

Health Care Cost Transparency Board

March 15, 2021

Health Care Cost Transparency Board Board Book

March 15, 2021
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

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Agenda

TAB 1

Health Care Cost Transparency Board

March 15, 2021
2:00 p.m. – 4:00 p.m.
Zoom Meeting

AGENDA

Board Members:

<input type="checkbox"/>	Susan E. Birch, Chair	<input type="checkbox"/>	Pam MacEwan	<input type="checkbox"/>	Carol Wilmes
<input type="checkbox"/>	Lois C. Cook	<input type="checkbox"/>	Molly Nollette	<input type="checkbox"/>	Edwin Wong
<input type="checkbox"/>	John Doyle	<input type="checkbox"/>	Mark Siegel	<input type="checkbox"/>	Laura Kate Zaichkin
<input type="checkbox"/>	Bianca Frogner	<input type="checkbox"/>	Margaret Stanley		
<input type="checkbox"/>	Sonja Kellen	<input type="checkbox"/>	Kim Wallace		

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome, roll call, and agenda review	1	Susan E. Birch, Chair, Director Health Care Authority
2:05-2:10 (5 min)	Approval of February meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:10-2:35 (25 min)	What is a Health Care Cost Growth Benchmark, why pursue one, and its impact on health care costs	3	Michael Bailit and January Angeles Bailit Health Purchasing
2:35-3:15 (40 min)	Review of other states' Health Care Cost Growth Benchmark Programs	3	Michael Bailit and January Angeles Bailit Health Purchasing
3:15-3:30 (15 min)	Cost growth benchmarks amid the COVID-19 pandemic	3	Michael Bailit and January Angeles Bailit Health Purchasing
3:30-3:40 (10 min)	Advisory Committee of Providers and Carriers: Role and appointment process	3	AnnaLisa Gellermann, Board Manager Health Care Authority
3:40-3:50 (10 min)	Approval of Proposed Charter and Operating Procedures	4	AnnaLisa Gellermann, Board Manager Health Care Authority
3:50-4:00 (10 min)	Public comment and adjournment		Susan E. Birch, Chair, Director Health Care Authority

In accordance with Governor Inslee's Proclamation 20-28 et seq amending requirements of the Open Public Meeting Act (Chapter 42.30 RCW) during the COVID-19 public health emergency, and out of an abundance of caution for the health and welfare of the Board and the public, this meeting of the Health Care Cost Transparency Board meeting will be conducted virtually.

February Meeting Minutes

TAB 2

Health Care Cost Transparency Board meeting minutes

February 18, 2021
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2-4 p.m.

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

Members present

Sue Birch, chair
Lois Cook
Bianca Frogner
Sonja Kellen
Pam MacEwan
Molly Nollette
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong
Laura Kate Zaichkin

Call to order and welcome remarks

Sue Birch, chair, called the meeting to order at 2:04 p.m.

Agenda items

Welcoming remarks

Sue Birch

Ms. Birch welcomed the board to the first meeting. She remarked that health care costs are growing at an unsustainable rate, that the high cost is squeezing business, family and state budgets, and that Washington is a leader in innovation. She reminded the board of its obligation to participate fully.

Orientation to HB 2457 legislation and board purpose

Mich'l Needham, chief policy officer, Health Care Authority
PowerPoint presentation

Board member and staff introductions

Individuals were asked to introduce themselves with a sentence describing their perspective on the work of the Board.

Open public meetings training

Katy Hatfield, AAG
PowerPoint presentation

Review of draft charter and operating procedures

AnnaLisa Gellermann
PowerPoint presentation, complete draft document in materials

Detailed review of meeting plan

Michael Bailit, Bailit Health

Public comment

Nancy Guinto, Washington Health Alliance, welcomed members and shared her support of addressing increasing health care cost.

Next meeting

Monday, March 15, 2021
Meeting to be held on Zoom
2-4 p.m.

Meeting adjourned at 3:59 p.m.

Presentations

TAB 3



What is a cost growth benchmark, why pursue one, and its impact on health care costs

March 15, 2021



What is a cost growth benchmark and why pursue one?

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



**Per Capita Health Care
Cost Growth 2018-2019:
4.1%¹**

**GDP Growth
2018-2019:
4.0%²**

**Average Wage Growth
2018-2019:
3.3%³**

SOURCES:

- 1) Centers for Medicare & Medicaid Services, [National Health Expenditure Accounts](#), accessed February 17, 2021.
- 2) U.S. Bureau of Economic Analysis, Gross Domestic Product [GDP], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/GDP>, February 16, 2021.
- 3) U.S. Bureau of Labor Statistics, Average Hourly Earnings of All Employees, Total Private [CES0500000003], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/CES0500000003>, February 16, 2021.

