Health care spending growth in Washington, 2017–2019

Health Care Cost Transparency Board's health care spending growth benchmark baseline brief (2023)

Washington State Health Care Authority

Table of Contents

Table of Contents **2**

Acronym glossary **4**

Executive Summary **5**

Key Findings *5*
Figure 1: Growth in Total Health Care Expenditure (THCE) 5
Figure 2: Growth in state TME per member per year, by market 6

Introduction **7**

Background *7*
What is the health care spending growth benchmark? *7*
Table 1: Spending growth benchmark for Washington State 7
Table 2: Reporting schedule 8
Spending growth benchmark methodology *8*
THCE measurements 8
Figure 3: THCE formula (TME plus NCPHI) 8
Figure 4: Components of THCE 9
Total medical expenses *9*
Figure 5: Components of Total Medical Expenses 9
Overview of data collection and analysis methodology *10*
Data Sources 10
Table 3: Data categories and sources, TME 10
Table 4: Data categories and sources, NCPHI 10
What's included in claims and non-claims spending categories? 11
Assessment of performance against the spending growth benchmark for future years' reports 12
Caveats and limitations of the data 12

THCE in Washington, 2017-2019 ..... **13**

THCE, statewide, PMPY *13*
Figure 6: Growth in THCE 13
Components of THCE *14*
NCPHI 14
Other spending 14
TME 14
Figure 8: Components of THCE 14

TME trends in Washington, 2017-2019 ..... **15**

Claims spending, statewide *15*
Figure 9: Statewide TME spending and proportion by category 15
TME growth by market and category *16*
Statewide TME growth 16
Figure 10: Statewide TME spending growth by category 16

Figure 11: Statewide TME contribution to spending growth by category 16
Medicare TME growth 17
Figure 12: Medicare TME spending growth by category 17
Figure 13: Medicare TME contribution to spending growth by category 17
Commercial TME growth 18
Figure 14: Commercial TME spending growth by category 18
Figure 15: Commercial TME contribution to spending growth by category 18
Medicaid TME growth 19
Figure 16: Medicaid TME spending growth by category 19
Figure 17: Medicaid TME contribution to spending growth by category 19
TME growth in PMPY spending by category – statewide and by market 20
State spending by category, PMPY 21
Figure 18: State claims PMPY growth by category, 2017-2018 21
Figure 19: State claims PMPY growth by category, 2018-2019 21
Medicare spending by category, PMPY 22
Figure 20: Medicare claims PMPY growth by category, 2017-2018 22
Figure 21: Medicare claims PMPY growth by category, 2018-2019 22
Commercial spending by category, PMPY 23
Figure 22: Commercial claims PMPY growth by category, 2017-2018 23
Figure 23: Commercial claims PMPY growth by category, 2018-2019 23
Medicaid spending by category, PMPY 24
Figure 24: Medicaid claims PMPY growth by category, 2017-2018 24
Figure 25: Medicaid claims PMPY growth by category, 2018-2019 24

Conclusion **25**

COVID-19 will impact future benchmark reports 25
This is a high-level view, additional research necessary 25

Appendix A: Definitions of key terms **26**

Appendix B: Cost Board members **28**

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.

DSHS — **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. Read more in **Appendix A: Definitions of key terms**.

PCMH — **Person-Centered Medical Home**
A facility offering complete care focused on quality, effectiveness, and efficiency of services delivered, responding to each patient’s unique needs and preferences.

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

This report presents baseline data on health care cost growth in Washington between 2017 and 2019. As part of the Health Care Cost Growth Benchmark initiative, the Washington Health Care Cost Transparency Board collects data from payers and other sources to provide a comprehensive view into health care cost growth. This report sets the stage for policymakers, health system partners, and other stakeholders to identify opportunities and strategies to slow cost growth and address growing affordability concerns across all markets, including public and private care insurance markets. Key findings were presented at a **public board meeting in December 2023** and are summarized in this report.

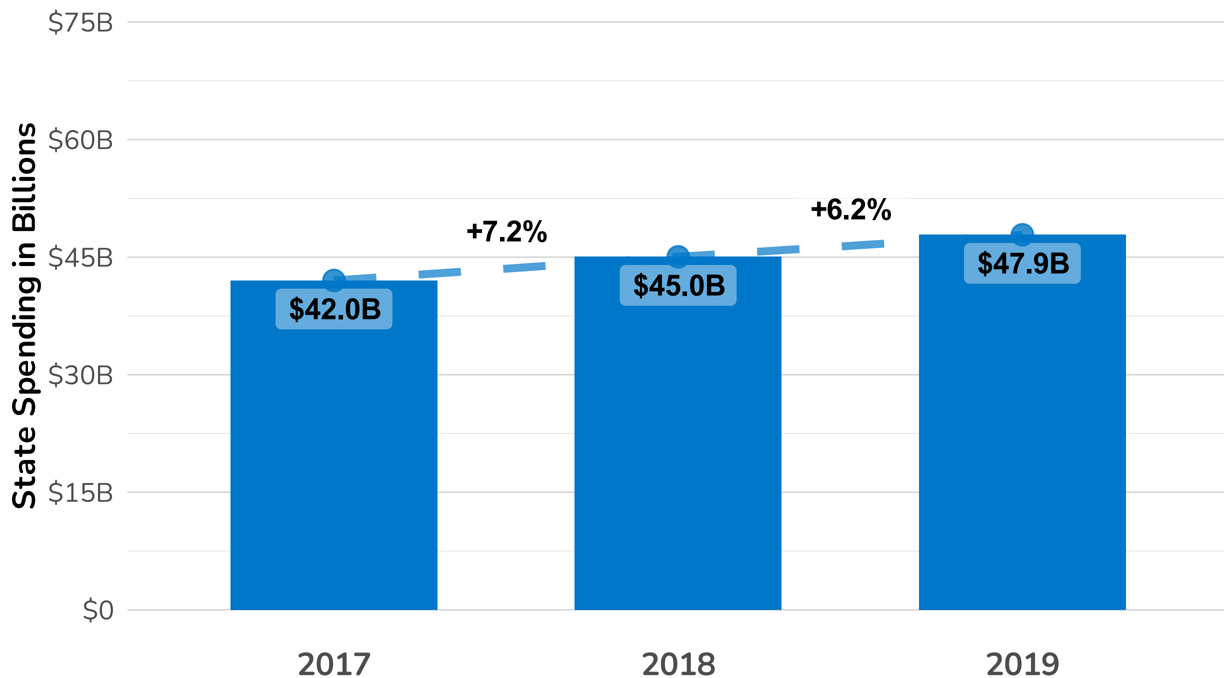
Key Findings

Total health care expenditures (THCE)[1] in Washington increased by $5.8 billion between 2017–2019:

- $3 billion increase between 2017–2018
- $2.8 billion increase between 2018–2019

Overall, THCE in Washington increased from $42 billion in 2017 to $47.9 billion in 2019. Between 2017 and 2018, THCE increased by 7.2% from $42 billion to $45 billion. This continued to grow by another 6.2% to $47.9 billion between 2018 and 2019.

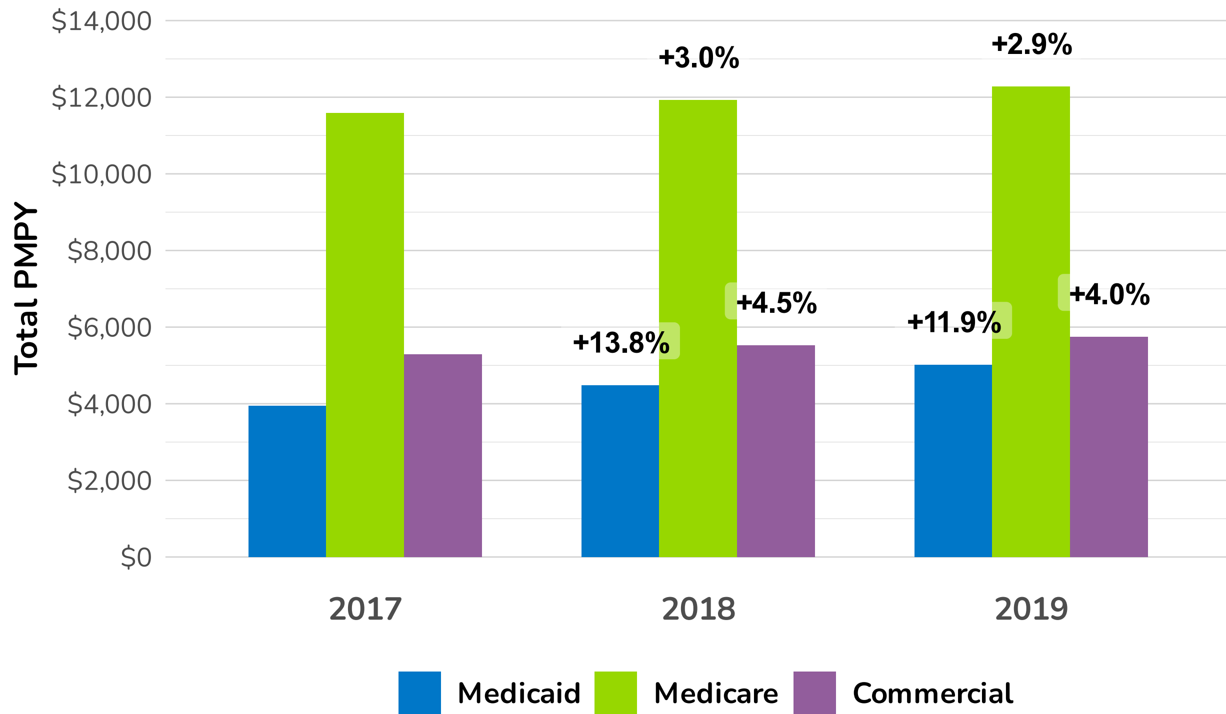
Figure 1: Growth in Total Health Care Expenditure (THCE)



[1] Total Health Care Expenditure is the sum of all public and private spending on the delivery of health care to a population, including medical services, government subsidy, and administrative costs.

