Peterson-Milbank
Program for Sustainable
Health Care Costs

Making Health Care More Affordable

A Playbook for Implementing a State Health Care Cost Growth Target, 2025 Edition

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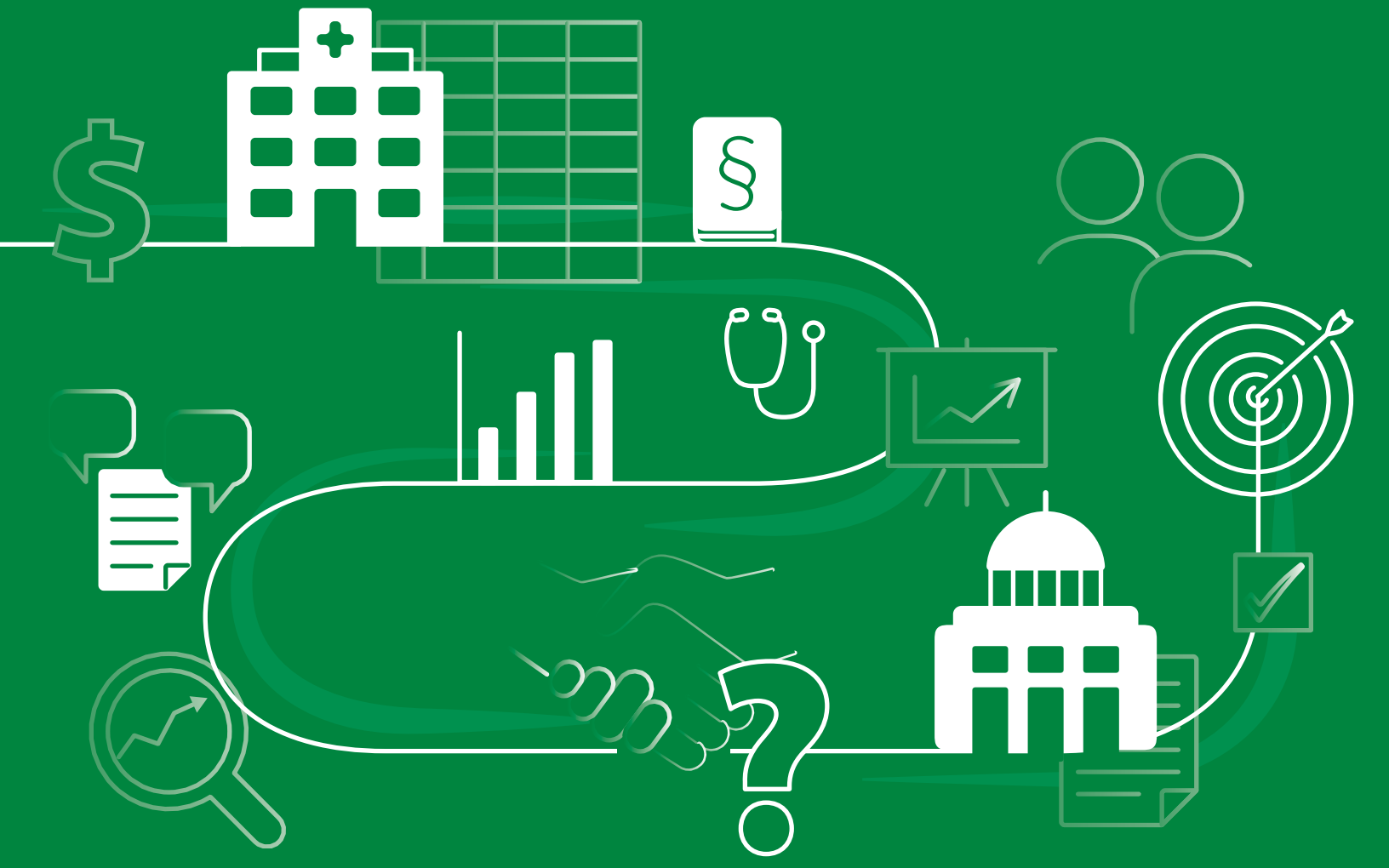

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The organization is working to transform U.S. healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs and accelerating their adoption on a national scale. Established by the Peter G. Peterson Foundation, the Center collaborates with stakeholders across the healthcare system and engages in grant-making, partnerships, and research. For more information, visit **petersonhealthcare.org**.

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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

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, a number of states have established 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.

These initiatives set a health care cost growth target, also referred to as a benchmark, which is a shared expectation of how much per capita total health care spending in the state should grow annually. These targets, set by a committee of stakeholders, are often tied to other measures of economic well-being, such as growth in the state economy or median income. Once established, the state measures and publishes how spending by health care payers and large provider organizations performs against this expectation. The state may also 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 partners to identify specific opportunities to take individual or collective steps to lower cost growth.

Massachusetts was the first state to pass legislation in 2012 authorizing a statewide target out of concern that the health care system would be unsustainable without efforts to control spending growth. Since then, seven more states — Connecticut, California, Delaware, New Jersey, Oregon, Rhode Island and Washington — followed suit and have committed to increasing transparency and accountability around health care cost growth; these states are also pursuing companion initiatives to bend the cost curve and make health care more affordable.

First published in 2023, 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. It is informed by the experience of **five states** participating in the **Peterson-Milbank Program for Sustainable Health Care Costs** and that

receive technical assistance from **Bailit Health** and communications assistance from **Burness**, as well as the experiences in California, Delaware, and Massachusetts. The Peterson-Milbank Program for Sustainable Health Care Costs provide a forum for these states to share their experiences and collaborate on efforts to make health care more affordable. This latest version draws on lessons learned by these states as their programs have matured, and describes new challenges states faced particularly in the areas of governance, data, and accountability.

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.

As states consider a cost growth target initiative, they have several options for how to structure their policies and processes. In some cases, states may choose 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

Communications for Sustained Stakeholder Engagement

Ongoing

1. Identify the audience
2. Develop clear messages
3. Identify messengers
4. Build communications into staffing
5. Refute industry concerns
6. Build will for action through ongoing communication

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. Establish accountability mechanisms for meeting the target

Implementation
(0–12 months)

2. Build the structure to hold entities accountable for not meeting the target

Ongoing
(After year 1)

3. Consider extending accountability beyond primary care-based providers

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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.[2] Legislative support is also critical for long-term sustainability, and to ensure that the program endures changes in executive branch and agency leadership.

Codifying the program in statue is important for sustainability as it affirms and institutionalizes specific activities by making them part of a state agency's core mission and responsibilities.

Determine the Appropriate Vehicle for Authorizing the Program

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.

Ultimately, the process for setting targets should ideally be established in law so that they endure through election cycles and are appropriately resourced. Executive orders can be halted with changes in administration. This was exemplified in Nevada. After setting cost growth target values, analyzing cost growth drivers, and collecting data to measure performance against the target, Nevada's program implementation was halted in January 2023 when a new governor took office. This experience underscores that 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. (See Sustainability section.)

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

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 California have set up by law 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 ensure transparency in policy development and decision-making and help build trust among 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,

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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 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 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 Health implements the program in coordination with an interagency working group comprising other executive branch departments and agencies, including the Department of Banking and Insurance, the Department of Human Services, and the Division of Consumer Affairs. While the scope of these agencies is much broader than the target program itself, health care affordability is a critical part of their mission.

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Evolving Governing and Advisory Bodies

As cost growth target programs mature, states need to evaluate and potentially modify the purpose and/or composition of their governing and advisory bodies to reflect changing needs and priorities. The expertise and perspectives needed when building a program are different from those needed when considering actions a state should take to slow cost growth. For example, states in the early phases of building the data collection and analysis infrastructure to support cost growth target programs may seek more input from individuals and organizations with data expertise, while states with more mature programs might benefit more from guidance on the appropriate cost containment strategies to pursue.

In addition, some states have found that as their focus shifted from measurement and reporting to cost containment policy, industry representatives on advisory bodies became oppositional to efforts aimed at curbing spending growth. As a result, these states are exploring options to restructure their primary advisory body by either: a) excluding industry representatives and establishing a separate platform for industry stakeholders to provide input, or b) increasing the presence of purchaser, labor, and consumer representatives to achieve a more balanced perspective.

