Health care spending growth in Washington, 2019–2022

Results from the Health Care Cost Transparency Board's 2024 data call

Acknowledgements:

The Health Care Authority (HCA) expresses its gratitude to the Centers for Medicare and Medicaid Services, the Washington State Department of Social and Health Services, Department of Health, Department of Corrections, and the Office of the Insurance Commissioner for submitting data for this report.

The Health Care Cost Transparency Board also thanks the insurance carriers and health care providers for their cooperation and collaboration on this initiative.

The Board thanks the Peterson-Milbank Program for Sustainable Health Care Costs for grant funding, staff support and technical support. The Board thanks the Health Care Stakeholder Advisory Committee, the Advisory Committee on Data Issues, and the Advisory Committee on Primary Care, for their guidance and expertise. The Board also thanks Sue Birch, outgoing HCA Director and Cost Board Chair, for her leadership.

Acronym glossary

CMS	**Centers for Medicare and Medicaid Services** The federal agency that provides health coverage to more than 160 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.
DOC	**Department of Corrections** Washington State DOC manages all state-operated adult prisons and supervises individuals who live in the community and are under DOC supervision.
DSS	**Department of Social and Health Services** The DSHS manages the administration of aging and long-term care, behavioral health, development disabilities, vocational rehabilitation, Medicaid pathways based on age and disability, and other public benefits in partnership with federal government agencies.
FFS	**Fee-for-service** A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.
HCA	**Washington State Health Care Authority** HCA administers a wide range of programs and initiatives, working to ensure Washington residents have access to better health, better care, and lower costs.
L&I	**Department of Labor and Industries** L&I is the administrator of Washington's workers' compensation system. They are similar to a large insurance company, providing medical and limited wage-replacement coverage to workers who suffer job-related injuries and illness.
MCO	**Managed care organization** An entity contracted by a state Medicaid agency that accepts a set per member per month (capitation) payment for health care services.
NCPHI	**Net cost of private health insurance** The difference between total premiums collected from enrollees and payments made to providers for health care delivered.
PGSP	**Potential gross state product** An estimate of the total economic value of goods produced and services provided if growth were steady and inflation stable.
THCE	**Total health care expenditures** The amount spent on health care and related activities such as private and public health insurance, government agency-provided health care, and public health activities.
TME	**Total medical expenses** The amount paid to providers for the delivery of health care services to the member population, including patient out-of-pocket costs and non-claims payments.
VHA	**Veterans Health Administration** The largest integrated health care system in America, providing health care services for military veterans, with facilities throughout the country.

Executive Summary

In response to rising health care costs, Washington State's Legislature established the Health Care Cost Transparency Board (Cost Board) in 2020. As part of their efforts, the Cost Board set an annual statewide health care cost growth benchmark. The benchmark serves as a common goal for spending growth that carriers and providers should aim to stay below to make health care more affordable for consumers. To assess performance against the benchmark, the Cost Board measures annual spending growth against each targeted benchmark year. The Cost Board set the 2022 annual cost growth benchmark – — the first growth benchmark — at 3.2%.

In 2022, the Cost Board collected total health care spending data for 2017–2019 from the largest health insurance carriers doing business in Washington State. The purpose of gathering this data was to establish a baseline for spending growth. Earlier this year, the Cost Board launched the 2024 data call and collected data for 2020–2022. Cost Board staff presented key findings at the **December 12, 2024 Health Care Cost Transparency Board Public Hearing**, and are further discussed in this report.

Using these data, the Cost Board is able to monitors overall cost growth performance against the first annual benchmark. These data also inform the Cost Board on health care cost increases by the state's largest carriers and provider organizations.

Findings

A. Comparing 2022 cost growth performance against the benchmark

According to the data, **statewide or overall per-member spending exceeded the benchmark**. The per-member total health care expenditure (THCE) grew year over year by 3.6% in 2022, exceeding the 3.2% percent growth benchmark. Although the actual growth exceeded the benchmark, 2022 growth is the slowest since 2018 (excluding 2020 during of the COVID-19 pandemic).

Other findings from 2021–2022 include:

- The Medicare market's growth of 4.3% exceeded the 3.2% benchmark.
- Five out of 12 carriers exceeded the benchmark. Marketwise, nine of the 11 carriers operating in the Medicare market exceeded the benchmark while four out of the 10 carriers exceeded the benchmark in the commercial market. None of the five carriers offering coverage in the Medicaid market exceeded the benchmark.
- Five out of the 28 large provider organizations exceeded the benchmark.

B. Analysis of cost growth during the pandemic (2019–2022)

To better understand the pandemic-related drop in health care utilization in 2020 and substantial recovery in 2021, the report also compares 2022 spending to pre-pandemic levels. Findings include:

- Per-member THCE in 2022 was 7.9% higher than in 2019. Faster growth in the commercial, Medicare, and Veterans Affairs markets propelled spending.
- The top contributors to spending growth were:
    - Prescription drug spending in Medicare and commercial markets.
    - Non-claims spending (specifically capitation/bundled payments) in the Medicare market.
    - Hospital outpatient spending in the Medicare and commercial markets.
- Per capita Medicaid spending decreased from 2019–2022 due to a decline in Other Claims (e.g., durable medical equipment, freestanding diagnostic facility services) that more than offset an uptick in prescription drug spending.
- Compared to 2017, per member spending statewide is higher by 21.8% in 2022.

This benchmark report is organized into four sections. The first section covers the introduction which provides background on the work of the Cost Board, including the work on the cost growth benchmark and performance against the benchmark (the focus of this report). The rest of the sections present the analysis of the spending data collected by the Cost Board. The second section analyzes the overall spending in 2022 relative to previous years. The third section compares year-over-year per member spending growth rate, in 2022 against the benchmark. The last section looks at per member spending growth in 2022 relative to pre-pandemic levels.

Introduction

Background

In 2020, House Bill 2457 established the Cost Board to support reducing health care cost growth and increasing price transparency. The goal is to help make health care affordable for individuals, families, businesses, and others in Washington State.

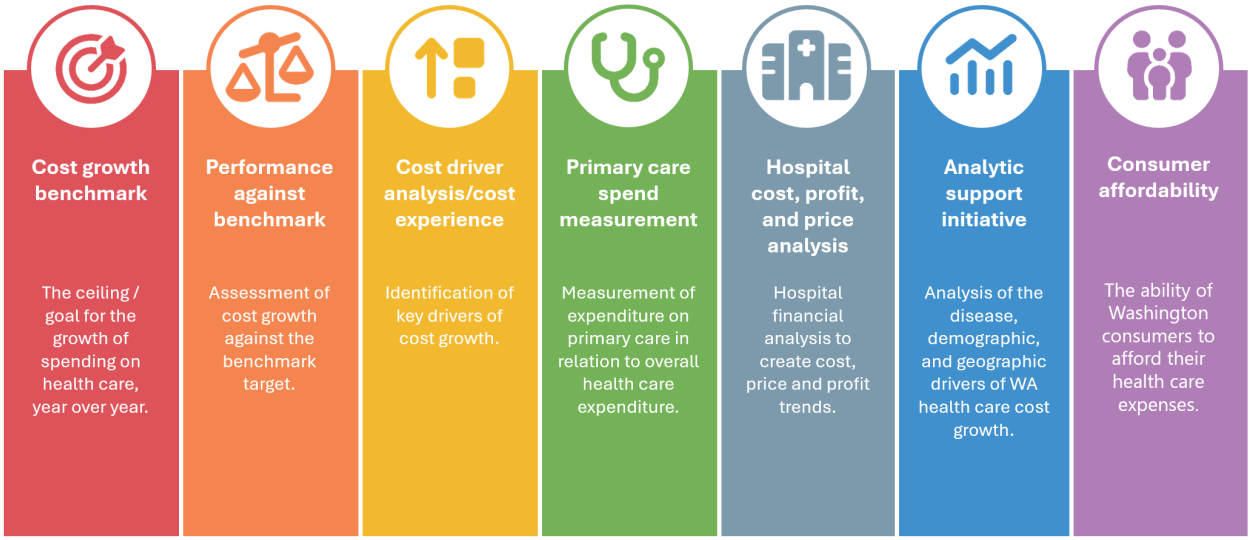
The Cost Board strives to achieve this goal by:

- Determining the state's total health care expenditures.
- Setting a health care cost growth benchmark for providers and payers.
- Identifying cost trends and cost drivers in the health care system.
- Providing policy recommendations for lowering health care costs to the Legislature.

In 2024, the Cost Board made strides across data analysis efforts (Figure 1) in partnership with numerous stakeholders, and is summarized in the **Annual Report to the Legislature** . Meanwhile, the following report focuses specifically on performance against the benchmark.

The Cost Board is releasing this benchmark performance report, which presents health care expenditure trends from 2017–2022 with a focus on assessing performance for 2022 and trends during the pandemic period (2019–2022). This follows the **brief released in 2024**, which presented analysis on health care spending data in the period 2017–2019.

Figure 1: The data streams of the Cost Board



Health care spending growth benchmark

In September 2021, the Cost Board approved Washington's spending growth benchmark from 2022–2026 (Table 1). The benchmark is a specific rate that the expenditure performance of carriers and providers will be measured against, beginning in 2022. In establishing the benchmark, the Cost Board reviewed how other states created their benchmarks and considered many different factors that might influence their choice of benchmark. To derive the cost growth benchmark, the Cost Board adopted a methodology that uses a 70/30 weighting of the growth rates of historical nominal median wage and nominal per capita potential gross state product (PGSP). The goal is to encourage health care industry players to achieve a health care spending growth at the same or slower rate as the growth of income. A slower cost growth helps ensure affordability of health care.

