Health Care Cost Transparency Board meeting

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

HEALTH CARE COST TRANSPARENCY BOARD
AGENDA

April 10, 2024
2:00-4:00 p.m.
Hybrid Meeting

Board Members:					
☐	Susan E. Birch, Chair	☐	Jodi Joyce	☐	Kim Wallace
☐	Jane Beyer	☐	Gregory Marchand	☐	Carol Wilmes
☐	Eileen Cody	☐	Mark Siegel	☐	Edwin Wong
☐	Lois C. Cook	☐	Margaret Stanley		
☐	Bianca Frogner	☐	Ingrid Ulrey		

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome and roll call	1	Sue Birch, Director Health Care Authority
2:05-2:10 (5 min)	Approval of the February Meeting Summary	2	Sue Birch, Director Health Care Authority
2:10-2:20 (10 min)	Public Comment	3	Mandy Weeks-Green Health Care Authority
2:20 – 2:40 (20 mins)	Legislative updates (related bills, challenges, etc.)	4	Evan Klein, Health Care Authority & Jane Beyer, Office of the Insurance Commissioner
2:40 – 2:45 (5 min)	Update on 1508	5	Rachelle Bogue Health Care Authority
2:45– 3:45 (60 min)	Presentation: Medical Debt in America -Q&A / Discussion	6	Noam Levey, Senior Correspondent, KFF Health News
3:45 – 4:00 (15 min)	Next steps: • Discussion on strategy with the Board following medical debt presentation • Overview of policy selections from Retreat • Draft workplan and proposed sequence based on what/when data is available	7	Facilitator: Gary Cohen, Health Management Associates
4:00	Wrap Up and Adjourn The Board's next meeting is May 15, 2024, 2-4 PM		Sue Birch, Director Health Care Authority

Unless indicated otherwise, meetings will be hybrid with attendance options either in person at the Health Care Authority or via the Zoom platform.

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

February 9, 2024

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
10 a.m. – 3:30 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
Jane Beyer
Eileen Cody
Lois Cook
Bianca Frogner
Greg Marchand (remote)
Mark Siegel
Margaret Stanley (remote)
Ingrid Ulrey
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Jodi Joyce

Call to order

Sue Birch, Board Chair, called the meeting to order at 10:02 a.m.

Agenda items

Welcoming remarks

Chair Sue Birch welcomed members of the Health Care Cost Transparency Board (the Board) to their in-person retreat. After conducting roll call, to recognize Black History Month, Chair Birch introduced a new book, *Blacks in Thurston County, Washington*, highlighting the stories and contributions of Black Washingtonians in the South Puget Sound. Members of Health Management Associates (HMA), Liz Arjun, Gary Cohen, and Craig Schneider, have been recently contracted to facilitate meetings and the decision-making of the Board. Finally, the agenda was reviewed and **approved unanimously**.

Washington State Health Care Authority

Meeting summary review from the previous meeting

The Board **voted by consensus to adopt** the December 2023 meeting summary.

Washington Health Care Affordability Reports

Office of the Insurance Commissioner's Preliminary Report

Jane Beyer, Senior Health Policy Advisor, Office of the Insurance Commissioner (OIC)

In the 2023 budget, the Legislature directed the OIC to evaluate the structure and business of the health care industry in Washington to improve affordability. OIC's preliminary report, produced by HMA, includes information about vertical and horizontal consolidation of health insurers, hospitals, health care providers, and private equity (PE) investment trends. Survey data indicates that 81% of Washingtonians are worried about affording health care in the future. Employers struggle to provide health care for their workforce, and more that 20% of the Washington general fund budget is spent on health care.

There is vertical integration among insurers where insurers are actively purchasing physician groups and clinics. Private equity acquisitions are also a growing national trend. Between 2014 and 2019, there were 97 health care acquisitions in Washington State by PE firms operating across numerous states. A recent review of 55 studies found that PE ownership was most consistently associated with increased costs to patients/payers and mixed-to-harmful impacts on quality of care.

The OIC identified several affordability policy options, including cost growth benchmarks, and health insurance rate review with cost caps on specific services. Reinsurance programs implemented in other states have lowered premiums between 5%-38%. Other options include reference-based pricing, facility fee reform, medical loss ratio requirements, public option plans, and prescription drug pricing regulation. Next steps include discussing policy options with stakeholders and Legislators to identify which to investigate further, followed by an in-depth economic and actuarial analysis on selected policy options and key informant interviews. The OIC's final report is due August 1, 2024.

Office of the Attorney General's Healthcare Affordability Preliminary Report

Kelly Richburg, Senior Health Policy Advisor, Office of the Attorney General (AGO)

The Attorney General's Office produced a preliminary report that examines the impact that consolidation and anticompetitive practices have on health care affordability by comparing what is done in Washington to what is done in other states. Consolidation of health care entities is associated with increased patient prices, but with no significant improvement in quality of care. Furthermore, it has historically led to suppression of wage growth and poorer working conditions for employees working in the health care sector. While Washington is able to review a wide variety of transactions to review harm to competitiveness, there is no consideration specific to affordability and no approval authority.

Since 2020, Washington requires 60-day notice of all health care mergers and acquisitions for review from the perspective of the federal Consumer Protection Act. This law covers hospital and provider networks with no minimum revenue threshold but does not cover physician groups with fewer than seven providers, does not consider quality or affordability impact, and has no public involvement. State Attorneys General in Massachusetts, California, and Oregon have more extensive powers to halt transactions, allow for public review, and impose conditions. In the current legislative session, SB 5241, the Keep Our Care Act, seeks to expand transaction review and address certain anticompetitive contract clauses in Washington.

Board members discussed these reports, seeking clarification of the pace and longevity of health care consolidation in Washington. While specific analysis is still ongoing on the extent and impact, it has been reported that there has been a six-fold increase in PE acquisition nationally over the last ten years. The contents of SB5241 were discussed, noting that beyond affordability, transactions are assessed regarding access to reproductive, end-of-life, and gender-affirming care.

Washington State Health Care Authority

Policy Discussion Panel

David Seltz, Executive Director, Massachusetts Health Policy Commission (HPC)
Cory King, Acting Health Insurance Commissioner, Rhode Island Office of the Health Insurance Commissioner (OHIC)
Sarah Bartelmann, Cost Growth Target & Health Care Market Oversight Program Manager, Oregon Health Authority (OHA)

Beginning in 2006, Massachusetts (MA) passed legislation with the goal of universal coverage, and shortly thereafter moved to consider cost containment as an important focus. Premiums, out-of-pocket costs, and deductibles were a concern for both employers and consumers. In 2012, the state established the first program to set a health care spending benchmark. Working with the state data repository, the Center for Health Information and Analysis, spending growth and health care quality are investigated to craft and propose legislation to realize cost savings. The HPC is able to convene an annual Cost Trends Hearing to hear from health care CEOs regarding spending growth trends, monitors markets, and implement experimental policy programs to curb growth. Since the program's implementation, Massachusetts has realized rates of growth below the national average in eight of the nine years of monitoring, saving approximately $8 billion over that span.

For the past 20 years, Rhode Island's Office of the Insurance Commissioner (RI-OIC) has housed a dedicated Office of Health Insurance Commissioner (OHIC) charged with policy reform and regulatory enforcement of the health insurance industry. Insurance rate review is a significant portion of the office's work, with affordability and access integral to the process. While the HPC has a board of citizen experts which implement their benchmark, the RI-OIC has a steering committee of insurers and stakeholders working to contain cost growth, as well as study value-based payment and data use methodology. The steering committee is a public-private partnership, so agreeing on goals and strategy can be challenging. Policy discussions happen in an open forum. OHIC has in place numerous levers to control cost growth including insurance plan rate review, a hospital price growth cap, and a primary care investment target. Public interactive dashboards, one-pager "data stories", and full reports are tools used to investigate and engage Rhode Islanders around issues of health care cost growth.

The Oregon Health Authority's Cost Growth Target & Health Care Market Oversight Program was modeled on much the same approaches pioneered by states like Massachusetts and Rhode Island. An advisory group comprised of 50% payer and provider membership helps craft policy proposals, and early on settled on value-based payment models to achieve control of cost growth. This evolved into the advanced value-based payment compact, which currently has 63 signatories representing 70% of covered lives in Oregon (OR). In the wake of the COVID-19 pandemic, the effectiveness of this voluntary approach is under discussion as compared to more direct, authoritative approaches to control cost. Initial work of the Pharmacy Drug Affordability Board and Transparency Board were not able to settle on specific policies in 2023 to curb drug costs, but efforts are ongoing. Factors holding back recommendations include a need for more data and subject matter expertise. Performance Improvement Plans (PIPs) and financial penalties for entities consistently missing the cost growth target are levers available to Oregon under current statute. Balancing issues of solvency with penalties levied to providers at meaningful levels is a challenge. Finally, oversight of mergers and acquisition is another power available to Oregon.

Discussion between members of the Board and the panel touched upon many subjects. Value-based payment and other cost-containment efforts face a difficult market landscape at the moment due to the pandemic and providers and payers lacking incentive to fundamentally change the system. It was noted that spending on primary care has been diminishing in recent years in opposition to the efforts of government entities in many states. A gap in transparency was identified in older cost-containment programs, where exits from insurance markets were not always understood in terms of reasoning, and sometimes were found to be examples of new models of mergers being utilized to avoid public scrutiny. PIP methodology was also discussed, comparing differences between how they are conceptualized and implemented in MA and OR. Massachusetts implemented their first PIP in 2022 for a large hospital system. The design of the plan involved many rounds of discussion and seems to be yielding promising results, saving up to $180M over the course of 18 months. The Board discussed

efforts to improve interstate collaboration on cost growth work, including working with OR to synchronize on market review efforts for provider and payer entities which have footholds in both OR and Washington.

Legislative Session Update

Evan Klein, Special Assistant for Policy and Legislative Affairs, HCA
Mich'l Needham, Chief Policy Officer, HCA
Jane Beyer, Senior Health Policy Advisor, OIC
Ingrid Ulrey, Chief Executive Officer, Washington Health Benefit Exchange (HBE)

The Washington Legislature is currently in the middle of a short 60-day session and a number of bills under consideration were reviewed. Firstly, HB 1508, sponsored by Rep. Nicole Macri in the previous session, was meant to increase the enforcement authority of the Cost Board, but has been pared back in this session. No longer including language regarding the levying of penalties for missing cost growth benchmarks, the bill focuses on expanding the membership of the Advisory Committee on Providers and Carriers to include representation from consumers and labor. It would shift the Board's legislative report delivery from August to December and allow for public hearings about the findings. SB 5241 would establish a stronger regulatory review framework within the AGO for mergers and acquisitions, focusing on cost and coverage. SB 5213 would look at pharmacy benefit managers from the standpoint of affordability. There are continuing legislative efforts around balance billing, behavioral health funding, and Apple Health (Medicaid) expansion.

Additional discussion was led by Jane Beyer, specifying that current legislative efforts around balance billing are honing in on ground ambulance services. Ensuring residential substance use treatment coverage is being worked on, with additional efforts to ensure mental health parity. Key legislation for the HBE has centered on a bill that works to improve access to plans with standardized administration, which have been shown to hold down costs to consumers.

Policy Option Discussion to Lower Costs and Improve Affordability

Liz Arjun, HMA
Gary Cohen, HMA

A variety of policy options that the Board can evaluate fall on spectrums of complexity, impact, and timeline. To settle on policies that could ultimately be recommended to the Legislature, HMA facilitated a discussion of policy options and decision making with the Board. Options discussed include:

- Limiting Facility Fees
- Balance Billing Protections
- Restricting Anti-competitive Contracting
- Increased Hospital Price Transparency
- Community Benefit Transparency
- Mergers and Acquisition
- Limiting Out-of-Network Charges
- Strengthening Rate Review Authority
- Administrative Simplification
- Spread Pricing/Pharmacy Benefit Manager Reform
- Private Equity Purchasing of Health Care Providers
- Provider Rate Setting
- Price Growth Caps
- Global Budgets
- Reference-based Pricing
- Further Consolidate and Expand State Purchasing

(Expected policy impacts are organized in a table at the end of this meeting summary)

Approaching how to prioritize the policy options led to a good discussion of incremental change, equity, and what prioritization means. Factors of viability and impact include Employee Retirement Income Security Act of 1974 (ERISA) restrictions, legislative cycle, and whether options are already being considered and advocated for elsewhere at the state or national levels. True cost savings should be prioritized rather than cost shifting, and there was skepticism about the impact that consolidation review would have in Washington when the health care marketplace is already fairly consolidated. Ideally, the mix of policy options to investigate and consider over the next year would be comprised of a mix of short- and long-term and higher- and lower-complexity. After a round of voting personal preference by each member of the Board, **the policies agreed upon** were simplified, merged due to significant overlap, and tallied to four primary and two secondary focuses as follows:

Primary Focus

- Restricting Anti-competitive Contracting (7 votes)
- Limiting Facility Fees (8 votes)
- Private Equity Purchasing of Health Care Providers + Mergers and Acquisition (combined 7 votes)
- Provider Rate Setting + Price Growth Caps (combined 9 votes)

Secondary Focus

- Increased Hospital Price Transparency (4 votes)
- Community Benefit Transparency (4 votes)

Moving forward, analysis will be examined by the Board and support given to the efforts of other government agencies and Washington's Universal Health Care Commission.

Discussion of Committees, Charters, and Expectations

Liz Arjun, HMA

With the workplan for 2024 and policy preferences chosen, charters for the established committees of the Board can be created to ensure that meaningful work is being done to support decision making. Furthermore, board members were encouraged to step into leadership roles in the committees to help guide and align the work with the Board's goals and timeline. Those interested would be able to reach out to staff.

Data Call 2024

Sheryll Namingit, Health Economics Research Manager, HCA

The call to carriers for aggregated data spanning from 2020 to 2022 is to be sent out on February 12, with responses expected within 60 days. Data is expected to be validated through July, followed by analysis of the data that will result in individual reports shared with carriers and providers. The final results will be presented to the Board by December, summarizing cost growth of these entities against the benchmark set in 2017 to 2019.

Public comment

Chair Sue Birch called for comments from the public.

Drew Oliveira, the Executive Director of the Washington Health Alliance (WHA), provided an overview of the efforts of the organization, including supporting Primary Care and Alternative Payment Models. Investigating Fair Hospital/Facility Pricing and Pharmacy Costs will be key to their goals of championing high quality, affordable care in Washington.

Elizabeth Mitchell, CEO of Purchaser Business Group on Health and board member on the California Office of Health Care Affordability, spoke about early efforts to support health care affordability in California, including setting an initial cost growth benchmark. Support for Centers of Excellence and Primary Care have been early successes, holding down costs in both urban and rural locations.

Jed Shepherd of the Washington Medical Association extended thanks for the Board's prioritization of alleviating administrative burden in their efforts to control health care costs, noting that beyond higher costs, small practices encumbered by this burden have driven some of the consolidation discussed at the retreat.

Written public comments can be found in the meeting materials.

Adjournment

The meeting was adjourned at 3:15 p.m.

Washington State Health Care Authority

Policy Options and Voting by the Board at the February Retreat

	Policy	Magnitude of Impact	Complexity for Development & Implementation	Term of Goal	Current Policy Efforts Underway	Final Votes	Selected for Study
	Limiting Facility Fees	Low to overall costs, High to purchases and consumers	Low	Short-term	Covered in OIC report, HB2378	8	**X**
	Balance Billing Protections	Low to overall costs, High to purchases and consumers	Low to Medium	Short-term	SB5986, protecting consumers from out-of-network charges	0	
	Restricting Anti-competitive Clauses in Contracting	Significant impact on costs and spending	Low to Medium	Short-term	AG's report and SB2066, Affordability through Provider contracting	7	**X**
	Increase Hospital Price Transparency	Medium to consumers	Low to Medium	Short- to medium-term	Federal action needed, but CMS is reviewing	4	
	Community Benefit Transparency	Medium to consumers, does not address costs	Low	Short- to medium-term	None	3	
Merged	**Mergers and Acquisition**	Significant	Medium	Medium-term	Covered in OIC report, and SB5241 Keep Our Care Act	7	**X**
Merged	**Private Equity Purchasing of Health Care Providers**	Lower impact, does not address cost	Medium	Medium-term	None		
	Limiting Out-of-Network Charges	Medium to cost, Significant to purchasers and consumers	Medium	Medium-term	Strengthens Balanced Billing efforts	2	
	Strengthening Rate Review Authority	Medium impact on cost, medium to purchasers and consumers	Medium to High	Medium-term	Covered in OIC report	0	

	Administrative Simplification	Medium impact	Medium	Medium-term	Being studied by the Universal Health Care Commission, considered at state and federal level	3	
	Spread Pricing/Pharmacy Benefit Manager Reform	Medium to cost, Significant to purchasers and employers	Medium	Medium-term	SB5213, Studied by Prescription Drug Affordability Board	1	
Merged	**Provider Rate Setting**	Significant impact on costs and spending, potentially significant impact for purchasers and consumers	High	Longer-term	Included in OIC report	2 + 7 **9**	**X**
	Price Growth Caps	Significant impact on costs and spending, significant impact for purchasers and consumers	High	Longer-term	Included in OIC report, Cascade Care uses this mechanism		
	Global Budgets	Significant impact on costs and spending	High	Longer-term	Included in OIC report	0	
	Reference-based Pricing	Significant impact on costs and spending	High	Longer-term	Included in OIC report	2	
	Further Consolidate and Expand State Purchasing	Significant impact on costs and spending	High	Longer-term	None	4	

Tab 3

Washington State Health Care Authority

Public comment

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Health Care Cost Transparency Board

Written Comments

Received Since Last Meeting

Written Comments Submitted by Email

1. Washington State Hospital Association
2. Washington State Medical Association

Comments Received at the February Meeting

The Zoom video recording is available for viewing here:
https://www.youtube.com/watch?v=Yz4lKNESq70

Washington State Hospital Association

March 29, 2024

Dear Members of the Health Care Cost Transparency Board (Board),

The Washington State Hospital Association (WSHA) supports the Board's work to address our shared goal in understanding health care spending and promoting affordability while maintaining appropriate, effective, and accessible health care.

At the retreat in February, the Board focused on ways the state might be able to address health care costs and selected policy options to review in 2024. These policy options were presented to the Data and Health Care Provider and Carrier advisory committees at their joint meeting in March. Members were asked what resources, and what information from those resources, would be helpful for the Board in its review.

Members from both committees shared concerns about the lack of Washington-specific data and questions about the effectiveness of the policies if imposed in Washington.

Policy options should consider their potential impact on access to care and support for a robust health care workforce:
Most of the options under consideration focus primarily on hospitals and health systems. Unlike other health care organizations, such as insurers, 55% or more of hospital operating costs are attributable to labor.[1] Direct care cannot be provided without physicians, nurses, and health care techs. It is important to hospitals and Washington policymakers to maintain a robust and well compensated health care workforce. Washington hospital employee compensation costs increased 16% between 2022 and 2023[1]. Washington has the fifth highest paid registered nurses in the United States.[2]

Washington hospitals had a -5% operating margin in 2023 and a -7% operating margin in 2022[1]. Given the negative margins and the high proportion of operating costs attributable to labor, limiting costs and cost growth without reducing direct care services is likely infeasible.

When considering policy options, the Board should always ask whether the policy will negatively impact access to care or the health care workforce.

Policy options should focus on health care cost drivers:
To effectively curtail health care costs, policy options should focus on health care cost drivers. The OnPoint cost driver analysis found that hospital outpatient services, pharmacy, and hospital inpatient services were the key cost drivers of commercial spending. Growth in outpatient services was driven by increased utilization (in part due to years of cost containment policies that encouraged movement of inpatient services to less costly outpatient settings), growth in inpatient services was effectively flat, and growth in pharmacy services was due to price increases. The policy options selected by the Board do not address these drivers.

Policy options and data should be specific to Washington:
To effectively curtail health care costs, the Board should consider policy options and data that are

[1] Washington State Hospital Association year-end member financial surveys 2022 and 2023.
[2] Becker's Hospital Review. December 19, 2023, "RN median wage for all 50 states." https://bit.ly/3OyQe71

specific to Washington. The Board has selected policy options used in other states, but it is unclear whether those options will have an impact in Washington.

As compared to other states, Washington has low hospital costs and the Board's own consultants found that Washington is a low margin state. Rate setting and price caps would therefore result in negligible change, and there is no data demonstrating that anticompetitive contracting, mergers and acquisitions, or facility fees have resulted in increased health care costs in Washington.

As the Board considers these new policy options, we hope the discussion will include fundamental questions such as: Are hospital costs in areas with these solutions already in place lower than in Washington? If so, how have these efficiencies been achieved: is it through reducing salary expenses for personnel, reducing the number of staff, lowering margins, reducing hospital use for certain conditions, or having a smoother functioning system to handle behavioral health patients and patients no longer in need of acute care? We look forward to providing input into the future discussions.

Sincerely,

Katerina LaMarche, JD
Policy Director, Government Affairs
Washington State Hospital Association
katerinal@wsha.org

Washington State Medical Association
Physician Driven, Patient Focused

March 29, 2023

Health Care Cost Transparency Board
626 8th Avenue SE
Olympia, WA 98501

Dear members of the Health Care Cost Transparency Board,

On behalf of the Washington State Medical Association and our 13,000 physician and physician assistant members, we are writing to provide feedback on the policy strategies the Health Care Cost Transparency Board (Board) selected at its February 9 retreat to investigate during 2024 and develop recommendations to the legislature.

Affordability in Washington

We want to share a new Forbes Advisor study that ranks states with the most affordable healthcare across nine key metrics.

We were pleased to learn that Washington is the third most affordable state in which to receive health care:

Washington's score: *11.51 out of 100*

Washington State claims the third spot as the most affordable state for healthcare, trailing just 5.14 points behind Michigan on our index scale.

The Evergreen State has these key metrics:

- *The state boasts the second lowest average premium for residents with family health insurance coverage through an employer ($5,320 annually).*
- *Washington holds the fourth lowest percentage of children whose families struggled to pay for their child's medical bills in the past 12 months (5.9%).*
- *It also offers the fourth lowest average premium for residents with plus-one health insurance coverage through an employer ($3,758 annually).*
- *The state features the fifth lowest average premium for residents with single health insurance coverage through an employer ($1,240.33 annually).*
- *Washington ranks ninth for the lowest health insurance premium for those with silver plans in the Affordable Care Act marketplace ($389 annually).*

Despite the national trend in rising healthcare costs, our legislature and state agencies, in partnership with health care stakeholders, have been leaders in adopting measured policies and

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practices that have, relative to other states, kept health care more affordable for our residents.

The WSMA acknowledges that more needs to be done to address cost containment across the health care system. It's imperative that the efforts the Board makes to reduce costs not be disproportionately imposed on one element of the industry, and we're disappointed that the policy topics selected at the retreat are largely aimed at providers. We urge the Board to approach the policies that were selected deliberately and suggest consideration of recommendations that lean into proven and successful approaches to reducing healthcare costs, like the significant and intentional shift in care provided in the inpatient setting to the outpatient setting – as demonstrated by OnPoint's study on cost growth drivers.

