OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

March 31, 2026

The Honorable Louis P. DiPalma
Chairman, Senate Committee on Finance
Rhode Island State House
82 Smith Street
Providence, RI 02903

RE: Letter of Support – Health Spending Accountability and Transparency Program – Article 11 Sections 12 and 13

Dear Chairman DiPalma:

I'm writing in support of Article 11 – Sections 12 and 13 regarding the Health Spending Accountability and Transparency Program. A January 2026 national KFF Health Tracking Poll found that "health care costs top the list of what the public worries about being able to afford for themselves and their family. Two-thirds (66%) of the public say they worry about paying for health care, including the cost of health insurance and out-of-pocket costs for things like office visits and prescription drugs, ranking higher as a financial worry than other household expenses like utilities, food, and rent or mortgage."[1] These national findings echo a 2024 survey of Rhode Island residents which found that four in five (82%) worried about affording health care in the future.[2] Given the recent rise in health care costs and insurance premiums these findings are not surprising.

Article 11 Sections 12 and 13 of Governor McKee's proposed FY 2027 budget will provide the Office of the Health Insurance Commissioner (OHIC) with new regulatory tools to lower Rhode Islanders' health care costs. These new tools will complement existing regulatory levers that OHIC utilizes to make health care more affordable and build on efforts OHIC has undertaken in recent years through the Health Spending Accountability and Transparency Program. The proposal comprises five key components:

1. A health care cost growth target tied to economic indicators
2. An all-payer primary care investment target
3. Public reporting on health care costs and cost drivers
4. An annual public hearing with testimony on cost drivers
5. Enforcement authorities through performance improvement plans and potential financial penalties

Through OHIC Rhode Island has made enormous strides in health care spending transparency. The General Assembly has provided operational funding to support these efforts in OHIC's budget since FY 2023. OHIC's Data Hub provides unprecedented insight into health care spending in the state that did not exist before, and

[1] KFF Health Tracking Poll (January 13-20, 2026). https://www.kff.org/public-opinion/kff-health-tracking-poll-health-care-costs-expiring-aca-tax-credits-and-the-2026-midterms/
[2] Consumer Healthcare Experience State Survey: Rhode Island. Altarum Health Care Value Hub. 2024.. https://healthcarevaluehub.org/consumer-healthcare-experience-state-survey/rhode-island/

is being replicated by other states. An annual Cost Trends Report tracks health care spending growth and provides focused analyses into the leading drivers of spending growth. Still, key components of the Health Spending Accountability and Transparency Program remain voluntary, including insurer data reporting and the cost growth target. Additionally, OHIC lacks a mechanism to enforce adherence to the cost growth target.

Codifying core components of the Health Spending Accountability and Transparency Program and creating new enforcement tools through statute will:

- **Strengthen the program for the future**. Nearly all states with cost growth targets have their programs in statute (CA, CT, DE, MA, OR, WA). NJ, the only other state operating without statute, has already filed legislation to change that in 2026.
- **Create new tools to ensure that Rhode Island restrains spending growth and meets its cost growth target, while making necessary investments in primary care**. Per capita health care spending growth in Rhode Island has been distressingly high in the past few years, and well above the cost growth target. Aspirational targets alone are now insufficient for ensuring accountability for affordable rates of spending growth. At the same time, investment in primary care has lagged.

To support the committee and the public's review of this proposal, on February 9th OHIC published a Review of State Cost Growth Target Programs. This report covers the history of Rhode Island's efforts to measure health care costs and reviews approaches taken in other states that informed Article 11 Sections 12 and 13. I have included this report as Attachment 1.

Sincerely,

Cory B. King
Health Insurance Commissioner

CC: Honorable Members of the Senate Finance Committee
Kristen Silvia, Director of Legislation and Deputy Chief of Staff

Attachment 1: Review of State Cost Growth Target Programs

Review of State Cost Growth Target Programs

February 9, 2026

This report contains a review of state cost growth target program statutes and recommendations for Rhode Island.

STATE OF RHODE ISLAND
Office of The Health Insurance Commissioner
Department of Business Regulation

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OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

February 9, 2026

To the Reader:

The Office of the Health Insurance Commissioner (OHIC) has long been at the forefront of state policy initiatives to make health care more affordable. These initiatives have produced some successes in terms of relatively lower premiums and cost trends than neighboring states.[1] Still, each state is unique and health care costs continue to rise at a pace that burdens Rhode Islanders and threatens affordability. We know that rising health care costs affect working families by slowing wage growth and potentially leading employers to defer or reduce hiring. This hurts the economy. Rising health care costs also force some Rhode Islanders to make difficult choices to forgo care or sacrifice necessities.

In the last two years, commercial market cost trends have been high and have contributed to double-digit premium increases for 2025 and 2026. In the face of these emerging trends OHIC evaluated policy and regulatory levers that could be enhanced to support more affordable health insurance. One component of Rhode Island's affordability strategy is its health care cost growth target program, which is supported by robust data collection and analysis. There is an opportunity to codify various components of Rhode Island's program and strengthen it with new authorities to support our ability to further tackle increasing costs. Identification of this opportunity comes from reflection on lessons learned over time and work in other states.

This report reviews the history of Rhode Island's cost growth target and reviews approaches taken in other states. In recent years OHIC has collaborated with a network of policymakers from states who share a common commitment to affordability.[2] Among this network of states, eight states use cost growth targets as part of an affordability strategy, and six of the eight states have codified their programs in statute. OHIC reviewed laws in these six states – California, Connecticut, Delaware, Massachusetts, Oregon, and Washington. Our review shows that successful cost growth target programs share common statutory foundations. These include formal governance, data reporting, public hearings, and, in some cases, enforcement mechanisms. These approaches highlight the importance of embedding authority, independence, and

[1] These successes are highlighted in OHIC's FY 2027 budget request strategic plan.
[2] This includes the following states: California, Connecticut, Delaware, Maine, Massachusetts, Minnesota, New Jersey, Oregon, Utah, Vermont, Washington.

accountability for cost growth target programs into law. This research informed OHIC's proposal in Governor McKee's FY 2027 budget, specifically Section 12 of *Article 11 – Relating to Affordability.*

Insurers, pharmacy benefit managers, pharmaceutical manufacturers, large provider entities, and government all have a role to play in making health care more affordable for Rhode Islanders. I hope that the research we conducted to inform OHIC's proposal is informative and helpful to stakeholders as they review the proposal.

Sincerely,

Cory B. King
Health Insurance Commissioner

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I. Executive Summary

Rhode Island's health care spending has grown at an unsustainable pace, outpacing household income, employer resources, and the state budget. To address this, the state launched the Cost Growth Target initiative in 2018. The initiative began as a voluntary public-private partnership, and was subsequently formalized by Executive Order 19-03 in 2019, positioning Rhode Island as a national leader in health care affordability.

Over seven years, the program has achieved some success, meeting targets in 2020–2022, outperforming other cost growth target states, and maintaining strong transparency and stakeholder engagement. In 2022, the state launched the Health Spending Accountability and Transparency Program with funding from the Rhode Island General Assembly to improve data and transparency over the drivers of health care spending growth.[1] The program subsumed the Cost Growth Target initiative. Shortly after, in 2023, Rhode Island updated its target-setting methodology for 2023–2027 to reflect trends in both state economic growth and household income.

Despite this progress, core program elements rest solely on executive authority and voluntary stakeholder participation. These elements include governance, data collection authority, and the cost growth target methodology.[2] Without statutory codification, Rhode Island risks losing the gains it has made in the areas of health care cost containment and affordability. To further advance affordability, new enforcement authorities for controlling health care costs are needed.

The Office of the Health Insurance Commissioner's (OHIC) review of laws in six peer states – California, Connecticut, Delaware, Massachusetts, Oregon, and Washington – shows that successful cost growth target programs share common statutory foundations. These include formal governance, data reporting, public hearings, and, in some cases, enforcement mechanisms. These approaches highlight the importance of embedding authority, independence, and accountability for cost growth target programs into law.

OHIC recommends that core elements of Rhode Island's cost growth target program be codified into law, with the following key elements:

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[1] See OHIC Bulletin 2022-02.

[2] Presently, these program elements rely on voluntary compact among health care stakeholders. In 2022, OHIC executed the Compact to Reduce the Growth in Health Care Costs while Improving Health Care Access, Equity, Patient Experience, and Quality in Rhode Island. The compact extended prior commitments from the 2018 Compact and adopted a series of specific annual Cost Growth Targets through 2027.

- **Lead Agency:** The statue should recognize OHIC as the lead agency for implementing the program, with rulemaking authority over data, reporting, and enforcement processes.
- **Governance:** Rhode Island should adopt a dual advisory body model – one non-industry affordability body to ensure consumer- and employer purchaser-focused oversight, and one broader stakeholder forum that allows for industry input and guidance.
- **Target Methodology:** The statute should link future targets to economic indicators but allow OHIC flexibility to refine methodologies in response to changing economic and market conditions in collaboration with stakeholders.
- **Data Authority:** OHIC should have clear authority to require payer data submissions to support measurement and accountability, impose penalties for failure to provide complete and accurate data on time, and establish data-sharing with other state agencies.
- **Reporting and Transparency:** The statute should direct OHIC to publish an annual report on spending and spending growth, hold public hearings, and compel testimony from entities that contribute significantly to high and rising costs.
- **Enforcement:** The statute should allow OHIC to require performance improvement plans from entities that repeatedly exceed the target in the commercial market and potentially assess financial penalties as a last resort.

