Health Care Cost Transparency Board's Advisory Committee on Data Issues & Advisory Committee of Health Care Providers and Carriers

(Joint Meeting)
March 7, 2024

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

JOINT MEETING

Advisory Committee on Data Issues *and* Advisory Committee of Health Care Providers and Carriers

March 7, 2024
2:00 – 4:00 p.m.
Hybrid Meeting: Zoom with In-Person Availability

AGENDA

Advisory Committee on Data Issues Committee Members:					
☐	Christa Able	☐	Chandra Hicks	☐	Mark Pregler
☐	Megan Atkinson	☐	Leah Hole-Marshall	☐	Russ Shust
☐	Amanda Avalos	☐	Lichiou Lee	☐	Mandy Stahre
☐	Jonathan Bennett	☐	David Mancuso	☐	Julie Sylvester
☐	Bruce Brazier	☐	Ana Morales		
☐	Jason Brown	☐	Hunter Plumer		

Advisory Committee of Health Care Providers and Carriers Committee Members:					
☐	Bob Crittenden	☐	Stacy Kessel	☐	Natalia Martinez-Kohler
☐	Justin Evander	☐	Ross Laursen	☐	Jeb Shepard
☐	Paul Fishman	☐	Eric Lewis	☐	Dorothy Teeter
☐	Jodi Joyce	☐	Todd Lovshin	☐	Wes Waters
☐	Louise Kaplan	☐	Vicki Lowe		

Committee Facilitators:
Health Management Associates, Rachelle Bogue & Mandy Weeks-Green

Time	Agenda Items	Tab	Lead
2:00 - 2:10 (10 min)	Welcome, Agenda, Roll Call, and Introduction to Health Management Associates	1	Rachelle Bogue Health Care Authority
2:10 – 2:15 (5 min)	Approval of the January Meeting Summary	2	Rachelle Bogue Health Care Authority
2:15 – 2:30 (15 min)	Public Comments	3	Rachelle Bogue Health Care Authority
2:30 – 2:50 (20 min)	Legislative Updates	4	Evan Klein Health Care Authority
2:50 - 3:30 (40 min)	Cost Board Workplan and Discussion	5	Liz Arjun and Gary Cohen Health Management Associates
3:30 – 3:40 (10 min)	2024 Data Call	6	Sheryll Namingit Health Care Authority
3:40	Adjourn (Potentially adjourning shortly before 4 pm)		Rachelle Bogue Health Care Authority

Tab 2

Washington State Health Care Authority

Joint Meeting of Advisory Committee on Data Issues and Advisory Committee of Health Care Providers and Carriers meeting summary

January 18, 2024

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

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the Committees is available on the **Advisory Committee on Data Issues** and the **Advisory Committee of Health Care Providers and Carriers** webpages.

Advisory Committee on Data Issues

Members present

Christa Able
Megan Atkinson
Amanda Avalos
Chandra Hicks
Lichiou Lee
Leah Hole-Marshall
David Mancuso
Ana Morales
Hunter Plumer
Mark Pregler
Russ Shust
Mandy Stahre
Julie Sylvester

Members absent

Jonathan Bennett
Bruce Brazier
Jason Brown

Advisory Committee of Health Care Providers and Carriers

Members present

Bob Crittenden
Justin Evander
Louise Kaplan
Stacy Kessel
Eric Lewis
Vicki Lowe
Natalia Martinez-Kohler
Jeb Shepard
Dorothy Teeter
Wes Waters

Members absent

Paul Fishman
Jodi Joyce
Ross Laursen
Todd Lovshin

Washington State Health Care Authority

Call to order

Mandy Weeks-Green, committee facilitator, called the meeting to order at 2:03 p.m.

Agenda items

Welcoming remarks

Mandy Weeks-Green welcomed the committee members to the joint session and introduced Eric Lewis, Chief Financial Officer of the Washington State Hospital Association, as the newest member of the Cost Board's Advisory Committee of Health Care Providers and Carriers.

Public comment

Mandy Weeks-Green called for comments from the public, having received no written comments prior to the meeting.

