

Health Care Cost Transparency Board

February 18, 2021

Health Care Cost Transparency Board Board Book

February 18, 2021
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Agenda and Presentations

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Agenda and Presentations

TAB 1

Health Care Cost Transparency Board

February 18, 2021
2:00 p.m. – 4:00 p.m.
Zoom Meeting

AGENDA

Board Members:

<input type="checkbox"/>	Susan E. Birch, Chair	<input type="checkbox"/>	Molly Nollette	<input type="checkbox"/>	Laura Kate Zaichkin
<input type="checkbox"/>	Lois C. Cook	<input type="checkbox"/>	Margaret Stanley		
<input type="checkbox"/>	Bianca Frogner	<input type="checkbox"/>	Kim Wallace		
<input type="checkbox"/>	Sonja Kellen	<input type="checkbox"/>	Carol Wilmes		
<input type="checkbox"/>	Pam MacEwan	<input type="checkbox"/>	Edwin Wong		

Time	Agenda Items	Tab	Lead
2:00-2:15 (15 min)	Welcome and Call to Order		Susan E. Birch, Chair, Director Health Care Authority
2:15-2:35 (20 min)	Orientation to HB 2457 Legislation and Board purpose	2	Mich'I Needham, Chief Policy Officer Health Care Authority
2:35-3:00 (25 min)	Board member and staff introductions		AnnaLisa Gellerman, Board Manager Health Care Authority
3:00-3:20 (20 min)	Open Public Meetings Training	3	Katy Hatfield, Assistant Attorney General Attorney General's Office
3:20-3:35 (15 min)	Review of draft charter and operating procedures	4	AnnaLisa Gellerman, Board Manager Health Care Authority
3:35-3:50 (15 min)	Detailed review of meeting plan	5	Michael Bailit, President Bailit Health Purchasing
3:50-4:00 (10 min)	Public Comment and Adjournment		Susan E. Birch, Chair, Director Health Care Authority

In accordance with Governor Inslee's Proclamation 20-28 et seq amending requirements of the Open Public Meeting Act (Chapter 42.30 RCW) during the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Board and the public, this meeting of the Health Care Cost Transparency Board meeting will be conducted virtually.

Agenda and Presentations

TAB 2

Brief introduction to Washington's health care cost growth legislation

Mich'l Needham, Chief Policy Officer
February 18, 2021

What is a cost growth target and why pursue one?

- A health care cost growth target is a *per annum rate-of-growth* target for health care costs for a given state.
- States have pursued cost growth targets to curb health care spending growth but to be effective, it must be complemented by supporting strategies.



Legislative charge – HB 2457

House Bill 2457 (2020) established the **Health Care Cost Transparency Board** and charged it with the following tasks:

1. Establishing a health care cost growth **benchmark** or target percentage for growth.
2. Analyzing **total health care expenditures**.
3. Identifying **trends** in health care cost growth.
4. Identifying **entities that exceed** the health care cost growth benchmark.

Legislative charge – HB 2457 (cont'd)

- Appointing **advisory committees** to provide input on topics relevant to the work of the board, including two required committees:
 - Advisory committee of health care providers and carriers
 - Advisory committee on data issues
- **Report** to the Governor and the Legislature on:
 - Progress in development of the health care cost growth benchmark (by August 1, 2021).
 - Beginning August 1, 2022, report annually on total health care expenditures and benchmark.

Board makeup

Governor-appointed, 13-member (voting) board – purchaser focused

- Insurance commissioner (or designee)
- Health Care Authority director (or designee)
- Labor & Industries director (or designee)
- Washington Health Benefit Exchange chief executive officer (or designee)
- Local government purchaser
- Consumer representative
- Consumer representative
- Taft-Hartley health benefit plan representative

Board makeup (cont'd)

- Large employers (at least one self-funded)
- Large employers
- Small business representative
- Actuary or other expert in health care economics
- Health care financing expert
- Member with operational experience in health care delivery (**non-voting**; to also serve on the advisory committee of health care providers and carriers)

Meeting the board's legislative charge

- Convene monthly until December 2021 to develop the benchmark methodology and other program components.
- Consider and incorporate input from the two advisory committees and from other stakeholders as needed and appropriate.
- Leverage work of other states that have developed cost growth benchmark programs.

Agenda and Presentations

TAB 3

Open Public Meetings



Health Care Cost Transparency Board

Presented by:

Katy Hatfield

Assistant Attorney General

February 2021



Washington's Open Public Meetings Act (OPMA)

- Passed in 1971 as part of nationwide effort
- Requires meetings to be open to the public, gavel to gavel
- Chapter 42.30 RCW



OPMA and Public Records Act Are Often Called “Transparency Laws” or “Sunshine Laws”

U.S. Supreme Court Justice Louis Brandeis once famously said, "Sunlight is the best disinfectant." *



Transparency builds public confidence in government.

* This is not medical advice.

Court's Interpretation of OPMA

Washington State Supreme Court (*Columbia Riverkeeper v. Port of Vancouver*, 188 Wn.2d 421 (2017)):

- “The purpose of the Act is to allow the public to view the decisionmaking process at all stages”
- “...the statute itself declares that its protections ‘shall be liberally construed.’ Liberal construction requires that we resolve ambiguous provisions in favor of government transparency.”
- “As a result, where multiple reasonable alternatives of an exception are available, we are directed to adopt the narrowest of the alternatives.”

OPMA Applies To:

Multi-member public state and local agencies, such as boards, commissions, committees, education institutions, counties, cities, school districts, subagencies created by statute or ordinance (such as planning commissions and library or park boards). *RCW 42.30.020*



The Health Care Cost Transparency Board and its subcommittees are subject to the Open Public Meeting Act.

RCW 70.390.030(7)

What Meetings Are Subject to OPMA?

All meetings of the **governing body** of a public agency shall be open and public and all persons shall be permitted to attend any meeting of the governing body of a public agency, except as otherwise provided in the OPMA. *RCW 42.30.030*

But the mere presence of a quorum of Board members, in and of itself, does not create a public meeting so long as the members do not engage in any official business of the Board, including deliberations, discussions, receipt of public testimony, or voting. *Op. Att'y Gen. 6 (2006)*

What Is a Governing Body?

Under the OPMA, the governing body is either:

(1) a majority of the multimember board's members or

(2) **any committee** of the board *when:*

- the committee acts on behalf of the governing body,
- conducts hearings, or
- takes testimony or public comment

RCW 42.30.020; Citizens Alliance for Property Rights Legal Fund v. San Juan County, 184 Wn.2d 428 (2015).

However, the Health Care Cost Transparency Board law states that all subcommittees are subject to the OPMA.

RCW 70.390.030

What Is a Meeting?

- **“Meeting”** means meetings of the governing body at which action is taken. Physical presence of the members of a governing body is not necessary for there to be a “meeting.”
 - A governing body can hold a public meeting by telephone or video conferencing so long as the speaker phone or video is provided at the designated meeting place at the designated meeting time and attending members of the public can hear all discussion and provide testimony. *Op. Att’y Gen. 4 (2017)*
- **“Action”** is very broad and includes any official business such as deliberations, discussions, considerations, reviews, evaluations, receipt of testimony, and votes. *RCW 42.30.020*.
 - The requirements of the OPMA are triggered regardless of whether “final action” is taken. Final action is a collective positive or negative decision or vote.
- OPMA applies to “meetings” even if not called a “meeting,” such as retreats, workshops, study sessions, dinners, e-mail exchanges, etc.
 - The mere passive receipt of information or email does not constitute a meeting. Do not hit “reply all” and start a deliberation. If a majority of members communicate via email about issues that may or will come before the governing body, it can constitute a meeting. *Wood v. Battle Ground School District*, 107 Wn. App. 550 (2001).
 - Be careful during the pre- and post-meeting time



Travel and Gathering

- A majority of the members of a governing body may travel together or gather for purposes other than a regular meeting or a special meeting, so long as no “action” is taken.
- Remember “action” is defined very broadly, and includes discussion of agency business.

RCW 42.30.070



Regular Meetings



- “**Regular meetings**” are recurring meetings held in accordance with a periodic schedule by ordinance, resolution, bylaws, or other rule.
- A state public agency must:
 - Yearly, file with the Code Reviser a schedule of regular meetings, including time and place
 - Publish changes to regular meeting schedule in the state register at least 20 days prior to rescheduled date
 - Make the agenda available online no later than 24 hours in advance of the published start time
 - Boards are not restricted from later modifying the agenda of a Regular meeting

RCW 42.30.070; RCW 42.30.075, RCW 42.30.077

Special Meetings



- A “**special meeting**” is a meeting that is not a regular meeting
- Called by presiding officer or majority of the members
- At least 24 hours before the special meeting, written notice including the time, place, and agenda must be:
 - Given to each member of the governing body (unless waived)
 - Given to each local newspaper of general circulation, radio, and TV station that has a notice request on file
 - Posted on the agency’s website
 - Prominently displayed at the main entrance of the agency’s principal location and the meeting site
- At a special meeting, final disposition shall not be taken on any topic not listed in the agenda

Emergency Meetings

- Notice is not required when a special meeting is called to deal with an emergency
 - Emergency involves injury or damage to persons or property or the likelihood of such injury or damage
 - Where time requirements of notice make notice impractical and increase likelihood of such injury or damage

RCW 42.30.080(4)



Public Attendance

- A public agency can't place conditions on public to attend meeting subject to OPMA:
 - Cannot require people to register their names or other information, complete a questionnaire, or otherwise fulfill any condition precedent to attendance

RCW 42.30.040

- Reasonable rules of conduct can be set
- Cameras and tape recorders are permitted unless disruptive

Op. Att'y Gen. 15 (1998)

- No public comment period required by OPMA



Interruptions and Disruptions

- The OPMA provides a procedure for dealing with situations where a meeting is being interrupted so the orderly conduct of the meeting is unfeasible, and order cannot be restored by removal of the disruptive persons.
- Meeting room can be cleared and meeting can continue, or meeting can be moved to another location, but final disposition can occur only on matters appearing on the agenda. More details set out in the OPMA.

RCW 42.30.050

Executive Session

- Part of a regular or special meeting that is closed to the public
- Limited to specific purposes set out in the OPMA
- Purpose of the executive session (and why public is excluded) and the time it will end must be announced by the presiding officer before it begins; time may be extended by further announcement

RCW 42.30.110



Executive Sessions

Specified Purposes Set Out in OPMA.

Includes, for Example:



- National security
- Real estate transactions, if certain conditions met
- Review negotiations on the performance of publicly bid contracts, if certain conditions met
- Consider propriety or confidential nonpublished information related to development, acquisition, or implementation of state-purchased health care
- Evaluate qualifications of applicant for public employment
- Meet with legal counsel regarding enforcement actions, litigation or potential litigation, if certain conditions met
- Other purposes listed in RCW 42.30.110

RCW 42.30.110

Final Action

- “**Final action**” is a collective positive or negative decision, or an actual vote, by a majority of the governing body or committee
 - A consensus position can occur without a formal vote. *Eugster v. City of Spokane*, 110 Wn. App. 212 (2002).
- Must be taken in public, even if deliberations were in executive session
- Secret ballots are not allowed

RCW 42.30.060; RCW 42.30.020



Meeting Minutes

- Minutes of all regular and special public meetings must be promptly recorded and open to public inspection
- Minutes of an executive session are not required
- No format specified in law

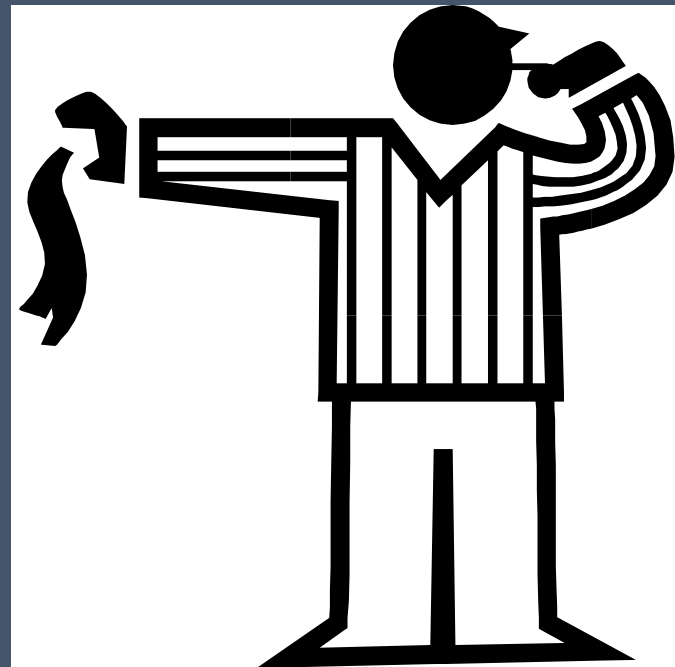
RCW 42.30.035



Penalties for Violating the OPMA

- A court can impose a \$500 civil penalty against each member (personal liability) for the first violation and \$1,000 for a subsequent violation
- Court will award costs and attorney fees to a successful party seeking the remedy
- Action taken at meeting can be declared null and void

*RCW 42.30.120; RCW 42.30.130;
RCW 42.30.060*





Recent Headlines

- “Lawsuit claims Yakima City Council broke transparency rules,” *Yakima Herald* (8/14/2018)
- “Lawsuit accuses Seattle [City Council] of violating open-meetings law before head-tax repeal vote,” *The Seattle Times* (6/14/2018)
- “Spokane Valley council could use a refresher course in open meetings law,” *The Spokesman-Review* (2/25/2016)
- “KPLU Listeners Express Anger Over Station’s Surprise Sale to KUOW,” *KNKX (formerly KPLU)* (11/25/2015)
- “Judge: UW Trustees’ Private Dinners Violated Open Meetings Laws,” *KNKX (formerly KPLU)* (4/24/2015)
- “Tacoma council violated open meetings laws on anti-Walmart moratorium, developer alleges in lawsuit,” *The News Tribune* (9/10/14)

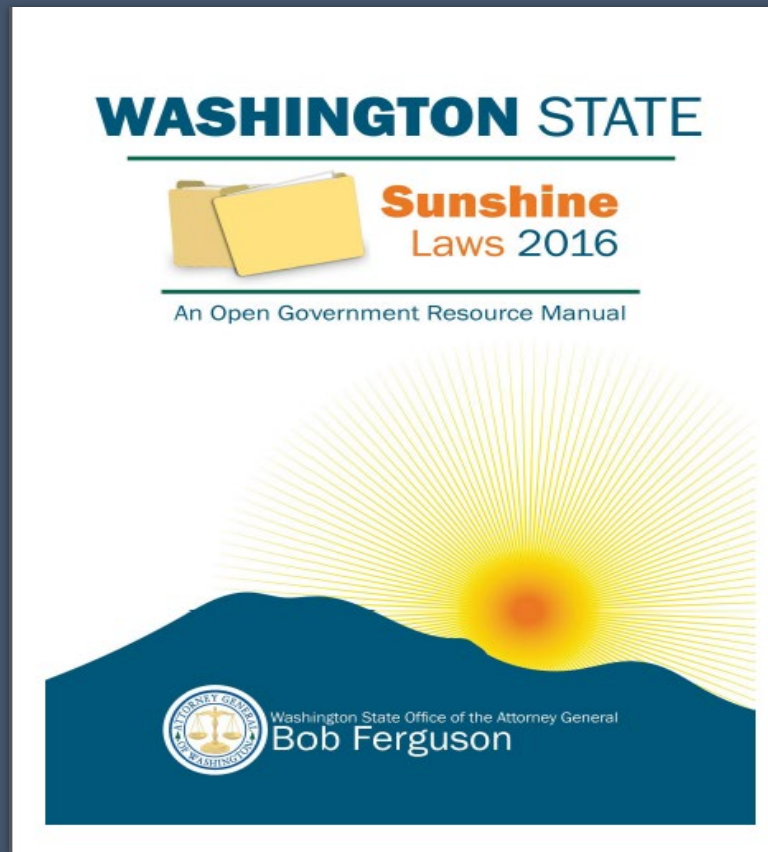
Risk Management Tips

- Establish a culture of compliance with the OPMA
- Receive training on the OPMA
- Review available resources and institute best practices
- Keep updated on current developments in OPMA (OPMA can be amended by the legislature and interpreted by the courts)
- Consult with agency's legal counsel

Open Government Training

- Every member of the governing body of a public agency must complete training on the requirements of the OPMA no later than 90 days after the date the member takes the oath of office or otherwise assumes his or her duties as a public official.
- Every member must complete refresher training at intervals of no more than four years.
- The Attorney General's Office can provide the OPMA training (or training may be completed remotely including an internet-based training).
- Training resources, videos, and more information about the OPMA (including legislative updates and a resource manual) are available on the Attorney General's Office Open Government Training Web Page:
<http://www.atg.wa.gov/OpenGovernmentTraining.aspx>

AGO Open Government Resource Manual



Municipal Research & Service Center

OPMA – AGENCY OBLIGATIONS: A STARTING POINT

PRACTICE TIPS

For Local Government Success



The basic requirement of the Open Public Meetings Act (OPMA) is that meetings of governing bodies be open and public. Use these practice tips to guide your agency's OPMA compliance.* For more information and resources visit www.mrsc.org/opmapra.

