Universal Health Care Commission's
Finance Technical Advisory Committee meeting

May 15, 2025

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Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission's
Finance Technical Advisory Committee (FTAC)

Agenda

Thursday, May 15, 2025
2:00–4:30 PM
Zoom meeting

FTAC members:		
☐ David DiGiuseppe, FTAC Liaison	☐ Esther Lucero	☐ Pam MacEwan
☐ Christine Eibner	☐ Ian Doyle	☐ Robert Murray
☐ Eddy Rauser	☐ Kai Yeung	☐ Roger Gantz

Time	Agenda Items	Tab	Lead
2:00–2:05 (5 min)	Welcome and call to order	1	David DiGiuseppe, FTAC Liaison to the Universal Health Care Commission (Commission)
2:05–2:08 (3 min)	Roll call		Mary Franzen, Health Care Authority (HCA)
2:08–2:10 (2 min)	Approval of March meeting minutes	2	David DiGiuseppe, FTAC Liaison to the Commission
2:10–2:25 (15 min)	Public comment	3	David DiGiuseppe, FTAC Liaison to the Commission
2:25–2:30 (5 min)	Workplan update	4	Mary Franzen, HCA
2:30–3:40 (70 min)	Universal Health Care Commission update and next steps	5	David DiGiuseppe, FTAC Liaison to the Commission
3:40–3:50 (10 min)	BREAK		
3:50–4:00 (10 min)	Cost containment	5	Todd Bratton, HCA
4:00–4:10 (10 min)	Health Care Cost Transparency Board update	6	Todd Bratton, HCA Ross Valore, HCA
4:10–4:30 (20 min)	Cost containment discussion and potential recommendation	5	Liz Arjun, HMA Ross Valore, HCA
4:30	Adjourn		David DiGiuseppe, FTAC Liaison to the Commission

Tab 2

Washington State Health Care Authority

Universal Health Care Commission's

Finance Technical Advisory Committee (FTAC) meeting summary

March 13, 2025

Virtual meeting held on Zoom
2-4:30pm

Note: The meeting materials packet and a full recording of this meeting can be found at: https://www.hca.wa.gov/about-hca/who-we-are/universal-health-care/finance-technical-advisory-committee.

All votes made by the committee during this meeting are highlighted throughout in blue.

Members present

Christine Eibner
David DiGiuseppe
Eddy Rauser
Ian Doyle
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Esther Lucero

Call to order

David DiGiuseppe, FTAC Liaison, called the meeting to order at 2:02pm. Sufficient members were present to allow a quorum.

DRAFT

Washington State Health Care Authority

Agenda items

I. Welcoming remarks

DiGiuseppe began with a land acknowledgement and welcomed members to the fourteenth meeting of the committee.

II. Meeting summary

The January 2025 meeting summary was approved by unanimous vote.

III. Public comment

The following members of the public provided comments:

- **Rachael Snell**
- **Kathryn Lewandowsky**, Whole Washington
- **Raleigh Watts**, Whole Washington and Health Care is a Human Right
- **Maureen Brinck-Lund**, Health Care is a Human Right

Topics brought forth during public comments included a request to address governance, questions regarding administrative costs in the Milliman analysis, and a request for FTAC to ask for a dynamic fiscal note for the Washington Health Trust bill.

Their full testimonies can be found in the meeting recording here (time stamp: 7:15).

IV. Universal Health Care Commission (UHCC) update

David DiGiuseppe, FTAC Liaison

DiGiuseppe provided a brief update on UHCC's February 13th meeting. His update included an overview of public comments received during the meeting, UHCC's vote to support HB 1123/SB 5083, key takeaways from Oregon's reference-based pricing presentation, and an overview of the rural health roundtable.

The full update can be found in the meeting recording here (time stamp: 19:17).

V. Workplan update

Mary Franzen, HCA

Mary Franzen provided a brief update on UHCC's 2025 workplan, which aims to address the Phase 1 milestones (excluding financing) in 2025. Franzen noted that there have been several public comments asking UHCC to consider changing the overall workplan developed in 2022 so that it addresses governance (currently in Phase 3) much sooner.

The full update can be found in the meeting recording here (time stamp: 27:20).

VI. Milliman analysis findings and discussion

Peter Hallum, Milliman and Mary Franzen, HCA

DRAFT

Franzen began the presentation noting that the results of this analysis are to be used as a starting point for discussion of benefits and services that could be included in a universal design. She also highlighted that the scenarios modeled in the analysis are not proposals or recommendations that have been endorsed by FTAC or UHCC. Peter Hallum, Consulting Actuary at Milliman, then presented a detailed review of the analysis including summary results, an overview of the cost sharing scenarios, sensitivity analyses, the methodological approach, and further considerations for next steps. The full report is available at: https://www.milliman.com/en/insight/universal-health-care-system-population-benefit-scenarios.

Following the presentation, committee members were encouraged to ask questions. Committee members asked for clarification about the identified population, whether the analysis accounted for different types of drugs and biologics coming on the market, and how UHCC will use the findings from this report. DiGiuseppe indicated FTAC should share key takeaways from the Milliman analysis with UHCC as well as a potential pathway for what questions could be answered with this analysis.

DiGiuseppe requested committee members send their ideas for next steps ahead of UHCC's next meeting on April 17, 2025. HCA staff will circulate a draft version of these ideas to FTAC members prior to UHCC's April meeting.

The full presentation and discussion can be found in the meeting recording here (time stamp: 33:23).

VII. Cost containment memo discussion

Todd Bratton, HCA

Todd Bratton presented the draft cost containment principles for discussion and potential adoption. Committee members provided suggestions and comments for consideration, including condensing the principles. Bratton noted that the plan is to present the principles to UHCC at the April meeting for additional feedback. It was determined that HCA staff would circulate an updated draft with FTAC members via e-mail prior to UHCC's April meeting.

Bratton then presented the cost containment framework for discussion and potential adoption. The framework included four categories: Utilization Modifiers, Price and Spending Control Regulation, Administrative and Market Oversight, and Program Modification and Investment. Bratton noted that the purpose of the framework is to create a shared understanding between FTAC and UHCC about how cost containment strategies might be organized. Committee members did not indicate any concerns about how the framework was structured. No vote was taken.

Bratton then asked committee members to discuss coding the different cost containment strategies to gain consensus among committee members about which strategies should be included in a unified system, which strategies should be transitional only, which strategies could be either, and which strategies should be excluded altogether. Committee members noted that some of the strategies could be considered, but their utility may be limited if implemented concurrently. No vote was taken, and it was determined that HCA staff would circulate an updated draft with FTAC members for further feedback.

The full presentation and discussion can be found in the meeting recording here (time stamp: 1:53:29).

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Washington State Health Care Authority

Adjournment

Meeting adjourned at 4:31pm.

