductible.

Cost growth: The change in the cost of health care. In this report, cost growth is measured per person per year.

Cost sharing: The portion of the cost of covered services (that is, claims spending) paid by members as opposed to carriers. It encompasses various out-of-pocket costs that people may incur when accessing health care services, such as deductibles, copayments, and coinsurance.

Deductible: The amount that members pay for covered health care services before their insurance plan starts to pay. After meeting their deductible, members will pay a copayment or coinsurance and the carrier will pay the rest.

Fee-for-service: A system of health insurance payment in which a doctor or other health care provider receives payment for each service they perform. Although private carriers can reimburse providers on a fee-for-service basis, in this report, fee-for-service refers to insurance coverage that the government administers (the federal government for Medicare coverage and the New Jersey state government for Medicaid coverage).

Managed care: A system of health insurance payment in which a carrier uses a payment structure other than fee-for-service to reimburse providers for care delivered to covered members. In lieu of simply paying a health care provider for each service provided, managed care typically uses a combination of provider networks, capitation payments, incentive payments, utilization management, and other strategies with the intent to manage costs while promoting quality and efficiency in care. In this report, managed care broadly refers to insurance coverage in the Medicare and Medicaid markets that a private (that is, nongovernmental) entity administers. Managed care plans in the Medicare market are referred to as Medicare Advantage, whereas managed care plans within the Medicaid market are referred to as Medicaid Managed Care.

Market: A grouping of types of health insurance that is based on the source of the plan's funding. This report divides health insurance into three markets: commercial, Medicare, and Medicaid.

Net cost of private health insurance: The cost to New Jersey residents associated with administering private health insurance. It is the difference between the health premiums earned and the claims and other payments made to providers. It consists of carriers' costs related to paying bills, advertising, sales commissions, other administrative costs, premium taxes, and other fees. It also includes carriers' profits (contribution to margin) or losses. Net cost of private health insurance is calculated for the commercial, Medicare Advantage, and Medicaid Managed Care submarkets but not for the Medicare fee-for-service and Medicaid fee-for-service submarkets.

Non-claims payments: All payments other than providers' claims that carriers make to providers. This includes incentive payments, capitation or bundled payments, payments that support care transformation and infrastructure (for example, care manager payments, lump sum investments, and patient-centered primary care home payments), and other payments that support provider services.

Pharmacy benefit managers: Third-party administrators that manage prescription drug benefits on behalf of health insurance plans, self-insured employers, and government programs. Pharmacy benefit manager services include negotiating drug prices with pharmaceutical manufacturers, developing formularies, processing prescription claims, and administering pharmacy networks.

Provider: An organization with primary care providers who engage in total cost of care contracts for a significant proportion of the population they serve and for whom carriers attribute and report total medical expense data.

Risk adjustment: A methodology that adjusts carrier spending by accounting for differences among carriers in the distribution of patients across demographic groups and insurance categories. In this report, risk adjustment does not account for clinical risk of individual members.

Service category: A standard practice in health policy research of grouping payments for health care services in which spending is categorized based on where the service is delivered and how it is billed. In this report, we use seven service categories: hospital inpatient facility, hospital outpatient facility, professional, retail pharmacy, long-term care facility, other claims, and non-claims payments.

Submarket: Subcategories of the Medicare and Medicaid market including Medicare Advantage, Medicare fee-for-service, Medicaid Managed Care, and Medicaid fee-for-service.

Total cost of care contract: A term referring to value-based care arrangements that carriers have with providers in which the providers are financially responsible for a vast majority of a patient population's health care spending, regardless of how carriers pay the provider (for example, fee-for-service with retrospective reconciliation, prospective payment, and so on) or the provider's risk level for the associated contract (for example, shared savings or upside risk, two-sided or downside risk, and so on).

Total health care expenditures: The sum of the total medical expenses New Jersey residents incurred for all health care services that carriers report to the state plus the net cost of private health insurance for administering carriers' plans.

Total medical expenses: The sum of total claims payments and total non-claims payments to providers for health care services delivered to New Jersey residents. It includes payments by carriers and cost sharing payments by members. The program truncates and risk adjusts claims spending (see Appendix C) for carrier and provider level reporting. For provider level reporting, Total medical expenses reflect all medical costs for an attributed member.

Truncation: A means of accounting for high-cost outliers on carriers' and providers' cost growth. In carriers' data submissions, if an individual member has more than $250,000 in claims spending during a calendar year, the carriers truncate claims spending at $250,000. Carriers do not truncate non-claims spending.