Basic Requirements

- All meetings open and public. All meetings of governing bodies of public agencies must be open to the public, except for certain exceptions outlined in the OPMA. RCW 42.30.03
- Quorum. Generally, a meeting occurs when a quorum (which includes discussion or deliberation as well as votes) is present.
- Attendees. All persons must be permitted to attend and participate in the meeting, unless the meeting is otherwise provided for in the OPMA.
- No secret ballots. Votes may not be taken by secret ballot.
- Adoption of ordinances. Ordinances, resolutions, rules, and other actions must be adopted at public meetings, unless they are invalid. RCW 42.30.060(1).

Position in Agency

- Member of a governing body
- City or Town Councilmember or Mayor
 - County Commissioner or County Councilmember
 - Special Purpose District Commissioner/Board Member
- Member of a subagency created by ordinance or legislative action
- Planning Commission
 - Library Board
 - Parks Board
 - Civil Service Commission

- Member of a committee
- Committees that act on behalf of the governing body
 - Committees that act on behalf of the governing body

Agency staff

Penalties for Noncompliance

- Actions null and void. Any action taken at a meeting that is not held in accordance with the OPMA is null and void. RCW 42.30.060(1).
- Personal liability. Potential personal liability of \$100 for each violation of the OPMA. RCW 42.30.120(1).
- Agency liability. Any person who prevails against an agency must be awarded all costs, including attorney fees, incurred in the litigation. RCW 42.30.120(2).

OPMA Training Requirements, Effective July 1, 2014

- Every member of a governing body of a public agency must receive training on the OPMA before assuming office or taking the oath of office.
- In addition, every member of a governing body must continue to receive training on the OPMA throughout their term of office.

*DISCLAIMER: These practice tips are meant to provide summary information on the notice requirements of the OPMA; these tips are not intended to be regarded as specific legal advice. Consult with your agency's legal counsel about this topic as well.

OPMA – NOTICE REQUIREMENTS

PRACTICE TIPS

For Local Government Success



Under the Open Public Meetings Act (OPMA), to ensure that agency deliberations and other actions are conducted and taken openly, agencies are required to provide sufficient public notice of their meetings. Use these practice tips as a starting guide for OPMA notice requirements.* For more information and resources visit www.mrsc.org/opmapra.

	Regular Meetings (RCW 42.30.070)	Special Meetings (RCW 42.30.080)
Definition	Held in accordance with a schedule fixed by ordinance, resolution, bylaws, or other rule.	Anything other than a regular meeting. May be called by the presiding officer or a majority of the members of the governing body.
Notice and Agendas	Effective June 12, 2014, agendas must be made available on the agency's website at least 24 hours in advance of the meeting unless the agency: <ol style="list-style-type: none"> 1. Doesn't have a website; or 2. Employs fewer than 10 full-time equivalent employees. There are no other notice requirements for regular meetings in the OPMA. However, other relevant laws apply to some local governments. For example, cities and towns are required to establish a procedure for notifying the public of the preliminary agenda for the forthcoming council meeting (although not necessarily online) as well as regarding upcoming hearings. RCW 35A.12.160; RCW 35.22.288; RCW 35.23.221; RCW 35.27.300. There are no similar requirements for counties or special purpose districts related to preliminary agendas.	The special meeting notice must specify the date, time, and place of the special meeting, and the business to be transacted. <ul style="list-style-type: none"> • Personal notice. Written notice must be delivered personally, by mail, fax, or e-mail at least 24 hours before the meeting to: <ol style="list-style-type: none"> 1. Each member of the governing body, unless the member submits a written waiver of notice in advance with the clerk, or the member is actually present at the meeting; and 2. Each member of the news media who has on file with the governing body a written request for notice of special meetings. • Website notice. Notice must be posted on the agency's website 24 hours in advance of the meeting, unless the agency: <ol style="list-style-type: none"> 1. Doesn't have a website; or 2. Employs less than 10 full-time equivalent employees; or 3. Doesn't employ personnel whose duty, as defined by a job description or existing contract, is to maintain or update the website. • Notice at agency's principal location. Notice must be prominently displayed at the main entrance of the agency's principal location and the meeting site if the meeting isn't held at the agency's principal location.
Emergencies	In an emergency situation (e.g., fire, flood, earthquake, or other emergency), a meeting may be held at a site other than the regular meeting site, and the notice requirements under the OPMA are suspended during such an emergency.	The notices required for special meetings aren't required if a special meeting is called to deal with an emergency involving injury or damage to persons or property or the likelihood of such injury or damage, when time requirements of such notice would make notice impractical and increase the likelihood of such injury or damage.
Holidays	Regular meetings shall not be held on holidays. If a regular meeting falls on a holiday, the meeting must be held on the next business day.	Although not specifically addressed by the OPMA, we recommend that special meetings not be held on holidays out of consideration for public participation.
Business Transacted	There are no restrictions on the type of business that may be transacted at regular meetings.	Final disposition cannot be taken on any matter not listed in the special meeting notice.

*DISCLAIMER: These practice tips are meant to provide summary information on the notice requirements of the OPMA; these tips are not intended to be regarded as specific legal advice. Consult with your agency's legal counsel about this topic as well.
May 2014

OPMA – EXECUTIVE SESSIONS

CHECKLIST

For Local Government Success



The Open Public Meetings Act (OPMA) requires specific steps be taken in order to hold an executive session. Use this checklist to guide your agency's compliance with the OPMA related to executive sessions.* For more information and resources visit www.mrsc.org/opmapra.

Requirement	Completed/ Applicable
Regular or special meeting.	<input type="checkbox"/>
Purpose of the executive session.	<input type="checkbox"/>
Time the executive session will end.	<input type="checkbox"/>
Topics, if required. (See topics below and on the OPMA related to executive sessions.)	<input type="checkbox"/>
Confidentiality. (See topics below and on the OPMA related to executive sessions.)	<input type="checkbox"/>
Reminded that discussions are confidential.	<input type="checkbox"/>
That nothing in RCW 42.30.110(1) can be discussed in executive session.	<input type="checkbox"/>
That disclosure would increase the likelihood of such injury or damage.	<input type="checkbox"/>
That there is a sale or lease of real estate if there's a public hearing. RCW 42.30.110(1)(c).	<input type="checkbox"/>
That property must be taken in open session.	<input type="checkbox"/>
That the meeting is a contract. RCW 42.30.110(1)(d). See back of page.	<input type="checkbox"/>
That the meeting is for a purchase or sale of real estate. RCW 42.30.110(1)(e).	<input type="checkbox"/>
That the meeting is for a contract. RCW 42.30.110(1)(f).	<input type="checkbox"/>
That the meeting is for a contract. RCW 42.30.110(1)(g). See back of page.	<input type="checkbox"/>
That the meeting is for a contract. RCW 42.30.110(1)(h). See back of page.	<input type="checkbox"/>
That the meeting is for a contract. RCW 42.30.110(1)(i). See back of page.	<input type="checkbox"/>
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That the meeting is for a contract. RCW 42.30.110(1)(p). See back of page.	<input type="checkbox"/>
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That the meeting is for a contract. RCW 42.30.110(1)(s). See back of page.	<input type="checkbox"/>
That the meeting is for a contract. RCW 42.30.110(1)(t). See back of page.	<input type="checkbox"/>
That the meeting is for a contract. RCW 42.30.110(1)(u). See back of page.	<input type="checkbox"/>
That the meeting is for a contract. RCW 42.30.110(1)(v). See back of page.	<input type="checkbox"/>
That the meeting is for a contract. RCW 42.30.110(1)(w). See back of page.	<input type="checkbox"/>
That the meeting is for a contract. RCW 42.30.110(1)(x). See back of page.	<input type="checkbox"/>
That the meeting is for a contract. RCW 42.30.110(1)(y). See back of page.	<input type="checkbox"/>
That the meeting is for a contract. RCW 42.30.110(1)(z). See back of page.	<input type="checkbox"/>

*DISCLAIMER: This checklist is not intended to be regarded as specific legal advice. Consult with your agency's legal counsel about this topic as well.
May 2014

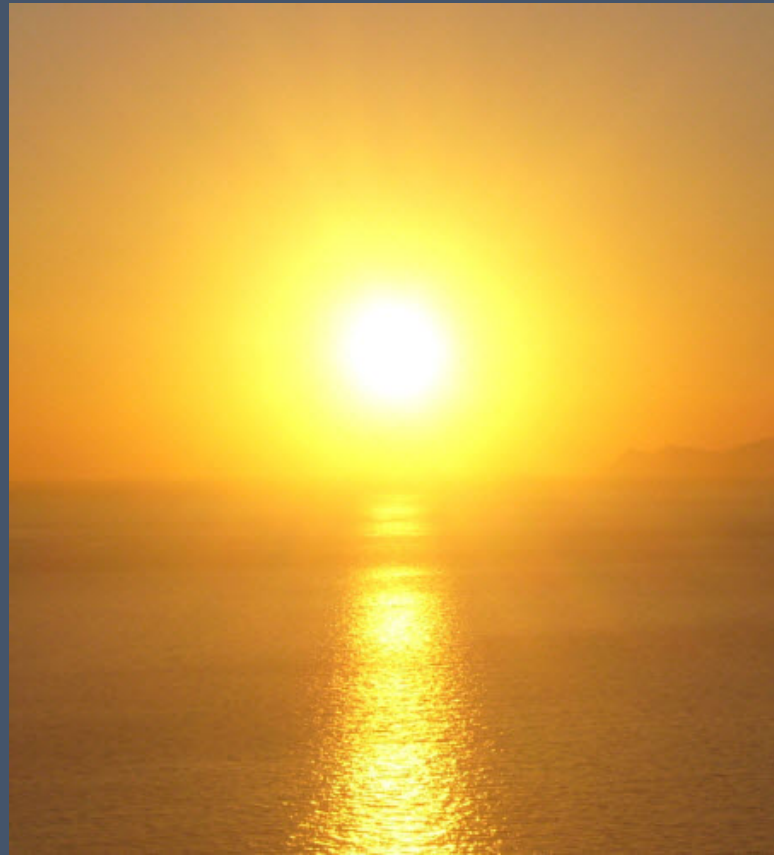
COVID-19 Impacts on OPMA

- On 3/24/2020, Governor Inslee issued Proclamation 20-28 prohibiting in-person public meetings and waiving and suspending certain OPMA laws. These provisions were updated and amended multiple times in subsequent sequentially numbered proclamations (last I checked, it was up to 20-28.15)
- On 1/15/2021, Legislature passed Senate Concurrent Resolution 8402, extending the Governor's emergency proclamation 20-28 until the termination of the state of emergency, or until rescinded, whichever occurs first

COVID-19 Impacts on OPMA (cont.)

- During the emergency:
 - Agencies are prohibited in most circumstances from conducting in-person public meetings
 - Agencies must provide an option(s) for the public to attend through, at a minimum, telephonic access, and agencies may also provide other electronic or internet means of remote access that provides the ability for all persons attending the meeting to hear each other at the same time
 - Agencies are not required to have a physical location where the public can watch and/or listen
 - If the agency permits public comment, all attendees must have a means to speak and be heard
 - For special meetings, agency is not required to post a paper agenda or paper meeting notice at the physical location

Thank you!



Agenda and Presentations

TAB 4

Proposed Charter and Operating Procedures

AnnaLisa Gellermann, Board Manager
February 18, 2021

I. Vision and Mission

To understand the factors driving health care cost growth in Washington, and lower growth to a financially sustainable rate

The Board's primary objective is to understand and curb the State's health care cost growth. The Board aims to achieve this objective by:

- (1) analyzing the state's total health care expenditures;
- (2) identifying drivers in health care cost growth; and
- (3) establishing a health care cost growth benchmark.

II. Purpose

- 1) Hold payers and providers publicly accountable for reducing growth in the costs of health care
- 2) Rebalance negotiations between payers and providers and thereby temper price growth, which is a significant contributor to cost growth
- 3) Understand the various factors driving health care cost growth and develop future policies to address them

IV. (B) Member Responsibilities

- Reviewing background materials and analysis to understand the issues to be addressed in the review process;
- Working collaboratively with one another to explore issues and develop recommendations;
- Attending Board meetings; and
- Considering and integrating Advisory Committee recommendations and general public input into Board recommendations as appropriate

IV. (F) Board Principles

- to the extent practical, be inclusive of all populations and all categories of spending;
- recommend a stable benchmark upon which payers, providers, and policymakers can rely;
- develop benchmark reporting methods that are statistically robust;
- be sensitive to the impact that high health care spending growth has on Washingtonians;
- align recommendations with other state health reform initiatives to lower the rate of growth of health care costs

V. (A) Protocols

- Members agree to make every effort to bring all aspects of their concerns about these issues into this process to be addressed
- Members agree to refrain from personal attacks, intentionally undermining the process, and publicly criticizing or misstating the positions taken by any other participants during the process.
- Members are advised that email, blogs and other social networking media related to the business of the board are likely to be considered public documents.