Next meeting

Thursday, May 15, 2025 from 2-4:30pm
Meeting to be held on Zoom

DRAFT

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission's

Finance Technical Advisory Committee

Written Comments

Received since 2/27/2025

Written comments submitted via e-mail:

Additional comments received at the March 13, 2025 FTAC meeting:

- The recording is available here: https://www.youtube.com/watch?v=kli1d9YN08Q

From: Kathryn Lewandowsky
To: HCA Universal FTAC
Subject: Additional Written Comments from Mar_2025 FTAC meeting
Date: Friday, March 21, 2025 10:28:39 AM

External Email

Hello, FTAC members, here are my complete written comments from your March meeting which I did not have enough time to deliver at the meeting. Followed by some additional comments regarding your committee materials discussed on that day.
"Hello FTAC members, Kathryn Lewandowsky, Retired RN and Board vice-chair of Whole Washington. In your packet, you are reminded of the UHCC's mandate from the legislature in 2021 to…
…create immediate and impactful changes in the health care access and delivery system in Washington and to prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the necessary federal authority has become available." (RCW 41.05.840)

Obviously, in the process of obtaining such "federal authority", many of Washington's residents will lose their savings, their homes, their productivity and for many…their lives. We do not live in a perfect world and we do not have a perfect government. In this last election the citizens of Washington state clearly said that "We live in a liberal state! We care about what happens to our neighbors, our friends and our families." At Whole Washington, We understand that obtaining permission and support from our federal government will be difficult. But the Washington Health Trust can be passed and the transition plan can be started, we can begin to realize savings for our government, our businesses and our citizens.

What IS so ingenious about the Washington Health Trust is that it is NOT dependent on obtaining "federal authority" in advance to begin deconstructing our current unsustainable healthcare system. It allows for a reasonable transition plan to get the ball rolling and CAN make impactful changes that will help all of our state to survive our current crumbling for profit financing system and bumbling federal administration. From research done by other states, it MUST be passed before any "federal authority' can be even applied for.

Even if we could say that people love their health insurance companies, which they clearly don't, we must clearly state again, "The current system is unaffordable, stressful, wasteful, it does not improve people's lives and we are sick and tired of being forced to deal with for profit middle men standing between us and our doctors when we JUST need healthcare!

So, what I would really love is if your committee could please run a dynamic fiscal note in order to discover the true "cost" and potential savings on the proposed funding mechanisms within SB5233/HB1445. "

Additional written comments-

Principle 1 – Adoption of a comprehensive cost containment strategy is an essential prerequisite to prepare Washington state for a universal health care system with unified financing. **Agreed! This is why there must be adoption of a plan that the state can move forward on. Where would we be now if we had adopted a "plan" 2 years ago, 4 years ago, 6 years ago!**

Principle 2 – Adopt transitional cost containment and affordability strategies while state policymakers consider options a universal health care system. **The time for this is long past. It is time to finally make impactful and sustainable change!**

Principle 3 – Adopt evidence-based strategies that do not create barriers to care or disrupt the provision of necessary and high-quality care. **This can not really happen without having collaborative discussions with care providers. This is inherent in the Washington Health Trust through the providers committee!**

Principle 4 – Address health care cost with respect to patient access, quality of care, affordability, price of services, volume of services, and the cost of administration. **This is the main focus of the Washington Health Trust through the Financial and Citizen's committees!**

Principle 5 – Identify and focus on primary drivers of health care spending and spending growth, including actions to limit excessive provider price growth, the provision of unnecessary health services, and administrative waste and inefficiency. **Again, this is well covered within the design model of the Washington Health Trust!**

Principle 6 – Utilize a variety of targeted cost containment strategies with flexibility to modify those interventions over time to address unintended consequences and/or improve cost containment success over time. **This is most easily evaluated over time within the construction of the Washington Health Trust through the oversight of the Trust Board and that involves all of the committees created as part of the trust!**

Principle 7 – Align and coordinate cost containment strategies with the work of the Health Care Cost Transparency Board. Adopt transitional and long-term strategies which help Washington meet its health care cost growth benchmarks. **Through passage of the Washington Health Trust the state will have the ability to openly evaluate all of these costs and how to best contain them. Providers and state regulators would no longer be restrained by a system of trade secrets and accounting shuffleboarding that value corporate profits over maintaining sustainable hospitals, encouraging and promoting provider opportunities to practice their trade unencumbered with corporate restraints, thereby creating places of healing rather than Wall Street opportunities for creating wealth over health.**

Principle 8 – Emphasize the goal of improving the overall equity of Washington's health delivery system, including addressing payment equity and systemic inequities, reducing disparities in care quality and access, and other equity goals. Review final decisions with use of the Health Care Authority's health equity toolkit. **Creating the Washington Health Trust would create equal reimbursement of all patients which is fundamental in creating an equitable healthcare system.**

Kathryn Lewandowsky, BSN, RN
Whole Washington- Board Vice-Chair
One Payer States- Treasurer

To the Universal Health Care Commission,

Thank you for the invitation to clarify the public comment I made at the Commission's April 17, 2025 meeting. My public comment stated that during the FTAC's March 13, 2025 meeting several FTAC members shared compelling rationale for moving decisions about governance and system design further up on the Commission's work plan. While these comments were not an explicit recommendation from the FTAC, I felt it was important for the Commission to be aware of these individual comments as "governance first" was on the Commission's April 17 agenda.

I was referring to comments made by Pam MacEwen and Roger Gantz. In a previous health reform process Pam was involved with, governance was determined at the start of the process, which "brought a lot of clarity to the work." She shared that clarifying the governance up front may help the UHCC and FTAC know how to proceed at "forks in the road." Later in the meeting, Pam and Roger stated that it is hard to make decisions about specific cost containment strategies without knowing the overall design of the system or the "general structure in which to place them." Roger used the example that some cost containment strategies would only be applicable if the government administers the new system through health plans, but this has not been decided by the Commission.

You'll find these comments at 0:31:00 and 2:22:00 in the recording of the FTAC meeting, linked here: https://www.youtube.com/watch?v=kIi1d9YN08Q

Thank you for this opportunity to elaborate on the rationale for moving decisions about governance and system design forward on the Commission's work plan.

