

Policy Short Takes: State Policies that Establish Health Care Spending Targets

FOCUS ON BENDING THE COST CURVE

Policy Short Takes are short publications by MDH's Health Economics Program to summarize available evidence on particular health policy questions. We select topics for Policy Short Takes based on interest in the community and the availability of resources. This particular Policy Short Take is intended to supplement this year's report on health care spending trends.¹

In 2017, health care spending reached \$50.3 billion in Minnesota and \$3.3 trillion in the United States, continuing a persistent trend of health care spending growth.² Increasingly, policymakers, payers, and employers in Minnesota and across the country have been looking for ways to make health care more affordable and to limit future spending growth. However, as we have reported elsewhere, there are considerable barriers to containing spending growth, and evidence of measurable success has been modest to date.³

Increasingly, states' are becoming impatient and at the same time aware of their ability to serve as laboratories for reform, and are implementing or are considering a range of options to address health care affordability, including by containing trends in health care spending.⁴ These efforts range from governors, such as from California and New Jersey, establishing state offices focused on consumer affordability to state legislatures establishing price transparency initiatives, such as Maine.

This Policy Short Take presents detail on **one** of the options: implementing health care spending growth targets – either in the form of benchmarks, caps or global budgets. We offer examples from seven state initiatives and include a brief historical review of Minnesota's attempts to constrain health care spending through cost containment limits.

What States Have Established Growth Targets?

Below, we summarize key aspects of each state's initiative:

1. The name and time frame of the policy;
2. How spending targets were set and their parameters;
3. What, if any, penalties were established for exceeding limits;
4. What payers or providers of health care services are targeted by the policy;
5. What reporting requirements have been paired with the initiative; and
6. What, if any, impact on health care spending is currently discernable.

Table 1 illustrates the variation in the implementation of this approach across states, as well as the different time horizon states are operating under. Programs range from being announced just a few weeks ago (Connecticut) to Maryland's conversion from an all-payer hospital rate regulation system (developed in the 1970s) to an all-payer model in 2014.

Table 1: Summary of State Approaches to Establish Health Spending Targets

State	Year(s)	Spending Limit & Parameters ¹	Penalties	Payers and Providers Targeted by Policy	Reporting Requirements	Results
Connecticut	2021-2025	Health care spending benchmark, target for primary care spending share of total spending	Not indicated	Medicare, Medicaid, Commercial, Health Plan Co's, Providers	Annual report	Not yet available
Delaware	2019 to 2023	Per capita spending growth limit	None (voluntary)	Medicare, Medicaid, Commercial, Health Plan Companies, providers, medical groups, and ACOs	Annual report	Not yet available
Maryland (All Payer Model)	2014 to 2018	Global per capita hospital budget with growth limit	Return to national Medicare payment system	Hospitals, and all payers of hospital services	Annual report	Growth limit met; Medicare savings
Maryland (Total Cost of Care Model)	2019 to 2026	Expanded global budget with per capita total cost of care growth limit	State at-risk for all Medicare Fee-for-Service beneficiaries	Providers and payers in hospital and non-hospital settings	Annual report	Not yet available
Massachusetts	2013 to 2023	Per capita spending growth limit	PIP and monitoring for payers/providers going over benchmark (potential)	Medicare, Medicaid, Commercial, Health Plan Co's, Providers	Annual report and public hearing	Growth limits met in certain years
Oregon	2021 forward	Health care spending benchmark	PIP, financial penalties if no plan (potential)	Medicare, Medicaid, Commercial, Health Plan Co's, Providers	Annual report and public hearing	Not yet available
Pennsylvania	2019 to 2024	Global budget with per beneficiary inpatient and outpatient hospital growth limit	None (voluntary)	Rural Hospitals, Medicare, Medicaid, some Commercial Health Plan Co's	Hospital-based transformation plans, quarterly evaluation by state	Not yet available
Rhode Island	2019 to 2022	Per capita spending growth limit	None (voluntary)	Medicare, Medicaid, Commercial, ACOs	Annual report	Not yet available

Notes: Acronyms used include PIP (Performance Improvement Plan), CMS (Center for Medicare and Medicaid Services), ACO (Accountable Care Organization) and MCO (Managed Care Organization).