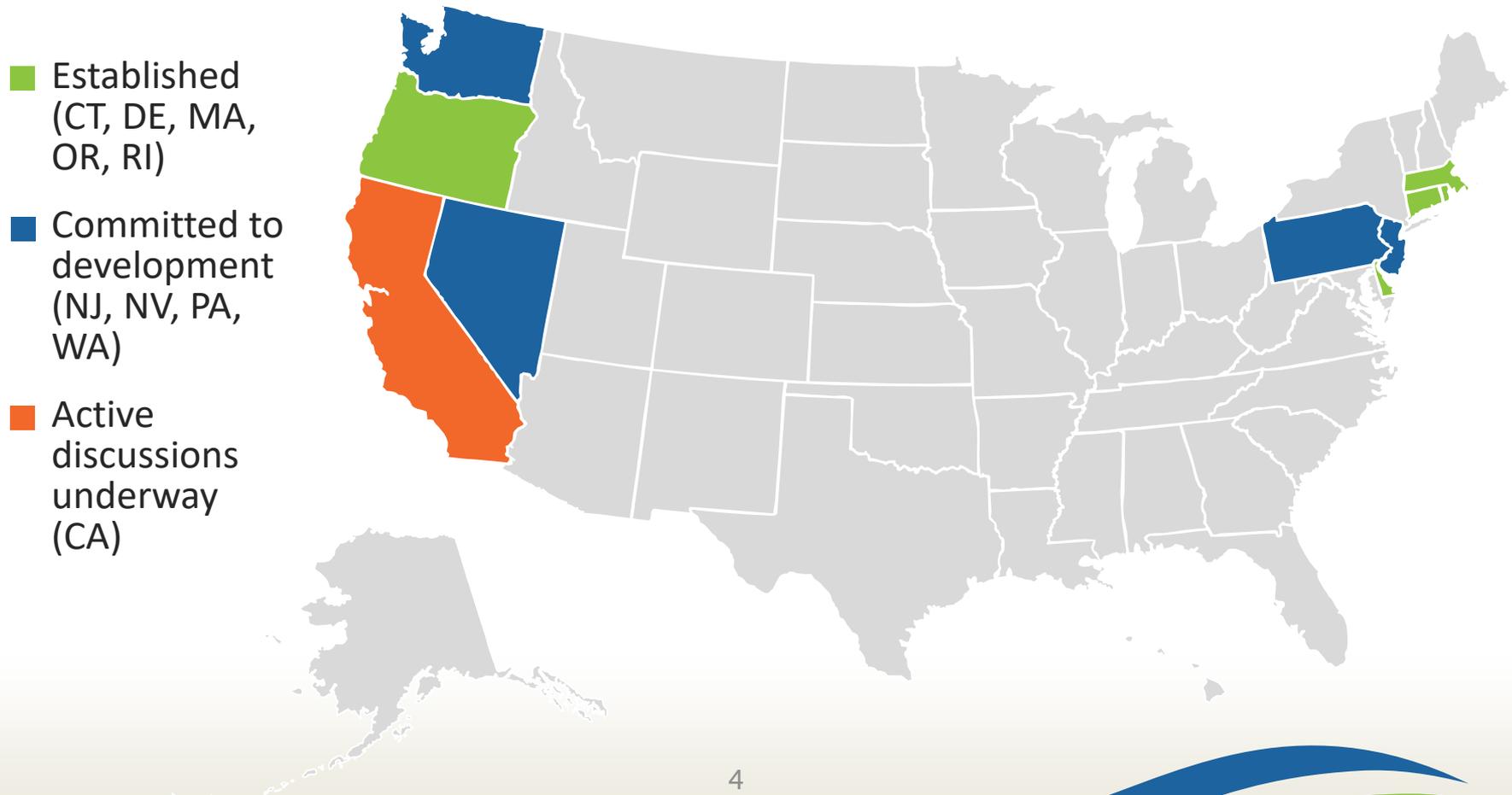
A note on terminology

- States use different terminology, with some using “benchmark” and others using “target.” They are treated in other states as synonyms.

“Benchmark”	“Target”
<ul style="list-style-type: none"> • Connecticut • Delaware • Massachusetts 	<ul style="list-style-type: none"> • Oregon • Rhode Island

- WA authorizing statute uses “benchmark.”

State activity on health care cost growth benchmarks



States pursued cost growth benchmarks to curb health care spending growth

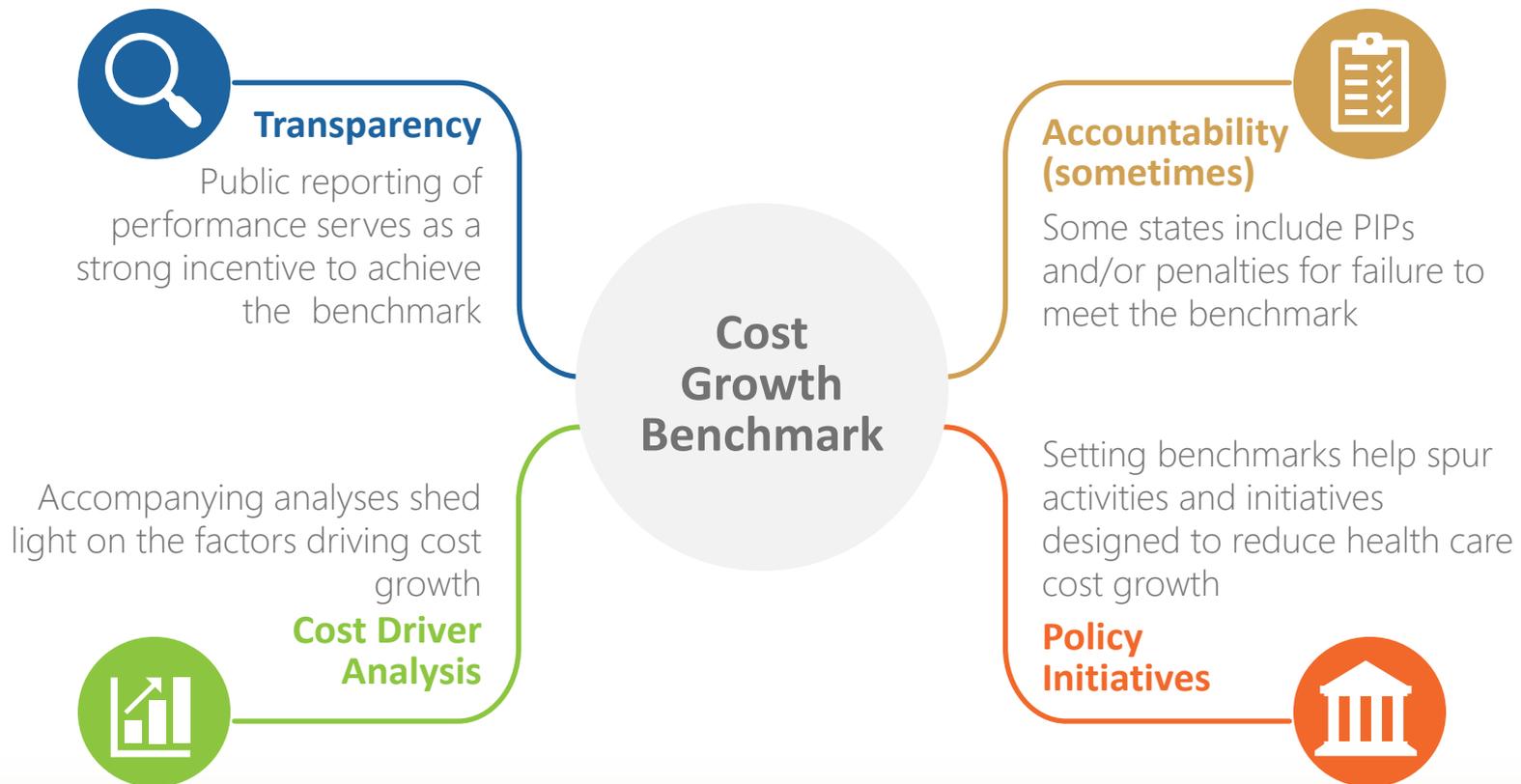
- **MA:** State-purchased health care rose 40% over 12 years while spending on other services was reduced by 17% on average.
- **OR:** health insurance premiums cost 29% of a family's total income.
- **DE:** the State's per capita total health spending was the 3rd highest in the nation.
- **RI:** 7 of 10 health insurance filings in the large and small group market outpaced annual wage growth.
- **CT:** health care costs outpaced growth in the State's economy, with personal health care expenditures taking up a larger portion of the State's GDP.