Codifying the cost growth target program and creating new enforcement authority would ensure that Rhode Island continues to lead in health care affordability, protecting residents, employers, and taxpayers from escalating costs, and provide shared accountability for long-term, sustainable health spending.

II. Introduction

Health care spending in Rhode Island continues to grow at an unsustainable rate – outpacing growth in household income, employer resources, and state budgets. OHIC's recently approved rates for 2026 coverage include double-digit increases, ranging from 13.3% to 22.0%.[3] While steep, these are lower than insurers' original requests, which ranged from 13.5% to 28.9%.[4] Such increases are driven by health care cost growth and they will add to the significant financial strain already experienced by families and business. It is unfair to ask consumers and employers to keep carrying this burden when they have little to no control over the underlying drivers of health care costs. Fairness demands that responsibility for addressing rising health care costs be more evenly shared, with insurers, pharmacy benefit managers (PBMs), providers, and policymakers working together to deliver better value.

Rhode Island has taken several steps to address health care affordability, including through the establishment of the cost growth target initiative in 2018. Originally launched as a public-private partnership and subsequently formalized by Executive Order 19-03 in 2019, the program has helped position Rhode Island as a national leader in health care affordability efforts.

However, core elements of the program currently rely on executive authority and voluntary commitments from health care stakeholders. This absence of statutory enforcement authority leaves the program vulnerable to uneven participation and non-adherence to the target. Codifying the cost growth target program in statute would provide the foundation necessary to ensure its continuity, guarantee transparency in reporting, and strengthen accountability for providers, insurers, PBMs, drug manufactures, and all others who influence health care costs. Without it, Rhode Island risks losing the progress it has made in managing health care cost growth and promoting affordability for residents, employers, and taxpayers.

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[3] Rhode Island Office of the Health Insurance Commissioner, 2026 Commercial Health Insurance Rates Approved with Modifications, September 15, 2025, available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-09/Rate%20Review%20Process%20Press%20Release%20-%20Approved%20Rates%20September%202025%20version%20for%20release.pdf .

[4] Rhode Island Office of the Health Insurance Commissioner, 2026 Commercial Health Insurance Rates Have Been Submitted to OHIC for Review, June 13, 2025, available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-06/Rate%20Review%20Process%20Press%20Release%20-%20Requested%20Rates%20June%2013%202025.pdf

This report reviews the history of Rhode Island's cost growth target program initiative, examines the statutory frameworks adopted in other states with cost growth targets, and presents recommendations for fully establishing the program in statute to secure its future as a cornerstone of state health policy. The recommendations determined the content of Article 11 Section 12 of Governor McKee's proposed budget for fiscal year 2027.

III. History and Evolution of Rhode Island's Cost Growth Target Program

Program Origins

Rhode Island's cost growth target initiative began in 2018 through a partnership among state leaders, insurers, providers, employers, and consumer advocates. With foundation support, the State launched the Health Care Cost Trends Project, which established a multi-stakeholder Steering Committee. This committee was tasked with recommending a methodology for setting a cost growth target and exploring policy approaches to address rising health care spending.

By the end of 2018, Steering Committee members signed a compact agreeing to a statewide annual per capita health care cost growth target of 3.2 percent for 2019 through 2022, aligned with the growth rate of Rhode Island's potential gross state product (PGSP). The Steering Committee also committed to working collaboratively toward affordability and long-term sustainability.[5]

Early Implementation

Shortly thereafter, on February 6, 2019, Executive Order 19-03 was issued, formally adopting the 3.2% annual cost growth target. The Executive Order directed the Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services (EOHHS) to oversee implementation, develop technical guidance, and establish annual public reporting on performance against the target. OHIC assumed the role of lead agency. EOHHS has provided OHIC with access to the state's all-payer claims database (APCD) to support health care cost analytics.

The initiative emphasized transparency through reporting based on payer-submitted data. In the first four years of implementation, Rhode Island exceeded its statewide all-payer target in 2019, but met it in 2020 through 2022.[6] In 2021 – when health care spending rose sharply due to post-COVID utilization – Rhode Island was the only state among its peers to meet its statewide target, aided in part by restrained outpatient hospital spending and an

[5] Rhode Island Health Care Cost Trends Steering Committee, Compact to Reduce the Growth in Health Care Costs while Improving Health Care Access, Equity, Patient Experience, and Quality in Rhode Island, December 19, 2018, available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/cost-trends-project/Compact-to-Reduce-the-Growth-in-Health-Care-Costs-and-State-Health-Care-Spending-in-RI.pdf.

[6] Rhode Island Office of the Health Insurance Commissioner, Annual Report: Health Care Spending and Quality in Rhode Island 2025, May 12, 2025, available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-05/OHIC%20Cost%20Trends%20Report_final%2005.12.2025.pdf.

OHIC hospital price growth cap tied to the Consumer Price Index plus one percentage point.[7]

On July 1, 2022, Rhode Island launched the Health Spending Accountability and Transparency Program with funding from the General Assembly, institutionalizing goals around data transparency on health care costs and drivers of cost growth, shared accountability for health care costs and cost growth, and lessening the negative impact of rising health care costs on Rhode Island residents, businesses, and government.[8]

Evolution of the Target Methodology

In 2022 the Steering Committee executed a new compact, setting forth a new set of targets for 2023 and future years. In response to post-COVID inflation spikes, Rhode Island revised its target-setting methodology. For the 2023–2025 period, targets were established using a 75% PGSP and 25% median household income growth blend, with adjustments included for actual inflation in 2021–2023. This resulted in new targets of 6.0% (2023), 5.1% (2024), and 3.6% (2025), before tempering back to 3.3% for 2026–2027 under the long-term forecast methodology.

State and Commercial Market Performance Against the Cost Growth Target

In three of the five years for which performance data are available, Rhode Island's spending growth was below the target (see Table 1). Notably, of the cost growth target states, it was the only one to meet its target in 2022[9], and overall, its cost growth has been lower than that of other states.[10] However, commercial market spending growth has exceeded the target each year except 2020.

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[7] January Angeles, States Setting Health Care Spending Growth Targets Experienced Accelerated Growth in 2021, Health Affairs Forefront, June 29, 2023, available at: https://www.healthaffairs.org/content/forefront/6-29-angeles-piece.

[8] See OHIC Bulletin 2022-02. https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-08/OHIC%20Bulletin%202022-2%208-31-22%20Final.pdf

[9] Jessica Mar and January Angeles, In States With Health Care Spending Targets, Spending Growth Moderated in 2022 But Still Exceeded Targets, Health Affairs Forefront, August 8, 2024, available at: https://www.healthaffairs.org/content/forefront/states-health-care-spending-targets-spending-growth-moderated-2022-but-still-exceeded.

[10] Jessica Mar and January Angeles, For States With Cost Growth Targets, 2023 Was High Across The Board, Health Affairs Forefront, August 29, 2025, available at: https://www.healthaffairs.org/content/forefront/states-cost-growth-targets-2023-spending-growth-high-across-board.

Table 1. Growth in Rhode Island's Total Health Care Expenditures and Commercial Market Total Medical Expense

Calendar Year	Statewide Target	State Total Health Care Expenditures Growth	Commercial Total Medical Expense Growth
2019	3.2%	4.1%	4.7%
2020	3.2%	-2.9%	-3.0%
2021	3.2%	3.2%	9.7%
2022	3.2%	1.6%	3.3%
2023	6.0%[11]	7.8%	6.9%

Since 2022, OHIC has held an annual public forum to review progress on the state's cost growth target and discuss strategies to address rising costs. In 2023, it began to annually supplement this effort with an annual report on health care spending and quality, along with a chartbook on commercial market trends.

Future Need: Codifying and Strengthening Rhode Island's Cost Growth Target Program

Now in its seventh year of implementation, Rhode Island's cost growth target program has become a cornerstone of the state's health care affordability strategy. However, for the program to endure and produce more shared accountability for health care affordability, core components need to be codified in statute. This would reinforce the State's commitment to health care affordability and signal to health care stakeholders that managing health care cost growth is a shared, ongoing responsibility rather than a time-limited initiative. All but one of the seven other cost growth target states have their programs established in statute.

In addition, the program needs to have the appropriate tools to ensure accountability for meeting the target. Experience in other states has revealed that transparency and reporting are not enough to drive meaningful action to mitigate cost growth over the long run.[12] Strengthening enforcement and accountability measures would give the State more effective tools to protect residents, employers, and government from the financial burden of high and rising health care costs.

