Peterson-Milbank
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Beyond Public Reporting: Strengthening Accountability to States' Cost Growth Targets and Leveraging Targets in Health Care Oversight

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Policy Points

- Because transparency alone is insufficient to constrain cost growth, three state with cost growth target programs strengthened payer and provider organization target accountability and five states are leveraging the target in market oversight programs
- States should enforce payer and provider organization accountability judiciously, use discretion, allow flexibility in choice of strategy to contain costs, and build robust state infrastructure to implement enforcement tools

ABSTRACT

Eight states have established cost growth target programs to curb rising health care costs. These programs set an annual target for the rate at which health care costs should increase and publicly report health care spending data. Experience has shown, however, that transparency alone is insufficient to constrain cost growth. This issue brief examines how three of these states —Massachusetts, Oregon, and California — have strengthened cost growth target accountability. It also highlights five states — California, Connecticut, Delaware, Massachusetts, and Oregon — that have leveraged their cost growth targets in other health care oversight programs. These efforts provide valuable insights and lessons for other states seeking to improve the effectiveness of their health care affordability initiatives.

INTRODUCTION

States have established cost growth target programs to curb rising health care costs, improve affordability, and enhance transparency and accountability in the health care system. These programs set an annual target (sometimes called a benchmark) for the rate at which health care costs should increase, often basing the target on income or economic growth.

All states with cost growth target programs publicly report health care spending data. Experience has shown, however, that transparency alone is insufficient to constrain cost growth. For example:

- A qualitative evaluation of Massachusetts' cost growth benchmark program found that its transparency initially motivated provider organizations to meet the benchmark. However, this faded over time as provider organizations realized there were few real consequences for spending growth above the state's benchmark.

- In Delaware, health care spending has exceeded the state's benchmark every year since its establishment, except in 2020 when COVID restrictions significantly reduced utilization. Reflecting on these outcomes, Delaware legislators acknowledged that their initial expectation for the major health care stakeholders in the state to collaborate and voluntarily implement initiatives to reduce cost growth and meet the state's benchmark had not been realized.
- Officials from six states with cost growth target programs (California, Connecticut, Delaware, Maryland, Oregon, and Rhode Island) shared in interviews that unless states have significant enforcement power and the political will to use it, targets risk being ignored. As one state official put it, "Transparency doesn't drive change."

These experiences, along with broader research showing the limited impact of public performance reporting on sustained cost containment or robust quality improvements, demonstrate that cost growth targets, regular monitoring and analysis, and public reporting are necessary but not sufficient. States need stronger tools to ensure payers and provider organizations meet their cost growth targets.

There are generally two approaches to strengthening accountability for meeting a cost growth target: (1) enforcement of actual cost growth target performance through tools like performance improvement plans (PIPs) and financial penalties, and (2) incorporating the cost growth target (or a payer's or provider's ability to meet the target in the future) into state policies such as health care market oversight or hospital budget reviews. Of the eight states with cost growth target programs, three—Massachusetts, Oregon, and California—have strengthened enforcement of cost growth target performance (see Table 1). Other states have incorporated their cost growth targets into other health care oversight policies, either formally or informally. We highlight five of those states (California, Connecticut, Delaware, Massachusetts, and Oregon) in this brief.

ENFORCEMENT OF COST GROWTH TARGET PERFORMANCE

As noted previously, all states with cost growth targets publicly report payer and provider organization performance against the target. Massachusetts, Oregon, and California have stronger enforcement tools, including performance improvement plans and financial penalties, for entities that exceed their cost growth targets.

Massachusetts' Performance Improvement Plans

Massachusetts was the first state to implement a health care cost growth target program with the passage of Chapter 224 of the Acts of 2012. The legislation established two agencies responsible for monitoring and controlling health care spending growth. The Center for Health Information and Analysis (CHIA) collects and analyzes data from provider organizations and payers, producing annual reports on health care spending trends in Massachusetts. The Health Policy Commission (HPC) monitors spending trends and enforces the state's benchmark and has the authority to act when entities

Table 1. Comparison of State Cost Growth Target Enforcement and Accountability Initiatives

	CA	CT	DE	MA	NJ	OR	RI	WA
Enforcement of Cost Growth Target Performance								
Public reporting	✓	✓	✓	✓	✓	✓	✓	✓
Performance improvement plan	✓			✓		✓		
Financial penalties for exceeding the target	✓					✓		
Oversight Activities Tied to Cost Growth Targets								
Oversight of mergers and acquisitions	✓	✓		✓		✓		
Hospital budget review			✓					
Certificate of need		✓						

Who Are the Entities That Are Accountable to Cost Growth Targets?