Respectfully,

Raleigh Watts
Whole Washington and Co-Chair, HCHR-UHCC Subcommittee, "HUX"

Tab 4

Washington State Health Care Authority

Workplan update

Finance Technical Advisory Committee

May 2025

Universal Health Care Commission charge

As directed by the Legislature, the Commission must:

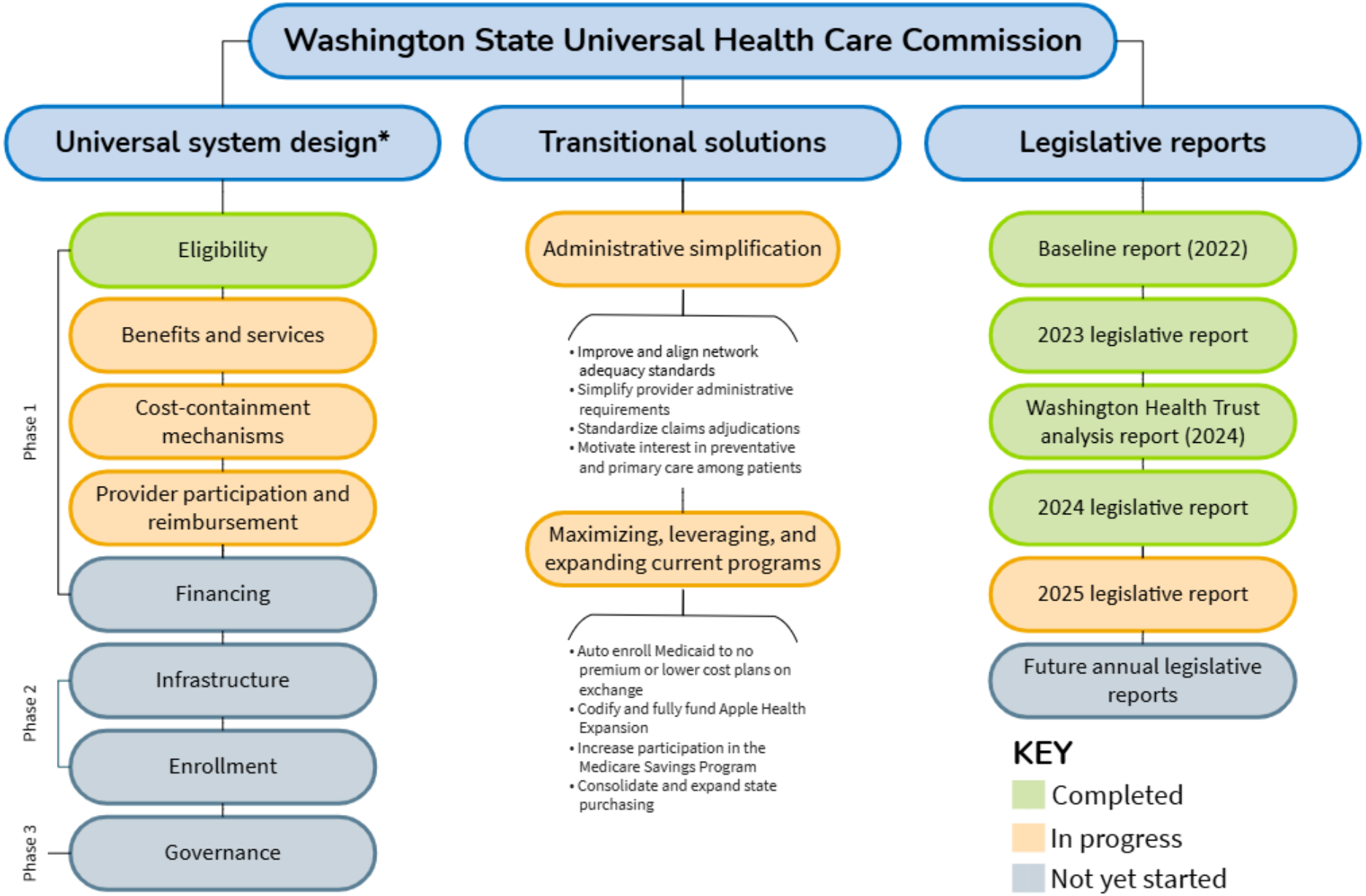
Transitional Solutions

"…create immediate and impactful changes in the health care access and delivery system in Washington and to prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the necessary federal authority has become available." (RCW 41.05.840)

Universal System Design

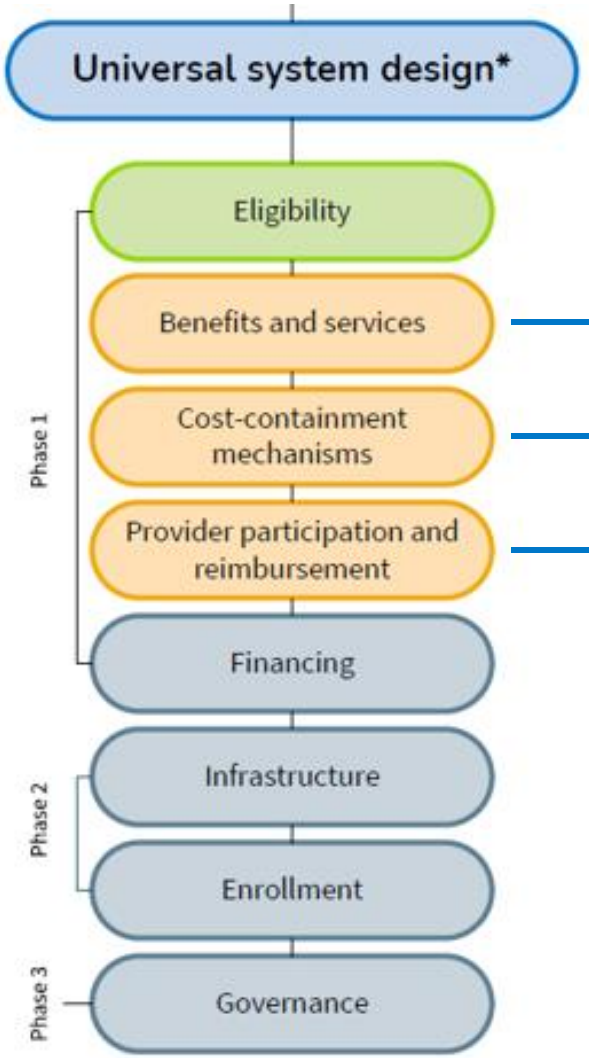
Milestone Tracker

Last updated: April 28, 2025



*Note: Health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.

