Washington State Health Care Authority

Health Care Cost Transparency Board

March 16, 2022

Washington State Health Care Authority

Health Care Cost Transparency Board
Board Book

March 16, 2022
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting Materials

Washington State Health Care Authority

Agenda

TAB 1

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Washington State Health Care Authority

March 16, 2022
2:00 p.m. – 4:00 p.m.
Zoom Meeting

Health Care Cost Transparency Board
AGENDA

Board Members:					
☐	Susan E. Birch, Chair	☐	Sonja Kellen	☐	Kim Wallace
☐	Lois C. Cook	☐	Pam MacEwan	☐	Carol Wilmes
☐	John Doyle	☐	Molly Nollette	☐	Edwin Wong
☐	Bianca Frogner	☐	Mark Siegel		
☐	Jodi Joyce	☐	Margaret Stanley		

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome, Roll Call, and Agenda Review	1	Susan E. Birch, Chair, Director Health Care Authority
2:05 – 2:10 (5 min)	Approval of February meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:10 – 2:15 (5 min)	Recap of February Board meeting **Decision:** Approve updated criteria for selecting strategies to support cost growth benchmark attainment	3	Michael Bailit and January Angeles Bailit Health
2:15 – 2:25 (10 min)	Advisory Committee feedback on impacts to consider and cost growth driver analyses	4	AnnaLisa Gellermann Health Care Authority Michael Bailit and January Angeles Bailit Health
2:25 -2:30 (5 min)	Data on spending and spending growth in Washington: Introduction	5	Michael Bailit and January Angeles Bailit Health
2:30 – 3:00 (30 min)	Washington State commercial trends in cost, 2016 - 2019	6	Jane Beyer, Office of the Insurance Commissioner Amy Kinner, OnPoint
3:00 – 3:10 (10 min)	Public Comment		Susan E. Birch, Chair, Director Health Care Authority
3:10 – 3:30 (20 min)	Other data on health care cost trends in Washington **Discussion:** Opportunities for cost growth mitigation	7	Michael Bailit and January Angeles Bailit Health
3:30 – 3:55 (25 min)	The Impact of COVID 19 and rising inflation on the Cost Growth Benchmark program **Discussion:** What actions does the Board wish to take regarding COVID and inflation?	8	Michael Bailit and January Angeles Bailit Health
3:55 – 4:00 (5 min)	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.

Washington State Health Care Authority

February meeting minutes

TAB 2

Health Care Cost Transparency Board meeting minutes

February 16, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

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

Members present

Sue Birch, chair
John Doyle
Bianca Frogner
Molly Nollette
Pam MacEwan
Mark Siegel
Margaret Stanley
Carol Wilmes
Edwin Wong

Members absent

Jodi Joyce
Lois Cook
Sonja Kellen
Kim Wallace

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Ms. Birch welcomed the members. She recognized that she and Board members were eager to start bending the cost curve and reminded them that the true promise of the Board was to make recommendations based on solid data analysis, including the benchmark data call. She told the Board they would be reviewing other cost analyses in the state over the next months.

Approval of minutes

The minutes were approved.

Topics for today

The topics were listed as review of state activities to mitigate cost growth and help meet the benchmark, establishing criteria for selecting strategies to support cost growth benchmark attainment, and next steps.

Review of state activities to mitigate cost growth and help meet the benchmark

Michael Bailit and January Angeles, Bailit Health
PowerPoint presentation

Mr. Bailit reminded the Board of the cost growth benchmark logic model, which included identification of opportunities and strategies to slow cost growth, and implementation plans. The goal of the discussion was to learn about mitigation activities in benchmark states and provide an opportunity to recommend and prioritize possible initiatives. He distinguished two categories of interventions: specific strategies to address cost drivers identified through analysis, and broad-based strategies that do not target a particular driver. The review of state mitigation efforts fell into four categories: market consolidation oversight, price growth caps, prescription drug pricing legislation, and advance value-based payment models.
One Board member asked for clarification about Washington's certificate of need process, and how it differed from Oregon's review of material change transactions.
Related to price growth caps, one Board member had questions about the direct comparison with smaller states with dominant health systems, and how these interventions might play out in the Washington market. One Board member mentioned the interaction with the state's rate review authority and how caps might impact on current pricing. One Board member sought clarification of which entities would be subject to the cap- Mr. Bailit clarified that state regulation was limited to fully insured entities, but that based on the nature of contracting caps in Rhode Island were found to influence all pricing. One Board member asked for clarification on how affordability caps would interact with hospital global budgets.
Related to prescription drug pricing legislation, one Board member asked for clarification about the impact of utilization (including a new costly drug) vs. unit cost on overall spend. Mr. Bailit shared that it was unit cost, growing fastest in infusion drugs and other drugs at a higher cost point.
Related to value-based payment models, one Board member discussed the strong regional engagement in the Northwest and work underway with regional hospitals on new budget models. Mr. Bailit shared that Oregon is moving away from fee-for-service payment, toward prospective primary care, capitated specialist costs, and global budgets. One Board member discussed the history of hospital payment reform and considered whether most of the potential hospital consolidation had been achieved and supported looking at more innovative solutions. The Board engaged in a vigorous conversation around the current cost of care and cost concerns in general.

Public comment

Ms. Birch called for comments from the public.

Jeb Shepard, Director of Policy for the Washington State Medical Association commented that WSMA seeks to be an engaged and constructive partner and as such has raised concern that the benchmark adopted by the Board is unrealistic, citing 40-year high inflation, changes in utilization and changes in labor cost. Mr. Shepard reminded the Board that WSMA has submitted several detailed letters detailing its concerns, and he requested that the Board either engage in a public discussion of the issues raised by WSMA or provide a written response to the issued raised in their letters.

Establishing criteria for selecting strategies to support cost growth benchmark attainment

Michael Bailit and January Angeles, Bailit Health
PowerPoint presentation

January Angeles discussed the importance of criteria and a structure supporting the selection of potential strategies to address cost growth. Systematic selection will help ensure that the most important issues are addressed, and better reflect the realities of stakeholders involved. Bailit presented the following criteria:

- Implementation of the strategy is likely to have a substantive impact on cost growth target attainment, as supported by evidence or a compelling logic model.
- The strategy is actionable for the State, payers, or provider organizations.
- Relevant stakeholders have the capacity to design and execute the strategy successfully.

The Board was invited to discuss the proposed criteria and propose changes or new criteria. One Board member shared that the principles seemed very practical and asked about capacity. Ms. Bailit responded that capacity would be related to the specific intervention. Members suggested a principle related to federal approval or funding, and another suggested that financial resources would be an important part of selecting an intervention. Staff agreed to develop wording related to consideration of CMS and financial elements and recirculate the criteria for approval and adoption.

Next steps and educational topics

AnnaLisa Gellermann, Health Care Authority
PowerPoint presentation

Ms. Gellermann informed the Board that in future meetings, the Board would receive information on Washington specific data on health care costs, updates on the 2022 session, and education topics on Washington efforts related to cost growth.
The Board reviewed a list of potential educational topics, and was asked to identify those of immediate interest, to facilitate future agenda items. Board members expressed interest in hospital pricing strategy, workforce/labor costs, value-based payments in Washington (including updates on progress and performance), rating standards, and consolidation oversight in Oregon.
One Board member noted the Total Cost of Care Tool developed by the Washington Health Alliance as a valuable resource for the Board. Bailit and staff agreed that the Board could be informed by the tool, and other sources of information as well.

Adjournment

Meeting adjourned at 3:56 p.m.

Next meeting

Wednesday, March 16, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Washington State Health Care Authority

Recap of February Board meeting

TAB 3

Recap of the February Board meeting

Washington State Health Care Authority

Recap of the February Board meeting

- Board members reviewed state activities to mitigate cost growth and help meet the benchmark.
- Board members were most interested in diving deeper into the following issues:
  - **Market oversight**, including oversight of market consolidation and setting affordability standards.
  - **Hospital pricing strategy**, including global budgets and understanding the impact of labor costs.
  - **Value-based payments**, in particular challenges to getting traction.
- Board members were also interested in hearing more about innovative approaches that states have *not* pursued and why they have not pursued them.

Recap of the February Board meeting

- Board members also agreed on the following three criteria for selecting strategies to support cost growth benchmark attainment:
  - Implementation of the strategy is likely to have a substantive impact on cost growth benchmark attainment.
    - Evidence supports the strategy, or if not, there is a compelling logic model for the strategy.
  - The strategy is actionable for the state, payers or provider organizations.
    - Approval from federal partners is not required to implement the strategy, or there is a high likelihood of obtaining required approval.
  - Relevant stakeholder have the capacity to design and execute the strategy thoughtfully and successfully.

Washington State Health Care Authority

Advisory Committee feedback on impacts to consider and cost growth driver analyses

TAB 4

Feedback from the Advisory Committees

Feedback from the Advisory Committee of Providers and Carriers: Impacts to consider

- Committee members discussed possible consequences of transparency and cost reduction efforts, and suggested the following areas for monitoring and counter-measurement.
  - Unintended negative impacts on vulnerable populations, fragile health delivery systems, small practices, and primary care utilization and reimbursement.
  - Unwanted cost cutting, including slimming of benefit design and increased barriers to care, resulting in reduced access.

Feedback from the Advisory Committee of Providers and Carriers: Impacts to consider

- Committee members agreed on effects of the COVID pandemic on spending that will likely influence benchmark results.
  - Rising labor costs.
  - Changes in utilization.
  - Required benefit changes (vaccine payments).
- One Committee member suggested the creation of a "Learning Community" to support understanding and insight related to the data at a population and total investment level.