Table 1: Spending growth benchmark for Washington State

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

Starting with 2022 data, the Cost Board compares the spending growth benchmark is compared against actual health care cost per member per year (PMPY) growth rate (performance) at the following levels of aggregation: statewide, by market (i.e., commercial, Medicare, Medicaid), by carrier, and by large provider organization. Performance in these groups is specifically measured by the metrics in Table 2.

Table 2: Performance indicators by aggregation levels

Aggregation level:	Performance is based on:
Statewide	Total health care expenditure (THCE) PMPY growth rate
Markets	Total medical expenditure (TME) PMPY growth rate
Carriers	Confidence interval of age-sex risk-adjusted truncated TME PMPY growth rate
Large Provider Organizations	Confidence interval of age-sex risk-adjusted truncated TME PMPY growth rate

Appendix A explains the data sources and the formulas for calculating the various performance indicators. In a nutshell, data was collected from carriers (insurers) at the parent company level and from other entities that have health care spending in Washington (CMS, HCA, L&I, DOC, Veteran's Affairs). It is important to note that since non-carrier data is not broken down by large provider entities and by carriers, carrier and large provider organization performance is based on carrier data alone. Since data by large provider organizations come from carrier data, carriers must attribute members to large provider organizations. Moreover, to ensure that a few high-cost clients do not impact carrier and large provider organization performance is not impacted by a few high-cost clients, the Cost Board calculates performance is calculated based on truncated and age-sex risk-adjusted spending numbers. Based on these adjusted numbers, a confidence interval of the spending growth rate is calculated and compared to the benchmark. Appendix A provides links to detailed discussion on attribution and the methodologies used to measure carrier and large provider organization performance.

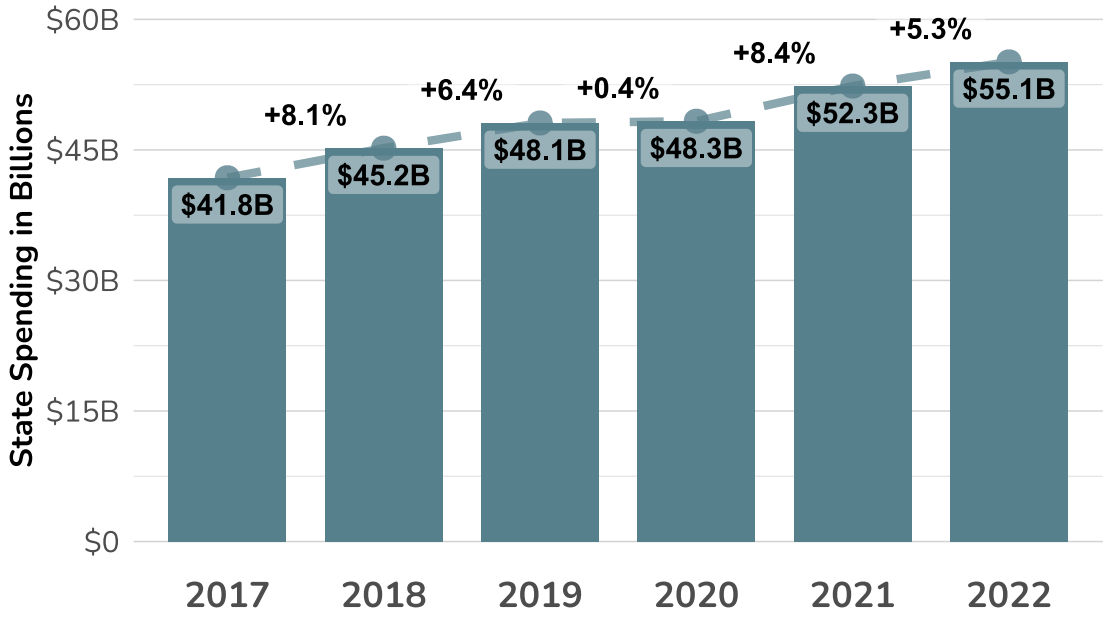
Overall spending

This section provides an analysis of health care spending trends in Washington state. The analysis covers total health care expenditures (THCE), segmented by markets, carriers, and large provider organizations.

Total health care expenditures

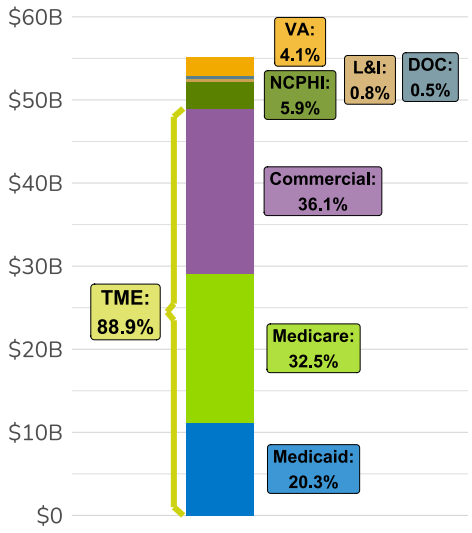
Total health care expenditures (THCE) in Washington State grew by 5.3% ($2.8B), reaching $55.1 billion in 2022 (Figure 2). Except for the pandemic year of 2020, the annual growth rate of total spending has exceeded 5% every year.

Figure 2: Growth in total health care expenditure (THCE)



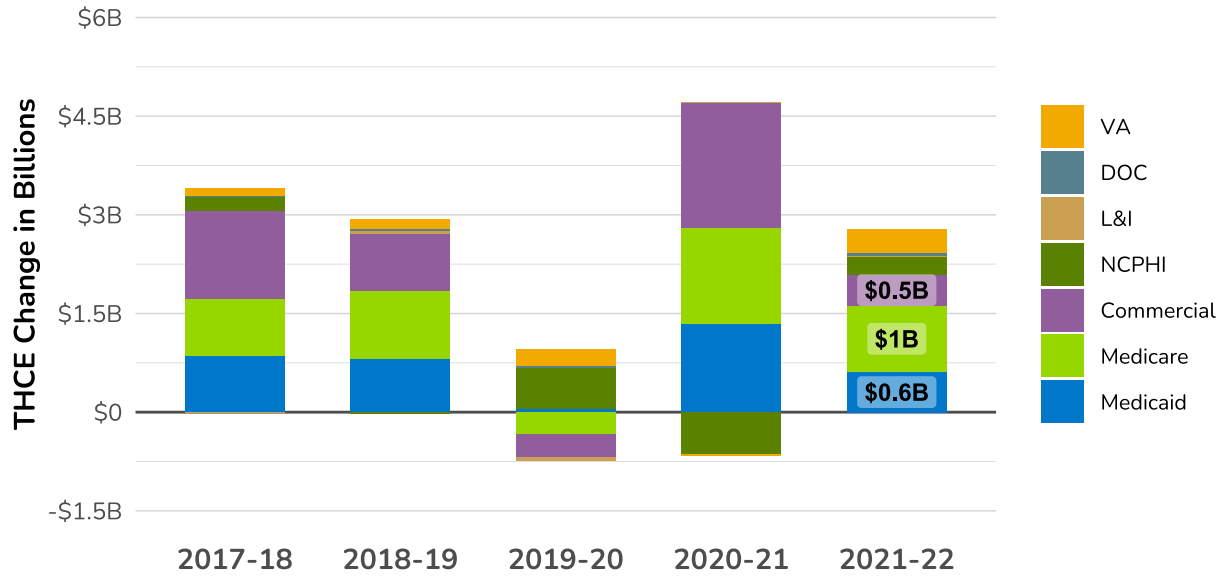
THCE is composed of seven components, shown in Figure 3 and detailed in Appendix A. Of the $55.1 billion, 88.9% is comprised of the total medical expense (TME), or the total sum of claims and non-claims paid to providers in Washington in the commercial, Medicare and Medicaid markets (Figure 3). The other 11.1% of THCE includes the net cost of private health insurance (NCPHI), and the administration of state health services such the Department of Corrections, the Department of Veterans Affairs, and the Department of Labor and Industries.

Figure 3: Proportions of THCE by component in 2022



The $2.7 billion increase in 2022 is largely driven by the increase in the Medicare market, followed by Medicaid and commercial (Figure 4). While the increase in commercial spending is more muted compared to other markets in 2022, it follows a marked increase in 2021 that more than offsets the decrease in 2020. Previous non-pandemic years show similar patterns, with spending in commercial and Medicare interchangeably driving the bulk of the spending increases.

Figure 4: Change in THCE by component, year over year



Comparing 2022 performance against the benchmark

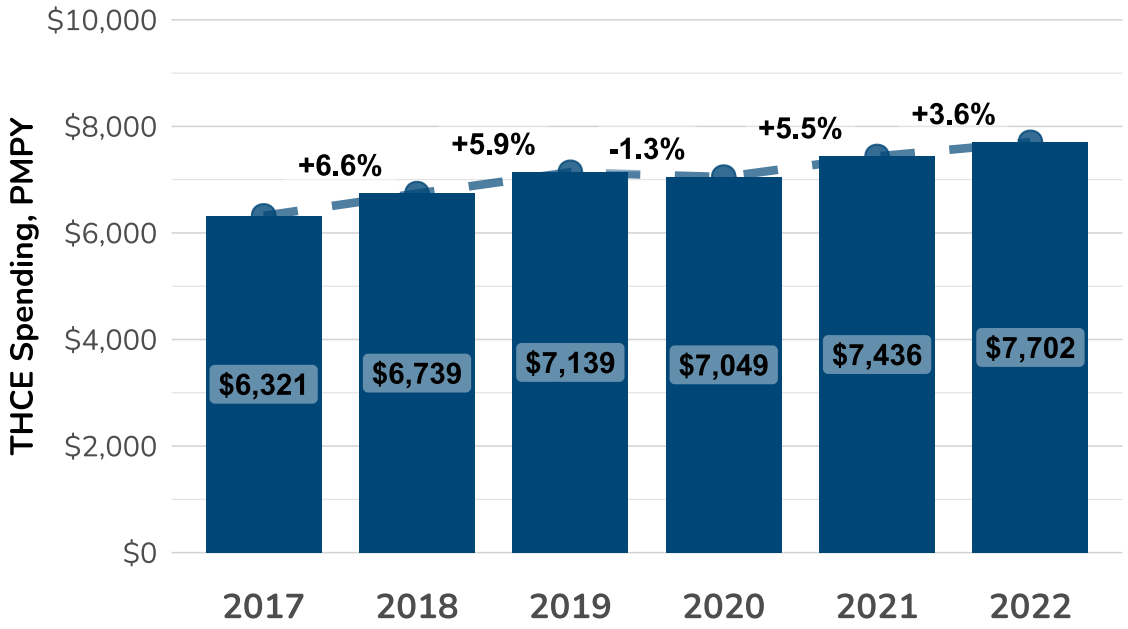
This section compares statewide, market, carrier and large provider organization 2022 performance against the benchmark. Additionally, there is a performance comparison against states with cost measurement efforts that employ similar cost containment strategies.