[11] Adjusted to account for the lagged impact of the post-pandemic spike in general inflation.
[12] Debra Lipson, Cara Orfield, Rachel Machta, Olivia Kenney, Marian Wrobel, and Sule Gerovich, The Massachusetts Health Care Cost Growth Benchmark and Accountability Mechanisms: Stakeholder Perspectives, Mathematica, October 2022, available at: https://www.milbank.org/wp-content/uploads/2022/10/MassCostGrowthBenchmarkEvaluation_Mathematica_Oct2022.pdf.

IV. Review of Other States' Cost Growth Target Program Statutes

Of the eight states that have cost growth targets, six have enacted programs in statute, while New Jersey and Rhode Island continue to operate under Executive Order. Although states share common goals of promoting affordability and accountability, their approaches differ on several dimensions. To inform recommendations for a statutory framework for Rhode Island's cost growth target, OHIC examined the statutory language of the six states with programs established through legislation – California, Connecticut, Delaware, Massachusetts, Oregon, and Washington. The review focused on the following areas:

- Program governance
- Establishment of annual per capita cost growth targets
- Establishment of all-payer primary care spending targets
- Data reporting requirements to measure and track cost growth target performance
- Annual reporting on health care spending trends and performance relative to the cost growth target
- Annual hearings on health care spending and performance relative to the cost growth target
- Enforcement of the cost growth target

The following sections summarize the findings from OHIC's review. Appendix 1 contains more detail on these states' laws and includes references.

Program Governance

Governance structures establish the authority, independence, and processes through which cost growth targets are developed, monitored, and enforced. They also shape stakeholder participation and the balance of representation from technical experts, consumers, employers, and health care industry stakeholders. While membership rules and advisory structures differ, all six states have established formal oversight bodies responsible for setting and monitoring cost growth targets.

- **California:** The Office of Health Care Affordability oversees the program, while the Health Care Affordability Board sets the health care cost growth targets and approves key benchmarks. Statute establishes strict membership rules for the Health Care Affordability Board to avoid conflicts of interest, prohibiting board members from receiving compensation from health care entities. The Health Care Affordability Board also appoints an Advisory Committee to which includes

representatives from consumer groups, payers, hospitals, physicians, labor, and purchasers.

- **Connecticut:** The Office of Health Strategy manages the program with advisory input from multiple committees. Until fall 2025, the Office of Health Strategy relied on a single steering committee, but it is now transitioning to two separate advisory bodies: one composed of non-industry members to ensure unbiased input, and one inclusive of industry stakeholders.
- **Delaware:** The Delaware Health Care Commission governs the program, supported by a subcommittee of the Delaware Economic and Financial Advisory Council, which recommends methodologies and reviews trends. Membership to the subcommittee includes a mix of gubernatorial and legislative appointments, and ex officio members from key state agencies.
- **Massachusetts:** The Health Policy Commission is governed by an 11-member board representing multiple appointing authorities, including the Governor, Attorney General, and State Auditor. Statute prohibits members from financial ties to health care entities, though this has not always been strictly enforced. An advisory council adds additional perspectives from across the health care system.
- **Oregon:** The Oregon Health Authority manages the program under oversight of the Health Policy Board. Oregon's governance model has changed over time, with the State phasing out its Cost Growth Target Advisory Committee in favor of two newer committees: one prioritizing consumer and purchaser perspectives, and another focused on industry expertise.
- **Washington:** The Health Care Cost Transparency Board includes 14 members who represent state agencies, employers, consumers, and health care economics and financing experts. Statute also requires the establishment of a Stakeholder Advisory Committee and a Data Advisory Committee. One member of the Stakeholder Advisory Committee sits on the Health Care Cost Transparency Board, but has a non-voting role that is limited to providing input.

Establishment of Annual Cost Growth Targets

A central element of cost growth target programs is the methodology used to define annual spending targets. The process for establishing annual targets varies by state, with targets usually tied to broad economic indicators such as personal income growth and state economic growth. Statutes also vary in terms of flexibility regarding how cost growth target methodologies are set, the frequency with which they are updated, and requirements for public and legislative review of the target methodologies and values.

- **California:** Targets are developed by Office of Health Care Affordability, approved by Health Care Affordability Board, and informed by a wide set of factors such as economic growth, COVID-related anomalies, workforce costs, and health equity.
- **Connecticut:** The Office of Health Strategy sets benchmarks every five years. Any deviation of more than 0.5% from the prior benchmark requires legislative approval.
- **Delaware:** Delaware statute ties the benchmark directly to Potential Gross State Product, subject to an annual review by a subcommittee of the Delaware Economic and Financial Advisory Council. Any changes to the methodology require public input.
- **Massachusetts:** Massachusetts sets its benchmark values annually, linked to Potential Gross State Product. The benchmark can be modified with a two-thirds Health Policy Commission vote, but only after a public hearing.
- **Oregon:** Oregon's statute requires the benchmark to promote sustainable growth and apply uniformly across providers and payers. The benchmark values were initially set for 10 years, although the state has opted to reconsider the value for the second five years during 2025.
- **Washington:** Washington's statute requires the Health Care Cost Transparency Board to establish a benchmark starting with the "highest cost drivers" in the health care system and then developing a phased approach to include other components of the health care system. In practice, however, the Health Care Cost Transparency Board established a statewide target, based on growth in the Potential Gross State Product and median household income, that applies uniformly to all Total Medical Expense (TME)-attributable entities.

Primary Care Spending Targets

Investment in primary care is widely recognized as a strategy for improving population health and moderating long-term cost growth. Since 2010, Rhode Island has had a primary care spend target for commercial insurers as part of OHIC's Affordability Standards – a set of insurer requirements designed to control costs and improve the quality of care. OHIC amended the regulatory primary care spending target in March 2025 to mandate an increase in primary care investment by commercial insurers in Rhode Island. Currently, the Affordability Standards require commercial insurers to dedicate at least 10% of total medical expenditures to primary care.

In our review, we found that the six states have established primary care spending targets, though enforcement authority varies.

- **California:** A long-term benchmark requires 15% of all spending to be dedicated to primary care by 2034, with annual incremental increases for each payer. Although

the Office of Health Care Affordability reports on progress, it lacks authority to enforce compliance.

- **Connecticut:** The state set a 10% target for primary care spending through 2030. As with the cost growth benchmark, this target is reviewed every five years.
- **Delaware:** Delaware mandates an 11.5% minimum for commercial insurer primary care spending, modeled after Rhode Island's Affordability Standards.
- **Massachusetts:** In December 2025 a statutorily prescribed task force charged with developing recommendations for a primary care spending target recommended a 15% spending target.[13]
- **Oregon:** A 12% statutory minimum applies to Medicaid managed care, state employee health plans, and public educator plans. Carriers that fall short must file compliance plans. This makes Oregon one of the few states with an enforceable mandate.
- **Washington:** Washington statute set a 12% primary care spending target, while leaving flexibility for the Health Care Cost Transparency Board to define how primary care spending is measured.

Data Reporting and Transparency

Reliable, timely data is essential for monitoring performance and holding stakeholders accountable under cost growth target programs. Since the 2019 performance year, OHIC has collected annual data from payers to measure spending growth and performance against the state's cost growth target. Although OHIC currently lacks statutory authority to require and enforce this data collection, all major payers from whom OHIC has requested information have complied.

Our review of state statutes found that most explicitly authorize annual data collection. However, they generally lack penalties for non-compliance, with Oregon providing the clearest authority to mandate reporting from both payers and providers.

- **California:** The Office of Heath Care Affordability has broad authority to require reporting from providers and payers and can create interagency data-sharing agreements. It also has authority to assess penalties against entities that fail to submit complete and accurate data.
- **Connecticut:** Payers must submit data annually by August 15, but penalties are not specified, limiting enforcement power.

[13] Massachusetts Health Policy Commission. Press Release: State Task Force Recommends Rebalancing Health Care Spending to Support Primary Care.

- **Delaware:** Insurers and public programs must report annually by October 1. Non-compliance penalties are not included in statute.
- **Massachusetts:** The Health Policy Commission is authorized to develop reporting requirements by regulation, but statutory language does not specifically mention penalties. The Center for Health Information and Analysis plays a key role in data collection in Massachusetts.
- **Oregon:** The Oregon Health Authority has explicit statutory authority to require reporting from providers and payers, making its framework more robust than other states. Oregon recently applied its first civil penalty for failure to submit data.
- **Washington:** Authority exists for rulemaking, but no explicit penalties are written into law.

Annual Reporting and Hearings

Public reporting and hearings support transparency and provide an opportunity for stakeholder input and broader community engagement. Since 2022, OHIC has hosted a public forum annually in May to present and discuss performance against the state's cost growth target. This forum brings together policymakers, insurers, providers, and the public to discuss the impact of rising health care costs and potential strategies to mitigate it. In 2023, OHIC began publishing an annual report on health care spending and quality in Rhode Island, along with a chartbook on commercial market spending trends.

Among the six states we reviewed, all produce annual reports on health care spending. Some also required hearings, though requirements for frequency, timing, and testimony differ.

