Manatt Health
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October 2021 Edition

The Manatt State Cost Containment Update
October 5, 2021

Introduction

Welcome to the Manatt State Cost Containment Update, a digital publication produced with generous support from the Robert Wood Johnson Foundation and in collaboration with the Peterson-Milbank Program for Sustainable Health Care Costs. This Manatt series, to be released quarterly through 2022, shares the latest updates on state cost growth benchmarking programs and other data-driven initiatives states are undertaking to contain health care cost growth. In each edition, we also feature a spotlight issue that speaks to how state benchmarking programs are collectively evolving to meet new regulatory or landscape needs. Below are our October updates.

October Spotlights

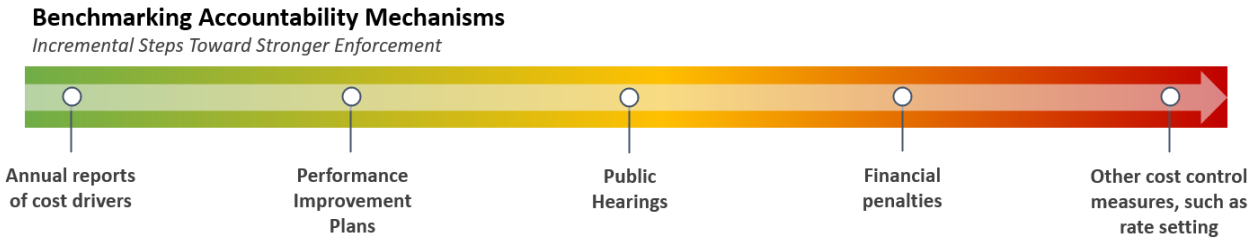
In each edition, Manatt will feature "deep dive" topics that share new cross-cutting benchmarking program developments as states seek to evolve and advance their cost growth benchmarking programs to meet new regulatory and landscape needs. In this issue, Manatt examines recent program changes in accountability and consumer affordability.

Accountability

The takeaway. State cost growth benchmarking programs are building on their market reporting to more rigorously define unjustified spending growth and what actions states should take to address entities driving such growth.

What it is. State cost growth benchmarking programs collect health care data that can help policymakers, regulators and stakeholders better understand the cost centers and cost drivers in their markets. Programs include a cost growth benchmark that annual health care cost growth should not exceed. States have a continuum of mechanisms for holding payers and providers accountable for unjustified spending above benchmarks, as illustrated in Figure 1. Where spending exceeds benchmarks, states are discussing two issues: First, how do we identify cases where the excess spending merits more aggressive action than public transparency? Second, what kind of escalating actions are appropriate to address unjustified spending above the benchmark?

Figure I. The Continuum of Benchmarking Accountability Mechanisms



What it means. Three states exceeded their cost growth benchmarks during 2019: Delaware, Massachusetts, and Rhode Island – by 4.0, 1.2, and 0.9 percentage points, respectively.[1,2,3] While all three programs have largely relied on public transparency to support cost growth containment, the tactic alone has not been a powerful enough deterrent to keep overall cost growth beneath established thresholds, spurring reviews of how excessive cost growth is identified and can be responded to.

States are exploring strategies to better understand cost drivers and refine the methods they use to identify unjustified or excessive cost growth. For example, **Massachusetts** has traditionally assessed entity accountability to the cost growth benchmark on a "health status"-adjusted basis, generally holding entities accountable for factors over which they have more influence: health service utilization (by working with individuals to identify conditions and health needs earlier) and health service prices (by negotiating contracts that hold service spending growth beneath required levels and steering patients to more appropriate, lower-cost service settings where possible). But cost growth due to the changing health of members (i.e., illness burden and expected resource use) has been largely exempt from measurement, with payers providing health status-adjusted growth rates in their reporting.