¹ For purposes of this table summary, we are not including any quality, population health, or other non-spending parameters or reporting requirements.

Connecticut

1. **Name and Year(s):** Executive Order 5 (health care spending growth benchmarks established); 2021 through 2025.
2. **Spending Limit and Parameters:** By December 2020 there will be established annual per capita health care cost growth benchmarks for five years (2021 through 2025). These will be based on all public and private health care expenditures.⁵

Within these benchmarks, there will be targets for increased primary care spending as a share of total health care spending for each year, reaching 10 percent by 2025.

Executive Order 5 also directs the state to develop quality benchmarks across public and private payers, effective 2022. (Executive Order 6 directs development of public transparency for Connecticut Medicaid cost and quality reports by January 31, 2020, with the intent to create payment and care delivery strategies that improve health outcomes and reduce health disparities.)⁶

3. **Penalties:** The Executive Order does not specify if there are any penalties.
4. **Payers and Providers Targeted by Policy:** All payers, private and public payers.
5. **Reporting Requirements:** Results will be published annually for the preceding year. Detailed reporting requirements were not contained in the Executive Order.
6. **Results:** As this program has not yet started, we are not able to identify any impact it has had on Connecticut health care spending.

Delaware

1. **Name and Year(s):** Executive Order 25 (health care spending benchmarks); 2019 through 2023.
2. **Spending Limit and Parameters:** An annual per capita growth rate, tied to the Delaware per capita Potential Gross State Product (PGSP) and a transitional market adjustment. Growth benchmarks range from 3.0 to 3.8 percent over five years (2019 through 2023), but are subject to change if there are unanticipated economic changes. It may continue for 2024 after a reassessment of the methodology.

The spending limit also includes health care quality benchmarks, effective 2019, but for purposes of this policy short take, we only discuss health care spending limits.⁷

3. **Penalties:** The benchmark is voluntary, meaning that there are no penalties or incentives for stakeholders to limit costs. The goal of the initiative is to allow stakeholders to begin to focus on strategies to manage health care spending trends and help create accountability through improved transparency.⁸
4. **Payers and Providers Targeted by Policy:** Medicare, Medicaid, commercial, health plan companies, and medical group and Accountable Care Organizations (ACOs) of sufficient size.
5. **Reporting Requirements:** Results will be published annually for the preceding year and include aggregate spending, per capita spending, per member per year spending, and the rate of change against the benchmark.

6. **Results:** As this program is in its first year, we are not able to identify any impact it has had on Delaware health care spending.

Maryland

All-Payer Model (2014- 2018)

1. **Name and Year(s):** All-Payer Model, effective 2014 through 2018.⁹
2. **Spending Limit and Parameters:** The model established global budgets for Maryland general, acute care hospitals, providing these hospitals with a fixed revenue for the year. The goal of this model was to improve health, lower health care costs and enhance patient care, while moving away from a fee-for-service payment model to a value-based payment model.¹⁰

The model created an all-payer per capita hospital (inpatient and outpatient) growth rate tied to the ten-year compound Maryland annual per capita Potential Gross State Product (PGSP), requiring growth to be 3.58 percent or less. Maryland also made a commitment to CMS to have \$330 million in cumulative Medicare savings over five years, along with specific minimum performance targets each year.

The ability for Maryland to employ this program was predicated on having hospital rate regulations (i.e., an all-payer hospital rate program), which were implemented in the 1970s.