Statewide performance

As mentioned in Table 2, statewide performance is measured by the growth rate in THCE per member per year (PMPY). Statewide cost growth exceeded the cost growth benchmark of 3.2% with year-over-year THCE PMPY growth registering 3.6% in 2022. Excluding 2020, the growth seen in 2022 is the slowest since 2018. THCE PMPY grew on average by 6.3% per year before the pandemic (2018, 2019) before decreasing by 1.3% in 2020 (Figure 5).

As of 2022, THCE PMPY reached $7,841, roughly 22.2% of the 2022 annual income of a minimum wage worker in Washington State.[1]

Figure 5: Total health care expenditure, per member per year

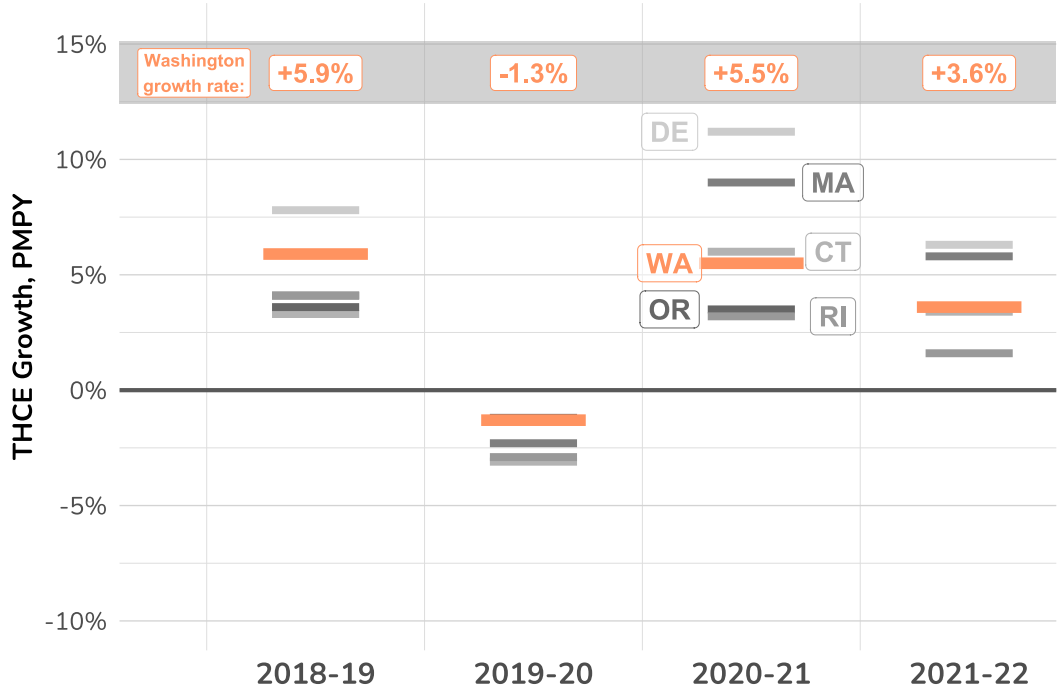


Washington's statewide performance relative to other states'

Washington State's 2022 THCE PMPY growth is comparable to the median PMPY growth rate of most states with similar cost transparency programs (Figure 6), following a broad trend of a drop in THCE PMPY in the 2020 pandemic year, followed by precipitous growth in 2021 before a leveling off of spending in 2022.

[1] Assuming 260 working days in a calendar year at 8 hours per day at the 2025 minimum wage of $16.66. **Read more from Department of Labor and Industries**.

Figure 6: Growth in THCE PMPY compared to five other benchmark states

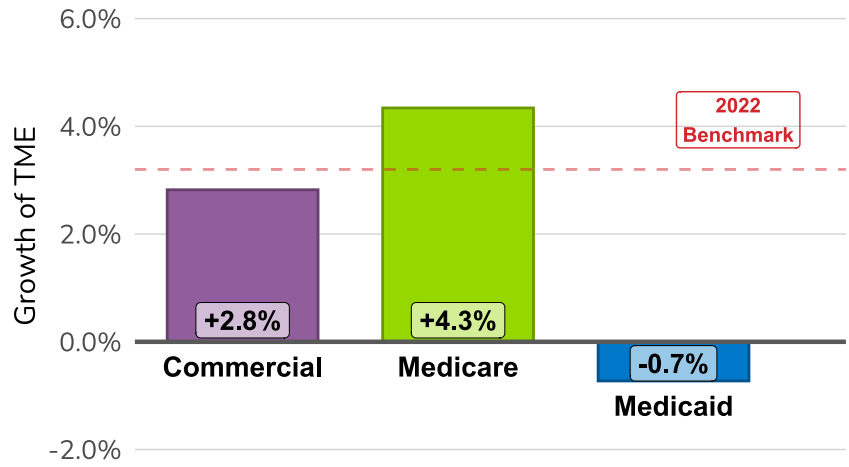


Source: WA Health Care Cost Transparency Board Data Calls, Bailit Health Analysis from Other States' Data Calls

Market performance

To assess market performance against the benchmark, each market's total medical expenditure (TME) per member per year (PMPY) growth is compared to the benchmark. TME PMPY in the Medicare market grew by 4.3%, exceeding the 3.2% benchmark in 2022 (Figure 7). The TME PMPY in the commercial market grew at a slower pace of 2.8% while that of the Medicaid market declined by 0.7 % in 2022. The performance of both commercial and the Medicaid markets did not exceed the benchmark.

Figure 7: Total medical expense growth in 2022, PMPY

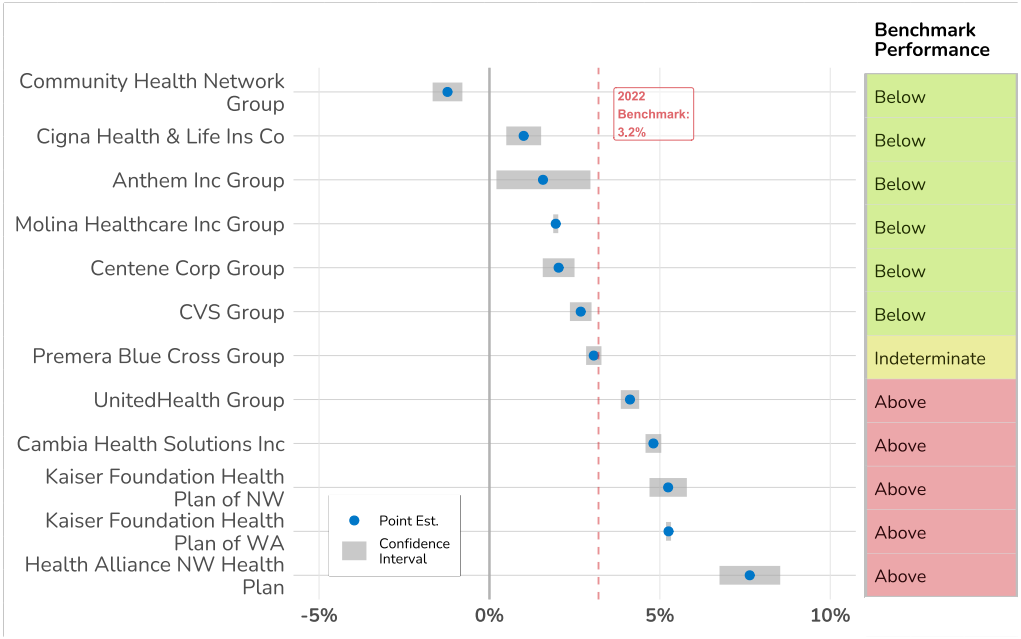


Carrier performance

Overall carrier performance

Across all lines of business, five of the 12 carriers exceeded the 3.2% benchmark (Figure 8), exhibiting a very broad range of performances. For these five carriers, the lower bound of the confidence interval of performance (i.e., growth rate of the truncated and age-sex risk adjusted TME PMPY) is higher than the 3.2% benchmark and hence, the performance exceeded the benchmark.