Katerina LaMarche, Washington State Hospital Association (WSHA), had questions regarding the provider report template that would be presented at this meeting. She deferred her questions to being able to review the updated document, but referenced the motion brought forward by WSHA and the Washington State Medical Association at the previous meeting. The amended motion which passed had requested clarification of methodology and metrics of the benchmark materials so that providers can offer greater access to health care.

The public comment section of the meeting begins at **timestamp 10:04**.

Preliminary Spending Growth Benchmark of the Cost Board

Vishal Chaudhry, Chief Data Officer, HCA

Vishal Chaudhry **presented preliminary results** of the Washington Health Care Spending growth benchmark data. Prefacing the data, Vishal Chaudhry emphasized that there is still ongoing work to finalize results. The presentation began with a review of the reporting cycle timeline over the next five years, key terminology, and which payers submitted data that went into the report. The context of the data and caveats of what data is still missing was communicated prior to presenting the State and Market levels results for 2017-2019. Total health care expenditures in Washington were $48B in 2019, reflecting a cost growth of 7.15 percent and 5.81 percent from 2017 and 2018 levels respectively. State Spending by Category (Claims, Non-Claims, Retail Rx, Long Term Care, Physician, Hospital Inpatient, and Hospital Outpatient) showed little change in proportion between 2017-2019. Medicaid showed Per Member Per Year (PMPY) yearly growth of 13.8 and 11.9 percent in that same period, with Megan Atkinson, HCA's Chief Financial Officer, offering policy-related context for the growth during this period. Much of the growth was a product of legislative directives that increased behavioral health spending, provider reimbursement rates, and expanded eligibility. Medicare spending PMPY grew slower than Medicaid in the same period (6.2 and 7.0 percent), even while total Medicare spending is significantly higher than that of Medicaid. Commercial spending increased 4.5 and 4.0 percent between 2017 and 2019. Vishal Chaudhry concluded by discussing 2024 work that included finalization of this data, the next data call for 2021 and 2022, and exploration of cost containment strategies to recommend to the Legislature. The board's discussion of the data begins at **timestamp 46:20**. Discussion from committee members included clarification that FMAP, ED visits, and value-based payments were captured in the data, and similarly the analysis in the pandemic years will need to account for the infusion of federal dollars. Committee members confirmed that trends seen in the analysis reflect trends in the health care sector which saw movement of patient treatments from inpatient to outpatient. Additional analysis was requested to better understand how this trend affected overall spending. Members discussed the high inflation rates and increased labor costs of recent years, noting that benchmark targets may be difficult to achieve. Vishal Chaudhry noted that the Board is expected to review the benchmark in future meetings.

Washington State Health Care Authority

Informational Updates and 2024 Workplan

Mandy Weeks-Green, Board and Commissions Director at the Health Care Authority
Sheryll Namingit, Health Economics Research Manager

Mandy Weeks-Green **provided a series of informational updates** for committee members. The first reports are expected to be sent in around one month after final identification of the relevant list of providers. 2024 is not a reporting year, so providers will not be compared to the benchmark. The draft cover letter was made available in meeting materials, noting that participation of a webinar will be available to providers to ask questions regarding methodology. Sheryll Namingit **presented the draft report** that will be sent to providers attributed more than 10,000 lives. The cover page of the spreadsheet gives a brief explanation of the work of the Cost Board and the 2022 Data Call, as well as providing contact information for questions and feedback. In total, there are eight tables (Table 1-Table 8) in the report, beginning in Table 1 with an overview of provider performance across the commercial, Medicare, and Medicaid markets against all providers in table and graph form. These figures are risk adjusted and a 95% confidence interval is calculated for each measure. Table 2 and 3 show Member Month calculations. Table 4 breaks down claims expenses by market and year. Table 5 covers non-claims expenses and Table 6 shows Total Medical Expenditure (TME) for the provider by market and year. Table 7 breaks down TME by service category for each market and year. Finally, Table8 provides details on provider risk scores and the confidence interval calculation.