All health care markets (including Commercial, Medicare, and Medicaid) experienced growth in per person per year total medical expenses (TME)[2] between both 2017-2018 and 2018-2019.

Figure 2: Growth in state TME per member per year, by market



All monitored health care markets, including commercial, Medicare, and Medicaid, experienced health care cost growth between 2017 and 2019. TME, standardized to per member per year (PMPY), increased the most for Medicaid between 2017-2018 (13.8%) and the least for the Medicare market between 2018-2019 (2.9%). While the growth trend of Medicare is lower than other markets when measured PMPY, the absolute spending is substantially higher, reflecting a population that is older and with a higher prevalence of chronic disease.

[2] Total medical expense (TME) differs from THCE in that TME excludes spending related to administration of private health insurance, and state and federal agency spending (e.g. DOC).

Introduction

Background

House Bill 2457 (2020) established the Health Care Cost Transparency Board (Cost Board) under the Health Care Authority (HCA). The board is responsible for reducing Washington's health care cost growth by:

- Determining Washington's THCE.
- Identifying cost trends and cost drivers in the health care system.
- Setting a health care cost growth benchmark for health care providers and payers.
- Reporting annually to the Legislature on benchmark performance and cost drivers.

Washington is one of nine states in the nation to adopt a spending growth benchmark. It is also a participant in the **Peterson-Milbank Program for Sustainable Health Care Costs**. The Cost Board established the benchmark in 2022 for the subsequent five years and will evaluate the benchmark performance annually moving forward. The spending growth benchmark represents a common goal for payers, purchasers, regulators, and consumers to improve health care affordability. It serves as a starting point to monitor health care spending growth with the growth of the economy, state revenue, or wages.

Performance against the benchmark is assessed by measuring annual spending growth against each annual benchmark. Benchmark performance data in future reports will reflect the performance of payers and providers against the spending growth benchmark at an aggregate level for each insurance market (e.g., commercial, Medicare, Medicaid). The benchmark data comes from aggregate expenditure data from all payers (carriers) and includes claims-based and non-claims-based expenditures.

What is the health care spending growth benchmark?

The benchmark is a specific rate that the expenditure performance of carriers and providers will be measured against, beginning in 2022. The goal of the benchmark is to influence slower health care spending growth to ensure access to affordable health care. The Cost Board's benchmark target covers a five-year period, granting providers and policymakers the ability to plan for future years when calculating total expenditures.

In September 2021, the Cost Board approved Washington's spending growth benchmark from 2022–2026 (see Table 2). This benchmark is based on a hybrid of median wage and potential gross state product (PGSP) at a 7:3 ratio. Median wage was selected to link the measure to consumer affordability, and PGSP as a reflection of business cost and inflation.

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%

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. One of these factors included current economic indicators, such as wages and inflation. In designing Washington's benchmark methodology, the Cost Board examined rates of health care inflation in other states with spending growth benchmarks, as well as those states' benchmark methodologies.

The spending growth benchmark will be applied and measured in future years of analysis at four different levels: statewide, by market, by payer, and by large provider organization.

Table 2: Reporting schedule

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

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

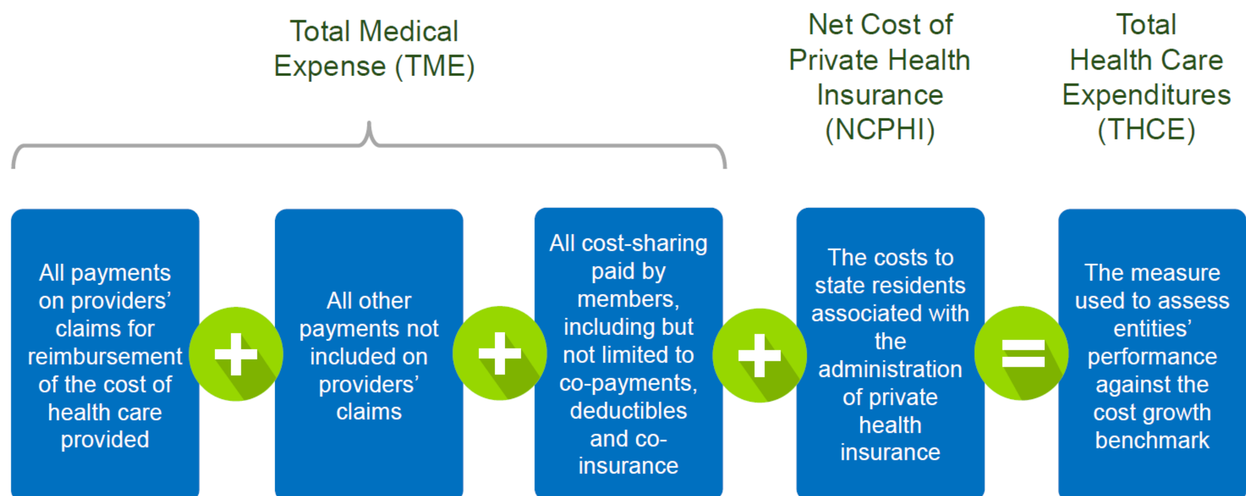
To ensure that payers and provider organizations have flexibility in their contracting and in their operations, the spending growth benchmark is calculated at a high-level, using a total-cost-of-care approach. This aggregates all costs related to an individual's care, rather than focusing on a single factor like prices. Washington's health care spending growth benchmark sets a target annual rate of growth for health care spending in the state. Spending growth benchmarks do not limit or cap health care spending; they aim to achieve a sustainable rate of growth.

Spending growth benchmark methodology

THCE measurements

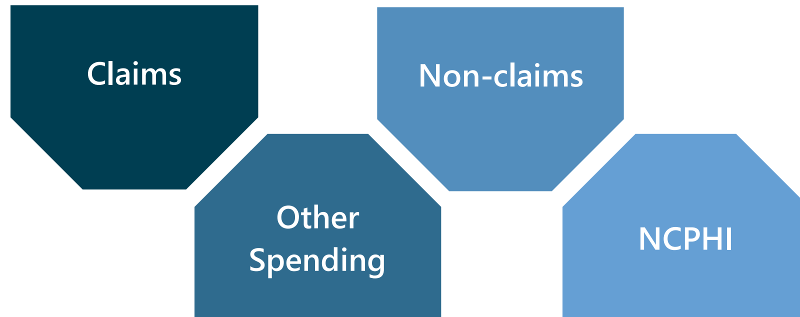
This Cost Board utilized THCE to report on health care spending growth between 2017 and 2019 at the state level and utilized TME for the market level (Medicaid, Medicare, commercial). THCE includes claims and non-claims payments between payers and provider organizations, as well as other health care spending in public programs like Department of Corrections (DOC), Veterans Affairs, and the Department of Labor and Industries (L&I). The net cost of private health insurance (NCPHI) are costs associated with administering health plans.

Figure 3: THCE formula (TME plus NCPHI)



This report also looks at health care spending by category, e.g., hospital inpatient, retail pharmacy, capitated payments, etc. Statewide and market-level cost growth is reported using THCE.

Figure 4: Components of THCE



Total medical expenses

The Cost Board also utilized TME to measure health care spending. TME is a subset of THCE and includes claims and non-claims spending reported by payers. For market level spending, TME is reported unadjusted and not truncated. For payers and providers, TME will be demographically adjusted and truncated.

Payer and provider organization cost growth is measured using TME, a subset of THCE that includes only claims and non-claims spending (see **What's included in claims and non-claims spending categories?**).

Figure 5: Components of Total Medical Expenses

Overview of data collection and analysis methodology

This section provides a summary of how performance will be assessed against the benchmark in future years' analyses. For detailed methodological information about the cost growth benchmark, see **Washington's Healthcare Cost Growth Benchmark Technical Manual**.

Data Sources

Like other states, the Cost Board utilizes data from a large number of sources for assessing health care spending and spending growth.

Table 3: Data categories and sources, TME

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

Table 4: Data categories and sources, NCPHI

Category	Data Source
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

What's included in claims and non-claims spending categories?

