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Commissioning Change:
How Four States Use Advisory Boards to Contain Health Spending

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Contents

Introduction

Controlling the growth of health care spending is central to any state effort to achieve universal coverage and to bring relief to consumers struggling with premiums and out-of-pocket costs. As it pursues these goals, California can learn from several states that have established state commissions to measure, monitor, and set targets to control health care cost increases.

Four states — Maryland, Massachusetts, Oregon, and Rhode Island — have well-developed regulatory bodies or independent authorities aimed at controlling growth in health spending in their states. No single blueprint exists for these state health care spending commissions. Each state has taken its own path. (Detailed descriptions of each state commission are included in Appendix B.) However, a closer look at these models offers valuable lessons for California and other states looking to emulate their successes and plan for the inevitable trade-offs.

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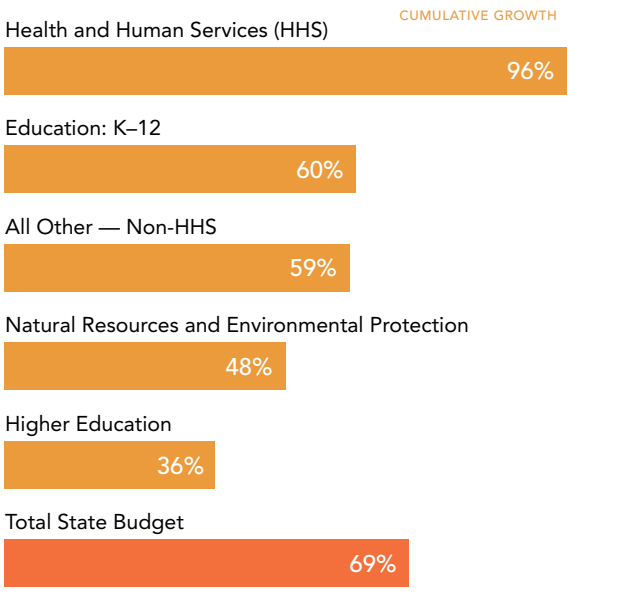
Health Spending at the State Level and Why It Matters

Rapidly growing health care expenditures have long challenged state policymakers. Over the last 10 years, California state budget expenditures on health and human services grew by 96% from 2009 through 2018, while spending on all other non-HHS programs increased by 59% (see Exhibit 1). Similarly, state spending on health care programs in Massachusetts grew 57% between 2009 and 2018, more than double the percentage increase on education, public safety, and the environment (Exhibit 2, page 4).

States are not always getting good value for their dollars spent: This unprecedented spending has not resulted in a commensurate rise in quality of care. Among US states, risk- and wage-adjusted spending per enrollee across Medicare and Medicaid shows no consistent relationship with quality.[1] Even within

Exhibit 1. California State Spending, by Category
FY 2009–10 to FY 2018–19



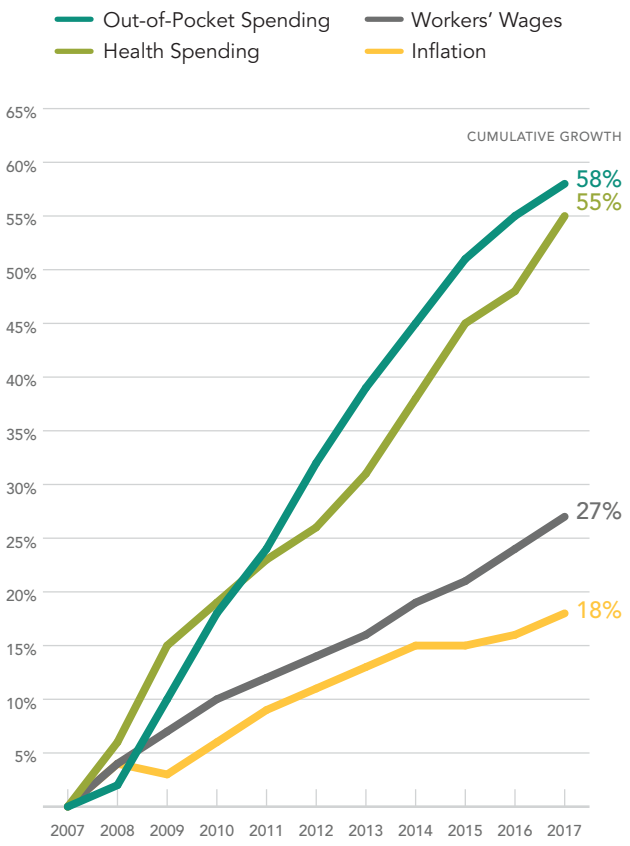
Sources: *Enacted Budget Summary – All Chapters* (2009–10), State of California, n.d.; and *Enacted Budget Summary – All Chapters* (2018–19), State of California, n.d.

Exhibit 2. Massachusetts State Spending, by Category
FY 2009–10 to FY 2018–19

*Includes debt service, pension, and administration.

Source: "Massachusetts State Budget," Massachusetts Budget and Policy Center, n.d.

