# Lessons Learned from State Efforts to Slow and Shift Health Care Spending

BY ROBERT SEIFERT, EMMA ROURKE, AND MARY JO CONDON,
FREEDMAN HEALTHCARE

REPORT | FEBRUARY 2025

Peterson-Milbank
Program for Sustainable
Health Care Costs

# CONTENTS

Abstract .................................................. 4

Introduction .................................................. 5

Theory of Change .................................................. 7

Setting the Targets: Policy Approaches .................................................. 8

States' Experiences Implementing Targets: Emerging Themes and State Approaches .................................................. 10

Conclusion .................................................. 16

About this Report .................................................. 18

About The Authors .................................................. 19

## About the Peterson Center on Healthcare

The Peterson Center on Healthcare is a non-profit organization dedicated to making higher quality, more affordable healthcare a reality for all Americans. The organization is working to transform US 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.

## About the Milbank Memorial Fund

The Milbank Memorial Fund works to improve population health and health equity by collaborating with leaders and decision makers and connecting them with experience and sound evidence. Founded in 1905, the Milbank Memorial Fund advances its mission by identifying, informing, and inspiring current and future state health policy leaders to enhance their effectiveness; convening and and supporting state health policy decision makers to advance strong primary care and sustainable health care costs; publishing high-quality, evidence-based publications and The Milbank Quarterly, a peer-reviewed journal of population health and health policy. For more information, visit www.milbank.org.

## About The Peterson-Milbank Program for Sustainable Health Care Costs

The Peterson-Milbank Program for Sustainable Health Care Costs supports state-led efforts to make health care more affordable for everyone. Starting with setting a target for reasonable cost increases, states across the country are collecting data on their annual health care spending and analyzing it to find the cost growth drivers. With this information, everyone in the state who has a stake in health care can work together to identify community-wide solutions to improve affordability. For more information, visit The Peterson-Milbank Program for Sustainable Health Care Costs.

## Freedman HealthCare

Established in 2005, Freedman HealthCare (FHC) is a focused, independent consulting firm that helps states put health data to work to solve complex problems. FHC's team of seasoned experts support clients in using data to identify opportunities to improve healthcare quality, affordability and equity and measure the impact of meaningful policy change. FHC's work to develop and implement health policy initiatives, including measuring progress toward quality and cost growth, primary care and behavioral health investment targets, in more than 15 states and several national non-profit organizations provides us with a broad and deep understanding of various healthcare data sources, and how to make meaningful connections.

© 2025 Milbank Memorial Fund. All rights reserved. This publication may be redistributed digitally for noncommercial purposes only as long as it remains wholly intact, including this copyright notice and disclaimer.

Milbank Memorial Fund
645 Madison Avenue
New York, NY 10022
www.milbank.org

## ABSTRACT

State governments have created a pathway to improve health care affordability by setting targets (or benchmarks) for annual cost growth. Some of these states have concurrently set targets for primary care investment and the adoption of alternative payment models, reflecting the theory that these goals are mutually supportive and their parallel achievement can result in improved health outcomes. This report describes the experiences of states that have designed and implemented policies to pursue these multiple targets and gathers lessons from their experiences to inform future policy development. Interviews with state officials and a multi-state convening revealed the strategies states used to establish their targets and their experiences implementing them. Officials described challenges to implementation and efforts to overcome them. Three major themes emerged:

1. Multi-stakeholder alignment is critical; achieving it requires a clear, shared vision and close, ongoing collaboration.
2. The shared vision should provide a framework to articulate the multiple goals holistically.
3. Enforcement and accountability can be messy and non-linear; creativity, patience, and fortitude are common attributes of the most successful approaches.

The states' experiences can serve as a map for other states interested in using the complementary strategies of cost growth, primary care investment, and alternative payment model targets to make health care more affordable and improve outcomes.

# INTRODUCTION

The high cost of health care continues to vex American society, consuming nearly one-fifth of the national economy, displacing other critical public investment priorities, and affecting the finances, health, and well-being of millions of people. Some state governments, with input from stakeholders, have created a pathway to make health care more affordable by setting targets (also called benchmarks) for annual per-person health care cost growth, challenging payers and providers to keep annual increases below a defined threshold. To promote improved health along with cost containment, some of these states also have established targets for primary care spending, usually expressed as a portion of total health spending. (The terms "primary care spending" and "primary care investment" have the same meaning in this report.) These policies are based on the idea (and international evidence) that increasing investment in primary care benefits population health and, over time, reduces the need for more costly, intensive services. With similar intent,[1,2] some states also have set targets for health care payers to move toward alternative payment models (APMs) that aspire to reward providers for quality and value rather than the volume of services they provide.

