Making Health Care More Affordable

A Playbook for Implementing a State Health Care Cost Growth Target

By January Angeles, Bailit Health

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About Bailit Health

Bailit Health is a consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and employer purchasers. Bailit Health Purchasing, LLC was founded in 1997 by former senior executives of the Massachusetts Executive Office of Health and Human Services. Bailit Health's mission is to assist organizations to achieve measurable improvements in quality and cost management for enrolled or covered populations, from contracted or regulated providers and health plans. For more information, visit **bailit-health.com**.

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Introduction

Health care costs have been rising faster than inflation for decades, meaning health care is taking up larger and larger proportions of government, employer, and household budgets and crowding out other critical priorities.

Policymakers across the political spectrum have long recognized the widespread and growing burdens posed by high and rising health care costs,[1] but state governments have not looked at cost growth patterns across insurance markets using standard metrics. As a result, it has been difficult to create a comprehensive and cohesive picture of overall costs or identify where costs are growing fastest. To draw attention to the problem of health care affordability and increase systemwide health care cost transparency and accountability, more and more states are taking action through cost growth target initiatives.

A health care cost growth target, also referred to as a benchmark, is an expectation of how much per capita total health care spending in the state should grow annually. Once a target is established, the state measures and publishes how all health care payers and large provider organizations perform against this expectation and may develop accountability mechanisms to encourage them to meet the target. Establishing a target, in and of itself, is not likely to slow health care cost growth. The process must be supported by additional data analyses to understand the specific drivers of health care costs and cost growth. These reports allow states and their partnering stakeholders to identify specific opportunities to take individual or collective steps to lower cost growth.

Massachusetts was the first state to implement a statewide target in 2012. At that time, Massachusetts' commercial cost growth (spending among private payers) was above the national average. But from 2013 to 2019, commercial cost growth fell below the national average. Stakeholders reported that the target, and the potential for scrutiny of payers or providers that exceeded it, had a sentinel effect that helped restrain cost growth.[2] A recent assessment of Massachusetts' efforts indicates that the program influenced contract negotiations and fostered commitment among health care stakeholders to reduce cost growth, at least in the early years.[3]

Seven more states — Connecticut, Delaware, Nevada, New Jersey, Oregon, Rhode Island, and Washington — have since implemented targets. In addition, California recently passed legislation to establish an Office of Health Care Affordability that is responsible for setting targets as part of a suite of measures to enhance transparency and accountability around health care cost growth.

A health care cost growth target, also referred to as a benchmark, is an expectation of how much per capita total health care spending in the state should grow annually.

This playbook provides a program design and implementation roadmap for states that are interested in, or in the process of, establishing a target. It offers concrete steps, practical tools, best practice strategies, and insights to guide states through the work. This playbook is organized into six types of activities:

1. Program planning, development, and sustainability

2. Public–private stakeholder engagement

3. Establishing the target methodology and value

4. Measuring performance against the target

5. Understanding the drivers of cost growth

6. Accountability and action to slow cost growth

Exhibit 1 presents the key action steps and their timing, which are described in greater detail in this playbook. While these activities and steps are presented linearly and discretely, many of them are interconnected and interrelated.

The playbook is informed by the experience of six states that are participating in the **Peterson–Milbank Program for Sustainable Health Care Costs** and receive technical assistance from **Bailit Health** as they implemented targets, as well as the experiences in Massachusetts and Delaware.

As states consider a target initiative, they have several options for how to structure their policies and processes. In some cases, states may need to take incremental steps — establishing short-term processes while paving the way for long-term commitments. No two states have implemented targets in the same way, but all of them have built on lessons learned from other states' experiences to fit the pieces together and build a program that recognizes and respects their local context.

EXHIBIT 1. Activities and Steps to Implement a Health Care Cost Growth Target

Program Planning, Development & Sustainability

Pre-Implementation
(Establishing program)

1. Determine the appropriate vehicle for authorizing the program
2. Identify the governance model to guide policy and program administration

Implementation
(0–12 months)

3. Build a core program management team

Ongoing
(After year 1)

4. Lay the foundation for future sustainability

Public–Private Stakeholder Engagement

Pre-Implementation
(Establishing program)

1. Socialize the concept of cost growth targets
2. Identify goals for stakeholder engagement

Implementation
(0–12 months)

3. Develop a strategic communications plan

Ongoing
(After year 1)

4. Conduct repeated outreach using strategic messaging

Establishing the Target Methodology & Value

Implementation
(0–12 months)

1. Identify a target methodology and calculate the value
2. Determine the target duration and any adjustments to the methodology or value

Ongoing
(After year 1)

3. Monitor for conditions that might call for revisiting the target methodology or value

Measuring Performance Against the Target

Implementation
(0–12 months)

1. Define the approach to measuring cost growth
2. Identify the entities that will be held accountable to the target

Ongoing
(After year 1)

3. Develop and implement a process and timeline for collecting, analyzing, and reporting data

Understanding the Drivers of Cost Growth

Implementation
(0–12 months)

1. Establish a framework to guide the analyses

Ongoing
(After year 1)

2. Identify opportunities to slow cost growth and set the stage for future policy action

Accountability & Action to Slow Cost Growth

Pre-Implementation
(Establishing program)

1. Consider accountability mechanisms for meeting the target

Implementation
(0–12 months)

2. Build the structure to hold entities accountable

Ongoing
(After year 1)

3. Pursue strategies to mitigate cost growth and help meet the target

1   Jones DK, Page C. Bipartisan Approaches to Tackling Health Care Costs at the State Level. Milbank Memorial Fund, October 2020. https://www.milbank.org/publications/bipartisan-approaches-to-tackling-health-care-costs-at-the-state-level/

2   Waugh L, McCarthy D. How the Massachusetts Health Policy Commission Is Fostering a Statewide Commitment to Contain Health Care Spending Growth. Commonwealth Fund, March 2020. https://www.commonwealthfund.org/publications/case-study/2020/mar/massachusetts-health-policy-commission-spending-growth

3   Lipson D, Orfield C, Machta R, Kenney O, Ruane K, Wrobel M, Gerovich S. The Massachusetts Health Care Cost Growth Benchmark and Accountability Mechanism: Stakeholder Perspectives. Mathematica, October 2022. https://www.milbank.org/wp-content/uploads/2022/10/MassCostGrowthBenchmarkEvaluation_Mathematica_Oct2022.pdf

1 Program Planning, Development, & Sustainability

States interested in establishing targets need to engage in planning well in advance of program authorization to facilitate support among a wide array of stakeholders and pave the way for statutory codification to ensure continued success of the program.

This section describes considerations for obtaining the necessary authority to establish the program, identifying a governance structure, and ensuring program sustainability. For all these activities, states should have program champions to help secure support for the target initiative. Executive branch buy-in is especially important since agency staff will need to develop the policies and infrastructure to implement and manage the program on an ongoing basis.[1]

Determine the Appropriate Vehicle for Authorizing the Program

Ideally, targets should be established in law so that they endure through election cycles and are appropriately resourced. Codifying the program in statute is important for sustainability as it affirms and institutionalizes specific activities by making them part of a state agency's core mission and responsibilities.

EXHIBIT 2. **Approaches to Authorizing a Cost Growth Target Program**

Voluntary Compact	Executive Order	Statute
✓ May facilitate earlier buy-in from stakeholders	✓ Can be executed quickly ✓ Allows greater flexibility in implementation	✓ More difficult to overturn than an executive order ✓ Can include accountability and enforcement mechanisms ✓ Can be accompanied by authorization of state funding
✗ Vulnerable to shifting organizational priorities ✗ Cannot compel action in ways that other approaches can ✗ Does not authorize state funding to support program design and operations	✗ Vulnerable to changes in administrations and can be rescinded ✗ Limited in scope and enforcement mechanisms ✗ Does not authorize state funding to support program design and operations	✗ Legislative negotiation process can take more time and result in changes to the original policy intent

However, states can take incremental approaches to establishing authority (Exhibit 2) as they build support. For example, Rhode Island developed its target program in 2018 through a voluntary compact signed by public and private stakeholders that included payers, providers, and business and community leaders, which was quickly followed by an executive order. In 2022, the state included budget language to fund the program and is now pursuing legislation to establish it on a permanent basis. Similarly, Connecticut began with an executive order and subsequently adopted legislation that made the program permanent and further strengthened it by establishing public hearings to focus attention on health care cost growth target performance.

Identify the Governance Model to Guide Policy and Program Administration

A program governance model defines the structure and processes that guide program administration, decision-making, and accountability. There is no "one-size-fits-all" approach to governance, and states' approaches vary based on available resources and the local cultural and political norms.

Massachusetts, Washington, and most recently California have set up a formal governing board comprising external stakeholders and ex-officio or state agency staff to direct the agency implementing the target. Program staff present options and recommendations to these boards that in turn make binding decisions on critical policies, such as the target methodology and value and the use of available tools to compel entities to meet the target. Board discussions and deliberations are subject to open public meeting laws, which ensures transparency in policy development and decision-making and helps build trust across stakeholders.

Instead of having a formal governing board, other states have stakeholder committees that advise the implementing state agency. The agency retains formal decision-making authority but uses the stakeholder committee to obtain critical subject-matter expertise, stakeholder input, and buy-in.

Regardless of the governance structure, a critical consideration for states is how to ensure representation of key stakeholder groups and obtain the needed technical expertise, while protecting against undue influence of groups that might have a financial interest in maintaining the status quo. To protect policy decisions against the influence of special interests, states could fill their board or advisory committee with appointees who have expertise in health care purchasing, delivery, financing, and/or administration but who do not represent organizations such as insurers, pharmaceutical manufacturers, or providers that could be held accountable to the target or contribute to cost growth. States could also include employer purchasers, consumers, and consumer advocates to ensure a focus on affordability.

The board or stakeholder committee could then appoint technical subcommittees to advise on specific issues. These committees offer a way for providers and insurers that may be held accountable to the target to provide input and an important perspective on how the target might impact their operations and ultimately patient care. For example, in Washington, the Health Care Authority administers its program under the oversight of the Health Care Cost Transparency Board (HCCTB), which has formal decision-making authority. Members of the HCCTB include state agency

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officials, large and small employer representatives, health care economics and financing experts, and consumer representatives. Two committees — one including a diverse group of health care providers and payers, and another including experts in data collection, analysis, and reporting — advise the HCCTB on issues related to the HCCTB's work.

Another important consideration for states is which entity or entities should be responsible for developing and implementing the program, collecting spending data, reporting performance against the target, and analyzing drivers of cost growth. Massachusetts and California established new agencies focused on solely on implementing the target. In a dedicated agency, all staff have the same priorities and can concentrate exclusively on the target. However, this approach requires significant resources and is not always feasible, particularly in smaller states where it is difficult to achieve economies of scale.

