Health Care Cost Transparency Board Meeting

January 30, 2025

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board
Agenda

Thursday, January 30, 2025
2:00 – 4:00 PM
Hybrid Zoom and in-person

Board Members		
☐ Mich'l Needham, Interim Chair	☐ Ken Gardner	☐ Ingrid Ulrey
☐ Jane Beyer	☐ Jodi Joyce	☐ Kim Wallace
☐ Eileen Cody	☐ Gregory Marchand	☐ Carol Wilmes
☐ Lois C. Cook	☐ Mark Siegel	☐ Edwin Wong
☐ Bianca Frogner	☐ Margaret Stanley	

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome and roll call • Agenda overview	1	Mich'l Needham, Chief Policy Officer Health Care Authority
2:05-2:10 (5 min)	Approval of the November Meeting Summary	2	Mich'l Needham, Chief Policy Officer Health Care Authority
2:10-2:20 (10 min)	Public Comment	3	Mich'l Needham, Chief Policy Officer Health Care Authority
2:20 – 2:25 (5 min)	Operational Updates • HCA staff updates • Introduce new board member • 2025 meeting schedule	4	Mich'l Needham, Chief Policy Officer Health Care Authority
2:25 – 2:40 (15 min)	Nominating Committee Updates • Committee recommendations • Vote on updated Advisory Committee charters	5	Carol Wilmes, Nominating Committee Member
2:40-3:45 (65 min)	Performance Against the Benchmark • Reflections from public hearing • Discussion about Performance Against the Benchmark analysis	6	Vishal Chaudhry, Chief Data Officer, Health Care Authority Amanda Avalos, Deputy for Enterprise Analytics, Research, and Reporting, Health Care Authority Kahlie Dufresne, Special Assistant for Health Policy & Programs, Health Care Authority
3:45-4:00 (15 min)	Committee updates • Medical debt (Stakeholder Advisory Committee) • Market oversight data collection (Data Issues Advisory Committee) • New assignments to committees	7	Eileen Cody, Stakeholder Chair Bianca Frogner, Data Issues Chair Harrison Fontaine, Senior Health Policy Analyst, Health Care Authority
4:00	Wrap Up and Adjourn Next meeting: March 5, 2-4 PM		Mich'l Needham, Chief Policy Officer Health Care Authority

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

November 7, 2024

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
2:00 – 5:00 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
Mark Siegel
Ingrid Ulrey
Kim Wallace
Carol Wilmes
Greg Marchand

Members absent

Jodi Joyce
Margaret Stanley
Edwin Wong

Call to order

Sue Birch, Chair, called the meeting of the Health Care Cost Transparency Board (Cost Board) to order at 2:02 p.m.

Agenda items

Welcome and Roll Call

Chair Sue Birch welcomed members of the Cost Board, gave an overview of the agenda, and shared updates about a recent University of Washington meeting about healthcare trends in Washington and nationally with major journal articles. Chair Birch then proceeded to do a roll call.

Washington State Health Care Authority

Approval of September Meeting Summary

A Cost Board member asked to have the word Medicare removed from "without facility fee… Medicare" and be replaced with MultiCare.

Another board member noted that the Advisory Committee on Data Issues meeting summary was included in the meeting packet.

The Cost Board **voted to adopt** the September 19, 2024, meeting summary.

Public Comment

Chair Sue Birch called for comments from the public.

Jeb Shepard representing the Washington Medical Association congratulated the Cost Board and Health Care Authority for distributing the benchmark reports and completing the annual legislative report. Jeb highlighted that Medicare data is incomplete, covering only 30-35% of the total Medicare population and excluding significant Medicare Advantage partners. Jeb added that there is a need for a process to allow physician groups to verify data accuracy, that the process to verify data is currently burdensome, and encouraged a more robust collaborative system. Jeb recommended including context for cost data indicating that costs attributed to physician groups should reflect contracted hospital rates beyond their control. Finally, he advocated for inclusion of utilization data to provide a more comprehensive review.

Katerina LaMarche representing the Washington State Hospital Association. Katerina highlighted the critical role of facility fees in sustaining hospitals by funding staff, supplies, and essential costs. Katerina emphasized that hospitals, especially safety-net providers are already in financial distress due to underpayment from government programs like Medicare and Medicaid for outpatient care. Katerina indicated that reducing or eliminating facility fees could severely impact patient access to care particularly in rural areas. Katerina requested that the Cost Board carefully vet any recommendations regarding facility fees to fully understand their impact on access and services for vulnerable populations.

Zocia Stanley Vice President and Associate General Counsel of the Washington State Hospital Association. Zocia provided comments regarding the Cost Board's discussion and vote regarding business oversight. She mentioned that it is important to consider Washington's specific data and laws. She said that the state already requires pre-transaction notice for healthcare transactions involving seven or more providers with a 60-day review period by the Attorney General's Office. Zocia also mentioned that Washington's corporate practice of medicine doctrine exists in case law rather than statute and that hospitals already report ownership and control through annual reporting. She indicated the National Academy for State Health Policy model legislation doesn't align with these existing reporting practices. Lastly, Zocia advised the Cost Board to account for Washington's existing laws and frameworks in their decision-making process.

Best Practices Report

Gary Cohen and Jeanene Smith, Health Management Associates

Presenters discussed the State Health Care Cost Growth Programs' Infrastructure: Study of Best Practices report requested by the Washington State Legislature. The study focused on program structures, scopes, financing and staffing in eight states with active cost growth programs. The eight states studied were Massachusetts, Delaware, Oregon, Connecticut, Washington, New Jersey, and California. Some of the common features of the programs were: 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 among others.

The presenters also offered a breakdown of some examples such as Massachusetts, which is the oldest program established in 2012 operating through an independent Health Policy Commission. Some of their program components are comprehensive data collection, and progressive enforcement including performance improvement plans. On the other hand, Oregon combines growth targets and markets within the Oregon Health Authority focused on affordability with hospital payments caps tied to Medicare rates. Rhode Island for example,

uses insurance commissioner oversight with a voluntary compact of stakeholders and it caps hospital price increases based on Medicare price index and inflation. Finally, California, recently launched their program in 2022 with a focus on growth, market oversight and value- based payment. Additionally, they have significant funding with plans to transition from consultants to permanent staff. A full report with all the insights on this study is included in the meeting packet as well as this year's legislative report.

Introduction: Business Oversight of Mergers and Acquisitions

Liz Arjun, Gary Cohen, and Jeanene Smith, Health Management Associates

Jeanene reminded the Cost Board that the purpose of the board is to develop 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. Jeanene showed a breakdown of strategies which included long-term which would target healthcare costs, medium term which would look at consumer health care affordability and short-term actions focused on mitigating consumer medical debt.

Regarding consolidation and oversight what stood out was that consolidation both horizonal and vertical has been linked to higher prices and increased medical debt. Also, private equity investments in healthcare raise concerns about increased costs and potentially harmful impacts on care quality. Data from Washington state shows significant consolidation across the healthcare market, prompting concerns about reduced competition and higher costs. Another topic discussed this year was transparency and facility fees, the focus on this topic is about improving -consumer affordability by addressing the lack of transparency in healthcare pricing and facility fees.

The presenters shared that Washington's healthcare market is highly consolidated, with ongoing mergers and acquisitions. They mentioned that consolidation and private equity involvement have contributed to rising healthcare prices and medical debt.

The Cost Board's discussions and proposed strategies highlight the critical need to balance healthcare affordability with robust market oversight to prevent unchecked consolidation and its negative impact on costs, quality and consumer access.

National Academy for State Health Policy (NASHP) Model Policy to Address Consolidation and Closures in Health Care

Maureen Hensley-Quinn, MPA, NASHP
Hayden Rooke-Ley, JD, Brown University School of Public Health

NASHP presented a model policy to help states improve oversight and regulation in three areas. The first is healthcare transaction oversight, which strengthens the requirements for reviewing, approving, or denying healthcare mergers and acquisitions, especially those involving private equity or large-scale consolidations. Also, corporate practice of medicine which focuses on preventing management services organizations and private equity from exerting undue control over physician practices.

Ownership and transparency require annual or transactional reporting of ownership changes, covering various entities like hospitals, insurers, and long-term care facilities. States like Oregon, Massachusetts, and California have implemented transaction oversight models and shared feedback on best practices. The focus is on enhancing state agencies' authority to monitor transactions, assess long term impacts, and ensure transparency in healthcare ownership.

Healthcare market consolidation and private equity investments often lead to reduced access, higher costs and reduced quality of care. Private equity often employes strategies like management services organizations to bypass corporate practice of medicine laws. NASHP model has transaction oversight which includes mandatory notification, review, and monitoring of healthcare transactions. Corporate practice of medicine reforms prohibits restrictive contracting and ensures that healthcare practices retain clinical autonomy. Ownership transparency enhances reporting requirements to help states understand the healthcare market better.

Washington state has made strides in healthcare market data collection, making it potentially well-positioned to adopt these reforms incrementally. The Cost Board was encouraged to evaluate the feasibility and scope of such legislative changes considering existing state resources and market dynamics.

Discussion and Recommendations Regarding Business Oversight

Sue Birch, Chair

The Cost Board discussed recommendations for addressing healthcare consolidation, improving oversight and harmonizing data collection and policy implementation efforts. Health market consolidation increases prices, raises consumer costs and jeopardizes access. A way to solve this is strengthen state oversight of mergers and acquisitions and harmonizes reporting. The NASHP model was proposed as a guiding framework for state oversight of healthcare mergers to improve transparency and ensure public benefit.

A recommendation was discussed to mandate healthcare entities to report ownership structures, including private equity involvement. This would improve transparency and aid policy decisions. The need for better coordination of data collection and reporting among state agencies was emphasized. It was suggested to consolidate reporting efforts into a single, streamlined process for efficiency and better outcomes.

The Cost Board **approved the following recommendations**:

> 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.
>
> 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.

Concerns were raised about limited resources for new initiatives leading to a focus on practical, phased approaches rather than large, resource intensive recommendations. Oregon's model of using existing resources to create an integrated data and policy framework was highlighted as potential example. Reference based pricing was noted as immediate opportunity to apply downward pressure on healthcare costs. It was suggested as a key area to highlight in the report to the legislature.

The Cost Board discussed aligning recommendations with legislative priorities and the upcoming legislative session to maximize impact. It was also suggested to use the NASHP model to guide Washington's oversight of healthcare mergers and acquisitions adapting it to fit local needs and limitations. Requiring healthcare entities to report ownership, private equity involvement, and legal affiliations, will make it essential to include specific reporting elements such as National Provider Identifier and Tax Identification number for better data consistency.

Furthermore, it was suggested to coordinate data collection and analysis across agencies and establish a consolidated office or framework in the future to enhance data sharing and policy alignment. Asking the committee to review reporting gaps, analyze existing data sources and align them with the NASHP model recommendations.

Staff and consultants will integrate these recommendations into the legislative report, ensuring they are actionable and aligned with current resources. The Advisory Committee on Data Issues will begin cross-referencing existing data and identifying opportunity gaps. The Board will consider how to effectively communicate the need for better agency coordination and harmonization in the legislative report.

Washington State Health Care Authority

Analytic Support Initiative (ASI) Report

Joe Dieleman, PhD, Institute for Health Metrics and Evaluation (IHME)

Joe Dieleman gave an update on health care spending trends in the state through 2022 using the All-Payer Claims Data Base (APCD). Joe discussed the following topics: Washington ranks low nationally in per capita healthcare spending however the growth rate in spending (2010-2022) is slightly above the median at approximately 4.5% annually. Total healthcare spending in 2022 is estimated at $60.1 billion. Private insurance accounts for approximately 50% (26.4B) Medicare $16B Medicaid $10.4B ambulatory care makes up about 50% of spending. Some of the drivers are service price and intensity. Utilization is declining especially for inpatient and ambulatory care.

Medicare has the highest per beneficiary growth driven by an aging population and more complex care needs. Home health and nursing facilities are seeing high growth, often aligned with care shifts from hospitals. High spending and growth concentrated in counties like King, Lewis and Pierce. Growing fastest Chelan, San Juan Islands. Regional disparities exist even after adjusting for population and beneficiary metrics.

The top spending categories are musculoskeletal disorders, cancers, and cardiovascular diseases at about $6-7B each in 2022. Behavioral health conditions show the fastest growth with mental disorders at about 6.9% and substance use disorders at about 9.4%. A significant portion of spending in ambulatory care includes drugs administered in clinical settings, examples are cancer treatments, highlighting their cost impact.

Board members emphasized price and intensity as the primary drivers of spending increases, citing Gerald Anderson's "It's the prices, stupid" argument as still relevant. Another topic of discussion was how utilization per capita is decreasing, countering assumptions that increased healthcare use is driving costs. Board members also discussed distinguishing between necessary growth area such as home health, versus excessive pricing. Proposed legislation such as reference-based pricing was mentioned as expected to address pricing disparities and inform targeted interventions. There were recommendations to analyze spending alongside health status indicators such as life expectancy and population age to uncover disparities and inform targeted interventions.

Board members also questioned how spending trends vary across demographics, such as older populations and Medicaid beneficiaries in regions with high birth rates. Board members also proposed using models to project the impact of cost-control strategies on overall expenditure growth. There was also a discussion about the need for insights into proportional impacts of commercial versus public payer spending.

As final discussion suggested exploring overlays of healthcare spending with population health metrics and demographics, also model potential scenarios for reducing growth in healthcare spending with a focus on pricing reforms.

Facility Fees

Gary Cohen and Jeanene Smith, Health Management Associates

The board revisited the topic of facility fees, recapping prior discussions and decisions. Facility fees charged by hospitals and clinics in addition to service fees, have increased with healthcare consolidation, but lack comprehensive reporting or transparency on their consumer impact. Current reporting requirements in Washington capture only a subset of entities charging facility fees and lack of detailed data on services and consumer impact. There are concerns about facility fee prohibitions or caps leading to cost-shifting in commercial markets through alternative revenue streams.

2024 Legislative Report

Sue Birch, Chair

There was a high level overview of the draft report which provides a comprehensive summary of the Cost Board's 2024 activities. The following were highlighted during the Cost Board Meeting: Facility fees and primary care expenditures recommendations **have been approved.** Data activities include the benchmark and

performance targets, cost driver analysis, primary care spend measurement, hopspital spend assesment and Analytic Support Initiative (ASI). Market Oversight was pending consideration.

Comments to the report:

Comments were to be accepted unitl November 18, and thus integrated on the report.

A Cost Board member suggested adding the recommendations to the executive summary, which would strengthen it for legislative review.

Another comment emphasized framing the report within the broader context of healthcare cost control.

The Cost Board expressed strong support for the proposed bill to increase affordability by capping prices for public employee benefits (PEBB) enrolles through reference-based pricing. There was a clarification to emphasize a shift in expenditures toward primary care without increasing overall healthcare spending. There were also recommendations to include voted-on actions in the summary for clear and concise communication to the legislature.

The Cost Board **approved the draft legislative report**, indicating the need to incorporate the discussed changes, with final adjustments delegated to staff.

Next Steps:

Staff will refine the executive summary and align it with the board priorities, ensuring the report communicates key recommendations effectively.

The finalized report will be submitted to the governor's office and legislature by December, with further public comments and board edits addressed beforehand.

At future meetings, the Cost Board will revist discussions on key issues, such as facility fees prohibitions to ensure comprehensive exploration and concensus.

Adjournment

The next meeting is Thursday, December 12, 2024, at 1:30 p.m. Meeting adjourned at 5:00 p.m.

Washington State Health Care Authority

Health Care Cost Transparency Board Public Hearing Meeting Summary

December 12, 2024

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
1:30 – 4:00 p.m.

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

Members present

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

Members absent

Lois Cook
Carol Wilmes
Mark Siegel

Call to order

Sue Birch, Chair, called the public hearing of the Health Care Cost Transparency Board to order at 1:30 p.m.

Agenda items

Welcome and roll call

Sue Birch, Chair of the Cost Board and Director, Health Care Authority

Chair Birch welcomed everyone and walked through the agenda and roll call. Chair Birch indicated that the agenda would focus on reviewing performance against the benchmark for carriers and large provider organizations in Washington State. This review included a presentation by Chief Data Officer Vishal Chaudhry and Amanda Avalos, Deputy for Enterprise Analytics, from the Health Care Authority. Board members would then have an opportunity to discuss the results, followed by panel presentations from consumer advocates, provider and carrier representatives, and business/labor partners.

The Cost Board's charge: understanding health care costs and improving affordability

Sue Birch, Chair of the Cost Board and Director, Health Care Authority

Chair Birch talked about the Board's key directives, which include establishing cost growth rates, understanding healthcare expenditures, identifying cost drivers, recommending ways to improve transparency and affordability, and evaluating the cost growth performance of carriers and providers. Since 2020, the board has analyzed healthcare expenditures and trends, including primary care, hospital and disease-specific costs, establishing growth targets to keep cost increases below consumer purchasing power, and state economic growth. For the first time, it assessed provider and payer performance against these benchmarks, noting improved data submission processes. She indicated that while the analysis offers insights into cost trends, it does not yet address the unaffordability many Washingtonians face.

Performance against the benchmark (2022)

Vishal Chaudhry, Chief Data Officer, Health Care Authority

Amanda Avalos, Deputy for Enterprise Analytics, Research, and Reporting, Health Care Authority

The presenters shared insights into the key findings of the first performance against the benchmark.

The key takaways are summarized below:

Total Health Care spending in Washington State increased from $48.1 billion in 2019 to $55.1 billion in 2022, with $2.8 billion of this growth attributed to Medicare. Between 2021 and 2022, there was a noticeable stabilization in spending trends. During the same period, overall member spending grew by 3.6%, reaching $7,841 per member in 2022. This amount equates to approximately one-quarter of a minimum wage earner's annual income in Washington State for that year. Accelerating growth in per-member spending was particularly evident in Medicare, VA, and DOC markets, primarily driven by older populations and dental care. Notably the Medicare market was the only market to exceed the 2022 cost growth benchmark, while Medicaid enrollment increased, although growth remained applied at the per-member level.

The Benchmark performance showed that 5 out of 28 provider organizations and 5 out of 12 carriers exceeded the state's 2022 benchmark. During the public hearing it was noted that growth could vary across different lines of business. For instance, standalone dental plans were not included in the data, and questions were raised about the primary care spend in comparison to the other states such as Oregon, Washington, and Rhode Island, where Rhode Island specifically tracks primary care expenditures. Additionally, the non-claims category, which includes incentive payments and value-based plans, stood out and prompted further inquiries about further research on this topic. A closer examination of inpatient and outpatient care across the three major markets was suggested, particularly whether keeping procedures as inpatient might have led to increased cost growth.

Board discussion

Facilitated by Sue Birch

The following discussions took place during the performance against the benchmark presentation as well as thereafter:

There was a discussion about primary care initiatives in other states like Oregon, Connecticut, and Rhode Island and how Washington's performance compares.

There was also a discussion on the non-claims category being a significant driver of growth, particularly for Medicare and the complexity of interpreting this category. There was a question about whether this growth is due to incentives, value-based payments, or other factors like Medicare Advantage plans.

There was a discussion about hospital inpatient versus outpatient trends and how they differ across Medicare, Medicaid, and commercial markets. There were questions raised about the factors driving different growth patterns across markets, particularly Medicaid's low growth in outpatient services.

Some Board members asked clarifying questions about product mix for carriers and its impact on performance, for instance Medicaid versus commercial products. It was noted that performance may differ when broken down by product lines with more Medicaid coverage leading to lower growth.

Board members asked for further analysis, particularly for more granular data such as Medicare Advantage plans and more detailed distinctions between Medicare and Medicaid. There was also an ask to refine, if possible, the non-claims category for better transparency.

Washington consumer affordability

Emily Brice, Co-Executive Director of Advocacy, Northwest Health Law Advocates

Jim Freeburg, Patient Coalition of Washington

Sam Hatzenbeler, Senior Policy Associate, Economic Opportunity Institute

The presenters focused on the urgent need to expand access to affordable healthcare in Washington State and reduce healthcare costs. The presenters believe that despite efforts, Washington healthcare entities collectively failed to meet the healthcare spending growth benchmark, signaling a significant issue. From a consumer perspective, healthcare cost growth should be zero, as current trends are unsustainable and concerning for many Washingtonians.

To better understand consumer health care challenges in Washington, the presenters conducted an independent public opinion poll of 1,006 survey respondents, from June 13-June 27.

The following are key findings presented at the hearing. The whole presentation can be found at: Health Care Cost Transparency Board Meeting, December 12, 2024:

- 63% of respondents are worried about current costs of their health care
- 88% of respondents are worried about the cost of health care in the future
- 57% of respondents avoided seeking medical treatment or changed their use of prescription medications due to cost in the last year
- There were health disparities in managing health care costs, with respondents who identified as Hispanic or Latino the most impacted (75% Hispanic/Latino experiencing impact, 75% African American experiencing impact)
- Prevalence of medical debt
    - 3 in 10 Washingtonians live in a household with medical debt
        - 63% would struggle to pay or couldn't pay for unexpected medical bill
- The presenters also discussed primary sources of medical debt, highlighting:
    - 44% a hospital or hospital-owned facility
    - 16% an urgent care facility
- Facility fees
    - 39% have been charged a facility fee
    - 3 out of 4 respondents had difficulty understanding, using, affording or accessing care through insurance

The presentation concluded by emphasizing the need for elected leaders and government officials to take action to reduce healthcare costs, address disparities, and improve healthcare access.

Provider and carrier reflections

Don Anderson, Jr., VP of Reimbursement, Providence

Don Anderson highlighted the challenges with data aggregation and validation in provider reports, particularly at the provider entity level, which hinders cost analysis. Don emphasized the need for accurate and reliable data, advocating for a centralized process to obtain data directly from payers and carriers. Additionally, changes in Medicare payment systems, including the wage index factor for rural areas, contribute to unpredictable cost drivers, necessitating further analysis of Medicare's impact on overall costs.

Jeb Shepard, Director of Policy, Washington State Medical Association

Jeb Shepard acknowledged the affordability challenges and high costs of healthcare delivery, expressing a commitment to being constructive partners in minimizing costs. Jeb identified five key areas for improvement including, meeting with providers, addressing incomplete medical data aggregation, and refining patient attribution methodologies. He also stressed the importance of providing context in reporting, as not all healthcare costs are within providers' control. He indicated that provider groups face challenges meeting benchmarks due to inflation and contracts negotiated in 2020, which no longer may reflect current realities.

Jennifer Ziegler, Contract Lobbyist, Association of Washington Healthcare Plans

Jennifer Zeigler, contract lobbyist representing 12 carriers, emphasized the lessons learned through the data call process highlighting the importance of context in understanding cost drivers for outpatient versus inpatient care. Jennifer indicated that some costs are beyond the control of system participants and urged policymakers to view healthcare as a comprehensive system. Lastly, she shared that cost driver data aligns with carrier observations, particularly regarding drug prices. Jennifer expressed gratitude for policy recommendations and legislative efforts addressing facility fees.

Business and labor reflections

Zenovia Harris, CEO, Kent Chamber of Commerce

This presenter did not attend the meeting.

Patrick Connor, CEO, WA National Federation of Independent Business

Patrick indicated that the lack of affordable health insurance is a problem. He noted that trying to find coverage is difficult and only 40% of small businesses can offer health insurance. He called for more opportunities for employers, including alternative approaches that allow workers access to quality insurance. Patrick discussed transparency, better access to quality data for better informed decisions, nonprofit carriers (unrestricted surplus), and suggested monitoring sight of unrestricted. Patrick also shared that small providers are having to consolidate just so they are able to keep their practices.

Christina Johansen, Managing Director of Health Benefits Trust, SEIU 775

Christina discussed multi-employer trusts, Washington state caregivers, and the need for health plans designed to minimize out-of-pocket costs. She highlighted the high rates of chronic conditions, the lack of prescription pricing transparency, and the large cost variances in per member in rural versus urban settings, with rural settings being higher.

Washington State Health Care Authority

Public comment

Chair Birch indicated the public could submit written comments online prior to the hearing. The following are highlights from the verbal comments shared during the hearing from different members of the public:

Kelsey Wulfkuhle, State Advocacy Manager, United States of Care

Commenter noted that spending growth does not mean people are getting better care and that we need more oversight of mergers, acquisitions, and the consolidation of hospital and providers. Commenter sited a survey which rates quality of care as "lowest quality of care" in two decades. Lastly, commenter suggested a focus on how financial decision making of hospitals impacts affordability.

Christa Able, Division Director Payer Strategy at Pacific Northwest Division, Virginia Mason Franciscan Health & current member of HCCTB's Advisory Committee on Data Issues

Commenter indicated they submitted comments via email and wanted to take this time to talk about the comments. Christa noted that it is important the benchmark is accurate and suggested a closer look at calculations and the attribution methodology. As an example she said that there is an extreme shortage of primary care providers and the attribution methodology relies on unstandardized methods. Age and sex adjustments don't go far enough.

Clair Olivers, President of the Retired Public Employees Council of Washington

Commenter noted that they represent 13,000 public employees and wanted to thank the Board for increasing merger and acquisition oversight. Commenter also thanked the board for looking into viable solutions for increasing healthcare cost transparency. Commenter also discussed network providers and specialists, increasing fee reporting requirements, transparency in billing, and rising costs affecting retired public employees.

Adam Zarrin, Director of State Government Affairs, Leukemia and Lymphoma Society

Commenter indicated more than half of Washingtonians have avoided medical treatment or modified their use of prescriptions in the last year due to costs. Commenter noted that some patients won't start treatment when they have big out of pocket costs and discussed how many accumulate medical debt. Commenter shared anecdotal story about Rachel, who had incurred medical debt.

Katerina LaMarche, Washington State Hospital Association

Commenter asked the question, how does access and how does quality look? Commenter suggested improving provider data reporting and noted that policy recommendations could address what drives increases, not control over wages and pharmaceuticals.

