

Advisory Committee on Data Issues

July 8, 2021

Advisory Committee on Data Issues Meeting Materials Book

July 8, 2021
10:00 a.m. – 12:00 p.m.

(Zoom Attendance Only)

Agenda and Presentations

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Agenda

TAB 1

Advisory Committee on Data Issues

July 8, 2021
10:00 a.m. – 12:00 a.m.
Zoom Meeting

AGENDA

Committee Members:

<input type="checkbox"/>	Megan Atkinson	<input type="checkbox"/>	Jerome Dugan	<input type="checkbox"/>	Ana Morales
<input type="checkbox"/>	Amanda Avalos	<input type="checkbox"/>	Leah Hole-Marshall	<input type="checkbox"/>	Thea Mounts
<input type="checkbox"/>	Allison Bailey	<input type="checkbox"/>	Karen Johnson	<input type="checkbox"/>	Hunter Plumer
<input type="checkbox"/>	Jonathan Bennett	<input type="checkbox"/>	Scott Juergens	<input type="checkbox"/>	Mark Pregler
<input type="checkbox"/>	Purav Bhatt	<input type="checkbox"/>	Lichiou Lee	<input type="checkbox"/>	Julie Sylvester
<input type="checkbox"/>	Bruce Brazier	<input type="checkbox"/>	Josh Liao		
<input type="checkbox"/>	Jason Brown	<input type="checkbox"/>	Dave Mancuso		

Committee Facilitator:

J.D. Fischer

Time	Agenda Items	Tab	Lead
10:00-10:05 (5 min)	Welcome, call to order, and agenda review	1	J.D. Fischer, Board Manager Health Care Authority
10:05-10:15 (10 min)	Welcome from the Board		Sue Birch, Director and Chair Health Care Authority
10:15-10:30 (15 min)	Committee member and staff introductions		J.D. Fischer, Facilitator Health Care Authority
10:30-10:50 (20 min)	Open public meetings training	2	Katy Hatfield, Assistant Attorney General Attorney General's Office
10:50-11:05 (15 min)	Washington's health care cost growth benchmark legislation	3	Mich'I Needham, Chief Policy Officer Health Care Authority
11:05-11:15 (10 min)	Public comment		J.D. Fischer, Facilitator Health Care Authority
11:15-11:30 (15 min)	Introduction to Health Care Cost Growth Benchmarks	4	AnnaLisa Gellerman, Board Manager Health Care Authority
11:30-11:55 (25 min)	Future topics and design decisions requiring committee input	5	J.D. Fischer, Facilitator Health Care Authority
11:55-12:00 (5 min)	Wrap-up and adjournment		J.D. Fischer, Facilitator 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 Advisory Committee of Providers and Carriers will be conducted virtually.

Open public meetings training

TAB 2

Open Public Meetings



Health Care Cost Transparency Board

Presented by:

Katy Hatfield

Assistant Attorney General

July 2021



Washington's Open Public Meetings Act (OPMA)

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



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

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



Transparency builds public confidence in government.

* This is not medical advice.

Court's Interpretation of OPMA

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

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

OPMA Applies To:

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



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

RCW 70.390.030(7)

What Meetings Are Subject to OPMA?

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

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

What Is a Governing Body?

Under the OPMA, the governing body is either:

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

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

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

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

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

RCW 70.390.030

What Is a Meeting?

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



Travel and Gathering

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

RCW 42.30.070



Regular Meetings



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

RCW 42.30.070; RCW 42.30.075, RCW 42.30.077

Special Meetings



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

Emergency Meetings

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

RCW 42.30.080(4)



Public Attendance

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

RCW 42.30.040

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

Op. Att'y Gen. 15 (1998)

- No public comment period required by OPMA



Interruptions and Disruptions

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

RCW 42.30.050

Executive Session

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

RCW 42.30.110



Executive Sessions

Specified Purposes Set Out in OPMA.

Includes, for Example:



