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State Benchmarking Models
Promising Practices to Understand and Address Health Care Cost Growth

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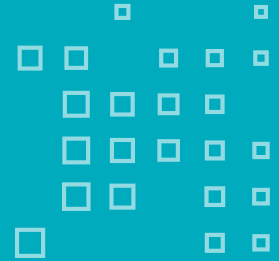Managing Director
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Executive Summary

As states grow increasingly concerned with rising health care costs, establishing health care cost growth benchmarking programs can provide a structure and process for increasing health system transparency and developing strategies for containing costs. At least eight states have adopted benchmarking programs that bring stakeholders together to set cost growth targets for health care spending, collect data from payers to measure progress, and identify where policy or program action may be required.

Health care cost growth benchmarking programs can provide a structure and process for increasing health system transparency and developing strategies for containing costs.

This white paper explores the evolution of cost growth benchmarking programs across a growing list of states. In Section I, we summarize the history of benchmarking programs, starting with the Massachusetts program that was enacted in 2012 and remains the nation's most expansive program, with an annual reporting and hearing process that engages stakeholders across the state's health care system to inform and shape potential policy interventions. The next two states were Delaware and Rhode Island, which adopted streamlined programs by executive orders in 2018 and 2019. These three pioneering states were followed by five states that have initiated benchmarking programs since 2019 with support from Peterson-Milbank Program for Sustainable Health Care Costs—Oregon in 2019, Connecticut and Washington in 2020, and Nevada and New Jersey in 2021.

In Section II, we discuss the five common features of cost growth benchmarking programs, as well as some features, such as accountability, that are works in progress. The five common features are:

- Authority to collect and use data to monitor health system spending trends

- Growth target against which to measure spending trends

- Spending measurement to collect and track healthcare expenditures

- Data and analytic capacity to support data analysis, reporting and use cases

- Data use strategy to advance state use cases

An essential ingredient in how the features fit together in each state's overall program is the state's strategy for engaging stakeholders in program development and goal-setting. Holding payers and providers accountable for not exceeding the benchmark is a state concern as well, with Oregon recently adopting legislation to impose financial penalties when performance improvement plans do not achieve compliance.

An essential ingredient in how the features fit together in each state's overall program is the state's strategy for engaging stakeholders in program development and goal-setting.

In Section III, we highlight some leading use cases states are pursuing. States have tailored their benchmarking programs to pursue a broad range of use cases that reflect local priorities for expanding transparency, addressing cost drivers and various contributors of health

care cost growth, and ensuring that health care spending is being directed to the most beneficial and cost-effective services. States may use cost growth benchmarking programs to support and reinforce existing cost-containment and transparency initiatives, providing a new mechanism to collect data and convene stakeholders around common goals. Four leading use cases are:

- Improving health care cost transparency

- Investing in primary care

- Identifying trends in patient cost sharing

- Advancing alternative payment models

States also are broadening and deepening their benchmarking programs by linking their programs to a wide range of cost-related initiatives, including addressing provider consolidation, accounting for geographic variation, advancing health equity, and ensuring workforce stability.

In Section IV, we discuss how standardization could support the continued growth and utility of benchmarking programs. Increased standardization would allow for more consistent data collection and effective data use across states, including the potential for cross-state comparisons; would reduce cost barriers to establishing programs; and would reduce payer burdens as benchmarking programs spread to more states. Potential areas for advancing standardization include:

- Model language for legislation and executive orders

- Step-by-step guide to setting a cost growth target

- Standard methodology for benchmark data collection

- Strategies for ensuring data accuracy and completeness

- Case studies on state data use cases

- Interstate working group to shape practices and understanding of emerging issue

In the Conclusion, we look forward and anticipate the complex questions that benchmarking programs may help answer as they become the centerpiece of state efforts to understand healthcare cost growth trends and what can be done to contain costs and direct spending toward efficient and equitable investments.

This paper was informed by primary research and 16 interviews with state officials, experts from national organizations, and other key stakeholders (see Appendix: Interview Table); supported with a generous grant from the Robert Wood Johnson Foundation; and developed in close coordination with the Peterson-Milbank Program for Sustainable Health Care Costs.

I. Introduction to Health Care Cost Growth Benchmarking

As states grow increasingly concerned with rising health care costs, establishing health care cost growth benchmarking programs can provide a structure and process for increasing health system transparency and developing strategies for containing costs. At least eight states have adopted health care cost growth benchmarking programs—five in the past two years—that bring stakeholders together to set cost growth targets for health care spending, collect data from payers to measure progress, and identify where policy or program action may be required. Recent program momentum indicates growing state interest in understanding, monitoring and responding to health system performance. This paper will briefly discuss the history of cost growth benchmarking programs, their common features and tailored use cases, before highlighting several opportunities for standardization as more states adopt similar models.

History of State Cost Growth Benchmarking Programs

In 2012, Massachusetts became the first state to enact a cost growth benchmarking program, passing legislation that created a statewide infrastructure, including two new agencies—the Center for Health Information and Analysis (CHIA) and the Health Policy Commission (HPC)—to monitor and respond to health care cost drivers. The Massachusetts program remains the nation's most expansive cost growth benchmarking program, with an annual reporting and hearing process that engages stakeholders across the state's health care system to inform and shape potential policy interventions.

The next two states to adopt cost growth benchmarking programs were Delaware and Rhode Island, which adopted streamlined programs by executive orders (EOs) in 2018 and 2019, respectively. Delaware's program is run by a subcommittee of the Delaware Economic and Financial Advisory Council (DEFAC) and was the first to establish health care quality-specific benchmarks within its program.[1] Rhode Island's program is jointly operated by the state's Office of the Health Insurance Commissioner (OHIC) and Executive Office of Health and Human Services (EOHHS) and expects to pair high-level benchmarking findings with targeted analyses using the state's all-payer claims database (APCD) to derive actionable insights. These programs offer a model for smaller states with limited resources.[2]

In 2019, Oregon, which had previously extended its long-standing Medicaid cost growth target to cover state employees and teachers, enacted SB 889 to create a cost growth benchmarking program to cover all state health care spending. The state hopes to leverage the program as the centerpiece of its strategy for improving health care transparency and cost containment, adopting many of the robust features of the Massachusetts model and expanding on specific use cases to address state-specific priorities.

In 2020 and 2021, four more states—Connecticut (2020), Washington (2020), New Jersey (2021) and Nevada[i] (2021)—joined Oregon, taking initial steps to establish state cost growth benchmarking programs with support from the Peterson-Milbank Program for Sustainable Health Care Costs.[3] While these five state

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[i] Nevada actually passed authorizing legislation in 2019 but the program was not operative until Governor Sisolek used his broad authority under the bill to start a benchmarking program in 2021.

programs are at varying stages of implementation, all have committed to an inclusive stakeholder process for providers, insurers, employers and consumer interests to set a cost growth target and allocate the resources necessary to address cost growth drivers and make health care costs more affordable and sustainable. (See Exhibit 1 below.)

