Health Care Cost Transparency Board

To ensure health care affordability for all Washingtonians

October 18, 2023 Meeting

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board
Meeting Materials Book

October 18, 2023
2:00 p.m. – 4:00 p.m.

(Hybrid attendance options)

Agenda and Presentations

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

HEALTH CARE COST TRANSPARENCY BOARD
AGENDA

October 18, 2023
2:00 – 4:00 p.m.
Hybrid Meeting

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

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome and roll call	1	Sue Birch, Director Health Care Authority
2:05 – 2:10 (5 min)	Approval of June meeting summary	2	Mandy Weeks-Green Health Care Authority
2:10 – 2:20 (10 min)	Public comment	3	Sue Birch, Director Health Care Authority
2:20 - 2:30 (10 min)	Primary Care Non-Claims Based Measurement Recommendations • **Discussion and vote**	4	Dr. Judy Zerzan-Thul, Medical Director Health Care Authority
2:30 – 3:05 (35 min)	Washington State Health Care Affordability Activities • Introduction and Overview • Health Benefit Exchange Strategies to Approach Rising Costs • Office of the Insurance Commissioner Affordability Activities	5	Mich'l Needham, Health Care Authority Laura Kate Zaichkin, Health Benefit Exchange Jane Beyer, Office of the Insurance Commissioner and Board Member
3:05 – 3:25 (20 min)	Benchmark and Analytic Status Report	6	Vishal Chaudhry, Chief Data Officer Health Care Authority
3:25 - 4:00 (35 min)	Analytic Support Initiative	7	Joseph L Dieleman, Associate Professor for Health Metrics and Evaluation | University of Washington
4:00	Adjourn		Sue Birch, Director Health Care Authority

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

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

June 21, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

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

Members present

Sue Birch, Chair
Eileen Cody
Lois Cook
Bianca Frogner
Leah Hole-Marshall
Molly Nollette
Margaret Stanley
Kim Wallace
Edwin Wong

Members absent

Jodi Joyce
Mark Siegel
Carol Wilmes

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:01 p.m.

Agenda items

Welcome, roll call, and agenda review

Chair Birch called the meeting to order and reviewed the agenda.

Approval of April meeting summary

The board approved the Meeting Summary from the April 2023 meeting.

Topics for Today

The main topics were a presentation on the new analytic support initiative, an overview of the board's current legislative reports, and a presentation on primary care claims-based measurement recommendations.

Analytic Support Initiative Presentation

Joseph L. Dieleman, Associate Professor for Health Metrics and Evaluation, University of Washington

Joseph Dieleman introduced the Institute for Health Metrics and Evaluation (IHME) and the analytical support initiative. IHME is charged with completing work related to measurements and health. IHME's previous projects connect closely with the report, *A Data Use Strategy for State Action to Address Health Care Cost Growth*, funded by the Peterson Center on Healthcare and Milbank Memorial Fund. The report posed the question of what data is needed and how it should be used to curve cost growth. The first part of the analytic initiative describes all the health care spending in Washington using ten key metrics and the second part uses a trends analysis to compare Washington's growth to other states and counties. The analysis reviews which geographic units, health conditions, markets, and service categories have the most growth and how changes in population, disease prevalence, service utilization, and prices contribute to spending growth. The project is externally funded by the Peterson Center on Healthcare and Gates Ventures and is a partnership between the Health Care Authority (HCA) and IHME, with IHME supplying analytical support to HCA. The project is expected to last from June 2023 to July 2025. Joseph Dieleman provided a brief overview of key deliverables and respective due dates.

Next, the committee heard an overview of the Disease Expenditure (DEX) research project and its findings, which include proportions of national personal health care spending for 161 health conditions and their growth rates over time. IHME conducted an analysis to understand why health care spending has been increasing. At the national level, the analysis reviewed all health care spending, diseases, and age groups and attributed cost growth to one of five categories. The analysis identified the factors driving the increases in spending (such as ambulatory care, pharmaceuticals, nursing facility care, and emergency departments) for specific health conditions. For its work with HCA, IHME will take a similar approach to its earlier analyses but with a focus on Washington. The initiative will access the Washington All Payer Claims Database (APCD), begin data landscaping (finding and understanding data sources unique to Washington), learn and receive feedback, and form an analytical strategy to act as a guide for the first year on the project.

Questions from board members:

One board member asked how IHME's work relates to and complements other current cost work e.g., OnPoint and hospital cost work. Chair Birch responded that IHME gives the board an additional perspective and supplements current efforts to better understand cost drivers and appropriate policy solutions. Joe Dieleman added that IHME's work is meant to be complementary with OnPoint and not contradictory.

Another board member asked if spending on diagnostic work and testing is included when a diagnosis is unknown. Joe Dieleman confirmed undiagnosed conditions and testing would be included.

Another board member asked about pharmacy spending and specialty drugs. Would specialty drugs be lumped into the service price, utilization, in inpatient and ambulatory care? Joe Dieleman affirmed specialty drugs would be integrated. There's a dedicated member on the IHME team responsible for tracking prescription drug costs.

Public Comment

Katerina LaMarche, Policy Director of the Washington State Hospital Association (WSHA), provided comments on behalf of Allison Bailey and on behalf of herself. Receiving meeting agendas close to the meeting time makes it difficult to prepare for public comment but the joint meeting materials were supplied well in advance. Allison is the Associate Vice President of revenue cycle at Multi-Care Health Care Health System and a member of the Advisory Committee on Data Issues. At the last board meeting, the state's consultants presented an overview of how performance for providers would be assessed against the benchmark. Which providers will be considered in what networks and what information will be provided to providers if they exceed the benchmark? Will there be data at the provider specific level on how to verify that information is correct, and will the data be detailed enough to

understand what changes need to be made to improve? The data must be specific, verifiable, and actionable. It is important that there is enough information for providers to know where and how to make changes if they exceed the benchmark. Not providing enough information and not providing specific verified data will set providers up to fail. On behalf of WSHA, Katerina asked two questions about the annual legislative report. Based on the agenda, the board will be voting to adopt the report and board and stakeholder feedback will be incorporated into the final draft. Will advisory committees have a chance to review and provide feedback to the board? Will the board have a chance to review the final draft with the incorporated feedback before submission? Chair Birch responded that there will be opportunities to provide feedback through public comment periods. As HCA gains more definitive information, updates will come through the committees to the board.

Jonathan Bennett, Vice President of Data Analytics and IT services at WSHA and a member of the Advisory Committee on Data Issues noted that during the April board meeting, an overview of how provider performance against benchmark was shared. This left the board and committee members with a lot of general and specific questions. It is unclear which providers will be measured against the benchmark. To improve the understanding of the performance measurement process by the board and providers, WSHA requests that HCA staff provide a follow-up presentation to provide additional clarity. Advisory committee members introduced a motion at the June combined meeting but due to timing, members were unable to act on this motion. WSHA urges the board not to wait for a formal motion but to move ahead with HCA staff and consultants to provide requested clarification. It's important for the board to have a comprehensive understanding of the benchmark method including both its strengths and weaknesses since it's one of the primary tools to control cost growth. It is imperative for providers to understand how they're being measured and what resources they can expect to receive throughout the process. HCA needs to build engagement with providers to provide information and resources to the board and its committees to understand how providers will be measured. Is there a clear path for providers to take if they exceed the benchmark? Chair Birch noted that the board and its committees have discussed methodologies many times at multiple committee and board meetings. These discussions will continue. HCA is currently working on the establishment of the baseline of the benchmark, which will not include a report on providers and carriers initially. In future years following the baseline report, RCW 70.390 requires the board to report annually on performance relative to the baseline benchmark at the state, health insurance market, individual payer, and large provider entity levels, but not for small or individual providers. Initially, HCA and the board are collecting only aggregate information.

Jim Freeburg, Patient Coalition of Washington expressed support for the board's deep dive on cost drivers and urged the board to proceed as quickly as possible on policy solutions. Consumers continue to be hurt by high health care spending with no relief on the horizon. Many may be aware of the recent premium increases proposed by the Office of the Insurance Commissioner (OIC), with more significant increases expected in future years. There is incredible variation in care, cost, and quality and significant room for improvement. The board shouldn't get stuck on methodology but should move forward with real action items. IHME's work will help the board achieve its goals sooner rather than later.

Ronnie Sure, President of Healthcare for All Washington voiced support for the board's partnership with IHME to look at comprehensive data.

One board member asked how letters received from WSHA and the Washington State Medical Association (WSMA) are processed by HCA staff and relayed to the board for input. Chair Birch responded that HCA would provide more information on the process later.

HCCTB's Legislative Reports: Cascade Select and Annual Update Report

Mandy Weeks-Green, Board Director, HCA
Laura Kate Zaichkin and Kristin Villas, Health Benefit Exchange (HBE)

Mandy Weeks-Green, Laura Kate Zaichkin, and Kristin Villas provided an overview of the draft Cascade Select Report. A Word version of the report was provided to the board for feedback. This report is part of a series of reports. HBE is currently analyzing public option plan rates paid to hospitals for in-network services and analyzing rates' potential impacts on hospital financial sustainability. The board's report analyzes the effect of enrollment in public option plans on consumers, including benefits, premiums, and cost-sharing amounts. HBE will provide recommendations to the Legislature based on both sets of analyses and will submit recommendations by December 1, 2023. The board's Cascade Select report doesn't include general recommendations on the public option or recommendations on procurement or standard plan design. Based on board member feedback, members highly ranked access to care, broad issues of affordability, premiums, and cost-sharing as areas of interest. Additional areas of interest included drivers of enrollment in public option plans, qualitative data from consumers, and drivers of variability in public option premium affordability. The board's report uses data from a variety of sources, including Exchange data from 2021 to 2023 spring enrollment reports, carrier rate filings from 2021 to 2023 from the OIC, other Cascade Care analyses, and qualitative information from reviews of Exchange surveys, reports, and enrollment partner feedback.

Laura Kate Zaichkin provided a brief overview of Cascade Care and reviewed some of the feedback received in the report. Cascade Care exists to increase access to high-quality, affordable health coverage on a healthy individual market. Cascade Care plans differ from non-standard plans which are designed by carriers and vary in deductibles and co-pays. Cascade Care plans have uniform benefits and offer more coverage. Cascade Care plans are high quality, low-cost, standard benefit plans available exclusively to Washington Healthplanfinder customers. Some plans are called Select Plans and are part of the public option. Public option plans provide the same predictable benefits as all other Cascade Care plans; however, public option plans include narrower provider networks and lower premiums in many counties. In addition to standard benefits, carriers in public option plans are required to meet higher quality standards and state defined reimbursement rates for providers. As of 2023, hospitals are required to contract with at least one public option plan. The goals are affordability, statewide access, and quality and equity, each of which are associated with a set of policy levers.

Kristin Villas provided an overview of the analysis of public option premiums and cost sharing. At the end of the latest open enrollment, 11 percent of Exchange customers were enrolled in public option plans, with new enrollees being more likely to enroll in the public option. Public option enrollees tend to be younger than non-public option enrollees and, in 2021 and 2023, had lower incomes. Lower premiums drive enrollment in the public option. The informal target for lower premiums in public plans is 10 percent lower than the next premium cost plan. While initially higher, public option plan premiums have consistently trended downward. The average public option premiums across all levels are lower than non-Cascade Care premiums for the first time in plan year 2023. Public option plans are the lowest-cost silver premium qualified health plans in 25 counties in 2023, up from 13 counties in 2022. Public option enrollees pay less out of pocket when using their benefits. Cost sharing is lower for high-value services like primary care. Deductibles are an average of $1,000 less than non-Cascade plan deductibles. The introduction of Cascade Care plans to the marketplace decreased deductibles across Exchange plans. Public option plan enrollees select plans with more generous coverage but with narrower networks and access. Early affordability analysis suggests that current provider reimbursement targets may not be enough to meaningfully reduce premiums. While enrollment has increased, public option plans are still not available statewide.

Board member questions:

One board member asked about the percentage of people buying non-standardized plans, and whether this can be broken down by income level. For counties that still don't have the public option, did plans indicate the problem, e.g., lack of providers? HCA and HBE are currently investigating counties that don't have the public option. HBE is also conducting an analysis of the effect of elimination of non-standard plans on the market that could address plan demographics.

Another board member asked for more information on networks and how they differ between standard and non-standard plans. So far, analysis has shown that networks are the same between standard and non-standard, but that public option plans are narrower.

Chair Birch asked for a motion to adopt the public option report with the understanding that additional feedback from the board and other stakeholders would be incorporated into the final draft. The motion passed unanimously.

Mandy Weeks-Green noted the inclusion of the draft of the board's annual cost report in the meeting materials. The board will receive a Word version for further review and feedback. Board members and other stakeholders have until July 6 to provide feedback. One board member requested that for future reports, the board receive a copy that includes final edits to vote on before submission to the Legislature. Chair Birch asked for a motion to adopt the final report, with the understanding that final edits will be incorporated into the final draft and, if there are concerns, that the report be brought back for an additional vote. The motion passed unanimously.

Primary Care Claims-Based Measurement Recommendations: Discussion and Vote

Dr. Judy Zerzan-Thul, Medical Director, HCA

Dr. Zerzan-Thul provided an update on the Advisory Committee on Primary Care's recommendations. So far, the committee has voted on a high-level definition and is in the process of finalizing measurement methods for assessing claims and non-claims-based spending. The committee hasn't settled yet on a broad versus narrow definition. To measure claims, the committee is looking at the who (providers), the what (services) and the where (location). Reviewing sample data will allow the committee to refine the codes. In the board's report to the Legislature, the committee previewed several possible data strategies to align with primary care committee members' preliminary interests. The committee is developing recommendations on how to achieve the 12 percent target. The committee will review non-claims-based data collection policies and general data barriers at the end of June. In July, the committee will review a sample data analysis to finalize the code set and primary care definition and will continue the discussions of policies to advance primary care spending. The committee will use the remainder of the year to develop a measurement implementation plan.

Chair Birch made a motion to adopt the draft recommendation for claims-based measurement. The motion was approved unanimously.

Adjournment

Chair Birch adjourned the meeting at 4:00 p.m.

Next meeting

October 18, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Tab 3

Washington State Health Care Authority

Public Comment

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Health Care Cost Transparency Board

To ensure health care affordability for all Washingtonians.

Answers to Questions from the Advisory Committee Members

A Member in both the Advisory Committee on Data Issues (Jonathan Bennett with the Washington State Hospital Association) and Advisory Committee of Health Care Providers and Carriers (Mika Sinanan representating the Washington State Medical Association) motioned to request that the Board respond to the questions below. Neither motion passed within the Committees as HCA Staff offered to provide responses to the questions to assist the Committees. Below are the questions and responses.

Important:
The benchmark analysis is currently measuring the baseline year. This means that when this analysis is complete there will only be reporting on state and market level information and includes years 2017-2019. There will be no reporting on carriers or large providers.

Background

The Health Care Cost Transparency Board is responsible for reducing the state's health care cost growth by:

1. Determining the state's total health care expenditures.
2. Identifying cost trends and cost drivers in the health care system.
3. Setting a health care cost growth benchmark for providers and payers.
4. Reporting annually to the Legislature, including providing recommendations for lowering health care costs.

The Board must set a benchmark for the annual rate of growth of total health care spending in Washington State. After establishing the baseline measurement, in future years the Board will identify health care providers and payers that are exceeding the established benchmark. The purpose of the benchmark and reporting is to:

- Reduce the overall trend of health care cost growth in Washington State.
- Make health care costs more transparent to the public and policymakers.
- Encourage providers and payers to keep costs at or below the benchmark.

The Board and its advisory committees have discussed the methodology questions in the past and incorporated the guidance in the data submission technical manual. A summary of each topical area is captured below:

Attribution Methodology

Will plans report the numbers of attributions made using each method? Will large provider entities be able to review provider attributions to ensure accuracy?

Attribution of individual patients to a primary care provider (PCP) follow the following hierarchy:

1. **Member Selection**: Members who were required to select a PCP by plan design should be assigned to that PCP.
2. **Contract Arrangement**: Members not included in #1 and who were attributed to a PCP during the performance period pursuant to contract between the carrier and the provider, should be attributed to that PCP.
3. **Utilization**: Members not included in #1 or #2, and who can be attributed to a PCP based on the member's utilization history should be attributed to that PCP. Carriers may apply their own primary care-based methodology when attributing a member to a PCP based on utilization.

Additional information may be found on page A-2 of the technical manual for the data call. The manual can be found here: https://www.hca.wa.gov/assets/program/benchmark-data-call-manual-july-2022.pdf

Additional relevant information is available in the Health Care Cost Growth Benchmark Value and Methodology document and the Measuring Benchmark Performance document, which are included in this response and available on the Board's webpage.

For the process of reviewing attribution when the Board initiates the provider performance measurement process, please see below in the section on provider performance.

Risk Adjustment

Will specific adjustments made for each of the provider organizations be disclosed and reviewable?

This risk adjustment method was chosen from several options considered by the Advisory Committee on Data Issues (see also the Health Care Cost Growth Benchmark Value and Methodology document and the Measuring Benchmark Performance document). This methodology is utilized by several states engaged in benchmarks and reflects the same methodology used by those other cost boards that use age/sex risk adjustment. The age/sex risk adjustment is straightforward in that it will adjust the overall truncated claims spending based on the carrier/large provider's proportion of those categories based on the overall market.

Risk adjustment does not apply to the baseline benchmark, it will only be applied to the measurement of performance in future years. Milliman is currently proving a secondary review of the methodology and calculations to ensure accuracy. When Milliman's work is complete and the Board begins to collect data to measure performance, the Board will publish additional documentation of the methodology.

Analysis for Specific Provider Performance

What information will be given to large provider entities that exceed the benchmark and will that information help inform their practices, e.g., whether exceeding the benchmark was due to increased price of services versus increased use of services? Is there other information that can be provided to inform their practices on how to make improvements?

Analysis is currently being conducted only to establish the baseline information. These are pre-benchmark years (2017-2019) and will only focus on state and market performance. To date, the Board has not yet initiated the data call to begin measuring performance.

HCA is currently developing a template for payer and large provider reports for future reporting years. This template will be shared for feedback.

After the development of the historical benchmark, and finalization of a reporting template, HCA will work with carriers and large providers to review their growth trends on overall performance as well as individual service categories which are defined in the technical manual. The template will be populated with large provider and carrier information from the baseline years that is not made publicly available, to ensure large providers and carriers have opportunity to review their information and communicate any issues.

Measurement of future years' performance is likely to follow a similar process before public release of the information. There are no performance improvement plans in statute for providers or carriers, therefore the Board does not have the resources, data or staffing to advise providers on their business practices.

Provider Identification and Notice

Are the provider entities identified in the technical manual the finalized list that will be compared against the benchmark? How and when will providers be notified that they are subject to the benchmark?

There is a current list of anticipated large provider entities that may be identified in future years in the data call technical manual on page A-6 here: https://www.hca.wa.gov/assets/program/benchmark-data-call-manual-july-2022.pdf. The list in the manual is based on initial data from carriers. Large providers listed in the manual can expect to have their performance publicly reported if they meet minimum threshold sizes (e.g., 10,000 covered lives). However, this list will be verified with data collected from the benchmark to ensure these entities reach a minimum threshold of covered lives and that all entities have been captured. The Board methodology currently outlines the use of a minimum threshold of covered lives after the historical benchmark analysis that is similar to other cost boards which is a minimum of 10,000 covered lives.

The baseline data and minimum threshold covered lives data are still under review. The current estimated completion date for the minimum threshold analysis is March 2024. At that time, a webinar will be announced for all large provider entities included in the public report for orientation to the report. Public reporting of carrier and large provider experience is not anticipated until late 2024 or early 2025.

When the Board begins measuring performance, HCA will send information to large providers on payers' previously submitted data submissions, which will include the number of attributed members before HCA publishes large provider level cost growth. Large providers and carriers will have the opportunity to review their information and communicate any issues.

Washington State Health Care Authority
Health Care Cost Transparency Board

Health Care Cost Growth Benchmark Value and Methodology

What is a benchmark?

The benchmark is a spending growth rate that carriers and providers should try to stay under to make health care more affordable for individuals, families, states and businesses.

The purpose of Washington's benchmark is to:

- Make health care costs more transparent to the public and policymakers.
- Encourage carriers and providers to keep costs at or below the benchmark.
- Reduce the overall trend of health care cost growth in Washington State.