John Godfrey, Community Action Network

Commenter indicated premium increases on exchange plan affect small business owners and that there has to be a solution to do better for patients and taxpayers, especially with regards to medical debt. Commenter suggested policy levers as reference pricing and the monitoring of mergers.

2025 preview and call to action

Sue Birch, Chair of the Cost Board and Director, Health Care Authority

Chair Birch thanked the staff, data experts, panelists, and board members for contributing to the first public hearing of the Health Care Cost Transparency Board. She highlighted the important need for transparency and visibility, and that there is no pointing fingers, as this work requires working with stakeholders and partners. As this was Chair Birch's last Cost Board meeting, she thanked everyone involved in making this great work happen.

Adjournment

Final meeting for 2024, the next meeting is January 30, 2025, from 2:00-4:00 p.m. Meeting adjourned at 4:01 p.m.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Tab 4

Washington State Health Care Authority

Operational updates

HCA staff updates

New member introductions

Nominating Committee recommendations

2025 meeting schedule

Washington State Health Care Authority

HCA staff updates

MaryAnne Lindeblad

HCA, Acting Director

Ross Valore

Board and Commissions Director

Jenn Scott

Senior Health Policy Analyst

Harrison Fontaine

Senior Health Policy Analyst

Washington State Health Care Authority

Welcome to the Board
Ken Gardner

Washington State Health Care Authority

2025 meeting schedule

Date	Entity
January 30	Cost Board
March 5	Cost Board
March 27	Stakeholders and Data Issues
April 24	Cost Board
May 22	Stakeholders and Data Issues
June 3	Cost Board
July 22	Cost Board
August 7	Stakeholders and Data Issues
August 28	Primary Care
September 25	Cost Board
October 23	Stakeholders and Data Issues
November 20	Cost Board
December TBD	Cost Board Public Hearing

Tab 5

Washington State Health Care Authority

Nominating Committee updates

Committee recommendations

Vote on updated Advisory Committee charters

Washington State Health Care Authority

Stakeholder Advisory Committee: new member vote

- Requirement: One member representing an ambulatory surgery center selected from a list of three nominees
  - Nominated by the Ambulatory Surgery Center Association
- Nominating Committee recommendation to approve Jamie Fowler to join the Stakeholder Advisory Committee
  - Director of Operations at SCA Health Washington and Oregon Region
  - Formerly Billing Office Manager at Pacific Surgery Center in Poulsbo, WA
  - Master in Healthcare Administration from the University of Washington

Stakeholder Advisory Committee: Jamie Fowler's experience

- Professional with over 22 years of Ambulatory Surgery Center experience and over 12 years of management and leadership experience.
- Led centers with all components of the quadruple aim at the forefront to include efforts around: improving population health, improving patient experiences, reducing costs and improving the well-being of team and providers.
- Engages daily with stakeholders to drive continued success for WA centers and access for community.
- 2021–current, Merger & Acquisition: Coordinated due diligence, negotiations, and final integration of ASC through acquisition by SCA Health.
- 2020–2022 Construction Project Manager: Project Manager for extensive remodel project to expand square footage, addition of operating room and PACU spaces.

Advisory Committee on Data Issues: new member vote

- Dr. Nnabuchi Anikpezie is the Senior Director of Health Systems & Workforce Intelligence within the Executive Office of Healthcare Innovation & Strategy at the Washington State Department of Health
- DrPH in Health Services Research from UT Health Science Center at Houston
- MPH in Public Health Administration and Policy from the University of Minnesota
- Medical degree from the University of Ibadan

Advisory Committee on Data Issues: Dr. Nnabuchi Anikpezie's experience

- Experience in major academic health centers, federally qualified health centers, and the pharmaceutical industry
- 10+ years using large volumes of real-world data to improve population health, healthcare access, and equity
- Leads management of state health workforce data to provide insights and inform policy decisions, especially related to cost management, Medicaid populations, and underserved communities

Board vote for new stakeholder and data advisory committee members

Vote 1

- Health Care Stakeholders Advisory Committee
  - Jamie Fowler, MHA

Vote 2

- Advisory Committee on Data Issues
  - Dr. Nnabuchi Anikpezie, DrPH, MPH, MBBS

Committee charter changes: attendance policy vote

- Proposed new text in the charters for the Stakeholder Advisory Committee and the Advisory Committee on Data Issues

Attendance:

Regular attendance of committee members is essential for the work of the Advisory Committee of [Health Care Stakeholders/Data Issues] in order to provide feedback to the Health Care Cost Transparency Board. If a committee member misses three meetings in a calendar year (50%), or three consecutive meetings over a twelve-month period, they will be notified by a staff member of the Health Care Authority supporting the work of the Cost Board that they are being removed due to attendance and the nominating entity will be notified to initiate the process of replacing that vacant membership.

HEALTH CARE COST TRANSPARENCY BOARD
Advisory Committee of Health Care Stakeholders

What is the Purpose of the Advisory Committee of Health Care Stakeholders?

Assisting the Health Care Cost Transparency Board ("Board"), the role of the Advisory Committee of Health Care Stakeholders is to provide subject matter expertise, feedback, and support to the Board regarding the cost growth benchmark. The Advisory Committee of Health Care Stakeholders will also help the Board identify opportunities to slow cost growth and address growing affordability concerns for the state of Washington at various levels (state, market, carrier, and large provider entity.)

Membership:

As indicated in House Bill 2457, section 4 and related RCWs, the Advisory Committee of Health Care Stakeholders will be appointed by the Board and appointments to the advisory committee must include the following membership:

- One member representing hospitals and hospital systems, selected from a list of three nominees submitted by the Washington State Hospital Association;
- One member representing federally qualified health centers, selected from a list of three nominees submitted by the Washington Association of Community Health;
- One physician, selected from a list of three nominees submitted by the Washington State Medical Association;
- One primary care physician, selected from a list of three nominees submitted by the Washington State Academy of Family Physicians;
- One member representing behavioral health providers, selected from a list of three nominees submitted by the Washington council for behavioral health;
- One member representing pharmacists and pharmacies, selected from a list of three nominees submitted by the Washington state pharmacy association;
- One member representing advanced registered nurse practitioners, selected from a list of three nominees submitted by ARNPs united of Washington state;
- One member representing tribal health providers, selected from a list of three nominees submitted by the American Indian health commission;
- One member representing a health maintenance organization, selected from a list of three nominees submitted by the association of Washington health care plans;
- One member representing a managed care organization that contracts with the authority to serve medical assistance enrollees, selected from a list of three nominees submitted by the association of Washington health care plans;
- One member representing a health care service contractor, selected from a list of three nominees submitted by the association of Washington health care plans;
- One member representing an ambulatory surgery center selected from a list of three nominees submitted by the ambulatory surgery center association; and

- Three members, at least one of whom represents a disability insurer, selected from a list of six nominees submitted by America's health insurance plans.

As indicated in House Bill 1508, the Advisory Committee of Health Care Stakeholders shall also have the additional members:

- At least two members representing the interests of consumers, selected from a list of nominees submitted by consumer organizations;
- At least two members representing the interests of labor purchasers, selected from a list of nominees submitted by the Washington state labor council; and
- At least two members representing the interests of employer purchasers, including at least one small business representative, selected from a list of nominees submitted by business organizations. The members appointed under this subsection (3)(p) may not be directly or indirectly affiliated with an employer which has income from health care services, health care products, health insurance, or other health care sector-related activities as its primary source of revenue.

Roles and Responsibilities:

The Advisory Committee of Health Care Stakeholders is responsible for:

- Providing recommendations to the Board about the types of sources of data necessary to annually calculate total health care expenditures and health care cost growth, and to establish the health care cost growth benchmark, including execution of any necessary access and data security agreements with the custodians of the data.
- Helping to identify existing data sources, such as the statewide health care claims database established in chapter 43.371 RCW and prescription drug data collected under chapter 43.71C RCW, and primarily rely on these sources when possible, in order to minimize the creation of new reporting requirements.
- Reporting to the Board the means and methods for gathering data to annually calculate total health care expenditures and health care cost growth, and to establish the health care cost growth benchmark.
- Providing feedback to the Board to select an appropriate economic indicator to use when establishing the health care cost growth benchmark.
- Providing recommendations to the Board on data issues regarding the value and feasibility of reporting various categories of information regarding the value and feasibility of reporting various categories of information, such as urban and rural, public sector and private sector, and major categories of health services, including prescription drugs, inpatient treatment, and outpatient treatment.
- Providing recommendations based on the annual calculation of total health care expenditures and health care cost growth:
    - Statewide and by geographic rating area;
    - For each health care provider or provider system and each payer.
- Offering the Board feedback in relation to the growth benchmark, including understanding for outliers or unexplained trends with the cost growth data analysis.

- Collaborating with the Board and HCA staff to help create buy-in across the various markets and provider organizations and offering suggestions that may help streamline the data collection process with carriers and HCA.
- Serving as a liaison between the Board and health care community by relaying essential information to carriers and providers and bringing forth feedback from carriers and providers to the Board to ensure all parties involved have an opportunity to address how to slow cost growth and address growing affordability concerns for the state of Washington at various levels (state, market, carrier, and large provider entity.)
- Regular attendance and participation in advisory committee meetings. This includes reviewing meeting materials ahead of the scheduled meeting, coming prepared to engage in an active discussion with other advisory board members, and providing any input to help the conversation continue moving forward.

Meetings:

The Advisory Committee of Health Care Stakeholders will meet as needed (likely no more than six times annually), to fulfill its mandate to the Board of providing subject matter expertise and advise related to health carriers and large provider organizations.

Quorum:

A majority of the Advisory Committee of Health Care Stakeholders members constitutes a quorum for a meeting of the committee.

Accountability and Reporting:

The Advisory Committee of Health Care Stakeholders is accountable to the Board and reports its activities and recommendations to the Board. Time-sensitive issues are brought to the Board's attention in a timely manner.

Attendance:

Regular attendance of committee members is essential for the work of the Advisory Committee of Health Care Stakeholders in order to provide feedback to the Health Care Cost Transparency Board. If a committee member misses three meetings in a calendar year (50%), or three consecutive meetings in a twelve-month period, they will be notified by a staff member of the Health Care Authority supporting the work of the Cost Board that they are being removed due to attendance.

HEALTH CARE COST TRANSPARENCY BOARD'S

Advisory Committee on Data Issues

What is the Purpose of the Advisory Committee on Data Issues?

Assisting the Health Care Cost Transparency Board ("Board"), the role of the Advisory Committee of Data Issues is to provide expert advice to the Board on data calls and in the analysis of existing data sources to determine cost drivers.

Membership:

As indicated in House Bill 2457, section 4 and related RCWs, the Advisory Committee of Data Issues will be appointed by the Board.

Roles and Responsibilities:

The Board has the authority to establish and appoint advisory committees, in accordance with the requires of section 4 of House Bill 2457 and seek input and recommendations from the advisory committee on topics relevant to the work of the board. The roles and responsibilities of the advisory committee shall include:

- Determine the types of sources of data necessary to annually calculate total health care expenditures and health care cost growth, and to establish the health care cost growth benchmark, including execution of any necessary access and data security agreements with the custodians of the data.
- Help to identify existing data sources, such as the statewide health care claims database established in chapter 43.371 RCW and prescription drug data collected under chapter 43.71C RCW, and primarily rely on these sources when possible in order to minimize the creation of new reporting requirements.
- Determine the means and methods for gathering data to annually calculate total health care expenditures and health care cost growth, and to establish the health care cost growth benchmark.
- Providing feedback to the Board to select an appropriate economic indicator to use when establishing the health care cost growth benchmark.
- Providing recommendations to the Board on data issues regarding the value and feasibility of reporting various categories of information.
- Collaborating with the Board and HCA staff to help create buy-in across the various markets and provider organizations and offering suggestions that may help streamline the data collection process.

- Serving as a liaison between the Board and health care community by relaying essential information to carriers and providers and bringing forth feedback from carriers and providers to the Board to ensure all parties involved have an opportunity to address how to slow cost growth and to address growing affordability concerns for the state of Washington at various levels.
- Regular attendance and participation in advisory committee meetings. This includes reviewing meeting materials ahead of the scheduled meeting, coming prepared to engage in an active discussion with other advisory board members, and providing any input to help the conversation continue moving forward.

Meetings:

The Advisory Committee on Data Issues will meet as needed (likely no more than six times annually) to fulfill its mandate to the Board of providing subject matter expertise and support to the Board.

Quorum:

A majority of the Advisory Committee on Data Issues members constitutes a quorum for a meeting of the committee. If a meeting does not have a quorum of members present or does not maintain a quorum, the meeting may be cancelled or rescheduled so that there are sufficient members to fulfill the Committee's responsibilities.

Accountability and Reporting:

The Advisory Committee on Data Issues is accountable to the Board and to report its activities and to provide subject matter expertise at the request of the Board or to follow up on requests of the Board.

Attendance:

Regular attendance of committee members is essential for the work of the Advisory Committee on Data Issues in order to provide feedback to the Health Care Cost Transparency Board. If a committee member misses three meetings in a calendar year (50%), or three consecutive meetings in a twelve-month period, they will be notified by a staff member of the Health Care Authority supporting the work of the Cost Board that they are being removed due to attendance.

Tab 6

Washington State Health Care Authority

Health care cost growth trends in Washington:

Findings from the Health Care Cost Transparency Board's data call — follow up from December public hearing

January 30, 2025

Washington State Health Care Authority

Outline

- **Key takeaways** from performance against the benchmark
  - Total health care spending data and health care cost growth benchmark
  - Highlights from performance against the benchmark analysis (2022, and trends from 2019–2022)
- **Respond to questions** raised in December public hearing
- **Next steps**: benchmark performance vs. cost-driver analysis
- **Discussion**

Cost Board data and analytic initiatives

Cost growth benchmark

The goal for the growth of spending on health care year over year.

Data sources: Based on WA's economic indicators

Performance against benchmark

Assessment of cost growth against the growth benchmark.

Data sources: WA Health Care Cost Transparency Board Data Calls

Cost driver analysis/cost experience

Assessment of key drivers of cost growth.

Data sources: Washington All Payer Claims Database (WA-APCD)

Primary care spend measurement

Expenditure on primary care in relation to overall health care expenditure.

Data sources: WA-APCD

Hospital cost, profit, and price analysis

Hospital financial analysis to identify cost, price and profit trends.

Data sources: Medicare hospital cost reports

Analytic support initiative

Analysis of cost growth by UW's IHME*.

Data sources: WA-APCD, public and private claims databases, public health data

Consumer affordability

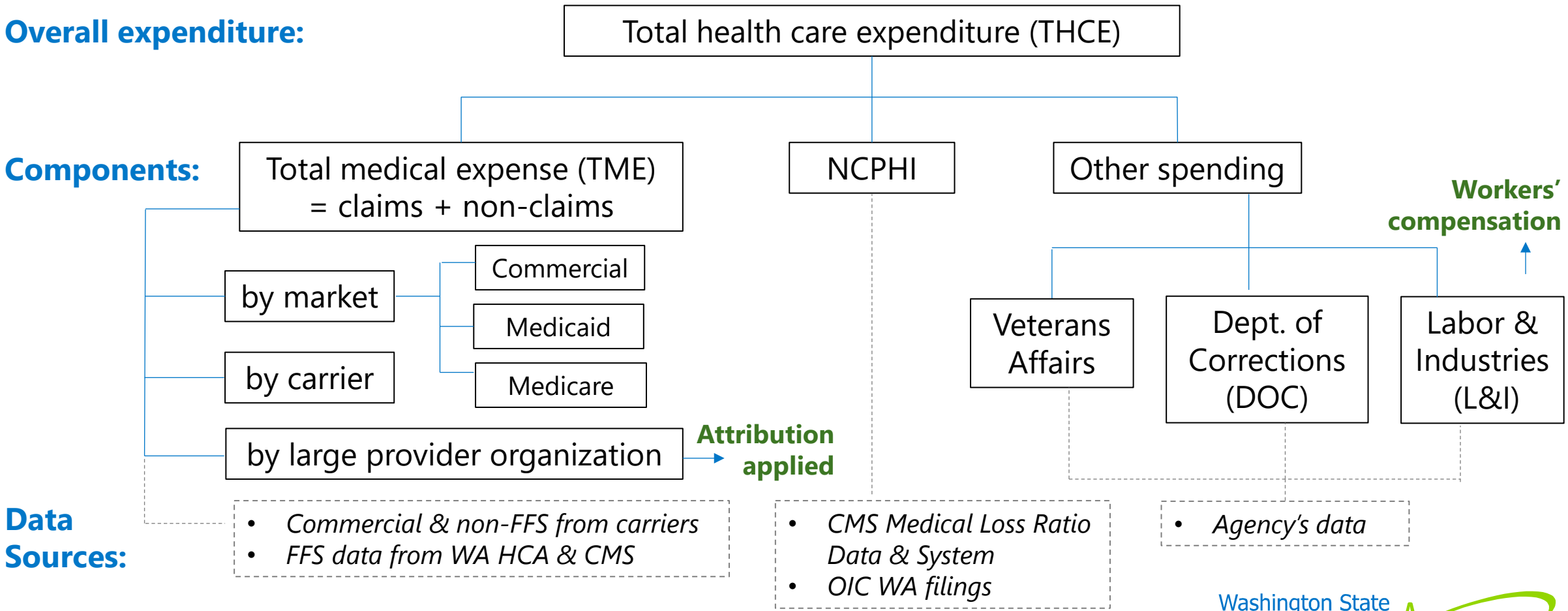
The ability for a consumer to afford their health care insurance.

Data sources: Survey data

Source: Health Care Authority. *University of Washington's Institute for Health Metrics and Evaluation

Washington State Health Care Authority

Health care cost data overview



NCPHI: Net Cost of Private Health Insurance; FFS: Fee-for-service; Non-FFS refers to Medicaid Managed Care and Medicare Advantage Plans; HCA: Health Care Authority; CMS: Centers for Medicare & Medicaid Services; OIC: Office of the Insurance Commissioner
For more details on data collection and submission, please see the Cost Board's Data Call Technical Manual.

Washington State Health Care Authority

2022: First year with health care cost growth benchmark

Calendar year	Benchmark value
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Source: Health Care Cost Transparency Board

Per-member spending cost growth vs. benchmark:

- Statewide
- Markets
- Carriers
- Provider organizations

Cost growth performance metrics

Aggregation level	Performance is based on
Statewide	THCE PMPY growth rate
Markets	TME PMPY growth rate
Carriers	Confidence interval of age-sex risk-adjusted truncated TME PMPY growth rate
Large Provider Organizations	

Source: Health Care Cost Transparency Board

THCE: Total Health Care Expenditures, TME: Total Medical Expenditures
PMPY: Per Member Per Year

Methods are explained in the Benchmark Brief and slide appendices for:

- Attribution
- Truncation
- Age-sex risk adjustment
- Confidence interval calculation

Key takeaways, 2022

- 2022 statewide per-member cost growth at 3.6% is slightly above the 3.2% growth benchmark and (excluding 2020) is the slowest growth since 2018.
  - Marketwise, only the Medicare market exceeded the benchmark.
  - 5 out of 12 carriers and only 5 out of the 28 large provider organizations exceeded the benchmark.
  - Spending for Veterans Affairs (VA) members also pushed growth
- But one-year analysis on 2022 year-over-year growth may not fully capture developments during the pandemic period.

Key takeaways, 2019-2022

- Per-member spending growth from 2019–2022 is driven by growth in:
  - Commercial and Medicare markets
  - VA spending
- Per capita spending growth from 2019–2022 led by these top contributors to growth:

Top	Category	Market sources
1	Prescription drugs	Medicare, Commercial
2	Non-claims	Medicare, Medicaid
3	Hospital outpatient	Medicare, Commercial

- Per-capita Medicaid spending decreased from 2019–2022 due to a decline in Other Claims that more than offset an uptick in prescription drug spending.

Public hearing stakeholder reflections

- Cost growth is a burden across the state:
  - Only 40% of small businesses can afford to offer health insurance
  - Businesses need more tools to compare plan and provider cost and quality
  - Cost sharing mechanisms are becoming more burdensome
  - Providers feel effects in their own practices driving consolidation
  - Drug prices rising without transparency, and role of PBMs and rebates is unclear
  - Costs are different in rural vs. urban areas
- Request for the Board to revisit data collection/aggregation process:
  - TIN-level reporting to understand drivers and address cost growth at entity level
  - Centralized process to streamline data collection
  - Refine patient attribution methodology
    - Note that attribution method applies a patient's total costs to a primary provider, but that primary provider may not have rendered all services
  - Enhance collaboration between HCA & provider groups including organizations validating data attributed to them

Questions from public hearing (Dec 2024)

1. Do the other states with Cost Board programs have primary care initiatives that support prevention of other spending?
2. Can we break out carrier performance by market?
3. How does WA's expenditure growth compare to other states?
4. What are non-claims expenditures? What non-claims expenditures are driving growth in each market?
5. Why do the markets have different inpatient and outpatient hospital spending trends?

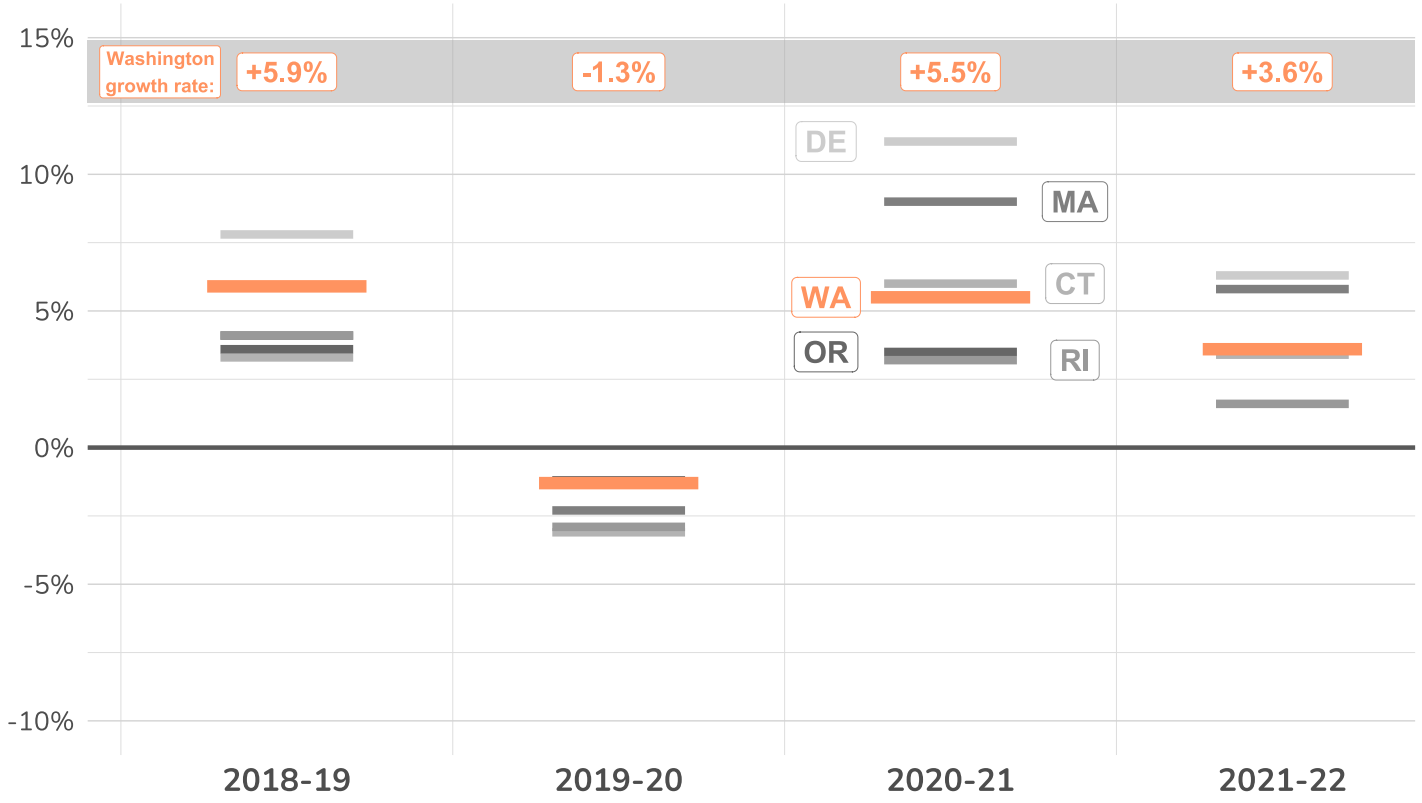
Overall growth across states

- Compared to other states, WA's annual growth is close to the median rate from 2018 to 2022

Question 1: Do these states have primary care initiatives that support prevention of other spending?