Exhibit 3. US Health Spending Is Growing Faster Than Wages and Inflation, 2007 to 2017



Source: Matthew Rae, Rebecca Copeland, and Cynthia Cox, "Tracking the Rise in Premium Contributions and Cost-Sharing for Families with Large Employer Coverage," Peterson-KFF, August 14, 2019.

states, including California, health spending can vary substantially across geographic regions with no observable differences in health outcomes.[2]

The high and rising cost of health care is also hitting family budgets hard. Many families are struggling to pay for double-digit premium increases and rising out-of-pocket expenses in an environment of slow wage growth. For example, from 2007 through 2017, total out-of-pocket health spending by US households (including family contributions to health insurance premiums, co-insurance, and deductibles) grew a cumulative 58% while workers' average wages grew only 27% (see Exhibit 3).

California families are especially impacted. From 2003 through 2018, total health care–related spending for a family with employer-sponsored insurance cumulatively increased by 142%, while median household income in California grew 43% (Exhibit 4, page 5). As a result, average total health-related spending for a family with employer-sponsored insurance ($24,104) now represents more than one-third (34%) of median household income in California ($70,489). Increasingly, a growing share of the modest increases in household incomes is being used to pay for rising health care costs.

Exhibit 4. Rising Out-of-Pocket Costs Put Pressure on Household Budgets in California

	2003	2018	CUMULATIVE GROWTH
Employer Premium Contribution	$6,052	$15,730	160%
Family Premium Contribution	$2,452	$5,101	108%
Family Out-of-Pocket Health Spending	$1,465	$3,273	124%
Total Family Out-of-Pocket Health Spending	$3,917	$8,374	114%
Total Health-Related Spending (employer and family)	$9,969	$24,104	142%
Median Income in California	$49,300	$70,489	43%
Percentage of California Median Income:			
➤ Total Out-of-Pocket Health Spending (family)	8%	12%	
➤ Total Health-Related Spending (employer and family)	20%	34%	

Source: Matthew Rae, Rebecca Copeland, and Cynthia Cox, "Tracking the Rise in Premium Contributions and Cost-Sharing for Families with Large Employer Coverage," Peterson-KFF, August 14, 2019.

State polls reveal both the necessity and urgency of policy efforts to reduce health care spending. A recent *Los Angeles Times* survey found that 40% of adults with employer-sponsored coverage had problems paying medical bills during the last year, including bills for their portion of health insurance premiums, deductibles, copays, or unexpected expenses for themselves or a family member.[3] A Latino Community Foundation survey found that making health care more affordable was the number one policy priority for California's Latinos.[4] A 2019 survey of state residents by KFF (Kaiser Family Foundation) and the California Health Care Foundation revealed that more than 8 out of 10 state residents want the governor and legislature to prioritize making health care more affordable.[5]

The four states with health care cost commissions studied in this report share both similarities and differences with California. Given its geographic size and population, California's health care infrastructure is bigger and total health spending is much higher than the four states studied (Exhibit 5, page 6). When adjusted for population size, however, California is more comparable to these states. Health care spending has been rising as a percentage of family incomes, state budgets, and state economic growth in all the states studied. Forty-seven percent of Californians are now enrolled in HMOs — a substantial proportion, but also only 7 and 8 percentage points higher than Rhode Island and Massachusetts, respectively. Spending per state resident is lowest in California among the states studied, due in part to relatively low rates of Medicaid spending per enrollee.

Exhibit 5. State Summary Statistics

	CALIFORNIA	MASSACHUSETTS	MARYLAND	OREGON	RHODE ISLAND
Sociodemographics					
State Population	39,560,120	6,902,100	6,043,900	4,191,000	1,057,900
Percentage in Poverty (0%–199% of FPL)	27%	20%	19%	27%	24%
Percentage Uninsured	7%	3%	6%	7%	5%
Median Annual Income	$71,805	$77,385	$80,776	$60,212	$63,870
Health System Characteristics					
Hospitals — General Acute Care	341	64	49	60	11
Physicians — Active	112,906	36,506	24,676	12,149	4,988
HMO Enrollment — Total (millions)	18,128	2,617	1,983	1,330	0.418
HMO Enrollment — Percentage	47%	39%	33%	33%	40%
Health Care Spending (billions)	**$292**	**$71**	**$51**	**$32**	**$10**
Private Health Insurance Spending	$104	$24	$17	$10	$3
Medicare Spending	$65	$14	$11	$7	$2
Medicaid Spending	$84	$18	$12	$9	$3
As a Percentage of Gross State Product (GSP)	10.4%	13.1%	12.8%	14.1%	17.0%
Per Capita Health Spending					
Total Health Care Spending	$7,381	$10,326	$8,493	$7,616	$9,520
Per Capita Private Health Insurance Spending	$4,735	$5,302	$4,343	$4,232	$4,620
Medicare Spending per Enrollee	$11,833	$11,899	$12,000	$8,942	$10,901
Medicaid Spending per Enrollee	$4,193	$7,458	$7,324	$6,207	$7,983
Commercial Health Insurance Premium (per employee enrolled in a family plan)	**$19,567**	**$21,801**	**$19,237**	**$18,977**	**$18,623**
Employee's Share	$5,376	$5,693	$6,177	$5,913	$5,493
Employer's Share	$14,191	$16,108	$13,060	$13,064	$13,130
State Financial Statistics					
Total GSP (trillions)	$2,798	$543	$400	$227	$59
Total State Expenditures per Capita	$6,607.00	$8,097.00	$7,158.00	$9,665.00	$8,352.00
State Pension Liability — Percentage Funded	70%	60%	69%	83%	54%

Notes: *FPL* is federal poverty level. US federal poverty guidelines are published annually by the Office of the Assistant Secretary for Planning and Evaluation of the US Department of Health and Human Services. Data are most current available, please see source for dates associated with each data point.

