Washington State Health Care Authority

Report to the Legislature

Health Care Cost Transparency Board

Annual Report

Second Substitute House Bill 2457; Section 7(2); Chapter 340; Laws of 2020

Substitute Senate Bill 5589; Section 1(3); Chapter 155; Laws of 2022

Second Engrossed Substitute House Bill 1508; Section 3(1); Chapter 80; Laws of 2024

December 1, 2024

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Executive summary

Health care is increasingly unaffordable in Washington State. High prices and cost growth pose a significant burden on individuals, families, businesses, and governments. Over the past decade, health insurance premiums in Washington surged by 112.5 percent in the individual market, with average monthly premiums more than doubling. Washingtonians express growing concern about the sustainability of health care costs; 81 percent worry about affordability of care. As premiums are set to rise further, many residents are increasingly vulnerable, with 31 percent facing medical debt.

In 2020, the Legislature established the Health Care Cost Transparency Board (Cost Board) to support reducing health care cost growth and increasing affordability and price transparency.

In 2024, the Cost Board made strides with their multiple data efforts, including:

- **Benchmark and performance.** The Cost Board anticipates releasing the first benchmark performance report in December 2024, revealing growth rates for health care expenditures for 2022 from the baseline period 2017-2019 relative to a 3.2 percent growth target. Background, carriers, and relevant data contributing to the benchmark will be discussed later.
- **Cost driver analysis.** The Cost Board anticipates releasing an updated cost driver analysis at the end of 2024. This report will provide an overview of the updated cost drivers through 2022, including Medicare data from 2020 and 2021, to identify trends in utilization, price, service mix, and patient characteristics that impact cost.
- **Primary care spend measurement.** The Cost Board completed its legislatively mandated task to define primary care, and to annually measure the ratio of primary care to total health care expenditures.
- **Hospital spending assessment.** The Cost Board reviewed a deep dive into hospital expenditures, comparing Washington hospitals' prices and efficiency metrics against similar hospitals in other states.
- **Analytic Support Initiative (ASI).** In partnership with the University of Washington Institute for Health Metrics and Evaluation (IHME) Disease Expenditure Project, the Cost Board reviewed granular health care spending estimates, broken down by demographics, health condition, and time.

Through these data initiatives and via consideration of policy options to address cost transparency and affordability challenges, the Cost Board focused conversations in 2024 around a few key regulatory interventions.

- **Outpatient facility fee reporting requirements** that mandate hospitals report detailed data on outpatient facility fees with a unique provider identifier.
- **Market oversight enhancements** that require transparency of ownership arrangements and legal affiliations and consider stronger regulations for health care mergers and acquisitions to prevent price inflation resulting from market consolidation.
- **Increase percent of spending on primary care relative to total expenditures** by establishing a clear target for annual expenditure ratio growth and increasing Medicaid reimbursement.

- **Review of affordability studies and price regulation proposals**, including an Affordability Study completed by the Office of Insurance Commissioner which examined several price setting approaches, including reference-based pricing, reinsurance, medical loss ratio standards, hospital global budgeting, and cost growth benchmarks.

These conversations lead to the Cost Board to propose the following recommendations:

Recommendation 1: Outpatient Facility Fee Reporting Requirements
Require hospitals to report on outpatient facility fee billing, including the locations charging facility fees and the revenue from those fees, as well as the volume and amounts of facility fees by service, payer, and location.

Recommendation 2: Billing and Ownership Transparency
Require hospital-owned and -affiliated providers to acquire and include unique National Provider Identifiers[1] (NPIs) specific to the location of care on all claims so that claims and fees can be tracked via the All-Payer Claims Database.

Recommendation 3: Require ownership structures and legal affiliations reporting
The Legislature should require all carriers, health systems, hospitals, and other health care facilities, such as ambulatory surgery and dialysis centers, to report ownership structures and legal affiliations. Reporting should include any acquisition or ownership state by a private equity firm and be designed to provide transparency into any private equity or corporate affiliations with a system, facility or provider

Recommendation 4: Increase Washington State's oversight of mergers and acquisitions
Given the evidence that market consolidation increases prices, raises consumer costs, and jeopardizes access, the Cost Board proposes the Legislature use the National Academy for State Health Policy's **Model Act for State Oversight of Proposed Health Care Mergers** to draft legislation to increase Washington State's oversight of mergers and acquisitions.

Recommendation 5: Setting a target rate of primary care expenditure ratio increases
Increase primary care expenditures as a percentage of total health care spending by one percentage point annually until Washington achieves a primary care expenditure ratio of 12 percent.

[1] National Provider Identifiers (NPIs) are a unique 10-digit identification number for covered health care providers.

Recommendation 6: Increasing Medicaid reimbursement for primary care services
The Legislature should increase Medicaid reimbursement for primary care to no less than 100 percent of Medicare by 2028.

Recommendation 7: **The Legislature should continue to explore reference-based pricing models** as discussed in the OIC report, Final Report on Health Care Affordability. HCA has proposed legislation to maintain access and impact affordability with a cap on hospital reimbursement and minimum reimbursement levels for critical behavioral health and primary care services for the Public Employees Benefit Board (PEBB) and School Employees Benefits Board (SEBB) programs.

The Board continues to build on transparency initiatives and data analyses to inform policy interventions for a more sustainable health care system in Washington. The board acknowledges transparency and data analysis alone will not achieve affordability for everyone in Washington. The Cost Board prioritized advancing initiatives already proposed or in process, including targeted improvements in transparency (for facility fees and market oversight), increasing the share of total expenditures that go to primary care services, and reference-based pricing models. A common theme among the different data initiatives shows increasing health care prices drive spending, even where utilization is decreasing. Further exploration of this theme will continue in the new year. The Cost Board also recognizes additional policy and financing work will be necessary and anticipates additional engagement on provider prices, pharmaceutical costs, and other important topics as its work continues into 2025.

Background

Affordability challenges

"The high cost of health care is—and has been for some time—a burden on individual patients, their families, and society as a whole."[2] Rising health care costs are a problem nationwide, and Washington is no exception.

Health insurance rates have increased exponentially in the last decade. According to the Office of Insurance Commissioner (OIC) **Preliminary Report on Health Care Affordability**, between 2014-2024, premiums increased 112.5 percent in the individual market in Washington. The OIC **Final Report on Health Care Affordability** reports that the average premiums for health plans purchased through the Washington Health Benefit Exchange more than doubled, from $295 to $629 per month between the same time period.

Total expenditures increased in the double digits during a similar reference period spanning across all markets. The OIC Final Report on Health Care Affordability also found that Washington State employees and businesses have experienced double-digit health care cost increases over the last decade. In 2022, OIC commissioned an analysis of the commercial health insurance market that showed that between 2016 and 2019, health care costs in Washington increased by 13 percent, nearly double the rate of inflation.[3]

We hear the voices of those impacted most

The **Washington Consumer Healthcare Experience State Survey** conducted by Altarum found that 81 percent of Washingtonians worry about health care in the future. At almost every meeting, the **Health Care Cost Transparency Board** and its committees hear the voices of Washington residents struggling with the continued and escalating challenges of affordable health care.

At the July 30, 2024, Cost Board meeting, a program manager for Washington Community Action Network **shared their deep frustration as a small business owner**. The public member said their staff's premiums have risen nearly 20 percent in each of the two years, and it is "unacceptable and unsustainable." Premiums will continue to rise in 2025. In Washington, consumers are facing premium increases ranging from 5.7 to 23.7 percent with an average premium **increase of 10.7 percent in the individual market in 2025**. Almost a quarter of Washingtonians will see an increase of at least 14.9 percent. At the national level and across the broader commercial landscape, carriers are on average requesting increases of 7 percent, citing growing health care costs as one of the main reasons.[4] This includes increased demand for specialty prescription drugs, hospital market consolidation, health care workforce shortages, and residual effects of COVID.[5]

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[2] **Making Medicines Affordable: A National Imperative - National Library of Medicine**. 2018.
[3] **Health care cost affordability | Washington state Office of the Insurance Commissioner**
[4] **How much and why ACA Marketplace premiums are going up in 2025 - Peterson-KFF Health System Tracker.** August 2, 2024.
[5] Ibid.

In addition, a group representing 20 organizations from Fair Health Prices Washington[6] sent a letter to the Cost Board emphasizing the need for systemic and bold action to address the impact of rising costs on the residents of Washington. The **2024 Washington State Health Care Affordability Survey** showed 31 percent of households are in medical debt with 88 percent worried about the future of health care costs. The Cost Board hears these challenges and strives to address the rising costs of health care.

Goals of the Cost Board

In 2020, **House Bill 2457** established the Cost Board to support reducing health care cost growth and increasing price transparency. The goal is to help make health care affordable for individuals, families, businesses, and others in Washington State. The Cost Board strives to achieve this goal by:

- Determining the state's total health care expenditures.
- Setting a health care cost growth benchmark for providers and payers.
- Identifying cost trends and cost drivers in the health care system.
- Providing policy recommendations for lowering health care costs to the Legislature.

Through multiple data efforts and with the partnership of numerous stakeholders, the Cost Board is on target to release the first benchmark performance report in December 2024, displaying growth rates for health care expenditures for 2022 from the baseline period 2017–2019. The board reviewed a deep dive into hospital expenditures to address increasing costs for patients. Additionally, they reviewed a cost driver analysis with the University of Washington's **Institute for Health Metrics and Evaluation** (IHME) to investigate geographic and disease-based reviews of expenditures and anticipate an updated cost driver analysis with Washington All-Payer Claims Database (WA-APCD) claims data in late 2024.

Legislative charges

In 2024, the Legislature passed **House Bill 1508** (HB 1508) expanding the roster for the newly renamed Health Care Stakeholder Advisory Committee (formerly known as the Advisory Committee of Providers & Carriers). The bill incorporates the voices of stakeholders, patients, and consumers by mandating consumer, labor, and employer purchaser representation on the committee. Certain nominating criteria is required for each member. These voices join existing members including care providers, payers, and health care cost researchers.

The Cost Board statute allows the board to determine the types and sources of data needed to calculate total health expenditures and health care cost growth, establish a health care growth benchmark, and analyze the impact of cost drivers on heath care spending. Additionally, the statute encourages sharing data across the Washington State Health Care Authority (HCA) and other agencies to promote administrative efficiencies. The Cost Board is to review the financial earnings of health care providers and payers, including but not limited to profits, assets, accumulated surpluses, reserves, and investment income. The Cost Board also considers utilization trends and adjustments for demographic changes and severity of illness.

[6] Fair Health Price Washington is a partnership of patient and advocacy groups, businesses, and labor unions working to address high health care costs in Washington

In 2024, the Legislature directed the Cost Board to conduct two new surveys at least biennially. One is a survey of underinsurance among Washington residents, and the other covers insurance trends between employers and employees. The legislation also adjusted the due date of the annual report from August to December and requires an annual public hearing related to the year's benchmark results. The first release of benchmark performance will be reviewed in a December hearing. These charges will provide more data and perspective to help the Cost Board continue its engagement in meaningful conversations with Washingtonians about health care costs.

Cost Board committees

This work of the Cost Board would not have been possible without the support and dedication of its advisory committees. The Cost Board and its committees have heard from so many how these rising costs of health care essentially make it unaffordable for many individuals, families, and businesses in Washington State. They also focused on the importance of better understanding how Washington's geographic environment impacts cost and access to care. These committees include:

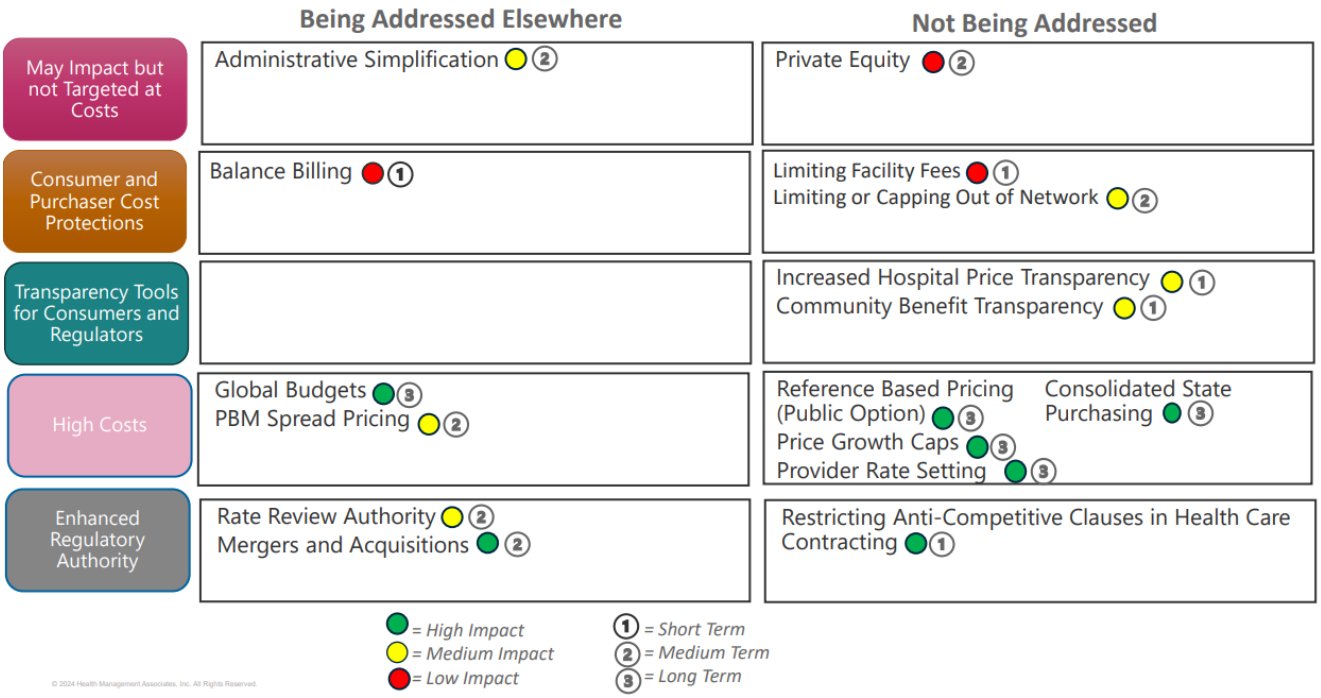
- **Advisory Committee on Data Issues** – comprised of experienced health care data leaders and fiscal and actuarial experts from across the state.
- **Advisory Committee on Primary care** – develop recommendations related to the state's 12 percent primary care spending target for the board's review.
- **Health Care Stakeholders Advisory Committee** – provides expert advice from the provider, carrier, business, and consumer perspective and inform the creation of the benchmark and supporting data calls.
- **Nominating Committee** – selects qualified nominated members for the Cost Board and its committees for the board's review and appointment.

Policy options to improve affordability

In February 2024, the Cost Board reviewed potential policy options to lower health care costs and improve affordability. The Centers for Medicare & Medicaid Services (CMS) reports that approximately $4.5 trillion is spent on health care in the United States annually, which saw an increase of 4.1 percent in 2022 alone. Most of that spending went towards hospitals and physicians or clinics, representing 50 percent of total health expenditures.[7] The Cost Board wanted to focus on this spending, given the outsized impact on progress towards the cost growth benchmark and on patient spending.

These costs negatively impact those who can least afford it, particularly Black people, people with disabilities, and those in poor socioeconomic circumstances or health.[8] The Cost Board worked with Health Management Associates (HMA)[9] to prioritize potential policy recommendations with this in mind, focusing on mechanisms to achieve cost savings without letting private actors simply shift costs to other sources (Figure 1).

Figure 1: Policy options considered by the Cost Board based on cost impact and complexity



Source: HMA

[7] Health Policy 101 - Health Care Costs and Affordability (kff.org). May 2024.
[8] Ibid.
[9] Health Management Associates is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation.

The Cost Board began the year reviewing a range of policy interventions that might help address health care cost growth and selected a range of options to review in depth this year and in the future. At the board's February 2024 retreat, each option was presented with relevant background information, impact on cost growth goals, and time intensity (short-, medium-, or long-term goals). Ongoing policy efforts by the federal government, other state agencies, and organizations were also noted to prevent redundancy. Board members voted on which policy option they wanted to pursue with the top recommendations going forward for further consideration in 2024 by the board and its committees. The Cost Board voted to further discuss the following policy options:

1. Provider rate setting and price growth caps
2. Limiting facility fees[10]
3. Mergers and acquisitions, private equity purchasing, ownership and closures
4. Restricting anticompetitive clauses in health care contracting
5. Increased hospital price transparency
6. Community benefit transparency

Based on the conversations to date, the Cost Board presents some initial recommendations to the Legislature for consideration in the next section.

In addition to these policy topics, the Cost Board also discussed **medical debt** and the impact on consumers. Charity care and medical debt laws in Washington help, but there is more that can be done to support consumers. The Cost Board has charged the Health Care Stakeholders Advisory Committee with digging deeper into how to measure, prevent, and reduce medical debt for Washingtonians. Policy recommendations addressing medical debt are anticipated in 2025.

Cost Board policy recommendations

Facility fees

Ideally, safely shifting surgical services from inpatient to outpatient care settings would help contain consumer health care costs. However, facility fees undercut improvements in affordability, impacting health care costs at more than $100 million per year in Washington.

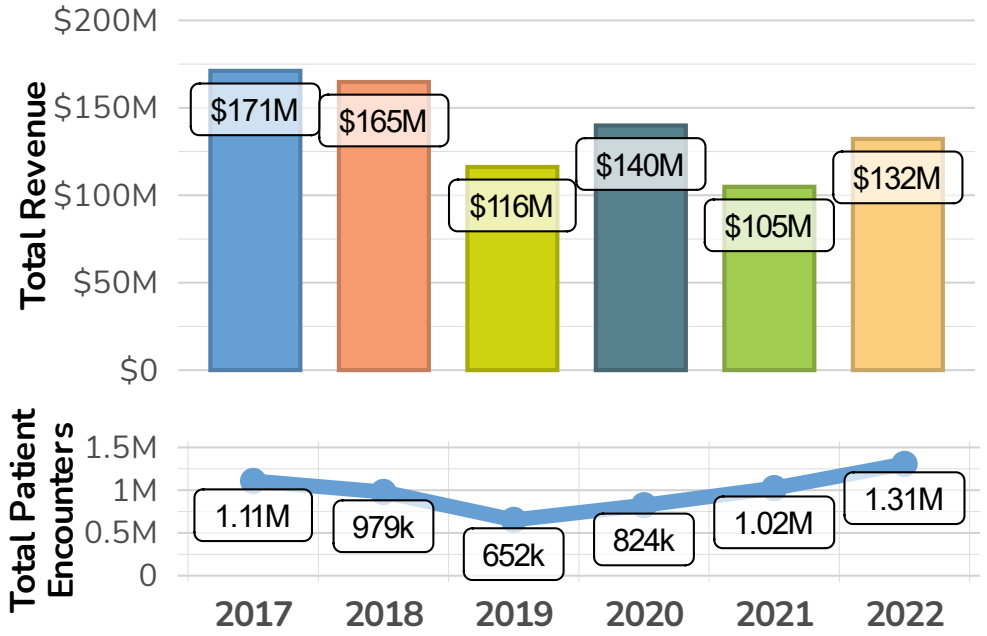
Washington consumers are frequently charged additional fees for health care services when receiving outpatient care at health care facilities or physician offices owned by a hospital system. These fees were **originally designed** to compensate hospitals for "stand-by" capacity required in emergency departments and inpatient services. They are increasingly added to more routine services to cover overhead expenses not directly related to medical care.

As hospital systems have consolidated in Washington, the assessment of these fees has become more common in nonhospital settings, growing by 18 percent—from 1.1 million to 1.3 million patient visits—between 2017 and 2022. Likewise, as consolidation has increased, patients have experienced **increased out-of-pocket costs and premiums**. These fees can rise into the thousands of dollars, **increasing the financial burden** on patients. Some are even charged facility fees **without stepping foot** inside the

[10] This report refers to "facility fees" charged in a provider-based clinic as outlined in **RCW 70.01.040**.

location they are charged for. In 2022, Washington hospitals collected more than $125 million in revenue from facility fees, averaging $100 per patient encounter (Figure 2).

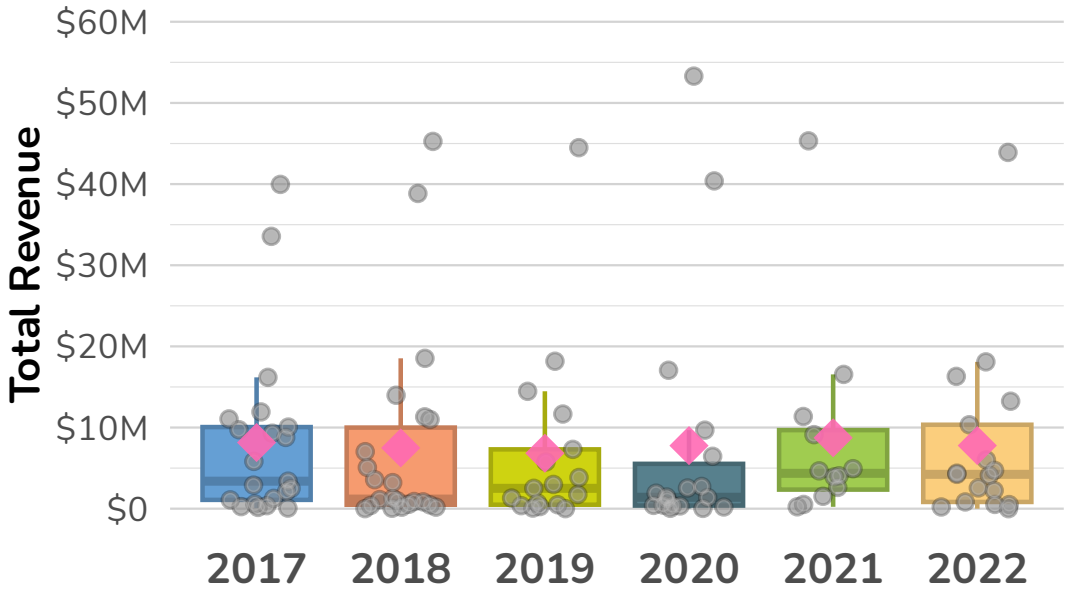
Figure 2. Total facility fees revenue, charged encounters, 2017–2022



Source: Washington State Department of Health

Although **Washington law** requires hospitals to provide notice to patients for nonemergency services and prohibits the practice for audio-only telehealth, facility fees continue to contribute to consumer costs. Washington law also **requires hospital systems to report specified data** pertaining to facility fees. The data includes the number of locations in each system and the number of patient visits where facility fees were charged. Revenue data includes total revenue per system, and the minimum and maximum amount charged in facility fees across the hospital system. The currently available data illustrates the unregulated nature of facility fees, with some hospital systems charging tens of millions of dollars in total fees, and others far less (Figure 3).

Figure 3. Facility fees revenue by year, provider



Source: Washington State Department of Health. The yearly distribution of revenue by providers is summarized by the boxes; each gray dot represents an individual provider; the pink diamonds represent the mean provider revenue for the year.

The Cost Board identified opportunities to improve facility fee reporting requirements. First, there are numerous exceptions within the law as to what services require reporting for facility fee charges, limiting its scope. For instance, establishments specializing in laboratory testing, therapy, and X-rays are exempt as are on-campus facilities. Second, increasing consolidation means a provider may bill for services under a parent facility, **making it difficult for payers** to determine where a service is provided. Third, Washington does not track which services included a facility fee. Finally, while hospitals must report the range of fees charged, there is no detail regarding how many times a maximum amount was charged within a hospital system. In response to these challenges, the Cost Board recommends changes to facility fee reporting requirements to help the state better track the total cost impact of facility fees and add to the understanding of patient impacts.

Recommendation 1: Outpatient Facility Fee Reporting Requirements
Require hospitals to report on outpatient facility fee billing, including the locations charging facility fees and the revenue from those fees, as well as the volume and amounts of facility fees by service, payer, and location.

Recommendation 2: Billing and Ownership Transparency
Require hospital-owned and -affiliated providers to acquire and include unique National Provider Identifiers[11] (NPIs) specific to the location of care on all claims so that claims and fees can be tracked via the All-Payer Claims Database.

The Cost Board also considered recommendations to prohibit facility fees outright, and to adopt site-neutral payment policy (e.g. to limit provider reimbursement for services at the professional, non-facility rate). Board members expressed interest in pursuing these policies to control health care costs. However, they noted that such actions can result in cost containment only in a system where provider prices are regulated, **such as Medicare**. Washington State does not regulate prices in the commercial insurance market and therefore prohibiting facility fees or requiring site neutral payments means that carriers and providers could shift that revenue into other sources by negotiating higher reimbursement rates or other fees. The Cost Board emphasized that further work is necessary to understand the purpose and breadth of facility fees, and to ensure that the financial impact of the fees is **not simply shifted to other sources** (e.g. reimbursement increases, new types of fees). To that end, the Cost Board will embed **further discussions about facility fees** into its assessment of broader policy options about price monitoring and regulation.

Market oversight

The Cost Board has considered market oversight to include mergers and acquisitions, private equity investments, provider closures, and ownership changes. This can lead to **more consolidation** in health systems which can help provide more leverage in contract negotiations and increased prices for medical visits and premiums, and may impact access to care for Washingtonians. The federal government has **strengthened guidelines concerning mergers**. **Washington law** also addresses mergers and acquisitions in part, but national models demonstrate opportunities to strengthen the oversight.

Although a nationwide issue, Washington State has also seen a significant degree of consolidation and integration that is likely to continue without intervention. **Private equity purchasing and corporate buyers** are increasing and changing the landscape of health care. From 2014 to 2023, private equity firms had 97 health care acquisitions in Washington. Washington physician staffing companies and certain specialties have also been purchased by private equity. In health care, **private equity acquisitions** are linked to higher costs for patients and insurers and lower patient satisfaction. **The Office of the Attorney General** does review some transactions: between two Washington State entities or one Washington entity and one out-out-state if more than $10 million in revenue is generated from Washington patients. However, the limitations mean smaller transactions may go unreported and unreviewed. To help fill gaps, the Cost Board captured the following recommendations at the November 2024 meeting.

[11] National Provider Identifiers (NPIs) are a unique 10-digit identification number for covered health care providers.

Recommendation 3: Require ownership structures and legal affiliations reporting
The Legislature should require all carriers, health systems, hospitals, and other health care facilities, such as ambulatory surgery and dialysis centers, to report ownership structures and legal affiliations. Reporting should include any acquisition or ownership state by a private equity firm and be designed to provide transparency into any private equity or corporate affiliations with a system, facility or provider

Recommendation 4: Increase Washington State's oversight of mergers and acquisitions
Given the evidence that market consolidation increases prices, raises consumer costs, and jeopardizes access, the Cost Board proposes the Legislature use the National Academy for State Health Policy's **Model Act for State Oversight of Proposed Health Care Mergers** to draft legislation to increase Washington State's oversight of mergers and acquisitions.

The Cost Board asked its Advisory Committee on Data Issues to investigate and recommend best practices for such ownership and affiliation reporting, taking the approach used in the NASHP Model Act for State Oversight of Proposed Health Care Mergers. The committee will assess the regulatory body that should collect the reporting, the frequency of reporting, how and where information should be made available to the public, and methods to minimize the burden of reporting (including adapting existing reporting requirements). The committee will conduct this work in 2025. The Cost Board noted that if its recommendations make it into law before the Data Issues committee can complete this work, the Legislature should request the committee define the reporting requirements.

Primary care expenditures

Primary care is a cornerstone of the health care system, providing crucial preventive care and addressing both short- and long-term health issues. Primary care not only serves as an entry point for early detection and chronic disease management but can also help decrease hospital utilization, as reported by the **U.S. Department of Health and Human Services**. Despite its importance, primary care spending remains low compared to other medical expenditures. In 2022, primary care spending in Washington State represented just four and seven percent of total expenditures for the Medicaid and commercial market, respectively. This figure contrasts with the Legislature's goal to achieve 12 percent of total health care spending.

Senate Bill 5589 (2022) directed the board to, among other tasks:

- Define primary care for purposes of calculating primary care expenditures as a proportion of total health care expenditures (the primary care expenditure ratio),
- Identify methods to incentivize the achievement of desired levels of primary care relative to total expenditures (12 percent ratio).

To address these tasks, the Cost Board convened an Advisory Committee on Primary Care. First, the advisory committee recommended—and the Cost Board adopted—a two-pronged definition of primary care: claims-based, and non-claims based. The claims-based definition specifies a list of service codes,

places of service, and provider specialties that comprise primary care. The non-claims definition includes expenditures paid outside of fee-for-service claims, including capitation, salaries, and value-based payment arrangement incentives. The definition of primary care can be found in **Appendix A**.

In addition to this definition, the advisory committee recommended—and the Cost Board adopted—a package of actions to increase percent of spend on primary care relative to total expenditures. The board endorsed five of the prescribed strategies that are either already underway or can be implemented without further legislative intervention (described further in the primary care expenditure section). The board formally recommended the following two strategies for Legislative consideration.

Recommendation 5: Setting a target rate of expenditure ratio increases
Increase primary care expenditures as a percentage of total health care spending by one percentage point annually until Washington achieves a primary care expenditure ratio of 12 percent.

Recommendation 6: Increasing Medicaid reimbursement for primary care services
The Legislature should increase Medicaid reimbursement for primary care to no less than 100 percent of Medicare by 2028.

Price Regulation

Recommendation 7: **The Legislature should continue to explore reference-based pricing models** as discussed in the OIC report, Final Report on Health Care Affordability. HCA has proposed legislation to maintain access and impact affordability with a cap on hospital reimbursement and minimum reimbursement levels for critical behavioral health and primary care services for the Public Employees Benefit Board (PEBB) and School Employees Benefits Board (SEBB) programs.

The Cost Board expressed interest in price regulation policy, with interest in reference-based pricing (RBP). RBP requires the employer or insurer to pay a set amount towards the price charged by the provider while the patient pays the remainder. According to **OIC's 2024 Final Affordability Report**, the percentage chosen becomes the reference rate paid for health care services. The report also states that implementing RBP is possible by capping what health care facilities and providers are allowed to charge. RBP could also be used to increase rates and accessibility for critical services where evidence suggests potential underinvestment, such as for behavioral health and primary care services. The individual market public

option Cascade Select meaningfully leverages both of these reference-based pricing approaches with a maximum aggregate cap for all services and a required minimum payment target for primary care.

The Cost Board is interested in HCA's proposed access and affordability bill to implement a RBP design for state and school employee purchasing programs (PEBB and SEBB). The proposal is intended to maintain access to critical hospital services, while setting a maximum payment for hospital inpatient and outpatient services, and increasing payments for behavioral health and primary care services. The proposal aims to maintain robust health plan networks and access to services while containing costs for employees and taxpayers.

Benchmark and performance

Washington is one of eight states in the nation to adopt a **health care spending growth benchmark**, supported by the **Peterson-Milbank Program for Sustainable Health Care Costs**. The board referenced several different states when considering how to set their benchmark. The year-by-year target (see Table 1) is calculated based on a hybrid of median wage and potential gross state product (PGSP) at a 7:3 ratio. Median wage was selected to link the measure to consumer affordability, and PGSP as a reflection of business cost and inflation. The Cost Board's initial targets cover a five-year period, allowing policy makers and health care leaders to monitor health care expenditures and assess performance over time. Each year's specific rate denotes how carrier and provider expenditure performance will be gauged in 2022 and beyond.

Table 1: Washington cost growth benchmark targets for 2022–2026 (approved September 2021)

Year	Benchmark target
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Source: The Washington Benchmark Technical Manual

The goal of gathering data and the analytic process is to make visible the rising cost of care in the context of a growth rate that could be considered sustainable for consumers. Payers (carriers) submit both claims-based and non-claims-based aggregate expenditure data, and the data is processed according to the publicly available methodology laid out in the **Washington Benchmark Technical Manual**.

The initial reporting cycle captured statewide health care spending data from 2017–2019 in the Cost Board's health care spending growth benchmark baseline brief, **Health care spending growth in Washington, 2017–2019**. In future cycles, the data will be collected and measured against the benchmark level and analyzed at four different levels of aggregation: statewide, by market, by payer, and by large provider organization. Table 2 details the reporting scope and years of data under review through 2028.

The benchmark performance with analysis of 2022 data is nearing completion and will be available after this report is submitted. The data is anticipated to be released for a December public hearing, marking a significant milestone for the board. The data collection and analysis has been a thoughtful process, allowing additional time for data submissions from carriers, and review and validation by carriers and large provider groups prior to public release.

Table 2: Reporting performance against the cost growth benchmark 2023–2027

Year of release	Includes data from specified years	Data included
Late 2023	2017–2019	State and market data only — the Cost Board did not publicly report insurance payer or provider cost growth for this period
Late 2024	2020–2022	For large provider entities and payers – with cost growth target of 3.2%
Late 2025	2022–2023	For large provider entities and payers – with cost growth target of 3.2%
Late 2026	2023–2024	For large provider entities and payers – with cost growth target of 3.0%
Late 2027	2024–2025	For large provider entities and payers – with cost growth target of 3.0%
Late 2028	2025–2026	For large provider entities and payers – with cost growth target of 2.8%

Source: The Health Care Spending Growth Benchmark Baseline Brief, Health care spending growth in Washington, 2017–2019.

The benchmark process compiles the statewide Total Health Care Expenditure (THCE), the sum of all public and private spending on the delivery of health care to a population, including medical services, government subsidies, and administrative costs.

THCE is the sum of the net cost of private health insurance, health spending in programs such as Veterans Affairs and Department of Corrections, and total medical expense (TME) across the Medicaid, Medicare, and commercial markets. The TME segment is reliant on data submissions from health care carriers and providers listed in Table 3.

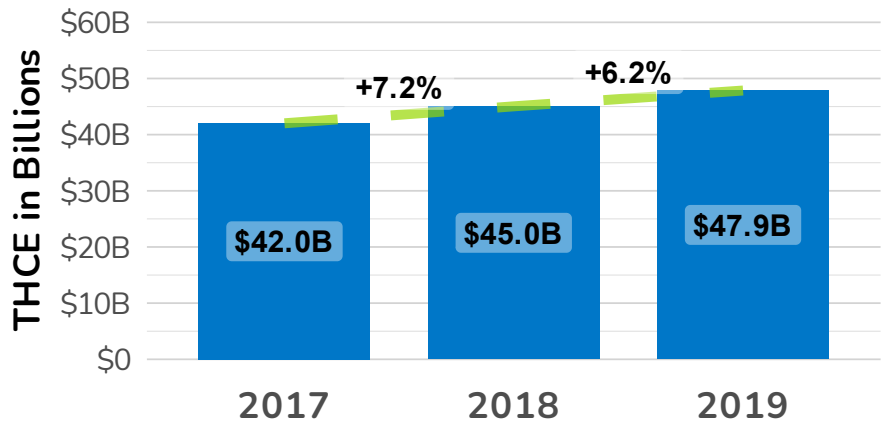
Table 3: Health care carriers who submitted data to HCA, 2023–2024

Health care carriers who submitted data to HCA
Anthem Inc. Group
Cambia Health Solutions Inc
Centers for Medicare & Medicaid Services (Medicare fee-for-service)
Centene Corp Group
Cigna Health & Life Insurance Co
Community Health Network Group
CVS Group
Health Alliance NW Health Plan
Humana Group
Kaiser Foundation Health Plan of NW

Kaiser Foundation Health Plan of WA
Molina Healthcare Inc Group
Premera Blue Cross Group
UnitedHealth Group
Washington State Department of Corrections
Washington State Health Care Authority (Medicaid fee-for-service)
Washington State Labor & Industries
Washington State Department of Social and Health Services (Medicaid fee-for-service)

As shown in Figure 4, in aggregate, 2019 Washington health care spending was roughly $47.9 billion, up from $45 billion in 2018. This is a 6.2 percent increase, following an increase of 7.2 percent between 2017 and 2018, up from $42 billion.