Consensus Process/Voting

- A participatory process where the representatives strive for agreements that they can accept, support, live with, or agree not to oppose.
- To ensure the Board receives the collective benefit of the individual views, experience, background, training and expertise of its members.
- Decisions will be made by consensus. If no consensus is reached, a vote will be called and go to majority.
- Minority positions will be documented. Those with minority opinions are responsible for proposing alternative solutions or approaches to resolve differences.

Agenda and Presentations

TAB 5

Detailed Review of Meeting Plan

Michael Bailit, Board Consultant
February 18, 2021

HCCTB meeting plan

Meeting #	Date	Meeting Goals
2	Mar 15, 2021 2:00-4:00pm	<ul style="list-style-type: none"> • Adoption of charter and operating procedures • Role of Advisory Committee of Providers and Carriers and Advisory Committee on Data issues vis-à-vis the board. • Review of cost growth benchmarks, including their use in other states
3	Apr 13, 2021 10:00am-12:00pm	<ul style="list-style-type: none"> • Approval of member appointments to the Advisory Committee of Providers and Carriers and Advisory Committee on Data Issues • Measuring total health care expenditures <ul style="list-style-type: none"> - How to define total health care expenditures - Whose expenditures to measure
4	May 13, 2021 9:00-11:00am	<ul style="list-style-type: none"> • Determining a benchmark methodology <ul style="list-style-type: none"> - How to identify a target value - Special conditions under which the benchmark may be modified

HCCTB meeting plan (cont'd)

Meeting #	Date	Meeting Goals
5	Jun 16, 2021 2:00-4:00pm	<ul style="list-style-type: none"> • Possible benchmark values and recommendations on the benchmark methodology
6	Jul 19, 2021 2:00-4:00pm	<ul style="list-style-type: none"> • Review of advisory committee input on measuring total health care expenditures and the benchmark methodology • Assessing performance against the benchmark • Transparency and accountability mechanisms
7	Aug 17, 2021 2:00-4:00pm	<ul style="list-style-type: none"> • Review of advisory committee input on the benchmark methodology, performance measurement, and transparency • Review of any outstanding issues

HCCTB meeting plan (cont'd)

Meeting #	Date	Meeting Goals
8	Sept 14, 2021 2:00-4:00pm	<ul style="list-style-type: none"> • Data use strategy <ul style="list-style-type: none"> - Use of APCD or other data to identify health care cost and cost growth drivers - Primary audiences for such analyses • Cost-growth mitigation strategies to ensure success of the cost growth benchmark program
9	Oct 14, 2021 10:00-12:00pm	<ul style="list-style-type: none"> • Review of advisory committee input on the data use and cost growth mitigation strategies • HCCTB process for 2022 and beyond
10	Nov 17, 2021 2:00-4:00pm	<ul style="list-style-type: none"> • HCCTB process for 2022 and beyond • Implementation strategy <ul style="list-style-type: none"> - Baseline evaluation timeline and process - Implementation activities
11	Dec 15, 2021 2:00-4:00pm	<ul style="list-style-type: none"> • Review of final recommendations

Background and Topical Material

TAB 6

**Washington Health Care Cost Transparency Board
Charter and Operating Procedures
February 18, 2021**

I. Vision and Mission

A. Vision

To understand the factors driving health care cost growth in Washington, and lower growth to a financially sustainable rate.

B. Mission

The Board's primary objective is to understand and curb the State's health care cost growth. The Board aims to achieve this objective by: (1) analyzing the state's total health care expenditures; (2) identifying drivers in health care cost growth; and (3) establishing a health care cost growth target. The total health cost expenditures for each qualified health care provider and payer will be measured against the target, and the Board will identify providers and payers whose cost growth meets or exceeds the target.

II. Health Care Cost Growth Target

A. Purpose

Health care costs are rising and are continuing to take up a larger proportion of State, employer and family budgets. In 2019 Washington's health care costs represented over 20% of the general fund budget and health care costs have been growing at a higher rate than general inflation for personal consumption.¹ Family premiums were over 25% of household income in Washington as of 2016.² Nationally, employer-sponsored health insurance premiums grew 4% from 2019 to 2020 and have increased by 22% in the past five years, outpacing inflation (10%) and wages (15%).³

A health care cost growth target is a target for the annual rate of growth of total health care spending in the state. By setting a target and then publicly reporting

¹ Washington Office of Financial Management. Changes in medical costs.

<https://www.ofm.wa.gov/washington-data-research/statewide-data/washington-trends/budget-drivers/change-medical-costs>

² Penn Leonard Davis Institute of Health Economics. United States of Care. April 2019.

https://unitedstatesofcare.org/wp-content/uploads/2019/04/Penn-LDI-and-US-of-Care-Cost-Burden-Brief_Final-1.pdf

³ Claxton G, et al. Health Benefits in 2020: Premiums in Employer-Sponsored Plans Grow 4%; Employers Consider Responses to Pandemic. *Health Affairs*. October 8, 2020.

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01569>

state, regional, payer and provider performance relative to the target, Washington will have the ability to:

- 1) *Hold payers and providers publicly accountable for reducing growth in the costs of health care.* Public reporting is a significant motivator to improve performance. Transparently reporting performance relative to the target allows payers, providers, the state, and consumers to better understand who bears responsibility for increased costs.
- 2) *Rebalance negotiations between payers and providers and thereby temper price growth, which is a significant contributor to cost growth.* Massachusetts' experience has shown that the cost growth target has been a starting point for price negotiations between payers and providers, giving payers leverage against providers with significant market power.⁴
- 3) *Understand the various factors driving health care cost growth and develop future policies to address them.* It is not sufficient to simply report whether payers and providers have met the target. Further analysis must be conducted to understand the reasons for health care cost growth to identify future state policy, and provider and payer actions to reduce the overall rate of growth.

III. Health Care Cost Transparency Board Charge

Substitute House Bill 2457 established the Health Care Cost Transparency Board (Board) to determine the annual total health care expenditures and growth in Washington state and establish a health care cost growth target. Its work is to include:

- Annually establishing the health care cost growth target, including:
 - Determining the types of data and sources needed to calculate total health care expenditures and health care cost growth
 - Determining the means and methods for gathering data to calculate performance against the target
- Annually calculating performance against the cost growth target, total health care expenditures, and health care cost growth, including at the:
 - Statewide and geographic rating area level
 - Payer-level
 - Provider-level
 - And on a per capita basis
- Analyzing the impacts of cost drivers and cost growth drivers
- Releasing reports on total health care expenditures, including:
 - A preliminary report by August 1, 2021 on progress to achieving the goals listed above

⁴ Bailit M, et al. Balancing Health Care's Checkbook: New Strategies for Providers and States. *Health Affairs Blog*. July 20, 2018. www.healthaffairs.org/doi/10.1377/hblog20180717.572276/full/

- Annual reports thereafter on total health care expenditures and establishing the cost growth target for the following year.

IV. Board Duties and Responsibilities

A. Membership and Term

Board members are appointed by the Governor from lists of nominees submitted by the Senate and House of Representatives.⁵ Additional members include the Insurance Commissioner, Administrator of the Health Care Authority, Director of Labor and Industries, and the Chief Executive Officer of the Health Benefit Exchange, or their designee. The Governor shall also appoint a chairperson.

Initial members of the Board will serve staggered terms, not to exceed four years. Subsequently appointed Board members will serve two-year terms.

The Board will convene beginning in February 2021.

B. Board Member Responsibilities

Members of the Board agree to fulfill their responsibilities by attending and participating in Board meetings, studying the available information, directing the work of advisory committees, and participating in the development of the required reports, including a preliminary report to the Governor and each chamber of the legislature by August 1, 2021. Beginning August 1, 2022, the Board shall submit annual reports to the Governor and each chamber of the legislature.

Members agree to participate in good faith and to act in the best interests of the Board and its charge. To this end, members agree to place the interests of the State above any particular political or organizational affiliations or other interests. Members accept the responsibility to collaborate in developing potential recommendations that are fair and constructive for the State. Members are expected to consider a range of issues and options to address them, discuss the pros and cons of the issues or options presented, and deliver a set of recommendations with key conclusions. The Board should include the rationale behind each recommendation adopted.

Specific Board member responsibilities include:

- Reviewing background materials and analysis to understand the issues to be addressed in the review process;
- Working collaboratively with one another to explore issues and develop recommendations;

⁵ The Governor appoints members from a list of nominees provided by the two largest caucuses in both the house of representatives and the senate.

- Attending Board meetings; and
- Considering and integrating Advisory Committee recommendations and general public input into Board recommendations as appropriate.

C. Vacancies Among Governor-appointed Board Members

Vacancies among Governor-appointed Board members for any cause will be filled by an appointment of the Governor. Upon the expiration of a member's term, the member shall continue to serve until a successor has been appointed and has assumed office. When the person leaving was nominated by one of the caucuses of the House of Representatives or the Senate, his or her replacement shall be appointed from a list of five nominees submitted by that caucus within thirty days after the person leaves. If the member to be replaced is the chairperson, the Governor shall appoint a new chair within thirty days after the vacancy occurs.

D. Role of the Washington Health Care Authority (HCA)

HCA shall assist the Board and Advisory Committees by facilitating meetings, conducting research, furnishing information and advising the members.

E. Chairperson's Role

The Chair will encourage full and safe participation by members in all aspects of the process, assist in the process of building consensus, and ensure all participants abide by the expectations for the decision-making process and behavior defined herein. The Chair will develop meeting agendas, establish subcommittees if needed, and otherwise ensure an efficient decision-making process. The Chair will also serve as the liaison between the Board and the Legislature.

F. Board Principles

The principles, listed below, are to guide decision-making during the development and adoption of recommendations by the Board. The principles can be revised if proposed by the chairperson or by majority of members. The Board's recommendations will:

- support the development of a cost growth target by August 1, 2021 for implementation by no later than January 1, 2023;
- to the extent practical, be inclusive of all populations and all categories of spending;
- recommend a stable target upon which payers, providers, and policymakers can rely;
- develop target reporting methods that are statistically robust;

- be sensitive to the impact that high health care spending growth has on Washingtonians;
- align recommendations with other state health reform initiatives to lower the rate of growth of health care costs, and
- be mindful of state financial and staff resources required to implement recommendations.

V. Operating Procedures

A. Protocols

All participants agree to act in good faith in all aspects of the Board's deliberations. This includes being honest and refraining from undertaking any actions that will undermine or threaten the deliberative process. It also includes behavior outside of meetings. Expectations include the following:

- Members should try to attend and participate actively in all meetings. If members cannot attend a meeting, they are requested to advise HCA staff. After missing a meeting, the member should contact staff for a briefing, and review presentation and meeting summaries.
- Members agree to be respectful at all time of other Board members, staff, and audience members. They will listen to each other and seek to understand the other's perspectives, even if they disagree.
- Members agree to make every effort to bring all aspects of their concerns about these issues into this process to be addressed.
- Members agree to refrain from personal attacks, intentionally undermining the process, and publicly criticizing or mis-stating the positions taken by any other participants during the process.
- Any written communications, including emails, blog and other social networking media, will be mindful of these procedural ground rules and will maintain a respectful tone even if highlighting different perspectives.
- Members are advised that email, blogs and other social networking media related to the business of the board are considered public documents. Emails and social networking messages meant for the entire group must be distributed via a Board facilitator.
- Requests for information made outside of meetings will be directed to HCA staff. Responses to such requests will be limited to items that can be provided within a reasonable amount of time.

B. Communications

1) Written Communications

Members agree that transparency is essential to the Board's deliberations. In that regard, members are requested to include both the Chairperson and Board staff in written communications commenting on the Board's deliberations from/to interest groups (other than a group specifically represented by a member); these communications will be included in the public record as detailed below and copied to the full Board as appropriate.

Written comments to the Board, from both individual Board members and from agency representatives and the public, should be directed to HCA staff. Written comments will be distributed by HCA staff to the full Board in conjunction with distribution of meeting materials or at other times at the Chairperson's discretion. Written comments will be posted to the Board web page.

2) Media

While not precluded from communicating with the media, Board members agree to generally defer to the Chairperson for all media communications related to the Board process and its recommendations. Board members agree not to negotiate through the media, nor use the media to undermine the Board's work.

Board members agree to raise all of their concerns, especially those being raised for the first time, at a Board meeting and not in or through the media.

C. Conduct of Board Meetings

1) Conduct of Board Meetings

The Board will meet by videoconference or in person at times proposed by the Chairperson or by a majority of voting members.

A majority of voting members constitutes a quorum for the transaction of Board business. A Board member may participate by telephone, videoconference, or in person for purposes of a quorum.

Meetings will be conducted in a manner deemed appropriate by the Chairperson to foster collaborative decision-making and consensus building. Robert's Rules of Order will be applied when deemed appropriate.

2) Establishment of Advisory Committees

The Advisory Committees on Data Issues and the Advisory Committee of Health Care Providers and Carriers will be established by the Board with membership approved by a majority of Board voting members. Other work

groups, subcommittees or other advisory processes will be established by approval of a majority of Board voting members.

Meetings of these groups will be conducted in accordance with these operating procedures.

3) Consensus Process/Voting

A consensus decision-making model will be used to facilitate the Board's deliberations and to ensure the Board receives the collective benefit of the individual views, experience, background, training and expertise of its members. Consensus is a participatory process whereby, on matters of substance, the representatives strive for agreements that they can accept, support, live with, or agree not to oppose.

Members agree that consensus has a high value and that the Board should strive to achieve it. As such, decisions on Board recommendations will be made by consensus of all present members unless voting is requested by a Board member. Voting shall be by roll call. Final action on Board recommendations requires an affirmative vote of the majority of the Board members. A Board member may vote by video-conference, telephone, or in person.

If no consensus is reached on an issue for proposed Board recommendation, minority positions will be documented. Those with minority opinions are responsible for proposing alternative solutions or approaches to resolve differences.

Members will honor decisions made and avoid re-opening issues once resolved.

4) Documentation

All meetings of the Board shall be recorded and written summaries prepared. The audio records shall be indexed and shall be posted on the Board's public web page in accordance with Washington law. Meeting agendas, summaries and supporting materials will also be posted to the Board's web page.

Interested parties may receive notice of the Board meetings and access Board materials on the website, or via GovDelivery.

At the end of the process, HCA staff will draft recommendations for which there is consensus and any remaining issues on which the Board did not reach consensus.

D. Public Status of Board and Advisory Meetings and Records

Board and Advisory meetings are open to the public and will be conducted under the provisions of Washington's Open Public Meetings Act (Chapter 42.30). Members of the public and legislators may testify before the Board upon the invitation of the Chairperson or at the invitation of the majority of the members of the Board. In the absence of a quorum, the Board may still receive public testimony.

Any meeting held outside the Capitol or by video-conference shall adhere to the notice provisions of a regular meeting. Recordings will be made in the same manner as a regular meeting and posted on the Board website. Written summaries will be prepared noting attendance and any subject matter discussed.

Committee records, including formal documents, discussion drafts, meeting summaries and exhibits, are public records. Communications of Board members are not confidential because the meetings and records of the Board are open to the public. "Communications" refers to all statements and votes made during the Committee meetings, memoranda, work products, records, documents or materials developed to fulfill the charge, including electronic mail correspondence. The personal notes of individual Committee members will be considered to be public to the extent they relate to the business of the Board.

