

# Health Care Cost Transparency Board

**April 13, 2021**

## Health Care Cost Transparency Board Board Book

April 13, 2021  
10:00 a.m. – 12:00 p.m.

(Zoom Attendance Only)

### Agenda and Presentations

Meeting Agenda .....	1
March Meeting Minutes .....	2
Proposed Charter and Operating Procedures .....	3
Advisory Committee of Providers and Carriers Nominees .....	4
Beginning the Process of Defining the Benchmark Methodology and Decisions .....	5
Presentations .....	6
Wrap-up and Next Steps .....	7

### Background and Topical Material

New Advisory Committee Nominee Bios .....	8
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# Agenda

# TAB 1

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## Health Care Cost Transparency Board

April 13, 2021  
10:00 a.m. – 12:00 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
10:00-10:05 (5 min)	Welcome, roll call, and agenda review	1	Susan E. Birch, Chair, Director Health Care Authority
10:05-10:10 (5 min)	Approval of March meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
10:10-10:15 (5 min)	Approval of Proposed Charter and Operating Procedures	3	AnnaLisa Gellermann, Board Manager Health Care Authority
10:15-10:45 (30 min)	Discussion and Appointment: Advisory Committee of Providers and Carriers	4	AnnaLisa Gellermann, Board Manager Health Care Authority
10:45-10:50 (5 min)	Beginning the process of defining the benchmark methodology and decisions we will cover today	5	Michael Bailit and January Angeles Bailit Health
10:50-11:10 (20 min)	Defining total health care expenditures	6	Michael Bailit and January Angeles Bailit Health
11:10-11:30 (20 min)	Defining the population for whom total medical expenses are being measured	6	Michael Bailit and January Angeles Bailit Health
11:30-11:45 (15 min)	Establishing criteria for choosing an economic indicator	6	Michael Bailit and January Angeles Bailit Health
11:45-11:50 (5 min)	Wrap-up and next steps	7	AnnaLisa Gellermann, Board Manager Health Care Authority
11:50-12:00 (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.*

# March Meeting Minutes

## TAB 2

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## Health Care Cost Transparency Board meeting minutes

March 15, 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  
John Doyle  
Bianca Frogner  
Sonja Kellen  
Pam MacEwan  
Molly Nollette  
Mark Siegel  
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 2:02 p.m.

### Agenda items

#### Welcoming remarks

Sue Birch

Ms. Birch welcomed the board to the second meeting. She reminded the Board of the importance of reducing the growth curve of health care costs. She introduced two new Board members, Mark Siegel and John Doyle, and noted that Board membership is now complete.

#### Adoption of February 18 minutes

AnnaLisa Gellermann, Board Manager, instructed the Board on the consensus process. The February 18 minutes were adopted unanimously, and consensus was put on the record.

**Presentation: What is a cost growth benchmark, why pursue one, and its impact on health care costs**  
Michael Bailit, Bailit Health

**Presentation: Review of other states' health care cost growth benchmark programs**  
January Angeles, Bailit Health  
Discussion of programs in Massachusetts, Delaware, Rhode Island, Oregon, and Connecticut.

**Presentation: Cost growth benchmarks amid the COVID-19 pandemic**  
Michael Bailit, Bailit Health

### **Update on Advisory Committee of Providers and Carriers**

AnnaLisa Gellermann, Board Manager, updated the Board on the role of the committee and the nomination process for members. The Board is anticipated to vote on the Committee membership at the April 13 meeting.

### **Vote on Proposed Charter and Operating Procedures**

AnnaLisa Gellermann shared with the Board suggested edits that had been received on the version presented at the February 18 Board meeting. It was requested that additional language reflecting the purpose of the Board be included. The Board determined by consensus to reconsider the Proposed Charter including the additional language at the April 13 meeting, at which time they intend to vote.

### **Public comment**

There was no public comment.

### **Next meeting**

Tuesday, April 13, 2021  
Meeting to be held on Zoom  
10-12 a.m.

Meeting adjourned at 4:00 p.m.

# Proposed Charter and Operating Procedures

## TAB 3

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**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.<sup>1</sup> Family premiums were over 25% of household income in Washington as of 2016.<sup>2</sup> 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%).<sup>3</sup>

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

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<sup>1</sup> 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>

<sup>2</sup> 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](https://unitedstatesofcare.org/wp-content/uploads/2019/04/Penn-LDI-and-US-of-Care-Cost-Burden-Brief_Final-1.pdf)

<sup>3</sup> 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) *Increase the affordability of health care in Washington state by lowering health care cost growth to a financially sustainable rate.*~~
- ~~1)2) *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.<sup>4</sup>*~~
- 3) *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.*

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### 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

<sup>4</sup>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/](http://www.healthaffairs.org/doi/10.1377/hblog20180717.572276/full/)

- Releasing reports on total health care expenditures, including:
  - 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.<sup>5</sup> 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;

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<sup>5</sup> 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 V](#).

