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Oregon's Health Care Cost Growth Target program:

Implications of health plan penalties

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Executive Summary

Oregon's Health Care Cost Growth Target program[1] has established a long-term target in the annual growth of healthcare expenditures among healthcare providers and payers in the state, which is set at 3.4% through 2025 and 3.0% from 2026 to 2030. To increase transparency around the drivers of health care cost trends, these entities are required to annually report their actual cost growth relative to the target and explain the primary cost drivers if the trends exceed the target. To increase accountability for health care cost trends, entities unable to meet the target that do not provide a justification deemed satisfactory to state authorities will be subject to increasing sanctions in the form of either performance improvement plans or direct financial penalties.

The Oregon program shares features with the Massachusetts Health Care Cost Growth Benchmark, an ongoing annual data collection and reporting initiative. The program aims to increase visibility into drivers of healthcare expenditures and related trends in cost sharing, quality of care, and the adoption of alternative payment methods. Similar programs with varying levels of enforcement have been adopted elsewhere, including mandated premium trend reductions in Colorado and a cost growth benchmark program in the early stages of implementation in California.

With general inflation reaching 8% during 2022[2], it is clear that there are significant, external drivers of cost growth that can, at different times, explain why the cost of healthcare grows faster than the target. It is not unreasonable to expect that some health plans may exceed the growth target by a significant amount, such as 5%, which raises the stakes significantly if the justification they provide for the cost growth drivers is not accepted by the government. Proposed financial penalties currently under consideration by policymakers could, at that level, easily reverse two years of typical health plan income and cause adverse deterioration in the adequacy of their capital.

Naturally, there is heightened focus toward the assessment criteria for adequate justifications for growth above the target as well as how the penalties could be implemented. The assessment criteria should be predictable and transparent, while allowing for company-specific nuance to be taken into account, including the degree to which each cost driver can be influenced by the company. Similarly, the potential financial penalties should be applied fairly and consider negative unintended consequences, both to the healthcare system in general as well as to the solvency and sustainability of both providers and payers alike.

OHA anticipates that health plan justifications for growth above the 3.4% growth target, which it will review for reasonableness, will increase public awareness of cost drivers, demonstrate actions taken to promote financial sustainability, and highlight which cost drivers can be influenced the most by health plans.

Consumers may directly benefit from lower growth in the cost of healthcare, though cost is not the only criteria for value. For example, some of the nonfinancial effects from cost cutting could affect consumers in the form of fewer available health insurance options, greater restrictions on expensive treatments and new drugs, more limited access to preferred healthcare providers, and reduced investment in healthcare quality. Consumers will weigh these considerations against overall cost.

Proposals for the exact formulation and magnitude of these financial penalties are currently being discussed, and they are scheduled to come into effect as early as the 2024-2025 cost growth evaluation period. The high-stakes potential impact of these penalties increases scrutiny into the details and inherent challenges of their implementation.

While health plans have a direct incentive to reduce the growth of healthcare costs in order to become more competitive, their

[1] See Health Care Cost Growth Target landing page created by OHA at https://www.oregon.gov/oha/hpa/hp/pages/sustainable-health-care-cost-growth-target.aspx.

[2] Federal Reserve Bank of Minneapolis. Consumer Price Index, 1913-. U.S. Bureau of Labor Statistics. Retrieved September 27, 2023, from https://www.minneapolisfed.org/about-us/monetary-policy/inflation-calculator/consumer-price-index-1913-.

ability to affect each cost growth driver can be limited, achievable savings may vary by area and market, and savings may be one-time rather than reductions in long-term trend.

Proposed financial penalties for unacceptable justifications could be severe and lead to unintended consequences in the Oregon healthcare system. Therefore, the evaluation process should be predictable, transparent, reliable, and take into account nuanced, company-specific factors.

Adding direct financial penalties for failing to achieve savings may cause nonfinancial impacts, including but not limited to incentives to limit healthcare provider reimbursement, consumer access to higher-cost providers, centers of excellence and teaching hospitals, and coverage of higher-cost treatments and drugs, and they may discourage participation in Oregon healthcare markets.

Background

In 2021, Oregon's legislature[3] established the Health Care Cost Growth Target program (Program), whose stated primary intent is to increase the sustainability and affordability of the state's healthcare system and increase the accountability of healthcare providers[4] and payers to the rate of cost growth. The Oregon Health Authority (OHA), which also oversees the state's Medicaid plan, was charged with administering[5] the Program in collaboration with the Oregon Department of Consumer and Business Services (DCBS)[6] and the Oregon Health Policy Board (OHPB).[7]

The Program's first objective was to establish an annual target for the growth of per capita healthcare expenditures that applies to both providers and payers, that is based on economic indicators, and that is sustainable over the long term. In its January 2021 report[8], OHA announced a cost growth target through 2030 as shown in Figure 1.

FIGURE 1: OHA HEALTH CARE COST GROWTH TARGETS

	2021 - 2025	2026-2030[x]
Annual per capita healthcare cost growth target	3.4%	3.0%

[x] Note: OHA indicated[9] that it would revisit healthcare costs and economic indicators in 2024 to determine whether the annual 2026-2030 target was set appropriately and if adjustments are needed.

In addition to establishing the cost growth target, the legislature authorized OHA to pursue escalating accountability measures for providers and payers, including annual reporting of data, mandatory performance improvement plans (PIPs), and financial penalties.[10]

INITIAL REPORTING RESULTS

OHA has shared[11] its findings from the annual data reporting obtained from payers and providers so far through 2021. The first three years of reporting for the main markets—commercial, Medicaid managed care, and Medicare Advantage—showed mixed results, with the actual growth exceeding the target in most markets and years. The exception is the 2019-2020 trend, which was heavily influenced by suppressed healthcare encounters during the onset of the COVID-19 pandemic.

3 House Bill 2081, passed by House and Senate in the 2021 Regular Session, which followed Senate Bill 889 from the 2019 Regular Session.

4 Note that only healthcare providers in the state are included and medical equipment and pharmaceutical suppliers from outside the state are not subject to these accountability measures.

5 See Health Care Cost Growth Target landing page created by OHA at https://www.oregon.gov/oha/hpa/hp/pages/sustainable-health-care-cost-growth-target.aspx.

6 DCBS includes the Division of Financial Regulation (DFR), which has oversight over commercial health insurance plans, such as the individual and small group carriers serving the Oregon Health Insurance Marketplace.

7 The OHPB is a nine-member citizen board that oversees OHA and develops and guides implementation of healthcare policy in the state. See https://www.oregon.gov/oha/ohpb/pages/index.aspx.

8 Oregon Health Authority (January 2021). Sustainable Health Care Cost Growth Target: Implementation Committee Recommendations, Final Report to the Oregon Legislature. Retrieved September 27, 2023, from https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf.

9 Ibid., p. 5.

10 See Appendix D below for implementation timeline and Appendix E for related programs in selected other states.

11 In May 2023, OHA released two reports: analysis of 2018-2019 and 2019-2020 reporting periods in https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Oregon-Cost-Growth-Target-Annual-Report-FINAL.pdf and analysis of the 2020-2021 reporting period in https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2023-Oregon-Cost-Growth-Target-Annual-Report.pdf.