Claims spending includes the allowed amount from payers to provider organizations and any member cost sharing such as co-payments, deductibles, and co-insurance. Professional services can be broken out into several sub-categories, including primary care, specialty, long-term care, and others. Claims spending in this section is reported net of pharmacy rebates. Non-claims spending includes all payments made from payers to provider organizations outside of claims.

- **Claims**
  - Hospital inpatient
  - Hospital outpatient
  - Professional – primary care providers
  - Professional – specialty providers
  - Professional – other providers
  - Long-term care
  - Retail pharmacy (net)
  - Other – including, but not limited to durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services.
- **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

Service category definitions utilized within claims and non-claims spending:

- **Hospital outpatient**
  - All hospital types and payments made for hospital-licensed satellite clinics
  - Emergency room services not resulting in admittance
  - Observation services
- **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
- **Retail prescription**
  - Claims paid to retail pharmacies for prescription drugs, biological products or vaccines
- **Non-claims**
  - Incentives
  - Capitation
  - Risk settlements
  - Direct payments
  - Other non-claims-based payments
- **Claims other**
  - Durable medical equipment
  - Freestanding diagnostic facility services
  - Hearing aid services
  - Optical services
- **Long-term care**
  - Skilled nursing facility services
  - Home health services
  - Custodial nursing facility services
  - Home- and community-based services including personal care

Assessment of performance against the spending growth benchmark for future years' reports

To assess health care spending growth in a manner similar to other states, the Cost Board measures THCE or TME annually, in aggregate dollars, and on a PMPY or per-member-per-month (PMPM) basis. The aggregate dollar figure is for informational purposes only. The percentage change in THCE/TME on a PMPY/PMPM basis between the measurement year and the prior calendar year will be used in future years to assess performance against the benchmark applicable to the specific measurement year. Spending is calculated at each of level or reporting as follows:

- **State**: Aggregate spending and PMPY spending using THCE.
- **Market (Medicare, Medicaid, commercial)**: Aggregate spending and PMPY spending using TME.
- **Payer (carrier), stratified by market**: PMPM spending using truncated, age/sex adjusted TME
- **Large provider entity stratified by market**: PMPM spending using truncated, age/sex adjusted TME.

Spending at the payer and provider entity levels will not be included in this initial benchmark report but will be reported beginning in 2024. All spending data at the state and market levels (and payer, in future reports) are or will be reported net of pharmacy rebates. Spending data at the large provider entity level will be reported in future reports gross of pharmacy rebates since carriers provide rebate data in the aggregate, and the Cost Board cannot attribute rebates to specific providers.

Caveats and limitations of the data

In this first data call, there are gaps in the compiled data. Some gaps were anticipated, such as the Cost Board's exclusion insurance policies offering limited benefits: accident, disability, Medicare supplemental insurance, vision or dental stand-alone policies. Another category of health care expenditure not captured is charity care or customer cash payment.

Additional instances of incomplete data were unanticipated for various reasons. The carrier Anthem was unable to produce data for 2017 due to the difficulty of accessing their archived data. Humana did not present data for their Medicare Advantage plans citing a federal preemption and that such a requirement was not included within the state license agreement. There were also unforeseen difficulties gathering and integrating certain non-claims spending in

- Publicly funded behavioral health services.
- Custodial nursing facility services.
- Home- and community-based services.
- Intermediate care facilities and services for persons with developmental disabilities paid by Washington State Department of Social and Health Services.

Efforts are currently underway to assess the feasibility of incorporating these services in future reporting.

Finally, all data is reported as the net of prescription drug rebates. Both medical and retail prescription rebates were collected, but due to the complexity of medical rebates and the limited value of insight gained in breaking them down, these have been subtracted from the Retail Rx category.

THCE in Washington, 2017-2019

Health care cost growth trends measured using THCE includes several measurements:

- Aggregate expenditures, statewide
- THCE, PMPY
- THCE, annual growth by market
- Other components of THCE:
    - NCPHI, aggregate
    - Other spending
    - TME

Health care spending is reported as total dollars spent on health care in Washington. This measurement can be affected by the number of people in Washington overall and the number of people with health insurance coverage.

THCE are utilized by Washington to identify health care spending growth at the state level. THCE includes all claims and non-claims-based spending, as well as spending on other public programs and the NCPHI. THCE provides a standardized comparison of how much is spent on health care per member each year that accounts for any underlying changes in the number of people.

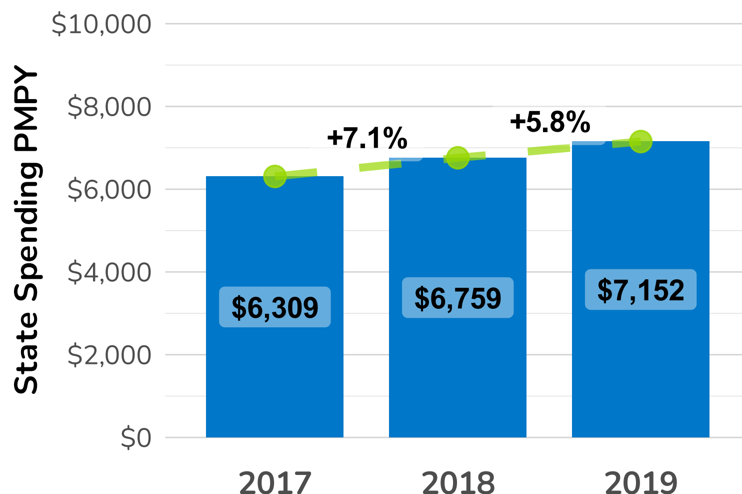
NCPHI measures the costs to Washington residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred, and consists of carriers' costs of paying bills, 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.

THCE, statewide, PMPY

In 2019, health care spending in Washington on a per member per year basis was $7,152, increasing from $6,309 in 2017 and $6,759 in 2018. This represents a 7.1% increase between 2017-2018 and a 5.8% increase between 2018-2019.

If the spending growth target was in effect during this measurement period, statewide, across all markets, Washington would have exceeded the 2022 target of 3.2%.

Figure 6: Growth in THCE



Components of THCE

NCPHI

NCPHI applies to commercial insurers, Medicare Advantage insurers, and Medicaid managed care organizations (MCOs). NCPHI is utilized to pay payer costs related to health care claims, paying bills, advertising, sales commissions, other administrative costs, premium taxes, and fees. It also includes a payer's profits (contribution to margin) or losses. NCPHI can fluctuate year to year depending on how accurately premium projections are able to forecast actual services rendered.

Aggregate NCPHI represents approximately 5.5% of total health care spending in Washington, roughly $2.6 billion in 2019.

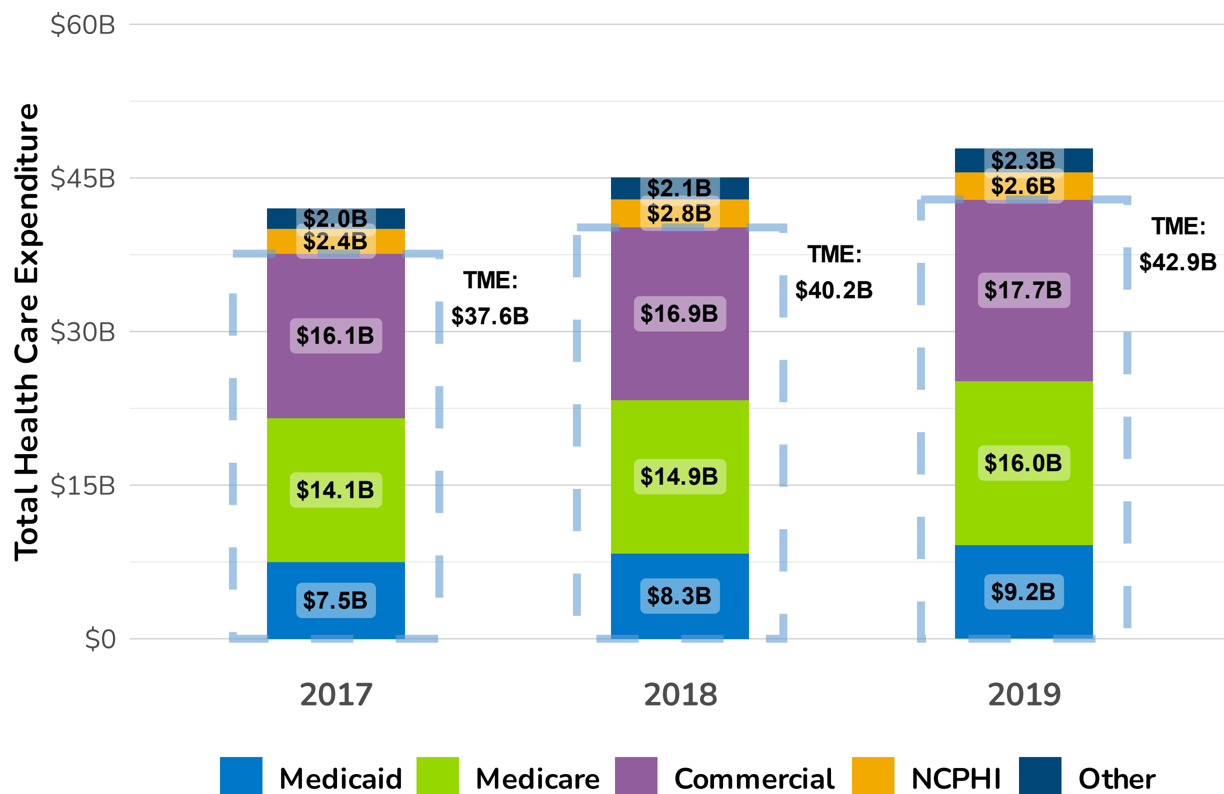
Other spending

Other spending includes health care spending in programs like the DOC, Veterans Affairs, and the L&I. Other spending totaled $2.3 billion in 2019, or about 4.8%.

