Health Care Cost Transparency Board

To ensure health care affordability for all Washingtonians

December 7, 2023 Meeting

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

HEALTH CARE COST TRANSPARENCY BOARD AGENDA

December 7, 2023
2:00 – 4:00 p.m.
Hybrid Meeting

Board Members:					
☐	Susan E. Birch, Chair	☐	Bianca Frogner	☐	Ingrid Ulrey
☐	Jane Beyer	☐	Jodi Joyce	☐	Kim Wallace
☐	Eileen Cody	☐	Mark Siegel	☐	Carol Wilmes
☐	Lois C. Cook	☐	Margaret Stanley	☐	Edwin Wong

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome and roll call	1	Sue Birch, Director Health Care Authority
2:05 – 2:10 (5 min)	Approval of October meeting summary	2	Mandy Weeks-Green Health Care Authority
2:10 – 2:20 (10 min)	Public comment	3	Sue Birch, Director Health Care Authority
2:20 - 3:00 (40 min)	Analytic Support Initiative • **Discussion and vote on analytic strategy**	4	Joseph L Dieleman, Associate Professor for Health Metrics and Evaluation | University of Washington
3:00 – 3:40 (40 min)	Benchmark and Analytic Status Report • **Discussion**	5	Vishal Chaudhry, Chief Data Officer Health Care Authority
3:40 - 3:45 (5 min)	Primary Care Advisory Committee	6	Dr. Judy Zerzan-Thul, Medical Director Health Care Authority
3:45-3:55 (10 min)	Creating a Nomination Subcommittee • Committee Nominations • **Discussion and vote**	7	Sue Birch, Director Health Care Authority
3:55 – 4:00 (5 min)	Calendar and Workplan for 2024	8	Mandy Weeks-Green, Health Care Authority
4:00	Adjourn		Sue Birch, Director Health Care Authority

Unless indicated otherwise, meetings will be hybrid with attendance options either in person at the Health Care Authority or via the Zoom platform.

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

October 18, 2023

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

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

Members present

Sue Birch, Chair
Jane Beyer
Lois Cook
Bianca Frogner
Ingrid Ulrey
Margaret Stanley
Kim Wallace
Edwin Wong

Members absent

Eileen Cody
Jodi Joyce
Mark Siegel
Carol Wilmes

Call to order

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

Agenda items

Welcoming remarks

Chair Sue Birch welcomed board members and provided an overview of the meeting agenda. Sue Birch introduced Ingrid Ulrey as a new member of the Health Care Cost Transparency Board.

Meeting summary review from the previous meeting

The Board voted by consensus to adopt the June 2023 meeting summary.

Washington State Health Care Authority

Public comment

Chair Sue Birch explained, by way of background, that during prior committee meetings, a member of the Advisory Committee on Data Issues and a member of the Advisory Committee of Health Care Providers and Carriers requested that their committees consider bringing a motion to the Board. The motion included a series of questions for the Board to respond to. HCA staff agreed to respond to the questions in upcoming committee meetings as the information becomes available. The committee members voted that instead of requesting the Board to respond to the questions brought forth in the motion, a response from HCA would be sufficient. The written motion and HCA's current written response is found under **Tab 3 of the board book**.

Chair Sue Birch called for comments from the public. Katerina LaMarche, Washington State Hospital Association (WSHA), stated they were providing public comment on behalf of Jonathan Bennett, WSHA representative and member of the Advisory Committee on Data Issues, who proposed the motion. Katerina LaMarche expounded on the items brought forth in the motion during the prior committee meetings and noted the motion requested for information they believe has not been addressed to date.

Thom Hightower, Board President of the Board of Commissioners at the Olympic Medical Center, remarked that the cost to provide care to patients has increased with inflation. Statewide hospitals lost $750 million from operations during the first 6 months of 2023. There were unforeseen expenses in 2022 related to the necessary costs of the pandemic and labor costs continuing to increase. Their commercial payer mix decreased from roughly 18 to 15 percent causing an operating loss this year. He communicated that it is important that the cost growth benchmark does not decrease access to care.

Jeb Shepard, Washington State Medical Association (WSMA), provided further comment on the motion. They wish to inform the large provider entities that will be subject to the benchmark of the answers to the key questions to allow them to improve performance prior to public reporting. Health care costs are expected to increase significantly in the next year, including but not limited to increased price of goods, unnecessary administrative burden, prescription drug costs, and labor costs.

The public comment section of the meeting begins at **timestamp 11:22**.

Primary Care Data Collection and Reporting Strategy

Judy Zerzan-Thul, Medical Director of HCA, Chair of the Advisory Committee on Primary Care

Judy Zerzan-Thul **provided an overview** of the current data collection process from payers and the differences between the All-Payer Claims Database (APCD) and the HCA aggregate data call. The existing data call can be modified to incorporate the Board-approved primary care definition and to solve for missing data elements in the APCD. However, there are persistent challenges and data limitations by only using this method. HCA staff proposed a hybrid solution: collect claims-based expenditures from the APCD and non-claims-based expenditures from the data call. Questions and comments from the Board begin at **timestamp 29:07**. The Board voted by consensus to adopt the recommendation of a hybrid solution of the data collection and reporting for claims-based and non-claims-based expenditures on primary care.

Washington State Health Care Affordability Activities

Mich'l Needham, Chief Policy Officer, HCA
Laura Kate Zaichkin, Senior Policy Advisor, Health Benefit Exchange (HBE)
Jane Beyer, Senior Health Policy Advisor, Office of the Insurance Commissioner (OIC) and Board Member

Mich'l Needham **provided a general overview** of other cost transparency efforts across the state, including but not limited to the Department of Health's Hospital Financial Reports, Rx Price Transparency, and the newly formed Prescription Drug Affordability Board (PDAB). The Board heard about several affordability activities in the state and their respective timelines for review and reporting.

Laura Kate Zaichkin **discussed efforts undertaken at the HBE** to approach rising health care costs. After addressing the fact that the Individual Market only comprises 4.5 percent of the total insurance market in Washington, the HBE can identify price differences in both premiums and utilization. She presented policy options to reduce costs and address market failures at the state-level, as well as within the exchange. She summarized the performance of Cascade Care, Washington's public option, with regards to premiums, showing an overall increase of 0.5 percent as compared to an average increase of 19 percent across other carriers between 2022-2024. Finally, while premiums of Cascade Care have risen at a slower pace than other carriers, there are policy options to strengthen the offering moving forward through innovation and analysis. Questions from the committee begin at **timestamp 52:30**.

Jane Beyer **presented an introduction** to the legislatively-mandated Health Care Cost Affordability Report produced jointly by the OIC and the Office of the Attorney General (AGO) as provided by the 2023 Budget. The OIC has contracted with Health Management Associates (HMA) to prepare the report, while the AGO is focused on merger & acquisition and anti-competitive issues regarding health care affordability. A preliminary report will be delivered to the Legislature on December 1, 2023, providing an overview of the "business of health care" in Washington, and identifying policy options to address issues around affordability. A final report is due to be delivered on August 1, 2024, that contains a deeper actuarial and economic analysis of findings from the preliminary report. Jane Beyer briefly discussed the OIC's scope on rate setting, then shared initial findings of what is driving health care costs up in Washington. Based on these drivers, recommendations to the Legislature may address balance billing for medical transport and coverage of transportation services to behavioral health or crisis service facilities. Questions from the Board begin at **timestamp 1:07:06**.

Benchmark and Analytic Status Report

Vishal Chaudhry, Chief Data Officer, HCA

Vishal Chaudhry **provided an update** to the Board on the Benchmark Analysis. He reviewed the components of Total Health Care Expenditure (THCE) in Washington, surveyed the data sources, summarized the analytic process and reporting schedule, and benchmark targets through 2026. On the HCA's analytic process, Vishal discussed the validation of carrier-level aggregation of expenditures and how unexpected results require further clarifications with individual carriers. While the initial benchmark report will summarize state and market-level spend from 2017-19, later benchmark reports will delve into carrier- and provider-level performance against the benchmark to better understand cost drivers in Washington State. A progress report regarding the 15 carriers charged with submitting data for the benchmark was provided in anticipation of the December 7, 2023, presentation of results to the Board. The Board's questions and comments in the presentation begin at **timestamp 1:25:16**.

Analytic Support Initiative

Joe Dieleman, Associate Professor at the University of Washington's Institute for Health Metrics and Evaluation (IHME)

Joe Dieleman **led a discussion** to enable the Board to identify analyses that would assist with the development of health care cost mitigation strategies. The goal of the discussion was to survey eight potential analyses that IHME could produce in 2024 meeting key criteria: serve a Board need; yield actionable outputs; be both impactful and novel. Of the eight potential products proposed, five stood out as optimally meeting the criteria, while aligning with potential use cases identified by cost boards in other states. Over the course of the discussion, the Board reached a consensus to focus on Options B, C, and G, citing potential hurdles with A and D. Joe Dieleman will formalize and present the strategy for approval at the December 7, 2023 meeting. The Board's questions and comments in the presentation begin at **timestamp 1:41:00**.

Adjournment

The meeting adjourned at 4:02 p.m.

Tab 3

Washington State Health Care Authority

Public Comment

Washington State Health Care Authority

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Health Care Cost Transparency Board

Written Comments

Received Since Last Meeting

Written Comments Submitted by Email

1. Fred Yancey
2. Washington State Medical Association
3. Washington State Hospital Association

From: Fred Yancey <Fyancey@comcast.net>
Date: October 20, 2023 at 12:47:36 PM PDT

Subject: Health Care Affordability

Thank you for looking at the issue of Health Care costs and affordability. Medical expenses are often crippling, not to mention the high costs of insurance as well.

I noted, however, that there was no information/data presented by HCA on the high cost of medical care and insurance for retirees, particularly those that are Medicare eligible. Insurance costs in the private sector, in PEBB, and SEBB offerings have risen dramatically. As an example, Uniform Medical under the PEBB program for retirees (44,000 enrollees) rose from a single subscriber cost of $438 to $533 per person ($6,395/year). Add the fact that the drug formularies in both private and state plans are constantly in flux dropping some drugs from coverage.

Please do not overlook this population who are reeling from the costs. Their primary income in retirement is fixed or modestly inflated which in no way offsets these increases.

Thank you for your time.

Fred Yancey

Washington State Medical Association
Physician Driven, Patient Focused

November 27, 2023

Delivered electronically

Dear members of the Health Care Cost Transparency Board,

On behalf of the Washington State Medical Association (WSMA), we appreciate the opportunity to share two recent, local media items that serve as an update on challenges facing the physician community. The first piece is an op-ed submitted by Judy Kimelman, MD, to the Seattle Times explaining the myriad challenges the Seattle Obstetrics & Gynecology Group faced that resulted in its pending closure. The second article from the Kitsap Sun was written by Niran Al-Agba, MD, a pediatrician in Silverdale and highlights the importance of increasing Medicaid reimbursement rates—WSMA's top legislative and advocacy priority to improve access to health care.

The Seattle Times piece highlights many challenges independent physician practices are facing such as reimbursement rates that do not cover the cost of delivering care due to ever-rising practice costs (such as insurance carrier and state regulatory administrative burden), staff salaries, and other issues which are out of a practice's control. The author points out that our state's specialty Medicaid reimbursement rates are some of the lowest in the country and warns readers that our medical system is "ailing", noting the issues Seattle OB/GYN group faced are "impacting physician practices across our state and country." We have watched this dynamic – accelerated by the pandemic – unfold over the last decade across our state, with more and more independent practices put in the position of selling or merging with large health systems so that access to care is maintained in our communities.

The Kitsap Sun piece serves as an example of how some investments, even when they represent an increase in healthcare spending, are necessary to maintain and improve access to health care for Washingtonians. The article notes that increased investments in Medicaid rates improve access to care, and health outcomes for Medicaid beneficiaries.

The WSMA thanks the Board for its consideration of these important issues facing the physician community. With questions or for more information, please do not hesitate to contact Jeb Shepard, Director of Policy, at jeb@wsma.org with any questions.

Sincerely,

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Jeb Shepard
Director of Policy
Washington State Medical Association

Closure of Seattle clinic after 73 years adds to health care pain
Nov. 17, 2023 at 10:45 am
Updated Nov. 17, 2023 at 10:45 am

The Seattle OB/GYN practice is closing in December, stranding thousands of patients... (Judy Kimelman, MD)
By Judy Kimelman
Special to The Seattle Times

After 73 years, the Seattle OB/GYN Group will permanently close its doors in December. While it's tragic for our patients and heart-wrenching for the doctors who care for them, our closure is a symptom of a much larger problem in health care today.

The loss of our clinic will affect over 16,000 patients, which includes over 300 pregnant patients who now have to scramble to find a new doctor to deliver their babies, some within weeks of their due date. Our practice's closure is the result of the same issues impacting physician practices across our state and country that make it increasingly hard to find timely and necessary medical care.

Physician shortages have been predicted for years. A study published in 2021 by the Health Resources and Services Administration predicted that by 2030 there will be a shortage of OB-GYNs (physicians who deliver babies) across the country with the West being hit the hardest. The supply of these doctors will decrease by 7% while the need for their services will increase by 4%. The COVID-19 pandemic has accelerated this trend. Post-pandemic, many physicians have decided to retire early due to burnout from caring for so many sick patients coupled with poor reimbursement, stressful work environments and long hours.

Reimbursement for primary care, and especially women's health care, has long been undervalued. If you are a patient on Medicaid or Medicare, it can be difficult to find an office that will see you because of our inadequate reimbursement rates. Medicaid reimbursement rates in Washington are some of the lowest in the country. This especially hurts independent medical clinics that treat pregnant patients because half of all the deliveries in Washington are covered by Medicaid. A normal vaginal delivery and the follow-up care currently nets around $360 for the provider after all their overhead expenses are covered. Reimbursement can be even lower for patients on Medicaid, the number of which expanded during the pandemic.

Within our practice, we also treat patients who are not pregnant but on Medicare. Over the last 20 years, Medicare reimbursement rates (adjusted for inflation) have fallen by 26% while costs to run a practice have increased by almost 50%. This issue will be worsened by the looming Medicare physician payment cuts expected in January.

Along with low reimbursement rates, there are other expenses that make it difficult (and in our case impossible) to keep our doors open. Obstetricians and gynecologists have some of the highest malpractice insurance rates. Malpractice insurance premiums are driven up by large jury awards, since Washington has no cap on noneconomic damages. Additionally, like other employers, our staff salaries have been driven up by inflation and the high cost of living in the Seattle area. As a private practice, we can't compete against the salaries offered by the larger health systems in our area.

The closure of our OB-GYN group should serve as a warning that our medical system is ailing. People need to contact their members of Congress to let them know medicine is in trouble. We should not be cutting physician reimbursement for Medicare, but instead should plan for yearly inflationary increases. Locally, we need to urge state legislators to increase Medicaid rates for those treating patients, not just hospitals, so that more physicians and medical groups can afford to see these patients.

The physicians at Seattle OB/GYN Group are heartbroken to see an end to our legacy. We can only hope this serves as a sign that we need to make significant changes to our broken system. We all deserve top-quality health care with doctors we trust.

Judy Kimelman *is a physician with the Seattle OB/GYN Group and the District VIII chair of the American College of Obstetricians and Gynecologists.*

Source:
https://www.seattletimes.com/opinion/closure-of-seattle-clinic-after-73-years-adds-to-health-care-pain/#:~:text=After%2073%20years%2C%20the%20Seattle,problem%20in%20health%20care%20today.

The hearts — and kids — at risk by under-funding primary care
Kitsap Sun – Opinion

Niran Al-Agba

The heart must feed itself first. Before pumping blood (and oxygen) to the body, the heart sends blood to itself, by way of the coronary arteries. If those arteries are blocked and unable to carry blood to heart muscle, a heart attack occurs. Without intervention, the heart will stop beating.
If you ask most physicians why they chose medicine, they will tell you about their heart. They love helping people. No one enters the medical profession to get rich. And those who do quickly learn there are many faster and easier ways earn money that sidesteps spending an extra decade in school.

Sadly, the healthcare system abuses the heart. Nearly 150,000 physicians hung up their stethoscopes for the final time in 2021-2022. The primary care specialties sustained the greatest loss, including internal medicine, pediatrics, and family practice. As a result, patients face more obstacles to accessing primary care services than ever before, particularly those on Medicaid.

Today, one in 4 Washingtonians receives health coverage through Medicaid. Most clinics limit the number of Medicaid patients they see to make ends meet. Healthcare professionals face a Faustian bargain: Either follow their heart and go bankrupt, or close your heart to keep your clinic going.

Financial incentive for physicians has been shown to improve access to care for Medicaid recipients. According to the Washington State Medical Association, "it has been decades since the last general Medicaid reimbursement rate increase in Washington state, resulting in reimbursement rates today that are nearly the lowest in the nation." Improved access to primary care improves health outcomes for everyone, like this patient of mine.

"I don't plan to live past my 18th birthday," she stated, as if it was a fact. I was stunned. Eighteen. That was less than six months away. I could feel the tears coming. Before I could stop them, they slid down my face.

We first met at the Kitsap County Juvenile Detention Center, about a decade ago. At her intake appointment she asked for depo-Provera, an injectable birth control medication that lasts for three months. After updating her vaccinations and verifying she was not already pregnant, I gave her the shot and reminded her to see her doctor in 12 weeks for another dose.

Three months to the day after that first visit, she was back at the detention center asking for another shot. I obliged. She told me she did not have a doctor. She did not have health insurance either. Before her release from juvenile hall, social workers helped her obtain Medicaid coverage and connected her to the healthcare system. Before I knew it, I was her doctor.

By the time she shared her 18-year plan, I had been caring for her nearly 2 years. Looking back, until that day, I knew little about her. I never met her parents. They had both succumbed to drug overdoses before she turned 15. She always came to her medical appointments alone. I knew she traveled mostly by bus, because early one morning as I arrived to work, she got off at the bus stop more than an hour before her appointment. When I asked why, she explained it the last bus she could take to arrive at her appointment on time.

"Why are *you* crying?" she asked me. I was not sure. "What about dreams for the future?" I asked. She shrugged, as if never planning to have one.

She asked me what was so great about 19. I was a junior in college and applying to medical school that year. I told her my life began at 19. At least, my journey to become a doctor did. It was around that age my heart guided me toward becoming a pediatrician — so I could help as many children as possible throughout my lifetime. I realize how naïve that sounds now.