### 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.

# Advisory Committee of Providers and Carriers Nominees

## TAB 4

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**Health Care Cost Transparency Board**  
**Providers and Carriers Advisory Committee Nominees**  
**HCA's suggested members**

	Nominating Entity	Nominee Name	Title	Place of Business
<b>America's Health Insurance Plans</b>				
1		Byron Okutsu	AVP Network Management, Pacific Northwest	Cigna
2		Todd Lovshin	Vice President and Washington State Executive	PacificSource Health Plans
3		Eric Lo	Vice President of Underwriting/Actuarial	Delta Dental of Washington
4		Stephanie Garnett	Network Market Head, Northwest	Aetna
<b>American Indian Health Commission</b>				
1		*Vicki Lowe	Executive Director	American Indian Health Commission
<b>ARNPs United of Washington State</b>				
1		*Louise Kaplan	Associate Professor, Vancouver	Washington State University College of Nursing
2		*Linda Van Hoff	Nurse Practitioner Specialist	Overlake Hospital and Medical Center
<b>Association of Washington Healthcare Plans</b>				
1		Bill Ely	Vice President of Actuarial Services	Kaiser Permanente
2		Patricia Auerbach	Market Chief Medical Officer	United Healthcare
3		Ross Larsen	Vice President of Healthcare Economics	Premera Blue Cross
4		Todd Lovshin	Vice President and Washington State Executive	PacificSource Health Plans
<b>Washington Academy of Family Physicians</b>				
1		Bob Crittenden	Physician and Consultant	Empire Health Foundation
2		Chris Wheelock	Physician and Director	Family Medicine Residency of Southwest Washington
3		Lydia Bartholomew	Physician and Chief Medical Officer	Aetna
<b>Washington Ambulatory Surgery Center Association</b>				
1		Mark Barnhart	Chief Exective Officer	Proliance Surgeons, Inc., P.S.
2		Emily Studebaker	Executive Director and Legal Counsel	Studebaker   Nault Law Firm
3		Rachel Todd	Division Vice President	Gastro Health

**Health Care Cost Transparency Board**  
**Providers and Carriers Advisory Committee Nominees**

	Nominating Entity	Nominee Name	Title	Place of Business
<b>Washington Association for Community Health</b>				
1		Jodi Joyce	Chief Exective Officer	Unity Care NW
2		Ian Randall	Senior Advisor	Washington Association for Community Health
<b>Washington Council for Behavioral Health</b>				
1		Natalia Martinez-Kohler	Vice President of Finance and Chief Financial Officer	MultiCare Behavioral Health
2		Paul Eisenhower	Executive Vice President and Chief Financial Officer	Sound Health
<b>Washington State Hospital Association</b>				
1		Mike Marsh	President and Chief Executive Officer	Overlake Hospital and Medical Center
2		Ian Warden	Chief Operating Officer	Virginia Mason Franciscan Health
3		Eric Lewis	Chief Financial Officer	Washington State Hospital Association
<b>Washington State Pharmacy Association</b>				
1		*Megan McIntyre	Pharmacy Director, Business Services	Virginia Mason
<b>Washington State Medical Association</b>				
1		Mika Sinanan	Surgeon and Medical Director for Contracting and Value-based Care	University of Washington Medical Center
2		Monica Blykowski-May	Physician and Chief Medical Director	CHAS Health
3		Ralph Rossi	Internal Medicine Physician	The Polyclinic

*\*Did not submit a resume or letter of interest.*

# Beginning the Process of Defining the Benchmark Methodology and Design Decisions we will make Today

## TAB 5

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# Beginning the process of defining the benchmark methodology

- During the March Board meeting, we reviewed how other states have:
  - designed and implemented health care cost growth benchmarks; and
  - complemented their benchmarks with data analysis to identify and address cost growth drivers.
- Today we begin a process spanning several meetings to design what Washington's approach should be.
- We will work through a series of benchmark *design decisions*, sharing information about other state approaches, and asking for your recommendations.

# Design decisions we will cover today

1. Defining total health care expenditures (THCE)
2. Defining the population for whom total health care expenditures are being measured
3. Establishing criteria for choosing an economic indicator

# Presentations

## TAB 6

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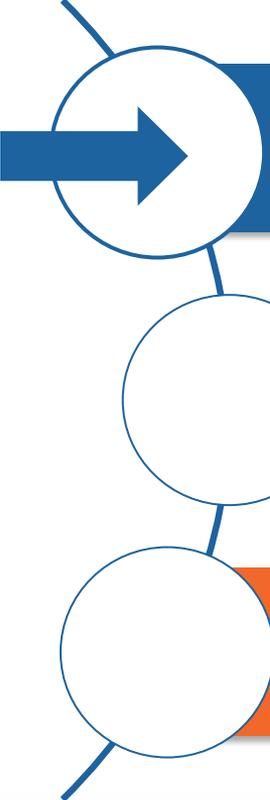
# Defining total health care expenditures

April 13, 2021

# Total health care expenditures (THCE)

- **Total health care expenditures** refers to the spending we will be measuring when assessing performance against the benchmark.
- HB 2457 defines THCE as all health care expenditures in Washington State by public and private sources, including:
  - All payments to providers including:
    - Claims reimbursements for the cost of health care provided
    - Non-claims payments
  - All cost-sharing paid by residents of Washington, including copayments, deductibles and coinsurance; and
  - The net cost of private health insurance

# Defining the specific components of THCE



All categories of medical expenses and all non-claims payments to providers

All patient cost-sharing amounts, including, but not limited to, deductibles and copayments

Net cost of private health insurance

# Definition of total medical expense

**Total medical expense (TME)** is payments to providers on all *covered services*. This includes:

- **Claims-based payments:** all payments on providers' claims for reimbursement of the cost of health care provided
- **Non-claims-based payments:** all other payments not included on providers' claims

Note that the definition of covered services differs across commercial, Medicare and Medicaid markets.