Total health care expenditure per member per year growth

Washington and five other benchmark states



Source: WA Health Care Cost Transparency Board Data Calls, Bailit Health Analysis from Other States' Data Calls

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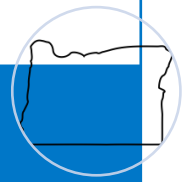
NEW

Other state primary care initiatives

Oregon

- Established Primary Care Payment Reform Collaborative in 2017
- Participated in Comprehensive Primary Care Plus (CPC+) model
- Participated in Primary Care First model



Rhode Island

- Established minimum PC spending target in 2004
- Enacted PCMH Collaborative in 2011
- Directed commercial insurers to spend 10.7% on PC in 2022
- Participated in CPC+

Connecticut

- Established PC spend targets in 2020
- Set target of 5.3% in 2022 (will be 10% by 2025)
- Participating in AHEAD model

Massachusetts

- Measures primary care expenditures through Center for Health Information and Analysis (CHIA)
- Maintains PC ACO within Medicaid program
- Participating in Making Care Primary model

NEW

State primary care expenditure ratios

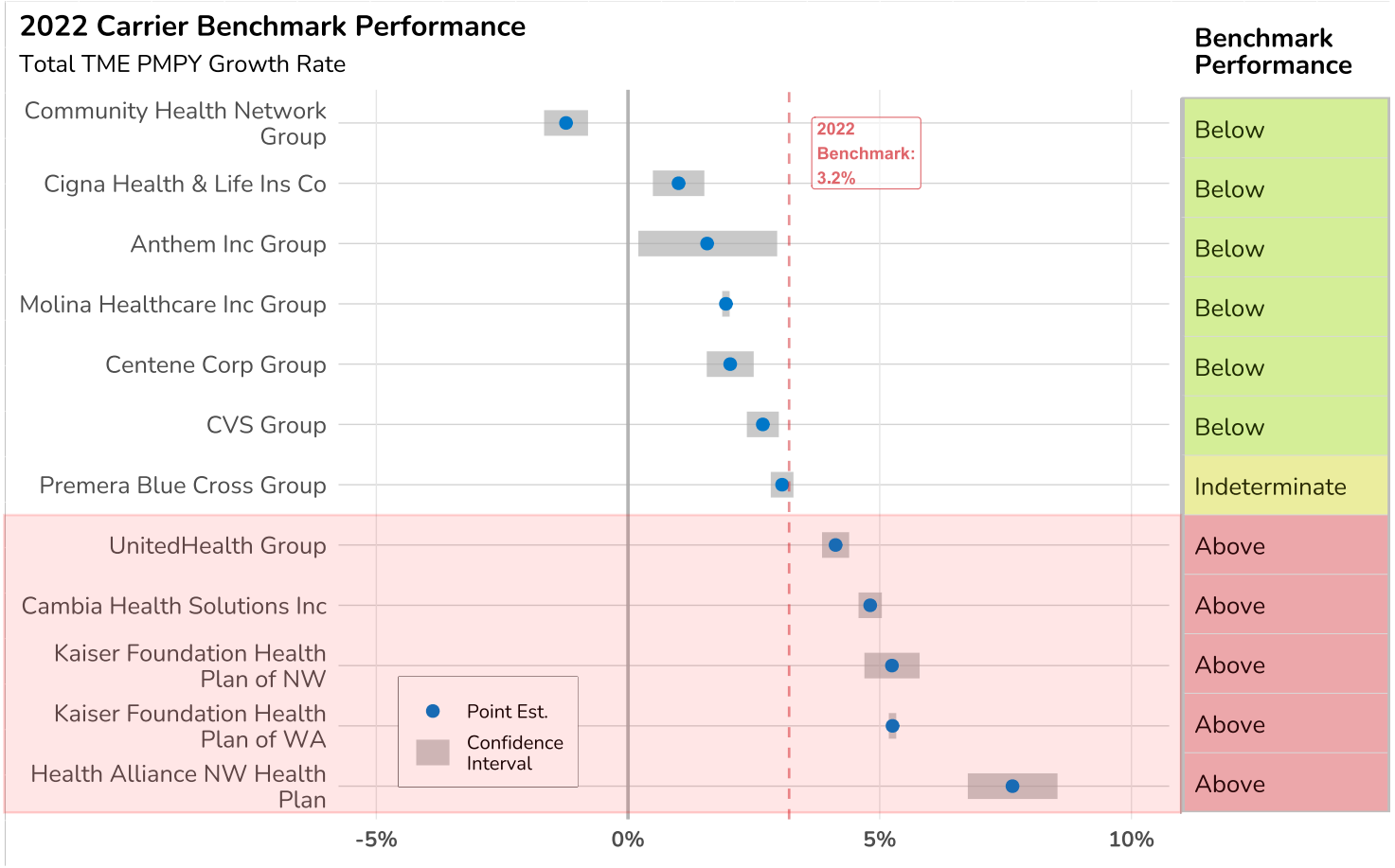
	Market	CT	OR	MA	WA
2021	Commercial	3.9%	12.5%	6.9%	4.6%
	State Employee	-	13%	-	-
	Medicare Advantage	3.0%		3.9%	3.4%
	Medicaid	7.3%	11%	7.1%	5.0%
2022	Commercial	4.0%	11.5%	6.8%	4.6%
	State Employee	-	11-13%	-	-
	Medicare Advantage	3.2%		4.1%	3.1%
	Medicaid	7.0%	15%	7.5%	5.1%

***Notes**: "-" no publicly available data for the market. RI did not have publicly available PCE data.*
***Sources**: CT, MA, WA: carriers' data from data call, includes non-claims spend. OR: APAC database, which includes non-claims.*

- Primary care definitions vary by state
  - Oregon includes some behavioral health
- WA PCE calculated from data call. PCE ratio is PC claims spending over all claims spending.

Washington State Health Care Authority

5 out of 12 carriers exceeded the benchmark



Question 2: Can we break out carrier performance against the benchmark by market?

Source: WA Health Care Cost Transparency Board Data Calls; Confidence interval is from HCA staff estimates

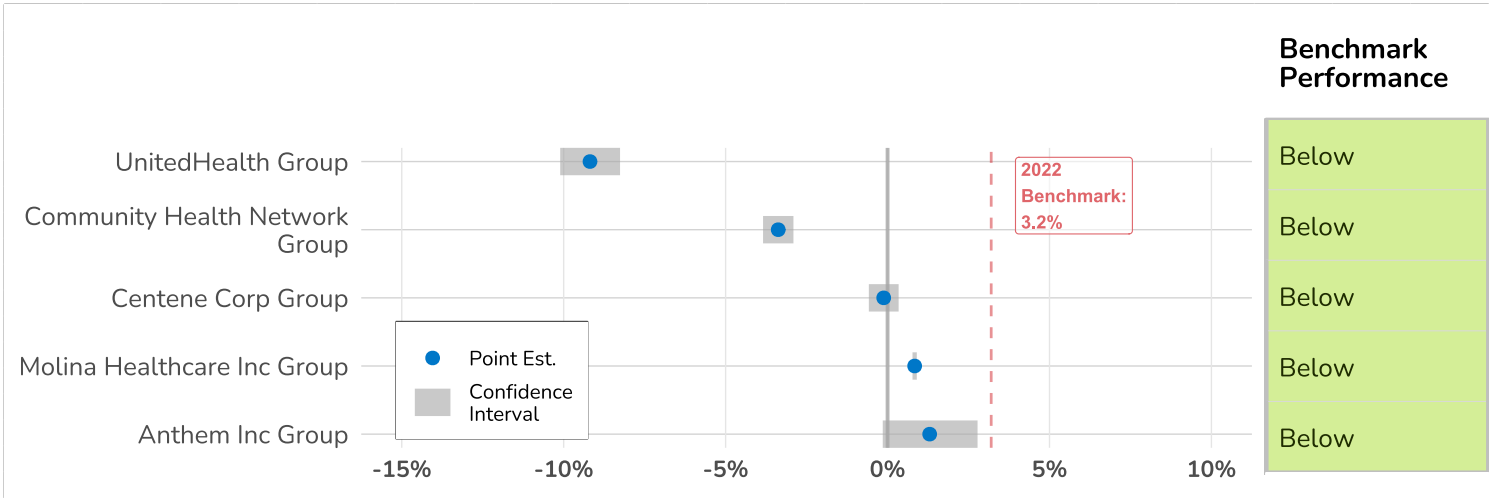
Notes: a/ Only includes large provider organizations that meet 10k covered lives threshold.
b/ TME numbers are truncated and age-sex risk-adjusted. See appendix for link on methods used.

Washington State Health Care Authority

NEW

Carrier performance against benchmark- Medicaid market

2022 Carrier performance against the benchmark in the Medicaid market, measured by the growth rate of Total Medical Expense (TME) Per Member Per Year (PMPY)



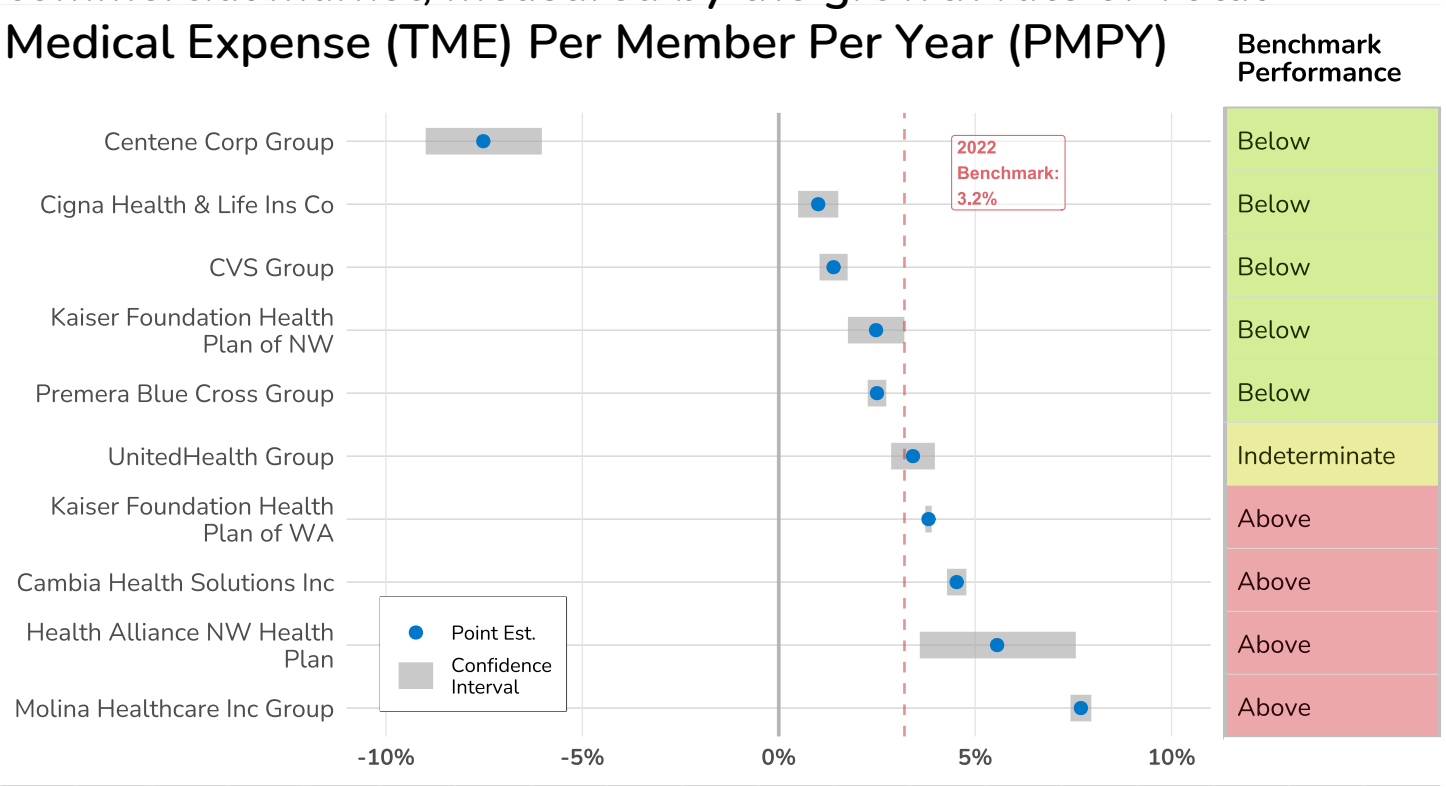
- None of the 5 carriers exceeded benchmark in 2022

Washington State Health Care Authority

NEW

Carrier performance against benchmark-commercial market

2022 Carrier performance against the benchmark in the commercial market, measured by the growth rate of Total Medical Expense (TME) Per Member Per Year (PMPY)



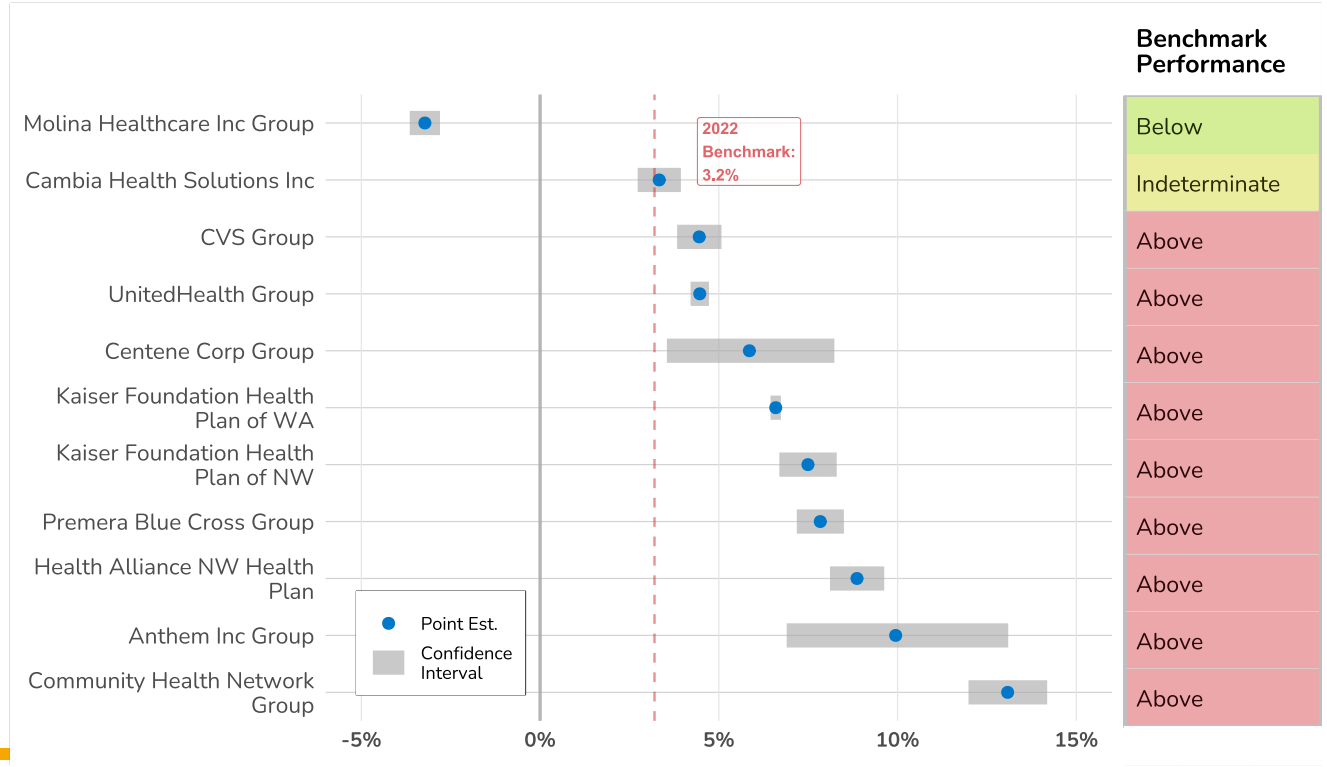
- 4 of 10 carriers exceeded benchmark in 2022

Washington State Health Care Authority

NEW

Carrier performance against benchmark- Medicare Advantage market

2022 Carrier performance against the benchmark in the Medicare Advantage market, measured by the growth rate of Total Medical Expense (TME) Per Member Per Year (PMPY)



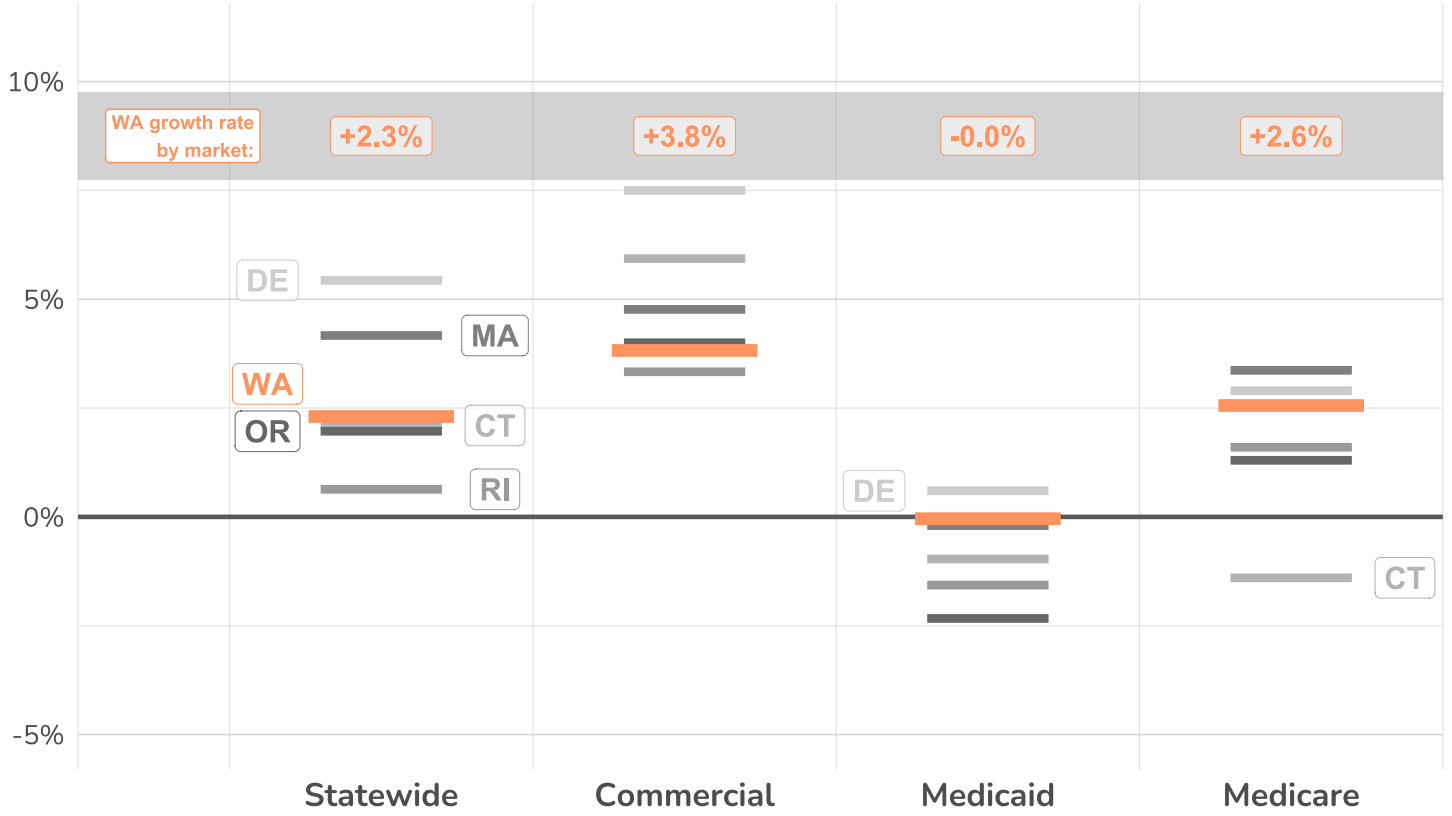
- 9 of 11 carriers exceeded benchmark in 2022

Washington State Health Care Authority

Average growth across states, by market

- Like other states, Commercial market registered the highest growth

Average total medical expense per member per year growth rate, 2019-2022
Washington and five other benchmark states



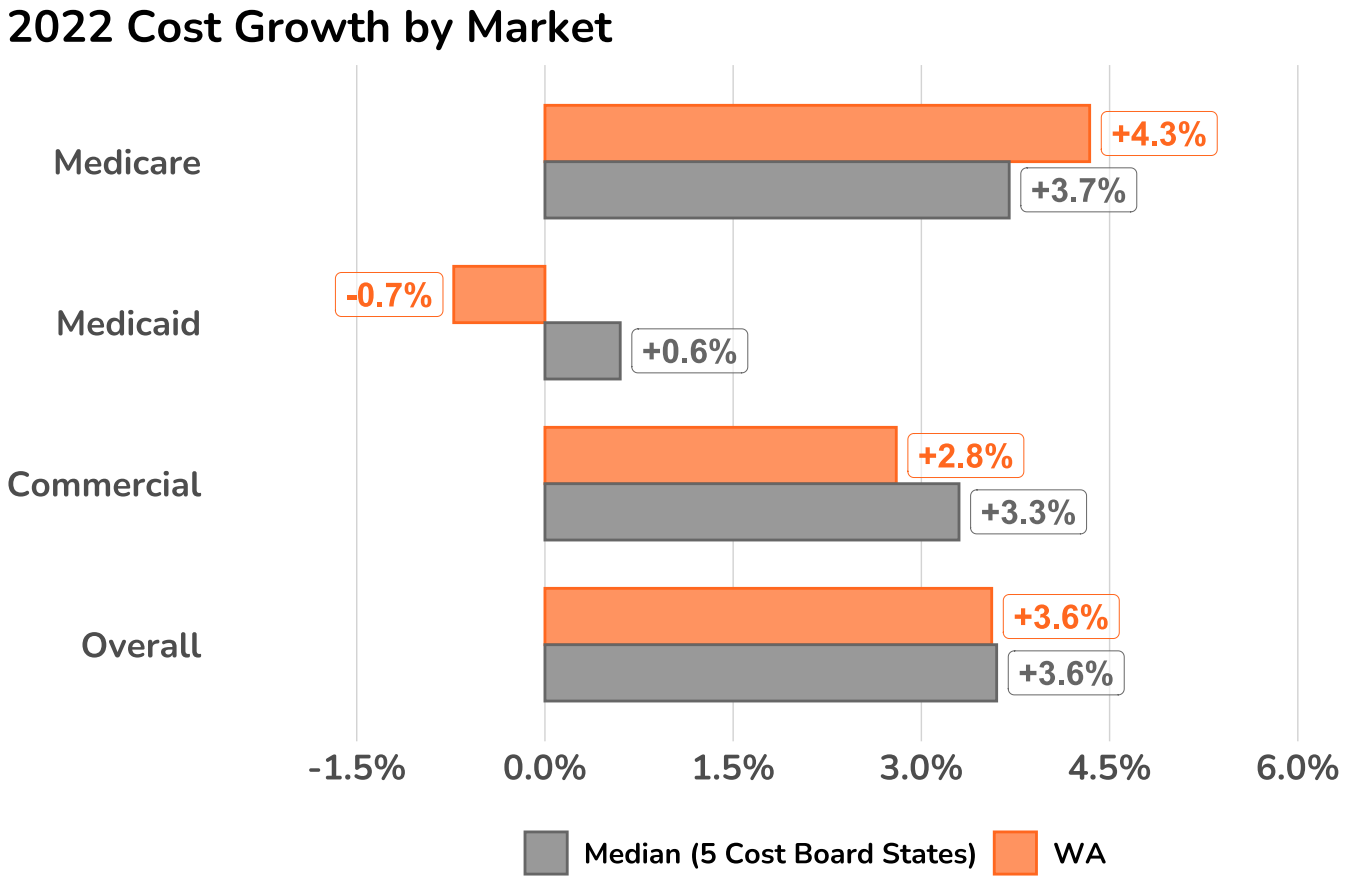
Question 3: How does WA's expenditure growth compare to other states?