Exhibit 1. States Implementing/Considering a Benchmarking Program, March 2021
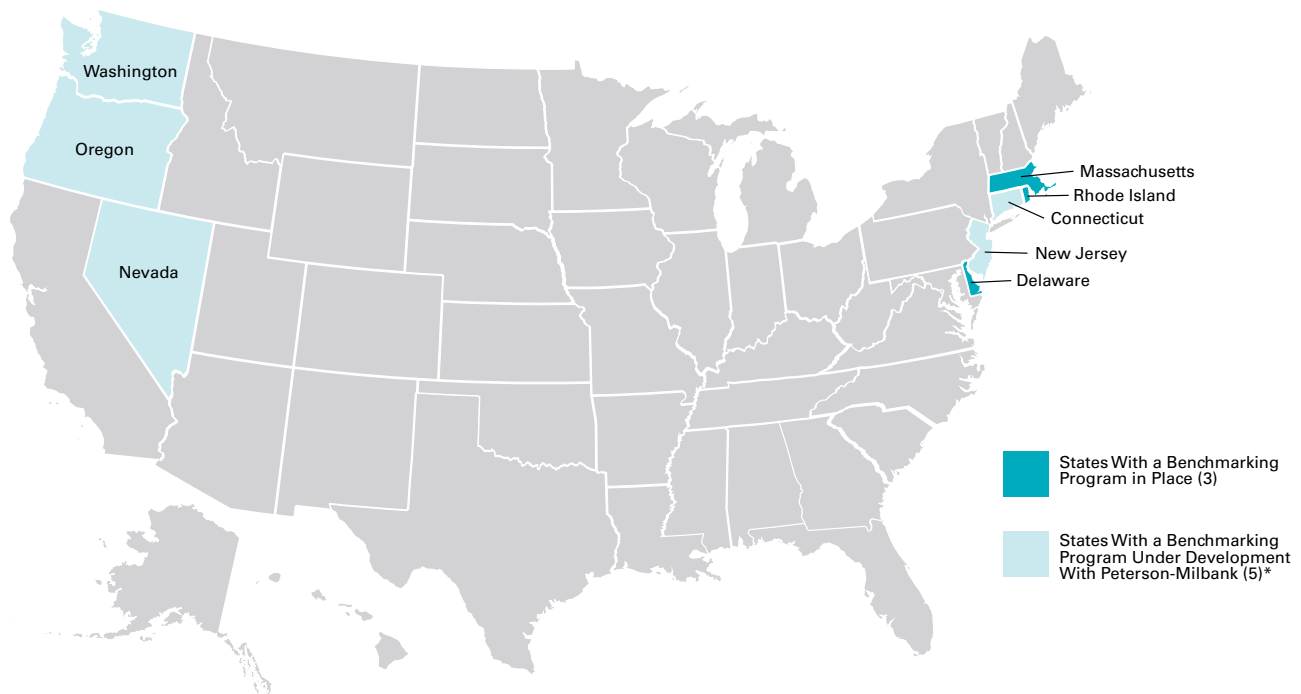
* Five states that have been selected to be part of the Peterson-Milbank Program for Sustainable Health Care Costs. Selected states must demonstrate their leadership commitment (through EO or legislation) to establish the target-setting process, the resources to support it and the appointment of a multistakeholder commission to oversee the work.

California is among the next wave of states considering a cost growth benchmarking program. Governor Newsom's 2021 budget summarizes the aspirations California has for using its program to reinforce and amplify other health care transparency and transformation activities:

The Office of Health Care Affordability will be charged with "increasing transparency on cost and quality, developing cost targets for the health care industry, enforcing compliance through financial penalties, and filling gaps in market oversight of transactions that may adversely impact market competition, prices, quality, access, and the total cost of care. In addition to lowering costs, the Office will promote health care workforce stability and training needs, report quality performance and equity metrics on the entire health care system, advance payment models that reward high-quality, cost-efficient care, and promote investments in primary care and behavioral health."[4]

Exhibit 2. Benchmarking Program Governance by State

	State	Benchmark Development	Governing State Agency
Established Benchmark	**Massachusetts**[5]	HPC	HPC
	Delaware[6]	DEFAC Health Care Spending Subcommittee	Delaware Health Care Commission (DHCC)
	Rhode Island[7]	OHIC and EOHHS	OHIC and EOHHS
Under Development	**Connecticut**[8]	Cost Growth Benchmark Technical Team Stakeholder Advisory Board	Office of Health Strategy (OHS)
	Oregon[9]	Sustainable Health Care Cost Growth Target Implementation Committee	Oregon Health Authority (OHA), Department of Consumer and Business Services (DCBS), Oregon Health Policy Board (OHPB)[10]
	Washington[11]	Health Care Cost Transparency Board	Washington Health Care Authority (HCA)
	New Jersey[12]	Interagency Health Care Affordability Workgroup, Health Care Affordability Advisory Board	Office of Health Care Affordability and Transparency, Department of Banking and Insurance (DOBI)
	Nevada[13]	Patient Protection Commission (PPC)	Department of Health and Human Services (DHHS)

While all eight cost growth benchmarking states have modeled their programs on Massachusetts' initial design, each has tailored elements of their approach and methods to address their state's unique needs. For example, some states are aiming to use their benchmarking programs not only to measure and contain overall health care system costs, but to monitor how spending is distributed among high-priority preventive care services, such as primary care and behavioral health; states also are combining their core benchmarking programs with broader cost-containment efforts, such as tracking and promoting alternative payment model (APM) adoption, and collecting information on provider consolidation and other market trends that impact health care costs.

> Each state has tailored elements of their approach and methods to address their state's unique needs.

Benchmarking programs are being established alongside other cost-containment initiatives in areas such as drug and hospital pricing and antitrust enforcement, providing an opportunity to leverage their emphasis on broad stakeholder involvement in understanding spending trends and offer a valuable platform for gathering information and addressing a wide range of cost-related challenges. In the past year, California's Governor Newsom and Pennsylvania's Governor Wolf have proposed benchmarking programs with expansive mandates to coordinate state efforts across multiple cost-containment priorities.

II. Common Features of Benchmarking Programs

State cost growth benchmarking programs share several common features, including: (1) authority and governance, (2) growth targets, (3) spending measurement, (4) data quality and analytics and (5) data use strategy, all of which are supported by and critical to meaningful stakeholder engagement.

Five Common Features	
Authority to collect and use data to monitor health system spending trends	
Growth Target against which to measure spending growth	**ESSENTIAL: Stakeholder Engagement** to foster cross-sector participation and support for program development and goals
Spending Measurement to collect and track healthcare expenditures	
Data & Analytic Capacity to support data analysis, reporting and use cases	
Data Use Strategy to advance state use cases	

Authority and Governance

States may establish benchmarking programs by EO or legislation,[14] depending on their objectives, level of stakeholder buy-in and prior history with cost containment. Four states have established cost growth benchmarking programs by EO. EOs allow states to:

- Move quickly to advance cost-containment goals and address specific policy priorities;

- Define programmatic goals without the compromises often inherent in a legislative process; and/or

- Immediately engage stakeholders around practical program design questions to inform future legislation.

However, establishing a program by EO may also limit a benchmarking program's scope and sustainability. For example, EOs may not provide the broad authority needed to collect all the data required to fully measure health care system spending against a benchmark or generate the level of public attention and system buy-in required for meaningful accountability. Further, EOs established by one governor may not be supported, or consistently implemented, by the next; without legislative support, long-term staffing and funding are also

more exposed to shifting priorities. Establishing a program by EO can allow the process to move quickly, but it could also weaken buy-in from key stakeholders, such as providers and insurers, whose participation is critical for the program's long-term success.