The logic model for a cost growth benchmark

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



The logic model for a cost growth benchmark

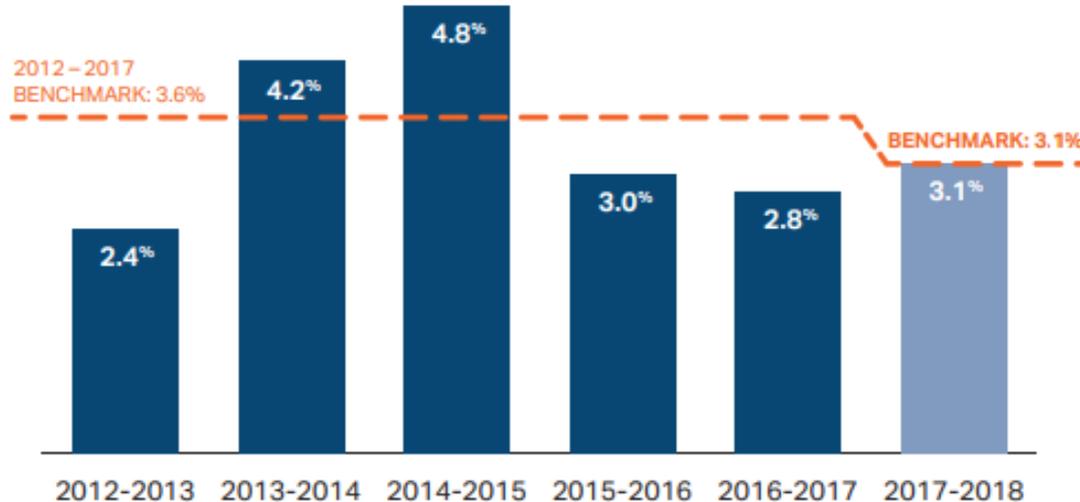


Other activities to complement the benchmark

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

Massachusetts' cost growth benchmark experience

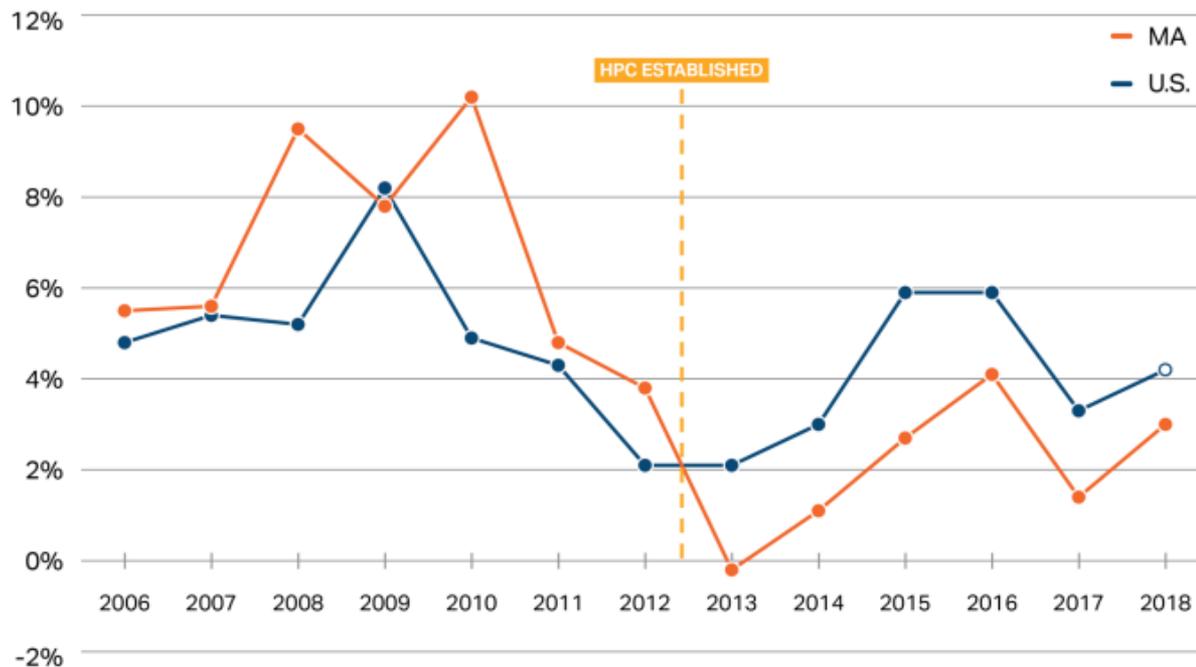
Since establishing the cost growth benchmark in 2012, annual all-payer health care spending growth has averaged the cost growth benchmark level, and has been below the U.S. average.



SOURCE: Massachusetts Health Policy Commission, 2019 Annual Health Care Cost Trends Report, February 2020.

Massachusetts' cost growth benchmark experience

Annual growth in commercial medical spending per enrollee, Massachusetts and the U.S., 2006-2018



Commercial spending growth in MA has been below the national rate every year since 2013.

SOURCE: Auerbach, David. "Health Care Spending Trends and Impact on Affordability." Presentation, 2019 Health Care Cost Trends Hearing, October 22-23, 2019.

The cost growth benchmark's impact in Massachusetts



Common goal

Payers and providers have aligned on a common target for reducing health care cost growth.



