Health Care Cost Transparency Board Meeting

May 15, 2024

Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

HEALTH CARE COST TRANSPARENCY BOARD AGENDA

May 15, 2024
1:00-4:00 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
1:00-1:05 (5 min)	Welcome and roll call	1	Sue Birch, Director Health Care Authority
1:05-1:10 (5 min)	Approval of the February Meeting Summary	2	Sue Birch, Director Health Care Authority
1:10-1:20 (10 min)	Primary Care Committee • Potential policy options preview	3	Dr. Judy Zerzan-Thul, Medical Director Health Care Authority
1:20-1:50 (30 min)	Financial Analysis of Washington Hospitals (Costs, Prices, & Profits Analysis) • Q&A / Discussion	4	John Bartholomew & Tom Nash Bartholomew-Nash & Associates
1:50-2:20 (30 min)	Strategic Lever: Business Oversight: Mergers & Acquisitions, Private Equity Investments, Provider Ownership & Closures • Q & A / Discussion	5	Jeanene Smith Health Management Associates
2:20-2:30 (10 min)	BREAK		
2:30-2:55 (25 min)	Strategic Lever: Facility Fees • Q & A / Discussion	6	Zach Sherman Health Management Associates
2:55-3:10 (15 min)	Potential Levers: Consumer Medical Debt • Q & A / Discussion	7	Liz Arjun Health Management Associates
3:10-3:40 (30 min)	Analytic Support Initiative • Discussion of DEX Report	8	Joseph L Dieleman, Associate Professor for Health Metrics and Evaluation | University of Washington
3:40-3:50 (10 min)	Nomination Committee Recommendations and Appointment of Chairs	9	Liz Arjun Health Management Associates
3:50-4:00	Public Comments	10	Sue Birch, Director Health Care Authority
4:00	Wrap Up and Adjourn The Board's next meeting: July 30, 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

April 10, 2024

Virtual meeting held electronically (Zoom) and in person at the Health Care Authority (HCA)
2 – 4 p.m.

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

Members present

Sue Birch, Chair
Jane Beyer
Eileen Cody
Lois Cook
Bianca Frogner
Jodi Joyce
Greg Marchand
Margaret Stanley
Ingrid Ulrey
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Mark Siegel

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:05 p.m.

Agenda items

Welcoming remarks

Chair Sue Birch welcomed members of the Health Care Cost Transparency Board (the Board) to the meeting and drew their attention to materials in the meeting packet that report on the challenges of medical debt and health care affordability in the US. The agenda was previewed.

Meeting summary review of the previous meeting

After a scrivener's error was pointed out, the Board **voted to adopt** the February 2024 meeting summary.

Public comment

Chair Sue Birch called for comments from the public.

Jeb Shepherd of the Washington State Medical Association provided comment summarizing his letter that appears in the written comments, stating that WA is ranking third in health care affordability relative to other states. This success is due to the collaborative nature of entities like the Board and advocacy groups like the Bree Collaborative and Washington Health Association. While acknowledging that health care costs continue to increase year after year, pricing is the function of many complex factors. The risk of recommendations that target specific sectors of health care like providers may not have the intended effects, instead voicing support for addressing administrative burdens.

Diane Blake, CEO of Cascade Medical in Leavenworth, lent perspective on health care costs of critical access hospitals and rural clinics. At this facility, Medicare and Medicaid services are generally charged at cost, and the policy levers of focus chosen by the Board may not address underlying issues. With labor costs skyrocketing (currently at 69% of operating expenses), it is unlikely Cascade Medical will meet the growth benchmark, if it was an organization identified for benchmarking purposes.

Adam Zarrin, Director of Legislative Affairs at Leukemia and Lymphoma Society (LLS) commented that seven in ten Americans are getting medical bills they can't afford, as costs continue to rise at double the rate of inflation. Consolidation is identified as one of the major drivers, highlighting an LLS report and additional written comment outlining policy recommendations of the organization.

Emily Brice, Deputy Director of Northwest Health Law Advocates (NoHLA) lent support for current policy directions, noting that contrary to other public and written comments offered, there are plenty of opportunities for change. The policy options of interest to the Board are relevant and impactful. Medical debt is durable, staying on the books for seven years with 9% interest rates that can last for 20 years. Tackling this problem is crucial to families in the state of Washington.

Katarina LaMarche of Washington State Hospital Association yielded time to Krista Able, a member of the Board's Advisory Committee of Health Care Providers and Carriers.

Krista Able, Director at Virginia Mason/Franciscan Health drew attention to her interpretation of the OnPoint Cost Drivers analysis. She also contended that action on mergers and acquisitions at this point might not be effective given the current state of consolidation. Policy regarding anti-competitive clauses in contracting needs additional clarity, discussion, and definition. Chair Birch asked that more information be presented at the next meeting that gives clarity about utilization from OnPoint data.

Sam Hatzenbeler, Senior Policy Associate at the advocacy group, the Economic Opportunity Institute, lent support for the policy focuses of the Board, especially consolidation in the health care field. Washington's success relative to other states does not mean health care is affordable, referencing survey results from **Altarum** that highlight equity concerns. Underlying problems of affordability and health equity have come to include the concept of "underinsurance", which the Board will study in upcoming years.

Written public comments can be found in the meeting materials.

Legislative Updates

Evan Klein, Health Care Authority
Jane Beyer, Office of the Insurance Commissioner (OIC)

Evan Klein offered a brief overview of the short 60-day legislative session that concluded on March 7, 2024. Though some notable bills did not pass in the 2024 session, the Legislature is taking health care affordability seriously with earnest conversation continuing after session.

Comprehensive reform of pharmacy benefit managers passed in E2SSB 5213. Price caps for inhalers and auto-injectors passed in SHB 1979, as did consumer protections for out-of-network charges in SSB 5986. ESHB 1957 passed, preserving coverage of preventative services without cost sharing for Washingtonians.

One bill that failed to pass was ESB 5241, the Keep Our Care Act, which was designed to monitor mergers and acquisitions in the health care market, studying the impacts that consolidation would have on health care accessibility. The Health Benefit Exchange supported a bill that sought to standardize the individual market. Both bills engaged the House and Senate in discussions around improving accessibility and will likely be reintroduced in a future legislative session. HB 2476 seeking to clarify covered lives assessments in contracting also failed, as did HB 2066 that focused on anti-competitive clauses in health care contracting.

Through the budgetary process, an Apple Health Expansion was funded, covering Washington residents whose immigration status is not federally recognized, as did additional staff resources for the Public and School Employees Benefits Boards (PEBB and SEBB). A study on coverage for essential health workers also passed. Information Technology efforts around improvements for community information exchange and interoperability efforts for electronic health records were funded.

Finally, rate increases that covered tribal encounters, non-emergency medical transport, private duty nurses, and substance-using pregnant people (SUPPs) were approved.

Legislative updates from the OIC covered experimentation of rate setting on allowed amounts in private insurance, which will have a direct impact on consumers. Behavioral health transport was also covered this session. Additionally, legislation passed to support prior-authorization synchronization across insurers moved forward.

Update on E2SSB 1508

Rachelle Bogue, Health Care Authority

Legislation passed this year with changes to the board, the Advisory Committee of Health Care Providers and Carriers will be expanded and its name changed to the "Health Care Stakeholder Advisory Committee." Moving forward, it will add seats for consumer advocates, labor, and employer purchasers.

Two new biannual surveys are funded covering underinsurance and cost drivers for employers and employees. Greater flexibility for interagency data sharing is also granted by the bill. Finally, the annual report of the Board to the Legislature is pushed back from August 1st to December 1st, coinciding with a new annual public hearing covering health care expenditures and affordability concerns of Washingtonians.

Medical debt in America

Noam Levey, Senior Correspondent, Kaiser Familiy Foundation (KFF) Health News

Medical debt is a crisis hiding in plain sight, with more than 100 million Americans carrying some form of medical debt. The work that went into the report included hundreds of interviews, including one middle class family flooded by medical debt when their newborn needed immediate care in an intensive care unit. Other stories included a woman haunted by lingering costs from a mistakenly billed rape kit and a family's financial well-being undone by emergency surgery. People tap into home equity, borrow from family, credit cards, and take out payday loans to cover medical expenses. Medical debt like this becomes invisible when it is essentially shifted from health care providers into the financial system. 57% of Americans have been forced into medical debt in just the last 5 years. Among those who carry medical debt, one in five say they expect to never pay back the debt. Those with the burden of chronic disease are at the most risk of falling into medical debt. To grapple with medical expenses, many cut back other spending, move residence, or take on additional extra work.

While poor social determinants of health are strongly linked to health risks, medical debt creates crises of social determinants of health by driving housing instability, avoidance of medical care, and poor nutrition. Young adults have poor quality insurance and are at risk of falling into debt. There is also a substantial racial gap in medical debt across America driven by wealth disparity, a consequence of mid-20th century policy decisions like redlining and freeway expansion.

Provider networks have established a collection machine for this debt over the past two decades. KFF investigated 500 hospital systems and found that two-thirds are empowered to report outstanding debts to credit agencies. One quarter of providers will sell debt and one-fifth will deny care for non-emergent problems

to those who carry medical debt. General economic trends in America show that while deductibles are on the rise, people lack savings due to increasing costs of living and end up in debt.

Options explored by policymakers in other states to deal with the worst excesses include establishing barriers on extraordinary collection actions by providers. Restrictions on interest charged, credit reporting, and wage garnishment have also been passed. The problem needs better transparency, uniform standards, and tightened rules for community benefits. Additionally, aggressively setting out-of-pocket maximums, standardized benefit design, exempting deductibles on primary care could help alleviate Americans of health care cost burdens.

Comments offered by board members touched upon how to find a better balance of burden between large and small firms in purchasing quality health care, noting that a two-employee small business can spend $28,000 per year for a plan. Compounding this problem, most people in medical debt are now insured, but have out of pocket costs. Another member referenced a New York Times article about medical debt, and sought detail on the role of crowd funding to stave off medical debt, which was especially prevalent during the pandemic. Notably the largest number of campaigns on GoFundMe cover medical expenses, and research out of UW Bothell reports that this mechanism deepens racial disparities in the health care arena. Balance billing and control of out-of-network expenses alone will not necessarily fix this crisis.

Medical debt policy review and the 2024 Cost Board workplan

Gary Cohen, Health Management Associates

A discussion of policies which could tackle medical debt touched upon charity care, exploring whether people entitled to and in need of financial support actually receive it. Along these lines, the Attorney General's Office (AGO) reached a $158 million settlement with Providence for failing to offer proper levels of charity care. Six states require that hospitals provide a minimum level of charity care. Oregon has specific regulatory policies in place, creating a function using revenue and operating margin to calculate how much charity care should be provided by hospitals.

Regarding how to control billing and collections practices, work is being done by the Biden administration to put in place regulations preventing medical debt from affecting credit ratings. In Washington, health care providers may transmit medical debt to collection agencies after a waiting period, but in other states, this practice is expressly prohibited. Members offered comments indicating that Washington is one of the better states in the US with respect to medical debt, but more needs to be done.

Discussing the 2024 workplan, the Board reviewed data efforts that will guide discussions regarding policy recommendations. September will focus on a report from the OIC that studies consolidation and performs an actuarial analysis. A report was expected from the AGO as well but may be delayed.

The Board considered how many and what policies should receive the most focus in 2024. Members differed in their approach to the decision, with one member stating that all policies on the list are very important and deserve the support of the Board, while another member believed that focusing on the top two policies were more practical given the tight timeframe in 2024. It was noted that administrative simplification is an important approach which did not receive adequate attention, but Chair Birch remarked that both the Universal Health Care Commission and the Advisory Committee on Primary Care are coming back with additional recommendation along those lines.

Next Meeting

The next meeting of the Health Care Cost Transparency Board is scheduled for 5/15/2024 and will start at 1pm to accommodate a busy agenda.

Adjournment

The meeting was adjourned at 4:05 p.m

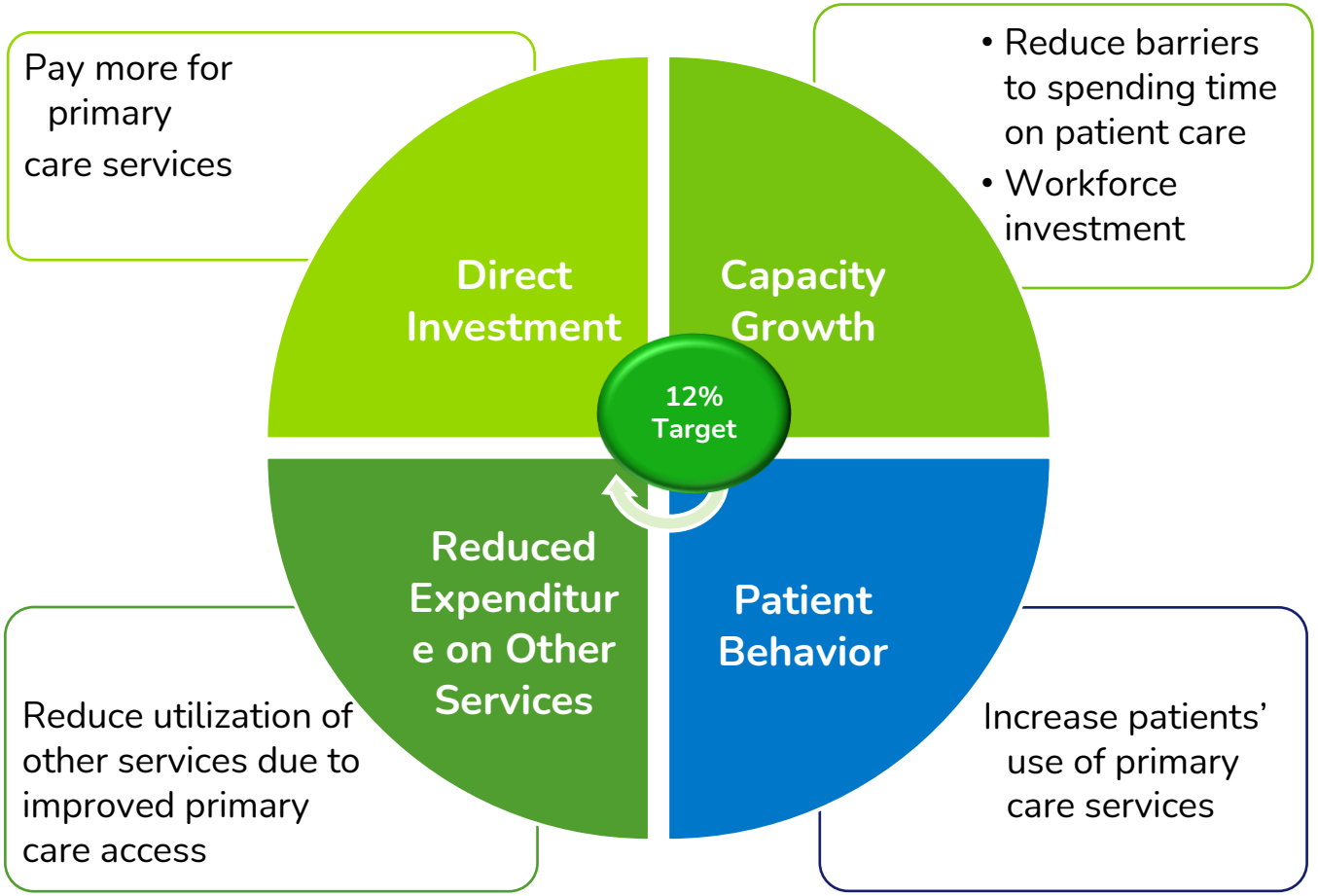
Tab 3

Washington State Health Care Authority

Strategies to Increase and Sustain Primary Care

Washington State Health Care Authority

Four key areas used to evaluate primary care expenditures



Washington State Health Care Authority

Policy development principles

- Policy recommendations should adhere to the following principles:
  - Unambiguous linkage between policy and achieving 12% primary care expenditure target
  - Clearly defined action and actors
  - Policies are financially, operationally, and politically feasible
  - Policies result in improved access and quality, not just expenditure

Current Policies under Consideration to increase and sustain investment in Primary Care.

1. **Increase primary care expenditures** as a percentage of total health care spending by one percentage point annually until a primary care expenditure ratio of 12% is achieved.
2. **Increase Medicaid reimbursement** for primary care to no less than 100% of Medicare no later than 2028.
3. **Multi-payer alignment policy** - support for the Multi-payer Collaborative's alignment efforts.
4. **Patient engagement policy** – payer and purchaser education and incentives to promote utilization of primary care and preventive services.
5. **Workforce development** – prioritize funding for state primary care workforce initiatives as collaboratively identified through the Health Workforce Council.
6. Following the 2024 reporting of primary care expenditures by HCP-LAN category, the **committee may make recommendations to the Cost Board for the portion of primary care expenditures that must be tied to alternative payment methodologies** for spending to count towards the expenditure growth target.
7. The Cost Board should **identify primary care expenditure targets that are based on per capita expenditures** instead of an aggregate ratio of 12% of total health expenditures.

Next Steps

- Primary Care Advisory Committee will continue evaluating these strategies and will bring prioritized recommendations to the Board in an upcoming meeting.

Tab 4

Washington State Health Care Authority

Financial Analysis of Washington Hospitals

Presentation to the Washington Health Care Cost Transparency Board

May 15, 2024

John Bartholomew & Tom Nash
Bartholomew-Nash & Associates

This Presentation Covers:

- HCCTB Cost Growth Benchmark
- WA Hospital Financial Analysis Goals
- 3-Prong Approach in Reviewing Hospitals
- Hospital Inventory: 45 WA Hospitals Analyzed
- 1st Analysis: Peer Group Comparisons
- 2nd Analysis: Medicare Payment-to-Cost Ratio
- 3rd Analysis: Price and Cost Trends
- Conclusion
- Appendices: Methodology and other information

HCCTB Cost Growth Benchmark Targets

Health Care Cost Transparency Board, Annual Report, August 1, 2023	
Cost Growth Benchmark for Washington State	
Years	**Target**
2022	**3.2%**
2023	**3.2%**
2024	**3.0%**
2025	**3.0%**
2026	**2.8%**

From the HCCTB Annual Report, 8/1/2023: The benchmark target is a specific rate against which carriers' and providers' expenditure performance will be measured.

Hospitals comprise approximately 35% of health care costs. Therefore, the price paid to this provider type influences the health care cost trend.

This set of analyses reviews both the price hospitals receive as well as the cost hospitals incur in providing services.

Project Goals, Second Level Review of Hospital Financial Analysis:

1. How does the WA hospital industry compare to the nation on costs, prices, and margins/profits?

2. Can we identify WA hospitals that appear to be outliers* on cost, price, and margins/profits?

* An outlier Washington hospital is defined as having a metric whose value is 10% greater than the median of its peer group.

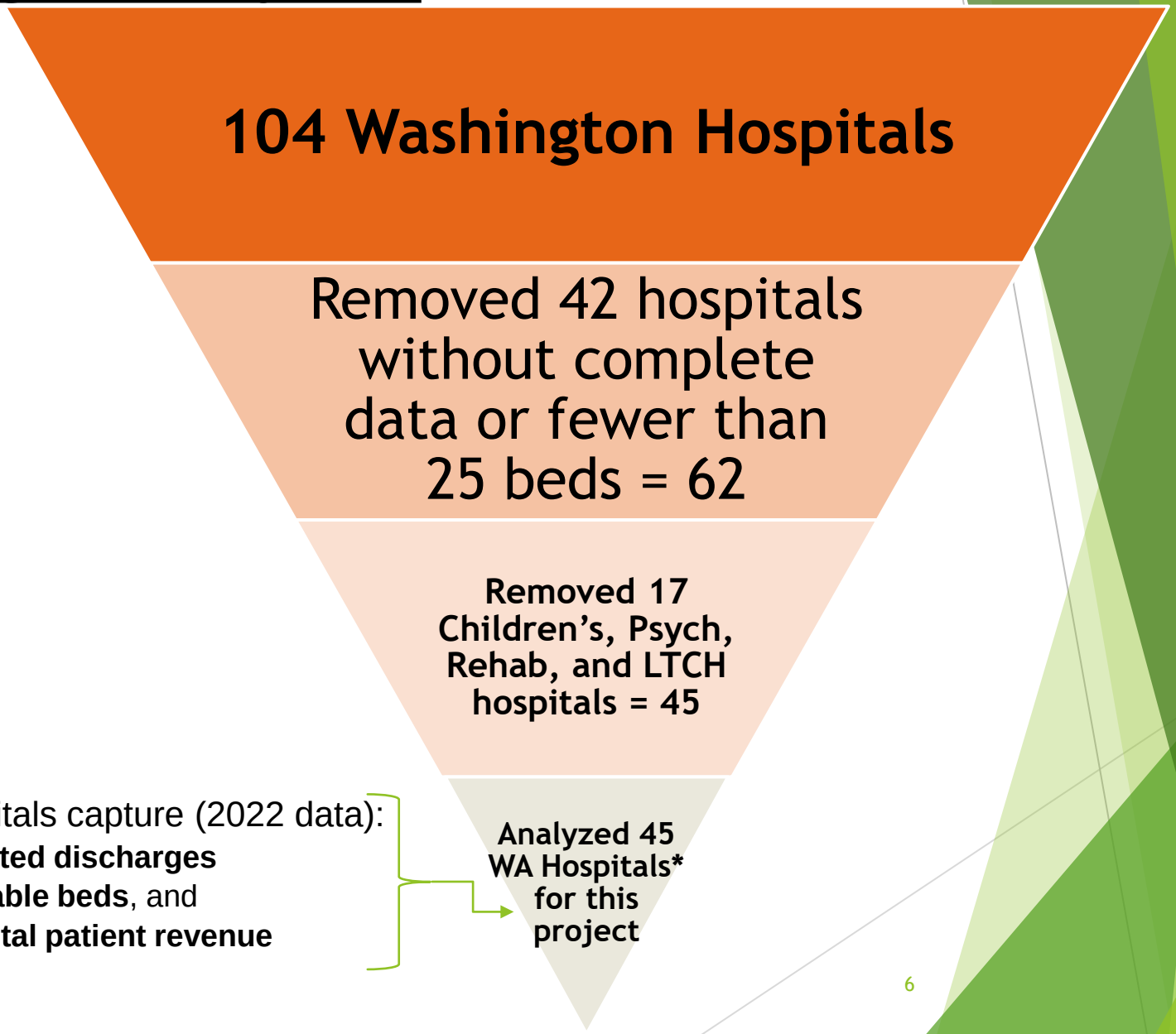
Financial Analysis of Washington Hospitals

A. 3-prong approach to fulfilling Project Goal

1. **Peer Group Comparisons:** Create high-level metrics on **cost, price and profit at the patient level** that enable comparison to other 'like' hospitals within the nation. Adjust for regional cost differences and acuity.
2. **Medicare Payment-To-Cost Ratio Analysis:** Review Medicare revenues and costs as a measure of hospital efficiency by creating a **Medicare payment-to-cost ratio**. Medicare payments are adjusted to reflect individual hospital characteristics, comparing payments to the related costs can provide an indication of how well hospitals are managing expenses.
3. **Price and Cost Trend Analysis:** Conduct **hospital price and cost trend analysis** on the state's hospitals with comparisons to national trends.

B. Combining the findings from the **three analyses provides insights** to health care administrators, health care purchasers/payers, and the hospitals themselves by **allowing them to triangulate** price, cost and profit information from several different perspectives.

Washington Hospitals



These 45 hospitals capture (2022 data):

- **88% of adjusted discharges**
- **90% of available beds**, and
- **85% of hospital patient revenue**

* A list of 45 Washington hospitals with name, city, and county can be found in Appendix D.

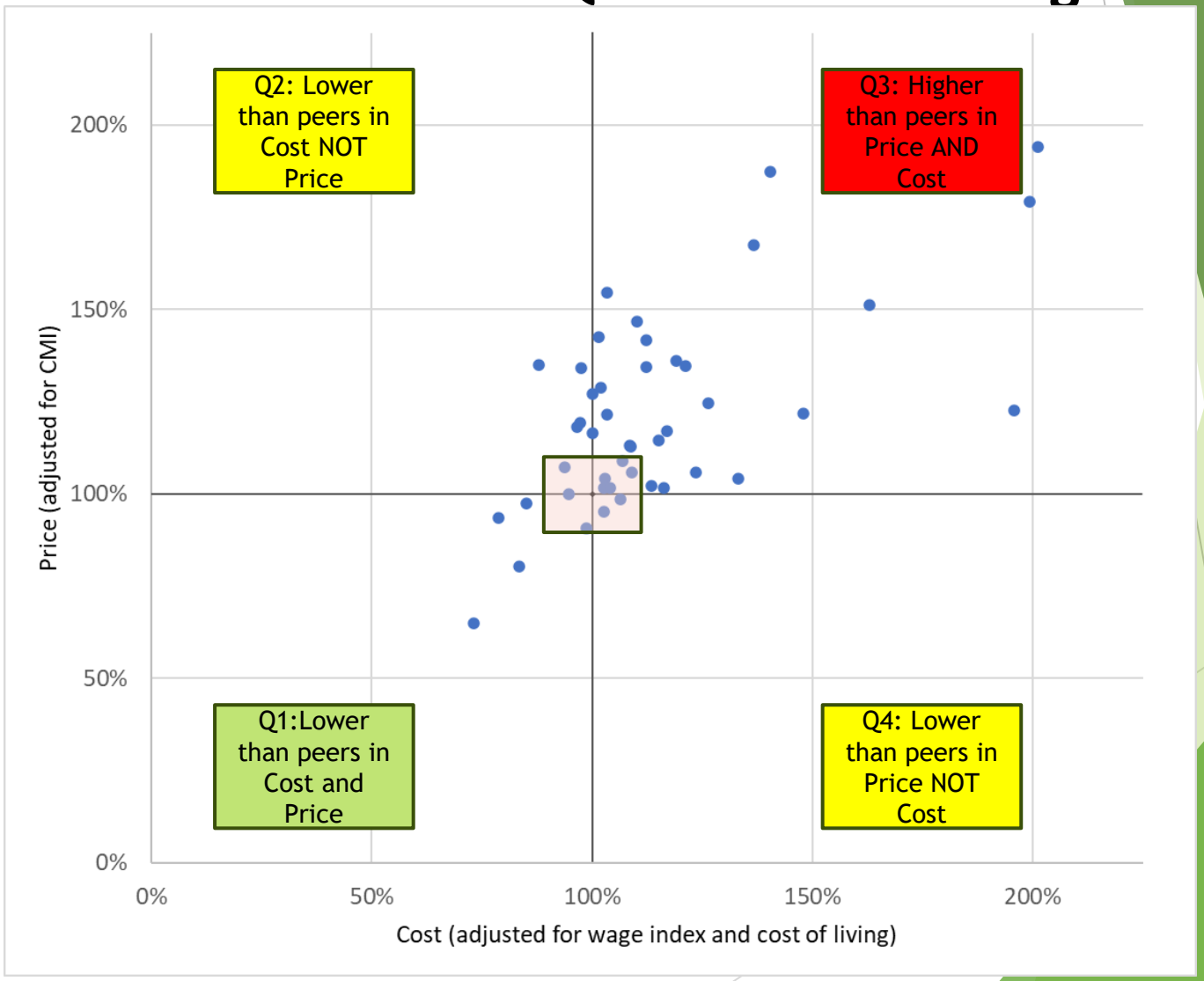
1. Peer Group Comparisons:

Most of the WA hospitals examined have both prices and costs that are higher than their peers:

* 27 hospitals, which receive about 70% of patient revenue, have higher prices;
* 19 hospitals, with about 39% of patient revenue, have higher costs.
* 15 hospitals, with about 32% of patient revenue, are higher than their peers in BOTH price **and** cost.

1: Peer Group Comparisons

Washington Hospitals Compared to Peer Group Medians for Price and Cost: Quadrants 1 through 4



1: Peer Group Comparisons – Outliers

Price		Cost		Profit	
High	27	Normal	11	High	1
				Normal	7
				Low profit	3
		High	15	High	2
				Normal	7
				Low	6
		Low	1	High	0
				Normal	1
				Low	0
Normal	16	Normal	10	High	1
				Normal	3
				Low	6
		High	4	High	0
				Normal	1
				Low	3
		Low	2	High	1
				Normal	0
				Low	1
Low	2	Normal	0	High	0
				Normal	0
				Low	0
		High	0	High	0
				Normal	0
				Low	0
		Low	2	High	1
				Normal	0
				Low	1

Yellow shading = Hospitals of interest

Price Outliers: 27 Hospitals are high-price as compared to their national peers comprising of 70%* of 2022 statewide hospital revenue; many are also Cost outliers.

Cost Outliers: 19 Hospitals are high-cost compared to their national peers comprising of 39%* of 2022 statewide hospital revenue. 15 of these hospitals comprising 32%* of 2022 statewide hospital revenue **are high price as well.**

- These high-price, high-cost hospitals representing 1/3 of statewide hospital revenue could put upward pressure on the overall Washington health care cost trend.

Profit Outliers: 6 Hospitals comprising of 6%* of 2022 statewide hospital revenue are high profit as compared to their national peers.

Trifecta: 2 hospitals were found to be high price, high cost and high profit

*Percentages represent portion of hospital net patient revenue for the 45 hospitals analyzed.

Note: Details of outliers are in Appendix A

2. Medicare Payment-to-Cost Ratio Analysis:

Of the 45 Washington hospitals reviewed, 39 were found to have a Medicare payment to cost ratio below 95% in 2022. The state median is 83%.

MedPAC March 2024 Report to the Congress:

Above 97% = Efficient Hospital

Below 97% = Inefficient Hospital

2: Medicare Payment-to-Cost Ratio Analysis*

- Per the Medicare Payment Advisory Commission (MedPAC), Medicare rates are set to enable an efficient hospital to breakeven on Medicare payments. In the March 2024 report, MedPAC noted that hospital margins have decreased in 2022, and relatively efficient hospitals could achieve a 97% Medicare payment to cost ratio for the Medicare FFS population.

- Of the 45 Washington hospitals reviewed, 39 were found to have a Medicare payment to cost ratio below 95% in 2022.

- The Median Medicare payment to cost ratio for the hospitals analyzed was 83%.
  - An 83% Medicare payment to cost ratio indicates a loss of $.17 on every dollar of cost incurred serving Medicare patients.
  - This may indicate a cost efficiency problem with Washington hospitals and could contribute to higher health care cost trends if not addressed

* Details of this metric can be found in Appendix B

3. Price and Cost Trend Analysis:

Nearly 1/3 of the 45 WA hospitals reviewed exceeded national trends in both price and cost.

3: Price and Cost Trend Analysis*

HCCTB Cost Growth Benchmark for 2022 = 3.2%

Compound Annual Growth Rates: National and Washington State				
	2012 to 2022 NPR WHOLE Dollar CAGR	2018 to 2022 NPR WHOLE Dollar CAGR	2012 to 2022 WHOLE Dollar Cost CAGR	2018 to 2022 WHOLE Dollar Cost CAGR
National Short-Stay (Excluding CAH)	4.82%	5.59%	5.18%	6.68%
Washington Short-Stay (Excluding CAH)	4.85%	3.76%	5.26%	5.94%
	2012 to 2022 NPR PAD CAGR	2018 to 2022 NPR PAD CAGR	2012 to 2022 Cost PAD CAGR	2018 to 2022 Cost PAD CAGR
National Short-Stay (Excluding CAH)	4.30%	6.00%	4.66%	7.10%
Washington Short-Stay (Excluding CAH)	5.00%	5.59%	5.40%	7.80%

Acronyms:

CAGR: Compound Annual Growth Rate
NPR: Net Patient Revenue
Cost: Hospital-only Operating Expense
WHOLE Dollar: Total dollars
PAD: Per Adjusted Discharge, whole dollars divided by adjusted discharges

* Details of hospital trend analysis can be found in Appendix C

3: Price and Cost Trend Analysis

Hospitals that Exceeded 11-year and/or 5-year National Trends:

Review was concentrated on hospitals that comprise 1.9%* or more of statewide net patient revenue.

- 23 hospitals have a share of NPR greater than 1.9% totaling 83% of all NPR for the 45 hospitals reviewed
  - Average NPR share is 3.6%
- 22 hospitals have a share of NPR less than 1.5% totaling 17% of all NPR for the 45 hospitals reviewed
  - Average NPR share is 0.8%

*Percentage represents portion of hospital net patient revenue for the 45 hospitals analyzed.

3: Price and Cost Trend Analysis

Hospitals that Exceeded 11-year and/or 5-year National Trends:

	Trend Analysis (Step 3)		From Peer Benchmarking (Step1)			
	# of Hospitals	Percent of Statewide NPR	# of High Price Hospitals	# of High Cost Hospitals	# of High Price and High Cost Hospitals	Location
Exceeded 11-year and/or 5-year national trends for **whole-dollar cost**	16	55.82%	11	6	6	Appendix C, Table 1
Exceeded 11-year and/or 5-year national trends for **whole-dollar revenue**	14	49.08%	10	6	6	Appendix C, Table 2
Exceeded 11-year and/or 5-year national trends for **both whole-dollar cost and revenue**	14	49.08%	10	6	6	Appendix C, Table 3
Exceeded 11-year and/or 5-year national trends for **per-patient cost**	17	57.16%	13	8	7	Appendix C, Table 4
Exceeded 11-year and/or 5-year national trends for **per-patient revenue**	19	62.74%	14	9	8	Appendix C, Table 5
Exceeded 11-year and/or 5-year national trends for **both per-patient cost and revenue**	17	57.16%	13	8	7	Appendix C, Table 6
Exceeded 11-year and/or 5-year national trends for **both whole-dollar and per-patient costs**	10	30.42%	7	4	4	Slide Deck
Exceeded 11-year and/or 5-year national trends for **both whole-dollar and per-patient revenue**	10	29.26%	7	5	5	Slide Deck
Exceeded 11-year and/or 5-year national trends for **both whole-dollar and per-patient cost and revenue**	8	23.67%	6	4	4	Slide Deck

Note: Percent of Statewide NPR is based on the 45 hospitals included in the analysis

3: Price and Cost Trend Analysis

Hospitals that Exceeded 11-year and/or 5-year National Trends:

The following hospitals exceeded the national trends for **price** on both a **whole-dollar** and **per-patient** basis:

10 Hospitals in BOTH NPR WHOLE Dollar and Price PAD	2022 Percent of Statewide NPR	2012 to 2022 Price PAD CAGR	2018 to 2022 Price PAD CAGR	2012 to 2022 NPR WHOLE Dollar CAGR	2018 to 2022 NPR WHOLE Dollar CAGR
Skagit Valley Hospital	1.92%	4.97%	6.23%	6.08%	6.16%
Confluence Health Hospital	2.57%	5.44%	6.93%	10.85%	10.62%
PeaceHealth St. Joseph	3.26%	9.94%	3.86%	4.91%	4.43%
Yakima Valley Memorial	2.43%	3.74%	13.47%	5.36%	9.60%
St Michael Medical Center	3.02%	3.38%	6.50%	6.65%	6.08%
Peacehealth Southwest Medical Center	3.45%	7.42%	10.63%	3.97%	6.83%
Kadlec Regional Medical Center	3.44%	5.43%	6.17%	9.24%	3.60%
Valley Medical Center	3.41%	5.63%	9.25%	13.49%	5.11%
Evergreen Health Kirkland	3.68%	5.36%	4.18%	6.67%	4.38%
Legacy Salmon Creek	2.08%	4.60%	7.35%	8.77%	5.13%
Total	**29.26%**				
Median		**5.40%**	**6.72%**	**6.66%**	**5.60%**
National		**4.30%**	**6.00%**	**4.82%**	**5.59%**

Light red shading denotes exceeding National Trend

Note: 2022 Percent of Statewide NPR is based on the 45 hospitals included in the analysis

3: Price and Cost Trend Analysis

Hospitals that Exceeded 11-year and/or 5-year National Trends:

The following hospitals exceeded the national trends for **costs** on both a **whole-dollar** and **per-patient** basis:

10 Hospitals that Exceed National Trend for both WHOLE Dollar Cost and Cost PAD	2022 Percent of Statewide NPR	2012 to 2022 Cost PAD CAGR	2018 to 2022 Cost PAD CAGR	2012 to 2022 WHOLE Dollar Cost CAGR	2018 to 2022 WHOLE Dollar Cost CAGR
Skagit Valley Hospital	1.92%	5.93%	8.94%	7.04%	8.87%
Providence Regional Everett	3.85%	8.05%	10.98%	5.93%	7.54%
PeaceHealth St. Joseph	3.26%	10.70%	4.77%	5.64%	5.34%
Yakima Valley Memorial	2.43%	4.39%	11.20%	6.02%	7.41%
Peacehealth Southwest Medical Center	3.45%	7.40%	11.36%	3.95%	7.54%
Evergreen Health Kirkland	3.68%	5.62%	8.05%	6.93%	8.26%
Legacy Salmon Creek	2.08%	4.12%	8.20%	8.26%	5.96%
Overlake Medical Center	2.90%	6.50%	14.60%	4.32%	6.74%
Kadlec Regional Medical Center	3.44%	4.96%	7.52%	8.74%	4.92%
Valley Medical Center	3.41%	5.44%	11.63%	13.29%	7.40%
Total	**30.42%**				
Median		**5.77%**	**9.96%**	**6.48%**	**7.40%**
National		**4.66%**	**7.10%**	**5.18%**	**6.68%**

Light red shading denotes exceeding National Trend

Note: 2022 Percent of Statewide NPR is based on the 45 hospitals included in the analysis

3: Price and Cost Trend Analysis

Hospitals that Exceeded 11-year and/or 5-year National Trends:

The following hospitals exceeded the national trends for both **price and cost** on both a **whole-dollar** and **per-patient** basis:

8 Hospitals in BOTH Price/Cost PAD and WHOLE Dollar Price/Cost	2022 Percent of Statewide NPR	Peer Group Comparison - Price	Peer Group Comparison - Cost	Peer Group Comparison - Profit
Skagit Valley Hospital	1.92%	High Price	High Cost	Normal Profit
PeaceHealth St. Joseph	3.26%	High Price	High Cost	Normal Profit
Yakima Valley Memorial	2.43%	High Price	Normal Cost	Normal Profit
Peacehealth Southwest Medical Center	3.45%	Normal Price	Normal Cost	Normal Profit
Evergreen Health Kirkland	3.68%	Normal Price	Normal Cost	Low Profit
Kadlec Regional Medical Center	3.44%	High Price	High Cost	Normal Profit
Valley Medical Center	3.41%	High Price	High Cost	Low Profit
Legacy Salmon Creek	2.08%	High Price	Normal Cost	Normal Profit
Total	**23.67%**			

Shading represents a hospital who exceeds peer group median by 10% or more

Note: 2022 Percent of Statewide NPR is based on the 45 hospitals included in the analysis

Conclusion/So What?

- A comparison to national peers reveals that Washington hospitals representing **a significant amount of hospitals' business** in the state generate **higher per-patient revenue and per-patient costs.**
  - Hospital costs are a significant driver of the prices hospitals charge.
  - Higher prices negatively impacts public and commercial payers.
- **Most of the Washington hospitals** analyzed had a Medicare payment-to-cost ratio of less than 95% which may be an indicator that hospitals **are not operating at optimal efficiency.**
- **Hospitals contribute significantly to health care cost growth trends.** Hospitals representing **a majority of the state's hospital industry are experiencing price and/or cost trends that exceed national trends.**
  - **Meeting the HCCTB Cost Growth Benchmark may be in jeopardy if hospital price trends exceed the targeted increase.**
  - **Increases in hospital input costs put pressure on the prices hospitals charge. Therefore, hospital efficiency is a key factor in limiting health care cost growth.**
- **The current financial condition** of hospitals in many ways is a result of strategic **decisions that were made long ago**. **Altering the direction** of the hospital industry, even if efforts start today, **is a long-term endeavor.**

Additional Questions/Comments?

Appendices

1: Peer Group Comparisons - Definitions

- This analysis uses self-reported Medicare Cost Report data to create metrics on per-patient Net Patient Revenue, per-patient Hospital-Only Operating Expense, and Patient Services Profit Margin:
  - Adjusted discharges - a volume measure that restates outpatient volumes as equivalent inpatient discharges. Combining these equivalent inpatient discharges with actual inpatient discharges results in adjusted discharges.
  - Net Patient Revenue per Adjusted Discharge, adjusted for Medicare Case Mix Index (CMI)* = **Price per Patient**
  - Hospital-Only Operating Expense per Adjusted Discharge, adjusted for WI and C2ER COLA* = **Cost per Patient**
  - Patient Services Profit Margin = **Patient Profit Percent**
- Other tools/clients using similar processes: NASHP's hospital cost tool, Idaho Dept of Health & Welfare, Colorado Medicaid, the Colorado Division of Insurance, and the St. Louis Business Healthcare Coalition.

* Definitions and acronyms on next slide

1: Peer Group Comparisons - Cost and Price Adjustment Methodology to Account for Regional Differences

Adjustment to Cost Data

- Adjustment to Hospital-only Operating Expense: Utilized labor wage index (WI) information from the CMS wage index files to adjust the salary portion of costs then applied the Council for Community and Economic Research (C2ER) cost of living index to adjust the remaining costs.
  - Salary portion of costs was calculated from the Medicare Cost Report.
- Adjusted cost data was then divided by adjusted discharges to express costs on a per patient basis.

Adjustment to Price Data

- Adjustment to Net Patient Revenue: Net Patient Revenue per-patient was adjusted to account for differences in patient acuity.
  - Adjusted discharges were multiplied by an aggregate Medicare CMI for each hospital.
  - Medicare CMI is reported in the Medicare Inpatient Prospective Payment System (IPPS) final rule public use files – this index captures the level of acuity at a hospital.
- Net patient revenue was then divided by adjusted discharges as adjusted for Medicare CMI.

1: Peer Group Comparisons - Peer Selection Criteria

Initial peers were selected that matched the subject hospital's characteristics as follows:

- **Bed size** - Subject hospitals were compared to hospitals that fell into the same bed-size range : 26 to 100, 101 to 300, 301 to 500, 501 to 800, >800
- **Medicare case mix**: Subject hospitals were compared to other hospitals with a Medicare Case Mix that fell within the same national quartile as the subject hospital.
- **Teaching intensity**: Subject hospitals were compared to hospitals with a resident to bed ratio that fell within the same national quartile as the subject hospital.
- **Service intensity**: Subject hospitals were compared to hospitals with a percentage of intensive care costs that fell within the same national quartile as the subject hospital.

These criteria were tightened or relaxed to reach a target of between 5 and 20 peers for each subject hospital.

1: Peer Group Comparisons – Outliers

WA Hosptials: Yellow Shaded Hospitals Are Reviewed																
High price							Normal price							Low price		
27							**16**							**2**		
Normal cost			High cost			Low Cost	Normal cost			High cost		Low Cost		Low cost		
11			15			1	10			4		2		2		
High profit	Normal profit	Low profit	High profit	Normal profit	Low profit	Normal profit	High profit	Normal profit	Low profit	Normal profit	Low profit	High profit	Low profit	High profit	Normal profit	Low profit
1	7	3	2	7	6	1	1	3	6	1	3	1	1	1	0	1

Price Outliers: 27 price outliers; 70% of NPR; many include High Cost

Hospital	2022 % of Statewide NPR	Price	Cost	Profit
Skagit Valley Hospital	1.92%	High Price	High Cost	Normal Profit
Virginia Mason Medical	2.94%	High Price	Low Cost	Normal Profit
Univesity of Washington Medical Center	8.48%	High Price	Normal Cost	Normal Profit
Confluence Health Hospital	2.57%	High Price	High Cost	Normal Profit
Providence Centralia	1.12%	High Price	High Cost	High Profit
Providence St. Peter Hospital	2.52%	High Price	Normal Cost	Low Profit
Swedish Cherry Hill	2.16%	High Price	High Cost	Low Profit
Swedish Edmonds	1.14%	High Price	High Cost	Low Profit
Swedish First Hill	6.40%	High Price	Normal Cost	Low Profit
PeaceHealth St. Joseph	3.26%	High Price	High Cost	Normal Profit
Samaritan Hospital	0.64%	High Price	High Cost	High Profit
Yakima Valley Memorial	2.43%	High Price	Normal Cost	Normal Profit
Astria - Toppenish Community Hospital	0.26%	High Price	High Cost	Normal Profit
PeaceHealth St. John	1.47%	High Price	Normal Cost	Normal Profit
Overlake Medical Center	2.90%	High Price	Normal Cost	Normal Profit
Trios Health	0.72%	High Price	High Cost	Low Profit
Kadlec Regional Medical Center	3.44%	High Price	High Cost	Normal Profit
Cascade Valley Hospital	0.37%	High Price	Normal Cost	High Profit
Harborview Medical Center	5.06%	High Price	High Cost	Normal Profit
Olympic Medical Center	1.11%	High Price	Normal Cost	Low Profit
Multicare - Good Samaritan Hospital	3.05%	High Price	High Cost	Low Profit
Evergreen Health Monroe	0.22%	High Price	High Cost	Normal Profit
Valley Medical Center	3.41%	High Price	High Cost	Low Profit
St Joseph Medical Center	3.25%	High Price	High Cost	Low Profit
Tacoma General Allenmore	6.18%	High Price	Normal Cost	Normal Profit
Legacy Salmon Creek	2.08%	High Price	Normal Cost	Normal Profit
Swedish Issaquah	1.32%	High Price	Normal Cost	Normal Profit

Shading represents a hospital who exceeds peer group median by 10% or more

Hospitals who have a share of the statewide Net Patient Revenue greater than 1.9%

Note: 2022 Percent of Statewide NPR is based on the 45 hospitals included in the analysis

1: Peer Group Comparisons – Outliers

WA Hosptials: Yellow Shaded Hospitals Are Reviewed																
High price							Normal price							Low price		
27							**16**							**2**		
Normal cost			High cost			Low Cost	Normal cost			High cost		Low Cost		Low cost		
11			15			1	10			4		2		2		
High profit	Normal profit	Low profit	High profit	Normal profit	Low profit	Normal profit	High profit	Normal profit	Low profit	Normal profit	Low profit	High profit	Low profit	High profit	Normal profit	Low profit
1	7	3	2	7	6	1	1	3	6	1	3	1	1	1	0	1

Cost Outliers: 19 cost outliers; 39% of NPR; many include High Price

Hospital	2022 Percent of Statewide NPR	Price	Cost	Profit
Skagit Valley Hospital	1.92%	High Price	High Cost	Normal Profit
Multicare - Auburn Medical Center	1.00%	Normal Price	High Cost	Normal Profit
Confluence Health Hospital	2.57%	High Price	High Cost	Normal Profit
Providence Centralia	1.12%	High Price	High Cost	High Profit
St Clare Hospital	0.69%	Normal Price	High Cost	Low Profit
Swedish Cherry Hill	2.16%	High Price	High Cost	Low Profit
Swedish Edmonds	1.14%	High Price	High Cost	Low Profit
PeaceHealth St. Joseph	3.26%	High Price	High Cost	Normal Profit
Samaritan Hospital	0.64%	High Price	High Cost	High Profit
Astria - Toppenish Community Hospital	0.26%	High Price	High Cost	Normal Profit
Trios Health	0.72%	High Price	High Cost	Low Profit
Providence Sacred Heart	4.41%	Normal Price	High Cost	Low Profit
Kadlec Regional Medical Center	3.44%	High Price	High Cost	Normal Profit
Harborview Medical Center	5.06%	High Price	High Cost	Normal Profit
Multicare - Good Samaritan Hospital	3.05%	High Price	High Cost	Low Profit
Evergreen Health Monroe	0.22%	High Price	High Cost	Normal Profit
Valley Medical Center	3.41%	High Price	High Cost	Low Profit
St Joseph Medical Center	3.25%	High Price	High Cost	Low Profit
St. Anthony Hospital	0.82%	Normal Price	High Cost	Low Profit

Shading represents a hospital who exceeds peer group median by 10% or more

Hospitals who have a share of the statewide Net Patient Revenue greater than 1.9%

1: Peer Group Comparisons – Outliers

WA Hosptials: Yellow Shaded Hospitals Are Reviewed																
High price							Normal price							Low price		
27							**16**							**2**		
Normal cost			High cost			Low Cost	Normal cost			High cost		Low Cost		Low cost		
11			15			1	10			4		2		2		
High profit	Normal profit	Low profit	High profit	Normal profit	Low profit	Normal profit	High profit	Normal profit	Low profit	Normal profit	Low profit	High profit	Low profit	High profit	Normal profit	Low profit
1	7	3	2	7	6	1	1	3	6	1	3	1	1	1	0	1

Profit Outliers: 6 Hospitals with high profits; 2 hospitals hit the trifecta with High Price, High Cost, and High Profit outlier status.

Hospital	2022 Percent of Statewide NPR	Price	Cost	Profit
Providence Centralia	1.12%	High Price	High Cost	High Profit
Samaritan Hospital	0.64%	High Price	High Cost	High Profit
St Michael Medical Center	3.02%	Low Price	Low Cost	High Profit
Cascade Valley Hospital	0.37%	High Price	Normal Cost	High Profit
Multicare - Valley Hospital	0.73%	Normal Price	Low Cost	High Profit
Multicare Covington Medical Center	0.45%	Normal Price	Normal Cost	High Profit

Shading represents a hospital who exceeds peer group median by 10% or more

Hospitals who have a share of the statewide Net Patient Revenue greater than 1.9%

2: Medicare Payment to Cost Ratio Analysis

- The Medicare payment-to-cost ratio is calculated by dividing Medicare payments by the costs of serving Medicare patients.

- Medicare payments are adjusted to reflect individual hospital characteristics, such as case mix, teaching intensity, and geographic location, comparing them to the related costs can show how well hospitals are managing expenses and thus serve as a measure of efficiency.

- The degree of efficiency on Medicare business can be assumed to be similar across all payers. If a hospital is inefficient on Medicare business, it is likely inefficient on other payer business, which can result in a hospital charging higher prices.

The 2024 Medicare Payment Advisory Commission (MedPAC) report states that efficient hospitals should breakeven, or come close to breakeven, on Medicare payments.

- March 2024 Report to the Congress: Medicare Payment Policy – MedPAC

3: Price and Cost Trend Analysis

- An indication of a hospitals price and cost trajectory can be achieved by reviewing a hospital's revenue and operating expense on a whole dollar and/or per-patient basis over time and comparing it to the state and national trends, and the trends for other hospitals in the state.
- The variables used in the trend analysis are Net Patient Revenues and Hospital-Only Operating Expenses. Unlike the peer group comparisons, revenues and cost were not adjusted for regional differences to analyze trends.
- Growth rates were calculated using a compound annual growth rate for two periods of time: 2012 through 2022 and 2018 through 2022.