Some states have established benchmarking programs by EO with the intent of pursuing more comprehensive legislative action. In New Jersey, for instance, Governor Murphy's 2021 EO explicitly defines a set of steps designed to build stakeholder support for legislation in 2022.[15]

Four states established their cost growth benchmarking programs through legislation. This approach allows for:

- Setting broad new authority to collect and use health care data

- Generating critical stakeholder and political buy-in around the program's goals and objectives

- Clarifying specific program roles and responsibilities related to other programs/agencies

- Establishing a long-term funding plan to support the program's implementation and management

Legislation can, however, take a long time to develop. Oregon engaged in a multiyear process and considered multiple cost-containment approaches before settling on cost growth legislation. Legislatively enacted programs will generally reflect broader stakeholder input and be less vulnerable to changing political priorities, but legislation typically involves compromises, often related to the scope of data collection and enforcement authority. For example, the 2019 Oregon legislation included performance improvement plans (PIPs), but the Legislature deferred action on how they would be enforced;[16] the Oregon Legislature recently updated the law to mandate a multistep enforcement process.[17]

Exhibit 3. States Having Established a Benchmark via Executive Order or Legislation

Established a Benchmark via Executive Order		Established a Benchmark via Legislative Action	
DE	RI	MA	OR
EO No. 25, 2018	EO 19-03, 2019	Chapter 224 of the Acts of 2012	SB 889 Chapter 560 (2019)
CT	NJ	WA	NV
EO No. 5, 2020	EO 217, 2021	HB 2457 Chapter 340 (2020)	SB 544[ii] Chapter 473 (2019)

ii In 2019, Nevada established the PPC to analyze and make recommendations on health care affordability issues. On March 8, 2021, Governor Sisolek directed the PPC to 1) develop a statewide health care cost growth benchmark, 2) calculate and analyze statewide health care cost growth, and 3) analyze drivers of health care cost growth and serve

Once created, a benchmarking program must have a governance structure to oversee it—and effective leadership willing to build diverse coalitions in order to realize program goals. In Massachusetts, program governance rests with the HPC, an agency created by the benchmarking law; in every other state, governance rests with preexisting state agencies. However, stakeholder advisory committees often play a key role in early program implementation, charged with making specific decisions during programs' early days, such as Oregon's Sustainable Health Care Cost Growth Target Implementation Committee.

Growth Targets

Five states have established cost growth targets for their benchmarking programs as of May 2021 (Exhibit 4). All five targets considered potential gross state product (PGSP), a measurement of expected state economic growth, in setting their growth targets, though other indicators—median household income and several consumer price indices (CPIs)—were frequently considered in initial deliberations. States have tied targets to PGSP to indicate that, at

> Five states have established cost growth targets for their benchmarking programs as of May 2021.

a minimum, state health care cost growth should not exceed the long-run average growth rate of the state's economy. PGSP accounts for a number of economic factors, including the expected growth in national labor force productivity, state civilian labor force, national inflation and state population growth.[iii] State targets are presently set to range from 2.9% to 3.5% per-capita annual growth.

All five states that have established their targets have also instituted processes for adjusting these targets over time. As illustrated in Exhibit 4, the trend has been to reduce the target over time, with variations as to the baseline year(s) and other state-specific factors impacting the timing and magnitude of changes.

Massachusetts, for example, set its target through legislation to be equal to the growth rate of PGSP for 2013–2017 (3.6%), then directed the HPC to set its 2018–2022 target to be PGSP minus 0.5 percentage points. During this time, the HPC has limited authority to modify the target back up to PGSP if it determines that such an adjustment is "reasonably warranted."[iv]

Delaware set its benchmark through EO to be 3.8% for 2019, with preset annual reductions down to 3.0% in 2022.[18] Rhode Island set its benchmark through EO to equal the state's PGSP (3.2%) for 2019–2022, with the state planning to reassess its targets for 2023 and beyond.[19,20]

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as the focal point for the Peterson-Milbank program, Governor Sisolak Letter to the PPC. March 8, 2021. Available here: https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2021/2021-03-08_GovernorSisolakLtrToPPC.pdf.
[iii] In Massachusetts, the Secretary of Administration and Finance and the House and Senate Ways and Means committees met to develop an estimate of PGSP growth with input from outside economists; the estimate is established as part of the state's existing consensus tax revenue forecast process.
[iv] Requires a public hearing prior to making any modification and a two-thirds vote from the board for approval.

Exhibit 4. Statewide Cost Growth Targets by Year

State	Statewide Cost Growth Targets by Year					
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
MA[21]	3.1%	3.1%	TBD	TBD	TBD	TBD
DE[22]	3.5%	3.25%	3.0%	TBD	TBD	TBD
RI[23]	3.2%	3.2%	TBD	TBD	TBD	TBD
CT[24]	3.4%	3.2%	2.9%	2.9%	2.9%	TBD
OR[25]	3.4%	3.4%	3.4%	3.4%	3.4%	3.0%

Oregon's benchmark was determined by the state's Sustainable Health Care Cost Growth Target Implementation Committee,[26] which considered PGSP as well as measures of wage and personal income growth before recommending the state set its cost growth target at 3.4% for 2021–2025,[v] which is the current cost growth target for the Oregon Health Plan (Medicaid) and for public employee plans, with a reduction to 3.0% for 2026–2030.[vi] The committee's decision to use 2020 as the baseline year was significant in that it was done with the recognition that 2020 was a lower-than-average spending year with increased COVID-19 costs more than matched by decreased costs due to deferred care.

Connecticut's OHS[27] based its 3.4% cost growth benchmark on a predetermined blend of the growth in per-capita PGSP and the forecasted growth in median income of Connecticut residents, with a recommended reduction to 3.2% for 2022 and 2.9% for 2023–2025.

Spending Measurement

States collect total health care spending data from payers for measurement against established target(s).[vii] A state's total health care spending is referred to as total health care expenditures (THCE). Massachusetts uses a comprehensive 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; and the net cost of private health insurance,

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[v] The target of 3.4% is slightly below the state's projected PGSP for 2025–2029 (3.9%) and projected income for 2025–2029 (3.5%). The implementation committee noted it received stakeholder encouragement to set an aggressive target that would reduce the level of health care spending relative to the rest of the economy and not merely maintain spending at its current level.

[vi] The committee also recommended that, in 2024, the successor committee should review 20-year historic values of Oregon's per-capita gross state product trend and median wage trend to determine whether the annual 2026–2030 target is appropriately set and whether it should be adjusted on those findings to be higher or lower than 3.0%.

[vii] All states measure THCE at the statewide aggregate level and per-capita level (to account for changes in population over time); some states additionally measure health care cost growth by geographic region, provider system, health care entity, payer and/or market segment.

which includes administrative expenses and operating margins for commercial payers.[28] Delaware, Rhode Island and Oregon have largely adopted the Massachusetts model for their respective state THCE measurements with relatively minor modifications. (See Exhibit 5.)

Exhibit 5. Data Collected for Spending Measurement by State

Payer Spending	MA[29]	DE[30]	RI[31]	CT[32,33]	OR[34,35]
Private Commercial	✓	✓	✓	✓	✓
Medicare Advantage (MA)	✓	✓	✓	✓	✓
Medicare Fee-for-Service (FFS)	✓	✓	✓	✓	✓
Medicaid Managed Care Organization (MCO)	✓	✓	✓	✓	✓
Medicaid FFS	✓	✓	✓	✓	✓
Veterans Affairs[viii]	✓	✓	✕	✓	✓
Indian Health Service	✕	✕	✕	✕	✓
State Correctional Facilities	✕	✕	✕	✓	✓
Insurer Net Cost of Private Health Insurance	✓	✓	✓	✓	✓

Oregon's implementation committee recommended the state's THCE include spending by the Indian Health Service for Oregon residents and by state correctional facilities on those incarcerated in the state to the extent the data is "accessible, comparable, and the collection of data can be replicated over time."

Data Quality and Analytics

States must 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. These processes require trained staff to manage activities from data specification development and data collection to quality assurance and reporting. Massachusetts established a robust annual process for collecting and analyzing data, and while Oregon has indicated that it will follow a similar process, it is unclear whether additional states will follow that resource-intensive model.

Massachusetts has two agencies with designated staff responsible for supporting the state's benchmarking program: CHIA, which annually assigns a team of analysts to work with a hired actuarial contractor to support the data collection and analytic process, and the HPC, which provides extensive staff support for the state's subsequent public hearings on results and to translate data findings into recommendations for stakeholder consideration and implementation.[ix]

[viii] Data varies by state. In Massachusetts, Delaware and Connecticut, VA data is included. In Oregon, TRICARE is included in implementation committee recommendations. Rhode Island does not include either VA or TRICARE data.
[ix] CHIA and the HPC support numerous data and oversight activities that extend beyond the management of the benchmarking program.