Feedback from the Advisory Committee on Data Issues on the cost growth driver analyses

- Committee members agreed that HCA's proposed approach to initial analyses of cost growth drivers, which include the following, seemed reasonable:
  - Spend and trend by geography.
  - Trends in price and utilization.
  - Spend and trend by health condition .
  - Spend and trend by demographics.
  - Monitoring of potential unintended adverse consequences.

Feedback from the Advisory Committee on Data Issues on the cost growth driver analyses

- One Committee member suggested use of the CMS Chronic Condition Warehouse for identifying and grouping chronic conditions to analyze.
- Some members were interested in seeing spending on pediatric conditions analyzed independently from adult conditions.
- One member emphasized the importance of articulating that analyses involving demographic information are not at the individual level.
- Another member mentioned using an area deprivation index as a potential tool for incorporating demographic information.

Washington State Health Care Authority

Data on spending and spending growth in Washington

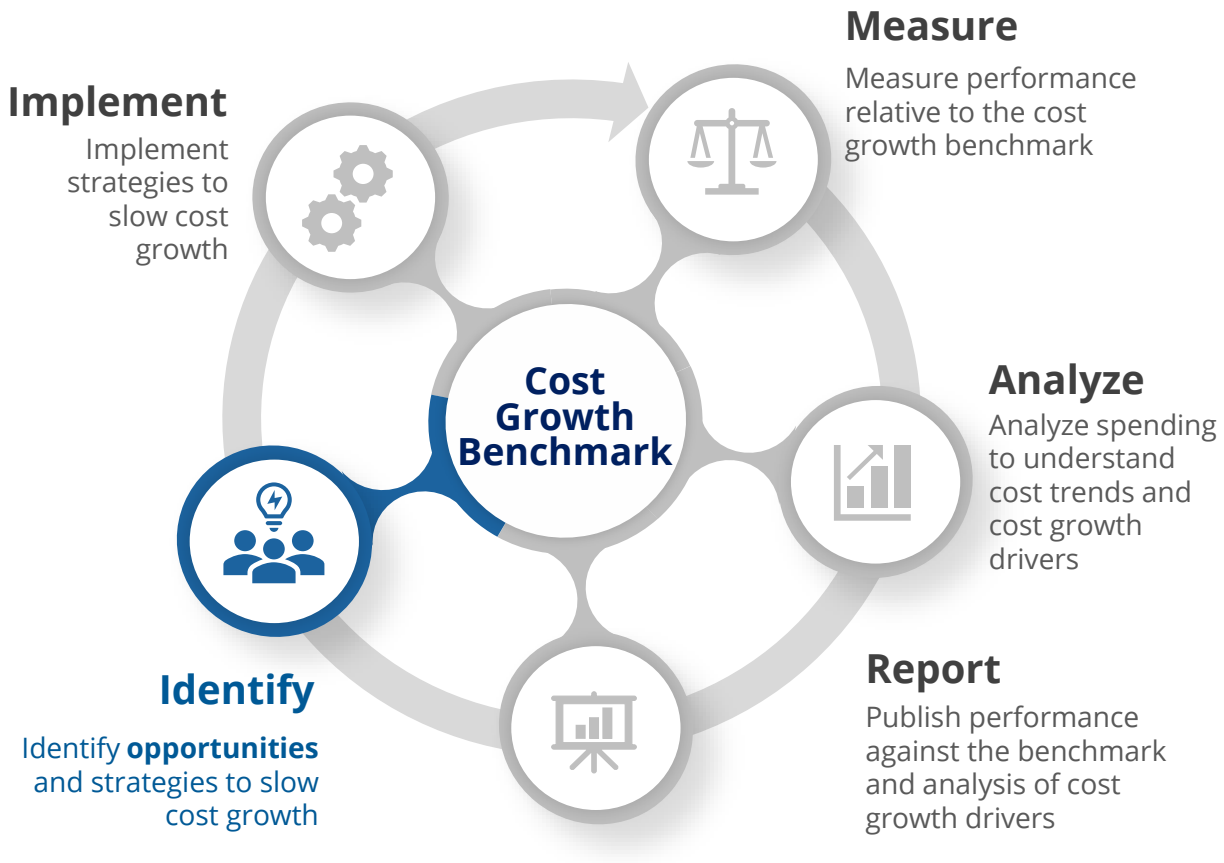
TAB 5

Data on spending and spending growth in Washington

Washington State Health Care Authority

Goals for today's discussion on Washington-specific cost and cost growth data

- To be effective, a cost growth benchmark must be complemented by supporting strategies designed to identify and mitigate cost growth.
- We will look at existing data about health care spending in Washington to identify potential opportunities to slow cost growth.



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Three key questions to consider while reviewing data on state health care costs

1. What do the data say about where the costs are highest and rising fastest?
2. Do you identify any concerns we should be taking into account when interpreting the data?
3. What further analyses should HCA consider to better understand what is driving spending and spending growth?

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Washington State commercial trends in cost

TAB 6

Washington State commercial trends in cost 2016-2019

Washington State Health Care Authority

ONPOINT Health Data

Washington All-Payer Claims Database (WA-APCD) Cost Trend Analysis

March 16, 2022

Goals of Project

- Calculate rate of cost growth in Washington for commercial insurance spending
- Identify drivers of cost
    - Acute inpatient, outpatient ED, outpatient non-ED, professional, pharmacy, ambulance
- How much of the change in cost is due to price versus utilization?
- Additional drill-downs/dashboards:
    - Type of inpatient service
    - Mental health services
    - Air ambulance services
    - Exchange and PEBB

Methodology – Population Criteria

- Population
  - Commercial carriers only
  - Aged 0-64
  - WA state residents only
  - 2016-2019
- Claims – Limited to first service date between Jan 1 and Dec 31 of the study year
- Eligibility – Limited to members with both pharmacy and medical eligibility during the study year
- Fee for service – Limited to members in groups with the majority of their care paid in a fee-for-service (non-capitated)

Methodology – Key Metrics

- Per Member Per Month (PMPM) rates
  - Sum of all dollars paid by the plan and member/total member months of coverage for the population
- Utilization per 1,000 Average Members
  - Total services*12,000/total member months of coverage for the population
  - Services = claims for most services; discharges for inpatient; prescription fills for pharmacy
- Average price – Total amount paid by the plan and member for services in category/count of services
- Percent Change – All percent changes represent the aggregate percent change from baseline year 2016

Methodology – Service Categories

Term	Definition
Total (All Claims)	The sum of all pharmacy and medical claims for a patient during the year
Medical (Total)	The sum of all medical claims for a patient during the year
Pharmacy (Total)	The sum of all pharmacy claims for a patient during the year (excluding pharmacy services reported in the medical claims)

Methodology – Service Categories

Term	Definition
Acute Inpatient	Includes all of the claims for services incurred during an acute inpatient stay (both professional and facility claims). Acute stays are identified using place of setting.
Outpatient ED	Includes all claims for services rendered in the emergency department (ED). These include professional and facility claims billed for ED services.
Outpatient non-ED	Includes all of the facility claims for services incurred where the type of setting was outpatient, excluding any claims rendered in the ED setting. Outpatient non-ED could include hospitals, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), free-standing ambulatory surgery centers, etc.
Outpatient (Total)	The sum of outpatient ED and outpatient non-ED claims
Professional	The sum of all claims where the claim type was professional and the type of setting was provider. Professional claims for services rendered in the ED setting or acute inpatient setting are not included in this category to avoid double-counting.

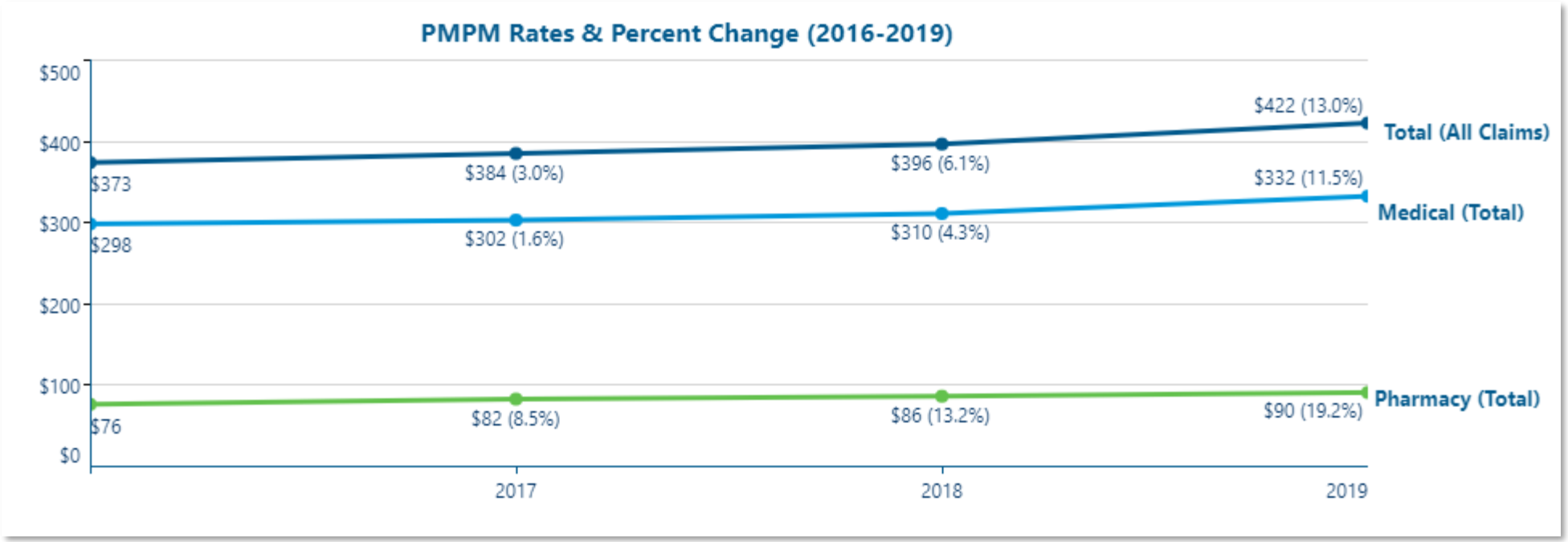
Methodology – Service Categories

Term	Definition
Ambulance	The sum of all ambulance claims
Air Ambulance	The sum of claims where procedure codes A0430 or A0431 were billed. All lines of the claim have been included as one air ambulance service.
Other Ambulance	Any ambulance claims not identified as air ambulance services.
Mental Health Services	Limited to claims with primary diagnoses of mental health. Because substance use disorder claims are not consistently submitted to the WA-APCD due to 42 CFR Part 2 regulations, this study does not include substance use disorder claims.