3: Price and Cost Trend Analysis

Table 1

16 WA Hospitals greater than 1.9% NPR; WHOLE Dollar Cost CAGR greater than National Trend for Either 11yr or 5yr Trend

HOSPITAL	Medicare Payment-to-Cost Ratio	2022 Percent of Statewide Net Patient Revenue	2012 to 2022 WHOLE Dollar Cost CAGR	2018 to 2022 WHOLE Dollar Cost CAGR
Skagit Valley Hospital	0.83	1.92%	7.04%	8.87%
Providence Regional Everett	0.93	3.85%	5.93%	7.54%
PeaceHealth St. Joseph	0.91	3.26%	5.64%	5.34%
Yakima Valley Memorial	0.74	2.43%	6.02%	7.41%
Multicare - Deaconess Medical Center	0.97	2.10%	6.54%	12.10%
Peacehealth Southwest Medical Center	0.89	3.45%	3.95%	7.54%
Evergreen Health Kirkland	0.77	3.68%	6.93%	8.26%
Legacy Salmon Creek	0.88	2.08%	8.26%	5.96%
St Michael Medical Center	0.85	3.02%	6.24%	6.56%
Tacoma General Allenmore	0.80	6.18%	4.93%	12.69%
Overlake Medical Center	0.79	2.90%	4.32%	6.74%
Univesity of Washington Medical Center	1.00	8.48%	7.28%	9.70%
Confluence Health Hospital	0.78	2.57%	9.82%	10.19%
Kadlec Regional Medical Center	0.83	3.44%	8.74%	4.92%
Multicare - Good Samaritan Hospital	0.83	3.05%	5.88%	12.97%
Valley Medical Center	0.85	3.41%	13.29%	7.40%
Total		**55.82%**		
Median	**0.84**		**6.39%**	**7.54%**
National			**5.18%**	**6.68%**

Shading denotes exceeding National Trend

3: Price and Cost Trend Analysis

Table 2

14 WA Hospitals greater than 1.9% NPR: NPR WHOLE Dollar CAGR greater than National Trend for Either 11yr or 5yr Trend				
HOSPITAL	**2022 Percent of Statewide Net Patient Revenue**	**2012 to 2022 NPR WHOLE Dollar CAGR**	**2018 to 2022 NPR WHOLE Dollar CAGR**	**2022 NPR WHOLE Dollar Increase**
Skagit Valley Hospital	1.92%	6.08%	6.16%	4.49%
Univesity of Washington Medical Center	8.48%	8.00%	11.10%	5.49%
Confluence Health Hospital	2.57%	10.85%	10.62%	3.00%
PeaceHealth St. Joseph	3.26%	4.91%	4.43%	6.14%
Yakima Valley Memorial	2.43%	5.36%	9.60%	-4.55%
St Michael Medical Center	3.02%	6.65%	6.08%	7.79%
Multicare - Deaconess Medical Center	2.10%	6.12%	13.58%	7.17%
Peacehealth Southwest Medical Center	3.45%	3.97%	6.83%	8.19%
Kadlec Regional Medical Center	3.44%	9.24%	3.60%	0.20%
Multicare - Good Samaritan Hospital	3.05%	4.57%	5.75%	-1.84%
Valley Medical Center	3.41%	13.49%	5.11%	3.28%
Evergreen Health Kirkland	3.68%	6.67%	4.38%	2.70%
Tacoma General Allenmore	6.18%	7.14%	3.97%	-16.84%
Legacy Salmon Creek	2.08%	8.77%	5.13%	8.20%
Total	**49.08%**			
Median		**6.66%**	**5.91%**	**3.88%**
National		**4.82%**	**5.59%**	

Light red shading denotes exceeding National Trend

Yellow shading denotes exceeding 1 Year Cost Growth Benchmark Rate of 3.2%

3: Price and Cost Trend Analysis

Table 3

14 Hospitals On Both Price and Cost Outlier Lists	2022 Percent of Statewide Net Patient Revenue	2012 to 2022 NPR WHOLE Dollar CAGR	2018 to 2022 NPR WHOLE Dollar CAGR	2012 to 2022 WHOLE Dollar Cost CAGR	2018 to 2022 WHOLE Dollar Cost CAGR
Skagit Valley Hospital	1.92%	6.08%	6.16%	7.04%	8.87%
PeaceHealth St. Joseph	3.26%	4.91%	4.43%	5.64%	5.34%
Yakima Valley Memorial	2.43%	5.36%	9.60%	6.02%	7.41%
Multicare - Deaconess Medical Center	2.10%	6.12%	13.58%	6.54%	12.10%
Peacehealth Southwest Medical Center	3.45%	3.97%	6.83%	3.95%	7.54%
Evergreen Health Kirkland	3.68%	6.67%	4.38%	6.93%	8.26%
Legacy Salmon Creek	2.08%	8.77%	5.13%	8.26%	5.96%
St Michael Medical Center	3.02%	6.65%	6.08%	6.24%	6.56%
Tacoma General Allenmore	6.18%	7.14%	3.97%	4.93%	12.69%
Univesity of Washington Medical Center	8.48%	8.00%	11.10%	7.28%	9.70%
Confluence Health Hospital	2.57%	10.85%	10.62%	9.82%	10.19%
Kadlec Regional Medical Center	3.44%	9.24%	3.60%	8.74%	4.92%
Multicare - Good Samaritan Hospital	3.05%	4.57%	5.75%	5.88%	12.97%
Valley Medical Center	3.41%	13.49%	5.11%	13.29%	7.40%
Total	**49.08%**				
Median		**6.66%**	**5.91%**	**6.73%**	**7.90%**
National		**4.82%**	**5.59%**	**5.18%**	**6.68%**

Light red shading denotes exceeding National Trend

3: Price and Cost Trend Analysis

Table 4

17 WA Hospitals greater than 1.9% NPR; Cost PAD CAGR greater than National Trend for Either 11yr or 5yr Trend

HOSPITAL	2022 Percent of Statewide NPR	2012 to 2022 Cost PAD CAGR	2018 to 2022 Cost PAD CAGR
Skagit Valley Hospital	1.92%	5.93%	8.94%
Virginia Mason Medical	2.94%	5.97%	8.04%
Providence Regional Everett	3.85%	8.05%	10.98%
Providence St. Peter Hospital	2.52%	5.71%	8.44%
Swedish Cherry Hill	2.16%	6.77%	6.93%
Swedish First Hill	6.40%	6.15%	7.82%
PeaceHealth St. Joseph	3.26%	10.70%	4.77%
Yakima Valley Memorial	2.43%	4.39%	11.20%
Peacehealth Southwest Medical Center	3.45%	7.40%	11.36%
Overlake Medical Center	2.90%	6.50%	14.60%
Providence Sacred Heart	4.41%	6.89%	7.75%
Kadlec Regional Medical Center	3.44%	4.96%	7.52%
Harborview Medical Center	5.06%	5.91%	6.24%
Valley Medical Center	3.41%	5.44%	11.63%
St Joseph Medical Center	3.25%	9.90%	12.43%
Evergreen Health Kirkland	3.68%	5.62%	8.05%
Legacy Salmon Creek	2.08%	4.12%	8.20%
Total	**57.16%**		
Median		**5.97%**	**8.20%**
National		**4.66%**	**7.10%**

Light red shading denotes exceeding National Trend

3: Price and Cost Trend Analysis

Table 5

19 WA Hospitals greater than 1.9% NPR; Price PAD CAGR greater than National Trend for Either 11yr or 5yr Trend				
HOSPITAL	2022 Percent of Statewide NPR	2012 to 2022 Price PAD CAGR	2018 to 2022 Price PAD CAGR	2022 Price PAD Increase
Skagit Valley Hospital	1.92%	4.97%	6.23%	3.71%
Virginia Mason Medical	2.94%	8.85%	12.03%	30.21%
Providence Regional Everett	3.85%	6.83%	5.87%	9.68%
Confluence Health Hospital	2.57%	5.44%	6.93%	7.24%
Providence St. Peter Hospital	2.52%	4.67%	5.06%	4.07%
Swedish Cherry Hill	2.16%	6.48%	4.65%	4.54%
Swedish First Hill	6.40%	6.44%	7.01%	7.73%
PeaceHealth St. Joseph	3.26%	9.94%	3.86%	4.18%
Yakima Valley Memorial	2.43%	3.74%	13.47%	-10.13%
St Michael Medical Center	3.02%	3.38%	6.50%	-12.41%
Peacehealth Southwest Medical Center	3.45%	7.42%	10.63%	14.93%
Overlake Medical Center	2.90%	6.26%	11.23%	7.07%
Providence Sacred Heart	4.41%	5.29%	5.50%	3.56%
Kadlec Regional Medical Center	3.44%	5.43%	6.17%	5.77%
Harborview Medical Center	5.06%	6.44%	6.54%	6.00%
Valley Medical Center	3.41%	5.63%	9.25%	11.25%
St Joseph Medical Center	3.25%	6.22%	8.69%	2.46%
Evergreen Health Kirkland	3.68%	5.36%	4.18%	3.97%
Legacy Salmon Creek	2.08%	4.60%	7.35%	15.75%
Total	**62.74%**			
Median		**5.63%**	**6.54%**	**5.77%**
National		**4.30%**	**6.00%**	

Light red shading denotes exceeding National Trend

Yellow shading denotes exceeding 1 Year Cost Growth Benchmark Rate of 3.2%

3: Price and Cost Trend Analysis

Table 6

17 Hospitals in BOTH Price PAD and Cost PAD	2022 Percent of Statewide NPR	Peer Group Comparison - Price	Peer Group Comparison - Cost	Peer Group Comparison - Profit
Skagit Valley Hospital	1.92%	High Price	High Cost	Normal Profit
Virginia Mason Medical	2.94%	High Price	Low Cost	Normal Profit
Providence Regional Everett	3.85%	Normal Price	Normal Cost	Low Profit
Providence St. Peter Hospital	2.52%	High Price	Normal Cost	Low Profit
Swedish Cherry Hill	2.16%	High Price	High Cost	Low Profit
Swedish First Hill	6.40%	High Price	Normal Cost	Low Profit
PeaceHealth St. Joseph	3.26%	High Price	High Cost	Normal Profit
Yakima Valley Memorial	2.43%	High Price	Normal Cost	Normal Profit
Peacehealth Southwest Medical Center	3.45%	Normal Price	Normal Cost	Normal Profit
Overlake Medical Center	2.90%	High Price	Normal Cost	Normal Profit
Providence Sacred Heart	4.41%	Normal Price	High Cost	Low Profit
Kadlec Regional Medical Center	3.44%	High Price	High Cost	Normal Profit
Harborview Medical Center	5.06%	High Price	High Cost	Normal Profit
Valley Medical Center	3.41%	High Price	High Cost	Low Profit
St Joseph Medical Center	3.25%	High Price	High Cost	Low Profit
Evergreen Health Kirkland	3.68%	Normal Price	Normal Cost	Low Profit
Legacy Salmon Creek	2.08%	High Price	Normal Cost	Normal Profit
Total	**57.16%**			

Shading represents a hospital who exceeds peer group median by 10% or more

Appendix D: List of Hospitals

45 Washington hospitals name, city, and county

Hospital Name	City	County
Astria - Toppenish Community Hospital	TOPPENISH	YAKIMA
Evergreen Health Monroe	MONROE	SNOHOMISH
St Anne Hospital	SEATTLE	KING
Multicare - Auburn Medical Center	AUBURN	KING
Samaritan Hospital	MOSES LAKE	GRANT
St. Anthony Hospital	GIG HARBOR	PIERCE
Yakima Valley Memorial	YAKIMA	YAKIMA
Swedish Issaquah	ISSAQUAH	KING
Multicare - Capital Medical Center	OLYMPIA	THURSTON
St Clare Hospital	LAKEWOOD	PIERCE
St Joseph Medical Center	TACOMA	PIERCE
Evergreen Health Kirkland	KIRKLAND	KING
Confluence Health Hospital	WENATCHEE	CHELAN
Cascade Valley Hospital	ARLINGTON	SNOHOMISH
Overlake Medical Center	BELLEVUE	KING
Tacoma General Allenmore	TACOMA	PIERCE
Olympic Medical Center	PORT ANGELES	CLALLAM
Trios Health	KENNEWICK	BENTON
Multicare - Good Samaritan Hospital	PUYALLUP	PIERCE
Kadlec Regional Medical Center	RICHLAND	BENTON
Providence St. Mary Hospital	WALLA WALLA	WALLA WALLA
Skagit Valley Hospital	MOUNT VERNON	SKAGIT
Swedish Edmonds	EDMONDS	SNOHOMISH

Hospital Name	City	County
St. Francis Hospital	FEDERAL WAY	KING
Valley Medical Center	RENTON	KING
St Michael Medical Center	BREMERTON	KITSAP
PeaceHealth St. John	LONGVIEW	COWLITZ
Multicare Covington Medical Center	COVINGTON	KING
Multicare - Valley Hospital	SPOKANE	SPOKANE
Harbor Regional Hospital	ABERDEEN	GRAYS HARBOR
Virginia Mason Medical	SEATTLE	KING
Legacy Salmon Creek	VANCOUVER	CLARK
Harborview Medical Center	SEATTLE	KING
Providence St. Peter Hospital	OLYMPIA	THURSTON
Peacehealth Southwest Medical Center	VANCOUVER	CLARK
Island Hospital	ANACORTES	SKAGIT
PeaceHealth St. Joseph	BELLINGHAM	WHATCOM
Swedish First Hill	SEATTLE	KING
Providence Regional Everett	EVERETT	SNOHOMISH
Swedish Cherry Hill	SEATTLE	KING
Providence Sacred Heart	SPOKANE	SPOKANE
Multicare - Deaconess Medical Center	SPOKANE	SPOKANE
Univesity of Washington Medical Center	SEATTLE	KING
Providence Holy Family	SPOKANE	SPOKANE
Providence Centralia	CENTRALIA	LEWIS

Tab 5

Washington State Health Care Authority

Cost Board Strategic Levers:
To Address Increasing Health Care Costs That Are Impacting Washingtonians

Business Oversight: Mergers/Acquisitions, Private Equity Investments and Provider Ownership/Closure

Potential strategy levers to decrease rate of health care cost increases

May 15 – Strategy Review

1. **Business Oversight**
   - **Mergers and Acquisitions**
   - **Private Equity Investments**
   - **Provider Ownership & Closures**
2. **Facility Fees**

July 30 - Strategy Review

3. **Provider Rate Setting**
4. **Price Growth Caps**
5. **Anti-Competitive Contracting**

***Potentially will include OIC findings**

Other strategies and policies under consideration

We will continue to incorporate other policy options as information is available such as:

- Policy recommendations from the Primary Care Committee
- Universal Commission reports and findings, including administrative simplification
- Prescription Drug Affordability Board reports, updates and findings
- Other affordability efforts in the state
- Additional policy options identified by the Board for future consideration

Business Oversight Strategies:

Mergers and Acquisitions, Private Equity Investments and Provider Ownership/Closure

Why Is This Important?

All these activities can contribute to **consolidation** in the health care market resulting in:

1. Increase leverage in negotiations for contracts with health plans by the larger players
2. Increased leverage can lead to increases in prices for visits and raise premiums
3. Consolidation can have mixed implications for access to care for Washingtonians

Types of activities that lead to consolidation

- **Horizontal integration:** between hospitals, other facilities, between physician groups, other health care industries that offer same types of services
- **Vertical integration:** hospitals or insurers purchasing physician practices, urgent care entities or others that offer different services along the same supply chain.
- **Cross-sector mergers**: Providers that operate in different geographic markets merge for patient care
- **Private equity**– pool funds from investors to invest in various industries
- **Closures** of providers of health care services (i.e. rural hospitals, provider practices, etc.)
- Other "Soft" forms: Accountable Care Organizations or other joint ventures that clinically integrate into networks are often designed to improve care coordination but this can contribute to consolidation

Washington State already has a significant degree of consolidation and integration, but many of the activities identified above are likely to continue

Business Oversight: Mergers and Acquisitions

Approaches to Address the Impact of Mergers and Acquisitions on Washingtonians:

- ***Notice and Review***: require reporting based on criteria, often financial value of the entities, and could include analysis of trends in the market and report publicly, as is done in WA State.
- ***Notice, Review and Approval:*** Require reporting by the entities with review and approval of proposed mergers and acquisitions with varying criteria for preliminary to comprehensive review and types of conditions that can be placed on the merger if approving.

Considerations for expanding review/adding approval authorities:

- Currently in WA, the state AG needs to go to court to oppose a merger and only reviews larger mergers
- Limiting mergers could potentially reduce necessary partnerships for preserving access to care.
- Consolidation could lead to regionalization of certain services where higher volume is associated with better quality, or it could facilitate enhanced care coordination resulting in improved value.

New **Merger Guidelines from FTC & DOJ out 12/23** to replace previous guidelines from 2010 and include:

- How to analyze newer and more complex forms of consolidation, including serial acquisitions, cross-market mergers, vertical consolidation, and transactions involving private equity firms.
- Recognize that mergers can impact labor markets that could lead to lower wages and worse working conditions.

Business Oversight: Private Equity

What do we know:

- Focused is on getting a return for investors.
- Private equity firms had 97 health care acquisitions in WA State in the last decade (2014-2023).
- WA physician staffing companies such as in anesthesia, emergency medicine and post-acute care in addition to certain specialties have been purchased by private equity.
- Corporate buyers have also come into the market such as CVS, Amazon, UnitedHealth.

Approaches

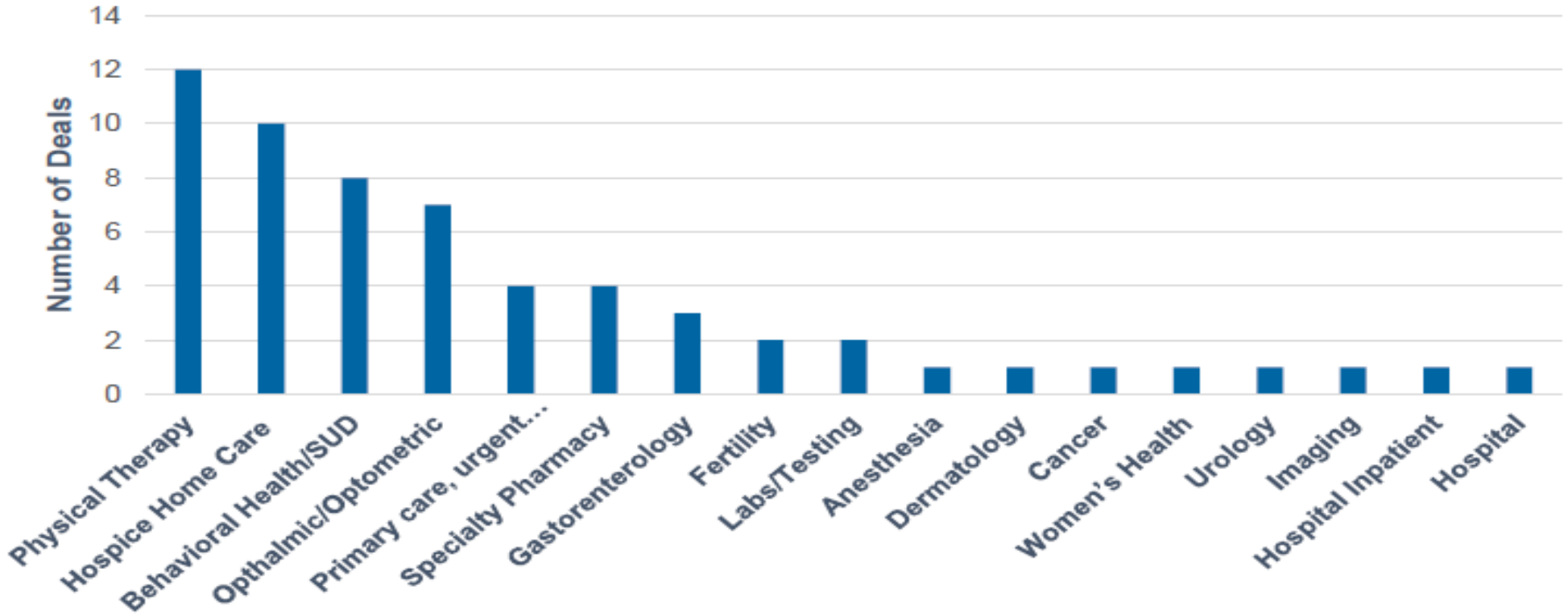
- Like Mergers/Acquisitions: States could require a) ***Notice and Review*** to monitor trends or b) ***Notice, Review and Approve*** private equity transactions.
- If transitioning a clinical organization from non-profit to PE-owned, could **require a community benefit** as is done with larger hospital or health system mergers, health plans.

Other Considerations:

- Depending on how structured, could prevent investments to sustain access to care for some providers/entities, specialties or in some regions.
- Need to set criteria on which transactions, and extent of any approval authority.

Washington State Private Equity Acquisitions by Subcategories of Clinical Services

Figure 3: Subcategories of Clinical Services that Have Been Acquired



Business Oversight: Provider Ownership/Closure

What Do We Know:

- Incomplete and difficult to get information on ownership of health care facilities in WA State and the number/types of providers they employ; Often smaller transactions not reviewed by Washington AG currently.
- Closure or reduction in services lines (e.g. labor and delivery or emergency services) may not be reviewed by the AG and don't always require prior notice or approval by the state.
- Could improve identification of trends in consolidation across the health care markets and impact of closures on access.

Potential Approaches

- **Comprehensive and Transparent Database with Notice and Review:** State could require certain categories of health care entities, such as hospitals, physician practice groups of a specified size and private equity firms, to report on who owns them, what other health care entities they own, and the number and types of health care professionals they employ.
- Maintain database with ongoing monitoring for areas of consolidation or lack of access. MA has a provider organization registration requirement with its Massachusetts Health Policy Commission.

Other Considerations:

- Assess what data is already being reported to the state under business licensing, Dept. of Health, Corporate Ownership Practice of Medicine (CPOM), Medicaid or other agencies and can that data be easily shared.

Comparing State Health Care Market Oversight Authority

Authority	Nonprofit or For Profit	AG Authority	Dept of Health	+ Health Care Market Oversight Entity
Notice & Review *(Must go to court to challenge)*	Nonprofit only	AZ, GA, ID, MI, ND, NH, NJ, PA, TN, VA	AZ, NJ	
	Both	CO, HI, IL, MA, MN, **WA***	HI, MN, **NY***	**MA*, CA***
Approve; Approve with Conditions or Disapprove	Nonprofit only	CA, LA, MD, NE, OH, OR, VT, WI	MA, NE, VT	
	Both	CT, **NY*,** RI	CT, RI, WA (CON only), WI	**OR***

***Have authority for nonhospital transactions, including provider groups/private equity transactions**

From Models for Enhanced Health Care Market Oversight from Milbank Memorial Fund

What does the data show (including any other state's experience)?

New York CON program: The state passed a law in 2021 requiring a **health equity assessment** to be filed with the CON program for any merger, acquisition, closure, or substantial reduction, expansion, or addition of a hospital service, including a demonstration how a project will improve or affect access to hospital services by members of medically underserved groups.

Health Care Market Oversight Program inside the Oregon Health Authority As of December 2023:

- 16 transactions filed notices across a range of entity types
- 2 requested a determination and were not subject to review
- 15 preliminary reviews, 2 comprehensive reviews and 2 follow-up reviews
- 2 transactions involved a private equity firm
- More than 180 public comments related to transactions
- Recent emergency decision to allow merger to prevent closure of major provider group in a smaller market, preventing significant access issues
- In 2024 – will conduct 1-year and 2-year follow-up reviews on several transactions; can monitor for up to ten years

California Office of Health Care Affordability (OHCA): Analyze transactions that are likely to significantly affect market competition, the state's ability to meet targets, or affordability for consumers and purchasers. Based on results of the review, OHCA coordinate with other state agencies to address. Referral to AG for enforcement.

How does this impact consumers? (access, cost, equity)

Studies have typically found that consolidation leads to higher health care spending, which could increase costs for families, employers, states, and public programs, like Medicare and Medicaid*

- Consolidation creates less competition that directly contribute to higher costs
- Recent review of 55 studies: associated with increased cost to patients/payers with mixed findings on impacts on the quality of care for patients.
- Mergers between hospitals and health systems can lead to higher prices even when entities operate in different markets
- Small number of studies have evaluated the association between consolidation with rural hospital closures and service eliminations, with mixed results.
- Can limit consumer/patient options for care either due to lack of services in a region/market or make available care unaffordable.
- Can lead to lower wages for some skilled workers, such as nurses, but broader evidence is unclear

Increasing Business Oversight of these activities can:

- With more reporting and analysis, a state can identify areas of consolidation and “hot spot” regions that may need more regulation to ensure less of an impact on consumers
- Enhanced review with approval authorities can stop or limit the impact of these business activities

Specific policies under Business Oversight to address health care costs for Washingtonians

1. Enhance Current Washington State Health Care Business Oversight and Strengthen Enforcement

a) Expand the Review/Approve Authority of the Attorney General – require prior notice of a broader scope of transactions and/or establishing the ability to block or impose conditions upon the transaction without a court order.

b) Give Authority to Review/Approve Transactions to Additional Oversight Entities – vesting another state entity (in addition to the state attorney general) with the authority to review and report on a proposed transaction's broader health care market impact, and include in the authority the ability to block or impose conditions upon the transaction without a court order

c) Comprehensive and Transparent Provider Business Ownership and Closure reporting

2. Increase competition and/or pre-empt consolidation: Washington State already has significant consolidation and breaking up mergers is difficult. Approaches to consider:

- Reduce incentives for providers to consolidate such as site-neutral payment, reduce admin burden
- Increase price transparency to help patients, plans and employers can shop for providers; this may encourage greater competition
- Allow more providers to enter the market through reforms to Certificate of Need (CON), Corporate Ownership Practice of Medicine (CPOM) and scope of practice laws

WA's next steps to activate Business Oversight and Address Consolidation

- **Enhancing Business Oversight:**
  - Determine what, if any, ***additional authority for the AG*** for monitoring health care transactions
  - Determine what, if any, ***additional state entity*** would conduct reviews and for what types of transactions
  - Determine if the AG and/or the state entity have ***approval authority*** that could block or impose conditions upon transactions without a court order.
  - Establish ***review criteria*** to assess whether the transaction impacts access, quality, equity, workforce or the community as a whole - specifically define "in the public interest"
  - Design the key requirements for a robust ***mechanism and timeframe for monitoring compliance*** with conditions, including if any penalties or required performance improvement reporting
  - Align current reporting towards a **comprehensive and transparent database of provider ownership and noticing of closures**
  - How would the **AG, Dept of Health and the state entity (if different) collaborate**?
- **Enhancing competition or pre-empting consolidation**
  - Assess what incentives, if any, could be adjusted by the state, or through federal changes that might assist?
  - Assess potential for price transparency
  - Assess barriers, if any, to allowing more providers to enter the market to decrease consolidation

Actions to take or questions to discuss for Board's advisory committees?

- What additional information would the Board like for its next meeting on this strategy?
  - Is there a policy for additional focus and development?
  - Is there a policy that should be eliminated for further consideration?

- What would you like to ask the Board's Stakeholder Advisory Committee to examine for this strategy?

- What would you like to ask the Board's Data Advisory Committee to examine for this strategy?

- How would you order these priorities for the Board in terms of meeting the charge of reducing the increases in cost growth?

Appendix

Business Oversight References-

- Ten Things to Know About Consolidation in Health Care Provider Markets | KFF
- State Actions to Strengthen Oversight of Health Care Transactions at https://www.milbank.org/wp-content/uploads/2024/03/Models_Enhanced_Market_Oversight_3.19.pdf
- Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices | Health Affairs
- California Health System Consolidation Leads Higher Prices | Commonwealth Fund
- US. Department of Justice and the Federal Trade Commission, Merger Guidelines, December 18, 2023
  US. Department of Justice and the Federal Trade Commission, Merger Guidelines, December 18, 2023
- Catalyst for Payment Reform: Microsoft Word - 3_Issue Brief Shore up Market Against Consolidation and Rising Prices - CLEAN_format.docx (catalyze.org)
- A Tool for States to Address Health Care Consolidation: Prohibiting Anticompetitive Health Plan Contracts – NASHP
- Weighing Policy Trade-offs: Overview of NASHP's Model Prohibiting Anticompetitive Contracting - NASHP

Appendix

Business Oversight References continued

- COVID-19, Market Consolidation, And Price Growth | Health Affairs
- Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities | Milbank Memorial Fund
- HCMO 2023 Annual Report.pdf (oregon.gov)
- Private Equity–Acquired Physician Practices And Market Penetration Increased Substantially, 2012–21 | Health Affairs
- Consolidation by Any Other Name: The Emergence of Clinically Integrated Networks | RAND

Tab 6

Washington State Health Care Authority

Cost Board Strategic Levers:
To Address Increasing Health Care Costs That Are Impacting Washingtonians

Examining Facility Fees

Facility Fees

Why Is This Important?

- Hospitals and some clinics charge a fee that is in addition to and not directly related to the service provided.
- **Washington does not require notice of facility fees charged by providers not affiliated with a health system or hospital.**
- Both purchasers and patients pay more as a result of these fees.

Facility Fees: Summary Background

- In 2022, hospitals in Washington collected **more than $125** million in revenue from facility fees**.**

- Because there is no required reporting of facility fees charged by providers not affiliated with a health system or hospital and existing reporting is limited, **it is likely that significant amounts of these fees are not being reported to the state.**

- Generally, hospitals have stated that facility fees make it possible to provide services to the community that are not adequately paid for by their charges for professional services and that the fees help keep Emergency Departments open 24/7.

Facility Fees: Summary Background Continued

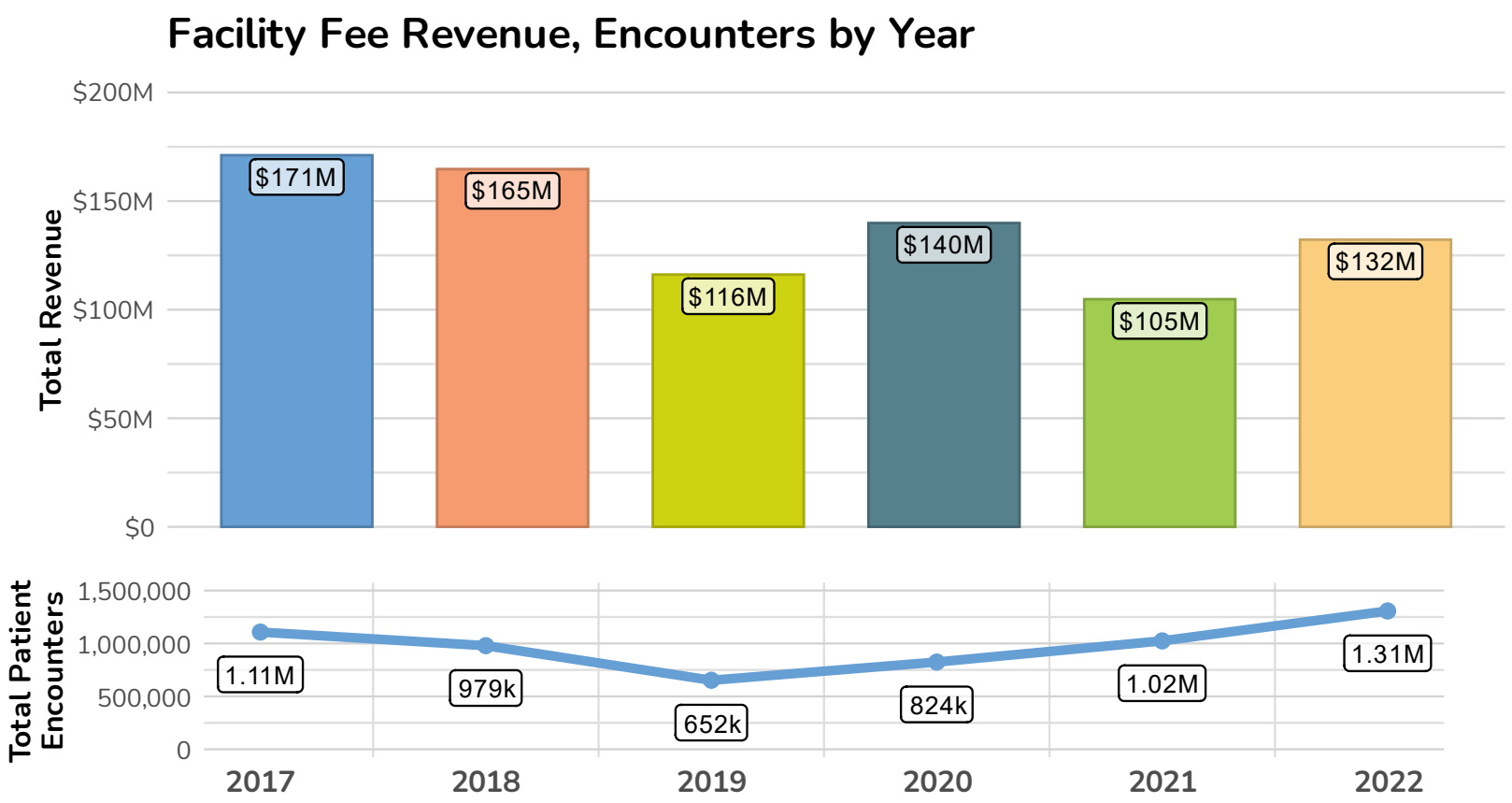
What have other states done?

- Similar to Washington, several states require reporting of facility fees.
- A few states have prohibited facility fees entirely. Some states have prohibited facility fees for certain, specified services, such as telehealth or preventive care.
- Some states have prohibited fees charged by hospitals for services provided at "off-campus" facilities.

What else?

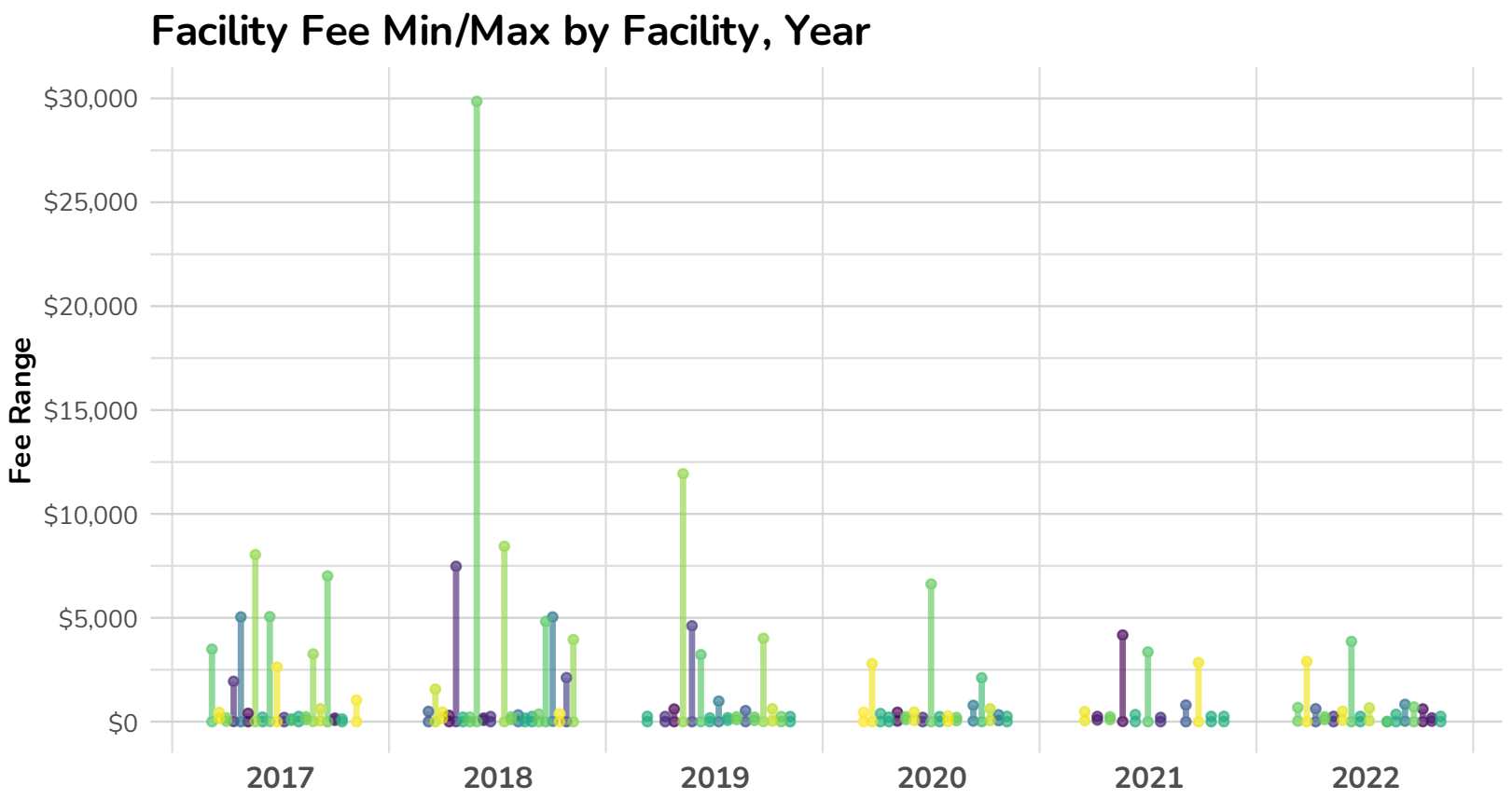
- Legislation has been introduced in Congress that would require that Medicare charges be the same, regardless of the site at which they are delivered.

Facility Fees: What does the existing data show?



- Total reported revenue from facility fees has been relatively steady from 2017-2022.
- In both 2021 and 2022, the average facility fee assessed was $100 per patient encounter

Facility Fees: Impact on consumers



- Providers are only required to report the minimum and maximum facility fee charged each year.
  - Only hospitals report this data and only for certain types of facilities.
- The reported data lacks transparency with regards to *how many times* high facility fees are being charged to consumers.

How do facility fees impact Washingtonians?

For purchasers and consumers of health care facilities fees are significant.

- Research indicates facility fees are one of the key cost drivers resulting from consolidations. Physician practices purchased by health systems become outpatient departments of their parent hospital, even if they are not located on the same campus. As a result, the services rendered by the acquired physician can charge facility fees – even for routine services delivered off the hospital's campus.
- **For consumers**, Facility fees vary by health system/provider and procedure and can add up quickly. According to a Massachusetts claims data report, average facility fees for out-patient evaluation and management (E&M) services, such as colonoscopies and MRIs, can be over $1,000, which is double the price of the provider's fee to conduct the procedure.
- **For purchasers**, these costs can also add up quickly. One state employee health plan stated that facility fees charged for COVID-19 testing conducted in outpatient hospital settings ranged from $53 to $150 per test — culminating in $344,589 in additional costs over several months.

Increasing transparency, limiting, or prohibiting these activities:

- Would help the patients avoid additional, unexpected costs.
- Potentially reduce the impact of consolidation.

Facility Fees: Policy Options

1. **Increase Transparency:**
   Washington already requires notice before a hospital charges a facility fee and requires reporting of some of these fees to the Department of Health. However, **fees charged by other providers are not subject to these requirements**.
   A. Modify advance notice requirements before providers charge a facility fee
   B. Modify reporting requirements for all providers and facilities (e.g., provider offices, labs, x-rays, therapies…) and improve reporting detail to account for all facility fees (each charges, all locations, etc).

2. **Limitations or Prohibitions on Facility Fees:** Facility fees can be prohibited entirely, or limited by type of service, or by location of service.

Facility Fees: Increase Transparency

What difference does the intervention make?

- Advance notice of the fee allows patients to know the cost of obtaining a service and have clarity on the amount that they will be charged to see their provider, and may allow an opportunity to shop for comparable services.

- Reporting of all facility fees charged would increase transparency and accountability – who is charging what and who is paying?

Would it be effective?

- Full reporting will increase transparency on the entire scope of facility fees charges to consumers and purchasers.
- Effectiveness of reporting and advance notice requirements may be limited - there is some data showing that this may remain difficult for patients to use the information shop for services.

What other states have implemented these policies?

- Colorado, Florida, Indiana, Maine, Massachusetts, Minnesota, New York, Texas (in addition to Washington)

Facility Fees: Limitations or Prohibition on Facility Fees

What difference does the intervention make?

- Facility fees on some services or facilities could be limited

Would it be effective?

- Limitations could lessen the impact of facility fees; prohibitions would resolve impacts on patients. However, it is possible that health systems, hospitals and other providers no longer able to charge a facility fee would increase their professional charges to make up for the lost revenue.

What other states have implemented these policies?

- **Limitations:** Colorado, Georgia, Maryland, New York, Ohio, Texas (in addition to Washington)
- **Prohibitions:** Connecticut, Indiana, Maine

***In Indiana, the prohibition applies only to off-campus services provided by not-for-profit hospitals having annual patient service revenue of at least $2 billion*

*** Massachusetts' Health Policy Commission has recently recommended limiting facility fees.*

Actions to take or questions to discuss for Board's advisory committees?

- What additional information would the Board like for its next meeting on this strategy?
  - Is there a policy for additional focus and development?
  - Is there a policy that should be eliminated for further consideration?

- What would you like to ask the Board's Stakeholder Advisory Committee to examine for this strategy?

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Appendix

1. RCW 70.01.040 Re: Facility Fees https://app.leg.wa.gov/rcw/default.aspx?cite=70.01.040
2. Maine Recommendations: https://www.pressherald.com/2024/04/19/maine-lawmakers-approve-slimmed-down-version-of-hospital-facility-fee-bill/
3. Massachusetts Recommendations: https://www.mass.gov/news/new-hpc-report-identifies-key-health-care-cost-drivers-and-calls-for-immediate-action-to-confront-pressing-affordability-challenges-facing-the-commonwealth
4. NASHP: https://nashp.org/combat-rising-health-care-costs-by-limiting-facility-fees-with-new-nashp-model-law/
5. https://unitedstatesofcare.org/wp-content/uploads/2023/06/State-Successes-Passing-Laws-to-Promote-Fair-Billing_Facility-Fees.pdf
6. https://www.pressherald.com/2022/08/21/hidden-charges-denied-claims-medical-bills-leave-patients-confused-frustrated-helpless/

Tab 7

Washington State Health Care Authority

FOLLOW-UP: MEDICAL DEBT DISCUSSION

Examples of additional consumer protections were mentioned:

- Six states require hospitals to provide minimum amount of charity care; Washington does not. Oregon uses a formula considering revenue and operating margin.
- 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.
- Additional examples…

DISCUSSION

- Are there additional questions and information you would like to know about the medical debt policies?
- Should we bring back any additional information for further consideration on one or more of these?

Tab 8

Washington State Health Care Authority

Analytic Support Initiative Preliminary Disease Expenditure Report

May 15, 2024

HCA & Institute for Health Metrics and Evaluation

ASI

Refresher

1. In December, the **Cost Board endorsed the *ASI Analytic Strategy*** containing three key analyses to be completed in 2024
    a) Estimate spending and utilization per capita and prevalent case for key diseases disaggregated by age, sex, type of care, location, payer group, and health condition
    b) Direct age- and indirect risk-adjustment of spending and utilization estimates for comparison across counties, states, and time
    c) Decompose differences in spending across counties and time

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    c) Decompose differences in spending across counties and time

2. In February, the Cost Board conducted a planning retreat and **identified four strategic objectives to evaluate further**
    a) Implement provider rate setting and price growth caps
    b) Limiting facility fees
    c) Restricting anti-competitive clauses in contracting
    d) Ensuring environment where mergers and acquisitions and private equity purchasing of health care providers could be evaluated

Refresher

3. In March, IHME finished its **first complete set of estimates** tracking spending by health condition, age, sex, type of care, payer, and county of the entire US for 2010 through 2019

Refresher

3. In March, IHME finished its **first complete set of estimates** tracking spending by health condition, age, sex, type of care, payer, and county of the entire US for 2010 through 2019

4. In April, IHME produced an updated draft of the **Preliminary Disease Expenditures Report**

Caveats about the Preliminary Disease Expenditure Report

- *It doesn't not include novel analyses*
- *It is based on previous research focused on estimating spending by county in the US*
- *It is a model of the type of research that could be done for the ASI*

Objective of today's presentation to the Cost Board

1. *Evaluate the Draft Preliminary Disease Expenditure Report and identify ways it could be strengthened prior to finalization*

    - How can these estimates be presented or fine-tuned to be clearer and more relevant to the work of Cost Board?

2. *Identify ways this research could be tailored to meet the goals and strategic objectives of the Cost Board*

    - Ahead of the completion of the draft ASI report in October, how can these analyses be delivered to aid the Cost Board policy study efforts?

Estimates feeding into the report

IHME Disease Expenditure estimates come from the broader national-wide study, and span 2010-2019.

Over 60 billion insurance claims and 1 billion administrative records are used to inform that national estimates.

Over 550 million insurance claims and 30 million administrative records informed the WA estimates.

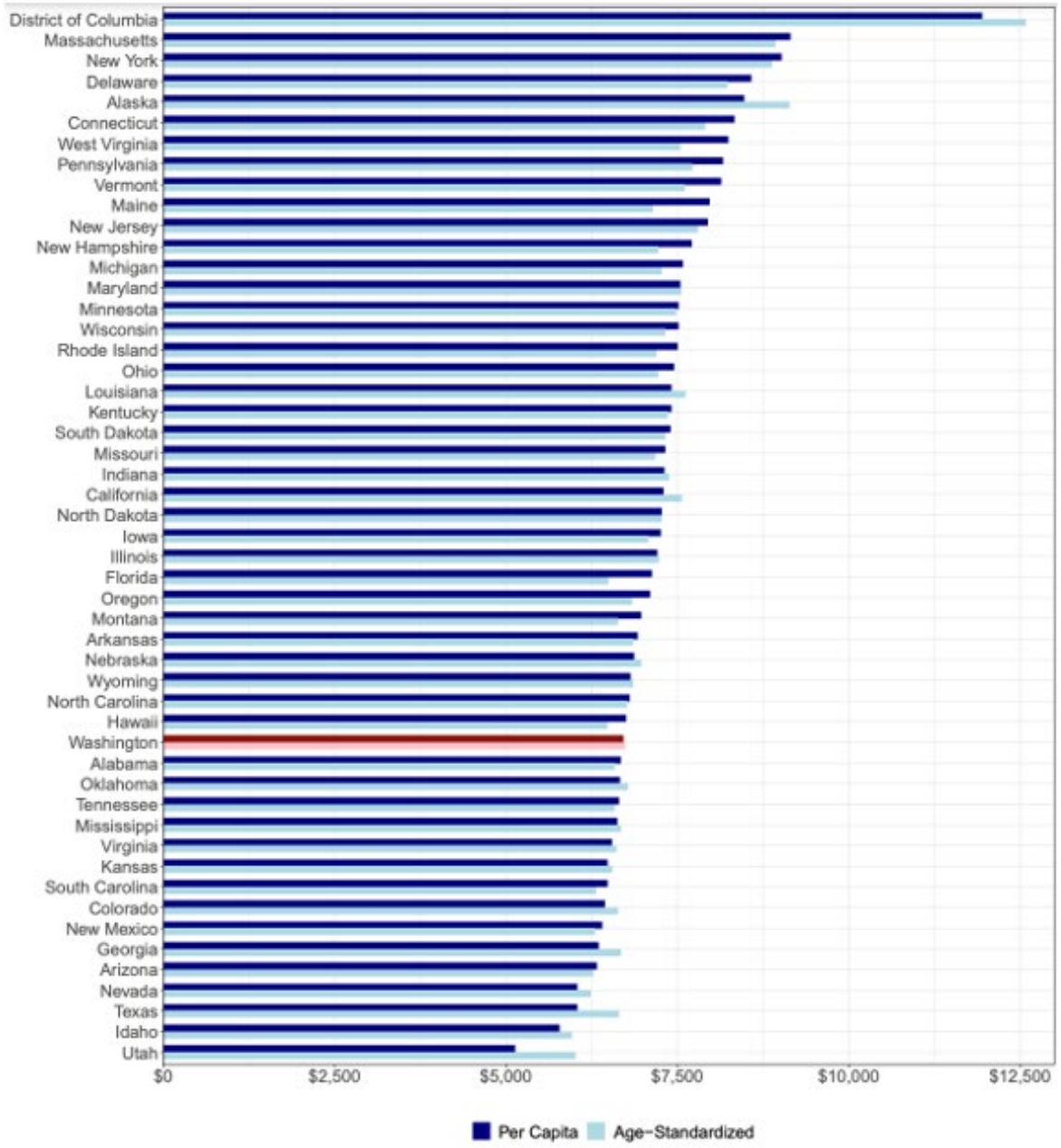
Estimates are adjusting for comorbidities in order to track spending attributable to each health condition.

Pharmaceutical spending includes spending on pharmaceuticals in a retail setting, and drugs administered in a clinic or inpatient are included in the ambulatory care and inpatient care categories.

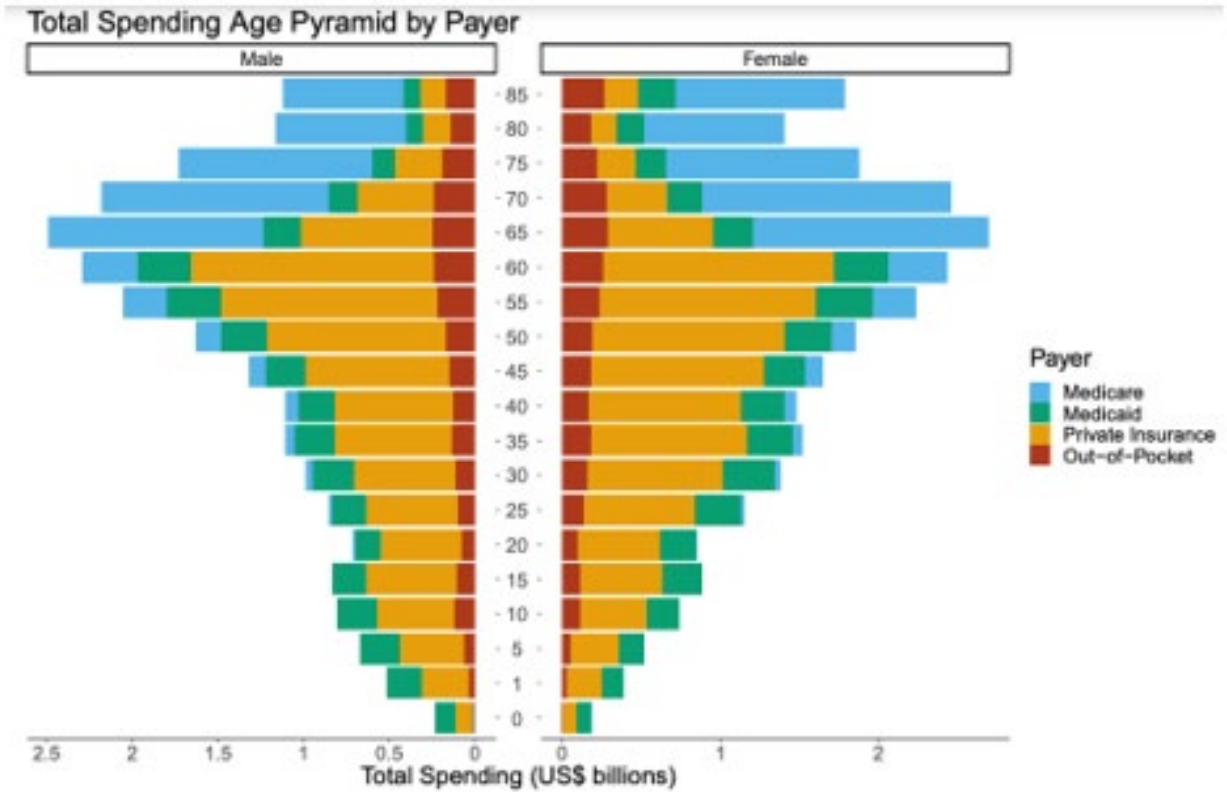
2019 WA spending per capita

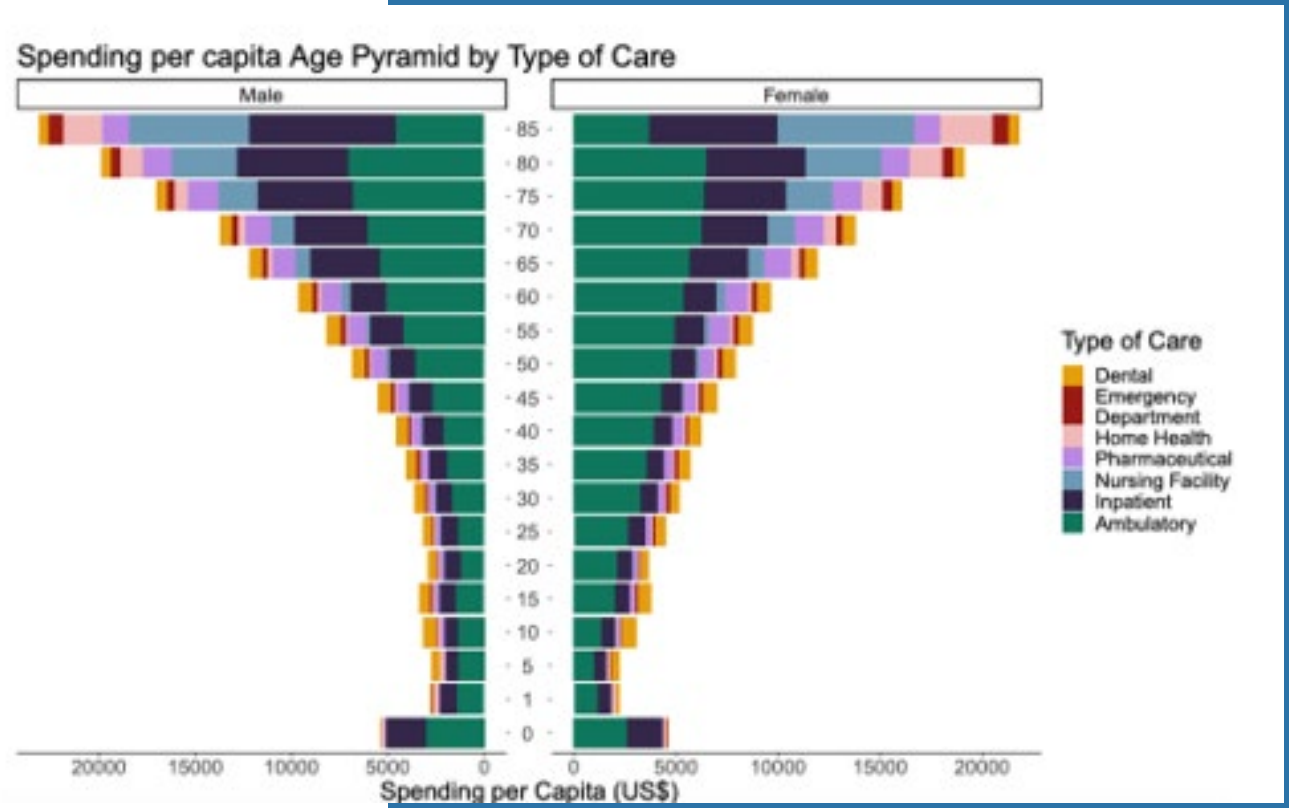
WA spending the 16th lowest amount of spending per capita across US states.

Because WA has a slightly younger population than the US, age-standardized spending estimates are slightly larger than the observed spending estimates.