Source: WA Health Care Cost Transparency board data calls, Bailit Health analysis from other states' data calls

Washington State Health Care Authority

NEW

Comparing state growth trends (2022)



- WA market spending growth was comparable to the other states with Cost Measurement efforts (CT, DE, MA, OR, RI)

Sources: WA State Health Care Cost Transparency Board Data Calls and Bailit Health for CT, DE, MA, OR, RI data

Washington State Health Care Authority

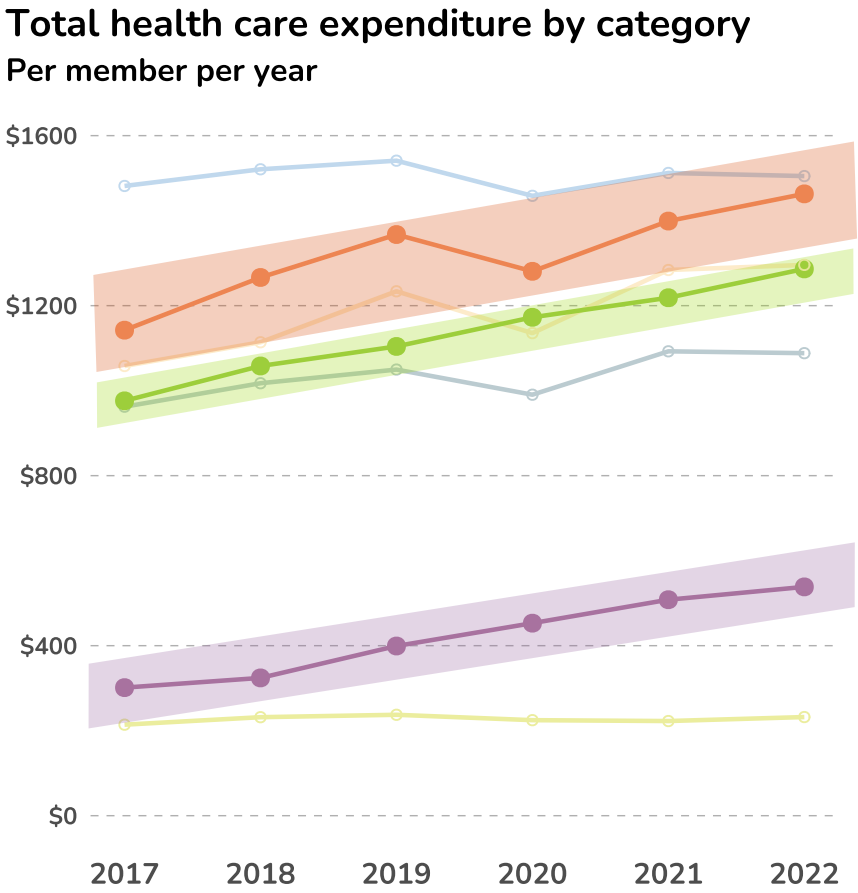
Contribution to overall per-member spend growth, by service category

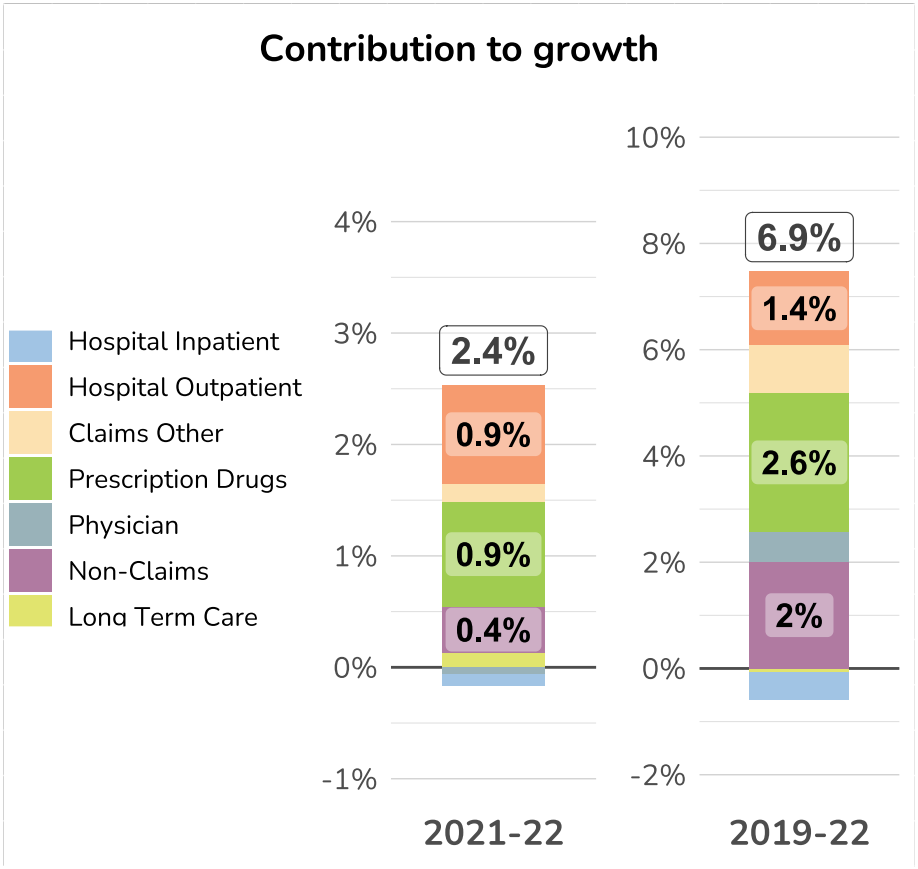
Top cost contributors:

- Prescription drugs
- Non-claims
- Hospital outpatient

Question 4: Non-claims spending

Question 5: Inpatient and outpatient hospital trends





Source: WA Health Care Cost Transparency Board data calls

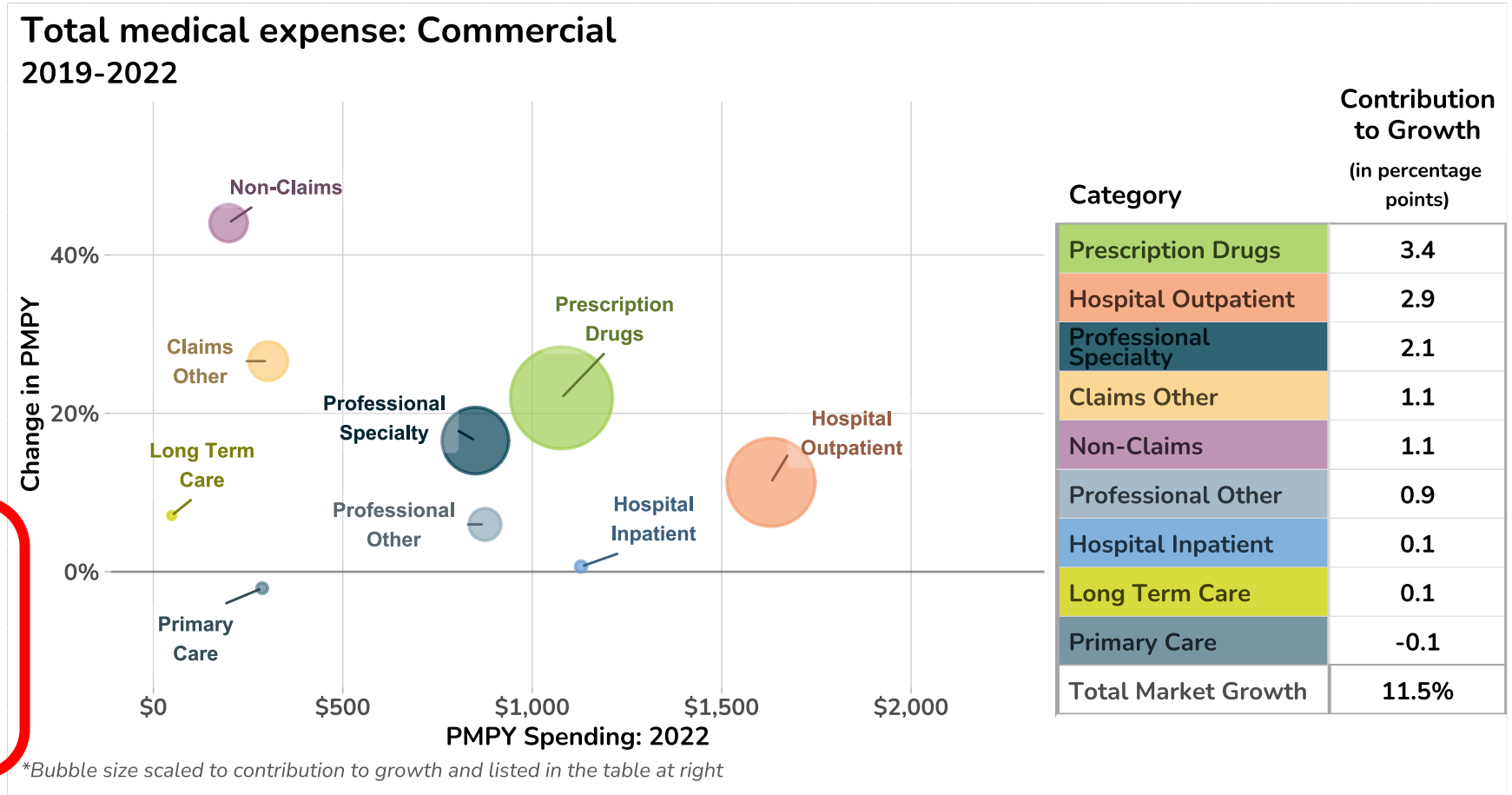
Washington State Health Care Authority

Top contributors to commercial growth

- Prescription drugs
- Hospital outpatient
- Professional specialty

Question 4: Non-claims spending

Question 5: Inpatient and outpatient hospital trends



Category	Contribution to Growth (in percentage points)
Prescription Drugs	3.4
Hospital Outpatient	2.9
Professional Specialty	2.1
Claims Other	1.1
Non-Claims	1.1
Professional Other	0.9
Hospital Inpatient	0.1
Long Term Care	0.1
Primary Care	-0.1
Total Market Growth	11.5%

Source: WA Health Care Cost Transparency Board data calls

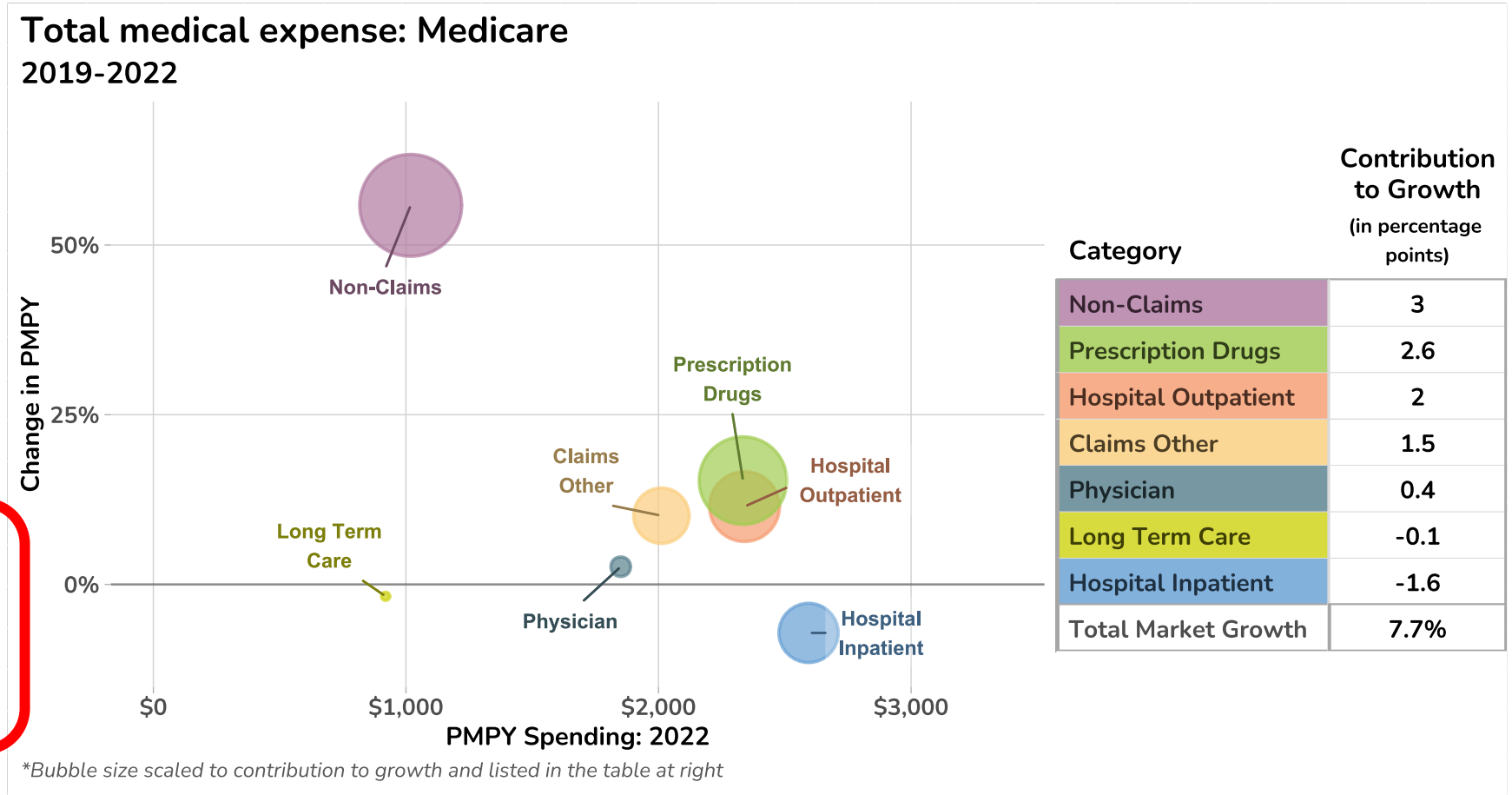
Washington State Health Care Authority

Top contributors to Medicare growth

- Non-claims
- Prescription drugs
- Hospital outpatient

Question 4: Non-claims spending

Question 5: Inpatient and outpatient hospital trends



Category	Contribution to Growth (in percentage points)
Non-Claims	3
Prescription Drugs	2.6
Hospital Outpatient	2
Claims Other	1.5
Physician	0.4
Long Term Care	-0.1
Hospital Inpatient	-1.6
Total Market Growth	7.7%

Source: WA Health Care Cost Transparency Board data calls

Washington State Health Care Authority

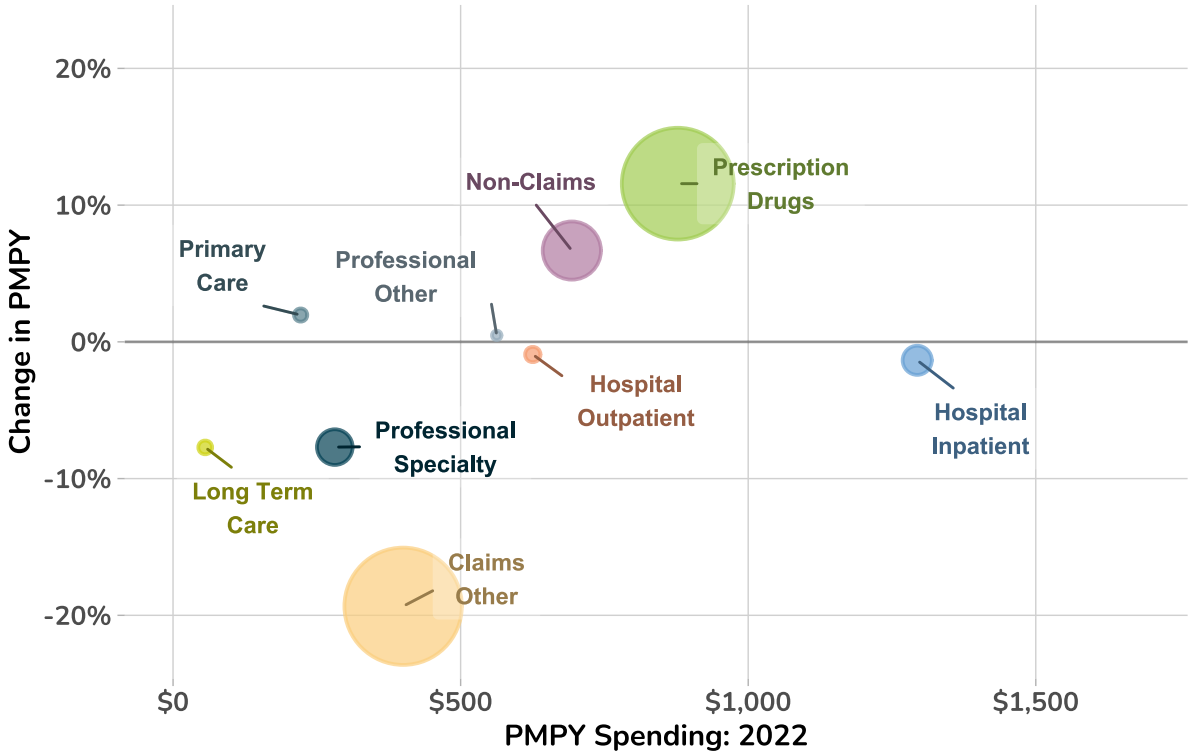
Top contributors to Medicaid growth

- Prescription drugs
- Non-claims

Question 4: Non-claims spending

Question 5: Inpatient and outpatient hospital trends

Total medical expense: Medicaid
2019-2022



*Bubble size scaled to contribution to growth and listed in the table at right

Category	Contribution to Growth (in percentage points)
Prescription Drugs	1.8
Non-Claims	0.9
Primary Care	0.1
Professional Other	0.1
Long Term Care	-0.1
Hospital Outpatient	-0.1
Hospital Inpatient	-0.4
Professional Specialty	-0.5
Claims Other	-1.9
Total Market Growth	-0.1%

Source: WA Health Care Cost Transparency Board data calls

Washington State Health Care Authority

Question 4

What are non-claims expenditures? What non-claims expenditures are driving growth in each market?

NEW

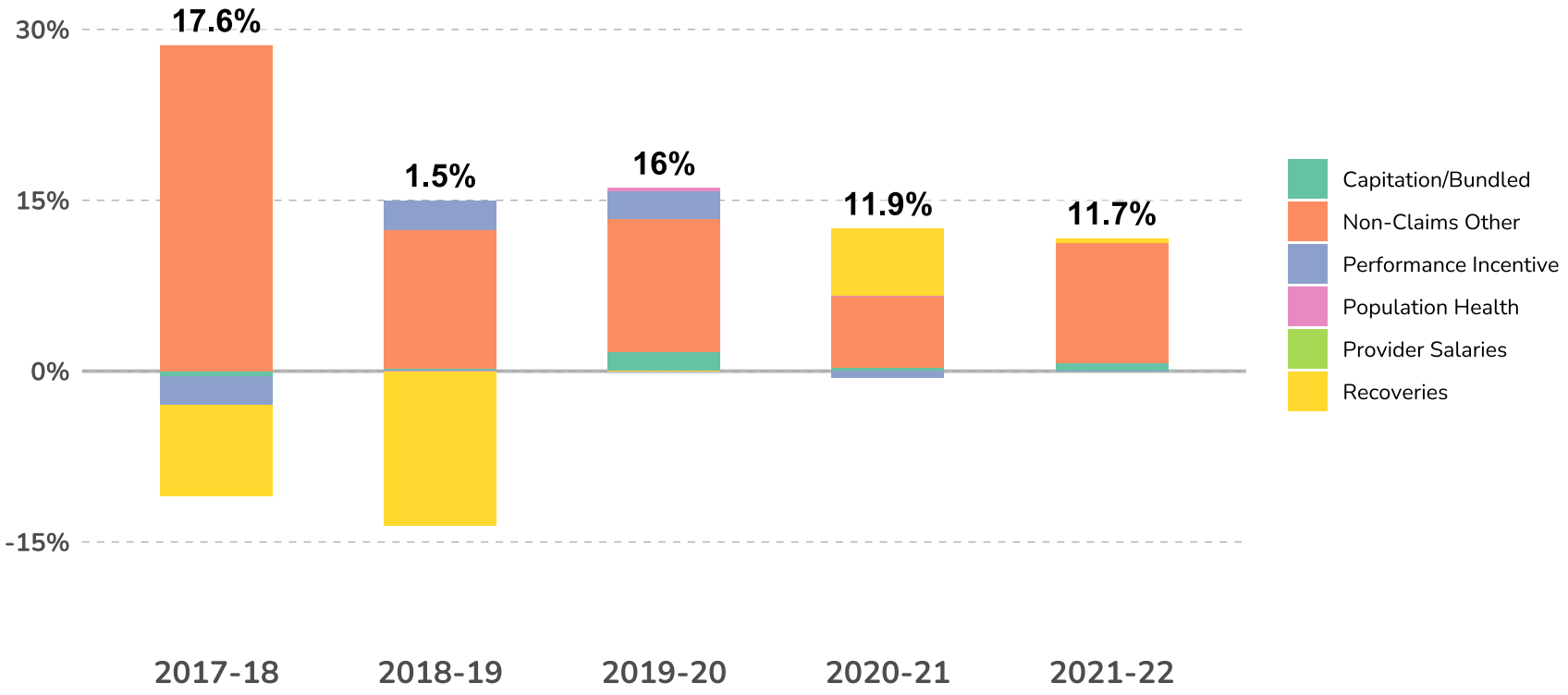
Non-claims spending category

- Definition: Payments that health plans make to provider organizations outside of claims. Examples:
  - Incentives
  - Risk settlements or recoveries
  - Capitation
  - Direct payments (salaries, IT infrastructure, training)
  - Other non-claims-based payments (care coordination fees, population-health payments)

NEW

Commercial non-claims spending

Contribution to Commercial Non-Claims PMPY growth



- Except for 2020 when spending on recoveries significantly contributed to non-claims growth, other non-claims spending has been the top non-claims growth contributor.

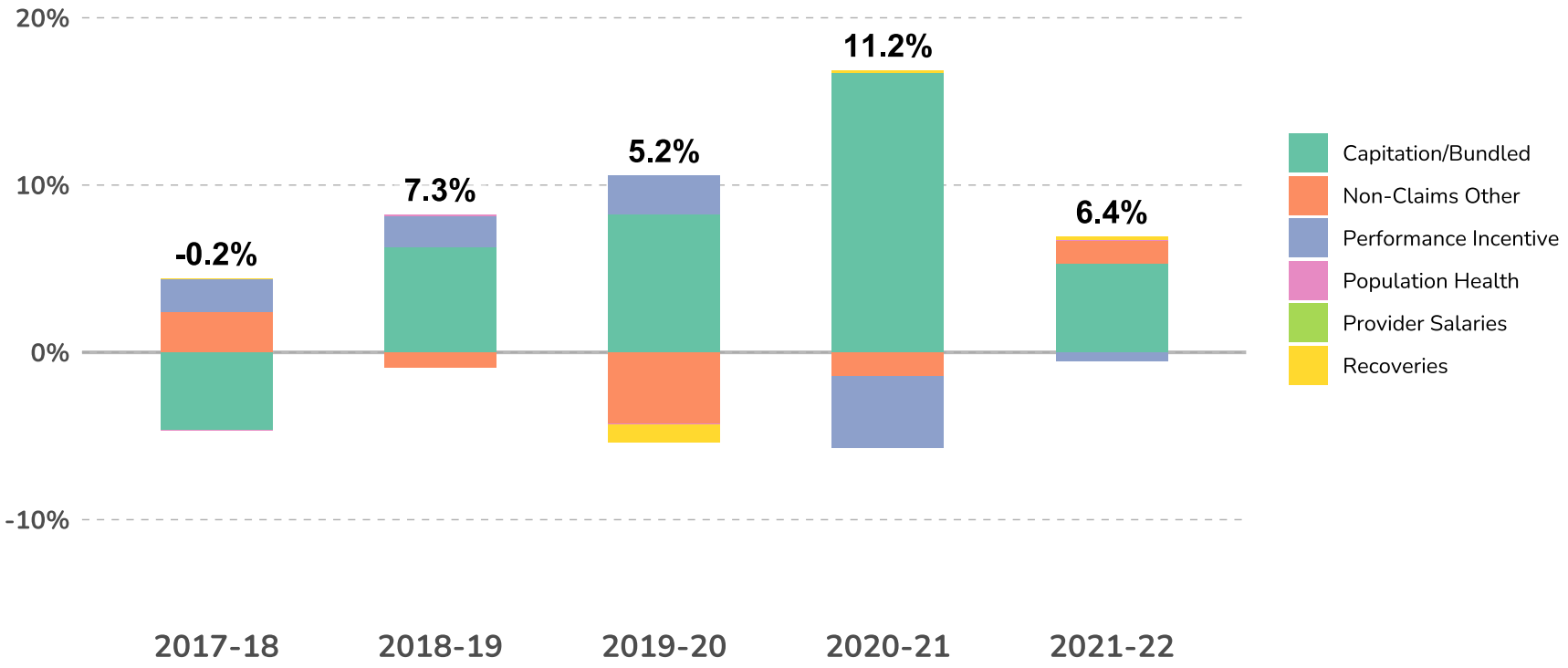
Source: WA Health Care Cost Transparency Board data calls

Washington State Health Care Authority

NEW

Medicare non-claims spending

Contribution to Medicare Non-Claims PMPY growth



Source: WA Health Care Cost Transparency Board data calls

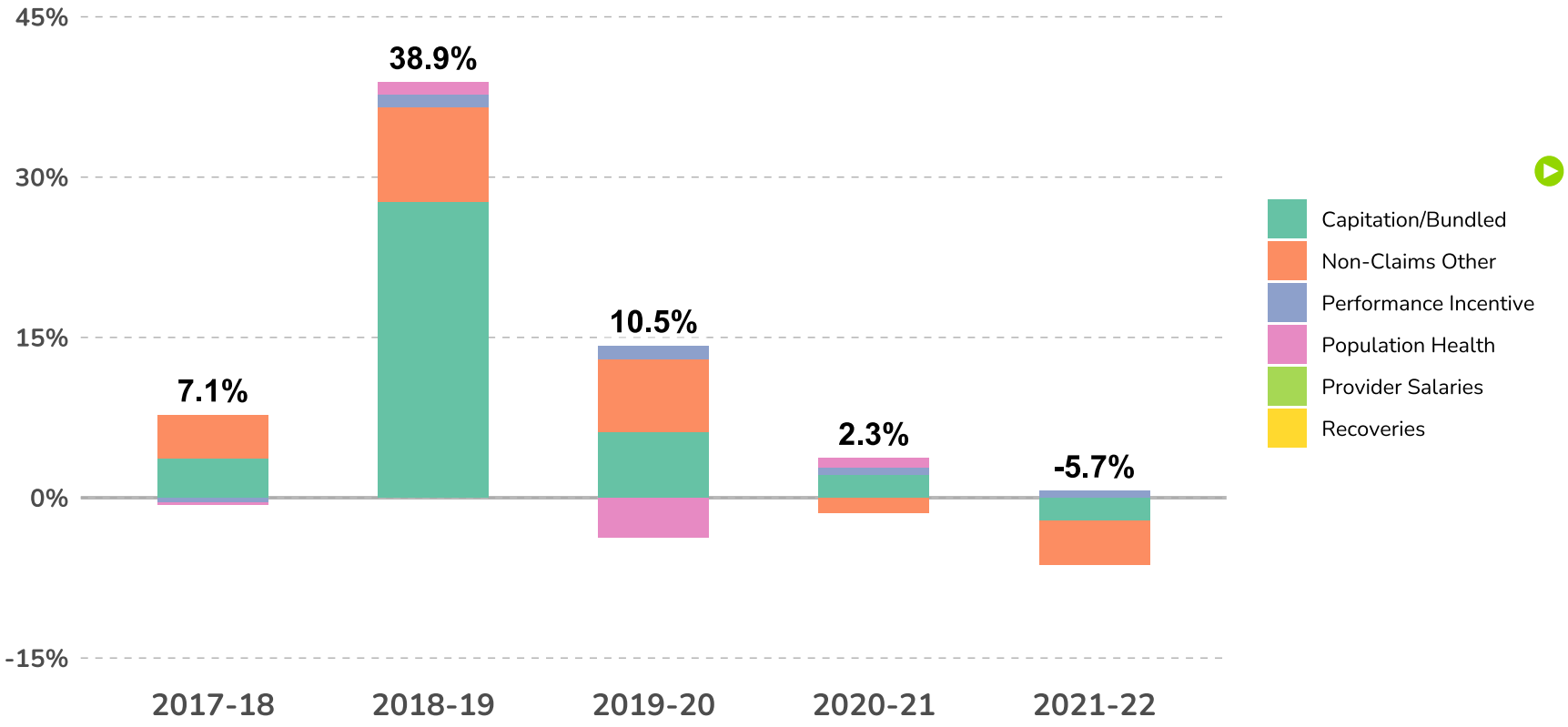
- Non-claims spending had the highest growth among service categories within Medicare (2019-2022).
- Only Medicare Advantage has non-claims spending
- From 2017-2022, MA enrollment grew by 62% while FFS Medicare enrollment declined 5%
- Category reflects medical spending **excluding** non-health supplemental benefits (like fitness memberships, etc.)