ONPOINT Health Data

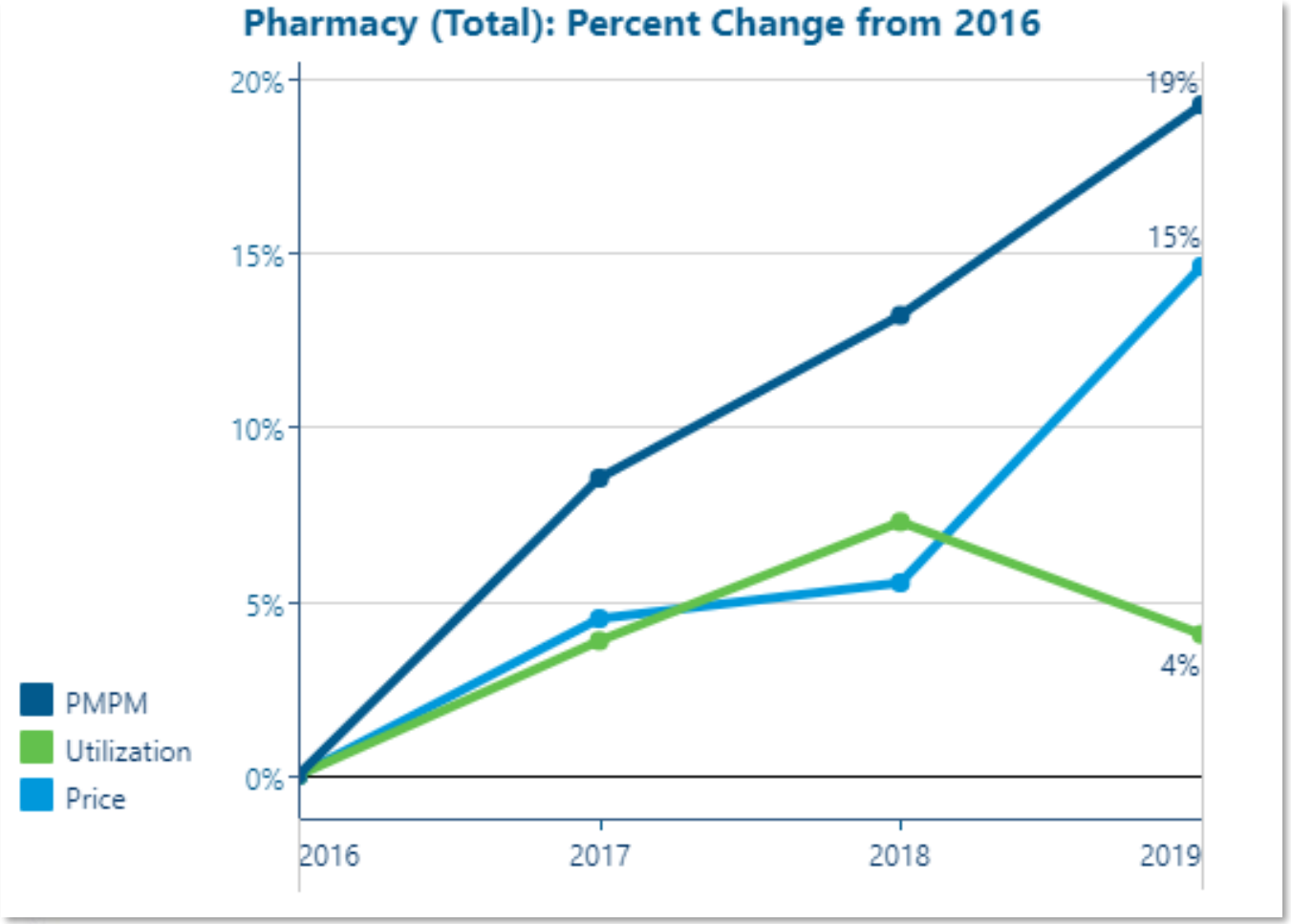
Summary of Key Findings

PMPM Spending in Washington Increased 13% between 2016 and 2019

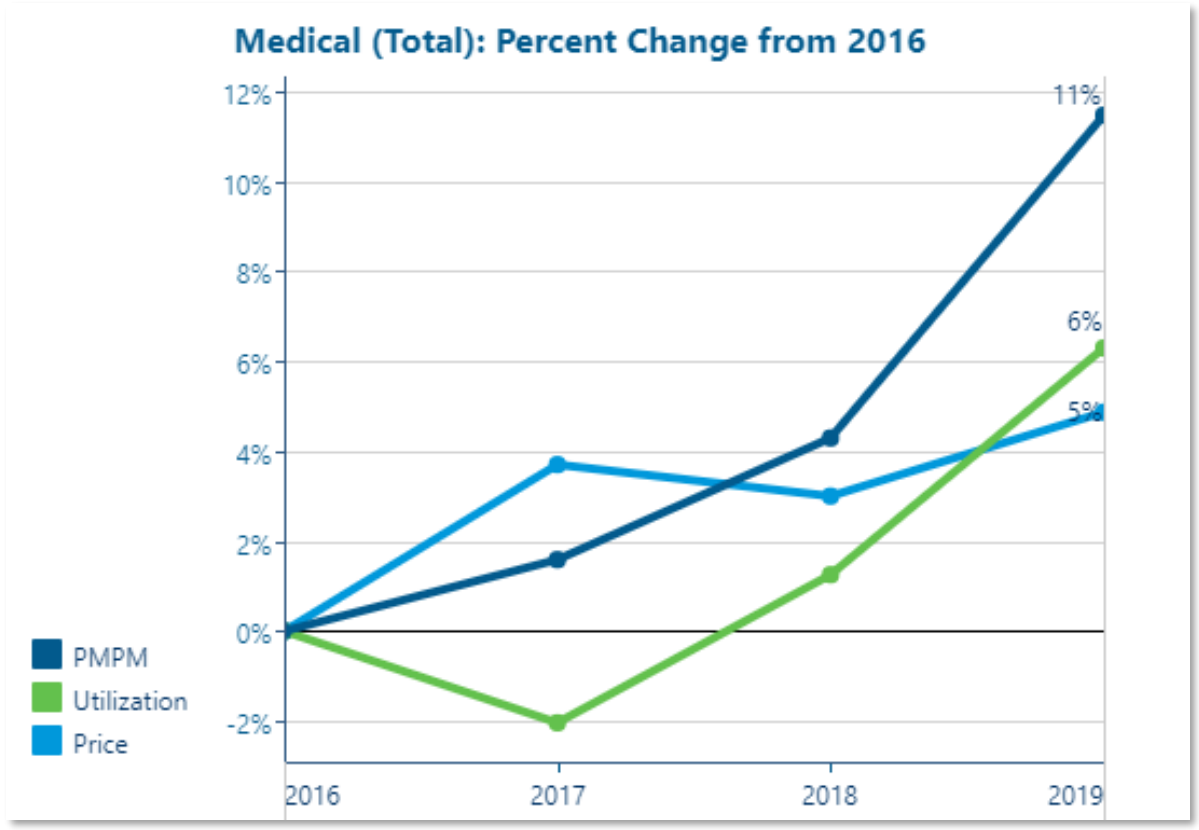


Total Commercial spending was $422 per member per month (PMPM) in 2019. Of this, medical spending comprised $332, while pharmacy accounted for $90 PMPM. Pharmacy spending increased at a greater rate from the 2016 baseline (19.2%), than medical spending 11.5%.