Table 1 shows the states that have some combination of these policies. Several of these states (Maryland, Connecticut, and Rhode Island) along with a few other states and jurisdictions (Vermont, Hawaii, and five New York counties) are pursuing similar objectives as participants in the federal "States Advancing All-Payer Health Equity Approaches and Development" (AHEAD) model. AHEAD is currently in the planning stage and is scheduled to launch in January 2026.[3]

Table 1. States with Combinations of Cost Growth, Primary Care Spending, and Alternative Payment Model Targets

| State | Cost Growth Target | Primary Care Spending Target | Alternative Payment Model Target |
|---|---|---|---|
| California | X[a] | X[b] | X[c] |
| Connecticut | X[d] | X[d] | 0 |
| Delaware | X[e] | X[f] | X[f] |
| Maryland | X[g] | X[h] | 0 |
| Massachusetts | X[i] | 0 | 0 |
| Oregon | X[j] | X[k,l] | X [k,l] |
| Rhode Island | X[m] | X[n] | X[n] |
| Washington | X[o] | 0 | X[o] |

X: Denotes states that have set a target.
0: Denotes states that measure and monitor spending but have not (or not yet) established a target.

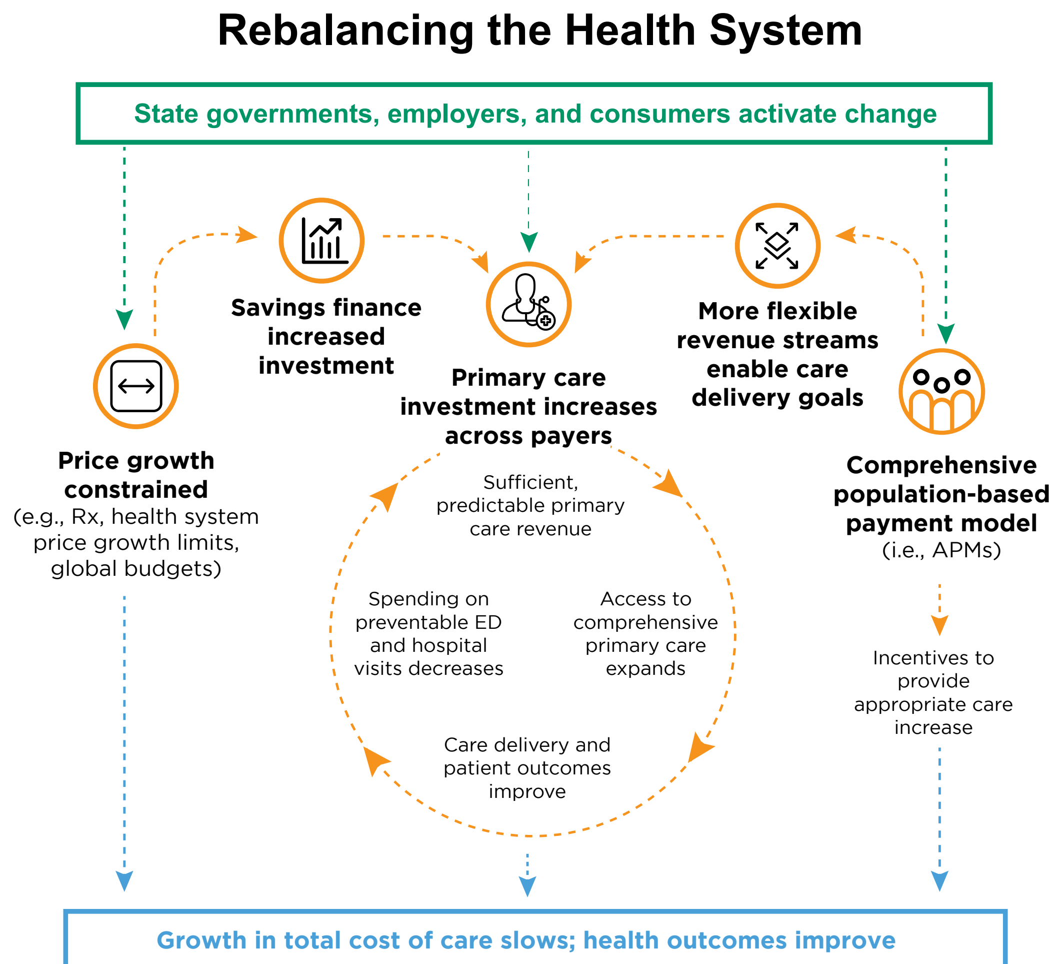
[a] California Department of Health Care Access and Information. Statewide Health Care Spending Target Approval Is Key Step Towards Improving Health Care Affordability for Californians. Published April 24, 2024. https://hcai.ca.gov/statewide-health-care-spending-target-approval-is-key-step-towards-improving-health-care-affordability-for-californians/.
[b] California Department of Health Care Access and Information. Primary Care Investment Benchmark. https://hcai.ca.gov/affordability/ohca/primary-care-investment-benchmark/.
[c] California Department of Health Care Access and Information. Alternative Payment Model Standards and Adoption Goals. https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/apm-standards-and-adoption-goals/.