Other states rely on existing agencies with broader responsibilities. For example, Rhode Island's target program is housed in the Office of the Health Insurance Commissioner, which is the state's commercial health insurance policy reform and regulatory enforcement agency. In New Jersey, the Department of Banking and Insurance implements the program in coordination with an interagency working group chaired by the Governor's Office of Health Care Affordability and Transparency. While the scope of these agencies is much broader than the target program itself, health care affordability is a critical part of their mission.

Build a Core Program Management Team

Regardless of where administration of the program resides, having strong leadership and management is essential for the program's successful launch and long-term sustainability. A strong team can sustain momentum and program activities during political and other transitions. Leadership and expertise on cost growth targets cannot depend solely on one individual. Instead, states need to "build the bench" and develop capacity among career agency staff.

Staffing needs and structure may change over time as the program matures, but at a minimum, states need a team to perform the following core functions:

- Ensuring the program's goals align with the state's overall strategy, and working with state agencies, legislators, industry leaders, and the other stakeholders to prioritize health care affordability

- Performing ongoing strategy development and implementing the program's day-to-day operations, including planning, directing, coordinating, and executing the program's essential functions

- Conducting research to inform policy solutions, preparing written reports, and presenting information to targeted audiences or the public

- Performing administrative tasks such as managing contracts and coordinating meetings

- Supporting the development of a communications strategy and executing the communications plan, including ongoing messaging related to the state's health care affordability goals

Another important consideration for states is which entity or entities should be responsible for developing and implementing the program, collecting spending data, reporting performance against the target, and analyzing drivers of cost growth.

- Shaping the analytic strategy and agenda, overseeing data collection, analyzing the data, interpreting findings, validating data with payers and providers, and preparing reports and other work products for internal review and public dissemination

Larger states with more resources may dedicate one or more staff members to each of these functions. However, smaller states may consolidate these responsibilities among a smaller staff and leverage expertise in other parts of the agency or other agencies for some functions, such as communications and analytics. States that take this approach will need to monitor for shifting priorities and competing demands and ensure that a core team is available to sustain, and potentially expand, the cost growth target program.

Many factors and conditions influence state decisions on staffing, and states will vary in how they define and fill the staff structure to implement the program. Some states may not be able to hire full-time staff to run a cost growth target program and must procure expertise from outside vendors. While procuring the required expertise is a more costly option, a vendor can fill gaps in knowledge and skill sets that occur in the event of state staff vacancies or turnover. Still, contracting will require a core state team to effectively manage the vendor and ensure knowledge transfer over time to avoid long-term dependence on vendors.

Lay the Foundation for Future Sustainability

At every point in the planning, development, and implementation of a cost growth target, states should consider how to navigate the program through changes in leadership, personnel, and political and health system contexts. Sustained focus from state executive leadership is critical to advancing the program and ensuring its long-term sustainability.

States that establish targets through a voluntary compact or executive order should begin planning for future legislation to codify the cost growth target program in statute. Even those states that already have legislation authorizing the program should consider potential improvements based on lessons learned from the first few years of implementation. For example, states could strengthen data collection requirements to improve compliance. Or, if stakeholders neglect to take action to address persistent and excessive cost growth, states could consider new or additional enforcement mechanisms, such as performance improvement plans and penalties.

In addition, after a few years, states that rely on vendor support to establish processes and perform key program activities should think about whether and how to develop expertise within the implementing state agency to assume these critical functions.

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Resources

Executive Orders on Health Care Cost Growth Targets

- Delaware's **Executive Order 25** to establish state health care spending and quality benchmarks
- Nevada's **Executive Order 2021-29** to establish a health care cost growth benchmark
- New Jersey **Executive Order 217** to establish an Interagency Health Care Affordability Working Group to develop proposals for the development and implementation of an annual health care cost growth benchmark and health insurance affordability standards
- New Jersey **Executive Order 277** to launch the cost growth benchmark
- Rhode Island **Executive Order 19-03** to establish a health care cost growth target

Legislation on Health Care Cost Growth Targets

- California's **legislation** to establish the Office of Health Care Affordability
- Delaware's **House Bill 442** to codify health care spending and quality benchmarks established through Executive Order 25
- Massachusetts' **legislation** on health care cost containment, which included establishment of health care cost growth benchmarks
- Nevada's **Assembly Bill 348** designating the Patient Protection Commission as the governing body for the state's cost growth benchmark program
- Oregon's **Senate Bill 889** and **House Bill 2081** to establish the Sustainable Health Care Cost Growth Target Program within the Oregon Health Authority
- Washington's **legislation** to establish the Health Care Cost Transparency Board

Voluntary Compacts on Health Care Cost Growth Targets

- New Jersey's Health Care Affordability, Responsibility, and Transparency Program **Blueprint**, including language for a stakeholder compact to reduce the rate of health care cost growth in the state
- Rhode Island's **Voluntary Compact** to reduce the growth in health care costs and state health care spending

Reports and Publications

- **Rhode Island's Cost Trends Project: A Case Study on State Cost Growth Targets**

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1   Boxall AM. What Does the State Innovation Model Experiment Tell Us About States' Capacity to Implement Complex Health Reforms? Milbank Quarterly, March 29, 2020. **https://doi.org/10.1111/146 8-0009.12559**

2 Public–Private Stakeholder Engagement

Effective stakeholder engagement and communications are critical to the cost growth target's success. The factors driving health care cost growth are complex, and the impact of the target on affordability will occur over the long term, so explaining the benefits and progress of the target program requires clear and ongoing communications.

Likewise, earning and maintaining stakeholder buy-in amid inevitable changes in state administrations, the economy, and other circumstances demands consistent engagement. This section describes key communication activities that states need to undertake to gain and maintain momentum to implement cost growth targets.

Socialize the Concept of Health Care Cost Growth Targets

Well before obtaining any authority to establish the program, state leaders need to introduce members of the health care community to the concept of cost growth targets and reasons to implement one. In doing so, states need to make the case that rising health care costs harm governments, employers, and families and clearly delineate how targets can help address this issue. The following are key talking points that states could use to define the problem and make the case for a cost growth target:

- **No person should have to choose between going to the doctor and putting food on the table for their family.** Health care costs are eating into household budgets, leading many individuals and families to skip needed care and/or forgo other household necessities.

- **High health care costs affect everyone.** High deductibles, premiums, and out-of-pocket costs comprise a growing percentage of total household income, including for those with job-based health insurance.

- **Rising health care costs stretch the budgets of the state government and state employers.** As states spend more and more on health care, fewer dollars are left for other policy priorities like education and housing. Likewise, employers, especially small businesses, are burdened by health care costs, making it hard to stay competitive.

- **COVID-19 expenses and high inflation reinforce the need to understand health care cost growth.** The COVID-19 pandemic and high inflation have stressed state, employer, and household budgets, underscoring the need to understand statewide health care costs and address the drivers of unsustainable increases.

> **States need to make the case that rising health care costs harm governments, employers, and families and clearly delineate how health care cost growth targets can help address this issue.**

- **Cost growth targets pave the way to identifying effective ways to reduce health care costs.** Developing the capacity to track and benchmark spending across payers at the state level will promote a new understanding of health care costs. Analysis of spending data will pinpoint drivers of cost growth and enable states to devise specific strategies to contain costs.

- **Target programs can measure and improve care for people of color and other marginalized groups.** States can measure and address health inequities as part of their implementation process by prioritizing cost driver analyses that focus on variation in utilization and costs by population, and by ensuring that the governing and/or advisory bodies that develop related policy recommendations are representative of the state's demographics.

Identify Goals for Stakeholder Engagement

States need to engage stakeholders regularly to educate them, increase buy-in, and garner support. States must conduct outreach with each key stakeholder group: state legislators, employers, health providers, payers, journalists, consumer advocates, and the public. Engagement of organized labor and local funders may also be important. Three goals for stakeholder engagement are:

- **Ensure opportunities for feedback and guidance from affected stakeholders.** This exchange will primarily occur through engagement with groups most directly impacted by the initiative, such as payers and provider organizations. A state's program lead and dedicated staff should cultivate relationships with influencers in these groups to hear and respond to input and concerns.

- **Foster necessary support to effect change.** Outreach will likely include all stakeholders, but may especially emphasize contact with legislators, employers, organized labor, local funders, and consumer advocates who have a vested interest in affordable health care and can serve as major allies in advancing strategies to slow health care cost growth.

- **Maintain clear communications on the value and role of target programs.** Health care costs affect all state residents. Outreach should ensure a clear understanding of the target program's goal of lowering health care costs for all constituencies.

Throughout the initiative, states should aim to build a culture of accountability in which all stakeholders are committed to transparency in health care costs and holding down cost growth. However, as states move further along in their implementation, the program priorities, and consequently the specific goals for stakeholder communication, will evolve. In the early stages, most of the communication should focus on obtaining buy-in and describing how targets can help advance affordability. As the initiative matures, stakeholder engagement should move toward actions the state and its partnering stakeholders can take to mitigate cost growth. States should also routinely assess any changes in the environment or new opportunities that may require a shift in focus and revision of goals for stakeholder engagement.

> **Throughout the initiative, states should aim to build a culture of accountability in which all stakeholders are committed to transparency in health care costs and holding down cost growth.**

Develop a Strategic Communications Plan

To prioritize communications in the implementation process, a dedicated member of the target program team should work regularly with communications staff, if available, to ensure the state conveys the value and progress of the program in a consistent and understandable way. In the absence of dedicated communications staff, the state lead should assign staff communications responsibilities, such as working with appropriate department staff on a website or web page and creating fact sheets or Q&A documents based on examples provided in the resources section below.

States should develop a **communications plan** as a roadmap for informing and engaging stakeholders. The communications plan should detail:

- **Communications goals** that are derived from the program goals. If a state is pursuing a target program to promote health care affordability, for example, a communications goal might include sharing data demonstrating that health care costs are currently rising at an unsustainable rate, making health care less affordable for individuals, employers, and the state. Another goal might be promoting an understanding of the steps involved in the target-setting and implementation process to generate buy-in for the approach among stakeholders.

- **Target audiences** who need to know about the program, such as state officials, legislators, and members of stakeholder groups directly involved in the cost growth work; the broader group of stakeholders, such as insurers, health providers, employers, and patient advocates; and the public at large.

- **Key messages** that emphasize the capacity to address core health care cost challenges. These should include broad, overarching messages on the importance and relevance of the target to key state priorities, but should also be customized to emphasize the target's value proposition to each audience group.

Best Practices to Ensure Successful Messaging

- Tell a complete and compelling story so that conclusions drawn from the information are not left up to interpretation.

- Highlight that target programs are systemwide, collaborative efforts that incorporate public-private partnerships.

- Draw attention to the systemic factors that have led to the problem of rising health care costs, so people are less inclined to blame state governments, employers, and individuals for health care affordability challenges.