For example, as Oregon pivoted to exploring cost containment strategies, in December 2024 it decided to sunset its Cost Growth Target Advisory Committee, which helped shape the state's annual reporting and public hearing processes, provided insights into spending trends and factors driving cost growth, and created principles for holding entities accountable to cost growth. Instead, Oregon is creating a new Affordability Committee that elevates consumers' and purchasers' voices to inform identification of new cost containment approaches. In Washington, to provide more balanced input to the HCCTB, that state changed its "advisory committee of providers and carriers" to a "health care stakeholder advisory committee" that includes representation of consumers, labor, and employer purchasers. These additions ensure that the voices of individuals and businesses that bear the burden of high and escalating health care costs are considered in the HCCTB's discussions and recommendations.

States establishing new advisory bodies or restructuring existing ones should consider the following key insights from the experience of other states:

- **Consider the role of industry representatives carefully.** Current cost growth target states' experience is that provider organizations, insurers, and pharmaceutical companies rarely play a constructive role in advancing state health care affordability policies. While their input is important and should be acknowledged, the platform for their involvement should not allow them to hinder the state's affordability goals.
- **Clearly define the role of advisory bodies, emphasizing their advisory nature.** While some states depend on these groups for strategic direction, advisory bodies are most effective when they respond to state-led proposals, provide sector-specific insights, and highlight potential impacts, rather than drive policy development.
- **Ensure sufficient staffing in place to fully leverage advisory bodies.** In addition to administrative and project management support, program leadership should actively shape advisory body agendas and ensure discussions align with strategic objectives.
- **Set a meeting frequency that aligns with the purpose of the advisory body, rather than adhere to a rigid schedule.** Advisory bodies do not need to meet monthly to be effective. States should determine meeting cadence based on program needs, ensuring discussions remain focused and productive. When advisory bodies do meet, it should be to serve strategic state purposes, not primarily to educate advisory body members.

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
- 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.

How States Have Passed Legislation to Strengthen their Cost Growth Target Programs

States have used incremental approaches to strengthen their programs over time. Rhode Island passed a budget bill to specifically fund the Healthcare Affordability and Transparency Program. This allows for dedicated funding to support data analysis around drivers of health care spending and spending growth in the state, as well as development of policies to address affordability. In Washington, the legislature passed SB1508, which added consumers, labor purchasers, and employer purchasers to the HCTTB's stakeholder advisory committee. It also added a requirement to conduct a public hearing to publicize benchmark performance, and gave the HCA flexibility to streamline analysis of cost drivers through sharing of information with other agencies.

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 amend legislation to strengthen data collection requirements to improve compliance or direct additional funding and resources to program implementation. 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.

States should consider how to navigate the program through changes in leadership, personnel, and political and health system contexts.

Protecting Cost Growth Target Programs Against Proposals to Weaken It

Cost growth target programs and related cost containment initiatives have been met with strong industry opposition. Thus, the legislative work that states need to engage is not just about making program improvements; it also often involves protecting against attempts to weaken their programs through legislation, including efforts to limit data collection authority or accountability mechanisms.

For example, in Oregon, legislation was proposed to weaken the state's cost growth target program. House Bill 2742, which ultimately did not pass, would have excluded cost increases related to the workforce, pharmaceutical drugs, and many basic services that are currently included in measuring performance against the state's cost growth target. Removing them from the measurement of health care spending growth would have essentially rendered the target useless and significantly weakened the state's cost containment efforts.

To protect against such efforts, states need to cultivate relationships with legislators and educate them of the importance of cost growth target programs in promoting health care affordability. Having legislators who understand the program and will champion health care spending transparency and affordability is critical to preserving the program. When considering program improvements, states also need to evaluate whether further legislative debate about the program could instead make the program more vulnerable to legislative amendments to dismantle or weaken it.

Resources

Executive Orders on Health Care Cost Growth Targets

- Connecticut's **Executive Order #5** charging the Office of Health Strategy to benchmark total health care expenditure growth in the state.
- Delaware's **Executive Order 25** to establish state health care spending and quality benchmarks
- 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
- Connecticut's **C.G.S. §217-223 of Public Act 22-118** to codify Executive Order #5's provisions establishing health care cost growth benchmarks.
- 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

- **Cost Growth Benchmarks Can Make Health Care More Affordable and Equitable**
- **Health Care Cost Commissions: How Eight States Address Cost Growth**
- **How States Use Cost-Growth Benchmark Programs to Contain Health Care Costs**
- **Rhode Island's Cost Trends Project: A Case Study on State Cost Growth Targets**
- **State Benchmarking Models: Promising Practices to Understand and Address Health Care Cost Growth**.

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Communications for Sustained Stakeholder Engagement

Effective communication is a cornerstone of successful stakeholder engagement. The cost growth target is a systemic approach to a complex problem, and explaining its benefits and progress to secure and sustain stakeholder support 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 communication and education. This section describes key communication activities that states need to undertake to gain and maintain stakeholder momentum to implement cost growth targets.

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.

Identify The Audience

States need to engage stakeholders regularly to educate them, increase buy-in, and garner support in establishing and implementing the cost growth target program. Key stakeholders include members of the state's health care industry such as its payers and hospitals; those who represent groups directly harmed by rising costs, including employers, organized labor, and consumer advocates; and policymakers, including regulators and legislators who can support the program and effect policy change. Engaging local media and funders may also be important. Table1 outlines the stakeholder engagement opportunities at various points of program implementation.

TABLE 1. **Stakeholder Engagement Opportunities**

Activity	Target Audience		
	Industry	**Advocates (Consumers, Employers, Labor)**	**Legislators**
Creating governance structure		Invite participation in the governing board or commission as a chance to provide input, citing affordability surveys.	Highlight the importance of the board or commission, drawing on its role in other states.
Establishing the target	Create opportunities for feedback and guidance from health care industry stakeholders in setting the target value.	Recruit advocates to serve as major allies in advancing a cost growth target program and pushing for a target value that is meaningful.	Build buy-in and support by educating legislators about the program's implementation and goals.

Activity	Target Audience		
	Industry	Advocates (Consumers, Employers, Labor)	Legislators
Collecting data to measure performance against the target	Collaborate with payers and provider organizations whose data will be analyzed and reported, to explain the methodology and navigate technical challenges.		
Reporting performance and issuing any accountability actions	Keep industry stakeholders updated and create processes to hear and respond to input and concerns.	Engage advocates around key milestones, including report releases and public hearings, to keep attention focused on affordability.	Educate legislators about the annual performance against the target and what it means for consumers and businesses in the state.
Reporting cost driver analyses and advancing solutions for affordability	Engage industry around developing solutions for addressing system-wide problems.	Educate advocates about cost drivers and engage them in identifying and supporting strategies to slow health care cost growth.	Support legislators in identifying and advancing policies to slow health care cost growth.

Develop Clear Messages

As state leaders seek to educate industry, policymakers, and the larger community about cost growth targets — whether introducing the concept, setting a target or measuring progress against it — they must clearly communicate how targets are an important first step toward making health care affordable. The following are key messages that states could use to make the case that rising health care costs harm families, employers, and governments and clearly delineate how targets help solve the problem:

The Problem

- **No one should have to choose between going to the doctor and putting food on the table for their family.** Unreasonably high health care costs are eating into household budgets, leading many individuals and families to skip needed care and/or forgo other household necessities. They have also driven more than 40% of Americans into medical debt.
- **Rising health care costs stretch the budgets of the state government and employers in the state.** As states spend more and more on health care, fewer dollars are left for other policy priorities like education and housing. Likewise, high health care costs lead employers to lay off workers and limit pay increases.
- **High health care costs affect many individuals and families.** High deductibles, premiums, and out-of-pocket costs comprise a growing percentage of total household income, particularly for those with job-based health insurance.

The Solution

- **Cost growth targets provide a starting point for improving health care affordability.** Health care costs are rising faster than wages, state revenue, and the economy. This has made health care unaffordable. Cost growth targets serve as spending goals that states set to constrain health care spending so that it does not grow faster than increases in wages and/or the state economy.
- **Cost growth targets bring transparency to health care spending.** In tracking and reporting how payers and providers are performing against the cost growth targets, states open up the "black box" of health care costs. This allows everyone to compare spending between different health care insurers and providers. By further analyzing the spending data states are also able to pinpoint drivers of cost growth and devise specific strategies to contain costs.
- **Cost growth targets can lead to actions that improve affordability.** Setting a cost growth target is just the first step. With the information generated by cost growth target programs, policymakers can make data-informed decisions about how to make health care more affordable, for example, by controlling pharmaceutical prices or standardizing hospital prices.
- **Cost growth targets create accountability.** Cost growth target programs hold insurers and providers accountable to a common goal through annual reporting, and in some states, performance improvement plans and financial penalties.