If you would like more information on the benchmark and how it was created and the process as it was developed, below are descriptions and links to each of the meetings that touched on the benchmark.[1]

Meeting Dates	Topics and Discussions
March 15, 2021 **Health Care Cost Transparency Board**	What is a cost growth benchmark? Why pursue one? How will it impact health costs? Reviewing other states' cost growth benchmark programs.
April 13, 2021 **Health Care Cost Transparency Board**	Beginning the process of defining the methodology.
April 27, 2021 **Advisory Committee of Health Care Providers and Carriers**	Review of the Health Care Cost Growth Benchmark legislation and Massachusetts's Cost Growth Benchmark program experience.
May 13, 2021 **Health Care Cost Transparency Board**	Establishing a benchmark methodology and value: • Economic indicators (e.g., gross state product, mean wage, median wage, consumer price index) • Using historical vs. forecasted values

[1] Written links to meetings materials:
Health Care Cost Transparency Board: https://www.hca.wa.gov/about-hca/who-we-are/meetings-and-materials
Advisory Committee of Health Care Providers and Carriers: https://www.hca.wa.gov/about-hca/who-we-are/advisory-committee-health-care-providers-and-carriers
Advisory Committee on Data Issues: https://www.hca.wa.gov/about-hca/who-we-are/advisory-committee-data-issues

May 25, 2021 **Advisory Committee of Health Care Providers and Carriers**	Benchmark methodology and value: • Economic indicators • Historical vs. forecasted data
June 16, 2021 **Health Care Cost Transparency Board**	Comparing historical health care cost growth in Washington to income growth. Establishing a benchmark methodology and value: • Economic indicators • Historical vs. forecasted values • How long should the initial benchmark value apply for? • Should the benchmark value should adjust over time? • Should there be a trigger to allow the benchmark methodology to be reevaluated? Preliminary decisions: • To set the benchmark value using a 70/30 hybrid of historical median wage and potential gross state products (PGSP), yielding a benchmark value of 3.2%. ○ Based on 20-year historical median wage at 3% and PGSP forecast for 2021-2025 at 3.8%. • To set the benchmark value for an initial period of five years.
June 29, 2021 **Advisory Committee of Health Care Providers and Carriers**	Historic health care cost growth trends in Washington. Benchmark methodology and value: • Economic indicators • Historical vs. forecasted values Adjustments to the benchmark. The committee provided feedback on the benchmark value, how long the initial benchmark value should apply for, whether the value should change over the initial period, and incorporating a trigger.
July 8, 2021 **Advisory Committee on Data Issues**	Introduction and overview of health care cost growth benchmarks.
July 19, 2021 **Health Care Cost Transparency Board**	Feedback from the Advisory Committee of Health Care Providers and Carriers: The Board reviewed feedback on the benchmark methodology – economic indicators, how long the initial benchmark should apply for and if the value should adjust over the initial period, incorporating a trigger to re-evaluate. Recap and discussion on the benchmark methodology and value:

	• Options for a phasedown of benchmark values during the five-year period. • Affirming the rationale for the chosen methodology (70/30 median wage/PGSP) and strong intention to select a benchmark that would provide relief to consumers and employers. The Board discussed phasing down the benchmark value over the five-year period: 2022 – 2023: 3.2% 2024 – 2025: 3% 2026: 2.8%. Trigger for the benchmark methodology.
August 10, 2021 **Advisory Committee on Data Issues**	Overview of preliminary benchmark decisions. Phasing down the benchmark value over a five-year period.
August 17, 2021 **Health Care Cost Transparency Board**	The Board reviewed and approved the proposed trigger language, which included an annual review of performance against the benchmark, and the opportunity to revisit the benchmark value under extraordinary circumstances.
September 14, 2021 **Health Care Cost Transparency Board**	Reviewed feedback from the Advisory Committee of Health Care Providers and Carriers. Options for the benchmark value and methodology and the estimated costs each option would save. The majority voted to approve the following benchmark values: 2022 – 2023: 3.2% 2024 – 2025: 3% 2026: 2.8%
September 30, 2021 **Advisory Committee of Health Care Providers and Carriers**	Review of the Board's decision on the benchmark methodology and value: • Recap of the Board's decision on benchmark methodology and values after receiving feedback from the Advisory Committee of Health Care Providers and Carriers. • Review of Board-adopted language for annual review of performance against the benchmark and for a trigger to consider reevaluation of the benchmark. • Review of projected savings under three selected benchmark scenarios.

	Impacts of the benchmark on the health care delivery systems to consider in terms of access, quality, and cost. The committee discussed unintended potential impacts.
March 16, 2022 **Health Care Cost Transparency Board**	Impact of COVID-19 and rising inflation on the cost growth benchmark: • Impact of COVID-19 on spending trends in 2019 and 2020. • Trend for 2020 and 2021 is expected to be higher. • Rising costs, supply chain issues, labor shortages, and elevated labor costs. • Review of how other states retained their benchmark values and interpret 2020 and 2021 results in the context of the economic impact of COVID-19. The Board determined not to adjust the benchmark, but to monitor the situation closely. Feedback from the Advisory Committee of Providers and Carriers – Impacts to consider: • Possible consequences of transparency and cost reduction efforts and suggestions of areas for monitoring and counter-measurement. • Effects of COVID-19 on spending that will most likely influence benchmark results (rising labor costs, utilization changes, required benefit changes such as vaccines).
April 6, 2022 **Advisory Committee of Health Care Providers and Carriers**	Impact of COVID-19 and rising inflation on the cost growth benchmark: • Impact of COVID-19 on spending trends in 2019 and 2020. • Trend for 2020 and 2021 is expected to be higher. • Rising costs, supply chain issues, labor shortages, and elevated labor costs. • Review of how other states retained their benchmark values and interpret 2020 and 2021 results in the context of the economic impact of COVID-19. • The committee learned that the Board determined not to adjust the benchmark but would continue to monitor and maintain engagement with stakeholders.
October 19, 2022 **Health Care Cost Transparency Board**	Update on the cost growth benchmark in other states. Discussion on possible inflation adjustments: • The data being collected came from a period prior to the inflation spike. • There would be more time to monitor other states' approaches to inflation adjustments before the data call in 2023.

February 15, 2023
 	
Health Care Cost Transparency Board
	Inflation's impact on health care spending for the cost growth benchmark:
	• Recent growth in inflation; goods and services; and health care services.
	  ○ Inflation by product type. While prices of goods and services increased in 2021, health care inflation was constant. Research literature has found macroeconomic changes affect health care spending on a lagged basis.
	  ○ Changes in Consumer Price Index (CPI-U) for medical services compared to other goods and services.
	• Economic indicators used by the six Peterson-Milbank states.
	• Accounting for inflation and increased labor costs when measuring benchmark performance:
	  ○ Whether to allow for performance to exceed the benchmark for a limited time.
	  ○ Making adjustments does not necessarily mean restating the benchmark. A state can set a temporary allowance.
	• Considerations on creating an allowance.
	  ○ Arguments for and against adjusting for inflation and/or labor costs.
	• Key policy considerations.
	• Reviewing other states' responses to rising inflation.
	
	Discussion and Decision: Should there be an adjustment to the benchmark to account for inflation?
	
	A motion was made and approved to maintain the benchmark values as the Board awaits further data.

Washington State Health Care Authority
Health Care Cost Transparency Board

Measuring Benchmark Performance

The Health Care Cost Transparency Board (the Board) will review how the state, markets, health insurance carriers, and large provider entities are performing compared to the benchmark. To collect data needed to measure performance, HCA will conduct the benchmark data call annually for the benchmark analysis.

The technical manual includes details on the data collection process, methodology, data specifications, and calculation methods.

Key Acronyms and Terms

Calculating Spending

Total health care expenditures (THCE): Refers to the spending used to measure performance against the benchmark. THCE is the allowed amount of claims-based and non-claims-based spending from payer to provider plus the carriers' net cost of private health insurance.

- THCE is calculated at the state level.

Total medical expenditures (TME): All payments (total claims and total non-claims payments) to providers incurred for all health care services.

- TME is reported at the state, market, payer, and large provider entity levels.

Net cost of private health insurance (NCPHI): The costs to Washingtonians associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is the difference between health premiums earned and benefits incurred, and consists of carriers' costs of paying bills, advertising, sales commission and other administrative costs, premium taxes, and profits (or contributions to reserves) or losses.

- NCPHI is reported as a component of THCE at the state level.

Methods to Ensure Accuracy and Reliability

Risk adjustment: Accounting for changes of a population that might impact spending growth.

- Risk-adjustment by age/sex will be applied at the provider and carrier levels.

Truncation: Mitigating high-cost outliers on provider and carrier performance against the benchmark.

- Applied at the provider and carrier levels.

Confidence interval: Statistical testing to ensure confidence in calculating cost growth. The confidence interval is a range of values in which we can say with a certain degree of confidence, that our true value lies.

- Applied at the provider and carrier levels.

Meeting Dates and Topics

If you would like more information on how the methodology for measuring performance against the benchmark was developed, the topics and links to the meetings are available in the table below.[1]

Meeting Dates	Topics and Discussions
April 13, 2021 **Health Care Cost Transparency Board**	Defining THCE and TME.
April 27, 2021 **Advisory Committee of Health Care Providers and Carriers**	Massachusetts's cost growth benchmark program structure and experience. This included how the state measured performance against the benchmark using THCE (which includes TME, patient cost-sharing, and the net cost of private health insurance).
May 13, 2021 **Health Care Cost Transparency Board**	Defining THCE and TME. Defining the population for whom TME are being measured: • Sources of coverage. • State of residence and care location.
May 25, 2021 **Advisory Committee of Health Care Providers and Carriers**	Defining THCE and TME. Committee members provided recommendations on additional items to include in the definitions. Determining whose TME to measure. The committee was presented with the Board's preliminary decisions to include spending for all Washington residents, regardless of where they receive their care, and the sources of coverage to include. The committee provided feedback.
July 19, 2021 **Health Care Cost Transparency Board**	Review of the feedback from Advisory Committee of Health Care Providers and Carriers on the definitions for THCE and TME. Feedback included a desire to include additional expenditures. The Board determined these did not meet the definitions due to not representing medical expenditures or not involving payment.
August 10, 2021 **Advisory Committee on Data Issues**	What constitutes THCE when measuring against the benchmark. Overview of data collection and sources for the benchmark analysis. Reporting performance against the cost growth benchmark. • Benchmark performance analysis vs. cost growth driver analysis

[1] Written links to meeting materials:
Health Care Cost Transparency Board: https://www.hca.wa.gov/about-hca/who-we-are/meetings-and-materials
Advisory Committee of Health Care Providers and Carriers: https://www.hca.wa.gov/about-hca/who-we-are/advisory-committee-health-care-providers-and-carriers
Advisory Committee on Data Issues: https://www.hca.wa.gov/about-hca/who-we-are/advisory-committee-data-issues

	• Benchmark performance reported at four levels: state, market, payer, large provider entity.
	• Defining and identifying provider entities whose benchmark performance will be measured will be addressed later.
	
	Methods to Ensure Accuracy and Reliability when measuring performance against the benchmark:
	
	• Statistical testing on data
	  ○ The committee supported the use of confidence intervals. One member supported the use provided there is clear documentation within the reports pertaining to methodology used to construct the confidence intervals.
	• Mitigating the impact of high-cost outliers
	  ○ Most committee members recommend using truncation of high-cost outliers' spending when measuring performance against the benchmark for provider entity and carriers.
	• Accounting for changes in population health status that might impact spending growth.
	  ○ The majority agreed that risk-adjusting by age and sex to assess performance against the benchmark is reasonable. The committee provided feedback and discussed concerns.
	• Determining the minimum population sizes for gathering benchmark data to measure performance against the benchmark.
	  ○ Review of how other states determined the thresholds for payer reporting and public reporting of provider performance. For example, carriers with market share of at least five percent would be required to submit data reports.
	  ○ Many committee members requested additional information about the Washington market to make a more informed decision.

August 17, 2021 **Health Care Cost Transparency Board**	Defining THCE and sources of coverage: Wrap up discussion and review of feedback from the Advisory Committee of Health Care Providers and Carriers. The Board approved the sources of coverage included in the definition of THCE (such as Medicaid, Medicare, and commercial).
September 14, 2021 **Health Care Cost Transparency Board**	Distinguishing between the benchmark analysis (performance against the benchmark) and the cost driver analysis.

	Review of how other states report performance against the benchmark. Typically, states report at four different levels:
	
	1. State.
	2. Market.
	3. Carrier/Payer.
	4. Large provider entity.
	
	The Board was provided feedback from the Advisory Committee on Data Issues on using confidence intervals and truncation to ensure accuracy and reliability of measurement.
	
	Methods and strategies to ensure accuracy and reliability of benchmark performance measurement.
	
	• Statistical testing on benchmark performance data.
	  ○ Confidence intervals.
	• Mitigating the impact of high-cost outliers: using truncation.
	  ○ To not unfairly judge carrier and provider performance against the benchmark when it is influenced by spending on high-cost outliers.
	  ○ Truncation is a common practice to prevent a small number of extremely costly members from significantly affecting providers' per capita expenditures.
	
	Decision: After reviewing feedback from the Advisory Committee on Data Issues, the Board approved the use of confidence intervals and truncation.

September 30, 2021 **Advisory Committee of Health Care Providers and Carriers**	Introduction to reporting performance against the benchmark: Cost growth benchmark analysis vs. cost driver analysis: what they are, what data type will be used, and the data sources. Sources of coverage for the benchmark data call. Provider level reporting: Limited to provider entities that are large enough to accurately and reliably measure and have responsibility for meeting all a patient's needs. Methods selected to ensure the accuracy and reliability of benchmark performance measurement. The Board's activities related to developing the benchmark data call was shared. The Board's intent is to use best practices to ensure accurate, valid, and consistent data to support confidence in the results. Larger decisions will be made by the Board with recommendations from the Advisory Committee on Data Issues. Some will be made by HCA staff.

	The committee was presented with information on the use of confidence intervals (a range of values in which we are fairly sure our true value lies) and truncation (mitigating the high-cost outliers when assessing provider and carrier performance against the benchmark). The committee also heard how other states use these strategies to ensure the benchmark performance data is reliable.
October 28, 2021 **Advisory Committee on Data Issues**	Defining the list of carriers that will report THCE for the cost growth benchmark. • HCA staff researched and developed a list of carriers with at least 10,000 enrolled lives that would be required to report data. The list was vetted with other state staff. ○ Staff recommended 12 carriers with substantial market share. Together, the 12 carriers account for 96% of covered lives (after excluding limited benefit plans). • Discussed recommendation to not include standalone third-party administrators (TPA) and health care benefit managers at the time. • Discussed how to account for members on self-funded employer plans. Identifying large provider entities for whom carriers will report spending. • Review of methodologies for attributing clinicians to large provider entities. • Staff developed an initial list of potential providers. The committee provided feedback. Risk adjustment options. The committee reviewed strengths and weaknesses on four options for risk adjustment and provided recommendations.
September 8, 2021 **Advisory Committee on Data Issues**	Key questions to address for provider-level reporting: • How members should be attributed to clinicians. ○ Comparing two methodologies for attributing member to clinicians. • Discussion on how to organize clinicians into large provider entities. The committee did not recommend mandating a specific methodology, but felt it was important to have material consistency in attribution methodologies and to have documentation of those methodologies

	from payers. The committee recommended allowing payers to use their own attribution methodology based on the following hierarchy: 1. Member selection 2. Contract arrangement 3. Utilization
October 28, 2021 **Advisory Committee on Data Issues**	Defining the list of large provider entities for whom the carriers will be reporting THCE on. • Methodologies for attributing clinicians to large provider entities. • Review of the process and considerations for identifying providers. • Staff conducted research and developed an initial list of 50 entities, which was vetted with staff from other state agencies with knowledge of the provider landscape. • Review of provider thresholds used in other states. For example, public reporting of providers with more than 10,000 Medicaid or commercial lives or 5,000 Medicare lives.
November 17, 2021 **Health Care Cost Transparency Board**	Using risk adjustment when determining performance against the benchmark. The Board reviewed four options to risk adjust health data: • age/sex adjustment performed by the payers • age/sex adjustment performed by the state • clinical risk adjustment normalization performed by payers • clinical risk adjustment normalization performed by the state Feedback from the Advisory Committee on Data Issues • Most supported age/sex performed by the state. Some supported that the state performs clinical adjustment normalization on all payer data; however, this option was not feasible within current resources. The Board decided to select age/sex risk adjustment using standard weights developed by HCA based on current resources. The Board directed that staff explore the future ability to perform clinical risk adjustment normalization using data from the Washington State All Payer Claims Database (APCD). Key questions to address for provider-level reporting: preliminary discussion on provider attribution methodology. • How members can be attributed to clinicians

	• How clinicians should be organized into larger entities for reporting. Review of approaches, including methodologies used in other states. The Board also reviewed feedback from the Advisory Committee on Data Issues.
December 15, 2021 **Health Care Cost Transparency Board**	Attribution in Health Care Authority programs. To achieve the mandate to report cost trends at the provider level, payers would need instructions on how to do to levels of attribution: member to clinician and clinician to large provider entity. The Board was informed that all other states were allowing carriers to use their own attribution methodology, either with or without a recommended hierarchy. The Board reviewed about attribution methodology of the Washington Health Alliance (WHA), which uses primary care provider (PCP) based attribution. Staff recommended allowing insurers to use their own PCP-based attribution methodology, within the following hierarchy: member selection, contract arrangement, and utilization. This would be in line with recommendation by the Advisory Committee on Data Issues. Decision: Member attribution methodology. The Board approved the recommendation of allowing carriers to use their own PCP-based attribution methodology, based on a hierarchy that prioritizes member selection, then contract arrangements, then utilization. Presentation and discussion: Provider entities accountable for total medical expenditures. The Board was provided information related to how to attribute clinicians to large provider entities and discussed concerns. The Board revisited research investigating the feasibility of existing state directories. Staff recommended pursuing use of the Washington Health Alliance (WHA) directory and asking issuers to do attribution based on contracting arrangements as a fallback option should a WHA contract not prove feasible. Decision: Clinical Attribution. The Board accepted the recommendation to pursue use of WHA's directory, and then to ask carriers to do attribution

	based on contracting arrangement as a fallback option. HCA staff was directed to explore whether there were other large entities in the state who do not employ PCPs that would be appropriate for inclusion. Cost growth benchmark accountability. The Board reviewed the legislative language on benchmark accountability, as well as Massachusetts's accountability process. The presenter asked the Board several questions to consider, including the process(es) that should be in place for reporting against the benchmark, how performance should be reported, types of communication that should accompany the cost trends report, and any other activities that should accompany the release of the cost trends report.
January 31, 2022 **Advisory Committee on Data Issues**	Pre-benchmark data collection process and timeline. The Board will adopt the technical manual to collect data. The Board expects the committee will have the opportunity to comment prior to adoption. Payer survey of provider entity contracts A payer survey will be issued confirming total cost of care contracts. The purpose of the survey is to confirm the list of provider entities that will be subject of the benchmark reporting data are correctly identified. Benchmark Performance Assessment Proposed truncation thresholds, consistent with Rhode Island's approach: Commercial: $150,000. Medicaid: $250,000. Medicare: $100,000. Truncation amounts would be valued at the member level, cumulatively (rather than treatment level), and applied to provider entities and carriers by market. The committee provided feedback and recommendations including having an approach that permits reviewers to understand what had been excluded (either through the ability to "toggle" the truncation on and off, or through an ad-hoc report).
February 1, 2022	Pre-benchmark data collection process and timeline.

Advisory Committee of Health Care Providers and Carriers	The Board will adopt the technical manual to collect data. The Board expects the committee will have the opportunity to comment prior to adoption.
	
	Payer survey of provider entity contracts
	A payer survey will be issued confirming total cost of care contracts. The purpose of the survey is to confirm the list of provider entities that will be subject of the benchmark reporting data.
	
	Accountability – reporting performance against the benchmark
	• Review of accountability processes adopted by other states.
	• Draft principles:
	  ○ Accountability process (including preparation, review, reporting, and recommendations) will be transparent and predictable.
	  ▪ The benchmark analysis report will identify the entities who are reported on, permitting comparison between them.

March 1, 2022
Advisory Committee on Data Issues
	Benchmark Performance Assessment.
	• Risk Adjustment of benchmark data.
	  ○ Future measurement of carriers and large provider entity performance against the benchmark will be risk-adjusted by age/sex.
	  ○ Carriers will submit aggregate spending and member months data by age/sex cells.
	  ○ Proposed age bands: 0-1, 2-18, 19-39, 40-54, 55-64, 65-75, 77- 84 and 85+. Rhode Island was the first state to use age/sex risk adjustment, and this was the method used.
	• Truncation analysis update.
	  ○ The Board contracted with OnPoint to perform an analysis of truncation level impacts in Washington.
	  ○ A truncation dashboard, created by a committee member, was shared. The dashboard was based on MEPS data.

April 20, 2022 **Health Care Cost Transparency Board**	Benchmark attainment: Feedback from the Advisory Committee of Health Care Providers and Carriers on criteria the Board adopted for selecting strategies to support benchmark attainment.

May 5, 2022 **Advisory Committee on Data Issues**	Truncation report and recommendations. • Specifications for the truncation analysis and the approaches used. • Results of the truncation study prepared for the Board upon recommendation by the committee. • Staff recommended to adopt truncation points removing the top ~5% of spending: Commercial: $200,000. Medicaid: $125,000. Medicare: $125,000. • Truncation was used where it would most impact reporting: at the carrier and provider levels. Truncation is used in other states as change of frequency or incidence of high-cost outliers would be greater at the provider and carrier levels due to smaller population sizes and shifting year-to-year. • The purpose of truncation is to ensure high-cost outliers would not unduly shift the appearance of spending growth to one carrier or provider entity. The goal is to hold provider entities and carriers accountable fairly for spending trends. Benchmark data call technical manual and updates. Technical manual: • Which carriers are required to submit data. • Large provider entities for which insurers will submit spending data (tentative). • Data specifications. • Data submission process. • Data submission template. Washington's data specifications compared to other states. HCA will conduct a data validation process including: • Early review of submissions. • An initial analysis of trends across service categories and from year to year looking for anomalies. • A series of validation calls with submitters to ensure data was submitted correctly. It was noted that ensuring the quality of submitted data often required back-and-forth communication with submitters. The process needs

	extensive one-on-one engagement and learning to respond was an iterative process.