E. Amendment of Operating Procedures

These procedures may be changed by an affirmative vote of the majority of the Board members, but at least one day's notice of any proposed change shall be given in writing to each Board member.

Background and Topical Material

TAB 7



Rhode Island's Cost Trends Project: A Case Study on State Cost Growth Targets

Erin Taylor, MPH, Michael Bailit, MBA, Megan Burns, MPP, and Justine Zayhowski, MPP

Policy Points

- > A health care cost growth target forms the basis for accountability for spending growth at the state, provider, and insurer levels.
- > Rhode Island's experience highlights how a small team of state staff, engaged state and private sector leadership, and committed stakeholders can address rising health care costs.

EXECUTIVE SUMMARY

State efforts to curb health care cost growth have largely focused on Medicaid and public employee benefits programs because states have direct purchasing control over those programs and responsibility to manage costs for individuals enrolled in them. Governors and legislators are now considering strategies to constrain *total health care spending* statewide, across all populations. As health care spending takes up a greater portion of state and local budgets, employer budgets, and personal income, there are fewer dollars for other uses. At the state and local level, health care spending can crowd out funding for other public services, such as housing or nutrition, which are both important to improve population health.

Addressing growth in health care spending requires a system-wide view and the collective action of payers and stakeholders. States are leading the way by setting health care spending targets, developing new capabilities to collect and analyze data, and forging strong partnerships with stakeholders to make sure there is buy-in and trust in the resulting actions.

Rhode Island is among a few states that have implemented a cost growth target to stimulate action to improve health care affordability and curb health care spending growth. Massachusetts and Delaware are the two other states that first established a target for health care spending growth. A cost growth target is an expected rate of annual per capita growth of total health care spending in a state. The target itself forms the basis for accountability for spending growth at the state, insurer, and provider levels.

Setting a cost growth target alone is unlikely to slow the rate of health care spending growth. Rhode Island recognized this and pursued parallel strategies to analyze cost growth and drivers of cost growth. The state engaged leaders in the health care industry to develop the target, pursue a complementary data strategy to analyze factors contributing to health care spending growth, and then take action.

Through a public-private partnership, and with funding from the Peterson Center on Healthcare, Rhode Island established the Health Care Cost Trends Project (Cost Trends Project) in 2018 to address health care cost growth and set a cost growth target. This partnership underscored the commitment of state officials and industry leaders to address the affordability of health care for consumers, businesses, and the state.

The project has involved several key steps, from convening a stakeholder group to selecting a cost growth target methodology to recommending policy actions based on the data (Figure 1). Rhode Island's experience highlights how the resolve of a small team of state staff, engaged and effective state and private sector leadership, and a shared commitment of stakeholders can address rising health care costs. It also provides important insights for other states considering a cost growth target, such as the

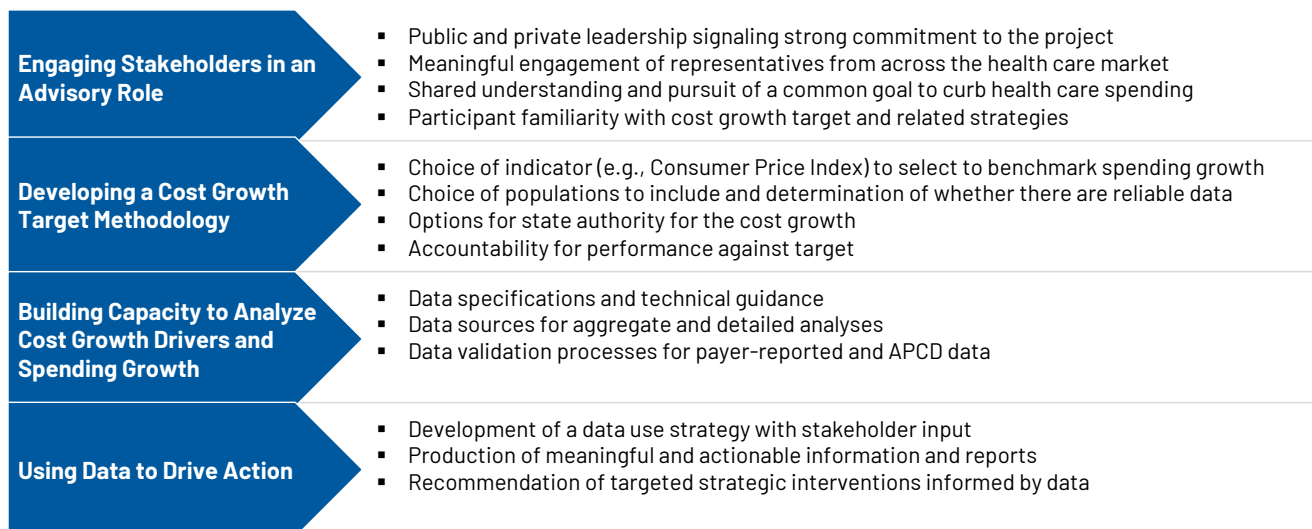
value of providing reporting guidance on data submission to insurers and developing a data validation process.

INTRODUCTION

Commercial health care cost growth in Rhode Island has exceeded the growth rate of the state's economy, and both employers and employees are seeing a greater portion of their revenue and income go to health care.¹ State budgets are also strained under rising health care costs, which are crowding out investments in other public and social services. This mirrors a national trend of health care expenditures increasing at a faster rate than the national gross domestic product.² To cover ever-increasing health care costs, states may face decisions about cutting spending in other critical sectors that directly impact health outcomes, such as housing and nutritional programs.

Recognizing that rising health care costs restrict public and private investments in other areas, Rhode Island developed and implemented a strategy in 2018 to address total health care spending in the state. Rhode Island followed Massachusetts and Delaware to become the third state to design and implement a health care cost growth target.³ A cost growth target is an expected rate of annual per capita growth of total health care spending in a state. Like those in Massachusetts and Delaware,

Figure 1. Key Components of Rhode Island's Cost Trends Project



Rhode Island's cost growth target is based on the state's economic growth forecast.

This case study offers insights for other states considering how to address unsustainable rates of health care spending growth. It describes Rhode Island's experience establishing a cost growth target and its major policy and implementation decisions. The case study also reviews Rhode Island's development of a complementary strategy to analyze factors influencing health care spending to inform action.

Establishing the Health Care Cost Trends Project

Through a public-private partnership, and with funding from the Peterson Center on Healthcare, Rhode Island established the Health Care Cost Trends Project (Cost Trends Project) in 2018 to address health care cost growth. A primary feature of the Cost Trends Project is Rhode Island's health care cost growth target.⁴ In developing its target, Rhode Island considered the experience of other states with similar initiatives, especially Massachusetts, which was the first state to operationalize a health care cost growth target. States' efforts to contain health care costs have largely focused on their Medicaid or employee benefits programs, areas in which states have direct purchasing control. Rhode Island's Cost Trends Project sought to address total health care spending across all populations and service categories. The Cost Trends Project also endeavored to leverage data and analytics to inform action by the state, insurers, and providers to meaningfully address health care spending and improve system performance.

Rhode Island's governor prioritized the development of a cost containment strategy that included a cost growth target as a mechanism to control spending. The governor directed the Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services (EOHHS) to lead the effort on behalf of the state. External contractors, including a leading research university in the state, provided technical assistance, process support, and data analytics expertise.

The Peterson Center on Healthcare provided financial support for robust analytic capacity to examine health care costs, identify core drivers of cost growth, and develop a plan for sustained data analysis.

Kick-Starting the Cost Trends Project

The Cost Trends Project was the result of years-long stakeholder work and health care sector collaboration with public officials. In 2014, a coalition of industry leaders issued a set of health care reform recommendations, including one that called for state and health care leaders to "collect the necessary data to establish a strategy to control costs and examine various options, such as linking health care inflation to Gross State Product."⁵ Using those recommendations as a blueprint, Governor Gina Raimondo in 2016 convened a working group of the state's health care provider and insurer leaders to advise the administration on the adoption of a cost growth target as a health care cost containment strategy. Following a series of five meetings, the working group submitted recommendations to the governor, concluding that the state should only pursue a cost growth target strategy if it took parallel action to:

- rigorously analyze drivers of cost and cost growth;
- facilitate collaborative action addressing system performance improvement opportunities; and
- supplement the cost target with other non-cost performance targets such as population health and clinical outcomes of care.

Convening the Cost Trends Project Steering Committee

The governor's office, with input from OHIC and EOHHS, called on members of the state's health care community to participate in a steering committee to guide the Cost Trends Project work. The health insurance commissioner and secretary of health and human services co-signed individual letters to steering committee members formalizing their participation and establishing clear expectations about the role and tasks of the committee. The state appointed a health insurance executive and a medical group executive to serve as co-chairs with the health insurance commissioner. The co-chairs

expressed strong support for the state’s prioritization of health care cost containment, and their past demonstrated leadership in the state conferred additional legitimacy to the project.

Steering committee members were intentionally selected to represent diverse entities and perspectives including government, business, consumers, and community leaders, though the composition of the committee is balanced more toward payers and providers.

Key Takeaways and Insights: There are many factors that contributed to the steering committee’s effectiveness, including:

Public and private leadership: Steering committee members included supportive, high-profile, and respected leaders in the state’s health care community. At the state level, the governor, commissioner of health insurance, and secretary of health and human services all expressed strong support, with the commissioner taking the most active role as co-chair of the steering committee. This conferred legitimacy to the project and signaled the importance of addressing health care spending through a cost growth target.

Shared purpose: Steering committee members aligned around the goals of the Cost Trends Project, particularly the development of a cost growth target to curb spending growth and thereby support affordability. This helped to focus the steering committee’s work.

Culture of collaboration: Strong, pre-existing working relationships and a culture of collaboration were instrumental. Many steering committee members were involved in the governor’s 2016 working group, which

shaped the Cost Trends Project. Early and ongoing public and private collaboration and a willingness to engage in a cooperative and productive way helped the group acknowledge and work through policy decisions. Familiarity and prior involvement of steering committee members in discussions of a target allowed the work to move faster than if the topic had been introduced as a new concept.

As the state transitioned from development to implementation of the cost growth target, it expanded the stakeholders involved to include representation from large businesses, community non-profit organizations, a long-term care organization, and the pharmaceutical industry. The steering committee has also expressed an interest in including an economist in future discussions.

Developing a Cost Growth Target Methodology

The primary task of the Cost Trends Project was to develop a methodology for setting a cost growth target. The steering committee accomplished this in four months, an accelerated timeline. Familiarity with the topic and a willingness to commit to the state’s aggressive meeting schedule enabled the steering committee to complete required work in the short time frame.

The project’s external contractor structured meetings around a series of cost growth target “design decisions,” including insights into other states’ approaches, that the steering committee discussed. Co-chairs reviewed discussion documents in advance of each meeting so that they were prepared to facilitate decision-making and consensus-building.



There is a true desire to do something different, and passion to do it collectively. The governor commissioned us, but we are driving our own destiny for the state. We are leading and not having something done to us.

Kim A. Keck, former President and Chief Executive Officer, Blue Cross & Blue Shield of Rhode Island, former Cost Trends Project Steering Committee Co-Chair

Key Takeaways and Insights: The following contributed to the steering committee’s success in setting a cost growth target in a compressed timeline:

- Prior awareness of a cost growth target;
- Application of experience and lessons of the approach in Massachusetts;
- Extensive meeting preparation, planning, and other project management work; and
- Prioritization among participants of an intensive planning and engagement process.

For most states, a six-month timeline would likely be more feasible.

A description of the key design decisions the steering committee made as it developed the cost growth target methodology follows.

a. Scope of the cost growth target strategy

A cost growth target can stand alone or be pursued in conjunction with other state strategies to constrain health care costs. States should establish the scope of a cost growth target and its relationship to other state initiatives early in the planning process. The Rhode Island Cost Trends Project adopted a singular strategy to develop its cost growth target. (Notably, Rhode Island employs complementary strategies to the cost growth target, but they preceded the target.)

Standalone cost growth target strategy: States can pursue a cost growth target as a standalone cost containment strategy in which they set the value of the target, and measure and report performance relative to the target. A standalone cost growth target can, however, be accompanied by other activities to extend the target’s reach. These other actions may include: (a) an extensive transparency strategy, (b) a “data use” strategy to help understand cost growth drivers and to identify opportunities for intervention and improvement, and (c) stakeholder engagement in independent and collaborative work to address underlying drivers of spending. Rhode Island took this approach.

Singular component of a larger cost containment strategy: Other states may take a broader view and integrate a cost growth target with additional cost containment strategies. For example, Oregon’s legislation combined a cost growth target with expanded use of value-based

payment.⁶ Similarly, Pennsylvania’s Governor Tom Wolf announced a health reform plan that includes increasing affordability through a cost growth target strategy combined with other initiatives to address health disparities and increase affordability.⁷

Complementing a cost growth target with other cost-focused initiatives may help with target attainment, but it also places a larger administrative and political challenge before the state.

b. Determining the basis upon which to set the target

After considering tying spending growth to household income, personal income, or inflation growth, the steering committee recommended basing the target on per capita potential gross state product (PGSP) growth, concluding that it most closely aligned with a goal of making sure that health care did not take up an increasing portion of the state’s budget. The 2019–2022 cost growth target in Rhode Island is set to the value of the state’s PGSP (3.2% annually). (Table 1 presents a summary of the considerations for the different approaches.)

Before a state sets the value of a cost growth target, it must assess the per capita rate at which health care costs have been growing. This requires collecting and analyzing the best available data to understand the full view of total health care costs and comparing the data to the values produced by the benchmarking indicator options.

c. Populations to include in the spending calculation

States need to determine the population(s) for which spending will be measured relative to the cost growth target. The size of different populations and the reliability of the source of data are among the factors states need to consider. The steering committee decided to include Medicare, Medicaid, and commercial market spending, which represents the majority of health care expenditures in the state. The steering committee also opted to include spending by the Veterans Health Administration on state residents and the state’s correctional health system spending. States seeking to obtain reliable and complete data on the self-insured commercial market will need to request it from payers. In Rhode Island, the self-insured population represented 42% of the commercially insured market in 2019.⁸

Table 1. Benchmarking Options: Economic Growth versus Consumer Finance

Indicator	Implications of selecting indicator as a benchmark
Economic growth	
Gross State Product (GSP)	Establishes that health care spending should not outpace overall state economic growth.
Consumer finance	
Household Income	Establishes that health care spending should not grow more than household income, a more consumer-centric concept than GSP.
Consumer Price Index (CPI) All Items	Establishes that health care spending growth should not exceed growth in other consumer costs, tying health care spending growth to price changes only.
CPI Less Food and Energy	Establishes that health care spending growth should not exceed growth in other consumer costs, removing historically volatile food and energy price changes.
CPI Medical Care	More generous to health care payers and providers than other CPI measure options, recognizing that, historically, health care cost growth has greatly exceeded All Items CPI.

d. Cost growth target authority

The steering committee established a multi-year cost growth target through a compact signed by all committee members.⁹ The target was subsequently codified by executive order,¹⁰ which also directed executive branch agencies to take necessary steps to implement and support the cost growth target program. Rhode Island's path – an executive order following a voluntary compact – is unique among states that have pursued a cost growth target and the direct result of stakeholder convening, cooperation, and compromise. The steering committee considered different authorities for the cost growth target as shown in Table 2.