After referring her to a counselor, I assigned homework: to create a "bucket" list of things to do before she died. She returned two weeks later with her bucket list: 1.) become a beautician and 2.) move to New York City. She wanted to help young women feel better about themselves while living in a big city. I saw her every month until her 18th birthday, when she left for the Big Apple. She promised to write, and she has. Occasionally, a postcard with no return address comes in the mail. I recognize her handwriting instantly. I know our relationship made a difference in her life.

According to the National Health Interview Survey, for each $10 increase in payment rate parents are 25% more likely to report little to no difficulty finding a provider for their children when insured by Medicaid. That same $10 increase reduces school absences among elementary-aged Medicaid recipients by 14 percent, according to data from the National Assessment of Educational Progress. More importantly, with each $10 increase in payment rate, a Medicaid recipient is 1.1 percent more likely to report very good or excellent health across all age groups.

What happens when a physician must choose between her heart and her livelihood? I would love to tell you I chose my heart. But I did not. I chose my livelihood and to support my family. I have not accepted new Medicaid patients for the past five years. I hate knowing that. I hate writing it. And I hate acknowledging it to all of you. I hope sharing it serves as a call to action for Washingtonians to contact lawmakers and push hard this session for a long-overdue increase in Medicaid payments to all medical specialties.

Remember, even the heart must feed itself first, or it cannot keep beating.

Dr. Niran Al-Agba is a pediatrician in Silverdale and writes a regular opinion column for the Kitsap Sun. Contact her at niranalagba@gmail.com.

This article originally appeared on Kitsap Sun: Medicaid reimbursement rates that discourage doctors and patients

Source:
https://www.kitsapsun.com/restricted/?return=https%3A%2F%2Fwww.kitsapsun.com%2Fstory%2Fopinion%2Fcolumnists%2F2023%2F11%2F21%2Fmedicaid-reimbursement-rates-that-discourage-doctors-and-patients%2F71626545007%2F

Washington State Hospital Association

November 27, 2023

Dear Members of the Health Care Cost Transparency Board (Board),

The Washington State Hospital Association (WSHA) supports the Board's work to address our shared goal in understanding health care spending and promoting affordability while maintaining appropriate, effective, and accessible health care.

As part of this process, we feel it's important to note the position from which Washington is starting. The benchmark model is built on the experience of states such as Massachusetts where per capita health care expenditures have historically been far above the national average. That is not the case in Washington. The Board's consultants have found that Washington is a low margin state. National data also shows that we rank 10th overall for access and affordability[1], and in the top ten[2] for:

- Lowest percentage of individuals under age 65 with high out-of-pocket medical costs relative to their annual household income;
- Lowest percentage of employee total potential out-of-pocket medical costs as a share of state median income; and
- Lowest percentage of people with medical debt.

Providers in Washington have managed to achieve this success despite rising costs that are outside our control. Consistent with the experience in Washington state, a national study found that more than half of excess U.S. health spending was associated with factors likely reflected in higher prices, including more spending on the following, while utilization may explain a large portion of the remainder. [3]

- Administrative costs of insurance (~15% of the excess);
- Administrative costs borne by providers (~15%);
- Prescription drugs (~10%);
- Wages for physicians (~10%) and registered nurses (~5%); and
- Medical machinery and equipment (less than 5%).

The study also found that reductions in administrative burdens and drug costs could substantially reduce the difference between U.S. and peer nation health spending.

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[1] Radley, D. C., Baumgartner, J. C., Collins, S. R., & Zephyrin, L. C. (2023, June 22). 2023 Scorecard on State Health System Performance. The Commonwealth Fund. Retrieved October 4, 2023, from https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance#6

[2] Radley, D. C., Baumgartner, J. C., Collins, S. R., & Zephyrin, L. C. (2023, June 22). 2023 Scorecard on State Health System Performance Washington Ranking Highlights. The Commonwealth Fund. Retrieved October 4, 2023, from https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance#6

[3] Turner, A., Miller, G., & Lowry, E. (2023, October 4). High U.S. Health Care Spending: Where Is It All Going? The Commonwealth Fund. Retrieved October 4, 2023, from https://www.commonwealthfund.org/publications/issue-briefs/2023/oct/high-us-health-care-spending-where-is-it-all-going

As the Board continues its work, we hope it will prioritize solutions that fit within the context of care and recognize the efficiencies that have already been achieved in Washington.

Sincerely,

Katerina LaMarche, JD
Policy Director, Government Affairs
Washington State Hospital Association
katerinal@wsha.org

Tab 4

Washington State Health Care Authority

Analytic Support Initiative Analytic Strategy

WA Health Care Cost Transparency Board

December 7, 2023

Institute for Health Metrics and Evaluation

ASI

Objective: Approval of or concrete path forward for the proposed analytic strategy

Objective: Approval of or concrete path forward for the proposed analytic strategy

Agenda:

I. Three proposed analyses
II. A potential fourth analysis
III. Proposed analytic products
IV. Examples of potential use cases

Proposed analyses

How we identified these three analyses:

1. Intersection of IHME's strengths and data expertise (i.e., feasible), probability of impact, and magnitude of impact

2. Consultation with Washington Health Care Cost Transparency Board and its advisory committees

3. Engagement with additional health care and health care data experts

4. Undertook efforts to ensure the approach is distinct and not duplicative of other research underway or previously conducted

I. Three proposed analyses

Analysis #1: Estimate:

- spending, spending per capita, spending per beneficiary, spending per prevalent case, and spending per encounter
- number of encounters, encounters per person, encounters per beneficiary, and encounters per prevalent case

For each WA county, age/sex group, four payer categories, seven types of care, 161 health conditions for 2010-2022.

Analysis #2: Age and risk-standardize counties based on county-level characteristics

Analysis #3: Decompose differences across counties and across time into factors that are considered key drivers: population age, disease prevalence, health care utilization, and price/intensity of care.

III. Analytic products (1 of 3)

Context setting:

a) Background knowledge on WA health care spending and utilization will be provided. These states will provide information about spending per capita for the state as a whole and will, among other analyses, identify the health conditions with the most spending in WA.

III. Analytic products (2 of 3)

Cross-county variation:

b) Maps highlighting spending per capita and spending per encounter for each WA county, WA Accountable Communities of Health (ACHs), and/or Geographic Rating Area (GRA). These maps will be unadjusted, adjusted for age, and adjusted for county-level age and key risk factors. Primary comparisons will be based on the age- and risk-adjusted estimates. These results will highlight counties where spending and prices are inexplicably higher than elsewhere. Highlight key age aggregations as relevant – children, working age adults, retirees.

c) Maps highlighting utilization rates per prevalent case for ambulatory care, inpatient care, emergency department care, and for prescribed retail pharmaceuticals as a marker of access and potential systematic barriers or overuse.

d) List of health conditions with the most variation in cause-specific utilization and the most variation in cause-specific prices.

e) Figure for each county, ACH, or GRA illustrate the factors that cause spending to be different from the all-state mean (age vs disease prevalence vs service utilization and price and intensity of care), in aggregate and for the health conditions that stand out for each county as having spending rates higher than the all-state mean (see part c).

III. Analytic products (3 of 3)

Cross-time increases in spending:

f) Line plots showing time trends of age- and risk-adjusted spending per capita, spending per encounter, and encounter per person for each WA county.

g) Table reporting, for each WA county, ACH, or GRA, the health conditions with spending per person that increased the most between 2010 and most recent year possible.

h) A figure for each county, ACH, or GRA illustrating the factors that have led to spending increases over time, in aggregate and for the health conditions that have increased the most in each state.

All products to be presented with context and comprehensive narrative.

A potential fourth analysis

Analysis #4: Assess price differentials across distinct sites of care

- Service line analysis
- Wouldn’t call out providers/payers, but would highlight the impact of site selection for key services

IV. Proposed use cases

The primary use case of these analytic products is **to inform Cost Board regarding cross-county variation and increases in health spending.** We intend to answer specific questions regarding:

i. *Which counties* and *health conditions* have the highest spending

ii. *Where* it is growing the fastest

iii. *Why* it is highest in those counties or for those health conditions.

In practice we believe that this information, if delivered clearly and succinctly, can be a catalyst for action, leading to additional feasibility studies and eventually concrete recommendations from the Cost Board for legislative action.

IV. Proposed use cases

Key legislative strategies that could be informed and/or catalyzed by our analytic products include a number of strategies, such as those outlined by Hwang, Bailit, Kanneganti, and Flaherty in *State Strategies for Controlling Health Care costs: Implementation Guide.* Those strategies include, but are not limited to:

1. Limiting the rate of growth of provider prices
2. Capping high provider prices
3. Adopting multi-payer value-based payment models
4. Adopting multi-payer hospital global budgets
5. Using rate review to make health insurance more affordable

IV. Proposed use cases

Realization and illustration of unexplained variation and growth in spending is a salient and important story to share with the public and other health care stakeholders so all can be informed.

Secondary use-cases include **informing other WA state health care stakeholders**, as well as the public via local media.

This will lend support to other cost containment efforts which will create consistent messaging.

V. Other potential users (beyond the Cost Board)

Other WA state public agencies

- *Health Benefit Exchange*
- *Office of the Insurance Commissioner*
- *WA Dept. of Health*
- *Prescription Drug Affordability Board*
- *Universal Health Care Commission and its Finance Technical Advisory Committee*

Other organizations with some focus on cost-containment

- *The National Academy for State Health Policy (NASHP)*
- *The Bree Collaborative*
- *Comagine Health*

Business and purchaser groups

- *National Alliance of Health Care Purchaser Coalitions*
- *Purchaser Business Group on Health (PBGH)*
- *The Washington Health Alliance*

Consumer groups

- *AARP*
- *Northwest Health Law Advocates*

Note: *This is a sample of users, not an exhaustive list.*

Timeline

1. Build dataset ← January-July of 2024
2. Analysis #1 ← August 2024
3. Analysis #2 ← September 2024
4. Analysis #3 ← October 2024
5. Report for Cost Board provided in early 2025 in hopes of providing information relevant for the Cost Board's 2025 legislative report

Objective: Approval of or concrete path forward for the proposed analytic strategy

Options:

#1: Approve analytic strategy based on three analyses

- Spend and utilization trend and spatial variation analyses
- Risk adjust based on contextual factors
- Drivers analysis

#2: Approve analytic strategy based on three analyses, with recommendation to also explore the fourth analysis

- Impact of site selection on spending

#3: Alternative concrete path forward

Tab 5

Washington State Health Care Authority

WA Health Care Cost Transparency Board

WA health care spending growth preliminary results

Washington State Health Care Authority

Presentation overview

- Health care cost transparency
  - Spending growth
- Health care cost spending growth preliminary results
  - State
    - Other spending
    - Net cost of private health insurance
  - Market
- Summary
- Next steps

Washington's spending growth

The Health Care Cost Transparency Board established the benchmark for 2022 and the subsequent five years and will evaluate the benchmark annually moving forward

Represents a common goal for payers, purchasers, regulators, and consumers to increase health care affordability

Serves as a starting point from which to align health care spending to ensure that spending growth does not increase at a faster rate than the economy, state revenue, or wages

Performance against the benchmark will be assessed by measuring annual spending growth against each annual benchmark

Washington State Health Care Authority

Washington's Spending Growth Benchmark

- Washington is one of nine states in the nation to adopt a spending growth benchmark
  - Specific rate that carrier and provider expenditure performance will be measured against
    - 2022 and onward
  - Based on a hybrid of median wage and potential gross state product (PGSP)
  - Data sourced from aggregate expenditure data from payers (carriers) and include claims-based and non-claims-based expenditures

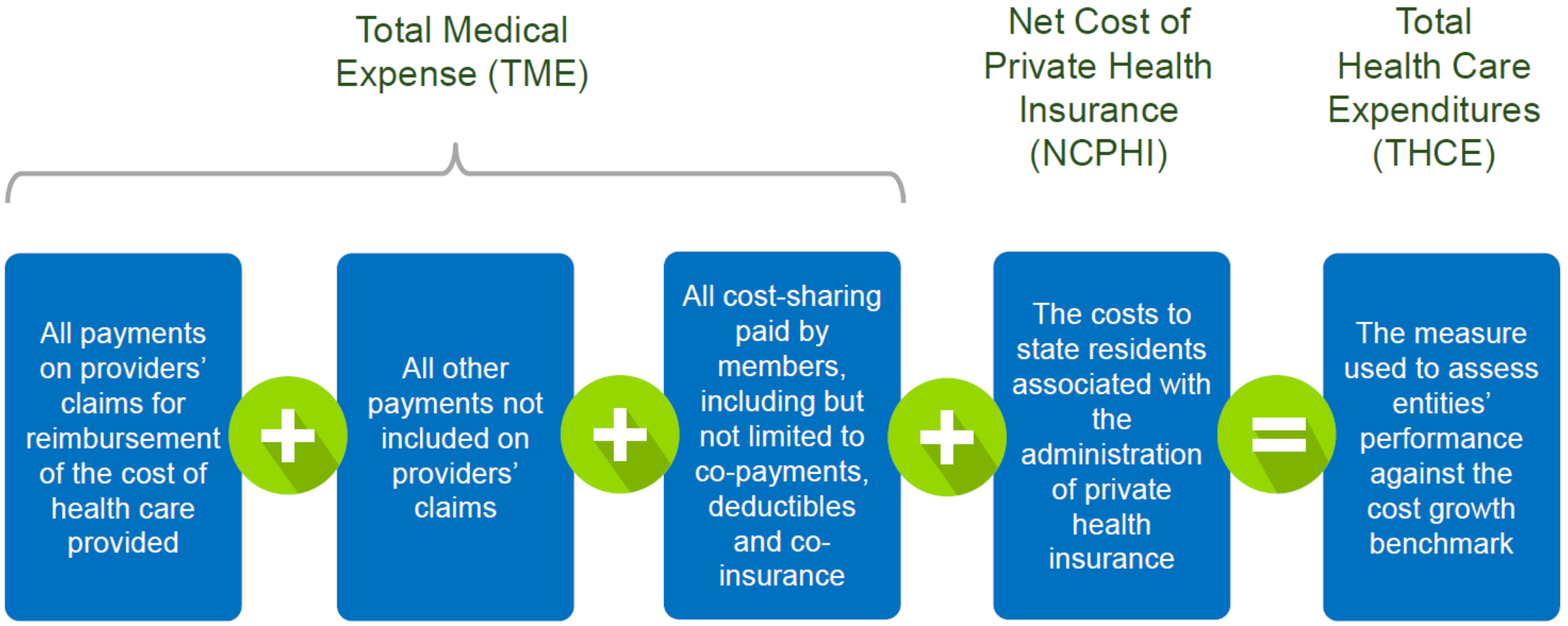
Years	Benchmark
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Reporting performance against benchmark

Current reporting cycle →

Year of Release	Includes Data from Specified Years	Data Included
Late Fall 2023	2017 – 2019	State and market data only – the board will not publicly report insurance carrier or provider cost growth for this period
Late Fall 2024	2020 – 2022	For large provider entities and carriers – with cost growth target of 3.2%
Late Fall 2025	2022 – 2023	For large provider entities and carriers – with cost growth target of 3.2%
Late Fall 2026	2023 – 2024	For large provider entities and carriers – with cost growth target of 3.0%
Late Fall 2027	2024 – 2025	For large provider entities and carriers – with cost growth target of 3.0%
Late Fall 2028	2025 – 2026	For large provider entities and carriers – with cost growth target of 2.8%

What is being measured?



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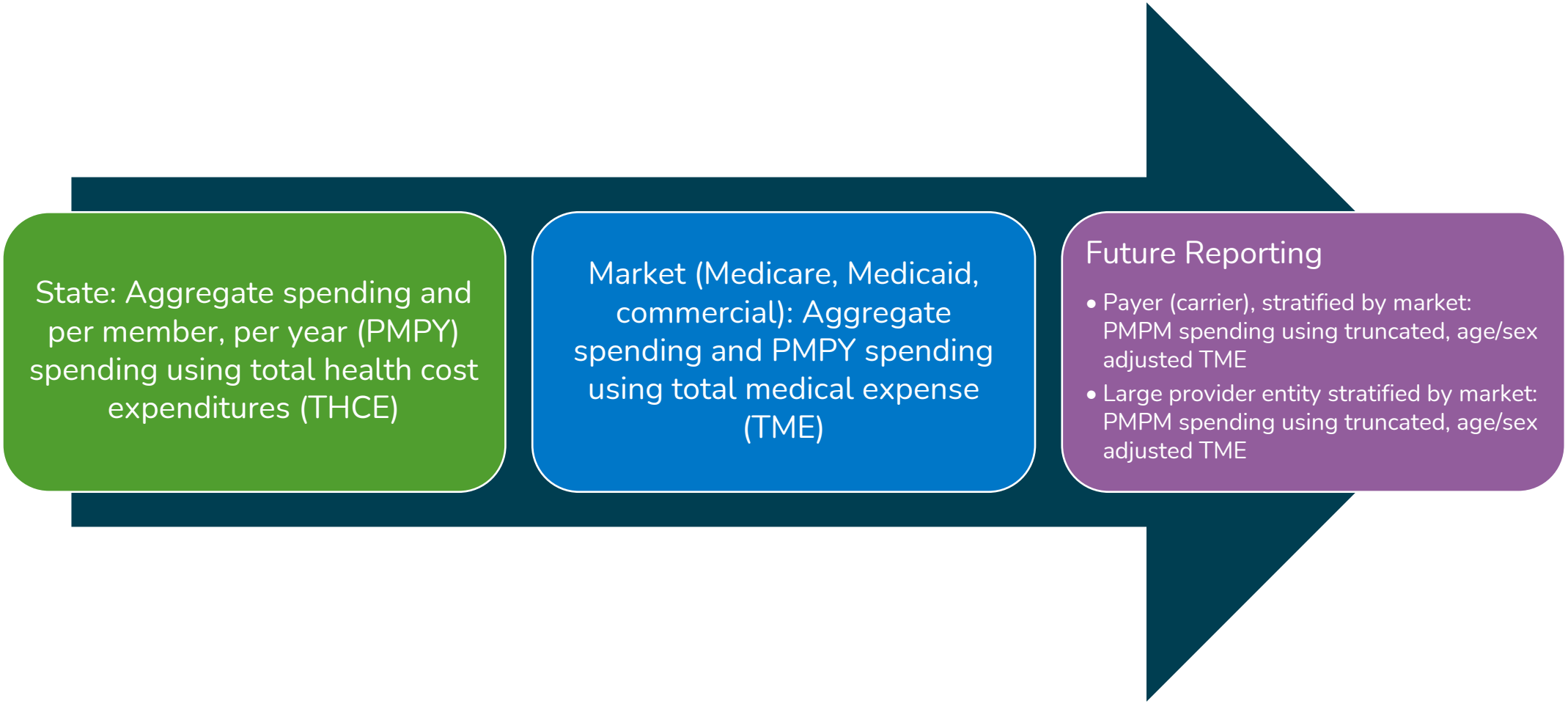
Performance measurement against the benchmark