Delaware and Rhode Island have more streamlined programs with more limited government staffing for data collection (sometimes with only one or two staff partially assigned) and a heavier reliance on outside partnerships for actuarial assurances and analytics.

While most cost growth benchmarking programs are still developing, many will likely rely on a mix of public employees and private contractors to support their programs, similar to the models established for state APCD management.

Data Use Strategy

Effective state benchmarking programs are driven by core questions about the performance of a state's health care system and its cost drivers. The methods of answering those questions, including how a state may leverage its other data resources to contextualize and reinforce findings, define a state's data use strategy. For public transparency—a common use case across benchmarking programs—states develop reporting specific to their audiences, and often collect and use additional data in their presentations.

> For public transparency—a common use case across benchmarking programs—states develop reporting specific to their audiences, and often collect and use additional data in their presentations.

Data collected through benchmarking programs may be supplemented with other companion requests (supplemental reporting) or with data from other data assets the state may already have access to (e.g., APCD data, hospital discharge data, payer expenditure reports, provider financial reports, surveys of employers and households). Massachusetts, for example, established a robust supplemental data reporting process to support its benchmarking program's numerous use cases, including data on:

- APM adoption
- Consumer premium, cost-sharing and plan type (e.g., high deductible health plan, tiered network plan)
- Prescription drug costs[x]
- Provider-relative price data (i.e., how prices for similar services and patients vary by hospital)

Massachusetts uses this data to answer specific questions about health system performance and provide greater context for overall changes in health care cost growth.

Rhode Island, meanwhile, plans to pair use of its APCD with its benchmarking data to support richer and more contextualized analyses around specific areas of interest. For example, the Rhode Island Cost Trends Project Steering Committee has already analyzed the state's APCD data (HealthFactsRI) 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 data also demonstrated that prices for medical pharmacy, rather than rates of medical pharmacy utilization, were key drivers for overall pharmaceutical

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[x] Includes pharmacy benefit manager reporting.

cost growth trends. The committee ultimately recommended the need for additional interventions to control pharmaceutical prices in the state as well as additional monitoring of medical pharmacy trends moving forward.[36]

Exhibit 6. Benchmarking Data vs. APCD Data Examples

Benchmarking Data	APCD Data
Pharmaceutical service category spending growth across payers and lines-of-business	Pharmaceutical product price and utilization changes across payers, lines-of-business, and populations

Accountability: The Next Frontier

Although questions about accountability are integral to benchmarking programs, discussions about how to measure compliance with the cost growth target and address noncompliance remain a work in progress. While there is general agreement on the need for accountability mechanisms, accountability is best characterized as unfinished business rather than as a key feature of benchmarking programs.

The 2012 Massachusetts legislation provided PIPs for payers and providers who exceeded spending targets, but PIPs have not been made public. Oregon adopted PIPs in 2019, and 2021 legislation has built on that foundation with a multistep approach to accountability designed to be a collaborative, transparent and supportive process between the state, payers and providers, with the overall goal of collectively achieving the cost growth target. PIPs have been recommended as the first line of accountability when an organization's spending has exceeded the cost growth target "with statistical certainty and without a reasonable basis for doing so." HB 2081, which was signed in May 2021, also directed the OHA to adopt rule criteria for imposing financial penalties on entities that either fail to report cost growth data or repeatedly exceed the benchmark without reasonable cause for three out of five calendar years (CYs), as recommended by Oregon's implementation committee.[xi] Oregon plans to continue the development of potential accountability measures as appropriate for the benchmark program's implementation.[37,38]

[xi] The bill language does note that the criteria used to impose a financial penalty must be based on the degree to which the entity exceeded the target, in addition to the consideration of other factors.

III. Emerging Use Cases in Benchmarking Programs

States have tailored their benchmarking programs to pursue a broad range of use cases that reflect local priorities for expanding transparency, addressing cost drivers and ensuring that health care spending is directed to the most beneficial and cost-effective services. States may use cost growth benchmarking programs to support and reinforce existing cost-containment and transparency initiatives, providing a new mechanism to collect data and convene stakeholders around common goals.

In this section, we look at four leading use cases and some emerging trends in other areas. The four leading use cases are:

- Improving health care cost transparency

- Investing in primary care

- Identifying trends in patient cost-sharing

- Advancing APMs

Improving Health Care Cost Transparency

The Issue: Health care spending for an average American was six times greater in 2019 than it was in 1970.[39] Health care spending growth has consistently outpaced gross domestic product (GDP) growth, with CMS projecting expenditures to reach $6.0 trillion and comprise nearly 20% of our GDP by 2027.[40] Health care spending is consistently one of the biggest budgetary items for states and for families, with health care spending by families who have large-employer health plans increasing twice as fast as workers' wages over the past decade.[41]
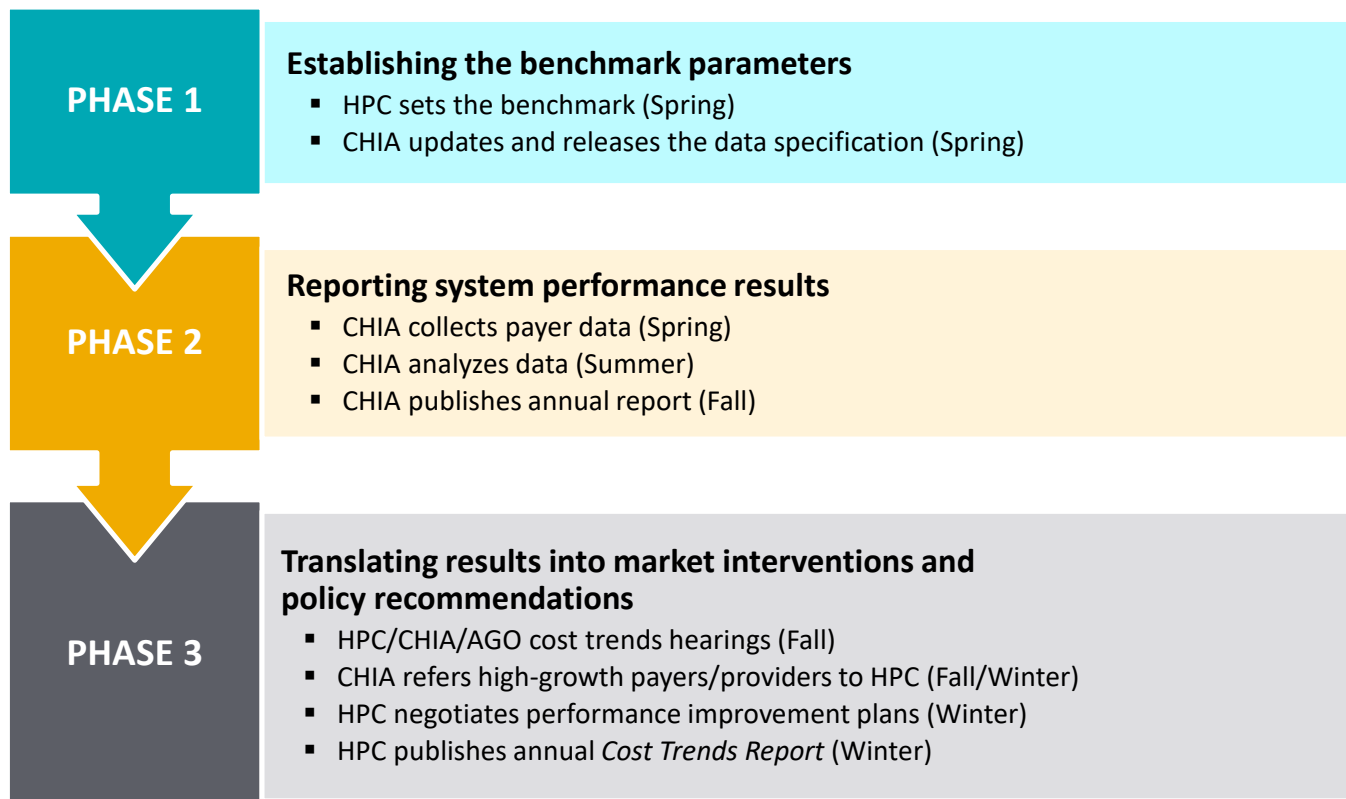
Understanding the contributors to health care cost growth is essential to developing comprehensive and cohesive strategies to contain it. Data on health care cost drivers—across payers, providers and services—provides policymakers and regulators with new insights into market performance failures to develop more targeted policies and program responses, and provides purchasers with additional information to negotiate more rigorous and innovative contracts with their plan and provider partners.