TME

TME is the final component of THCE and includes the commercial, Medicare, and Medicaid markets. TME is covered in greater detail in the next section of this report.

Figure 8: Components of THCE



TME trends in Washington, 2017-2019

Health care cost growth trends measured using TME includes several measurements:

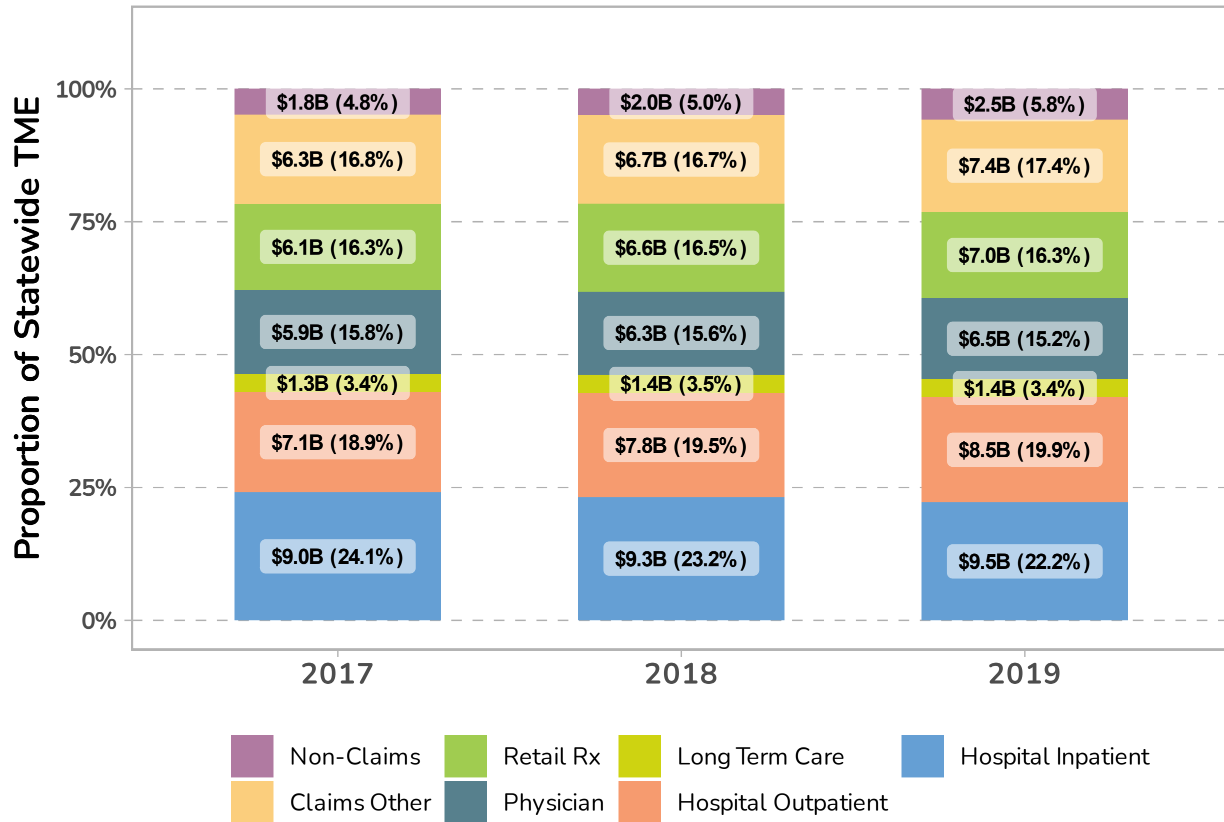
- Claims and non-claims spending, statewide
- TME growth by category, statewide and by market
- TME growth in per member per year spending, statewide and by market

When reporting on health care spending growth by service categories, Washington uses the TME measure, the methodology utilized by other states. TME is a subset of THCE and includes claims and non-claims payments only. Claims data for TME are reported net of pharmacy rebates.

Claims spending, statewide

The largest share of claims spending in Washington is Hospital Inpatient, totaling $9.5 billion in 2019 (roughly 22.2% of claims spending). Notably, while spending in this category increased, the proportion of overall claims spending declined in this period, from 24.1% to 22.2%. Hospital Outpatient services are the next largest spending category, at $8.5 billion (19.9%) in 2019, followed by the Other Claims category at $7.4 billion (17.4%).

Figure 9: Statewide TME spending and proportion by category



TME growth by market and category

Statewide TME growth

TME for the state increased from $37.6 billion in 2017 to $40.1 billion in 2018, representing a 6.8% increase. Similar spending growth was seen in 2019, reaching $42.8 billion in 2019, another 6.8% increase. Spending for all claims categories increased year-over-year between 2017-2019.

Figure 10: Statewide TME spending growth by category

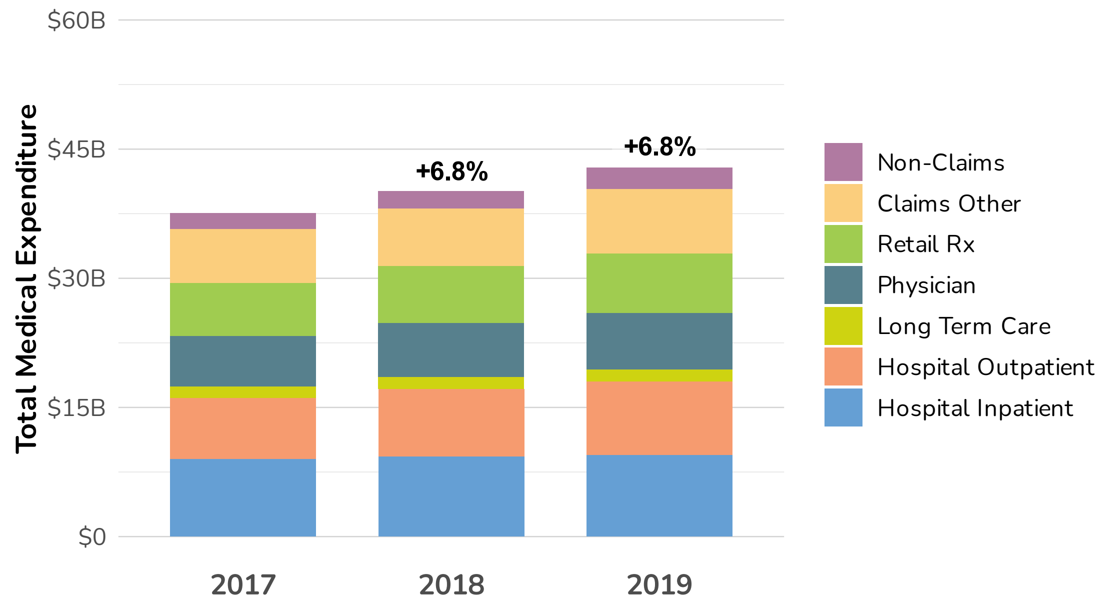
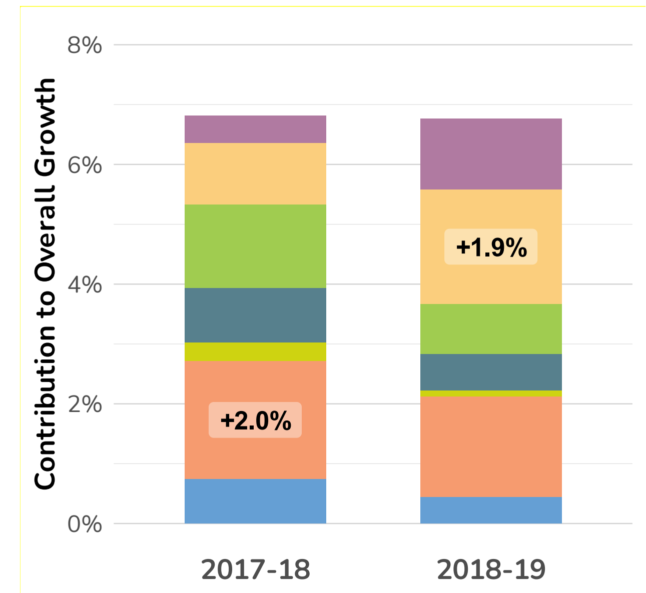


Figure 11: Statewide TME contribution to spending growth by category



Hospital Outpatient spending contributed the largest amount of growth between 2017 and 2018 spending, accounting for 2% of the 6.8%. Between 2018 and 2019, Claims Other contributed the most growth, accounting for 1.9% of the 6.8%.