- **California:** The Office of Health Care Affordability must publish a comprehensive annual report that includes information on spending trends, cost drivers, access and equity analysis, and performance improvement plans. Within 30 days of publication, the report must be presented publicly to the Health Care Affordability Board.
- **Connecticut:** OHS must publish an annual report by March 31 and must hold a public hearing by June 30. It can require testimony from payers, providers, and drug manufacturers deemed significant contributors to cost growth.
- **Delaware:** The Delaware Health Care Commission publishes spending and quality reports annually, but it does not hold public hearings.
- **Massachusetts:** The HPC must submit its annual report to legislative leaders by December 31 and hold a hearing by October 1. Hearings include compulsory testimony from payers and providers.

- **Oregon:** OHA publishes reports and holds one or more annual public hearings, with one typically in June two years after the measurement year. The hearings provide opportunities for stakeholders to review the information and discuss solutions.
- **Washington:** The Board reports to the legislature and governor by December 1 and holds public hearings, including testimony from entities exceeding the cost growth benchmark.

Enforcement Mechanisms

The effectiveness of cost growth target programs ultimately depends on the ability to respond to instances when organizations exceed the target. Enforcement provisions determine whether targets function as a soft goal, or carry compliance requirements. Currently, OHIC lacks enforcement authority, limiting the impact of Rhode Island's cost growth target program. In contrast, among the six states reviewed, California, Massachusetts, and Oregon have enforcement mechanisms.

- **California:** Beginning in 2028, the Office of Health Care Affordability may require performance improvement plans and impose tiered financial penalties for entities failing to meet its benchmark. Enforcement is designed to escalate with repeated noncompliance.
- **Connecticut, Delaware, and Washington:** No enforcement provisions exist; the programs rely solely on public accountability and reporting.
- **Massachusetts:** The Health Policy Commission can require entities exceeding the benchmark to submit a performance improvement plan within 45 days, outlining corrective strategies with measurable outcomes. These may be waived for entities the State deems to be already pursuing efficiency measures.
- **Oregon:** The Oregon Health Authority may require performance improvement plans and impose financial penalties through regulation, with penalties applied if entities exceed targets without valid justification in three out of five years. Waivers are available for equity or market disruption concerns.

V. OHIC Recommendations on Codification of the Cost Growth Target Program

Rhode Island's cost growth target program has provided a foundation for monitoring health care spending trends, fostering transparency, and engaging stakeholders in addressing the drivers of rising costs. However, with premiums increasing sharply[14] and health care costs consuming an ever-growing share of household, employer, and state budgets, there is a clear need to reinforce and strengthen this work.

While Executive Order authority and legislative appropriations to support data collection, analysis, and agency technical assistance has enabled Rhode Island to launch and operate the cost growth target program, codifying it in statute would provide the continuity and independence needed to support long-term efforts to make health care more affordable. It would also align Rhode Island with nearly all the other cost growth target states that have formalized their programs in law, ensuring that the state's cost growth target is recognized as a core element of its health care affordability policy framework.

The following presents OHIC's recommendations for codifying the State's cost growth target program in statute, informed by OHIC's review of other states' statutes. These recommendations determined the content of Article 11 Section 12 of Governor McKee's proposed budget for fiscal year 2027.

Lead Agency Designation and Authority

The legislation should designate OHIC as the lead agency responsible for administering Rhode Island's cost growth target program. OHIC should be granted comprehensive statutory authority to design, implement, and enforce the cost growth target program. OHIC should utilize rulemaking authority to define key program elements, such as data submission requirements, reporting formats, and enforcement procedures.

Rhode Island's statute should establish the program's purpose, scope, and governance, while allowing flexibility to adapt the program in response to changing health care markets and conditions.

[14] Rhode Island Office of the Health Insurance Commissioner, 2026 Commercial Health Insurance Rates Approved with Modifications, September 15, 2025, available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-09/Rate%20Review%20Process%20Press%20Release%20-%20Approved%20Rates%20September%202025%20version%20for%20release.pdf

Program Governance

Since its inception, Rhode Island's cost growth target program has relied on a multi-stakeholder Steering Committee to guide program decisions. While this structure has fostered meaningful collaboration, experience of other states show that industry-heavy governance can limit progress on affordability.

OHIC recommends establishing two distinct advisory bodies. This model best addresses the challenge of industry representation diluting affordability-focused discussions. By adopting this model, Rhode Island can ensure that its cost growth target program remains firmly grounded in consumer affordability, while still providing meaningful opportunities for valuable industry input and engagement. This dual-body model has been adopted in states such as Connecticut and Oregon – two states that transitioned away from single, industry-heavy advisory bodies. California, Massachusetts, and Washington also have non-industry advisory bodies, with separate, larger advisory bodies. Experience elsewhere demonstrates that separating technical, consumer-oriented oversight from industry input provides stronger guardrails for affordability efforts.

Target Methodology

The statute should require OHIC to base the cost growth target methodology on relevant economic indicators and stakeholder engagement. This approach ensures that the cost growth target is based on a formulaic framework that provides predictability but allows for flexibility to adjust in response to changing market conditions.

The statute should also direct OHIC, in collaboration with the Rhode Island Executive Office of Health and Human Services, to establish an all-payer primary care investment target, consistent with the all-payer design of the state's cost growth target. An all-payer approach is essential to ensure that primary care receives adequate support across all market segments, not just commercial insurance. This target should complement and align with OHIC's existing regulatory requirements for commercial insurers.

Data Collection

Statute should grant OHIC clear authority to require all payers to submit data necessary to monitor cost growth and evaluate compliance with the targets. OHIC should be authorized to define, through rulemaking, the types of data required, including but not limited to spending, utilization, payment rates, cost drivers, primary care expenditures, and financial performance.

OHIC should also be given explicit authority to impose administrative penalties or fines on entities that fail to submit required data, submit incomplete data, or otherwise obstruct

reporting. OHIC should also be authorized to establish data-sharing agreements with EOHHS, Medicaid, and other relevant state agencies to ensure a comprehensive view of health care spending trends.

Reporting of Findings

Statute should require OHIC to publish a detailed annual report on statewide health care spending and spending growth. The report should include, at minimum:

- Total and per capita health care spending trends for the state, by market, by payer, and by provider;
- Progress toward meeting the cost growth target;
- Identification of cost drivers;
- Analysis of primary care;
- Analysis of health care quality and health equity measures;
- Status of performance improvement plans and any penalties imposed, and
- Recommendations for policy changes or regulatory reforms necessary to improve affordability.

The report should be published annually on a fixed schedule to ensure predictability and a timely legislative review.

OHIC should also be required to convene a public hearing following the release of the annual report. The hearing should:

- Present findings in a transparent and accessible format;
- Provide a forum for public comment, including testimony from consumers, employers, and community organizations; and
- Authorize OHIC to compel testimony from payers, providers, or other entities (such as pharmacy benefit managers and pharmaceutical manufacturers) that exceed the targets or contribute disproportionately to spending growth, and grant OHIC the authority to impose financial penalties on entities that fail to comply when called to testify.

Enforcement and Accountability

To ensure the cost growth target program is effective, enforcement mechanisms must balance meaningful accountability with opportunities for corrective action. The statue should give OHIC explicit authority to implement the two main tools for enforcement adopted by other states –performance improvement plans and financial penalties. OHIC recommends the following enforcement structure for the cost growth target:

- **Performance improvement plans.** When an organization that is accountable to the target fails to meet it in two years out of a three-year period, OHIC may require the organization to submit a performance improvement plan. OHIC recommends limiting this form of accountability to performance within the commercial market, where cost trends tend to be highest and are a key driver of health insurance premiums. OHIC would not require performance improvement plans based on Medicaid or Medicare cost performance. The performance improvement plan should include the organization's assessment of specific factors driving its spending growth and the strategies it will implement to address them. The plan should outline the specific actions the organization will take, along with timelines for implementation and outcome measures. OHIC would review and approve, modify, or reject performance improvement plans. This process would include guidance, feedback and additional recommendations. OHIC would also monitor entities' implementation to assess compliance with the performance improvement plan's terms and determine whether the entity has adequately addressed the targeted cost drivers. Performance improvement plans create an opportunity for dialogue between OHIC and organizations that exceed the target, encouraging collaboration on sustainable cost-containment strategies.
- **Financial penalties.** OHIC may also levy financial penalties when an organization consistently exceeds the cost growth target and does not demonstrate sufficient progress toward corrective measures. Financial penalties would be a last-resort accountability mechanism for entities that refuse or fail to implement a performance improvement plan. The penalty amounts would be proportional to the organization's size, the extent to which it exceeded the target, and other factors specified in statute.

VI. Conclusion

As health care affordability challenges continue, the cost growth target program represents a cornerstone of Rhode Island's broader strategy to support consumers, employers, and the state's economy. Codifying the program and enhancing its design will strengthen its ability to deliver on these goals, while providing a durable framework for ongoing collaboration and accountability across all sectors of the health system.

