Washington State Health Care Authority

Frequently asked questions (FAQ)

2025 Health Care Cost Transparency Board data call

This FAQ shares responses to questions from health insurance carriers and state agencies that are submitting data for the 2025 benchmark data call. The Health Care Cost Transparency Board (Cost Board) will continue to update this FAQ as we receive additional questions.

Submitting your report

1. **Please clarify the file submission schedule for this year's data.**

   Please submit all data on or before **April 18, 2025**.

2. **How do I provide my data submission to HCA?**

   Please email your data submission to the **Cost Board data team**.

3. **What level of leadership should provide the data submission's attestation signature?**

   A chief financial officer, chief data officer, or other executive should sign the attestation.

Changes from 2024

4. **What changes were implemented in the 2025 data call?**

   - Updated the primary care definition to align with the Cost Board's Advisory Committee on Primary Care's definition.
   - Updated reporting years (2022 and 2023).
   - Provided more specific guidance on run-out periods. While a run-out period for claims of at least 180 days is required, submitters are asked to use the maximum amount of run-out period possible for the submission and specify the actual length of the run-out period used.
   - Added submission of carrier business name(s) and federal employee identification number(s) to the data submission template's cover page: This information helps us pull medical loss ratio (MLR) data from Centers for Medicare & Medicaid Services (CMS) database. MLR helps us calculate the net cost of private health insurance (NCPHI).
   - Changed carrier name Anthem Inc Group to Anthem Ins Co Inc to align with OIC records.

5. **What are the changes to the primary care definition?**

   Starting with the 2025 data call, the primary care definition will now be based on the Advisory Committee on Primary Care's approved definition (see Appendix A of the **Cost Board's 2024 annual report to the Legislature**) and will no longer be based on the **Office of Financial Management definition.**

   More details on the updated definition can be found in the **data call technical manual** (Appendix A, Attachment 1) and the on the Advisory Committee on Primary Care **webpage**.

Common errors

6. **What are some tips for avoiding common validation errors?**

- The reported amounts in the columns "TME22: Truncated claims spending" and "SD06: Total claims truncated spending" in the 2_TME and 3_SD tabs should be the sum of spending after truncation has been applied. In other words, these columns should be the sum of spending that did not exceed the threshold. Please see the sample calculation in the technical manual.
- The sum of "TME22: Truncated claims spending" stratified by large provider entity code, market code, and reporting year from the 2_TME tab should have the same sum as "SD06: Total claims truncated spending" in the 3_SD tab also stratified by large provider entity code, market code, and reporting year. The 3_SD tab stratifies data at the market level instead of the insurance category level like the 2_TME tab does. You'll need to roll up insurance categories to their market level for comparison. (Please refer to the reference tab in the submission template for how to roll up from insurance category code level to market code level.)

  For example, you need to add all commercial full claims and commercial partial claims to get aggregated commercial market. You can quickly check by comparing aggregated truncated claims spending across these two tabs and making sure that the numbers are equal for each provider entity for each reporting year.

- Similar to the previous bullet point, the sum of member months stratified by large provider entity code, market code, and reporting year should be equal between the 2_TME and 3_SD tabs. You can quickly check by comparing aggregated market level member months across these two sheets and making sure that the numbers are equal.
- The sum of member months by reporting year should be equal across the following tabs: 2_TME, 3_SD, and 4_LOB_ENROLL. As a note, the 4_LOB_ENROLL tab has a section for Medicare, Medicare duals, Medicaid, and Medicaid duals, but not for commercial full and commercial partial. To compare the overall member months in the commercial market from the 2_TME and 3_SD tabs, you will need to aggregate member months of all commercial lines of business in the 4_LOB_ENROLL tab to get the member months at the commercial market level. . You can quickly check by comparing aggregated member months for each year across these tabs and making sure that the numbers are equal.
- Carriers should provide the standard deviation for the overall spending at the carrier level (i.e., large provider entity code = 100) in the 3_SD tab. Additionally, please ensure that you provide the standard deviation for each large provider entity for each market and reporting year in which you are reporting spending.
- Please see the technical manual for information regarding the file-naming rule and examples. Ensure that you name the file using this updated format:

  CarrierCode_CarrierName_TME_YYYYMMDD.xlsx

Data Reporting

7. **Can you confirm that I will report spending aggregated at the parent company level?**

   Yes, please report at the parent company level.

8. **In the large provider entity code list, what does code 100 "over all provider entities" mean?**

   Use this code when you are reporting data that includes all spending. For example, you would use this code in the standard deviation tab where you provide all the standard deviation of all of the parent company's spending.

9. **In the large provider entity code list, what does code 999 "unattributed to a large provider entity" mean?**

   Please mark spending by assigning a member to a primary care provider as detailed by the methodology found in page 18 of the technical manual, and then to a provider entity. If the assigned provider entity is not in the large provider entity code list, code the provider as "999" (meaning that associated spending is unattributed to a large provider entity). For more information, please refer to the Reporting by Large Provider Entity and Attribution section in Appendix A of the technical manual.

10. **How do I associate spending for capitated payments if the member went to multiple provider entities, resulting in capitated payments to multiple provider entities?**

    Please assign a member to a primary care provider, and then that primary care provider to a sole provider entity. You should assign all spending for that member (and their member months) to the sole provider entity.

11. **Should I report prescription drug (Rx) spending gross of rebates, even if another entity administered the benefit? Or if the submitter was not at risk for the benefit?**

    Please report Rx spending gross of rebate in the total medical expense tab and use the Rx rebate tab to report the rebate amounts. We'll calculate the net Rx spending.

12. **I consider some forms of payment to be incentive payments; however, they may also be associated with payments to enhance infrastructure. Should I report these in the performance incentive payments category or the health and practice infrastructure payments category?**

    If the payment is **contingent** on the receiver of the payment to meet a certain metric (e.g., pay for performance, pay for value), then include the payment in the performance incentive payments category.

    If the payment is **not contingent** on achieving a certain metric, include the payment in the health and practice infrastructure payments category.

Adjustments and Other Calculations

13. **How will the Cost Board consider risk adjustments for the cost growth benchmark?**

    As part of the data submission, we require submitters to provide data stratified by age and sex. For provider and carrier reports on performance against the benchmark, we'll calculate an adjustment factor, based on the submitted age and sex spending.

14. **Will the Cost Board calculate the net cost of private health insurance (NCPHI)? And will this be at the state level?**

    Yes, you are required only to report total medical expense. We will calculate NCPHI at the state level only.