Washington State Health Care Authority

Health Care Cost Transparency Board

December 14, 2022

Washington State Health Care Authority

December 14, 2022
2:00 p.m. – 4:00 p.m.
Zoom Meeting

Health Care Cost Transparency Board
AGENDA

Board Members:					
☐	Susan E. Birch, Chair	☐	Molly Nollette	☐	Edwin Wong
☐	Lois C. Cook	☐	Mark Siegel		
☐	Bianca Frogner	☐	Margaret Stanley		
☐	Leah Hole-Marshall	☐	Kim Wallace		
☐	Jodi Joyce	☐	Carol Wilmes		

Time	Agenda Items	Tab	Lead
2:00 – 2:10 (10 min)	Welcome, roll call, and agenda review	1	Sue Birch, Director Health Care Authority
2:10 – 2:15 (5 min)	Approval of November meeting summary	2	AnnaLisa Gellermann, Cost Board Dir. Health Care Authority
2:15 – 3:00 (45 min)	Introduction to 2022 Cost Growth Drivers Study	3	Amy Kinner, OnPoint
3:00 – 3:15 (15 min)	Public comment		Sue Birch Health Care Authority
3:15 – 3:55 (40 min)	Cost Driver Discussion continued		Sue Birch Health Care Authority
3:55 – 4:00 (5 min)	Adjournment		Sue Birch Health Care Authority

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Board has agreed this meeting will be held via Zoom without a physical location.

Health Care Cost Transparency Board meeting summary

November 16, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2 p.m.-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

Bianca Frogner
Carol Wilmes
Edwin Wong
Jodi Joyce
Kim Wallace
Leah Hole-Marshall
Lois Cook
Margaret Stanley
Molly Nollette
Sonja Kellen

Members absent

Mark Siegel
Sue Birch

Agenda items

Welcome, Roll call, Agenda Review

Mich'l Needham called the meeting to order at 2:02 p.m.

Approval of Minutes

The board approved the minutes.

Topics for Today

Topics were listed as Primary Care: 2022 Legislative Report Review; Patient Stories and Consumer Health Experience State Survey (CHESS); and 2023: Meetings and Milestones.

Primary Care: 2022 Legislative Report Review

Jean Marie Dreyer, Senior Health Policy Analyst, Washington State Health Care Authority

Jean Marie Dreyer gave a presentation on the cost board's soon-to-be published initial legislative report on primary care expenditures. Jean Marie reviewed each section of the report, including report background, the formation of the advisory committee on primary care, details from each of the committee meetings, and a preview of future primary care recommendations and committee work to be described in the annual August 2023 cost board report. Jean Marie also noted that the board would review a preliminary definition of primary care developed by the primary care committee at the board's next meeting. Jean Marie concluded with a description of the primary care committee's 2023 meetings and objectives.
Board member Leah Hole-Marshall asked whether there will be a review of the current work to consider other lenses, from a spend-cost perspective. The board should look at common definitions that are used for slightly different purposes. A comparison of definitions will be reviewed by the Advisory Committee of Providers and Carriers as well as the board. Mich'l Needham explained that the report would likely be late to allow the board to review the recommendations from the advisory committee in its December meeting.

Patient Stories and Consumer Healthcare Experience State Survey

Emily Brice, Senior Attorney, Policy Advisor Northwest Health Law Advocates
Joelle Craft, Member, Washington Consumer Action Network
Dorothy Roca, Member, Washington Consumer Action Network
Alexandra Allen, Health Policy Analyst, Altarum Healthcare Value Hub

Emily Brice referenced the September meeting where consumer members shared information about the pressures consumers faced in the last decade. There are several indicators to track, including growth in premiums, cost sharing, and uninsurance. Washington doesn't track underinsurance metrics on a state specific level, which means there is missing information regarding real world cost pressures. Dorothy Roca and Joelle Craft also shared stories about the cost burdens from a patient perspective.
Joelle Craft, a member of Washington Community Action Network, shared challenges with multiple sclerosis since childhood. Joelle is on disability and doesn't make enough in a year to cover the cost of care. Most of Joelle's care was at Providence, but Joelle wasn't informed about charity care and entered bankruptcy. Joelle lives with family instead of a separate home. The failures of charity care to counter greed is just one example of how half measures can't fully address the full scope of cost burden. Patients must be at the core of every decision that impacts them.
Dorothy Roca, also a member of the Washington Community Action Network, spoke about the experience of trying to afford care for a child. Dorothy's eldest child has schizophrenia. Dorothy was forced to look for programs out of state and found a long-term behavioral health program in Oregon. Dorothy's Cigna claims were denied, and the family spent $160,000 of savings to cover the costs, which cut into Dorothy's other child's tuition for college. Choosing between the health of one child and the education of another is not a decision a family should be forced to make. Patients are subjected to a capricious and arbitrary system where companies like Cigna can deny care.

Alexandra Allen, health policy analyst from Altarum Healthcare Value Hub, gave a presentation on healthcare affordability and disparities in Washington using results from the Consumer Healthcare Experience State Survey (CHESS).
Affordability burdens involve three components: foregoing insurance due to high cost, delaying or foregoing care due to cost, and receiving care but struggling with resulting bills. More than half of burdens involved delayed or skipped care due to cost. This was an issue across the income spectrum. Half of people of all income groups went without care due to cost. Nearly a third of those earning $50,000 or less and those earning higher than $75,000 to $100,000 report rationing medication due to cost. Alexandra also discussed survey respondents who went without care by insurance types. Those with Apple Health reported the highest rates of going without care and rationing medication at a rate of 70 percent. Some Apple Health members reported difficulty accessing services, or stated

that services weren't covered, including dental, mental health, behavioral health, physical therapy and eyecare. These members also noted a lack of providers who would accept their insurance.
Board member Margaret Stanley asked about the Apple Health responses and was surprised that people went without care due to cost. This pattern is seen across states and Apple Health members explicitly referenced that certain services weren't covered. Some said they could reach a provider, but that it was either unaffordable or inaccessible due to distance. Mich'l Needham suggested adding a footnote that Apple Health does not have cost-sharing.
Rural residents reported higher rates of going without care due to cost. Some respondents of color had higher rates of going without care due to cost. Compared to white respondents, 67 percent of American Indian or Alaska Native (AI/AN) went without care due to cost compared to 55 percent of white respondents. The raw frequency and weighted frequency were less than 100 responses, so this sample was not reliable as an estimate, but still useful for consideration. Respondents of color also reported higher rates of not filling prescriptions or cutting doses compared to white respondents.
The survey also found that respondents with a disability, or those who lived with someone with a disability, reported far higher rates of going without care and rationed medication. Nearly 39 percent of respondents struggled to pay their medical bills. Respondents in rural areas, black respondents, Latinx or Hispanic, and AI/AN and persons with a disability reported the highest rates of financial hardships.
Seventy-one percent of respondents believed the healthcare system needs to change. Respondents viewed the government as the key stakeholder in producing change and supported pricing and prescription drug price interventions by political affiliation.
Board member Bianca Frogner noted that the presentation brings up what is in control of the board and highlights the need to capture non-claims-based data. The board also has difficulty analyzing cost sharing. Bianca Frogner asked to what extent COVID may have influenced responses and caused variation. Beth, a colleague at Altarum, referenced previous CHESS surveys prior to COVID that determine the pandemic's influence on responses.
Economic issues have begun to take precedence alongside concerns with healthcare costs. By August of 2022, the impact of the pandemic was more economy-based around inflation. Healthcare affordability is starting to rise again. Data is point-in-time and not a longevity study and it would be difficult to use this instrument to determine a direct cause or relation to any policy changes that this board may pass or want to see as an evaluation tool. This tool is not recommended for a formal evaluation of policy.

Emily Brice agreed that ideally data would be compiled year over year with a broader sample size. Washington residents are struggling deeply with healthcare costs and rely on bodies like this board to make a difference. The board should be careful to balance the interests of residents' challenges when considering increasing the benchmark due to inflation.
Board member Jodi Joyce noted that it will be important to track costs that may not accrue under the formal category of the benchmark and to think carefully about any unintended consequences of definitions of spending used for measurement and tracking purposes.

Public comment

Molly Dutton, occupational nurse consultant with Labor and Industry (L&I) suggested that a lot of healthcare transformation work should be viewed in a top-down manner. Burnout has not been selective to certain professions but has been hard hit in healthcare. There hasn't been accountability for healthcare entities as far as provider turnover, which leads to lack of access, and expensive hiring and recruiting. There needs to be something to incentivize retention or discourage turnover as efforts value-based transformation efforts continue.
Suzyn Danie, L&I, described "no-show" situations where patients are charged after waiting on the phone to attend virtual appointments. Patients are told by providers that costs cannot be explained in advance to avoid the appearance of discrimination between cash pay over PPOs or HMOs.

2023: Meetings and Milestones

AnnaLisa Gellermann, Cost Board Director, Washington State Health Care Authority

AnnaLisa Gellermann gave a presentation on 2023 milestones and meetings. In 2023, the board will consider the 2022 cost driver analysis, the 2022 benchmark report (lookback for 2017 through 2019 data), and primary care recommendations. The 2023 Benchmark Data Call will take place in June 2023 and the next round of Cost Driver Analysis will occur in November. AnnaLisa provided an overview of 2023 board and committee meetings as they relate to specific milestones and reviewed feedback from committees about the meeting process.

Board member Margaret Stanley noted that it would be helpful to hear directly from committee members to hear their reactions and suggested a representative of the committee to the board.

Mich'l Needham drew board members' attention to the Mathematica report on findings from Massachusetts. Massachusetts has different authorities not currently available to Washington to monitor entities' adherence to the benchmark.

Board member Leah Hole-Marshall noted that the group of states and leaders working on benchmarking will be helpful for Washington to reference as it continues its work.

Adjournment

Meeting adjourned at 3:59 p.m.

Next meeting

December 14, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

ONPOINT Health Data

Washington State Health Care Authority

Cost Growth Drivers Study

Preliminary Findings

December 14, 2022

Amy Kinner, *Director of Health Analytics*

ONPOINT Health Data

Washington State Health Care Authority

Overview of Study

Purpose of the Cost Growth Drivers Study

- Use the Washington State All-Payer Health Care Claims Database (WA-APCD) to identify cost trends and drivers of cost growth in the health care system to inform the Board as it works to curb spending growth. The study discusses:
  - Spend/trend by market
  - Spend/trend by geography
  - Spend/trend by health conditions and demographics
  - Potential unintended consequences

Key Topics for Phase I Analysis

- How has insurance enrollment changed during the last 5 years?
- How has spending – on a total and per-member basis – changed during the last 5 years?
- How is spending changing for different products (e.g., commercial, Medicaid, Medicare Advantage)?
- Does spending vary by category of service (e.g., inpatient, outpatient, professional, primary care, specialty care)?
- Are there differences in spending by region?
- Are there differences in spending by age and gender categories?
- How do “high-cost members” impact spending?

ONPOINT Health Data

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Summary of Methods

Reporting Periods Included in the Analysis

- Study looked at 5 years of data: CY 2017–2021
- This period aligns with the cost-benchmarking period

Product Types & Markets

Product Type	Notes
Commercial	Limited data from self-insured plans
Medicaid	Includes managed care only; FFS members and payments are excluded; FFS data do not include line-level payments (a challenge for some categories)
Medicare Fee-for-Service (FFS)	Only available through 2019
Medicare Advantage	Covered by commercial plans; pharmacy data for these members is not included because many are covered by Medicare Part D (FFS)
Public Employees Benefits Board (PEBB)	Commercial and Medicare Advantage
WA Health Benefit Exchange	Commercial
Dual-eligibles	Not broken out separately in this analysis due to missing FFS data beyond 2019

Categories Aligned with Benchmarking Initiative

Category	Notes
Hospital inpatient	Room and board and ancillary payments for hospital inpatient
Hospital outpatient	All hospital types, satellite clinics, and outpatient ED services
Professional – PCPs	WA narrow definition of primary care
Professional – Specialty providers	Non-PCP physicians
Professional – Other providers	Other professionals (e.g., physician assistants (PAs), nurse practitioners (NPs), occupational therapists, counselors); community health centers and freestanding ASCs also included
Long-term care	SNFs, hospice, home health, personal care services, etc.
Retail pharmacy	Pharmacy claims
Other	All other dollars

Limitations

- Self-insured commercial plans are not required to report data to WA-APCD
- No data is available for the uninsured
- Medicare FFS data (including Medicare Part D pharmacy) is available only through 2019
- Alternative payments (e.g., capitated payments, pharmacy rebates) currently are not reported
- Long-term care data for Medicaid is not reported but is a significant contributor to spending
- Payments for Medicaid FFS data are not included