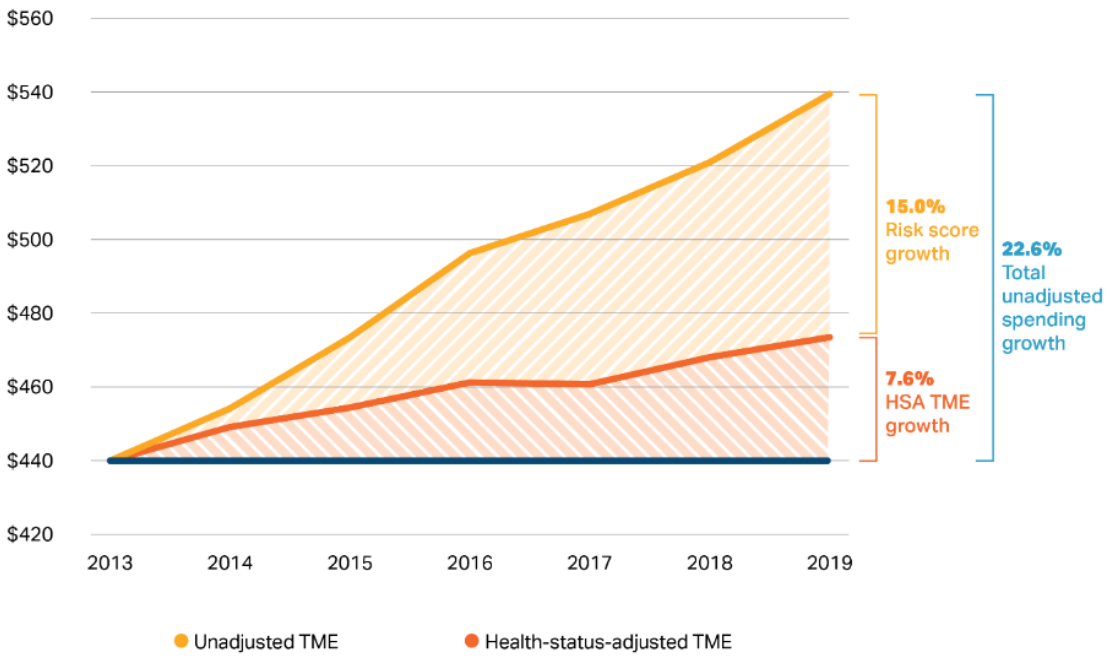
However, recent analyses by the Massachusetts Health Policy Commission (HPC) identified unexplained inflation in payer-provided health status adjustment values – potentially caused by changing methodologies, upcoding of health status indicators, or broader improvements in health status indicators (i.e., stronger identification of previously observed but not recorded population health concerns) – and likely indicating chronic and continual underassessment of cost growth against which individual payers and providers should be held accountable. The HPC is assessing whether to modify health status adjustment methodology requirements or base future payer/provider accountability against unadjusted cost growth measures.

[1] Delaware's per capita cost increased from $7,814 in 2018 to $8,424 in 2019, or 7.8% – more than twice as high as the 3.8% target. Available here: https://news.delaware.gov/2021/04/01/state-releases-first-health-care-benchmark-trend-report-for-201/#:~:text=Latest%20Step%20in%20Effort%20to,Quality%20of%20Care%20in%20Delaware&text=The%20per%2Dcapita%20cost%20increased,high%20as%20the%203.8%25%20target.

[2] From 2018 to 2019, the per capita growth in total health care expenditures in Massachusetts was 4.3%, exceeding the health care cost growth benchmark of 3.1% set by the HPC. Available here: https://www.mass.gov/info-details/health-care-cost-growth-benchmark.

[3] Rhode Island's per capita health care spending grew 4.1% between 2018 and 2019, exceeding the state's 3.2% health care cost growth target. Available here: http://www.ohic.ri.gov/documents/2021/April/Cost%20Trends/steering%20committee%20meeting%202021%204-29%20for%20sharing.pdf.

Figure II. Total Unadjusted Spending Growth in Massachusetts, 2013-2019[4]



Oregon, similarly grappling with the question of when excess spending should spur enforcement, has proposed a different approach. The Oregon Implementation Committee Recommendations Report recommended statistical criteria for determining whether payers and providers in Oregon would be subject to certain accountability measures.[5] These include:

- In any given year, per capita cost growth exceeds the cost growth benchmark with 95% confidence; or
- Across two consecutive years, per capita cost growth exceeds the benchmark in both years with 80% confidence; or,
- For three out of five consecutive years (each independently assessed), per capita cost growth exceeds the cost growth target with 80% confidence.

Entities that "unreasonably" exceed the cost growth target during any performance year with statistical certainty for one or more markets would be automatically subject to a performance improvement plan (PIP). **Connecticut's** Cost Growth Benchmark Technical Team has similarly recommended incorporating into its own cost growth benchmark a statistical methodology for determining entity accountability.[6]

[4] "The Next Evolution of Healthcare Cost Growth Benchmarking Models," NAHDO 36th Annual Conference. Presented September 28, 2021. Chart sources: Massachusetts CHIA TME databooks.
[5] "Oregon Implementation Committee Recommendations Report," Oregon Health Authority. January 25, 2021. Available here: https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf.
[6] Cost Growth Benchmark Technical Team February 21, 2021, Meeting Notes, stating "the Technical Team recommended that OHS perform calculations of statistical significance when reporting benchmark performance to ensure the accuracy of findings," Connecticut Office of Health Strategy. Available here: https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/CGB-TT-Information/CGB--TT-Meetings-2021/February-22-2021/CT-OHS---Technical-Team-Meeting---Minutes-2021-2-22.pdf.