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

RCW 42.30.110

Final Action

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

RCW 42.30.060; RCW 42.30.020



Meeting Minutes

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

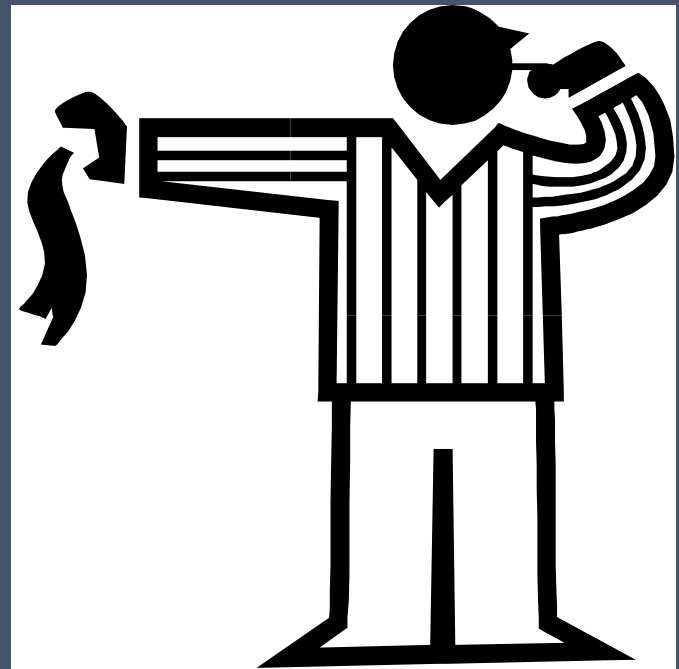
RCW 42.30.035



Penalties for Violating the OPMA

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

*RCW 42.30.120; RCW 42.30.130;
RCW 42.30.060*





Recent Headlines

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

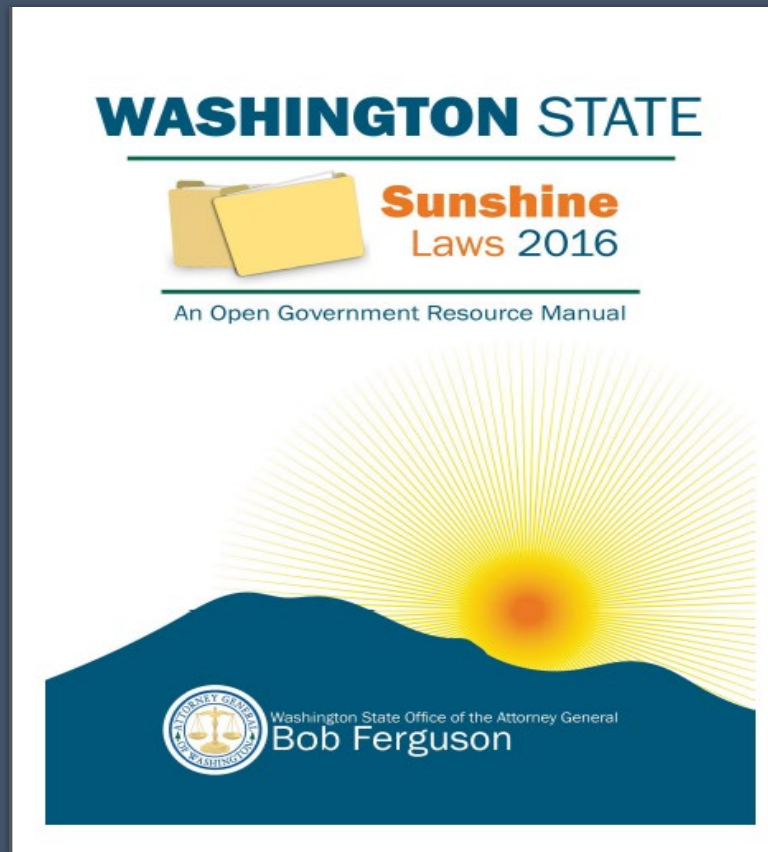
Risk Management Tips

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

Open Government Training

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

AGO Open Government Resource Manual



Municipal Research & Service Center

OPMA – AGENCY OBLIGATIONS: A STARTING POINT

PRACTICE TIPS

For Local Government Success



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

Basic Requirements

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

Position in Agency

- Member of a governing body
 - City or Town Councilmember or Mayor
 - County Commissioner or County Councilmember
 - Special Purpose District Commissioner/Board Member

- Member of a subagency created by ordinance or legislative action
 - Planning Commission
 - Library Board
 - Port Board
 - Civil Service Commission

- Member of a committee
 - Committees that act on behalf of the governing body or make public comment

Agency staff

Penalties for Noncompliance

- Actions null and void. Any action taken at a meeting that is not in compliance with the OPMA is void. RCW 42.30.060(1).
- Personal liability. Potential personal liability of \$100 for each meeting that it violates the OPMA. RCW 42.30.120(1).
- Agency liability. Any person who prevails against an agency is entitled to recover all costs, including attorney fees, incurred in connection with the lawsuit. RCW 42.30.120(2).

OPMA Training Requirements, Effective July 1, 2014

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

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

OPMA – NOTICE REQUIREMENTS

PRACTICE TIPS

For Local Government Success



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

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

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

OPMA – EXECUTIVE SESSIONS

CHECKLIST

For Local Government Success



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

Requirement	Completed/ Applicable
Regular or special meeting.	<input type="checkbox"/>
Purpose of the executive session.	<input type="checkbox"/>
Time the executive session will end.	<input type="checkbox"/>
Legal counsel (if required. [See topics below and on the page regarding legal counsel].)	<input type="checkbox"/>
Confidentiality (reminded that discussions are confidential).	<input type="checkbox"/>
Discussions that are prohibited in RCW 42.30.110(1) can be discussed in executive session.	<input type="checkbox"/>
Disclosure that disclosure would increase the likelihood of such injury or damage.	<input type="checkbox"/>
Real estate (sale or lease of real estate if there's a conflict of interest. RCW 42.30.110(1)(c). Property must be taken in open session.)	<input type="checkbox"/>
Contract (RCW 42.30.110(1)(d). See back of page.)	<input type="checkbox"/>
Personnel (officer or employee. RCW 42.30.110(1)(f). Must be in open session.)	<input type="checkbox"/>
Records (RCW 42.30.110(1)(g). See back of page.)	<input type="checkbox"/>
Gifts (gift or benefit to elective office.)	<input type="checkbox"/>
Special meetings (RCW 42.30.110(1)(i). See back of page.)	<input type="checkbox"/>
Website (RCW 42.30.110(1)(j). See back of page.)	<input type="checkbox"/>
Website (RCW 42.30.110(1)(k). See back of page.)	<input type="checkbox"/>
Website (RCW 42.30.110(1)(l). See back of page.)	<input type="checkbox"/>
Website (RCW 42.30.110(1)(m). See back of page.)	<input type="checkbox"/>
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Website (RCW 42.30.110(1)(y). See back of page.)	<input type="checkbox"/>
Website (RCW 42.30.110(1)(z). See back of page.)	<input type="checkbox"/>

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

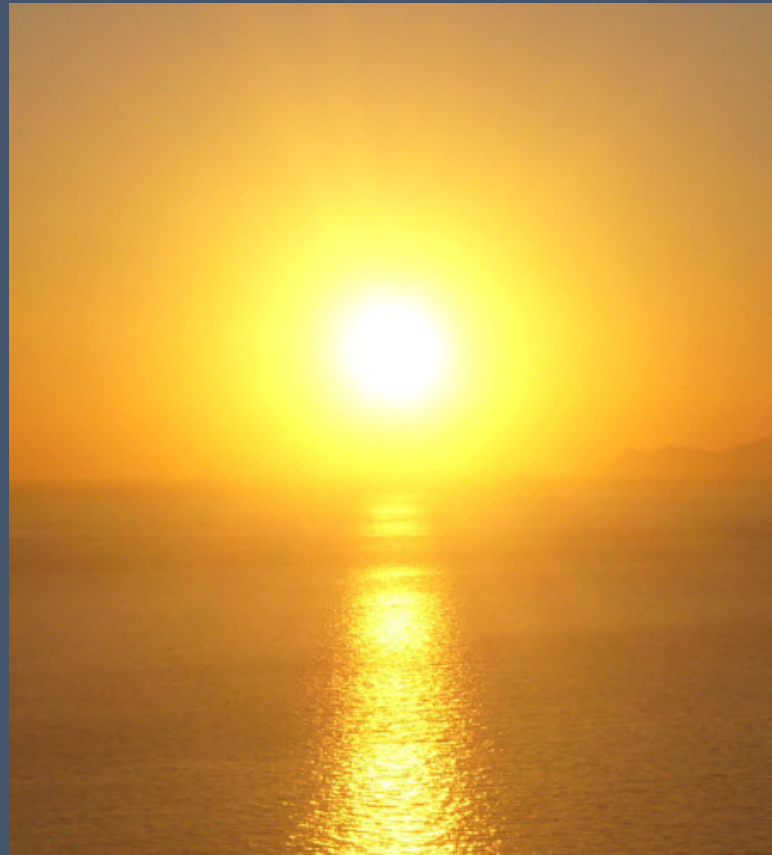
COVID-19 Impacts on OPMA

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

COVID-19 Impacts on OPMA (cont.)

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

Thank you!



Washington's health care cost growth benchmark legislation

TAB 3



Washington's health care cost growth benchmark legislation

Advisory Committee on Data Issues
July 8, 2021

Legislative charge – HB 2457

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

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

Legislative charge – HB 2457 (cont'd)

In addition, the board must:

- **Appoint** advisory committees to provide input on topics relevant to the work of the board, including two required committees:
 - Advisory Committee of Health Care Providers and Carriers
 - Advisory Committee on Data Issues
- **Report** to the Governor and the Legislature on:
 - Progress in development of the health care cost growth benchmark (by August 1, 2021).
 - Beginning August 1, 2022, report annually on total health care expenditures and benchmark.