States with cost growth target programs hold health care payers and provider organizations accountable for curbing spending growth. **Payers** typically include commercial insurers, Medicaid managed care organizations, and Medicare Advantage plans. **Provider organizations** generally include large physician groups, health systems, or clinically integrated networks that meet minimum attributed lives thresholds by market.

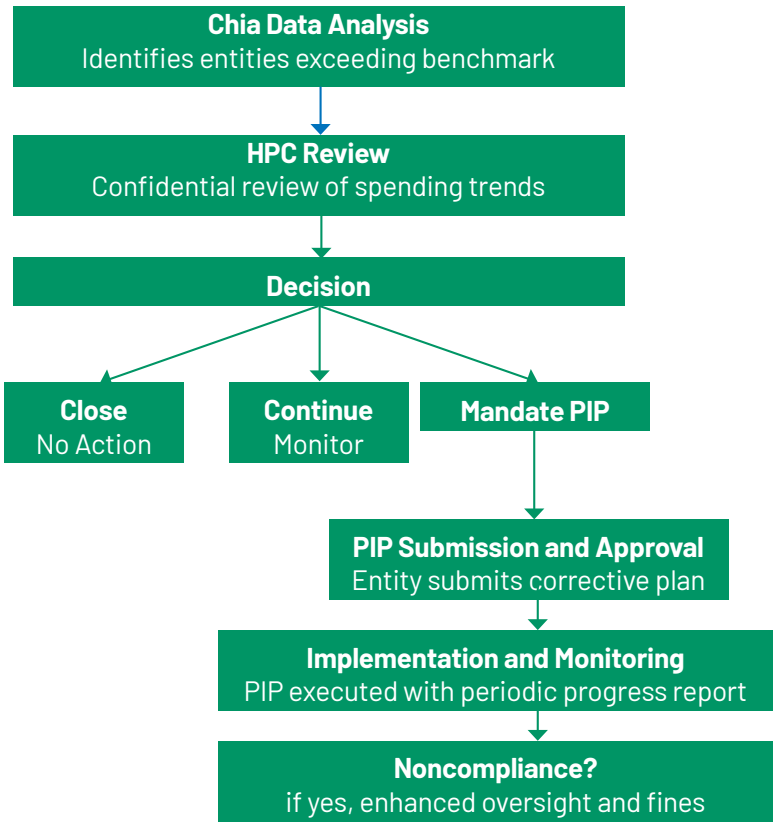
As discussed in this issue brief, California is unique in that it can hold specific provider types (e.g., hospitals) accountable for cost growth target performance.

exceed it. In addition, the HPC has market oversight authority, convenes stakeholders, invests in care delivery models, makes policy recommendations, and provides research and reporting to policymakers and the public.

Massachusetts has the authority to enforce its cost growth benchmark through performance improvement plans (PIPs), which require entities exceeding the benchmark to take corrective action to slow cost growth (see Figure 1). Massachusetts' PIP process includes the following steps:

1. **Data collection and referral.** CHIA analyzes spending data, identifies payers or physician groups exceeding the cost growth benchmark, and refers those entities to the HPC.
2. **HPC review and determination.** The HPC conducts a confidential review of the entity's financial and operational data to assess whether cost growth was unreasonably high.
3. **Decision to require a PIP.** After completing its confidential review, for each entity referred to the HPC by CHIA, the HPC may close the review, continue collecting data, or vote to require a PIP. If the HPC requires a PIP, the entity's identity, along with the HPC's findings, are publicly disclosed on the HPC's website.
4. **PIP submission and approval.** The HPC formally notifies the entity of the PIP requirement. The entity must then develop and submit a detailed PIP that describes the specific actions it will take to bring its cost growth in line with the state's benchmark.
5. **Implementation and monitoring.** Throughout the PIP implementation period, the HPC actively monitors the entity's progress. At the end of the PIP period, the HPC evaluates whether the entity has successfully met its cost-containment goals and determines whether further intervention is required.
6. **Consequences of noncompliance.** If an entity fails to comply with an approved PIP, the HPC may take additional enforcement actions to ensure accountability. The HPC board can also assess a fine of up to $500,000 for noncompliance as a last resort.

Figure 1. Massachusetts PIP Process



The HPC has had the authority to require PIPs since the benchmark program was established in 2012, but has exercised it only once. In 2022, the HPC voted to require Mass General Brigham (MGB), the state's largest health care system, to develop and implement a PIP. This decision followed six consecutive years (2014-2019) of MGB exceeding the benchmark. MGB had $293 million in commercial spending growth above the benchmark during this five-year period, significantly more than any other provider organization. (Other entities' cumulative spending growth in excess of the benchmark ranged from $33.2 million to $130.2 million.) The HPC determined that MGB's case was particularly egregious given the health system's size and influence over health care spending in the state. The decision was also based on other financial analyses that showed MGB's hospital and physician prices were higher than most other provider organizations in the commonwealth.

As part of the PIP, MGB was required to implement measures to achieve a target of $176.7 million in savings and reduce spending and pricing trends. To determine whether MGB had successfully completed the PIP, the HPC conducted a comprehensive review process. This included examining MGB's financial data, validating reported cost savings, assessing pricing trends, monitoring cost-containment strategy implementation, and comparing MGB's performance against benchmarks and peer organizations to confirm that spending reductions were meaningful, sustainable, and not offset by increases elsewhere.

From these analyses, the HPC concluded that MGB had successfully met its PIP obligations. The evaluation determined that MGB achieved $197.1 million in cost savings ($20.4 million more savings than required), the majority of which ($125 million, or 70%) was achieved through price reduction strategies. As a result, the PIP was formally closed, and MGB was not subject to further enforcement actions.

Oregon's Performance Improvement Plans and Financial Penalties

Oregon established its Sustainable Health Care Cost Growth Target Program in 2019 through Senate Bill 889. The Oregon Health Authority (OHA) oversees the program and has some of the most robust enforcement tools of any state with a cost growth target. OHA is phasing in PIPs and financial penalties for exceeding the cost growth target (see Table 2).

Performance improvement plans.

OHA will soon require organizations that "unreasonably exceed" its cost growth target to complete a PIP based on 2023 performance. OHA's PIP process involves the following stages:

1. **Identification of entities.** OHA annually analyzes data to determine which payers and provider organizations exceeded the cost growth target.
2. **Determination of reasonableness.** OHA conducts a thorough review to assess whether underlying factors justify the cost increases. Oregon has included its list of acceptable reasons for exceeding the cost growth target in subregulatory guidance (e.g., growth in frontline worker costs, service expansions to meet community needs). OHA meets with entities to discuss potential reasons for cost growth. Entities can provide additional data and context to justify reasonable increases.

Table 2. Oregon Cost Growth Target Accountability Timeline

Cost Growth Target Year	0	1	2	3	4	5
Cost growth between	2018-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Data submitted in	2021	2022	2023	2024	2025	2026
Report published in	2022	2023	2024	2025	2026	2027
Are payers/providers publicly identified?	No	**Yes**	Yes	Yes	Yes	Yes
Do PIPs apply?	No	No	No	**Yes**	Yes	Yes
Applies to a potential $ penalty in 2026	No	No	**Yes**	Yes	Yes	Yes

3. **Written determination notice.** If cost growth is found to be excessive without sufficient demonstration of a reasonable cause, affected entities receive a formal notice detailing the determination.
4. **PIP submission and approval.** The identified entities must develop and submit a detailed PIP outlining corrective measures. OHA reviews these plans to ensure they are both feasible and capable of reducing cost growth.
5. **PIP periodic and final reports.** Throughout implementation, organizations must submit periodic progress reports, culminating in a final report to evaluate the effectiveness of the cost-containment strategies.