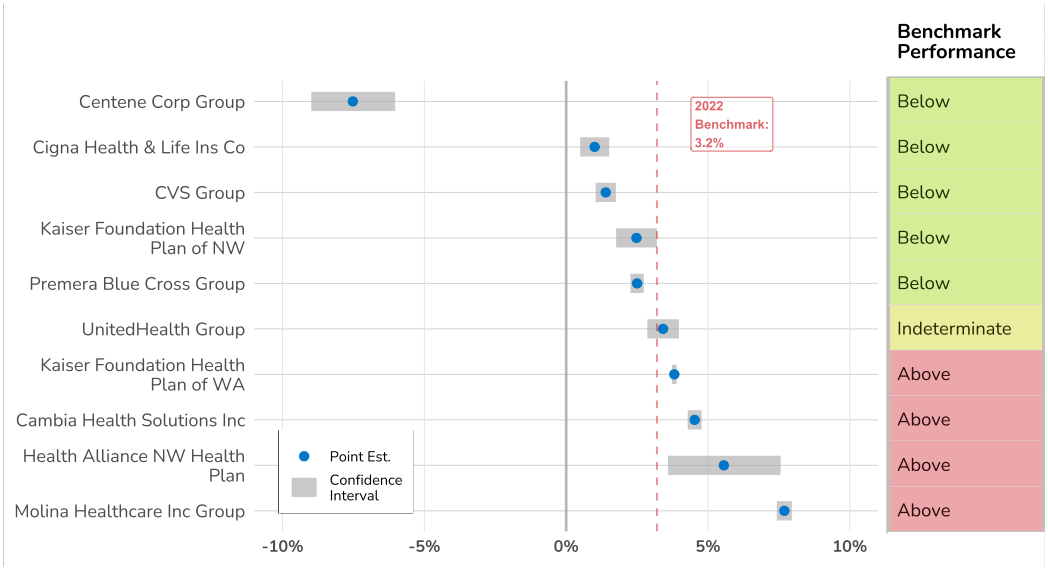
Figure 81: 2022 Carrier performance against the benchmark across all markets, measured by the growth rate of total medical expense, PMPY



Carrier performance by market

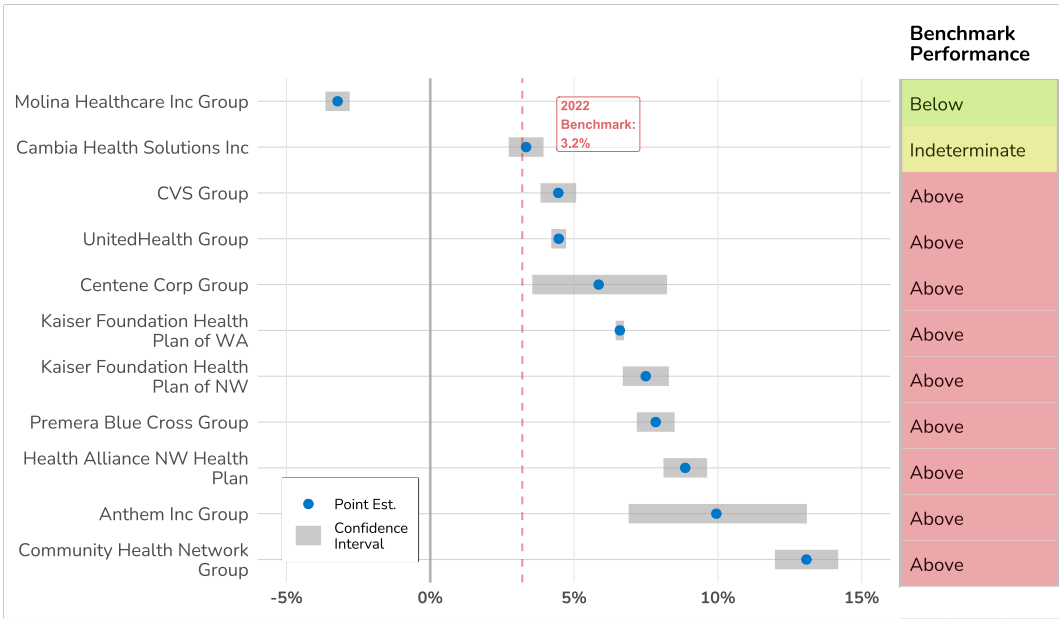
When broken out by market, performance against the benchmark shows a broad range of growth rates across carriers, while following the market growth trends for 2022. In the commercial market, only four out of the 10 carriers exceeded the benchmark (Figure 9).

Figure 9: 2022 carrier performance against the benchmark in the commercial market, measured by the growth rate of TME PMPY



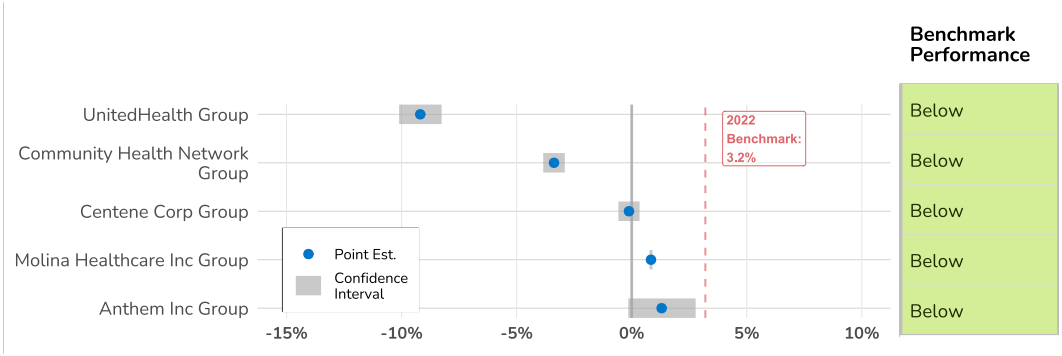
Nine of the 11 carriers operating in the Medicare market grew faster than 3.2% in 2022, with only one carrier significantly below the benchmark, in line with the statewide trend in the Medicare spending.

Figure 10: 2022 carrier performance against the benchmark in the Medicare market, measured by the growth rate of TME PMPY



None of the five carriers offering coverage in the Medicaid market exceeded the 2022 benchmark, which is consistent with the slightly negative growth rate for the overall Medicaid market.

Figure 11: 2022 carrier performance against the benchmark in the Medicaid market, measured by the growth rate of TME PMPY



Provider performance

Like the carriers', provider performance is measured by the confidence interval for the growth in the truncated, age-sex risk adjusted total medical expenditures per member per year (PMPY). Five of the 28 large provider organizations (identified by those with more than 10,000 attributed primary care lives) exceeded the 3.2% benchmark (Figure 12). Growth of TME PMPY for members that are unattributed to large provider entities (approximately 40% of total member months) significantly decelerated from 11.3% in 2021 to 2.6% in 2022.

Figure 12: 2022 provider performance against the benchmark, measured by the growth rate of total medical expense, all markets, PMPY

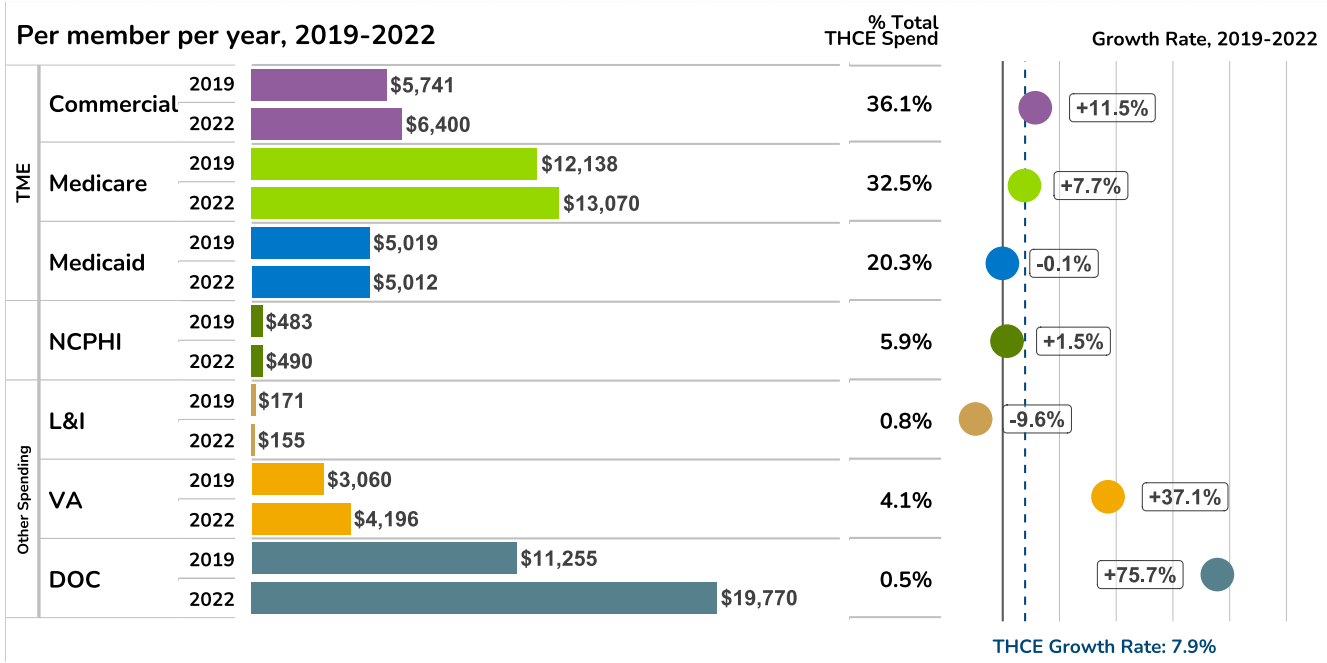
Spending growth during the pandemic (2019–2022)

Adding to the 2022 growth analysis in the prior section, this section looks at the per member spending trends from 2019–2022. Between 2019 and 2022, health care spending in Washington state dropped in 2020 (as many had forgone non-emergent medical services at the onset of the pandemic) and subsequently recovered. For some sectors, the growth in 2021 more than offset the declines experienced in 2020, creating an overall trajectory that highlights key areas of cost acceleration. This analysis focuses on cumulative growth across markets to identify trends that persisted during the pandemic.