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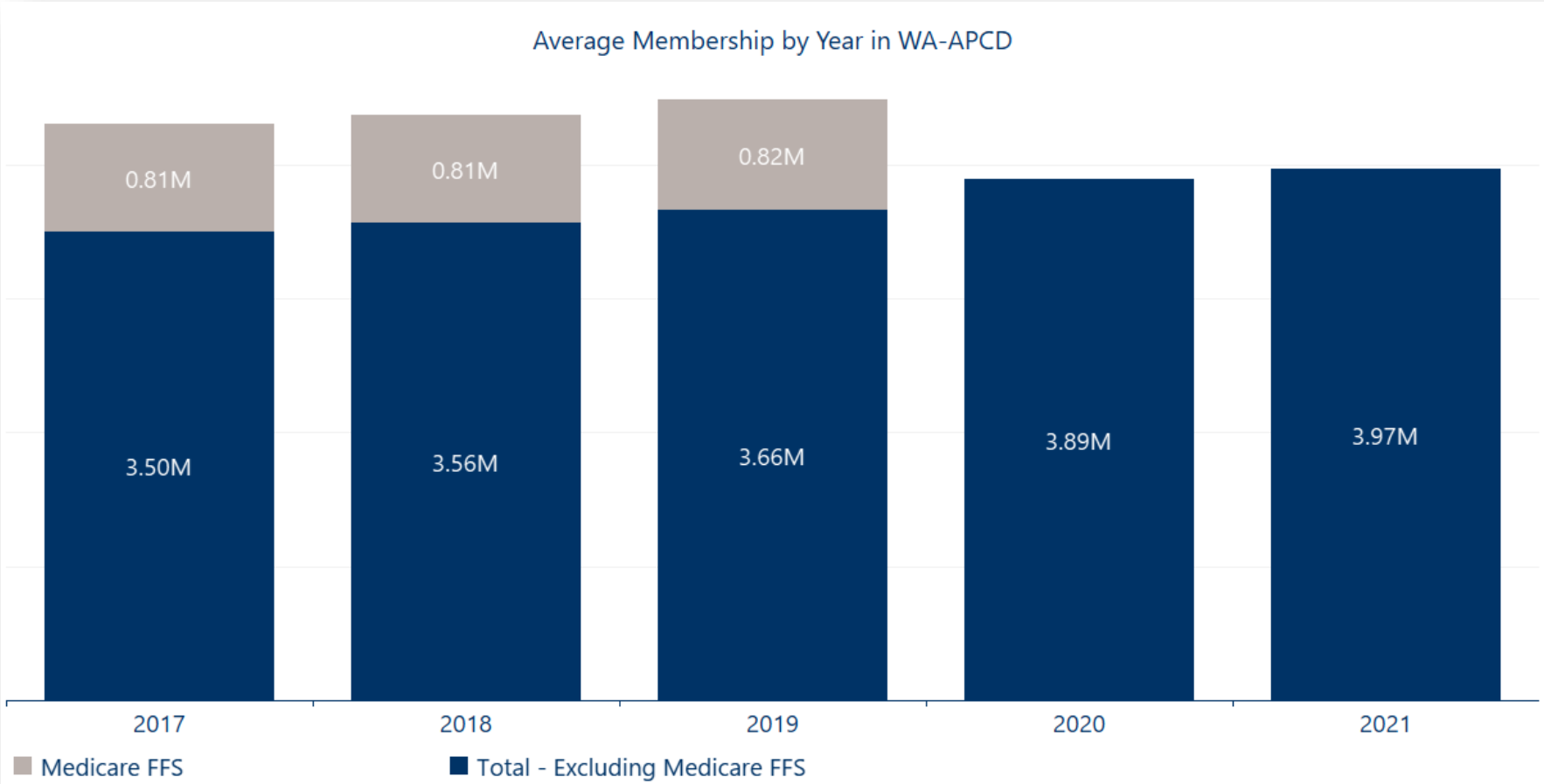
How Has WA-APCD Membership Changed?

Enrollment Trends (2017–2021)

WA-APCD Membership, 2017-2021



Average membership is calculated as number of member months of eligibility/12. This yields a slightly lower total than a count of distinct members during the year because some members have less than 12 months eligibility.

Average WA-APCD medical plan membership increased steadily between 2017 (3.50 million members) and 2021 (3.97 million members).

Medicare Fee-For-Service (FFS) contributed another ~800,000 members annually.

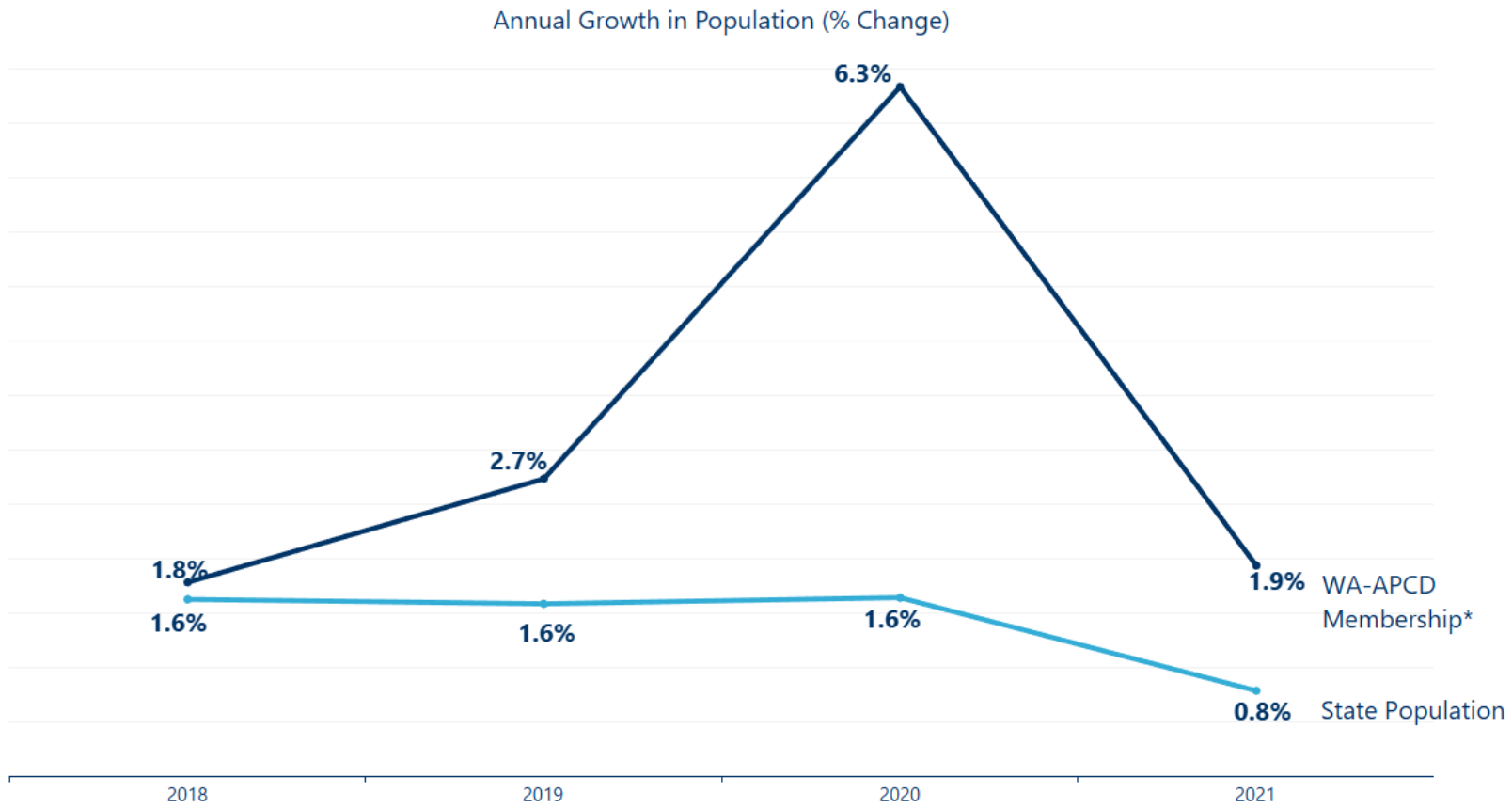
Medicare FFS data are not yet available for 2020 and 2021.

Medicaid FFS members are not included in this analysis.

WA-APCD Membership Growth Exceeded WA Population Growth

Annual percent growth in WA-APCD membership has exceeded the rate of population growth in WA.

In 2020, the WA-APCD grew by 6.3% compared to 1.6% population growth in the state.

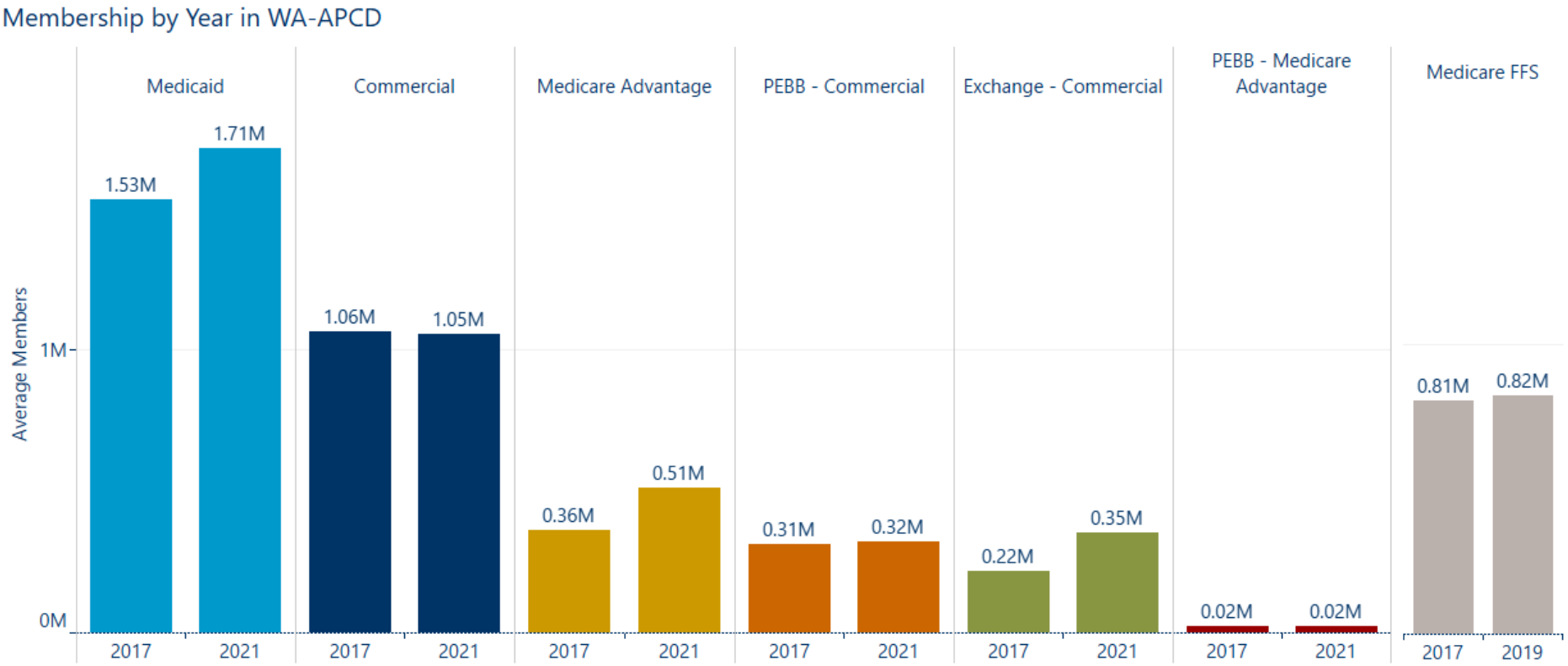


* Excludes Medicare Fee-For-Service (FFS). 2020 and 2021 data are not available for Medicare FFS. Medicaid FFS members are also excluded.

WA-APCD Enrollment by Product (2017 & 2021)

The number of members in Medicaid, Exchange, and Medicare Advantage plans increased significantly between 2017 and 2021 in WA.

Commercial plans and Public Employees Benefits Plan (PEBB) stayed relatively stable during this time.



Notes:

Medicare Fee-For-Service (FFS) data is not available for 2020-2021. Data for 2019 are presented here in place of 2021.