FIGURE 2: OHA MEASURED PER CAPITA COST GROWTH

	Per Capita cost growth			#Meeting Cost Growth Target		
	2018-2019	2019-2020	2020-2021	2018-2019	2019-2020	2020-2021
Commercial	3.9%	1.2%	12.1%	2 (of 9)	8 (of 9)	1 (of 8)
Medicaid	4.5%	-7.2%	-2.1%	6 (of 16)	11 (of 16)	13 (of 16)
Medicare	3.7%	-3.9%	6.5%	5 (of 10)	10 (of 10)	2 (of 10)

Note: # meeting the growth target refers to payers identified by OHA as having substantial involvement in each market in Oregon

FINANCIAL PENALTIES

The enforcement mechanisms will include financial penalties as well as other actions available to OHA and DCBS, as these entities oversee state-based healthcare plans (e.g., Medicaid, public employee plans), have rate review authority over individual and small group plans, and govern the certification of health insurance plans.

In its May 2023 Technical Advisory Group meeting, OHA presented an initial draft of the financial penalty formula[12].

1. Penalties would apply to health plans or providers that exceed the growth target with statistical significance and without providing justification acceptable to OHA in three of the five years.
2. The penalty would be calculated as the amount of healthcare costs in excess of the growth target in each year in which the excess occurred, plus an additional 10%.
3. No credit would be given for years in which the actual cost growth was less than the target. For example, lower-than-expected cost growth during the onset of social distancing during a pandemic would not be netted against higher-than-expected cost growth during subsequent years.
4. Under current rules, if OHA does not accept a health plan's justification for some portion of the growth over the target, then the health plan would be penalized for all growth over the target, plus 10%.

WHEN WILL A HEALTH PLAN BE CONSIDERED TO HAVE EXCEEDED THE GROWTH TARGET?

To be found to have exceeded the growth target with statistical significance, and therefore be subject to a PIP and have one strike toward a financial penalty, a health plan must exceed the target in one of its markets by a margin deemed by OHA statisticians to represent a difference detectable with 95% confidence. If this occurs one year, then the difference in the subsequent year need only be detectable at 80% confidence to earn a second strike. OHA calibrated its statistical model using detailed claims data.[13]

According to OHA's methodology document, the statistical confidence will be based on typical variability observed at the individual person level in a broadly representative data set of Oregon healthcare encounters. The calculation will give greater leeway to smaller health plans that have inherently more volatile experience as well as health plans whose enrollment mix is distributed more in markets that have higher volatility. In theory, the largest health plans should have almost no permissible margin to exceed the growth target.

One drawback of this approach is that it cannot, by itself, account for all sources of variability. The COVID-19 pandemic led to extraordinarily lower healthcare costs in 2020 due to the suppression of healthcare encounters from either cancellation or deferment during mandated lockdowns, social distancing, and heightened risk aversion. This contributed to lower-than-expected health cost growth from 2019 to 2020, but it also led to higher-than-expected cost growth from 2020 to 2021 and into future years, as much of the pent-up, deferred care was fulfilled and healthcare patterns began to normalize. In this environment, the purely statistical measure may indicate that a health plan exceeded the growth target from 2020 to 2021 when it was only a natural normalization of healthcare costs after a period of suppression. In the Medicare market, for example, OHA measured cost growth of -3.9% and +6.5% during these two periods; had they progressed smoothly, it would have been two years of +2.4% growth, well under the growth target. The single year of +6.5% growth could lead to substantial penalties, whereas two years of +2.4% growth would not.

The onset of the COVID-19 pandemic was an extraordinarily rare event, but it provides a timely example of how trends "catch up". There may be more routine events that lead to a low trend followed by a catch-up year. For example, there could be a relatively light flu season one year, followed by a relatively severe flu season the next. In a Medicare population, this may translate into trend below benchmark in the first year and trend above benchmark in the second year, even though the trend was at benchmark on average over the two-year period.

[12] OHA & Program (May 24, 2023). Oregon Cost Growth Target: Technical Advisory Group. Retrieved September 27, 2023, from https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20Meeting%20Documents/1.2-CGT-TAG-May-2023-Slides.pdf.

[13] Methodology is outlined in a technical document at https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Statistical-Analysis-for-Cost-Growth-Target.pdf.

HOW CAN A HEALTH PLAN JUSTIFY THE REASONS FOR EXCEEDING THE GROWTH TARGET?

OHA recognized that there are numerous valid reasons why the growth target may be exceeded in any particular year. It introduced a second criteria to augment the statistical significance test, which is that, if a health plan provides a reasonable basis or justification for higher growth, then that year would not count as a strike toward a financial penalty and no PIP would be required.

OHA identified[14] several factors that may drive cost growth changes above the target, such as changes in mandated benefits, new pharmaceuticals or treatments, changes in taxes or other administrative expense requirements, "acts of God" (e.g., pandemics, wars), changes in federal or state policy or law, investments to improve population health and/or address health equity, macroeconomic factors, and others. This is an effective list that is representative of key cost growth drivers, and we attempt to go into more detail in Appendix A. It is the responsibility of payers and providers is to formulate a reasonable explanation for cost growth above the target and to quantify the relevant drivers. For payers in particular, this responsibility aligns well with existing requirement to justify rate increases subject to regulatory review and approval.

OHA RECOGNIZES THE TRADE-OFFS

Some ways that health plans might reduce healthcare cost trend are to pay healthcare providers less or tighten controls on the frequency or complexity of healthcare services provided.

OHA recognized the danger of unintended consequences that could arise from some cost containment measures, including impacts on the healthcare workforce arising from controlling the growth in reimbursement, reductions in the provision of medically necessary or preventive care, and investments in healthcare innovation.[15]

Moreover, OHA recognized that cost containment may run contrary to other priorities, such as increasing investment in the provision of care to advance health equity and improve health outcomes for all people. OHA intends to collect qualitative information and identify quantitative measures to monitor and determine whether there are unintended consequences.

Primary cost growth drivers

When OHA established the 3.4% growth target, it was based on economic indicators and forecasts of overall economic growth in the state, rather than a direct forecast of healthcare spending. As health payers aim to justify their actual cost growth, they will need to identify and quantify the contribution of cost growth drivers to increases above the growth target. In Appendix A, we have outlined a list of common cost growth drivers affecting health plans. These cost growth drivers are likely to be among the factors put forward to justify higher cost growth.

Not all health plans are subject to the same cost drivers and they may manage these costs with varying degrees of success. This explains why there is considerable variation in cost growth by market and also by payer (as seen in Appendix B). Therefore, a company-specific evaluation of cost drivers is necessary to evaluate whether cost growth above the target is reasonable. Some drivers that affect all payers, such as a pandemic, may nevertheless affect each payer at different levels—payers with relatively younger, healthier enrollees typically had a lower cost impact of the pandemic than payers with relatively older or sicker enrollees, because the pandemic affected different segments of society in dramatically different ways.