Medicare TME growth

Medicare is the largest health care market in Washington by total dollars spent. Medicare serves adults aged 65 or older and some younger people with disabilities.

Figure 12: Medicare TME spending growth by category

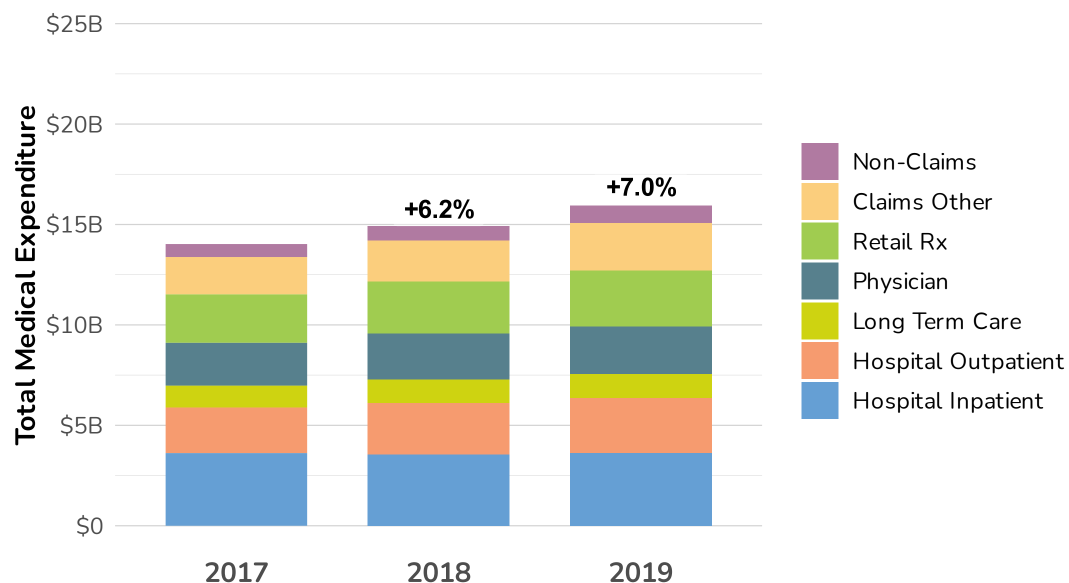
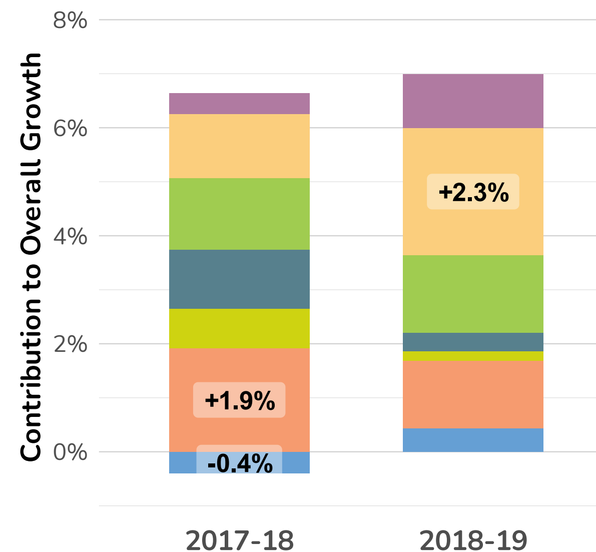


Figure 13: Medicare TME contribution to spending growth by category



Claims-based Medicare spending totaled $15.9 billion in 2019, rising 6.2% and 7% from 2017 to 2018 and 2018 to 2019, respectively. Growth in spending for Hospital Outpatient constituted 1.9%, the largest contributor to 2017-2018 growth. From 2018 to 2019, Claims Other represented the largest share of spending growth at roughly 2.3% of overall growth.

A small 0.4% decline in Hospital Inpatient spending between 2017 and 2018 reflects a long-term policy focus to control hospital spending by moving many procedures to outpatient facilities.

Commercial TME growth

Commercial health insurance is the second largest market in Washington. Individual, self-insured, student health insurance, and small and large group products are collectively referred to as the "commercial market."

Figure 14: Commercial TME spending growth by category

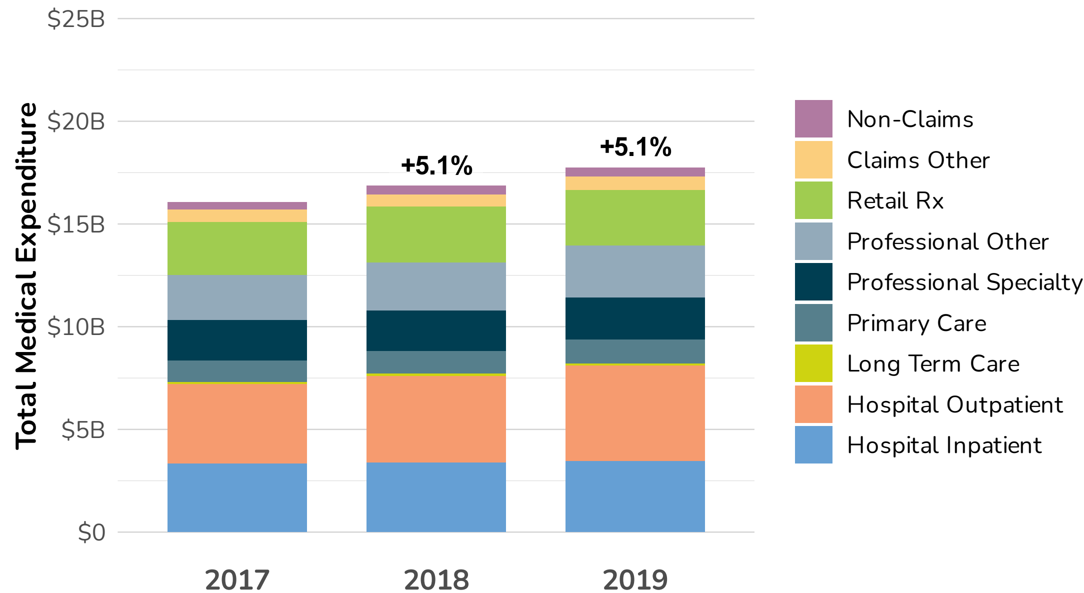
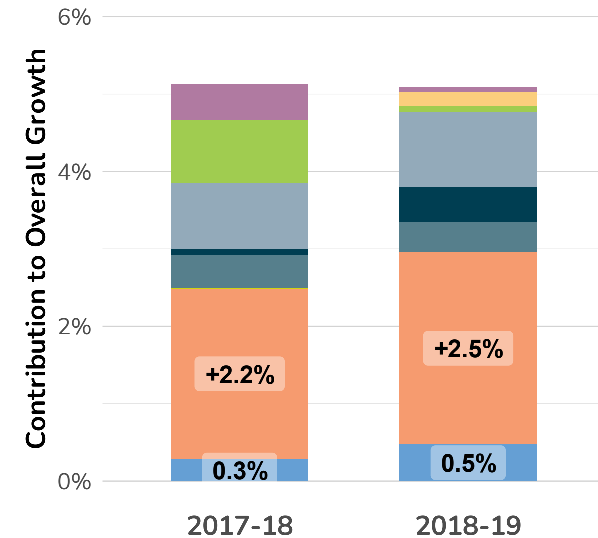


Figure 15: Commercial TME contribution to spending growth by category



Spending in the commercial market grew from $16.1 billion in 2017 to $16.9 billion in 2018 and $17.7 billion in 2019, growing by 5.1% each year. The largest contribution to growth from this period was Hospital Outpatient, which contributed 2.2% and 2.5% of the overall 5.1% growth between each year.

The policy to shift surgical procedures to outpatient facilities yielded increased spending in the commercial market, but hospital inpatient spending still grew by a modest 0.3% and 0.5%, respectively.

Medicaid TME growth

Medicaid provides health coverage to millions of Washingtonians, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. These figures reflect total spend for both Medicaid managed care and fee-for-service (FFS).