Sources: "State Health Facts," KFF, n.d.; and HMO/PPO Rx Digest, 2016, Sanofi, 2016.

State Commissions a Tool to Address Rising Costs

The idea of using independent state commissions to control health spending is not new (Exhibit 6). Started in 1972, the Maryland Health Services Cost Review Commission (HSCRC) is the oldest commission of its kind in the country. HSCRC initially focused on setting payment rates for hospital services, although its scope has since expanded to include total hospital budgets and targets for total statewide spending per capita.

Rhode Island's Office of the Insurance Commissioner began conducting health insurance rate reviews in 2004, and it has recently added a Health Care Cost Trends Steering Committee tasked with setting a comprehensive statewide spending target.

Since 2009, the Oregon Health Authority (OHA) has focused on controlling costs for the state's Medicaid program and premium costs for state employee health plans. A formal committee charged with establishing a statewide growth benchmark for health care costs was created within OHA in 2019.

The Massachusetts Health Policy Commission (HPC) was established in 2012 to set a total statewide growth target for health care costs and to monitor how much individual systems and groups contribute in relation to overall spending trends.

Exhibit 6. Legislative History and Commission Structure

	MARYLAND	OREGON	MASSACHUSETTS	RHODE ISLAND
Year Formed	1972	2009	2012	2004
Most Recent Update	2018	2019	2017	2019
Commission/ Implementing Agency	Maryland Health Services Cost Review Commission (HSCRC)	Oregon Health Policy Board (OHPB)	Massachusetts Health Policy Commission (HPC)	Office of the Health Insurance Commissioner (OHIC)
Health Care Expenditure Target Role	Oversees hospital global budget system	Oversees design and implementation of Sustainable Health Care Cost Growth Benchmark program	Oversees statewide cost growth targets	Oversees annual premium growth targets
Commissioners	Appointed by governor	Nominated by governor, approved by senate	Appointed by governor, attorney general, and state auditor	Appointed by governor
Number of Commissioner Members	7	9	11	1 (the State Health Insurance Commissioner)
Commissioner Member Representation	Independent experts, payers, providers, and consumers	Independent experts, providers, labor, and consumers	Experts, consumers and labor; no industry health care stakeholders	State official

Source: Author review of state websites and interviews.

Varying Goals Among Cost Commissions

While varying in their structure, regulatory authority, and scope, all four state's health care cost-containment commissions establish targets to help make health care more affordable for individual consumers and to improve the value delivered by a wide range of health care entities. Each of these states has supplemented its growth targets for health care costs and premiums with information about health care quality, and several states explicitly promote reforms to payment and delivery systems that improve population health.

Each of the four states sets and measures its spending benchmarks differently. Maryland began regulating inpatient hospital payment rates for all payers. It has since expanded its scope and rate-setting model to set total hospital budgets for all inpatient and outpatient services among all payers. For example, each year, the HSCRC explicitly sets total revenue targets for each facility and determines the specific payment rates necessary to meet those targets. The broader focus on global budgets allows the commission to control total expenditures within the hospital sector, taking into account both prices and utilization. The state is exploring how to add physician services to its total cost framework.

Massachusetts measures total statewide health care expenditures for insured services, and it collects detailed data from providers and commercial health insurers and public payers in the state. In 2018, the state's target growth rate for health care costs was 3.1% — slightly below the growth rate of the overall state economy. The statewide health spending target is applied to a broad range of "health care entities," which include health insurance payers, hospitals, clinics, and medical groups. Entities that grow faster than the target growth rate are subject to detailed reviews and may be required to submit improvement plans designed to bring their spending growth in line with the target.

Oregon's model focuses on setting targets for total Medicaid spending and limiting the growth of public employee health plan costs. In 2019, the target growth rate for costs was 3.4% for both Medicaid and public employee health plans. The state applies overall targets to individual organizations, including participating coordinated care organizations (CCOs). To enforce its targets, health plans covering public employees can impose price caps on hospital services (200% of Medicare payment rates) as part of contract negotiations.

Rhode Island is the only one of the four states studied that focuses its target growth benchmark on commercial insurance premiums. In 2019, the state's target rate of premium growth was 3.2%, a level tied to the projected growth of the state's Gross State Product. This target is applied to health insurance products sold in the fully insured commercial market. The Office of Health Insurance reviews proposed insurance products and premium rates for the coming year. The state commissioner can require changes, including reductions in rates as well as requirements for specific plan benefits that must be included (such as smoking cessation) before the commissioner approves plans for the coming year.