How a Benchmark Helps: Cost growth benchmarking programs allow states to collect comprehensive data about the performance of their health care systems, providing stakeholders with crucial information about their market's health care cost centers and cost drivers. Benchmarking programs also provide recurring opportunities—as health care cost growth assessments are released—to convene stakeholders around results in order to provide additional context and to begin developing actionable policy and program interventions. Improving health care cost transparency is a primary and universal function of state benchmarking programs, though the extent of data collected and released, stakeholder engagement around results and stakeholder accountability for results vary considerably by state.

What States Have Done: Massachusetts supports an annual cycle of data reporting and public hearings in which payers, providers and hospital leaders discuss performance, key trends, identified cost drivers and strategies to improve system performance. The annual process starts each spring with the confirmation of the cost growth target by the HPC and the release of the annual payer data request from CHIA. It is followed by CHIA's collection and analysis of the data through the summer, and reporting of its findings in the fall. The HPC, CHIA and the Attorney General's Office (AGO) then host formal hearings about the results, inviting key stakeholders—leadership from the Legislature, payers, providers, pharmacy benefit managers and consumer groups, among others—to testify, sharing context for results and offering potential future cost mitigation strategies for state consideration. The following winter and spring, the HPC documents its assessment of the results in an annual policy report that outlines actionable recommendations for stakeholders.[42] Through this process, in addition to the release of summary findings and policy recommendations, CHIA releases a significant amount of data about payer and provider cost trends and cost drivers through a series of organized "databooks" for use by policymakers, regulators, purchasers, advocates and researchers in their ongoing work, creating a more transparent health care system.

Exhibit 7. HPC Annual Timeline[43]

PHASE 1	**Establishing the benchmark parameters**
	▪ HPC sets the benchmark (Spring)
	▪ CHIA updates and releases the data specification (Spring)

PHASE 2	**Reporting system performance results**
	▪ CHIA collects payer data (Spring)
	▪ CHIA analyzes data (Summer)
	▪ CHIA publishes annual report (Fall)

PHASE 3	**Translating results into market interventions and policy recommendations**
	▪ HPC/CHIA/AGO cost trends hearings (Fall)
	▪ CHIA refers high-growth payers/providers to HPC (Fall/Winter)
	▪ HPC negotiates performance improvement plans (Winter)
	▪ HPC publishes annual *Cost Trends Report* (Winter)

Investing in Primary Care

The Issue: States are increasingly seeking to ensure health system spending is being invested in services and activities that support long-term health, including primary care. Higher investments in primary care are linked to improved patient health, including decreases in emergency department visits, fewer patient hospitalizations and long-term cost reductions.[44] In 2017, U.S. health care spending allocated to primary care was less than half of that allocated to prescription drugs.[45,46] Data to understand the proportion of primary care spending by population is essential to developing policies and programs that promote redistribution of spending and to promoting the long-term health of state residents.

How Benchmarking Helps: Benchmarking programs provide states with a mechanism to measure and monitor primary care spending against total system spend, and use this information to influence market redistribution of funds to increase these important, preventive investments. Benchmarking data on primary care spending will allow policymakers to compare spending patterns by payer, provider and population, and the results will guide further analysis on where primary care initiatives are having the greatest impact on patient health and total health care spending. As benchmarking programs get better at cost attribution, payers and providers will gain better insights into which payment models are most effective in increasing high-value care and decreasing low-value care.

What States Have Done: In 2020, **Connecticut's** Governor Lamont issued EO No. 5, which charged the OHS with developing and recommending a primary care spending target for the state beginning in 2021 in order to reach a primary care spending target as a percentage of THCE of 10% by 2025. The OHS estimated the current statewide primary care spending to be approximately 4.8% of total health care expenditures and recommended a statewide distribution target of 5.0% in the state's first year of pursuing a primary care spending target.[xii] The OHS is collecting primary care and overall baseline spending data for 2018, 2019 and 2020 during this calendar year. OHS will collect primary care spending data from payers within their cost growth benchmark data submissions in late 2022. The OHS intends to convene a primary care-focused work group to make further recommendations for annual primary care spending targets for the state in 2022–2024 and other initiatives, including care delivery and payment models, to improve investments in primary care that improve access, quality and the patient and provider experience.

> "Setting a primary care spending target can help the State not only increase the percentage of total healthcare spending allocated toward primary care, but also provide valuable data on this foundational component of Connecticut's healthcare system." —CT Office of Health Strategy

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[xii] The OHS calculated a statewide weighted average of current primary care spending by total health care expenditures. Commercial and Medicare data was from the University of Connecticut and Medicaid data was from Freedman HealthCare and the Department of Social Services. While the OHS' best estimate of statewide primary care spending is 4.8%, Freedman HealthCare's data suggests that Medicaid primary care spending alone is 9.0%. This tracks with trends observed in other states, where Medicaid tends to lead in primary care spending compared to commercial insurance, self-insured insurance and Medicare.

Behavioral Health Spending Targets: Similar to primary care, states may wish to assess health system investments in other core health care services, such as behavioral health, where upfront spending could lead to long-term health improvement and cost reductions. Expanding behavioral health treatment is closely linked to expanding primary care since primary care providers (PCPs) are often well positioned to identify patients with behavioral health needs or substance use disorders and help coordinate their care.

Benchmarking programs can provide states with an opportunity to better understand local behavioral health spending and promote stakeholder investments in these preventive activities. In 2019, **Massachusetts'** Governor Baker called for statewide "aggregate primary care and behavioral health expenditure target[s]" and set a goal of increasing spending on these services by 30% between 2019 and 2022.[47] CHIA has since leveraged its data collection authority to begin collecting behavioral health data as part of its regular benchmark data collection process for reporting commencing in 2021. **Pennsylvania** is similarly exploring whether to establish and support data collection against a behavioral health spending target in its nascent benchmarking program as it pursues broader delivery system reforms.

Identifying Trends in Patient Cost-Sharing

The Issue: Consumers are increasingly bearing the burden of health care system cost growth with rising premium contributions and out-of-pocket expenses. Nationally, from 2008 to 2018, the average premiums for families with employer health coverage increased by 55% and average out-of-pocket spending increased 70%, as health plans frequently cost more to cover less. Health care spending continues to consume a greater share of employee wages, which have only grown by 12% over the same period.[48] Data to understand not only how health care costs are changing over time but who is bearing the burden of those costs is critical information for understanding the direct impact of health system performance on households.

> Consumers are increasingly bearing the burden of health care system cost growth with rising premium contributions and out-of-pocket expenses.

How Benchmarks Help: States can build on their benchmarking programs' data collection processes to collect "supplemental" data on consumer premiums, cost-sharing and plan design to better understand how consumer spending and spending liability for health care services are changing over time. States may collect average annual premium and cost-sharing data by line-of-business and member characteristics—such as employer size, resident geography and plan type (e.g., HMO, PPO)—as well as benefit type (e.g., high deductible health plans, tiered network plans). Data can be received with and reconciled against other benchmarking reporting, providing states with a more comprehensive picture of cost trends and burdens.