June 2, 2022
Advisory Committee of Health Care Providers and Carriers
	Update on large provider entities subject to attribution by carriers for the benchmark analysis report.
	• Draft list of provider entities was presented, along with the rationale.
	  ○ While patients are attributed to a specific provider, the reporting for TME falls to the large entity provider, not the individual clinician.
	  ○ Reportable provider entities include those that could take on the total cost of care contracts because they:
	  ▪ Include primary care providers who direct a patient's care.
	  ▪ Can exert influence over where a patient receives care.
	• There will be no public reporting on carriers and providers in the first benchmark analysis report.

April 4, 2023
Advisory Committee on Data Issues
	Benchmark data collection and reporting.
	• Distinguishing between the cost growth benchmark analysis and the cost growth driver analysis.
	• What is measured against the cost growth benchmark? (TME, THCE, NCPHI).
	• Performance against the benchmark will be reported at four levels:
	  ○ State (THCE).
	  ○ Market (TME only).
	  ○ Carrier (TME only).
	  ○ Large provider entity (TME only).
	• Data sources for measuring THCE:
	  ○ Carrier-submitted reports.
	  ○ Other data sources such as:
	  ▪ Center for Medicare and Medicaid Services (CMS).
	  ▪ State Medicaid agency for non-managed care payments (fee-for-service).
	  ▪ Other public coverages: Department of Corrections, Department of Labor & Industries, Veteran's Health Administration.
	  ▪ Regulatory reports to calculate NCPHI.
	• Specifications for carrier-submitted data:
	  ○ Population the data is reported on.

- What data the carriers will report (such as member enrollment, income from fees of uninsured plans, variance or standard deviation data, pharmacy rebates).
- How carriers report spending and membership data.
- Other specifications.

- Categories of claims and non-claims-based spending.
- Adjustments to increase confidence and measurement and reporting performance:
  - State and market levels: No adjustments to data.
  - Carrier and large provider entity levels:

    Risk-adjusting aggregate spending data by age and sex. Overview of how other states have moved (or recommended moving) away from using clinical risk adjustment. The Board will risk-adjust by age/sex factors. To implement this, carries were asked to submit aggregate spending and member months data by age/sex cells, which will used to create standardized weights.

    Truncating spending for high-cost outliers. To prevent a small number of extremely costly members from significantly affecting carrier and provider per capita expenditures, truncation will not count spending above certain thresholds:

    Commercial: $200,000.

    Medicaid: $125,000.

    Medicare: $125,000.

    Using confidence intervals around cost growth rates. The Board will calculate confidence intervals (a degree of uncertainty or certainty) to minimize the impact of small numbers.

    Reporting performance only for carriers and large provider entities[2] that meet minimum threshold for attributed lives. Using confidence intervals will help the issue of determining "sufficient" population sizes to become less pressing. The Board previously recommended deferring the determination of the minimum membership sizes for carrier and large provider entity performance.

Updates on the 2023 benchmark data call.

- Calendar years: 2020 – 2022. Performance against the benchmark will be calculated using 2021 and 2022.

[2] The definition of a "large provider entity" will be determined after the benchmark analysis is completed.

	• Additional insurance category for the Federal Employee Health Benefits (FEHB). • Implementing a way to associate non-claims spending to providers without age/sex stratification. • Changes to materials such as the technical manual and submission template.

April 19, 2023
Health Care Cost Transparency Board
	Data projects overview:
	• Cost growth benchmark.
	• Performance against the benchmark.
	• Cost Driver Analysis.
	• Primary Care Spend measurement.
	
	What they are, what they represent, the analytic basis, risk adjustment considerations, and other considerations.
	
	Benchmark data collection and reporting:
	• Reminder: Distinguishing between the cost growth benchmark analysis vs. the cost growth driver analysis.
	• What is measured against the cost growth benchmark?
	  ○ TME, NCPHI, THCE: What they are and what is included in the calculations.
	• Performance against the benchmark will be reported at four levels:
	  ○ State (THCE).
	  ○ Market (TME only).
	  ○ Carrier (TME only).
	  ○ Large provider entity (TME only).
	• Data sources for measuring THCE.
	• Specifications for carrier-submitted data:
	• Categories of claims and non-claims-based spending.
	• Adjustments to increase confidence and measurement and reporting performance:
	  ○ State and market levels: No adjustments to data.
	  ○ Carrier and large provider entity levels:
	  1. Risk-adjusting aggregate spending data by age and sex.
	  2. Truncating spending for high-cost outliers.
	  3. Using confidence intervals around cost growth rates.

	4. Reporting performance only for carriers and large provider entities that meet minimum threshold for attributed lives. Updates on the 2023 benchmark data call.

Washington State Health Care Authority
Health Care Cost Transparency Board

Cost Driver Analysis

What is the cost driver analysis?

A first-level drill down analysis of key drivers of health care cost growth. Identification of cost drivers provides the greatest opportunities for mitigating cost growth by creating targeted policies that help Washingtonians by better understanding and controlling these key drivers of costs.

To develop the cost driver analysis, the Health Care Cost Transparency Board (the Board) contracted with OnPoint, a data vendor, to utilize the All-Payer Claims Database (APCD) to examine drivers of health care cost in Washington.

The first year of cost driver analysis included a high-level review of:

- Trends in price and utilization.
- Spend and trend by market and geography.
- Spend and trend by health conditions and demographics.

If you would like more information on the cost driver analysis, how it was created and the process as it was developed, below are descriptions and links to each of the meetings that touched on the cost driver analysis.[1]

Meeting Dates	Topics and Discussions
September 14, 2021 **Health Care Cost Transparency Board**	A general overview of two separate analyses: • Benchmark analysis – Data call from insurance carriers and public payers at an aggregate level to allow assessment of benchmark achievement at multiple levels. • Cost driver analysis – A plan to analyze cost drivers and identify opportunities for reducing cost growth and informing policy decisions using granular claims and/or encounters from data sourced from the APCD.
November 17, 2021 **Health Care Cost Transparency Board**	The Board determined to address the legislative mandate to account for utilization, service intensity, and regional pricing differences in the cost growth driver analysis.
January 19, 2022	Discussion of analyses of cost and cost growth drivers:

[1] Written links to meeting materials:
Health Care Cost Transparency Board: https://www.hca.wa.gov/about-hca/who-we-are/meetings-and-materials
Advisory Committee of Health Care Providers and Carriers: https://www.hca.wa.gov/about-hca/who-we-are/advisory-committee-health-care-providers-and-carriers
Advisory Committee on Data Issues: https://www.hca.wa.gov/about-hca/who-we-are/advisory-committee-data-issues

Health Care Cost Transparency Board	• Distinguishing between the cost benchmark analysis and cost driver analysis. • Purpose and framework. • Two types of cost driver analyses: Phase I and Phase II. • HCA's recommendation and proposed plan for Phase I. • Data sources and types of analyses to include. • Proposed process for conducting and vetting the analyses.
January 31, 2022 **Advisory Committee on Data Issues**	Discussion of analyses of cost and cost growth drivers: • Distinguishing between the cost benchmark analysis vs. the cost driver analysis. • Purpose and framework. • Two types of cost driver analyses: Phase I and Phase II. • HCA's recommendation and proposed plan for Phase I. • Data source and types of analyses to include. • Proposed process for conducting and vetting the analyses. • Recommended Phase II analyses to identify opportunities to reduce cost growth. Committee members asked questions and provided feedback.
February 1, 2022 **Advisory Committee of Health Care Providers and Carriers**	Discussion of analyses of cost and cost growth drivers: • Distinguishing between the cost benchmark analysis vs. the cost driver analysis. • Purpose and framework. • Two types of cost driver analyses: Phase I and Phase II. • HCA's recommendation and proposed plan for Phase I. • Data source and types of analyses to include. • Proposed process for conducting and vetting the analyses. • Recommended Phase II analyses to identify opportunities to reduce cost growth. The committee provided feedback and recommendations.
March 16, 2022 **Health Care Cost Transparency Board**	Review of feedback and recommendations from the Advisory Committee on Data Issues on the cost growth driver analysis and the Advisory Committee of Health Care Providers and Carriers on

	potential unintended consequences of transparency and cost reduction efforts.
November 1, 2022 **Advisory Committee on Data Issues**	The APCD study of cost growth drivers – specifications for Year 1 cost driver analysis. • Purpose, data source (APCD), and scope of the study. • Key topics for the baseline analysis. • Background on the APCD data – what is included and its limitations. • Five years of data: 2017 – 2021. • Payer types and markets. • Categories aligned with the benchmarking initiative. • Geography, age groups, and chronic conditions. • Measures of access and quality. • Primary care. • Behavioral health. Cost driver considerations for 2023: Discussion and feedback.

December 14, 2022
Health Care Cost Transparency Board
	Introduction to the 2022 cost growth drivers study – preliminary findings.
	• Purpose, data source (APCD), and scope of the study.
	• Key topics to consider for Phase I analysis.
	• Summary of methods.
	  ○ Five years of data: 2017 – 2021.
	  ○ Types of coverage and markets.
	  ○ Categories aligned with the benchmarking initiative.
	  ○ Data limitations.
	• Enrollment trends.
	• Trends in medical claims expenditures (medical and pharmacy).
	• Spending by category of service (e.g., primary care, inpatient, specialist).
	• Trends in Per Member Per Month (PMPM) expenditures.
	• Spending growth rate trends for different types of coverage and by categories of service.
	• Regional differences in health care spending.
	• Spending by age and gender.
	• Impact of high-cost members.
	Discussion and feedback on the cost growth drivers study.

February 7, 2023 **Joint committee meeting:**	Introduction to the 2022 cost growth driver study – preliminary findings.

Advisory Committee on Data Issues
 	
Advisory Committee of Health Care Providers and Carriers
	• Purpose, data source (APCD), and scope of the study.
	• Key topics to consider for Phase I analysis.
	• Summary of methods.
	  ○ Five years of data: 2017 – 2021.
	  ○ Types of coverage and markets.
	  ○ Categories of service.
	  ○ Data limitations.
	• Enrollment trends.
	• Trends in medical claims expenditures (medical and pharmacy).
	• Spending by category of service (e.g., primary care, inpatient, specialist).
	• Trends in Per Member Per Month (PMPM) expenditures.
	• Spending growth rate trends for different types of coverage and by categories of service.
	• Regional differences in health care spending.
	• Spending by age and gender.
	• Impact of high-cost members.

February 15, 2023
 	
Health Care Cost Transparency Board
	Cost driver analysis:
	• Key takeaways from the Phase I analysis.
	• Cost growth analyses findings in other states.
	  ○ Washington's findings were generally consistent with other state and national findings. Hospital and pharmacy services are driving overall health care spending growth.
	• Potential Phase II "drill-down" analyses to consider for:
	  ○ Hospital spending.
	  ○ Retail pharmacy spending.
	• Other potential Phase II analyses identified by HCA and OnPoint.
	
	Discussion: What types of drill-down analyses does the Board wish to prioritize?

April 4, 2023 **Advisory Committee on Data Issues**	The APCD study of cost growth drivers – specifications for Phase 1 cost driver analysis. • Purpose, data source (APCD), and scope. • Background on the APCD data – what is included and its limitations. • Reporting periods. • Product types and markets. • Categories of care. • Geography, age groups, and gender categories.

	• Chronic conditions.
	• Measures of access and quality.
	• Metrics:
	  ○ Member months/eligibility.
	  ○ Expenditures.
	  ○ Other metrics.

April 19, 2023 **Health Care Cost Transparency Board**	Data projects overview: • Cost growth benchmark. • Performance against the benchmark. • Cost Driver Analysis. • Primary Care Spend measurement. What they are, what they represent, the analytic bases, risk adjustment considerations, and other considerations.
June 6, 2023 **Joint Committee Meeting:** **Advisory Committee on Data Issues** **Advisory Committee of Health Care Providers and Carriers**	Cost Driver Analysis: Options for Phase II. Options presented were inspired by other states' Phase II analyses. The analyses on pharmacy spending are intentionally left out as a newly created Prescription Drug Affordability Board (PDAB) will review pharmacy trends. • Adding more chronic condition flags. • Inpatient and outpatient descriptives: Overall inpatient/outpatient price growth, trends in inpatient/outpatient severity. • Inpatient to outpatient services: Looking to see if an increase in outpatient services is due to transitions from inpatient services and looking at changes in services, case mixes, and/or diagnostic-related groups (DRGs). • Out-of-pocket spending.

Washington State Hospital Association

October 4, 2023

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

The Advisory Committee on Data Issues passed a motion related to the provider-specific benchmarking process at our meeting on October 3. A similar motion was also discussed at the Advisory Committee of Health Care Providers and Carriers at its recent committee meeting.

As the person who introduced the motion, I am writing to the Board to explain its purpose, express how pleased we are the committee will have the opportunity to more fully understand the process by which the benchmark will be set and applied to providers, and share that I hope the committee's work will inform the work of the board. The motion was intended to prompt additional discussion between the committees and the Board and obtain more information about the implementation and operational elements of the benchmarking process. The motion adopted by the committee accomplishes this goal and I want to thank the committee for its willingness to engage in guiding the analytical work that will be applied in the benchmarking process.

The motion raised the following process issues:

- **Attribution.** For provider-specific benchmarking**,** plans will be attributing patients using several different methods. Will plans report the numbers of attributions made using each method? Plans will also be attributing primary care providers to large provider entities. Will large provider entities be able to review and vet these specific provider attributions to ensure accuracy?
- **Risk adjustment.** Will specific adjustments made for each of the provider organizations be disclosed and reviewable?
- **Analysis.** What information will be given to large provider entities that exceed the benchmark and will that information help inform their practices, e.g., whether exceeding the benchmark was due to increased price of services versus increased use of services? Is there other information that can be provided to inform their practices on how to make improvements?
- **Notice.** Are the provider entities identified in the technical manual the finalized list that will be compared against the benchmark? How and when will providers be notified that they are subject to the benchmark?

Although provider-specific comparisons likely won't be made until 2025, it is important to address these elements now. Data from the base year, 2022, and the current year, 2023, will be used to determine providers' performance. Provider organizations should know whether they are subject to that benchmark and understand how that process will unfold. The process ideally should also allow providers to ensure the data used in the calculations are accurate. More broadly, and most importantly, the findings from this process should be concrete and help providers make targeted corrections and meaningful improvements.

Again, I look forward to working with the committee members on these issues and appreciate the opportunity to develop recommendations that will help support the Board's work.

Sincerely,

Jonathan Bennett
Vice President, Data Analytics and IT Services
Washington State Hospital Association
Member, Advisory Committee on Data Issues

PORT ANGELES (June 19, 2023) – With costs continuing to outpace government reimbursement and the difficulties presented by a profound healthcare workforce shortage across the state and nation, Olympic Medical Center is looking at ways to turnaround its financial picture in the coming year or two.

Through May of this year, OMC has suffered a loss of $12 million.

“Most hospitals and hospital systems are really struggling right now because of many factors largely out of our control,” says Darryl Wolfe, chief executive officer. “The costs of providing care – healthcare workers, pharmaceuticals, equipment, supplies, facility maintenance, etc. – are growing where government reimbursement through Medicare and Medicaid aren’t keeping pace.”

“Workforce shortages are also a significant issue for us,” adds Wolfe. “To maintain some very key services, we are contracting with traveling health care workers in nursing, respiratory therapy, social services, physical therapy and more. Traveler services are incredibly costly.”

OMC expects some reimbursement relief in mid-2024 when the recently revamped Safety Net Assessment Program (SNAP) in Washington State is expected to bring in approximately $10 million more per year in Medicaid reimbursement. “The increase we’ll see through the updated SNAP program is sorely needed, but until that funding starts to flow, we need to make adjustments right now to financially stabilize.”

Critical Services to Remain Intact

OMC is working through a financial turnaround process that aims to control expenses and improve productivity. Critical services, such as hospital services, are expected to be maintained at the status quo, with safety and quality a priority. OMC is currently targeting hiring efforts to fully staff patient care areas that must contract traveler services.

> We can’t control our government reimbursement, we must comply with regulatory mandates, and we can’t simply raise rates, so we must do everything we can to control costs where we can. We fully believe health care is best delivered locally, and to achieve this with have to buckle down in this moment.
>
> Darryl Wolfe, CEO

Phased Approach

In addition to priority hiring, the initial phase of OMC's financial recovery plan includes tighter management of overtime and a close look at how to better manage productivity.

"After about a month of working on this initial phase, we aren't seeing a significant financial shift and our expenses still significantly outweigh our income," says Wolfe. "We recognize we have to more tightly manage overtime and approve overtime when it meets specific criteria such as patient safety. We also need everyone to take their scheduled breaks and adhere to punctuality at the time clock to better manage overtime."

The upcoming phase two will involve responding to our careful assessment of productivity, and staff and patients alike will see adjustments to our operations to make sure staffing is mindful of operational needs. "To explain what maximizing productivity may look like, a possible approach is to reduce operating hours of a service that is less busy or has days that are less busy," explains Wolfe. "We may take a service currently offered from 8 a.m. to 5:30 p.m. five days a week and change it from 7:30 a.m. to 6 p.m. four days a week if that service is traditionally slow on Fridays."

"We know this strategy could be disruptive for employees and patients, but it allows us to utilize time more effectively and it's an area of expense we can control. We have to try it," adds Wolfe.

The Finish Line

What does success look like for financial recovery? Ultimately it looks like fewer contracted travelers, more employees and decreased expenses, says Wolfe. "Until our reimbursement levels improve and we have enough employees to fully open up access to largely meet the healthcare needs of our community, we need to intentionally tighten our belts to stabilize," he says. "The board has always had a priority to ensure OMC can be financially stable and remain an independent community hospital."

"We can't control our government reimbursement, we must comply with

regulatory mandates, and we can't simply raise rates, so we must do everything we can to control costs where we can. We fully believe health care is best delivered locally, and to achieve this with have to buckle down in this moment."

OMC will be providing opportunities in the coming weeks for the public to hear from Darryl Wolfe and ask questions. Follow Olympic Medical Center on Facebook or watch olympicmedical.org for more information on these events.

Recent Posts

Level III Trauma Care at Olympic Medical Center

Rwandan healthcare delegation collaborates at Olympic Medical Center

Technical Difficulties at Our Virtual Community Forum

DAISY Award: RN Rosie Dehoyos honored by OMC

BEE Award: Certified Nursing Assistant Jennifer McKee receives OMC's BEE Award

Categories

A Day in the Life

Auxiliary News

BEE Award

Cancer Care

COVID-19

Educational

Employee Recognition

Financial Services

Tab 4

Washington State Health Care Authority

Primary Care Data Collection and Reporting Strategy

Health Care Cost Transparency Board-

October 18, 2023

Washington State Health Care Authority

HCCTB Advisory Committee on Primary Care Charges

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

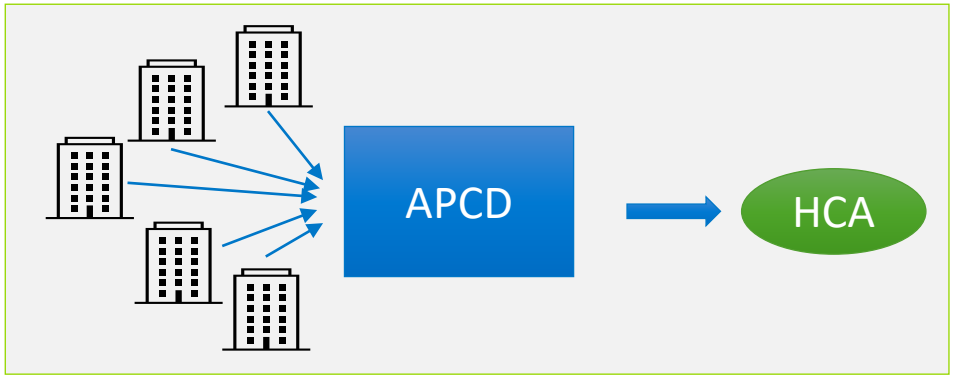
- Data Focused to support primary care
  - Report on barriers to access and use of primary care data and how to overcome them
  - Report annual progress needed for primary care expenditures to reach 12 percent of total health care expenditures
  - Track accountability for annual primary care expenditure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

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

How Does Data Collection From Payers Work Today?