3. **Penalties:** Maryland hospitals would have transitioned, over two years, to the national Medicare payment system (which they had not operated under since the 1970s) had they not met the spending limits and parameters of this model.
4. **Payers and Providers Targeted by Policy:** Hospitals, and all payers of hospital services, with a focus on Medicare and Medicaid (including CHIP).
5. **Reporting Requirements:** Results were made available annually to CMS and included items such as spending and quality measures, regulated revenue rates, patient experience of care, and population health measures.¹¹
6. **Results:** Through 2018, the program showed an estimated 796 million in Medicare savings in hospital expenditures and \$975 million in total Medicare savings,¹² and kept per capita growth rates under 3.58 percent, while meeting several quality targets, such as admissions.¹³ There was no improvement in coordination with community providers following hospitalization, and utilization results were not consistent across all types of hospitals. As the All-Payer Model focused only on hospitals, it constrained Maryland in sustaining the rate of Medicare savings and quality improvements.¹⁴

Total Cost of Care Model (2019-2026)

1. **Name and Year(s):** Maryland Total Cost of Care (TCOC) model; 2019 through 2026.
2. **Spending Limit and Parameters:** CMS approved the expansion of Maryland's All-Payer Model with which it extends limits to Medicare spending increases to providers in non-hospital settings. The model sets a per capita limit on the total hospital cost of care (3.58 percent), and promotes care coordination between hospital and non-hospital providers,

and patient-centered care. Maryland is fully at-risk for the total cost of care for Medicare fee-for-service beneficiaries. This is the first state to implement this at-risk contract model.¹⁵

The model includes three components: a hospital payment program, a Care Redesign Program, and the Maryland Primary Care Program. The TCOC calculation can be adjusted by outcomes-based credits, which Maryland would earn based on its performance for population health measures and targets, these are based on assumed future savings from a healthier population.¹⁶

Maryland committed to CMS that between 2019 through 2023 there will be \$1 billion in cumulative Medicare savings. Specific savings to other payers are not explicitly stated.

3. **Penalties:** Maryland appears to be fully at-risk for the TCOC for Medicare FFS beneficiaries. In practice, if targets are not met, corrective action plans will be implemented.
4. **Payers and Providers Targeted by Policy:** Providers and payers in hospital and non-hospital settings (i.e., outpatient services); with a focus on Medicare and Medicaid (including CHIP).
5. **Reporting Requirements:** Results on spending and quality measures are reported annually to CMS for the preceding year, including the regulated revenue and growth rate for each Maryland hospital.¹⁷
6. **Results:** As this new model is in its first year, we are not able to identify any impact it has had to date on Maryland health care spending.

Massachusetts

1. **Name and Year(s):** Chapter 224 of the Acts of 2012 (health care cost growth benchmark); 2013 through 2023.
2. **Spending Limit and Parameters:** A limit on the annual per capita growth rate tied to the Massachusetts per capita Potential Gross State Product (PGSP). Benchmarks were 3.6 percent for 2013 through 2017 (PGSP), 3.1 percent for 2018 through 2022 (PGSP minus 0.5 percent), and set to PGSP again in 2023.¹⁸ The growth rate beginning 2018 can be adjusted up to 3.6 percent if reasonably warranted. The per capita growth rate is based on total health care expenditures, including private and public payer medical expenses (in an attempt to control cost-shifting between payers), patient cost-sharing, and the net cost of private insurance
3. **Penalties:** When the health care spending benchmark is not met, Performance Improvement Plans (PIP) can be required of payers and providers whose health care spending growth are excessive, as well as requiring them to undergo strict monitoring and authority to levy penalties of up to \$500,000 for noncompliance with PIP.¹⁹
4. **Payers and Providers Targeted by Policy:** All private and public payers (e.g., commercial, MassHealth (Medicaid), Medicare Advantage, Medicare FFS), and providers.
5. **Reporting Requirements:** Results are published annually for the preceding year and include spending trends, underlying factors, and strategies for improving the efficiency of the health care system. There are also extensive public hearings (conducted with the Office of the Attorney General) which include information from a representative sample of witnesses

including providers, payers and other entities (i.e., academic medical centers) describing information on prices and utilization trends, among other topics, as well as hearings on any modifications to the benchmark.²⁰ The Center for Health Information and Analysis (CHIA) monitors the benchmark and spending trends, and produces the report; the Massachusetts Health Policy Commission makes policy recommendations.