Today's meeting



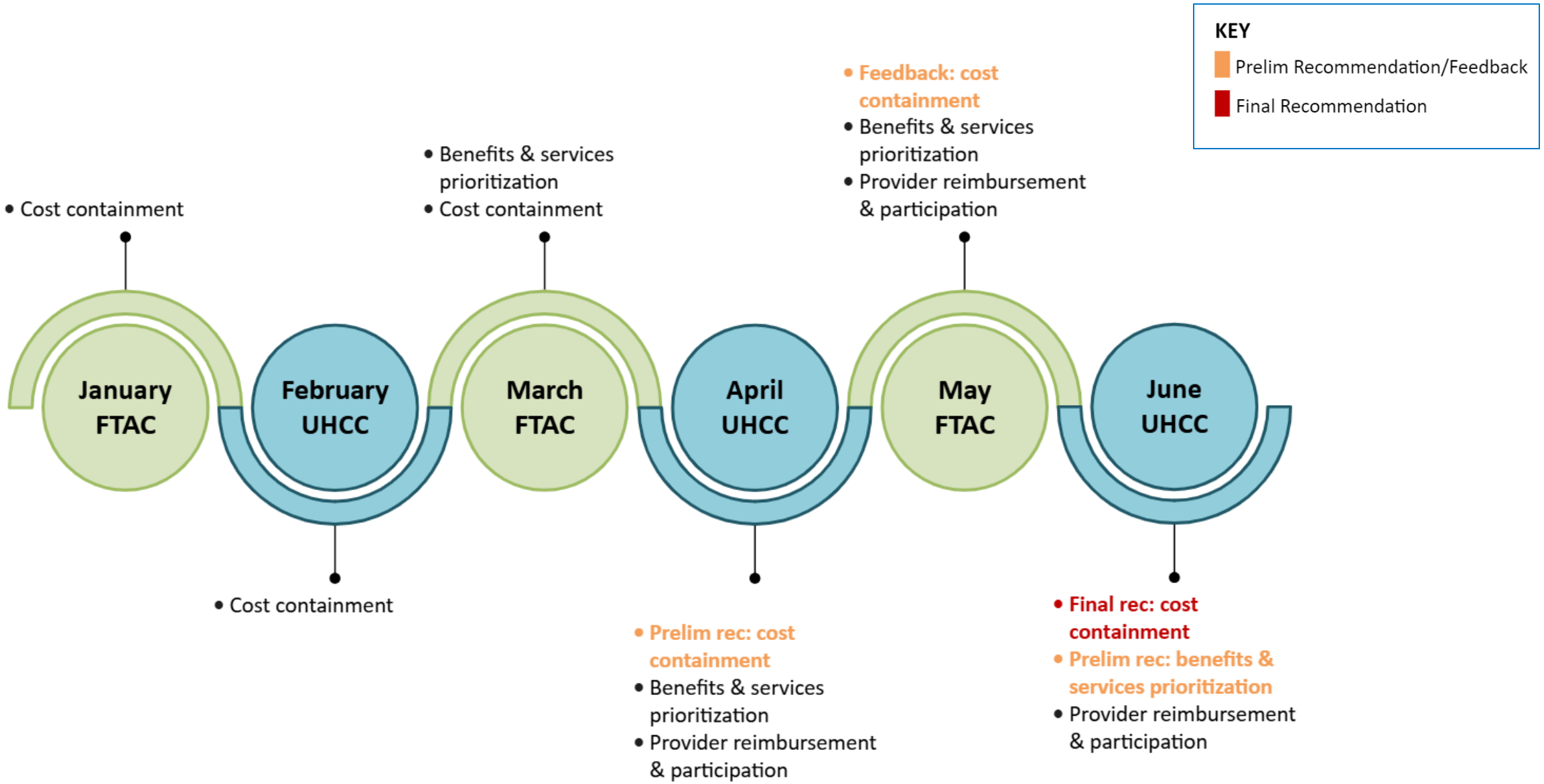
Feedback from Universal Health Care Commission and next steps

Cost containment and Health Care Cost Transparency Board update

Feedback from Universal Health Care Commission and next steps

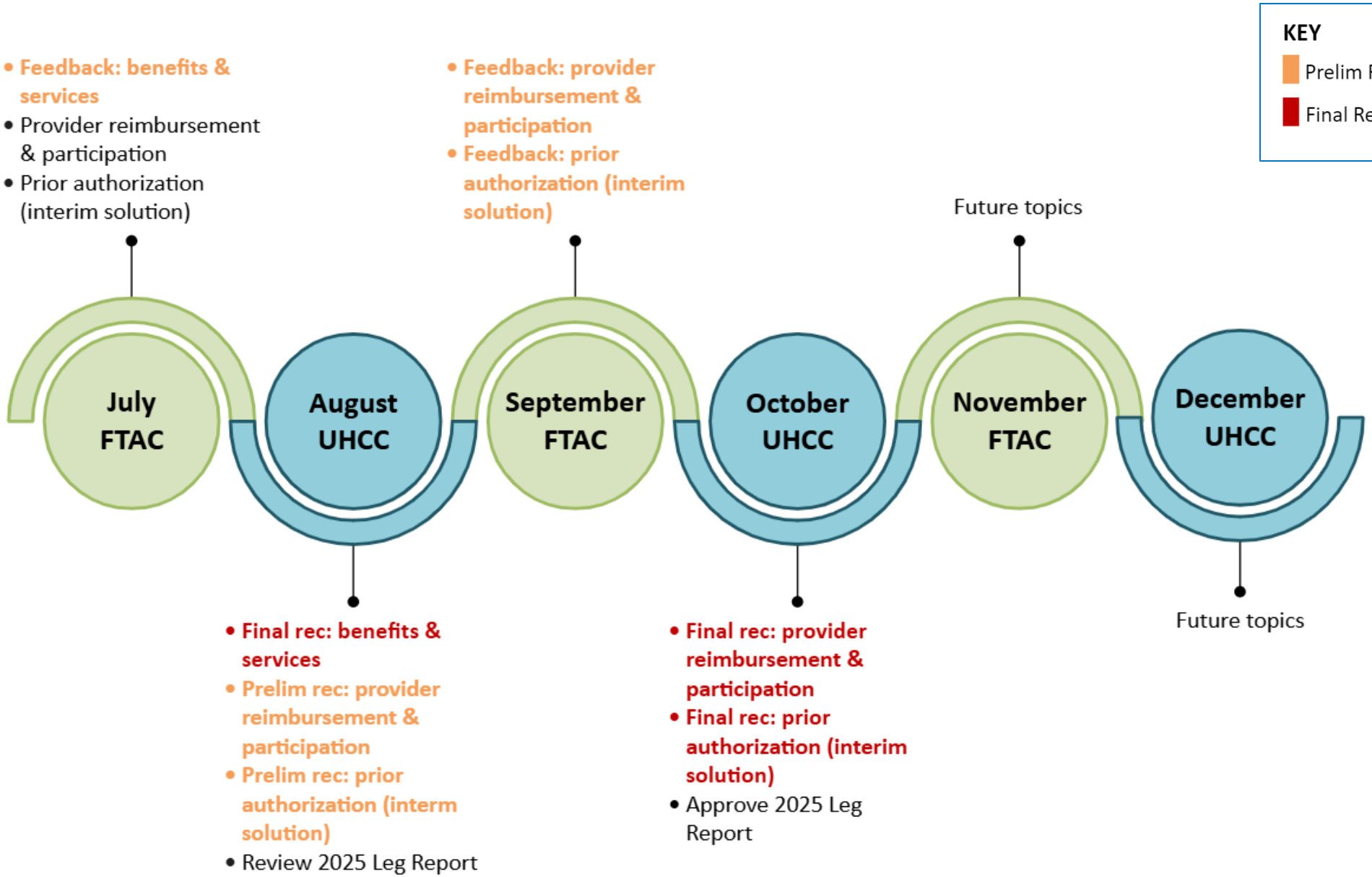
2025 Workplan | January-June

Last updated: April 2025



2025 Workplan | July-December

Last updated: April 2025



Tab 5

Washington State Health Care Authority

Universal Health Care Commission update

David DiGiuseppe, FTAC Liaison to the UHCC

Washington State Health Care Authority

Overview

- Debrief: 4/17/2025 Universal Health Care Commission (Commission)
  - Public comment
  - Governance
  - Cost modeling analysis
- Open questions after Commission meeting
  - Governance
  - Cost modeling analysis
  - “Stakes in the ground” approach
- Cost Containment recommendations