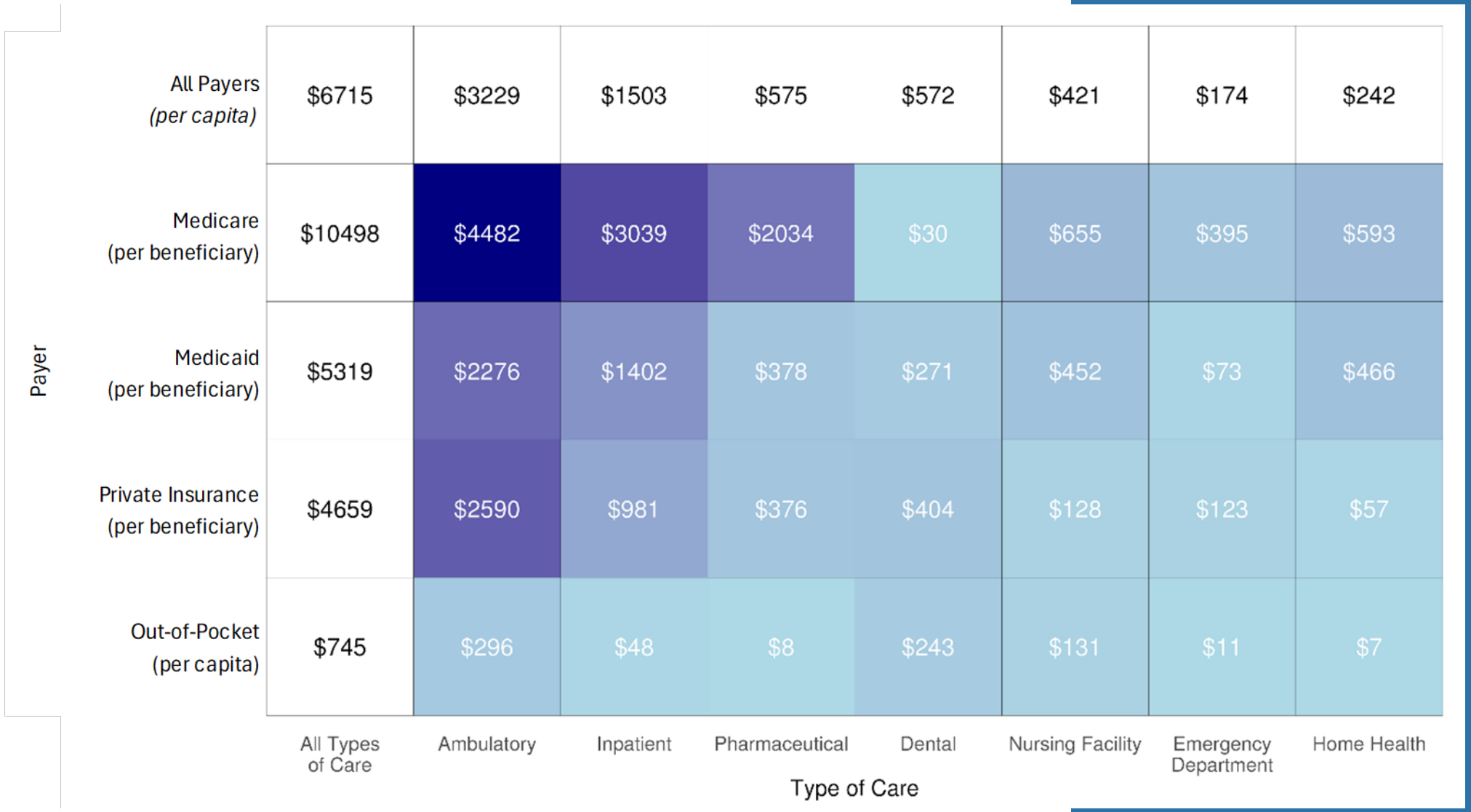
2019 WA spending



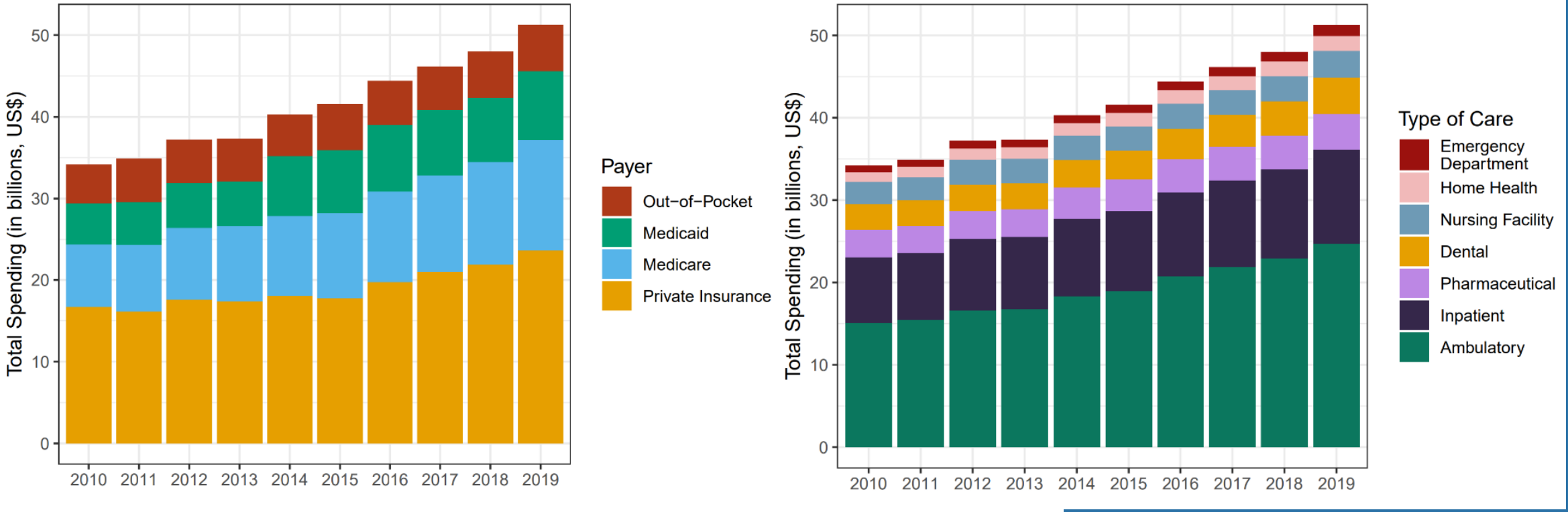


2019 WA spending

2019 WA spending

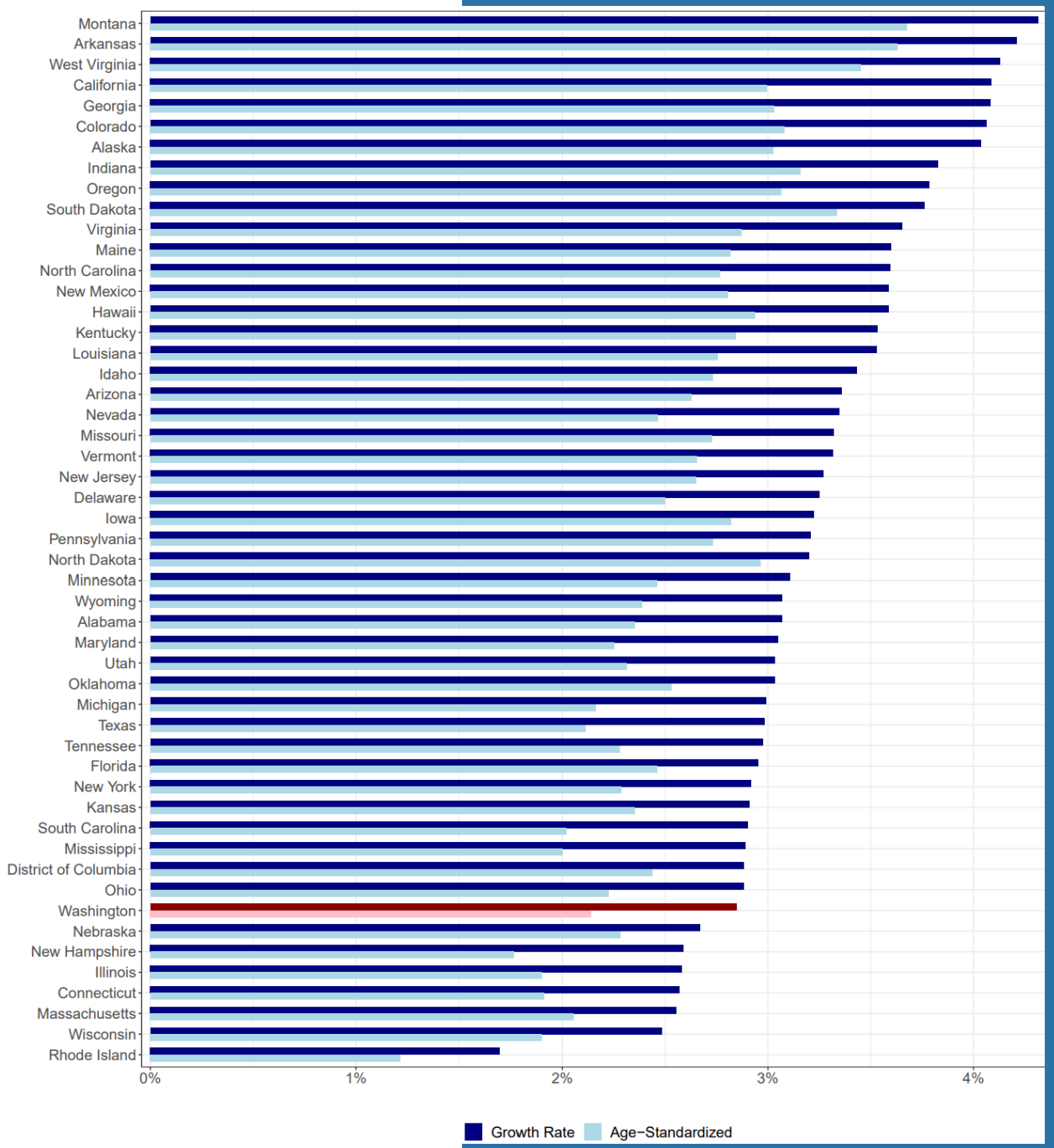


WA health spending over time

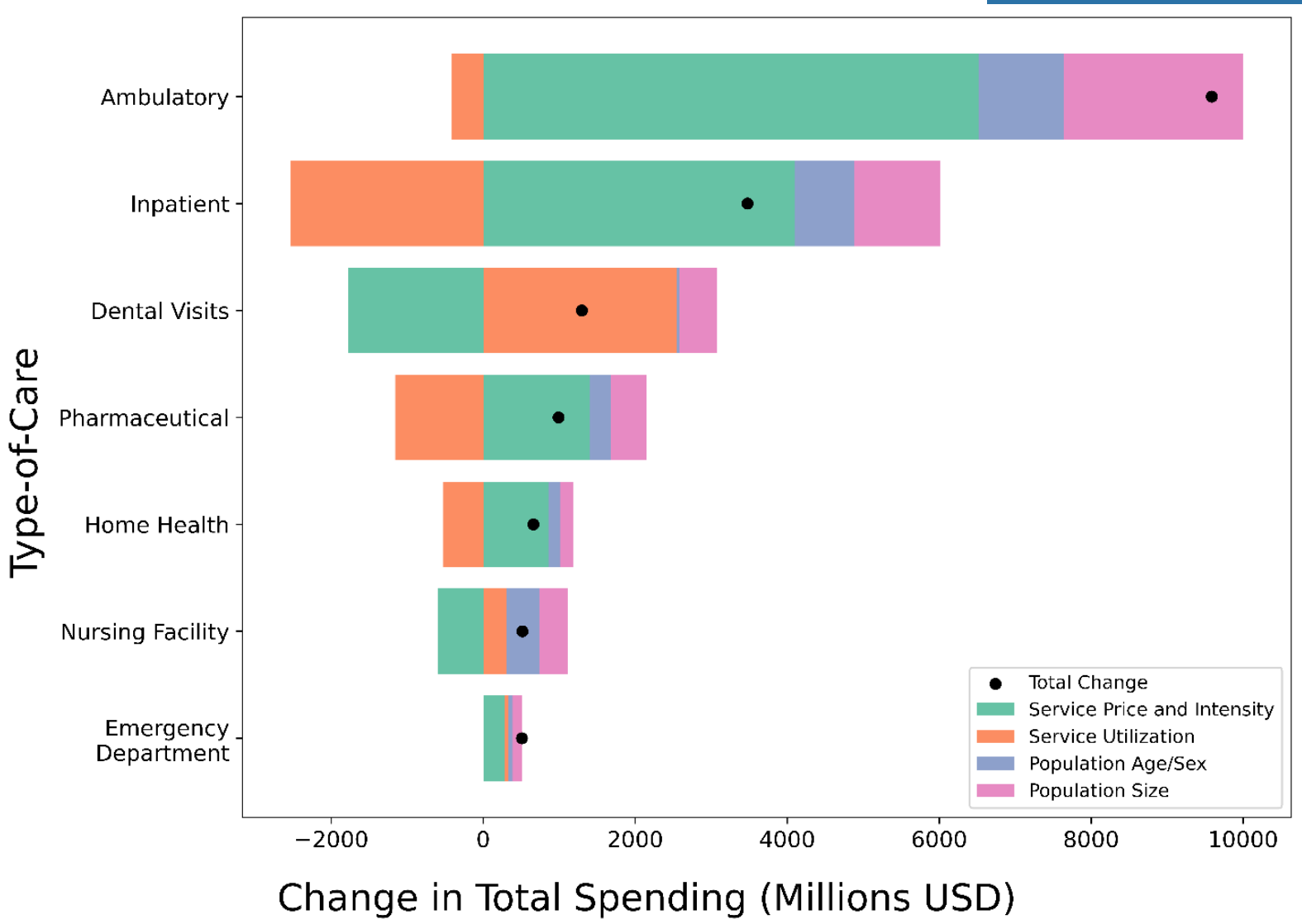


WA state spending growth 2010-2019

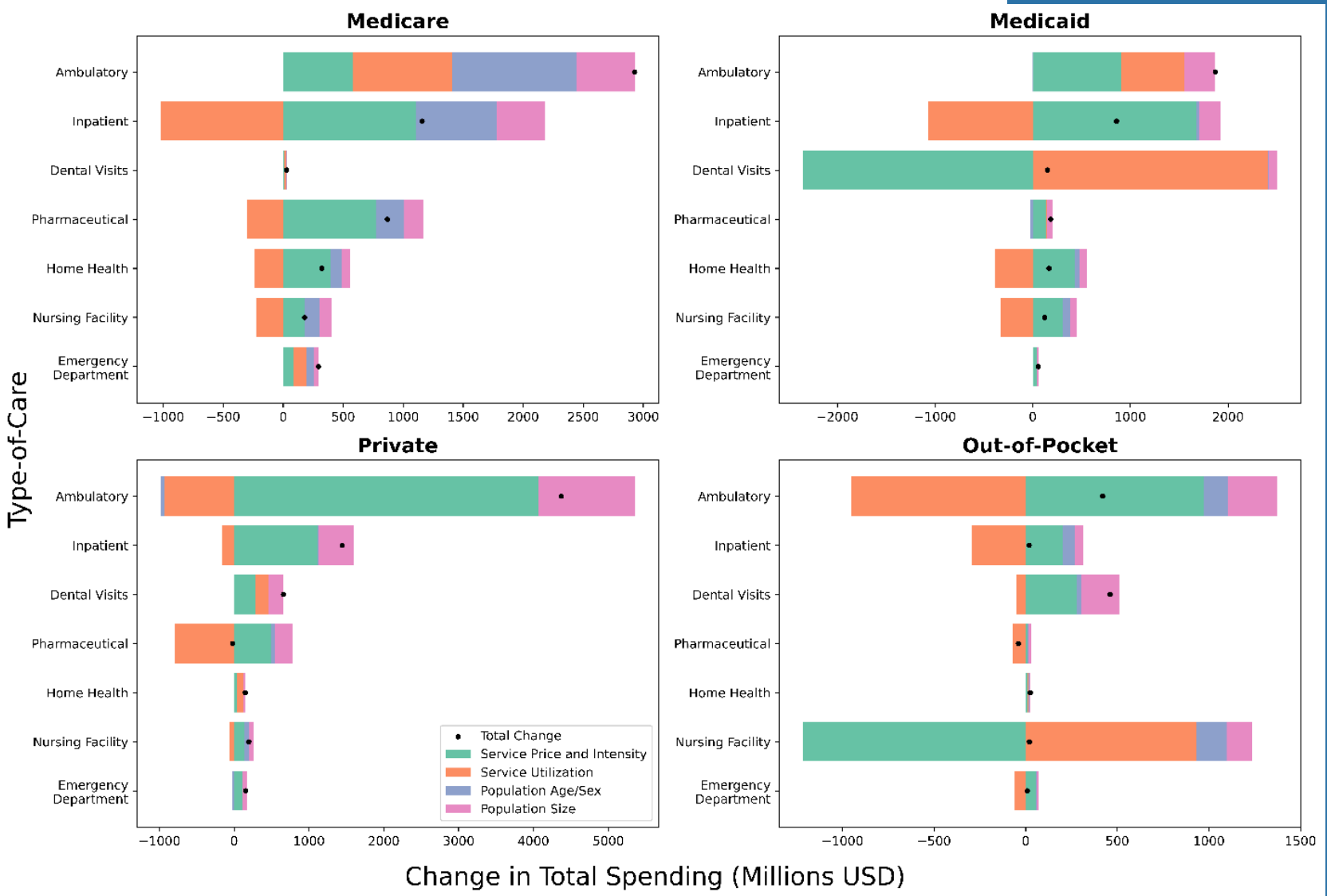
WA has spending increase that is eighth lowest. After standardizing for age, WA spending has increased the tenth slowest.



WA state spending growth 2010-2019



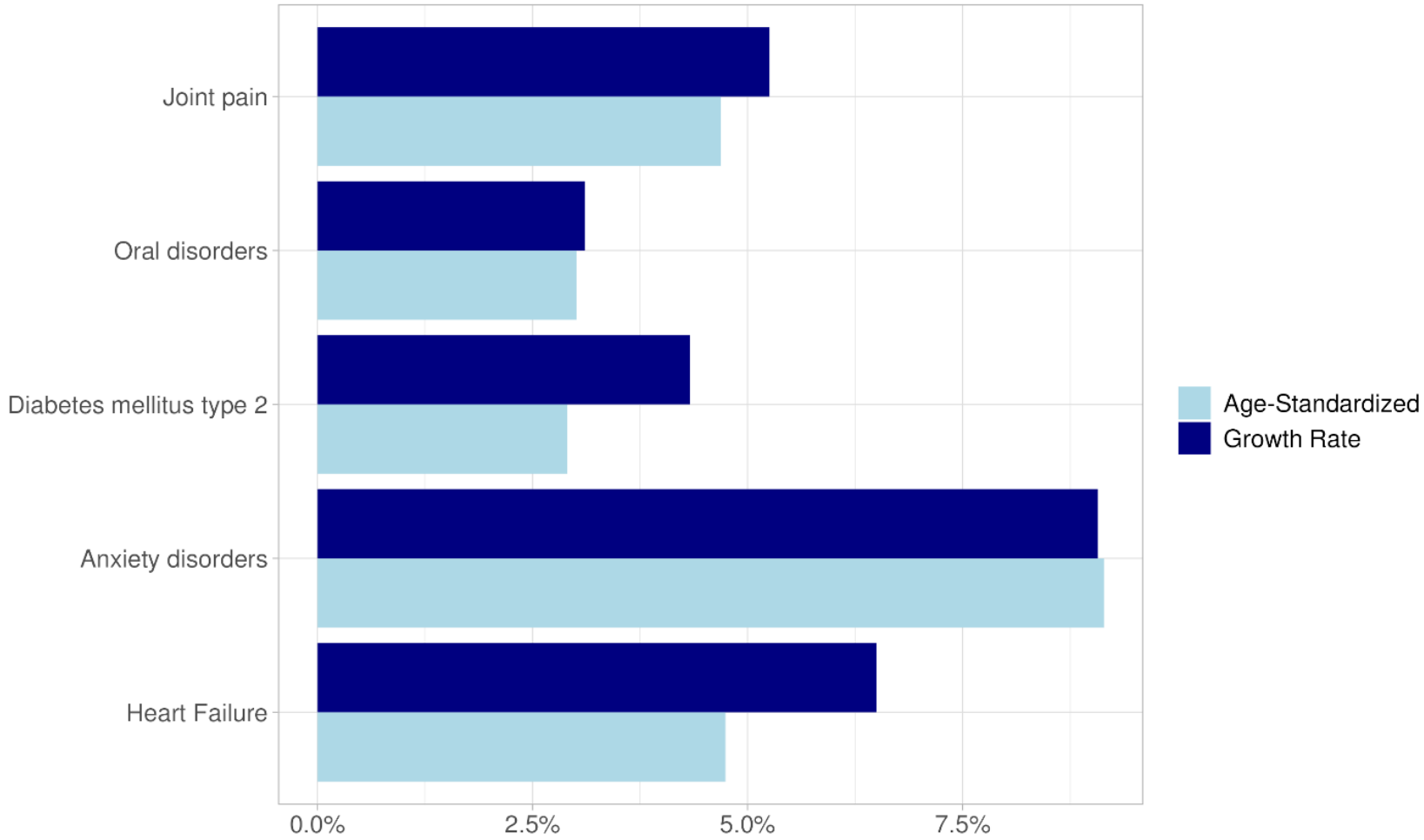
WA state spending growth 2010-2019



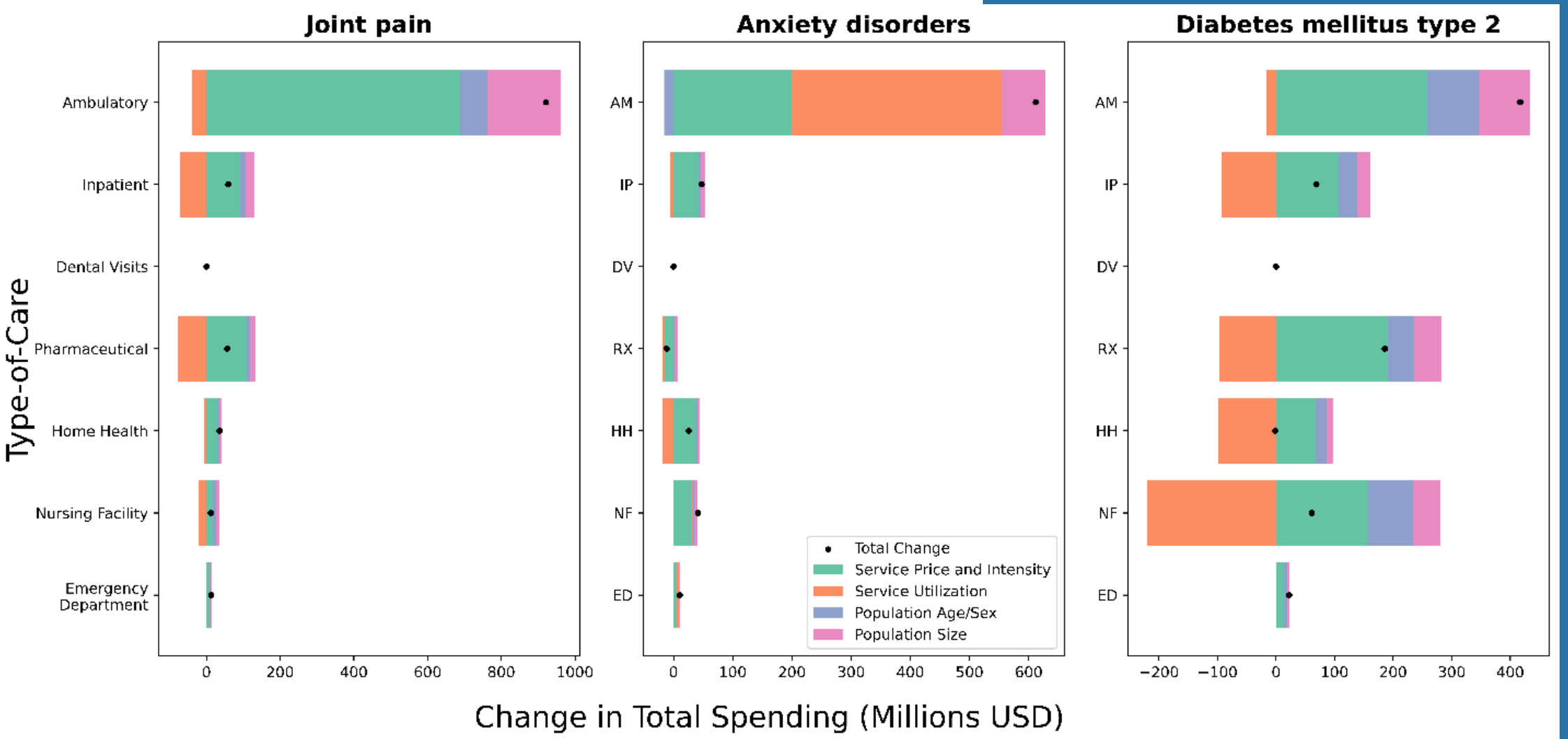
WA state spending by disease

Cause	Total Spending (billions)	Growth Rate	Age-Standardized Growth Rate	Under 20	Over 65	Inpatient	Ambulatory	Pharmaceutical	Nursing Facility	Medicare	Medicaid	Private Insurance	Out-of-Pocket
Oral disorders	$3.05	1.5%	1.4%	17.0%	18.4%	0.7%	1.9%	0.1%	0.0%	1.2%	2.9%	40.1%	55.8%
Joint pain	$2.74	3.6%	3.0%	8.8%	29.6%	9.1%	78.2%	6.7%	2.7%	22.7%	8.9%	58.7%	9.7%
Diabetes mellitus type 2	$2.18	2.7%	1.3%	0.1%	53.6%	9.6%	42.1%	23.0%	18.7%	36.9%	14.2%	36.9%	12.0%
Lower back and neck pain	$1.68	0.4%	0.0%	1.9%	34.2%	16.6%	75.5%	1.3%	2.0%	25.8%	7.1%	56.7%	10.5%
Skin and subcutaneous diseases	$1.53	2.1%	1.7%	12.5%	32.0%	16.9%	51.6%	23.7%	1.8%	27.4%	16.8%	48.3%	7.4%
Urinary tract disorders	$1.51	1.6%	0.6%	6.7%	48.7%	18.4%	60.9%	5.0%	5.8%	35.5%	16.9%	38.8%	8.7%
Ischemic heart disease	$1.48	1.0%	-0.5%	0.1%	65.5%	45.8%	34.1%	3.4%	9.1%	43.9%	10.4%	37.6%	8.2%
Well dental	$1.40	3.1%	3.2%	28.5%	13.2%	0.0%	0.0%	0.0%	0.0%	0.8%	25.9%	62.0%	11.3%
Heart Failure	$1.30	4.8%	3.1%	0.3%	80.8%	49.6%	7.0%	0.8%	34.7%	54.2%	14.2%	15.8%	15.9%
Anxiety disorders	$1.25	7.3%	7.4%	26.0%	9.3%	7.2%	78.1%	4.1%	5.4%	8.2%	33.4%	49.7%	8.7%
Gynecological diseases	$1.21	1.5%	1.8%	4.0%	7.1%	3.7%	91.2%	2.9%	0.0%	6.5%	10.1%	73.3%	10.1%
Other neoplasms	$1.09	1.9%	1.2%	3.7%	34.6%	9.1%	86.1%	4.0%	0.2%	25.6%	4.8%	59.6%	10.0%
Alzheimer's disease and other dementias	$1.01	0.5%	-0.5%	0.0%	94.6%	12.8%	6.6%	0.9%	69.1%	39.8%	24.5%	8.5%	27.2%
Acute renal failure	$0.98	3.7%	2.3%	0.9%	46.3%	34.3%	61.5%	1.2%	0.8%	40.9%	32.4%	21.6%	5.1%
Upper digestive system diseases	$0.95	0.7%	-0.2%	6.3%	45.3%	26.7%	46.2%	3.6%	15.6%	32.9%	17.5%	38.9%	10.7%
Osteoarthritis	$0.94	2.9%	1.5%	0.0%	60.8%	44.4%	39.3%	1.4%	10.1%	34.0%	6.4%	49.7%	10.0%
Endocrine, metabolic, blood, and immune disorders	$0.93	1.7%	0.9%	10.8%	43.2%	22.1%	32.1%	22.8%	16.4%	29.6%	16.4%	45.1%	8.9%
Breast cancer	$0.93	4.8%	4.0%	0.0%	32.3%	2.2%	89.2%	7.9%	0.3%	26.8%	5.9%	62.7%	4.6%
Depressive disorders	$0.91	3.4%	3.3%	21.6%	15.7%	25.8%	57.7%	7.3%	2.9%	14.7%	30.1%	49.0%	6.1%
Falls	$0.90	2.8%	2.0%	9.7%	55.7%	36.4%	31.4%	0.1%	16.4%	33.2%	10.7%	43.1%	13.0%

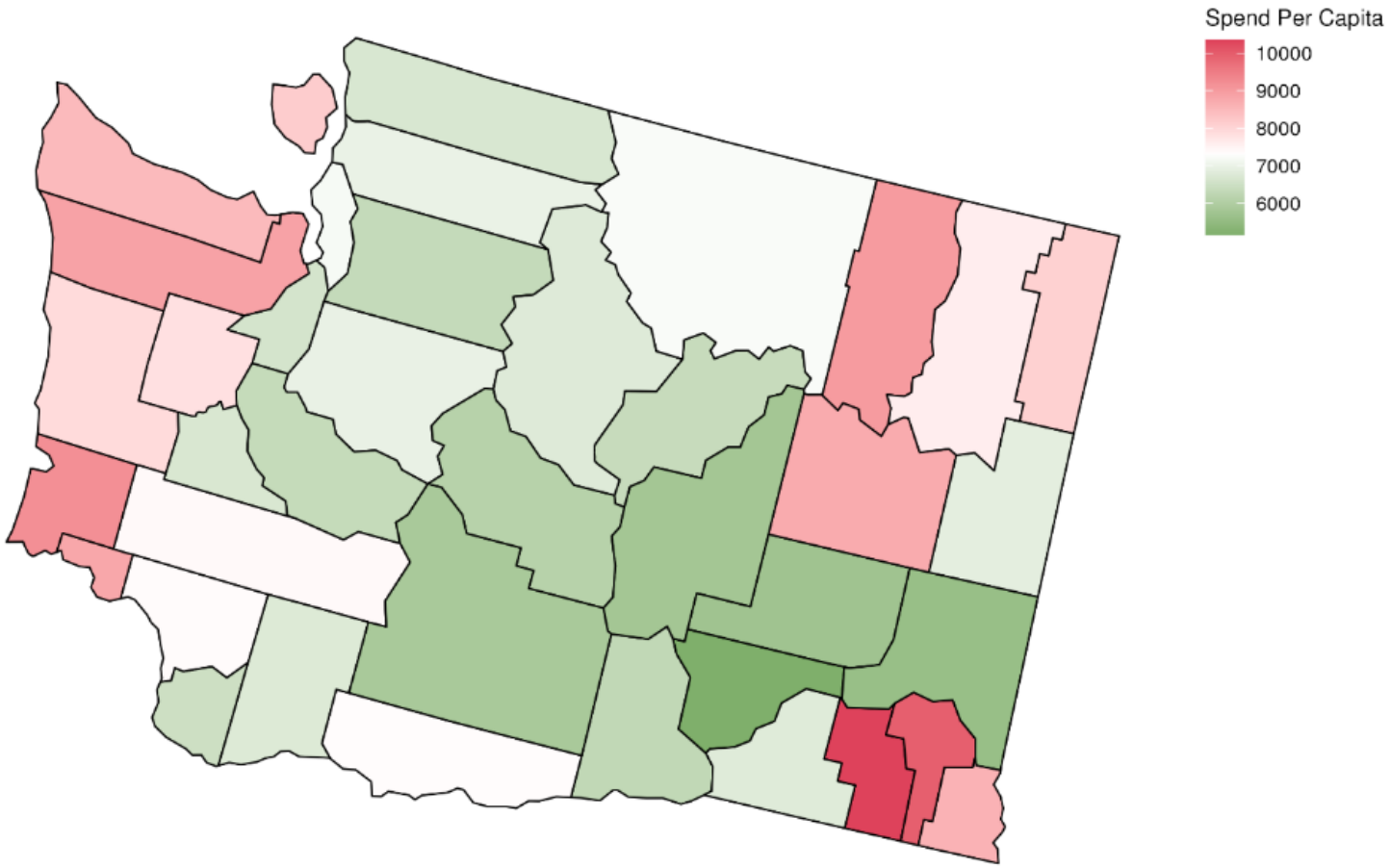
Health conditions with the most growth in annual spending between 2010 and 2019



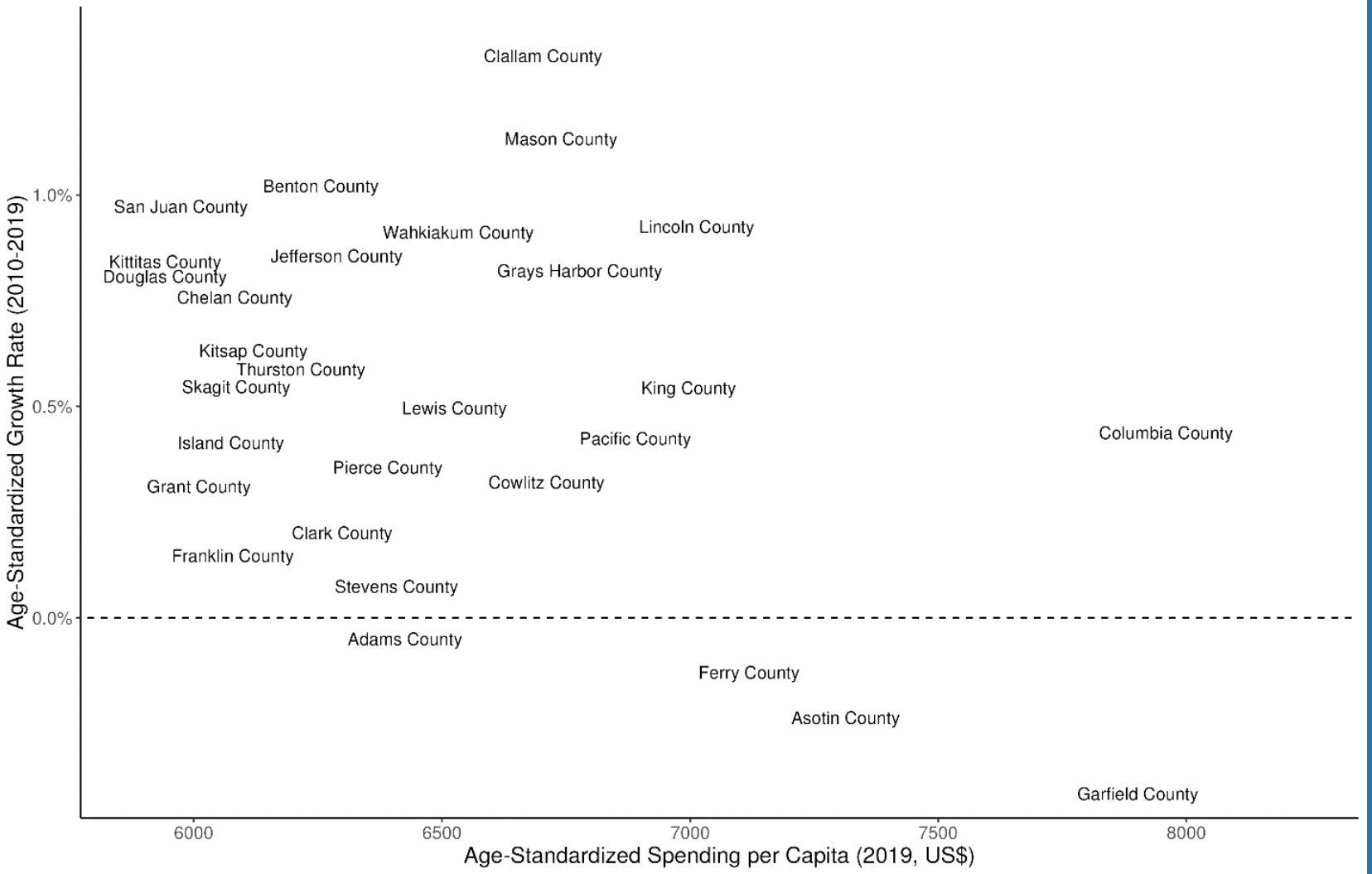
Health conditions with the most growth in annual spending between 2010 and 2019



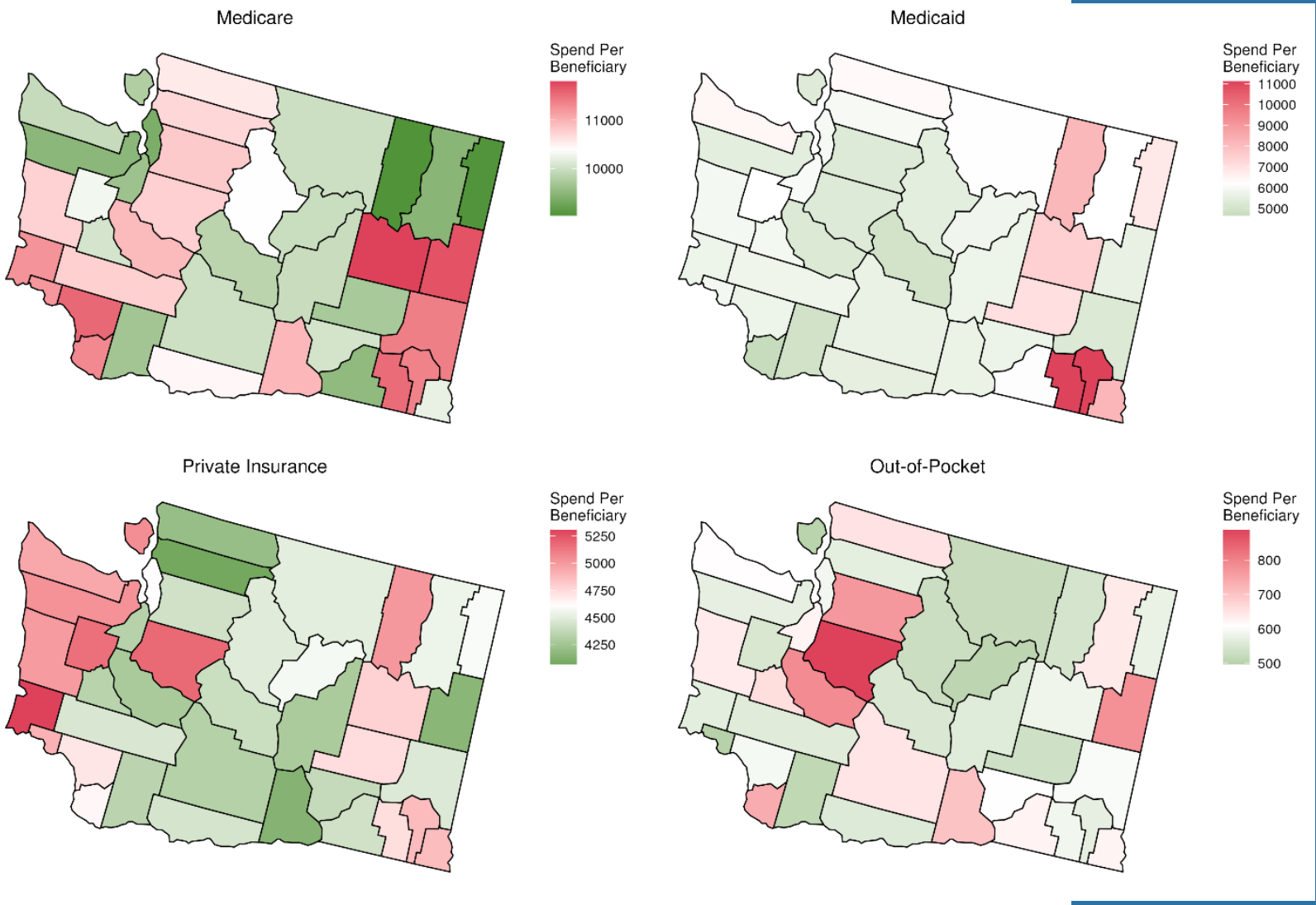
Health care spending in 2019



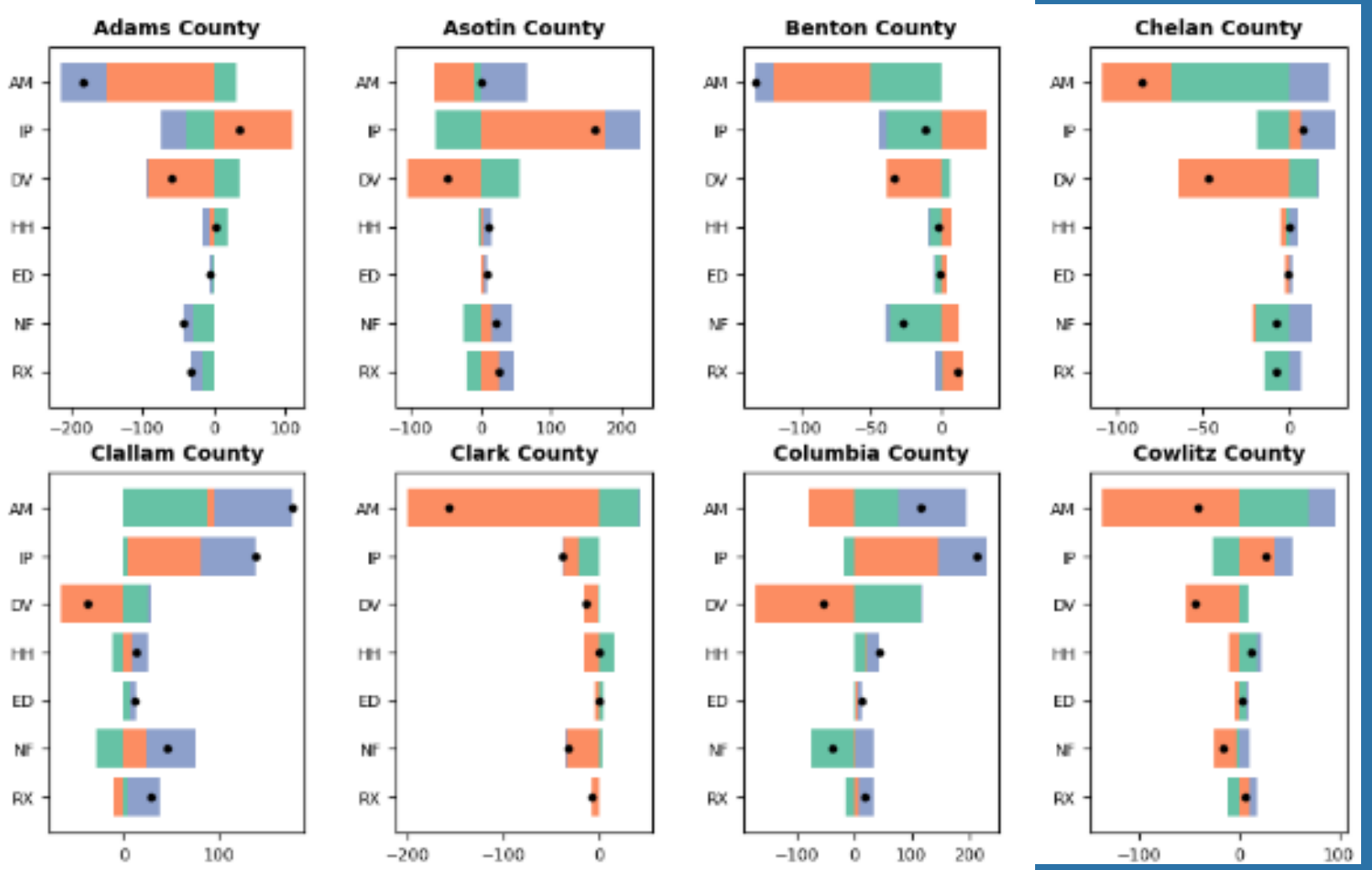
Health care spending in 2019



Health care spending in 2019



Health care spending in 2019 by county, relative to WA state



Objective of today's presentation to the Cost Board

1. *Evaluate the Draft Preliminary Disease Expenditure Report and identify ways it could be strengthened prior to finalization*

    - How can these estimates be presented or fine-tuned to be clearer and more relevant to the work of Cost Board?

2. *Identify ways this research could be tailored to meet the goals and strategic objectives of the Cost Board*

    - Ahead of the completion of the draft ASI report in October, how can these analyses be delivered to aid the Cost Board policy study efforts?

Next steps

1. *April – July* → Fully incorporate the WA APCD into the IHME disease expenditure project

2. *August – October* → Three agreed upon ASI analyses:
    1. Generate estimates of WA spending and utilization through 2022
    2. Standardize those estimates
    3. Decompose differences in spending across counties and time
3. *November* → Report delivery to Board
4. *December – January 2025* → Report Approval and Analytic Strategy v2.0
5. *February – April 2025* → Legislative Recommendation Refinement

Tab 9

Washington State Health Care Authority

NOMINATING COMMITTEE & ADVISORY COMMITTEE UPDATES

OVERVIEW:

- **Nominating Committee**
  - *First meeting held on April 22*
  - *Confirmation votes on Advisory Committee Members:*
    - 5 new Health Care Stakeholder Committee members (based on 1508 updates / committee expansion)
    - 2 members were nominations to replace previously filled seats on Health Care Stakeholder Advisory Committee
- **Chair confirmation**
- **Stakeholder Charter** (review—are updates needed?)
- **Vote to adopt Nominating Committee recommendations**

HEALTH CARE STAKEHOLDER ADVISORY COMMITTEE NOMINEES (1508 UPDATES):

Number of members	Representing the interests of…	Selected from a list of nominees submitted by…
At least 2	Consumers: ➢ ***Adriann Jones*** Washington Community Action Network (WACAN) represents consumers. Nominated by John Godfrey Community Organizing Manager WACAN ➢ ***Emily Brice*** of Northwest Health Law Advocates (NOHLA) represents consumers and nominated by Janet Varon, CEO of NOHLA	Consumer organizations
At least 2	Labor purchasers: ➢ ***Justin Gill*** President, Washington State Nurses Association ➢ ***Sulan Mlynarek*** Lead Research Analyst, Service Employees International Union (SEIU) Healthcare 1199NW	Washington State Labor Council
At least 2, including at least 1 small business representative	Employer purchasers: ➢ ***Patrick Connor*** of NFIB, represents small businesses nominated by NFIB	Business organizations

HEALTH CARE STAKEHOLDER ADVISORY COMMITTEE NOMINEES (TO FILL PREVIOUSLY FILLED SEATS):

- **Paul Schultz**
  - Kaiser Permanente, represents carrier nominated by Peggi Fu, ED, Association of WA Health Plans
  - As indicated in House Bill 2457, filling role of:
    - One member representing a health maintenance organization, selected from a list of three nominees submitted by the Association of Washington Health Care Plan
  - *Replacing:*
    - Justin Evander, Executive Director Care Delivery Finance, Kaiser Permanente
- **Nariman Heshmati**
  - President, Washington State Medical Association
  - As indicated in House Bill 2457, filling role of:
    - One physician, selected from a list of three nominees submitted by the Washington State Medical Association
  - *Replacing:*
    - Jeb Shepard, (interim, non-voting member), Washington State Medical Association

CHAIR CONFIRMATIONS

Health Care Cost Transparency Board

Nominating Committee

- Ingrid Ulrey
- Carol Wilmes
- Kim Wallace

HCCTB Advisory Committee on Data Issues

Chair

Bianca Frogner

(Non-voting member)

HCCTB Advisory Committee on Health Care Stakeholders

Chair

Eileen Cody

(Non-voting member)

Liaison: Jodi Joyce

HCCTB Advisory Committee on Primary Care

Chair

Judy Zerzan-Thul

(Voting member)

HEALTH CARE STAKEHOLDER ADVISORY COMMITTEE CHARTER

- The Advisory Committee Charter has been updated to reflect changes in both name and composition as indicated in HB 1508.
  - The Updated Charter is included in the materials

DISCUSSION & VOTE

- Any questions?
- Vote to approve Chairs
  - Eileen Cody
  - Bianca Frogner
- Vote to approve recommended nominees

HEALTH CARE COST TRANSPARENCY BOARD'S

Advisory Committee of Health Care Stakeholders

What is the Purpose of the Advisory Committee of Health Care Stakeholders?

The role of the Advisory Committee of Health Care Stakeholders is to assist the Health Care Cost Transparency Board ("Board") by providing subject matter expertise, and support to the Board regarding the cost growth benchmark. The Advisory Committee of Health Care Stakeholders will also help the Board identify opportunities to slow cost growth, address growing affordability concerns for the state of Washington at various levels (state, market, carriers, large provider entities, as well as consumers). The Advisory Committee of Health Care Stakeholders will also assist with other areas proving subject matter expertise as identified by the Board through the perspective of the providers, carriers, and consumers.

Membership:

As indicated in House Bill 2457, section 4 and related RCWs, and updated House Bill 1508, the Advisory Committee of Health Care Stakeholders will be appointed by the Board.

Appointments to the Advisory Committee of Health Care Stakeholders must include the following membership:

a) One member representing hospitals and hospital systems, selected from a list of three nominees submitted by the Washington State Hospital Association;
b) One member representing federally qualified health centers, selected from a list of three nominees submitted by the Washington Association of Community Health Centers;
c) One physician, selected from a list of three nominees submitted by the Washington State Medical Association;
d) One primary care physician, selected from a list of three nominees submitted by the Washington State Academy of Family Physicians;
e) One member representing behavioral health providers, selected from a list of three nominees submitted by the Washington Council for Behavioral Health;

f) One member representing pharmacists and pharmacies, selected from a list of three nominees submitted by the Washington State Pharmacy Association;
g) One member representing advanced registered nurse practitioners, selected from a list of three nominees submitted by ARNPs United of Washington State;
h) One member representing tribal health providers, selected from a list of three nominees submitted by the American Indian Health Commission;
i) One member representing a health maintenance organization, selected from a list of three nominees submitted by the Association of Washington Health Care Plans;
j) One member representing a managed care organization that contracts with the Health Care Authority to serve medical assistance enrollees, selected from a list of three nominees submitted by the Association of Washington Health Care Plans;
k) One member representing a health care service contractor, selected from a list of three nominees submitted by the Association of Washington Health Care Plans;
l) One member representing an ambulatory surgery center selected from a list of three nominees submitted by the Ambulatory Surgery Center Association; and

As indicated in House Bill 1508, the Advisory Committee of Health Care Stakeholders shall also have the additional members:

m) Three members, at least one of whom represents a disability insurer, selected from a list of six nominees submitted by America's Health Insurance Plans.
n) At least two members representing the interests of consumers, selected from a list of nominees submitted by consumer organizations;
o) At least two members representing the interests of labor purchasers, selected from a list of nominees submitted by the Washington state labor council;
    a. *The members appointed under this subsection may not be directly or indirectly affiliated with an employer which has income from health care services, health care products, health insurance, or other health care sector-related activities as its primary source of revenue*.

Member Responsibilities:

Members of the Advisory Committee of Health Care Stakeholders are responsible for:

- Providing subject matter expertise in relation to the growth benchmark and benchmark, including understanding for outliers or unexplained trends with the cost growth data analysis.
- Representing the representing the interests of consumers, labor, and employer purchasers and may include others with expertise in the advisory committee's jurisdiction, such as health care providers, payers, and health care cost researchers, and

bringing forth issues impacting health care cost transparency and affordability to the Board.

- Collaborating with the Board and HCA staff to help create buy-in across the various markets, provider organizations, and consumer organizations and offering suggestions that may help streamline the data collection process.
- Serving as a liaison between the Board and health care community by relaying essential information to carriers, providers, consumers, and laborers as well as bringing forth feedback to the Board to ensure all parties involved have an opportunity to address how to slow cost growth and to address growing affordability concerns for the state of Washington at various levels.
- Attendance and participation in Advisory Committee meetings. This includes reviewing meeting materials in advance of the scheduled meeting, coming prepared to engage with other members, working collaboratively with other members and the Board, being sensitive to the impact that high health care spending growth has on Washingtonians, and providing input to help the conversation continue moving forward.
- If a member cannot attend a meeting, they are requested to advise HCA before the meeting and contact staff for a recording of the meeting.
- Members will adhere to the requirements of the Open Public Meetings Act and the Public Records Act. Records related to the Advisory Committee are public records.

Meetings:

The Advisory Committee of Health Care Stakeholders will meet as needed (likely no more than six times annually) to fulfill its mandate to the Board by providing subject matter expertise and support to the Board.

Quorum:

A majority of the members that make up the Advisory Committee of Health Care Stakeholders constitutes a quorum for a meeting of the committee. If a meeting does not have a quorum of members present or does not maintain a quorum, the meeting may be cancelled or rescheduled so that there are sufficient members to fulfill the Advisory Committee's responsibilities.

Accountability and Reporting:

The Advisory Committee of Health Care Stakeholders is accountable to the Board and to report its activities and to provide subject matter expertise at the request of the Board or to follow up on requests of the Board.

Tab 10

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board

Public Comment Materials & Written Comments

Public Comment Materials and Written Comments Submitted by Email

1. Correction to Information Provided in Public Comments
2. Washington Health Alliance
3. Leukemia & Lymphoma Society
4. Washington State Hospital Association
5. Christa Able

Comments Received at the April Meeting

The Zoom video recording is available for viewing here:
https://youtu.be/hFoxjdCkdJE

Washington State Health Care Authority

Correction to information provided in public commenters

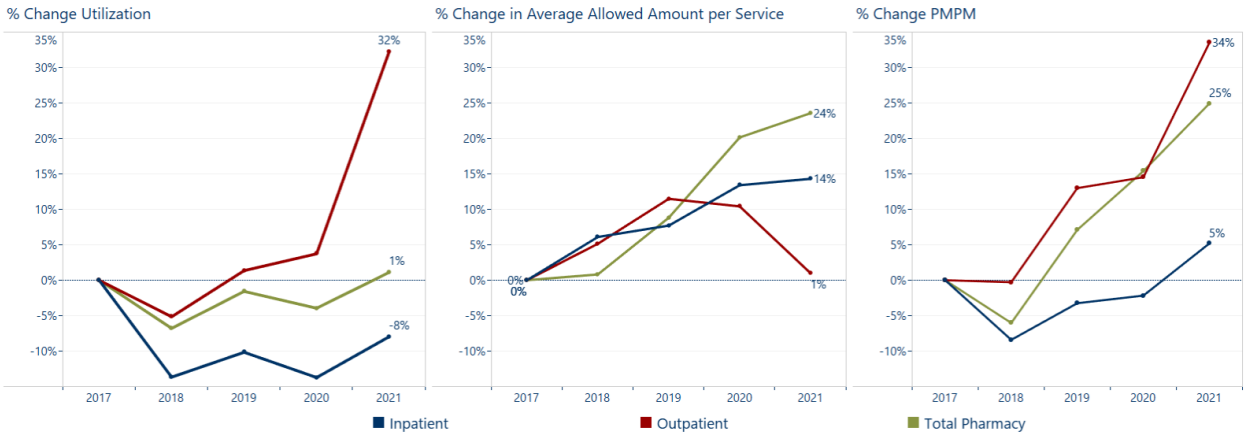
Background

During verbal and written public comments provided at the Health Care Cost Transparency Board (Cost Board) meeting on April 10, 2024, several commenters drew conclusions from the Cost Board's Cost Driver Analysis that warranted review and response. Chair Birch requested staff to review the references to the Board's Cost Driver Analysis to provide follow-up with the Cost Board and correct any inaccuracies. This is a synopsis of cost driver analysis findings and corrections to certain statements made during public comment, where appropriate.

Cost increases are due to increased prices and not attributable to utilization

Several public comments stated the Cost Driver Analysis attributes increased costs to increased utilization and referred to the growth for inpatient services as relatively flat. However, the Cost Driver Analysis analyzed utilization trends and accounted for utilization in analyzing increased costs by looking at averages per service in addition to per member per month (PMPM) and total spend trends. The analysis shows that inpatient hospital discharges declined by 8% between 2017-21 and that the **average allowed amount per service went up 14%** and **inpatient spending increased by 5% PMPM.** Figure 1 is from the **Cost Driver Analysis presentation on December 14, 2022**, and details the changes in commercial cost drivers.

Figure 1: Changes in commercial cost drivers (2017–2021)



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

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

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

Washington State Health Care Authority

The most significant increases in spending were seen in inpatient and outpatient spending

One public commenter suggested that the Cost Driver Analysis shows that spending only increased slightly for inpatient services. However, the most significant increases in spending were seen in inpatient and outpatient spending, when looking at cost growth from 2017 to 2021. Note that Figure 2 below, which is from the **Cost Driver Analysis presentation on December 14, 2022**, is impacted by changes to average allowed amounts by service and utilization. However, it was observed, per the charts above, that both utilization and price were driving this significant increase in total expenditures.

Figure 2: Growth in medical claims expenditures, 2017 & 2021

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

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

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

Washington's Uneven Hospital Landscape: How Price Levels Vary Statewide

May 2024

WASHINGTON HEALTH ALLIANCE

Table of Contents

The Washington Health Alliance (Alliance) is a 501(c)(3) nonprofit nonpartisan organization working collaboratively to transform Washington state's health care system for the better. The Alliance brings together more than 140 committed member organizations to improve health and health care by offering a forum for critical conversation and aligned efforts by health plans, employers, union trusts, hospitals and hospital systems, health care professionals, start-up companies, consultants, consumers, and other health care partners. The Alliance believes strongly in transparency and offers trusted, credible reporting of progress on health care quality, value, pricing, and overall spending. The Alliance publishes its reports at **www.WACommunityCheckup.org** and provides guidance for consumers at **www.OwnYourHealthWA.org** so that individuals can make informed health care decisions.

About this Report

In the face of a mounting health care affordability crisis, transparency in hospital pricing and costs, representing about a third of the total health care dollars,[1] has become a substantial concern among those who pay for and receive health care services across Washington state.

In this analysis, which includes a large volume of data from self-insured employers in Washington state, we found hospitals ranging from 150 percent to nearly 700 percent of the price of Medicare. **On average, Washington hospitals price levels are 288 percent of what Medicare pays.**

The price levels reported by the Alliance offer an independent view into the billions of dollars spent annually in acute care hospitals and outpatient facilities. For a more comprehensive view, our report includes cancer facilities, children's hospitals, as well as the two dozen critical access hospitals spread across our state.

The importance of understanding hospital price levels cannot be understated. It is a key piece in determining what is a fair price for hospital spending. Without this information, we fall short in taking the necessary steps to ensure affordable and equitable value-based care. In Washington, like much of the nation, hospitals face pressures driving up expenses, but the price paid for services delivered in hospitals needs to be balanced by reasonable expenses to come to a fair pricing level. This report is a start to that conversation.

Most Washington residents receive their health insurance through their employer.[2] These employers and union trusts have a fiduciary responsibility to operate their plans in the best interest of their participants,[3] yet it is not readily apparent if the price paid correlates with the cost of the delivery service, the quality of care to patients provided or the safety of the facility.

In Washington, hospital spending is a major source of health care spending, and it is increasing steadily.[4] Yet the picture is opaquer than ever. Against the backdrop of increased hospital network consolidation, hospital prices have become less transparent as contracts are negotiated among a smaller cohort of companies.

Patients and those paying for health care have little public information to openly compare the price for facilities in their networks. Health care purchasers must stand together to reduce unwarranted variation in prices.

To lift the veil on hospital price, the Alliance utilized its voluntary All-Payer Claims Database, comprised of data from 2.2 million commercially insured from health plans, self-funded employers, and union trusts, to determine how hospital price levels for a commercial plan differ from the Medicare rates.

This report provides a summary of the stark differences in hospital price levels across county lines or in the same city. Starting with the prices hospitals receive from commercial purchasers is a step toward finding a fair price.

What we do know is that individuals and families across Washington are bearing an increasing health care cost burden. The squeeze from rising health care costs, in part driven by pricing for services delivered in hospital, is being felt by families. A recent Commonwealth Foundation survey showed that 51 percent of working-aged Americans said it was difficult to afford their health care costs. For those with employer-sponsored plans, the rate was nearly as high.[5]

These increasing costs have a substantial impact on employers, who must allocate an even greater proportion of an employee's total compensation toward health care spending and away from wages. In a survey this fall, 9 in 10 employers said that rising health care costs are affecting their competitiveness in securing and retaining talent.[6]

We must dive deeper to understand how health care purchasers, plans and providers can work together and with policymakers to better respond to rising costs by addressing the realities of hospital pricing. Hospitals should be paid for the actual cost to deliver the service plus a reasonable margin for profit. To ensure everyone benefits, the service must be high quality, and patient safety is a must.

Methodology

Our Data (what is and is not included)

For this analysis, the Washington Health Alliance relied on calendar year 2022 claim data from our voluntary All-Payer Claim Database, which includes more than 2.2 million commercially insured lives in Washington state. Our data comes from self-insured employers and union trusts, and health plans.

The results in this report are combined for commercial payers in the Washington Health Alliance Voluntary All-Payer Claims Database. The methodology relies upon privately negotiated contractual prices (also known as **allowed amounts**) and Milliman's Global Relative Value Units.