Other activities to complement the benchmark

- Some states have augmented their benchmark program with other strategies:
 - DE also established a quality benchmark program.
 - CT set a primary care spending target and will set quality benchmarks for 2022.
- While HB 2457 focuses solely on establishing cost growth benchmarks, HCA is separately working on complementary strategies.
- The board and advisory committees will also discuss complementary initiatives that could help the benchmark program be more successful.

Introduction to health care cost growth benchmarks

TAB 4



Introduction to health care cost growth benchmarks

Advisory Committee on Data Issues
July 8, 2021



What is a cost growth benchmark and why pursue one?

- A health care cost growth benchmark is a per annum rate-of-growth target for health care costs for a given state.



**Average Per Capita
Health Care Cost Growth
2015-2019:
4.1%¹**

**Average Per Capita GDP
Growth
2015-2019:
3.5%²**

**Average Hourly Wage
Growth 2015-2019:
2.6%³**

SOURCES:

1) Centers for Medicare & Medicaid Services, [National Health Expenditure Accounts](#), accessed February 17, 2021.

2) U.S. Bureau of Economic Analysis, Gross Domestic Product [GDP], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/GDP>, February 16, 2021.

3) U.S. Bureau of Labor Statistics, Average Hourly Earnings of All Employees, Total Private [CES0500000003], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/CES0500000003>, February 16, 2021.

States pursued cost growth benchmarks to curb health care spending growth

- **MA:** State-purchased health care rose 40% over 12 years while spending on other services was reduced by 17% on average.
- **OR:** health insurance premiums cost 29% of a family's total income.
- **DE:** the state's per capita total health spending was the third highest in the nation.
- **RI:** 7 of 10 health insurance filings in the large and small group market outpaced annual wage growth.
- **CT:** health care costs outpaced growth in the state's economy, with personal health care expenditures taking up a larger portion of the state's gross domestic product (GDP).

2021 benchmark values for other cost growth benchmark states

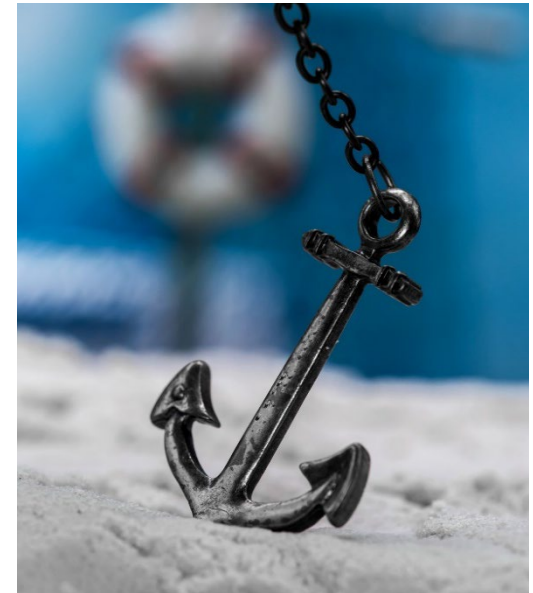
MA	DE	RI	OR	CT
3.1% (PGSP-0.5%)	3.25% (PGSP+0.25%)	3.2% (PGSP)	3.4% (roughly...average annual change of nominal per capita gross state product and median wage over the last 20 years)	3.4% (20% PGSP/80% Median Income + 0.5%)

- MA previously dropped its benchmark from 3.6% to 3.1%.
- CT will drop to 2.9% by 2023.
- DE will drop to 3.0% by 2022.
- OR will drop to 3.0% by 2026.

PGSP = potential gross state product, a forecast of state economic growth years 5-10 into the future

The logic model for a cost growth benchmark

- Setting a public benchmark for health care spending growth alone will not slow rate of growth.
- A cost growth benchmark serves as an anchor, establishing an expectation that can serve as the basis for transparency at the state, insurer and provider levels.
- To be effective, it must be complemented by supporting strategies if it is likely to be effective.



The logic model for a cost growth benchmark



The board's charge: THCE

- Determine types and sources of data necessary to calculate total health care expenditures (THCE) and cost growth and establish benchmark
 - Identify existing data sources and primarily rely on them when possible, e.g., APCD and pharmacy reporting.
 - Determine the means and methods of capturing the data.
 - Accept recommendations from both advisory committees regarding the value and feasibility of reporting various categories, including:
 - Urban and rural
 - Public sector and private sector,
 - Major categories of health services, including prescription drugs, inpatient treatment and outpatient treatment.

The board's charge: THCE

- Calculate THCE
 - Statewide and by geographic rating area.
 - For each health provider or provider system.
 - Taking into account health status, utilization, service intensity, and regional differences in input prices.
- Annual Report by:
 - Market segment
 - Per capita
 - Other categories recommended by Advisory Committees.

The board's charge: Cost driver analysis

- Cost drivers should include (where feasible data exists):
 - Labor: wages, benefits, salaries
 - Capital costs
 - Supply costs (including drugs)
 - Uncompensated care
 - Administrative and compliance costs
 - Federal, state, and local taxes
 - Capacity, funding, and access to post acute care, long-term services and supports, and housing
 - Regional differences in input prices

Future topics and design decisions requiring committee input

TAB 5



Future topics and design decisions

July 8, 2021



Benchmark performance evaluation design decisions

- Minimum payer/provider size for requiring data submission and publicly reporting performance.
- Application of risk adjustment.
- Strategies for dealing with high-cost outliers.
- Using standard deviation/variance/confidence interval/statistical testing to evaluate whether the benchmark was achieved.
- Methodology for attributing providers to large provider organizations.

Data use strategy design decisions

- Goals of the data use strategy.
- Identifying types of analyses and data sources.
- Interpretation of analyses.

What is a “data use strategy?”

- A “data use strategy” is a plan to purposely leverage state data to achieve state health policy objectives.
- In this instance, we are discussing how to leverage the state’s All Payer Claims Database (APCD), and perhaps other data sources, to make sure the aims of HB 2457 are achieved.

