Health Care Cost Transparency Board meeting

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board
Agenda

Thursday, Nov. 7, 2024
2:00 – 5:00 PM
Hybrid Zoom and in-person

Board Members		
☐ Susan E. Birch, Chair	☐ Jodi Joyce	☐ Kim Wallace
☐ Jane Beyer	☐ Gregory Marchand	☐ Carol Wilmes
☐ Eileen Cody	☐ Mark Siegel	☐ Edwin Wong
☐ Lois C. Cook	☐ Margaret Stanley	
☐ Bianca Frogner	☐ Ingrid Ulrey	

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome and roll call	1	Sue Birch, Chair of the Cost Board and Director, Health Care Authority
2:05-2:10 (5 min)	Approval of the September Meeting Summary	2	Sue Birch
2:10-2:25 (15 min)	Public Comments	3	Sue Birch
2:25-2:55 (30 min)	Best Practices Report • 20 min presentation, 10 min discussion	4	Presentation and discussion facilitated by Gary Cohen and Jeanene Smith, Health Management Associates
2:55-3:00 (5 min)	Introduction: Business Oversight of Mergers and Acquisitions	5	Introduction by Gary Cohen and Jeanene Smith, Health Management Associates
3:00-3:30 (30 min)	National Academy for State Health Policy (NASHP) Model Policy to Address Consolidation and Closures in Health Care	6	Maureen Hensley-Quinn, MPA, NASHP Hayden Rooke-Ley, JD, Brown University School of Public Health
3:30-3:45 (15 min)	Discussion and Recommendations Regarding Business Oversight • Board considers and votes on recommendations regarding market oversight and transparency	7	Discussion facilitated by Liz Arjun and Gary Cohen, Health Management Associates Consideration of recommendations facilitated by Sue Birch
3:45-3:50 (5 min)	BREAK		
3:50-4:35 (45 min)	Analytic Support Initiative (ASI) Report	8	Joseph Dieleman, PhD, Institute for Health Metrics and Evaluation (IHME)
4:35-4:55 (20 min)	Facility Fees • Recap and finalization	9	Discussion facilitated by Jeanene Smith, Health Management Associates
4:55-5:00 (5 min)	2024 Legislative Report • Board votes to adopt the Report (assuming incorporated edits from Board discussion, votes, and public comment)	10	Sue Birch
5:00	Wrap Up and Adjourn • Next meeting: December 12, 2024, 2-4 PM		Sue Birch

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board's

Advisory Committee on Data Issues summary

August 21, 2024

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
3:30– 5 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the **Advisory Committee on Data Issues**.

Members present

Bianca Frogner, Chair
Christa Able
Megan Atkinson
Amanda Avalos
Jonathan Bennett
Chandra Hicks
Leah Hole-Marshall
Lichiou Lee
David Mancuso
Mark Pregler
Russ Shust
Mandy Stahre

Members absent

Bruce Brazier
Jason Brown
David DiGiuseppe
Ana Morales
Julie Sylvester
Hunter Plumer

Call to order

Bianca Frogner, committee chair, called the meeting of Advisory Committee on Data Issues (committee) to order at 3:37 p.m.

Washington State Health Care Authority

Agenda items

Welcome, Agenda, Introduction of New Member, and Roll Call

Bianca Frogner, Chair

Committee chair, Bianca Frogner, welcomed everyone and provided an overview of the agenda, roll was taken.

Approval of Meeting Summary

Bianca Frogner, Chair

The committee **voted to approve** the June 12, 2024 meeting minutes.

Public Comment

Rachelle Bogue, Cost and Transparency Manager, HCA

No comments were received for public comment.

Update of 7/30 Cost Board Meeting

Bianca Frogner, Chair

The Health Care Cost Transparency Board (Cost Board) met on July 30, 2024. The meeting included a facility fees panel and member discission regarding national perspective around facility fees and provider perspective, there was also a discussion about potential policy recommendations around facility fees. There were also new committee member nominations from the nominating committee, from the stakeholder group there is Michele Ritala and from the data issues David DiGiuseppe.

Business Oversight

Jeanene Smith, Health Management Associates (HMA)

Jeanene gave an overview of the business oversight work which includes mergers and acquisitions, private equity, and ownerships and closures. On May 15, 2024, HMA presented a survey of transaction oversight authority across the country to the Cost Board. The Cost Board referred the subject to the committee to help make recommendations about what data is missing and what might be useful for greater business oversight. In the June 2024 meeting there was discussion around data issues such as when data is collected, who is collecting it, and what is captured or not.

Business Oversight Data Collection Panel

Jane Beyer, Senior Health Policy Advisor and Cost Board Member, Office of the Insurance Commissioner (OIC)

Mandy Stahre, Senior Forecast and Research Manager and Data Issues Committee Member, Office of Financial Management (OFM)

AAG Travis Kennedy, Assitant Attorney General, Antitrust Division, Attorney General's Office (AGO)

Ian Doyle, Tax Policy Specialist, Legislation and Policy, Department of Revenue (DOR)

Panel presentations emphasized challenges in obtaining comprehensive data on healthcare system ownership, competition, and the role of private equity. For instance, DOR highlighted limitations in tax reporting on ownership changes, while hospital consolidation data from several sources was discussed. Various presenters also discussed data sources and limitations in understanding healthcare affordability and competition in Washington. Other topics were the integration of hospital systems in Washington, with about 80% of licensed hospital beds controlled by multihospital systems. Furthermore, vertical integration of insurers and healthcare providers, which affects competition and pricing, especially with private equity involvement. Limitations of available data, including gaps, in non-claims-based payments and incomplete ownership and affiliation data for hospitals, making it challenging to fully access healthcare competition and costs.

Washington State Health Care Authority

Discussion

Jeanene Smith, HMA
Gary Cohen, HMA

Facilitators asked committee members how Washington could use the data it already has to understand the impact on consumers and purchasers of consolidation and private equity investment. Also, how could data be gathered and shared more efficiently to reduce administrative burden on data providers, and if the state currently collects data necessary to comprehensively consider business oversight with regards to health care affordability. Several committee members indicated it was essential to have better data collection and analysis tools to understand the impact of consolidations and mergers on healthcare access, quality, and costs. Members proposed exploring ways to centralize this data for more efficient oversight.

Chair Bianca introduced David DiGuiseppe as the newest committee member.

Adjournment

The meeting was adjourned at 4:03 p.m.

Next meeting

Wednesday, November 20, 2024 at 2:00 p.m.
Meeting to be held in-person and on Zoom

Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

September 19, 2024

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
2:00-4:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the **Health Care Cost Transparency Board webpage**.

Members present

Sue Birch, Chair
Jane Beyer
Eileen Cody
Lois Cook
Bianca Frogner
Jodi Joyce
Margaret Stanley
Ingrid Ulrey
Kim Wallace
Edwin Wong

Members absent

Greg Marchand
Carol Wilmer
Mark Siegel

Call to order

Sue Birch, committee facilitator, called the meeting of the Health Care Cost Transparency Board (Cost Board) to order at 2:04 p.m.Agenda items

Welcoming remarks

Chair Sue Birch welcomed members of the Cost Board and mentioned she attended national meetings in which affordability and cost containment are key topics. Chair Birch also reminded the audience of the importance of focusing on cost containment which is what the Cost Board is tasked to do per the charter. Chair Birch gave an overview of the agenda.

Approval of meeting summary

Kim Wallace asked to have the word *not* added to "hospital services provided could *not* be reimbursed like a hospital."

The Cost Board **voted to adopt** the July 30, 2024, Meeting Summary.

Public comment

Chair Sue Birch called for comments from the public.

Bill Robertson, CEO of MultiCare Health System, offered comments on the following three topics: rate setting proposal, the Office of the Insurance Commissioner (OIC) final affordability report, and facility fees. Bill reminded the audience that MultiCare operates more than 300 primary Urgent Pediatric and specialty care clinics, 12 hospitals (soon to be 13), is a major employer with nearly 24,000 team members, a significant health care purchaser, and interested in cost containment and lowering total cost of care. Bill mentioned how significant healthcare purchaser rate setting systems in Maryland failed at controlling costs impacting Health Systems by creating time consuming and expensive regulatory challenges. Furthermore, Bill indicated that Maryland's rate setting system is not a viable solution for Washington as it has done little to produce lower costs of care for Maryland. Bill indicated trying to replicate "a similar program in Washington would cost Medicare program at least 3 billion dollars more than it does currently." Facility fees help cover the costs associated with staffing, supplies, equipment, buildings. Without facility fees, Medicare would not be able to continue operating in the Yakima area due to payment rates being unsustainable. Bill concluded that eliminating facility fees has a big impact on rural communities, creating dramatic reduction in access to care, thus he urges the Cost Board to consider impact before moving with a recommendation.

Drew Oliveira, the Executive Director of the Washington Health Alliance (WHA) commented regarding facility fees, this was discussed in July 2024 meeting. Drew indicated they are interested in looking at facility fees, but there needs to be a definition of which fees would be reviewed. For example, charging facility fees for procedures makes sense, such as, being able to catalogue when facility fees are occurring, when they are appropriate, and that some settings might be more appropriate than others. WHA is happy to look at this topic with HCA to come up with an analysis.

Jeb Shepard of the Washington Medical Association commented on the OIC final report on affordability and the Cost Board report to the Legislature. Reference-based pricing and enforcement of the benchmark assume physician practices operate on fixed costs overhead and overall cost of medical supplies staff salary benefits, are not fixed costs. Reimbursement has been trending down in Washington State, Medicaid reimbursement for specialists on average 57% of Medicare rate. Unsustainable course as evidenced by practice closure and increased consolidation over the last decade is an area of concern. Additionally, the report to the Legislature should include an analysis of underlying cost drivers. The focus should include impacts, positive and negative, of each policy proposal lawmakers need to make informed decisions.

Caitlin Safford, Senior Policy Director Government Affairs, Washington State Hospital Association, commented on the OIC final report on affordability. Caitlin indicated that the comments should be considered as remarks as the Cost Board develops policy recommendations. Two of the five OIC recommendations concentrate based on hospitals and hospital rates. However, the Cost Board established that hospital rates were not the driver of increases. The Cost Board cost driver report shows inpatient costs have been flat over the past five years while outpatient costs have been growing at high rates, this is due to increase use rather than price increases. Caitlin urged the Cost Board to identify how both hospitals and providers would be affected and how impactful unintended consequences could be. Caitlin concluded that additional enforcement mechanisms are not

appropriate until the Cost Board has a track record of developing goals and recommendations for providers on how the goals can be achieved in a feasible way.

Chris Ramirez, Senior Policy Advisor, Seattle Children's Hospital. Without facility fees Seattle Children's Hospital would have to make decision about potentially discontinuing certain services at regional clinics, this puts the burden on families to drive to Seattle. Access to specialty care and equity would be the most impacted. Seattle's main campus serves regional-based clinics located in Federal Way, Everett, and Bellevue the clinics provide complex diagnostics and therapeutic services to children regardless of ability to pay. These clinics were additions to communities where they were located and not acquired by the hospital. At these clinics 49% of patients are black, indigenous, and people of color, 76 languages are spoken and more than 50% of children's patients have Medicaid insurance coverage. In 2023, Seattle Children's saw nearly 400,000 patients and 41% of the visits were at the clinic-based setting. The Cost Board should consider the impact on access to care and engage in cost effective analysis before endorsing cuts to healthcare services in Washington State.

Advisory Committee of Healthcare Stakeholders Update

Eileen Cody, Chair of the Advisory Committee of Health Care Stakeholders

Chair Cody provided an overview of the August 21, 2024 committee meeting. Chair Cody mentioned the stakeholder committee welcomed a new member Michele Ritala, there was a discussion about medical debt from the Center on Health Insurance Reform based on the Commonwealth Fund Report. Medical debt policy prioritization discussions that will continue at the next meeting in November 2024. Received comments from the members. Chair Cody mentioned that there was frustration from some members because of the focus on what happens after medical debt instead of trying to prevent medical debt. Chair Cody indicated the members were reminded that their job as committee members was to give the Cost Board ideas that would affect consumers, collectors, hospitals, and insurers.

Advisory Committee on Data Issues update

Bianca Frogner, Chair of the Advisory Committee on Data Issues

Chair Frogner provided an overview of the August 21, 2024 committee meeting. Chair Frogner mentioned the data issues committee welcomed a new member, David DiGiuseppe. The committee focused on business oversight and reviewed where this fits in the Cost Board's priorities. Most of the time was spent hearing from the business oversight data collection panel who talked about challenges across different agencies on collecting data, especially around mergers and acquisitions. There was also a robust discussion about data and availability of data. There was some frustration about why the focus was on mergers and acquisitions, there was mention that potentially there is already enough data being collected. The committee was also reminded that these are opportunities for talking and identifying these issues.

Primary Care Committee Update

Dr. Judy Zerzan-Thul, Medical Director, Health Care Authority

Judy Zerzan-Thul, Chair of the Primary Care Committee, provided additional information regarding the committee's recommendations for the Cost Board's consideration and vote. Chair Zerzan-Thul reminds audience the Legislature directed the Cost Board to define and measure primary care spending and develop recommendations on how to increase primary care expenditures to 12% of total health care expenditures. Chair Zernan-Thul presented the committee's recommendations and mentioned two policy recommendations for legislative action. The first is increase primary care expenditure by 2% points per year until Washington achieves the goal of 12%. If there's a 2% increase, there would be an additional 635 million in primary care. The second recommendation is to increase Medicaid reimbursement for primary care to no less than 100% of Medicare no later than 2028. Chair Zerman-Thul recommended the Cost Board endorse the following strategies that already under way but don't require legislative action: Multi-payer alignment policy, patient engaged policy, workforce development, use of alternative payment models, PCE measurement.

The Cost Board inquired about the current Medicaid reimbursement for primary care, noted to be around 65% of Medicare. Questions arose regarding the process and authority needed to adjust these rates. It was clarified that increasing Medicaid reimbursement would require legislative budget authority. Chair Zerzan-Thul confirmed that a decision package was in place to address this. Chair Zerzan-Thul expressed caution regarding the ambitious goal of a 2% increase in primary care spending. She pointed out that achieving this would require significant effort and suggested that starting with a 1% increase might be more realistic, especially since no other states have successfully implemented a 2% increase. The discussion acknowledged that moving from 4.2% to 12% of spending on primary care might take approximately four years, emphasizing the need for a strategic approach.

There was a consensus that understanding the non-claims-based primary care spending is crucial. The board recognized that current data on quality and incentive payments is lacking, and that further analysis is necessary. It was suggested that more information about experiences from Oregon and Rhode Island be incorporated into the recommendations to better guide Washington's approach. Members deliberated on the types of reporting needed, such as claims data to assess utilization of emergency department services and inpatient admissions. A distinction was made between focusing on per capita expenditures versus total spending, with a preference for starting with traditional measures while exploring per capita costs in parallel

The Cost Board **approved the recommendation** to increase primary care spending, specifying a goal of up to 2% with a minimum expectation of 1%. This includes a friendly amendment to clarify the dual targets.

The Cost Board **approved the recommendation** to increase Medicaid reimbursement for primary care to no less than 100% of Medicare no later than 2028.

Chair Zerzan-Thul was tasked with refining the measurement approach, focusing on how to effectively implement the proposed spending increase while considering the various metrics discussed. The Cost Board agreed to further investigate the data collection processes for non-claims-based payments and look into legislative opportunities to support the recommended changes. Future meetings will include discussions on the integration of insights from Oregon and Rhode Island's experiences to ensure the Washington State strategy is informed and robust.

Facility Fees

Jeanine Smith, Health Management Associates

Jeanine Smith, Health Management Associates, spoke about whether or not facility fees were contributing to increased costs. Hospitals and some clinics charge fees in addition to and not directly related to the service provided. As consolidation has increased, so has the use of facility fees. All hospitals with provider-based clinics that bill a separate facility fee must report to the Department of Health as part of year-end financial reporting. Not all clinics are required to give notice, ambulatory surgical centers or other providers unaffiliated with hospitals or health systems are not required to give advanced notice. Potential recommendations for billing and ownership transparency include monitoring health care provider affiliations and acquisitions and outpatient facility fee reporting requirements, and requiring hospitals to report on outpatient facility fee billing. Colorado requires every off-campus location of a hospital to obtain unique Identifier Number (NPI). Massachusetts health policy commission does not have a unique NPI requirement but maintains a provider registry on ownership and affiliation.

David Auerbach, Senior Director of Research, Massachusetts Health Policy Commission. Spoke about data and background. David focused on cost disparities and the implications of service settings (hospital versus office) Some of the key points David mentioned were service settings and costs and indicated many healthcare services are provided in both hospital outpatient departments (HOPD's) and office settings, often with no significant qualitative differences. HOPD's are overutilized for services that could be performed in less costly settings. David indicated that payments for services are typically higher in hospital settings due to higher out of pocket costs for

patients. This pricing structure contributes to the consolidation of hospitals and physician practices. David presented data illustrating significant price difference between independent labs and hospital settings, using examples like lipid panels and CT scans. For instance, a basic lipid panel averages $30 in HOPD's compared to $14 in independent labs. ACT scan costs around $1300 in commercial settings, significantly more than in other facilities. Massachusetts made nine policy recommendations with a focus on limiting excessive provider prices. A specific proposal involved site-neutral payment for services to address the pricing discrepancies. The aim is to use the Medicare benchmark to constrain excessive provider prices.

A question was raised by a board member as to how limiting excessive provider prices relates to facility fees. David specified that the proposal encompasses a broader range of services beyond just those affected by facility fees, aiming for overall price reductions based on Medicare benchmarks.

Vashal Chaudhry, Chief Data Officer Health Care Authority, indicated there is a wall, there are stipulations separately calling out facility fees negotiation practices drivers are different looking at overall costs. Vashal agreed with David's points particularly emphasizing the challenges associated with facility fees in commercial healthcare settings. He indicated that while Medicare and Medicaid have specific regulations for identifying facility fees, commercial contracts often do not require this separation, complicating the analysis. Vashal suggested that evaluating overall affordability and pricing rather than just focusing on specific components (like facility fees) maybe be a more effective health policy approach.

Dr. Zerzan-Thul acknowledged here is significant consumer concern regarding facility fees, particularly around issues of duplicate billing and lack of reimbursement eligibility for certain services. A board member recognized that facility fees are often confusing for consumers and can lead to frustration. Another Cost Board member made a recommendation for more comprehensive data collection and ownership transparency.

The Cost Board considered the following recommendations:

Recommendation 1: Outpatient facility fee reporting requirements. Require hospitals to report on outpatient facility fee billing, including locations charging facility fees and 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 National Provider Identifiers specific to the location of care on all claims so can track via the All-Payer Claims Database. Monitor health care provider affiliations and acquisitions.

Recommendations 3: Facility Fee Billing Prohibitions. Prohibit Hospital- owned and affiliated facilities from charging facility fees for specified outpatient services, such as those that can be safely and effectively provided outside of a hospital setting.

Recommendation 4: Prohibit hospital-owned and affiliated facilities from charging facility fees for specified outpatient services and cap provider services.

Motion to Endorse recommendations:

A **motion was made to endorse** recommendation 1 and to amend recommendation 2 as discussed. Recommendations 3 and 4 to be refined and brought back at the next meeting.

Staff will work on refining recommendations 3 and 4 with input from the WHA. Further exploration of the impact on consumers related to facility fees will be conducted.

OIC Affordability Final Report

Jane Beyer. Senior Health Policy Advisor, Office of the Insurance Commissioner

Jane indicated that a preliminary report was released in December 2023, discussing horizontal and vertical consolidation and private equity ownership in the state. OIC reviewed multiple options based on consultations with legislators, state agencies, and stakeholders. Five primary policy options were identified to balance affordability and impact on carriers, providers and premiums.

Jane shared information about the following topics:

Establishing a reinsurance program targeted towards the individual and small group markets, this pulls high cost away from insurers. It estimates a 10% premium reduction through reinsurance. This ranges between $42 million and $60 million annually, influenced by federal American Rescue Plan Act (ARPA) subsidies slated to expire in 2026.

Medical loss ratio increase. Discussion on requiring insurers to spend a higher percentage of premiums on medical claims. Current standard is at 80% for individual/small group and 85% for larger group. Potential to increase to 88% was analyzed. Most insurers already meet or exceed this threshold, leading to minimal additional savings (estimated at 1.6 billion over five years).

Two approaches were discussed about capping payer payments or provider charges. Models from Oregon and Montana demonstrate potential savings. Current Washington public health option uses a cap of 160% of Medicare. Estimated savings could range from 3% to 20%, depending on design. Projected savings of $445 million in 2022 alone, with an additional $320 million in economic impact. Similar to Maryland's model, excluding certain types of hospitals. Savings estimated between 0% to 7% depending on implementation and growth rates. Significant long-term impact estimated at $6 billion over five years if successful. Meeting growth expenditure targets potential savings between $1.4 billion and $1.9 billion annually if CMS benchmark is met. Aggressive cost management can yield positive economic outcomes.

The presentation concluded with a summary of the options and their potential impacts on healthcare affordability and economic growth. Acknowledgement of the effort involved in modeling and data analysis, especially contributions from Wakeley for actuarial insights.

Legislative Affordability Priorities from State Agencies

Evan Klein, Special Assistant for Policy and Legislative Affairs, Health Care Authority
Ingrid Ulrey, Chief Executive Officer, Washington Health Benefit Exchange

Evan presented two bills proposed for the upcoming legislative session, focusing on Public Employee Benefits Board (PEBB) and School Employee Benefits Board (SEBB)programs. Evan indicated risings costs and recent contract terminations by large health systems have prompted the need for legislative intervention. Premium rates in the PEBB and SEBB programs have increased approximately by 20% since 2021, with expectations of further increases. This bill highlights network access requirement in which hospitals must participate in networks upon receiving good faith contract offer from carriers. The bill proposes a cap on reimbursement for inpatient and outpatient hospital services starting at 200% Medicare in 2027, reducing to 190% by 2029. Floor for critical access hospitals ensures adequate reimbursement levels for critical access and sole community hospitals. Behavioral health and primary care reimbursement proposes a floor of 150% Medicare for these services, aimed to enhance access and sustainability. All these would allow maintain access to critical hospital services, improve access to behavioral health and primary care. The budget packet also outlines potential cost containment strategies, predicting significant cost avoidance over the next few years.

The All-Payer Claims Database (APCD) bill aims to enhance the administration of the APCD by allowing the agency to serve as the lead organization or to procure one. The bill seeks to align state definitions of proprietary financial information with federal transparency requirements, facilitating better access to data for policymakers and the public.

Ingrid Ulrey, Chief Executive Officer for Washington Health Benefit Exchange (HBE). Ingrid reminded the audience that the HBE operates as a public-private partnership governed by bipartisan board. Ex officio board members include the Director of Health Care Authority and the Insurance Commissioner from OIC. Ingrid indicated that the board expressed frustration over rising premiums, averaging a 10% increase over the last three years, making healthcare increasingly unaffordable for individuals not covered by Medicare, Medicaid, or employee- based insurance. There is also a pressing need to support those who were uninsured prior to the Affordable Care Act but now have access through the market. The Cascade Care Savings program, particularly as federal enhanced subsidies are set to expire at the end of 2025, which could lead to significant cost increases.

Standardization of the Exchange Market, the goal is to simplify the shopping experience and protect consumers from unexpected costs, thereby reducing medical debt. Ingrid emphasized the importance of reference-based pricing as highlighted in the OIC report. The Cost Board supports collaborating with HCA to improve the reference-based pricing structure in the public option, particularly to include a floor for behavioral health services.

Chair Birch concluded the meeting thanking all those who were in attendance. She mentioned that a draft version of the legislative report was anticipated to be available at the next board meeting.

Adjournment

The next meeting is Thursday, November 7, 2024, at 2 p.m. Meeting adjourned at 4:39 p.m.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Providence
1801 Lind Avenue SW
Renton, WA 98057
Providence.org

October 3, 2024

Mandy Weeks-Green, Cost Board & Commissions Director
Washington State Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

Submitted via email: hcacostboarddata@hca.wa.gov

Dear Members of the Health Care Cost Transparency Board and Staff,

On behalf of Providence, thank you for the opportunity to provide feedback regarding Providence's Cost Growth Benchmark report published in September 2024. We appreciate the ability to review the reports and would like to share our questions and recommendations about the data for the HCCTB Board and staff to consider.

Providence is a not-for-profit health care system committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. As Washington's longest-serving health care system, Providence in Washington includes 15 hospitals, physician clinics, senior services, supportive housing, hospice and home health programs, care centers and diverse community services. In 2023, Providence provided $885 million in community benefit, including $632 million in unfunded costs of Medicaid and other government programs and $93 million in free and discounted care for Washingtonians who could not afford to pay. Together, we are working to improve quality, increase access and reduce the cost of care in all the communities we serve.

After reviewing our report, Providence offers the following recommendations for HCCTB's consideration.

Data aggregation and data validation process

Providence is concerned that the aggregation of data at the provider entity level poses significant challenges for us to validate, and that data aggregated at this level does not provide actionable information to track and analyze costs, understand whether there are outliers that need to be addressed, or other actions to take to contribute to the overall goal of managing health care costs. Without more granular data, we cannot leverage this information in a meaningful way to influence our cost management strategies.

Additionally, based on the level of aggregation of the data in this report, it is not possible to validate the data on our end. The inability to validate the data is concerning because we are unable to ensure the data's accuracy and reliability. If we cannot confirm the integrity of the data presented, we risk flawed or incomplete data being presented upon our behalf.

In order for this data to be validated, each hospital would need to have the gross total medical expenditure dollar amount for each tax identification numbers (TINs) that were reported under the

benchmarking provider entity code. In order to accurately track patient attribution, we would need medical expenditures to be provided by the national provider identifiers (NPI) .

While we understand the HCCTB has not collected data in this form from carriers, we request that HCCTB revisit providing reports that include data provided from carriers to the HCCTB by TIN. Since Providence had provided TINs to the HCCTB for the purposes of directing carriers on which data to include, it seems possible to request data in this format from carriers to the HCCTB, for inclusion in the reports back to Providence, which would decrease the number of individual requests on carriers for disaggregated data that we need to truly validate and replicate how the data was calculated. Data that is at least provided at the entity level is crucial for making meaningful comparisons across facilities within our system.

The ability to validate data is critical if we want these reports to drive change. Providence is also concerned that the current process for validating information is significantly burdensome on providers and carriers, as the HCCTB has directed each provider entity to reach out to each carrier independently to understand how data was reported. Approaching payors individually to obtain data creates burden on carriers who are then responding to multiple data requests. Finally, we are unclear if payors have the capacity to respond to numerous requests from various providers. This raises further concerns about the feasibility and effectiveness of relying on each provider to approach each payor for accurate and timely data, highlighting the need for a more streamlined and transparent process.

Medicare data

Providence would like to point out that changes in the wage index portion of the Medicare data is likely driving the difference between Medicare rates across all hospitals and the HCCTB benchmark. Additionally, Medicare data will likely show volatility over the next several years, due to changes made at the federal level in how the rate is calculated.

Each year, changes to the wage index can create substantial variances, with the impacts to individual hospitals varying based on local market conditions. It is important for the HCCTB to know that the wage index changes each year but the adjustment has not been adequately reflected in the current benchmark. The Centers for Medicare & Medicaid Services (CMS) routinely changes payment rates and finalized significant changes to the rural floor calculations in 2024.

The volatility in the wage index can result in unpredictable increases or decreases in Medicare payments. This fluctuation is well known and we are concerned that this volatility will persist, leading to misrepresentations in the Medicare cost and payment columns. If we do not normalize for these variations, the data will likely continue to show discrepancies that could be misleading for the purposes of tracking cost growth year over year within the Medicare program as compared to the HCCTB benchmark.

Cost growth cap

Providence remains concerned with the cost growth caps that the Board has chosen. Health care is not immune from the rates of inflation which we have seen in the broader economy. Further, the growth rate targets chosen by the Board do not reflect the realities of healthcare-specific costs,

especially on pharmaceuticals, supplies, and labor, which are not in our full control. As a result, we continue to have concerns regarding the targets chosen.

Requests to improve collaboration

Providence sees opportunities to improve collaboration within the HCCTB process. Meetings are often conducted with very little notice regarding the agenda, leaving stakeholders unclear about the topics to be discussed and unable to align attendance accordingly, even though written comments from the public are requested 10 days prior to a meeting. It would improve our ability to participate in the discussion if the Board could provide an agenda two weeks ahead of a meeting.

Additionally, we would welcome the opportunity to walk through the Providence provider report with HCCTB staff, to ensure greater shared understanding of how these reports are being viewed and interpreted. This will help improve our comments and feedback within the process, improve our understanding of what's important to the Board within these reports, and dialogue regarding both the capabilities and limitations that impact the reports that providers receive.

Thank you for the opportunity to submit comments to the HCCTB on our 2022 Cost Growth Benchmark report. If you have questions or would like to talk about Providence's recommendations, please contact Lauren Platt McDonald (Lauren.Platt@providence.org).

Sincerely,

Lauren Platt McDonald
Executive Director, State Government Relations
Providence

From: LINDA HERMAN
To: HCA HCCT Board
Subject: Family of 4, $25,000 out of pocket Healthcare
Date: Friday, September 20, 2024 4:13:09 PM

External Email

Dear HCCT Board,
It appears your goal is to make healthcare more affordable, however, our family is not able to afford healthcare coverage. Healthcare accommodations are routinely made for low income families but there's zero help for middle income families who bear the burden of paying full price for everything while contributing to the tax base.
My husband worked for a company that supplied our healthcare insurance coverage until he became permanently disabled due to complications from his genetic disease and kidney transplant 6 years ago. He is 58 and qualifies for Medicare, we were able to purchase a supplement plan to help pay for the high cost of his medical care.
I work part time, due to the time it takes to manage the household and his medical requirements. This has left myself and our 2 daughters without healthcare coverage except through the health exchange. The policy just for myself cost about $800 a month in premiums and has a $7000 deductible. This does not include dental or vision coverage.
We pay our bills on time, work as much as we're able, pay our taxes and have a fixed income with no ability to keep up with the rate of inflation and yet low income workers are given so many benefits. Our daughters qualified for Medicaid if we paid a portion of the premiums. We were able to get our oldest now in college on a college plan for $3600 per year. She also has my husband's genetic disease and needs a good health plan, attending a college out of state meant Medicaid was not an option. In addition to the premiums, we pay 20% of the bill.
This is not sustainable, I dropped my coverage and purchased a Medishare plan, which has a $12,000 deductible. I shopped for other coverage but for some reason only a limited number of cost sharing plans are available in WA state. I have ended up paying cash for every appointment because I won't reach the $12,000 deductible, so it saves a little to get the cash pay discount. The cost sharing plan is more money thrown away unless I get cancer, it's of no use.
We can not be the only family struggling to pay for healthcare, the costs are simply not attainable. We are not wealthy and have many bills to pay out of our benefits since we don't have any breaks due to our fixed income. Low income families qualify for tax breaks, food, electricity, a break on the phone bill, etc. we get zero breaks and not even allowed to write off all the medical bills on our taxes. Meanwhile costs keep going up!
How about someone looks at providing Medicaid or Medicare to families already paying high out of pocket costs for a disabled parent. My husband's Medicare, supplement plan, and drug plan are very expensive and we pay cash for dental and vision on top of it. A family of 4, $25,000/yr. in out of pocket Healthcare bills!
Linda Herman

Tab 4

Washington State Health Care Authority

HMA

State Health Care Cost Growth Programs' Infrastructure:

Study of Best Practices

DRAFT November 2024

STUDY OF BEST PRACTICES

- The Legislature directed the Washington State Health Care Cost Transparency Board to study best practices from other states regarding the infrastructure of state health care cost growth programs
- An environmental scan was conducted looking across states that had active health care cost growth programs
- Four states identified for more detailed survey and interviews to further understand their Cost Growth programs, structure, scope, financing and staffing
- Information also requested regarding the infrastructure of those focus states that also have business oversight programs to oversee mergers/acquisitions etc.
- Comparisons with Washington State's current efforts are summarized here –with a detailed overview in the Best Practices report attached to the legislative report

EIGHT STATES HAVE COST GROWTH BENCHMARKING PROGRAMS

2012: Massachusetts

2018: Delaware

2019 Rhode Island, Oregon

2020: Connecticut, Washington State

2021: New Jersey

2022: California

The benchmark programs have had variable results over the years with the Covid pandemic impacts due to changes in healthcare utilization and inflation, and some programs are very new and just beginning their program

Common Features

- Authority to collect and use data to monitor health system spending trends
- Growth target against which to measure spending trends
- Spending measurement to collect and track healthcare expenditures
- Data and analytic capacity to support data analysis, reporting and use cases
- Data use strategy to advance state strategies
- Public reporting with steering committees' oversight
- Some states also have market oversight programs

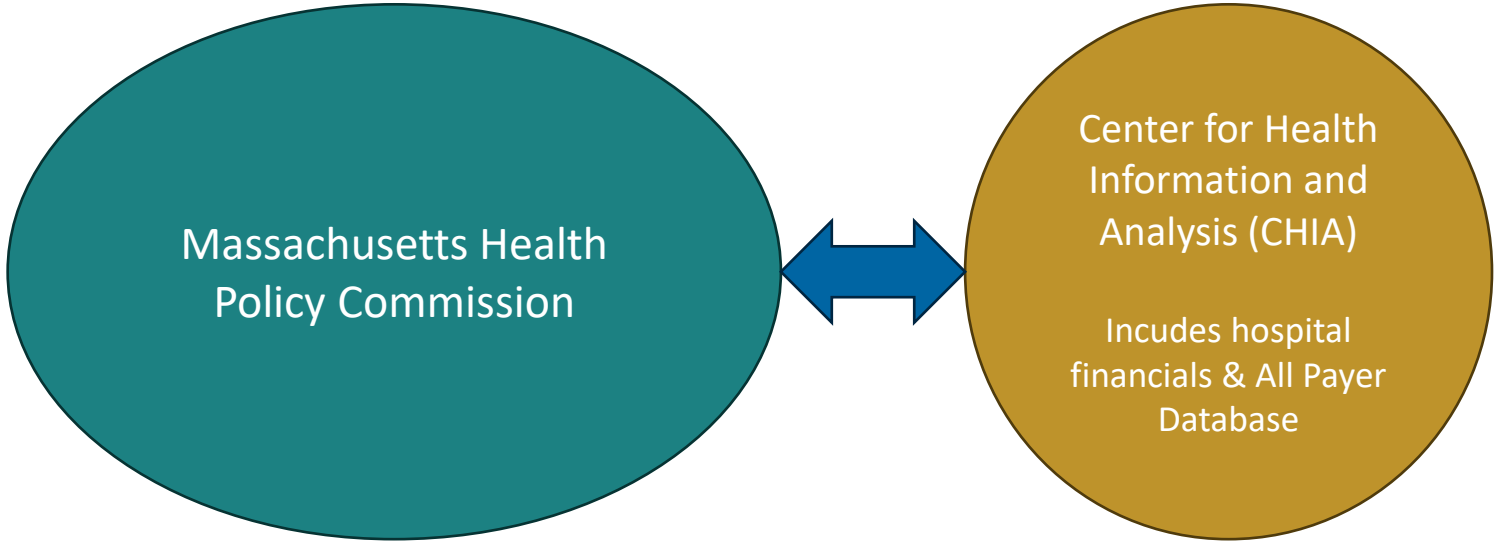
Note: A ninth state, Nevada, initiated efforts by Executive order in 2021 but not supported by current governor, so efforts were not continued as of 2023

FOUR KEY STATES – GOVERNANCE STRUCTURE

State	Public Body Involved	State Agency Responsible for the Program and its structure	New or Existing Entity? How established?
CA	Health Care Affordability Board (HCAB) Advisory Committee, with multiple workgroups	California Office of Health Care Affordability Located in the Dept of Health Care Access and Information within the larger California Health and Human Services Agency (which also includes Medicaid, Public Health, Aging, Social Services and other	**New office created within an existing health agency structure Established legislatively**
MA	Board of Commissioners	Massachusetts Health Policy Commission	**New agency, established legislatively**
OR	Cost Growth Target Advisory Committee Cost Growth Target Technical Advisory Group (TAG)	Cost Growth Target Program, Oregon Health Authority	**New program inside existing Health Agency, established legislatively**
RI	Rhode Island Health Spending Accountability and Transparency Program Steering Committee with workgroups	Health Spending Accountability and Transparency Program, Office of the Health Insurance Commission	**New program inside Insurance regulation agency, established by executive order**

MASSACHUSETTS: HEALTH POLICY COMMISSION

- Established in 2012 by Legislation
- 3 key functions of the Health Policy Commission:
  - Care Delivery Transformation
  - Health Care Cost Containment
  - Market Oversight and Monitoring
- Structure in Government: Independent state agency



Infrastructure

Funding

- *$12 million for HPC*
- *CHIA has separate budget of ~$30 million*

Staffing

- *Averages 60-65 positions overall for the Cost Growth program, Market Oversight, operations and a grant program*

Ability to Engage Consulting & Other Resources

- *Works closely with MA's CHIA which houses the All-Payer Database, hospital financial data*

Key Features

- *Funding is via an annual assessment of hospitals/delivery systems, payers and ambulatory surgical centers.*
- *Close relationship with CHIA for data*

Infrastructure

Funding

- *Biannual budget of $2 million for CGT*
- *Biannual budget of $1 million for HCMO*

Staffing

- *Authority for 8 positions for CGT*
- *Authority for 4 positions for HCMO*
- *Integrated within Office of Health Analytics*

Ability to Engage Consulting Services & Other Resources

- *Housed in OHA's Health Analytics office w APCD & actuaries, work closely together*
- *Funding through Peterson Foundation's grants to states for additional consultants*

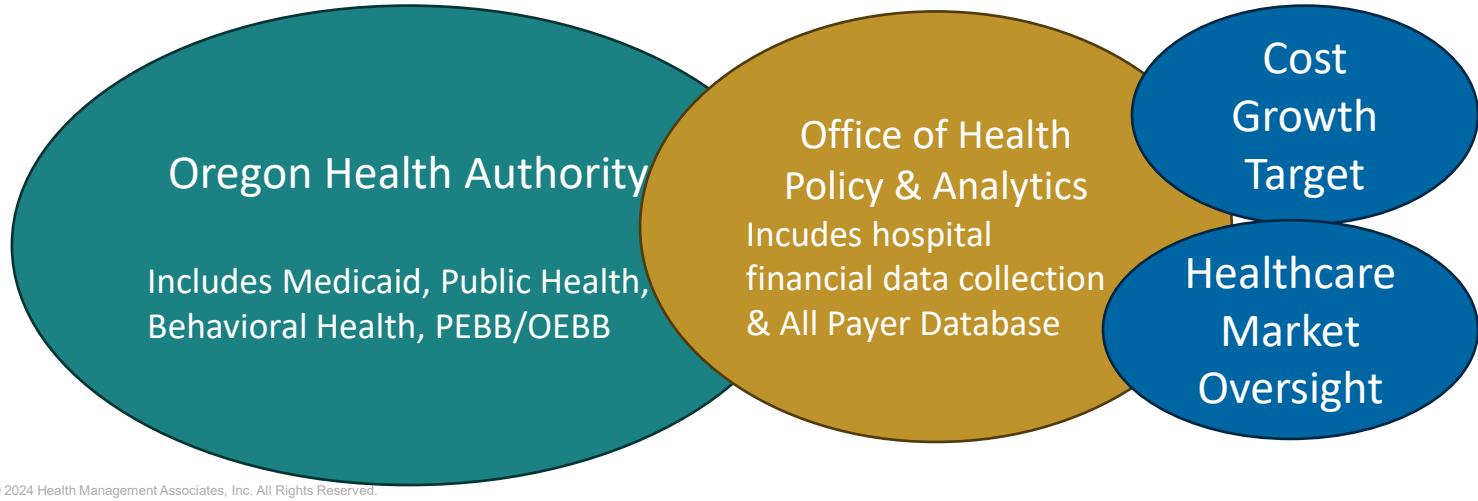
Key Needs/Wishes

More dedicated funding for:

- *Staffing for data analysis and policy development*
- *Legal expertise particularly for accountability*

OREGON: COST GROWTH TARGET (CGT) & HEALTHCARE MARKET OVERSIGHT PROGRAMS (HCMO)

- Both programs established by Legislation
  - **Cost Growth Target Program Goals**
    - Set and update the Cost Growth target
    - Ensure that health care costs don't outpace wages or the state's economy
    - Identify opportunities to reduce waste and inefficiency, resulting in better care at a lower cost.
  - **Market Oversight Program Goals:**
    - Promote transparency
    - Support statewide priorities
    - Monitor impacts
- Structure in Government:



RHODE ISLAND: HEALTH SPENDING ACCOUNTABILITY & TRANSPARENCY PROGRAM

Infrastructure

Funding

- *~$1.5 million*

Staffing

- *No dedicated staff, work done by Consultants*

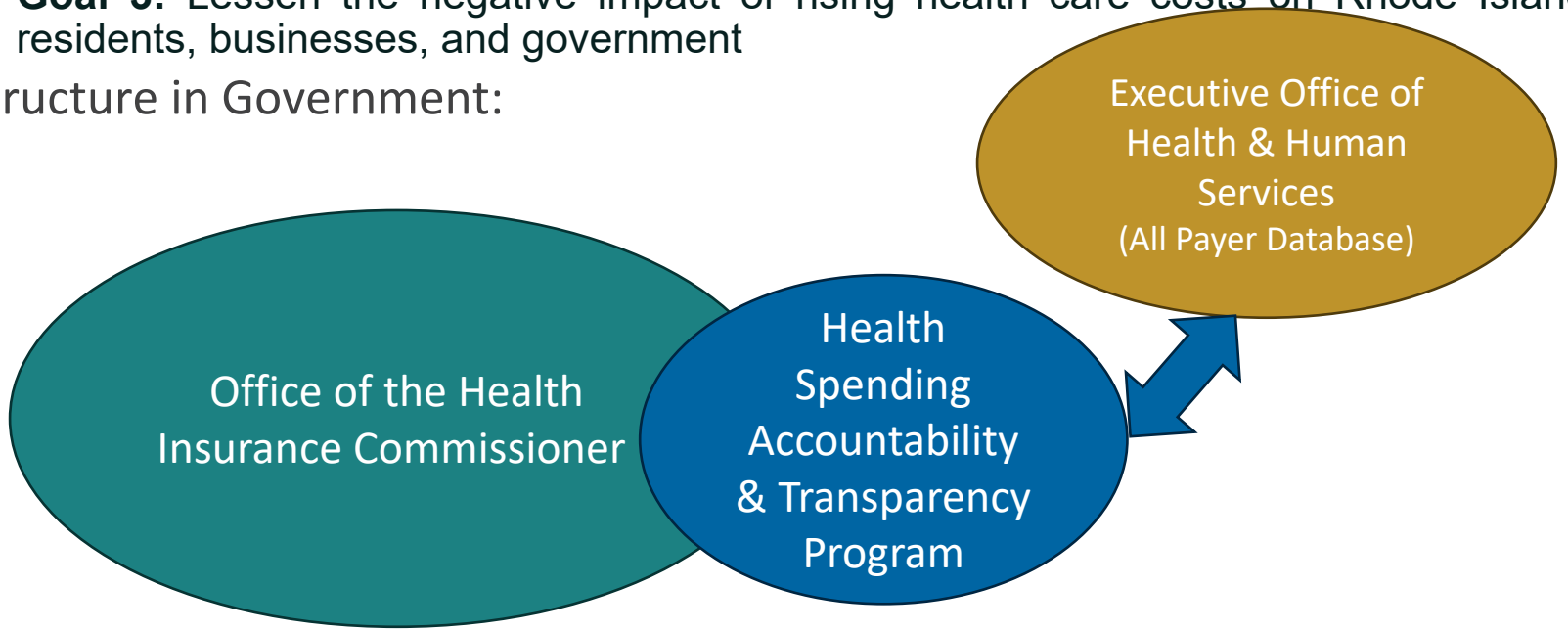
Ability to Engage Consulting & Other Resources

- *Work closely with the state's APCD consultants that include claims and data scientists*
- *Not used actuaries or economists to date*
- *Not used legal expertise to date as no enforcement authority*

Key Distinctions

- *Voluntary compact between Insurance Commissioner and stakeholders*
- *Commissioner Uses rate review authority to cap reimbursement rates paid to hospitals*

- Established by Exec Order; Overseen by a Steering Committee and the Office of the Health Insurance Commissioner
- 3 Key Goals:
  - **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
- Structure in Government:



Infrastructure

Funding

- *Annual continuing appropriation of $22 million overall for OHCA*
- *More dollars going toward market consolidation work, smaller portions to cost growth and high value areas*

Staffing

- *Authority for 80 positions- still working on hiring staff*
- *Mix of data analysts, policy analysts and stakeholder engagement/Board support*

Ability to Engage Consulting & Other Resources

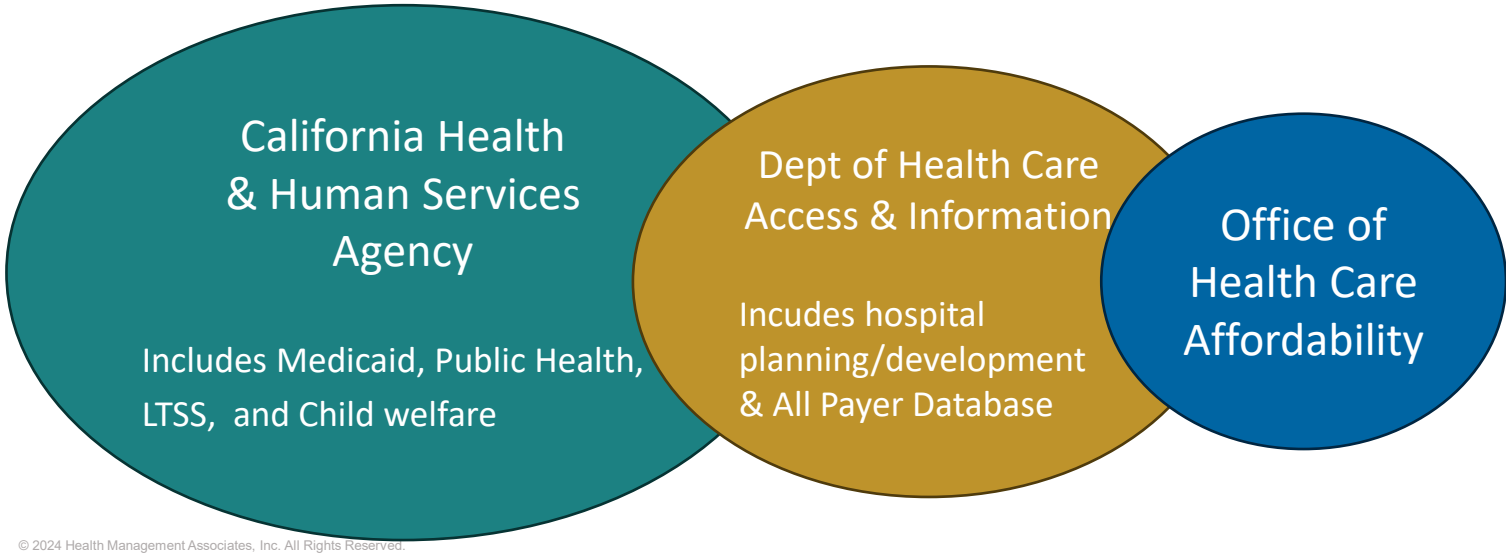
- *Have resources if dollars not otherwise spent on internal staff*
- *Have engaged with higher priced services like actuaries that are hard to entice into state salaries*
- *Have flexibilities from contracting rules and ability to hire quickly for rapid access to services needed*

Note: *OHCA is just starting up its programs*

CALIFORNIA: OFFICE OF HEALTH CARE AFFORDABILITY (OHCA)

- Three Areas of Focus:
  - Slow spending growth with target and monitoring of expenditures
  - Assess market consolidation with cost and market impact reviews
  - Promote high value with focus on primary care, behavioral health, workforce, APMs, equity and quality

- Structure in Government: Established by Legislation



BEST PRACTICES HIGHLIGHTS

- **Governance Structure:** Each structure has trade-offs; some structures may enable the program to be more efficient in carrying out the functions they have been assigned, have credibility and "buy-in" from stakeholders.
- **Comprehensive data collection:** Allowing analysis and reporting providing insight into the entire health care system is key to the success of the programs.
  - MA stands out as the best example with comprehensive data collection via their CHIA; OR has consolidated its data and analytics into one office inside the Oregon Health Authority
- **Authority to Enforce Compliance:** Some states have the authority through the use of performance improvement plans (PIPs) and/or civil penalties.
  - MA, CA, and OR all have enforcement authority with MA required one for Mass General Brigham Health System that has directed $176.3 million in savings that the system is on track to achieve.
- **Market oversight authority** augments the cost growth programs in MA, OR and CA
  - Oregon's Market Oversight program can review transactions involving health care entities, such as mergers and acquisitions and private equity investment, with the authority to deny or approve with conditions.
  - Massachusetts' Health Policy Commission just completed a report focused on private equity's impact on the health care market and see it as an area of increased interest for their state.

BEST PRACTICES HIGHLIGHTS, CONTINUED

- **Other State Authority to Impact Prices beyond cost growth programs**
  - Oregon passed a law in 2017 that requires health insurers and third-party administrators that contract with the state employee plan to cap payments for hospital facility services at 200% of Medicare rates for in-network and 185% of Medicare rates for out-of-network services.
    - Outpatient rates declined by 25% in the first 2 years. Smaller price reductions in inpatient but reductions resulted in $107.5 million in savings for the state in the first 27 months of the policy
  - Rhode Island has used rate review authority to limit increases in hospital prices, using affordability standards
    - Net reduction in enrollee spending by a mean of $55 in 2016; utilization didn't change with an increase in primary care spending by $21 per enrollee
  - Washington has proposed legislation for requiring reference-based pricing for health care services for public employees (PEBB) and school employees (SEBB) plans
- **Funding scaled to scope and expectations**
  - Massachusetts and California are examples of programs with dedicated funding source that includes an assessment on health care entities.
  - Oregon and California can assess entities for the cost of the full reviews for their Market Oversight programs

DISCUSSION

- Board feedback – kicking off the discussion
- Clarify next steps for report
  - Being submitted with Legislative report as required deliverable
  - Future discussions?

APPENDIX

Cost Growth Programs' Infrastructure Best Practice Additional Examples

BEST PRACTICES: COMPREHENSIVE DATA COLLECTION FOR ANALYSIS AND REPORTING

- **Comprehensive data collection** allowing analysis and reporting providing insight into the entire health care system is key to the success of the programs.
- Several factors influence each state's ability 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 (whether authority given to the cost growth program or to other state agencies)
  - The staff and funding available to do data analysis
- Data reflecting growth in health care costs has been used to determine compliance with cost growth targets and to analyze drivers of cost growth
- The methodologies selected to set cost growth targets have not depended on historical data on the cost of health care, but have been general measures of growth in the economy as a whole;
  - Targets have been based on measures such as anticipated growth gross domestic state product and consumer prices. California has shown growth based on household income.
- Massachusetts stands out as the best example with comprehensive data collection via their CHIA; Oregon has consolidated its data and analytics into one office inside the Oregon Health Authority

BEST PRACTICES: AUTHORITY TO ENFORCE COMPLIANCE

- Some of the states have the authority to enforce compliance through the use of performance improvement plans (PIPs) and/or civil penalties
- **Massachusetts'** Health Policy Commission has the authority to **PIP and to impose civil fines on entities.**
  - Jan 2022, first PIP issued to Mass General Brigham asking for 10 interventions including price reductions, reducing utilization, shifting care to lower cost sites, and accountability through value-based care.
  - Estimated savings of $176.3 million over the eighteen-month period the plan would be in effect.
- **California's** OHCA given substantial authority to undertake progressive **enforcement of its targets cost growth targets** when entities exceed them. Since a new program, first enforcement actions could be sometime in 2028.
- **Oregon also has progressive enforcement authorities** but has been delayed with 2025 to be the first year for PIPs, fines by 2029

BEST PRACTICE: MARKET OVERSIGHT AUTHORITY

- **Oregon's Market Oversight** program can review transactions involving health care entities, such as mergers and acquisitions and private equity investment
  - The program has the authority to apply criteria including their potential impacts on health care cost, access, quality and equity.
  - This can include denying the transactions.
- **Massachusetts' Health Policy Commission** just completed a report focused on private equity's impact on the health care market and see it as an area of increased interest for their state.

BEST PRACTICES: OTHER STATE AUTHORITY TO IMPACT PRICES

- **Oregon** passed a law in 2017 that requires health insurers and third-party administrators that contract with the state employee plan to cap payments for hospital facility services at 200% of Medicare rates for in-network and 185% of Medicare rates for out-of-network services.
  - Started in 2019 for educators; 2020 for public employees
  - Exempt hospitals include rural or crucial access hospitals, and sole community hospitals located in counties with fewer than 70,000
  - Outpatient rates declined by 25% in the first 2 years. Smaller price reductions in inpatient but reductions resulted in $107.5 million in savings for the state in the first 27 months of the policy
- **Rhode Island** has used rate review authority to limit increases in hospital prices, using affordability standards
  - Net reduction in enrollee spending by a mean of $55 in 2016; utilization didn't change with an increase in primary care spending by $21 per enrollee

BEST PRACTICES: FUNDING ADEQUATE TO PERFORM FUNCTIONS

- **Massachusetts and California** are examples of programs with dedicated funding source that includes an assessment on health care entities.
  - Massachusetts invoices provider organizations (hospitals/health systems), payers and ambulatory surgical centers annually to support both the Health Policy Commission and CHIA (data) to cover their budgets
- **Oregon and California** can assess entities for the cost of the full reviews for their Market Oversight programs

REFERENCES

(FULL *LEGISLATIVE REPORT IN TAB 10)*

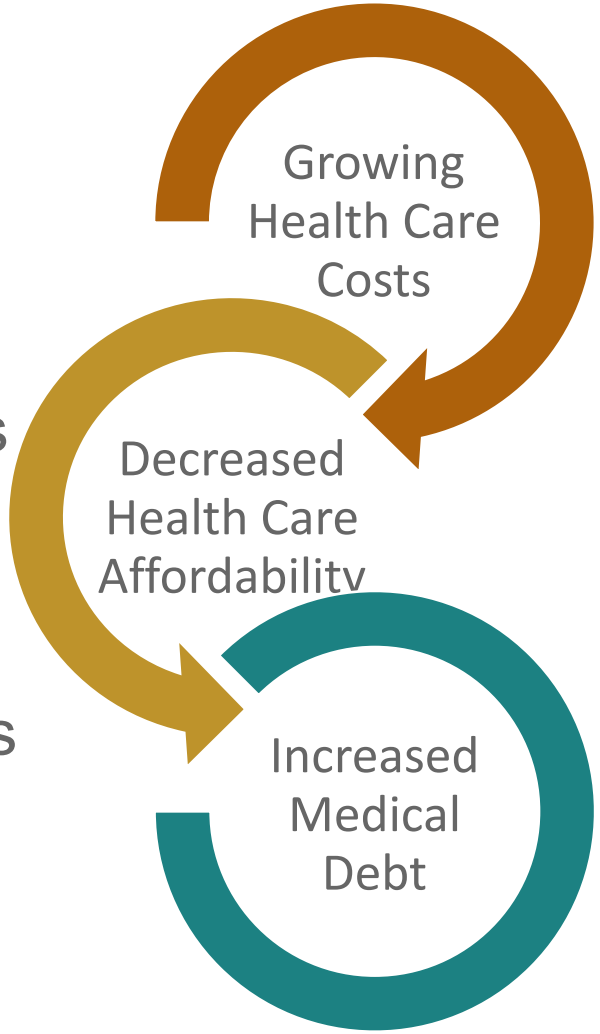
- WA Office of the Insurance Commissioner 2024 Final Affordability Report, and 2023 Preliminary Affordability Report
- National Academy of State Health Policy model legislation Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine, and Transparency
- Milbank 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

Tab 5

Washington State Health Care Authority

REFRESHER - COST BOARD CHARGE

- Cost Board is tasked with developing benchmarks and understanding the underlying drivers of growing health care costs in response to the growing impact on health care consumers, employers and the state budget
- Interventions to address drivers of growing health care costs are longer-term strategies
- Consumers continue to face growing out-of-pocket expenses through premiums, co-pays, facility fees, which lead to medical debt
- Important to protect consumers from this debt while Cost Board deliberates and recommends policies to address costs



Reducing Health Care Costs, Increasing Health Care Affordability and Lowering Consumer Medical Debt: Policy Levers

Health Care Costs (Long term)

- Reference based pricing
- Provider rate setting
- Price growth caps/ Price caps
- Hospital global budgets
- Consolidated state purchasing
- Business oversight of mergers and acquisitions
- Restricting anti-competitive practices
- Increased rate review

Consumer Health Care Affordability (Medium Term)

- Increase transparency of facility fees
- Ban or limit facility fees
- Standardize health plans
- Increase medical loss ratio
- Implement reinsurance
- Increase subsidies for premiums and cost-sharing

Consumer Medical Debt (Short Term)

- Reduce barriers to applying for financial assistance (e.g., presumptive eligibility)
- Expand entities required to provide financial assistance
- Set minimum spending floors for financial assistance
- Require income-based repayment plans
- Further cap interest rates
- Limit credit reporting
- Prohibit wage garnishment
- Restrict liens and foreclosures
- Buy existing medical debt
- Require reporting of collections actions
- Break down financial assistance data by patient demographics

TODAY'S POLICY FOCUS AREAS

Health Care Costs

- Business oversight of mergers and acquisitions

Consumer Affordability

- Increase transparency of facility fees

HMA

Business Oversight of Mergers and Acquisitions

BACKGROUND

Provider consolidation, including both horizontal and vertical integration, limits options for purchasers and carriers and leads to higher health care prices, increased health care costs and increased medical debt.

Private equity ownership has been consistently associated with increased cost to patients or payers and with mixed to harmful impacts on quality

BACKGROUND (CONT.)

- Last year's OIC report covered the state of health care consolidation and private equity in Washington.
  - 40 of the 101 hospitals in the state are part of the five largest hospital systems and another 15 are part of smaller multi-hospital systems
  - 79.51% of all licensed beds are part of multi-hospital systems
  - Approximately 50% of physicians are employed by hospitals and of these, 65.6% are employed by multi-hospital systems
  - From 2014–2023, a total of 97 private equity acquisitions within the health care sector documented in Washington State
  - Insurers are actively purchasing physician practices, PBMs, health care benefit managers, data and analytics

BACKGROUND (CONT.)

- Several states have adopted policies that permit review of proposed mergers and acquisitions for impact on cost, access, equity and quality in addition to antitrust analysis, as described in the Best Practices Report.
- The Board has held several conversations on business oversight this year
  - February Board Retreat, May Board meeting, Data Advisory Committee June meeting
  - Noted that the state doesn't have complete information on ownership of health care entities and private equity investment, which is not reported.
- 2024: "Keep Our Care Act" (SB 5241) – did not pass
  - Would have required additional entities to file material change transactions for AG review with authority to approve or place conditions on transactions and monitor compliance, with civil penalties
- The National Academy for State Health Policy (NASHP) has worked to develop model legislation for states to consider, focused on providing more oversight on mergers and acquisitions.

Tab 6

Washington State Health Care Authority

Model Policy to Address Corporatization, Consolidation, and Closures in Health Care

Washington Health Care Cost Transparency Board Meeting on Nov. 7, 2024

Maureen Hensley-Quinn, MPA, NASHP

Hayden Rooke-Ley, JD, Brown University School of Public Health

NASHP | NATIONAL ACADEMY FOR STATE HEALTH POLICY

NASHP Model Law: Addressing to Corporatization of Health Care, Consolidation, Closures

https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers/

	Policy Approach	Policy Concerns
	**Health Care Transaction Oversight Authority** (NASHP Model Part I)	Consolidation, costs, closures, sale-leasebacks
	**Strengthening the Prohibition on Corporate Practice of Medicine, Banning physician noncompetes, nondisparagement agreements** (NASHP Model Part II)	Professional autonomy, workforce effects, interference with clinical decision-making
	**Ownership Transparency** (NASHP Model Part III)	Opacity, lack of accountability

NASHP Model Law Part I:

Enhanced Oversight over Material Health Care Transactions

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Addressing Corporatization of Health Care, Consolidation, and Closures: Updated NASHP Market Oversight Model Legislation

by Vicki Veltri, Maureen Hensley-Quinn

Part I: Enhanced Oversight over Material Health Care Transactions

Part II: Strengthening the Ban on the Corporate Practice of Medicine

Part III: Creating Transparency in Ownership and Control of Health Care Entities

Policy 1: Enhanced Transaction Oversight

Policy concern: Traditional antitrust tools can be inadequate to address novel forms of health care consolidation, including private equity and other corporate investment

Response: Strengthen oversight authority over health care transactions in two primary ways

(1) Expanding the Oversight Authority:

- Require **prior notice** of material transactions
- Expand **review** authority
- Enable authority to **block or impose conditions** upon the transaction without a court order

(2) **Expanding role of state health agencies:** vest another state health entity (in addition to the state attorney general) with the authority to review and report on a proposed transaction's broader health care market impact.


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UPDATED ON 07-26-2024

A Model Act for State Oversight of Proposed Health Care Mergers


Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities

BY ERIN C. FUSE BROWN AND KATHERINE L. GUDIKSEN

REPORT | February 2024

Milbank Memorial Fund

NASHP Model Part I: Review of Proposed Material Change Transactions

NASHP released updated health care transaction oversight model in July 2024:

- Expands scope of entities covered:
  - Private equity, management services orgs (MSOs), Real Estate Investment Trusts (REITs), payers, staffing companies
- Expands types of transactions covered:
  - Sale-leasebacks, MSO agreements, serial transactions going back 5 years, JVs, closures of key facilities or services, staffing agreements
- Strengthens enforcement authority:
  - AG enforcement, penalties, injunctive relief
  - State health agency enforcement
  - Ongoing monitoring of transactions

NASHP Model Law Part II:

Strengthening Protections of Health Care Professionals from Corporate Control: CPOM, Restrictive Covenants

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by Vicki Veltri, Maureen Hensley-Quinn

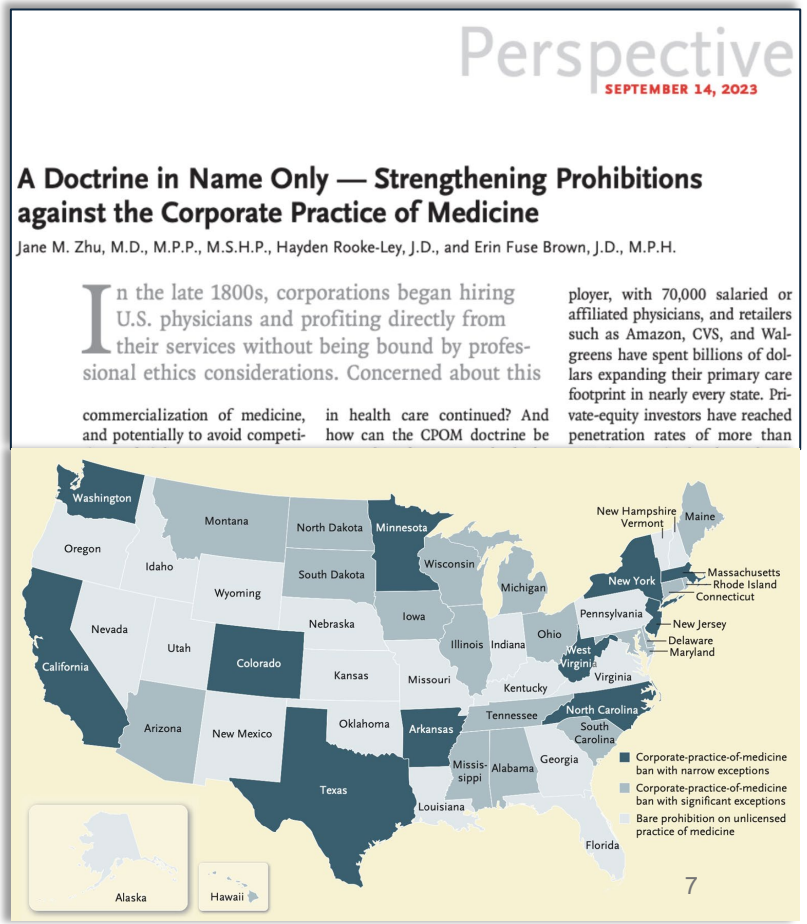
Part I: Enhanced Oversight over Material Health Care Transactions

Part II: Strengthening the Ban on the Corporate Practice of Medicine

Part III: Creating Transparency in Ownership and Control of Health Care Entities

Policy 2: Strengthening the Corporate Practice of Medicine Prohibition

- **Policy concern:** Corporate control over *physicians and other independent practitioners* (e.g., PE, Optum, etc)
- **What it is:** The Corporate Practice of Medicine (CPOM) doctrine generally bans unlicensed lay entities from owning, employing, or controlling medical practices. Stems from ban on the unlicensed practice of medicine.
- **What it isn't:** CPOM does not address corporate/for-profit control of *hospitals* or other facilities
- **Why it needs strengthening:** CPOM laws eroded over time, coinciding with the "managed care" revolution, with exceptions (HMOs, Hospitals) and nonenforcement.
- Corporations contractually circumvent CPOM bans to exert *de facto* control over a medical practice they did not formally own through MSOs and "friendly PCs"



Perspective

SEPTEMBER 14, 2023

A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine

Jane M. Zhu, M.D., M.P.P., M.S.H.P., Hayden Rooke-Ley, J.D., and Erin Fuse Brown, J.D., M.P.H.

In the late 1800s, corporations began hiring U.S. physicians and profiting directly from their services without being bound by professional ethics considerations. Concerned about this commercialization of medicine, and potentially to avoid competi- in health care continued? And how can the CPOM doctrine be ployer, with 70,000 salaried or affiliated physicians, and retailers such as Amazon, CVS, and Walgreens have spent billions of dollars expanding their primary care footprint in nearly every state. Private-equity investors have reached penetration rates of more than

NASHP Model Part II: Strengthening CPOM

- **Add or clarify CPOM prohibition in statute:**
  - Prohibit unlicensed lay-entities from owning, employing, or controlling medical practices
  - Prohibit any unlicensed lay-entities from interfering with clinical decisions
- **Regulate Friendly PC/MSO structure (does <u>not</u> ban MSOs)**
  - Restrict dual compensation / control of PC and MSO
  - Require that licensed professionals maintain ultimate control over clinical and business decisions in contracts with management services organizations (MSOs)
  - Enumerate types of clinical and business decisions that implicate CPOM
  - Ban or limit non-competes, gag-clauses
- **Protections for employed physicians** (e.g., by hospitals or other exempted entities)
  - Ban or limit non-competes, gag-clauses
  - Noninterference with clinical decisions
- **Multiple routes of enforcement: AG, administrative agency, private actions**
  - Private enforcement (by aggrieved employee or competitor) can supplement administrative enforcement, whistleblower as “private AG”

NASHP Model Law Part III:

Transparency of Ownership and Control of Health Care Entities

Part I: Enhanced Oversight over Material Health Care Transactions

Part II: Strengthening the Ban on the Corporate Practice of Medicine

Part III: **Creating Transparency in Ownership and Control of Health Care Entities**

Policy 3: Transparency of Ownership/Control

Require all existing health care entities to report information on owners, controlling entities, business structure, including the ultimate owners or controlling parent, subsidiaries, entities under common control, and any management services organizations

Require all health care entities to report any *changes* to ownership or control (would also constitute a material change transaction for notice and review purposes)

Make this information available to the public

NASHP Model Part III: Transparency of Ownership/Control

Part III of NASHP Model requires health care market participants to report ownership and control to the Dep't of Health or other designated state health care entity.

- **Applicability**: group practices, hospitals, health systems, nursing facilities, insurers, PBMs
- **Frequency**: Annually and upon any material change notice (under Part I)
- **Required information to be reported**: Name, location, TIN, NPI, EIN, CCN, NAIC, owners, significant equity investors, control entity, MSO, corporate org chart, subsidiaries, entities under common control, financial reports
- **Enforcement:** DOH/Health Commission administrative penalties, audits

State Policy Options to Address PE Investment in Health Care

Policy Approach	Policy Concerns	State Examples
Health Care Transaction Oversight Authority (NASHP Model Part I)	Consolidation, costs, closures, sale-leasebacks	MA, OR, CA (AG + oversight entity) CT, MN, NY, RI, VT, WA, WI (AG + DOH)
Corporate Practice of Medicine Doctrine, Physician Non-Competes/Non-Disparagement Clauses (NASHP Model Part II)	Professional autonomy, workforce effects, interference with clinical decision-making	OR HB 4130 (introduced 2024) MA S 2871 (introduced 2024) CA AB 3129 (passed leg 2024, vetoed) IN SEA 7 (passed 2023, banning noncompetes for some MDs)
Ownership Transparency (NASHP Model Part III)	Opacity, lack of accountability	Massachusetts provider registry Mass. S 2871 (introduced 2024) Mass. H 4653 (introduced 2024) IN HB 1327 (introduced 2024)
Banning Anticompetitive Contract Provisions (Provider-Payer) (separate NASHP model)	Use of market power in payer contracting	CT HB 6669 (passed 2023) TX HB 711 (passed 2023) NV AB 47 (passed 2021)

Thank you!

NASHP's Health System Costs Resources:

- Written research and analysis & state legislative tracking
- Model legislation & regulation to address consolidation and more
- Hospital Cost Calculator & hospital financial transparency reporting template
- Available Now! Interactive Hospital Cost Tool
- https://www.nashp.org/policy/health-system-costs/

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NASHP | National Academy for State Health Policy

Tab 7

Washington State Health Care Authority

MARKET OVERSIGHT, RECOMMENDATION 1

» Given the evidence that market consolidation increases prices, raises consumer costs, and jeopardizes access, the Board proposes the Legislature use the "NASHP Model Act for State Oversight of Proposed Health Care Mergers" to draft legislation to increase Washington State's oversight of mergers and acquisitions.

MARKET OVERSIGHT, RECOMMENDATION 2

» 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.

» The Board directs the Data Advisory Committee to investigate and recommend best practices for such ownership and affiliation reporting. The Committee should consider best practices from other states and the NASHP Model Act for State Oversight of Proposed Health Care Mergers. Committee recommendations should include, but are not limited to the following:

- The regulatory body that should collect the reporting
- The frequency of reporting
- How and where information should be made available to the public
- Methods to minimize the burden of reporting, including adapting existing reporting requirements

Health Care Cost Transparency Board meeting

We are currently on a short break

Washington State Health Care Authority

Tab 8

Washington State Health Care Authority

Analytic Support Initiative

WA Health Care Cost Transparency Board

November 7, 2024

HCA & Institute for Health Metrics and Evaluation

ASI

Analytical Support Initiative Overview

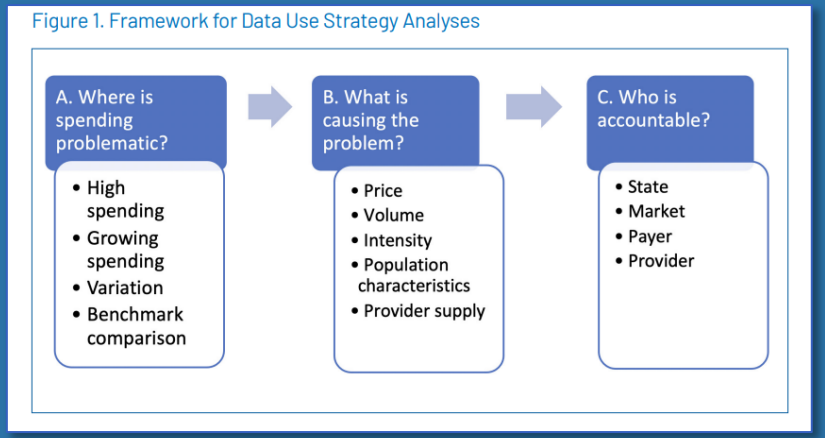
Condensed objective:

- **develop WA specific analyses of cost growth trends** to identify specific areas of focus for discussion, additional analysis, and support of cost mitigation strategies
- **provide information** that will result in actionable recommendations on reducing health care cost growth in WA

Philanthropic funding for July 2023-July 2025

Timeline:

- 1st six months → building foundation
- 2nd and 3rd six-month periods → doing the work collaboratively
- 4th six months → formalizing recommendations



Update

1. In December 2023, the **Cost Board endorsed the *ASI Analytic Strategy*** containing three key analyses to be completed in 2024
   - ✓ **Estimate spending and utilization per capita and prevalent case** for key diseases disaggregated by age, sex, type of care, location, payer group, and health condition
   - ❑ **Direct age- and indirect risk-adjustment** of spending and utilization estimates for comparison across counties, states, and time
   - ✓ **Decompose differences in spending** across counties and time

Update

1. In December 2023, the **Cost Board endorsed the *ASI Analytic Strategy*** containing three key analyses to be completed in 2024

2. In April, IHME produced a draft of the **Preliminary Disease Expenditures Report**

    Caveats about the Preliminary Disease Expenditure Report

    - *It is based on previous research focused on estimating spending by county in the US*
    - *It is a model of the type of research that could be done for the ASI*

Update

1. In December 2023, the **Cost Board endorsed the *ASI Analytic Strategy*** containing three key analyses to be completed in 2024

2. In April, IHME produced a draft of the **Disease Expenditures Report**

3. In October, IHME produced an updated draft of the **Disease Expenditures Report**
    - *Estimates extend through 2022*
    - *Professionally laid out report*

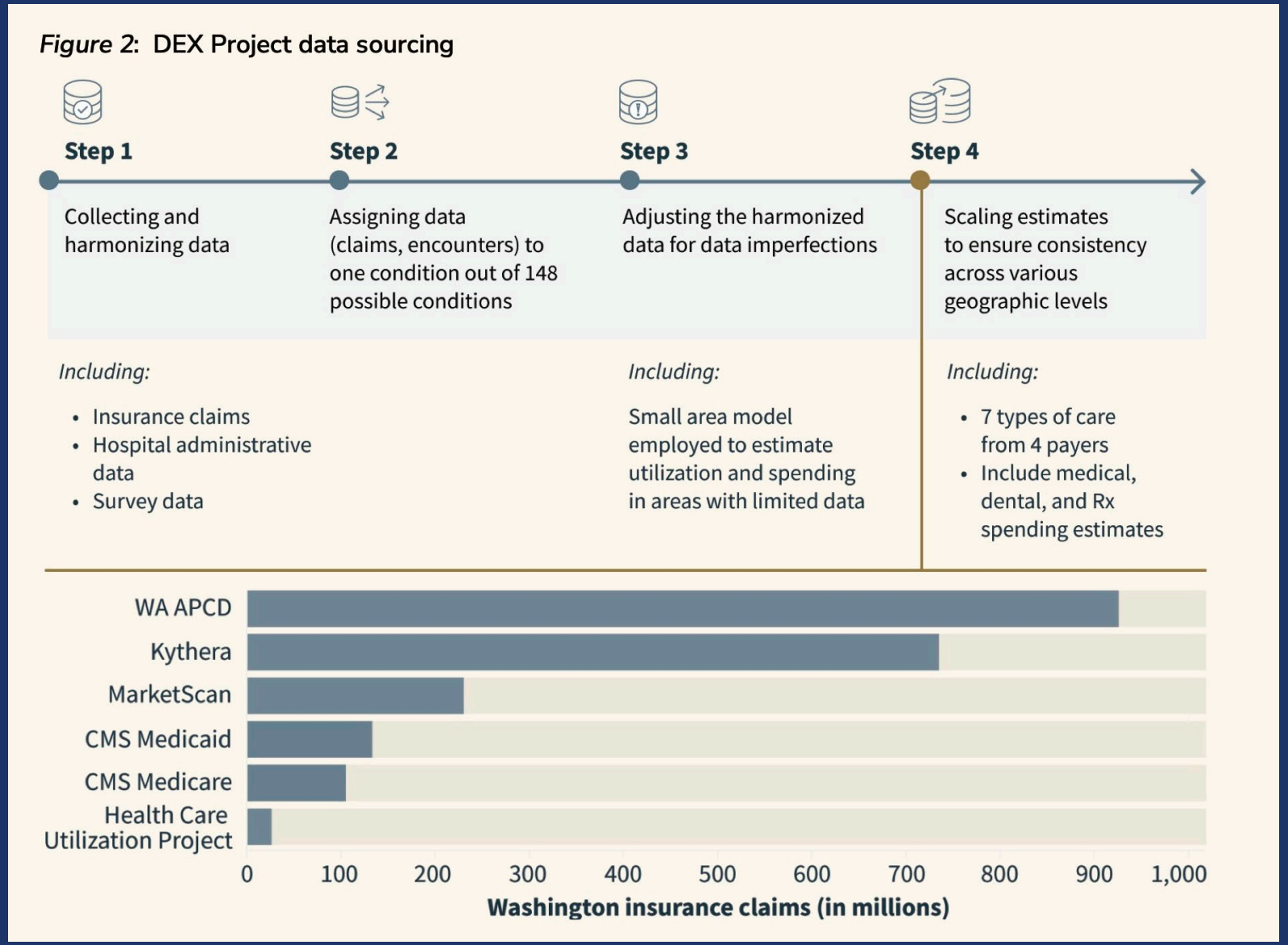
Objective for today

1. Review the updated report

2. As we go into the last part of this grant are there specific things you would like the ASI to focus on?

Estimates extend to 2022

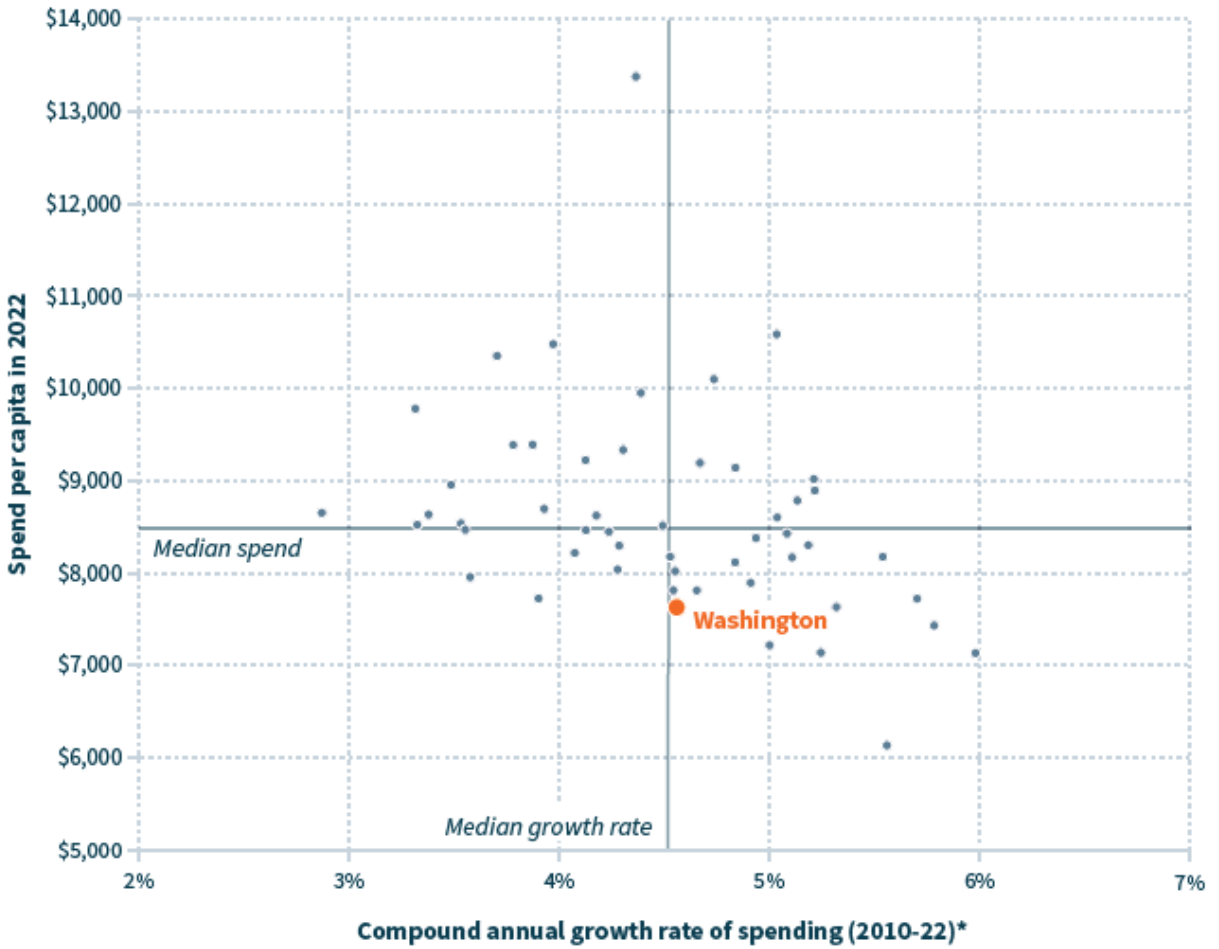
Incorporated WA APCD



Comparing WA to the other US states

- WA has the 6th lowest spending per capita
- WA has roughly average health care spending growth