These messages can be further customized to emphasize the cost growth target's value proposition to each audience group. For example, when speaking to legislators, it may help to talk about the importance and relevance of health care affordability and the cost growth target to key state priorities like attracting or maintaining local businesses.

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 people of all incomes.
- 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.

Identify Messengers

States should consider building a coalition of supporters who can engage public officials and develop talking points that they can use to discuss issues publicly or privately. For example, in California, the legislation establishing the Office of Health Care Affordability (OHCA) was supported by efforts from a diverse coalition of consumers, employers, and organized labor. In every meeting of the OHCA board, representatives from various unions provided public comment on the detrimental impact of high health care costs on the lives of working people. As a result, when the OHCA board published the cost growth target for California, public comments in support far outnumbered industry opposition.

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.

Build Communications into Staffing

To prioritize communications, 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.

Refute Industry Concerns

Health systems and hospitals are likely to bring up concerns about cost growth targets to explain spending that exceeded the target. Common concerns include the validity of the cost growth target methodology, their own fixed operating costs, and the argument that higher commercial prices are needed to cover gaps left by low Medicare and Medicaid payment rates. State officials should be prepared to respond to these arguments by preparing talking points and tough Q&As and participating in practice sessions led by communications staff.

Build Will for Action Through Ongoing Communication

As the initiative matures, stakeholder engagement should move toward actions the state and its partnering stakeholders can take to mitigate cost growth. 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 and policy actions that the cost growth mitigation strategy will address in the future. The cost-driver messaging should be done early, long before the development of any cost mitigation strategy.

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. There should be a designated staff member responsible for this function.

- **Newsletters, blog posts, videos, and social media posts:** States can leverage these tools to share information about program developments and bring attention to health care affordability and the need to address cost growth.
- **Public hearings:** Some states have created public hearings on target performance and mitigation strategies. In Massachusetts, the Health Policy Commission (HPC) holds an annual hearing 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.
- **Invitation-only forums, private meetings of associations, and webinars:** States 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.
- **Legislator briefings:** 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. To assist with these efforts, the Peterson-Milbank Program on Sustainable Health Care Costs has developed two fact sheets – one that addresses health care cost trends and their impact on households, employers and states, and another that explains and provides and overview of complementary policies to slow cost growth.
- **Media coverage and op-eds:** Media outreach is an effective way to reach a broader audience, and states should cultivate relationships with local reporters who cover health care affordability. States 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.

At each opportunity, states should lean on their messages to highlight the problem of health care affordability and describe what it means for families, employers, and the state.

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 and policy actions that the cost growth mitigation strategy will address in the future.

Resources

State officials are encouraged to contact the Peterson-Milbank Program for Sustainable Health Care Costs for information and guidance on how to communicate the value of and progress within a state's cost growth target initiative, as well as respond to industry concerns.

Additional resources include:

Information on Health Care Affordability

- **Consumer Healthcare Experience State Survey (CHESS).** Altarum's Health Care Value Hub includes results from the Consumer Healthcare Experience State Survey (CHESS), which surveys residents on a wide range of health system issues, including confidence using the health system, financial burden and views on fixes that might be needed, and offers state-specific data briefs.
- **Diagnosis Debt.** This KFF Health News series shows that medical debt is now the defining feature of the US health system, illustrating the problem with data and personal stories.
- The **National Alliance of Health Care Purchasers Hospital Fair Price** is a resource that offers employers guidance on how to leverage storytelling and data to advocate for lower prices, and is useful for providing insights into collaborating with employers.
- **Opinion Poll: Rising Healthcare Costs Continue to Hurt Small Business Bottom Lines.** This 2024 poll finds small businesses are struggling to keep up with rising healthcare costs and a majority support policy solutions, including facility fee bans, hospital price caps, and enhanced health care market oversight.
- **Our Health Care System Has Lost Its Way.** This Families USA report highlights the problem of unaffordable and low-quality care in the United States.
- **Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer.** The Commonwealth Fund Affordability Survey finds many Americans, regardless of where their insurance comes from, have inadequate coverage that has led to delayed or foregone care, significant medical debt, and worsening health problems.
- 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 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

Explainers such as accessible infographics, leave-behind fact sheets, FAQs, or videos that share topline findings from target performance or cost driver reports, ideally using a combination of graphics and text.

- **A State-led Approach to Health Care Affordability** (video)
- **California Office of Health Care Affordability Fact Sheet**
- **HPC Short: Out-of-Pocket Spending for Birth Care**
- **HPC Health Care Cost Growth Benchmark Frequently Asked Questions**
- **New Jersey Health Care Affordability, Responsibility, and Transparency (HART) Program Blueprint** (fact sheet)
- **Spending and Use of Emergency Department Services in Rhode Island** (data story)
- **Washington State Health Care Transparency Board FAQ**

- **Press releases** announcing new developments, such as establishment of an implementation committee, setting of target values, releases of target or cost driver reports, and announcements of the deployment of enforcement mechanisms.
  - Connecticut's First-Ever Healthcare Cost Growth Benchmark Report Confirms the Need for Reforms To Make Healthcare More Affordable
  - HPC Finds Mass General Brigham Cost Trends and Expansions Threaten State Health Care Affordability Efforts
  - Oregon Passes Bipartisan Legislation to Slow Rising Cost of Health Care and Increase Transparency for Consumers
  - Statewide Health Care Spending Target Approval is Key Step Towards Improving Health Care Affordability for Californians
- **Reports** featuring baseline data, performance against the target, or analysis of cost drivers.
  - Massachusetts Annual Health Care Cost Trends Reports
  - Oregon Health Care Cost Growth Target Data and Reports
  - Rhode Island Annual Report on Health Care Spending and Quality, 2024
  - Washington's Baseline Benchmark Report, 2017-2019
- **Op-eds** from a state official or committee member making the case for targets to help raise the program's profile.
  - What States Can Do to Get Rising Health-Care Costs Under Control (Washington and Connecticut)

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.
  - California Office of Health Care Affordability Slow Spending Growth
  - Connecticut Office of Health Strategy Healthcare Benchmark Initiative
  - Delaware Health Care Spending and Quality Benchmarks
  - New Jersey Health Care Cost Growth Benchmark Program
  - Oregon Health Authority's Sustainable Health Care Cost Growth Target
  - Rhode Island Health Spending Accountability and Transparency Program
  - Washington Health Care Cost Transparency Board
- **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 X (formerly Twitter)
- **Email updates and newsletters** that keep audiences informed and reminded of how cost growth target programs are helping move the needle on affordability.
  - Rhode Island newsletters
- **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's 2024 Health Care Cost Trends Public Forum: presentation and chartbook
  - Connecticut Office of Health Strategy Virtual Forum on the Health Care Cost Growth Benchmark
  - Connecticut Healthcare Affordability: How It Impacts Your Company and Employees Symposium
  - New Jersey Informational Webinar for Hospital and Provider Stakeholders

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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-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.

The methodology used to determine the target value is critical in helping stakeholders, including the public, understand the policy and reasoning behind the target.

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.

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.

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.

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 and 2023 led some states to review their target values and methodologies. Two states – Connecticut and Rhode Island adjusted their target values in response to high inflation. Rhode Island needed to set new target values for 2023 through 2027 and in the process of doing so, changed its target methodology to incorporate median household income growth rather than solely rely on PGSP. However, rather than use long-term inflation forecasts as a component of PGSP, Rhode Island used actual inflation and short-term forecasts, which yielded higher target values. Connecticut made a similar adjustment for one year (2024), using actual inflation instead of long-term forecasts in the calculation of PGSP, and also updated the forecasted median household income growth.

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.

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.

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.