Steering committee members voiced different opinions on which approach to pursue. The co-chairs initially favored an executive order, but other members strongly preferred a compact. They reasoned that it would signal to the public the health care industry's cooperation to reduce cost growth and it would reduce the role of government. Committee members expressed concern about the legislative approach, noting that it would be difficult to pass legislation without evidence that a target is effective in achieving its goals. Many members indicated that future legislation might be a viable option once the state had experience and results from the target. In the end, the steering committee agreed to a

Table 2. Approaches to Authorizing a Cost Growth Target

Approach	Advantages and Disadvantages
1. Executive Order	An executive order can be executed quickly relative to other approaches, for example, a statute. In Rhode Island, the executive order sustained the momentum of the cost growth target development and allowed for almost immediate implementation. However, executive orders are vulnerable to changes in administrations as priorities and policies may shift. They are also limited in their scope. For example, an executive order alone does not provide funding to support program design and operations.
2. Statute	A statute establishes a cost growth target in law, making it more difficult to overturn or amend compared to an executive order. Yet the legislative negotiation process can be lengthy, with a positive outcome uncertain, and it can result in changes to the original policy intent.
3. Regulation (without new legislation)	New regulations directing the implementation of a cost growth target can be executed relatively quickly, compared to legislative action. However, this approach requires that an agency have existing statutory authority and state funding to proceed with program design and operations.
4. Voluntary Compact	A compact entered into voluntarily creates engagement and buy-in from stakeholders. Like an executive order, it is vulnerable to shifting priorities, and without a mechanism for accountability, it may not motivate widespread change. Other strategy options can compel action in ways a compact does not. A compact also does not provide funding for program support.



A shared commitment to transparency regarding cost performance of systems, payers, and larger physician groups is a distinguishing characteristic of this initiative that speaks to the level of accountability that participants have been willing to embrace.

**G. Alan (AI) Kurose, President and CEO of Coastal Medical,
Cost Trends Project Steering Committee Co-Chair**

hybrid approach whereby the cost growth target parameters would be established in a compact signed by the members of the steering committee in conjunction with an executive order, which references the compact and its terms. Because of Governor Raimondo's role in initiating the planning process, she wanted to make a public statement in support of the cost growth target. The governor also wished to apply the power of her office and the resources of state government to support the initiative.

The status of the steering committee as an advisory body to the state, its express charge to support development of a cost growth target, and the representation of large health care system leaders, health insurers, smaller provider organizations, and business and consumer advocate members on the committee were all critical factors for successfully translating the concept of a cost growth target into policy.

e. Accountability for performance relative to the target

To bolster the potential impact of a cost growth target, states should incorporate mechanisms to encourage action by payers and providers to curb costs and enforce performance relative to the target. Those actions can take different forms. One approach is to hold annual cost trends meetings (as in Massachusetts) and require health plans and large providers to report on cost performance. Another option is requiring payers or providers to implement performance improvement plans if the target is not met. Finally, states can take more aggressive action by using their regulatory and purchasing authority. Examples of this approach include

influencing insurer premiums, provider rates, state contract awards, or provider mergers, acquisitions, or expansions, or levying fines.

The Cost Trends Project steering committee endorsed a strategy of publicly reporting payer and provider performance by entity name.¹¹ Reporting of first year (2019) performance will occur in early 2021, and a public meeting to review and discuss findings will follow. This transparency about performance is intended to hold health care entities accountable for curbing costs while providing valuable information about cost drivers to the public to inform targeted interventions.

Neither the compact nor the executive order, by design, incorporates additional accountability mechanisms, such as the examples cited above. Omitting such mechanisms was a factor in garnering payer and provider support for the initiative.

Analyzing Performance against the Cost Growth Target: Early Insights and Lessons

Once a cost growth target is established, it is necessary to assess performance relative to the target. This analysis is customarily conducted using aggregate data reported by payers, rather than a state's all-payer claims database (APCD) data. Like most state APCDs, Rhode Island's APCD, HealthFacts RI, does not contain most commercial self-insured claims payments, nor does it capture non-claims provider payments or pharmacy rebates. This data analysis is distinct from evaluating cost growth and identifying cost growth drivers, which do use the APCD. (See Figure 2.)

Figure 2. Purpose of Data Sources for Rhode Island's Cost Trends Project

Payer-Reported Aggregate Data

Primary purpose: Assess performance against the cost growth target

Payer-reported data are provided in aggregate and are limited in detail but do represent all health care spending in the state (including spending in self-insured employer benefit programs).



How much did spending increase or decrease from one year to the next?

APCD Analyzed Data

Primary purpose: Identify underlying cost and cost growth drivers

APCD data are more detailed than payer-reported aggregate data. Claims-level analyses can be performed. While not all state spending data are included, there is more than enough information to understand underlying trends.



What is driving overall cost and cost trends? Where are opportunities?

The Cost Trends Project staff developed payer data specifications for reporting performance against the target and prepared an implementation manual containing technical guidance to assist entities with reporting. Specifications and technical guidance articulated the types of claims and non-claims spending for payers to report and the method for attributing spending to members, primary care providers, and commercial and Medicaid accountable care organizations (ACOs). The state performed an initial analysis of 2017 and 2018 spending using data collected from the Centers for Medicare and Medicaid Services (CMS), Rhode Island Medicaid, and the major commercial, Medicaid managed care, and Medicare Advantage insurers in the state. The state then publicly reported state and market-level spending in the summer of 2020. This process revealed that some payers had difficulty interpreting the data specifications, which resulted in inaccurate data submission. Thus, the state developed a set of procedures for data validation for breaking down spending by service and on a per-member-per-month basis to guide future reporting. In the fall of 2020, OHIC collected revised 2018 data and new 2019 data. The state intends to publicly report performance at the insurer and large provider entity level in early 2021.

Key Takeaways and Insights: There are several lessons learned from Rhode Island's experience collecting data and analyzing total medical expenditure data, including:

Reporting guidance: There is value in publishing an instruction manual that describes how the state will calculate performance relative to the target. The manual should include specific details about data requests of insurers. Those reporting guidelines facilitate more accurate and efficient data submission, but states should be prepared that it will take time for payers to adapt their data reporting processes to respond.

Communication with insurers: Initiating conversations early with insurers about the data needed to assess performance and the collection process ensures a mutual understanding of data requests and open lines of communication to discuss data integrity concerns. States should also review findings with payers in advance of public reporting to allow for a final quality check and discussion of any data concerns.

Process to validate data: Developing a validation process to identify potential inconsistent reporting promotes data integrity. In Rhode Island, *completeness checks* were performed to ensure that there were no obvious errors or omissions in the submitted data. An example of an error is if a payer reports a claims runout period that is different than the specifications. An omission example is when a payer does not submit data for all relevant lines of business. *Reasonableness checks* were performed to ensure that data seemed appropriate when compared to other sources and at face value. For example, member enrollment reported

by the payers should be similar to enrollment reported by CMS for Medicare Advantage patients.

Data-Driven Actions to Address Cost Drivers and Spending Growth

Stakeholder input prior to the launch of the Cost Trends Project included recommendations that the state rigorously analyze drivers of costs and cost growth. This would enable the state to explore factors contributing to health care spending growth and then direct action to address primary cost drivers. Setting a cost growth target allows states to measure spending relative to an established benchmark. The measurement of spending alone, relative to a target, does not show what is driving spending growth. Analyses must be done to identify specific categories of high spending (e.g., pharmacy spending) and drivers of growth to identify opportunities for targeted interventions to reduce growth.

The state partnered with the Brown University School of Public Health for expertise to conduct a thorough analysis of claims data and assess the feasibility of using HealthFacts RI to identify cost trends and cost growth drivers and to deconstruct total medical expenditures by volume and price. The assessment showed HealthFacts RI to be a viable data source for analyses related to drivers of cost, drivers of cost trends, and related analyses that could support cost growth reductions and quality improvement. This viability is despite the absence of most self-insured and non-claims data. While

greater self-insured employer participation would make HealthFacts RI a more robust data resource, there are enough data to understand the underpinnings of most health care spending in the state.

Prior to the Cost Trends Project, the state's APCD had limited use and underdeveloped quality control mechanisms. Brown University's robust analysis of the APCD uncovered data integrity issues that required investigation and correction.¹²

With confidence that the APCD could support robust data analyses after data integrity issues were addressed, the Cost Trends Project steering committee began discussing how to leverage HealthFacts RI to enhance the value of health care in Rhode Island. Specifically, the Cost Trends Project sought to design and produce reports from the APCD to inform and motivate improved health care system performance. This is termed the "data use strategy."¹³ Consistent with the cost growth target development, the state engaged key stakeholders and the public in the development of a data use strategy. The Cost Trends Project hosted a data use conference to bring together officials from other states and organizations to share their data use strategies to facilitate learning. During the conference, steering committee members and other invited members of the public talked with national experts about opportunities for Rhode Island to maximize use of its APCD. Following the conference, the Cost Trends Project held two focus groups to gather



The Cost Trends Project provides an invaluable opportunity to analyze the root causes of health care spending growth in our state and utilize that data to change behaviors and take steps to reduce the costs of quality care in our state. The data analyses from the Cost Trends Project will be instrumental in arming our health care leaders with the tools needed to collaboratively transform our health care system into one characterized by maintenance of both high quality and affordability.

**Marie Ganim, former Rhode Island Health Insurance Commissioner,
former Cost Trends Project Steering Committee Co-Chair**

input on meaningful analyses of the APCD, leveraged the steering committee meetings to structure ongoing conversation about a data use strategy, and hosted an open meeting to publicly present draft recommendations for leveraging HealthFacts RI.

Strategic Analyses Using Rhode Island's APCD
1. Cost drivers, including: <ol style="list-style-type: none"> a. Utilization variation b. Price and cost variation c. Low-value services d. Potentially preventable services
2. Cost growth drivers
3. Population demographics, including social determinants of health
4. Quality of care

Key Takeaways and Insights: Several key themes that emerged in the process of developing a data use strategy offer an important roadmap as the state pursues institutionalized analyses and reporting practices. They include:

Stakeholder engagement is at the heart of leveraging APCD analyses to promote health system change. Stakeholder involvement from a project's inception is essential to building trust and producing actionable results. Community involvement in communicating and framing results about cost in the context of quality; ensuring data are accessible to stakeholders, noting a tension with potentially exposing market-sensitive information; and ensuring diverse voices are also key considerations and should be addressed in the development of analyses and reporting.

Producing **actionable results** is equally important. Rhode Island's initial focus is producing reports for providers and the public as the primary audiences. To ensure reports are meaningful and actionable, it is important to involve provider organization representatives, state policymakers, and other intended report users, including employer purchasers, to ensure reports are effective for routine publication.

Sustainability planning is of the utmost importance to ensure the implementation of the data use strategy and ongoing analyses of the APCD.

Finally, states with APCDs, particularly those without robust analytics or collection processes, should not wait until performance is ready to be assessed before performing a **thorough examination of their claims data**. This early analysis of the APCD may reveal where data are missing or incomplete.

In late 2020, the state began analyzing three primary cost drivers: pharmacy spending, outpatient hospital spending, and specialist spending. Analysis of pharmacy spending led to the identification of potential strategies to address price growth, and steering committee recommendations to the state on how it should proceed. Rhode Island anticipates that these analyses will identify opportunities for improved clinical care and is planning to convene a provider collaborative in 2021 to focus on the first prioritized opportunity related to outpatient hospital or specialist spending.

Leveraging state APCDs to conduct sophisticated cost analysis, and then translating those analyses to strategic action on cost growth, constitutes both a significant opportunity and a challenge.

Sustaining Cost Growth Target Work

The executive order initiating the cost growth target does not (and cannot) appropriate funds for ongoing implementation or sustainability. Although grant funding from the Peterson Center on Healthcare provided the necessary start-up investment to develop the target and support data analysis, the state will need to determine an ongoing financing mechanism to sustain the work. The governor's FY22 budget will propose an assessment (i.e., a tax) on commercial insurers, Medicaid, and self-funded businesses to provide sustaining funding to support the program and to codify the work in statute. In addition, the state has sought local foundation funding to support aspects of program operations.

Key Takeaway and Insight: States that have operationalized a target through voluntary compact and/or executive order may often have more difficulty finding funding to sustain the work than those with enabling legislation.

Cost Growth Targets and Health Care Reform

A state health care cost growth target is a powerful way to advance health care cost containment. Targets for growth in total health care spending can help states

gain a clearer picture of spending and support targeted policies and interventions to curb spending and improve system performance.

Yet targets alone are unlikely to contain cost growth, improve health care system performance, and better population health. Rhode Island and its participating stakeholders are well aware of this. As a result, the state has undertaken multiple other initiatives, including a Medicaid accountable care program that involves shared savings and risk contracting with large provider entities, regulation of commercial insurer hospital rate increases, targeted increases for accountable care organization budgets, greater adoption of alternative payment models, and support for broad-scale primary care transformation.

The Cost Trends Project complements these and other initiatives, largely by identifying the underlying, core drivers of cost and arming the state, providers, and payers with information to take meaningful action. Investments in analytics extend beyond the cost growth

target, yielding additional value. Lastly, there is the long-lasting impact of stakeholder collaboration to address systemic issues, a benefit that the state hopes will pay dividends as it faces other challenges.

Rhode Island's cost growth target development and design were specific to the state, its culture, and its environment. Other states will need to customize their process and design, cognizant of the extent of state personnel and data resources to support the work, stakeholder perspectives on cost containment as a public good, and the extent to which there is a proclivity for collaborative effort in the state. Despite these state-specific considerations, the policy and technical questions any state considers will likely be similar to those Rhode Island faced. Just as Rhode Island learned from Massachusetts, other states will now benefit from Rhode Island as they design and implement their own cost growth initiatives.

This work was funded by the Peterson Center on Healthcare.