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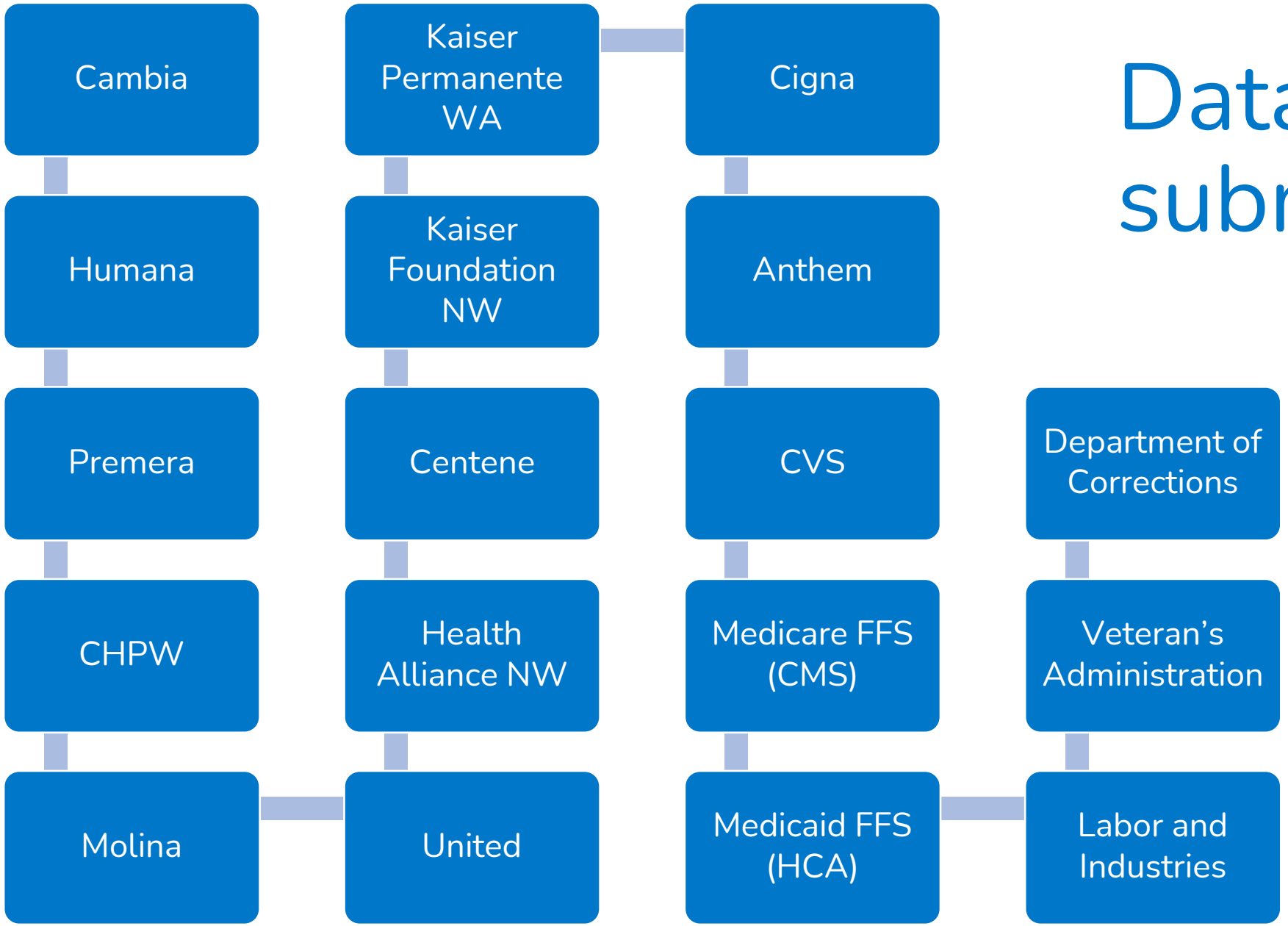
Data submitters



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Service category definitions

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

Service category definitions, continued

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

Note: Due to Medicare FFS reporting capability, grouping of physicians along with Cost Board categories Primary Care & Specialty Professional

Caveats & limitations

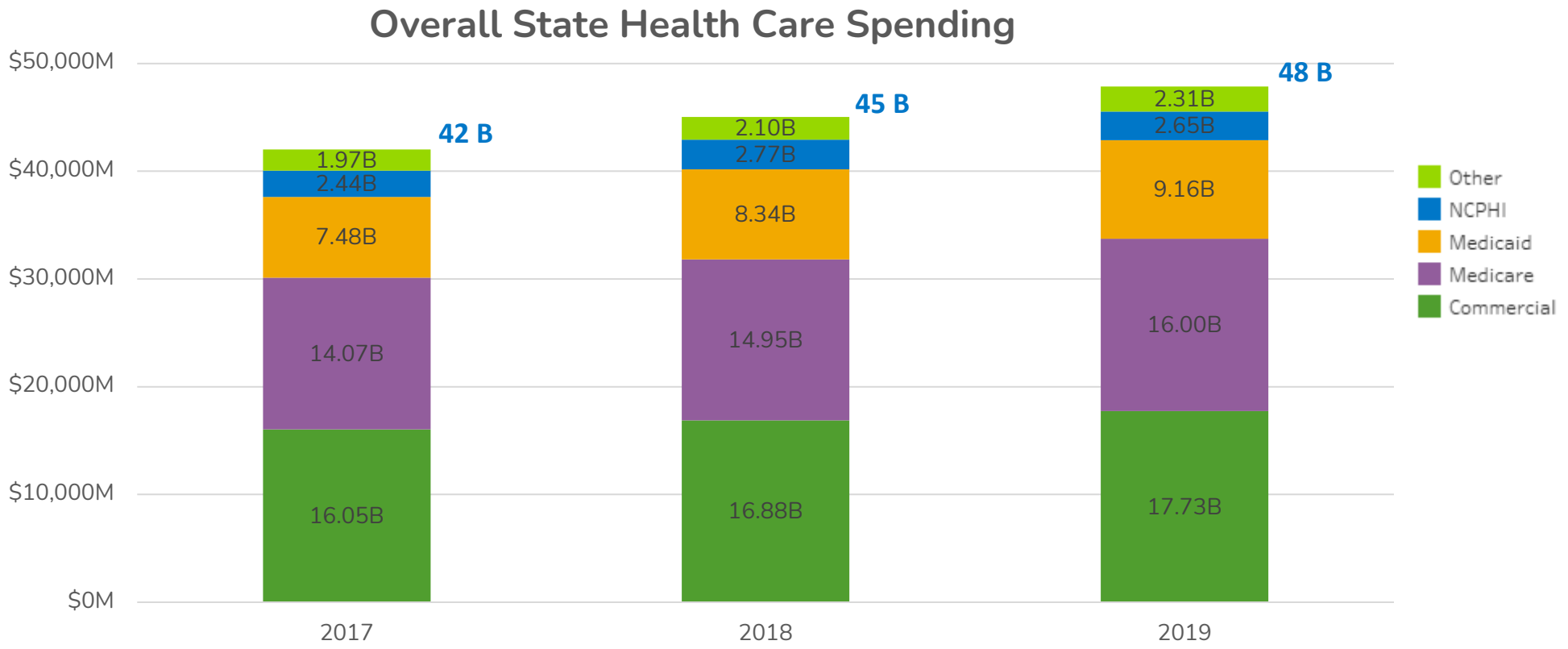
- **Exclusions**
  - Policies offering limited benefits, such as accident, disability, Medicare supplemental insurance, vision or dental stand-alone policies
  - Health care paid through charity care or by customer cash payment
  - Certain non-claims publicly funded behavioral health services
  - Anthem 2017 data
  - Humana Medicare data
  - Custodial nursing facility services, home- and community-based services, and intermediate care facilities and services for persons with developmental disabilities paid by Washington State Department of Social and Health Services (DSHS)
- **All figures are net of prescription drug rebates**
- **Both Medical and Retail Rx Rebates were collected**
  - All rebates (Medical & Retail) subtracted from the Retail Rx category due to the complexity of medical rebates

Highlights

- In 2019, total health care expenditures (THCE) was $48 billion
  - Hospital outpatient services are significant and growing
- Growth between 2017-2019
  - Statewide total health care expenditures increased in 2018 (7.15%) and 2019 (5.81%)
  - Medicare PMPY appears to have slower growth than Medicaid or commercial
  - Medicaid seems to be growing faster than other markets but still has a lower PMPY spending than commercial or Medicare

State

Total health care expenditures (THCE) statewide



NCPHI (Net Cost of Private Health Insurance) are associated with the administration of health insurance.
Other category includes LNI, DoC, & VA health care expenditures.

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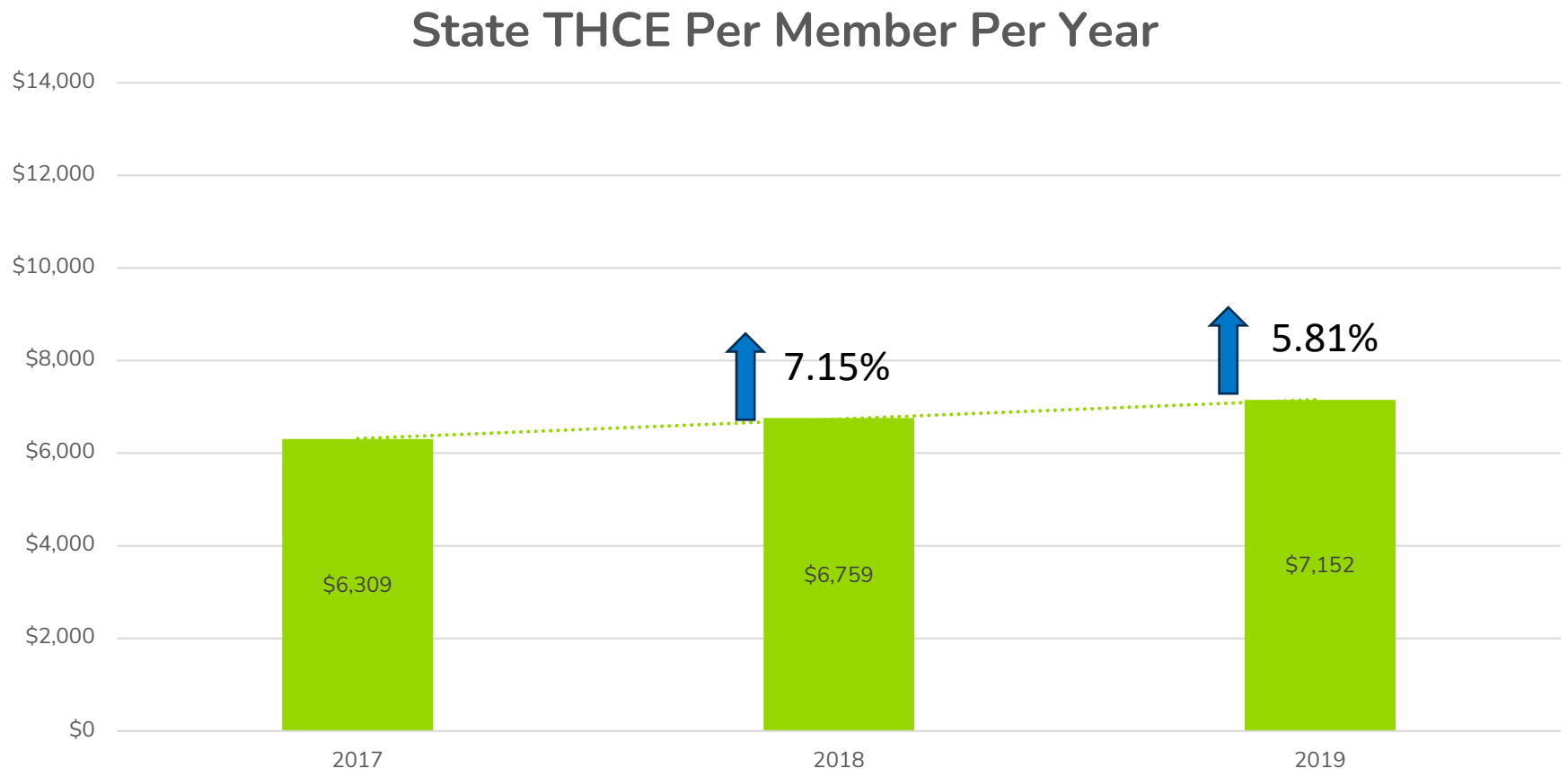
Total health care expenditures for WA



* MA and RI identified 3%-4% annual growth over this period

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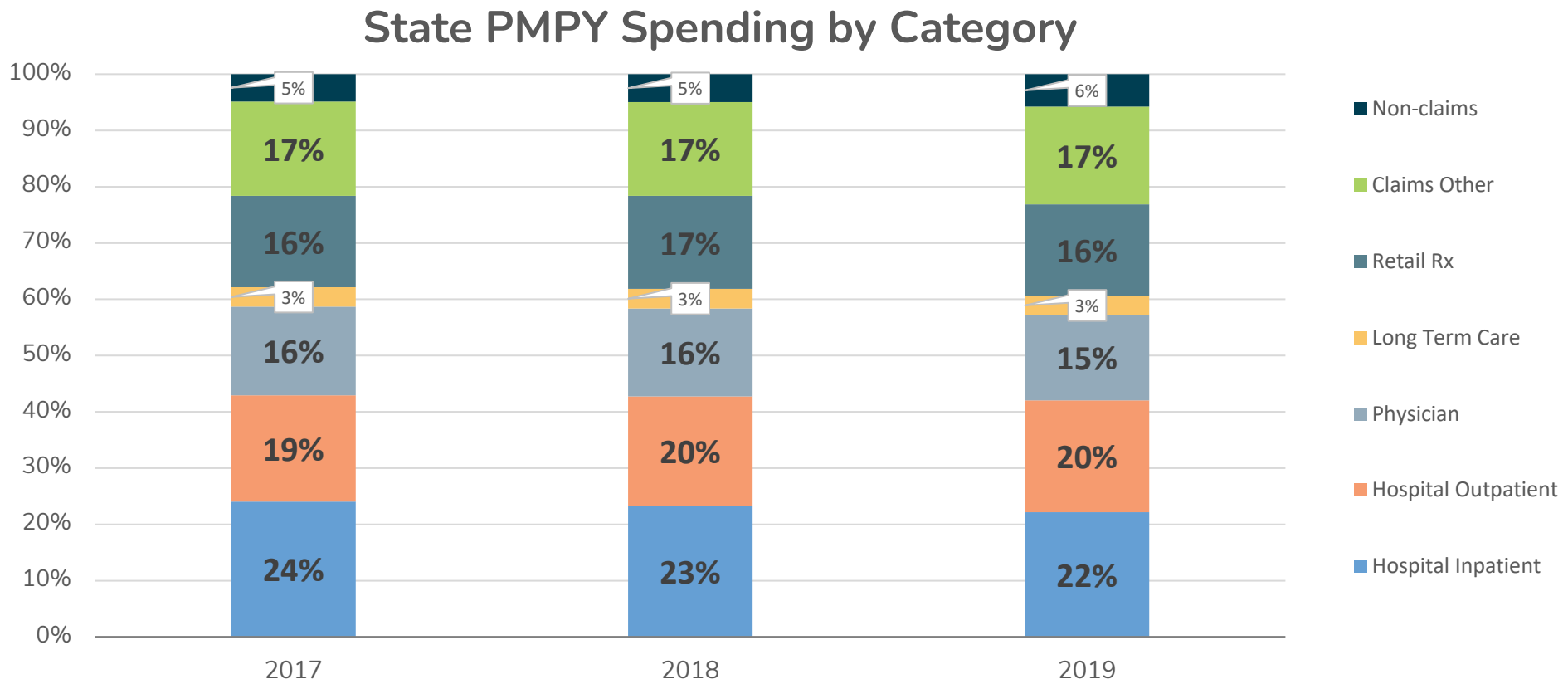
TME, per member per year spending



Note: Long term care spending from DSHS is not included

Includes Commercial, Medicaid (MCO & FFS), & Medicare (Adv & FFS).
NCPHI and Other spending is excluded.