- For example, long-term care is covered by Medicaid, but not by commercial policies.

# HB 2457 definition of health care

HB 2457 specifically defines health care to include, but not be limited to, the following services:

- Medical
- Behavioral
- Substance use disorder
- Mental health
- Surgical
- Optometric
- Dental
- Podiatric
- Chiropractic
- Psychiatric
- Pharmaceutical
- Therapeutic
- Preventive
- Rehabilitative
- Supportive
- Geriatric
- Long-term care

# Typical claims-based payments as defined by other states

- Hospital Inpatient
- Hospital Outpatient
- Professional: Primary Care
- Professional: Specialty
- Professional: Other
- Long-Term Care
- Retail Pharmacy<sup>1</sup>
- Other (e.g., durable medical equipment, transportation)

<sup>1</sup> Most states include medical pharmacy in the hospital inpatient and outpatient service categories

## Reconciling HB 2457's definition with other states' definition

- HB 2457's definition of health care services to include in the measurement of performance against the benchmark can be mapped to the service categories, as defined by other states.
- Two items need further clarification, however. Other states include dental and vision services only to the extent they are part of a comprehensive services benefit plan.

# Advantages and disadvantages of including spending on dental and optical services

	<b>Advantages of Including</b>	<b>Disadvantages of Including</b>
Dental	<ul style="list-style-type: none"> <li>Including spending on dental care that is covered through standalone plans would provide a more comprehensive picture of overall state spending.</li> </ul>	<ul style="list-style-type: none"> <li>Obtaining data from dental carriers would require significant additional resources.</li> </ul>
Vision	<ul style="list-style-type: none"> <li>Including spending on optical services that is covered through standalone vision plans would provide a more comprehensive picture of overall state spending.</li> </ul>	<ul style="list-style-type: none"> <li>Obtaining data from vision carriers would require significant additional resources.</li> </ul>



## Design decision: Claims-based spending

Does the board wish to refine the definition of claims-based spending to indicate that services need to be part of a standard comprehensive services benefit plan, consistent with other state practices? This would mean:

- Including dental and vision to the extent they are covered under a comprehensive medical benefit.
- Excluding dental and vision services covered through standalone dental and vision plans.

# Typical non-claims-based spending

- 1. Prospective service payments:** Prospective payments to cover health care services (e.g., capitation, episode-based payments, case rates).
- 2. Performance incentive payments:** All payments made to providers for achievement relative to specific pre-defined goals for quality, cost reduction, or infrastructure development (e.g., pay-for-reporting and pay-for-performance payments). This includes shared savings distributions and shared risk recoupments.

## Typical non-claims-based spending

- 3. Population health and practice infrastructure payments:** All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs.
- 4. Provider salaries:** All payments for salaries of providers who provide health care services not otherwise included in claims and non-claims categories.

## Typical non-claims-based spending

5. **Recoveries:** All payments recouped during the performance year as the result of a prior review, audit or investigation, regardless of the time period of the initial payment. (Value is reported as a negative.)
6. **Other payments:** All other payments pursuant to a payer's contract with a provider that were not made on the basis of a claim for a medical service and not classified in any of the other categories above (e.g., governmental payer shortfall payments, grants, or surplus payments).



## Design decision: Non-claims-based spending

1. Prospective service payments
2. Performance incentive payments
3. Population health and practice infrastructure payments
4. Provider salaries
5. Recoveries
6. Other payments

Does the board wish to use the definition of non-claims-based spending adopted by other states?

- Are there any modifications you wish to recommend?

# Prescription drug rebates

- Drug manufacturers commonly provide prescription drug rebates to pharmacy benefit managers and health insurers. These rebates can be quite substantial.
  - Nationally, Medicaid prescription drug spending in 2017 was cut in half after accounting for rebates.<sup>1</sup>
  - In RI, pharmacy rebates accounted for 15% of commercial pharmacy spending.
- HB 2457 does not specifically address pharmacy rebates.
- In MA, DE, RI, OR and CT, payers must report prescription drug rebates received. Total medical expense is reported net of rebates.<sup>2</sup>

<sup>1</sup> Medicaid and CHIP Payment and Access Commission, “Medicaid Drug Spending Trends,” February 2019.

<sup>2</sup> States cannot access data on Medicare FFS rebates.

# Advantages and disadvantages of reporting TME net of pharmacy rebates

	<b>Advantages of Including</b>	<b>Disadvantages of Including</b>
Pharmacy rebates	<ul style="list-style-type: none"><li>• Provides a more accurate picture of actual pharmacy spending.</li></ul>	<ul style="list-style-type: none"><li>• Pharmacy rebate amounts are highly confidential and difficult to validate.</li></ul>



## Design decision: Pharmacy spending

Does the Board wish to measure total medical expense net of pharmacy rebates?