- Highlight that targets are a practical approach to addressing high costs.

- Explain that health care cost containment can benefit all stakeholders, including high- and low-income people.

- Avoid crisis language (to avoid fatalism) and other language that can distract from the systemic causes of rising costs.

Source: Adapted from the FrameWorks Institute.

- **Tactics** that state staff will employ to share key messages, including conducting outreach to media to share announcements or new reports, engaging with stakeholders, and hosting informational events. Staff should develop content that covers topics in varying levels of detail — from accessible fact sheets to detailed reports or data dashboards. Staff should also make the content available via a range of platforms and approaches, such as a dedicated website, social media channels, and/or an annual public hearing.

- **A timeline** of releases and events, which states should update every six months based on key events such as report releases and public meetings.

Conduct Repeated Outreach Using Strategic Messaging

Continued stakeholder engagement is necessary to maintain momentum and sustain the program. In addition to obtaining stakeholder input on the policy development, states should conduct regular outreach that includes strategic messaging about what is driving health care cost growth. Opportunities to communicate about the program include:

- Creation of the new governing structure and/or governing board and committees

- Identification of the target value

- Publication of annual performance reports as well as cost driver analyses

- Similar activities in other states, or the release of national publications that underscore the need to address affordability and/or support the target program's approach

- Consumer health care affordability survey results

- Accountability actions, such as issuance of a performance improvement plan or penalty

Approaches to ongoing communication should include:

- **Dedicated website:** States should maintain a website that describes the program and how it can address the issue of affordability. The site should include board or advisory committee meeting materials and recordings and other documents related to program implementation.

- **Public meetings of state boards and committees:** At a minimum, states need to report performance annually to the program's governing body, which will review the state's performance and associated analyses and explain the findings via public meetings. Streaming public meetings, as well as posting and distributing recordings and summaries of meetings, will improve program visibility.

- **Public hearings:** Some states have created public hearings on target performance and mitigation strategies. In Massachusetts, the Health Policy Commission (HPC) holds a two-day annual forum where payers and providers testify under oath and answer questions from members of the HPC's governing board and state officials. Members of the public are invited to share stories on their challenges with the cost of health care in the state.

Continued stakeholder engagement is necessary to maintain momentum and sustain the program.

- **Invitation-only forums and private meetings of associations:** The state should present about the target and related analyses on affordability and cost growth in the state at forums or meetings held for other purposes, such as legislative briefings, state interagency meetings, and meetings of the state's hospital association, medical association, and consumer advocacy associations.

- **Media mentions and op-eds:** Media outreach is an effective way to reach a broader audience, and the state should cultivate relationships with local reporters who cover health care affordability. The state should also consider opportunities, such as program milestones reached or current events tied to health care affordability, to draft op-eds in collaboration with target program stakeholders.

- **Newsletters, blog posts, videos, and social media posts:** The state can leverage these tools to share information about program developments and bring attention to health care affordability and the need to address cost growth.

At each opportunity, states should highlight the problem of health care affordability and describe what it means for families, employers, and the state. States should also consider building a coalition of supporters who can engage public officials, and develop talking points that can be used to discuss issues publicly or privately.

In addition, because meaningful action to address drivers of cost growth is the most challenging part of a target program, the communications strategy should repeatedly and effectively elevate the key cost drivers that the cost growth mitigation strategy will address in the future. This cost-driver messaging should be done early, long before the development of the cost mitigation strategy.

Through repeated strategic messaging about what is driving health care cost growth, states can set the stage for future policy action. For example, Connecticut was able to pass legislation to codify its target program by gaining support via extensive outreach. The Connecticut Office of Health Strategy (OHS) held regular meetings and briefings with legislators on issues around affordability and how the target program was working to address them. The OHS also developed relationships with stakeholders most closely aligned with the target program's goals, including members of the business community, and worked with them to garner support.

Resources

Communications Toolkit

- The Peterson-Milbank Program for Sustainable Health Care Costs **communications toolkit** helps state policymakers develop a local communications plan to share the value of and progress within a state's cost growth target initiative.

Information on Health Care Costs' Impacts on Individuals and Families

- **Altarum's Consumer Healthcare Experience State Survey (CHESS) Briefs** provides consumers' views on a wide range of health system concerns (e.g., confidence using the health system) in several states.

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- Families USA's report **Bleeding Americans Dry** highlights big hospital corporations' role in making health care unaffordable.

- Families USA's report **Our Health Care System Has Lost Its Way** highlights the problem of unaffordable and low-quality care in the United States.

- The monthly **Peterson-Milbank Program for Sustainable Health Care Costs Newsletter** features the latest research and analysis relevant to health care cost transparency and accountability.

- **The Manatt State Cost Containment Update**, a digital publication produced with support from the Robert Wood Johnson Foundation and in collaboration with the Peterson-Milbank Program for Sustainable Health Care Costs, features news on data-driven state activity on cost containment. The resourced page also includes related publication and webinar recordings.

- **The Peterson-KFF Health System Tracker** provides clear, up-to-date information on US health care cost trends, drivers, and issues — and shows how the US is performing relative to other countries.

Examples of Communications Content

- **Press releases** announcing new developments, such as establishment of an implementation committee, setting of target value, releases of target or cost driver reports, and announcements of the deployment of enforcement mechanisms.
  - **Oregon Passes Bipartisan Legislation to Slow Rising Cost of Health Care and Increase Transparency for Consumers**
  - **HPC Finds Mass General Brigham Cost Trends and Expansions Threaten State Health Care Affordability Efforts**

- **Explainers** such as accessible infographics, fact sheets, FAQs, or videos that explain the program or share topline findings from target performance or cost driver reports, ideally using a combination of graphics and text.
  - **Key Components of Nevada's Health Care Cost Growth Benchmark**
  - **New Jersey Health Care Affordability, Responsibility, and Transparency (HART) Program Blueprint**
  - Washington State **Health Care Transparency Board FAQ**
  - **HPC Short: Out-of-Pocket Spending for Birth Care**

- **Reports** featuring baseline data, performance against the target, or analysis of cost drivers.
  - **Health Care Cost Trends: State and Market-Level Cost Growth in Oregon, 2013–2019**

- **Blogs or op-eds** from a state official or committee member making the case for targets to help raise the program's profile.
  - **How Connecticut Is Moving to Control Health Care Costs**

Examples of Dissemination Approaches

- **Websites** ideally include a home page with overview text and sections for meeting materials, information for data submitters, and reports and explainers.
  - **Oregon Health Authority's Sustainable Health Care Cost Growth Target**
- **Social media** includes YouTube, LinkedIn, and other social media accounts for posting videos of events or key findings from explainers and reports.
  - **Massachusetts Health Policy Commission on Twitter**
- **Events** include in-person or virtual briefings/forums targeting specific audiences, such as legislators, employers, or public advocates, or a public hearing that aims to draw media attention and involve a range of stakeholders. Videos and slides can be posted.
  - **Rhode Island Health Care Cost Trends Project 2020 Cost Growth Target Performance**
  - **Connecticut Office of Health Strategy Virtual Forum on the Health Care Cost Growth Benchmark**
  - **New Jersey Informational Webinar for Hospital and Provider Stakeholders**

3

Establishing the Target Methodology & Value

The process of setting a target represents an opportunity to educate, engage with stakeholders, and develop buy-in among payers and providers whose performance will be measured against the target.

States should strive to be clear and transparent about why the target is needed and the factors to consider in setting the target methodology and value. This section describes key steps in this activity.

Identify a Target Methodology and Calculate the Value

The methodology used to determine the target value is critical in helping stakeholders, including the public, understand the policy and reasoning behind the target. For the most part, states have tied their targets to measures of the larger economy, so future health care cost growth does not exceed overall state economic growth, and to a measure of household finances such as income growth.

States have considered indicators that fall into three general categories:

1. **State economic output:** Such measures represent the total value of goods produced and services provided in a state during a defined period. Using this type of measure sets an expectation that health care costs should not grow faster than the state economy, and that state spending on health care should not take up a greater proportion of the state's overall spending in the future than it does currently.

2. **Inflation:** Inflation measures the decrease in the purchasing power of money, reflected as increases in prices consumers pay for goods and services. Using a measure of inflation signals that health care costs should not grow faster than the increase in the cost of goods and services, tying the target to consumers' experiences at the grocery store or shopping mall.

3. **Income or wages:** These measures represent the individual earnings of a state's population and the ability to afford to live in and purchase goods and services in the state. Tying the health care target to such measures puts health care in the context of individual and family experiences and signals that spending on health care should not take up a greater proportion of a family's budget than it currently does.

If a state chooses an economic indicator as its target methodology, it must then calculate the growth rate of that indicator to derive an initial target value. This can be done using historical or forecasted growth. While using historical growth reflects actual experience, it can be volatile from year to year. Alternatively, long-

For the most part, states have tied their targets to measures of the larger economy, so future health care cost growth does not exceed overall state economic growth, and to a measure of household finances such as income growth.

term forecasted growth is estimated using historical experience but smooths out significant swings caused by short-lived economic booms or busts, which are poor predictors of future trends.

Before finalizing the target value, states should consider short- and long-term historical cost growth to ensure the target is reasonable and set at a level that would put appropriate downward pressure on cost growth. Some of the resources available to states to understand historical spending include the following:

- **All-payer claims database (APCD):** These databases include medical, pharmacy, and sometimes dental claims collected from private and public payers. For states that have an APCD, this is the best source for data on fully insured commercial, Medicare, and Medicaid claims spending, so long as the APCD has been tested and the data are clean and ready to use.

- **State employee health benefit experience:** For states that do not have an APCD, data from the state employee health plan can serve as a proxy for commercial market experience.

- **Medicaid Management Information System (MMIS):** States may choose to use claims data directly from their MMIS to understand Medicaid spending.

- **Insurer rate filing data:** In states that require submission of spending information as part of the rate review process, insurer rate filing data can be a source of trend information for commercial spending.

- **Publicly available research:** The Health Care Cost Institute, the Institute for Health Metrics and Evaluation, the State Health Expenditure Accounts, and FAIR Health provide national, regional, and/or state reports on cost growth.

Determine the Target Duration and Any Adjustments to the Methodology or Value

If not previously determined through executive order or legislation, the state must decide how long to keep the target in place. States have set targets for periods ranging from four to 15 years. Four years is the minimum recommended length for the target policy because 10 to 14 months are needed after the end of a performance year to assess and publish performance against the target and to make changes in contracts or payment policies that could change cost growth trends.