Statewide per member spending, overall and by component

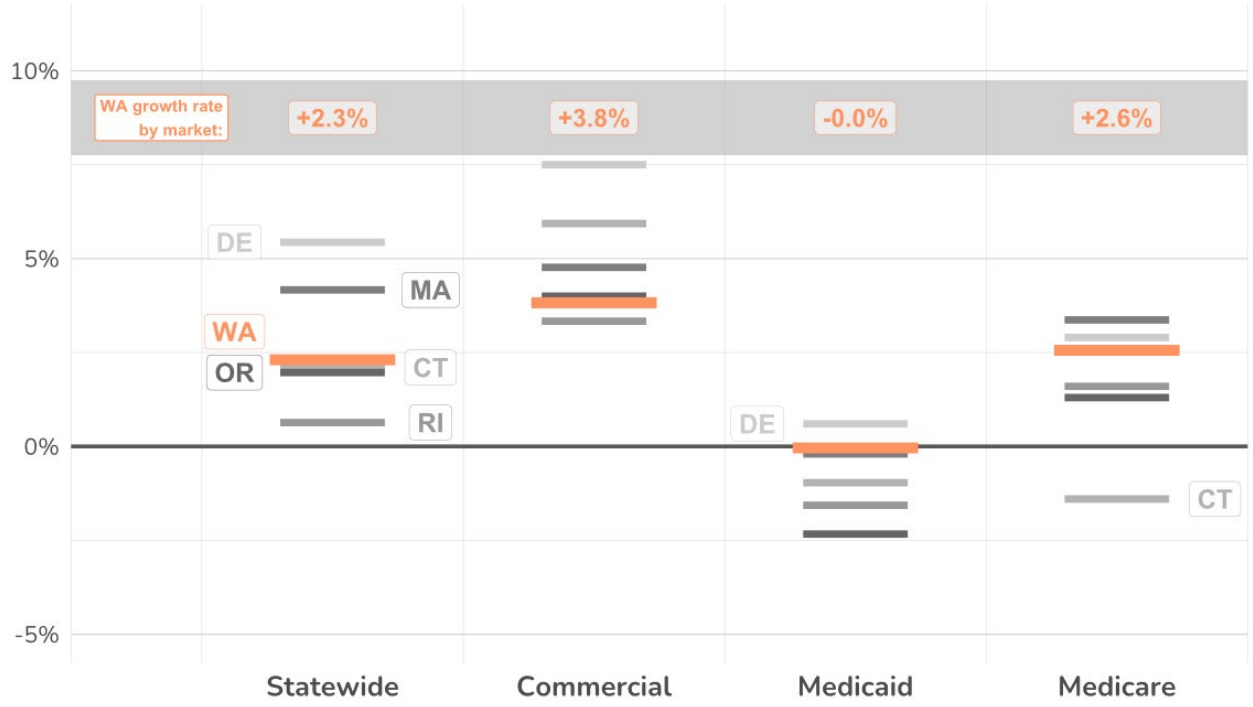
From 2019 to 2022, overall growth in per member per year THCE reached 7.9%, largely driven by growth in the commercial sector (11.5%) and, to a lesser extent, growth in the Medicare market (7.7%) (Figure 13). The commercial market growth is notably higher than the -0.1% growth in the Medicaid market. The decline in the Medicaid market underscores the rapid growth of the number of covered lives relative to overall Medicaid spending. Pandemic-related expansion in the Medicaid program increased membership. While there has been accelerating growth in per member spending for Veterans Affairs (VA) and Department of Corrections (DOC), these components cover small populations that do not significantly drive overall growth.

Figure 132: Growth in THCE component from 2019 to 2022



The market trends seen during the pandemic are similar to trends seen in other states (Figure 13). By looking at the average year-over-year growth rate of TME PMPY from 2020–2022, the commercial and Medicare markets drive overall growth, while growth in the Medicaid market was subdued.

Figure 143: Average total medical expense per member per year growth rate from 2019 to 2022 in Washington and five other benchmark states

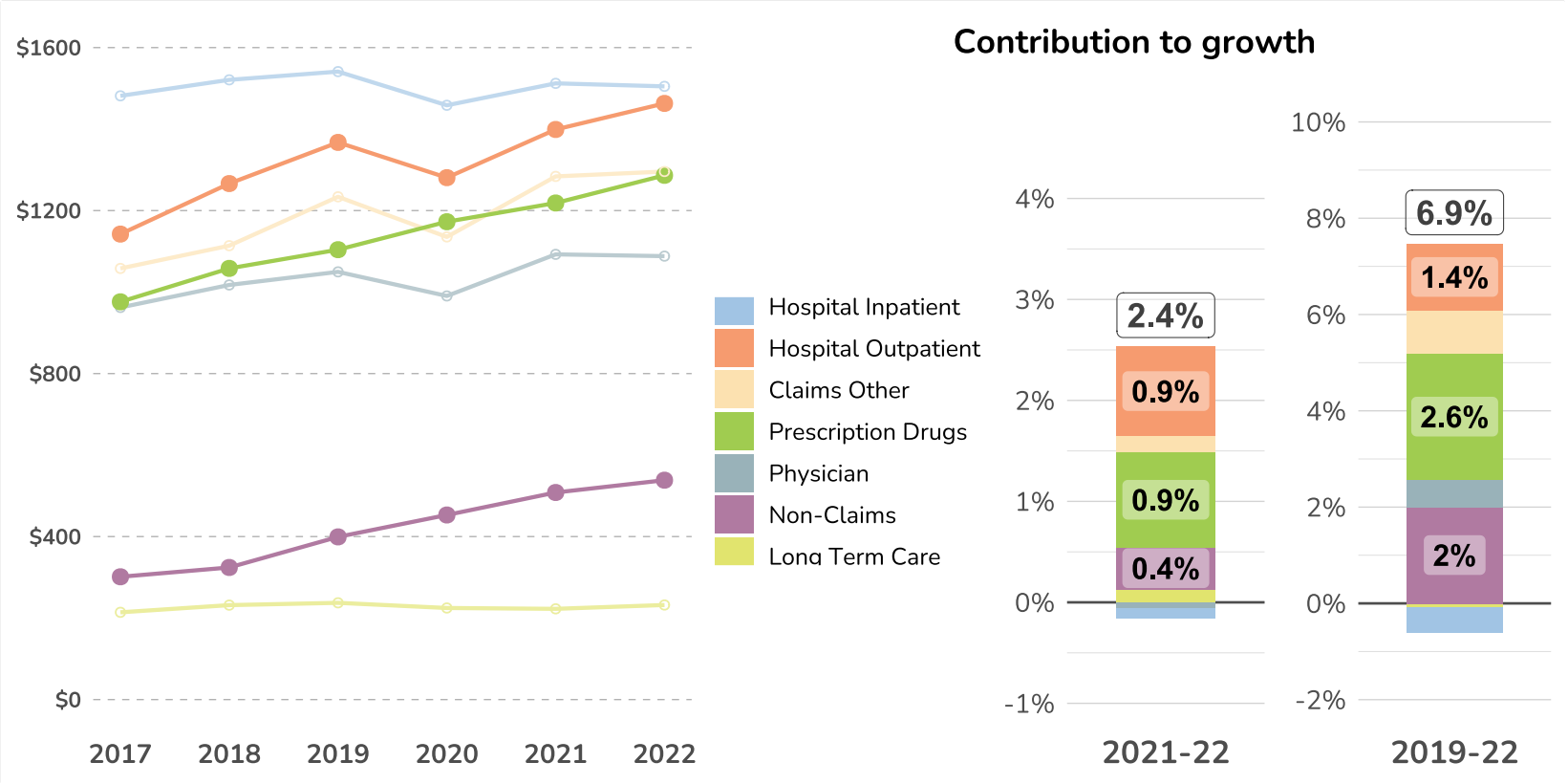


Source: WA Health Care Cost Transparency Board Data Calls, Bailit Health Analysis from Other States' Data Calls

Per member spending by service category

Across all three markets, prescription drugs, non-claims (payments that health plans make to provider organizations outside of claims), and hospital outpatient services emerged as the top contributors to health care spending growth during the pandemic (Figure 14). Robust growth in prescription drugs spending in the Medicare and commercial markets placed an upward pressure on overall cost growth. While spending on most service categories declined in 2020, prescription drugs continued to increase such that as of 2022, this category explains almost 40% of the spending growth (2.6 percentage points (or ppts) of the 6.9% growth THCE PMPY growth) seen from 2019–2022. Per member per year non-claims spending accounts for close to 2 ppts of the overall 6.9% growth since prior to the pandemic, driven by sustained increases in capitation and bundled payments in the Medicare Advantage sector. Hospital outpatient spending accounts for 20% of overall growth, specifically driven by growth in the Medicare and commercial markets.