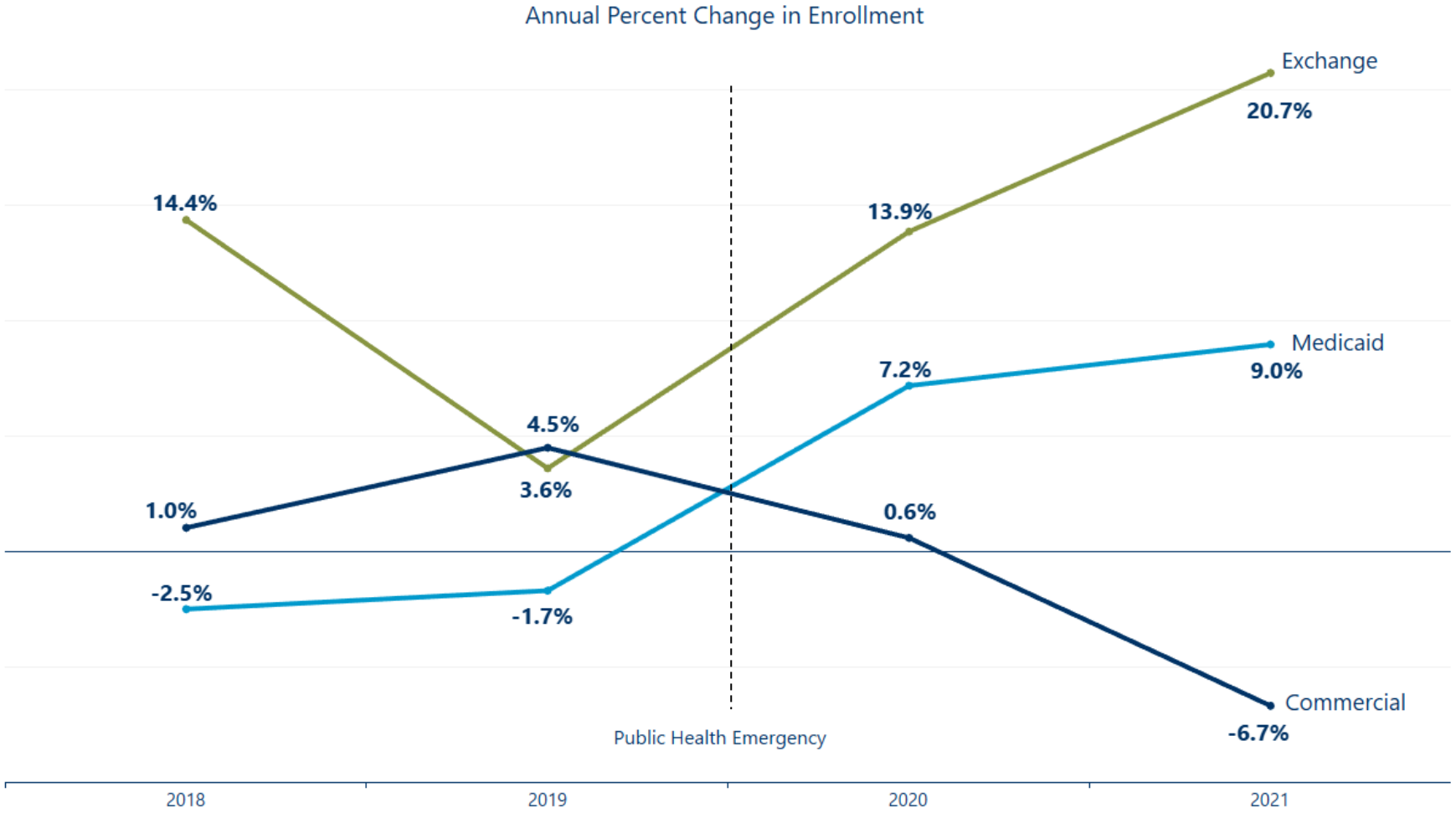
Medicaid data include only members with eligibility under Medicaid Managed Care.

Average membership is calculated as numer of member months of eligibility/12. This yields a slightly lower total than a count of distinct members during the year because some members have fewer than 12 months of eligibility.

Enrollment Trends during COVID-19 Emergency

Enrollment in Medicaid and Exchange plans increased during the COVID public health emergency.

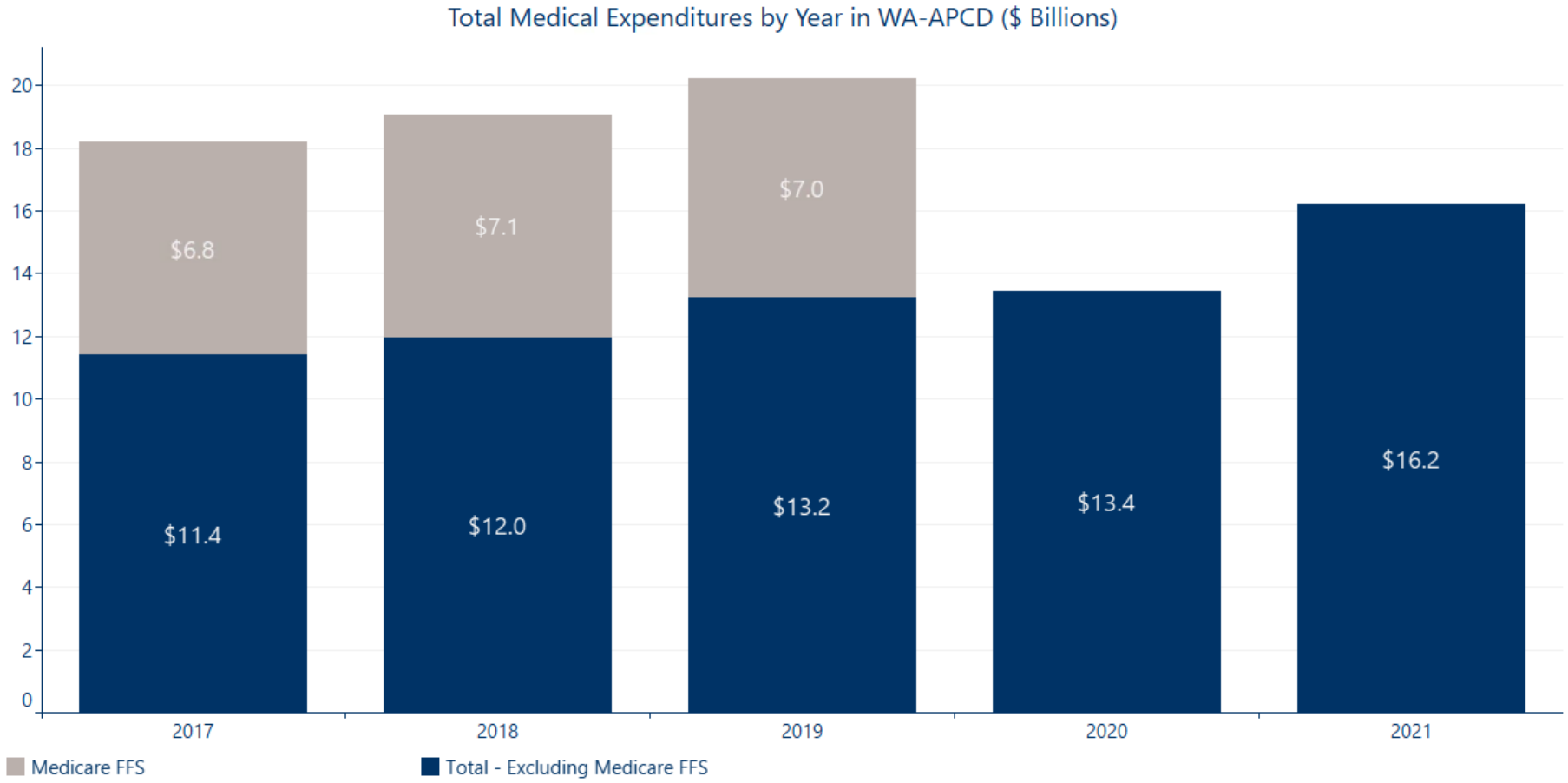
Some members joined or stayed on these plans or stayed on these plans longer than usual, which may have resulted in a downward enrollment trend for commercial payers.



How Have WA-APCD Total Expenditures Changed?

Medical & Pharmacy Claims

Total Medical Claims Expenditures (WA-APCD)



Medical expenditures for claims submitted to the WA-APCD increased from $11.4 billion in 2017 to $16.2 billion in 2021. This includes both plan and member payments.

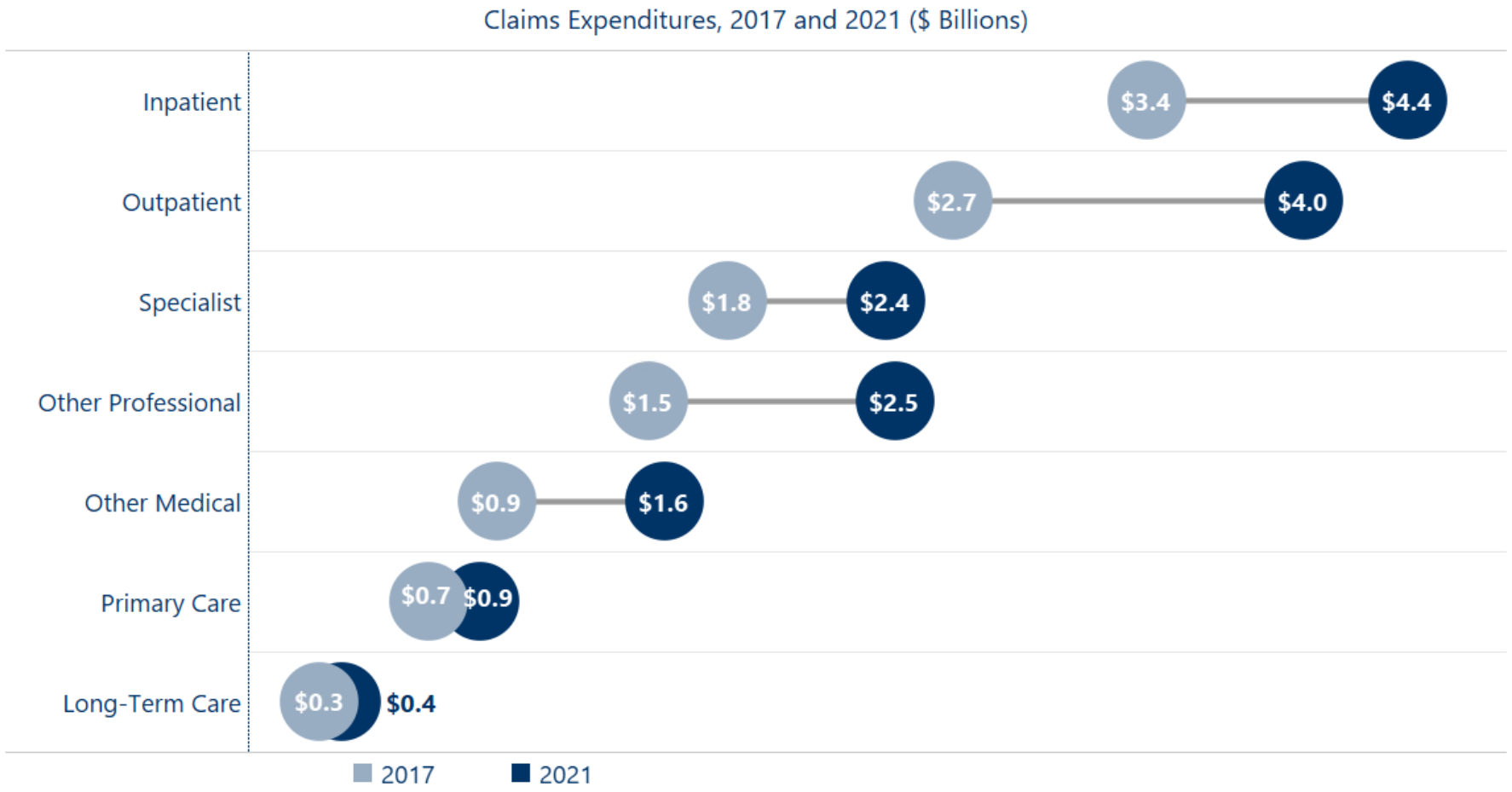
Medicare FFS claims comprised another approximately $7 billion in spending annually.

Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, or retail pharmacy claims.

Growth in Medical Claims Expenditures, 2017 & 2021

Spending for all medical categories increased between 2017 and 2021. The most significant increases were in outpatient spending ($2.7 billion to $4.4 billion), inpatient spending ($3.4 billion to $4.0 billion), and other professional ($1.5 billion to $2.5 billion).

In 2021, total inpatient spending ($4.4 billion) remained greater than outpatient spending ($4.0 billion), but **outpatient spending has been growing at a more rapid pace.**

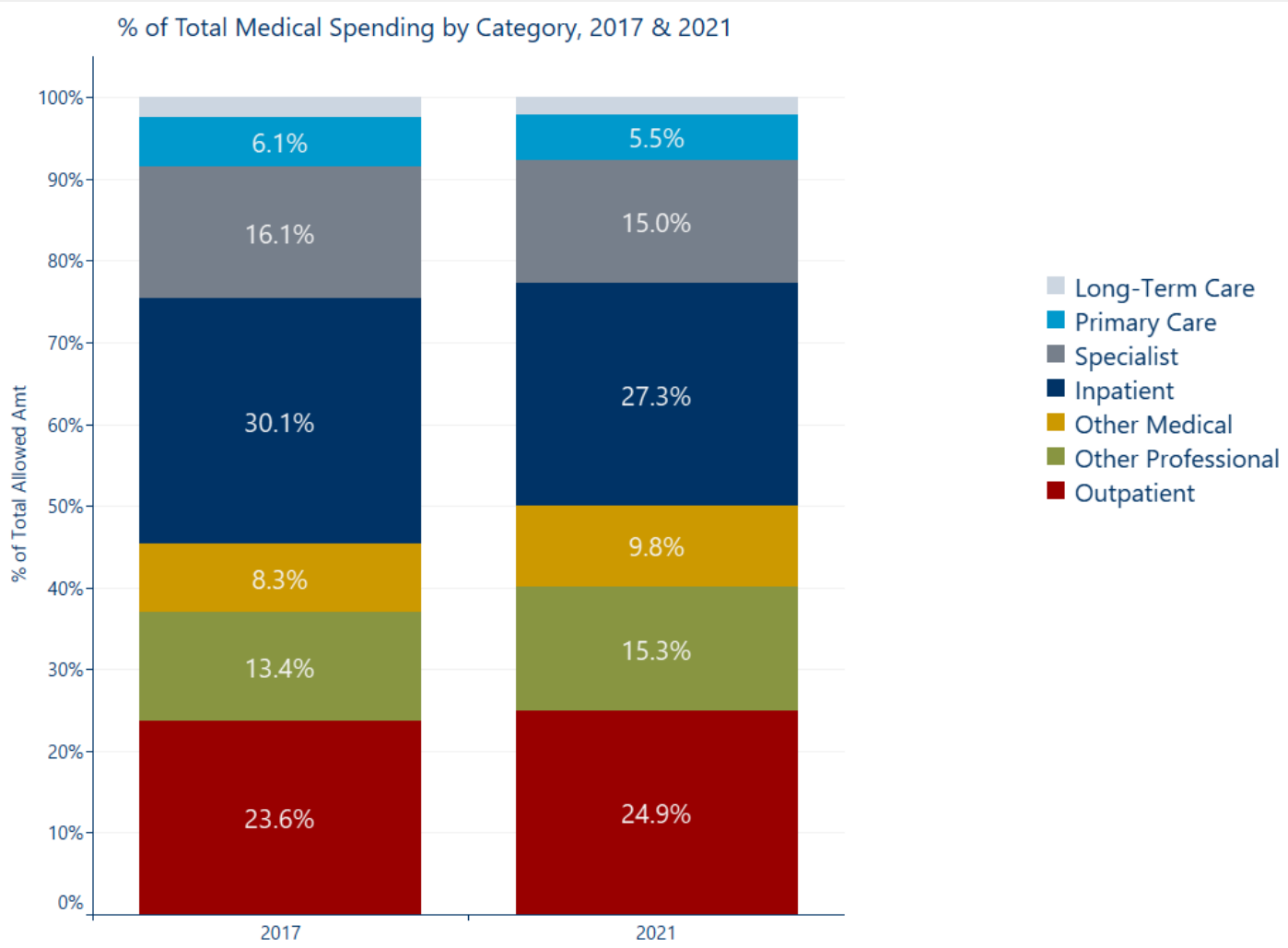


Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, Medicare FFS dollars, or retail pharmacy claims.