States can also opt to adjust the target value, or the target methodology, when setting targets over multiple years. By adjusting the value, states can help providers and payers adjust to a target over time and accelerate the drive to reduce health care cost growth. For example, New Jersey based its target methodology on 25% potential gross state product (PGSP) and 75% median income, resulting in a target of 3.2%. New Jersey then used "add-on factors" to adjust the value to ease the transition for stakeholders. Nevada took a slightly different approach, which yielded similar results. Rather than adjusting the value of the target, Nevada adjusted the methodology itself over the course of five years. Nevada used a changing blend of forecasted median wage and PGSP, with increasing weight placed on forecasted median wage in future years. The aim was to signal that affordability is a state priority and that, over time, health care cost growth should more closely reflect individuals and families' ability to purchase goods and services.

Monitor for Conditions That Might Call for Revisiting the Target Methodology or Value

States should view the target as a long-term policy. However, recognizing that the landscape and economic circumstances of a state may change significantly in ways that are difficult to predict (e.g., the COVID-19 public health emergency), states may opt to revisit the target methodology at intervals or in response to external circumstances. For example, Washington developed a provision that would allow it to consider changes to its target or target methodology in the event of extraordinary circumstances, including highly significant changes in the economy or health care system. Delaware, on the other hand, annually reviews the methodology.

The sharp rise in inflation in late 2021 that persisted through 2022 led some states to review their target values and methodologies. States can consider several options when deciding whether and how to update target methodologies and values based on such circumstances:

- Recalculate the value of future targets **using new inputs**.

- Revise the target **methodology**.

- Retain existing target values and **contextualize** short-term trends resulting from elevated inflation.

Resources

Data on Health Care Spending and Growth

- The Health Care Cost Institute's **Health Care Cost and Utilization Reports** examine trends in health care spending for individuals with employer-sponsored insurance. Users can explore spending by health care service category.

- The **National Health Expenditure Accounts** provide historical and projected spending on health care in the United States. Spending is presented by type of good or service (e.g., hospital care, retail prescription drugs) and source of funding (e.g., Medicare, Medicaid, private health insurance, out-of-pocket).

- The **State Health Expenditure Accounts** provide state level aggregate and per capita estimates of health spending for the Medicare, Medicaid, and private health insurance markets from 1991 to 2020.

Data on Economic Indicators That May Be Used to Determine the Target Methodology

- The Congressional Budget Office's **Budget and Economic Outlook Report** contains national data on potential labor force productivity and projected inflation that can be used as inputs to calculate PGSP.

- The Federal Reserve Bank of St. Louis' research data portal, **FRED**, provides access to over 800,000 economic indicators that can be sorted by state or geographic region.

4 Measuring Performance Against the Target

Once the target is set, states need to measure the change in annual per capita health care expenditures against the target. This is done using aggregate claims and non-claims spending data collected from payers, which requires developing specifications for data submission.

This section outlines considerations for how to approach the measurement of cost growth, identify the payer and provider entities whose performance will be measured, collect spending data, and analyze performance in relation to the target.

Define the Approach to Measuring Cost Growth

Define the Health Care Spending That Will Be Measured

All states calculate total health care expenditures (THCE), a measurement defined as the sum of total medical expense (TME) plus the net cost of private health insurance (NCPHI). All states define TME in terms of provider payments. TME comprises claims and non-claims payments to providers, and patient cost-sharing. States request aggregate claims data in broad categories, such as hospital inpatient, hospital outpatient, professional, pharmaceutical, and long-term care, to allow for deeper

What Is Not Included in Total Health Care Expenditures?

Stakeholders in many states have expressed a desire to include spending by the uninsured in measuring cost growth. However, no state has been able to do so because there is no comprehensive source of such data.

Similarly, hospitals have noted that uncompensated care constitutes a significant medical expense that is not included in the measurement. Nationally, uncompensated care costs for uninsured individuals reached nearly $43 billion in 2020.[1] These costs include charity care — free or deeply discounted services for patients who cannot afford treatment —

for which hospitals must budget, and "bad debt," or write-offs for bills that go unpaid. These are not considered payments to providers, and therefore do not represent spending as defined by states. No state has developed a provision to subtract uncompensated care from a provider's spending performance. Because of the administrative burden of reporting charity care and bad debt consistently across all providers in a state, states have accepted these as known challenges to complete measurement for now.

analysis. Non-claims costs include incentive program payments and prospective service payments, among others. These payments are increasingly important as more services are paid through value-based arrangements that do not flow through the claims system. To capture patient cost-sharing data, states require payers to report the "allowed amount" on a claim, which indicates what portion the patient owes the provider according to the patient's benefit plan.

NCPHI is the spending associated with administering private health insurance and is calculated as the difference between health premiums earned and benefits incurred. It includes administrative expenditures, net additions to reserves, rate credits and dividends, and profits and losses.

Define the Population Whose Spending Will be Measured

All states measure costs for the commercial, Medicare, and Medicaid populations, as they typically represent about 90% of all covered individuals in a state.[2] To be more inclusive, some states have also considered incorporating spending for populations that receive health care coverage through other sources, such as veterans who typically access health care through Veterans Health Administration (VHA) facilities, incarcerated individuals for whom the state pays health care costs, the Native American population that receives care from the Indian Health Service, and employees who receive workers' compensation health care benefits. In determining whether to include these types of health care spending, states need to account for data availability and whether the gain from including the additional spending outweighs the level of effort involved to access the data.

Currently, all states measure the health care spending of all state residents with commercial, Medicare, or Medicaid coverage, regardless of whether they seek care in or out of the state. States have also considered measuring spending of (1) state residents who seek care only from in-state providers, or (2) all individuals who seek care from in-state providers, regardless of where they live. However, no state has pursued these options due to the data collection and reporting challenges of segmenting data by provider location and/or a decision to focus only on spending associated with state residents.

Another consideration for states is what population to use as the denominator for calculating per capita spending. Reporting on a per capita basis allows states to account for migration and population changes that could significantly affect total health care spending. It also facilitates comparisons of cost growth between states that have different population sizes. States can take one of two approaches:

- **Use the state's total population.** Massachusetts calculates state performance against the target by taking the change in THCE and dividing it by the state's entire population. Policymakers felt using the entire population was reasonable because Massachusetts has very low rates of uninsurance. However, using the total population in the denominator and using only spending reported by payers in the numerator could mask the true cost growth if there is a significant shift in the number of people who are uninsured.

- **Use membership figures reported by payers.** Rhode Island uses the annualized number of member months reported in the data collection process as its

denominator for calculating per capita spending and cost growth. In Rhode Island, the number of individuals for whom payers reported data was significantly smaller than the state's population, possibly because some residents work in bordering states and are insured by out-of-state payers. When including spending from other sources such as the VHA, Department of Corrections, and workers' compensation, states need to think carefully about how to use reported membership to avoid double-counting individuals.

Consider Strategies to Strengthen the Accuracy and Reliability of Target Performance Measurement

Because public reporting of performance against the target involves identifying specific entities' cost growth, it is important to have confidence in the measurement. At the state and market levels, population sizes are significant enough that measurements are statistically stable and there is no need to apply additional methodologies. At the payer and provider levels, however, states should consider additional strategies to ensure the accuracy and reliability of assessments of cost growth:

- **Develop confidence intervals around an entity's cost growth.** This allows a provider entity's performance to be reported as a point within a range of values. The state then determines performance based on whether that range intersects with the target value.

- **Truncate spending of high-cost outliers.** High-cost outliers are people with extremely high levels of annual health care spending, who mostly are distributed randomly in a population. Some states mitigate their impact on payer and provider entity trends by removing per-member or per-patient expenditures above a certain threshold.

- **Decide not to apply clinical risk adjustment.** Risk adjustment is a statistical process used to account for a population's underlying health status when looking at their health care outcomes or costs. Some states risk-adjust spending data submitted by payers when assessing performance against the target. However, states' experience and other empirical research show that clinical risk scores used for risk adjustment have increased substantially over time due to changes in how providers code patients' conditions, and not because of actual decline in the population's health status.[3] Thus, applying clinical risk adjustment in target performance assessment could cause payer and provider organizations' cost growth to appear lower than it actually is. Consequently, some states moved toward risk-adjusting only by age and sex to avoid overstating the population's illness burden, and some states dropped risk adjustment altogether.

- **Establish a minimum number of members/patients for payer- and provider-level reporting.** Setting a minimum threshold for the number of enrolled or attributed individuals that a payer or provider should have before performance is reported helps minimize the impact of random variation on cost trend performance. Based on analyses performed in multiple states, the recommended minimum threshold for publicly reporting performance is 5,000 members/patients at the payer and provider levels.

Identify the Entities That Will Be Held Accountable to the Target

Most states measure cost growth at the state, market, payer, and provider levels. Reporting at the state and market levels is straightforward once the state develops its measurement approach. For payer and provider entity reporting, states must first identify the payers and provider entities whose cost growth will be measured and reported against the target. Medicaid managed care states usually require all managed care contractors to report data for the target program. For the Medicare Advantage and commercial markets, states aim to include enough payers to capture approximately 85% to 90% of covered individuals in those markets. A state's department of insurance typically collects and publishes information on payers' market share, which states can use to identify which insurers should be required to report. However, commercial market data are usually limited to fully insured plans that are state-regulated.

In defining the list of provider entities, states typically include large provider entities that can be reasonably expected to influence total health care costs, such as medical groups, health systems, federally qualified health centers, and independent practice associations. Some states identify provider entities by whether they have a total cost of care contract. Other states include provider entities deemed large enough to have a total cost of care contract, whether or not they do so.

Once a state defines the list of provider entities, it must develop clear specifications on how to attribute member-level spending to provider entities (Exhibit 3). This requires two levels: (1) attribution of members to a clinician and (2) attribution of clinicians to a large provider entity.

EXHIBIT 3. Process for Attributing Spending to Large Provider Entities

Spending is assigned to an individual member

Members are assigned to a primary care provider (PCP), if possible

PCPs are assigned to a large provider entity, if possible

Provider entities' aggregate spending information is reported to the state
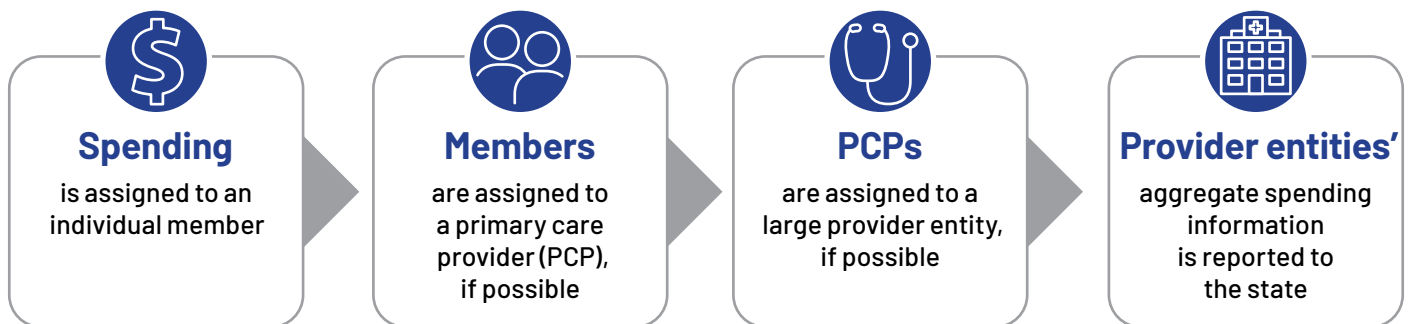
To date, all states use a primary care–based methodology for attributing members to providers. This approach is a matter of necessity, not policy choice, as no method is available to associate per capita spending with other types of entities on a large scale. Some states leave the specific methodology to the carriers, although a few states, such as Oregon and Washington, ask insurers to follow a hierarchy that prioritizes member selection of primary care provider, followed by attribution used in value-based payment (VBP) contracts, and then utilization.

