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Health Care Cost Commissions:
How Eight States Address Cost Growth

Limiting the growth of unnecessary health care spending is central to any state effort to achieve universal coverage and to bring relief to the millions of California consumers now struggling with premiums and out-of-pocket costs. As policymakers pursue these goals, they can learn from states that have established state-based commissions or new regulatory authority to measure, set, and enforce growth targets designed to lower costs and improve value across the health care system.

This issue brief documents efforts in eight states — Connecticut, Delaware, Massachusetts, Nevada, New Jersey, Oregon, Rhode Island, and Washington — that have established new independent commissions or increased the authority of an existing regulatory body to limit unnecessary growth in health spending. It updates a previous CHCF issue brief that looked at independent commissions in four states.[1]

While each state described in this report has taken its own path, both the common features and unique characteristics of these models offer valuable lessons for those looking to monitor and limit unnecessary spending growth in California.

Health Spending at the State Level and Why It Matters

The unjustifiably high and rapidly growing cost of health care services has long challenged state policymakers in California. The high cost of services within the delivery system limits the state's ability to fund them at a level adequate to ensure equitable access to comprehensive physical and behavioral care, and — particularly during economic downturns — generates enormous opportunity costs for other pressing policy priorities such as housing and education. State budget expenditures on health and human services have, over the long term, consistently grown faster than all other programs and now make up nearly one-third of the state's total budget.[2] While a significant portion of this growth can be attributed to an increase in the number of Californians receiving coverage through state health care programs, evidence suggests that value can be dramatically improved: Experts have identified billions of dollars in waste within California's health care delivery system.[3]

At the household level, rapidly growing costs within the system are fueling an affordability and public health crisis for millions of California families. For example, the monthly premium in 2020 for an individual with health maintenance organization coverage in California has grown by 300% since 2000 while median family income in California has grown by 65% over the same 20-year period.[4] While escalating premiums limit wage growth, the dramatic rise in deductibles and copayments over the past decade is making the state sicker: Recent surveys show one of two Californians has taken at least one action to delay, skip, or cut back on health care within the past year because of cost, and half of those report their conditions getting worse because of it.[5]

More than 80% of Californians say that it is important for the governor and legislature to prioritize making health care more affordable this year.[6]

State Programs to Monitor and Control Health Care Cost Growth

In states taking steps to eliminate unnecessary spending growth and provide relief to consumers, one increasingly popular tool is the establishment of enforceable systemwide and sectoral cost growth targets. Table 1 provides descriptive demographic and health system data for eight states that have implemented cost growth programs in recent years, along with baseline data for California.

All eight states have experienced average annual growth in total health care spending in excess of 5% between 1991 and 2014, with three states experiencing at least 7% annual growth. California's health expenditure growth rate sits in the middle of these states — lower than four states' and above four others. Meanwhile, the cumulative growth from 2010 to 2020 in employer-sponsored health insurance premiums for a family of four was higher in California than in all but two of the states that have adopted cost growth programs.

Ongoing Development of State-Level Programs and Setting Growth Targets

To date, the eight states listed in Table 2 on page 3 have designated agencies or entities to monitor and lower health care spending growth within their state. With the exception of Washington, all have established a statewide health care expenditure growth target in excess of recent state-level economic growth to accommodate long-term health care inflationary forces such as the development and diffusion of new medical technologies and the changing health status of the population.

Massachusetts implemented a cost growth benchmarking program in 2012. Two state-based agencies — the Center for Health Information and Analysis and the Health Policy Commission — provide the data and regulatory authority needed to measure, identify, and mitigate unnecessary health care cost growth drivers. The Massachusetts program includes a statewide cost growth target and establishes accountability for meeting that target across broad sectors (e.g., health

Table 1. Descriptive Data for California and for States Implementing Cost Growth Programs in Recent Years