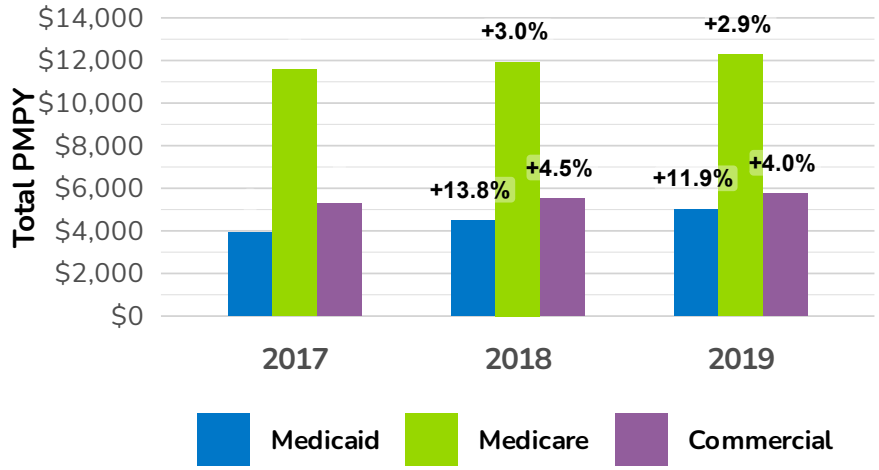
Figure 4: Growth in Total Health Care Expenditure (THCE)



Source: Health Care Spending Growth Benchmark Baseline Brief, Health care spending growth in Washington, 2017–2019

Benchmark data can be assessed on a per member per year (PMPY) basis to take population growth into consideration. In Figure 5, Washington data is reported across Medicaid, Medicare, and commercial markets.

Figure 5: Growth in expenditure per member by market

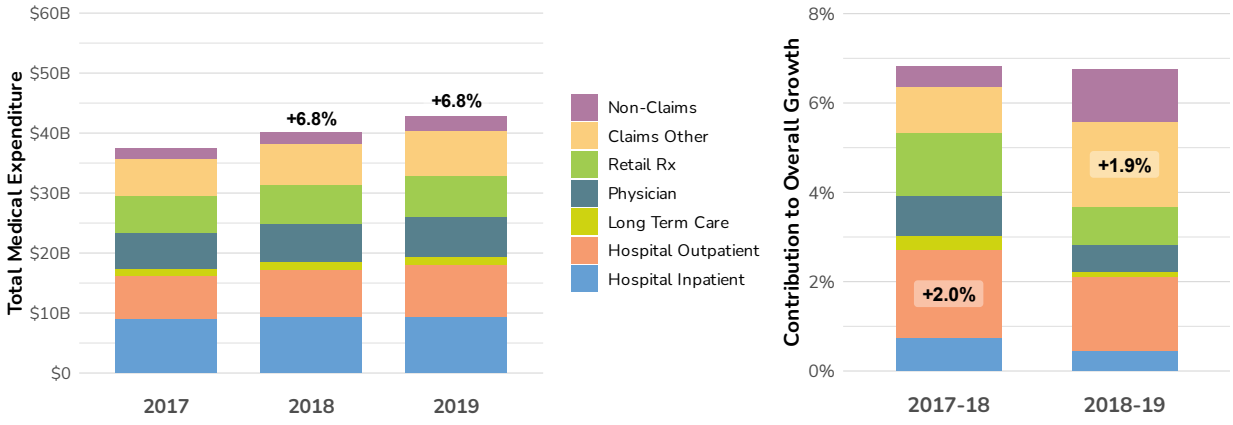


Source: The Health Care Spending Growth Benchmark Baseline Brief, Health care spending growth in Washington, 2017–2019

TME is a subset of THCE and includes claims and non-claims payments only. Claims data for TME are reported not including pharmacy rebates. This spending can be categorized by service for each year of reporting, with growth rates calculated for each.

The data, visualized in Figure 6, shows a yearly increase in the state's TME of 6.8 percent between 2017 and 2019, again exceeding the benchmark. The Hospital Outpatient category showed the greatest increase, contributing 2 percent of the total 6.8 percent from 2017–2018. The Claims Other category showed the highest growth the next year, accounting for 1.9 percent of the total 6.8 percent, a category composed of such spending as eye care, durable medical equipment, and hearing aid services.

Figure 6: Growth in state PMPY TME by category



Source: The Health Care Spending Growth Benchmark Baseline Brief, Health care spending growth in Washington, 2017–2019

Cost driver analysis

In addition to the cost growth benchmark, the Legislature directed the Cost Board to analyze cost drivers in the health care delivery system. While the benchmark and cost driver analyses utilize different data, the outcomes of both highlight that health care costs are increasing faster than growth in Washingtonians' income. This medical inflation outpaces the cost of goods and services on a national scale, according to the **Peterson-KFF Health System Tracker**.

Cost driver analyses are utilized to inform, track, and monitor the impact of the target. These analyses examine spending patterns, including use, price, service mix, and demographics, and assist with identifying patterns for further investigation via in-depth reports. Combined, the analyses provide the basis for identifying the greatest opportunities for mitigating cost growth.

To develop the cost driver analysis, the Cost Board contracted with OnPoint Health Data[12] to review WA-APCD data. OnPoint Health Data provided preliminary findings of its cost growth drivers study in December 2022 (reported in **last year's annual legislative report**), and finalized findings in the 2023 report, **Health care spending growth in Washington, 2017–2019**. The report provided a high-level view of health care spending in Washington from 2017–2019, prior to the COVID-19 pandemic.

In 2023, the Cost Board discussed options for a second cost driver analysis to update the cost drivers through 2022, adding another year of data to the cost driver analysis. It will include the Medicare data from 2020 and 2021 that was not available for the first analysis due to delays in data availability. This is currently underway with a release date anticipated by the end of 2024. The report will be available on the HCA website along with a dashboard visualizing the results. The updated cost driver analysis will analyze trends in price and utilization, spend and trend by geography, and spend and trend by population and patient demographics.

[12] OnPoint Health Data is a vendor that collects, integrates, and distributes health care data.

Primary care spend measurement

In 2022, primary care spending in Washington State represented just four percent and seven percent of TME for the Medicaid and commercial market, respectively. This figure contrasts with the Legislature's assignment to the Cost Board asking for recommendations to increase primary care expenditures to 12 percent of total health care spending.

Background

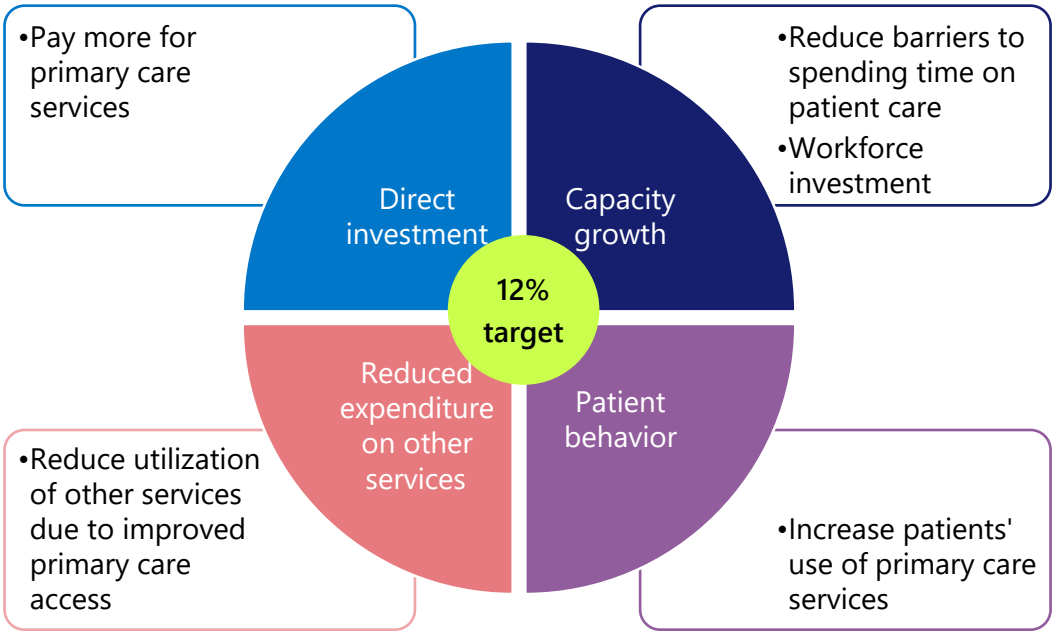
Primary care is a cornerstone of the health care system, providing crucial preventive care and addressing both short- and long-term health issues. Despite its importance, primary care spending remains low compared to other medical expenditures, and Washington's reporting on this spending could be improved. Primary care not only serves as an entry point for early detection and chronic disease management but can also help decrease hospital utilization, as reported by the **U.S. Department of Health and Human Services**.

As expectations for primary care grow, it is essential to address workforce shortages and inequities to ensure that primary care receives adequate support and investment. To address the challenge of increasing precent of spend on primary care to 12 percent of total health care spending, the Cost Board adopted a comprehensive set of policy recommendations for 2024, developed by the board's Advisory Committee on Primary Care. This initiative was set in motion by the directive in **Senate Bill 5589** to define primary care and to recommend methods to enhance primary care expenditures.

In 2023, the Advisory Committee on Primary Care refined the definition of primary care for reporting purposes. The definition includes a claims-based component (identified by specified place of service code, practitioner type, and service code) and non-claims-based component (includes capitated or salaried expenditures, payments for non-billable services, health IT and workforce investments, and incentives/bonuses for quality performance or shared savings). As of calendar year 2023 expenditures, HCA required contracted carriers to use the revised definition to self-report primary care expenditures.

In April 2023, the committee began a discussion of policies to achieve the 12 percent primary care expenditure target. The Advisory Committee on Primary Care used a four-domain framework to begin exploration of different types of policies that could support the expenditure target goal. The four domains (direct investment, capacity growth, patient behavior, and reduced expenditure on other services) are shown in Figure 7.

Figure 7: Four key areas used to evaluate primary care expenditures



The advisory committee set criteria that policy recommendations also needed to adhere to the following principles:

- Unambiguous linkage between policy and achieving 12 percent primary care expenditure target.
- Clearly defined action and actors.
- Financially, operationally, and politically feasible policies.
- Policies that result in improved access and quality, not just expenditure.

Subject matter experts from universities, primary care organizations, and other agencies provided their shared knowledge and insight to support the committee's proposal to the Cost Board. This included experts from the University of Washington, Center for Evidence-based Policy, the Washington Workforce Training & Education Coordinating Board, Milbank Memorial Fund, and HCA staff. The Center for Evidence-based Policy also helped facilitate discussions and organize the final recommendations to the Cost Board.

Primary care policy recommendations to the Cost Board

At the Cost Board meeting on September 19, 2024, the board voted to approve the recommendation package presented by the Advisory Committee on Primary Care. This package encompasses all seven of the recommendations considered, specifying two as policy recommendations (numbers one and two, further detailed following) that will require legislative action and the remaining five (numbers three through seven) as endorsements of strategies that are either already underway or can be implemented without further legislative intervention.

1. Increase primary care expenditures as a percentage of total health care spending annually by one percentage point until a 12 percent primary care expenditure ratio is achieved.

2. Increase Medicaid reimbursement for primary care by no less than 100 percent of Medicare no later than 2028.
3. Multi-payer alignment policy supporting the Multi-payer Collaborative's alignment efforts.
4. Patient engagement policy supporting payer and purchaser education and incentives to promote utilization of primary care and preventative services.
5. Workforce development prioritizing funding for state primary care workforce initiatives as collaboratively identified through the **Health Workforce Council** and other government agencies and educational institutions.
6. Following the 2024 reporting of primary care expenditures by category from the **Health Care Payment Learning Action Network (HCP-LAN) alternative payment model framework**, the committee may make recommendations to the Cost Board for the portion of primary care expenditures that must be tied to alternative payment methodologies for spending to county towards the expenditure growth target.
7. The Cost Board should identify primary care expenditure targets based on per capita expenditures instead of an aggregate 12 percent ratio of total health expenditures.

Recommendation 1: Increase primary care expenditures as a percentage of total health care spending

The Cost Board's first recommendation aims to boost the proportion of total health care spending that goes towards primary care. Increasing the primary care expenditure ratio can be achieved by either:

- Increasing primary care spend while keeping overall spend constant, or
- Keeping primary care spend constant while decreasing overall spend.

Historically, primary care has often received a smaller portion of health care budgets compared to other areas like specialty care, hospital services, and pharmaceuticals. This imbalance can affect the accessibility and quality of primary care services.

Research indicates that stronger primary care systems are associated with better health outcomes and lower costs over time. Increasing funding for primary care is intended to improve overall health outcomes and reduce long-term health care costs by emphasizing preventive care, early diagnosis, and management of chronic conditions.

The Cost Board suggests a gradual increase in the percentage of health care spending allocated to primary care. Specifically, the board proposes increasing this expenditure by one percentage points each year until it reaches a target of 12 percent of total health care spending. This recommendation requires legislative action to amend budgetary allocations and health care spending guidelines. It may involve changes to funding formulas or budget priorities within the state's health care system.

Recommendation 2: Increase Medicaid reimbursement for primary care by no less than 100 percent of Medicare no later than 2028

The Cost Board's second primary care recommendation seeks to ensure that Medicaid reimbursement rates for primary care are competitive and adequately reflect the cost of providing these services. Medicaid often reimburses providers at lower rates compared to Medicare. This has led to lower provider participation in Medicaid and potentially reduced access to care for Medicaid beneficiaries.

The board recommends that Medicaid reimbursement rates for primary care be raised to at least 100 percent of Medicare rates by 2028. This means that by 2028, the amount Medicaid pays for primary care services should be at least equal to what Medicare pays for similar services.

Aligning Medicaid reimbursement rates with Medicare rates is expected to improve provider participation in Medicaid, thus enhancing access to primary care services for low-income populations. It also aims to address disparities in compensation that can disincentivize providers from offering care to Medicaid patients. This proposal would require legislative action to adjust Medicaid reimbursement rates and would also necessitate coordination with federal guidelines and funding sources.

Both recommendations aim to bolster Washington State's primary care system by increasing investment and ensuring fair provider compensation. These measures are designed to enhance the effectiveness and accessibility of health care, improving overall population health.

Hospital spend

In May 2024, Batholomew-Nash & Associates gave a presentation to the Cost Board about the spending trends for Washington hospitals based on their **Washington Hospital Financial Analysis report**.[13] Out of 104 Washington hospitals, 45 were included in the analysis, representing 88 percent of discharges, 90 percent of available beds, and 85 percent of hospital patient revenue based on 2022 data.[14] The analysis shows that Washington generates higher per-patient revenue and per-patient costs than similar hospitals in the US.

The **Peterson-KFF Health System Tracker** found that in 2022, 29 percent of uninsured patients and 6 percent with insurance attested to delaying health care due to medical costs.[15] Whether insured or uninsured, higher costs can lead to patients being unable to pay medical costs or delaying much needed medical care, leading to even higher medical expenses.[16] Approximately 73 percent of patients with medical debt owe some amount to hospitals, and about a quarter of these patients owe at least $5,000 or more.[17] Current hospital spending trends in Washington could continue to negatively impact patients' health and financial wellbeing.

The results of the analysis were based on a three-pronged approach: peer-group comparisons, Medicare payment-to-cost ratio analysis, and price- and cost-trend analysis. Combining the findings from each provided insight by triangulating price, cost, and profit information from several different perspectives.

Peer-group comparisons

Peer-group comparisons create high-level metrics on cost, price, and profit at the patient-level that enable comparison to similar U.S. hospitals. Results were adjusted for regional cost differences and acuity.

Most of the Washington hospitals examined have both prices and costs that are higher than their peers. Of the 45 hospitals analyzed, 27 hospitals, which receive about 70 percent of patient revenue, have higher prices. A total of 19 hospitals had higher costs, representing about 39 percent of patient revenue. 15 hospitals are both high-price and high-cost, with about 32 percent of patient revenue.

These high-price, high-cost hospitals represent one-third of statewide hospital revenue and could put upward pressure on the overall Washington health care cost trend. Six hospitals are high-profit, comprising six percent of 2022 statewide hospital revenue. Two hospitals were high-price, high-cost, and high-profit.

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[13] Analysis was conducted by Bartholomew-Nash & Associates, a health care financial consultant firm and presented by John Bartholomew, former Chief Financing Officer of Medicaid, Colorado and Thomas Nash, former vice president of financial policy for the Colorado Hospital Association.
[14] Batholomew-Nash & Associates removed hospitals with incomplete data, less than 25 beds, and hospitals specializing in children, psych, rehabilitation, and long-term care.
[15] **How does cost affect access to healthcare? - Peterson-KFF Health System Tracker**. January 12, 2024.
[16] **Americans' Challenges with Health Care Costs | KFF**. March 1, 2024.
[17] **Most adults with medical debt owe some of it to hospitals, study finds (cnbc.com)**. March 22, 2023.

Medicare payment-to-cost ratio

Medicare payment-to-cost ratio reviews Medicare revenues and costs as a measure of hospital efficiency by creating a Medicare payment-to-cost ratio. Medicare payments are adjusted to reflect individual hospital characteristics, comparing payments to the related costs can provide an indication of how well hospitals are managing expenses.

According to the March 2024 **Medical Payment Advisory Commission (MedPAC) report to Congress**, a payment-to-cost ratio above 97 percent denotes an efficient hospital. Of the 45 Washington hospitals reviewed, 39 were found to have a Medicare payment-to-cost ratio below 95 percent in 2022. The state median is 83 percent which means the Medicare payment-to-cost ratio indicates a loss of $0.17 on every dollar of cost incurred serving Medicare patients. If this is unaddressed, this could represent a cost efficiency problem with Washington hospitals contributing to higher health care cost trends.

According to the report, Medicare rates are set to enable an efficient hospital to break even on Medicare payments. MedPAC noted that hospital margins have decreased in 2022, and relatively efficient hospitals could achieve a 97 percent Medicare payment-to-cost ratio for the Medicare fee-for-service population.

Price- and cost-trend analysis

This approach conducts hospital price- and cost-trend analysis on the state's hospitals with comparisons to national trends. Net patient revenue (NPR) and operating expenses can help project hospitals' price and cost using whole-dollar or per-patient metrics. Comparing results to other U.S. hospitals gives an estimate of how Washington hospitals align with national trends.

Nearly one-third of the 45 Washington hospitals reviewed exceeded national trends in both price and cost. Growth rates were calculated using a compound annual growth rate for two periods of time: 2012 through 2022 and 2018 through 2022. There is concern that if these price and cost trends continue in Washington, the benchmark may not be met.

Analytic Support Initiative (ASI)

Project initiation

With generous support from funders at Gates Ventures and the **Peterson Center on Healthcare**, HCA and the University of Washington's IHME launched the Analytic Support Initiative (ASI). The work leverages IHME's existing Disease Expenditure (DEX) project to model granular health care spending estimates, broken down by demographics, health condition, and time. This project joins the IHME's methodology, data analytics, and visualization expertise with HCA's policy and legislative experience to assist the Cost Board's mission of making data-informed policy recommendations to the Washington State Legislature. The goal of ASI is to develop analyses of cost growth trends specific to Washington to identify specific areas of focus for discussion, additional analysis, and development of cost-mitigation strategies.

Strategy approval

Dr. Joe Dieleman[18] of IHME presented three proposed analyses for Cost Board consideration in December 2023. Approval of these analyses focused IHME's methodology to shape DEX outputs to the data needs of the Cost Board. The three analyses were identified using the intersection of IHME's strengths and the expected magnitude of impact. By consulting with the board and its advisory committees, and through engagement with health care data experts, IHME ensured each approach was distinct from other research available to the Cost Board. Each analyses results in an analytic product intended to reveal cross-county variation and increases in health spending.

The three proposed analyses are:

1. **Estimate spending, spending per capita, spending per beneficiary, spending per prevalent case, and spending per encounter. The analysis will be for each Washington county, age/sex group, four payer categories, seven types of care, and 161 health conditions for 2010–2022.** The analytic product includes background knowledge on Washington health care spending and utilization. This will provide information about spending per capita for the state as a whole and will, among other analyses, identify the health conditions with the most spending in Washington.
2. **Age- and risk-standardize counties based on county-level demographic and population health.** Analytic products include cross-county variation maps highlighting spending per capita and spending per encounter for each Washington county, Washington Accountable Communities of Health (ACHs), and/or geographic rating area (GRA).
3. **Decompose differences across counties and across time into factors that are considered key drivers: population age, disease prevalence, health care utilization, and price/intensity of care.** The visualizations for this option involve cross-time changes in spending at the county level.

The Cost Board endorsed the analytic strategy defining the work to be completed in 2024.

[18] Joseph Dieleman, PhD, is Associate Professor in the Department of Health Metric Sciences at the University of Washington and faculty lead of the Resource Tracking team at the IHME.

Disease Expenditure Report

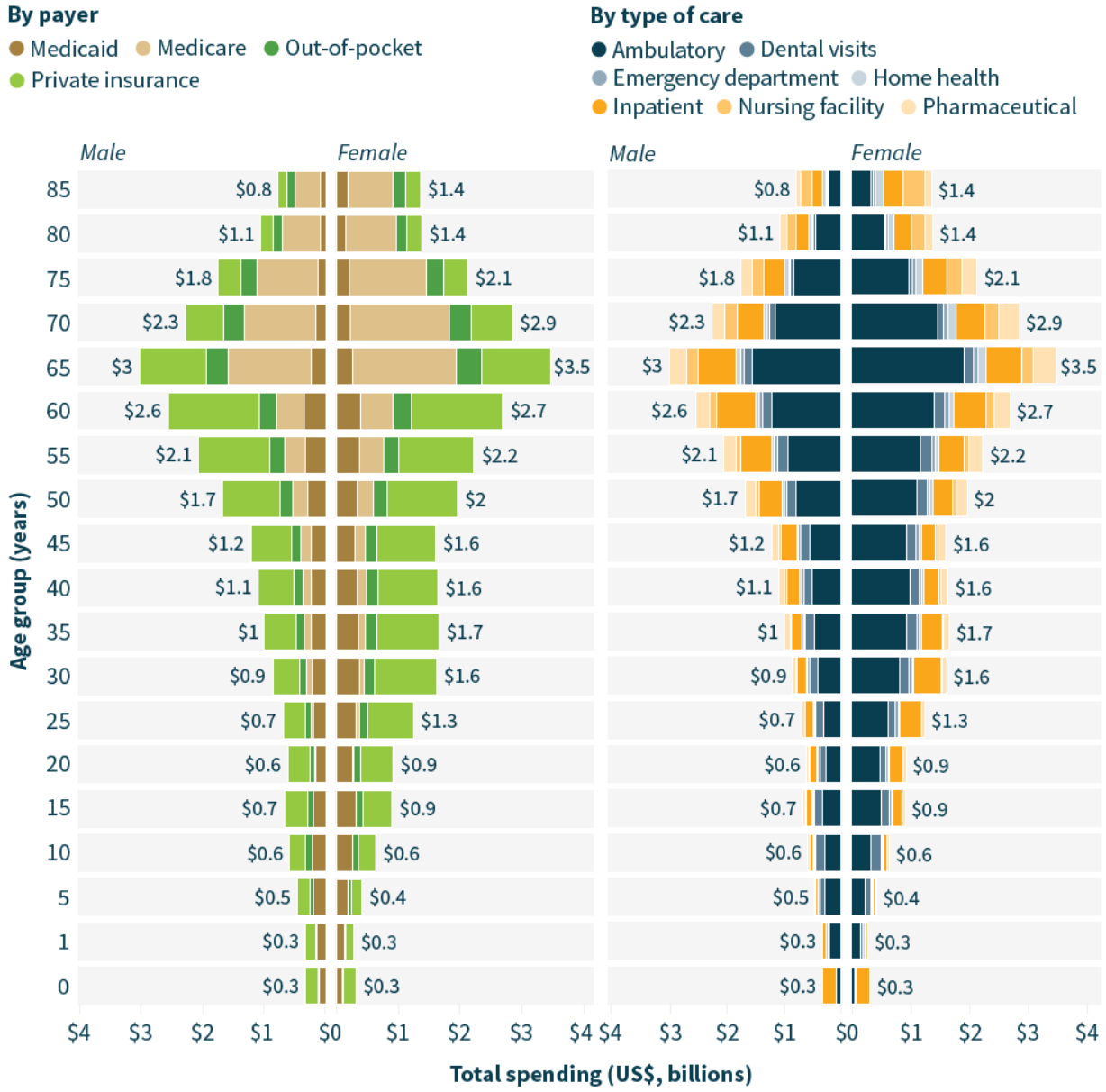
In March 2024, IHME finished a DEX modeling update, creating a complete set of estimates tracking spending by health condition, age, sex, type of care, payer, and U.S. for 2010 through 2019. In May 2024, IHME produced a Washington-specific summary of the project, the Preliminary Disease Expenditure Report, which was the first data product of the ASI project. An updated report (Appendix B) was presented in November 2024 to the Cost Board and advisory committees extends the data to include estimates up through 2022.

Over 60 billion insurance claims and one billion administrative records were used to inform the national estimates, with over 550 million insurance claims and 30 million administrative records informing the estimates for Washington. Additionally, the WA-APCD serves as an essential data source for the ASI project, allowing for estimates to track spending attributable to each of 148 health conditions with great specificity.

Broad trends are seen in the data when broken down by age, sex, payer, and type of care (Figure 8). Aligning with expectations, ambulatory care, comprised of professional (primary and specialty care) and other outpatient services, represents the largest expenditure category in Washington in nearly all age brackets.

The deconstruction of this information can help address health care cost growth and provide policy support to counter its effects. This can identify high spending, growth spending, variation among other states and demographics, and benchmark comparison. Understanding where the spend is coming from can help identify significant cost drivers that impact affordability. This can include price, volume, intensity, population characteristics, and provider supply. Learn more in the Peterson-Milbank Program for Sustainable Health Care Cost's **Data Use Strategy for State Action to Address Health Care Cost Growth**.

Figure 8: Health care spending amid age groups across payer and care type, 2022.



Source: IHME DEX Project.

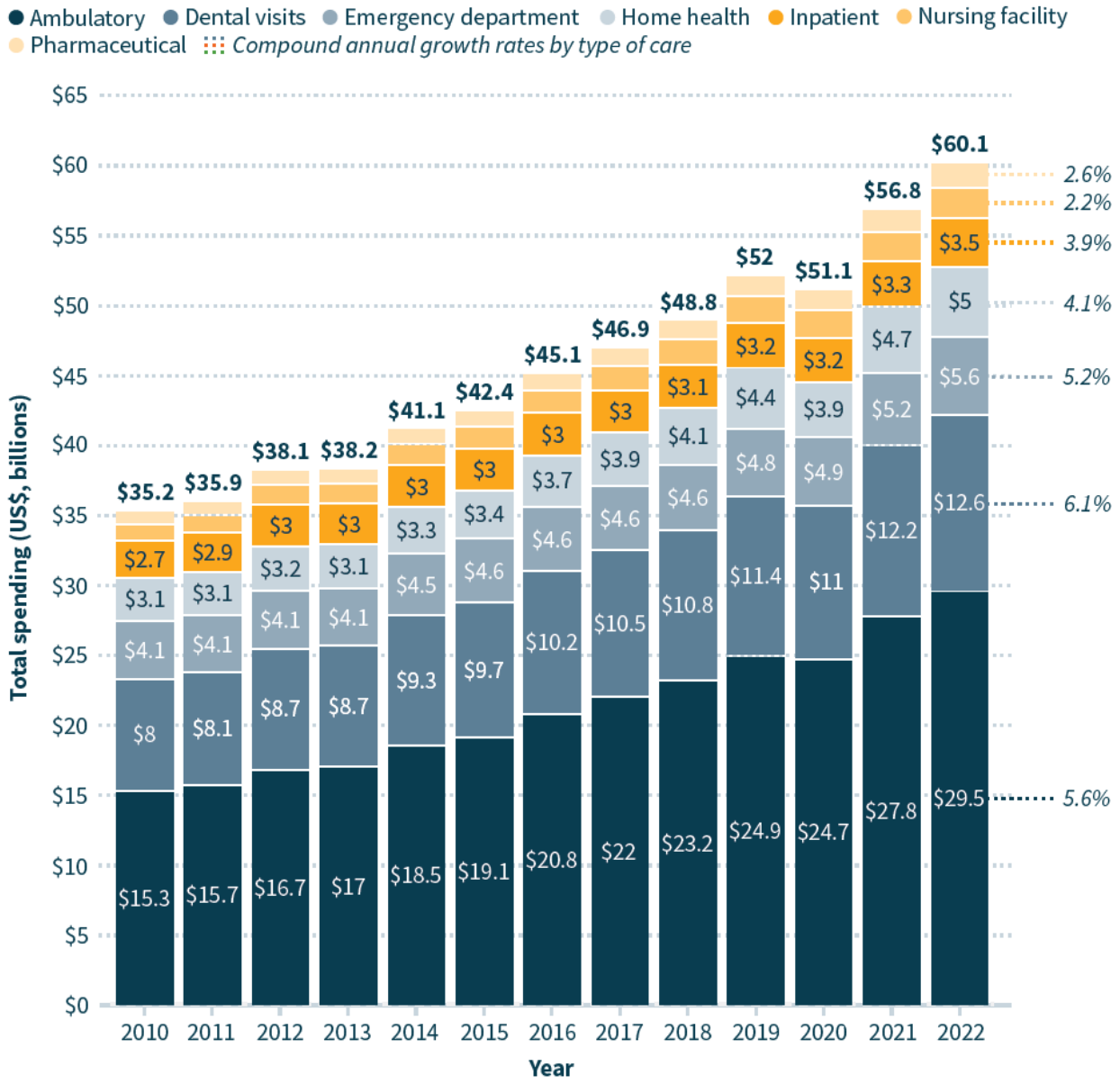
Note: Pharmaceutical spending includes spending on pharmaceuticals in a retail setting, and drugs administered in a clinic or inpatient are included in the ambulatory care and inpatient care categories.

The DEX project estimated that overall spending increased from $35.2 billion to $60.1 billion between 2010 and 2022 (Figure 9).

Across time, it is possible to view annualized growth to see trends in spending by type of care, with some of the fastest growth occurring in ambulatory settings. Growth in dollar terms is higher here than all other settings, increasing by $14.2 billion in expenditure, from $15.3 billion in 2010 to $29.5 billion in 2022.

Home health and emergency department care categories exhibited the slowest growth, increasing at 2.2 percent and 2.6 percent compound annual growth rates respectively.

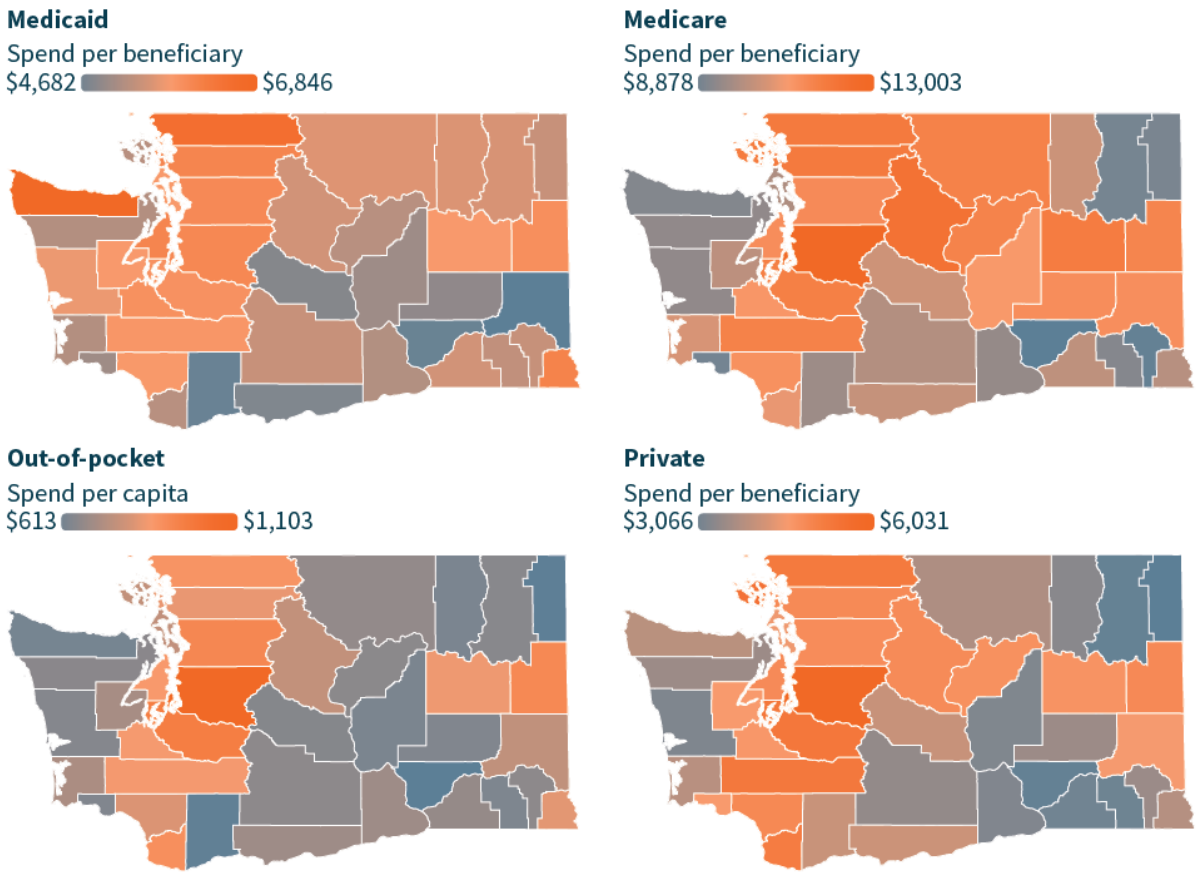
Figure 9: Total spending in Washington by type of care, 2010-2022



Source: IHME DEX Project

Finally, geographic trends can be explored using DEX estimates, showing substantial spending variation by payer across the counties of Washington. In 2022, the largest range in values was seen in Medicare expenditures, with King and Chelan counties estimated at over $10,000 in spend per beneficiary compared to Franklin County in the southeast at less than $9,000 (Figure 10).

Figure 10: Age-standardized spending per beneficiary by payer, 2022



Source: IHME DEX Project

Looking ahead, these DEX estimates will be leveraged for further analysis to produce a set of policy recommendations that the Cost Board will present to the Legislature in early 2025. The full ASI DEX Report can be found in **Appendix B**.