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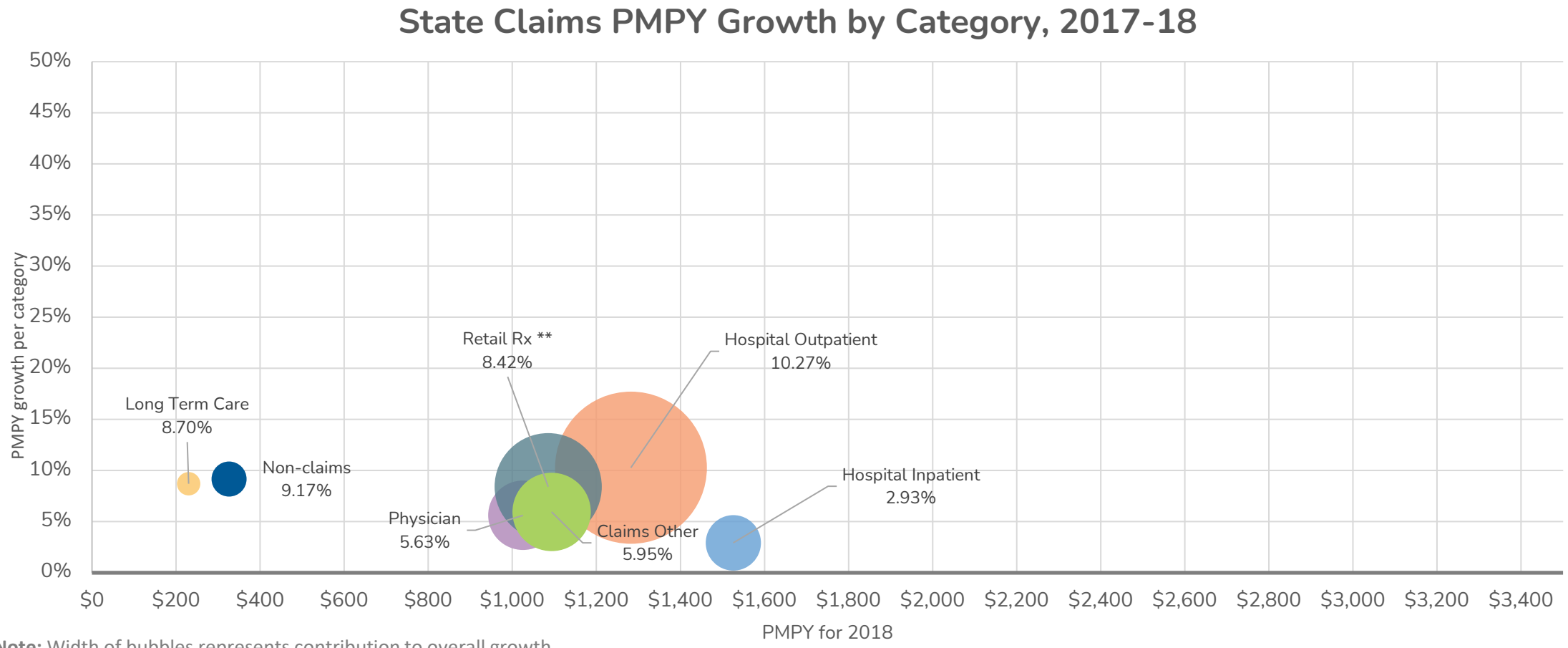
Overall service category contribution to cost growth for 2017 - 2018



Note: Width of bubbles represents contribution to overall growth
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Washington State Health Care Authority

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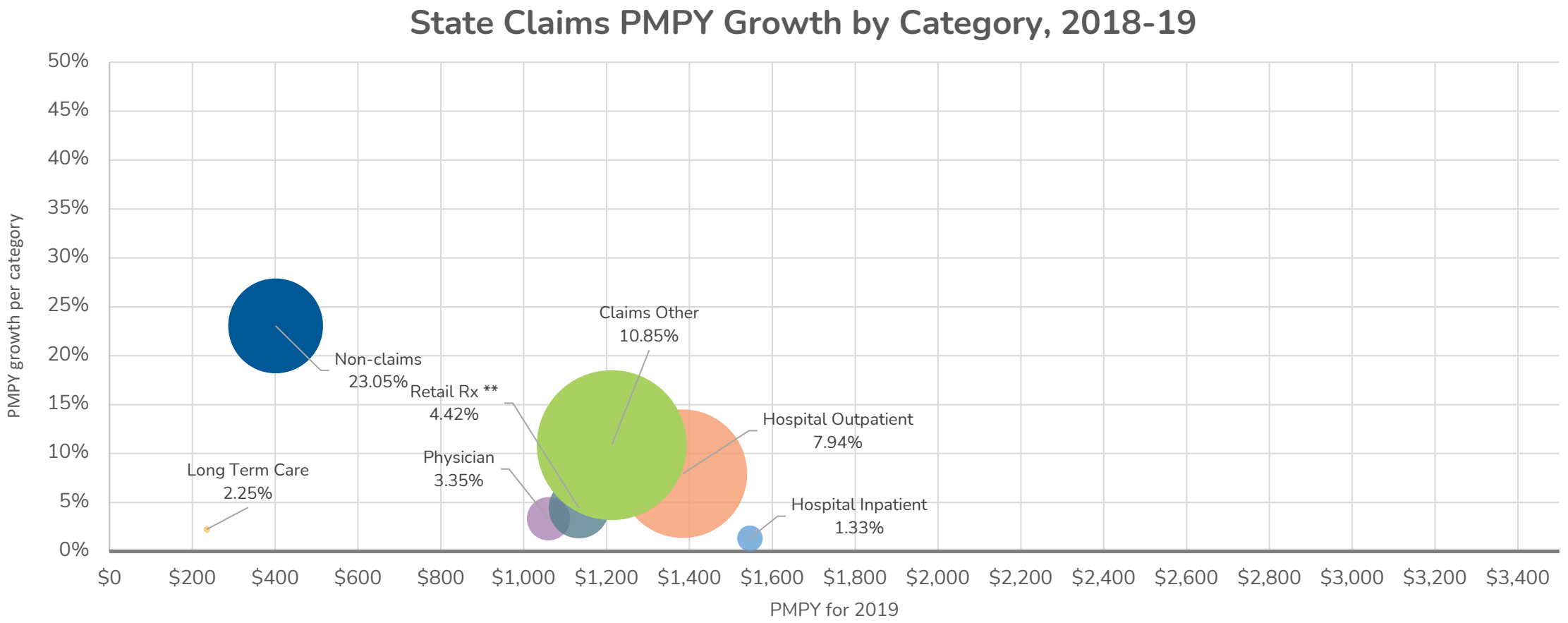

Note: Width of bubbles represents contribution to overall growth
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Medicaid

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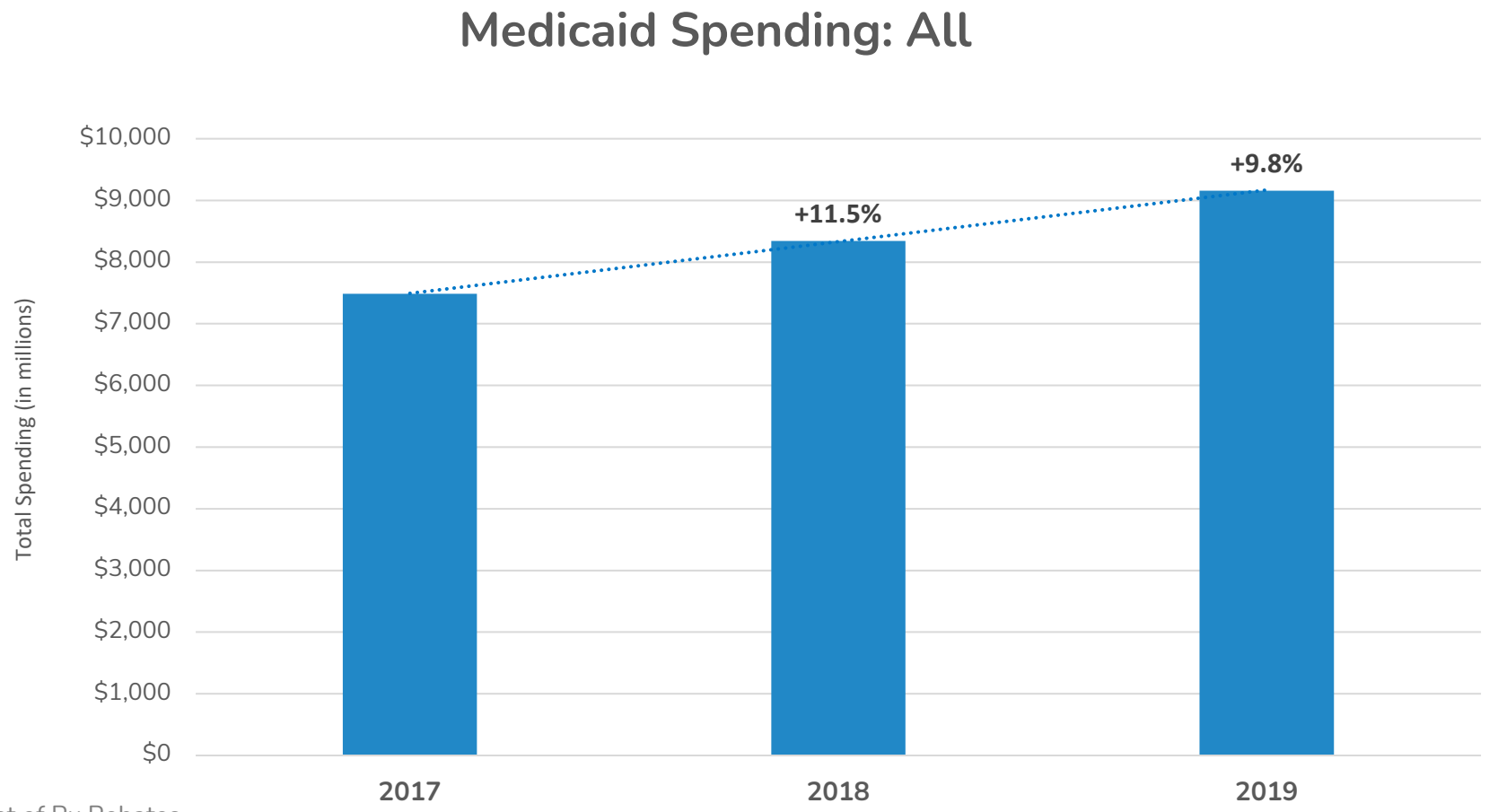
Medicaid growth



* Net of Rx Rebates
Includes Medicaid MC & FFS

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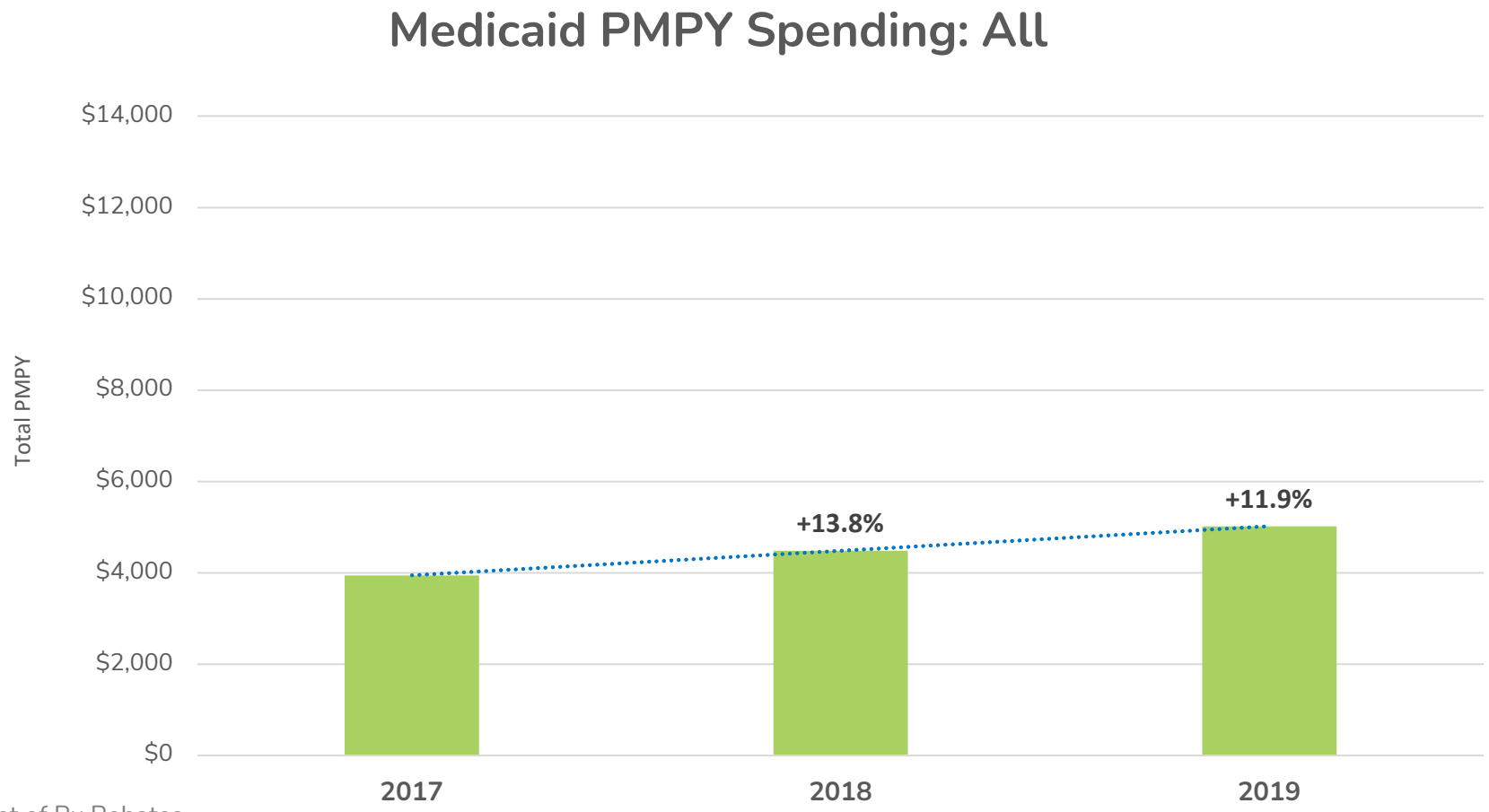
Medicaid PMPY growth



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Included Medicaid MC & FFS

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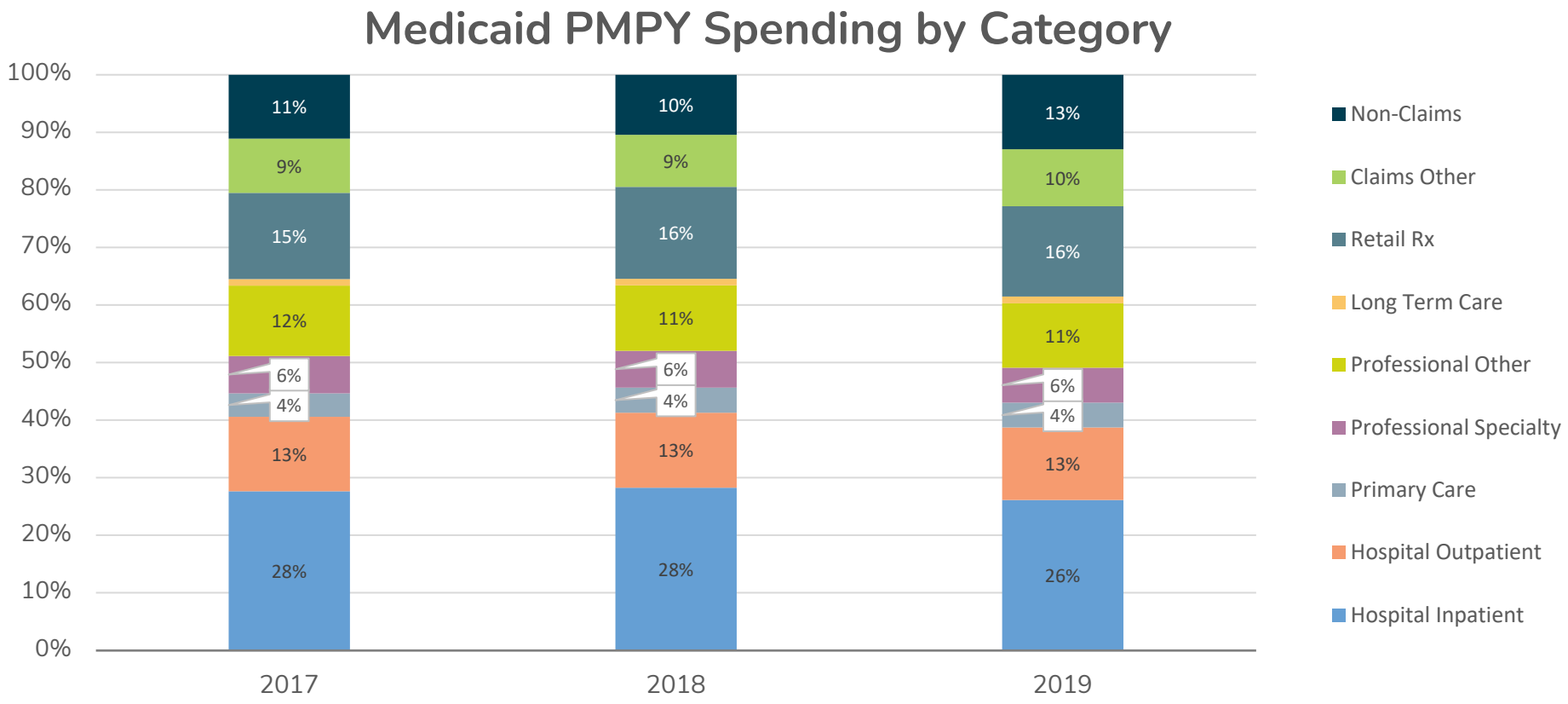
Medicaid TME category PMPY spending