Comments from committee members began at **timestamp 1:08:45**. A key question addressed was how a 'provider' was defined, and members were referred to the definition in the cover letter of the report. A large provider subject to benchmark reporting is a provider with 10,000 covered lives that offers primary care services, with 26 providers passing validation for the 2022 benchmark. The provider report will not include information about which lives, carriers, and physicians are attributed to them to avoid a risk to privacy, but providers would be able to work with carriers to cross-validate figures in the report. The attribution model used for this benchmark is similar to the model used by other states doing similar work.

Mandy Weeks-Green **shared the 2024 Workplan** with the committees that plans to have the two committees meet jointly throughout the year to ensure that information and feedback is given and received for the key goals of the year including analytic reports, 2024 data call, and benchmark information. Key dates and meeting cadence is included in the meeting materials.

Adjournment

The meeting was adjourned at 3:26 p.m.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Tab 4

Washington State Health Care Authority

SECOND ENGROSSED SUBSTITUTE HOUSE BILL 1508

State of Washington 68th Legislature 2023 Regular Session

By House Appropriations (originally sponsored by Representatives Macri, Riccelli, Simmons, Fitzgibbon, Berry, Alvarado, Bateman, Ormsby, Doglio, Reed, Callan, Stonier, Tharinger, and Bergquist)

READ FIRST TIME 02/24/23.

AN ACT Relating to improving consumer affordability through the health care cost transparency board; amending RCW 70.390.040, 70.390.050, 70.390.070, and 70.405.030; adding new sections to chapter 70.390 RCW; and adding a new section to chapter 43.71C RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 70.390.040 and 2020 c 340 s 4 are each amended to read as follows:

(1) The board shall establish an advisory committee on data issues and ((~~an~~)) a health care stakeholder advisory committee ((~~of health care providers and carriers~~)). The board may establish other advisory committees as it finds necessary. Any other standing advisory committee established by the board shall include members representing the interests of consumer, labor, and employer purchasers, at a minimum, and may include other stakeholders with expertise in the subject of the advisory committee, such as health care providers, payers, and health care cost researchers.

(2) Appointments to the advisory committee on data issues shall be made by the board. Members of the committee must have expertise in health data collection and reporting, health care claims data analysis, health care economic analysis, ((~~and~~)) actuarial analysis, or other relevant expertise related to health data.

(3) Appointments to the health care stakeholder advisory committee ((~~of health care providers and carriers~~)) shall be made by the board and must include the following membership:

(a) One member representing hospitals and hospital systems, selected from a list of three nominees submitted by the Washington state hospital association;

(b) One member representing federally qualified health centers, selected from a list of three nominees submitted by the Washington association for community health;

(c) One physician, selected from a list of three nominees submitted by the Washington state medical association;

(d) One primary care physician, selected from a list of three nominees submitted by the Washington academy of family physicians;

(e) One member representing behavioral health providers, selected from a list of three nominees submitted by the Washington council for behavioral health;

(f) One member representing pharmacists and pharmacies, selected from a list of three nominees submitted by the Washington state pharmacy association;

(g) One member representing advanced registered nurse practitioners, selected from a list of three nominees submitted by ARNPs united of Washington state;

(h) One member representing tribal health providers, selected from a list of three nominees submitted by the American Indian health commission;

(i) One member representing a health maintenance organization, selected from a list of three nominees submitted by the association of Washington health care plans;

(j) 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;

(k) One member representing a health care service contractor, selected from a list of three nominees submitted by the association of Washington health care plans;

(l) One member representing an ambulatory surgery center selected from a list of three nominees submitted by the ambulatory surgery center association; ((~~and~~))

(m) 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;

(n) At least two members representing the interests of consumers, selected from a list of nominees submitted by consumer organizations;

(o) At least two members representing the interests of labor purchasers, selected from a list of nominees submitted by the Washington state labor council; and

(p) 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.

Sec. 2. RCW 70.390.050 and 2020 c 340 s 5 are each amended to read as follows:

(1) The board has the authority to establish and appoint advisory committees, in accordance with the requirements of RCW 70.390.040, and shall seek input and recommendations from ((~~the~~)) relevant advisory committees ((~~on topics relevant to the work of the board~~)).