[d] Connecticut Health Strategy. Healthcare Benchmark Initiatives. https://portal.ct.gov/ohs/-/media/ohs/cost-growth-benchmark/public-hearing/ohs-healthcare-benchmarks-initiative—-executive-summaries.pdf.
[e] Delaware Code. Title 16, Chapter 99, § 9903(k). Delaware Health Care Commission. https://delcode.delaware.gov/title16/c099/sc01/index.html#9903
[f] Delaware Code. Title 18, Chapter 3, § 334. Office of Value-Based Health Care Delivery. https://delcode.delaware.gov/title18/c003/index.html#334.
[g] Health Services Cost Review Commission. Maryland's Total Cost of Care Model. https://hscrc.maryland.gov/Pages/tcocmodel.aspx.
[h] Maryland Health Care Cost Commission. Primary Care Investment Analysis and Reporting Plan. Published October 2023. https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/pcw/pci_wrkgrp_rpt.pdf
[i] Massachusetts Health Policy Commission. Health Care Cost Growth Benchmark. https://masshpc.gov/cost-containment/benchmark.
[j] Oregon Health Authority. Health Care Cost Growth Target. https://www.oregon.gov/oha/hpa/hp/pages/sustainable-health-care-cost-growth-target.aspx.
[k] Oregon Health Authority and Department of Consumer and Business Services. 2022 Primary Care Spending in Oregon Report Executive Summary. Published October 2024. https://www.oregon.gov/oha/HPA/ANALYTICS/APAC Page Docs/2024-PCSR-executive-summary.pdf.
[l] Oregon Legislative Assembly. Senate Bill 934. 2017 Regular Session. https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/SB934.
[m] Rhode Island Office of the Health Insurance Commissioner. Health Spending Accountability and Transparency Program. https://ohic.ri.gov/policy-reform/health-spending-accountability-and-transparency-program.
[n] Rhode Island Office of the Health Insurance Commissioner. 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner.
[l] Washington State Health Care Authority. Health Care Cost Transparency Board. https://www.hca.wa.gov/about-hca/who-we-are/health-care-cost-transparency-board.
[o] Washington State Health Care Authority. Washington Multipayer Primary Care Transformation Model (PCTM). Finalized January 27, 2022. https://www.hca.wa.gov/assets/program/wa-pct-model-description.pdf.

This report describes the experiences of states that have implemented policies to measure and set targets for statewide health care cost growth, primary care spending, and APM adoption, and gathers lessons from these experiences to inform their future policy development and guide other states planning similar initiatives. The information draws from a series of interviews with officials from six states conducted during the summer of 2024 and a roundtable convening of representatives of five of these states in October 2024. The interviews covered topics such as governance of the initiatives; how the state publicly articulated its goals and generated stakeholder buy-in; the mechanisms used to set the growth targets; the state's approach to collecting data and holding payers accountable for achieving the targets; and lessons learned from its experiences to date. The multi-state convening expanded on these topics and gave state officials the opportunity to interact and compare their experiences. Using these lessons, states pursuing these strategies can refine them, and states considering similar policies can benefit from them in their planning. Using targets for cost growth, primary care investment, and APM adoption can be an important tool in making health care more affordable, if the targets are realistic, broadly accepted, and effectively enforced.

# THEORY OF CHANGE

**Figure 1. Theory of Change to Achieve Cost Growth Targets**




States working to contain cost growth while also increasing investment in primary care and, for some, expanding the use of APMs have an implicit or explicit theory of how these goals interact and support each other. During the interviews, the theory of change depicted in Figure 1 emerged. The diagram was informed and modified by interviewees' perspectives on the key interactions among primary care investment, population-based payment models, and health care cost growth. Though these interactions are more complex in practice than in theory, the model in Figure 1 shows the concepts that underlie the states' approaches to improving health outcomes while slowing the growth of health care costs.

This model shows cost growth constrained through government policies and contracting practices that are driven by state government leaders, employers, and consumers who demand change. As described, one way for states to inspire and devise policy changes that will moderate cost growth is to work with health care stakeholders to set annual targets for the growth of total health care costs. Such target programs involve states collecting and analyzing payers' health care spending data, then publishing reports so that stakeholders may transparently identify cost drivers and policy solutions. The savings from lower health

care cost growth can be reallocated to investments in primary care. At the same time, payers' expanded use of APMs supports improvements in primary care by creating more flexible revenue streams for primary care practices. For example, when a primary care practice receives a capitation payment — a fixed monthly payment for each of its patients, regardless of their service use — it can use some of that revenue for care coordination, which adds value and improves outcomes but is not always a payable service in a fee-for-service structure.

The theory aligns with the recommendation of the National Academies of Science, Engineering, and Medicine that the increased and predictable revenue flowing to primary care providers as a result of the reallocation of savings and the adoption of APMs will allow for the expansion of comprehensive primary care, which improves care delivery and outcomes and reduces spending on more costly emergency department visits and hospital stays that are preventable with better primary care.[4]

## SETTING THE TARGETS: POLICY APPROACHES

With this theory of change in common across the states, the interviews with state officials addressed how they established their targets for cost growth, primary care investment, and, if relevant, APM adoption, and whether they were satisfied with the target levels.

Most states used a multi-stakeholder work group or advisory group process — involving payers, providers, consumer representatives, and state government, among others — to set their cost growth target. Maryland collaborated with the Centers for Medicare and Medicaid Services (CMS) to set its target because of the state's ongoing agreement with CMS to manage the total cost of care. States are generally satisfied with their cost growth target level, but perspectives varied. Some state officials credited an inclusive, data-driven process for their satisfaction. Another state official said their target level was appropriate because there had not been significant complaints about it; still another said its aggressive target was meant to signal that it was not reinforcing the status quo. The states noted a lack of universal support across stakeholders, with some providers and payers pushing back on the targets as being too aggressive or not allowing sufficient ramp-up to address underlying cost structures.