6. **Results:** Through 2017, per capita growth rates were below 3.6 percent in three of the five years.²¹ Reports noted that higher priced providers with significant market volume and increased growth in prescription drug spending were the largest contributors for non-compliance in meeting the per capita growth rate in 2014 and 2015.²² Nonetheless, even with slower growth rates, Massachusetts per capita spending remains significantly higher than other states, due to higher hospital care and long-term care spending, and in 2016 and 2017, member cost sharing grew faster than inflation, average wages and premiums.²³

Oregon

1. **Name and Year(s):** Sustainable Health Care Cost Growth Target program (Senate Bill 889), effective 2021.²⁴
2. **Spending Limit and Parameters:** Parameters are not yet defined, but a benchmark rate related to health care spending growth will be measured against an economic indicator (e.g., Oregon economy, personal income) on a per capita, statewide, and health care company basis. The Oregon Health Authority will develop the benchmark in partnership with stakeholders and consumers.

Currently, there is a health care spending benchmark for clients of publicly funded health insurance (3.4 percent), which initially began with Medicaid in 2012 and expanded to cover public employee health plans in 2014.²⁵

3. **Penalties:** The implementation committee will provide recommendations for making health plan companies and providers accountable if they exceed targets. Additionally, for providers and payers who exceeded the cost growth target in the previous year, the program can require Performance Improvement Plans (PIP).²⁶
4. **Payers and Providers Targeted by Policy:** All payers and providers in the state.
5. **Reporting Requirements:** Annual report on spending trends, data by categories of services, underlying factors and cost drivers, information on the affordability of health care, insurance premiums and types of payments, and strategies for improving the efficiency of the health care system. The report will include which providers and payers exceeded costs from the prior years, and results will be discussed in public hearings.
6. **Results:** As this program has not yet started, we are not able to identify any impact it has had on Oregon health care spending.²⁷

Pennsylvania

1. **Name and Year(s):** Pennsylvania Rural Health Model, 2019 through 2024.

Spending Limit and Parameters: Global Budget model for rural hospitals to support stable financing, transform hospital care delivery, advance the health needs of rural communities, and to improve the quality of care.

Creates a global budget with an all-payer annual per beneficiary inpatient and outpatient hospital services growth rate tied to the Pennsylvania Gross State Product between 1997 and 2015, as well as population health targets.²⁸ The growth rate is of 3.38 percent, for six years (2019 through 2024), for all participating payers. The global budget of each hospital will be at least 75 percent of the hospital's net hospital revenue in 2019, and at least 90 percent for years 2020 through 2024.

Further, there will be \$35 million in Medicare hospital savings between 2019 through 2024 and the growth rate for rural Pennsylvania Medicare spending per beneficiary will not exceed the growth rate of national rural Medicare spending per beneficiary (by a certain percentage for 2020 through 2023).²⁹

2. **Penalties:** Participation is voluntary, meaning hospitals are not required to participate. The goal is that this model will increase health care access, reduce rural health disparities, and decrease mortality from substance use and opioid abuse.³⁰
3. **Payers and Providers Targeted by Policy:** Rural critical access and acute care hospitals; Medicare, Medicaid, certain commercial health plan companies.
4. **Reporting Requirements:** Participating hospitals create individualized Rural Hospital Transformation plans, approved by CMS and Pennsylvania, which outline their proposed delivery transformation. Pennsylvania performs quarterly evaluations.
5. **Results:** As this program is in its first year, we are not able to identify any impact it has had on Pennsylvania health care spending.

Rhode Island

1. **Name and Year(s):** Rhode Island Health Care Cost Growth Target (Executive Order 19-03, February 6, 2019), 2019 through 2022.³¹
2. **Spending Limit and Parameters:** An annual per capita growth rate directly tied to the Rhode Island per capita Potential Gross State Product (PGSP). The model sets a benchmark rate of 3.2 percent annually for 2019 through 2022. It may continue after 2022; however, before then the methodology will be reassessed.
3. **Penalties:** The benchmark is voluntary, meaning that there are no penalties or incentives for stakeholders to limit costs. Publishing performance may promote accountability.
4. **Payers and Providers Targeted by Policy:** Medicare, Medicaid, commercial, health plan companies, and Accountable Care Organizations (ACOs).