Comparison of recent rate increases to growth target

The Oregon Division of Financial Regulation (DFR) has a rigorous rate review process for annual rate increases for individual and small group plans offered on the Oregon Health Insurance Marketplace, which includes extensive documentation standards, public hearings, and parallel actuarial review. Health plans are accustomed to providing a justification of their trends under DFR's analytical scrutiny. Through this process, DFR has approved rate increases well above the growth target, most recently averaging 6.2% for the individual market and 8.1% for the small group market.[16] This demonstrates that increases above the growth target can be satisfactorily justified through the rate review process. Additionally, the range of approved rate increases by payer demonstrates that justified rate increases are specific to each payer. In summarizing its rate review process, DFR states "medical costs continue to rise due to inflation, increased use, and the cost of new specialized prescription

[14] OHA & Program (May 9, 2023). Health Care Cost Growth Trends in Oregon, 2020-2021, p. 12. Retrieved September 27, 2023, from https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2023-Oregon-Cost-Growth-Target-Annual-Report.pdf.

[15] OHA (January 2021). Sustainable Health Care Cost Growth Target, p. 6 and p. 40. Retrieved September 27, 2023, from https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf.

[16] DFR (September 5, 2023). Oregon finalizes 2024 health rates for individual, small group markets; sees robust options in all counties. News release. Retrieved September 27, 2023, from https://dfr.oregon.gov/news/news2023/Pages/20230905-finalized-health-rates-2024.aspx.

drugs," a reason that has been given for each of the rate review cycles from 2022 through 2024.

Oregon Medicaid's Coordinated Care Organization (CCO) capitation rates increased by 3.5% in 2021, 4.2% in 2022, and 3.6% in 2023.[17] In each press release, OHA indicated that that the increases above the growth target were justified.

The Centers for Medicare and Medicaid Services (CMS) tracks trends in the cost of care throughout the country and uses it as the basis for funding the Medicare Advantage program. CMS's payment rates to Oregon Medicare Advantage organizations (MAOs) increased by approximately 6.5% in 2021, 4.4% in 2022, and 1.8% in 2023, with significant variation by county.[18]

Implementation challenges for financial penalties

Financial penalties on payers could be significant under different scenarios, in terms of their impact on profitability, diminishing the adequacy of existing capital and surplus, and public damage to the payer's reputation. High stakes such as these will sharpen scrutiny on every detail of how the penalties are calculated and assessed. Here are some key challenges to overcome in implementing the financial penalty mechanism.

NO CREDIT GIVEN FOR GOOD YEARS

If penalties are based only on the years in which growth exceeded the target, irrespective of how low the growth was in other years, then the overall penalty will not reflect the true, long-term average growth rate that has led to current cost levels.

As we have already discussed, there was higher growth from 2020 to 2021 owing to the bounce-back from COVID-19's initial suppression of healthcare encounters in mid-2020, thereby accentuating the growth trend reported from 2020 to 2021. If no credit is given for the lower trends from 2019 to 2020 that created this situation, then it leads to a higher assessed penalty attributed to the 2020-2021 period.

If a health plan makes a large investment that leads to lower cost growth in a particular year, then it may create a liability if the effects of that investment begin to wear off and there is a period of higher cost growth. Thus, even though overall healthcare costs were reduced over a period of time, there was a higher trend reported in some years. This approach may dissuade health plans and providers from taking bold action in a particular year, opting instead to spread initiatives more thinly across multiple years or delay them.

ALL OR NOTHING AND DIFFERENCES OF OPINION

If OHA does not accept the justification for cost growth above the target, then the full amount may be penalized, even if an acceptable justification is given for a portion of the difference.

Healthcare trends are notoriously difficult to concisely attribute into constituent, underlying drivers. A payer may reasonably estimate a cost driver and OHA may reasonably estimate the same cost driver, and yet both parties may arrive at different numbers.

DIFFERENTIAL TREATMENT OF PROVIDERS AND PAYERS AND DOUBLE PENALIZATION

Healthcare costs as reported by payers tend to reflect the underlying costs of the healthcare providers as expressed through the negotiated reimbursement for the healthcare services performed. However, penalties assessed to high-cost-growth providers so far are not subtracted from the penalty assessed to payers, which may result in a double penalty for the same underlying cost driver (i.e., a penalty assessed on the provider and on the payers).

In June 2023, the Oregon legislature passed an amendment[19] to preferentially adjust the cost growth reporting by providers. Under HB 2045, a provider shall not be accountable for cost growth resulting from the overall compensation and benefits paid to nonmanagerial staff earning less than $200,000. The amendment is intended to encourage higher compensation for nurses and other front-line healthcare workers without penalizing the cost growth calculation of the healthcare provider organizations that employ them. Yet, over time, these compensation increases necessarily translate into higher reimbursement by payers through bilateral contract negotiations between providers and payers, and the higher reimbursement drives costs for which payers remain accountable.

LAG BETWEEN HEALTH PLAN OPERATIONAL DECISIONS AND OHA REVIEW OF COST GROWTH JUSTIFICATION

OHA released its second report on healthcare cost growth trends in May 2023, covering data on healthcare spending from 2020 to 2021. To the extent that health plans could have affected 2021 costs, they would have made operational decisions about healthcare coverage and delivery and would have negotiated provider reimbursement contracts by the spring of 2020, which is

[17] Oregon Health Authority releases CCO capitation rates ahead of each plan year: https://content.govdelivery.com/accounts/ORDHS/bulletins/3337ade; https://content.govdelivery.com/accounts/ORDHS/bulletins/2f674a0; https://www.oregon.gov/oha/ERD/Pages/OHAReleases2021CapitationRates.aspx

[18] Based on Milliman analysis of rate books from CMS Announcement of Calendar Year 2024 Medicare Advantage Capitation rates and Part C and Part D Payment Policies, as well as announcements for prior years. See https://www.cms.gov/files/document/2024-announcement-pdf.pdf. Composite trends are based on county payment rates for 5-star quality bonus-eligible plans, weighted using estimated 2023 beneficiary counts.

[19] See House Bill 2045, passed by the House in May 2023 and by the Senate in June 2023.

when Oregon regulators began to review and validate rate filings. Therefore, there could be at least a three-year lag between when health plans set operational and cost goals and when OHA determines whether the justification for cost growth above the target is acceptable. Such a long period of time could create significant challenges, including:

- Being in limbo as to the acceptability of cost growth above target, even if regulators have already approved the rates
- Reserving for potentially large penalties for multiple years at a time prior to a final determination

GUARDRAILS FOR CAPITAL ADEQUACY

Penalties that are likely under the current proposed formula could cause a total reversal of typical profit over multiple years and/or cause adverse capital adequacy events and reduce the security of health insurance in Oregon. Setting guardrails around maximum penalties will be a challenging endeavor, especially because evaluating the security of capital and surplus levels tends to be company-specific.

FREQUENCY OF UPDATE AND ABILITY TO FORECAST

OHA expressed its intent to revisit the benchmark forecast in 2024, and it has not yet made a major change to the growth target forecast (see the table in Figure 1 above). According to the U.S. Bureau of Labor Statistics (BLS), the consumer price index (CPI),[20] a common measure of overall price inflation, had just wrapped up 2020 at 1.2%. In just two years, however, the CPI had jumped to 8.0%. While OHA recognizes that outside economic forces, such as general inflation, are a legitimate rationale for payers' actual cost growth to exceed the benchmark, higher and unpredictable inflation raises the stakes for payers to justify cost increases above the growth target, as it remains near 3%.