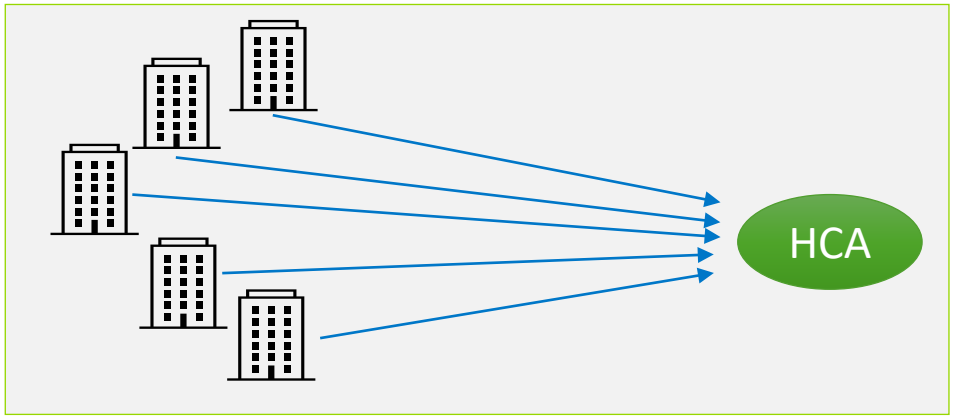
All Payer Claims Database

- **Detailed data** submitted by **subset of payers** to APCD
- APCD detailed data can be queried by HCA
- **Does not** include ERISA plans
- **Does not** include non-claims-based expenditures



HCA Aggregate Data Call

- **Aggregate data** submitted by all payers directly to HCA
- **Includes** ERISA plans' data
- **Includes** non-claims-based expenditures
- HCA updates reporting specifications to meet current policy needs regularly.

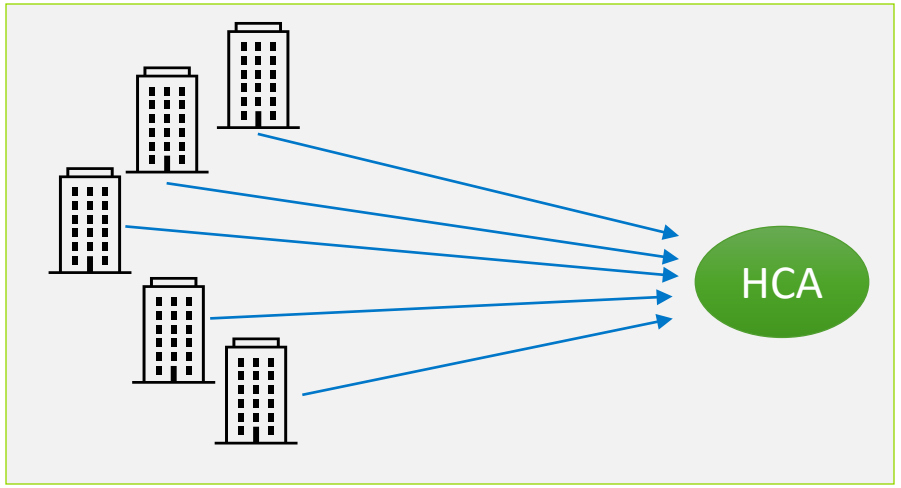


Washington State Health Care Authority

Data Collection Mechanism

Existing aggregate data call that can be modified to incorporate the Board-approved primary care definition and to solve for missing data elements in the APCD. However, there are several persistent challenges:

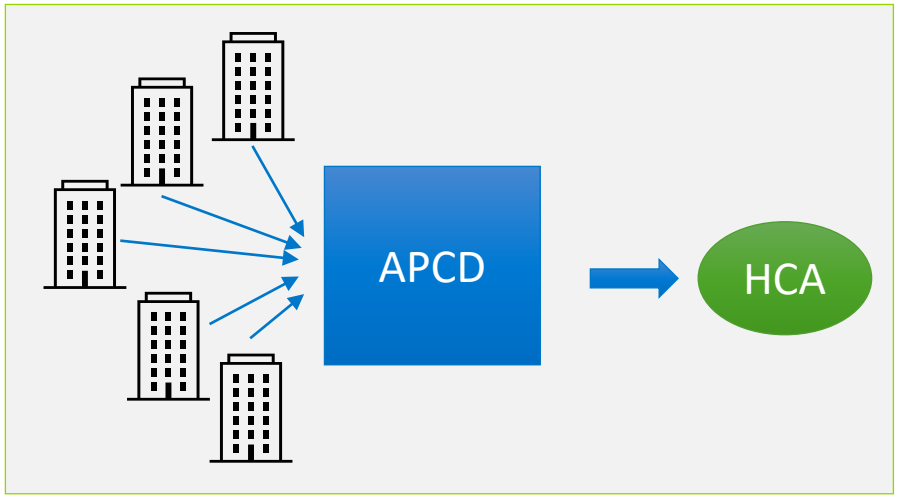
- Multiple entities calculate PC expenditures based on state-provided specifications = opportunity for inconsistent application of the specifications.
- Self-reported aggregate data reduces accountability and transparency
- The process is administratively burdensome and partially duplicative with APCD reporting by plans.



Washington State Health Care Authority

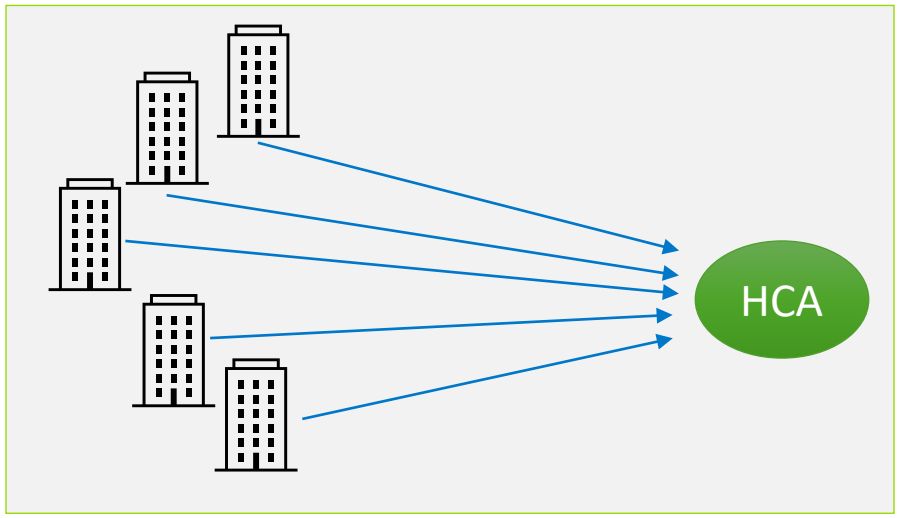
HCA Proposal – A Hybrid Solution

Claims-based Expenditures



- Standardization of reporting and interpretation
- Increased process transparency
- Leverage existing infrastructure

Non-claims-based Expenditures



- Solution for APCD data gaps
- Customizable for reporting under value-based purchasing or other categorical frameworks

Washington State Health Care Authority

Tab 5

Washington State Health Care Authority

Health Care Affordability for Washingtonians: Snapshot of Current Affordability Efforts

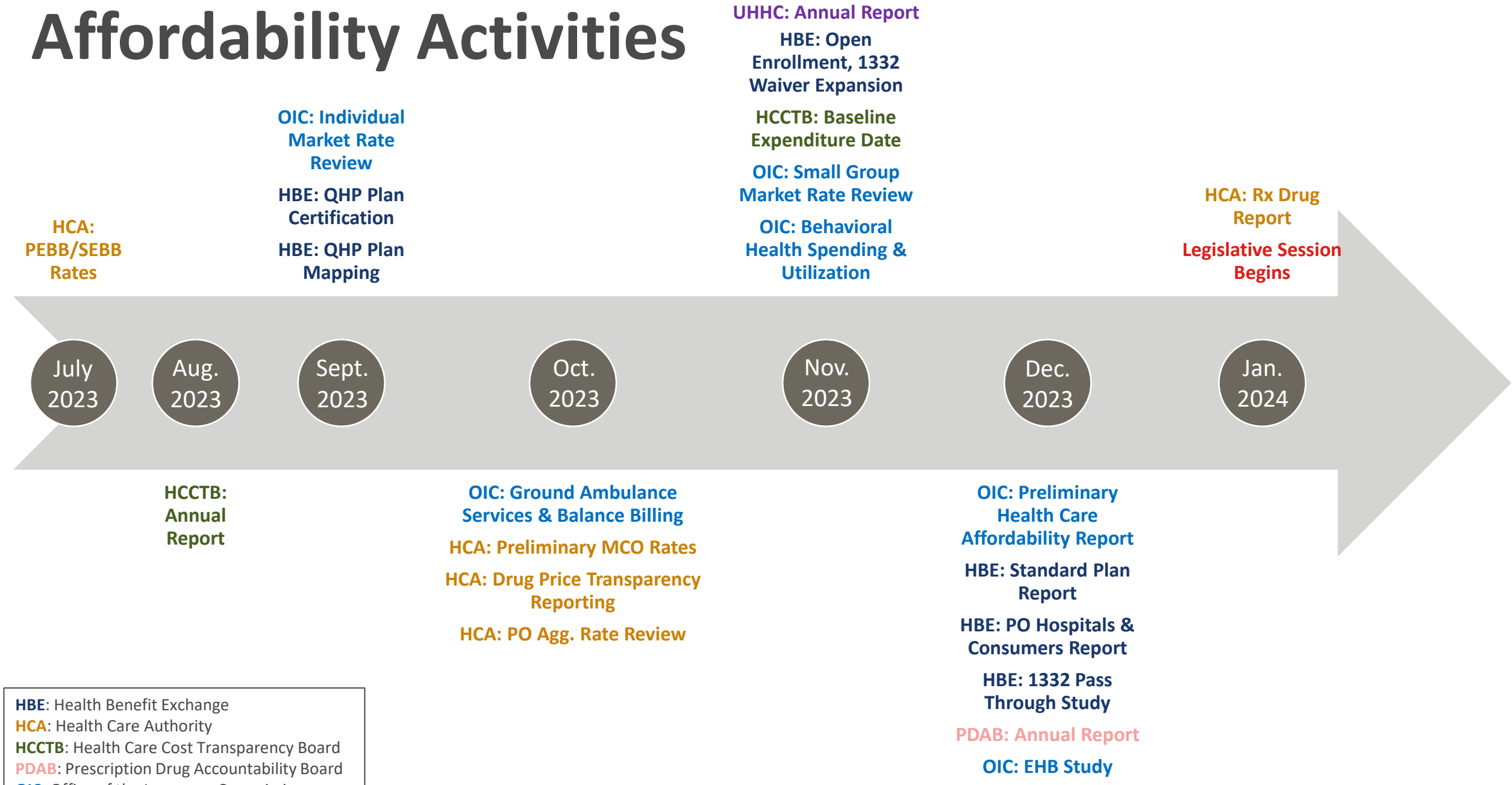
by Mich'l Needham

Washington State Health Care Authority

Sample of Washington Cost Transparency Efforts

- Rx Price Transparency (2019) - RCW 43.71C
- DOH Hospital financial reports – RCW 43.70.052
- All Payer Claims Database – RCW 43.371
- Health Care Cost Transparency Board (2020) – RCW 70.390
- Prescription Drug Affordability Board (2022) – RCW 70.405

Affordability Activities



HBE: Health Benefit Exchange
HCA: Health Care Authority
HCCTB: Health Care Cost Transparency Board
PDAB: Prescription Drug Accountability Board
OIC: Office of the Insurance Commissioner
UHHC: Universal Health Care Commission

Questions?

- Visit out webpages for more information on these projects at www.hca.wa.gov

Washington State Health Care Authority

Exchange Strategies to Approach Rising Costs

Health Care Cost Transparency Board

October 18, 2023

Laura Kate Zaichkin, Senior Policy Advisor (she/her)

washington healthbenefitexchange
powering washington healthplanfinder

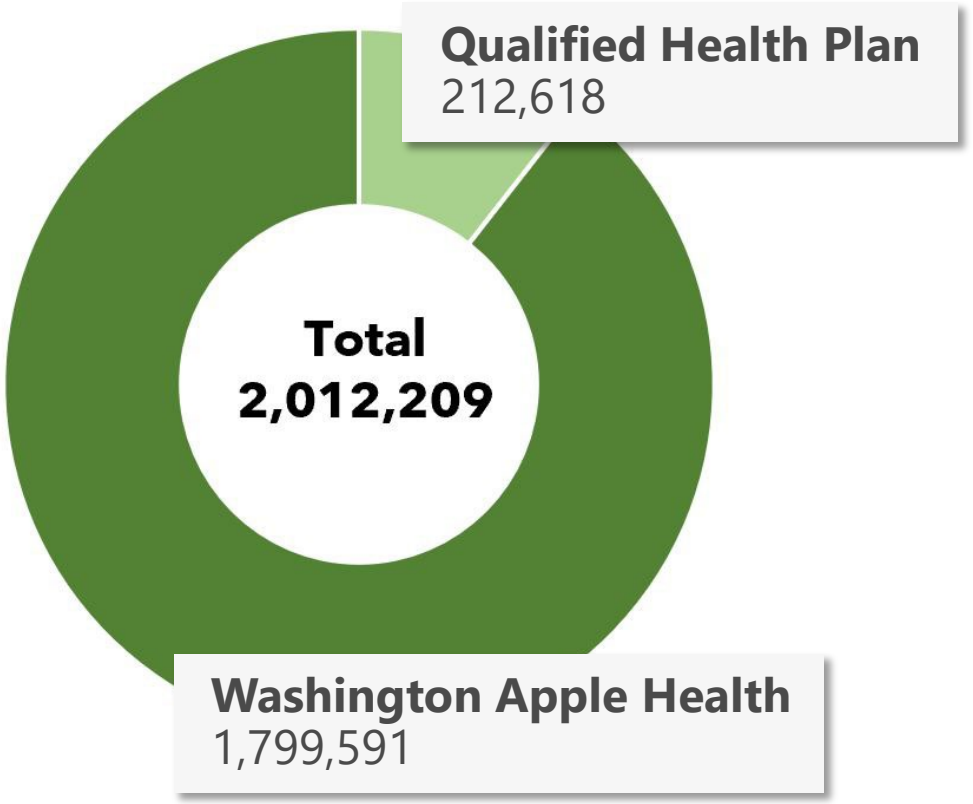
Exchange Background

The Exchange operates *Washington Healthplanfinder*, the state's online health insurance marketplace.

Over 2 million people –1 out of every 4 – Washingtonians use **www.wahealthplanfinder.org** to get health insurance.

- 1.8M Apple Health (Medicaid) customers
- 212K Qualified Health Plan (QHP) customers

The Exchange is publicly funded and governed by a bi-partisan board nominated by WA Legislature



Individual Market/QHP represents about **4.5%** of WA market

Market Health Summary

High premiums and high cost sharing remain the primary barriers to more Washingtonians being insured and getting access to care.

Exchange Premium Increases Threaten Access & Affordability

2024 Exchange premiums increasing 9% for the second year

- Third wave of nearly 10% rate increases in successive years.
- 70% of Exchange customers facing rate increases above 5%.
- Average customer paying $360 more in premiums in 2024.
- 23% (~48,000) of consumers do not receive federal or state subsidies.

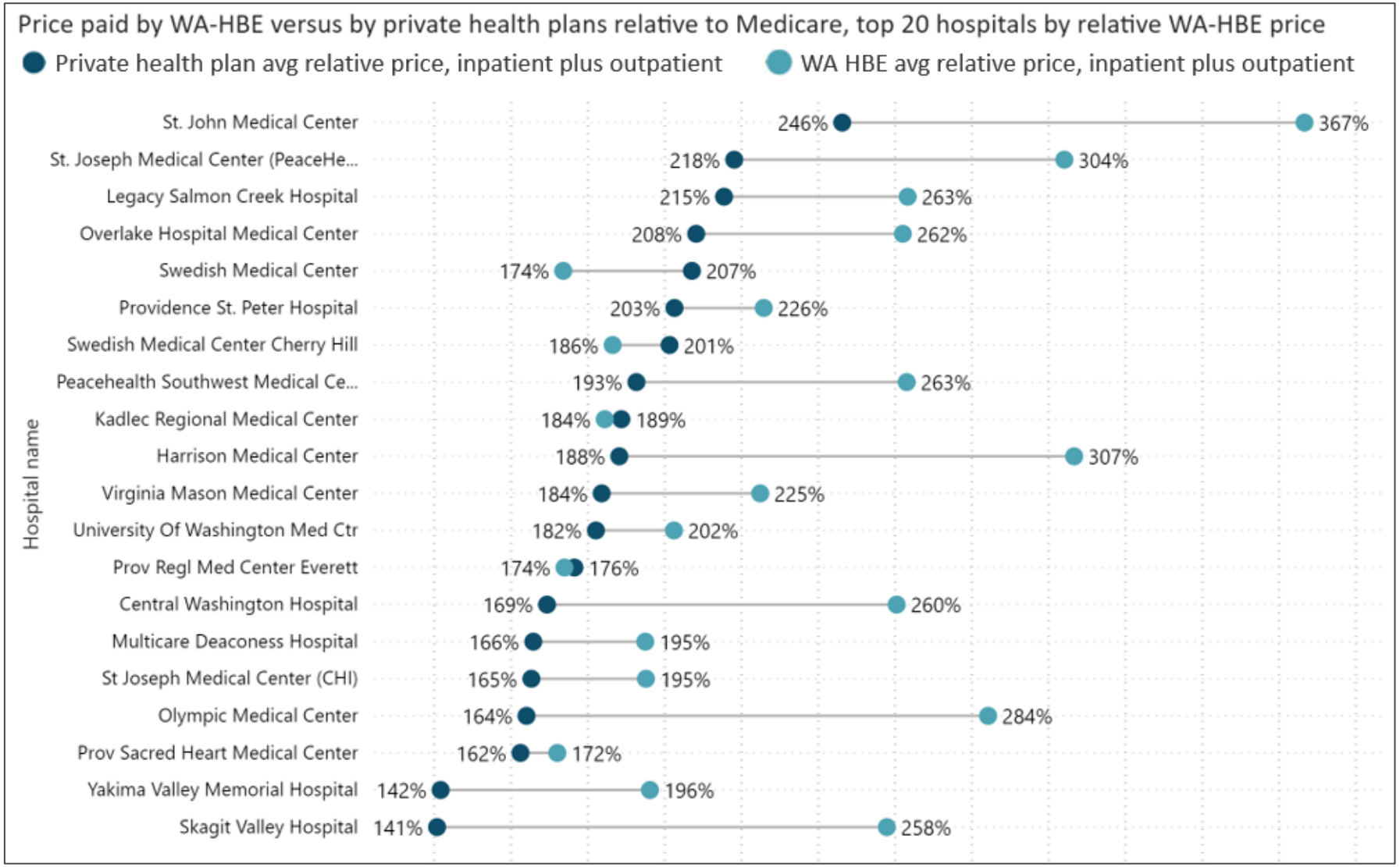
Carrier	2024 Average Rate Change
Kaiser Foundation Health Plan of Washington	18%
Premera Blue Cross	17%
BridgeSpan Health Company	16%
PacificSource Health Plans	9%
LifeWise Health Plan of Washington	8%
Regence BlueCross BlueShield of Oregon	8%
Kaiser Foundation Health Plan of the Northwest	7%
Molina Healthcare of Washington	6%
Coordinated Care Corporation	5%
Regence BlueShield WA	4%
UnitedHealthcare of Oregon, Inc.	-0.5%
Community Health Plan of Washington	-1%

Average rate changes are weighted for Exchange enrollment

Exchange Customers Pay More For Health Care

Exchange customers pay 35% more for their hospital care than other commercially insured WA residents.

- WA relative price: 174% of Medicare.
- Exchange customer relative price: 210% of Medicare.



Source: RAND 4.0, Prices Paid to Hospitals by Private Health Plans

State Policy Options to Reduce Cost

	Policy Category	Washington State Levers	Exchange/Cascade Care Levers*
1	**Market Based Approaches**	• Price transparency • Evidence based payment/Value Based Purchasing • Active Purchasing/Collaboratives • Reference Pricing	• Price Transparency • Cascade Select/Public Option Rate Cap • Standard Benefit Design • Selective Contracting

2	**Address Market Failures**	• Payment Limits/Oversight commission
		  • Balance Billing, Site neutral payments, Spread pricing, Rebate pass through
		  • Rate or Growth Caps
		• All-payer rate setting, global budgets
			• Public Insurance Plan Option
			• Market Participation (Carrier) Limits

3	**Eliminate Regulatory Barriers to Competition**	• Reform certificates of need • Licensing, scope of practice, telehealth	
4	**Prohibit Antitrust and Anticompetitive Practices**	• State merger enforcement • Address anticompetitive practices and contracts • Certificate of Public Advantage	

*Note: State Based Marketplaces also reduce consumer cost burden through subsidies such as Federal and State Premium and Cost Sharing Subsidies, Reinsurance and Basic Health Plan.