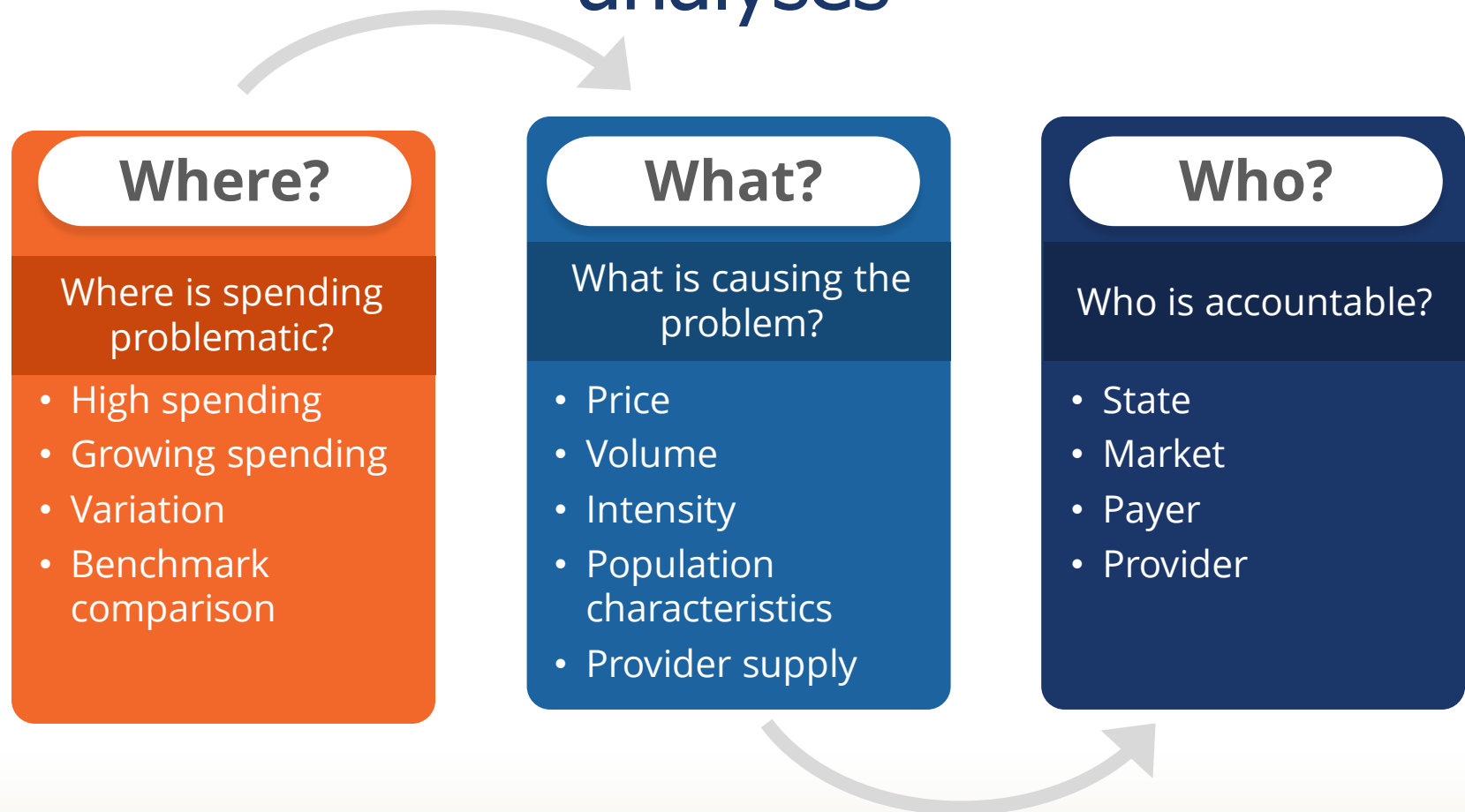
The rationale for a data use strategy

- Making progress in reducing cost growth to achieve the benchmark requires information on where costs are **high, growing rapidly, and variable**.
- By analyzing data, the HCA can shine light on these three areas and identify what spending categories warrant greatest attention for **moving the needle on the cost growth benchmark**.

The rationale for a data use strategy (cont.)

- While identifying opportunities to reduce cost growth is a priority, it should not be the only focus. Additional analyses should:
 - Examine **cost growth benchmark impact**, including identification of any unintended adverse consequences of the benchmark.
 - Examine whether consumer **out-of-pocket spending** is being positively affected by benchmark implementation.
 - Look at **health disparities** (in utilization, cost and quality) and at **quality** more generally.

Framework for data use strategy analyses



Request data example

Reporting Year	Provider Organization	Note as Commercial/Medicaid/Medicare	Member Months	Risk Adjustment Score	Claims: Hospital Inpatient	Claims: Hospital Outpatient	Claims: Professional, Primary Care Providers	Claims: Professional, Specialty Providers

Request data example (cont.)

Claims: Professional, Behavior Health Providers	Claims: Professional, Other Providers	Claims: Long Term Care	Claims: Retail Pharmacy	Claims: Other	Non-Claims: Capitation and Risk Settlements	Non-Claims: Performance Incentive Payments	Non-Claims: Care Management	Non-Claims: Recovery	Non-Claims: Other

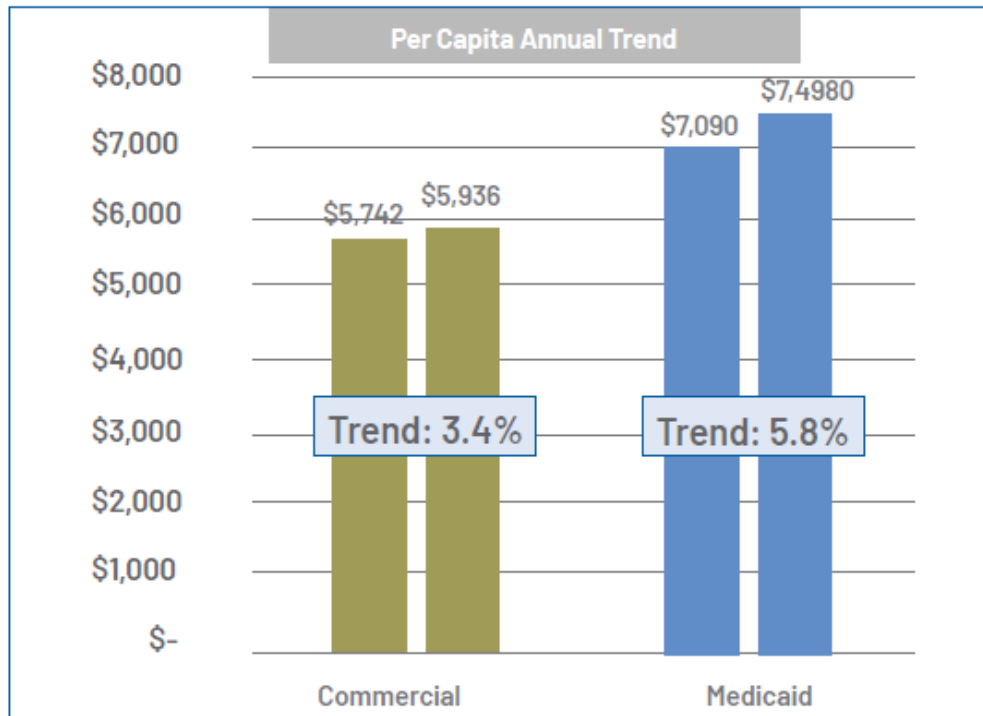
Request data example (cont.)