Ideally, a state will have a provider directory that maps each primary care provider to a large provider entity so that attribution is consistent across insurers. However, very few states maintain a statewide provider directory. Consequently, most states have required insurers to attribute providers to large provider entities based on their contracting arrangements. This is an imperfect approach, as different payers may contract with different configurations of provider organizations and may have different arrangements with the same provider organization by market.

Develop and Implement a Process and Timeline for Collecting, Analyzing, and Reporting Data

Target programs require significant and ongoing investment in data collection and analysis. The process typically takes approximately one year from data collection to reporting of results (Exhibit 4).

EXHIBIT 4. Typical Timeline for Collecting, Analyzing, and Reporting Target Performance Data

Step 1 **SPRING** 1–2 months	Step 2 **SUMMER** 3 months	Step 3 **FALL** 3 months	Step 4 **WINTER** 1–2 months	Step 5 **WINTER** 1 month	Step 6 **WINTER/ SPRING** 1 month
SET Re-evaluate & document the target policies	**COLLECT** Collect data from payers & other sources	**VALIDATE** Validate data with payers	**ANALYZE** Analyze cost growth	**REVIEW** Review results with payers & providers	**REPORT** Report performance against the target

Because of typical delays in reporting claims and the time required to reconcile alternative models of payment, the earliest that states can require data submission is usually six months after the end of a performance period. For example, performance data for calendar year 2023 would not be available until at least summer of 2024. This determines the timing of related activities, including preparing for data collection, validating and analyzing data, and reporting results.

Document Specifications and Review Them with Data Submitters

States must develop specifications to ensure data are reported consistently. Data specifications should minimally include:

- Description of the target policy
- Formulae for developing the target
- Methodology for calculating total health care spending

- Data reporting specifications, such as population inclusions and exclusions, definition of service categories, and types of spending to include
- Process for publicly reporting the results

States set most policies during the first year of implementation when they make key design decisions around target performance measurement. However, states should review these methodologies each year and adjust on the basis of experience with data collection and analysis, innovative practices developed by other states, and changes in the state's health care landscape. It is also helpful to review other states' methodologies, and, where appropriate, aim for consistency to minimize the data reporting effort for health plans that cover members in multiple states with target programs.

States should review the data submission process and specifications with data submitters to educate them and clarify the data request. This review should take place annually to accommodate new data submitters, turnover of analysts responsible for submitting data, and implementation of new methodologies.

Collect, Validate, and Analyze Data from Multiple Sources

States must obtain health care spending data from multiple sources, according to the chosen methodology, including the following populations:

- **Commercial fully and self-insured:** Commercial fully insured and self-insured spending data come from health insurers operating in the state. All states with target programs obtain aggregate spending data from insurers (not claim-level, member-level, or employer-level information).

- **Medicare:** Medicare spending data typically come from two sources: the Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage carriers. CMS offers a consistent set of data to states. While not completely aligned with state specifications, it is an excellent source for Medicare fee-for-service spending and all Part D (retail pharmacy) spending. Medicare Advantage carriers are a better source than CMS for Medicare Advantage product spending as the carriers can submit data according to the state's specifications.

- **Medicaid:** In non-managed care states, all the data will come from the state. In Medicaid managed care states, a significant portion of the data will come from the state's contracted managed care organizations, and some will come from the state's fee-for-service (FFS) program. States need to carefully develop a methodology to obtain nonduplicated information for the managed care and FFS populations. Duplication can occur, for example, when certain services for managed care populations are carved out for different coverage or when the state provides wraparound services through the FFS system.

- **Medicare and Medicaid dually eligible:** Because of the many different combinations through which dually eligible individuals can receive Medicare and Medicaid benefits, states need to pay special attention to capture costs for this population appropriately. FFS spending information for dually eligible individuals is embedded within data supplied by CMS and, depending on the state, may be included in Medicaid FFS data supplied by the state Medicaid agency. Dually

Oregon's Use of a Technical Advisory Group to Obtain Feedback

Before requesting data from health plans, the Oregon Health Authority (OHA) created a **Technical Advisory Group** (TAG) to work with OHA on its specifications and data collection process. The TAG meets monthly and is open to all payers that submit data, provider organizations, and other interested parties. OHA uses the TAG to gain insight into how best to collect data, gather feedback on implementation, and answer questions on the data collection and reporting process. Oregon payers report that this group is a positive approach to two-way communication on data reporting.

eligible individuals can also be covered through Medicare Advantage, Medicaid managed care, or, in select states, through the CMS Financial Alignment Initiative, which provides Medicare and Medicaid coverage through a unified plan. States need to tailor their data specifications and reporting processes for the dually eligible population to be clear on which entity reports what spending and to avoid omitting or duplicating any spending data. Approaches will depend on how the state provides Medicaid coverage to dually eligible individuals (e.g., through FFS, managed care, or an integrated Medicare and Medicaid product).

- **Other populations:** States that choose to include spending on other sources of coverage — such as the VHA, Indian Health Service, state corrections, or workers' compensation — need to collect data for those populations from the respective entities or agencies.

States need to validate the data received to ensure consistent reporting according to specifications, particularly in the first years of implementation. Flawed data can result in incorrect assessments of entities' target performance. Ensuring entities are assessed correctly before performance is reported publicly is critical. Exhibit 5 depicts a process that states can implement to promote integrity and stakeholder confidence in the cost data.

Flawed data can result in incorrect assessments of entities' target performance.

Why States Can't Use APCD Data to Measure Performance Against the Target

To minimize data collection burdens, some states with fully functioning APCDs have proposed using APCD data to measure cost growth. Yet, health insurers continue to be the most complete source of spending data for the commercial, Medicaid managed care, and Medicare Advantage populations.

APCDs lack pharmacy rebate amounts that are used to produce a net pharmacy spending calculation.

In addition, APCDs typically lack payments made to providers outside of the claims system, such as incentives, shared savings, or other similar value-based payments. Finally, APCDs do not include self-insured groups, which typically represent well over half of the commercially insured population in a state.

EXHIBIT 5. Process for Collecting, Validating, Analyzing, and Reviewing Cost Data

```
                    ┌─────────────────────┐
                    │   Payers submit     │
                    │  data to the state  │
                    └─────────────────────┘
                              │
                              ▼
                    ┌─────────────────────┐
                    │ The state reviews   │
                    │ data and holds      │
                    │ calls with payers   │◄──────────────┐
                    │ to confirm shared   │               │
                    │ understanding of    │               │
                    │ the data            │               │
                    └─────────────────────┘               │
                              │                            │
                              ▼                            │
   ┌──────────────┐     ◆◆◆◆◆◆◆◆◆◆◆◆                      │
   │ The state    │ YES  State and payer                  │
   │ requests     │◄──── calls reveal data                │
   │ resubmission │     ◆  issues                         │
   └──────────────┘     ◆◆◆◆◆◆◆◆◆◆◆◆                      │
                              │ NO                         │
                              ▼                            │
                    ┌─────────────────────┐               │
                    │ The state includes  │               │
                    │ the payer's data in │               │
                    │ initial analyses of │               │
                    │ state, market,      │               │
                    │ payer and provider  │               │
                    │ cost growth         │               │
                    └─────────────────────┘               │
                              │                            │
                              ▼                            │
                        ◆◆◆◆◆◆◆◆◆◆                        │
                        The state          YES             │
                        identifies ────────────────────────┘
                        potential
                        additional
                        data issues
                        ◆◆◆◆◆◆◆◆◆◆
                              │ NO
                              ▼
                    ┌─────────────────────┐
                    │ Payers & provider   │
                    │ entities receive    │
                    │ reports & have a    │
                    │ "first look" at     │
                    │ performance         │
                    └─────────────────────┘
                              │
                              ▼
                    ┌─────────────────────┐
                    │ Payers & providers  │
                    │ may discuss data    │
                    │ concerns with each  │
                    │ other               │
                    └─────────────────────┘
                              │
                              ▼
                        ◆◆◆◆◆◆◆◆◆◆
                        Payer &            YES
                        provider    ───────────────┐
                        conversations               │
                        identify                    ▲
                        potential       (back to "first look")
                        additional
                        data issues
                        ◆◆◆◆◆◆◆◆◆◆
                              │ NO
                              ▼
                    ┌─────────────────────┐
                    │   State publishes   │
                    │   final results     │
                    └─────────────────────┘
```

The data validation process can be lengthy, and payers may need to resubmit data multiple times, particularly when they are new to reporting target performance data. Providing comprehensive upfront assistance and tools for data submitters will reduce the need for resubmission later in the process. For example, some states' data submission templates include validation steps that allow data submitters to review trends before submission. States should conduct two types of validation checks:

- **Completeness checks** ensure there are no obvious errors or omissions. For example, states should check each submission to ensure it has all the required data elements and includes the expected lines of business for a particular payer.

- **Reasonableness checks** ensure the data are appropriate at face value and when compared with other sources. These subjective assessments can point to potential errors. For example, high per member per month spending on long-term care for a commercial insurer may point to an error since commercial plans typically do not cover many long-term care services. States can also compare Medicare member months submitted by a payer to Medicare Advantage enrollment data published by CMS to confirm that the payer included the appropriate population. Analysts can also look at year-over-year changes in populations and per capita costs, and probe areas that show significant increases or decreases.

Once a state is confident in the quality of the data, it can move on to analysis. The primary analyses consist of calculating performance at four levels:

1. **Overall state performance:** The growth in per capita spending, as measured by THCE, in the state compared with the target.

2. **By market:** The growth in per capita spending, as measured by THCE or TME, in each of the Medicare, Medicaid, and commercial markets compared with the target.

3. **By payer, by market:** A single carrier's THCE or TME performance for each of the markets in which it operates and for which the carrier has sufficient members.

4. **By provider entity, by market:** A single provider entity's TME performance for each of its markets, so long as the number of attributed patients meets a predetermined threshold.

States can also conduct additional analyses, such as aggregate spending at the state and market levels, costs and cost growth by service categories (e.g., hospital inpatient, hospital outpatient), and how much growth in spending in a service category contributed to overall cost growth. These reviews provide important clues about where to conduct more in-depth analyses of claims databases.