LEVEL OF GRANULARITY

The cost growth measures currently combine multiple lines of business, such as combining individual, small group, and large group insurance into the broader commercial grouping. Therefore, some apparent cost growth over time may be due to changes in the mix of lines of business and populations within a grouping. Fairly adjusting for mix changes, including morbidity levels, can be challenging to implement and review.

Potential magnitude of penalties

When the growth target is exceeded, it can be exceeded by a potentially large amount, especially at the health plan and market level. It is not unprecedented for the growth target to be exceeded by the entire statewide market on average by a significant amount. As seen in the table in Figure 2 above, average growth exceeded the 3.4% target by 8.7% from 2020 to 2021 for commercial, 1.1% from 2018 to 2019 for Medicaid, and 3.1% from 2020 to 2021 for Medicare. Regulatory authorities and government payers approved prospective increases in average per capita spending in excess of the 3.4% target by 3% to 5% for plan years 2023 and 2024 in the commercial individual and small group markets, 0.8% from 2021 to 2022 for Medicaid, and 3.1% from 2021 to 2022 in the Medicare market. Prospectively, even greater differences were approved for specific health plans or in specific counties. See Appendix 2 for more detail.

In the next two sections, we discuss some of the financial and nonfinancial impacts of penalties, given their potential severity and in context of the Program overall.

Nonfinancial impacts of penalties on health plans

THE "SENTINEL EFFECT"

Having established an annual reporting requirement for providers and payers, subject to detailed analysis by OHA, and with public disclosure, the legislature is increasing transparency and awareness about the drivers of cost growth. The reporting and justification of trends further promotes a shared objective of controlling healthcare cost growth, reducing waste, and increasing affordability. In most markets, there are already significant rate review and cost reporting functions in place, including medical loss ratio (MLR) filings, public financial statements, public rate filings, and public rate review processes. However, detailed reporting on historical trends in each market meaningfully expands the public's awareness and understanding of cost growth.

INCENTIVE TO TRY NEW HEALTHCARE IMPROVEMENT INITIATIVES

There is a strong incentive for health plans to demonstrate their willingness to try new ways to reduce healthcare costs because it may also help to mitigate the chance of a financial penalty. On the other hand, bold and yet unproven initiatives may be avoided because they could end up increasing costs. There may be an unwillingness to try new health improvement initiatives that don't already have a strong, demonstrated return on investment (ROI), which could discourage innovation.

AVOIDANCE OF INVESTMENTS IN HEALTH OUTCOMES AND INCREASED HEALTH EQUITY

Initiatives to improve health outcomes and close gaps across the population may add significantly to costs, unless there is a

[20] Consumer Price Index, 1913-, op cit.

predictable method for mitigating their impact on reported cost growth.

REDUCED COMPETITION IN SOME MARKETS

Health plans that struggle to meet the target may choose to exit a particular service area or market where costs are trending higher to avoid a financial penalty. As shown in Appendix B, premium increases in the commercial market tend to be greater than those in the Medicare and Medicaid markets. A health plan may choose to exit the commercial market if it thinks it can more easily meet the cost growth target by focusing more on the Medicaid market, which may reduce competition and consumer choice.

TRANSFER OF RISK TO HEALTHCARE PROVIDERS

Health plans have typically taken on most of the risk from uncertain healthcare cost levels, which they can more readily manage through stronger balance sheets and broad diversification across many enrollees and markets. By passing on variability and growth risk to providers through capitation, they can make their own cost growth more predictable. This technique can align financial incentives for providers to help control cost growth and it is a fundamental reason why there is interest in value-based payment arrangements by commercial and government payers. One of the main drawbacks of transference is that it also increases the financial risk that must be managed by individual healthcare providers. An undue transfer of risk to healthcare providers may result in loss of coverage or healthcare disruption if individual providers end up taking on too much risk.

LIMITS OR REDUCTIONS IN COVERED BENEFITS

A health plan may jettison some higher-cost products or plans with richer benefits to create a temporary reduction in its overall cost growth trend.

CONSOLIDATION OF HEALTH PLANS

Smaller health plans with less negotiating power and that struggle to meet the growth target may opt to consolidate with larger health plans.

CONSOLIDATION OF HEALTHCARE PROVIDERS

Similarly, smaller healthcare providers may merge with larger healthcare systems to help even out the reporting of cost growth. Such consolidation may reduce costs due to greater economies of scale and better coordination of care, though it may also create healthcare provider monopolies that can negotiate higher reimbursement from health plans. Effective in 2022, the Oregon legislature placed restrictions on healthcare provider consolidation through HB 2362,[21] and the House Committee on Health Care staff measure summary[22] of the bill noted the key motivations: while consolidation can create opportunities for greater efficiency and cost savings, “research suggests hospitals with larger market shares can negotiate higher reimbursement from commercial insurers, with price increases exceeding 20 percent when mergers occur in such markets. Of interest [to the legislature] are the effects of hospital and provider consolidation on access, quality, costs, and market competition. Related are the implications of health insurer concentration in a geographic market and insurers’ ability to negotiate rates (prices) with hospitals and providers, and the correlated effects on insurance premiums.”

REDUCE NON-HEALTHCARE-RELATED ACTIVITIES

Administrative functions not directly related to paying for healthcare encounters may be reduced. As a one-time reduction to cost growth, this can reduce wasteful and unnecessary activities, and it can also increase the chance of administrative error or failing to meet regulatory requirements.

REPUTATIONAL DAMAGE

A health plan that is deemed by the state to have higher-cost growth that is not reasonably justified will suffer a significant reputational impact among residents and other stakeholders.

MARKET EXITS

If financial penalties are untenable, then health plans may exit the Oregon market entirely. As a historical precedent, when Washington state introduced guaranteed access provisions in the ‘90s, residents began to purchase coverage only when they needed it, leading to higher premiums and enrollment drops. Health insurers fled the state and, by 1999, it was impossible to buy an individual health plan in Washington.[23]

MANAGING UP TO THE GROWTH TARGET

During periods when underlying cost drivers are more tame and it is easier to manage growth below the target, there could be an incentive to let growth drift up toward the target. This would help payers manage growth more effectively in the future as cost drivers rebound due to some “slack” compounding. While this may be helpful to payers because no credit is given for years of lower growth, it may not serve the goal of reducing costs where possible.

[21] The full text of Oregon House Bill 2362 is available at https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2362/Enrolled.

[22] The full text of the staff measure summary is available at https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureAnalysisDocument/59974.

[23] Kliff, S. (June 17, 2012). Health reform without a mandate: Lessons from Washington state. Washington Post. Retrieved September 28, 2023, from https://www.washingtonpost.com/blogs/ezra-klein/post/health-reform-without-a-mandate-lessons-from-washington-state/2012/06/16/gJQAosKghV_blog.html

Financial impacts of penalties on health plans

Financial impacts of penalties may be the most significant kind of impact to health plans due to their effect on financial stability and profitability.