* Net of Rx Rebates
Included Medicaid MC & FFS

Note: Long term care spending from DSHS is not included

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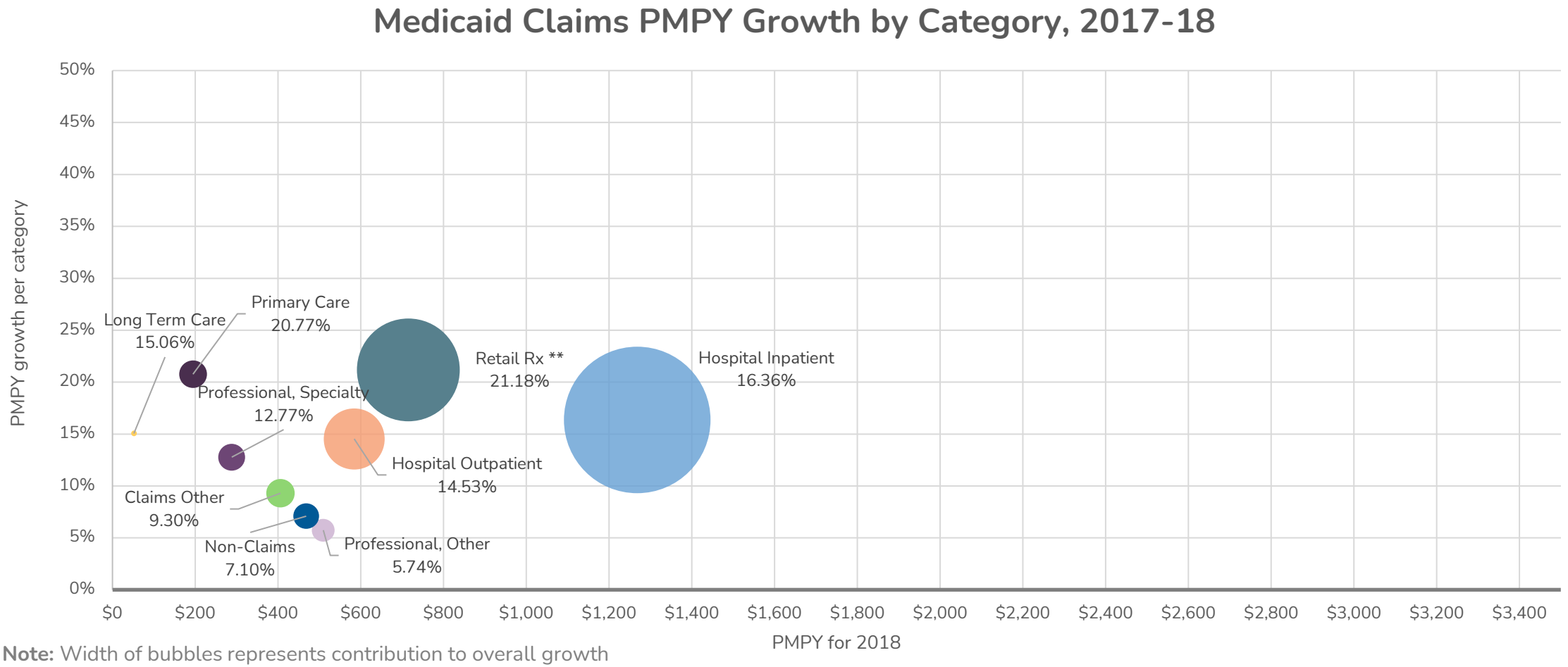
Medicaid service category contribution to cost growth for 2017-2018



Note: Width of bubbles represents contribution to overall growth
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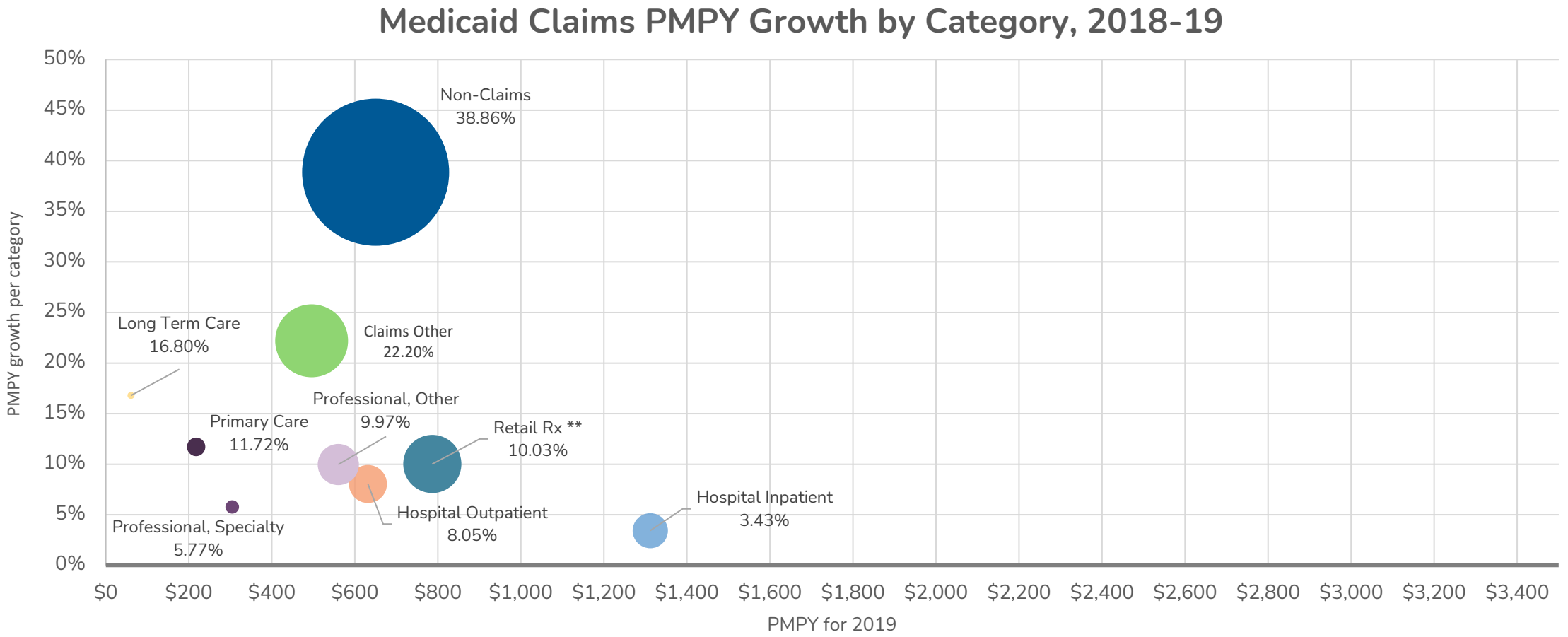
Medicaid service category contribution to cost growth for 2018-2019



Note: Width of bubbles represents contribution to overall growth
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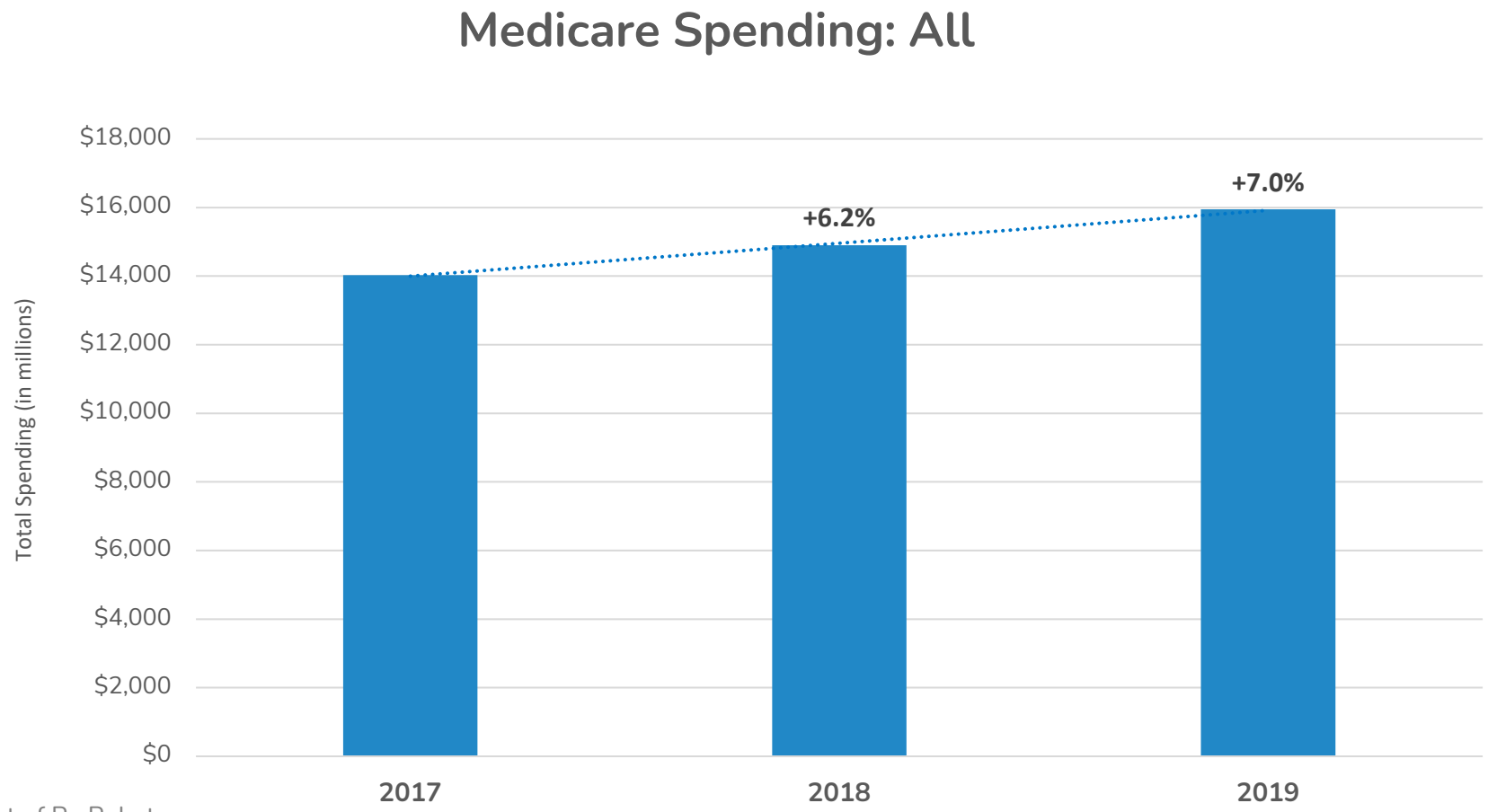
Medicare

Medicare growth



* Net of Rx Rebates
Included Medicare Adv & FFS

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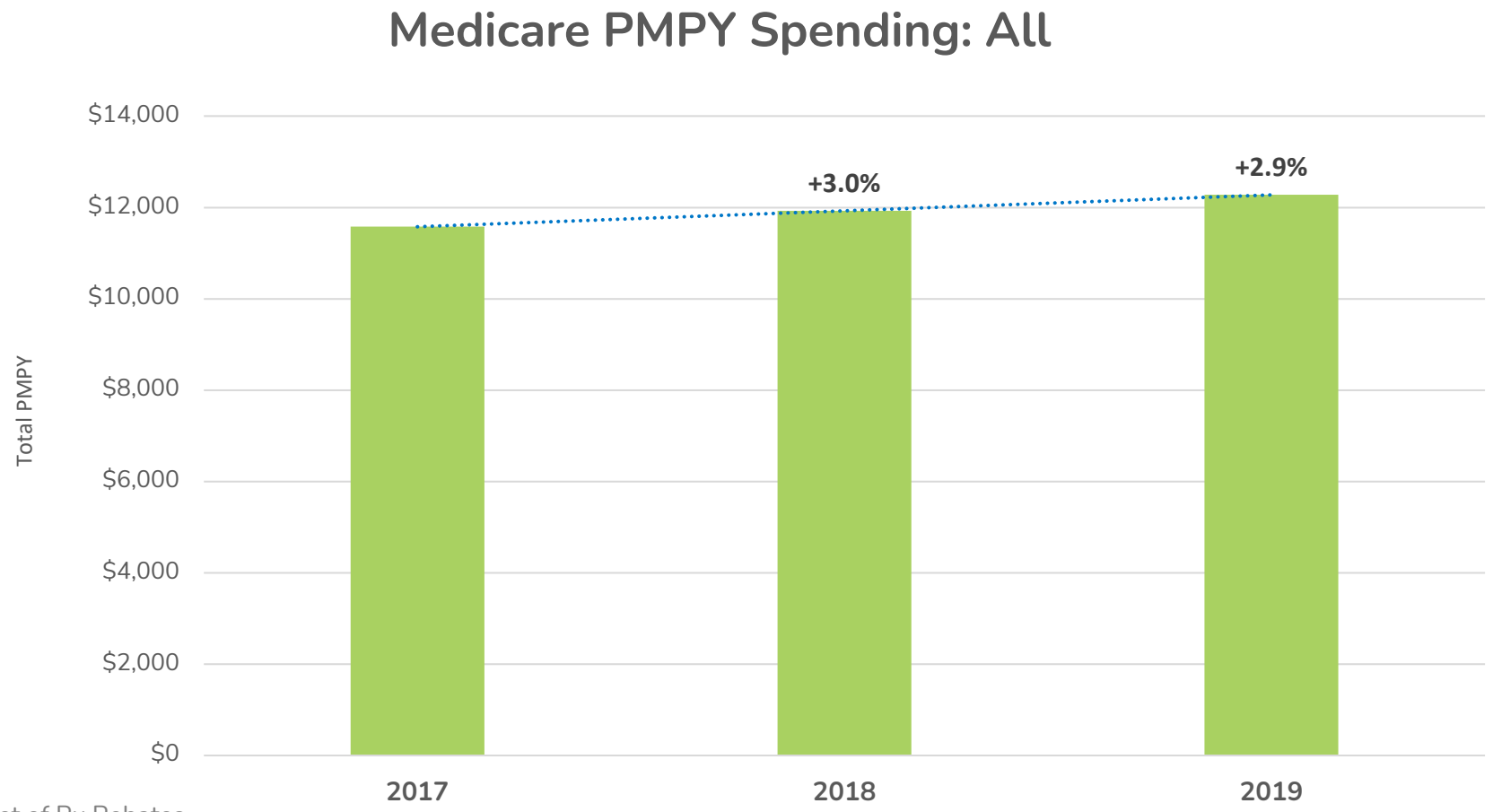
Medicare PMPY growth



* Net of Rx Rebates
Included Medicare Adv & FFS

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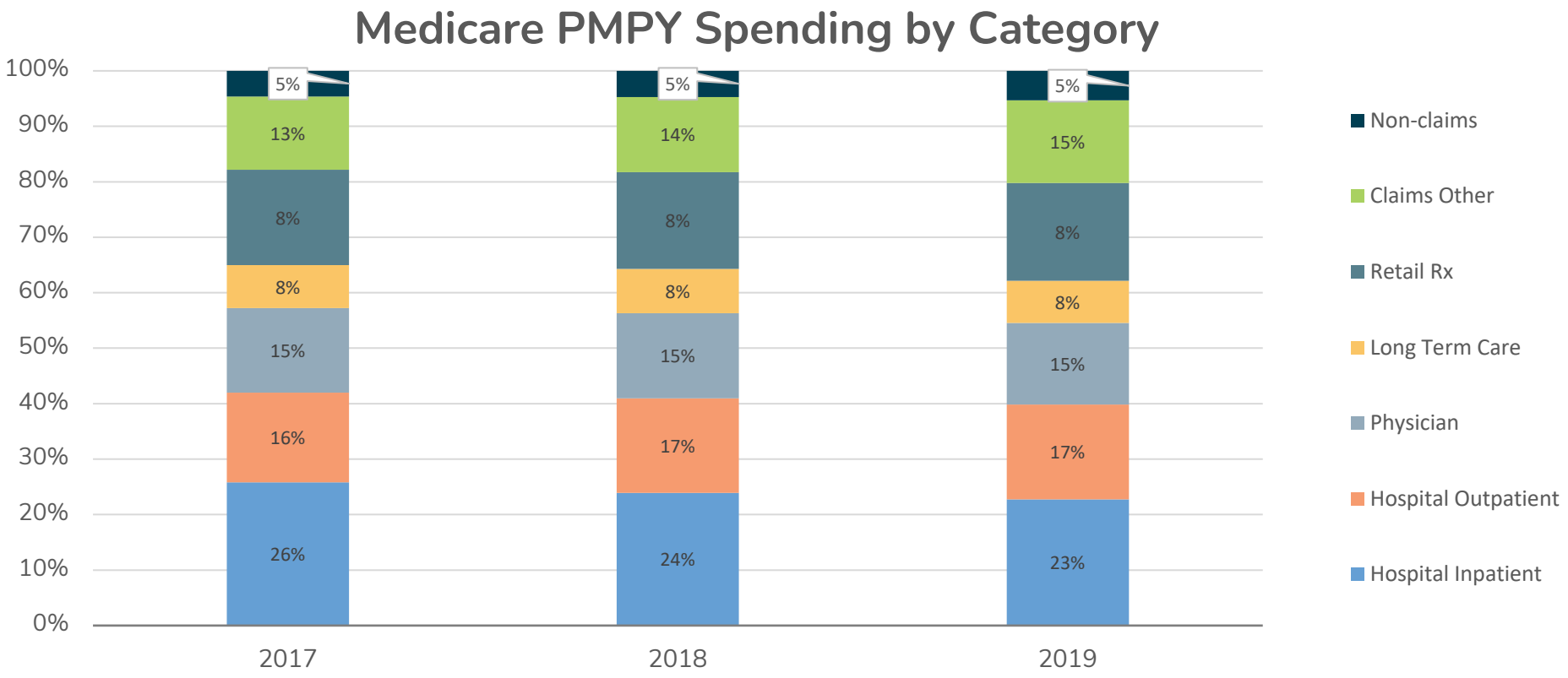
Medicare TME category PMPY spending



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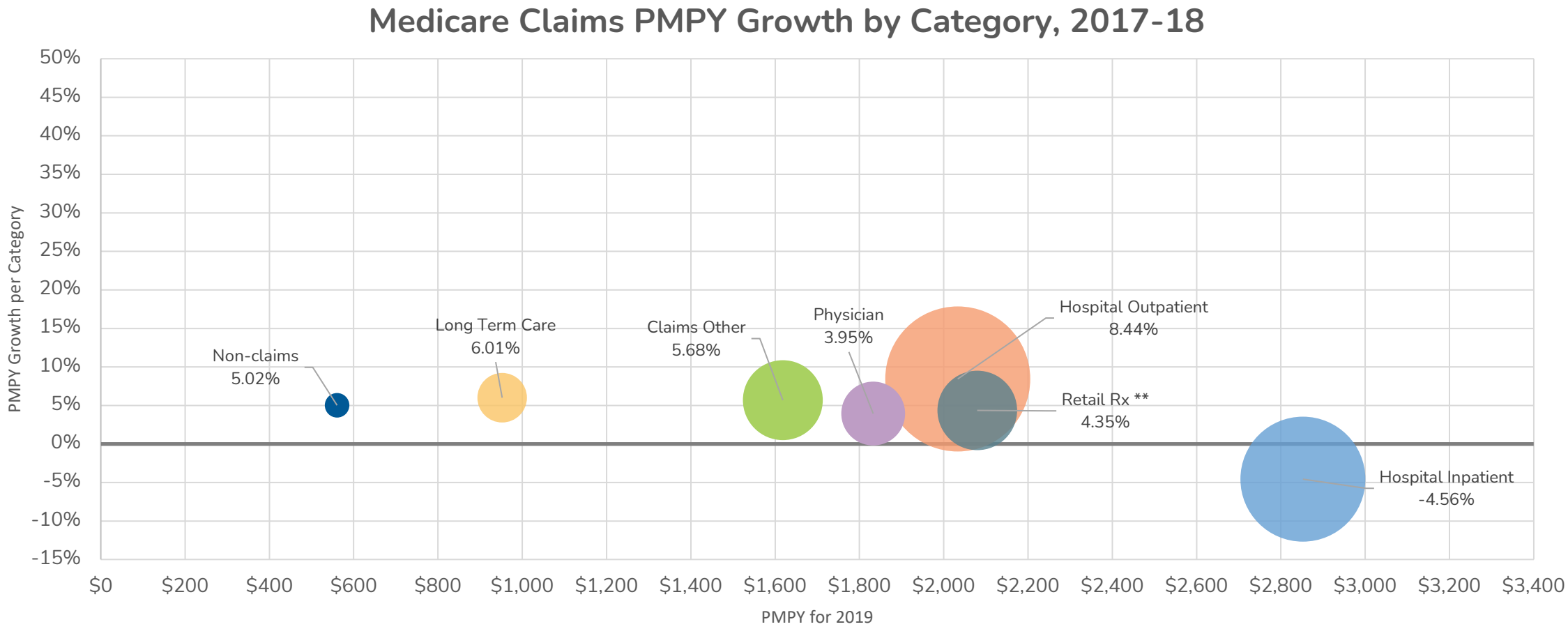
Medicare service category contribution to cost growth for 2017-2018