Appendix B. Population Included in the Report

A. Population inclusion

The Cost Growth Benchmark report relies on health care spending and enrollment data that public payers and private carriers submit to the New Jersey Department of Banking and Insurance. In their data submissions, carriers are directed to include all New Jersey residents who have comprehensive health care coverage, regardless of the plan's situs (that is, where the insurer for the given plan is located).

The list of private carriers from which the data was collected includes Aetna Better Health, Amerigroup, AmeriHealth Insurance Company, Cigna Health & Life Insurance Company, Horizon Healthcare of New Jersey, United HealthCare Insurance Company, and WellCare/Fidelis Health Plans of New Jersey.

B. Population table and notes

Exhibit B.1 presents the population included in this report as member years by submarket and year, along with year-over-year assessment of change.

Exhibit B.1. Report population in member years by submarket and year

Submarket	2022	2023	Absolute change	Percentage change
Commercial	4,036,739	4,131,517	94,778	2.3%
Medicare Advantage	516,311	544,977	28,666	5.6%
Medicare FFS	1,061,310	1,055,481	5,829	-0.5%
Medicaid Managed Care	2,078,176	2,167,287	89,111	4.3%
Medicaid FFS	92,010	111,702	19,693	21.4%
Subtotal	**7,784,546**	**8,010,963**	**226,418**	**2.9%**
Medicaid portion of coverage for dually eligible beneficiaries	207,114	217,122	10,008	0.1%
Total	**7,577,431**	**7,793,841**	**216,410**	**2.9%**

FFS = fee-for-service.

1. Medicare fee-for-service population

For the Medicare fee-for-service population, the member years reflected in Exhibit B.1 represent those beneficiaries with Part A or Part B coverage during the year. This total serves as the denominator in all per person per year calculations that involve Medicare fee-for-service spending totals, such as service category-level spending for the Medicare market (this includes per person per year calculations for the retail pharmacy service category).

2. Treatment of dually eligible beneficiaries

Spending and enrollment information for beneficiaries dually eligible for Medicare and Medicaid coverage is collected separately from those beneficiaries that are not dually eligible for the two programs. How spending and enrollment are handled for this population depends on the level of reporting:

- At the **statewide level**, spending for the Medicare and Medicaid portions of their coverage are included in spending totals, but only the *Medicare* portion of their enrollment is included in the population total for per person per year calculations.
- At the **market and submarket levels**, spending for the given market is included in spending totals, and dually eligible beneficiaries' enrollment for the given market is included in the population total for per person per year calculations (that is, the dually eligible population appears in the population total for both Medicare and Medicaid).

3. Member years

Public payers and private carriers report enrollment data using member months. For per person per year calculations in this report, member years is calculated by dividing the member months by 12.

Appendix C. Methodology Notes

A. Pharmacy rebate estimation

In some instances, private carriers did not submit pharmacy rebate data for the commercial partial claims insurance category. When this occurred, the state estimated pharmacy rebates on their behalf using the following formula:

$$Estimated\ pharmacy\ rebates\ PPPY\ for\ commercial\ partial\ claims = Retail\ pharmacy\ claims\ PPPY\ for\ commercial\ partial\ claims\ x\ \frac{Pharmacy\ rebate\ PPPY\ for\ commercial\ full\ claims}{Retail\ pharmacy\ claims\ PPPY\ for\ commercial\ full\ claims}$$

PPPY = per person per year.

B. Primary care definitions

Primary care spending data are collected from private carriers (that is, primary care data are not collected for the Medicare or Medicaid fee-for-service submarkets). For the data submission process and subsequently this report, primary care services are those that meet all the following criteria:

1. The rendering or billing provider practices included any of the following specialties: family medicine, geriatric medicine, internal medicine, or pediatric medicine.
2. The care delivered included any of the following services: care management, care planning, consultation services, health risk assessments, screenings, counseling, home visits, hospice, immunization administrations, office visits, and preventive medicine visits.
3. The setting in which they delivered services was at any of the following sites of care: primary care outpatient setting (for example, office, clinic, or center), Federally Qualified Health Center, school-based health center, or via telehealth.

A complete table of codes (provider taxonomies, procedure codes, and place of service codes) used to define primary care services can be found in Appendix B of the Carrier Benchmark Data Submission Guide.