# THCE as broadly defined in HB 2457 and other cost growth benchmark states

All categories of medical expenses and all non-claims payments to providers

All patient cost-sharing amounts, including, but not limited to, deductibles and copayments

Net cost of private health insurance

# Member cost-sharing

- Insured individuals pay out-of-pocket costs dictated by their insurance product's benefit design.
  - Copayments
  - Deductibles
  - Coinsurance
- Other states exclude from their definition of member cost sharing any out-of-pocket spending on:
  - Non-covered services (e.g., non-medical cosmetic surgery);
  - Non-health care services using discounts offered by an insurer (e.g., gym membership), and
  - Health care costs paid by individuals who are uninsured.
    - Why? Because there is no systematic means of capturing such spending.

## Approaches to capturing member cost-sharing

- To measure performance against the benchmark, other states require payers to submit claims-based costs using “allowed amounts.”
  - This includes the amounts paid to a provider for a health care service, plus any required member cost-sharing.
  - In these states, cost-sharing is not separately reported and cannot be separately analyzed.\*
  - “Allowed amounts” exclude out-of-pocket spending on non-covered services, non-medical services and costs incurred by the uninsured.
  - By measuring “allowed amounts” states assume that members always pay their required cost-sharing. We know, however, that is not always the case.
- This definition is consistent with HB 2457.

\* It can, however, be assessed via APCD analysis.

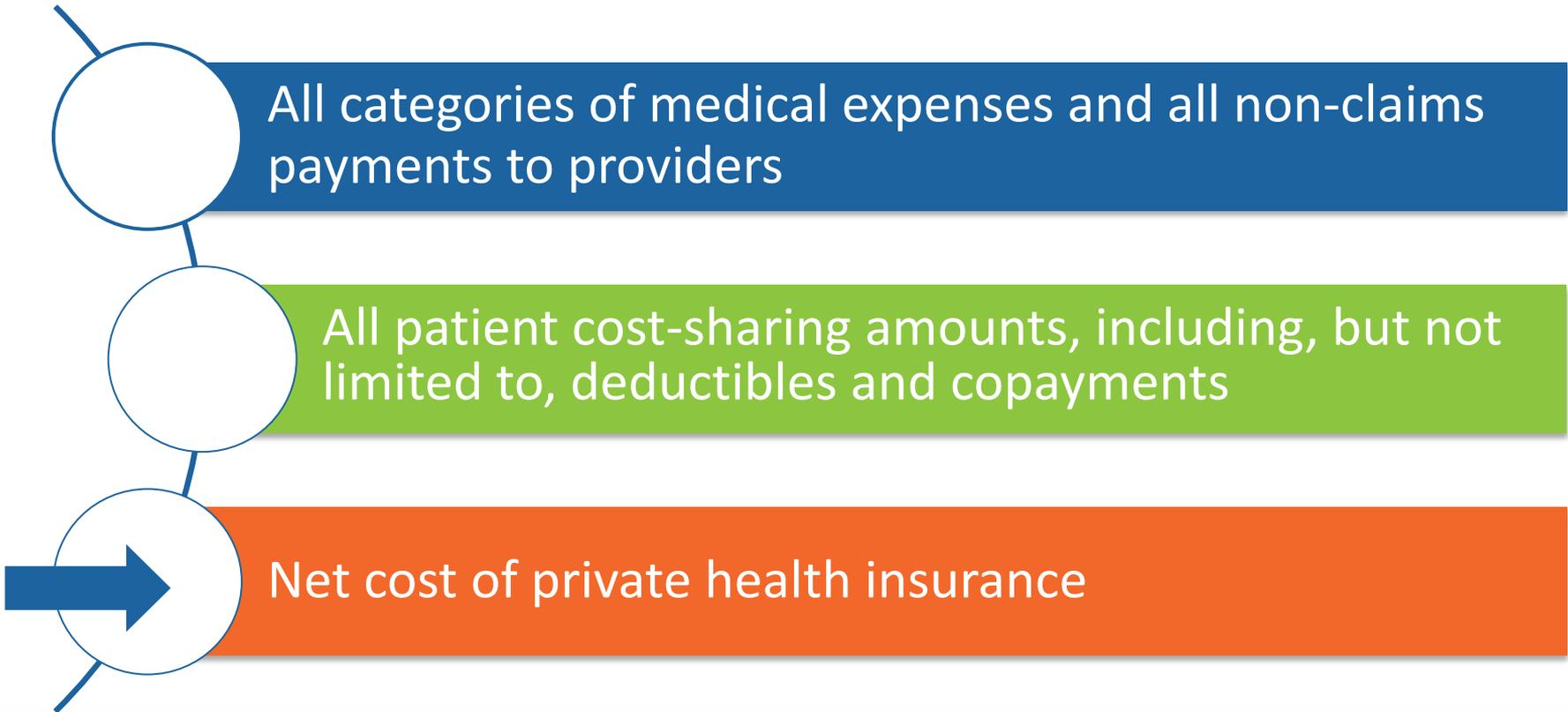


## Design decision: Cost-sharing spending

Does the Board wish to adopt the definition of cost-sharing spending used by other cost growth benchmark states?

- Are there any modifications you wish to recommend?

# THCE as broadly defined in HB 2457 and other cost growth benchmark states



All categories of medical expenses and all non-claims payments to providers

All patient cost-sharing amounts, including, but not limited to, deductibles and copayments

Net cost of private health insurance

# Net cost of private health insurance (NCPHI)

- NCPHI captures the cost associated with the administration of private health insurance. It is the difference between health premiums earned and benefits incurred.
- It consists of insurers' costs related to:
  - Paying bills
  - Advertising
  - Sales commissions
  - Other administrative costs
  - Premium taxes and other fees
- It also includes insurer profits<sup>1</sup> and/or losses.