(2) The board shall:

(a) Determine the types and 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, and analyze the impact of cost drivers on health care spending, including execution of any necessary access and data security agreements with the custodians of the data. The board shall first 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. The board may use data received from existing data sources including, but not limited to, publicly available information filed by carriers under Title 48 RCW and data collected under chapters 43.70, 43.71, 43.71C, 43.371, and 70.405 RCW, in its analyses and discussions to the same extent that the custodians of the data are permitted to use the data. As appropriate to promote

administrative efficiencies, the board may share its data with the prescription drug affordability board under chapter 70.405 RCW and other health care cost analysis efforts conducted by the state;

(b) 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. The board must select an appropriate economic indicator to use when establishing the health care cost growth benchmark. The activities may include selecting methodologies and determining sources of data. The board shall ((~~accept~~)) solicit and consider recommendations from the advisory committee on data issues and the health care stakeholder advisory committee ((~~of health care providers and carriers~~)) regarding the value and feasibility of reporting various categories of information under (c) of this subsection, such as urban and rural, public sector and private sector, and major categories of health services, including prescription drugs, inpatient treatment, and outpatient treatment;

(c) Annually calculate total health care expenditures and health care cost growth:

(i) Statewide and by geographic rating area;

(ii) For each health care provider or provider system and each payer, taking into account the health status of the patients of the health care provider or the enrollees of the payer, utilization by the patients of the health care provider or the enrollees of the payer, intensity of services provided to the patients of the health care provider or the enrollees of the payer, and regional differences in input prices. The board must develop an implementation plan for reporting information about health care providers, provider systems, and payers;

(iii) By market segment;

(iv) Per capita; and

(v) For other categories, as recommended by the advisory committees in (b) of this subsection, and approved by the board;

(d) Annually establish the health care cost growth benchmark for increases in total health expenditures. The board, in determining the health care cost growth benchmark, shall begin with an initial implementation that applies to the highest cost drivers in the health care system and develop a phased plan to include other components of the health system for subsequent years;

(e) Beginning in 2023, analyze the impacts of cost drivers to health care and incorporate this analysis into determining the annual total health care expenditures and establishing the annual health care cost growth benchmark. The cost drivers may include, to the extent such data is available:

(i) Labor, including but not limited to, wages, benefits, and salaries;

(ii) Capital costs, including but not limited to new technology;

(iii) Supply costs, including but not limited to prescription drug costs;

(iv) Uncompensated care;

(v) Administrative and compliance costs;

(vi) Federal, state, and local taxes;

(vii) Capacity, funding, and access to postacute care, long-term services and supports, and housing; ((~~and~~))

(viii) Regional differences in input prices; ((~~and~~ ~~(f)~~)) (ix) Financial earnings of health care providers and payers, including information regarding profits, assets, accumulated surpluses, reserves, and investment income, and similar information;

(x) Utilization trends and adjustments for demographic changes and severity of illness;

(xi) New state health insurance benefit mandates enacted by the legislature that require carriers to reimburse the cost of specified procedures or prescriptions; and

(xii) Other cost drivers determined by the board to be informative to determining annual total health care expenditures and establishing the annual health care cost growth benchmark; and

(f) Release reports in accordance with RCW 70.390.070.

Sec. 3. RCW 70.390.070 and 2020 c 340 s 7 are each amended to read as follows:

((~~(1) By August 1, 2021, the board shall submit a preliminary report to the governor and each chamber of the legislature. The preliminary report shall address the progress toward establishment of the board and advisory committees and the establishment of total health care expenditures, health care cost growth, and the health care cost growth benchmark for the state, including proposed methodologies for determining each of these calculations. The preliminary report shall include a discussion of any obstacles related to conducting the board's work including any deficiencies in~~

~~data necessary to perform its responsibilities under RCW 70.390.050 and any supplemental data needs.~~

~~(2) Beginning August 1, 2022~~)) By December 1st of each year, the board shall submit annual reports to the governor and each chamber of the legislature. ((~~The first annual report shall determine the total health care expenditures for the most recent year for which data is available and shall establish the health care cost growth benchmark for the following year.~~)) The annual reports may include policy recommendations applicable to the board's activities and analysis of its work, including any recommendations related to lowering health care costs, focusing on private sector purchasers, and the establishment of a rating system of health care providers and payers.