Washington State Health Care Authority

NEW

Medicaid non-claims spending

Contribution to Medicaid Non-Claims PMPY growth



Source: WA Health Care Cost Transparency Board data calls

- Non-claims spending in the Medicaid market decelerated during the pandemic.
- The slowdown is driven by slower growth in capitation/ bundled payments and other non-claims

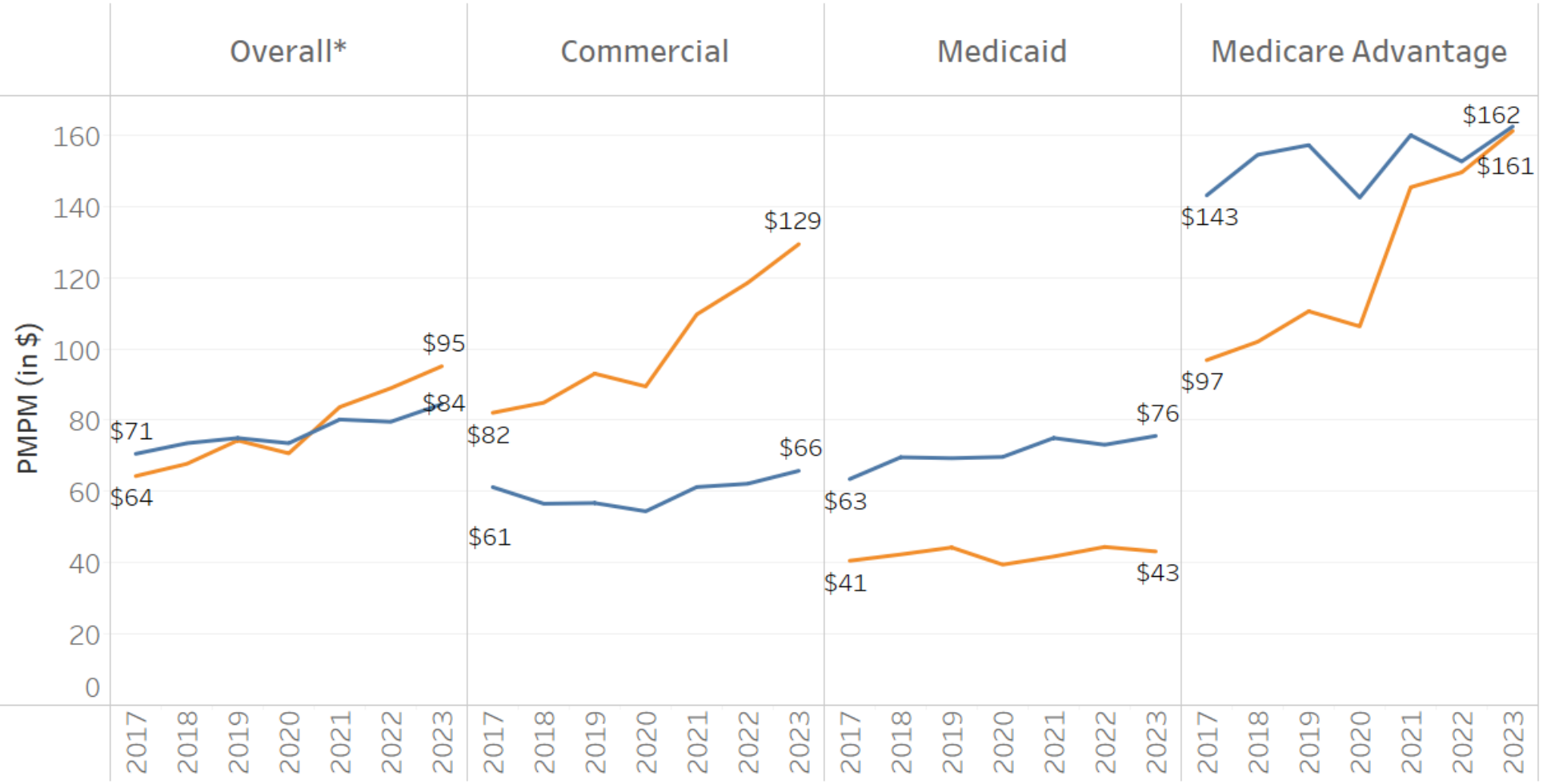
Washington State Health Care Authority

Question 5

Why do the markets have different inpatient and outpatient hospital spending trends?

Inpatient vs. outpatient hospital spending growth by market

NEW



- Overall outpatient spending PMPM has surpassed overall inpatient spending PMPM in 2021.
- Increase in outpatient spending is driven by growth in outpatient spending in Commercial and Medicare Advantage markets.

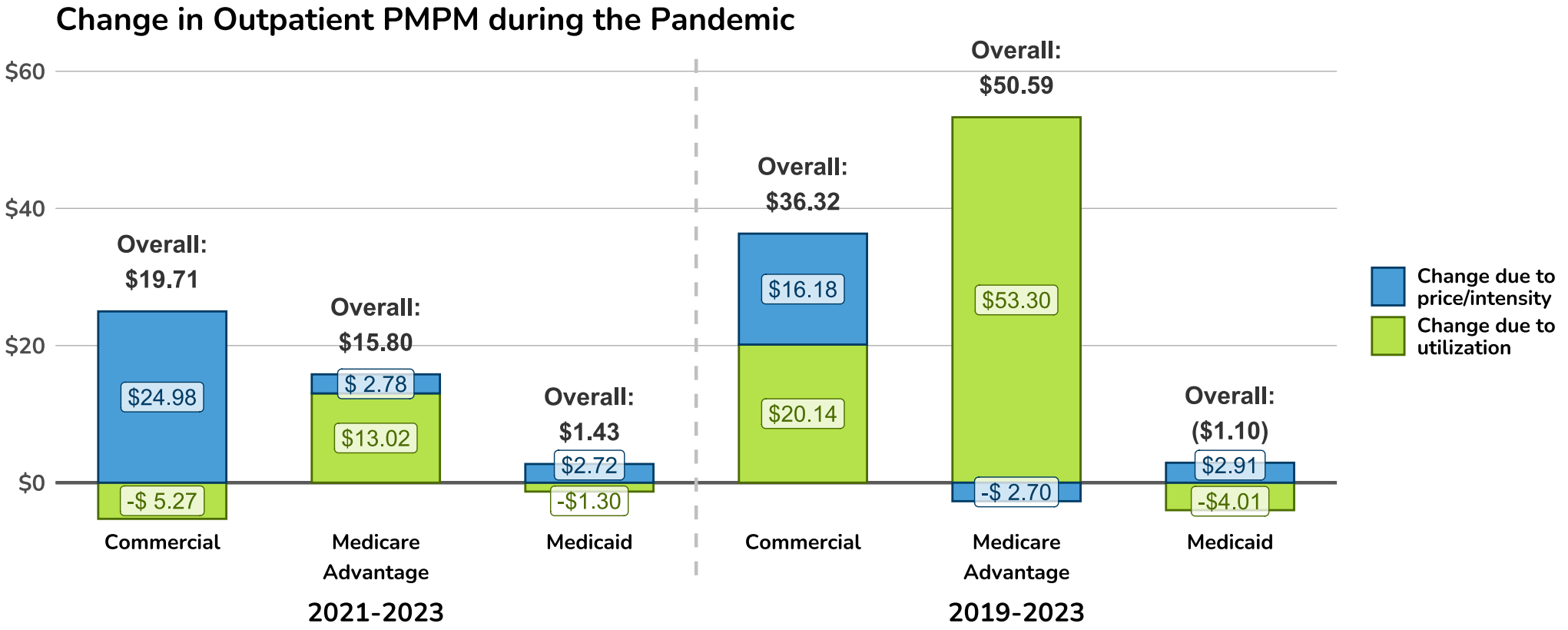
*Excluding Medicare FFS

Source: APCD, OnPoint 2024 Cost Driver Analysis

Washington State Health Care Authority

Inpatient vs Outpatient PMPM growth drivers: utilization or price/intensity?

NEW



Source: HCA staff calculations; APCD, Onpoint 2024 Cost Driver Analysis
Breakdown methodology: The amount attributed to utilization was calculated by looking at what the change in PMPM would have been if the average allowed amount per service had stayed the same and only utilization changed. The remainder of the change in PMPM is assumed to be due to changes in price and/or intensity of services. Since the data source only provides an average allowed amount per service aggregated at service category level, HCA staff are unable to disentangle changes in price (costs increased for the same service) from intensity (members received more intense, and therefore more costly, services).

Important caveat: This assumes that the only factors that impact PMPM are utilization and price/intensity.

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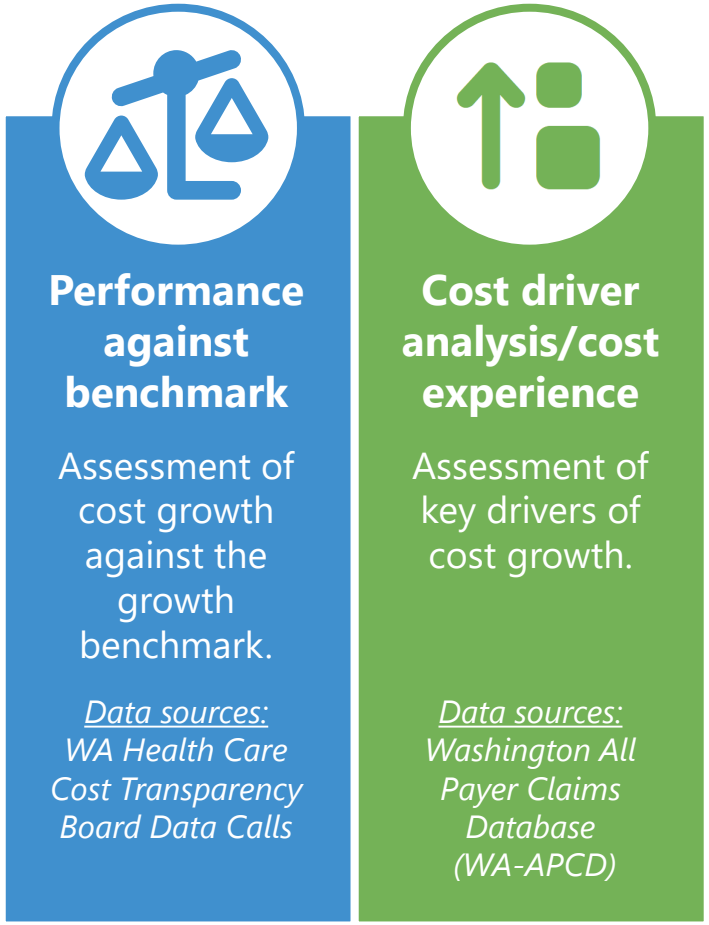
Next steps

Next steps



- The performance against the benchmark analysis helps us understand baseline health care expenditures and categories of state spending growth.
- To identify policies and programs that can help reduce cost growth, we need a deeper **cost driver analysis**.
- We'll dive into this analysis at the March 5 board meeting.

Washington State Health Care Authority

Analyzing health care costs

Components	Performance against benchmark (data call)	Cost Driver Analysis (WA-APCD)
Utilization: Volume of services utilized per capita		X
Service Category: High-level service categories (Inpatient, Outpatient, Rx, etc.)	X	X
Price: Price charged for service (contracted rate or paid amount)		X
Business Practice: Affiliations/Mergers/Acquisitions and other business practices including VBP, pricing strategies, etc.	X	
Disease Burden: Clinical conditions of those who seek care (using Chronic Conditions Warehouse definitions)		X*
Demographics: Core changes in population characteristics (e.g., aging population)		X*
Geographic: Regional or geographic factors		X
Health Equity: Including factors such as Race, Ethnicity, and Rural/Urban		X
Health Policy: Including factors such as supplemental payments, etc.	X	

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* Data elements available to perform analyses

Data sources — technical notes

Characteristic of data source	Performance against Benchmark (Data Call)	Cost Driver Analysis (WA-APCD)
Data completeness: Health care expenditure from all sources	X	
Aggregated: Summarized information in data source	X	
Detailed: Claims-level information detail in data source		X
High Level: Overall indicator of state cost growth performance	X	
Deep-dive: Allows for more specificity and insights		X
Non-Claims: Includes non-claims payments, including incentives, direct payments	X	
Self-insured data: Submission from self-insured health carriers. *Note: self-insured carriers' submissions are voluntary to the APCD.	X	

Announcing a new APCD dashboard

Washington State Health Care Authority

Feedback request

Potential Stakeholder Advisory Committee assignment

- Review attribution method in the benchmark performance analysis
  - Assess best practices from other states
  - Advise if the attribution approach provides actionable insights about provider and carrier expenditure growth
  - Recommend process steps that Cost Board and staff should take to engage providers and carriers
  - By fall 2025, recommend potential revisions to attribution method, in concert with data advisory committee as appropriate
- Invite providers/carriers that were below benchmark to share reflections on their performance

Discussion

Questions?

Contact:

- HCACostBoardData@hca.wa.gov (for data-related questions)
- HCAHCCTBoard@hca.wa.gov (for all other questions)

Appendix

Appendix: acronym definitions

- **Centers for Medicare & Medicaid Services (CMS)**
- **Fee-for-service (FFS)**
- **Net cost of private health insurance (NCPHI):** Measures the costs to Washington residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred, and consists of carriers' costs of paying bills, advertising, sales commission and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of total health care expenditures at the state level.
- **Office of the Insurance Commissioner (OIC)**
- **Per-member per-year (PMPY):** Total spending in a year divided by the total number of members for that year.
- **Total health care expenditures (THCE):** The total medical expense incurred by Washington residents for all health care services for all payers reporting to HCA, plus the carriers' NCPHI.
- **Total medical expense (TME):** The sum of the allowed number of total claims and total non-claims spending paid to providers incurred by Washington residents for all health care services. TME is reported at multiple levels: State, market, payer, and large provider entity level.

Appendix: acronym definitions, continued

- **U.S. Department of Veterans Affairs (VA):** VA medical spending is published by the Veterans Health Administration National Center for Analysis and Statistics. This spending includes expenditures for medical services, medical administration, facility maintenance, educational support, research support, and other overhead items.
- **University of Washington's Institute for Health Metrics and Evaluation (UW IHME)**
- **Washington State Health Care Authority (HCA)**
- **Washington State Department of Corrections (DOC):** DOC submits medically necessary health and mental health care spending given to incarcerated individuals in its facilities through the Washington DOC Health Plan.
- **Washington State Department of Labor and Industries (L&I):** L&I submits medical claims spending spent on worker's compensation benefits.
- **Washington State All Payer Claims Database (WA-APCD)**

Appendix: service category definitions

- **Hospital outpatient:** Includes all hospital types and payments made for hospital-licensed satellite clinics, emergency room services not resulting in admittance, and observation services.
- **Hospital inpatient:** Includes all room and board and ancillary payments for all hospital types and payments for emergency room services when the member is admitted to the hospital.
- **Retail prescription:** Includes claims paid to retail pharmacies for prescription drugs, biological products, or vaccines.
- **Non-claims:** Includes incentives, capitation, risk settlements, direct payments, or other non-claims-based payments.
- **Claims other:** Includes durable medical equipment, freestanding diagnostic facility services, hearing aid services, and optical services.
- **Long-term care:** Includes skilled nursing facility services, home health service, custodial nursing facility services, and home- and community-based services including personal care.

Appendix: service category definitions, continued

- **Professional, other providers:** Includes but is not limited to licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors, and any fees that do not fit other categories, including facilities fees of community health center services and freestanding ambulatory surgical center services.
- **Professional, specialty providers:** Includes services provided by a doctor of medicine or osteopathy in clinical areas other than family practice, geriatrics, internal medicine, and pediatrics.
- **Professional, primary care:** Includes care management; care planning; counseling; domiciliary, rest home, or custodial care; FQHC visits; health risk and screenings; home health services; immunization administrations; and office visits and preventive medicine visits. Determined by taxonomy and/or services types.
- **Note:** Due to Medicare fee-for-service (FFS) reporting capability, grouping of physicians along with Cost Board categories Primary Care & Specialty Professional.

Appendix: notes on data

- The following are excluded in the data:
  - Policies offering limited benefits, such as accident, disability, Medicare supplemental insurance, vision or dental stand-alone policies
  - Health care paid through charity care or by customer cast payment
  - Certain non-claims publicly funded behavioral health services
  - Anthem 2017 data
  - Humana 2017 data
  - Humana Medicare data
  - Custodial nursing facility services, home- and community-based services, and intermediate care facilities and services for person with developmental disabilities paid by Washington State Department of Social and Health Services (DSHS). This includes DSHS's Aging and Long-Term Support Administration (ALTSA) spending.

Appendix: notes on data, continued

- Prescription drug rebates
  - Statewide and market analyses are net of pharmacy rebates. These rebates include both medical and prescription drug rebates and are netted out of the prescription drug category. While medical rebates are related to hospital spending, accurately separating those from other pharmacy rebates is often difficult.
  - Carrier/provider level reporting is gross of pharmacy rebates.
- FFS data
  - Statewide and market analyses include Medicare and Medicaid FFS data while carrier and large provider reporting excludes Medicare and Medicaid FFS data.

Appendix: notes on data, continued

- There were revisions for 2017–2019 data due to data resubmissions from few carriers and revisions of NCPHI data.
- Member months data from DOC includes prison population and Rent-a-bed program population. The latter is limited to members with claims as existing data systems make it challenging to get information on those without claims.
- Federal Employee Health Benefit Plan (FEP) that have benefits split between two carriers are included only in the statewide and Commercial market spending. Split FEP was removed from provider/carrier benchmarking.
- L&I member months are estimates and rounded off at the 100,000th level.
- Methodologies (i.e., risk adjustment, standard deviation pooling, and confidence interval calculation) used in large provider organization and carrier reporting are documented in:
  - Attribution (pages A3-A4 of the Cost Board's data call technical manual)
  - Truncation (pages A11-A15 of the Cost Board's data call technical manual)
  - Cost growth calculations - demographic risk adjustment, pooled variance, and confidence interval (provider organizations)
  - Cost growth calculations - demographic risk adjustment, pooled variance, and confidence interval (carriers)

Health care spending growth in Washington, 2019–2022

Results from the Health Care Cost Transparency Board's 2024 data call

Acknowledgements:

The Health Care Authority (HCA) expresses its gratitude to the Centers for Medicare and Medicaid Services, the Washington State Department of Social and Health Services, Department of Health, Department of Corrections, and the Office of the Insurance Commissioner for submitting data for this report.

The Health Care Cost Transparency Board also thanks the insurance carriers and health care providers for their cooperation and collaboration on this initiative.

The Board thanks the Peterson-Milbank Program for Sustainable Health Care Costs for grant funding, staff support and technical support. The Board thanks the Health Care Stakeholder Advisory Committee, the Advisory Committee on Data Issues, and the Advisory Committee on Primary Care, for their guidance and expertise. The Board also thanks Sue Birch, outgoing HCA Director and Cost Board Chair, for her leadership.

Acronym glossary

CMS	**Centers for Medicare and Medicaid Services** The federal agency that provides health coverage to more than 160 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.
DOC	**Department of Corrections** Washington State DOC manages all state-operated adult prisons and supervises individuals who live in the community and are under DOC supervision.
DSS	**Department of Social and Health Services** The DSHS manages the administration of aging and long-term care, behavioral health, development disabilities, vocational rehabilitation, Medicaid pathways based on age and disability, and other public benefits in partnership with federal government agencies.
FFS	**Fee-for-service** A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.
HCA	**Washington State Health Care Authority** HCA administers a wide range of programs and initiatives, working to ensure Washington residents have access to better health, better care, and lower costs.
L&I	**Department of Labor and Industries** L&I is the administrator of Washington's workers' compensation system. They are similar to a large insurance company, providing medical and limited wage-replacement coverage to workers who suffer job-related injuries and illness.
MCO	**Managed care organization** An entity contracted by a state Medicaid agency that accepts a set per member per month (capitation) payment for health care services.
NCPHI	**Net cost of private health insurance** The difference between total premiums collected from enrollees and payments made to providers for health care delivered.
PGSP	**Potential gross state product** An estimate of the total economic value of goods produced and services provided if growth were steady and inflation stable.
THCE	**Total health care expenditures** The amount spent on health care and related activities such as private and public health insurance, government agency-provided health care, and public health activities.
TME	**Total medical expenses** The amount paid to providers for the delivery of health care services to the member population, including patient out-of-pocket costs and non-claims payments.
VHA	**Veterans Health Administration** The largest integrated health care system in America, providing health care services for military veterans, with facilities throughout the country.

Executive Summary

In response to rising health care costs, Washington State's Legislature established the Health Care Cost Transparency Board (Cost Board) in 2020. As part of their efforts, the Cost Board set an annual statewide health care cost growth benchmark. The benchmark serves as a common goal for spending growth that carriers and providers should aim to stay below to make health care more affordable for consumers. To assess performance against the benchmark, the Cost Board measures annual spending growth against each targeted benchmark year. The Cost Board set the 2022 annual cost growth benchmark – — the first growth benchmark — at 3.2%.

In 2022, the Cost Board collected total health care spending data for 2017–2019 from the largest health insurance carriers doing business in Washington State. The purpose of gathering this data was to establish a baseline for spending growth. Earlier this year, the Cost Board launched the 2024 data call and collected data for 2020–2022. Cost Board staff presented key findings at the **December 12, 2024 Health Care Cost Transparency Board Public Hearing**, and are further discussed in this report.

Using these data, the Cost Board is able to monitors overall cost growth performance against the first annual benchmark. These data also inform the Cost Board on health care cost increases by the state's largest carriers and provider organizations.

Findings

A. Comparing 2022 cost growth performance against the benchmark

According to the data, **statewide or overall per-member spending exceeded the benchmark**. The per-member total health care expenditure (THCE) grew year over year by 3.6% in 2022, exceeding the 3.2% percent growth benchmark. Although the actual growth exceeded the benchmark, 2022 growth is the slowest since 2018 (excluding 2020 during of the COVID-19 pandemic).

Other findings from 2021–2022 include:

- The Medicare market's growth of 4.3% exceeded the 3.2% benchmark.
- Five out of 12 carriers exceeded the benchmark. Marketwise, nine of the 11 carriers operating in the Medicare market exceeded the benchmark while four out of the 10 carriers exceeded the benchmark in the commercial market. None of the five carriers offering coverage in the Medicaid market exceeded the benchmark.
- Five out of the 28 large provider organizations exceeded the benchmark.

B. Analysis of cost growth during the pandemic (2019–2022)

To better understand the pandemic-related drop in health care utilization in 2020 and substantial recovery in 2021, the report also compares 2022 spending to pre-pandemic levels. Findings include:

- Per-member THCE in 2022 was 7.9% higher than in 2019. Faster growth in the commercial, Medicare, and Veterans Affairs markets propelled spending.
- The top contributors to spending growth were:
    - Prescription drug spending in Medicare and commercial markets.
    - Non-claims spending (specifically capitation/bundled payments) in the Medicare market.
    - Hospital outpatient spending in the Medicare and commercial markets.
- Per capita Medicaid spending decreased from 2019–2022 due to a decline in Other Claims (e.g., durable medical equipment, freestanding diagnostic facility services) that more than offset an uptick in prescription drug spending.
- Compared to 2017, per member spending statewide is higher by 21.8% in 2022.

This benchmark report is organized into four sections. The first section covers the introduction which provides background on the work of the Cost Board, including the work on the cost growth benchmark and performance against the benchmark (the focus of this report). The rest of the sections present the analysis of the spending data collected by the Cost Board. The second section analyzes the overall spending in 2022 relative to previous years. The third section compares year-over-year per member spending growth rate, in 2022 against the benchmark. The last section looks at per member spending growth in 2022 relative to pre-pandemic levels.

Introduction

Background

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.

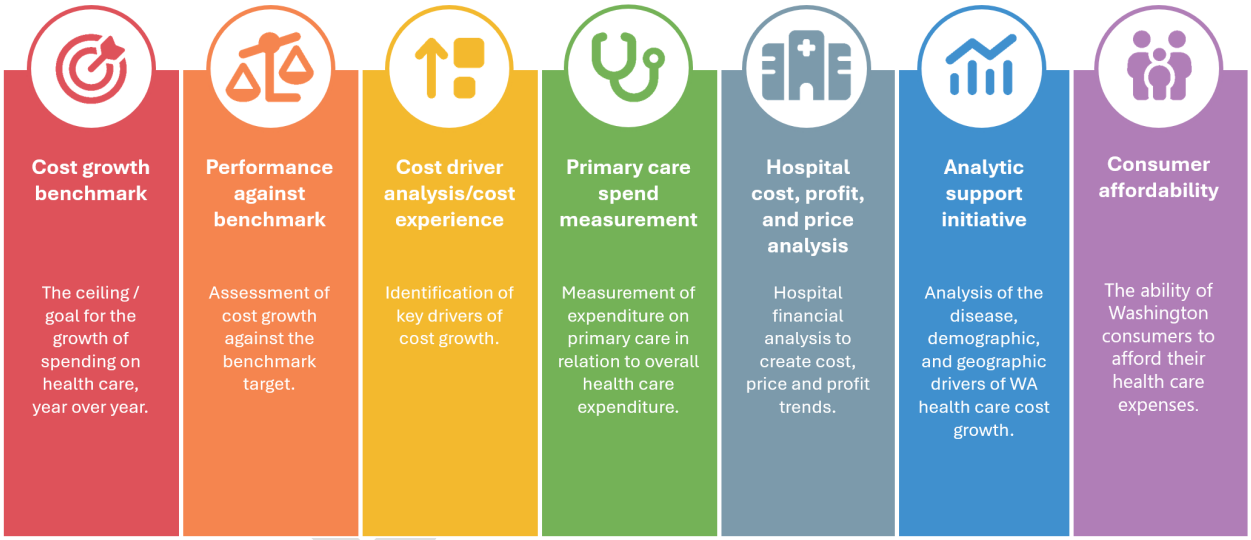
The Cost Board strives to achieve this goal by:

- 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.