Oregon's HB 2081 builds on the accountability recommendations articulated in the Recommendation Report.[7] This includes charging the Oregon Health Authority (OHA) with adopting rule criteria for imposing financial penalties for entities that exceed the cost growth target "without reasonable cause" in three out of five calendar years beginning in 2026, as part of the "escalating accountability mechanism" recommended by the Implementation Committee. The law does not specify the financial penalty amount, but does specify that it must be based on "the degree to which the provider or payer exceeded the target and other factors," including but not limited to:

(a) The size of the provider or payer organization;
(b) The good faith efforts of the provider or payer to address health care costs;
(c) The provider's or payer's cooperation with the authority or the department;
(d) Overlapping penalties that may be imposed for failing to meet the target, such as requirements relating to medical loss ratios; and
(e) A provider's or payer's overall performance in reducing cost across all markets served by the provider or payer.

The law also sets new financial penalties of up to $500 per day for entities that fail to report cost growth data and/or fail to develop and implement a PIP if required.

Even in states with accountability measures already incorporated into their benchmarking programs, holding specific entities accountable for exceeding cost growth has not been widespread. For example, while Massachusetts' HPC has the authority to impose PIPs and financial penalties of up to $500,000[8] under Chapter 224 of the Acts of 2012, it has not yet exercised either option, though it has indicated an increasing willingness to do so.[9] Notably, the HPC's 2021 Annual Cost Trends Report puts forth a recommendation that demonstrates a willingness to increase accountability and address excessive provider price increases by establishing price caps for the highest-priced providers in the state.[10]

[7] House Bill 2081. Available here: https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2081/Enrolled.

[8] Under Chapter 224 of the Acts of 2012, if the HPC determines a health care entity has willfully neglected to file a PIP, failed to file an acceptable PIP in good faith, failed to implement the PIP in good faith, or knowingly failed to provide or falsified information required by the HPC, the HPC may assess a civil penalty to the health care entity of up to $500,000 as a last resort. Available here: https://malegislature.gov/laws/sessionlaws/acts/2012/chapter22%204.

[9] "As premiums rise, Health Policy Commission mulls adding accountability measures," MetroWest Daily News. July 15, 2021. Available here: https://www.metrowestdailynews.com/story/news/2021/07/15/massachusetts-family-health-insurance-premiums-21-424-average-2019/7977321002/.

[10] 2021 Annual Cost Trends Report, Massachusetts Health Policy Commission. September 2021. Available here: https://www.mass.gov/doc/2021-health-care-cost-trends-report/download.

Consumer Affordability

The takeaway. States are increasingly interested in understanding not only what is driving health care cost growth, but also how consumer costs are being impacted by that growth. States, however, should proceed carefully in developing new measures for consumer cost growth, ensuring that data is collected and reported with appropriate context.

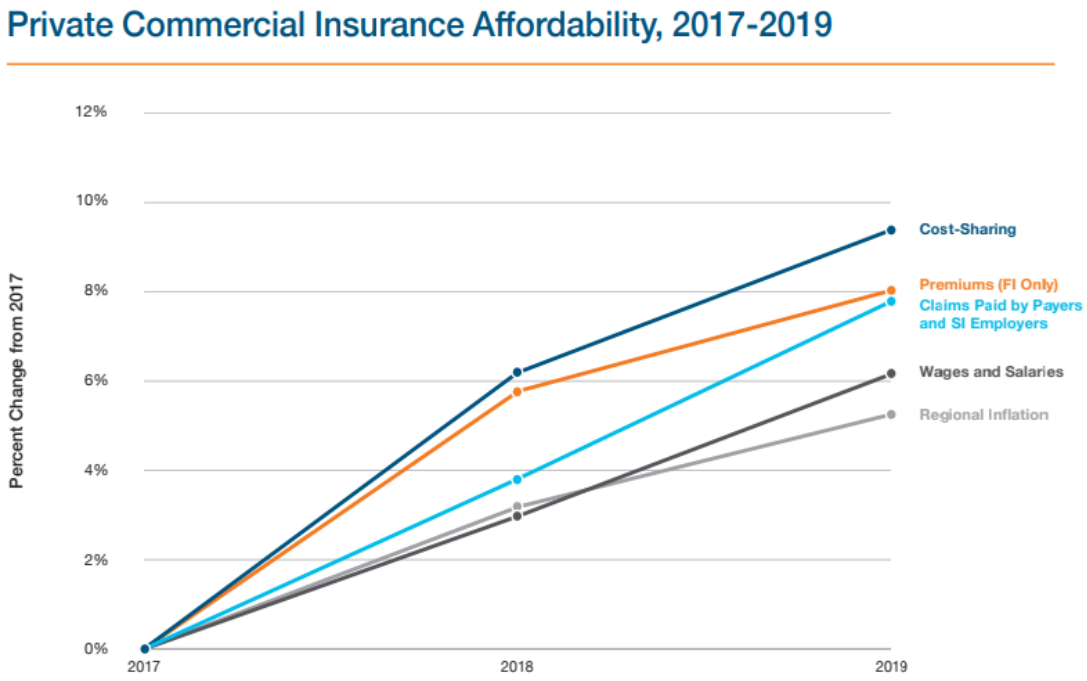
What it is. Beyond addressing aggregate health care cost growth, states are increasingly turning their attention to understanding who is ultimately bearing the burden of rising health care costs. In particular, states are exploring new strategies to better understand and address the increases in consumer cost-sharing (e.g., deductibles, coinsurance, copays) that make access to care challenging even for consumers who have health coverage.