Consumers and affordability

Cost Board consumer outreach efforts

The Cost Board continued to collect consumer input during the public comment period of each of the board and advisory committee meetings. The board also engaged in numerous consumer outreach activities.

Media from the board members

In February 2024, Sue Birch, chair of the Cost Board and director of HCA, and Drew Oliveira, executive director of the Washington Health Alliance, wrote the op-ed ***Health Care Costs are Increasing, but There's a Way Out*** for **State of Reform**. In it, they discuss why costs are so high and what the Cost Board is doing about it. They also provide recommendations for what public and private organizations, employers, health plans, and providers can do to slow down the increasing cost of health care.

In March 2024, TVW's *Inside Olympia* aired a **segment on the Health Care Cost Transparency Board**. Host Austin Jenkins interviewed Sue Birch and board member and former state legislator Eileen Cody. They discussed:

- The benchmark and upcoming benchmark report
- How health care consolidation and mergers impact costs
- Prescription drug costs
- The history of hospital cost-setting in Washington State

HCA posted on their social media accounts—which have a combined following of over 22,000 people across Facebook, Instagram, LinkedIn, and X—about the interview, so that board members could also reshare and generate more support for the board.

Benchmark report communications

This year the Cost Board released their first benchmark report. At the December 2023 meeting, Vishal Chaudhry, chief data officer of HCA, presented the preliminary results of the 2022 benchmark data call. **Watch a recording of the presentation** and **view the presentation slide deck**.

Communications continued into 2024 with a webinar hosted by Sheryll Namingit, health economics research manager at HCA, updating providers on the methodologies and importance of the benchmark. **Watch the webinar**.

In June, the Cost Board released the final report **Health care spending growth in Washington, 2017–2019**. It was accompanied by a **one-page summary** on the impact of high health costs in Washington State.

The report and the summary were posted to HCA's website and shared with consumers via an **email announcement** that included the key take-aways. HCA's social media accounts also posted about the report.

Website presence refresh

In 2024, the Cost Board added and updated its website pages to boost its online presence and share the work of the board. We created several new webpages:

- **What we're working on** – includes short explanation of the role of the board and how it is identifying the rate of growth of health care spending.
- **Tracking success** – shares high-level results from the benchmark report with graphics about spending growth in Washington.
- **Resources** – a library of resources that includes reports and publications from and about the Cost Board and other states' cost containment efforts. This includes an **updated frequently asked questions (FAQ)** about the board.
- **News** – announcements from the board.
- **Health Care Stakeholder Advisory Committee** – shares the work and information on this advisory committee.
- **Nominating Committee** – shares information about of the board's Nominating Committee.

Affordability

Upcoming consumer surveys

In HB 1508 (2024), the Legislature directed the Cost Board to conduct two biennial surveys due by December 1, 2025. The first will measure underinsurance among Washington residents. Underinsurance will be measured as the share of Washington residents whose out-of-pocket costs over the prior 12 months, excluding premiums, are equal to:

- Ten percent or more of household income for persons whose household income is over 200 percent of the federal poverty level.
- Five percent or more of household income for persons whose household income is less than 200 percent of the federal poverty level.
- Deductibles of five percent or more of household income for any income level.

The second survey will measure insurance trends among employers and employees, conducted among a representative sample of Washington employers and employees.

Best practices report

In 2024, a budget proviso provided funding to the Cost Board to examine:

- Regulatory approaches to encouraging compliance with the health care cost growth benchmark and
- Best practices from other states regarding the infrastructure of state health care cost growth programs, including the scope, financing, staffing, and agency structure of such programs.

This proviso permitted the Cost Board to conduct all or part of the study through HCA, by contract with a private entity, or by arrangement with another state agency conducting related work. The study, as well as any recommendations for changes to the Cost Board arising from the study, must be submitted by the board as part of the annual legislative report no later than December 1, 2024.

To develop the survey and assist with creating recommendations, the Cost Board contracted with HMA. The survey questions were designed to maximize the board's information gathering about practices in other states, and to evaluate effective opportunities that might be applicable to the efforts in Washington State. The resulting report is included in **Appendix C**.

This report first provides background information on the eight states with active cost growth benchmark programs, describing how they were established, the scope of their authority, and their governance structure. After reviewing publicly available information on the experience in these eight states, four were chosen for a more in-depth analysis, including interviews with leaders responsible for overseeing their work. These states—California, Massachusetts, Oregon and Rhode Island—were selected because they represent the range of different approaches among the states and because they exemplify best practices in areas that have the greatest impact on the success of these programs.

The report then highlights best practices in one or more of these four states and compares Washington's program to the approaches taken in these other states. The best practices that were identified as providing the greatest opportunities for Washington to consider are the following:

- Comprehensive data collection allowing analysis and reporting providing insight into the entire health care system, ideally provided to a single entity (California, Massachusetts).
- Responsibility for examining and addressing a broad range of factors impacting health care cost growth, including the prices charged for health care services, adoption of alternative payment models and less reliance on fee-for-service reimbursement, encouraging investment in services that currently are under-resourced, such as primary care and behavioral health, consolidation, and health equity (California, Rhode Island).
- Authority to enforce compliance with cost growth targets (California, Massachusetts)
- Authority to regulate health care prices (Oregon, Rhode Island).
- Budget authority adequate to perform the functions of the program (California, Massachusetts).

In its report, HMA notes that it is important to recognize that the results achieved by cost growth benchmark programs have been mixed: in some years, the targets have been met, while in other years they have not. In addition, COVID-19 had a major impact on health care utilization, initially leading to reduced health care utilization and then to increased utilization and inflation. Some of the states established their cost growth programs quite recently, so it is too soon to be able to assess what impact

which of the best practices discussed in this report will have on mitigating cost growth. Nevertheless, these best practices are worth consideration by policymakers in Washington. The Cost Board will take this into consideration while increasing coordination with other state agencies for a more comprehensive approach to better serve the people of Washington.

Conclusion

Health care costs are high and continue to grow at a rapid pace that directly impacts consumers. The board is making strides to gather extensive data and examine policy options that may impact growth in costs. The Cost Board has included initial recommendations that continue to build transparency and accountability and will continue to examine policy options that can help address costs for consumers.

The Cost Board's recommendation on primary care investments fulfils the Legislative assignment to recommend options to increase spend on primary care (relative to total expenditures). Investing in primary care is essential for reducing health care costs in Washington. By addressing health issues early, primary care leads to timely interventions, better patient outcomes, and fewer emergency visits and hospital admissions. It also supports preventive care and effective management of chronic conditions, making the health care system more efficient and cost-effective.

Efforts to slow the growth of health care costs and ease the growing financial burden on patients will require a multi-faceted approach, with more data transparency and deeper analytics. Understanding the multiple data streams, including data sourced from ASI and the cost driver analysis, will continue to inform policy options to address health care spending.

Additional information

For additional information on the Cost Board and its committees, including membership rosters, meeting materials and schedules, and the benchmark data call specifications, visit the **website**.

Appendix A: Definition of primary care

Non-claims-based definition

Total non-claims-based payments includes all primary-care-related payments for:

Capitated, sub-capitated, and salaried expenditures: Capitation arrangements with primary care providers not billed or captured through claims (total amount, un-adjusted; see next row for how to enter "leakage" adjustments); and salaried arrangements with primary care providers not billed or captured through claims. (See row 19 to enter global capitation.)

> *Example: A fixed payment for each person attributed/assigned to primary care provider for a defined set of services.*

"Leakage" adjustments on capitated or sub-capitated primary care expenditures (report as a negative number): Any downward adjustments to primary care capitation to reflect payments to non-capitated providers for services to patients who are attributed to a capitated provider (aka "leakage").

> *Example: If the Carrier pays $100/month to PCP Dr. Karen for attributed member John Doe, but Carrier also paid $40 to Dr. Lee for providing services to John Doe. Carrier deducts this $40 "leakage" from the capitated payments to Dr. Karen. The total annual deducted amount should be reported here as a negative number. If the Carrier does not adjust rates in this way, leave this row blank.*

Estimated primary care expenditures as a subset of global capitation: Enter the total amount of global capitated payments in cell D19 (blue); these are arrangements with providers that include all or nearly all covered services, including primary care. Then estimate the value of the primary care portion of the global capitation and enter it in cell E19 (yellow). Only the primary care amount will be included in the "Total WA Primary Care NON-CLAIMS-BASED Payments."

Provider Incentives: Net financial incentive payments (bonuses minus penalties) made to primary care providers or practices in a value-based payment arrangement or alternative payment model conditioned on reporting or on the quality of services provided. The incentives should be detailed by the applicable LAN Category (see LAN CATEGORIES tab for definitions). *Note: this is only the incentive (bonus and/or penalty) portion of the payment arrangement, NOT the amount of payment for services or the capitated rate.* Please be sure to report the net amount as a negative number if penalties were greater than bonuses.

> **LAN Category 2B:** Net of bonus payments for reporting data on quality, and/or penalties for not reporting data, for primary care providers or practices.
>
> **LAN Category 2C:** Net of bonus payments for performance on clinical quality measures, and/or penalties for poor performance, for primary care providers or practices.
>
> **LAN Category 3A:** Shared savings payments made under arrangements with primary care providers/practices that are based on cost (and occasionally utilization) performance, as long as quality targets are met.

LAN Category 3B: Net of payments and/or penalties made under arrangements with primary care providers/practices that both reward and penalize cost (and occasionally utilization) performance, as long as quality targets are met.

LAN Category 4A: Net of incentives and/or penalties paid/incurred as part of prospective, population-based payment to primary care providers or practices for a certain set of condition-specific services or for care delivered by particular types of clinicians (e.g. primary care).

LAN Category 4B: Net of incentives and/or penalties paid/incurred as part of prospective, population-based payments to primary care providers or practices for all of an individual's health care needs.

LAN Category 4C: Net of incentives and/or penalties paid/incurred as part of payments to primary care providers or practices for comprehensive care that integrate the financing arm with a delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, and in others, they consist of delivery systems that offer their own insurance products.

Patient support fees & practice support fees: Capitated, lump-sum, per-member-per-month or other forms of payment for a defined set of patient support activities or for a defined set of practice support activities or infrastructure.

Example: Payments for activities that may be billable or non-billable to support patients via care coordination, case management, nurse care management, peer navigators, patient education, behavioral health integration or other patient support activities; Or, payments to practices/clinics for achieving NCQA Patient-Centered Medical Homes recognition, or participation in other proprietary or multi-payer medical-home initiative, or other payments to support practice transformation or to support capacity for improving care for a defined population of patients. ***If you cannot distinguish between capitation payments and patient support fees, please include the total in the "Capitated, sub-capitated, or salaried primary care expenditures" category and make a note in the comment box.***

Expenditures for health information technology (HIT): Payments that enable or reward practices' HIT infrastructure, and data analysis and/or reporting capacity.

Example: Payments to support transition from paper to electronic health records, to upgrade an EHR system, to purchase an EHR license, to invest in a health or community information exchange platform, to invest in a population health data platform, to invest in staff to support data analysis or reporting, etc.

Workforce expenditures: payments to support workforce or worker development.

Example: Payments or expenses for supplemental staff or supplemental activities integrated into the primary care practice (i.e., practice coaches, etc.)

Other expenditures (including those not paid directly to primary care providers or practices): Please include and describe any other non-claims-based expenditures you currently incur to support primary care providers or practices, including those that are not paid directly to primary care practices.

Examples: Some home visits, mobile fairs, member incentives, direct-to-consumer primary care telehealth services, when reimbursement for these services does not go to a primary care practice.

Place of service codes

Place of service code*	Place of service description	Include	Comment
2	Telehealth / Telehealth Provided Other than in Patient's Home	Yes	
3	School	Yes	
5	Indian health service free-standing facility	Yes	
6	Indian health service provider-based facility	Yes	
7	Tribal 638 free-standing facility	Yes	
8	Tribal 638 provider-based facility	Yes	
10	Telehealth Provided in Patient's Home	Yes	
11	Office	Yes	
12	Home	Yes	
19	Off Campus - Outpatient Hospital	Yes	
20	Urgent care facility*	Yes*	Clinic must have a specific PCP attached to it, otherwise, don't include
22	On Campus - Outpatient Hospital	Yes	
31	Skilled nursing facility	Yes	
32	Nursing facility	Yes	
49	Independent clinic	Yes	
50	Federally qualified health center	Yes	
72	Rural health clinic	Yes	

Provider specialty-sub list

Specialty description	Subspecialty description	Provider taxonomy code
Clinic/Center	Primary Care	261QP2300X
Clinic/Center	Federally Qualified Health Center (FQHC)	261QF0400X
Clinic/Center	Critical Access Hospital	261QC0050X
Clinic/Center	Urgent Care	261QU0200X
Clinic/Center	Rural Health	261QR1300X
Clinical Nurse Specialist	Family Health	364SF0001X
Clinical Nurse Specialist		364S00000X
Clinical Nurse Specialist	Pediatrics	364SP0200X
Clinical Nurse Specialist	Gerontology	364SG0600X
Clinical Nurse Specialist	Adult Health	364SA2200X
Clinical Nurse Specialist	Women's Health	364SW0102X
Clinical Nurse Specialist	Chronic Care	364SC2300X
Clinical Nurse Specialist	Holistic	364SH1100X
Family Medicine	Geriatric Medicine	207QG0300X
Family Medicine		207Q00000X
Family Medicine	Adolescent Medicine	207QA0000X
Family Medicine	Adult Medicine	207QA0505X
General Practice		208D00000X
Internal Medicine		207R00000X
Internal Medicine	Geriatric Medicine	207RG0300X
Internal Medicine	Adolescent Medicine	207RA0000X
Naturopath		175F00000X

Nurse Practitioner		363L00000X
Nurse Practitioner	Pediatrics	363LP0200X
Nurse Practitioner	Primary Care	363LP2300X
Nurse Practitioner	Adult Health	363LA2200X
Nurse Practitioner	Family	363LF0000X
Pediatrics		208000000X
Pediatrics	Adolescent Medicine	2080A0000X
Physician Assistant		363A00000X
Physician Assistant	Medical	363AM0700X
Preventive Medicine	Preventive Medicine/Occupational Environmental Medicine	2083P0500X

Procedure codes

Code	Description
11976	Remove Contraceptive Capsule
11981	Insert Drug Implant Device
11982	Remove Drug Implant Device
11983	Remove W/ Insert Drug Implant
57170	Fitting Of Diaphragm/Cap
58300	Insert Intrauterine Device
58301	Removal of IUD
90460	Immunization Admin 1St/Only Component 18 Years<
90461	Immunization Admin Each Addl Component 18 Years<
90471	Immunization Admin 1 Vaccine Single/Combo
90472	Immunization Admin Each Add-On Single/Combo
90473	Immunization Admin Oral/Nasal Single/Combo
90474	Immunization Admin Oral/Nasal Addl Single/Combo
96110	developmental screening, including autism
96127	Brief developmental or behavioral health screening
96160	Pt-Focused Hlth Risk Assmt

96161	Caregiver Health Risk Assmt
96372	Ther/Proph/Diag Inj Sc/Im
98925	Osteopath Manj 1-2 Regions
98926	Osteopath Manj 3-4 Regions
98927	Osteopath Manj 5-6 Regions
98928	Osteopath Manj 7-8 Regions
98929	Osteopath Manj 9-10 Regions
98966	Hc Pro Phone Call 5-10 Min
98967	Non-Physician Telephone Services 11-20 Min
98968	Non-Physician Telephone Services 21-30 Min
98969	Online Service By Hc Pro
99202	Office/OutPt Visit New 15-29 Min
99203	Office/OutPt Visit New 30-44 Min
99204	Office/OutPt Visit New 45-59 Min
99205	Office/OutPt Visit New 60-74 Min
99211	Office/OutPt Visit Est
99212	Office/OutPt Visit Est 10-19 Min
99213	Office/OutPt Visit Est 20-29 Min
99214	Office/OutPt Visit Est 30-39 Min
99215	Office/OutPt Visit Est 40-54 Min
99241	Office Or Other OutPt Consultations 15 Min
99242	Office Or Other OutPt Consultations 30 Min
99243	Office Or Other OutPt Consultations 40 Min
99244	Office Or Other OutPt Consultations 60 Min
99245	Office Or Other OutPt Consultations 80 Min
99304	Initial Nursing Facility Care/Day 25 Min
99305	Initial Nursing Facility Care/Day 35 Min
99306	Initial Nursing Facility Care/Day 45 Min
99307	Sbsq Nursing Facility Care/Day E/M Stable 10 Min
99308	Sbsq Nursing Facil Care/Day Minor Complj 15 Min

99309	Sbsq Nursing Facil Care/Day New Problem 25 Min
99310	Sbsq Nurs Facil Care/Day Unstabl/New Prob 35 Min
99315	Nursing Facility Discharge Management 30 Min<
99316	Nursing Facility Discharge Management 30 Min>
99318	E/M Annual Nursing Facility Assess Stable 30 Min
99339	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 15-29 Min
99340	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 30 Min
99341	Home Visit New Pt 20 Min
99342	Home Visit New Pt 30 Min
99343	Home Visit New Pt 45 Min
99344	Home Visit New Pt 60 Min
99345	Home Visit New Pt 75 Min
99347	Home Visit Established Pt 15 Min
99348	Home Visit Established Pt 25 Min
99349	Home Visit Established Pt 40 Min
99350	Home Visit Established Pt 60 Min
99354	Prolonged Service OutPt 60 Min
99355	Prolonged Service OutPt Add 30 Min
99356	Prolonged Service Requiring Unit/Floor 60 Min
99357	Prolonged Service Requiring Unit/Floor Add 30 Min
99358	Prolong Service W/O Contact
99359	Prolong Serv W/O Contact Add 30 Min
99360	Standby Service
99366	Team Conf W/ Pt By Healthcare Prof 30 Min W/Physician
99367	Team Conf W/Out Pt By Healthcare Prof 30 Min W/Physician
99368	Team Conf W/Out Pt By Healthcare Prof 30 Min W/Out Physician
99381	Init Pm E/M New Pat Infant
99382	Init Pm E/M New Pat 1-4 Yrs
99383	Prev Visit New Age 5-11

99384	Prev Visit New Age 12-17
99385	Prev Visit New Age 18-39
99386	Prev Visit New Age 40-64
99387	Office Visit - New Pt 65+ Yrs
99391	Periodic Pm Reeval Est Pat Infant 1>
99392	Prev Visit Est Age 1-4
99393	Prev Visit Est Age 5-11
99394	Prev Visit Est Age 12-17
99395	Prev Visit Est Age 18-39
99396	Prev Visit Est Age 40-64
99397	Per Pm Reeval Est Pat 65+ Yr
99401	Preventive Counseling Indiv 15 Min
99402	Preventive Counseling Indiv 30 Min
99403	Preventive Counseling Indiv 45 Min
99404	Preventive Counseling Indiv 60 Min
99406	Behav Chng Smoking 3-10 Min
99407	Behav Chng Smoking > 10 Min
99408	Audit/Dast 15-30 Min
99409	Alcohol/Substance Screen & Intervention >30 Min
99411	Preventive Counseling Group 30 Min
99412	Preventive Counseling Group 60 Min
99429	Unlisted Preventive Service
99441	Phys/Qhp Telephone Evaluation 5-10 Min
99442	Phone E/M Phys/Qhp 11-20 Min
99443	Phys/Qhp Telephone Evaluation 21-30 Min
99450	Basic Life And/Or Disability Exam
99451	Interprofessional Electronic Health Assessment 5 Min >
99452	Interprofessional Electronic Health Record Referral Service(S) Provided By A Treating Physician Health Care Professional, > 16 Min
99453	Remote Monitoring Physiologic Parameters Initial

99454	Remote Monitoring Physiologic Parameters Programed Transmission
99455	Work Related Disability Exam
99456	Disability Examination
99457	Remote Physiologic Monitoring Treatment Management Services, First 20 Min
99483	Assmt & Care Planning Pt W/Cognitive Impairment
99484	Care Mgmt Svc Bhvl Health Conditions 20 Min
99487	Complex Care W/O Pt Vsit 60 Min
99489	Complex Chronic Care Addl 30 Min
99490	Chron Care Mgmt Srvc 20 Min
99494	1St/Sbsq Psyc Collab Care
99495	Trans Care Mgmt 14 Day Disch
99496	Trans Care Mgmt 7 Day Disch
99497	Advncd Care Plan 30 Min
99498	Advncd Care Plan Addl 30 Min
G0008	Admin Influenza Virus Vaccine
G0009	Admin Pneumococcal Vaccine
G0010	Admin Hepatitis B Vaccine
G0101	Cancer Screen; Pelvic/Breast Exam
G0102	Prostate Cancer Screening; Digital Rectal Examination
G0179	Phys Re-Cert Mcr-Covr Hom Hlth Srvc Re-Cert Prd
G0180	Phys Cert Mcr-Covr Hom Hlth Srvc Per Cert Prd
G0181	Home/Nursing Facility Visits W/Out Pt Medicare Approved
G0182	Hospice Facility Visits Medicare Approved
G0396	Alcohol/Subs Misuse Intervention 15-30 Min
G0397	Alcohol/Subs Misuse Intervention 30 Min <
G0402	Welcome to Medicare visit
G0438	Ppps, Initial Visit
G0439	Ppps, Subseq Visit
G0442	Annual Alcohol Screen 15 Min

G0443	Brief Alcohol Misuse Counsel
G0444	Depression Screen Annual 15 Min
G0463	Hospital Outpt Clinic Visit
G0466	FQHC Visit, New Pt
G0467	FQHC Visit, Established Pt
G0468	FQHC Preventive Visit
G0469	FQHC Visit, Mh New Pt
G0470	FQHC Visit, Mh Estab Pt
G0506	Comprehensive Asses Care Plan Chronic Care Mgmt Services
G0513	Prolong Preventative Services, First 30 Min
G0514	Prolonged Preventive Service Addl 30 Min
Q0091	Obtaining Screen Pap Smear
T1015	Clinic Service All-Inclusive

Appendix B: DEX report

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Analytic Support Initiative Disease Expenditures Report

This Analytic Support Initiative (ASI) report for the Cost Board assesses health care spending by geography, health condition, and type of care, while controlling for key demographic and epidemiological trends.

Washington State Health Care Authority

Analytic Support Initiative Disease Expenditures Report

Version 2 | November 2024

The Analytic Support Initiative (ASI) is a collaborative effort between the Washington State Health Care Authority (HCA) and the Institute for Health Metrics and Evaluation (IHME), supported by a grant from the Peterson Center on Healthcare and Gates Ventures.

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About the Analytic Support Initiative

HCA and IHME were awarded a 2-year grant to leverage the IHME Disease Expenditure Project's health care data expertise to inform the policy study of the Health Care Cost Transparency Board of Washington.

The primary goal of the Analytic Support Initiative (ASI) is to address the unsustainable rise in health care spending by providing policymakers with timely, actionable data and research to enhance access to quality, affordable care for Washington residents.

The ASI benefits from combining the HCA's in-house expertise in health care spending, state data, and policy with IHME's analytic capabilities. This partnership builds on Washington's existing efforts to improve health care affordability and transparency through the Health Care Cost Transparency Board (Cost Board). The Cost Board, comprised of public and private purchasers and health care experts, aims to analyze total health care expenditures, identify drivers of spending growth, establish benchmark growth rates, and pinpoint providers and payers exceeding the benchmark.

The ASI's contributions are intended to complement several other data initiatives supporting the Cost Board. These include setting and measuring performance against the cost growth benchmark, the cost drivers analysis, the primary care spending analysis, hospital cost and profit analysis, and the overall consumer and affordability initiative. The value add of the ASI is its analysis of the Washington All-Payer Claims Database, ability to complete county-level analyses, and ability to tie underlying disease prevalence to spending estimates.

Figure 1: Data initiatives supporting the Washington Health Care Cost Transparency Board

	Cost growth benchmark	Performance against benchmark	Cost driver analysis/cost experience	Primary care spend measurement	Hospital cost, profit, and price analysis	Analytics support initiative	Consumer and affordability
Description	The ceiling/goal for the growth of spending on health care year over year.	Assessment of cost growth against the benchmark target.	Assessment of key drivers of cost growth.	Measurement of expenditure on primary care in relation to overall health care expenditure.	Hospital financial analysis to create cost, price and profit trends.	Analysis of the drivers of WA health care cost growth by University of Washington's IHME. IHME will use its deep analytic capacity as well as expertise in data integration.	The ability for a consumer to afford their health care insurance.
Data sources	Reported through benchmark data collection from carriers and providers.	Reported through benchmark data collection from carriers and providers.	Washington All Payer Claims Database.	Washington All Payer Claims Database.	Medicare Cost Report Data.	Washington All Payer Claims Database, other claims databases, and hospital records. (See page 6 for more detail.)	Survey results gathered from external sources such as KFF, BRFSS, Altarum, etc., giving context to aforementioned datastreams.

About this report

Through a series of data views, the ASI will give the Cost Board useful data to estimate and understand drivers of historical health spending in the state of Washington.

This report is a product of the ASI for the Cost Board. It assesses health care spending with stratification by geography, health condition, and type of care at a granular level while controlling for key demographic and epidemiological trends. The analytics that support this report were developed for the Institute for Health Metrics and Evaluation for the Disease Expenditure Project (DEX). These existing estimates are being leveraged to (a) provide information about health care spending to the Cost Board, and (b) to facilitate Cost Board discussion regarding the type of future analysis that the ASI can complete. The ASI will provide materials to the Cost Board in an iterative fashion.

This initial report was developed for, presented to, and edited based on feedback from ASI's key advisors and the Cost Board during the first half of 2024. This version of the report builds from the Washington All-Payer Claims Database and extends estimates through 2022. Future analyses will address trends over time, quantify attributable drivers of health care spending, and explore factors associated with key drivers of spending growth.

Data source and methods

Using various data sources such as claims and administrative data, DEX modeling produces granular health condition-and geographically-specific estimates of health care spending.

The IHME Disease Expenditure (DEX) Project generates estimates of health care spending and encounters for each US county for 2010-2022 stratified by age, sex, type of care, payer, and health condition. These estimates are generated using a four-step process. The first step entails collecting and harmonizing data from various sources, including 45 billion insurance claims billed to Medicare, Medicaid, and private insurance companies (including data from Health Care Cost Institute, Kythera, Fluent, and Marketscan), as well as data from Washington state's All-Payer Claims Database. In Washington, approximately 2 billion claims and 33 million administrative records were used for 2010 through 2022 to inform these estimates. The DEX project also uses hospital administrative data, from the Healthcare Cost and Utilization Project, and survey data from the Medical Expenditure Panel Survey. The second step of the DEX project involves assigning each claim or encounter to one of 149 health conditions, while the third step focuses on adjusting for data imperfections, such as reallocating spending for comorbidities that increase costs. Additionally, a small area model is employed to estimate utilization and spending in geographic areas with limited input data. In the fourth step, the estimates are scaled to ensure internal consistency across county and state levels, and alignment with official U.S. government estimates of health care spending.

These estimates are slated to be updated to reflect the integration of WA-specific APCD data as well.

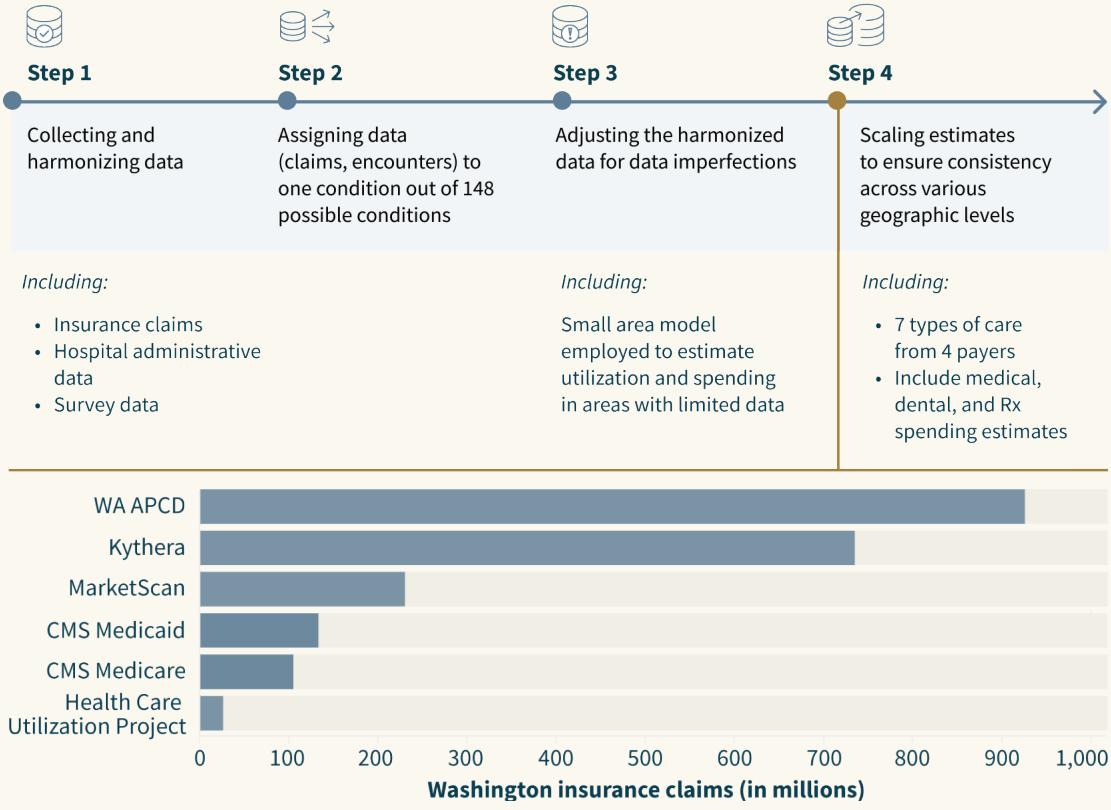
Estimates produced for the DEX project include spending on seven types of care – ambulatory care, hospital inpatient care, retail-prescribed pharmaceutical,

Across seven types of care, four payer categories, DEX estimates use disease and location-specific attribution methodology to assess spending levels over time, space, and disease.

nursing facility care, home health care, emergency department care, and dental care – from four payers – private insurance, Medicare, Medicaid, and out-of-pocket spending. Spending on over-the-counter drugs, durable medical equipment, public health, and from Tri-care, Indian Health Services, and Veterans Affairs are excluded. These estimates include medical, dental, and prescribed pharmaceutical spending estimates. For prescribed retail pharmaceuticals, we track spending paid by the patient or third-party payers (i.e. insurance companies) prior to any rebates or discounts being provided. Finally, the disease-specific spending estimates highlighted in this report are spending that has been attributed to each health condition. It is not based merely on the primary diagnosis, but rather when a health condition is a secondary diagnosis but leads to excess spending on the primary diagnosis, that excess spending is attributed to the secondary diagnosis.

In this report, all estimates are reported in nominal currency, meaning they are not adjusted for inflation. Age-standardization is conducted using direct age-standardization, relative to the 2022 national or Washington age-profile. Rates of change are all annualized, so they are comparable across different length time periods. Decomposition of variation or change across time was calculated using demographic decomposition methods based on Das Gupta (1993).

Figure 2: DEX Project data sourcing



Executive summary

This report provides an analysis of health care spending in Washington state from 2010-2022 based on the Institute for Health Metric and Evaluation's DEX Project. In 2022, the DEX project assessed $60.1 billion of health care spending in Washington, which amounted to $7,620 per person. (See Data Source and Methods section above regarding what is specifically included and excluded from this estimate.) This is 10% less than the DEX project's estimate of national spending per person, which is $8,506. Across the 50 states and the District of Columbia, Washington had the 6th lowest per capita spending.

WA health care expenditure shows growth in line with national average in aggregate, but reveals material variation by type of care, location, and payer type - suggesting potential value in further examination of pathways to ensure affordability measures and reasonable pricing across sites of care are examined.

Between 2010 and 2022, total per person spending increased to $7,620. The specific health conditions with the greatest increase in spending included cancers, mental disorders, diabetes and kidney diseases, and musculoskeletal disorders. Ambulatory care was the spending category with the greatest spending increase, growing by $14.2 billion between 2010 and 2022.

The DEX project showed that ambulatory care, which includes all outpatient care regardless of whether it is provided in a hospital, clinic, or surgical or rehabilitation center, emerged as the dominant category, constituting 49% of the total spending, amounting to $29.5 billion. The report highlights the significant role of private insurance, contributing 44% of total spending, with the majority allocated to ambulatory and inpatient care. The DEX project estimated that out-of-pocket spending reached $7.3 billion in 2022, covering expenses like deductibles and co-pays.

The DEX project estimated that between 2010 and 2022, Washington had an overall spending increase of $24.9 billion, reaching $60.1 billion. Even after adjusting for population size increases, health care spending increased above and beyond the inflation rate. Ambulatory care witnessed the most substantial increase, fueled by population growth, an aging population, and higher spending per visit. Hospital inpatient care also saw significant growth, mainly attributed to increased spending per admission.

The report further delves into spending variations based on health conditions, with the DEX project identifying musculoskeletal disorders, cancers, cardiovascular diseases, other non-communicable diseases, and diabetes and kidney diseases as the top five categories with the highest attributable spending[1]. Notably, substance use disorders exhibited a substantially higher annualized growth rate compared to other top conditions at 9.4%.

Furthermore, the analysis explores spending variations within Washington, showcasing significant disparities across counties. The DEX project showed that San Juan, Lewis, and Lincoln counties exhibited the highest spending per person,

Policies with strongest interest for 2024: Price growth caps and provider rate setting, limiting facility fees, restricting anti-competitive clauses in health care contracting, and review of mergers and acquisition, private equity, and health care facility closures.

while Franklin, Adams, and Yakima counties demonstrated the lowest. The report provides a detailed breakdown of spending differences, highlighting the drivers of spending changes and offering valuable insights into the dynamics of health care expenditures at both the state and county levels. This report highlights the role prices play in driving increases in health care spending in Washington and supports the call for many of the policies being considered by the Washington Health Care Cost Transparency Board, including price growth caps and provider rate setting, restricting anti-competitive clauses in health care contracting, review of mergers and acquisitions, and limits on facility fees for some clinical services.

[1] Attributable spending is spending that has been attributed to a health condition. In this research we reallocate spending on a claim to the health condition determining the amount of spending. When a comorbidity (a co-occurring disease that isn't the primary diagnosis) exacerbates spending the excess spending is attributed to the comorbidity, not the primary diagnosis.

Background

One of the initial and explicitly legislated tasks of the Cost Board was to establish total health spending growth targets. These targets are meant to be a goal for individual payers and providers to aim for and in later years the Cost Board will hold payers and providers accountable for reaching these targets. The benchmark growth targets established by the Cost Board range from 3.2% to 2.8%. These are growth targets for total aggregate expenditure on health, including claims-based and non-claims-based expenditures.