Finally, as mentioned above, all four states have explicit goals for transforming the delivery system and improving quality. Oregon has adopted a wide range of additional performance measures related to health care access, quality, experience of care, and health status for populations covered by CCOs, using data from the National Committee for Quality Assurance (NCQA) and the Agency for Healthcare Research and Quality. To foster coordinated care, the Massachusetts Health Policy Commission develops standards for the formal certification of patient-centered medical homes within its Medicaid program, as well as the certification of accountable care organizations (ACOs). Maryland has set specific quality targets to lower rates of hospital readmission and hospital-acquired infection below the national average. To foster more coordinated care, Rhode Island has set a target of 80% of primary care physicians practicing in patient-centered medical

homes, and the state has also adopted selected targets for improving quality and outcomes from NCQA and the Healthcare Effectiveness Data and Information Set.

Cost Commissions and Data

Targeting and monitoring performance in relation to benchmarks requires a sophisticated data infrastructure and analytic capability in each state (Exhibit 7). Measuring total cost or quality is generally calculated on an annual basis and is based on highly aggregated reports that summarize large data sets. Analyzing, monitoring, and enforcing targets at the level of an individual plan, facility, or medical group requires much more disaggregated data and more sophisticated analyses of patient-level risk adjustments and other factors affecting spending and outcomes.

All-payer claims databases (APCDs) represent the single most important data source among all four states in the study. Some states collect data and build their APCDs directly via a state agency — in Massachusetts, the Center for Health Information and Analysis (CHIA) is responsible for data collection, analysis, and reporting, for example. All state commissions have access to member-level Medicaid claims data, given the substantial proportion of Medicaid enrollees in each state and federal policy goals for improving value across the entire health care market. California is currently building an APCD through the Office of Statewide Health Planning and Development.[6] That effort is expected to include Medicaid data and to be substantially implemented by 2023.[7]

Measurement and analysis of total cost growth rates requires data at the level of patients, claims, and populations. All states in the study have either developed the capacity to link disparate data sources or have requested specific data sets that match service costs to patient and provider identifiers. While this places an additional reporting burden on organizations submitting patient-level data, federal health care privacy laws such as the Health Insurance Portability and Accountability Act allow "protected" data to be submitted to "health oversight agencies," including the state-level commissions included in this study.

Exhibit 7. Data Collection and Support for State Cost Commissions

	MARYLAND	OREGON	MASSACHUSETTS	RHODE ISLAND
External/Supplemental Data Collection and Support	Yes	Yes	Yes	Yes
Data Collection and Support Agency	Chesapeake Regional Information System	Oregon Health Authority, Oregon Insurance Division	Massachusetts Center for Health Information and Analysis	Executive Office of Health and Human Services

Source: Author review of state websites and interviews.

Strengths and Limitations of Current Models

Each of the four state cost-containment commissions included in this study offers important insights for those considering implementing reforms in other states. First, Maryland's HSCRC sets fixed growth targets and has the regulatory authority to enforce stringent compliance with targets (Exhibit 8). This has improved the ability of hospitals to manage costs and has produced savings from the program. While the program is limited to hospital spending, this segment remains the largest component (about one-third) of total health spending, as well as the main driver of overall cost increases in recent years. At the same time, the Maryland model does not easily allow for the transition to value-based models such as ACOs, which provide incentives to improve health status, health care quality and utilization, and population health. Finally, Maryland's model is built on a broad Medicare waiver that many observers consider unlikely to be offered to other states.

The Massachusetts Annual Growth Target and Statewide Benchmark model offers the most comprehensive framework for measuring total health care expenditures and for setting statewide targets that cover total health expenditures for the entire population (Exhibit 9, page 11). One advantage of the Massachusetts program has been broad support from stakeholders. For example, insurers voluntarily submit claims and other data for the self-insured commercial population. Under federal law, states cannot compel plans to supply self-insured data. One potential limitation of the Massachusetts model is the lack of a formal enforcement mechanism. While the HPC may require entities that exceed the growth target to submit justifications and performance improvements plans, the commission has no formal authority to sanction individual plans, hospitals, and medical groups that may be unduly contributing to state health spending increases.

Under Rhode Island's Health Insurance Premium Review Model (Exhibit 10, page 11), the state has authority to regulate premiums for the fully insured

Exhibit 8. Maryland Model: All-Payer Global Revenue Budgets for Hospitals

STATE-LEVEL PROGRAM ATTRIBUTES	STRENGTHS	LIMITATIONS	FUTURE CHALLENGES	BUILDING BLOCKS IN CALIFORNIA
Sets Global Revenue Budgets for All Hospitals	Effectively controls spending for the largest component of health care costs for all payers Sets statewide target for total spending for all payers	Limited to hospitals only Patient population and attribution difficult under hospital global budgeting	Complexity establishing and maintaining global budgets, avoiding regulatory capture Measure spending across hospital types (DRG, Type A, B, & C hospitals), services, and adjusting for patient mix	OSHPD currently collects detailed and comprehensive hospital data and patient-level data
Transitions Rural Hospitals from Cost-Based Reimbursement to Global Budgets	Provides predictable, stable revenue and cash flows for rural hospitals	Accounting for factors outside hospital control; preventing or adjusting for "leakage" of care from hospital to nonhospital (uncapped) setting	Adequate operational infrastructure	
Provides Financial Incentivizes for Prevention and Population Health	All providers working toward incentives for efficiencies Coordinate solutions to primary care issues	Potential difficulty obtaining federal approval through waivers	Long-term federal waiver authority not guaranteed Integration of quality measures	

Source: Author review of state websites and interviews.