Exchange Affordability Action Plan

1. Cascade Care – a central affordability initiative
   - Standard Plans
   - Public Option
   - State Premium Subsidy
2. Price transparency and Exchange claims analysis
   - HBE is a member of WA Health Care Cost Transparency Board
   - RAND V4.0 hospital pricing study
   - UCLA research partnership on public option (underway)
3. Expand federal premium assistance
   - Maintain $200 million additional premium assistance through Inflation Reduction Act
4. Partner with Medicaid and employers
   - Washington Health Alliance and PGBH
   - Incent high quality care that improves health and reduces overall costs; Focus: Advanced primary care

Cascade Care

Cascade Care makes health insurance accessible and affordable for every *Washington Healthplanfinder* customer.

- **Lower premiums**
- **Higher quality benefits**
- **Lower copays**
- **Easier plan shopping**
- **Available in all counties**
- **Extra savings for those who qualify**

2 in 3

Washington Healthplanfinder QHP customers are enrolled in Cascade Care plans

55,000+

Washington Healthplanfinder customers have lowered their monthly premiums with Cascade Care Savings

14%

Lower premiums before subsidies in public option plans, on average, compared to non-Cascade plan premiums

Data as of 5/2023

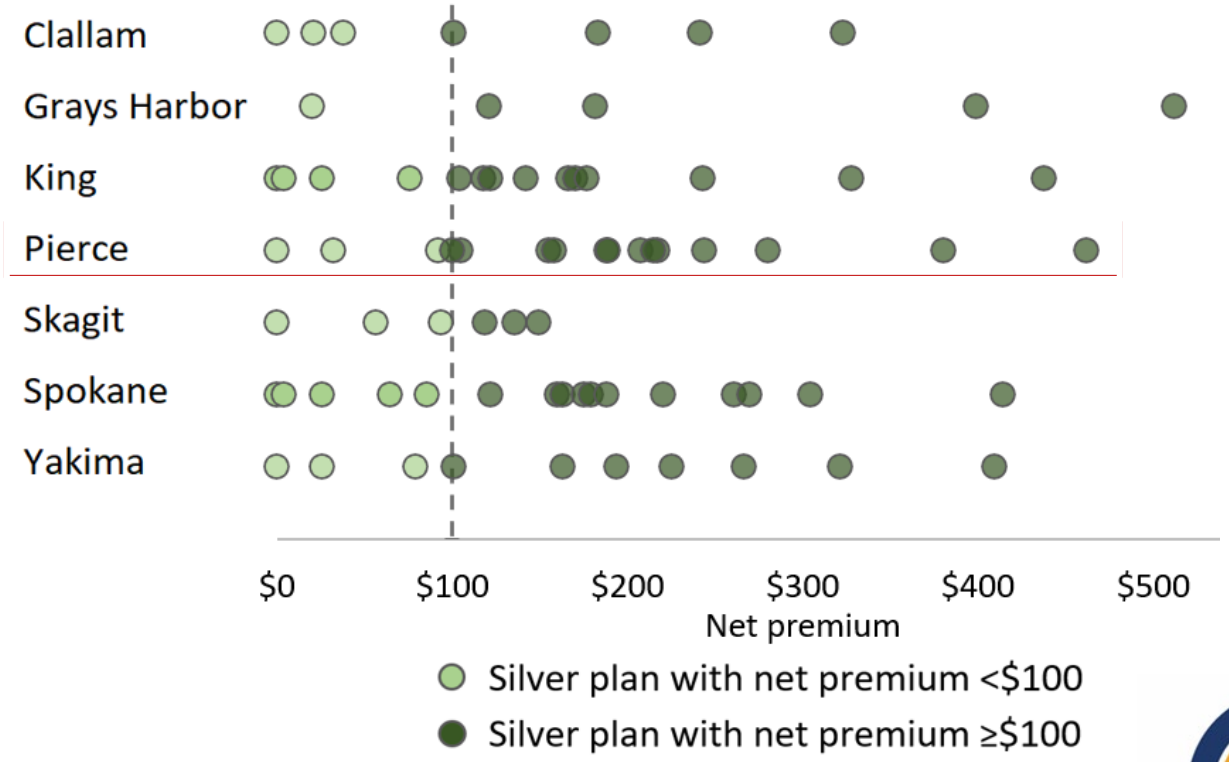
Cascade Care: Helping make health insurance affordable and accessible for every *Washington Healthplanfinder* customer

- All **Cascade Care plans** let customers pay less at the doctor's office with more predictable costs. For example, regular check-ups and mental health office visits are covered without a deductible.
- **Standard plans** are high-quality, low-cost, thoughtfully designed plans available exclusively to *Washington Healthplanfinder* customers.
- The nation's first **public option plan**, Cascade Select, is selected by the State and intended to be the most affordable plans for *Washington Healthplanfinder* customers.
- A **state subsidy** named Cascade Care Savings lowers customers' premiums through state-funded premium assistance. Low-income customers can get Cascade Care Silver or Gold plans for lower costs than non-Cascade plans.

Subsidies Alone Insufficient to Address Affordability

- Majority of plans are unaffordable even after Cascade Care Savings and Federal Tax Credits are applied.
- For customer at 250% FPL ($36,450 income):
  - Only a few silver plans in each county have a net premium under $100.
  - Monthly premium over ~$300 is more than 10% of income spent on premiums.

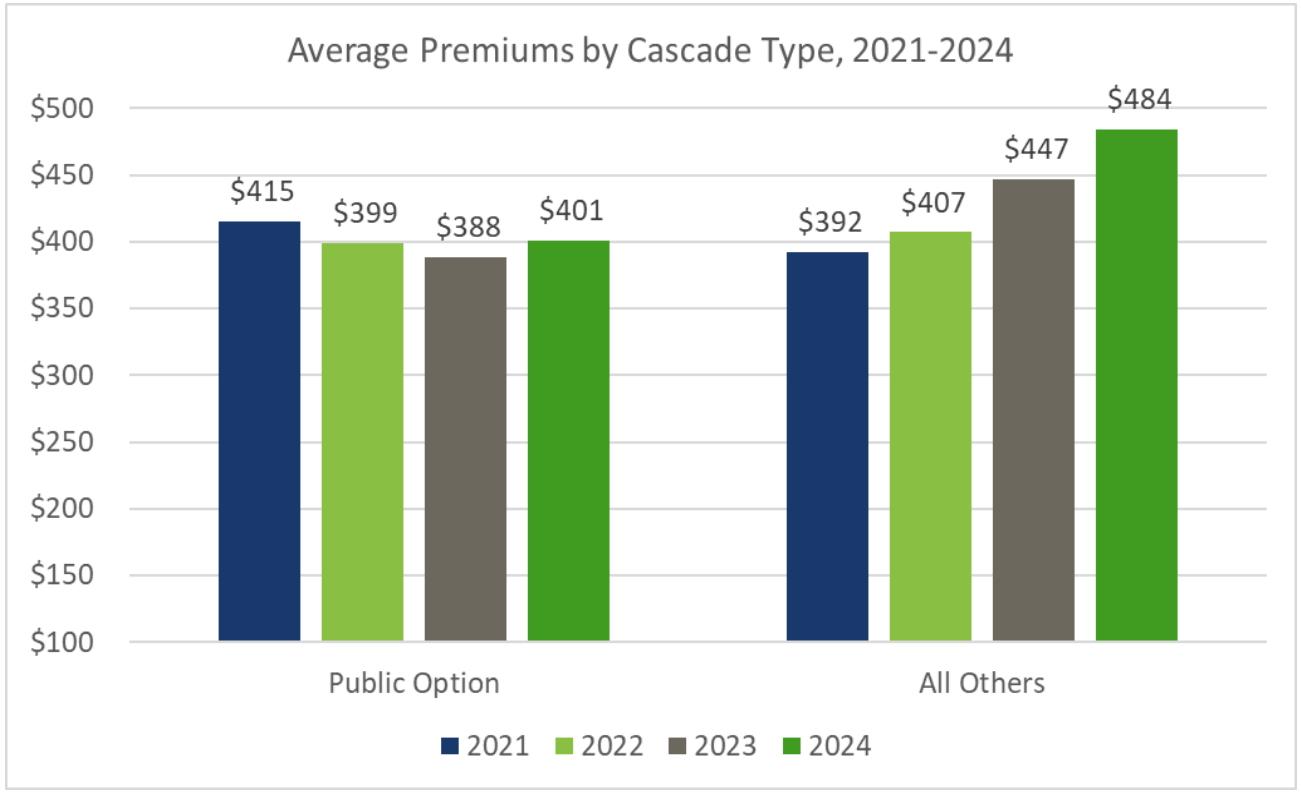
Net Premium after APTC and Cascade Care Savings Applied, 2024 Rates, 40-year-old Non-Smoker at 250% FPL*



CASCADE CARE

Public Option Shows Promise

Public option plans show promise in advancing customer affordability compared to other Exchange plans



Plan Type	Last Year	This Year	2022-2024
Cascade Public Option	-3%	3%	**0.5%**
All Others	10%	8%	**19%**

Rates for 40-year-old nonsmoker, inclusive of all counties, and are not weighted for enrollment. Rates are before any available state or federal subsidy.

Source: 2021-2024 OIC Carrier Rate Filings

CASCADE CARE

Public Option Presents Opportunity To Meaningfully Reduce Premiums, But Needs Strengthening

- Participating public option plans are generally meeting the current provider reimbursement cap (160%).
- Intended premium reduction of 10% has not been achieved by the cap.

Exhibit 2
Cascade Care Public Option - Results of Reimbursement Target Review
Affordability Requirement Performance Summary
Claims Incurred from January 1, 2021 through December 31, 2021

ALL CARRIERS — Member months: 26,622

Affordability Requirement	Metric Results		
	Requirement	Performance	Results
A) Aggregate Percent of Medicare Reimbursement[1]	< 160%	164%	FAIL
B) Physician Primary Care Percent of Medicare Reimbursement	> 135%	139%	PASS
C) Critical Access and Sole Community Hospital Reimbursement	> 101%	160%	PASS
Summary of Affordability Requirements[2]	**FAIL**		

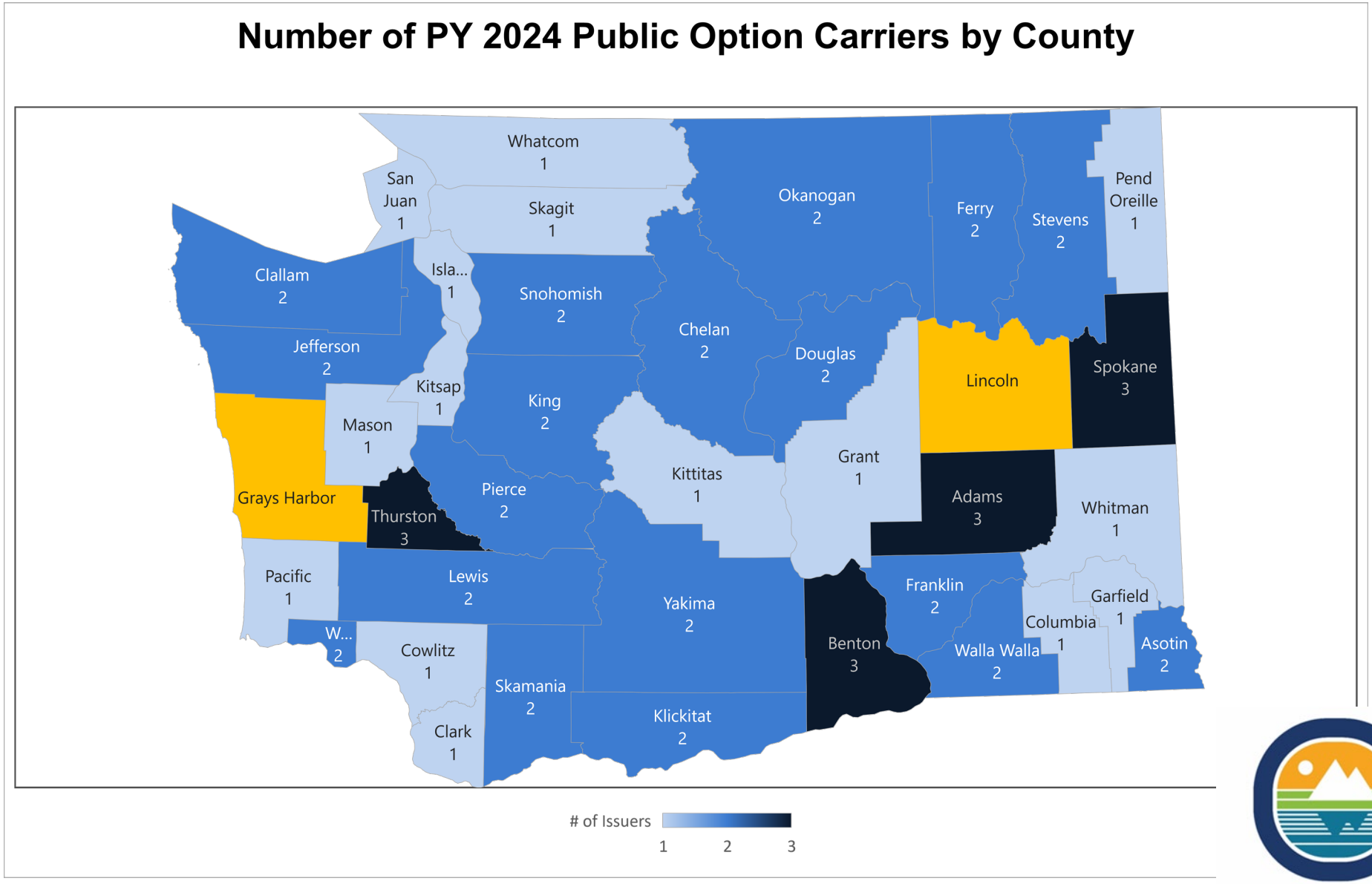
Notes
1. Inpatient hospital claims experience and percent of Medicare reimbursement rates adversely affected by several large outlier claims in late 2021.
2. Of five 2021 carriers, two carriers meet all three affordability requirements and one carrier has insufficient experience for evaluation.

Source: Milliman analysis of 2021 public option carrier claims: https://www.hca.wa.gov/assets/program/cascade-select-leg-report-20221216.pdf

CASCADE CARE

Public Option Presents Opportunity To Meaningfully Reduce Premiums, But Needs Strengthening

Strengthened provider participation requirements may be needed to ensure statewide public option access and healthy competition.



CASCADE CARE

Legislative Direction

Legislative reports due by December 1, 2023

Public Option Impacts

- Exchange report about the impact of public option on hospital financial sustainability.
- Health Care Cost Transparency Board report about the impact of public option on consumers.
- Based on above analyses, Exchange recommendations to the Legislature about how to address public option financial or other issues.

Offering Only Cascade Care Plans

- Analyze impact to Exchange customers of offering only Cascade Care (standard & public option) plans on the Exchange starting in 2025.

1332 Waiver Pass Through Study

- Assess waiver amendment(s) to capture federal pass-through funding to support affordability programs, focusing on methods being used in other states that could be most readily leveraged in Washington.