Appendix 1:

Review of Statutory Language on Cost Growth Target Programs

Review of Statutory Language on Cost Growth Target Programs

Program Governance

CA	The Office of Health Care Affordability administers the cost growth target program. Legislation creating the program established the Health Care Affordability Board (HCAB) as a decision-making body charged with setting statewide and sector-specific spending targets, appointing a Health Care Affordability Advisory Committee, and approving key benchmarks, such as for alternative payment model adoption and the share of spending dedicated to primary care and behavioral health. Membership is defined by statute and includes: the California Health and Human Services Secretary; CalPERS Chief Health Director (nonvoting); four Governor-appointed and Senate-confirmed members; and one appointee each from Assembly and Senate. Board members may not receive compensation from health care entities. Legislation also required the establishment of the Health Care Affordability Advisory Committee, members of which are appointed by the HCAB. Representation includes consumer and patient groups; payers; fully integrated delivery systems; hospitals; organized labor; health care workers; medical groups; physicians; and purchasers.
CT	The Office of Health Strategy (OHS) is responsible for administering the cost growth benchmark program. Though not specified in legislation, OHS has established three advisory committees. The Steering Committee includes representation from a wide array of health care stakeholders. Its goals and objectives are to provide OHS with insight and feedback to facilitate successful implementation of the cost growth benchmarks, quality benchmarks and quality measure alignment, advanced primary care, and use of the All-Payer Claims Database (APCD). OHS terminated the Steering Committee in August 2025 and replaced it in September 2025 with two bodies – a non-industry advisory body and a broadly inclusive advisory body (including the health care and insurance industry). The Technical Team was an ad hoc body convened in late 2024 and early 2025. It included local and national experts on health care delivery, financing, and economics who were not affiliated with insurers or providers; consumer advocates; and employer/labor union purchasers. It was charged with making recommendations on the benchmark methodology and values, primary care spend targets, and reporting. The Data Analytics Workgroup advises OHS on the design and implementation of cost driver analyses and cost growth benchmark methodology.

DE	The Delaware Health Care Commission (Commission) is primarily responsible for administering the state's cost growth benchmark program, in coordination with the Health Care Spending Benchmark Subcommittee of the Delaware Economic and Financial Advisory Council (DEFAC Subcommittee). The Commission leads implementation, collects and analyzes spending data, and publishes annual benchmark performance reports. The DEFAC Subcommittee recommends benchmark values and methodologies, and reviews spending trends. Of the Commission's 11 members, 7 are appointed: 5 by the Governor, 1 by Senate President Pro Tempore, and 1 by the Speaker of the House. The remaining 4 are ex officio members representing the Insurance Commissioner, the Secretary of Finance, the Secretary of Health and Social Services, and the Secretary of Services for Children, Youth and Their Families.
MA	The Health Policy Commission (HPC) administers the cost growth benchmark program. The HPC is governed by an 11-member board. Members include the Secretary for Administration and Finance, the Secretary of Health and Human Services, 3 Governor appointees, 3 Attorney General appointees, and 3 Auditor appointees. Members serve a 5-year term. Statute requires that Commission members not be affiliated with or have a financial stake in a health care while serving. However, this requirement has not always been strictly observed in practice. The legislation also establishes an advisory council to the HPC, members of which are chosen by the HPC Executive Director and must reflect a broad distribution of health care system perspectives.
OR	The Oregon Health Authority (OHA) administers the cost growth target program, in collaboration with the Department of Consumer and Business Services, subject to the oversight of the Oregon Health Policy Board. Though not required in statute, the OHA established the Cost Growth Target Advisory Committee, which helped shape the state's annual reporting and public hearing processes, provided insights into spending trends and factors driving cost growth and created principles for holding entities accountable for cost growth. OHA sunset the Advisory Committee in December 2024. Instead, Oregon created two advisory bodies: (1) the Committee on Health Care Affordability that provides a broader forum for discussions on affordability and elevates consumers' and purchasers' voices, and is charged with developing and recommend cost reduction policies and initiatives; and (2) the Industry Advisory Committee to provide input and expertise to the Committee on Health Care Affordability.

WA	The Health Care Cost Transparency Board (Board) has responsibility for setting program direction. The 14- member Board includes representation from: state agencies (4); local government purchaser (1); Taft-Hartley benefit plan (1); large employers (2); small business (1); consumers (2); health care economics and financing expert (2); industry (1, non-voting member from the Stakeholder Advisory Committee). Board members are appointed by the Governor, who must consider recommendations from the House and Senate. They cannot represent entities that might benefit financially from decisions of the Board. The Board is required to establish a Stakeholder Advisory Committee, and a Data Advisory Committee. Specific appointments to the Data Advisory Committee are at the discretion of the Board. Membership on the Stakeholder Advisory Committee, however, is set in statute, and is largely dominated by industry representatives. Subsequent legislation added representation from consumers and employers, but they constitute a very small minority of members.

Establishment of Annual Cost Growth Targets

CA	OHCA is responsible for developing the methodology for setting target values, which must be approved by HCAB. The methodology must take into account: historical cost and spending across public and private payers; economic indicators and population-based projections; COVID-related anomalies; labor costs, technology price trends, provider mix, and regulatory mandates; Medi-Cal specific payment dynamics and funding structures; quality-performance-based adjustments; and requests for labor cost adjustments by affected entities.
CT	OHS must set cost growth benchmarks every five years. OHS must hold at least one informational public hearing before adopting the benchmarks for each 5-year period. Legislation does not specify a methodology but requires OHS to consider growth in median income and PGSP, inflation, and most recent report on spending growth. If the average annual benchmark for a succeeding 5-year period differs from that of the preceding 5-year period by more than 0.5%, the joint standing committee of the General Assembly must approve the new benchmarks.
DE	The methodology for calculating the benchmark is set in statute as the per capita growth rate in Potential Gross State Product (PGSP). The DEFAC Subcommittee must review the methodology annually, and may recommend changes to the DEFAC and the Commission if it determines there is a more effective or precise methodology. Any proposed changes must go through a public comment process before being adopted. During the summer of 2025 the State was considering whether to make a change to the PGSP-based methodology that has been in place since program inception.
MA	The HPC must establish a benchmark no later than April 15, of every year. For calendar years 2023 and beyond, the benchmark is set to the growth rate of potential gross state product. The benchmark value may be modified if the HPC determines that an adjustment is reasonably warranted, upon approval by a two-thirds vote of the Board. The HPC must hold a public hearing on any recommended modifications of the benchmark prior to Board voting on it.

OR	The statute requires the program to establish a health care cost growth target, and to review and modify the target on a periodic basis. The target must promote a predictable and sustainable rate of growth for spending, apply to all providers and payers in the state, use established economic indicators, and be measurable on a per capita basis (statewide and by entity).
WA	The legislation requires the Board to annually establish a health care cost growth benchmark, starting with the highest cost drivers in the health care system and then developing a phased plan to include other components of the health system for subsequent years. In practice, the Board has established statewide targets for 2022-2026 that apply uniformly to all entities.

Establishment of All-Payer Primary Care Spend Targets

CA	Legislation mandates that the HCAB measure primary care investment and set benchmarks. In October 2024, the HCAB set a statewide goal of spending 15% of total health care expenditures on primary care by 2034. It also set an annual improvement target for each payer to increase primary care spending by 0.5 to 1 percentage point per year from 2025 through 2033. OHCA intends to measure and report on the statewide investment and annual improvement benchmarks, however, it does not have authority to enforce them.
CT	OHS must set primary care spend targets every five years, with similar considerations for setting cost growth targets. The annual target through 2030 is 10%.
DE	The state has a primary care spend obligation of 11.5% for commercial insurers. These targets are part of Delaware's Affordability Standards, modeled after Rhode Island OHIC's Affordability Standards.
MA	Massachusetts does not have a primary care expenditure target. Section 80 of Chapter 343 of the Acts of 2024 established a new task force on primary care in the Commonwealth. Among other things, the task force was charged with a recommendation for establishing a primary care spending target. The task force was meeting as of the summer of 2025.
OR	Separate legislation (SB 934) requires coordinated care organizations (Oregon's version of Medicaid managed care plans), the Public Employees' Benefit Board, and the Oregon Educators Benefit Board to spend at least 12 percent of total medical expenditures on primary care. It also directed the Department of Consumer and Business Services to establish requirements for carriers that did not meet that threshold to submit a plan for increasing primary care spending to 12 percent of total spending.
WA	A 12% primary care spend target is set in statute, with authorization for the Board to determine how best to define and measure primary care spending.