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



*Not adjusted for inflation

Source: IHME Disease Expenditure (DEX) estimates

Health care spending by type of care and payer

- We estimated $60.1 billion of health care spending in 2022**
  ** Not official WA estimates
- Nearly half is from private insurance and over a quarter is from Medicare
- Medicaid and especially Medicare spending is increasing
- Half of that spending was on ambulatory care

***Pharmaceutical spending estimates are only for retail pharmaceuticals

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

*Age-standardized growth rate (2010-22)** -3.6–2.2% 2.2–4.2% 4.2–5.9% 5.9–23.8%

Type of care	Medicaid	Medicare	Out-of-pocket	Private	All payers
Pharmaceutical	$0.8	$2.2	$0.6	$2	$5.6
Nursing facility	$0.9	$0.9	$1	$0.7	$3.5
Inpatient	$2.7	$4.3	$0.3	$5.3	$12.6
Home health	$0.9	$0.9	$0.1	$0.3	$2.2
Emergency department	$0.1	$0.7	$0.1	$0.8	$1.7
Dental	$0.5	<$0.1	$2.1	$2.3	$5
Ambulatory	$4.6	$7	$3	$15	$29.5
All types of care	$10.4	$16	$7.3	$26.4	**$60.1**

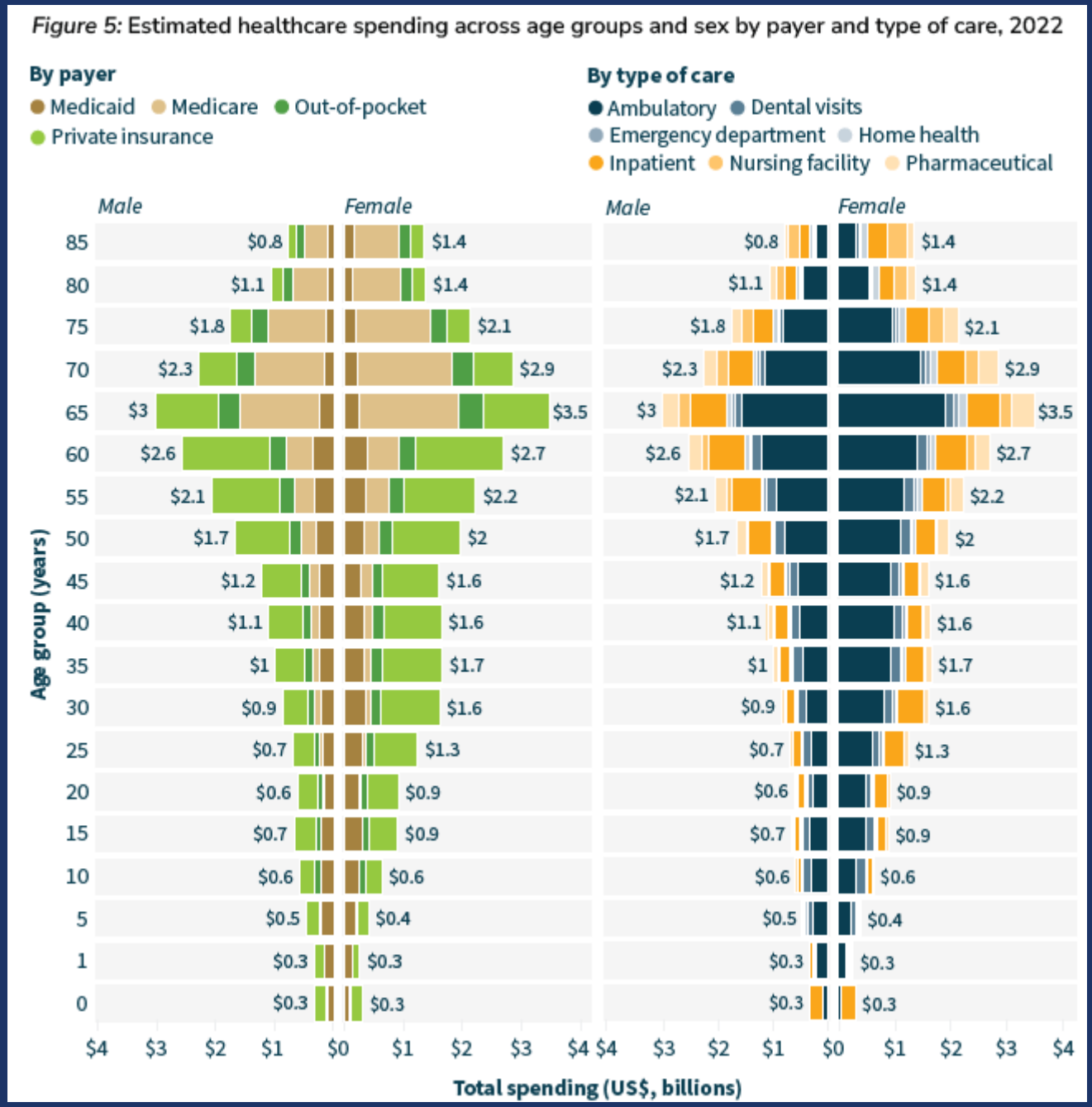
Payer

**Not adjusted for inflation*

Source: IHME Disease Expenditure (DEX) estimates

Health care spending by age, sex, payer, and type of care

- More spending is on 65–69-year-olds than any other group
- Ambulatory care makes up nearly half of spending
- Private insurance makes almost half of health care spending, with most but certainly not all spending on those less than 65 years

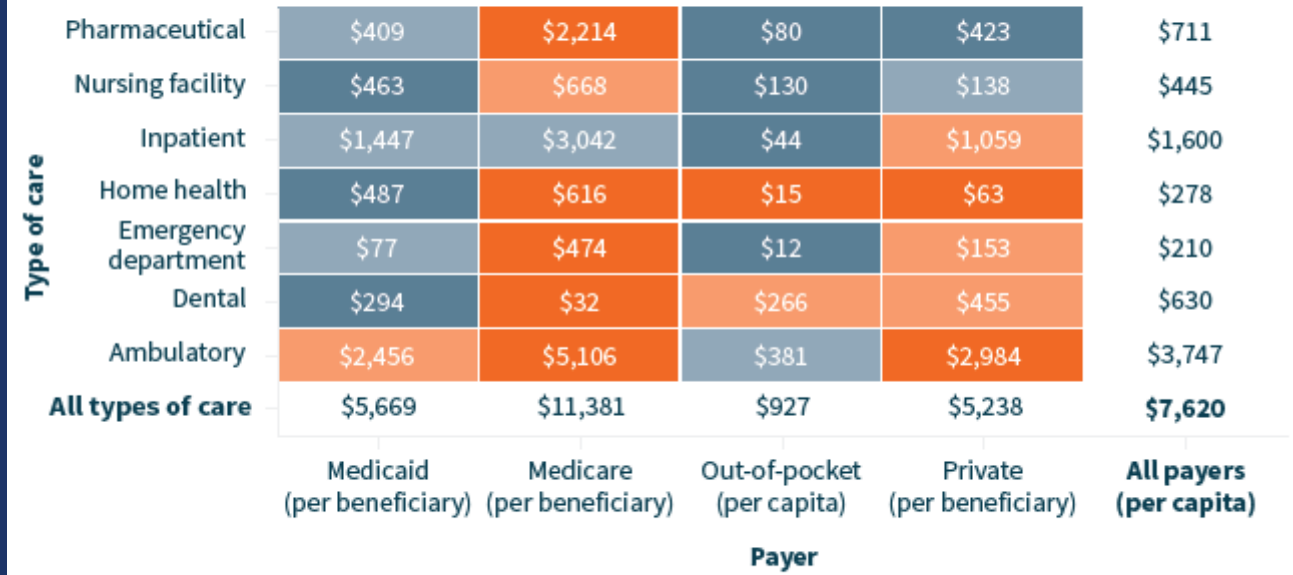


Health care spending per beneficiary by type of care and payer

- In per beneficiary terms, Medicare spending is nearly double Medicaid and Private insurance
- Medicare spending and private insurance spending per beneficiary is growing the most

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

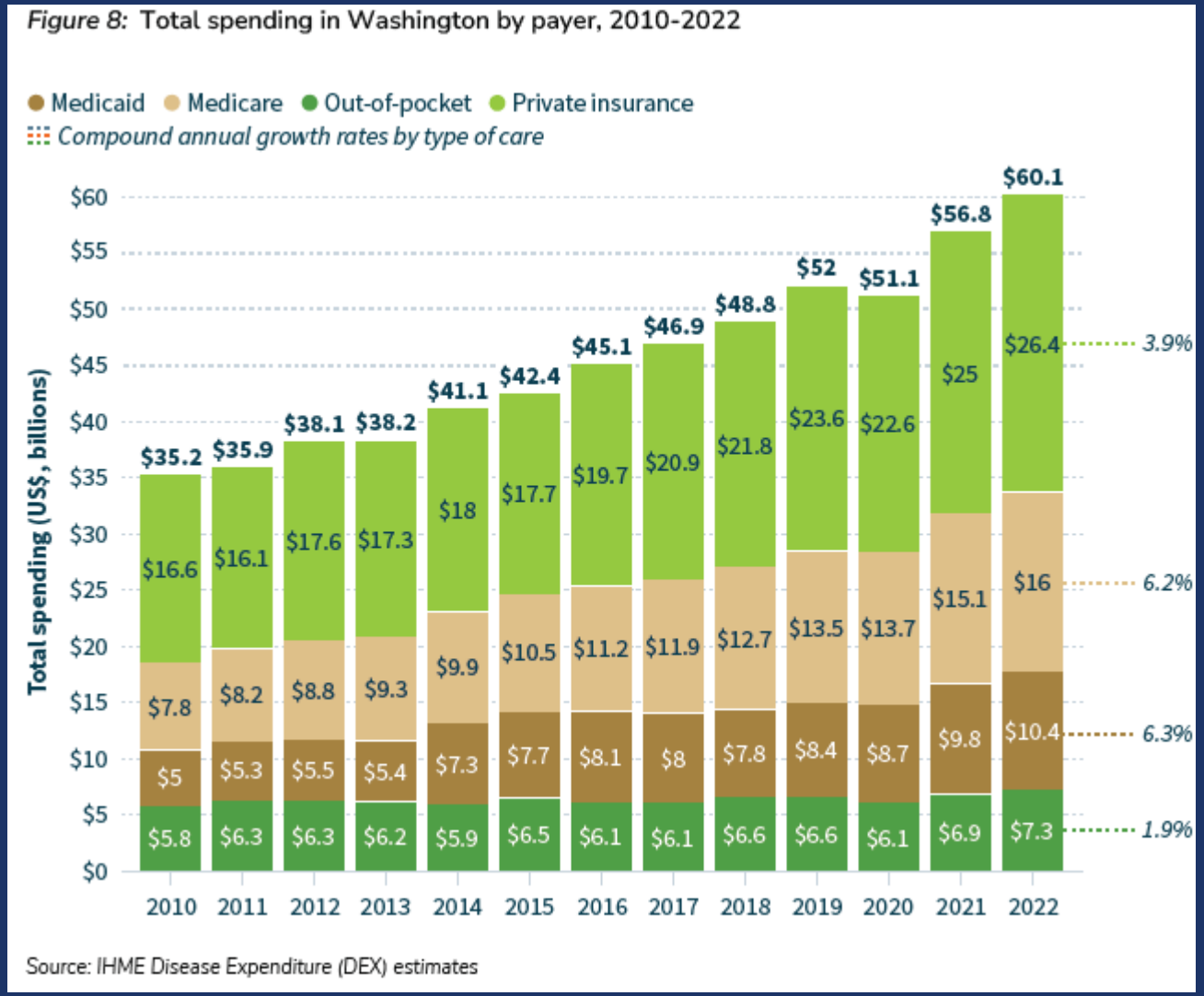
Source: IHME Disease Expenditure (DEX) estimates

Health care spending by payer over time

- Health care spending has increased from $35.2 billion in 2010 to $60.1 billion in 2022**

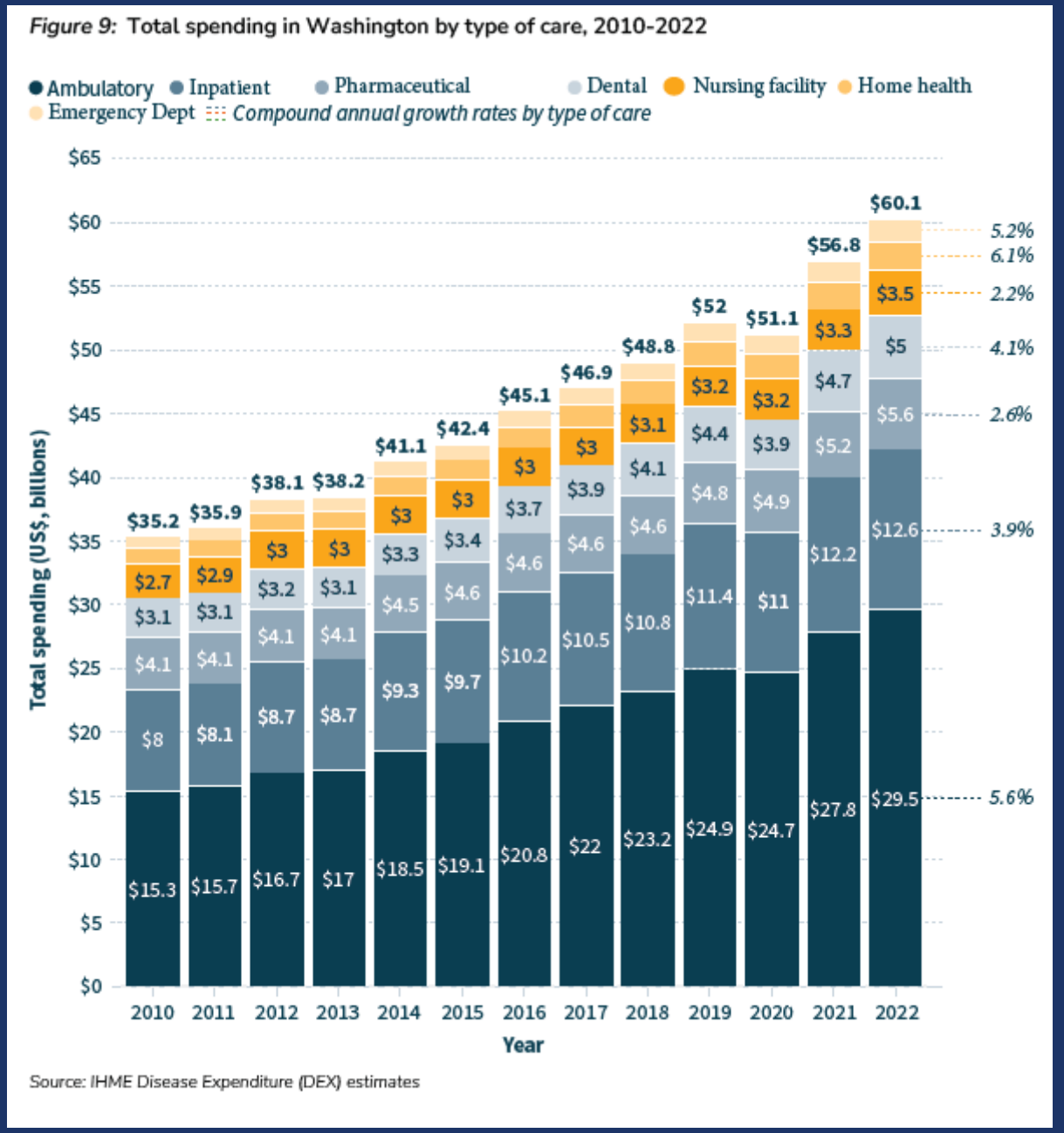
  **Not official WA estimates

- Medicare and Medicaid spending is growing the fastest



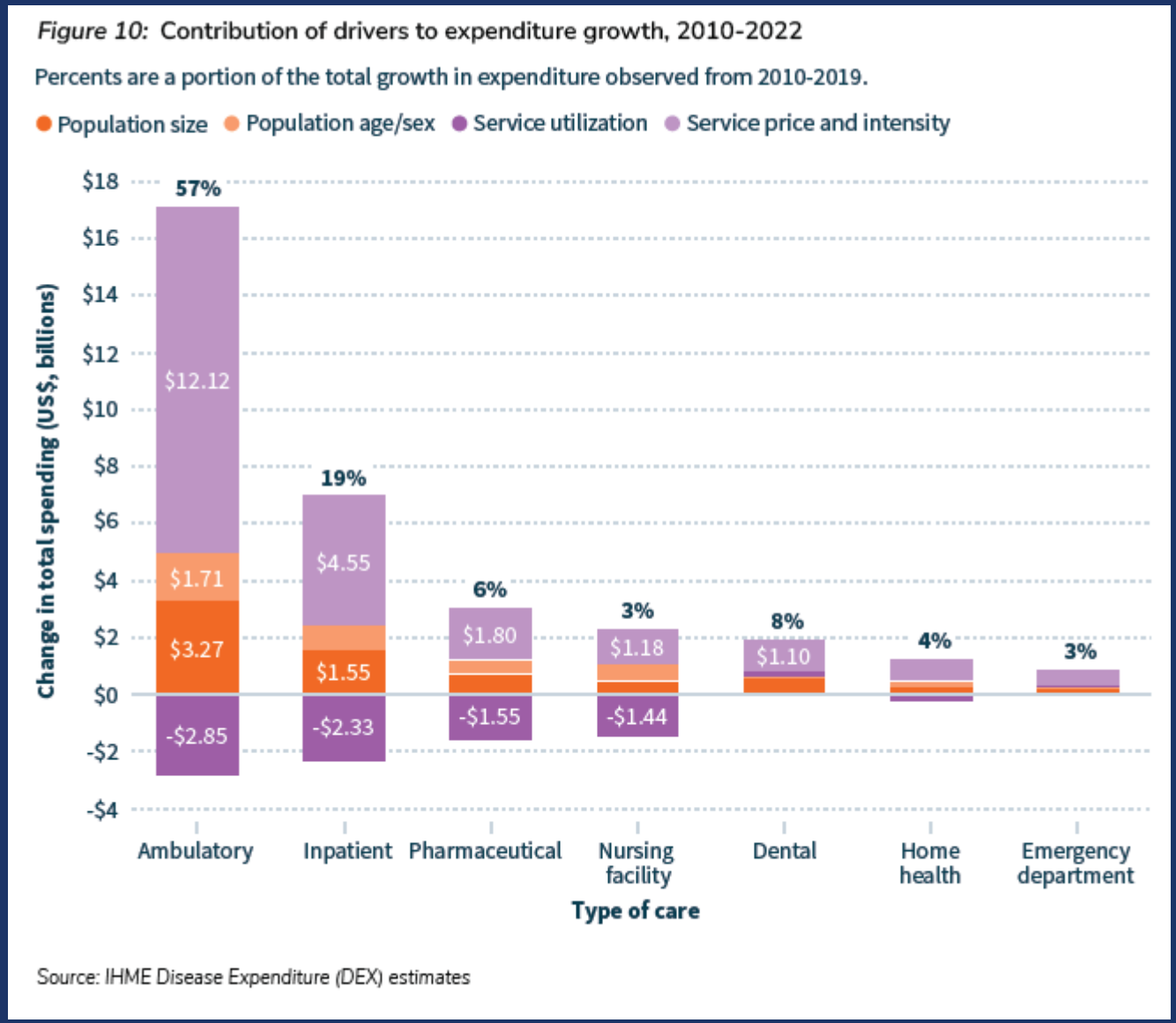
Health care spending by type of care over time

- Spending on ambulatory care is large and growing quickly
- Spending home health care and ED are a small amounts ($2.2b and $1.7b) but are types of care that are growing the quickly



Assessing drivers of increases in spending

- 57% of the increase in spending was because of increases in ambulatory spending. While ambulatory utilization was down, the spending per visit was way up
- Increases in price and intensity of care was responsible for much of spending increases
- Larger and older population also increased spending



Assessing drivers of increases in spending for each payer

- There was a lot of similarities across payers
- Increases in price and intensity of care seem to be driving increases in spending in most types of care for most payers. Especially true for ambulatory care, inpatient care, and private insurance

Health care spending by disease

- Musculoskeletal disorders make up 14% of all health care spending, while cancers and cardiovascular diseases each make up 12%
- Spending on mental disorders and substance abuse disorders is growing the fastest of all aggregate health conditions

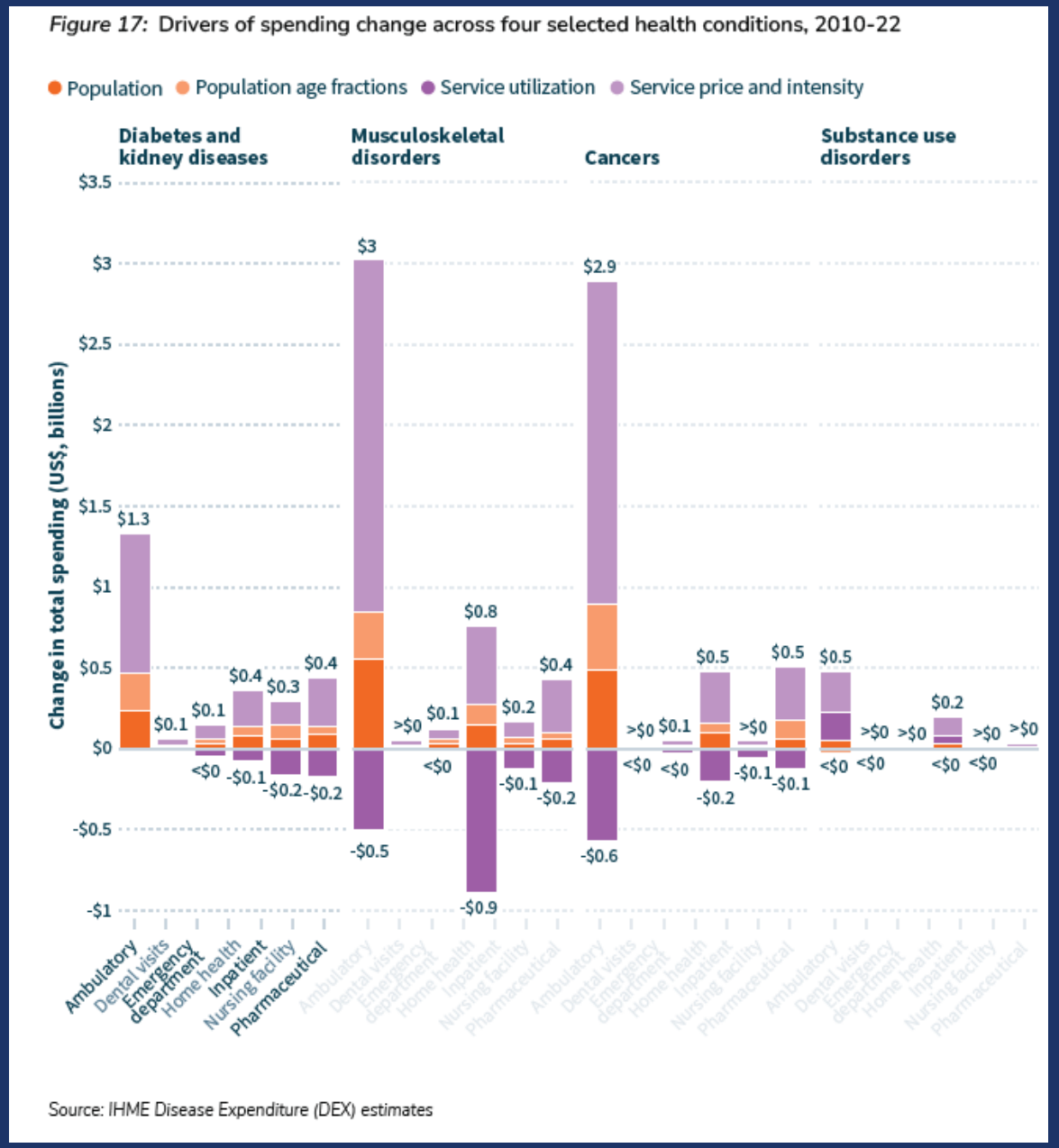
Aggregated health condition categories	Total spending (billions)	Growth rate; 2010-2022*	Percent of state spending
Musculoskeletal disorders	$ 6.91	4.4%	13.5%
Cancers	$ 6.33	5.6%	12.4%
Cardiovascular diseases	$ 6.26	4.5%	12.2%
Other non-communicable diseases	$ 5.07	3.7%	9.9%
Diabetes and kidney diseases	$ 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

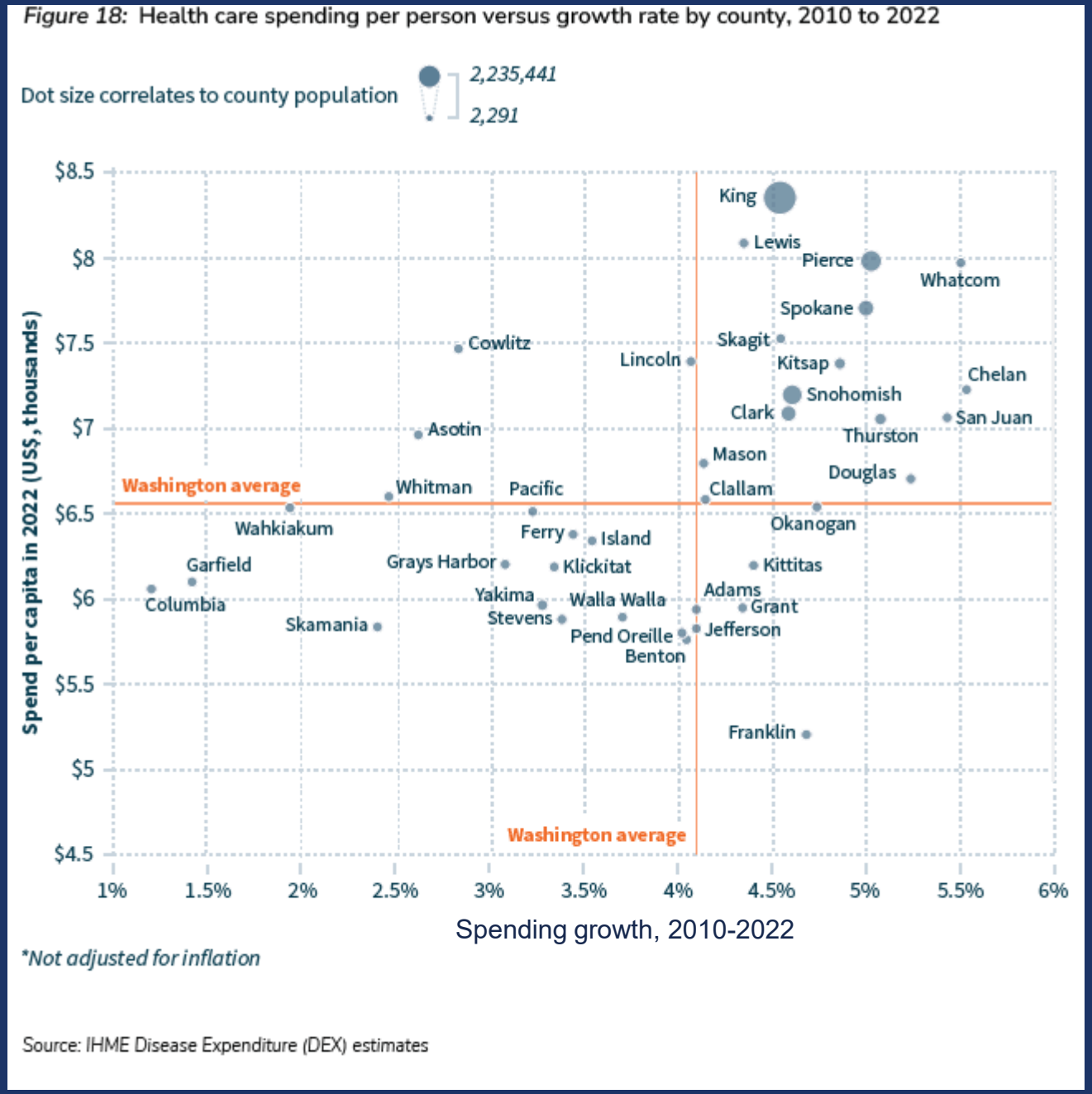
Assessing drivers of health care spending by disease

- Each category of diseases has spending being driven by something different, but across all diseases price and intensity of care is the largest contributor to growth in spending



Spending and growth in spending for each WA county

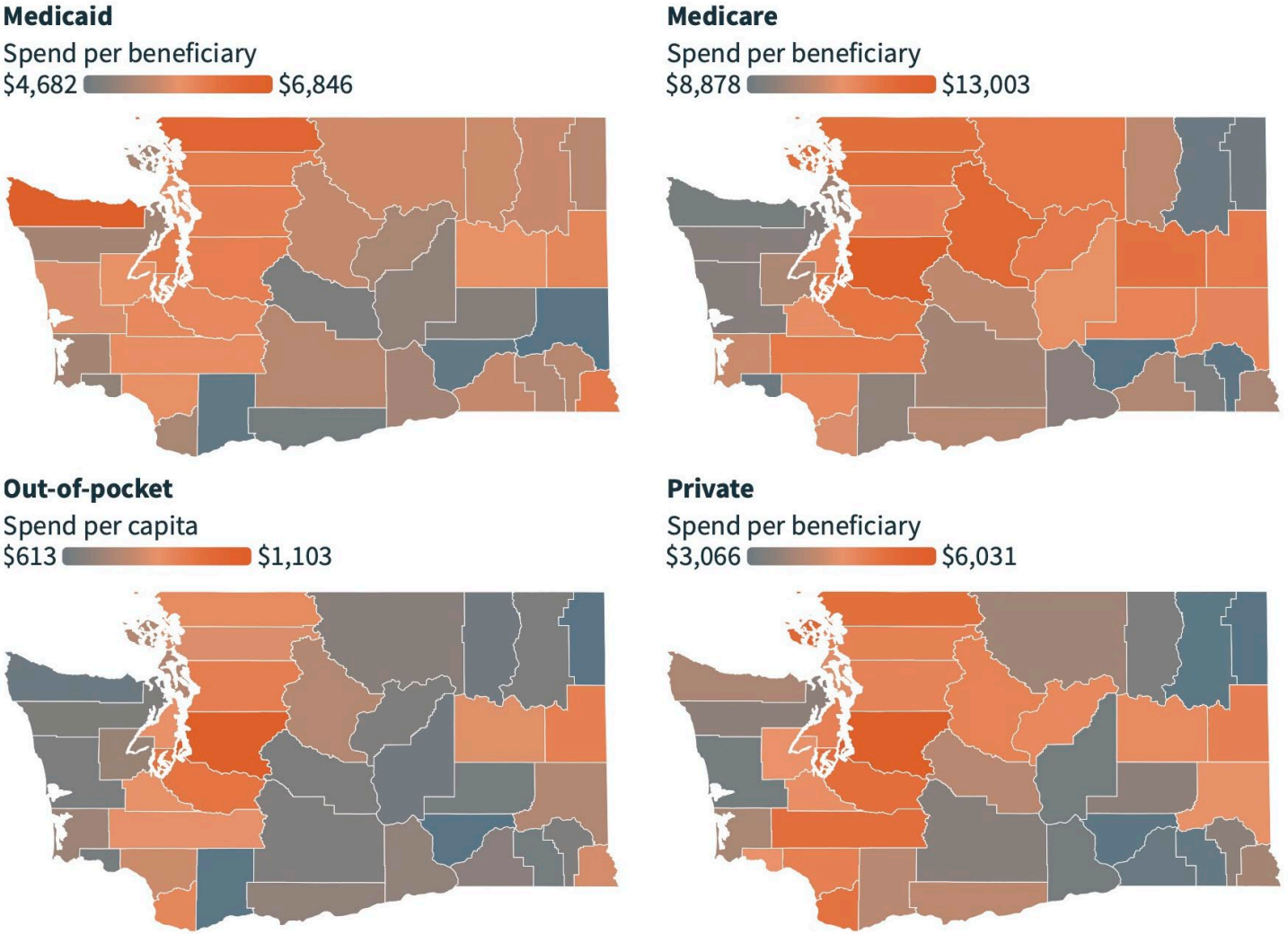
- In per capita terms, King, Lewis, and Pierce counties have the highest spending
- Chelan, San Juan, and Whatcom counties have the largest health care spending growth rates



Spending by payer and county

- Across payers, highest spending rates are I-5 corridor
- Lowest spending rates are in Olympic Peninsula, and northeast and southeast corners of the state

Figure 19: Age-standardized spending per beneficiary by payer

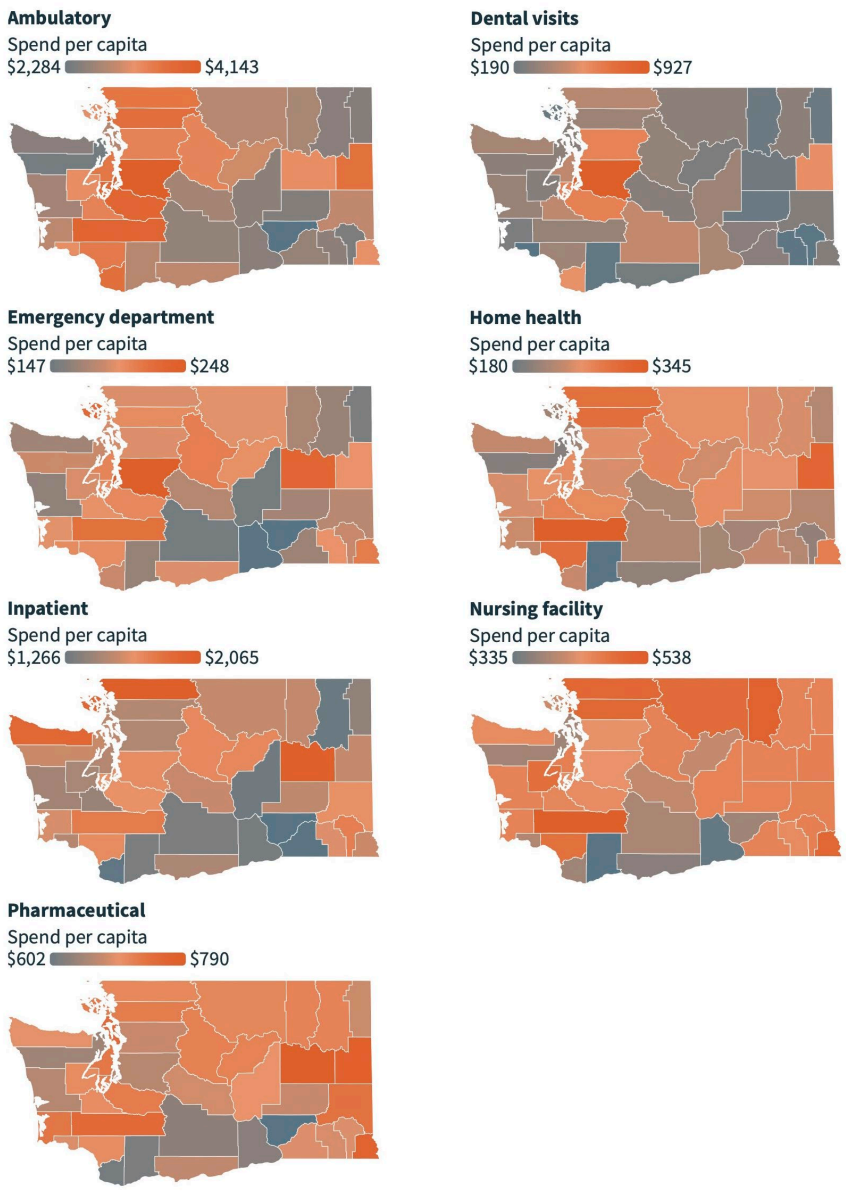


Source: IHME Disease Expenditure (DEX) estimates

Spending by type of care and county

- Dental care spending is the most concentrated across the state
- Counties in the Olympic Peninsula have relative less ambulatory care spending relative to inpatient and ED spending

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



Source: IHME Disease Expenditure (DEX) estimates

Thank you

ASI

Tab 9

Washington State Health Care Authority

HMA

Facility Fees

FACILITY FEES

- **The issue:**
  - Hospitals and some clinics charge fees in addition to and not directly related to the service provided
  - As consolidation has increased, so has the use of facility fees

- **All hospitals with provider-based clinics that bill a separate facility fee must report to DOH** as part of year-end financial reporting:
  - The number of entities in their network that charge and # of visits
  - Overall revenue collected and the price range of the fees

- **What isn't reported?**
  - *Not capturing all entities or locations that charge a facility fee in WA State*
  - *Not capturing which services have a facility fee charged*
  - *Not able to quantify impact on consumer*

RECOMMENDATIONS CONSIDERED IN SEPTEMBER (REPORTING >>> PROHIBITIONS)

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 approved by Board

Recommendation 2: Billing & Ownership Transparency

- Require hospital-owned and-affiliated providers to acquire and include unique National Provider Identifiers specific to the location of care on all claims so can track via the All-Payer Claims Database. Monitor health care provider affiliations and acquisitions.