What States Have Done: Massachusetts collects supplemental data on changes in consumer premiums, cost-sharing and plan types as part of its annual reporting process. This data provides critical context to the state's overall benchmarking findings. The state's 2021 Annual Report[49] found that consumer premiums and cost-sharing continued to increase at a faster rate than worker wages and salaries 2017–2019. (See Exhibit 8.[50])

In response to the growing cost burden on consumers and the threat it poses to health care coverage and service access in Massachusetts, in 2021, a bill was filed with the Massachusetts Legislature (S.782) that proposed the development of a consumer cost growth benchmark for reporting beginning in CY 2023.[xiii,51,52] The bill further proposes that payers identified as exceeding the benchmark would be subject to a confidential referral by CHIA to the HPC and may be subject to a PIP requirement; the HPC would also have the discretion to conduct a public hearing for carriers identified as exceeding the consumer benchmark if the PIP submitted by that carrier is considered unacceptable or incomplete.[53,54]

Exhibit 8. Private Commercial Insurance Affordability in Massachusetts, 2017–2019
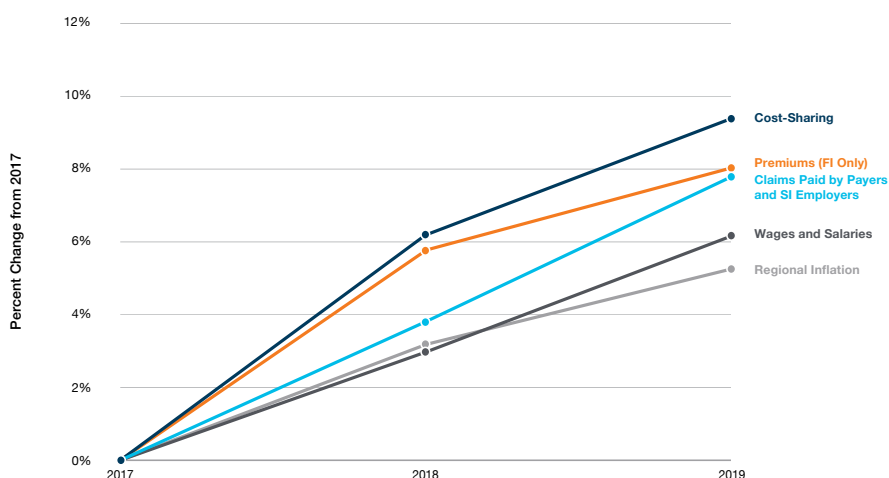
Source: CHIA 2021 Annual Report.

Alternative Payment Methods (APMs)

The Issue: The health care industry is increasingly moving away from traditional FFS payments, which encourage more services rather than high-value and well-coordinated services. Both public and commercial payers are experimenting with multiple APMs, which encourage plans and providers to align and share accountability—through various forms of risk-sharing—for achieving the Triple Aim (access, quality and cost of care) for a defined or attributed population.

How Benchmarking Helps: A cost growth benchmarking program can collect information on the number of lives covered under APMs, including definitions of how each model shares risk between payers and providers for both up- and downside risk. As APMs evolve from relatively narrow performance incentives to broad

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xiii The consumer cost benchmark would be set equal to the overall cost growth benchmark for CY 2023 and 2024, but may be adjusted by the HPC as necessary for CY 2025 and beyond.

capitation payments, benchmarking programs can help facilitate common understanding between payers and providers on how progress will be measured and what reasonable goals are. By bringing consumers, workers, state officials and other stakeholders to the table, benchmarking programs can also ensure broader buy-in to payer-provider risk-sharing arrangements.

What States Have Done: Oregon has made a major commitment to expanding APMs and intends to use its benchmarking program to track progress and facilitate collaboration between payers and providers necessary to achieve its ambitious goals. The state has invested heavily in expanding APMs or value-based purchasing (VBP) within its Medicaid program since 2012, and views that work as central to the state having saved $6.5 billion over ten years (2012–2022).[55] The state intends to double down on further expanding VBP through its community care organizations (CCOs)[xiv] and is committed to replicating the savings it has achieved in Medicaid spending with a larger group of providers and payers in the commercial market through the benchmarking program.

In its January 2021 final report, Oregon's implementation committee identified three benefits for providers in replacing FFS with APMs: financial stability against unforeseen factors that may reduce patient volume, such as COVID-19; financial flexibility to address patients' most critical health needs rather than be limited to providing reimbursable treatments; and the ability to invest in a population with "holistic patient-centered care."[56]

The committee report detailed a two-step strategy for payers to have 70% of all their payments in "advanced VBP models" by 2024, as tracked by benchmark data. First, the committee developed 16 principles for aligning VBP models across payers, including the use of common performance measures, technical assistance to small and safety net providers, and mitigation of adverse impacts on health equity. Second, the committee developed a draft VBP compact charter that has recently been embraced by a broad group of Oregon's leading payers and providers.[57]

> The Oregon committee developed 16 principles for aligning VBP models across payers, including the use of common performance measures, technical assistance to small and safety net providers, and mitigation of adverse impacts on health equity.

Oregon's VBP goals are ambitious—70% of all payments under advanced VBP models tied to national standards for risk-sharing by 2024—and provide a model for how states can leverage a benchmarking program, not just to measure VBP, but also to use the stakeholder process to forge agreements on goals and timetables.[xv,xvi]

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xiv Coordinated Care Organizations (CCOs) are the managed care entities that deliver Medicaid care in Oregon. The targets for CCOs under the "CCO 2.0" program are as follows: For 2021: > 35% CMS Learning Action Network (LAN) 2C+; for 2022: > 50% LAN 2C+; for 2023: > 60% LAN 2C+ and > 20% LAN 3B+; for 2024: > 70% LAN 2C+ and > 25% LAN 3B+.
xv Oregon's VBP Principle #7: Payers should have the following percentage of all their payments under advanced VBP models (3A and higher) in the following time periods: 35% by 2021, 50% by 2022, 60% by 2023 and 70% by 2024.
xvi Oregon's VBP Principle #8: Payers should have the following percentage of their payments to primary care practices and general acute care hospitals made under advanced VBP models (3B and higher) in the following time periods: 25% by 2022, 50% by 2023 and 70% by 2024.

Exhibit 9. The APM Framework, the Health Care Payment Learning and Action Network

Category 1	Category 2	Category 3	Category 4
FFS—No Link to Quality and Service	FFS—Link to Quality and Value	APMs Built on FFS Architecture	Population-Based Payment
	A Foundational Payments for Infrastructure and Operations **B** Pay for Reporting **C** Rewards for Performance **D** Rewards and Penalties for Performance	**A** APMs With Upside Gainsharing **B** APMs With Upside Gainsharing/ Downside Risk	**A** Condition-Specific Population-Based Payment **B** Comprehensive Population-Based Payment

Source here: https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

Broadening and Deepening the Focus of Benchmarking Programs

As states consider the broad range of factors that impact cost growth trends, benchmarking programs will similarly evolve to address new use cases and view old use cases in new ways. In many states, efforts to restrain hospital costs and prescription drug prices predate benchmarking programs, and states may decide to more closely link these initiatives to benchmarking programs as benchmarking evolves. In the meantime, policymakers already are linking benchmarking programs to a wide range of cost-related initiatives.

Provider Consolidation. Provider consolidation, especially vertical integration into health systems, has increased in recent years,[58] driving states' interest in understanding the effects of these changes on their health care systems and consumers. Benchmarking programs can provide important information to inform provider consolidation discussions and may be enhanced to include supplemental reporting requirements such as advance notice of proposed large provider mergers, acquisitions and changes in ownership. **Massachusetts**, for example, has tracked provider changes in ownership since the inception of its benchmarking program, requesting that providers "file cost reports with the Center within 60 days after a change of ownership"[59] as a means of tracking consolidation activities. The HPC played a key role in helping forge a compromise solution with respect to one high-profile merger that was ultimately approved with a set of cost control requirements.[60] Recently, in the 2021 state legislative session, Massachusetts also considered a bill that seeks to improve transparency of high-cost hospitals by requiring CHIA to report on how much acute care hospitals are contributing to total medical expense (TME) and growth in TME over time.