Nationally, from 2010 to 2020, the average premiums for families with employer health coverage increased by 55% and average deductibles among all covered workers increased by 111%, as health plans frequently cost more to cover less.[11] Health care spending continues to consume a greater share of employee wages, which have only grown by 27% over the same period.[12] Further, trends show that enrollment in high deductible health plans (HDHPs) has increased significantly since the passage of the Affordable Care Act (ACA), and these plans are shown to be associated with a significant reduction in preventive care and office visits, which in turn leads to a reduction in both appropriate and inappropriate care for consumers.[13] Additionally, while HDHP enrollment has increased steadily over time across all racial and income groups, studies show that Hispanic and Black HDHP enrollees are significantly less likely to have a health savings account (HSA) to offset the costs of such high deductibles compared with their non-Hispanic White counterparts.[14] These trends indicate not only that consumers are increasingly bearing the burden of overall health care system spending growth, but also that shifting costs onto consumers is not necessarily an effective strategy for reducing overall spending growth and has significant implications for health access and equity.

What it means. Benchmarking programs offer an important opportunity for states to build on established reporting capabilities and authorities in order to gather additional information on consumer affordability and examine its impacts. For example, **Massachusetts** collects supplemental reporting on consumer premiums and out-of-pocket (OOP) costs as part of its cost growth benchmark in order to identify trends and changes over time. In the 2021 Annual Report on the Performance of the Massachusetts Health Care System, the state reported that member cost-sharing and premiums increased at a faster rate than wages and inflation between 2017 and 2019, and the percentage of

[11] "2020 Employer Health Benefits Survey," Kaiser Family Foundation. October 8, 2020. Available here: https://www.kff.org/report-section/ehbs-2020-summary-of-findings/.
[12] "Average Family Premiums Rose 4% to $21,342 in 2020, Benchmark KFF Employer Health Benefit Survey Finds," Kaiser Family Foundation. October 8, 2020. Available here: https://www.kff.org/health-costs/press-release/average-family-premiums-rose-4-to-21342-in-2020-benchmark-kff-employer-health-benefit-survey-finds/.
[13] https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0610.
[14] Ellison J., Shafer P., and Cole M.B. "Racial/Ethnic And Income-Based Disparities In Health Savings Account Participation Among Privately Insured Adults," Health Affairs. November 2020. Available here: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00222.

members that had an OOP maximum of at least $5,000 increased from 35.5% in 2017 to 43.9% in 2019.[15]



Oregon's Implementation Committee Recommendations Report also recommended the state's annual health care cost trend report discuss the market's performance relative to the cost growth target as well as its implications for consumers, including:[16]

- Premium growth;
- Benefit levels;
- Consumer OOP spending;
- Quality of care (process, outcome, patient experience);
- Access to care; and
- Health care disparity and health care inequity.

Oregon has also recommended annual reporting of other potential unintended consequences, including employer spending, clinician satisfaction, workforce impacts, and consolidation impacts.

Both **Washington** and **Connecticut** have proposed embedding consumer affordability into their benchmarking design, tying a portion of benchmark value to median wage growth. Washington's Health Care Transparency Board is proposing a 30/70 hybrid of the state's potential gross state product (PGSP)

[15] "2021 Annual Report on the Performance of the Massachusetts Health Care System," Massachusetts Center for Health Information Analysis. March 2021. Available here: https://www.chiamass.gov/assets/2021-annual-report/2021-Annual-Report.pdf.

[16] "Oregon Implementation Committee Recommendations Report," Oregon Health Authority. January 25, 2021. Available here: https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf.

and historical median wage, which would yield a benchmark value of 3.2% for 2022 and 2023.[17] Connecticut is using a 20/80 weighting of PGSP and median income, with an add-on factor that grades down over time from 2021 to 2025, yielding a benchmark value of 3.4% in 2021, 3.2% in 2022, and 2.9% for 2023-2025.[18] By incorporating wages into the statewide benchmark, these states are reinforcing that health care costs should not be growing faster than consumer finances and the state economy.