Recommendation approved, noting minor edit

Recommendation 3: Facility Fee Billing Prohibitions

- Prohibit hospital-owned and -affiliated facilities from charging facility fees for specified outpatient services, such as those that can be safely and effectively provided outside of a hospital setting (i.e., lab tests, basic imaging and diagnostic services as well as physician office visits)

Determine which services by applying the codes recommended by MedPAC

Recommendation 4: Site-Neutral Payment Caps

- Combine Recommendation 3 **AND** Cap provider reimbursement for these services (e.g., at a percentage of Medicare rates or the median price insurers pay independent physician offices in the same area).

SEPTEMBER DISCUSSION: FACILITY FEE PROHIBITIONS AND SITE NEUTRAL PAYMENT POLICY

- Board members requested additional information about consumer impact. This data is not yet available, but can be considered for the future.
- Board members noted that facility fee prohibitions and site neutral payments may be less effective in a commercial market because the costs could be shifted into other revenue streams (higher reimbursement rates, other services/fees).
- Staff recommends that site neutral payment policy be wrapped into broader exploration of price monitoring and regulation in 2025-2026.

SEPTEMBER DISCUSSION: BILLING AND OWNERSHIP TRANSPARENCY

- Don’t know the breadth of the problem, because challenges with being able to tie fees to “one entity” even when owns affiliates or provider groups
- Interested in more transparency, but don’t want to require more reporting – focus on Recommendation #2.
- APCD has capacity to track fees with unique National Provider Identifiers
- Earlier votes on market oversight language will allow for more monitoring of acquisitions.

REVISED RECOMMENDATION 2 ON FACILITY FEES

- Require hospital-owned and -affiliated providers to acquire and include unique National Provider Identifiers (NPIs) specific to the location of care on all claims so that claims and fees can be tracked via the All-Payer Claims Database.
  - Board members requested language requiring all health systems to report ownership structures and affiliations. Per our prior vote on market oversight, we proposed shifting that into its own recommendation.
  - Administrative changes denoted in red

Tab 10

Washington State Health Care Authority

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

Table of contents

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, revealing growth rates for health care expenditures for 2022 from the baseline period 2017-2019 relative to a 3.2 percent growth target.
- **Cost driver analysis.** The Cost Board anticipates releasing an updated cost driver analysis in late 2024, 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 primary care expenditures** by establishing a clear target for annual expenditure growth and increasing Medicaid reimbursement.

Adoption of recommendations within each of these policy areas aims to create a more sustainable health care system in Washington, while acknowledging these proposals alone will not achieve affordability for everyone in Washington. By prioritizing transparency with facility fees, market oversight, and support for

primary care, the Cost Board picked up on various initiatives already in-flight or proposed and emphasizes the need to continue work in these spaces. The Cost Board also continues to recognize additional policy and financing work will be necessary and anticipates additional engagement on provider pricing, paying for value, 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."[1] 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 commissioned that showed that between 2016 and 2019, health care costs in Washington increased by 13 percent, nearly double the rate of inflation.[2]

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.[3] This includes increased demand for specialty prescription drugs, hospital market consolidation, health care workforce shortages, and residual effects of COVID.[4]

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

In addition, a group representing 20 organizations from Fair Health Prices Washington[5] 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, and 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.

[5] 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. One is a biennial survey of the underinsurance of Washington residents, and the other covers insurance trends among 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:

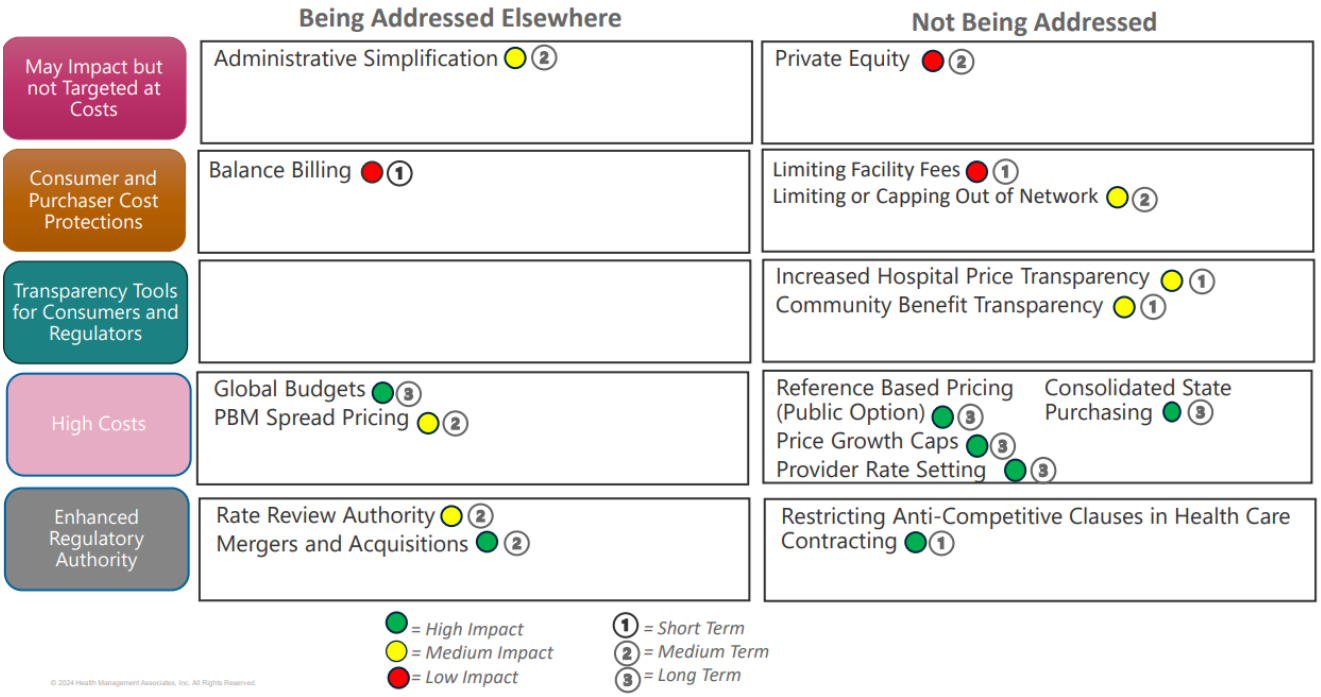
- **Advisory Committee on Data Issues** – comprised of experienced health care data leaders and fiscal and actuarial experts from across the state.
- **Advisory Committee on Primary care** – develop recommendations related to the state's 12 percent primary care spending target for the board's review.
- **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 by 4.1 percent in 2022 alone. Most of that spending went towards hospitals and physicians or clinics, representing 50 percent of total health expenditures.[6] 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.[7] The Cost Board worked with Health Management Associates (HMA)[8] 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

[6] Health Policy 101 - Health Care Costs and Affordability (kff.org). May 2024.
[7] Ibid.
[8] 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 political 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
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

The Cost Board chose to focus on a few areas for 2024 and will continue to examine options going forward. 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

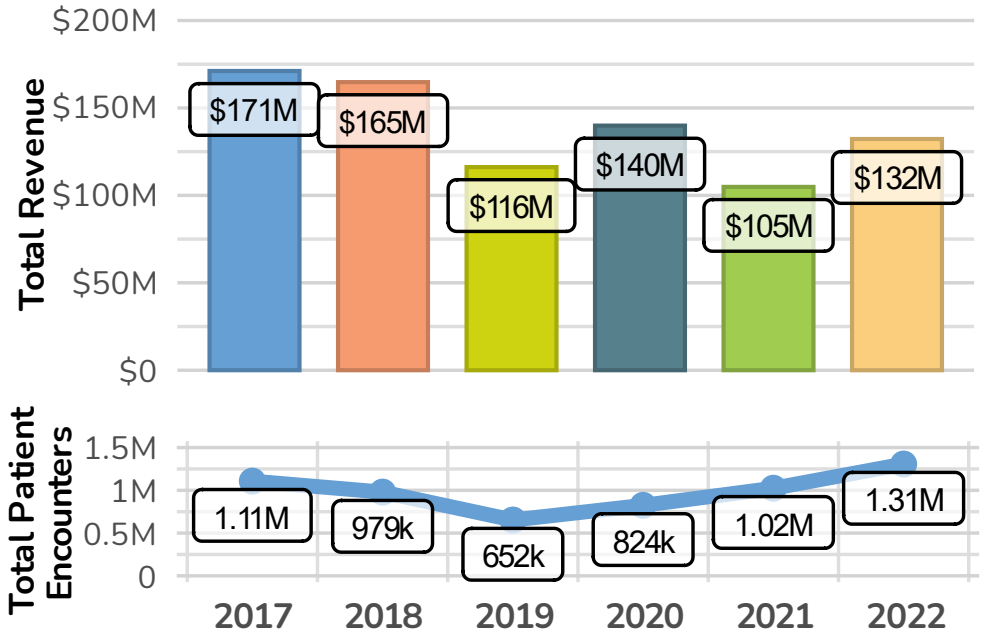
Facility fees

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 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).

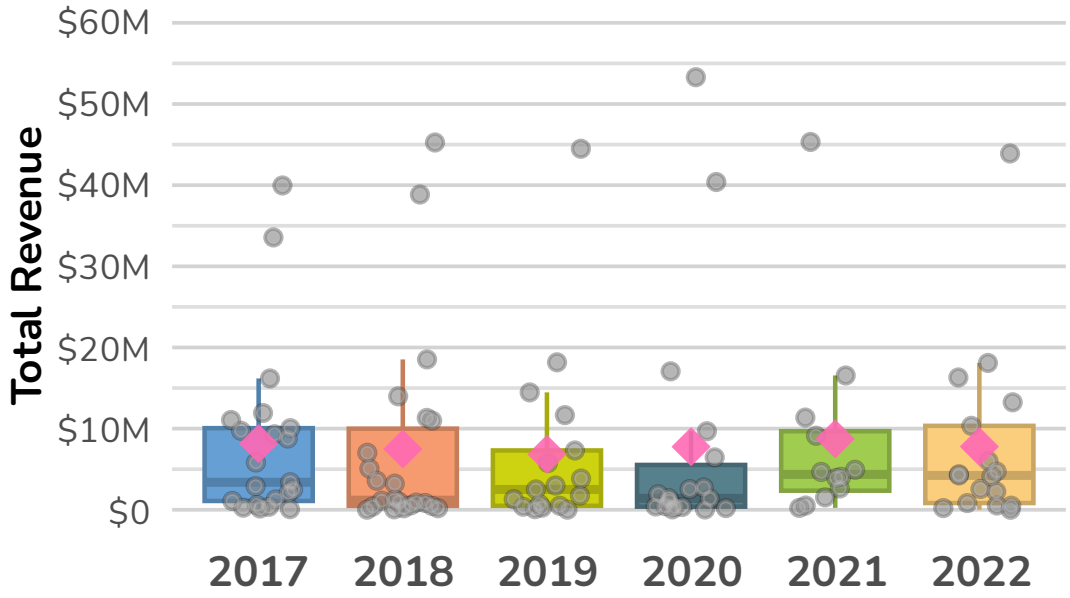
Figure 2. Total facility fees revenue, charged encounters, 2017–2022



Source: Washington State Department of Health

Although **Washington law** requires hospitals to provide notice to patients for nonemergency services and prohibits the practice for 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 the 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 recommend 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[9] (NPIs) specific to the location of care on all claims so that claims and fees can be tracked via the All Payer Claims Database.

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 healthcare, **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 gap, the Cost Board captured the following recommendations at the November 2024 meeting.

Recommendation 3: 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 4: 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

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

equity firm and be designed to provide transparency into any private equity or corporate affiliations with a system, facility or provider

The board asked its Advisory Committee on Data Issues to investigate and recommend best practices for such ownership and affiliation reporting. 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.

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,
- Identify methods to incentivize the achievement of desired levels of primary care to total expenditures (12 percent).

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.

In addition to this definition, the advisory committee recommended—and the Cost Board adopted—a package of actions to increase primary care 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 increases
Increase primary care expenditures 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.

These recommendations, and the board's framework for review, are discussed further in the primary care expenditure section.

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 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%

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 subsidy, 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.

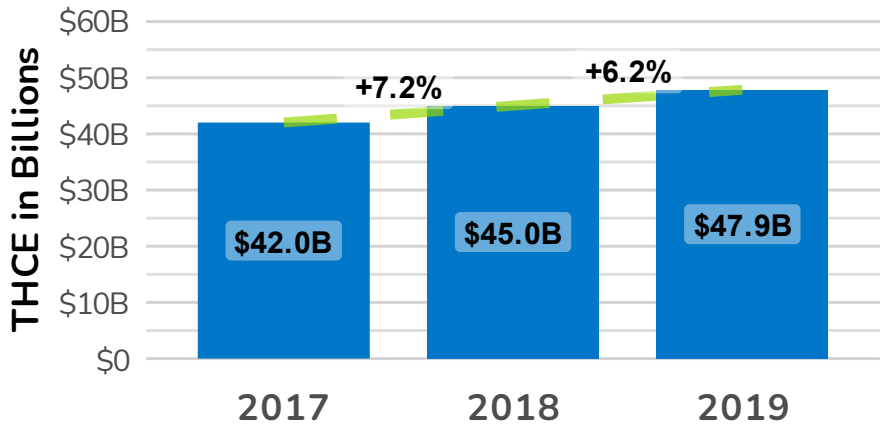
Table 3: Health care carriers who submitted data to HCA, 2023–2024

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.

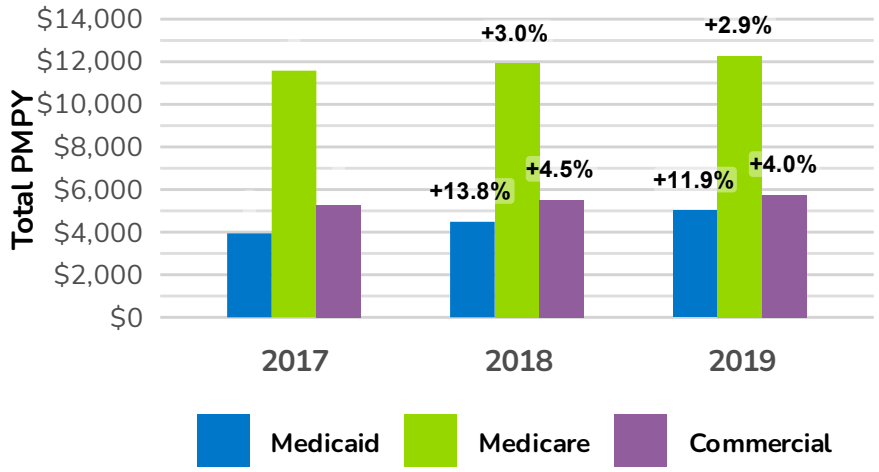
Figure 4: Growth in Total Health Care Expenditure (THCE)



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

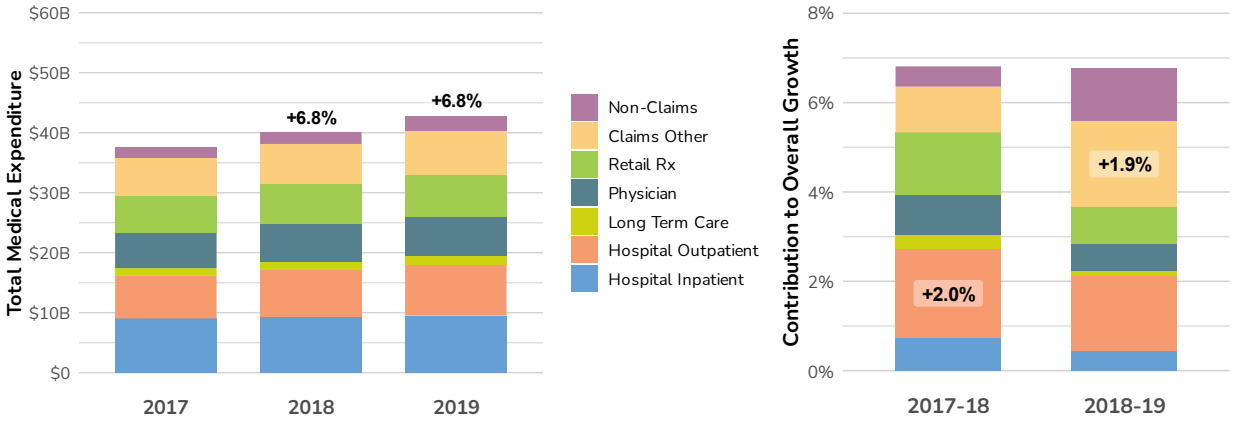


Source: The Health Care Spending Growth Benchmark Baseline Brief, Health care spending growth in Washington, 2017–2019

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[10] 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.

[10] OnPoint Health Data is a vendor that collects, integrates, and distributes healthcare 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

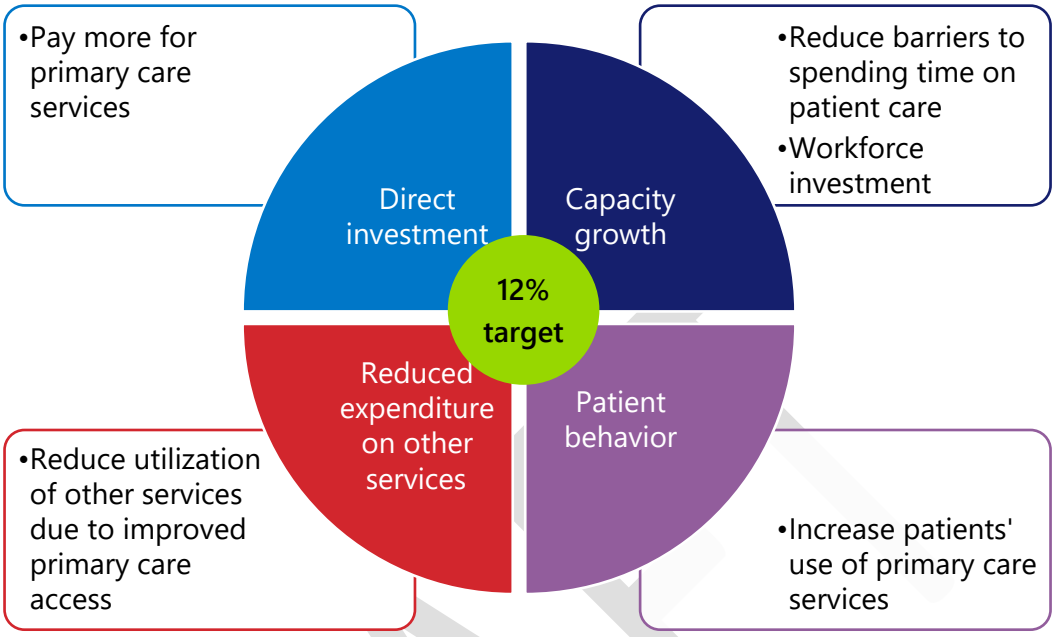
Primary care is a cornerstone of the health care system, providing crucial preventive care and addressing both short- and long-term health issues. Despite its importance, primary care spending remains low compared to other medical expenditures, and Washington's reporting on this spending could be improved. 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 primary care expenditures 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**.
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 found in Appendix A.[11] 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.[12] 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.[13] 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.[14] 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.[15] 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.

[11] 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.
[12] Batholomew-Nash & Associates removed hospitals with incomplete data, less than 25 beds, and hospitals specializing in children, psych, rehabilitation, and long-term care.
[13] **How does cost affect access to healthcare? - Peterson-KFF Health System Tracker**. January 12, 2024.
[14] **Americans' Challenges with Health Care Costs | KFF**. March 1, 2024.
[15] **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. View the detailed results in the Washington Hospital Financial Analysis by John Bartholomew and Thomas Nash found in **Appendix A**.

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[16] 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.

[16] 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

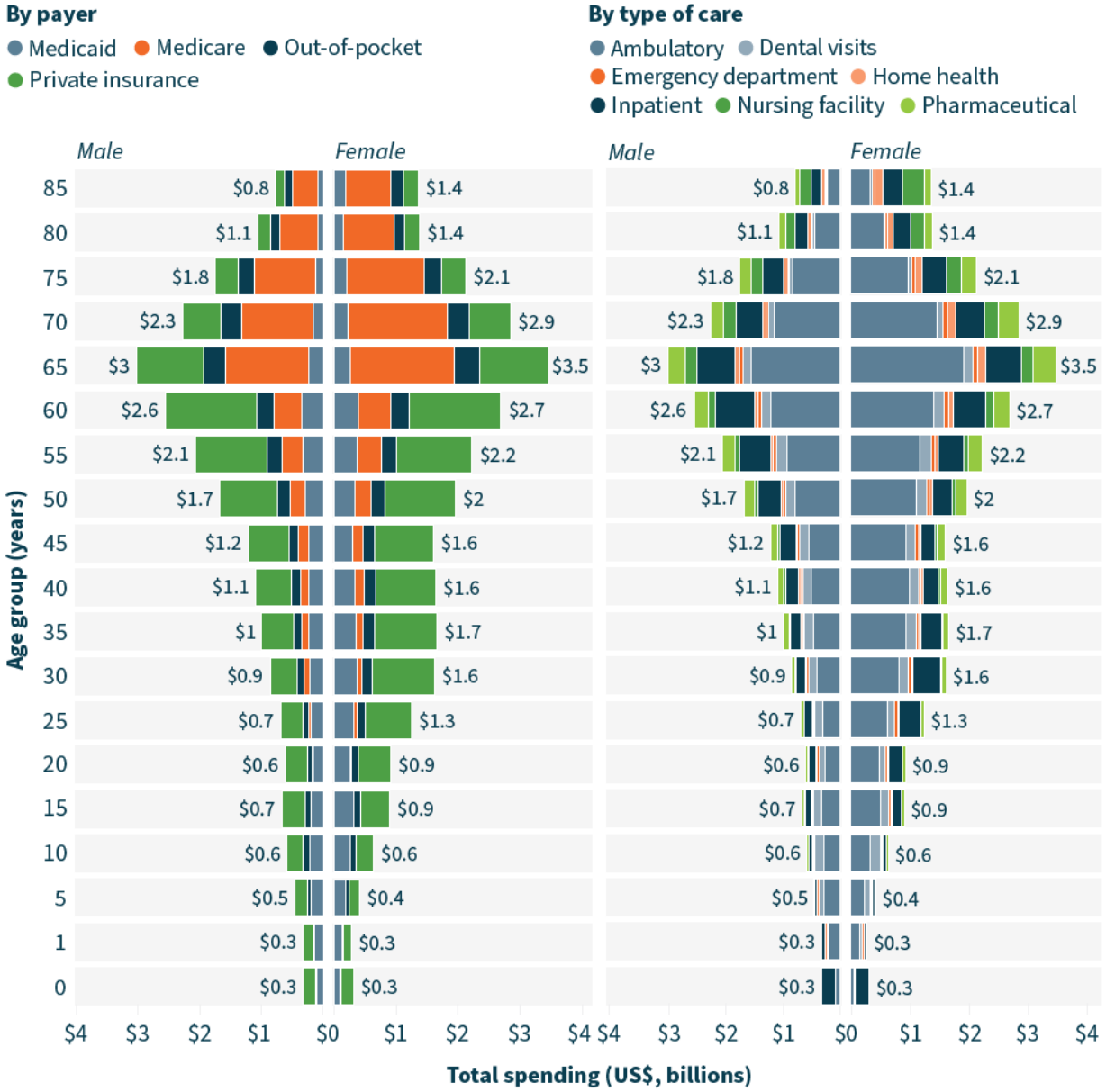
In March 2024, IHME finished a DEX modeling update, creating a complete set of estimates tracking spending by health condition, age, sex, type of care, payer, and U.S. for 2010 through 2019. In May 2024, IHME produced a Washington-specific summary of the project, the Preliminary Disease Expenditure Report,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

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: Healthcare spending amid age groups across payer and care type, 2022.



Source: IHME DEX Project.

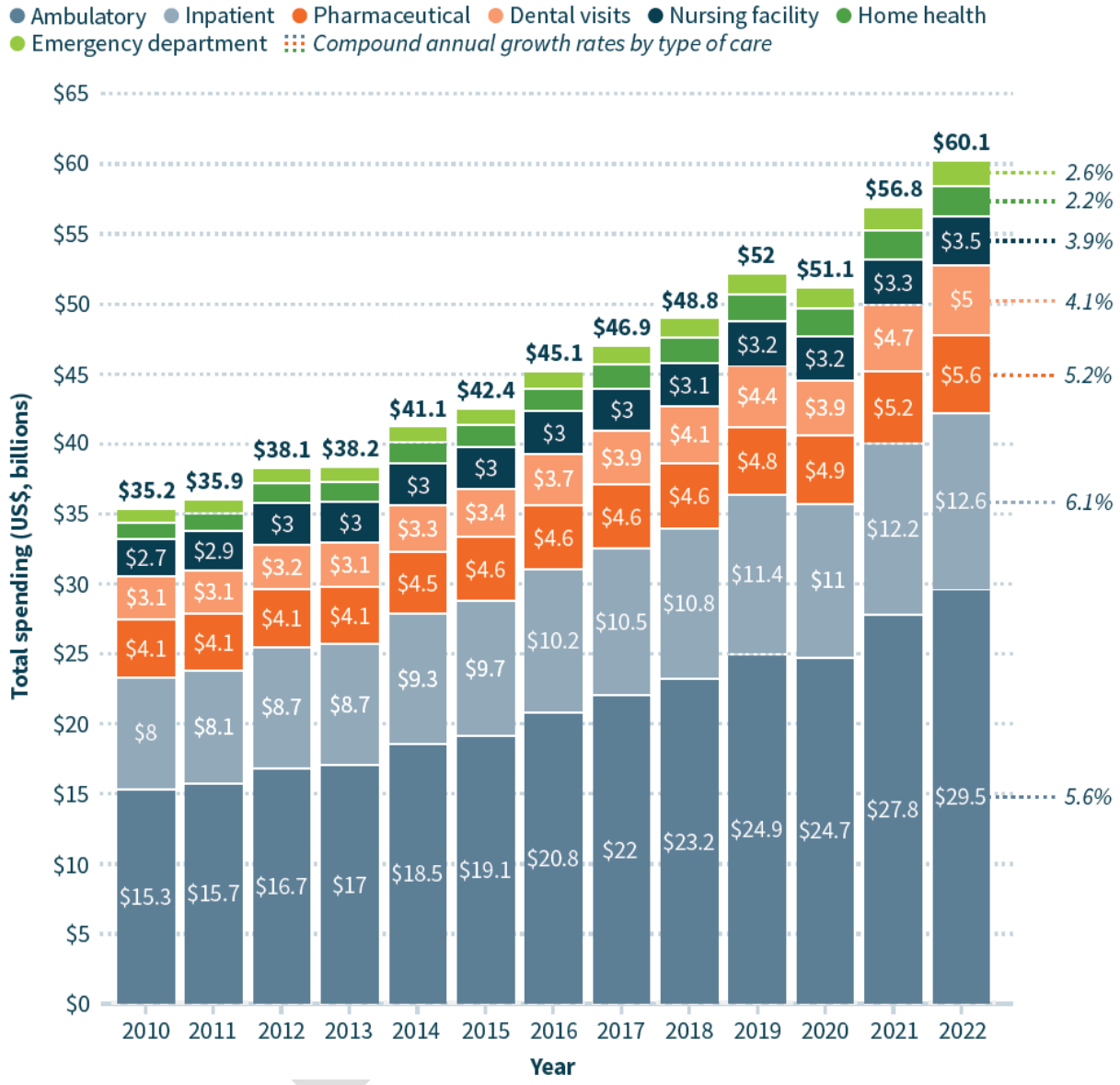
Note: Pharmaceutical spending includes spending on pharmaceuticals in a retail setting, and drugs administered in a clinic or inpatient are included in the ambulatory care and inpatient care categories.

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.

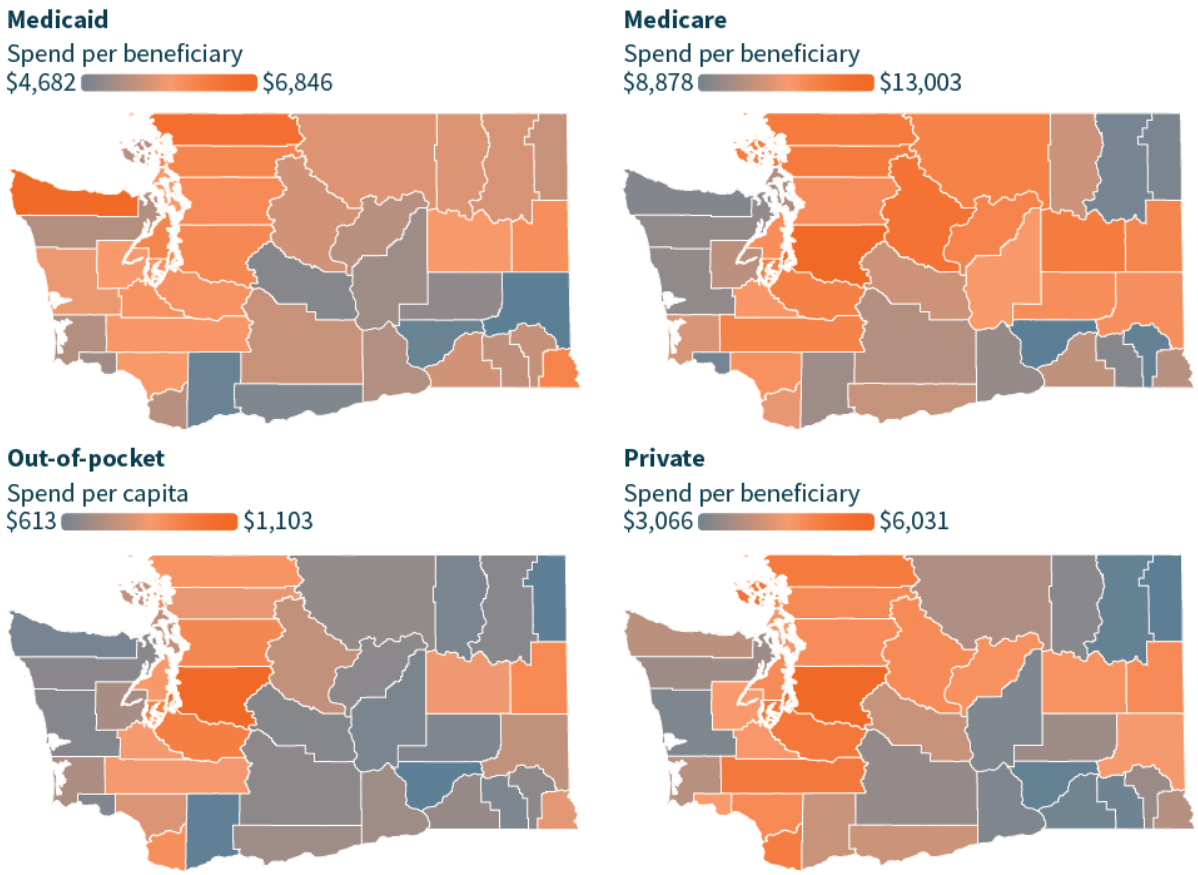
Figure 9: Total spending in Washington by type of care, 2010-2022



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 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.

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 primary care expenditures (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: Washington hospital financial analysis

Note: This July 2024 report was prepared for the Cost Board by John Bartholomew and Thomas Nash of Bartholomew-Nash & Associates.

Introduction

Washington is one of nine states to adopt a cost growth benchmark, which was established by the Heath Care Cost Transparency Board (Board).[17] The State also participates in the Peterson-Milbank Program for Sustainable Health Care Costs and has established cost growth benchmark targets for 2022 and the subsequent five years. "The cost growth benchmark represents a common goal for payers, purchasers, regulators, and consumers to increase health care affordability. It serves as a starting point from which to align health care spending to ensure that spending growth does not increase at a faster rate than the economy, state revenue, or wages."[18]

The Board's Cost Driver Analysis revealed that the most significant increases in spending occurred in inpatient and outpatient hospital spending.[19] Combined, inpatient and outpatient hospital spending comprise the largest share of health care costs ranging from approximately 33% of the total health care spending in Medicaid to about 38% of total health care spending for the commercial market.[20]

Therefore, a deeper dive into the Washington hospital industry is warranted as hospital prices and costs have an impact on the HCCTB's cost growth benchmark targets. This project details hospitals who are exceeding benchmarks or appear to be outliers as compared to their peers in terms of price, cost, and profit. The current financial condition of hospitals is in many ways a reflection of business decisions, potentially made years ago. Any impact on altering the course of hospitals' prices and costs should begin today with the acknowledgement that those efforts may not be visible in the data for a several years.

Project Description

Hospital financial information is generally opaque and not easily comparable across hospitals because of the multitude of variables that can impact hospital finances including geographic differences, differences in services offered, multiple payers paying different amounts for similar services, varied mixes of patient acuity, varying levels of non-patient-related activities, and more. Hospitals also report financial information in a variety of ways for different purposes.

However, most hospitals or their associated systems prepare audited financial statements. Non-profit hospitals also report selected financial information in their annual Form 990. Hospitals may also prepare other financial reports to satisfy various state or local requirements. Unfortunately, none of these reporting mechanisms are standardized or comprehensive enough to allow meaningful comparison across

[17] https://www.milbank.org/focus-areas/total-cost-of-care/peterson-milbank/
[18] https://www.hca.wa.gov/assets/program/leg-report-hcctb-20230905.pdf
[19] *Ibid.*
[20] Source: U.S. Department of Health and Human Services 2022 National Health Expenditure data. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

hospitals**. Yet, health care administrators and health care purchasers/payers would benefit greatly from comparative hospital financial information to provide insight into how well hospitals are managing their costs and to ensure some degree of accountability** to the communities they serve. This insight is especially important for tax-exempt, non-profit hospitals and the systems that own them.

Purpose/Goal

The goal of this project was two-fold:

1) How does the WA hospital industry compare to the nation in terms of costs, prices, and margins/profits?
2) Can we identify WA hospitals that appear to be outliers* on cost, price, and margins/profits? (* An outlier Washington hospital is defined as having a metric whose value is 10% greater than the median of its peer group.)

To accomplish this goal, a 3-prong approach was used to analyze hospital prices, costs, and profits:

1. ***Peer Group Comparisons:*** High-level metrics on per-patient **prices and costs as well as profit margins** for each Washington hospital were compared to a set of peer hospitals from across the country. These comparisons facilitate the identification of outliers with respect to relative pricing levels and cost efficiency.
2. ***Medicare Payment-to-Cost Review:*** A review of Medicare revenues and costs provides another indicator of relative **cost efficiency** for each hospital by creating a **Medicare payment-to-cost ratio**. Since Medicare payments are adjusted to reflect individual hospital characteristics, comparing Medicare payments to Medicare related costs illustrates how well hospitals are managing expenses.
3. ***Price and Cost Trend Review:*** Finally, **hospital price and cost trends for each hospital were compared** national trends and the healthcare cost growth benchmark.

Combining the findings from the three analyses provides insights for not only the Board, but also health care administrators, health care purchasers/payers, and the hospitals themselves by allowing them to triangulate price, cost, and profit information from several different perspectives.

Hospitals Included in the Analysis

Only short-stay acute hospitals are included in the analysis. Further, only those hospitals that have a published Medicare case mix and wage index are included. In 2022, 104 Washington hospitals filed MCRs. Long-term care, psych and rehab hospitals were excluded as they are not considered short-stay acute hospitals. Hospitals with less than 26 beds, including all critical access hospitals, were also excluded since they do not have a published Medicare case mix and/or wage index. After excluding these hospitals, 45 hospitals were included in the analysis (see **Appendix A**). These hospitals represent approximately 85% of statewide short-stay hospital net patient revenue and 90% of available beds in the state of Washington (2022). A list of hospital names and their city and county can be found in **Appendix E**.

Data Source

The Medicare Cost Report (MCR) was the primary data source for this project. Unlike the previously mentioned reporting mechanisms, the MCR is a standard report prepared by nearly every hospital across the country. While the MCR is primarily intended to assist the Centers for Medicare and Medicaid Services in "settling-up" with the hospitals for services provided to Medicare patients and to inform future Medicare policymaking, it contains a wealth of financial and volume information in a standardized format. The MCR is the most comprehensive and standardized financial reporting mechanism publicly available for the hospital industry.

Peer Group Comparisons

Peer hospitals were selected for each Washington hospital based on the following criteria as determined from the 2022 MCRs:

- **Bed size** – All short-stay hospitals across the country were separated into bed-size groups - 26 to 100, 101 to 300, 301 to 500, 501 to 800 and >800. Subject hospitals were compared to peers that fell within the same bed-size group.
- **Medicare Case Mix Index (CMI)** as reported in the Medicare final rule public use files. This index captures the level of acuity at a hospital. All short-stay acute hospitals across the country were segregated into quartiles based on CMI (Q1 = lowest and Q4 = highest). Subject hospitals were compared to peers that fell within the same CMI quartile.
- **Teaching Intensity** – This measure was determined based on the hospital's resident-to-bed ratio as reported in the MCR. All short-stay acute hospitals across the country were separated into quartiles based on the resident to bed ratio (Q1 = lowest and Q4 = highest). Subject hospitals were compared to peers that fell within the same resident-to-bed ratio quartile. If a subject hospital had no residents, they were compared to peers that also had no residents.
- **Service Intensity** – This measure was calculated as intensive care costs as a percentage of total costs. All short-stay acute hospitals across the country were separated into quartiles based on this ratio (Q1 = lowest and Q4 = highest). Subject hospitals were compared to peers that fell within the same service intensity quartile.