5. **Reporting Requirements:** Results will be published annually for the preceding year and include aggregate spending, per capita spending, per member per year spending, and the rate of change against the benchmark.
6. **Results:** As this program is in its first year, we are not able to identify any impact it has had on Rhode Island health care spending.

What Was Minnesota’s Earlier Approach to Constraining Health Care Spending?

In response to substantial health care spending growth between 1980 and 1991,³² the Minnesota Legislature established the Minnesota Health Care Commission (Laws of Minnesota 1992, Chapter 549; House File 2800 “HealthRight”), effective 1992. The Commission was tasked with developing cost containment plans to reduce health care spending growth rates by at least 10 percent per year, over five years.

The goal was to build a partnership between the government and private stakeholders for a common mission, understanding that there were regional variations in health care delivery, access, quality and spending.³³ The 1993 Minnesota Legislature enacted several cost containment initiatives based on recommendations from the commission that included capital expenditure reporting and review, strengthening administrative uniformity, as well as establishing annual health care spending growth limits for 1994 through 1998 (Laws of Minnesota 1993, Chapter 345).³⁴

Similar to the previous section, the following section summarizes the requirements of the legislation, as well as the evidence on potential impact on health care spending in the state.

1. **Name and Year(s):** Minnesota Cost Containment – statewide expenditure limits (Laws of Minnesota 1993, Chapter 345), 1994 through 1998.
2. **Spending Limit and Parameters:** Health care spending growth for health plan companies was limited to the consumer price index (CPI) plus percentage points specified in statute.³⁵ The specified percentage points declined from 6.5 in 1994 to 2.6 in 1998. These goals were set with the intention of reducing spending growth by 10 percent per year, and it was estimated that this would result in savings of \$6.9 billion over five years across all payers.³⁶
3. **Penalties:** The law envisioned growth limits would be reinforced by two other components of the cost containment plan: through the voluntary development of integrated networks called Integrated Service Networks (ISNs) (similar to the current Health Maintenance Organizations), and the establishment of a “Regulated All Payer Option” (RAPO) to control costs provided on a fee-for-service basis, which was never fully implemented.³⁷
4. **Payers and Providers Targeted by Policy:** The cost containment legislation applied to total spending growth for Minnesotans and explicitly targeted health plan companies through the establishment of (“interim”) goals for growth in net expenditure.
5. **Reporting Requirements:** One of the unique aspects of this legislation was that it included a long-term data strategy of collecting data on health care expenditures across the state – an initiative that remains in place today. The health department would review compliance with

`descriptions, actual spending, the difference in projected and actual spending, and the impact and validity of cost containment goals.³⁸

6. **Results:** It is unclear to what extent the health care spending growth limits had a measurable impact. Between 1993 and 1997, health care spending growth slowed, but this was likely attributable to other factors, including the failure of national health reform, subsequent repeal of state-level reform components, and changes in the underlying economic trends.³⁹ The state never took action against entities that did not meet the growth limits, in part because they were likely due to data irregularities, or because the factors driving growth were viewed as being outside the control of the individual entities. By 1997, two components of the Minnesota cost containment plan, RAPOs and ISNs, were either repealed or delayed.⁴⁰ The requirement to maintain spending and net expenditure targets (for the state and health plan companies, respectively), was not extended past 1998 by the Minnesota Legislature.

End Notes

¹ Minnesota Department of Health, Health Economics Program “Minnesota Health Care Spending: 2017 Estimates and Ten-Year Projections.” Legislative Report, February 2020; www.health.state.mn.us/healthconomics

² Minnesota Department of Health, Health Economics Program “Minnesota Health Care Spending: 2017 Estimates and Ten-Year Projections.” Legislative Report, February 2020; www.health.state.mn.us/healthconomics

³ IBID, p. 31

⁴ Minnesota Department of Health, Health Economics Program, Minnesota Health Care Spending: 2015 and 2016 Estimates and Ten-Year Projections. February 2019 [PDF] (www.health.state.mn.us/data/economics/docs/costs/healthspending2019.pdf)

⁵ State of Connecticut. Executive Order No. 5. January 22, 2020 (<https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-5.pdf?la=en>)