<sup>1</sup> For non-for-profit insurers, profits are referred to as “contribution to reserves.”

# Other state approaches to measuring NCPHI

- MA, DE, RI, OR and CT all define and measure NCPHI in the same way.
- Each state collects information related to NCPHI from carriers on the self-insured market, and through federally mandated financial reporting forms. NCPHI is calculated on a PMPM basis for each market segment:
  - Individual
  - Small group, fully insured
  - Large group, fully insured
  - Student markets
  - Medicare Advantage
  - Medicaid MCO
  - Self-insured market

## HB 2457 definition of NCPHI

- HB 2457 defines NCPHI as “the difference in premiums received by a payer and the claims for the cost of health care paid by the payer.”
  - In financial forms used, NCPHI includes non-claims spending. However, this is not duplicative of non-claims spending captured separately.



# Defining the population for whom total medical expenses are being measured

April 13, 2021

At the bottom of the slide, there are decorative wavy lines in blue and green, mirroring the design at the top.

# Determining whose total medical expense to include

- HB 2457 does not provide highly specific guidance on whose costs to measure. It states only that total medical expense include “all health care expenditures in this state by public and private sources.”
- Therefore, we needed to determine:
  - the population whose health medical expense should be measured
  - the sources of insurance coverage for that population

## Total medical expense for whom?

- We need to be specific with the definition of “for whom.” We will walk through a series of questions to help define the coverage status of individuals whose health care spending is being measured.
- Data access may play a role in which coverage groups can be included.

# Primary sources of health care coverage

- Medicare
  - Fee-for-service
  - Medicare Advantage
- Medicaid
  - Fee-for-service
  - Managed care
- Medicare & Medicaid “Duals”
- Commercial
  - Fully-insured
  - Self-insured

All cost growth benchmark states include these sources of coverage.

HB 2457 requires all public and private sources of coverage to be included, which we assume to be those listed.

# Other sources of health care coverage

- Veterans Health Administration (VHA)
- State Correctional Health System
- Indian Health Services (IHS)

States vary on inclusion of these sources of coverage.

We will review the considerations of including each of these sources.

Note: TRICARE is not presented for separate consideration as we assume that spending will be captured in the data request to commercial carriers.

# Total medical expense for which sources of coverage?

	Advantages of Including	Disadvantages of Including
Veterans Health Administration (MA, DE and CT)	<ul style="list-style-type: none"> <li>Including VHA would make WA's definition comprehensive (In 2019 1.8% of WA residents were covered through the VHA or Tricare).</li> </ul>	<ul style="list-style-type: none"> <li>Data are limited and not "apples-to-apples."</li> </ul>
Correctional Health System (OR and CT)	<ul style="list-style-type: none"> <li>Including state correctional health system health care spending would make WA's definition more comprehensive (In 2018, only 17,845 individuals were incarcerated in WA, which is approximately 0.2% of the state population).</li> </ul>	<ul style="list-style-type: none"> <li>Some inpatient costs are already included under Medicaid (in certain circumstances).</li> <li>State spending for corrections is disaggregated and may be complex to obtain in an apples-to-apples manner.</li> </ul>
Indian Health Service (OR)	<ul style="list-style-type: none"> <li>Including spending by the Indian Health Service would make WA's definition more comprehensive (In 2020 1.8% of WA's population was Native American/Alaskan Native, though not all were likely served by the IHS).</li> </ul>	<ul style="list-style-type: none"> <li>Data are extremely difficult to collect and require consent from all tribes.</li> </ul>



## Design decision: Sources of coverage to include

Per HB 2457, THCE will include the following sources of coverage:

- Medicare (FFS and Medicare Advantage)
- Medicaid (FFS and managed care)
- Commercial (fully and self-insured)



## Design decision: Sources of coverage to include

What sources of coverage does the Board wish to include?

- Veterans Health Administration
- Correctional Health System
- Indian Health Service

Are there any other sources of coverage to consider for inclusion?