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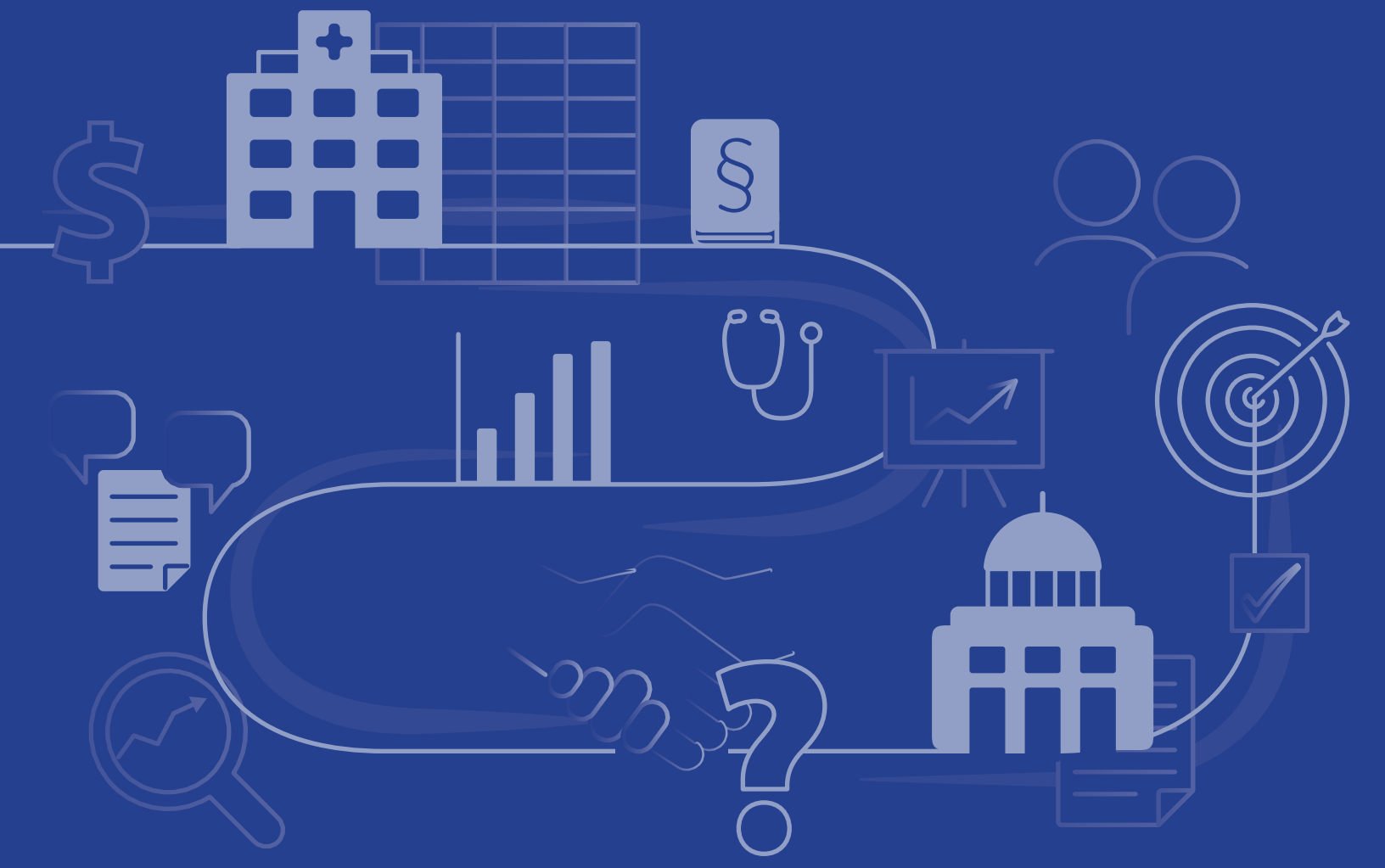
4 Measuring Performance Against the Target



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 analysis.

Adopting Standardized Approaches to Measuring Health Care Cost Growth Target Performance

States follow a general framework for cost growth target performance measurement but tailor approaches based on their specific policy goals and health care landscape. As states collaborate to share best practices, they have made recommendations for how to approach specific data collection and analysis issues that merit standardization, including:

- How to further stratify non-claims spending into specific service categories, including apportioning payments for primary care and behavioral health.
- How to handle pharmacy rebates and members without utilization.
- Adjustments to the data, including risk-adjustment and how to treat spending for carved-out services.

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.[4] 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, individuals who are incarcerated 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.

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 no comprehensive source of such data exists.

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.[3] 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.

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 decided that 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

Because public reporting of performance against the target involves identifying specific entities' cost growth, it is important to have confidence in the measurement.

entity trends by removing per-member or per-patient expenditures above a certain threshold. States need to monitor whether truncation points need to be adjusted as spending grows over time, and the distribution of spending shifts. Without such adjustments, states may be classifying more individuals as high-cost outliers and removing a larger proportion of spending than is warranted.

- **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.[5] 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, states have moved toward risk-adjusting only by age and sex to avoid overstating the population's illness burden, and some states have 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.

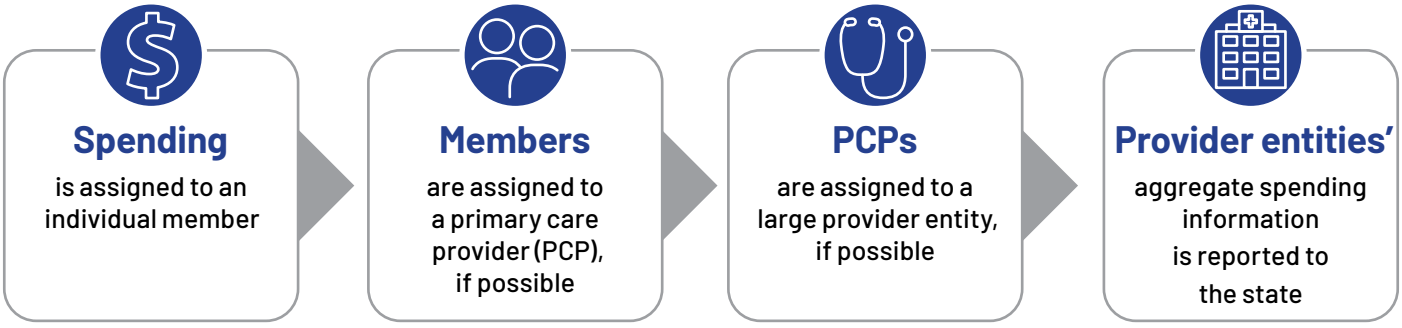
Identify the Entities That Will Be Held Accountable to the Target

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 payers 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. "Attribution" is the process of assigning or linking members' health care spending to specific provider entities. Payers routinely perform attribution in value-based contracting with provider entities, or for their own internal analyses. For cost growth performance measurement, this involves first attributing members to a clinician, and then attributing clinicians to a large provider entity that is ultimately subject to the cost growth target (Exhibit 3).

EXHIBIT 3. **Process for Attributing Spending to Large Provider Entities**



Attribute Members (and their Health Care Spending) to a Clinician

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. With time and experience, states have modified their specifications and provided more transparency into how member spending is attributed to primary care clinicians. This can provide more insight into why provider entities' attributed lives counts may differ from those reported in the value-based contract reports they receive from payers.[6] California, Connecticut, Massachusetts, Oregon, and Washington require payers to attribute and report spending to a primary care clinician according to a tiered hierarchical attribution method that considers member selection of a primary care provider, a provider's contract arrangement with the insurer, and member utilization of primary care services.

Attribute the Clinician to a Responsible Provider Entity

Most cost growth target programs attribute all spending to provider entities; they do not restrict reported spending to that captured through a contractual value-based payment arrangement. There are several challenges with this approach, including payers not having complete or updated information about which clinicians are affiliated with a provider entity. In addition, not all clinicians that are affiliated with provider entities are part of all of a payer's value-based contract agreements (e.g., clinicians participate in a value-based contract arrangement for a payer's Medicare line of business but not commercial.)

Ideally, a state will have a provider directory — or registry — that maps each primary care provider to a large provider entity so that attribution is consistent across payers. However, very few states maintain a statewide provider directory, so payers must rely on their internal processes to organize providers into a state's list of large provider entities. States ask payer cost growth target data submitters to attribute spending to a list of provider organizations defined by the state. This can be difficult as payers may not necessarily know which clinicians are associated with the provider organization or the clinicians' Tax Identification Numbers (TINs) unless the payer holds a value-based contract (VBP) with the provider organization. To address this issue, Connecticut convened an Attribution Work Group including insurers and providers, which then recommended that the state facilitate collection and exchange of TIN information, as described in detail in a Milbank Memorial Fund **issue brief** on attribution.