In some cases, these criteria needed to be broadened or narrowed to achieve a goal of 5 to 20 peers per subject hospital.

The subject hospitals were compared to their respective peers on the following metrics:

- **Price per Patient** - Net patient revenue divided by adjusted discharges, adjusted for the Medicare Case Mix Index (CMI).

- **Cost per Patient** - Hospital-only operating expense[21] divided by adjusted discharges, adjusted for Medicare wage index and the Council for Community and Economic Research (C2ER) cost of living.
- **Patient Profit Percent** - Patient services net income divided by net patient revenue.

To enhance comparability amongst national peers, each hospital's per-patient net patient revenue was adjusted using the Medicare case mix index (while this index is specific to Medicare inpatient activity, analyses in several states have shown this index is representative of overall hospital case mix). Further, for comparisons of cost, the estimated salary and salary related costs portion of each hospital's hospital-only operating expense was adjusted for geographic differences in labor costs using the Medicare wage index. All other costs were adjusted using C2ER cost of living index. Other organizations using similar processes include the National Academy for State Health Policy (NASHP) Hospital Cost Tool, Idaho Department of Health & Welfare, Colorado Medicaid, and the Colorado Division of Insurance.

Outliers

Hospitals were identified as outliers if any of the following criteria were met:

- **Price per Patient** – Subject hospital's net patient revenue per adjusted discharge was less than 90% or greater than 110% of the hospital's peer group median.
- **Cost per Patient** - Subject hospital's hospital-only operating expense per adjusted discharge was less than 90% or greater than 110% of the hospital's peer group median.
- **Patient Profit Percent** – Subject hospital's patient profit percentage fell within the 1st or 4th quartiles of the peer group.

In ***Figure 1***, Washington hospitals are graphed according to their percentage of peer group medians for price and cost. The lightly shaded square at the center of the graph represents the 10% plus or minus boundary for defining an outlier. Most of the 45 Washington hospitals reviewed fall into the upper right quadrant (quadrant 3), and above the outlier boundary. In quadrant 3, each blue dot represents one Washington hospital whose price and cost exceed that of its peer price and/or cost medians. The hospitals in quadrant 3 that fall outside of the shaded square are the outliers upon which this report will focus.

[21] Hospital-only operating expenses are a subset of total operating expenses and represent only those costs that are typical for short stay hospitals. In general, hospital-only operating expenses exclude Medicare non-reimbursable costs and costs associated with interns and residents.

***Figure 1*: Washington hospitals graphed according to their percentage of peer group medians for price and cost**

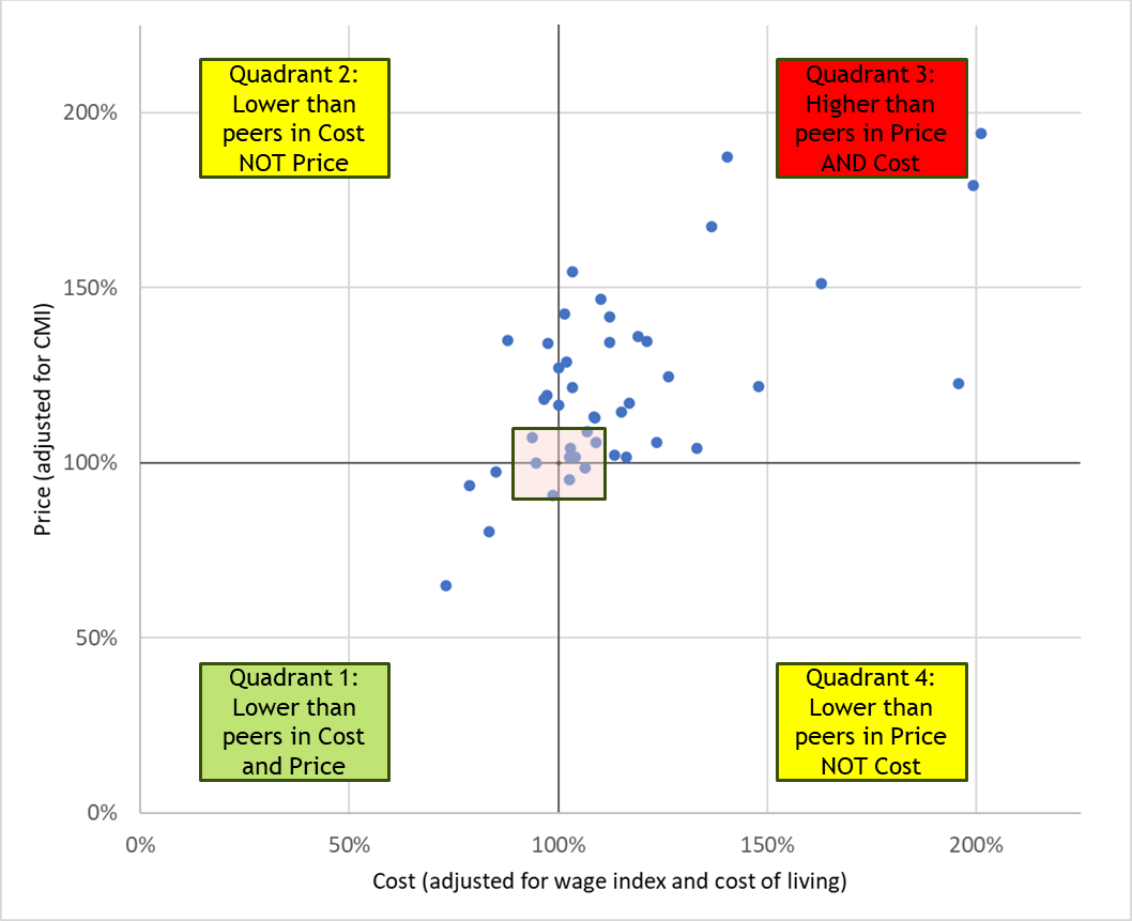


Table 1 summarizes in tabular form the information contained in Figure 1. The table shows how the 45 subject hospitals compared to their respective peers in terms of price and cost and adds information about comparison to peers in terms of profit.

Table 1: Washington hospitals compared to peer group medians for price and cost

WA Hosptials: Yellow Shaded Hospitals Are Reviewed																		
Price	High price							Normal price							Low price			
	27							**16**							**2**			
Cost	Normal cost			High cost			Low Cost	Normal cost			High cost		Low Cost		Low cost			
	11			15			1	10			4		2		2			
Profit	High profit	Normal profit	Low profit	High profit	Normal profit	Low profit	Normal profit	High profit	Normal profit	Low profit	Normal profit	Low profit	High profit	Low profit	High profit	Normal profit	Low profit	
	1	7	3	2	7	6	1	1	3	6	1	3	1	1	1	0	1	

Price Outliers: 27 Hospitals comprising 70%[22] of 2022 statewide hospital revenue are high-price hospitals compared to their national peers; many are also cost outliers.

Cost Outliers: 19 Hospitals comprising 39%[23] of 2022 statewide hospital revenue are high-cost hospitals compared to their national peers. 15 of these hospitals comprising 32%* of 2022 statewide hospital revenue are high-price hospitals as well.

- These high-price, high-cost hospitals, representing 1/3 of statewide hospital revenue, could put upward pressure on the overall Washington health care costs, trending data and the benchmark.

Profit Outliers: Three Hospitals comprising 6%[24] of 2022 statewide hospital revenue are high-price hospitals as compared to their national peers. Three additional hospitals are profit outliers but have normal or low prices and costs.

Price, Cost and Profit Outliers: 2 hospitals were found to be high price, high cost and high profit.

Details of hospital outliers can be found in **Appendix B**.

Medicare Payment-to-Cost Ratio Review

The second component of this analysis focuses on the Medicare payment-to-cost ratio, which can be used as another indicator of hospital efficiency. A Medicare payment-to-cost-ratio of 1.0 implies that a hospital breaks even on its Medicare payments for its Medicare utilization. A value less than 1.0 implies that a hospital loses money and a value greater than 1.0 implies that a hospital profits from serving its Medicare population.[25]

[22] Percentage represents the portion of hospital net patient revenue for the 45 hospitals analyzed.
[23] *Ibid.*
[24] *Ibid.*
[25] The degree of efficiency on Medicare business can be assumed to be similar across all payers.

If a hospital is inefficient on Medicare business, it is likely inefficient on Medicaid and any other public payer business, which can result in a hospital negotiating for higher commercial prices. Conversely, if the hospital is efficient on Medicare business, it can be implied it is efficient in serving patients covered by all payers, lessening the pressure to negotiate for higher commercial prices.

The Medicare payment-to-cost ratio is calculated by dividing Medicare payments by the costs of serving Medicare patients. Since Medicare payments are adjusted to reflect individual hospital characteristics, such as case mix, teaching intensity, and geographic location, comparing them to the related costs can provide an indication of how well hospitals are managing expenses and thus serve as a measure of efficiency. The 2024 Medicare Payment Advisory Commission (MedPAC) report states that relatively efficient hospitals can realize a Medicare payment-to-cost ratio of 97%. MedPAC defines relatively efficient hospitals as those providers that perform relatively well on cost and quality metrics and have consistent performance on all chosen metrics over the past three years.[26] Being below 97% represents an inefficient hospital, whereas being above 97% is an efficient hospital.

Of the 45 Washington hospitals reviewed, 39 were found to have a Medicare payment to cost ratio below 97% in 2022. The Median Medicare payment to cost ratio for the hospitals analyzed was 83%. An 83% Medicare payment to cost ratio indicates a loss of $0.17 on every dollar of cost incurred serving Medicare patients. This may indicate a cost efficiency problem with Washington hospitals and could contribute to higher health care cost trends if not addressed. See **Appendix C** for a complete list of Washington hospitals and their Medicare payment-to-cost ratios.

Revenue and Cost Trend Review

An indication of a hospitals price and cost trajectory can be achieved by reviewing a hospital's revenue and operating expense on both a whole-dollar and/or per-patient basis over time and comparing it to the state and national trends, and the trends for other hospitals in the state. A review of a hospital's whole-dollar revenue or price per patient trends can identify where issues may arise in the state meeting its cost growth benchmark target. Also, a review of whether a hospital appears cost efficient or cost inefficient can be achieved by reviewing a hospital's costs over time and comparing it to the state median, national trend, and other hospitals in the state that have been identified through the peer group comparison analysis.

The variables used in the trend analysis are Net Patient Revenues (revenues) and Hospital-Only Operating Expenses (costs). Unlike the peer group comparisons, revenues and costs were not adjusted for regional differences to analyze trends. Growth rates were calculated using a compound annual growth rate (CAGR) for two periods of time: 2012 through 2022 and 2018 through 2022, or an 11-year trend and a 5-year trend, respectively (see ***Table 2 below***).

The 11-year whole-dollar revenue trend for Washington hospitals was 4.85% which was close to the 4.82% national trend. For the more recent 5-year period, whole-dollar revenues for Washington hospitals increased 3.76% which was below the national trend of 5.59%.

[26] 2024 MedPAC Report to the Congress Chapter 3: MedPAC March 2024 Report to the Congress: Medicare Payment Policy, page 72-73.

The 11-year whole-dollar cost trend for Washington hospitals was 5.26% which was slightly above the 5.18% national trend. For the more recent 5-year period, whole-dollar costs for Washington hospitals increased 5.94% which was below the national trend of 6.68%.

With respect to per-patient revenues and costs, the trends for Washington hospitals exceeded national trends in three of the four calculations. The 11-year Washington Net Patient Revenue Per Adjusted Discharge (NPR PAD) trend was 5.00% which exceeded the 4.30% national trend. For the more recent 5-year period, the NPR PAD for Washington of 5.59% was lower than the national trend of 6.00%. The Washington hospitals' Cost Per Adjusted Discharge (Cost PAD) trends were 5.40% and 7.80% for the 11-year and 5-year periods, respectively. Both trends exceeded the national trends of 4.66% and 7.10, respectively.

Table 2: Compound Annual Growth Rates: National and Washington

Compound Annual Growth Rates: National and Washington State				
	2012 to 2022 NPR WHOLE Dollar CAGR	2018 to 2022 NPR WHOLE Dollar CAGR	2012 to 2022 WHOLE Dollar Cost CAGR	2018 to 2022 WHOLE Dollar Cost CAGR
National Short-Stay (Excluding CAH)	4.82%	5.59%	5.18%	6.68%
Washington Short-Stay (Excluding CAH)	4.85%	3.76%	5.26%	5.94%
	2012 to 2022 NPR PAD CAGR	2018 to 2022 NPR PAD CAGR	2012 to 2022 Cost PAD CAGR	2018 to 2022 Cost PAD CAGR
National Short-Stay (Excluding CAH)	4.30%	6.00%	4.66%	7.10%
Washington Short-Stay (Excluding CAH)	5.00%	5.59%	5.40%	7.80%

*NPR = Net Patient Revenue; PAD = per adjusted discharge; CAGR = compound annual growth rate; CAH = critical access hospital.

Table 3 Provides more detail on the number of hospitals that exceeded national trends, the share those hospitals have of the market, and the count of those hospitals also exhibiting high costs or prices in the peer group comparison. **If these hospitals continue to have cost and/or price growth trends that exceed the national trends and/or the Washington cost growth benchmark, the cost growth benchmark target may not be met.**

To focus only on those hospitals that drive statewide trends, ***Table 3*** limits the number of hospitals to those that comprised at least 1.9% or more of 2022 net patient revenue for the 45 hospitals reviewed.

- 23 hospitals had a share of NPR greater than 1.9% in 2022 representing 83% of all NPR for the 45 hospitals reviewed. The average NPR share for these hospitals was 3.6%.
- 22 hospitals had a share of NPR less than 1.9% in 2022 representing 17% of all NPR for the 45 hospitals reviewed. The average NPR share for these hospitals was 0.8%.

Trends reviewed include:

- 11 year and 5-year trend duration
- Whole-dollar cost

- Whole-dollar revenue
- Per-patient cost
- Per-patient revenue (price)

Table 3: Peer Group Comparisons

	Price and Cost Trend Review		Peer Group Comparisons			
	# of Hospitals	Percent of Statewide NPR	# of High Price Hospitals	# of High Cost Hospitals	# of High Price and High Cost Hospitals	Location
Exceeded 11-year and/or 5-year national trends for **whole-dollar cost**	16	55.82%	11	6	6	Appendix D, Table D1
Exceeded 11-year and/or 5-year national trends for **whole-dollar revenue**	14	49.08%	10	6	6	Appendix D, Table D2
Exceeded 11-year and/or 5-year national trends for **both whole-dollar cost and revenue**	14	49.08%	10	6	6	Appendix D, Table D3
Exceeded 11-year and/or 5-year national trends for **per-patient cost**	17	57.16%	13	8	7	Appendix D, Table D4
Exceeded 11-year and/or 5-year national trends for **per-patient revenue**	19	62.74%	14	9	8	Appendix D, Table D5
Exceeded 11-year and/or 5-year national trends for **both per-patient cost and revenue**	17	57.16%	13	8	7	Appendix D, Table D6
Exceeded 11-year and/or 5-year national trends for **both whole-dollar and per-patient costs**	10	30.42%	7	4	4	See Below, Table 4
Exceeded 11-year and/or 5-year national trends for **both whole-dollar and per-patient revenue**	10	29.26%	7	5	5	See Below, Table 5
Exceeded 11-year and/or 5-year national trends for **both whole-dollar and per-patient cost and revenue**	8	23.67%	6	4	4	See Below, Table 6

The first section of Table 3 highlights individual hospitals whose **whole dollar cost or whole dollar revenue trends** exceed either the 11-year national trend or the 5-year national trend or exceeded the trend in both timeframes. The second section highlights individual hospitals whose **per-patient cost or per-patient revenue trends** exceed either the 11-year national trend or the 5-year national trend or exceeded the trend in both timeframes. In most cases, hospitals in either the first section or second section represent hospitals with more than half of the net patient revenue for the 45 hospitals reviewed. The lists of these hospitals can be found in Appendix D, Table's 1 through 6.

The third section of Table 3 isolates individual hospitals who **exceed BOTH whole dollar and per-patient costs and prices trends** as compared to the national trends. The list of hospitals who exceed both types of metrics ranges between 8 and 10 hospitals and represents 24% to 30% of the net patient revenue for the 45 hospitals reviewed. The list of the hospitals exceeding both whole dollar trends and per-patient trends in cost and price can be found in Table's 4 through 6 below.

Table 4: Hospitals that exceed 11-year and/or 5-year on whole-dollar and per-patient national trends for price

10 Hospitals in BOTH NPR WHOLE Dollar and Price PAD	2022 Percent of Statewide NPR	2012 to 2022 Price PAD CAGR	2018 to 2022 Price PAD CAGR	2012 to 2022 NPR WHOLE Dollar CAGR	2018 to 2022 NPR WHOLE Dollar CAGR
Skagit Valley Hospital	1.92%	4.97%	6.23%	6.08%	6.16%
Confluence Health Hospital	2.57%	5.44%	6.93%	10.85%	10.62%
PeaceHealth St. Joseph	3.26%	9.94%	3.86%	4.91%	4.43%
Yakima Valley Memorial	2.43%	3.74%	13.47%	5.36%	9.60%
St Michael Medical Center	3.02%	3.38%	6.50%	6.65%	6.08%
Peacehealth Southwest Medical Center	3.45%	7.42%	10.63%	3.97%	6.83%
Kadlec Regional Medical Center	3.44%	5.43%	6.17%	9.24%	3.60%
Valley Medical Center	3.41%	5.63%	9.25%	13.49%	5.11%
Evergreen Health Kirkland	3.68%	5.36%	4.18%	6.67%	4.38%
Legacy Salmon Creek	2.08%	4.60%	7.35%	8.77%	5.13%
Total	**29.26%**				
Median		**5.40%**	**6.72%**	**6.66%**	**5.60%**
National		**4.30%**	**6.00%**	**4.82%**	**5.59%**

Light red shading denotes exceeding National Trend

Table 5: Hospitals that exceeded 11-year and/or 5-year whole-dollar and per-patient national trends for costs

10 Hospitals that Exceed National Trend for both WHOLE Dollar Cost and Cost PAD	2022 Percent of Statewide NPR	2012 to 2022 Cost PAD CAGR	2018 to 2022 Cost PAD CAGR	2012 to 2022 WHOLE Dollar Cost CAGR	2018 to 2022 WHOLE Dollar Cost CAGR
Skagit Valley Hospital	1.92%	5.93%	8.94%	7.04%	8.87%
Providence Regional Everett	3.85%	8.05%	10.98%	5.93%	7.54%
PeaceHealth St. Joseph	3.26%	10.70%	4.77%	5.64%	5.34%
Yakima Valley Memorial	2.43%	4.39%	11.20%	6.02%	7.41%
Peacehealth Southwest Medical Center	3.45%	7.40%	11.36%	3.95%	7.54%
Evergreen Health Kirkland	3.68%	5.62%	8.05%	6.93%	8.26%
Legacy Salmon Creek	2.08%	4.12%	8.20%	8.26%	5.96%
Overlake Medical Center	2.90%	6.50%	14.60%	4.32%	6.74%
Kadlec Regional Medical Center	3.44%	4.96%	7.52%	8.74%	4.92%
Valley Medical Center	3.41%	5.44%	11.63%	13.29%	7.40%
Total	**30.42%**				
Median		**5.77%**	**9.96%**	**6.48%**	**7.40%**
National		**4.66%**	**7.10%**	**5.18%**	**6.68%**

Light red shading denotes exceeding National Trend

Table 6: Hospitals that exceeded 11-year and/or 5-year on whole-dollar and per-patient national trends for price and cost

8 Hospitals in BOTH Price/Cost PAD and WHOLE Dollar Price/Cost	2022 Percent of Statewide NPR	Peer Group Comparison - Price	Peer Group Comparison - Cost	Peer Group Comparison - Profit
Skagit Valley Hospital	1.92%	High Price	High Cost	Normal Profit
PeaceHealth St. Joseph	3.26%	High Price	High Cost	Normal Profit
Yakima Valley Memorial	2.43%	High Price	Normal Cost	Normal Profit
Peacehealth Southwest Medical Center	3.45%	Normal Price	Normal Cost	Normal Profit
Evergreen Health Kirkland	3.68%	Normal Price	Normal Cost	Low Profit
Kadlec Regional Medical Center	3.44%	High Price	High Cost	Normal Profit
Valley Medical Center	3.41%	High Price	High Cost	Low Profit
Legacy Salmon Creek	2.08%	High Price	Normal Cost	Normal Profit
Total	**23.67%**			

Shading represents a hospital who exceeds peer group median by 10% or more

Conclusion/Summary

A comparison to national peers reveals that Washington hospitals representing **a significant amount of hospitals' business in the state generate higher per-patient revenue and per-patient costs compared to peer hospitals.** Hospital costs are a significant driver of the prices hospitals charge. Higher prices negatively impact public and commercial payers.

Most of the Washington hospitals analyzed had a Medicare payment-to-cost ratio of less than 95% which may be an indicator that hospitals **are not operating at optimal cost efficiency.**

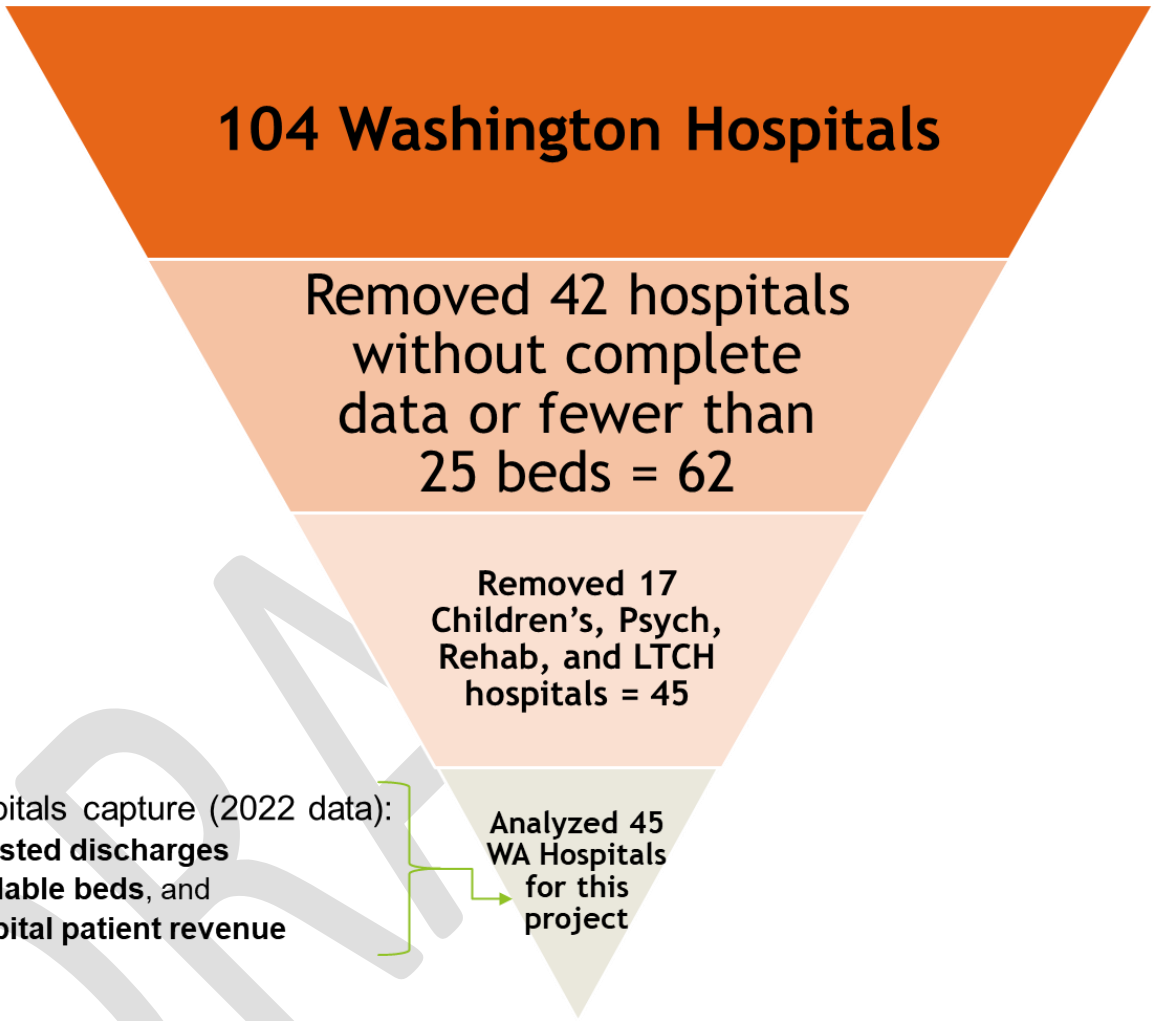
Hospitals contribute significantly to health care cost growth trends. **Hospitals representing most of the state's hospital industry are experiencing price and/or cost trends that exceed national trends.**

Meeting the HCCTB Cost Growth Benchmark may be in jeopardy if hospital price trends exceed the targeted increase.

Increases in hospital input costs put pressure on the prices hospitals charge. Therefore, hospital efficiency is a key factor in limiting health care cost growth.

The current financial condition of hospitals in many ways may be a result of strategic decisions that were made years ago. Without significant intervention, **altering the direction of the hospital industry, even if efforts start today, will be a long-term endeavor.**

Appendix A



These 45 hospitals capture (2022 data):

- **88% of adjusted discharges**
- **90% of available beds**, and
- **85% of hospital patient revenue**

Appendix B

Table B1: Peer Group Comparisons - Price Outliers

WA Hosptials: Yellow Shaded Hospitals Are Reviewed																
High price							Normal price						Low price			
27							**16**						**2**			
Normal cost			High cost			Low Cost	Normal cost			High cost		Low Cost		Low cost		
11			15			1	10			4		2		2		
High profit	Normal profit	Low profit	High profit	Normal profit	Low profit	Normal profit	High profit	Normal profit	Low profit	Normal profit	Low profit	High profit	Low profit	High profit	Normal profit	Low profit
1	7	3	2	7	6	1	1	3	6	1	3	1	1	1	0	1

Price Outliers: 27 price outliers; 70% of NPR; many include High Cost

Hospital	2022 % of Statewide NPR	Price	Cost	Profit
Skagit Valley Hospital	1.92%	High Price	High Cost	Normal Profit
Virginia Mason Medical	2.94%	High Price	Low Cost	Normal Profit
Univesity of Washington Medical Center	8.48%	High Price	Normal Cost	Normal Profit
Confluence Health Hospital	2.57%	High Price	High Cost	Normal Profit
Providence Centralia	1.12%	High Price	High Cost	High Profit
Providence St. Peter Hospital	2.52%	High Price	Normal Cost	Low Profit
Swedish Cherry Hill	2.16%	High Price	High Cost	Low Profit
Swedish Edmonds	1.14%	High Price	High Cost	Low Profit
Swedish First Hill	6.40%	High Price	Normal Cost	Low Profit
PeaceHealth St. Joseph	3.26%	High Price	High Cost	Normal Profit
Samaritan Hospital	0.64%	High Price	High Cost	High Profit
Yakima Valley Memorial	2.43%	High Price	Normal Cost	Normal Profit
Astria - Toppenish Community Hospital	0.26%	High Price	High Cost	Normal Profit
PeaceHealth St. John	1.47%	High Price	Normal Cost	Normal Profit
Overlake Medical Center	2.90%	High Price	Normal Cost	Normal Profit
Trios Health	0.72%	High Price	High Cost	Low Profit
Kadlec Regional Medical Center	3.44%	High Price	High Cost	Normal Profit
Cascade Valley Hospital	0.37%	High Price	Normal Cost	High Profit
Harborview Medical Center	5.06%	High Price	High Cost	Normal Profit
Olympic Medical Center	1.11%	High Price	Normal Cost	Low Profit
Multicare - Good Samaritan Hospital	3.05%	High Price	High Cost	Low Profit
Evergreen Health Monroe	0.22%	High Price	High Cost	Normal Profit
Valley Medical Center	3.41%	High Price	High Cost	Low Profit
St Joseph Medical Center	3.25%	High Price	High Cost	Low Profit
Tacoma General Allenmore	6.18%	High Price	Normal Cost	Normal Profit
Legacy Salmon Creek	2.08%	High Price	Normal Cost	Normal Profit
Swedish Issaquah	1.32%	High Price	Normal Cost	Normal Profit

Shading represents a hospital who exceeds peer group median by 10% or more

Hospitals who have a share of the statewide Net Patient Revenue greater than 1.9%

Note: 2022 Percent of Statewide NPR is based on the 45 hospitals included in the analysis

Table B2: Peer Group Comparisons - Cost Outliers

WA Hosptials: Yellow Shaded Hospitals Are Reviewed																
High price							Normal price						Low price			
27							**16**						**2**			
Normal cost			High cost			Low Cost	Normal cost			High cost		Low Cost		Low cost		
11			15			1	10			4		2		2		
High profit	Normal profit	Low profit	High profit	Normal profit	Low profit	Normal profit	High profit	Normal profit	Low profit	Normal profit	Low profit	High profit	Low profit	High profit	Normal profit	Low profit
1	7	3	2	7	6	1	1	3	6	1	3	1	1	1	0	1

Cost Outliers: 19 cost outliers; 39% of NPR; many include High Price

Hospital	2022 Percent of Statewide NPR	Price	Cost	Profit
Skagit Valley Hospital	1.92%	High Price	High Cost	Normal Profit
Multicare - Auburn Medical Center	1.00%	Normal Price	High Cost	Normal Profit
Confluence Health Hospital	2.57%	High Price	High Cost	Normal Profit
Providence Centralia	1.12%	High Price	High Cost	High Profit
St Clare Hospital	0.69%	Normal Price	High Cost	Low Profit
Swedish Cherry Hill	2.16%	High Price	High Cost	Low Profit
Swedish Edmonds	1.14%	High Price	High Cost	Low Profit
PeaceHealth St. Joseph	3.26%	High Price	High Cost	Normal Profit
Samaritan Hospital	0.64%	High Price	High Cost	High Profit
Astria - Toppenish Community Hospital	0.26%	High Price	High Cost	Normal Profit
Trios Health	0.72%	High Price	High Cost	Low Profit
Providence Sacred Heart	4.41%	Normal Price	High Cost	Low Profit
Kadlec Regional Medical Center	3.44%	High Price	High Cost	Normal Profit
Harborview Medical Center	5.06%	High Price	High Cost	Normal Profit
Multicare - Good Samaritan Hospital	3.05%	High Price	High Cost	Low Profit
Evergreen Health Monroe	0.22%	High Price	High Cost	Normal Profit
Valley Medical Center	3.41%	High Price	High Cost	Low Profit
St Joseph Medical Center	3.25%	High Price	High Cost	Low Profit
St. Anthony Hospital	0.82%	Normal Price	High Cost	Low Profit

Shading represents a hospital who exceeds peer group median by 10% or more

Hospitals who have a share of the statewide Net Patient Revenue greater than 1.9%

Table B3: Peer Group Comparisons - Profit Outliers

WA Hosptials: Yellow Shaded Hospitals Are Reviewed																
High price							Normal price						Low price			
27							**16**						**2**			
Normal cost			High cost			Low Cost	Normal cost			High cost		Low Cost		Low cost		
11			15			1	10			4		2		2		
High profit	Normal profit	Low profit	High profit	Normal profit	Low profit	Normal profit	High profit	Normal profit	Low profit	Normal profit	Low profit	High profit	Low profit	High profit	Normal profit	Low profit
1	7	3	2	7	6	1	1	3	6	1	3	1	1	1	0	1

Profit Outliers: 6 Hospitals with high profits; 2 hospitals hit the trifecta with High Price, High Cost, and High Profit outlier status.

Hospital	2022 Percent of Statewide NPR	Price	Cost	Profit
Providence Centralia	1.12%	High Price	High Cost	High Profit
Samaritan Hospital	0.64%	High Price	High Cost	High Profit
St Michael Medical Center	3.02%	Low Price	Low Cost	High Profit
Cascade Valley Hospital	0.37%	High Price	Normal Cost	High Profit
Multicare - Valley Hospital	0.73%	Normal Price	Low Cost	High Profit
Multicare Covington Medical Center	0.45%	Normal Price	Normal Cost	High Profit

Shading represents a hospital who exceeds peer group median by 10% or more

Hospitals who have a share of the statewide Net Patient Revenue greater than 1.9%

Appendix C

Medicare Payment-to-cost Ratio

Hospital Name	Medicare Payment-to-Cost Ratio	Hospital Name	Medicare Payment-to-Cost Ratio
Astria - Toppenish Community Hospital	0.60	St. Francis Hospital	0.84
Evergreen Health Monroe	0.67	Valley Medical Center	0.85
St Anne Hospital	0.69	St Michael Medical Center	0.85
Multicare - Auburn Medical Center	0.70	PeaceHealth St. John	0.86
Samaritan Hospital	0.73	Multicare Covington Medical Center	0.87
St. Anthony Hospital	0.74	Multicare - Valley Hospital	0.87
Yakima Valley Memorial	0.74	Harbor Regional Hospital	0.87
Swedish Issaquah	0.75	Virginia Mason Medical	0.88
Multicare - Capital Medical Center	0.75	Legacy Salmon Creek	0.88
St Clare Hospital	0.76	Harborview Medical Center	0.88
St Joseph Medical Center	0.76	Providence St. Peter Hospital	0.89
Evergreen Health Kirkland	0.77	Peacehealth Southwest Medical Center	0.89
Confluence Health Hospital	0.78	Island Hospital	0.90
Cascade Valley Hospital	0.78	PeaceHealth St. Joseph	0.91
Overlake Medical Center	0.79	Swedish First Hill	0.92
Tacoma General Allenmore	0.80	Providence Regional Everett	0.93
Olympic Medical Center	0.81	Swedish Cherry Hill	0.96
Trios Health	0.82	Providence Sacred Heart	0.97
Multicare - Good Samaritan Hospital	0.83	Multicare - Deaconess Medical Center	0.97
Kadlec Regional Medical Center	0.83	Univesity of Washington Medical Center	1.00
Providence St. Mary Hospital	0.83	Providence Holy Family	1.01
Skagit Valley Hospital	0.83	Providence Centralia	1.03
Swedish Edmonds	0.83	**Statewide Median**	**0.83**

Appendix D

Price and Cost Trend Analysis: Table D1

16 WA Hospitals greater than 1.9% Statewide NPR; WHOLE Dollar Cost CAGR greater than National Trend for Either 11yr or 5yr Trend				
HOSPITAL	**Medicare Payment-to-Cost Ratio**	**2022 Percent of Statewide Net Patient Revenue**	**2012 to 2022 WHOLE Dollar Cost CAGR**	**2018 to 2022 WHOLE Dollar Cost CAGR**
Skagit Valley Hospital	0.83	1.92%	7.04%	8.87%
Providence Regional Everett	0.93	3.85%	5.93%	7.54%
PeaceHealth St. Joseph	0.91	3.26%	5.64%	5.34%
Yakima Valley Memorial	0.74	2.43%	6.02%	7.41%
Multicare - Deaconess Medical Center	0.97	2.10%	6.54%	12.10%
Peacehealth Southwest Medical Center	0.89	3.45%	3.95%	7.54%
Evergreen Health Kirkland	0.77	3.68%	6.93%	8.26%
Legacy Salmon Creek	0.88	2.08%	8.26%	5.96%
St Michael Medical Center	0.85	3.02%	6.24%	6.56%
Tacoma General Allenmore	0.80	6.18%	4.93%	12.69%
Overlake Medical Center	0.79	2.90%	4.32%	6.74%
Univesity of Washington Medical Center	1.00	8.48%	7.28%	9.70%
Confluence Health Hospital	0.78	2.57%	9.82%	10.19%
Kadlec Regional Medical Center	0.83	3.44%	8.74%	4.92%
Multicare - Good Samaritan Hospital	0.83	3.05%	5.88%	12.97%
Valley Medical Center	0.85	3.41%	13.29%	7.40%
Total		**55.82%**		
Median	**0.84**		**6.39%**	**7.54%**
National			**5.18%**	**6.68%**
Shading denotes exceeding National Trend				

Price and Cost Trend Analysis: Table D2

14 WA Hospitals greater than 1.9% Statewide NPR: NPR WHOLE Dollar CAGR greater than National Trend for Either 11yr or 5yr Trend				
HOSPITAL	**2022 Percent of Statewide Net Patient Revenue**	**2012 to 2022 NPR WHOLE Dollar CAGR**	**2018 to 2022 NPR WHOLE Dollar CAGR**	**2022 NPR WHOLE Dollar Increase**
Skagit Valley Hospital	1.92%	6.08%	6.16%	4.49%
Univesity of Washington Medical Center	8.48%	8.00%	11.10%	5.49%
Confluence Health Hospital	2.57%	10.85%	10.62%	3.00%
PeaceHealth St. Joseph	3.26%	4.91%	4.43%	6.14%
Yakima Valley Memorial	2.43%	5.36%	9.60%	-4.55%
St Michael Medical Center	3.02%	6.65%	6.08%	7.79%
Multicare - Deaconess Medical Center	2.10%	6.12%	13.58%	7.17%
Peacehealth Southwest Medical Center	3.45%	3.97%	6.83%	8.19%
Kadlec Regional Medical Center	3.44%	9.24%	3.60%	0.20%
Multicare - Good Samaritan Hospital	3.05%	4.57%	5.75%	-1.84%
Valley Medical Center	3.41%	13.49%	5.11%	3.28%
Evergreen Health Kirkland	3.68%	6.67%	4.38%	2.70%
Tacoma General Allenmore	6.18%	7.14%	3.97%	-16.84%
Legacy Salmon Creek	2.08%	8.77%	5.13%	8.20%
Total	**49.08%**			
Median		**6.66%**	**5.91%**	**3.88%**
National		**4.82%**	**5.59%**	
Shading denotes exceeding National Trend				
Yellow shading denotes exceeding 1 Year Trend				