These results are not actual prices but are relative price levels. Specifically, commercial prices are compared to corresponding Medicare prices, and reported as "percent of Medicare." For example, 200 percent of Medicare means that commercial prices are about twice what Medicare is likely to have paid. The results consider the varying treatment intensity at different hospitals.

The Medicare pricing reference we use is the published Medicare conversion factor for the United States overall. Apart from categorizing hospitals into broad groups such as acute care and critical access, no other hospital-specific adjustments have been made. Examples of these might include whether a facility is an academic teaching hospital, the share of low-income patients treated, or regional differences in prevailing wages.
The report includes over $3 billion worth of allowed payments.

Service Setting

Utilizing Milliman's Health Cost Guidelines (HCG) grouper, claims were defined by service setting as "facility inpatient," "facility outpatient," and "professional" claims to capture the widest representation of hospital visits.

Claims under the "professional" service setting are those services related to the hospital inpatient or outpatient services to offer a comprehensive view to the total hospital encounter.

Facilities were identified by the Centers for Medicare and Medicaid Services (CMS) certification number and the Washington Health Alliance Master Facility List.

Difference between Medicare and Commercial Insurance

Commercial insurance is different from Medicare in several ways and as such each incurs a different volume of certain claims. Notably, given that Medicare is primarily for adults age 65 and older, reproductive, and maternity care is not a significant source of claims, while it is for commercial insurance. We chose to include maternity services and care for children for a more comprehensive view of the commercial market.

Key Findings

This first-ever report from the Washington Health Alliance offers a number of findings that merit further research and can inform efforts to address the rising cost of care across our state.

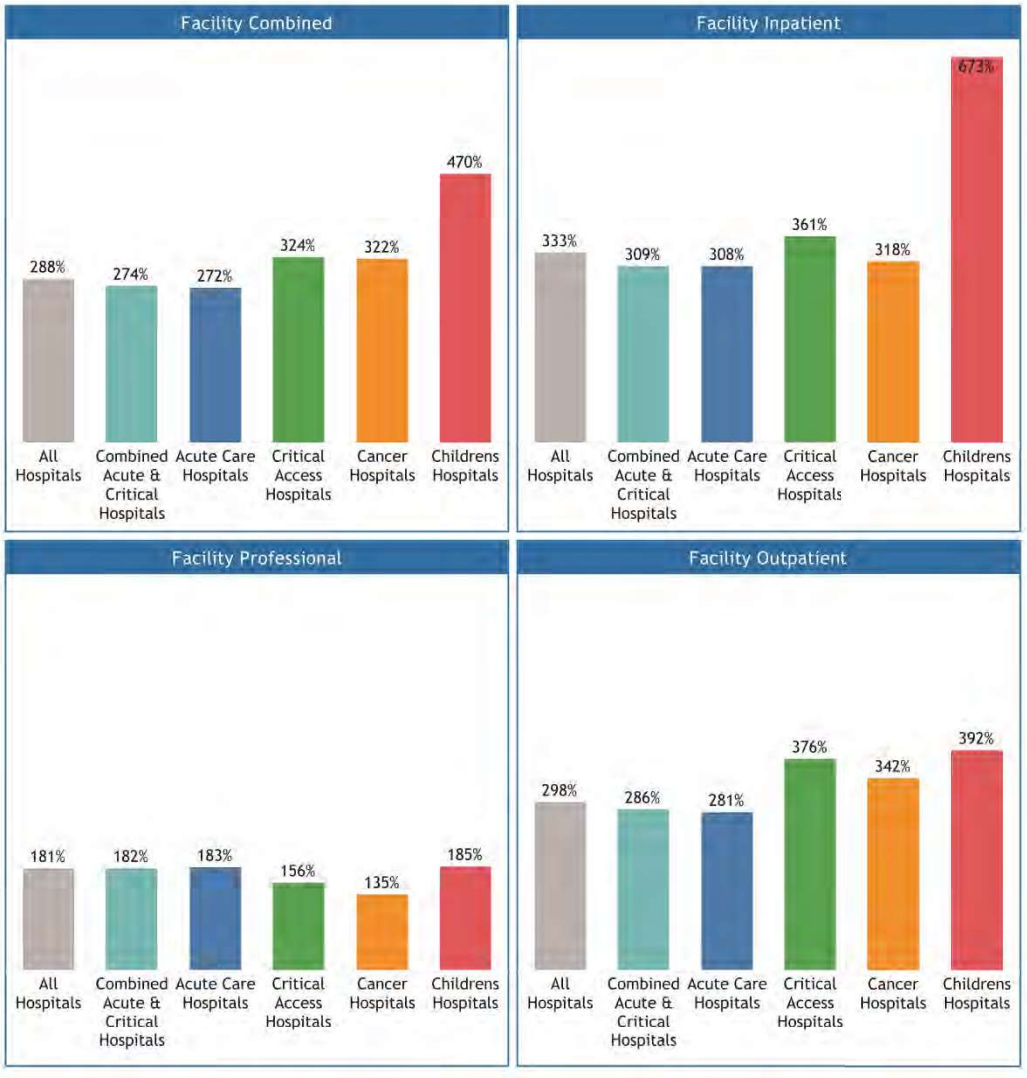
- For all types of hospitals, the average price level for services provided in hospitals statewide is 288 percent of Medicare.

- The hospital price levels compared to Medicare were highest in children's hospitals – 470% -- and lowest on average in acute care hospitals – 272%.

- Critical access hospitals, which make up more than one-third of all hospitals in Washington state, on average had hospital price levels that were 324%. However, these hospitals are a small percentage of overall hospital spending. Variations of hospital price levels compared to Medicare were most significant among these critical access hospitals.

- The average hospital price level was highest in facility inpatient – 333% of Medicare.

Figure 1: Average percentage of Medicare for services provided in hospitals by service group.



Charts

Figure 2: Commercial insurance percent of Medicare pricing level by hospital (Bubble size relates to allowed dollars).

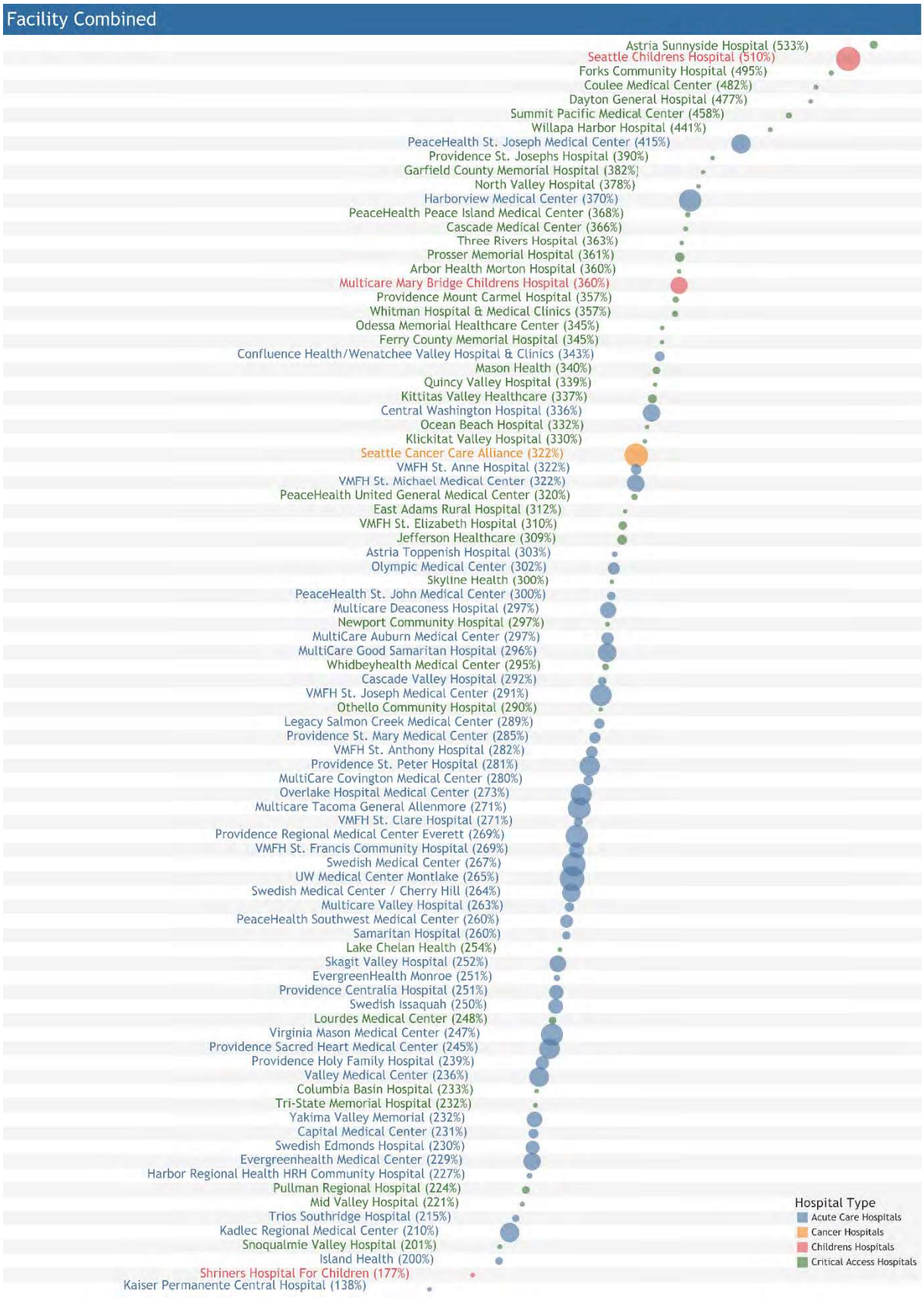


Figure 3: Commercial insurance percent of Medicare pricing level by hospital for facility inpatient services. (Bubble size relates to allowed dollars)

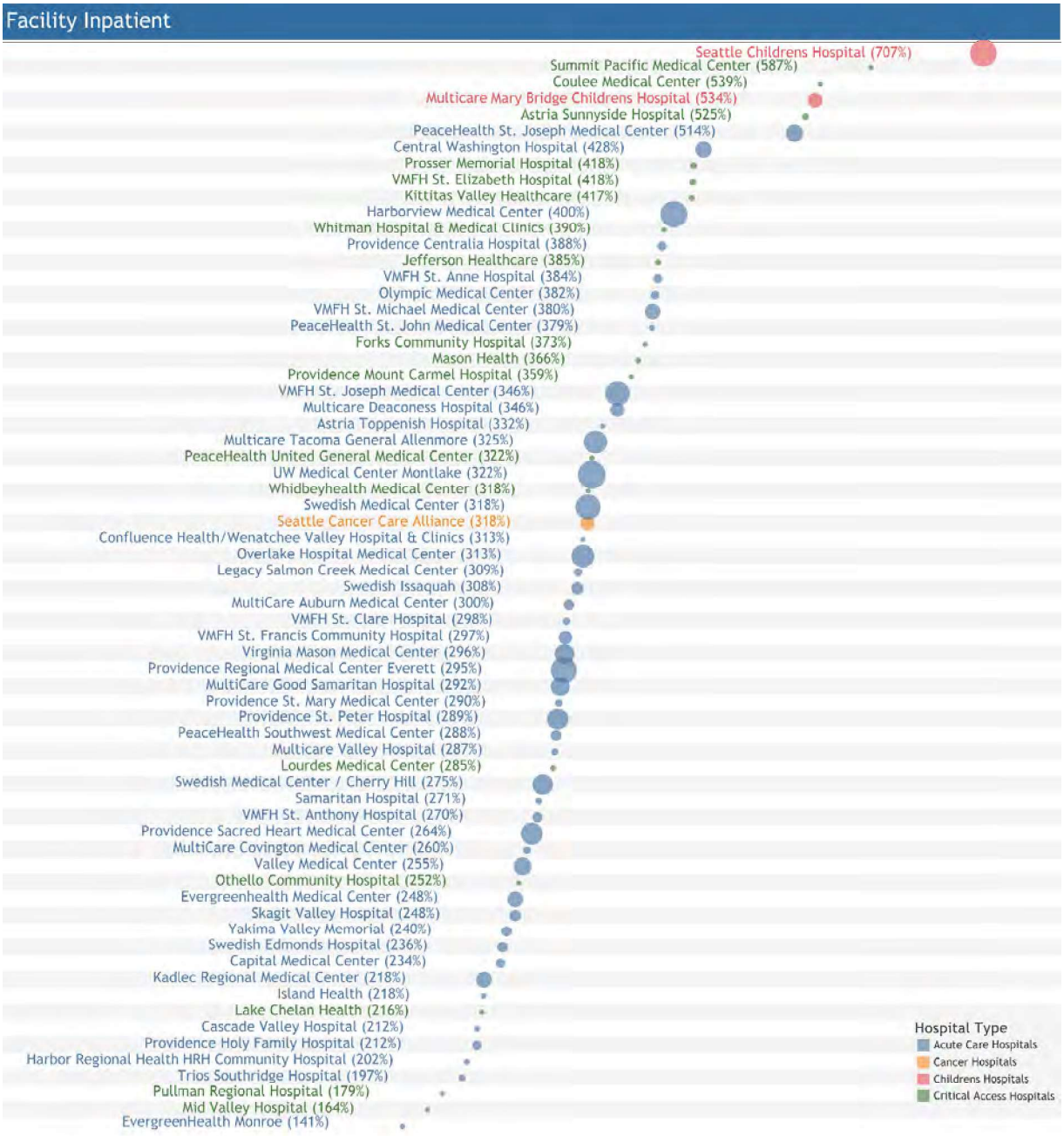


Figure 4: Commercial insurance percent of Medicare pricing level by hospital for facility outpatient services. (Bubble size relates to allowed dollars)

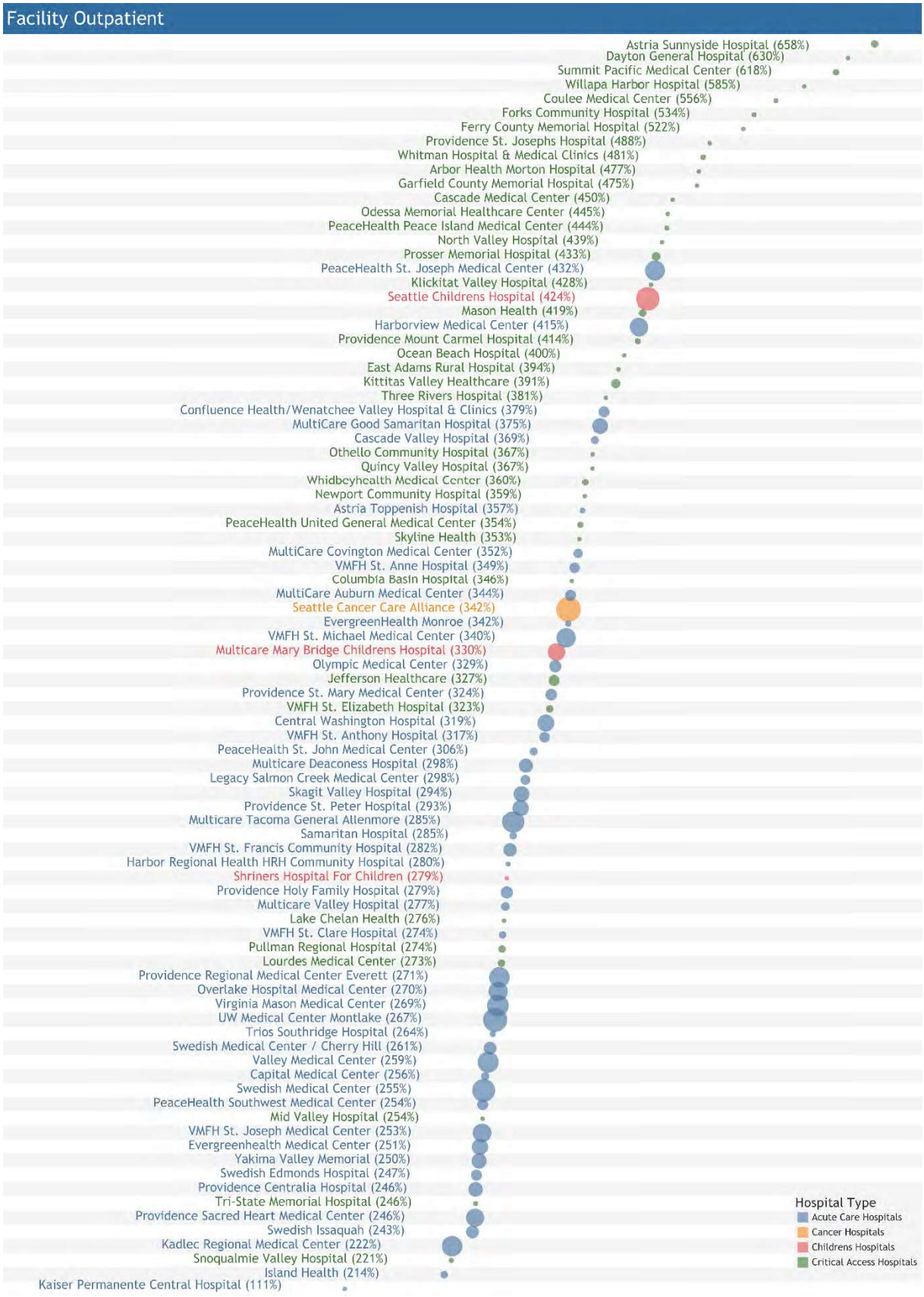


Figure 5: Commercial insurance percent of Medicare pricing level by hospital for facility professional services. (Bubble size relates to allowed dollars)

Figure 6: Percent of Medicare price levels by city in a Hospital Service Area*

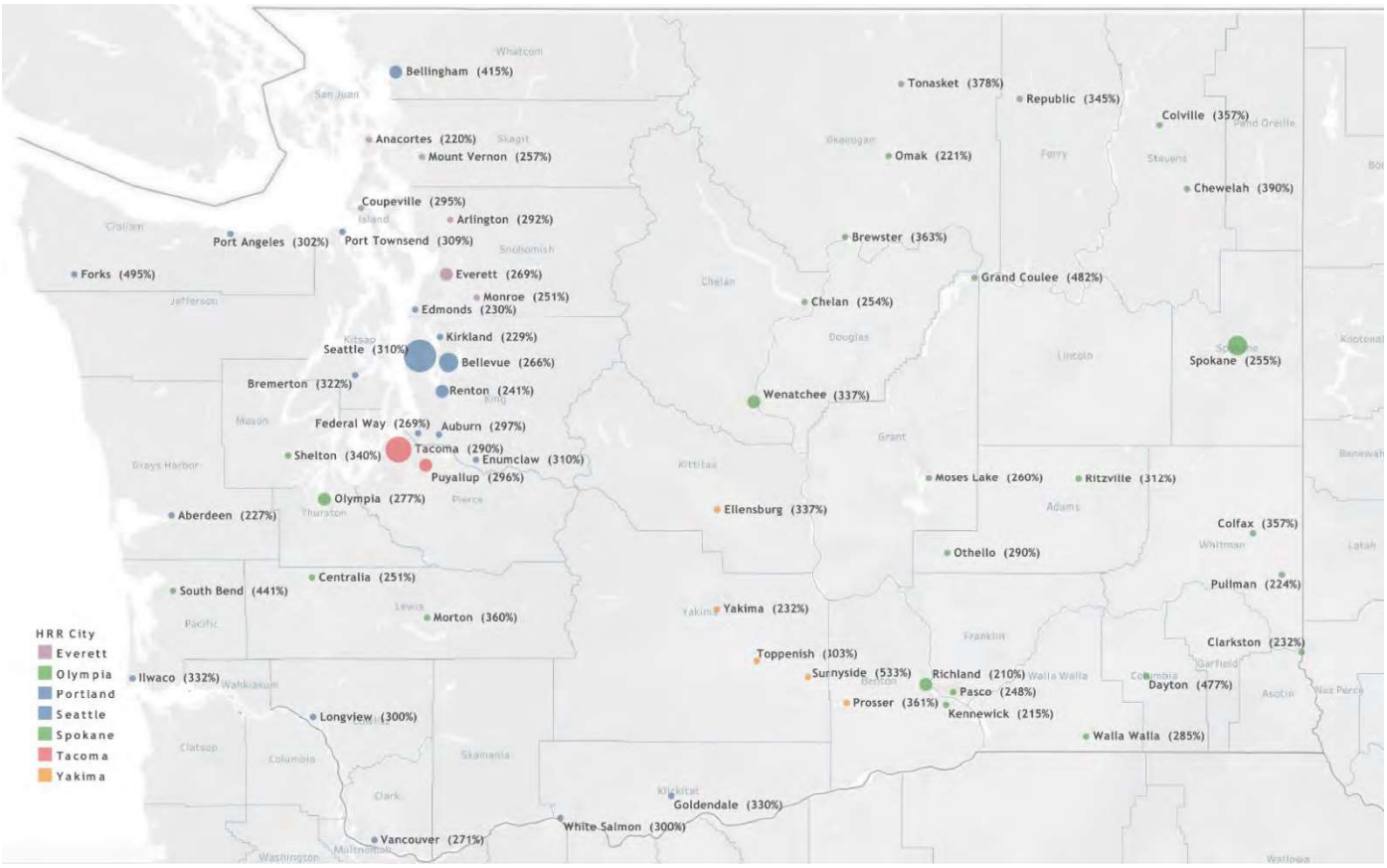
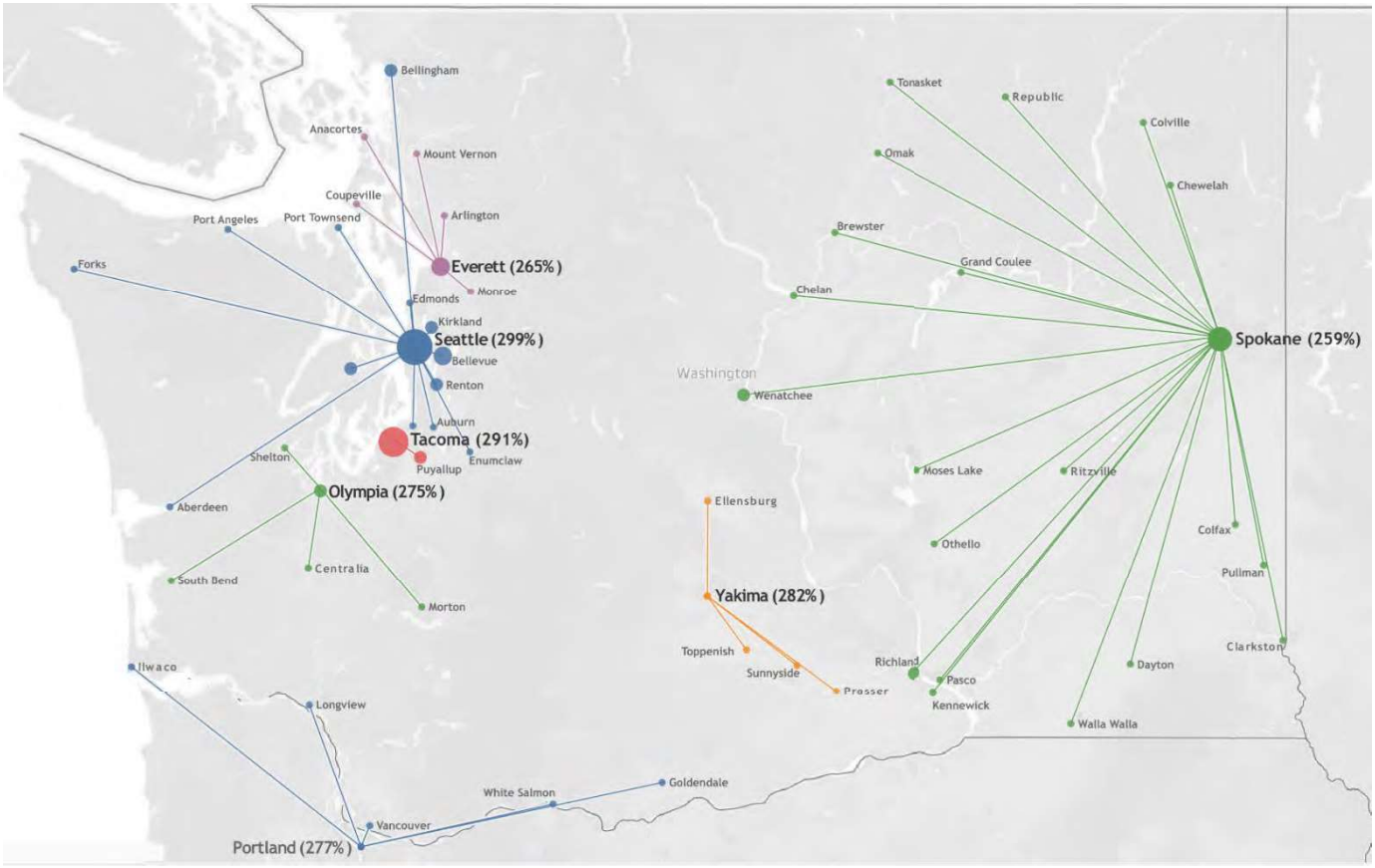


Figure 7: Percent of Medicare price levels by city in a Hospital Referral Region**



Are We Paying Too Much? Recommendations for Next Steps

Our analysis, among the first from an independent organization in Washington state, offers a high-level view of hospital price levels, but much more is needed to understand what a fair price is.

Charity Care, patient medical debt burden:

Washington state is home to more than 40 nonprofit hospitals with obligations to provide charity care and give back to their respective communities. This could influence the overall costs to run the organization. However, a recent Lown Institute report shows that 98% of these hospitals are falling short when it comes to their charity obligations by a total amount of almost $1 billion.[7]

Washington boasts one of the lowest uninsured populations in the country, but medical debt is still high among insured and underinsured populations – 6.5 percent carry medical debt in the state.[8] Further research would be needed to understand how unpaid medical debt could be affecting hospital net revenue.

Rising staffing costs:

Given that the COVID-19 pandemic and its aftermath led to increased strains on staffing at Washington hospitals, it would be useful to understand how increasing labor costs may impact the hospital price levels for commercial insurance.

Plan, service line disparities:

These price levels are the allowed amounts across all data providers. With more than a half-dozen major health plans in the state, the allowed amounts vary based on the contracted health plan.

Another key area to explore further would be disparities in hospital price levels by service lines within these broad areas such as professional, facility outpatient and facility in-patient to get an even more accurate and detailed look into cost drivers in hospitals and differences in pricing levels.

Fair price equation:

To have a correct idea of whether the hospital price levels are appropriate, further study needs to be done to determine what is a fair price. This requires accurate net hospital revenues minus validated operating expenses that then factor in other operating revenue to better calculate a facility break-even cost. There needs to be an evaluation of variations in operating expenses by peer facility and within the same system, and an assessment of the payer mixed impact of reimbursement, especially in rural settings. As it relates to childrens hospitals, given the small number in each state, a national analysis would offer broader insight.

Those who purchase care should pay for the actual cost to deliver a high-quality service plus a reasonable margin for profit. Hospitals should be paid a fair price to deliver that service. We expect this work may allow us to better articulate both the complexities and solutions to create a fair and sustainable health system.

References

***** Hospital referral regions (**HRR**) represent regional health care markets for tertiary medical care. HRR were defined by assigning HSA to the region where the greatest proportion of major cardiovascular procedures and neurosurgeries were performed.

****** Hospital service areas (**HSA**) are collections of ZIP codes whose residents receive most of their institutional care from the hospitals in that area. The HSA were defined by assigning ZIP codes to the hospital area where the greatest proportion of their Medicare residents were hospitalized.

1. Centers for Medicare & Medicaid Services (CMS) (2022, May 2). National Health Expenditures 2022 Highlights. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data
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Learn more about the Alliance at: www.wahealthalliance.org.

WASHINGTON HEALTH ALLIANCE

LEUKEMIA & LYMPHOMA SOCIETY®

April 10, 2024

TO: Washington Health Care Transparency Board
FROM: Adam Zarrin, Director, State Government Affairs

RE: Medical Debt and the Cost of Healthcare

Thank you, Chair and members of the board.

My name is Adam Zarrin. I am the Director of State Government Affairs for the Leukemia & Lymphoma Society, also known as LLS.

Our mission is to cure blood cancer and improve the quality of life for patients and their families.

Patients feel trapped by medical debt. According to a recent LLS national survey, nearly 7 in 10 U.S. adults say they receive medical bills they cannot afford.

Many are forced to delay paying the bill, put it on a credit card, or challenge the bill. 74% of those with past or present medical debt have experienced negative impacts as a result.

More than 4 in 10 delayed medical care because they did not want to go further into debt. And 32% of Americans say they became more depressed and anxious due to their medical debt.

Why is this happening?

In short, a few large health systems are increasingly purchasing local healthcare systems, hospitals, and doctors' offices.

Those big health systems are gaining more control of their markets—leaving insurers and employers with less leverage to negotiate lower costs.

These increased costs are passed on to consumers through higher premiums, out-of-pocket costs, and even lower wages.

These are well-researched and documented facts about our healthcare system.

The research also shows that consolidation—particularly hospital mergers—is especially harmful to Black, Hispanic, Indigenous, low-income, and LGBTQ+ people, as well as other people of color and women.

Mergers among healthcare providers often lead to fewer services offered, leaving people in marginalized and disenfranchised communities with fewer options for where to receive certain types of care.

LEUKEMIA & LYMPHOMA SOCIETY®

So, what can policymakers do? LLS's report entitled Healthcare Consolidation is Raising Prices and Jeopardizing Cancer Care: Policymaker Recommendations outlines possible pathways.

They strengthen anti-trust enforcement, reform pricing and reimbursement rules, prohibit anticompetitive contracting terms, and improve transparency standards.

We appreciate this opportunity to share this information with the committee and look forward to future conversations with this committee to address healthcare affordability. I've also shared these two resources along with my testimony.

Thank you.

Fact Sheet

Trapped: America's Crippling Medical Debt Crisis

Over 100 million people living in America, one in three, struggle with the weight of medical debt. The American Cancer Society Cancer Action Network (ACS CAN), The Leukemia & Lymphoma Society, and RIP Medical Debt sponsored a national survey to explore these issues and shed light on patients' experiences and attitudes towards medical debt – and potential policy solutions. The poll was conducted by PerryUndem, a non-partisan research firm.

Key Findings:

Medical debt has become a shared experience for patients across the country. Patients feel trapped in debt and see no way out.

- Nearly 7 in 10 U.S. adults say they receive medical bills they cannot afford. Many are forced to delay paying the bill, put it on a credit card, or challenge the bill.
- 74% of those with past or present medical debt have experienced negative impacts as a result.
    - More than 4 in 10 (42%) delayed medical care because they did not want to go further into debt.
    - 1 in 5 (21%) avoided going back to the same provider where they owed money because they feared they would not treat them.
    - One in three (32%) say they became more depressed and anxious due to their medical debt and nearly half say they feel trapped by their medical debt. 45% felt they would never be able to pay it off.

There are ways to challenge a medical bill but most people don't know about it.

- 7 in 10 U.S. adults have never challenged or appealed a medical bill and nearly half didn't know providers offer financial assistance. People of color are more likely to say both of these things, and younger patients are also more likely to not know about provider financial assistance.
- Only 1 in 4 patients report being offered financial assistance from a provider to reduce their medical bills.

High health care costs have a particularly crippling impact on people with cancer and other chronic conditions.

- Over 6 in 10 U.S. adults say they would be unable to afford the cost of cancer treatment if they were diagnosed tomorrow.
- Over 9 in 10 feel cancer care is too costly - even if a patient has comprehensive health insurance.

U.S. adults will hold the government accountable if they don't bring down high health care costs.

- 84% of U.S adults agree that it is "the responsibility of the government to ensure health care is affordable for all people in the U.S."
- 91% agree that "elected officials should pass policies that protect people with serious illnesses like cancer from medical debt and harassment from collection agencies."
- Nearly 9 in 10 blame the health care industry for fueling the medical debt crisis - not patients themselves. They say the problem stems from the system putting profit over patients.

There is strong bipartisan support for action to protect consumers from medical debt and high health care costs, and 64% of U.S. adults said they would likely blame policymakers if they fail to act.

- All 12 policy ideas to prevent or lessen the impact of medical debt tested in the poll received between 75-95% bipartisan support.
- Seven in 10 say they would view lawmakers more positively if they passed these patient protection policies.
- 80% say they want their state and federal elected officials to also pass policies to reduce health care costs.

About the Poll:

This was a national survey of 2,663 adults in the U.S. conducted August 10-30, 2023. It was offered online via YouGov. The survey included large numbers of individuals with current or past medical debt, and with a chronic illness; as well as representative sampling of several racial / ethnic groups.

Impacts of Medical Debt

Findings from a National Survey

PREPARED FOR THE AMERICAN CANCER SOCIETY CANCER ACTION NETWORK (ACS CAN),
THE LEUKEMIA & LYMPHOMA SOCIETY (LLS), AND R.I.P MEDICAL DEBT

October 2023

PERRY
UNDEM

Introduction.

Over a hundred million Americans, one in three, struggles with the weight of medical debt. Nearly half of U.S. adults delay or skip medical care due to high costs. Those with chronic health conditions like cancer are even more vulnerable to medical debt and the hardships of expensive medical care, treatments, and medications.

ACS CAN, LLS, and R.I.P. Medical Debt sponsored this national survey to explore these issues. They hear daily from patients and families about the impacts of medical debt on their emotional, physical, and financial health.

This study is meant to create a national picture of experiences and attitudes on medical debt. The poll was conducted by PerryUndem, a non-partisan research firm.

Methods.

This was a national survey of 2,663 adults in the U.S. conducted August 10-30, 2023. It was offered online with YouGov's panel.

The survey included:

- 1,179 adults who have current or past medical debt
- 1,828 adults with a chronic illness
- 174 adults with cancer
- 420 Asian / Pacific Islander adults
- 421 Black adults
- 475 Hispanic / Latino adults
- 133 Native American adults

8 Key Findings.

1.

Most Americans struggle with high health care costs and medical bills they cannot pay.

- **Most believe medical debt is a big problem in the country.** 89% believe “lots of people have medical debt currently.” Six in 10 (61%) say they are concerned about going into medical debt when they use the health system.

- **It has become a common experience to receive medical bills you cannot afford.** In fact, 69% say this happens to them. Many delay paying the bill, put it on a credit card, or talk to the provider to try to reduce the bill.

- **The problem is high health care costs.** 67% say they are personally concerned about affording health care currently.

- **They are making sacrifices to afford health care.** 63% say they are delaying dental care, skipping doctor appointments, changing the foods they eat, delaying paying medical bills, or making other sacrifices.

2.

They look to the government to bring down high health care costs.

- **Survey respondents identify drug companies, health insurance companies, and the federal government when asked who is most responsible for high health care costs.**
- **But they look mainly to the state and federal government to bring costs down.** 84% agree that it is "the responsibility of the government to ensure health care is affordable for all people in the U.S."
- **Medical debt is the only kind of debt we tested where blame is placed on institutions rather than on individuals.** 86% agree that "usually, people with medical debt are not to blame for it. The problem is really the health industry prioritizes profits."

3.

Most are not fighting the medical bills they receive – in some cases, it is because they did not know they could or doubted they would be successful. Also, nearly half are unaware many providers offer financial assistance programs to help with debt.

- **30% say they have fought or appealed a medical bill in the past.** This leaves 70% who have not. Respondents of color are least likely to report they have fought a medical bill. Of note, 70% of those who fought a bill say they were successful in having the bill lowered or even dismissed.

- **Some say they didn't know they could fight medical bills**. Those with current medical debt, young adults, AAPI adults, and Hispanic / Latino adults are most likely to say they did not know they could fight medical bills. Others just assumed they would not be successful or didn't know the steps to take.

- **Nearly half (46%) didn't know many providers offer financial assistance programs to help with medical bills.** Respondents of color and younger respondents are most likely to say they did not know about provider financial assistance programs. Only a quarter say they have actually asked for or been offered financial assistance from a provider to reduce their medical bills.

4.

Nearly half of adults have current or past medical debt and they say it has negatively impacted them. Many feel “trapped” and are experiencing depression because of their debt.

- **46% of survey respondents say they have current or past medical debt.** Adults ages 50-64, rural adults, Native American adults, and those with cancer or a chronic illness are most likely to say they have current or past medical debt.

- **74% of those with past or present medical debt have experienced negative impacts as a result.** More than 4 in 10 (42%) delayed medical care because they did not want to go further into debt and 1 in 5 (21%) avoided going back to the same provider where they owed money because they feared they would not treat them.

- **Medical debt has negative effects on mental and emotional health.** One-third (32%) say they became more depressed and anxious due to their debt. Uninsured, younger, AAPI, and Hispanic / Latino adults are most likely to say they became more depressed as a result of their medical debt.

- **48% say they feel trapped by their medical debt.** Nearly as many (45%) felt they would never be able to pay it off.

5.

Many have experience with payment plans / installments to pay off their medical debt. Some feel these plans made their debt manageable, but others say they locked them into payments they could not afford.

- **6 in 10 of those with current or past medical debt had a payment plan / installments to pay their debt.** Survey respondents have mixed feelings about payment plans – 47% say they were thankful, but 26% said they found them frustrating because they locked them into payments they couldn't afford and took a long time to pay off.

- **Half (48%) say they felt pressured to enroll in a payment plan.** Young adults and parents with children under age 18 were most likely to say they felt pressured.

6.

Most agree cancer treatments are too expensive and believe they would likely go into debt if they had to pay these costs. They want elected officials to do more to protect those with serious illnesses like cancer.

- **Nine in 10 (90%) say they are concerned that people with chronic conditions like cancer struggle more with medical debt.**

- **Most don't think they could afford cancer care for themselves.** When they hear that insured cancer patients pay $4,000-$13,000 on average out-of-pocket in the year they are diagnosed, 65% say they could probably NOT afford the out-of-pocket costs of treating cancer without going into debt. This is relevant since 34% think it is at least somewhat likely that they will be diagnosed with cancer in the next 5 years.

- **Almost all feel cancer care is too costly.** 92% agree that "cancer treatments and medications are so expensive that even with good health insurance, many cancer patients still have large copays, coinsurance, and costs they have to pay out of pocket that put them into debt."

- **They want elected officials to step in.** 91% agree that "elected officials should pass policies that protect people with serious illnesses like cancer from medical debt and harassment from collection agencies."

7.

Depending on who you are, medical debt experiences differ.

- **The survey reveals certain populations are more impacted by medical debt and less aware of their options.** These populations include uninsured individuals, parents of children under age 18, younger adults ages 18-34, pre-retirement adults ages 50-64, rural adults, and communities of color (particularly Native American individuals).

- **Women also seem to be more affected by medical debt than men**. Gender differences are consistent throughout the survey results with women generally feeling impacts of high health care costs and medical debt more.

- **Those with chronic illness or cancer also seem to be more impacted.** People with cancer, for example, are more likely than most others to say they have current or past medical debt.

- **Many have a sense that underlying inequalities are beneath some of these different experiences.** For example, 48% agree that structural barriers and systemic racism make it more difficult for households of color to manage medical bills and pay debts on time.

8.

There is strong bipartisan support for action to protect patients from medical debt and high health care costs.

- **We tested 12 policy ideas to protect people from medical debt and all received strong majority support.** Top policies include giving patients more time to pay back bills, capping interest rates for medical debt, using professional navigators to help patients find resources to lower their debt, requiring hospitals to screen all patients for financial assistance programs, and requiring all providers / hospitals to offer financial assistance.

- **Seven in 10 (69%) say they would view lawmakers more positively if their states passed patient protection policies such as these.**

- **80% say they want their state and federal elected officials to also pass policies to reduce health care costs.** And 64% said they would likely blame them if they fail to act. There is bipartisan agreement behind both sentiments.

Detailed Findings.

Survey respondents are concerned about a lot of costs right now, including health care.

Q: Think about yourself, personally. Right now, how concerned are you, if at all, with the following?

% very or somewhat concerned

79%

The cost of food and basic household goods rising.

67%

Affording health are costs (including dental care).

57%

Affording transportation costs (like gas or bus fare).

45%

Paying rent or mortgage.

63%

are making hard choices due to health care costs.

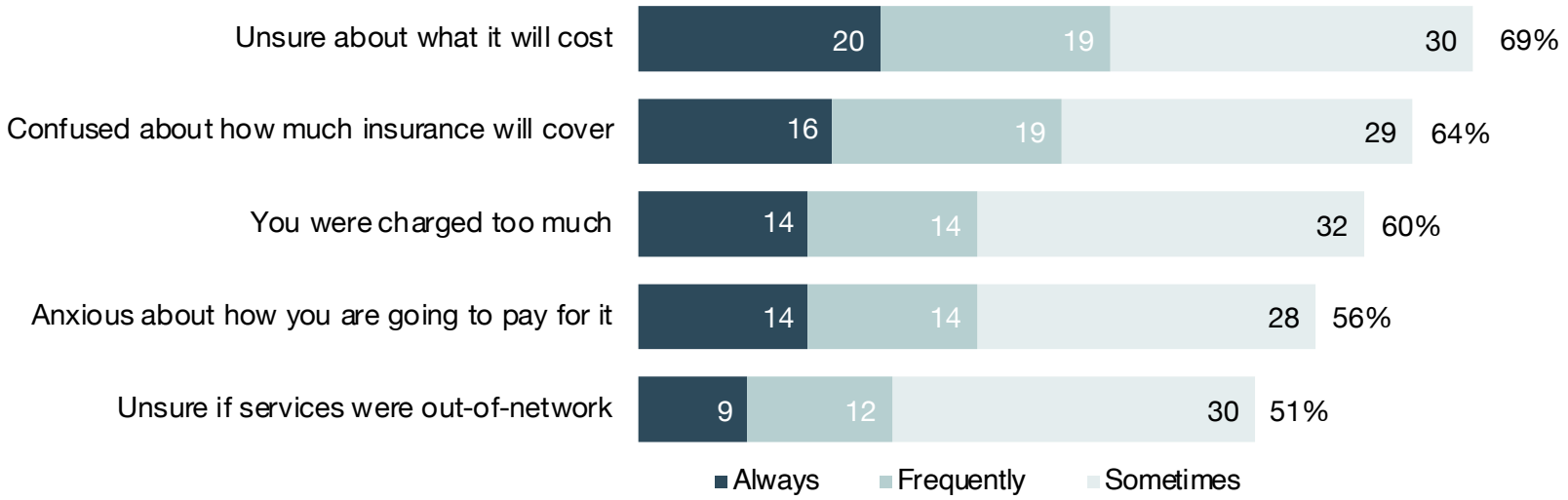
Six in 10 respondents report they have self-treated, delayed or skipped dental and medical care, changed the food they eat, delayed paying a medical bill, or made other difficult decisions to afford health care costs in the last two years.

Q: In the last 2 years, have you experienced or done any of the following due to health care costs?

	% yes
Self-treated with home remedies / over the counter medications	31
Delayed or skipped dental care	30
Delayed or skipped going to a doctor or clinic for physical health concerns	23
Changed the types of food you ate / bought	22
Delayed paying a medical bill	20
Delayed or skipped getting mental health care	16
Left a prescription(s) at the pharmacy because it / they were too expensive	16
Didn't put money into savings to afford health care	16
Didn't put money away for retirement to afford health care	15
Delayed or skipped going to a hospital emergency room	14
Experienced physical pain because you could not afford medical care	14
Ate less food or cut down on food costs to afford health care	12
Went deeper into medical debt	11
Cut pills in half or skipped doses of medicine	11
Borrowed money from family / friends to afford health care	8
Didn't pay other household bills so you could afford health care	7
Went into debt for the first time	5
At least one of the above	63

Many say they are unsure or confused about costs after they receive health care services.

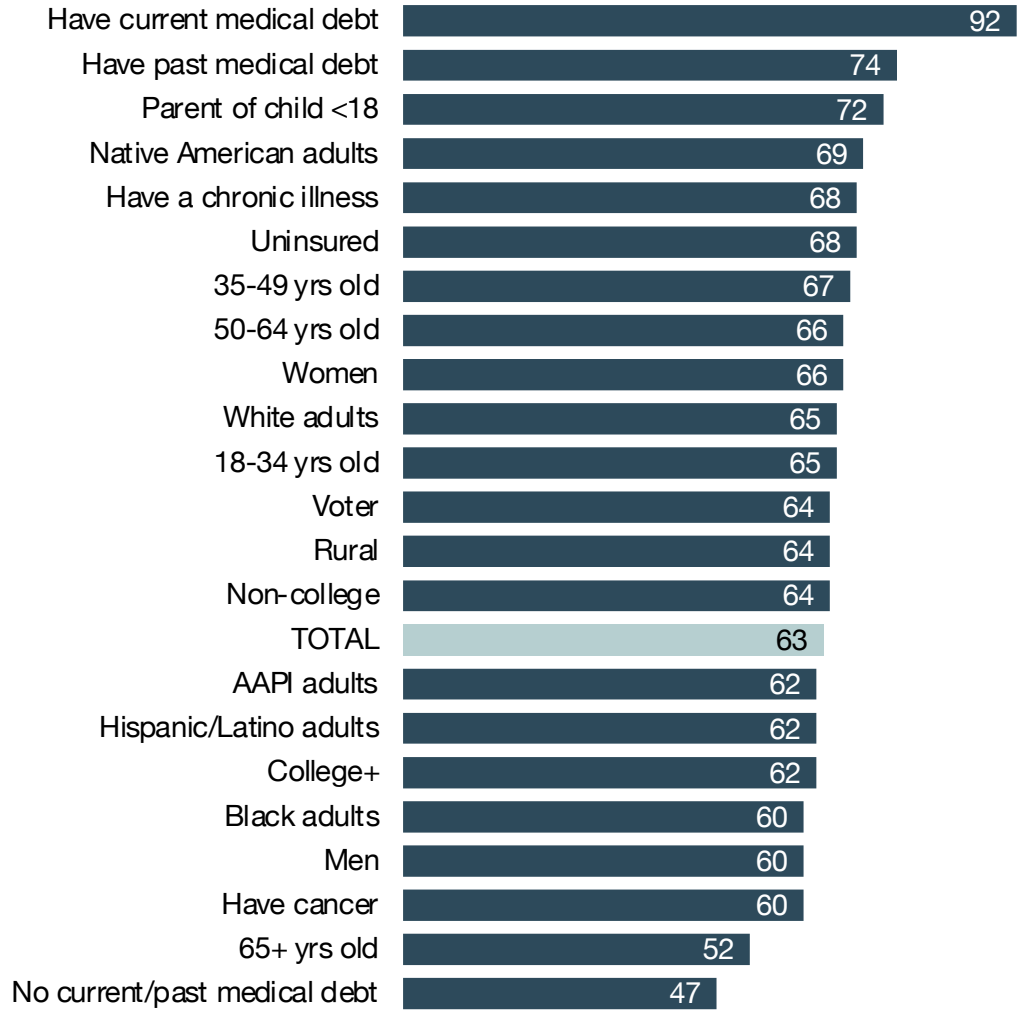
Q: Now, think again about how you feel after you get health care services. After you get health care services, how often do you feel…



Those with current or past medical debt, along with parents of children under 18, are most likely to say they delayed or skipped medical care or made other difficult decisions due to health care costs.

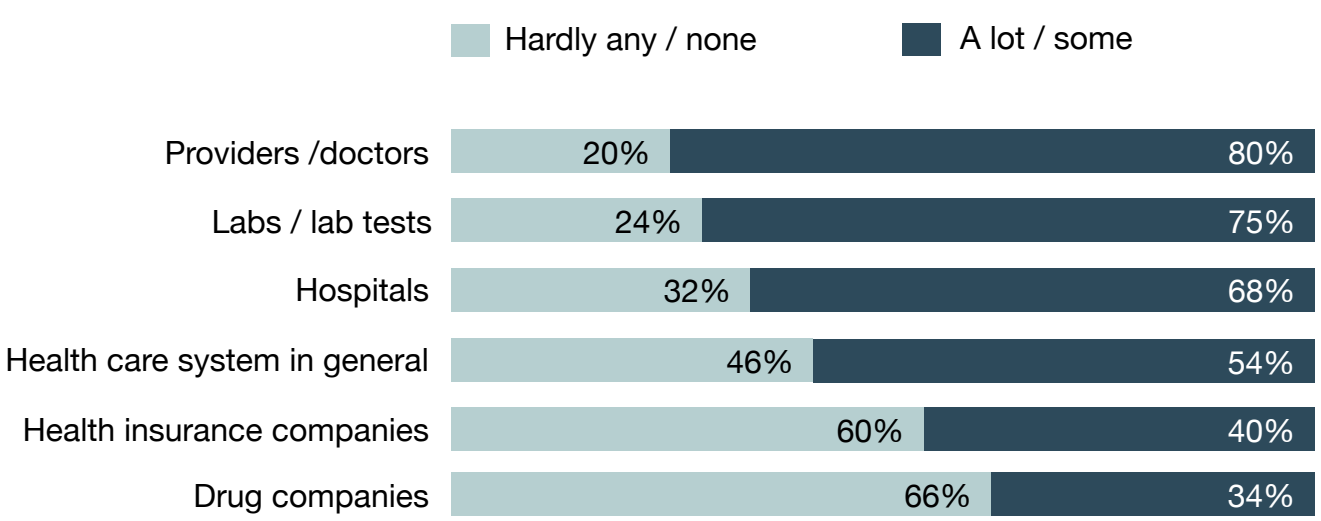
Q: In the last 2 years, have you experienced or done any of the following (delay care, etc.) due to health care costs?

% yes to any



Survey respondents have the most trust in providers / doctors to look after their best interests but have the least trust in health insurance companies and drug companies.

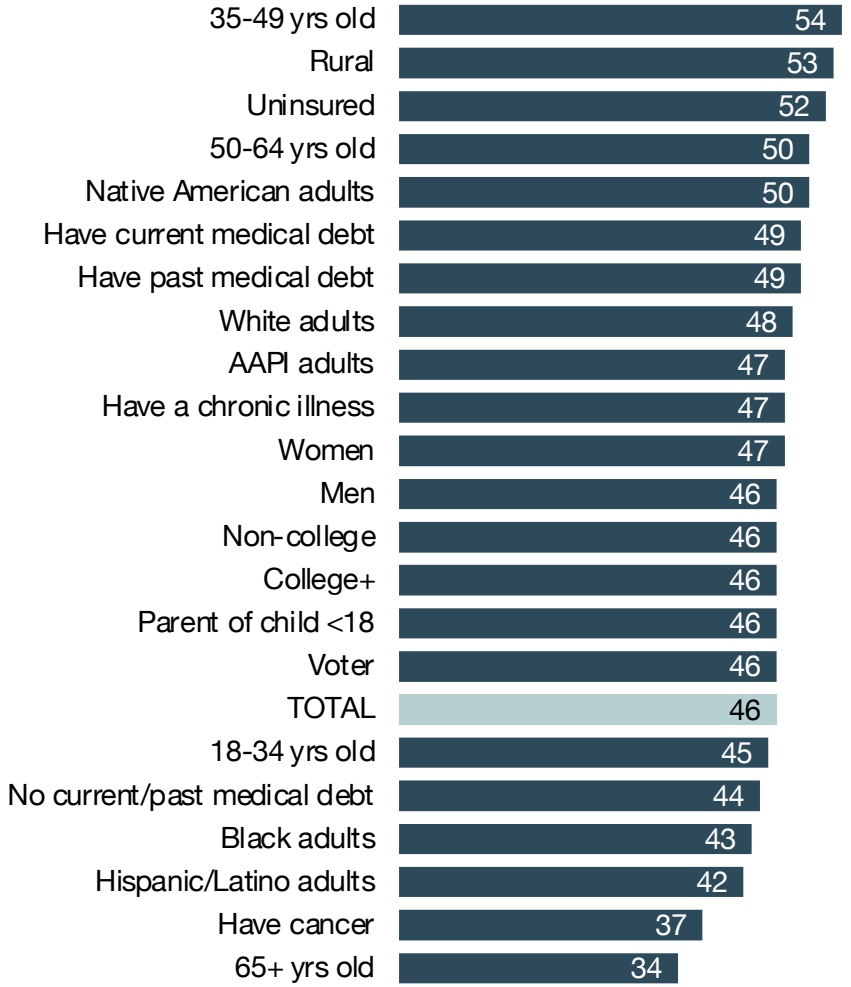
Q: How much trust do you have in _____ to look after your best interests?



Those with the least trust in the "health care system in general" include adults ages 35-49 as well as those pre-retirement age (50-64), uninsured individuals, rural residents, Native American adults, and those with current or past medical debt.

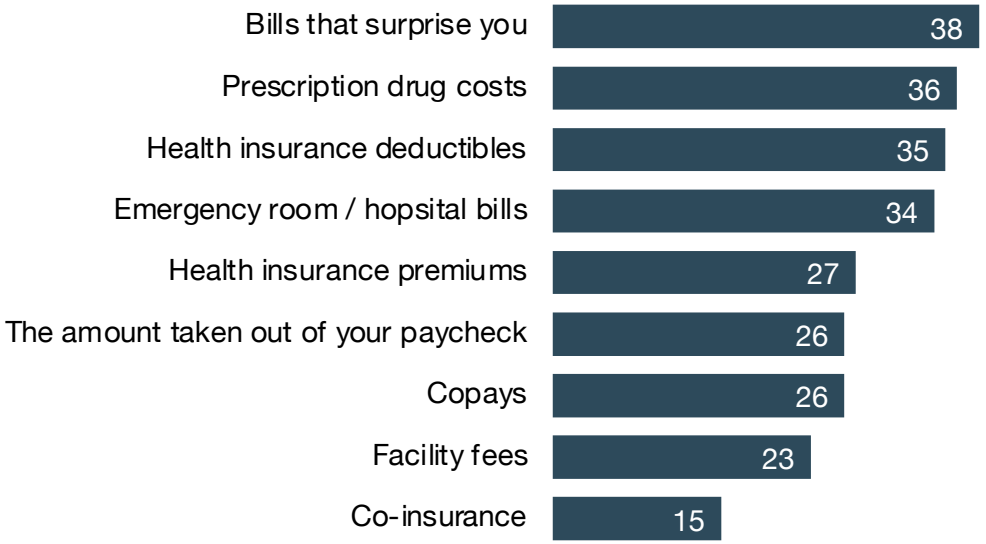
Q: How much trust do you have in the health care system in general to look after your best interests?

% hardly any / none



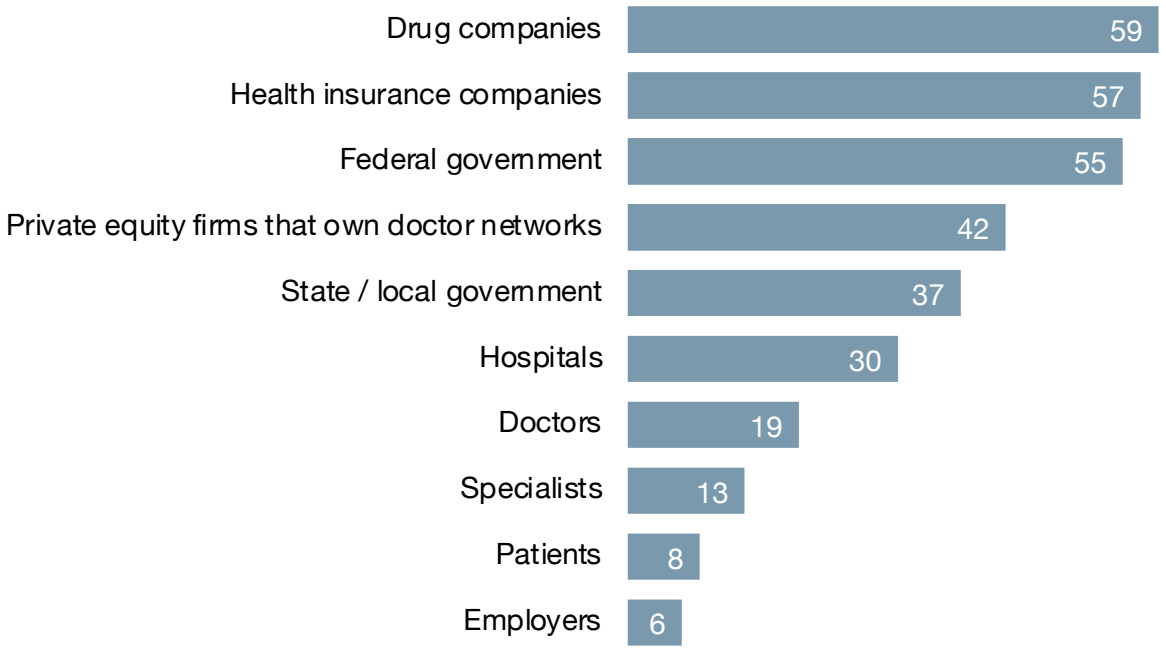
Survey respondents say surprise medical bills, prescription drug costs, insurance deductibles, and bills from ERs / hospitals frustrate them the most.