Figure 3: Washington State benchmark growth targets

Year of release	Timeline of included data	Data included
Late 2023	2017 – 2019	State and market data only; the Board will not publicly report insurance payer or provider cost growth for this period
Late 2024	2020 – 2022	For large provider entities* and payers, with cost growth target of 3.2%
Late 2025	2022 – 2023	For large provider entities and payers, with cost growth target of 3.2%
Late 2026	2023 – 2024	For large provider entities and payers, with cost growth target of 3.0%
Late 2027	2024 – 2025	For large provider entities and payers, with cost growth target of 3.0%
Late 2028	2025 – 2026	For large provider entities and payers, with cost growth target of 2.8%

**Large provider entities will be determined using 2017-2019 as a historical baseline.*

Source: *Washington Health Care Authority*

In late 2024, the Washington Health Care Authority release updated data against these state benchmarks. The report showed that the total health care spending in Washington on a per member basis increased 21.8% between 2017 and 2022, including 3.6% from 2021 to 2022. The most recent data reported showed that when measured in terms of per member per year, growth was highest for Medicare spending (4.3% in 2022), slightly below the benchmark for commercial insurance (2.8%), and slightly contracting for Medicaid (-0.7% in 2022).

The DEX project builds on the HCA findings by providing increased granularity regarding age, health conditions, and county.

Findings from the DEX project, outlined in the remainder of this report, substantiate, and build upon the findings from HCA's report. Using different data sources and measuring slightly different quantities (the DEX project includes nursing facility care and out-of-pocket spending), the DEX project comes to many of the same conclusions but provides increased granularity by also assessing spending by age, health condition, and county.

Connecting indings to the Cost Board's key priorities

This report and the initial Analytic Strategy for the ASI, approved on December 7, 2023, align well with the efforts of Health Care Cost Transparency Board (the Board) to control the growth of health care spending in Washington. At the Board retreat held on February 9, 2024, members discussed and were polled on what policies would be the focus for further discussion in 2024. The following four strategies received the strongest interest.

1. Price growth caps and provider rate setting
2. Limiting facility fees
3. Restricting anti-competitive clauses in health care contracting
4. Review of mergers & acquisition, private equity, and health care facility closures

Capping price growth is a method to curtail health care spending increases far in excess of inflation and wage growth, relying on oversight and enforcement mechanisms to incentivize cost savings. Along similar lines, provider rate setting is a more direct method to control spending, setting payment levels of services across providers. This approach lowers the administrative burden for providers and carriers by eliminating the need for negotiations and streamlining claims processing. Together, these concepts have garnered the strongest interest from the Board.

The policies under review by the Board require detailed regional and driver-focused analysis of health care spending, and the ASI framework can help identify areas for further examination and targeted improvement.

Critically, by providing granular estimates of spending, this project offers insights into how these specific policies could be leveraged to contain the spiraling growth of health care spending. The primary reason for spending increases over time in the state, other than increases in the population size and age, are related to increases in price and intensity of care. Increases in price and intensity led to increases in spending across all types of care except emergency department care. In ambulatory care and inpatient care, increases in price and intensity led to an increase in annual spending of $12.1 and $4.5 billion between 2010 and 2022.

Looking ahead, the impacts of the policies of most interest to the Board will be examined by a broad set of analytic efforts. The data products produced by the ASI project will take a more comprehensive examination of pricing by incorporating data from the HCA's All Payer Claims Database. Building on the solid foundation of IHME's nationally focused DEX project, the successor ASI analysis will generate valuable insights with a report and data products specific to Washington.
The baseline analysis will generate state- and county-level health care spending estimates across 149 health conditions and four payer categories. These estimates will also be adjusted by leveraging demographic and disease prevalence data, examining drivers by county and examining specific outlying trends when identified. Together, the report and dashboard will offer in-depth examination of spending across markets, equipping the Board with needed information to evaluate policies which could curb the growth of health care spending in Washingtonanalysis to highlight the impact of policies of most interest to the Board. Together, the report and dashboard will offer in-depth examination of spending across markets, equipping the Board with needed information to evaluate policies which could curb the growth of health care spending in Washington.

Data summary

Health care spending in Washington state in 2022

Washington state's performance, in terms of spending levels, is middle-of-the-pack relative to national comparators – but is beginning to face headwinds given an aging population.

WA state expenditure is largely consistent with national distributions around outpatient expenditure (a broad category encompassing broader shifts of service lines historically exclusive to inpatient setting) and a large fraction of spend still sits within private insurance markets.

The broader trends of an aging population, and the rising per capita spending suggests a sustainability challenge in the future.

Key takeaways

- Adjusting for age, Washington ranks 6th lowest among US states in age-standardized health care spending per person.
- Health care spending increases with age, peaking at $14,948 per year for males and $16,243 for females aged 85+. The highest spending was for the 60-64 age group.
- Ambulatory care had the highest spending at $29.5 billion (49%), followed by hospital inpatient care at $12.6 billion (21%). Pharmaceuticals and dental care each exceeded $4 billion, with nursing facility care at $3.5 billion, home care at $2.2 billion, and emergency care under $2 billion.
- Private insurance was the largest payer at $26.4 billion (44%), primarily for ambulatory and inpatient care. Medicare spent $16 billion (27%), Medicaid $10.4 billion (17%), and out-of-pocket expenses totaled $7.3 billion.
- Medicare spending per beneficiary was the highest at $11,381, compared to $5,669 for Medicaid and $5,238 for private insurance.

In 2022, the DEX project estimated $60.1 billion was spent on health across seven types of care - hospital inpatient care, ambulatory care, emergency department care, pharmaceuticals, nursing facility care, home care, and dental care – in Washington.[2] This was $7,620 per person. During the same year, the DEX project estimated that national spending on the same types of care was $8,506 per person on the same types of care. Across the 50 states and the District of Columbia,

[2] Excluded from this analysis is spending on durable medical equipment, over-the-counter drugs, R&D and other investments, and spending on public health.

Washington ranks 6th lowest among US states in spending per person.

***Figure 4*: State-level spend and long-term growth performance**

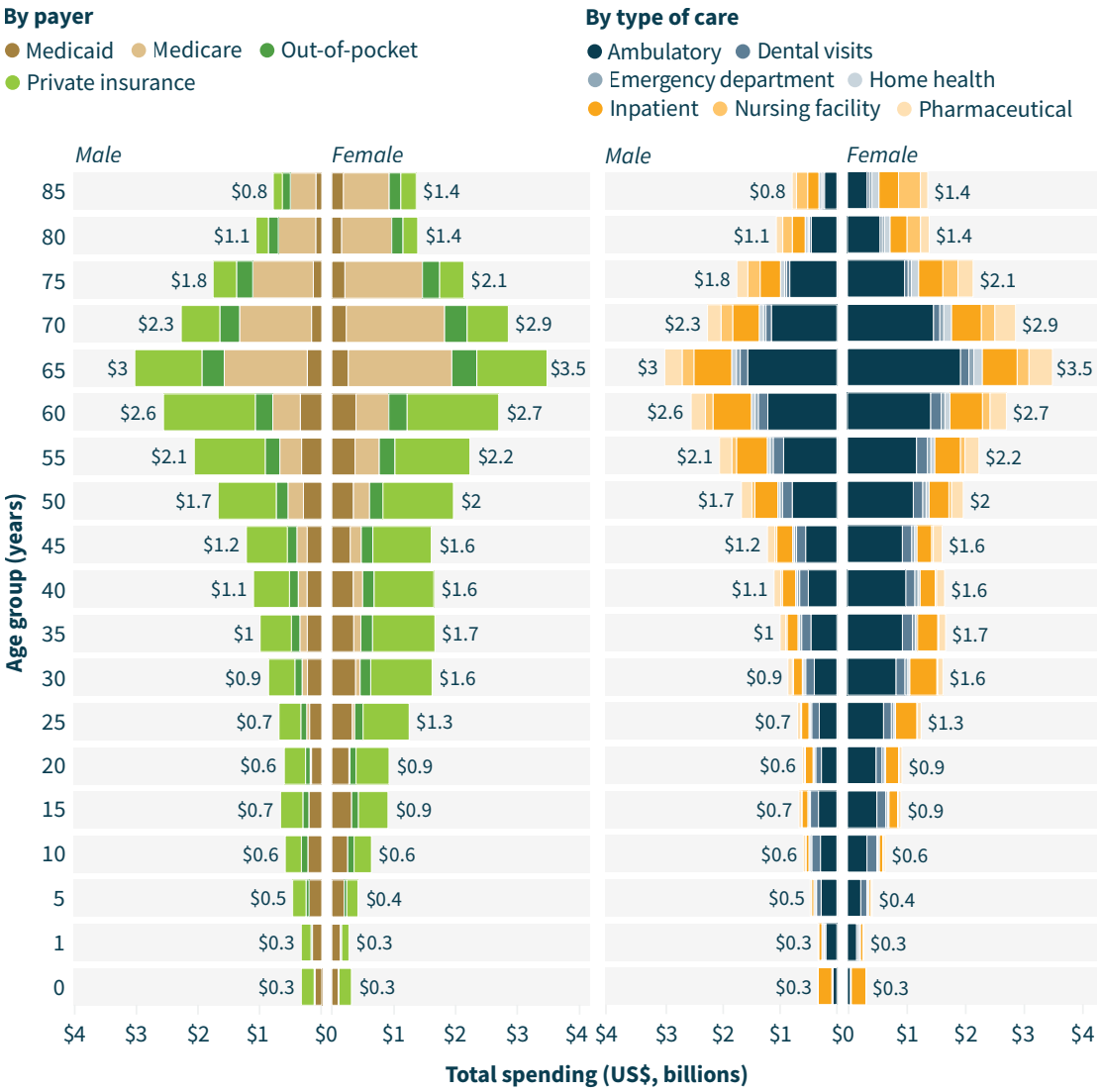
**Not adjusted for inflation*

Source: *IHME Disease Expenditure (DEX) estimates*

As it is in all US states, health care spending is greater for individuals as they age, with the DEX project showing that spending per person in Washington state reached $14,948 per year for males 85 and older and $16,243 for females 85 years and older. At the oldest age group, the most spending is on nursing facility care and ambulatory care, with a great amount of spending on hospital inpatient care as well. Despite spending going up with age, there is more spending in Washington on 60- to 64-year-olds than any other age group. While there are fewer people in the oldest age groups, it is also true that there is a dramatic shift in spending at 65 from spending on private insurance, which tends to have higher prices, to Medicare, which has lower prices.

Health care spending increases with age, peaking at $14,948 per year for males and $16,243 for females aged 85+.

Figure 5: Estimated healthcare spending across age groups and sex by payer and type of care, 2022



Source: *IHME Disease Expenditure (DEX) estimates*

Ambulatory care had the highest spending at $29.5 billion (49%).

Private insurance was the largest payer at $26.3 billion (44%).

Across the seven types of care analyzed, the DEX project reports that more was spent on ambulatory care than any other type of care - $29.5 billion in 2022. This is 49% of the spending considered in this study. The type of care with the second most spending was hospital inpatient care, which has $12.6 billion or 21% of the total. The DEX project shows that more than $4 billion was spent on both prescribed retail pharmaceutical[3] and on dental care. $3.5 billion was spent on nursing facility care, while less than $2 billion was spent on emergency department care. Across the payers included in the DEX project,[4] nearly half of the spending was from private insurance companies - $26.3 billion or 44%. Most of this spending was on ambulatory care (57%) and inpatient care (20%). $16 billion or 27% of the spending was from Medicare, with the most spending on ambulatory care, but a relatively large share on hospital inpatient care as well.

The DEX project tracked $10.4 billion in Medicaid spending, which was 17% of the total. Like Medicare, ambulatory care was the type of care with the most spending, but relative to private insurance, a great deal was spent on hospital inpatient care, and relative to all other payers, a large share of spending was on nursing facility care. Finally, $7.3 billion was spent out-of-pocket. This includes spending on deductibles and co-pays, and by those without insurance. While more out-of-pocket spending was on ambulatory care than any other type of care, there were relatively large amounts of spending on dental care and nursing facility care.

[3] Prescribed pharmaceuticals administered in a facility such as a hospital or clinic are included in other types of care, such as hospital inpatient care and ambulatory care, respectively. They reflect what was paid for the drugs and do not include pharmaceutical rebates or discounts.

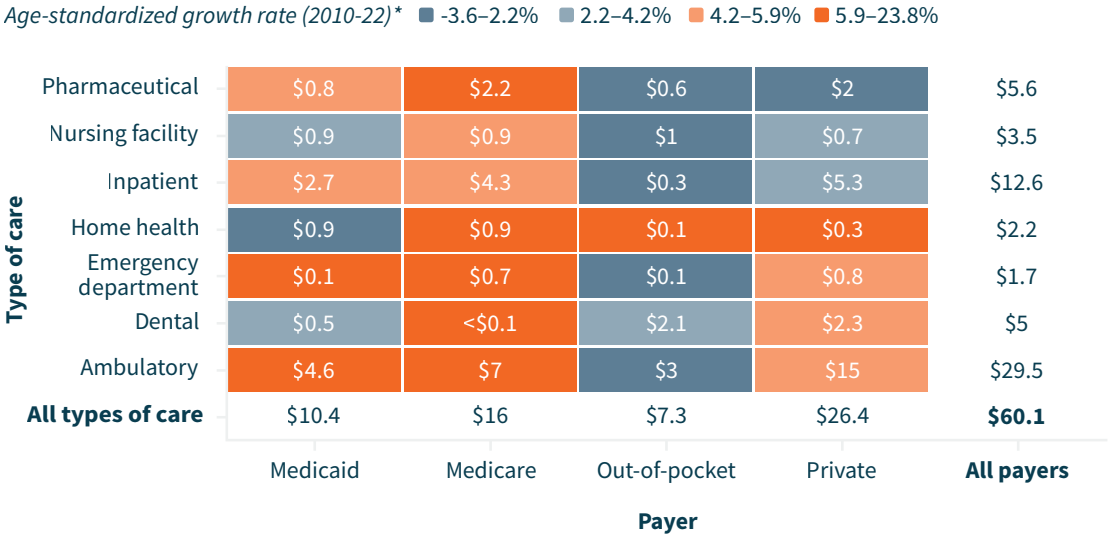
[4] Spending from Veterans Affairs, Tri-care, and Indian Health Services were omitted because of insufficient data.

How to read this chart: This figure captures total spending in WA state measured in billions of dollars. The rows are different types of care, while the columns are different payer categories. The color shows the growth rate for specific payer and type of care combinations. There was a total of $60.1 billion in health care spending in 2022.

Pharmaceutical spending captures spending on prescriptions filled at a pharmacy. The spending on physician administered drugs are included in ambulatory and inpatient care.

Figure 6: **Total spending by payer and type of care, 2022**

The dollar values in the heatmap correlate to total spending (billions, US$) by payer and type of care, while the box colors correlate to the age-standardized growth rate



**Not adjusted for inflation*

Source: *IHME Disease Expenditure (DEX) estimates*

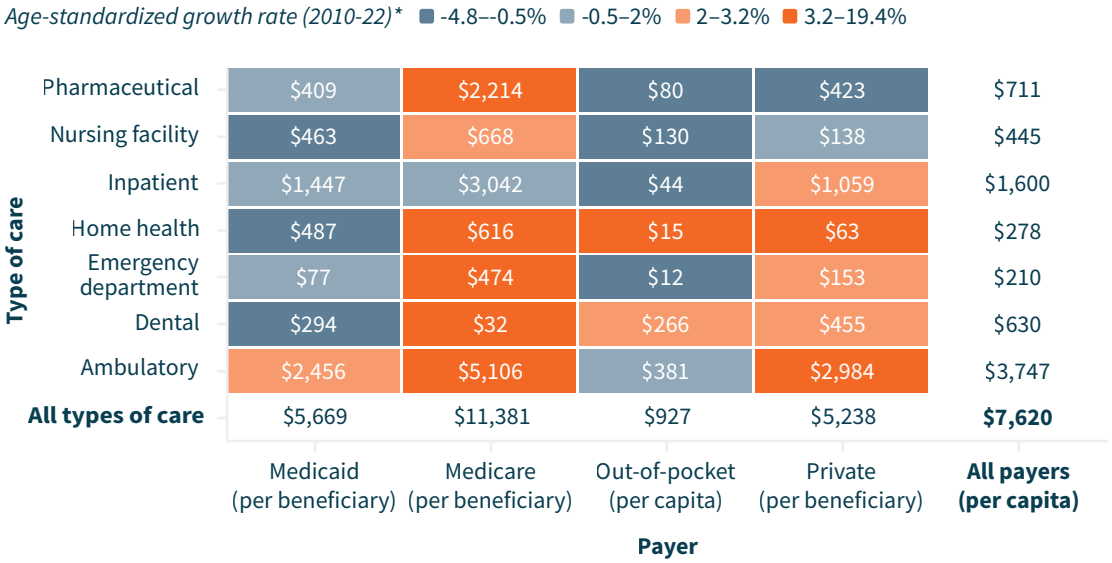
While the payer category with the most spending was private insurance, Medicare spending per beneficiary was much larger – and remained consistently so across all types of care (with the exception of dental care) - than every other payer (Figure 7). Medicare spending was $11,381 per beneficiary, while Medicaid spending was $5,669 per beneficiary and private insurance spending per beneficiary was only $5,238.

Medicare spending per beneficiary was the highest at $11,381 - through a combination of pharma, inpatient, and ambulatory spend.

Out of pocket spending is largely driven by spending in ambulatory, dental, and nursing facility expenditure.

Figure 7: Spending per beneficiary by payer and type of care, 2022

The dollar values in the heatmap correlate to spending per beneficiary by payer and types of care, while the box colors correlate to the age-standardized growth rate



*Not adjusted for inflation

Source: IHME Disease Expenditure (DEX) estimates

Data summary

Changes in health care spending in Washington state: 2010-2022

A long-term absolute growth rate of 4.6% observed – above the established threshold of 3% - was driven by a growth in Medicaid & Medicare – especially in the outpatient setting.

Furthermore, with the exceptions of dental services and nursing facility services – most of the growth observed was driven by rising prices and intensity of care.

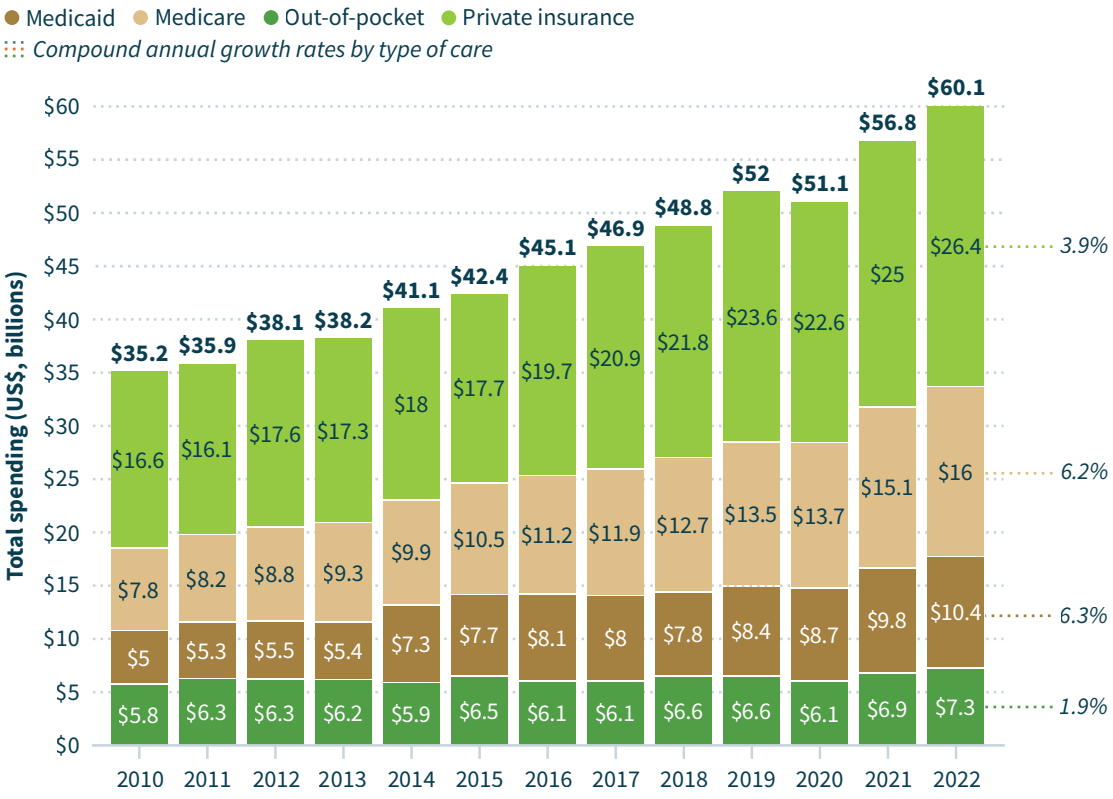
The growth of price and intensity in the private insurance marketplace over this time period may also translate into challenges around affordability observed in outpatient out-of-pocket expenditure growth – raising potential avenues of inquiry around non-covered expenses that may be worth further examination.

Key takeaways

- Private insurance spending decreased from 47% to 44%, while Medicare spending increased from 22% to 27% and Medicaid spending from 14% to 17%.
- The largest increase in spending was in ambulatory care, which rose by $14.2 billion. This was driven by population growth, aging, and higher spending per visit, despite fewer visits per person.
- Across most types of care, higher prices and increased intensity of care drove up spending. Utilization increased only in dental care, emergency department care, and marginally in ambulatory care.
- Changes in utilization were generally offset by increased price and intensity. Aging primarily affected Medicare spending, with other payers less influenced by demographic shifts.

The DEX project estimated that from 2010 to 2022, spending steadily increased with overall growth of $24.9 billion, from $35.2 billion in spending to $60.1 billion. During this time, private insurance spending decreased from 47% of the total to 44%, and Medicare spending increased from 22% to 27% and Medicaid spending increased from 14% to 17% spending across all payer types and types of care.

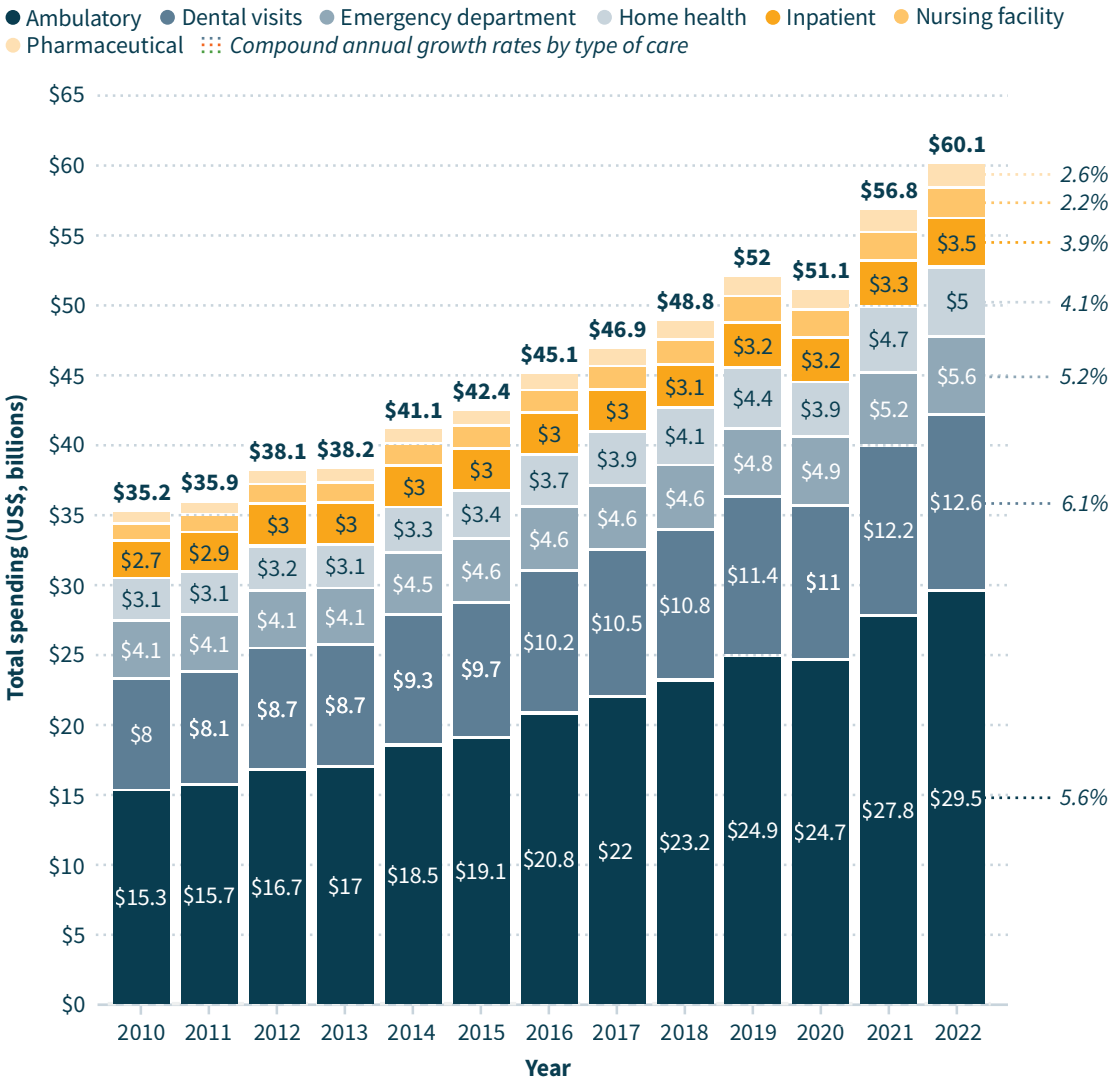
Figure 8: Total spending in Washington by payer, 2010-2022



Source: *IHME Disease Expenditure (DEX) estimates*

The largest increase in spending was in ambulatory care, which rose by $14.2 billion.

Figure 9: Total spending in Washington by type of care, 2010-2022



Source: IHME Disease Expenditure (DEX) estimates

The $24.9 billion increase in spending in Washington between 2010 and 2022 can be broken apart to assess which underlying factors led to more spending. The DEX project shows that the type of care that had the greatest increase was ambulatory care, which increased $14.2 billion in annual spending. This increase was driven by three factors – growth in population size, aging population, and higher ambulatory care spending per visit (first column of Figure 10). Higher spending per visit suggests that the price of care or intensity of care (or both) increased throughout this time.

Interestingly, there were fewer ambulatory care visits per person (i.e., lower service utilization) per person. The DEX project also shows that hospital inpatient care also increased a great deal – $4.6 billion increase in annual spending between 2010 and 2022. This increase was also driven partly by a larger and older population, but to a greater extent was driven by higher spending per admission. Admission per person decreased between 2010 and 2022 leading to a $2.9 billion decrease in spending, but that decrease was more than made up for by the $12.1 billion spending increase attributed to the increase in price and intensity of care. Across all types of care except emergency department spending, prices and intensity of care went up, while utilization of services increased only in dental care and emergency department care, and marginally in ambulatory care.

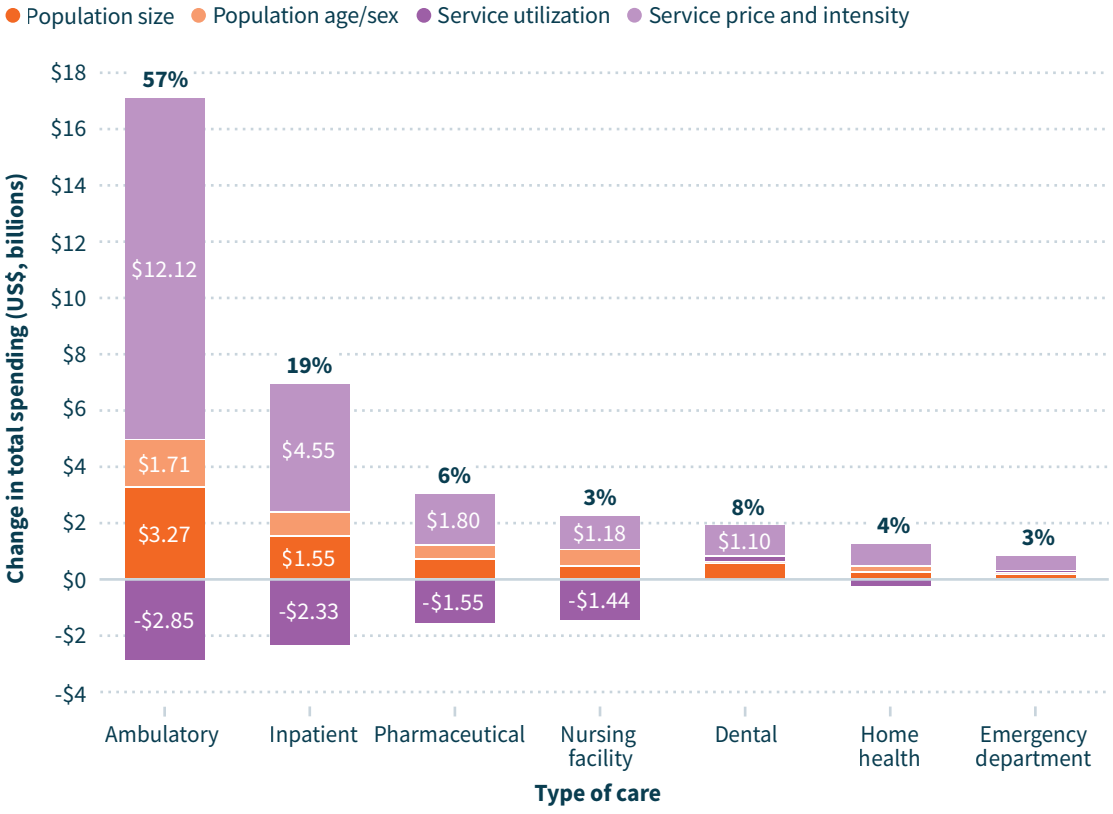
Growth in ambulatory and inpatient expenditure accounts for 76% of the growth observed over this period.

Growth in price and intensity explain 89% of growth observed, offsetting progress shifting sites away from high-acuity, inpatient settings.

How to read this figure: Each column shows the change in annual spending for a different type of care. Bars going up from zero highlight reasons why we are spending more in that type of care. While bars going down from zero highlight factors driving down annual spending.

Figure 10: **Contribution of drivers to expenditure growth, 2010-2022**

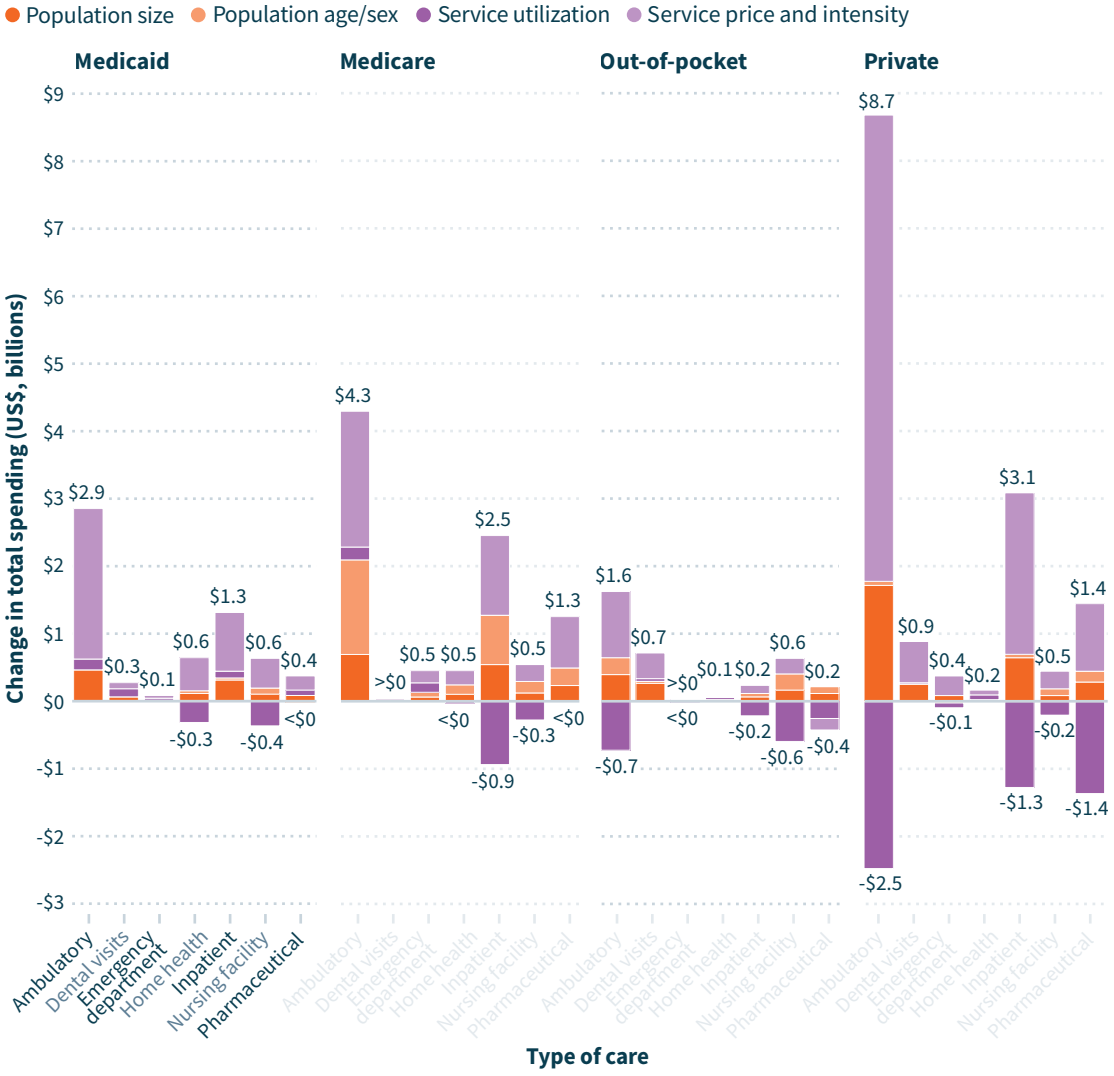
Percents are a portion of the total growth in expenditure observed from 2010-2019.



Source: *IHME Disease Expenditure (DEX) estimates*

Changes in utilization were generally offset by increased price and Intensity. Aging primarily affected Medicare spending, with other payers less influenced by demographic shifts.

Figure 11: Drivers of spending change for each payer in Washington, 2010-2022



Source: IHME Disease Expenditure (DEX) estimates

When broken down by payer, it is clear that changes in utilization were often offset by changes in price and intensity of care. For all payers except Medicaid, there were reductions in utilization for pharmaceutical and inpatient care (after adjusting for age and sex of the population). And across all payers, utilization for nursing facility care saw a similar reduction. The aging population influenced Medicare spending but did not have much of an effect on the other payers. Increases in price and intensity of care had an especially large effect on ambulatory and inpatient care.

Data summary

Health care spending by health condition in Washington

The top 5 disease categories alone account for 50% of WA state's health expenditure.

An examination of some of the largest spending categories (musculoskeletal disorders, cancers, and diabetes and kidney diseases), and a relatively small but rapidly growing category (substance use disorders) highlight the utility of examining a disease-specific approach to identifying growth drivers, potential solutions, and key payer / site of care combinations that must be engaged to tackle health care spending.