Figure 16: Medicaid TME spending growth by category

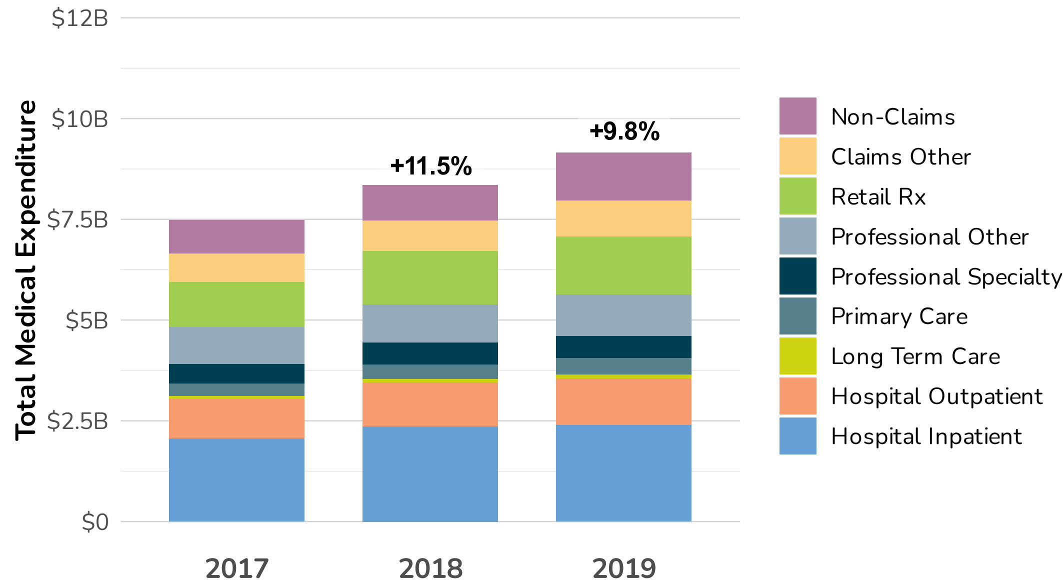
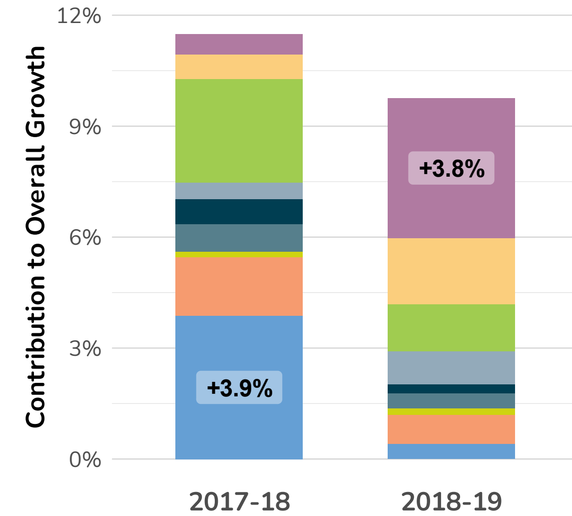


Figure 17: Medicaid TME contribution to spending growth by category



Total claims-based Medicaid spending in Washington was $1.2 billion in 2019, exhibiting the highest year-over-year growth of any market. From 2017 to 2018, Hospital Inpatient spending accounted for 3.9% of an 11.5% overall growth marker. Non-claims-based payments accounted for 3.8%, the largest portion of the 9.8% growth from 2018 to 2019.

Much of the growth of this period was driven by legislative directives on increased provider rates and hospital incentivization to increase access to health care. These policies supported expanding program eligibility and addressed market changes. Additionally, in this timeframe, behavioral health was being integrated into the Medicaid market.

Despite this spending growth rate, on a PMPY basis, Medicaid spending is still lower than in other markets (see Figure 2).

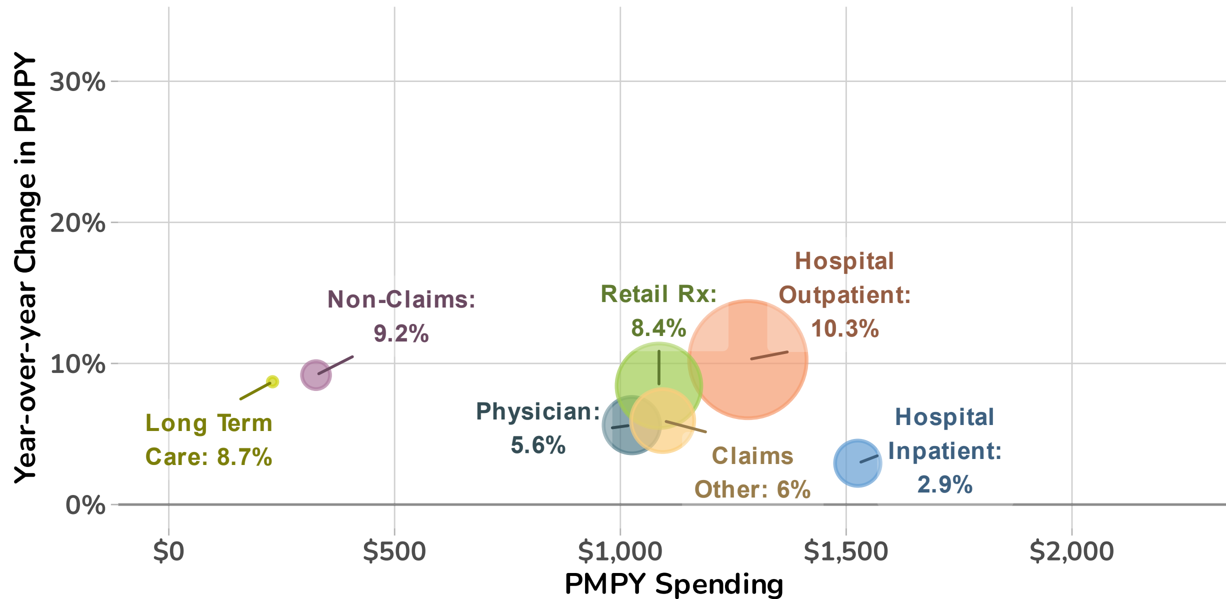
TME growth in PMPY spending by category – statewide and by market

The previous figures presented total dollars spent on health care in Washington by service category and by market. These sums, however, are a product of the number of people in Washington overall and the number of people with health insurance coverage in a particular market. TME can also be reported on a PMPY basis to provide a standardized comparison across markets and service categories. The next figures summarize the growth rate for PMPY spending, by market.

State spending by category, PMPY

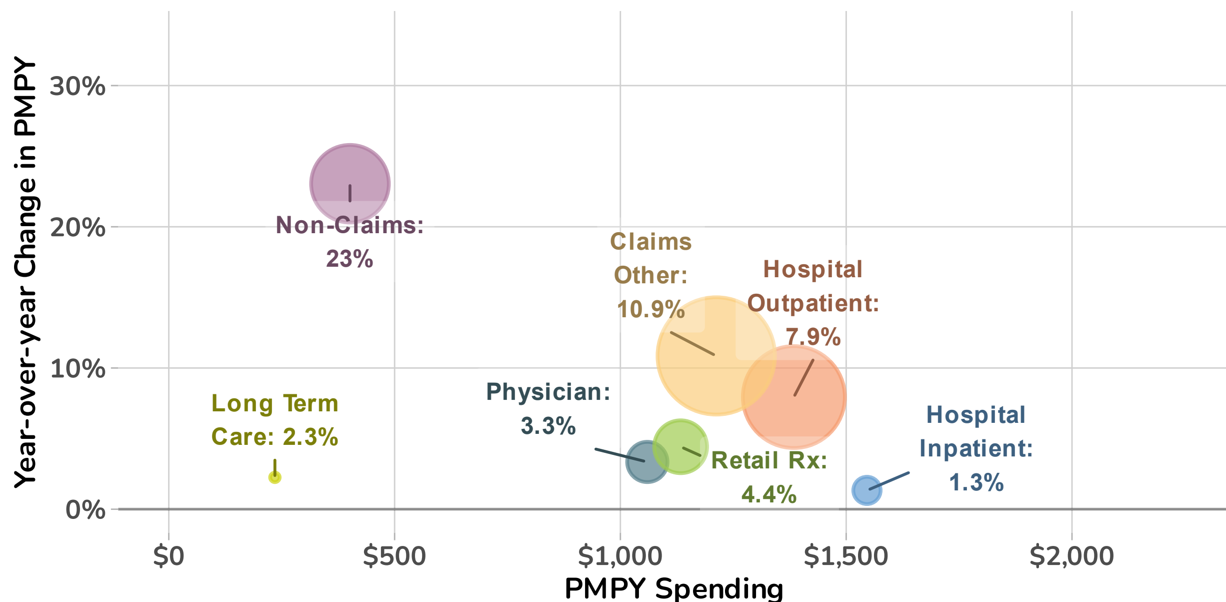
PMPY state spending increased between 2017-2018 in most service categories across all markets. Hospital Outpatient services experienced some of the largest growth at 10.27%. Hospital Inpatient spending grew as well, although at a lower rate, by 2.93%. Some of the most substantial growth was in Retail Rx, which saw an 8.42% increase.

Figure 18: State claims PMPY growth by category, 2017-2018



Again between 2018 and 2019, PMPY spending in all claims-based categories increased. Hospital Outpatient again saw substantial increased spending, climbing another 7.94%. The largest increases were seen in the Non-claims and Claims Other categories, growing by 23.05% and 10.85%, respectively. Those three categories comprised most of the growth in year-over-year spending during this period.