April 17 UHCC public comment

- Support for advocacy groups, request to provide further review of legislative proposals
- Recommendation to look to other countries, start with universal primary care, address high prices
- Interest in addressing governance early
  - Way to gain public support
  - Suggestion that actuarial study of administrative expense is critical

April 17 UHCC governance

- Further defining "governance"
  - Need to distinguish infrastructure (who administers) from oversight (who regulates)
  - Administer as work group "Model A" (single payer) or "Model B" (via carriers)?
  - Oversight: new state agency, existing state agency, or a combination?
  - Does Washington Health Benefit Exchange's governance structure provide a model for the Universal Health Care Commission?

April 17 UHCC governance

- Timing of decision making on governance
  - *In favor of Phase 3:*
    Bottom-up design makes more sense than top down
  - *In favor of sooner:*
    Will help focus accountability for the public
  - If governance addressed earlier than Phase 3, how might that affect the Phase 1 timeline?
  - Is it helpful for FTAC to have governance discussion earlier?

April 17 UHCC governance

- Decisions
  - Discuss again at Commission's June meeting
  - HCA to bring examples and Oregon information

- FTAC
  - Public comment advocating for acceleration
  - Stake in the ground: Current phasing makes sense
    - **Do any FTAC members think that governance needs to be accelerated?**

April 17 UHCC cost modeling report out

- Order of events
  - Slides were sent out for FTAC review before the Commission meeting
    - Part 1: Study findings (“Round 1”)
    - Part 2: Framework for next steps (“Round 2 & Round 3”)
  - Peter Hallum from Milliman fielded questions
    - Commissioners asked insightful questions
  - Liz Arjun from Health Management Associates facilitated Commission discussion and direction for FTAC
- Outcome
  - Multiple important decisions – thanks to HCA, Milliman and FTAC
  - Some open questions

Closing the open questions …

- Additional funding unlikely
- HCA working to form Commission subgroup to resolve the open questions

Slide presented 4/17/25

Benefits & services

Outstanding questions to the Commission

- Which service coverage options should the Legislature consider, beyond those covered by Medicaid, WA Essential Health Benefits and PEBB/SEBB's UMP Classic (all with dental coverage)?
- Which cost sharing options should the Legislature consider, beyond Medicaid (0% of actuarial value (AV) of medical expense), PEBB/SEBB's UMP Classic (13% AV), and Cascade Care – Silver (32% AV)?
- Should benefits and services be standardized across subpopulations? (e.g., should Medicaid beneficiaries continue to have all existing Medicaid services, and should all persons with incomes below 138% FPL have cost sharing under any design?)

FTAC recommendation

- Include additional options if the Commission desires additional options
- Assess feasibility of producing economic model
  - Project baseline and scenario results (currently CY 2023) to CY 2027-8, by subpopulation
  - Basis for understanding of financing requirements and impact by market segment

Benefits & services

UHCC decision(s)	• **No new benefit designs to model** • **Aim for Scenario 2 (PEBB/SEBB); Aspire to Scenario 1** • **Retain Scenario 3 as cost neutral point of reference** • **Consider: vision, higher cost sharing for more expensive procedures**

Open question(s)	• Under Scenario 2, should Medicaid beneficiaries continue to have:
	  • Medicaid-covered services?
	  • $0 cost sharing?

FTAC stakes in the ground	• Disentangle services covered and cost sharing
	  • Services
	  • PEBB/SEBB (essential health benefit) for all populations
	  • Vision is covered
	  • Cost sharing
	  • Individuals < 138% FPL experience $0 cost sharing
	  • Coinsurance addresses higher cost sharing for more expensive services

FTAC member concerns?

Slide presented 4/17/25

Eligibility

Options	Difference vs Round 1 Results ($B)*
Include ERISA fully insured population Note: This increases baseline expense from $16.3B to $20.0B. Differences calculated using higher baseline.	($1.3)–$11.0

Outstanding questions to the Commission

- How should additional populations be included? How much does that cost or save?
  - e.g., Veteran Affairs (VA) beneficiaries, out-of-state employees working in Washington, federal employees
  - e.g., for VA/Indian Health Service (IHS) beneficiaries, potential wraparound benefit for additional services (like Medigap), while maintaining choice of delivery system

FTAC recommendation

- Expand Round 2 analysis to assess cost of including additional populations and wraparound benefits noted above

* Derived from 3/13/2025 FTAC meeting packet, page 55; impact depends on scenario: $11B is max estimate of providing ERISA fully insured members with Medicaid services and 0% cost sharing.

Eligibility

UHCC decision(s)	• **Include ERISA fully insured** • **Model supplemental coverage in future round**
Open question(s)	• N/A

FTAC stakes in the ground	• Inclusion of ERISA fully insured subject limitations
	  • For future modeling: this decision affects provider reimbursement normalization
	• Supplemental coverage
	  • Currently in effect for LTSS
	  • Other benefits can be handled this way

FTAC member concerns?

Slide presented 4/17/25

Provider reimbursement

Round 1 & Sensitivity Analyses	Difference vs Round 1 Results ($B)*
125% of Medicare FFS (Round 1 assumption)	
119% of Medicare FFS	($0.9)–($0.8)
131% of Medicare FFS	$0.8–$0.9
160% of Medicare FFS	$4.4–$5.4

Note: Round 1 used a composite provider reimbursement rate based on a weighted average of payers' existing payment rates using Medicare as an index. It is intended to maintain the aggregate level of reimbursement for the baseline population.

Outstanding questions to the Commission

- Does the Commission want to model additional options?
- For example, additional payment rates, or other changes such as increased primary care payments?

FTAC recommendation

- FTAC needs additional time to discuss whether additional options warranted
- Expand Round 2 analysis based on Commission direction and FTAC discussions

*Derived from 3/6/2025 Milliman Report, Appendix C, Exhibit II.3; $ impact depends on scenario

Provider reimbursement

UHCC decision(s)	• **No new options to model** • **Incorporate SB5083 (200% cap on PEBB/SEBB)** • **Incorporate differentially higher payments for primary care** • **Address excluded populations crowding out appointment slots (higher payment)**
Open question(s)	• Primary care payment design? • Will excluded populations crowd out appointment slots? (higher payment)
FTAC stakes in the ground	• Account for HB1392: premium tax to raise Medicaid payments to Medicare level • Re SB5083, assume 200% cap applies to all markets, but likely not material • Yes, excluded populations are likely to crowd out without additional intervention • Continue to allow for differential payments for rural health clinics, etc. • Defer to HCA's Multi-Payer Collaborative for primary care payment designs

FTAC member concerns?