Notes

1. Between 2015 and 2017 the per capita growth rate of fully insured commercial allowed spending in Rhode Island was between 5.0% and 5.5%, as calculated from the Office of the Health Insurance Commissioner's rate templates. The average annual rate of gross state product between 2015 and 2017 was 2.3%, as calculated from data supplied by the U.S. Bureau of Economic Analysis.
2. National health care expenditures (NHEs) in the United States continue to grow at rates outpacing the broader economy: Inflation- and population-adjusted NHEs have increased 1.6% faster than the gross domestic product (GDP) between 1990 and 2018. US national health expenditure growth as a share of GDP far outpaces that of comparable nations in the Organization for Economic Cooperation and Development (17.2% versus 8.9%). Cahan EM, Kocher B, Bohn R. Why isn't innovation helping reduce health care costs? *Health Affairs Blog*, June 4, 2020. <https://www.healthaffairs.org/doi/10.1377/hblog20200602.168241/full/>. Accessed January 21, 2021.
3. Pearson E, Frakt A. Health care cost growth benchmarks in 5 states. *JAMA*. 2020;324(6):537-538. doi:10.1001/jama.2020.12437
4. Rhode Island's health care cost growth target is 3.2% per capita for 2019-2022. This is equal to the rate of long-term projected state economic growth.
5. Press release from the office of U.S. Senator Sheldon Whitehouse of Rhode Island. RI health care leaders send reform recommendations to Raimondo and General Assembly leaders. December 23, 2014. <https://www.whitehouse.senate.gov/news/release/ri-health-care-leaders-send-reform-recommendations-to-raimondo-and-general-assembly-leaders>. Accessed January 21, 2021.
6. The Oregon legislature through Senate Bill 889 (2019 Laws) has established the Sustainable Health Care Cost Growth Target Program within the Oregon Health Authority. <https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB889/Enrolled>. Accessed January 21, 2021.
7. Rubinkam, M. Wolf seeks commission to rein in health care spending. Associated Press, October 2, 2020. <https://apnews.com/article/pennsylvania-health-care-costs-tom-wolf-df2bbc0f5e11a25759f0ed3f1e41078b>. Accessed November 16, 2020.
8. Share of Private-Sector Enrollees Enrolled in Self-Insured Plans. Kaiser Family Foundation State Health Facts. 2019. <https://www.kff.org/other/state-indicator/share-of-private-sector-enrollees-enrolled-in-self-insured-plans-2018/?currentTimeframe=0&selectedRows=%7B%22states%22>. Accessed January 21, 2021.
9. State of Rhode Island: Office of the Health Insurance Commissioner. December 19, 2018. <http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php>. Accessed September 20, 2020.
10. Rhode Island Executive Order No. 19-03. February 6, 2019. <https://governor.ri.gov/newsroom/orders/>. Accessed December 3, 2020.
11. The steering committee established a minimum population size of 5,000 attributed lives (Medicare) and 10,000 attributed lives (commercial and Medicaid) for public reporting of performance.
12. This work was supported by a committed team of researchers and liaisons with the state's APCD vendor and the state. This support helped the state work through challenges encountered throughout the process, including not anticipating the amount of time it would take to transfer data using the APCD vendor's business practices. There was also a learning curve to fully understand the state-specific APCD features and operational capabilities. The Cost Trends Project leveraged the state's APCD in a way it had not been used before, and this first significant analysis of the APCD uncovered the need for data scrubbing and revealed that the time to access data was longer than anticipated.
13. State of Rhode Island: Office of the Health Insurance Commissioner. May 17, 2019. <http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php>. Accessed September 20, 2020.

AUTHORS

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The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

About the Peterson Center on Healthcare

The Peterson Center on Healthcare is a non-profit organization dedicated to making higher quality, more affordable healthcare a reality for all Americans. The organization is working to transform U.S. healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs, and accelerating their adoption on a national scale. Established by the Peter G. Peterson Foundation, the Center collaborates with stakeholders across the healthcare system and engages in grant-making, partnerships, and research. For more information, visit petersonhealthcare.org.

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Peterson-Milbank
Program for Sustainable
Health Care Costs

Background and Topical Material

TAB 8

CERTIFICATION OF ENROLLMENT
SECOND SUBSTITUTE HOUSE BILL 2457

Chapter 340, Laws of 2020

66th Legislature
2020 Regular Session

HEALTH CARE COST TRANSPARENCY BOARD

EFFECTIVE DATE: June 11, 2020

Passed by the House March 9, 2020
Yeas 67 Nays 29

LAURIE JINKINS

**Speaker of the House of
Representatives**

Passed by the Senate March 6, 2020
Yeas 32 Nays 17

CYRUS HABIB

President of the Senate

Approved April 3, 2020 1:49 PM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Bernard Dean, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SECOND SUBSTITUTE HOUSE BILL 2457** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BERNARD DEAN

Chief Clerk

FILED

April 3, 2020

**Secretary of State
State of Washington**

SECOND SUBSTITUTE HOUSE BILL 2457

AS AMENDED BY THE SENATE

Passed Legislature - 2020 Regular Session

State of Washington **66th Legislature** **2020 Regular Session**

By House Appropriations (originally sponsored by Representatives
Cody, Kloba, Robinson, Schmick, Tharinger, Macri, Pollet, and Wylie)

READ FIRST TIME 02/11/20.

1 AN ACT Relating to the establishment of a board for the
2 evaluation and containment of health care expenditures; and adding a
3 new chapter to Title 70 RCW.

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

5 NEW SECTION. **Sec. 1.** The definitions in this section apply
6 throughout this chapter unless the context clearly requires
7 otherwise.

8 (1) "Authority" means the health care authority.

9 (2) "Board" means the health care cost transparency board.

10 (3) "Health care" means items, services, and supplies intended to
11 improve or maintain human function or treat or ameliorate pain,
12 disease, condition, or injury including, but not limited to, the
13 following types of services:

14 (a) Medical;

15 (b) Behavioral;

16 (c) Substance use disorder;

17 (d) Mental health;

18 (e) Surgical;

19 (f) Optometric;

20 (g) Dental;

21 (h) Podiatric;

- 1 (i) Chiropractic;
 - 2 (j) Psychiatric;
 - 3 (k) Pharmaceutical;
 - 4 (l) Therapeutic;
 - 5 (m) Preventive;
 - 6 (n) Rehabilitative;
 - 7 (o) Supportive;
 - 8 (p) Geriatric; or
 - 9 (q) Long-term care.
- 10 (4) "Health care cost growth" means the annual percentage change
11 in total health care expenditures in the state.
- 12 (5) "Health care cost growth benchmark" means the target
13 percentage for health care cost growth.
- 14 (6) "Health care coverage" means policies, contracts,
15 certificates, and agreements issued or offered by a payer.
- 16 (7) "Health care provider" means a person or entity that is
17 licensed, certified, registered, or otherwise authorized by the law
18 of this state to provide health care in the ordinary course of
19 business or practice of a profession.
- 20 (8) "Net cost of private health care coverage" means the
21 difference in premiums received by a payer and the claims for the
22 cost of health care paid by the payer under a policy or certificate
23 of health care coverage.
- 24 (9) "Payer" means:
- 25 (a) A health carrier as defined in RCW 48.43.005;
 - 26 (b) A publicly funded health care program, including medicaid,
27 medicare, the state children's health insurance program, and public
28 and school employee benefit programs administered under chapter 41.05
29 RCW;
 - 30 (c) A third-party administrator; and
 - 31 (d) Any other public or private entity, other than an individual,
32 that pays or reimburses the cost for the provision of health care.
- 33 (10) "Total health care expenditures" means all health care
34 expenditures in this state by public and private sources, including:
- 35 (a) All payments on health care providers' claims for
36 reimbursement for the cost of health care provided;
 - 37 (b) All payments to health care providers other than payments
38 described in (a) of this subsection;
 - 39 (c) All cost-sharing paid by residents of this state, including
40 copayments, deductibles, and coinsurance; and

1 (d) The net cost of private health care coverage.

2 NEW SECTION. **Sec. 2.** The authority shall establish a board to
3 be known as the health care cost transparency board. The board is
4 responsible for the analysis of total health care expenditures in
5 Washington, identifying trends in health care cost growth, and
6 establishing a health care cost growth benchmark. The board shall
7 provide analysis of the factors impacting these trends in health care
8 cost growth and, after review and consultation with identified
9 entities, shall identify those health care providers and payers that
10 are exceeding the health care cost growth benchmark.

11 NEW SECTION. **Sec. 3.** (1) The board shall consist of fourteen
12 members who shall be appointed as follows:

13 (a) The insurance commissioner, or the commissioner's designee;

14 (b) The administrator of the health care authority, or the
15 administrator's designee;

16 (c) The director of labor and industries, or the director's
17 designee;

18 (d) The chief executive officer of the health benefit exchange,
19 or the chief executive officer's designee;

20 (e) One member representing local governments that purchase
21 health care for their employees;

22 (f) Two members representing consumers;

23 (g) One member representing Taft-Hartley health benefit plans;

24 (h) Two members representing large employers, at least one of
25 which is a self-funded group health plan;

26 (i) One member representing small businesses;

27 (j) One member who is an actuary or an expert in health care
28 economics;

29 (k) One member who is an expert in health care financing; and

30 (l) One nonvoting member who is a member of the advisory
31 committee of health care providers and carriers and has operational
32 experience in health care delivery.

33 (2) The governor:

34 (a) Shall appoint the members of the board. Each of the two
35 largest caucuses in both the house of representatives and the senate
36 shall submit to the governor a list of five nominees. The nominees
37 must be for members of the board identified in subsection (1)(f)
38 through (k) of this section, may not be legislators, and, except for

1 the members of the board identified in subsection (1)(j) and (k) of
2 this section, the nominees may not be employees of the state or its
3 political subdivisions. No caucus may submit the same nominee. The
4 caucus nominations must reflect diversity in geography, gender, and
5 ethnicity;

6 (b) May reject a nominee and request a new submission from a
7 caucus if a nominee does not meet the requirements of this section;
8 and

9 (c) Must choose at least one nominee from each caucus.

10 (3) The governor shall appoint the chair of the board.

11 (4)(a) Initial members of the board shall serve staggered terms
12 not to exceed four years. Members appointed thereafter shall serve
13 two-year terms.

14 (b) A member of the board whose term has expired or who otherwise
15 leaves the board shall be replaced by gubernatorial appointment. Upon
16 the expiration of a member's term, the member shall continue to serve
17 until a successor has been appointed and has assumed office. When the
18 person leaving was nominated by one of the caucuses of the house of
19 representatives or the senate, his or her replacement shall be
20 appointed from a list of five nominees submitted by that caucus
21 within thirty days after the person leaves. If the member to be
22 replaced is the chair, the governor shall appoint a new chair within
23 thirty days after the vacancy occurs. A person appointed to replace a
24 member who leaves the board prior to the expiration of his or her
25 term shall serve only the duration of the unexpired term. Members of
26 the board may be reappointed to multiple terms.

27 (5) No member of the board may be appointed if the member's
28 participation in the decisions of the board could benefit the
29 member's own financial interests or the financial interests of an
30 entity the member represents. A board member who develops such a
31 conflict of interest shall resign or be removed from the board.

32 (6) Members of the board must be reimbursed for their travel
33 expenses while on official business in accordance with RCW 43.03.050
34 and 43.03.060. The board shall prescribe rules for the conduct of its
35 business. Meetings of the board are subject to the call of the chair.

36 (7) The board and its subcommittees are subject to the provisions
37 of chapter 42.30 RCW, the open public meetings act, and chapter 42.56
38 RCW, the public records act. The board and its subcommittees may not
39 disclose any health care information that identifies or could

1 reasonably identify the patient or consumer who is the subject of the
2 health care information.

3 (8) Members of the board are not civilly or criminally liable and
4 may not have any penalty or cause of action of any nature arise
5 against them for any action taken or not taken, including any
6 discretionary decision or failure to make a discretionary decision,
7 when the action or inaction is done in good faith and in the
8 performance of the powers and duties under this chapter.

9 NEW SECTION. **Sec. 4.** (1) The board shall establish an advisory
10 committee on data issues and an advisory committee of health care
11 providers and carriers. The board may establish other advisory
12 committees as it finds necessary.

13 (2) Appointments to the advisory committee on data issues shall
14 be made by the board. Members of the committee must have expertise in
15 health data collection and reporting, health care claims data
16 analysis, health care economic analysis, and actuarial analysis.

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

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

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

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

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

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

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

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

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

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

7 (j) One member representing a managed care organization that
8 contracts with the authority to serve medical assistance enrollees,
9 selected from a list of three nominees submitted by the association
10 of Washington health care plans;

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

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

17 (m) Three members, at least one of whom represents a disability
18 insurer, selected from a list of six nominees submitted by America's
19 health insurance plans.

20 NEW SECTION. **Sec. 5.** (1) The board has the authority to
21 establish and appoint advisory committees, in accordance with the
22 requirements of section 4 of this act, and seek input and
23 recommendations from the advisory committees on topics relevant to
24 the work of the board;

25 (2) The board shall:

26 (a) Determine the types and sources of data necessary to annually
27 calculate total health care expenditures and health care cost growth,
28 and to establish the health care cost growth benchmark, including
29 execution of any necessary access and data security agreements with
30 the custodians of the data. The board shall first identify existing
31 data sources, such as the statewide health care claims database
32 established in chapter 43.371 RCW and prescription drug data
33 collected under chapter 43.71C RCW, and primarily rely on these
34 sources when possible in order to minimize the creation of new
35 reporting requirements;

36 (b) Determine the means and methods for gathering data to
37 annually calculate total health care expenditures and health care
38 cost growth, and to establish the health care cost growth benchmark.
39 The board must select an appropriate economic indicator to use when

1 establishing the health care cost growth benchmark. The activities
2 may include selecting methodologies and determining sources of data.
3 The board shall accept recommendations from the advisory committee on
4 data issues and the advisory committee of health care providers and
5 carriers regarding the value and feasibility of reporting various
6 categories of information under (c) of this subsection, such as urban
7 and rural, public sector and private sector, and major categories of
8 health services, including prescription drugs, inpatient treatment,
9 and outpatient treatment;

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

12 (i) Statewide and by geographic rating area;

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

22 (iii) By market segment;

23 (iv) Per capita; and

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

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

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

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

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

- 1 (iii) Supply costs, including but not limited to prescription
- 2 drug costs;
- 3 (iv) Uncompensated care;
- 4 (v) Administrative and compliance costs;
- 5 (vi) Federal, state, and local taxes;
- 6 (vii) Capacity, funding, and access to postacute care, long-term
- 7 services and supports, and housing; and
- 8 (viii) Regional differences in input prices; and
- 9 (f) Release reports in accordance with section 7 of this act.

10 NEW SECTION. **Sec. 6.** (1) The authority may contract with a
11 private nonprofit entity to administer the board and provide support
12 to the board to carry out its responsibilities under this chapter.
13 The authority may not contract with a private nonprofit entity that
14 has a financial interest that may create a potential conflict of
15 interest or introduce bias into the board's deliberations.

16 (2) The authority or the contracted entity shall actively solicit
17 federal and private funding and in-kind contributions necessary to
18 complete its work in a timely fashion. The contracted entity shall
19 not accept private funds if receipt of such funding could present a
20 potential conflict of interest or introduce bias into the board's
21 deliberations.

22 NEW SECTION. **Sec. 7.** (1) By August 1, 2021, the board shall
23 submit a preliminary report to the governor and each chamber of the
24 legislature. The preliminary report shall address the progress toward
25 establishment of the board and advisory committees and the
26 establishment of total health care expenditures, health care cost
27 growth, and the health care cost growth benchmark for the state,
28 including proposed methodologies for determining each of these
29 calculations. The preliminary report shall include a discussion of
30 any obstacles related to conducting the board's work including any
31 deficiencies in data necessary to perform its responsibilities under
32 section 5 of this act and any supplemental data needs.

33 (2) Beginning August 1, 2022, the board shall submit annual
34 reports to the governor and each chamber of the legislature. The
35 first annual report shall determine the total health care
36 expenditures for the most recent year for which data is available and
37 shall establish the health care cost growth benchmark for the
38 following year. The annual reports may include policy recommendations

1 applicable to the board's activities and analysis of its work,
2 including any recommendations related to lowering health care costs,
3 focusing on private sector purchasers, and the establishment of a
4 rating system of health care providers and payers.