States also used multi-stakeholder work groups to develop their primary care investment targets (Table 2), in most cases after first adopting a detailed definition of the providers, services, and care settings that constitute primary care. There was some uncertainty among state officials about whether their primary care target was at the "right level." One state official expressed the need for a national standard definition of primary care for the purpose of measuring primary care investment. States cited the absence of data on which to base a recommended threshold, though one state looked to other countries with high-performing health systems and positive reported primary care experiences for guidance. In Oregon, the decision to include a broad range of behavioral health and other services led to higher baseline primary care spend than originally projected. And in some states, officials felt that payers gamed the target by attributing more non-claims payments to primary care than were justified. One state cited primary care physicians who reported not seeing the level of investment payers claimed to be making in primary care through shared savings arrangements with providers, suggesting the payers were exaggerating the amount that this APM allocated to primary care. The experiences of these early states can help inform the development of a standard that could benefit other states undertaking measurement and benchmarking initiatives in the future.

## Table 2. Examples of State Primary Care Investment and Cost Growth Targets

| State | Primary Care Investment Target | Payers Affected | Cost Growth Target | Payers Affected | Alternative Payment Model Target | Payers Affected |
|---|---|---|---|---|---|---|
| CA | Increase 0.5%–1% of total medical expenses (TME) per year; 15% of TME by 2034 | All | 3.5% for 2025 and 2026, 3.2% for 2027 and 2028, 3.0% for 2029 and beyond | All | 95% attributed to Health Care Payment Learning & Action Network (HCPLAN) categories 3 and 4 | Commercial HMO and Medicare Advantage |
| | | | | | 75% attributed to HCPLAN categories 3 and 4 | Medi-Cal |
| | | | | | 60% attributed to HCPLAN categories 3 and 4 | Commercial PPO |
| CT | 10% of TME by 2025 | All | 4.0% for 2024, 2.9% for 2025 | All | None | |
| DE | 11.5% of TME by 2025[a] | Commercial fully insured | 3.0% for 2024 | All | 50% for HCPLAN category 3, 25% for HCPLAN category 3B, by 2023 | Commercial fully insured plans with >100,000 covered lives |
| RI | 10.7% | Commercial | 5.1% for 2024, 3.6% for 2025 | Commercial | 50% by 2018 | Commercial |
| OR | 12% | Commercial fully insured, state employees, Medicaid | 3.4% for 2021–2025, 3.0% for 2026 | Commercial fully insured, state employees, Medicaid | 70% by 2024 | Coordinated care organizations |

[a] Applies to members attributed to providers engaged in care transformation activities; the table shows the culmination of four years of gradual required increases of 1.5% of TME.

Note: The table includes states that have both a cost growth target and primary care investment target.

Some states are considering moving from a target for primary care investment framed as a percentage of total health care spending to one that reflects a specific investment level to support improvements in primary care delivery. In high-cost states, a target based on percentage of total spending may be more than what is needed to make evidence-based improvements in primary care; such a target could be inflationary. There may also be variation in how targets based on a percentage of spending affect different markets — commercial, Medicare, and Medicaid. For example, in a Medicaid program where total spending and reimbursement for specialty care are seen as low, primary care investment might appear relatively high as a percentage of the total, even if it is not sufficient to improve access and outcomes as the theory of change predicts. An emerging alternative approach is to determine

the amount required to sufficiently expand and update primary care practices — costs of additional care team members, infrastructure, and so on — and develop a target level of investment per member based on those costs.

Not all states have goals for APM adoption. Some encourage, monitor, and report on APM adoption without setting a specific target. One official emphasized that APMs in states that set a target should include a quality component that would count toward meeting the target. One state has seen significant progress on APM adoption that was not necessarily attributable to its target. Instead, payers had moved more dollars to APMs to enable them to meet the state's primary care target without increasing their fee-for-service rates.

## STATES' EXPERIENCES IMPLEMENTING TARGETS: EMERGING THEMES AND STATE APPROACHES

Health care delivery systems are complex. Solutions for containing cost growth, including increasing primary care investment and APM adoption, reflect those complexities. Stakeholders in different circumstances might view potential solutions as beneficial to their missions or as a hindrance. Payers face different incentives and constraints depending on their size, nonprofit status, and whether they are subject to state laws and regulations. Providers have similarly diverse motivations. Policymakers undertaking efforts to manage cost growth and increase primary care investment must make decisions within this environment about their policies' goals, the scope of the effort, and the tools they can use to attain their goals. Several themes emerged from the interviews with state officials, including multi-stakeholder alignment, goal messaging, and accountability. We explore how several states approached these challenges.

### *The Issue:* Multi-stakeholder alignment requires a clear, shared vision and close, ongoing collaboration.
### *One State's Approach:* Drive alignment through public agency collaboration.

Most states with both cost growth and primary care spending targets rely on voluntary alignment among stakeholders, including insurers, employers, and providers, to achieve the targets. The consensus among states, however, is that voluntary alignment around spending targets has been ineffective because of the disparate interests and motivations of the actors. As one official simply stated, "multi-payer alignment is hard."