Policies under consideration

We offer the following remarks on several policy items below.

1. *Provider rate setting and growth caps*

   We ask the board to exercise caution when considering recommendations on provider rate setting and growth caps. Government payers such as Medicaid and Medicare do not reimburse physicians at a rate that covers the cost of providing care. Eliminating the ability to negotiate rates with commercial plans will make it more difficult if not impossible to access care in the outpatient medical group setting and impact overall viability of the healthcare system.

2. *Limiting facility fees*

   We ask the Board to reflect upon the entire health care ecosystem when considering facility fees. In an attempt to limit facility fees, legislation (HB 2378) that did not pass this session would have had not only eliminated facility fees, but would have largely precluded the ability of all Ambulatory Surgical Centers (ASCs) from charging for services that they provide via their facility. This bill would have decimated the independent ASC community. As noted in this letter, Washington has made great progress shifting appropriate care to outpatient ASCs and we would urge the Board to not make any recommendations that would hinder further migration to a lower cost setting.

3. *Mergers and acquisitions/private equity/ownership/closures*

   As we noted through discussions around the recent proposal considered by the legislature (SB 5241) regarding consolidation, we share the goals of proponents of the bill in containing health care cost growth and ensuring access to a full suite of health care services in communities across the state. But we worried that the bill could have the unintended consequence of reducing avenues for care in communities by precluding the ability of physician groups to enter necessary partnerships.

   Consolidation of health care providers and facilities happens for several reasons. Among physician groups, contributing factors include low Medicaid reimbursement rates, declining Medicare reimbursement rates, increasing costs of operating a practice, administrative burden, and a state tax code that imposes a higher B&O tax rate on physician groups than other healthcare settings. Any policy approaches considered should seek to address upstream causes of consolidation.

In the report to the legislature, we urge the Board to consider and include both positive (ex. lower cost) and negative (ex. loss of access) potential outcomes of each policy discussed so that lawmakers may make informed decisions.

Thank you for the opportunity to provide comments on policy strategies the Board has selected to investigate during 2024. With questions, please don't hesitate to contact WSMA Director of Policy Jeb Shepard at jeb@wsma.org.

Sincerely,

Nariman Heshmati, MD, MBA, FACOG
President
Washington State Medical Association

Tab 4

Washington State Health Care Authority

2024 Legislative session recap

Evan Klein, Special Assistant
Legislative and Policy Affairs

Washington State Health Care Authority

2024 Legislative priorities

- Ensuring and expanding access
- Behavioral health investments
- Medicaid Transformation Project (MTP) renewal
- Investing in clinical quality
- Advancing equity
- Enhancing maternal services
- Rates, benefits, and operations

2ESSB 1508

- Adjusts the structure of the Health Care Cost Transparency Board's (HCCTB) stakeholder advisory committee and directs new work of the HCCTB.
- Required public hearing for entities subject to benchmark
- New requirements:
  - Underinsurance Survey
  - Survey of Insurance Trends

Coverage policy

- **E2SSB 5213** – Modifies and strengthens regulatory requirements for pharmacy benefit managers (PBMs), including those PBMs utilized by our state purchased programs.
- **SHB 1979** - Requires health plans (including PEBB+SEBB) to cap the out-of-pocket cost of 30-day supply of inhalers / epinephrine autoinjectors at $35 starting Jan 1st 2025.
- **SSB 5986** – Protecting consumers from out-of-network health care services charges.
- **ESHB 1957** – Preserving coverage of preventive services without cost sharing.

Failed bills

- **ESB 5241 (Keep Our Care Act) –** Concerning material changes to the operations and governance structure of participants in the health care marketplace.
- **HB 2476 –** Creating a covered lives assessment professional services rate account.
- **HB 2066** – Addressing affordability through health care provider contracting.

Expansion & Consolidation of Coverage

- Apple Health Expansion (Immigrant health Coverage) Investments
  - Coverage begins July 1, 2024
- PEBB/SEBB
  - Program staff resources
  - Study consolidation
- Essential Health Workers
  - Establish coverage program for essential health workers & explore options for expansion

IT investments

- **Community Information Exchange (CIE)**
  - Examine existing platforms, interoperability, and fiscal impacts.
  - Will serve as a tool for addressing social determinants of health.
- **Electronic Health Records (EHR)**
  - EHR interagency agreement with HCA who is, and will be, the reporting entity to the federal government on the application for and use of the federal funding.
- **Integrated Eligibility & Enrollment (IE&E)**
  - Continuation of efforts to design and implement a benefits access portal for clients across multiple HHS agencies.

Rate increases

- **Tribal Encounter Rates**
  - HCA to implement tribal encounter rates as part of the new pharmacy point-of-sale system.
- **Non-Emergency Medical Transportation (NEMT)**
  - Increase the NEMT broker admin rates.
- **Inpatient Per Diem Rates**
  - Increase inpatient per diem rates for inpatient Prospective Payment System hospitals by July 1, 2024.
- **Private Duty Nurses**
  - Increase rates for private duty nursing, home health, and medically intensive children's group home program services.
- **SUPP Rates Review**
  - Review rates for Substance Using Pregnant People program (SUPP) to determine if a rebasing is appropriate and submit a budget request if necessary.

Looking ahead

- Apple Health Expansion (July 1)
- HCCTB updated analyses
- PEBB/SEBB consolidation study
- Electronic Health Records (EHR)
- Reentry & MTP 2.0

Questions

Contact:

Evan Klein
Special Assistant,
Legislative & Policy Affairs
Email: evan.klein@hca.wa.gov

Shawn O'Neill
Legislative Relations Manager
Email: shawn.oneill@hca.wa.gov

Washington State Health Care Authority

Tab 5

Washington State Health Care Authority

House Bill 1508 Updates

Health Care Cost Transparency Board

Washington State Health Care Authority

Overview

- Committee expansion
- Expansion of potential cost driver analyses
- Two biannual surveys
  - Out of pocket costs and premiums
  - Insurance trends among employers and employees
- Changes to legislative report timing
- Public hearing on health care cost growth report
- Best practices analysis (new assignment from the budget)

Committee expansion:
Health Care Stakeholder Advisory Committee

- Advisory Committee of Providers & Carriers will change to "Health Care Stakeholder Advisory Committee"
- Member makeup:

Number of members	Representing the interests of…	Selected from a list of nominees submitted by…
At least 2	Consumers	Consumer organizations
At least 2	Labor purchasers	Washington State Labor Council
At least 2, including at least 1 small business representative	Employer purchasers	Business organizations

Expansion of potential cost driver analysis

- The Board may use data received from existing data sources
  - This includes, but is not limited to:
    - Publicly available information filed by carriers under Title 48 RCW
    - Department of Health
    - Health Benefit Exchange
    - HCA Prescription Drug Reporting
    - Washington State All Payer Claims Database (WA-APCD)
    - Prescription Drug Affordability Board
- The Board may share its data with:
  - Prescription Drug Affordability Board
  - Other health care cost analysis efforts conducted by the state

Two biannual surveys

First biannual surveys due by Dec 1, 2025

1. Underinsurance among Washington residents

- The Board shall measure underinsurance as the share of Washington residents whose out-of-pocket costs over the prior months, excluding premiums, are equal to:
  i. For persons whose household income is over 200% of the federal poverty level, 10% or more of household income
  ii. For persons whose household income is less than 200% of the federal poverty level, 5% or more of household income
  iii. For any income level, deductibles constituting 5% or more of household income

2. Insurance trends among employers and employees

- The survey must be conducted among a representative sample of Washington employers and employees.

Changes to legislative report timing

- Legislative report due **December 1**
  - Formerly due August 1

Public hearing requirements

- Board will hold an annual public hearing
- First hearing will be no later than December 1, 2024
- Hearing must include:
  - Discussion on growth in total health care expenditures in relation to the health care cost growth benchmark in the previous performance period
  - Cost growth benchmark data and provider/carrier performance
  - Provider groups with fewer than 10,000 unique attributed lives shall be exempt from identification The agenda and any materials for this hearing must be made available to the public at least 14 days prior to the hearing

Best practices analysis (budget assignment)

- The Board shall study:
  - Regulatory approaches to encouraging compliance with the health care cost growth benchmark established under chapter 70.390 22 RCW; and
  - Best practices from other states
- The study, as well as any recommendations for changes to the Board arising from the study, must be submitted by the board as part of the annual report by December 1, 2024

Tab 6

Washington State Health Care Authority

Medical Debt in America

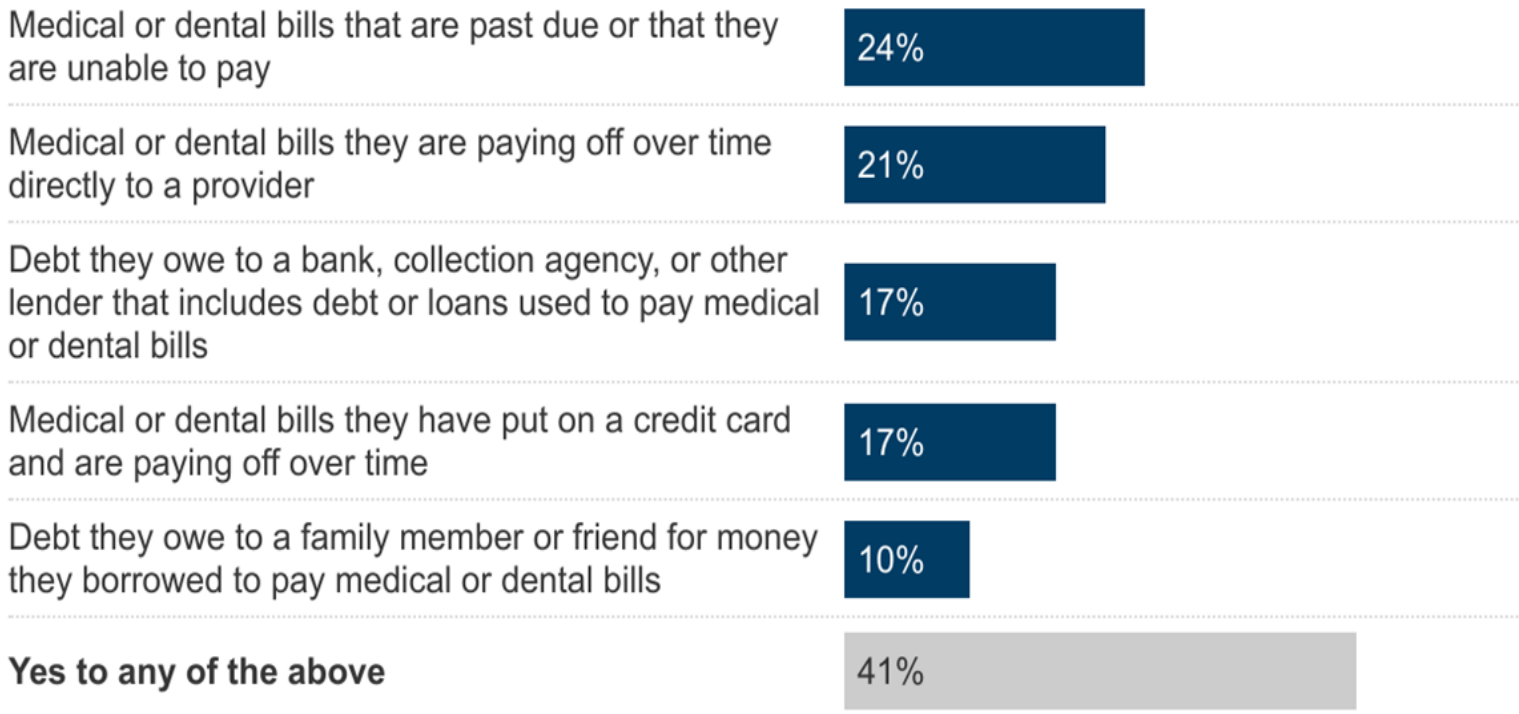
Noam N. Levey,
Senior Correspondent

KFF Health News

Medical Debt is Upending Millions of Lives

How Big Is the Problem?

100 Million People with Health Care Debt



Source: KFF

How Much Medical Debt?

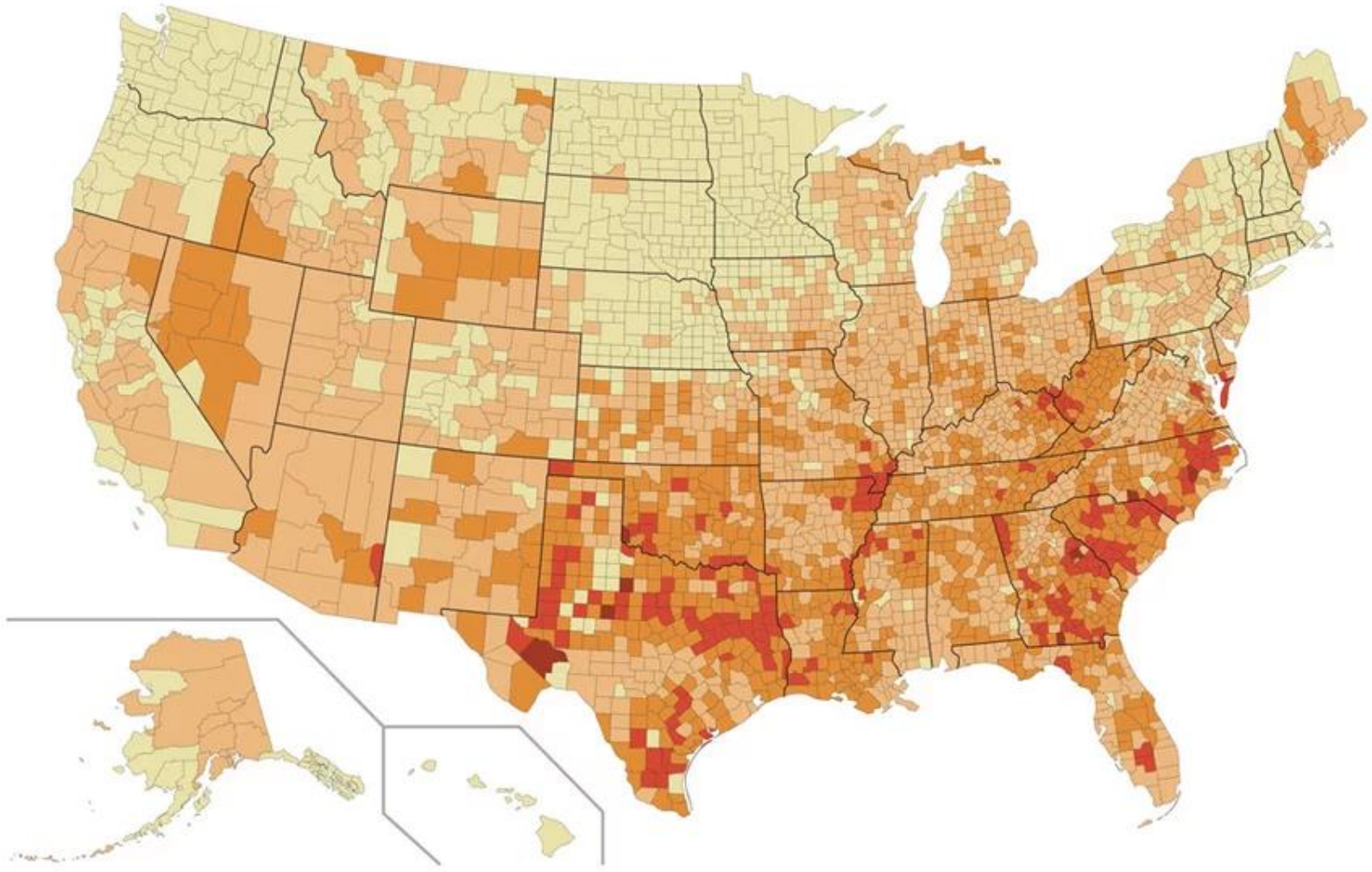
What Americans estimate they owe in health care debt

- **A third** owe less than $1,000
- **A quarter** owe at least $5,000
- **1 in 8** owe at least $10,000
- **1 in 5** don't expect to ever pay it off

Source: KFF

Where is Medical Debt?

Share of adults with medical bills in collections, by county



Source: Urban Institute

Impact of Medical Debt

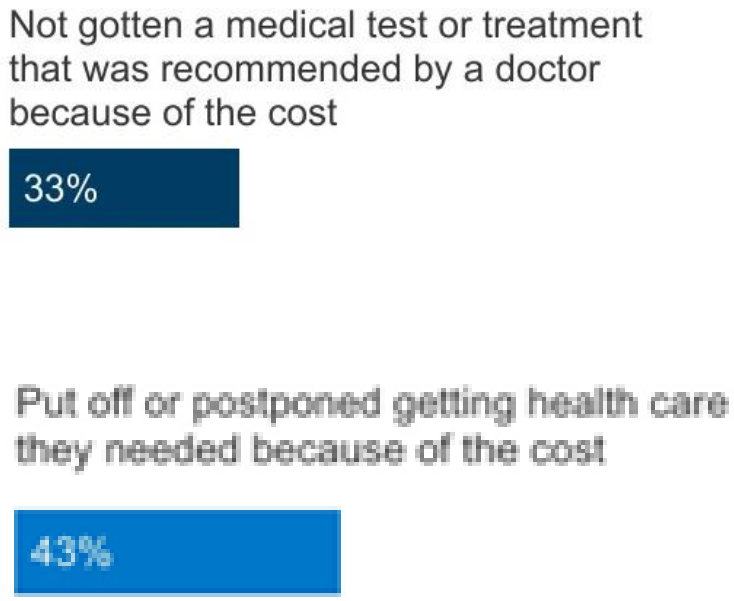
More than half of adults have made a difficult sacrifice

- **63%** cut spending on food, clothing & other basics
- **40%** took on extra work
- **19%** changed their living situation
- **12%** were denied medical or dental care

Source: KFF

What Are Patients Doing?

Millions Are Skipping or Postponing Care



Source: KFF

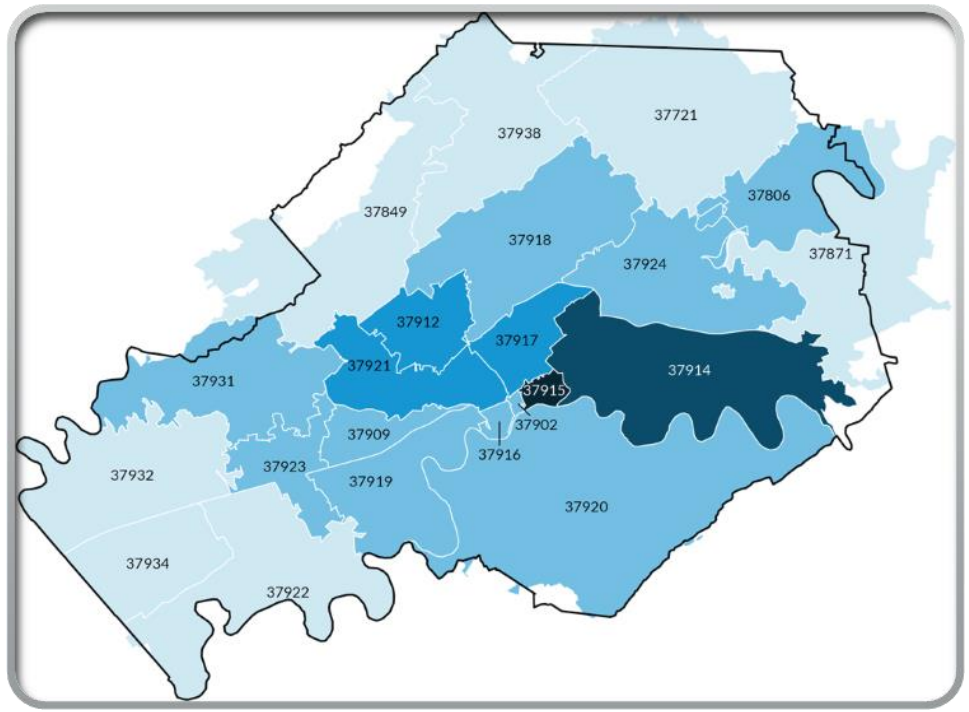
Medical Debt's Unequal Toll

- Black Americans are 50% more likely to have health care debt
- Young people (18-29) are twice as likely as seniors to have debt
- Parents are almost twice as likely as non-parents to have debt
- Sick Americans are a third more likely to have debt
- Low-income Americans are more than twice as likely to have debt

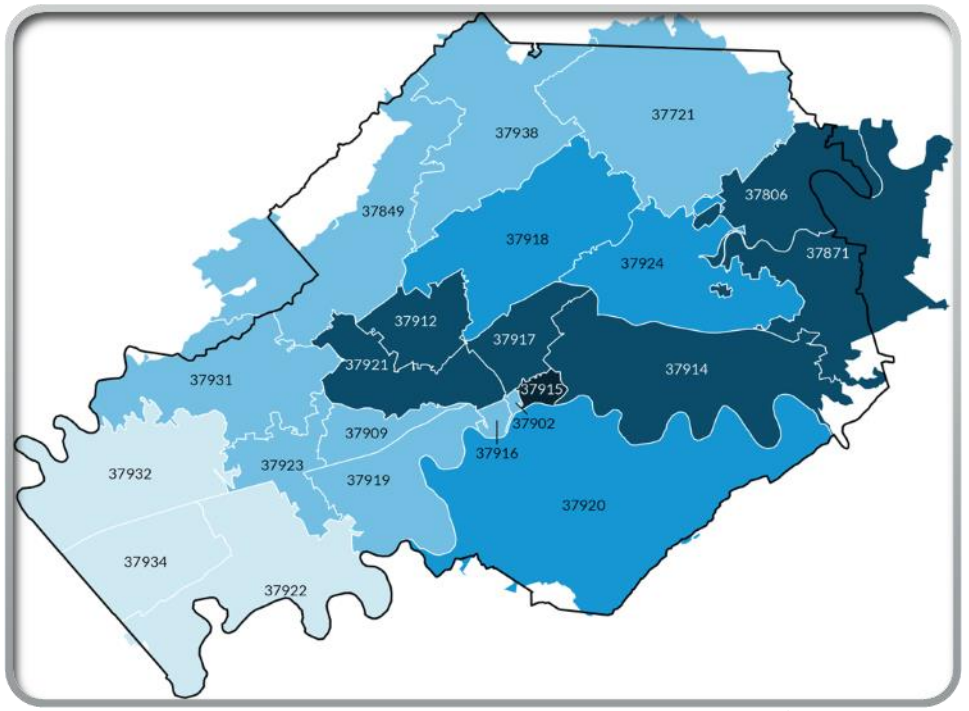
Source: KFF

Deepening Racial Disparities

Share of non-white residents by zip code in Knox County, Tenn.



Share of adults with medical bills in collections in Knox County, Tenn.



Source: Urban Institute

What’s Going on Here?