Data Reporting Requirements to Measure Cost Growth Target Performance

CA	Legislation gives OHCA broad authority to collect data from health care entities that OHCA deems necessary to carry out its functions. This includes payers, fully integrated delivery systems (e.g., Kaiser), and providers. OHCA may also enter into data sharing agreements with the State Department of Health Care Services, Covered California, the Department of Managed Health Care, the Department of Insurance, the Labor and Workforce Development Agency, the Business, Consumer Services and Housing Agency, and other relevant agencies that monitor complaints of plans and providers. OHCA may also enter into data sharing agreements with state agencies that collect payer and provider financial data, or other data about the health care workforce. OHCA can assess penalties against entities that fail to submit complete and accurate data.
CT	The legislation requires payers to report data to OHS for purposes of measuring performance against the benchmark by no later than August 15 of each year. However, there are no penalties enumerated for failing to submit data.
DE	Legislation requires payers, insurers, and public programs to annually submit data on performance against the spending and quality benchmarks by no later than October 1st of each calendar year. Additional payers may also be required to report subject to approval of the DEFAC, DEFAC Subcommittee, the Governor, and other relevant state agencies. However, there are no penalties enumerated for failing to submit data.
MA	There is no specific mention in statutory text of a requirement for insurers to report data, nor penalties for failing to report data. However, the legislation explicitly authorizes the HPC to adopt regulations to implement the benchmark program.
OR	The legislation explicitly states that OHA has authority to establish regulations requiring providers and payers to report data needed to calculate health care cost growth.
WA	There is no specific mention of a requirement for insurers to report data, nor penalties for failing to report data. However, the legislation explicitly authorizes the Health Care Authority (HCA) to create rules to implement the Board's responsibilities.

Annual Reporting on Health Care Spending Trends and Performance Against the Cost Growth Target

CA	OHCA must annually publish a report on health care spending and growth in California. The report must include: total and per capita health care spending by spending categories and region; progress on meeting the targets; key cost drivers and trends by sector; factors driving cost growth; data on access, quality, and equity; required performance improvement plans and penalties imposed; and best practices to improve affordability.
CT	OHS must submit a report to the joint standing committees of the General Assembly on spending trends by no later than October 15th of each year.
DE	Legislation does not specify a requirement for an annual report on performance. Instead, there is general language on the Commission's responsibility to produce timely publications and/or reports with validated data to ensure transparency regarding health care spending and quality in the state. Delaware typically publishes performance against the benchmark in June of each year.

MA	The HPC must produce an annual report on spending trends, including behavioral health expenditures, spending drivers, and recommendations to increase health system efficiency. The report must be submitted to the chairs of the House and Senate Committees on Ways and Means, and the chairs of the Joint Committee on Health Care Financing. The report must be published no later than December 31, of each year.
OR	OHA must also publish a report on spending trends that includes an analysis of factors impacting costs and spending as well as recommendations for improving system efficiency. There is no specified date by which the annual public report must be released. However, OHA typically publishes the report in June two calendar years following the measurement year, in conjunction with the public hearing.
WA	The Board must submit a report to the governor and each chamber of the legislature by Dec 1st of each year. The reports may include policy recommendations to lower costs focused on the commercial market, and establishment of a rating system of providers and payers.

Annual Hearings on Health Care Spending and Performance Against the Cost Growth Target

CA	No later than 30 days after publishing the annual report, OHCA must present it at a public meeting of the HCAB.
CT	OHS must hold informational public hearings no later than June 30th of each year. OHS may require testimony from payers or providers that are found to be a significant contributor to cost growth in the state or has failed to meet the primary care spending target. Other entities that contribute significantly to cost growth, such as pharmaceutical manufacturers, may also be called to testify. Entities required to provide testimony must provide information on issues identified by OHS and on actions taken to reduce their contribution to the state's cost growth in the future.
DE	Delaware does not hold any hearings on the benchmark.
MA	The HPC must hold hearings no later than October 1, of each year based on the report on spending growth for the preceding calendar year. The HPC must identify as witnesses payer and provider representatives, who would be required to provide testimony and be subject to examination and cross examination by the HPC.
OR	On annual basis, OHA is required to hold public hearings on spending growth for the previous calendar year. There is no specified date by which the annual public hearing must be held. However, OHA typically holds the hearing in June two calendar years following the measurement year, in conjunction with the release of the report.
WA	The Board must hold a public hearing no later than Dec 1st of each year. Hearings must include identification of entities exceeding the benchmark. The Board may require testimony from those entities that substantially exceed the benchmark.

Statutory Language on Enforcing Adherence to the Cost Growth Target

CA	OHCA can require entities to develop and implement performance improvement plans (PIPs) for excessive cost growth. OHCA can also establish a tiered system of financial penalties for failure to meet the cost growth target. The penalties will begin at levels commensurate with the degree of noncompliance and escalate for repeated or continuing failures to meet the targets. Specifics for implementing PIPs and penalties were under development in the summer of 2025. Enforcement will not take effect until 2028 (for 2026 performance).
CT	OHS does not have any mechanisms for enforcing adherence to the benchmark.
DE	The Commission does not have any mechanisms for enforcing adherence to the benchmark.
MA	The HPC may require any entity that exceeds the benchmark to develop and implement a PIP. Entities must submit the PIP within 45 days of receiving notice of this requirement. Each PIP must identify the drivers of the entity's cost growth, outline strategies to address them, and include an implementation timeline not exceeding 18 months, along with clearly defined and measurable expected outcomes. The HPC may waive or delay the PIP requirement based on an entity's financial condition, cost and utilization trends, demonstrated efforts to reduce total medical expenses, ongoing efficiency strategies, and other relevant factors.
OR	OHA has the authority to require providers and payers that exceed the target to develop and undertake a PIP. PIPs must identify key cost drivers, outline concrete steps to address them, include timeline for implementation, and define measures of success. Additionally, OHA is required to establish, by rule, criteria for waiving the PIP requirement in cases involving unforeseen market conditions or equity considerations. Oregon's legislation also authorizes OHA to impose financial penalties on entities that fail to meet the target; however, it does not specify the structure or amount of these penalties. Instead, OHA has established guidelines through regulations. The penalties will apply to entities that exceed the target with statistical confidence and without a valid reason in a rolling three-out-of-five-year period.
WA	The Board does not have any mechanisms for enforcing adherence to the benchmark.

Links to Statutory Language

- **California:** https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB184
- **Connecticut:** https://www.cga.ct.gov/2023/pub/chap_368dd.htm#sec_19a-754g
- **Delaware:** https://dhss.delaware.gov/wp-content/uploads/dhss/pdf/hb442.pdf
- **Massachusetts:** https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter6D
- **Oregon:** https://oregon.public.law/statutes/ors_442.386
- **Washington:** https://app.leg.wa.gov/RCW/default.aspx?cite=70.390

Appendix 2:

Compact to Reduce the Growth in Health Care Costs while Improving Health Care Access, Equity, Patient Experience, and Quality in Rhode Island

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Rhode Island Health Care Cost Trends Steering Committee

Compact to Reduce the Growth in Health Care Costs while Improving Health Care Access, Equity, Patient Experience, and Quality in Rhode Island

Background

On December 19, 2018, the Rhode Island Health Care Cost Trends Steering Committee executed the Compact to Reduce Growth in Health Care Costs and State Health Care Spending in Rhode Island, which adopted a health care cost growth target of 3.2% on an annual basis for 2019 through 2022, which was equal to the value of the growth rate of Rhode Island's potential gross state product. This represented and continues to represent a voluntary commitment by health care stakeholders to take all reasonable and necessary steps to annually keep cost growth below the target at the organizational level and state level while maintaining (or improving) quality and access. More recently, the Compact to Accelerate Advanced Value-Based Payment Model Adoption in Rhode Island was also developed and, on April 13, 2022, signed in order to issue a set of recommendations for accelerating the adoption of advanced value-based payment models in Rhode Island in order to help to reduce the growth rate of health care spending and support attainment of the state's target. The Steering Committee also committed to convening over the course of 2022 to determine whether to keep the existing target or establish a new target for 2023 and beyond.

Despite the critical foundational work to date completed by the Steering Committee including establishing the target, developing a data reporting structure, analyzing cost growth and its drivers, and publicly reporting cost growth performance by market participants, health care costs continue to grow faster than Rhode Island can afford, consuming a significant and increasing proportion of household income, business revenue, and state and municipal budgets. As a result, the positive impact of employee wage growth and business revenue growth is reduced and public investments in education, transportation, and economic development outside of the health care sector are diminished. Paradoxically, these increased costs may result in spending cuts in other critical sectors that directly impact health outcomes and quality of life, such as housing and nutritional programs.

Moreover, Rhode Island and the nation as a whole, continue to lag on critical public health indicators, such as life expectancy, infant mortality, maternal mortality, childhood obesity, and overdose deaths, with many indicators moving in the wrong direction and with outcomes for groups that have been economically/socially marginalized often trailing substantially. Therefore, reducing cost growth must explicitly be done in concert with improving health care access, equity, patient experience, and quality in Rhode Island to achieve necessary improvement in outcomes on a statewide scale.

We, the undersigned members of the Steering Committee, agree upon the following target values and target performance analysis and public reporting to continue to build a health care system that has as its features: affordable and predictable cost growth, improved financial stability, and population health management and quality excellence. Further, as signatories to this compact, we agree to work to achieve the target set forth in the context of broader efforts to improve the health care system. We agree that the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) should reconvene the signatories of this voluntary compact, as part of the office's Health Spending Accountability and Transparency Program, no later than July 1, 2027 to revisit this compact to ensure effectiveness in constraining health care cost growth and improving health outcomes and to determine whether to keep the existing targets or establish a new target for 2028 and beyond.