The Rise in Pharmacy Spending (19%) was Driven by a 15% Increase in Average Price per Fill

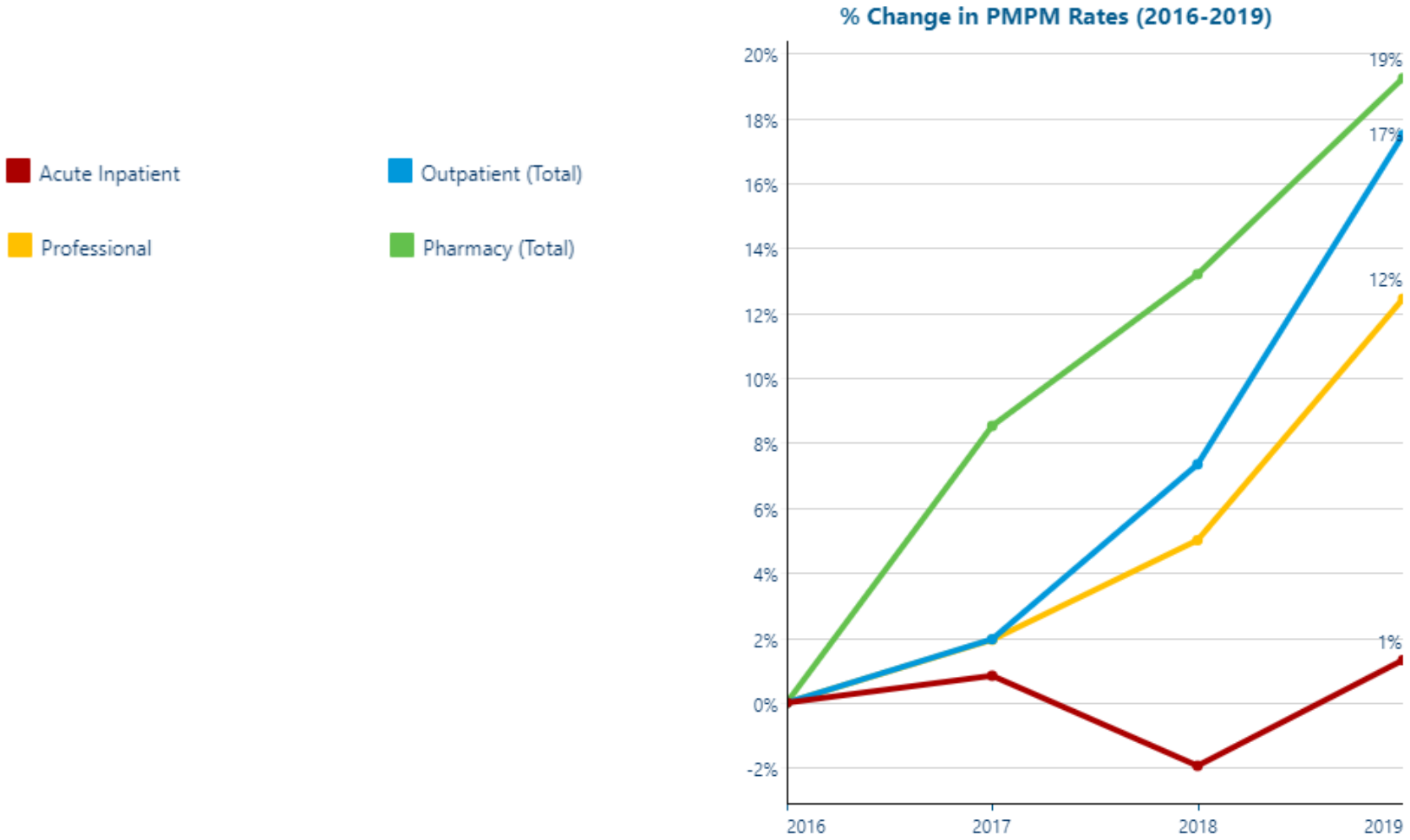


Medical Spending (Total) PMPM Increased by 11% between 2016 and 2019

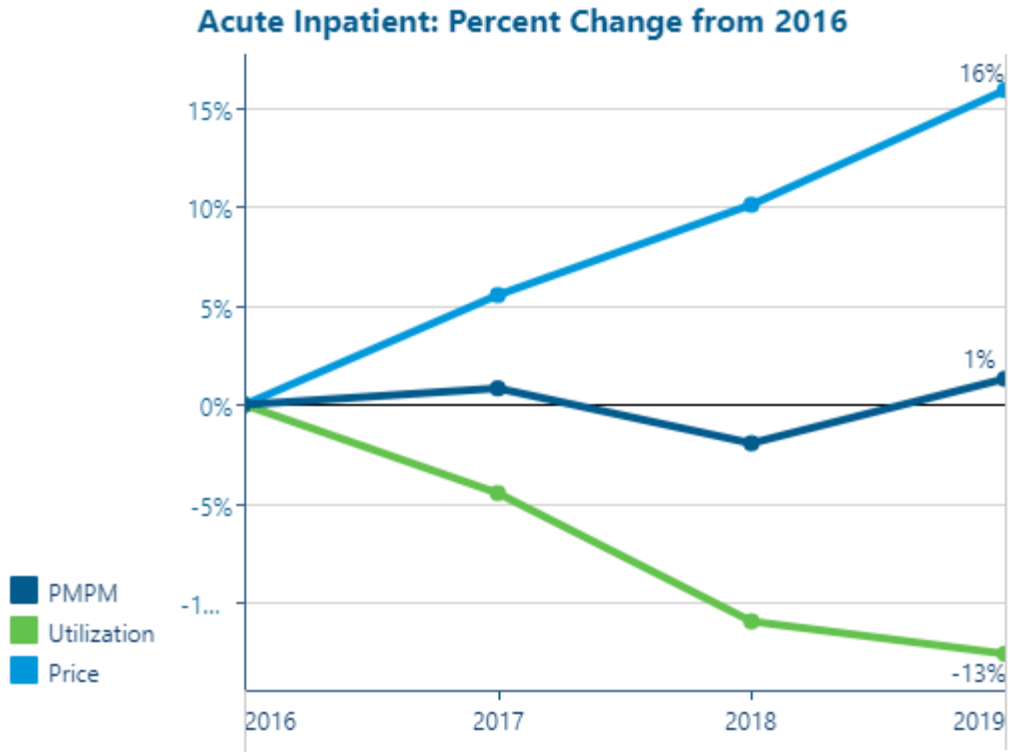


The increase in total medical spending was driven by both price (+5%) and utilization (+6%).

Increased Outpatient and Professional PMPM Rates Drove the Rise in Medical Spending

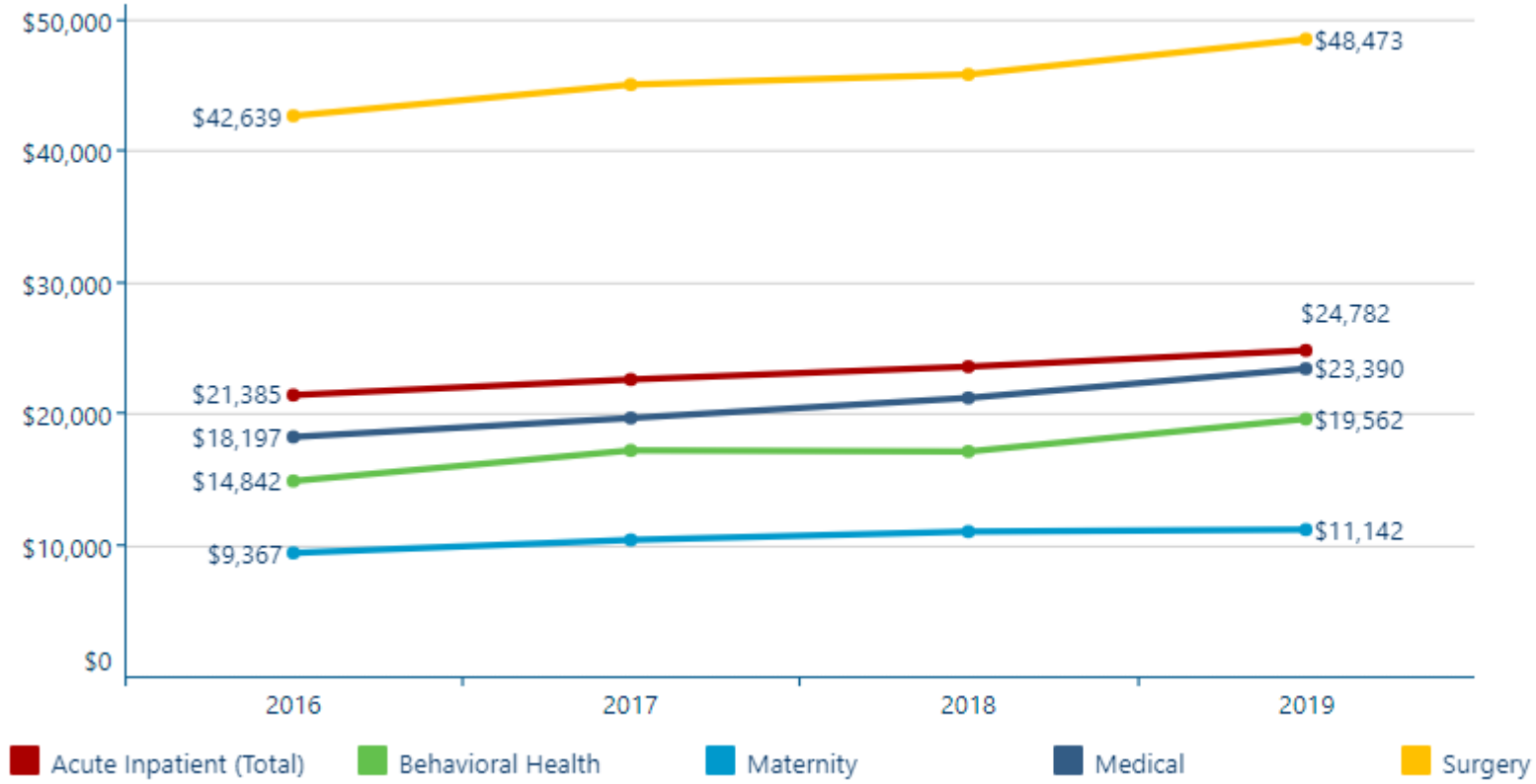


Acute Inpatient PMPMs Stayed Steady Due to Reduced Utilization Despite Significant Average Price Increases