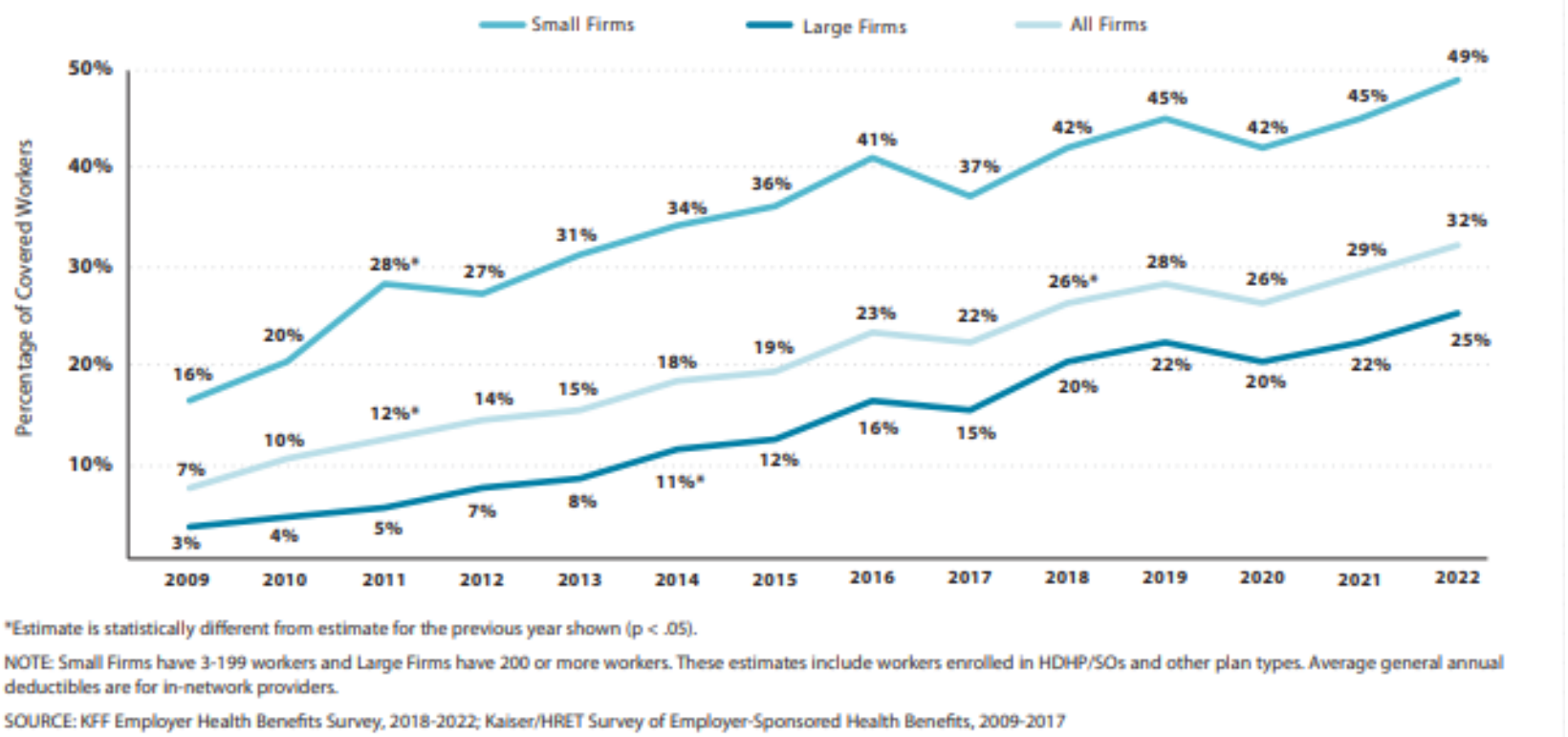
The Hospital Collection Machine

- **Two-thirds** sue patients or take other legal action, such as garnishing wages or placing liens on property
- **Two-thirds** report patients with outstanding bills to credit rating agencies
- **A quarter** sell patients' debts to debt collectors
- **1 in 5** deny nonemergency care

Source: KFF

The Bigger Problem

Share of US workers in a health plan with a deductible of $2,000 or more for single coverage



*Estimate is statistically different from estimate for the previous year shown ($p < .05$).

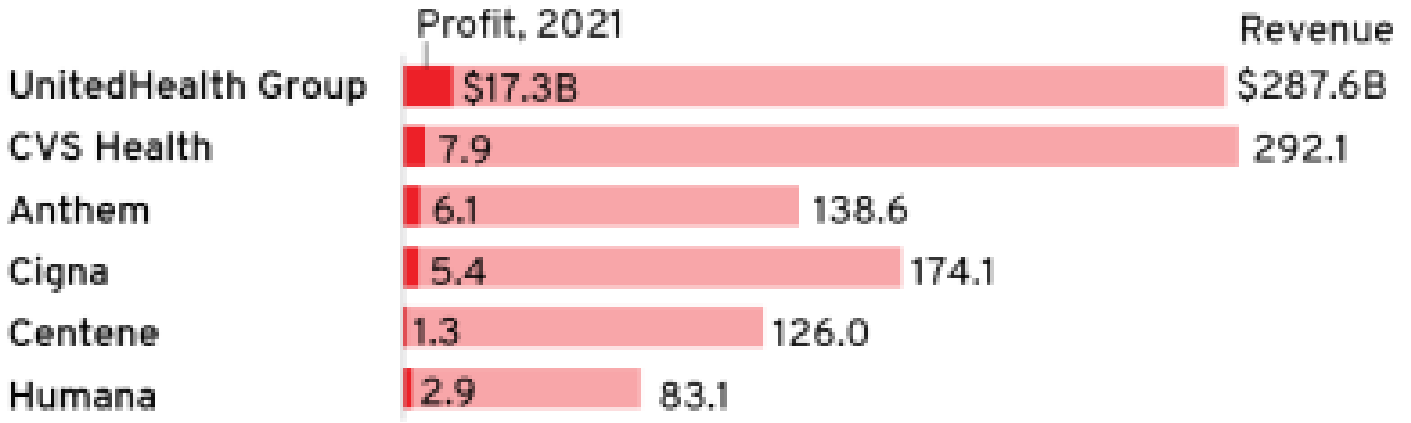
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Whose Problem Is This?

A Threat to Health Insurance Profits?

For-Profit Health Insurance Companies Are Earning Billions of Dollars



Source: Company earnings reports
By Randy Leonard

FIERCE

Big Opportunities for Patient Financing

Annual revenues of the U.S. patient financing industry:

$9.5 billion

Gross Domestic Product of Rwanda:

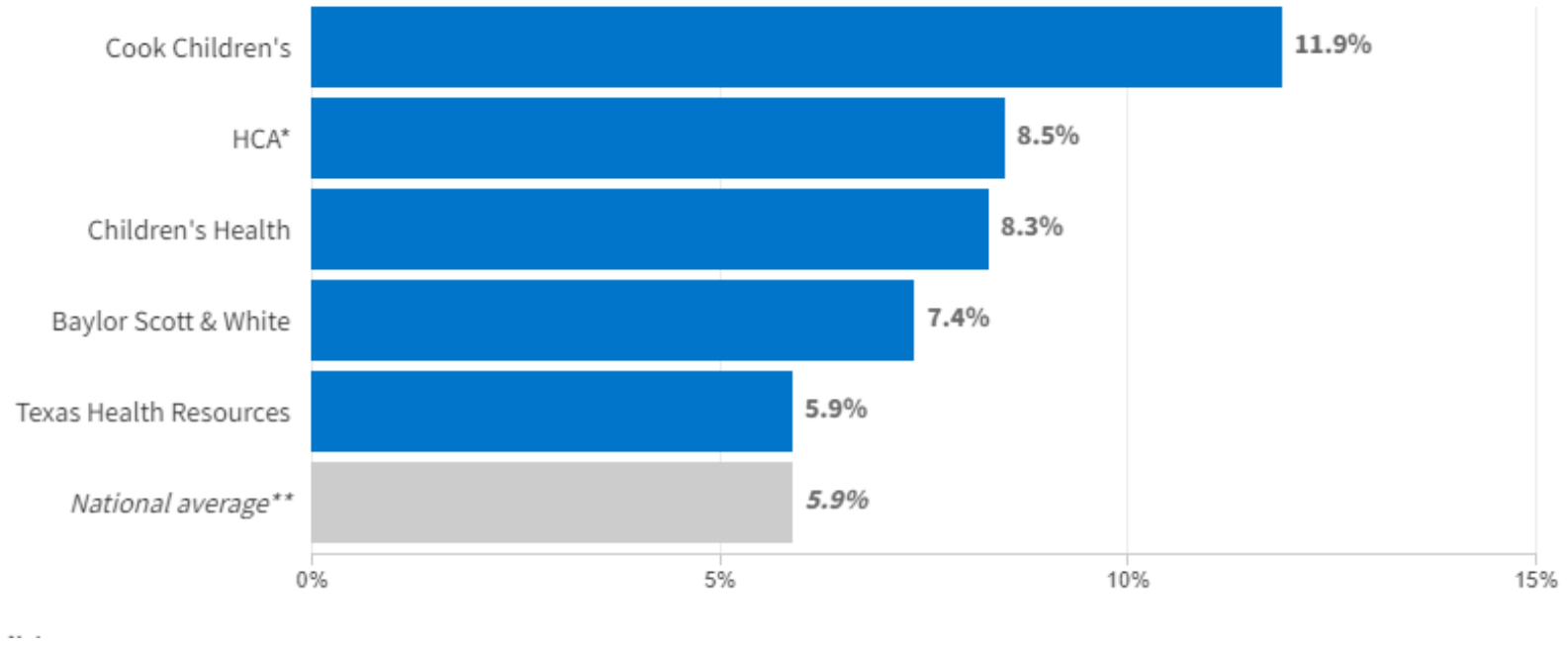
$9.1 billion

Source: IBIS World

A Threat to Hospital Margins?

Operating Margins at Major Hospital Systems Around Dallas-Fort Worth

The average operating margin for leading hospital systems in the Dallas-Fort Worth area from 2018 to 2021 was very strong. All the systems below are nonprofit, except HCA.



Source: KFF

What Do We Do Now?!?

Restrict Aggressive Collections

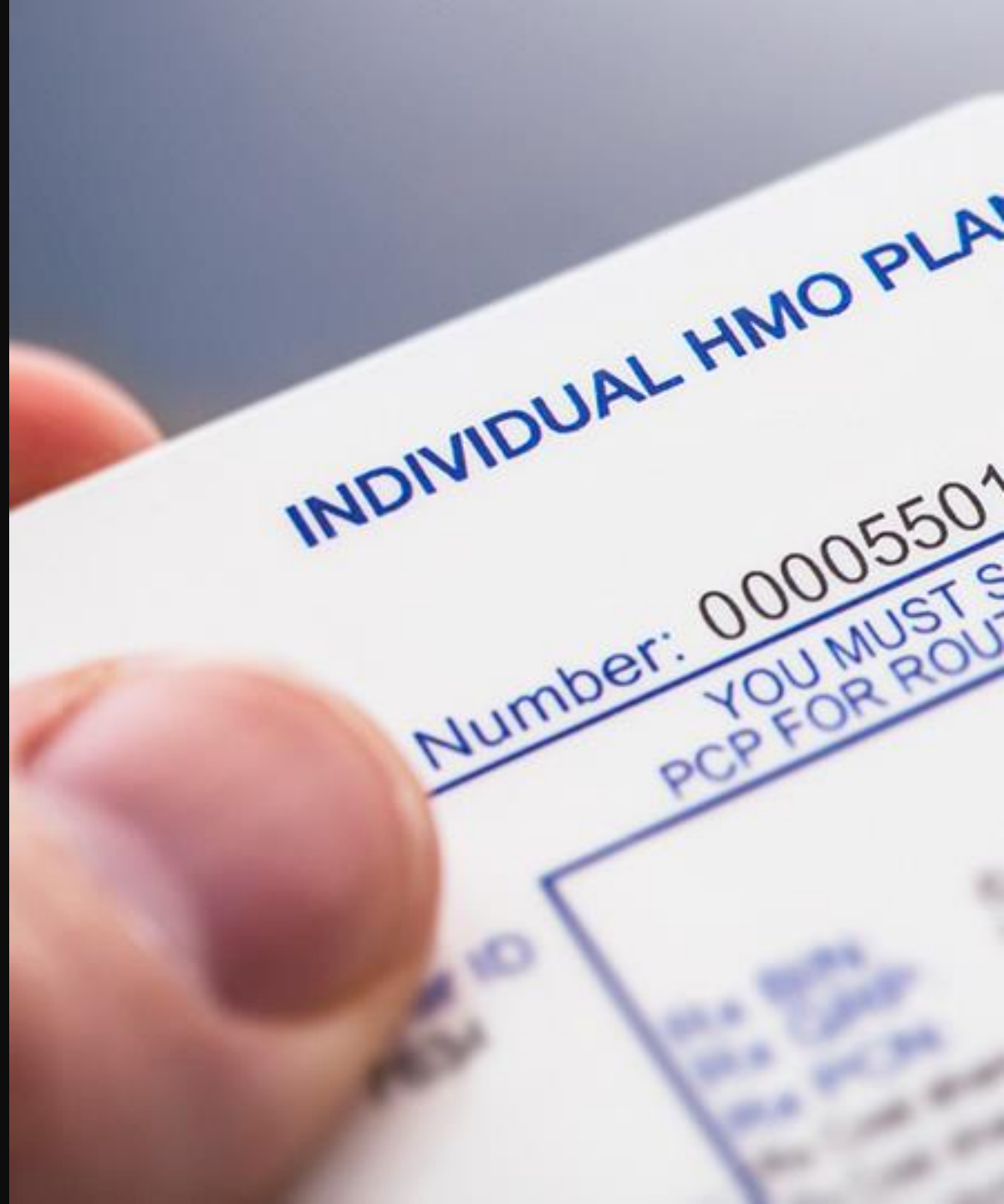
- Credit Reporting
- Lawsuits, Wage Garnishment
- Other “Extraordinary Collection Actions” – Debt Sales & Restrictions on Care
- Interest on Medical Debt

Improve Financial Assistance

- Transparency
- Uniform Standards
- Simpler Charity Care Applications
- Presumptive Eligibility
- Tighter Rules for Community Benefits

Rethink Health Plan Design

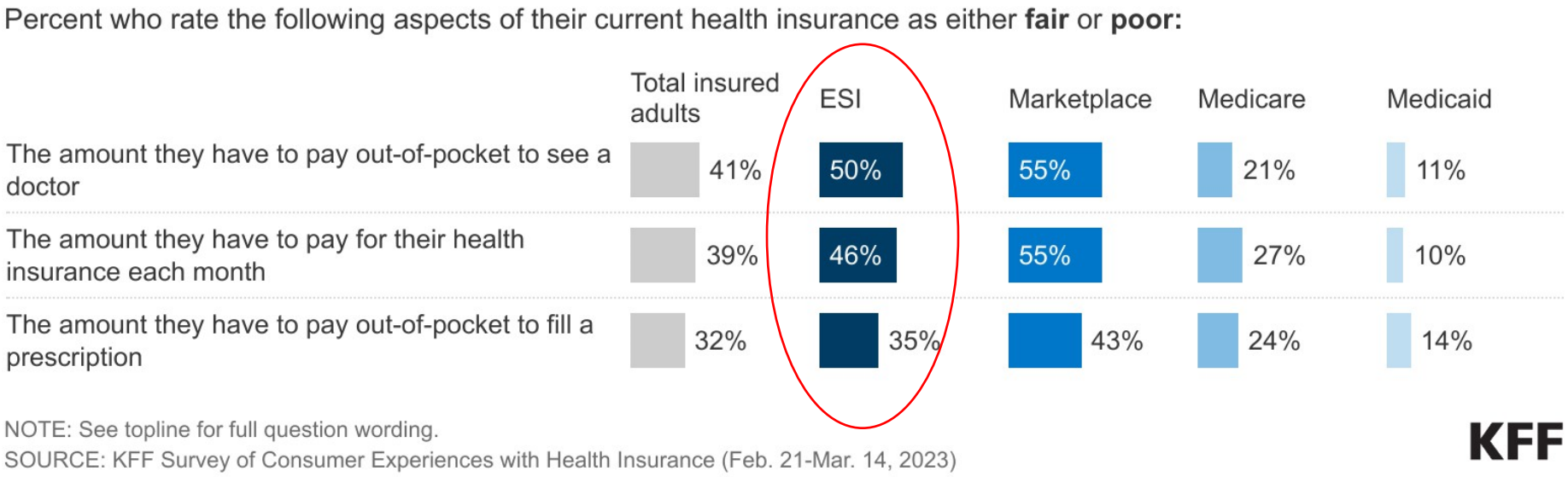
- Lower Out-Of-Pocket Maximums
- Exempt Primary Care & Other Services from Deductibles
- Cancer? Childbirth? Chronic Disease?
- Standardized Benefit Design



A Flashing Light for Employers …

Who Likes ESI?

How do Americans rate their insurance coverage?



Big Cost Barriers

Who is skipping care due to costs, by insurance type?

Percent who say they delayed or went without the following in the past 12 months because of the cost:

	Total insured adults	Main insurance coverage			
		ESI	Marketplace	Medicare	Medicaid
A visit to a doctor's office	14%	17%	18%	5%	10%
Prescription drugs	13%	12%	14%	11%	14%
Dental care	28%	25%	37%	26%	39%
Vision services, including eyeglasses	19%	17%	27%	14%	28%
Hearing services, including hearing aids	6%	5%	5%	10%	5%
Any of these types of care in the past year	41%	38%	50%	36%	51%

NOTE: See topline for full question wording.
SOURCE: KFF Survey of Consumer Experiences with Health Insurance (Feb. 21-Mar. 14, 2023)

KFF

Diagnosis: Debt

- Noam N. Levey
- KFF Health News
- nlevey@kff.org
- 202-247-0811

https://kffhealthnews.org/diagnosis-debt/

Tab 7

Washington State Health Care Authority

AGENDA

- Further discussion on medical debt presentation
- Overview of policy selections from Retreat
- Proposed sequence based on what/when data is available
  - Draft workplan for 2024
- Policy analysis considerations

DISCUSSION

- **Could Washingtonians benefit from greater protections regarding medical debt?**

  The following slides contain samples of current protections

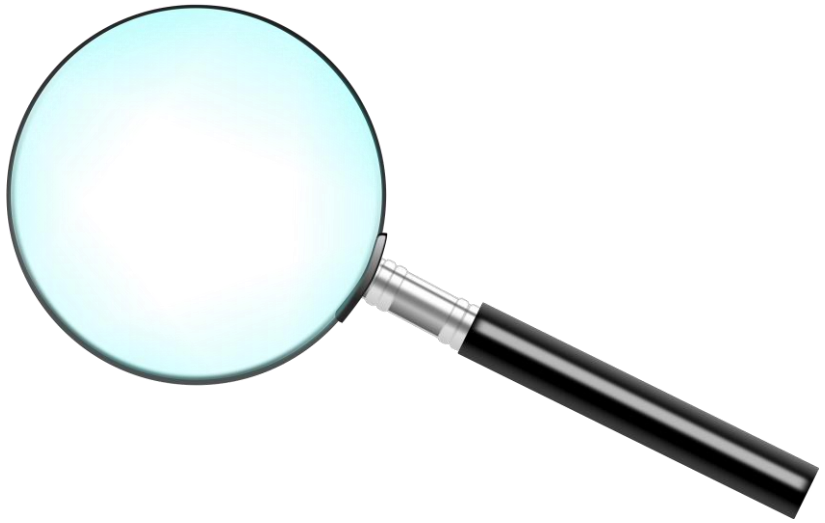
WASHINGTON AND OTHER STATE LAWS RE: MEDICAL DEBT, BILLING, COLLECTIONS

- Charity care
  - At larger hospitals (having 80% of beds in the state), with income up to 300% Federal Poverty Level (FPL) are entitled to receive treatment with no out of pocket costs, regardless of insurance or immigration status. Up to 350% FPL are entitled to 50% discount; 400% FPL are entitled to 25% discount.
  - In February, AG reached settlement with Providence over failure to offer charity care to those entitled to it, requiring $158 million in refunds and debt forgiveness
  - Six states require hospitals to provide minimum amount of charity care; Washington does not. Oregon uses formula considering revenue and operating margin.

WASHINGTON AND OTHER STATE LAWS RE: MEDICAL DEBT, BILLING, COLLECTIONS

- Billing and collections practices
  - Federal law requires waiting periods and notification before hospitals implement certain extraordinary collections practices (ECPs) such as garnishing wages or selling the debt to a debt collection agency
  - Washington requires a waiting period and a screen for eligibility for financial assistance before a hospital can send a bill to collections
  - The Biden Administration has proposed prohibiting medical debt from affecting credit scores; regulations have not yet been issued
  - Washington requires a waiting period before medical debt can be sent to a credit reporting agency, but does not prohibit it, as some states do
  - A few states require hospitals to offer a payment plan to low-income and uninsured patients; Washington does not.