NEW SECTION. **Sec. 4.** A new section is added to chapter 70.390 RCW to read as follows:

(1) At least biennially, the board shall conduct a survey of underinsurance among Washington residents.

(a) The survey shall be conducted among a representative sample of Washington residents. Analysis of the survey results shall be disaggregated to the greatest extent feasible by demographic factors such as race, ethnicity, gender and gender identity, age, disability status, household income level, type of insurance coverage, geography, and preferred language. In addition, the survey shall be designed to allow for the analyses of the aggregate impact of out-of-pocket costs and premiums according to the standards in (b) of this subsection as well as the share of Washington residents who delay or forego care due to cost.

(b) The board shall measure underinsurance as the share of Washington residents whose out-of-pocket costs over the prior 12 months, excluding premiums, are equal to:

(i) For persons whose household income is over 200 percent of the federal poverty level, 10 percent or more of household income;

(ii) For persons whose household income is less than 200 percent of the federal poverty level, five percent or more of household income; or

(iii) For any income level, deductibles constituting five percent or more of household income.

(c) Beginning in 2026, the board may implement improvements to the measure of underinsurance defined in (b) of this subsection, such

as a broader health care affordability index that considers health care expenses in the context of other household expenses.

(2) At least biennially, the board shall conduct a survey of insurance trends among employers and employees. The survey must be conducted among a representative sample of Washington employers and employees.

(3) The board may conduct the surveys through the authority, by contract with a private entity, or by arrangement with another state agency conducting a related survey.

(4) Beginning in 2025, analysis of the survey results shall be included in the annual report required by RCW 70.390.070.

NEW SECTION. **Sec. 5.** A new section is added to chapter 70.390 RCW to read as follows:

(1) No later than December 1, 2024, and annually thereafter, the board shall hold a public hearing related to discussing the growth in total health care expenditures in relation to the health care cost growth benchmark in the previous performance period, in accordance with the open public meetings act, chapter 42.30 RCW. The agenda and any materials for this hearing must be made available to the public at least 14 days prior to the hearing.

(2)(a) Except as provided in (b) of this subsection, to the extent data permits, the hearing must include the public identification of any payers or health care providers for which health care cost growth in the previous performance period exceeded the health care cost growth benchmark.

(b) Provider groups with fewer than 10,000 unique attributed lives shall be exempt from identification under (a) of this subsection.

(3) At the hearing, the board:

(a) May require testimony by payers or health care providers that have substantially exceeded the health care cost growth benchmark in the previous calendar year to better understand the reasons for the excess health care cost growth and measures that are being undertaken to restore health care cost growth within the limits of the benchmark;

(b) Shall invite testimony from health care stakeholders, other than payers and health care providers, including health care consumers, business interests, and labor representatives; and

(c) Shall provide an opportunity for public comment.

NEW SECTION. **Sec. 6.** A new section is added to chapter 43.71C RCW to read as follows:

Information collected pursuant to this chapter may be shared with the health care cost transparency board established under chapter 70.390 RCW, subject to the same disclosure restrictions applicable under this chapter.

Sec. 7. RCW 70.405.030 and 2022 c 153 s 3 are each amended to read as follows:

By June 30, 2023, and annually thereafter, utilizing data collected pursuant to ((~~chapter~~)) chapters 43.71C, 43.371, and 70.390 RCW, ((~~the all-payer health care claims database,~~)) or other data deemed relevant by the board, the board must identify prescription drugs that have been on the market for at least seven years, are dispensed at a retail, specialty, or mail-order pharmacy, are not designated by the United States food and drug administration under 21 U.S.C. Sec. 360bb as a drug solely for the treatment of a rare disease or condition, and meet the following thresholds:

(1) Brand name prescription drugs and biologic products that:

(a) Have a wholesale acquisition cost of $60,000 or more per year or course of treatment lasting less than one year; or

(b) Have a price increase of 15 percent or more in any 12-month period or for a course of treatment lasting less than 12 months, or a 50 percent cumulative increase over three years;

(2) A biosimilar product with an initial wholesale acquisition cost that is not at least 15 percent lower than the reference biological product; and

(3) Generic drugs with a wholesale acquisition cost of $100 or more for a 30-day supply or less that has increased in price by 200 percent or more in the preceding 12 months.