Q: Which health care costs frustrate you the most? Select up to FOUR.



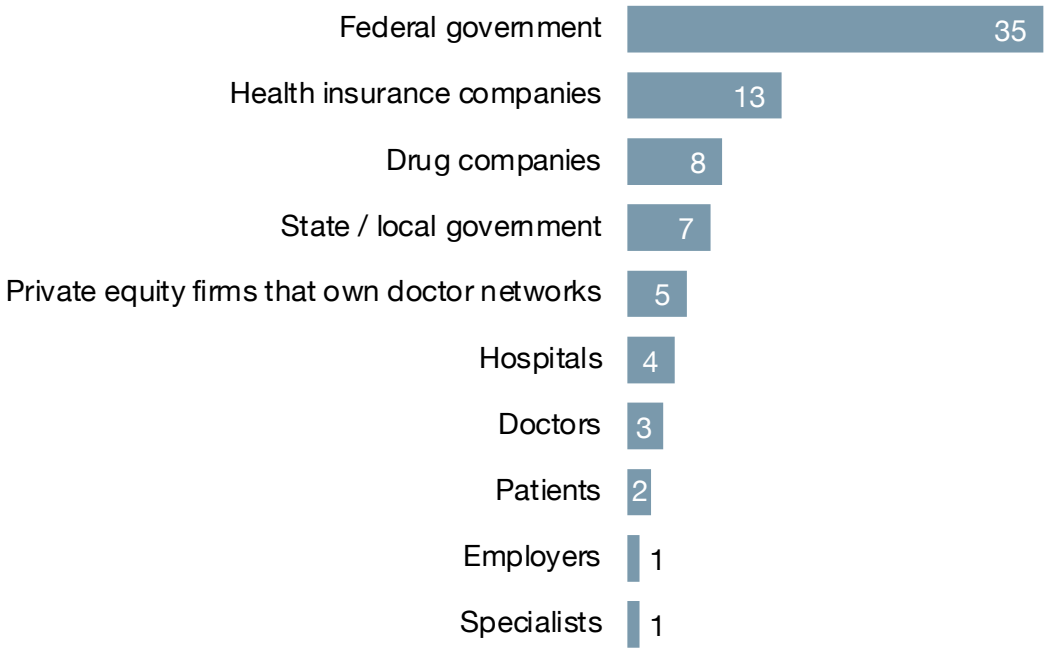
They mostly blame drug companies, health insurance companies, and the federal government for high health care costs.

Q: Who do you blame for high health care costs? Select any that apply.



But they look to the federal government to bring down high health care costs.

Q: Who do you think has the most responsibility to bring down high health care costs?
Select only ONE.



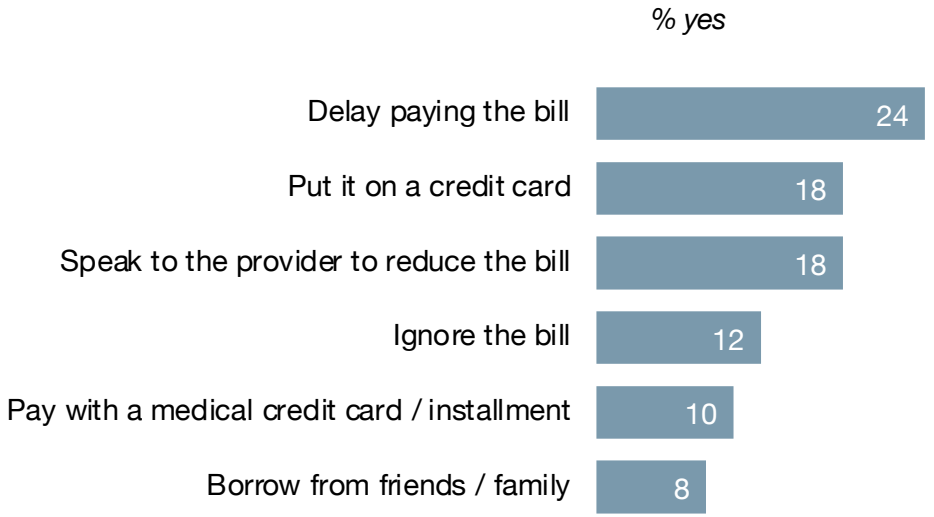
Health care bills.

69%

say they experience difficulty paying their medical bills at least sometimes.

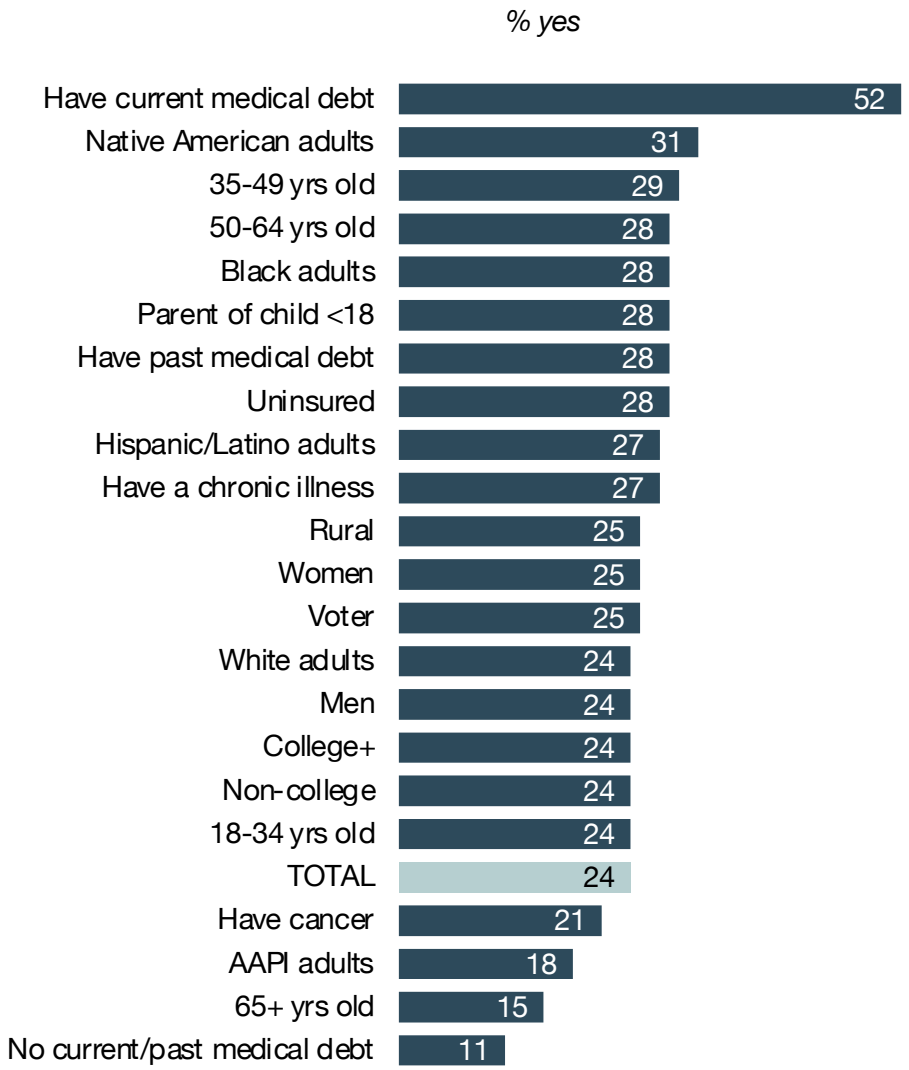
Only 31% say they have “always been able to pay all of my medical bills.” When they receive a health care bill they cannot afford, one-quarter delay paying the bill while nearly 1 in 5 put it on a credit card or talk to a provider to reduce the bill.

Q: When you receive a medical bill that you cannot pay, do you do any of the following?



Those with current medical debt are much more likely than others to delay paying a bill they cannot afford.

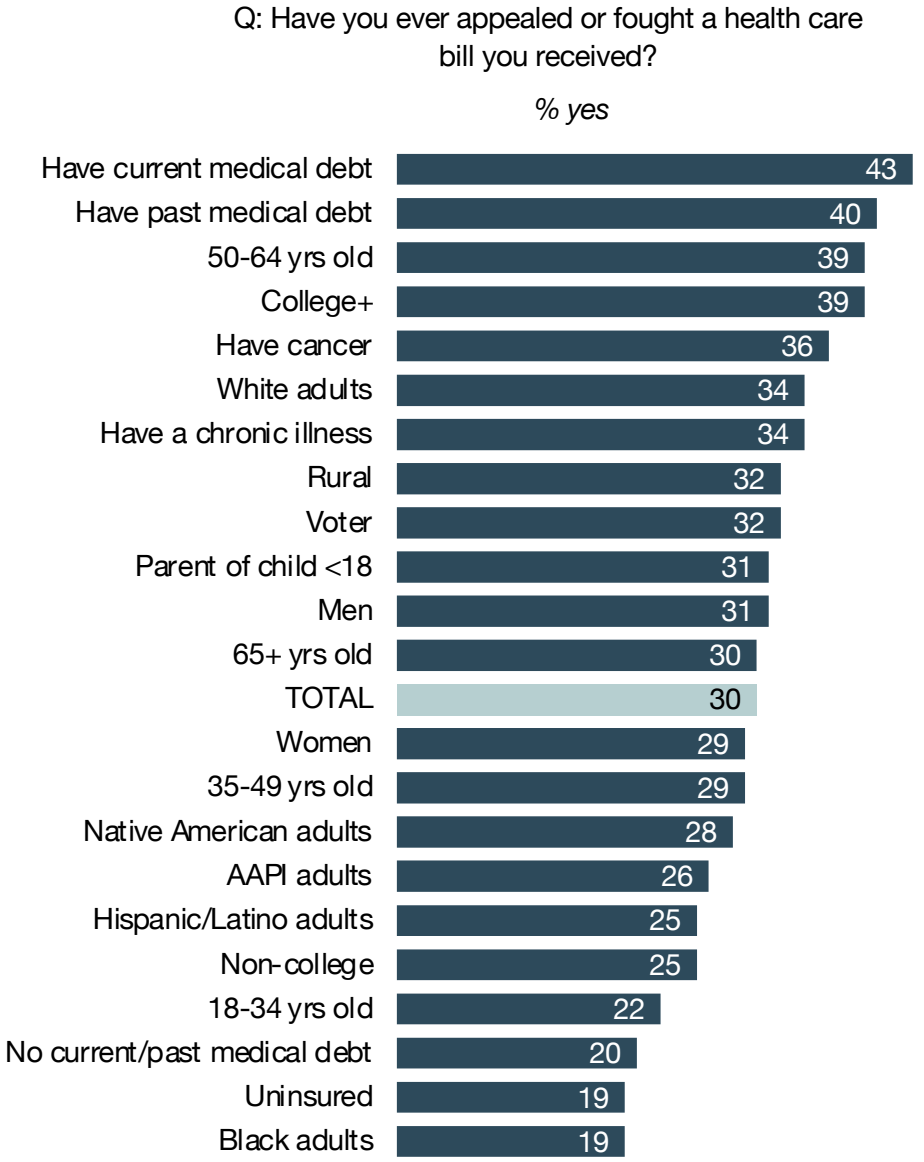
Q: When you receive a medical bill that you cannot pay, do you delay paying the bill?



Only 3 in 10

say they have fought or appealed a health care bill in the past.

But the overwhelming majority – 70% of survey respondents – have not fought a medical bill. Those with current or past medical debt are among those most likely to have fought a bill. Respondents of color and uninsured adults are least likely to report they have fought a medical bill.

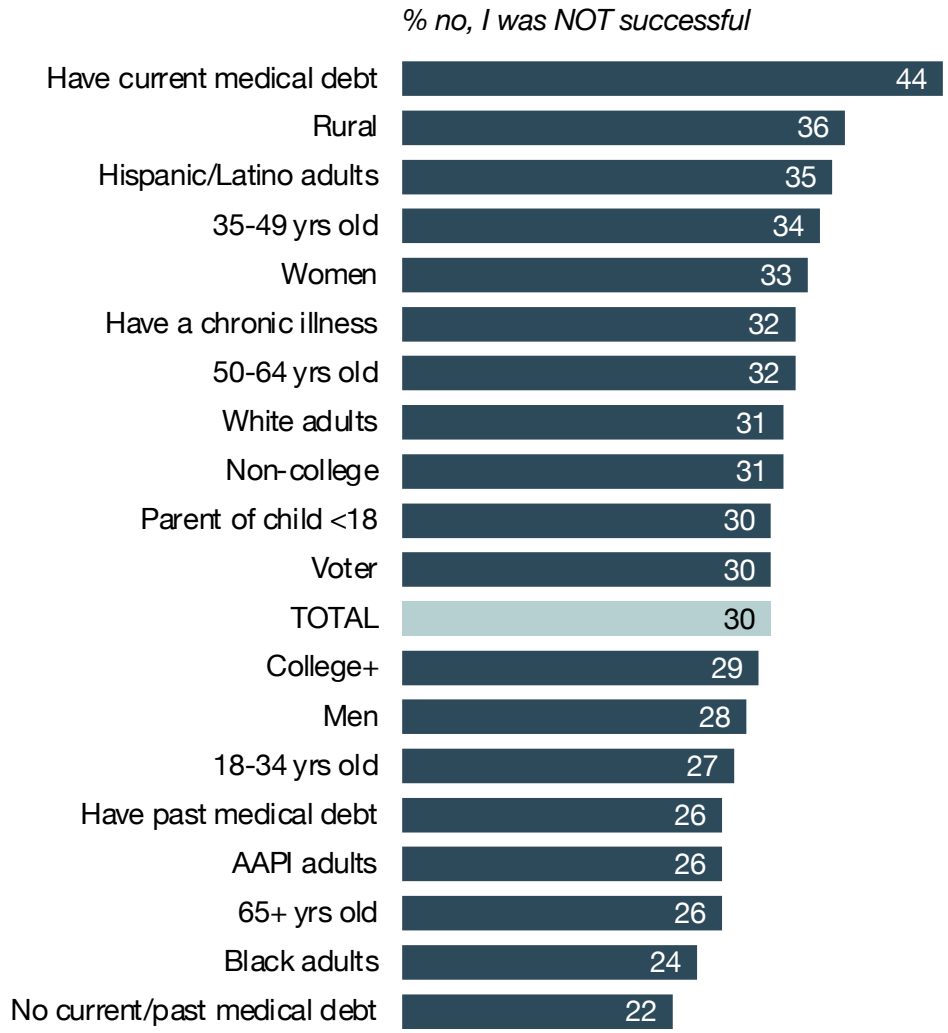


70%

who fought a bill say they were successful in lowering it or having the bill dismissed.

But 3 in 10 were not successful. Those with current medical debt stand out in saying they were NOT successful in having a bill lowered or dismissed. Of note, rural and Hispanic / Latino adults also report higher levels of failure in having medical bills lowered / dismissed.

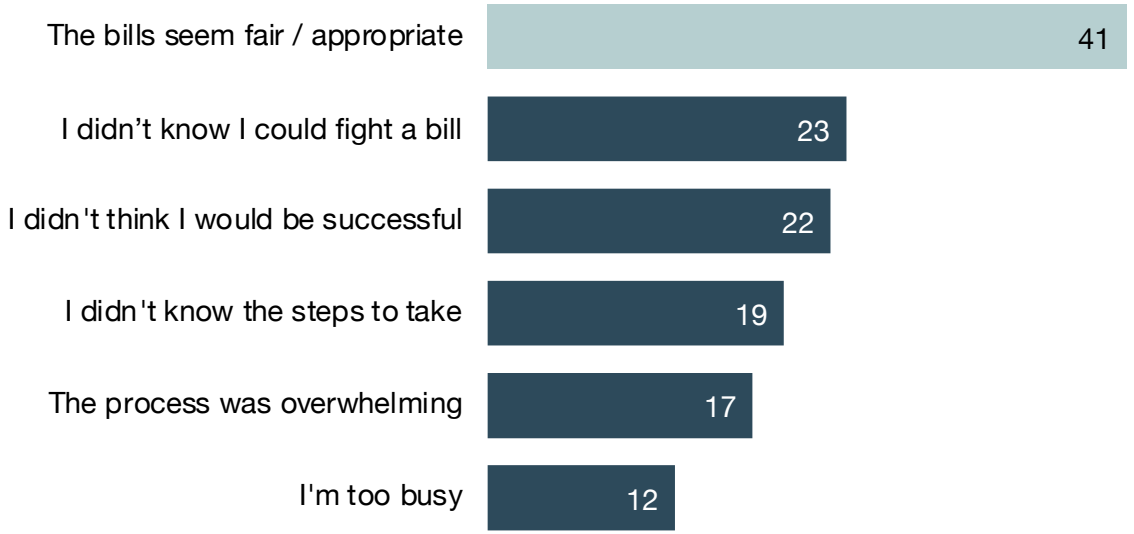
Q: IF FOUGHT A BILL: Were you successful in having the bill lowered or even dismissed? (N = 784)



** The n sizes were too small to include Native American adults, those with cancer, and uninsured respondents in this graph.*

A number of survey respondents say they didn’t know they could fight a bill or didn’t think they would be successful if they tried.

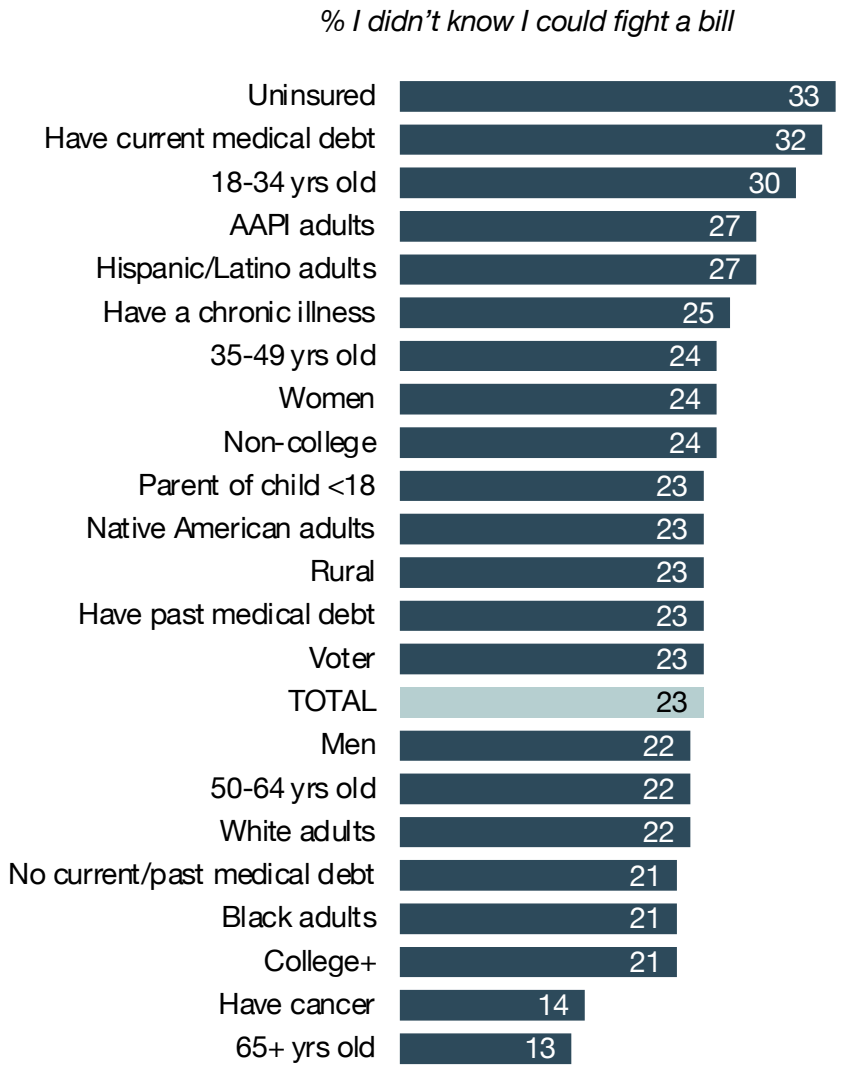
Q: IF DIDN’T FIGHT A BILL: What is the reason you have not appealed or fought a health care bill? Select any that apply. (N = 1,879)



Uninsured adults, those with current medical debt, and young adults are among those most likely to say they did not know they could fight a health care bill.

AAPI and Hispanic / Latino adults are also more likely than others to say they did not know they could fight medical bills.

Q: IF DIDN'T FIGHT A BILL: What is the reason you have not appealed or fought a health care bill? Select any that apply. (N = 1,879)



Medical debt.

Medical debt is the only kind of debt we tested where a majority of respondents blame institutions rather than the individual.

Q: As you know, there are lots of different types of debt. For each type of debt, who do you think is most to blame for having that debt?

	1 Individuals	2	3	4	5 Companies / Institutions
Medical debt	10	7	24	24	36
Student loan debt	32	10	20	14	23
Home mortgage debt	34	16	25	12	13
Car debt	43	17	20	9	11
Credit card debt	49	17	16	7	11

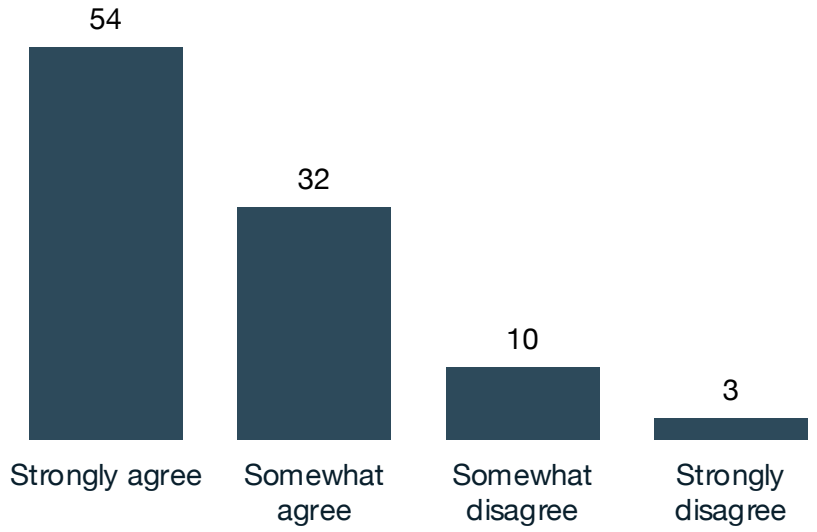
60%

86%

agree that patients are not really to blame for medical debt – it is the health industry prioritizing profits.

There is agreement across political ideology that the health industry rather than individuals are to blame for medical debt (Dem 90% agree; Ind 86% agree; Rep 81% agree).

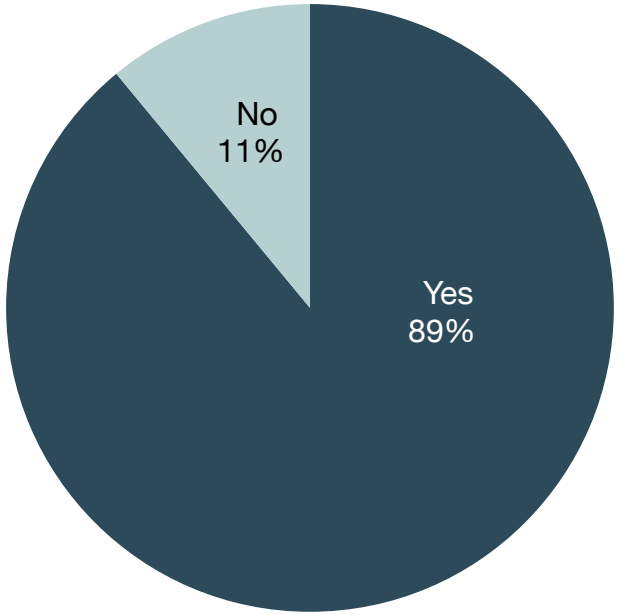
Q: Agree or disagree: Usually, people with medical debt are not to blame for it. The problem is really the health industry prioritizes profits.



9 in 10

believe lots of people have medical debt right now.

Q: Do you think lots of people in America have medical debt currently?

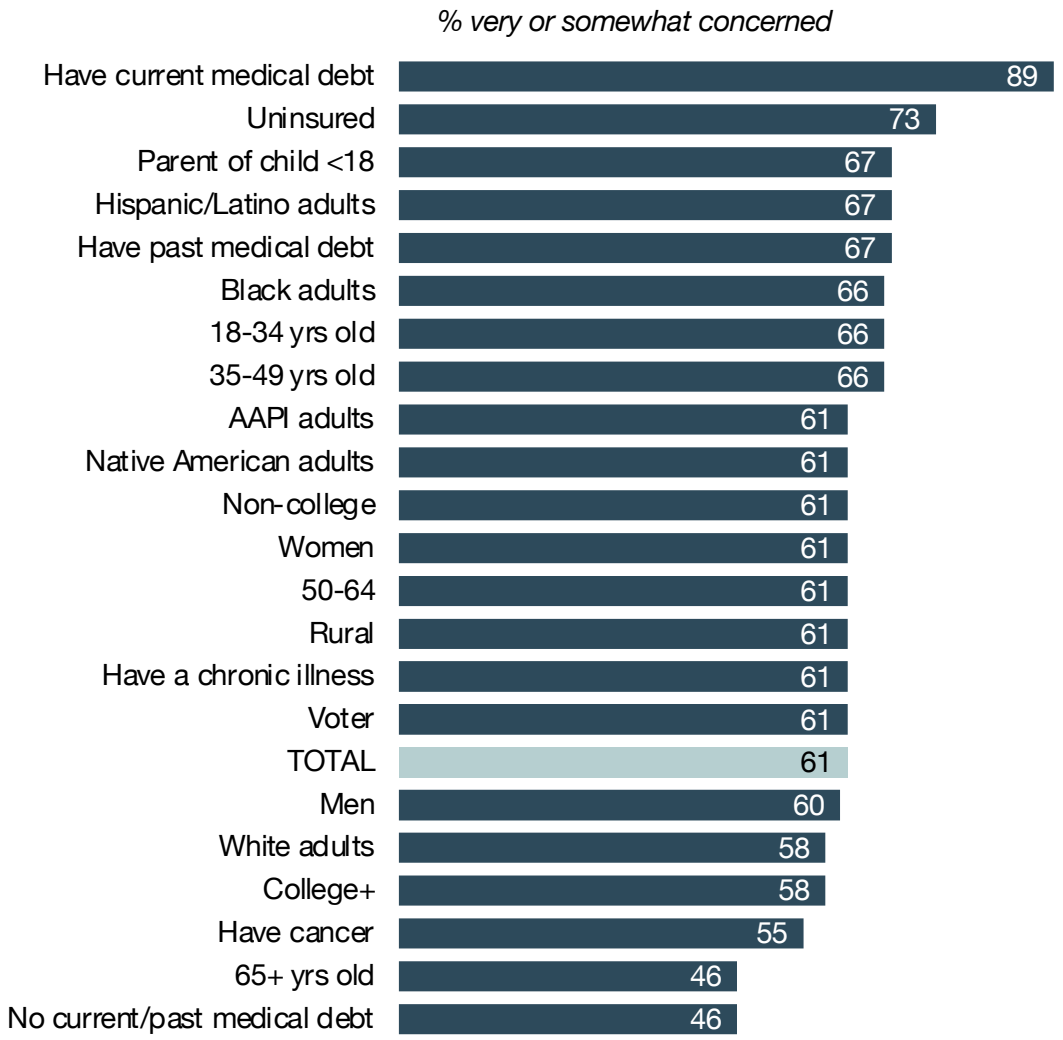


6 in 10

say they are concerned about going into medical debt when they use the health system.

Those with current medical debt and uninsured adults are most likely to be concerned about incurring debt when using health care services.

Q: How concerned are you, if at all, about going into medical debt when you use the health care system or get medical services?



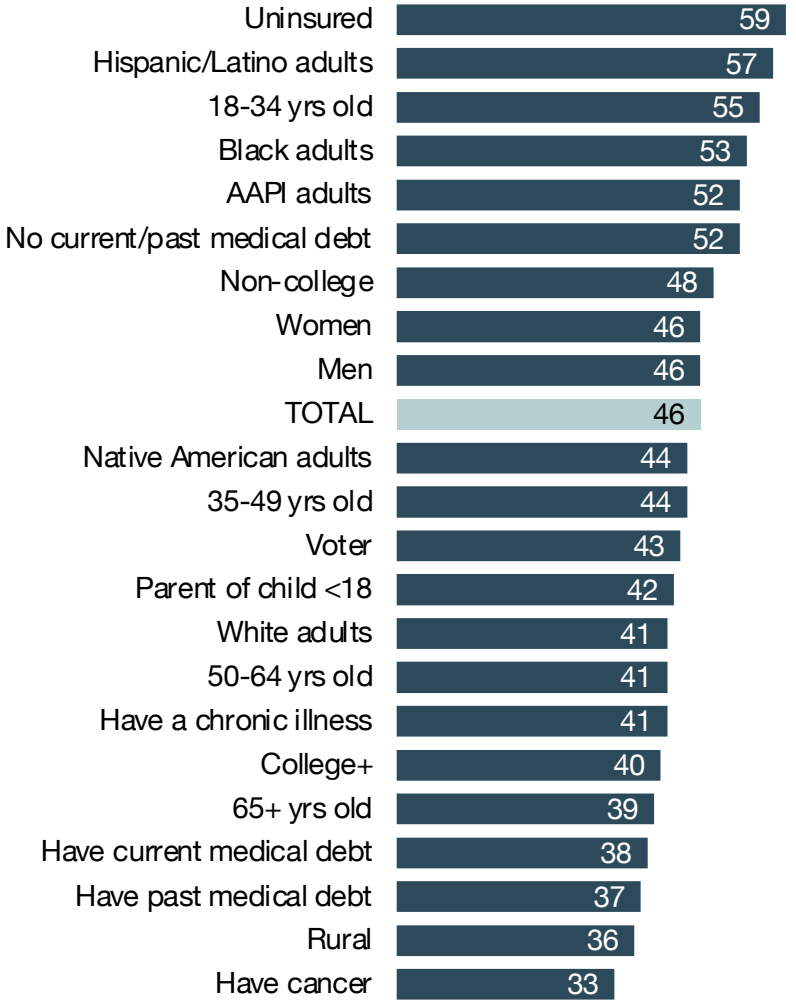
46%

are unaware of financial assistance programs that providers offer to help with debt.

Uninsured, adults of color, and younger respondents are most likely to say they did not know about provider financial assistance programs.

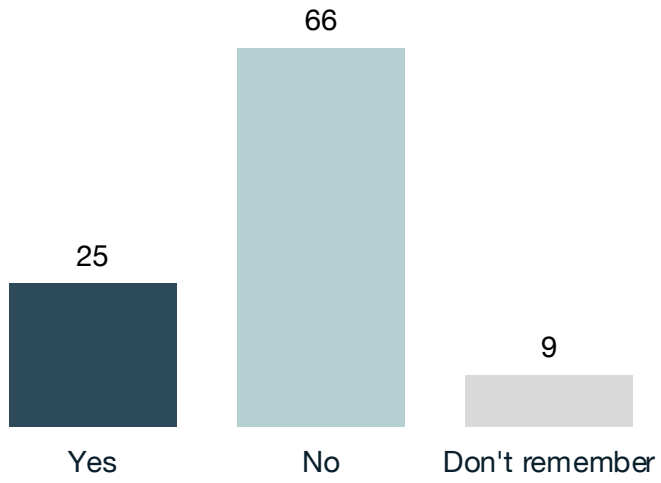
Q: Did you know that most hospitals and many other health providers have financial assistance programs that can assist those who qualify with paying their medical bills?

% didn't know or unsure

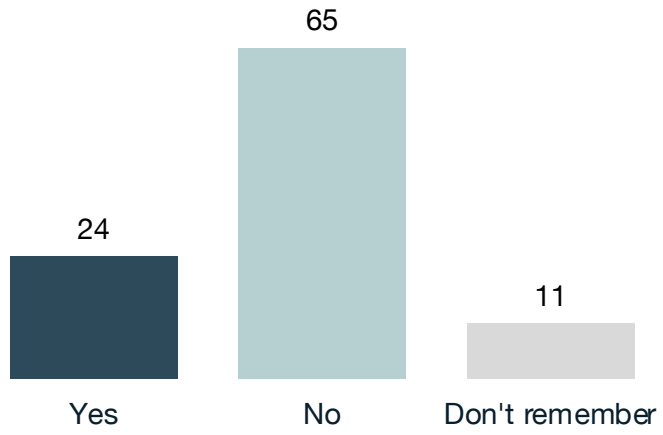


Only a quarter of survey respondents have either asked for financial assistance or been offered financial assistance by a provider.

Q: Have you ever asked for financial assistance from a hospital, doctor, or other health care provider to get a discount on your medical bills?

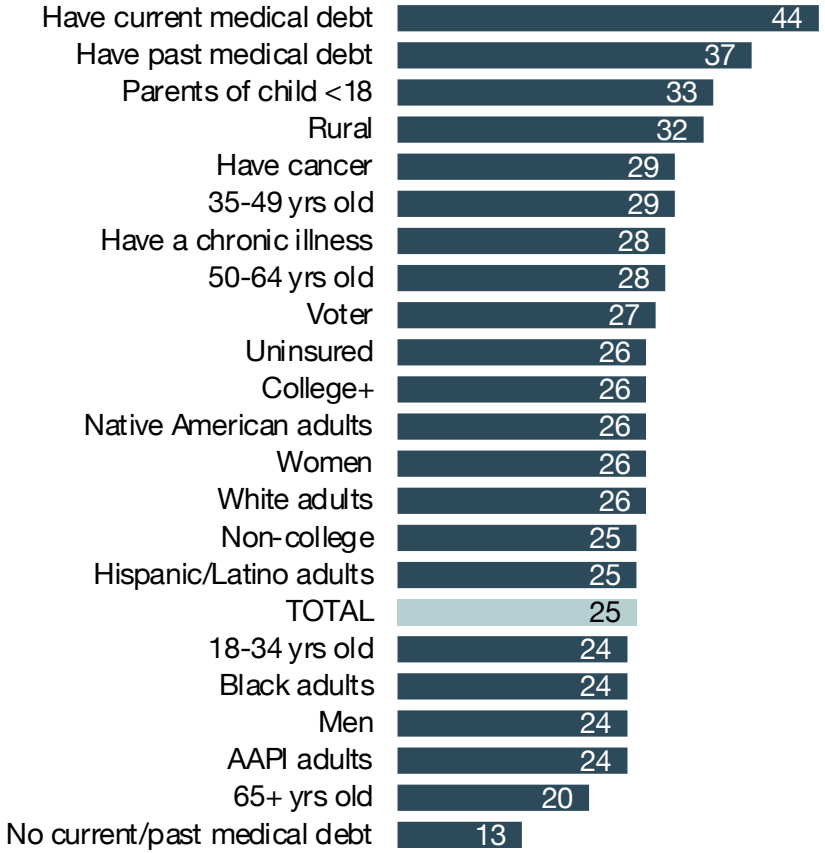


Q: Have you ever been offered financial assistance from a hospital, doctor, or other health care provider to get a discount on your medical bills?

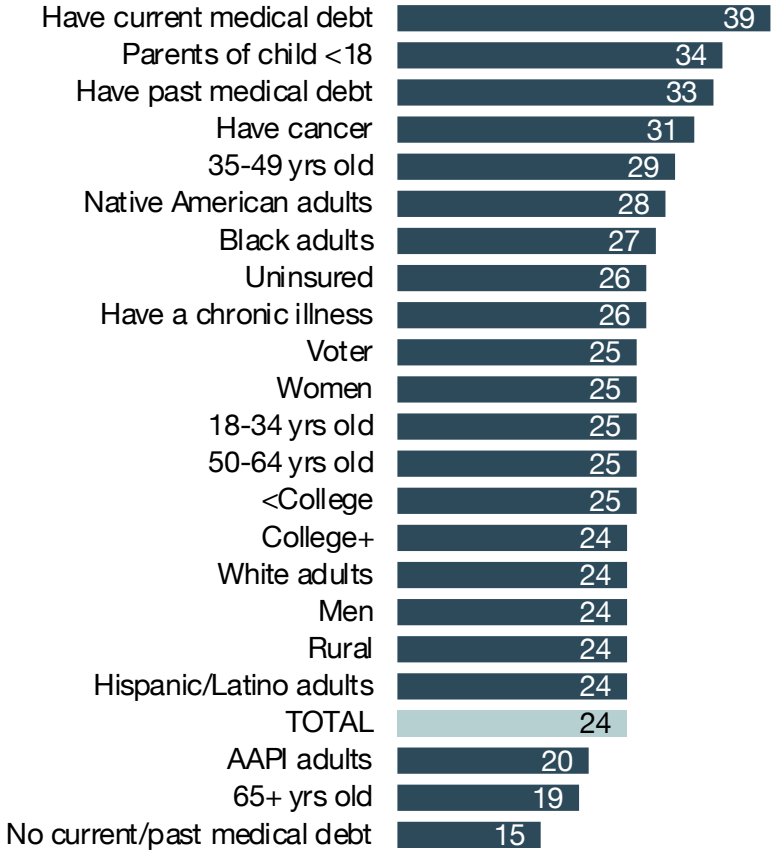


Those with current or past medical debt are most likely to have asked for and been offered financial assistance.

% have asked for financial assistance from a provider



% been offered financial assistance from a provider



Survey respondents see big consequences if health care costs and medical debt continue to rise.

Q: Do you think if health care costs continue to rise, and medical debt continues to increase, any of the following could happen?

	Yes %
People will get sicker because they put off health care	79
More people will be unable to save for retirement	78
Depression and anxiety will become even more widespread as people fall into medical debt	75
More people will die because they are not catching diseases like cancer earlier because they are avoiding health care	72
More people will be unable to buy homes, cars, or improve their financial situation because they will have poor credit due to medical debt	71
Everyone's health care costs will go even higher because so many people will only get health care when they are really sick, using the most expensive kinds of services and medications	70
Health insurance companies, drug companies, hospitals, and other health providers will have record profits each year	68
The workforce will become less productive because people are not as healthy	61
The economy will decline because people are sicker and don't have money to spend	60

Personal experiences.

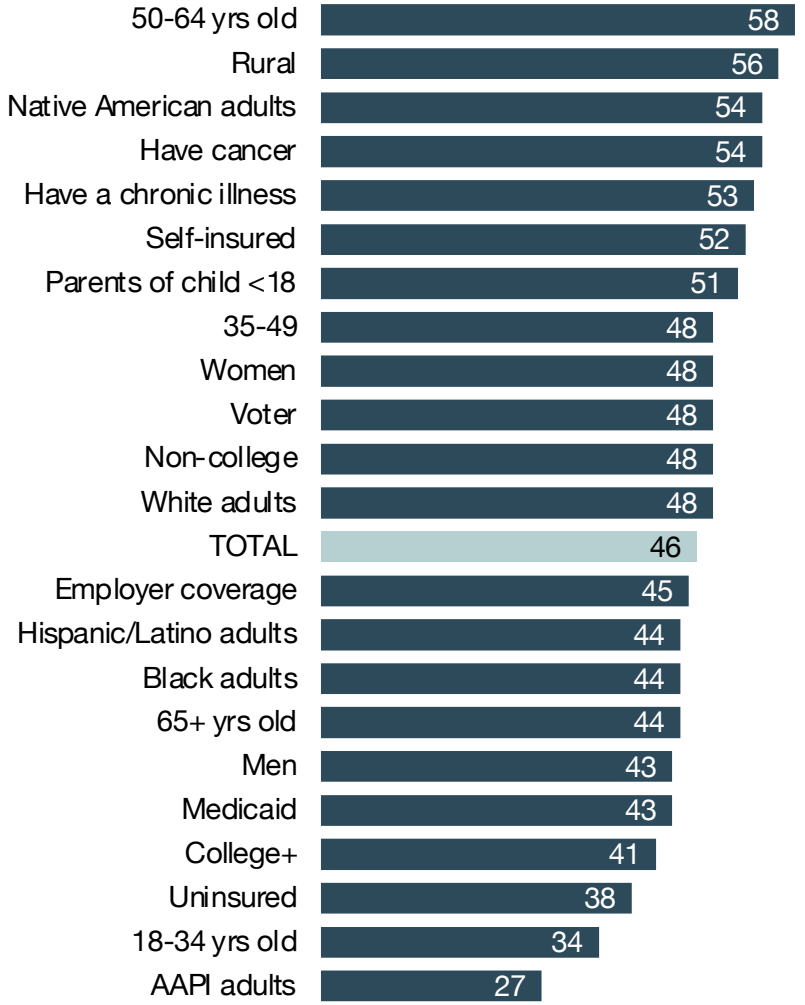
46%

of survey respondents say they have current or past medical debt.

Pre-retirement, pre-Medicare adults ages 50-64, rural adults, Native American adults, and those with cancer or a chronic illness are most likely to say they have current or past medical debt.

Q: Do you personally have medical debt? If not, have you had medical debt in the past?

% current or past medical debt



74%

of those with medical debt have experienced negative impacts as a result of that debt.

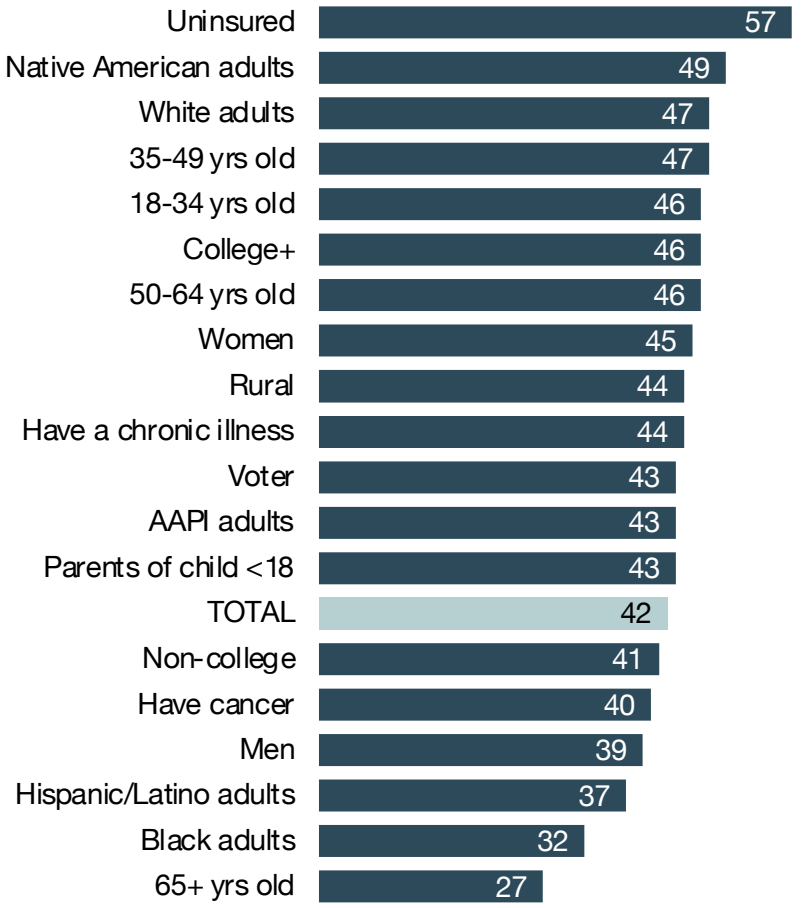
More than 4 in 10 delayed care and one-quarter say their mental health has been negatively impacted.

Q: Have any of the following happened to you because of your current or past medical debt? Select all that apply.
(N = 1,179)

	% yes
You delayed or skipped medical care because you did not want to go further into debt (either medical or other debt)	42
Your mental health was negatively impacted	26
Your health provider encouraged you to sign up for a payment plan, medical credit card, or pay installments	23
You avoided going back to the same provider / office / clinic / hospital where you owed money because you were afraid they would not treat you	21
You were required to sign up for a payment plan, medical credit card, or pay in installments before you could be treated	17
You were required to pay your debt in full before you could be treated	16
You became ill because you did not seek medical care due to your debt (either medical or other debt)	16
A provider / office / clinic / hospital where you owe(d) money refused to keep treating you	8
Your provider encouraged you to sign up for Medicaid / disability	8
A provider / office / clinic / hospital where you owe(d) money refused to start treating you	7
At least one of the above has happened	74

Uninsured, Native American, White adults, along with younger adults, are more likely to delay care due to their medical debt.

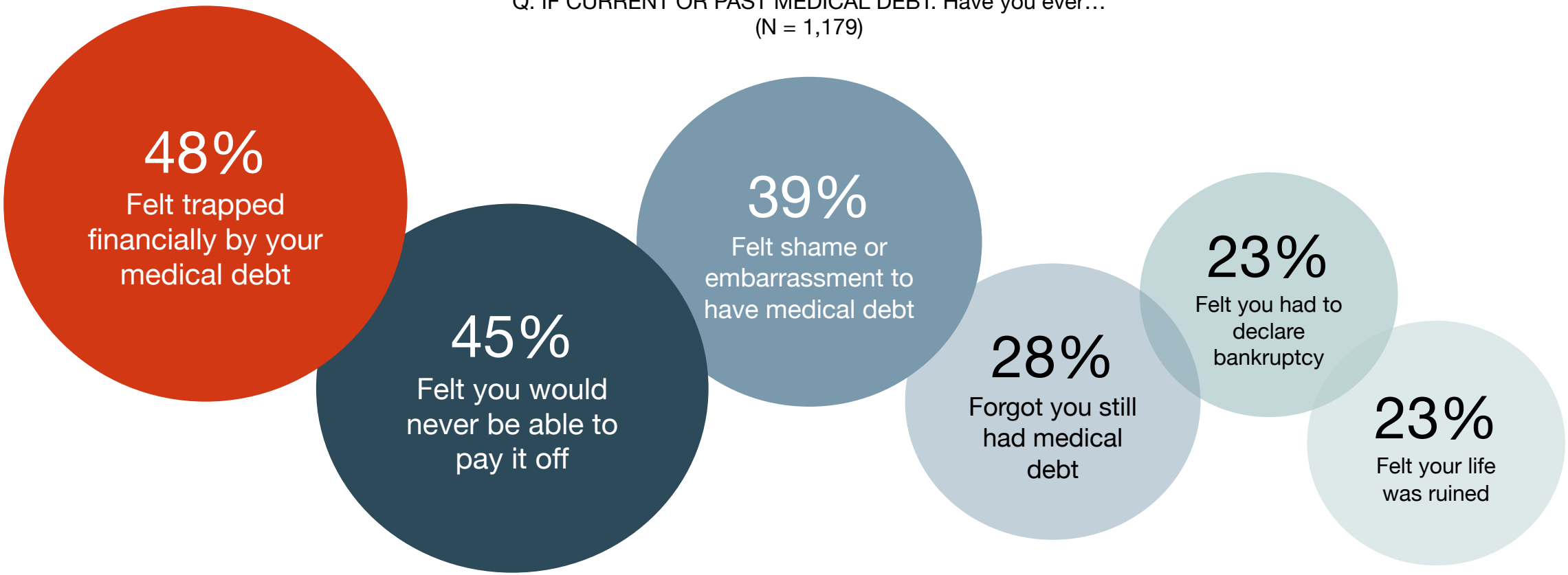
Q: Have any of the following happened to you because of your current or past medical debt? Select all that apply.
(N = 1,179)



Note: The Native American sample is small for this question (n=71)

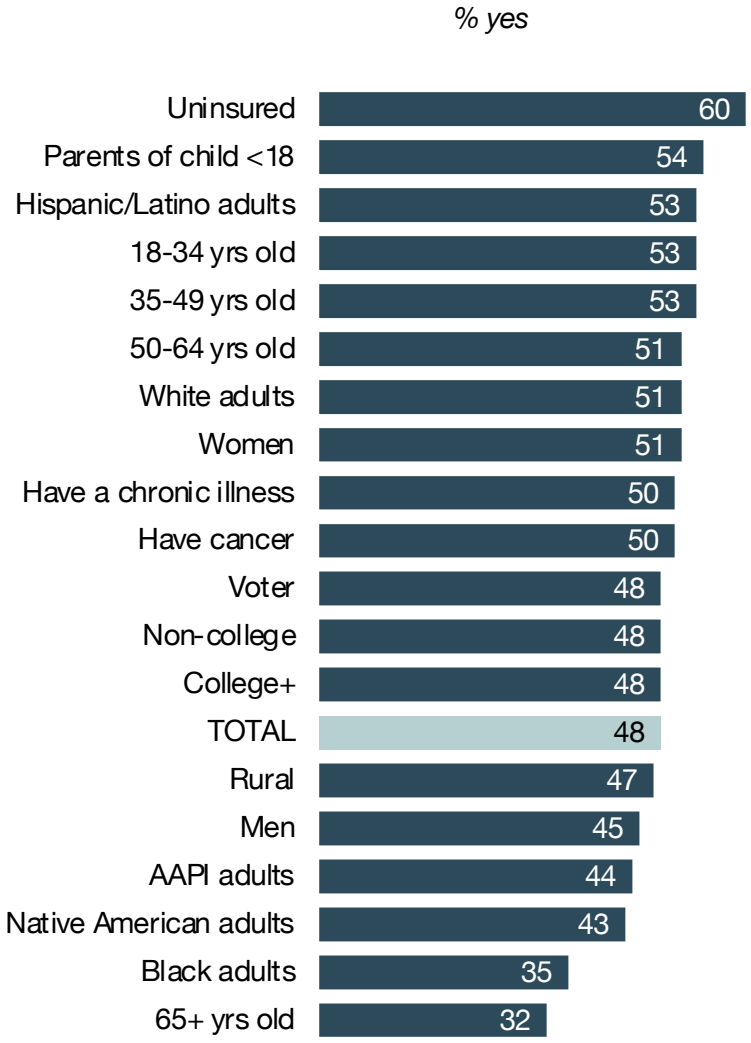
Nearly half say they feel “trapped” by their medical debt and almost as many said they thought they “would never be able to pay off” their debt.

Q: IF CURRENT OR PAST MEDICAL DEBT: Have you ever…
(N = 1,179)



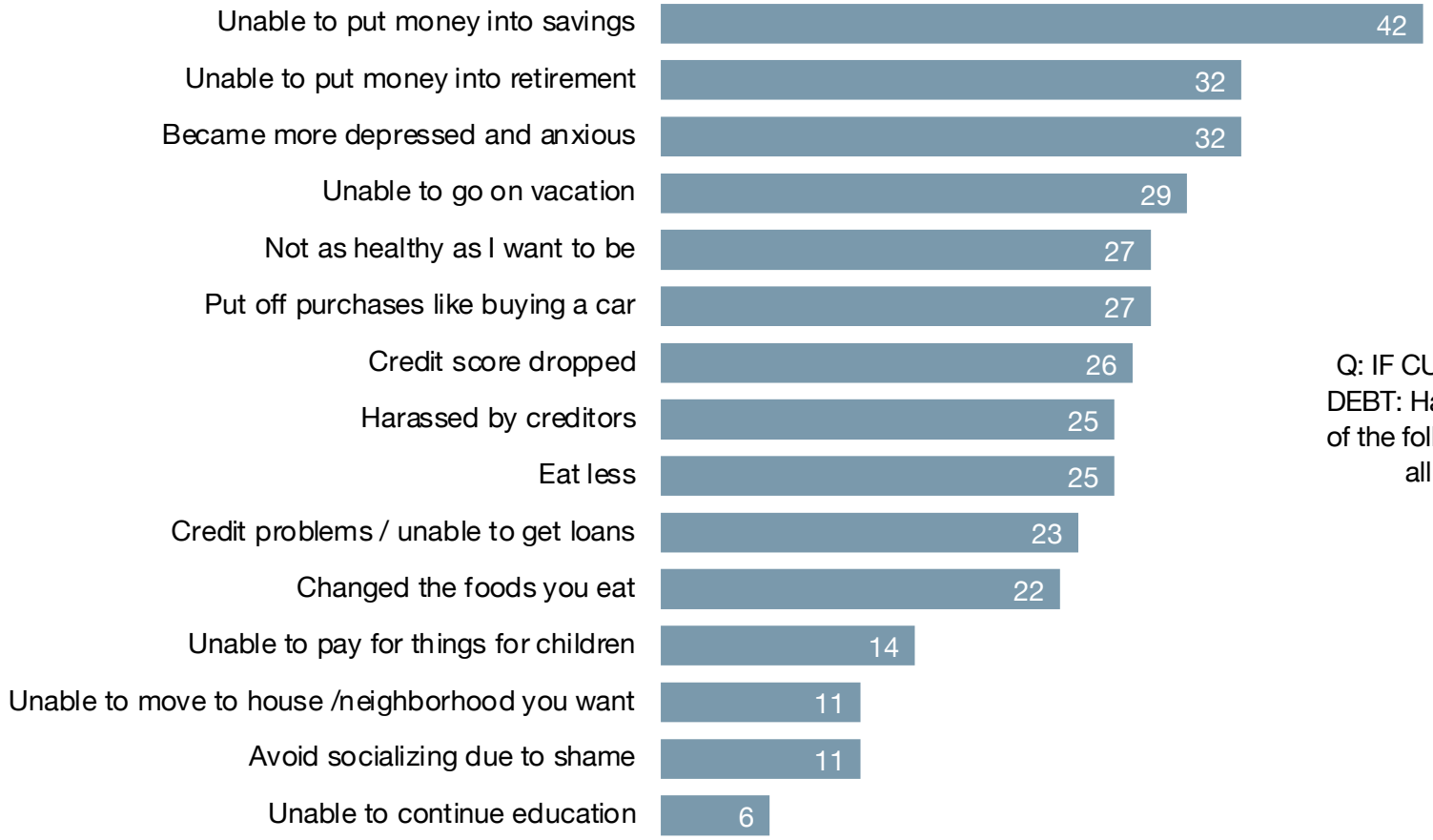
Uninsured, parents of children under 18, Hispanic / Latino adults, and younger adults are most likely to feel "trapped" by their medical debt.

Q: IF CURRENT OR PAST MEDICAL DEBT: Have you ever felt trapped financially by your medical debt?
(N = 1,179)



Note: The Native American sample is small for this question (n=71)

Medical debt has many negative effects on them – from being unable to put money away for the future to increased depression and anxiety.