Exhibit 9. Massachusetts Model: Total Health Care Spending Growth Target and Transparency and Reporting

STATE-LEVEL PROGRAM ATTRIBUTES	STRENGTHS	LIMITATIONS	FUTURE CHALLENGES	BUILDING BLOCKS IN CALIFORNIA
Establishes Single Target Growth Rate for All Payers and Providers	Explicitly links spending to affordability and economic growth	Potentially locks in existing high prices and other market-distorting factors	Updating statewide growth targets to incorporate other factors	California experience with cost of care analyses: IHA, Truven, others
Fixed, Stable, and Predictable Rate of Spending	Offers a single, transparent performance measure	Enforceability limited	Expansion of enforcement mechanisms if needed to address outliers	OSHPD currently collects detailed and comprehensive hospital data and patient-level data
Allows Market Flexibility to Meet Benchmark(s)	Demonstrated effectiveness based on Massachusetts experience	Does not explicitly address health disparities	Maintaining all-payer database to continue oversight of self-funded plans	OSHPD authorized to develop and administer new statewide health care all-payer claims database
Identifies Outliers and Requires Improvement Plans and Penalties	Recognizes and incorporates multiple factors that affect total cost growth including drug spending	Limited ability to control underlying drug costs	Integration of quality measures	
Provides Funds for Distressed Hospitals	May offer method for stabilizing rural hospitals	Does not explicitly address long-term economic trends	Development of long-term sustainable model	
Provides Funds for Infrastructure Development	Develops needed tools, data, and reporting regardless of provider type or payer source			

Exhibit 10. Rhode Island Model: Health Insurance Premium Regulation

STATE-LEVEL PROGRAM ATTRIBUTES	STRENGTHS	LIMITATIONS	FUTURE CHALLENGES	BUILDING BLOCKS IN CALIFORNIA
Review and approve health insurance premium rates — fully insured, commercial plans only	Directly regulates growth of one component of total health cost growth	Does not directly address provider market structure and performance factors that may affect premium growth; covers only fully insured population	Updating premium growth targets and impacting other factors including provider costs	California experience with health insurance reporting and rate review: Department of Insurance (DOI) and Department of Managed Health Care (DMHC)
Establish a global health spending cap for Rhode Island tied to economic growth	Explicitly links spending to affordability	Data needed for monitoring and enforceability are limited	Expansion of data reporting systems and enforcement mechanisms	California experience with cost of care analyses: IHA, Truven, others
Tie 80% of health care payments to quality	Recognizes the need to provide incentives for quality improvement	Data on quality are limited	Improvement in methods to measure quality to improve value	California experience with quality analyses: IHA, Medicare Compare, others
Develop a next-generation health information technology system for providers	Recognizes the need to improve data systems for comprehensive reporting and monitoring	Standardized IT and data systems not readily available	Development of comprehensive IT and data reporting systems that will provide comprehensive data	OSHPD currently collects detailed and comprehensive hospital data and patient-level data; DMHC and DOI collect health plan data

Source (Exhibits 9 and 10): Author review of state websites and interviews.

commercial population. The program has produced an estimated savings of $258 million from 2012 through 2018 and a projected savings of $22 million for 2019. These results demonstrate the effectiveness of a regulatory model that explicitly targets lower growth in health insurance premiums. Furthermore, the annual growth benchmark is tied to the underlying performance of the state's economy. However, while the program has produced savings to date, it does not currently have mechanisms in place to directly address underlying medical care costs within the state, such as health care utilization and provider prices. The lack of focus on medical costs, which make up 80% to 85% of premiums, may hamper efforts to moderate premium growth over the long term.

In Oregon, the OHA's focus has allowed the program to more directly control specific cost drivers within the Medicaid program and to limit hospital prices in commercial health plan contracts covering public employees (Exhibit 11). Although focusing on specific cost drivers can reduce spending, it can also create incentives for increases in utilization and shifts in care settings that ultimately do little to promote value. More recently, Oregon has endorsed the development of a health spending target for the entire population by 2020.

Considerations for California and Other States

Those considering and designing a cost-containment commission in California and other states can learn from these efforts:

1. Be Explicit About the Goals of the Cost-containment Commission.

Each of the states reviewed here has a different set of goals for its program, due in part to each state starting in a different period and evolving based on its own legislative history. Ultimately, each state wants to improve value in its health care system by limiting the growth of overall health care spending, in part to

Exhibit 11. Oregon Model: Regulation of Health Insurance Premium and Medicaid Program Costs

STATE-LEVEL PROGRAM ATTRIBUTES	STRENGTHS	LIMITATIONS	FUTURE CHALLENGES	BUILDING BLOCKS IN CALIFORNIA
Review and Approve Health Insurance Premium Rates for Public Employees	Directly regulates health cost growth for large commercially insured population	Does not directly address provider market factors that may affect premium growth; covers only one segment of fully insured population	Meeting premium growth targets and influencing underlying cost drivers including provider prices	California experience with health insurance reporting and rate review: Department of Insurance and Department of Managed Health Care
Control Total Cost Growth for Medicaid Program	Directly regulates health cost growth for government-funded, insured population	Does not directly address provider market factors that may affect provider costs; covers only portion of insured population	Meeting Medicaid program growth targets over the long run	California experience with selective contracting and managed care under the Medi-Cal program
Direct Regulation and Limitation of Hospital Prices Under Health Plan Commercial Contracts	Directly regulates provider prices under health plans serving a large commercially insured population (public employees)	Covers only one segment of fully insured population	Updating pricing regulations over time to account for other factors	California Workman's Compensation program

Source: Author review of state websites and interviews.

make health care more affordable for consumers and in part to reduce pressure on public and private purchasers of care.

