In 2018, national health care spending increased by 4.6% reaching $11,000 per person. Amid this growth, states are seeking novel ways to protect their budgets. One approach is to set a cost growth benchmark—a percentage growth rate under which states aim to maintain annual health care costs.

**Leadership in Massachusetts**

Massachusetts has had such an approach since 2013. Its Health Policy Commission monitors total health care cost growth in the state using a benchmark—including medical expenses paid by private and public payers, patient cost sharing, and the cost of private insurance—and works with clinicians, care organizations, and insurers one-on-one if they exceed that benchmark. Originally set at 3.6% growth by the legislature, since 2018, it has been reduced to 3.1% by the Board of Commissioners. Actual health care spending in the state has been at or below the benchmark during 4 of the past 6 years.

It is important to remember that Massachusetts is unique when it comes to health care. It has a significantly greater concentration of clinicians, hospitals, and other health care entities and higher costs than most states. Because reducing the rate of growth on a high level of spending may be easier than doing so on a lower level of spending, translating the success of the Massachusetts model to other states may be difficult.

Nevertheless, 4 other states have followed suit and implemented (or plan to implement) health care cost growth benchmarks.

**Health Care Cost Growth Benchmarks in 4 States**

Delaware was the first, establishing its total health care spending growth benchmark of 3.8% in November 2018 through an executive order, which went into effect in 2019. The order also requires tracking trends in quality and population health outcomes.

Rhode Island established its benchmark (3.2% total health care spending growth) at the end of 2018 as well, which went into effect in 2019. The state will assess cost growth and performance at the state, insurance market, insurer, and large provider organization levels. The state’s health insurance commissioner had already set strict inflation caps on hospital fee growth, beginning in 2011. “This made system-level cost growth containment less daunting,” said Cory King, MPP, director of policy for the Rhode Island Office of the Health Commissioner, in an interview. “Hospitals and payers agreed to participate in good faith, knowing the state was serious about this.” King explained that he felt that Rhode Island’s smaller size, relative to Massachusetts, provides an advantage in developing a plan. “We can rely more heavily on peer pressure to get stakeholders to the table and in agreement,” he said.

Oregon adopted a benchmark program (3.4% total health care spending growth) in 2019, to go into effect in 2021, based on the Massachusetts model. The program follows the state’s years-long monitoring of cost growth in its Medicaid and public employee benefit programs. “Establishing a total health care cost growth benchmark meant all parts of the health system would now be accountable in the fight to rein in costs,” said Jeremy Vandehey, JD, director of health policy and analytics for the Oregon Health Authority, in an interview.

This is an open access article distributed under the terms of the CC-BY License.
Oregon's legislation provides flexibility. Vandehey noted that because the state is using statistical modeling to determine how different-sized care organizations should be required to comply, it requires smaller organizations to be held accountable through more equitable, alternative measures. Equally important is maintaining equity at the patient level. "Under explicit orders from the governor, we need to assure we are not addressing cost growth by cutting access, benefits, or exacerbating existing health inequities," said Vandehey.

Connecticut established its benchmark through an executive order in early 2020. It has yet to set an explicit target but will do so for 2021 and through 2025. Victoria Veltri, JD, LLM, executive director of the Connecticut Office of Health Strategy, noted via email the extensive collaboration and bipartisanship required to get to this point, with the governor and legislature working together with guidance and mentorship from other states.

The state's approach is unique in its plan to also monitor primary care spending as a proportion of total health care spending, with the goal of increasing it to 10% of total spending by 2025. Connecticut was already laying the groundwork to modernize primary care delivery when the governor signed the executive order.

Compared with other states, Connecticut is one of the lowest spenders on primary care as a share of total health expenditures (Medicaid program aside), said Veltri. "But if we emphasize primary care, we have the chance to catch medical conditions before they get worse, offset expenses in other health care areas, and give our providers the flexibility and resources they need to address disparities in access and health outcomes."

It is important to note that these benchmarks were all established prior to the coronavirus 2019 pandemic (when the economy was doing well). Even though these increases were above the rate of inflation, health care costs as a percentage of the gross domestic product actually declined over the past few years. Given that states are likely to see a dramatic reduction in revenue in 2020, these benchmarks may need to be reconsidered during the short-term.

Health care cost containment is critical to the longevity and effectiveness of states' health care systems. Setting a total health care cost growth benchmark is one way states can assess spending patterns and work to maintain a more sustainable path forward. Five states have implemented this approach and may serve as examples for other states to follow and improve.

**ARTICLE INFORMATION**

Correction: This article was corrected on August 31, 2020, to update the corresponding author's address.

Open Access: This is an open access article distributed under the terms of the CC-BY License.

Corresponding Author: Austin Frakt, PhD, Partnered Evidence-Based Policy Resource Center, VA Boston Health Care System, 150 S Huntington Ave (152 H), Jamaica Plain, MA 02130 (frakt@bu.edu).

Author Affiliations: School of Public Health, Boston University, Boston, Massachusetts (Pearson, Frakt);
Partnered Evidence-Based Policy Resource Center, Veterans Health Administration, Boston, Massachusetts (Frakt).

Conflict of Interest Disclosures: Drs Pearson and Frakt reported receiving grants from the Laura and John Arnold Foundation during the conduct of the study.