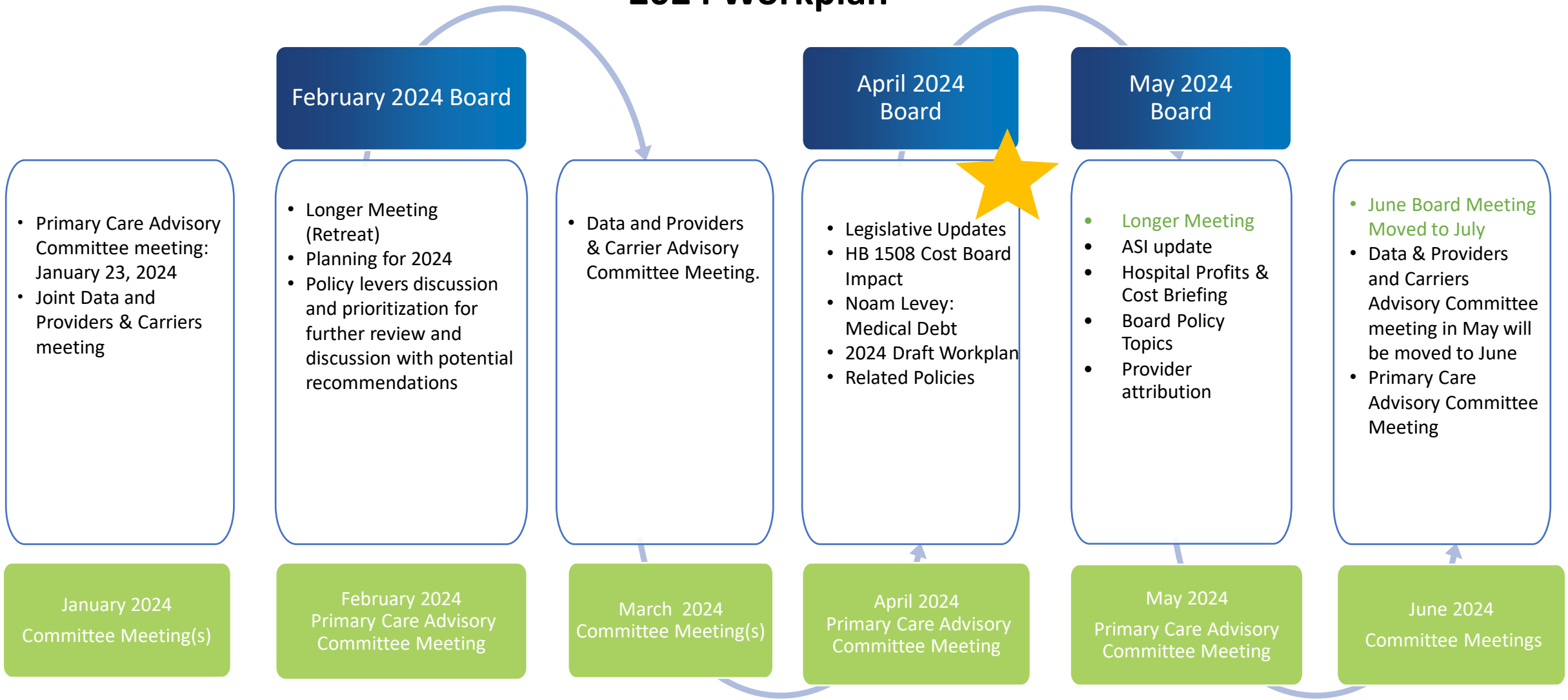
SELECTED POLICIES FOR EVALUATION



Policy	Votes
Provider Rate Setting (2) and Price Growth Caps (7)	9
Limiting Facility Fees	8
Mergers and Acquisitions/Private Equity/Ownership/Closures	7
Restricting Anti-Competitive Clauses in Health Care Contracting	7
Increased Hospital Price Transparency	4
Community Benefit Transparency	4

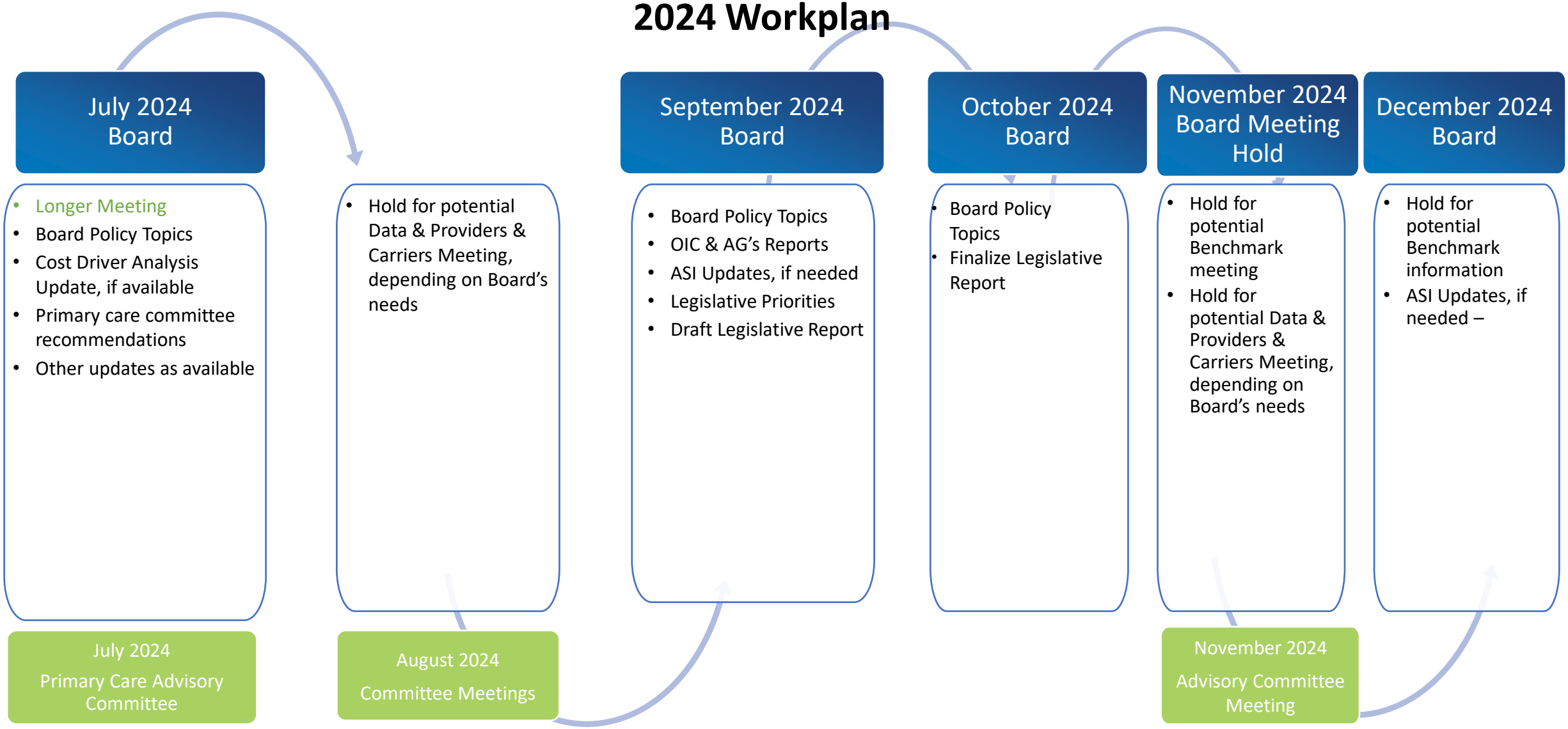
Also forthcoming, will be Primary Care policy recommendations

Health Care Cost Transparency Board
2024 Workplan



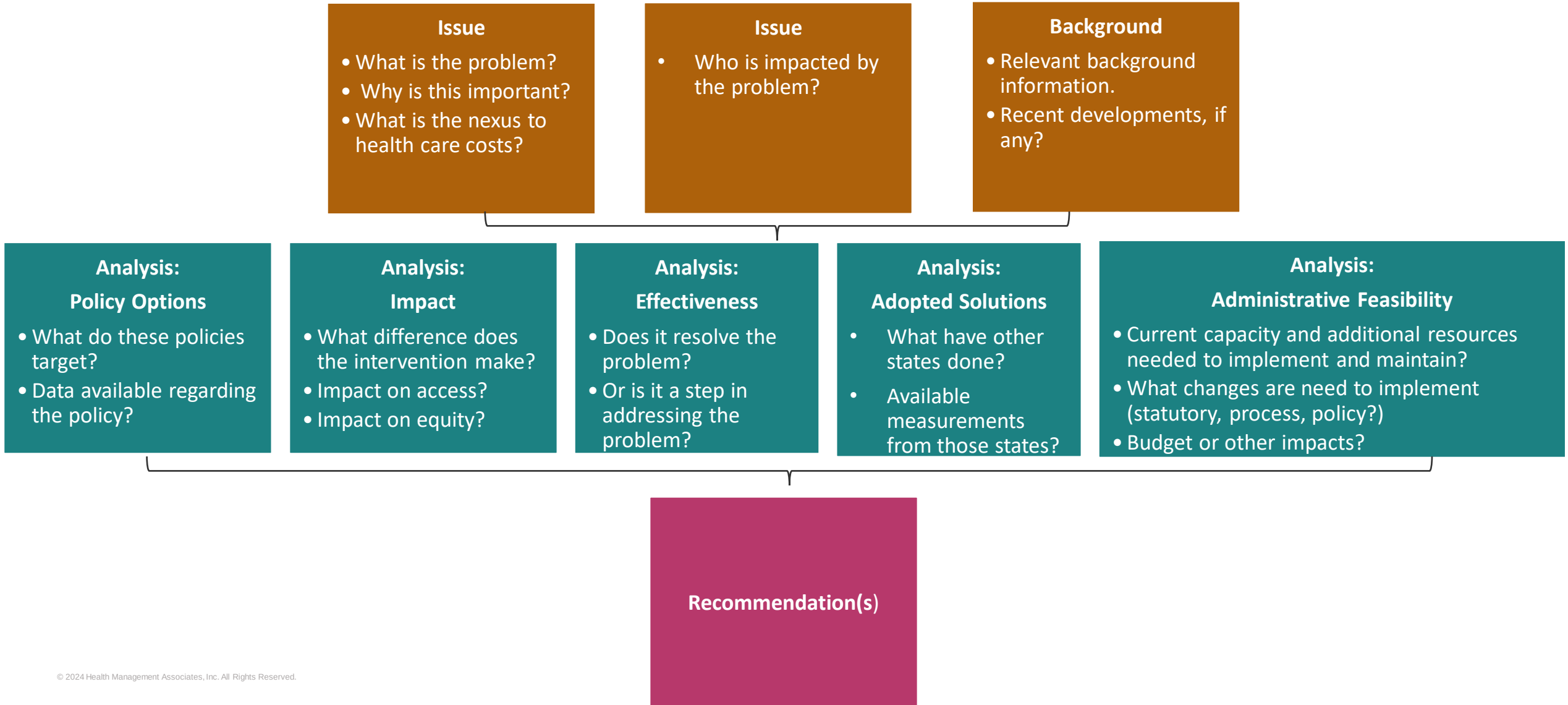
Workplan will change depending on progress made in each meeting

Health Care Cost Transparency Board
2024 Workplan



Workplan will change depending on progress made in each meeting

PROPOSED FRAMEWORK FOR POLICY EVALUATION



DISCUSSION

- Are there additional questions and information you would like to know about the policies as we consider them?

Thank you for attending the Health Care Cost Transparency Board meeting!

Washington State Health Care Authority

Tab 8

HEALTH CARE COST TRANSPARENCY BOARD

HEALTH CARE SPENDING GROWTH IN WASHINGTON, 2017-2019

Health Care Spending Growth Benchmark Baseline Brief (2023)

Washington State Health Care Authority

Table of Contents

Acronym glossary

APCD = All-Payer Claims Database

The Washington State All Payer Claims Database (WA-APCD) is a tool used to collect health care claims data for reporting, analytics, and to help the public make their health care decisions.

CMS = Centers for Medicare and Medicaid Services

The federal agency that provides health coverage to more than 160 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.

DOC = Department of Corrections

The Washington State DOC manages all state-operated adult prisons and supervises individuals who live in the community and are under DOC supervision.

DSS = Department of Social and Health Services

The DSHS manages the administration of aging and long-term care, behavioral health, development disabilities, vocational rehabilitation, Medicaid pathways based on age and disability, and other public benefits in partnership with federal government agencies.

FFS = Fee-for-service

A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

FQHC = Federally Qualified Health Center

Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of your ability to pay. Services are provided on a sliding scale fee based on your ability to pay.

HCA = Washington State Health Care Authority

The HCA administers a wide range of programs and initiatives, working to ensure Washington residents have access to better health, better care, and lower costs.

MCO = Managed care organization

An entity contracted by a state Medicaid agency that accepts a set per member per month (capitation) payment for health care services.

NCPHI = Net cost of private health insurance

The difference between total premiums collected from enrollees and payments made to providers for health care delivered.

PCMH = Person-Centered Medical Home

A facility offering complete care focused on quality, effectiveness, and efficiency of services delivered, responding to each patient's unique needs and preferences.

PGSP = Potential Gross State Product

An estimate of the total economic output produced if growth were steady and inflation stable.

THCE = Total health care expenditures

The amount spent on health care and related activities such as private and public health insurance, government agency-provided health care, and public health activities.

TME = Total medical expenses

The amount paid to providers for the delivery of health care services to the member population, including patient out-of-pocket costs and non-claims payments.

VHA = Veterans Health Administration

The largest integrated health care system in America, providing health care services for military veterans, with facilities throughout the country.

Executive Summary

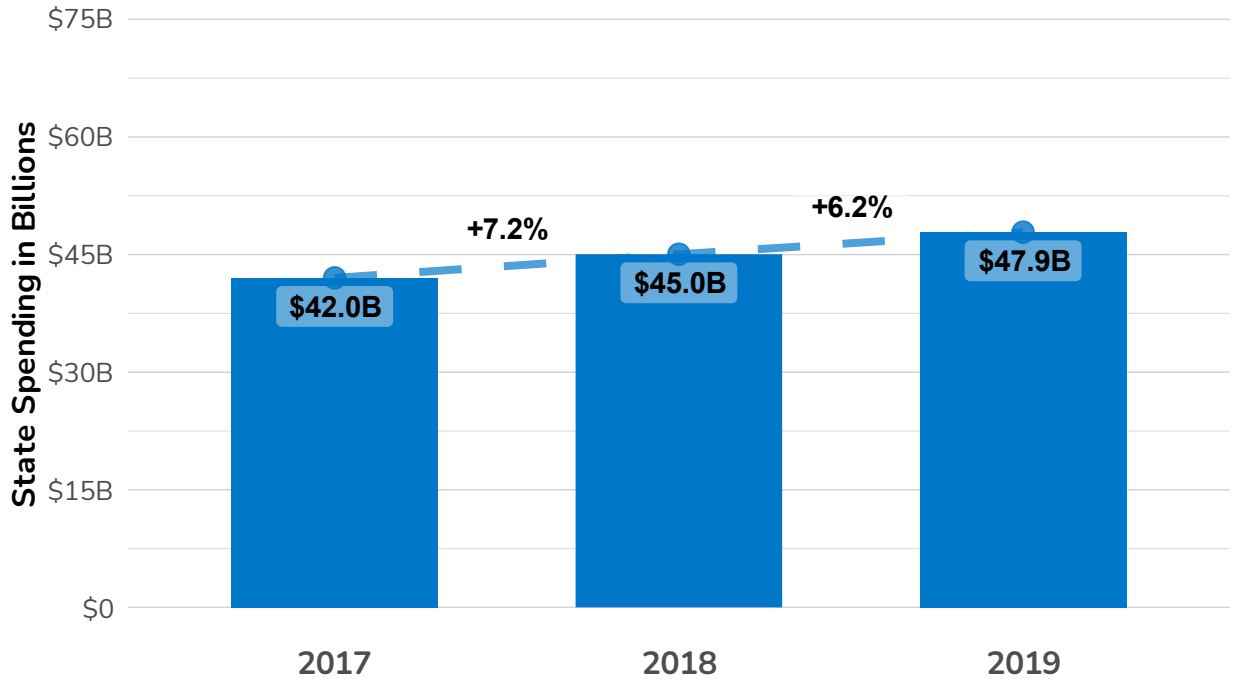
This report presents baseline data on health care cost growth in Washington between 2017 and 2019. As part of the Health Care Cost Growth Benchmark initiative, the Washington Health Care Cost Transparency Board collects data from payers and other sources to provide a comprehensive view into health care cost growth. This report sets the stage for policymakers, health system partners, and other stakeholders to identify opportunities and strategies to slow cost growth and address growing affordability concerns across all markets, including public and private care insurance markets. Key findings were presented at a public board meeting in December 2023 (link to meeting?) and are summarized in this report.

Key Findings

Total health care expenditures[1] in Washington increased by $5.8 billion dollars between 2017-2019, including a $3 billion increase between 2017-2018, and by $2.8 billion increase between 2018-2019.

Overall, Total Health Care Expenditures (THCE) in Washington increased from $42 billion dollars in 2017 to $47.9 billion in 2019. Between 2017 and 2018, THCE increased by 7.2% from $42 billion to $45 billion. This continued to grow by another 6.2% to $47.9 billion between 2018 and 2019.

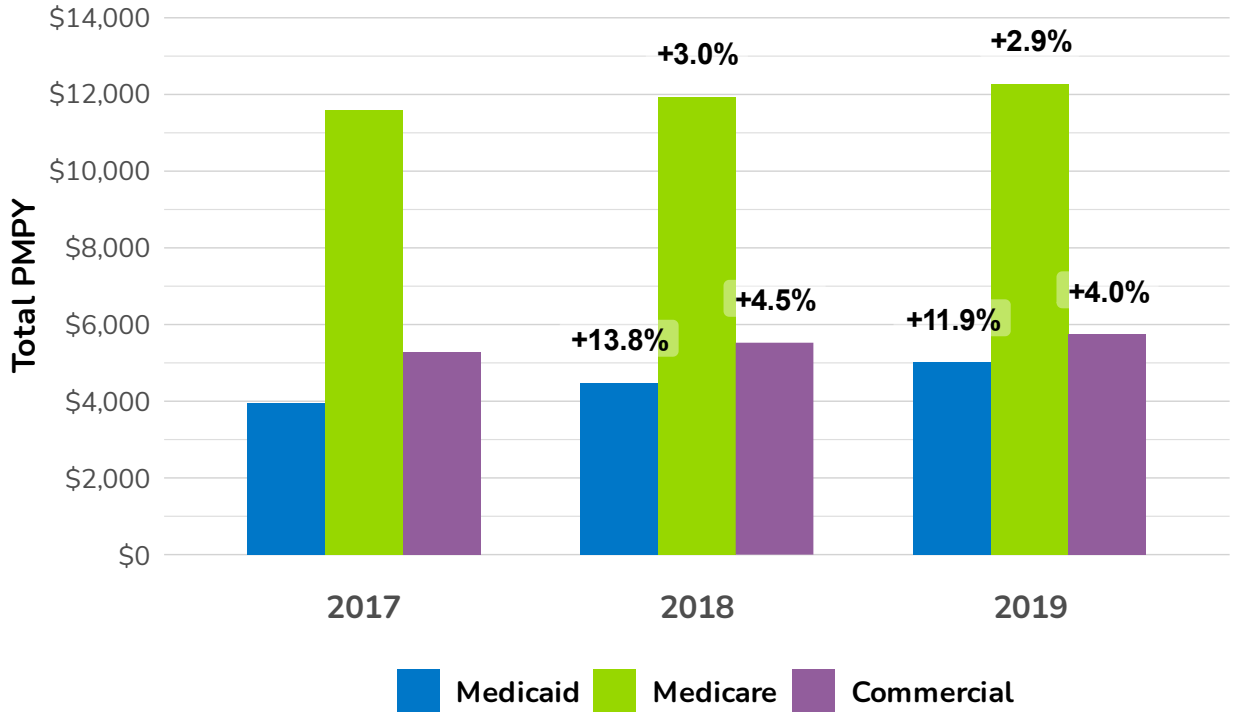
Figure 1: Growth in Total Health Care Expenditure (THCE)



[1] Total Health Care Expenditure is the sum of all public and private spending on the delivery of health care to a population, including medical services, government subsidy, and administrative costs.

All health care markets (including Commercial, Medicare, and Medicaid) experienced growth in per person per year total medical expenditures[2] between both 2017-2018 and 2018-2019.

Figure 2: Growth in state Total Medical Expenses per member per year, by market



All monitored health care markets, including commercial, Medicare, and Medicaid, experienced health care cost growth between 2017 and 2019. Total medical expenses, standardized to per member per year (PMPY), increased the most for Medicaid between 2017-2018 (13.8%) and the least for the Medicare market between 2018-2019 (2.9%). While the growth trend of Medicare is lower than other markets when measured per member per year, the absolute spending is substantially higher, reflecting a population that is older and with a higher prevalence of chronic disease.

[2] Total Medical Expense differs from THCE in that TME excludes spending related to administration of private health insurance, and state and federal agency spending (e.g. Department of Corrections).

Introduction

Background

House Bill (HB) 2457 (2020) established the Health Care Cost Transparency Board (Board) under the Health Care Authority (HCA). The board is responsible for reducing Washington's health care cost growth by:

- Determining Washington's total health care expenditures.
- Identifying cost trends and cost drivers in the health care system.
- Setting a health care cost growth benchmark for health care providers and payers.
- Reporting annually to the Legislature on benchmark performance and cost drivers.

Washington is one of nine states in the nation to adopt a spending growth benchmark. It is also a participant in the Peterson-Milbank Program for Sustainable Health Care Costs. The Board established the benchmark in 2022 for the subsequent five years and will evaluate the benchmark performance annually moving forward. The spending growth benchmark represents a common goal for payers, purchasers, regulators, and consumers to improve health care affordability. It serves as a starting point to monitor health care spending growth with the growth of the economy, state revenue, or wages.

Performance against the benchmark is assessed by measuring annual spending growth against each annual benchmark. Benchmark performance data in future reports will reflect the performance of payers and providers against the spending growth benchmark at an aggregate level for each insurance market (e.g., commercial, Medicare, Medicaid). The benchmark data comes from aggregate expenditure data from all payers (carriers) and includes claims-based and non-claims-based expenditures.

What is the health care spending growth benchmark?

The benchmark is a specific rate that the expenditure performance of carriers and providers will be measured against, beginning in 2022. The goal of the benchmark is to influence slower health care spending growth to ensure access to affordable health care. The Board's benchmark target covers a five-year period, granting providers and policymakers the ability to plan for future years when calculating total expenditures. In September 2021, the Board approved Washington's spending growth benchmark from 2022–2026 (see Table 2, below). This benchmark is based on a hybrid of median wage and potential gross state product (PGSP) at a 70:30 ratio. Median wage was selected to link the measure to consumer affordability, and PGSP as a reflection of business cost and inflation.

Table 1: Spending growth benchmark for Washington State

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

In establishing the benchmark, the Board reviewed how other states created their benchmarks and considered many different factors that might influence their choice of benchmark. One of these factors included current economic indicators, such as wages and inflation. In designing Washington's benchmark methodology, the Board examined rates of health care inflation in other states with spending growth benchmarks, as well as those states' benchmark methodologies.

The spending growth benchmark will be applied and measured in future years of analysis at four different levels: statewide, by market, by payer, and by large provider organization.

Table 2: Reporting Schedule

Year of Release	Includes Data from Specified Years	Data Included
Late 2023	2017 – 2019	State and market data only – the Board will not publicly report insurance payer or provider cost growth for this period
Late 2024	2020 – 2022	For large provider entities* and payers - with cost growth target of 3.2%
Late 2025	2022 – 2023	For large provider entities and payers – with cost growth target of 3.2%
Late 2026	2023 – 2024	For large provider entities and payers – with cost growth target of 3.0%
Late 2027	2024 – 2025	For large provider entities and payers – with cost growth target of 3.0%
Late 2028	2025 – 2026	For large provider entities and payers – with cost growth target of 2.8%

*** Large provider entities will be determined using 2017-2019 as a historical baseline.**

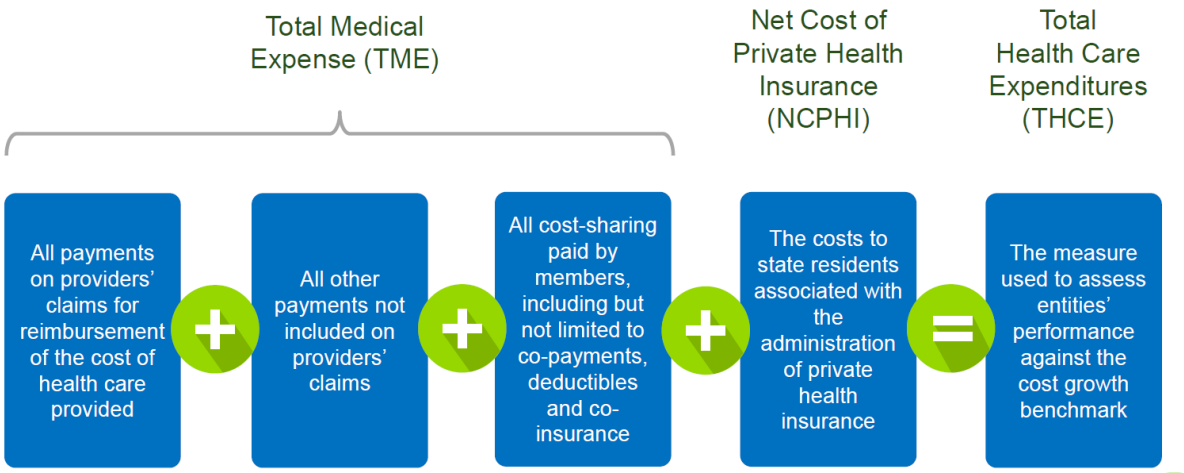
To ensure that payers and provider organizations have flexibility in their contracting and in their operations, the spending growth benchmark is calculated at a high-level, using a total cost of care approach. This aggregates all costs related to an individual's care, rather than focusing on a single factor like prices. Washington's health care spending growth benchmark sets a target annual rate of growth for health care spending in the state. Spending growth benchmarks do not limit or cap health care spending; they aim to achieve a sustainable rate of growth.