Each state has different ways of accomplishing its goals: Maryland started with explicit controls on hospital budgets; Oregon initially focused on the total cost of care for Medicaid beneficiaries and public employees; Rhode Island measured and controlled the cost of care through regulation of health insurance premiums in the fully insured population; and Massachusetts monitored and set targets for the annual growth of total health care expenditures per capita across the entire population (Exhibit 12).

Exhibit 12. Statewide Spending Targets and Benchmarks

	SPENDING CATEGORIES	YEARS COVERED	SPENDING GROWTH TARGETS	SPENDING GROWTH TARGETS: DETAIL	BENCHMARKS
Maryland	Hospital spending	2018–22	3.6% per year + $300 million in Medicare savings	Hold all payer per resident hospital spending growth below 3.6% per year; generate at least $330 million in Medicare per capita hospital savings over five years.	3.6% benchmark equals 10-year average all-payer hospital growth in 2002–12; expected to be below state GSP growth per capita; Medicare savings tied to CMS waiver.
Massachusetts	Total health care spending by all payers	2012–17; 2018–22	3.6%; 3.1%	Health care cost benchmark for the first five years is 3.6%; for years 6–10, it's 3.1%.	First five years at 3.6%, equal to the state's projected PGSP. Established by state leadership with input from outside economists. Years 6–10, benchmark at PGSP minus 0.5% (3.1%). Gave HPC the authority to adjust up to 3.6%.
Oregon	Health insurance premiums & Medicaid spending	2017–present	3.4%	2017 law limits annual growth in Public Employee Health Plan premiums and Medicaid spending to no more than 3.4% and limits payments to in-network hospitals to 200% of the Medicare allowable; 2019 law established new Total Health Care Cost Growth Benchmark (HCCGB) program to set total cost benchmark starting in 2020.	Expanded Sustainable Total Health Care Cost Growth Benchmark program will apply to insurance companies, hospitals, and health care providers. Health care costs should not outpace wages or the state's economy and the program will also identify opportunities to reduce waste and inefficiency.
Rhode Island	Health insurance premiums	2019–22	3.2%	Currently, regulatory authority covers Medicaid and fully insured health plans; expanded benchmark covers THCE for all residents. A 2019 executive order sets the annual target at 3.2% for 2019–22.	Statewide target for 2019–22 equal to Rhode Island's per capita PGSP. PGSP formula for forecast growth in per capita: expected growth in national labor force productivity + expected growth in the state civilian labor force + expected national inflation – expected state population growth.

Notes: *CMS* is the Centers for Medicare & Medicaid Services. *GSP* is gross state product. *HPC* is the Health Policy Commission. *PGSP* is potential gross state product. *THCE* is total health care expenditures.

Source: Author review of state websites and interviews.

2. Define and Measure Affordability in the Context of Both Consumer and State Budget Spending.

All the states in this study set overall cost or premium growth targets. These targets combined expenditures by employers and health insurance plans with direct out-of-pocket expenditures by families. This kind of data aggregation ignores how the distribution of spending can vary and does not account for the possibility that global spending could be below the prescribed target but out-of-pocket spending by families could increase faster than the global target and economic or income growth rates.

Detailed data collected by the Massachusetts HPC illustrate this dynamic in Massachusetts. Between 2016 and 2018 the total median family compensation showed a substantial increase of $712 per month (compensation is defined to include both salary and health insurance contributions from employers). However, health insurance premiums, along with family out-of-pocket payments for services, also increased during this period ($277). As a result, increased health-related spending consumed almost 40% of the increase in total compensation (and when increased taxes are deducted from income growth, net take-home pay is reduced by more than 60%). And this was during a period when the state met its overall health spending growth targets.

Another aspect of affordability relates to the ability of states to finance health care program costs that are growing faster than state revenues and overall budgets. Health-related spending growth in all states, including California, has outpaced state-level economic growth, per capita income growth, and tax receipts. These trends raise the question of how state health care cost-containment commissions might include additional data collection and targets tied to projected state-level expenditures unrelated to health care and total state budget growth to track the spillover effect of increased health spending on other important state programs.

3. Create a Commission Structure with a Robust Level of Stakeholder Participation.

The four states reviewed in this report vary in terms of their commission structure and makeup. Rhode Island relies on the Commissioner of Health Insurance as the lead agency. Oregon establishes both governmental agencies and extensive working groups. Maryland has an independent commission that oversees its hospital global budgeting system. And Massachusetts has an independent commission that is made up entirely of health care experts and consumers. However, all four states rely heavily on participation from a broad range of stakeholders, including health industry representatives and consumer groups. All the states emphasize the importance of transparency in their work, cooperation and support from all stakeholders, and political consensus and buy-in from key stakeholders to design, implement, and sustain their cost-control programs. For example, Massachusetts mandates annual public hearings for all stakeholders, and Rhode Island recently completed a written pledge (Compact to Reduce Growth in Health Care Costs) committing health industry stakeholders to agreed-upon cost growth targets.