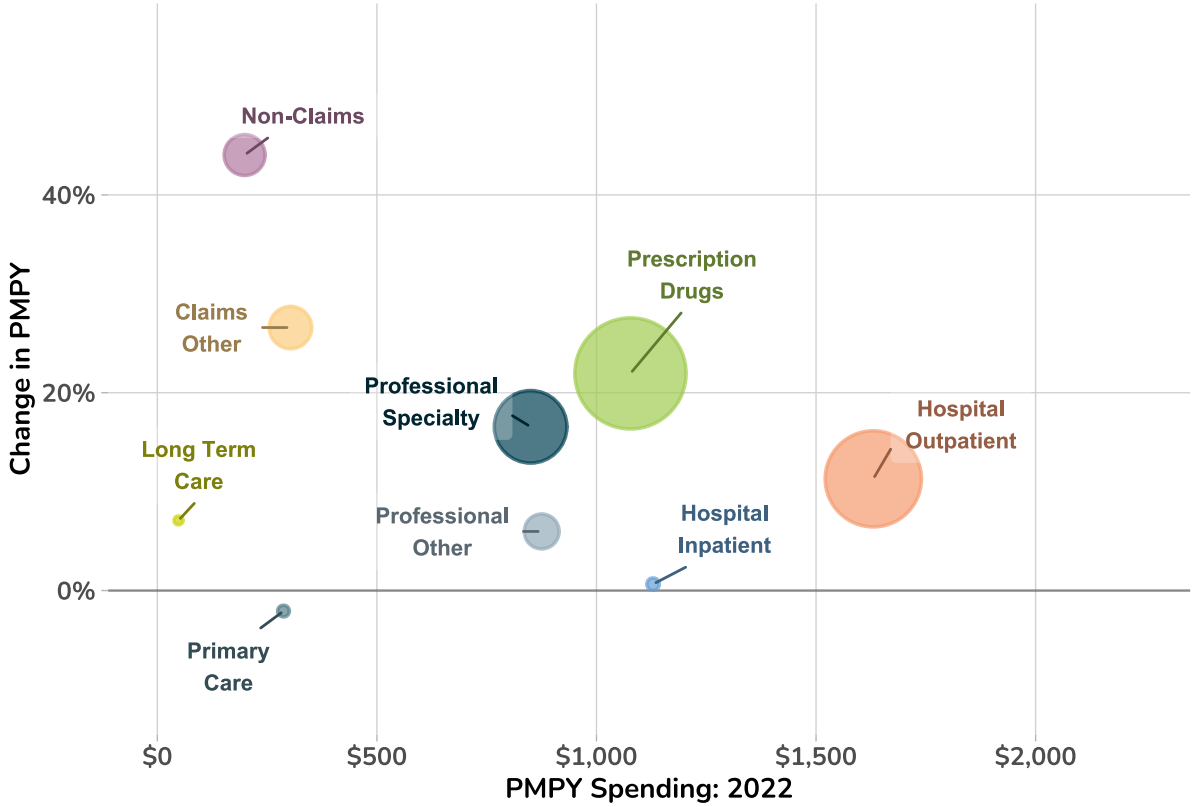
Figure 15: Growth of statewide TME PMPY spending by category of care from 2017–2022



Commercial market

In the commercial market, which registered an 11.5% growth from 2019–2022, the top three contributors to growth (indicated by the size of the bubble in Figure 16 and the numbers in the table within Figure 15) are prescription drugs (3.4 ppts), hospital outpatient (2.9 ppts) and professional specialty (2.1 ppts). The notable increase in spending on professional specialists is not seen in the Medicare nor Medicaid markets. Hospital outpatient spending is one of the largest contributors to growth across the pandemic years and is not offset by a drop in inpatient spending.

Figure 16: Change in total medical expense by category in the commercial market between 2019 and 2022



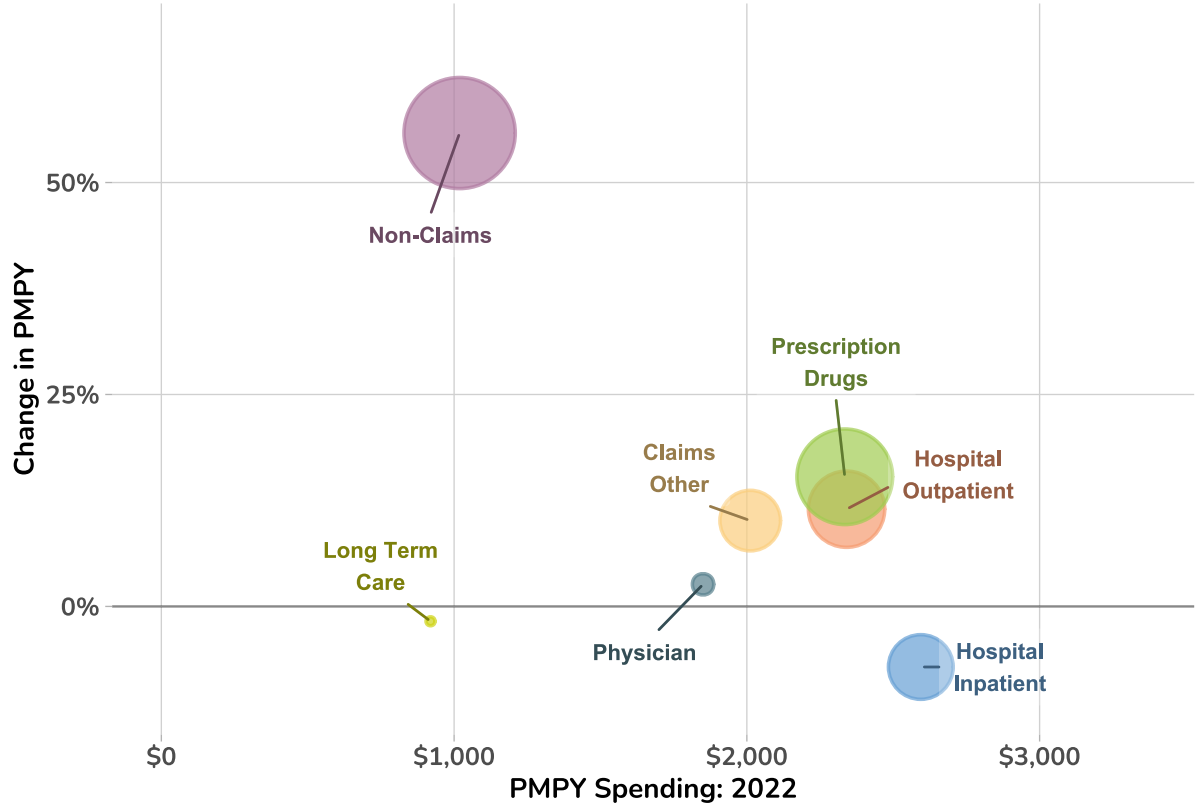
Category	Contribution to Growth (in percentage points)
Prescription Drugs	3.4
Hospital Outpatient	2.9
Professional Specialty	2.1
Claims Other	1.1
Non-Claims	1.1
Professional Other	0.9
Hospital Inpatient	0.1
Long Term Care	0.1
Primary Care	-0.1
Total Market Growth	11.5%

*Bubble size scaled to contribution to growth and listed in the table at right

Medicare market

The 7.7% growth in the Medicare market from 2019–2022 is largely driven by non-claims spending (3 ppts), prescription drugs (2.6 ppts) and hospital outpatient (2 ppts). Non-claims spending, mostly capitation or bundled payments, increased by more than 50% on a PMPY basis from 2019 to 2022. Prescription drugs accounted for one third of the overall 7.7% growth through the pandemic period. For the Medicare population, PMPY spending is roughly double that of members in the commercial and Medicaid markets, reflecting an older population and higher chronic disease prevalence. To a lesser extent than in the commercial market, the Medicare market also saw robust growth in the hospital outpatient category (Figure 17), but in this case, a decrease in inpatient spending largely offset the growth in outpatient spending.

Figure 17: Change in total medical expense by setting in the Medicare market between 2019 and 2022



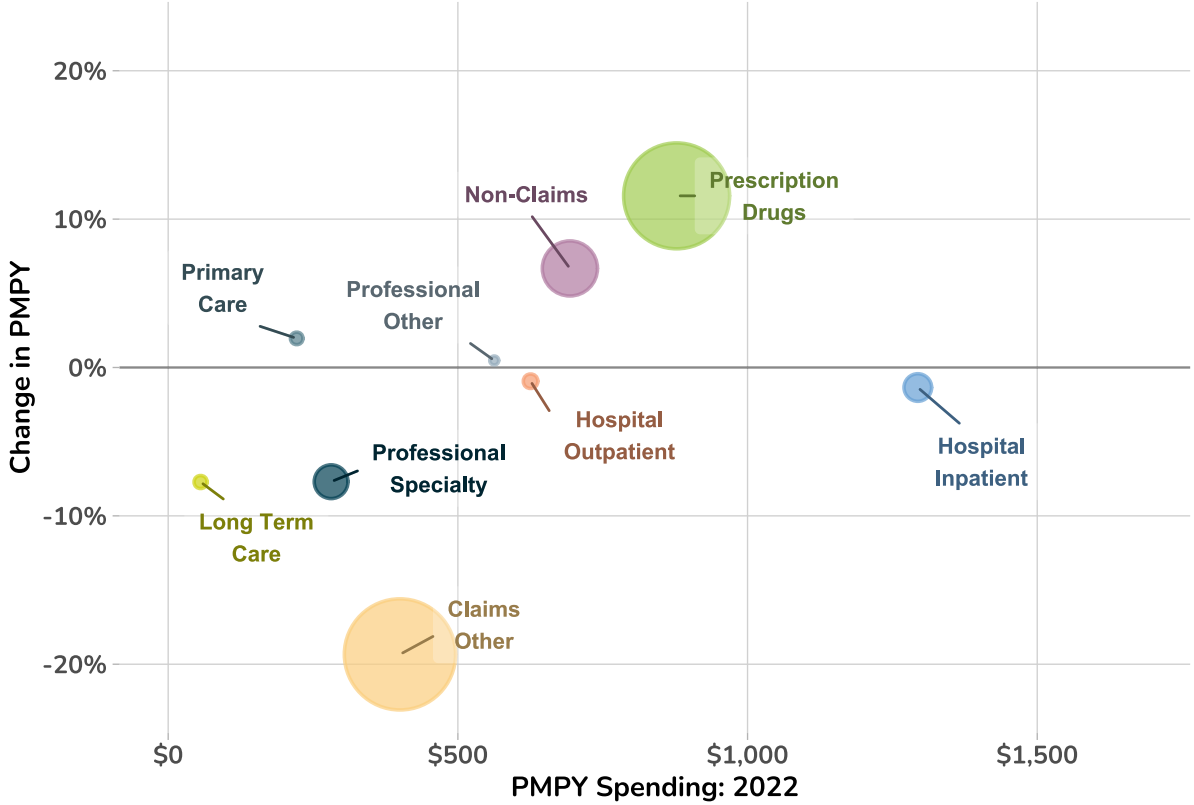
Category	Contribution to Growth (in percentage points)
Non-Claims	3
Prescription Drugs	2.6
Hospital Outpatient	2
Claims Other	1.5
Physician	0.4
Long Term Care	-0.1
Hospital Inpatient	-1.6
Total Market Growth	7.7%

Bubble size scaled to contribution to growth and listed in the table at right

Medicaid market

The Medicaid market registered a small 0.1% decrease in PMPY spending, as pandemic-driven enrollment expansion diluted per member costs (Figure 18). Nevertheless, prescription drugs remained the largest growth category and contributor to growth (1.8 ppts), with non-claims expenses being the second-largest contributor (0.9 ppts). A drop in the "Claims Other" category largely offset this increase (-1.9 ppts).