Oregon has similarly considered provider consolidation issues in its benchmarking program design, while **Pennsylvania** officials have recommended that its proposed Health Value Commission take a more active role in monitoring, reviewing and publishing information on provider consolidation activities in its state once it is established.[61] Additional states with high levels of provider consolidation may incorporate opportunities for provider consolidation review and/or establish future supplemental reporting requirements as part of their benchmarking efforts if trends continue.

Benchmarking programs can provide important information to inform provider consolidation discussions and may be enhanced to include supplemental reporting requirements such as advance notice of proposed large provider mergers, acquisitions and changes in ownership.

Accounting for Geographic Variation. As larger, more geographically diverse states establish cost growth benchmarking programs—such as Oregon, Pennsylvania and California—there will be a greater need to consider regional differences in populations and markets in assessing cost growth trends. The OHA, for example, intends to assess geographic approaches for measuring provider cost growth in future years and when analyzing cost trends.[62] **California's** proposed program, codified in AB 1130, would similarly require the director of the Office of Health Care Affordability to establish a regional health care cost target for THCE in addition to a statewide target.[63]

Advancing Health Equity. States are increasingly exploring how benchmarking programs may be used to advance health equity priorities, including assessing how health care spending may be inequitably distributed by community and population type and whether consumer cost and cost liability may present a disproportionate barrier for some populations more than others. **Oregon** has recommended advancing equity efforts by focusing cost analyses on variations in utilization and cost across populations and publishing that information as part of its data use strategy in order to inform future policy conversations around mechanisms to reduce inequities related to health care costs.

Ensuring Workforce Stability. One concern about state benchmarking programs is that providers, in an effort to reduce costs, will cut necessary and critical members of their workforces responsible for delivering high-quality care. **Oregon** recognized this concern and is planning to monitor the market for unintended workforce consequences of the benchmark. **California's** benchmarking bill similarly includes protective language: AB 1130 would make the state's new Office of Health Care Affordability responsible for collecting and analyzing data that would allow it to "track spending, set cost targets, approve corrective action plans, monitor impacts on health care workforce stability, and carry out all other functions of the office," and "advance standards for health care workforce stability and training, as these relate to costs." The office would also be responsible for reporting on any impacts to workforce stability as part of its annual report beginning in 2025.

IV. How Standardization Could Benefit Benchmarking Programs

States are the "laboratories of democracy" in our federal system and there are good reasons to encourage states to continue experimenting with different approaches to cost growth benchmarking. At the same time, however, state programs can benefit from coordination and even standardization in certain circumstances. Two trends suggest now is the time to consider how standardization could support the continued growth and utility of state benchmarking programs:

- **Program proliferation:** Massachusetts established the first benchmarking program in 2012 and it continues to serve as the model for new states' programs, though replication was slow to occur. Although states have long experimented with more targeted cost growth programs, such as primary care benchmarking in Rhode Island and Medicaid spending in Oregon, no state had followed Massachusetts in establishing a benchmarking program until Rhode Island (2018) and Delaware (2019) did so by EO. Since then, however, progress has been rapid, with five states establishing benchmarking programs in the past three years.

- **Common features:** All eight states that have state benchmarking programs share a common set of key features, as discussed in Section II of this paper. The Peterson-Milbank Program for Sustainable Health Care Costs has organically facilitated a level of standardization through the procurement of one vendor to support the establishment of the five newest state programs, with the vendor working with the states to tailor the baseline Massachusetts model to address local needs and priorities.

NAIC Annual Statement Offers Standardization Model

The National Association of Insurance Commissioners (NAIC) has a long history of developing standardized approaches for regulatory issues shared by state departments of insurance (DOIs), with the financial accreditation program exemplifying how effective standardization can be in supporting state goals. The crown jewel of the financial accreditation program is an annual financial statement with thousands of data points that is used by all DOIs and their stakeholders as the leading data resource on insurers' financial status. The annual statement is updated every year by the NAIC's Blanks Committee, which follows a rigorous process for developing and annually revising the annual statement and associated exhibits (the blank), including checklists and other materials to facilitate use of the blank.

Increased standardization of benchmarking program designs would allow for more consistent data collection and effective data use across states, including the potential for cross-state comparisons, would reduce cost barriers to establishing programs and would reduce payer burden as benchmarking programs continue to expand nationally. These benefits of standardization must be weighed against their costs, acknowledging that a standard approach for establishing a program or measuring health care spending may not always align with local market dynamics or state reporting priorities, and could stifle innovation. For example, state benchmarking stakeholders may reach consensus around different methods for provider-patient attribution, whether and how provider price variation should be considered in results, and whether and how data for other use cases (Section III) may be added to the benchmarking process.

> Benchmarking standardization should comprise both process and form, while allowing state customization and experimentation around a common core of processes and activities.

Ongoing Challenges With Standardizing APCDs

Determining the right time for standardization is challenging, since it is always harder to change an established state practice than to forge commonality before broad program development. For example, after slightly different APCD data collection models proliferated across the country, a compelling need for states to use a common data layout (CDL) emerged after the Supreme Court ruled that self-insured employers cannot be required to participate in APCD reporting. Harmonizing data collection since has been challenging, requiring states to make structural changes to long-established data collection and analytic processes. While progress has been made—California is using the CDL as its baseline and Virginia has adopted certain aspects of the CDL—it has been slow and piecemeal, only adding to calls to federalize standardized data collection.[64] The recently established State All-Payer Claims Database Advisory Committee, overseen by the U.S. Department of Labor, is expected to strengthen standardization—at least for the voluntary reporting of data for group health plans (i.e., self-insured plans).[65] These developments may be sufficient to bring more standardization to APCDs, but prospects remain uncertain and standardization is definitely more challenging with substantial and long-standing variations across states.

Benchmarking standardization should comprise both process and form, while allowing state customization and experimentation around a common core of processes and activities. Potential options for standardization are offered for consideration in the following table:

Program Design Feature	Standardization Opportunities
Authority and governance. States will pursue cost growth benchmarking programs through the authority of EOs or legislation.[xvii]	• Model EO and legislative text that includes program: definitions; purpose and scope; governance structure and representation; target, spending measure and data collection parameters; reporting expectations and time frames; accountability measures; and supplemental use cases.
Growth targets. States will need to assess measures of economic, workforce or health care cost growth when setting initial cost growth targets.	• Step-by-step guide to setting a cost growth target including potential federal- and state-calculated benchmarks and benchmark considerations.[xviii]
Spending measurement. States will need to determine whether and how to customize data collection methods and templates to account for local data needs.	• Baseline benchmark data collection methodology comprising: common definitions and data specifications; model processes for collection; templates for payer data collection; data requestor and submitter instructions (including how to engage the CMS in data collection); and options for how states may customize data collection without compromising benchmarking results.
Data quality and analytics. States will use similar processes—and access similar data—to ensure submitted data is accurate and complete, and to contextualize findings.	• Guide to federal and local data sources states may use to check data accuracy and completeness (e.g., federal/Center for Consumer Information and Insurance Oversight and state medical loss ratio reporting, NAIC Supplemental Health Care Exhibit). • Step-by-step guide for aggregating and analyzing quality-checked benchmarking data, including an inventory of other federal statistical resources (e.g., Medical Expenditure Panel Survey—Insurance Component) and local data resources (e.g., APCDs, discharge data) that may be leveraged to provide context for results.
Data use strategy. States will pursue use cases in alignment with their local needs, building and learning from other state examples, when available.	• Model reporting products, product formats, engagement strategies (e.g., hearings) and timelines for benchmark results. • Case studies on state use cases, with detailed examples of how data needs are identified, translated into data collection and reporting, and then used to inform practice. • Interstate working group to shape practices and understanding of emerging issues (e.g., non-claims-based payment reporting, provider-specific cost drivers, interstate provider spending, barriers to obtaining self-insured data).