Other requests and information

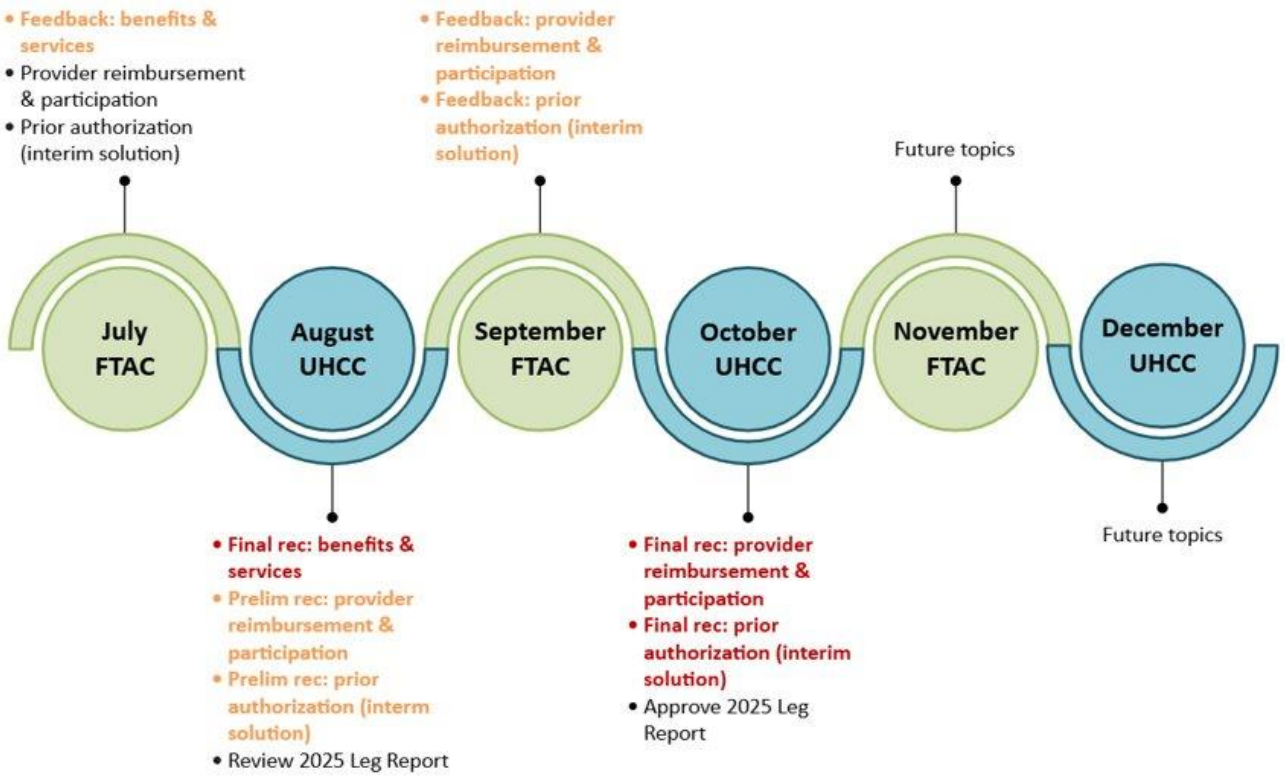
- For cost containment, consider how any reduced administrative burden on providers (e.g., streamlined prior authorization) could lead to lower provider reimbursement
- Consider logic model: interdependencies, supply & demand
- HCA awaiting legislative funding for additional analysis

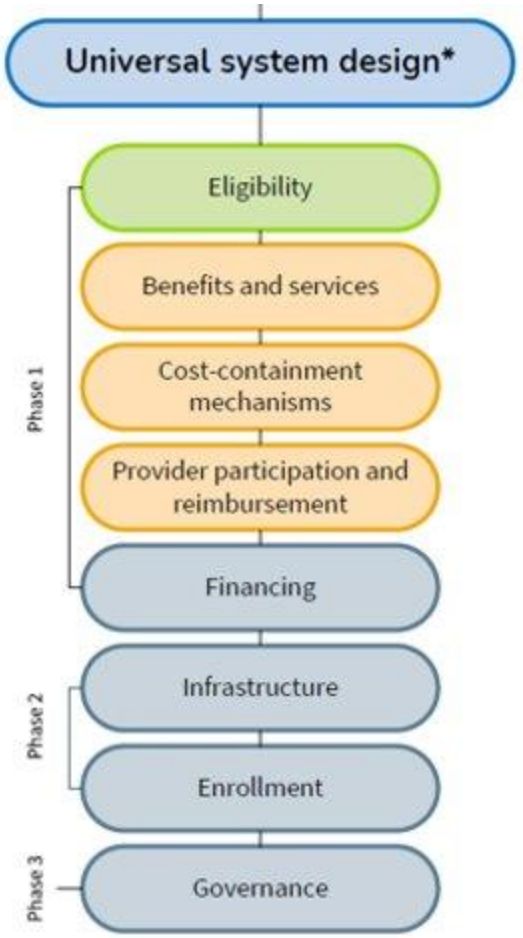
We are currently on a short break

Finance Technical Advisory Committee Meeting

Washington State Health Care Authority

Workplan orientation





Workplan topic - Cost containment

Todd Bratton, Senior Health Policy Analyst - HCA

Related to the provider reimbursement workplan topic,

FTAC has reviewed:

- Hospital global budgets
- Reference-based pricing
- Homework:
  - Office of Insurance Commissioner's (OIC) Affordability Report (2024)
  - OIC Preliminary Affordability Report (2023)
  - Attorney Generals Preliminary Affordability Report (2023)

Workplan topic: provider reimbursement

- Provider reimbursement next two meetings
  - Focus: options for design of universal system
    - ex. What levels set at? Enhanced rates for services?
  - Potentially reference cost containment mechanisms (no time for further study) during development of provider reimbursement design options

Cost containment future

- Continue reviewing transitional solutions
  - Agency report outs, Cost Board, etc.
- Address cost containment strategies within design.
  - Infrastructure
  - Finance
  - Governance

Tab 6

Washington State Health Care Authority

Health Care Cost Transparency Board update

Finance Technical Advisory Committee

May 2025

The Commission's directive (in part)…

Provide the legislature with:

"An inventory of the key design elements of a universal health care system including:

- A unified financing system including, but not limited to, a single-payer financing system;
- Eligibility and enrollment processes and requirements;
- Covered benefits and services;
- Provider participation;
- Effective and efficient provider payments, including consideration of global budgets and health plan payments;
- **Cost containment and savings strategies that are designed to assure that total health care expenditures do not exceed the health care cost growth benchmark**

Revised Code of Washington (RCW) 41.05.840

Sources:

The following slides were presented at the Health Care Cost Transparency Board (Cost Board) on April 24th, 2025.