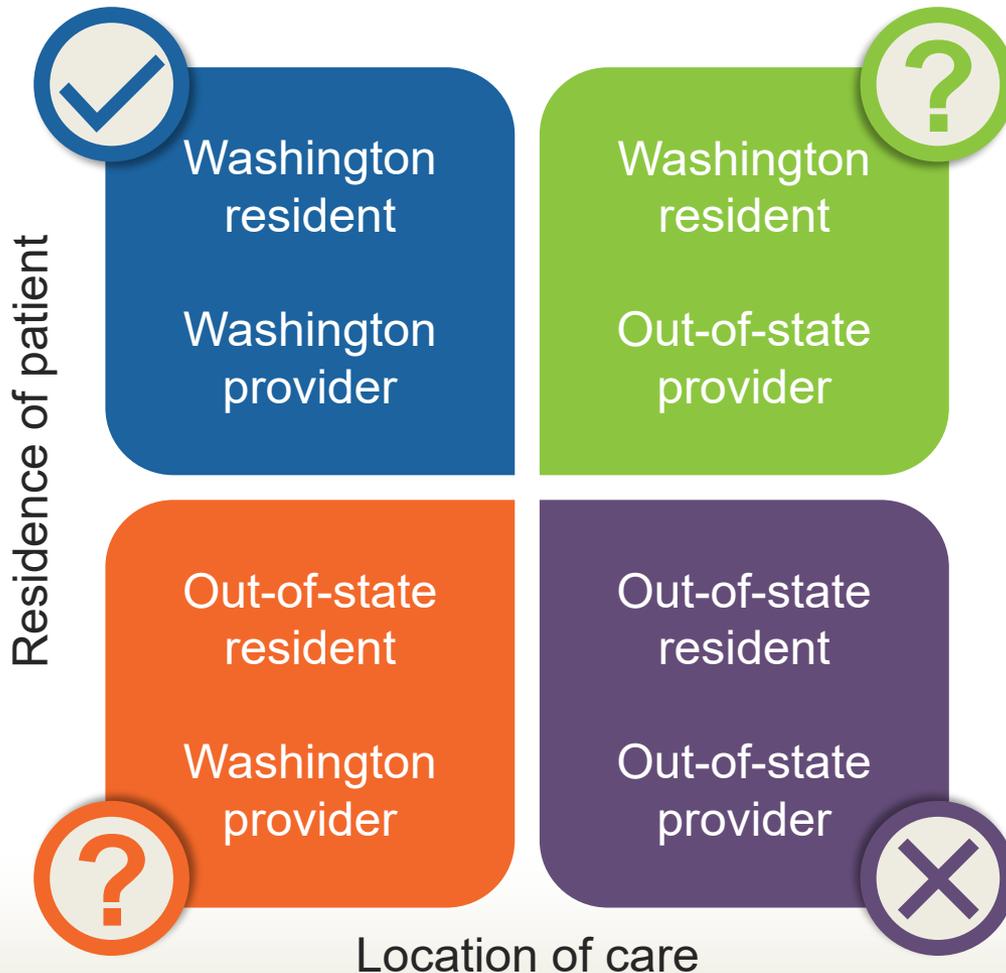
# Whose THCE is being measured?



For the services covered by the recommended payers, what should be the:

- **Residence** of the individual?
- **Location** of the provider?

# State of residence and care location



It's clear that we should:

- *Include* Washington residents who received care from Washington providers
- *Exclude* out-of-state residents who received care from out-of-state providers

## Considerations around spending on care received by state residents from out-of-state providers

- Some health systems and ACOs have affiliated or employed physicians who practice in bordering states.
- Some residents split their time between Washington and other states, e.g., community across the border, wintering in a southern state.
- MA, DE, RI, OR and CT include spending by state residents with out-of-state providers in the numerator for their cost growth benchmarks.



## Design decision: State of residence and care location

Residence of patient

Washington resident Washington provider	Washington resident Out-of-state provider
Out-of-state resident Washington provider	Out-of-state resident Out-of-state provider



Should we include health care spending on Washington residents that were incurred out-of-state?

Location of care

## Considerations around spending on care for non-state residents by in-state providers

- Bodies like the board in other states have debated whether to include spending associated with non-state residents.
  - State employees and other workers may commute into the state for work and receive their health care in the state. This spending represents an expense for Washington employers.
- These dollars can only be captured from those insurers required to report; insurers not licensed in the state are less likely to report.
- Do we care about this spending since it is not spending on behalf of Washington residents?
- MA, DE, RI, OR and CT do not include these expenditures.



## Design decision: State of residence and care location

Residence of patient

Washington  
resident

Washington  
provider

Washington  
resident

Out-of-state  
provider

Out-of-state  
resident

Washington  
provider

Out-of-state  
resident

Out-of-state  
provider

Should we include non-state residents who receive care from in-state providers?



Location of care



# Establishing criteria for choosing an economic indicator

April 13, 2021

## Why use an economic indicator?

- The primary reason for establishing a health care cost benchmark is that high and rising health care costs have been having a harmful impact on consumers and the non-health care economy.
- Using an economic indicator as the basis of the benchmark would link health care spending growth to state economic wellbeing.
- HB 2457 also requires the board to “select an appropriate economic indicator to use when establishing the health care cost growth benchmark.”

# Establishing criteria for choosing the economic indicator

- During the next meeting we will share economic indicator options to inform the value of the cost growth benchmark.
- Determining which one is a matter of preference – there is no objective right or wrong answer.
- Identifying decision-making criteria may help facilitate the process, however. We therefore offer three criteria suggestions.

## Suggested criteria

1. Provide a stable, and therefore, predictable benchmark.
2. Rely on independent, objective data sources with transparent calculations.
3. Lower health care spending growth.



## Design decision: Economic indicator criteria

Does the board wish to adopt the following criteria for choosing an economic indicator for the benchmark?

1. Provide a stable, and therefore, predictable benchmark.
2. Rely on independent, objective data sources with transparent calculations.
3. Lower health care spending growth.

Does the board wish to add other criteria for consideration?

# Wrap-up and Next Steps

## TAB 7

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## Wrap-up and next steps

- At our next meeting we will provide contextual information on historical health care cost growth in Washington.
- The Board will also deliberate the cost growth benchmark methodology, including:
  - Economic indicators that could be used to set a benchmark;
  - Use of historical versus forecasted values; and
  - Possible adjustments to the benchmark.