% Medical Spending by Category, 2017 & 2021

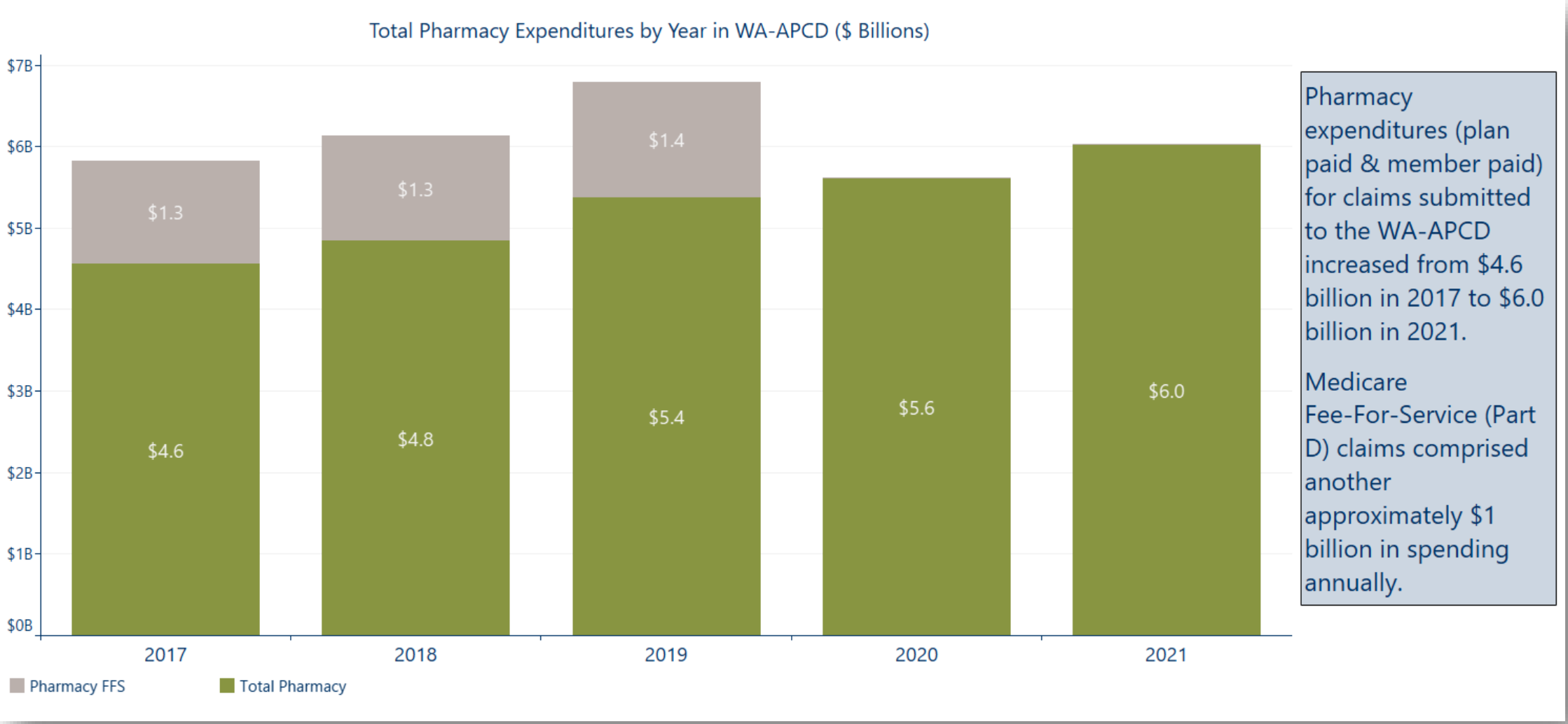
While expenditures for all categories increased between 2017 and 2021, there were some shifts in the relative spending by category.

Outpatient, other professional, and other medical spending categories increased as a percentage of total medical expenditures, while inpatient, specialist, primary care, and long-term care decreased as a percentage of total.



Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, Medicare FFS dollars, or retail pharmacy claims.

Total Pharmacy Claims Expenditures (WA-APCD)



Pharmacy expenditures (plan paid & member paid) for claims submitted to the WA-APCD increased from $4.6 billion in 2017 to $6.0 billion in 2021.

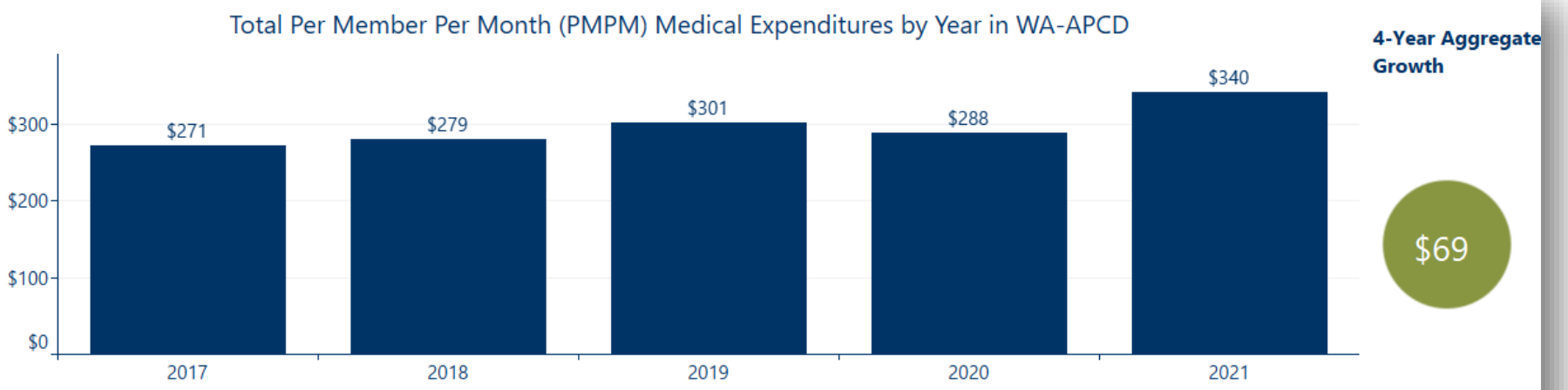
Medicare Fee-For-Service (Part D) claims comprised another approximately $1 billion in spending annually.

How Have WA-APCD Per Member Per Month (PMPM) Expenditures Changed?

Total PMPM Medical Expenditures (2017–2021)

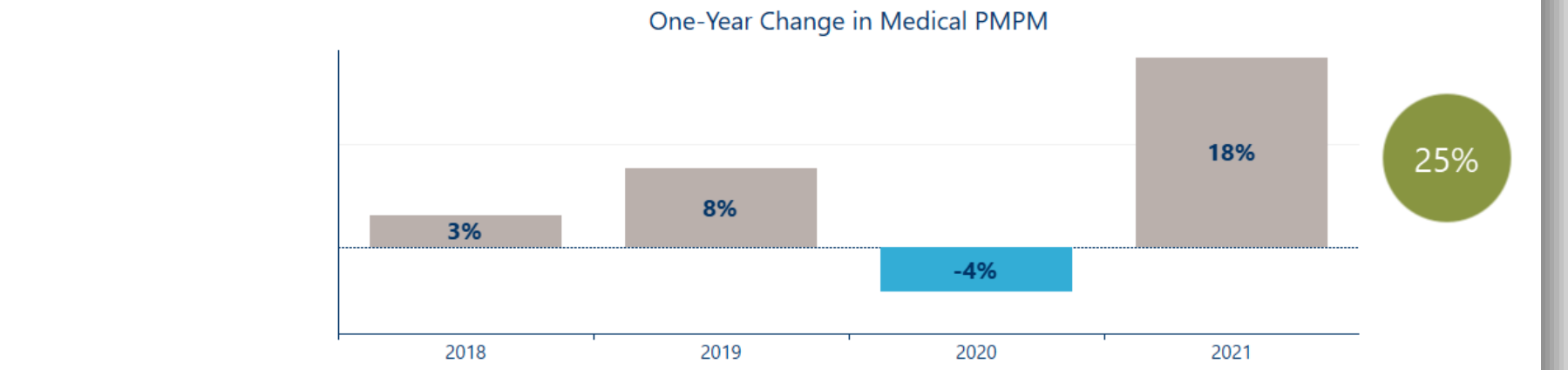
Per member per month (PMPM) is a way to adjust expenditures for the number of patients in the group.

For members in the APCD, total medical PMPMs increased from $271 PMPM in 2017 to $340 PMPM in 2021, a total of $69 PMPM.



There was a dip in PMPM spending in 2020, likely due to less use of medical care during the early days of the COVID pandemic.

Between 2020 and 2021, the rate of spending growth was much higher than other years (+18%). The total increase in medical spending between 2017 and 2021 was 25%.

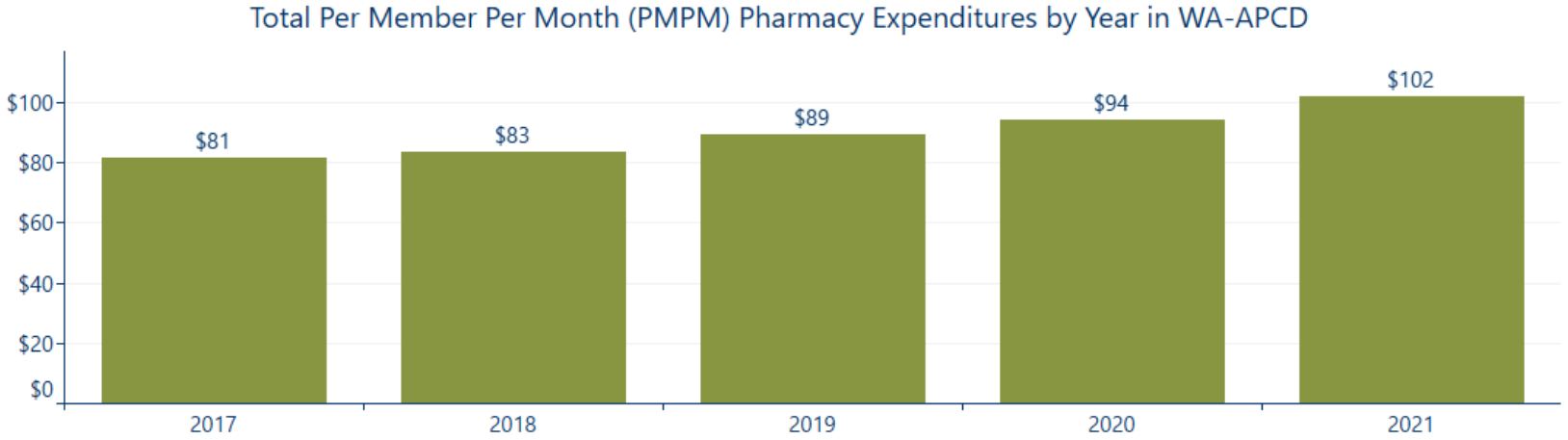


Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, Medicare FFS dollars, or retail pharmacy claims.

WA-APCD Pharmacy PMPM (2017–2021)

Per member per month (PMPM) is a way to adjust expenditures for the number of patients in the group.