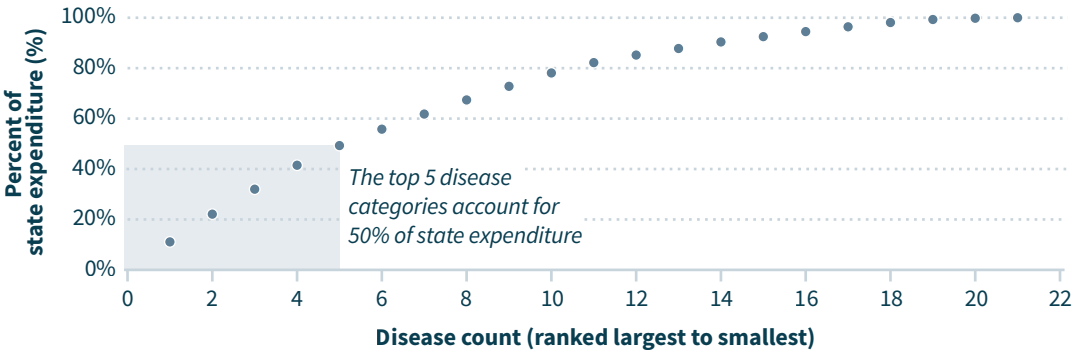
Key takeaways

- Musculoskeletal disorders, such as low back pain or osteoporosis, had the highest health care spending in Washington in 2022, totaling $6.91 billion, with 53% paid by private insurance and 26% paid by Medicare.
- Cancers had an annualized growth rate of 5.6%. The spending growth mostly occurred in ambulatory care, emergency department care, and pharmaceuticals, driven primarily by increased service price and intensity.
- Spending on diabetes and kidney diseases increased, with notable shifts including a rise in private insurance ambulatory care and a decrease in out-of-pocket nursing facility care spending.
- Spending on substance use disorders significantly increased, especially in ambulatory care. Increased service price and intensity drove most of the spending growth.
- Across nearly all types of care for musculoskeletal disorders and cancers, we see a decrease in service utilization, except in emergency department visits for musculoskeletal disorders.

Of the 21 aggregate health condition categories analyzed in the DEX project, musculoskeletal disorders ($6.91 billion); cancers ($6.33 billion); cardiovascular diseases ($6.27 billion); other noncommunicable diseases, which include oral disorders ($5.07 billion); and diabetes and kidney diseases ($4.47 billion) had the largest amounts in total spending in 2022 (Table 1). Musculoskeletal disorders are unique in that much of the health care is provided to working adults. Cancer spending has the highest growth rate of these five health conditions with annualized growth rate of 3%. Of all the aggregated health categories, substance use disorders has the greatest annualized growth rate between 2010 and 2022 at 6.8%.

Musculoskeletal disorders had the highest health care spending in Washington in 2022, totaling $6.91 billion, with 53% paid by private insurance and 26% paid by Medicare.

Figure 12/Table 1: Estimated disease-specific healthcare spending, and growth in 2022



Aggregated health condition categories	Total spending (billions)	Growth rate; 2010-2022*	Percent of state spending
Musculoskeletal disorders	$ 6.91	4.4%	13.5%
Cancers	$ 6.33	5.6%	12.4%
Cardiovascular diseases	$ 6.26	4.5%	12.2%
Other non-communicable diseases	$ 5.07	3.7%	9.9%
Diabetes and kidney diseases	$ 4.47	5.7%	8.7%
Mental disorders	$ 4.18	6.9%	8.2%
Oral disorders	$ 3.46	3.7%	6.8%
Digestive diseases	$ 3.27	3.6%	6.4%
Well care	$ 3.22	4.5%	6.3%
Neurological disorders	$ 2.83	3.6%	5.5%
Injuries	$ 2.21	3.5%	4.3%
Skin and subcutaneous diseases	$ 1.71	3.8%	3.3%
Chronic respiratory diseases	$ 1.66	3.4%	3.2%
Respiratory infections and tuberculosis	$ 1.66	3%	3.2%
Other infectious diseases	$ 1.57	5.6%	3.1%
Sense organ diseases	$ 1.43	5.5%	2.8%
Risk factors	$ 1.20	2.9%	2.3%
Maternal and neonatal disorders	$ 1.18	6.2%	2.3%
Substance use disorders	$ 1.08	9.4%	2.1%
HIV/AIDS and sexually transmitted infections	$ 0.24	3.4%	0.5%
Enteric infections	$ 0.15	1.8%	0.3%

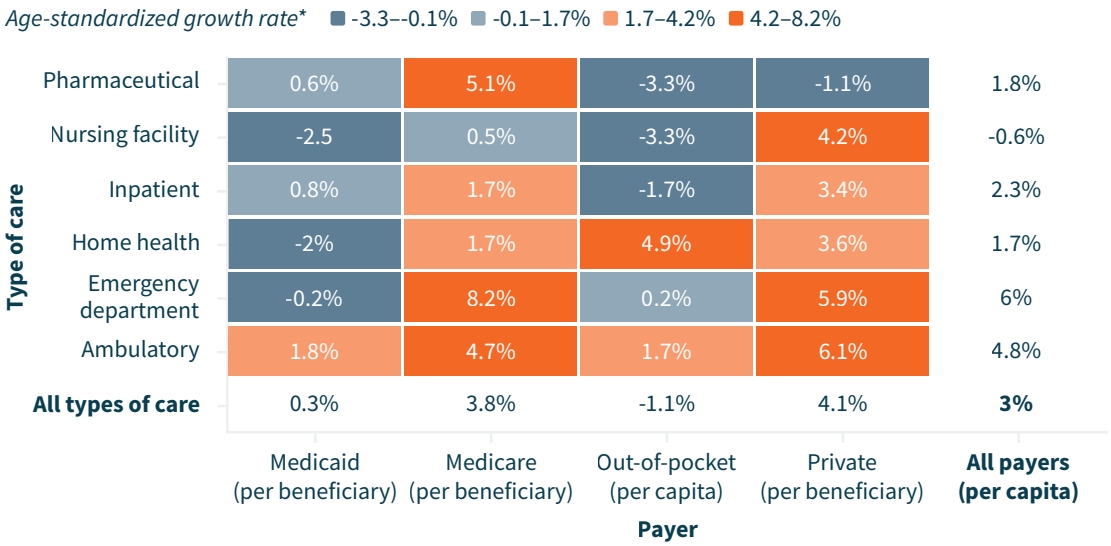
**Not adjusted for inflation*

Source: *IHME Disease Expenditure (DEX) estimates*

In Washington state in 2022, $4.5 billion was spent on diabetes and kidney diseases. Between 2010 and 2022, the annualized growth rate was 3.1%. After adjusting for age and the number of beneficiaries covered, private insurance spending increased the fastest between 2010 and 2022, at 4.1% annually. This growth was concentrated in ambulatory care, emergency department, and nursing facility care. Across all payers, spending in emergency departments and ambulatory care increased the fastest. Across all types of care, it was service price and intensity that led to the greatest increases in spending (Figure 17).

Spending on diabetes and kidney diseases increased, with notable shifts including a rise in private insurance ambulatory care and a decrease in out-of-pocket nursing facility care spending. Diabetes and kidney diseases grew at an annualized rate of 5.7%. After adjusting for population size, the growth rate was 3%.

Figure 13: **Age-standardized growth rate of spend per beneficiary for diabetes and kidney diseases, 2010-2022**



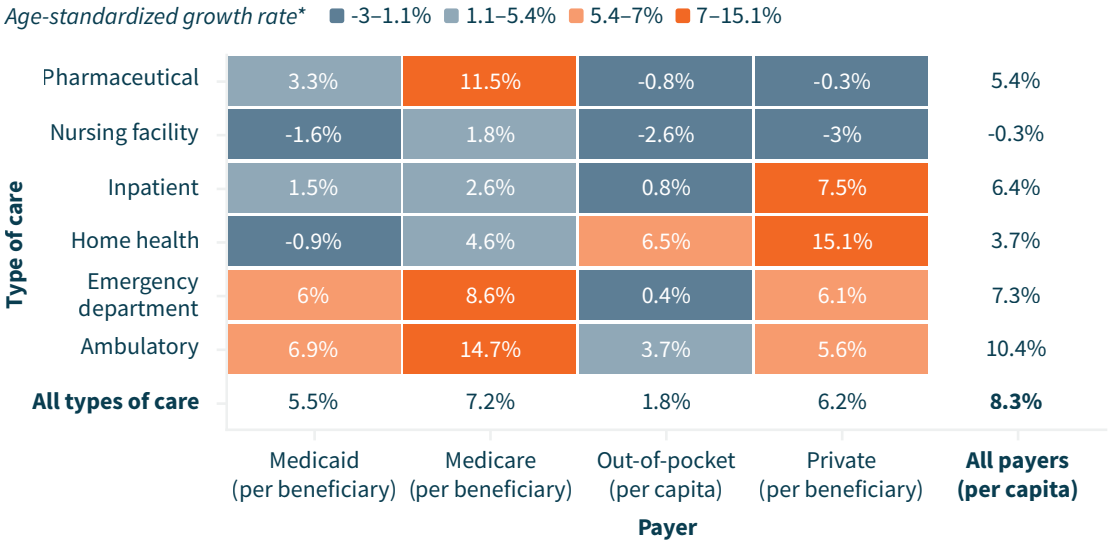
**Not adjusted for inflation*

Source: *IHME Disease Expenditure (DEX) estimates*

Spending on substance abuse disorders grew faster than any other aggregate health condition category at 6.8%. When looking at spending per beneficiary, Medicare spending increased the fastest at 7.2%, with spending on ambulatory care, pharmaceuticals, and emergency department care growing the fastest. Private insurance and Medicaid spending per beneficiary also increased dramatically, growing at 6.2% and 5.5% annually between 2010 and 2022.

Spending on substance use disorders significantly increased, especially in ambulatory care. Increased service price and intensity drove most of the spending growth. Spending on substance abuse disorders grew at 9.4% annually between 2010 and 2022. After adjusting for population size the growth rate was 8.3%.

Figure 14: **Age-standardized growth rate of spend per beneficiary for substance abuse disorders, 2010-2022**



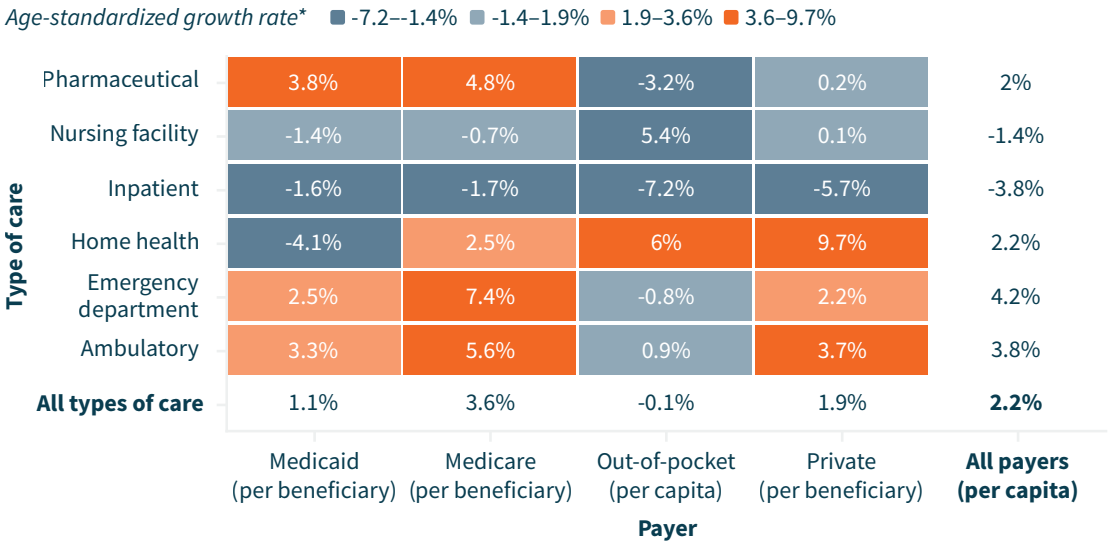
*Not adjusted for inflation

Source: IHME Disease Expenditure (DEX) estimates

Musculoskeletal disorders had the most spending in 2022 at $6.9 billion. Between 2010 and 2022, spending on this aggregate health condition increased by 1.9% annually (Figure 15). When assessing growth rates per covered beneficiary and adjusting for age, Medicare spending increased faster than other payers at 3.6% annually. Across all payers, emergency department and ambulatory care increased at the fastest rates. Spending increased the most because of increases in service price and intensity (Figure 17).

Across nearly all types of care for musculoskeletal disorders and cancers, we see a decrease in service utilization, except in emergency department visits for musculoskeletal disorders. Spending on musculoskeletal disorders grew at 4.4% annually between 2010 and 2022. After adjusting for population it grew at a rate of 2.2%.

Figure 15: Age-standardized growth rate of spend per beneficiary for musculoskeletal disorders, 2010-2022



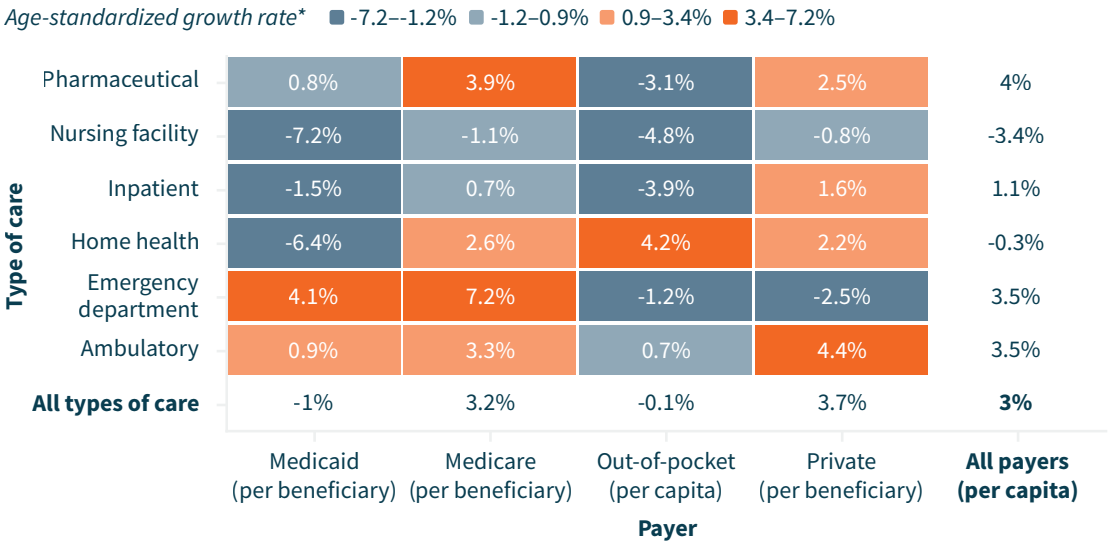
*Not adjusted for inflation

Source: IHME Disease Expenditure (DEX) estimates

All cancers combined led to $6.3 billion of spending in Washington in 2022. Between 2010 and 2022, spending on cancers grew by 3% annually (Figure 16). When assessing spending per beneficiary, spending growth was concentrated in private insurance and Medicare, which grew at 3.7% and 3.2% annually. Across all payers, pharmaceutical spending increased the fastest at 4% annually. A great deal of the spending increases were driven by increases in service price and intensity (Figure 17).

Cancers had an annualized growth rate of 5.6%. After adjusting for population size, the the growth rate was 3%. The spending growth mostly occurred in ambulatory care, emergency department care, and pharmaceuticals, driven primarily by increased service

Figure 16: Age-standardized growth rate of spend per beneficiary for cancers, 2010-2022



*Not adjusted for inflation

Source: IHME Disease Expenditure (DEX) estimates

Figure 17: Drivers of spending change across four selected health conditions, 2010-22

Source: *IHME Disease Expenditure (DEX) estimates*

Data summary

Healthcare spending variation within Washington

Variation across Washington counties highlights the local nature of health care. We can identify “exemplar” counties that are low total spend and low spending growth for further investigation about best practices.

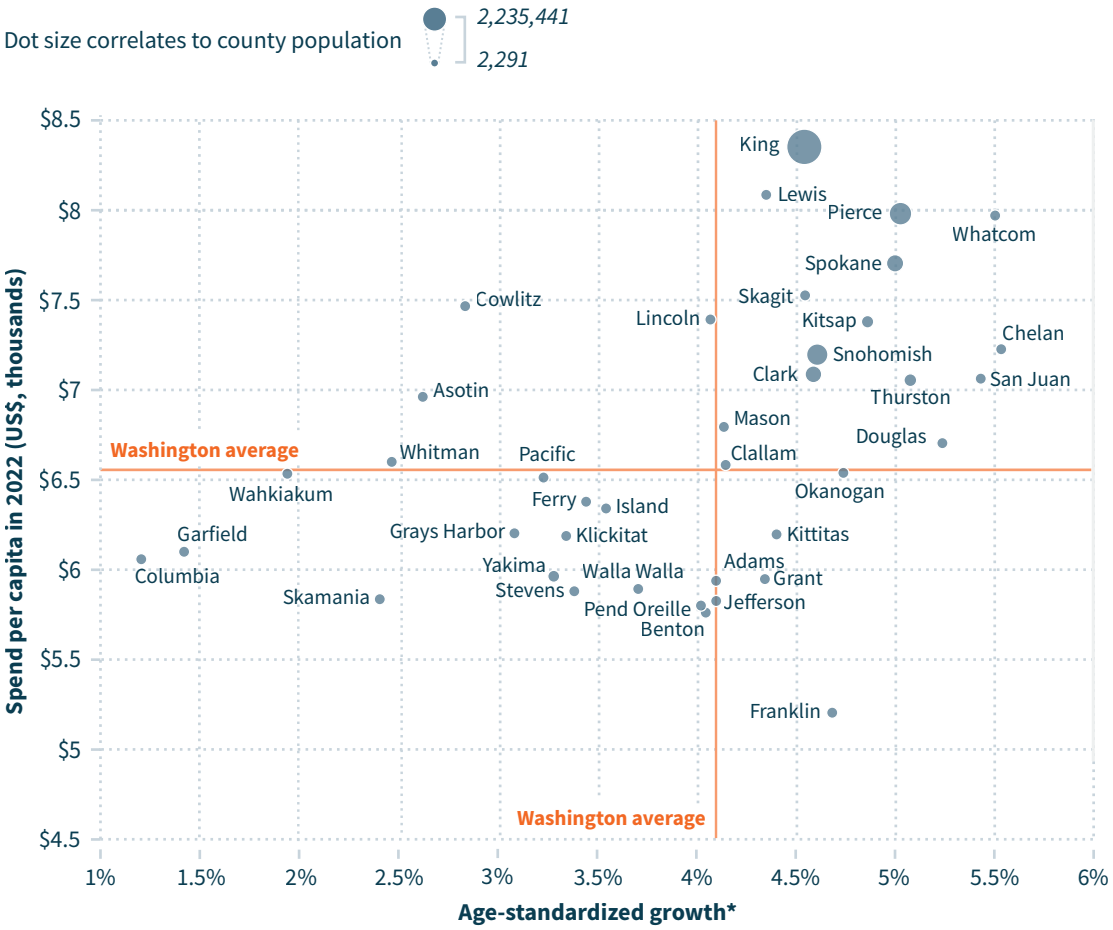
While expenditure distribution can vary by county, type of care, and payer – there appear to be consistent clustering patterns across counties which validate a need to further examine price/intensity in certain sites of care, or scale up supply/access to meet growing demand.

Key takeaways

- Health care spending varies dramatically throughout Washington state and spending varied dramatically for each payer category.

The DEX project shows that health care spending varies dramatically throughout Washington state. In 2022 the counties with the largest spending per person were San Juan County, Lewis County, and Lincoln County with $8,152, $7,748, and $7,584 health spending per person. On the other hand, Franklin County, Adams County, and Yakima County were the counties with the smallest spending per person with $3,815, $4,406, and $4,898 of health spending respectively.

Figure 18: **Health care spending per person versus growth rate by county, 2010 to 2022**



*Not adjusted for inflation

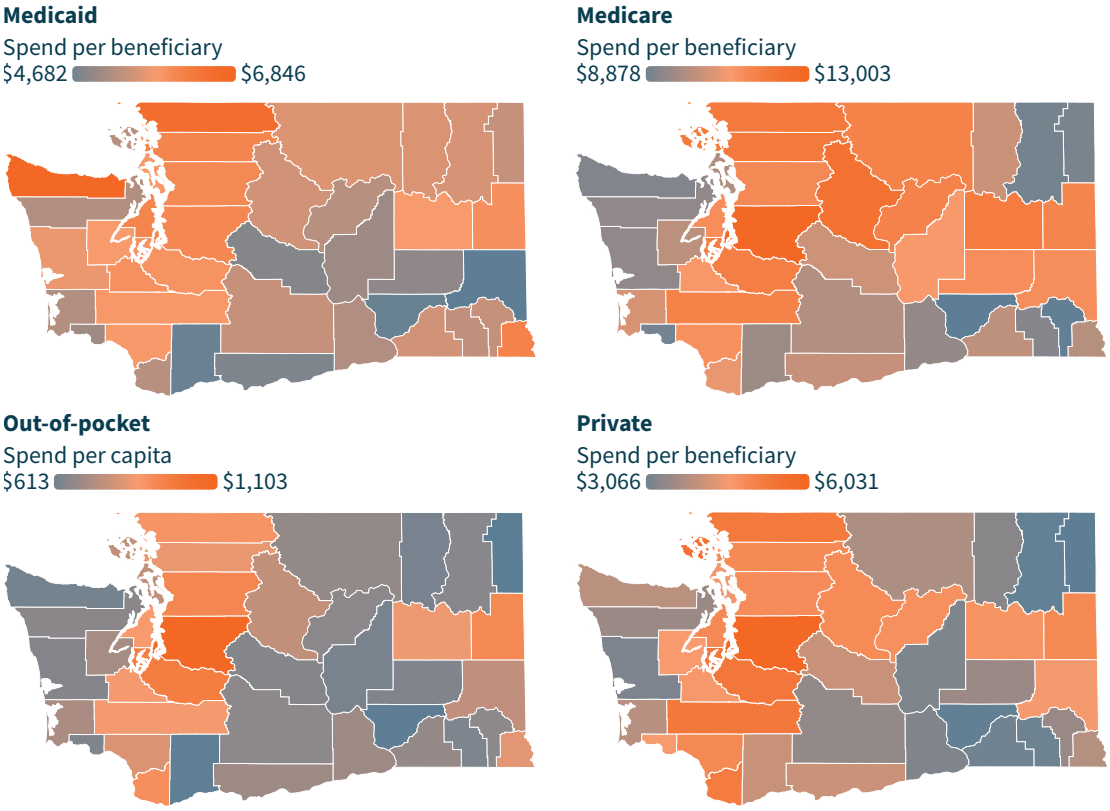
Source: IHME Disease Expenditure (DEX) estimates

When age-standardized, Franklin, Benton, and Pend Oreille County had the lowest spending per capita, with King and Lewis County having the highest spending per capita. Chelan County had the largest growth rate in 2022 (Figure 18).

The DEX project showed that spending varied dramatically for each payer category (Figure 20) and for each type of care (Figure 21). Differences in growth drivers are explained in Figure 21, which highlights the effect of drivers on each county's change in spending from 2010 – 2022.

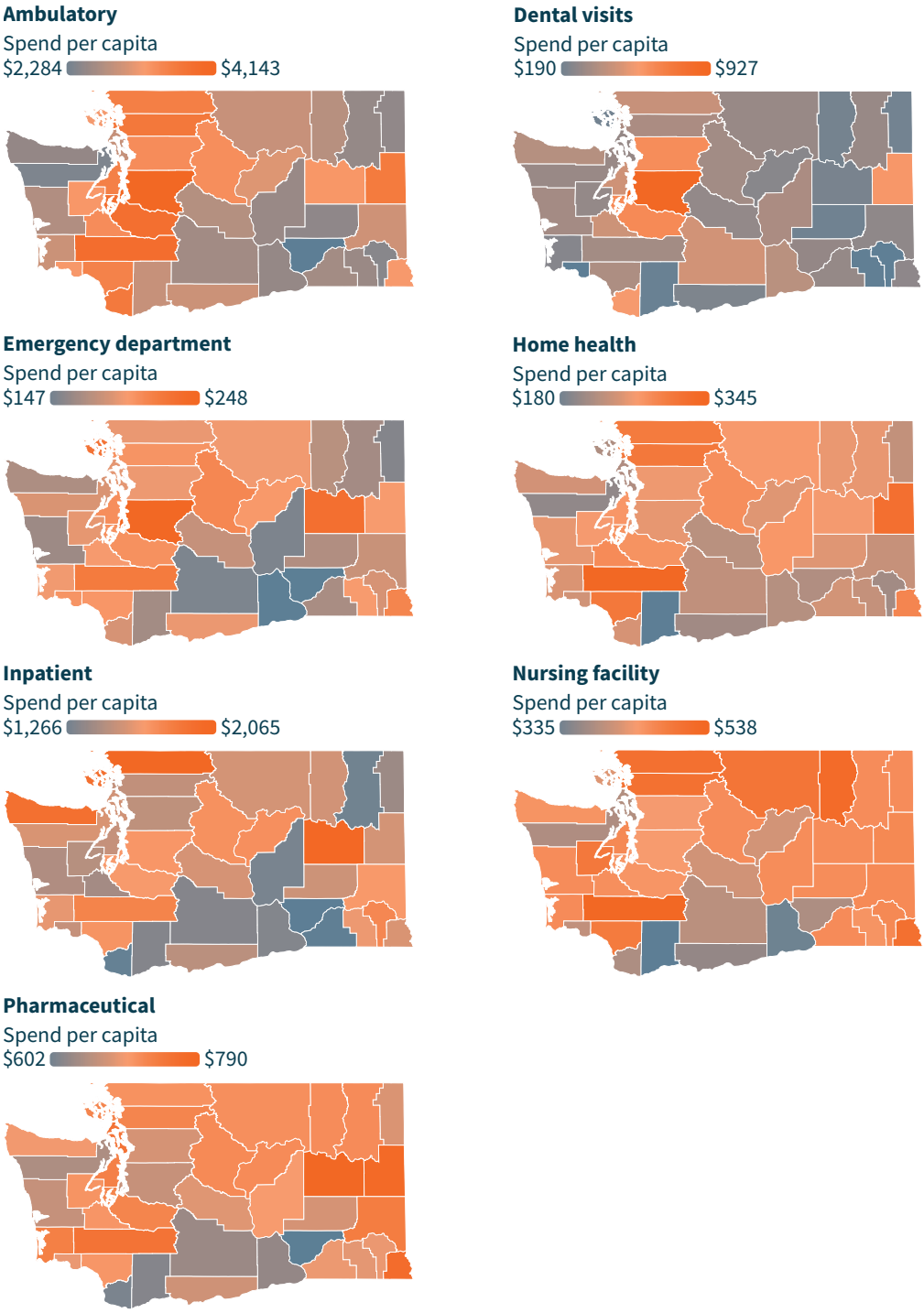
Health care spending varies dramatically throughout Washington state and spending varied dramatically for each payer category.

Figure 19: Age-standardized spending per beneficiary by payer, 2022



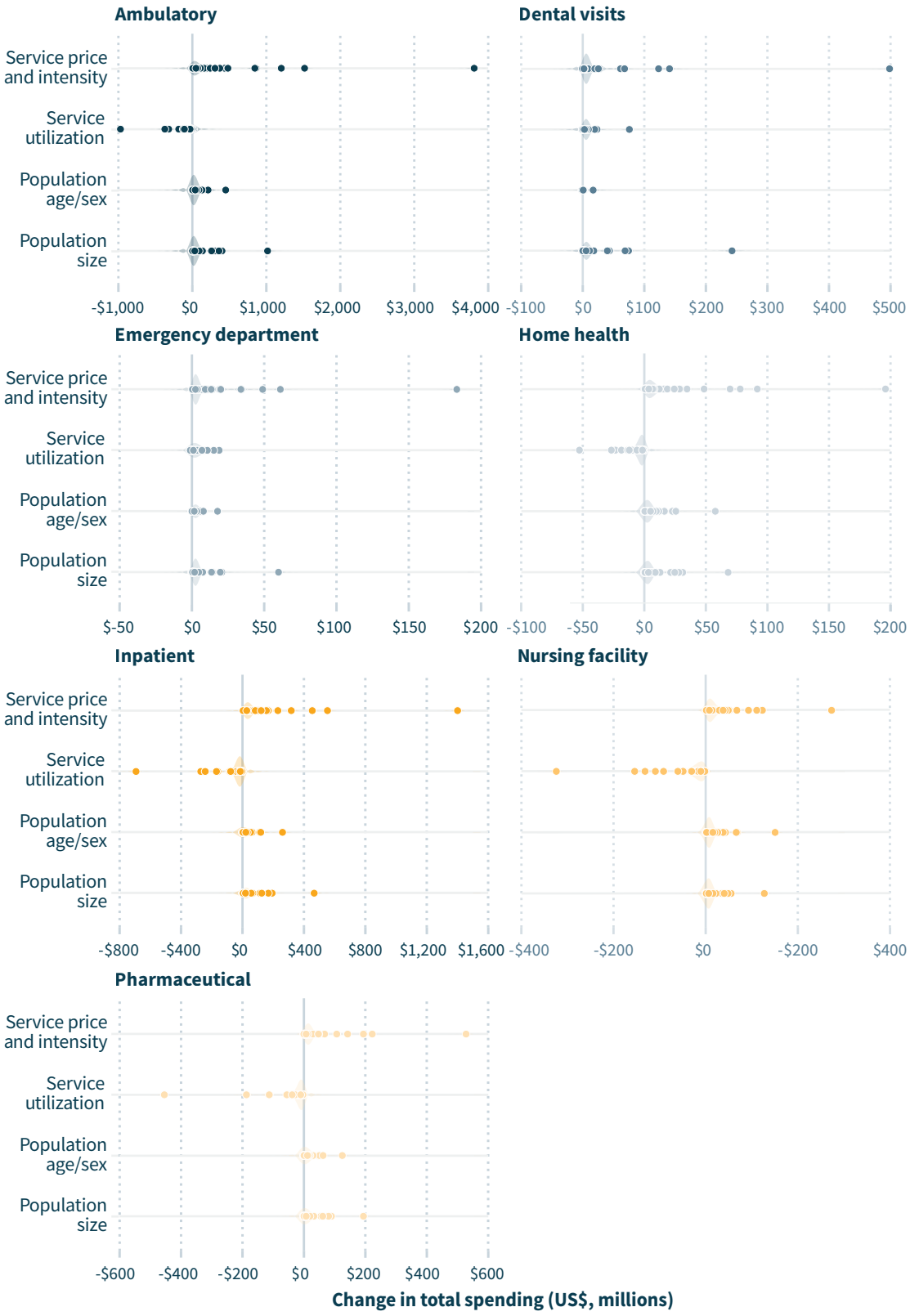
Source: IHME Disease Expenditure (DEX) estimates

Figure 20: Age-standardized spending per person by type of care, 2022



Source: *IHME Disease Expenditure (DEX) estimates*

Figure 21: Drivers of spending growth in Washington state counties, 2010-2022



Source: IHME Disease Expenditure (DEX) estimates

Washington State Health Care Authority

ASI Expenditures Report

Cherry Street Plaza 626 8th Avenue SE
Olympia, WA 98501

Appendix C: Best practices report

HMA

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State Health Care Cost Growth Programs' Infrastructure: Study of Best Practices

November 26, 2024

Table of Contents

EXECUTIVE SUMMARY

A recent budget proviso directed the Washington State Health Care Cost Transparency Board (Cost Board) to study the best practices other states have applied to establish the infrastructure for health care cost growth programs, including the scope, financing, staffing, and agency structure of such programs.[1] To assist in this process, the Health Care Authority (HCA)—the agency in which the Cost Board is housed—partnered with Health Management Associates, Inc. (HMA), a national consulting and research firm, to research similar programs in other states for the Cost Board and the HCA.

This report offers an overview of the eight states with active cost growth benchmark programs, describing how they were established, the scope of their authority, and their governance structure. After reviewing publicly available information on the experiences in these eight states, four were chosen for closer analysis—California, Massachusetts, Oregon, and Rhode Island. Information on these four states was gathered through interviews with program leaders. These states were selected because they represent a range of different approaches and exemplify best practices in carrying out the core functions of these programs, including:

- Authority to collect and use data to monitor health system spending trends
- Establishment of a growth target against which to measure spending trends
- Collecting and tracking health care expenditures
- Data and analytic capacity to support data analysis, reporting, and use cases
- Data use strategy to advance state strategies

[1] State of Washington. Sec. 211(85)(b) of Engrossed Substitute Senate Bill 5950: Washington State 2023 – 2025 Supplemental Operating Budget. Effective July 1, 2024. Available at: https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5950-S.SL.pdf?q=20241023143552.

The report then highlights best practices from these four states and concludes with a series of questions for Washington policymakers to consider as they define the goals of the Cost Board and determine which best practices are most applicable going forward, including:

- If policymakers **want the Cost Board to be better equipped to identify the drivers of health care costs, analyze and report on the financial performance of payers and providers, and study the impacts of health care consolidation, they might** look to the Massachusetts Center for Health Information and Analysis (CHIA) for the benefits of centralizing data collection, analysis, and reporting within a single entity
- If policymakers **conclude that giving the Cost Board enforcement authority is necessary to contain costs**, California, Massachusetts, and Oregon provide models for how that work might be done
- If policymakers would like to better **understand the impact of mergers, acquisitions, private equity investment** and other transactions causing material changes in ownership of health care entities on costs, access, quality, and equity, California, Massachusetts and Oregon provide models, with the Oregon Health Authority having the greatest authority prohibit transactions under certain circumstances
- If Washington determines that **policies that directly affect prices charged for health care services are needed to mitigate the increase in health care spending**, Cascade Care Select, Oregon and Rhode Island provide examples of such policies

Finally, the report underscores that whether the charge of the Health Care Cost Transparency Board remains unchanged or is expanded over time, it is essential that the board have adequate funding and staff to accomplish its mission.

It is important to recognize that the results achieved by cost growth benchmark programs are somewhat inconclusive. In some years, the targets have been met, while in other years they have fallen short of expectations. In addition, the COVID pandemic had a significant impact on health care utilization, initially leading to reduced health care utilization but then to increased use and inflation. Some of these cost growth programs are quite young, and it is too soon to assess their impact on mitigating cost growth. Nevertheless, these best practices warrant the consideration of Washington State policymakers.

INTRODUCTION

Recognizing the unchecked growth in health care costs and the impact on individual Washingtonians and the state budget, in 2020, state policymakers passed House Bill (HB) 2457, establishing the Health Care Cost Transparency Board (Cost Board).[2] Funds were allocated to the Washington State Health Care Authority (HCA) to establish and staff the Cost Board, providing funding for two positions initially and growing to five positions in fiscal year (FY) 2024. Two new positions were funded for FY 2025 for IT and data support which the state is in the process of filling.

The Cost Board was charged with the following key tasks:

- Establish the health care cost growth benchmark and determine the data necessary to annually calculate total health care expenditures and cost growth
- Annually compare health care cost growth performance against the benchmark
- Analyze the impacts of cost drivers in health care, incorporate this analysis into determining the annual total health care expenditures, and establish the annual health care cost growth benchmark[3]

BUDGET PROVISION FOR BEST PRACTICES STUDY

(i) ...Best practices from other states regarding the infrastructure of state health care cost growth programs, including the scope, financing, staffing, and agency structure of such programs.