**Cost growth targets.** Commercial payers are reluctant to commit voluntarily to cost growth goals in many states. State authority extends only to payers' fully insured plans, which are often a minority of their business. State governments have no enforcement power over large, multi-state, self-funded employers covered by the Employee Retirement Income Security Act of 1974, often referred to as ERISA. Payers often act as third-party administrators (TPAs) for these self-insured employers. As TPAs, payers are less motivated to pursue voluntary cost growth goals, particularly if the employers whose plans they administer are not championing those efforts. Indeed, state officials report little employer involvement in the state cost

containment efforts; as one put it, "no one is breathing down the necks of insurers to control spending." Self-insured employers' businesses and employees are often spread across multiple states, making any one state's cost growth targets less of a priority. Public employers are similarly removed from efforts to constrain cost growth, though for different reasons, according to state officials. State purchasers often are unwilling to use political capital to bring about change, for example by negotiating more aggressively with providers to achieve cost growth targets. On the other hand, Medicaid programs in some states have made better progress on meeting cost growth targets than commercial payers, presumably because the state has more direct influence on spending through their contracts with Medicaid managed care or accountable care organizations, or because overall spending and growth are constrained by public processes and state budgets.

Providers pose another challenge to achieving voluntary multi-stakeholder alignment on cost growth. Hospitals, especially those considered to be "must-have" hospitals for payers' networks, do not have incentives to participate. Hospital business models often focus on delivering high-margin services; from a hospital's perspective, efforts to slow spending growth are efforts to slow revenues. Relying on hospitals to limit revenues voluntarily, without incentives, is likely to have limited success.

New business models for health care organizations also can be a disruptive force where alignment is desired. Private equity owners of hospitals, physician groups, and other health care providers, for example, have short-term investment horizons and profit imperatives that are likely in conflict with cost growth targets and insensitive to enforcement mechanisms.

**Primary care investment.** Primary care investment targets face specific barriers related to stakeholder alignment. Some state purchasers, who face short time horizons linked to annual state budget pressures, are less open to the potential savings opportunity of increased primary care investment, because it does not yield immediate savings and may even increase short-term costs. Commercial payers tend to share similar concerns. Hospital systems, even those that own primary care practices, do not see primary care as a major profit center. Without meaningful incentives, they appear to have little business rationale to invest additional resources in primary care.

In addition to impeding the achievement of payment goals, the absence of alignment among payers on primary care investment efforts burdens primary care practices. If additional payments to reward performance or support practice transformation come from only some but not all payers, or if payers use different criteria for awarding enhanced payments, the money can be stretched too thin to have the intended effect, and the variety of requirements and metrics might be too burdensome an administrative task for practices to take on. This result may lead to a perception that an initiative does not have value, dampening enthusiasm for future primary care expansions.

These challenges to voluntary alignment among stakeholders point to the need for a force to drive alignment, or, in the context of the theory of change depicted in Figure 1, a motivator to set change in motion. Such motivation can come from political leaders in either the legislative or executive branch, stronger enforcement tools for administrative agencies, a respected champion among large employers, or an organized consumer voice.

### California's multi-agency collaboration

California's strategy is to drive stakeholder alignment through the focused collaboration of the state agencies that are key stakeholders. Three agencies — the Department of Health Care

Services, which administers the Medicaid program; CalPERS, which provides coverage for state employees and retirees; and Covered California, the state's health insurance exchange — account for the health insurance coverage of about half of California's residents. These three purchasers have collaborated to align many elements of their contracts with health insurers, including quality performance incentives, health equity requirements, and primary care and behavioral health standards.

When the state's Office of Health Care Affordability (OHCA) was created to establish and monitor targets for cost growth, APM adoption, and primary care investment, the office built on the existing collaborative spirit among the public purchasers and convened a work group together with related departments. In addition to purchasers, the work group includes the agencies that regulate the health insurance industry. In bimonthly sessions, the work group has reviewed and offered input on OHCA's proposed definitions, data collection approaches, and targets. As a result of this regular opportunity to help shape the targets, the public purchasers have committed to supporting the targets and have incorporated some of them into their contracts with payers.[5] In addition to aligning targets, the work group is working to align data collection structures and processes to limit the reporting burden on insurers. Purchasers responsible for half the state's coverage are actively engaged in the development process and supportive of OHCA's aligned targets, thus reinforcing the targets.

This early success could provide momentum for other purchasers and insurers to follow the state agencies' lead. The key to the approach is having the agencies work together to align their priorities for the targets and their values internally before making the targets public.

### *The Issue:* Shared vision is needed to articulate goals holistically. *One State's Approach:* Use regulations to make goals explicit and set expectations.