Price and Cost Trend Analysis: Table D3

14 Hospitals On Both Price and Cost Outlier Lists	2022 Percent of Statewide Net Patient Revenue	2012 to 2022 NPR WHOLE Dollar CAGR	2018 to 2022 NPR WHOLE Dollar CAGR	2012 to 2022 WHOLE Dollar Cost CAGR	2018 to 2022 WHOLE Dollar Cost CAGR
Skagit Valley Hospital	1.92%	6.08%	6.16%	7.04%	8.87%
PeaceHealth St. Joseph	3.26%	4.91%	4.43%	5.64%	5.34%
Yakima Valley Memorial	2.43%	5.36%	9.60%	6.02%	7.41%
Multicare - Deaconess Medical Center	2.10%	6.12%	13.58%	6.54%	12.10%
Peacehealth Southwest Medical Center	3.45%	3.97%	6.83%	3.95%	7.54%
Evergreen Health Kirkland	3.68%	6.67%	4.38%	6.93%	8.26%
Legacy Salmon Creek	2.08%	8.77%	5.13%	8.26%	5.96%
St Michael Medical Center	3.02%	6.65%	6.08%	6.24%	6.56%
Tacoma General Allenmore	6.18%	7.14%	3.97%	4.93%	12.69%
Univesity of Washington Medical Center	8.48%	8.00%	11.10%	7.28%	9.70%
Confluence Health Hospital	2.57%	10.85%	10.62%	9.82%	10.19%
Kadlec Regional Medical Center	3.44%	9.24%	3.60%	8.74%	4.92%
Multicare - Good Samaritan Hospital	3.05%	4.57%	5.75%	5.88%	12.97%
Valley Medical Center	3.41%	13.49%	5.11%	13.29%	7.40%
Total	**49.08%**				
Median		**6.66%**	**5.91%**	**6.73%**	**7.90%**
National		**4.82%**	**5.59%**	**5.18%**	**6.68%**
Shading denotes exceeding National Trend					

Price and Cost Trend Analysis: Table D4

17 WA Hospitals greater than 1.9% Statewide NPR; Cost PAD CAGR greater than National Trend for Either 11yr or 5yr Trend

HOSPITAL	2022 Percent of Statewide NPR	2012 to 2022 Cost PAD CAGR	2018 to 2022 Cost PAD CAGR
Skagit Valley Hospital	1.92%	5.93%	8.94%
Virginia Mason Medical	2.94%	5.97%	8.04%
Providence Regional Everett	3.85%	8.05%	10.98%
Providence St. Peter Hospital	2.52%	5.71%	8.44%
Swedish Cherry Hill	2.16%	6.77%	6.93%
Swedish First Hill	6.40%	6.15%	7.82%
PeaceHealth St. Joseph	3.26%	10.70%	4.77%
Yakima Valley Memorial	2.43%	4.39%	11.20%
Peacehealth Southwest Medical Center	3.45%	7.40%	11.36%
Overlake Medical Center	2.90%	6.50%	14.60%
Providence Sacred Heart	4.41%	6.89%	7.75%
Kadlec Regional Medical Center	3.44%	4.96%	7.52%
Harborview Medical Center	5.06%	5.91%	6.24%
Valley Medical Center	3.41%	5.44%	11.63%
St Joseph Medical Center	3.25%	9.90%	12.43%
Evergreen Health Kirkland	3.68%	5.62%	8.05%
Legacy Salmon Creek	2.08%	4.12%	8.20%
Total	**57.16%**		
Median		**5.97%**	**8.20%**
National		**4.66%**	**7.10%**
Shading denotes exceeding National Trend			

Price and Cost Trend Analysis: Table D5

19 WA Hospitals greater than 1.9% NPR; Price PAD CAGR greater than National Trend for Either 11yr or 5yr Trend				
HOSPITAL	**2022 Percent of Statewide NPR**	**2012 to 2022 Price PAD CAGR**	**2018 to 2022 Price PAD CAGR**	**2022 Price PAD Increase**
Skagit Valley Hospital	1.92%	4.97%	6.23%	3.71%
Virginia Mason Medical	2.94%	8.85%	12.03%	30.21%
Providence Regional Everett	3.85%	6.83%	5.87%	9.68%
Confluence Health Hospital	2.57%	5.44%	6.93%	7.24%
Providence St. Peter Hospital	2.52%	4.67%	5.06%	4.07%
Swedish Cherry Hill	2.16%	6.48%	4.65%	4.54%
Swedish First Hill	6.40%	6.44%	7.01%	7.73%
PeaceHealth St. Joseph	3.26%	9.94%	3.86%	4.18%
Yakima Valley Memorial	2.43%	3.74%	13.47%	-10.13%
St Michael Medical Center	3.02%	3.38%	6.50%	-12.41%
Peacehealth Southwest Medical Center	3.45%	7.42%	10.63%	14.93%
Overlake Medical Center	2.90%	6.26%	11.23%	7.07%
Providence Sacred Heart	4.41%	5.29%	5.50%	3.56%
Kadlec Regional Medical Center	3.44%	5.43%	6.17%	5.77%
Harborview Medical Center	5.06%	6.44%	6.54%	6.00%
Valley Medical Center	3.41%	5.63%	9.25%	11.25%
St Joseph Medical Center	3.25%	6.22%	8.69%	2.46%
Evergreen Health Kirkland	3.68%	5.36%	4.18%	3.97%
Legacy Salmon Creek	2.08%	4.60%	7.35%	15.75%
Total	**62.74%**			
Median		**5.63%**	**6.54%**	**5.77%**
National		**4.30%**	**6.00%**	
Light red shading denotes exceeding National Trend				
Yellow shading denotes exceeding 1 Year Cost Growth Benchmark Rate of 3.2%				

Price and Cost Trend Analysis: Table D6

17 Hospitals in BOTH Price PAD and Cost PAD	2022 Percent of Statewide NPR	Peer Group Comparison - Price	Peer Group Comparison - Cost	Peer Group Comparison - Profit
Skagit Valley Hospital	1.92%	High Price	High Cost	Normal Profit
Virginia Mason Medical	2.94%	High Price	Low Cost	Normal Profit
Providence Regional Everett	3.85%	Normal Price	Normal Cost	Low Profit
Providence St. Peter Hospital	2.52%	High Price	Normal Cost	Low Profit
Swedish Cherry Hill	2.16%	High Price	High Cost	Low Profit
Swedish First Hill	6.40%	High Price	Normal Cost	Low Profit
PeaceHealth St. Joseph	3.26%	High Price	High Cost	Normal Profit
Yakima Valley Memorial	2.43%	High Price	Normal Cost	Normal Profit
Peacehealth Southwest Medical Center	3.45%	Normal Price	Normal Cost	Normal Profit
Overlake Medical Center	2.90%	High Price	Normal Cost	Normal Profit
Providence Sacred Heart	4.41%	Normal Price	High Cost	Low Profit
Kadlec Regional Medical Center	3.44%	High Price	High Cost	Normal Profit
Harborview Medical Center	5.06%	High Price	High Cost	Normal Profit
Valley Medical Center	3.41%	High Price	High Cost	Low Profit
St Joseph Medical Center	3.25%	High Price	High Cost	Low Profit
Evergreen Health Kirkland	3.68%	Normal Price	Normal Cost	Low Profit
Legacy Salmon Creek	2.08%	High Price	Normal Cost	Normal Profit
Total	**57.16%**			
Shading represents a hospital who exceeds peer group median by 10% or more				

Appendix E

45 Washington hospitals name, city, and county

Hospital Name	City	County	Hospital Name	City	County
Astria - Toppenish Community Hospital	TOPPENISH	YAKIMA	St. Francis Hospital	FEDERAL WAY	KING
Evergreen Health Monroe	MONROE	SNOHOMISH	Valley Medical Center	RENTON	KING
St Anne Hospital	SEATTLE	KING	St Michael Medical Center	BREMERTON	KITSAP
Multicare - Auburn Medical Center	AUBURN	KING	PeaceHealth St. John	LONGVIEW	COWLITZ
Samaritan Hospital	MOSES LAKE	GRANT	Multicare Covington Medical Center	COVINGTON	KING
St. Anthony Hospital	GIG HARBOR	PIERCE	Multicare - Valley Hospital	SPOKANE	SPOKANE
Yakima Valley Memorial	YAKIMA	YAKIMA	Harbor Regional Hospital	ABERDEEN	GRAYS HARBOR
Swedish Issaquah	ISSAQUAH	KING	Virginia Mason Medical	SEATTLE	KING
Multicare - Capital Medical Center	OLYMPIA	THURSTON	Legacy Salmon Creek	VANCOUVER	CLARK
St Clare Hospital	LAKEWOOD	PIERCE	Harborview Medical Center	SEATTLE	KING
St Joseph Medical Center	TACOMA	PIERCE	Providence St. Peter Hospital	OLYMPIA	THURSTON
Evergreen Health Kirkland	KIRKLAND	KING	Peacehealth Southwest Medical Center	VANCOUVER	CLARK
Confluence Health Hospital	WENATCHEE	CHELAN	Island Hospital	ANACORTES	SKAGIT
Cascade Valley Hospital	ARLINGTON	SNOHOMISH	PeaceHealth St. Joseph	BELLINGHAM	WHATCOM
Overlake Medical Center	BELLEVUE	KING	Swedish First Hill	SEATTLE	KING
Tacoma General Allenmore	TACOMA	PIERCE	Providence Regional Everett	EVERETT	SNOHOMISH
Olympic Medical Center	PORT ANGELES	CLALLAM	Swedish Cherry Hill	SEATTLE	KING
Trios Health	KENNEWICK	BENTON	Providence Sacred Heart	SPOKANE	SPOKANE
Multicare - Good Samaritan Hospital	PUYALLUP	PIERCE	Multicare - Deaconess Medical Center	SPOKANE	SPOKANE
Kadlec Regional Medical Center	RICHLAND	BENTON	Univesity of Washington Medical Center	SEATTLE	KING
Providence St. Mary Hospital	WALLA WALLA	WALLA WALLA	Providence Holy Family	SPOKANE	SPOKANE
Skagit Valley Hospital	MOUNT VERNON	SKAGIT	Providence Centralia	CENTRALIA	LEWIS
Swedish Edmonds	EDMONDS	SNOHOMISH			

Appendix B: DEX report

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Analytic Support Initiative Preliminary 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 Preliminary Disease Expenditures Report

Version 2 | October 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.

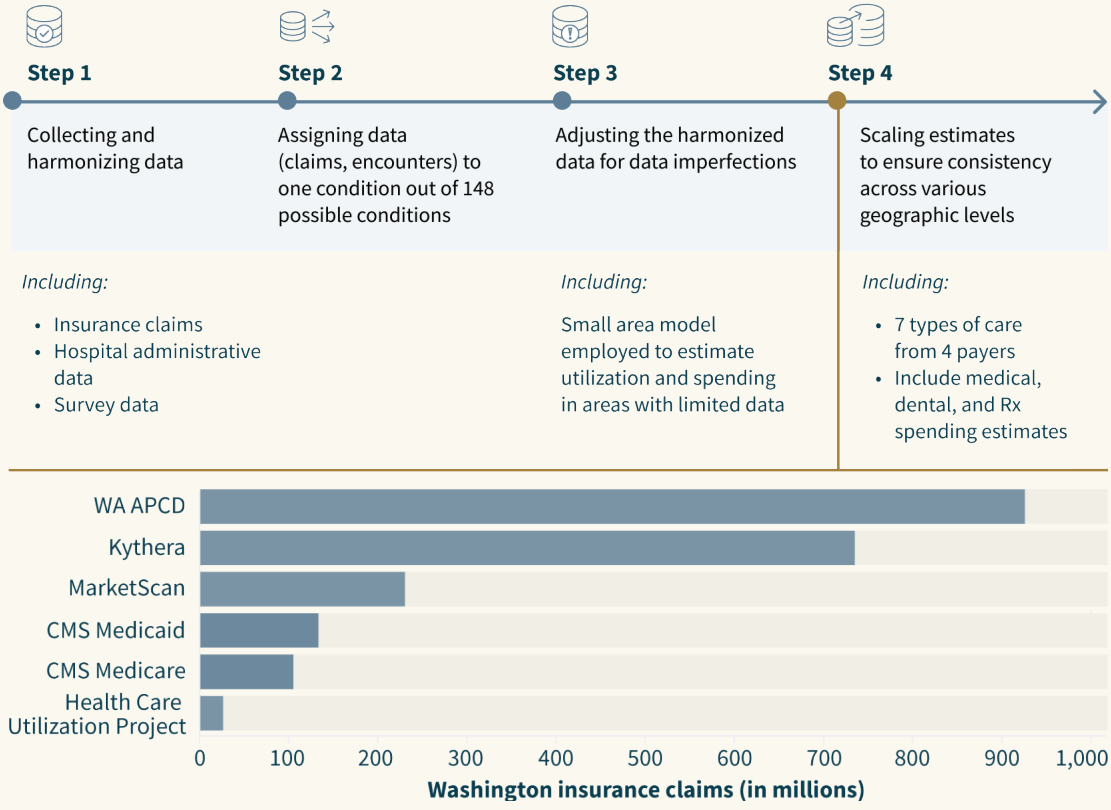
Estimates produced for the DEX project include spending on seven types of care – ambulatory care, hospital inpatient care, retail-prescribed pharmaceutical,

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 2023, the Health Care Cost Transparency Board provided a first report against these state benchmarks. The report showed that the total health care spending in Washington increased by 7.2% from 2017 to 2018, and 5.8% from 2018 to 2019. The reports also showed that when measured in terms of per member per year, growth was slowest for Medicare spending (2.9% per year in 2019), higher for private insurance (4.0%), and highest for Medicaid (11.9% in 2019), reflecting legislative investments in that program.

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 findings 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**

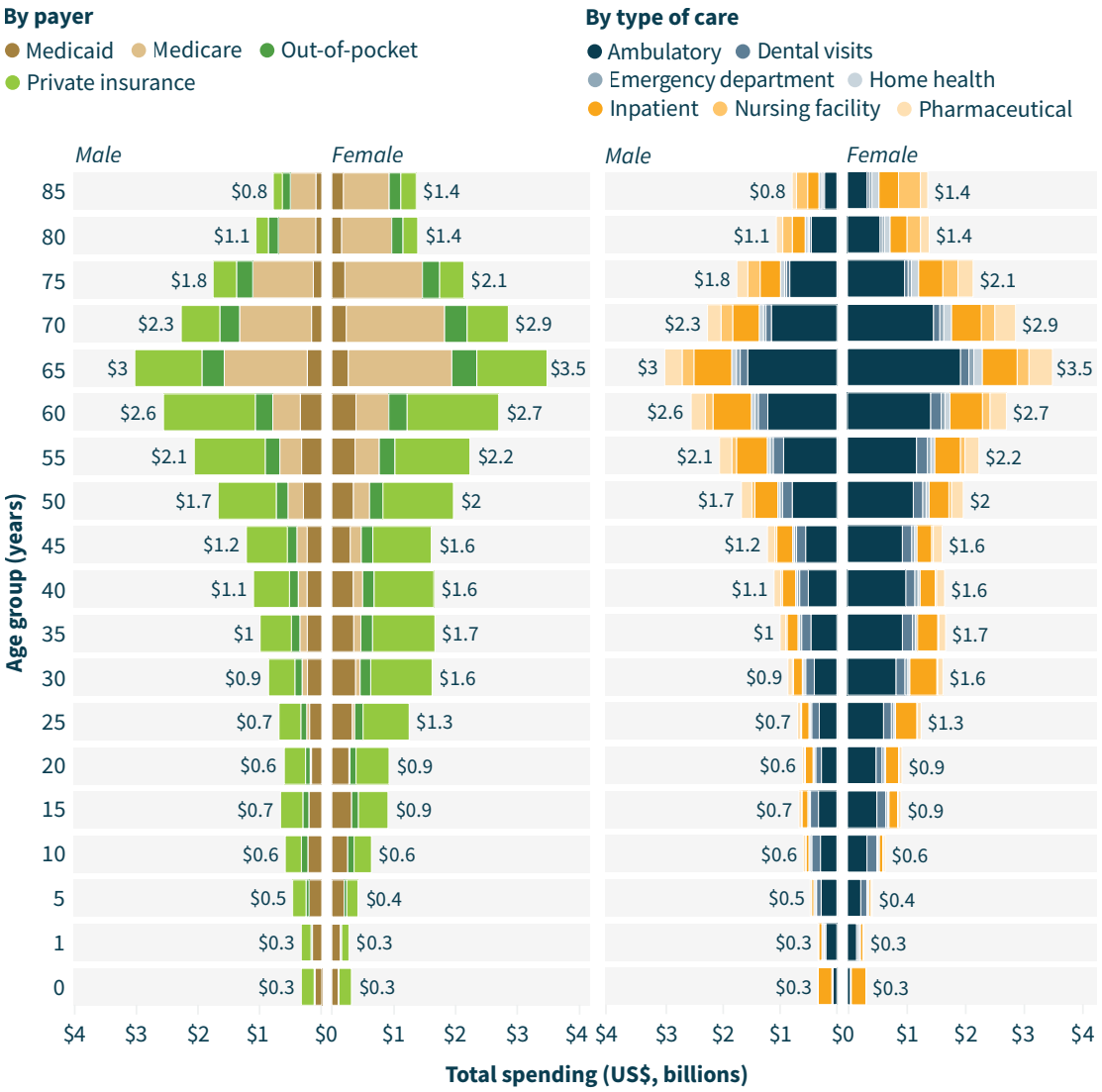
**Not adjusted for inflation*

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.

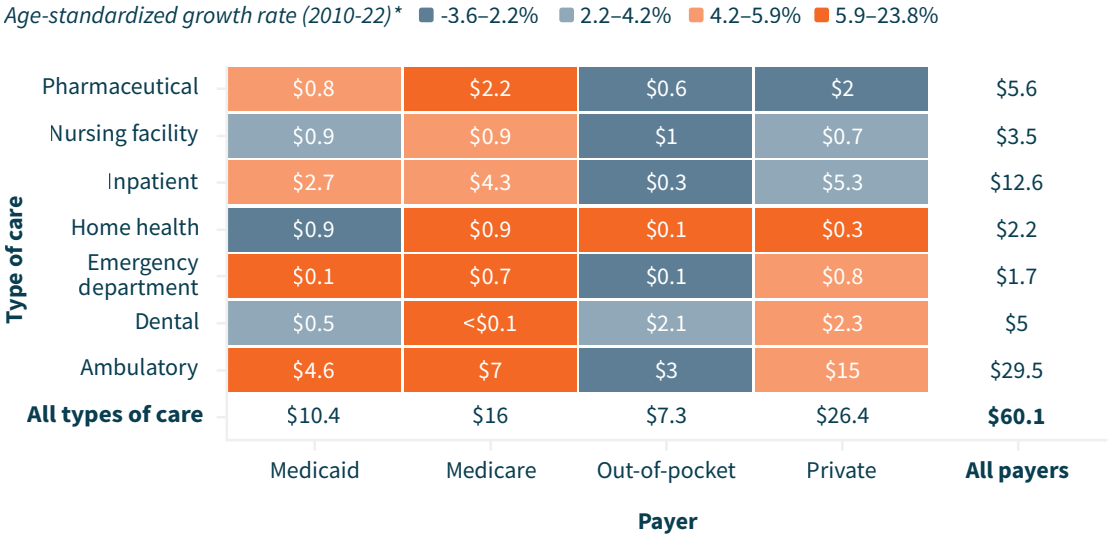
[4] Spending from Veterans Affairs, Tri-care, and Indian Health Services were omitted because of insufficient data.

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*

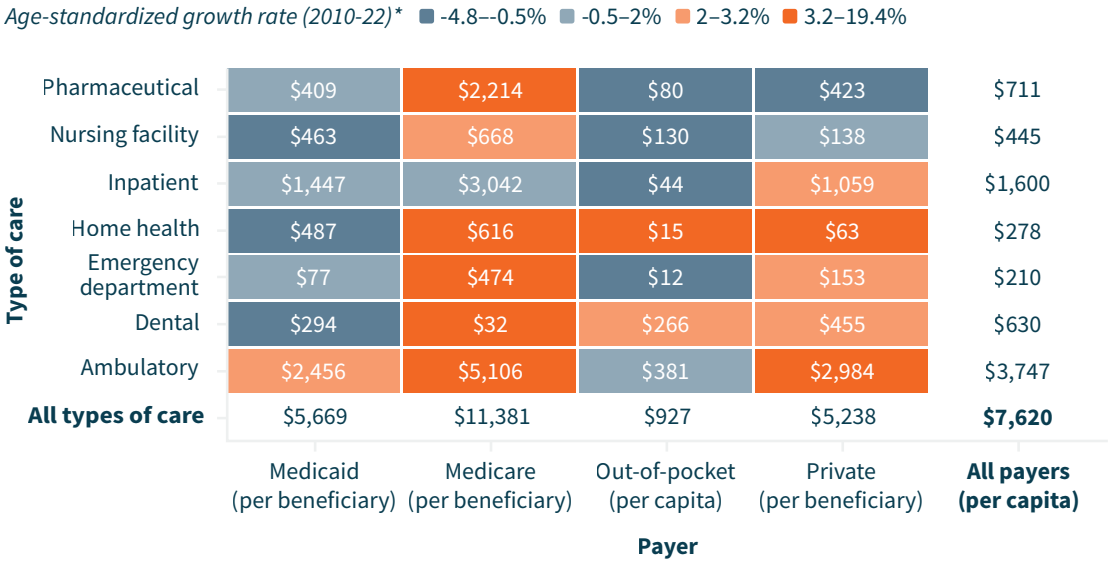
While the payer category with the most spending was private insurance, Medicare spending per beneficiary was much larger – and remained consistently so across all types of care (with the exception of dental care) - than every other payer (Figure 7). Medicare spending was $11,381 per beneficiary, while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

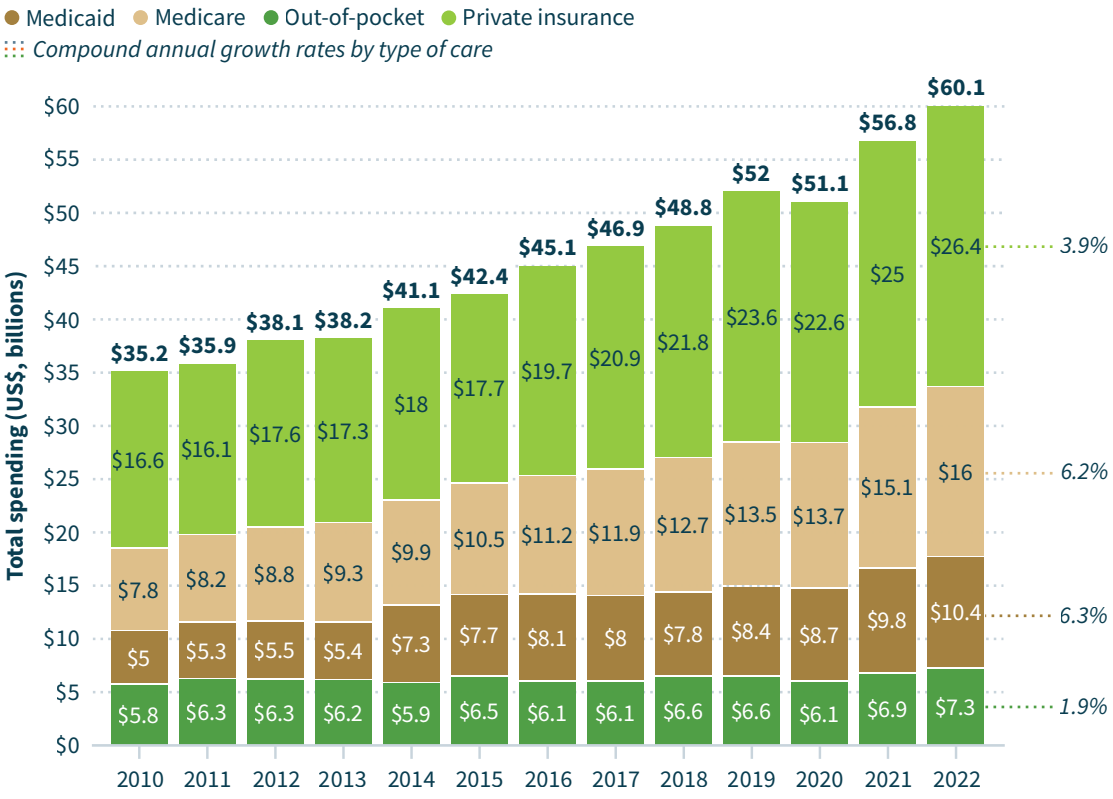
The growth of price and intensity in the private insurance marketplace over this time period may also translate into challenges around affordability observed in outpatient out-of-pocket expenditure growth – raising potential avenues of inquiry around non-covered expenses that may be worth further examination.

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.

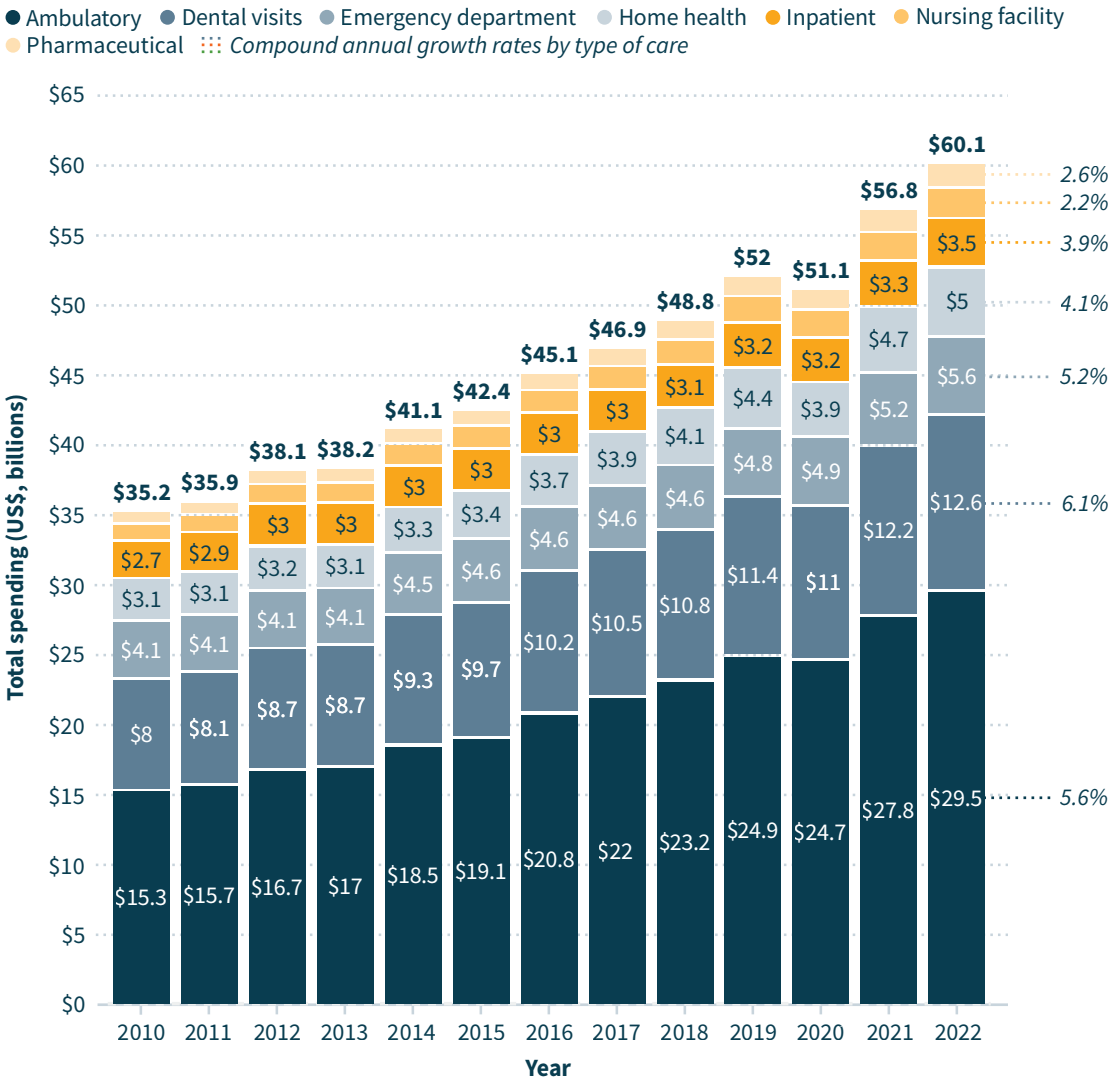
Figure 8: Total spending in Washington by payer, 2010-2022



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.

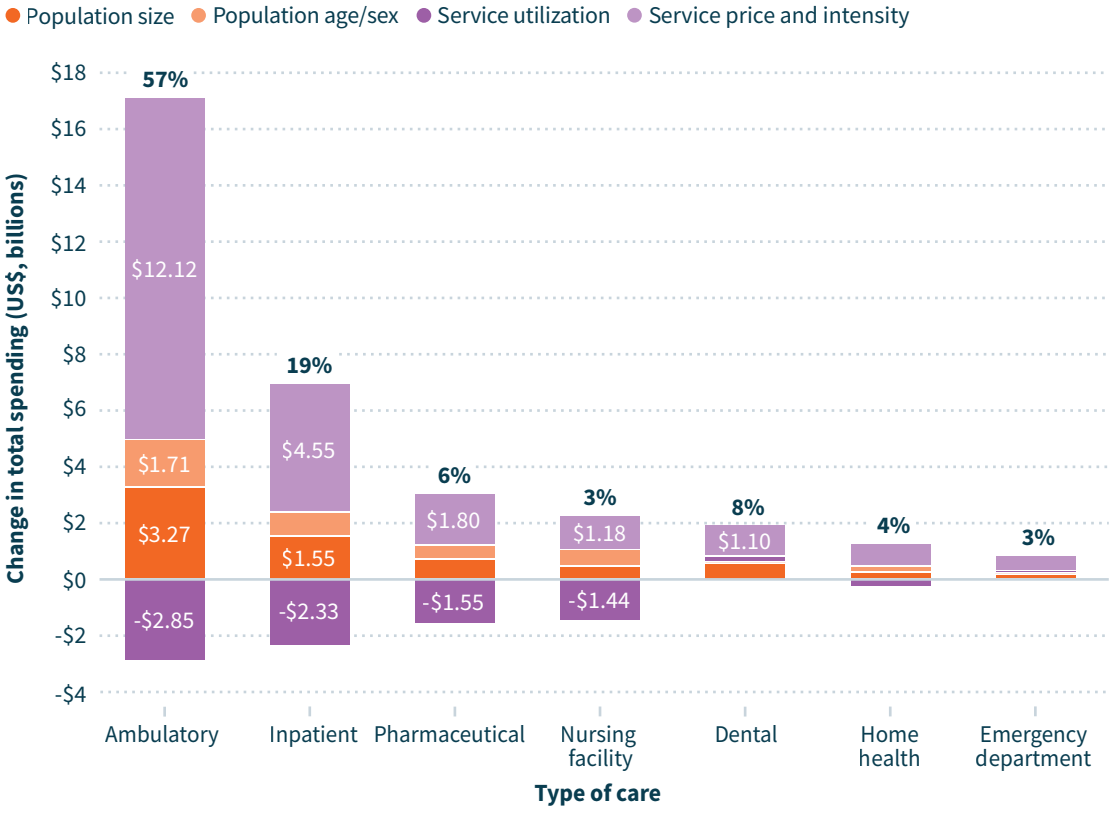
Growth in ambulatory and inpatient expenditure accounts for 76% of the growth observed over this period.

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**

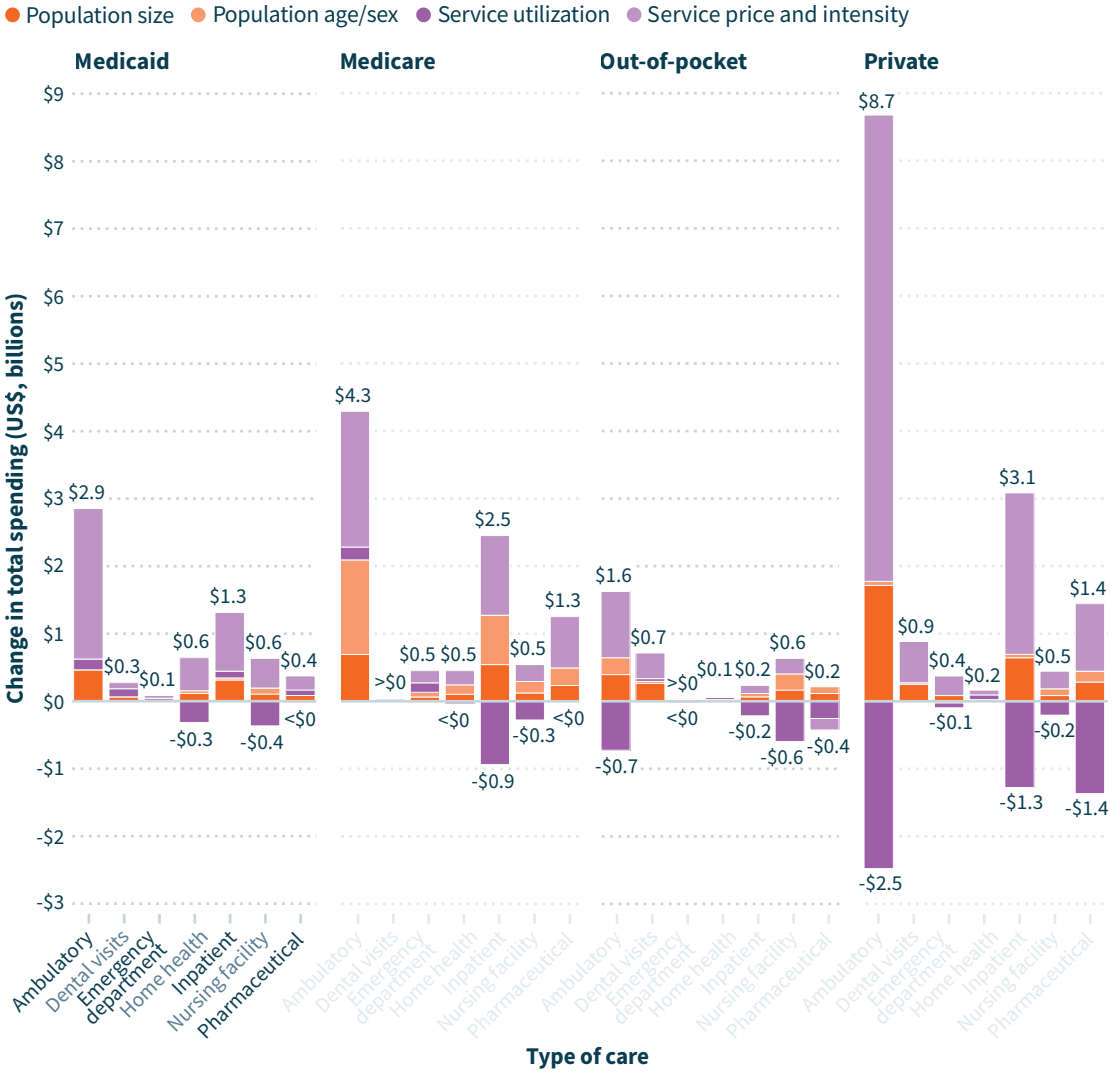
Percents are a portion of the total growth in expenditure observed from 2010-2019.



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.