The penalties have the potential to generate significant funds for the state to expand coverage or undertake healthcare initiatives. Tax revenues to the state may go down, however, depending on the tax treatment of the penalty, and this may offset some of the financial benefit of new funding.

Over the long term, financial penalties assessed on health plans may lead to higher premiums in the future, because health plans may need to increase margins in order to restore surplus levels or recover lost earnings. If there is a period where cost drivers are lower, then health plans may be slow to reduce premiums or give rate relief if they prioritize rebuilding surplus lost through previous penalties.

Health plans that are already in financial difficulty are likely to be those seeking higher rate increases. The challenge of justifying their higher-cost growth under a threat of financial penalty may take on a more existential quality.

COMPARISON TO TYPICAL PROFIT MARGINS IN OREGON

Oregon health plans have tended to have pretax income averaging in the -2% to +4% range over time, with considerable variation by year and by plan (especially among smaller plans). Therefore, a single financial penalty of 5% of revenue would typically eliminate one or two years' worth of average profit for the company.

Because healthcare claims are inherently uncertain, the actual profit margin of a health plan is not known in advance, though it is a key part of the projection of overall cost drivers that the company will incorporate into its premium rate development. In the case of Medicaid CCOs, OHA sets the rates, and the health plan aims to manage its expenses and profit within the per capita budget.

FIGURE3: HEALTH PLAN PROFITABILITY IN OREGON

	Net Underwriting Gain	
	Median	**Average**
2018	-0.5%	-1.8%
2019	1.7%	1.3%
2020	3.7%	3.5%
2021	1.7%	1.2%
2022	2.4%	2.1%

Note: The net underwriting gain of health plans represents the pretax profit margin from health insurance products, prior to assessing federal and state income tax (if applicable) and accounting for changes in investment earnings.

While profit margin affects overall healthcare premiums, it does not significantly affect the trend in premiums. A one percent reduction in profit margin will reduce the overall trend in premium by one percent in that year alone.

CAPITAL AND SURPLUS LEVELS IN OREGON

Currently, most Oregon health plans meet the safe harbor for having surplus above regulatory minimums. Currently, no Oregon health plans are below a 150% risk-based capital (RBC) ratio and so none are subject to increased regulatory intervention or about to be put under regulatory control.[24] After a single 5% penalty, however, around half of Oregon's health plans would be put into varying levels of jeopardy due to insufficient surplus, including having to create an action plan to restore surplus, being subject to regulatory actions to force an increase in surplus, or being put under direct control by regulators. See Appendix C for more analysis. A health plan's primary mode of getting out of these situations is to either reduce and eliminate coverage, withdraw from markets, or increase premiums.

FIGURE 4: IMPACTS FROM A SINGLE 5% PENALTY

[24] Some plans are in the 150%-300% range and either are or may soon be subject to increased reporting requirements.

RESERVING FOR POTENTIAL PENALTIES

If a health plan anticipates cost growth above the target, then it may take at least three years from plan design and rate development until the health plan learns whether the justification is acceptable to OHA, even if a different regulator has already approved the rates. Reserving for a large, potential penalty, especially where the likelihood of the penalty is hard to predict, may tie up a significant portion of a health plan's available capital and surplus. This could complicate the review of health plan financials by DCBS, especially for health plans needing more regulatory oversight.

Potential impacts on consumers

Greater transparency into cost drivers, especially measured consistently across all markets, health plans, and providers, can be very beneficial to consumers. OHA's "2023 Sustainable Health Care Cost Growth Target Annual Report" for the 2020-2021 period[25] released in May 2023, included a 57-page report and a 31-slide report chart pack.[26] The analysis was written for both technical as well as general audiences and contains valuable summaries hitherto unavailable to the general public in this form. Over time, as these reports are released annually, they will become a valuable asset to consumers seeking a greater understanding about costs and evidence of steps taken to improve the sustainability of healthcare system financing in Oregon.

Lower-cost growth is very important to consumers, especially when they pay for health insurance premiums themselves or have significant cost-sharing requirements (e.g., deductibles and coinsurance). However, there are other priorities, such as choice of plan design, choice of provider, and buy-in to the level of care management of healthcare decisions, which may also be valuable to some consumers. A reduction in choice may be one trade-off to be balanced with cost savings.

Caveats and limitations

The information in this paper is intended to provide actuarial analysis and considerations to support the review of the cost growth target program. The paper discusses impacts on various stakeholders, including consumers, regulators, healthcare providers, and health plans, but the main focus is on the impact of financial penalties on health plans. It is not a comprehensive evaluation of the program from the perspective of all stakeholders. The paper should not be relied on as legal interpretation of statute and regulation.

While the paper outlines potential negative impacts as well as areas where the program implementation may need to be clarified, it is not intended to advocate for any particular policy. This paper reflects the author's best understanding of current statute, regulations, and requirements. If these rules change, then the considerations presented this paper may no longer be valid.

Material presented in this paper is the opinion of the author and is not representative of the views of Milliman. As such, Milliman is not advocating for, or endorsing, any specific views in this paper related to the cost growth target program.

This report was commissioned by Cambia Health Solutions, a nonprofit health care company based in Portland, Oregon. It is the parent company of Regence, a member of the Blue Cross Blue Shield Association operating in Oregon, Idaho, Utah, and Washington. Regence BlueCross BlueShield of Oregon is a health plan that is subject to the requirements of the Oregon Health Care Cost Growth Target program.

The author is a member of the American Academy of Actuaries and meets the Academy's qualification standards to render the actuarial analyses presented herein. The author is not a lawyer and therefore cannot provide legal advice. Readers are advised to confer with counsel before using this information. Any distribution of this paper should be in its entirety. Milliman does not intend to benefit, or create a legal duty to, any third-party recipient of this paper.

[25] Health Care Cost Growth Trends in Oregon, 2020-2021, op cit.

[26] OHA & Program (May 2023). Health Care Cost Growth Trends in Oregon, 2020-2021: Report Chart Pack. Retrieved September 28, 2023, from https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Oregon-Cost-Growth-Target-Annual-Report%202020-2021%20Chartpack.pptx (PowerPoint download).

Appendix A

PRIMARY COST GROWTH DRIVERS

Cost Growth Driver	Description	Primary Impacts	Health Plan Ability to Reduce…	Potential Side Effects of Intervention…
General inflation	Average growth in the cost of goods and services.	Administrative overhead of health plan. Causes underlying price pressures on healthcare providers, which affects willingness to accept payer reimbursement levels.	None	NA
Population change	The mix of enrollment, by age and gender, can change over time. This can be especially pronounced at the market level.	Level of utilization and intensity of services required. Mix of services provided	None	NA
Health system or hospital reimbursement contracts	Payers negotiate or set reimbursement levels with major health systems, hospitals, physicians, and other professionals.	Direct impact on unit cost of healthcare encounters paid for by the health plan.	Outcome of bilateral negotiations, limited in areas with dominant health system or hospital and limited in provider specialties in high demand (e.g., cardiovascular). Government payers typically set reimbursement without negotiation (i.e., Medicaid and Medicare) and so have greater ability to reduce reimbursement than commercial payers.	Losing a hospital or health system in negotiation can prevent the health plan from offering coverage in an entire region. Losing physicians, particularly in rare specialties, can limit enrollee choice or health plan can fail to meet network adequacy criteria. If reimbursement is insufficient, quality of care may be reduced.
Pharmacy reimbursement contracts	Payers hire pharmacy benefit managers (PBMs) to negotiate net drug costs directly from manufacturers and suppliers and to develop a formulary of covered drugs.	Direct impact on unit cost of drugs prescribed through a pharmacy.	Limited due to drug manufacturers having national market share and leverage. Individual drugs, including blockbuster brand-name drugs, may have long exclusivity periods.	Dropping coverage for specific drugs may reduce enrollee choice and access.