Total cost of care approach

The benchmark is consistent with a TCOC contracting approach which has become the common contracting structure.



Influence on negotiations

Negotiations between payers and providers have been influenced by the benchmark, thereby tempering price growth.



Transparency

Reasons for cost growth have been studied and publicized, keeping the policy and its consequences in the public eye.

Policy experts' assessment of the cost growth benchmark's impact in MA

“With an expected utilization increase of about 2%, payers and providers generally agree on annual price increases of about 1.5%
- David Cutler, HPC member

“The [cost growth target]...sets the bar upon which most activities in the health system are judged. It's more than just a symbol, it's become an operational component of how our health system works.

- Stuart Altman, HPC Chair

Payer and provider rate negotiations are now conducted in light of the 3.6% target

- State Auditor study

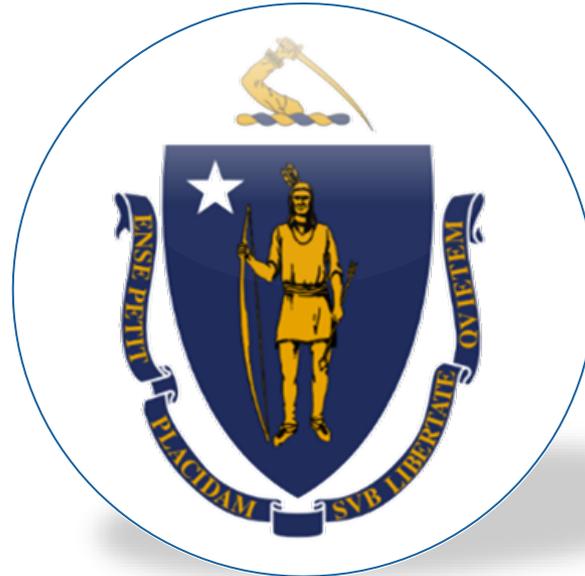


Review of other states' health care cost growth benchmark programs

March 15, 2021

Review of other states' cost growth benchmark programs

- To date, five states have established health care cost growth benchmarks (MA, DE, RI, OR, CT).
- For each of these states we will review:
 - Enabling legislative, regulatory or administrative requirements
 - Benchmark values and supporting methodology
 - Assessment of performance assessment against the benchmark:
 - Measurement of health care costs
 - Data sources
 - Statistical testing
 - Accountability and enforcement mechanisms



Massachusetts' Health Care Cost Growth Benchmark Program



Enabling legislative, regulatory or administrative requirements

- Chapter 224 of the Acts of 2012 established health care cost growth benchmarks as part of sweeping health system reforms.
- Chapter 224 created two entities:
 - Health Policy Commission (HPC) to set and enforce the benchmark
 - Center for Information and Analysis (CHIA) to collect and measure health system performance against the benchmark.



Cost growth benchmark values and methodology

- Benchmarks are set in statute and pegged to Potential Gross State Product (PGSP), a forecasted average growth rate of the state's economy, according to the following rules:
 - 2013 – 2017: equivalent to PGSP (calculated at 3.6%)
 - 2018 – 2022: PGSP minus 0.5% (or 3.1%), unless the HPC votes that an adjustment is warranted (requires 2/3 majority)
 - 2023 and beyond: equivalent to PGSP, with authority for the HPC to adjust it to any value



Assessment of performance against the benchmark

- Measured using Total Health Care Expenditures (THCE) by and for MA residents from public and private sources, which consist of:
 - Total Medical Expense (TME) spending on all medical services for all MA residents regardless of where care was provided, including non-claims-related payments to providers;
 - Patient cost-sharing; and
 - Net Cost of Private Health Insurance (NCPHI), a measure of the costs to MA residents associated with administration of private health insurance (including Medicare Advantage and Medicaid managed care).



Assessment of performance against the benchmark

- THCE does not include:
 - Non-medical spending made by payers (e.g., gym membership);
 - Vision or dental care not otherwise covered by a medical plan; or
 - Expenditures recorded by providers, but not insurers (e.g., spending for uninsured residents).



Assessment of performance against the benchmark

- Commercial insurers submit TME summary-level information, including:
 - “Allowed amount” expenditures made on behalf of MA residents, which includes patient cost-sharing
 - Fully-insured and self-insured plans
 - Medicare Advantage, Medicaid MCOs, and dual eligible products
 - Payer completion factor adjustment to estimate costs that have been incurred but not reported (IBNR)
- For carved-out services (behavioral health, pharmacy), CHIA makes actuarial adjustments.



Assessment of performance against the benchmark

- CHIA also collects medical expenses for other payers that don't report TME, including:
 - Medicaid primary care case management program and other fee-for-service data from the Medicaid agency
 - Medicare Part A and/or B and stand-alone Part D membership and expenditure data from CMS
 - Other sources of health spending (e.g., Veterans Health Administration)



Accountability and enforcement of the benchmark

- On an annual basis, CHIA publicly reports performance at four levels:
 - State
 - Market (i.e., Commercial, Medicare, Medicaid)
 - Payer or insurer
 - Provider entity



Accountability and enforcement of the benchmark

- The HPC can require providers whose cost growth exceeds the benchmark to:
 - Implement a performance improvement plan (PIP); and
 - Levy penalties of up to \$500,000 for noncompliance with the PIP.
- In years when the State exceeds the benchmark, the HPC may conduct a review of one or more provider entities.
- To date, there have been referrals, but *no PIPs*.



Delaware's Health Care Spending and Quality Benchmarks Program



Enabling legislative, regulatory or administrative requirements

- In September 2017, the Delaware Legislature passed House Resolution 7 to establish and plan for the monitoring and implementation of an annual healthcare benchmark.
- In November 2018 Governor Carney issued Executive Order 25 to formally establish the health care spending and quality benchmarks.
- The DE Health Care Commission (DHCC) and DE Economic and Financial Advisory Council (DEFAC) Health Care Spending Benchmark Committee oversee the program.



Health care spending benchmark values and methodology

- The benchmark is set at the State's PGSP (3.0%) with transitional adjustments.
 - 2019: 3.8%
 - 2020: 3.5%
 - 2021: 3.25%
 - 2022 and 2023: 3.0%
- Annually, a DEFAC subcommittee reviews all PGSP components and recommends whether material changes and warrant a change in the benchmark.
 - By March 2023, it will consider whether to change the benchmark's methodology for future years.