(ii) The board may conduct all or part of the study through the authority, by contract with a private entity, or by arrangement with another state agency conducting related work.

(iii) The study, as well as any recommendations for changes to the health care cost transparency board arising from the study, must be submitted by the board as part of the annual report required under RCW 70.390.070, no later than December 1, 2024.

[2] State of Washington Legislature. Second Substitute House Bill 2457: Health Care Cost Transparency Board. Effective June 11, 2020. Available at: https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/2457-S2.SL.pdf?q=20210212125253

[3] Ibid.

In 2024, legislation added further responsibilities for the Cost Board, including:

- Conducting a biennial survey of underinsurance in the state
- Conducting a biennial survey of insurance trends among employers and employees
- Holding an annual public hearing about the findings of the Cost Board focused on the growth in total health care expenditures in relation to the health care cost growth benchmark that identifies payers or large providers (i.e., those serving more than 10,000 individuals) that exceeded the health care cost growth benchmark[4]

Also in 2024, a budget proviso directed the Cost Board to study best practices from other states regarding the infrastructure of state health care cost growth programs, including the scope, financing, staffing, and agency structure of such programs.[5] To assist in this process, HCA partnered with Health Management Associates, Inc. (HMA), a national consulting and research firm, to study other similar programs in other states.

HMA conducted an environmental scan of states that have initiated health care cost growth programs and identified four states for more detailed survey and participation in semi-structured interviews to further understand their programs, structure, scope, financing, and staffing. Comparisons with Washington State's current efforts and recommendations were developed and are provided in this report. The study will be included in the 2024 legislative report about the Cost Board's findings and work to provide the legislature with more information specifically about the support necessary to further the work of the Cost Board going forward.

[4] Washington State Legislature. Second Engrossed Substitute House Bill 1580: Health Care Cost Transparency Board—Various Provisions. Effective June 6, 2024. Available at: https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/House/1508-S.SL.pdf?q=20241023175455.

[5] Washington State Legislature. Sec. 211(85)(b) of Engrossed Substitute Senate Bill 5950: Washington State 2023 – 2025 Supplemental Operating Budget. Effective March 29, 2024. Available at: https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5950-S.SL.pdf?q=20241023143552.

This report begins with an overview of the eight states with health cost growth benchmarking programs, describing the early results and lessons learned from these programs. This summary is followed by a more in-depth examination of programs in four states—California, Massachusetts, Oregon, and Rhode Island—with a focus on five common functions identified as part of these programs:

- 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 health care expenditures
- Data and analytic capacity to support data analysis, reporting, and use cases
- Data use strategy to advance state goals

Following the description of each of the four states and their approach to performing these functions, the report describes best practices for each of the five common functions that Washington might consider as it works to further the Cost Board's impact. The report concludes with a discussion of Washington policymakers' potential goals and which best practices are most likely to result in the outcomes they are seeking.

STATE COST GROWTH BENCHMARKING EFFORTS

According to The Health Affairs Council on Health Care Spending and Value, "Health care spending growth has far outpaced growth in the US economy. Between 1970 and 2019 alone, total US health care spending grew from 6.9 percent to 17.7 percent of [the gross domestic product]."[6] The council encourages states, with federal support, "to convene stakeholders… in the establishment, monitoring, and enforcement of spending growth targets that are calibrated to growth in the overall economy."[7] Unsustainable health care cost increases were the principle driver of cost growth benchmarking implementation, along with political support (e.g., governor, legislator, or health insurance commissioner as champion) and initial/start-up funding in the eight states that have implemented programs.

Massachusetts introduced the first cost growth benchmarking program in the country, starting in 2012 with annual reporting, public hearing processes, and stakeholder engagement to inform policy interventions. It is now one of the most expansive programs in the nation. Delaware, in 2018, and Rhode Island, in 2019, both used executive orders to initiate programs that are more streamlined than Massachusetts. Rhode Island received support from the Peterson-Milbank Program for Sustainable Health Care Costs, as did four other states that have initiated programs since 2019—Oregon in 2019, Connecticut and Washington in 2020, and New Jersey in 2021.[8] California passed legislation in 2022 to initiate its cost growth benchmarking program. A ninth state, Nevada, initiated efforts by executive order in 2021, but the current governor opposes them, so the initiative was discontinued in 2023. Information about each of the active state programs is included in Appendix B at the end of this report. Most states have looked to Massachusetts as the model given that it is the state with the most experience, with each state adjusting its approach to meet its individual needs and its specific charge. States have established independent commissions or have increased the authority of an existing regulatory body to set the cost growth targets. The methodology used to establish targets varies somewhat, but the targets that have been set are in a similar range.[9]

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[6] Health Affairs Council on Health Care Spending and Value. A Road Map for Action: Recommendations of the Health Affairs Council on Health Care Spending and Value. February 2023. Available at: https://www.healthaffairs.org/pb-assets/documents/CHS_Report/CHS_Report_2022_R5-1675432678.pdf.

[7] Ibid.

[8] Ario JS, McAvey KC, Zhan A. State Benchmarking Models – Promising Practices to Understand and Address Health Care Cost Growth. Manatt. June 17, 2021. Available at: State Benchmarking Models: Promising Practices to Understand and Address Health Care Cost Growth - Manatt, Phelps & Phillips, LLP.

[9] Ibid.

Most of these states have worked closely with their all-payer claims databases (APCDs). States without an APCD use available claims data from public programs such as Medicaid and state employee health benefit programs. Other data sources used include available data for the state to examine health care spending by market, geography, health condition, and demographics.[10]

States have varying capacities and approaches to gathering and analyzing data to obtain a more comprehensive view of health care spending and the drivers of health care cost growth. For example, some states have focused on gathering data on primary care and behavioral health spending. Some states assess cost drivers such as provider consolidation, prescription drug spending, and differences in cost depending on site of care and other market trends that affect health care costs.

Having significant analytics capacity is needed. This capacity can come in many forms; as part of the program staffing, through the support of vendors (including university partners and consultants), or a combination of both. Furthermore, resources are needed to ensure stakeholder and public engagement, data collection, and a data analytics infrastructure is built to launch the initiative and maintain the program.

Benchmarking programs in several of the states are being established alongside other cost-containment initiatives in areas such as drug and hospital pricing and antitrust enforcement. Engagement of parties involved in these activities provides an opportunity to leverage their understanding of spending trends and offers additional opportunities for gathering information and addressing a wide range of cost-related challenges.

Consolidation in the health care industry has been linked to increased patient prices without improvements in the quality of care and impacts on health care labor markets, such as suppressed wage growth for health care workers and degrading working conditions.[11] Concerns about the effects of horizontal consolidation, vertical integration, and private equity investment on the health care system have led some states to give the administrators of cost growth benchmark programs authority to review certain transactions that cause material changes in ownership of health care entities. Washington's Cost Board lacks such authority.

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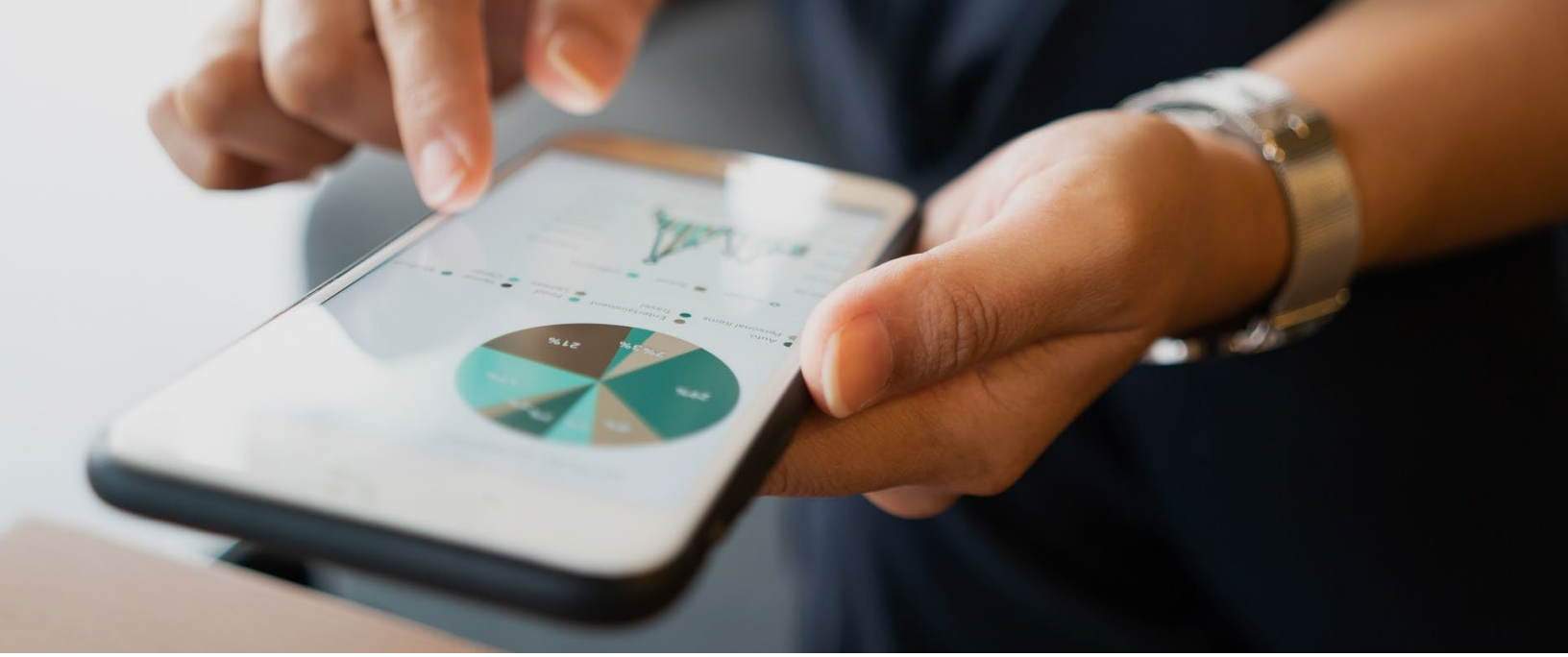
[10] The Commonwealth Fund. Implement a Health Care Cost Growth Target—Cost Driver Targeted: Global Spending. *Profiles of Cost Containment Strategies*. February 2022. Available at: https://www.commonwealthfund.org/sites/default/files/2022-02/Hwang_health_care_cost_growth_strategy_01_target.pdf.

[11] Washington Office of the Attorney General. Preliminary Report: Health Care Affordability. 2023. Available at: https://agportal-s3bucket.s3.us-west-2.amazonaws.com/uploadedfiles/AGO_Healthcare%20Affordability%20Preliminary%20Report.pdf.



As the state's attorney general (AG) reported in 2023, Washington does require advance notice of certain transactions, and the attorney general has authority to review transactions for anticompetitive impacts; however, neither the attorney general nor the Cost Board has authority to review their influence on affordability, access, quality, or equity.[12] A chart describing states' authority to conduct market oversight is provided in Appendix D.

HMA chose four states for more detailed examination in this report: California, Massachusetts, Oregon, and Rhode Island. These states represent differences in infrastructure, strategies to gather and analyze data, authority, and resources, collectively providing insights for Washington's consideration as the state moves toward implementation of a successful cost growth benchmarking program. HMA administered a survey and/or interviewed the leadership of these four state programs to better understand what is necessary to implement and run these programs. Specifically, the questions assessed the structure, staffing, and support needed to implement a cost growth benchmark program. If the state also has programs focused on business oversight or other health care affordability programs, HMA sought to determine the structure, staffing, and support of those programs as well.

An overview of the infrastructure of each of the four state programs is summarized below in Table 1. A description of how each of the four states addresses the key topics common to the establishment and functioning of their programs follows. Also provided is a description of the status of Washington's initiative.

[12] Ibid.

Table 1. Cost Growth Benchmarking Programs and Responsible State Agencies

State	Public Body Involved in Cost Growth Benchmark	State Agency Responsible for the Program and Its Structure	New or Existing Entity? How Established?
WA	Washington Health Care Cost Transparency Board Health Care Stakeholders Committee Data Issues Committee Primary Care Committee	Washington Health Care Authority	New program inside the Health Care Authority (HCA), established legislatively
CA	Health Care Affordability Board (HCAB) Advisory Committee with multiple workgroups	California Office of Health Care Affordability Located in the Department of Health Care Access and Information (HCAI) within the larger California Health and Human Services Agency, which also includes Medicaid, Public Health, Aging, Social Services, Behavioral Health, and other services	New office created within an existing health agency structure Established legislatively
MA	Health Policy Commission (HPC) Board of Commissioners	HPC	New agency, established legislatively
OR	Cost Growth Target Advisory Committee Cost Growth Target Technical Advisory Group (TAG)	Cost Growth Target Program, in Health Policy and Analytics division of the Oregon Health Authority, which includes Medicaid, Public Employees Benefit Board, Public Health, Behavioral Health	New programs created inside existing health agency structure, established legislatively
RI	Rhode Island Health Spending Accountability and Transparency Program Steering Committee with workgroups	Health Spending Accountability and Transparency Program in the Office of the Health Insurance Commission	New program inside insurance regulation agency, established by executive order

A more comprehensive description of each state's cost growth benchmark programs is contained in Appendix C, including individual authorities, progress to date since implementation of the program, and details on staffing, consulting service needs, and any future needs identified as necessary by state officials to sustain the programs.

California

California established the Office of Health Care Affordability (OHCA) through legislation enacted in 2022. OHCA is an office within the Department of Health Care Access and Information (HCAI) and the state's Health and Human Services Agency. HCAI is responsible for managing the state's health care payments database and for gathering and analyzing data regarding health care facilities and workforce. OHCA established its first cost growth targets in 2024.

Governance

- OHCA's Health Care Affordability Board (HCAB) has specific, limited authority. It must approve the following:
    - Setting cost growth targets, including the methodology for setting cost targets, and adjustment factors to modify cost targets when appropriate
    - The scope and range of administrative penalties and the penalty justification factors for assessing penalties
    - The benchmarks for primary care and behavioral health spending
    - The statewide goals for the adoption of alternative payment models (APMs) and standards that may be used between payers and providers during contracting
    - The standards to advance the stability of the health care workforce that may apply in the approval of performance improvement plans
- The board advises the office on other aspects of the program, such as collection, analysis and reporting of data, factors that influence health care cost growth, and strategies to improve affordability.

- The members of the HCAB include the state's Secretary of Health and Human Services and the Medical Director of CalPERS, which administers the state public employee health plan (both non-voting); and four members appointed by the governor and one each by the state Senate and Assembly.
- OHCA appoints members of an Advisory Committee of stakeholders that may make recommendations but has no decision-making authority.

Data

- As OHCA's parent agency, HCAI is responsible for the state's APCD and for gathering, analyzing, and reporting other data from health care providers.

Enforcement of cost growth targets

- OHCA has authority to enforce compliance through progressive methods including technical assistance, performance improvement plans, and civil penalties.

Market oversight

- OHCA has the authority to conduct market oversight by conducting cost and market impact reviews of proposed transactions that meet specific criteria for their impacts on competition, prices, access, quality and equity. It reports its findings and can refer proposed transactions to the attorney general. It does not have authority to prohibit proposed transactions.[13] The attorney general has broad authority to prohibit transactions involving nonprofit entities under a public interest standard; its authority over transactions involving for-profit entities is limited to traditional antitrust analysis.[14]

[13] California Department of Health Care Access and Information. Introduction to OHCA. 2024. Available at: https://hcai.ca.gov/affordability/ohca/.

[14] Chang SM, Gudiksen KL, Greaney TL, King JS. Examining the Authority of California's Attorney General in Health Care Mergers. California Health Care Foundation. April 2020. Available at: https://www.chcf.org/wp-content/uploads/2020/04/ExaminingAuthorityCAAttorneyGeneralHealthCareMergers.pdf.

Funding

- OHCA's work has been one of Governor Newsom's priorities. It has an ongoing appropriation of approximately $22 million to fund 80 positions annually. More than half of this budget is for the market oversight program within OHCA and supports the high value/quality arm of their work.
- Funding is through the state's general fund.

Massachusetts

Massachusetts has the longest experience in implementing a cost growth benchmark program. The legislature established the Health Policy Council (HPC) in 2012 as a new state agency and established its first cost growth targets in that year. Massachusetts is unique in having a separate state agency responsible for gathering, analyzing, and reporting on data pertaining to the health care system.

Governance

- HPC is responsible for setting cost growth targets and for all aspects of the cost growth benchmark program.
- HPC's members are appointed by the governor, attorney general and State Auditor and must have demonstrated expertise in specified aspects of health care management, delivery, finance, purchasing, workforce, innovation, behavioral health, economics, or consumer advocacy.[15]
- The Governor appoints members of the HPC Advisory Council, a group of health care leaders who meet quarterly to advise HPC's work.[16]

[15] Massachusetts Health Policy Commission. Meet the Board. 2024. Available at: https://masshpc.gov/about/board.

[16] Massachusetts Health Policy Commission. HPC Advisory Council Membership. 2024. Available at: https://masshpc.gov/about/council.

Data

- The Massachusetts legislature established the Center for Health Information and Analysis (CHIA), which is responsible for the state's APCD and for gathering, analyzing, and reporting on a range of data relating to the health care system. The executive director of CHIA is appointed by a majority vote of the governor, attorney general, and state auditor.

Enforcement of cost growth targets

- HPC has authority to enforce compliance with targets by requiring adoption and implementation of performance improvement plans (PIPs) and by imposing civil penalties.

Market oversight

- HPC has authority to administer market oversight by conducting cost and market impact reviews of proposed transactions that meet specified criteria. It publishes the results of those reviews and can refer proposed transactions to the state's attorney general. The program does not have the authority to prohibit proposed transactions. The attorney general's office may consider possible further action on behalf of health care consumers but does not have the power to block or modify a transaction beyond its existing antitrust authority.

Funding

- Funding for the HPC and its work is drawn from an annual assessment on acute care hospitals and health system providers, ambulatory surgery centers, and surcharge payers such as third-party administrators.
- The HPC's budget is approximately $12 million, and CHIA's is approximately $30 million.
- HPC uses 70 percent of its budget for internal positions serving the cost growth program, the market oversight program, and overall operations, with approximately 30 percent available for outside consulting services.

Oregon

Oregon's legislature established the Sustainable Cost Growth Target Program in 2019 and 2021. The program operates under the purview of the Health Policy and Analytics Division of the Oregon Health Authority (OHA), which administers the state's Medicaid program, its public employee and teacher health plans, and other health care programs and services. OHA also manages the state's All Payer All Claims database.

Governance

- All aspects of implementation of the program are carried out by OHA, which is a component of the executive branch.
- The Cost Growth Advisory Committee, advises and makes recommendations to the OHA, but has no decision-making authority. Its members are selected to represent various sectors in the health care industry, to have expertise on topics relevant to the work of the program and to reflect the diversity of the state's population.

Data

- Administration of the APCD and other data gathering relevant to the program is carried out by OHA.

Authority to enforce cost growth targets

- OHA has authority to enforce cost growth targets by imposing PIPs and financial penalties.[17]

Market oversight

- Through its Health Care Market Oversight Program, OHA has authority to conduct cost and market impact reviews of proposed transactions that meet specific criteria. It publishes the results of those reviews and may approve, approve with conditions, or prohibit proposed transactions.

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[17] As an additional state policy to control health care costs the Oregon legislature has imposed a cap on reimbursement rates to hospitals that provide services to members of the public employee and teachers' health plans. Source: Murray RC, Whaley CM, Fuse Brown EC, Ryan AM. How Payment Caps Can Reduce Hospital Prices and Spending: Lessons from the Oregon State Employee Plan. Milbank Memorial Fund. July 10, 2024. Available at: https://www.milbank.org/publications/how-payment-caps-can-reduce-hospital-prices-and-spending-lessons-from-the-oregon-state-employee-plan/.

Funding

- The Cost Growth Target Program has approximately $2 million in funding for eight positions, including an economist, policy analyst, research analyst, and actuary and administrative staff. Most of the funding is from the state general fund, with a small amount of federal funds matching costs for two positions. The initial biennial funding was for staffing with no dedicated funding for contractors.
- The Health Care Market Oversight Program was budgeted for initial general fund start-up dollars of approximately $1 million to support staffing, with the expectation that fees collected from the entities involved in the full cost and market impact reviews of the transactions would cover the costs of the program going forward. The program is examining its ongoing funding needs as the current fees structure may be inadequate to cover all the statutorily required work.

Rhode Island

Rhode Island's cost growth benchmark program is unique in having been first established through a voluntary commitment by a group of stakeholders. In 2018, the Health Care Cost Trends Steering Committee, a group of health care leaders appointed by the governor and the Office of the Health Insurance Commissioner, executed the Compact to Reduce Growth in Health Care Costs and State Health Care Spending in Rhode Island. The compact is a voluntary commitment by health care stakeholders to keep cost growth below a target at the organizational level and state level while maintaining or improving quality and access.[18] Subsequently, the Health Spending Accountability and Transparency Program was established within the Office of the Health Insurance Commissioner (OHIC) by executive order in 2022.[19] A second compact was entered into in 2022; it will expire in 2027.

[18] Rhode Island Health Care Cost Trends Sterring Committee. Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island. December 19, 2018. Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/cost-trends-project/Compact-to-Reduce-the-Growth-in-Health-Care-Costs-and-State-Health-Care-Spending-in-RI.pdf.

[19] Rhode Island Governor's Office. Rhode Island Executive Order No. 19-03. February 6, 2019. Available at: https://governor.ri.gov/newsroom/orders/.

Governance

- The OHIC administers the program.
- The Health Care Cost Transparency Committee sets growth targets, representing a voluntary commitment from stakeholders to work to achieve the spending threshold.

Data

- Rhode Island's APCD is administered as a collaborative effort among the Department of Health, the OHIC, the Executive Office of Health and Human Services, and HealthSource RI—the state's Affordable Care Act marketplace.

Authority to enforce cost growth benchmarks

- OHIC lacks the authority to enforce the cost growth benchmarks; however, as discussed below, OHIC has used its rate review authority to set affordability standards, including a cap on reimbursement rates that insurers may pay to hospitals. Notably, unlike Washington, Rhode Island's OHIC has rate review authority over fully insured large group plans.

Market oversight

- OHIC does not have authority to review proposed health care market transactions.

Funding

- Initial funding was through a public-private partnership from the Peterson Center on Healthcare and the OHIC.
- Over the past few years, the program has had a legislatively approved budget of $500,000 and has used $1 million in funding for the state's Office of Health and Human Services for data collection and analysis using the state's APCD for an overall budget totaling approximately $1.5 million.

BEST PRACTICES

The following section describes best practices in the cost growth benchmark programs in California, Massachusetts, Oregon, and Rhode Island. These best practices are worth considering depending on Washington's policy goals and its objectives for the future role of the Health Care Cost Transparency Board. This section is organized by subject matter topics: governance; data collection, analysis, and reporting; authority to enforce cost growth benchmarks; market oversight; sources of funding.

Governance

The cost growth benchmark programs in the four states that are the focus of this report differ with respect to the sources of their authority (legislation or executive order); where they sit in state government (as a program within an existing state agency, a new office within an existing state agency, or a new state agency); and to some degree, where the decision-making authority lies. Table 2 provides a summary by state.

Table 2. Comparison of Governance Structures and Authority Across the Four States and Washington

State	Program Location and Decision-Making Authority
Washington	A new, independent board staffed by an existing state agency (HCA)
California	A new office within an existing state agency, with an oversight board with express, limited authority provided in statute
Massachusetts	A new state agency governed by a board independent of other executive branch agencies, with a separate new, independent agency with responsibility for gathering, analyzing, and reporting on data
Oregon	A program within an existing state agency, with an advisory board without any decision-making authority
Rhode Island	A program within an existing state agency, created by executive order and dependent on a voluntary compact with stakeholders

These different structures developed more as a reflection of the political process that led to creation of these programs rather than a desire to create a structure most likely to aid in their success. Each structure has trade-offs; some structures may enable the program to be more efficient in carrying out the functions described in this report. In general, it is important to consider the political environment in the state and the structure that will enable the program to have the most credibility and buy-in from stakeholders and the public.

Of all the states that HMA reviewed, Massachusetts offers the best example of robust program that is equipped to address the growth of health care costs and not just measure them—an unsurprising finding given that it is the most mature program in the country. Most importantly, in addition to providing transparency and the staff support to manage complex data analysis, detailed tracking of provider performance year-over-year, analytic support for policymakers, CHIA has the expertise and resources to couple its enforcement responsibilities with expertise to support policy development and delivery system transformation activities that can help providers meet established benchmarks and improve affordability.

Data Collection, Analysis, and Reporting

Each state's cost growth benchmark program collects, analyzes, and reports on data related to the cost of health care. Several factors influence each state's capacity to obtain a comprehensive view of the drivers of cost growth, including the existing data infrastructure; the authority that the state has to collect data (i.e., whether authority is given to the cost growth program or to other state agencies); and the staff and funding available to analyze data.

The methodologies selected to set cost growth targets have not been tied to historical data on health care expenditures. The metrics used to set the targets have been general measures of growth in the economy as a whole; in every state other than California, targets have been based on measures such as anticipated growth in gross domestic state product and consumer prices. California chose growth in household income. Data reflecting growth in health care costs has been used to determine compliance with cost growth targets and to analyze drivers of cost growth and is essential to developing policies to mitigate increases in health care spending.

Washington's data strategy has been largely determined through legislative direction and has been directed toward the following activities: establishing a cost growth benchmark, measuring performance against the benchmark, conducting cost driver analysis, and evaluating primary care spending. In addition, the Cost Board has conducted a hospital spending assessment, which offers a deep dive into hospital expenditures.

This evaluation benchmarks Washington hospitals' prices and efficiency metrics against similar hospitals in other states and includes an analytic support initiative in partnership with the Institute for Health Metrics and Evaluation at the University of Washington, with funding support from Peterson Health Care Foundation and the Gates Foundation. The assessment also focuses on health care spending estimates broken down by demographics, health condition, and over time.

The data to support these activities has largely come from the state's APCD, which includes claims data that represents approximately 4 million individuals, out of the state population of approximately 7.5 million, across Medicaid managed care, Medicare, Medicare Advantage, fully-insured employer, Public Employees Benefits Board, and the Health Benefit Exchange markets.[20] Another source of data has come from the Cost Board's call to carriers and providers for information about health care expenditures.

The Department of Health (DOH) collects information about ownership and licensure for health care facilities and health professional licensure. DOH also operates the Comprehensive Hospital Abstract Reporting System, which is used to identify and analyze trends in hospitalizations, compare hospital stays across the state, and identify issues with healthcare access, quality, and cost containment. In addition, DOH also collects data from hospitals and emergency medical services on hospital discharges, financial reports, charity care, and adverse events—additional information that might offer more insights about cost drivers and performance against the state benchmarks.

The Office of the Insurance Commissioner collects financial reporting and ownership information from health insurance plans. The Office of Financial Management collects and analyzes data about the health care system, including workforce, utilization, and coverage to inform health policy development. The Department of Social and Health Services Research and Data Analysis provides data, analytics, and decision support tools (includes behavioral health, long term care and other health related social needs). Figure 1 provides a high level overview of the data about the health care system that is being collected by different state agencies.

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[20] Washington has two All-Payer Claims Databases—one administered by the Washington Health Alliance (WHA), a membership organization that comprises more than 150 employers, union trusts, health plans, hospitals and physician groups, government agencies, community-based organizations, educational institutions, and pharmaceutical companies. Member organizations share data with the WHA. A key difference between the WHA and HCA APCDs is that the former includes some self-funded insurers, whereas the state APCD includes Medicare data through an agreement with the Centers for Medicare & Medicaid Services.

Figure 1: Data Collected by Washington's State Agencies about the Health Care System

Department of Health

- Collects information about ownership and licensure of certain health care facilities and health professional licensure,
- Collects information through the Comprehensive Hospital Abstract Reporting System (CHARS)
- Collects Data from hospitals and Emergency Medical Services (EMS) on hospital discharges, financial reports, charity care, and adverse events.

Office of the Insurance Commissioner

- Collects financial reporting and ownership from health insurance plans

Office of the Attorney General

- If part of a merger, collects ownership information - primarily larger merger/acquisition transactions as reviews and/or pursues action

Office of Financial Management

- Collects and analyzes data about the health care system including workforce, utilization and coverage to inform health policy development.

Department of Social and Health Services Research and Data Analysis

- Provides data, analytics, and decision support tools (includes behavioral health, long term care and other health related social needs)

The Cost Board Data Advisory Committee has recognized some gaps in the data, particularly related to market oversight. This includes some information that is not collected at all. Specifically, the state does not require reporting of private equity purchases of health care entities, and closure or reduction in service lines as a result of mergers and acquisitions may not be reviewed except by the state attorney general. Moreover, such changes in service access do not always require prior notice or state approval.

Best Practice Highlight: Data — Massachusetts

Massachusetts stands out among all the states with cost growth benchmark programs for its unique and comprehensive approach to data collection and analysis. The state legislature created CHIA, "whose mission is to serve as a steward of Massachusetts health information to promote a more transparent and equitable health care system that effectively serves all residents of the Commonwealth." CHIA has an Oversight Council, members of which are appointed by the Governor, attorney general, and State Auditor.[21]

[21] Center for Health Information and Analysis. About the Agency. 2024. Available at: https://www.chiamass.gov/about-the-agency/.

CHIA's statutory duties are as follows:

- Collect, analyze, and disseminate health care information to assist in the formulation of health care policy and in the provision and purchase of health care services
- Analyze health care spending trends as they compare with the health care cost growth benchmarks
- Collect, analyze, and disseminate information regarding providers, provider organizations, and payers to increase the transparency and improve the functioning of the health care system
- Collaborate with other state agencies to collect and disseminate data concerning the cost, price, and functioning of the health care system in the Commonwealth and the health status of individuals
- Participate in and provide data and data analysis concerning health care provider and payer costs, prices, and cost trends
- Report comparative health care cost and quality information to consumers[22]

[22] Ibid.

CHIA collects data and publishes reports on a range of aspects of health care spending. Its annual report includes a calculation of total health care expenditures (THCE) and examines trends in costs, utilization, coverage, and quality indicators. Its 2023 report included a new chapter on health care affordability presenting a consumer-centric picture of rising health care costs and its downstream implications, as well as a section and interactive dashboard that provides comparative insights into how medical spending varies by community demographics.[23] CHIA's authority to collect data from payers, providers, and others is set forth in statute and in regulations promulgated by the agency.[24, 25] In addition to specific reporting requirements established by the legislature, CHIA "may require in writing, at any time, additional information reasonable and necessary to determine the financial condition, organizational structure, business practices, or market share of a registered provider organization."[26]

In addition to its annual report, CHIA has published information on topics including APMs, premiums and member cost sharing in commercial insurance, enrollment trends, hospital financial performance, hospital readmissions, and relative price/price variation.[27]

CHIA has received adequate funding to perform its mission; a portion of that funding is provided by an assessment on acute care hospitals, ambulatory surgery centers, and surcharge payers such as third-party administrators.[28] Funding to CHIA supports approximately 60 staff, many of whom work closely with the HPC. CHIA also has funding for any needed consulting. The HPC has staff 60 to 65 staff positions, some of whom collaborate with CHIA staff for data analysis. The HPC also uses its funds for consulting services.

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[23] Center for Health Information and Analysis. Annual Report on the Performance of the Massachusetts Health Care System. March 2024. Available at: https://www.chiamass.gov/annual-report/.

[24] The 193rd General Court of the Commonwealth of Massachusetts. Chapter 12C: Center for Health Information and Analysis. 2024. Available at: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter12C.

[25] Center for Health Information and Analysis. Regulations. 2024. Available at: https://www.chiamass.gov/regulations/.

[26] The 193rd General Court of the Commonwealth of Massachusetts. Chapter 12C, Section 9: Reporting Requirements for Registered Provider Organizations. 2024. Available at: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter12C/Section9.

[27] Center for Health Information and Analysis. Publications. 2024. Available at: https://www.chiamass.gov/publications/.

[28] The 193rd General Court of the Commonwealth of Massachusetts. Chapter 12C, Section 7: Payment by Acute Hospital, Ambulatory Surgical Center or Surcharge Payor for Estimated Expenses of Center and Other Purposes Under this Chapter. 2024. Available at: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter12C/Section7.

Though all states collect, analyze, and report data on health care spending and health care entities' financial performance, most have not established an agency that is solely responsible for these efforts and has express statutory authority and adequate funding. None of the states with cost growth benchmark programs have done so. This type of agency serves as a credible source of information on a range of factors that affect health care spending and is considered a **best practice.**

Authority to Enforce Cost Growth Targets

An issue that all states have confronted in the creation and implementation of their cost growth benchmark programs is what authority, if any, they should give to their boards to enforce compliance with the established targets. A related but distinct question is whether the state has any authority to regulate the prices charged for health care services.

Washington's board has no authority to enforce compliance with its cost growth targets. The legislature considered granting the board the authority to issue PIPs and impose civil fines on entities that exceed the cost growth targets over a period of time during the 2023−24 legislative session. Those provisions were excluded from the legislation as enacted; instead, the board is directed to hold an annual public hearing, during which it:

"…May require testimony by payers or health care providers that have substantially exceeded the health care cost growth benchmark in the previous calendar year to better understand the reasons for the excess health care cost growth and measures that are being undertaken to restore health care cost growth within the limits of the benchmark…."[29]

[29] Washington State Legislature. RCW 70.390.100 Health Care Expenditure Hearing. Available at: https://app.leg.wa.gov/RCW/default.aspx?cite=70.390.100&pdf=true.

Best Practice Highlight: Enforcement—California

OHCA has substantial authority to undertake progressive enforcement of its cost growth targets when entities exceed them. Specific steps that the OHCA may take include:

- Providing technical assistance, such as analysis of drivers of health care spending or identification of best practices
- Requesting testimony be given at a public hearing
- Issuing a PIP
- Imposing financial penalties "in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets"[30]

The first enforcement period will begin with the 2026 statewide spending target, with data collection in 2027 and public reporting in 2028. Based on that timeline, the soonest enforcement actions could occur would be in 2028.[31]

Best Practice Highlight: Enforcement—Massachusetts

The Health Policy Board has the authority to impose PIPs and civil fines on entities that exceed cost growth targets in certain circumstances. In January 2022, the HPC issued its first PIP to the Mass General Brigham (MGB) health system. To date, this is the only PIP any state cost growth program has issued for failure to meet cost growth targets. The plan, which MGB submitted and the HPC Board approved after it was amended, includes 10 interventions across four categories: price reductions, reduced utilization, shifts in care to lower cost sites, and accountability through value-based care. The PIP estimated savings of $176.3 million over 18 months.[32]

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[30] California Health and Safety Code Division 107 Health Care Access and Information Part 2. Health Policy and Planning 127502.5 (d)(1) through (5). Available at: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=107.&title=&part=2.&chapter=2.6.&article=3.

[31] California Department of Health Care Access and Information. OHCA Background & Resources: Overview. 2024. Available at: https://hcai.ca.gov/affordability/ohca/ohca-background-resources/.