Presenters:

Michael Bailit, Cost Board consultant

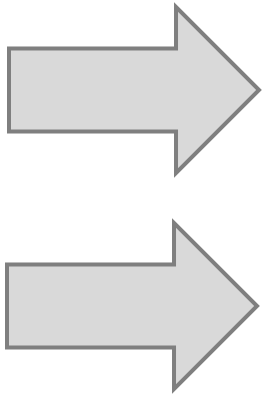
Harrison Fontaine, HCA Senior Health Policy Analyst

Full meeting materials can be accessed here: link

Cost Board directives

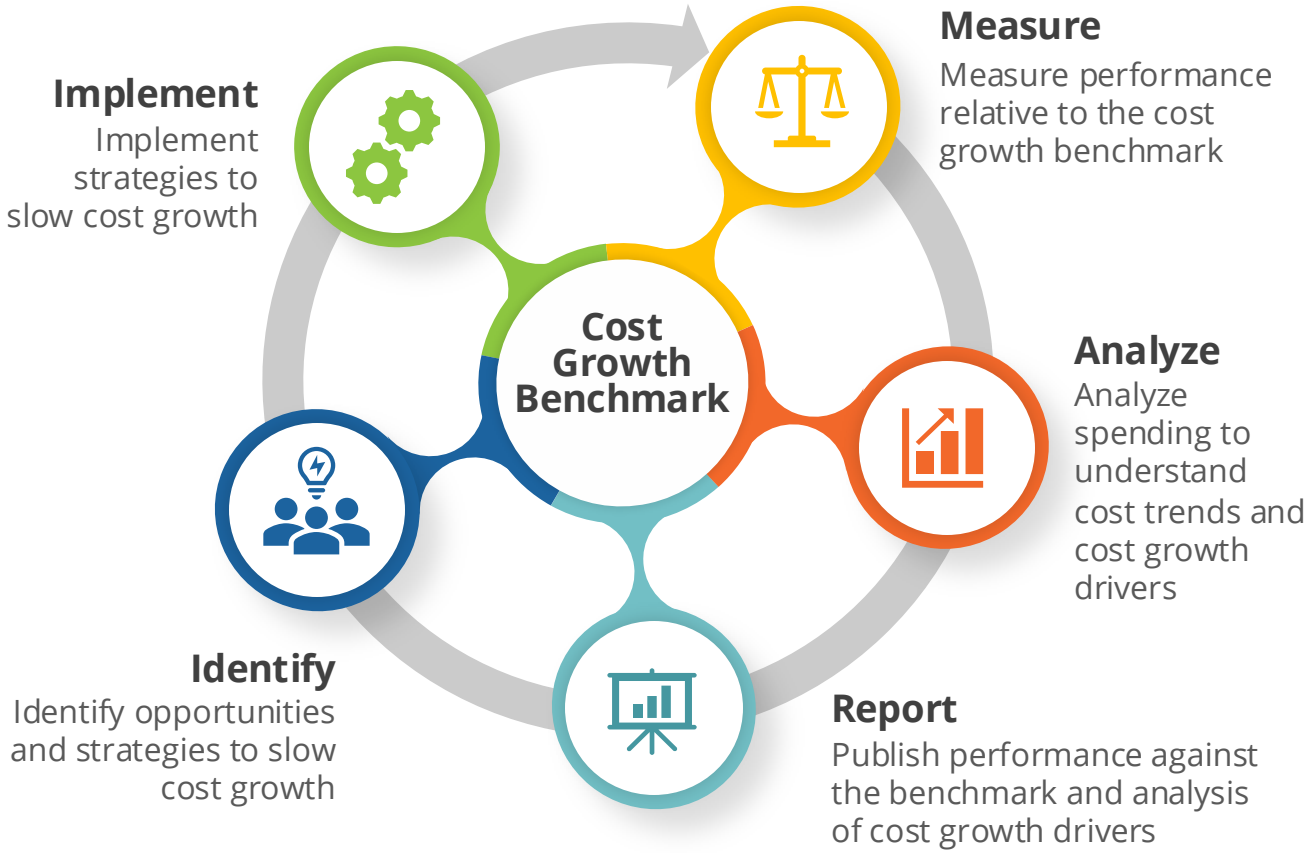
Identify **trends** in health care cost growth

Analyze total **health care expenditures**



Provide **policy recommendations** to the Legislature to increase transparency and affordability

Cost growth benchmark programs need to be complemented by policy action



- Cost growth benchmarks alone **do not result in meaningful action** to constrain cost growth.
- Cost growth benchmarks programs were designed to serve as a **catalyst** for other affordability policy actions.

Cost growth benchmarks do not sufficiently address hospital price growth

- Cost growth benchmarks **do not hold hospitals accountable** for their specific contributions to spending growth.
  - Total medical expense accountability is assessed for a population of patients based on an attributed primary care relationship.
  - A significant percentage of hospital services are delivered to patients who have not been attributed to the hospital's employed or contractually affiliated PCPs
- Cost growth against the benchmark measurement does not assess the role of price and utilization.

Why focus on hospital spending?

- From 2018–2022, high and fast-growing **hospital prices were the #1 driver of commercial market spending** in the U.S.
- Most Peterson-Milbank states have identified hospital spending and, particularly, hospital prices, as a primary contributor to commercial market spending growth.

Note: By "**prices**," we don't mean what hospitals charge, but rather the payments they receive. Most of these payments are at contractually defined levels. Thus, when we say "price," we really mean "**payment per service unit**."

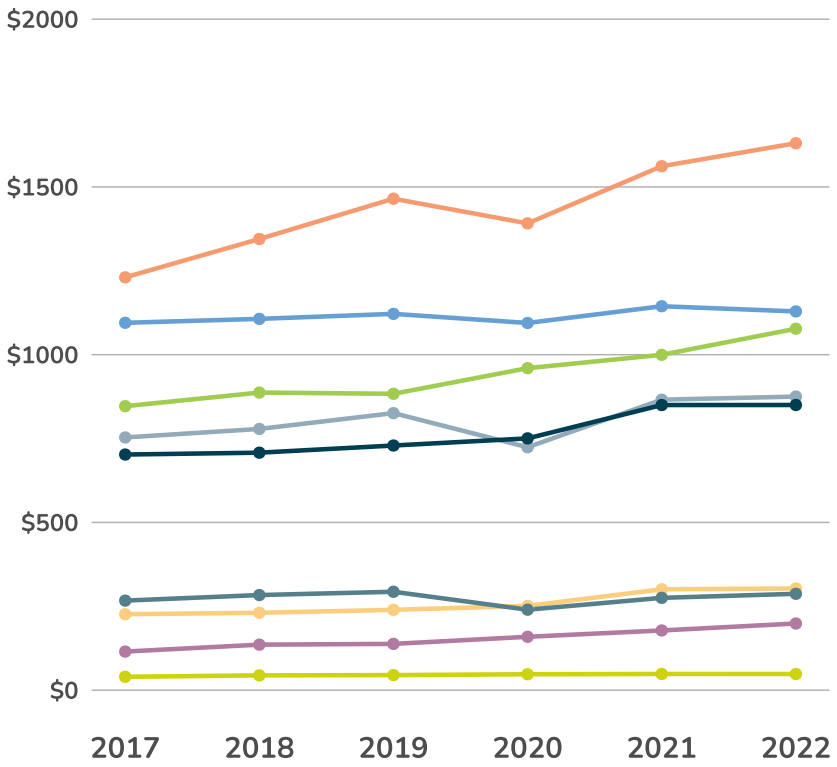
Source: Health Care Cost Institute. 2022 Health Care Cost and Utilization Report. April 2024.