Rhode Island's Health Care Cost Growth Target Program



Enabling legislative, regulatory or administrative requirements

- In 2016, at Governor Raimondo's request, a group of health leaders recommended a method for setting a cost growth target for the State.
- After a long delay, foundation funding helped launch a more public effort to establish a target and analyze the State's APCD to highlight spending patterns and trends.
- In August 2018, the State convened a Steering Committee of 18 diverse RI stakeholders to develop recommendations on a target.



Enabling legislative, regulatory or administrative requirements

- The Steering Committee made recommendations and in December 2018 signed a voluntary compact to meet the benchmark, which is in effect through December 2022.
- Governor Raimondo established the target through Executive Order 19-03 in February 2019.
- The State administers the program, with ongoing advice and support from its stakeholder Steering Committee.



Cost growth target values and methodology

- The Steering Committee established the target, which is set to the State's PGSP as calculated in 2018.
 - 2019 – 2022: 3.2%
 - 2023 and beyond: to be re-evaluated and determined in 2022
- The methodology can be revisited under highly significant changes in the economy, with the Steering Committee working with the State to determine a functional definition of “highly significant.”
- The target is coupled with a data use strategy leveraging the APCD to give policymakers and providers information to manage health care cost growth.

DE and RI's benchmark programs are largely modeled off MA

- DE and RI use THCE to measure performance against the benchmark.
- Insurers submit per member per year TME for the commercial fully and self-insured, Medicare Advantage, and Medicaid managed care.
- Both states will publish performance at the state, market, insurer and provider entity levels for the purposes of transparency.
- We will review the details that vary by state when we discuss key design decisions for WA's program.



Oregon's Sustainable Health Care Cost Growth Target Program



Enabling legislative, regulatory or administrative requirements

- In June 2019, the OR legislature passed SB 889 to establish a cost growth target program.
- SB 889 charged the OR Health Authority (OHA), in collaboration with the Department of Consumer and Business Services (DCBS) and the OR Health Policy Board (OHBP), to develop and implement the program.
- It created a stakeholder-populated Implementation Committee to oversee program details, with broad and flexible authority.



Cost growth target values and methodology

- The Implementation Committee based its target on historical gross state product (GSP), median wage, and the growth “cap” in OR’s Medicaid and publicly purchased programs.
 - 2021 – 2025: 3.4%
 - 2026 – 2030: 3.0%
- In 2024, a to-be-determined advisory body will review historical PGSP and median wage trend to determine the appropriateness of the 2026-2030 target and make recommendations to the OHPB.



Assessment of performance against the target

- Similar to MA, DE and RI, OR assesses performance against the benchmark using THCE.
- Unlike in these other states, THCE includes spending on OR residents by the Indian Health Service and in a state correctional facility (to the extent data are accessible).
- In addition, OR will conduct statistical testing to determine whether the target has been met.



Accountability and enforcement of the target

- OR will report performance against the benchmark at all four levels (state, market, payer, provider entity).
- A bill currently before the OR legislature proposes that OR will apply an “escalating accountability mechanism” for payers or provider organizations who exceed the target *without a reasonable basis*.
 - Initially payers or provider organizations that don’t meet the target will be subject to PIPs.
 - Those that don’t meet the target in 3 out of 5 years (on a rolling basis) will be subject to a financial penalty.



Accountability and enforcement of the target

- In addition, OHA may:
 - Assess fines for late or incomplete data and/or PIPs.
 - Apply accountability measures earlier for payers or provider organizations not engaging in the program.



Connecticut's Health Care Benchmark Initiative



Enabling legislative, regulatory or administrative requirements

- In January 2020, Governor Lamont’s Executive Order #5 directed the Office of Health Strategy (OHS) to develop health care cost growth benchmarks for 2021-2025, quality benchmarks and primary care spend targets.
- Executive Order #5 directs OHS to convene a “Technical Team,” including representatives from various state agencies and other health care stakeholders to advise on benchmark program policies.
- OHS also convenes a Stakeholder Advisory Board – a broader group of stakeholders – to provide input to the Technical Team.



Cost growth benchmark values and methodology

- The Technical Team established a benchmark based on 20/80 blend of the growth in forecasted PGSP and forecasted median income, with an add-on factor in the first two years.
 - 2021: 3.4%
 - 2022: 3.2%
 - 2023 – 2025: 2.9%
- OHS may revisit the methodology and calculation should there be a sharp rise in inflation between 2021 and 2025.



Assessing performance against the benchmark

- CT assesses performance against the benchmark using THCE, similar to other states.
- Key differences from some other states are that THCE includes:
 - Spending on CT residents through the Veterans Health Administration.
 - Spending on CT residents in state correctional facilities.
- Similar to OR, CT will apply statistical testing to determine if payers or provider entities met the benchmark.



Accountability and enforcement of the benchmark

- Similar to other states, CT will publicly report performance at the state, market, payer and provider entity levels.
- There are no financial penalties associated with not meeting the benchmark.



Cost growth benchmarks amid the COVID-19 pandemic

March 15, 2021

COVID-19's impact on health care spending

- Health services revenue fell by 2.4% compared to 2019 (compared to a 5% increase from 2018 to 2019).
- Spending on health services dropped sharply in March and April but mostly recovered by October 2020.
- As of the 3rd quarter of 2020, the largest drops in spending were in ambulatory care settings.
- Hospital admissions fell in spring 2020 but were back to about 95% by July.
- Little yet is known about the fall surge's impact on health care spending.

Consideration of the COVID-19 experience when setting the benchmark value

- The benchmark's intended use is to establish a stable, multi-year expectation for spending growth.
- Unusual events – including a pandemic – may cause occasional and time-limited fluctuations in spending.
- Providers and plans should not be penalized for increased spending associated with COVID-19.
- MA, DE and RI all kept their benchmarks in place, and CT and OR did not modify theirs for COVID-19.

How will COVID-19 impact Washington's policy?

- The board will need to weigh whether to consider the pandemic's anticipated economic impact when setting the benchmark.
- We now have a partial understanding of how the pandemic affected 2020 spending.
 - 2022 trend could be aberrant due to the impact of COVID-19 on 2021 utilization.