# New Advisory Committee Nominee Bios

## TAB 8

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**Health Care Cost Transparency Board  
Providers and Carriers Advisory Committee  
Nominees (New)**

**April 13, 2021**

**Health Care Cost Transparency Board  
Providers and Carriers Advisory Committee  
Nominees (New)**

**American Indian Health Commission**.....1  
    Vicki Lowe .....1

**ARNPs United of Washington State** .....2  
    Louise Kaplan .....2  
    Linda Van Hoff .....2

**Washington State Pharmacy Association** .....3  
    Megan McIntyre .....3

# TAB 1

## American Indian Health Commission

1. **Vicki Lowe**, Executive Director, American Indian Health Commission

## **Vicki Lowe, AIHC Executive Director**

Vicki Lowe, Executive Director of the American Indian Health Commission for Washington State (AIHC) since July 2015, is a Jamestown S’Klallam descendant. She has also worked in the Health Department of the Jamestown S’Klallam Tribe since December of 1996. Through their Purchased and Referred Care (PRC) Program, the Jamestown S’Klallam Tribe purchased insurance for their Tribal Members without access to any other coverage since 1995. Ms. Lowe has seen this program through many changes in the private insurance world as well as



Medicare and Medicaid. She participated on the Basic Health Sponsorship Workgroup, negotiated a Tribal Member only plan with a commercial carrier, initiated contracting with commercial carriers at the Jamestown Family Health Clinic, participated in the creation and implementation of the Jamestown S’Klallam Tribe Employee Plan, a self-funded plan, worked with Jamestown S’Klallam Tribe’s newly created Human Resources Department to review and update benefits for the employee’s plans - benefits including Life, AD&D and LTD, Long Term Care Coverage, Self-Funded Worker’s Compensation and Wellness benefits. She also worked on implementation of the Indian provisions of the Affordable Care Act into the Employee Benefits and PRC programs.

Beginning in 2012 she began working with the AIHC and WAHBE to implement the Tribal Assister program for the Washington Health Benefits Exchange. This project has been expanded to include Medicare, Medicaid and I.H.S. benefits training.

Ms. Lowe is also very involved in the Jamestown S’Klallam Tribal Community. She has been part of the Jamestown Canoe Family since 2009, pulling in the Tribe’s canoe since 2012. She supports singing and drumming, language, weaving classes and other culture programs. In 2012, she was honored as the Jamestown S’Klallam Tribe’s Volunteer of the Year. Most of all she enjoys spending time with her family, husband Jim, five children and four grandchildren.

# TAB 2

## ARNPs United of Washington State

1. **Louise Kaplan**, Associate Professor, Vancouver, Washington State University College of Nursing
2. **Linda Van Hoff**, Nurse Practitioner Specialist, Overlake Hospital and Medical Center

# Louise Kaplan



Associate Professor, Vancouver  
FNP Clinical Track Co-Coordinator

[kaplanla@wsu.edu](mailto:kaplanla@wsu.edu)

360-485-6387

VLIB 210V1

4204 NE Salmon Creek Ave.,  
Vancouver, WA 98686

Louise Kaplan, an associate professor in the Washington State University College of Nursing, has more than 20 years of academic experience. A family nurse practitioner since 1981, she has extensive primary care clinical experience. Her PhD focused on health policy and she has been actively engaged in legislative and regulatory changes throughout her career. Dr. Kaplan has conducted research and published on topics including APRN workforce issues, NP education; prescribing of controlled substances, prescriptive authority and medical marijuana. Active in many professional organizations, she chairs the legislative committee of ARNPs United of Washington State and serves on the organization's Board of Directors. Dr. Kaplan is also the Washington State Representative for the American Association of Nurse Practitioners. She is a member of the Washington State Nurses Association's Hall of Fame, and a Fellow of both the American Association of Nurse Practitioners and the American Academy of Nursing.

## Education

- BA Simmons College, Boston, MA
- MN, University of Washington, Seattle, WA
- PhD, Brandeis University, Waltham, MA
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## Research Interests

- ARNP prescribing of controlled substances
- APRN workforce
- ARNP reimbursement
- DNP program evaluation
- Landscape assessment of readiness for implementation of the family nurse practitioner role in Swaziland
- Medical marijuana

## **Methodological Strengths**

- Survey research
- Qualitative research

## **Areas of Expertise**

- Health policy both legislative and regulatory
- Primary care
- Global health
- ARNP workforce
- Rural NP practice

## **Funded Research**

“Hiring, Credentialing, and Privileging of Nurse Practitioners as Hospitalists: A National Workforce and Employment Analysis.” National Council of State Boards of Nursing Center for Regulatory Excellence. Tracy Klein, PhD, ARNP, FNP, FRE, FAANP, FAAN and Louise Kaplan, PhD, ARNP, FNP-BC, FAANP, FAAN, Co-Principal Investigators, Julie Stanik-Hutt, PhD, ACNP, CNS, FAANP, FAAN and Carol Hartigan, MN, RN, Co-Investigators. \$146,583 (direct). Awarded December 2018. (In Progress).

“Routes to Rural Readiness: Enhancing Clinical Training Experiences for Nurse Practitioner Practice in Rural Primary Care”, Davis Patterson, PhD, Susan Skillman, MS, Louise Kaplan, PhD, ARNP, FNP-BC, FAANP, FAAN, Co-Principal Investigators. University of Washington Center for Health Workforce Studies Subcontract, \$38,056. July 6, 2018. (In progress).