[32] Massachusetts Health Policy Commission. Mass General Brigham Performance Improvement Plan. July 12, 2023. Available at: www.mass.gov/doc/mass-general-brigham-performance-improvement-plan-july-2023-board-meeting-update/download#:~:text=The%20HPC%20approved%20MGB's%20PIP,over%20the%2018-%20month%20PIP.

Best Practice Highlight: Enforcement—Oregon

Beginning in 2025, Oregon will have the authority to require a payer or provider that exceeds a cost growth target "without reasonable cause" to submit a PIP. Requirements for what must be included in the PIP and the steps OHA will take to approve or seek modification of the PIP are set forth in regulations OHA issued in 2024.[33]

Beginning in 2026, OHA may impose financial penalties on a payer or provider that exceeds the cost growth target in three of five reporting years. The amount of penalties must be based on the amount by which the payer or provider exceeded the target; the method of determining the penalty is set forth in regulation. The penalty must be paid to consumers or designed to directly benefit consumers.[34, 35]

Authority to Conduct Market Oversight

The Washington State Health Care Cost Transparency Board has been examining policies to increase oversight of health care business transactions as a means of mitigating cost growth. Several states with cost growth benchmarking programs have implemented efforts to monitor and oversee mergers and acquisitions and private equity investment in health care. Most states have antitrust authority through their attorneys general.

As noted in a recent report by the Washington State Attorney General's Office,[36] some states have broader authority, which allow for reviews based on criteria other than antitrust issues, including concerns about the impact of such transactions on affordability, access to services, quality of care, and health equity. This work generally is imbedded outside the attorney generals' offices, in agencies already doing other health policy work or working on cost growth benchmarking or other programs addressing affordability. See Table 3 below for an overview across the states.

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[33] Oregon Secretary of State. Oregon Health Authority: Health Policy and Analytics - Chapter 409, Division 65: Sustainable Health Care Cost Growth Target Program, Regulation 409-065-0040. Available at: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5882.

[34] Oregon Laws. ORS 442.386**:** Health Care Cost Growth Target Program Established. Available at: https://oregon.public.law/statutes/ors_442.386.

[35] Oregon Secretary of State. Oregon Health Authority: Health Policy and Analytics - Chapter 409, Division 65: Sustainable Health Care Cost Growth Target Program. Available at: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5882.

[36] Attorney General of Washington. Preliminary Report: Healthcare Affordability. Available at: https://agportal-s3bucket.s3.us-west-2.amazonaws.com/uploadedfiles/AGO_Healthcare%20Affordability%20Preliminary%20Report.pdf.

Table 3. Comparing State Health Care Market Oversight Authority Nationally

Authority	Nonprofit or for Profit	AG Authority	Dept. of Health	+ Health Care Market Oversight Entity
Notice and Review *(Must go to court to challenge)*	Nonprofit only	AZ, GA, ID, MI, ND, NH, NJ, PA, TN, VA	AZ, NJ	
	Both	CO, HI, IL, MA, MN, **WA***	HI, MN, **NY***	**MA*, CA***
Approve, Approve with Conditions, or Disapprove	Nonprofit only	CA, LA, MD, NE, OH, OR, VT, WI	MA, NE, VT	
	Both	CT, **NY*,** RI	CT, RI, **WA** (CON only), WI	**OR***

*Have authority for transactions outside the hospital, including provider groups/private equity transactions/
Source: Milbank Memorial Fund. Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities. January 25, 2024. Available at: https://www.milbank.org/publications/models-for-enhanced-health-care-market-oversight-state-attorneys-general-health-departments-and-independent-oversight-entities/.

Three states—California, Massachusetts, and Oregon—have created a state entity that is dedicated to oversight of health care transactions. Only Oregon's Health Care Market Oversight (HCMO) program, however, has the authority to block or place conditions on mergers and other transactions involving a material change in ownership. Review authority is similar in Massachusetts and California; they publish their review findings and may refer transactions to the state attorney general for review. The infrastructure for these functions is included in Appendix C.

Best Practice Highlight: Market Oversight—Oregon

Oregon launched its HCMO in March 2022. The OHA reviews health care transactions that meet certain criteria for size of the entities involved and the significance of the transaction. Proposed transactions must be reported to the OHA before closing. OHA then reviews proposed transactions to determine whether they support statewide goals related to cost, equity, access, and quality. OHA has the authority to approve, approve with conditions, disapprove, or exempt the transaction. It also monitors transactions that have closed to determine the impacts they are having.[37]

As of December 2023, the HCMO program had worked on 16 transactions. It conducted 15 preliminary reviews, two comprehensive reviews, and two follow-up reviews. Five transactions were approved, four were approved with conditions, and five reviews were in progress as of that date.[38]

Other State Authority to Regulate Prices

As part of their efforts to improve health care affordability, two states—Oregon and Rhode Island—have adopted policies to regulate the health care prices. This work is conducted through a separate program within the OHA outside of Oregon's cost growth program. As stated in the Washington OIC's recent affordability report, without additional policy interventions, setting targets is unlikely to achieve Washington's goal of mitigating cost growth.[39]

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[37] Davison R, Gudiksen K, Montague A, King J. A Step Forward for Health Care Market Oversight: Oregon's Health Care Market Oversight Program. Milbank Memorial Fund. March 2023. Available at: https://www.oregon.gov/oha/HPA/HP/Pages/About_HCMO.aspx.https://www.milbank.org/wp-content/uploads/2023/03/Oregon-HCMO-Program-Report_4.pdf.

[38] Oregon Health Authority. Health Care Market Oversight 2023 Annual Report. Available at: https://www.oregon.gov/oha/HPA/HP/Pages/About_HCMO.aspx. For a complete list of the transactions that have come before HCMO and their status, go to: https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-transaction-notices-and-reviews.aspx.

[39] Health Management Associates. WA OIC Final Report on Health Care Affordability. July 29, 2024. Available at: https://www.insurance.wa.gov/sites/default/files/documents/OIC-final-report-on-health-care-affordability-092324-update.pdf.

Researchers have consistently found that pricing is a key contributor to health spending growth, particularly in the commercial sector. The Health Care Cost Institute found that rising service prices accounted for approximately two-thirds of the 21.8 percent increase in commercial US health spending from 2015 to 2019, with increased utilization accounting for approximately one-fifth of overall spending growth, as per person use (number of inpatient visits, outpatient visits and procedures, professional services and filled prescription days) increased by only 3.6 percent. General inflation accounted for approximately one-third of total spending growth.[40]

Similarly, studies have demonstrated that the primary reason the United States pays more for health care than do other developed countries is because we pay more for goods and services. The most famous study, "It's the Prices, Stupid," by Uwe Reinhardt and colleagues, was published in *Health Affairs* in 2003. Using 2000 OECD data, it compared the United States with other industrialized countries in terms of the level of health care spending, the level of real resources (i.e., physicians, hospital beds, nurses, etc.), administrative costs, and other factors that contributed to the higher level of spending. It also examined the price of selected goods and services. The main conclusion was that the primary factor responsible for most of the higher levels of spending in the United States was the higher price for many goods and services. Several of Reinhardt's coauthors replicated the study using data from 2015 and 2016, finding that "on key measures of health care resources per capita (hospital beds, physicians, and nurses), the US still provides significantly fewer resources compared to the OECD median country. Since the US is not consuming greater resources than other countries, the most logical factor [contributing to overall higher per capita health spending in the US] is the higher prices paid in the US."[41]

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[40] Health Care Cost Institute. 2019 Health Care Cost and Utilization Report. October 2021. Available at: https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf.

[41] Anderson GF, Hussey PS, Petrosyan V. It's Still the Prices, Stupid: Why the United States Spends So Much on Health Care and a Tribute to Uwe Reinhardt, *Health Affairs*. 2019;38(1):87-89. doi: 10.1377/hlthaff.2018.05144

Similarly, in 2018, Irene Papanicolas and colleagues compared the United States with 10 other high-income countries and found that despite the fact that we spent almost twice as much on medical care, no corresponding disparity in health care use rates could be discerned, indicating that higher spending in the United States was driven by factors beyond "the fee-for-service system encouraging high volume of care, or defensive medicine leading to overutilization." Their findings also contradict the belief that the United States spends more on health care because it underinvests in social spending. The authors conclude that "prices of labor and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference in overall cost between the United States and other high-income countries."[42, 43]

The Washington Health Care Cost Transparency Board's 2023 Annual Report presented data on spending in 2017−2021, which showed that commercial market inpatient utilization declined by 8 percent, whereas the average charge per service increased by 14 percent, with total per member, per month spending increasing by 5 percent. However, outpatient utilization increased by 32 percent, while average charge per service increased by only 1 percent, with total per member, per month increasing by 34 percent.[44]

Although inflation is a major driver of cost growth, few states directly regulate the prices that hospitals and other providers may charge in the commercial market. Washington has ventured into price regulation through its public option, Cascade Care Select, which requires that participating insurers pay 160 percent of Medicare reimbursement rates or less on an aggregate basis for all services. In 2024, premiums in the Cascade Care Select program were lowest in 31 of the 37 counties where the plans were offered.

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[42] The Role of Prices in Excess US Health Spending. *Health Affairs* Research Brief. June 9, 2022. doi: 10.1377/hpb20220506.381195.

[43] Papanicolas I, Woskie L, Jha A. Health Care Spending in the United States and Other High-Income Countries, *JAMA.* 2018;319(10):1024-1039. doi:10.1001/jama.2018.1150

[44] Report to the Legislature: Health Care Cost Transparency Board annual report. The COVID-19 pandemic influenced this experience, with a substantial increase in utilization and decline in average charges from 2020-2021. In 2017−2020, utilization increased less than 5 percent, whereas average charges increased approximately 10 percent.

Best Practice Highlight: Regulate Prices —Oregon

A 2017 Oregon law requires health insurers and third-party administrators that contract with the state employee plan to cap payments for hospital facility services at 200 percent and 185 percent of Medicare rates, respectively, for in-network and out-of-network services. The hospital payment cap took effect in October 2019 for Oregon teachers and January 2020 for public employees. Only 24 of Oregon's 62 hospitals are subject to the policy. Rural hospitals, or critical access hospitals, and sole community hospitals located in counties with less than 70,000 people that receive at least 40 percent of their revenue from Medicare are exempt from these requirements.[45]

A study published in *Health Affairs* showed that Oregon's hospital payment cap led to reductions in the prices paid by the state employee health plan for hospital facility services. Specifically, outpatient prices declined by 25 percent per procedure, and inpatient prices per admission in the first two years and three months of the policy dropped by 3 percent. Price reductions were lower in the inpatient setting because hospitals with lower charges initially increased their prices to the cap; they were prohibited from doing so the first year. The study estimated that these price reductions resulted in $107.5 million in savings for the state in the first 27 months, amounting to 4 percent of plan spending. All the targeted hospitals remained in-network, and there was no evidence that hospitals increased their prices for non-state employee commercial health plans to compensate for revenue losses.[46]

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[45] How Oregon is Limiting Hospital Payments and Cost Growth For State Employee Health Plans - NASHP

[46] How Payment Caps Can Reduce Hospital Prices and Spending: Lessons from the Oregon State Employee Plan.

Best Practice Highlight: Regulate Prices—Rhode Island

The Rhode Island Office of the Health Care Insurance Commissioner (OHIC) has used its rate review authority to limit the increase in hospital prices. Its affordability standards, adopted by regulation, limit the average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Center for Medicare and Medicaid Services' National Prospective Payment System Input Price Index ("IPPS") plus 1 percent for all contractual years. The affordability standards also require an increase in non-fee-for-service primary care spending.[47, 48]

A 2019 *Health Affairs* review found that implementation of Rhode Island's affordability standards led to a net reduction in enrollee spending by a mean of $55 in 2016. Inpatient and outpatient utilization did not significantly change; quarterly spending per encounter decreased by $76 per enrollee, while the increase in primary care spending raised enrollee spending by $21.[49]

Regulating the prices charged by hospitals and other health care providers, or the prices paid by health insurers, is complex. Nevertheless, considering price regulation as one means of controlling the growth of health care costs, as Oregon and Rhode Island have done, is a **best practice.**

Funding Scaled to Scope and Expectations

The success of a cost growth benchmark program depends on whether it has adequate resources to collect, analyze, and publish cost data, to analyze cost drivers, to monitor the performance of entities in the health care system, to examine and develop policies that mitigate cost growth; to hold public meetings and engage with stakeholders; and to otherwise carry out its scope of responsibility. States employ both state workers and external consultants to perform these functions.

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[47] Rhode Island Office of the Insurance Commissioner. 230-RICR-20-30-4 TITLE 230 – Department of Business Regulation Chapter 20 – Insurance Subchapter 30 – Health Insurance Affordability Standards. August 20, 2023. Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-08/230-RICR-20-30-4%20Effective%20August%2020%202023.pdf

[48] Butler J. Insurance Rate Review As a Hospital Cost Containment Tool: Rhode Island's Experience. National Academy for State Health Policy. February 1, 2022. Available at: https://nashp.org/insurance-rate-review-as-a-hospital-cost-containment-tool-rhode-islands-experience/.

[49] Baum A, Song Z, Landon B, Phillips R, Bitton A, Basu S. Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers. *Health Affairs*. 2019;38(2):237−241.

Best Practice Highlight: Funding—Massachusetts

The Massachusetts HPC has a different funding approach than the other three states. Its budget comes from an annual assessment on acute care hospitals and health system providers, ambulatory surgery centers, and surcharge payers such as third-party administrators. The HPC's budget is approximately $12 million, and CHIA's is approximately $30 million. This assessment allows the HPC to be independent of the general fund for ongoing funding toward both its cost growth and market oversight programs. The HPC does not charge a separate fee to entities for the transaction reviews in the market oversight program.

Best Practice Highlight: Funding—California

More than half of the OHCA's budget is allocated to the market oversight program and supports the high value/quality arm of its work. The OHCA budget has been adequate to perform the duties assigned to the agency. The OHCA was given flexibility to use some of the funds on outside consulting, if needed. The agency also has exemption from some state contracting rules, allowing it to use either procurement processes or direct contracting, which has enabled it to be nimble in launching new programs.

CONCLUSION

The best practices described in this report were chosen because they seem best suited to meeting Washington's goals for its cost growth benchmark program. The state must determine whether adoption of any of these best practices would better enable the Health Care Cost Transparency Board to fulfill its mission or whether its mission should be changed or expanded so it can better carry out the state's goal of mitigating the growth in health care costs.

For example, if Washington policymakers want the Cost Board to be better able to identify the drivers of health care costs, to analyze, and report on the financial performance of payers and providers and to study the impacts of health care consolidation, then centralizing data gathering, analyzing, and reporting to a single entity, like CHIA in Massachusetts, is one approach for consideration.

If Washington policymakers determine that the Cost Board should have authority to enforce cost growth targets to improve the likelihood that they will be met, California, Massachusetts, and Oregon have models for adaptation.

If Washington policymakers want to better understand the impact of mergers, acquisitions, private equity investment, and other transactions causing significant changes in ownership of health care entities on costs, access, quality and equity, California, Massachusetts, and Oregon provide models, with Oregon going the furthest in authorizing OHA to impose conditions on or prohibit transactions under certain circumstances.

Should Washington policymakers determine that policies directly affecting the prices that are charged for health care services are needed to mitigate the increase in health care spending, Cascade Care Select, Oregon, and Rhode Island can serve as examples.

Finally, whether the authority for the Health Care Cost Transparency Board remains unchanged or expands over time, it is essential that it have adequate funding and staff to accomplish its mission.

The totality of these best practices, if enacted in concert, could significantly strengthen the state's ability to measure and contain cost growth and its impact on Washingtonians. This report provides a spectrum of best practices, each of which may bring its own benefits, allowing the state to pursue a variety of approaches as it advances this important work.

APPENDIX A: COST GROWTH AND MARKET OVERSIGHT PROGRAMS IN FOUR STATES COMPARED WITH WASHINGTON

State Program	Placement in Government	Market Oversight	Enforcement Authority	Budget	Staffing
Washington	Health Care Cost Transparency Board	No	No		Initial Staff: 2 Current Staff: 5 Current Funding: 7 Support from outside consultants and philanthropic dollars to support data analytics
California Office of Health Care Affordability (OHCA)	Office inside state health agency	Yes; separate unit inside the OHCA	• Public reporting • Performance Improvement Projects (PIPs) • Fines Reviews only for market oversight	$22 million, with ~60% used by Market Oversight section of office	80 positions
Massachusetts Health Policy Commission (HPC)	Independent state agency, works closely with CHIA	Yes; separate unit inside the OHCA	• Public reporting • PIPs • Fines Reviews only for market oversight		
Oregon Sustainable Cost Growth Target Program Health Care Market Oversight Program	Both programs are in office that operates within state health agency	Yes; work closely as separate programs in same office with oversight from same manager	• Public Hearings • PIPs • Fines Deny or approve with conditions mergers/ acquisition or post-merger reviews	Cost growth Program: $2 million Market Oversight: $1 million initial startup & fees	8 positions 4 positions
Rhode Island	Program in the Office of the Insurance Commissioner	No	No	~$1.5 million	Outside consultants

APPENDIX B: COMPARISON OF STATE BENCHMARK PROGRAMS[50]

State	Authority	Collecting and Reporting Agency	Cost Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
Washington	HB 2457/ Chapter 340 (2020)	The Health Care Authority established the Health Care Cost Transparency Board	CY 2022: 3.2% CY 2023: 3.2% CY 2024: 3.0% CY 2025: 3.0% CY 2026: 2.8%	THCE means all public and private health care expenditures in the state, including: All payments on providers' claims for reimbursement for the cost of health care provided • All payments to health care providers other than the aforementioned payments • All cost sharing paid by residents of the state, including copayments, deductibles, and coinsurance • The net cost of private health care coverage	Quality measures are not discussed in the establishing legislation for Washington's benchmark program.	Enforcement not discussed.

[50] Pulled from articles on Health Care Cost Growth Target Programs Available at: Peterson-Milbank Program for Sustainable Health Care Costs | Milbank Memorial Fund

State	Authority	Collecting and Reporting Agency	Cost Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
California	AB 1130 (2021−2022)	AB 1130 established the Department of Health Care Access and Information (HCAI) Office of Health Care Affordability (OHCA) to, among other responsibilities, set and enforce cost targets under the Health Care Affordability Board.	The Board must set the first statewide target for 2025 by June 1, 2024. The Board also may develop targets that apply to specific sectors, such as geographic regions, as well as targets specific to fully integrated delivery systems, types of health care entities, and individual health care entities. The Board will define sectors by October 1, 2027, and set sector-specific targets by June 1, 2028.	Total health care expenditures (THCE) is defined as all health care spending in the state by public and private sources, including: (1) All claims-based payments and encounters for covered health care benefits (2) All non-claims-based payments for covered health care benefits such as capitation, salary, global budget, or other alternative payment methods (3) All cost sharing for health care benefits paid by residents of this state, including, but not limited to, copayments, coinsurance, and deductibles (4) The net cost of health coverage (5) Pharmacy rebates and any inpatient or outpatient prescription drug costs not otherwise included in this subdivision	Though quality benchmarks were not established in statute, the office will adopt a single set of standard measures to assess health care quality and equity across health care service plans, health insurers, hospitals, and physician organizations. Health care entity performance will be included in the annual public report. The measures will use recognized clinical quality, patient experience, patient safety, and utilization measures for health care service plans, health insurers, hospitals, and physician organizations. They also consider available means for reliable measurement of disparities in health care, including race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status.	Commensurate with the health care entity's offense or violation, the director may take the following progressive enforcement actions: (1) Provide technical assistance to the entity to assist it with compliance (2) Require or compel public testimony by the health care entity regarding its failure to comply with the target (3) Require submission and implementation of PIPs, including review and input from the board prior to approval (4) Assess penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets

State	Authority	Collecting and Reporting Agency	Cost Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
Connecticut	Executive Order No. 5 (2020)	Office of Health Strategy	The Office of Health Strategy (OHS) recommended benchmarks of: • 3.4% for Calendar Year 2021 • 3.2% for CY 2022 • 2.9% for CYs 2023, 2024, and 2025 All payers and populations are to reach a primary care spending target of 10% by 2025, with OHS having set a conservative target of 5.0% for 2021 and convening a work group to make recommendations for 2022−2024.	To be determined by the technical team and advisory board along with the OHS.	Office of Health Strategy's Quality Council will develop quality benchmarks across all public and private payers, including: • Clinical quality measures; • Under-utilization measures; • Patient safety measures. Measures under consideration include: • Consumer Assessment of Healthcare Providers and Systems Patient-Centered Medical Home (PCMH) Survey • Plan all-cause readmission • Breast Cancer Screening	Enforcement not discussed.

State	Authority	Collecting and Reporting Agency	Cost Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
Delaware	Executive Order 25 (2018)	The Delaware Economic and Financial Advisory Committee sets the health care spending benchmark. The Delaware Health Care Commission is responsible for collecting information and analyzing performance against the benchmark.	Benchmark set in executive order at: • Calendar year (CY) 2019: 3.8% per capita spending growth • CY 2020: 3.5% + 0.5% (transitional market adjustment) • CY 2021: 3.25% + 0.25% (transitional market adjustment) • CY 2022: 3% + 0% (transitional market adjustment) • CY 2023: 3% + 0% (transitional market adjustment)	THCE in aggregate = commercial total medical expenses (TME) + Medicare Advantage (MA) TME + Medicare fee-for-service (FFS) TME + Medicaid and Children's Health Insurance Program managed care organization (MCO) TME + Medicaid Fee-for-Service TME + Veterans Affairs (VA) TME + insurer net cost private health insurance (NCPHI) THCE (per capita) = THCE in aggregate/population. This measurement excludes payment on behalf of out-of- state residents and generally excludes payment on vision and dental. Reported amounts represent the total allowed amount (payer paid + copay and deductible associated, but premiums are not included).	• Emergency department utilization rates • Opioid-related overdose deaths • Residents with overlapping opioid and benzodiazepine prescriptions • Adult obesity • Adult tobacco use • High school students who were physically active • Statin therapy for patients with cardiovascular disease, with adherence of 80% • Persistence of beta-blocker treatment after a heart attack	Silent on enforcement. Public information is not yet available on recourse if/when benchmark is exceeded. Performance against the benchmark will be reported publicly, as per member, per year costs and made at the statewide level with drill-down analyses.

State	Authority	Collecting and Reporting Agency	Cost Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
Massachusetts	MA Chapter 224 of the Acts of 2012	Center for Health Information and Analysis (CHIA) and Health Policy Commission (HPC)	Benchmark codified in MA Chapter 224 of the Acts of 2012: • 2013−2017: 3.6% which is equal to growth rate of potential gross state product (PGSP). • 2018−2022: PGSP minus 0.5% (3.1% in 2018), but the Health Policy Commission had the authority to vote it back up to the PGSP or 3.6% and voted to maintain the benchmark at 3.1%. • 2023 and beyond: PGSP growth rate	CHIA, the state's all-payer claims database, measures the THCEs and compares them with the state economy's growth. The HPC is charged with monitoring health care costs trends, price variation, cost growth at individual health care entities, and scrutinizing health care market power.	Patient-reported experience during acute hospital admission Primary care patient-reported experiences for adults Primary care patient-reported experiences for pediatrics Trends in statewide, all-payer adult acute hospital readmission rate, discharges, and readmissions • All-payer readmissions among frequently hospitalized patients • Rates of maternity-related procedures relative to performance targets • Number of hospitals meeting Leapfrog standards for implementing interventions to improve medication safety • Incidence of health care- associated infections	If the HPC determines that an entity has an unwarranted pattern of contributing to excessive health care spending in the Commonwealth, it may vote to require the entity to submit a PIP to achieve meaningful, specified cost savings. The PIP must be submitted within 45 days of the entity receiving notification. If HPC approves the entity's PIP, it is implemented over 18 months. The HPC will monitor the implementation and ultimately determine whether the outcome is sufficient to address the underlying causes of the entity's spending growth or additional action is needed. A $500,000 fine may be assessed for non-compliance.

State	Authority	Collecting and Reporting Agency	Cost Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
Nevada	Executive Order 2021−2029	The Nevada Department of Health and Human Services Patient Protection Commission (PPC) was designated as the sole state agency responsible under AB 348 (2021), enacted before the governor's December 2021 executive order.	CY 2022: 3.19% CY 2023: 2.98% CY 2024: 2.78% CY 2025: 2.58% CY 2026: 2.37% By October 1, 2026, the PPC shall recommend to the Governor appropriate benchmarks for 2027 and beyond	THCE has three components: • All medical expenses paid to providers by private and public payers, including Medicare and Medicaid • All patient cost sharing amounts (e.g., deductibles and co- payments) • Net cost of private health insurance (e.g., administrative expenses and operating margins for commercial payers)	Quality measures are not discussed in Executive Order 2021-29 or AB 348.	The PPC advanced a bill draft request to codify Executive Order 2021-29. The proposed legislation, AB 6 (2023), included public reporting and an annual informational public hearing on health care cost trends and the factors contributing to such costs and expenditures. The PPC is considering additional enforcement mechanisms such as PIPs and financial penalties.

State	Authority	Collecting and Reporting Agency	Cost Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
New Jersey	Executive Order 217 (2021)	The Governor's Office of Health Care Affordability and Transparency is leading an Interagency Working Group.	The target growth rate is 3.2% based on a 25% PGSP and 75% median household income blend: CY 2022: Initiate data collection and reporting CY 2023: 3.5% CY 2024: 3.2% CY 2025: 3.0% CY 2026: 2.8% CY 2027: 2.8%	Total health care expenditures include: • All payments on providers claim for reimbursement of the cost of health care provided • All other payments not included in providers' claims • All cost sharing paid by members including copayments, deductibles, and coinsurance • Net cost of private health insurance expenditures include claims for: hospital inpatient and outpatient spending; primary care; specialty care and other professional spending; long- term care; pharmacy; and all other claims-based spending Also included are non-claims payments (i.e., incentive and value-based payments to providers), patient cost-sharing, and the cost of administering health insurance	Quality will be a component of New Jersey's Cost Driver Analysis as part of the benchmark effort. Other key components include equity, access, and affordability. Reports will be released annually with further details to identify the causes of cost increases and specific areas driving spending growth.	Enforcement not discussed.

State	Authority	Collecting and Reporting Agency	Cost Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
Oregon	SB 889/ Chapter 560 (2019)	Collection responsibilities are to be determined by the Health Care Cost Growth Benchmark Implementation Committee. The following entities are responsible for Cost Growth Target Program Authority, Department of Consumer and Business Services, Oregon Health Policy Board.	The Implementation Committee recommended a benchmark of 3.4% for 2021−2025 and 3.0% for 2026−2030 (to be adjusted in 2024 if needed). State programs (Medicaid/State Employee Health Plan) are already subject to a 3.4% growth target.	THCE should be defined as the “allowed amount” of claims-based spending from an insurer to a provider, all non-claims-based spending from an insurer to a provider, pharmacy rebates, and the net cost of private health insurance.	Implementation Committee recommended that The Health Plan Quality Metrics Committee identify a subset of its menu of quality measures for reporting as part of the Sustainable Health Care Cost Growth Program, while aligning with the coordinate care organizations, Public Employees' Benefit Board, and Oregon Educators Benefit Board contractual measure sets as much as possible.	Oregon HB 2081 (2021) requires PIPs from any payer or provider organization that unreasonably exceeds the benchmark during any year. Fines are assessed for late or incomplete submission of data and/or performance improvement plans. Payer or provider organizations that exceed the benchmark in any three of five years are subject to a financial penalty that varies based on the amount of excessive spending.

State	Authority	Collecting and Reporting Agency	Cost Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
Rhode Island	Executive Order 19-03 (2019)	Office of Health Insurance Commissioner (OHIC) and Executive Office of Health and Human Services	Benchmark set in executive order at 3.2% for 2019−2022, equal to Rhode Island's per capita gross state product. • In 2022, target will be reassessed and maintained or replaced for 2023. Health care cost growth target is expressed as the percentage growth from the prior year's per capita spending.	OHIC will lead efforts to perform a series of data collection activities and calculations. THCE in aggregate = Commercial TME + MA TME + Medicare fee-for-service (FSS) TME + Medicaid managed care organization TME + RI Executive Office of Health and Human Services FFS TME + Insurer net cost of private health insurance THCE (per capita) = THCE in aggregate/RI Population This measurement includes all the same qualifiers as Delaware. In addition, provider resources applied in the delivery of care for uninsured individuals are not included as they are not technically spending.	Quality measures are not discussed.	Silent on enforcement. OHIC will publicly report on performance against the target at a statewide level, with several drill-down analyses. Silent as to what action should be taken if benchmark is exceeded.

APPENDIX C: DETAILED DESCRIPTION OF FOUR STATE COST GROWTH AND MARKET OVERSIGHT PROGRAMS

California

California Cost Growth Program

In June 2022, California passed the Health Care Quality and Affordability Act, which established the Office of Health Care Affordability (OHCA) within the California Department of Health Care Access and Information (HCAI). HCAI is part of the California's Health and Human Services Agency. HCAI houses several other programs, such as hospital planning and development; that is, hospital financial reporting, workforce development, and information services, including the state's all-payer database.

The OHCA was charged with setting cost growth targets and collecting healthcare data to better analyze drivers of cost. It has three main programs to carry out its statutory requirements:

- Slow spending growth[51]
    - Statewide spending target
    - Total Health Care Expenditures
- Assess market consolidation
    - Material change notices
    - Cost and market impact reviews

[51] The vehicles for establishing and funding CGB activities include:

- Health and Safety Code, Division 107, Part 2, Chapter 2.6, the California Health Care Quality and Affordability Act, describes the legislative intent and activities of OHCA
- Title 22, Division 7, Chapter 11.5, Article 1 of the California Code of Regulations sets forth the regulatory requirements for Material Change Transaction Notices and Cost and Market Impact Reviews

- Promote High Value
    - Primary care
    - Behavioral health
    - Workforce stability
    - APMs
    - Equity
    - Quality

OHCA's Health Care Affordability Board is composed of state appointees and an advisory committee of industry stake holders to advise on decision making.[52]

Enforcement Authority

The Director of the OHCA may take the following progressive enforcement actions commensurate with the health care entity's failure to meet its cost growth target:

- Provide technical assistance to the entity to assist it in coming into compliance
- Require or compel public testimony from the health care entity regarding its failure to comply with the target
- Require submission and implementation of a PIP
- Assess penalties in amounts initially commensurate with the failure to meet the targets and in escalating amounts for repeated or continuing failure to meet the targets

Enforcement of the target is set to start in 2026, and the state may escalate enforcement as needed.[53]

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[52] Manatt. California Gets Rolling: Health Care Affordability Board Appointed and Set to Convene on March 21, 2023. The Manatt State Cost Containment Update. March 2023. Available at: https://www.manatt.com/Manatt/media/Media/Images/Manatt-State-Cost-Containment-Update_2023-03_b.pdf.

[53] Ibid.

California's Implementation

Since enactment of the enabling legislation, OHCA has appointed the HCAB and the Advisory Committee. It has also chartered workgroups and workshops to support the development of APMs, data submission, and primary care and behavioral health standards and benchmarks.

On January 16, 2024, OHCA published its recommendations for a proposed statewide health care cost target. The recommendation was to adopt a five-year, single fixed-value statewide spending target of 3.0 percent for 2025−2029, based on the average change in median household income for the 20-year period from 2002 to 2022. California's benchmark uses the historical median household income. This is a different approach than other states have taken in setting the target, but it was chosen as it correlates with what consumers can afford.[54]

At its April 2024 meeting, the HCAB voted to phase in the cost growth target. Rather than adopt the staff recommendation of 3 percent cost growth, the target was set at 3.5 percent for 2025 and 2026, 3.2 percent for 2027 and 2028, and then 3 percent for 2029 and beyond.[55] The first year that entities are held responsible is 2026, and data analysis will not be completed until 2028. OHCA is beginning efforts to assess its approach to accountability and enforcement, wanting to move beyond "naming and shaming" to ensure efforts to stem cost growth are undertaken.

Funding

OHCA's work has been one of Governor Newsom's priorities and it has an ongoing appropriation of $22 million to fund 80 positions annually. More than half of this budget is for the market oversight program within OHCA and supports the high value/quality arm of its work. The OHCA was given flexibility in using the some of the funds for outside consulting if needed. The agency was also given exemptions from some state contracting rules to allow for either procurement processes or direct contracting, which has enabled it to be nimble in launching programs.

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[54] California Department of Health Care Access and Information. Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Statewide Spending Target. Available at: https://hcai.ca.gov/wp-content/uploads/2024/01/OHCA-Recommendations-to-Board_Proposed-Statewide-Spending-Target.pdf.

[55] California Department of Health Care Access and Information. Statewide Health Care Spending Target Approval Is Key Step Towards Improving Health Care Affordability for Californians. April 24, 2024. Available at: https://hcai.ca.gov/statewide-health-care-spending-target-approval-is-key-step-towards-improving-health-care-affordability-for-californians/.

Staffing

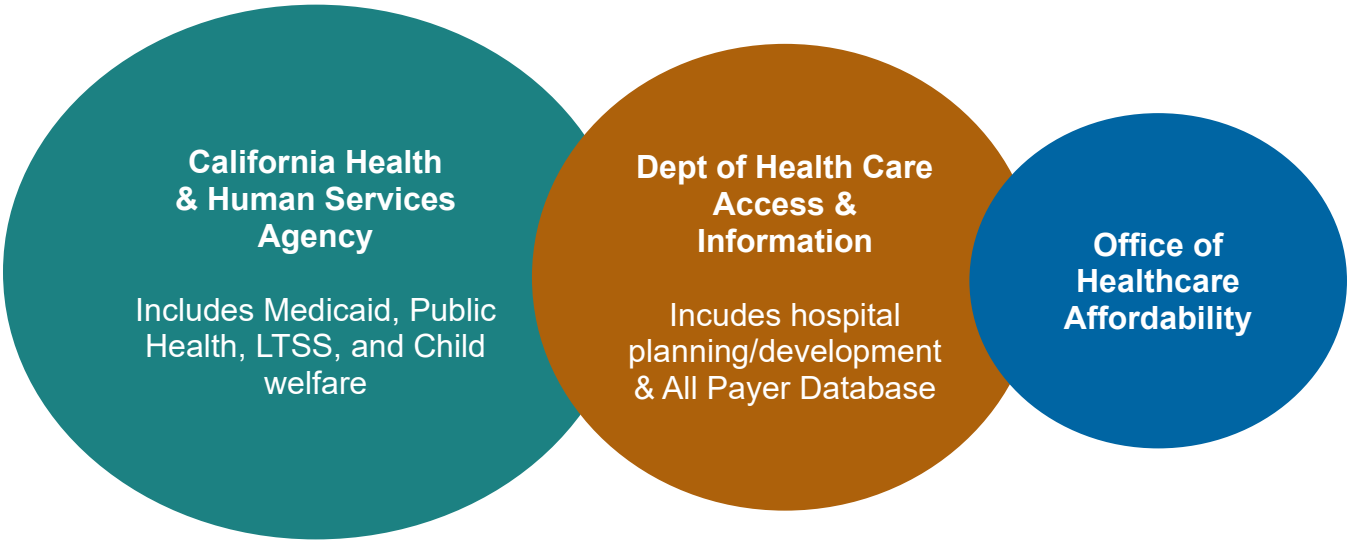
OHCA has started to hire personnel for this work to fill the 80 positions, with 60 percent allocated to the market oversight program and 40 percent to the cost growth program and operations of the agency. OHCA has relied on consultants for some projects as it hires staff. The agency has been moving more to internal staff over time as the program develops but anticipates some ongoing consulting service needs.