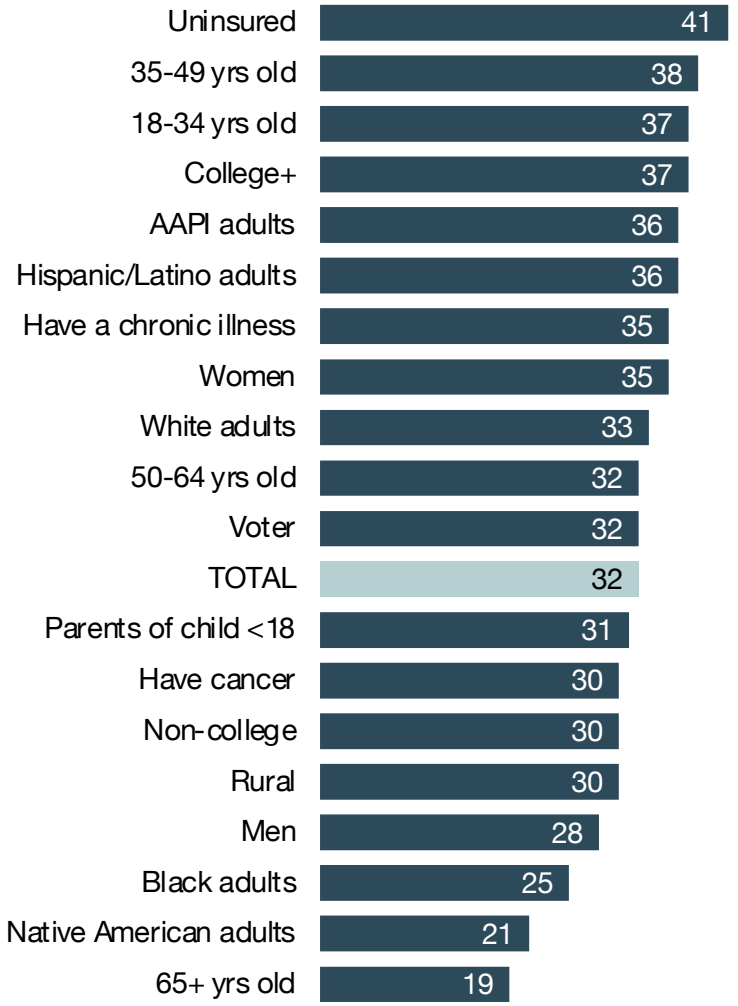
Q: IF CURRENT OR PAST MEDICAL DEBT: Has your medical debt had any of the following effects on you? Select all that apply. (N = 1,179)

Uninsured, younger, AAPI, and Hispanic / Latino adults are most likely to say they became more depressed due to their medical debt.

Women more than men also say they became more depressed.

Q: IF CURRENT OR PAST MEDICAL DEBT: Has your medical debt had any of the following effects on you? (N = 1,179)

% you became more depressed or anxious



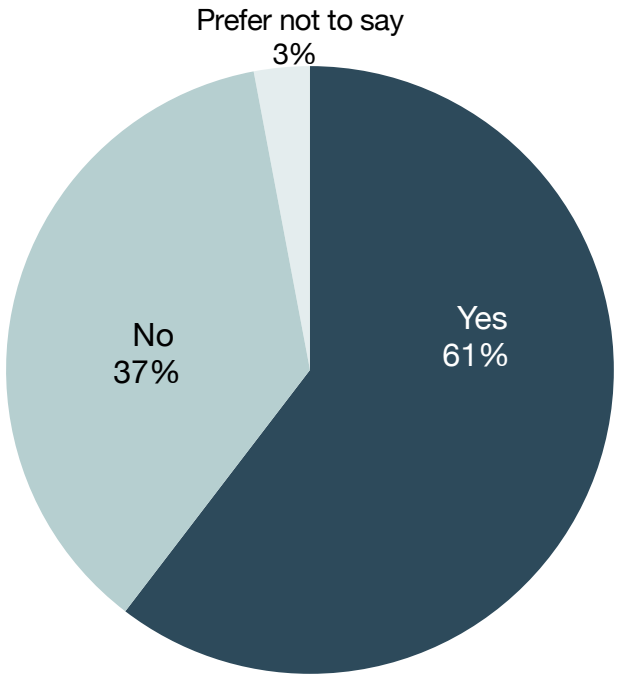
Note: The Native American sample is small for this question (n=71)

Payment plans.

6 in 10

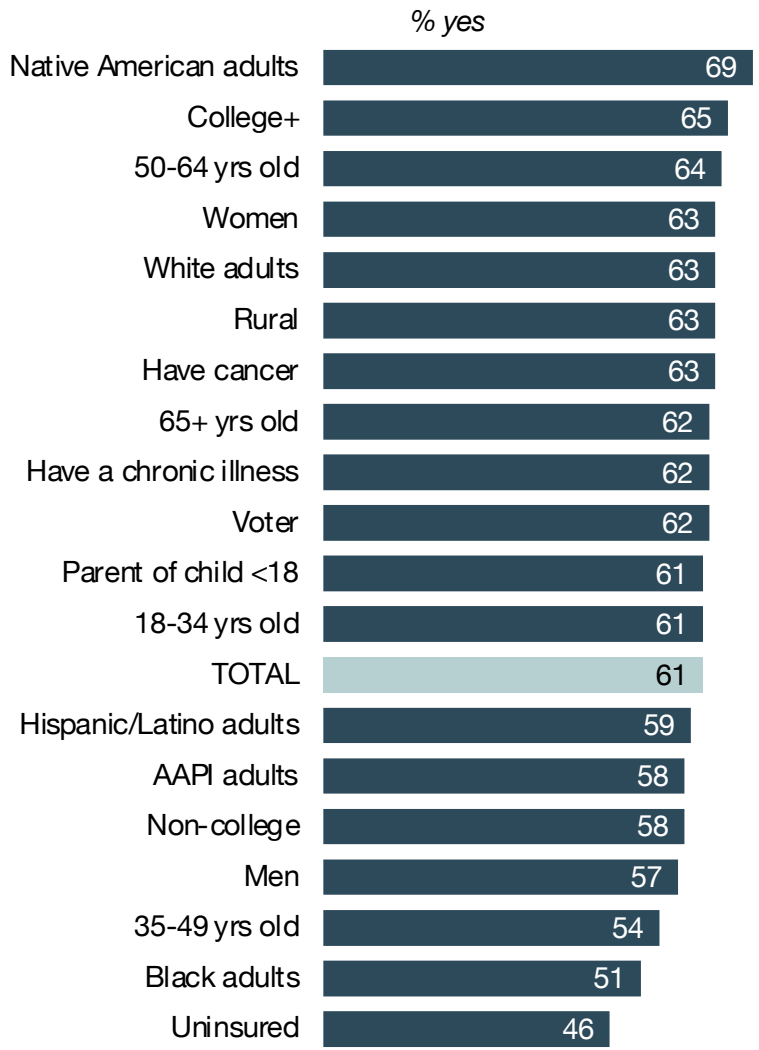
of those with current or past medical debt had a payment plan / installments to pay their debt.

Q: Have you ever had a payment plan, a medical credit card, or had to pay in installments for medical debt?
(N = 1,179)



Uninsured and Black adults with current or past medical debt are least likely to have had a payment plan to pay off their medical debt.

Q: Have you ever had a payment plan, a medical credit card, or had to pay in installments for medical debt?
(N = 1,179)



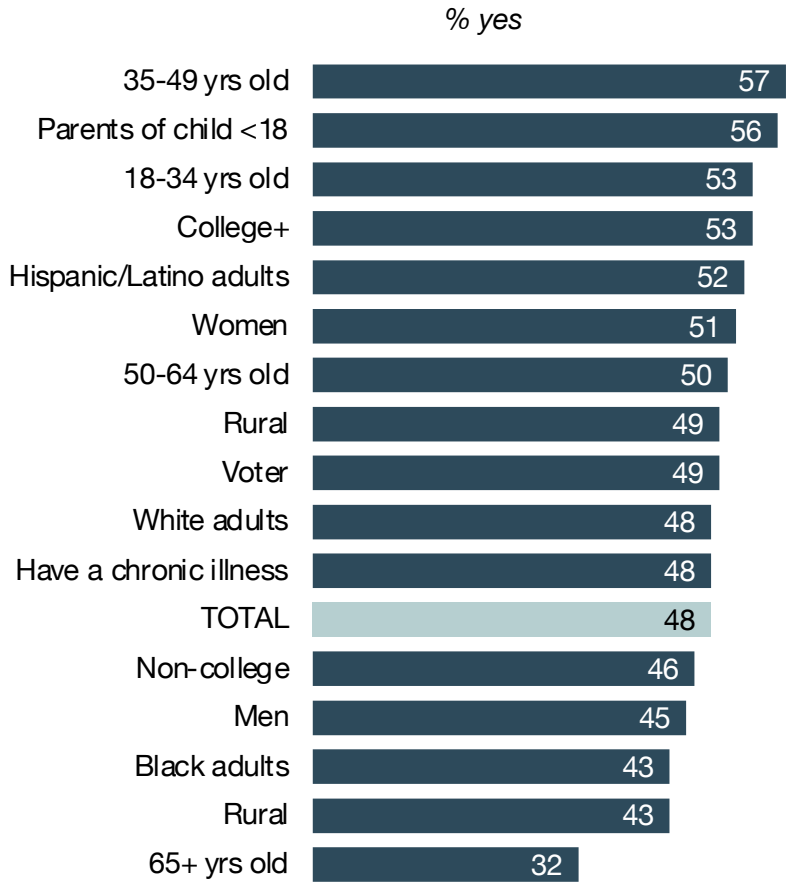
Note: The Native American sample is small for this question (n=71)

48%

of those with payment plans say they felt pressured into agreeing to the plan.

Younger adults and parents with children under age 18 are most likely to say they felt pressure.

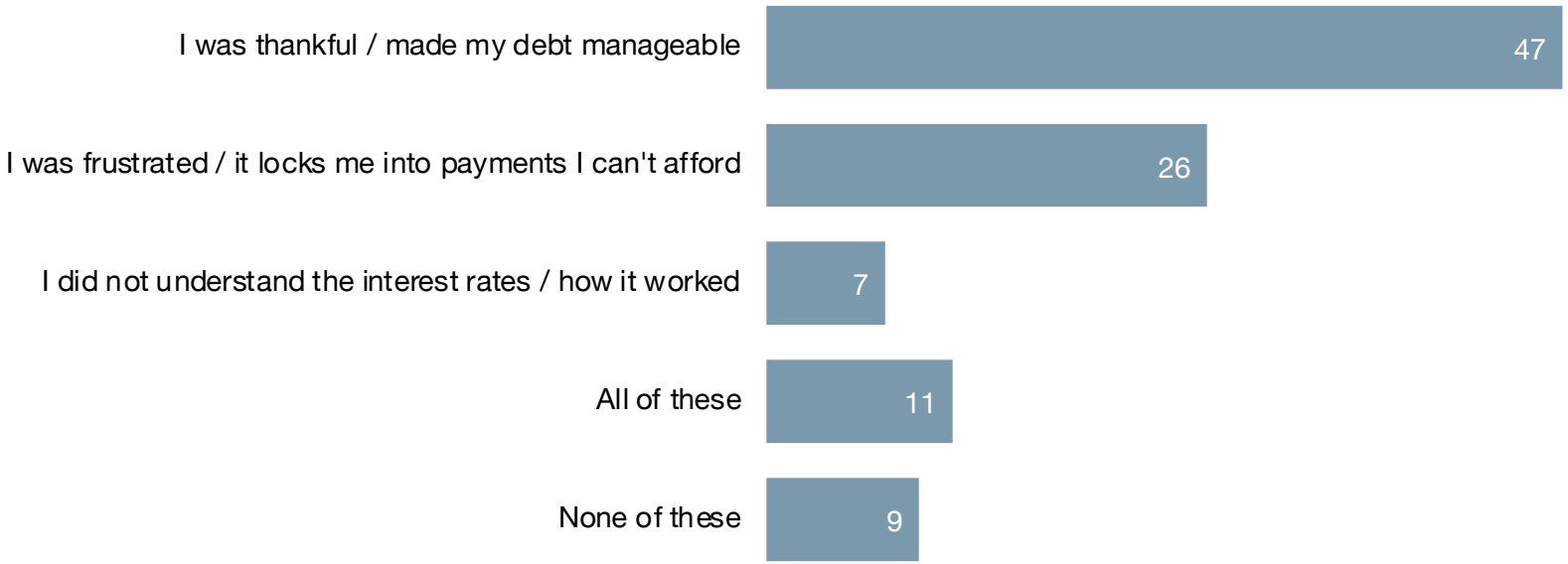
Q: Did you feel pressured into getting the payment plan, a medical credit card, or paying in installments by the health provider, bank, or collection agency?
(N = 699)



Note: The samples for AAPI and Native American adults, uninsured adults, and individuals with cancer were too small to include here.

They have mixed feelings about payment plans.

Q: IF HAVE A PAYMENT PLAN:: Which statement comes closest to your feelings about the payment plan / medical credit card / paying in installments you have or had for your medical debt?
(N = 699)



Systemic racism.

After reading information about the issue, nearly half of respondents believe systemic racism puts people of color more at risk of medical debt.

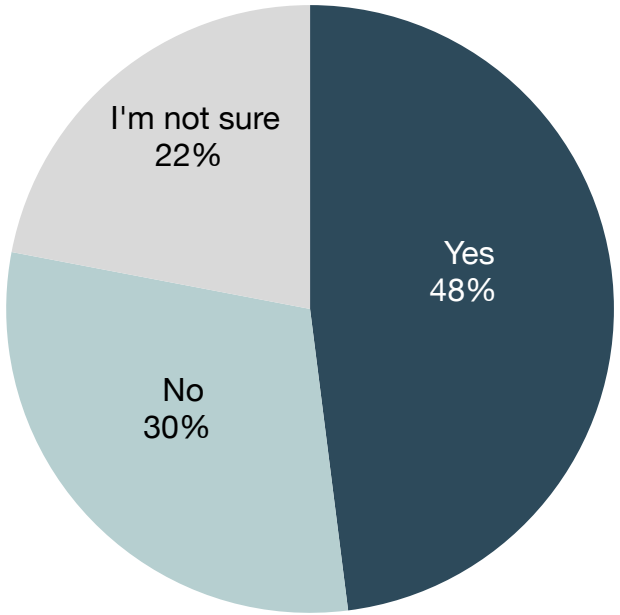
RESPONDENTS READ…

Data shows that medical debt has a bigger impact on certain populations in America. For example, studies show that communities of color have higher rates of medical debt than white communities. Below is a statement about this:

"Structural barriers and systemic racism in housing, credit, and employment opportunities increase financial risk among communities of color, making it more difficult for households of color to manage medical bills and pay debts on time. Higher rates of uninsured among communities of color also increase the risk of medical debt. And some studies have found collections agency seeking to collect payments for medical debt tend to use more aggressive tactics with communities of color."

THEN THEY WERE ASKED…

Q: Do you believe systemic racism puts communities of color more at risk of medical debt than other communities?

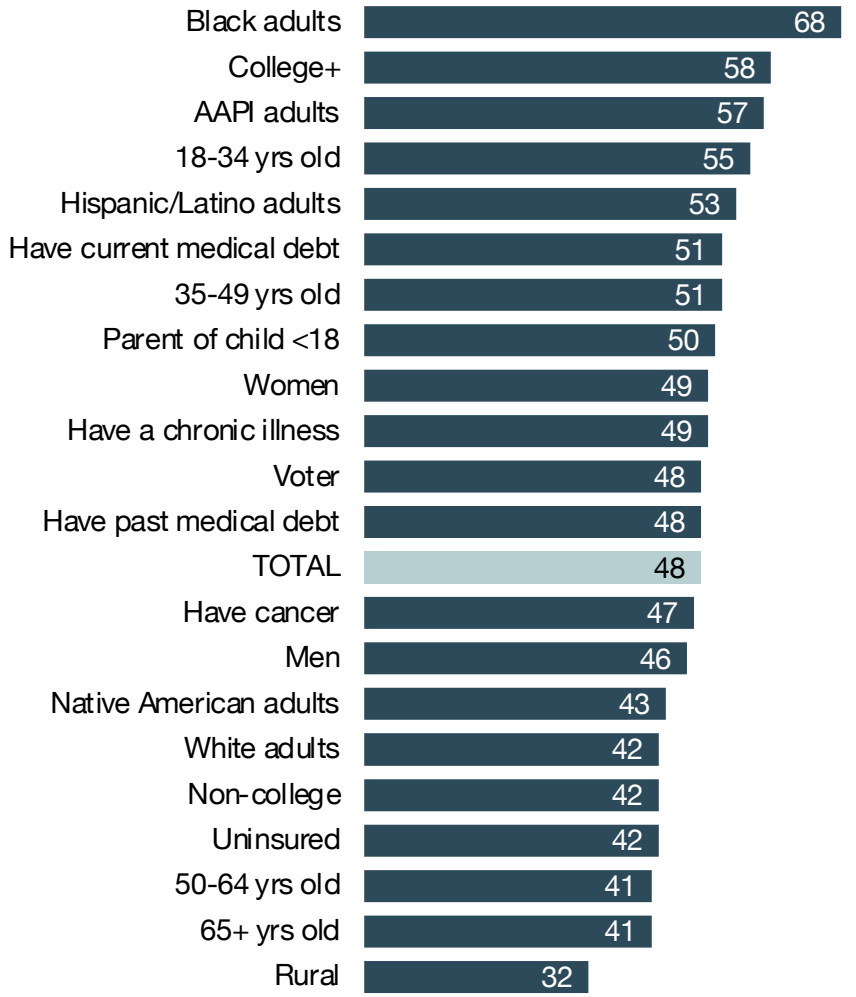


Black, Hispanic / Latino, and AAPI adults – along with college-educated and young adults – are most likely to say systemic racism puts people of color more at risk of medical debt.

Rural residents and older respondents are less likely to agree with this.

Q: Do you believe systemic racism puts communities of color more at risk of medical debt than other communities?

% yes

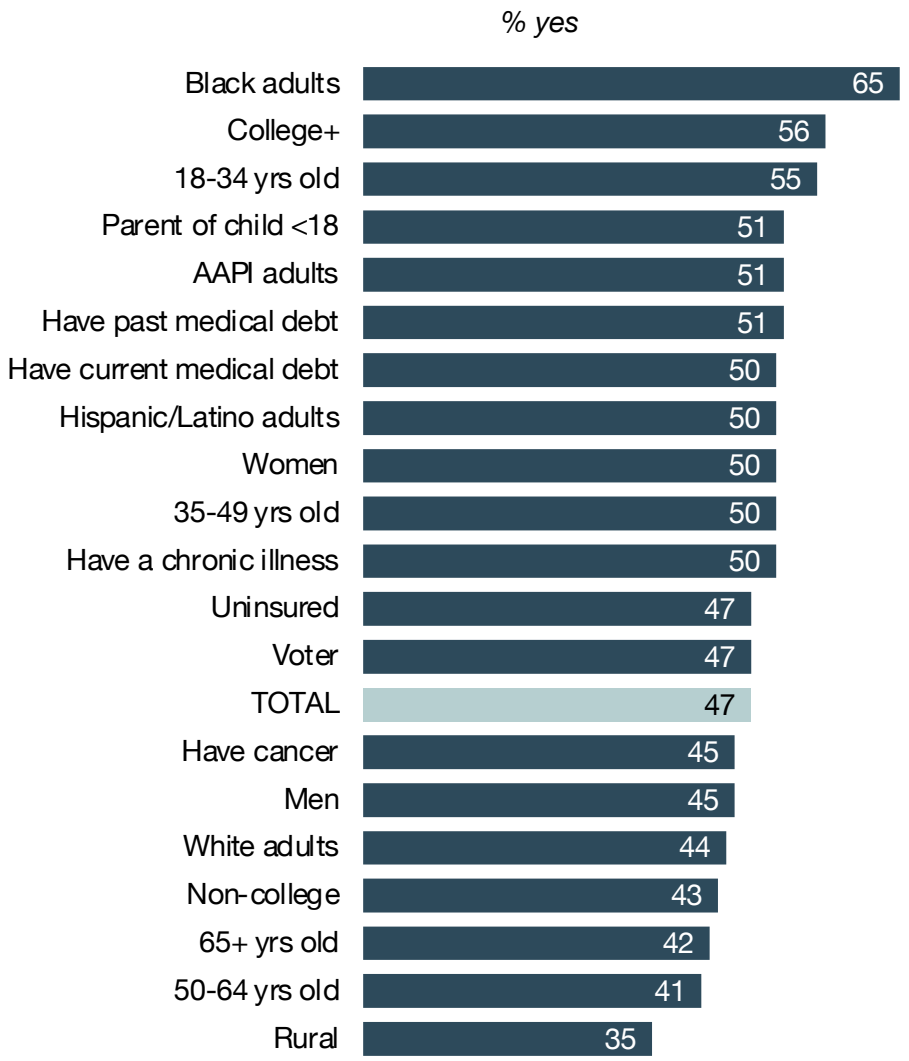


47%

believe policies seeking to protect patients from medical debt should also try to reduce systemic racism.

But 29% disagree with this and another 23% say they are unsure. Black adults, those who are college-educated, and younger adults are the most likely to believe medical debt policies should also address systemic racism.

Q: Do you think policies that protect patients from medical debt should also seek to address systemic racism that puts communities of color more at risk of this debt?



Cancer.

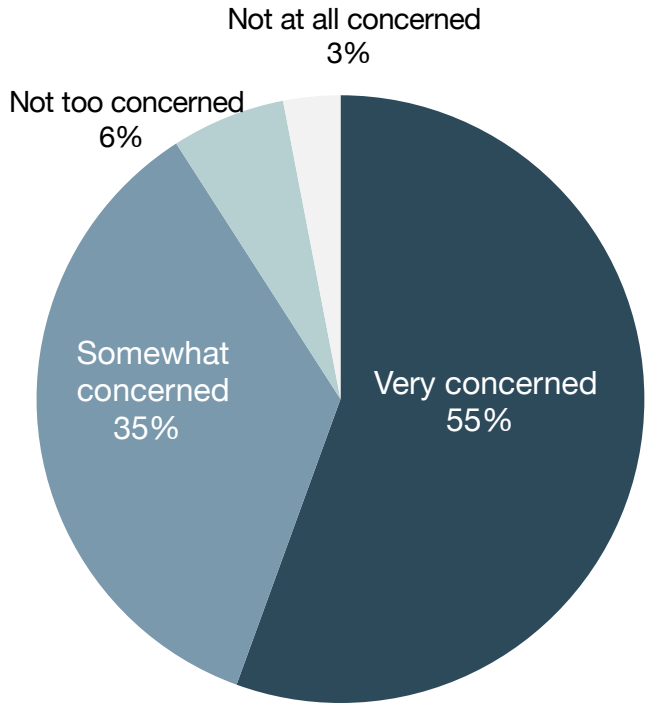
9 in 10 survey respondents say they are concerned when they learn people with chronic conditions like cancer struggle more with medical debt.

RESPONDENTS READ…

Data also shows that people in poorer health – for example, those with a chronic condition or serious health illness – are also more likely to struggle with medical debt. For example, a large portion of debt in this country is related to cancer treatments and studies show that over half of cancer patients and survivors have medical debt related to their care.

THEN THEY WERE ASKED…

Q: How concerned are you, if at all, that people with chronic conditions or serious health illnesses like cancer are at much higher risk of having medical debt?

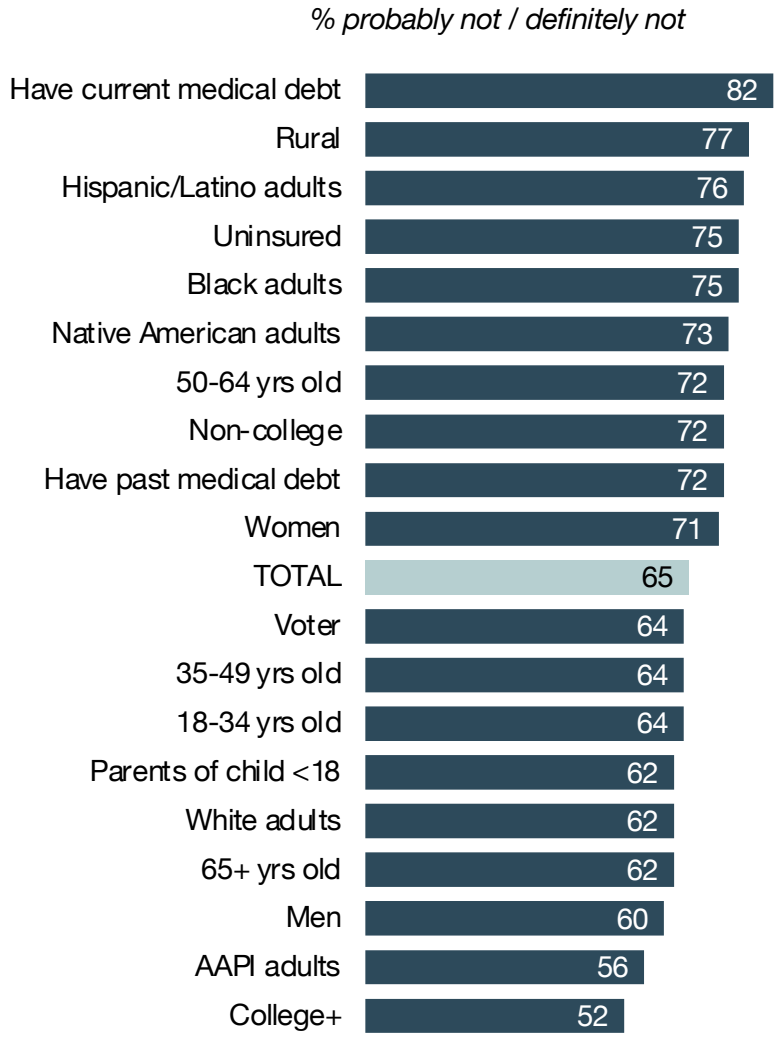


65%

feel they could probably NOT afford the out-of-pocket costs of treating cancer without going into debt.

This is relevant to many survey respondents – 34% think it is at least somewhat likely that they will be diagnosed with cancer in the next 5 years.

Q: Studies show that insured cancer patients pay somewhere in the range of $4,000-$13,000 out-of-pocket in the year they are diagnosed. Hypothetically, if you were diagnosed with cancer tomorrow, could you afford these costs without going into debt?



Survey respondents have strong feelings about cancer care and medical debt.

Q: Here are some statements about cancer and medical debt. Please indicate if you agree or disagree with these statements.

	Strongly agree	Somewhat agree	TOTAL
Cancer treatments and medications are so expensive that even with good health insurance, many cancer patients still have large copays, coinsurance, and costs they have to pay out of pocket that put them into debt.	63%	29%	92%
Elected officials should pass policies that protect people with serious illnesses like cancer from medical debt and harassment from collection agencies.	65%	26%	91%
Cancer patients should not have to go deep into medical debt just to save their lives.	69%	21%	90%
Insurance companies know it is illegal to drop people with cancer or deny them health coverage. So now they simply refuse to cover the costs of many cancer treatments and medications so that people with cancer can't afford them.	46%	33%	79%

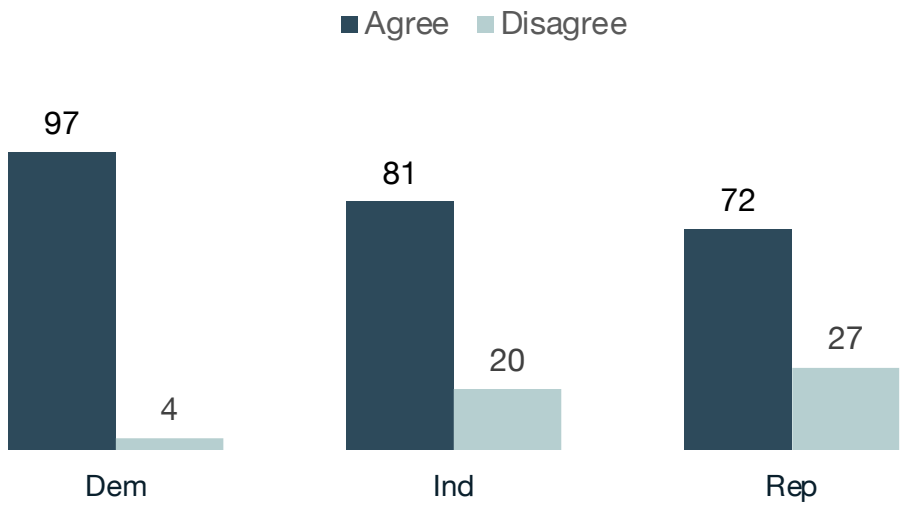
Policies.

84%

of survey respondents agree that “it is the responsibility of the government to ensure that health care is affordable to all people in the US.”

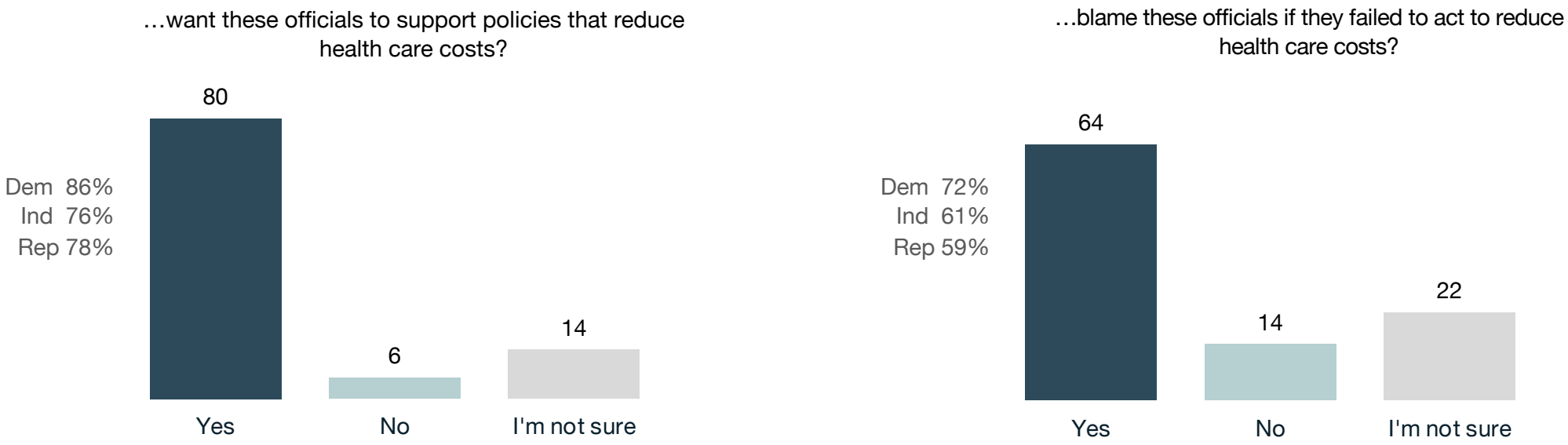
There is bipartisan agreement on this issue.

Q: Do you agree or disagree with the following statement: It is the responsibility of the government to ensure that health care is affordable for all people in the U.S.?



Majorities (across political party ID) want their federal and state officials to act to reduce health care costs and are likely to blame them if they fail to act.

Q: Think about the elected officials who represent you on the state and federal level. Would you…



There is strong bipartisan support for policies that protect patients from medical debt.

Q: Here are some statements about cancer and medical debt. Please indicate if you agree or disagree with these statements.

	TOTAL SUPPORT		
	Dem %	Ind %	Rep %
Give patients more time to pay back bills and at a lower interest rate	92	95	92
Have advocates or navigators, including those who speak different languages, available to help patients complete financial assistance forms and access other resources to help lower their medical debt	93	89	87
Cap the interest rate allowed to be charged for medical debt	89	91	91
Make hospitals screen a patient, both the insured and uninsured, for its financial aid program before attempting to collect on a bill (i.e., ensure those who are eligible for financial support can get it)	93	87	87
Make more health care providers offer financial aid programs	91	88	85
Ban aggressive collection practices such as suing people, taking their assets (i.e., homes, cars, etc.) or garnishing people's wages	90	87	85
Place limits on extreme debt collecting efforts like liens on patients' homes	88	88	87
Require all hospitals and their providers to offer charity care (i.e., free or discounted health services for people who meet a criteria for assistance)	93	85	82
Delay reporting of unpaid medical debts to credit bureaus until one year after a patient is billed	89	86	83
Cap the amount a patient would have to pay in a year (for example, a limit of $2,300) towards their medical debt	88	83	80
Establish a uniform criteria for who can access hospital financial assistance (i.e., patients with SNAP / food stamps, people who are experiencing homelessness, and people with Affordable Care Act (ACA) / state marketplace plans)	91	80	76
Make home foreclosures due to medical debt illegal	83	83	80

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HEALTHCARE CONSOLIDATION IS RAISING PRICES AND JEOPARDIZING CANCER CARE: Policymaker Recommendations

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The price of cancer care—and, ultimately, the consumer cost of care—is rising at an alarming rate. Patients' out-of-pocket costs are increasing through higher deductibles, co-pays, co-insurance, and premiums. Thus, patients are less able to afford the care they need, which compels them to delay or even forego necessary treatment due to cost. A significant driver of the rising cost of healthcare in the U.S. is consolidation across and among hospitals, providers, and health systems.

Consolidation has an outsized impact on cancer patients, as more individuals receive cancer care from hospital-affiliated outpatient settings rather than independent physician offices.

Today, a handful of large health systems increasingly dominate several U.S. markets. This allows those systems, hospitals, and providers to demand higher reimbursement from commercial payers through concentrated market power. Market consolidation directly impacts patients' ability to afford care and services. When markets are highly concentrated, insurers and employers have reduced leverage to negotiate with providers to keep prices down and ensure that care is affordable for their members. Ultimately, insurers and employers pass the burden of provider price increases onto consumers through higher premiums, out-of-pocket costs, and reduced wages.

This paper considers several mechanisms by which state and federal policymakers can constrain market consolidation and, in doing so, address both system-wide and individual consumer healthcare costs. Policymakers should consider the following policy levers to combat consolidation:

At-A-Glance: Policymaking Recommendations

Strengthen anti-trust enforcement	• Increase funding for state and federal regulatory agencies to better monitor and regulate monopolistic behavior • Expand statutory authority for state and federal regulatory agencies to investigate mergers, including mergers of non-profit entities and mergers below the current annual acquisition value threshold • Clarify the authority of state and federal regulators to identify and challenge cumulative mergers and acquisitions
Reform pricing and reimbursement rules	• Enact site-neutral payment reforms that standardize provider reimbursement across care settings for routine services • Protect consumers from burdensome fees associated with care provided at hospitals and hospital-outpatient settings
Prohibit anticompetitive contracting terms	• Ban the use of anticompetitive contracting terms that harm patients and consumers • Empower state and federal regulatory agencies to evaluate the impact of anticompetitive contracting terms
Improve transparency standards	• Refine, expand, and enforce data reporting requirements for health systems to improve economic and community benefit transparency • Require health systems to report data to appropriate regulators concerning ownership, mergers and acquisitions, and any changes in ownership or controlling interest • Establish all-payer claims databases (APCD)

BREAKING DOWN PROVIDER CONSOLIDATION

01

The price of cancer care – and ultimately the consumer cost of care, has risen at a constant and alarming rate for years and is projected to continue to grow.[1] As a result, patients are expected to foot more of the bill for their care in the form of increased deductibles, cost sharing, and premiums. As employers and issuers alter their health insurance options for consumers and employees to help defray rising costs—frequently by shifting costs to their enrollees—patients are increasingly unable to afford care, which leaves them with no choice but to delay or even forego necessary treatments.

"Financial toxicity" presents its own set of significant threats to patient quality of life alongside the actual diseases and conditions that patients are battling. At the same time, rapid increases in treatment costs year after year for cancer and other disease areas will eventually strain the overall healthcare delivery system such that patients' access to high-quality care will be severely impacted.

In this country, a significant driver of persistent price increases for healthcare is increasing consolidation among hospitals and health systems.

Why consolidation matters

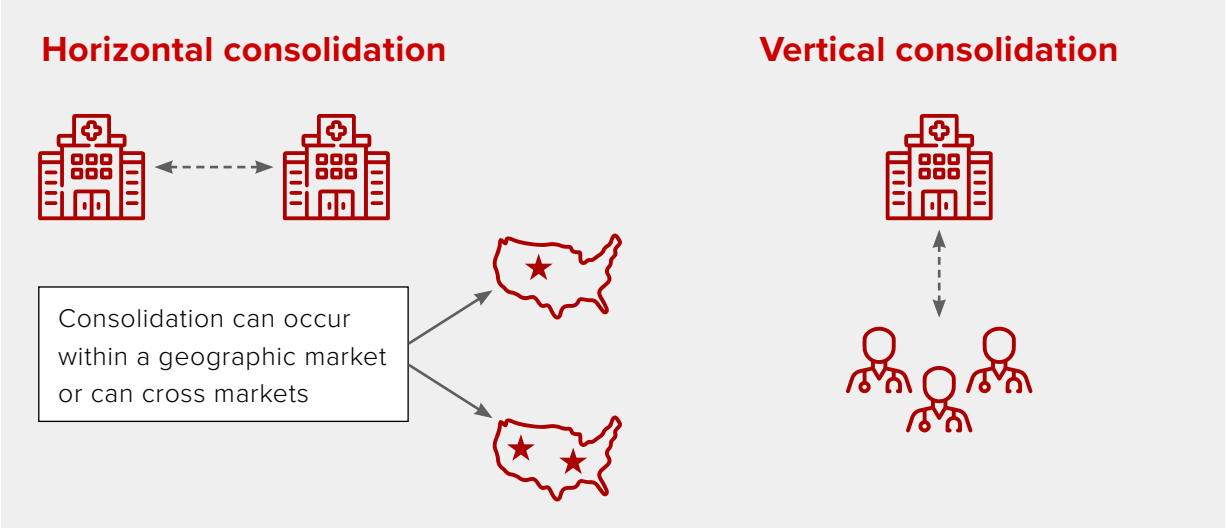
Historically, employers and health insurance plans have been able to assemble networks of providers and hospitals that provide affordable services for their enrollees by negotiating with available, competing providers within a given area. However, as consolidation has reduced competition between large facilities such as hospitals and concentrated smaller providers under the umbrella of large healthcare systems, fewer markets offer sufficient competition to serve as a lever for controlling costs. Between 1998 and 2021, over 1,800 hospital mergers led to a decrease of approximately 2,000 hospitals around the country. Meanwhile, more than half of all physicians in the country were employed by hospitals by 2020, which is an increase of nearly 20% since 2012.[2]

Put simply, a smaller number of enormous health systems increasingly dominate several U.S. markets, enabling hospitals and providers to demand higher reimbursement from commercial payers through monopolistic market power.[3] This has a significant impact on the patients served by these health systems. Ultimately, insurers and employers pass the burden of provider price increases onto consumers through higher premiums and out-of-pocket costs—and in the case of employers, reduced wages.[4]

With healthcare costs growing twice as fast as workers' wages,[5] it comes as no surprise that 46% of respondents in a 2022 national survey reported skipping or delaying care due to cost barriers.[6]

Experts generally agree that rising healthcare costs are primarily driven by increases in the prices charged by healthcare providers rather than high patient utilization of services.[7] Additionally, increased costs are not always correlated with cutting-edge care or better health outcomes.[8] These concerning cost trends are particularly problematic in the commercial market. In 2018, privately insured consumers and employers paid 247% of Medicare rates on average for the same inpatient and outpatient hospital services.[9]

Consolidation has an outsized impact on individuals receiving cancer care as more individuals receive cancer care from hospital-affiliated outpatient settings rather than physician offices.[10]



Types of consolidation

Consolidation in the healthcare industry can be either "horizontal" or "vertical." Horizontal consolidation refers to a merger or acquisition that occurs between directly competing entities offering the same services, such as in the case of a hospital merging with another hospital. Vertical consolidation (often referred to as "vertical integration") occurs when one type of entity purchases another that operates at a different stage in the healthcare delivery system, such as in the case of a hospital acquiring a physician practice. Clinically integrated networks, accountable care organizations, and other joint arrangements between healthcare entities that fall short of complete ownership can also influence market forces in ways similar to mergers and acquisitions.[11]

Consolidation can happen within or across markets. This distinction may make a difference in how the consolidation ultimately impacts prices and consumer affordability. Consolidation that occurs within a market could involve a merger between two hospital systems operating within the same geographic area, whereas consolidation occurring across markets could involve a hospital system operating in one geographic area merging with a hospital system that operates in a different geographic area. Research suggests that *both* types of consolidation drive up prices.[12]

While this paper focuses on provider and/or hospital system consolidation, the available data indicate that this type of consolidation has the most significant impact on rising prices. Moreover, the increasing horizontal consolidation across insurers is also worth noting. Unlike consolidation of providers, horizontal insurer consolidation has sometimes been found to *lower* prices by leveraging bargaining power.[13] Unlike the relatively unregulated ecosystem of hospital market consolidation, there are protections for ACA-regulated insurance plans that may mitigate the impact of consolidation on consumers. For instance, fully insured plans must meet medical-loss-ratio protections and individual and small group plans must meet network adequacy standards. There is, however, relatively little data on the impact of vertical integration between insurers and other health systems entities on prices, quality, and affordability.

Consolidation is Increasing

Provider consolidation has been on the rise in the U.S. for some time. The ten largest health systems in the country now control nearly a quarter of the national market.[14] As a result of the 1,887 hospital mergers announced between 1998 and 2021, the number of hospitals in the country fell from 6,000 to 4,000.[15] By 2017, a single hospital system had more than a 50% market share of hospital discharges in most markets.[16]

Vulnerable populations are more likely to feel the impacts of consolidation. The shuttering of independent and community hospitals has disproportionally reduced access to services for residents of rural areas[17] and urban neighborhoods of color.[18] Low-income communities are also more likely to live in highly concentrated hospital markets.[19]

Similarly, physician practices have also consolidated significantly over the past decade. Today, physicians are more likely to practice in larger groups than in smaller or independent practices, a trend that has been observed across different specialties.[20] Physicians are also increasingly being employed by hospitals. As of 2020, more than 50% of physicians were directly employed by hospitals, an almost 20% increase compared to 2012.[21] Further, hospitals are increasingly acquiring physician practices. As of 2018, close to half the physician practices in the country are owned by hospitals.[22]

Finally, the increasing role of private equity in healthcare has also accelerated provider consolidation.[23] Research has found that while private equity investments can provide an infusion of cash into hospital and provider systems, the business strategies at the heart of private equity ventures often prioritize short-term revenue generation over long-term sustainability, patient access, quality care, and affordability.[24] In addition, private equity firms often engage in end-runs around antitrust protections, for instance, through "roll ups," where the firm buys up multiple smaller companies one at a time, avoiding federal merger scrutiny.[25]

Private Equity and Provider Consolidation

Over the past decade, private equity firms have invested more than $750 billion into the U.S. healthcare system. Because of its focus on short-term revenue generation, private equity has added fuel to the fire of market consolidation and other anticompetitive practices, driving up prices and compromising patient access to quality care.

The Impact of Consolidation on Consumers

- Provider consolidation weakens competition
- Weakened competition erodes the ability of payers to control prices
- Increased provider prices are passed onto consumers in the form of higher premiums and cost sharing
- Vulnerable and marginalized communities who already struggle with access to healthcare are disproportionately impacted by the loss of community providers as more providers consolidate

CONSOLIDATION AND THE IMPACT ON CONSUMERS

02

As the pace of provider consolidation has increased, there has been more in-depth research to assess the impact of consolidation, including the effects of consolidation on prices, affordability, access and utilization, and quality. There has also been more attention to the health equity implications of consolidation, specifically the ways that consolidation disproportionately impacts particular communities.

Prices

Research on hospital mergers uniformly finds that they raise hospital prices, and this finding holds for both for-profit and nonprofit hospital mergers.[26] Post-merger, hospital prices have been estimated to increase by anywhere between 2.6%[27] and 13.2%.[28] For example, a study commissioned by the Indiana Legislative Services Agency found that prices at the 22 Indiana hospitals that participated in merger activity were 13.2% higher than the 18 hospitals that did not participate in such activity.[29] Although research finds that hospital mergers that occur within the same geographic market have the biggest impact on increased prices, cross-market consolidation can also drive up prices. For instance, one study estimated that cross-market mergers between hospitals located in the same state resulted in a 7–9% increase in prices.[30]

These price increases are not limited to hospital consolidation and studies have found that provider group mergers also raise prices.[32] Studies have consistently found that physicians in more consolidated markets charge more than those in less consolidated markets. These price differences can be considerably high. One study estimated that providers in counties with higher physician consolidation charged private Preferred Provider Organization (PPO) plans 8 to 26% more,[33]

Research on hospital mergers uniformly finds that they raise hospital prices, and this finding holds for both for-profit and nonprofit hospital mergers.[31]

while another found that practices in the most consolidated markets (i.e., those in the 90th percentile) charge 14 to 30% more in fees.[34] The specialty of the physician can also impact how big these price differences are, with one study that in the most consolidated markets, internal medicine physicians charged 16.1% higher prices for office visits compared to orthopedic physicians, who charged 8.3% higher prices.[35]

A growing evidence base also connects vertical consolidation to rising prices, with one study estimating the increase in hospital prices after a vertical hospital and provider group consolidation at 3–5%.[36] Vertical consolidation also increases physician prices. Estimates of the price increases vary across the studies, with a physician's specialty being a determining factor in how much their prices were affected by the integration.[37] For example, one study found that vertical integration increased primary care physicians' prices by 2.1–12% and specialty physicians' prices by 0.7–6%, with the greatest increases happening when physicians merge with larger health systems.[38]

Horizontal consolidation: This refers to a merger or acquisition that occurs between directly competing entities offering the same services, such as a hospital merging with another hospital.

Vertical consolidation: This occurs when one type of entity purchases another operating at a different stage in the healthcare delivery system, such as a hospital acquiring a physician practice.

Facility Fees

Under Medicare payment rules, which are also followed by many commercial payers, physicians who join a hospital can charge higher fees for the same services (known as "facility fees"). One study found that acquired physicians increased their prices by an average of 14.1% and that about half of this increase was attributable to the addition of facility fees.

The increase in physician prices after integrating with hospitals can be the result of several drivers. First, as with any other kind of consolidation, these types of mergers result in providers accruing market power allowing them to extract higher prices from payers. Second, these arrangements can take advantage of payment rules that allow for additional charges for services provided by a hospital system, allowing physician groups acquired by hospitals to impose hefty facility fees for services provided in outpatient settings.[39]

Another factor that drives up healthcare prices after physicians integrate with hospitals is that physicians steer or refer patients toward the hospitals with which they are affiliated.[40] Studies show that these hospitals can be costlier while not necessarily providing better care.[41]

Consumer Affordability

In addition to increasing prices, a growing evidence base points to higher hospital and/or physician market consolidation as a driver of premiums and out-of-pocket costs.

Four studies specifically researched the impact of hospital market consolidation on Affordable Care Act (ACA) Marketplace premiums and all four found that increased consolidation drives up Marketplace premiums.[42] Areas with the highest levels of hospital market consolidation were found to have annual premiums that were 5% higher on average compared to areas with the least concentrated hospital markets. Additionally, an increase from the 10th to 90th percentile of hospital consolidation was associated with an average increase of almost $200 in annual premiums for the second-lowest-cost silver-level plans. One study even estimated that reducing the level of hospital market consolidation to a "moderately competitive" level would bring premiums down by 2% (or more than 10% in some markets).[43]

A study assessing a hospital merger in Toledo, Ohio found that post-merger, out-of-pocket costs for inpatient childbirth increased by about 77%.

Like hospital mergers, physician group consolidation also increases premiums. One study found that an increase from the 10th to the 90th percentile of physician consolidation increased annual premiums for the second-lowest-cost silver-level Marketplace plans by almost $400 (nearly double the impact of hospital consolidation).[44]

Consolidation not only affects Marketplace premiums and cost-sharing[45] but also drives up employer-sponsored insurance premiums and deductibles. For instance, researchers found that, between 2010 and 2018, hospital mergers led to a $638 wage reduction for workers with employer-sponsored insurance, and employers responded to hospital mergers by offering less generous benefits and more high-de-

ductible health plans.[46] These decisions by employers might be driven by the fact that employers who purchase insurance plans end up paying higher premiums in highly concentrated provider markets.[47]

There are fewer studies assessing the impact of vertical consolidation on premiums and cost-sharing. While the emerging research on this topic is mixed, at least one study found that vertical integration in highly concentrated hospital markets was associated with a 12% increase in ACA Marketplace premiums.[48]

Equity

Consolidation—particularly hospital mergers—has an outsized impact on marginalized and disenfranchised communities. Research has found that those most affected by hospital downsizing and closings have been Black, Latino/Latinx, Indigenous, low-income, and LGBTQ+ people, as well as other people of color and women.[49] This is particularly true when mergers lead to the closure of key services not easily accessible elsewhere or where the merger involves the acquisition of independent hospitals by religiously affiliated systems whose doctrine limits the type of services offered.[50]

Access and Utilization

Hospital and physician consolidation also impacts patients' ability to access care when they need it. Studies aimed at evaluating access to services before and after hospital mergers have found that mergers led to reductions in access and utilization. In particular, two studies that examined the impact of small rural hospitals joining larger health systems found that post-merger, rural hospitals were more likely to eliminate or reduce the availability of certain service lines, including primary care, and that there was a reduction in the utilization of inpatient mental health services, outpatient nonemergency visits, and diagnostic imaging.[51] These studies demonstrate that hospital consolidation can harm patients' ability to seek and receive the care they need. These findings are particularly important in light of the arguments supporting rural hospital mergers to improve their financial sustainability.[52]

> *While there is some evidence suggesting that hospitals can improve their profitability through consolidation, given the evidence that points to drops in access, it is very likely that these gains are coming at the expense of patient access.*

One study found that access challenges post-hospital consolidation may be even more pronounced for low-income people. The study examined the impact of increasing hospital market consolidation on healthcare access for Medicaid patients in New York. Researchers found that as market consolidation of hospitals increased, the distribution of Medicaid admissions shifted away from non-profit hospitals to public hospitals, putting strain on systems that already serve a disproportionate number of low-income and uninsured individuals.[53] Researchers attributed this shift to the simple fact that once hospitals consolidate, they can negotiate higher reimbursement rates from private insurers, which are typically greater than Medicaid rates. Instead of investing the increased profits they receive from higher commercial reimbursement rates into providing care for low-income populations, consolidated hospital systems are moving away from safety-net care altogether.

Quality

Despite claims from hospitals and health systems that vertical consolidation will improve care coordination for their patients, there is little evidence suggesting that such consolidation improves the quality of care. In fact, the mix of available evidence leans toward the opposite conclusion, with numerous studies finding that consolidation has negatively impacted patient outcomes. One study in particular found that hospital mergers were associated with a 1.7% increase in inpatient mortality,[54] while two others associated mergers with a decrease in several quality metrics[55] and slower growth in patient satisfaction compared to hospitals that had not undergone mergers.[56] Similarly, studies comparing quality and outcome measures across different markets with higher and lower levels of provider consolidation tied higher levels of provider consolidation with increased mortality[57] and lower patient satisfaction.[58]

The same arguments for horizontal consolidation are often at the heart of vertical consolidation, namely, that the goal of consolidation is ostensibly to improve care coordination, quality of care, and health outcomes. However, studies delving into the effects of vertical integration have offered mixed results across different quality measures. While some studies point to improvements, a few studies even link these acquisitions to lower quality of care. For example, one study found that acquired physicians are financially incentivized to change how they provide care to save on costs and that this can increase the occurrence of post-procedure complications.[59] Other studies found that vertical integration caused an increase in readmission rates[60] and a decrease in patient satisfaction.[61]

POLICY PRIORITIES TO PROTECT CONSUMERS AND LOWER PRICES

03

Policymakers should consider mechanisms to regulate provider consolidation in ways that tamp down on anticompetitive practices and protect consumers. The following principles and priorities should guide their actions.

Strengthen anti-trust enforcement

Anti-trust protections are a critical but underused tool against anticompetitive and ultimately harmful provider consolidation. The Federal Trade Commission (FTC) and the Department of Justice (DOJ) work collaboratively to enforce a range of federal antitrust laws. Because of resource and regulatory constraints, federal regulators investigate a very small number of hospital mergers each year.[62] Current rules require entities to report mergers to the FTC and the DOJ which involve a transaction of at least $111.4M in 2023 (this amount is adjusted annually with inflation). However, many consolidations, especially those by provider groups, do not hit that threshold in a single acquisition, although they may reach it over time as acquisitions accumulate. In addition, neither the FTC nor the DOJ currently has statutory authority to investigate non-profit entities, leaving a significant gap in oversight.

The FTC and the DOJ released joint draft guidelines earlier this year to lay out a more robust vision for cracking down on anticompetitive horizontal, vertical, and, for the first time, cross-market mergers.[63] Now, it will be up to the administration to finalize these draft guidelines and empower both the FTC and the DOJ to use their authority to scrutinize mergers.

States have the potential to monitor the competitive health of markets within their borders and can engage in robust antitrust oversight and review; however, not all state antitrust agencies currently have the necessary authority.[64] State lawmakers should consider implementing or expanding antitrust laws to ensure that state regulators, such as attorneys general, have the tools and the mandate necessary to monitor and intervene in healthcare mergers.

To strengthen anti-trust enforcement, policymakers should consider the following actions:

- Increase funding for state and federal regulatory agencies to expand both agencies' capacity to investigate a wider swath of anticompetitive consolidation.
- Expand regulatory authority to investigate nonprofit mergers.
- Ensure that states have the authority to engage in necessary scrutiny and oversight of healthcare mergers and acquisitions.
- Allow the FTC and the DOJ to investigate a larger number of mergers by lowering the annual acquisition value threshold.
- Allow state regulators to review mergers that fall below the existing federal thresholds.

- Make it easier to challenge mergers by amending current law to allow for the effect of "cumulative" mergers and acquisitions to be taken into account, rather than each merger individually.[65]
- Direct the FTC and the DOJ to develop and utilize a robust health equity framework that takes into account the disproportionate impact of consolidation on medically underserved communities.[66]
- Ensure that state agencies have the mandate and the authority to scrutinize or challenge mergers and acquisitions, oftentimes even in the absence of federal action.[67]

Reform pricing and reimbursement rules

Pricing dynamics can incentivize anticompetitive consolidation and exacerbate the price increases associated with already consolidated markets. The incentive for provider consolidation is largely driven by unchecked pricing practices, allowing providers and hospitals to amass outsized market power and effectively set their own prices with employers and issuers that are divorced from value. For instance, under current law, providers are allowed to charge higher Medicare rates for services provided by off-campus hospital outpatient departments than for services in the same type of outpatient settings not affiliated with a hospital, and/or charge additional facility fees for those services once the office is hospital-affiliated. This incentivizes hospital acquisition of provider groups and can significantly drive up prices and consumer costs post-consolidation.

To curb predatory pricing practices, lawmakers should consider the following actions:

- Enact site-neutral payment legislation, thus creating parity between on-campus and off-campus hospital outpatient departments and independent physician offices in both the Medicare and commercial markets.[68]
- Protect consumers from burdensome fees associated with care provided at hospitals and hospital outpatient settings.

Prohibit anticompetitive contracting terms

The contracting terms between insurers and providers also contribute to an anticompetitive environment and exacerbate the price hikes that are associated with consolidation.[69] As consolidation empowers health systems to wield outsized market power in negotiations with payers, anticompetitive contract terms can further disadvantage competitors – with little ability for insurers to push back.

Though this paper is focused on the use of provider anticompetitive practices in combination with consolidation, both providers and insurers have used these provisions at the expense of a competitive healthcare market.

To strengthen competitive contracting arrangements, policymakers should consider the following actions:

- Ban the use of anticompetitive contracting terms that harm patients and consumers.
- Direct relevant agencies to evaluate the impact of anticompetitive contracting terms in their antitrust enforcement activities.