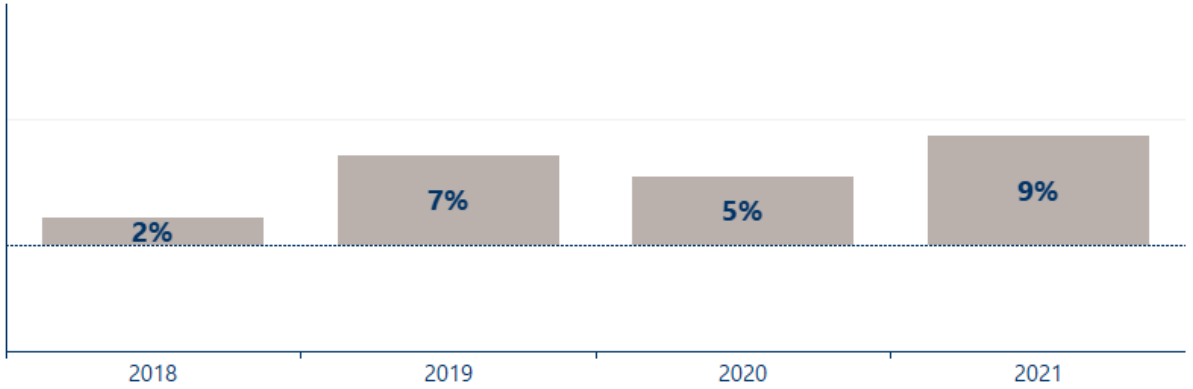
For members in the APCD (excluding Medicare), total pharmacy PMPMs increased from $81 PMPM in 2017 to $102 PMPM in 2021, a total of $21 PMPM.



4-Year Aggregate Growth

$21

Between 2017 and 2021, the rate of PMPM spending growth was 25%, similar to medical spending growth.



25%

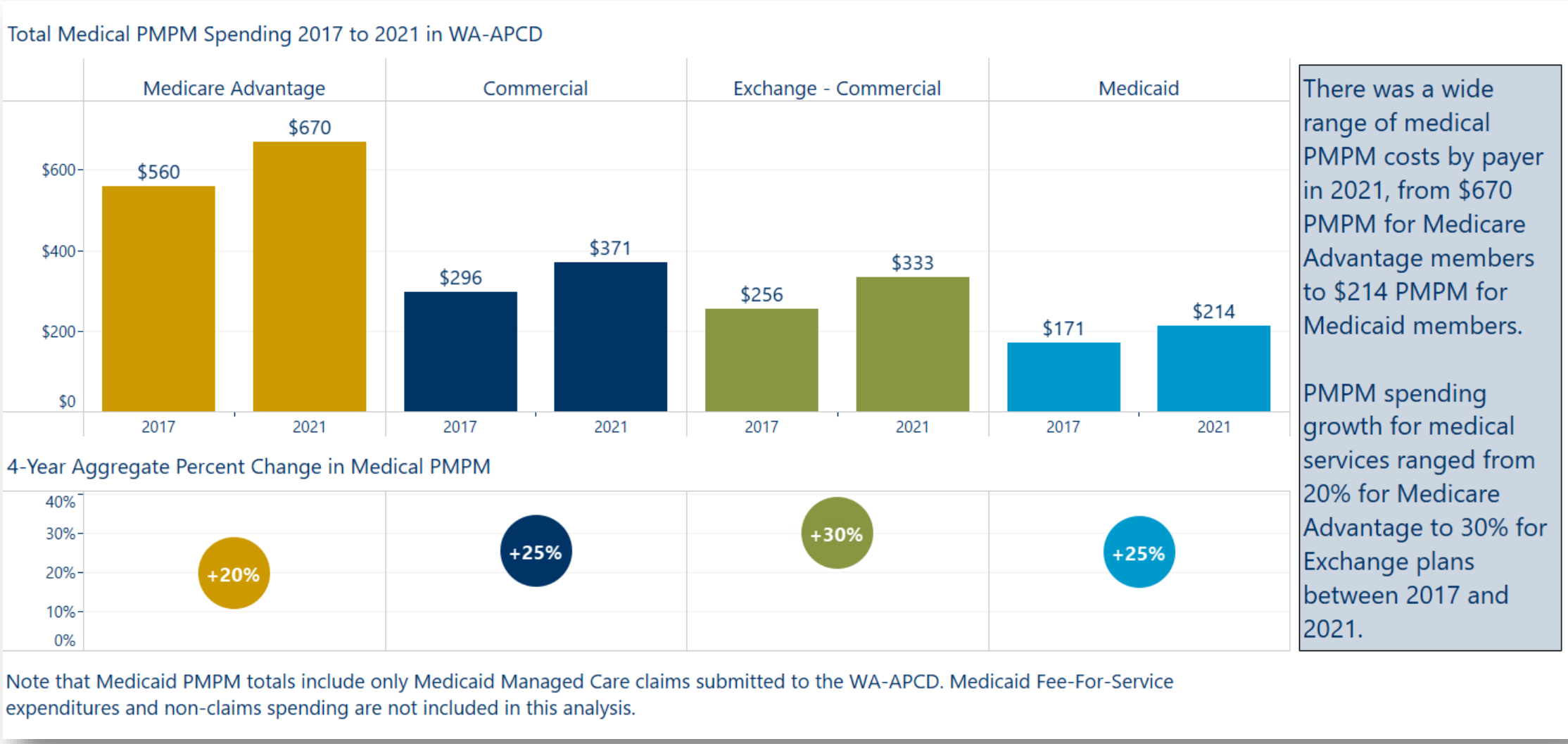
Note: These figures do not include spending for Medicare FFS or Medicare Advantage members. Retail pharmacy expenditures in this analysis are gross of rebates.

ONPOINT Health Data

Washington State Health Care Authority

Are Different Products Experiencing Different Rates of Growth?

Medical PMPM Spending by Product (2017 & 2021)

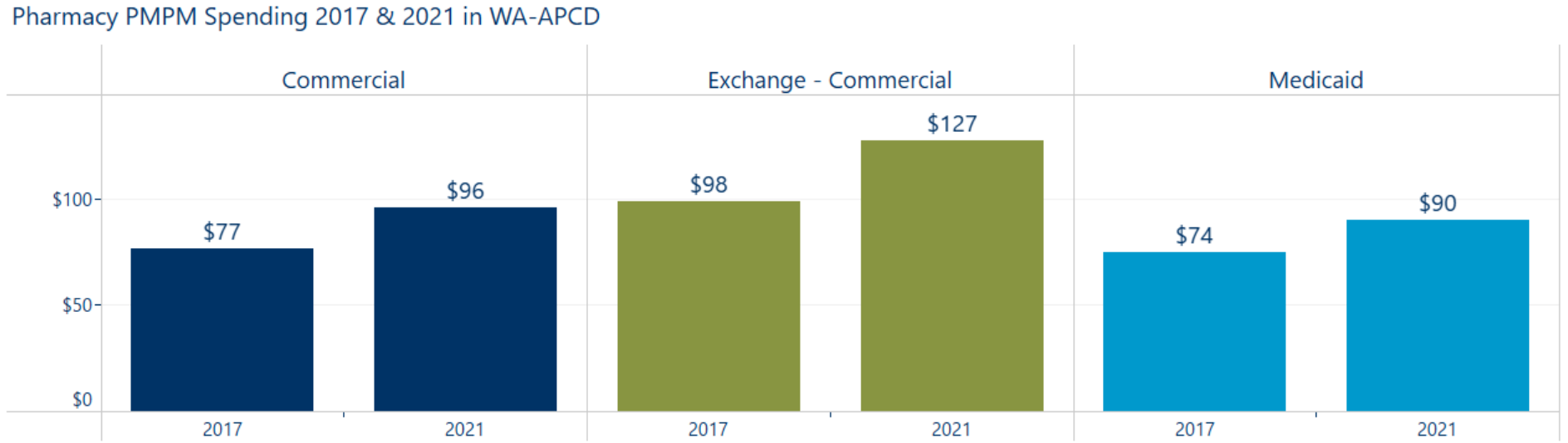


There was a wide range of medical PMPM costs by payer in 2021, from $670 PMPM for Medicare Advantage members to $214 PMPM for Medicaid members.

PMPM spending growth for medical services ranged from 20% for Medicare Advantage to 30% for Exchange plans between 2017 and 2021.

Note that Medicaid PMPM totals include only Medicaid Managed Care claims submitted to the WA-APCD. Medicaid Fee-For-Service expenditures and non-claims spending are not included in this analysis.

Pharmacy PMPM Spending by Product (2017 & 2021)



Pharmacy PMPM spending ranged from $90 for Medicaid members to $127 for Exchange members in 2021.

PMPM spending growth ranged from 21% in 2017 to 29% in 2021. The growth in pharmacy PMPM spending was similar to the growth in medical spending growth.

Note that Medicaid PMPM totals include only Medicaid Managed Care members in the WA-APCD. Medicaid Fee-For-Service members are not included in this analysis. Medicare FFS and Medicare Advantage are not included in pharmacy reporting for 2021 because Medicare Part D pharmacy data are not available for 2020 and 2021 in the WA-APCD. Retail pharmacy expenditures in this analysis are gross of rebates.

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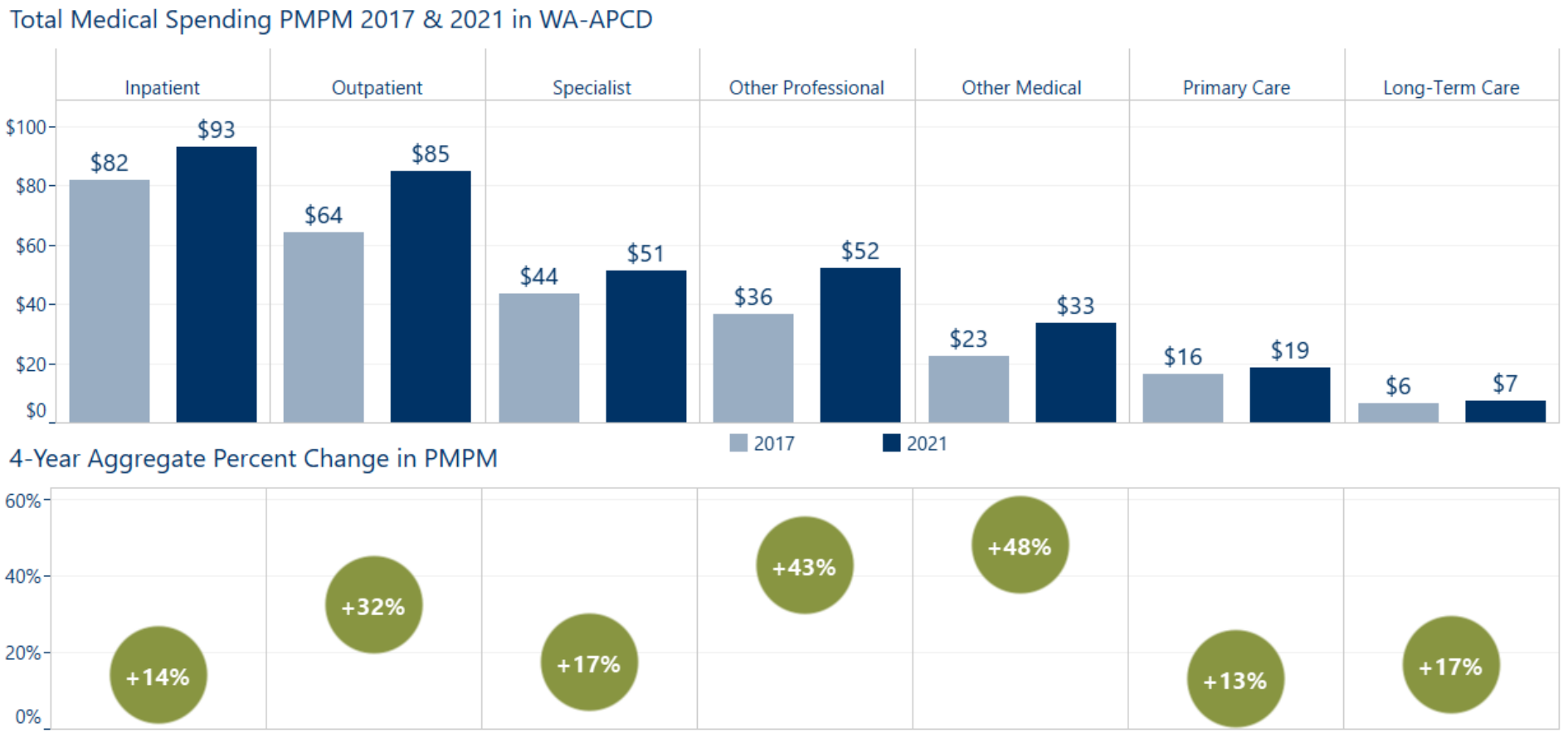
How Does Spending Growth Vary by Category?

PMPM by Category of Medical Service, All Products



Medical per member per month (PMPM) expenditures were calculated by category of spending. In 2021, spending was highest for inpatient ($93 PMPM), and outpatient ($85 PMPM) services.

The four-year aggregate percent growth in PMPM spending ranged from +13% for primary care to +48% for other medical services.

PMPM aggregate spending growth in other professional services (+43%) and outpatient services (+33%) were substantial.

Note that these data do not include non-claims payments, Medicaid long-term care, Medicaid FFS dollars, Medicare FFS dollars, or retail pharmacy claims.