Washington State
Health Care Authority

Advisory Committee of Providers and Carriers: Role and Appointment

March 15, 2021



Key deliberating bodies of Washington's cost growth benchmark program

- **Health Care Cost Transparency Board (the Board)** is charged with establishing and analyzing performance against the cost growth benchmark.
- The Board must establish and seek input on topics relevant to its work from:
 - The **Advisory Committee of Providers and Carriers**;
 - The **Advisory Committee on Data Issues**; and
 - Other advisory committees as it deems necessary.

Advisory Committee of Providers and Carriers (1 of 2)

15 members representing:

- Hospitals and hospital systems: WA State Hospital Association.
- Federally qualified health centers: WA Association for Community Health.
- Physician: WA State Medical Association
- Family Physician: WA Academy of Family Physicians.
- Behavioral health provider: WA Council for Behavioral Health.
- Pharmacists and pharmacies: the WA State Pharmacy Association.

Advisory Committee of Providers and Carriers (2 of 2)

- Advanced registered nurse practitioners: ARNPs United of WA state.
- Tribal health providers: American Indian Health Commission.
- Ambulatory surgery center: Ambulatory Surgery Center Association.
- HMO, HCSC, Medicaid MCO: Association Washington Health Plans
- Three members nominated by America's Health Insurance Plans, at least one of whom represents disability insurers.

Nominations and Selection

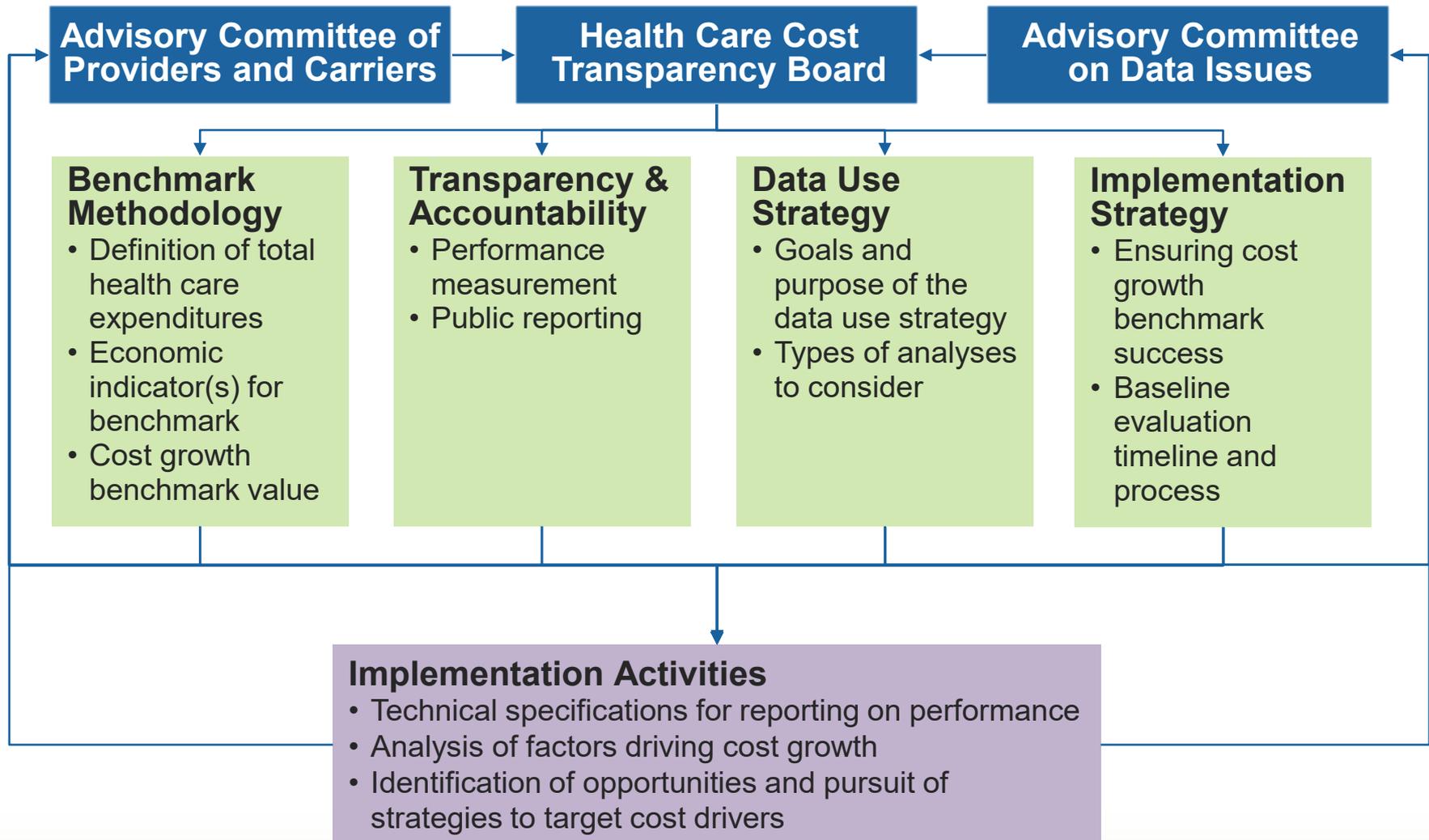
- Call for nominees February 24.
- Submit names with resume and letter of intent.
- Submissions provided to Board .
- Approval of Committee in April 13 Board Meeting.
- First meeting late April, meeting monthly through September.
- Review deliberations and provide feedback.

Advisory Committee on Data Issues

Committee members must have expertise in:

- Health data collection and reporting
- Health care claims data analysis
- Health care economic analysis
- Actuarial analysis

Call for nominations in Early May, first meeting late June



Proposed Charter and Operating Procedures

TAB 4

**Washington Health Care Cost Transparency Board
Charter and Operating Procedures
February 18, 2021**

I. Vision and Mission

A. Vision

To understand the factors driving health care cost growth in Washington, and lower growth to a financially sustainable rate.