Total Claims Expenses	Total Non-Claims Expenses	Unadjusted Total Expenses	Unadjusted TME PMPM	Risk Adjusted Total Expenses	Risk Adjusted TME PMPM
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Recommended standard analytic reports

Report No.	Report Description	In-Depth Trend Analysis
1	Spend by Market (PMPM)	None
2	Trend by Market (Per Capita)	Price, Volume, Intensity
3	Spend by Geography (PMPM)	Price, Volume
4	Trend by Geography	Price, Volume, Intensity
5	Spend by Service Category	Price, Volume
6	Trend by Service Category	Price, Volume, Intensity
7	Spend by Health Condition	Price, Volume
8	Trend by Health Condition	Price, Volume, Intensity
9	Spend by Demographic Variables	Price, Volume
10	Trend by Demographic Variables	Price, Volume, Intensity
11	Cost Growth Benchmark Unintended Consequences	N/A

Reports 1 and 2: Spend and trend by market

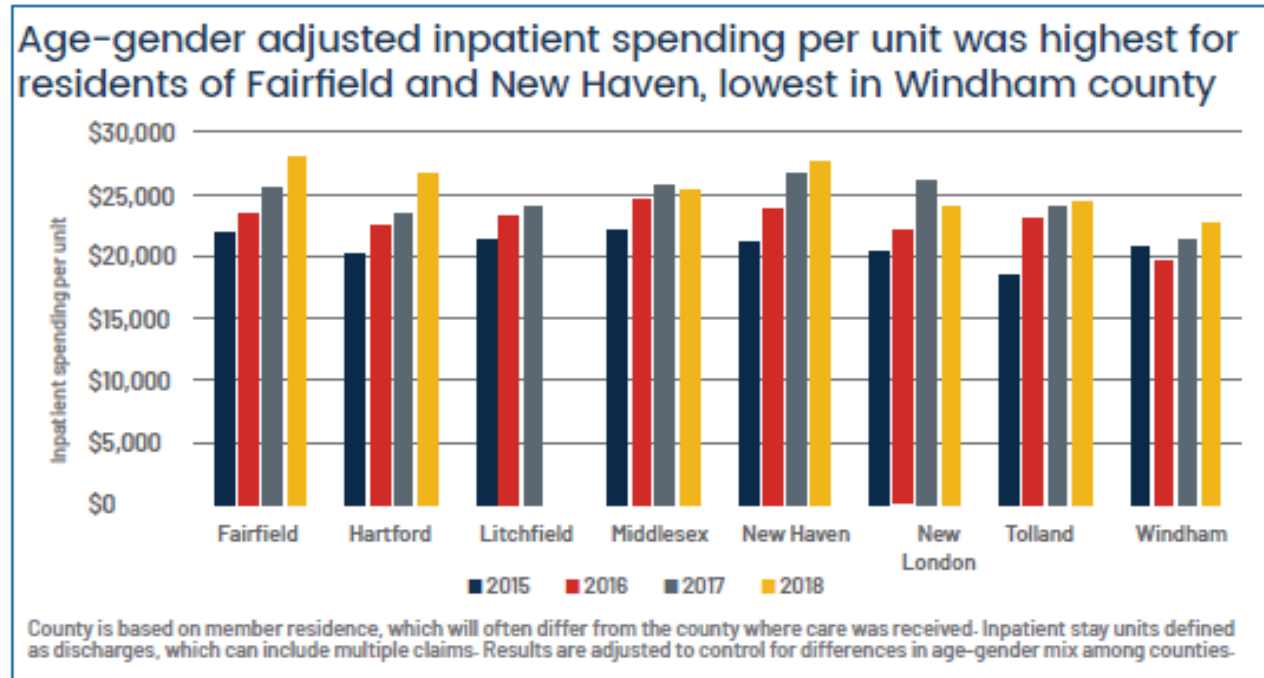


- These reports provide the highest level of analysis of spending and spending growth by commercial, Medicaid, and Medicare markets.

Source: Rhode Island Office of the Health Insurance Commissioner. *Baseline 2017-2018 Performance Against the Cost Growth Target*. <http://www.ohic.ri.gov/documents/2020/November/Cost%20Trends/steering%20committee%202020-8-17.pptx>. August 17, 2020. Accessed February 24, 2021.

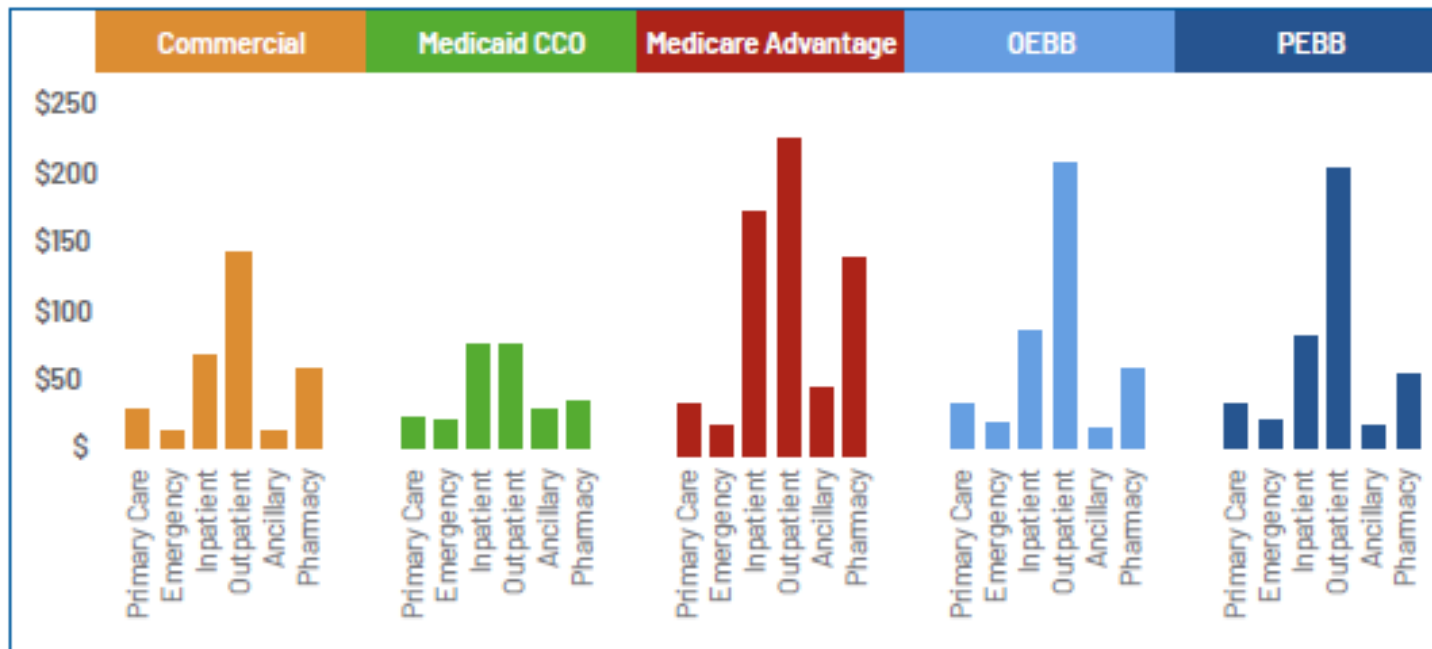
Reports 3 and 4: Spend and trend by geography

- These reports look at market spending by state geography.