Cost Growth Driver	Description	Primary Impacts	Health Plan Ability to Reduce…	Potential Side Effects of Intervention…
			Health plan may have limited ability to drop coverage for specific drugs if there are no affordable alternatives with similar therapeutic uses.	
Value-based payments to providers	Incentives and bonuses paid to healthcare providers for meeting value and quality of care targets.	Increases overall cost, but may also create offsetting savings by reducing unnecessary care and aligning providers' financial incentives. May improve population health outcomes through better or more care as well.	Value-based payment program may be initiated by the payer or prescribed by a particular program (e.g., Medicaid and Medicare).	Transfer of financial risk to providers that are not as financially stable as payers.
New healthcare treatments	Innovations in treatments, such as for cancer.	Can add more volume of care at a high price, while also potentially improving health outcomes and mortality.	Limited ability to delay coverage of experimental treatments.	Limiting availability of new treatments can prevent life-saving interventions.
New healthcare technology	New devices, such as imaging machines and monitoring devices, telehealth infrastructure, and others can be very expensive to introduce and require significant investment.	Introduces new types of services, contributing to volume growth, which can initially be at higher prices.	Limited ability to delay coverage of new technologies. Many medical device and equipment suppliers are not exclusive to the local health market and it is more difficult to negotiate lower prices.	Limiting availability of new technology can prevent life-saving interventions.
New drugs	New drugs are continually entering the market to treat more conditions or to improve efficacy.	Increases volume of drugs provided and at a significantly higher cost per drug.	Limited due to exclusivity of new brand-name drugs and the national or international scope of manufacturers. Coverage can more readily be limited when there are already drugs in the same therapeutic class.	Limiting coverage to save cost may delay or reduce improvements in health outcomes.

Cost Growth Driver	Description	Primary Impacts	Health Plan Ability to Reduce…	Potential Side Effects of Intervention…
New mandated health benefits	State and federal government may mandate the coverage of new benefits.	Increase to volume of care and overall cost, usually with the goal of expanding coverage or improving health outcomes.	None	NA
Health status	Changes in health status of the average enrollee can increase the need for healthcare services.	Direct impact on volume of care, including a shift to higher-cost care.	Long-term improvements in health status may be achieved through value-based care, care management programs, quality improvement activities, or broader coverage.	Investments toward improving health status may increase costs in the short term.
Catastrophes	Natural disasters, pandemics, wars, and other large-scale events.	Direct impact on volume of care. Impact may differ significantly by payer depending on their enrollee mix and location.	None	NA
Regulatory coverage mandates	For example, network adequacy (breadth) requirements; mental health parity; limits on care management initiatives.	Increase volume and unit cost of covered healthcare services.	Limited	Failure to meet regulatory requirements can cause financial penalties, reputational damage, and regulatory sanction.
Items below primarily affect the overall premium through non-claims expenses and have little to no impact on underlying healthcare costs.				
Regulatory reporting and operations mandates	Reporting, monitoring, filing, and other regulatory requirements.	Increases administrative expense to comply as well as from penalties for noncompliance.	Limited. Streamlining administrative functions over time.	Failure to meet regulatory requirements due to limiting staff and administrative functions can cause financial penalties, reputational damage, and regulatory sanction.
Taxes	State and federal governments assess income taxes, fees, and assessments to fund other programs and budgets.	Passes directly through to the non-healthcare expense portion of healthcare premiums.	None	NA
Health plan profit margin	Margin on premium to build surplus for future investment and to pay dividends to owners in exchange for risk to capital.	Percentage typically added to health plan premiums.	One-time reductions in margin can save cost in a single year, though it does not affect long-term trends.	Can reduce capital adequacy and stability of health plan, discourage participation in some markets or service areas.

Appendix B

RECENT PROSPECTIVE RATE INCREASES AND BENCHMARKS

Having seen the OHA reporting of its measure of retrospective cost of care growth in the table in Figure 2 above, we can also review precedents elsewhere in Oregon in terms of the prospective growth of payer payment rates and premiums. This provides insight on the cost growth that is built into governmental payer funding levels as well as rate increases approved during regulatory oversight.

		Commercial Rate Review				Government Programs			
	Oregon Health Authority	Rate Review by Oregon Division of Financial Regulation				CMS Payment Rates to Oregon Medicare Advantage Organizations		Medicaid: Oregon Health Authority	
Year	Health Care Cost Growth Targets	Individual Health Plans	Range of Approved Rates (Individual)	Small Group Health Plans	Range of Approved Rates (Small Group)	Average Oregon County	Range by County	Coordinated Care Organization Capitation Rates	Milliman Medical Index
Population Cohort	Statewide Target	Working Age & Dependents	""	Working Age & Dependents	""	Seniors	Seniors	Low-Income	Family of Four: National
2021	3.4%	1.8%	-3.5% - 11.1%	3.7%	-1.1% - 7.0%	3.7%	0.2% - 7.6%	3.5%	8.4%
2022	3.4%	1.5%	-0.9% - 4.9%	1.5%	-3.3% - 3.4%	6.5%	3.5% - 9.0%	4.2%	3.9%
2023	3.4%	6.7%	2.3% - 12.6%	7.8%	3.4% - 10.6%	4.4%	-1.4% - 6.5%	3.6%	5.6%
2024	3.4%	6.2%	3.5% - 8.5%	8.1%	0.8% - 12.4%	1.8%	-1.5% - 3.9%		

Note: This table shows premium and payment rate trends approved by DFR for the commercial market, CMS payment rates for Medicare Advantage markets, and OHA capitation rates for Coordinated Care Organizations in the Medicaid market.

Elsewhere in the country, the growth in the underlying cost of healthcare can be gauged by broad industry benchmarks. According to the Milliman Medical Index,[27] the cost of healthcare for a hypothetical American family of four covered by an average employer-sponsored preferred provider organization (PPO) plan increased by 8.4% in 2021, 3.9% in 2022, and 5.6% in 2023.

[27] Bell, D., Gaal, M., Houchens, P. et al. (May 2023). 2023 Milliman Medical Index. Milliman Research Report. Retrieved September 28, 2023, from https://www.milliman.com/-/media/milliman/pdfs/2023-articles/5-24-23_mmi_2023-final.ashx.