Slower health care cost growth and increased primary care investment can seem like conflicting goals. While Figure 1 illustrates that they can be mutually supportive, states sometimes struggle to explain to stakeholders their holistic vision of health care spending. Some states take this on directly, explaining the interacting strands of their policy vision to stakeholders and the public in forums and policy work groups. Others face political or bureaucratic constraints, described below, that limit their ability to do this. As noted, most states rely heavily on multi-stakeholder work groups to test ideas, gather input, develop a shared vision for the future, and solicit feedback. These work groups tend to be both necessary and insufficient. Unless states bring significant enforcement power and the political will to use it, the best chance for success is for stakeholders to believe the targets are achievable and represent meaningful compromise; otherwise, targets risk being ignored. This level of negotiation tends to occur in one-on-one and smaller group conversations with like-minded stakeholders.

Some states report being able to deliver a clear message about their aims. One official spoke of using a "triangular" approach, in which they talk about managing cost growth, increasing primary care investment, and improving quality in a connected way. Another describes primary care investment and APM adoption as vehicles to promote savings and high-value care and ties the targets to the goal of improved affordability for consumers. That state emphasizes that the intention is not to "shrink the pie," but for it to grow more slowly, and that part of their strategy for this is to better allocate health care dollars and change the relative size of the pie's slices. The connection between the goals may be easier to understand in

states that have policies to offset increased primary care spending — through hospital global budgets, for example, or limits on hospital price growth. States recognize that achievement of cost growth goals might lag an increase in primary care investment. As a result, there is some tolerance, either formal or informal, for falling short of short-term cost growth goals due to demonstrated increases in primary care investment.

Other states report challenges in describing multiple goals simultaneously. Most states (Rhode Island is an exception, as described next) rely on the agencies implementing the targets to communicate their interdependence, rather than making that explicit in statute or regulation. The agencies can be limited in their ability to exert the influence necessary to move stakeholders toward concurrent multiple goals because of conflicting agency priorities, absence of committed leadership, or vocal stakeholder resistance, for example. The lack of a clear, overarching message can lead to mischaracterization of the goals. For example, state officials report stakeholders perceiving the state as simply aiming to reduce costs without considering optimal reallocation of dollars, and payers citing increased primary care investment as a rationale for disregarding the cost growth benchmark. One state official explained that difficulty in talking about multiple goals might result in focusing primarily on one, typically the cost growth targets. Adding to this challenge is the widespread concern across states about the health care workforce. Strategies to relieve shortages — through increased investment or rate increases, for example — can be in tension with states' other goals around spending.

### Rhode Island's affordability standards

Rhode Island describes in its regulations for the Office of the Health Insurance Commissioner (OHIC) the state's goals of improving quality and reducing costs and its requirements for commercial payers (not Medicaid, and only indirectly for self-insured employers) to achieve that goal. The regulations, known as the "Affordability Standards," state that affordability depends on "improving the performance of the Rhode Island health care system as a whole."[6] To accomplish this, the Affordability Standards "emphasize insurer investment in primary care, integration of physical and behavioral health care, utilization of alternative payment models, structural provider contracting requirements that limit cost growth and encourage quality improvement, and alignment of clinical quality measures across value-based contracts."[7] Each subsection of the regulations includes a clear statement of its purpose, and the regulations concentrate authority to set and enforce insurers' compliance with the Affordability Standards within OHIC.

Incorporating standards into regulations in this way can make policies cumbersome to change; other states' statutes and regulations simply establish an extra-regulatory process for setting spending standards and targets, which creates more flexibility but might weaken the state's authority to enforce the targets. Rhode Island's approach is useful in making clear how the standards support improvements and how those improvements are necessary for achieving affordability goals. Investing responsibility for communication with stakeholders, implementation, and enforcement in a single agency whose purpose is to regulate commercial health insurance helps Rhode Island address the barriers to articulating goals that other states face.

## *The Issue:* Enforcement approaches should blend creativity, fortitude, and patience to achieve accountability.
## *States' Approaches:* Foster accountability with data collection and through contracting and compacts.

All states agree that the enforcement of targets has been weak. Officially, states have a range of enforcement tools, ranging from transparency through the ability to impose performance improvement plans and penalties. Though state law or regulations might invest an agency with enforcement power, compliance with spending targets in most states is effectively voluntary, particularly for private-sector payers. In the current environment, states have little more than public exposure and private persuasion as means to influence payers to change their spending. This is often insufficient; as one state official put it, "transparency doesn't drive change." Some states with stronger enforcement tools do not yet have experience using them, as their programs are in early implementation stages.

One notable disconnect is that regulatory authority to enforce compliance or impose penalties for not meeting the targets frequently does not lie with the agency that sets and monitors the spending targets. Payers in many states follow rules set by departments of insurance or managed care, or by the Medicaid agency. A health care reform-focused agency with governance over cost growth and payment goals often has no authority to apply direct pressure on commercial and Medicaid health plans to achieve targets. When enforcement authority is placed with the insurance regulator or, alternatively, with the Medicaid agency, it can be challenging for those agencies and their constituencies to align their priorities.

States have had better success holding payers accountable when a contractual obligation is involved. Some states report seeing progress on spending goals among the payers that contract, largely or exclusively, with the state Medicaid program. In the same states, commercial payers operating in a more voluntary relationship to the state do not perform as well in meeting cost growth and primary care spending targets. State laws and regulations may include a theoretical threat for noncompliance, but states report that substantial enforcement rarely occurs. Agencies with enforcement authority might forgo strong enforcement, which potentially alienates insurers, in the interest of other goals, such as keeping commercial insurers in the market to foster competition and hold down premium increases.