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Health Care Cost Growth Target Values

1. For 2023 through 2027, the target shall be the value noted below:
   - **2023:** 6.0%
   - **2024:** 5.1%
   - **2025:** 3.6%
   - **2026:** 3.3%
   - **2027:** 3.3%
2. These values represent a 75%/25% blend of potential gross state product values and forecasted median household income growth. They use the current forecast for median household income growth for three years, 2023 through 2025, and long-term forecast for 2026 and 2027. The values also account for the lagged impact of inflation on health care costs by adjusting the PGSP inflation input with inflation experience on a two-year lagged basis for 2023-2025 and uses the long-term forecast of inflation for 2026 and 2027. As such, the Steering Committee believes that they help to advance affordability by dampening the effect of elevated inflation, reflect consumer impact by taking into account household income growth, and represent accountable, challenging, and achievable values for payers and providers.

Public Health and Health Equity Improvement Goals

1. The Steering Committee believes that improvement in health outcomes with a specific focus on those that advance public health and health equity must be prioritized in tandem with improvements in affordability.
2. To this end, the Steering Committee will agree upon a discrete set of public health and health equity accountability measures with associated improvement goals on an annual basis as well as the methodology and practices to be utilized for analysis and public reporting of performance on these accountability measures. An initial set of priority measures and improvement goals will be agreed to by March 31, 2024, with methodology and practices utilized for analysis and public reporting of performance against the improvement goals agreed to by September 30, 2024. The Steering Committee intends for 2024 baseline values to be reported during 2025, with 2025 serving as the first performance period. It is not the intent of the Steering Committee to establish accountability measures for specific providers or health systems.

Performance Analysis and Public Reporting

1. Analysis and public reporting of performance against the target shall be completed consistent with the same methodology and practices utilized for analysis and public reporting of performance against the target for 2020, which was last completed on April 27, 2022.
2. Any material change to analysis and public reporting of performance against the target methodology and practices shall be reviewed with the Steering Committee in advance.

Parties in Compact

This compact, signed on [month] [day], 2022, shall remain in effect until December 31, 2027.

DocuSigned by:
Cory King
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Cory King
Name, Title: Acting Health Insurance Commissioner

Rhode Island Office of the Health Insurance Commissioner
Organization

DocuSigned by:
Al Kurose
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Al Kurose
Steering Committee Co-chair
Name, Title: SVP for Primary Care and Population Health

Lifespan
Organization

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DocuSigned by: Michele Lederberg CE9448AAEDB4CC...	Michele Lederberg, Steering Committee Co-chair, EVP CAO & CLO	Blue Cross Blue Shield of Rhode Island
	Name, Title	Organization
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	Name, Title	Organization
DocuSigned by: Tony Clapsis 2C24CE4F81D34A9...	Tony Clapsis, SVP	CVS Health
	Name, Title	Organization
DocuSigned by: Michael DiBiase CE48DB77FEAC442...	Michael DiBiase, President & CEO	Rhode Island Public Expenditure Council
	Name, Title	Organization
DocuSigned by: Diana Franchitto 99C9E0DBC845435...	Diana Franchitto, President & CEO	Hope Health
	Name, Title	Organization
DocuSigned by: Peter Hollmann ACECB88AD794453...	Peter Hollmann, Physician, Board member	Rhode Island Medical Society
	Name, Title	Organization
DocuSigned by: Jim Loring 5F631DFF2F2942D...	Jim Loring, CFO	Amica
	Name, Title	Organization
DocuSigned by: Sam Salganik F31E9B3C9AE8490...	Sam Salganik, Executive Director	Rhode Island Parent Information Network
	Name, Title	Organization
DocuSigned by: Kristin Lewis 3FDBAC021BE74BE...	Kristin Lewis, EVP & Chief Public and Community Affairs Officer	Point32Health
	Name, Title	Organization
DocuSigned by: Michael Wagner 2F34A445723248C...	Michael Wagner, CEO	Care New England
	Name, Title	Organization
DocuSigned by: Teresa Paiva Weed D67553AA9D0947F...	Teresa Paiva Weed, President	Hospital Association of Rhode Island
	Name, Title	Organization
DocuSigned by: Peter Marino 83884DEAE38F490...	Peter Marino, President & CEO	Neighborhood Health Plan of Rhode Island
	Name, Title	Organization

DocuSigned by:
Ana Novais
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Ana Novais
Name, Title: Acting Secretary

Rhode Island Executive Office of Health and Human Services
Organization

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Lawrence E. Wilson
Name, Title: Managing Director

The Wilson Organization
Organization

DocuSigned by:
Neil Steinberg
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Neil Steinberg
Name, Title: President & CEO

Rhode Island Foundation
Organization

DocuSigned by:
Al Charbonneau
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Al Charbonneau
Name, Title: Executive Director

Rhode Island Business Group on Health*
Organization

DocuSigned by:
D17D5F11A85A425...

Arthur Sampson
Name, Title: Interim President and CEO

Lifespan
Organization

*RIBGH supports the process but disagrees with the percent chosen for 2023.

Appendix 3:

Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island

Rhode Island Health Care Cost Trends Steering Committee

Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island

We, the undersigned members of the Rhode Island Health Care Cost Trends Steering Committee (Steering Committee), convened by the Governor, Rhode Island Executive Office of Health and Human Services (EOHHS), and the Office of the Health Insurance Commissioner (OHIC) to develop an annual health care cost growth target for Rhode Island, have developed a set of recommendations (attached) which we believe will help Rhode Island reduce the growth in health care costs and state health care spending.[1]

Specifically, we agree upon and support the following cost growth target and methodology, and commit to taking all reasonable and necessary steps to annually keep health care cost growth below the target at the organizational level (as applicable to our organization) and state level, while maintaining (or improving) quality and access:

- The cost growth target shall be the value of Rhode Island's Potential Gross State Product (PGSP). PGSP is the total value of the goods produced and services provided in a state at a constant inflation rate and is 3.2%.[2]

- The target's duration is four years, i.e., 2019 through 2022, with the stable value of 3.2% maintained throughout. We commit to revisit the methodology of the cost growth target during 2022 and advise the State on whether to keep the existing target or establish a new target for 2023 and beyond.

- Only highly significant changes in the economy will trigger re-visiting of the target methodology. The Steering Committee will work with the state to determine a functional definition of "highly significant" and develop a plan for handling such events.

- The cost growth target will be used to assess health care cost growth for all Rhode Island residents who have commercial (insured and self-insured), Medicaid, and Medicare coverage. Performance assessment relative to the target will include consideration of claims spending, non-claims-based spending, pharmacy rebates, consumer cost sharing and insurer administrative costs and margin.

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[1] Components of health care spending are described in the "Methodology to Measure and Report on the Total Cost of Health Care in Rhode Island" section of the attached recommendations.

[2] PGSP is the sum of the forecast growth in potential labor force productivity, forecast potential labor force growth and forecast inflation, minus the annual rate of population growth in the state. The 3.2% value was calculated using the most recently available data on November 7, 2018.

- EOHHS and OHIC will publicly report performance against the cost growth target at the 1) state, 2) insurance market, 3) insurer, and 4) large provider organization levels, while adjusting for annual changes in population clinical risk. They will seek sustainable funding to support the operation of the cost growth target related activities.

- As applicable, we will participate in the data collection processes led by EOHHS or OHIC required to support reporting performance against the cost growth target transparently, consistent with our recommendations.

This Compact, signed on December 19, 2018, shall remain in effect until December 31, 2022.

Parties in Compact:

Kevin Keck, CEO — Blue Cross Blue Shield of RI
Name, Title — Organization

CEO — COASTAL MEDICAL
Name, Title — Organization

CEO — LIFESPAN
Name, Title — Organization

CEO — Rhode Island Foundation
Name, Title — Organization

Rhode Island Public Exp. Council
Name, Title — Organization

Rhode Island Parent Information Network
Name, Title — Organization

CARE NEW ENGLAND Health System
Name, Title — Organization

NEIGHBORHOOD HEALTH PLAN OF RI
Name, Title — Organization

Name, Title	Organization
	RHODE ISLAND MEDICAL SOCIETY
	RI Business Group on Health
	Tufts Health Plan
	Office of the Health Insurance Commissioner
	THE WILSON ORGANIZATION, LLC.
	UnitedHealthcare
Betty Rawe, Professor	
	Bank Newport
M. Teresa Paiva Weed	Hospital Association of RI

Rhode Island Health Care Cost Trends Steering Committee

Rhode Island Health Care
Cost Growth Target Recommendations
November 27, 2018

I. Introduction

In August 2018, the Rhode Island Executive Office of Health and Human Services, the Office of the Health Insurance Commissioner, and the Governor's Office first convened a Health Care Cost Trends Steering Committee (Steering Committee) with funding from the Peterson Center on Healthcare. The Steering Committee is comprised of 18 diverse Rhode Island stakeholders, representing government, business and community leaders, for the purpose of advising the OHIC, EOHHS, and the Governor on cost growth target recommendations, including methods for:

1. establishing an annual health care cost growth target;
2. measuring and reporting on the total cost[3] of health care in Rhode Island, and
3. analyzing and reporting performance relative to the target.[4]

The Steering Committee has met six times between August 29, 2018 and November 26, 2018. This document puts forth the Steering Committee's recommendations for 2019 implementation of a Rhode Island cost growth target.