Improve transparency requirements

Timely, accurate, and complete data is essential for regulators to enforce appropriate oversight, for lawmakers to implement the right policies, and for patients to make informed decisions. That includes data on healthcare prices, claims, and utilization but also information on who owns and controls the facilities and providers within the health system. To date, efforts to increase transparency within the health system have met a number of challenges that leave a fragmented patchwork of incomplete information, hampering efforts to make meaningful progress on the challenges facing patients and consumers. For instance, despite efforts by both the Biden and Trump administrations to increase the transparency of hospital prices through price transparency regulatory requirements,[70] hospitals have been very slow to comply with these requirements.[71] Even with widespread noncompliance, few financial penalties have been levied on noncomplying hospitals to date, although enhanced scrutiny and oversight has resulted in an increase in the number of complying facilities.[72]

To strengthen transparency requirements, policymakers should consider the following actions:

- Use oversight and investigatory powers to hold hearings spotlighting the hospitals that have not complied with the existing transparency requirements.
- States should consider additional enforcement mechanisms, such as prohibiting hospitals that are not in compliance with the transparency requirements to collect debts.
- Enact new transparency requirements that require a range of health systems players (including hospitals, provider groups, surgical centers, and equity funds) to report the data on ownership, mergers and acquisitions, and any changes in ownership to key agencies, such as state or federal departments of health and human services.
- Establish state and federal all-payer claims databases (APCD) to better track prices across insurance markets.[73]
- States could pass additional laws to effectively mandate or enforce appropriate hospital compliance with federal transparency guidelines or add additional reporting and transparency requirements as necessary.[74]

CONCLUSION

04

It is clear that despite its touted goals of enabling health systems to better coordinate care for their members and creating systemwide efficiencies,[75] the reality is that provider consolidation might not do much of either. Not only does consolidation contribute to rising healthcare prices, premiums, and cost-sharing, but substantial evidence points to its negative impacts on the quality of care patients receive in heavily consolidated markets. Thus, this anticompetitive system impacts everyone, although it has the potential to do particular harm to individuals in need of cancer care and treatment who, by virtue of increased utilization of health services, are far more likely to feel the effects of price hikes.

Both state and federal governments have demonstrated some degree of commitment to addressing what is inherently a market failure and enacting laws and regulations that support a competitive healthcare market. Yet greater action is needed. It is time for policymakers to take a stronger approach to abuses of the system and put patient care, treatment, and affordability needs over corporate and health system profits.

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To learn more about this work, please contact advocacy@lls.org.

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Washington State Hospital Association

May 3, 2024

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

The Washington State Hospital Association (WSHA) supports the Board's goal to reduce health care cost growth. Over the course of the Board's work, however, we have raised various concerns with the approach, data, and analyses used to help achieve that goal.

The state can only effectively address health care cost growth in Washington if it adopts realistic measures supported by data that is timely, comprehensive, and accurately reflects the health care landscape in Washington. Washington is already a leader in health care, and we should strive to continue to be a leader in providing access to affordable quality care. However, it is unrealistic to think Washington will be able to completely buck all national trends when our hospitals compete nationwide for workers, when drugs and other hospital products are provided by a national market and when expectations on benefits and care are shaped by national policy and culture.

Without understanding the baseline starting point for Washington and how it compares to national practices, it is difficult to determine whether proposed policies will be effective, and if so, to what extent. We must first understand our baseline and whether any other states or areas have surpassed the performance in Washington in order to set realistic goals.

For example, Massachusetts is often looked to as a leader for its work on cost growth benchmarking, but we note that Massachusetts sometimes uses Washington's performance to illustrate that it can lower the costs in their state. Similarly, last month the Board heard a presentation on medical debt (further discussed below), and it was clear from the presentation that most other states in the country could learn from Washington's policies and experience, not the other way around.

We would like to offer comment on three topics that were included in the April Board meeting materials:

Proposed Framework for Policy Evaluation
The Board reviewed a proposed framework to use in evaluating the policy levers selected in February. The framework includes issue identification and questions to consider in the analysis. We hope that when answering those questions, you ensure Washington-specific data is used as a baseline along with an understanding of how this compares to other areas.

Health Care Spending Growth Benchmark Baseline Brief
A Health Care Spending Growth Benchmark Baseline Brief was included in your materials but not addressed during the meeting. The brief covers health care spending growth in Washington from 2017-2019, and key findings were presented at the Board meeting in December 2023.

Will there be discussion on the final brief and will the Board be addressing comments? We are specifically interested in a discussion of the findings from the OnPoint study that hospital inpatient costs remained flat during this time period and that growth in outpatient hospital was related to increased use rather than increased price. These specific findings are not even noted in the brief but seem very relevant to the work on determining policy solutions.

Medical Debt
The Board heard a presentation on medical debt in the US and discussed potential policy solutions. We support this effort to help patients access care. However, as you consider this issue, we ask that you not rely on outdated information, national data, and national solutions. We ask that the data be current and Washington-specific so that we can better ensure effectiveness and success for Washington patients.

The presentation included a US map showing the share of adults with medical bills in collections, and Washington's is amongst the lowest. This is consistent with national data from the Commonwealth Fund that shows that Washington ranks in the top 10 for lowest for percentage of people with medical debt. That is the case for our state because we have many low-income programs, an expanded Medicaid program, and robust hospital charity care policies, which are well enforced.

The presentation was from a national vantage point and not about Washington State. It highlighted patient stories from states that do not have comparable policies and one of the stories occurred prior to the implementation of the Affordable Care Act. Similarly, there is a slide that uses profit margin data from hospitals in the Dallas-Fort Worth area. Hospital margins in that area are not germane to policy considerations in Washington, which has low hospital margins according to the state's consultants, Bartholomew-Nash. They found that Washington hospitals were running low and negative margins during the period covered in the presentation. More recent data confirm Washington hospitals have low and even negative operating margins, -7% in 2022 and -5.2% in 2023.[1]

More importantly, Washington has also undertaken some unique solutions, which were not discussed. These include the development of a standard financial assistance form adopted by most Washington hospitals, which is straight forward and simple to complete. Washington also requires debt collection entities to notify patients about charity care if the debt is owed to a hospital.

When considering policies to help address the issue of medical debt and to address other policy issues beyond debt, we ask the Board to assess the current policies and data on performance in Washington and, in considering solutions from other states, determine if they would provide a needed remedy for our state.

Sincerely,

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

[1]Washington State Hospital Association year-end member financial surveys 2022 and 2023.

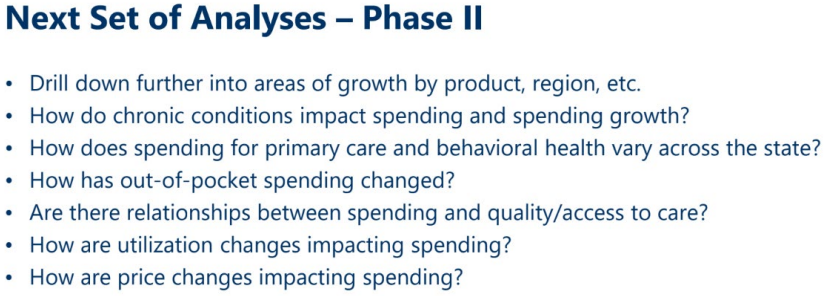
Good Afternoon,

I am a Director of Payer Strategy & Relationships at Virginia Mason Franciscan Health (VMFH). I joined the Health Care Cost Transparency Board's (HCCTB) Advisory Committee on Data Issues in April, 2023. My understanding is that the role of a committee member is to support the efforts underway to identify the pertinent cost trends and drivers in healthcare. That information is used by the HCCTB in its efforts to curb healthcare spending growth.

Last year, information was presented by Amy Kinner, OnPoint Director of Health Analytics about its Washington State All-Payer Health Care Claims Database (WA-APCD) Study of Cost-Growth Drivers *(See attached meeting agenda and materials).* The purpose of that work is to use the WA-APCD to identify healthcare cost trends and drivers. There are several conclusions that can be drawn regarding cost trends and cost drivers between 2017 and 2021.

- Commercial *(including exchange)* healthcare spend represents about half of the total healthcare spend in Washington State; commercial hospital spend represents about half of that.
- Medicare and Medicaid and other non-commercial healthcare spend makes up the other half of Washington healthcare spend. Since these programs pay for healthcare services utilizing non-negotiated fee schedules and inflators, **the largest portion of Washington State healthcare spend will not be impacted by any of the new areas of focus described below**.
- Increases in other factors -- **not increases in the amounts negotiated by hospitals** -- make up the largest portion of the increase in healthcare costs across all programs.
- When considering increases in overall commercial hospital healthcare spend over the four-year period, the average annual cost increases attributed to hospital allowed spend **was 1.9%,** or less than 8% for all four years. **This is the percentage of the increase in hospital spend that is negotiated and might be impacted by the topics that this committee is now being asked to focus on which is well below reasonable CPI increases especially in recent years.**

Phase II is described as follows:



Despite these analyses, the rhetoric and direction of the HCCTB is that the focus needs to be primarily on hospital spend since it is the key driver of increases in cost (*undisputed since it represents the costs of providing care to the sickest patients who utilize the most healthcare resources)* and that hospital outpatient services are driving the cost of care *(no context about shifts from inpatient to outpatient which lowers the cost of care, nor information provided about combined costs).*

The request for feedback from the Advisory Committee states that "there is no easy solution for addressing rising health care costs in Washington State, these strategies were decided through a voting process at the Cost Board Retreat on February 9th as potential policy recommendations that may lead to the biggest impact at reducing health care cost growth and addressing price transparency—the Board's primary objective as directed by House Bill 2407."

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

How can policy recommendations for these topics lead to the "biggest impact at reducing healthcare cost growth" when, at best, they will primarily only impact the commercial allowed portion of hospital spend increases (not utilization or other factors)?

There should be concern that the true cost drivers of healthcare spend increases (i.e. increases in utilization, pharmacy spend, administrative burden and increase in utilization for other non-commercial programs such as Medicare and Medicaid etc.) will not be the focus of either this Advisory Committee or the HCCTB.

The complexity of our current environment encumbers all providers, patients, and health systems with unnecessary administrative burden, waste and time delays. It is well documented that one of the most significant areas for saving is in administration which approaches $1 trillion a year nationally across providers, payers, etc.[1] Why is this not a focus topic?

My general comments related to the recently issued *Healthcare Affordability Report* that drove the voting process in the recent HCCTB Retreat are as follows:

- Provider rate setting and price growth caps - Why should this be a focus area when it has been determined in Phase I that hospital commercial negotiations are not a key driver of healthcare spend? Hospital allowed spend increased by less than 2% on average over the four years which was a fraction of the actual hospital cost of inflation during that time.
- Mergers and acquisitions - Are there potential mergers / acquisition that are going to significantly impact cost of healthcare in the future? For the record, most merger and acquisitions occur because the acquired entities are no longer financially sustainable on their own.
- Anti-competitive clauses and other contract language issues. Are there recent examples of this contract language in Washington State that can be redacted and shared? Is there an assumption that the referenced language issues (based on activities in other states such as CA) are in fact occurring in Washington State and driving increases in healthcare spend?
- The low hospital spend increase demonstrates that these issues (price increases, mergers and acquisitions and anti-competitive language) did not create an unreasonable hospital spend increase.

[1] Universal Health Care Commission Meeting Materials, February 2, 2024, tab 8, McKinsey & Co, How to save a quarter-trillion dollars in health care, February 2, 2024 https://www.hca.wa.gov/assets/program/uhcc-meeting-materials-20240202.pdf

VMFH is not the only healthcare system that engages in value based initiatives. We have deployed an Ambulatory Quality and Population Health team whose sole focus is to improve quality performance and reduce unnecessary utilization for our patients. What this means is that we (along with other hospital systems) have teams of employees that work to reduce our own revenue stream. These activities are population focused, payer agnostic and therefore include all patients regardless of the source of payment. VMFH actively participates in over 50 value based programs for over 300,000 patients, including the CMS Medicare Shared Savings Program (MSSP) which has generated $86 Million dollars in total savings over the past five years, managing over 60,000 Medicare beneficiaries. VMFH also owns and administers the Puget Sound High Value Network (PSHVN), a Clinically Integrated Network which currently manages over 50,000 lives through a contract with the HCA for the Public Employees Benefits Board (PEBB) and the School Employees Benefits Board (SEBB). For this program alone, PSHVN generated $40 Million in total savings during the three year period, 2020-2022. VMFH would be happy to share more information about our many population health initiatives that provide real value to the residents of Washington State. We also encourage you to reach out to other healthcare systems to learn more about the great work that is being done by healthcare systems like ours to reduce healthcare spend.

I respectfully ask that this information be shared with the HCCTB.

Christa Able

Thank you for attending the Health Care Cost Transparency Board Meeting

Washington State Health Care Authority

Appendix

Analytic Support Initiative Preliminary Disease Expenditures Report

Version 6.0
May 9, 2024

Contents

About the Analytic Support Initiative

The Analytic Support Initiative (ASI) is a collaborative effort between the Washington State Health Care Authority (HCA) and the Institute for Health Metrics and Evaluation (IHME), supported by a grant from the Peterson Center on Healthcare and Gates Ventures. The primary goal of the ASI is to address the unsustainable rise in health care spending by providing policymakers with timely, actionable data and research to enhance access to quality, affordable care for Washington residents.

The ASI benefits from combining the HCA's in-house expertise in health care spending, state data, and policy with IHME's analytic capabilities. This partnership builds on Washington's existing efforts to improve health care affordability and transparency through the Health Care Cost Transparency Board (Cost Board). The Cost Board, comprised of public and private purchasers and health care experts, aims to analyze total health care expenditures, identify drivers of cost growth, establish benchmark growth rates, and pinpoint providers and payers exceeding the benchmark.

The ASI's contributions are intended to complement several other data initiatives supporting the Cost Board. These include setting and measuring performance against the cost growth benchmark, the cost drivers analysis, the primary care spending analysis, hospital cost and profit analysis, and the overall consumer and affordability initiative. The value add of the ASI is its analysis of the Washington All-Payer Claims Database, ability to complete county-level analyses, and ability to tie underlying disease prevalence to spending estimates.

Figure 1: Data initiatives supporting the Washington Health Care Cost Transparency Board

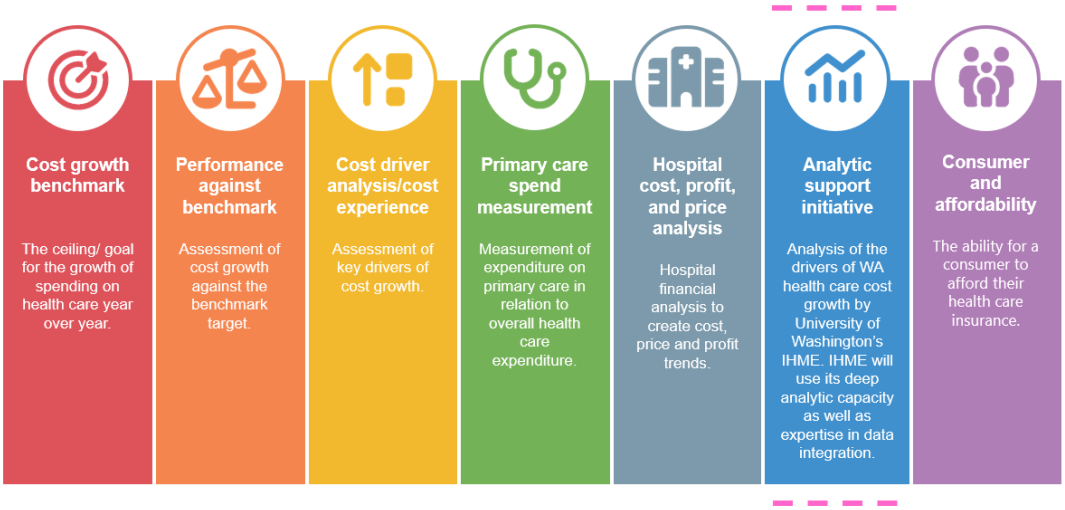


Figure source: The Washington Health Care Authority

About this report

This report is a product of the ASI for the Cost Board. It assesses health care spending with stratification by geography, health condition, and type of care at a granular level while controlling for key demographic and epidemiological trends. The analytics that support this report are from previous research conducted by the Institute for Health Metrics and Evaluation for the Disease Expenditure Project (DEX). These existing estimates are being leveraged to (a) provide information about health care spending to the Cost Board, and (b) to facilitate Cost Board discussion regarding the type of future analysis that the ASI can complete. The ASI will provide materials to the Cost Board in an iterative fashion.

This initial report was developed for, presented to, and edited based on feedback from ASI's key advisors and the Cost Board during the first half of 2024. An updated version of this report will be available to the Cost Board in late 2024. That report will be built from the Washington All-Payer Claims Database extending through at least 2022. Future analyses will address trends over time, quantify attributable drivers of health care spending, and explore factors associated with key drivers of spending growth.

Data Source and Methods

The IHME Disease Expenditure (DEX) Project generates estimates of health care spending and encounters for each US county for 2010-2019 stratified by age, sex, type of care, payer, and health condition. These estimates are generated using a four-step process. The first step entails collecting and harmonizing data from various sources, including 45 billion insurance claims billed to Medicare, Medicaid, and private insurance companies (including data from Health Care Cost Institute, Kythera, Fluent, and Marketscan). In Washington, 552 million claims and 33 million administrative records were used for 2010 through 2019 to inform these estimates. The DEX project also uses hospital administrative data, from the Healthcare Cost and Utilization Project, and survey data from the Medical Expenditure Panel Survey. The second step of the DEX project involves assigning each claim or encounter to one of 148 health conditions, while the third step focuses on adjusting for data imperfections, such as reallocating spending for comorbidities that increase costs. Additionally, a small area model is employed to estimate utilization and spending in geographic areas with limited input data. In the fourth step, the estimates are scaled to ensure internal consistency across county, state, and national levels, and alignment with official U.S. government estimates of health care spending.

Estimates produced for the DEX project include spending on seven types of care – ambulatory care, hospital inpatient care, retail prescribed pharmaceutical, nursing facility care, home health care, emergency department care, and dental care – from four payers – private insurance, Medicare, Medicaid, and out-of-pocket spending. Spending on over-the-counter drugs, durable medical equipment, public health, and from Tri-care, Indian Health Services, and Veterans Affairs are excluded. These estimates include medical, dental, and prescribed pharmaceutical spending estimates. For prescribed retail pharmaceuticals, we track spending paid by the patient or third-party payers (i.e. insurance companies) prior to any rebates or discounts being provided. Finally, the disease-specific spending estimates highlighted in this report are spending that has been attributed to each health condition. It is not based merely on the primary diagnosis, but rather when a health condition is a secondary diagnosis but leads to excess spending on the primary diagnosis, that excess spending is attributed to the secondary diagnosis.

Unless otherwise indicated, all estimates in this report are extracted from the existing IHME DEX project database. The second report of the ASI will include additional Washington-specific data and custom analytics for the Cost Board.

In this report, all estimates are reported in nominal currency, meaning they are not adjusted for inflation. Age-standardization is conducted using direct age-standardization, relative to the 2019 national or Washington age-profile. Rates of change are all annualized, so they are comparable across different length time periods. Decomposition of variation or change across time was calculated using demographic decomposition methods based on Das Gupta (1993).

Executive Summary

This report provides an analysis of health care spending in Washington state from 2010-2019 based on the Institute for Health Metric and Evaluation's DEX Project. In 2019, the DEX project assessed $51.2 billion of health care spending in Washington, which amounted to $6,715 per person. (See Data Source and Methods section above regarding what is specifically included and excluded from this estimate.) This is 7% less than the DEX project's estimate of national spending per person, which is $7,201. Across the 50 states and the District of Columbia, Washington was the state with the 16th lowest spending per person. However, when age-standardized to account for the state's younger population, Washington's spending per person positioned it as the 18th lowest state. The findings outlined in the remainder of this report substantiate and build upon the results from other analytic efforts by the Health Care Cost Transparency Board.

- Between 2010 and 2019, total per person spending increased to $6,715
- The specific health conditions with the greatest increase in spending included oral disorders, type 2 diabetes, joint pain, skin and subcutaneous diseases, and lower back and neck pain
- Ambulatory care was the spending category with the greatest spending increase, growing by $7.0 billion between 2010 and 2019

The DEX project showed that ambulatory care, which includes all outpatient care regardless of whether it is provided in a hospital, clinic, or surgical or rehabilitation center, emerged as the dominant category, constituting 48% of the total spending, amounting to $24.6 billion. The report highlights the significant role of private insurance, contributing 46% of total spending, with the majority allocated to ambulatory and inpatient care. The DEX project estimated that out-of-pocket spending reached $5.7 billion in 2019, covering expenses like deductibles and co-pays.

The DEX project estimated that between 2010 and 2019, Washington had an overall spending increase of $17.1 billion, reaching $51.2 billion. Even after adjusting for population size increases, health care spending increased above and beyond the inflation rate. Ambulatory care witnessed the most substantial increase, fueled by population growth, an aging population, and higher spending per visit. Hospital inpatient care also saw significant growth, mainly attributed to increased spending per admission.

The report further delves into spending variations based on health conditions, with the DEX project identifying oral disorders[1], type 2 diabetes, joint pain, skin and subcutaneous diseases, and lower back and neck pain as the top five conditions with the highest attributable spending[2]. Notably, joint pain exhibited a substantially higher annualized growth rate compared to other top conditions.

[1] This report includes medical spending on dental care as well as dental care spending (i.e. spending through dental insurance). The category of oral disorders includes treatment of dental carries, dental surgery, and orthodontia, among other categories associated with non-preventative dental treatments.

[2] Attributable spending is spending that has been attributed to a health condition. In this research we reallocate spending on a claim to the health condition determining the amount of spending. When a comorbidity (a co-occurring disease that isn't the primary diagnosis) exacerbates spending the excess spending is attributed to the comorbidity, not the primary diagnosis.

Furthermore, the analysis explores spending variations within Washington, showcasing significant disparities across counties. The DEX project showed that Columbia, Garfield, and Pacific counties exhibited the highest spending per person, while Franklin, Whitman, and Adams counties demonstrated the lowest. The report provides a detailed breakdown of spending differences, highlighting the drivers of spending changes and offering valuable insights into the dynamics of health care expenditures at both the state and county levels.

This report highlights the role prices play in driving increases in health care spending in Washington and supports the call for many of the policies being considered by the Washington Health Care Cost Transparency Board, including price growth caps and provider rate setting, restricting anti-competitive clauses in health care contracting, review of mergers and acquisitions, and limits on facility fees in some areas.

Background

One of the initial and explicitly legislated tasks of the Cost Board was to establish total health spending growth targets. These targets are meant to be a goal for individual payers and providers to aim for and in later years the Cost Board will hold payers and providers accountable for reaching these targets. The benchmark growth targets established by the Cost Board range from 3.2% to 2.8% (Figure 1). These are growth targets for total aggregate expenditure on health, including claims-based and non-claims-based expenditures.

Figure 1: Washington State benchmark growth targets

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%

Source: Washington Health Care Authority

In late 2023, the Washington Health Care Authority provided a first report against these state benchmarks. The report showed that the total health care spending in Washington increased by 7.2% from 2017 to 2018, and 5.8% from 2018 to 2019. The reports also showed that when measured in terms of per member per year, growth was slowest for Medicare spending (2.9% per year in 2019), higher for private insurance (4.0%), and highest for Medicaid (11.9% in 2019), reflecting legislative investments in that program.

Findings from the DEX project, outlined in the remainder of this report, substantiate, and build upon the findings from HCA's report. Using different data sources and measuring slightly different quantities (the DEX project includes nursing facility care and out-of-pocket spending), the DEX project comes to many of the same conclusions but provides increased granularity by also assessing spending by age, health condition, and county.

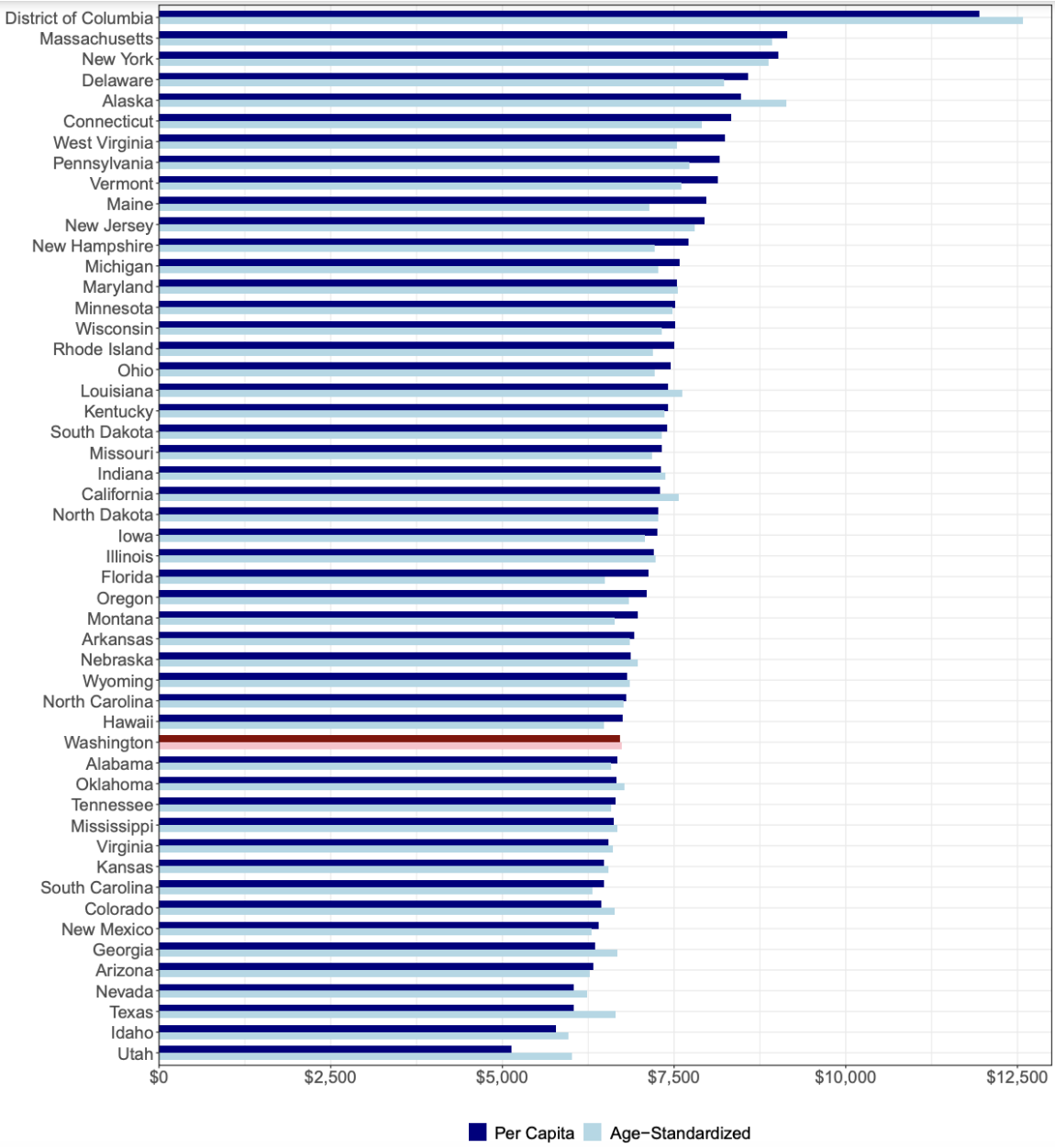
Health care spending in Washington state in 2019

In 2019, the DEX project estimated $51.2 billion was spent on health across seven types of care -- hospital inpatient care, ambulatory care, emergency department care, pharmaceuticals, nursing facility care, home care, and dental care – in Washington.[3] This was $6,715 per person. During the same year, the DEX project estimated that national spending on the same types of care was $7,201 per person on the same types of care. Across the 50 states and the District of Columbia, Washington was 16th least and less than California, Oregon, and Montana. Washington has a relatively young population. Since spending increases with age,

[3] Excluded from this analysis is spending on durable medical equipment, over-the-counter drugs, R&D and other investments, and spending on public health.

a fairer state comparison uses age-standardized spending per person. Age-standardized spending reports what spending in the state would be if Washington had the same age profile as the US as whole. Once age-standardized, Washington has the 18th lowest spending amount across the US (Figure 2).

Figure 2: Health care spending per person, 2019

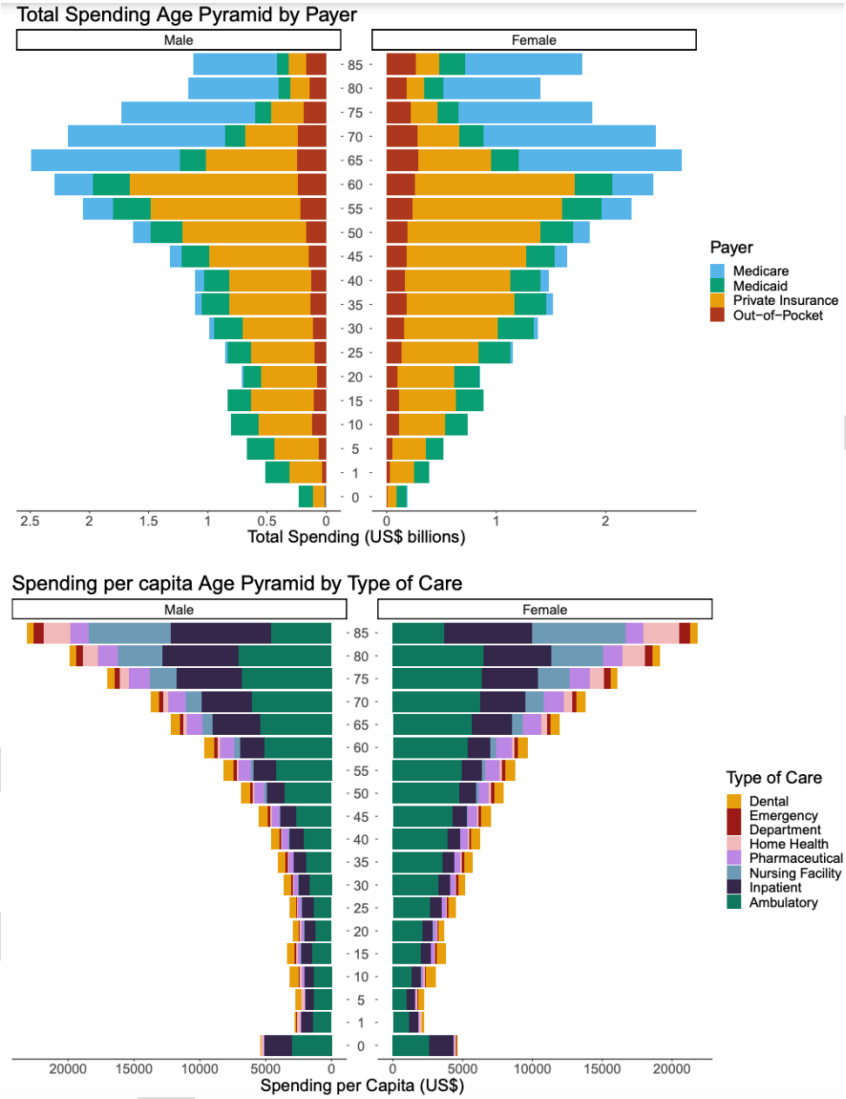


Source: The DEX Project

Like it is in all US States, health care spending is greater for individuals as they age, with the DEX project showing that spending per person in Washington state reached $23,115 per year for males 85 and older and $21,809 for females 85 years and older (Figure 3). At the oldest age group, the most spending is on nursing facility care and ambulatory care, with a great amount of spending on hospital inpatient care as well. Despite spending going up with age, there is more spending in Washington on 60- to 64-year-olds

than any other age group. While there are fewer people in the oldest age groups, it is also true that there is a dramatic shift in spending at 65 from spending on private insurance, which tends to have higher prices, to Medicare, which has lower prices.

Figure 3: Health care spending and spending per person by age, 2019



Source: The DEX Project

Across the seven types of care analyzed, the DEX project reports that more was spent on ambulatory care than any other type of care -- $24.6 billion in 2019. This is 48% of the spending considered in this study. The type of care with the second most spending was hospital inpatient care, which has $11.5 billion or 22% of the total. The DEX project shows that more than $4 billion was spent on both prescribed retail pharmaceutical[4] and on dental care. $3.2 billion was spent on nursing facility care, while less than $2 billion

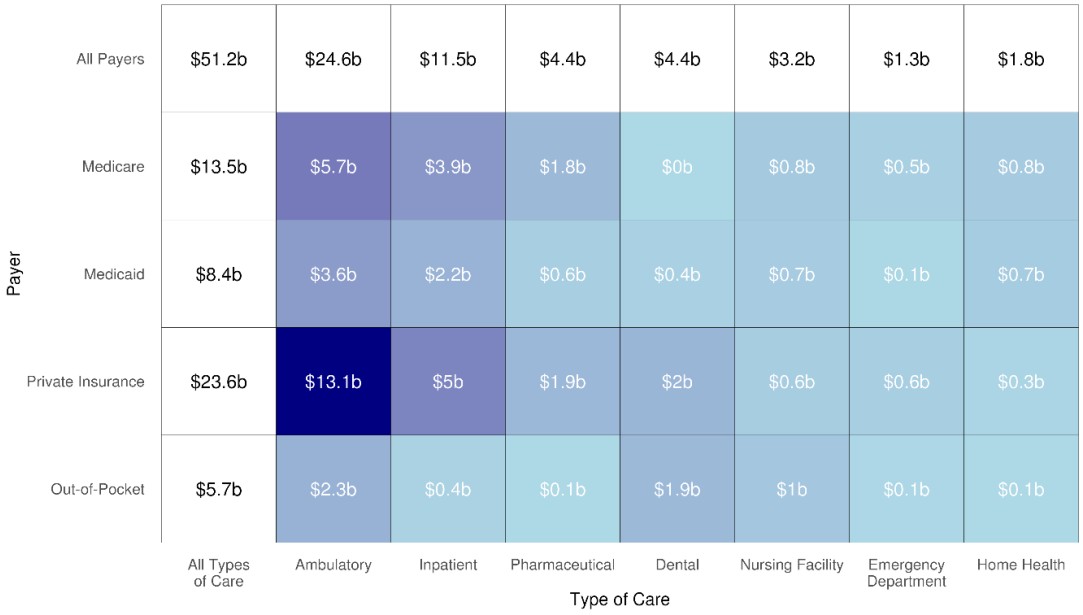
[4] Prescribed pharmaceuticals administered in a facility such as a hospital or clinic are included in other types of care, such as hospital inpatient care and ambulatory care, respectively. They reflect what was paid for the drugs and do not include pharmaceutical rebates or discounts.

was spent on emergency department care and home health care (Figure 4). Across the payers included in the DEX project,[5] nearly half of the spending was from private insurance companies -- $23.6 billion or 46%. Most of this spending was on ambulatory care (56%) and inpatient care (21%). $13.5 billion or 26% of the spending was from Medicare, with the most spending on ambulatory care, but a relatively large share on hospital inpatient care as well.

The DEX project tracked $8.4 billion in Medicaid spending, which was 16% of the total. Like Medicare, ambulatory care was the type of care with the most spending, but relative to private insurance, a great deal was spent on hospital inpatient care, and relative to all other payers, a large share of spending was on nursing facility care. Finally, $5.7 billion was spent out-of-pocket. This includes spending on deductibles and co-pays, and by those without insurance. While more out-of-pocket spending was on ambulatory care than any other type of care, there were relatively large amounts of spending on dental care and nursing facility care.

While the payer category with the most spending in Washington was private insurance, Medicare spending per beneficiary was much larger in all types of care than for any other payer category (Figure 5).[6] Medicare spending was $10,498 per beneficiary, while Medicaid spending was $5,319 per beneficiary and private insurance spending per beneficiary was only $4,659.

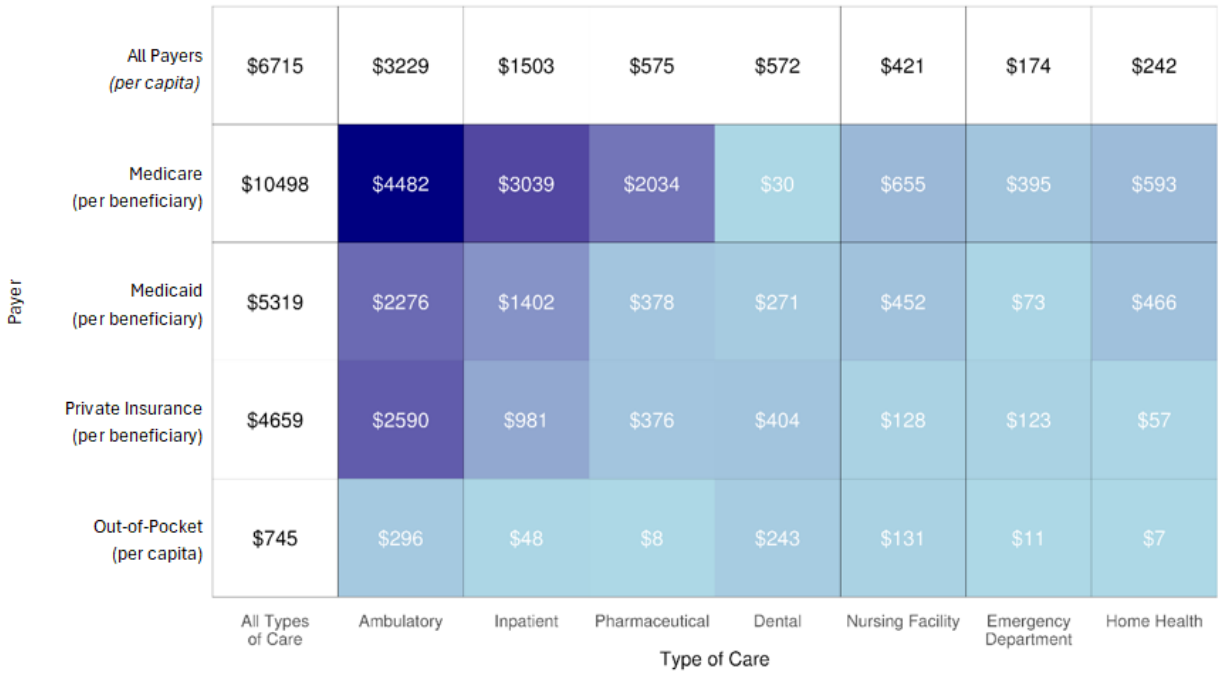
Figure 4: Total spending by payer and type of care, 2019



Source: The DEX Project

Figure 5: Spending per beneficiary by payer and type of care, 2019 -- Medicare, Medicaid, and private insurance per beneficiary, out-of-pocket spending is reported in per person terms.

[5] Spending from Veterans' Affairs, Tri-care, and Indian Health Services were omitted because of insufficient data.
[6] While Figure 3 reports Medicare, Medicaid, and private insurance per beneficiary, out-of-pocket spending is reported in per person terms.

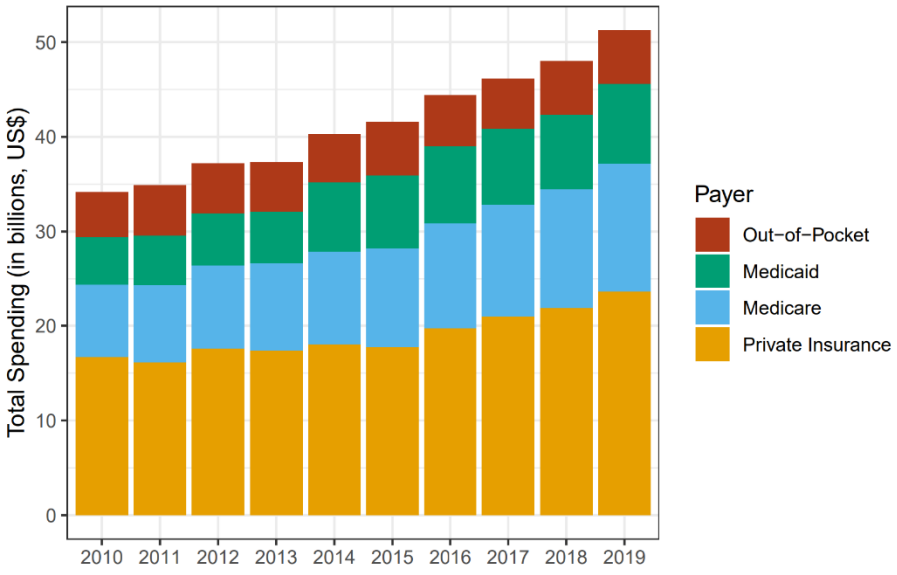


Source: The DEX Project

Changes in health care spending in Washington state; 2010-2019

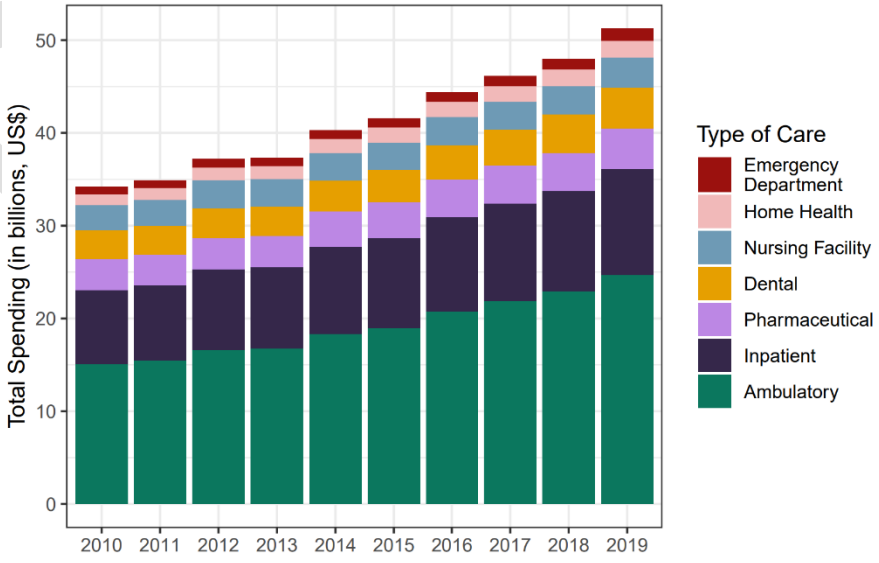
The DEX project estimated that from 2010 to 2019, spending steadily increased with overall growth of $17.1 billion, from $34.1 billion in spending to $51.2 billion (Figure 6). During this time, private insurance spending decreased from 49% of the total to 46%, and Medicare spending increased from 23% to 26% and Medicaid spending increased from 14% to 16%. Spending on all types of care increased (Figure 7).

Figure 6: Total spending in Washington by payer, 2010-2019



Source: The DEX Project

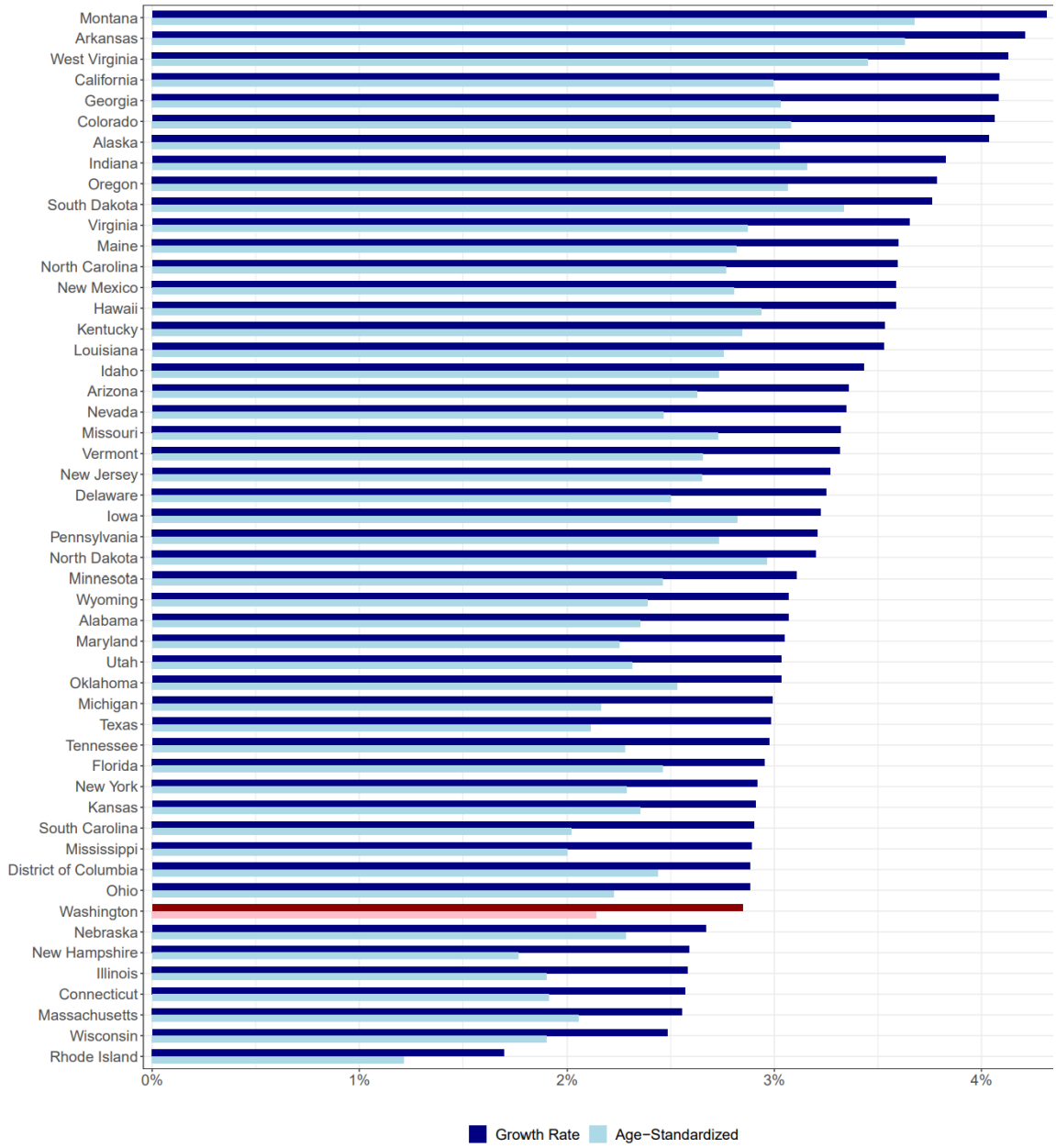
Figure 7: Total spending in Washington by type of care, 2010-2019



Source: The DEX Project

The DEX project estimated spending in Washington increased between 2010 and 2019 at an annualized rate of 2.8% (Figure 8). During this same period, the US increased at an annualized rate of 3.2%. Of the 50 states and the District of Columbia, Washington had the eighth smallest growth rate.

Figure 8: Comparison of raw and age-standardized growth rates of per person spending

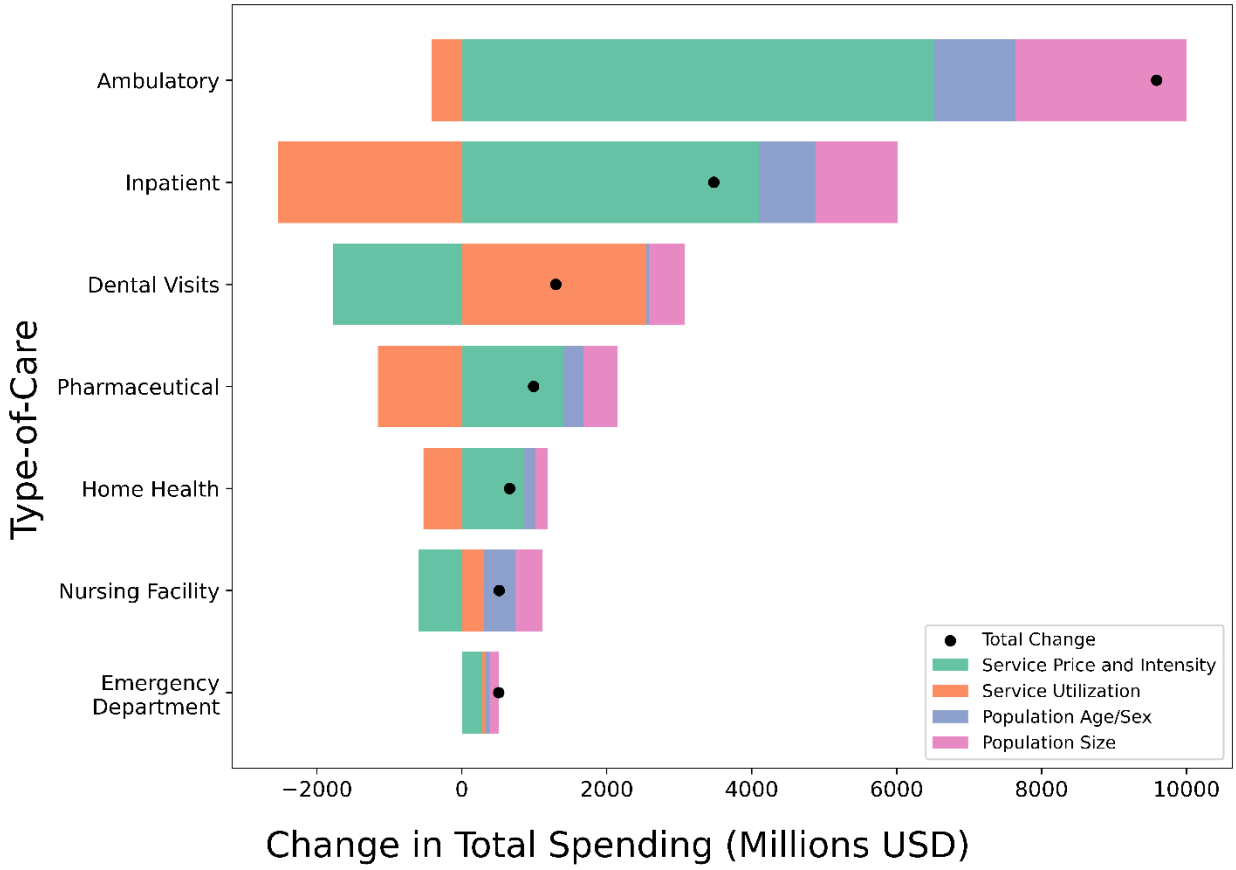


Source: The DEX Project

The $17.1 billion increase in spending in Washington between 2010 and 2019 can be broken apart to assess which underlying factors led to more spending (Figure 9). The DEX project shows that the type of care that had the greatest increase was ambulatory care, which increased $9.6 billion in annual spending. This increase was driven by three factors – growing population (pink), aging population (blue), and higher ambulatory care spending per visit (green). Higher spending per visit suggests that the price of care or

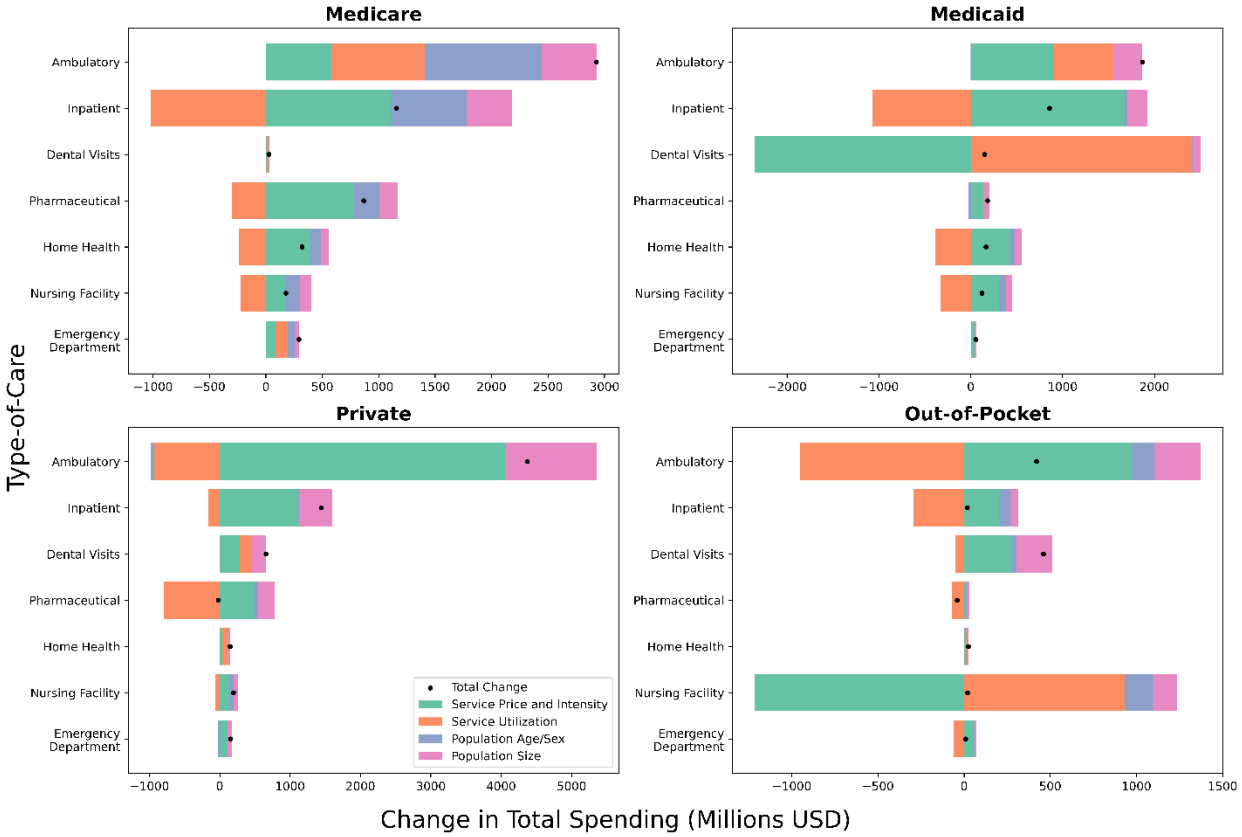
intensity of care (or both) increased throughout this time. Interestingly, there were fewer ambulatory care visits per person in 2019 than in 2010, leading to a reduction in ambulatory care spending (orange). The DEX project also shows that hospital inpatient care also increased a great deal – $3.5 billion increase in annual spending between 2010 and 2019. This increase was also driven partly by a larger and older population, but to a greater extent was driven by higher spending per admission. Admission per prevalent case decreased between 2010 and 2019 leading to a $2.54 billion decrease in spending, but that decrease was more than made up for by the $4.10 billion spending increase attributed to the increase in price and intensity of care. Across all types of care except emergency department spending, prices and intensity of care went up, while utilization of services went up only in dental care and emergency department care, and marginally in ambulatory care.

Figure 9: Drivers of spending change for Washington State, 2010-2019



Source: The DEX Project

Figure 10: Drivers of spending change for each payer in Washington, 2010 to 2019



Source: The DEX Project

When broken down by payer, it is clear that changes in utilization were generally offset by changes in price and intensity of care. For most payer and types of care (all except Medicare ambulatory care, Medicaid ambulatory and dental care, private insurance spending on dental care, and out-of-pocket spending on nursing facility care), there were reductions in utilization (after adjusting for age and sex of the population). The aging population influenced Medicare spending but did not have much of an effect on the other payers. Increases in price and intensity of care had an especially large effect on ambulatory and inpatient care (Figure 10).

Health care spending by health condition in Washington

Of the 148 health conditions analyzed in the DEX project, oral disorders ($3.05 billion); type 2 diabetes ($2.18 billion); skin and subcutaneous diseases, which includes all dermatology ($1.53 billion); joint pain ($2.74 billion); and lower back and neck pain ($1.68 billion) had the largest amounts in total spending in 2019 (Table 1). Oral disorders, which includes dental carries, oral surgery, and orthodontia, were mostly paid for out-of-pocket (55.8%) and by private insurance (40.1%). On the other hand, type 2 diabetes, which had nearly 54% of the spending on patients older than 65 years old was mostly paid for by Medicare (36.9%). Skin and subcutaneous disorders had 51.6% of the spending focused on ambulatory care with 48.3% of the spending coming from private insurance.