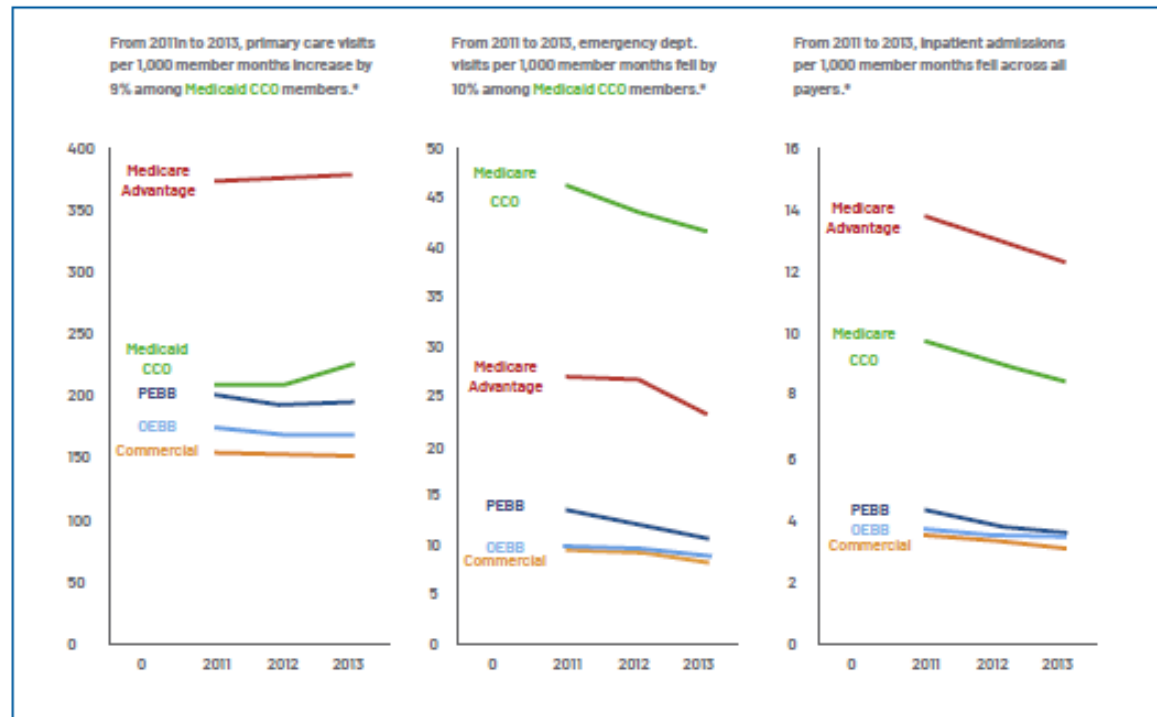
Source: Connecticut Office of Health Strategy. *CT Commercial Cost Trends*. Analysis of the Connecticut commercial market performed by Mathematica. January 21, 2021.

Reports 5 and 6: Spend and trend by service category



Source: Oregon Health Authority. *Leading Indicators for Oregon's Health Care Transformation: Quarterly Data from the All-Payer, All-Claims Reporting Program.* https://www.oregon.gov/oha/HPA/ANALYTICS/APAC_Page_Docs/Leading-Indicators-Report-April-2015.pdf. April 30, 2015. Accessed February 24, 2021.

Reports 5 and 6: Spend and trend by service category



Source: Oregon Health Authority. *Leading Indicators for Oregon's Health Care Transformation: Quarterly Data from the All-Payer, All-Claims Reporting Program.* https://www.oregon.gov/oha/HPA/ANALYTICS/APAC_Page_Docs/Leading-Indicators-Report-April-2015.pdf. April 30, 2015. Accessed February 24, 2021.

Reports 7 and 8: Spend and trend by health condition

Condition	2018		
	Members with condition	%	PMPY for members with this condition
All members	455,780	100.0	\$6,151
Hyperlipidemia	73,081	16.0	\$11,842
Hypertension	70,419	15.5	\$13,739
Rheumatoid Arthritis/Osteoarthritis	67,943	14.9	\$13,866
Depression	50,979	11.2	\$13,501
Diabetes	28,608	6.3	\$14,197
Anemia	26,723	5.9	\$25,355
Acquired Hypothyroidism	25,918	5.7	\$12,911
Glaucoma	18,035	4.0	\$9,004
Chronic Kidney Disease	17,732	3.9	\$24,029
Asthma	17,500	3.8	\$16,887
One or more of 27 chronic conditions	218,598	48.0	\$10,336
Two or more of 27 chronic conditions	115,855	25.4	\$14,379

Source: Connecticut Office of Health Strategy. *CT Commercial Cost Trends*. Analysis of the Connecticut commercial market performed by Mathematica. January 21, 2021.

Reports 9 and 10: Spend and trend by demographic variable

Decile	Percentage white	Median family income	PMPM (adj.)	ED visit rate (adj.)	Percentage with condition				
					One or more conditions	Two or more conditions	Hyper-tension	Diabetes	Asthma
All	0 – 100	\$97,310	\$526.69	494	0.48	0.25	15.5	6.3	3.8
1	0 – 31	\$45,663	\$545.33	736	0.51	0.30	22.2	11.8	5.6
2	31 – 50	\$68,060	\$561.26	606	0.49	0.27	18.1	8.6	4.5
3	50 – 61	\$82,466	\$562.29	591	0.50	0.28	17.3	7.9	4.6
4	61 – 71	\$105,442	\$494.28	477	0.48	0.26	15.2	6.7	3.7
5	71 – 77	\$103,407	\$497.68	494	0.48	0.26	16.1	6.6	3.9
6	77 – 82	\$122,067	\$499.30	434	0.47	0.25	14.1	5.4	3.5
7	83 – 87	\$149,181	\$506.68	413	0.46	0.23	13.6	5.0	3.5
8	87 – 91	\$127,302	\$481.19	457	0.47	0.24	14.1	5.0	3.4
9	91 – 94	\$118,223	\$484.70	493	0.48	0.25	14.7	5.0	3.5
10	94 – 100	\$112,875	\$526.69	476	0.49	0.26	15.4	5.1	3.7
Ratio of 1st to 10th decile		0.40	1.09	1.55	1.03	1.17	1.44	2.33	1.51

Source: Connecticut Office of Health Strategy. *CT Commercial Cost Trends. Analysis of the Connecticut commercial market performed by Mathematica. January 21, 2021.*

Report 11: Cost growth benchmark unintended consequences

States should consider changes over time (pre/post benchmark) in the following areas:

1. Quality measures assessing utilization of preventive and chronic illness care.
2. Patient self-reported access to care, including but not limited to access to specialty care.

Report 11: Cost growth benchmark unintended consequences (cont.)

States should consider changes over time (pre/post benchmark) in the following areas:

3. Provider patient panel composition (to detect possible efforts to shun high-need, high-cost patients in lieu of healthier patients).
4. Specific-and disparate-impact of the benchmark on groups that have been economically and socially marginalized, people with disabilities, and Black, Indigenous, and people of color (BIPOC).