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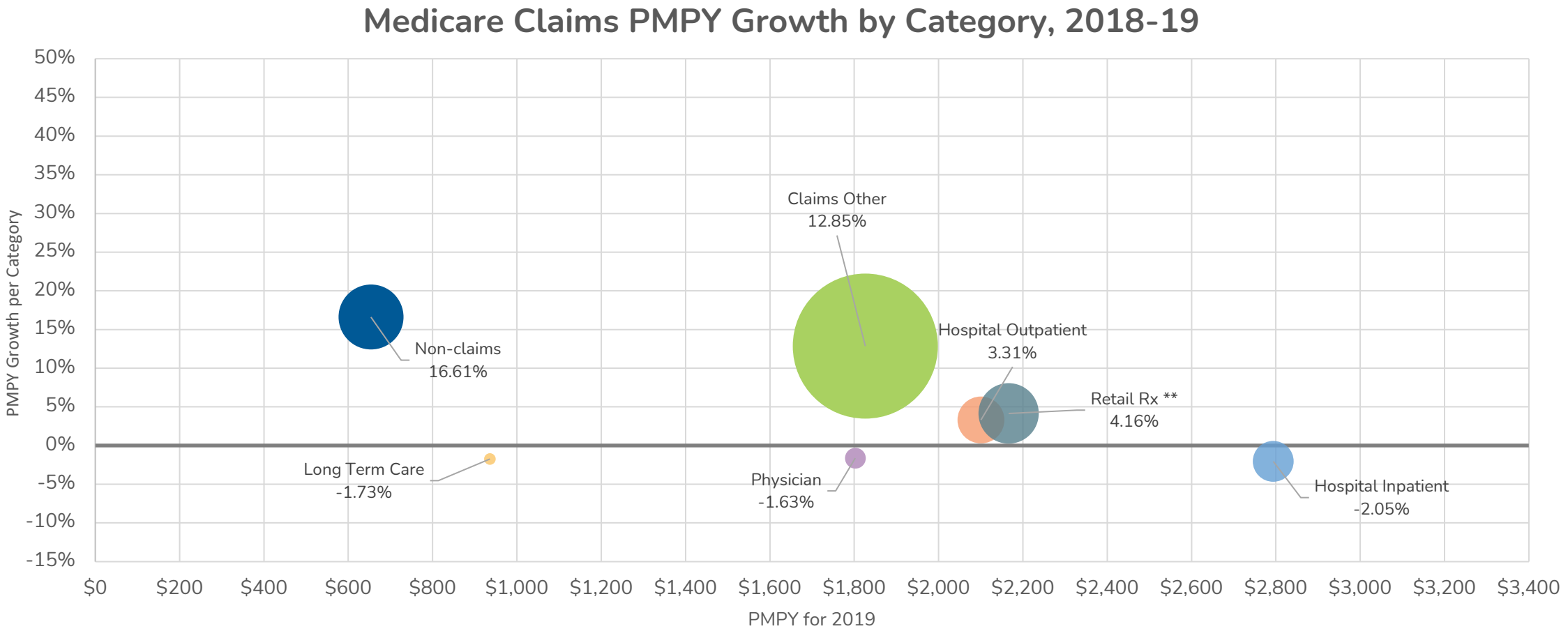
Medicare service category contribution to cost growth for 2018-2019



Note: Width of bubbles represents contribution to overall growth
Includes Medicare Adv & FFS

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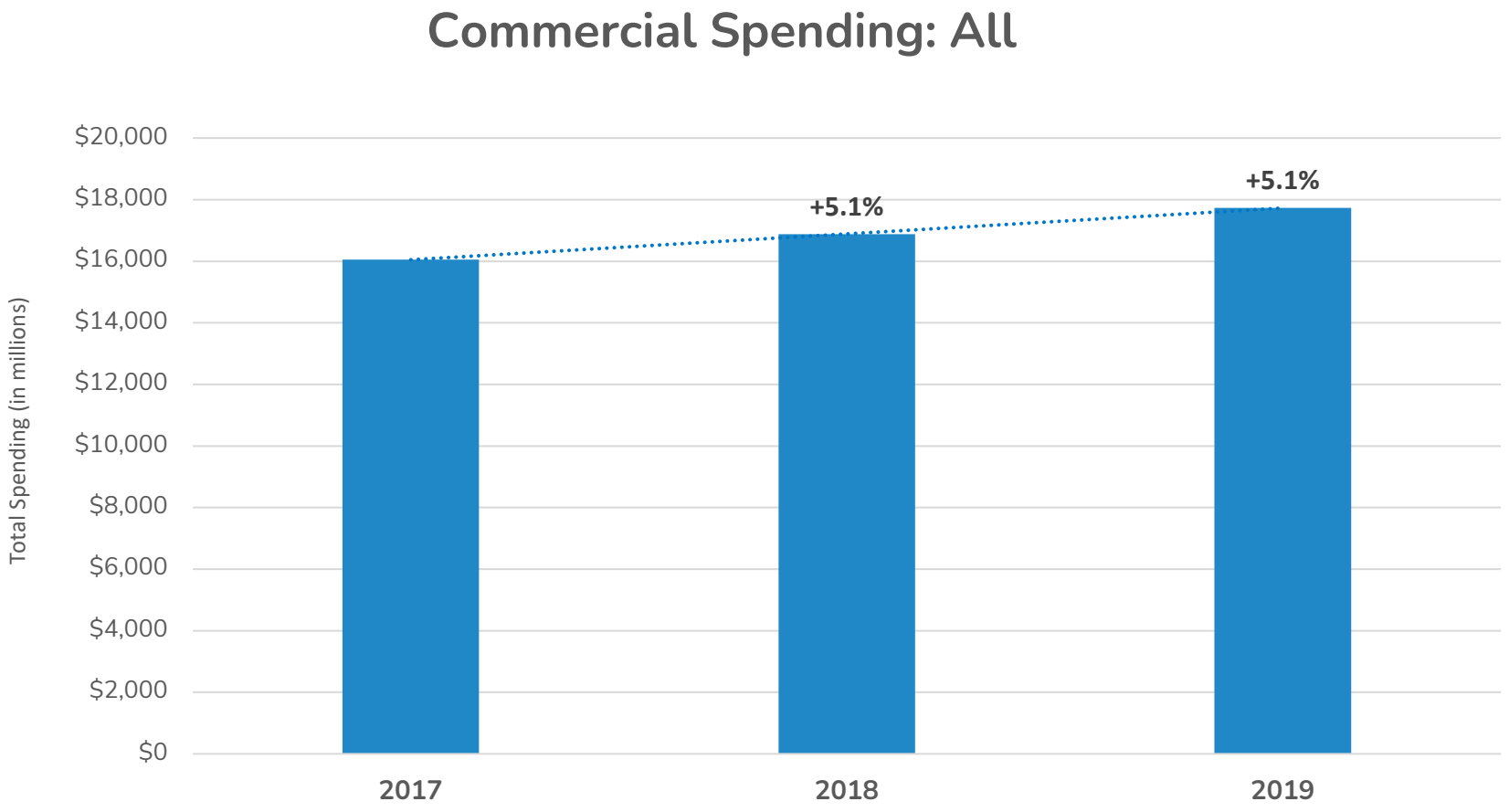
Commercial

Commercial growth



* Net of Rx Rebates

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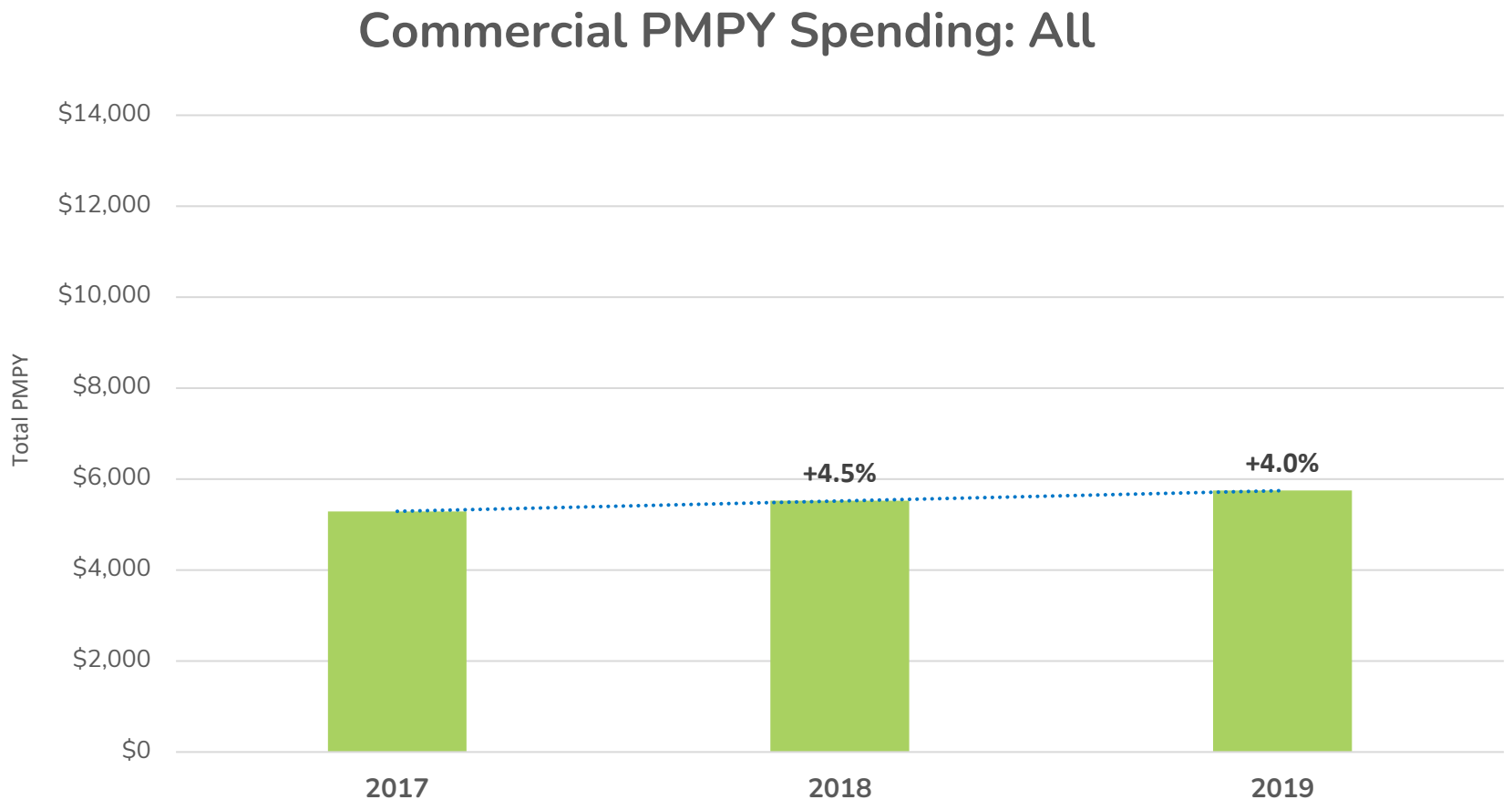
Commercial PMPY growth



* Net of Rx Rebates

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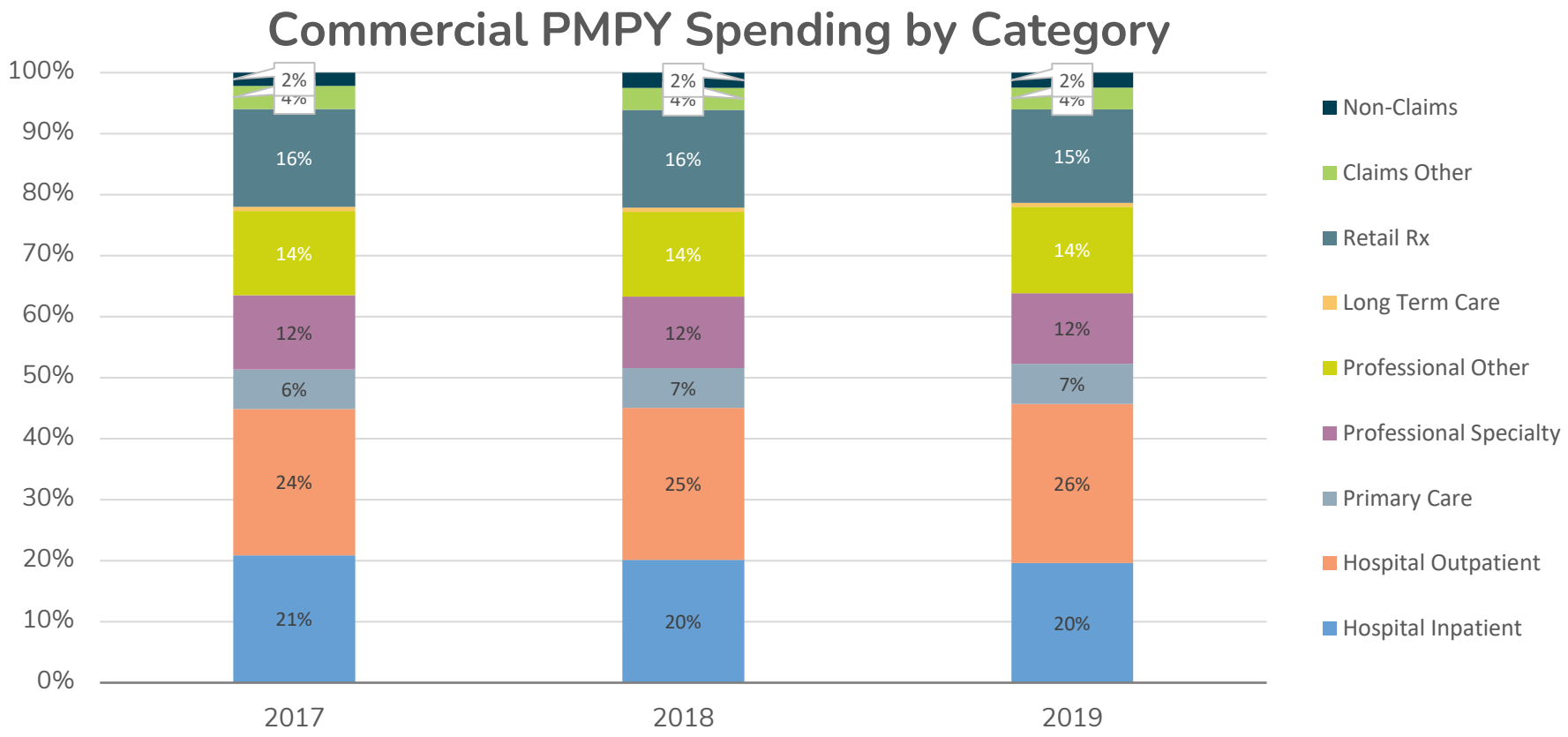
Commercial TME category PMPY spending



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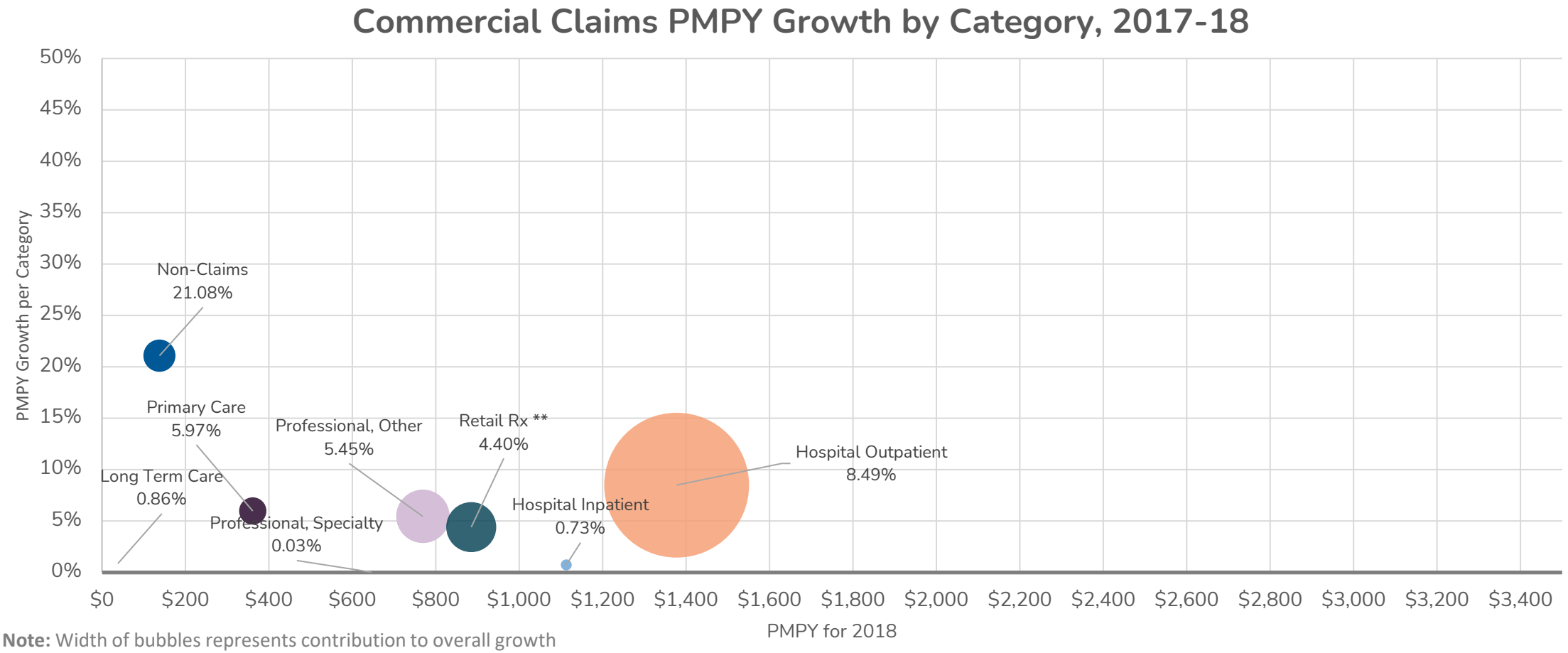
Commercial service category contribution to cost growth for 2017-2018