5 NEW SECTION. **Sec. 8.** Sections 1 through 7 of this act
6 constitute a new chapter in Title 70 RCW.

Passed by the House March 9, 2020.

Passed by the Senate March 6, 2020.

Approved by the Governor April 3, 2020.

Filed in Office of Secretary of State April 3, 2020.

--- END ---

Background and Topical Material

TAB 9



The Peterson-Milbank Program for Sustainable Health Care Costs *Technical assistance and resources to support state cost growth initiatives*

Program Description

August 2020

We are pleased to introduce the Peterson-Milbank Program for Sustainable Health Care Costs, supported through a partnership between the Milbank Memorial Fund (the Fund) and the Peterson Center on Healthcare (the Center). This program will assist states that are seeking to improve health care quality and lower costs for their residents by implementing a cost growth target. To help states navigate the stakeholder engagement process, analytic complexity and required policy actions, the program will provide technical assistance (TA) and resources modeled after states that have successfully implemented such targets.

Background

Both the Fund and the Center have program areas dedicated to supporting state work to measure total health care costs and growth rates. We think this is an important and broadly relevant focus because health care cost growth affects all states and their constituents, and it crowds out other spending priorities at the state level – affecting all categories of spending including state and local employee benefit plans. As health care costs grow, there are fewer public and private resources available for other services, including some that may have a greater impact on the health of populations – including housing, nutrition and income security.

Historically, states have focused on their direct responsibilities: to manage costs for the Medicaid program and also for public employees. However, a growing number of states have developed policies and operational models designed to address total health care costs across populations and service categories. These pioneers recognized that effective controls on health care costs need to be based on a common understanding of how system-wide health care costs compare to other state economic indicators and the specific drivers contributing to increasing health care costs.

We recognize that COVID has had many impacts on health care – there has been significant interruption to “regular” health care delivery which cut health care costs in the short run and may threaten the sustainability of key parts of health care delivery such as primary care. The economic impacts of COVID include increased unemployment (and reductions in health insurance coverage) and pressures on employers to reduce their costs. While cost growth has

abated for the time being, it is important to have the capacity to monitor health care cost growth trends and the factors contributing to cost growth as the system will likely reset to normal operations and previous cost growth trends. In addition, COVID may accelerate health care consolidation that in turn can increase health care costs.

Peterson-Milbank Program Overview

For this program, we are focused on the specific strategy used by Massachusetts and adapted by Delaware and Rhode Island that involves state government leadership, convening of health care stakeholders, and a public process to:

- Measure total health care costs across all sources of funding (Medicare, Medicaid, employers, self-pay, etc.);
- Set a target growth rate for per capita health care costs in the state;
- Monitor and analyze health system performance relative to that target;
- Conduct targeted analyses of areas affecting health care costs; and
- Facilitate policy coordination to address health system transformation.

This program does not rely primarily on state regulation to achieve its goals – instead it emphasizes coordination of policy and market responses to commit to the goals of reducing health care cost growth and to achieve more effective allocation of health care costs primarily by providing information on a consistent set of measures statewide and by region, and across payers and service categories.

Specific program activities. Based on the experience of these states, we developed a program to effectively measure and monitor total health costs, which is centered around providing technical assistance that helps up to 5 states develop the capacity to:

- Foster multi-stakeholder collaboration and agreement among purchasers, employers, and providers with state executive leadership;
- Measure, set targets, and monitor per capita trends in total health care costs at the state level and by payer, region, and large provider systems and groups;
- Assess data capacities and use ongoing local analytic capacity to identify key drivers of health care cost growth;
- Participate in virtual and in-person learning opportunities;
- Organize communications, take specific steps to inform the public on a regular basis, and establish accountability for performance;
- Identify public policy options, leverage public and private sector contracting, and foster collective actions on specific cost drivers to support target achievement; and
- Foster the development of long-term sustainability plans that support continued collaboration, measurement, and action.

Technical assistance for states. Each state will receive technical assistance for a total of 24 months. Once accepted into the program, states will receive the following support:

- Technical assistance from Bailit Health, a health care consulting firm that has worked with Rhode Island, Delaware, Oregon, and Connecticut, to develop capacity to measure, set targets for and monitor spending growth;
- Direct financial assistance for the state to contract with a local data analytics entity to help plan and execute the state’s health care spending data use and analytics plan; and
- Ad hoc support and three cross-state learning collaboratives to facilitate exchange of best practices among participants.

State participation process

States will submit a letter of intent (LOI) indicating their readiness to participate and designating a senior state official who is responsible for the state’s project.

Once the LOI has been accepted, we will send the state an application to participate. The application will provide details about the state’s approach and other relevant information about the state’s policy, health care purchasing, and data analytics environment, including:

- Convening a steering group to advise and participate in decisions about the state’s health care cost growth target and data strategy activities;
- Documenting the state’s experience with multi-stakeholder collaboration on related health care issues;
- The ability or commitment to access and analyze health care cost data from local commercial and public payers to support the process; and
- A sustainability plan to support the work of the stakeholder group with communications, policy activities, leadership, and a financial model for sustained reporting and communications.

Upon review of these materials, we will:

- Select states for participation;
- Work with each state to set specific technical assistance priorities for state health care cost targets and strategies for data infrastructure and analytics;
- Implement a comprehensive communications program to publicize state experience and develop a repository of information about state cost target activities; and
- Facilitate learning and exchange of best practices among the program participants.

Contact Information:

Please contact Rachel Block, Program Officer, Milbank Memorial Fund if you need additional information. You can reach her at rblock@milbank.org.

Additional Resources

Please see the following resources for more information and examples on how states are setting, measuring, and ensuring sustainable health care costs:

- “State Models for Health Care Cost Measurement: A Policy and Operational Framework,” available at <https://www.milbank.org/publications/state-models-for-health-care-cost-measurement-a-policy-and-operational-framework/>
- “How the Massachusetts Health Policy Commission Is Fostering a Statewide Commitment to Contain Health Care Spending Growth,” available at <https://www.commonwealthfund.org/publications/case-study/2020/mar/massachusetts-health-policy-commission-spending-growth>
- “Implementing a Statewide Healthcare Cost Benchmark,” available at <https://www.manatt.com/insights/white-papers/2019/blueprint-for-building-an-effective-statewide-heal>
- “Overview of States’ Health Care Cost-Growth Benchmark Programs,” available at <https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/>

Background and Topical Material

TAB 10



February 9, 2021

Sue Birch
Executive Director
Washington State Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, WA 98504

Sent via email

Dear Ms. Birch:

Thank you for submitting Washington State's application to participate in the Peterson-Milbank Program for Sustainable Health Care Costs. Based on our review of the application, including completion of the Governor's appointments to the Health Care Cost Transparency Board, I am pleased to inform you that we have approved your application.

We look forward to supporting you and the HCA staff as the Board begins its work next week. In addition, there are three specific program commitments for HCA to focus on as you launch this initiative.

Technical assistance plan: With planning assistance from Bailit Health, we know you have developed the initial workplan to guide the Health Care Cost Transparency Board's work for a health care cost target/benchmark. The next step is to complete the development of a technical assistance (TA) plan that will identify key work streams and priorities to accomplish the activities identified in the state's application and meet the Peterson-Milbank program criteria. Either Milbank or Bailit Health can offer guidance on the development of the TA plan if that is helpful. *We request that the completed TA plan be submitted to Milbank as soon as possible.*

Data use and analysis strategy: One of the most complex activities to be conducted through the Peterson-Milbank program is development of the state's data use and analysis strategy. This strategy will need to address (1) uses of the state's APCD and possibly other important claims data sources and (2) the analysis of cost drivers to inform policies for sustainable health care cost growth. In addition to the Bailit Health TA resources, the program will provide additional, direct grant support for data strategy plan development as well as future data analytics; we would expect that additional state

resources will also need to be identified for this work. Given the importance and complexity of this component of the program, we request the state to complete a draft data strategy plan within six months of program approval.

Communications: Once the program is launched, we will work with you to identify specific communication needs and activities and determine how we can help you further develop a communications plan; we would also request this plan to be submitted within six months of program approval.

We look forward to working with you to advance sustainable health care cost growth policies in Washington. Please let me know if you have any questions.

Sincerely,



Rachel Block

Milbank Memorial Fund
Program Officer

645 Madison Avenue, 15th Floor
New York, NY 10022-1095
Tel: (518) 860-2226 | Fax: (212) 355-8599
rblock@milbank.org
www.milbank.org

xc: Frederica Stahl and Keanan Lane, Peterson Center on Healthcare
Michael Bailit, Bailit Health

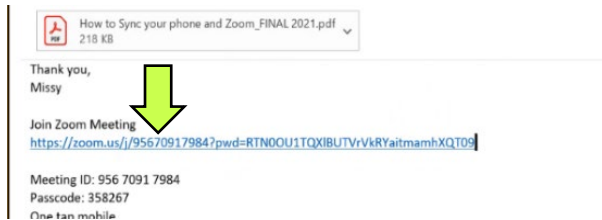
Additional Resources

TAB 11

How to join a Zoom meeting

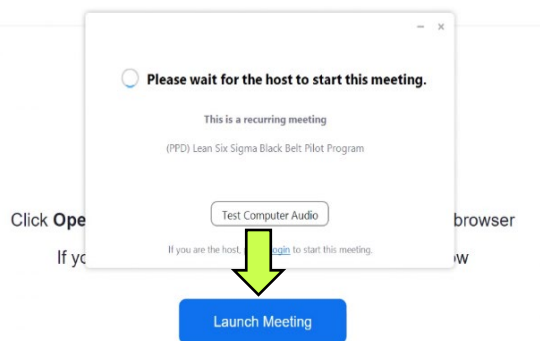
1. Find the meeting on your calendar and open it.

Click the Zoom hyperlink in the body of your invitation.

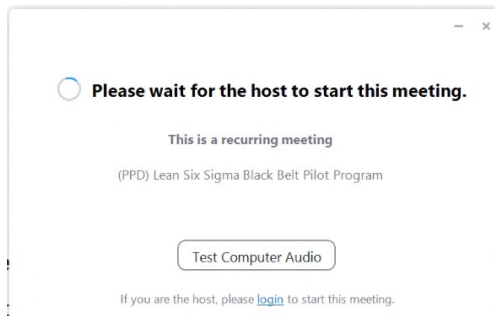


2. Your browser will automatically download Zoom for you

Click *Launch Meeting* if it does not start automatically.

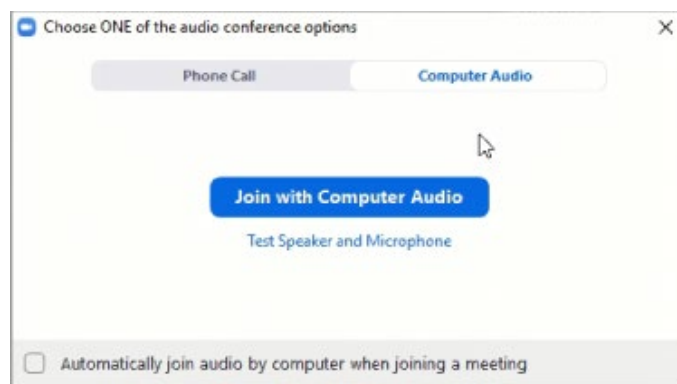


3. You will be placed in the waiting room until the meeting begins.



4. When the meeting starts, you will be prompted to select your audio.

Choose the option that best suits you. If you choose **Phone Call** please follow the directions provided for how to sync your phone and zoom profile.



Already downloaded Zoom?

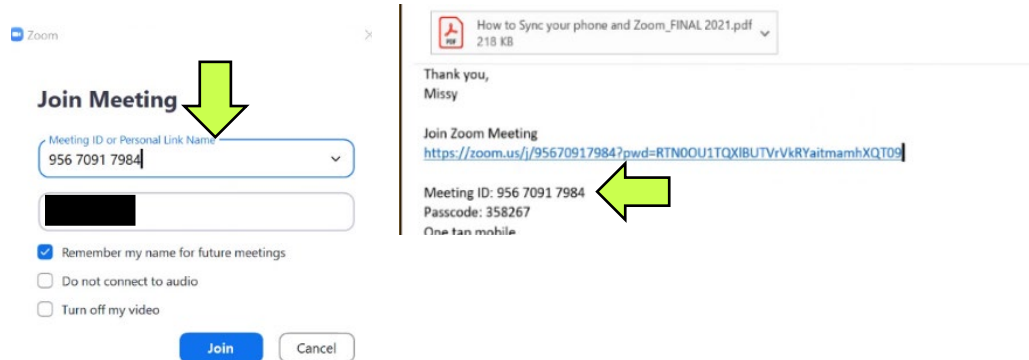
1. Open your application.

Click *Join a Meeting*.



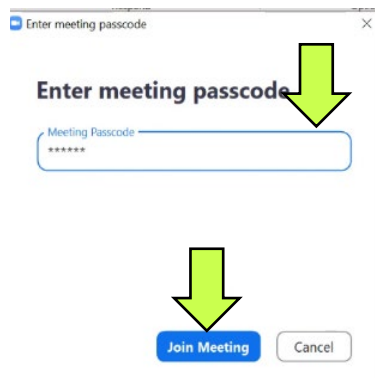
2. Enter the meeting ID.

This can be found in the body of your invitation on your calendar.



3. Enter the passcode.

This can be found in the body of your invitation on your calendar. When you're done click *Join Meeting*.



Additional Resources

TAB 12

Member biographies



Susan E. Birch, MBA, BSN, RN

Director and chair

Washington State Health Care Authority

Sue Birch serves as director of the Washington State Health Care Authority (HCA), the state's largest health care purchaser. Appointed by Governor Jay Inslee in January 2018, Birch oversees efforts to transform the health care system, helping ensure Washington residents have access to high-quality, affordable health care.

HCA purchases care for nearly 2.7 million residents through Washington Apple Health (Medicaid), the Public Employees Benefits Board (PEBB) Program, and the School Employees Benefits Board (SEBB) Program. HCA also is responsible for the state community-based behavioral health system.

A nurse by training, Birch is passionate about improving population health and reducing overmedicalization by focusing on the social determinants of health. She has led efforts to combat the opioid public health crisis through increased access to treatment and public education, eliminate Hepatitis C through innovative value-based drug purchasing, and implement a Medicaid benefit for supportive housing and supported employment.

Before joining Governor Inslee's Cabinet, Birch served as the executive director of the Colorado Department of Health Care Policy and Financing. She led the state's successful implementation of the Affordable Care Act, which expanded coverage to more low-income Coloradans while focusing on cost containment and improved service delivery. She also has served as chief executive officer of the Northwest Colorado Visiting Nurse Association.

Birch has completed appointments to the National Advisory Committee on Rural Health and Human Services and served as the Bonfils-Stanton Foundation Livingston Fellow and the Robert Wood Johnson Executive Nurse Fellow.