⁶ State of Connecticut. Executive Order No. 6. January 22, 2020 (<https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-6.pdf?la=en>)

⁷ Delaware, Office of the Governor John Carney. Executive Order 25. November 20, 2018 (<https://governor.delaware.gov/executive-orders/eo25/>)

⁸ Walker KO. Health Affairs Blog. “Can a Small State Improve Both Health Care Costs and Health Outcomes? Lessons from Delaware.” June 6, 2019 (www.healthaffairs.org/doi/10.1377/hblog20190530.589329/full/)

⁹ Maryland All-Payer Model Agreement. Accessed August 23, 2019 [PDF] ([http://hsrc.maryland.gov/documents/md-maphs/stkh/MD-All-Payer-Model-Agreement-\(executed\).pdf](http://hsrc.maryland.gov/documents/md-maphs/stkh/MD-All-Payer-Model-Agreement-(executed).pdf))

¹⁰ Report to the Governor. Fiscal Year 2015. Health Services Cost Review Commission. State of Maryland Department of Health and Mental Hygiene. October 2015 [PDF] (www.hsrc.state.md.us/documents/pdr/ar/Governor-Report-MD-HSCRC-2015.pdf)

¹¹ Maryland All-Payer Model Agreement. Accessed August 23, 2019 [PDF] ([https://hsrc.maryland.gov/documents/md-maphs/stkh/MD-All-Payer-Model-Agreement-\(executed\).pdf](https://hsrc.maryland.gov/documents/md-maphs/stkh/MD-All-Payer-Model-Agreement-(executed).pdf))

¹² Maryland All-Payer Model Final Evaluation Report 2014-2018: Findings at a Glance. The Centers for Medicare & Medicare Services (CMS). Accessed March 10, 2020 [PDF] (<https://innovation.cms.gov/Files/reports/md-allpayer-finalevalrpt-fg.pdf>)

¹³ Maryland All-Payer Model. The Centers for Medicare & Medicare Services (CMS). Accessed August 23, 2019 (<https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/>)

¹⁴ Centers for Medicare & Medicaid Services. Maryland Total Cost of Care Model. Accessed August 21, 2019 (<https://innovation.cms.gov/initiatives/md-tccm/>)

¹⁵ Centers for Medicare & Medicaid Services. Maryland Total Cost of Care Model. Accessed August 21, 2019 (<https://innovation.cms.gov/initiatives/md-tccm/>)