As noted, hospitals often do not have incentives to participate in slowing cost growth or increasing primary care investment. This makes it hard for payers to meet spending goals, especially when a large hospital system that is a crucial part of the network represents a significant portion of a payer's total spending. More generally, market consolidation among providers and payers is a barrier to slowing cost growth, because consolidation tends to drive prices higher and because dominant market actors have less incentive to meet benchmarks and more power to resist enforcement.

In addition, measuring payers' compliance with primary care spending targets can be a challenge and further limit enforcement. The degree to which non-claims payments to large health systems flow to primary care can be opaque and difficult to quantify. Results based on payers' data regarding achievement of targets can therefore be somewhat ambiguous, further hindering states' ability to use their enforcement tools.

### Delaware's approach to data collection and accountability

Health insurance carriers covering Delaware's commercial fully insured population submit data on primary care investment, price growth for hospital and other services, and APM adoption to the Department of Insurance's Office of Value-Based Health Care Delivery (OVBHCD) at least three times per year, and more frequently if the payer is at risk for non-compliance with its related regulations. Data are submitted for individual, small-group, and large-group markets with information on non-claims payments to support primary care, reported by payment type and provider organization. The OVBHCD provides robust, carrier-specific technical assistance each year, including working with the carriers one-on-one to develop plans to achieve compliance. The state recently began requiring additional quarterly data submissions to more closely monitor progress throughout the year and make the technical assistance sessions more productive. Aggregate results from the Affordability Standards Data Submission are published in the office's annual report.

### Oregon's experience with integrated, voluntary targets

Oregon sets targets for per-person cost growth, APM adoption, and primary care investment. The Oregon Health Authority (OHA) and the Department of Consumer and Business Services signed a voluntary compact with 47 health care entities, which committed to explicit APM targets: 35% of their total budgets in 2021, 40% in 2022, and 70% by 2025. In addition, Oregon's target for cost growth per person in 2021–2022 was 3.4%. OHA published results in August 2024 showing that about half of the payers in the state met the 2022 APM target, and half of the payers met or were below its cost growth target. Six payers met both targets, and four of them are coordinated care organizations, which contract with the state's Medicaid program. Eight payers — all in either Medicare Advantage or commercial lines of business — did not meet either of the targets. (The primary care investment target — set at 13% of total spending — was first enforced for 2023, and results have not yet been reported.)

It is notable that coordinated care organizations were the most successful group of payers in achieving the targets. These health plans contract with the state's Medicaid program, which is administered by OHA. Those contracts are more likely to reflect the state's cost growth and payment targets, and to provide assurance that pursuit of the targets is monitored and enforced. In contrast, the voluntary nature of the APM compact and the state's lack of leverage to enforce the cost growth target in the commercial and Medicare Advantage markets leave payers and providers free to pursue their financial interests without the threat of material penalties for failing to achieve the targets. However, OHA's August 2024 report published every payer's results by name, calling out those that failed to achieve either target and those that achieved both, as well as those that achieved one or the other.[8] OHA also adopted updated regulations in July 2024, requiring a performance improvement plan beginning in 2025 and, beginning in 2028, assessing financial penalties for payers and provider organizations that do not meet the cost growth target.[9] It remains to be seen whether these additional measures have an effect on future results. If not, the Oregon legislature can consider making the APM targets mandatory and authorizing stronger enforcement tools.

# CONCLUSION

Several states are seeking to make health care more affordable and improve health outcomes by pursuing a strategy that combines targets for cost growth, primary care investment, and the use of APMs. Officials responsible for carrying out their states' policies have made inroads into aligning the interests of stakeholders, articulating how separate but interrelated goals support the state's policy vision, and holding stakeholders accountable for achieving the targets. States have learned:

- Multi-stakeholder alignment requires a clear, shared vision and close collaboration. One way to achieve this is by creating a vehicle for public purchaser collaboration as a vanguard to drive the engagement of other payers and stakeholders.
- This shared vision is needed to articulate goals holistically. Regulations can make the goals explicit and establish expectations.
- Enforcement approaches blend creativity, fortitude, and patience to achieve accountability. Effective examples of this combination include an expansive data collection and monitoring approach and fostering accountability through contracting language and regulation.

During the multi-state convening that was part of this project, state officials were interested to hear from their counterparts in other states. For example, participants were interested in Oregon's criteria and process for determining when payers and providers have "acceptable reasons" for exceeding the cost growth target; Oregon officials shared with the group their sub-regulatory guidance on the topic.[10] In a similar way, legislators and policymakers in other states who are seeking to address health care affordability and the redistribution of health care dollars can look to the experiences of these early states, and the lessons they have drawn from those experiences, as a map for future policy development.

# NOTES

[1] National Academies of Science, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press, 2021. https://doi.org/10.17226/25983.

[2] Institute of Medicine. Primary Care: America's Health in a New Era. Washington, DC: The National Academies Press, 1996. https://doi.org/10.17226/5152.

[3] Centers for Medicare & Medicaid Services. States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. https://www.cms.gov/priorities/innovation/innovation-models/ahead.