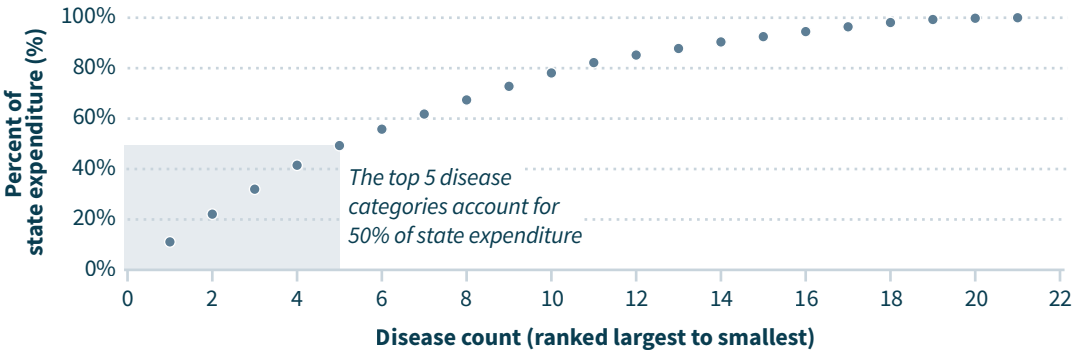
Key takeaways

- 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%

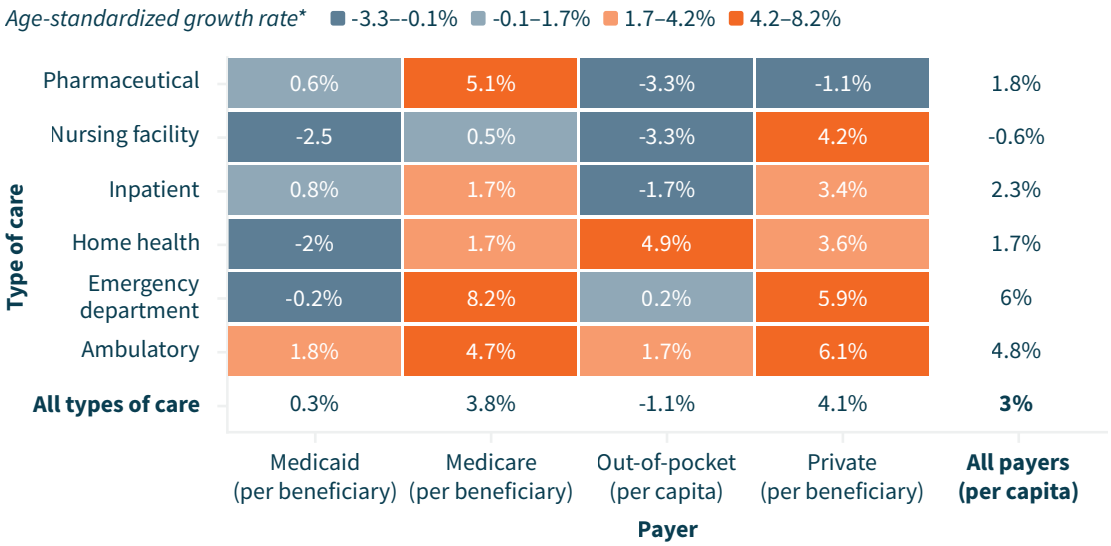
**Not adjusted for inflation*

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**



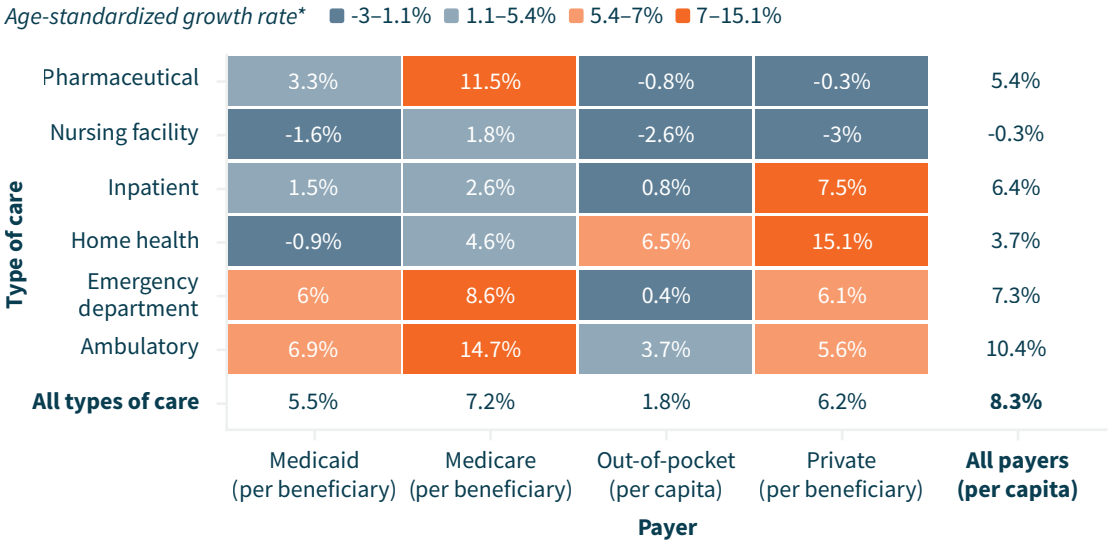
**Not adjusted for inflation*

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**



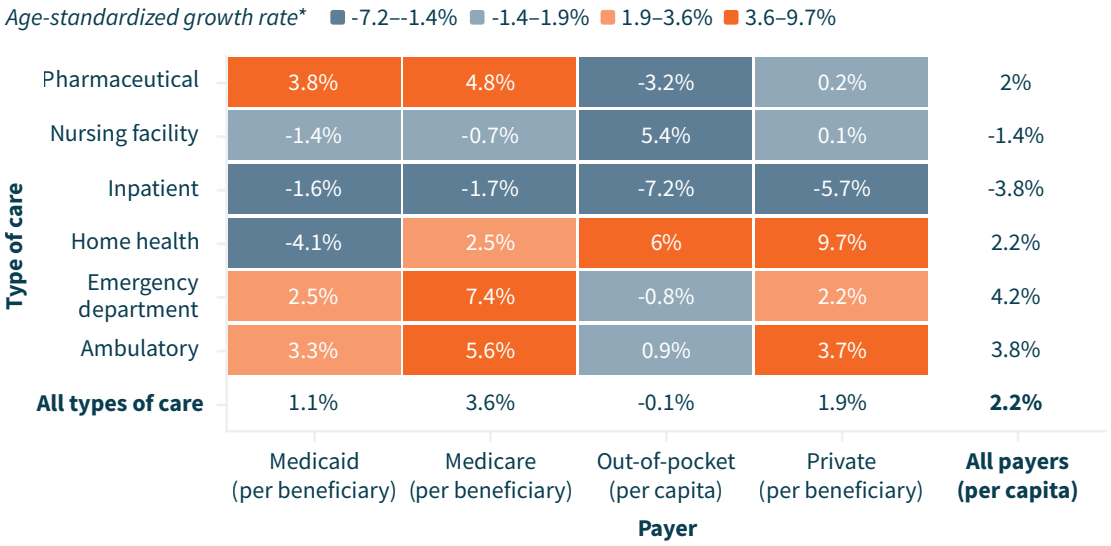
*Not adjusted for inflation

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



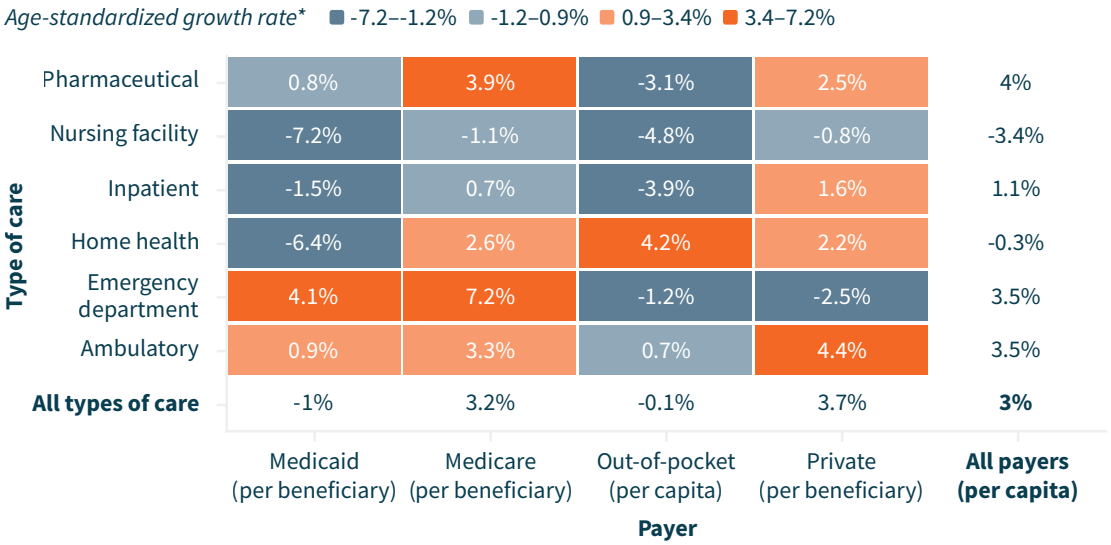
*Not adjusted for inflation

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.

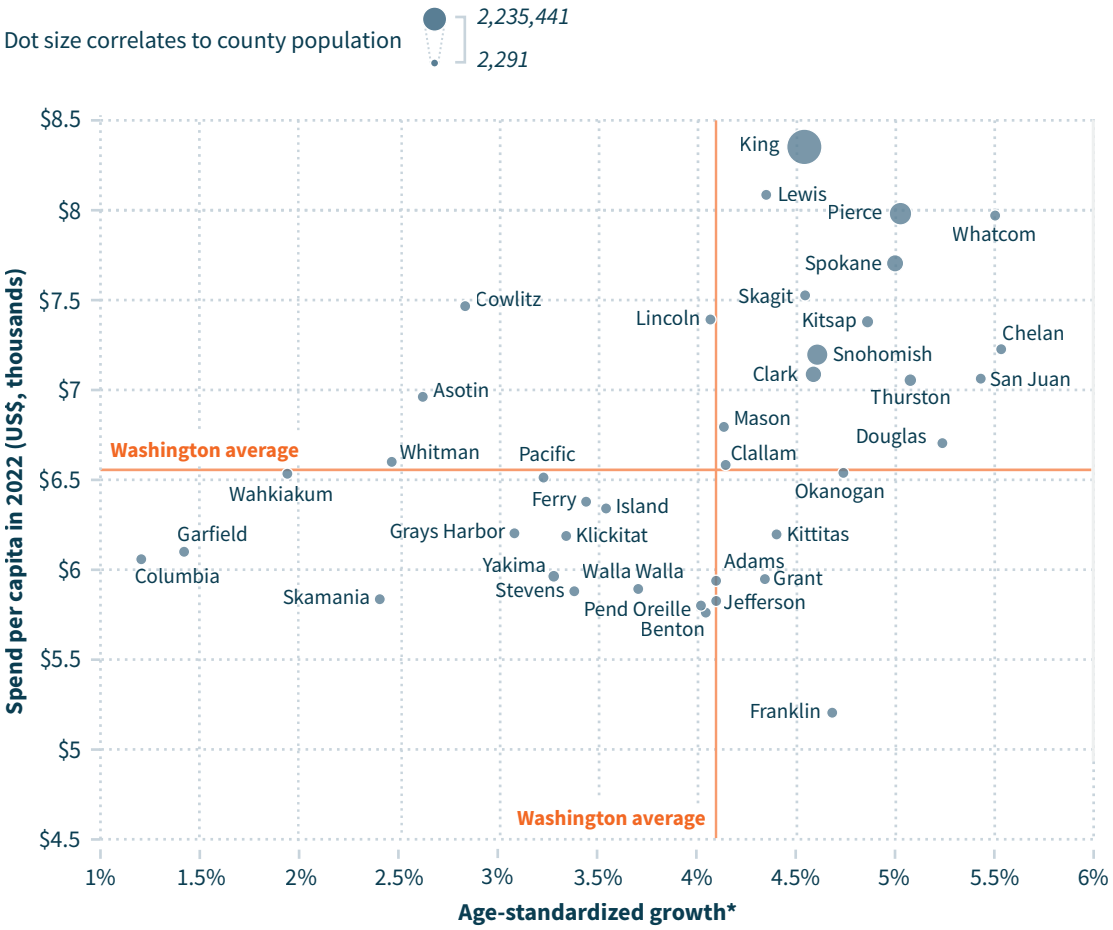
While expenditure distribution can vary by county, type of care, and payer – there appear to be consistent clustering patterns across counties which validate a need to further examine price/intensity in certain sites of care, or scale up supply/access to meet growing demand.

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

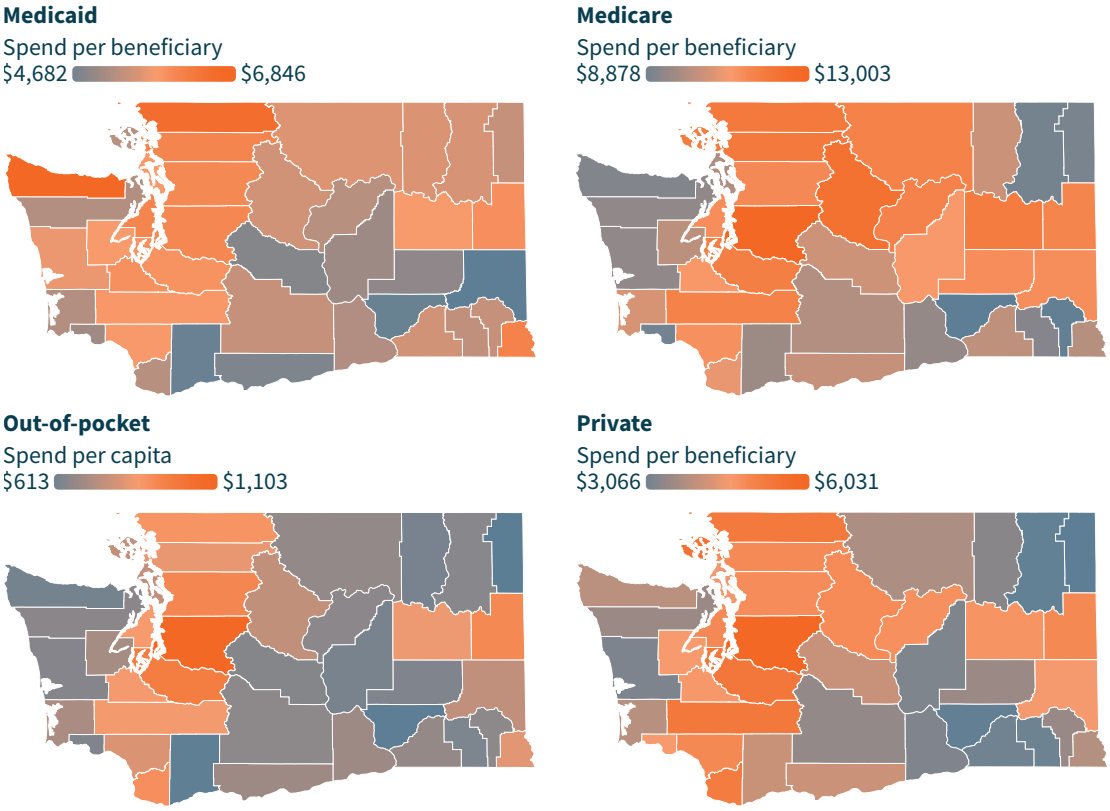
Source: IHME Disease Expenditure (DEX) estimates

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.

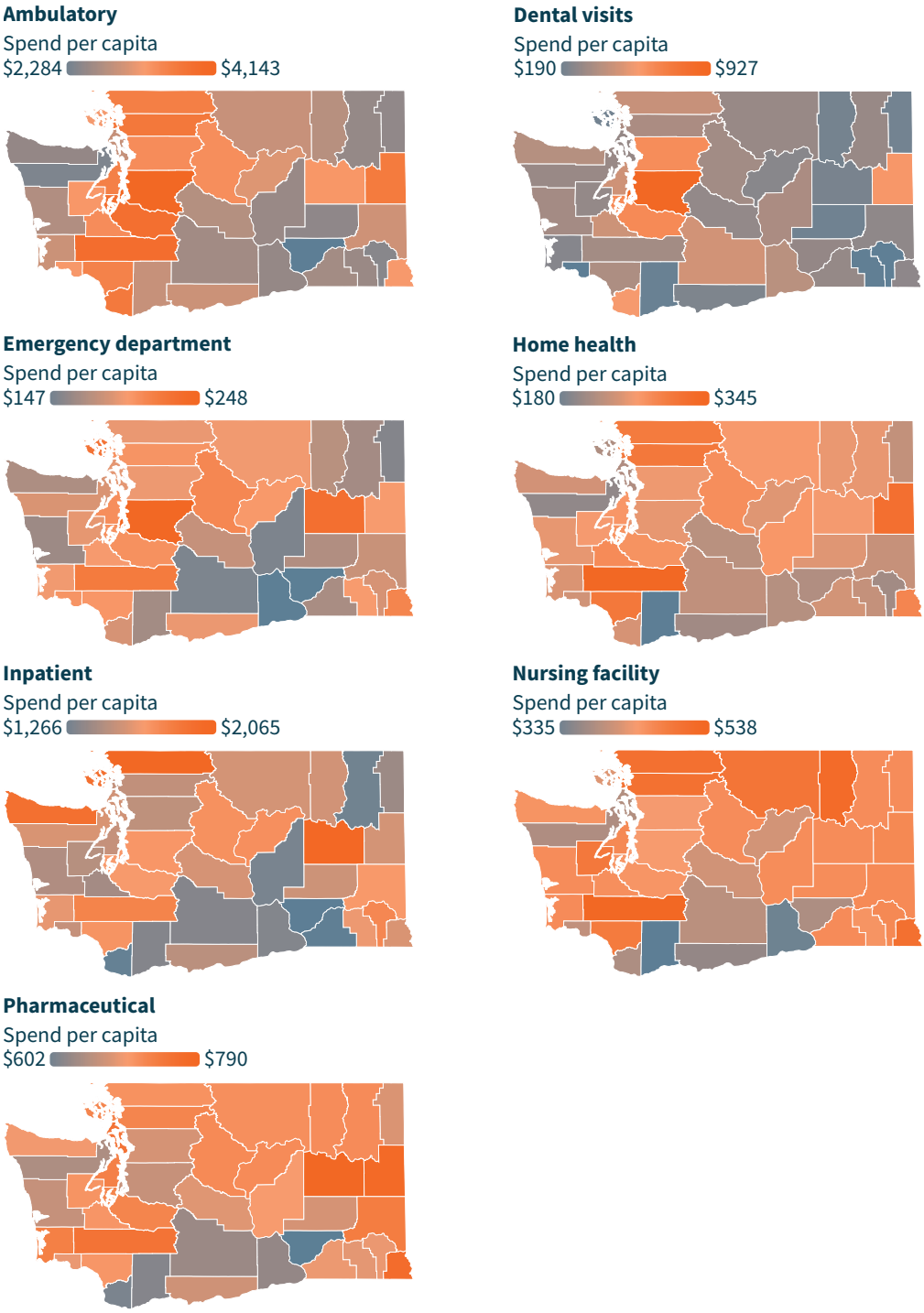
Health care spending varies dramatically throughout Washington state and spending varied dramatically for each payer category.

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



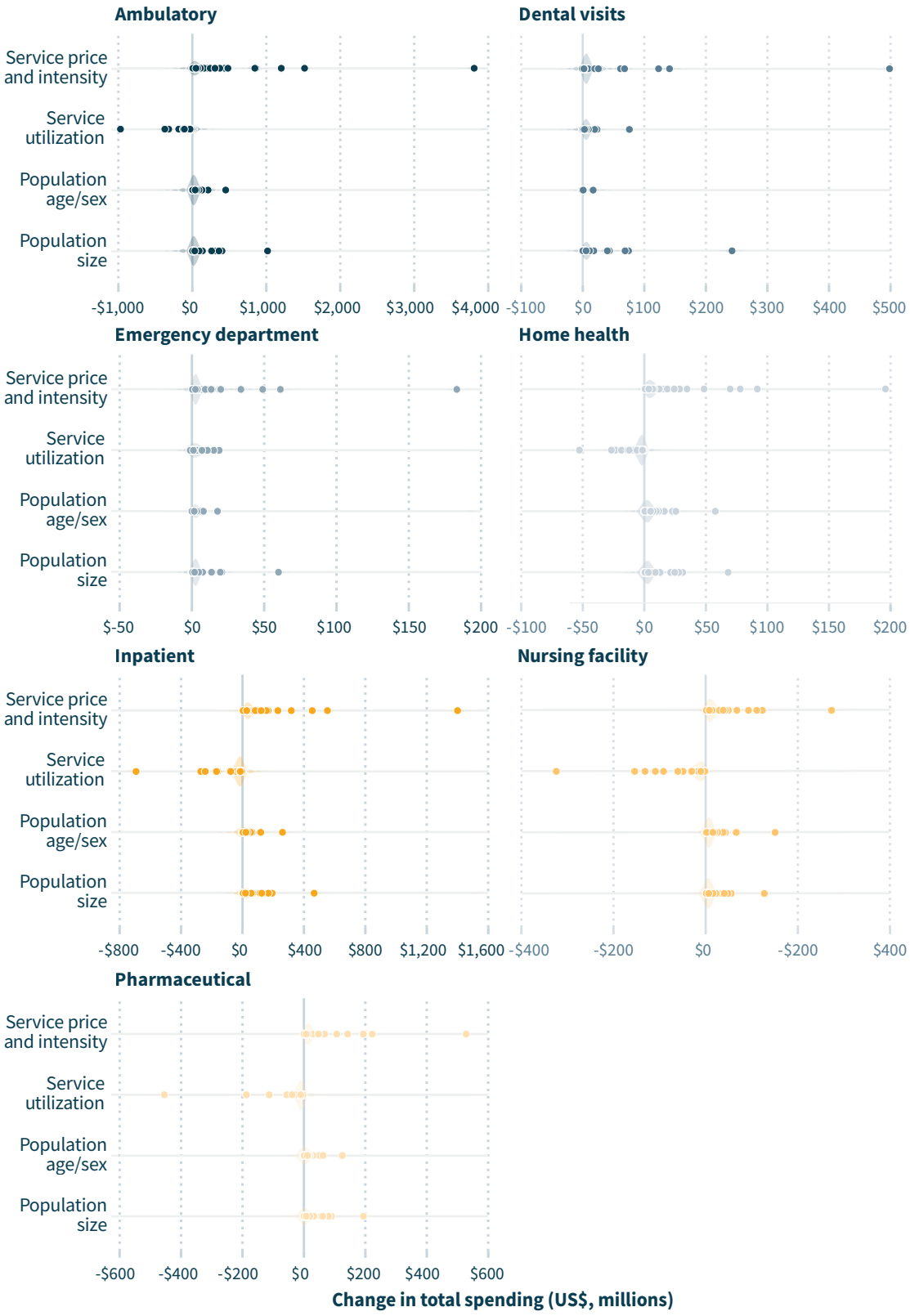
Source: IHME Disease Expenditure (DEX) estimates

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

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

DRAFT November 07, 2024

Table of Contents

EXECUTIVE SUMMARY

A recent budget proviso directed the Washington State Health Care Cost Transparency Board ("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.[1] To assist in this process, the HCA partnered with Health Management Associates (HMA), a national consulting and research firm, to conduct research on other similar state programs 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. [OBJ] After reviewing publicly available information on the experiences in these eight states, four were chosen for a closer [OBJ]gathered through interviews with program leaders. These states—California, Massachusetts, Oregon and Rhode Island -- were selected because they represent a range of different approaches and because they exemplify best practices in the core functions of these programs including:

- Authority to collect and use data to monitor health system spending trends
- Growth target against which to measure spending trends
- Spending measurement to collect and track healthcare expenditures
- Data and analytic capacity to support data analysis, reporting and use cases
- Data use strategy to advance state strategies

The report then highlights best practices from these four states and suggests questions Washington policymakers might consider when establishing the goals of the Cost Board and evaluating the best practices most likely to support those goals in the coming years.

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[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

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, the COVID pandemic 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 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.

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 2457, establishing the Health Care Cost Transparency Board (the Cost Board).[2] Funds were allocated to the Washington State Health Care Authority (HCA) to establish and staff the Cost Board, providing funding for five positions with two new positions provided this fiscal year for IT and data support that the state is in the process of creating and filing.

The Cost Board was charged with these key tasks:

- Determining what data is necessary for and a plan to obtain the data to annually calculate total health care expenditures and health care cost growth, and to establish the health care cost growth benchmark;
- Annually calculating total health care expenditures and health care cost growth;
- Annually establishing the health care cost growth benchmark for increases in total health expenditures;
- Analyzing the impacts of cost drivers to health care and incorporating this analysis into determining the annual total health care expenditures and establishing the annual healthcare cost growth benchmark (beginning in 2023). [3]

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

- Conducting a biennial (at minimum) survey of underinsurance in the state;

[2] State of Washington Second Substitute House Bill House Bill 2457: 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] State of Washington Second Substitute House Bill House Bill 2457: 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

- Conducting a biennial (at minimum) 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 (serving more than 10,000 individuals) health care cost growth in the previous performance period exceeded the health care cost growth benchmark. [4]

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.

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, the HCA partnered with Health Management Associates (HMA), a national consulting and research firm, to conduct research on other similar state programs for the Cost Board and the HCA.

An environmental scan was conducted looking across states that had initiated health care cost growth programs, with four states identified for more detailed survey and semi-structured interviews to further understand their programs, structure, scope, financing, and staffing.

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[4] State of Washington Second Engrossed Substitute House Bill House Bill 1580: 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] State of Washington 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

Comparisons with Washington state's current efforts and recommendations were developed and are provided in this report. The study will be included as part of the 2024 legislative report about the Cost Board's findings and work to provide the legislature more information specifically about the support necessary to further the work of the Cost Board going forward.

This report begins with an overview of the eight states with health cost growth benchmarking programs, the early results and lessons learned from these programs. This 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 healthcare expenditures
- Data and analytic capacity to support data analysis, reporting and use cases
- Data use strategy to advance state strategies

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

STATE COST GROWTH BENCHMARKING EFFORTS

The *Health Affairs* Council on Health Care Spending and Value cites that "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 [gross domestic product]."[6] The council also 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

[6] https://www.healthaffairs.org/pb-assets/documents/CHS_Report/CHS_Report_2022_R5-1675432678.pdf
[7] https://www.healthaffairs.org/pb-assets/documents/CHS_Report/CHS_Report_2022_R5-1675432678.pdf.

political support (e.g., Governor, legislator, or Health Insurance Commissioner as champion) and initial/start-up funding in eight states that have implemented programs.

Massachusetts initiated 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 one of the most expansive programs currently operating. Delaware (2018) and Rhode Island (2019) both used executive orders to start programs that are more streamlined than Massachusetts. Five other states have initiated programs since 2019, with support from Peterson-Milbank Program for Sustainable Health Care Costs—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 they were not supported by the current governor, so efforts were not continued as of 2023. Information about each of the active state programs is included in Appendix B at the end of this report.

With most states using Massachusetts as the model, each adjusted their approach to meet their state's individual needs. 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

Most of these states have worked closely with their states' 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 healthcare 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

[8] Ario, J et al. State Benchmarking Models – Promising Practices to Understand and Address Health Care Cost Growth, June 2021 accessed on 9.30.2024 at State Benchmarking Models: Promising Practices to Understand and Address Health Care Cost Growth - Manatt, Phelps & Phillips, LLP

[9] Ario, J et al. State Benchmarking Models – Promising Practices to Understand and Address Health Care Cost Growth, June 2021 accessed on 9.30.2024 at State Benchmarking Models: Promising Practices to Understand and Address Health Care Cost Growth - Manatt, Phelps & Phillips, LLP

[10] Commonwealth Fund, Profiles of Cost Containment Strategies: Implement a Health Care Cost Growth Target, February 2022

spending. Some, notably Massachusetts and Oregon, assess cost drivers such as provider consolidation, prescription drug spending and, differences in cost depending on site of care and other market trends that impact health care costs.

Having significant analytics capacity is needed either inside the program and/or through the support of vendors including university partners. Additionally, resources are needed to provide stakeholder and public engagement, data collection, and data analytic infrastructure needed to initially launch the program 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, providing an opportunity to leverage their emphasis on broad stakeholder involvement in understanding spending trends and offer a valuable platform for gathering information and addressing a wide range of cost-related challenges.

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 degraded working conditions.[11] Concerns about the impacts of horizontal consolidation, vertical integration and private equity investment on the health care system have led some states to give their cost growth benchmark programs authority to review certain transactions that cause material changes in ownership of health care entities. Washington's Cost Board does not have such authority. As the state Attorney General reported in 2023, Washington does require advance notice of certain transactions. The Attorney General has authority to review transactions for anticompetitive impacts (antitrust), but neither the AG nor the Cost Board has authority to review their impacts on affordability, access, quality, or equity.12 A chart describing states' authority to conduct market oversight is provided in Appendix D.

Four states were chosen for more detailed examination and description for this report: California, Massachusetts, Oregon, and Rhode Island. These states represent differences in infrastructure, strategies to gather and analyze data, authority and resources that collectively provide insights for consideration by Washington for a successful cost growth benchmarking program. HMA administered a survey and/or interviewed the leadership of these four states'

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

programs to better understand what is necessary to implement and run these programs. Specifically, the questions assessed the structure, staffing and support needed for implementation of a cost growth benchmark program. If the state also had programs focused on business oversight or other healthcare affordability programs, questions were also asked to determine the structure, staffing, and support of those programs.

An overview of the infrastructure of each of the four state programs is summarized below in Table X. A description of how each of the four states address the key topics common to the establishment and functioning of their programs follows.

Table X: Four States Overview of Cost Growth Benchmarking Programs and Location in State Government

State	Public Body Involved in Cost Growth Benchmark	State Agency Responsible for the Program and its structure	New or Existing Entity? How established?
CA	Health Care Affordability Board (HCAB) Advisory Committee, with multiple workgroups	California Office of Health Care Affordability Located in the Dept 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	HPC Board of Commissioners	Massachusetts Health Policy Commission (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 within the Oregon Health Authority (which also 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 work groups	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 detailed description of each of these states cost growth benchmark programs is contained in Appendix C. The appendix material includes their individual authorities, their progress to date since they have implemented their programs, more details on staffing, consulting service needs, and any future needs if identified by the state officials for sustaining their programs.

California

California established the Office of Health Care Affordability by legislation enacted in 2022. OHCA is an office within the Department of Health Care Access and Information (HCAI) within the state Department of Health and Human Services. HCAI is responsible for managing the state's Healthcare 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 has specific, limited authority provided by the legislature. It must approve:
    - 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 and standards that may be used between payers and providers during contracting;
    - the standards to advance the stability of the health 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 Health Care Affordability Board include the Secretary of Health and Human Services, the Medical Director of CalPERS, which administers the state public employee health plan (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

- HCAI, OHCA's parent agency, 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 authority to conduct market oversight by conducting cost and market impact reviews of proposed transactions meeting specified 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 non-profit entities under a public interest standard; its authority over transactions involving for-profit entities is limited to traditional antitrust analysis.[14]

Funding

- OHCA's work has been one of Governor Newsom's priorities. It has an ongoing appropriation that is in the range of $22 million to fund 80 positions annually. Over 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

[13] https://hcai.ca.gov/affordability/ohca/ohca-background-resources/

[14] Chang, S., Gudiksen K., Greaney, T, King, J., Examining the Authority of California's Attorney General in Health Care Mergers, California Health Care Foundation, April 2020, www.chcf.org/wp-content/uploads/2020/04/ExaminingAuthorityCAAttorneyGeneralHealthCareMergers.pdf. AB 2089 and B 2091, bills to give the Attorney General broader authority over health care transactions, have been introduced but not passed during the past two legislative sessions. A bill to give the Attorney General authority to review transactions involving private equity or hedge fund investments under a public interest standard was signed into law by Governor Newsom in September 2024. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3129

Massachusetts has the longest experience in implementing a cost growth benchmark program. The Health Policy Council (HPC) was established by the legislature 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 relating 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]

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 broad 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 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 Attorney General. The

[15] https://masshpc.gov/about/board
[16] https://masshpc.gov/about/council

program does not have authority to prohibit proposed transactions. The AG can consider possible further action on behalf of consumers in the health care market but does not have any additional power to block or modify a transaction beyond existing Massachusetts AG authority

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 assessment.
- HPC uses 70% of its budget for internal positions for both their Cost Growth program, their Market Oversight program, and overall operations, with about 30% available for outside consulting services

Oregon

Oregon's legislature established the Sustainable Cost Growth Target Program in 2019 and 2021. It is a program within the Health Policy and Analytics Division of the Oregon Health Authority (OHA) agency, which is responsible for administering the state's Medicaid program, its public employee and teacher health plans, as well as other health care programs and services. OHA also administers the state's All Payer All Claims database.

Governance

- All aspects of implementation of the program are carried out by OHA, which is within the executive branch.
- The Oregon Health Policy Board, whose members are appointed by the Governor with consent of the state senate, appoints the members of the Cost Growth Advisory Committee, which advises and may make 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 performance improvement plans 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 specified criteria. It publishes the results of those reviews and can approve, approve with conditions, or prohibit proposed transactions.

Funding

- The Cost Growth Target program has funding of approximately $2 million for 8 positions, including an economist, policy analyst, research analyst, and actuary and administrative staff. The majority of the funding is from the state general fund with a small amount of federal funds matching costs for 2 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 not be adequate 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 convening of health care leaders appointed by the Governor and the Office of the Health Insurance Commissioner, executed the Compact to Reduce

[17] As an additional state policy to control health care costs, not part of the Sustainable Growth Target Program, the Oregon legislature has imposed a cap on reimbursement rates to hospitals as part of the public employee and teachers' health plans. See How Payment Caps Can Reduce Hospital Prices and Spending: Lessons from the Oregon State Employee Plan | Milbank Memorial Fund

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 its Office of the Health Insurance Commissioner (OHIC) by Executive Order in 2022.[19] A second compact was entered into in 2022, which will expire in 2027.

Governance

- The Office of the Health Insurance Commissioner administers the program.
- Cost growth targets are set by the Health Care Cost Transparency Committee and represent a voluntary commitment by stakeholders to work to achieve the target.

Data

- Rhode Island's APCD is administered as a collaborative effort among the Department of Health, the Office of the Health Insurance Commissioner, the Executive Office of Health, and Human Services and HealthSource RI (the state's ACA marketplace).

Authority to enforce cost growth benchmarks

- OHIC does not have authority to enforce the cost growth benchmarks. However, as discussed below, OHIC has used its rate review authority to set affordability standards that include 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

[18] RI Health Care Cost Trends Sterring Committee Compact 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 Executive Order No. 19-03. February 6, 2019. https://governor.ri.gov/newsroom/orders/

- Initial funding was through a public-private partnership from the Peterson Center on Health care and the OHIC.
- Over the past few years, the program has had a legislative-approved budget of $500,000 and have 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 of 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 in achieving those goals. 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 four cost growth benchmark programs in the four states that are the focus of this report differ with respect to the sources of their authority (legislations 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 authority to make decisions lies. A summary by state is below in Table X

Table X; The 4 States' Programs: Position in Government and Decision-Making Authority

State	Program Location and Decision-Making Authority
California	A new office within an existing state agency, with an oversight board with expressed, 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 to gather, analyze and report on data.
Oregon	A program within an existing state agency, with an advisory board without any decision-making authority.

State	Program Location and 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 the success of the program. 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 what structure will enable the program to have the most credibility and "buy-in" from stakeholders and the public.

Data collection, analysis, and reporting

Each state's cost growth benchmark program collects, analyzes, and reports on data relating to the cost of health care. Several factors influence each state's ability 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 (whether authority 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 depended on historical data on the cost of health care. 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 by legislative direction and has included the following activities: establishing a cost growth benchmark, measuring performance against the benchmark, conducting cost driver analysis and evaluating primary care spending. In addition to these activities, the Cost Board has also conducted a hospital spending assessment which offers a deep dive into hospital expenditures, comparing Washington hospitals' prices and efficiency metrics against similar hospitals in other states and an analytic support initiative (through a partnership with the Institute for Health Metrics and Evaluation at the University of Washington), focused 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 All-Payer Claims Database (APCD) which includes claims data that represents approximately four million individuals, out of the state population of approximately seven and a half million, across Medicaid managed care, Medicare, commercial, commercial Medicare Advantage (MA), commercial and MA Public Employees Benefits Board (PEBB), and the commercial Health Benefit Exchange (HBE) markets.[20] Another source of data has come from the Cost Board's call to carriers and providers for information about health care expenditures.

Given the recent focus on the impact of mergers and consolidation as a potential cost driver, these data sources could offer some additional insights, the Cost Board's Data Advisory Committee has recently been discussing other types of data that could help support their work, some of which are collected by other state agencies. The Department of Health (DOH) collects information about ownership and licensure for health care facilities and health professional licensure. DoH also collects the Comprehensive Hospital Abstract Reporting System (CHARS), 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. DoH also collects data from hospitals and Emergency Medical Services (EMS) on hospital discharges, financial reports, charity care, and adverse events, additional information that could offer more insights about cost drivers and performance against the state benchmarks.

The Data Advisory Committee has also recognized some gaps in data that is not collected at all. Specifically, there is not currently a requirement to report private equity purchasing. 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, these changes in service access do not always require prior notice or approval by the state.

Best practice highlight - Data: Massachusetts

[20] Washington has two All-Payer Claims Databases including one administered by the Washington Health Alliance (WHA), a membership organization that has over 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 Washington Health Alliance The key difference between the Health Alliance APCD and HCA's APCD is that the former includes some self-funded insurers, which are not included in the HCA's APCD.

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 the Center for Health Information and Analysis (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 is overseen by an Oversight Council, whose members are appointed by the Governor, Attorney General and State Auditor.[21]

CHIA's statutory duties include:

- to 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;
- to provide analysis of health care spending trends as compared to the health care cost growth benchmarks;
- to collect, analyze and disseminate information regarding providers, provider organizations and payers to increase the transparency and improve the functioning of the health care system;
- to 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;
- to participate in and provide data and data analysis concerning health care provider and payer costs, prices, and cost trends;
- to report to consumers comparative health care cost and quality information.[22]

CHIA collects data and publishes reports on a broad 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

[21] https://www.chiamass.gov/about-the-agency/
[22] *Ibid.*

demographics.[23] CHIA's broad authority to collect data from payers, providers and others is set forth in statute and in regulations promulgated by the agency.[24] 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."[25]

In addition to its annual report, CHIA has published reports on topics including alternative payment models; premiums and member cost sharing in commercial insurance; enrollment trends; hospital financial performance; hospital readmissions; and relative price/price variation.[26]

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.[27] Funding to CHIA supports around 60 staff with many working closely with the HPC. CHIA also has funding for any needed consulting. The HPC has a staff of around 60-65 positions, with some working closely with CHIA staff for data analysis, and the HPC also uses its funds for their own consulting services.

While all states, including Washington, collect, analyze and report data on health care spending and health care entities' financial performance, the establishment of an agency with such data efforts as its sole mission, given broad express statutory authority and adequate funding, thereby providing a credible source of information on a wide range of factors affecting health care spending, is 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 targets they establish. A related, but distinct, question is whether the state has any authority to regulate the prices charged for health care services

[23] https://www.chiamass.gov/annual-report/
[24] https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter12C; https://www.chiamass.gov/regulations/
[25] https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter12C/Section9
[26] https://www.chiamass.gov/publications/
[27] https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter12C/Section7

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Washington's Board has no authority to enforce compliance with its cost growth targets. The Legislature considered granting the Board the authority to issue Performance Improvement Plans (PIPs) and impose civil fines to entities exceeding the cost growth targets over a period of time during the 2023-24 legislative session. Those provisions were not contained in the bill as enacted; instead, the Board is directed to hold a public hearing each year, at 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…".*[28]

Best Practice Highlight: Enforcement —California

OHCA is given substantial authority to undertake progressive enforcement of its cost growth targets when entities exceed them. The specific steps outlined in statute are:

- Technical assistance, such as analysis of drivers of health care spending or identification of best practices.
- Compelled testimony at a public hearing.
- A performance improvement plan.
- 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."

The first enforcement period will be on the 2026 statewide spending target. Data collection will take place in 2027 and public reporting in 2028. Based on that timeline, the soonest enforcement actions can occur would be sometime in 2028.[29]

Best Practice Highlight: Enforcement—Massachusetts

The Health Policy Board has the authority to require performance improvement plans and to impose civil fines on entities that exceed cost growth targets in certain circumstances. In January 2022, the HPC issued its first Performance Improvement Plan, to the Mass General

[28] https://app.leg.wa.gov/RCW/default.aspx?cite=70.390.100&pdf=true
[29] https://hcai.ca.gov/affordability/ohca/ohca-background-resources/

Brigham (MGB) health system. To date, this is the only PIP that has been issued by any state cost growth program for failure to meet cost growth targets. The plan, as ultimately submitted by MGB and approved by the HPC Board, includes ten interventions across four categories: price reductions, reducing utilization, shifting care to lower cost sites, and accountability through value-based care. It estimated savings of $176.3 million over the eighteen-month period the plan would be in effect.[30]

Best Practice Highlight: Enforcement—Oregon

Beginning in 2025, Oregon has authority to require a payer or provider entity that exceeds a cost growth target "without reasonable cause" to submit a PIP. Requirements for what must be provided in the PIP, and the steps OHA will take to approve or seek modification of the PIP, are set forth in regulations issued by OHA in 2024.[31]

Beginning in 2026, OHA may impose financial penalties on a payer or provider entity that exceeds the cost growth target in three of five reporting years. The size 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.[32]

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 component of strategies to mitigate 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 Attorney General Offices. As noted by Washington State's recent AGO's report,[33] some states have broader

[30] 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.
[31] Regulation 409-065-0040, https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5882.
[32] ORS 442.386, https://oregon.public.law/statutes/ors_442.386; Regulation 409-065---45, https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5882.
[33] AG Report, p.8 https://agportal-s3bucket.s3.us-west-2.amazonaws.com/uploadedfiles/AGO_Healthcare%20Affordability%20Preliminary%20Report.pdf

authority than Washington has that allow for reviews based on criteria that go beyond antitrust. The reviews include concerns about the impact of such transactions on affordability, access to services, quality of care and health equity.

The work is imbedded outside the AG Offices and in agencies already doing other health policy work or working on cost growth benchmarking or other programs addressing affordability. See Table X below for an overview across the states.