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- ¹⁶ [Centers for Medicare & Medicaid Services. Maryland Total Cost of Care Model. Accessed August 21, 2019 \(https://innovation.cms.gov/initiatives/md-tccm/\)](https://innovation.cms.gov/initiatives/md-tccm/)
- ¹⁷ [Maryland Health Care Services Cost Review Commission. Maryland Total Cost of Care Model State Agreement. Accessed November 5, 2019 \[PDF\] \(https://hscrc.maryland.gov/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf\)](https://hscrc.maryland.gov/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf)
- ¹⁸ [Massachusetts Health Policy Commission. Health Care Cost Growth Benchmark. Accessed August 21, 2019 \(www.mass.gov/info-details/health-care-cost-growth-benchmark\)](http://www.mass.gov/info-details/health-care-cost-growth-benchmark)
- ¹⁹ [Commonwealth of Massachusetts. Health Policy Commission \(HPC\) DataPoints, Issue 10: Health Care Cost Growth Benchmark. Accessed August 27, 2019 \(www.mass.gov/service-details/hpc-datapoints-issue-10-health-care-cost-growth-benchmark\)](http://www.mass.gov/service-details/hpc-datapoints-issue-10-health-care-cost-growth-benchmark); [Waugh L. and McCarthy D. The Commonwealth Fund. How the Massachusetts Health Policy Commission Is Fostering a Statewide Commitment to Contain Health Care Spending Growth. March 5, 2020 \(https://www.commonwealthfund.org/publications/case-study/2020/mar/massachusetts-health-policy-commission-spending-growth\)](https://www.commonwealthfund.org/publications/case-study/2020/mar/massachusetts-health-policy-commission-spending-growth)
- ²⁰ [Commonwealth of Massachusetts. Chapter 224 of The Acts of 2012 \(https://malegislature.gov/laws/sessionlaws/acts/2012/chapter224\)](https://malegislature.gov/laws/sessionlaws/acts/2012/chapter224)
- ²¹ [Massachusetts Health Policy Commission. Hearing on the Potential Modification of the Health Care Cost Growth Benchmark. March 13, 2019 \[PDF\] \(www.mass.gov/files/documents/2019/03/13/HPC%20Hearing%20on%20Potential%20Benchmark%20Modification_final%20presentation.pdf\)](http://www.mass.gov/files/documents/2019/03/13/HPC%20Hearing%20on%20Potential%20Benchmark%20Modification_final%20presentation.pdf)
- ²² Commonwealth of Massachusetts, Office of the Attorney General. Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12, § 11N, Report for Annual Public Hearing Under G.L. c. 6D, § 8. September 18, 2015.
- ²³ [Commonwealth of Massachusetts. Health Care Spending Benchmark. Accessed August 27, 2019 \(www.mass.gov/info-details/health-care-cost-growth-benchmark\)](http://www.mass.gov/info-details/health-care-cost-growth-benchmark)
- ²⁴ [Oregon Health Authority. Charting a Sustainable Path for Health Care Spending. Accessed November 5, 2019 \[PDF\] \(www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost-Growth-Target-Overview.pdf\)](http://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost-Growth-Target-Overview.pdf)
- ²⁵ [Oregon's latest recommendation for a health care spending growth target, came from Senate Bill 419 \(2017\) Task Force Recommendations. Accessed August 21, 2019 \(www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx\)](http://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx) Originally the task force had been tasked with studying Maryland's hospital rate-setting model, but ultimately did not choose to recommend this model for a variety of reasons (e.g., hospital spending decreasing as share of total spending, focused mainly on fee-for-service, complex and administratively burdensome, requires federal Medicare waiver).
- ²⁶ [Oregon Health Authority. Sustainable Health Care Cost Growth Target Health Care Provider Frequently Asked Questions \(FAQs\), October 16, 2019 \[PDF\] \(www.oregon.gov/oha/HPA/HP/HCCGBDocs/FAQ-provider-final-10-16-2019.pdf\)](http://www.oregon.gov/oha/HPA/HP/HCCGBDocs/FAQ-provider-final-10-16-2019.pdf); [Oregon State Legislature, 2019 Regular Session, Enrolled Senate Bill 889 \[PDF\] \(https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB889/Enrolled\)](https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB889/Enrolled)
- ²⁷ [Oregon Health Authority, Office of Health Policy. Health Care Cost Growth Benchmark Program. Accessed August 21, 2019 \(www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx\)](http://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx)
- ²⁸ Population health targets, which may tie in financial incentives, are based on three goals: increased primary and specialty care access, reduced rural health disparities from improved chronic disease and preventive screenings, and decreased deaths from substance use disorder and improved treatment access for opioid abuse. [Centers for Medicare & Medicaid Services. Pennsylvania Rural Health Model. Accessed August 21, 2019 \(https://innovation.cms.gov/initiatives/pa-rural-health-model/\)](https://innovation.cms.gov/initiatives/pa-rural-health-model/)
- ²⁹ [Centers for Medicare & Medicaid Services. Pennsylvania Rural Health Model. Accessed August 21, 2019 \(https://innovation.cms.gov/initiatives/pa-rural-health-model/\)](https://innovation.cms.gov/initiatives/pa-rural-health-model/)
- ³⁰ As of March 5, 2019, five hospitals and five payers committed to participation in year one. As of January 2020, 18 rural hospitals and as of January 2021, 30 rural hospitals, will be participating in this model. [Association of State and Territorial Health Officials. ASTHO Experts Blog. Pennsylvania's Rural Health Model: A Conversation with the Secretary of Health. October 28, 2019 \(www.astho.org/StatePublicHealth/Pennsylvania-Rural-Health-Model-Conversation-with-the-Secretar-of-Health/10-28-19/\)](http://www.astho.org/StatePublicHealth/Pennsylvania-Rural-Health-Model-Conversation-with-the-Secretar-of-Health/10-28-19/)
- ³¹ [State of Rhode Island and Providence Plantations. Executive Order 19-03. February 6, 2019 \[PDF\] \(https://files.constantcontact.com/572742fa401/4cea8cdb-7832-4fe2-a790-7ac74b45ddda.pdf\)](https://files.constantcontact.com/572742fa401/4cea8cdb-7832-4fe2-a790-7ac74b45ddda.pdf)
- ³² From 1980 to 1991, Minnesota health care spending grew substantially higher than the Twin Cities consumer price index (10.5 percent compared to 4.7 percent on average annually). Information accessed from [Research Department of the House of Representatives. The Basics of MinnesotaCare: A Guide for Legislators. December 2014 \[PDF\] \(www.leg.state.mn.us/docs/pre2003/other/950191.pdf\)](http://www.leg.state.mn.us/docs/pre2003/other/950191.pdf)
- ³³ [Containing Costs in Minnesota's Health Care System: A Report to Governor Arne H. Carlson and the Minnesota Legislature, Summary, January 25, 1993 \[PDF\] \(www.leg.state.mn.us/docs/pre2003/mandated/930097.pdf\)](http://www.leg.state.mn.us/docs/pre2003/mandated/930097.pdf)