The staffing plan includes:

- Staff for engagement and governance to work with their Board, Advisory Committee, and workgroups and to engage with stakeholders and the public. OHCA plans to incorporate staff to work on program-focused policy as well as developing overall potential state policy to address costs and affordability
- Staff for data and policy analysis and research. OHCA has sought to coordinate and cross pollinate with the hospital planning and development and the APCD sections of the larger HCAI
- Staff for the Office's operations and administration

OHCA staff meet informally with stakeholders, including hospitals, health systems and providers to gain insight and feedback outside of formal meetings. The agency has devoted approximately $5 million to $8 million so far for outside consultants, particularly when the office first opened and had few state staff hired. OHCA worked to give the consultants a broad scope of work in the contracts but controlled the hours monthly. Each year the agency is spending less on consultants, as it has grown the internal staff; however, certain areas of expertise are much harder to recruit, such as actuarial expertise because state salaries are much lower than those in the private sector, particularly for staff such as actuaries and economists. Other areas where OHCA has used consultants include finance and accounting, claims, and qualitative and quantitative analysis. OHCA has found that having third-party support for its board and advisory committees has been valuable in working with stakeholders and those providing public comment.

Figure C1. California's Health Care Cost Containment Infrastructure within the State Government



Business Oversight: Program

In addition to its cost growth benchmark program, OHCA analyzes market transactions that are likely to affect market competition, the state's ability to meet targets, or affordability for consumers and purchasers. Based on results of the review, OHCA will coordinate with other state agencies to address consolidation as appropriate.[56]

As noted above in the funding for the OHCA, more than half of the overall budget is directed to the market oversight area presently, and it currently have nine staff with a variety of expertise in business, healthcare, and regulation. Most are lawyers, which has been beneficial for the type of work and extensive review and writing required for the market oversight program. OHCA plans to hire a financial team with accounting experience as they grow their internal staff. The program just started in 2024 and so far has completed a limited number of reviews. Actuarial and economic expertise would also be valuable for this area and have relied on consultants for these harder to hire for state service positions. Being inside the same agency, the market oversight team uses OHCA's communication and stakeholder engagement staff.

[56] California Department of Health Care Access and Information. Introduction to OHCA. Available at: https://hcai.ca.gov/ohca/.

Massachusetts

Massachusetts' Cost Growth Program

Massachusetts has the longest and deepest experience with setting cost growth benchmarks, having established its Health Policy Commission (HPC) in 2012. The state enacted Chapter 224 of the Acts of 2012[57] to bring health care spending growth in line with the growth in the state's overall economy by establishing the health care cost growth benchmark—a statewide target for the rate of growth of total health care expenditures (THCE). The HPC agency is directed by Chapter 224 to set benchmarks annually and −report on spending trends.

Chapter 224 defines three multi-year targets for THCE growth:

- From 2013 through 2017, the benchmark had to be set equal to the growth rate of potential gross state product (PGSP), or 3.6%.
- From 2018 through 2022, the HPC had to set the benchmark equal to PGSP (3.6%) −0.5 percent (3.1%) in 2018. During this period, the HPC had limited authority to modify the benchmark up to the PGSP level if it determined, after consideration of data, information, and testimony, that such an adjustment was reasonably warranted.
- For 2023 and beyond, the benchmark will be established by law at a default rate of PGSP, although the HPC Board can modify it to any amount deemed reasonable, subject to legislative review.

THCE is calculated on a per capita basis to control for increases in health care spending due to population growth. The inclusion of public and private payers in the measure is intended to reduce the likelihood of cost-shifting among different payer types and ensure that gains are shared with both public and private purchasers.

[57] The 193rd General Court of the Commonwealth of Massachusetts. Chapter 224: An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation. Available at: https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224.

Massachusetts has a separate state agency, the Center for Health Information and Analysis (CHIA),[58] which operates the state's APCD. The HPC funds CHIA to collect cost growth data and it reports out to the HPC and the public.[59] CHIA measures the Commonwealth's THCE annually, and these data are then used to measure the state's health care expenditures against growth of the Commonwealth's economy[60] and reported publicly. CHIA has an extensive and easily understood array of data reports related to cost, quality, access, and health systems performance. The cost data includes the THCE and TME as well as alternative payment methods, primary and behavioral health care spending, prescription drugs, provider price variation, insurance premiums and member cost sharing, hospital financial performance and cost reports. For details, go to: HOME (chiamass.gov).

The HPC has additional responsibilities and authorities beyond those of Washington State's Health Care Cost Transparency Board, including:

- Creating standards for care delivery systems that are accountable to better meet patients' medical, behavioral, and social needs
- Analyzing the impact of health care market transactions on cost, quality, and access
- Investing in community health care delivery and innovations
- Safeguarding the rights of health insurance consumers and patients regarding coverage and care decisions by health plans and certain provider organizations[61]

[58] Massachusetts Center for Health Information and Analysis. Health Care Costs & Payments. Available at: https://www.chiamass.gov/.

[59] Massachusetts Center for Health Information and Analysis. About the Agency. Available at: https://www.chiamass.gov/about-the-agency/.

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

[61] Massachusetts Health Policy Commission. 2023 Annual Health Care Cost Trends Annual Report. September 2023. Available at: https://www.mass.gov/doc/2023-health-care-cost-trends-report/download.

Enforcement Authority

The HPC has authority to enforce the provisions of its program and is permitted to require that a health care entity[62] file a performance improvement plan (PIP) if it exceeds the cost growth benchmark. The commission also has the authority to impose a civil penalty of up to $500,000 as a last resort if an entity that has been ordered to submit a PIP fails to file an acceptable plan or fails to implement a PIP in good faith.[63]

Massachusetts' Implementation

The HPC Board of Commissioners started its work and sets the benchmark for the following calendar year annually between January 15 (when the potential gross state product is established) and April 15. There have been benchmark hearings annually since 2017 to determine the health care cost growth benchmark for the following calendar year. The latest benchmark hearing was in March 2024 and the HPC Board of Commissioners set the benchmark at 3.6%, equal to the potential gross state product.

The HPC voted in 2022 to require Mass General Brigham (MGB) to implement a PIP; it was the first time it had ordered a PIP, and at present it is the only PIP in the nation pertaining to a cost growth benchmark program. The commission approved MGB's PIP in September 2022; it proposed an annual savings target of $176.3 million over the PIP's 18-month implementation period. MGB's most recent public report states that it is on track to meet its savings target.[64]

After more than 10 years of conducting cost growth benchmarking, the Massachusetts HPC made recommendations to improve its program, which other states have noted (some of the policies were reflected in the legislation establishing California's program). Massachusetts is in the process of implementing these recommendations, which include:

- Adjusting the methodologies and metrics so that entities other than payers and providers with primary care networks are subject to review
- Strengthening the PIP process

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[62] A health care entity is defined as a clinic, hospital, ambulatory surgery center, physician organization, accountable care organization, or payer. Physician contracting units with a patient panel of 15,000 or fewer or who collectively receive less than $25,000,000 in annual net patient service revenue are exempted, under Massachusetts General Law, Title I, Chapter 6D, Section 10

[63] Ibid.

[64] Mass General Brigham Performance Improvement Plan. March 2023 Update. Available at: download (mass.gov)

- Establishing a new affordability index to reflect health insurance premiums and cost sharing impacts
- Initiating a new equity benchmark
- Working to constrain excessive provider prices such as reference-based pricing[65]

Funding

Funding for the HPC and its work is from an annual assessment on acute care hospitals and health system providers, ambulatory surgery centers, and surcharge payers such as third-party administrators. The HPC's budget is approximately $12 million, and CHIA's is approximately $30 million from that same assessment.

Staffing

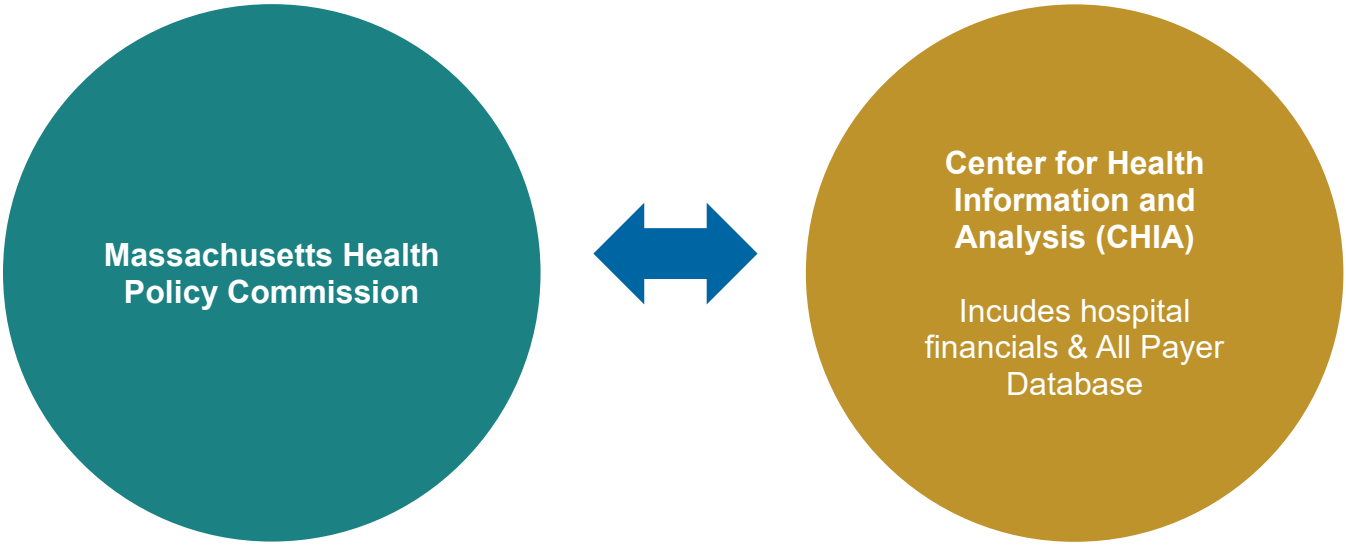
Massachusetts HPC has three main components:

- The Health Care Cost Containment unit manages the health care cost growth benchmark program, PIPs, and health care cost trends research.
- The Market Oversight and Monitoring unit manages the impact reviews, the registry of provider organizations, and conducts drug pricing reviews.
- The Care Delivery Transformation unit is responsible for accountable care organizations and patient-centered medical homes (PCMH) standards and certification, investment programs to promote innovative models and work with communities to address social determinants of health and efforts to encourage partnerships with other state agencies and stakeholders.

[65] HCP 2023 Annual Health Care Cost Trends Annual Report. Available at: https://www.mass.gov/doc/2023-health-care-cost-trends-report/download at pp. 51-58. Several of the policy recommendations in the report relate to functions of the HPC which are outside of HCCTB's purview.

HPC also has a Communications unit that works with the 11-member Board of Commissioners and the 32-member Advisory Council of stakeholders and an operations team that supports all three areas of the HPC. The Advisory Council is considered on HPC's greatest assets, bringing members together four times annually, with members serving two-year terms. It has allowed HPC to have a closer relationship with stakeholders and has met separately with some of them based on their expertise or affiliation to provide some insights and perspectives on their projects. Expertise across HPC leaders includes a variety of knowledge and skills, with the cost growth team composed of data analysts and those with policy expertise. The director of the Cost Growth program is an economist, and consultants provide actuarial services. Overall, HPC has approximately 60−65 staff who work closely with the approximately 60 staff at CHIA. Reportedly, approximately 70 percent of the HPC's budget is spent on internal staff positions and 30 percent on consulting services.

Figure C2. Massachusetts's Cost Containment Infrastructure within the State Government



Massachusetts' Business Oversight Authority

The Massachusetts HPC, per Chapter 224 (2021), is also directed to conduct the following activities:

- Cost and market impact reviews (CMIRs)
- Mandatory reporting of ownership, organizational charts, corporate and contracting affiliations, clinical affiliations, incentive structures/compensation models; financials; sites of practice
- Public reporting on trends

CMIRs are required when health care organizations initiate large mergers, acquisitions, and affiliations.[66] Providers and health systems must notify the HPC and state attorney general of any material change in ownership or affiliation.[67] If the proposed changes are considered to have a potential impact on the state's ability to meet cost growth benchmarks, the commission can conduct a detailed impact review of the proposed change."[68]

Funding

A portion of the HPC's budget is directed to the positions and consulting needs of the market oversight program, reportedly approximately 60 percent of the budget HPC receives through the annual provider/hospital and payer assessment. HPC does not charge the entities for the transaction reviews.

Staffing

Of the 60 to 65 staff at the HPC, more than half are working with the market oversight program. The HPC has found a need for more staff in the market oversight program and is looking to expand the team further. The market oversight team comprises people with legal expertise, and the senior director is a lawyer.

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[66] Melnick G. Health Care Cost Commissions: How Eight States Address Cost Growth. California Health Care Fund. April 2022. Available at: https://www.chcf.org/wp-content/uploads/2022/04/HealthCareCostCommissionstatesAddressCostGrowth.pdf.

[67] Ibid.

[68] Ibid.

Oregon

Oregon's Cost Growth Program

Oregon had initiated efforts to control costs before launching the current program. These effort included:

- In 2012, the state set a trend cost cap at 3.4 percent per capita for the Medicaid coordinated care organizations (CCOs: Medicaid managed care entities for physical, oral, and behavioral health).
- In 2015, it extended that same growth cap to the Public Employees Benefit Board and the Oregon Educators Benefit Board for their commercial-based plan offerings in 2015.[69,70]
- In 2015, to address costs, Senate Bill (SB) 900 was enacted, requiring the OHA to post hospital price information using the APCDs for the 50 most common inpatient procedures and 100 most common outpatient procedures on a public website.[71]

Despite these efforts, costs continued to escalate. The Oregon Legislature, through SB 889 (2019) and House Bill 2081 (2021) established the Sustainable Health Care Cost Growth Target Program within the OHA—the state's health agency that also includes Medicaid, public health, behavioral health, and state and school district employees benefit programs. The program was placed inside the OHA's Division of Health Policy and Analytics, which also manages the state's all-payer all claims database (APCD) and the hospital financial reporting program.

SB 889 directs the OHA to work with stakeholders and consumers to set a Sustainable Health Care Cost Growth Target that would apply to insurance companies, hospitals, and other providers with the intent that health care costs do not outpace wages or the state's economy.

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[69] Oregon Health Authority. PEBB & OEBB Cost Containment Strategies to Meet the 3.4% Annual Growth Limit. House Bill 2266. 2019. Available at: https://www.oregonlegislature.gov/committees/2019I1-HHC/Reports/HB%202266%20-%20PEBB%20and%20OEBB%20Cost%20Containment%20Strategies%20to%20Meet%20the%203.4%20Percent%20Annual%20Growth%20Limit.pdf.

[70] Ibid.

[71] Oregon Legislative Assembly. Senate Bill 900. Available at: https://olis.oregonlegislature.gov/liz/2015R1/Downloads/MeasureDocument/SB900/Enrolled.

Through this program, OHA was directed to also identify opportunities to reduce waste and inefficiency, resulting in better care at a lower cost.[72]

The SB 889 Implementation Committee, selected by then Governor Kate Brown and operating under the supervision of the Oregon Health Policy Board (OHPB), recommended:

- A target for the annual per capita rate of growth of total health care spending in the state
- Steps to implement the Sustainable Health Care Cost Growth Target
- Spending measures that maximize available data and minimize new data collection
- A process to hold insurance companies and large providers accountable if their cost growth rises above the target[73, 74]

Enforcement Authority

Oregon's Cost Growth Target Program has the authority for three primary accountability mechanisms:

1. Transparency through public reporting and hearings
2. PIPs
3. Financial penalties to hold payers and provider organizations accountable

Cost growth target accountability is being phased in over several years, Payers or provider organizations that exceed the benchmark in any three out of five years are subject to a financial penalty that varies based on the amount of excessive spending and other factors. The program's rules allow exceptions to the cost growth accountability measures for "reasonable" causes of growth. They include changes in federal law, new pharmaceuticals, changes in taxes of administrative requirements, natural disasters, investments to improve community health, most labor costs, macroeconomic factors, and unusually costly patients.

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[72] Oregon Health Authority. Health Care Cost Growth Target. Available at: https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx.

[73] Oregon Health Authority. Cost Growth Target Implementation Committee Archive. 2019-2021. Available at: https://www.oregon.gov/oha/HPA/HP/Pages/cost-growth-target-implementation-committee.aspx.

[74] Oregon Health Authority. Sustainable Health Care Cost Growth Target. Implementation Committee Recommendations Final Report to the Oregon Legislature. Senate Bill 889. Available at: https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf.

Oregon has not yet required any entity to file a PIP; 2025 is the first year that any organization could be subject to a PIP, based on its cost growth between CY 2022−2023 (and data submitted in 2024). OHA will not issue penalties against any entities until 2029 at the earliest based on rules finalized in July 2024.

Oregon's Implementation

With the goal of reducing health care cost growth and increasing price transparency, Oregon measures health care cost growth with two different indicators—TCHE and TME. THCE in Oregon is an aggregate measure of health care spending, including all claims and non-claims spending reported by payers as well as NCPHI (i.e., the administrative costs of health insurance) and other spending, such as health care for military veterans and people incarcerated in state facilities. TME is a subset of THCE and includes claims and non-claims spending reported by payers.

OHA is measuring the health care cost growth against the health care cost growth target, which is based on a blend of the growth in PGSP, which is a predicted measure of growth in the economy, and median wage and income data for Oregonians. The cost growth target is not a spending cap, nor does it limit health care spending. Instead, it aims to achieve a sustainable rate of growth for health care spending that does not outpace other economic growth.

For CY 2021–2030, the healthcare cost growth target values are as follows:

- CY 2021–CY 2025: 3.4 percent
- CY 2026–CY 2030: 3.0 percent

OHA assesses performance relative to the cost growth target at four levels: (1) statewide, (2) market (i.e., commercial, Medicare, and Medicaid), (3) payers, and (4) provider organizations. OHA uses data collected from insurance carriers, CMS, Oregon's All Payer All Claims database, the VA, and other state and federal data sources to assess performance against the cost growth target.

Funding (Cost Growth Program)

The Cost Growth Target Program was provided with approximately $2 million in funding for staff positions, with the majority from the state's all general fund and a small amount of federal support. The initial biennial funding was for staffing with no dedicated funding for contractors.

Staffing (Cost Growth Program)

The Cost Growth Target Program was initially authorized for eight positions, which included an economist, a policy analyst and a few research analysts, an actuary, and administrative staff. The program is has the same management as Oregon's Health Care Market Oversight (HCMO) program. The staff are housed strategically and with direct access to the state's APCD and hospital financial reporting.

As the program has developed, more staff have become necessary to continue supporting the advisory groups and run the program. Of particular need are both data and policy analysts and ongoing legal expertise as the program further develops and implements accountability standards through PIPs and potentially financial penalties. Discussions are under way in the upcoming budget process with the legislature to seek the additional resources.

Oregon's HCMO Program

In 2021, the Oregon Legislature passed HB 2362 to oversee health care consolidation, creating the HCMO program. The law[75] directs the OHA to review proposed health care business deals to ensure they do not harm people and communities in Oregon. After completing a review, the OHA issues a decision about whether a business deal or transaction involving a health care company should proceed.

In the authorizing statute, the Oregon Legislature specified what types of proposed transactions are subject to review and the criteria OHA must use when analyzing a given proposed transaction. The program used the experience of efforts in other states including Massachusetts and California programs, but unlike other states, the legislature granted the OHA authority to block transactions outright or to impose conditions that will mitigate potential impacts resulting from the transaction. OHA uses a two-phase framework to analyze the proposed transaction's impact on the cost, access, equity, and quality of health care in the state. In addition to identifying the potential impacts of transactions, OHA must review the effects of transactions after they occur.[76]

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[75] The HCMO program is governed by Oregon Revised Statute 415.500 et seq. and Oregon Administrative Rules 409-070-0000 through -0085

[76] Or. Rev. Stat. Ann. § 415.501(19)

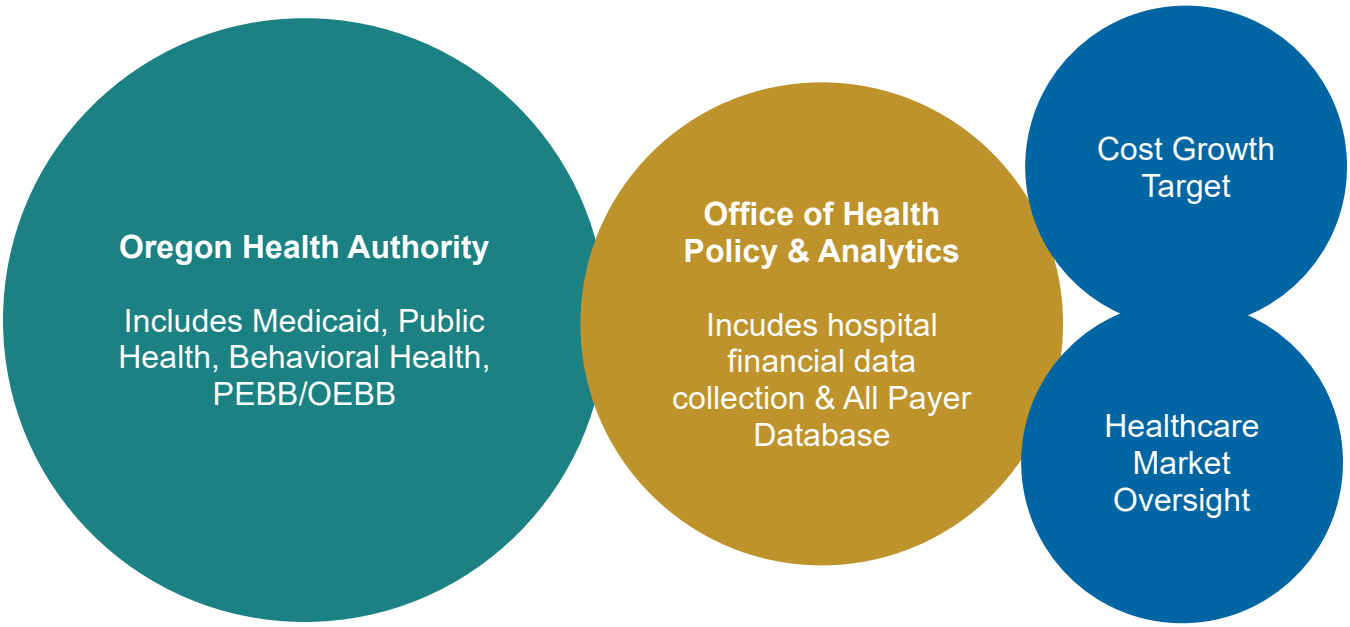
Funding (Market Oversight)

The HCMO was budgeted for initial general fund start-up dollars totaling approximately $1 million to support staffing, with the expectation that fees collected from the entities involved in the transactions would cover the costs of the program going forward. The program is examining its ongoing funding needs as the current fees structure may be inadequate to cover all the statutorily required work.

Stafffing (Market Oversight)

The Health Care Market Oversight Program is budgeted for four positions, including policy analysts, a research analyst, an economist, plus two unbudgeted junior policy analyst positions. The program is overseen by the same manager as Oregon's Cost Growth Target program. The staff are housed strategically and with direct access to the state's APCD and hospital financial reporting.

Figure C3. Oregon's Health Care Cost Containment Infrastructure within the State Government



Rhode Island

Rhode Island's Cost Growth Program

The Health Spending Accountability and Transparency Program started in July 2022. Three key goals of the program[77] include:

- **Goal 1:** Understand and create transparency around health care costs and the drivers of cost growth
- **Goal 2:** Create shared accountability for health care costs and cost growth among insurers, providers, and government by measuring performance against a cost growth target tied to economic indicators
- **Goal 3:** Lessen the negative impact of rising health care costs on Rhode Island residents, businesses, and government

Rhode Island's program builds on its Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island that was developed and signed by the Health Care Cost Trends Steering Committee on December 19, 2018. The compact's recommendations helped implement Executive Order 19-03 and the Health Care Cost Trends Project.

The Health Spending Accountability and Transparency Program was implemented via an executive order following the voluntary compact as the direct result of stakeholder collaboration. The executive order expedited implementation and was the preferred option of the Steering Committee. which "reasoned that it would signal to the public the health care industry's cooperation to reduce cost growth, and it would reduce the role of government." Committee members also agreed it would be "difficult to pass legislation without evidence that a target is effective in achieving its goals…[and] that future legislation might be a viable option once the state had experience and results from the target."[78]

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[77] State of Rhode Island. Office of The Health Insurance Commissioner. Health Spending Accountability and Transparency Program. Available at: https://ohic.ri.gov/policy-reform/health-spending-accountability-and-transparency-program.

[78] Taylor E, Bailit M, Burns M, Zayhowski J. Peterson-Milbank Program for Sustainable Health Care Costs. Rhode Island's Cost Trends Project: A Case Study on State Cost Growth Targets. Available at: https://www.milbank.org/wp-content/uploads/2021/01/Fund_Peterson_RI_case_study_v8.pdf.

The Office of the Health Insurance Commissioner (OHIC) implemented the Health Spending Accountability and Transparency Program, building on the work described above. The program is implemented according to existing statute and Executive Order 19-03[79]; Rhode Island General Laws § 42-14.5-2 states that "[the OHIC shall…] view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access."[80] Nothing in statute requires stakeholders to submit, as the program still uses voluntary cooperation as its means of collecting data.

The work of the cost growth program is overseen by the Rhode Island Health Spending Accountability and Transparency Program Steering Committee, with workgroups as needed. The work is complementary to the several other bodies of work in OHIC to address affordability including setting standards for primary care investment and care transformation through patient-centered medical homes, the adoption of payment reform strategies, quality metrics alignment, and promoting integrated behavioral health.

Rhode Island currently lacks a focused health care business oversight program.

Implementation

The state developed specific payer data specifications and an implementation manual containing guidance to assist entities with reporting. Specifications included claims to report and the methods for attributing spending.[81] These standards allow the state to report at the insurer, large provider entity, and statewide levels. The program continues to endorse an enforcement strategy of publicly reporting payer and provider performance by name.[82] No additional mechanisms are in place for enforcement, and public transparency without penalty has been a contributing factor in stakeholder involvement and collaboration.[83]

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[79] State of Rhode Island. Office of The Health Insurance Commissioner. Health Spending Accountability and Transparency Program. Available at: https://ohic.ri.gov/policy-reform/health-spending-accountability-and-transparency-program.

[80] RI General Laws 42-14.5-2 available at: webserver.rilin.state.ri.us/Statutes/title42/42-14.5/42-14.5-2.htm

[81] Taylor E, Bailit M, Burns M, Zayhowski J. Peterson-Milbank Program for Sustainable Health Care Costs. Rhode Island's Cost Trends Project: A Case Study on State Cost Growth Targets. Available at: https://www.milbank.org/wp-content/uploads/2021/01/Fund_Peterson_RI_case_study_v8.pdf.

[82] Ibid.

[83] Ibid.

Rhode Island uses provider data by leveraging the APCD to understand the patterns but does not "have capacity to collect, analyze, interpret and publicly report data on provider finances and operating costs, and oversight of physician practice group acquisitions."[84]

Rhode Island recognizes that "reducing cost growth must explicitly be done in concert with improving health care access, equity, patient experience, and quality… to achieve necessary improvement in outcomes on a statewide scale."[85] In addition to the cost growth benchmarking work, as outlined in the timeline above, the Steering Committee continues to collaborate on targets to improve health equity and design value-based payment models.

Funding

The work in Rhode Island was initially funded through a public-private partnership between the Peterson Center on Healthcare and the OHIC. Over the past few years, they have had a budget of $500,000 funded through the legislature and included in the OHIC's overall budget, and have used approximately $1 million in funding for the state Office of Health and Human Services for analysis and reporting of data from the state's APCD for an overall budget of approximately $1.5 million.

Staffing

The Health Spending and Accountability and Transparency program does not have dedicated state staffing. Outside consultants collaborate closely with the Health Insurance Commissioner and the OHIC's Director of Policy to do the following:

- Collect and aggregate data, in close collaboration with the staff of the state's APCD
- Develop health care cost trends reporting
- Support the Steering Committee work and its stakeholder engagement

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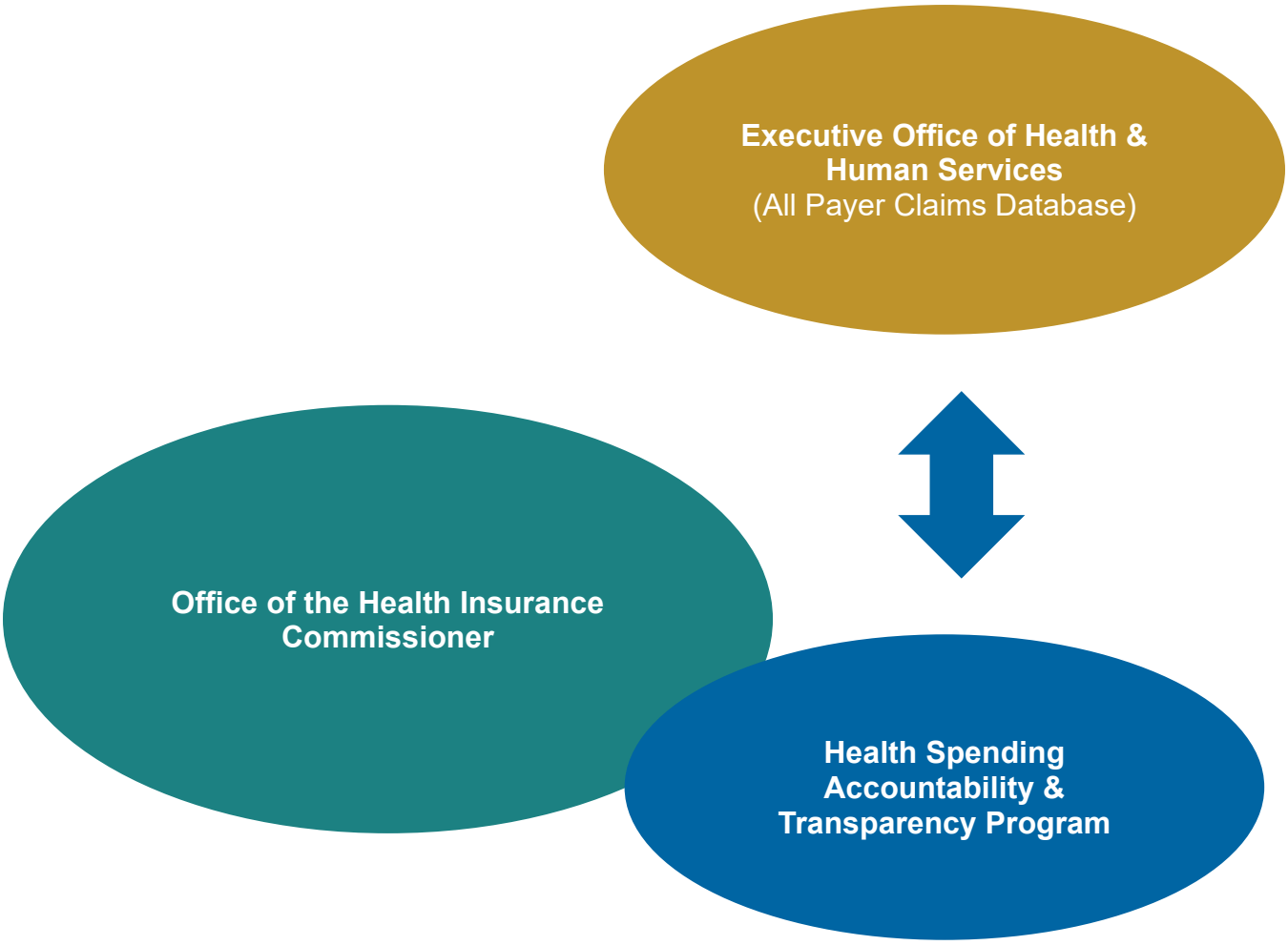
[84] State of Rhode Island. Office of The Health Insurance Commissioner. Annual Report: Health Care Spending and Quality in Rhode Island. 2024. Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-05/OHIC%20Cost%20Trends%20Report_20240513%20FINAL.pdf.

[85] Rhode Island Health Care Cost Trends Steering Committee. Compact to Reduce the Growth in Health Care Costs while Improving Health Care Access, Equity, Patient Experience, and Quality in Rhode Island. Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-07/RI%20Health%20Care%20Cost%20Growth%20Target%20Compact%20final%20signed%202023%2004-14.pdf.

They have not included actuaries or economists into the work to date, and since is a voluntary data submission effort with no enforcement authorities, have not to date needed legal expertise

Figure C4. Rhode Island's Health Cost Containment Infrastructure within the State Government



APPENDIX D: OVERVIEW OF STATES' AUTHORITY FOR BUSINESS OVERSIGHT

Authority	Nonprofit or For Profit	AG Authority	Dept of Health	+ HCMO Entity
Notice & Review *(Must go to court to challenge)*	Nonprofit only	AZ, GA, ID, MI, ND, NH, NJ, PA, TN, VA	AZ, NJ	
	Both	CO, HI, IL, MA, MN, WA*	HI, MN, NY*	MA*, CA*
Approve; Approve with Conditions or Disapprove	Nonprofit only	CA, LA, MD, NE, OH, OR, VT, WI	MA, NE, VT	
	Both	CT, NY*, RI	CT, RI, WA (CON only), WI	OR*

*Have authority for nonhospital transactions, including provider groups/private equity transactions

From: Models for Enhanced Health Care Market Oversight from Milbank Memorial Fund

REFERENCES

WA OIC Final Report on Health Care Affordability, July 29, 2024 https://www.insurance.wa.gov/sites/default/files/documents/OIC-final-report-on-health-care-affordability-092324-update.pdf.,

National Academy for State Health Policy resources:

- Cost Growth programs: How States Use Cost-Growth Benchmark Programs to Contain Health Care Costs - NASHP
- Health System Costs: State Strategy Implementation - NASHP
- Market Oversight: A Tool for States to Address Health Care Consolidation: Improved Oversight of Health Care Provider Mergers - NASHP

Milbank Case Studies To Transparency and Beyond : Snapshots of States Using Cost Growth Targets to Improve Health Care Affordability (milbank.org) from the web page: To Transparency and Beyond: Snapshots of States Using Cost Growth Targets to Improve Health Care Affordability | Milbank Memorial Fund

CA Healthcare Foundation: Health Care Cost Commissions: How Eight States Address Cost Growth (chcf.org) and Commissioning Change: How Four States Use Advisory Boards to Contain Health Spending (chcf.org)

How State Health Care Cost Commissions Can Advance Affordability and Equity - Center for American Progress

Tools to Reduce State Healthcare Costs | Commonwealth Fund