Appendix C

RISK-BASED CAPITAL IN OREGON

CAPITAL AND SURPLUS OF OREGON HEALTH PLANS POTENTIAL IMPACT OF FINANCIAL PENALTIES

While still healthy, a typical (median) Oregon health plan tends to have lower surplus levels than elsewhere in the United States. There are a number of small, regional health plans focusing on Medicaid as a Coordinated Care Organization (CCO) or as a regional Medicare Advantage organization (MAO), and they tend to have lower surplus levels. The larger, multi-line health plans in the state tend to pull the average surplus levels up. These health plans include for-profit entities owned by nationwide publicly traded parent companies along with not-for-profit entities whose parent companies focus on a few states.

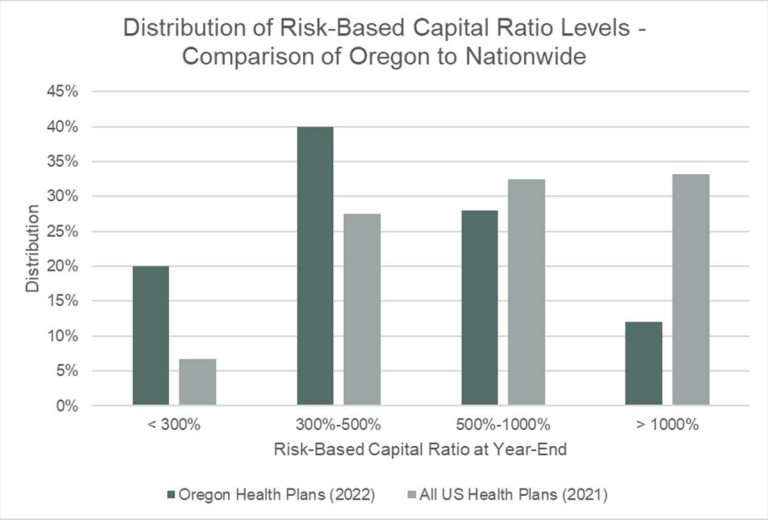
HOW DO HEALTH PLANS MEASURE THE ADEQUACY OF THEIR SURPLUS?

Health plans report to regulators on the ratio of their capital and surplus to a risk-based capital standard, using a formula that takes into account some of the unique risk factors and financial situation of the company. The actual ratio that the company targets is based on a company-specific evaluation of their risk factors, access to outside capital, and other factors.[28]

The average RBC ratio in Oregon is around the nationwide average, though the median is lower (the large companies pull the average up, but the median is lower due to many smaller companies).

COMPARISON OF RBC LEVELS

	RISK-BASED CAPITAL RATIOS	
	MEDIAN	AVERAGE
OREGON (2022)	470%	663%
NATIONWIDE (2021)	630%	635%



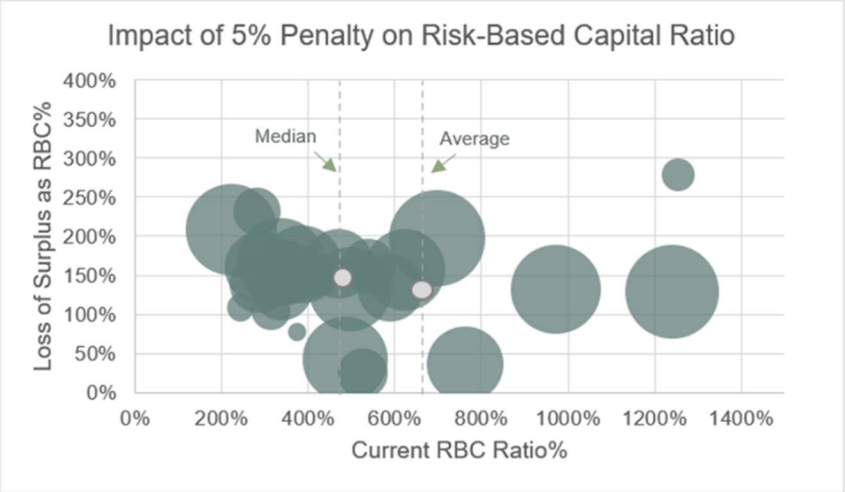
The impact of a hypothetical financial penalty representing 5% of revenue (i.e., caused by exceeding the growth target and failing to provide justification satisfactory to OHA) is shown below for an illustrative health plan in Oregon.

ILLUSTRATIVE IMPACT OF A 5% PENALTY FOR A HEALTH PLAN WITH AN AVERAGE BALANCE SHEET IN OREGON

Annual Revenue in Oregon	$730M
Health Plan Balance Sheet	
Assets	$325M A
Liabilities	$145M L
Capital and Surplus	$180M TAC = A - L
Risk-Based Capital	
Authorized Control Level	$27M RBC ACL
RBC Ratio	667% = TAC / (RBC ACL)
Scenario - 5% of Revenue Penalty	
Penalty	-$36.5M Penalty
Health Plan Balance Sheet and RBC After Penalty	
Assets	$288.5M A' = A - Penalty
Liabilities	$145M L
Capital and Surplus	$143.5M TAC' = TAC - Penalty
Authorized Control Level	$27M RBC ACL
RBC Ratio	531% = TAC' / (RBC ACL)
Loss of RBC Ratio	-135%

[28] Jones, S. (August 2020). Comparing Health Insurance Company Surplus Levels. Milliman White Paper. Retrieved September 28. 2023, from https://us.milliman.com/en/insight/comparing-health-insurance-company-surplus-levels.

Modeling a single 5% penalty across all major health plans in Oregon would have varying effects on their surplus levels and RBC, depending on their current balance sheets.



Note: The size of each circle reflects the relative size of each health plan's total health insurance coverage in Oregon.

Currently, most Oregon health plans meet the safe harbor for having surplus above regulatory minimums. Some are either slightly below the 250% mark or are in the 250%-300% range, making it more likely that they will have to create a company action plan now or in the near future, should they incur a penalty. Currently, no Oregon health plans are below a 150% RBC ratio and so none are subject to increased regulatory intervention or about to be put under regulatory control. After a single 5% penalty, however, around half of Oregon's health plans would be put into varying levels of jeopardy due to insufficient surplus, including having to create an action plan to restore surplus, being subject to regulatory actions to force an increase in surplus, or being put under direct control by regulators. A health plan's primary mode of getting out of these situations is to either reduce and eliminate coverage, withdraw from markets, or increase premiums.

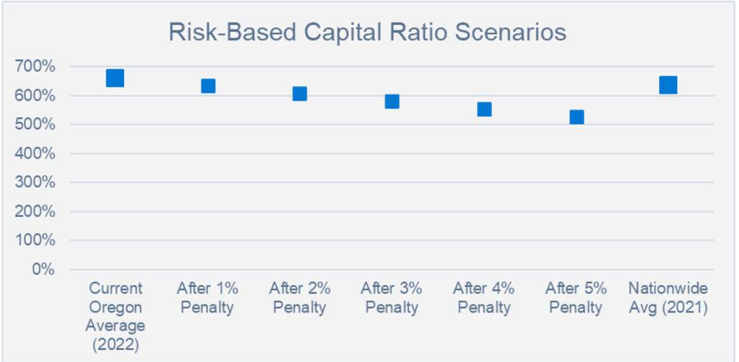
Events at Key RBC Ratio Thresholds

150%-300%: A company may have to develop an action plan for maintaining or increasing RBC above 250% if its RBC falls below 250% or if it falls below 300% while running losses over -5%.