Spending growth benchmark methodology

Total health care expenditures measurements

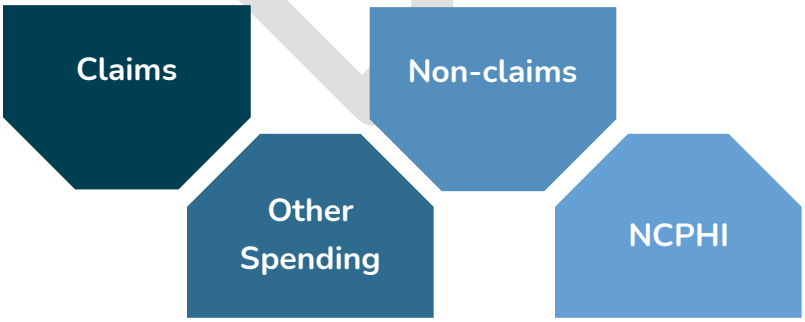
This Board utilized Total Health Care Expenditures (THCE) to report on health care spending growth between 2017 and 2019 at the state level and utilized Total Medical Expenses (TME) for the market level (Medicaid, Medicare, Commercial). THCE includes claims and non-claims payments between payers and provider organizations, as well as other health care spending in public programs like Department of Corrections, Veterans Affairs, and the Department of Labor and Industry. The Net Cost of Private Health Insurance (NCPHI) are costs associated with administering health plans.

Figure 3: THCE formula (TME plus NCPHI)



This report also looks at health care spending by category, e.g., hospital inpatient, retail pharmacy, capitated payments, etc. Statewide and market level cost growth is reported using THCE.

Figure 4: Components of Total Health Care Expenditures



Total medical expenses

The Board also utilized Total Medical Expenses (TME) to measure health care spending. TME is a subset of THCE and includes claims and non-claims spending reported by payers. For market level spending, TME is reported unadjusted and not truncated. For payers and providers, TME will be demographically adjusted and truncated.

Payer and provider organization cost growth is measured using TME, a subset of THCE that includes only Claims and Non-claims spending (see pg. 11).

Figure 5: Components of Total Medical Expenses

Overview of data collection and analysis methodology

This section provides a summary of how performance will be assessed against the benchmark in future years' analyses. For detailed methodological information about the cost growth benchmark, please see Washington's Healthcare Cost Growth Benchmark Technical Manual.

Data Sources

Like other states, the Board utilizes data from a large number of sources for assessing health care spending and spending growth.

Table 3: Data categories and sources

Component of Total Health Care Expenditures	Category	Data Source
Total Medical Expenses	Carrier claims payments	Carrier data submission template
	Carrier non-claims payments	Carrier data submission template
	Carrier enrollment	Carrier data submission template
	Carrier pharmacy rebates	Carrier data submission template
	Medicare fee-for-service claims payments and enrollment, and all Part D spending	Centers for Medicare & Medicaid Services
	Non-managed care claims and non-claims payments and enrollment for Medicaid	Washington Health Care Authority submission template
	Veterans Health Administration medical spending and enrollment	Department of Veterans Affairs
	Medical spending for state workers' compensation and enrollment	Washington Department of Labor & Industries submission template
	Health care spending for incarcerated individuals and enrollment	Washington Department of Corrections submission template
Net Cost of Private Health Insurance	NCPHI for the commercially fully insured market	Federal Commercial medical loss ratio (MLR) reports
	NCPHI for Medicare Advantage	The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC)
	NCPHI for Medicaid Managed Care	The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC)
	Income from Fees of Uninsured Plans to calculate NCPHI for the commercial self-insured market	Carrier data submission template
	Number of member months in each market for calculating NCPHI	Carrier data submission template

What's included in claims and non-claims spending categories?

Claims spending includes the allowed amount from payers to provider organizations and any member cost sharing such as co-payments, deductibles, and co-insurance. Professional services can be broken out into several sub-categories, including primary care, specialty, long-term care, and other. Claims spending in this section is reported net of pharmacy rebates. Non-claims spending includes all payments made from payers to provider organizations outside of claims.

Claims –

Hospital inpatient
Hospital outpatient
Professional – primary care providers
Professional – specialty providers
Professional – other providers
Long-term care
Retail pharmacy (net)
Other – including, but not limited to durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services.

Non-Claims –

Capitation or bundled payments
Performance incentive payments
Population health and practice infrastructure payments
Provider salaries
Recovery payments as the result of a prior review, audit, or investigation
Other – including, but not limited to governmental payer shortfalls, grants, other surplus payments, and Medicaid Transformation Project (MTP) payments made directly to carriers by providers.

The following are the service category definitions utilized within claims and non-claims spending:

- **Hospital outpatient:** Includes all hospital types and payments made for hospital-licensed satellite clinics, emergency room services not resulting in admittance; and observation services
- **Hospital inpatient:** Includes all room and board and ancillary payments for all hospital types and payments for emergency room services when the member is admitted to the hospital
- **Retail prescription:** Includes claims paid to retail pharmacies for prescription drugs, biological products or vaccines
- **Non-claims:** Includes incentives, capitation, risk settlements, direct payments or other non-claims-based payments
- **Claims other:** Includes durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services
- **Long-term care:** Includes skilled nursing facility services, home health service, custodial nursing facility services home- and community-based services including personal care

Assessment of performance against the spending growth benchmark for future years' reports

To assess health care spending growth in a manner similar to other states, the Board measures THCE or TME annually, in aggregate dollars, and on a per member per year (PMPY) or per member per month (PMPM) basis. The aggregate dollar figure is for informational purposes only. The percentage change in THCE/TME on a PMPY/PMPM basis between the measurement year and the prior calendar year will be used in future years to assess performance against the benchmark applicable to the specific measurement year. Spending is calculated at each of level or reporting as follows:

- **State:** Aggregate spending and PMPY spending using THCE.
- **Market (Medicare, Medicaid, commercial):** Aggregate spending and PMPY spending using TME.
- **Payer (carrier), stratified by market:** PMPM spending using truncated, age/sex adjusted TME, and
- **Large provider entity stratified by market:** PMPM spending using truncated, age/sex adjusted TME.

Spending at the payer and provider entity levels will not be included in this initial benchmark report but will be reported beginning in 2024. All spending data at the state and market levels (and payer, in future reports) are or will be reported net of pharmacy rebates. Spending data at the large provider entity level will be reported in future reports gross of pharmacy rebates since carriers provide rebate data in the aggregate, and the Board cannot attribute rebates to specific providers.

Caveats and limitations of the data

In this first data call, there are gaps in the compiled data. Some gaps were anticipated, such as the Board's exclusion insurance policies offering limited benefits: accident, disability, Medicare supplemental insurance, vision or dental stand-alone policies. Another category of health care expenditure not captured is charity care or customer cash payment.

Additional instances of incomplete data were unanticipated for various reasons. The carrier Anthem was unable to produce data for 2017 due to the difficulty of accessing their archived data. Humana did not present data for their Medicare Advantage plans citing a federal preemption and that such a requirement was not included within the state license agreement. There were also unforeseen difficulties gathering and integrating certain non-claims spending in publicly funded behavioral health services, custodial nursing facility services, home- and community-based services, and intermediate care facilities and services for persons with developmental disabilities paid by Washington State Department of Social and Health Services (DSHS). Efforts are currently underway to assess the feasibility of incorporating these services in future reporting.

Finally, all data is reported as the net of prescription drug rebates. Both medical and retail prescription rebates were collected, but due to the complexity of medical rebates and the limited value of insight gained in breaking them down, these have been subtracted from the Retail Rx category.

Spending trends in Washington, 2017-2019

Health care cost growth trends measured using THCE includes several measurements:

- Aggregate expenditures, statewide
- Toal health care expenditures, per member per year
- Total health care expenditures, annual growth by market
- Other components of THCE:
    - Net cost of private health insurance (NCPHI), aggregate;
    - Other spending;
    - TME

Health care spending is reported as total dollars spent on health care in Washington. This measurement can be affected by the number of people in Washington overall and the number of people with health insurance coverage.

Total health care expenditures are utilized by Washington to identify health care spending growth at the state level. THCE includes all claims and non-claims-based spending, as well as spending on other public programs and the Net Cost of Private Health Insurance. Total Health Care Expenditures provides a standardized comparison of how much is spent on health care per member each year that accounts for any underlying changes in the number of people.

NCPHI measures the costs to Washington residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred, and consists of carriers' costs of paying bills, advertising, sales commission and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of total health care expenditures at the state level.

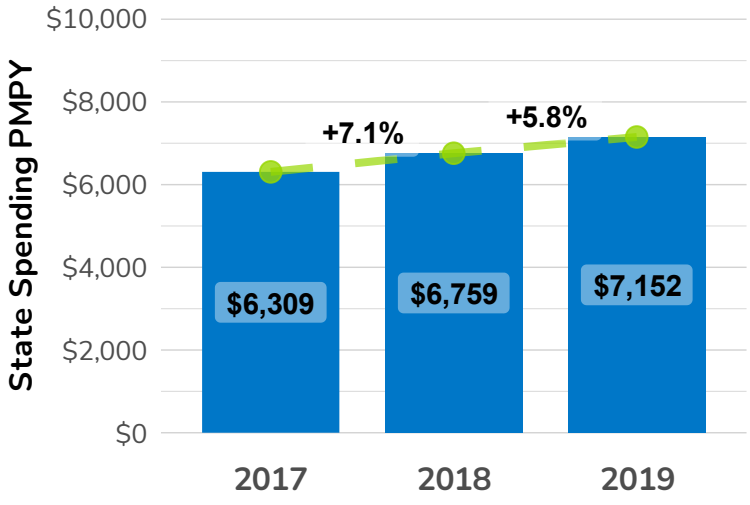
Total health care expenditures in Washington

THCE, statewide, per member per year

In 2019, health care spending in Washington on a per member per year basis was $7,152, increasing from $6,309 in 2017 and $6,759 in 2018. This represents a 7.1% increase between 2017-2018 and a 5.8% increase between 2018-2019.

If the spending growth target was in effect during this measurement period, statewide, across all markets, Washington would have exceeded the 2022 target of 3.2%.

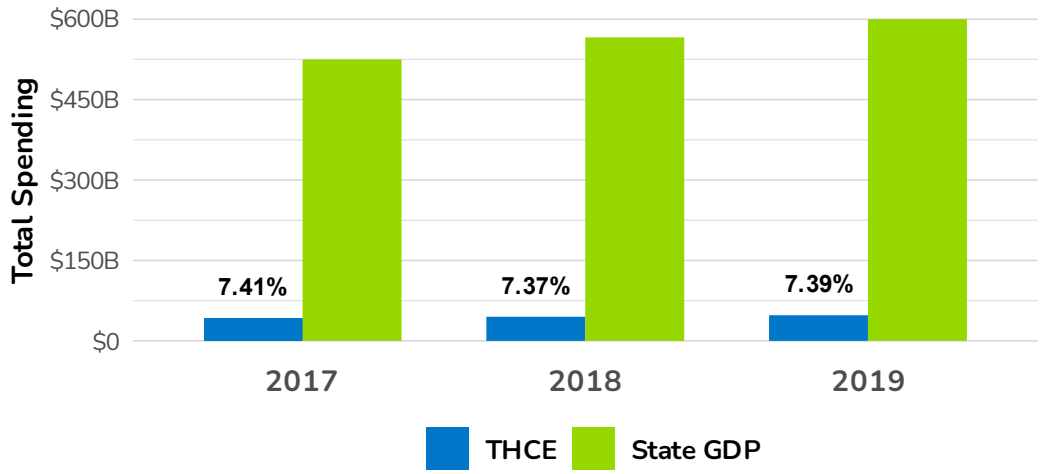
Figure 6: Growth in Total Health Care Expenditure



Health Care Spending Growth in Washington, 2017-2019

Total health care spending as a portion of state gross domestic product[3] was roughly unchanged, decreasing slightly from 7.41% in 2017 to 7.39% in 2019.

Figure 7: THCE as a Proportion of State GDP



Source: Bureau of Economic Analysis, Benchmark report

Components of THCE

Net cost of private health insurance (NCPHI),

NCPHI applies to commercial insurers, Medicare Advantage insurers, and Medicaid Managed Care Organizations (MCOs). NCPHI is utilized to pay payer costs related to health care claims, paying bills, advertising, sales commissions, other administrative costs, premium taxes, and fees. It also includes a payer's profits (contribution to margin) or losses. NCPHI can fluctuate year to year depending on how accurately premium projections are able to forecast actual services rendered.

Aggregate NCPHI represents approximately 5.5% of total health care spending in Washington, roughly $2.6 billion in 2019.

Other spending

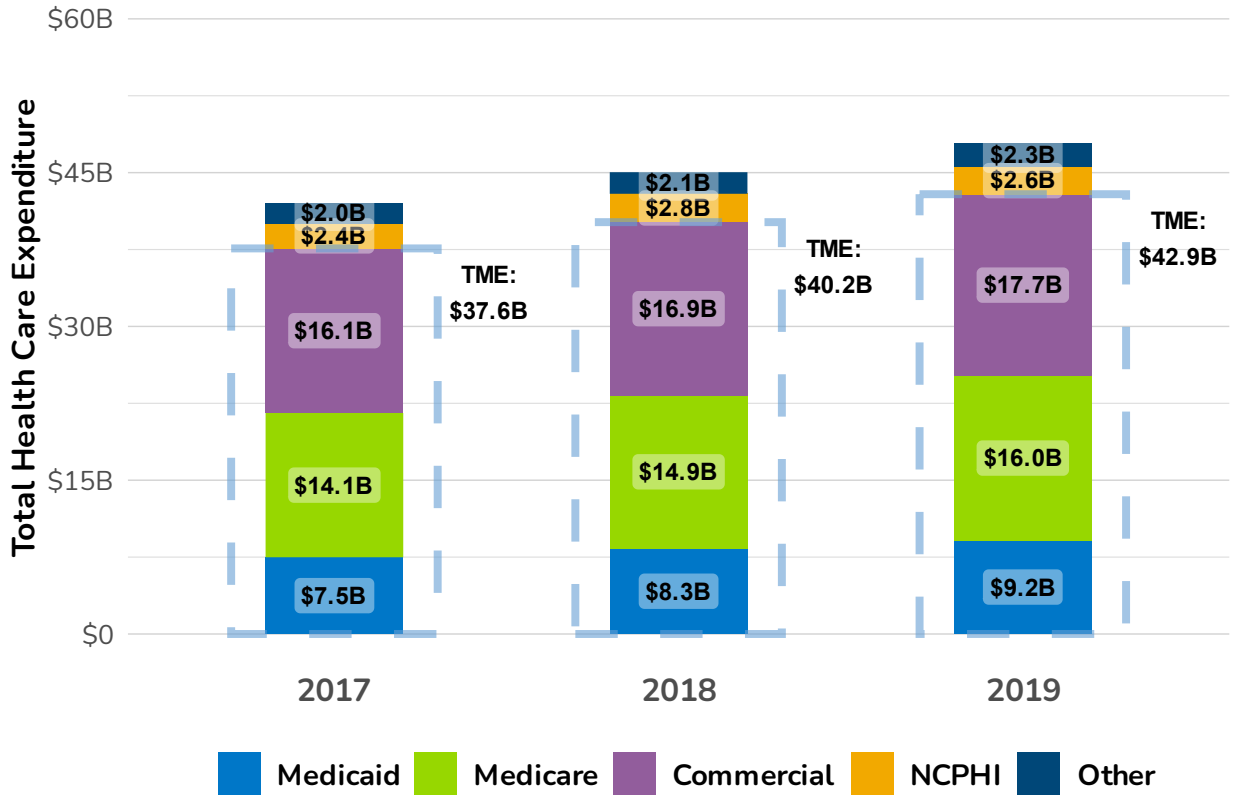
Other spending includes health care spending in programs like the Department of Corrections, Veterans Affairs, and the Department of Labor and Industries. Other spending totaled $2.3 billion in 2019, or about 4.8%.

TME

TME is the final component of THCE and includes the commercial, Medicare, and Medicaid markets. TME is covered in greater detail in the next section of this report.

[3] Data on estimated State GDP was collected from the Bureau of Economic Analysis: Gross Domestic Product by State, Fourth Quarter and Annual 2019. https://apps.bea.gov/regional/histdata/releases/0420gdpstate/index.cfm

Figure 8: Components of THCE



TME trends in Washington, 2017-2019

Health care cost growth trends measured using TME includes several measurements:

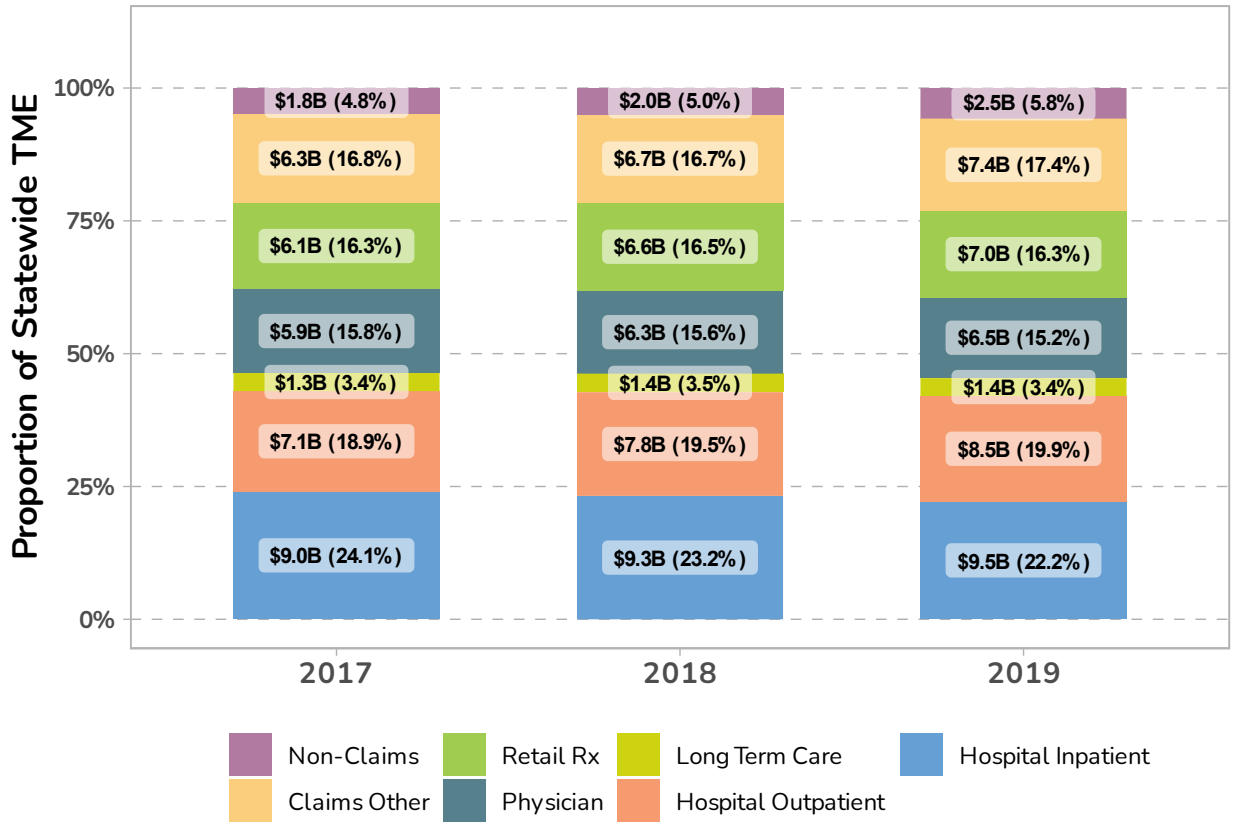
- Claims and non-claims spending, statewide
- TME growth by category, statewide and by market
- TME growth in per member per year spending, statewide and by market

When reporting on health care spending growth by service categories, Washington uses the TME measure, the methodology utilized by other states. TME is a subset of Total Health Care Expenditures and includes claims and non-claims payments only. Claims data for TME are reported net of pharmacy rebates.

Claims spending, statewide

The largest share of claims spending in Washington is Hospital Inpatient, totaling $9.5 billion in 2019 (roughly 22.2% of claims spending). Notably, while spending in this category increased, the proportion of overall claims spending declined in this period, from 24.1% to 22.2%. Hospital Outpatient services are the next largest spending category, at $8.5 billion (19.9%) in 2019, followed by the Other Claims category at $7.4 billion (17.4%).