In January 2025, OHA made its first determination that three health care organizations—two payers and one provider organization—exhibited unreasonably high cost growth from 2021 to 2022. These three health care organizations were among 28 entities that went over the target during this time period.

OHA worked with these organizations for six months to understand the reasons behind their elevated spending growth. For all except three, OHA found that they had acceptable reasons, such as increased Medicaid utilization or limited skilled nursing facility capacity. The three entities that OHA identified as having unreasonably high cost growth had increased their annual spending by between 6.5% and 11.6%. Starting with 2022-2023 cost growth data, which OHA reported in June 2025, organizations identified by OHA as unreasonably exceeding the target will be required to submit PIPs.

Financial penalties. As a supplemental measure, OHA has established a system of financial penalties for organizations that exceed the cost growth target with statistical confidence and without a valid reason in any three of five years. Oregon structured the financial penalties in relation to how many times the entity has exceeded the cost growth target:

First instance: 5% of net total cost above the cost growth target[1] over a five-year period.

Second instance: 10% of the net total cost above the target over a five-year period.

Third instance: 15% of the net total cost above the target over a five-year period.

Fourth instance and beyond: For each subsequent violation, the penalty increases by an additional five percentage points.

OHA plans to begin assessing these financial penalties in 2026 if any entity has exceeded the target for three years within a five-year period without a justifiable explanation.

California's Performance Improvement Plans and Financial Penalties

California is the latest state to establish a cost growth target program. In 2022, California enacted legislation to create the Office of Health Care Affordability (OHCA), which is responsible for setting its cost growth targets. California's program is unique in that in addition to a statewide target, it can set specific targets for different sectors of the industry, such as hospitals. This allows the state to hold accountable entities that can contribute significantly to cost growth that are otherwise not subject to cost growth targets. In January 2025, the California Health Care Affordability Board voted to establish a hospital health care sector. At the April 2025 Health Care Affordability Board meeting, OHCA voted to define "high-cost hospital," set hospital sector spending target values, and identified seven high-cost hospitals.

California's cost growth target enforcement tools—PIPs and financial penalties—are similar to Oregon's. OHCA has the authority to mandate that entities develop and implement corrective actions for excessive cost growth. Additionally, OHCA can establish a tiered system of financial penalties for failure to meet the cost growth target. These penalties will begin at levels commensurate with the degree of noncompliance and escalate for repeated or continuing failures to meet the targets.

Since California's program was only recently established, the PIPs and financial penalties implementation details have yet to be developed. Enforcement for both PIPs and financial penalties will apply to the 2026 statewide spending target, for which data collection will occur in 2027 with results publicly reported in 2028. Consequently, the earliest enforcement actions are anticipated in 2028.

[1] The "net total cost above the cost growth target" is the combined difference between a payer's or provider organization's actual costs and what their costs would have been if they had grown only at the allowed target rate, multiplied by their member months.

LEVERAGING THE COST GROWTH TARGET TO SHAPE OTHER AFFORDABILITY POLICIES

In addition to, or instead of, enforcing target performance, states can leverage the cost growth target to shape other health care affordability policies. Oregon, Massachusetts, California, Connecticut, and Delaware have done so through health care market oversight programs, certificate of need programs, and hospital cost review boards that work in tandem with cost growth targets to slow health care cost growth.

Oregon's Health Care Market Oversight Program

OHA uses its authority to review proposed mergers and acquisitions to enhance health care entities' accountability for meeting the cost growth target. Oregon's HCMO program complements the cost growth target by evaluating how mergers and acquisitions may impact future health care costs, including the state's ability to meet its cost growth target. Health care entities above a certain size that are planning mergers or acquisitions must notify the OHA, which initiates OHA's HCMO review. The review consists of two stages:

1. **Preliminary review.** An initial evaluation to identify potential concerns.
2. **Comprehensive review.** A deeper assessment to determine whether the transaction will either "reduce growth in patient costs in accordance with the health care cost growth targets" or "maintain a rate of cost growth that exceeds the target that the entity demonstrates is in the public interest."