Average Prices for Acute Inpatient Discharges Increased for All Categories

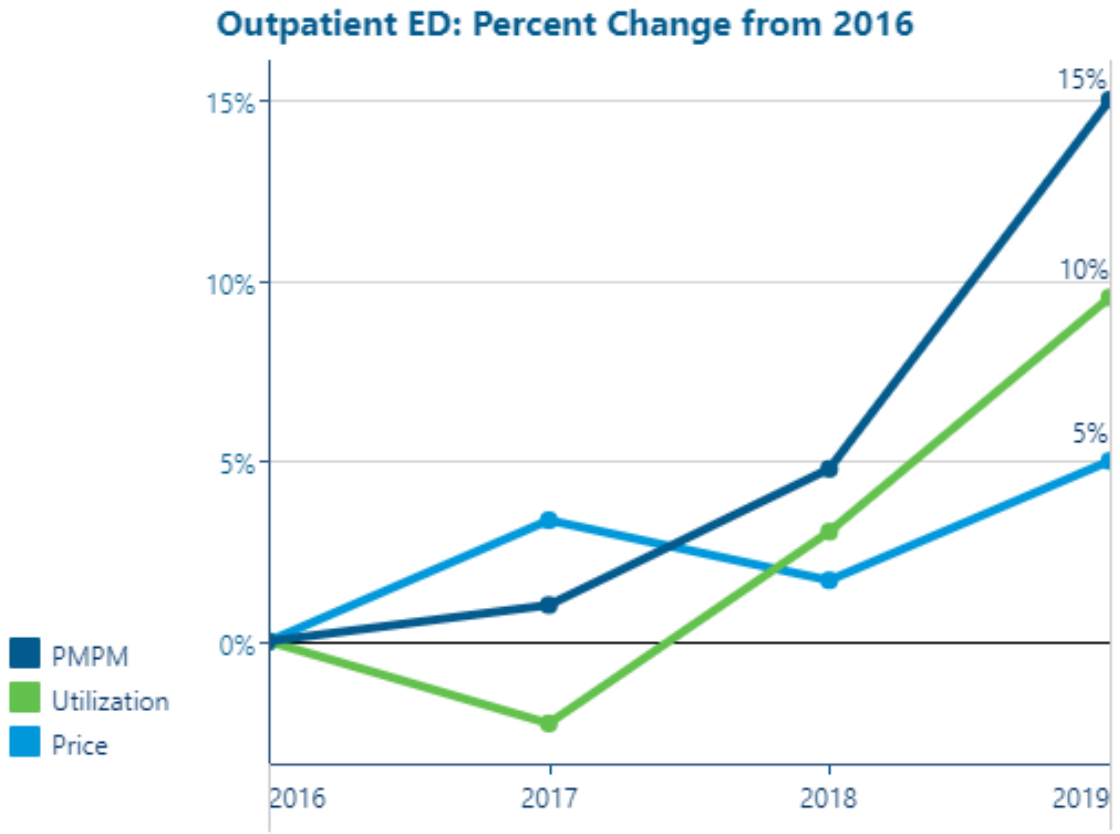
Average Price of an Acute Inpatient Discharge (2016-2019)



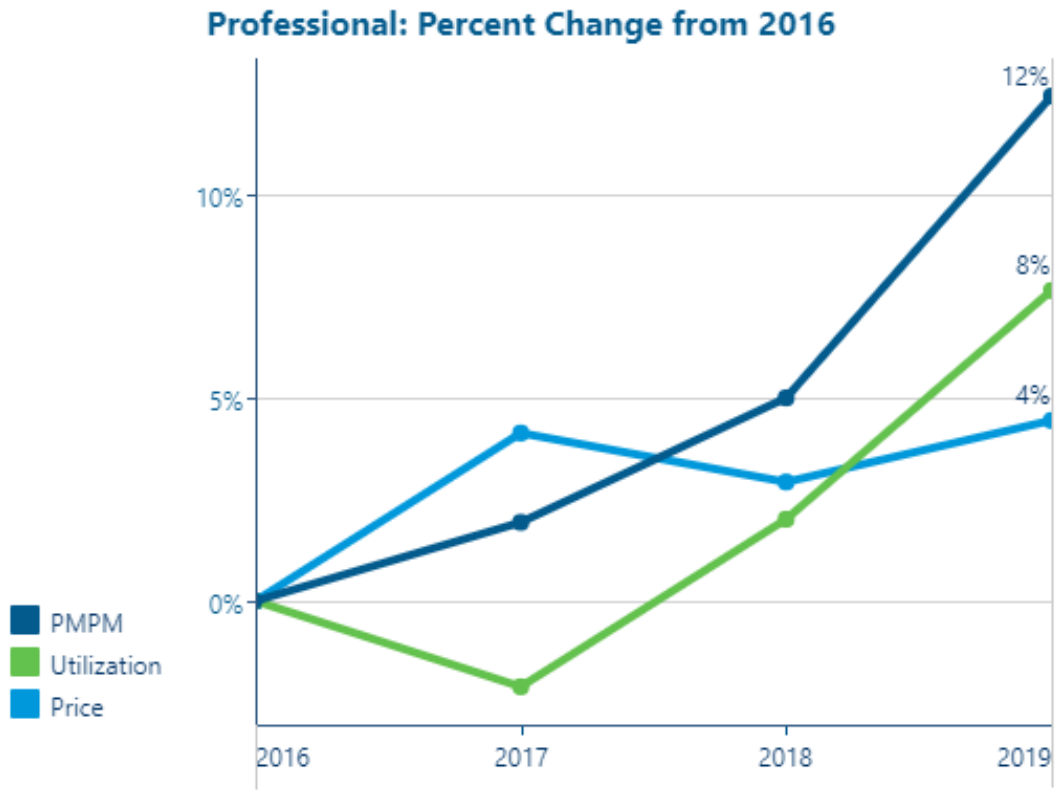
Increase in Average Price per Discharge (2016-2019)

Acute Inpatient (Total)	**$3,397**
Behavioral Health	**$4,719**
Maternity	**$1,775**
Medical	**$5,194**
Surgery	**$5,834**

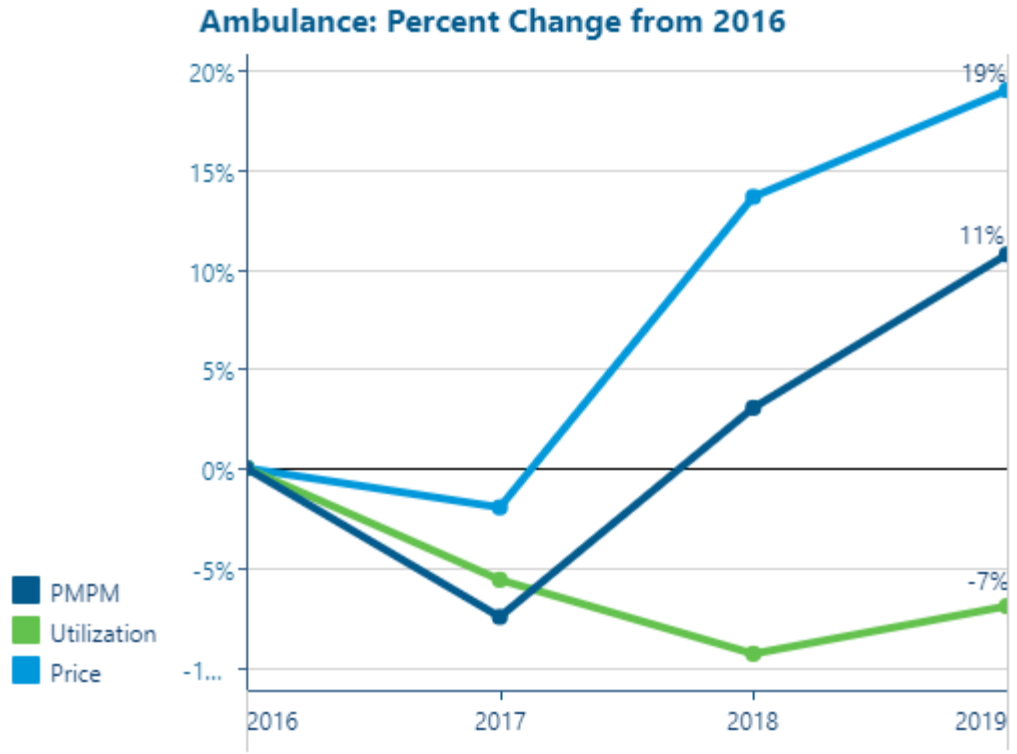
Outpatient ED PMPM Rates Increased by 15%



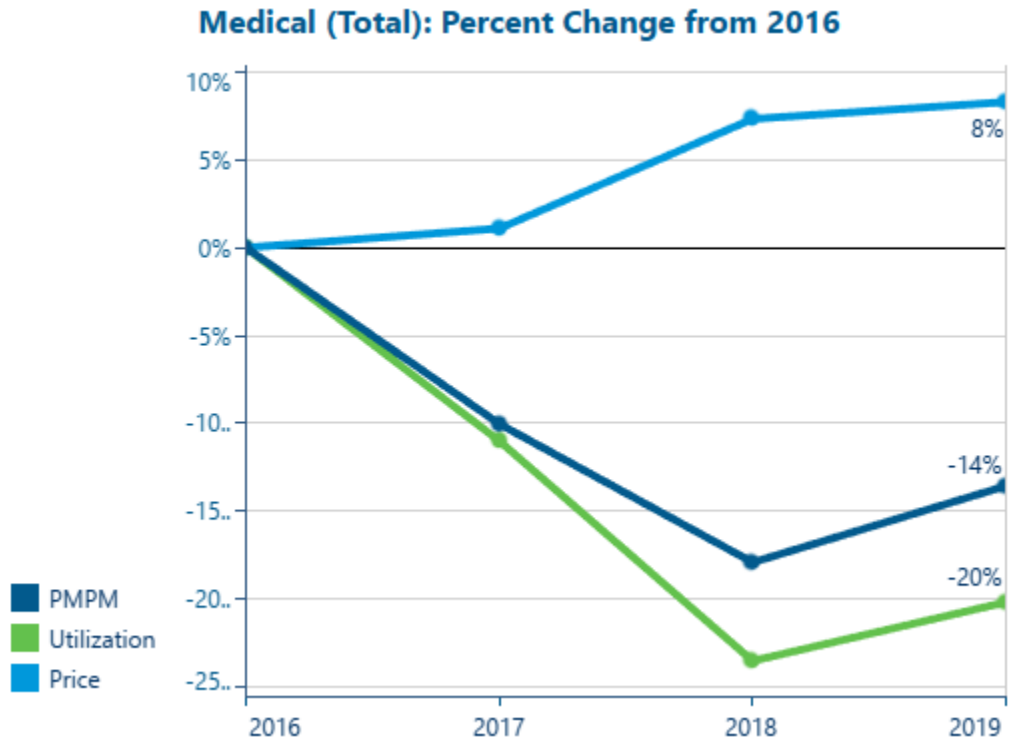
Professional PMPM Rates Increased by 12%