Additionally, the **Connecticut** Office of Health Strategy (OHS) and the Office of the State Comptroller (OSC) have developed a companion measure to the state's cost growth benchmark reporting – a Healthcare Affordability Index to measure the impact of health care costs (including premiums and OOP costs) on a household's ability to afford basic needs.[19] The Index establishes an affordability threshold for families' health care spending of approximately 7%-11% of their household expenses, depending on family size.[20] This tool was developed to help policymakers understand the impact of health care cost growth on households, and shows that as of June 2021, approximately 18% of households in Connecticut with working adults face costs that exceed the target for affordability.[21] When paired with results from the state's cost growth benchmark reporting process, Connecticut will have greater insight into not only how overall health care spending is trending over time but also how much of this cost is falling directly to consumers, and how many consumers are facing potentially untenable costs.

What happens next. With increasing interest in monitoring consumer cost burden within cost growth benchmarking programs, states are considering how to:

- Incorporate a consumer cost growth measures into their cost growth benchmark data collection and reporting processes;
- Build consumer income growth data into their benchmark threshold; and/or
- Build separate "companion" data collection and reporting processes to assess consumer affordability.

For example, in **Massachusetts**, consumer advocates recently introduced the More Affordable Care (MAC) Act (H. 1247/S. 782),[22] which, among other provisions, seeks to create a health care consumer cost growth benchmark for OOP and premium cost growth, in which payers and providers accountable to the statewide benchmark would further be held accountable to a cost growth target for consumer premiums and OOP spending. The state legislature recently held a hearing for the MAC Act, which is now pending a committee recommendation.

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[17] The Washington Health Care Transparency Board recommended the state set its benchmark value using a 70/30 hybrid of the state's historical median wage and PGSP, yielding a benchmark value of 3.2% beginning in 2023. Available here: https://www.hca.wa.gov/assets/program/hcctb-board-book-20210914.pdf.

[18] "Cost Growth/Quality Benchmarks/Primary Care Target," Office of Health Strategy. Available here: https://portal.ct.gov/OHS/Services/Cost-Growth-Quality-Benchmarks-Primary-Care-Target.

[19] "Healthcare Affordability Index," Connecticut Office of Health Strategy. Available here: https://portal.ct.gov/healthscorect/Affordability-Index?language=en_US.

[20] The affordability target was based on the 2019 Connecticut Self-Sufficiency Standard report, which found that, depending on composition, households spend between 6% and 10% of their budget on health care costs, including premiums and OOP expenses.

[21] "Healthcare Affordability Index Executive Summary," Connecticut Office of Health Strategy. June 2021. Available here: https://portal.ct.gov/healthscorect/-/media/HealthscoreCt/CHAI-Executive-Summary-OHS_OSC_June_2021.pdf.

[22] Senate Bill 782 (2021). Available here: https://malegislature.gov/Bills/192/S782.

Further, in the Massachusetts HPC's 2021 Annual Cost Trends Report,[23] consumer affordability was emphasized as an urgent issue for state action. The HPC recommended the state strengthen accountability for consumer cost growth, including developing population-specific affordability standards; incorporating standards into rate review; supporting efforts to improve the consumer health plan shopping experience; and strengthening benefit design and advancing designs that may serve as alternatives to HDHPs.

While consumer benchmarks – like those proposed in Massachusetts – can provide states with a concrete metric to monitor the impacts of cost growth on consumer affordability, their operationalization and interpretation can present issues that should be considered in advance of implementation. For example, many state benchmarking programs are presently collecting aggregate "total" spending data from payers across various segmentations (e.g., market sector, line of business, geography) without distinction between payer- and consumer-paid amounts. Requiring further parsing of these amounts has the potential to double the size of existing payer data requests. Consideration should be given to both use cases and reporting burden before implementation.

Further, measures of consumer burden should be presented with appropriate context to ensure proper interpretation. For example, many cost containment advocates have advanced benefit designs that incentivize consumer choice, including the adoption of consumer-directed HDHPs with HSAs and health reimbursement accounts (HRAs). Higher HDHP adoption, resulting in higher observed consumer spending, should be paired with consideration of:

- Corresponding declines in premiums;
- Potentially lower overall cost growth resulting from newly incented "price shopping" behavior (where observed); and
- The limitations of state cost growth benchmarking programs' data collection.

States – and the payers that provide them with data – typically do not have HSA/HRA reimbursement data, and to the extent that employers contribute to HRAs, collected data could potentially result in an overstatement of how much consumers are directly paying in OOP costs.

States seeking to address cost growth through a benchmarking program recognize that to address a problem is to first understand its scope. Being equipped with the right information is critical for ultimately developing strategies that can ensure containing cost growth does not come at the expense of consumer affordability or otherwise exacerbate health inequities.