Based on its review, OHA will issue a decision that may include conditional approval of the transaction or mandates for mitigating measures.

Massachusetts' Health Care Market Oversight Program

Massachusetts uses its market oversight authority to reinforce accountability for its health care cost growth benchmark. The HPC's Market Oversight and Transparency program evaluates how changes in provider ownership and affiliations may impact cost, quality, and market functioning, including the state's ability to meet its cost growth target. The program supports the benchmark by reviewing proposed "material changes" to provider operations and governance, such as mergers, acquisitions, joint contracting arrangements, and new accountable care organizations.

Provider organizations must notify the HPC at least 60 days before a material change takes effect. The HPC's review process includes two steps:

1. **Preliminary review.** An initial 30-day assessment of the transaction's potential impacts using data on relative prices, total medical expenses, claims, and discharges.
2. **Cost and market impact review (CMIR).** A comprehensive, public analysis of transactions likely to significantly affect health care costs or market dynamics. CMIRs evaluate how a transaction may impact the state's ability to meet the cost growth benchmark, as well as market competition, quality, equity, and access.

Although the HPC cannot block transactions or impose conditions, it may refer its findings to other state agencies, such as the Attorney General's Office or the Department of Public Health, for further action.

California's Health Care Market Oversight Program

California's OHCA has the authority to conduct cost and market impact reviews of material changes in ownership or governance such as mergers, acquisitions, and corporate affiliations. Similar to the Massachusetts HPC, although OHCA does not have the ability to deny a proposed transaction, it uses the cost and market impact review findings to collaborate with other state agencies in addressing consolidation when necessary. Among the factors that OHCA examines as part of the review is a proposed transaction's impact on the state's ability to meet its cost growth targets.

Connecticut's Certificate of Need (CON) Program

Certificate of need (CON) programs are state regulatory tools used to evaluate and approve major capital expenditures and projects for certain health care facilities—including establishment, expansion, construction, renovation, and major medical equipment acquisitions. The primary goal of CON programs is to control health care costs and ensure the rational distribution of resources

by restricting duplicative services and ensuring that new capital expenditures align with community needs.

In Connecticut, the Office of Health Strategy (OHS), which oversees the Healthcare Benchmark Initiative, also administers the CON program. OHS reviews proposed transactions involving the initiation or termination of services, as well as transfers of ownership of health care facilities or large practices. As part of this review, OHS may hold public hearings, subpoena witnesses, and request records. CON approvals may include conditions related to cost containment, patient access, and reporting requirements.

In 2024, a CON application approval allowed Yale New Haven Health System to acquire Prospect CT's three Connecticut hospitals, contingent on Yale New Haven Health System limiting growth in commercial prices to within 0.5% of the cost growth benchmark for the first five years.

Delaware's Hospital Cost Review Board

Delaware was the second state to establish a cost growth benchmark, initially through Executive Order 25 in 2018 and later codified through House Bill 442. The Delaware Health Care Commission oversees the cost growth benchmark initiative.