--- END ---

Tab 5

Washington State Health Care Authority

Joint Meeting

Advisory Committee of Health Care Providers and Carriers & Advisory Committee on Data Committees

March 7, 2024

Washington State Health Care Authority

Today's Agenda

- Legislative Update
- Cost Board Workplan and Process Update
  - Policy Selection
- Data Call Update

POLICY OPTIONS TO LOWER HEALTH CARE COSTS AND IMPROVE AFFORDABILITY

HEALTH CARE COST TRANSPARENCY BOARD RETREAT RECAP

- With the Board's increased attention towards how the state and purchasers might address health care costs, several policies were presented to the Board at the February retreat for potential analysis in 2024.

- The list was gathered by HCA staff and the consultant team and included policies that ranged from targeted to broad, from short-to-medium-to-long term with varying degrees of expected impacts.

- The list also included information as to whether or not there was an active effort associated with the policy underway in the state.

HEALTH CARE COST TRANSPARENCY BOARD RETREAT RECAP

- At the retreat, the Board heard from:
  - OIC Senior Policy Analyst Jane Beyer about an affordability study they are in the midst of which may include actuarial and economic analyses of some of these policies.
  - Office of the Attorney General regarding the AG's Health Care Affordability Preliminary Report
  - Cost Board Managers from several states to discuss policies, process and actions taken in those states including:
    - Massachusetts
    - Oregon
    - Rhode Island

OPTIONS TO ADDRESS HEALTH CARE COSTS AND IMPROVE AFFORDABILITY

	Being Addressed Elsewhere	Not Being Addressed
May Impact but not Targeted at Costs	Administrative Simplification 🟡 (2)	Private Equity 🔴 (2)
Consumer and Purchaser Cost Protections	Balance Billing 🔴 (1)	Limiting Facility Fees 🔴 (1) Limiting or Capping Out of Network 🟡 (2)
Transparency Tools for Consumers and Regulators		Increased Hospital Price Transparency 🟡 (1) Community Benefit Transparency 🟡 (1)
High Costs	Global Budgets 🟢 (3) PBM Spread Pricing 🟡 (2)	Reference Based Pricing (Public Option) 🟢 (3) Consolidated State Purchasing 🟢 (3) Price Growth Caps 🟢 (3) Provider Rate Setting 🟢 (3)
Enhanced Regulatory Authority	Rate Review Authority 🟡 (2) Mergers and Acquisitions, 🟢 (2)	Restricting Anti-Competitive Clauses in Health Care Contracting 🟢 (1)

🟢 = *High Impact*
🟡 = *Medium Impact*
🔴 = *Low Impact*

(1) = *Short Term*
(2) = *Medium Term*
(3) = *Long Term*

HEALTH CARE COST TRANSPARENCY BOARD RETREAT RECAP

- Following a robust discussion, the Board was asked to prioritize which policies they would like to focus on during 2024 to identify recommendations in their legislative reports to the Legislature.
  - The Board was asked to try to prioritize a variety of policies in terms of time required, level of effort and potential impact.

- Of note, the Board recognized that prioritizing specific policies does not mean the other policies will not ever be taken up by the Board.
  - The Board may also consider and support additional polices as identified.

2024 POLICIES FOR EVALUATION

Policy	Votes
Provider Rate Setting (2) and Price Growth Caps (7)	9
Limiting Facility Fees	8
Mergers and Acquisitions/Private Equity/Ownership/Closures	7
Restricting Anti-Competitive Clauses in Health Care Contracting	7
Increased Hospital Price Transparency	4
Community Benefit Transparency	4

- *Before the prioritization exercise, Board members combined mergers and acquisitions with addressing private equity. They also wanted to be sure that the analysis includes information about closures and their impact.*
- *During the prioritization exercise, Board members decided to combine provider rate setting and price growth caps which is why they have separate votes.*