4. Ensure the Commission Has Access to Comprehensive Data.

The data landscape varies from state to state, but all the states studied recognize and emphasize the importance of having the right data to carry out their missions, and all the states hope to expand the data they collect to emulate the Massachusetts program. The HPC in Massachusetts has the most complete health care data system of any cost-containment commission in the country. HPC gathers data from all payers and providers to calculate total health care expenditures as well as to support extensive, detailed analyses of the underlying factors affecting growth in health spending. These analyses provide transparency, support program development, and generate buy-in from stakeholders for controlling spending.

But building a comprehensive data structure requires both regulations and voluntary cooperation from stakeholders. States can put in place reporting regulations and surveys that collect the data assembled under the comprehensive HPC model. However, federal law currently limits the ability of states to mandate reports of claims-level data for the self-insured commercial population, which represents approximately half of the commercially insured population in each state. States can mandate reporting of aggregate data for this population but not the claims-level data needed to support detailed analyses of underlying cost factors and to properly adjust for differences in patient and population characteristics.

5. Consider an Array of Enforcement Mechanisms.

All the states studied rely heavily on data reporting, analysis, and transparency to meet their targets. Additionally, each of the states takes different types of enforcement actions when growth in costs exceeds target rates. The HPC has two main mechanisms: First, the HPC can analyze changes in market structure, including mergers and other consolidations, and refer matters to the state attorney general for action; second, the HPC monitors annual spending growth rates for many reporting entities, including health providers and plans, and it can require remedial action and impose fines if it finds excessive growth.

Oregon controls overall Medicaid spending growth and can impose limits on payments to in-network hospitals of no more than 200% of the Medicare rate. Maryland enforces its program by controlling the total amount of revenue that each hospital receives based on its approved budget, and it sets rates to meet agreed-upon targets with the Centers for Medicare & Medicaid Services (CMS). The Commissioner of Health Insurance in Rhode Island can request and enforce reductions in proposed health insurance premiums for forthcoming years.

Conclusion

The idea of using independent, state-level commissions to control unnecessary health care spending is not new. Nor are the problems and pressures that excess health care spending presents to individuals, families, and state policymakers. This study has found that Maryland, Massachusetts, Oregon, and Rhode Island have taken varying approaches to developing independent regulatory agencies that monitor and enforce actions designed to reduce wasteful health spending.

A closer look at each of these models illustrates the complexities facing any state cost-containment commission. But with the right design, informed by the lessons learned from these examples, California and other states looking to adopt new cost-containment strategies have the potential to leapfrog ahead of other states and generate far-reaching impact toward the elusive goal of containing health spending.

Appendix A. Methodology

The research for this report analyzed information from multiple sources, including published papers, studies, and articles in the literature related to the health care cost-containment commissions in each state; publicly available presentations by state commissioners and/or staff; websites for each state, including laws, regulations, reports, policy documents, and public announcements; phone interviews with commissioners and/or senior staff from each state; and feedback from state staff related to descriptions of each state's program. Study participants included these:

	INTERVIEWEE	POSITION
Maryland	Robert Murray, MA, MBA	Former Executive Director, Maryland Health Services Cost Review Commission (HSCRC)
	Joe Antos, PhD	Vice-Chair, HSCRC
Massachusetts	David Seltz	Executive Director, Massachusetts Health Policy Commission (HPC)
	David Auerbach, PhD	Senior Director for Research and Cost Trends, HPC
Oregon	Jeffrey Scroggin	Policy Advisor, Oregon Health Authority (OHA)
	Zachary Goldman, MPP	Economic Policy Advisor, OHA
Rhode Island	Marie L. Ganim, PhD	Commissioner, Office of the Health Insurance Commissioner (OHIC)
	Cory King, MPP	Director of Policy, OHIC

Appendix B. An Overview of State Cost-Containment Commissions

Massachusetts Health Policy Commission

In 2012, Massachusetts established the Health Policy Commission (HPC) to set statewide targets for reducing health care spending growth. The spending target is comprehensive and covers all payers (both public and private) and total health care expenditures (THCE) — including all medical expenses, non-claims-related payments, patient out-of-pocket expenses, and the net cost of private insurance. Massachusetts policymakers initially considered a regulated approach similar to Maryland's statewide hospital rate-setting model, but ultimately adopted a model that relies on the private market rather than regulations to set rates and influence spending.

The commission is designed to improve system transparency and ultimately improve the health care market's performance through the following actions: conducting applied research, preparing reports and convening stakeholders, adopting a statewide THCE growth target, monitoring market performance and compliance with the target, and working with organizations to advance innovation. The commission is supported by a sister agency, the Center for Health Information and Analysis (CHIA), which is responsible for all data collection and selected analyses and reporting.

While largely a transparency-oriented model, mandated reporting requirements are in place for health care organizations to provide market oversight and enforcement. If an individual provider organization exceeds specified benchmarks, it is put on a list, referred to the HPC, and may be required to file a performance improvement plan. The law governing the commission also requires health care organizations to increase the adoption of alternative payment models, including value-based models.