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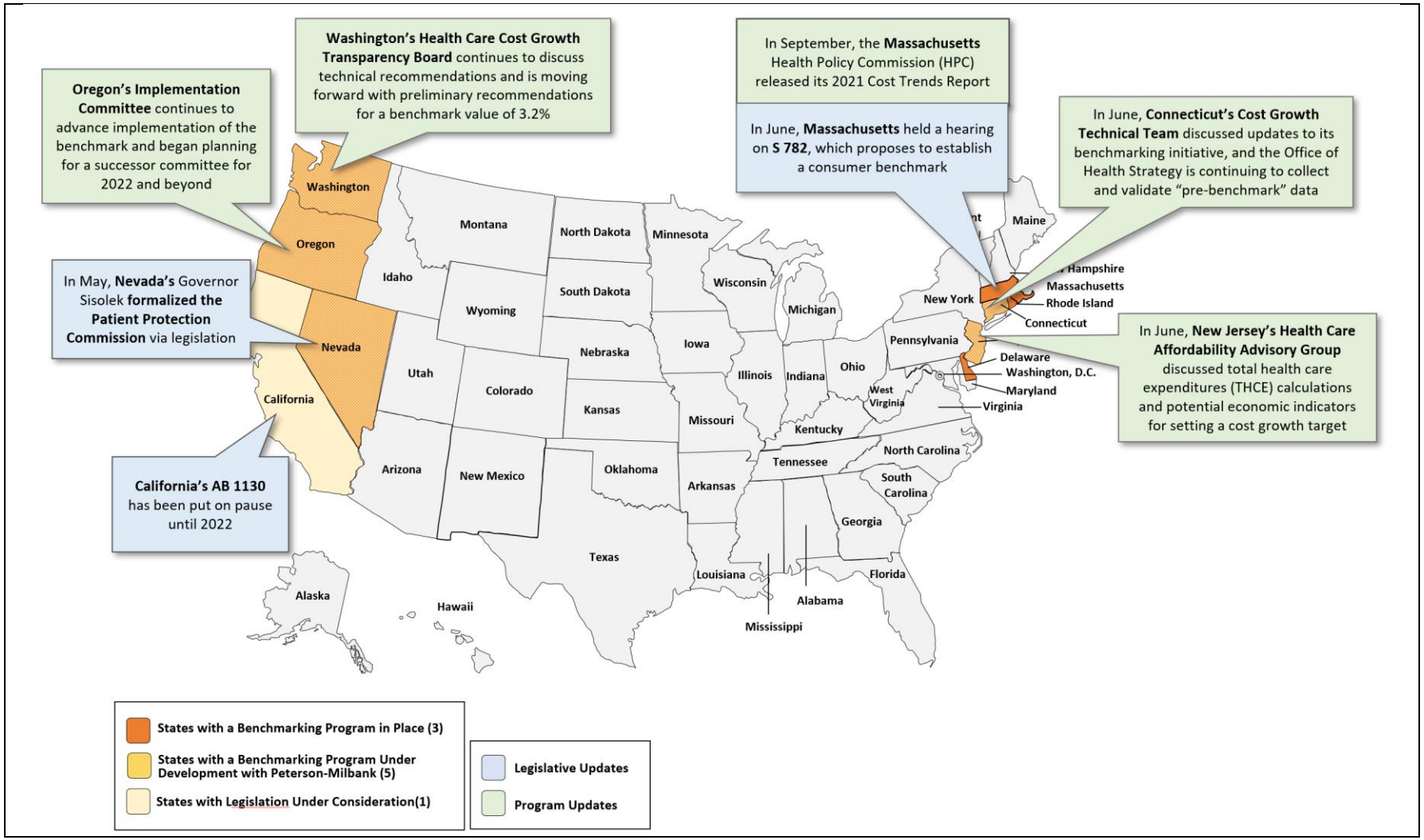
[23] 2021 Annual Cost Trends Report, Massachusetts Health Policy Commission. September 2021. Available here: https://www.mass.gov/doc/2021-health-care-cost-trends-report/download.