Figure 18: Change in total medical expense by setting in the Medicaid market between 2019 and 2022



Category	Contribution to Growth (in percentage points)
Prescription Drugs	1.8
Non-Claims	0.9
Primary Care	0.1
Professional Other	0.1
Long Term Care	-0.1
Hospital Outpatient	-0.1
Hospital Inpatient	-0.4
Professional Specialty	-0.5
Claims Other	-1.9
Total Market Growth	-0.1%

Bubble size scaled to contribution to growth and listed in the table at right

Conclusion

To address rising health care costs, Washington State has established a heath care cost growth benchmark program, worked to increase transparency, conducted analysis to understand cost drivers and worked to bring about policy interventions to manage health care cost growth.

At the **December 12, 2024, Health Care Cost Transparency Board public hearing**, the Health Care Cost Transparency Board had the opportunity to hear about the results of the first performance against the benchmark and other health care spending trends during the pandemic. The first public hearing also provided a platform for consumers, providers, carriers, and business and labor to share their experiences with the data call, as well as how they envision the work around the benchmark in the future. The 2022 performance against the benchmark marks a significant milestone for the Cost Board and sets an important foundation for years to come.

What's contributing to spending growth?

Key components of health care spending growth from 2019 to 2022 included **prescription drugs**, **non-claims**, and **hospital outpatient services**, with contributions varying by market. As the utilization trends begin to recover from the COVID-19 spending dip, future reports may reflect more stabilized trends. However, there are also serious upside risks coming from the lagged effects of inflation. Further exploring the drivers of health care cost growth will help the Cost Board consider policy interventions that can impact cost growth. In its discussions, the Cost Board highlighted the need to better understand how prices and utilization rates separately impact spending growth.

What's next?

In 2022, Washington State's overall health care spending growth was above the benchmark (3.2%). This first benchmark performance report helps Washington leaders and consumers understand the status of health care cost growth in the state and will help the Cost Board better identify trends that require further investigation. For example, the Cost Board suggested it would further study the impact of primary care spending on overall health care expenditures, plus utilization versus prices. The Cost Board will continue to examine the drivers of costs and explore policy interventions that help curb cost growth.

Appendix A: Data sources and performance against the benchmark methodologies

Data sources

The data used to identify health care spending trends as well as statewide, market, carrier and large provider organization performance comes from the data collected by the Cost Board in the 2022 and 2024 data calls. The 2022 data call collected data from 2017–2019, while the 2024 data call collected 2020–2022 data (see Table A1). The data collected includes claims, non-claims, health spending and health insurance administrative cost data from carriers and non-carriers. Claims spending refers to the allowed amounts from payers to provider organizations based on claims while non-claims spending refers to payments that health plans make to provider organizations outside of claims.

On the carrier side, the data call collected claims and non-claims data from the largest carriers (those that cover more than 10,000 covered lives in the commercial, Medicare Advantage, and Medicaid Managed Care businesses in Washington; see Table A2 for list of carriers participating in the data call). The data collected is broken down by large provider organizations (or provider organizations that has at least 10,000 attributed covered lives — see Table A3 for list of large provider organizations). Carriers first attributed members to a primary care provider or PCP (based on member selection of PCP, contract arrangements, and utilization). If a member is attributed to a PCP, carriers attributed this member to a large provider entity based on which large provider entity is the PCP is associated with. If the member could not be attributed to a PCP or the PCP was not associated to a large provider entity, the member was considered as unattributed. See pages A3–A4 of the Cost Board's **data call technical manual** for more information on the attribution methodology.

Table A1: Reporting schedule

Data call	Includes data from specified years	Expenditure data reported
2022	2017–2019	State and market data only — the Cost Board will not publicly report insurance payer or provider cost growth for this period
2024	2020–2022	Large provider entities and payers — with cost growth target of 3.2%
2025	2022–2023	Large provider entities and payers — with cost growth target of 3.2%
2026	2023–2024	Large provider entities and payers — with cost growth target of 3.0%
2027	2024–2025	Large provider entities and payers — with cost growth target of 3.0%
2028	2025–2026	Large provider entities and payers — with cost growth target of 2.8%

On the non-carrier side, the data call collected fee-for-service health care spending data from the Washington Health Care Authority for Medicaid FFS and from the Centers for Medicare & Medicaid Services for Medicare FFS. In addition, the data call gathered Washington state health care spending data from Veterans Affairs and two state agencies (Department of Corrections and Department of Labor and Industries). Moreover, the data call also gathered various data needed to be able to calculate the net cost of private health insurance (NCPHI). See Table A4 for a list of the data collected and their specific sources).

Table A2: List of carriers

Anthem Inc Group
Cambia Health Solutions Inc
Centene Corp Group
Cigna Health & Life Ins Co
Community Health Network Group
CVS Group
Health Alliance NW Health Plan
Humana Group
Kaiser Foundation Health Plan of NW
Kaiser Foundation Health Plan of WA
Molina Healthcare Inc Group
Premera Blue Cross Group
UnitedHealth Group

Table A3: List of provider organizations

Community Clinic Contracting Network (includes Yakima Valley, CHC Snohomish, Columbia Basin, Columbia Valley, International Community Health, Mariposa, Peninsula Community Health, Unity Care, & Sea Mar)
Community Health Association of Spokane
Community Health Care
Community Health of Central Washington
Confluence Health
Country Doctor Community Health Centers
Cowlitz Family Health Center
Evergreen Health
Family Care Network
Family Health Centers
Franciscan Health — including Virginia Mason Franciscan Health (part of Pacific NW Division of Common Spirit)
HealthPoint
Kaiser Permanente of Washington (medical centers in Western WA and Spokane)
Kaiser Permanente NW (medical centers in SW WA)
Legacy Health
Lewis County Community Health Services (Valley View Health Center)
Moses Lake Community Health Center
MultiCare Health includes Mary Bridge Children's Hospital; Navos

Wellfound Behavioral Health Hospitals — partnership with CHI Franciscan and MultiCare
NeighborCare Health
NEW Health Programs Association
North Olympic Healthcare Network PC
Optum Care (includes Everett Clinic, Polyclinic, and Northwest Physician's Network)
Overlake Medical Center
PeaceHealth
Providence Health/Swedish Health Services/PacMed/Kadlec
Rose Medical
Seattle Children's Care Network
Seattle-King County Public Health Dept (Health Care for the Homeless Network)
The Vancouver Clinic
Tri-Cities Community Health
UW Medicine (Valley Medical Center, Neighborhood Clinics)
Yakima Neighborhood Health Services

Community Clinic Contracting Network (CCCN) was excluded in the 2024 public reporting since CCCN negotiates contract arrangements on behalf of a handful of Federally Qualified Health Centers (FQHCs) identified in this list and does not share accountability across these FQHCs.

Table A4: Data categories and sources

Category	Data Source
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 (FFS) claims payments and enrollment, and all Part D spending	CMS
Non-managed care claims and non-claims payments and enrollment for Medicaid	HCA submission template
Veterans Health Administration medical spending and enrollment	Department of Veterans Affairs
Medical spending for state workers' compensation and enrollment	L&I submission template
Health care spending for incarcerated individuals and enrollment	Washington DOC submission template
NCPHI for the commercially 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

Data aggregation

Total health care expenditure (THCE)

The Cost Board utilized THCE to report on health care spending growth at the state level. THCE includes claims and non-claims payments between payers and provider organizations. Total medical expense (TME) is the sum of all claims and non-claims payments. Besides TME, THCE also includes other health care spending in public programs (i.e., Department of Corrections, Veterans Affairs, and the Department of Labor and Industries) as well as the net cost of private health insurance (NCPHI). The NCPHI refers to all costs associated with administering health plans. THCE is net of pharmacy rebates. Figure 18 shows the components of THCE and Figure 19 shows the various contributions to THCE.