In 2024, the Cost Board made strides across data analysis efforts (Figure 1) in partnership with numerous stakeholders, and is summarized in the **Annual Report to the Legislature** . Meanwhile, the following report focuses specifically on performance against the benchmark.

The Cost Board is releasing this benchmark performance report, which presents health care expenditure trends from 2017–2022 with a focus on assessing performance for 2022 and trends during the pandemic period (2019–2022). This follows the **brief released in 2024**, which presented analysis on health care spending data in the period 2017–2019.

Figure 1: The data streams of the Cost Board



Health care spending growth benchmark

In September 2021, the Cost Board approved Washington's spending growth benchmark from 2022–2026 (Table 1). The benchmark is a specific rate that the expenditure performance of carriers and providers will be measured against, beginning in 2022. In establishing the benchmark, the Cost Board reviewed how other states created their benchmarks and considered many different factors that might influence their choice of benchmark. To derive the cost growth benchmark, the Cost Board adopted a methodology that uses a 70/30 weighting of the growth rates of historical nominal median wage and nominal per capita potential gross state product (PGSP). The goal is to encourage health care industry players to achieve a health care spending growth at the same or slower rate as the growth of income. A slower cost growth helps ensure affordability of health care.

Table 1: Spending growth benchmark for Washington State

Year	Target
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Starting with 2022 data, the Cost Board compares the spending growth benchmark is compared against actual health care cost per member per year (PMPY) growth rate (performance) at the following levels of aggregation: statewide, by market (i.e., commercial, Medicare, Medicaid), by carrier, and by large provider organization. Performance in these groups is specifically measured by the metrics in Table 2.

Table 2: Performance indicators by aggregation levels

Aggregation level:	Performance is based on:
Statewide	Total health care expenditure (THCE) PMPY growth rate
Markets	Total medical expenditure (TME) PMPY growth rate
Carriers	Confidence interval of age-sex risk-adjusted truncated TME PMPY growth rate
Large Provider Organizations	Confidence interval of age-sex risk-adjusted truncated TME PMPY growth rate

Appendix A explains the data sources and the formulas for calculating the various performance indicators. In a nutshell, data was collected from carriers (insurers) at the parent company level and from other entities that have health care spending in Washington (CMS, HCA, L&I, DOC, Veteran's Affairs). It is important to note that since non-carrier data is not broken down by large provider entities and by carriers, carrier and large provider organization performance is based on carrier data alone. Since data by large provider organizations come from carrier data, carriers must attribute members to large provider organizations. Moreover, to ensure that a few high-cost clients do not impact carrier and large provider organization performance is not impacted by a few high-cost clients, the Cost Board calculates performance is calculated based on truncated and age-sex risk-adjusted spending numbers. Based on these adjusted numbers, a confidence interval of the spending growth rate is calculated and compared to the benchmark. Appendix A provides links to detailed discussion on attribution and the methodologies used to measure carrier and large provider organization performance.

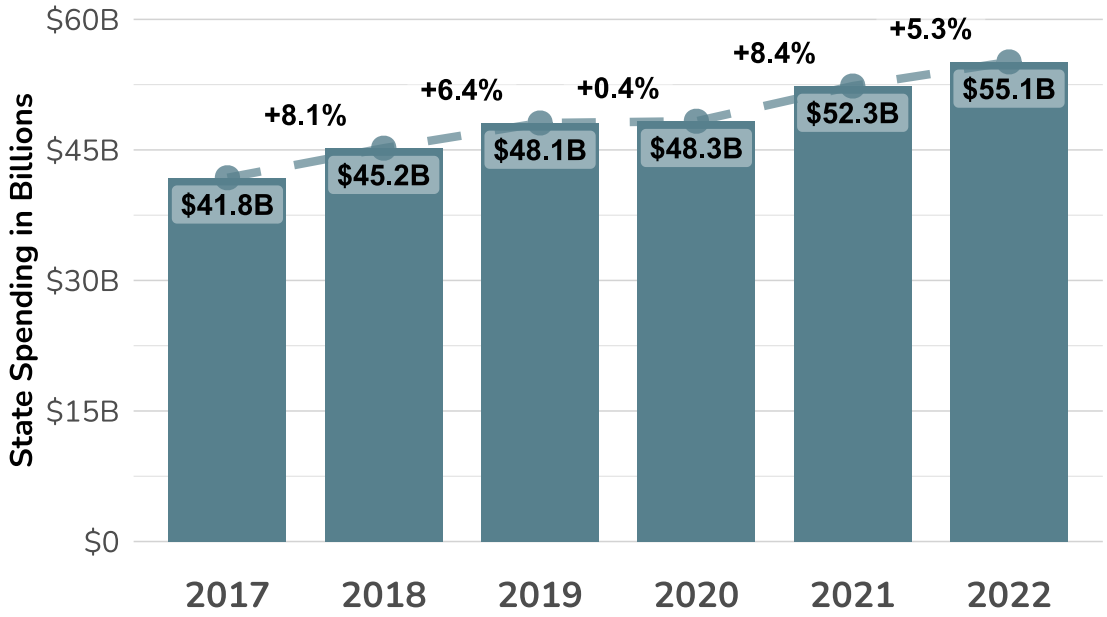
Overall spending

This section provides an analysis of health care spending trends in Washington state. The analysis covers total health care expenditures (THCE), segmented by markets, carriers, and large provider organizations.

Total health care expenditures

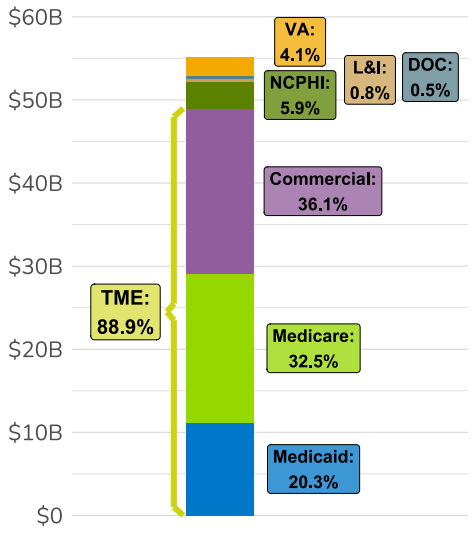
Total health care expenditures (THCE) in Washington State grew by 5.3% ($2.8B), reaching $55.1 billion in 2022 (Figure 2). Except for the pandemic year of 2020, the annual growth rate of total spending has exceeded 5% every year.

Figure 2: Growth in total health care expenditure (THCE)



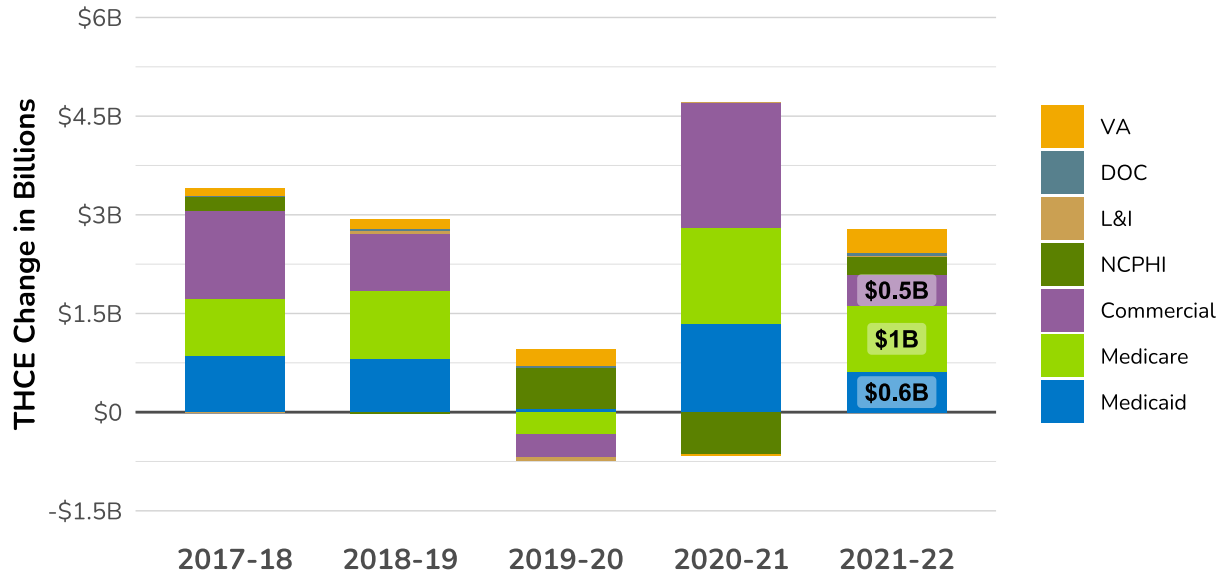
THCE is composed of seven components, shown in Figure 3 and detailed in Appendix A. Of the $55.1 billion, 88.9% is comprised of the total medical expense (TME), or the total sum of claims and non-claims paid to providers in Washington in the commercial, Medicare and Medicaid markets (Figure 3). The other 11.1% of THCE includes the net cost of private health insurance (NCPHI), and the administration of state health services such the Department of Corrections, the Department of Veterans Affairs, and the Department of Labor and Industries.

Figure 3: Proportions of THCE by component in 2022



The $2.7 billion increase in 2022 is largely driven by the increase in the Medicare market, followed by Medicaid and commercial (Figure 4). While the increase in commercial spending is more muted compared to other markets in 2022, it follows a marked increase in 2021 that more than offsets the decrease in 2020. Previous non-pandemic years show similar patterns, with spending in commercial and Medicare interchangeably driving the bulk of the spending increases.

Figure 4: Change in THCE by component, year over year



Comparing 2022 performance against the benchmark

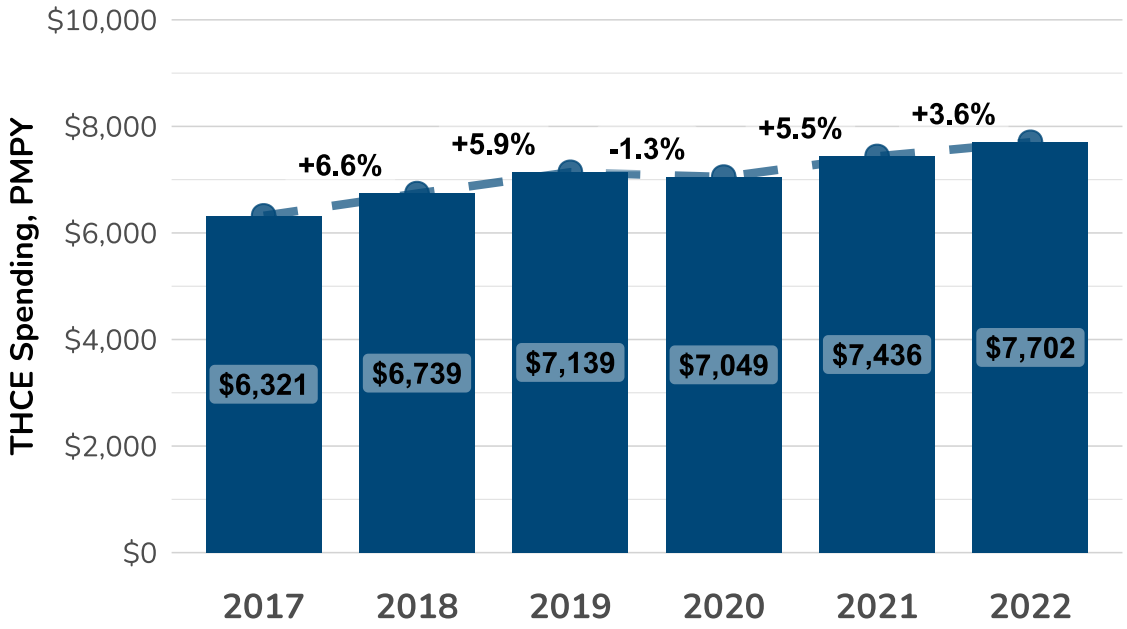
This section compares statewide, market, carrier and large provider organization 2022 performance against the benchmark. Additionally, there is a performance comparison against states with cost measurement efforts that employ similar cost containment strategies.

Statewide performance

As mentioned in Table 2, statewide performance is measured by the growth rate in THCE per member per year (PMPY). Statewide cost growth exceeded the cost growth benchmark of 3.2% with year-over-year THCE PMPY growth registering 3.6% in 2022. Excluding 2020, the growth seen in 2022 is the slowest since 2018. THCE PMPY grew on average by 6.3% per year before the pandemic (2018, 2019) before decreasing by 1.3% in 2020 (Figure 5).

As of 2022, THCE PMPY reached $7,841, roughly 22.2% of the 2022 annual income of a minimum wage worker in Washington State.[1]

Figure 5: Total health care expenditure, per member per year

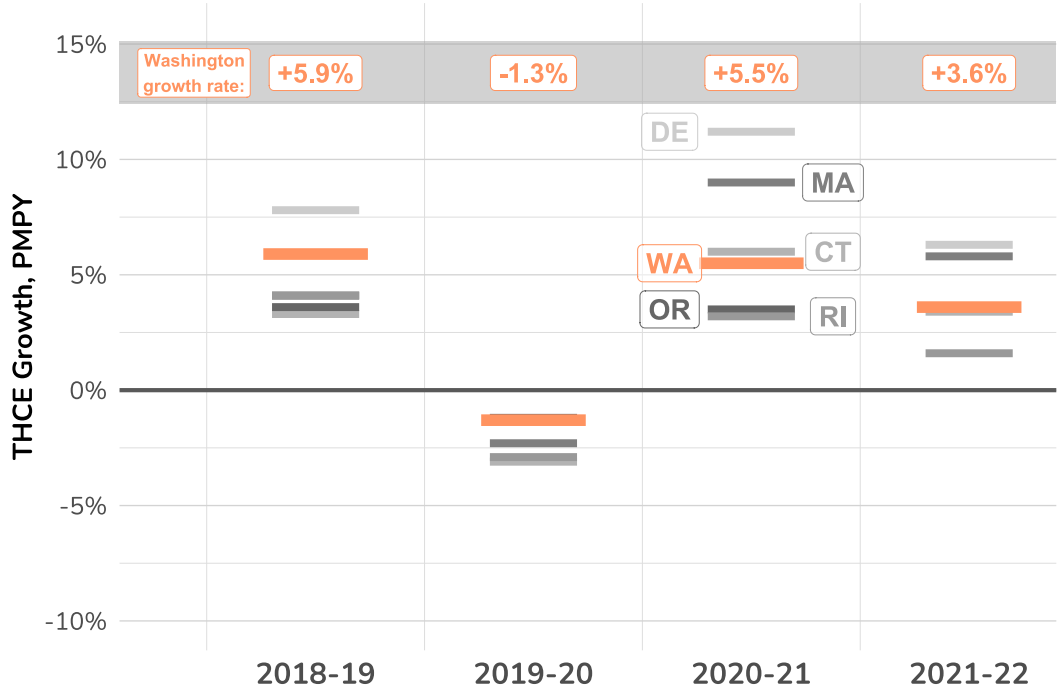


Washington's statewide performance relative to other states'

Washington State's 2022 THCE PMPY growth is comparable to the median PMPY growth rate of most states with similar cost transparency programs (Figure 6), following a broad trend of a drop in THCE PMPY in the 2020 pandemic year, followed by precipitous growth in 2021 before a leveling off of spending in 2022.

[1] Assuming 260 working days in a calendar year at 8 hours per day at the 2025 minimum wage of $16.66. **Read more from Department of Labor and Industries**.

Figure 6: Growth in THCE PMPY compared to five other benchmark states

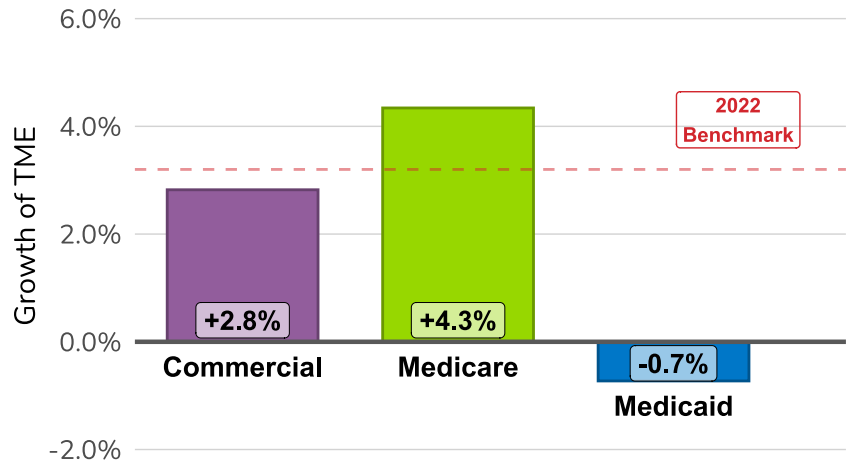


Source: WA Health Care Cost Transparency Board Data Calls, Bailit Health Analysis from Other States' Data Calls

Market performance

To assess market performance against the benchmark, each market's total medical expenditure (TME) per member per year (PMPY) growth is compared to the benchmark. TME PMPY in the Medicare market grew by 4.3%, exceeding the 3.2% benchmark in 2022 (Figure 7). The TME PMPY in the commercial market grew at a slower pace of 2.8% while that of the Medicaid market declined by 0.7 % in 2022. The performance of both commercial and the Medicaid markets did not exceed the benchmark.

Figure 7: Total medical expense growth in 2022, PMPY

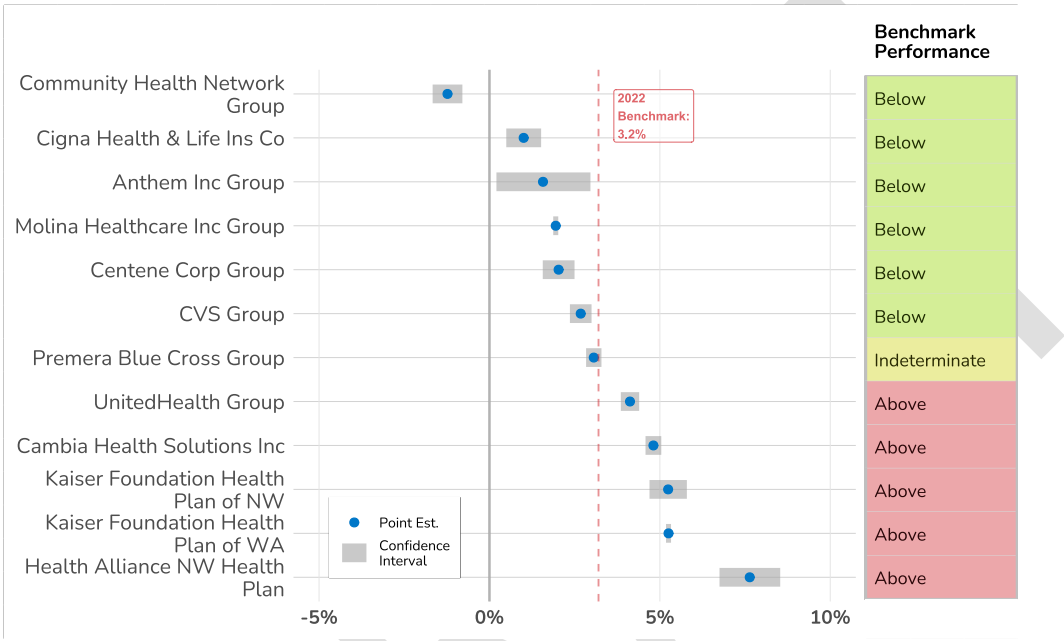


Carrier performance

Overall carrier performance

Across all lines of business, five of the 12 carriers exceeded the 3.2% benchmark (Figure 8), exhibiting a very broad range of performances. For these five carriers, the lower bound of the confidence interval of performance (i.e., growth rate of the truncated and age-sex risk adjusted TME PMPY) is higher than the 3.2% benchmark and hence, the performance exceeded the benchmark.

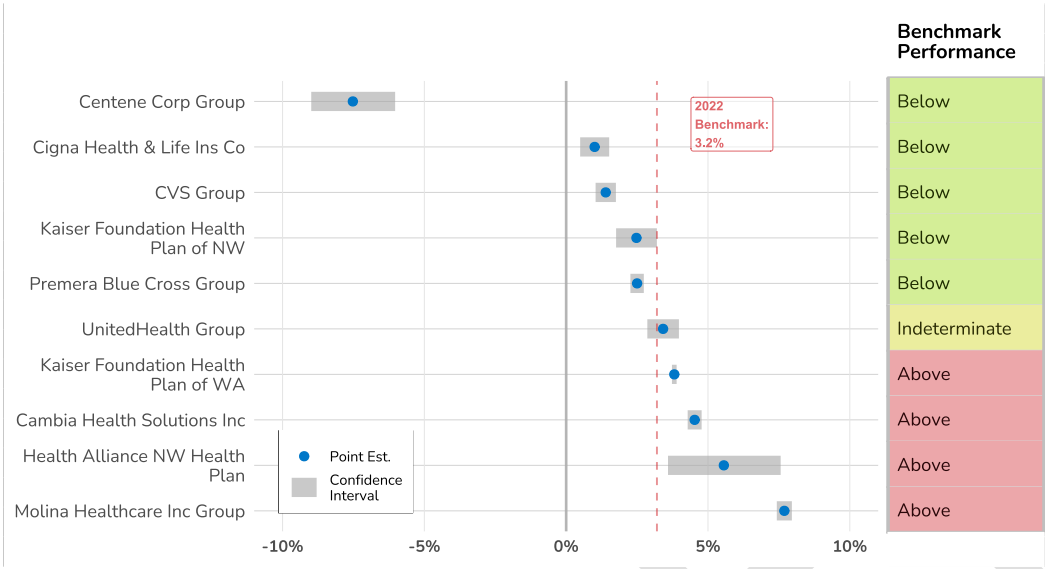
Figure 81: 2022 Carrier performance against the benchmark across all markets, measured by the growth rate of total medical expense, PMPY



Carrier performance by market

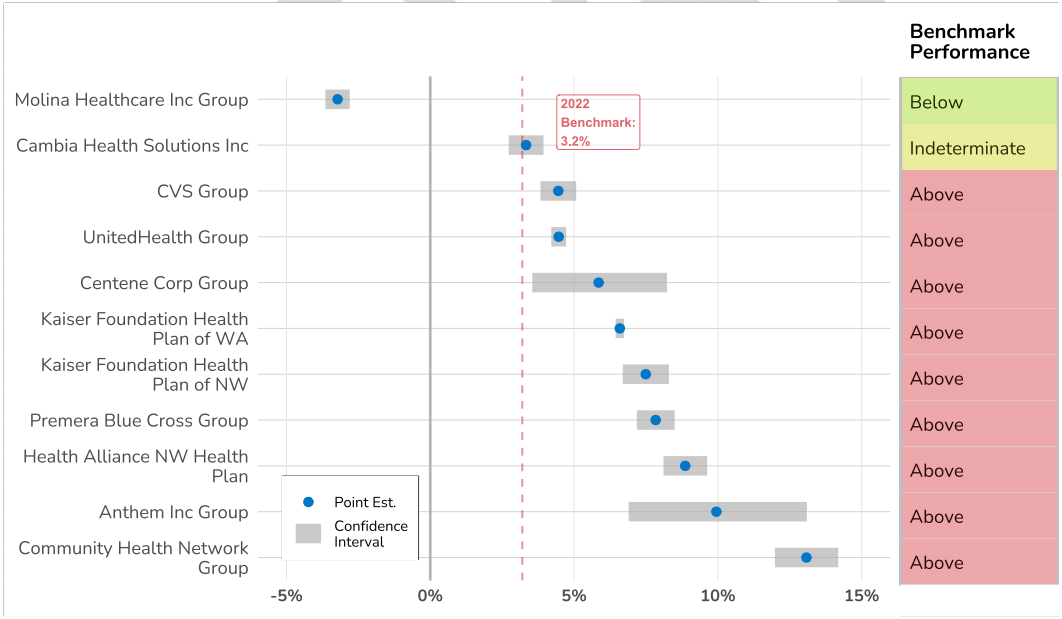
When broken out by market, performance against the benchmark shows a broad range of growth rates across carriers, while following the market growth trends for 2022. In the commercial market, only four out of the 10 carriers exceeded the benchmark (Figure 9).