Note: Width of bubbles represents contribution to overall growth

* Net of Rx Rebates

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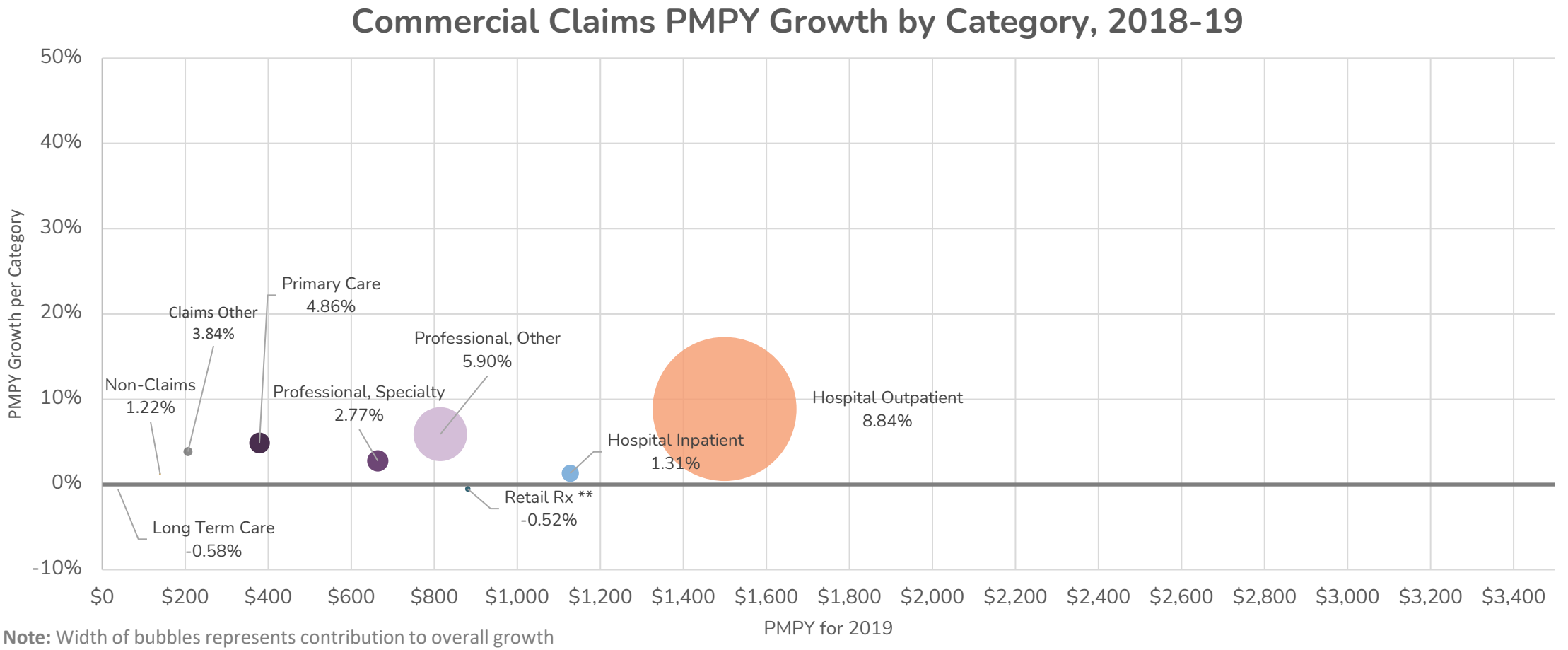
Commercial service category contribution to cost growth for 2018-2019



Note: Width of bubbles represents contribution to overall growth

** Net of Rx Rebates

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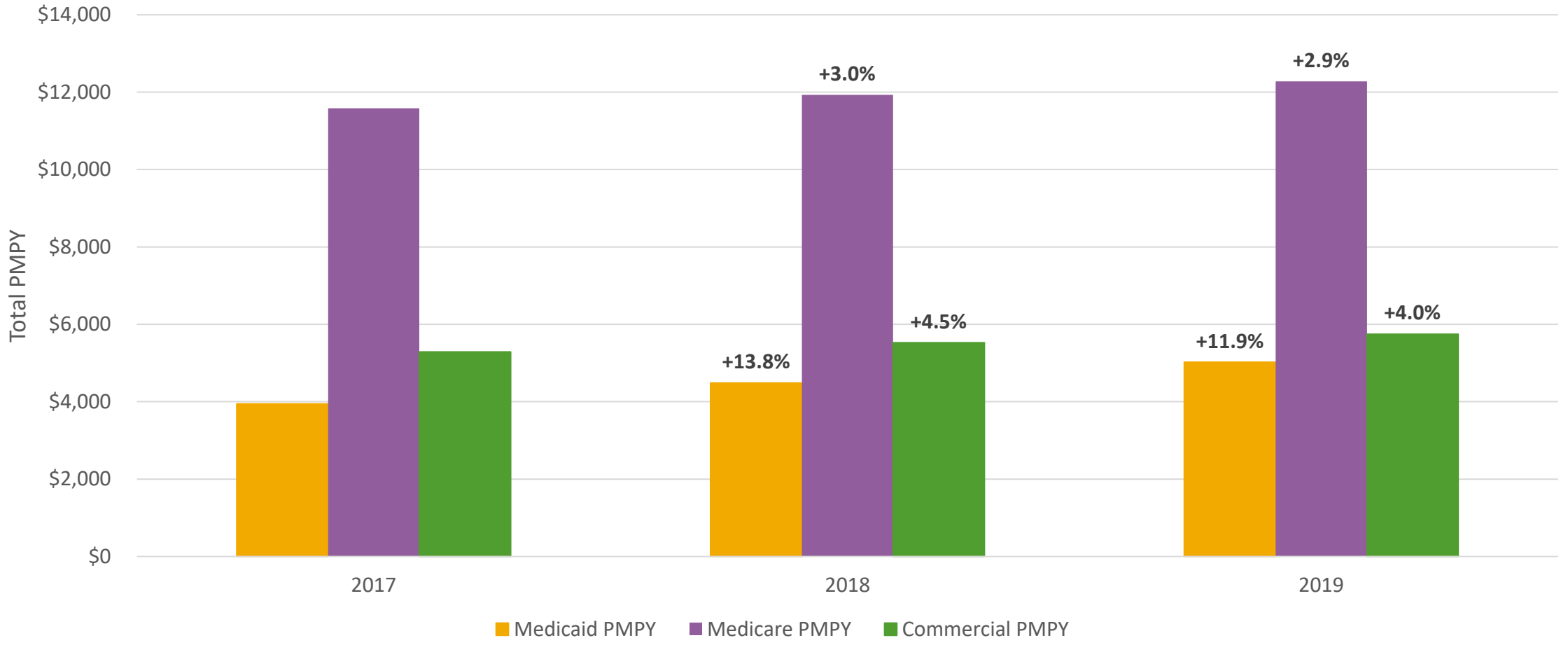
Summary & Next Steps

PMPY growth by market – at a glance



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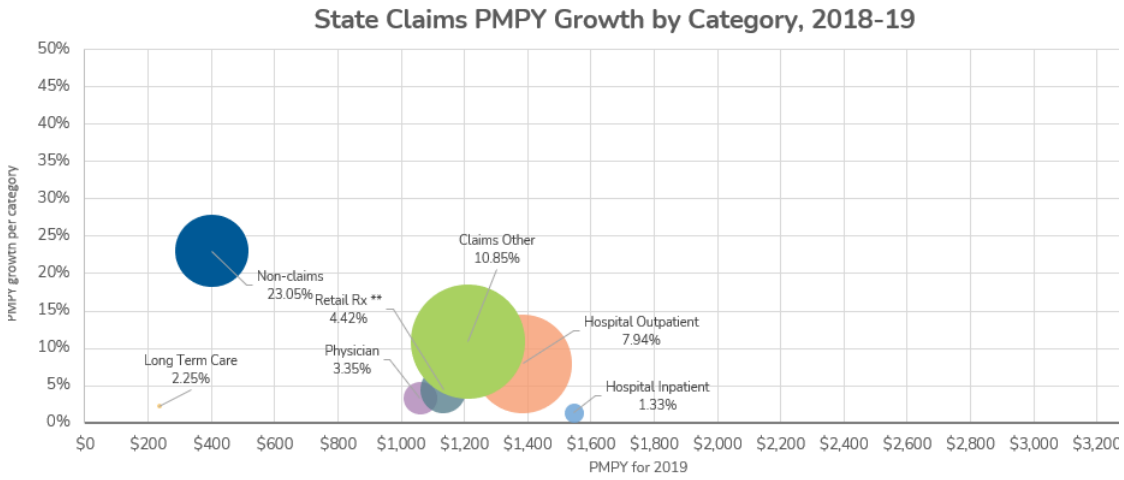
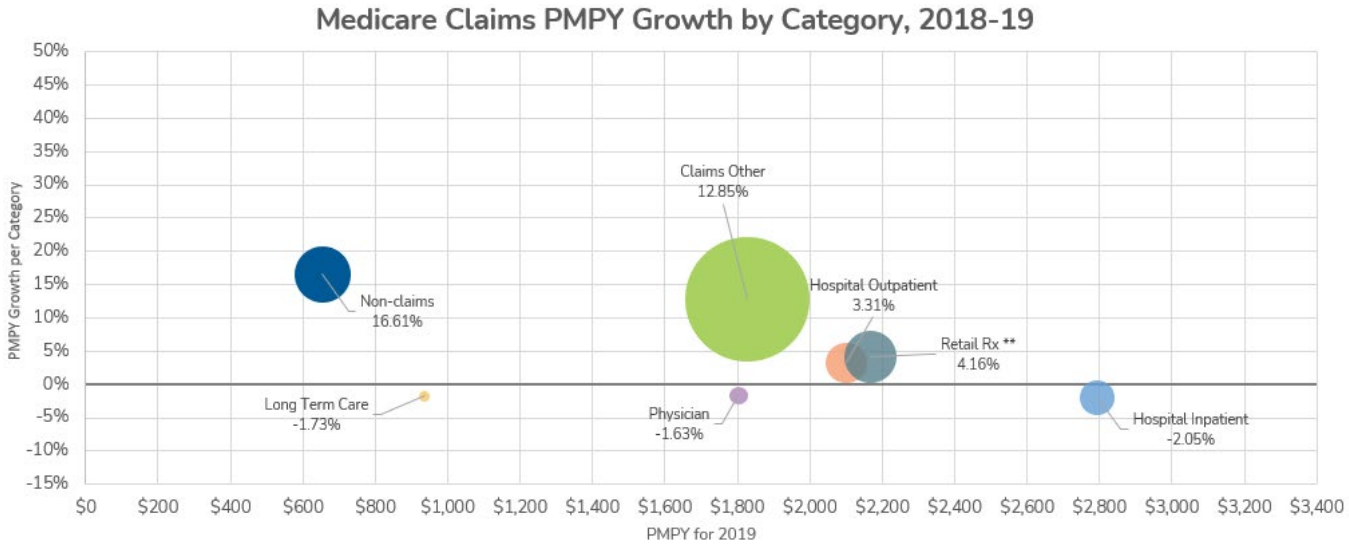
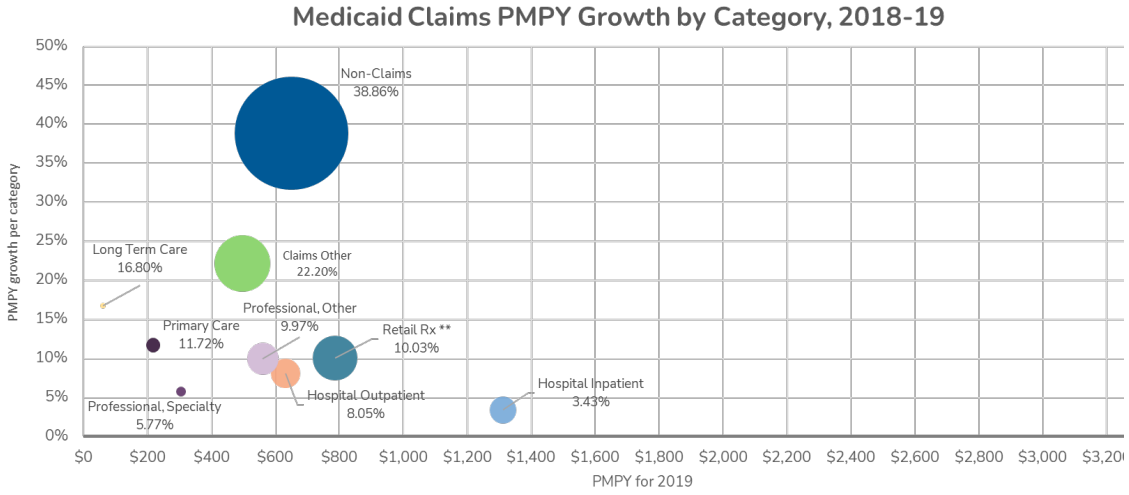
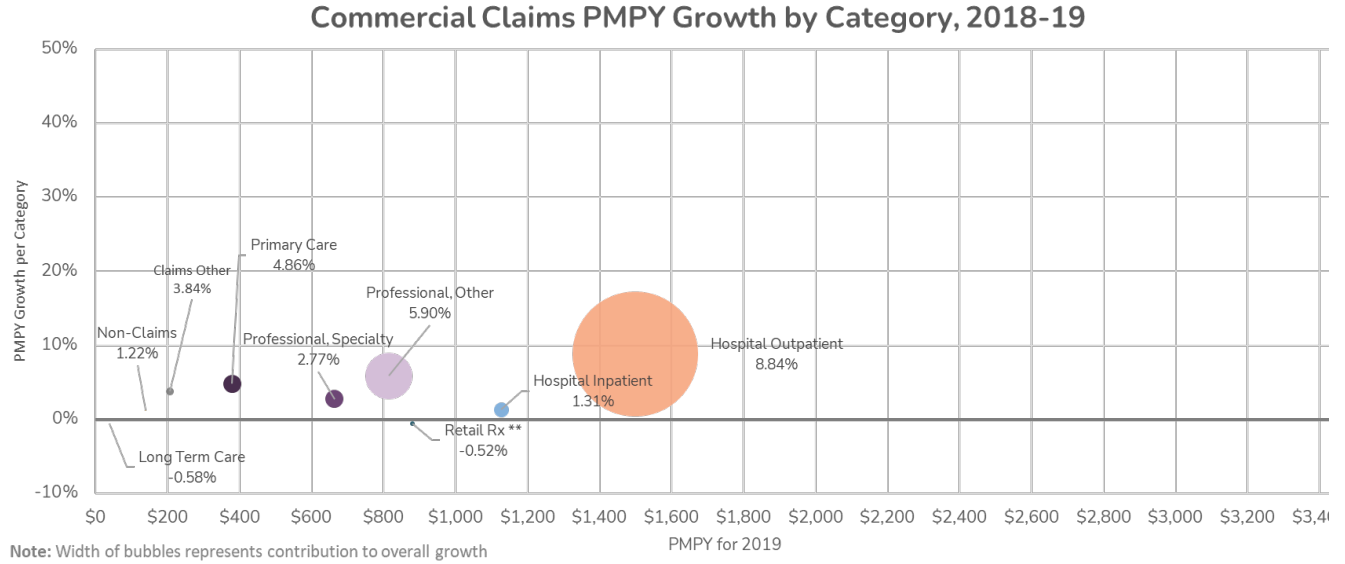
Service category contribution to cost growth – at a glance







Note: Width of bubbles represents contribution to overall growth
Included Medicaid MC & FFS



Note: Width of bubbles represents contribution to overall growth
** Net of Rx Rebates

Next steps

This high-level report sets the stage for the Cost Board's work in 2024

- Next data submission call for carriers
  - Measuring spending against the cost growth benchmark for the first time
    - Explore spending growth from 2021 to 2022, and how that compares to the cost growth benchmark set at 3.2% for 2022
  - Begin reporting on spending at the payer and large health care provider level
- Deeper dives into health care spending
  - Analyze how changes in price and utilization contribute to spending growth
  - Report at the end of 2024 by the Institute for Health Metrics and Evaluation
- Review cost containment strategies to recommend to the legislature

Questions

Discussion

- What additional data would you like to explore to assist with achieving the health care cost growth benchmark in Washington?
- Do you have any follow-up questions for the Board's Advisory Committee on Data Issues?
  - About these findings or future areas for analysis?
- Do you have any follow-up questions for the Board's Advisory Committee of Health Care Providers and Carriers?