Lois C. Cook

Managing member

America's Phone Guys

Ms. Cook owns and operates America's Phone Guys in Vancouver, Washington with her husband, Caleb, who started the business in 2001. The company sells telephone equipment and VoIP Phone Services to other businesses in the northwest. She also serves as a member of the Business Advisory Council for the Washington State Department of Revenue and is the vice chair for the NFIB's Washington State Leadership Council.



Bianca Frogner, PhD

Associate professor, Department of Family Medicine
Director, Center for Health Workforce Studies
Deputy director, Primary Care Innovation Lab
University of Washington

Bianca Kiyoe Frogner, PhD is an associate professor in the Department of Family Medicine in the School of Medicine at University of Washington (UW). She is the director of the UW Center for Health Workforce Studies (CHWS) and deputy director of the Primary Care Innovation Lab (PCI-Lab), which are housed in the Department of Family Medicine.

Dr. Frogner is a health economist (NIH T32 trainee) with expertise in health services delivery, health workforce, labor economics, health spending, health insurance coverage and reimbursement, and international health systems. She is the principal investigator of two Health Resources and Services Administration (HRSA) Health Workforce Research Center (HWRC) grants, one focused on allied health and another focused on the training and education of health professionals to address health equity.

In 2016, Dr. Frogner served on an Institute of Medicine (IOM) Consensus Study Committee on Educating Health Professionals to Address the Social Determinants of Health. She serves on the editorial boards of *Medical Care Research and Review* and *Health Systems*. She received the 2019 John M. Eisenberg Article-of-the-Year Award as lead author of a study investigating physical therapy as the first point of care for low back pain treatment published in *Health Services Research*. Dr. Frogner's has over 100 publications including peer-reviewed articles, book chapters, and reports. Her research has been shared in over 200 scholarly presentations and has appeared in popular media outlets including CNN, NPR, Wall Street Journal, Vox, and Politico.

Dr. Frogner completed a post-doctoral fellow at the University of Illinois at Chicago School of Public Health. Dr. Frogner received her PhD in health economics at the Johns Hopkins Bloomberg School of Public Health, and BA at University of California, Berkeley in Molecular and Cell Biology.

Sonja Kellen

Senior director
Global Health and Wellness
Microsoft Corporation

Sonja Kellen is the Sr. Director of Global Health and Wellness for Microsoft Corporation. She provides leadership in the design, governance, and execution of Microsoft's health and wellness plans and programs around the world. Sonja has responsibility for ensuring Microsoft's global health and wellness benefits are aligned with the overall total rewards strategy and philosophy, as well as with broader business objectives.

Sonja has over 22 years of experience in the global benefits space, previously leading Global Retirement for Microsoft. Prior to Microsoft, Sonja worked as a retirement plans record-keeper and consultant. Sonja holds the Certified Employee Benefits Specialist designation from the International Foundation of Employee Benefit Plans and Wharton School of the University of Pennsylvania and the Qualified 401(k) Administrator designation from the American Society of Pension Professionals and Actuaries.

Sonja grew up in South Dakota and moved to the Seattle area for college, where she earned a Bachelor of Arts (Honors) in Speech Communication and a Business degree from the University of Washington.



Pam MacEwan

Chief executive officer
Washington Health Benefit Exchange

Pam MacEwan is the chief executive officer for the Washington Health Benefit Exchange (HBE). Prior to joining the leadership team at HBE, Pam served as executive vice president for Public Affairs and Governance for Group Health Cooperative. She directed Medicare and Medicaid program performance and strategy, government relations, public policy, communications, and consumer governance serving on Group Health's leadership team for 16 years.

Previously, Pam served as a commissioner with the Washington Health Services Commission implementing the Health Services Act. She worked with a broad coalition to pass health reform legislation. Pam has served on several health policy initiatives in the public and private sector, chairing the Association of Washington Health Plans, serving on the Washington State Hospital policy committee, the King County Health Action Plan, and the Children's Health Initiative. She holds an MAT in history from Brown University and a BA in economics from The Evergreen State College.

Molly Nollette

Deputy commissioner

Washington State Office of the Insurance Commissioner



Molly Nollette is deputy insurance commissioner of the Rates, Forms, and Provider Networks division, serving Insurance Commissioner Mike Kreidler. She joined the Office of Insurance Commissioner (OIC) in 2010 to work on the newly passed Affordable Care Act and was appointed to her current position in 2013. Molly and her team are responsible for ensuring that Health and Disability, Property and Casualty, and Life and Annuities insurance plans sold in Washington comply with state and federal law and regulations.

As deputy commissioner, she is active in advancing and implementing the commissioner's policy and legislative agenda, including representing him at multiple national and state forums, including the National Association of Insurance Commissioners and the Washington State Insurance Pool (WSHIP) Board. Prior to joining the OIC, Molly worked at Starbucks Coffee Company, where she led a shared services team that supported a global department focused on employee and customer safety and security. As a native Washingtonian, she is an avid gardener and optimistically plants tomatoes every spring. She loves working in public service and is particularly in support of access to affordable and meaningful health care for all. Molly was awarded a B.A. from Reed College and J.D. from Tulane University School of Law.



Margaret Stanley

Consumer representative

Margaret Stanley has served in executive positions in health care in both the public and private sectors. She was the first administrator of the Washington State Health Care Authority and served as vice chair of the Washington Health Care Commission and chair of the Public Employees Benefits Board. She later chaired the Washington State Health Benefits Exchange Board.

Ms. Stanley also served as the executive director of the Puget Sound Health Alliance, now the Washington Health Alliance. She has held executive positions at the California Public Employees' Retirement System (CalPERS), Group Health Cooperative, Premera Blue Cross, and Regence BlueShield. She has served on many

health care boards. She has a master's degree in health care administration from the University of Washington.



Kim Wallace

Medical administrator

Office of the Medical Director

Washington State Department of Labor & Industries

Kim is the medical administrator in the Office of the Medical Director at the state Department of Labor & Industries. Over the past 25 years, Kim has held numerous public and private sector leadership positions in health care policy and finance, health IT, health benefits management, and public health. She has an MBA from Wharton and a B.S. in Clinical Dietetics from the University of Washington.



Carol Wilmes

Director

Member Pooling Programs

Association of Washington Cities

Carol Wilmes is the director of Member Pooling Programs for the Association of Washington Cities (AWC), overseeing AWC's Employee Benefit Trust, Risk Management Service Agency, Workers' Comp Retrospective Rating Program, and Drug & Alcohol Consortium.

For most of her 38 years with the AWC, Carol administered the Employee Benefit Trust, insuring 36,000 members from over 280 municipalities and special purpose districts. She serves as a resource for labor-management task forces addressing the complexities of health care coverage, and frequently speaks at the state and national level on governmental entity health pools and public sector risk management trends. She was appointed to the Washington State Health Benefit Exchange Advisory Committee in 2015; serves as chair to the Board of Directors to the National League of Cities Risk Insurance Sharing Consortium (NLC RISC); and serves on the Washington Health Alliance Board of Directors and Executive Committee.



Edwin Wong, PhD

Research associate professor
Department of Health Services
University of Washington



Dr. Edwin Wong is a research associate professor in the Department of Health Services at the University of Washington and a core investigator at the Center for Veteran-Centered and Value-Driven Care within the VA Puget Sound Health Care System. Dr. Wong is a health economist and health services researcher with a diverse portfolio of federally funded research.

His work applies big data analytics to address questions in four key areas: 1) understanding economic and policy factors influencing health care utilization and costs, 2) examining the economic implications of large-scale health system interventions, 3) assessing the economic burden of chronic disease and 4) developing novel methods applications to improve measurement of health system performance. Dr. Wong also serves as a mentor to numerous graduate students, and postdoctoral and clinical fellows. Dr. Wong received his BS in Computer Science from Texas Christian University, and his MA and PhD in economics from the University of Washington.



Laura Kate Zaichkin

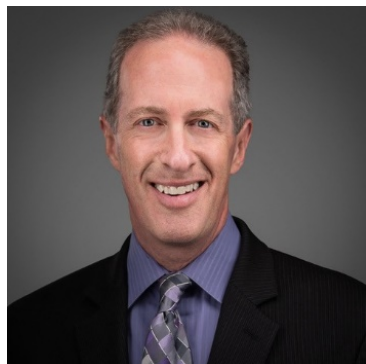
Director
Health Plan Performance and Strategy
SEIU Benefits Group

Kate Zaichkin (she/her) is the director of Health Plan Performance and Strategy for SEIU 775 Benefits Group, an organization dedicated to improving the skills, health, and stability of the state's caregiving workforce. As deputy director of the Benefits Group's Health Benefits Trust, Laura Kate leads health purchasing strategy and manages the performance of contracted carriers and vendors serving nearly 52,000 long-term home caregivers receiving safety and wellness benefits, and the 23,000 caregivers enrolled in the health plan.

Laura Kate brings a decade of experience in health policy, reform, and health systems transformation. Her past roles include serving as the deputy chief policy officer for the Washington State Health Care Authority and convening a public-private partnership of national health care entities to help implement the Affordable Care Act at the National Quality Forum in Washington, DC.



Consultant biographies



Michael H. Bailit, MBA

President
Bailit Health

Michael founded Bailit Health in 1997 and has since worked with a wide array of state agencies and employer purchasing coalitions in over 30 states. Michael's professional interests focus on how purchasers and regulators can influence health care markets to operate as effectively and efficiently as possible.

Michael has worked with clients on payment and delivery system reform, including ACO, Medical Home and episode-based payment strategy design and implementation, performance measurement, value-based purchasing, and multi-stakeholder change process guidance and facilitation. Since 2018, he has worked with Connecticut, Delaware, Oregon, and Rhode Island to design and implement cost growth target strategies.

Prior to founding Bailit Health, Michael served as the assistant commissioner for Benefit Plans in the Massachusetts Division of Medical Assistance, the state Medicaid agency. His responsibilities included the management of all the division's benefit plans, including the HMO, behavioral health, primary care case management, and senior care programs. Also, while with Massachusetts, Michael founded the Massachusetts Healthcare Purchaser Group and served as its chairman and president.

Previously, Michael worked for Digital Equipment Corporation and was engaged in health and welfare benefit planning and management activities for Digital's 60,000 U.S. employees.

Michael earned a Bachelor of Arts degree from Wesleyan University and earned an M.B.A. from the Kellogg School of Management at Northwestern University.

Rachel Block

Program officer
Milbank Memorial Fund

Rachel Block is a program officer at the Milbank Memorial Fund where she focuses on a variety of state health policy issues. She has previously served in numerous executive roles in the public and private sectors, including spearheading development of the health information technology strategy as deputy commissioner for Health Information Technology Transformation in the New York State Department of Health, and as the founding executive director of the New York eHealth Collaborative.

Ms. Block has also worked at the Centers for Medicare & Medicaid Services, where she held several senior management positions directing policy development and operations for Medicaid, State



Children’s Health Insurance, and federal survey and certification programs. She was the founding executive director for the Vermont Health Care Authority and had senior health policy staff roles in the New York State Legislature.



January Angeles, MPP

Senior consultant
Bailit Health

January has over 20 years of experience in health care policy and management. Her expertise includes legislative and policy analysis, program development and implementation, and program management and evaluation with an emphasis on publicly financed health care. January’s current work focuses on helping states establish health care cost growth target programs, working with Connecticut and Washington on developing the target methodology and assessing performance against the target.

She also works with states to leverage procurement and contract oversight processes to strengthen their Medicaid managed care programs. Most recently she assisted North Dakota on its Medicaid managed care procurement for expansion adults. January’s past work at Bailit Health includes providing technical assistance to Mississippi and New Jersey on strategies to implement value-based payments in their Medicaid managed care contracts and facilitating a work group to advise the Rhode Island on future telemedicine policies.

Prior to joining Bailit Health, January served as deputy Medicaid director for Managed Care and Oversight and as CHIP director for Rhode Island. She led cross-functional teams responsible for managed care contracting, delivery system reform, policy and regulatory compliance, data analytics, and program integrity. Her accomplishments include spearheading the successful renewal of Rhode Island’s Section 1115 waiver, developing, and implementing processes and measures for better oversight of the Medicaid program’s contracted health, dental and transportation programs, and directing the Accountable Entities program’s transition from pilot to implementation phase.

January’s Rhode Island state work also included serving as interagency operations manager for HealthSource RI, the state’s health insurance exchange. In this role, January facilitated coverage for thousands of Rhode Island residents by strengthening Medicaid and HealthSource RI’s eligibility policy and operations.

Before working for the State of Rhode Island, January was a Senior Policy Analyst at the Center on Budget and Policy Priorities, where she worked on Affordable Care Act legislation and implementation with a focus on expanding Medicaid, implementing the premium tax credits, and coordinating eligibility for health and human services programs. January’s other health policy experience includes working at the Center for Health Care Strategies, American Institutes for Research, and Mathematica Policy Research.

January earned a Bachelor of Arts degree in Psychology from Oberlin College, and a Master of Public Policy Degree from the University of California, Berkeley’s Goldman School of Public Policy.

Additional Resources

TAB 13



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: February 02, 2021

TIME: 9:59 AM

WSR 21-04-127

Following is the **revised** schedule of regular meetings for the Washington State Health Care Authority Health Care Cost Transparency Board meetings for 2021:

Date	Time	Location
February 18, 2021	2:00-4:00 p.m.	Health Care Authority Sue Crystal Conf Rooms A/B 626 8 th Ave. SE Olympia, WA 98501
March 15, 2021	2:00-4:00 p.m.	Health Care Authority Sue Crystal Conf Rooms A/B 626 8 th Ave. SE Olympia, WA 98501
April 13, 2021	10:00-12:00 a.m.	Health Care Authority Sue Crystal Conf Rooms A/B 626 8 th Ave. SE Olympia, WA 98501
May 13, 2021	9:00-11:00 a.m.	Health Care Authority Sue Crystal Conf Rooms A/B 626 8 th Ave. SE Olympia, WA 98501
June 16, 2021	2:00-4:00 p.m.	Health Care Authority Sue Crystal Conf Rooms A/B 626 8 th Ave. SE Olympia, WA 98501
July 19, 2021	2:00-4:00 p.m.	Health Care Authority Sue Crystal Conf Rooms A/B 626 8 th Ave. SE Olympia, WA 98501
August 17, 2021	2:00-4:00 p.m.	Health Care Authority Sue Crystal Conf Rooms A/B 626 8 th Ave. SE Olympia, WA 98501
September 14, 2021	2:00-4:00 p.m.	Health Care Authority Sue Crystal Conf Rooms A/B 626 8 th Ave. SE Olympia, WA 98501
October 14, 2021	10:00-12:00 p.m.	Health Care Authority Sue Crystal Conf Rooms A/B 626 8 th Ave. SE Olympia, WA 98501

November 17, 2021	2:00-4:00 p.m.	Health Care Authority Sue Crystal Conf Rooms A/B 626 8 th Ave. SE Olympia, WA 98501
December 15, 2021	2:00-4:00 p.m.	Health Care Authority Sue Crystal Conf Rooms A/B 626 8 th Ave. SE Olympia, WA 98501

If you need further information or you are a person with a disability and need a special accommodation, please contact Tamarra Henshaw, P.O. Box 45502, Olympia, WA 98504-5502, 360-725-1419, tamarra.henshaw@hca.wa.gov.