Next Steps on Standardization

States, among other benchmarking stakeholders, will increasingly benefit from standardization as state programs proliferate. Leading states, foundations, health data associations and payers may consider establishing a cross-stakeholder workgroup to outline the parameters of benchmarking standardization while so many programs are in their infancy, while also looking to other best practices and lessons learned from similar data collection processes.

[xvii] May also be pursued through regulatory action or more informal, voluntary coalition building, not discussed here.
[xviii] Bailit Health's recent "Rhode Island's Cost Trends Project: A Case Study on State Cost Growth Targets" includes a good model. Available here: https://www.milbank.org/wp-content/uploads/2021/01/Fund_Peterson_RI_case_study_v8.pdf.

V. Conclusion

With eight states on board and others looking closely at cost growth benchmarking, these programs are destined to become a critical data resource for states seeking to understand healthcare cost growth trends and what can be done to contain costs and direct spending toward efficient and equitable investments. As these programs evolve, the questions will become more complex and require robust stakeholder engagement and cooperation to address quandaries such as:

- How do we control total health care costs in a fragmented system?

- Who is bearing the burden of health care cost growth?

- Are health care dollars being spent on the "right" types of services that can improve long-term health and well-being?

- How can benchmarking be leveraged to understand and address issues of health equity

Benchmarking programs are certainly not a panacea; the hard work of controlling costs in a healthcare system that has grown faster than inflation for decades will require states to overcome entrenched interests and make difficult choices. What benchmarking can do is help states identify cost drivers and make data-driven decisions with the full spectrum of stakeholders at the table.

Appendix: Interview Table

Organization	Name	Role	Interview Date
Washington State Office of the Insurance Commissioner	Jane Beyer	Senior Policy Advisor	August 19, 2020
National APCD Council	Josephine Porter	Co-Chair of the APCD Council	September 1, 2020
Rhode Island Office of Health Insurance Commissioner	Cory King	Director of Policy	September 14, 2020
Massachusetts Center for Health Information and Analysis	Ray Campbell	Executive Director	September 18, 2020
	Deb Schiel	Deputy Director of Analytics & Chief Analytics Officer	
	Kathy Hines	State Director of Partner Operations and Data Compliance	
	Michael Cocchi	Chief Data Officer, CIO & Deputy Executive Director	
	Gregory Wheeler	Financial Policy Development Manager	
	Amina Khan	Analytic Development Specialist	
Colorado Division of Insurance	Michael Conway	Insurance Commissioner	September 23, 2020
National Association of Health Data Organizations (NAHDO)	Norm Thurston	Executive Director	October 6, 2020
Connecticut State, Office of Health Strategy	Victoria Veltri	Executive Director	October 14, 2020
	Olga Armah	Research Associate	
Pennsylvania Department of Human Services	Doug Jacobs	Chief Innovation Officer	October 19, 2020
Pennsylvania Insurance Department (PID)	Jessica Altman	Insurance Commissioner	November 13, 2020
Oregon Health Authority	Jeremy Vandehey	Health Policy and Analytics Director	November 13, 2020
	Sarah Bartelmann	Policy Lead	
	Amy Clary	APCD Specialist	
Rhode Island Office of Insurance Commissioner	Marie Ganim	Health Insurance Commissioner	November 16, 2020
Delaware Health Care Commission (DHCC)	Steven Costantino	State Senator	November 19, 2020
	Ayanna Harrison	Public Health Administrator I	
Washington State Health Care Authority	Mich'l Needham	Chief Policy Officer	December 14, 2020
National Association of Insurance Commissioners (NAIC)	Mary Caswell	Staff to NAIC Blanks Working Group	January 12, 2021
National Association of Insurance Commissioners (NAIC)	Scott White, VA Insurance Commissioner	Virginia Insurance Commissioner and Chair of NAIC Financial Condition Committee	January 27, 2021
New Jersey Department of Banking and Insurance	Justin Zimmerman	Chief of Staff	April 12, 2021

1 "Delaware Health Care Spending and Quality Benchmarks Implementation Manual Version 1.0," Delaware Health Care Commission, Mercer. January 31, 2019. Available here: https://dhss.delaware.gov/dhss/files/benchmarksummary013119.pdf.

2 "Implementing a Statewide Healthcare Cost Benchmark: How Oregon and Other States Can Build on the Massachusetts Model," Manatt Health. December 2019. Available here: https://www.manatt.com/Manatt/media/Documents/Articles/RWJ-Phase-5-Report-Cost-Benchmarking-Paper-December-2019_FOR-WEB.PDF.

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4 Governor's Budget Summary—2021–22, Health and Human Services. January 1, 2021. Available here: http://www.ebudget.ca.gov/2021-22/pdf/BudgetSummary/HealthandHumanServices.pdf.

5 https://www.mass.gov/orgs/massachusetts-health-policy-commission.

6 "Minutes of the Delaware Economic & Financial Advisory Council Health Care Spending Benchmark Subcommittee." October 10, 2020. Available here: https://dhss.delaware.gov/dhcc/files/hcsbqltysbcomins_101020.pdf.

7 "Rhode Island Health Care Cost Growth Target: Implementation Manual." July 31, 2019. Available here: http://www.ohic.ri.gov/documents/July%202019/Cost%20Trends/RI%20Implementation%20Manual%202019%207-31.pdf.

8 "Preliminary Recommendations of the Healthcare Cost Growth Benchmark Technical Team," Connecticut Office of Health Strategy, Victoria Veltri, Executive Director. September 2020. Available here: https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/CGB-TT-Information/CGB--TT-Meetings-2020/September-24-2020/CT-OHS-Technical-Team-Recommendations-Report---September-2020_final-draft.pdf.

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11 Health Care Cost Transparency Board. Available here: https://www.hca.wa.gov/about-hca/health-care-cost-transparency-board.

12 "Governor Murphy Signs Executive Order Advancing Health Care Affordability Efforts," Press Release. January 28, 2021. Available here: https://www.nj.gov/governor/news/news/562021/20210128b.shtml.

13 Governor Sisolak Letter to the Patient Protection Commission (PPC). March 8, 2021. Available here: https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2021/2021-03-08_GovernorSisolakLtrToPPC.pdf.

14 States may also establish new regulations and/or voluntary compacts as intermediary steps toward creating a benchmarking program.

15 Executive Order No. 217, Office of Governor Phil Murphy, State of New Jersey. January 28, 2021. Available here: https://nj.gov/infobank/eo/056murphy/pdf/EO-217.pdf.

16 Enrolled Senate Bill 889, 80th Oregon Legislative Assembly, 2019 Regular Session. Available here: https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB889/Enrolled.

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[21] https://www.mass.gov/info-details/health-care-cost-growth-benchmark.

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[23] "Rhode Island Health Care Cost Growth Target: Implementation Manual." July 31, 2019. Available here: http://www.ohic.ri.gov/documents/July%202019/Cost%20Trends/RI%20Implementation%20Manual%202019%207-31.pdf.

[24] "Preliminary Recommendations of the Healthcare Cost Growth Benchmark Technical Team," Connecticut Office of Health Strategy, Victoria Veltri, Executive Director. September 2020. Available here: https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/CGB-TT-Information/CGB--TT-Meetings-2020/September-24-2020/CT-OHS-Technical-Team-Recommendations-Report---September-2020_final-draft.pdf.

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[28] "Benchmark Overview," Massachusetts Health Policy Commission. Available here: https://www.mass.gov/info-details/health-care-cost-growth-benchmark.

[29] https://www.chiamass.gov/assets/2018-annual-report/2018-Annual-Report-THCE-TME-APM-Technical-Appendix.pdf.

[30] https://dhss.delaware.gov/dhss/files/benchmarkmanual06252020.pdf.

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