Figure 18: THCE formula (TME plus NCPHI plus other spending)

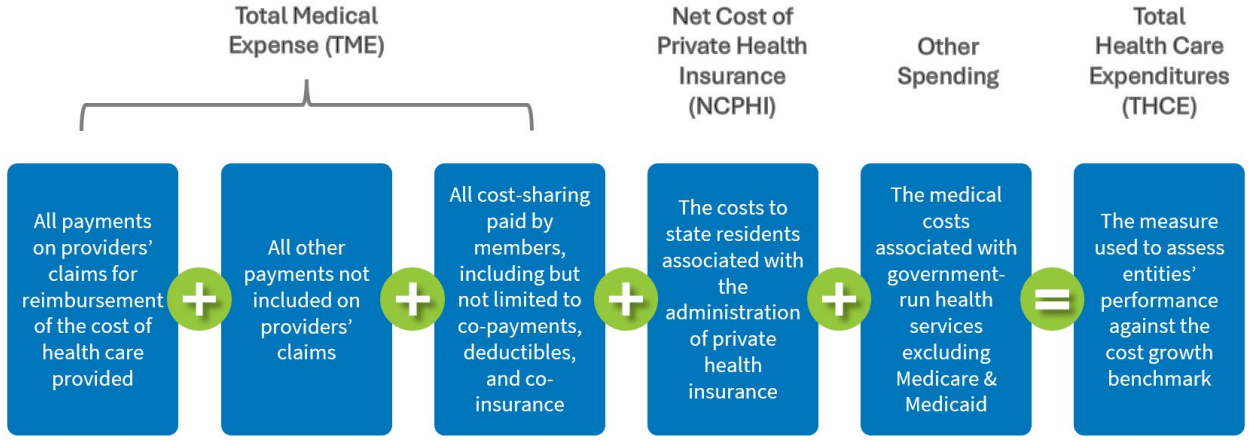
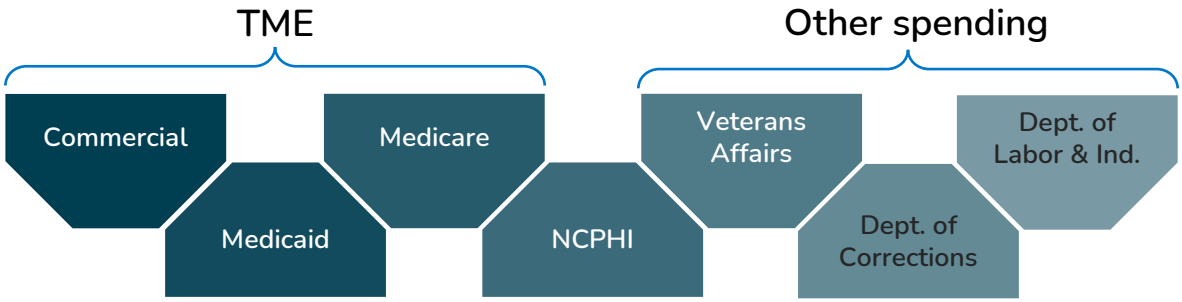


Figure 19: Components of THCE



Total medical expenses (TME)

The Cost Board also utilized TME to measure health care spending for market, carrier and large provider reporting. TME, which is a subset of THCE, includes claims and non-claims spending and exlcudes other spending and NCPHI (see Figure 20).

- TME for market level reporting: TME is reported as net of pharmacy rebates but is not age-sex risk adjusted and not truncated (i.e., not adjusted for high-cost clients). Moreover, TME includes FFS spending from Medicaid and Medicare.
- For carrier and large provider reporting:
    - TME is age-sex risk adjusted and truncated and excludes FFS data from Medicaid and Medicare. FFS data is not broken down by carrier and large provider organization.
    - Performance is based on the confidence interval of the growth rate of the adjusted TME. If the lower bound of the confidence interval exceeds the benchmark, performance exceeds the benchmark. It is indeterminant if the confidence interval contains the growth benchmark. Performance did not exceed the growth benchmark if the upper bound of the cost growth rate is lower than the benchmark.
    - The following links provide detailed description of the methodologies used to calculate performance:
        - Truncation (pages A11–A15 of the Cost Board's **data call technical manual**)
        - **Cost growth calculations: demographic risk adjustment, pooled variance, and confidence interval** (provider organizations and carriers)

Figure 20: Expenditures contributing to total medical expenses

Claims and non-claims spending by service categories

Claims and non-claims spending can be broken down into various service categories. See Table A5 for breakdown and examples.

Table A5: Claims and non-claims spending categories

A. Claims	
Hospital inpatient	• All room and board and ancillary payments for all hospital types • Payments for emergency room services when the member is admitted to the hospital
Hospital outpatient	• All hospital types and payments made for hospital-licensed satellite clinics • Emergency room services not resulting in admittance • Observation services
Professional	• Primary care providers • Specialty providers • Other providers

Long-term care	• Skilled nursing facility services • Home health services • Custodial nursing facility services • Home- and community-based services including personal care
Prescription Drugs	• Claims paid to retail pharmacies for prescription drugs, biological products or vaccines
Other	• Durable medical equipment • Freestanding diagnostic facility services • Hearing aid services • Optical services
B. Non-claims	
Non-claims	• Capitation or bundled payments • Performance incentive payments • Population health and practice infrastructure payments • Provider salaries • Recovery payments as the result of a prior review, audit, or investigation • Other — including, but not limited to governmental payer shortfalls, grants, other surplus payments, and Medicaid Transformation Project payments providers paid directly to carriers

For more information on the data collected, see the Cost Board's **data call technical manual**.

Caveats and limitations of the data

The following are excluded in the data:

- Policies offering limited benefits, such as accident, disability, Medicare supplemental insurance, vision or dental standalone policies
- Health care paid through charity care or by customer cast payment
- Certain non-claims publicly funded behavioral health services
- Anthem 2017 data
- Humana 2017 data
- Humana Medicare data
- Custodial nursing facility services, home- and community-based services, and intermediate care facilities and services for persons with developmental disabilities paid by Washington State Department of Social and Health Services (DSHS). This includes DSHS's Aging and Long-Term Support Administration (ALTSA) spending.
- Prescription drug rebates
- Statewide and market analyses are net of pharmacy rebates. These rebates include drugs covered under both the medical benefit and the pharmacy benefit. While costs for drugs covered under the medical benefit are accounted for in other types of service (inpatient, outpatient, or other claims), accurately separating the rebates on these drugs from other pharmacy rebates is difficult, so all pharmacy rebates are netted out of the prescription drug category. Carrier/provider level reporting is gross of pharmacy rebates.
- Statewide and market analyses include Medicare and Medicaid FFS data while carrier and large provider reporting excludes Medicare and Medicaid FFS data.
- There were revisions for 2017–2019 data due to data resubmissions from few carriers and revisions of NCPHI data.

- Member months data from DOC includes prison population and Rent-a-bed program population. The latter is limited to members with claims as existing data systems make it challenging to get information on those without claims.
- Federal Employee Health Benefit Plan (FEP) that have benefits split between two carriers are included only in the statewide and commercial market spending. Split FEP was removed from provider/carrier benchmarking.
- Member months from the Department of Labor and Industries are estimates and rounded off at the 100,000th level.

Appendix B: Definitions of key terms

Allowed amount: The amount the carrier paid a provider, plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of total medical expense.

Health care cost growth benchmark (the benchmark): The benchmark is the value against which the Cost Board has agreed to measure THCE and total medical expense. It is the value of 70% of Washington's historic median wage and 30% of Washington's PGSP.

Health insurance carrier (carrier): A private health insurance company that offers one or more of the following: commercial insurance, Medicare Advantage and/or Medicaid managed care products.

Large provider entity: A term referring to provider organization that delivers health care services, employs primary care providers, and is large enough to enter into a total cost of care contract, for whom carriers must report total medical expense data.

Market: The highest levels of categorization of the health insurance market. For example, FFS Medicare and Medicare Advantage are collectively referred to as the "Medicare market." FFS Medicaid and Medicaid managed care are collectively referred to as the "Medicaid market." Individual, self-insured, small and large group products and student health insurance are collectively referred to as the "commercial market."

Measurement year: The measurement year is the calendar year for which performance is measured against the prior calendar year for purposes of calculating the growth in health care costs.

Net cost of private health insurance (NCPHI): Measures the costs to Washington residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as 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.

Payer: A term used to refer collectively to both carriers and public programs that are submitting data to HCA.

Payer recoveries: Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payer recoveries is a separate, reportable field in carrier total medical expense reporting.

Pharmacy rebates: Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.[2] Spending at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).[3]

Provider: A term referring to an individual clinician, medical group, individual provider, large provider entity or similar entities.

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[2] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., carrier, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.)

[3] CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the state and Medicare market levels, spending will be gross of Medicare FFS pharmaceutical rebates.

Public program: A term used to refer to payers that are not carriers. This includes Medicare Fee For-Service, Medicaid FFS and similar programs.

Total health care expenditures (THCE): The total medical expense incurred by Washington residents for all health care services for all payers reporting to HCA, plus the carriers' NCPHI. Defining specifications of THCE are included in Section II. THCE per capita: THCE (as defined above) divided by Washington's reported membership. The annual change in THCE per capita is compared to the benchmark at the state, market and carrier levels.

Total medical expense (TME): The sum of the allowed amount of total claims and total non-claims spending paid to providers incurred by Washington residents for all health care services. TME is reported at multiple levels: state, market, payer and large provider entity level. TME is reported net of pharmacy rebates at the state, market and payer levels only.

Appendix C: Cost Board members

Member	Title	Agency or Organization	Board Member Position
Sue Birch	Director and Chair	HCA	Representing HCA
Jane Beyer	Senior Health Policy Analyst	The Office of the Insurance Commissioner	Representing the Insurance Commissioner
Eileen Cody	Consumer Advocate		Representing consumers
Lois Cook	Managing Member	America's Phone Guys	Representing small businesses
Bianca Frogner	Associate Professor	University of Washington	Representing as an expert in health care financing
Jodi Joyce	Chief Executive Officer	Unity Care NW	Nonvoting member who is a member of The Advisory Committee of Providers and Carriers with experience in health care delivery
Greg Marchand	Director, Global Benefits	Boeing	Representing large employers/self-funded group health plan
Mark Siegel	Director, Employee Benefits	Costco Wholesale Corporation	Representing large employers
Margaret Stanley	Consumer Advocate		Representing consumers
Ingrid Ulrey	Chief Executive Officer	Washington Health Benefit Exchange	Representing the Health Benefit Exchange
Kim Wallace	Medical Administrator	L&I	Representing the L&I
Carol Wilmes	Director, Member Pooling Programs	Association of Washington Cities	Representing local governments that purchase health care for employees
Edwin Wong	Research Associate Professor	University of Washington	Representing member who is an actuary or expert in health care economics