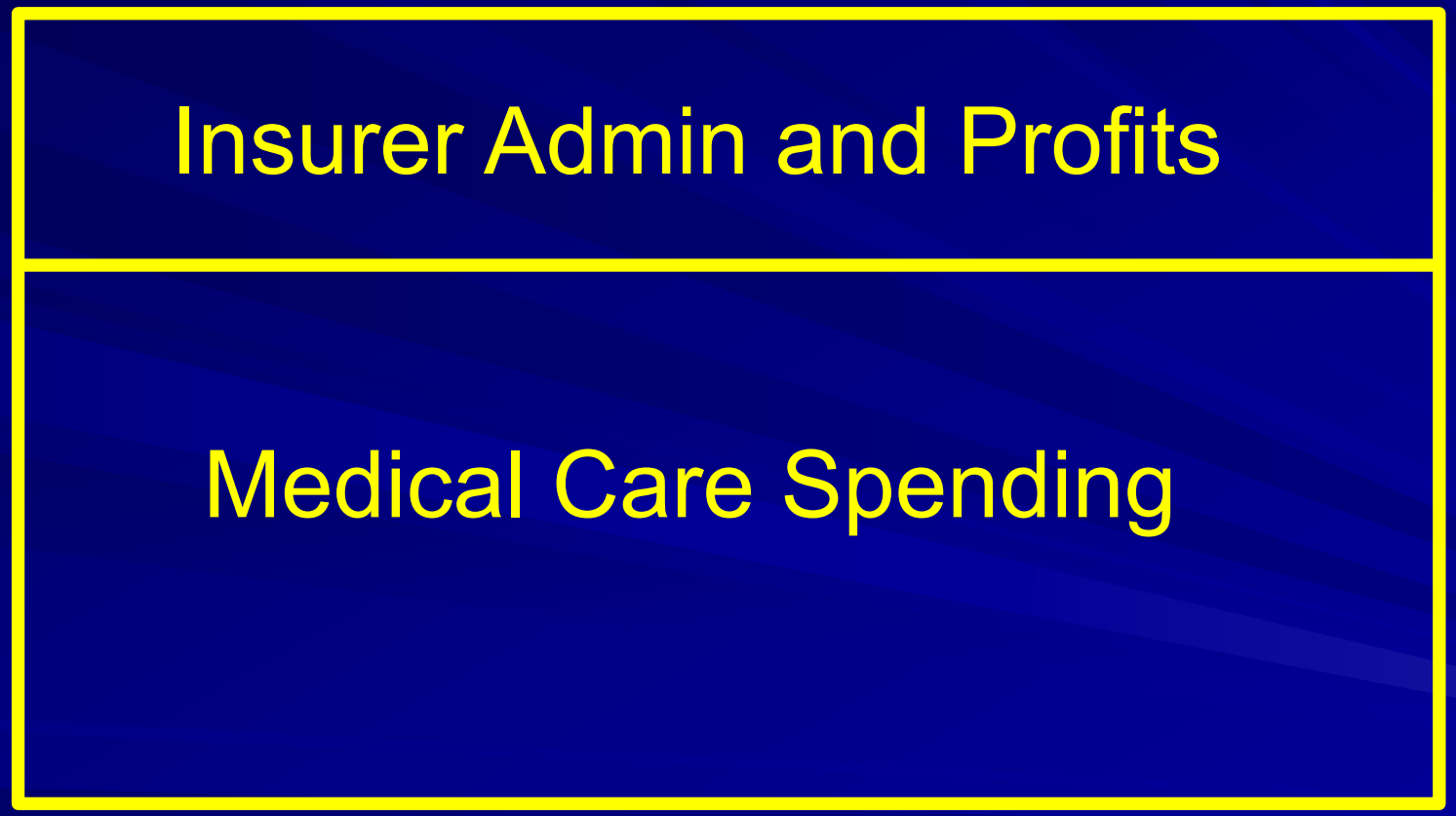
CASCADE CARE

Questions & Discussion

Laura Kate Zaichkin, Senior Policy Advisor
laurakate.zaichkin@wahbexchange.org

Appendix

Basic Spending Math



Price

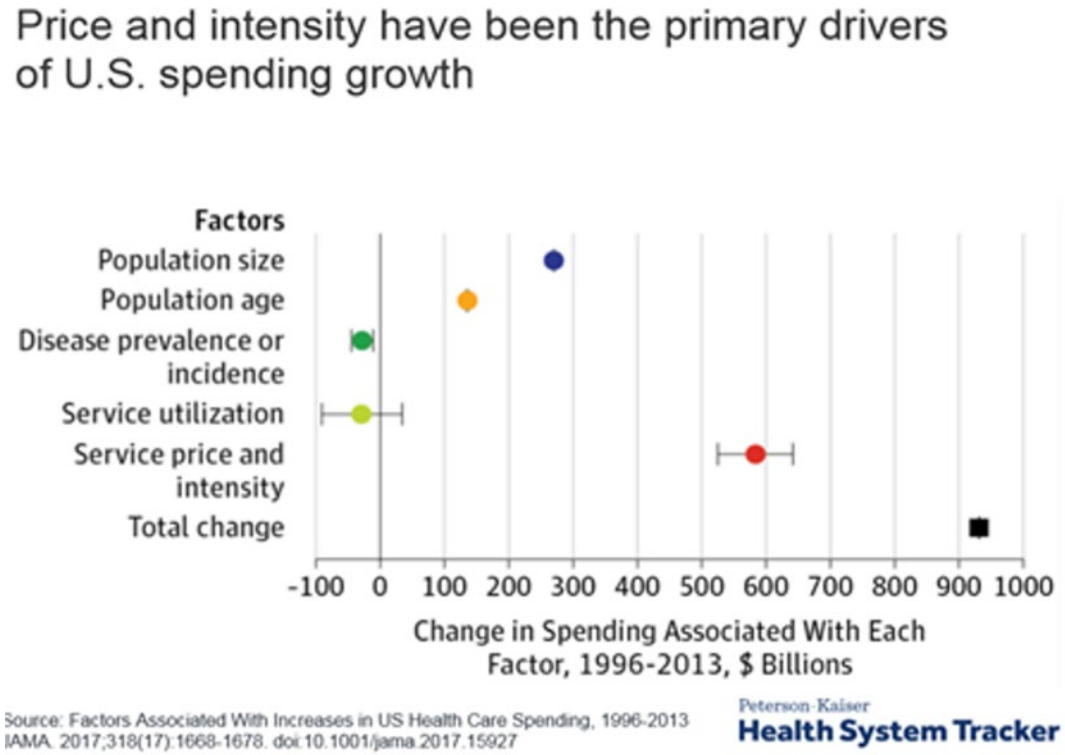
Utilization

Michael Chernew, PhD

Harvard Medical School

Nationally - Medical Costs are High

Prices are the driving factor and hospital costs are largest share of costs



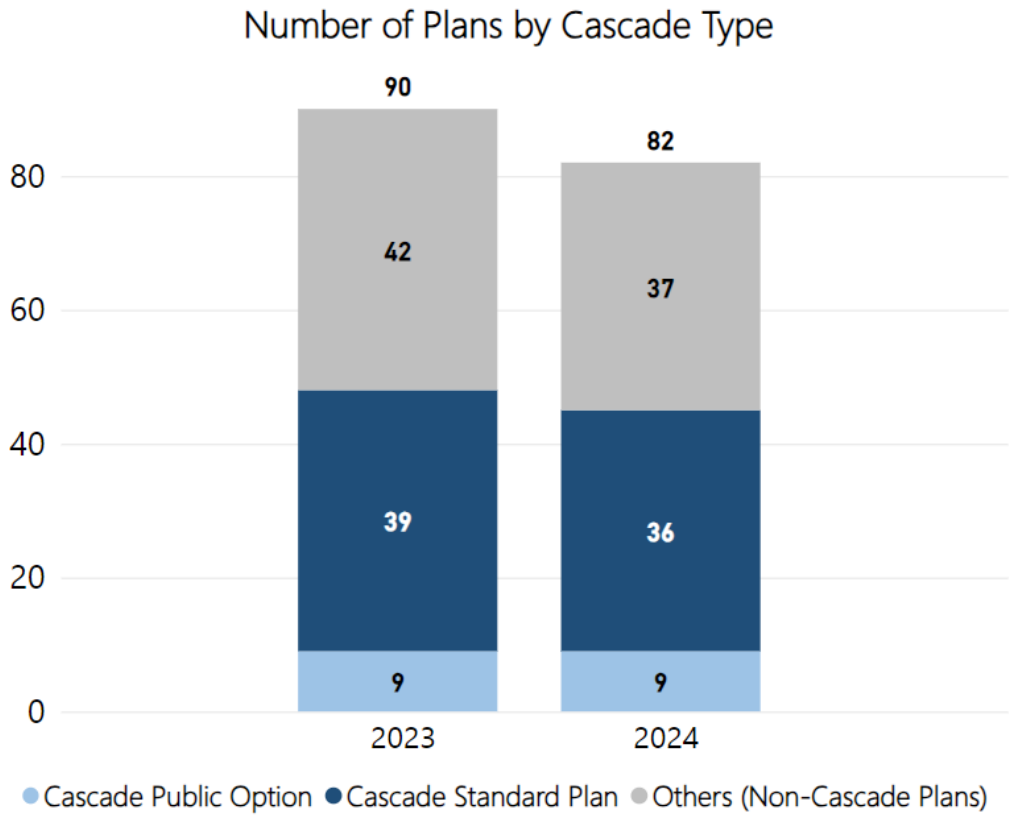
Health Care Cost Institute 2021 Report

2024 Market: Overview

82 qualified health plans

12 carriers

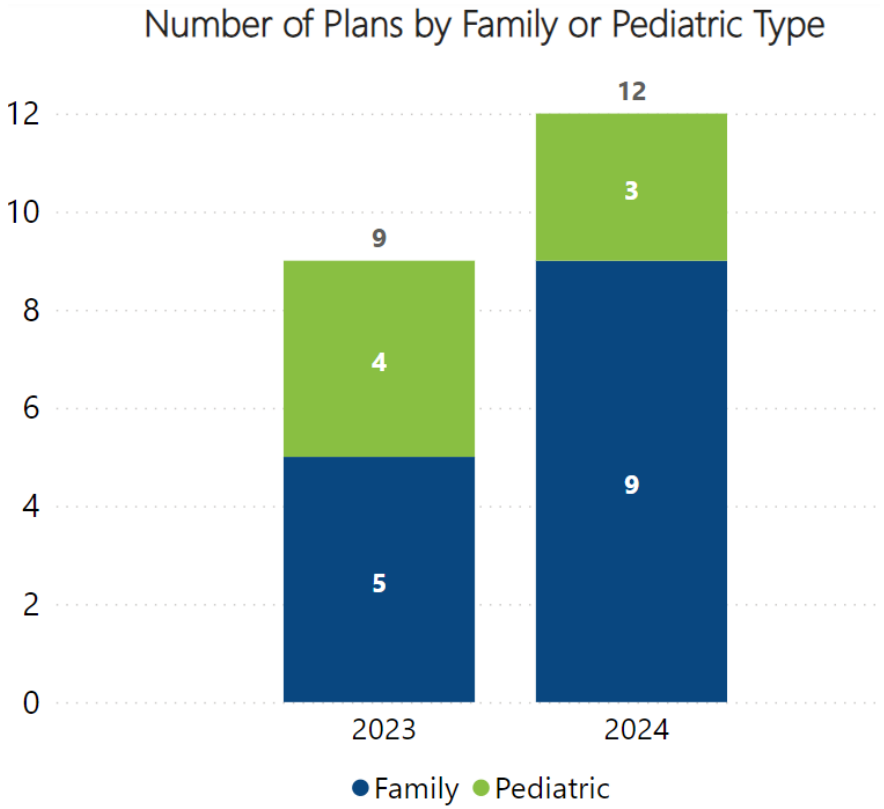
2-10 carriers in every county



12 qualified dental plans

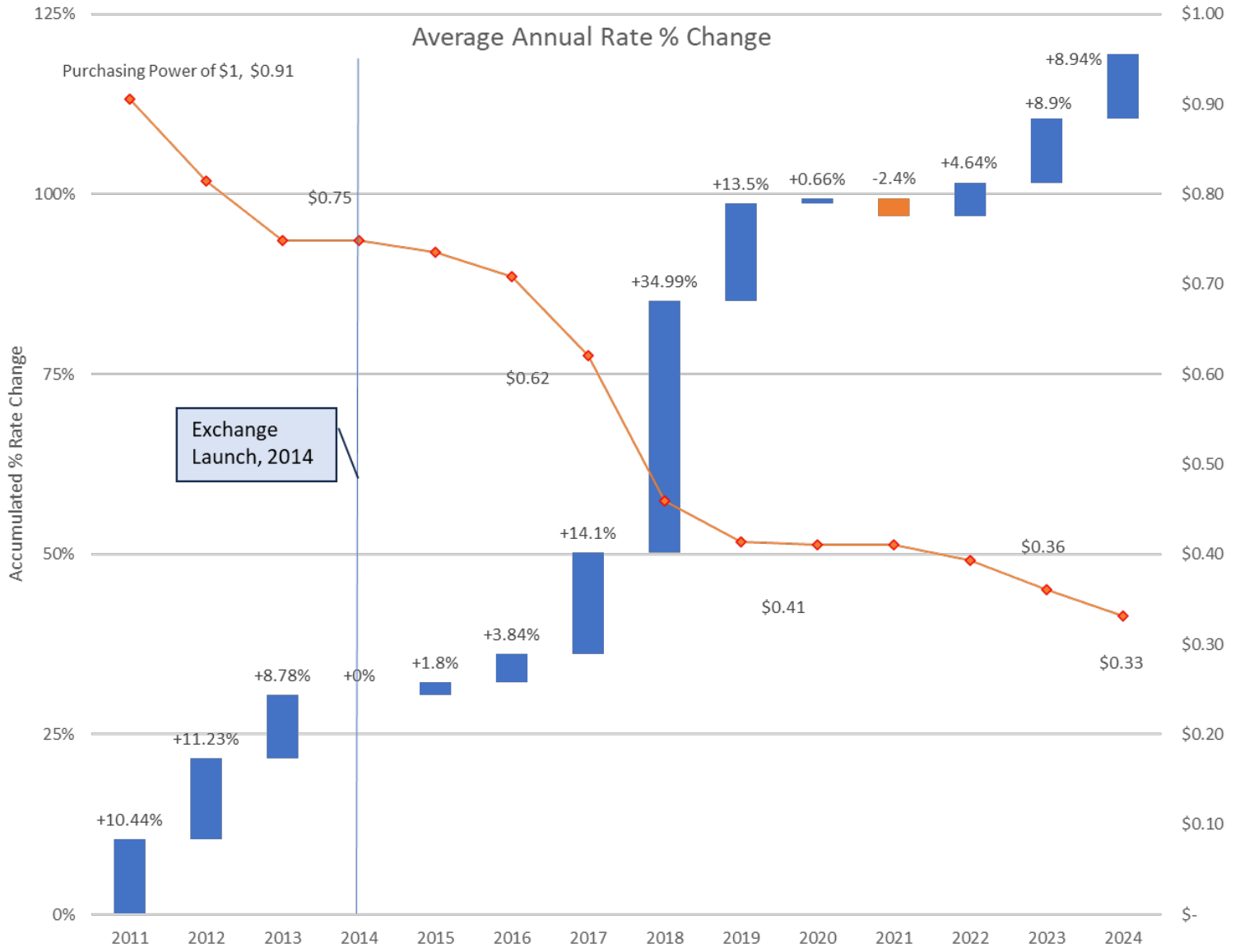
6 carriers

New dental carrier



Historical Rate Changes Compound 2024's Large Rate Increase

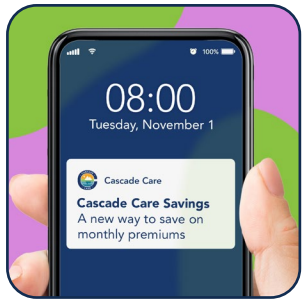
Weighted Average Rate Changes
Washington State Individual Market



Health Benefit Exchange Enrollment

Year	QHP Enrollment
2014 OE 1	139,700
2015 OE 2	152,517
2016 OE 3	166,098
2017 OE 4	204,334
2018 OE 5	209,802
2019 OE 6	196,328
2020 OE 7	191,857
2021 OE 8	191,526
2022 OE 9	212,618
2023 OE 10	210,380
Medicaid Redetermination 9/2023	222,562

Legislative Direction to Date



2019: Cascade Care 1.0

- Cascade Care is created, providing new coverage options available through *Washington Healthplanfinder*:
  - **Standard Plans** (Cascade) designed by HBE to have the same benefit design & lower cost sharing for easy comparison and better value.
  - **Public Option Plans** (Cascade Select) standard plans procured by HCA that include additional quality, value, and provider reimbursement expectations.
- The Exchange is directed to develop a plan to implement a state premium assistance program and analyze the impact of offering only standard plans beginning in 2025.

2021: Cascade Care 2.0

- Improvements are made to Cascade Care by:
  - Limiting the number of non-Cascade plans carriers could offer on the Exchange.
  - Requiring public option participation by hospital systems participating in other public programs.
- The Exchange is directed to establish a state premium assistance program (Cascade Care Savings) in 2023, with an initial annual funding level of $50 million.
- The Exchange is directed to explore coverage solutions for individuals without a federally recognized immigration status (1332 Waiver) beginning in 2024.

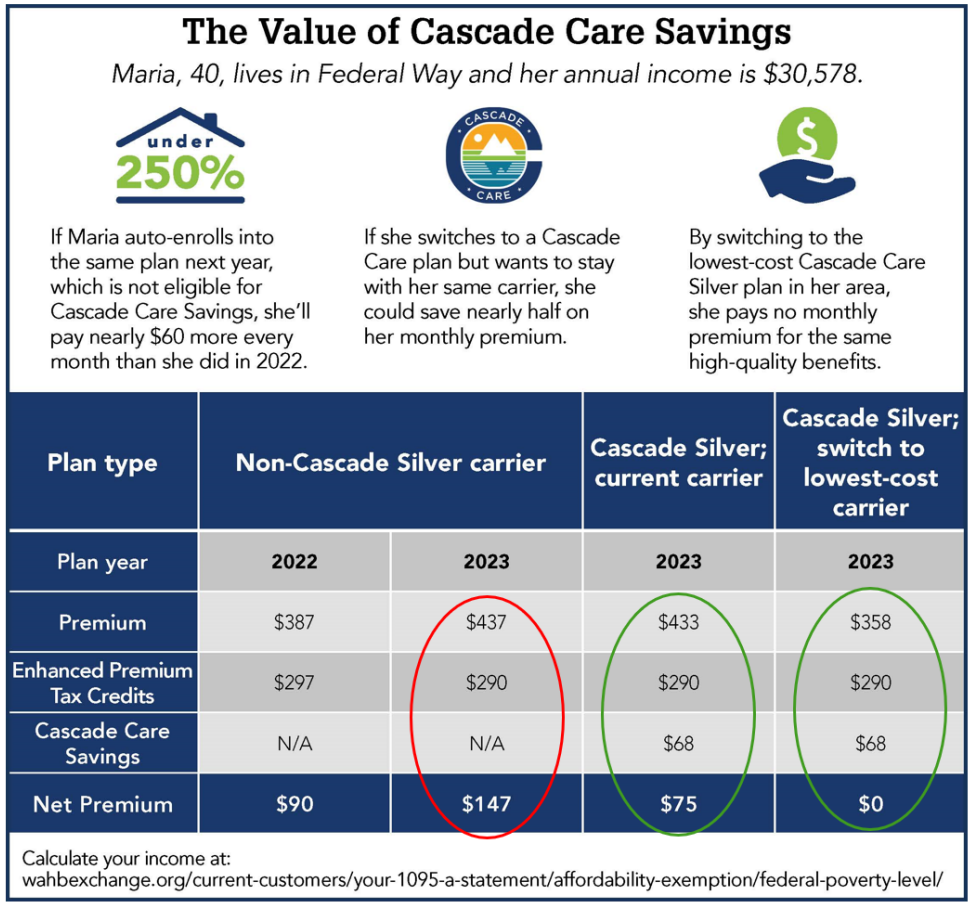
2023 Session

- Cascade Care Savings funding is sustained at $50 million annually, with an additional $5 million annually to provide subsidies to new customers under the 1332 Waiver.
- The Exchange is directed to conduct a study on how the 1332 Waiver could be amended to generate federal pass-through funding to support Exchange affordability programs.

Cascade Care 1.0 – Notable "Firsts"

- Broad-based recognition of how much Exchange customers were paying (as a percentage of their income) for both premiums and cost-sharing (particularly deductibles).
- Broad-based recognition of the difficulties Exchange customers were facing comparing plan designs and costs (premiums, co-pays, coinsurance, etc.).
- Exchange authorized to design standard plans.
- First state in the country to pass a public option bill.
- First time state's broader purchasing authority leveraged to help lower costs in Exchange market.
- First aggregate provider reimbursement cap in Exchange market (protections included for rural and primary care providers).
- First indication of support for a state premium subsidy.

Cascade Care 2.0 – Notable "Firsts"



The Value of Cascade Care Savings

Maria, 40, lives in Federal Way and her annual income is $30,578.

under 250%

If Maria auto-enrolls into the same plan next year, which is not eligible for Cascade Care Savings, she'll pay nearly $60 more every month than she did in 2022.

If she switches to a Cascade Care plan but wants to stay with her same carrier, she could save nearly half on her monthly premium.

By switching to the lowest-cost Cascade Care Silver plan in her area, she pays no monthly premium for the same high-quality benefits.

Plan type	Non-Cascade Silver carrier		Cascade Silver; current carrier	Cascade Silver; switch to lowest-cost carrier
Plan year	2022	2023	2023	2023
Premium	$387	$437	$433	$358
Enhanced Premium Tax Credits	$297	$290	$290	$290
Cascade Care Savings	N/A	N/A	$68	$68
Net Premium	$90	$147	$75	$0

Calculate your income at:
wahbexchange.org/current-customers/your-1095-a-statement/affordability-exemption/federal-poverty-level/

- First updates to Cascade Care to strengthen existing requirements post launch (2021). Focus on:
  - Improving plan offerings/limiting 'me too' plans/further addressing 'choice overload.'
  - Maximizing available federal subsidies (limiting non-standard plans at silver level).
  - Expanding availability of public option plans (provider participation requirements).
- First state premium assistance program established for low-income customers (up to 250% FPL).
  - Established for federally subsidized and non-federally subsidized customers.
  - Tied to silver and gold Cascade Care plans.
- Exchange authorized to pursue a first-in-kind federal 1332 waiver to expand QHP/QDP coverage to all Washingtonians, regardless of immigration status, starting in 2024.

2023 Session – Notable Accomplishments

- Sustained state investment in Cascade Care Savings.
- Member education on Cascade Care: increased enrollment, expanded availability and competitive pricing of public option plans (lower premiums and lower deductibles compared to non-Cascade).
- New state investments in 1332 waiver implementation, including enhanced community-based outreach.

	Required standard deductibles for all 2023 Cascade Care plans	Range of deductibles for 2023 non-Cascade plans
GOLD	$600	$0-$2,000
SILVER	$2,500	$750-$7,550
BRONZE	$6,000	$3,800-$8,900

Public Option Background

Standard Cascade Care Plans With Additional Quality, Value, & Affordability Requirements

Public Option Goal	Policy Lever to Advance Goal	Policy Description

Affordability: Meaningfully Lower Premiums	• State-defined provider reimbursement requirements.
	• Participation requirements for hospital systems that participate in other public programs.
	• Competitively procured by the State.
		• Provider reimbursement requirements:
		  • May not exceed 160% of Medicare for all covered benefits in statewide aggregate.
		  • Reimbursement floors for critical access/sole community hospitals and primary care services.
		• Hospitals must contract with at least one public option plan.
		• HCA procures and contracts for public option plans offered on the Exchange.

Statewide Access	• Participation requirements for hospital systems that participate in other public programs. • Competitively procured by the State.	
Quality & Equity	• Cost and quality transparency requirements. • Requires adoption of state quality, equity standards.	• Reporting on health improvement activities, primary care spend, quality measures. • Adoption of Bree and Health Technology Clinical Committee recommendations.

As required by SB 5526 & SB 5377

2023 Health Plans Offered on *Washington Healthplanfinder*

		Non-Cascade plans	Cascade Care Plans	
			Cascade (standard) plans	Cascade Select (public option) plans
Meets all QHP requirements	Requirements for all QHPs in 2023: • All plans must meet all requirements under RCW 43.71.065. • Carriers must offer gold and silver Cascade Care health plans to participate in Washington Healthplanfinder. • Carriers offering a non-Cascade bronze plan on Washington Healthplanfinder must also offer one bronze Cascade Care health plan on Washington Healthplanfinder in any county where it offers a bronze plan. • Carriers offering Cascade Care health plans may offer up to two non-Cascade gold plans, two non-Cascade bronze plans, one non-Cascade silver health plan, one non-Cascade platinum health plan, and one non-Cascade catastrophic health plan in each county where the carrier offers a qualified health plan.	X	X	X
Eligible for tax credits		X	X	X
Eligible for Cascade Care Savings state premium subsidy for residents earning up to 250% FPL.			X	X
Includes standard health plan benefit design set by the Exchange.			X	X
Includes quality, value, and provider reimbursement requirements set by the Legislature and Health Care Authority.				X
Hospital participation requirements set by the Legislature.				X
Procured through the Health Care Authority.				X

OIC -- Health care cost/affordability

Presentation to Health Care Cost Transparency Board

Jane Beyer, Senior Health Policy Advisor

October 18, 2023

OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

Affordability Study

Legislative directive

Budget proviso (ESSB 5187, Sec. 144(13)) directs OIC, in collaboration with the Attorney General's office, to undertake a health care affordability study.