Appendix A: Other spending

Source	2017	2018	2019
DoC	$159,373,434.40	$180,885,549.01	$200,640,533.76
LNI	$400,995,307.95	$397,069,029.47	$445,486,818.21
VA	$1,412,362,918.49	$1,526,068,781.06	$1,665,541,164.18

Tab 6

Washington State Health Care Authority

Broad vs. Narrow Definitions Update: Moving Forward the Narrow Definition

HCCTB Advisory Committee on Primary Care Charges

- Primary Care Definition
  - Recommend a definition of primary care
  - Recommend measurement methodologies to assess claims-based spending
  - Recommend measurement methodologies to assess non-claims-based spending

- Data Focused to support primary care
  - Report on barriers to access and use of primary care data and how to overcome them
  - Report annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures
  - Track accountability for annual primary care expenditure targets

- Policies to Increase and Sustain Primary Care
  - Recommend methods to incentivize achievement of the 12 percent target
  - Recommend specific practices and methods of reimbursement to achieve and sustain primary care expenditure targets

Narrow vs. Broad General Differences

Provider types included in the broad definition that are not included in the narrow definition

- Advanced Practice Midwife
- Advanced Practice Registered Nurse
  - Psychiatric Mental Health
- Counselors
  - Addiction (Substance Use Disorder)
  - Mental Health
- Family Medicine
  - Addiction Medicine
  - Bariatric Medicine
  - Hospice and Palliative Care
- Internal Medicine
  - Addiction Medicine
  - Bariatric Medicine
- Marriage and Family Therapist
- OBGYN
- Physician Assistant
  - Psychiatric Mental Health
- Psychologist
  - Addiction (Substance Use Disorder)
  - Clinical
  - Adult Development and Aging
  - Etc.
- Registered Nurse
- Social Worker
  - Clinical
  - School

Key Considerations

- The narrow definition is more closely aligned with definitions used in other states. This includes states that were used as a benchmark when setting the 12% primary care expenditure ratio target in statute.
- The narrow definition will require greater primary care investment to hit the 12% target.
- The broad definition may be more direct in supporting team-based care, but the narrow definition can still be used to support teams-based care due to the increased investment in primary care more broadly.

Questions?

Tab 7

Washington State Health Care Authority

HEALTH CARE COST TRANSPARENCY BOARD

Nomination Committee Terms of Reference

What is the Purpose of the Nomination Committee?

Assisting the Health Care Cost Transparency Board ("Board"), the primary role of the Nomination Committee is to recruit and evaluate member nominations for the Board and its sub-committees to ensure an effective and appropriate mix of representation and diversity (including gender, geography, expertise, background, and qualifications) that allow them the ability to properly fulfill their roles and adhere to the strategic vision of the Board and Board's mandate.

Membership:

The Nomination Committee will consist of no less than three members actively serving on the Health Care Cost and Transparency Board. Membership will be on a voluntary basis.

Roles and Responsibilities:

The Nomination Committee is responsible for:

- Collaborating with the Board, committee chairs, and HCA staff to assess the appropriate mix of competencies, diversity, qualifications, and subject matter expertise of the Board and committees (for example, members of the data advisory committee must have expertise in health data collection and reporting, health care claims data analysis, etc. as indicated in House Bill 2457, section 4 and related RCWs).
- Implementing a Board-approved process for corresponding with, recruiting, evaluating, and selecting qualified and diverse candidates for selection to the Board and appointment to its committees.
- Recommending to the Board candidates to apply for membership.
- Updating membership to reflect the expertise and backgrounds being sought within membership.
- Updating relevant materials to clearly reflect the specific purpose of the committee and expectations of its members.

Meetings:

The Nomination Committee will meet as needed (likely no more than quarterly), to fulfill its mandate to the Board of recruiting and selecting qualified candidates to fill any open positions on its committees and other Nomination Committee work.

Quorum:

A majority of the Nomination Committee members constitutes a quorum for a meeting of the committee.

Accountability and Reporting:

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

Nomination Committee Voting

Support the creation of a Nomination Committee?

Please email if you would volunteer for the Nomination Committee.

Allow the Nomination Committee to review current nominations?

Permit temporary appointments until Nomination Committee has completed its review to fill vacancies?

PDF **RCW 70.390.040**

Advisory committees—Appointment.

(1) The board shall establish an advisory committee on data issues and an advisory committee of health care providers and carriers. The board may establish other advisory committees as it finds necessary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[**2020 c 340 § 4**.]

Member	Title	Place of Business
Bob Crittenden	Physician and Consultant	Empire Health Foundation
Justin Evander	Executive Director Care Delivery Finance	Kaiser Permanente
Paul Fishman	Professor, Dept. of Health Services	University of Washington
Jodi Joyce	Chief Executive Officer	Unity Care NW
Louise Kaplan	Associate Professor, Vancouver	WSU College of Nursing
Stacy Kessel	Chief Finance and Strategy Officer	Community Health Plan of Washington
Ross Laursen	Vice President of Healthcare Economics	Premera Blue Cross
Todd Lovshin	Vice President and WA State Executive	PacificSource Health Plans
Vicki Lowe	Executive Director	American Indian Health Commission
Mike Marsh	President and Chief Executive Officer	Overlake Hospital and Medical Center
Natalia Martinez-Kohler	Vice President of Finance and CFO	MultiCare Behavioral Health
Mika Sinanan	Surgeon and Medical Director	UW Medical Center
Dorothy Teeter	Consultant	Teeter Health Strategies
Wes Waters	Chief Financial Officer	Molina Healthcare of Washington

Eric Lewis

ericl@wsha.org * 360/461-6889

Work Experience:

Washington State Hospital Association – June 2020 to Current

Chief Financial Officer

- Oversees the financial operations of WSHA and its related entities
- Assists with policy and advocacy at the state and federal level primarily in financial policy issues and the Safety Net Assessment Program.
- Works with large and small hospital/hospital system CFOs on financial and advocacy issues
- Leads Washington Hospital Services which is a wholly owned for-profit subsidiary of WSHA
- Member of senior executive team and helps in operational and strategic priorities and projects

Olympic Medical Center – November 1998 to June 2020

Chief Executive Officer – December 2006 to June 2020

- Leader of operations for a 76 bed Hospital with a birth center and Trauma Level 3 ER and outpatient services with $216 million of net revenues and 1,550 employees including Olympic Medical Physicians with 105 providers, Cancer Center, Heart Center and Home Health Agency
- Prioritized strategic planning and implementation
- Focused on workforce development including recruiting, retaining and implementing an intentional culture called “The OMC Way”
- Emphasized advocacy at Federal and State level
- Team awards and team accomplishments:
    - Medicare 5 Star hospital in 2020
    - National Rural Healthcare Association Top 20 Rural Community Hospital in 2017 and 2018 and Top 100 in 2019
    - DNV Certified in Infection Prevention in 2018 (first in State)
    - Developed a large Sequim Campus and completed MOB in Port Angeles Campus in 2017
    - Implemented Providence Epic Community Connect in 2013

Chief Financial Officer – November 1998 to November 2006

- Led financial operations including accounting, financial analysis, payroll, accounts payable, purchasing, and revenue cycle departments
- Provided financial analysis, projections and advice to improve operations
- Compliance Officer and organized compliance program
- Managed investments, insurance program and retirement plans

Stevens Healthcare (currently Swedish Edmonds) April 1991 to October 1998

Vice President of Finance / Controller

- Led financial operations including accounting, financial analysis, payroll, accounts payable, purchasing, and revenue cycle departments
- Member of Senior Leadership Team during last few years
- Provided financial analysis, projections and advice to improve operations
- Helped implement Stevens Health Network which accepted capitation for Medicare, Medicaid and commercial patients

Arthur Andersen – December 1985 to April 1991 (Healthcare Division)

Staff, promoted to Senior, promoted to Manager

- Performed financial statement audits of hospitals and hospital systems
- Provided consulting engagements including financial projections and hospital turnarounds
- Assisted clients on numerous projects and reimbursement issues

Education:

- University of Washington School of Business – Bachelors of Arts in Business Administration (concentrations in Accounting and Finance) - 1985
- CPA Certificate 1992, No. 15031 (expired)
- Annual national and state conferences, webinars and reading

Skills and Qualifications:

- Financial accounting, reporting, projections and stewardship
- Health care advocacy in Washington D.C. and Olympia
- Understand Medicare, Medicaid and other reimbursement programs
- Teamwork and listening are focuses
- Nearly 30 years of hospital operations experience
- Strategic plan development and implementation with a focus on vision and mission
- Rural health care expertise and focus
- Strong interpersonal and communication skills with even keeled approach

Boards and Activities:

- Cub Scout and Boy Scout leader and volunteer – 2001 to 2011
- Dungeness Valley Health and Wellness Clinic (Sequim Free Clinic) Board member and volunteer – 2009 to 2017 and 2021 to current
- Clallam County Economic Development Corp Board – 2009 to 2020
- Olympic Community of Health Board Member – 2016 to 2018
- Association Washington of Public Hospital Districts Board member 2012-2019 and Board President – 2017/2018
- WSHA Board member and committees – Board Chair Oct. 2018 to Oct. 2019

Awards:

- WSHA Most Valuable PAC Player – 2013
- Clallam County Economic Development Corp Olympic Leader Award - 2015
- AHA Grassroots Champion Award – 2016
- WSHA Joe Hopkins Memorial Award – 2017
- Seattle Business Magazine Leader in Healthcare Silver Award – 2018
- Sequim Free Clinic Beitzel Award – 2018

Personal Interests:

- Hiking, Traveling, Reading, Investing, Sports, Golfing and Wellness Activities

KAISER PERMANENTE®

Susan E. Birch and Board Members
Washington State Health Care Authority
Health Care Cost Transparency Board
Olympia, WA
RE: Letter of Interest to the Advisory Committee of Health Care Providers and Carriers

September 29, 2023

Dear Chair Birch and Board Members,

I am pleased to submit this letter to express my interest in serving on the Health Care Cost Transparency Board's Advisory Committee of Health Care Providers and Carriers. Justin Evander has enjoyed representing Kaiser Permanente on the Advisory Committee, and as he transitions to a new role, I would be honored to bring my expertise to this important work.

I am the Senior Director of Actuarial Services for Kaiser Permanente. In this role, I lead actuarial and financial analysis for Kaiser Permanente. This role requires a deep understanding of both financial and provider delivery due to Kaiser's unique integrated care delivery system. Previously, I have has held senior management positions at both Intermountain Health Care of Utah as well as Sentara Hospital systems in Virginia. I have over 30 years of experience of actuarial and integrated care delivery systems. I am a Fellow of the Society of Actuaries (FSA) and a member of the American Academy of Actuaries. In addition to actuarial certifications, I have a bachelor's degree in Biological Systems.

I would be pleased to bring my combination of actuarial, integrated health systems, financial expertise and insights, and my experience using reporting to continually improve productivity and care to the Advisory Committee. I look forward to engaging in this important work.

Thank you for your consideration of my nomination.

Sincerely,

Gregory Daniel
Senior Actuarial Director
Kaiser Permanente, Northwest

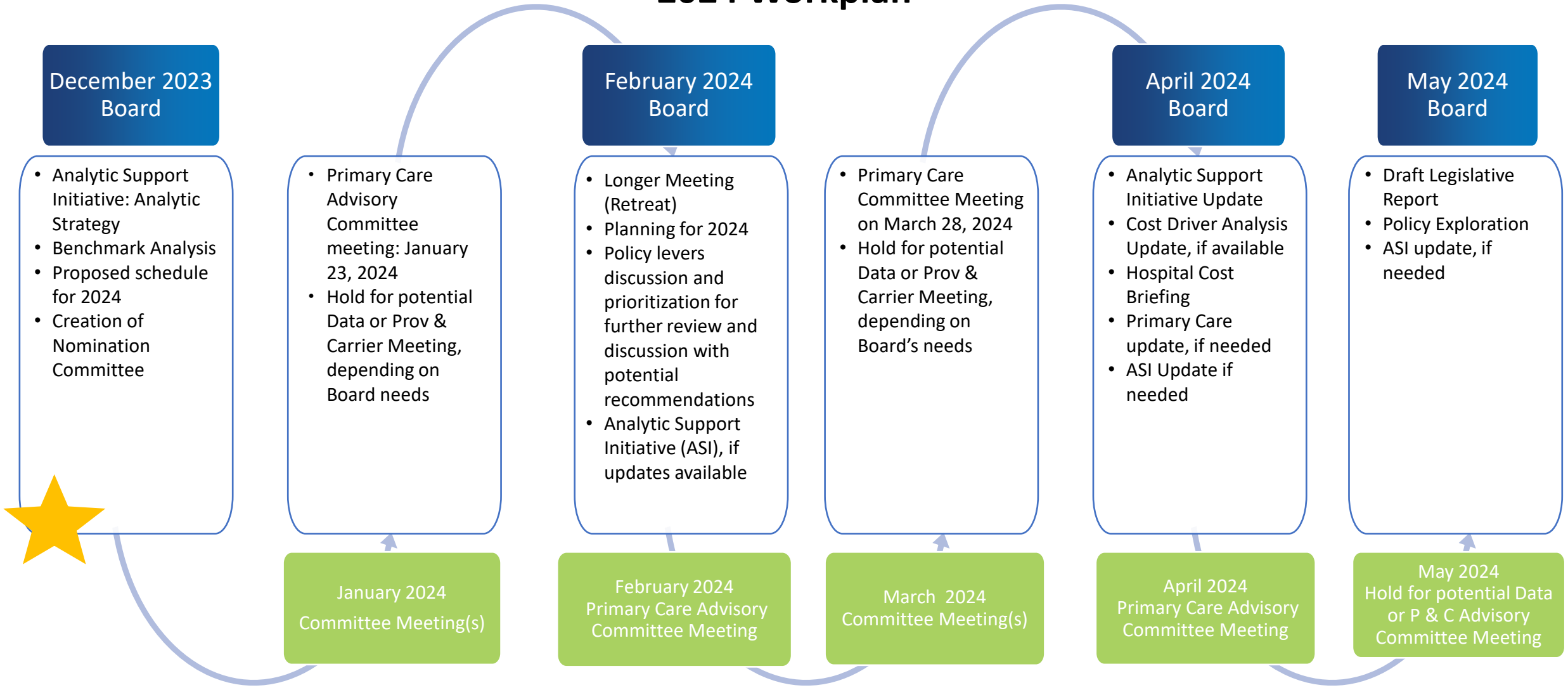
1300 SW 127th Street
Renton, WA 98057

Gregory Daniel is the Senior Actuarial Director for Kaiser Permanente Northwest. Daniel is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries. Prior to coming to Kaiser Permanente, he led actuarial teams at several health insurers and health systems, including Sentara Hospital system, Intermountain Health Care, Blue Cross Blue Shield and Amerigroup. Daniel served for 7 years in the Air Force and graduated from Drake University.

Tab 8

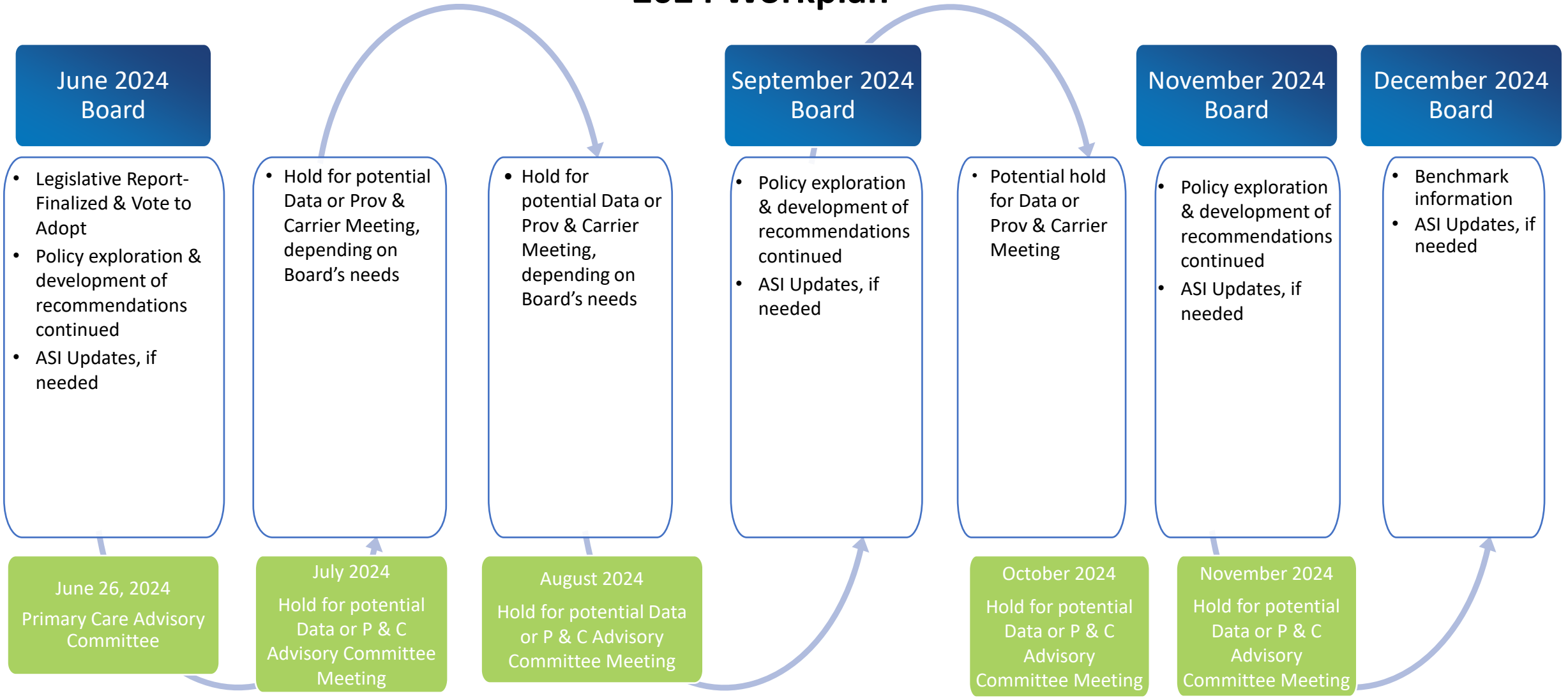
Washington State Health Care Authority

Health Care Cost Transparency Board
2024 Workplan



Workplan will change depending on progress made in each meeting

Health Care Cost Transparency Board
2024 Workplan



Workplan will change depending on progress made in each meeting

Calendar of Health Care Cost Transparency Board Meetings 2024

Health Care Cost Transparency Board	
Date	**Time**
February 9	9am-3pm Retreat
April 10	2-4pm
May 15	2-4pm
June 12	2-4pm
September 19	2-4pm
November 20	2-4pm
December 12	2-4pm

Thank you for attending the Health Care Cost Transparency Board meeting!

Washington State Health Care Authority