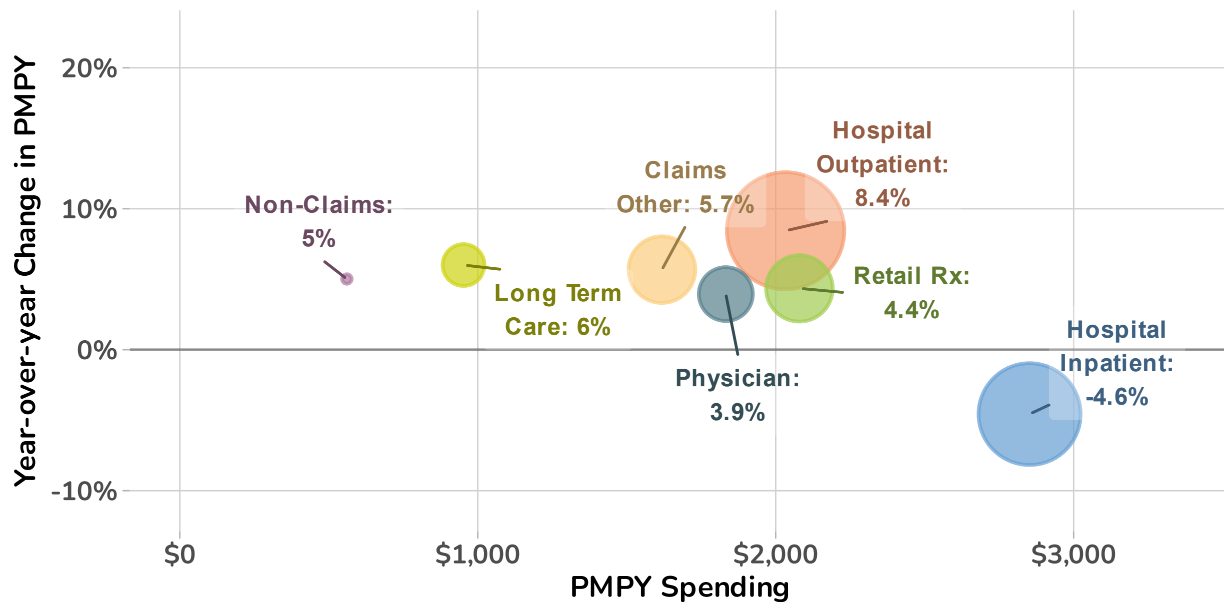
Figure 19: State claims PMPY growth by category, 2018-2019



Medicare spending by category, PMPY

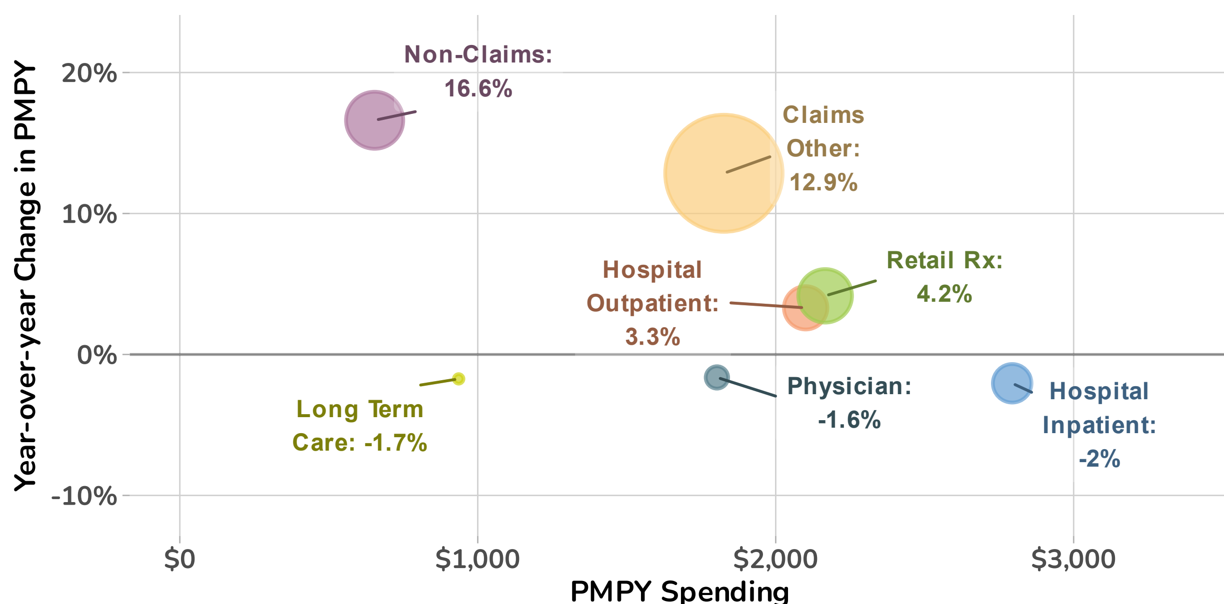
Between 2017-2018, PMPY spending in the Medicare markets increased across most claims-based categories. The most notable exception was the Hospital Inpatient category, which saw a 4.6% decrease. At the same time, Hospital Inpatient decreased by 4.6%, reflecting the implementation of a strategy to shift some surgical procedures to outpatient facilities to control costs. All other categories increased during this time period.

Figure 20: Medicare claims PMPY growth by category, 2017-2018



From 2018 to 2019, that same shift in Medicare spending can be observed between Hospital Inpatient and Outpatient, albeit a more modest shift of -2% and +3.3%, respectively. The two highest increases were observed in Non-Claims and Claims Other categories.

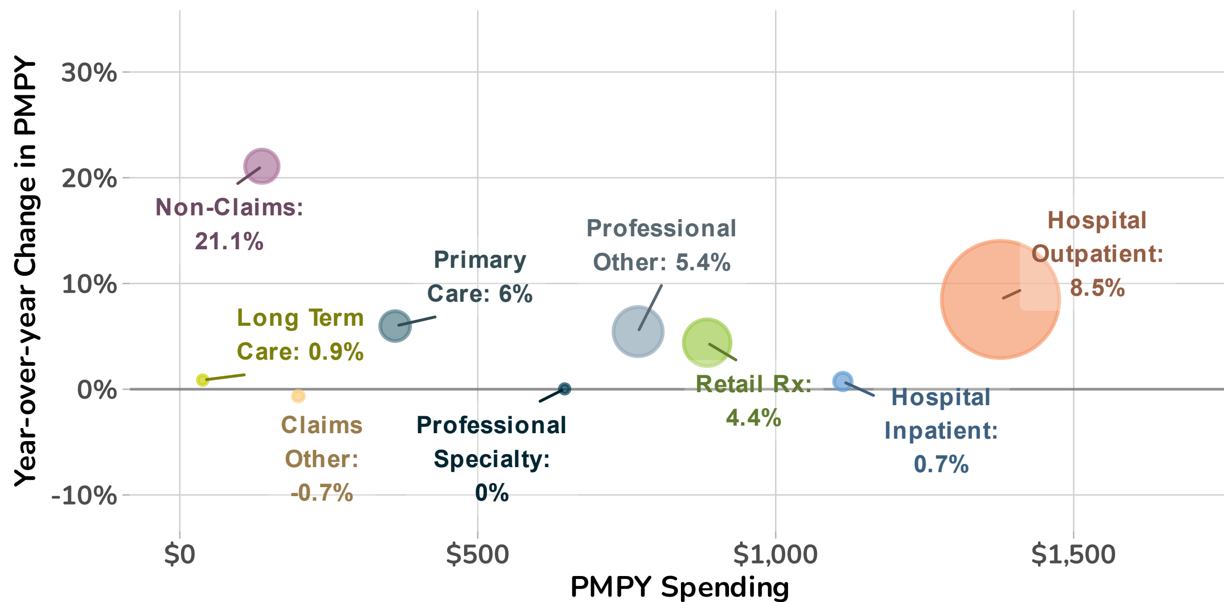
Figure 21: Medicare claims PMPY growth by category, 2018-2019