Figure 9: 2022 carrier performance against the benchmark in the commercial market, measured by the growth rate of TME PMPY



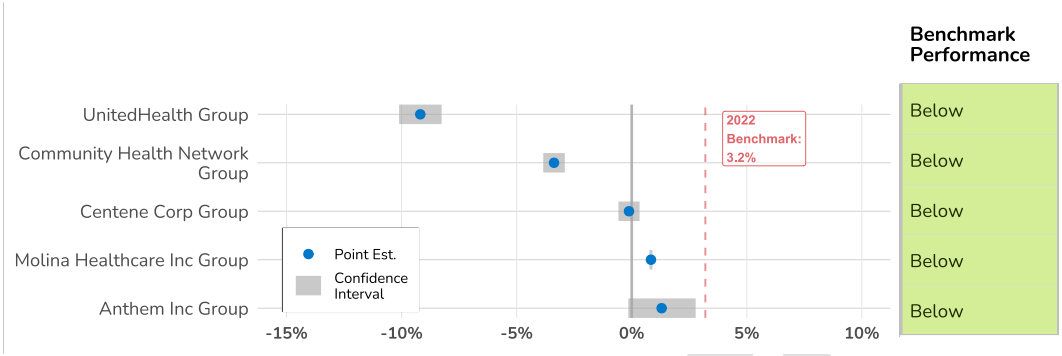
Nine of the 11 carriers operating in the Medicare market grew faster than 3.2% in 2022, with only one carrier significantly below the benchmark, in line with the statewide trend in the Medicare spending.

Figure 10: 2022 carrier performance against the benchmark in the Medicare market, measured by the growth rate of TME PMPY



None of the five carriers offering coverage in the Medicaid market exceeded the 2022 benchmark, which is consistent with the slightly negative growth rate for the overall Medicaid market.

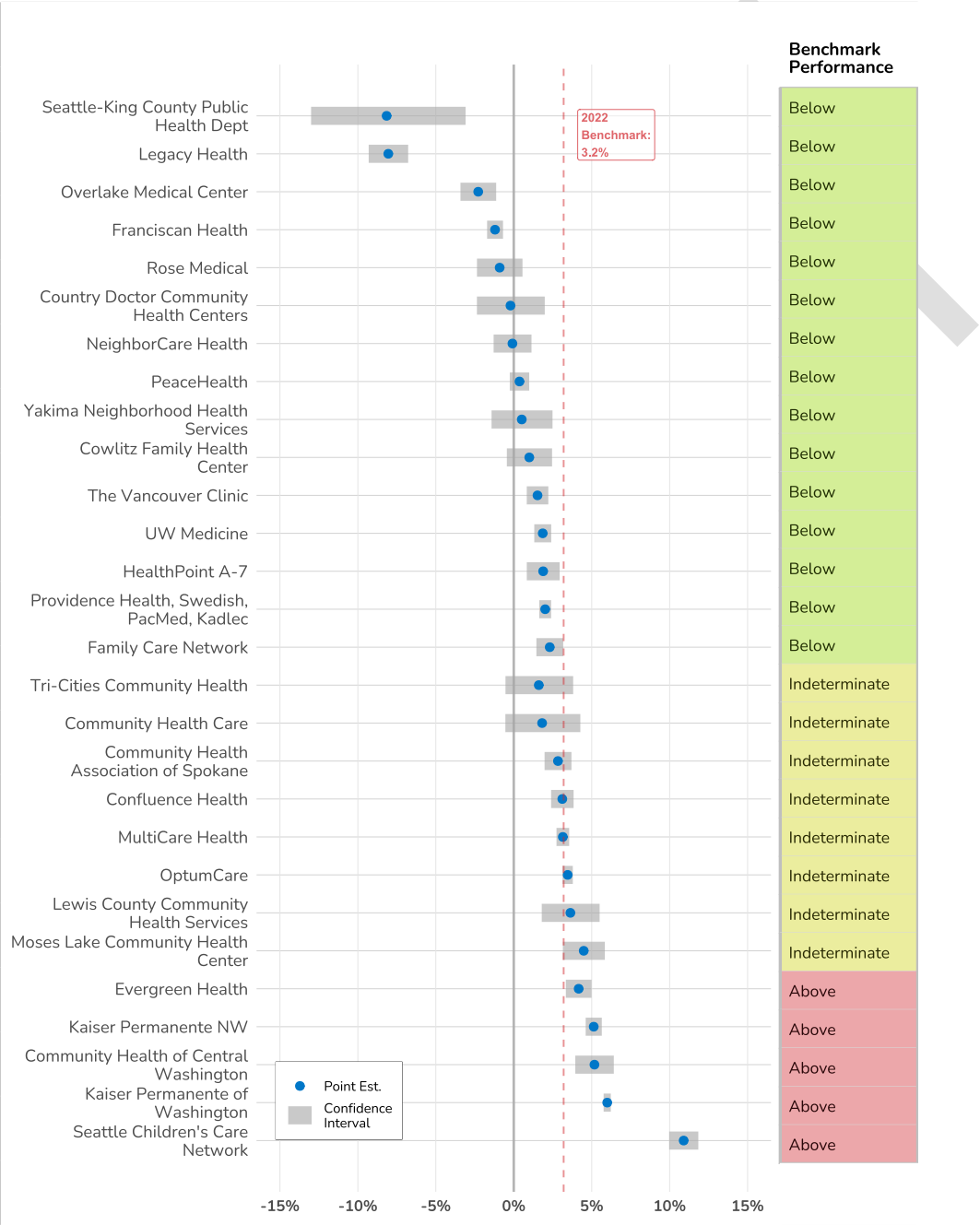
Figure 11: 2022 carrier performance against the benchmark in the Medicaid market, measured by the growth rate of TME PMPY



Provider performance

Like the carriers', provider performance is measured by the confidence interval for the growth in the truncated, age-sex risk adjusted total medical expenditures per member per year (PMPY). Five of the 28 large provider organizations (identified by those with more than 10,000 attributed primary care lives) exceeded the 3.2% benchmark (Figure 12). Growth of TME PMPY for members that are unattributed to large provider entities (approximately 40% of total member months) significantly decelerated from 11.3% in 2021 to 2.6% in 2022.

Figure 12: 2022 provider performance against the benchmark, measured by the growth rate of total medical expense, all markets, PMPY



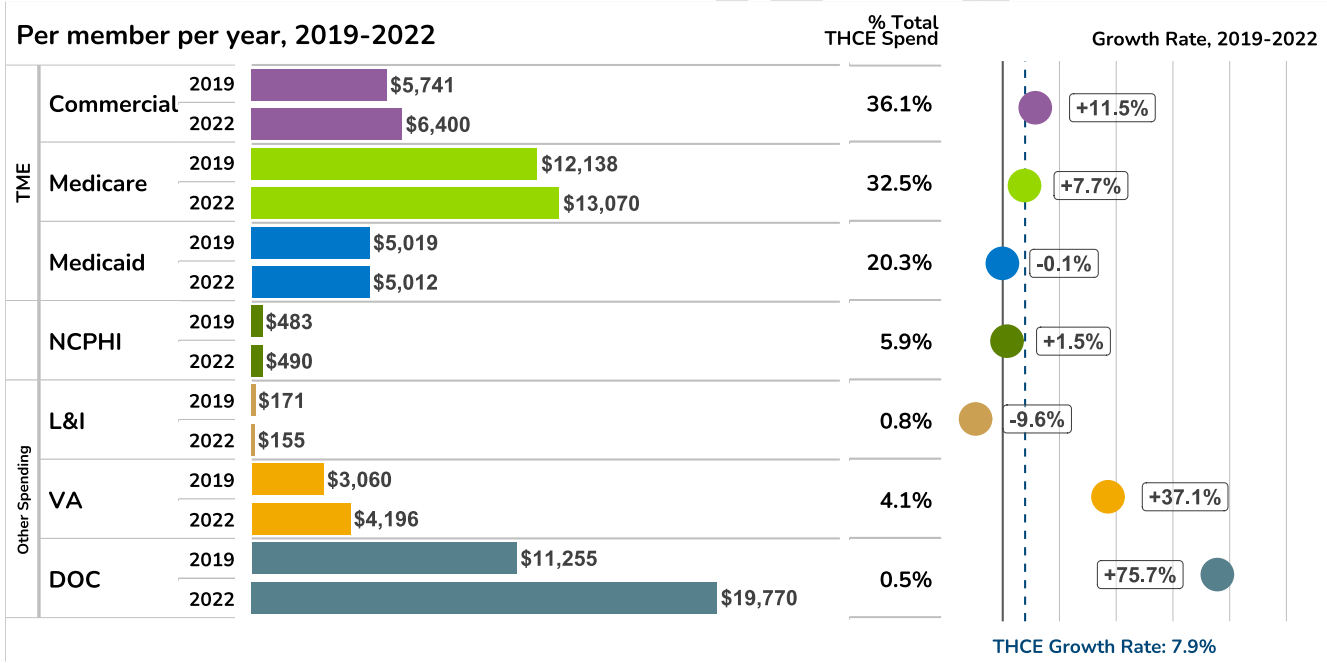
Spending growth during the pandemic (2019–2022)

Adding to the 2022 growth analysis in the prior section, this section looks at the per member spending trends from 2019–2022. Between 2019 and 2022, health care spending in Washington state dropped in 2020 (as many had forgone non-emergent medical services at the onset of the pandemic) and subsequently recovered. For some sectors, the growth in 2021 more than offset the declines experienced in 2020, creating an overall trajectory that highlights key areas of cost acceleration. This analysis focuses on cumulative growth across markets to identify trends that persisted during the pandemic.

Statewide per member spending, overall and by component

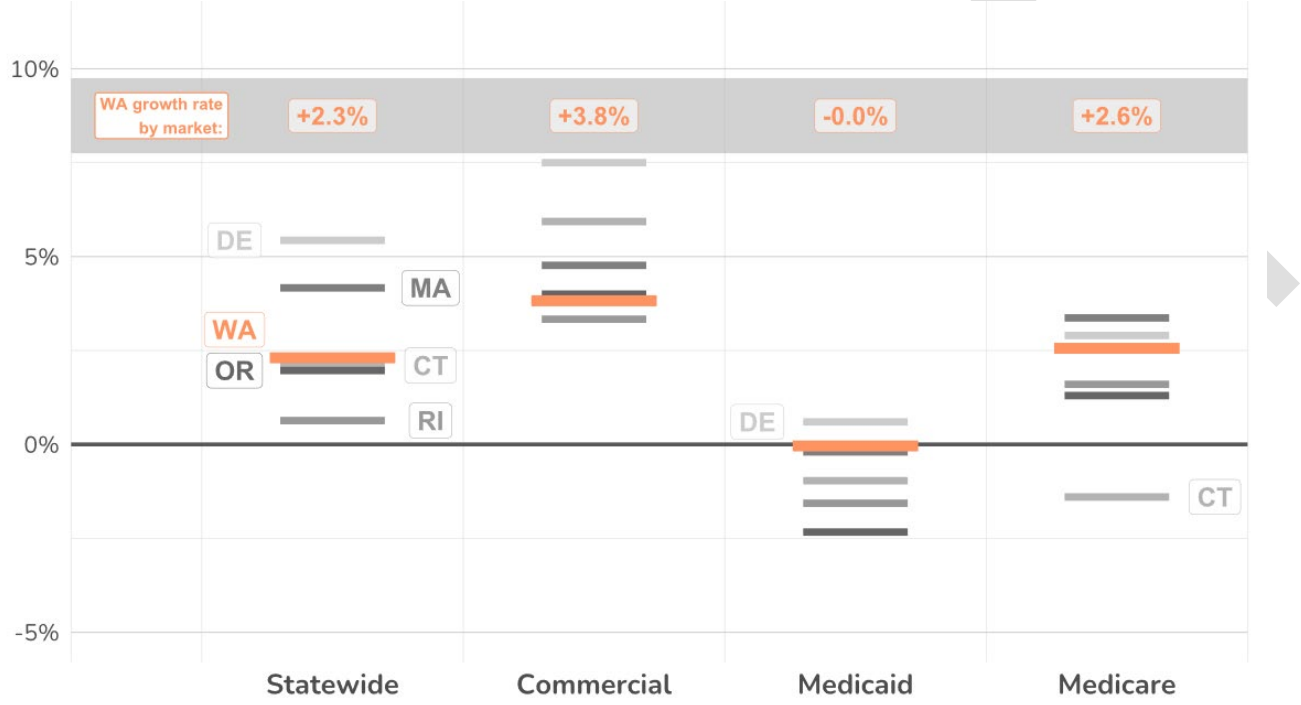
From 2019 to 2022, overall growth in per member per year THCE reached 7.9%, largely driven by growth in the commercial sector (11.5%) and, to a lesser extent, growth in the Medicare market (7.7%) (Figure 13). The commercial market growth is notably higher than the -0.1% growth in the Medicaid market. The decline in the Medicaid market underscores the rapid growth of the number of covered lives relative to overall Medicaid spending. Pandemic-related expansion in the Medicaid program increased membership. While there has been accelerating growth in per member spending for Veterans Affairs (VA) and Department of Corrections (DOC), these components cover small populations that do not significantly drive overall growth.

Figure 132: Growth in THCE component from 2019 to 2022



The market trends seen during the pandemic are similar to trends seen in other states (Figure 13). By looking at the average year-over-year growth rate of TME PMPY from 2020–2022, the commercial and Medicare markets drive overall growth, while growth in the Medicaid market was subdued.

Figure 143: Average total medical expense per member per year growth rate from 2019 to 2022 in Washington and five other benchmark states

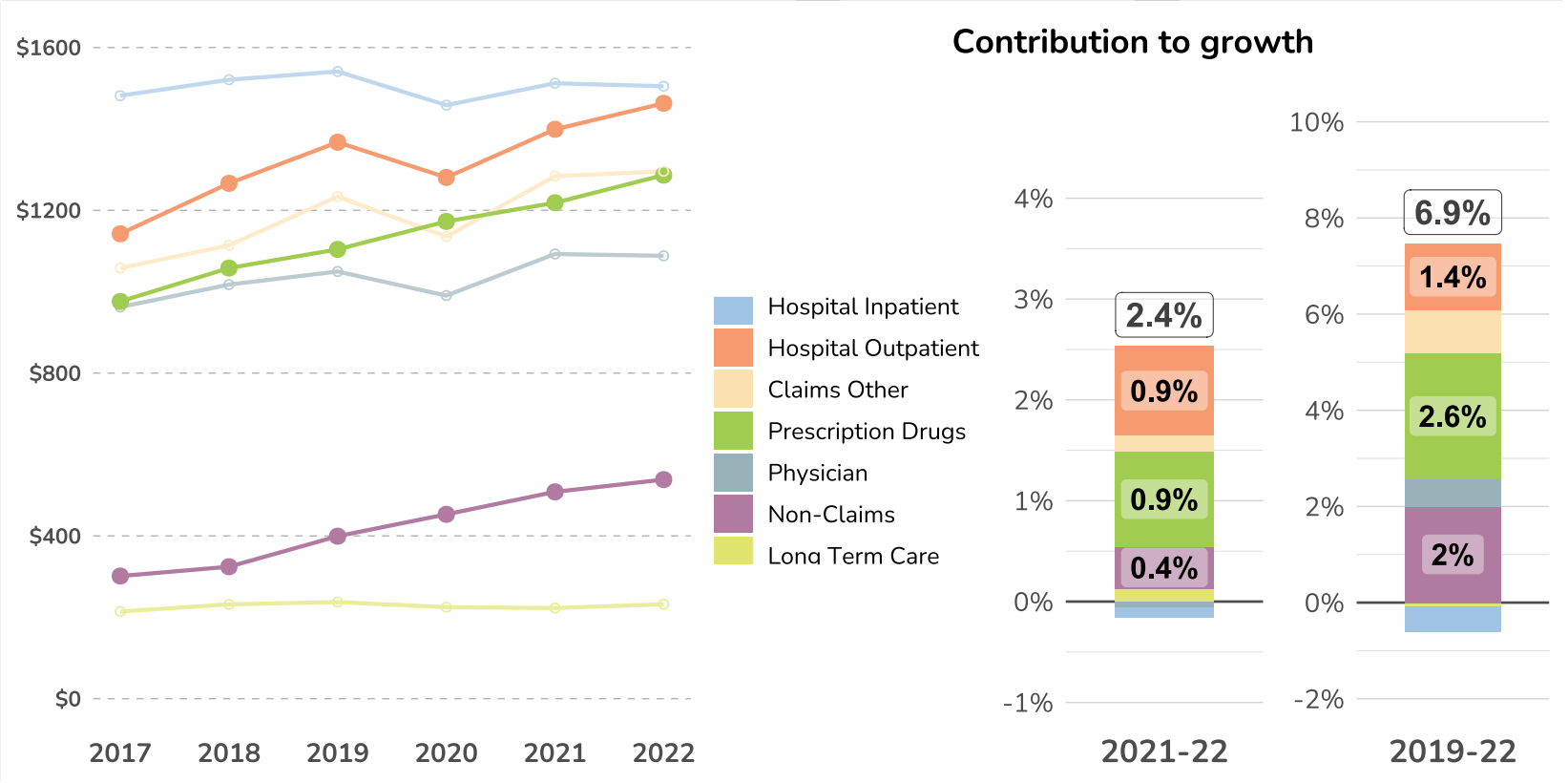


Source: WA Health Care Cost Transparency Board Data Calls, Bailit Health Analysis from Other States' Data Calls

Per member spending by service category

Across all three markets, prescription drugs, non-claims (payments that health plans make to provider organizations outside of claims), and hospital outpatient services emerged as the top contributors to health care spending growth during the pandemic (Figure 14). Robust growth in prescription drugs spending in the Medicare and commercial markets placed an upward pressure on overall cost growth. While spending on most service categories declined in 2020, prescription drugs continued to increase such that as of 2022, this category explains almost 40% of the spending growth (2.6 percentage points (or ppts) of the 6.9% growth THCE PMPY growth) seen from 2019–2022. Per member per year non-claims spending accounts for close to 2 ppts of the overall 6.9% growth since prior to the pandemic, driven by sustained increases in capitation and bundled payments in the Medicare Advantage sector. Hospital outpatient spending accounts for 20% of overall growth, specifically driven by growth in the Medicare and commercial markets.

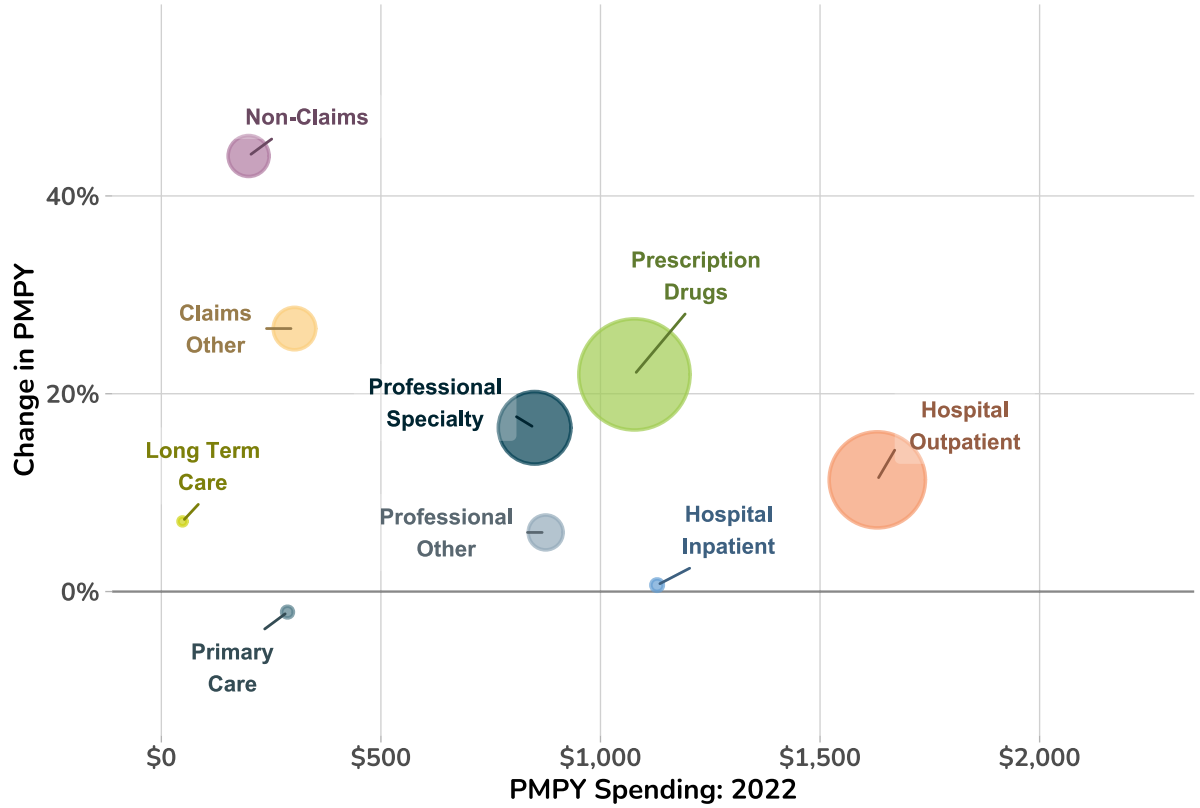
Figure 15: Growth of statewide TME PMPY spending by category of care from 2017–2022



Commercial market

In the commercial market, which registered an 11.5% growth from 2019–2022, the top three contributors to growth (indicated by the size of the bubble in Figure 16 and the numbers in the table within Figure 15) are prescription drugs (3.4 ppts), hospital outpatient (2.9 ppts) and professional specialty (2.1 ppts). The notable increase in spending on professional specialists is not seen in the Medicare nor Medicaid markets. Hospital outpatient spending is one of the largest contributors to growth across the pandemic years and is not offset by a drop in inpatient spending.

Figure 16: Change in total medical expense by category in the commercial market between 2019 and 2022



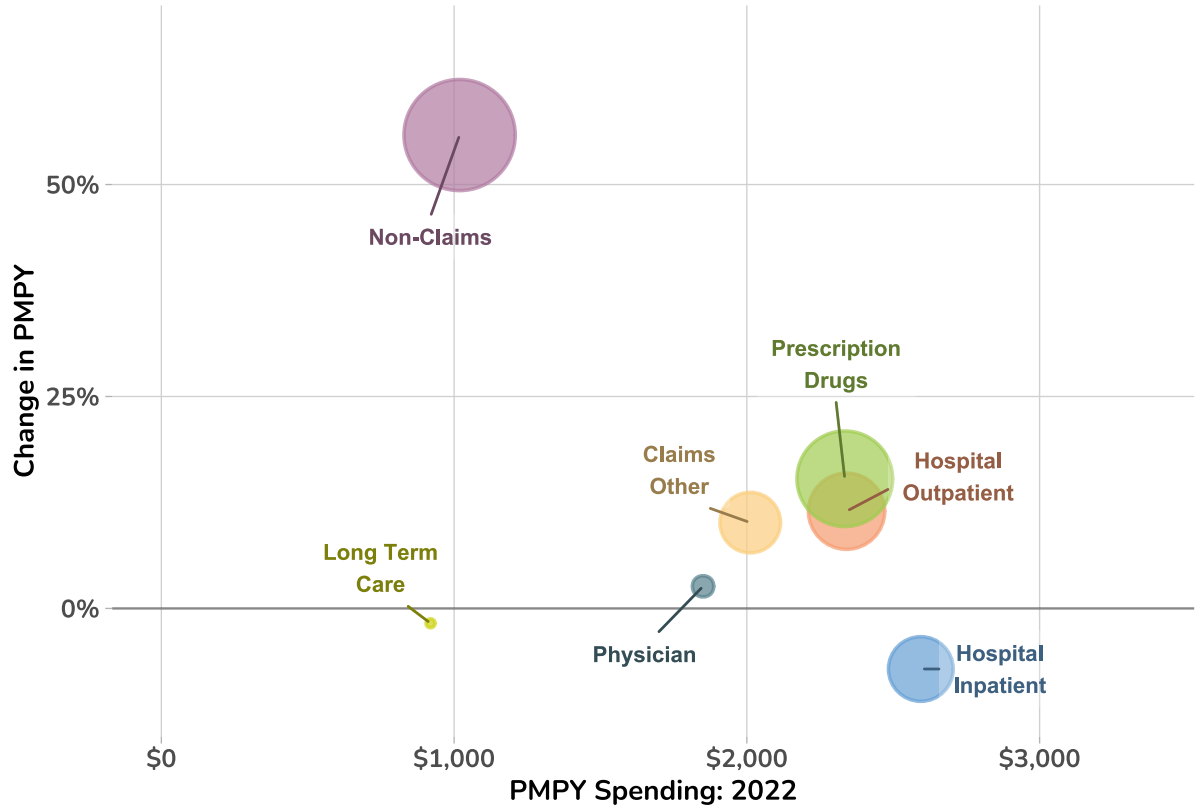
*Bubble size scaled to contribution to growth and listed in the table at right

Category	Contribution to Growth (in percentage points)
Prescription Drugs	3.4
Hospital Outpatient	2.9
Professional Specialty	2.1
Claims Other	1.1
Non-Claims	1.1
Professional Other	0.9
Hospital Inpatient	0.1
Long Term Care	0.1
Primary Care	-0.1
Total Market Growth	11.5%

Medicare market

The 7.7% growth in the Medicare market from 2019–2022 is largely driven by non-claims spending (3 ppts), prescription drugs (2.6 ppts) and hospital outpatient (2 ppts). Non-claims spending, mostly capitation or bundled payments, increased by more than 50% on a PMPY basis from 2019 to 2022. Prescription drugs accounted for one third of the overall 7.7% growth through the pandemic period. For the Medicare population, PMPY spending is roughly double that of members in the commercial and Medicaid markets, reflecting an older population and higher chronic disease prevalence. To a lesser extent than in the commercial market, the Medicare market also saw robust growth in the hospital outpatient category (Figure 17), but in this case, a decrease in inpatient spending largely offset the growth in outpatient spending.