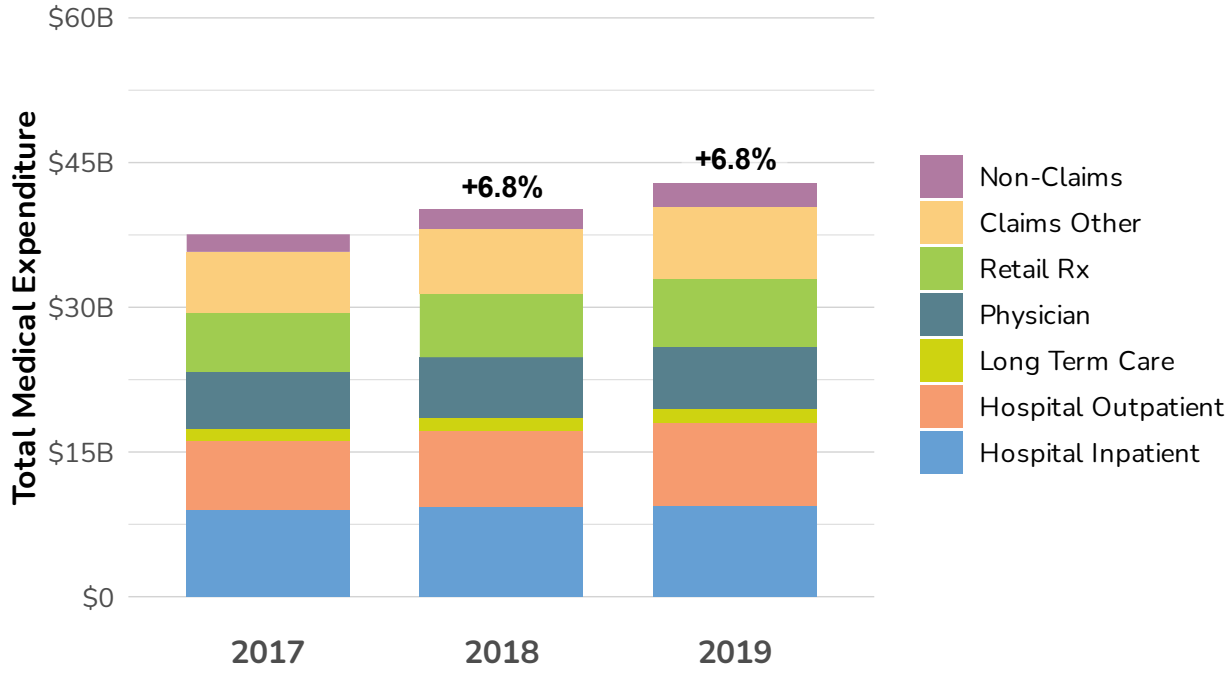
Figure 9: Statewide TME Spending and Proportion by Category



TME growth by market and category

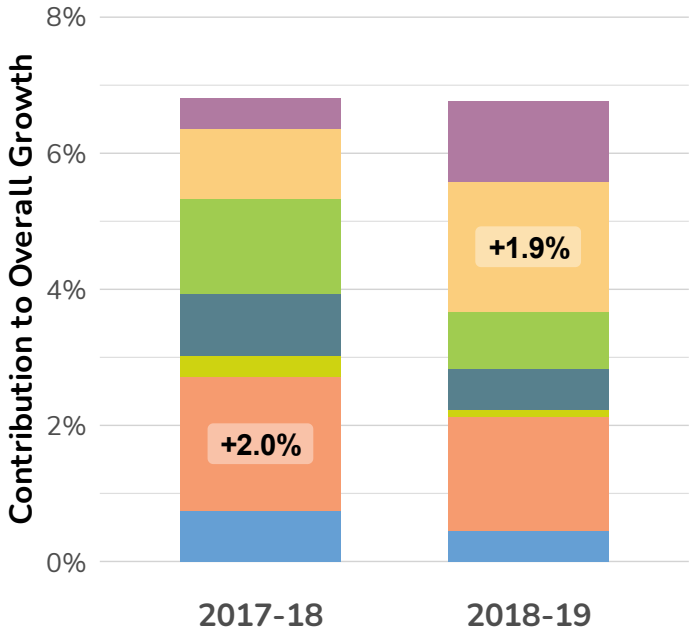
Total Medical Expenditure for the state increased from $37.6 billion in 2017 to $40.1 billion in 2018, representing a 6.8% increase. Similar spending growth was seen in 2019, reaching $42.8 billion in 2019, another 6.8% increase. Spending for all claims categories increased year-over-year between 2017-2019.

Figure 10: Statewide TME Spending Growth by Category



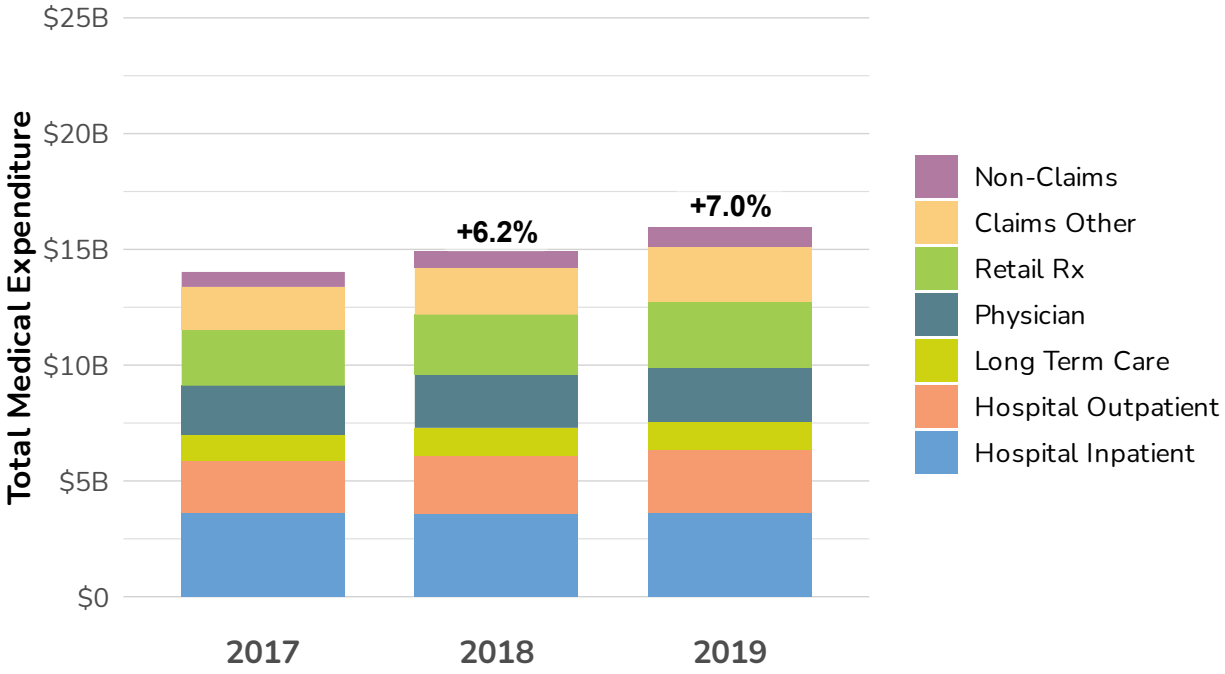
Hospital Outpatient spending contributed the largest amount of growth between 2017 and 2018 spending, accounting for 2% of the 6.8%. Between 2018 and 2019, Claims Other contributed the most growth, accounting for 1.9% of the 6.8%.

Figure 11: Statewide TME Contribution to Spending Growth by Category



Medicare is the largest health care market in Washington by total dollars spent. Medicare serves adults aged 65 or older and some younger people with disabilities.

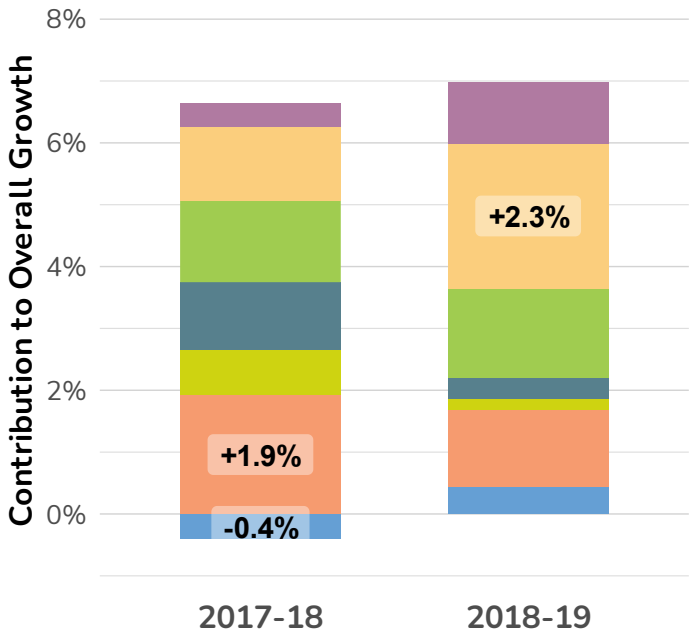
Figure 12: Medicare TME Spending Growth by Category



Claims-based Medicare spending totaled $15.9 billion in 2019, rising 6.2% and 7% from 2017 to 2018 and 2018 to 2019 respectively. Growth in spending for Hospital Outpatient constituted 1.9%, the largest contributor to 2017-2018 growth. From 2018 to 2019, Claims Other represented the largest share of spending growth at roughly 2.3% of overall growth.

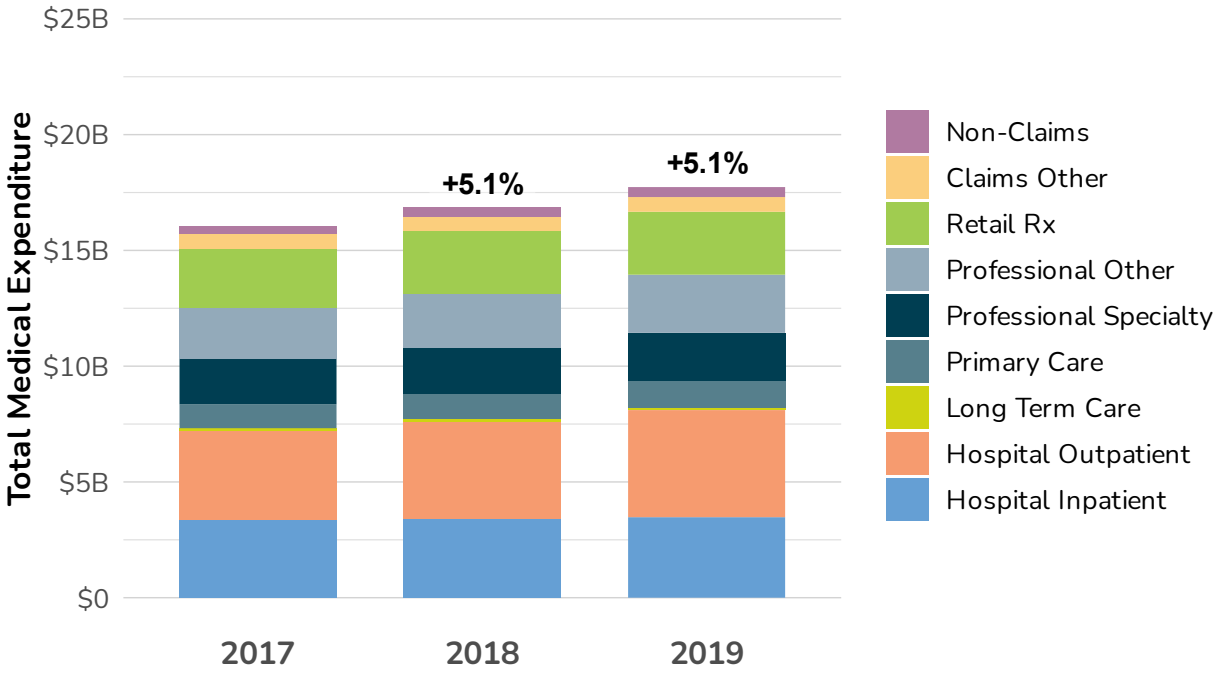
A small 0.4% decline in Hospital Inpatient spending between 2017 and 2018 reflects a long-term policy focus to control hospital spending by moving many procedures to outpatient facilities.

Figure 13: Medicare TME Contribution to Spending Growth by Category



Commercial health insurance is the second largest market in Washington. Individual, self-insured, student health insurance, and small and large group products are collectively referred to as the "commercial market."

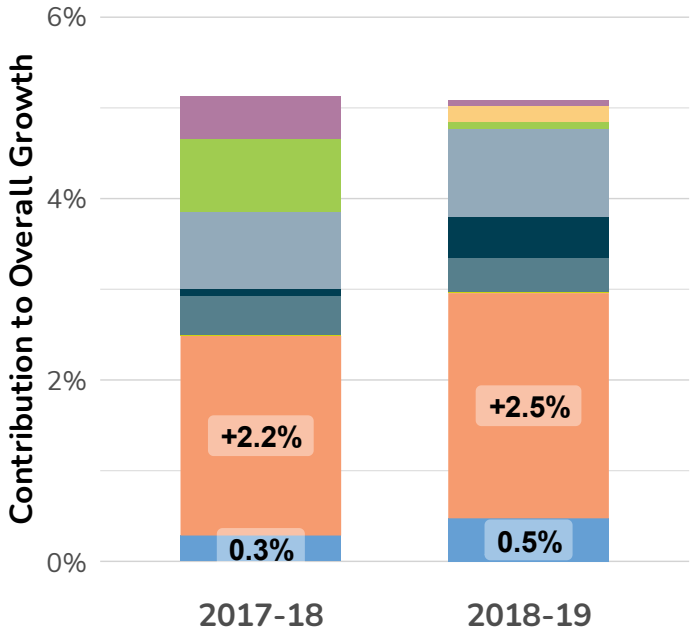
Figure 14: Commercial TME Spending Growth by Category



Spending in the commercial market grew from $16.1 billion in 2017 to $16.9 billion in 2018 and $17.7 billion in 2019, growing by 5.1% each year. The largest contribution to growth from this period was Hospital Outpatient, which contributed 2.2% and 2.5% of the overall 5.1% growth between each year.

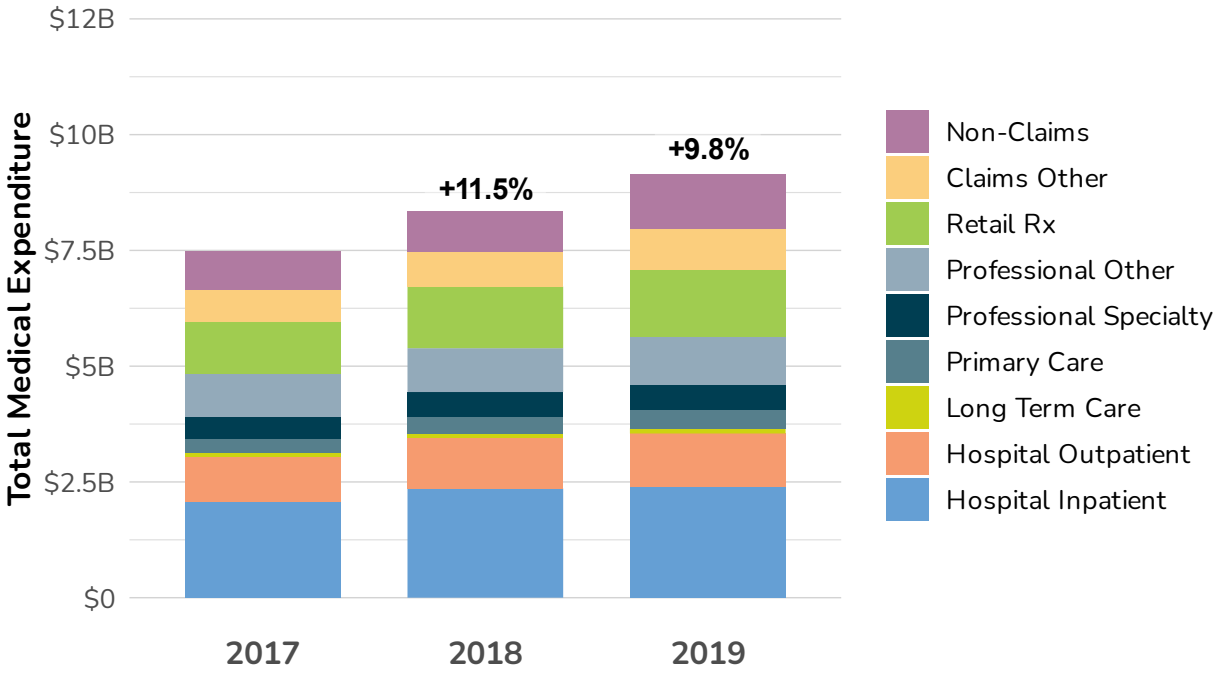
The policy to shift surgical procedures to outpatient facilities yielded increased spending in the commercial market, but hospital inpatient spending still grew by a modest 0.3% and 0.5% respectively.

Figure 15: Commercial TME Contribution to Spending Growth by Category



Medicaid provides health coverage to millions of Washingtonians, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. These figures reflect total spend for both Medicaid managed care and fee-for-service.

Figure 16: Medicaid TME Spending Growth by Category

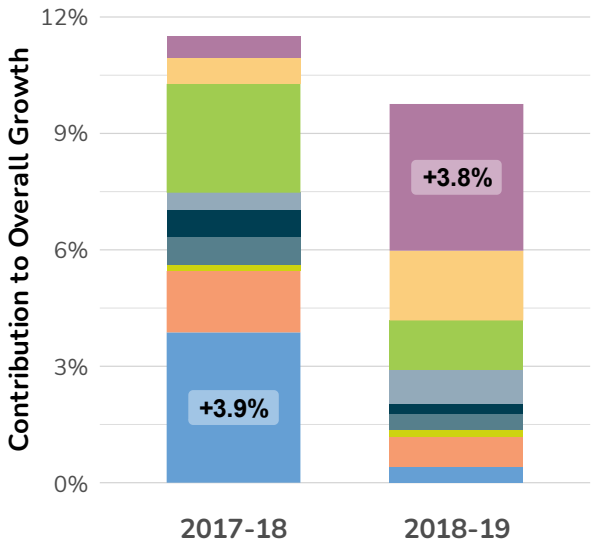


Total claims-based Medicaid spending in Washington was $1.2 billion in 2019, exhibiting the highest year-over-year growth of any market. From 2017 to 2018, Hospital Inpatient spending accounted for 3.9% of an 11.5% overall growth marker. Non-claims-based payments accounted for 3.8%, the largest portion of the 9.8% growth from 2018 to 2019.

Much of the growth of this period was driven by legislative directives on increased provider rates and hospital incentivization to increase access to health care. These policies supported expanding program eligibility and addressed market changes. Additionally, in this timeframe, behavioral health was being integrated into the Medicaid market.

Despite this spending growth rate, on a per member per year basis, Medicaid spending is still lower than in other markets (see Figure 2).

Figure 17: Medicaid TME Contribution to Spending Growth by Category



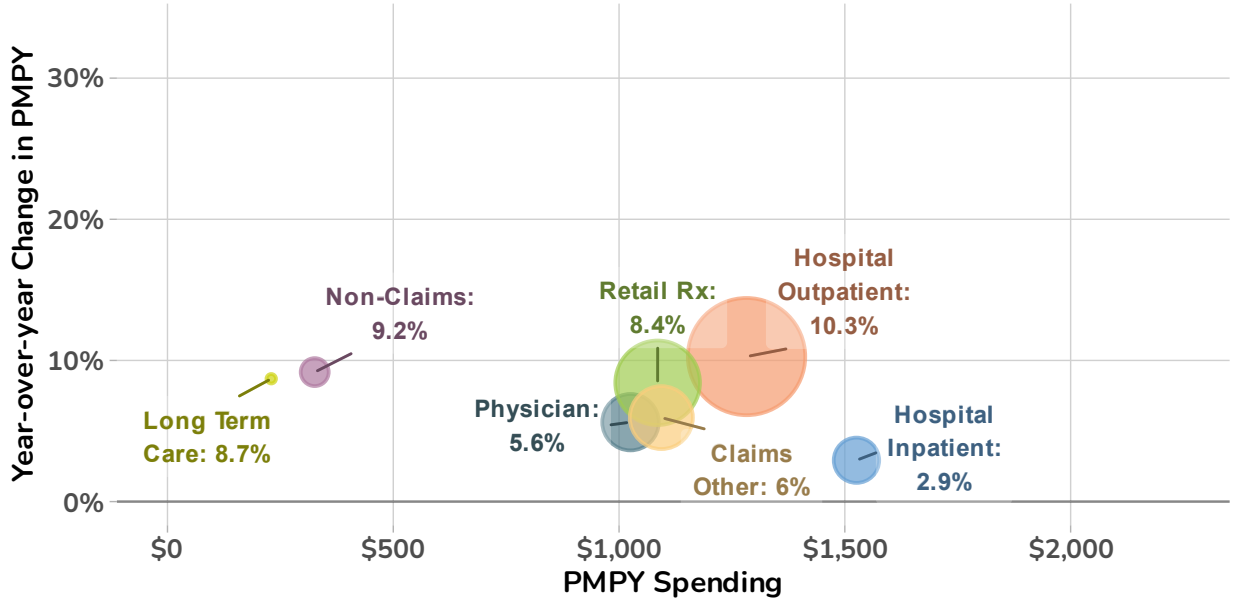
TME growth in per member per year spending by category – statewide and by market

The previous figures presented total dollars spent on health care in Washington by service category and by market. These sums, however, are a product of the number of people in Washington overall and the number of people with health insurance coverage in a particular market. Total Medical Expenses can also be reported on a per member per year basis to provide a standardized comparison across markets and service categories. The next figures summarize the growth rate for per member per year spending, by market.

State spending by category, per member per year

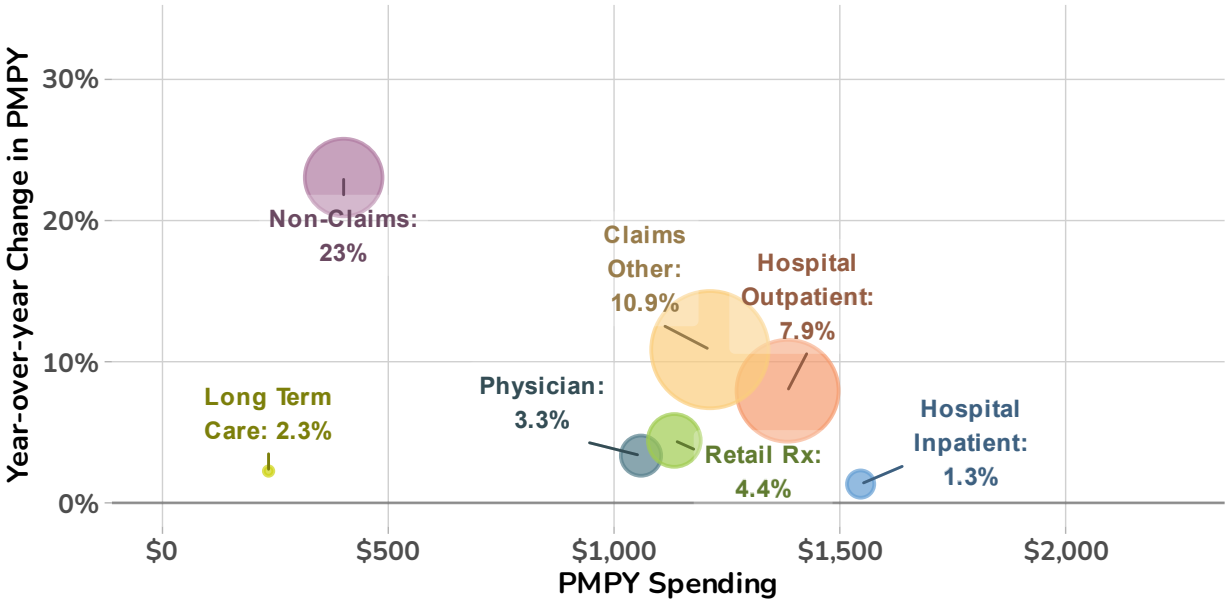
Per member per year state spending increased between 2017-2018 in most service categories across all markets. Hospital Outpatient services experienced some of the largest growth at 10.27%. Hospital Inpatient spending grew as well, although at a lower rate, by 2.93%. Some of the most substantial growth was see in Retail Rx, which saw an 8.42% increase.