Ambulance PMPM Rates Increased by 11% due to Price Increases of 19%



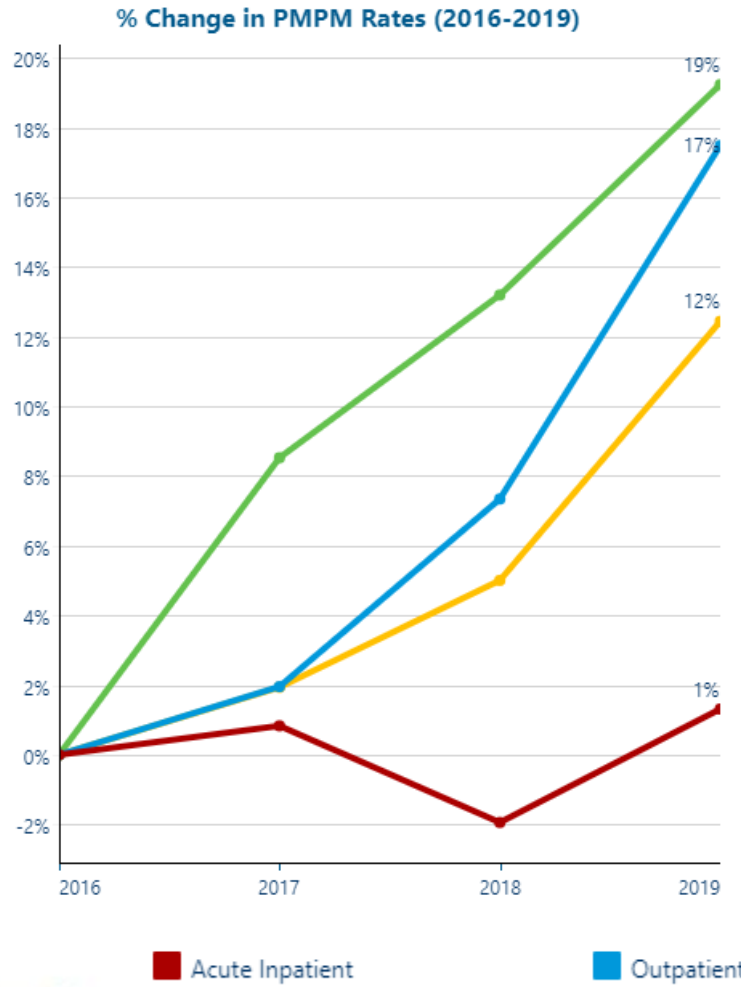
Exchange Plans: PMPM Rates for Medical Services Decreased by 14% due to Decreased Utilization



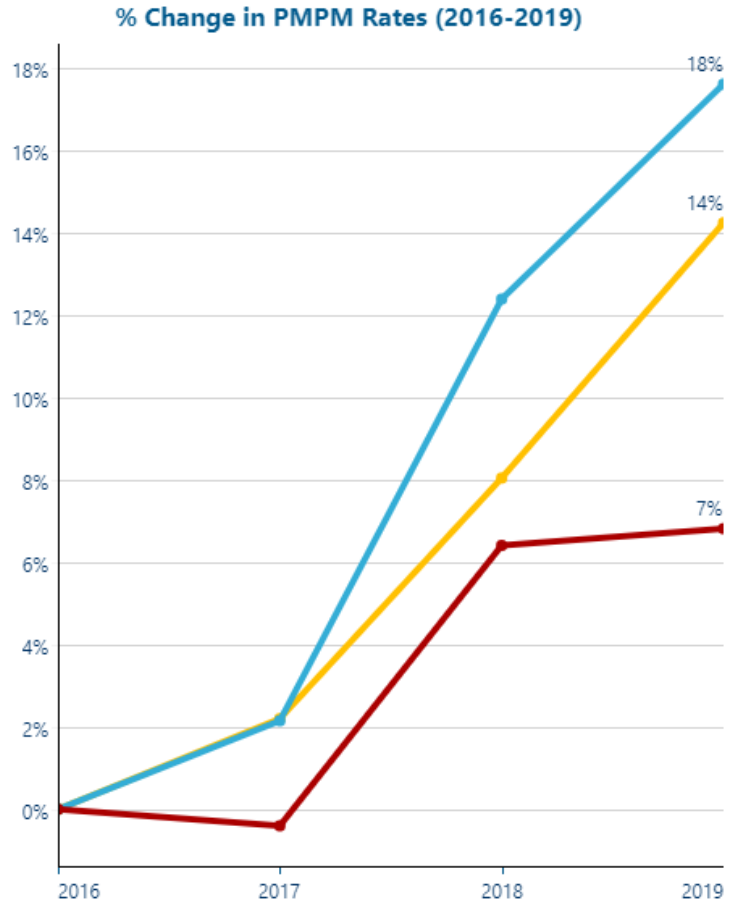
Acute Inpatient | Outpatient (Total) | Professional | Pharmacy (Total)

PEBB: PMPM Trends Were Similar to Statewide

Statewide Commercial



PEBB



Acute Inpatient | Outpatient (Total) | Professional | Pharmacy (Total)

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

Other data on health care cost trends in Washington

TAB 7

Other Data on Health Care Cost Trends in Washington

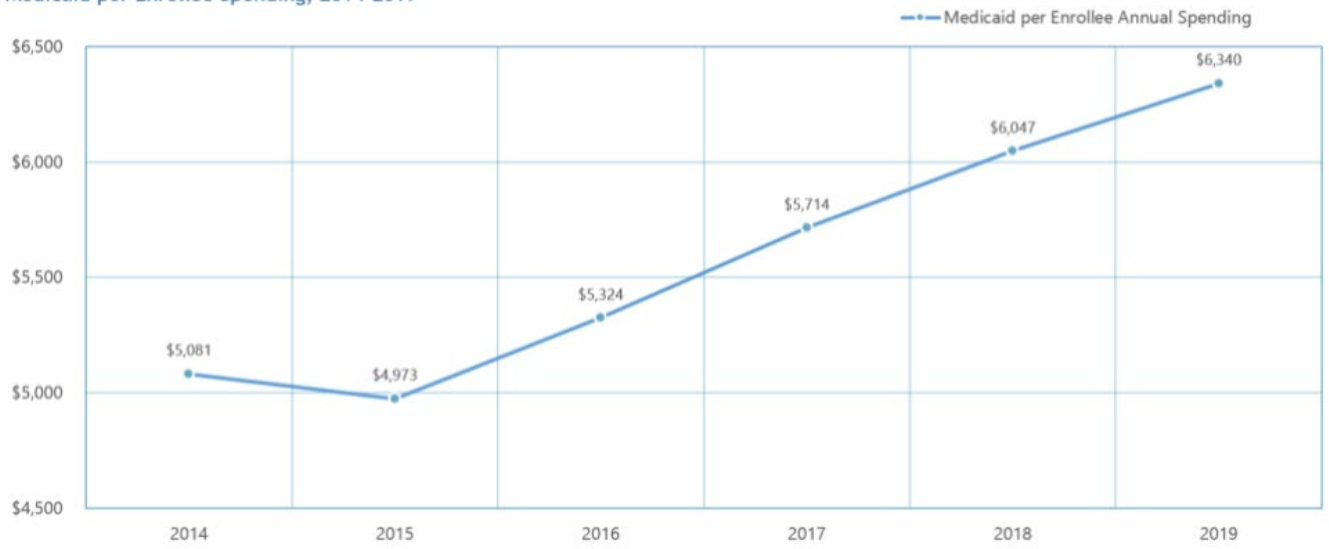
Washington State Health Care Authority

Medicaid per enrollee spending increased 25% from 2014-2019

Medicaid per Enrollee Spending in Washington State, 2014-2019

	Medicaid Expenditures		Medicaid Average Member Enrollment		Medicaid per Enrollee Annual Spending	
2014	$7,770,845,879		1,529,351		$5,081	
2015	$8,601,485,828	11% Change	1,729,490	13% Change	$4,973	-2% Change
2016	$9,541,115,297	11% Change	1,792,218	4% Change	$5,324	7% Change
2017	$10,268,142,189	8% Change	1,797,122	0% Change	$5,714	7% Change
2018	$10,629,921,937	4% Change	1,757,854	-2% Change	$6,047	6% Change
2019	$10,933,109,371	3% Change	1,724,390	-2% Change	$6,340	5% Change

Medicaid per Enrollee Spending, 2014-2019



- Medicaid's per enrollee spending increased an average of 4.6% annually.
- Data Committee members noted that these years included significant coverage expansions.

Source: Washington Health Alliance, Health Care Spending in Washington State, 2021.