	POPULATION	MEDIAN INCOME FOR ALL HOUSEHOLDS (UNDER AGE 65)*		HEALTH CARE EXPENDITURES		EMPLOYER-SPONSORED HEALTH INSURANCE PREMIUM (FAMILY OF 4)	
		2019–20	Average annual growth, 2010–20	2014 (millions)	Average annual growth, 1991–2014	Annual premium, 2020	Cumulative growth, 2010–20
California	38,642,700	$68,495	4.3%	$291,989	5.7%	$21,137	53%
Connecticut	3,453,300	$87,761	1.6%	$35,413	5.2%	$21,952	47%
Delaware	940,300	$65,732	2.0%	$9,587	7.2%	$21,565	47%
Massachusetts	6,650,800	$87,831	2.7%	$71,274	5.7%	$21,965	50%
Nevada	3,029,700	$61,249	3.0%	$19,020	8.2%	$19,524	56%
New Jersey	8,699,400	$91,757	3.4%	$79,066	5.5%	$23,042	64%
Oregon	4,128,900	$75,346	4.8%	$31,920	7.0%	$20,213	47%
Rhode Island	1,017,100	$78,075	3.6%	$10,071	5.5%	$21,425	45%
Washington	7,423,900	$86,116	4.4%	$55,819	6.7%	$19,476	37%

Sources: ***Personal Income by County and Metropolitan Area, 2019*** (PDF), Bureau of Economic Analysis, retrieved January 24, 2021; and "State Health Facts," KFF.

insurance plans, hospitals, medical groups) and individual entities and systems (e.g., Blue Cross Blue Shield of Massachusetts, Mass General Brigham).

Delaware and Rhode Island adopted health cost growth benchmarking programs through executive orders in 2018 and 2019, respectively. The Delaware program sets statewide health care cost and quality targets. Rhode Island monitors spending at the insurer and accountable care organization level by market (commercial, Medicare, Medicaid).

The Rhode Island program includes total health care price inflation caps and mandates the adoption of certain hospital payment methodologies designed to help achieve consumer affordability standards.

Oregon also created a total cost growth benchmarking program in 2019. Oregon's initiative built on previous efforts that set limits for expenditure growth within the state Medicaid program and coverage programs for state employees and teachers. The expanded Oregon initiative is designed to achieve broad state-level cost growth goals measured at four levels: statewide, market (e.g., Medicaid, Medicare, commercial insurance), by payer, and by provider organization.

More recently, four states — Connecticut (2020), Nevada (2021), New Jersey (2021), and Washington (2020) — took initial steps to establish state cost growth measurement and benchmarking programs.

In recent years, several states have begun more closely monitoring spending among payer-specific service lines (e.g., primary care and behavioral health spending) and at the subpayer (e.g., health system, provider group) level to support cost growth targets. Several states also are combining their core system-level

Table 2. State-Level Health Cost Growth Programs, State Economic Growth, and Health Cost Targets

	TYPE OF AUTHORIZATION	IMPLEMENTING/ADMINISTERING AGENCY (AGENCIES)	AVERAGE HEALTH CARE GROWTH TARGET (2021–23)	AVERAGE GSP GROWTH (2016–19)
Connecticut	Legislative	Cost Growth Benchmark Technical Team Stakeholder Advisory Board	3.20%	1.20%
Delaware	Executive Order	Delaware Economic and Financial Advisory Council	3.30%	0.40%
Massachusetts	Legislative	Center for Health Information and Analysis, Health Policy Commission	3.10%	2.50%
Nevada	Legislative	Patient Protection Commission	3.10%	2.90%
New Jersey	Legislative	Interagency Health Care Affordability Workgroup, Health Care Affordability Advisory Board	3.50%	1.70%
Oregon	Legislative	Sustainable Health Care Cost Growth Target Implementation Committee	3.40%	3.20%
Rhode Island	Executive Order	State Office of the Health Insurance Commissioner, Executive Office of Health and Human Services	3.20%	1.30%
Washington	Legislative	Health Care Cost Transparency Board	3.20%	4.70%
California	Proposed	Office of Health Care Affordability		3.10%

Note: *GSP* is gross state product.

Source: ***The Manatt State Cost Containment Update*** (PDF), Manatt, Phelps & Phillips, February 1, 2022, 9–11.

benchmarking programs with broader health reform goals. These include measuring and fostering development of alternative payment model adoption and, importantly, collecting data to measure and assess the effects of provider consolidation that have been conclusively linked to unnecessary health care costs.[7]

Six Basic Components of State-Level Health Cost Commissions

While each of the cost growth benchmarking efforts described in this brief has unique features, Table 3 shows the six universal components that have emerged across state models.

Each component is described in detail below.