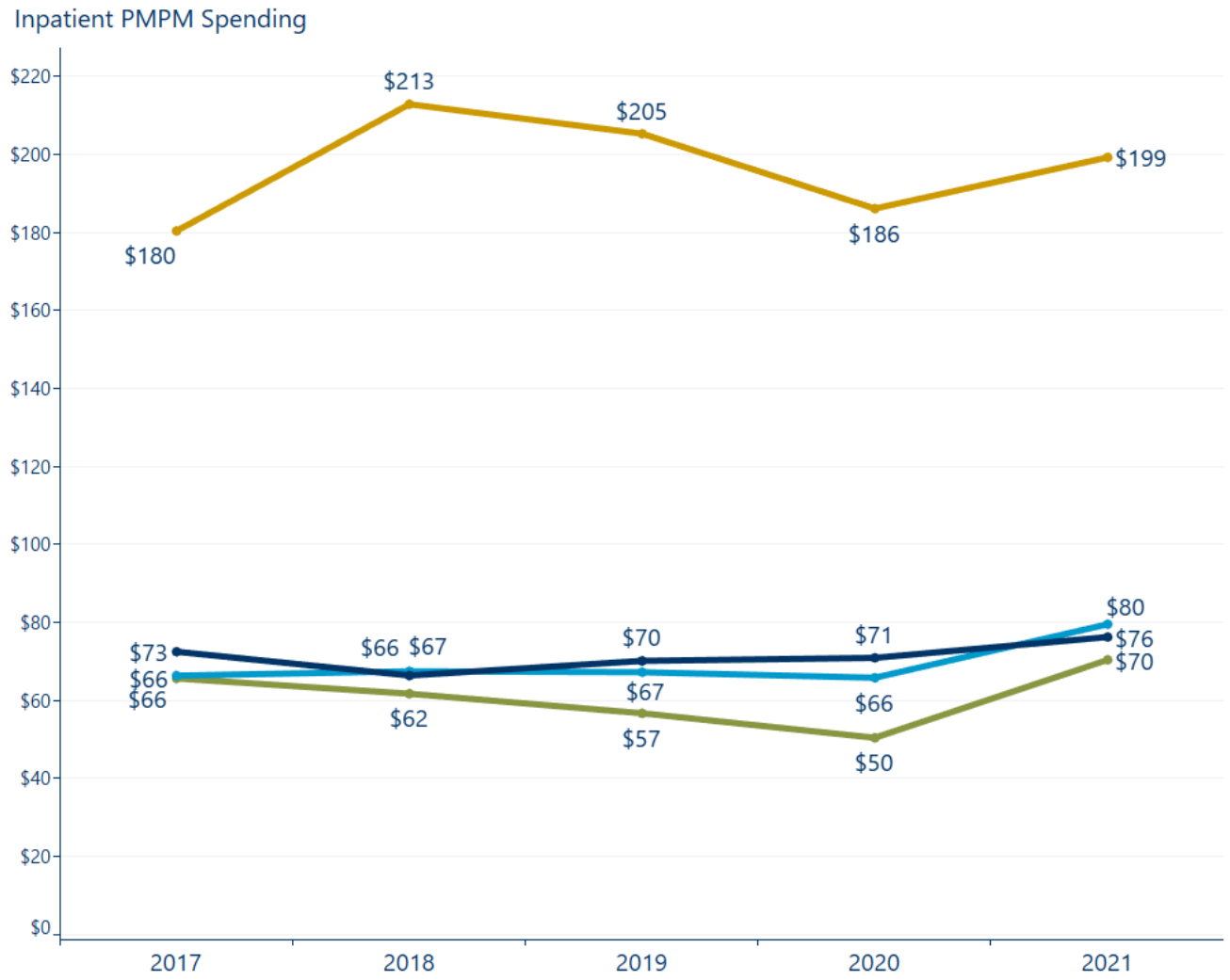
Inpatient PMPM Spending by Product

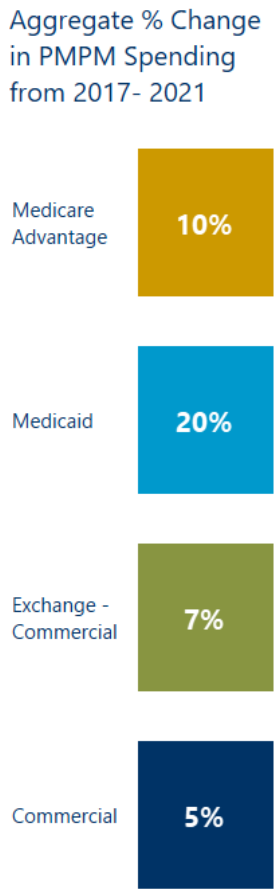
Medicare Advantage patients had the highest inpatient PMPM spending ($199 PMPM in 2021) due to the older population age.

Inpatient PMPM spending for other products ranged from $70 PMPM (Ex-change-Commercial) to $80 PMPM (Medicaid) in 2021.

Inpatient PMPM spending decreased in 2020 during the COVID pandemic but increased again in 2021 across all products.

The 4-year aggregate percent change in PMPM spending ranged from 20% (Medicaid) to 5% (commercial).

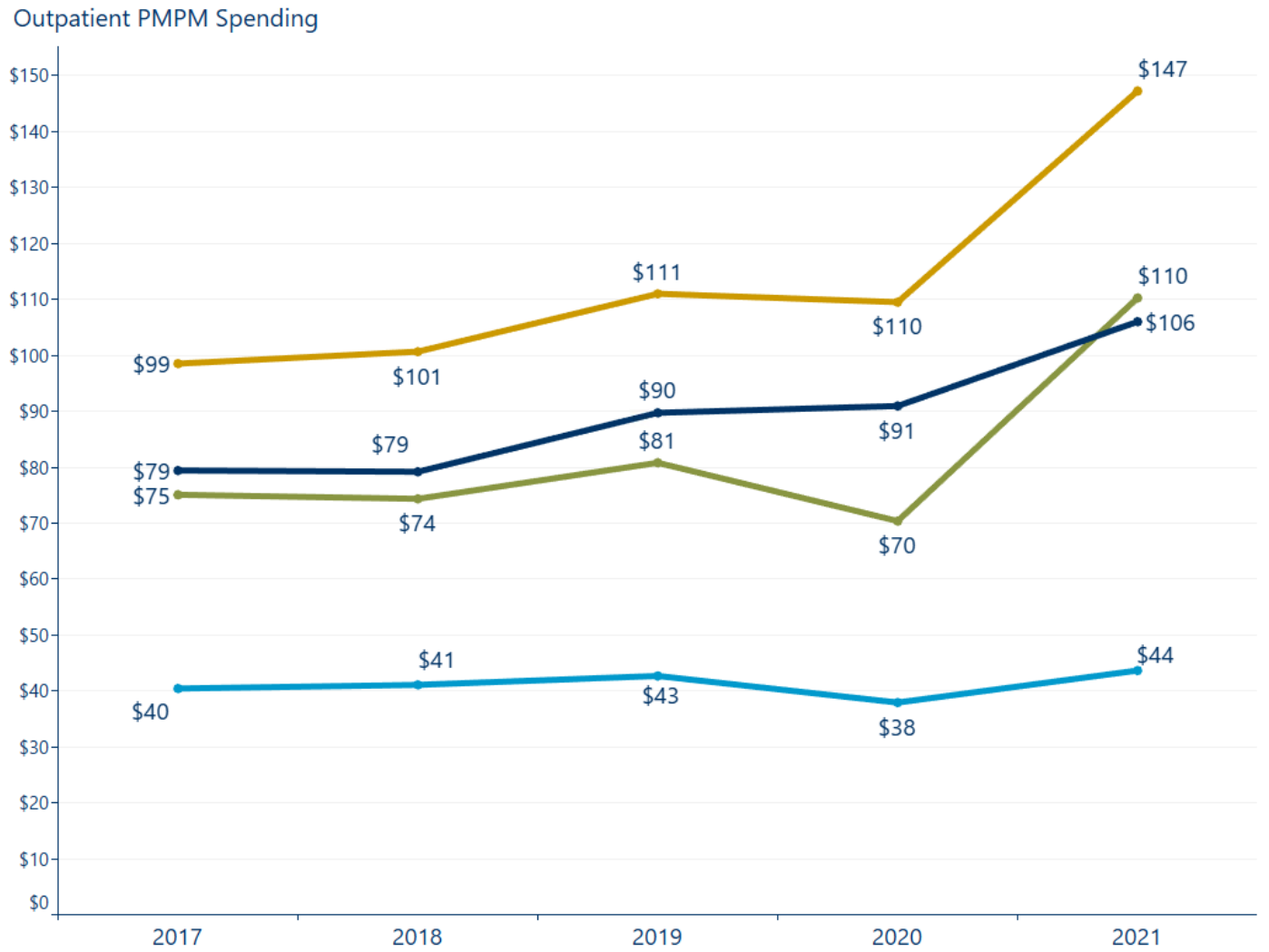


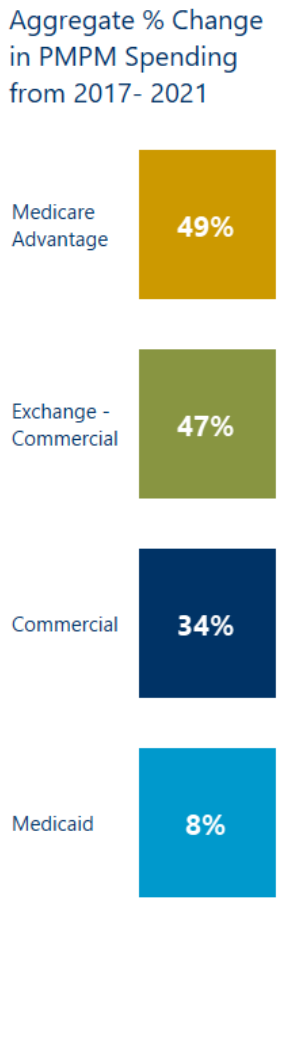


Outpatient PMPM Spending by Product

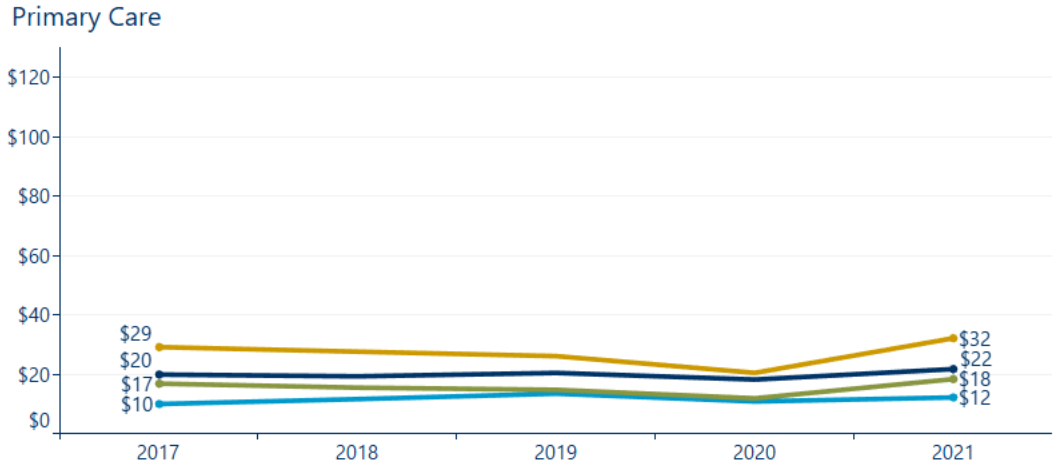
Medicare Advantage patients had the highest outpatient PMPM spending ($147 in 2021) due to the older population age. Outpatient PMPM spending for other products ranged from $44 (Medicaid) to $110 (Exchange-Commercial) in 2021.

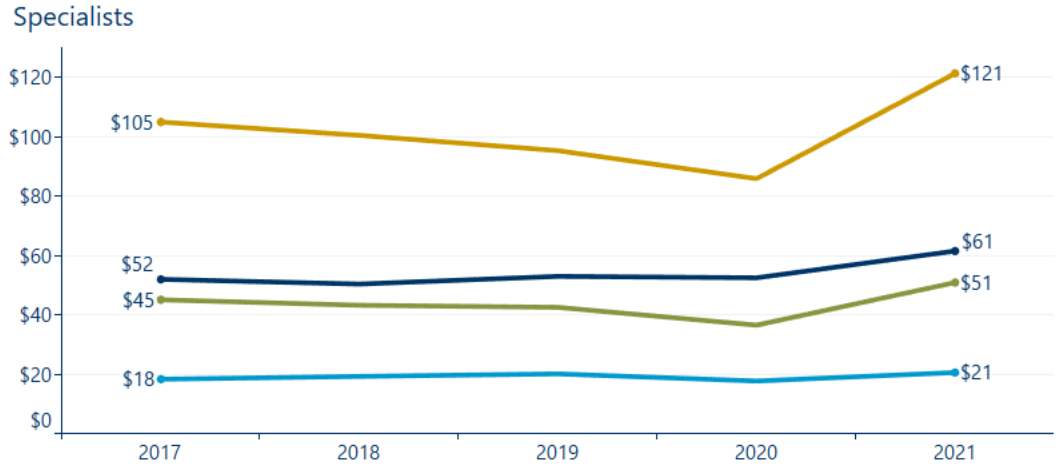
The 4-year aggregate percent change in outpatient PMPM spending ranged from 49% (Medicaid) to 8% (Medicaid).