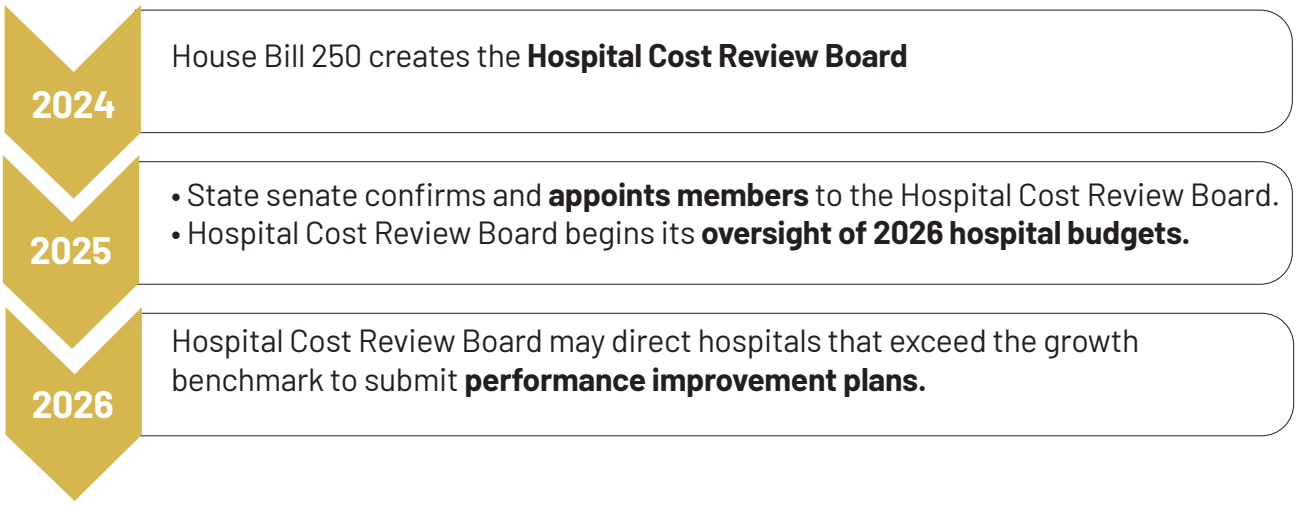
Despite years of public reporting, Delaware has exceeded its cost growth benchmark in every year since its inception (except for 2020), with cost growth ranging from 5.8% to 11.2%. In June 2024, the Delaware legislature cited this consistent failure to meet the benchmark as grounds for pursuing stronger cost containment tools, and enacted House Bill 350, creating the Diamond State Hospital Cost Review Board ("the Board").

Modeled loosely on the Vermont Green Mountain Care Board's Hospital Budget Review process, the Board has the authority to conduct annual reviews of hospital budgets and related financial information and ensure that hospital prices grow at a more sustainable pace. Part of the Board's review includes determining whether the hospital has met the state's health care spending benchmark.

Starting in 2026, the Board can require hospitals that exceed the spending benchmark to submit a PIP that details specific actions (e.g., renegotiating contracts, streamlining operations) they will take to improve cost performance. Exceeding the benchmark does not automatically trigger a PIP requirement, however. The Board has the flexibility to grant exceptions or waivers for unique circumstances.

Once approved, the hospital implements its PIP under the Board's supervision, providing regular progress updates and any additional data as requested. If the hospital meets its cost-reduction goals, the process concludes; otherwise, more stringent measures may follow. If a hospital does not show sufficient improvement or refuses to comply, the Board can issue fines, increase oversight, or limit rate increases. The type of penalty imposed is intended to reflect the severity of noncompliance. If a hospital exceeds its board-approved budget, the Board may either deduct the overage from the following year's

Figure 2. Delaware Hospital Cost Review Board Implementation Timeline



budget or permit the hospital to retain the extra revenue. The Board's authority to approve a hospital's budget expires after three consecutive years of successful budget compliance.

As of June 2025, the state senate has confirmed all eight members to the Board. The Board began its work in 2025 (see Figure 2). Although early in its implementation, the Board has already faced opposition. Delaware's largest hospital system filed a lawsuit in July 2024 challenging its constitutionality.

Figure 2. Delaware Hospital Cost Review Board Implementation Timeline

Key Themes

After several years of cost growth target program implementation, states are now progressing from transparency and reporting toward more robust accountability strategies. This shift marks the next phase in the evolution of cost growth target programs. Some strategies are directly tied to cost growth target performance (e.g., financial penalties for exceeding the cost growth target) and others are complementary affordability strategies that leverage the cost growth target (i.e., the authority to deny a merger or acquisition based on its potential to impact cost growth target performance). Massachusetts, Delaware, Oregon, and California's efforts in particular serve as a road map for other states seeking to strengthen accountability to their cost growth targets. Although each of the four pioneering states has adopted distinct strategies, several common themes have emerged.