“Washington State ARNP Workforce and Practice Reimbursement.” Louise Kaplan, PhD, ARNP, FNP-BC, FAANP, FAAN principal investigator, and Justin Gill, MN, ARNP, co-investigator. Washington Center for Nursing, \$10,000 (direct) Completed.

“Washington State ARNP Workforce and Practice Reimbursement.” Louise Kaplan, PhD, ARNP, FNP-BC, FAANP, FAAN Principal investigator, and Justin Gill, MN, ARNP, co-investigator. American Association of Nurse Practitioners, \$2,500 (direct). Completed.

“Landscape Assessment of Readiness for Implementation of the Family Nurse Practitioner Role in the Primary Care Setting in Swaziland” Project of Seed Global Health and the University of Swaziland. \$50,000 grant received by Seed Global Health. Louise Kaplan, PhD, ARNP, FNP-BC, FAANP, FAAN, consultant and project lead. (Completed).

“Knowledge, Practices and Attitudes Regarding Medical Marijuana Among Washington State Healthcare Providers and Certified Marijuana Consultants.” Louise Kaplan, PhD, ARNP, FNP-BC, FAANP, FAAN, Principal Investigator; Tracy Klein, PhD, ARNP, FNP, FRE, FAANP, FAAN; Marian Wilson, PhD, MPH, RN-BC. Alcohol and Drug Abuse Research Program Office of Research Dedicated Marijuana Account. \$25,000 (direct). (In progress).

## **Honors & Awards**

- 2018 – University of Washington School of Nursing Influencer
- 2017 – Fellowship in Global Clinical Education, Massachusetts General Hospital Global Health
- 2016 – University of Washington School of Nursing Distinguished Alumni Award
- 2014 – Fellow, American Academy of Nursing
- 2013 – American Association of Nurse Practitioners Advocate State Excellence Award

- 2010 – Fellow, American Association of Nurse Practitioners
- 2010 – Outstanding Policy Award National Organization of Nurse Practitioner Faculties
- 2010 – Inductee, Washington State Nurses Association Hall of Fame
- 2007 – Nurse Researcher of the Year, Washington State Nurses Association

# Linda A. Van Hoff, ARNP

Nurse Practitioner Specialist

Linda A. Van Hoff is a Nurse Practitioner Specialist in Bothell, Washington. She graduated with honors in 1996. Having more than 25 years of diverse experiences, especially in NURSE PRACTITIONER, Linda A. Van Hoff affiliates with many hospitals including Overlake Hospital Medical Center, Evergreen health Medical Center, cooperates with many other doctors and specialists in medical group Overlake Medical Clinics LLC.

## Education

Linda A Van Hoff attended to a university and then graduated *in 1996*.

## Medical License

Linda A. Van Hoff has primarily specialized in Nurse Practitioner for over 25 years.

# TAB 3

## Washington State Pharmacy Association

1. **Megan McIntyre**, Pharmacy Director, Business Services, Virginia Mason

# Megan McIntyre, PharmD, MHA

Senior Pharmacist Leader

As an authentic and passionate healthcare leader, I effectively combine clinical knowledge, business acumen with analytic skills, creativity and the ability to succeed through ambiguity. My leader and team member style combines laughter with listening, action and accountability.

## Experience

*Virginia Mason Medical Center*

15 years 10 months

### **Director, Pharmacy Business Services**

Jan 2020 - Present 1 year 4 months

Creating opportunities for improvement and growth across Virginia Mason Health System with a focus on key pharmacy financial transactions (buy and sell side) and resource utilization (product, service, provider), contract opportunities and vendor performance. Plays a critical role in leading transformative initiatives, acts as a key liaison with leadership, an advisory resource to teams system-wide and as a representative to external organizations.

### **Administrative Director/VP, Pharmacy Health Resource Services LLC**

Jan 2017 - Jan 2020 3 years 1 month

Greater Seattle Area

Group purchasing organization leadership position, working closely with key organizational leaders; driving efficiencies in resource utilization, adherence to industry regulations, and optimization of procurement processes for greater member value. Purview spans pharmacy and supply acquisition, supplier partner relationships, and contract administration, as well as continued support of Virginia Mason Medical Center Health Plan drug expenses.

### **Virginia Mason Institute - Senior Faculty / Transformation Sensei**

Nov 2015 - Jan 2017 1 year 3 months

Greater Seattle Area

### **Director, Pharmacy Residency Programs**

May 2008 - Dec 2015 7 years 8 months

### **Manager, Medication Use Quality**

May 2008 - Nov 2015 7 years 7 months

### **Clinical Pharmacist**

Jul 2006 - May 2008 1 year 11 months

### **Pharmacist Resident**

Jul 2005 - Jun 2006 1 year

### **Pharmacist**

*Bartell Drugs*

May 2004 - Jun 2005 1 year 2 months

Staff and Head Pharmacist; full-time, float and per diem; also intern, management rotation

## Education

### **University of Washington**

Master of Healthcare Administration/Management  
2010 - 2012

### **University of Montana**

Doctor of Pharmacy (PharmD)  
1998 - 2004

### **University of Montana School of Pharmacy**

Doctor of Pharmacy (PharmD)  
1998 - 2004