II. Methodology to Establish an Annual Health Care Cost Growth Target

A cost growth target is a percentage by which Rhode Island's total health care spending should annually grow no faster. The Steering Committee considered multiple economic indices as the basis for defining the Rhode Island health care cost growth target. The recommended index and its use follow below.

- **Economic Indicator:** The cost growth target should be the value of Rhode Island's Potential Gross State Product (PGSP). PGSP is the total value of the goods produced and services provided in a state at a constant inflation rate. It is calculated as follows:

Calc.	Element	Value	Source
	Growth in the Potential Labor Force Productivity	1.4%	The source is the most recently published Congressional Budget Office Budget and Economic Outlook Report.[5] Included within the report is a table of Key Inputs in the

[3] "Cost" is used as a synonym for "spending" in this document. Both terms refer to expenditures made to providers by consumers, employers, insurers and government agencies.
[4] Transparency of performance is the sole intended consequence of performance relative to the cost growth target.
[5] As of September 20, 2018, the Congressional Budget Office published its Budget and Economic Outlook Reports here: www.cbo.gov/about/products/major-recurring-reports#1.

Calc.	Element	Value	Source
			CBO's Projections of Real Potential GDP that includes the potential labor force productivity projected average annual growth from 2023–2028 (Page 13, Table 2 of the August 2018 report). In general, the figure used to calculate PGSP should be the value that is forecast for five through 10 years into the future.
+	Potential Labor Force Growth	0.0%	Rhode Island Office of Management and Budget purchased forecast from IHS Economics.
+	Forecasted Inflation	2.0%	The source is the most recently published Congressional Budget Office Budget and Economic Outlook Report.[6] Included within the report is a table of CBO's Economic Projections for Calendar Years 2018 to 2028 (Page 5, Table 1 of the August 2018 report). In general, the figure used to calculate PGSP should be the value of the "PCE price index" percentage change from year-to-year that is forecast for five through 10 years into the future.
-	State Population Growth	0.2%	The source is the Rhode Island Population Projections Summary Tables from the Division of Statewide Planning. In general, the figure used to calculate PGSP should be the percentage change from year-to-year that is forecast for five through 10 years into the future. In this case, because the Division of Statewide Planning provides forecasts in five-year bands, the calculation used the figures that were as close to five through 10 years into the future. Specifically, the figure used to calculate PGSP is the annualized growth rate between 2025 and 2030.
=	**Rhode Island PGSP**	**3.2%**	The calculation consists of the sum of the expected growth in national labor force productivity, plus the expected growth in Rhode Island's labor force, plus the expected national inflation; minus Rhode Island's expected population growth.

- **Target Duration:** The target's duration should be four years, i.e., 2019 through 2022, and maintain the stable value of 3.2% throughout. During 2022, the State should revisit the methodology of the cost growth target and keep the existing or establish a new target for 2023 and beyond.

- **Periodic Review:** Significant changes in the economy should trigger re-visiting of the target methodology. The State should develop a functional definition of "significant changes" in consultation with the Steering Committee or a successor stakeholder body.

[6] As of September 20, 2018, the Congressional Budget Office published its Budget and Economic Outlook Reports here: www.cbo.gov/about/products/major-recurring-reports#1.

III. Methodology to Measure and Report on the Total Cost of Health Care in Rhode Island

The table below outlines recommended payer populations, states of residence and locations of care, and types of spending to be included in the measurement of Rhode Island's total health care spending. Spending should be calculated net of pharmacy rebates.

Methodological Consideration	Include	Exclude
Payer Populations*	• Commercial (both fully insured and self-insured populations), • Medicaid • Medicare	• Correctional Health • TRICARE • Veteran's Health Administration
States of Residence and Locations of Care	• Rhode Island residents with Rhode Island providers • Rhode Island residents with out-of-state providers	• Out-of-state residents with Rhode Island providers • Out-of-state residents with out-of-state providers
Types of Spending	• Claims-based spending • Non-claims-based spending • Pharmacy carveouts	• Behavioral health carveout contracts[7]

*Provider resources applied in the delivery of care for uninsured Rhode Islanders should not be included in calculations of health care spending because they are technically not "spending" as defined herein. Future reporting on spending relative to the target should, however, indicate that while these resource applications are not captured in the measurement of total health care spending, they may be significant for certain providers.

IV. How to Analyze Performance Relative to the Target

The Steering Committee discussed the levels at which accountability will be measured, and how calculations of performance should be made.

- **Level of Performance:** Performance against the cost growth target should be assessed at the 1) state, 2) insurance market, 3) insurer, and 4) large provider organization levels.

- **Data Source:** The data source used to assess performance relative to the target should be determined prior to 2020. The State should complete ongoing research into whether the state's APCD can be used as a data source, with payer supplementation, or whether the use of payer-reported calculations would be a preferable data source.

- **Risk Adjustment:** Assessment of payer and provider performance relative to the target should be adjusted for annual changes in population clinical risk. The approach to risk adjustment will depend on the data source. If the data source is solely payer-reported, then payers should use their existing risk-adjustment methodologies. If the data source is primarily the APCD with payer supplementation, a common risk adjuster should be used.

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[7]Most behavioral health care coverage in Rhode Island is provided through the insurer, be it for insured or self-insured business, and will be included in the calculation of total health care spending. Steering Committee members noted that the behavioral health carveout spend is small and the trend is stable.

- **Provider-Level Reporting:**
  - Provider-Level Attribution: The data source will ultimately determine how patient attribution should be done. If the data source will primarily be the APCD, then patient attribution will be done across payers by line of business, meaning that an ACO will have one attributed population for each of commercial, Medicaid and Medicare (as applicable). If the data source will primarily be payer-reported data, then patient attribution should be reported by payer and by line of business, meaning an ACO will have one attributed population for each line of business by each payer.

    In addition:
    - Patient attribution should be conducted at the ACO level by line of business for all attributable patients.
    - For those providers in an ACO but without the minimum number of attributed lives required to report provider performance, their performance should be reported in aggregate in an "all other ACO" category calculated by line of business.
    - For those providers not in an ACO, there should be an aggregate "all other providers" value calculated by line of business for all attributable patients.

  - Minimum Number of Attributed Members Required to Report Provider Performance:
    - Commercial and Medicaid: Providers should have a minimum of 10,000 attributable member lives per year.
    - Medicare:[8] Providers should have a minimum of 5,000 attributable member lives per year.
  - Performance Confidence Interval Bands: The State should develop guidelines for when to signify provider deviation from the cost growth target as statistically meaningful (not at high risk of influence by random variation) in consultation with the Steering Committee or a successor stakeholder body. This might entail additional analyses of the APCD to develop performance confidence interval bands. These confidence interval bands should be applied to provider reporting.

V. How to Report Performance Relative to the Target

The Steering Committee discussed how performance should be reported to the public.

- **Timeline for Reporting Performance:** Annually, performance data should be collected and analyzed in the year following the performance year. Results should be made public as soon as data are available and analyzed, but no later than the fourth quarter of the year following the performance year.
  - Should APCD data be used, results should be discussed with payers and providers prior to public dissemination.

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[8] If the data source is primarily payer-reported, Medicare FFS members will be unattributable to an Rhode Island provider and provider performance on Medicare will not include the FFS population.

VI. Establishment and Monitoring of the Health Care Cost Growth Target

The Steering Committee discussed the establishment of the cost growth target as well as what body should periodically review questions related to the cost growth target methodology and reporting.

- **Establishment:** The parameters of the cost growth target should be established in a compact signed by the members of the Steering Committee in conjunction with an executive order, referencing the terms of the compact with respect to the cost growth target and directing state agencies to assign resources needed to support data collection, analysis and public reporting related to assessment of performance relative to the cost growth target. At a future time, the State should consider legislation to ensure necessary funding to support ongoing authorization and operations of cost growth target-related activities.

- **Monitoring:** The Steering Committee should serve as the advisory body to the State for methodological and reporting questions related to the cost growth target. In addition, the Steering Committee should assist the State by identifying potential market factors that significantly influenced cost growth in a given year. The State should consider the potential addition of members to the Steering Committee to voice perspectives not currently represented.

VII. Relationship between OHIC's Hospital Price and ACO Budget Growth Caps and the Health Care Cost Growth Target

The Steering Committee did not address the relationship between OHIC's hospital price and ACO budget growth caps and the cost growth target. The Steering Committee recommends that the State give attention to this relationship in the future.