100%-150%: In this range, the regulator may take greater oversight and require certain actions to improve surplus levels, including higher rate increases.

70%-100%: The regulator may take over the company to ensure policyholders are protected.

Under 70%: The regulator must take over the company.



Appendix D

COST OF CARE GROWTH TARGET PROGRAM – IMPLEMENTATION TIMELINE

Accountability Measure	Description	Considerations	Implementation Timeline[29]
Annual data reporting	Payers and providers required to submit data.	OHA uses to calculate per capita cost growth to compare to target	The 2021 reporting covers 2018-2020 cost growth.
Performance Improvement Plans	Entities whose cost growth exceeds the target materially[T] in the previous year must create a PIP.	▪ Identify key cost drivers ▪ Identify concrete steps to address cost drivers ▪ Set an appropriate timeline for making progress and review by OHA ▪ Have clear measurements for success	Currently[TT] set to begin with 2022-2023 cost growth, as reported during 2024.
Financial penalty	OHA will assess a financial penalty on an entity exceeding the target without reasonable cause in three out of five years.	Penalty must account for: ▪ Degree to which target is exceeded ▪ Size of the entity ▪ Previous or ongoing efforts to address cost drivers Avoid double-counting other penalties, such as minimum medical loss ratio (MLR) rebates and remittances.	*Criteria and penalty formula currently under development in fall 2023. Earliest penalty would occur after reporting of 2024-2025 cost growth.*

Notes:

[T] to be subject to a Performance Improvement Plan (PIP) requirement, an entity must exceed the target with statistical significance and without providing good reason.

[TT] the 2021-2022 period was originally planned to be the first performance year for this purpose, but it was deferred.

[29] OHA (August 2023). Sustainable Health Care Cost Growth Target Program: Update to Accountability Timeline. Retrieved September 28, 2023, from https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/CGT-accountability-update_August-2023.pdf.

Appendix E

RELATED PROGRAMS IN OTHER STATES

There are existing programs in other states that have similar features and objectives to varying degrees.

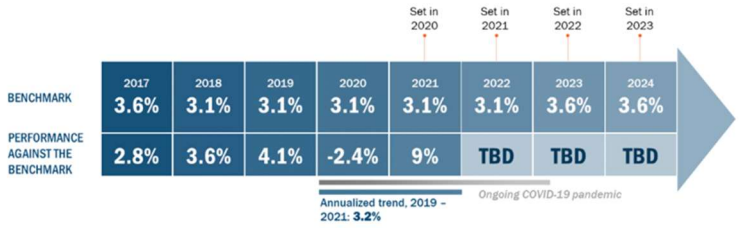
Massachusetts

The Health Care Cost Growth Benchmark program in Massachusetts mandated the Health Policy Commission (HPC) to establish a cost growth benchmark. The resulting benchmark, annually developed by the Center of Health Information and Analysis (CHIA), is tied to its estimate of the growth rate potential of gross state product. Initially set at 3.6% beginning in 2013, the cost growth benchmark has been updated over time; it was set at 3.1% for 2022, 3.6% for 2023, and 3.6% for 2024.[30] Healthcare providers and health plans are held accountable for cost growth in excess of CHIA thresholds by being referred to HPC for further review and consultation. Referred entities are not subject to automatic actions or a performance improvement plan.[31]

For example, if a hospital exceeds the benchmark, it may receive a letter informing it of its status and requesting an explanation. There is no automatic sanction or financial penalty associated with these events.

MEASURING PERFORMANCE AGAINST THE HEALTH CARE COST GROWTH BENCHMARK IN MASSACHUSETTS

Source: Massachusetts Health Policy Commission



California

The California Office of Health Care Affordability (OHCA) collects data on healthcare expenditures and cost growth drivers while promoting strategies to manage growth, increase affordability, and maintain quality and equity.[32] Like Oregon and Massachusetts, OHCA plans to set an annual cost growth target, but it also intends to set specific targets for different geographic regions, types of healthcare systems, and other groups. The first growth target will be set in June 2024 for the 2025 calendar year.[33] In the future, there may be enforcement in the form of performance improvement plans or assessment of financial penalties, which could begin as early as 2028.

Colorado

A different approach was taken in Colorado by mandating premium reductions.[34] Health plans in the individual and small group markets must offer a "Colorado Option Standardized Plan" at each benefit level in counties where they offer existing plans. For the first year of the mandate, the 2023 benefit year, these plans were required to be offered at a 5% discount from their 2021 equivalent, adjusting for an external inflation measure.[35] The plans must achieve a 10% discount in 2024 and a 15% discount beginning in 2025. Colorado regulators were given the authority to mandate provider reimbursement reductions and other cost reductions, subject to the guardrail that rates remain actuarially sound.

In the 2024 rate filings, most health plans were unable to meet the mandated premium reduction target. The regulator hired a consultant to publicly identify the healthcare providers most responsible for higher healthcare spending for each health plan. Under pressure from the regulator, health plans and healthcare providers negotiated reductions in their reimbursements to the maximum amount allowed under the statute. There were contentious, public arguments between the regulator, health plans, and providers about who was to blame for the inability to achieve mandated premium reductions.[36,37]

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[30] Mass.gov. Health Care Cost Growth Benchmark. Retrieved September 28, 2023, from https://www.mass.gov/info-details/health-care-cost-growth-benchmark.

[31] Massachusetts Health Policy Commission (April 2023). Health Care Cost Growth Benchmark: Frequently Asked Questions, #4. Retrieved September 28, 2023, from https://www.mass.gov/doc/health-care-cost-growth-benchmark-faqs-0/download.

[32] California Department of Health Care Access and Information (October 25, 2022). Get the Facts About the Office of Health Care Affordability. Retrieved September 28, 2023, from https://hcai.ca.gov/get-the-facts-about-the-office-of-health-care-affordability/.

[33] See "cost growth targets" section of OHCA Background and Resources – Retrieved September 28, 2023 from https://hcai.ca.gov/data-and-reports/ohca-background-resources/

[34] Colorado Department of Regulatory Agencies. Colorado Option Public Hearings. Retrieved September 28, 2023, from https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/colorado-option/colorado-option.

[35] The medical care index component of the BLS consumer price index for medical care services and medical care commodities for the Denver-Aurora-Lakewood area. Growth is averaged over three years to arrive at the permissible trend elevator.

[36] Wingerter, M. (June 11, 2023). Most Colorado Option health insurance plans aren't hitting state's cost-reduction requirement. Denver Post. Retrieved September 28, 2023, from https://www.denverpost.com/2023/06/11/colorado-option-premium-reductions-insurance-companies/

[37] Ingold, J. (June 7, 2023). Why a showdown over Jared Polis' big health insurance reform program fizzled – and what it means. Colorado Sun. Retrieved September 28, 2023, from https://coloradosun.com/2023/06/07/colorado-option-health-insurance-public-hearing/.

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