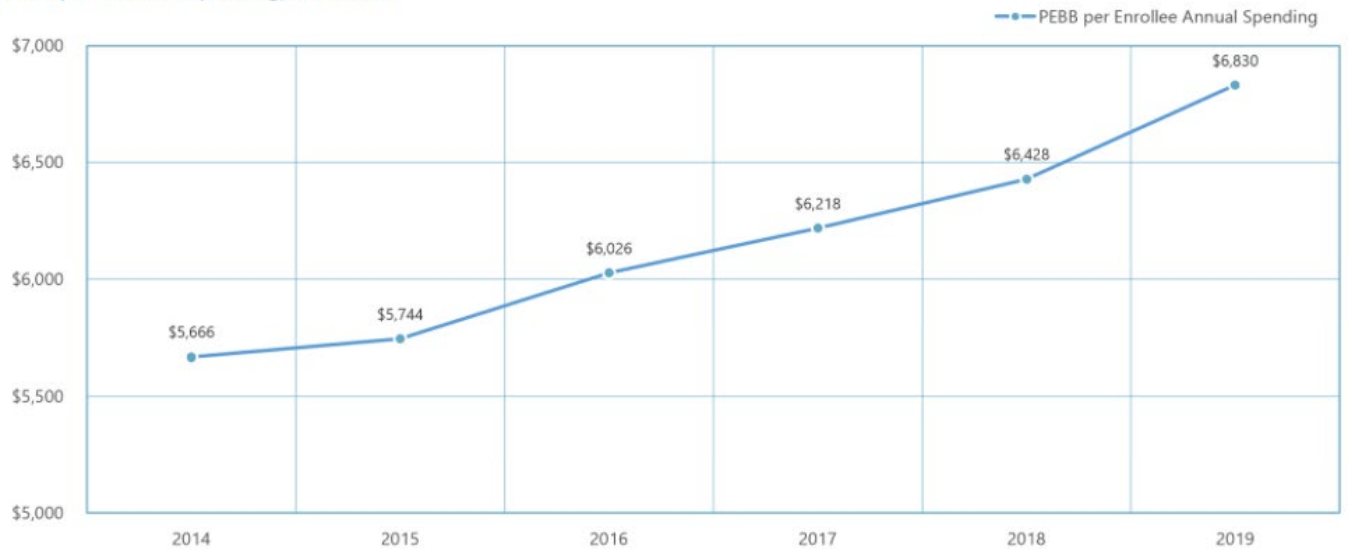
Washington State Health Care Authority

PEBB per enrollee spending increased 21% from 2014-2019

PEBB per Enrollee Spending in Washington State, 2014-2019

	PEBB Expenditures		PEBB Average Member Enrollment		PEBB per Enrollee Annual Spending	
2014	$1,544,516,576		272,595	0% Change	$5,666	
2015	$1,568,336,379	2% Change	273,060	1% Change	$5,744	1% Change
2016	$1,662,664,532	6% Change	275,896	2% Change	$6,026	5% Change
2017	$1,744,640,727	5% Change	280,568	2% Change	$6,218	3% Change
2018	$1,836,343,715	5% Change	285,676	0% Change	$6,428	3% Change
2019	$1,951,826,186	6% Change	285,763	0% Change	$6,830	6% Change

PEBB per Enrollee Spending, 2014-2019



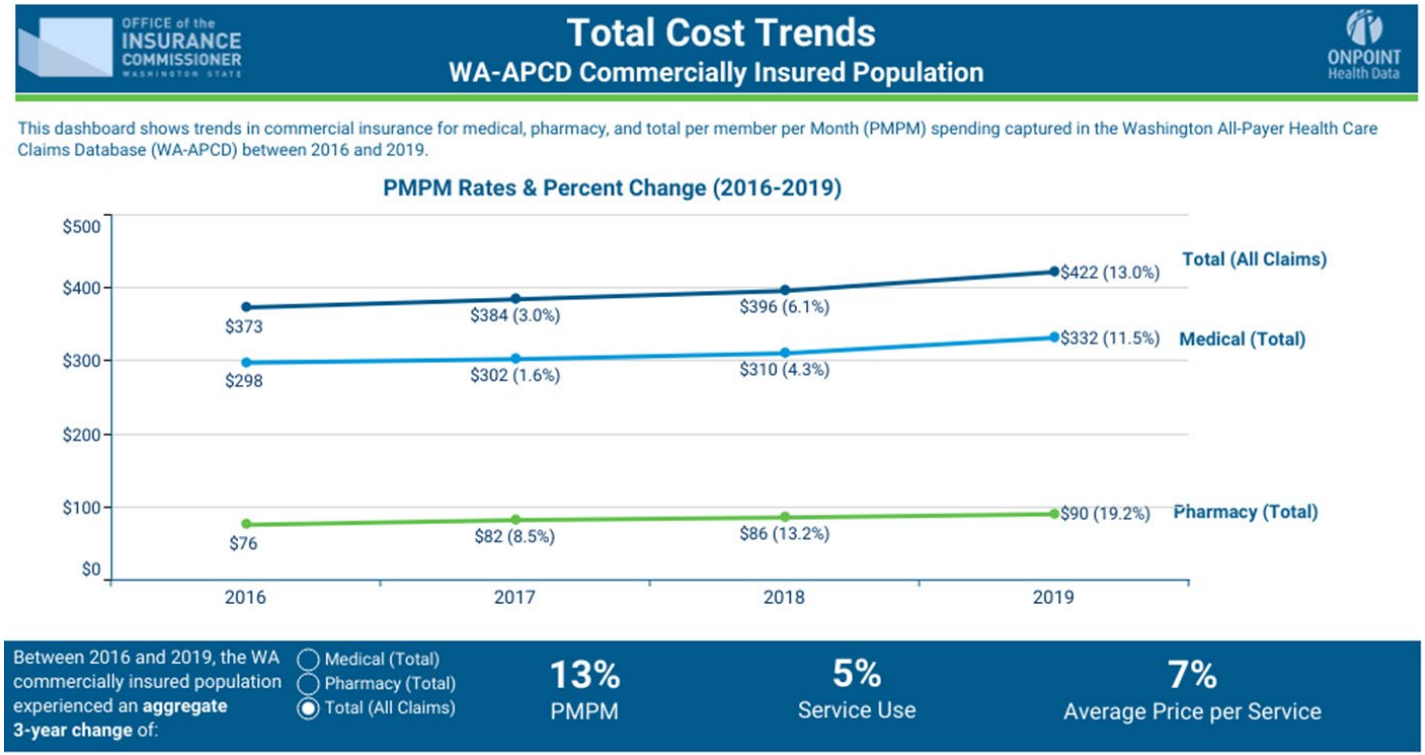
- PEBB's per enrollee spending increased an average of 3.6% annually.

Source: Washington Health Alliance, Health Care Spending in Washington State, 2021.

Washington State Health Care Authority

Non-PEBB commercially insured PMPM spending increased 13% from 2016-2019

- Commercial spending grew an average of 4.2% annually. Increases were driven by both price and utilization.



Source: Office of the Insurance Commissioner, Interactive Dashboard on Total Cost Trends (2016-2019). Published Dec 15, 2021.

Washington's commercial health care spending compared to the US

Commercial spending is Washington is less than the national average, but has been **growing at a faster rate**.

Per Person Spending (2018)	
WA	**US Average**
$5,772	$5,892

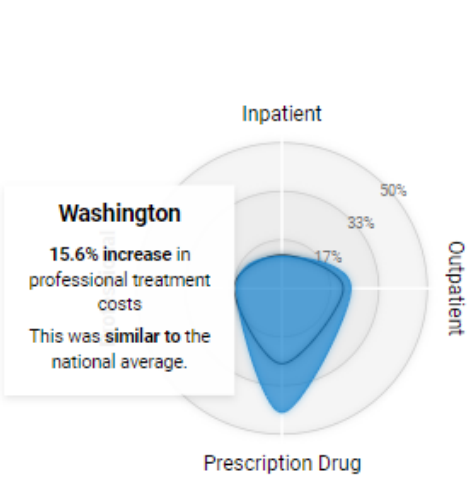
Cumulative Growth (2014-2018)		
	Washington	**US Average**
Spending	21.1%	18.4%
Utilization	4.4%	3.1%
Price	16.3%	15.0%

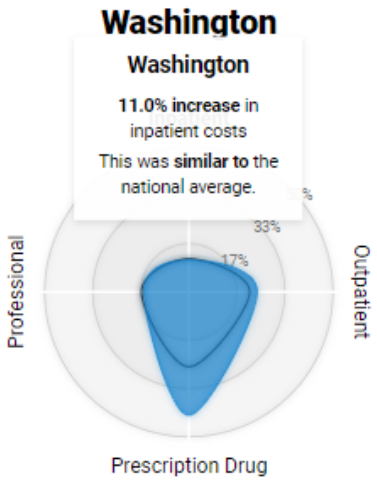
Source: Health Care Cost Institute, 2018 Health Care Cost and Utilization Report, 2018.

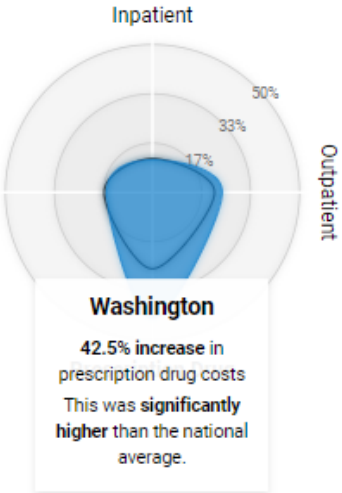
Washington State Health Care Authority

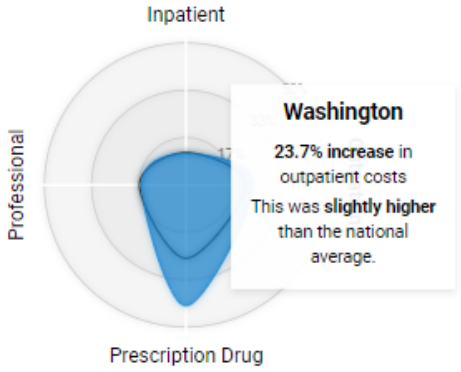
Washington vs national growth in service category spending for the commercial market

- Washington's increase in **prescription drug** spending was significantly higher than the national average.