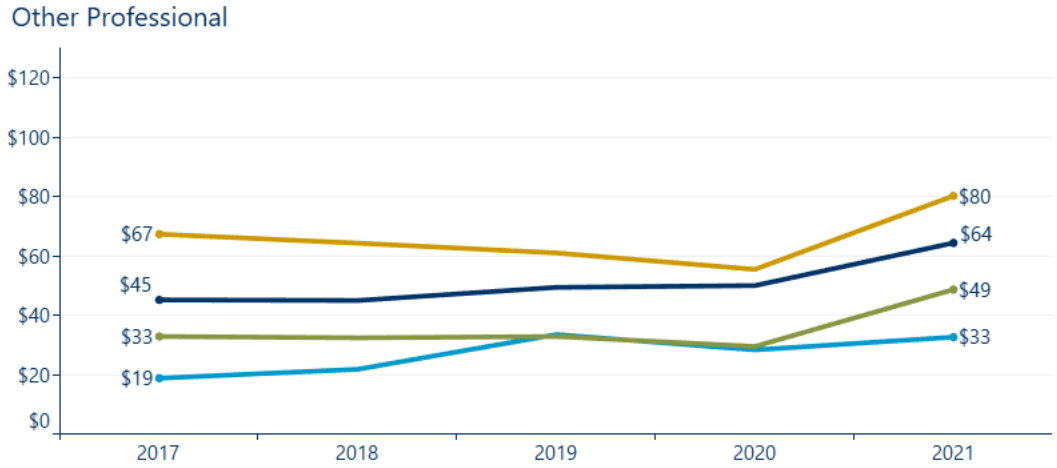




Professional PMPM Spending by Product





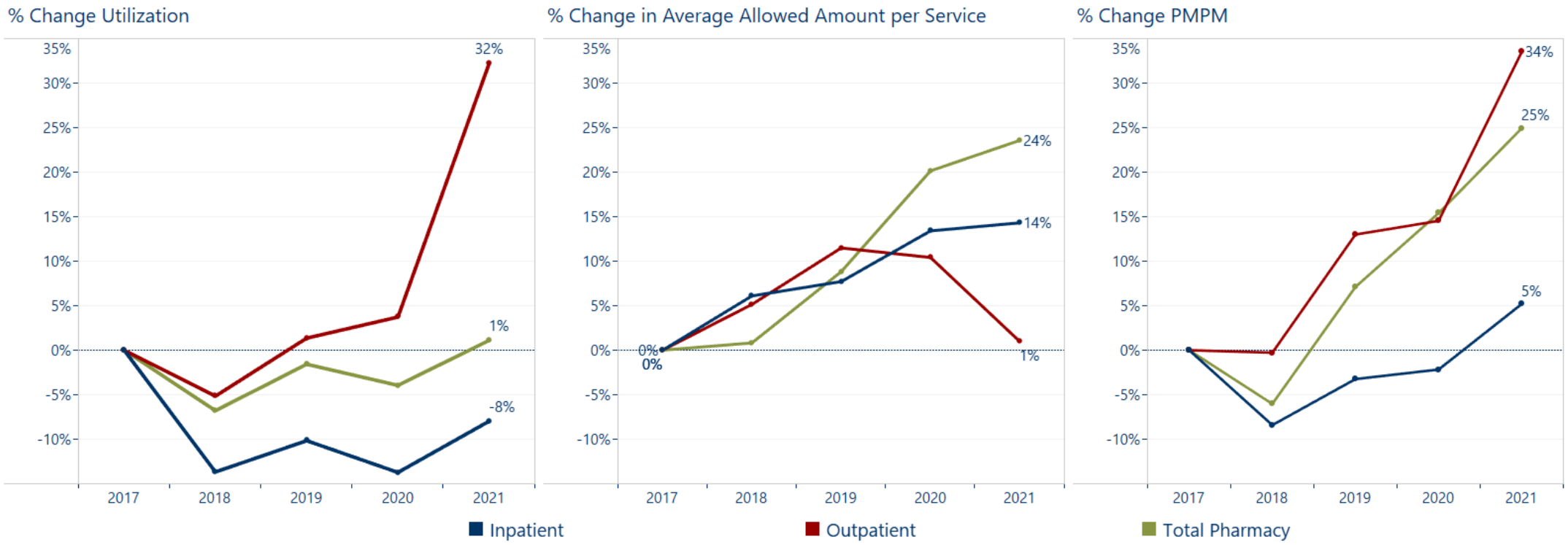


PMPM spending on the specialist and other professional categories was significantly greater than spending on primary care for all products. Fee-for-service PMPM spending for primary care services did not increase much between 2017 and 2021.

Note that the other professional category includes a diverse set of providers, including nurse practiftioners, physicians assistants, occupational therapists, counselors, etc. Facility fees for community health centers and free-standing ambulatory surgery centers also are bucketed into this category.

Medicare Advantage Commercial Exchange - Commercial Medicaid

Changes in Commercial Cost Drivers (2017–2021)



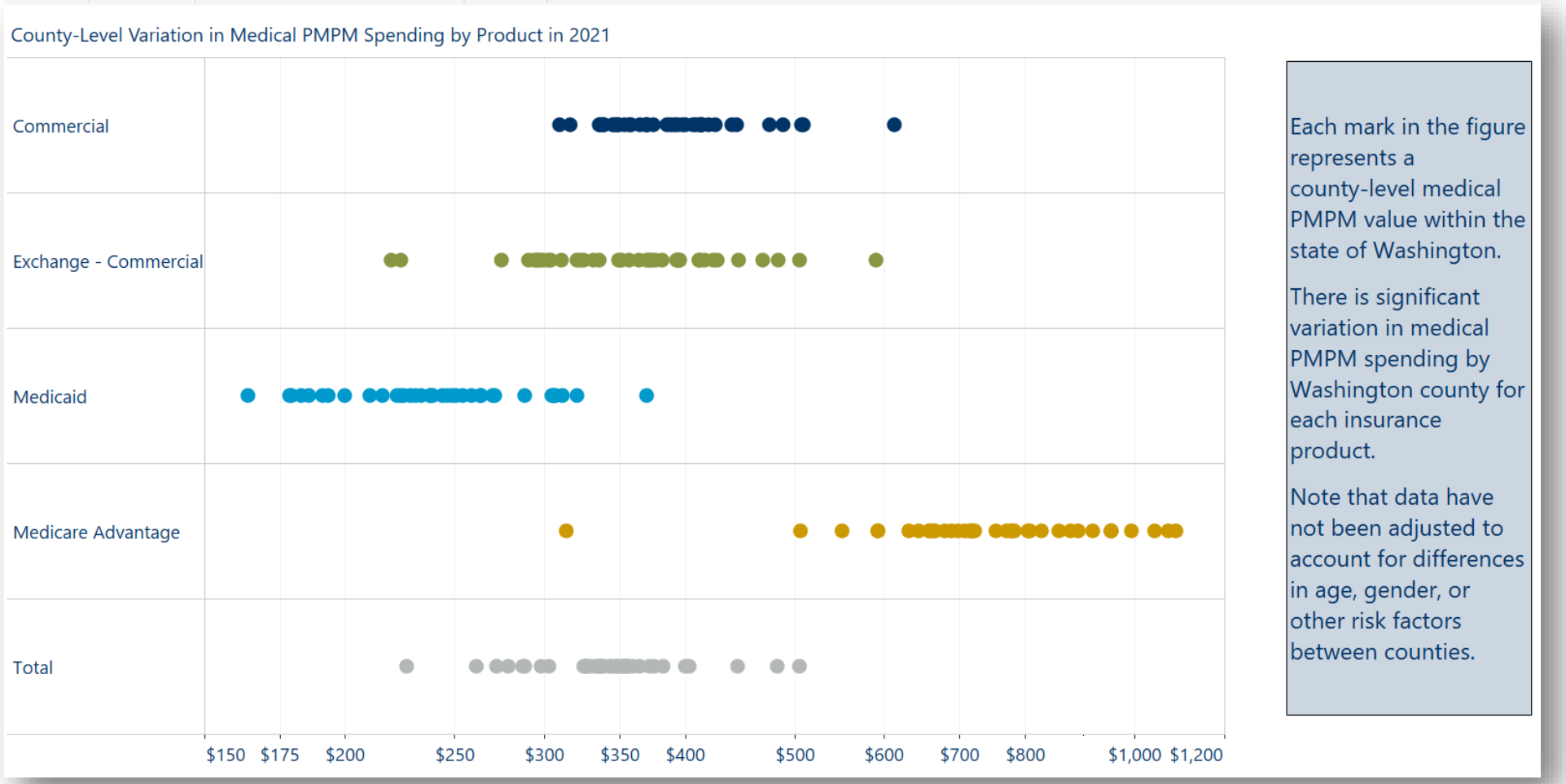
In the commercial population, outpatient spending PMPM grew by 34% between 2017 and 2021 (see graph on far right). This was driven by a 32% increase in outpatient services per 1,000 members during that time, while the average allowed amount per service grew by only 1%.

The pattern for pharmacy was much different. Pharmacy spending PMPM increased by 25% between 2017 and 2021, but this was primarily driven by an increased average allowed amount per service (24% increase), while pharmacy use per 1,000 members increased by only 1%.

Inpatient spending PMPM grew by 5% between 2017 and 2021. Allowed amounts per inpatient discharges increased by 14%, while inpatient discharges per 1,000 members decreased by 8%.

Are There Regional Differences in Spending?

Medical PMPM Spending Varies Widely by Patient County of Residence



Each mark in the figure represents a county-level medical PMPM value within the state of Washington.

There is significant variation in medical PMPM spending by Washington county for each insurance product.

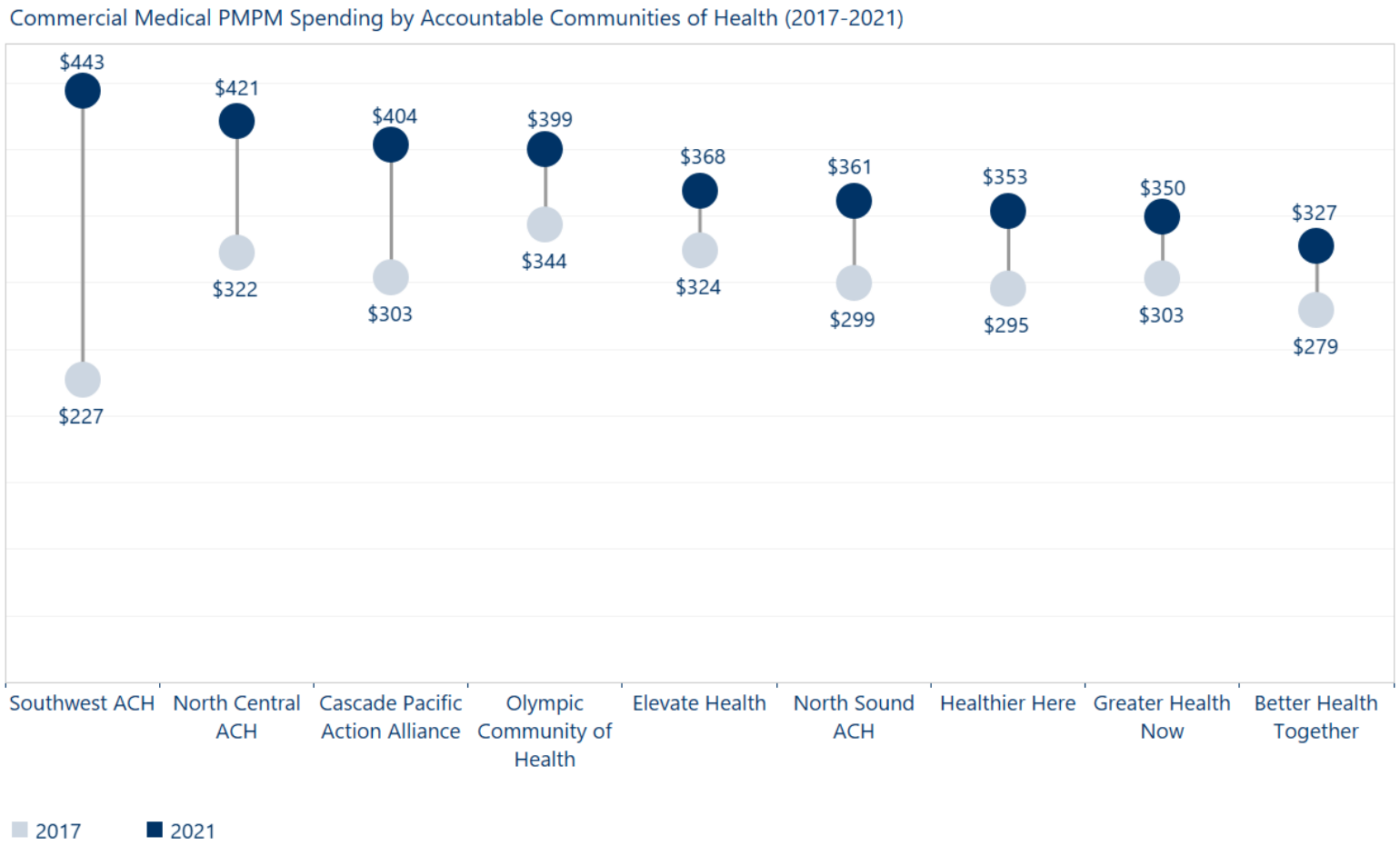
Note that data have not been adjusted to account for differences in age, gender, or other risk factors between counties.