Figure 18: State Claims PMPY Growth by Category, 2017-2018



Again between 2018 and 2019, per member per year spending in all claims-based categories increased. Hospital Outpatient again saw substantial increased spending, climbing another 7.94%. The largest increases were seen in the Non-claims and Claims Other categories, growing by 23.05% and 10.85% respectively. Those three categories comprised most of the growth in year-over-year spending during this period.

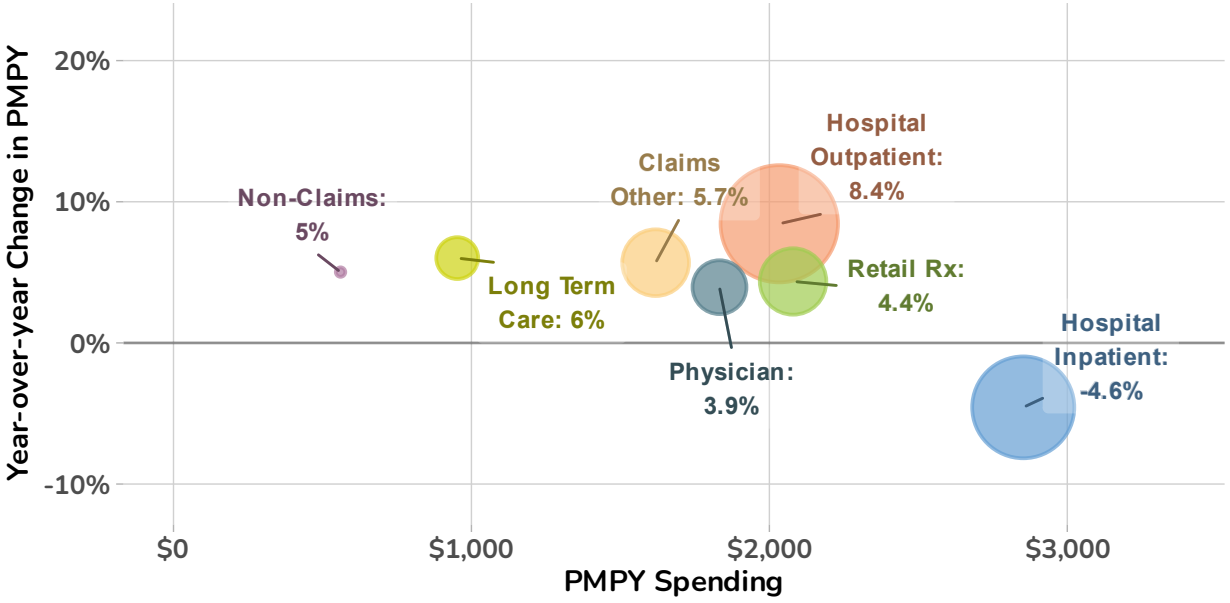
Figure 19: State Claims PMPY Growth by Category, 2018-2019



Medicare spending by category, per member per year

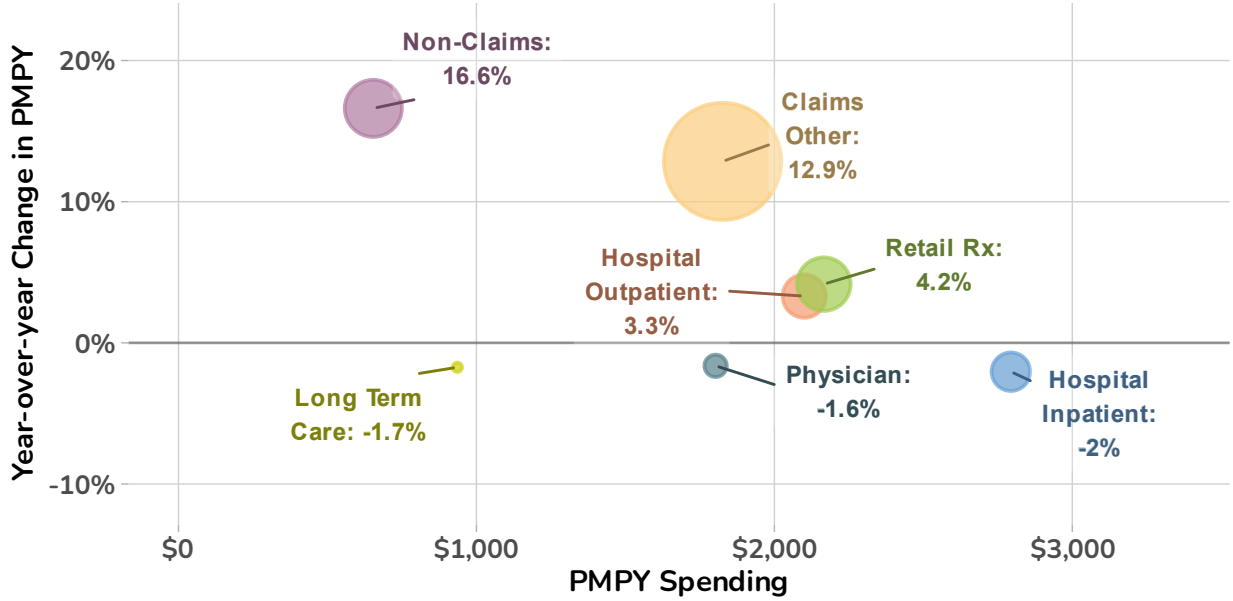
Between 2017-2018, per member per year spending in the Medicare markets increased across most claims-based categories. The most notable exception was the Hospital Inpatient category, which saw a 4.6% decrease. At the same time, Hospital Inpatient decreased by 4.6%, reflecting the implementation of a strategy to shift some surgical procedures to outpatient facilities to control costs. All other categories increased during this time period.

Figure 20: Medicare Claims PMPY Growth by Category, 2017-2018



From 2018 to 2019, that same shift in Medicare spending can be observed between Hospital Inpatient and Outpatient, albeit a more modest shift of -2% and +3.3% respectively. The two highest increases were observed in Non-Claims and Claims Other categories.

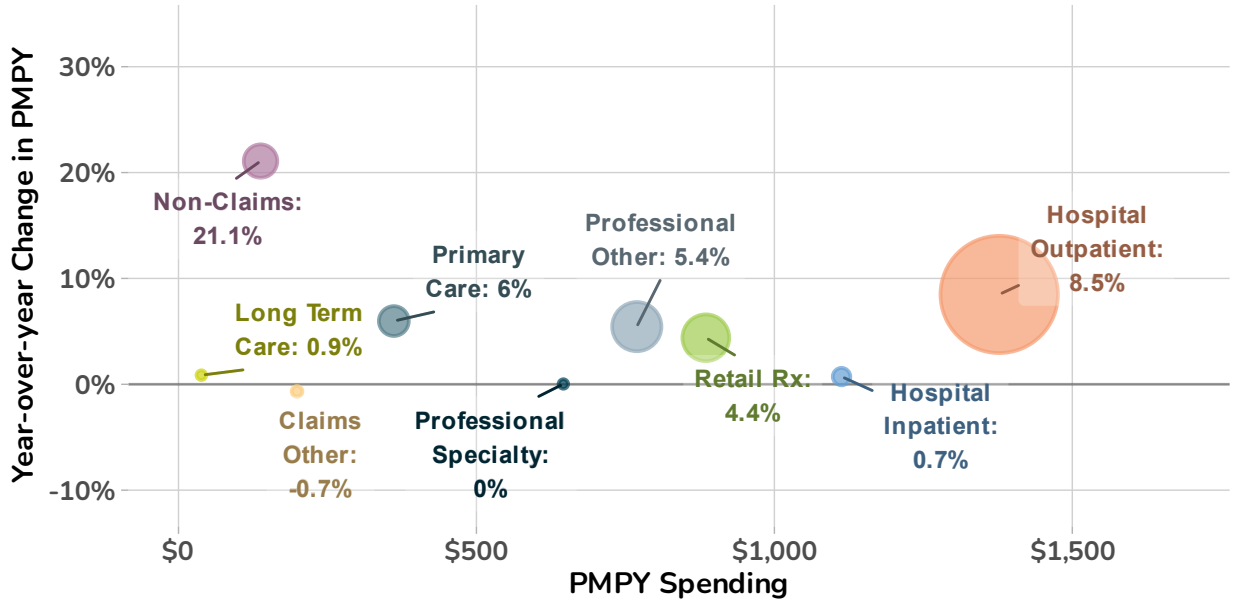
Figure 21: Medicare Claims PMPY Growth by Category, 2018-2019



Commercial spending by category, per member per year

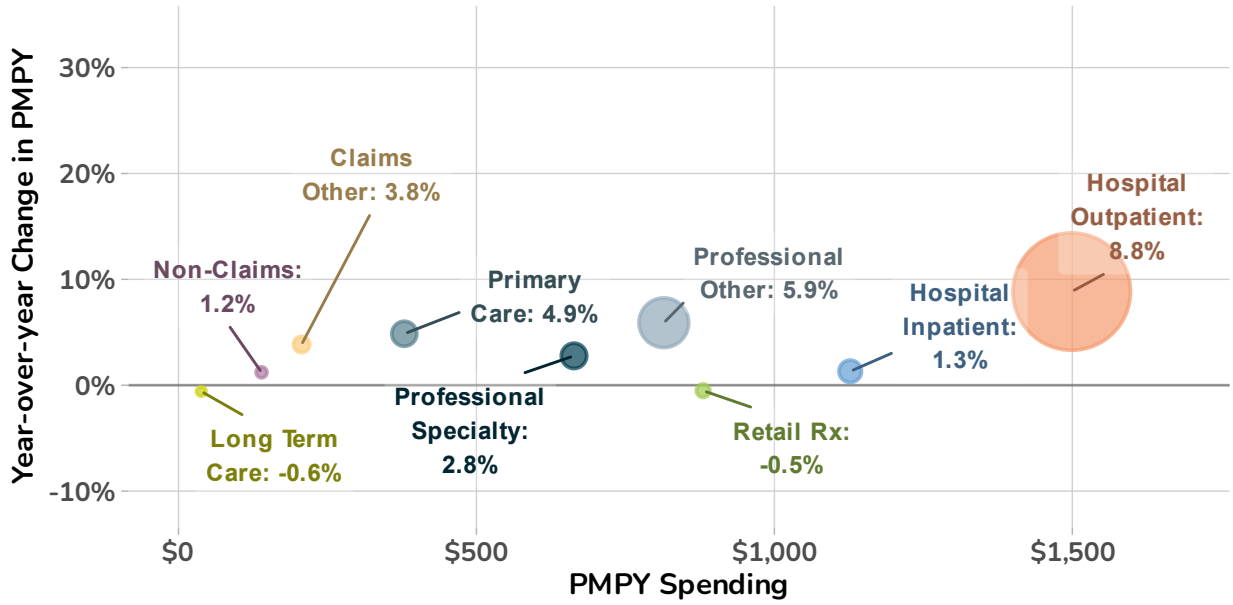
The commercial market saw substantial growth in per member per year spending between 2017-2018; spending in nearly all claims-based categories increased. The category with the highest spending level, Hospital Outpatient services, saw an 8.49% increase. High year-over-year variation was also seen in Non-Claims and Primary Care categories with 21.08% and 5.97% increases.

Figure 22: Commercial Claims PMPY Growth by Category, 2017-2018



The Hospital Outpatient category again saw substantial increased spending between 2018 and 2019, climbing an additional 8.8%. Also, for this year, the Professional Other category saw large increased spending of 5.9%.

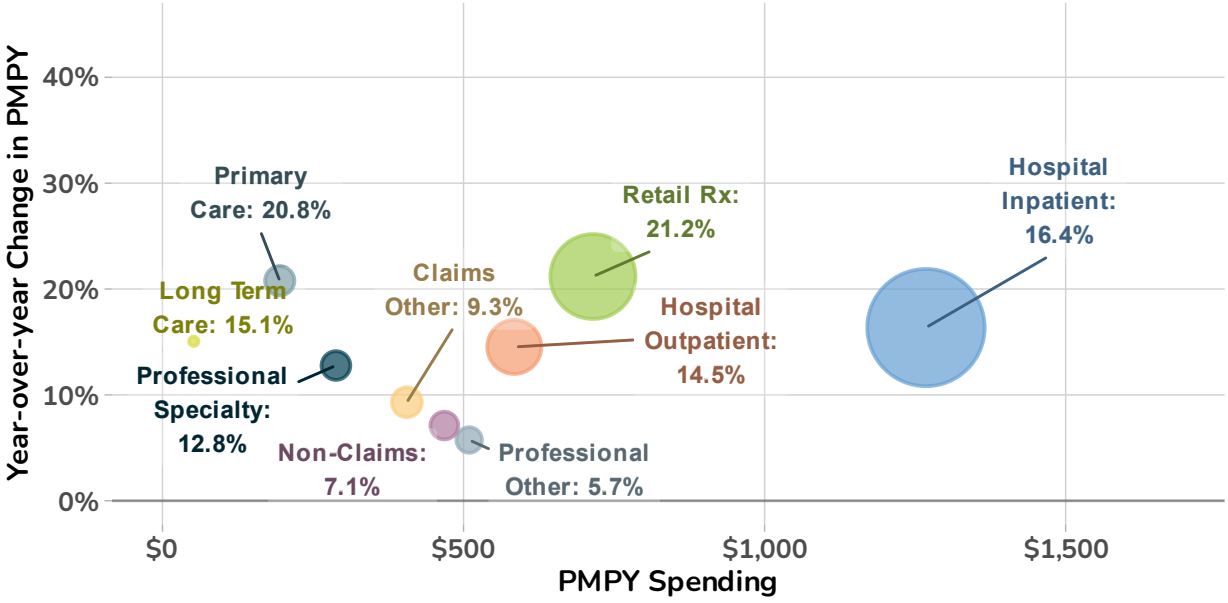
Figure 23: Commercial Claims PMPY Growth by Category, 2018-2019



Medicaid spending by category, per member per year

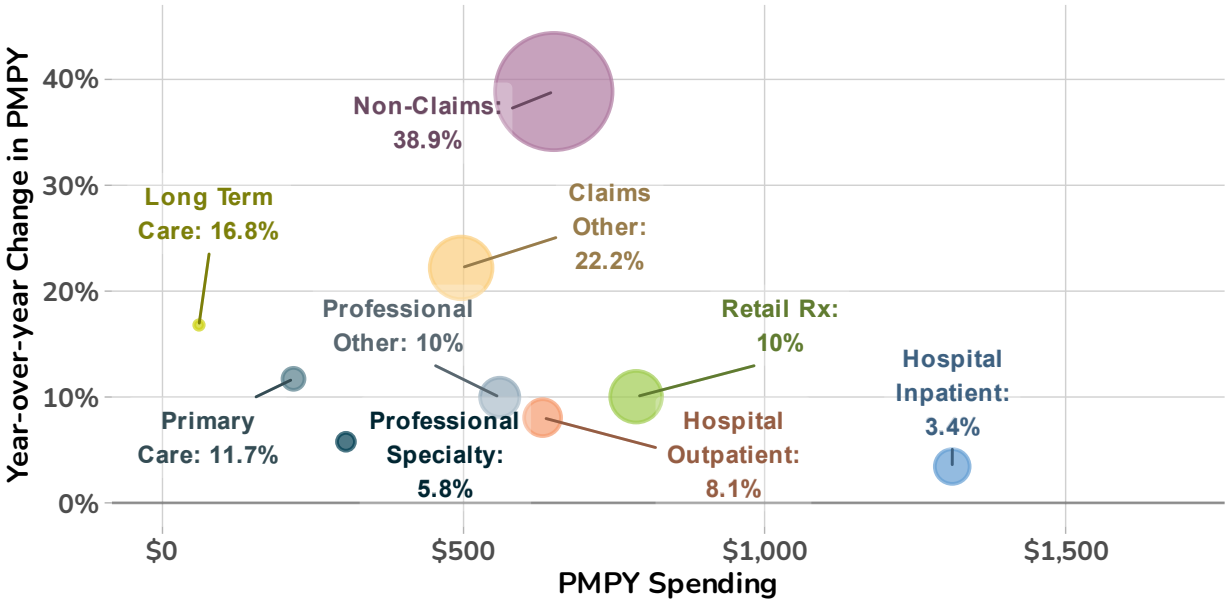
The 13.8% increase in THCE between 2017-2018 (Figure 2) was driven by substantial spending increases in all service categories. Hospital Inpatient and Outpatient increased by 16.36% and 14.53%. Two service categories increased by even greater measures, with Retail Rx increasing by 21.18% and Primary Care increasing by 20.77%. These across-the-board increases reflect new legislation going into effect that increased provider reimbursement rates.

Figure 24: Medicaid Claims PMPY Growth by Category, 2017-2018



Between 2018-2019, per member per year spending increased in all claims-based categories for Medicaid. The largest increase in spending was for Non-Claims, increasing by 38.86%. Claims Other increased by 22.2%, while the category with the highest spending PMPY, Hospital Inpatient, increased by a modest 3.43%.

Figure 25: Medicaid Claims PMPY Growth by Category, 2018-2019



Conclusion

Covid-19 pandemic impact on future benchmark reports

Collecting total cost of care data from 2017 to 2019 provides insight into where health spending was before the COVID-19 pandemic. Future years' reports, with data from 2020 onwards, will provide additional insights into the impacts of the pandemic on health care spending.[4] While those reports are not built to comprehensively examine the complex nature and impacts of a global infectious disease outbreak, they will shine a light on the initial impacts that the pandemic had on utilization and on payments between payers and provider organizations.

Summary

Total cost of care spending in Washington is a high-level view of how health care dollars are flowing in the system. Many factors influence Washington's total cost of care, including insurance coverage across the state, health care prices set by contracts negotiated between health insurers and providers in the previous year, non-claims payment arrangements (e.g., value-based payments), insurance premium rates, and patient utilization. Additional research and understanding of increasing health care spending are necessary to facilitate and enhance efforts to improve affordability. The Board's evidence-based approach to health care cost data provides a common understanding of spending trends for consumers, purchasers, and regulators to help make health care more affordable in Washington.

[4]Peterson-KFF Health System Tracker. How have health spending and utilization changed during the coronavirus pandemic? March 2021

Appendix A – Definitions of key terms

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

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

Potential gross state product (PGSP): PGSP is the total value of goods produced and services provided in a state at a constant inflation rate.

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

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

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

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

Net cost of private health insurance (NCPHI): Measures the costs to Washington residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred, and consists of carriers' costs of paying bills, advertising, sales commission and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of total health care expenditures at the state level.

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

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

Pharmacy rebates: Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.[5] Spending at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).[6]

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

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

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

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

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

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

Appendix B – Cost Board members

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

Tab 9

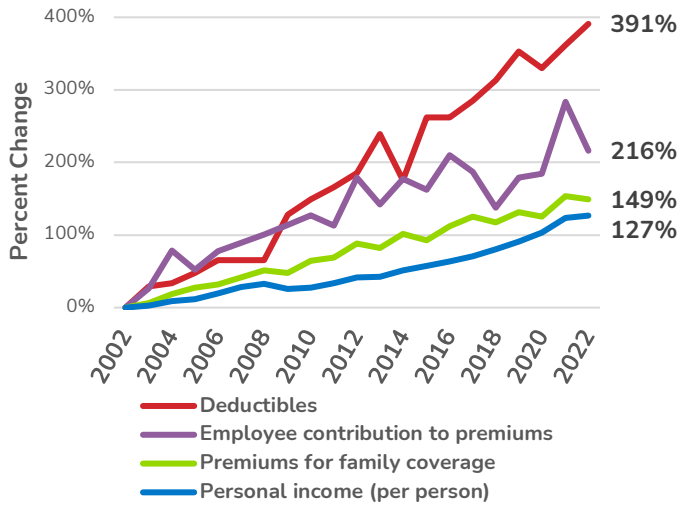
Washington State Health Care Authority

The Impact of High Health Care Costs in the State of Washington

Affordability for consumers

Over the past two decades, out-of-pocket health care costs for Washington consumers such as co-pays and deductibles have been outpacing wage growth. Higher health care costs have also translated to higher monthly premiums for consumers. For Washingtonians with health insurance through their employer, more health care spending gets passed on to employees in the form of employee contributions. While more is being subtracted from workers' paychecks every month, deductibles have risen even faster, increasing workers' overall financial responsibility for health care services they receive.

Figure 1. Health care premiums and deductibles outpacing income in Washington



Source: The Bureau of Economic Analysis (BEA) and the Medical Expenditure Panel Survey (MEPS)

This rise in health care costs has a real impact on affordability for Washingtonians. Mounting out-of-pocket costs drive consumers to delay care, negatively impacting their health and putting a strain on household budgets.

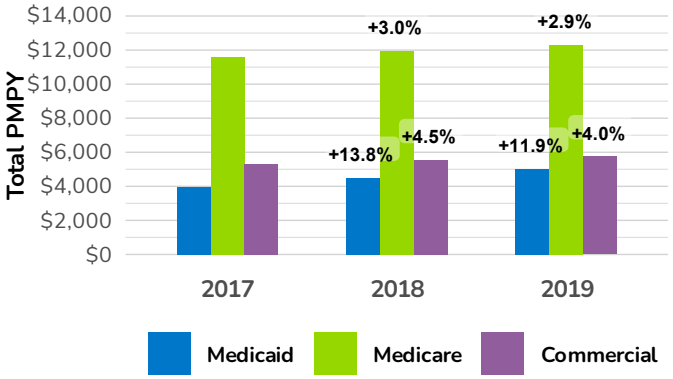
Figure 2. In 2022, 62% of WA respondents reported experiencing health care affordability burdens in the past 12 months

Source: Altarum's Consumer Healthcare Experience State Survey (CHESS)

Increasing costs across markets

The high out-of-pocket costs experienced by Washington consumers are driven by the increasing costs of health care services for each patient. Data show that spending in each health insurance market including commercial, Medicare, and Medicaid saw substantial growth between 2017 and 2019.

Figure 3. Health care spending increasing across all markets, 2017 - 2019



Source: WA Benchmark Report: 2017-2019

The path forward

The Health Care Cost Transparency Board has been charged with gathering data annually from providers and carriers in Washington to analyze health care spending growth. Policy makers and stakeholders will use this information to find ways to control the growth of health care costs. Some opportunities may include:

- **Provider Rate Setting:** Assigning reimbursement levels for certain health care services
- **Price Growth Caps:** Establishing the highest rate of growth allowable for certain types of health care services
- **Limiting Facility Fees:** Capping additional out-of-pocket charges in outpatient services
- **Mergers and Acquisitions:** Preventing further consolidation in the health care industry

Tab 10

Washington State Health Care Authority

HEALTHCAREDIVE

DIVE BRIEF

Medical credit cards 'exploit loopholes' in healthcare debt protection, report finds

The credit cards, which can promise patients deceptive no- or low-interest rates, are increasingly being offered in hospitals and physician offices.