Understand Relationships Between Responsible Entities and Identify Which Entity/Entities Should Be Held Accountable for Spending

Another difficult task related to attribution is determining which entity is ultimately accountable to the cost growth target. In an increasingly consolidated market, several large provider entities may be connected to one another by a relationship with an even larger provider group or organization. The subsidiaries may be owned or jointly managed by the larger organization. The larger organization may have direct influence over the strategic functions and operations of the subsidiary entity or entities and a financial interest or stake in its performance. For example, UnitedHealth Group comprises provider groups, organized under Optum, UnitedHealthcare, the payer, and the pharmacy benefit manager, OptumRx. In some states, Optum may include major provider subsidiaries, each large enough to meet the membership thresholds states set for reporting spending growth and influence the care and costs of a sizeable population.[7]

Depending on the complexity of the provider organizational landscape, states should consider how to assess performance when multiple provider entities are part of a larger group to identify the entity that is ultimately accountable to the target. Establishing accountability at the "highest" level simplifies data collection and public reporting; however, the subsidiaries may be the entities with the greatest control over the day-to-day operations and the influence to slow spending.

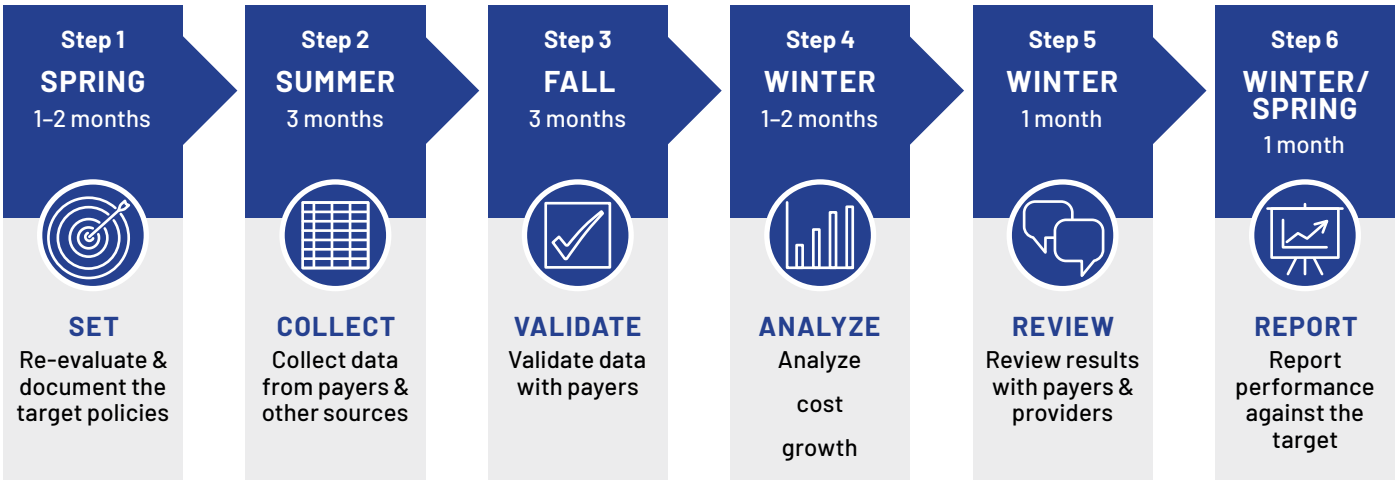
Depending on the complexity of the provider organizational landscape, states should consider how to assess performance when multiple provider entities are part of a larger group to identify the entity that is ultimately accountable to the target. Establishing accountability at the "highest" level simplifies data collection and public reporting; however, the subsidiaries may be the entities with the greatest control over the day-to-day operations and the influence to slow spending. In addition, contracting arrangements may vary within a large provider entity. For example, an Independent Practice Association (IPA) may partner with one medical group for a commercial contract with one insurer, but partner with a different medical group for a Medicare Advantage contract with the same insurer. As described in the prior section, states should take steps to understand the relationships and structures of their provider groups to inform their decisions regarding provider-level accountability.

Understanding and addressing these attribution-related challenges is essential for states to successfully implement their cost growth target programs and ensure that health care spending growth is accurately monitored at the provider organization level.

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. They also require continuous and intensive consultation with the affected plans and providers. 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**



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 based on 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.

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. However, 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.

- **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 included in data supplied by CMS and, depending on the state, may be included in Medicaid FFS data supplied by the state Medicaid agency. Dually 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.

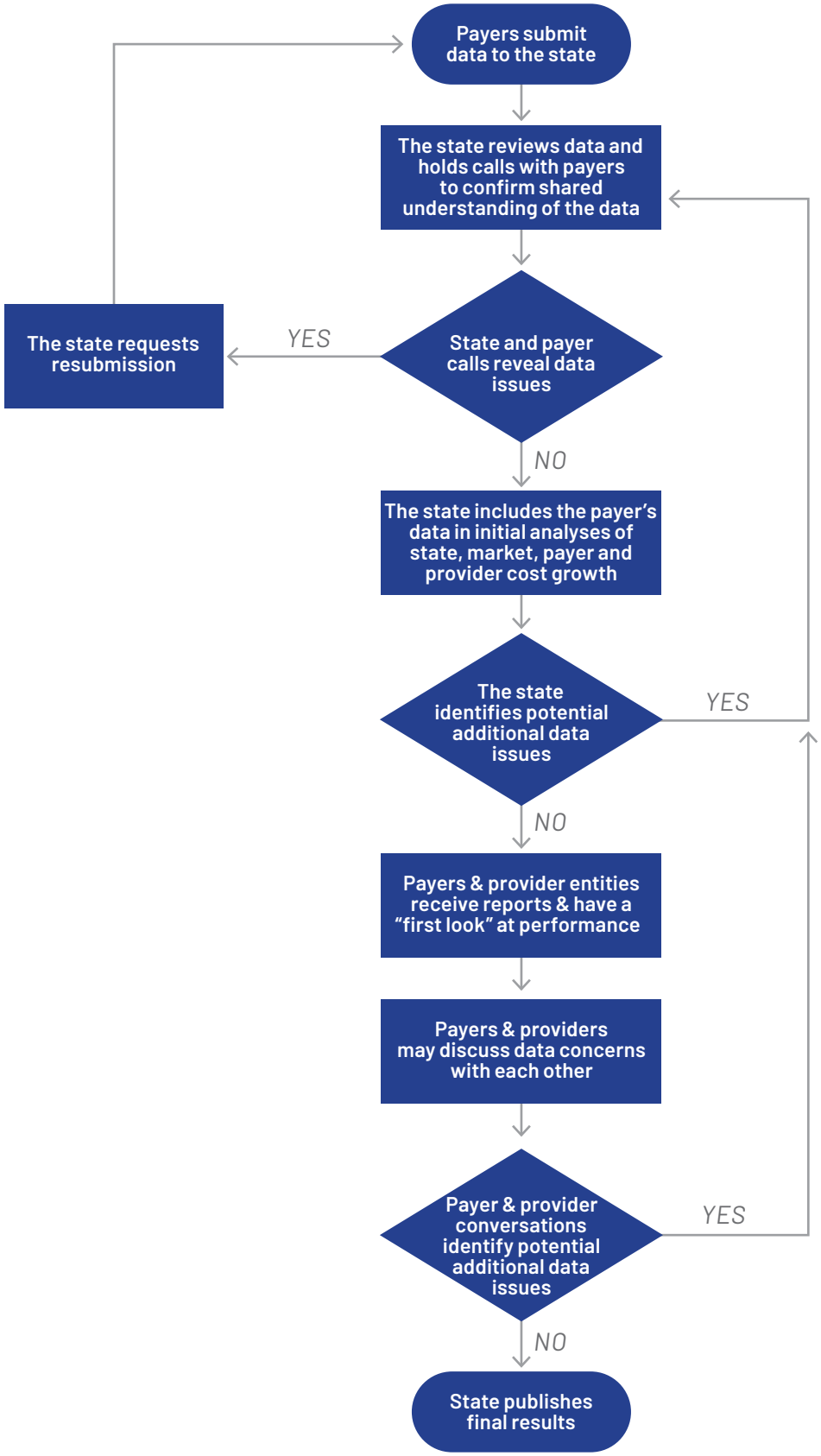
The data validation process can be lengthy, and payers may need to resubmit data multiple times, particularly when they are new to reporting target performance data. Providing comprehensive upfront assistance and tools for data submitters will reduce the need for resubmission later in the process. For 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.