Commercial Medical PMPM Spending, Stratified by ACH of Patient Residence, 2017 & 2021

There is significant variation in medical PMPM spending by region in Washington. For the commercially insured population, in 2021, medical PMPM spending ranged from $443 in the Southwest Accountable Communities of Health (ACH) to $327 PMPM in the Better Health Together ACH.

Regional spending may vary due to pricing as well as the age, gender, and other population risk factors.

Spending growth varied by ACH. For example, commercial spending almost doubled between 2017 and 2021 in the SW Regional Alliance Area.

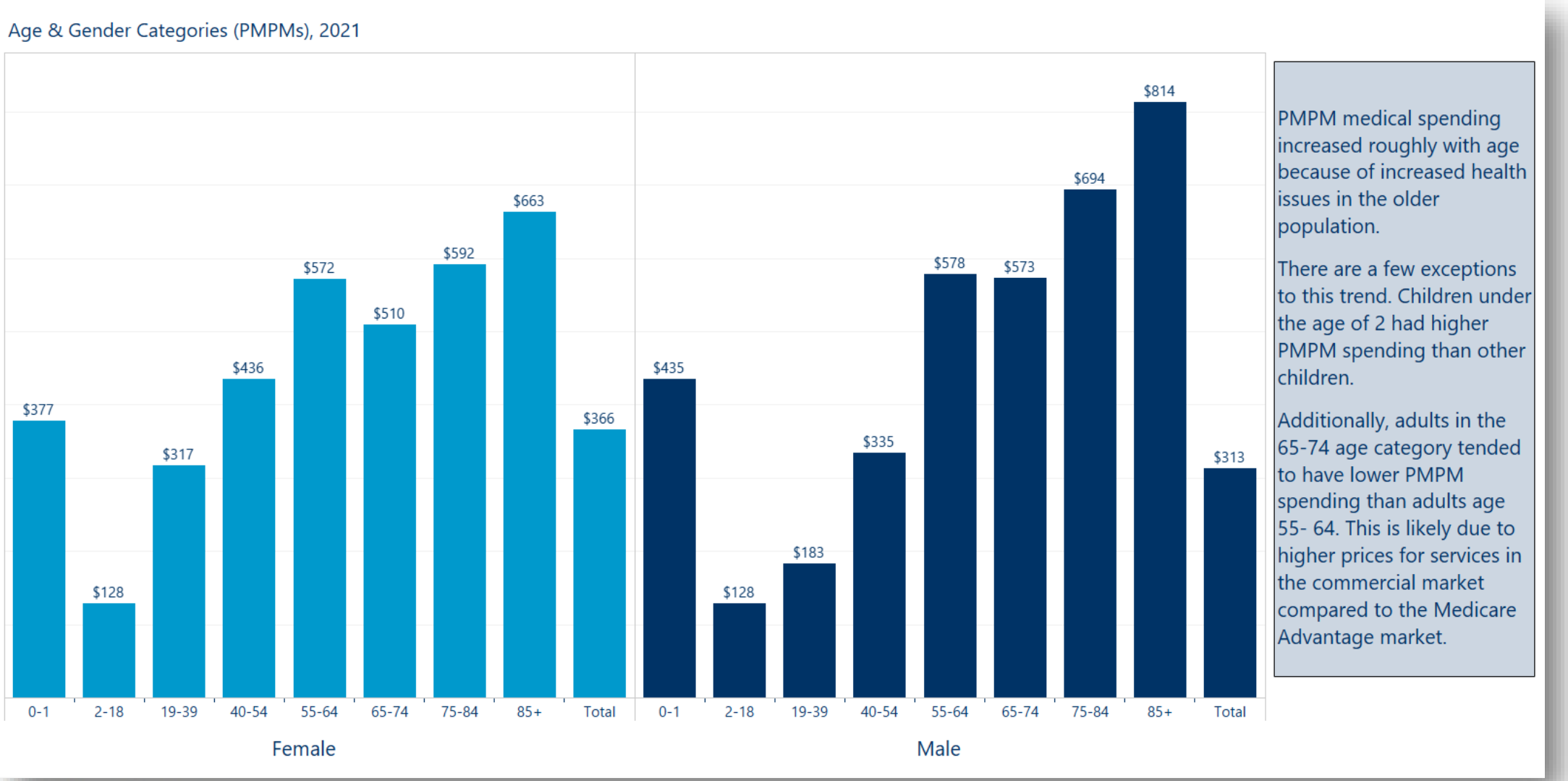


ONPOINT Health Data

Washington State Health Care Authority

How Does Spending Vary by Age & Gender?

Medical PMPM Totals by Gender & Age (Years), 2021

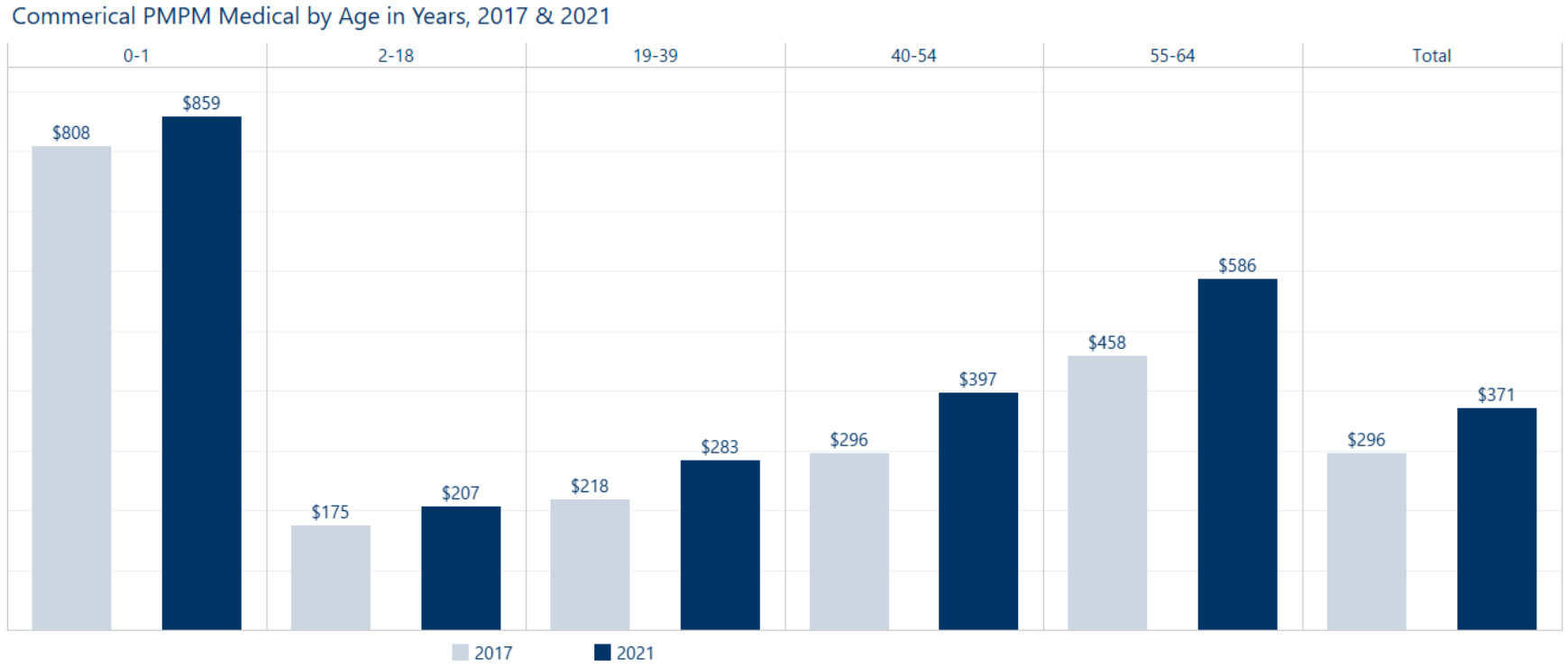


PMPM medical spending increased roughly with age because of increased health issues in the older population.

There are a few exceptions to this trend. Children under the age of 2 had higher PMPM spending than other children.

Additionally, adults in the 65-74 age category tended to have lower PMPM spending than adults age 55- 64. This is likely due to higher prices for services in the commercial market compared to the Medicare Advantage market.

Commercial PMPM Medical by Age, 2017 & 2021



For the commercially insured population (<65 years), medical PMPM spending varied from $859 in the 0-1 age group to $207 in the 2-18 age group. With the exception of the 0-1 age group, spending increased with age.

Spending growth between 2017 and 2021 was moderate in the pediatric population and ranged from 28%-34% growth in the adult population groups.

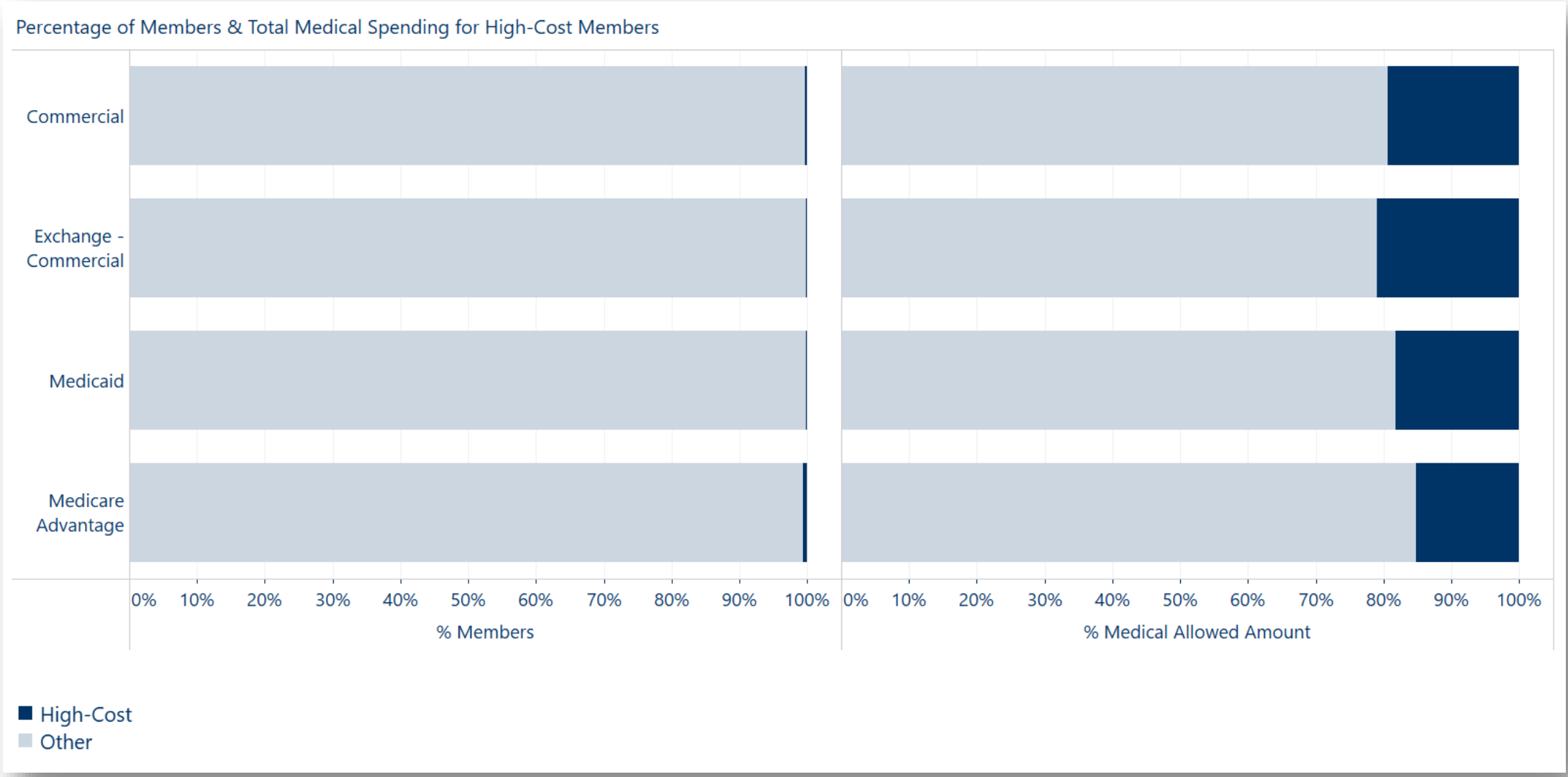
What is the Impact of High-Cost Members?

Impact of High-Cost Members on Spending, 2021

- High-cost members (>$125K medical spending) comprised less than 1% of the membership but 15% – 21% of total spending

Product	Members		Total Medical Spending		Medical PMPM	
	High-Cost	Other	High-Cost	Other	High-Cost	Other
Commercial	0.28%	99.72%	19.41%	80.59%	$22,837	$300
Exchange - Commercial	0.26%	99.74%	21.01%	78.99%	$22,907	$264
Medicaid	0.16%	99.84%	18.21%	81.79%	$24,530	$175
Medicare Advantage	0.57%	99.43%	15.23%	84.77%	$17,828	$571

Impact of High-Cost Members on Spending (cont.)



Next Steps

Next Set of Analyses – Phase II

- Drill down further into areas of growth by product, region, etc.
- How do chronic conditions impact spending and spending growth?
- How does spending for primary care and behavioral health vary across the state?
- How has out-of-pocket spending changed?
- Are there relationships between spending and quality/access to care?
- How are utilization changes impacting spending?
- How are price changes impacting spending?

Thank you.

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