The Massachusetts model calls for broad involvement of stakeholders, including providers, health plans, and the public. A key part of the transparency and public accountability process involves an annual hearing over a two-day period at which health care organizations testify under oath. Implicit in this approach is that increased transparency will spur provider organizations to change their financial goals and performance. In general, health plans, providers, and hospitals have broadly supported the benchmark growth rate for costs. Health plans incorporate the benchmark into their contract negotiations with providers, including hospitals.

Hospital spending growth has slowed in the state since the HPC was established. During the commission's first five years, the state experienced annual cost growth of 3.44%, slightly below the target rate of 3.6%, including even lower growth for hospital costs. Data for the most recent year show even slower growth in costs to meet the new lower target of 3.1%. Growth in costs has been contained in settings such as acute care hospitals.

Maryland Health Services Cost Review Commission

Maryland state officials, with input from Maryland health care leaders, negotiated a new agreement with the federal government to extend its hospital-based model to include all care for Maryland's Medicare enrollees under its Health Services Cost Review Commission (HSCRC). The commission adopted a new model (total cost of care, or TCOC) in 2019 and has a 10-year term during which Maryland must meet agreed-upon performance requirements. During the term, the state can develop flexible payment programs that encourage providers to improve health and the quality of care while at the same time keeping growth in Medicare spending below the national growth rate. The TCOC model encourages value-based health care redesign and provides new tools and resources for primary care providers to better meet the needs of patients with complex and chronic conditions as well as to achieve better health for all Maryland residents. The TCOC model is designed to move the state from its initial inpatient hospital rate-setting approach to a more comprehensive population-based health model that includes both inpatient and outpatient costs.

Key elements of the model include the following:

- Hospital cost growth per capita for all payers must not exceed 3.58% per year. The state can adjust this growth limit based on economic conditions, subject to federal review and approval.
- The state expects to generate savings of $300 million in annual total Medicare spending for Medicare Part A and Part B by the end of 2023.
- A state commission sets and enforces quality of care and population health goals.
- Federal resources can be invested in primary care and delivery system innovations to improve chronic care and population health, as well as resources and systems to help physicians and other providers improve care and care coordination.
- Incentive programs reward population health and encourage participation in voluntary value-based care programs.
- The state cannot regulate Medicare and private fee schedules for physicians and clinicians.

Rhode Island Office of the Health Insurance Commissioner

In 2004, Rhode Island became the first state to establish a commission that conducts rate reviews for health insurance plans, known as the Office of the Health Insurance Commissioner (OHIC). The commissioner, citing the broad statutory language that created OHIC, expanded the focus of OHIC in 2009 to mandate that insurers spend one percentage point more in total spending on primary care for five years, expand a statewide multipayer medical home program to better manage care for those with diabetes and chronic conditions, expand the use of electronic medical records to reduce unnecessary utilization and to identify high-risk patients, and reform payment systems to provide incentives for quality.

In 2010, Rhode Island formally adopted affordability standards to promote expanded goals that include the development of a patient-centered medical home system to expand primary care, reduce costs, and increase adoption of payment reform strategies. Strategies include promoting population-based contracting, adopting alternative payment methods, improving hospital contracting practices, and controlling cost increases associated with population-based contracts. In 2018, Rhode Island established its Working Group on Healthcare Innovation to develop recommendations for establishing a global health spending cap for Rhode Island, linking a large proportion of health care payments (80%) directly with quality, developing a more standardized health information technology system for all payers, and establishing performance frameworks to achieve population health and wellness goals. The state also formed the Working Group to Reinvent Medicaid to develop recommendations for regulations that improve system performance, generate state budget savings, and form a statewide health information exchange, including an all-payer claims database.

Oregon Health Policy Board

In 2009, the Oregon Legislature created the Oregon Health Policy Board (OHPB) to help align policies that affect the broader health care system. The board consists of eight members nominated by the governor and approved by the state senate. The OHPB oversees the Oregon Health Authority (OHA), which is responsible for state health care transformation programs.

The OHPB established working groups focused on metrics and scoring for coordinated care organizations (CCO), including growth in total costs. CCOs are networks of health care providers — physical health care, behavioral health care, and sometimes dental care providers — who have agreed to work together to serve people in their communities who receive health care coverage under the Oregon Health Plan (Medicaid). In 2012, Oregon received a CMS 1115 waiver to establish a coordinated care strategy that allows the state to set specific cost growth targets for Medicaid and to invest a portion of savings in new care models, including an expansion of CCOs. CMS extended the waiver through 2022. The plan caps Medicaid cost growth at 3.4% per year.

The OHPB also works to establish a baseline for sustainable health expenditures and to develop potential measures beyond Medicaid. An all-payer, all-claims technical advisory group focuses on enhanced data resources on total cost. In 2019, the Oregon Legislature laid the groundwork for developing a health spending target for the entire state population. The law established the Sustainable Health Care Cost Growth Target program and mandated that the OHA — in collaboration with the Department of Consumer and Business Services, the OHPB, and an implementation committee of consumers and stakeholders — develop a statewide spending growth target and recommendations to the assembly in 2020 for instituting a benchmark to contain the growth of health spending.

Endnotes

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