Establish Authority for Program

As discussed, states have established their state-level benchmarking programs either by executive order or by adopting authorizing legislation. Four states have established cost growth benchmarking programs by executive order, while four states have passed legislation to establish their programs. Each authorization has created a new body — or established new authority for an existing body — to set cost growth targets for all entities within the state's health care system. They also collect comprehensive data in support of those efforts, and ensure that progressive enforcement creates accountability for achieving growth benchmarks.

Table 3. Six Basic Components of State-Level Health Cost Commissions

	DESCRIPTION OF COMPONENT
Establish Authority for Program	States create broad authority under executive order or legislation to establish cost growth targets for all entities in the state's health care system, collect comprehensive data in support of those efforts, and ensure that progressive enforcement creates accountability for achieving growth benchmarks.
Establish Governance Body and Administrative Infrastructure	States employ different approaches to govern their programs. Massachusetts created a new quasi-independent agency, other states administer their target program within existing executive branch agencies.
Set Targets for Cost Growth and Delivery System Reform	States have defined a health care cost growth target that brings health care cost growth in line with economic indicators, such as gross state product and wage growth. Many also have set or are considering targets for specific delivery system reforms such as adoption of alternative payment models and spending on primary care.
Collect Data to Measure and Monitor Health Care Cost Growth at the Payer Level	States establish benchmark and data collection processes, and collect aggregate spending data from payers to determine per capita health care cost growth and publicly report performance against the health care cost growth target.
Collect Necessary Data at the Subpayer Level to Identify and Analyze Cost Drivers Across the Delivery System	States supplement aggregate spending data with additional, detailed, and disaggregated data to identify factors driving unnecessary cost growth (e.g., low-value services, anticompetitive contracting).
Develop and Implement Strategies and Procedures to Enforce Targets	States are developing new mechanisms, as performance measurement and public reporting on their own may not be sufficient to slow cost growth over the long term.

Source: "State Benchmarking Updates: The State of Play — The Manatt State Cost Containment Update," Manatt, Phelps & Phillips, February 1, 2022.

Establish Governance Body and Administrative Infrastructure

Each benchmarking program has a governance structure that allows for both broad stakeholder input and program integrity by explicitly defining and proscribing financial conflicts among officials with formal decisionmaking authority. For example, in Massachusetts, the Health Policy Commission is overseen by an 11-member board of commissioners with formal decisionmaking authority, while a separate 34-member advisory council that includes a diverse group of health care leaders and stakeholders meets quarterly to provide input to the commission.

Set Targets for Cost Growth and Delivery System Reform

All eight states have defined a health care cost growth target that brings health care cost growth in line with economic indicators, such as gross state product and wage growth. In most states, state agencies or stakeholder bodies define the target value through public deliberation. At present, annual health care cost growth targets range from 2.37% to 3.8% per capita and have been set for a minimum of four years.

Several states have also set targets for delivery system goals to support reduction of unnecessary cost growth. For example, Connecticut's governor recently issued an executive order to develop and recommend policies that help ensure 10% of total state health expenditures are directed toward primary care services by 2025.[8] Oregon has set benchmarks to expand alternative payment methods and intends to use its benchmarking program to track progress and to facilitate the collaboration between payers and providers necessary to achieve savings goals.[9]

Collect Data to Measure and Monitor Health Care Cost Growth at the Payer Level

All states described in this brief have the capacity to collect, assess the quality of, and analyze the health care spending data they receive to inform the state's specific data use goals. A state's total health care spending is referred to as total health care expenditures (THCE). Massachusetts collects the most comprehensive data to date and constructs a THCE measure that includes:

- Medical expenses paid to providers by private and public payers, including commercial insurance, Medicare, Medicaid, and any non-claims-related payments
- All patient cost-sharing amounts, such as deductibles and copays
- Net cost of private health insurance, which includes administrative expenses and operating margins for commercial payers

Delaware, Oregon, and Rhode Island have largely adopted the Massachusetts model for their THCE measurements. Oregon's implementation committee recommended the state's THCE include spending on Oregon residents receiving care in the Indian Health Service and those receiving care in state correctional facilities to the extent the data are "accessible, comparable, and the collection of data can be replicated over time."