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.

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



- **Reasonableness checks** ensure the data are appropriate at face value and when compared with other sources. These 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.

Addressing Provider Criticisms of the Data

States' public reporting of cost growth target performance have been met with significant provider pushback and challenges to the integrity and legitimacy of such data, with the with the goals of discrediting the state's work and blunting efforts to advance policies to slow spending growth. For this reason, it is important for states to undertake additional cost driver analyses that can support the findings of the cost growth target performance measurement. No one data source or set of analyses is perfect; even the most rigorous data collection and research studies have limitations. However, having multiple sources of data and analyses that point in the same direction make it more difficult for critics to challenge the conclusion.

States also need to be able to distinguish between feedback that are substantive from those that are meant to detract attention from important issues at hand, and be judicious in how they direct resources in response. As noted earlier, in Connecticut, some provider entities raised concerns about how clinicians were being attributed to them. To address this, Connecticut worked with a group of providers and insurers to improve the cost growth target attribution process, which was implemented during the collection of 2023 data. While this involved significant effort, the state undertook it to enhance stakeholder buy-in of the data.

Other criticisms, however, may not be worthwhile to address. For example, provider entities continuously press for applying clinical risk adjustment to measurement of cost growth target performance despite evidence to show that risk adjustment can make members appear sicker than they actually are, which has the effect of "discounting" spending and spending growth.

States can also conduct additional analyses, such as calculating 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. 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.

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.

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.

- California **Data Submission Guide**
- Connecticut **Implementation Manual**
- Delaware **Implementation Manual**
- Massachusetts **Data Specification Manual**
- Oregon **Data Specification Manual**
- Rhode Island **Implementation Manual**

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** (available upon request)
- Massachusetts **TME-APM Data Reporting Template**
- Oregon **Submission Template**
- Rhode Island **Submission Template**

Technical Implementation Webinar Materials and Recordings

- Connecticut **Benchmark Technical Webinar Slides**
- Delaware **Benchmark Technical Webinar Recording**
- Oregon **Data Submission Training Slide Deck**
- Oregon **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 **2022 Cost Growth Benchmark Report**
- Delaware's **2022 Benchmark Trend Report**
- Massachusetts' **Annual Report of 2021–2022 Data**
- Oregon's **2020–2022 Health Care Cost Growth Target Annual Report**

- Rhode Island's **Annual Report on Health Care Spending and Quality** in 2022
- Washington's 2023 **Health Care Spending Growth Benchmark Baseline Brief**

Health Care Cost Growth Target Hearings and Public Forums

- Connecticut's Cost Growth Benchmark **Public Hearings** in 2024
- Massachusetts' **recording of its annual public hearing** in 2024
- Oregon's **annual cost growth target public hearing** in 2024
- Rhode Island's presentation of **2022 health care cost growth target performance** at a public forum in 2024
- Washington's 2024 **public hearing on 2022 performance against the benchmark**

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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:

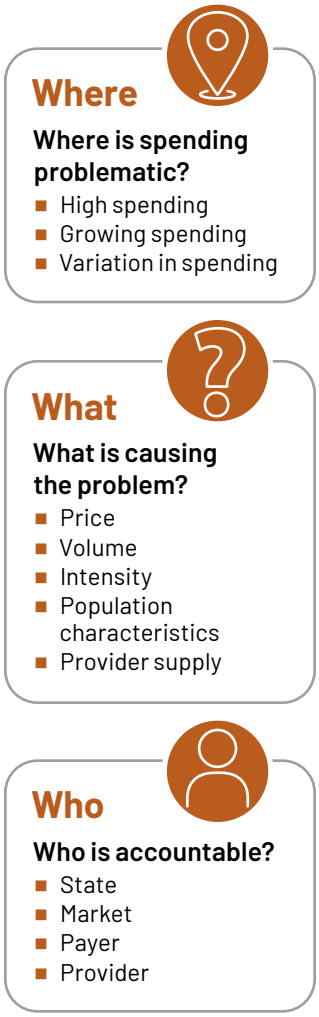
1. **Routine standardized analyses to inform, track, and monitor the impact of the target.** These regular reports should examine spending patterns, including use, price, service mix, and demographics, and should help draw attention to patterns that call for further investigation via in-depth reports. 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.[8] 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, payer, 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**



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.

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 publicly available data sources, including some of the following, 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.[9]
- **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.

The Peterson-Milbank Program for Sustainable Health Care Costs' Health Care Cost and Affordability Data Resource Inventory provides information on 20 publicly available national and state data sources, including some of the above, on health care cost and affordability. For each data source, the inventory details what data are included, how often the data are updated, the latest data year available, the level of difficulty involved in analyzing the data, the geographic granularity of the data and the known limitations of the data. An accompanying guide offers direction on how states can leverage these data to identify solutions to improve health care affordability. A separate guide to conducting hospital financial analysis can also facilitate understanding of health system and hospital revenue and cost drivers.

Standardizing Health Care Cost Driver Definitions and Methodologies

States that have analyzed their APCDs to understand cost and cost growth drivers have used different methodologies and definitions, making cross-state comparisons difficult. To address this, the Peterson-Milbank Program for Sustainable Health Care Costs convened a workgroup of states, analytic contractors, and subject matter experts in cost driver analyses to develop consensus definitions of terms, categories and methodologies for use such analyses. The workgroup discussed and made recommendations on issues such as how to define medical pharmacy, how to measure utilization of retail pharmacy, what to include in the definition of hospital inpatient and outpatient service categories, and what adjustments to make to the data.

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. In doing so, they need to balance supplying enough detail to demonstrate credibility of the analyses while keeping the key takeaways simple. To identify 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?

When 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 Communications for Sustained Stakeholder Engagement section of this playbook provides ideas on where and how to communicate this information.

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.

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 and compelled public testimony of hospitals for which increased rates of payment contributed to spending growth in the state. 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.

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.
- The National Academy for State Health Policy's **Interactive Hospital Cost Tool** looks at hospital revenue, costs, profitability and other measures for over 5,000 hospitals across the nation using data from the Healthcare Cost Report Information System.

Examples of Cost Driver Analyses

- Connecticut's presentation of **Healthcare Cost Drivers in the state**
- Massachusetts' **2024 Health Care Cost Trends Report and Policy Recommendations** and accompanying **Chartpack**
- Oregon's analyses of **2013–2019 Price and Utilization Trends**
- Rhode Island's **Tableau analyses** of cost trends
- Washington State's **Commercial Trends in Cost for 2016–2019**

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6 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.

However, 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, strategies and considerations for holding entities accountable to the cost growth, and cost containment strategies that states have pursued.

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

Establish 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 four states — Delaware, Massachusetts, Oregon, and California — go beyond public reporting to motivate payers and providers to meet the target. These states can require performance improvement plans or 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, market, payer, and provider organization levels, sharing the findings in multiple venues and formats to garner attention.

Massachusetts' recent experience, however, points to the limits of public reporting in sustaining voluntary cost containment efforts. Stakeholders in the state 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. However, this influence waned as the program matured and health care entities exceeded the target without consequences.[10] While the HPC had the ability to impose a performance improvement plan on entities that exceed the target, it didn't exercise this authority until 2022. Consequently, states may wish to consider greater accountability and enforcement measures to ensure all stakeholders involved work towards meeting the cost growth target.

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.

Oregon, which can require PIPs, provides guidance to entities on the PIP process in the form of templates and examples of acceptable plans and provide technical assistance and feedback to support entities to develop their PIPs. The Oregon Health Authority (OHA) will accept draft PIPs and provide feedback to entities to support final plans before they are submitted for approval.