Commercial spending growth, by service category

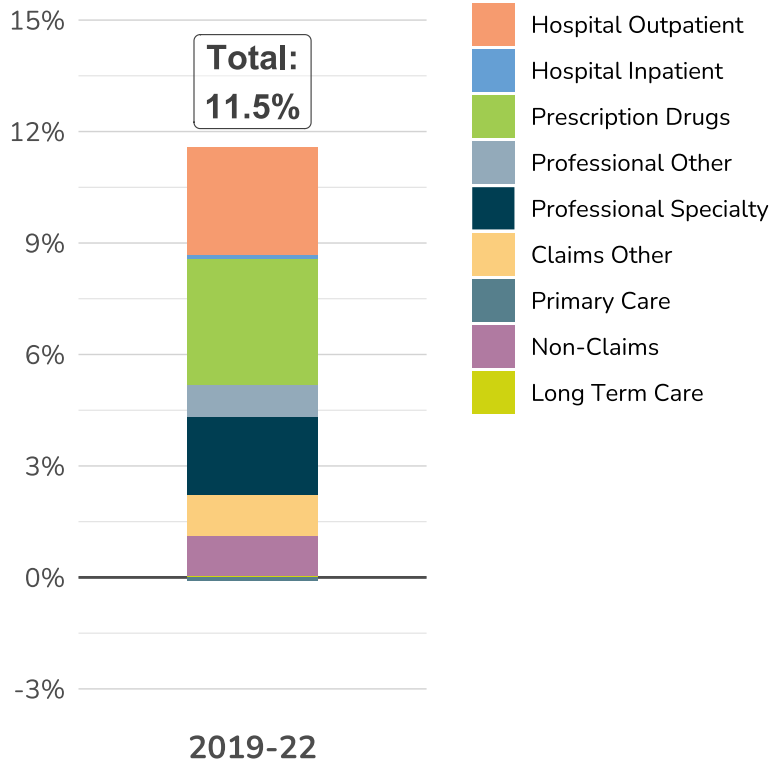
Top contributors by **total** spending or by **growth**:

- Hospital outpatient
- Hospital inpatient
- Prescription drugs
  - Focus of PDAB
- Professional specialty

Total medical expense by category
Commercial market, per member per year



Contribution to Growth
Ordered by 2022 PMPM

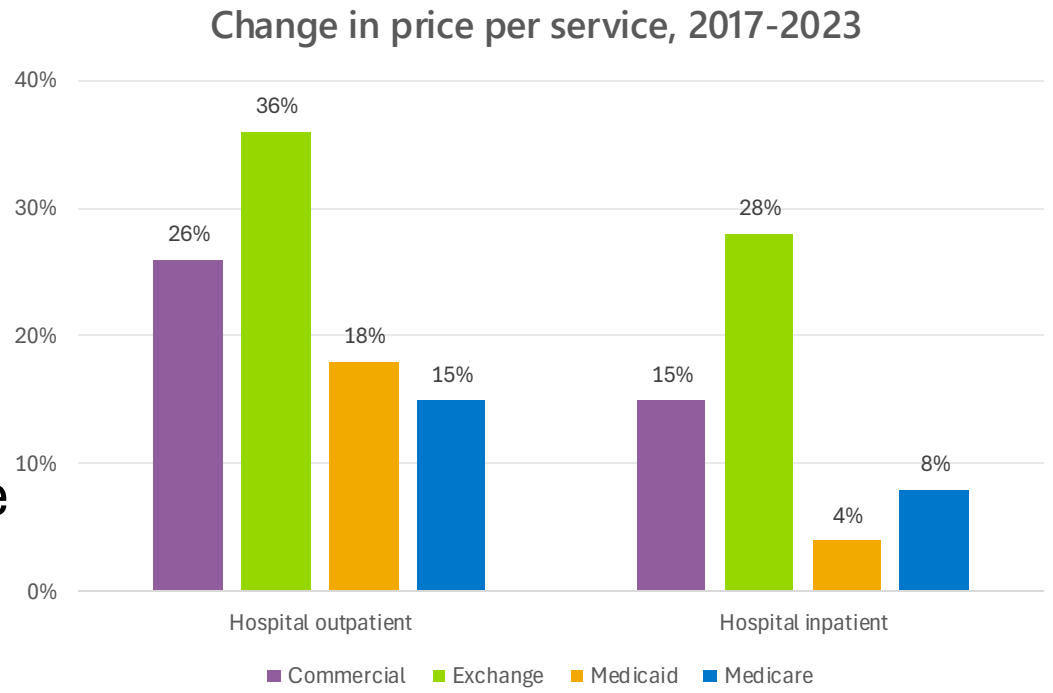


Source: WA Health Care Cost Transparency Board data calls

Washington hospital spending in context

Analysis conducted for the Cost Board shows that for hospitals in Washington State:

- **Price and cost are higher** than for peer hospitals.[1]
- **Commercial reimbursement was nearly twice what Medicare would pay.**[2]
- **Price per service increased** across all markets from 2017-2023. Increases were highest in commercial and exchange markets. [3]



Source: OnPoint's WA Cost Driver Analysis Using APCD Data

Sources:
1. Washington Hospital Financial Analysis
2. RAND Report Round 5 Washington State Analysis
3. OnPoint's WA Cost Driver Analysis Using APCD Data

Overview of potential strategies

Tied to cost growth benchmark values

1. Publish data on hospital prices and price growth, and “name names.”

2. Create a complementary hospital price growth benchmark.

3. Tie the terms of hospital CON and CMIR approvals to the cost growth benchmark value.

Independent but complementary

4. Take direct action on specific hospital pricing policy issues, e.g., facility fees, OON fees.

5. Establish a hospital price growth cap.

6. Set a hospital price cap (aka “reference-based pricing”).

Could be independent of or tied to cost growth benchmarks

7. Prospectively review and approve hospital revenue and/or price growth.

OON = Out of Network

Discussion

Thank you for attending the Finance Technical Advisory Committee meeting!

Washington State Health Care Authority