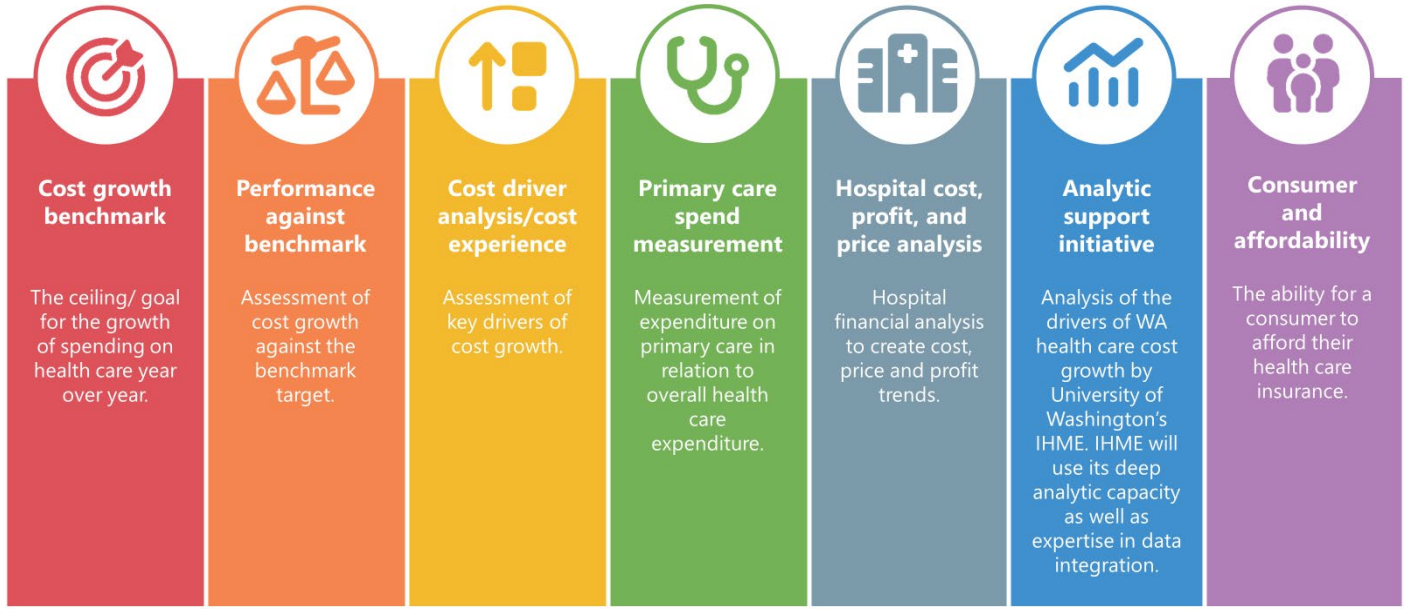
POLICIES NOT PRIORITIZED IN 2024

Policy	Reasons offered for not selecting
Address Services Not Covered by the Balanced Billing Protection Act	Legislation introduced.
Limiting/or Capping Out-of-Network Charges by Providers	
Strengthen Rate Review Authority	
Administrative Simplification	Universal Health Care Commission evaluating.
Prohibition on spread pricing across markets / Pharmacy Benefit Managers (PBM) regulatory reform.	Legislation being considered and PDAB is focused on prescription drugs overall.
Reference-based pricing	
Global Budgeting	Will be addressed in OIC study.
Further consolidate and expand state purchasing	Universal Health Care Commission evaluating.

QUESTIONS FOR ADVISORY COMMITTEE MEMBERS

- What data resources would provide insights for each of these policies?
  - What information from the resources would be helpful?

Policy	Votes
Provider Rate Setting (2) and Price Growth Caps (7)	9
Limiting Facility Fees	8
Mergers and Acquisitions/Private Equity/Ownership/Closures	7
Restricting Anti-Competitive Clauses in Health Care Contracting	7
Increased Hospital Price Transparency	4
Community Benefit Transparency	4



Washington State Health Care Authority

Tab 6

Washington State Health Care Authority

DATA CALL 2024

1

Feb 12:
Launch Data Call

2

May 15:
Receive Data Submission

3

Apr - Jul:
Conduct data validation

4

Aug - Oct:
Conduct analysis & generate carrier/provider reports

5

Nov-Dec:
Report analysis to the Board