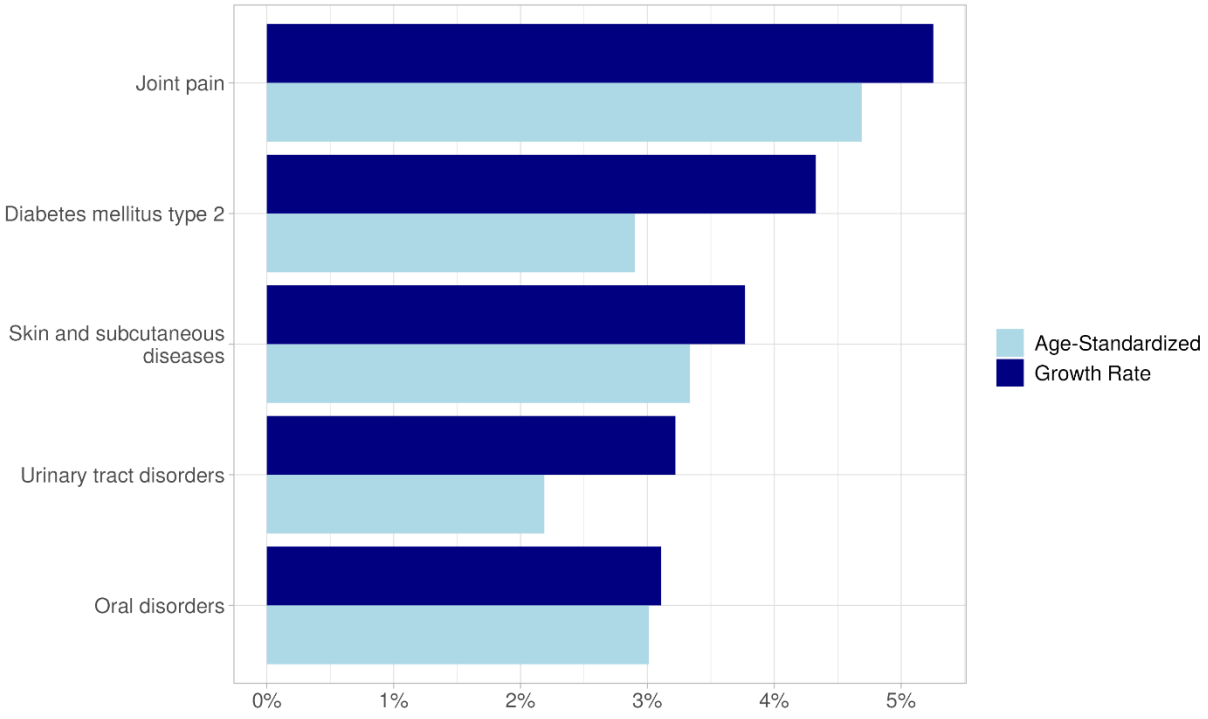
Table 1: Estimated health care spending in 2019 for the 47 most expensive health conditions of the 144 health conditions analyzed

Cause	Total Spending (billions)	Growth Rate	Age-Standardized Growth Rate	Under 20	Over 65	Inpatient	Ambulatory	Pharmaceutical	Nursing Facility	Medicare	Medicaid	Private Insurance	Out-of-Pocket
Oral disorders	$3.05	3.1%	3.0%	17.0%	18.4%	0.7%	1.9%	0.1%	0.0%	1.2%	2.9%	40.1%	55.8%
Joint pain	$2.74	5.3%	4.7%	8.8%	29.6%	9.1%	78.2%	6.7%	2.7%	22.7%	8.9%	58.7%	9.7%
Diabetes mellitus type 2	$2.18	4.3%	2.9%	0.1%	53.6%	9.6%	42.1%	23.0%	18.7%	36.9%	14.2%	36.9%	12.0%
Lower back and neck pain	$1.68	2.0%	1.6%	1.9%	34.2%	16.6%	75.5%	1.3%	2.0%	25.8%	7.1%	56.7%	10.5%
Skin and subcutaneous diseases	$1.53	3.8%	3.3%	12.5%	32.0%	16.9%	51.6%	23.7%	1.8%	27.4%	16.8%	48.3%	7.4%
Urinary tract disorders	$1.51	3.2%	2.2%	6.7%	48.7%	18.4%	60.9%	5.0%	5.8%	35.5%	16.9%	38.8%	8.7%
Ischemic heart disease	$1.48	2.6%	1.1%	0.1%	65.5%	45.8%	34.1%	3.4%	9.1%	43.9%	10.4%	37.6%	8.2%
Well dental	$1.40	4.8%	4.8%	28.5%	13.2%	0.0%	0.0%	0.0%	0.0%	0.8%	25.9%	62.0%	11.3%
Heart Failure	$1.30	6.5%	4.7%	0.3%	80.8%	49.6%	7.0%	0.8%	34.7%	54.2%	14.2%	15.8%	15.9%
Anxiety disorders	$1.25	9.1%	9.1%	26.0%	9.3%	7.2%	78.1%	4.1%	5.4%	8.2%	33.4%	49.7%	8.7%
Gynecological diseases	$1.21	3.2%	3.5%	4.0%	7.1%	3.7%	91.2%	2.9%	0.0%	6.5%	10.1%	73.3%	10.1%
Benign and in situ neoplasms	$1.09	3.5%	2.8%	3.7%	34.6%	9.1%	86.1%	4.0%	0.2%	25.6%	4.8%	59.6%	10.0%
Alzheimer's disease and other dementias	$1.01	2.1%	1.1%	0.0%	94.6%	12.8%	6.6%	0.9%	69.1%	39.8%	24.5%	8.5%	27.2%
Acute renal failure	$0.98	5.4%	4.0%	0.9%	46.3%	34.3%	61.5%	1.2%	0.8%	40.9%	32.4%	21.6%	5.1%
Upper digestive system diseases	$0.95	2.3%	1.4%	6.3%	45.3%	26.7%	46.2%	3.6%	15.6%	32.9%	17.5%	38.9%	10.7%
Osteoarthritis	$0.94	4.5%	3.1%	0.0%	60.8%	44.4%	39.3%	1.4%	10.1%	34.0%	6.4%	49.7%	10.0%
Endocrine, metabolic, blood, and immune disorders	$0.93	3.3%	2.5%	10.8%	43.2%	22.1%	32.1%	22.8%	16.4%	29.6%	16.4%	45.1%	8.9%
Breast cancer	$0.93	6.4%	5.6%	0.0%	32.3%	2.2%	89.2%	7.9%	0.3%	26.8%	5.9%	62.7%	4.6%
Depressive disorders	$0.91	5.1%	4.9%	21.6%	15.7%	25.8%	57.7%	7.3%	2.9%	14.7%	30.1%	49.0%	6.1%
Falls	$0.90	4.4%	3.6%	9.7%	55.7%	36.4%	31.4%	0.1%	16.4%	33.2%	10.7%	43.1%	13.0%
Lower respiratory infections	$0.75	3.4%	2.9%	24.6%	38.6%	68.1%	21.5%	2.1%	2.0%	31.2%	20.8%	42.7%	5.2%
Blindness and vision loss	$0.74	4.2%	2.4%	4.5%	71.0%	2.2%	92.0%	2.7%	1.4%	52.2%	7.4%	30.1%	10.4%
Well person	$0.74	4.8%	4.8%	34.1%	16.0%	0.0%	97.6%	0.0%	0.0%	12.6%	15.6%	68.1%	3.7%
Congenital birth defects	$0.72	2.9%	3.6%	81.8%	3.2%	40.4%	45.9%	1.4%	0.7%	3.7%	34.3%	56.3%	5.7%
Stroke	$0.72	4.0%	2.5%	1.6%	61.9%	54.8%	19.0%	0.8%	14.6%	35.9%	18.7%	36.6%	8.8%
Colon and rectum cancer	$0.68	7.7%	7.1%	0.2%	30.2%	10.0%	86.8%	1.0%	0.7%	21.0%	5.7%	67.9%	5.4%
Septicemia	$0.67	8.4%	7.2%	4.4%	50.6%	93.1%	1.5%	0.1%	2.2%	28.9%	20.0%	45.7%	5.4%
Atrial fibrillation and flutter	$0.66	4.7%	3.4%	0.0%	77.9%	26.1%	36.0%	22.1%	6.7%	57.0%	6.9%	29.3%	6.8%
Chronic kidney disease	$0.59	3.7%	2.1%	1.4%	68.9%	22.7%	59.9%	2.2%	1.3%	56.5%	19.9%	17.7%	5.9%
Other unintentional injuries	$0.53	2.5%	2.5%	24.0%	16.8%	20.4%	65.9%	2.0%	1.0%	13.4%	14.7%	62.3%	9.6%
Inflammatory bowel disease	$0.53	7.1%	7.0%	15.2%	16.1%	13.3%	55.8%	22.3%	0.5%	14.7%	9.4%	71.3%	4.6%
Treatment of hypertension	$0.51	-0.1%	-1.3%	1.0%	58.7%	0.3%	48.5%	27.2%	1.3%	48.9%	14.3%	29.5%	7.2%
Transport injuries	$0.50	3.3%	3.6%	17.6%	10.7%	56.0%	29.9%	0.0%	3.1%	6.9%	10.1%	77.1%	5.8%
Tracheal, bronchus, and lung cancer	$0.48	9.2%	7.3%	0.1%	57.0%	14.8%	76.6%	6.0%	1.2%	47.6%	6.2%	42.5%	3.7%
Asthma	$0.46	4.2%	4.0%	27.5%	22.8%	19.1%	48.6%	26.4%	0.2%	22.1%	20.1%	51.5%	6.3%
Upper respiratory infections	$0.46	1.0%	1.3%	42.7%	8.4%	2.6%	89.6%	3.2%	0.1%	6.8%	23.7%	57.6%	12.0%
Other neurological disorders	$0.44	4.1%	3.2%	4.8%	43.6%	29.7%	42.6%	15.6%	2.7%	41.1%	13.8%	39.4%	5.8%
Multiple sclerosis	$0.44	5.7%	5.6%	0.3%	17.7%	2.3%	40.2%	50.7%	3.3%	34.6%	7.4%	55.0%	3.0%
Opioid use disorders	$0.41	11.7%	11.9%	1.6%	7.9%	11.4%	74.9%	8.2%	0.7%	10.4%	70.2%	17.0%	2.3%
Chronic obstructive pulmonary disease	$0.40	3.2%	1.4%	0.4%	70.6%	32.6%	23.5%	22.4%	3.4%	57.0%	19.8%	18.1%	5.1%
Other chronic respiratory diseases	$0.40	2.9%	2.6%	14.7%	22.6%	6.8%	62.1%	11.8%	1.7%	17.0%	14.8%	55.8%	12.5%
Headache disorders	$0.34	2.4%	2.5%	9.6%	17.8%	8.4%	63.2%	6.7%	4.6%	18.4%	13.8%	57.7%	10.1%
Idiopathic epilepsy	$0.33	4.7%	4.5%	34.8%	22.1%	46.6%	18.5%	10.9%	16.2%	20.8%	28.3%	43.3%	7.6%
Pregnancy and postpartum care	$0.32	3.3%	2.9%	6.6%	0.0%	48.3%	44.9%	1.2%	0.0%	0.2%	36.9%	55.0%	7.9%
Schizophrenia	$0.32	7.4%	7.5%	3.1%	8.7%	38.4%	21.2%	16.3%	13.0%	20.8%	66.6%	11.5%	1.2%
Leukemia	$0.31	5.4%	4.8%	22.7%	36.8%	37.5%	33.2%	27.9%	0.3%	32.6%	7.8%	57.0%	2.6%
Rheumatoid arthritis	$0.31	5.6%	4.7%	1.6%	43.9%	2.5%	45.2%	48.9%	1.5%	40.5%	9.1%	47.0%	3.4%
Prostate cancer	$0.30	4.7%	2.7%	0.0%	72.9%	7.7%	70.7%	20.5%	0.4%	53.9%	2.3%	38.1%	5.7%
Multiple myeloma	$0.30	8.9%	7.0%	0.0%	58.6%	5.4%	59.5%	34.5%	0.2%	48.6%	2.9%	46.3%	2.1%
Cirrhosis and other chronic liver diseases	$0.29	5.6%	5.0%	3.3%	29.1%	47.2%	39.6%	4.1%	1.8%	26.1%	20.2%	48.0%	5.7%

Source: The DEX Project

Among the most expensive health conditions, the DEX project shows that joint pain stands out as having a larger annualized growth rate (5%), without adjusting for inflation. Type 2 diabetes, skin and subcutaneous diseases, oral disorders, and urinary tract disorders had annualized spending increase between 3% and 4.5% per year (Figure 11).

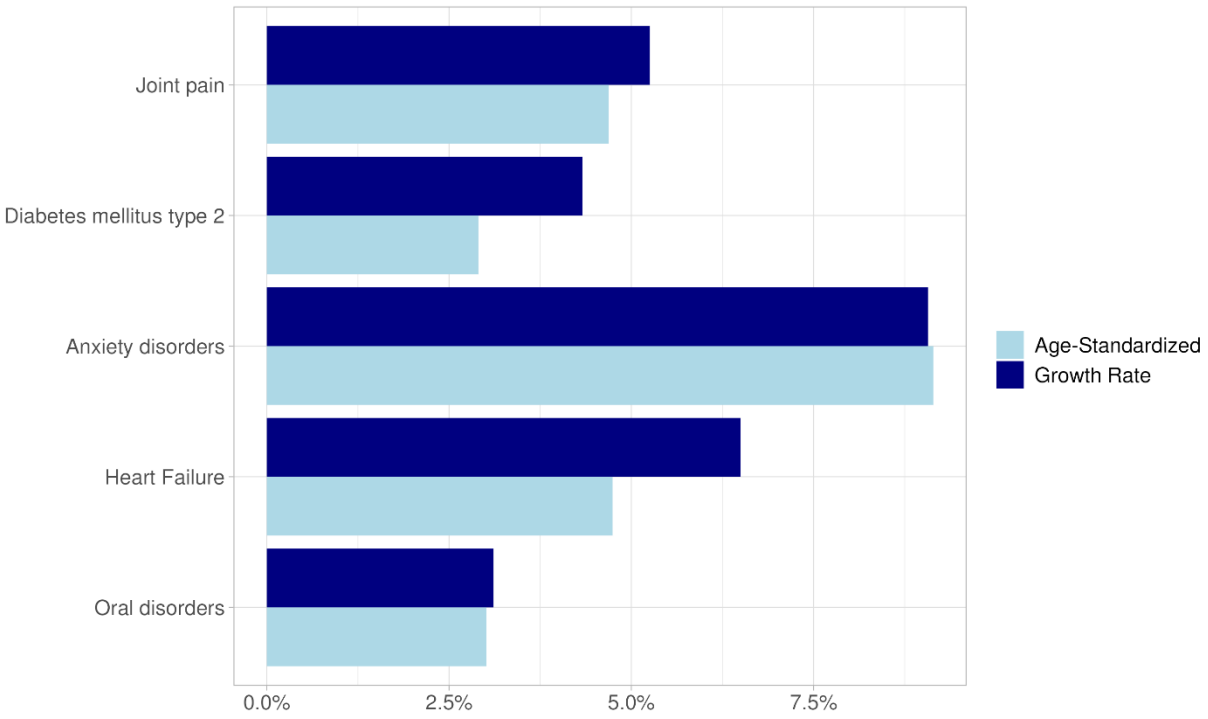
Figure 11: Growth Rates of the five highest spending health conditions in Washington, 2010-2019



Source: The DEX Project

Between 2010 and 2019, anxiety disorders, heart failure, joint pain, type 2 diabetes, and oral disorders, were the health conditions with the largest increases in annual spending (Figure 12).

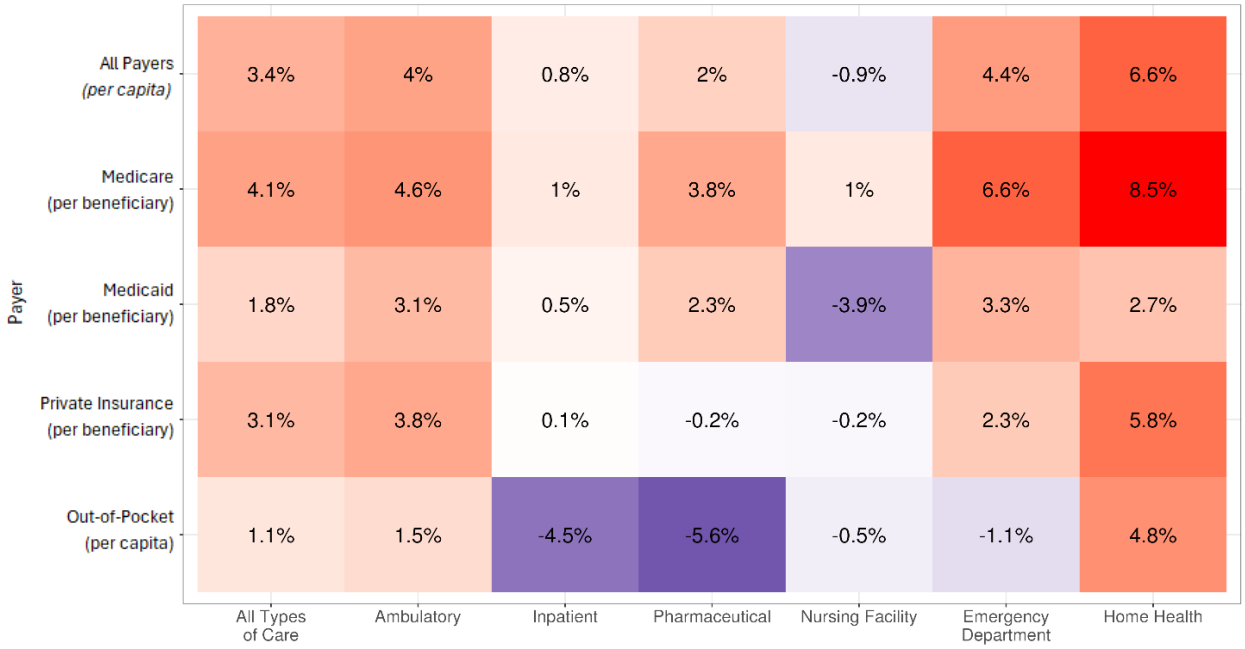
Figure 12: Growth rate of the five health conditions with the largest absolute growth since 2010



Source: The DEX Project

According to the DEX project, spending on joint pain, the health condition that increased the most between 2010 and 2019, increased especially for home health, ambulatory, and emergency department care (Figure 13). Even in 2010 so much spending was on joint pain that increases in only these types of care led to sizable increase in total spending. In absolute terms, most of the spending growth on joint pain was in ambulatory, and most of the spending increase in ambulatory care for joint pain could be attributed to increases in utilization (Figure 16).

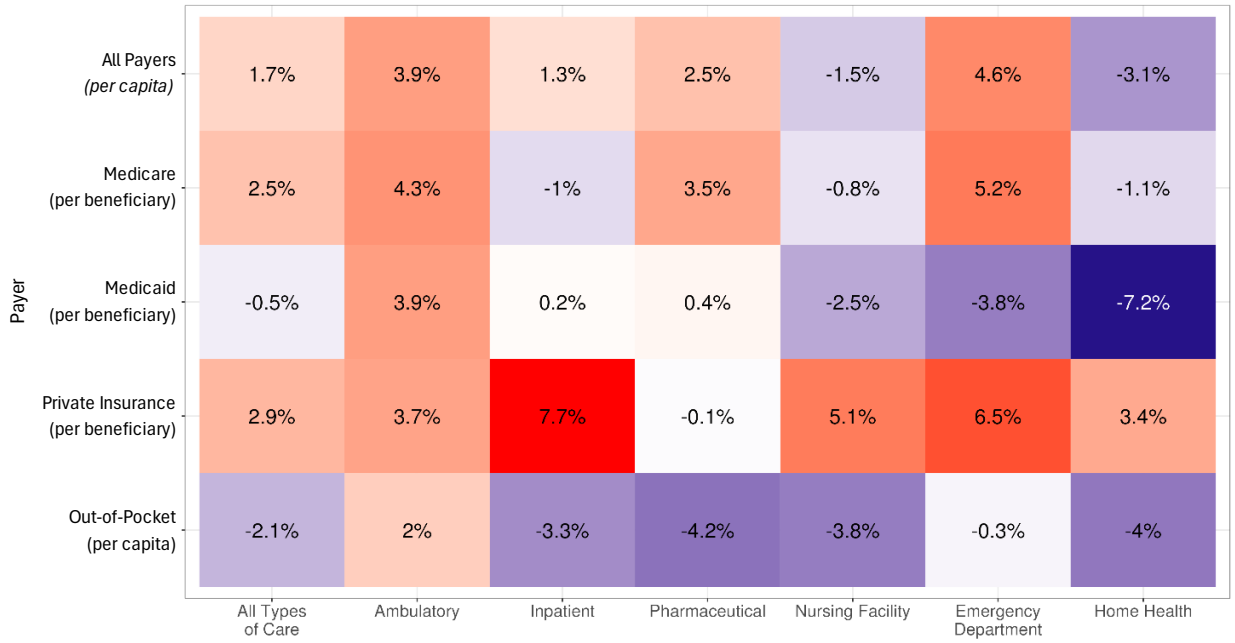
Figure 13: Age-standardized growth rate of spend per beneficiary for joint pain, 2019



Source: The DEX Project

According to the DEX project, spending on type 2 diabetes had an absolute growth of $753 million from 2010 to 2019. Private insurance payers for inpatient care saw the highest increase at 2.9% per beneficiary while Medicaid payers had the highest decrease in home health care spending at 7.2%. Across all types of care, we see a decrease in service utilization and a growth population size (Figure 16).

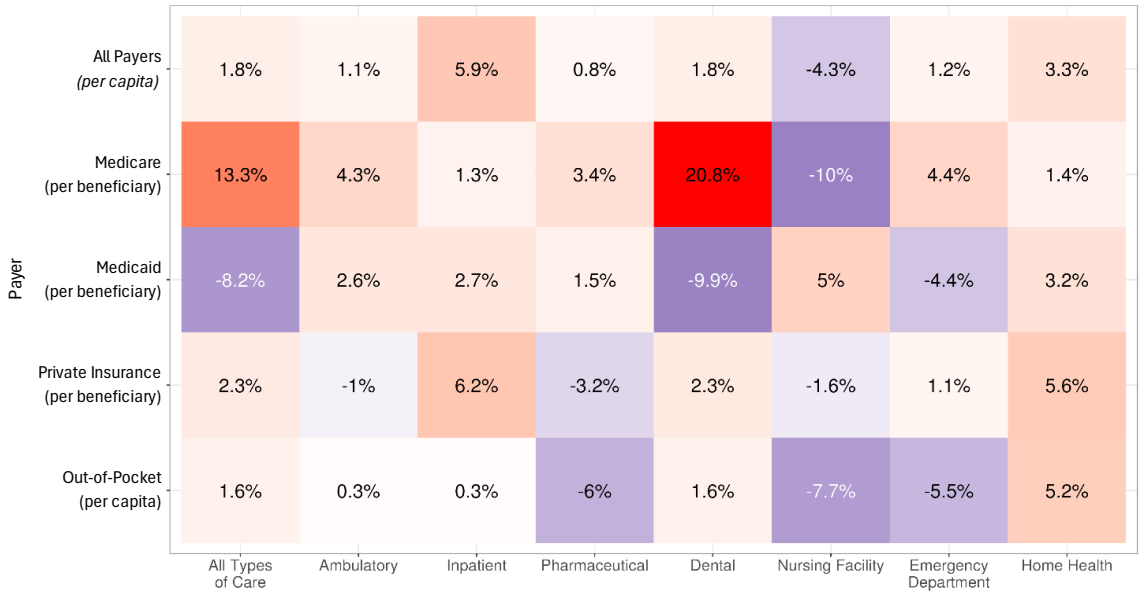
Figure 14: Age-standardized growth rate of spend per beneficiary for diabetes type 2, 2019



Source: The DEX Project

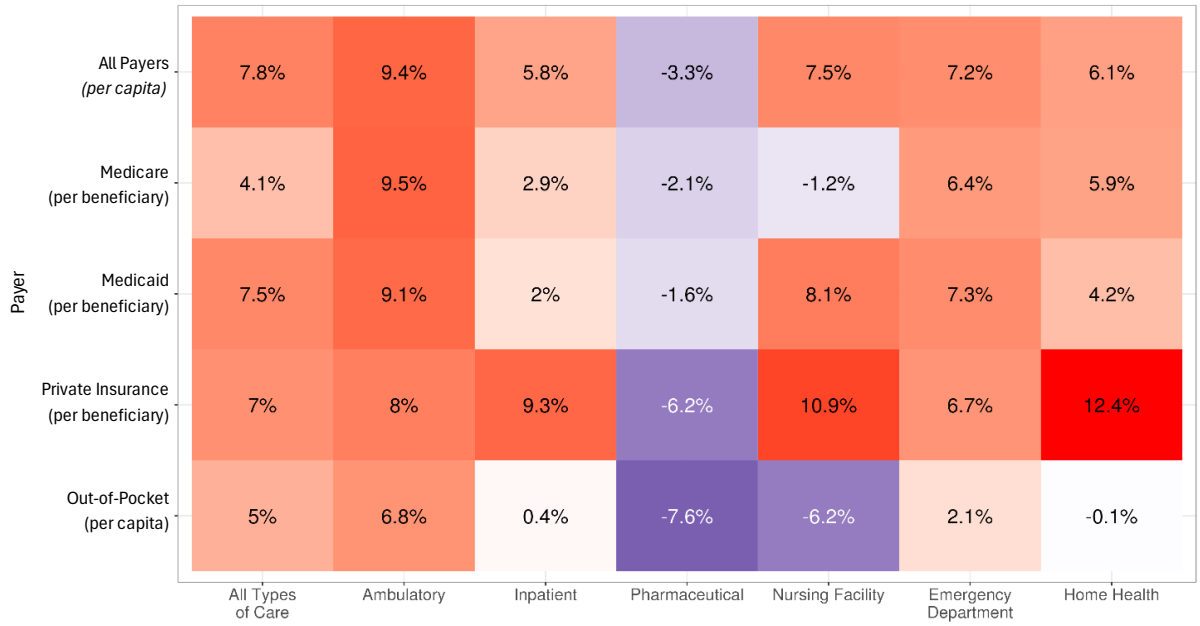
According to the DEX project, spending on oral disorders, increased especially for dental care at 20.8% with Medicare as the payer with the largest increase across all types of care at 13.3% (Figure 15). During this period, spending on nursing facility care for oral disorders decreased across all payers. In absolute terms, most of the spending growth on oral disorders was in dental care and the vast majority of the spending increase in dental care and anxiety disorders could be attributed to increases in utilization (Figure 17).

Figure 15: Age-standardized growth rate of spend per beneficiary for oral disorders, 2019



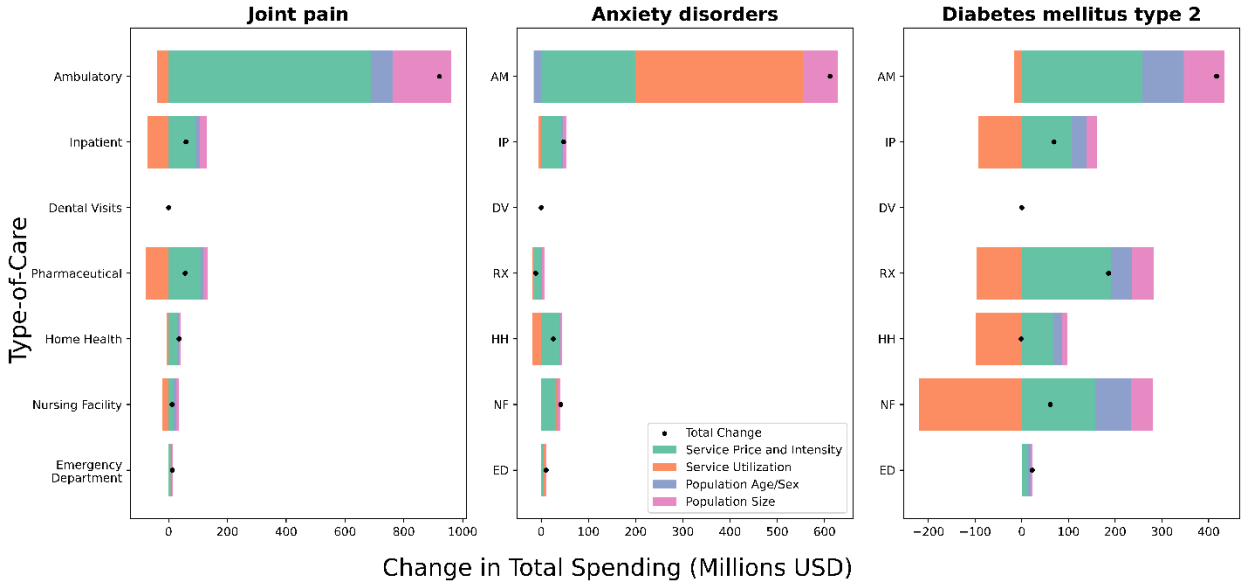
According to the DEX project, spending on anxiety disorders had an absolute growth of $725 million from 2010 to 2019. Private insurance payers for home health care saw the highest increase at 12.4% per beneficiary while out-of-pocket payers had the highest decrease in pharmaceutical spending at 7.6%. Across all types of care, we see a decrease in service utilization and a growth population size (Figure 16).

Figure 15: Age-standardized growth rate of spend per beneficiary for anxiety disorders, 2019



Source: The DEX Project

Figure 16: Drivers of spending change for three health conditions with largest growth, 2010 - 2019

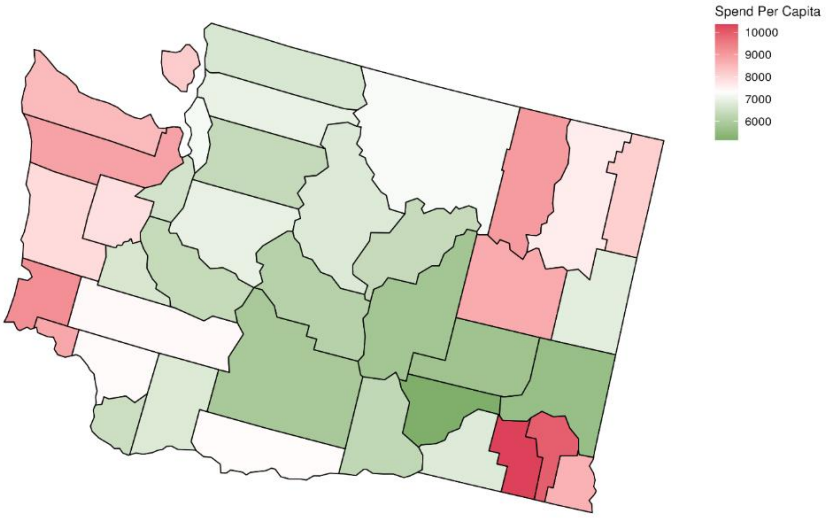


Source: The DEX Project

Health care spending variation within Washington

The DEX project shows that health care spending varies dramatically throughout Washington state. In 2019 the counties with the largest spending per person were Columbia County, Garfield County, and Pacific County, with $10,355, $9,964, and $9,214 health spending per person. On the other hand, Franklin County, Whitman County, and Adams County were the counties with the smallest spending per person.

Figure 17: Health care spending per person in Washington by county, 2019



Source: The DEX Project

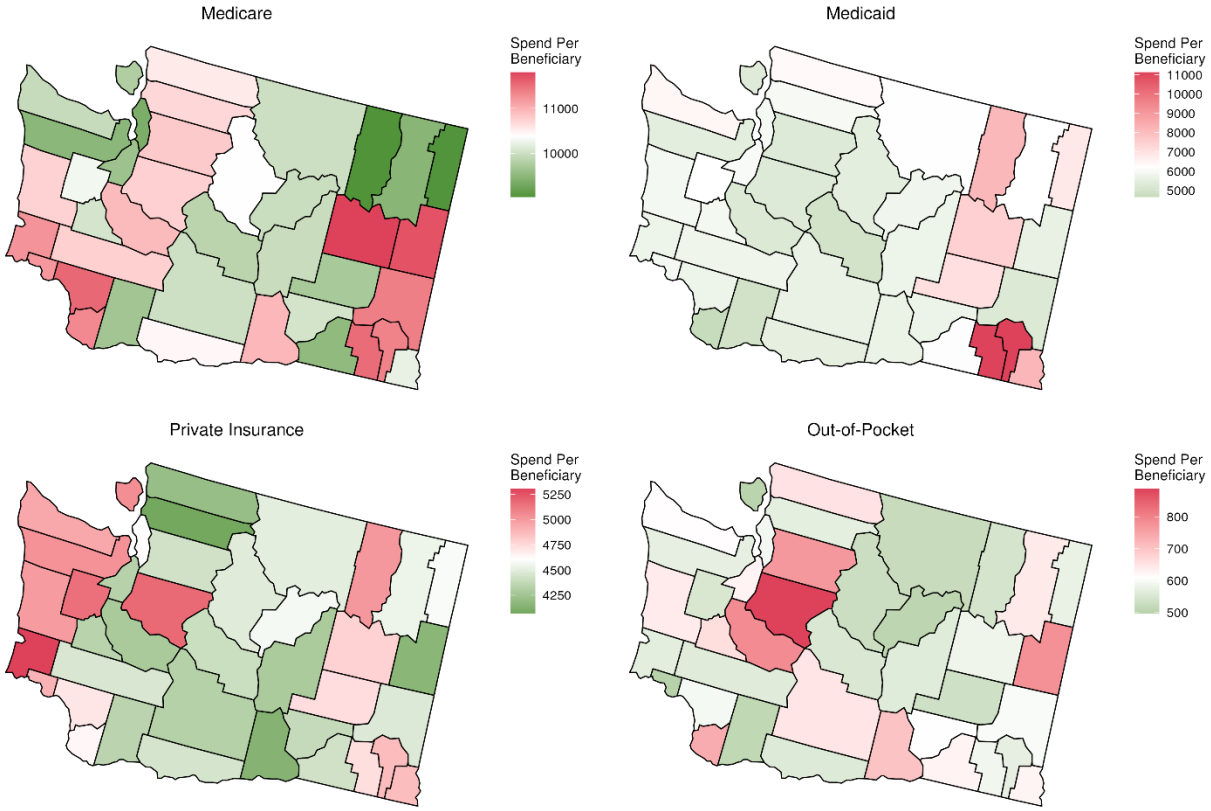
Figure 18: Health spending per person versus growth rate by county, 2010 to 2019

Source: The DEX Project

When age-standardized, Douglas, San Juan, and Kittitas County had the lowest spending per capita, with Columbia and Garfield County having the highest spending per capita. Clallam county had the largest growth rate in 2019 yet still does not surpass Garfield County – which experienced a near 1% growth rate of age-standardized spending (Figure 18).

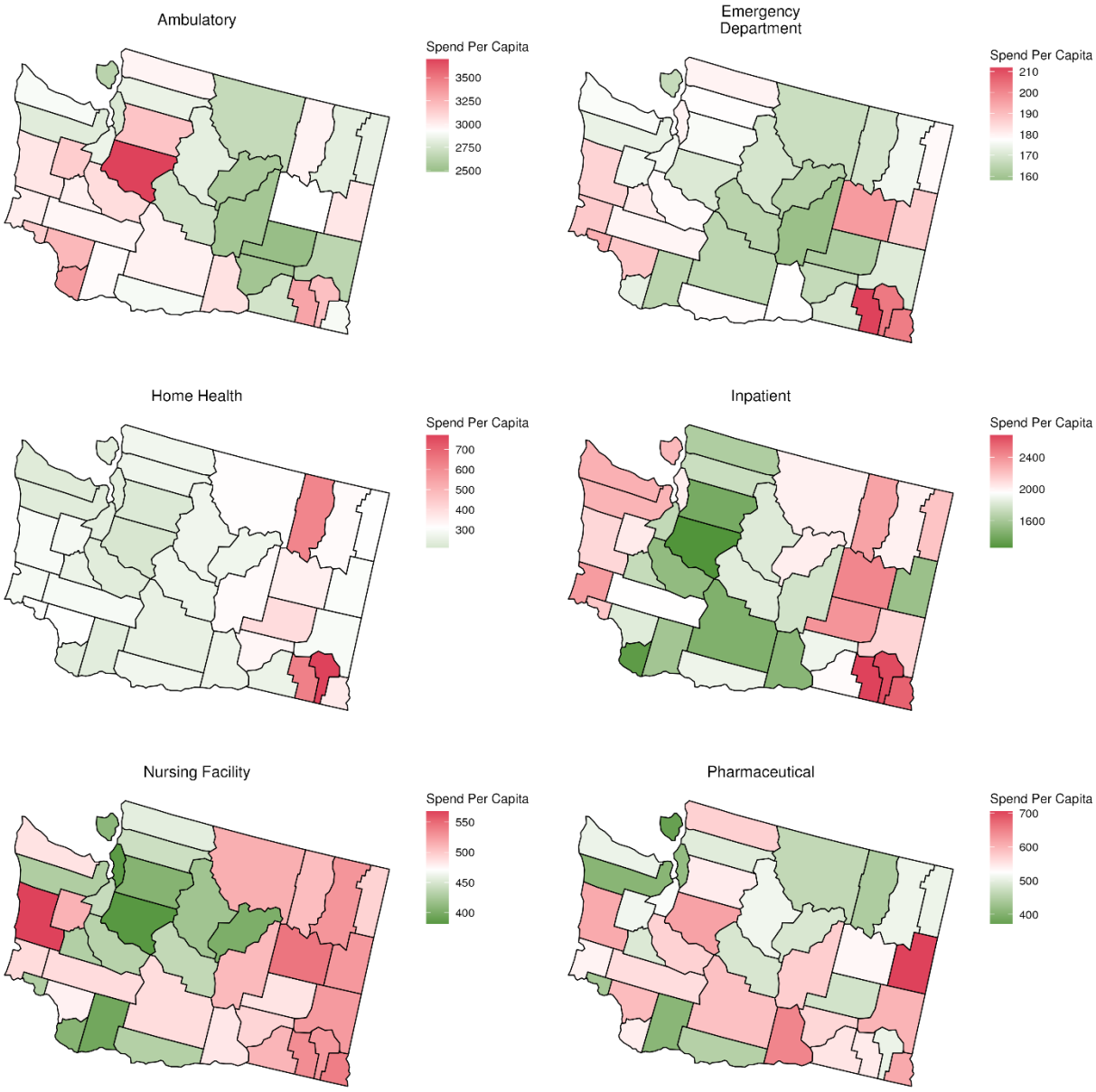
The DEX project showed that spending varied dramatically for each payer category (Figure 19) and for each type of care (Figure 20). These differences are explained in Figure 21 which breaks apart the difference in each county's spending per person relative to the all-Washington mean. Figure 22 highlights the drivers of higher spending in each county between 2010 and 2019.

Figure 19: Age-Standardized Spending per Beneficiary by Payer



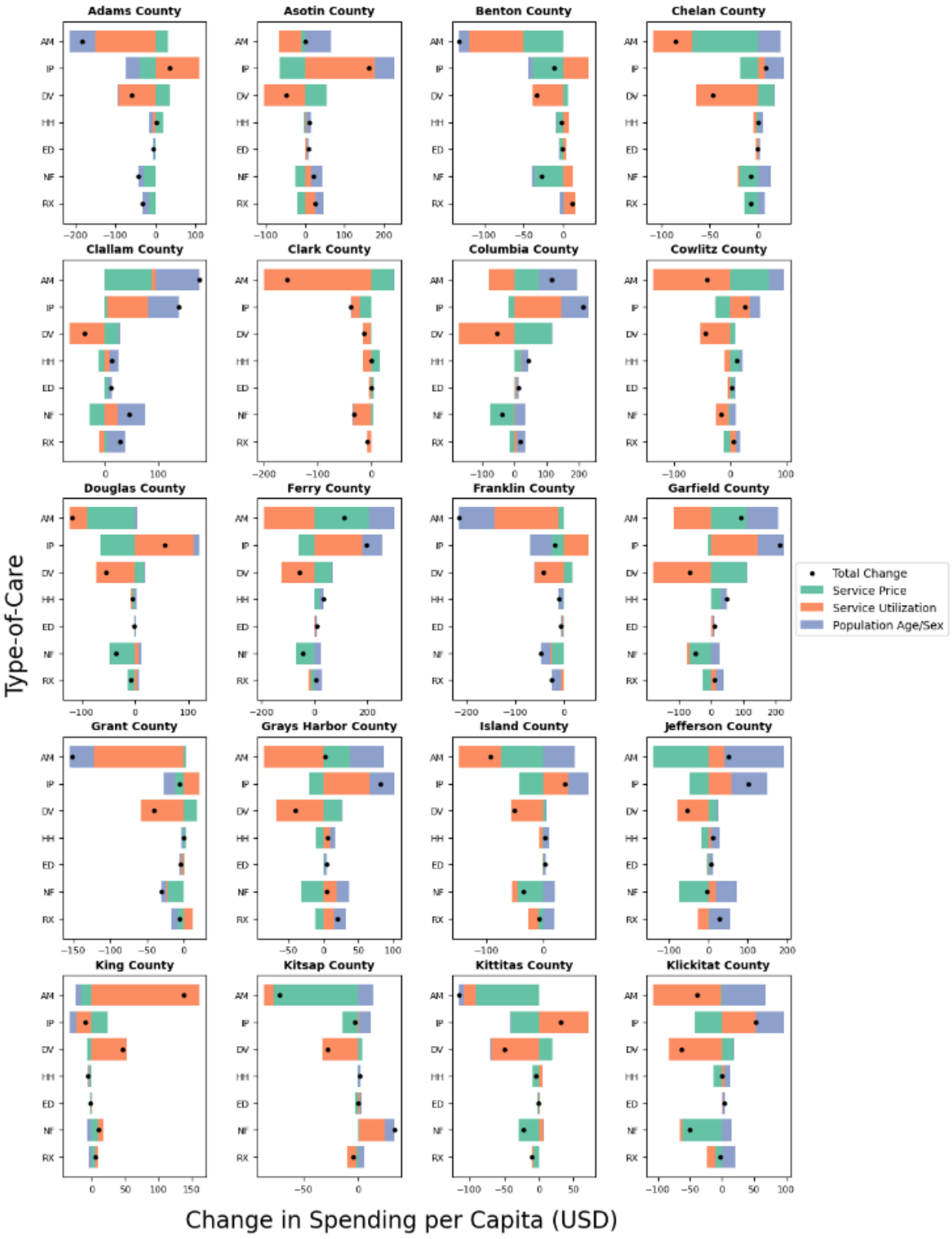
Source: The DEX Project

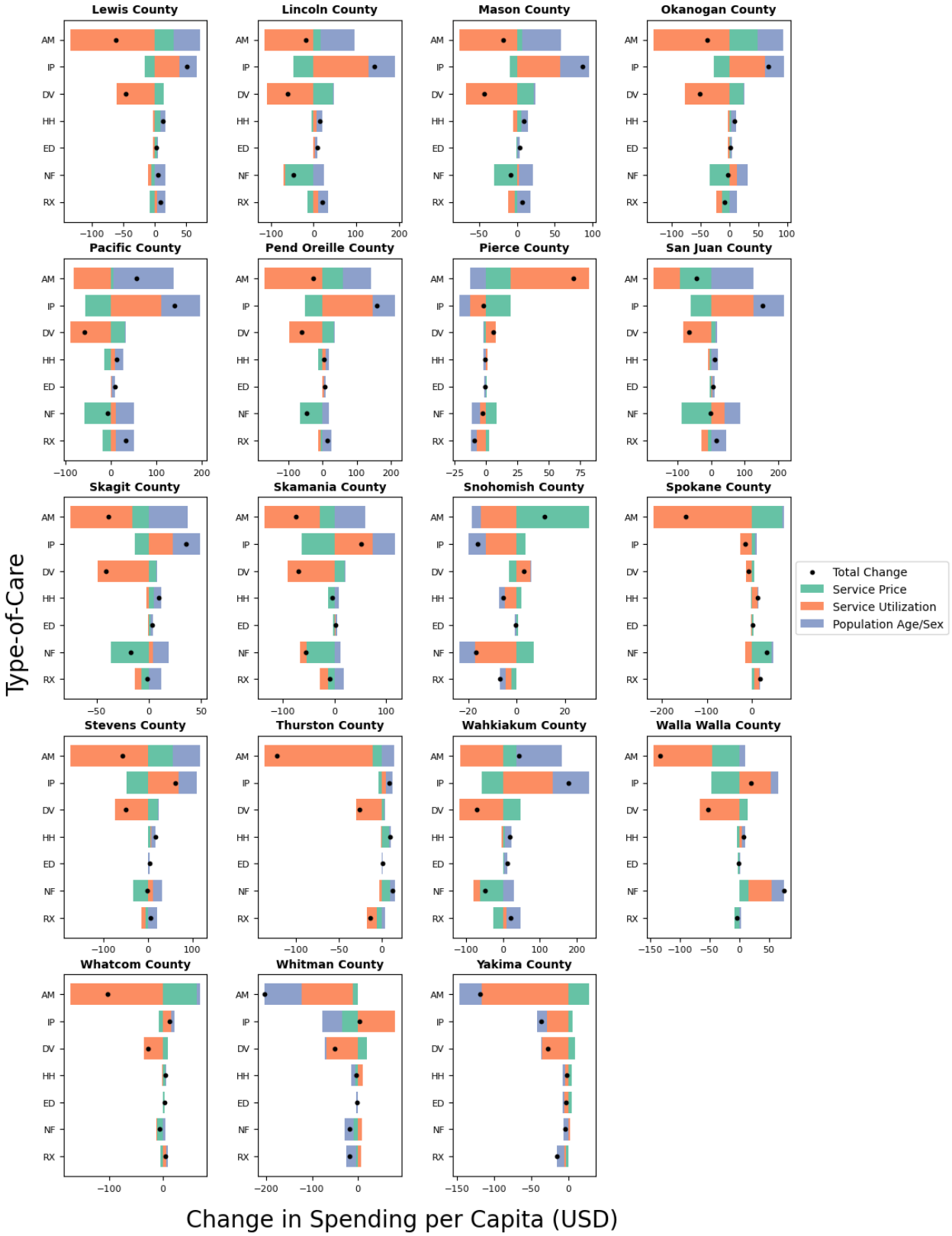
Figure 20: Age-Standardized Spending per Person by Type of Care



Source: The DEX Project

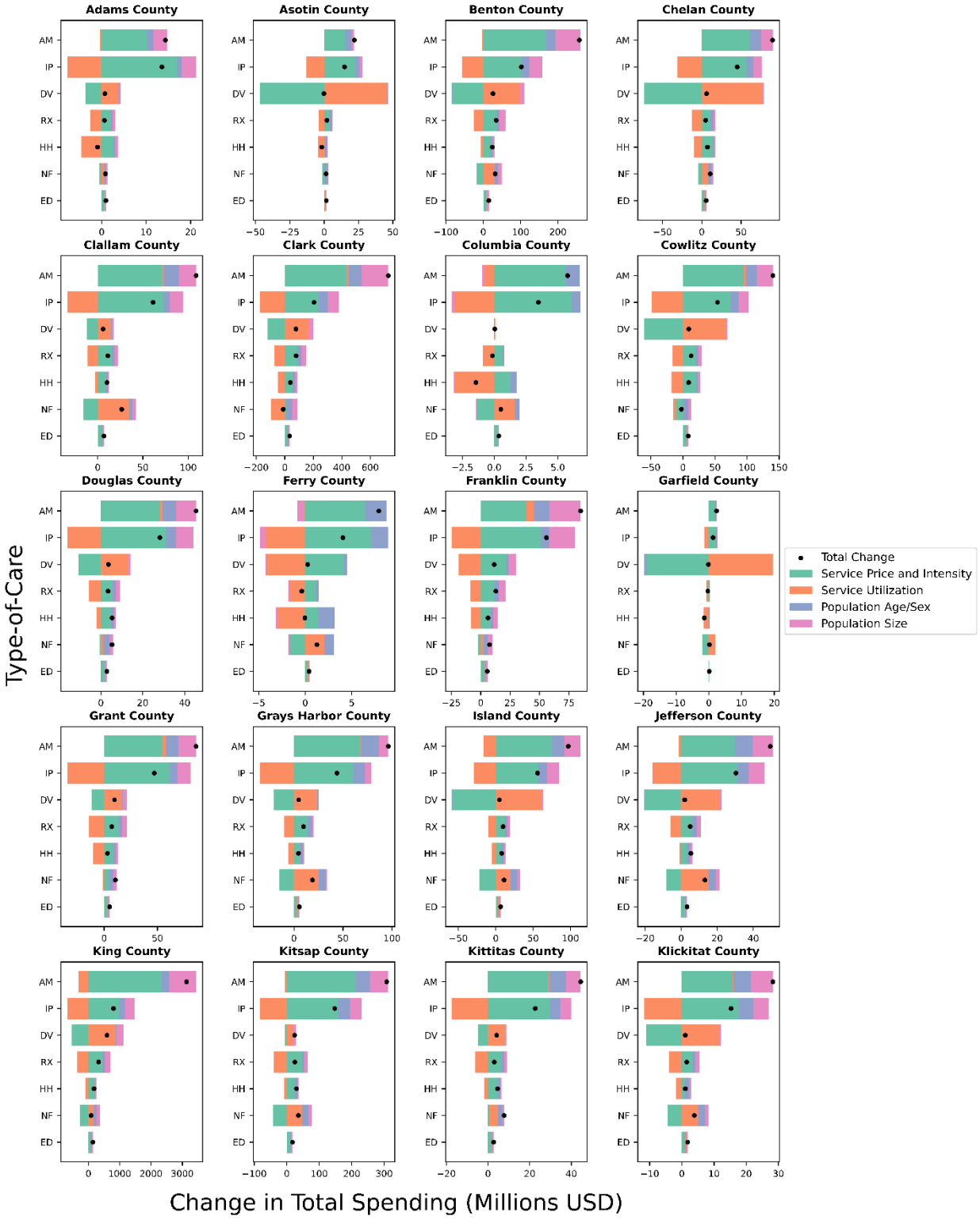
Figure 21: Drivers of Spending per Person Change for Washington State Counties Compared to Overall State Spending per Person, 2019

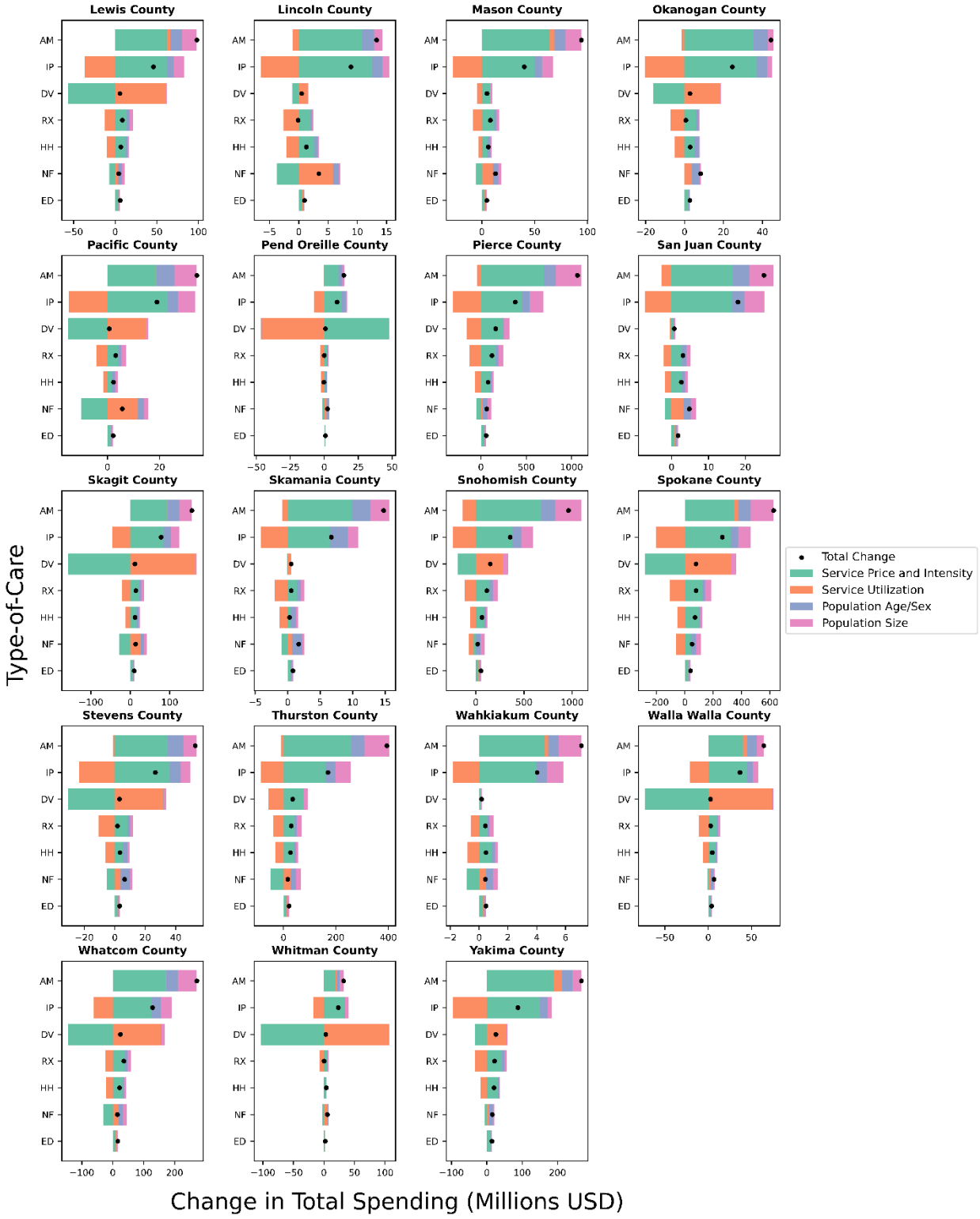




Source: The DEX Project

Figure 22: Drivers of spending change for Washington state counties, 2010-2019





Source: The DEX Project

Connecting these findings to the Health Care Cost Transparency Board's key priorities

This initial report and the initial Analytic Strategy for the ASI, approved on December 7, 2023, align well with the efforts of Health Care Cost Transparency Board (the Board) to control the growth of health care costs in Washington. At the Board retreat held on February 9, 2024, members discussed and were polled on what policies would be the focus for further discussion in 2024. The following four strategies received the strongest interest.

1. Price growth caps and provider rate setting
2. Limiting facility fees
3. Restricting anti-competitive clauses in health care contracting
4. Review of mergers & acquisition, private equity, and health care facility closures

Capping price growth is a method to curtail health care spending increases far in excess of inflation and wage growth, relying on oversight and enforcement mechanisms to incentivize cost savings. Along similar lines, provider rate setting is a more direct method to control spending setting payment levels of services across providers. This approach lowers the administrative burden for providers and carriers by eliminating the need for negotiations and streamlining claims processing. Together, these concepts have garnered the strongest interest from the Board.

Critically, by providing granular estimates of spending, this project offers insights into how these specific policies could be leveraged to contain the spiraling growth of health care costs. Figure 9 highlights acutely that the primary reason for spending increases over time in the state, other than increases in the population size and age, are related to increases in price and intensity of care. Increases in price and intensity led to increases in spending across all types of care except emergency department care. In ambulatory care and inpatient care, increases in price and intensity led to an increase in annual spending of $6.4 and $1.9 billion between 2010 and 2019.

Looking ahead to 2024, the impacts of the policies of most interest to the Board will be examined by a broad set of analytic efforts. The data products produced by the ASI project will take a more comprehensive examination of pricing by incorporating data from the HCA's All Payer Claims Database. Building on the solid foundation of IHME's nationally focused DEX project, the successor ASI analysis will generate valuable insights with a report and data products specific to Washington. The baseline analysis will generate state- and county-level health care spending estimates across 158 health conditions and four payer categories. These estimates will also be adjusted by leveraging demographic and disease prevalence data, examining drivers by county and examining specific extraordinary spending when identified. An interactive dashboard will leverage the estimates produced in the ASI analysis to highlight the impact of policies of most interest to the Board. Together, the report and dashboard will offer in-depth examination of spending across markets, equipping the Board with needed information to evaluate policies which could curb the growth of health care spending in Washington.