Review Results with Payers and Providers and Publicly Report Performance

States should confidentially review the results with payers and providers whose performance is measured against the target before formally reporting results. This review provides another quality control check, gives entities the opportunity to understand and identify reasons for their performance, and helps foster goodwill between the state and those entities.

In reviewing results, provider entities may compare their target performance with their performance on total cost of care contracts, if they contract on that basis.

Data Validation Tips

- Ensure that individuals conducting the validation have knowledge of **market trends** when determining the reasonableness of data.

- Create a **validation checklist** to ensure consistency when reviewing multiple submissions.

- Start with the **largest payers**, whose data will have the greatest impact on overall results.

- **Document** every observation, conversation, and decision, and circulate notes to ensure all parties agree on the next steps.

- **Re-review everything** in a submission, since new issues could arise as a result of resubmission.

Variation in findings can occur for several reasons. TME and total cost of care contracts may define services differently. For example, some total cost of care contracts may not hold a provider responsible for certain services, like pharmacy or long-term care expenditures, while those are included in target policies. They may also apply risk adjustment and deal with high-cost outliers differently.

States should disseminate the results for state, market, payer, and provider performance against the target via several mediums, such as a presentation to the program's governing body, a public forum focused on affordability, an issue brief on the findings, and other strategies outlined in the stakeholder engagement activities described in this playbook. In addition to reporting cost growth, states should consider presenting employer and consumer perspectives on affordability to reinforce the importance of controlling cost trends. For example, at Rhode Island's Health Care Cost Trends Public Forum in April 2022, a small employer described the financial squeeze experienced by employees. This employer described the limited ability to raise employee wages because of high benefit costs and employees' limited ability to afford high-deductible health plans. These types of stories provide human interest, context, and further justification for the target policy.

Resources

Health Care Cost Growth Target Data Specification Manuals

Data specification manuals provide instructions to payers for how to submit data the state needs to calculate state- and market-level cost growth and payer and provider performance against the target.

- Connecticut **Implementation Manual for 2019-2021 Reporting**
- Delaware **Implementation Manual for CY 2022**
- Massachusetts **Data Specification Manual**
- Nevada **Data Specification Manual for Pre-Benchmark Reporting**
- Oregon **Data Specification Manual for 2020-2021 Reporting**
- Rhode Island **Implementation Manual for 2020–2021**

Health Care Cost Growth Target Data Submission Templates

These data submission templates are used to collect TME data from payers.

- Connecticut **Submission Template**
- Delaware **Submission Template**
- Massachusetts **TME-APM Data Reporting Template**
- Nevada **Submission Template**
- Oregon **Submission Template**
- Rhode Island **Submission Template**

Reporting Total Health Care Expenditures (THCE) or Total Medical Expense (TME) at the Market and Payer Levels

Some states have elected not to report THCE at the market and payer levels because of the year-to-year volatility of the net cost of private health insurance (NCPHI), a component of THCE. NCPHI can vary significantly from one year to the next as payers post profits or losses on certain products, premium rates change, or federal tax and refund policies change. Additionally, these data can be hard to validate. Measuring NCPHI is important, but some states prefer to focus on TME, which accounts for the vast majority of health care spending.

Technical Implementation Webinar Materials and Recordings

- Connecticut **Benchmark Technical Webinar Slides**
- Delaware **Benchmark Technical Webinar Recording**
- Nevada **Data Specifications Webinar**
- Oregon **Data Submission Training Slide Deck**
- Oregon **2022 Health Care Cost Growth Target Data Submission Training Webinar Recording**

Data Sources for Calculating the Net Cost of Private Health Insurance

- CMS publishes **Medical Loss Ratio data** that health insurers are required to disclose under the Affordable Care Act.
- The **National Association of Insurance Commissioners** makes available for purchase data from Supplemental Health Care Exhibits that insurers submit to states.
- The Securities and Exchange Commission publishes **Company Filings**, which can be used to estimate commercial self-insured NCPHI if information on income from fees of uninsured plans is not available.

Health Care Cost Growth Target Performance Reports

- Connecticut's **pre-benchmark data analysis brief**
- Connecticut's public report of its **2018–2019 pre-benchmark analysis** to its stakeholder advisory committee
- Delaware's **2020 Benchmark Trend Report**
- Massachusetts' **Annual Report of 2019–2020 Data**
- Massachusetts' **recording of its annual public hearing** in 2022
- Rhode Island's presentation of **2020 health care cost growth target performance** at a public forum

1   American Hospital Association. Fact Sheet: Uncompensated Hospital Care Cost. February 2022.
     https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost

2   Kaiser Family Foundation. State Health Facts: Health Insurance Coverage of the Total Population. 2019.
     https://www.kff.org/other/state-indicator/total-population/

3   Massachusetts Health Policy Commission. 2019 Annual Health Care Cost Trends Report. February 2020.
     https://www.mass.gov/doc/2019-health-care-cost-trends-report/download

5 Understanding the Drivers of Cost Growth

A critical part of the target program is granular analysis of the health care system's overall performance and the factors driving costs in the state.

These cost growth driver analyses supplement the analyses of target performance (see Exhibit 6). They provide the basis for identifying the greatest opportunities for mitigating cost growth and getting stakeholders to accept and promote these strategies. This section describes key considerations for analyzing health care cost growth drivers in the state and using the results to pinpoint opportunities for individual or coordinated action to mitigate cost growth.

EXHIBIT 6. Description of Analyses Needed

Health Care Cost Growth Target Analysis	VS.	Cost Growth Driver Analysis
What: A calculation of health care cost growth over a given period to assess performance against the target		**What:** An analysis of spending levels and drivers of cost growth to inform policy decisions and identify opportunities for action to reduce health care costs
Data type: Aggregate data that allow for assessment of target achievement at multiple levels		**Data type:** Granular data (e.g., claims and encounters)
Data source: Insurers and public payers		**Data source:** Primarily the APCD

Establish a Framework to Guide the Analyses

States should perform two complementary types of analysis to find areas of opportunity to mitigate cost growth:

1. **Routine standardized analyses to inform, track, and monitor the impact of the target.** These regular reports should examine spending patterns, including use, price, service mix, and demographics, and should help draw attention to patterns that call for further investigation via in-depth reports. Initial reports should focus on spending patterns at the state and market levels, followed by analyses at the payer and large provider levels, with special attention to retail and medical pharmacy expenses.

2. **In-depth analyses of the drivers of high spending, spending variation, and spending growth that are identified from the routine analyses.** These in-depth reports shed light on the factors influencing health care costs and inform efforts to identify and implement cost mitigation strategies. They might look at variation in spending across payers, providers, and geographies; provider supply as a driver of spending; market consolidation as a spending driver; and spending on specific procedures by site of care, among other analyses.

Producing these analyses will serve as the foundation for future action to mitigate cost growth.

Having a framework to identify types of analyses states should produce is helpful for prioritizing and focusing attention on analyses that generate the greatest value. The Peterson-Milbank Program for Sustainable Health Care Costs developed an **analytic framework** that states can use to design their cost growth driver analyses.[1] The Peterson-Milbank **brief** also provides suggestions on how to approach certain analyses and examples of analyses that states have undertaken. The framework (Exhibit 7) is organized around three major questions:

1. **Where is spending problematic?** Problematic spending refers to spending that is high and/or growing rapidly, varies significantly within the state, or greatly exceeds certain benchmarks. Identifying these areas of problematic spending helps pinpoint where strategies to mitigate cost growth can have the greatest impact. In all states with target programs, analyses have pointed to pharmacy and hospital services as areas where spending is high and growing fast.

2. **What is causing the problem?** These analyses focus on the primary drivers of health care costs and cost growth, such as price, volume, scope and types of services used for treatment, population characteristics, and provider supply. For example, an analysis of supply could look at the numbers of hospital beds and specialists in a region and how they correlate with utilization. These analyses could point to instances where demand for health care services may exceed a limited supply, driving unnecessary price increases. States could also look at how prices in regions with significant market consolidation might differ from regions without a dominant provider.

3. **Who is accountable for the problem?** In addition to conducting state-level analyses, states should consider stratifying analyses by market, insurer, and provider since addressing cost growth will require purposeful and coordinated effort across all these stakeholders. States could also consider analyzing providers that are not directly accountable for cost performance but may significantly contribute to spending, such as drug manufacturers, hospitals, or imaging centers.

EXHIBIT 7. Peterson-Milbank Framework for Analyzing Drivers of Health Care Spending and Spending Growth

Where

Where is spending problematic?
- High spending
- Growing spending
- Variation in spending

What

What is causing the problem?
- Price
- Volume
- Intensity
- Population characteristics
- Provider supply

Who

Who is accountable?
- State
- Market
- Payer
- Provider

Many of the data sources discussed in the Establishing the Target Methodology and Value section of this playbook — APCD, state employee health benefit claims, MMIS, insurer rate filings — can be used for cost growth driver analyses. States can also use data from the following sources to better understand cost trends:

- **Hospital discharge data:** Almost all states have statewide hospital discharge data, which often include information on inpatient discharges, outpatient procedures and services, and emergency department visits. These typically have de-identified patient-level information to support analyses on issues including hospital utilization patterns, hospital market share, and outcomes.

- **Prescription drug price transparency data:** Some states have drug price transparency laws that require drug manufacturers, pharmacy benefit managers, and health plans to supply information on prescription drug pricing.

- **Data from the No Surprises Act:** The No Surprises Act (2022) requires health plans and health insurers in group and individual markets to annually submit information to the federal government about prescription drug and health care spending. However, CMS delayed enforcement of this requirement, and while some insurers are voluntarily making the data available, the files are too large to analyze. Thus, this may not be a viable near-term option.

- **Hospital and insurer price transparency data:** Federal price transparency rules require hospitals to publish standard charges for items and services online in a machine-readable file. This could be useful for examining how individual hospitals' pricing compares with other hospitals in a state and how geography and market share influence pricing. Unfortunately, compliance with the rule has been poor.[2]

- **Risk factor data:** Many states have expressed interest in adjusting analyses to account for social risk factors. Until states can gather demographic and social risk data more completely and reliably, states can use the Census Bureau's American Community Survey (ACS), which has race and income data. Such adjustments using the ACS, however, can only be made at the population level and not at the individual level.

Identify Opportunities to Slow Cost Growth and Set the Stage for Future Policy Action

States need to share results of the cost driver analyses in ways that are easy to understand. States will need to balance supplying enough detail to demonstrate credibility of the analyses and keeping the key takeaways simple. In identifying the key takeaways from cost driver analyses, it is useful to ask the following questions:

- What information does the analysis demonstrate that is already known?

- What new information can be gleaned from the analysis?

- How can the state use the information gained to meet its affordability goals?