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³⁴ Other initiatives included encouraging use of managed care through integrated service networks, creating a framework for a regulated all-payer option, and other cost containment measures (e.g., capital expenditure reviews, limits on mergers. [Research Department of the House of Representatives. The Basics of MinnesotaCare: A Guide for Legislators. December 1994 \[PDF\] \(www.leg.state.mn.us/docs/pre2003/other/950191.pdf\)](#)

³⁵ [Minnesota Statutes 2017. 62J.04. \[PDF\] \(www.revisor.mn.gov/statutes/2017/cite/62J.04/pdf\)](#)

³⁶ [Containing Costs in Minnesota's Health Care System: A Report to Governor Arne H. Carlson and the Minnesota Legislature, Summary, January 25, 1993 \[PDF\] \(www.leg.state.mn.us/docs/pre2003/mandated/930097.pdf\)](#)

³⁷ [Blewett LA. Health Affairs. State Report: Reforms in Minnesota: Forging the Path. Vol. 13. No. 4. Fall 1994. \(www.healthaffairs.org/doi/full/10.1377/hlthaff.13.4.200\)](#)

³⁸ [Minnesota Statutes 2017. 62J.04 \[PDF\] \(www.revisor.mn.gov/statutes/2017/cite/62J.04/pdf\)](#)

³⁹ Minnesota Health Department, Health Economics Program analysis of estimated health care spending data reflect growth between 0.1 percent and 5.0 percent between 1993 and 1997. [Coughlin TA, et al. The Urban Institute. Health Policy for Low-Income People in Minnesota. November 1997 \[PDF\] \(www.urban.org/sites/default/files/publication/67041/307320-Health-Policy-for-Low-Income-People-in-Minnesota.PDF\)](#); [Sparer MS. Health Affairs Commentary. Great Expectations: The Limits of State Health Care Reform. Vol. 14. No. 4. Winter 1995 \(https://www.healthaffairs.org/doi/10.1377/hlthaff.14.4.191\)](#)

⁴⁰ [Minnesota Statutes 62J.05 \[Repealed, 1997 c 225 art 2 s 63\]. The Commission decided to discontinue activity with the meeting of June 18, 1997 \(www.leg.state.mn.us/lrl/agencies/detail?AgencyID=718\)](#); [Minnesota Health Care Commission Report: Evolution of Minnesota's Health Care Delivery System, January 1997 \[PDF\] \(www.leg.state.mn.us/docs/pre2003/other/970182.pdf\)](#)

Minnesota Department of Health
Health Economics Program
PO Box 64882
St. Paul, MN 55164-0882
651-201-3550
Health.HEP@state.mn.us
www.health.state.mn.us/healthconomics

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