Commercial spending by category, PMPY

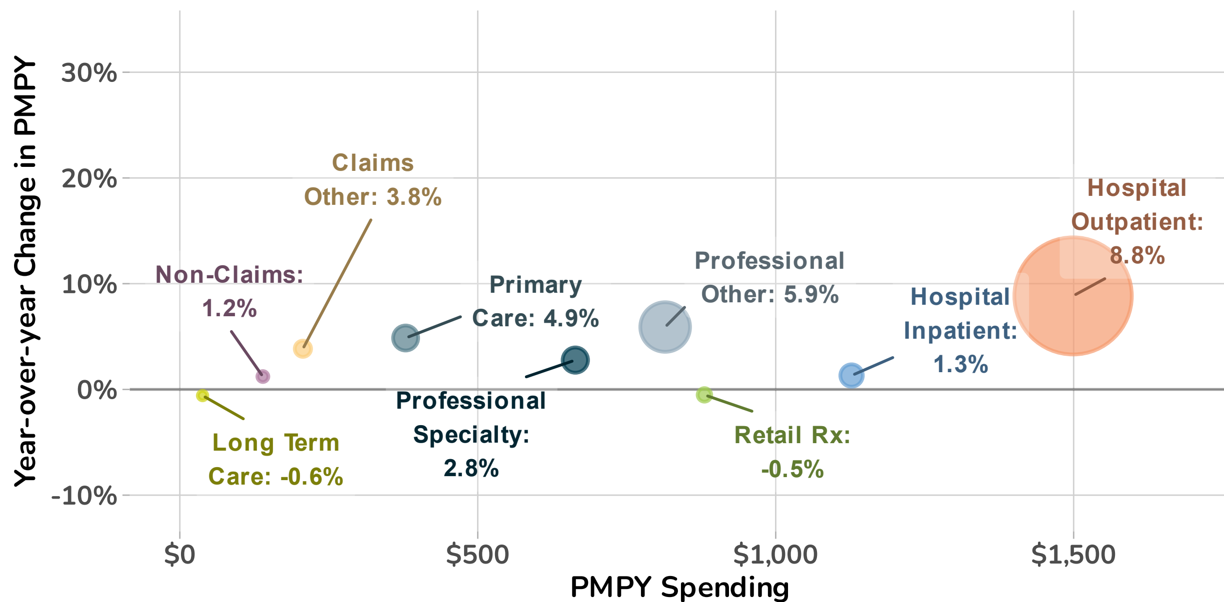
The commercial market saw substantial growth in PMPY spending between 2017-2018; spending in nearly all claims-based categories increased. The category with the highest spending level, Hospital Outpatient services, saw an 8.49% increase. High year-over-year variation was also seen in Non-Claims and Primary Care categories with 21.08% and 5.97% increases.

Figure 22: Commercial claims PMPY growth by category, 2017-2018



The Hospital Outpatient category again saw substantial increased spending between 2018 and 2019, climbing an additional 8.8%. Also, for this year, the Professional Other category saw large increased spending of 5.9%.

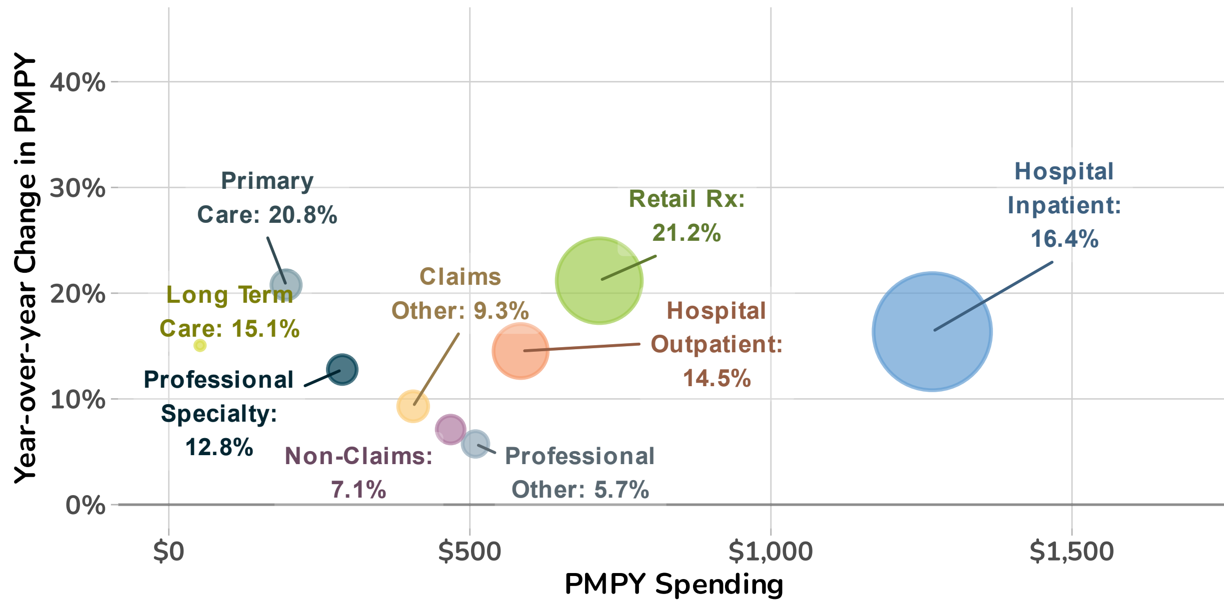
Figure 23: Commercial claims PMPY growth by category, 2018-2019



Medicaid spending by category, PMPY

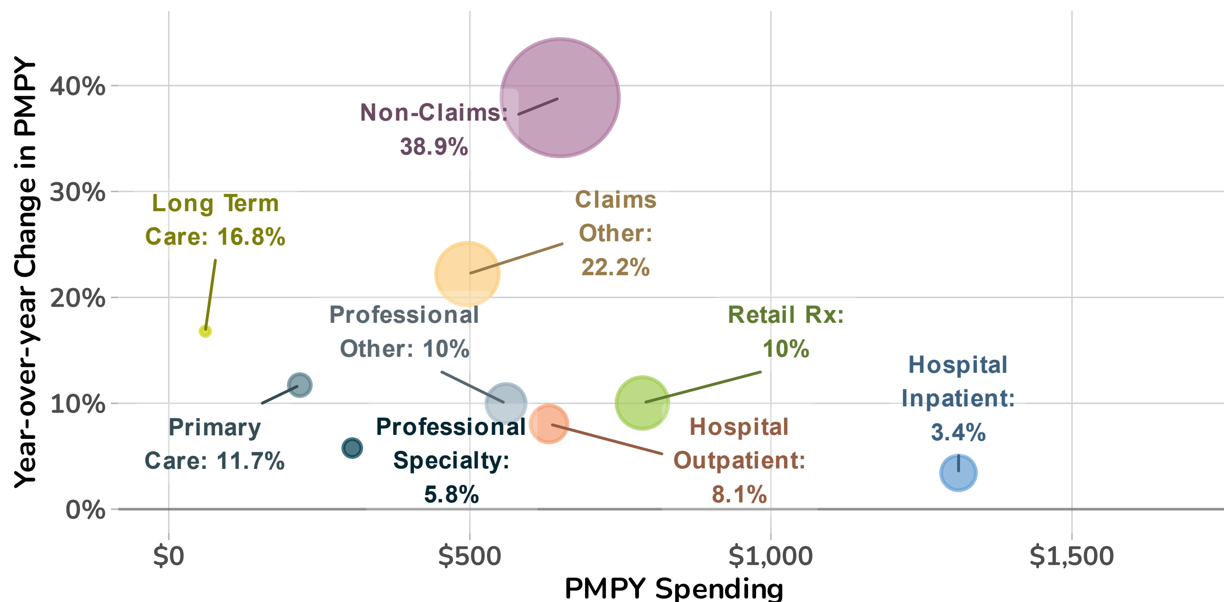
The 13.8% increase in THCE between 2017-2018 (Figure 2) was driven by substantial spending increases in all service categories. Hospital Inpatient and Outpatient increased by 16.36% and 14.53%. Two service categories increased by even greater measures, with Retail Rx increasing by 21.18% and Primary Care increasing by 20.77%. These across-the-board increases reflect new legislation going into effect that increased provider reimbursement rates.

Figure 24: Medicaid claims PMPY growth by category, 2017-2018



Between 2018-2019, PMPY spending increased in all claims-based categories for Medicaid. The largest increase in spending was for Non-Claims, increasing by 38.86%. Claims Other increased by 22.2%, while the category with the highest spending PMPY, Hospital Inpatient, increased by a modest 3.43%.

Figure 25: Medicaid claims PMPY growth by category, 2018-2019



Conclusion

COVID-19 will impact future benchmark reports

Collecting total cost of care data from 2017 to 2019 provides insight into where health spending was before COVID-19. Future years' reports, with data from 2020 onwards, will provide additional insights into the impacts of the pandemic on health care spending.[3] While those reports are not built to comprehensively examine the complex nature and impacts of a global infectious disease outbreak, they will shine a light on the initial impacts that the pandemic had on utilization and on payments between payers and provider organizations.

This is a high-level view, additional research necessary

The total cost of care spending in Washington is a high-level view of how health care dollars are flowing through the system. Many factors influence Washington's total cost of care, including insurance coverage across the state, health care prices set by contracts negotiated between health insurers and providers in the previous year, non-claims payment arrangements (e.g., value-based payments), insurance premium rates, and patient utilization.

Additional research and understanding of increasing health care spending are necessary to facilitate and enhance efforts to improve affordability. The Cost Board's evidence-based approach to health care cost data provides a common understanding of spending trends for consumers, purchasers, and regulators to help make health care more affordable in Washington.

[3]Peterson-KFF Health System Tracker. How have health spending and utilization changed during the coronavirus pandemic? March 2021

Appendix A: 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.

Capitation: A method of paying health care providers or organizations in which they receive a predictable, upfront, set amount of money to cover the predicted cost of all or some of the health care services for a specific patient over a certain period of time.

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.[4] 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).[5]

---

[4] 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.)

[5] 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.

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

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 B: 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