In presenting results, states should consider visualization tools that clearly show patterns and trends affecting high and rising health care costs. These data dashboards will help build confidence and buy-in among stakeholders. The Public-Private Stakeholder Engagement section of this playbook provides ideas on where and how to communicate this information.

Developing Data Analytics Capacity to Support Cost Growth Target Programs

Establishing the processes and staff to collect, manage, and analyze data requires significant investments in time and resources. States need to consider how to build this data analytics capacity. States that use advanced analytics, such as Massachusetts and Oregon, have dedicated staff while also leveraging existing state agency health analytics infrastructure. Another option is to procure the required expertise. Using a vendor is typically more costly for states but may ensure that the work will be completed with the necessary technical skill and in a timely fashion.

States can take steps to translate data from cost driver analyses into policy action. States can directly pursue state policies, such as through legislative or regulatory pathways that address drivers of cost growth. A broad group of supporters, like a steering committee or board consisting of multiple stakeholders, could make recommendations to the governor or legislature. States could also facilitate market-based solutions, for example, by gathering competing stakeholders together to show support for and reach agreement on private market solutions.

Resources

National and State-Level Comparative Data on Health Care Costs, and Resources for Conducting Cost Driver Analyses

- A Peterson-Milbank brief describes a **framework for conducting cost driver analyses** and provides examples of analyses conducted by states.
- The **RAND Hospital Price Transparency Study** is a three-part study examining hospital prices across the 50 states.
- The **Health Care Cost Institute's Health Marketplace index** tracks metrics of health care spending across more than 150 U.S. cities (focusing on metropolitan areas), hospital market concentration, and prices versus utilization.

Connecticut's Use of Analyses of Cost and Cost Growth to Elevate the Issue of Hospital Costs

Even before collecting data to measure target performance data, Connecticut analyzed its APCD to understand the primary drivers of cost growth in the state. Initial analyses showed year-over-year hospital cost growth was particularly high relative to professional services. More detailed analysis pointed to prices as the primary driver of increases in hospital spending. Further analysis showed that hospital discharges were concentrated in a few systems, and that spending on hospitals with the highest inpatient costs grew fastest while spending on those with the lowest costs grew slowest.

Connecticut shared and disseminated this information widely. This process led to engagement of all stakeholders, including the hospitals, and elevated discussions on the impact of hospital prices on the state's ability to meet the target.

While Connecticut has increased awareness of hospitals as the leading contributors to commercial cost growth, how the state will take corrective action remains to be seen. Nevertheless, by raising awareness of the issue, Connecticut has "primed the pump" for future policy action.

Examples of Cost Driver Analyses

- Connecticut **2015–2019 Commercial Spending Driver Analysis, 2015–2019 Commercial Spending Driver Analysis with Retail Pharmacy Added, 2017–2019 Commercial Pharmacy Spending Driver Analysis**

- Massachusetts **2022 Health Care Cost Trends Report and Policy Recommendations**

- Nevada **Medicaid Cost Driver Analysis**

- Nevada **Public Employees' Benefits Program Cost Driver Analysis**

- Oregon **2013–2019 State and Market-Level Cost Growth** and accompanying **Chart Pack**

- Rhode Island **Analysis of 2016–2018 Commercial and Medicaid Pharmacy Spending and Tableau analyses** of cost trends

- Washington State **Commercial Trends in Cost for 2016–2019**

1   Sayles JN, Kanneganti D, Bailit M. A Data Use Strategy for State Action to Address Health Care Cost Growth. Peterson-Milbank Program for Sustainable Health Care Costs, June 2021. **https://www.milbank.org/publications/a-data-use-strategy-for-state-action-to-address-health-care-cost-growth/**

2   Ario J, McAvey K, Zhan A. Assessing Implementation of Hospital Price Transparency. Manatt Health, January 2022. **https://www.manatt.com/Manatt/media/Documents/Articles/NYSHF-Hospital-Price-Transparency-Report-January-2022_c.pdf**

Accountability & Action to Slow Cost Growth

Setting a target, in and of itself, is not sufficient to slow cost growth. States and their partnering stakeholders need to take individual or collective action to implement strategies to slow cost growth and enable the state to meet the target.

Having a target in place fosters stakeholder engagement, data and information transparency, and a commitment to affordability that better positions states to develop and implement meaningful cost containment strategies.

This section describes accountability mechanisms that states can apply to motivate payers and providers to meet the target, considerations for building a structure to hold entities accountable to the target, and cost containment strategies that states have pursued.

Consider Accountability Mechanisms for Meeting the Target

The goal of measuring entities' cost growth is to ultimately hold them accountable for meeting the target. States have three primary accountability mechanisms: (1) public reporting of performance, (2) performance improvement plans, and (3) application of positive and/or negative incentives for meeting or not meeting the target.

Most states rely on public reporting, but three states — Massachusetts, Oregon, and California — go beyond public reporting to motivate payers and providers to meet the target. These states can require performance improvement plans and impose financial penalties; the approaches are considered a last resort after transparency and collaborative efforts to contain spending have failed.

Public Reporting of Performance

Public reporting has long been used to stimulate improvements in other domains of health care, such as quality. Public reporting of performance against the target draws attention to how health plans and providers contribute to health care cost growth and gives states the chance to engage all stakeholders in the conversation on cost growth drivers and strategies to address them. The assumption is that health plans and providers will undertake efforts to constrain costs when information about their performance is compared against the target and made available to their peers, regulators, legislators, and the public at large.

States typically wait years before public reporting to ensure that the entire process works successfully over time. States publicly report performance at the state,

The goal of measuring entities' cost growth is to ultimately hold them accountable for meeting the target.

market, payer, and provider organization levels, sharing the findings in multiple venues and formats to garner attention.

Performance Improvement Plans

If an entity exceeds the target, a state can require it to develop and implement a performance improvement plan (PIP). A PIP is a formal document that identifies the entity's specific cost growth drivers, contains concrete action steps the entity will undertake to address the cost drivers, sets a clear timeline for implementing action steps, and outlines measurable expected outcomes. Applied appropriately, a PIP can be a powerful accountability tool for states.

Mitigating cost growth takes time, so states need to closely monitor PIP performance and results for multiple years to measure impact. Massachusetts has implemented an **interactive tracker** that allows the public to see where entities required to file PIPs are in the process, view the PIPs, and track progress on cost mitigation.

Application of Positive and/or Negative Incentives

Oregon and California can impose financial penalties on entities that exceed the target. Financial incentives can be an effective motivator to improve performance, but a key consideration is how to determine the penalty. A flat penalty amount could overly burden smaller organizations but not be meaningful enough to spur change in large organizations. Oregon is still developing its financial penalties and is considering variable penalty amounts based on the amount by which the entity exceeds the target, the entity's size, and good-faith efforts to address health care spending and collaborate with the state. California's target program has not yet been developed.
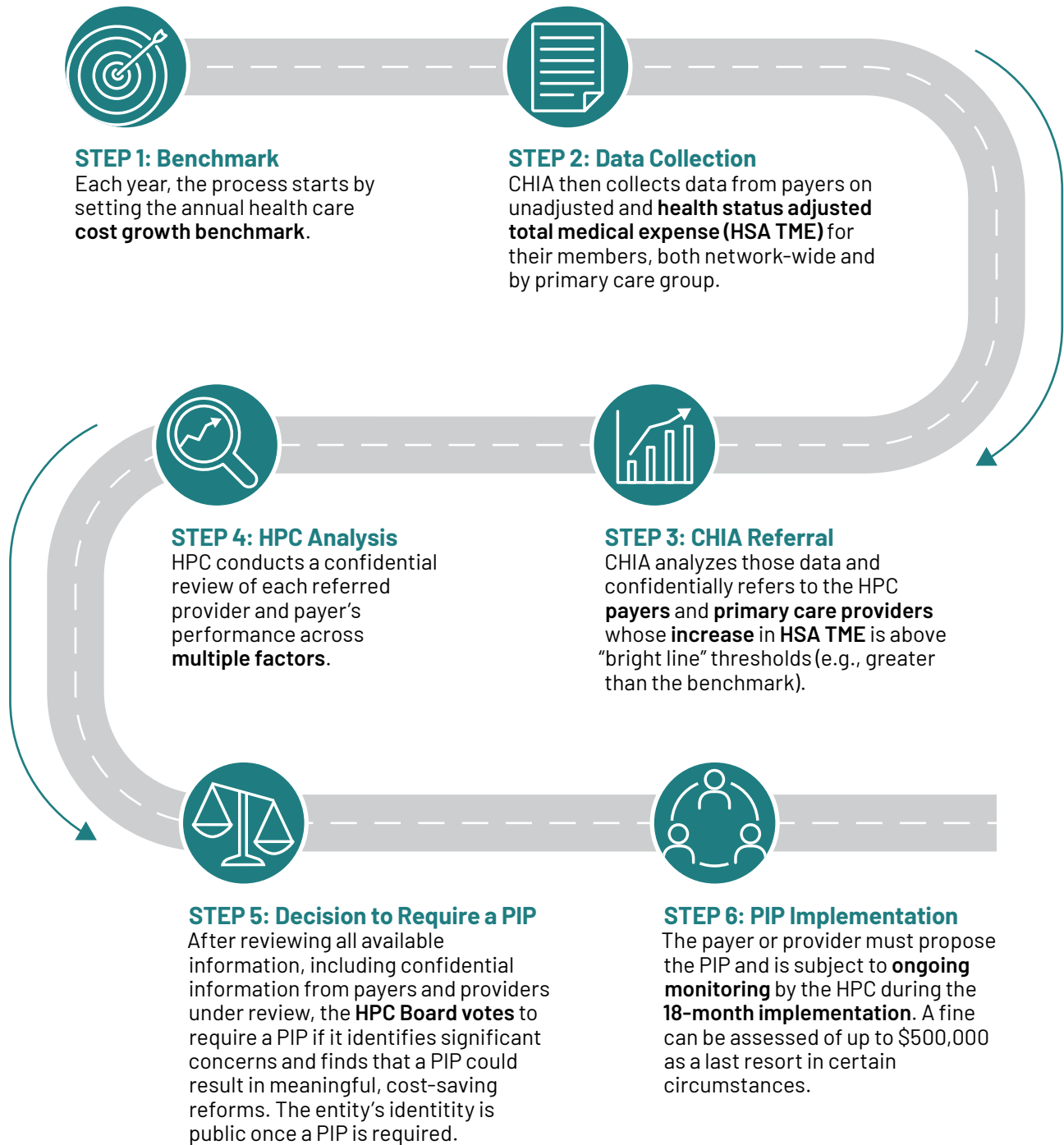
States could also consider positive incentives, which are not currently in use. For example, states could give special recognition to entities that meet the target.

Build the Structure to Hold Entities Accountable

Whether using public reporting, PIPs, financial penalties, or positive incentives, states need to have a well-established process for holding entities accountable to the target and enforcing compliance.