B. Mission

The Board's primary objective is to understand and curb the State's health care cost growth. The Board aims to achieve this objective by: (1) analyzing the state's total health care expenditures; (2) identifying drivers in health care cost growth; and (3) establishing a health care cost growth benchmark. The total health cost expenditures for each qualified health care provider and payer will be measured against the benchmark, and the Board will identify providers and payers whose cost growth meets or exceeds the benchmark.

II. Health Care Cost Growth Benchmark

A. Purpose

Health care costs are rising and are continuing to take up a larger proportion of State, employer and family budgets. In 2019 Washington's health care costs represented over 20% of the general fund budget and health care costs have been growing at a higher rate than general inflation for personal consumption.¹ Family premiums were over 25% of household income in Washington as of 2016.² Nationally, employer-sponsored health insurance premiums grew 4% from 2019 to 2020 and have increased by 22% in the past five years, outpacing inflation (10%) and wages (15%).³

A health care cost growth benchmark is a target for the annual rate of growth of total health care spending in the state. By setting a benchmark and then publicly

¹ Washington Office of Financial Management. Changes in medical costs. <https://www.ofm.wa.gov/washington-data-research/statewide-data/washington-trends/budget-drivers/change-medical-costs>

² Penn Leonard Davis Institute of Health Economics. United States of Care. April 2019. https://unitedstatesofcare.org/wp-content/uploads/2019/04/Penn-LDI-and-US-of-Care-Cost-Burden-Brief_Final-1.pdf

³ Claxton G, et al. Health Benefits in 2020: Premiums in Employer-Sponsored Plans Grow 4%; Employers Consider Responses to Pandemic. *Health Affairs*. October 8, 2020. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01569>

reporting state, regional, payer and provider performance relative to the benchmark, Washington will have the ability to:

- 1) *Hold payers and providers publicly accountable for reducing growth in the costs of health care.* Public reporting is a significant motivator to improve performance. Transparently reporting performance relative to the benchmark allows payers, providers, the state, and consumers to better understand who bears responsibility for increased costs.
- ~~2) *Rebalance negotiations between payers and providers and thereby temper price growth, which is a significant contributor to cost growth. Massachusetts' experience has shown that the cost growth benchmark has been a starting point for price negotiations between payers and providers, giving payers leverage against providers with significant market power.*~~⁴
- 3) 2) Understand the various factors driving health care cost growth and develop future policies to address them. It is not sufficient to simply report whether payers and providers have met the benchmark. Further analysis must be conducted to understand the reasons for health care cost growth to identify future state policy, and provider and payer actions to reduce the overall rate of growth.

III. Health Care Cost Transparency Board Charge

Substitute House Bill 2457 established the Health Care Cost Transparency Board (Board) to determine the annual total health care expenditures and growth in Washington state and establish a health care cost growth benchmark. Its work is to include:

- Annually establishing the health care cost growth benchmark, including:
 - Determining the types of data and sources needed to calculate total health care expenditures and health care cost growth
 - Determining the means and methods for gathering data to calculate performance against the benchmark
- Annually calculating performance against the cost growth benchmark, total health care expenditures, and health care cost growth, including at the:
 - Statewide and geographic rating area level
 - Payer-level
 - Provider-level
 - And on a per capita basis
- Analyzing the impacts of cost drivers and cost growth drivers
- Releasing reports on total health care expenditures, including:

⁴ ~~Bailit M, et al. Balancing Health Care's Checkbook: New Strategies for Providers and States. *Health Affairs Blog*. July 20, 2018. www.healthaffairs.org/doi/10.1377/hblog20180717.572276/full/~~

- A preliminary report by August 1, 2021 on progress to achieving the goals listed above
- Annual reports thereafter on total health care expenditures and establishing the cost growth benchmark for the following year.

IV. Board Duties and Responsibilities

A. Membership and Term

Board members are appointed by the Governor from lists of nominees submitted by the Senate and House of Representatives.⁵ Additional members include the Insurance Commissioner, Administrator of the Health Care Authority, Director of Labor and Industries, and the Chief Executive Officer of the Health Benefit Exchange, or their designee. The Governor shall also appoint a chairperson.

Initial members of the Board will serve staggered terms, not to exceed four years. Subsequently appointed Board members will serve two-year terms.

The Board will convene beginning in February 2021.

B. Board Member Responsibilities

Members of the Board agree to fulfill their responsibilities by attending and participating in Board meetings, studying the available information, directing the work of advisory committees, and participating in the development of the required reports, including a preliminary report to the Governor and each chamber of the legislature by August 1, 2021. Beginning August 1, 2022, the Board shall submit annual reports to the Governor and each chamber of the legislature.

Members agree to participate in good faith and to act in the best interests of the Board and its charge. To this end, members agree to place the interests of the State above any particular political or organizational affiliations or other interests. Members accept the responsibility to collaborate in developing potential recommendations that are fair and constructive for the State. Members are expected to consider a range of issues and options to address them, discuss the pros and cons of the issues or options presented, and deliver a set of recommendations with key conclusions. The Board should include the rationale behind each recommendation adopted.

Specific Board member responsibilities include:

- Reviewing background materials and analysis to understand the issues to be addressed in the review process;

⁵ The Governor appoints members from a list of nominees provided by the two largest caucuses in both the house of representatives and the senate.

- Working collaboratively with one another to explore issues and develop recommendations;
- Attending Board meetings; and
- Considering and integrating Advisory Committee recommendations and general public input into Board recommendations as appropriate.

C. Vacancies Among Governor-appointed Board Members

Vacancies among Governor-appointed Board members for any cause will be filled by an appointment of the Governor. Upon the expiration of a member's term, the member shall continue to serve until a successor has been appointed and has assumed office. When the person leaving was nominated by one of the caucuses of the House of Representatives or the Senate, his or her replacement shall be appointed from a list of five nominees submitted by that caucus within thirty days after the person leaves. If the member to be replaced is the chairperson, the Governor shall appoint a new chair within thirty days after the vacancy occurs.

D. Role of the Washington Health Care Authority (HCA)

HCA shall assist the Board and Advisory Committees by facilitating meetings, conducting research, furnishing information and advising the members.

E. Chairperson's Role

The Chair will encourage full and safe participation by members in all aspects of the process, assist in the process of building consensus, and ensure all participants abide by the expectations for the decision-making process and behavior defined herein. The Chair will develop meeting agendas, establish subcommittees if needed, and otherwise ensure an efficient decision-making process. The Chair will also serve as the liaison between the Board and the Legislature.