Source: Health Care Cost Institute, 2018 Health Care Cost and Utilization Report, 2018.

Washington State Health Care Authority

Commercial spending by service category

- After growth in 2019, in 2020 spending on all service categories went down except for prescription drugs.
- Downward trend in 2020 occurred nationwide.

Service Setting	2020 PMPM Spend	Proportion of Total Spending	2018-2019 Trend	2019-2020 Trend
Facility Inpatient	$87.87	18.9%	0.1%	-9.6%
Facility Outpatient	$133.53	28.7%	8.8%	-6.8%
Professional	$137.47	29.6%	4.6%	-8.7%
Prescription Drug	$92.04	19.8%	2.9%	5.9%
Ancillary	$13.88	3.0%	5.6%	-3.4%
All Settings	**$464.80**	**100.0%**	**4.6%**	**-5.6%**

Source: Washington Health Alliance, Total Cost of Care Tool, 2022.

Medicaid spending by service category

- Prescription drug spending is the highest and fastest growing service category for Medicaid.

Service Setting	2020 PMPM Spend	Proportion of Spending	2018-2019 Trend	2019-2020 Trend
Facility Inpatient	$63.16	22.7%	20.8%	0.2%
Facility Outpatient	$54.40	19.6%	12.2%	-10.6%
Professional	$69.58	25.1%	25.3%	-2.0%
Prescription Drug	$79.20	28.5%	46.4%	23.6%
Ancillary	$11.41	4.1%	21.7%	-3.2%
All Settings	**$277.75**	**100.0%**	**25.1%**	**2.6%**

Source: Washington Health Alliance, Total Cost of Care Tool, 2022.

Board discussion on opportunities for cost growth mitigation

- Based on the available data, what further analyses should HCA consider to better understand what is driving spending and spending growth?
- Based on these data, what areas of spending does the Board wish to focus on for cost growth mitigation?

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Impact of COVID 19 and rising inflation on the Cost Growth Benchmark Program

TAB 8

The Impact of COVID-19 and Rising Inflation on the Cost Growth Benchmark Program

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COVID-19 resulted in unusual spending trends in 2020 and 2021

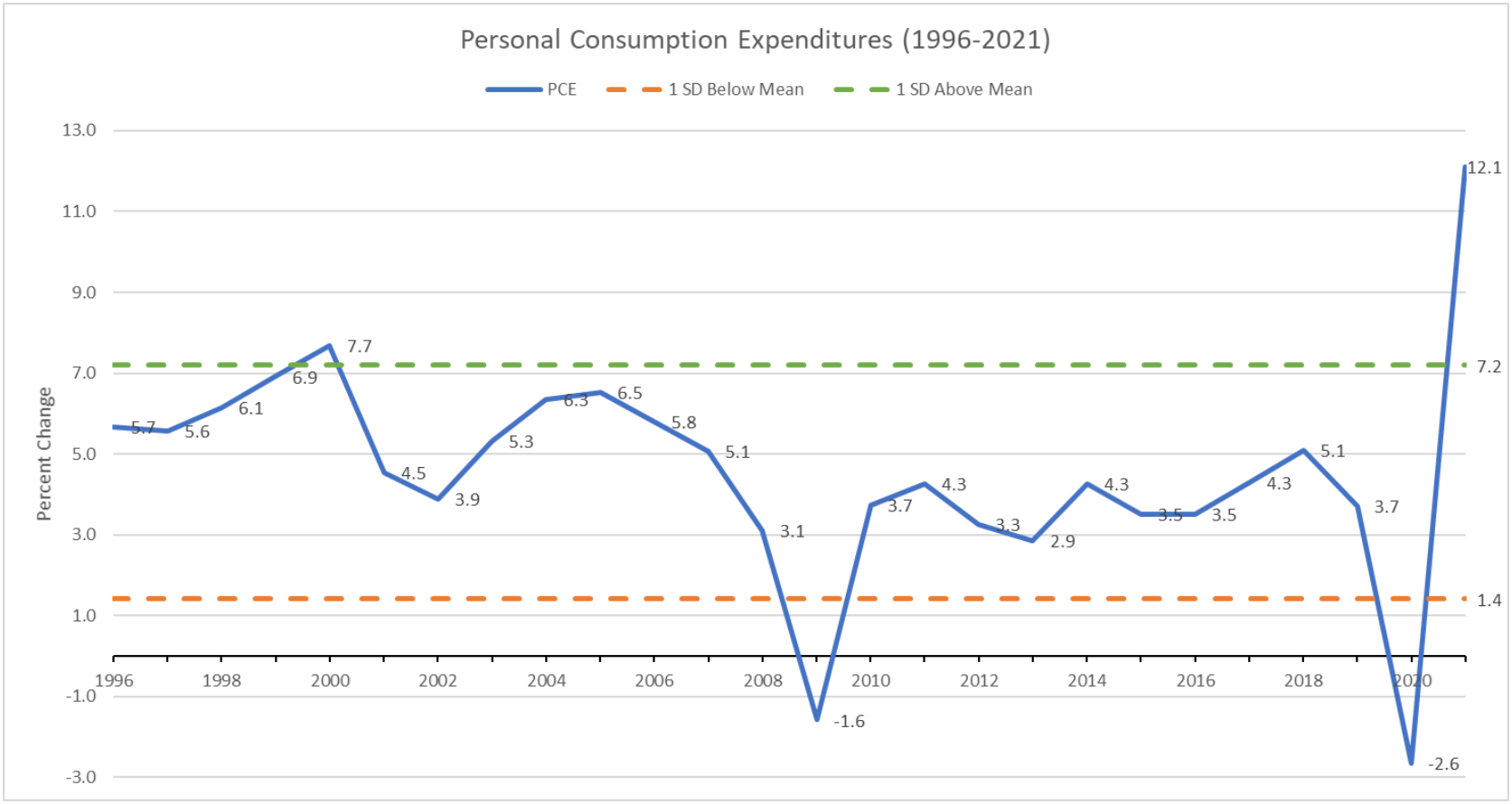
- What we know about COVID-19 impact on health care utilization:
  - Utilization dropped dramatically during March and April of 2020 nationally. While it rebounded thereafter, it never reached the 2019 baseline level.
  - Utilization was higher in 2021, but despite the impact of delayed care, may not have reached the annual level of 2019.
- What this means for benchmark performance assessment:
  - Trend for 2019-2020 will be very low (e.g., Minnesota has has reported -2%).
  - Trend for 2020-2021 will be much higher.

Hospitals and health care systems are contending with rising costs

- Health care providers are being affected by supply chain issues, labor shortages and elevated labor costs.
  - The *New York Times* reported that the Consumer Price Index climbed 7.5% in January 2022.
  - According to the Bureau of Labor Statistics, employment in health care is down 378,000 or 2.3% from its level in February 2020.
  - An analysis of hospital financial data showed that labor expenses climbed despite lower staffing levels.
- Such trends are raising concerns about near-term prospects for meeting the benchmark

Sources: Jeanna Smialek and Madeleine Ngo, "Rapid Inflation Stokes Unease From Wall Street to Washington," *The New York Times*, February 10, 2022; Bureau of Labor Statistics, "The Employment Situation – January 2022," February 4, 2022; and KaufmanHall, "National Hospital Flash Report," December 2021.

How different is current inflation from historical trends?



Source: U.S. Bureau of Economic Analysis, Personal Consumption Expenditures: Chain-type Price Index [PCEPI], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/PCEPI, March 7, 2022

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Economic changes impact health care spending on a lagged basis

- Inflation and real GDP are strong predictors of health care spending growth.
- Changes in inflation filter through the health care system over a period of two years.
  - Contracting for health care services, in which parties typically negotiate prices over a period of about three years, have likely limited the scope of price increases in the near term.

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Sources: Kaiser Family Foundation and Altarum Institute, "Assessing the Effects of the Economy on the Recent Slowdown in Health Spending." 2013; The Brookings Institution, "Health Spending Growth: The Effects of the Great Recession," 2015; and Thomas Getzen, "The Growth of Health Spending in the USA: 1776-2026," Temple University, 2017.

The Board included trigger language for revisiting the cost growth benchmark

"In the event of extraordinary circumstances including highly significant changes in the economy or the health care system, the Board may consider changes to the benchmark or to the benchmark methodology."

Other cost growth benchmark states are staying the course so far

- States know that the "COVID years" have been aberrant in terms of health care utilization and trend.
- Other states are retaining their benchmark values based on a belief that health care affordability remains a top public policy priority, and are planning to interpret 2020 and 2021 results (at least) in the context of the pandemic and its economic impact.
- These states view the cost growth benchmark as a long-term strategy, and have taken the position that the impact of COVID-19 should not diminish the goal of making health care more affordable.

Three questions the Board could consider in response to COVID and inflation

- Is there a specific threshold for inflation change to trigger reconsideration of benchmark values?
- Should the benchmark - or the assessment of benchmark performance - be adjusted to account for inflation? If so:
  - Should adjustments be made for the calendar year for which inflation is predicted to be high? Or, should adjustments be made 2-3 years out, in acknowledgement that inflation's impact on health care spending is lagged?
  - How much should the benchmark value (or assessment of performance against the benchmark) be adjusted to account for inflation?

Board discussion on COVID and inflation's impact on benchmark performance

- What actions, if any, does the Board wish to take regarding COVID and inflation?
- Does the Board wish to explore potential adjustments to the benchmark methodology/value or to performance against the benchmark?