To date, the first and only application of a PIP for failing to meet the target has been in Massachusetts. After several years of exceeding the state's cost growth benchmark, the HPC required Mass General Brigham, the largest health system in the state, to submit a PIP in 2022. The HPC found that from 2014 to 2019, Mass General Brigham had more cumulative spending in excess of the state's cost growth benchmark than any other provider. Mass General Brigham's PIP, which was approved by the HPC, included 10 interventions that were estimated to save $176.3 million over 18 months.[11]

Mitigating cost growth takes time, so states need to closely monitor PIP performance and results for multiple years to measure impact. To evaluate Mass General Brigham's PIP implementation efforts, the HPC looked at the following factors:

- Whether and to what extent significant concerns about costs have been addressed
- Whether the entity has implemented strategies outlined in the PIP in good faith
- Sustainability of efficiencies and cost savings of PIP initiatives
- The extent to which implementation of cost-saving initiatives and cost growth are influenced by events outside of the entity's control
- Other relevant factors, as determined by the HPC.

Leveraging the Cost Growth Target to Spur Action: Delaware's Hospital Cost Review Board

In June 2024, following years of failing to meet the state's cost growth benchmark, Delaware passed a bill establishing the Diamond State Hospital Cost Review Board. The Board is charged with conducting annual reviews of hospital budgets and related financial information and ensuring that growth in hospital costs align with the state's established benchmark. Hospitals whose cost growth exceeds the benchmark must engage with the Board and submit a performance improvement plan detailing strategies and concrete action steps to bring down costs. As part of the hospital budget review, the Board may also recommend and enforce changes to a hospital's budget to bring cost growth in line with the benchmark.

In its In December 2024, the HPC announced that Mass General Brigham's implementation of the PIP meaningfully reduced health care spending growth.

Applied appropriately, a PIP can be a powerful accountability tool for states. However, as seen in the Massachusetts experience, it can be time and resource-intensive to implement. The HPC's monitoring and review of the PIP entailed quarterly meetings, analyzing spending trends, validating savings methodologies and calculations, and reviewing contracts with health plans to determine whether Mass General Brigham's cost reduction initiatives achieved target outcomes, reduced spending and pricing during the period of the PIP, and could be sustained into the future. Massachusetts has significantly invested in the infrastructure for its cost growth target program; however, states with smaller programs and less resources may not have the capacity to undertake such an effort.

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. Alternatively, a penalty that is set too high could pose financial burdens that impede entities' ability to deliver services. In Oregon the penalty amount is based on the degree to which the entity exceeds the target and the entity's size. Oregon's financial penalties apply to entities that exceed the cost growth target with statistical confidence and without reasonable cause in a market for at least three out of five years.[12] To ensure that the program improves affordability, the state requires plans and providers to direct payment of the financial penalty to consumers or to programs designed to directly benefit them.

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.

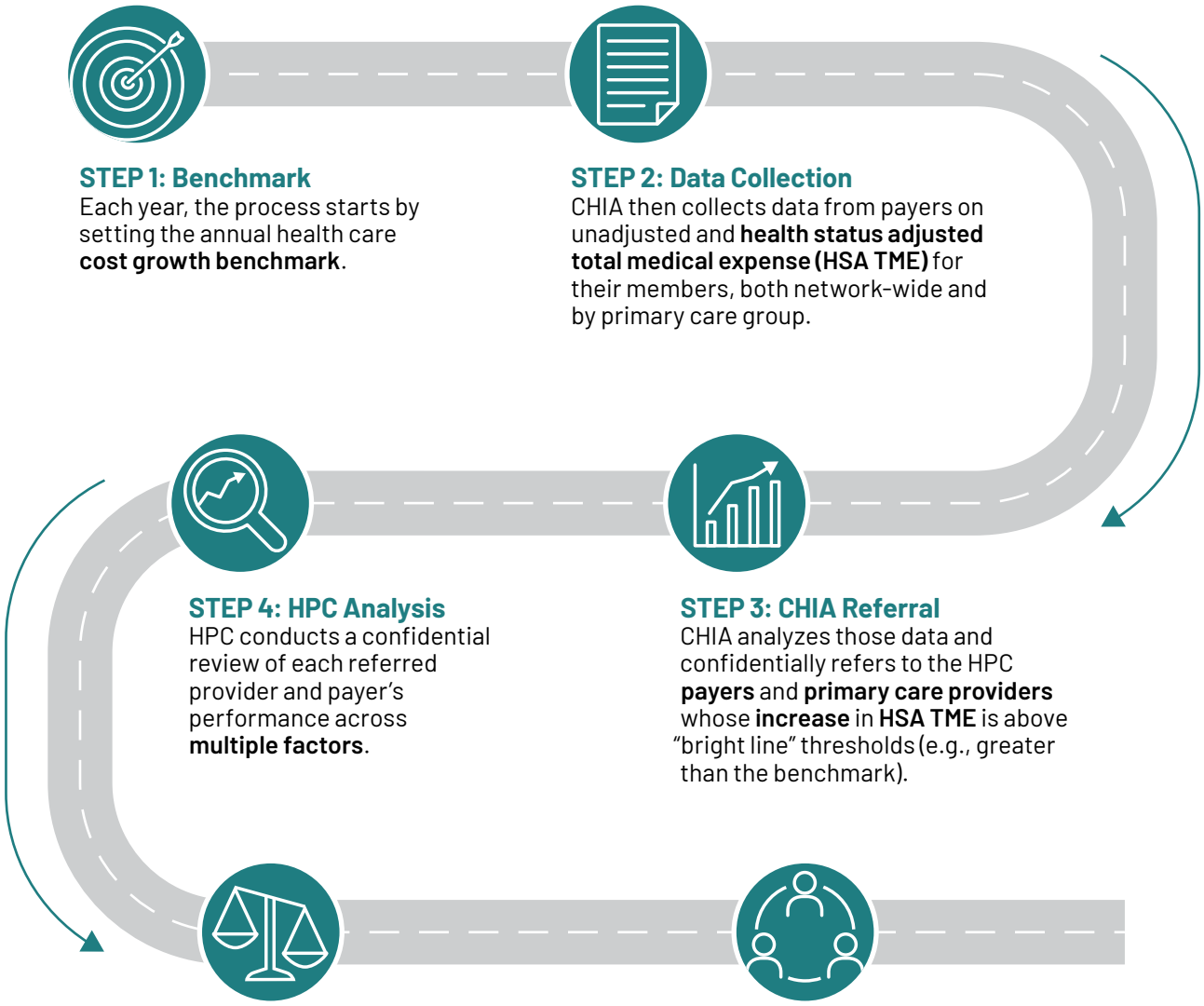
Build the Structure to Hold Entities Accountable for Not Meeting the Target

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.[13]

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.

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

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 identitity 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.[14] 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.

Consider Extending Accountability for Cost Growth Beyond Primary Care-Based Providers

Typically, states subject large provider entities that can be reasonably expected to influence total health care costs to the health care cost growth target. Those entities may include medical groups, health systems, federally qualified health centers, and independent practice associations that may or may not have value-based contract arrangements with payers. A significant limitation of this primary care–based approach to assessing TME is that many provider entities that contribute significantly to cost growth, such as hospitals and pharmaceutical manufacturers, do not have their spending growth assessed. This has led states to explore ways to extend accountability to such entities.

Determining the Reasonableness of an Entity's Excess Cost Growth

Oregon developed a list of potential factors that may cause a payer or provider entity to reasonably exceed the cost growth target, including:

1. Changes in federal or state law
2. Changes in mandated benefits
3. New pharmaceuticals and new uses of existing pharmaceuticals or new treatments / procedures / devices entering the market
4. Changes in taxes or other administrative factors
5. "Acts of God" (natural disasters, pandemics, other)
6. Investments to improve population health and/or address health equity
7. Macroeconomic factors
8. Total compensation for frontline workers

Following several years of obtaining stakeholder input, OHA has also set forth a process for how it will determine whether excess cost growth is reasonable, with intensive review to understand the factors contributing to an entity's excess cost growth. Oregon launched this process with its **assessment of health care entities' 2022 performance** against the state's target. OHA determined that 28 entities that exceeded the target had acceptable reasons for doing so, while three entities did not. Starting with the 2023 performance year, entities that exceed the target without an acceptable reason, as determined by this new process, will be required to submit and implement PIPs.

Developing a Methodology to Assess Hospitals' Spending

The primary care–based approach that states currently use to assess TME is not suitable for measuring individual hospital spending. States can attribute spending to hospitals that employ primary care clinicians or are contractually affiliated with them, but the many hospitals without such primary care relationships do not have their spending growth assessed. Yet hospital spending is a major health care cost driver at the state and national levels and is expected to continue to outpace spending growth of other types of health care services over the next decade.