Recommended supplemental reports: Phase 2

- Provider entity-and payer-level analysis
- Variation across payers, providers, and geographies
- Supply as a cost driver
- Market consolidation as a cost driver
- Pharmacy cost drivers
- Out-of-pocket spending
- Benchmark analysis
- Site of care
- Professional specialty analysis

Recommended supplemental reports: Phase 2

- Provider entity-and payer-level analysis
- Variation across payers, providers, and geographies
- Supply as a cost driver
- Market consolidation as a cost driver
- Pharmacy cost drivers
- Out-of-pocket spending
- Benchmark analysis
- Site of care
- Professional specialty analysis

**Background and topical material:
HB 2457**

TAB 6

CERTIFICATION OF ENROLLMENT
SECOND SUBSTITUTE HOUSE BILL 2457

Chapter 340, Laws of 2020

66th Legislature
2020 Regular Session

HEALTH CARE COST TRANSPARENCY BOARD

EFFECTIVE DATE: June 11, 2020

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

LAURIE JINKINS

**Speaker of the House of
Representatives**

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

CYRUS HABIB

President of the Senate

Approved April 3, 2020 1:49 PM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

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

BERNARD DEAN

Chief Clerk

FILED

April 3, 2020

**Secretary of State
State of Washington**

SECOND SUBSTITUTE HOUSE BILL 2457

AS AMENDED BY THE SENATE

Passed Legislature - 2020 Regular Session

State of Washington 66th Legislature 2020 Regular Session

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

READ FIRST TIME 02/11/20.

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

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

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

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

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

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

14 (a) Medical;

15 (b) Behavioral;

16 (c) Substance use disorder;

17 (d) Mental health;

18 (e) Surgical;

19 (f) Optometric;

20 (g) Dental;

21 (h) Podiatric;

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

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

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

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

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

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

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

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

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

22 (f) Two members representing consumers;

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

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

26 (i) One member representing small businesses;

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

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

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

33 (2) The governor:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (2) The board shall:

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

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

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

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

12 (i) Statewide and by geographic rating area;

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

22 (iii) By market segment;

23 (iv) Per capita; and

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

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

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

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

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

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

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

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

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

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

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

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

Passed by the House March 9, 2020.

Passed by the Senate March 6, 2020.

Approved by the Governor April 3, 2020.

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

--- END ---

Background and topical material: Peterson-Milbank Program description

TAB 7



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

Program Description

August 2020

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

Background

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

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

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

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

Peterson-Milbank Program Overview

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

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

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

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

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

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

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

State participation process

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

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

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

Upon review of these materials, we will:

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

Contact Information:

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

Additional Resources

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

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

**Background and topical material:
Peterson-Milbank Washington
acceptance letter**

TAB 8



February 9, 2021

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

Sent via email

Dear Ms. Birch:

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

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

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

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

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

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

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

Sincerely,



Rachel Block

Milbank Memorial Fund
Program Officer

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

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

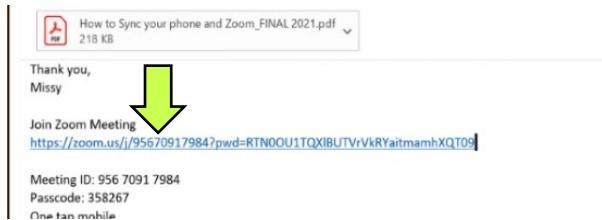
Additional resources: How to join a Zoom meeting

TAB 9

How to join a Zoom meeting

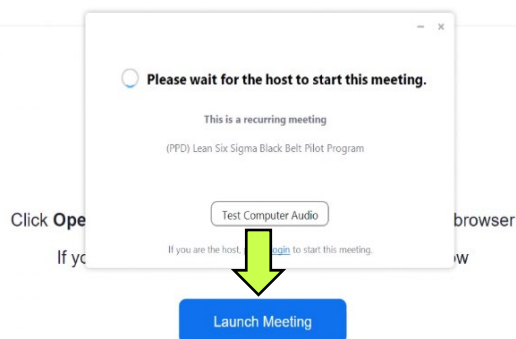
1. Find the meeting on your calendar and open it.

Click the Zoom hyperlink in the body of your invitation.

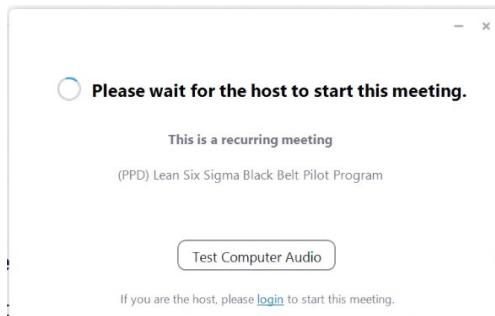


2. Your browser will automatically download Zoom for you

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

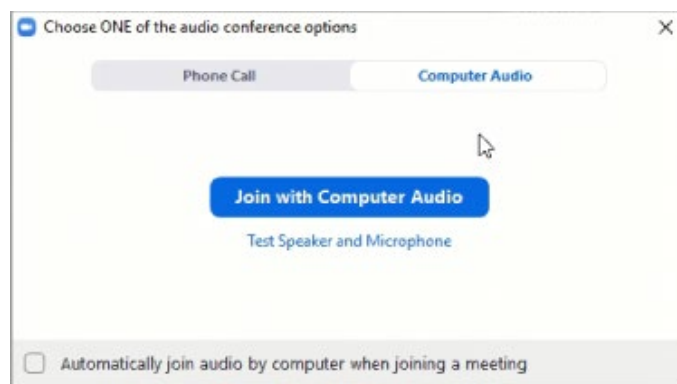


3. You will be placed in the waiting room until the meeting begins.



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

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



Already downloaded Zoom?

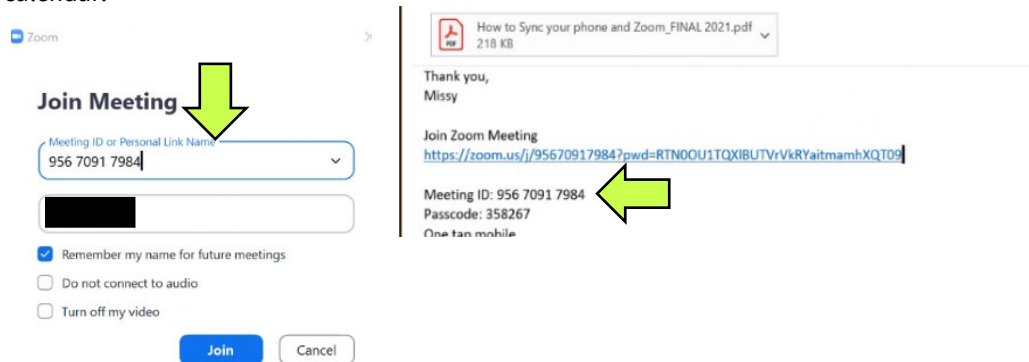
1. Open your application.