[4] National Academies of Science, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press, 2021. https://doi.org/10.17226/25983.

[5] CalPERS. CalPERS Announces New Health Plan Contracts to Lower Costs While Improving Quality and Accountability. Published June 12, 2024. https://www.calpers.ca.gov/page/newsroom/calpers-news/2024/calpers-announces-new-health-plan-contracts-to-lower-costs-and-improve-quality-and-accountability.

[6] 230-RICR-20-30-4.9(A).

[7] State of Rhode Island Office of the Health Insurance Commissioner. Next Generation Affordability Standards: Concepts, Rationale, and Additional Information. https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/2021/November/OHIC-Next-Generation-Affordability-Standards-Concept-Paper.pdf.

[8] Oregon Health Authority. Health Care Cost Growth & Insurers' Value-Based Payment Compact. Published August 2024. https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2021-2022_VBP-and-CGT-performance.pdf.

[9] OAR 409-065-0040, OAR 409-065-0045.

[10] Oregon Health Authority. Oregon's Health Care Cost Growth Target Program: CGT-7 Sub-regulatory Guidance: Determining Reasonableness & Accountability. Published June 2024. https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20Meeting%20Documents/CGT-7-Subregulatory-Guidance-Reasonableness-PIPs-Penalties.pdf.

# ABOUT THIS REPORT

This report was informed by interviews and a convening with state officials in states with cost growth and primary care target, and in some cases, APM targets.

State Participant List

| State/ Organization | Participant Name | Job Title |
|---|---|---|
| California Office of Health Care Affordability | Margareta Brandt | Assistant Deputy Director |
| California Office of Health Care Affordability | Debbie Lindes | Manager, Health Care Delivery System Group |
| Connecticut Office of Health Strategy | Diedre Gifford | Commissioner |
| Connecticut Office of Health Strategy | Alexander Reger | Director, Health Care Benchmark Program |
| Connecticut Office of Health Strategy | Lisa Sementilli | Lead Planning Analyst |
| Delaware Office of Value-Based Health Care Delivery | Cristine Vogel | Director |
| Delaware Health and Social Services | Nancy Fan | Chair, Primary Care Reform Collaborative |
| Delaware Health and Social Services | Steven Constantino | Director of Health Care Reform/ Associate Deputy Secretary |
| Maryland Health Care Commission | David Sharp | Director, Center for Health Information Technology and Innovative Care Delivery |
| Maryland Health Care Commission | Melanie Cavaliere | Division Chief, Innovative Health Care Delivery |
| Oregon Health Authority | Zachary Goldman | Health Care Cost Economist |
| Oregon Health Authority | Summer Boslaugh | Senior Value-Based Payment Policy Advisor |
| Oregon Health Authority | Sarah Bartlemann | Cost Growth Target Program Manager |
| Rhode Island Office of the Health Insurance Commissioner | Cory King | Health Insurance Commissioner |

# ABOUT THE AUTHORS

**Robert Seifert** is a public policy professional with experience in public sector, not-for-profit, and university settings. His primary focus is health care policies and programs that seek to improve access to care and correct inequities in health care delivery and outcomes. As an independent consultant since 2022, he has worked on projects related to health care spending, Medicaid, telemedicine, medical debt, and private equity ownership of health care providers. From 2007 to 2022, Bob was a senior leader at Commonwealth Medicine, the health care consulting and operations division of the University of Massachusetts Chan Medical School.

Prior to joining UMass Chan, Bob was executive director of the Massachusetts Medicaid Policy Institute, a program of the Blue Cross Blue Shield of Massachusetts Foundation. Earlier, he was policy director of The Access Project, a national not-for-profit organization providing technical assistance to community-based advocacy groups, and health policy manager at the Massachusetts Division of Health Care Finance and Policy, a state government agency. He was an adjunct instructor in the Department of Public Health and Community Medicine at Tufts University Medical School from 2013 to 2022, teaching courses in health care reform and the US health care system.

**Emma Rourke,** CSPO, a project manager for Freedman HealthCare, brings her project management knowledge, stakeholder engagement experience, and writing and report development skills to form well-crafted deliverables and responsive project support. While at Freedman HealthCare, Ms. Rourke has led project management and report development exploring health plan compliance and potential expansion of essential health benefits, managed state APCD data governance and release processes, and supported state efforts to measure primary care spend. Ms. Rourke is also FHC's expert on communications, shaping and implementing social media and communications strategy for both internal and client use.

**Mary Jo Condon,** MPPA, a principal consultant for Freedman HealthCare, has supported multiple states in the development of care delivery and payment models that put primary care at the center, expand care teams, integrate community resources, and utilize data to address the medical, behavioral, and social needs of patients and caregivers. While at Freedman HealthCare, Ms. Condon has led multilayered, data-driven health policy projects requiring extensive stakeholder engagement, complex analytic methodologies, and clear, concise presentation of cost and quality outputs. Recent projects include leading the Delaware Department of Insurance Office of Value-Based Health Care Delivery, developing an environmental scan of state approaches to behavioral health investment, and supporting the states of Massachusetts, California, and Maryland in efforts such as measuring investment in primary care and behavioral health and uptake of alternative payment models.