The State of Play

Benchmarking Updates as of September 17, 2021



Detailed State Updates as of September 17, 2021

Legislative Updates	
State	**Update**
Nevada	On May 27, Governor Sisolak approved Assembly Bill 348, which moves the Patient Protection Commission (PPC) to the Department of Health and Human Services and designates the PPC in law as the entity responsible for the state's participation in the Peterson-Milbank Program for Sustainable Health Care Costs, which works with states to establish and implement health care cost growth targets. Under AB 348, the PPC is also charged with facilitating interoperability of health information in the state, making recommendations on how the state can analyze and use health care data to improve access and quality, and how to make that data publicly available and transparent.
Massachusetts	On June 29, the Massachusetts State House and Senate held a joint hearing on Senate Bill 782, "An Act to Ensure More Affordable Care," which proposes to establish a consumer benchmark for premiums and OOP costs set at the state's aggregate cost growth benchmark beginning in 2023. This bill is now pending a recommendation from committee members.
California	California's legislative deliberations on Assembly Bill 1130 have been paused until next year. AB 1130 proposed to, among other provisions, establish the Office of Health Care Affordability within the Office of Statewide Health Planning and Development, and charge the office with analyzing the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers, setting and enforcing cost targets, and creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchaser. As Assemblyman Jim Wood, one of the leading champions of the cost growth benchmarking program in California, notes (regarding AB 1130), "although much progress has been made … other priorities in the state force us to begin discussions again next year."
Program Updates	
State	**Update**
Massachusetts	On September 16, the Massachusetts HPC released its 2021 Annual Cost Trends Report, sharing several recommendations that have implications for the state's cost growth benchmarking program, including: ▪ Strengthening payer/provider accountability by expanding the metrics examined and increasing financial penalties for above-benchmark spending (see here for our spotlight feature on accountability); ▪ Constraining excessive provider prices by establishing price caps for the highest-priced providers in the state,[24] limiting facility fees, enhancing scrutiny and monitoring of provider expansions and ambulatory care, and adopting default out-of-network payment rates;

[24] Massachusetts' Center for Health Information and Analysis (CHIA) reports annually on Relative Price and Provider Price Variation data, which facilitates the comparison of average provider prices and is one potential tool that may be used to classify the state's "high price" providers.

	▪ Holding health plans accountable for affordability by setting new affordability targets and affordability standards, improving health plan rate approval processes, and other strategies; and ▪ Examining increases in medical coding intensity and improving patient risk adjustment and taking action to mitigate the impacts of these practices on spending and performance measurement. Other recommendations outlined in the report include advancing health equity for all by setting health equity targets, addressing social determinants of health, and improving data collection; and other targeted strategies and policies to address a range of other issues, including curbing pharmaceutical drug spending, improving investments in primary care and behavioral health, and continuing to address low-value care.
Oregon	In late July, the Oregon Sustainable Health Care Cost Growth Target Implementation Committee announced plans to conduct broad provider outreach to expand awareness of the statewide benchmark and its implications for providers. The committee also identified priority analyses for implementation in 2022, including spending trends by market, geography, service category, and demographics, as well as quality measures and an assessment of negative impacts that may arise in pursuit of the cost growth target. The committee has also started planning for the establishment of a successor committee for 2022 and beyond, a Cost Growth Target Advisory Committee under the Oregon Health Policy Board (OHPB). The Advisory Committee will be charged with overseeing ongoing program implementation; reviewing, understanding, and monitoring cost growth trends and cost drivers; and advising OHA, the Department of Consumer and Business Services (DCBS) and OHPB, among other responsibilities.
Washington	In August and September, the Washington Health Care Cost Transparency Board continued to explore its preliminary recommendation to set the benchmark value using a 70/30 hybrid of the state's historical median wage and PGSP, which yields a benchmark value of 3.2%. The board also plans to tighten the benchmark over four years, following similar protocols implemented by other benchmarking program states. In September, the board modeled potential savings from various scenarios of cost growth benchmark value reductions over time, ranging from 3.0% to 3.2% to start in 2022 and 2023, down to 2.8% to 3.0% by 2026, and continued to deliberate its final recommendation of the benchmark value. The board has also discussed other technical recommendations, including the use of statistical confidence intervals to determine insurer and provider entities' benchmark performance, a method currently under development in Oregon and Connecticut.
Connecticut	Connecticut's OHS is currently collecting and validating pre-benchmark data from payers and large provider entities as it works to establish its analytic processes and quality assurance procedures. OHS intends to release cost growth data in the fall of 2021 at the state and market levels only.

New Jersey	As of late May,[25] the New Jersey Health Care Affordability Advisory Group finalized its charter, and it is discussing options for calculating total health care spending, as well as criteria and options for an economic indicator to which the state's spending growth target would be tied. Members of the advisory group emphasized the need for an indicator that links to "the pocketbooks of New Jersey consumers," is predictable and sustainable over time, and promotes quality and other desired investments.

Health Data Corner

The Health Data Corner compiles the latest state health care data capacity innovations and policy developments, as well as showcases novel data analytic use cases emerging from states. Other developments featured here include national/federal health/health care data use cases that may have state implications and provide potential opportunities for replication.

September 2021 Update

APCD Updates

- In 2021, six states are considering or have passed new legislation establishing all-payer claims databases (APCDs), including:
  - **Alaska** Senate Bill 93 was considered in 2021 and referred to the Finance Committee for further study; this legislation followed a feasibility analysis conducted in 2020;
  - **Indiana** House Bill 1402 was signed by the Governor in April 2021, establishing an APCD;
  - **Nevada** Senate Bill 40 was signed by the Governor in June 2021, establishing an APCD, following a 2020 Request for Information;
  - **Tennessee** House Bill 1258 was considered in April 2021 to establish an APCD using Consolidated Appropriations Act (CAA) funds and was sent to "summer study" by the Insurance Subcommittee;
  - **Texas** House Bill 2090 was signed by the Governor in June 2021, establishing a statewide APCD to "increase public transparency of health care information and improve the quality of health care in the state," effective September 1, 2021; and
  - **West Virginia** Senate Bill 390 moved the state Health Care Authority under the state Department of Health and Human Services (DHHS), instead of being a separate entity, and gave authority of the APCD to the secretary of DHHS, effective from passage in March 2021.