Cost growth target program analyses have provided states with greater insight into the role that hospital spending — and specifically hospital prices — plays in driving health care spending growth, particularly in the commercial market. This underscores the need for states to address hospital spending to advance their affordability goals. To hold hospitals accountable to cost growth targets, states are exploring methodologies for measuring spending and spending growth at the individual hospital level. This involves consideration of key design issues, including:

1. **Defining the services and spending that should be included in hospitals' spending. Inpatient and outpatient hospital services are categories of service that should be included in spending.** However, there is a question about whether professional services delivered in a hospital setting and billed by a hospital should be included as well. Including professional services holds hospitals accountable to a more comprehensive set of services for which they have influence over spending; however, state policies may prohibit some hospitals from billing for professional services delivered in a hospital setting, which could create differences across hospital spending measurement.
2. **Identifying the source(s) of data on hospital spending.** States may be able to rely on existing data sources, for example, hospital financial filings or all-payer claims database data, or determine if a new source is needed. States will need to weight the associated advantages and disadvantages of using a particular data source or sources. For example, a state's all-payer claims database contains detailed information with actual payments but may not contain all payments. In addition, hospital financial filings include attestation from hospitals that the data are complete and accurate, rendering them a trusted source of information.
3. **Determining which hospitals to hold accountable to the target.** When reporting performance relative to a cost growth target, states often provide context for interpreting results, including policy changes or rationale that may explain (and in some cases, even justify) higher spending growth. States may elect not to measure or report on certain hospitals or apply less stringent enforcement mechanisms should a hospital exceed the target based on policy priorities or certain hospital characteristics. Such hospitals might include facilities that are owned and operated by the state for which price growth is not contributing significantly to high and rising spending. In addition, there might be hospitals for which states have a policy objective for increasing spending, such as psychiatric hospitals.

Cost driver analyses have consistently pointed the role of hospital pricing in driving up spending growth. Consequently, several states are exploring ways to hold hospitals accountable and mitigate growth in hospital prices. For example, California's Office of Health Care Affordability (OHCA) is developing a methodology to measure hospital spending and assess performance relative to the state's health care cost growth target. OHCA convened a stakeholder workgroup with hospital and health system representatives, health plans, a consumer advocacy organization, and public purchasers to develop recommendations for OHCA consideration. OHCA also intends to develop a methodology for assessing performance of and extend accountability to specialty providers.[15] In Massachusetts, the HPC recommended that the legislature strengthen the state's health care cost growth target framework by authorizing the use of metrics beyond TME to assess performance of hospitals and specialists.[16]

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 that 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. This section describes some of the strategies that states with target programs have pursued.

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 convened a workgroup of healthcare stakeholders to develop recommendations on key parameters of an all-payer hospital global budget model.

Most recently, Rhode Island and Connecticut were accepted into the Center for Medicare and Medicaid Innovation's States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. This initiative, focused on curbing health care cost growth, improving population health and advancing health equity, involves implementation of an all-payer hospital global budget model.

Real change can only come about when states and their stakeholder partners engage in and implement cost growth mitigation strategies.

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.

States can also consider incremental approaches to implementing price caps. For example, Oregon passed **legislation in 2017** that prohibits its state employee plan from paying more than 200% of Medicare prices for in-network hospital facility services, and more than 185% of Medicare prices for services delivered out-of-network. **Research** shows that initiative successfully reduced hospital prices for the state employee health plan, and resulted in an estimated $107.5 million in savings to the state during the first two years of implementation. Washington **introduced similar legislation** in 2025 to cap prices that health plans in the state's Public Employee Benefits Board and School Employees Benefits Board pay for hospital services.

Containing Growth in Prescription Drug Prices

Connecticut and Massachusetts have tried to control drug costs by introducing 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. Such efforts, however, have met stiff resistance and several legal challenges from the pharmaceutical industry. Despite these setbacks, states remain resolute in addressing prescription drug prices given it is a significant driver of high and rising health care costs.

For example, in January 2025, Massachusetts **enacted legislation** expanding the scope of the Health Policy Commission and establishing a new Office of Pharmaceutical Policy and Analysis to collect and analyze pharmaceutical spending data, publish reports on access to and affordability of prescription drugs, and make recommendations on prescription drug policy. The legislation also expanded state oversight of the industry, giving the state's Department of Insurance authority to license and regulate Pharmacy Benefit Managers operating in the state.

Washington and Oregon have established Prescription Drug Affordability Boards (PDABs) to monitor and mitigate prescription drug price increases. Washington's PDAB can set an upper payment limit for drugs that it finds to be unaffordable.

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.[17]

In 2021, Oregon passed a bill directing the 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. Massachusetts' 2025 law that expanded state oversight of pharmaceuticals also expanded the Health Policy Commission's authority to review mergers, acquisitions and other material transactions. This includes the ability to scrutinize the role of private equity investments in health care the state. In addition, it directs the Department of Public Health to consider the Commonwealth's cost containment goals, impacts on patients, and comments and relevant data from the Center for Health Information and Analysis and the Health Policy Commission in its reviews of Determination of Need applications.

Tips for Prioritizing Cost Mitigation Strategies to Pursue

Having a framework for systematically evaluating what strategies to pursue ensures states focus on the most important cost mitigation efforts. It 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

- Materials and recordings from cost growth target public hearings:
  - Connecticut Office of Health Strategy 2024 public hearing on the Healthcare Cost Growth Benchmark: recording and presentation
  - Massachusetts' recording of its annual public hearing in 2024
  - Rhode Island's presentation of 2022 health care cost growth target performance at a public forum
- 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 blog posts on Oregon's payer accountability system and the Diamond State Review Board
- 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
  - Not Just Squeezing the Balloon: A Comprehensive Set of State Strategies for Addressing Health Care Cost
  - How Payment Caps Can Reduce Hospital Prices and Spending: Lessons from the Oregon State Employee Plan
- Oregon's compact to accelerate adoption of advanced VBP models
- Rhode Island's compact to accelerate adoption of advanced VBP models
- Rhode Island's Report of the Hospital Global Budget Working Group
- Washington's Report on Health Care Affordability

Conclusion

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

It 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.

As states move their programs from infancy to maturity and begin to take more concrete steps to develop programs and policies that address rising health care costs and make health care more affordable and accessible, they must navigate and balance the interests of multiple powerful stakeholders, including insurers, the pharmaceutical industry, healthcare providers, and patients. High levels of cost growth have plagued the US health care system for decades, and the strong institutional forces that oppose efforts to meaningfully constrain cost growth are at play.

In the two years since this playbook's first publication, states have seen more efforts to dismantle or weaken their target programs–from the repeal of executive orders that established the programs to challenges to the validity of data, and proposed legislation to strip down accountability and enforcement mechanisms. To some degree, these efforts are a testament to the attention that these target programs are drawing to the nation's healthcare affordability problem. They also highlight the significant challenges associated with slowing health care cost growth.

States need to be strategic in fighting to protect the foundation they have laid while simultaneously making improvements, drawing on strong leadership, compelling data, and effective communications and stakeholder engagement to actively address challenges and adapt to changing economic and political landscapes.

About the Authors

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Before joining Bailit Health, January was the Deputy Medicaid Director for Managed Care and Oversight and 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, January 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. January 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.

Erin Taylor, MPH, is a senior consultant at Bailit Health with more than a decade of experience helping states advance policies to improve health care delivery. Erin supports state efforts to slow health care spending growth, develop and implement payment and delivery system reforms, and promote equity within Medicaid managed care. Erin currently supports the development and implementation of health care cost target programs in California and New Jersey, and previously assisted Rhode Island with a stakeholder engagement process that led to recommendations for the state's cost growth target framework.

Prior to joining Bailit Health, Erin worked on health care payment and delivery system reform initiatives at the Massachusetts Executive Office of Health and Human Services. While at the Office of Medicaid, Erin developed managed care programs for individuals with dual Medicare and Medicaid eligibility. Erin also previously completed a fellowship at Health Leads performing health-related social needs screening in primary care.

Erin earned a Bachelor of Science degree from the University of Florida and a Master of Public Health degree with a concentration in Health Law, Bioethics, and Human Rights from Boston University.

Endnotes

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