Table X: Comparing State Health Care Market Oversight Authority Nationally

Authority	Nonprofit or For Profit	AG Authority	Dept of Health	+ Health Care Market Oversight 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

Three states, California, Massachusetts, and Oregon have gone further than the others to create a state entity that is dedicated to health care transactions. Only Oregon has the authority to block or place conditions on mergers and other transactions involving a material change in ownership through its Health Care Market Oversight program. Review authority is similar in Massachusetts and California; they publish their review findings and can refer transactions to the state AG for review. The infrastructure of these three states for these functions is included in the discussion of these states in Appendix C_.

Best Practice Highlight: Market Oversight—Oregon

Oregon launched its Health Care Market Oversight Program (HCMO) in March 2022. The Oregon Health Authority (OHA) reviews health care transactions that meet specified criteria for size of the entities involved and materiality of the transaction. Proposed transactions must be reported to the OHA before closing; OHA 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.[34]

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.[35]

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 prices paid for health care services. This work is carried out in a separate program within HCA, outside of Oregon's cost growth program. As stated in the Washington Office of the Insurance Commissioner's recent Affordability Report, without additional policy interventions, setting targets is not likely to achieve Washington's goal of mitigating cost growth[36]

Researchers have consistently found that prices are one of the most important contributors 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

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[34] https://www.oregon.gov/oha/HPA/HP/Pages/About_HCMO.aspx.; "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, https://www.milbank.org/wp-content/uploads/2023/03/Oregon-HCMO-Program-Report_4.pdf.

[35] HCMO 2023 Annual Report, https://www.oregon.gov/oha/HPA/HP/Pages/About_HCMO.aspx. A complete list of the transactions that have come before HCMO and their status can be found at https://www.oregon.gov/oha/HPA/HP/Pages/HCMO-transaction-notices-and-reviews.aspx

[36] WA OIC Final Report on Health Care Affordability, July 29, 2024, at p. 74, https://www.insurance.wa.gov/sites/default/files/documents/OIC-final-report-on-health-care-affordability-092324-update.pdf.

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.[37]

Similarly, studies have demonstrated that the primary reason the United States pays more for health care than do other rich countries is that the prices we pay for goods and services are higher. The most famous, "It's the Prices, Stupid," by Uwe Reinhardt and others, was published in *Health Affairs* in 2003. Using 2000 OECD data, it compared the US to other industrialized countries in terms of the level of health care spending, the level of real resources (such as physicians, hospital beds, nurses and so on, the cost of administration, and other factors that were considered responsible for the higher level of spending in the US. 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 US 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."[38]

Similarly, in 2018, Irene Papanicolas and colleagues compared the US with ten other high-income countries, finding that despite the US spending almost twice as much on medical care, there was not a corresponding disparity in health care use rates, indicating that higher spending in the US was likely not driven by "the fee-for-service system encouraging high volume of care, or defensive medicine leading to overutilization." Their findings also do not support the belief that the US has higher health spending because it underinvests in social spending. The authors conclude that "prices of labor and goods, including pharmaceuticals,

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[37] Health Care Cost Institute, 2019 Health Care Cost and Utilization Report, https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf, *cited in* The Role of Prices in Excess US Health Spending, Health Affairs Research Brief, June 9, 2022, https://www.healthaffairs.org/content/briefs/role-prices-excess-us-health-spending#:~:text=Consistent%20with%20Anderson%20and%20colleagues,is%20likely%20not%20driven%20by%20%E2%80%9C.

[38] 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, https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2018.05144

and administrative costs appeared to be the major drivers of the difference in overall cost between the United States and other high-income countries."[39]

The Board's 2023 Annual Report presented data on spending from 2017-2021, showing that in the commercial market inpatient utilization declined by 8 percent, while 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.[40]

Although increasing prices are a major driver of cost growth, few states directly regulate the prices that hospitals and other providers can charge in the commercial market. Washington has ventured into price regulation through its public option, Cascade Care Select, which requires that participating insurers pay no more than 160 percent of Medicare reimbursement rates on an aggregate basis for all services. In 2024, premiums in the Cascade Care Select program were the lowest in 31 of the 37 counties that the plans were offered in the state.

Best Practice Highlight: Regulate Prices —Oregon

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

A study published in *Health Affairs* found 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

[39] The Role of Prices in Excess US Health Spending, Health Affairs Research Brief, June 9, 2022, *supra*; Papanicolas, I, Woskie, L, Jha A, Health Care Spending in the United States and Other High-Income Countries, *JAMA* 2018; 319(10): 1024-1039, https://jamanetwork.com/journals/jama/article-abstract/2674671

[40] [Cite]. This experience was impacted by the COVID pandemic, with a substantial increase in utilization and decline in average charges from 2020-2021. Between 2017-2020, utilization increased less than 5 percent, while average charges increased from approximately 10 percent.

the first two years and three months of the policy dropped by 3 percent. Price reductions were smaller in the inpatient setting because low-priced hospitals initially increased their prices to the cap but were prohibited from doing so after 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 of the policy, 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.[41]

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.[42]

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 raise enrollee spending by $21.[43]

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[41] 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. The 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/#:~:text=The%20State%20of%20Oregon%20passed,out%2Dof%2Dnetwork%20prices.

[42] Rhode Island Office of the Insurance Commissioner Affordability Standards, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-08/230-RICR-20-30-4%20Effective%20August%2020%202023.pdf; NASHP blog 02/01/22, Insurance Rate Review as a Hospital Cost Containment Tool: Rhode Island's Experience, https://nashp.org/insurance-rate-review-as-a-hospital-cost-containment-tool-rhode-islands-experience/

[43] Affordability Standards, *supra;* 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, 237-245, https://www.healthaffairs.org/action/showCitFormats?doi=10.1377%2Fhlthaff.2018.05164&mobileUi=0

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 its having 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 to mitigate cost growth; to hold public meetings and engage with stakeholders; and to otherwise carry out their scope of responsibility. States employ both state workers and external consultants to perform these functions.

Best Practice Highlight: Funding—Massachusetts

Funding for Massachusetts' Health Policy Commission (HPC) has a different funding approach than the other three states with its budget coming 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. This assessment allows the HPC to not be dependent on the general fund for ongoing funding for both its cost growth and market oversight programs. When the legislature has given additional responsibility to HPC, such as to study pharmaceutical costs, HCA has sought additional funding. The HPC does not charge a separate fee to entities for the transaction reviews in the market oversight program.

Best Practice Highlight: Funding—California

OHCA's work has been one of Governor Newsom's priorities and it has an ongoing appropriation that is in the range of $22 million to fund 80 positions annually. Over half of this budget is for the market oversight program within OHCA and supports the high value/quality arm of their work. They feel this budget has been adequate to perform the duties they have been given by the legislature. They were given flexibility in their use of the funds so that some of it can be used for outside consulting if needed. They were also given flexibility for some administrative activities including exemptions from state contracting rules to allow for either procurement processes or direct contracting which has allowed them to be nimble in launching their programs.

CONCLUSION

The best practices discussed in this report were chosen because they seem best suited to enable the state to achieve the goals it has set for its cost growth benchmark program. Washington must determine whether adoption of any of these best practices would better enable the Health Care Cost Transparency Board to fulfill its mission, and whether its mission should be changed or expanded so that it could better carry out the policies set by the state.

For example, if the legislature would want the Cost Board to be better able 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, then centralizing data gathering, analyzing and reporting in a single entity, such as CHIA in Massachusetts, is one approach to consider.

If Washington concludes that giving the Cost Board authority to enforce cost growth targets will make it more likely that they will be met, each of California, Massachusetts and Oregon provide models for how that might be done.

If Washington 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 for how that might be done, with Oregon going the furthest in authorizing OHA to prohibit transactions under certain circumstances.

If Washington determines that policies directly impacting the prices that are charged for health care services are needed for it to mitigate the increase in health care spending, Cascade Care Select, Oregon and Rhode Island provide examples of such policies.

Finally, whatever goals the state has for the Health Care Cost Transparency Board, it is essential that the Board have funding and staff adequate to enable it to accomplish those goals.

APPENDIX A: SUMMARY OF COST GROWTH AND MARKET OVERSIGHT PROGRAMS OF FOUR STATES

State Program	Placement in Govt.	Also Market Oversight?	Enforcement Authority?	Budget	Staffing
California Office of Health Care Affordability (OHCA)	Office inside state health agency	Yes – separate unit inside the Office	• Public Reporting • Performance Improvement Projects • 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, working closely with CHIA	Yes – separate unit inside the office	• Public Reporting • Performance Improvement Projects • Fines Reviews only for market oversight		
Oregon Sustainable Cost Growth Target Program	Both programs are in office inside state health agency	Yes - Works closely as separate programs in same office overseen by same manager	Public Hearings PIPs Fines	Cost growth Program: $2 million	8 positions 4 positions

APPENDIX A: SUMMARY OF COST GROWTH AND MARKET OVERSIGHT PROGRAMS OF FOUR STATES

State Program	Placement in Govt.	Also Market Oversight?	Enforcement Authority?	Budget	Staffing
Health Care Market Oversight Program			Deny or approve with conditions mergers/acquisition or post-merger reviews	Market Oversight: $1 million initial startup & fees	
Rhode Island	Program in the Office of the Insurance Commissioner	No	No	~$1.5 million	Outside consultants

APPENDIX B: COMPARISON OF STATE BENCHMARK PROGRAMS[44]

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 establishes 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 will 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" is defined as all health care spending in the state by public and private sources, including all the following: (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.	While quality benchmarks were not established in statute, the office will adopt a single set of standard measures for assessing 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 to come into 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 performance improvement plans, 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.

[44] Milbank Memorial Fund. Health Care Cost Growth Target Values. Available at: https://www.milbank.org/focus-areas/total-cost-ofcare/peterson-milbank/health-care-cost-growth-benchmarks-by-state/. Accessed November 26, 2023.

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 Office of Health Strategy.	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 (CAHPS) Patient-Centered Medical Home (PCMH) Survey • Plan all-cause readmission • Breast Cancer Screening	Enforcement not discussed.
Delaware	Exec.Order 25 (2018)	The Delaware Economic and Financial Advisory Committee sets the health care spending benchmark. The Delaware Health Care Commission is responsible for	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	Total health care expenditures (THCE) in aggregate = commercial total medical expenses (TME) + Medicare Advantage TME + Medicare fee-for-service (FFS) TME + Medicaid Children's Health Insurance Program (CHIP) Managed Care Organization (MCO) TME + Medicaid Fee-for-Service TME + Veterans Affairs (VA) TME + insurer net	• Emergency department utilization rates • Opioid- related overdose deaths • Residents per 1,000 with overlapping opioid and benzodiazepine prescriptions • Adult obesity • Adult tobacco use • High school students who were physically active • Statin therapy for patients	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
		collecting information and analyzing performance against the benchmark.	adjustment) • CY 2022: 3% + 0% (transitional market adjustment) • CY 2023: 3% + 0% (transitional market adjustment)	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).	with cardiovascular disease, with adherence of 80% • Persistence of beta-blocker treatment after a heart attack	
Massachusetts	MA Chapter 224 of the Acts of 2012	Center for Health Information and Analysis and Health Policy Commission	Benchmark codified in MA Chapter 224 of the Acts of 2012: • 2013-2017: 3.6% 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 has the authority to vote it back up to the PGSP or 3.6% and voted to maintain the benchmark at 3.1%.	The Center for Health Information and Analysis - the state's all-payer claims database - measures the total health care expenditures and compares them against growth of the state's economy. The Health Policy Commission 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	If the Health Policy Commission (HPC) determines that an entity has an unwarranted pattern of contributing to excessive health care spending in the Commonwealth, it can vote to require the entity to submit a Performance Improvement Plan (PIP) to achieve meaningful, specified cost-savings. The PIP must be submitted within 45 days of the entity receiving the PIP notice. If the entity's PIP is approved by the HPC, it is implemented over 18 months. The HPC will monitor the implementation and ultimately determine if the outcome is sufficient to address the underlying causes of the entity's spending growth, or if additional action is

State	Authority	Collecting and Reporting Agency	Cost-Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
			•2023 and beyond: The PGSP growth rate		for implementing interventions to improve medication safety • Incidence of health care-associated infections	needed. A fine of $500,000 can be assessed for non-compliance.
Nevada	Executive Order 2021−2029	The Nevada Department of Health and Human Services Patient Protection Commission (PPC) was designated the sole state agency responsible under AB 348 (2021), enacted prior to 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) • The 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), includes 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 performance improvement plans and financial penalties.
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% potential gross state product and 75% median	Total health care expenditures include: • All payments on providers claim for reimbursement of the cost of health care provided • All other payments not	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.	Enforcement not discussed.

State	Authority	Collecting and Reporting Agency	Cost-Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
			household income blend Calendar Year 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%	included on providers' claims • All cost-sharing paid by members including but not limited to 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 (like incentive and value- based payments to providers), patient cost- sharing, and the cost of administering health insurance.	Reports will be released annually with further details to help point to the "whys" behind cost increases and specific areas driving spending growth.	
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 the cost growth target program: • Oregon Health Authority • Department of	The Implementation Committee recommended a benchmark of 3.4% for 2021−2025 and then 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.	Total Health Care Expenditures 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.	The Implementation Committee recommended that The Health Plan Quality Metrics Committee should identify a subset of its existing 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 performance improvement plans 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. Additionally, payer 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.

State	Authority	Collecting and Reporting Agency	Cost-Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
		Consumer and Business Services • Oregon Health Policy Board				
Rhode Island	Executive Order 19-03 (2019)	Office of Health Insurance Commissioner and Executive Office of Health and Human Services	Benchmark set in executive order at 3.2% for 2019−2022, which is equal to Rhode Island's per capita gross state product. • During 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.	Office of Health Insurance Commissioner will lead efforts to perform a series of data collection activities and calculations. Total health care expenditures (THCE) in aggregate = Commercial total medical expenses (TME) + Medicare Advantage 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. Office of Health Insurance Commissioner 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.

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	Calendar Year 2022: 3.2% CY 2023: 3.2% CY 2024: 3.0% CY 2025: 3.0% CY 2026: 2.8%	"Total health care expenditures" means all health care expenditures in the state by public and private sources, including: All payments on health care 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 this 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.

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 Healthcare Affordability (OHCA) within the California Department of Health Care Access and Information (HCAI). HCAI is a department of the California's Health and Human Services Agency. HCAI houses several other programs including hospital planning and development including hospital financial reporting, workforce development and information services which include 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 program to carry out its' statutory requirements:

- Slow Spending Growth[45]
    - Statewide Spending Target
    - Total Health Care Expenditures
- Assess Market Consolidation
    - Material Change Notices
    - Cost and Market Impact Reviews
- Promote High Value
    - Primary Care

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[45] The vehicles for establishing and funding CGB activities are: (From https://hcai.ca.gov/affordability/ohca/ohca-background-resources/)

- 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.

- Behavioral Health
- Workforce Stability
- Alternative Payment Models
- Equity
- Quality

OHCA includes a Health Care Affordability Board comprised of state appointed members and an Advisory Committee comprised of industry stakeholders to advise on decision making[46].

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 performance improvement plan.
- 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 for the target is planned to start in 2026 and the state may escalate enforcement as needed.."[47]

California's Implementation

Since enactment of the enabling legislation, OHCA has appointed the Health Care Affordability Board (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 2002-2022. California's benchmark uses the

[46] https://www.manatt.com/Manatt/media/Media/Images/Manatt-State-Cost-Containment-Update_2023-03_b.pdf
[47] https://www.manatt.com/Manatt/media/Media/Images/Manatt-State-Cost-Containment-Update_2023-03_b.pdf

historical median household income. This is a different approach than other states have taken in setting the target, but this approach was chosen as it correlates strongly with what consumers can afford[48].

At its April 2024 meeting, The HCAB voted to phase in the cost growth target rather than adopting the staff recommendation of 3%. The target was set at 3.5% for 2025 and 2026; 3.2% for 2027 and 2028 and then reaching 3% for 2029 and beyond[49]. The first year that entities are held responsible is not until 2026, and data analysis will not be completed until 2028. OHCA is beginning efforts to assess their 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 that is in the range of $22 million to fund 80 positions annually. Over half of this budget is for the market oversight program within OHCA and supports the high value/quality arm of their work. They were given flexibility in their use of the funds so that some of it can be used for outside consulting if needed. They were also given flexibility for some administrative activities including exemptions from state contracting rules to allow for either procurement processes or direct contracting which has allowed them to be nimble in launching their programs.

Staffing:

OHCA has started to hire personnel for this work to fill the 80 positions with 60% of those allocated to the Market Oversight Program and 40% to the Cost Growth Program and operations of the agency. OHCA has relied on consultants for some projects as they have been hiring staff. They anticipate moving more to internal staff over time as their program further develops but anticipate some ongoing consulting service needs.

Their 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. They plan to

[48] https://hcai.ca.gov/wp-content/uploads/2024/01/OHCA-Recommendations-to-Board_Proposed-Statewide-Spending-Target.pdf

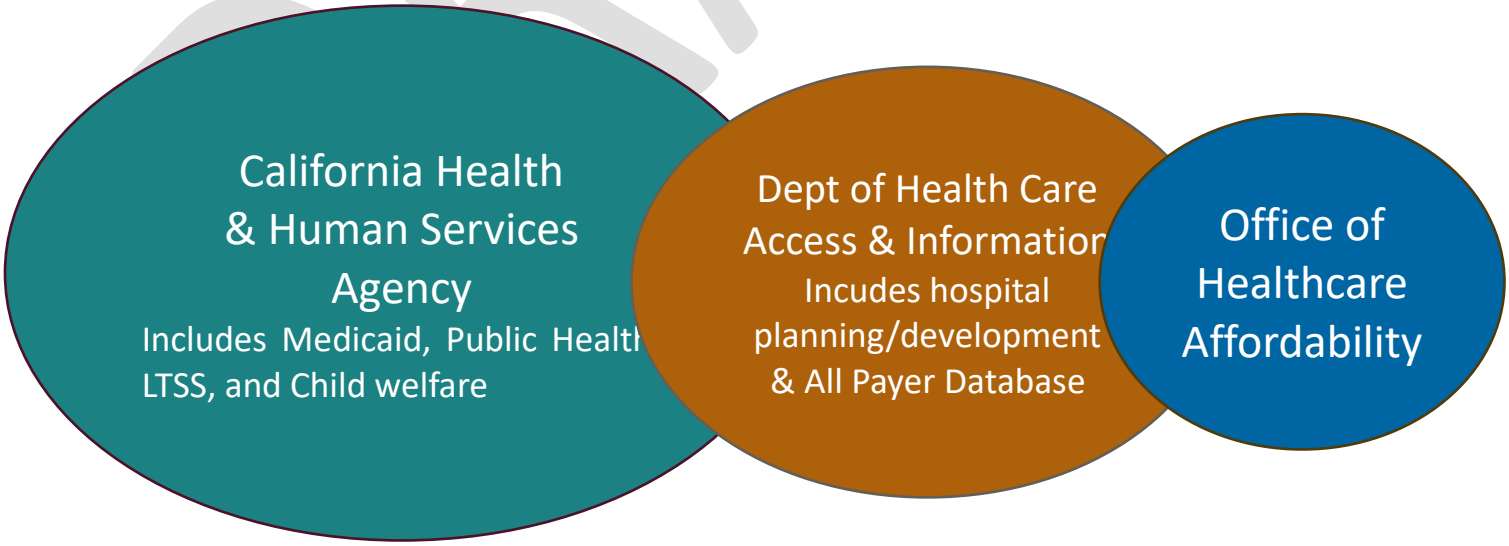
[49] Statewide Health Care Spending Target Approval is Key Step Towards Improving Health Care Affordability for Californians - HCAI

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. They have worked 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 do meet informally with stakeholders including hospitals, health systems and providers to gain insight and feedback outside of formal meetings. They have devoted around $5-$8 million so far for outside consultants, particularly when they first opened the office and only had few state staff hired. They worked to give the consultants broad scope of work in the contracts but controlled the hours monthly. Each year they are spending less to date on consultants as they have grown their internal staff, however certain areas of expertise are much harder to recruit such as actuarial expertise that is hard to recruit due to low state salaries in comparison to the private sector, particularly for staff such as actuaries and economists. Other areas they have used consultants for have included Finance and Accounting expertise, Claims, qualitative and quantitative analysis. They have found that having outside third-party support for their board and their advisory committees has been valuable to work with stakeholders and those providing public comment.

Figure X: California's Infrastructure within State Government



Business Oversight: Program

In addition to its cost growth benchmark program, OHCA analyzes market transactions that are likely to significantly 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.[50]

As noted above in the funding for the OHCA, over half of their overall budget is directed to the market oversight area presently and they currently have nine positions with a variety of expertise in business, healthcare, and regulation. The majority are lawyers which has been helpful for the type of work and extensive review and writing required for the market oversight program. They intend to hire a financial team with accounting experience as they grow their internal staff. The program just started in 2024 and so far has had a limited number of reviews to date. 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 OCHA's communication and stakeholder engagement staff.

[50] California Office of Health Care Affordability. Introduction to OHCA. Available at: https://hcai.ca.gov/ohca/. Accessed November 26, 2023

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[51] 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%) minus 0.5% (or 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.

Massachusetts has an established separate state agency, the Center for Health Information and Analysis (CHIA)[52] that operates the state's APCD. The HPC funds CHIA to collect cost growth data and it reports out to the HPC and the public.[53] The Commonwealth's THCE is measured annually by CHIA and this data is then used to measure the state's health care

[51] https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224
[52] https://www.chiamass.gov/
[53] Massachusetts Center for Health Information and Analysis. About the Agency. Available at: https://www.chiamass.gov/about-the-agency/. Accessed November 26, 2023.

expenditures against growth of the Commonwealth's economy[54]. 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. See HOME (chiamass.gov).

The HPC has additional responsibilities and authorities beyond those of Washington State's Health Care Cost Transparency Board. Other activities include:

- 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.[55]

Enforcement Authority

The HPC has authority to enforce the provisions of its program and is permitted to require that a health care entity[56] file a performance improvement plan (PIP) if it exceeds the cost growth benchmark. The commission also has 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 PIP or fails to implement a PIP in good faith.[57]

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

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

[55] 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. Accessed September 12, 2024.

[56] A Health care entity is defined as a clinic, hospital, ASC, 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

[57] Ibid.

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 to implement a PIP; this was the first time it had ordered a PIP, and at present it is the only PIP nationwide pertaining to a cost growth benchmark program. The commission approved Mass General Brigham's PIP in September 2022; it proposed an annual savings target of $176.3 million over the PIP's 18-month implementation period. Mass General Brigham's most recent public report states that it is on track to meet its savings target.[58]

After now over ten years 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

- Adjust the methodologies and metrics so that entities other than payers and providers with primary care networks are subject to review,
- Strengthen the PIP process,
- Establish a new affordability index to reflect health insurance premiums and cost sharing impacts,
- Initiate new equity benchmark
- Work to constrain excessive provider prices such as reference-based pricing[59].

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.

[58] Mass General Brigham Performance Improvement Plan. March 2023 Update. Available at: download (mass.gov)
[59] HCP 2023 Annual Health Care Cost Trends Annual Report, 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 not part of HCCTB's responsibility

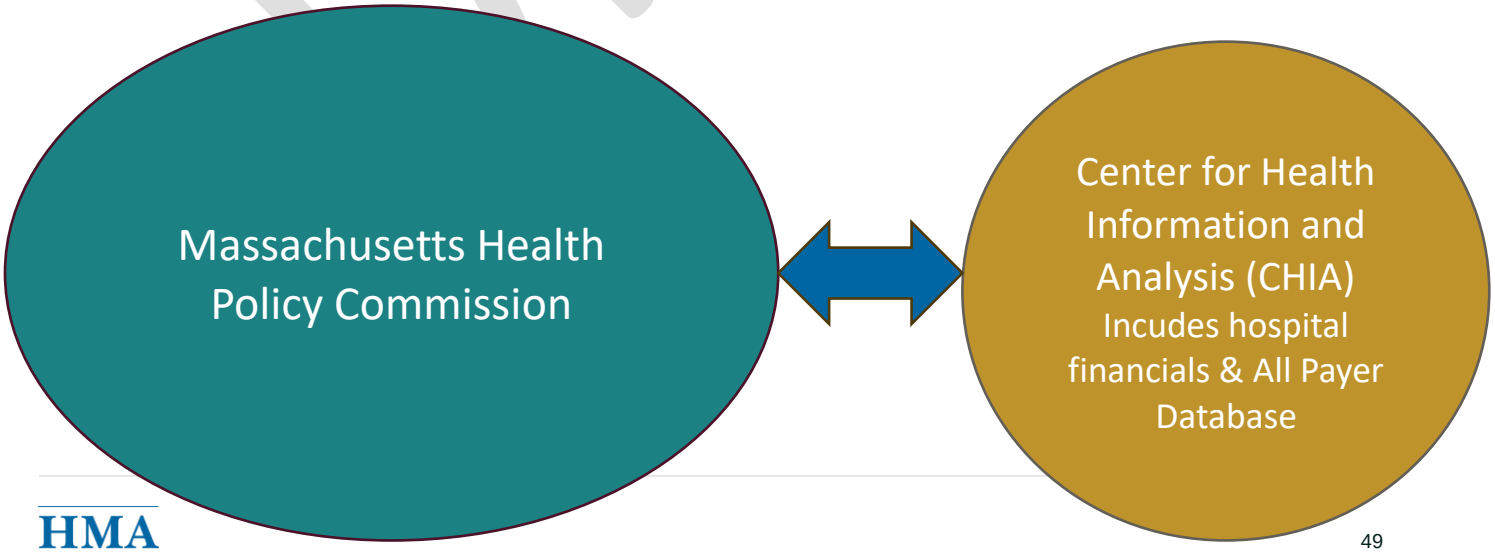
Staffing

The Massachusetts HPC has three main components:

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

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 support all the three areas of the HPC. They have found that the Advisory Council to be one of their biggest assets, brining them together four times a year with members serving two-year terms. It has allowed them to have a closer relationship with stakeholders and have met separately with some of them based on their expertise or affiliation to provide some insights and perspectives for their projects. Expertise across HPC includes a variety of knowledge and skills with the cost growth team made up of data analysts and those with policy expertise. The director of the Cost Growth program is an economist. They use consultants for actuarial services. Overall there are about 60-65 staff hired currently in the HPC that work closely with the approximately 60 positions at CHIA. They report approximately 70 % of the HPC's budget is spent on internal staff positions and 30% on consulting services.

Figure X: Massachusetts' Infrastructure within State Government



Massachusetts' Business Oversight Authority

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

- Cost and Market Impact Reviews (for large mergers, acquisitions, and affiliations)
- Mandatory reporting of ownership, org charts, corporate and contracting affiliations, clinical affiliations, incentive structures/compensation models; financials; sites of practice,
- Public reporting on trends

The Cost and Market Impact Reviews (CMIRs) are required when health care organizations initiate large mergers, acquisitions, and affiliations[60]. Providers and health systems must notify the HPC and state attorney general of any material change in ownership or affiliation[61] If the proposed changes are considered to potentially impact the state's ability to meet cost growth benchmarks, the commission can conduct a detailed impact review of the proposed change"[62].

Funding

A portion of the HPC's budget is directed to the positions and consulting needs of the market oversight program, reported to be about 60% of their budget they receive through the annual provider/hospital and payer assessment. They do not charge the entities for the transaction reviews.

Staffing:

Of the 60-65 positions currently at the HPC, over half are working with the market oversight program. They have found a need for more staff in the market oversight program and are looking to enlarge the team further. The market oversight team is made up those with legal expertise with the senior director a lawyer.

[60] Health Care Cost Commissions: How Eight States Address Cost Growth (chcf.org)
[61] *Ibid.*
[62] *Ibid.*

Oregon

Oregon's Cost Growth Program

Oregon had initiated efforts to control costs prior to their current program. These 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.[63,64]
- In 2015, to address costs, Senate Bill 900 was enacted, requiring the Oregon Health Authority (OHA) to post hospital price information using the all-payer claims database for the 50 most common inpatient procedures and 100 most common outpatient procedures on a public website.[65]

Despite these efforts, costs continued to escalate. The Oregon Legislature through Senate Bill (SB) 889 (2019) and House Bill 2081 (2021) established the Sustainable Health Care Cost Growth Target Program within the Oregon Health Authority (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.

Senate Bill 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. Through this program, OHA was directed to also identify opportunities to reduce waste and inefficiency, resulting in better care at a lower cost.[66]

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[63] Oregon's Medicaid Coordinated Care Organizations - PMC (nih.gov)
[64] HB 2266 - PEBB and OEBB Cost Containment Strategies to Meet the 3.4 Percent Annual Growth Limit.pdf (oregonlegislature.gov)
[65] SB0900 (oregonlegislature.gov)
[66] https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx

The SB 889 Implementation Committee, selected by then Governor Kate Brown (D) 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.[67,68]

Enforcement Authority

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

1. Transparency through public reporting and hearings
2. Performance improvement plans (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 what are called "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.

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 their cost growth between CY 2022-2023 (and data submitted in 2024). They will not issue penalties against any companies until 2029 at the earliest based on the most recent 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

[67] https://www.oregon.gov/oha/HPA/HP/Pages/cost-growth-target-implementation-committee.aspx
[68] Cost Growth Target Committee Recommendations Report FINAL 01.25.21.pdf (oregon.gov)

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 potential gross state product (PGSP), which is a forecasted 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%
- CY 2026 – CY 2030: 3.0%

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 utilizes data collected from insurance carriers, CMS, Oregon's All Payer All Claims (APAC) 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 funding of approximately $2 million for positions, with the majority all general fund with a small amount of federal funds. 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, policy analyst and a few research analysts, an actuary, and administrative staff. The program is overseen by the same manager as Oregon's Health Care Market Oversight program. The staff are housed strategically and with direct access to the state's APCD and hospital financial reporting.

As the program has developed, there has been a need for more staff to continue to staff the advisory groups and run the program with more need for both data and policy analysts and ongoing need for legal expertise as they further develop and implement accountability through performance improvement plans and potentially financial penalties. Discussions are underway in the upcoming budget process with the legislature to seek the additional resources.

Oregon's Health Care Market Oversight Program

In 2021, the Oregon Legislature passed HB 2362 to oversee health care consolidation, creating the Health Care Market Oversight (HCMO) program. The law[69] directs the Oregon Health Authority to review proposed heath care business deals to make sure they do not harm people and communities in Oregon. After completing a review, the Oregon Health Authority (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 to block transactions outright or impose conditions to mitigate potential impacts resulting from the transaction. They use 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 also review the effects of transactions after they occur[70].

Funding (Market Oversight)

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 transactions would cover the costs of the program going forward. The program is examining its ongoing funding needs as the current fees structure may not be adequate to cover all the statutorily required work.

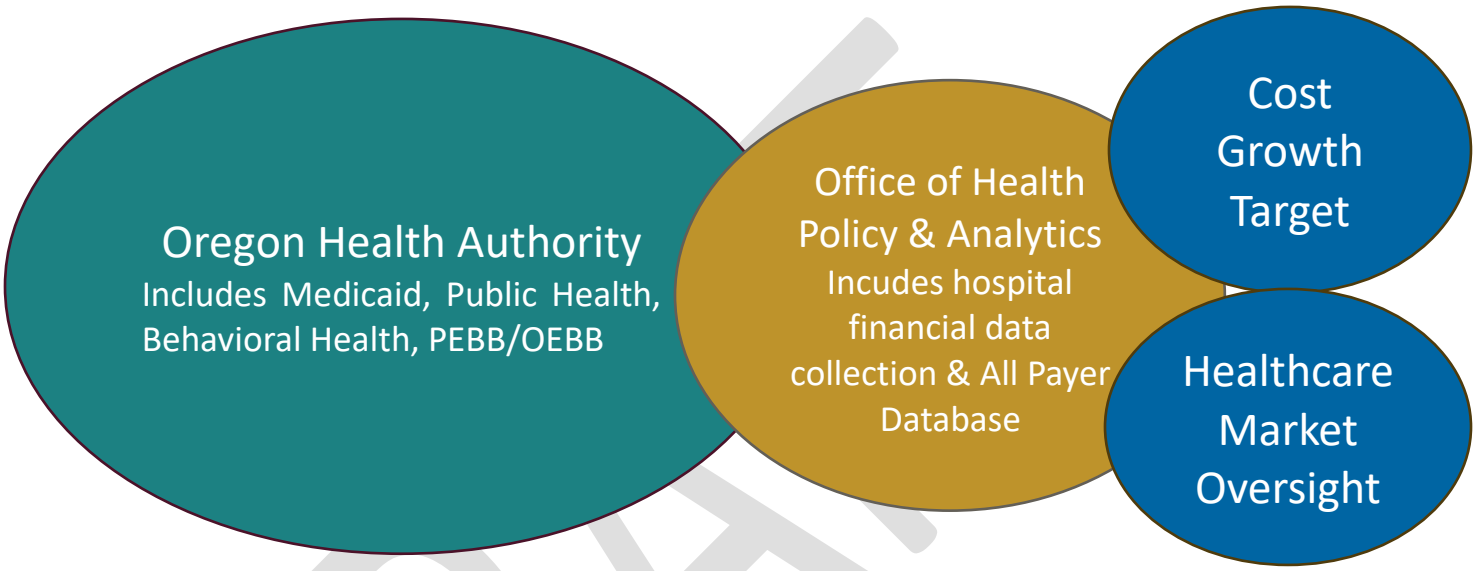
Stafffing (Market Oversight)

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.

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

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

Figure X: Oregon's Infrastructure within 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[71] 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 developed the program building 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.

Rhode Island's 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 within the Steering Committee: "[The Steering Committee] 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"[72].

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[73]; 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

[71] Health Spending Accountability and Transparency Program | Office of The Health Insurance Commissioner (ri.gov)
[72] https://www.milbank.org/wp-content/uploads/2021/01/Fund_Peterson_RI_case_study_v8.pdf
[73] http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php

welfare of the public through overall efficiency, improved health care quality, and appropriate access." There is nothing within statute to require stakeholders to submit, as the program still utilizes voluntary stakeholder 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 work groups as needed. The work is complimentary 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 does not currently have 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.[74] 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[75]. There are no additional mechanisms for enforcement, and public transparency without penalty has been a contributing factor in stakeholder involvement and collaboration.[76]

Rhode Island use data on providers by leveraging the APCD to understand the patterns but do not "have capacity to collect, analyze, interpret and publicly report data on provider finances and operating costs, and oversight of physician practice group acquisitions"[77]

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".[78] In addition to the cost growth benchmarking

[74] https://www.milbank.org/wp-content/uploads/2021/01/Fund_Peterson_RI_case_study_v8.pdf
[75] *Ibid.*
[76] *Ibid.*
[77] News Release 5/13/24 available at: Annual Report: Health Care Spending and Quality in Rhode Island 2024 (ri.gov)
[78] https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-07/RI%20Health%20Care%20Cost%20Growth%20Target%20Compact%20final%20signed%202023%2004-14.pdf

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 from the Peterson Center on Healthcare with the OHIC. Over the past few years, they have had a budget of $500,000 through the legislature that is included into 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.

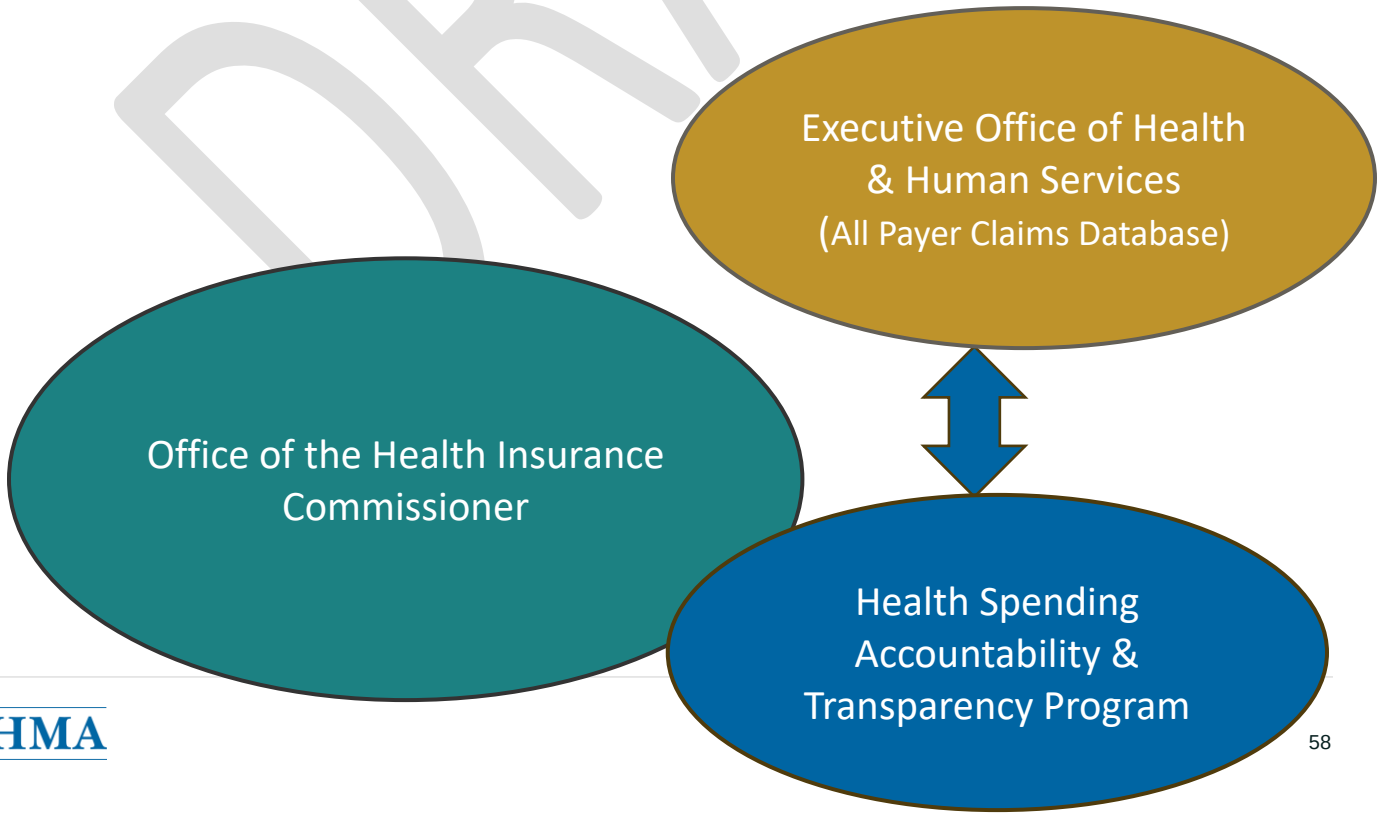
Staffing

The Health Spending and Accountability and Transparency program does not have dedicated state staffing. Outside consultants work 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

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 X: Rhode Island's Infrastructure within State Government



APPENDIX D: OVERVIEW OF STATES AUTHORITY FOR BUSINESS OVERSIGHT

Authority	Nonprofit or For Profit	AG Authority	Dept of Health	+ Health Care Market Oversight 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

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