Other Data Updates

- The Health Care Cost Institute (HCCI) released several new reports, including:
  - One on provider price variation, revealing significant variation in median prices for specific services both across metro areas and within metro areas;[26] and

[25] The New Jersey Health Care Affordability Advisory group also met on June 23, 2021. Meeting materials are not yet publicly available.

[26] In examining six service items across metro areas, HCCI found an up to 25-fold variation in median prices (specifically, this variation was observed for blood test median prices, which had a median price of $18 in Toledo, Ohio, compared with $443 in Beaumont-Port Arthur, Texas. Even within the same metro areas, certain services

    - Another on COVID-19's impact on service utilization, which found significant reductions in preventive services in 2020 compared with 2019, including childhood immunizations, mammograms and pap smears, colonoscopies, and prostate cancer screenings.
- The National Association of Insurance Commissioners' (NAIC) Special Committee on Race and Insurance has published draft Principles for Data Collection, establishing high-level guiding principles for the collection, use, and regulation of enrollee race, ethnicity, and other demographic data in the business of health insurance. These principles emphasize the expectation for health insurance companies to collect, maintain, protect, and report such data, and to do so in a voluntary manner that uses strategies and collection language that has been consumer-tested and widely recognized for accuracy and responsiveness. The report also provides examples, best practices, and additional resources that can be leveraged to support implementation of such data collection.

Additional Resources

State Reports

- **Massachusetts'** HPC released its 2021 Annual Cost Trends Report, which examines the state's cost growth trends in 2019 and includes five overarching policy recommendations for lawmakers, providers, payers, employers, and other health care market participants to create a more affordable and accessible high-quality health care system. These recommendations include key actions for the state to take to address the intersecting challenges of cost containment, affordability, and health equity.
- In June, **Connecticut** updated the figures within its Healthcare Affordability Index (CHAI) to reflect new, temporary premium subsidies enacted in the American Rescue Plan Act (ARPA) enacted in March 2021, and additional state subsidies enacted by the state budget in June 2021. The CHAI measures the impact of health care costs, including premiums and OOP expenses, on a household's ability to afford all basic needs. Following the passage of temporary ARPA subsidies, the CHAI estimated an additional 35,000 Connecticut households would see improved health care affordability; additionally, the new state subsidies were estimated to provide additional assistance to another 40,000 people in the state.

Additional Reports Relating to Health Affordability and Cost Containment

- Reducing Health Care Spending: What Tools Can States Leverage? (The Commonwealth Fund, August 18, 2021). The Commonwealth Fund's latest issue brief examines the range of strategies available to states to address rising health care costs, including promoting competition, reducing prices through regulation, designing incentives to reduce the utilization of low-value care, and broader, systemwide policies such as imposing spending targets and promoting payment reform. Recognizing that different states are likely to take varying approaches to address this issue, the brief articulates the value of health policy commissions in particular in advancing

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could cost up to 39 times more (again, this observation was for blood test median prices, which, within El Paso, Texas, demonstrated the most variation – an $808 difference in their 10th and 90th percentile prices).

reform by supporting initiatives of existing state agencies or by directly implementing new policies themselves.

- A Data Use Strategy for State Action to Address Health Care Cost Growth (Milbank Memorial Fund, June 24, 2021). States with health care cost growth targets conduct two types of analyses on collected payer and provider data: (1) routine standardized analyses to monitor the impact of the cost growth target; and (2) in-depth, ad hoc analyses of potential drivers of high costs, cost variation, and cost growth identified from routine reports, potentially using other data resources to do so. The latest brief from the Milbank Memorial Fund discusses the design of the first category of analysis, providing an analytic framework that asks, "Where is spending problematic? What is causing the problem? And who is accountable?" The report also outlines a series of 11 recommended standard reports that apply the framework to state cost growth analyses.
- State Benchmarking Models: Promising Practices to Understand and Address Health Care Cost Growth (Manatt Health, June 17, 2021). As state cost growth benchmarking models continue to develop and evolve, Manatt Health examines how states are shaping their programs, how they are supporting health care cost transparency, and other emerging data use cases, including identifying trends in patient cost-sharing and driving investments in primary care. This report also identifies opportunities for standardization in data collection and analysis as more states continue to establish cost growth benchmarking programs.

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