Click *Join a Meeting*.



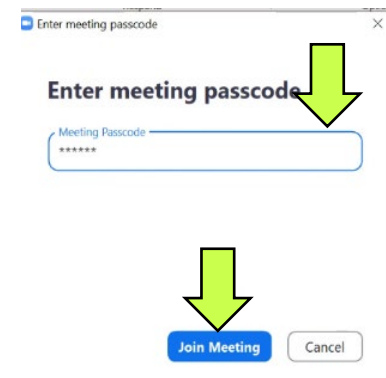
2. Enter the meeting ID.

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



3. Enter the passcode.

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



**Additional resources:
2021 board and advisory
committee's schedule**

TAB 10

HCCTB Meetings and Committees

	Date	Time	Location
Board Meeting (February)	February 18	2-4	Zoom
Board Meeting (March)	March 18	2-4	Zoom
Board Meeting (April)	April 13	10-12	Zoom
Advisory Committee of Health Care Providers and Carriers	April 27	1-3	Zoom
Board Meeting (May)	May 13	9-11	Zoom
Advisory Committee of Health Care Providers and Carriers	May 25	1:30-3:30	Zoom
Board Meeting (June)	June 16	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	June 29	10-12	Zoom
Advisory Committee on Data Issues	July 8	10-12	Zoom
Board Meeting (July)	July 19	2-4	Zoom
Advisory Committee of Health Care Providers and Carriers	July 29	2-4	Zoom
Advisory Committee on Data Issues	August 10	10-12	Zoom
Board Meeting (August)	August 17	2-4	Zoom
Advisory Committee on Data Issues	September 8	2-4	
Board Meeting (September)	September 14	2-4	
Advisory Committee of Health Care Providers and Carriers	September 30	10-12	
Board Meeting (October)	October 14	10-12	
Advisory Committee on Data Issues	October 28	2-4	
Board Meeting (November)	November 17	2-4	
Board Meeting (December)	December 15	2-4	
Advisory Committee on Data Issues	January 27, 2022	2-4	

**Additional resources:
Advisory Committee on Data
Issues members**

TAB 11

Name	Title	Place of Business
Megan Atkinson	Chief Financial Officer	Health Care Authority
Amanda Avalos	Deputy, Enterprise Analytics, Research, and Reporting	Health Care Authority
Allison Bailey	Executive Director, Revenue Strategy and Analysis	MultiCare Health System
Jonathan Bennett	Vice President, Data Analytics, and IT Services	Washington State Hospital Association
Purav Bhatt	Regional VP Operations, Management, and Innovation	OptumCare Washington
Bruce Brazier	Administrative Services Director	Peninsula Community Health Services
Jason Brown	Budget Assistant	Office of Financial Management
Jerome Dugan	Assistant Professor, Department of Health Services	University of Washington
Leah Hole-Marshall	General Counsel and Chief Strategist	Health Benefit Exchange
Karen Johnson	Director, Performance Improvement, and Innovation	Washington Health Alliance
Scott Juergens	Division Director, Payer Analytics and Economics	Virginia Mason Franciscan Health
Lichiou Lee	Chief Actuary	Office of the Insurance Commissioner
Josh Liao	Medical Director of Payment Strategy	University of Washington
Dave Mancuso	Director, Research and Data Analysis Division	DSHS, Research and Data Analysis
Ana Morales	National Director, APM Program	United Healthcare
Thea Mounts	Senior Forecast and Research Manager	Office of Financial Management
Hunter Plumer	Senior Consultant	HealthTrends
Mark Pregler	Director, Data Management and Analytics	Washington Health Alliance
Julie Sylvester	Senior Consultant, Contracting and Payer Relations	University of Washington Medicine

**Additional resources:
Board members and consultants'
biographies**

TAB 12

Member biographies



Susan E. Birch, MBA, BSN, RN

Director and chair

Washington State Health Care Authority

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

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

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

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

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

Lois C. Cook
Managing member
America's Phone Guys

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



John Doyle
Chief Financial Officer
America's Phone Guys

John Doyle currently serves as Chief Financial Officer for Starr Ranch Growers. Starr Ranch is a vertically integrated apple and cherry grower, packer, and brokerage firm. John is responsible for all financial activities of approximately 4,000 acres of orchard, two packing facilities, and \$450 million of fruit sales. Prior to joining Starr Ranch in 2019, John was Chief Financial Officer for Confluence Health/Wenatchee Valley Medical Group, a fully integrated health system located in Wenatchee WA, from 2003-2019.

John served on the Board of Directors for Health Alliance Northwest while employed at Confluence Health and has served as a Director for Cashmere Valley Bank since 2012.



Bianca Frogner, PhD

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

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



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

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

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





Sonja Kellen
Senior director
Global Health and Wellness
Microsoft Corporation

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

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

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

Pam MacEwan
Chief executive officer
Washington Health Benefit Exchange

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

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





Molly Nollette

Deputy commissioner

Washington State Office of the Insurance Commissioner

Molly Nollette is deputy insurance commissioner of the Rates, Forms, and Provider Networks division, serving Insurance Commissioner Mike Kreidler. She joined the Office of Insurance Commissioner (OIC) in 2010 to work on the newly passed Affordable Care Act and was appointed to her current position in 2013. Molly and her team are responsible for ensuring that

Health and Disability, Property and Casualty, and Life and Annuities insurance plans sold in Washington comply with state and federal law and regulations.

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

Mark Siegel

Costco Wholesale Corporation

Director, Employee Benefits





Margaret Stanley
Consumer representative

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

Ms. Stanley also served as the executive director of the Puget Sound Health Alliance, now the Washington Health Alliance. She has held executive positions at the California Public Employees' Retirement System (CalPERS), Group Health Cooperative, Premera Blue Cross, and Regence BlueShield. She has served on many health care boards. She has a master's degree in health care administration from the University of Washington.

Kim Wallace
Medical administrator
Office of the Medical Director
Washington State Department of Labor & Industries

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





Carol Wilmes

Director
Member Pooling Programs
Association of Washington Cities

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

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

Edwin Wong, PhD

Research associate professor
Department of Health Services
University of Washington

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



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





Laura Kate Zaichkin

Director

Health Plan Performance and Strategy

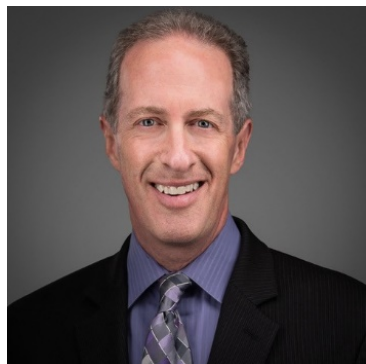
SEIU Benefits Group

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

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



Consultant biographies



Michael H. Bailit, MBA

President
Bailit Health

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

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

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

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

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

Rachel Block

Program officer
Milbank Memorial Fund

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



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

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



January Angeles, MPP

Senior consultant
Bailit Health

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

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

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

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

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

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