Massachusetts takes several steps before it requires a PIP (Exhibit 8). First, its data collection agency, the Center for Health Information and Analysis (CHIA), confidentially shares findings with the HPC about any payer or primary care provider whose spending exceeded the target. The HPC then conducts a confidential review of public and private information about the payer's or provider's spending. If the HPC determines the performance was within the organization's control and the organization could take reasonable action to institute meaningful cost reforms, the HPC Board can vote to require a PIP. If the Board votes for a PIP, the organization must develop an action plan to reduce costs. The HPC then evaluates the PIP to assess whether the action steps are likely to successfully address the underlying cause(s) of the entity's cost growth and whether the entity has the capability to successfully implement the PIP.[1]

> Applied appropriately, a peformance improvement plan can be a powerful accountability tool for states.

EXHIBIT 8. **Massachusetts' Accountability Process**

STEP 1: Benchmark
Each year, the process starts by setting the annual health care **cost growth benchmark**.

STEP 2: Data Collection
CHIA then collects data from payers on unadjusted and **health status adjusted total medical expense (HSA TME)** for their members, both network-wide and by primary care group.

STEP 4: HPC Analysis
HPC conducts a confidential review of each referred provider and payer's performance across **multiple factors**.

STEP 3: CHIA Referral
CHIA analyzes those data and confidentially refers to the HPC **payers** and **primary care providers** whose **increase** in **HSA TME** is above "bright line" thresholds (e.g., greater than the benchmark).

STEP 5: Decision to Require a PIP
After reviewing all available information, including confidential information from payers and providers under review, the **HPC Board votes** to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

STEP 6: PIP Implementation
The payer or provider must propose the PIP and is subject to **ongoing monitoring** by the HPC during the **18-month implementation**. A fine can be assessed of up to $500,000 as a last resort in certain circumstances.

Source: Adapted from David Seltz, presentation on the benchmark modification process, March 25, 2021, available at https://www.mass.gov/doc/presentation-benchmark-hearing-march-25-2021/download.

Determining when to impose a PIP or financial penalty is a key consideration for states. More specifically, how should states determine whether an entity had a reasonable or justifiable basis for exceeding the target? An evaluation of Massachusetts' program found that the level of discretion the HPC had in determining whether to issue a PIP weakened this accountability mechanism. The evaluation suggested that using more prescriptive and objective criteria to trigger a PIP would have made it more effective.[2] States should consider parameters to guide this assessment — such as the entity's spending level, the extent to which its cost growth exceeded the target, the entity's market share, and how much its excess cost growth contributed to the state's overall cost growth.

Pursue Strategies to Mitigate Cost Growth and Help Meet the Target

Real change can only come about when states and their stakeholder partners engage in and implement cost growth mitigation strategies. States can pursue broad-based strategies that can affect overall cost growth without focusing on particular contributors, or specific strategies to address cost growth drivers identified through analyses. The Commonwealth Fund identified 10 cost containment strategies, one of which is setting a cost growth target, and developed profiles of each strategy including design and implementation considerations, evidence of the strategy's potential to reduce cost growth, the strategy's potential impact on health equity, contextual features that influence the feasibility of implementing the strategy, and potential limitations. Among the 10 strategies, states with target programs have tended to focus on the four strategies described in this section.

Increasing Adoption of Advanced Value-Based Payments (VBPs)

By using financial incentives that reward providers for meeting certain quality or cost-saving benchmarks, VBPs aim to change the delivery system to focus on improving outcomes and providing care more efficiently.

Oregon's governing body developed a set of principles to increase the use of VBPs in the state. Oregon established a VBP compact with 47 organizational signatories that set targets for the percentage of provider payments to be made through an advanced VBP model. To support implementation, the state set up a VBP workgroup that is charged with identifying ways to accelerate all-payer VBP adoption, recommending policies to address barriers to adopting VBPs, coordinating VBP efforts across the state, and monitoring progress on VBPs.

Similarly, Rhode Island's governing body identified VBPs as the primary strategy for meeting the target. Health care leaders in the state signed a compact to accelerate adoption of advanced VBP models, and the state is working on the development of recommendations for key parameters of an all-payer hospital global budget model.

Capping Commercial Provider Rate Increases

States can place upper limits on how much an insurer can annually increase the price paid for a service. These caps allow for increased spending, but within certain limits. In Rhode Island, the Office of the Health Insurance Commissioner established

affordability standards that commercial insurers must follow to have their premium rates approved. These standards include a comprehensive payment reform provision that requires insurers to limit price increases for hospital services to the Medicare price index plus one percentage point. In 2021, Delaware implemented similar affordability standards for commercial insurers.

Containing Growth in Prescription Drug Prices

Some states try to control drug costs, either by imposing fines on drug manufacturers whose prices or price growth exceeds certain thresholds, or by establishing drug review boards that help set upper payment limits for drugs deemed unaffordable for purchasers and consumers in the state. In 2021, the governors of Connecticut and Massachusetts introduced legislative proposals to fine drug manufacturers whose price increases were considered excessive. In Rhode Island, the steering committee recommended that the governor pursue similar legislation.

Enhancing Oversight of Market Consolidation

Market consolidation occurs when two or more health care entities combine. These transactions can involve entities that supply different services, such as a hospital acquiring a physician practice, or entities that provide similar services, such as two hospitals. Studies show that consolidation in health care leads to higher costs without improving quality or patient outcomes.[3] In 2021, Oregon passed a bill directing the Oregon Health Authority (OHA), which administers the state's target program, to also oversee "material change transactions," which include mergers, affiliations, and acquisitions of a certain size. The framework for OHA's review includes the impact of such transactions on the state's ability to achieve its target.

Some states try to control drug costs, either by imposing fines on drug manufacturers whose prices or price growth exceeds certain thresholds, or by establishing drug review boards that help set upper payment limits for drugs deemed unaffordable for purchasers and consumers in the state.

Tips for Prioritizing Cost Mitigation Strategies to Pursue

To ensure that states focus on the most important cost mitigation efforts, it is helpful to have a framework for systematically evaluating what strategies to pursue. Having a framework also helps with stakeholder buy-in, particularly if the process incorporates the best available evidence and reflects the realities of the stakeholders that will need to implement the strategies. The decision-making process should also consider whether there could be unintended consequences such as diminished quality, equity, or access. Criteria that states can use to prioritize cost mitigation strategies include:

- Analysis of the strategy shows **significant opportunity**, such that its implementation would have a substantive impact on target performance. This means that there is evidence for the strategy or a compelling logic model that supports the strategy.

- The strategy is **actionable** at the state, payer, and/ or provider levels.

- There is **capacity to execute** the strategy in a way that will be effective.

Resources

- Mathematica **evaluation report** and **issue brief** on Massachusetts' accountability mechanisms
- Mathematica fact sheets on Massachusetts' health care cost growth benchmark:
  - **Annual health care cost trends reports**
  - **Annual health care cost trend hearings**
  - **Cost and market impact reviews**
  - **Performance improvement plans**
- Milbank Memorial Fund issue briefs on cost containment strategies:
  - **Mitigating the Price Impacts of Health Care Provider Consolidation**
  - **State Action to Oversee Consolidation of Health Care Providers**
  - **Who Can Rein in Health Care Prices? State and Federal Efforts to Address Health Care Provider Consolidation**
  - **Bipartisan Approaches to Tackling Health Care Costs at the State Level**
  - **Uniquely Similar: New Results from Maryland's All-Payer Model and Paths Forward for Value-Based Care**
- Oregon's **compact** to accelerate adoption of advanced VBP models
- Rhode Island's **compact** to accelerate adoption of advanced VBP models

1   Massachusetts Health Policy Commission. Performance Improvement Plan Process Overview. January 2022.
    https://www.mass.gov/doc/performance-improvement-plan-process-overview/download

2   Lipson D, Orfield C, Machta R, Kenney O, Ruane K, Wrobel M, Gerovich S. The Massachusetts Health Care Cost Growth Benchmark and Accountability Mechanism: Stakeholder Perspectives. Mathematica, October 2022.
    https://www.milbank.org/wp-content/uploads/2022/10/MassCostGrowthBenchmarkEvaluation_Mathematica_Oct2022.pdf

3   Gaynor M, Town R. The Impact of Hospital Consolidation. Robert Wood Johnson Foundation, June 1, 2012.
    https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html

Conclusion

Successfully implementing a health care cost growth target involves a substantial commitment from states.

I t requires significant stakeholder engagement to develop buy-in, a robust infrastructure operated with dedicated staff or contract resources for data collection and analysis to measure performance and identify cost growth drivers, and willingness to carry out enforcement measures as needed and take strong steps necessary to bend the cost growth curve.

Most importantly, it requires persistent and courageous public–private leadership, especially by state staff responsible for the program. High levels of cost growth have plagued the US health care system for decades, and strong institutional forces will oppose efforts to meaningfully constrain cost growth.

The experience of eight states that have implemented target programs shows that states can choose from a range of approaches. Smaller states like Connecticut and Rhode Island have implemented more streamlined programs and are slowly building the capacity and infrastructure to do more, while larger states such as Massachusetts and Oregon have invested significant resources and broadened the reach of their programs. California will soon make the largest investment any state has made in a cost growth program.

Regardless of the structure and level of investment, all these states have demonstrated how targets can be leveraged to shine a spotlight on the issue of cost growth and affordability, and to spur action around cost containment. In particular, the focus on transparency and having the data to pinpoint problematic areas has allowed states to elevate discussions around cost containment with broad stakeholder support.

About the Author

January Angeles, MPP, is a senior consultant at Bailit Health with over 20 years of experience in health care policy and management. Her expertise includes legislative and policy analysis, program development and implementation, and program management and evaluation, with an emphasis on publicly financed health care. Ms. Angeles currently focuses on helping states establish health care cost growth target programs, working with Connecticut and Washington on developing the target methodology and assessing performance against the target.

Prior to joining Bailit Health, Ms. Angeles served as Deputy Medicaid Director for Managed Care and Oversight and as CHIP Director for Rhode Island. Her accomplishments include spearheading the successful renewal of Rhode Island's Section 1115 waiver, developing and implementing processes and measures for better oversight of the Medicaid program's contracted health, dental and transportation programs, and directing the accountable entities program's transition from pilot to implementation phase. She was previously Interagency Operations Manager for HealthSource RI, the state's health insurance exchange.

Before working for the State of Rhode Island, Ms. Angeles was a senior policy analyst at the Center on Budget and Policy Priorities, where she worked on Affordable Care Act legislation and implementation. Her other health policy experience includes working at the Center for Health Care Strategies, American Institutes for Research, and Mathematica Policy Research. Ms. Angeles earned a Bachelor of Arts degree in Psychology from Oberlin College, and a Master of Public Policy degree from the University of California, Berkeley's Goldman School of Public Policy.

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