Enforcing Judiciously

A key consideration for states is judicious use of enforcement—taking action frequently enough to deter noncompliance but not so frequently that minor transgressions or single-year anomalies are penalized. Massachusetts has employed its enforcement tools sparingly. The Massachusetts HPC refrained from formal enforcement actions for years, only requiring a PIP from MGB in 2022, after six prior benchmark violations. Some stakeholders in the state believe this led to payers and providers not taking the cost growth target seriously. Oregon recently examined 28 organizations whose cost growth in 2022 exceeded the state's target but concluded that only 3 had unreasonably high cost increases that would warrant corrective action. Determining when to apply corrective action is a delicate balance. States must ensure entities view the cost growth target as a meaningful standard, rather than a suggestion. If enforcement authority is rarely applied, its impact will be diminished.

Balancing Clarity and Discretion

States must also balance the transparency of having explicit guidelines with the flexibility to address unanticipated circumstances when defining "excessive" cost growth. Oregon uses subregulatory guidance that lists acceptable reasons for temporarily exceeding the benchmark, such as expanding essential services or facing unexpected labor cost surges. Oregon also publishes its determinations for every entity that surpasses the target each year, which enhances transparency. However, by including these reasons in subregulatory guidance, Oregon has eliminated some flexibility to respond to unanticipated circumstances. Massachusetts, by comparison, follows a case-by-case review process, where entities can present evidence to justify overspending. The Massachusetts model offers greater flexibility than Oregon's, but also requires more subjective judgments, which can lengthen the review process and can create uncertainty in enforcement outcomes. Furthermore, Massachusetts discloses only those entities required to undertake PIPs, making its process less transparent than Oregon's.

Allowing Flexibility in the Choice of Strategies to Achieve Target Savings

Flexibility in enforcement, particularly in how PIPs are structured, is also important. States requiring PIPs set savings targets for entities but do not prescribe operational changes or cost-reduction tactics. This flexibility enables provider organizations and payers to tailor strategies to their unique markets, patient populations, and internal constraints. For example, the Massachusetts HPC specified the savings target for MGB but allowed the system to determine how best to achieve those reductions. Similarly, Oregon allows entities identified for a PIP to propose strategies, such as renegotiating contracts or streamlining care pathways. Delaware's emerging Hospital Cost Review Board also follows this model, giving hospitals that exceed the statewide benchmark the autonomy to propose corrective strategies, provided they meet the Board's criteria.

Building Robust Infrastructure

States need sufficient infrastructure and resources to implement enforcement tools like PIPs and financial penalties, as well as to leverage their cost growth target through mechanisms such as cost and market impact reviews. States must be equipped to collect and analyze complex financial and clinical data, conduct confidential and public reviews, and engage with health care entities. Massachusetts' HPC is supported by its sister agency, CHIA, which provides detailed data for evaluations of provider organizations and payers' spending. Reviewing MGB's finances and validating reported savings required extensive HPC staff time, sophisticated analytics, and ongoing collaboration with the health system.

States that are comparatively less resourced may struggle to replicate this level of rigor. States could choose to contract out data analysis, but some amount of qualified state staffing will always be needed to direct and oversee the work. Although stronger enforcement tools like PIPs may control cost growth more effectively than public reporting alone, states lacking resources may find such data-driven enforcement challenging to sustain.

Anticipating Resistance

It is important for states moving from transparency to enforcement to anticipate substantial resistance from health care payers and provider organizations. Publishing spending data alone has not triggered legal action in any state, but imposing financial penalties, mandating PIPs, or setting budget guidelines has provoked opposition, including lawsuits. Delaware's largest hospital system, for instance, sued the state to contest the authority of its new Hospital Cost Review Board. In California, the hospital association has spoken out against the state's planned hospital-specific cost growth targets. States must prepare to manage legal and political challenges while continuously refining their enforcement strategies to maintain accountability.

CONCLUSION

States with cost growth target programs must supplement public reporting of target performance with stronger enforcement measures, such as PIPs and financial penalties. Massachusetts, Oregon, and California provide valuable models for how to do so. Other complementary affordability strategies can be used to reinforce the cost growth target, such as hospital cost review boards and cost and market impact reviews. States should consider implementing these policies to achieve meaningful progress on curbing rising health care costs.

ABOUT THE AUTHORS

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

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

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

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