Published Sept. 8, 2023

Sydney Halleman
Editor

Joe Raedle / Staff via Getty Images

Dive Brief:

- Medical credit cards, which exploit loopholes in debt protection law and can add costs to already-high medical bills, are increasingly being offered to patients in medical offices and physician settings, nonprofit Public Interest Research Groups warned in a new report.
- The relatively new credit cards, which target patients with medical debt, lack the same consumer protections that limit how healthcare debt can impact credit scores, PIRG said.
- The Biden administration has been cracking down on medical credit cards over concerns they drive up the cost of healthcare services by luring patients with deferred interest rates, before hitting customers with interest rates higher than regular credit cards.

Dive Insight:

Medical credit cards are offered to patients in healthcare settings as a solution to pay off medical debt, often featuring enticing interest-free or deferred interest rate periods of several months.

Medical credit card companies say their products help families and individuals pay for out-of-pocket healthcare costs. But the deferred interest rates on the cards can lead to patients paying higher interest rates on medical bills than they would with normal credit cards if they miss a payment or are unable to pay the full card balance on time.

Patients in the U.S. paid $1 billion in deferred interest on medical credit cards and other healthcare financing between 2018 and 2020, according to a May report from the Consumer Financial Protection Bureau.

Increasingly, hospitals and physician offices themselves advertise medical credit cards. CareCredit, a medical credit card offered by Synchrony Bank, says it has partnerships with 250,000 providers to market the credit cards, according to the CFPB.

Providers can offer up the credit cards in lieu of other low- or no-cost payment plans that might be more beneficial to consumers, PIRG noted. Recently, a number of nonprofit health systems have come under increased scrutiny for deficits in programs meant to help low-income patients cover the cost of their care.

“MDs have the expertise to prescribe drugs — not financial advice. You wouldn’t go to an investment banker for a medical diagnosis,” said Patircia Kelmar, U.S. PIRG’s senior director of healthcare campaigns, in a press release. “Evidence shows that medical credit cards can worsen debt and even lead to bankruptcy. And your provider or hospital can’t cure that.”

Medical credit cards also exploit loopholes in debt protection laws, according to PIRG. They do not include consumer protections that limit the impact of medical debt, including those eliminate medical debt from credit reports after being paid off and those that remove debt under $500 from credit reports.

Before the three largest credit bureaus changed how they track medical debt between July 2022 and April this year, medical debt would remain on credit reports for up to seven years.

The Biden administration has zeroed in on medical credit cards as it increases scrutiny on rising healthcare costs. In July, three federal agencies — the HHS, the CFPB and the Treasury Department — issued a request for more information on the use of medical credit cards.

The collaborative effort followed the May report from the CFPB finding that the top companies offering medical cards — Wells Fargo, CareCredit and Bread Financial subsidiary Comenity — could push patients deeper into healthcare debt.

In Oregon alone, CareCredit is the single most frequently listed medical debt holder, beating the 10 most frequently reported health systems, according to an analysis of 2019 bankruptcy filings in the state from a PIRG affiliate.

DIAGNOSIS: DEBT

Medical Debt Affects Much of America, but Colorado Immigrants Are Hit Especially Hard

By Rae Ellen Bichell and Lindsey Toomer, Colorado Newsline

APRIL 3, 2024

Norma Brambila, a community organizer with Westwood Unidos, inside La Casita Community House in Denver. More than 1 in 5 adults in the ZIP code that includes the Westwood neighborhood have medical debt on their credit reports. Brambila, too, is dealing with a bill hanging over her head, after an emergency room visit for a bad sinus infection. (RACHEL WOOLF FOR KFF HEALTH NEWS)

DENVER — In February, Norma Brambila's teenage daughter wrote her a letter she now carries in her purse. It is a drawing of a rose, and a note encouraging Brambila to "keep fighting" her sickness and reminding her she'd someday join her family in heaven.

Brambila, a community organizer who emigrated from Mexico a quarter-century ago, had only a sinus infection, but her children had never seen her so ill. "I was in bed for four days," she said.

Lacking insurance, Brambila had avoided seeking care, hoping garlic and cinnamon would do the trick. But when she felt she could no longer breathe, she went to an emergency room. The $365 bill — enough to cover a week of groceries for her family — was more than she could afford, pushing her into debt. It also affected another decision she'd been weighing: whether to go to Mexico for surgery to remove the growth in her abdomen that she said is as big as a papaya.

Brambila lives in a southwestern Denver neighborhood called Westwood, a largely Hispanic, low-income community where many residents are immigrants. Westwood is also in a ZIP code, 80219, with some of the highest levels of medical debt in Colorado.

COLAB
COLORADO NEWS COLLABORATIVE

This story also ran on COLab. It can be republished for free.

About This Story

"Diagnosis: Debt Colorado" is a reporting partnership among Colorado newsrooms led by KFF Health News and the Colorado News Collaborative that explores the scale, impact, and causes of medical debt in Colorado. The ongoing series builds on KFF Health News' award-winning reporting on medical debt in the United States.

READ MORE

More than 1 in 5 adults there have historically had unpaid medical bills on their credit reports, more in line with West Virginia than the rest of Colorado, according to 2022 credit data analyzed by the nonprofit Urban Institute.

The area's struggles reflect a paradox about Colorado. The state's overall medical debt burden is lower than most. But racial and ethnic disparities are wider.

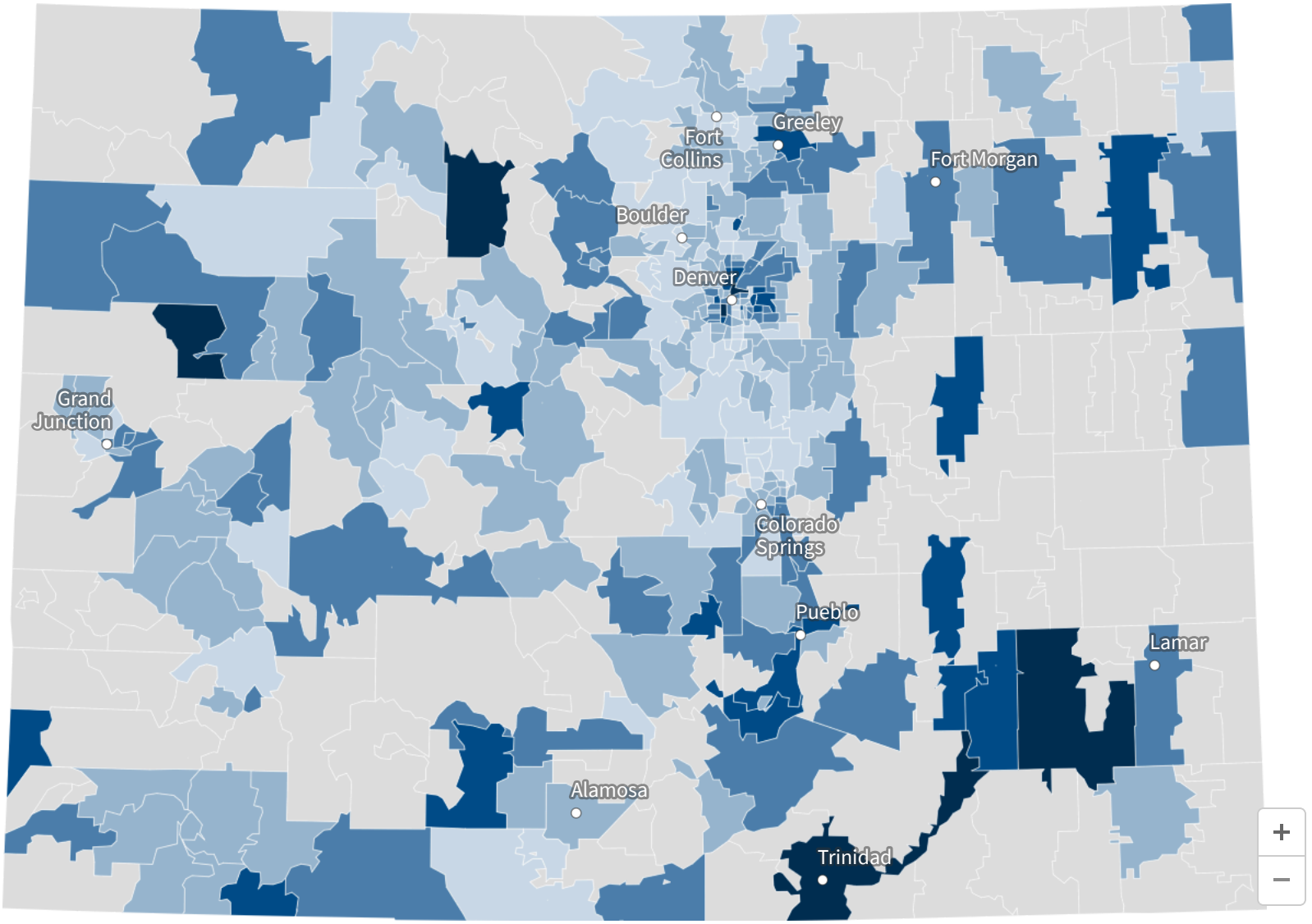
The gap between the debt burden in ZIP codes where residents are primarily Hispanic and/or non-white and ZIP codes that are primarily non-Hispanic white is twice what it is nationally. (Hispanics can be of any race or combination of races.)

All Colorado ZIP Codes Experience Medical Debt, But Six Are Hit Especially Hard

In six ZIP codes, at least 22.58% of adults had medical debt on their credit reports as of February 2022. In two of them, residents are primarily Hispanic.

Percent of Colorado adults with medical debt on credit reports, by ZIP code:

< 6.92% 6.92% to < 12.14% 12.14% to < 17.36% 17.36% to < 22.58% ≥ 22.58%



Source: Urban Institute
Credit: Rae Ellen Bichell/KFF Health News Map data: © Esri, TomTom North America, Inc., United States Postal Service Embed

Medical debt in Colorado is also concentrated in ZIP codes with relatively high shares of immigrants, many of whom are from Mexico. The Urban Institute found that 19% of adults in these places had medical debt on their credit reports, compared with 11% in communities with fewer immigrants.

Nationwide, about 100 million people have some form of health care debt, according to a KFF Health News-NPR investigation. This includes not only unpaid bills that end up in collections, but also those being paid off through installment plans, credit cards, or other loans.

Racial and ethnic gaps in medical debt exist nearly everywhere, data shows. But Colorado's divide — on par with South Carolina's, according to the Urban Institute data — exists even though the state has some of the most extensive medical debt protections in the country.

The gap threatens to deepen long-standing inequalities, say patient and consumer advocates. And it underscores the need for more action to address medical debt.

"It exacerbates racial wealth gaps," said Berneta Haynes, a senior attorney with the nonprofit National Consumer Law Center who co-authored a report on medical debt and racial disparities. Haynes said too many Colorado residents, especially residents of color, are still caught in a vicious cycle in which they forgo medical care to avoid bills, leading to worse health and more debt.

Brambila said she has seen this cycle all too often around Westwood in her work as a community organizer. "I really would love to help people to pay their medical bills," she said.

Brambila stands outside La Casita Community House in Denver's Westwood neighborhood. (RACHEL WOOLF FOR KFF HEALTH NEWS)

A mural in the Westwood neighborhood of Denver. (RACHEL WOOLF FOR KFF HEALTH NEWS)

Health or Debt?

Roxana Burciaga, who grew up in Westwood and works at Mi Casa Resource Center there, said she hears questions at least once a week about how to pay for medical care.

Medical debt is a “big, big, big topic in our community,” she said. People don’t understand what their insurance actually covers or can’t get appointments for preventive care that suit their work schedules, she said.

Many, like Brambila, skip preventive care to avoid the bills and end up in the emergency room.

Doctors and nurses say they see the strains, as well.

Amber Koch-Laking, a family physician at Denver Health’s Westwood Family Health Center, part of the city’s public health system, said finances often come up in conversations with patients. Many patients try to get telehealth appointments to avoid the cost of going in person.

Adding to the crunch is Medicaid "unwinding", the process of states reexamining post-pandemic eligibility for health coverage for low-income people, Koch-Laking said. “They say, ‘Oh, I'm losing my Medicaid in three weeks, can you take care of these seven things without a visit?’ Or like, ‘Can we just do it over the portal, because I can't afford it?’”

Looking for the Right Fix

Colorado has taken steps to protect patients from medical debt, including expanding Medicaid coverage through the 2010 Affordable Care Act. More recently, state leaders required hospitals to expand financial assistance for low-income patients and barred all medical debts from consumers’ credit reports.

But the complexities of many assistance programs remain a major barrier for immigrants and others with limited English, said Julissa Soto, a Denver-based health equity consultant focused on Latino Coloradans.

Many patients, for example, may not know they can seek help with medical bills from the state or community nonprofits.

“The health care system is a puzzle. You better learn how to play with puzzles,” said Soto, who said she was sent to collections for medical bills when she first immigrated to the U.S. from Mexico. “Many hospitals also have funding to help out with your debt. You just have to get to the right

person, because it seems that nobody wants to let us know that those programs exist.”

She said simplifying bills would go a long way to helping many patients.

Several states, including Oregon, Maryland, and Illinois, have tried to make it easier for people to access hospital financial aid by requiring hospitals to proactively screen patients.

Patient and consumer advocates say Colorado could also further restrict aggressive debt collection, such as lawsuits, which remain common in the state.

New York, for example, banned wage garnishment after finding that the practice disproportionately affected low-income communities. Research there also showed that medical debt burden was falling about twice as hard on communities of color as it was on non-Hispanic white communities.

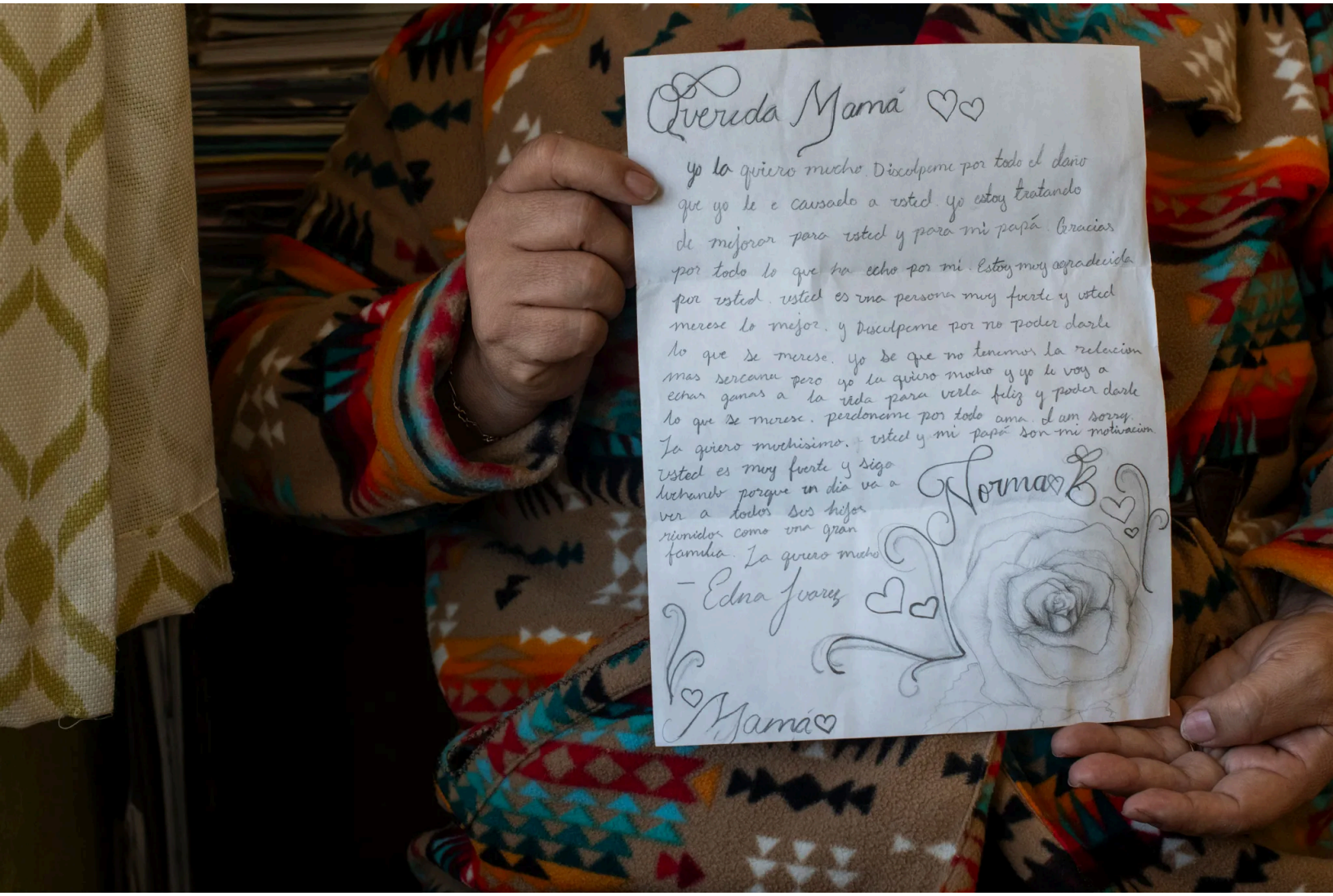
Elisabeth Benjamin, a lawyer with the Community Service Society of New York, said hospitals were garnishing the wages of people working at Walmart and Taco Bell.

Maryland enacted limits on debt collection lawsuits after advocates found that patients living in predominantly minority neighborhoods were being disproportionately targeted. Even in wealthy counties, “the pockets that are being pursued are majority Latino neighborhoods,” said Marceline White, executive director of the advocacy group Economic Action Maryland.

White's group helped pass a law requiring hospitals to pay back low-income patients and avoid the scenario she was seeing, in which hospitals were “suing patients who should have gotten free care.”

Exacting a Heavy Toll

Brambila is a community organizer with Westwood Unidos. (RACHEL WOOLF FOR KFF HEALTH NEWS)



When Brambila came down with a sinus infection, she put off seeking medical care, out of fear of the ensuing bill. She became so ill that her daughter wrote a letter in Spanish telling her how much she loved her and urging her to “keep fighting.” (RACHEL WOOLF FOR KFF HEALTH NEWS)

In Colorado, lawmakers are considering a measure to improve patients’ access to financial aid: a modification to the state’s Hospital Discounted Care program that would make hospitals presumptive eligibility sites for Medicaid.

Meanwhile, some consumer advocates say existing protections aren’t working well enough.

State data shows patients who received financial assistance were primarily white. And, though it’s unclear why, 42% of patients who may have been eligible were not fully screened by hospitals for financial assistance.

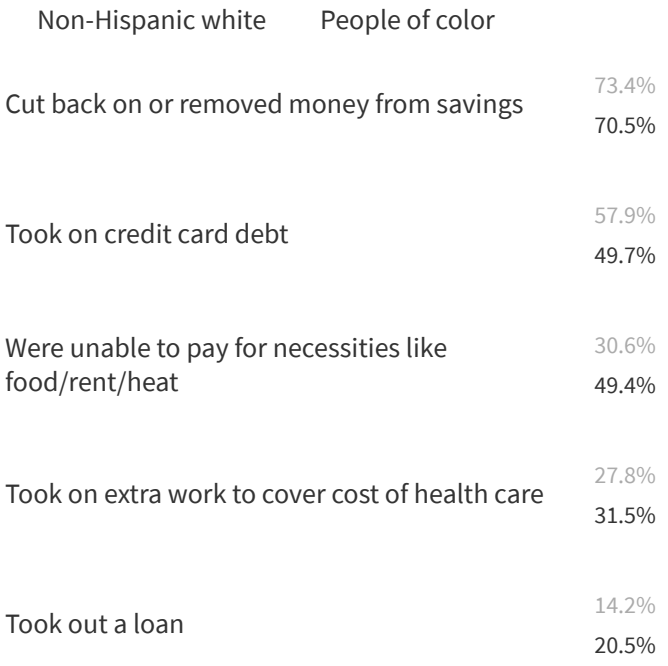
“What is clear is that a lot of people are not making it through,” said Bethany Pray, deputy director of the Colorado Center on Law and Policy, a Denver-based legal aid group that pushed for the discounted care legislation.

Within the state's immigrant communities, medical debt — and the fear of debt — continues to take a heavy toll.

"What we've heard from our constituents is that medical debt sometimes is the difference between them being housed and them being unhoused," said Denver City Council member Shontel Lewis. Her district includes the 80216 ZIP code, another place north of the city center that is saddled with widespread medical debt.

The Ripple Effect of Medical Debt in Colorado

About 11% of Coloradans said they had a problem paying medical bills in the past year. People of color were much more likely than non-Hispanic white residents to be unable to pay for food, rent, or heat because of difficulty paying medical bills. The share of Coloradans who:



Note: Data is from 2021.
Source: Colorado Health Institute's 2021 "Colorado Health Access Survey"
Credit: Rae Ellen Bichell/KFF Health News

Paola Becerra is an immigrant living in the U.S. without legal permission who was pregnant when she was bused to Denver from a Texas shelter a few months ago.

She said she has skipped prenatal care visits because she couldn't afford the $50 copays. She has emergency health coverage through Medicaid, but it doesn't cover preventive visits, and she has already racked up about $1,600 in bills.

"I didn't know that I was going to arrive pregnant," said Becerra, who thought she could no longer conceive when she left Colombia. "You have to give up your health. Either I pay the rent, or I pay the hospital."

For Rocio Leal, a community organizer in Boulder, medical debt has become a defining feature of her life.

Despite the health insurance she had through her job, Leal ended up with high-interest payday loans to pay for healthy births, wage garnishment, prenatal appointments she missed to save money, and a “ruined” credit score, which limited her housing options.

Leal recalled times she thought they’d be evicted and other times the electricity was cut off. “It's not like we're avoiding and don't want to pay. It's just sometimes we don't have an option to pay,” she said.

Leal said the worst times are behind her now. She’s in a home she loves, where neighbors bring cakes over to thank her son for shoveling the snow off their driveway.

Her children are doing well. One daughter got a perfect GPA for the second semester in a row. Another is playing violin in the school orchestra. Her third daughter attends art club. And her son was recently accepted to college for biomedical engineering. They are covered by Medicaid, which has removed the uncertainty around big medical bills.

But medical debt still haunts Leal, who has Type 2 diabetes.

When she was referred to Boulder Medical Center to get her eyes checked after the diabetes diagnosis, she said she was told there was a red flag by her name. The last time she’d interacted with the medical center was about a dozen years earlier, when she’d been unable to pay pediatrician bills.

“I was in the process of moving and then my wages were garnished,” she recalled. “I just was like, ‘What else do I owe?’”

Heart pounding, she hung up the phone.

KFF Health News senior correspondent Noam N. Levey contributed to this report.

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