F. Board Principles

The principles, listed below, are to guide decision-making during the development and adoption of recommendations by the Board. The principles can be revised if proposed by the chairperson or by majority of members. The Board's recommendations will:

- support the development of a cost growth benchmark by August 1, 2021 for implementation by no later than January 1, 2023;
- to the extent practical, be inclusive of all populations and all categories of spending;
- recommend a stable benchmark upon which payers, providers, and policymakers can rely;

- develop benchmark reporting methods that are statistically robust;
- be sensitive to the impact that high health care spending growth has on Washingtonians;
- align recommendations with other state health reform initiatives to lower the rate of growth of health care costs, and
- be mindful of state financial and staff resources required to implement recommendations.

V. Operating Procedures

A. Protocols

All participants agree to act in good faith in all aspects of the Board's deliberations. This includes being honest and refraining from undertaking any actions that will undermine or threaten the deliberative process. It also includes behavior outside of meetings. Expectations include the following:

- Members should try to attend and participate actively in all meetings. If members cannot attend a meeting, they are requested to advise HCA staff. After missing a meeting, the member should contact staff for a briefing, and review presentation and meeting summaries.
- Members agree to be respectful at all time of other Board members, staff, and audience members. They will listen to each other and seek to understand the other's perspectives, even if they disagree.
- Members agree to make every effort to bring all aspects of their concerns about these issues into this process to be addressed.
- Members agree to refrain from personal attacks, intentionally undermining the process, and publicly criticizing or mis-stating the positions taken by any other participants during the process.
- Any written communications, including emails, blog and other social networking media, will be mindful of these procedural ground rules and will maintain a respectful tone even if highlighting different perspectives.
- Members are advised that email, blogs and other social networking media related to the business of the board are considered public documents. Emails and social networking messages meant for the entire group must be distributed via a Board facilitator.
- Requests for information made outside of meetings will be directed to HCA staff. Responses to such requests will be limited to items that can be provided within a reasonable amount of time.

B. Communications

1) Written Communications

Members agree that transparency is essential to the Board's deliberations. In that regard, members are requested to include both the Chairperson and Board staff in written communications commenting on the Board's deliberations from/to interest groups (other than a group specifically represented by a member); these communications will be included in the public record as detailed below and copied to the full Board as appropriate.

Written comments to the Board, from both individual Board members and from agency representatives and the public, should be directed to HCA staff. Written comments will be distributed by HCA staff to the full Board in conjunction with distribution of meeting materials or at other times at the Chairperson's discretion. Written comments will be posted to the Board web page.

2) Media

While not precluded from communicating with the media, Board members agree to generally defer to the Chairperson for all media communications related to the Board process and its recommendations. Board members agree not to negotiate through the media, nor use the media to undermine the Board's work.

Board members agree to raise all of their concerns, especially those being raised for the first time, at a Board meeting and not in or through the media.

C. Conduct of Board Meetings

1) Conduct of Board Meetings

The Board will meet by videoconference or in person at times proposed by the Chairperson or by a majority of voting members.

A majority of voting members constitutes a quorum for the transaction of Board business. A Board member may participate by telephone, videoconference, or in person for purposes of a quorum.

Meetings will be conducted in a manner deemed appropriate by the Chairperson to foster collaborative decision-making and consensus building. Robert's Rules of Order will be applied when deemed appropriate.

2) Establishment of Advisory Committees

The Advisory Committees on Data Issues and the Advisory Committee of Health Care Providers and Carriers will be established by the Board with membership approved by a majority of Board voting members. Other work groups, subcommittees or other advisory processes will be established by approval of a majority of Board voting members.

Meetings of these groups will be conducted in accordance with these operating procedures [in section 5](#).

3) Consensus Process/Voting

A consensus decision-making model will be used to facilitate the Board's deliberations and to ensure the Board receives the collective benefit of the individual views, experience, background, training and expertise of its members. Consensus is a participatory process whereby, on matters of substance, the representatives strive for agreements that they can accept, support, live with, or agree not to oppose.

Members agree that consensus has a high value and that the Board should strive to achieve it. As such, decisions on Board recommendations will be made by consensus of all present members unless voting is requested by a Board member. Voting shall be by roll call. Final action on Board recommendations requires an affirmative vote of the majority of the Board members. A Board member may vote by video-conference, telephone, or in person.

If no consensus is reached on an issue for proposed Board recommendation, minority positions will be documented. Those with minority opinions are responsible for proposing alternative solutions or approaches to resolve differences.

Members will honor decisions made and avoid re-opening issues once resolved.

4) Documentation

All meetings of the Board shall be recorded and written summaries prepared. The audio records shall be indexed and shall be posted on the Board's public web page in accordance with Washington law. Meeting agendas, summaries and supporting materials will also be posted to the Board's web page.

Interested parties may receive notice of the Board meetings and access Board materials on the website, or via GovDelivery.

At the end of the process, HCA staff will draft recommendations for which there is consensus and any remaining issues on which the Board did not reach consensus.

D. Public Status of Board and Advisory Meetings and Records

Board and Advisory meetings are open to the public and will be conducted under the provisions of Washington's Open Public Meetings Act (Chapter 42.30). Members of the public and legislators may testify before the Board upon the invitation of the Chairperson or at the invitation of the majority of the members of the Board. In the absence of a quorum, the Board may still receive public testimony.

Any meeting held outside the Capitol or by video-conference shall adhere to the notice provisions of a regular meeting. Recordings will be made in the same manner as a regular meeting and posted on the Board website. Written summaries will be prepared noting attendance and any subject matter discussed.

Committee records, including formal documents, discussion drafts, meeting summaries and exhibits, are public records. Communications of Board members are not confidential because the meetings and records of the Board are open to the public. "Communications" refers to all statements and votes made during the Committee meetings, memoranda, work products, records, documents or materials developed to fulfill the charge, including electronic mail correspondence. The personal notes of individual Committee members will be considered to be public to the extent they relate to the business of the Board.

E. Amendment of Operating Procedures

These procedures may be changed by an affirmative vote of the majority of the Board members, but at least one day's notice of any proposed change shall be given in writing to each Board member.