Figure 17: Change in total medical expense by setting in the Medicare market between 2019 and 2022



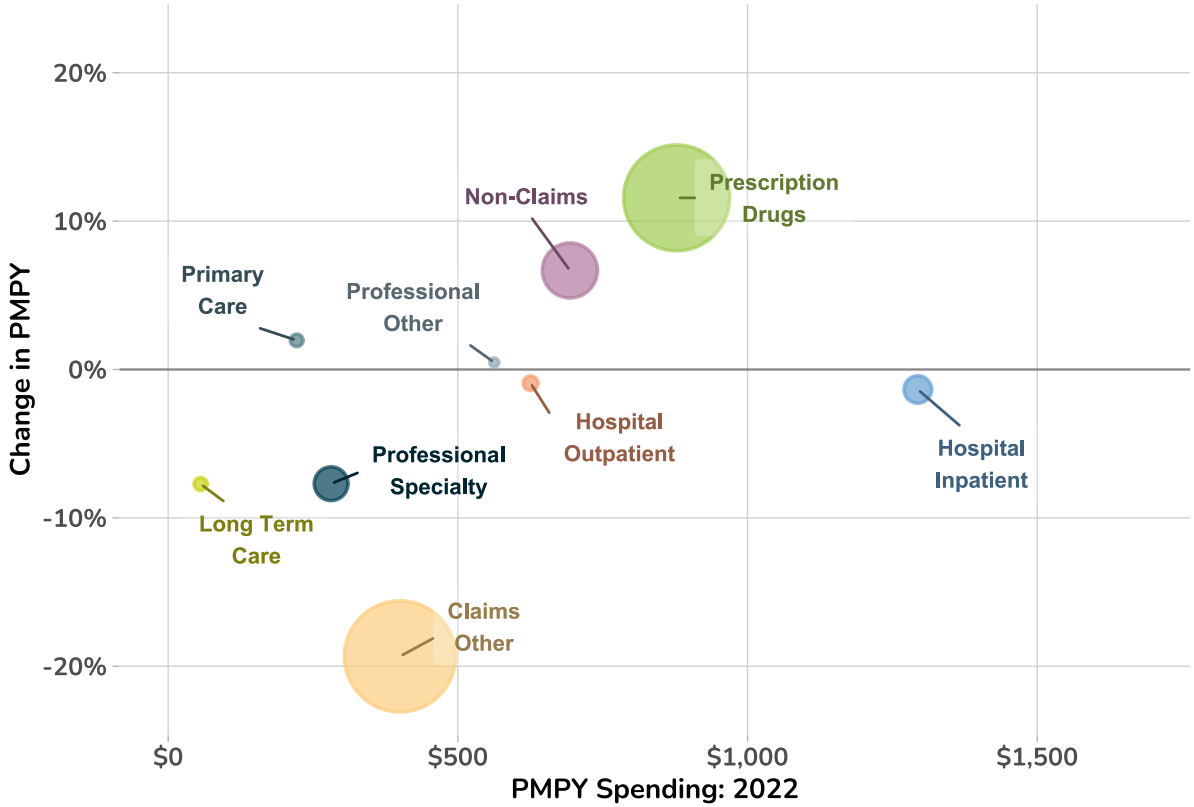
Category	Contribution to Growth (in percentage points)
Non-Claims	3
Prescription Drugs	2.6
Hospital Outpatient	2
Claims Other	1.5
Physician	0.4
Long Term Care	-0.1
Hospital Inpatient	-1.6
Total Market Growth	7.7%

Bubble size scaled to contribution to growth and listed in the table at right

Medicaid market

The Medicaid market registered a small 0.1% decrease in PMPY spending, as pandemic-driven enrollment expansion diluted per member costs (Figure 18). Nevertheless, prescription drugs remained the largest growth category and contributor to growth (1.8 ppts), with non-claims expenses being the second-largest contributor (0.9 ppts). A drop in the "Claims Other" category largely offset this increase (-1.9 ppts).

Figure 18: Change in total medical expense by setting in the Medicaid market between 2019 and 2022



Category	Contribution to Growth (in percentage points)
Prescription Drugs	1.8
Non-Claims	0.9
Primary Care	0.1
Professional Other	0.1
Long Term Care	-0.1
Hospital Outpatient	-0.1
Hospital Inpatient	-0.4
Professional Specialty	-0.5
Claims Other	-1.9
Total Market Growth	-0.1%

Bubble size scaled to contribution to growth and listed in the table at right

Conclusion

To address rising health care costs, Washington State has established a heath care cost growth benchmark program, worked to increase transparency, conducted analysis to understand cost drivers and worked to bring about policy interventions to manage health care cost growth.

At the **December 12, 2024, Health Care Cost Transparency Board public hearing**, the Health Care Cost Transparency Board had the opportunity to hear about the results of the first performance against the benchmark and other health care spending trends during the pandemic. The first public hearing also provided a platform for consumers, providers, carriers, and business and labor to share their experiences with the data call, as well as how they envision the work around the benchmark in the future. The 2022 performance against the benchmark marks a significant milestone for the Cost Board and sets an important foundation for years to come.

What's contributing to spending growth?

Key components of health care spending growth from 2019 to 2022 included **prescription drugs**, **non-claims**, and **hospital outpatient services**, with contributions varying by market. As the utilization trends begin to recover from the COVID-19 spending dip, future reports may reflect more stabilized trends. However, there are also serious upside risks coming from the lagged effects of inflation. Further exploring the drivers of health care cost growth will help the Cost Board consider policy interventions that can impact cost growth. In its discussions, the Cost Board highlighted the need to better understand how prices and utilization rates separately impact spending growth.

What's next?

In 2022, Washington State's overall health care spending growth was above the benchmark (3.2%). This first benchmark performance report helps Washington leaders and consumers understand the status of health care cost growth in the state and will help the Cost Board better identify trends that require further investigation. For example, the Cost Board suggested it would further study the impact of primary care spending on overall health care expenditures, plus utilization versus prices. The Cost Board will continue to examine the drivers of costs and explore policy interventions that help curb cost growth.

Appendix A: Data sources and performance against the benchmark methodologies

Data sources

The data used to identify health care spending trends as well as statewide, market, carrier and large provider organization performance comes from the data collected by the Cost Board in the 2022 and 2024 data calls. The 2022 data call collected data from 2017–2019, while the 2024 data call collected 2020–2022 data (see Table A1). The data collected includes claims, non-claims, health spending and health insurance administrative cost data from carriers and non-carriers. Claims spending refers to the allowed amounts from payers to provider organizations based on claims while non-claims spending refers to payments that health plans make to provider organizations outside of claims.

On the carrier side, the data call collected claims and non-claims data from the largest carriers (those that cover more than 10,000 covered lives in the commercial, Medicare Advantage, and Medicaid Managed Care businesses in Washington; see Table A2 for list of carriers participating in the data call). The data collected is broken down by large provider organizations (or provider organizations that has at least 10,000 attributed covered lives — see Table A3 for list of large provider organizations). Carriers first attributed members to a primary care provider or PCP (based on member selection of PCP, contract arrangements, and utilization). If a member is attributed to a PCP, carriers attributed this member to a large provider entity based on which large provider entity is the PCP is associated with. If the member could not be attributed to a PCP or the PCP was not associated to a large provider entity, the member was considered as unattributed. See pages A3–A4 of the Cost Board's **data call technical manual** for more information on the attribution methodology.

Table A1: Reporting schedule

Data call	Includes data from specified years	Expenditure data reported
2022	2017–2019	State and market data only — the Cost Board will not publicly report insurance payer or provider cost growth for this period
2024	2020–2022	Large provider entities and payers — with cost growth target of 3.2%
2025	2022–2023	Large provider entities and payers — with cost growth target of 3.2%
2026	2023–2024	Large provider entities and payers — with cost growth target of 3.0%
2027	2024–2025	Large provider entities and payers — with cost growth target of 3.0%
2028	2025–2026	Large provider entities and payers — with cost growth target of 2.8%

On the non-carrier side, the data call collected fee-for-service health care spending data from the Washington Health Care Authority for Medicaid FFS and from the Centers for Medicare & Medicaid Services for Medicare FFS. In addition, the data call gathered Washington state health care spending data from Veterans Affairs and two state agencies (Department of Corrections and Department of Labor and Industries). Moreover, the data call also gathered various data needed to be able to calculate the net cost of private health insurance (NCPHI). See Table A4 for a list of the data collected and their specific sources).

Table A2: List of carriers

Anthem Inc Group
Cambia Health Solutions Inc
Centene Corp Group
Cigna Health & Life Ins 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

Table A3: List of provider organizations

Community Clinic Contracting Network (includes Yakima Valley, CHC Snohomish, Columbia Basin, Columbia Valley, International Community Health, Mariposa, Peninsula Community Health, Unity Care, & Sea Mar)
Community Health Association of Spokane
Community Health Care
Community Health of Central Washington
Confluence Health
Country Doctor Community Health Centers
Cowlitz Family Health Center
Evergreen Health
Family Care Network
Family Health Centers
Franciscan Health — including Virginia Mason Franciscan Health (part of Pacific NW Division of Common Spirit)
HealthPoint
Kaiser Permanente of Washington (medical centers in Western WA and Spokane)
Kaiser Permanente NW (medical centers in SW WA)
Legacy Health
Lewis County Community Health Services (Valley View Health Center)
Moses Lake Community Health Center
MultiCare Health includes Mary Bridge Children's Hospital; Navos

Wellfound Behavioral Health Hospitals — partnership with CHI Franciscan and MultiCare
NeighborCare Health
NEW Health Programs Association
North Olympic Healthcare Network PC
Optum Care (includes Everett Clinic, Polyclinic, and Northwest Physician's Network)
Overlake Medical Center
PeaceHealth
Providence Health/Swedish Health Services/PacMed/Kadlec
Rose Medical
Seattle Children's Care Network
Seattle-King County Public Health Dept (Health Care for the Homeless Network)
The Vancouver Clinic
Tri-Cities Community Health
UW Medicine (Valley Medical Center, Neighborhood Clinics)
Yakima Neighborhood Health Services

Community Clinic Contracting Network (CCCN) was excluded in the 2024 public reporting since CCCN negotiates contract arrangements on behalf of a handful of Federally Qualified Health Centers (FQHCs) identified in this list and does not share accountability across these FQHCs.

Table A4: Data categories and sources

Category	Data Source
Carrier claims payments	Carrier data submission template
Carrier non-claims payments	Carrier data submission template
Carrier enrollment	Carrier data submission template
Carrier pharmacy rebates	Carrier data submission template
Medicare fee-for-service (FFS) claims payments and enrollment, and all Part D spending	CMS
Non-managed care claims and non-claims payments and enrollment for Medicaid	HCA submission template
Veterans Health Administration medical spending and enrollment	Department of Veterans Affairs
Medical spending for state workers' compensation and enrollment	L&I submission template
Health care spending for incarcerated individuals and enrollment	Washington DOC submission template
NCPHI for the commercially fully insured market	Federal commercial medical loss ratio (MLR) reports
NCPHI for Medicare Advantage	The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC)

NCPHI for Medicaid Managed Care	The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC)
Income from Fees of Uninsured Plans to calculate NCPHI for the commercial self-insured market	Carrier data submission template
Number of member months in each market for calculating NCPHI	Carrier data submission template

Data aggregation

Total health care expenditure (THCE)

The Cost Board utilized THCE to report on health care spending growth at the state level. THCE includes claims and non-claims payments between payers and provider organizations. Total medical expense (TME) is the sum of all claims and non-claims payments. Besides TME, THCE also includes other health care spending in public programs (i.e., Department of Corrections, Veterans Affairs, and the Department of Labor and Industries) as well as the net cost of private health insurance (NCPHI). The NCPHI refers to all costs associated with administering health plans. THCE is net of pharmacy rebates. Figure 18 shows the components of THCE and Figure 19 shows the various contributions to THCE.

Figure 18: THCE formula (TME plus NCPHI plus other spending)

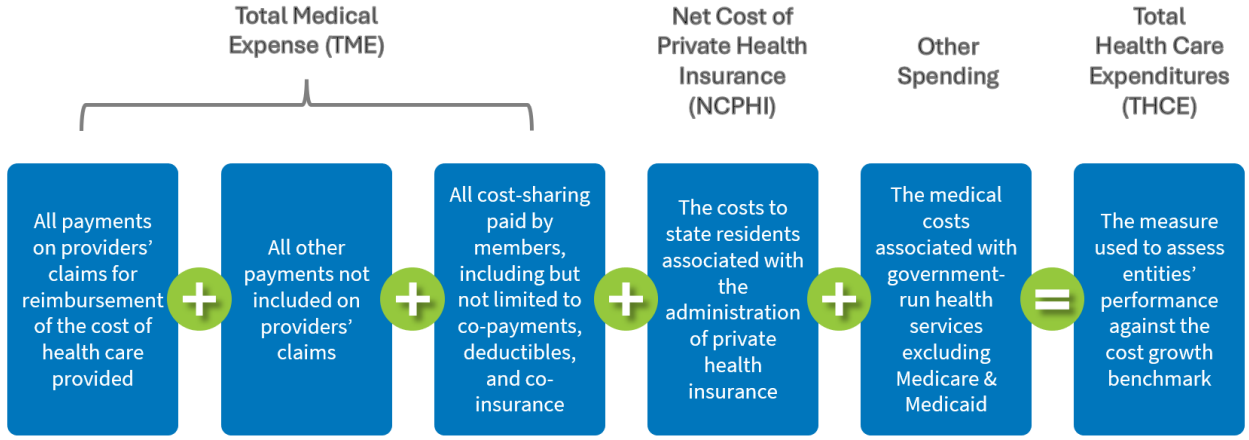
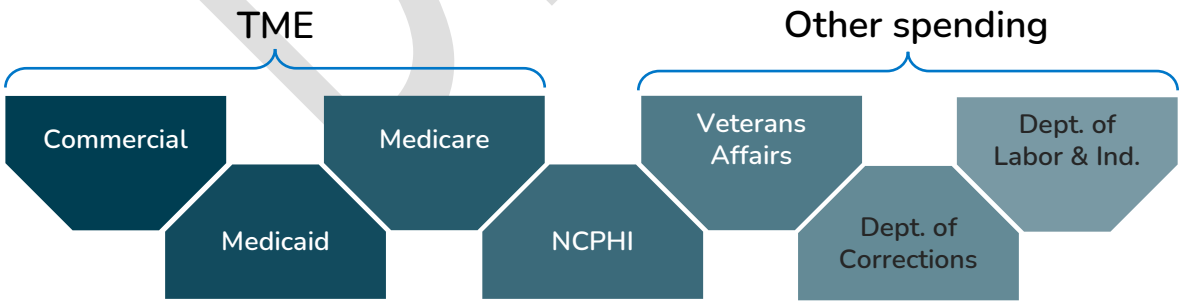


Figure 19: Components of THCE



Total medical expenses (TME)

The Cost Board also utilized TME to measure health care spending for market, carrier and large provider reporting. TME, which is a subset of THCE, includes claims and non-claims spending and exlcudes other spending and NCPHI (see Figure 20).

- TME for market level reporting: TME is reported as net of pharmacy rebates but is not age-sex risk adjusted and not truncated (i.e., not adjusted for high-cost clients). Moreover, TME includes FFS spending from Medicaid and Medicare.
- For carrier and large provider reporting:
    - TME is age-sex risk adjusted and truncated and excludes FFS data from Medicaid and Medicare. FFS data is not broken down by carrier and large provider organization.
    - Performance is based on the confidence interval of the growth rate of the adjusted TME. If the lower bound of the confidence interval exceeds the benchmark, performance exceeds the benchmark. It is indeterminant if the confidence interval contains the growth benchmark. Performance did not exceed the growth benchmark if the upper bound of the cost growth rate is lower than the benchmark.
    - The following links provide detailed description of the methodologies used to calculate performance:
        - Truncation (pages A11–A15 of the Cost Board's **data call technical manual**)
        - **Cost growth calculations: demographic risk adjustment, pooled variance, and confidence interval** (provider organizations and carriers)

Figure 20: Expenditures contributing to total medical expenses

Claims and non-claims spending by service categories

Claims and non-claims spending can be broken down into various service categories. See Table A5 for breakdown and examples.

Table A5: Claims and non-claims spending categories

A. Claims	
Hospital inpatient	• All room and board and ancillary payments for all hospital types • Payments for emergency room services when the member is admitted to the hospital
Hospital outpatient	• All hospital types and payments made for hospital-licensed satellite clinics • Emergency room services not resulting in admittance • Observation services
Professional	• Primary care providers • Specialty providers • Other providers

Long-term care	• Skilled nursing facility services • Home health services • Custodial nursing facility services • Home- and community-based services including personal care
Prescription Drugs	• Claims paid to retail pharmacies for prescription drugs, biological products or vaccines
Other	• Durable medical equipment • Freestanding diagnostic facility services • Hearing aid services • Optical services
B. Non-claims	
Non-claims	• Capitation or bundled payments • Performance incentive payments • Population health and practice infrastructure payments • Provider salaries • Recovery payments as the result of a prior review, audit, or investigation • Other — including, but not limited to governmental payer shortfalls, grants, other surplus payments, and Medicaid Transformation Project payments providers paid directly to carriers

For more information on the data collected, see the Cost Board's **data call technical manual**.

Caveats and limitations of the data

The following are excluded in the data:

- Policies offering limited benefits, such as accident, disability, Medicare supplemental insurance, vision or dental standalone policies
- Health care paid through charity care or by customer cast payment
- Certain non-claims publicly funded behavioral health services
- Anthem 2017 data
- Humana 2017 data
- Humana Medicare data
- Custodial nursing facility services, home- and community-based services, and intermediate care facilities and services for persons with developmental disabilities paid by Washington State Department of Social and Health Services (DSHS). This includes DSHS's Aging and Long-Term Support Administration (ALTSA) spending.
- Prescription drug rebates
- Statewide and market analyses are net of pharmacy rebates. These rebates include drugs covered under both the medical benefit and the pharmacy benefit. While costs for drugs covered under the medical benefit are accounted for in other types of service (inpatient, outpatient, or other claims), accurately separating the rebates on these drugs from other pharmacy rebates is difficult, so all pharmacy rebates are netted out of the prescription drug category. Carrier/provider level reporting is gross of pharmacy rebates.
- Statewide and market analyses include Medicare and Medicaid FFS data while carrier and large provider reporting excludes Medicare and Medicaid FFS data.
- There were revisions for 2017–2019 data due to data resubmissions from few carriers and revisions of NCPHI data.

- Member months data from DOC includes prison population and Rent-a-bed program population. The latter is limited to members with claims as existing data systems make it challenging to get information on those without claims.
- Federal Employee Health Benefit Plan (FEP) that have benefits split between two carriers are included only in the statewide and commercial market spending. Split FEP was removed from provider/carrier benchmarking.
- Member months from the Department of Labor and Industries are estimates and rounded off at the 100,000th level.

Appendix B: Definitions of key terms

Allowed amount: The amount the carrier paid a provider, plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of total medical expense.

Health care cost growth benchmark (the benchmark): The benchmark is the value against which the Cost Board has agreed to measure THCE and total medical expense. It is the value of 70% of Washington's historic median wage and 30% of Washington's PGSP.

Health insurance carrier (carrier): A private health insurance company that offers one or more of the following: commercial insurance, Medicare Advantage and/or Medicaid managed care products.

Large provider entity: A term referring to provider organization that delivers health care services, employs primary care providers, and is large enough to enter into a total cost of care contract, for whom carriers must report total medical expense data.

Market: The highest levels of categorization of the health insurance market. For example, FFS Medicare and Medicare Advantage are collectively referred to as the "Medicare market." FFS Medicaid and Medicaid managed care are collectively referred to as the "Medicaid market." Individual, self-insured, small and large group products and student health insurance are collectively referred to as the "commercial market."

Measurement year: The measurement year is the calendar year for which performance is measured against the prior calendar year for purposes of calculating the growth in health care costs.

Net cost of private health insurance (NCPHI): Measures the costs to Washington residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred, and consists of carriers' costs of paying bills, advertising, sales commission and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of THCE at the state level.

Payer: A term used to refer collectively to both carriers and public programs that are submitting data to HCA.

Payer recoveries: Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payer recoveries is a separate, reportable field in carrier total medical expense reporting.

Pharmacy rebates: Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.[2] Spending at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).[3]

Provider: A term referring to an individual clinician, medical group, individual provider, large provider entity or similar entities.

[2] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., carrier, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.)

[3] CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the state and Medicare market levels, spending will be gross of Medicare FFS pharmaceutical rebates.

Public program: A term used to refer to payers that are not carriers. This includes Medicare Fee For-Service, Medicaid FFS and similar programs.

Total health care expenditures (THCE): The total medical expense incurred by Washington residents for all health care services for all payers reporting to HCA, plus the carriers' NCPHI. Defining specifications of THCE are included in Section II. THCE per capita: THCE (as defined above) divided by Washington's reported membership. The annual change in THCE per capita is compared to the benchmark at the state, market and carrier levels.

Total medical expense (TME): The sum of the allowed amount of total claims and total non-claims spending paid to providers incurred by Washington residents for all health care services. TME is reported at multiple levels: state, market, payer and large provider entity level. TME is reported net of pharmacy rebates at the state, market and payer levels only.

Appendix C: Cost Board members

Member	Title	Agency or Organization	Board Member Position
Sue Birch	Director and Chair	HCA	Representing HCA
Jane Beyer	Senior Health Policy Analyst	The Office of the Insurance Commissioner	Representing the Insurance Commissioner
Eileen Cody	Consumer Advocate		Representing consumers
Lois Cook	Managing Member	America's Phone Guys	Representing small businesses
Bianca Frogner	Associate Professor	University of Washington	Representing as an expert in health care financing
Jodi Joyce	Chief Executive Officer	Unity Care NW	Nonvoting member who is a member of The Advisory Committee of Providers and Carriers with experience in health care delivery
Greg Marchand	Director, Global Benefits	Boeing	Representing large employers/self-funded group health plan
Mark Siegel	Director, Employee Benefits	Costco Wholesale Corporation	Representing large employers
Margaret Stanley	Consumer Advocate		Representing consumers
Ingrid Ulrey	Chief Executive Officer	Washington Health Benefit Exchange	Representing the Health Benefit Exchange
Kim Wallace	Medical Administrator	L&I	Representing the L&I
Carol Wilmes	Director, Member Pooling Programs	Association of Washington Cities	Representing local governments that purchase health care for employees
Edwin Wong	Research Associate Professor	University of Washington	Representing member who is an actuary or expert in health care economics

Tab 7

Washington State Health Care Authority

Committee Updates

Health Care Stakeholders Advisory Committee- Eileen Cody, Chair

Advisory Committee on Data Issues- Bianca Frogner, Chair and Harrison Fontaine, Sr. Health Policy Analyst, HCA

Washington State Health Care Authority

Stakeholder Advisory Committee: focus on medical debt

Meeting 1 (August)

- National overview of the issue with focus on what has been/can be done to prevent and address medical debt
- Overview of current laws in Washington related to preventing medical debt including charity care laws
- Identify other areas where you need more information

Meeting 2 (November)

- Consumer groups talked about impacts of medical debt here in WA and focus on recommendations
- Other identified topics
- Develop recommendations

Committee reviewed three approaches to addressing medical debt

Prevention	• 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
Relief	• Further cap interest rates • Limit credit reporting • Prohibit wage garnishment • Restrict liens and foreclosures • Buy existing medical debt
Transparency	• Require reporting of collections actions • Break down financial assistance data by patient demographics • Modify hospital community benefit reporting to distinguish between Medicaid/Medicare payments from charity care

Stakeholder Committee recommendations about medical debt

- Continue to focus on affordability as the Board is doing with the cost growth benchmark

- Focus on prevention of medical debt
  - Ensure required charity care efforts are happening such as financial assistance notification and assistance
  - Continue to monitor to assess barriers

Data Issues Committee update to Cost Board

Meeting held on Wednesday, November 20, 2024

- Topics relevant to 2024 Data Call
  - Difference between aggregate medical expense and PMPY growth rate from 2021-2022
  - Defining ‘large provider organization’ for reporting
- Review of best practices report
  - Common features: authority to collect comprehensive data, consolidated data and analytic capacity, market oversight programs, etc.
- Committee learned of its assignment from Board to review business oversight-related data

Cost Board's 2024 business oversight recommendations

Use the NASHP "State Oversight of Proposed Health Care Mergers" Model Act to draft legislation to increase state oversight of mergers and acquisitions

Health care entities should report ownership structures and legal affiliations

Washington State Health Care Authority

Board asked Data Advisory Committee to review reporting requirements

- Investigate and recommend best practices for ownership and affiliation reporting.

- Consider best practices from other states and the NASHP Model Act.

- Committee recommendations should include, but are not limited to:
  - 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.

Additional sources of data in WA

Department of Health

- Ownership and licensure of certain health care facilities and health professionals
- Comprehensive Hospital Abstract Reporting System (CHARS)
- Hospital discharges, financial reports, charity care, and adverse events from hospitals and Emergency Medical Services (EMS)

Office of the Insurance Commissioner

- Financial reporting and ownership from health insurance plans

Office of the Attorney General

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

Office of Financial Management

- Workforce, utilization and coverage to inform health policy development.

Department of Social and Health Services Research and Data Analysis

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

Data Advisory Committee next steps

- Catalog data elements that are already collected and by whom
  - Committee would not advise adding additional reporting requirements unless needed
- Staff drafting a crosswalk and will coordinate with partner agencies
- Staff will solicit feedback from Committee members in advance of a full review at the next Committee meeting (March 27)

Feedback request

Crosswalk scope and data elements

- Staff crosswalk is focusing on NASHP model legislation data elements relating to ownership of health care entities and IDs necessary to understand market consolidation:
  - Organizational information and IDs for key persons, affiliates, and subsidiaries
  - IDs for entities with ownership, investment, or controlling interests
  - IDs for entities that are significant equity investors or a management services organization
  - IDs for governing board members
  - IDs: TIN, NPI, EIN, CCN, NAIC, OIC ID, PBM ID, and business ID #
- Key informant interviews with partner agencies will also address data ownership, data structure, and potential barriers to integrating sources

Washington State Health Care Authority

Closing statements and adjournment

Washington State Health Care Authority