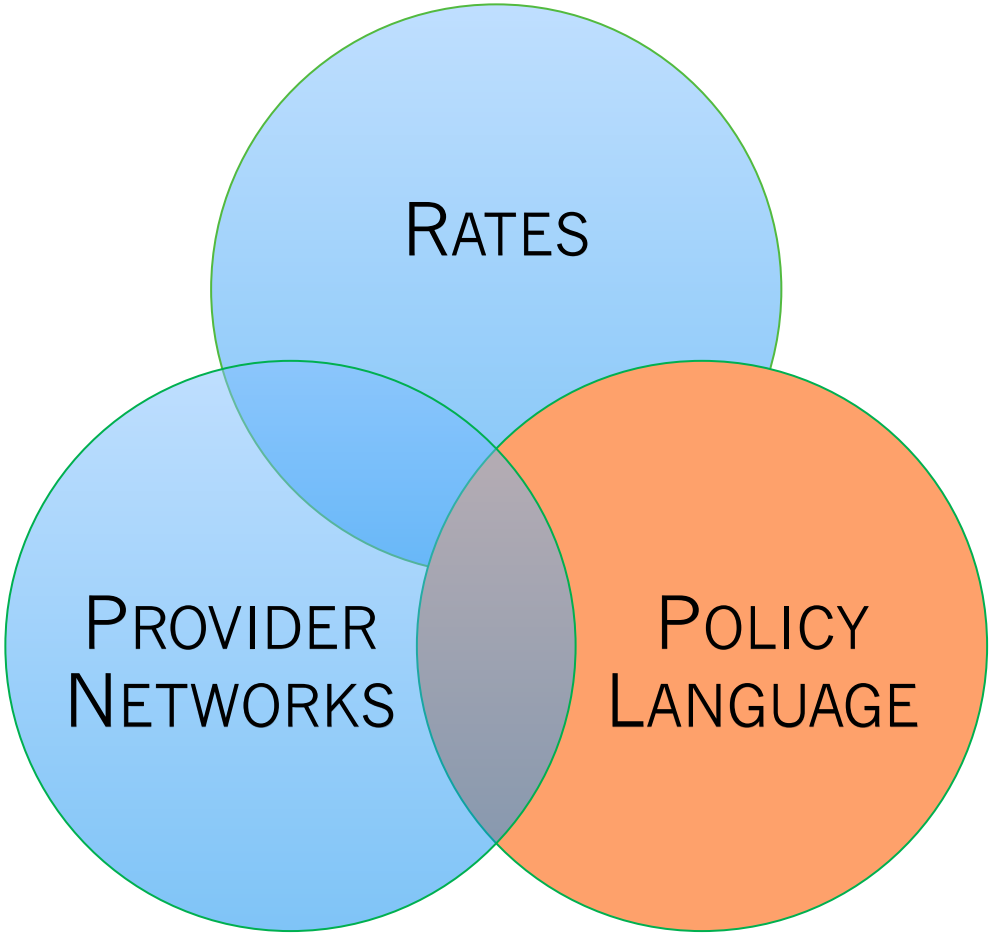
- OIC contracting with Health Management Associates (HMA) to prepare the report
- Office of the Attorney General: focus on merger and acquisition and anti-competitive contracting issues/options

Legislative directive

- Preliminary report: due to Legislature Dec. 1, 2023
  - Structure of "business of health care" in Washington, i.e. horizontal consolidation, vertical integration, physician employment and private equity acquisitions
  - Overview of policy options to address affordability, including adoption/experience in other states and authority/capacity to adopt in Washington
- Final report: due to Legislature August 1, 2024
  - Deeper actuarial and economic analysis of subset of policy options presented in preliminary report

2024 individual and small group plan rates

OIC REVIEW – INDIVIDUAL AND SMALL GROUP HEALTH PLANS



Rates must be actuarially sound

- Individual and SG rates must be approved if actuarially sound
- Rates must be reasonable in relation to the benefits provided
- Individual and small group health plans must meet all Affordable Care Act (ACA) rating requirements, as well as other state and federal requirements
  - Large group health plan rates can be negotiated per RCW 48.43.733(2); no review of reasonableness or prior approval of these rates
- Single risk pool for the individual market; single risk pool for the small group market

Rate Projection

For individual and small group plans, insurers are required to submit detailed calculations and justification to show that their proposed rates are actuarially sound and meet all applicable rating requirements

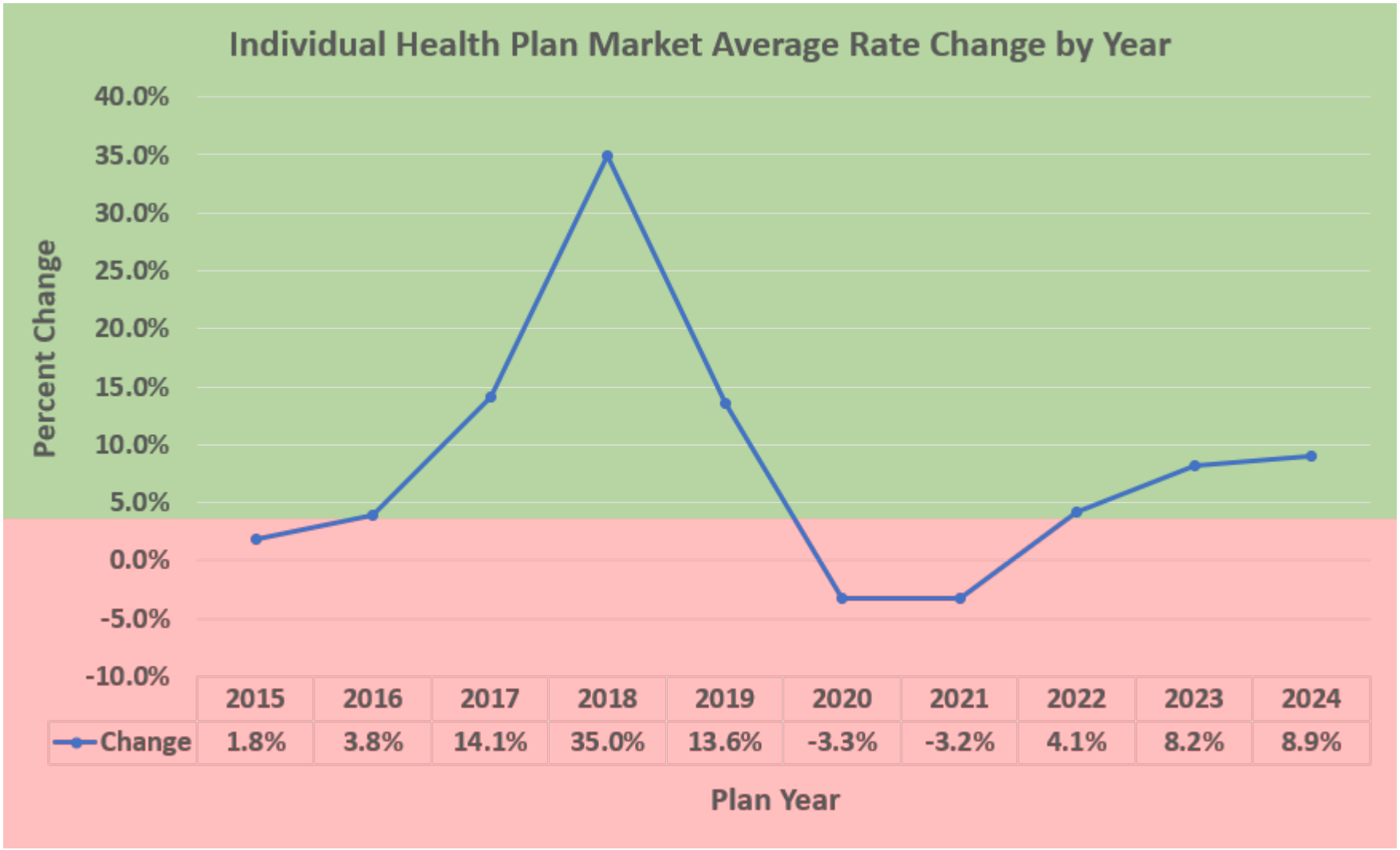
Components of (future prediction of) premium: medical claims, administrative expenses, and profit or loss

- Medical Claims: Key component to calculate projected claims is medical trend. Trend is combined impact of utilization of health services and changes in price
    - For plan year 2024, rate projections are based on the past experience of calendar year 2022 and predicted to future premiums in 2024

Rate Projection, con't

- Administrative Expenses: Expenses not related to paying medical claims including, but not limited to, employee salaries and benefits, office and equipment costs, customer service, appeals costs, taxes, and agent commissions
- Profit or loss: The company's projected profit (or contribution to surplus) is a small part of the premium. The reasonableness of the projected profit may depend on the company's current surplus level and the type of plan. For example, some plans attract more sick people and therefore take on more risk

Individual market rate trend



2024 Individual Health Plans Requested and Approved Average Rate Changes

Company Name	Exchange Status	Requested Average Rate Change	Approved Average Rate Change	People Impacted[1]
Asuris Northwest Health	Off Exchange	-3.39%	-7.03%	1,057
BridgeSpan Health Company	On Exchange	15.15%	16.35%	1,092
Coordinated Care Corporation	On Exchange	5.24%	4.92%	56,003
Community Health Plan of Washington	On Exchange	2.50%	-1.21%	6,735
Kaiser Foundation Health Plan of the Northwest	Both	8.81%	7.29%	7,799
Kaiser Foundation Health Plan of Washington	Both	17.90%	17.81%	54,253
LifeWise Health Plan of Washington	On Exchange	7.81%	7.79%	25,955
Molina Healthcare of Washington, Inc.	On Exchange	6.41%	6.50%	41,112
PacificSource Health Plans	Both	7.15%	8.49%	3,917
Premera Blue Cross	On Exchange	15.83%	17.20%	13,786
Providence Health Plan	Off Exchange	4.69%	4.69%	228
Regence BlueShield	Both	4.54%	4.40%	22,776
Regence Blue Cross Blue Shield of Oregon	Both	6.51%	8.40%	5,146
UnitedHealthcare of Oregon, Inc.	Both	2.76%	-0.47%	4,370
Total				**244,229**

Exchange Issuers Average Rate Change	
Requested:	**9.11%**
Approved:	**8.94%**

Footnotes

1. The number of people impacted is the most recent available number of enrollees (usually March enrollment of the prior year) from the rate filings.

Cost drivers behind PY 2024 rates

Cost Drivers:

- Increases in the price and utilization of health care services including pent-up demand for elective surgeries and prescription drug costs (including off-label)
- Increases in administrative costs (such as inflation).
- Changes to what payments insurers are either owed or received under the ACA risk adjustment program –
    - Stabilizes the market by spreading financial risk across all insurers. Requires federally collected funds be redistributed from plans with lower-risk enrollees to plans with higher-risk enrollees
- Whether the insurer has high risk enrollees who incur high dollar claims

Ground Ambulance Balance Billing

Legislative directive

OIC report to Legislature by October 1, 2023: How balance billing for ground ambulance services can be prevented. RCW 48.49.190

- Ground ambulance services are the remaining gap in balance billing protections in Washington & nationally
- Complex system:
  - 478 licensed EMS agencies; 299 provide transports
  - Large majority are public entities; public and private providers partner in many jurisdictions
  - Vast differences in staffing, capacity, organization

Key takeaways:

- Consumers' average potential ground ambulance balance bill is more than $500 for emergency services and $1,000 for non-emergency services
- Public and private ground ambulance providers partner to provide care. Public providers respond to emergency 911 dispatches and private providers often provide transport
- Funded by varied mix of public (Medicare and Medicaid, local levies) and private health plan revenue
- Ground ambulance providers contend that balance billing is used to cover some of the disparities between their costs and payment for Medicaid and Medicare patients and for services that are not reimbursed

Recommendations

1. Prohibit balance billing of consumers for emergency and non-emergency transports
2. Reimburse emergency ground ambulance services at a local jurisdiction's fixed rate or, if no local rate exists, at the lesser of a fixed percentage of Medicare or billed charges
3. Mandate coverage for emergency transportation to alternative sites, i.e., behavioral health emergency/crisis service facilities

Key findings

1. Uncompensated "treat but no transport" services, i.e., emergency responses that do not result in patient transport to a hospital ED
    - Undertake actuarial analysis of the cost and cost offsets of covering this service, with findings to the 2026 Legislature
2. Maintain supplemental public funding for public and private providers for Apple Health (Medicaid) ground ambulance services
3. Undertake study of EMS an as essential health service provided by local and state governments and funded by federal, state, and/or local funds

Essential health benefits benchmark plan update

Essential health benefits under the ACA

Under the Affordable Care Act, each state must designate an EHB "benchmark plan" to serve as a benchmark, i.e., minimum coverage, for all individual and small group health plans offered in the state

RCW 48.43.715 directs OIC to, by rule, select the largest small group plan in the state by enrollment as the EHB benchmark plan in Washington state

- Regence BlueShield Regence Direct Gold+ small group plan.

Designated EHB benchmark plan has not changed since 2012

EHB benchmark plan update option

Final 2019 HHS Notice of Benefits and Payment Parameters gives states an opportunity to update their EHB benchmark plans for years 2020 and beyond

If a state meets the requirements in the federal rules, including the "typicality" and "generosity" tests, benefits added to the state EHB through this EHB benchmark plan selection process meet the definition of EHB and are exempt from the ACA defrayment requirement

EHB benchmark plan update option

"Typicality test"

- Scope of benefits in new EHB benchmark plan must be equal to the scope of benefits provided under a typical employer plan in Washington

"Generosity test"

- New EHB benchmark plan must not exceed the generosity of the most generous among a set of comparison plans. Costs of the new plan cannot exceed those of the chosen comparison plan.

Benefits must be nondiscriminatory

Legislative directive

Legislature directed OIC to undertake EHB benchmark plan update in SSB 5338 (2023)

- OIC contracted with HMA/Wakely for actuarial analysis
- Report due to Legislature on December 31, 2023
- If OIC proceeds with proposed update, submit to CMS by May 1, 2024
- If submitted and approved, new EHB benchmark plan is effective January 1, 2026

Benefits to be reviewed

Must determine potential impacts on plan design, actuarial value, and premium rates if these services were included in the EHB benchmark plan:

- Hearing instruments and associated services
- Fertility services
- Biomarker testing
- Contralateral prophylactic mastectomies
- Donor human milk
- Treatment for pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDA)
- MRI for breast cancer screening

Actuarial analysis underway. Next public meeting October 20, 2023

Questions?

Jane Beyer

Senior health policy advisor

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Tab 6

Washington State Health Care Authority

Washington State Health Care Authority

Washington Health Care Cost Transparency Board

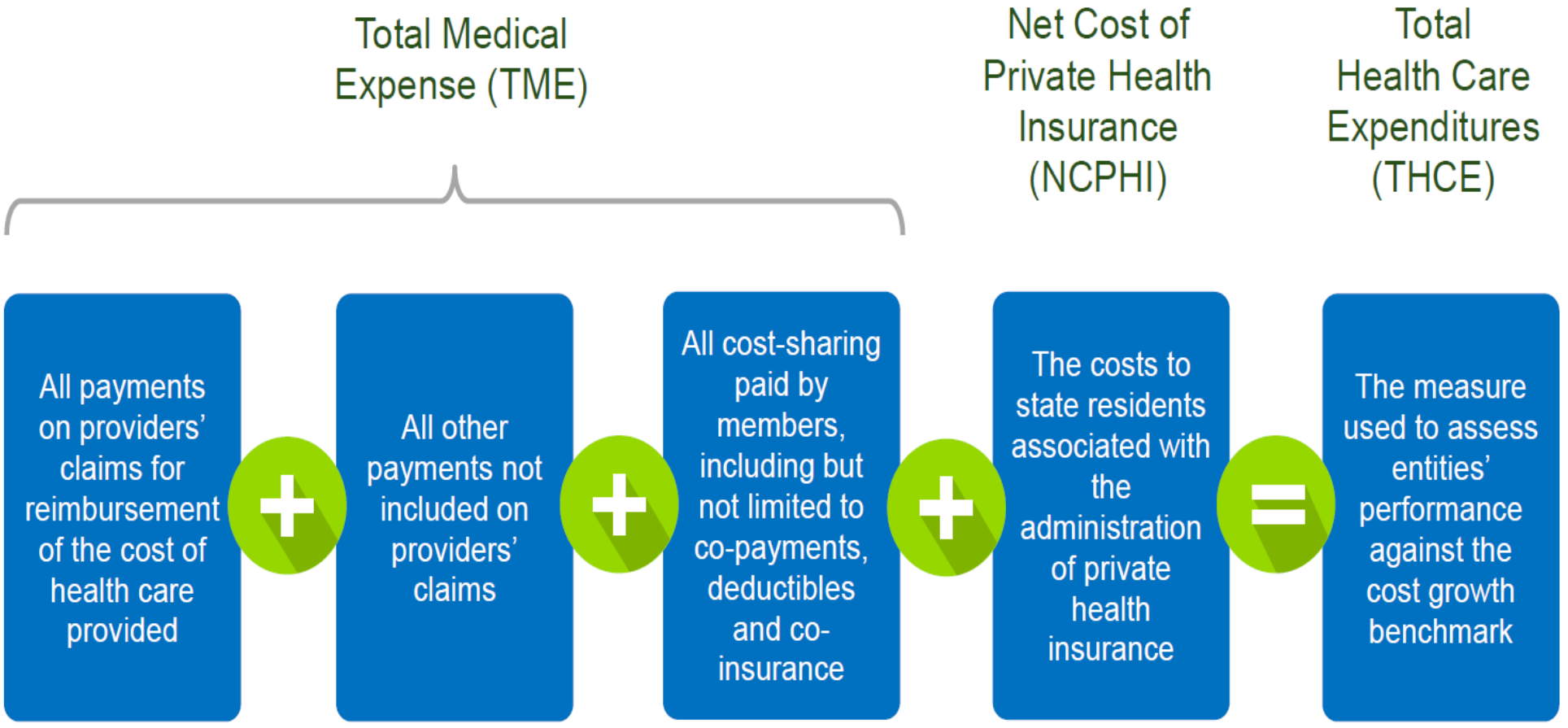
Analytic Status Report

October 2023

Presentation Outline

- Terminology
- Analytic approach
  - HCCTB analytic framework
  - Measuring performance against benchmark
- Current Status and Next Steps
  - Submissions, timeframes, inclusions/exclusions, limitations

Total Medical Expense; and Total Healthcare Expenditure



Washington State Health Care Authority

Data Sources for Calculating THCE

Component of Total Health Care Expenditures	Category	Data Source
Total Medical Expenses	Carrier claims payments	Carrier data submission template
	Carrier non-claims payments	Carrier data submission template
	Carrier enrollment	Carrier data submission template
	Carrier pharmacy rebates	Carrier data submission template
	Medicare fee-for-service claims payments and enrollment, and all Part D spending	Centers for Medicare & Medicaid Services
	Non-managed care claims and non-claims payments and enrollment for Medicaid	Washington Health Care Authority submission template
	Veterans' Health Administration medical spending and enrollment	Department of Veterans' Affairs
	Medical spending for state workers' compensation and enrollment	Washington Department of Labor & Industries submission template
	Health care spending for incarcerated individuals and enrollment	Washington Department of Corrections submission template
Net Cost of Private Health Insurance	NCPHI for the commercial fully insured market	Federal commercial medical loss ratio (MLR) reports
	NCPHI for Medicare Advantage	The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC)
	NCPHI for Medicaid Managed Care	The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC)
	Income from Fees of Uninsured Plans to calculate NCPHI for the commercial self-insured market	Carrier data submission template
	Number of member months in each market for calculating NCPHI	Carrier data submission template

Washington State Health Care Authority

Analytic Approach

Analytic framework, workstreams, aggregation, stratification

Analytic Framework

Washington State Health Care Authority

WA Healthcare Spending Growth Benchmark

Year	Target
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

Health System Performance: Measurement against the Benchmark

Topic 1:
per capita and total health care expenditures and health care cost growth

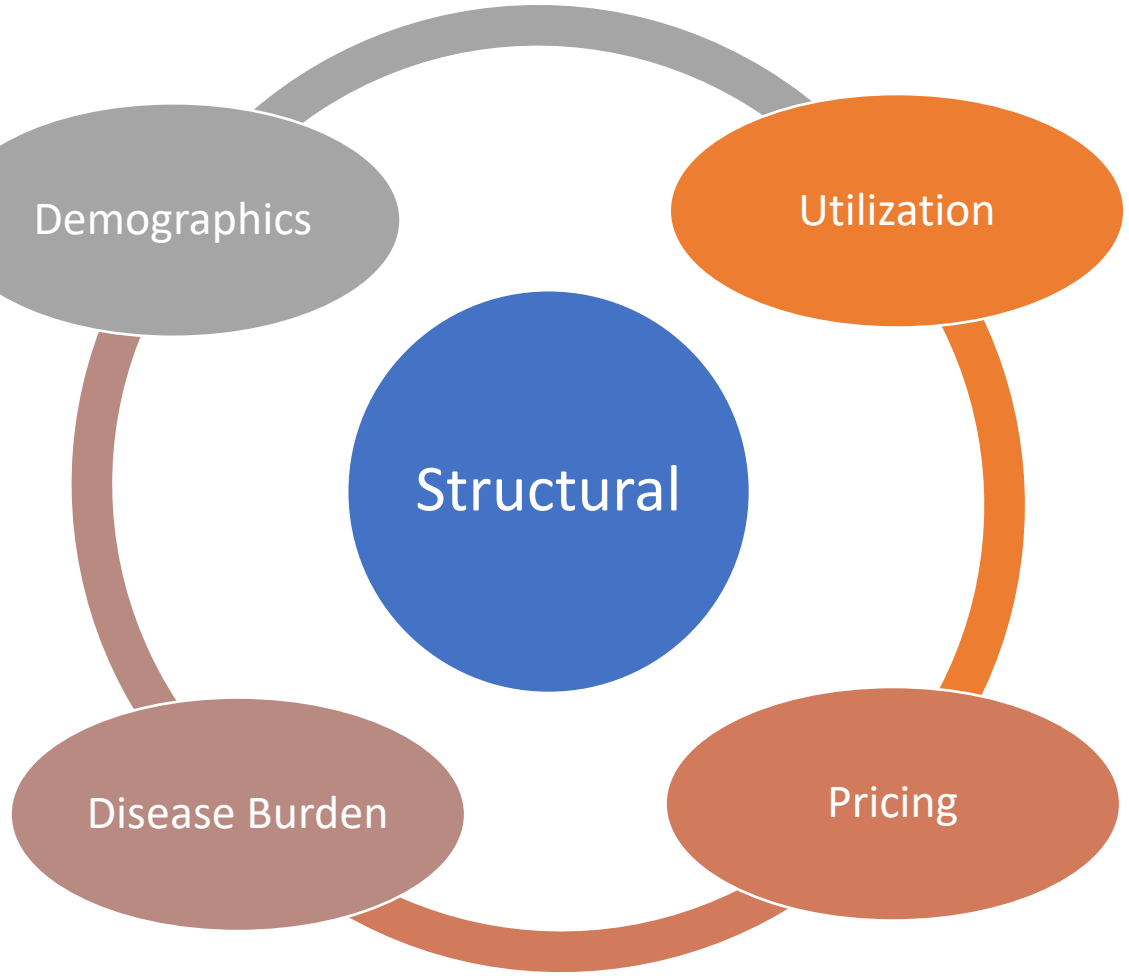
Topic 2:
statewide, by geographic rating area, and market segment

Topic 3:
by health care providers, provider systems, and payers

Topic 4:
by service category

** Topic 5: interactions between Topics 1 through 4

Drivers of Health Care Spending : Analytic Approach



HCCTB Analytic Workstreams

Washington State Health Care Authority

Cost growth benchmark

The ceiling/ goal for the growth of spending on health care year over year.