Collect Necessary Data at the Subpayer Level to Identify and Analyze Cost Drivers Across the Delivery System

Each state benchmarking program addresses core questions about the performance of a state's health care system and its cost drivers. Aggregate data collected at the payer (i.e., insurer) level are often supplemented with other data the state may already have access to or may fund as part of its benchmarking program. Examples include all-payer claims data (APCD), hospital discharge data, payer expenditure reports, provider financial reports, and surveys of employers and households. Massachusetts, for instance, examines supplemental data on consumer premiums, cost sharing, and plan type (e.g., high-deductible health plan, tiered network plan). It also reviews prescription drug costs and provider-relative price data — that is, how prices for similar services and patients vary by hospital.

Most states collect or plan to collect APCD as part their benchmark data systems. California already has a program in place and is collecting APCD.[10] Rhode Island combines use of its APCD with its benchmarking data to support richer and more contextualized analyses around specific areas of interest. The Rhode Island Cost Trends Project Steering Committee recently analyzed the state's APCD to examine the state's pharmaceutical cost drivers, identifying drugs administered in the retail and medical pharmacy settings as an important driver of total pharmacy costs. APCD also demonstrated that prices, rather than rates of pharmacy utilization, were key drivers for overall pharmaceutical spending.

Develop and Implement Strategies and Procedures to Enforce Targets

Enforcement of cost growth targets is an evolving area for all states. All eight states currently use public transparency as a key strategy for accountability. But performance measurement and public reporting on their own may not be sufficient to slow cost growth over the long term. Several states have established, and many have considered, additional authorities. The Massachusetts Health Policy Commission has the authority to require performance improvement plans from entities exceeding the cost growth target, and Oregon stipulates financial penalties for repeated unjustified growth above the target.

Using State-Level Benchmarking Authority to Understand and Mitigate Cost Growth Drivers: An Evolving Area

One important and widely acknowledged underlying factor driving sustained increases in unnecessary cost growth is consolidation within hospital, health system, and provider markets.[11] As such, several state cost growth benchmarking programs have incorporated or planned to incorporate additional authority to address the competitive structure of their health care markets, including the following.

Additional Data Collection on Provider Affiliations

Baseline data on the relationship between providers and their membership within and among larger organizations is not always available in existing databases. As such, some state benchmarking programs collect additional data on these relationships directly. For example, the Massachusetts Health Policy Commission requires registration and reporting from all provider organizations with at least $25 million in commercial net patient service revenue, as well as all risk-bearing provider organizations. Organizations are required to provide detailed information on operations, including organizational structure and finances, updated every two years.

Notification of Proposed Transactions

In Massachusetts, providers and provider organizations must notify the Health Policy Commission and state attorney general of any material change in ownership or affiliation, defined broadly to include mergers, acquisitions, affiliations, joint ventures, partnerships, and other arrangements. If the proposed material changes are considered likely to affect the state's ability to meet cost growth benchmarks, the commission can conduct a detailed impact review of the proposed change. Several states are also considering language triggering notification regarding changes to contracting affiliations, as those relationships can have the same effect on price and competition as formal mergers and acquisitions. Some states predetermine the standard data and documents they need to review the potential impacts of the transaction or affiliation — others have authority to request supplementary documentation.

Summary and Key Questions

With multiple states having established cost growth benchmarking and others actively considering their adoption, state-level programs are emerging as a major strategy to reduce unnecessary spending within the health care delivery system and ultimately return savings to consumers struggling with increasingly unaffordable premiums and deductibles.

As these programs evolve, policymakers continue to ask and address difficult questions including:

- What is the appropriate level to measure total health care cost growth?
- What is the most appropriate and efficient way to detect unnecessary cost growth drivers within the acute care delivery system?
- What types of enforcement mechanisms ensure accountability across the delivery system?
- How can cost growth benchmarking programs ensure that savings within the system are passed on to consumers facing escalating premiums, out-of-pocket health care expenses, and other affordability concerns?
- How can cost growth benchmarking be leveraged to understand and address issues of health equity?

Establishment of a state-level benchmarking program alone does not guarantee success. Much greater transparency around spending trends and cost drivers, inclusive stakeholder processes around challenges and opportunities, and broad authority for enforcement are all necessary to reduce unnecessary spending growth within a health care market as large and complex as California's. Fortunately, several states with equally unique and pressing affordability challenges have demonstrated that cost growth benchmarking and enforcement programs can help contribute to a health care system more accountable and accessible to all.

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About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

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