Performance against benchmark

Assessment of cost growth against the benchmark target.

Cost driver analysis/cost experience

Assessment of key drivers of cost growth.

Primary care spend measurement

Measurement of expenditure on primary care in relation to overall health care expenditure.

Hospital cost, profit, and price analysis

Hospital financial analysis to create cost, price and profit trends.

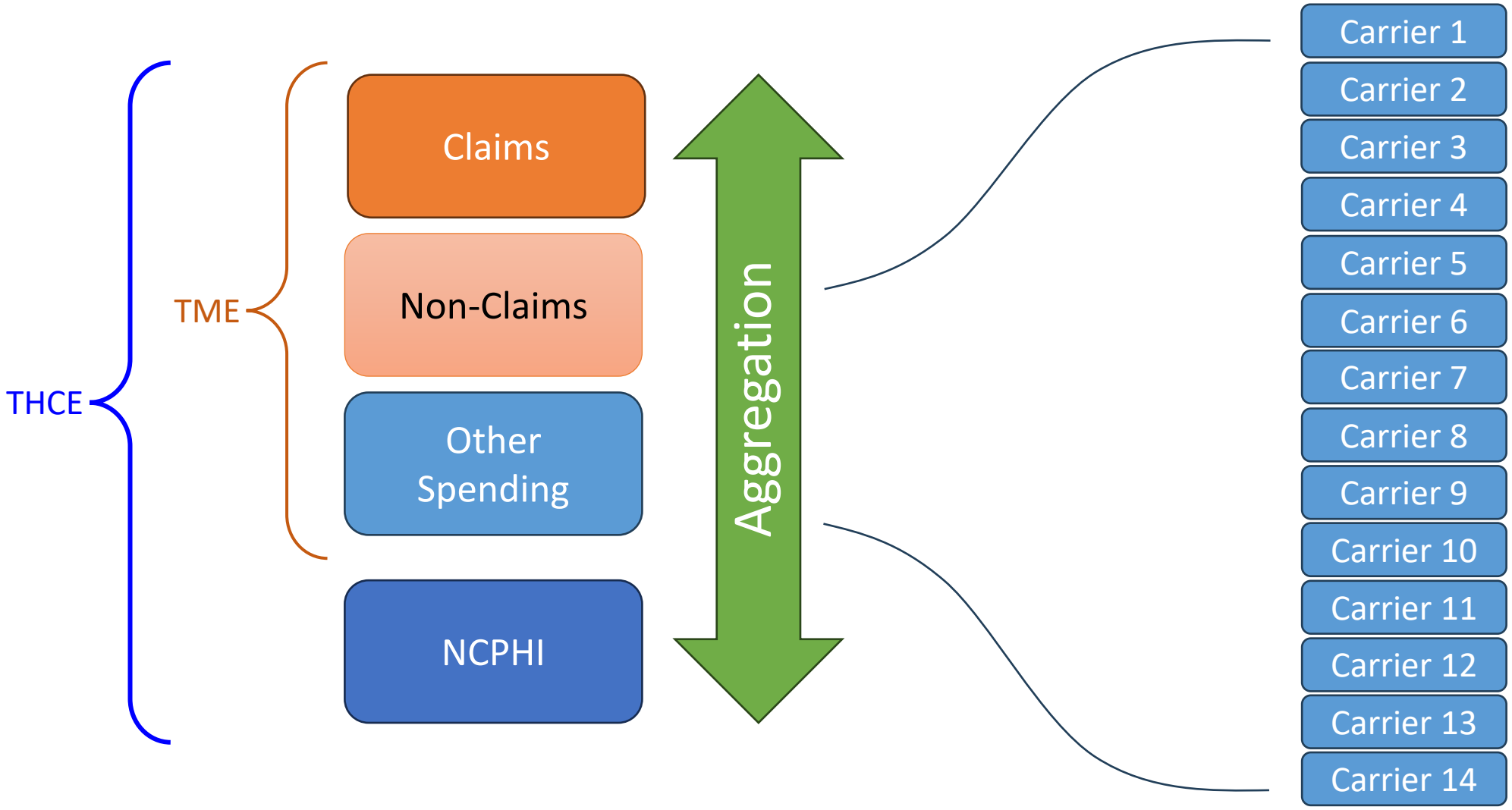
Analytic support initiative

Analysis of the drivers of WA health care cost growth by University of Washington's IHME. IHME will use its deep analytic capacity as well as expertise in data integration.

Consumer and affordability

The ability for a consumer to afford their health care insurance.

Analytic Approach – "Total" … Expenditure



Some Data Validation is performed at Carrier level:

Data element level checks only

Washington State Health Care Authority

Measuring Performance Against Benchmark*

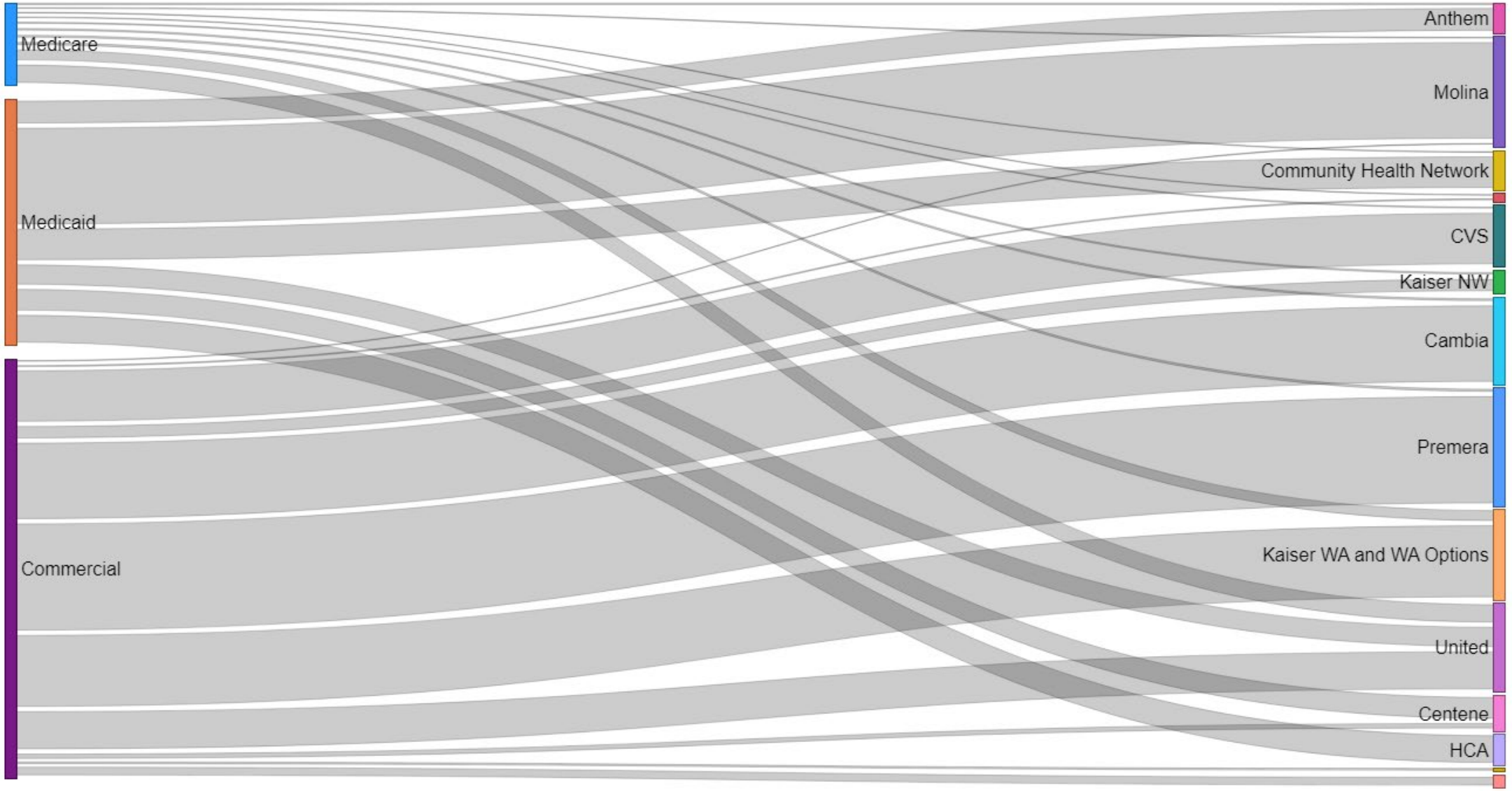
State	Aggregate spending and PMPY spending using THCE
Market (Medicare, Medicaid, commercial)	Aggregate spending and PMPY spending using TME
Payer (carrier) stratified by market	PMPM spending using truncated, age/sex adjusted TME
Large provider entity stratified by market	PMPM spending using truncated, age/sex adjusted TME

*Payer and provider not assessed until 2024

Current Status and Next Steps

Data submission, data validation, data analyses

Markets, Carriers, and Covered Lives



Carrier Data Submission Status

[Data Quality/Validation Complete]

First	Second	Third	Still Waiting (as of 10/6/2023)
• Cambia • Humana • Premera • CHPW • Molina • United • Health Alliance NW	• Centene • Kaiser Foundation HP • HCA	• Kaiser Permanente WA • Cigna	• Anthem • CVS

Note: Working with HCA to get other non-traditional healthcare expenditure data identified during initial aggregate analysis

Analytic Limitations and Caveats

- Baseline data for CY 2017 – 2019
- Data for Anthem and CVS is still missing
  - 3rd data submission from Anthem still had data quality/completeness issues
- Submission issues
  - For some carriers, long turnaround time
  - Data reported in different tabs are not consistent
  - Member month trends from year to year seem unreasonable
  - Missing important data elements
  - Truncated claims spending calculation not correct
  - Spending is not correctly categorized: Significant spending in the “other” category

Analytic Status, Plan, and Next Steps

- Original Timeframes
  - Original data submission deadline: 10/1/2022
  - Original data validation and analytic timeframe: **3-4 months**

- Current Status
  - Data submission, resubmission and validation: 10/1/2022-9/15/2023
  - Data analyses and further reasonableness check : 09/18/2023-current

- Next Steps and Plan
  - Preliminary analytic results by late November
  - Draft final analytic results by mid December
    - Caveat: Depends on timely acceptable submissions from remaining submitters


Questions?

Tab 7

Washington State Health Care Authority

Analytic Support Initiative

WA Health Care Cost Transparency Board's

October 18, 2023

Institute for Health Metrics and Evaluation

ASI

Analytic Support Initiative Timeline

1. **Determine analytical strategy & get data (6 months)**
2. **Complete analysis (12 months)**
3. **Use the analysis (6 months)**

Requirements for analytic strategy

A. Should support an identified Cost Board need

B. Should be as simple as possible

C. Should be presented in a clear and understandable manner

D. Should be appropriately specific and granular enough for action

E. Should have a high probability of being influential

F. Should have potential for high impact

G. Should be novel

Goal for today:

Come to a consensus on 2-4 analytical products for the Analytic Support Initiative to implement.

Next step:

Develop a complete analytic strategy based on the agreed upon analytical products.

Potential analytic products:

	ANALYTIC PRODUCT	ANALYTIC APPROACH, STRENGTHS, AND LIMITATIONS
A	Spending & price levels and trends	Showing growth rate in spending (by cause, care type, or payer category) for each county with age/sex-standardization and show variation in growth rate by type of care groups for private insurance. The presentation could be in the form of maps, line graphs, etc.
B	Risk-adjusted spending & price levels and trends	This could look like any of the examples discussed above reporting spending or price growth (maps, line graphs, heatmaps, etc.), but all of the estimates would be risk adjusted. Variation would be reporting by spending utilization, price, across time, and across counties
C	Drivers analysis	We could add drivers such as **type of care mix** and/or **payer category mix**, highlighting where spending is higher or lower because of concentration of care on specific types of care and/or specific payers at the county-level
D	Comparing spending & price growth to “like” counties	Spending, utilization, and price estimates where “like” is defined based on contextual factors such as underlying health, income, education, prevalence of key risks like obesity or smoking. Allows us to highlight where spending, utilization, or price growth is less than, the same as, or greater than similar counties.

Potential analytic products:

	ANALYTIC PRODUCT	ANALYTIC APPROACH, STRENGTHS, AND LIMITATIONS
E	Assessing deliver system value	**Risk-adjusted delivery system value could be estimated** for each county (and by cause if desired). This would be akin to identifying exemplars of positive (or negative) delivery system performance
F	Assessing impacts of hospital market concentration	The APCD cannot have specific provider reporting, so this could be at the county level and/or could be about illustrating how market concentration in WA is associated with prices (reporting the relationship rather than the specific estimates).
G	Reporting price variation across providers and payers	Price and trends in prices cannot be reported by provider or payer because of data use constraints, but we can **report information about variation in prices and variation in price growth** by county or by disease
H	Assessing spending effectiveness	**Spending effectiveness** is like a cost-effectiveness measure but is measured by cause rather than for a specific intervention. IHME has developed a peer-reviewed method for estimating cause-specific spending effectiveness. This could be repurposed and made specific to WA state and could highlight which diseases are treated with high levels of spending effectiveness.

Key question:

Which of the potential analytical products meets the previously determined requirements?

Requirements for analytic strategy

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Strengths and weaknesses of analytic products

	Potential analytic products	What does it tell us?
A	**Spending & price levels and trends**	• Which counties are spending & price outliers?
B	**Risk-adjusted spending & price levels and trends**	• Same as (a) but also levels the playing field
C	**Drivers analysis**	• Why there are outliers?
D	**Comparing spending & prices with 'like' counties**	• Same as (a) but relative to 'like' counties
E	**Assessing deliver system value**	• Which counties have higher levels of "value"?
F	**Assessing impacts of hospital market concentration**	• What is the impact of changing hospital market concentration?
G	**Reporting price variation across providers and payers**	• What counties or health conditions have unexplained price variation?
H	**Assessing spending effectiveness**	• Which health conditions are being treated effectively?

Requirements for analytic strategy

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Strengths and weaknesses of analytic products

	Potential analytic products	What does it tell us?	Strengths	Challenges
A	**Spending & price levels and trends**	• Which counties are spending & price outliers?	• Simple	• Without standardization, may suggest incomplete conclusions and/or discourage buy-in from providers
B	**Risk-adjusted spending & price levels and trends**	• Same as (a) but also levels the playing field	• Encouraged by data committee • Granular and clear output	
C	**Drivers analysis**	• Why there are outliers?	• Evokes actionable insight • Usable by multiple state agencies	
D	**Comparing spending & prices with 'like' counties**	• Same as (a) but relative to 'like' counties	• DEX project provides foundation to make this comparison	
E	**Assessing deliver system value**	• Which counties have higher levels of "value"?		• Too complex and/or abstract • Not actionable
F	**Assessing impacts of hospital market concentration**	• What is the impact of changing hospital market concentration?	• Influential, impactful	• Discouraged by data committee, not novel
G	**Reporting price variation across providers and payers**	• What counties or health conditions have unexplained price variation?	• Standardization by prevalence allows actionable insight • Companion of B, C	
H	**Assessing spending effectiveness**	• Which health conditions are being treated effectively?		• Too complex,and abstract • Not actionable

Various affordability efforts and policies considered by cost boards in other states

Example Policies	Cost driver targeted	Resources required	Potential magnitude of impact
Addressing facility fees	Increased inpatient/outpatient costs	Low	+
Contain growth in provider rates through a variety of polices such as provide rate caps or rate setting	Increased provider prices	High	++
Strengthen health insurance rate review	Increased health care costs	Medium to high	?
Improve oversight of provider consolidation including mergers and acquisitions	Increased health care costs	High	?
Preventing anti-competitive contract terms in health care contracts	Increased provider prices	Low to medium	+
Limiting out-of-network charges	Increased health care costs	Medium	+
Promote adoption of population-based provider payment/exploring global budgeting	Increased health care costs	Medium	++
Contain growth in prescription drug prices	Increased drug prices	High	++

Key	
++	on the order of magnitude of 1% or more of total health care spending
+	on the order of magnitude of 0.1% of total health care spending
?	unknown/highly variable impact

Without committing to a policy initiative, which of these might policies would Members be most interested in utilizing the ASI to gather more information on these policies?

How can these analytic products be utilized for the various affordability efforts discussed today and policies considered by cost boards in other states?

Example Policies	Which analytic products provide information that could support analysis for each policy?
Addressing facility fees	A B C D F G
Contain growth in provider rates through a variety of polices such as provide rate caps or rate setting	A B C D G
Strengthen health insurance rate review	G
Improve oversight of provider consolidation including mergers and acquisitions	F
Preventing anti-competitive contract terms in health care contracts	F
Limiting out-of-network charges	
Promote adoption of population-based provider payment/exploring global budgeting	G
Contain growth in prescription drug prices	A B C D G

	Potential analytic products
A	Spending & price levels and trends
B	Risk-adjusted spending & price levels and trends
C	Drivers analysis
D	Comparing spending & prices with 'like' counties
E	Assessing deliver system value
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H	**Assessing spending effectiveness**	• Which health conditions are being treated effectively?

Should we focus on B, C, and D? What about G?

Are we missing key strategic opportunities if we focus on B, C, and D?

Do these meet the key requirements?

Are there elements we're missing?

Next steps

- IHME will work with HCA and others including those from other states to focus on the analytic products that we discussed today to create use cases and analytic strategy.

- At the Dec 7th Board meeting, we will present a complete analytic strategy for approval based on today's indicators. We will use this strategy to develop the ASI work for 2024 and 2025.

- This will be followed by more in-depth Board discussions of a wide range of policy options in future Board meetings.

Appendix slides

Cost growth benchmark

The ceiling/ goal for the growth of spending on health care year over year.

Performance against benchmark

Assessment of cost growth against the benchmark target.

Cost driver analysis/cost experience

Assessment of key drivers of cost growth.

Primary care spend measurement

Measurement of expenditure on primary care in relation to overall health care expenditure.

Hospital cost, profit, and price analysis

Hospital financial analysis to create cost, price and profit trends.

Analytic support initiative

Analysis of the drivers of WA health care cost growth by University of Washington's IHME. IHME will use its deep analytic capacity as well as expertise in data integration.

Consumer and affordability

The ability for a consumer to afford their health care insurance.

Health Care Cost Transparency Board's Data Projects

IHME background methods applicable to this work

IHME has developed the DEX project which will:

- Estimate **spending**, **spending per capita**, **spending per beneficiary**, **spending per prevalent** (or incident, hereon prevalent) **case**, and **spending per encounter**. These different measures reflect spending and price.
- Estimate **encounters**, **encounters per person**, **encounters per beneficiary**, and **encounters per prevalent case**. These different measures all reflect utilization.

These estimates will exist for

- state and county
- 10 years (2010-2019)
- 36 age/sex groups
- 4 payer categories (Medicare, Medicaid, private insurance, and out-of-pocket)
- 7 types of care
- 161 health conditions

IHME background methods applicable to this work

In addition, IHME has several other resources that are accessible and can be used relatively easily.

- At the county level, we have **cause specific prevalence estimates** for a select set of about 70 health conditions, with **mortality estimates** and **life-expectancy**.
- At the state level, we can attribute health care burden and spending to **modifiable risk factors**, such as high body mass index, high blood pressure, and smoking.
- We have estimates of **hospital market concentration** (a measure of hospital market competition level) for each WA hospital, each Hospital Reference Region, and for the state as a whole. These estimates extend from 2000 to 2020. We also have a measure of insurer concentration at the state level.
- We have developed a peer-reviewed method for estimating **risk-adjusted delivery system value**. This could be calculated for each county.
- We have developed a peer-reviewed method for attributing spending growth to five distinct factors: **population size**, **population age-structure**, **disease prevalence**, **utilization**, and **price** (which includes intensity of care). These analyses can be performed by cause and/or for each county.

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

Washington State Health Care Authority